CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of SG
Hearing dates:	19-23 June 2023
Date of findings:	25 August 2023
Place of findings:	Lidcombe
Findings of:	Magistrate Kennedy Deputy State Coroner
Catchwords:	CORONIAL LAW – death of Aboriginal child; intentionally self-inflicted; protective care and treatment; recommendations made
File number:	2020/144089
Representation:	Mr Mark Anderson, counsel assisting instructed by Ms Rebecca Hubbard and Ms Alice Petch of the Crown Solicitor's Office Ms Hayley Bennett of counsel instructed by Darren Chennell of the Department of Communities and Justice for the Department of Communities and Justice Mr Ben Bickford of counsel instructed by Drew Hamilton of Hamilton Janke for LP Mr Lester Fernandez of counsel instructed by Nicole Cerisola, Kristine Gorgievski and Aashna Lohia of McCabes for the Department of Education Ms Eva Elbourne of counsel instructed by Amy Stenning of HWL Ebsworth For the Hunter New England Local Health District

Findings:	**I make the following findings pursuant to section 81(1) of the Coroners Act 2009 (NSW),** ***The identity of the deceased*** The deceased person was [redacted] ***Date of death*** 13 May 2020 ***Place of death*** [redacted] ***Cause of death*** Hanging ***Manner of death*** Intentionally self-inflicted
Recommendations	**<u>To the NSW Department of Education ("DOE"):</u>** 1. That the DOE implements a policy to ensure that a copy of any prior child protection history is accessed by school counsellors at the time of, or shortly after, meeting with suicidal students so that an assessment of cumulative trauma and post-traumatic stress can be more accurately obtained at the time of presentation to a counsellor. 2. That the DOE undertake a comprehensive review of current policies across all schools and implement a clear suicide and wellbeing policy, ensuring that the policy considers the following: a. the mandatory delivery of a suicide prevention or safety plan for all students reporting suicide

	attempts be implemented as soon as possible after a suicide attempt; b. If a safety plan is not developed or implemented for any reason, the reasons for this decision are documented and signed off jointly by the school principal and school counsellor, and parents/carers and other agencies (if involved) are informed; c. A mandatory checklist be developed to ensure all school staff are clear on the precise steps required, and the allocation of roles and responsibilities when there is a suicide attempt; d. Provide information and adequate resources to provide immediate support to staff, parents and students in the event of suicide attempts or suicidal behaviour; e. Ensure that steps required under the policies of the DOE are enacted at the local level; f. Implement a mandated and automatic system for follow-up by school counsellors, which is not dependent upon individual capacity or memory; and g. Implement an additional level of oversight for when a mandatory report or e-referral to DCJ is sent to the principal and deputy principal which does not permit human error to allow the child or young person to be unsupported. 3. That an education and training package be delivered to school staff (including principals, deputy principals, teachers and school counsellors) to ensure policies relating to student wellbeing and suicide at a local and

	state level are being followed; and provide comprehensive and practical training on responding to a suicide attempt or suicidal behaviours. **Jointly to the Department of Communities and Justice, NSW Department of Education and the Child and Adolescent Mental Health Service, Hunter New England Local Health District**: 4. Consideration be given to developing a joint agreement between the Department of Communities and Justice, NSW Department of Education and the Child and Adolescent Mental Health Service, Hunter New England Local Health District, so as to ensure cooperation, coordination, communication and information sharing takes places 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 a 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.

	<u>Jointly to the NSW Department of Education and the Child and Adolescent Mental Health Service, Hunter New England Local Health District</u>: 5. That an education package is developed by the above agencies to provide to parents and carers of children or young people who have attempted suicide or expressed suicidal behaviour. The package is to provide guidance in relation to dealing with suicide attempts, suicidal behaviour, initiating appropriate conversations with young people in relation to same, and general suicide and wellbeing education for parents, particularly around the possibility of any further attempts of suicide and risk factors. Such a package should be provided to parents following a report to a school counsellor or a referral to CAHMS about such behaviours. **<u>To Department of Communities and Justice:</u>** 6. 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.

Non-publication orders	Non-publication orders prohibiting publication of certain evidence pursuant to the *Coroners Act 2009* have been made in this Inquest. A copy of these orders, and corresponding orders pursuant to section 65 of the Act, can be found on the Registry file.

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Introduction

1. SG was just 15 years of age when he tragically took his own life. SG was an Aboriginal boy descended from the Biripi peoples.

2. He was a much-loved son, brother, nephew, grandchild and friend. He was funny, kind, loving and entertaining. He was very much part of his school community, he tried hard in his classes, caused no problems or issues at school and was excelling in the area that he loved, working with tools. He wanted to be an electrician and was already demonstrating excellent skill in related subjects at school. In many ways SG appeared as a very ordinary schoolboy. However, he was in fact quite extraordinary.

3. SG had managed to fit in, cause no trouble, apply himself at school and be well-loved in the face of a lifetime of adversity. He was Aboriginal, with Aboriginal heritage from his mother's side only. His mother suffered from significant mental health issues, and sadly as a result he suffered physical and mental abuse for many years, until the Court determined that his mother could no longer safely be part of his life. There were more than 40 reports to what was then Family and Community Services ("FACS") over the course of his life. He lived with a mild cognitive impairment which challenged him in the area of communication and language. He was eventually to be raised by his father and stepmother, with his two brothers, one who was profoundly deaf. As a result of family difficulties, he moved schools more than 5 times. He had not been diagnosed with any mental illnesses at the time of his death. Yet, despite of all of this, he was well behaved, compliant with rules, connected closely with family and friends and able to apply himself.

4. This inquest looks at SG s death in circumstances where he started to suffer with his own mental health difficulties. He disclosed to a school counsellor, after being taken there by a friend, that he had tried to take his own life.

5. A mandatory report was made to FACS, as well as a referral to the Child and Adolescent Mental Health Service ("CAMHS"). The mandatory report was sent to the school principal and the deputy principal. His father was informed.

6. The action that occurred following can be summarised as follows. CAMHS made contact with SG s father, and scheduled two appointments which SG failed

to attend. The CAMHS file was closed, FACS was informed, and the school was not informed.

7. The school made no follow up with SG or his father after a second counselling session in 2019.

8. FACS was aware of SG 's full history and was made aware that he did not attend the sessions at CAMHS, and closed his file.

9. Within six months, SG took his life by the same means as his first attempt.

10. As the inquest developed it became apparent that the real issue in the proceedings was to consider how three separate government agencies could close their file after a young Aboriginal school boy with a significantly traumatic, and known to be traumatic, past made a known attempt on his own life.

11. This is an important issue in circumstances where the community works to significantly decrease rates of suicide in our children, and in particular where Aboriginal children are overrepresented amongst that adolescent group.

12. To his family's credit, they were engaged and generous throughout the proceedings, and their questions related to how another child in the future can receive more protective treatment.

Introductory remarks

13. The coroner's primary function is set out in section 81 of the *Coroners Act 2009* (NSW) ("the Coroners Act"). It is to make findings as to the identity of the person who has died, the date and place of their death and the manner and cause of death. The inquest is not adversarial, but inquisitorial. The focus is to determine what happened without attributing blame, guilt or making findings of liability.

14. In this case, there is no controversy as to identity or the date and place of the death, nor the cause. The manner of death was the subject of the inquest.

The Inquest

A. Reflection on the life of SG

15. The inquest had the benefit of receiving family statements. SG was described as a delightful boy, who was very loving towards his family. He had a shyness to him, which his grandmother attributed to his learning disabilities. The family reported no difficulties with him in his behaviour, in fact he was a very cooperative boy. He loved soccer, and that was something he shared with his father, whom he was named after.

16. Although he was described as having learning delays in language development, a review of his school records would suggest that in spite of this fact he was a hard worker, and performed well. In his reports he was obtaining solid marks, in most subjects within the "sound" range, with excellent results of over 80% for history and PDHP and of over 70% in maths, which again demonstrates that in the face of cognitive impairment he was working very hard. The comments in his reports are that he was a quiet student, and a pleasure to have in the classroom. He was commended for his application to his studies.

