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Coroner Simon McGregor
Coroners Court of Victoria
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Warning: this letter contains references to an Aboriginal person who has passed away.

Dear Coroner McGregor

I refer to your findings in the inquest into the passing of Veronica Nelson.

Veronica was a proud Gunditjmara, Dja Dja Wurrung, Wiradjuri and Yorta Yorta woman. I wish to acknowledge that her passing, which occurred while she was separated from her family, community, culture and Country, was tragic and preventable. I also wish to extend my deepest sympathies to Percy Lovett, Aunty Donna Nelson and all of Veronica's family and those who loved her.
I, like every Victorian, found the circumstances of Veronica's passing profoundly upsetting. As Attorney-General, I am committed to improving our criminal justice system, especially for Aboriginal Victorians.

Some of the measures that the Victorian Government is taking to work towards this goal are set out in the response to your findings enclosed in this letter. These initiatives represent a necessary first step, but more work is needed to carefully consider how to best deliver systemic improvement. Given the issues brought to light by the inquest, it is critical that this work occurs in collaboration with Victorian Aboriginal communities to ensure their voices are at the centre of our reform initiatives.

Thank you for your thorough examination and for casting light not only on the circumstances of Veronica's passing but also on the person Veronica was to those who knew her best, using Veronica's own words.

You can contact Kate Houghton, Secretary, Department of Justice and Community Safety at [redacted] if you require any further information about the Victorian Government's response.

Yours sincerely

Jaclyn Symes MP
Attorney-General
Minister for Emergency Services

28/04/2023

VICTORIAN GOVERNMENT RESPONSE TO THE CORONER'S RECOMMENDATIONS

The Victorian Government response incorporates the responses of the Department of Justice and Community Safety (**DJCS**) and Department of Health. The Coroner will receive separate responses from Victoria Police, Magistrates' Court of Victoria, the Victorian Legal Admissions Board and the Commissioner of the Victorian Legal Services Board.

Overview

The Victorian Government accepts that action must be taken to ensure people who do not pose a threat to community safety do not needlessly enter our prison system. Where a person does enter the State's custodial system, that system must also safeguard their safety and wellbeing and – critically – ensure the person can receive person-centred, unbiased, and culturally appropriate healthcare that meets their needs. The Victorian Government recognises that Aboriginal Victorians disproportionately come into contact with the criminal justice system, placing them at greater risk of harm and creating the need for specialised services and support.

While the inquest concerned events that took place at Dame Phyllis Frost Centre (DPFC), the Government acknowledges the urgent need to prevent future tragic and unnecessary deaths of Aboriginal people in custody in all Victorian prisons. As critical first steps:

- The Government is committed to **amending the State's bail laws** as a matter of priority, including to address the disproportionate adverse effect on Aboriginal women.
- **Primary healthcare** services in the women's custodial corrections system **will be provided by public providers**, Western Health and Dhelkaya Health, from 1 July 2023.
- **All primary health care providers** across Victorian public prisons **will provide a new model of health services** from 1 July 2023, which includes:
    - An Aboriginal specific health check (equivalent to the Aboriginal and Torres Strait Islander Health Check (Medicare item 715) available to Aboriginal people in the community).
    - Integrated Care Plans for Aboriginal people to support an individual's health journey.
    - Added services to strengthen health-related release planning and continuity of care for Aboriginal people in prison.
    - An enhanced Aboriginal workforce that includes Aboriginal Health Practitioners and Aboriginal Health Workers.
- The Government has **funded the Aboriginal Justice Caucus (AJC)** to undertake **a review of Victoria's implementation of the recommendations made by the Royal Commission into Aboriginal Deaths in Custody**. The AJC is a self-determining body that works in partnership with the Victorian Government to improve Aboriginal justice outcomes through successive Aboriginal Justice Agreements spanning over 20 years. Its members are the Chairs of the Regional Aboriginal Justice Advisory Committees, Aboriginal community leaders, and representatives from Aboriginal peak bodies and Aboriginal Community Controlled Organisations.
- DJCS will work with the AJC on the outcomes of the AJC-led review, which may intersect with the implementation of the current, and development of future, Aboriginal Justice Agreements between AJC and government.

Responses to recommendations

The responses below include information about action that has been, is being, or will be, undertaken directly in response to the recommendations. Several recommendations require ongoing consideration, including by Cabinet, or consultation with stakeholders. These recommendations have therefore been marked ‘under consideration’.

RECOMMENDATIONS

Recommendation 1. I recommend that the Victorian government consider funding allocations sufficient to facilitate achievement of the recommendations that follow.

The Coroner's recommendation is under consideration.

The Victorian Government recognises the need to ensure that the outcomes sought by the Coroner's recommendations can be meaningfully realised. While many of the recommendations require little to no funding to implement, others may require more substantial investment. The Victorian Government will carefully consider funding and resourcing requirements to support implementation, having regard to your recommendations and the issues identified in the inquest and other priority reforms across the system, including any reforms arising from the Cultural Review into the Adult Custodial Corrections System (Corrections Cultural Review).

Recommendation 2. I recommend that the Victorian Government in consultation with Victoria Police, the Department of Justice and Community Safety, the Department of Health and peak Aboriginal and/or Torres Strait Islander organisations urgently develop a review and implementation strategy for the State's implementation of the 339 recommendations of the 1991 Final Report of the Royal Commission into Aboriginal Deaths in Custody.

An alternative to the Coroner's recommendation will be implemented and implementation has commenced.

The Victorian Government has funded the AJC to undertake an independent and Aboriginal-led review of Victoria's implementation of the recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADC). Funding for this review was allocated in April 2022, with the final report due in 2024. The AJC review of RCIADIC implementation will inform next steps to respond to outstanding recommendations as identified in the review. Government will work in partnership with AJC in responding to the review including options for implementation and the intersection with the implementation of the current, and development of future, Aboriginal Justice Agreements between AJC and government.

