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| **Reporting and Review of Prisoner Deaths** | | | |
| **Section** | | 1. Security and Control | |
| **CR Number** | 1.3.3 | **Current Issue Date** | September 2022 |
| **Legislation & Policy** | | Corrections Act 1986  Coroners Act 2008  Charter of Human Rights and Responsibilities Act 2006  Gender Equality Act 2020  Communications Protocol – Passings in Custody: Notifications and Processes for Aboriginal Persons | |
| **Standard** | | Safety and Security Services - Deaths in Prison | |
| **Attachments** | | Nil | |
| **Forms** | | Nil | |

1. **PURPOSE**

To define the requirements for reporting and review in relation to prisoner deaths.

1. **REQUIREMENT**

All reporting and reviews into prisoner deaths will be in accordance with this Commissioner’s Requirement.

1. **CONTEXT**
   1. A number of human rights are particularly relevant when a prisoner is nearing the end of life or passes away in prison custody, including the right to life (s9), privacy (s13) cultural rights (s19) and property rights (s20) and these are protected under the *Charter of Human Rights and Responsibilities Act* 2006. All staff must properly consider human rights when making decisions.
   2. The reporting of a death in prison custody must be undertaken in a manner which is culturally safe and considers the best interests of the prisoner and their family. Refer to section 4.2 for the reporting of the passing of an Aboriginal person in prison custody.
   3. The Justice Assurance and Review Office (JARO) is responsible for conducting a review on behalf of the Secretary of the Department of Justice and Community Safety into the management of the prisoner and the prison’s response to the death. The JARO review is assisted by Justice Health’s review on the provision of health services. These reviews are carried out to:

* provide oversight and monitoring of the corrections system;
* identify learning’s from major incidents; and
* assist the Coroner during the Coronial Inquest into the death.
  1. Corrections Victoria’s Manager, Litigation & Coronial Matters is the central point for communication with JARO, police and the Coroners Court of Victoria in relation to prisoner deaths.

1. **INSTRUCTION**
   1. **Reporting a Prisoner Death**
      1. Prison staff will be accountable and must follow correct procedures when dealing with a death in prison. Staff must ensure that they are respectful and maintain confidentiality.
      2. A death is a notifiable incident and must be reported as per the incident reporting matrix (refer to Commissioner’s Requirement – Incident Reporting). A death in prison custody, as per the definition in the *Coroners Act* 2008, is referred to as a ‘reportable death’, which means that a coroner must investigate.
      3. The death must also be recorded as an incident in the Prisoner Information Management System (PIMS) within 24 hours. The General Manager must prepare a written report containing the following information and forward this report (for public prisons, this is in the form of Schedule 1.19(1) and inclusive of staff memorandums and all Schedules) to the Commissioner within 24 hours of the death occurring:

