Communities and Justice

NSW GOVERNMENT

Ref: SGM23/8510

5 March 2024

The Hon. Michael Daley MP

Attorney General

GPO Box 5341

SYDNEY NSW 2001

Re: Progress on recommendations following an inquest into the death of a child

Dear Attorney General,

I am writing to provide you with advice about the Department of Communities and Justice's (DCJ) progress on recommendations made following a Coronial inquest into the death of SG [redacted], who died from suicide on 13 May 2020. Following the making of a non-publication order, SG [redacted] is known as 'SG'.

On 25 August 2023, Deputy State Coroner Kennedy handed down her findings and made the following two recommendations for DCJ:

Jointly to DCJ, Department of Education and Child and Adolescent Mental Health Service

1. Consideration be given to developing a joint agreement between DCJ, Department of Education (DoE) and the Child and Adolescent Mental Health Service (CAMHS), Hunter New England Local Health District, so as to ensure cooperation, coordination, communication and information sharing takes places [sic] in an appropriate, and timely manner in accordance with the provisions available under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*, to ensure that:
    a. Records and information are shared between the agencies, as appropriate, when a report is made regarding a child or young person
    b. Where an agency relies on the involvement of an external agency in the decision-making process, then each agency must notify the external agency if no further action is to be taken by their staff, and
    c. The agencies must implement a memorandum of understanding or policy to mandate that staff follow up with counterparts at the other agencies so that appropriate action for the young person occurs.

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2. To give consideration to the risk of suicide, including the weight given to a child's previous suicide attempts, within the comprehensive Prioritisation, Triage and Allocation Policy Review to ensure better identification and prioritisation of children most at risk.

Recommendation 1: Joint agreement

a. Records and information are shared between the agencies, as appropriate, when a report is made regarding a child or young person

The following has occurred to improve information sharing between each agency:

The Director Community Services, Hunter Child Protection and the John Hunter Hospital General Manager Child, Young People and Families Services have commenced bi-monthly meetings to discuss service delivery issues for children and families in contact with both DCJ and CAMHS. The meetings include the three DCJ manager client services from each child protection unit in the Hunter district as well as the Director of Nursing Service Manager – Violence, Abuse and Neglect and the CAMHS Service Manager from John Hunter Hospital. The purpose of these meetings is to support information sharing between the agencies and ensure services are tailored to the child's needs.

In October 2023, the Hunter district implemented a centralised triage team to create greater consistency in the response provided to children and families. The centralised team has allowed for improved escalation processes between NSW Health, DoE and DCJ when a child is identified as being at risk of self-harm or suicide.

In 2023, DCJ and CAMHS jointly drafted a position description to sponsor a DCJ caseworker to be outposted at CAMHS. The purpose of this new position is to provide a more streamlined approach to children who require a combined service response, increase information exchange and foster learning across the two agencies on agency specific processes and systems. DCJ and CAMHS continue to meet and discuss the best model for the outposted liaison position.

b. Where an agency relies on the involvement of an external agency in the decision-making process, then each agency must notify the external agency if no further action is to be taken by their staff

Over the course of 2023, the Hunter district triage team facilitated forums with local schools and Principals' Networks to improve information sharing and escalation of concerns for children. This was achieved through the support of the Department of Education Network Specialist Facilitator in Newcastle, Port Stephens and Cessnock. This process included providing feedback to agencies when DCJ is not able to allocate a report for a safety and risk assessment. The feedback included information on what steps have been taken, such as interagency case discussions and service network meetings, to link the child and their family with the most appropriate supports in the community.

In the first quarter of 2024, DCJ will undertake training with John Hunter Hospital staff to increase their awareness of the roles and responsibilities of DCJ and improve a coordinated response to children across the district. This training will be open to nursing staff, doctors, emergency department staff, social work staff, as well as staff from John Hunter Children's Hospital and CAMHS practitioners.

In 2024, the Hunter Child Protection Pathways Hub will continue to attend and present at the bi-monthly CAMHS staff inductions. At these meetings DCJ staff provide an overview of the child protection system, mandatory reporting and the DCJ safety and risk assessment process. This initiative, which began in 2022, has been a positive step forward in building positive working relationships between practitioners working with shared clients within DCJ and CAMHS.

c. *The agencies must implement a memorandum of understanding or policy to mandate that staff follow up with counterparts at the other agencies so that appropriate action for the young person occurs*

In March 2024, a meeting is scheduled with the three agencies (DCJ, DoE and CAMHS) to develop a memorandum of understanding to ensure effective communication and follow up between agencies.

Recommendation 2: The Prioritisation, Triage and Allocation Policy Review

As noted in the Coroner's recommendation, DCJ is undertaking a comprehensive policy review of the prioritisation, triage and allocation processes. The aim of the review is to improve the safety and wellbeing of children by ensuring that the NSW child protection system identifies and responds to the children who are most at risk, within available resources.

The review will result in a clearer policy position and an updated practice mandate that will strengthen decisions about the response to a child and their family. This includes strengthening other response pathways, for example, referrals to funded services.

The Prioritisation, Triage and Allocation Policy Review is well underway, and the findings and recommendation have been considered in the review process. DCJ has undertaken extensive stakeholder consultation, an analysis of current practice and a review of best practice research. This includes considering a child's risk of suicide and the weight given to a child's mental health and previous suicide attempts.

The Prioritisation, Triage and Allocation Policy Review is expected to be completed in mid-2024.

If you do require any additional information or would like to discuss further, please contact Belinda Edwards, Executive District Director at Belinda.Edwards@dcj.nsw.gov.au or on 0409 991 894.

Yours Sincerely,

Michael Tidball
Secretary

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