As noted in your findings, the Aboriginal Justice Agreements are a 23-year partnership between Victorian Aboriginal communities and successive governments. The agreements are a direct response to a recommendation of the RCIADIC and, following the Ministerial Summit on Indigenous Deaths in Custody, marked a move away from a recommendation by recommendation-based implementation approach to developing and prioritising criminal justice reforms agreed with the Victorian Aboriginal communities, represented through the AJC.

The development of actions under successive Aboriginal Justice Agreements are informed by the recommendations of RCIADIC but also utilise findings from more contemporary reviews and reports as well as the lived and professional experience of AJC members and the communities they represent, including the network of regional and local Aboriginal Justice Advisory Committees across Victoria.

LEGISLATIVE CHANGE

Recommendation 3. I recommend the urgent review of the Bail Act with a view to repeal of any provision having a disproportionate adverse effect on Aboriginal and/or Torres Strait Islander people.

An alternative to the Coroner's recommendation will be implemented and implementation has commenced.

The Victorian Government acknowledges the disproportionate impact that the 2018 Bail Act reforms have had on First Nations people and is committed to reform.

Bail Act reforms refining the unacceptable-risk test and limiting the reverse-onus test to those charged with serious offences and those who pose a terrorism risk have received in-principle support from Cabinet. DJCS is currently consulting on the proposed reforms, with a view to returning to Cabinet and reforms being introduced into Parliament later this year.

Recommendation 4. I recommend urgent legislative amendment of the Bail Act including that:

- **4.1. section 4AA(2)(c) is repealed ('double uplift');**
- **4.2. clause 1 of Schedule 2 is repealed (including any indictable offence in certain circumstances within reverse onus regime);**
- **4.3. clause 30 of Schedule 2 is repealed (including bail offences within reverse onus regime);**
- **4.4. section 18(4) is repealed;**
- **4.5. section 30 is repealed (failure to answer bail);**
- **4.6. section 30A is repealed (contravention of conduct condition of bail);**
- **4.7. section 30B is repealed (commit indictable offence on bail);**
- **4.8. section 18AA is amended so that –**
  - **4.8.1. an applicant for bail need not establish 'new facts and circumstances' before making a second application for bail; and**
  - **4.8.2. an applicant for bail who is vulnerable (for instance, by virtue of being an Aboriginal or Torres Strait Islander person, a child, or a vulnerable adult as these terms are defined in sections 3 and 3AAAA, respectively, of the Bail Act) need not establish 'new facts and circumstances' before making any subsequent application for bail;**
- **4.9. section 3A is amended to include more guidance to BDMs about the procedural and substantive matters to be considered to ensure application of the section gives effect to the purposes for which it was inserted, including to address the persistent over-representation of Aboriginal people in the criminal justice system;**
- **4.10. revision of section 3A should occur in a manner that is consistent with principles of self-determination of First Nations peoples;**
- **4.11. section 4E(1)(a)(ii) is amended to narrow the scope of commit 'offence' while on bail;**
- **4.12. before a BDM refuses bail to an Aboriginal person, they are required by law to articulate (and record) what enquiries were made into the surrounding circumstances and what factors relevant to sections s3A and s3AAA of the Bail Act were considered to reach the decision;**
- **4.13. BDMs intending to refuse an application for bail are required by law to make all necessary enquiries about, and where necessary note on any remand warrant, any potential custody management issues.**

An alternative to the Coroner's recommendation will be implemented and implementation has commenced.

The Government has committed to introduce a package of bail reforms into Parliament 2023. As noted above, the detail of the proposed reforms is currently subject to consultation with stakeholders and future Government consideration.

While the detail is being considered, the package of reforms is broadly intended to address provisions of the Bail Act that have a disproportionate impact on Aboriginal people. The proposed reforms that are being consulted on would:

- Refine the bail tests to focus on serious alleged offending and serious risk to community safety.
- Reduce the overrepresentation of vulnerable groups in the justice system including women, Aboriginal people and children.
- Provide clear guidance for bail decision makers where the applicant for bail is a child or an Aboriginal adult.
- Promote alternatives to remand and linkages with bail support services and balance the reforms with the rights and protection of victim/survivors and the community.

Recommendation 5. I recommend legislative amendment to section 464FA of the Crimes Act 1958 (Vic) (Crimes Act) to require an investigating official to inform an Aboriginal and/or Torres Strait Islander person in custody not only that the Victorian Aboriginal Legal Service (VALS) has been notified that the person is in custody but also that:

5.1. the purpose of the notification is for VALS to perform a welfare and wellbeing assessment on the person including –

5.1.1. identification of any medical, physical and mental health concerns, disability or impairment (including due to substance use); and

5.1.2. communication of any identified risks to the person's safety while in custody to Police so that appropriate management and care is provided;

5.2. the person may communicate with a VALS Client Notification Officer (CNO);

5.3. with the person's consent, CNOs may advise their family members, partner or other people of their wellbeing and whereabouts; and

5.4. with the person's consent, CNOs will contact a VALS on-call solicitor to provide pre-interview legal advice.

An alternative to the Coroner's recommendation will be implemented and implementation has commenced.

DJCS will consult with stakeholders in 2023 as to whether these requirements would be more appropriately given effect through practice and policy changes.

DJCS is working with Victoria Police to consider opportunities to better support Victoria Police members to provide meaningful information about the services VALS and Aboriginal Community Justice Panels (who deliver cultural and welfare support to Aboriginal people in custody) provide, and ensure an Aboriginal person brought into custody can make an informed decision about whether to ask to speak to a VALS Client Notification Officer.

Recommendation 6. I recommend legislative amendment to sections 464A(3) and 464C of the Crimes Act, respectively, to require, in accordance with the principles known as the Anunga Principles,[1] an investigating official to explain to an Aboriginal and/or Torres Strait Islander person in custody in simple terms:

- **6.1. the meaning of the caution and ask the person to tell the investigating official in their own words, phrase by phrase, what is meant by the caution to ensure that both the right to remain silent and that anything they do or say may be used in evidence is understood; and**
- **6.2. the meaning of each communication right and ask the person to tell the investigating official in their own words, phrase by phrase, what is meant by the rights to ensure they are understood.**

An alternative to the Coroner's recommendation will be implemented and implementation has commenced.

