7. Appendices

Appendix 1

Definitions

Definitions we have adopted to determine whether deaths are due to abuse or neglect or occurred in suspicious circumstances are:

Deaths due to abuse:

An act of violence by any person directly against a child or young person that causes injury or harm leading to death.

Deaths due to neglect:

Conduct by a parent or carer that results in the death of a child or young person, and that involves:

- failure to provide for basic needs such as food, liquid, clothing or shelter
- refusal or delay in providing medical care
- intentional or reckless failure to adequately supervise
- a reckless act.

Suspicious deaths:

Deaths where there is some evidence or information that indicates the death may have been a result of abuse or neglect. Deaths would be considered suspicious if:

- police identify the death as suspicious at the time of the death or any time subsequent to the death and there is some evidence that indicates the death may have occurred in circumstances of abuse or neglect (as defined above)
- the autopsy cause of death is undetermined and there is an indication of abuse or neglect
- the autopsy cause of death is a treatable illness and there is an indication that unjustified delay in seeking treatment may have contributed to the death.

We note that this definition of suspicious is broader than that used by the NSW Coroner's Office. In the Coronial context, suspicious is generally attributed to a death that is a possible homicide.

Appendix 2

Reviewable Child Deaths Advisory Committee: Members

NSW Ombudsman Annual Report 2004–0

Mr Bruce Barbour: Ombudsman (chair)

Mr Steve Kinmond: Deputy Ombudsman, Community and Disability Services Commissioner, Community Services Division

Dr Judy Cashmore: Associate Professor, Faculty of Law, University of Sydney; Honorary Research Associate, Social Policy Research Centre, University of New South Wales; Adjunct Professor, Arts, Southern Cross University.

Dr Ian Cameron: CEO, NSW Rural Doctors Network

Dr Michael Fairley: Consultant Psychiatrist, Department of Child and Adolescent Mental Health at Prince of Wales Hospital and Sydney Children's Hospital.

Dr Jonathan Gillis: Senior Staff Specialist in Intensive Care, The Children's Hospital, Westmead

Dr Bronwyn Gould: Child protection consultant and medical practitioner

Ms Pam Greer: Community worker, trainer and consultant

Dr Ferry Grunseit: Consultant paediatrician, former Chair of the NSW Child Protection Council and NSW Child Advocate

Assoc Prof Jude Irwin: Associate Professor, Faculty of Education and Social Work, University of Sydney.

Ms Toni Single: Clinical Psychologist, former Senior Clinical Psychologist, Child Protection Team, John Hunter Hospital, Newcastle

Ms Tracy Sheedy: Manager, Children's Court of NSW

Appendix 3

Agency responses to recommendations : Report of reviewable deaths in 2005 — Child deaths

Section 43(2)(c) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* requires us to provide information in our reviewable deaths annual report with respect to the implementation or otherwise of previous recommendations. In our *Report of reviewable deaths in 2005*, we made 34 recommendations in relation to child deaths:

- Sixteen recommendations were directed to DoCS
- Six recommendations were directed to NSW Health
- Three recommendations were directed to NSWPF
- Three recommendations were directed jointly to DoCS and NSWPF
- Four recommendations were directed jointly to DoCS and NSW Health
- Two recommendations were directed to Human Services Chief Executive Officers (HSCEOs)

NSWPF provided a response to the recommendations we made in March and August 2007. NSWPF indicated support for the six recommendations directed solely or jointly to them.

DoCS provided a response to the recommendations we made to them in March 2007. We sought further information from DoCS, and received this in July 2007.

NSW Health provided a response to the recommendations we made to them in March 2007. We sought further information from NSW Health, and received this in July 2007.

The Human Services Chief Executive Officers group provided a response to the two recommendations directed to the Group in May 2007.

The following provides an overview of what agencies told us they were doing to implement our recommendations, and our assessment of progress in this regard. Our assessment is based on the advice provided by agencies and, where appropriate, additional information from our work.

Agency identification and reporting of risk of harm

Recommendation 1

NSW Police should prioritise completion of the *Child protection standard operating procedures*, and ensure that the revised SOPS and where relevant, *Domestic violence operating procedures*:

- give adequate advice to police about circumstances where a risk of harm report to DoCS may be appropriate in cases where the child is not present with the adult and police are aware of a child protection history.
- give adequate guidance to police about circumstances where it may be appropriate for police to themselves seek further information about the safety of children.
- ensure that the procedures encourage full and relevant reporting to DoCS on the type and level of risk posed to children who are present at a domestic violence incident.

Recommendation 2

NSW Police should advise this office of plans for releasing the revised procedures, including associated information and training strategies.

Police Response

The recommendations were supported by NSWPF

NSWPF accepted this recommendation and advised that they are currently reviewing the Child Protection and Domestic Violence Standard Operating Procedures (SOPS). Police told us that they '*... will take into consideration the specific comments within this recommendation and the Report when drafting the SOPS.*'

In response to a draft copy of this report, NSWPF advised that the new Domestic and Family Violence SOPs remain on track for endorsement by the Commissioner in December 2007, and implementation in February 2008. They will link to the Child Protection SOPs, which are currently being drafted.

NSWPF told us that the Domestic and Family Violence SOPs will include a section on children, and provide advice on best practice for completing a risk of harm report for children involved in domestic violence incidents. They will

Recommendation 2 *(continued)*

also include a checklist to assist police to determine when a report should be made, and the type of information that should be provided to DoCS.

NSWPF said that the Child Protection SOPs will cover in detail police responsibility for reporting children at risk of harm, and the type of information required by DoCS to assist the department to respond appropriately.

Our Comments

We acknowledge the information provided about the proposed content of the SOPS.

The Child Protection SOPS have been under review for a significant period of time, and as noted in our report, it is critical for good practice that frontline police have clear guidance about identifying children at risk, and their reporting obligations.

We will continue to monitor progress with the Child Protection and Family and Domestic Violence SOPS through our reviewable deaths work and through monitoring the implementation of the recommendations arising from our report *Domestic Violence: improving police practice*.

Recommendation 3

DoCS and NSW Police should provide advice to this office on the progress of their joint work to improve risk assessment procedures for child protection reports from NSW Police, and details of any actions arising from this work.

Police Response

The recommendation is supported by NSWPF.

