Department of Justice

Secretary

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07 NOV 2011

Ms Leyla Stefano
Coroner's Registrar
Coroners Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE 3000

Dear Ms Stefano

Response to recommendations from the coronial inquest into the death of Mr Noel Robert Rogerson at St Vincent's Hospital on 28 March 2009

On 1 September 2011, the Department of Justice received the Coroners Court's findings into the inquest of the death of Mr Noel Rogerson, who died on 28 March 2009 at St Vincent's Hospital. The findings included two recommendations connected with the death of Mr Rogerson and, pursuant to Section 72(2) of the *Coroners Act 2008*, made two recommendations:

1. Both the Office of Correctional Services Review and Justice Health should ensure the smooth implementation of the proposals contained in their submissions in accordance with best practice principles and including:

Justice Health proposals to:

- amend the Notifiable Incident / Event Report template and guidelines including review of medical alert rating, risk rating, medical status and outcome
- develop a template palliative care plan to be used with palliative care prisoners and
- review the process to be followed for the purpose of a plea for mercy, so that a formal protocol is provided to contracted health service providers

2. The Office of Correctional Services Review proposal to amend the terms of reference and content of their reports and identify any deficiencies to better inform.

State Government Victoria

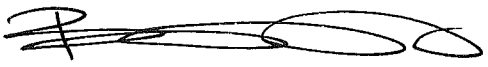
The Department of Justice's response to the coronial recommendations arising from the death of Mr Noel Rogerson is as follows:

- The Justice Health Notifiable Incident/Event Report template was amended and implemented by contracted health service providers in June 2011. The Justice Health Notifiable Incident/Event Guidelines were also amended in July 2011 to include notification by the contracted health service provider to Justice Health in instances where an advanced care plan is commenced.
- In instances where a prisoner is commenced on a palliative care regime, Justice Health confirms that St Vincent's Hospital has developed clinical pathways for palliative care patients. These guidelines are in use at both St Augustine's ward, St Vincent's Hospital and St John's ward, Port Phillip Prison. For end of life patients, the Liverpool Care Pathway is applied.
- With regards to the review of the process of a plea for mercy, Justice Health confirms that this process has been reviewed and submits a copy of the draft protocol. Justice Health anticipates this protocol to be finalised by late November 2011.
- The OCSR has amended the terms of reference for all future reports into deaths in custody to clearly reflect that the OCSR inquiry itself does not address the medical management and care of the prisoner. Any key findings and recommendations arising from the Justice Health review are identified, together with the OCSR recommendations, in the body of the OCSR report.
- The OCSR will ensure that all future OCSR reports clearly identify in the body of the report any deficiency in the medical management of a prisoner as identified in the Justice Health report, whether or not the deficiency has been identified as a key finding or been the subject of a recommendation in the Justice Health report.

In addition to these initiatives, in September 2011, a Clinical Standards and Review position was created within the OCSR, with dual reporting responsibilities to the OCSR and Justice Health. This role includes a range of health-related support to a range of work conducted by the OCSR, including more aligned delivery of reports relating to deaths in custody.

Please contact Liana Buchanan, Director, Office of Correctional Services Review on 9947 1664 if you would like any further information regarding these matters.

Yours sincerely



PENNY ARMYTAGE
Secretary