DJCS will consult with stakeholders in 2023 as to whether these requirements would be more appropriately given effect through practice and policy changes.

DJCS is working with Victoria Police to consider opportunities to better support Victoria Police members to provide meaningful information to Aboriginal people brought into custody about the meaning of the caution and each communication right, and to ensure those are understood.

CUSTODIAL HEALTH – GOVERNANCE AND SCRUTINY

Recommendation 18. I recommend that the Victorian Government revise the system for auditing and scrutiny of custodial health care services to ensure that it is:

- **18.1. independent;**
- **18.2. comprehensive;**
- **18.3. transparent;**
- **18.4. regular;**
- **18.5. designed to enhance the health, wellbeing and safety outcomes for Victorian prisoners;**
- **18.6. designed to ensure custodial health care services are delivered in a manner consistent with Charter obligations; and**
- **18.7. that the implementation of any recommendations for improved practice identified by the system for auditing and scrutiny is monitored.**

This recommendation will be implemented, and implementation has commenced.

Justice Health, a business unit within DJCS, is currently scoping the design for a new model for auditing and scrutiny of custodial health care services, with the aim of ensuring the system is independent, comprehensive, transparent, regular, appropriately monitored and designed to ensure quality services are delivered to people in custody in line with obligations under the *Charter of Human Rights and Responsibilities Act 2006* (Charter).

The scoping will:

[1] *R v Anunga and ors and R v Wheeler and another* (1976) 11 ALR 412.

- Build on improvements embedded through the new service specifications, a new Health Services Quality Framework, and performance framework, which come into effect from 1 July 2023 (discussed further at Recommendation 21 below).
- Occur in consultation with the Department of Health and regulatory bodies such as Safer Care Victoria, as well as with the AJC.

As an interim approach, Justice Health is also reviewing the clinical oversight that will be in place for each service provider when new primary health contracts commence on 1 July 2023.

Recommendation 19. I recommend that the Department of Health and the Department of Justice and Community Safety:

19.1. consult to determine, from a clinical patient outcome perspective, which department should have oversight of custodial health services; and

19.2. consult with stakeholders (including peak clinical bodies, organisations representing the lived experience of prison, public health services, private health providers, Aboriginal and Torres Strait Islander community representatives) to determine what model of healthcare delivery will achieve the best health outcomes for people in Victorian prisons.

Recommendation 19.1 will be implemented and implementation has commenced.

DJCS and the Department of Health are determining the best consultation mechanism.

Recommendation 19.2 has been implemented.

DJCS has developed a new service model for the provision of primary healthcare services across the State's public prison system, underpinned by a revised Health Services Quality Framework. The new service model was developed in consultation with key stakeholders, including:

- The Aboriginal Health, Public Health, Mental Health and Wellbeing, Alcohol and Other Drugs and System Commissioning divisions of the Department of Health.
- Aboriginal people with lived experience.
- AJC and its Reintegration and Rehabilitation Collaborative Working Group.
- The Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
- Peak bodies, such as the Royal Australian College of General Practitioners and VicHealth
- The School of Population and Global Health, University of Melbourne.
- Health and community service providers, including Wintringham, Forensicare and the Centre for Culture, Ethnicity and Health.
- Other jurisdictions – including, the Department of Health, Western Australia and Justice Health and Forensic Mental Health, New South Wales.

Further information about the new service model is at **Annexure A**.

A key feature of the new health services model is ongoing and regular consultation with stakeholders, particularly service users, to understand the impact of the new services. DJCS is developing a framework to support ongoing evaluation. The evaluation framework will measure the extent to which primary health services are being delivered as intended, and whether desired outcomes have been achieved. Measures will also be designed to reflect meaningful outcomes, such as improved continuity of care, culturally safe health services that support self-determination, qualified staff providing

respectful care, access to health information that enables health agency, and person-centred, high-quality care that meets individual needs.

CUSTODIAL HEALTH POLICY

Recommendation 20. I recommend that Justice Health:

20.1. immediately amend the Justice Health Opioid Substitution Therapy Guidelines (OST Guidelines) to enable medical practitioners to prescribe opioid substitution therapy to women whose health may be at significant risk by being required to undergo opiate withdrawal; and

20.2. urgently review the OST Guidelines to ensure that all women with opioid dependencies are given access to opioid substitution pharmacotherapy upon reception to prison, including the option of methadone or suboxone and their long-acting injectable buprenorphine formulations, irrespective of the length of incarceration.

This recommendation will be implemented and implementation has commenced.

As an immediate first step, DJCS will release updated guidance material to all Health Service Providers across the adult and youth custodial system stipulating that, where clinically appropriate:

- Opioid Substitution Therapy (OST) can be prescribed to people whose health may be at significant risk while undergoing opiate withdrawal.
- All people with opioid dependencies be considered for opioid substitution pharmacotherapy upon reception to prison.

Justice Health will engage with key experts in AOD health service provision, including Western Health, on this work.

Justice Health has also commenced a wholesale review and revision of its OST Guidelines. The Review will include:

- An assessment to identify any modifications needed to safeguard people's human rights in a custodial setting, in line with obligations under the Charter.
- External review of guidelines by addiction experts.
- Collaboration with Corrections Victoria to ensure the revised guidelines address the particular needs of custodial settings.

The review will be completed in 2023 and Justice Health will then provide updated OST Guidelines released to Health Service Providers. Justice Health will also support Health Service Providers to ensure the new guidelines are implemented. Corrections Victoria will also review its operational policies to align with the updated Guidelines.

Recommendation 21. I further recommend that Justice Health review and, if necessary, revise the Justice Health Quality Framework.