DoCS told us in October 2006 that the project, with NSWPF, would *'examine the characteristics of incidents reported to DoCS by police and the outcomes of those reports' and 'develop some options for improved reporting mechanisms and risk assessment in police reports.'*

NSWPF advised that it is currently in the process of coordinating data and related analysis to provide to DoCS, and that through this project, *'strategies can be developed to enhance the quality of information communicated between NSWPF and DoCS in relation to children at risk of harm, and consequently, improve decision making and the interagency response to children at risk of harm.'*

In addition to this NSWPF/DoCS project, NSW Health has since advised us that it is the lead agency for *'a cross-Agency Domestic Violence Risk Assessment Framework project in partnership with DoCS, NSW Police and the AG's. The project aims to develop a more integrated and consistent service response to domestic/family violence, for earlier, more effective and targeted services to those affected by violence including children.'*

DoCS response

DoCS told us that they continue to work with NSWPF on this project. DoCS has analysed child protection reports received from Police, and Police are preparing a similar analysis of their own data. The stated objective of this analyse is to *'help to identify the key pieces of information that the police could routinely supply to DoCS in order to better inform child protection reporting.'* DoCS anticipates that recommendations for improvements to reporting will be made in late 2007.

DoCS' response also says that they are in the process of finalising a Memorandum of Understanding (MOU) with NSWPF. The MOU is aimed at *'ensuring the consistency in practice and procedures for the lawful disclosure of information.'* DoCS provided a draft copy of the MOU.

Our Comments

We will continue to monitor initiatives to improve risk assessment procedures for child protection reports made by NSWPF.

Broader initiatives to improve risk assessment in domestic violence will be considered in monitoring the implementation of the recommendation arising from our report *Domestic Violence: Improving police practice.*

Determination of child protection history

Recommendation 4

DoCS should provide advice to this office of the current status of the Helpline quality review process, including the regularity and future focus of quality reviews.

DoCS Response

DoCS told us that five quality reviews are proposed for 2007, focusing on *'the Helpline Caseworker's compliance and consistency with recording information on KiDS.'*

DoCS have compiled a calendar for rolling reviews in 2007 and are looking to continue focusing on five areas of practice each year. The proposed methodology for the reviews is as follows: *'over a period of one month, the Team Leader will review two reports for each caseworker per week, with the emphasis on the current review topic. The Helpline Child Protection Casework Specialist will then collate the information received from the Team Leader in order to identify any caseworkers who may be experiencing difficulty or require further training in these areas.'*

By the end of 2007, DoCS advised that they will have completed or initiated quality reviews of:

- Completion of Helpline critical event and allegation forms by caseworkers.
- Data entries in relation to 'person profile' fields in the KiDS database.
- Contact narratives, that is, records of discussion between Helpline caseworkers and reporters.

Recommendation 4 *(continued)*

- Responses to questions contained in the initial assessment form that are designed to prompt the caseworker to consult with, and document outcomes, of discussions with Team Leaders and Managers.
- The analysis section of the initial assessment form.

Our Comments

Our recommendation was informed by our reviews of deaths in 2005 that found that administrative errors and inconsistency in assessment practice at the Helpline was impacting on the timeliness and quality of subsequent secondary assessment activities undertaken by CSCs. In the matters we reviewed in 2006, these issues remained apparent. From the advice provided by DoCS, the ongoing Helpline quality review process will provide the opportunity to identify problems and develop strategies to improve the accuracy and consistency of the initial assessment process. Our ongoing review work will continue to consider practice within the Helpline.

Reports indicating criminal offences

Recommendation 5

DoCS and NSW Police should provide advice to this office regarding the progress of, and timelines for, the DoCS, NSW Police and NSW Health review of JIRT systems, policies and procedures.

NSW Police Response

This recommendation was supported by NSWPF.

The JIRT review was completed in November 2006. The review generated 18 recommendations that covered:

- Decision making and planning
- Referral, investigation and response
- Governance and quality control
- Indigenous clients and communities

All recommendations have been accepted by NSWPF, NSW Health and DoCS. A 19th recommendation — that the three agencies develop an implementation plan, was added in December 2006. Police have told us that their work in this regard is underway.

DoCS Response

DoCS advised that a draft implementation plan for recommendations is in development. They anticipate that '*the plan will address issues around the JIRT response and improve procedures. Timelines for implementation will be dependent on the development of detailed project plans.*'

DoCS provided us with a copy of the review in August 2007.

Our Comments

We will continue to monitor DoCS and NSWPF's implementation of the recommendations arising out of the JIRT review.

Recommendation 6

In conducting the review of JIRT, DoCS and NSW Police should consider relevant issues raised in this report and our *Report of reviewable deaths in 2004*, in particular:

- That in those cases where JIRT rejects referrals, JIRT should clearly document the reasons for this decision, including details about any information that would be required to enable JIRT to take up the matter.
- The need for clarity about the type of reports that DoCS should refer to JIRT and/or police.
- The need to ensure appropriate child protection responses to children who are the subject of reports referred to, but rejected by, JIRT.

NSW Police Response

This recommendation was supported by NSWPF.

NSWPF told us that the recommendations coming out of the JIRT review address the concerns raised in our recommendation above. NSWPF advised that *'The JIRT review recommendations are consistent with government directions in the Aboriginal Child Sexual Assault Task Force and also take into account Ombudsman's recommendations.'*

DoCS response

Similarly, DoCS told us that the JIRT review has addressed the issues we identified. In particular, DoCS advised us that:

- Referrals to JIRT must be documented, and the rationale for accepting or rejecting a report is to be recorded on both NSWPF and DoCS systems. A hard copy is then to be faxed to the CSC. DoCS told us that the CSCs use this documentation to assist with assessment and subsequent decision-making about the type of protective response that is required.
- JIRT agencies have revised the JIRT physical abuse criteria, and all relevant DoCS, NSW Health and NSWPF staff received training about the new criteria in December 2006. The new referral criteria articulate the circumstances in which a JIRT referral would be appropriate, and provide staff with guidance about the types of physical injuries that would likely meet the required threshold. The referral criteria are accompanied by the *JIRT Injury Guide,* which outlines six broad categories of injury type and then provides specific descriptions of the indicators/markers of injury that fall within each category. The guide also points to potential sources of information that should be canvassed when deciding whether to accept or reject a referral, including for example, the results of any medical assessments, witness statements, inconsistencies in explanations, and results of any police crime scene examinations.
- DoCS' revised *Secondary Assessment Risk of Harm* procedures have been rolled out. DoCS states that '*these procedures reiterate the need for CSCs to ensure that any case plans rejected by JIRT and transferred to CSCs are responded to appropriately.*' Further to this, DoCS told us that the policies and procedures for managing case plans rejected by JIRT are currently under review and a new Business Help topic is being developed to operationalise these procedures.

Our Comments

Our recommendation was informed by our reviews of deaths in 2004 and 2005 that raised questions about appropriate referral of reports to JIRT or police. The intent of this recommendation was for DoCS to address the problems we identified regarding the lack of clarity and procedural guidance about this process. We acknowledge that DoCS have made good progress towards addressing the substance of our recommendation and have indicated that a similar review of the JIRT sexual abuse criteria is planned. We will continue to monitor the progress of the JIRT review, and evaluate the new JIRT sexual abuse criteria and Business Help topic on completion.