* prisoner’s full name and CRN;
* significant events leading up to the incident;
* description of the incident including location, time of discovery and preliminary assessment of the cause of death;
* names of all persons involved in the incident, including details of involvement; and
* if available, general overview of health issues.
  + 1. All prisons must develop and comply with reporting procedures and include notifications to:
* the Commissioner;
* the Deputy Commissioner, Custodial Operations;
* the Assistant Commissioner, Custodial Operations (for public prisons);
* the Duty Director;
* Victoria Police; and
* WorkSafe Victoria.
  + 1. The Deputy Commissioner, Custodial Operations or Duty Director will notify JARO and Justice Health immediately, and the Manager, Litigation & Coronial Matters will notify the Victim Support Agency, and where the deceased person identified as Aboriginal or Torres Strait Islander, Corrections Victoria’s Naalamba Ganbu and Nerrlinggu Yilam (the Yilam).
    2. A copy of the prisoner’s Individual Management File (IMF) must be made, as the police or the Coroner may require it. A copy is to be retained by the prison and the original IMF (unless taken by the police or Coroner), is sent to the Manager, Litigation & Coronial Matters who will provide it to JARO and others upon request. Requests related to the prisoner’s electronic medical file should be referred to the prison’s health services provider or Justice Health.
    3. Prison staff will also ensure that an email is sent to notify Corrections Victoria’s Sentence Calculation and Warrant Administration (SCWA) of the death, so that SCWA can update records. SCWA is to be emailed at: [scwa.operationalenquiries@justice.vic.gov.au](mailto:scwa.operationalenquiries@justice.vic.gov.au), with a courtesy copy to the Manager, Litigation & Coronial Matters.
  1. **Reporting the Passing of an Aboriginal Person in Prison** 
     1. There are detailed and considered notification and communication protocols in place in the event that an Aboriginal person passes in prison. These protocols take into account the need to be culturally informed, keep the best interests of the person that has passed and their family in mind and also align with the impacts and concurrent activity that takes place across the broader Aboriginal community.
     2. The roles and responsibilities for these communication protocols can be broadly categorised as follows:
        + Manager of the Yilam will focus on Corrections Victoria internal communications and have an inward focus on Aboriginal staff and prisoners at all locations.
        + The Department’s Director of the Koori Justice Unit (KJU) will have an outward focus, engaging with key external stakeholders.
        + The Coroner’s Koori Engagement Unit (CKEU) will be the family’s primary point of contact and facilitate warm introductions if required.
        + The Deputy Secretary CJS or the Commissioner will make phone calls to the Aboriginal Justice Caucus co-chairs to advise them and keep them up to date when an Aboriginal person has passed in prison or is involved in a critical medical incident.
     3. In the event that an Aboriginal or Torres Strait Islander person passes in prison, the Yilam Manager will establish a Teams’ group chat with the Deputy Commissioner, Custodial Operations (or nominee), the KJU Director, CKEU and a representative from Justice Health. This group will liaise on the actions taken by each area and ensure no duplication, information is shared and all actions are attended to.
     4. The department will consult with the CKEU to determine if the Coroner has made a decision about whether or not they will be investigating the passing of the prisoner as an Aboriginal death in custody, or if further information is still needed to confirm the person’s cultural status.
     5. The collateral information that the Coroner has access to, including contact with the family, should also inform the Department’s response and communications.
     6. If the family consent to making a public notification of the prisoner’s passing, the Yilam Manager will liaise with the CKEU for the family’s preferred point and method of contact to discuss the proposed content of the public notification and identify if there are any cultural practices that are important to follow.
     7. The proposed content of any public notice is to be drafted by the Department’s Strategic Communications Branch (Corrections team) in collaboration with the Yilam Manager, who will consult with the CKEU. The CKEU will also be aware of broader community activity and can advise for example if the family or community is already going through sorry business. The final draft is to be approved by the Deputy Commissioner, Custodial Operations and the Commissioner, prior to progressing through senior Departmental approvals to the Secretary.
     8. The Yilam Manager will remain in contact with the Director, KJU and once confirmation is received that Victoria Police has notified the next of kin, the Deputy Secretary CJS, or the Commissioner, will call the co-chairs of Caucus. The Director of KJU will then contact the CEO of the Victorian Aboriginal Legal Service (VALS) and the Aboriginal Independent Prison Visitor. After phone contact has been made with the Caucus co-chairs, the Yilam Manager will send an email to notify all Aboriginal Justice Caucus members.
     9. Only once consultation is complete with the family’s nominated point of contact and notifications have been made to VALS, along with any registered victims being notified of the passing, can notification of the passing be made public on Corrections Victoria’s website. A public notification will not be made if the family do not consent.
     10. The prison General Manager will ensure that arrangements are made with the Yilam Manager, so that a culturally appropriate response to the passing is enacted, which should include as a minimum:
         + - Aboriginal people at the location are permitted to conduct a cultural ceremony in a timely manner that adheres to cultural protocols;
           - Aboriginal elders and community members are engaged by the location to deliver yarning sessions and to conduct cultural ceremonies; and
           - Service providers are engaged to provide immediate and ongoing support to the Aboriginal prisoners to ensure the cultural, social and emotional wellbeing of Aboriginal prisoners is addressed.
     11. Following the public release of the notification, the Yilam Manager will send an email notification to all Aboriginal Engagement Advisors, Aboriginal Wellbeing Officers and a courtesy copy to all prison General Managers, Offender Services Managers and the Aboriginal Liaison Officers, so that support can be provided to all Aboriginal persons at their respective locations. A similar email will also be sent to RAJACs and Aboriginal Independent Prison Visitors.
  2. **Other Notification**
     1. Following the death / passing of a prisoner, the General Manager is required, as soon as is practicable, to provide Victoria Police with the details of the prisoner’s recorded family members, including nominated next of kin and emergency contacts, family relationships and all relevant telephone and visit contact details.
     2. Victoria Police is responsible for notifying the prisoner’s senior next of kin, identified by the list in the *Coroners Act* 2008 and as per the Memorandum of Understanding with Corrections Victoria. Victoria Police should be requested to advise the prison of such notification, to enable any further action to be taken by Corrections Victoria, including advising the Victim Support Agency via the Manager, Litigation & Coronial Matters, where there are registered victims, so that the victims can be notified of the death / passing.
  3. **Voluntary Assisted Dying**

While all deaths in prison are 'reportable' deaths subject to section 42(c) of the *Coroners Act* 2008, the death of a prisoner who has accessed the voluntary assisted dying (VAD) scheme, via the *Voluntary Assisted Dying Act* 2017 is not 'reportable' by virtue of section 121 of that Act. The death however remains a 'notifiable' death for prisons, as it's a death in prison custody and the Coroner retains the discretion to conduct an inquest into the death. As such, all VAD deaths are to be reported to the coroner.

Prison staff are to use the PIMS incident classification that has been created to record deaths from VAD, which is 130 – Voluntary Assisted Deaths.