This recommendation has been implemented.

Justice Health has recently updated the Healthcare Services Quality Framework for Victorian Prisons 2023 (Framework), which is included at **Annexure B**. The Framework will come into effect on 1 July 2023 in public prisons. The Framework will eventually apply across all adult prisons, and work is currently underway to plan for its implementation in private prisons.

The Framework – which aligns with the National Safety and Quality Health Service Standards – articulates the standard of care expected from Healthcare Service Providers and the unique requirements of delivering care in the prison system.

The Framework:

- Is structured around quality domains with clearly defined outcomes, action areas and corresponding requirements providing a clear structure for auditing the compliance of health service providers.
- Reflects the service enhancements in the new primary health contracts across the prison system, commencing on 1 July 2023 including:
    - Additional roles in the multidisciplinary team to manage complex care needs, including nurse practitioners
    - Designated Aboriginal roles and expectations on Health Service Providers to build cultural safety in their workplace
    - Strengthened response to priority cohorts to support community equivalence in health care
    - An enhanced population health approach to support early detection, prevention and health protection activities
    - End-to-end response to drive integration between medical and psychosocial responses to Alcohol and Other Drug (AOD) harm and withdrawal
    - Enhanced primary mental health services to include health promotion and education for prisoners to drive their own recovery and care decisions.
- Requires Health Service Providers to establish ongoing review and improvement processes in relation to inclusive, reflective and trauma informed practices, unconscious bias, and confidentiality.
- Incorporates Aboriginal cultural safety health standards, as previously endorsed by the AJC.
- Is intended to be a living document responsive to changes in clinical practice and the needs of service users. Justice Health will establish a cycle of regular reviews of the Framework, in consultation with stakeholders, service users and health service providers. The Framework will also be updated if new cultural safety standards are endorsed by AJC.

Justice Health has also developed a new service specification (included at **Annexure C**) and performance framework for the men's public prison contract, which set requirements for enhanced service delivery and more inclusive, person-centred care.

CUSTODIAL HEALTH SERVICES

Recommendation 22. I recommend that the Victorian Government establish a subacute unit at the Medical/Health Centre at Dame Phyllis Frost Centre available to all prisoners who require it, and that includes oversight by a specialist who has completed Advanced Training in Addiction Medicine.

This recommendation is under consideration. The intent of this recommendation is supported, but further work is required so that Government can consider the feasibility of implementing the recommendation as well as different options to achieve the recommendation's intent.

As noted in response to recommendation 19 above, Western Health will provide primary health services at DPFC from 1 July 2023. Justice Health and Western Health will work together to consider the capability, capacity, and infrastructure required to establish a sub-acute unit at DPFC, and to clearly define the services that should be provided in a sub-acute unit on site, as opposed to in a hospital. While consideration of this recommendation is ongoing, DJCS is exploring the measures included in recommendation 23 as an interim option (discussed further below).

Recommendation 23. As an interim measure, until a subacute unit on site at Dame Phyllis Frost Centre is operational, I recommend that an agreement or Memorandum of Understanding be agreed as a matter of urgency between Corrections Victoria, Justice Health and Correct Care Australasia and/or the Health Service Provider at the Dame Phyllis Frost Centre and the most appropriate proximate public hospital for the provision of equivalent community health services not presently provided at the Medical/Health Centre.

This recommendation is under consideration given the current transition to public provision by Western Health.

Justice Health is currently working with Western Health to transition to the new model of primary health service delivery at DPFC by 1 July 2023. This includes finalising processes and procedures to implement the new model of care and meet the needs of women at DPFC.

As part of that work, Justice Health, Western Health and Corrections Victoria will explore what health services may require an agreement or Memorandum of Understanding with the most appropriate proximate public hospital.

Recommendation 24. I recommend that the Victorian Government establish at the Medical/Health Centre at the Dame Phyllis Frost Centre Point-of-Care testing in accordance with requirements that are equivalent to the Royal Australian College of General Practitioners Standards for Point-of-Care testing.

This recommendation is under consideration with Western Health. The intent of this recommendation is supported, but further work is required so that Government can consider the feasibility of implementing the recommendation as well as different options to achieve the recommendation's intent.

Justice Health will explore options for introducing appropriate levels of Point-of-Care testing at DPFC with Western Health.

Recommendation 25. I recommend that the Department of Justice and Community Safety and/or Justice Health, in partnership with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), take concrete steps to build the capacity of VACCHO to provide in-reach health services in prisons.

Implementation of part of this recommendation has commenced, but the recommendation is otherwise under consideration.

The Continuity of Aboriginal Health Care Program, which commenced in March 2023, has been funded for two years at DPFC and Fulham Correctional Centre to support Aboriginal and Torres Strait Islander people's access to culturally safe health care.

The Program is being delivered by Victorian Aboriginal Health Service (VAHS) and provides pre and post release support to engage in culturally appropriate health services in the community upon release. As part of the Program, VAHS provides transition support at DPFC for two to three days per week to engage women in custodial health care services and pre-release health care planning.

The Program will be evaluated to measure changes in patient experience and health outcomes. This will help determine suitability, and required resources, for roll out to other prisons.

DJCS will partner with the ACCHO sector to develop an Aboriginal-led model of healthcare and identify additional measures to support capacity-building of Aboriginal Controlled Health Organisations to provide in-reach prison health services.

Recommendation 26. I recommend that Justice Health and Correct Care Australasia and/or the Health Service Provider at Dame Phyllis Frost Centre ensure that all Aboriginal and/or Torres Strait Islander prisoners have the option during the reception medical assessment of consulting with an Aboriginal Health Practitioner or Aboriginal Health Worker, either in person or by telehealth, within 48 hours. The prisoner's response to this offer should be documented.

An alternative to this recommendation will be implemented and implementation has commenced.