17. As indicated earlier, other than a few school issues, he was generally a good attender and participator. He did not draw attention to himself nor cause trouble.

18. I turn now to the challenges that SG had already faced in life, and I do so to better reflect the vulnerability of SG

19. He was reported to FACS which I will refer to as the Department of Communities and Justice ("DCJ") more than 40 times. Police had confirmed physical abuse by his mother towards SG and his brothers over the years. An Apprehended Domestic Violence Order ("ADVO") was taken out on 24 August 2015 to protect SG and his brothers from their mother. He was 12 when the court decided on 6 February 2017 that his mother could not have any physical contact nor communication with the children. She could send a birthday or Christmas card and gifts only.

20. His mother was his link to his Aboriginal heritage. SG had no further involvement with his mother's family from February 2017. Other allegations, of a sexual nature, had been raised against his maternal family. Although there was strong paternal

support for SG there was no evidence that there was a way for him to explore his Aboriginal heritage within his family.

21. It is important to note that SG 's father had been through struggles himself. He worked very hard to get assistance for SG 's mother as she declined in her mental health. He made the decision to remove himself and the children after a serious threat to set the family house alight. He tried to access mental health support, even taking her to hospital only to have her sent home. He had three sons, each with cognitive or physical disabilities, and was managing a complex family dynamic. SG 's younger brother being profoundly deaf meant that there was no mechanism for easy communication during this period of time. Again, that SG 's father managed to raise the boys in this environment says a lot for his character, but these environmental factors also further evidence why SG required support from outside agencies.

B. Chronological events

22. Counsel assisting provided a factual background that was not in contention in this inquest, which I repeat in part below.

23. As previously stated, during his childhood SG was officially reported to DCJ more than 40 times. The reports made when he was a baby and young child paint a picture of a chaotic, uncertain, and an often unsafe domestic environment. SG 's father was the carer for SG 's mother throughout their relationship and the primary carer for the children throughout the relationship. His mother had been under community mental health orders in the past in order to maintain compliance with her treatment. She also had a long history of psychotic episodes that appear to be characterised by paranoia, agitation, and unpredictable behaviour.

24. SG described his mother as a "cranky kind of person", he was reported to be sad when he stayed with her, and to feel that it wasn't safe with her. In contrast, SG reported he felt always safe and relaxed with his father. SG reported that on occasions his mother became angry and kicked and punched him all over his body.

25. In January 2013 SG 's parents separated and Federal Circuit Court (as that court was known then) ("the Court") proceedings were commenced.

26. In May 2013 his brother was hospitalised with severe medical issues requiring a feeding tube, and removal of a benign tumour on his neck. His younger brother also is deaf from birth and has had a cochlear implant. During that hospitalisation his mother was removed from the ward due to her behaviour.

27. The older of SG 's two younger brothers, like SG had delays in language development which impacted on his academic performance. After the separation of his parents, SG and his brothers were initially removed from their father's care pursuant to allegations made by his mother, and an interim ADVO based on those allegations was made. The reports made by his mother concerning his father's behaviour had little in the way of supportive evidence. The interim ADVO was dismissed after it was realised that there was no basis for it.

28. On 13 September 2013 his mother was admitted to a mental health ward and SG 's father took over the full-time care of the boys.

29. After the preparation of a Family Report prepared by the clinical psychologist appointed in the Federal Circuit Court dated 11 October 2013, Orders were made on 18 October 2013 providing for the children to live with their father, and for his mother to have only supervised time with SG and his brothers.

30. Prior to separation SG saw his mother pour petrol over the sunroom floor and attempt to light a fire. His father defused the situation by cleaning up the fuel before she lit it. SG 's father reported this event, he said witnessed by the children, in his statement to the police in this inquest as follows:

> "*About 2 or 3 weeks before* N *and I broke up,* JG, N *poured petrol all over the sun room floor. She stood in the petrol with a burning dishcloth. The kids all witnessed this incident. I took the kids for a drive to get away from her. I tried to have her scheduled for this, but the police and ambulance couldn't do it. I took her to hospital myself, but because* JG, N *was mentally coherent, the hospital wouldn't schedule her either*."

31. During the course of those Federal Circuit Court proceedings, SG reported to the psychologist preparing the reports that when he spent time with his mother, one of his mother's relatives (her half-brother) put him in the bin and wouldn't let him out.

It was reported that a heavy object was put on the lid. SG also reported that his mother flushed his brothers head down the toilet a few times. His brother himself reported that this happened 3 times. His mother denied the reports. Physical abuse by their mother was later confirmed by the children in interview with the Joint Investigation Response Team ("JIRT").

32. In January 2014 SG 's brother refused to spend time with their mother due to allegations of her mistreatment of him. In March 2014 SG also refused to spend time with his mother.

33. Orders were made on 30 June 2014 for SG 's father to have sole parental responsibility for the children and for them to live with him. His maternal grandmother was, pursuant to the orders, able to spend time with the children once per month for the weekend from Saturday morning to Sunday at 4:00pm, plus one week during school holiday periods in the term breaks, and two weeks in the Christmas holidays. His mother was allowed to spend supervised time with the children, supervised by the maternal grandmother as agreed with her. This was an agreement between the parties ratified by the Court.

34. The children made disclosures to their father of alleged physical, verbal and sexual abuse and neglect by their mother, experienced by them when spending time with her. There were JIRT investigations in about June 2015 into alleged sexual abuse by his mother towards his brother, which was alleged to have been observed by SG and his brother but not confirmed by that investigation. JIRT confirmed physical abuse which was not actioned into criminal proceedings but which resulted in an ADVO application, provisional ADVO issued on 24 June 2015, and final ADVO for a period of 2 years expiring on 24 August 2017, to protect SG and his brothers from their mother.

35. Orders were then made on 7 April 2016 for SG 's father to have sole parental responsibility for the children, and for the children to live with him. The children were not permitted to spend time or communicate with their mother or maternal grandmother.

36. After a further, more comprehensive Family Report, as referred to previously, Final Orders dated 6 February 2017 were made that SG 's father have sole parental responsibility for the boys and that they live with him. Under those orders his mother could not have any physical contact nor communicate with the children. The final orders only permitted his mother to send a birthday and a Christmas card, and gifts, to the children through the father. The psychologist who wrote that report had access to the records from DCJ in addition to Police records and health records produced under subpoena. The reports to DCJ and the police formed part of her consideration. At the time of SG 's death, DCJ was aware of these historical concerns.

37. SG and his brothers had no further contact with their mother due to these events and court orders.

38. On 8 November 2018 a report was received alleging that his younger brother's cochlear implant was not being maintained by his father and that the children's personal hygiene, and developmental and medical needs, were not being met. It was also alleged that SG was supervising and caring for his younger brothers in the home. The report was screened in as a Risk of Significant Harm ("ROSH") report on 25 November 2018 and referred to Maitland Community Service Centre ("Maitland CSC") recommending a response time of less than 72 hours. On 28 November 2018 Maitland CSC closed the report under current competing priorities. There was also no capacity to allocate the investigation to a caseworker.

39. On 11 November 2018 a report was received that the maternal grandmother and her partner had sexually assaulted the children and that the maternal family had physically assaulted the children. The report was screened in as a ROSH report and referred to Maitland CSC for a response time of less than 72 hours. On 21 November 2018 Maitland CSC considered the report during a peer review and closed the report under current competing priorities, and again there was no capacity to allocate the matter to a caseworker.

C. Report to the School Counsellor

40. On 4 December 2019 SG saw the school counsellor, LP. SG's friend, E, who was concerned for SG's safety, accompanied him. SG reported there was great conflict in his home, specifically relating to his stepmother.

41. SG told LP that he had tried to suicide by hanging himself the previous week. He told her that he had been feeling extremely sad and depressed because of abuse he was receiving from his stepmother. SG discussed spending the weekend at a friend's house to give himself a break from his stepmother.

42. LP told SG that she would contact his father and make a referral to CAMHS to get him additional support for his mental health concerns. LP made a referral to CAMHS and made an e-report to DCJ, as a mandatory reporter.