* 1. **Death of a Foreign National**

In the event of the death of a prisoner who is a Chinese, Vietnamese or Indonesian national, the General Manager is required to inform without delay the respective Chinese, Vietnamese or Indonesian consular official (refer to the Department of Foreign Affairs and Trades website for contact details – <http://protocol.dfat.gov.au> or call (02) 6261 1111 during office hours or 0418167127 for after hours emergencies). Public prison staff can refer to the brochure on the V drive (CV Operating Manuals\Prisons\Deaths in Prison Custody).

* 1. **Removal of Deceased**
     1. A doctor must ‘pronounce’ the prisoner deceased before the body can be removed from the prison. Where a doctor is unavailable immediately, a nurse or paramedic can ‘verify’ that death has occurred. It is the responsibility of the police to contact the Coroner’s undertaker and to arrange for the removal of the body. In the case of a suspected homicide, this will only occur once authorised by the Homicide Squad (Victoria Police) or the Coroner.
     2. Staff must ensure they do not hinder or interfere with any police investigation.
     3. If the event that a death occurs in a hospital or on escort, the above procedures must apply. Upon notification that the prisoner is deceased, the escort staff must notify the prison and are to remain with the body until police or the Coroner assumes control of the incident. The escort staff are then no longer responsible for the prisoner and will return to the prison or as directed.
  2. **Visits, Photos & Property**
     1. A deceased prisoner in hospital may receive visits where authorised by the General Manager.
     2. In such cases, the intending visitor must be on the prisoners approved visitor’s list or in exceptional cases and when approved by the General Manager, added to the prisoner’s visitor list, following appropriate clearances. All visits must be entered on the PIMS Visits Module.
     3. If family members request to take photographs of the deceased while at hospital, staff must take into consideration cultural and religious needs and seek the approval of their General Manager, prior to permitting the photo being taken.
     4. Where the cause of death is suspected to be unnatural (e.g. suicide, misadventure or a murder), photos should not be taken, particularly if the deceased is a high profile prisoner. Consideration should be given to requests by Victoria Police to take photos or where photos may be necessary to record changes to the scene for evidentiary purposes. Once the photos are handed over to Victoria Police, no (document or electronic) copies are to be retained by the prison.
     5. The General Manager must ensure the prisoner’s in-cell and stored property is reconciled with the E\*Justice property records and stored securely, until approval is granted by the Manager, Litigation & Coronial Matters, and where required, in consultation with the Coroner. Once approval is granted, the property and monies are to be released to the next of kin or nominee.
  3. **Post Incident Briefing and Formal Debrief**
     1. A Post Incident Briefing usually occurs within a few hours of the incident and the purpose is to ensure the wellbeing of all staff and to identify any immediate issues.
     2. The Formal Debrief usually occurs within seven days (where practicable) of the incident and aims to assess the incident response and related policies, procedures and practice, with a view to supporting staff and identifying best practice and ways in which incidents could be avoided or better managed in the future. A Formal Debrief is an opportunity to assess the incident response and is not intended to replace the formal review or investigations by JARO, police or the Coroner. A Formal Debrief should not occur where there is concern that it may compromise any formal review or investigation.
     3. The General Manager will determine if a Post Incident Briefing or Formal Debrief are required, following a death or passing.
     4. In the event of a suspected homicide, approval from Victoria Police is to be sought to proceed with a Formal Debrief.
  4. **Response to Review Findings and Recommendations**
     1. All deaths in custody, other than those the result of voluntary assisted dying, are routinely subject to a Coronial review.
     2. The department’s Justice Assurance and Review Office (JARO) is responsible for making available copies of its review reports and the Justice Health report to the Coroner.
     3. General Managers are responsible for responding to local prison management issues and procedures, as identified by a Formal Debrief and any recommendations identified by JARO’s review, via the Manager, Litigation & Coronial Matters.
     4. JARO will be responsible for reporting Corrections Victoria’s progress against implementation of any Coronial recommendations made and will liaise with the Manager, Litigation & Coronial Matters.
  5. **Coronial Investigation**
     1. The Manager, Litigation & Coronial Matters will liaise with the Coroners Court of Victoria and investigators, in consultation with the prison’s nominees and the Office of the General Counsel (OGC) or the department’s legal representatives, to provide response to requests.
     2. Staff are to refer requests to the Manager, Litigation & Coronial Matters in the first instance.

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| Larissa Strong ACM  **Commissioner** |

**Information below this point is administrative supporting detail**

**only and not subject to Commissioner’s review or approval.**

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| **Acronyms** | |
| CKEU | Coroner’s Koori Engagement Unit |
| IMF | Individual Management File |
| JARO | Justice Assurance and Review Office |
| KJU | Koori Justice Unit |
| PIMS | Prisoner Information Management System |
| SCWA | Sentence Calculation and Warrant Administration |
| VAD | Voluntary Assisted Dying |
| VALS | Victorian Aboriginal Legal Service |
| Yilam | Naalamba Ganbu and Nerrlinggu Yilam |

| **Definitions** | |
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| **Associated Commissioner’s Requirements** |
| 1.3.1 - Incident Reporting  2.7.1 - Aboriginal and Torres Strait Islander Prisoners  5.1.3 - Prisoners with an end of life illness |

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