Under the new health service model commencing 1 July 2023, two full-time Aboriginal Health Liaison Officers will be employed by Western Health and based at DPFC, to provide seven day a week coverage. The increased presence of Aboriginal Health Liaison Officers will enhance opportunities for Aboriginal women to engage with Aboriginal health professionals should they wish to do so. Justice Health is working with Western Health to explore rostering and on-call arrangements to maximise these opportunities.

All reception medical assessments must occur within 24 hours of reception. Currently over half of all receptions into DPFC occur after 4 pm, which may present challenges for Health Service Providers to meet the 24-hour requirement and ensure an Aboriginal Health Liaison Officer is available. Justice Health will work closely with Western Health during the transition-in period, and upon service commencement, to develop alternative options where Aboriginal staff are not available within the required 24 hour-timeframe. These may include a follow-up appointment as soon as practicable.

When an offer for a consultation with an Aboriginal Health Practitioner or Health Worker is made but declined, this will be noted in the prisoner's health record. Those services will also continue to be offered.

Recommendation 27. I recommend that Corrections Victoria and Correct Care Australasia and/or the Health Service Provider at the Dame Phyllis Frost Centre develop and implement a robust procedure for 'clearance' of a prisoner (at initial reception or subsequently) from the Medical/Health Centre to a cell elsewhere at Dame Phyllis Frost Centre that requires certification in writing by a medical practitioner that the prisoner is fit to be confined in an unobserved cell.

27.1. The medical practitioner's certification should include:

27.1.1. confirmation that the prisoner is medically fit to leave the Medical/Health Centre;

27.1.2. whether the medical practitioner recommends any medical or management observations to ensure the prisoner's health or wellbeing;

27.1.3. identification of any specific clinical deterioration risk indicators the medical practitioner recommends custodial and health staff monitor; and

27.1.4. instructions to guide the response, including escalation of the prisoner's care, if clinical deterioration risk indicators are observed.

27.2. If no medical practitioner is available, written certification may be provided by a registered nurse, but any prisoner cleared by a registered nurse should be placed on 60/60 management observations pending medical practitioner review of the prisoner as soon as practicable thereafter.

An alternative to this recommendation will be implemented and implementation has commenced.

The newly established DPFC Improving Shared Care Working Group, comprising of Corrections Victoria, Justice Health and the current Health Service Provider, is responsible for determining and documenting the decision-making processes in relation to the health advice provided on reception to inform initial placement. The group is also responsible for establishing processes to determine placement of women into cells in the Medical/Health centre and clearance out of the Medical/Health centre. This will include the development of procedures outlining custodial and health obligations in completing medical and management observations and in identifying and responding to health deterioration.

Based on the Working Group's preliminary discussions, the medical clearance process will align with the intent outlined in the recommendation with some amendments to ensure that the clinical risks are balanced against disruption to individual women. The proposed model provides for both doctors and registered nurses to certify a prisoner's fitness to leave the Medical/Health Centre, to ensure medical clearance can occur for any prisoners admitted after 6 pm when only nurses are onsite. This is preferred to limiting medical clearance to doctors only, which would see many prisoners placed on what the recommendation describes as 60/60 management observations (also known as 60/60 'custodial observations') where it may not be necessary. 60/60 custodial observations require hourly observations by custodial staff, in recognition that the prisoner's medical risk profile is yet to be assessed. While 60/60 custodial observation is sometimes the most appropriate way to monitor someone, nightly hourly checks can be very disruptive to prisoners, impact on sleep and not align with best-practice trauma-informed care.

While this work is underway, DPFC has introduced the practice of placing all women on 60/60 custodial observation if they are unable to be reviewed by a health professional on reception.

As noted above, Justice Health is also working with Western Health to finalise policies and procedures for implementation of the new primary health service delivery model from 1 July 2023. The Working Group's recommendations will feed into this work and Justice Health will work with Western Health to determine appropriate procedures to certify a woman's fitness to leave the Medical/Health Centre and to ensure clearance processes are robust and timely and appropriately manage clinical risk with trauma-informed care.

Recommendation 28. I recommend that Correct Care Australasia and/or the Health Service Provider at the Dame Phyllis Frost Centre, in collaboration with Corrections Victoria and Justice Health, develop and implement clear guidelines to assist custodial and clinical staff to identify a prisoner's clinical deterioration, including the indicators that must result in an escalation of a prisoner's care to clinical staff, a medical practitioner or transfer to hospital.

This recommendation will be implemented and implementation has commenced.

As an immediate response to this recommendation, Justice Health and Corrections Victoria – through the DPFC Improving Shared Care Working Group (referred to above in response to recommendation

27) – are determining and documenting the responsibilities of custodial and health staff to support the identification clinical deterioration; taking into account the different roles and expertise of the respective workforces.

As part of this work, the Working Group is examining supplementary training needs required to support custodial staff to support identification and respond to clinical deterioration including behaviours and observations to report to health staff and how to escalate concerns about a woman's care.

As noted above, Justice Health is also working with Western Health to finalise policies and procedures for implementation of the new primary health service delivery model from 1 July 2023. The Working Group's recommendations will feed into this work and Western Health will also leverage its considerable experience in providing home-based care and primary care in aged care facilities, where clear guidelines for escalation are critical for achieving good patient outcomes.

Recommendation 29. I recommend that Justice Health require custodial Health Service Providers to:

- **29.1. engage with Victoria's Aboriginal and Torres Strait Islander communities to learn how culturally safe and culturally appropriate principles can be embedded into their delivery of health services to Victorian prisoners. This process should be ongoing, guided by Victoria's Aboriginal and/or Torres Strait Islander communities and be conducted in the manner determined by these communities;**
- **29.2. encourage and facilitate the doctors employed by the Health Service Provider to become members of the RACGP to enable them to access RACGP training programs;**
- **29.3. identify alternative alcohol and other drugs training programs for medical practitioners;**
- **29.4. ensure medical practitioners employed or contracted by the Health Service Provider for a period of more than six months complete training equivalent to the Royal Australian College of General Practitioners' Alcohol and Other Drugs GP Education program within six months of the practitioners commencing.**
- **29.5. ensure registered nurses employed by the Health Service Provider complete the Australian College of Nursing's Continuing Professional Development modules in:**
  - **29.5.1. addressing AOD Use in Diverse Communities; and**
  - **29.5.2. opioid Withdrawal Nursing Care and Management.**
- **29.6. employ medical practitioners and nurse practitioner qualified to practise opioid pharmacotherapy; and**
- **29.7. employ a full-time specialist who has completed Advanced Training in Addiction Medicine.**

Recommendation 29.1 has been implemented.