43. LP made contact with SG's father by telephone to discuss her concerns arising from the session with SG His father was concerned for SG and agreed to the CAMHS referral. LP discussed the referral process with him, and he agreed to take a call from them to get support for SG LP also informed him that she would be seeing SG for a follow-up session, and he agreed to this further counselling.

44. Regarding this conversation, there is an evidentiary issue regarding whether LP told SG's father that there was a rope under SG's bed. LP believes that she was not aware that there was a rope under SG's bed. SG's father's account is that LP told him that there was a rope under his son's bed, and as a result he checked under the bed and found there was a rope tied into a noose. He also checked the lampshade on the ceiling of SG's room and saw there was dust on one side, so he thought something had pulled on the lamp.

45. His father said that when SG got home from school that day, he spoke to him and they both cried. He says that he asked SG what was wrong, and SG explained to him that memories of his mother were coming back. His father asked him if he wanted counselling and SG said words to the effect: "No, that's for nutters." His father told him to talk to him if he had any bad thoughts. After looking through SG's phone, his father found videos on how to tie a hangman's knot.

46. On 5 December 2019 LP called SG 's father and he informed her that he had a discussion with SG and felt everything was well with him. He admitted to LP that his wife was a bit hard on the children, and said they would try to have more open and honest discussions with SG over the weekend about his feelings.

47. On the same date, 5 December 2019, the Child Protection Helpline received an electronic report from LP raising concerns for SG and his siblings after SG disclosed that he had attempted to hang himself from a light in his bedroom on 24 November 2019. The report included information that " SG *did not feel safe at home on the weekends because his stepmother regularly yelled at him, had hit him and his younger brothers on the back and neck, had threatened to cut off his tongue and fingers, and badly pinched him and his siblings*."

48. SG also was reported to have said that his father did not protect him from the abuse which had been occurring since he was approximately in Year 4 at school. LP advised in the response that SG 's father had not been aware of SG 's suicide attempt, and denied any allegations of abuse. The helpline was informed that SG was referred to CAMHS.

49. This report was screened in on 9 December 2019 as a ROSH report and transferred to Maitland CSC with a required a response time of less than 72 hours. The report was then reviewed on 13 December 2019.

50. On 13 December 2019 LP had a follow-up counselling session with SG LP said that SG reported to her that he had discussed his concerns with his father and stepmother and was now feeling safer in the home. LP offered follow-up with SG in 2020 if he thought it would be beneficial. SG agreed to this.

51. On 16 December 2019 Luciana O'Gara, caseworker with DCJ contacted LP and asked some questions to which response was made that SG was "safe" as "several protective measures have been put into place", his father "is more protective and engaged in SG 's life since the report was made", and his step-mother "is also being more protective and using more gentle discipline with SG ."

52. That same day LP emailed Luciana O'Gara to inform her that she had contacted Maitland CAMHS about the referral for SG who confirmed they had actioned the referral , were waiting to hear back from his father and would try to reach him again in a few days. The ROSH report made on 5 December 2019 was then recommended to be closed.

53. LP says in her statement that on 16 December 2019 that she followed up the CAMHS referral, confirming that it had been received and that they were waiting to hear back from SG s father to make an appointment. LP also said that she had no further contact with CAMHS or with SG after this date.

54. On 17 December 2019 Kathryn Scott-Glassock, Manager Caseworker at DCJ, reviewed the received information and recommended that the ROSH report be closed. This recommendation was peer-reviewed on 19 December 2019 by Ms Renee Warby, Manager Casework with DCJ, who supported the closure recommendation. Ms Scott-Glassock believed that CAMHS Hunter Valley would provide the right level of specialist support for SG and would notify DCJ of any further risks requiring child protection intervention or action.

55. On 23 December 2019 the Child Protection Helpline received a further electronic report stating that SG had not attended two CAMHS assessments scheduled for him on 12 December 2019 and 23 December 2019. This report was screened in by the Child Protection Helpline as ROSH for significant psychological harm and excessive discipline. The report was transferred to Maitland CSC with a required response time of less than 72 hours.

56. On 24 December 2019 Maitland CSC workers reviewed this ROSH report of 23 December 2019 and recommended that the report be referred to the next weekly allocation meeting on 3 January 2020 for discussion and decision-making. On 3 January 2020 a joint decision was made by Ms Scott-Glassock and Ms Weller, another manager caseworker with DCJ, to close the report. This was said to be in accordance with the Triage Assessment Mandate. The reasons for closure were firstly, that no new allegations of abuse or self-harm had been made, secondly CAMHS, it was assumed, would try and further engage with SG and his family, and finally, due to the lack

of capacity of Maitland CSC to prioritise and allocate other more urgent reports if it were not closed.

57. Ms Scott-Glassock indicated that at this particular meeting thirty ROSH reports for thirty different families were reviewed, and only six families were able to be allocated to caseworkers to complete safety and risk assessments, two families were transferred to a different Community Service Centre closer to where they were residing, and nine ROSH reports were put over to the next weekly allocation meeting. Of those thirty ROSH reports, thirteen were closed because other families were prioritised. SG 's ROSH report was one of those.

58. At the Weekly Allocation Meetings, it was explained by Ms Scott-Glassock, allocation of matters to be further investigated is based on a summary assessment of risk level, whether immediate intervention is required because of the ages of the children, family vulnerability, parental risk factors and other information gathered during the triage phase. The allocation is also dependent upon the capacity of the CSC to allocate a child protection caseworker to the family.

D. Matters leading to the death of SG *on 13 May 2020*

59. Following that time there was no psychological, or other, intervention by any agency or department.

60. About 2 months after the initial contact with the school counsellor, SG 's father gave an account in his statement that SG came home from school and spoke with him. SG told his father that he had seen a video at school that brought up memories of his "ex-mum" and was crying. A few weeks after that, SG got very sad and told his dad that he was again having bad memories of his "ex-mum". On these occasions his father says that he hugged SG and afterwards they went to soccer practice where SG appeared to be normal.

61. On 13 May 2020 SG 's father recalls in his statement that SG was doing his schoolwork in the morning at home due to remote learning, online on his computer. SG didn't have any face-to-face contact with teachers that day. Because of COVID restrictions children were learning from home.

62. SG 's father recalled that after doing his homework SG played PlayStation online with some of his friends. SG 's brothers also were playing online. SG 's father recalls that he could hear SG laughing and joking with his friends while they were playing.

63. SG and his father went for a walk to the local primary school grounds where other children were playing basketball on the basketball court. SG did not interact with the boys, and he said he did not know who they were. One of the boys ran up to SG to say hello and SG said he did not know him.

64. They both then went home and ate and watched TV while SG also played on his phone. SG 's father says in his statement that everything seemed fine.

65. A few hours later they went to soccer practice at Maitland Park. SG 's father videoed SG performing a soccer drill which SG seemed happy doing. Following this, SG appeared to his father to be "flat". They practised for a little bit longer, but SG wasn't improving so they packed up and went home. They got home at about 5:00pm. SG 's father saw the boys into the home, then he went for a run and returned home at about 5:45pm.

66. When SG 's father arrived home from his run, he began tidying up the house. He asked SG 's brother where SG was, but SG could not be found His father checked his bedroom and through the house but could not locate him. He then got into his car and drove around the streets looking for SG He returned to the house and asked SG 's brother again if he had seen SG and he said he had not. He continued looking for SG attending the local shopping centre at [redacted] to look for him. He returned home just after 7:00pm.

67. SG 's father again looked through the house again for SG but could not find him. SG 's brother said to his father that the latch on the back door was unlocked. He then went into the back garden, and saw SG hanging from a tree. There was a ladder standing up next to him. He tried to lift SG 's body onto a trolley because he thought it would enable them to get him into an ambulance more quickly. SG 's body was too heavy to lift. SG 's father called an ambulance, and the operator instructed him how to do undertake cardiopulmonary resuscitation ("CPR").

68. When the first ambulance arrived, the paramedics took over CPR. The ambulance records show that the first call was received at 7:27pm and that ambulance arrived at 7:36pm. Attempts at resuscitation ceased at 7:57pm.