Recommendation 7

DoCS should provide advice to this office regarding the findings of the proposed analysis of a sample of JIRT declined referrals, and how DoCS will act on those findings.

DoCS Response

DoCS advised that the Helpline collected a sample of 636 declined JIRT referrals in December 2006. The department's analysis of these matters revealed that *'clearer JIRT criteria will assist with effective referral practices.'*

DoCS' response to this recommendation also noted that following an 'audit' of matters rejected by JIRT and referred to CSCs, all regions conducted training on *'current policies and business rules around matters rejected by JIRT'*.

Our Comments

As noted in the above recommendation, JIRT has been reviewed and new physical abuse criteria have been implemented. Sexual abuse criteria will also be reviewed. We will consider referral issues in our monitoring of the implementation of the JIRT review recommendations.

Response to maternal substance use

Recommendation 8

NSW Health should consider strategies to:

- Facilitate common benchmarks and standards for the provision of drugs-in-pregnancy services in NSW.
- Provide ongoing state-wide coordination and development of drugs-in-pregnancy services in NSW.
- Evaluate the effectiveness of drugs-in-pregnancy services in NSW.

NSW Health Response

This recommendation was supported by NSW Health.

NSW Health advised us that it is planning to audit drugs-in-pregnancy services in 2007. The audit will consider access to services, model of service and minimum standards. The audit will also focus on the level of coordination, assessment and planning by health services in the post-natal period for children born to mothers who have a history of substance abuse, or were known to have used substances during pregnancy. The findings

Recommendation 8 *(continued)*

of the audit will be the basis for development of minimum standards for drugs-in-pregnancy service provision.

NSW Health advised that it will provide this office with further advice regarding the audit and evaluation strategies.

Our Comments

We acknowledge the commitment of NSW Health to enhancing the effectiveness of drugs-in-pregnancy services. We will monitor the outcomes of the planned audit and seek further advice from NSW Health on evaluation strategies.

Recommendation 9

NSW Health should advise this office of strategies in place, or planned, to promote and ensure compliance with relevant procedures relating to maternal substance use, particularly the *Neonatal abstinence syndrome guidelines and National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn.*

NSW Health Response

This recommendation was supported by NSW Health

In regard to the *National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*, NSW Health advised that it will raise the issue of compliance across all jurisdictions at the Intergovernmental Committee on Drugs to *'determine an agreed approach and funding source'.*

NSW Health advised that the planned audit in 2007 of drugs-in-pregnancy services will address our recommendation in relation to promoting, and ensuring compliance with, *the Neonatal abstinence syndrome guidelines.*

Our Comments

In addition to recommendation 8, we will continue to monitor NSW Health responses to maternal substance abuse, including measures to ensure compliance with existing policy.

Response to pre-natal reports

Recommendation 10

DoCS should provide advice regarding progress in the development and roll out of a policy on responding to pre-natal reports, including a copy of the policy when completed.

DoCS Response

DoCS advised us in July 2007 that the draft policy of *Responding to prenatal reports 'is now close to finalisation [and] will be finalised pending further consultation with NSW Health.'* DoCS and NSW Health have agreed on four sites for trialling the Responding to prenatal reports policy. The trial is expected to commence in early 2008. DoCS provided a copy of the draft policy.

Recommendation 10 *(continued)*

Our Comments

We made this recommendation in the context of observations arising from our reviews that pre-natal reports often received a low priority for allocation for assessment by DoCS. We will await the final policy.

Child deaths resulting from methadone toxicity

Recommendation 11

NSW Health should provide advice to this office on the progress of the review into the systems related to reporting fatal and non-fatal child methadone overdoses.

Recommendation 12

As part of the review into the systems related to reporting fatal and non-fatal child methadone overdoses, NSW Health should consider the establishment of a consistent state-wide system for the collection and monitoring of data about children presenting to health services as a result of ingestion of methadone. Data collection should include the number and age of children presenting, and the circumstances in which methadone was ingested.

Recommendation 13

NSW Health should implement a policy requiring emergency department staff to identify and inform the relevant methadone prescriber of the admission of a child to an emergency department as a result of ingestion of methadone. This policy should be incorporated into relevant NSW Health policies and procedures relating to child protection and to opioid treatment.

NSW Health Response

These recommendations were supported by NSW Health.

NSW Health has advised of a number of strategies to address these recommendations:

The department is investigating options for reporting of fatal and non-fatal methadone overdoses through the state-wide hospital reporting systems. NSW Health has identified problems in the current data and reporting system in relation to child methadone poisoning and advised us that it is examining opportunities to establish routine monitoring and surveillance of the data contained within three state-wide hospital data collections:

- Public Health Real-time Emergency Department Surveillance System
- Emergency Department Information System, and
- Inpatient Statistics Collection

NSW Health has amended its *Incident Management Policy* to ensure mandatory reporting to NSW Health when a child presents at hospital with methadone poisoning. The policy now states that notification is required *'when methadone or buprenorphine is associated with or potentially associated with a child's presentation or admission to hospital.'* NSW Health will make a risk of harm report to DoCS in these cases.

Recommendation 13 *(continued)*

We were also advised that the Drug Budget 2007-2011 provides funding for NSW Health to establish an investigations unit to specifically investigate fatal and non-fatal methadone poisonings involving children.

NSW Health noted that where *'available information allows the identification of a relevant prescriber'*, NSW Health will notify the prescriber.

In response to our further query regarding the steps that will be taken by hospitals and NSW Health to identify a prescriber, NSW Health advised that information exchange protocols and mechanisms allow for DoCS to request information to identify a prescriber for the purpose of gathering information to inform risk of harm assessment. Currently however, *there is no provision for DoCS to advise prescribers that a child of their patient was presented to hospital with methadone poisoning.'*

NSW Health told us that it will negotiate with DoCS *'the specific roles and responsibilities of each Department when a report is made regarding child methadone poisoning'*, and that the department would advise us when consultation is finalised and a decision is made regarding who will be responsible for contacting prescribers.

NSW Health provided us with a copy of the revised Incident Management Policy and will provide further advice about data collection and reporting of child methadone poisonings.

Our Comments

We acknowledge the range of strategies being implemented by NSW Health to ensure effective responses to children who have ingested methadone. It appears that there is a significant outstanding issue in relation to the provision of critical information about child safety to prescribers.

We will monitor the progress of these strategies.

Recommendation 14

NSW Health should provide this office with a copy of the *NSW Clinical guidelines for methadone and buprenorphine treatment of opioid dependence (2006),* and advice regarding:

- Strategies by which NSW Health will monitor compliance with the guidelines, particularly in regard to contraindications for clients with children in their care.
- The current status of the Guidelines for prescribing methadone for unsupervised administration 'takeaway doses' in the context of the revised guidelines

NSW Health Response

This recommendation was supported by NSW Health.