The updated Framework (referred to in response to recommendation 21 above), requires all Health Service Providers to:

- Have an ongoing process of implementing strategies, training programs, and initiatives to continually build the cultural capability of all health staff, including reflective practice, trauma informed care, and training in unconscious bias.
- Deliver culturally safe care through actions such as cultural safety training for all health service staff, and meaningful ongoing partnerships with Aboriginal Community Controlled Organisations.

- Employ, retain and develop Aboriginal staff at all levels of the health workforce, and provide evidence of an Aboriginal employment and retention strategy including professional development and progression opportunities.
- Provide evidence of culturally safe practices for example: improved cultural safety of the health service through community engagement, and organisational initiatives and processes.
- Work closely with ACCHOs and the Aboriginal Health Unit within Justice Health throughout the period of the health services contract. This includes facilitating in-reach services by local ACCHOs. This will help to ensure services comply with the National Aboriginal Community Controlled Health Organisation and the Victorian Aboriginal Community Controlled Health Organisation standards for culturally safe health care.

These requirements do not just apply to the establishment of new healthcare services but are in place for the duration of the contract. They therefore require ongoing relationships and consultation with representatives from the Aboriginal and Torres Strait Islander community. Justice Health will also engage with Aboriginal communities, through the AJC, to inform continuous improvement.

Recommendations 29.2- 29.5 are under consideration.

All Health Service Providers will be required to ensure their staff are appropriately trained to deliver services to the standard required by the Framework. From 1 July, this will include AOD health services (these services are currently provided by a separate provider in public prisons but will be integrated into the primary health model from 1 July 2023).

Justice Health is engaging with new Health Service Providers to explore opportunities for their general practitioners to join the Royal Australian College of General Practitioners, or alternative approaches to enable access to equivalent training opportunities.

Justice Health is also working with all new Health Service Providers to review staff training plans to ensure staff working in custodial settings can access the training outlined in recommendations 29.3 – 29.5 or alternative training which provides equivalent learning outcomes.

Recommendations 29.6 and 29.7 will be implemented within the new service model.

As noted above, from 1 July, the new service model in public prisons will include AOD treatment and support as part of the primary health services. All service providers' staffing models will include practitioners suitably qualified to provide opioid pharmacotherapy. DPFC will also have an Addiction Medicine specialist provided by Western Health seven days per week. Evaluation of this model will inform consideration of expansion to other prisons.

33. I recommend that Corrections Victoria review its practice whereby only two Prison Officers have access to cell keys during the Second Watch overnight at Dame Phyllis Frost Centre and address any impediment to the timely entry to cells that might arise so to ensure prisoner health, welfare and safety.

This recommendation will be implemented and implementation has commenced.

Access to cell keys and the approval processes for opening cells (including, after hours) at the Dame Phyliss Frost Centre will be examined as part of a review being undertaken by Corrections Victoria. This review is expected to be completed by June 2023, with any process changes to be implemented by July 2023.

Recommendation 34. I recommend that the Department of Justice and Community Safety partners with appropriate Aboriginal Community Controlled Organisations to develop and implement a strategy for ongoing cultural awareness training, monitoring and performance review, which is applicable to:

34.1. CV; and

34.2 Correct Care Australasia and/or the Health Service Provider at Dame Phyllis Frost Centre.

Recommendation 34.1 is under consideration. The intent of this recommendation is supported, but further work is required so that Government can consider the feasibility of implementing the recommendation as well as different options to achieve the recommendation's intent.

Cultural awareness training is a mandatory element of all pre-service training for custodial staff working across the public and private prison system. Staff working in the public system participate in a three and a half hour training session delivered by the Koori Heritage Trust. Prison General Managers may also arrange for local level refresher training to prison staff.

In late-February 2023, the Aboriginal Healing Unit project commenced at DPFC, which provides support for Aboriginal women in custody through healing and rehabilitation in a culturally safe way. As part of that project, Aboriginal Cultural Safety training is being delivered by the Aboriginal consultancy, NJAC, to all custodial and Victorian Public Service staff at DPFC. The training was reviewed in consultation with the Aboriginal Justice Caucus Co-Chairs and commenced in late-February with a session delivered to all members of the DPFC Senior leadership team. The training will be progressively rolled-out until the end of 2023.

An alternative to recommendation 34.2 will be implemented and implementation has commenced.

In May and June 2022, Justice Health funded VACCHO to deliver six sessions of cultural awareness training for all Health Service Provider staff.

As detailed in the response to Recommendation 29.1, the new Framework also requires Health Service Provider staff participate in regular cultural awareness training.

The newly established Aboriginal Health Unit within Justice Health will also develop a cultural safety audit and review framework in consultation with community and AJC, to ensure the ongoing cultural safety of Health Service Providers. The Unit is also developing partnerships with the Aboriginal community-controlled sector, Aboriginal academics and subject matter experts to enhance the safety of custodial healthcare. This involves reviewing the current approach to cultural safety training, and monitoring and evaluation to determine its relevance to custodial settings.

In addition, Western Health's *Aboriginal Health Cultural Safety Plan 2022-2025* will apply to its service delivery in DPFC. Relevant actions within the Plan include:

- Mandatory face-to-face cultural safety training for the Board, Executive and Senior Leadership Group.
- Mandatory staff participation in online cultural awareness training for all staff and volunteers
- Development of a cultural learning strategy including a range of flexible learning modalities to cater for the diverse roles and programs within Western Health.