69. SG 's brother was later able to access SG 's phone and find a video it appeared was watched earlier that day about how to tie a hangman's knot. Investigations were undertaken but no note or other evidence of intention was located.

E. Events following SG 's death

70. On 14 May 2020 the Child Protection Helpline at DCJ assessed the report received concerning SG 's death as meeting ROSH and screened it in, with a referral to Maitland CSC recommending a response in less than 24 hours.

71. On 15 May 2020 the report was allocated for field assessment as part of the sibling safety assessment for SG 's brothers. On 17 May 2020 Maitland CSC completed a safety assessment with the outcome of "safe".

72. On 2 July 2020 a risk assessment was completed by Maitland CSC which was scored as "moderate". That risk assessment noted that the caseworkers met with SG 's father and step-mother. Both said the concerns previously raised about discipline were not true, and SG had apologised to his step-mother, saying that he made the allegations up after she disciplined him by removing his PlayStation. SG 's father said he tried to encourage SG to attend counselling, but he refused. At the time of his suicide SG appeared to be "happy and laughing" and they did not see any indicators that he was in a state of emotional grief and turmoil.

Issues for determination

1. Whether there was adequate support and services provided to SG and to his family, by and on behalf of, the agencies involved, including the Department of Communities and Justice, NSW Department of Education, and the Child and Adolescent Mental Health Service, Maitland Hospital, Hunter New England Local Health District (LHD) ("the Agencies").
2. Whether there was adequate communication and interagency consultation between the Agencies to ensure SG was engaged with services and receiving ongoing

monitoring and support, including mental health intervention and/or alternative casework responses.

3. Whether there was adequate liaison, collaboration or coordinated care between the Agencies as to the case management of SG
4. Whether the involvement of multiple agencies resulted in important issues or responsibilities being overlooked in the care being provided to SG
5. With respect to the Department of Communities and Justice ('DCJ'):
    i. Whether DCJ adequately and appropriately responded to SG and his family, including:
        (a) From November 2018 until SG 's death in May 2020, whether DCJ's response to reports about SG was adequate, including the decision to close Risk of Significant Harm reports due to competing priorities and the basis for decisions made in relation to same;
        (b) Had the reports made in December 2019 been allocated to a caseworker, what intervention from DCJ might have looked like, including culturally appropriate intervention, and how SG Senior may have been supported in his care of SG and
        (c) The appropriateness and adequacy of DCJ's response and any related communication with respect to the report made in December 2019 relating to SG 's attempted suicide.
6. With respect to the NSW Department of Education:
    i. The adequacy and appropriateness of the decisions and management of SG by the NSW Department of Education and their employees, noting his prior reports of intended self-harm and disclosure of potential physical abuse in the family home;
    ii. Whether SG 's mental health was appropriately monitored and managed by responsible staff;
    iii. Whether the NSW Department of Education had adequate and appropriate policies and procedures in place for managing reports of self-harm or potential physical abuse within the family home made by, or on behalf of, students.
7. With respect to Hunter New England LHD (CAMHS):

i. The appropriateness and adequacy of the care and treatment provided by CAMHS to SG including:

(a) The appropriateness and adequacy of the actions and response by CAMHS in relation to the referral made by LP in December 2019;

(b) The adequacy and appropriateness of the decision of CAMHS to close the service request without escalating the matter; and

(c) Whether SG's mental health, including any interventions, referrals and support were adequately or appropriately treated, monitored, actioned and managed by CAMHS, including what intervention was available from CAMHS.

8. The final issue for this inquest pursuant to section 82 of the *Coroners Act* 2009, is whether it is necessary or desirable to make any recommendations in relation to any matter connected with SG 's death.

Analysis of Evidence at inquest

73. The evidence at inquest was given by a large number of witnesses. There were witnesses of fact who were involved in engagement or attempted engagement of SG directly. There were case workers from DCJ involved in the ROSH reports. There were those engaged by CAMHS who received the referral and made attempts to see SG There were also representatives from each Department to speak to policy and procedure and whether those were followed in this case.

74. LP was a psychologist and school counsellor who was working at the school two days per week at the time that she saw SG in 2019. She indicated that SG presenting with a friend was unusual, it was E who was bringing SG to her, because he was concerned for his friend and thought that he needed to speak to LP She spoke with SG and determined that he had made a prior suicide attempt a week or so before. She took notes of that interaction. She then spoke to his father to alert him to the issues disclosed by SG She did not recall that she informed him of a noose under the bed, and did not believe that was a fact that she was aware of.

75. LP made a mandatory report to DCJ by email. She also made a referral to CAMHS. The e-report email was sent also to the relieving principal and deputy

principal. According to the policy in place, in the form of a flow chart which was generated by the school, it was the principal who was to gather a response team.

76. LP then followed up with SG On the next occasion when she spoke to him on 13 December 2019, she was of the view that he was doing much better, and that changes had occurred at home. She then, in effect, closed his file and did not undertake any further follow up with him or his father.

77. LP 's evidence must be taken in the context of her role. She was a part time school counsellor for over 1000 students, working two days per week at SG 's school. The explanation of an ordinary day in her work at the school at that time was somewhat likened to an emergency department. Some students would make appointments, other students, like SG would walk in. She was required to deal with matters as they arose, undertake her paperwork and at times assist staff with their own concerns. She said that she had no reason to think her email wouldn't be seen by the principal and the deputy principal, and maintained that she followed procedure as she understood it. Some issue was taken in submissions about whether she should feel like it was a role likened to an emergency department, however after listening to her evidence I accept that the day-to-day role at that time was very much a reactive and very busy role, and that SG was doing her best in what sounded like a difficult and challenging work environment.

78. She noted that the timing of SG 's disclosure was unfortunate in many respects, as it was coming to the very end of the school year in 2019. The holidays then occurred, and she reported the start of the school year to be very busy. School resumed but quickly shut down in 2020 due to COVID. It should also be noted that LP had a personal family illness that she was involved with around that time. The school students were then engaged in remote learning and there was limited access to supports that SG may otherwise have had provided to him. In the conditions of remote learning, she was not even in the position, as she would be in a normal school year, to see him around the school and possibly be prompted or reminded by his presence to follow him up.

79. LP described the limitations on information that she had access to about SG 's background. She gave evidence that there was a central school database

where the student's information is contained, and separate to that is the school counsellor file. She did not have access to the central database. She indicated at that time the counsellor's file was paper-based, and she would not have information as to whether a child identified as First Nations. It appeared that when seeing SG she knew little about his background, trauma or basic history. It was evident that the background information available in relation to SG would have had a significant impact on her, and raised her level of concern for him. She said in evidence that on the information that she now has, she believes SG would have been suffering from post-traumatic stress. She also agreed that he may not have had sufficient language skills to express the emotions that he was feeling. She noted in her report to DCJ that SG seemed very depressed, although he did not appear that way on the second presentation.

80. There was no safety plan put in place. There was no support team created for him as per the school's "Suicide attempt outside school" flow chart mandating the expected school response.

81. Indeed, when LP was asked about the document and flow chart, she indicated that she was not aware of the document. She was asked about whether she was involved in a school support team, and said that she had been, but particular students identified as requiring a support team would be placed in groups. Year 7, 8 and 9 would be referred and discussed on one week, and the year 10, 11 and 12 students would be listed at a meeting the next week. This evidence of practice at the time did not appear in keeping with the documentation requiring immediate action. LP was asked whether it was possible that there would be no teacher or principal involvement today if a student presented as SG did, and she indicated that was possible.

82. LP was taken by counsel for the Department of Education to a document dealing with non-suicidal self-injury, and was taken to "Roles and Responsibilities" in which it was suggested to her: "[t]he school principal should assemble a school support team which can include the principal, school counsellor, head teacher welfare, year advisors, to serve as the points of contact for other staff members when referring students." Further, it was suggested to her that "if it came to a situation where a

child actually attempted suicide it's all the more important to involve the school principal and a school support team? Do you agree with that?", to which she did agree. This was a document that LP seemed unfamiliar with, and that was not followed in this case. I will refer to this document as "the flow chart".