NSW Health provided our office with a copy of the guidelines and told us that *'The guidelines highlight child at risk issues and state that where there is DoCS involvement and/or risk of harm concerns, takeaway medication should not be provided.'*

Recommendation 14 *(continued)*

NSW Health Response (continued)

We note that the guidelines state that where there are doubts about the ability of a patient to provide a safe environment for a child, this *'should result in take away doses not being approved'* and a report to DoCS. The agreement that is required for takeaways seeks information from patients about DoCS involvement.

The combination drug buprenorphine-naloxene is recommended for patients who have children, as the drug is safer in overdose than methadone.

The guidelines further recommend that all patients (including those who have children in their care) be reviewed regularly, at least four times a year by an experienced clinician. This includes those patients that appear to be doing well.

NSW Health advised of a range of strategies for monitoring compliance with the guidelines including:

- Authorisation of prescribers. NSW Health has a formal authorisation process involving credentialing and authorisation of prescribers who must meet certain criteria and agree to follow departmental guidelines.
- *'NSW Health enforces adherence to the Guidelines through existing clinical governance arrangements. Adherence in the private sector is enforced through authorisation, audits and reaccreditation.'*
- Education, routine audits and reaccreditation. Elements identified by NSW Health include implementation of recommendations from a recent review of the Pharmacotherapy Credentialing Subcommittee (PCS), including *'proactive educational activities'*, and reaccreditation for prescribers every five years.
- Complaint and investigation. Of note is that the Mental Health and Drug and Alcohol office now initiates a full clinical audit in relation to any child death linked to the Opioid Treatment Program. The clinical audit addresses a range of aspects of practice and is provided to the PCS for consideration, along with the prescriber's submission. The PCS consideration results in a recommendation to the Director General regarding the prescriber's approval to prescribe. During 2006, NSW Health completed, or was about to complete, 18 investigations. Ten of these cases involved alleged risk of harm to children *'being the whole or part of the complaint'*.
- Takeaway census. In 2007, NSW Health will conduct a one-week census of prescribed methadone takeaway doses and observed doses across NSW. The objectives of the census include identification of, and intervention with *'prescribers whose prescription of methadone takeaway doses falls outside the parameters recommended in the Guidelines.'*
- NSW Health has also advised that the Drug Budget 2007-2011 provided additional funding for NSW Health to establish a Compliance and Quality Control Program for the NSW Opioid Treatment Program, with a special focus on cases involving child deaths. The program will:

Recommendation 14 *(continued)*

NSW Health Response (continued)

- Coordinate a system of supported practice visits to prescribers.
- Investigate matters related to fatal and non-fatal child methadone poisonings.
- Facilitate clinical audits of prescriber practice.
- Liaise with agencies associated with the regulation and management of incidents related to prescriber practice (eg the NSW Medical Board).

Our Comments

We acknowledge the scope of strategies being undertaken to assist compliance with the guidelines. We will seek a progress report on implementation of these strategies.

Recommendation 15

NSW Health and DoCS should provide this office with advice about the outcomes of the joint review of methadone-related child deaths, including a copy of the review report, and details of plans to respond to the review findings.

DoCS Response

DoCS provided us with a copy of the draft issues paper.

NSW Health Response

This recommendation was supported by NSW Health.

NSW Health noted the paper was close to finalisation, and that further information would be provided as to how the department would respond to the findings.

Our Comments

We will review the final report and seek progress on responses to the review findings.

Closure of reports — competing priorities

Recommendation 16

A key principle in child protection intervention should be that where a report raises issues of safety of a child, or failure to adequately provide for a child's basic physical or emotional needs, it should not be closed until adequate steps have been taken to assess the level of risk and resolve identified risk. In this context, DoCS should:

- Develop capacity within KiDS to enable collection of, and reporting on, data which details the reasons for case closure, including the number of cases closed due to competing priorities.
- Provide advice to this office regarding how DoCS intends to measure the degree to which reform initiatives have improved its capacity to assess risk of harm reports to the appropriate stage, and to provide necessary intervention where a child is assessed to be in need of care and protection.

Recommendation 17

DoCS should provide advice to this office about the department's capacity, and any plans, to enhance data reporting to identify the status and outcomes of all reports referred to CSCs and JIRTs for further assessment, with particular reference to the category of reports indicated in DoCS annual data as having 'no secondary assessment outcome recorded.'

DoCS Response

DoCS' responses to recommendations 16 and 18 were linked.

The department's initial response to recommendation 16 did not clearly address the specifics of our recommendation. Therefore, we wrote to DoCS to clarify our intent, and asked them to provide further advice, including:

- Whether it was DoCS' intention to develop capacity within KiDS to enable collection of, and reporting on, data which details the reasons for case closure, including the number of cases closed due to competing priorities.
- Whether it was DoCS' intention to enhance data reporting to identify the status and outcomes of all reports referred to CSCs and JIRTs for further assessment, particularly in relation to reports indicated in DoCS' annual data as having *'no assessment outcome recorded.'*

In response, DoCS advised:

- That an element of the CSC quality review process will include case sampling and *'will review case closure decision making.'*
- A Practice Review Tool to enable *'the systematic review of secondary assessment practice for both compliance with policy and procedure and for practice quality…'* has been piloted.
- A *'Practice Review Tool for Intake and Allocation Decision-Making'* has been developed, and is due to be piloted in August 2007. DoCS advise that the tool is designed to be used in the following ways:
  - By Managers Casework Intake and Child Protection to review and reflect on their work;
  - By Managers Client Services, within professional supervision of Managers Casework and as a quality assurance activity; and
  - As a key tool for the ongoing quality reviews of CSCs.
- A major project to reform the child protection program has been initiated. Key positions were recruited and appointed in July 2007. DoCS advised that *'improving and increasing DoCS' capacity to report and analyse data through KiDS will be part of the Child Protection Major Reform process.'*

In response to a draft of this report, DoCS commented that the term 'resolved' was unclear and that the ordinary meaning of adequate would mean that most level 2 and 3 reports would meet the test, which is why the department's response was framed in the above way. The department reiterated that the only reason a child protection agency would not take action in a 'high risk case' would be lack of resources to do so. DoCS stated that:

Recommendation 17 *(continued)*

DoCS Response (continued)

The increase in caseworker resources to be delivered by 2007/08 will improve the situation. DoCS is already seeing a dramatic increase in the capacity to investigate high priority cases at CSCs which have received their allocation of new caseworkers. An equally dramatic decline in cases with significant risk factors that are closed without further assessment will follow unless demand increases to levels that overwhelm available resources.

DoCS indicated a review of the situation in this context had commenced.

DoCS further stated the view that reliance on data for completed secondary assessments is not *'a sound approach to measuring system capacity'*, and pointed out that the department is developing robust indicators that should address our concerns.

Our Comments

We acknowledge that the increase in caseworker resources will improve the capacity of DoCS to respond to reports, however note identified issues of increasing demand.