Recommendation 35. I recommend that the Department of Justice and Community Safety develop and implement a policy and deliver training to Corrections Victoria staff about the operation of that policy, to ensure that cultural considerations are incorporated into management of a

deceased Aboriginal or Torres Strait Islander person in custody and, to the extent possible, the scene of that person's passing.

Part of recommendation 35 has been implemented, with the rest of the recommendation under consideration.

To ensure that cultural considerations are incorporated into the management of deceased Aboriginal persons, Corrections Victoria will amend:

- The Commissioner's Requirements (applicable to public and private prisons) relating to Reporting and Review of Deaths in Prison (CR 1.3.3) and Aboriginal and Torres Strait Islander Prisoners (CR 2.7.1).
- The corresponding Deputy Commissioner's Instructions (which must be followed by all public prison staff) relating to Deaths in Prison (DCI 1.20) and Aboriginal and Torres Strait Islander Prisoners (DCI 2.07).

The intent of the recommendation to train Corrections Victoria staff on the operation of the new requirements is supported, but further work is required so that Government can consider the feasibility of implementing that part of the recommendation as well as different options to achieve the recommendation's intent.

Recommendation 36. I recommend that the Department of Justice and Community Safety urgently redesign the Justice Assurance and Review Office and Justice Health Death In Custody reviews to ensure reviews:

36.1. are independent;
36.2. receive input from relevant staff who interacted with or were responsible for decisions affecting the prisoner proximate to their death;
36.3. are comprehensive;
36.4. identify opportunities for improved practice and to enhance the wellbeing and safety of prisoners, rather than merely assess compliance with relevant policies;
36.5. if the deceased is an Aboriginal and/or Torres Strait Islander person, that adequacy of their cultural care (including post-death treatment) is assessed by a suitable member of the Aboriginal community; and
36.6. are timely.

An alternative to recommendation 36.1 has been implemented.

DJCS understands the importance of ensuring that death in custody review processes are sufficiently independent of Corrections Victoria and service providers to provide the department assurance that the review identifies any issues related to the passing and informs immediate improvements prior to a coronial inquest being undertaken.

Justice Health and JARO operate independently of Corrections Victoria and health service providers, including when they review a death in custody and produce a report on that death for the Secretary of DJCS.

In August 2022, several enhancements were also made to Justice Health and JARO processes to bolster the internal assurance function their reports play within DJCS. Many of these are discussed below.

A key enhancement to ensure the independence of internal reviews is the establishment of a Review Oversight Committee (consisting of Deputy Secretaries from relevant DJCS business units) which provides stronger executive oversight and guidance in relation to all reviews into Aboriginal deaths in custody.

The new approach to reviewing any death in custody also ensures reviews support timely identification of actions necessary to prevent or reduce the likelihood of further deaths. This new approach adopts key aspects of Safer Care Victoria's adverse event process.

The reviews now consider the circumstances surrounding the person's death in custody, to identify anything that DJCS can change to prevent future deaths or harm. This includes consideration of:

- The intersection between the health and custodial systems.
- The circumstances preceding the death.
- The management of, and response to, the death.
- The direct cause of the death.
- Systemic factors that contributed to the death.
- The extent to which the person's human rights were protected and promoted.
- Opportunities for systemic improvement.
- Any other issues relevant to the review, such as the implementation of recommendations from previous reviews.

DJCS will also continue to evaluate its review processes and explore options to further improve the effectiveness of review processes in identifying anything that DJCS can change to prevent future deaths or harm.

Recommendation 36.2 has been implemented.

While staff cannot be compelled to participate in a review, the new review process requires:

- JARO and Justice Health to interview relevant health and custodial staff where a death is unexpected.
- Review reports to note where JARO and Justice Health have been unable to interview someone, along with reasons why.
- Regular briefings about staff interviews to the Review Oversight Committee and Aboriginal experts appointed to the reviews (referred to below in response to recommendation 36.6).

Recommendation 36.3 has been implemented.

The new review process:

- Brings together Justice Health and JARO reviews into a single investigation and report (rather than the old model of separate and sometimes conflicting reports). This ensures recommendations consider both health and operational perspectives, making them more meaningful.
- Requires JARO and Justice Health to conduct post-review debriefs to test their own processes and identify opportunities for improvement in future reviews.

Recommendation 36.4 has been implemented.

The new review process includes expanded terms of reference for reviews and new review methodologies with a greater focus on determining the root cause and investigating a greater breadth of issues, such as quality of the care, treatment, and supervision of the deceased prior to death.

Recommendation 36.5 has been implemented.

A panel of Aboriginal experts has been created to support and guide reviews into Aboriginal deaths in custody. A two-member panel has been appointed. The panel will provide advice to JARO and Justice Health to ensure the cultural appropriateness, safety, comprehensiveness and quality of reviews. The panel will have unrestricted access to evidence gathered by Justice Health and JARO and be able to advise on the scope and the direction of the reviews.

The new review process also outlines that reviews must expressly consider:

- Cultural safety and support.
- Human rights under the Charter, including the distinct cultural rights of Aboriginal persons.

In late 2022, JARO and Justice Health review staff also participated in cultural awareness training run by the Victorian Aboriginal Community Services Association Limited.

Recommendation 36.6 will be implemented.

DJCS is committed to ensuring that reviews into deaths in custody are conducted as expediently as possible. Noting the individualised nature of these reviews, DJCS is not proposing to introduce specific review timeframes, but will seek to identify process improvements to further enhance review timeliness while maintaining the integrity of the process.

Recommendation 37. I recommend that Justice Health, Corrections Victoria and Correct Care Australasia and/or the Health Service Provider at Dame Phyllis Frost Centre each review, and if necessary, amend any policy or practice relating to staff 'debriefs' following a death in custody or other sentinel events. The review should consider and clarify:

37.1. the purpose of debriefs, including whether they are intended to serve a staff welfare function, evaluate practice and/or policy to identify systems or other deficits, or a combination of these matters; and

37.2. a process to optimise the participation of relevant staff in any debrief.

