Department of Justice and Community Safety

Secretary

Level 26
121 Exh bition Street
Melbourne Victoria 3000
Telephone: (03) 9915 3759
www.justice.vic.gov.au

Our ref: EBC 23103735

His Honour John Olle
Deputy State Coroner
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Deputy State Coroner Olle

I refer to your findings and recommendations made on 30 August 2023 regarding the inquest into the death of Baby A, who tragically died on 18 August 2018 while residing with her mother in the Dame Phyllis Frost Centre (DPFC).

You made one recommendation directed to Corrections Victoria, and one recommendation directed to Justice Health, both business units of the Department of Justice and Community Safety (the department). The department response to the recommendations is as follows:

Recommendation 2
Any child who is living in a prison ought to be regarded as being in custody for the purposes of critical incidents and deaths.

This recommendation is accepted.

At the time of Baby A's death, all procedures and protocols of Corrections Victoria were followed in the same manner as if a prisoner had died in Corrections Victoria custody. However, there were flow on effects in the subsequent management of the matter based on the presumption that Baby A was not a prisoner of the State and therefore not considered to be in custody.

The first impact was that the Justice Assurance and Review Office (JARO) did not complete a review. Due to your recommendation, I have agreed for JARO to include any further death of this kind as within the scope of its review remit.

In your findings, you note that the death of Baby A was reportable under section 4(2)(a) of the *Coroners Act 2008* because it occurred in Victoria and appeared to be unexpected or unnatural. This is the provision under which the death was reported. You concluded that the death was also reportable under section 4(2)(c) due to Baby A being in the custody or care of the Secretary and any further death of a child in custody should result in notification under section 4(2)(c) as well as 4(2)(a) if appropriate.

Corrections Victoria will amend current policies to ensure that children residing in custody with their parent or guardian are considered to be in custody for the purposes of serious incidents or deaths. Corrections Victoria will also work with Victoria Police to update notification protocols to ensure that any future death of a child in a Victorian prison is reported to the Coroners Court under section 4(2)(c), as well as under section 4(2)(a) if applicable.

Recommendation 3

Children who reside in a correctional facility with their parent or guardian ought to have improved access to healthcare. Currently such children are reliant upon the resources of the prison, and do not have easy access to a team of specialists on-site. I recommend that DPFC consider having an attending neonatologist or midwife on-site every day whenever they have infants residing there. Whilst healthcare is an important and fundamental right of any prisoner, children- and especially vulnerable children – require access to healthcare outside of the structure ordinarily availably to prisoners.

This recommendation is accepted-in-principle.

At the time of Baby A's death, Correct Care Australasia was the contracted healthcare provider at DPFC. The primary health service model in place at the time of Baby A's death did not include children living with their mothers in prisons.

Since 1 July 2023, primary health services are now delivered by Western Health at DPFC and by Dhelkaya Health at Tarrengower Prison. Under the primary health service model now in place, primary health service providers at women's prisons are required to deliver healthcare for children in the care of their mother, including general primary care, facilitation of in-reach post-natal visits by midwives, social workers and Maternal Child and Health nurses from specialist services.

Justice Health will work with Western Health and Dhelkaya Health to identify any gaps in the service scope for children in the care of their mother, acknowledging the special needs of infants and vulnerable children. Justice Health notes that service delivery should be matched to identified need.

For completeness, I note Recommendation 1 is directed to the Victorian Department of Health, and note your findings and recommendations have been provided to the Secretary of the Department of Health.

Should you require any further information, please do not hesitate to contact Melissa Westin, Deputy Commissioner, Corrections Victoria [redacted] Susannah Robinson, Executive Director, Justice Health [redacted]

Yours sincerely

Kate Houghton PSM
Secretary

28/11/2023