Recommendation 16 was based on the principle that if a child is reported to be at risk, then that risk should be assessed to the degree necessary, and identified risk should be resolved. That is, where risk is confirmed by secondary assessment, a case plan for intervention should be developed and implemented.

In stating this principle, we recognised that in a context of limited resources and high and growing demand, that principle would be unlikely to be fully met. Therefore, a critical step would be assessing system capacity on an ongoing basis.

Our recommendation 18 related to the 47.1% of reports referred to a CSC for further assessment in 04/05, where DoCS data indicated there was 'no secondary assessment outcome recorded'. That is, no aggregate information is available on whether, or how, these reports were responded to, whether they are open or closed, and if closed, the reason for closure.

In previous years, we have consistently recommended that DoCS should develop the capacity to collect relevant data to track, and report on, risk of harm assessment outcomes. In this context, DoCS work to develop robust indicators is welcome.

We will seek further advice from DoCS about data capacity and reporting plans.

Recommendation 18

DoCS should provide advice to this office regarding progress toward the finalisation and implementation of the *Intake Assessment Guidelines*, including provision of a copy of the current draft guidelines.

DoCS Response

DoCS provided the following information:

- The draft guidelines were trialled for 12 months in various CSCs across the state. The guidelines were subsequently evaluated, amended and then endorsed by the Executive in October 2006.
- A key finding from the pilot was the need to have dedicated intake staff. As a result, a framework for intake procedures to support the roll out of the guidelines has been developed.
- The revised guidelines were endorsed by the Executive in July 2007 and an implementation plan has been developed.

DoCS noted that a copy of the guidelines will be provided to our office once consultation with the Public Service Association is complete.

Our Comments

We will await the finalisation of the guidelines.

Quality of risk of harm assessment

Recommendation 19

DoCS provide advice to this office regarding:

- An update of progress in implementing the proposed quality review of each CSC in NSW, including details of the quantitative and qualitative information that will be sought about priority systems, processes and practice.
- Progress of the roll out of the neglect policy and revised *Secondary assessment — risk of harm procedure*, and implementation of the *Secondary assessment — risk of harm practice review tool.*

DoCS Response

CSC Quality reviews

DoCS told us that the Professional Development and Quality Assurance Branch has been established, and other staffing enhancements have been made to support the reviews, including new regional positions. DoCS advised that the reviews are intended to encompass:

- Initial analysis of qualitative and quantitative information on CSC performance (including trends over a three-year period and comparison with like CSCs)
- A '360 degree' review of CSC practice by a regionally based team, including file reviews, observation of practice, focus groups with clients and interviews with local partners. Identification of areas for focused attention and development of a Quality Improvement Plan to address identified issues.

Recommendation 19 *(continued)*

DoCS Response (continued)

- Linking the Quality Improvement Plan with Regional quarterly review processes to monitor progress on achievements, and CSC reporting on key themes and strategies.

Draft practice standards intended to support the quality review program have been finalised, and development of a Quality Review Toolkit is near completion.

Neglect / Secondary Assessment Implementation Project

DoCS provided advice about the program to roll out revised secondary assessment and neglect policies. Details of topics provided in the training sessions include:

- Analysis dimensions within secondary risk of harm assessment.
- Supervising secondary assessments.
- Case planning and intervention in neglect.
- Applying the practice review approach to current neglect cases in early intervention, child protection and out of home care.

DoCS plans to evaluate the effectiveness of the above initiatives.

DoCS also advise that a literature review on neglect matters and the Children's Court has been completed.

A *Practice Review Tool Secondary Assessment* was piloted in two regions in March 2007 (refer to response to recommendation 16).

Our Comments

The proposed quality reviews of CSCs are a significant undertaking in relation to enhancing child protection responses within DoCS. We will continue to monitor the progress of implementation of the reviews.

We acknowledge the scope of the strategies to support the new policies and procedures.

Recommendation 20

In the ongoing development of alcohol and other drugs training and professional development strategies for caseworkers and managers, including the revision of the Alcohol and Other Drugs module of the Caseworker Development Course, DoCS should consider and incorporate the issues raised in this report, in particular:

- The challenges for DoCS staff in effectively engaging drug dependent parents, particularly where parents seek to avoid contact with agencies and/or conceal or minimise substance use.
- The challenges in effectively engaging with, and responding to, women using drugs-in-pregnancy, in order to minimise the subsequent risk to their child.

Recommendation 20 *(continued)*

- The need for caseworkers to have a solid understanding of the nature of drug dependence, the range of illicit and legal substances that may be used and the range of their effects, and guidance to apply this information in assessing risk to children.
- The high vulnerability of infants and very young children in an environment of parental substance abuse.
- The importance of obtaining critical information from relevant agencies to inform risk assessment.

DoCS Response

DoCS told us that the revised Alcohol and Other Drugs (AOD) module of the Caseworker Development Course is now complete and Practice Solutions Sessions have been delivered to all CSCs. According to recent advice from DoCS, the issues raised in our recommendation *'...have been incorporated in the AOD training modules and were also addressed in the AOD Practice Solutions Sessions delivered to all CSCs.'* The Helpline's Practice Session Module targeted to Team Leaders was introduced in July 2007. DoCS expects that all sessions in the module will have been piloted by the end of August 2007.

The department has established a Drug and Alcohol Expertise Unit to provide appropriate advice, resources and tools to DoCS staff.

DoCS notes that it is collaborating with NSW Health to develop additional training initiatives in relation to drugs and child protection issues that will be *'locally organised and rolled out gradually across CSCs, starting with the drug testing pilot sites.'*

Our Comments

This recommendation went to concerns we had in relation to the quality of some risk assessments for families where parental substance abuse was an identified problem. We were concerned that risk assessment was at times adversely affected by limited caseworker and supervisor expertise in the area of substance abuse. We acknowledge the strategies being implemented.

Recommendation 21

DoCS and NSW Health should work together to develop arrangements between the two agencies to ensure expert drug and alcohol assessments are appropriately sought by DoCS and provided by NSW Health in cases where parental substance abuse is identified as a child protection concern.

DoCS Response

DoCS refers to the response to recommendation 20 above. DoCS also reported that it is *'encouraging caseworkers to liaise with their counterparts in Area Health Services where there are shared clients to ensure that relevant information about child protection concerns is exchanged. Joint training for 2007 will support this liaison.'*

Recommendation 21 *(continued)*

NSW Health response

This recommendation was supported by NSW Health.

In relation to the joint DoCS / Health training indicated by DoCS, Health noted *'It is planned that as part of this training DoCS staff will receive drug and alcohol information and Health staff will receive additional child protection information, including information on the need for adequate and useful reporting.'* The training will include:

- Information and education for drug and alcohol clinicians on how to make an assessment of risk, *'what, when and how to report'*.
- Consideration of the parenting capacities of clients in the context of medical or health conditions.