83. LP was not informed that DCJ had closed the file, and was not made aware by CAMHS that they had been unsuccessful in their attempts to engage with SG

84. LP agreed, after being taken to a Department of Education document entitled "Management of suicidality in students: Advice to school counselling staff", there was additional reason to look at SG 's file and indeed to meet with SG again. That document said as follows:

> *"Suicidal thoughts and behaviour occur along a spectrum from passive thoughts of death to death by suicide. It is difficult to estimate the rate of suicidal thoughts but approximately 1 in 5 adolescents have fleeting suicidal thoughts without intention or plan, with 6% at any one time experiencing suicidal ideation with a plan. About half of those with a plan will go on to make an attempt within a year. About 3% of males and 8% female adolescents make a suicide attempt each year, and of these 1 in 4 will make a reattempt, most commonly with 6 months of the first attempt. (Brent et al 2011)"*

85. This study was the subject of much evidence and discussion, and I will refer to that further, however for the purpose of the Department of Education and LP , this was the information available to staff at the time. On the face of this document, information from the Department of Education provided to staff was that, following his first suicide attempt, there was a 25% chance that SG would make a further attempt to take his life. As this was the information available to staff at the time, this fact alone should have heightened the response to SG 's attempt, and indeed LP agreed with that proposition.

86. Ms O'Gara was the DCJ caseworker who received a triage assessment of the report made by LP . She did not relay any additional information to LP about SG but made contact with her to determine that LP had made a referral

to CAMHS. She was not made aware that SG failed to attend his appointments until she attended the Weekly Allocation Meeting on 3 January 2020.

87. Ms Scott-Glassock, manager caseworker at DCJ, had been involved with SG 's family since 2016. Earlier ROSH reports had been closed for "competing priorities". The first ROSH report in relation to SG in 2019 was closed because there was anticipated engagement with CAMHS. The second report was closed on 3 January 2020, even though there had been no engagement with CAMHS. The evidence of Ms Scott-Glassock was that there were competing priorities on each occasion, and there was no capacity to allocate the reports. Ms Scott-Glassock presented as a caseworker carrying a very demanding and busy case load.

88. The evidence, however, tended to support that there was a need to investigate SG , there should have been an interview with him and his family, discussion with CAMHS, and discussions with the school. DCJ also could have facilitated culturally appropriate intervention to encourage him to engage. There was no information communicated to LP , the school or to CAMHS that the DCJ file had been closed.

89. Ms Redfern, a very impressive registered nurse, took the referral made by LP to CAMHS, and immediately identified the high risk of harm that SG presented. She identified important risk factors including that he was only 15, he had attempted suicide and had moved through several schools.

90. Ms Barrett, also a registered nurse, was another impressive witness. She was clearly experienced and was able to identify SG was at risk, and appropriately classified him as medium level risk for the purpose of triage. High level is reserved for clients requiring immediate hospitalisation or other urgent treatment. She made contact with SG 's father, and although she identified that he was caring and engaged about SG , she also sensed that he didn't have the experience to understand the danger SG was in. She asked to speak to SG but was told that he was uncomfortable speaking on the phone with her, and was reluctant to engage with her, which she understood and did not find unusual with teenage children. She made the appointment for SG and that was the end of her involvement. He did not attend that appointment.

91. Daniel Mackertich is a psychologist with CAMHS. He contacted SG 's father on 12 December 2019 to talk about the missed appointment. SG 's father said that he had forgotten, and also said that SG was not wanting to attend. There was a new appointment made for 23 December 2019 and SG 's father agreed that he would bring SG to that appointment. Mr Mackertich provided evidence that there is nothing particularly unusual about non-attendance at CAMHS and indicated that it is a regular occurrence.

92. There was further non-attendance at the appointment on 23 December 2019. At the time there was no outreach service available to be utilised. Mr Mackertich made an e-report to DCJ about the failure to make contact with SG and the referral was closed. A letter was sent to SG 's father about the file being closed, but no contact was made with the school or LP

93. Before taking this step, there was no additional information obtained by CAMHS from DCJ about SG

94. Victoria Todd, clinical psychologist at CAMHS, gave evidence that there is now capacity for a home visit to occur in certain circumstances, subject to team discussion and capacity. This raises an issue of whether SG would qualify for outreach today. In circumstances where CAMHS knew little about SG , it is difficult to see how they would have known to prioritise him, unless they sought further information from DCJ.

95. Jonathon Holt is the Active Executive Director and General Manager, Mental Health Service, Hunter New England Local Health District. He is not a clinician. He provided updated evidence that, instead of a policy of 2 missed appointments and then file closure, as in SG 's case, the procedure is now that there must be 3 missed appointments, and closure after a 14-day period. He confirmed that there is now a community outreach team, accessed through the Mental Health Helpline, which commenced in December 2022. It was likely, in his view, that SG would have qualified for that outreach. Again, this may be a questionable assumption because it would need to be predicated by additional information about SG being gathered. SG 's father raised with Mr Holt that some education for him would have been helpful around the possibility of further suicide attempts and risk factors.

96. Belinda Edwards is the Executive District Director, Hunter and Central Coast District, DCJ. She identified areas that could have been improved, and indicated that more exploration with LP should have taken place to understand her comments about SG 's father now being more protective and his stepmother being gentler with discipline. Factors that increased the level of safety were not identified and were critical in the decision-making process. A true picture of SG 's safety was never developed by DCJ.

97. Some other issues were the failure to undertake a full analysis of SG 's child protection history, and how that history increased his individual vulnerability. There were opportunities missed to speak with SG and his family, CAMHS, and the school. She indicated that other referrals could also have been considered.

98. She was able to identify areas of improvement since SG 's case such as the creation of a new position as a CAMHS and DCJ liaison Officer, which was hoped to commence on 1 July 2023. This is a positive improvement.

99. When ROSH reports are closed without response, the report is now required to be escalated to the Manager Client Services. There has been increase in allocation of a triage worker from one to 1.6 caseworks since June 2022 at Maitland CSC. Children subject to a Child Protection Helpline report with less than a 24-hour response time, must be prioritised for a face-to-face assessment and risk assessment. They are referred to the Weekly Allocation Meeting or peer review meeting and cannot be closed prior to this time.

100. Cathy Brennan was the Executive Director for Metropolitan North/Relieving Deputy Secretary, School Performance North, Department of Education. She acknowledged that the school plays an important role in student support, wellbeing and mental health. Equally, she indicated that the school's role is not to provide ongoing therapeutic support for students with mental health issues.

101. In 2021 the Department of Education commenced the "Team around a school" model which would serve to support students such as SG with additional learning and wellbeing issues.

102. Since July 2022 Aboriginal students at risk of significant harm can be supported through the Child Wellbeing Unit Marama-Li Burralaa team. Ms Brennan indicated that in 2019 and 2020 there were processes where the head teacher wellbeing, year advisers, school counsellors and deputy principals would meet regularly each week to discuss children at risk. This did not occur for SG .

103. She indicated that the principal would be made aware of a mandatory report, and ensure wrap around support was offered to the student. The reason it did not occur here was because the principal, on his own account, was unaware of the mandatory report. Therefore, no wrap around support occurred for SG .

104. Leanne Nixon is the Acting Deputy Secretary Learning Improvement, Department of Education. She raised the Wellbeing and Health In-Reach Nurse Coordinator Program which was not available to SG s school. The NSW School Link Policy commenced in 2020 and identifies students with mental health concerns providing them with access to well-being support and specialist mental health services, a collaboration between the Department of Education, NSW Health and other services. This policy aims to identify Aboriginal children in rural communities who have experienced childhood trauma, and children with intellectual disabilities as a priority.

105. The policy "Responding to Student Suicide, Support Guidelines for Schools" provides:

> *"Priority groups include Aboriginal children, adolescents and families, those who have been exposed to abuse, violence neglect or other trauma, children and young people in out-of-home care; those with developmental disabilities or chronic physical health problems; those in contact with Juvenile Justice, and families with children where a parent has mental health problems."*

106. LP was the relieving principal while SG was at school. His evidence was requested during the course of the proceedings as a result of evidence given by LP that she had sent an email to him enclosing the e-report to DCJ. JG identified SG in his statement as "low risk". He did not see the email containing the mandatory report, and could not explain how that had occurred. The email was also sent to the acting deputy principal, from whom we heard no evidence.