This recommendation will be implemented and implementation has commenced.

Corrections Victoria circulated new Guidelines for prison General Managers and Assistant Commissioners across the State's public prison system on Formal Incident Response Debriefs at the end of March 2023.

The Guidelines:

- Focus on reviewing the response to the incident (rather than the antecedents to the incident) and staff wellbeing.
- Clarify that a Formal Incident Response Debrief is an opportunity to assess the incident response and is not intended to replace or guide the formal review process or investigations by JARO, Justice Health, police or the Coroner.
- Stipulate that a Formal Incident Response Debrief should not occur where there is concern that it may compromise any formal review or investigation.

- Include templates and considerations for the Chair of a Formal Incident Response Debrief.

Health Service Provider and Justice Health staff will be invited to attend debriefings, as appropriate.

Western Health has existing policies and procedures relating to debriefing staff following critical incidents and sentinel events. Justice Health will separately work with Western Health to determine whether any adaptations are necessary for the custodial environment (noting, that as outlined above, health staff will have opportunities to participate in Corrections Victoria debriefs).

Recommendation 38. I recommend that the Victorian Department of Health, in collaboration with relevant Aboriginal Community Controlled Health Organisations and other stakeholders, prioritise the design, establishment and adequately resource a culturally safe, gender-specific residential rehabilitation facility for Aboriginal and/or Torres Strait Islander women with drug and/or alcohol dependence.

This recommendation is under consideration. The coronial findings highlight the importance of a strong AOD system for all Victorians, and for Aboriginal specific specialist AOD services, including those involved in the criminal justice system.

The Victorian Department of Health has commenced a comprehensive mental health and wellbeing service and capital planning process which will progressively plan for future mental health and wellbeing services, including services in custodial settings. This is being guided by the development of the first Statewide Mental Health and Wellbeing Service and Capital Plan which is expected to be released in mid-2023, and subsequently eight regional mental health and wellbeing service and capital plans.

Project scoping for the regional planning process will include consideration of how AOD services (including access to services for specific cultural needs across mental health, wellbeing and AOD more broadly) could be incorporated to support planning for services at a regional level.

Further work is required so that Government can consider the feasibility of implementing the recommendation as well as options to achieve the recommendation's intent, in light of the service and capital planning underway. The Department of Health will collaborate with relevant Aboriginal Community Controlled Health Organisations and other stakeholders throughout this process.

The department has funded the VACCHO to lead the co-design for the establishment of two Aboriginal Healing Centres to be established by 2026. The two Healing Centres will be Aboriginal led and operated. They will complement the expansion of social and emotional wellbeing services across Victoria.

Recommendation 39. I recommend that no later than 12 months from the date of this Finding, Corrections Victoria, Justice Health and Correct Care Australasia, as public authorities under the Charter request that the Victorian Equal Opportunity and Human Rights Commission conduct a review under Section 41(c) of the Charter of any improvements to programmes, practices, and facilities made in response to the recommendations above, and provide an overview of the results of that review for publication on the Coroners Court of Victoria website along with the responses to the Recommendations made in this Finding.

This recommendation is under consideration with discussions with VEOHRC already commencing. The intent of this recommendation is supported, and further work is required so that Government can

consider the feasibility of implementing the recommendation, as well as different options to achieve the recommendation's intent.

In the interim, DJCS will work with VEOHRC to develop an implementation framework that can be used to review Government's progress in implementing the Coroner's recommendations and ensure that the outcomes intended by the recommendations are achieved.

ANNEXURE A – Further information about new health services model

The new service model will commence on 1 July 2023, with primary health services delivered by:

- GEO Healthcare in the men's public prison system under a five-year contract
- Western Health and Dhelkaya (Castlemaine) Health at the Dame Phyllis Frost Centre and Tarrengower Prison, respectively.

Recruiting, developing and maintaining a primary health Aboriginal workforce is a key component of service delivery under the new service model.

The model also includes a range of enhancements to improve health care for Aboriginal people in prison, such as:

- An Aboriginal specific health check (equivalent to community's standard of an Aboriginal and Torres Strait Islander (Medicare 715) check) upon reception into custody
- Integrated care plans for all Aboriginal people in custody to support the health journey
- Strengthened health-related release planning, with the appointments to be conducted in consultation with Aboriginal health staff and with involvement from family or local ACCHOs (with a person's informed consent) to support continuity of care
- Alcohol and Other Drug (AOD) health programs specifically tailored for Aboriginal men and women
- An enhanced Aboriginal workforce including Aboriginal Health Workers and Aboriginal Health Practitioners
- Meaningful relationships with ACCHOs to support improved cultural safety in service delivery.

GEO Healthcare's provision of primary health services also includes scholarships for Aboriginal Health Workers certificates and has committed to a five per cent Aboriginal employment target.

Western Health's provision of primary health services at DPFC will be delivered by a multidisciplinary team with new roles: Aboriginal Health Liaison Officers at DPFC, tailored AOD services and health promotion, Senior Drug and Alcohol Clinician, Addiction Medicine Consultant, social worker and dietician. Western Health will also engage the Victorian Aboriginal Health Service to provide in-reach services to Aboriginal women on site and will deliver ongoing health promotion and staff training to improve the cultural safety of the health service.

Dhelkaya (Castlemaine) Health will also deliver improved primary health services to women at Tarrengower Prison and will partner closely with the Bendigo & District Aboriginal Co-operative (BDAC) to deliver in-reach services to Aboriginal women. Dhelkaya Health's service delivery will include new roles, such as Aboriginal Health Workers, an Aboriginal Health Promotion Officer, an Alcohol and Other Drugs (AOD) worker, and a Family and Housing Worker.