NSW Health will also:

- Look to revise the Prescribers Accreditation Course to include a focus on child protection and child safety issues.
- Consider opportunities for better training of all clinicians in relation to drug and alcohol history and 'management planning' if a history of excessive use is obtained (child protection issues included).

Our Comments

We acknowledge the training strategies identified above are positive, as are proposed arrangements for supporting the drug testing policy. We will seek a progress report on key initiatives.

Recommendation 22

DoCS should provide advice to this office of:

- The outcomes of the trial of the Health Safety Assessment Tool and any proposals for broader application of the tool across DoCS.[139] Progress in the roll out of the protocol between NSW Health and DoCS on exchange of information concerning DoCS' clients on opioid treatment, and provision of a copy of the protocol.
- Progress in the development and trial of the policy on drug testing in a child protection context, including provision of a copy of the policy and key findings to date.

DoCS Response

Health Assessment Tool

A trial of the Health Assessment Tool is expected to commence in August 2007. The trial will include an evaluation component.

Protocol on information sharing between NSW Health and the NSW Department of Community Services in relation to persons participating in opioid treatment (methadone or buprenorphine) who have care and responsibility for children under 16 years of age in order to assess potential risk of harm under the Children and Young Persons (Care and Protection) Act 1998.

[139] The Health Assessment Tool is an assessment tool specifically designed to assess the safety of children in families where one or both parents present with drug or alcohol issues.

Recommendation 22 *(continued)*

DoCS Response (continued)

DoCS provided us with a copy of the protocol In March 2007 and recently confirmed that the protocol is currently being rolled out to CSCs. The protocol formalises how DoCS will seek information under s.248 about client's opioid treatment status if a risk of harm report for a child under 16 relates to misuse of an opioid or opioid treatment, and the report is open and allocated to a caseworker for further assessment.

Parental Drug Testing Policy

A 12-month operational trial of the DoCS *Parental Drug Testing Policy* has commenced in 4 CSCs (Penrith, Campbelltown, Eastern Sydney, and Central Sydney) after CSC staff had completed training in the use of Parent Responsibility Contracts. DoCS have advised that the policy will be evaluated.

The policy is designed to guide the use of parental drug testing and casework actions where positive test results are returned, to assist risk assessment for children and young people where risk is associated with parents' serious and persistent drug use (ie drug dependency and/or heavy or binge patterns of use). Key elements of the policy include:

- Drug testing is stated to be mandatory where serious and persistent drug abuse was a primary factor in removal of a child, and restoration is being considered. The policy notes that where there is an ongoing risk of drug use that will adversely impact on parenting capacity, there should be a presumption against restoration.
- The policy states that drug testing may also be used to inform decisions about removal in cases where there is a suspicion of serious or persistent drug use that cannot be confirmed by other means.
- The policy identifies timeframes and frequency of testing, when testing should commence, and provides some guide to responses where there are positive test results.

Our Comments

The drug testing policy and information sharing protocols are positive initiatives that go towards addressing our concerns. Our recommendation asked for advice only and DoCS have complied with this, however, we will continue to monitor the roll out and evaluation of the Hearth assessment pilot, the information sharing protocol, and the drug testing policy.

Aboriginal children and young people

Recommendation 23

DoCS should provide a copy of the Aboriginal Strategic Commitment to this office, and advice on the progress of major commitments to improve outcomes for Aboriginal clients.

Recommendation 23 *(continued)*

DoCS Response

The DoCS Aboriginal Strategic Commitment 2006–2011 was released in November 2006 and a copy was provided to our office. Development of *'various directorate and regional plans'* is underway.

The document is described as a 'corporate level' document, but implementation will be at the directorate and regional level, through the development of an annual 'Commitment of Service to Aboriginal & Torres Strait Islander Peoples' Plan', which will include specific actions to meet the projected results identified in the corporate document. Regions and directorates will report six-monthly against the actions contained in the plans.

DoCS confirmed that some of the specific initiatives under consideration include:

- Developing a consultation model for use by CSC staff. The model will *'define cultural consultation, comply with legislation (Aboriginal placement principle)and recognises local differences'* .
- Establishing a regional Aboriginal Advisory Group to inform and advise CSCs on projects and programs supporting Aboriginal families and communities.
- Strengthening the capacity of mainstream early intervention services to better meet the needs of Aboriginal children, young people, families and communities
- Increased resources to better support Aboriginal Foster Carer recruitment, training and support.
- Piloting an 'Aboriginal-specific genogram project' to enhance the provision of culturally responsive casework tools and practices, and
- Developing guiding principles and protocols to inform engagement with isolated communities.

Our Comments

We acknowledge the intent of the strategic commitment and will seek a progress report on outcomes of its implementation in areas key to our work.

Adolescents

Recommendation 24

DoCS should provide advice to this office regarding:

- Progress of work with relevant community sector representatives on the issue of youth in Supported Accommodation Assistance Program (SAAP) services.
- Progress of, and findings arising from, the Child Deaths and Critical Reports Unit research paper on matters arising from the unit's reviews of deaths of young people by suicide or risk taking behaviour.

Recommendation 24 *(continued)*

- Progress of DoCS' Centre for Parenting and Research projects to inform policy and practice relating to effective strategies and interventions for adolescents at risk, any findings to date and DoCS' plans to respond to those findings.

DoCS Response

Young people in SAAP

DoCS is working on a policy with Youth Accommodation Association (YAA) to develop a policy that clarifies the level of support provided to unaccompanied children under 16 who enter SAAP services. The policy '...will establish consistent, transparent and equitable arrangements for providing case management and financial assistance for children in YSAAP services.' DoCS then plan to develop a protocol that will clarify roles and responsibilities of DoCS and YSAAP services. DoCS indicated the policy will be 'settled' in a few months.

CDCRU research re suicide

DoCS' Child Death and Critical Reports Unit has established the Adolescents at Risk of Suicide and Risk Taking Behaviour Practitioner Advisory Committee. The committee is comprised of staff that have expertise in working with 'at risk' young people across child protection, out-of-home care and intensive support service programs. The panel will focus on the deaths of young people known to DoCS, as a result of suicide and risk taking behaviour. DoCS told us that 'at the end of a 12-month period the CDCR will prepare advice on the identification of issues and areas for learning and corporate development arising from the review of these cases.'

Parenting and Research Centre projects

DoCS advised that external peer review has been completed and that final editing is being undertaken on the following papers:

- Effective casework practice with adolescents: DoCS staff perceptions and practices
- Effective strategies and interventions for adolescents in the child protection context: A literature review
- Early intervention strategies for children and young people 8 – 14 years old: Literature review.

DoCS also advised that two further reports would be published by the end of 2007 which have a complementary focus on adolescents:

- Effective strategies and interventions to support children and young people living with parents who have a mental health problem: A review of the literature
- Domestic violence: Strategies and interventions to support families.