107. Much evidence was given regarding the flow chart – which mandated action by the principal and the formulation of a team to support SG . JG 's evidence was that he was not aware of that document. He also did not appear confident in who should play what role in a situation such as this. The flow chart document did not appear to be one that was being followed at the time, based on the evidence in this inquest.

108. JG said in his statement that he "would have relied on [LP 's] judgment as a school psychologist, and we may have put in place a safety plan based on our judgment and that of SG 's family" (emphasis added). He was asked whether after the suicide attempt it was essential for a safety plan to be put in place, and he then agreed that was so.

109. The evidence of JG and LP left some doubt that there was certainty of what needed to be done for a child who had attempted self-harm. They both did not seem aware of the individual school policy- flow chart, and this appears to be an area where staff could be assisted and provided with very clear guidance regarding how to support such a student.

110. JG 's evidence highlighted a number of areas of concern. I should note however that JG was performing a complex and extremely busy role, he clearly cared deeply for the staff and students and was personally very affected by SG 's death. At the time he was the person at the school that needed to assist students and staff alike deal with the terrible loss. He assisted the inquest in highlighting some areas that would benefit from attention, not at a personal level, but rather at a general level. Questions arose such as:

I. How could the acting school principal and school counsellor not be aware of the document developed to support appropriate actions after an attempt of self-harm?

II. How could it be that a mandatory report about an attempt at self-harm be missed by both a principal and a deputy principal?

III. How is it that SG ' traumatic history did not ensure that he was a boy that was considered to be at high risk in relation to risk of mental health injury?

Submissions

A. Hunter New England Local Health District (CAMHS)

111. Submissions for CAMHS raised the issue that SG had received no formal mental health diagnosis, and it was submitted that to suggest, in the absence of an appropriate professional assessment, an opinion about the existence of one can only be speculative. The point of supporting SG was to allow him to experience that process and to receive diagnosis and treatment where appropriate. However, he did not get the benefit of that support. Whether or not SG suffered a mental illness was not relevant to this process, indeed the process was supposed to assist him obtain any necessary diagnosis and associated treatment. The NSW Department of Education material regarding "Management of Suicidality in students - Advice to school counselling staff" at page 7 provides that mental illness has been found to be present in 90% of all young people who die by suicide. Again, presumably this relates to those who had the benefit of a previous diagnosis.

112. There is no criticism of anyone who was involved individually from CAMHS. However, there are several aspects of the CAMHS process that were of specific interest and justify exploration in this case. The evidence given was that many patients do not attend appointments. This would seem unsurprising given the fact they are dealing specifically with children and adolescents, transport is reliant upon parents, recalling appointments is also often relying upon parents' availability and recollection, and is predicated on a willingness of the child or adolescent to engage with strangers. All these factors make this demographic an understandably difficult one to engage. It also raises issues of whether working together with other agencies who may know the child or the parent might assist in encouraging engagement.

113. SG was not engaged personally by CAMHS, nor was there any attempt to engage him directly other than by the nurse who initially spoke to his father.

114. CAMHS had very limited information about SG so when evidence was given that they would now, in the present day, use an outreach program, one wonders if that would have occurred on the limited information they had.

115. Mr Mackertich appropriately made an e-report to DCJ given the non-attendance on two occasions by SG . A letter was also set to SG 's father informing him that the referral was closed. No letter or information was provided to the school or the school counsellor who had made the referral. CAMHS in submissions suggested that perhaps LP could have followed up with SG as to whether he attended.

116. It was further submitted that there would have been little utility reporting back to LP , because she was on school holidays for some two months over Christmas. In my view this made the utility of reporting back to her even more important. LP should have made aware of the fact that SG had received no treatment, and it may have helped prompt a further discussion and follow up with SG in 2020.

117. The date of the appointment was also of concern, the second appointment being 23 December 2019. It hardly seems unreasonable that an appointment of this nature just 2 days before Christmas might be missed. Nonetheless, his case was closed.

118. It was submitted that it is not strictly true that there was no safety plan in place. There was no safety plan developed for SG by LP nor by the school. A safety plan in this sense relates to steps set out clearly for SG and his family as to what was to be done to support him. SG at no time received a safety plan. In discussions on the phone, the nurse provided a plan to SG 's father, and did what she could in the circumstances. The letter from CAMHS closing the file was very brief, and may have left a parent feeling reassured, misunderstanding that if CAMHS closes the file, that does not mean there are no lingering concerns.

119. Issue was taken with the statistical material forming part of the Department of Education material. Concern was raised that the statistics taken from the material relating to SG 's risk of re-attempting suicide may be outdated, and also might not have applied to SG given that he was not hospitalised after his attempt, as those in the study were.

120. I accept that SG was not hospitalised after his first attempt, but note that nonetheless the very important research data presented in this case was evidence that, after the first attempt, SG was at increased risk of making a second. The research also supports a finding that the increased risk of a second attempt in

SG 's case was significant, and should have added another significant risk factor that required he received support, diagnosis and treatment.

121. The research presented is very helpful in understanding the risk to any person, but importantly a child, once they have made one serious attempt at self-harm intended to end life. The research speaks for itself, and it was agreed ultimately that when a child or adolescent engages in a suicide attempt, they are at considerably higher risk of making a further attempt. This information is alarming for any parent, carer, teacher or health professional. It is another factor which elevates the need to treat these children, and urgently so.

122. Further research that may be thought to be more up to date was applicable to all ages, "Risk of Suicide Attempt. Repetition After an Index Attempt: A Systematic Review and Meta-analysis" published 2023, indicates:

> *"One in five patients will engage in a suicide attempt after a previous one. The delivery of a preventative intervention considerably decreases the risk of attempt repetition with enduring effects. It becomes critical to conduct an exhaustive assessment of risk factors to reduce risk of attempt repetition. Healthcare follow-up should comprise intensive contact and long-term monitoring. The delivery of a prevention program should be mandatory due to its protective role against attempt repetition. Moreover it should be delivered as soon as possible as repetition risk may already be evidence right after the index attempt."*

123. Again, a distinction is drawn between SG and the study based on the parameters of the study, involving persons who were hospitalised following an attempt. In SG 's case no one was immediately aware of his attempt, therefore he was not given the benefit of hospitalisation which may have followed had anyone been aware of the immediate risk at the time.

124. A strong link exists link between previous suicide attempts, or a history of self-harm, and suicide. In research, tendered at Tab 84A, "Suicide and Youth: Risk Factors", published in October 2018, it is stated:

"About 25-33 % of all cases of suicide were preceded by an earlier suicide attempt, a phenomenon that was more prevalent among boys than girls. Research has shown that boys with a previous suicide attempt have a 30-fold increase in suicide risk compared to boys who have not attempted suicide. Girls with previous suicide attempts have a threefold increase in suicide risk. In prospective studies, it was found that 1-6% of people attempting suicide die by suicide in the first year. The risk of suicide is found to be related mainly to the self-inflicting act as such, and less to the degree of suicidal intention of that act."

125. As submitted by counsel assisting, this research is valuable to assist in formulating an appropriate response or reaction to suicide attempts, and to place a focus on repetition reduction strategies.

126. Although the studies vary, they provide a useful and helpful guide to each of the departments. The reality is that once a child attempts suicide, they are at increased risk of making a further attempt. That fact alone should be shared amongst agencies and with the general public. Parents need to be informed of the serious and heightened risk that children face in these circumstances. That fact alone may result in a very proactive approach by all involved in the care of such a child.

127. Risk factors identified in this research include: "[m]ental disorders, previous suicide attempts, specific personality characteristics, genetic loading and family processes in combination with triggering psychosocial stressor, exposure to inspiring models and availability of means of committing suicide are key risk factors in youth suicide. The only way forward is to reduce these risk factors and strengthen protective factors as much as possible by providing integrated and multi-sector (primary, secondary and tertiary) prevention initiatives." (Tab 84A – "Suicide and Youth: Risk Factors")

128. In relation to the issues list 1(a)-(c) relating to CAMHS, it was clear that the staff involved followed the protocol at the time. Improvements in the system have since been made as referred to above. There is now more focus of trying to engage with the child directly. It would seem however that CAMHS could benefit from as much information as possible about a client, and the information will invariably need to come from another agency. Further focus on asking for additional information, having

more opportunity to have conversations and access information would strengthen this very important agency.

129. CAMHS plays a very important role in this space. In this case they had very limited information about SG, information that could have made a difference as to whether they contacted LP or the school, or tried to contact SG directly. CAMHS are in the unique position that they are there for health and wellbeing. SG had extensive interactions with DCJ throughout his life, and personally for him as a young Aboriginal boy CAMHS may have provided a safer space. It certainly appears evident that handovers and introductions from people like school counsellors would be useful. The person who knows the child might be best placed to encourage the child to seek help.

130. CAMHS takes the approach of child and family. There is an obvious opportunity to help educate and inform parents to assist them to keep a child safe.

B. Department of Education Submissions

131. It was accepted there were things that JG and LP did not do and should have done. JG should have opened and read the email which had the heading "E-report of SG".

132. LP made a report to DCJ and a referral to CAMHS. She spoke to SG's father. She followed up with SG on 13 December 2019 and followed up with CAMHS on 16 December 2019.

133. It was identified that it was desirable that LP should have spoken directly to JG to ensure JG was aware of the e-report. However, this was not a direct breach of any policy nor procedure at the time. She did inform the principal, but he did not open or read the email. It is accepted in submissions that verbal communication is critical in cases such as SG's, however I was not taken to any Department of Education policy requiring this step.

134. It was further submitted that LP should have developed a safety plan for SG This seems contradictory to the school policy and flow chart raised by the Department of Education with LP which made it clear that the principal held that responsibility. However, as I have already indicated, I am left unclear on the

evidence who was even aware of, or implementing the steps in the flow chart, with no evidence of any awareness of the existence of that document.

135. Further, it was submitted that LP should have followed up with SG in 2020. This was desirable. However, it should also be seen in the context of a part time employee at that school, just two days a week. COVID shut down face to face learning. LP herself had personal family issues of some urgency. There was no doubt that LP was also deeply affected by the loss of SG. The nature of her work is a caring role, and she did try her best to assist him at the time.

136. It is difficult and undesirable to criticise the one person who really did wade into the arena for SG. True it is more could have been done, however the system to protect SG should not, and did not, come down to action or inaction by one individual. The system should provide checks and balances, back-ups and security to ensure that it was the school that provided a follow up, rather than be reliant on one individual.

137. It was submitted that adequate systems and policies were in place, but the systems were not completely followed. There was no policy or system to suggest a follow up needed by LP, or an easy mechanism for her to do so. That was a decision to be made by LP as a practitioner. LP was never informed that CAMHS was no longer involved. LP was not advised that DCJ were no longer involved. There was no system requiring discussion with the principal outside the mandatory report. I do accept that a safety plan should have been implemented from the outset.

138. It is open to find on the evidence that two people failed to open and read an email addressed to them enclosing a mandatory report to DCJ.

139. Ms Brennan, who was compassionate and caring in her approach to the treatment of SG, referred to the fact that one in seven children and young people experience a mental health issue each year. The Department of Education recognises that schools play an important role in supporting student wellbeing and mental health. She also noted that the Department of Education has partnerships with NSW Health and there are programs that are jointly provided, to provide general wellbeing support to

students. However, it is not a school's role to provide ongoing therapeutic support for students who have mental health issues.

140. While this is accepted, SG fell into the small percentage of children who do make a suicide attempt. In some literature this is noted at 3% of boys. On the Department of Education's own account, this heightened his risk of re-attempting to an alarmingly high risk.

141. School was the safe place that SG was able to make this disclosure. Looking at the available material, it seems there was a flow chart applicable to SG which was not followed. On the evidence there was a failure to follow the system of opening emails that related to e-reports, remembering that it was sent to not only one senior staff member, but two. Further, it was apparent on the evidence of both JG and LP that they did not fully appreciate the serious risk of harm that SG represented after a failed suicide attempt. These are all matters that deserve the attention of the Department of Education, and are areas that could be improved.

142. JG highlighted the serious impact of the loss of SG to the whole school community. Working to reduce the rate of suicide also works to protect staff and other students alike who are all exposed to risk of psychological harm in a case such as this. Many people were significantly affected by the loss of SG, and this is even further incentive to work towards reducing the incidents of self-harm.

143. The school did provide many supports for SG, and that should be acknowledged. He was recognised by JG as an important member of the school community. He had a personal learning support plan, and a teacher mentor, Mr AP. There was a recognition of his learning needs, and he as an Aboriginal student had a personal learning pathway program in place. SG was doing so well at school, it was a place that was providing him with security and support, and this inquest does not detract from that important work that the school was achieving. Indeed, he indicated that it was his friends that made him not follow through with the first attempt, and it was the place that he felt safe to make the significant disclosure that he did.

144. The issue in these proceedings in relation to the Department of Education is the reaction by the school to a disclosure of an attempted suicide, and whether

information sharing, education and training could further improve outcomes for at-risk students such as SG. It also relates to whether there is an opportunity for additional information sharing with the school counsellor in certain cases to allow them to deliver a more complete service to those in need.

145. There were equally supports for LP, that should also be acknowledged. She could have raised concerns with her own supervisor. She also could have raised concerns with the principal, deputy principal or head teacher welfare. She could have added SG to an agenda on the regular learning and support team meeting. In relation to the weekly meeting, LP noted that, at that time year, SG would have missed out, but agreed that he could have gone into the next year in February.

146. LP made a note that she would follow SG up in 2020, but this did not occur.

147. The Department of Education submitted that there were adequate procedures in place at the time of SG's death, but they were not followed. It was further submitted that there were adequate and appropriate policies in place at the time of his death, and that what occurred was a failure to follow these by a number of individuals.

148. In this case where we heard from two impressive people, JG and LP, both committed and passionate about their roles it would seem an opportunity for the Department to explore its implementation and education of those policies and procedures. Simplification of the policy in relation to self-harm would seem ideal, to ensure that important and dedicated employees are given clear guidelines on how best to deal with a situation such as this, which will arise within the school environment. Clearly defined roles and reporting structure communicated to the key position holders with responsibility to respond to self-harm would appear to be something that was not clear to two experienced and professional staff in this case.

149. The Department of Education did engage on the issue of improvements through recommendations. The exploration of the issues in this inquest has resulted in some agreed changes that will better improve the system.

C. Department of Communities and Justice submissions

150. The evidence discloses that there were five reports made about SG between November 2018 and May 2020. It was noted that Ms Edwards helpfully set out the generic mechanism by which reports are made to DCJ, and the process of screening and prioritising by the Child Protection Helpline, with a report that transferred to the local CSC. From there, a Triage Assessment Mandate document is followed, that provides practical guidance to caseworkers and managers when responding to and prioritising reports received

151. I agree with the submissions relating to the first two reports closed. The first report, dated 8 November 2018, focused on SG 's brother, and was closed due to currenting competing priorities. On 11 November 2018 a report was made relating to alleged perpetrators that were not then living in SG 's household. I make no comments in relation to the closing of these two matters, other than to note yet again that SG was being identified as a child at risk. The cumulative effect of this should have had some bearing on the latter reports.

152. The ROSH report received on 5 December 2019 was the report that required action. It was closed on 17 December 2019 because of the referral to CAMHS, information from the reporter that " SG 's father is more protective and engaged in SG 's life since the report", and as a result of competing priorities within Maitland CSC which were considered to be more urgent.