Recommendation 24 *(continued)*

Our Comments

We note the progress advised. In relation to young people in SAAP, we note that it appears to be over 2 years since YAA and DoCS commenced this process, and there are no clear timeframes for implementation

Protective intervention

Recommendation 25

DoCS should provide advice to this office on progress with the review of policies on the use of undertakings, including a copy of relevant revised policies when completed.

Recommendation 26

DoCS should provide details about the department's policy regarding the circumstances where case plans and unregistered care plans alone will be considered to be adequate protective measures.

DoCS Response

DoCS told us that recommendations 25 and 26 are being addressed as part of a broader project that commenced with the proclamation of amendments to the *Children and Young Persons (Care and Protection) Act 1998* that deal with Parent Responsibility Contracts (PRC). DoCS have provided us with the draft Business Help topic on PRCs and a trial has commenced in eight CSCs, four of which are also trialling the drug testing policy.

DoCS advised that the next phase of the project will be to revise the policy on the use of undertakings DoCS has started updating the Case Planning Business Help topic, which will *'iterate that undertakings are not a casework option unless they form part of an Order Accepting Undertakings (s 73).'*

In relation to our query about whether the policy will provide direction about circumstances where case plans and unregistered care plans alone will be considered to be adequate protective measures, DoCS advised that *'a case plan must exist for all children and young persons for whom DoCS provides or coordinates a service, so it is more appropriate to provide advice on when other casework options are appropriate in addition to the case plan.'*

DoCS also told us that they have developed a case management policy that is applicable across the Early Intervention, Child Protection and Out-of-Home-Care program streams. The policy:

- *Defines case management, outlines the elements of case management and provides a set of overarching principles to guide practice.*
- *Describes criteria for the assignment of case management and notes strategies to manage associated risks.*
- *Clarifies the roles and responsibilities of DoCS and the non-government sector in the delivery of case management.*

Recommendation 26 *(continued)*

DoCS Response (continued)

The policy is publicly accessible on the DoCS website. DoCS are also developing a best practice guide to case planning, monitoring and review. This will be supported by an integrated case planning template and is due for completion in November 2007.

Our Comments

Our long-term concerns with undertakings have included confusing policies and procedures (which DoCS agreed was the case), lack of explicit requirements for monitoring undertakings, and consequences of breaches.

We made this recommendation in the context of the use of undertakings relating to parental drug and alcohol issues. In this context, the Parent Responsibility Contracts are a positive response. We will monitor the implementation of the contracts and review the *Case Planning* and *Care Plan* policy when finalised.

Timeliness of intervention and monitoring of support services

Recommendation 27

The proposed DoCS quality reviews of CSCs should include review of CSC systems and practice in relation to timely implementation of case plans, and the efficacy of systems in place for monitoring the implementation of case plans.

DoCS Response

DoCS' response refers to the department's response to recommendation 19. DoCS also noted that the *Quality Review Toolkit* that was developed as part of the CSC quality review project, includes *Practice Review Tools* designed to '*assess practice in relation to timely implementation of case plans*.'

DoCS also told us that the case planning module of the *Early Intervention Practice Review Tool* has been piloted and reviewed. The results of the review confirmed *'the effectiveness and validity of the tool.'*

Our Comments

This recommendation was made following our finding that in some cases, a relatively significant amount of time elapsed between the decision that a child was in need of protective intervention or support, and the subsequent provision of such support.

The intent of this recommendation was for DoCS to incorporate measures into their CSC Quality Review process to help identify, and subsequently address, any gaps or systems issues in relation to the implementation of case plans.

From the information provided, it appears that this intent will be met by the methodology of the CSC Quality Reviews. As noted above, we will monitor the progress of the quality reviews.

Apprehended Violence Orders

Recommendation 28

NSW Police should provide advice to this office of progress with the AVO Compliance with Legislation project.

Police Response

This recommendation was supported by NSWPF

In response to a draft copy of this report, NSWPF noted that the AVO Legislation Alignment Project 'continues to improve the process of police applying for AVOs. Automatic electronic faxing of reports will commence in February 2008. This implementation will be supported by a training strategy.

NSWPF also advised that the issue of children having separate AVOs is under consideration by NSW Parliament.

Further, NSWPF noted that the Child Protection and Family and Domestic Violence SOPs will *'be consistent in relation to when police should use AVOs for children, including applying for AVOs on behalf of children.'*

Our Comments

Our original recommendation (2005 report) asked NSWPF to review whether AVOs for children were being used effectively and whether police had adequate procedural guidance for determining the circumstances that would warrant an AVO being taken out on behalf of a child.

Changes to part 15A of the Crimes Act and the AVO Legislation Alignment Project are relevant overall to the original intent of the recommendation — the changes expand relevant definitions related to domestic violence, increase the focus on children involved in domestic violence and allow for greater scope in making an application for orders, particularly in relation to telephone interim orders.

Interagency response to children at risk of harm

Recommendation 29

DoCS should advise this office of the progress of the review of evaluation frameworks for interagency practice, and timelines and method for the proposed evaluation of the *NSW Interagency Guidelines for Child Protection Intervention.*

DoCS Response

An evaluation framework was developed by DoCS and endorsed by Human Services CEOs in February 2007. The framework involves *'quantitative and qualitative surveys of a sample of CPSOG* [Child Protection Senior Officers Group] *agencies, key peaks and non government agencies with a child protection role to gauge the take-up and effectiveness of policy and practice from both an agency and field perspective.*

In March 2007, DoCS provided this office with a draft of the framework for comment. A final version was provided in April 2007. Following this, a

Recommendation 29 *(continued)*

DoCS Response (continued)

consultancy brief, based on the evaluation framework, was finalised in April 2007 and has been issued to an external consultant for further work.

DoCS expects the evaluation to be conducted in two stages, and anticipates completion in 2009.

Our Comments

The evaluation framework is solid and covers key aspects of the guidelines.

Pre-natal reports

Recommendation 30

NSW Health and DoCS should, through an appropriate joint forum, develop a state-wide policy by which hospitals can alert DoCS about the birth of a baby, and through which a coordinated response to any concerns about risk to the baby can be initiated.

NSW Health Response

This recommendation was accepted by NSW Health.

NSW Health refers to the Children and Young Persons (Care and Protection) Miscellaneous Amendments Bill 2006 and that it will *'strengthen links in reporting of risk of harm and information sharing between NSW Health and DoCS'*.

Further, *'NSW Health and DoCS have discussed systems for implementation of these changes, including mechanisms to facilitate enhanced information sharing and 'alerts' to DoCS upon the birth of babies determined to be at risk of harm following a prenatal report.'*

DoCS Response

DoCS advise that they continue to work collaboratively with NSW Health on the development of a system whereby DoCS *'may alert Health about prenatal reports deemed to be at medium to high risk of harm, and Health may, in turn, alert DoCS upon the birth of the baby where risk of harm is still present.'*

DoCS has recently completed a cost benefit analysis of a number of options and it is anticipated that a policy dealing with 'birth alerts' will be finalised shortly, pending further consultation with NSW Health.

DoCS also refer to their response to recommendation 10. In particular, their drafting of a policy on responding to prenatal reports, for which DoCS is *'working very closely with NSW Health.'* DoCS advised that: *...the Responding to pre natal reports policy will utilise existing DoCS assessment processes to prioritise reports for assessment within 72 hours and a section 248 request will be issued to Health and/or other agencies as part of a SAS1 as advice regarding the prenatal report. This will assist an agency in meeting its obligations under the new section 23(f) of the* Children and Young Persons (Care and Protection) Act 1998 *for reporting following a birth.'*

Recommendation 30 *(continued)*

Our Comments

Our recommendation was based on the finding that there are inconsistent systems and arrangements across different CSCs and Area Health Services for alerting DoCS that a baby the subject of a pre-natal report has been born.

We note that legislative amendments to prenatal reporting will strengthen obligations to report risk of harm in relation to children born in hospital. We will continue to monitor progress in relation to policy development and roll out of a relevant process.

Adolescents

Recommendation 31

DoCS and NSW Health should discuss, at an appropriate joint forum, the issues raised in the *Report of reviewable deaths in 2004* concerning adolescents. In particular, the agencies should consider strategies to promote effective and coordinated child protection and health responses to adolescents who are reported to be at risk of harm and where concerns include suicide risk and/or mental health.

DoCS Response

DoCS told us that they have met with the Child and Adolescent Mental Health Services Network to *'develop a draft framework which aims to meet the mental health needs of children and young people in care by seeking to ensure that they receive appropriate services.'*

A *Mental Health Outcomes and Assessment Tool — Child and Adolescent Triage Module* is currently being considered by DoCS to inform the development of a tool for DoCS caseworkers to use when making referrals to Child and Adolescent Mental Health Services.

The Human Services CEOs have endorsed a Child Protection Senior Officer's Group project to review assessment tools used with young people who are at risk. *'This project will involve identifying the range of assessment tools currently used to assess the needs of this group, across agencies, as well as identifying assessment tools for at risk young people used in other jurisdictions.'*

The stated purpose of the project is to achieve greater integration of assessment tools used with this client group, so as to avoid unnecessary duplication and repeat assessments. DoCS advise that *'the review aims to identify opportunities for greater streamlining and integration.*

NSW Health Response

This recommendation was supported by NSW Health.

NSW Health will work with DoCS, through the DoCS-Health Senior Officers Group, to identify strategies to promote effective and coordinated child

Recommendation 31 *(continued)*

NSW Health Response (continued)

protection and health responses to adolescents who are reported to be at risk of harm and where concerns include suicide risk and/or mental health.

NSW Health refers to the MOU as above, and the development of the addendum being developed to *'improve linkages between NSW Health and DoCS in the care of adolescents and young people'*, with a focus on adolescents with 'higher levels of need' or who may warrant admission to inpatient units. We confirmed the addendum relates to young people in statutory care.

Health also refers to a regional MOU developed between Northern Sydney/ Central Coast Area Health Service and DoCS (Central Coast) in 2002 to *'respond effectively to crisis situations and to provide ongoing support through sound case management practice'*.

Our Comments

The responses do not relate directly to the intent of the recommendation, in regard to the range of issues raised in our report of reviewable deaths in 2004. The recommendation was made in the context of our observation that most of the young people who had committed suicide had had contact with a number of agencies, but in some of these cases, there was limited commun-ication or coordination between services, including between mental health services and DoCS.

As noted in this report, there appears to be no clear cross-agency framework for responding holistically to young people at risk, particularly where child protection concerns are coupled with mental health issues/risk-taking behaviour.

Aboriginal children and young people

Recommendation 32

Human Service CEOs should provide advice to this office on the progress of:

- Human Services CEOs' initiatives in regard to strengthening joint responses to Aboriginal children and young people once a secondary risk of harm assessment has been conducted and risk of harm confirmed.
- Child Protection Senior Officer's Group identification and mapping of legal, policy, procedural and practice issues from recent reports on child protection for interagency action.

Recommendation 33

In progressing the above initiatives, Human Services CEOs should consider strategies to strengthen joint responses to Aboriginal children and families more broadly, particularly in relation to:

- exchange of information and consultation between DoCS and relevant agencies when assessing risk of harm, and
- coordination of support services to families where need is identified prior to confirmation of risk of harm.

Human Services CEOs' Response

In response to the recommendations, the Chair of the Human Services CEOs Forum advised

- The NSW government has released an *Interagency plan to tackle child sexual assault in Aboriginal communities*. The actions in the plan specifically address improvements to exchange of information when assessing risk of harm.
- The Child Protection Senior Officers Group has undertaken a mapping exercise to identify issues from recent reports on child protection that need an interagency response. This analysis has informed the Group's work plan for 2007–08.
- *NSW Interagency Guidelines for Child Protection Intervention* contain expanded content regarding practice commitments, including an improved interagency response after a secondary assessment has confirmed a child / young person is in need of care and protection.
- A comprehensive communication strategy about the content of the guidelines has been implemented, and evaluation of the guidelines will commence in 2007/08.

Our Comments

We note the strategies advised. We will continue to monitor responses by key agencies to the needs of Aboriginal children at risk and their families.

Integrated case management projects

Recommendation 34

DoCS should provide advice to this office on the progress of evaluation of service delivery models of interagency cooperation, and how the department intends to apply the outcomes of evaluation.

DoCS Response

An Anti Social Behaviour Case Coordination Framework is now being rolled out in a number of locations as part of an Anti Social Behaviour Pilot Strategy. The locations are based in NSW Local Police Area Commands (Canobolas — Orange and Cowra; Orana — Dubbo and some surrounds; Darling River — Bourke and some surrounds). The projects have taken over the structures of the Complex Case Management Response Team (Bourke) and Integrated Case Management (Dubbo).

The pilot is based on the model developed in Redfern-Waterloo, which involves a whole-of government approach with multiple human and justice agencies.

'The Case Coordination Framework provides for a more responsive, holistic and integrated case planning process for high risk children and young people with multiple and complex needs.' The focus is on partnerships for improving and coordinating strategies to *'reduce risks to, and anti social behaviours of, children and young people requiring multi agency intervention.'*

Recommendation 34 *(continued)*

DoCS Response (continued)

DoCS advised that future extension or expansion of the project will be a matter for the Premier's Department or Cabinet.

Our Comments

We acknowledge the roll out of the framework. Through our broader work on cross agency issues, this office will monitor progress of the pilot project.

NSW Ombudsman

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