153. The ICDR provided a review and found the following:

> *"Two reports were received in December 2019. The first was made by … on 5 December 2019.* SG *told…. That he had tried to hang himself from a light in his bedroom the week before but did not complete the suicide attempt because he was worried about how it would impact his friends.* SG *told …. That he did not feel safe at home because* J *yelled at him constantly, hit him on the back and neck, threatened to cut his tongue out and fingers off and pinched him and his brothers.* SG *said* J *had been hurting him since he was in year 4 and that* SG *SNR did not protect him from* J *The reporter described* SG *as "very depressed" and said he appeared 'visibly*

scared' to go home each weekend. …. Had spoken with SG *Snr and he denied that* J *hit the children. The reporter said* SG *Snr was not aware that* SG *had attempted suicide. The reporter referred* SG *to the Child and Adolescent Mental health service (CAMHS) and would continue to provide* SG *with support. The Helpline screened the report as risk of significant harm and transferred it to Maitland CSC with a recommended response timeframe of less than 72 hours.*

On 16 December 2019 a triage caseworker contacted the reporter who…. Had formed the view that SG *was now safe because 'several protective measures had been put in place." The reporter said* SG *Snr had become "more protective and engaged in* SG *'s life" and that he told….* J *was "using more gentle discipline with* SG *". The reporter also confirmed that CAMHS had accepted the referral for* SG *. A worker from CAMHS had left a voicemail message for* SG *Snr, and planned to contact him again after a few days.*

On 19 December 2019 a manager casework from Maitland CSC recommended the report be closed to 'current competing priorities.'"

154. The report went on to note that, although calling the reporter was a good use of the triage role, more effective questioning was required to determine why it was thought that SG was now safe. However, it was found that the only way to ensure SG 's safety was to conduct an assessment. The failure to do so meant that a true picture of SG 's safety was never understood. The report also noted that transferring the report electronically meant the opportunity to have a conversation about SG was lost. This could be seen as a regular pattern in SG 's case over several Government departments. The value of both intra-agency and inter-agency conversations to assist in obtaining a full picture of SG 's situation never occurred. Ms Edwards endorsed this analysis.

155. It is accepted that DCJ did not hide from this review. It undertook a critical analysis and has taken steps to improve as a result. It noted that "[r]esearch has identified psychosocial factors that may make a child more vulnerable to suicide. Disconnection from culture, experiences of abuse and neglect, exposure to suicide and previous suicidal behaviour are all factors known to increase a child's risk of completing suicide. SG had experienced all of these risk factors and it was now known that the elements that were being relied on to assume he was safe and receiving the support and care he needed were no longer present. His disconnection from school meant he was isolated from what appeared to be a safe and supportive community. The decision to close the report meant that the opportunities to support the family, understand the risks to SG and his brothers, and find ways to increase their safety, were missed.

156. The revised triage assessment mandate now requires that when previous ROSH were closed without a response, the new report should be escalated to the manager client services. Ms Edwards endorses this and says further that DCJ could have facilitated an interagency discussion with CAMHS. She highlighted that the purpose of triage was to gather as much information as possible

157. It is accepted by DCJ that the response to the mandatory reports in 2019 was not adequate nor appropriate. It is accepted that, without being critical of any one decision maker, that the responses were not appropriate nor acceptable.

158. A reflective case discussion was undertaken. The 2020 Child Deaths Annual Report considered 42 children who were known to have died as a result of suicide or suspected suicide. It provides clear practical advice around urgent, intentional support which can be utilised by practitioners to make a difference. This report is a publicly available resource.

159. Some of the changes to casework practices since SG 's death are as follows:

I. A revised Triage Assessment Mandate;

II. Child Protection Assessment Review Project;

III. NSW Interagency Guidelines for Practitioners – Collaborative Practice in Child Wellbeing and Protection, CSC casework journey; and

IV. Evan's Story Training Package: Talking with Children and young people about self-harm and suicide.

160. If the current revised triage assessment mandate was in force in 2019, it would have resulted in his matter being escalated to Manager Client Services when the report on 23 December was received, given the unallocated report of 5 December 2019.

161. DCJ helpfully embraces the recommendations, and also assisted by suggesting a further recommendation which will also be made.

162. The creation of an intermediary role between DCJ and CAMHS appears an important and significant improvement.

163. The passing on of SG from one organisation to another organisation occurred, resulting in no one carrying the responsibility for SG and his wellbeing. Each agency appeared to believe someone else was taking, or would take, responsibility for him.

Recommendations

164. The following possible recommendations were proposed by counsel assisting, and the submissions in relation to each are considered below.

A. Discussion of proposed recommendations to the Department of Education

165. Counsel assisting proposed the following recommendations be made to the Department of Education:

To the NSW Department of Education ("DOE"):

1. *That the DOE implements a policy to ensure schools identify priority or high-risk students upon enrolment by using interagency collaborations, for example, through Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998, including:*
    a. ensuring all First Nations students are identified upon enrolment, for noting on both the student file and the school counsellor file;
    b. *implementing a mandatory process to identify students at higher risk of suicide and priority groups, upon enrolment, and especially if they present to the school counsellor in relation to suicide attempts or suicidal ideation; and*
    c. *that a copy of any prior child protection history is accessed by school counsellors at the time of, or shortly after, meeting with suicidal students so that an assessment of cumulative trauma and post-traumatic stress can be more accurately obtained at the time of presentation to a counsellor.*
2. *That the DOE undertake a comprehensive review of current policies across all schools and implement a clear suicide and wellbeing policy, ensuring that the policy considers the following:*
    a. *the mandatory delivery of a suicide prevention or safety plan for all students reporting suicide attempts be implemented as soon as possible after a suicide attempt;*
    b. *if a safety plan is not developed or implemented for any reason, the reasons for this decision are documented and signed off jointly by the school principal and school counsellor, and parents/carers and other agencies (if involved) are informed;*
    c. *a mandatory checklist be developed to ensure all school staff are clear on the precise steps required, and the allocation of roles and responsibilities when there is a suicide attempt;*
    d. *provide information and adequate resources to provide immediate support to staff, parents and students in the event of suicide attempts or suicidal behaviour;*

e. *ensure that steps required under the policies of the DOE are enacted at the local level;*

f. *implement a mandated and automatic system for follow-up by school counsellors, which is not dependent upon individual capacity or memory;*

g. *implement a mandated and automatic system for follow-up by school counsellors which is not dependent upon individual capacity or memory; and*

h. *implement an additional level of oversight for when a mandatory report or e-referral to DCJ is sent to the principal and deputy principal which does not permit human error to allow the child or young person to be unsupported.*

3. *That an education and training package be delivered to school staff (including principals, deputy principals, teachers and school counsellors) to ensure policies relating to student wellbeing and suicide at a local and state level are being followed; and provide comprehensive and practical training on responding to a suicide attempt or suicidal behaviours.*

166. The Department of Education does not support the making of recommendations 1 a. and b. above. It was submitted that there are comprehensive enrolment procedures, and that these did not form part of the evidence in the inquest. Concern was raised that seeking information from families that they may not wish to provide could be counterproductive. There was a real lacuna of information gathered by the school generally. There was no evidence of a complete picture of SG. The principal noted in his report that "SG had come to the attention of the school because he had some learning difficulties. He was not identified as a student at risk." It seems unusual to be unaware of the complexity presented when SG joined the school, nor to identify the risk of harm presented as a result of the trauma SG had experienced. This evidence highlights the need for information sharing where possible between organisations, especially for those children who have been the subject of many DCJ reports. This equally applies for children who have suffered significant trauma, are Aboriginal and displaced from one or more parent.

167. However, I agree the focus of the inquest was not on enrolment, although the enrolment process was explored by counsel assisting. This issue can be addressed in later proposed recommendations. I accept the submissions made and I decline to make these recommendations.

168. The Department of Education does accept recommendation 1 c. in part, and I agree the inquest highlights the need for the school counsellor to have better access to information about a student at risk. Noting that concern, I make a modified version below.

169. Recommendations 2 a – 2 d. are supported and will be made.

170. Recommendations 2 e. and 2 f. are supported in principle, and have been slightly modified given the concerns raised by the Department of Education. The reminder system for counsellors to follow up was supported by LP and would be a very helpful addition in busy practice.

171. Recommendation 2 g. is not supported. Submissions were made that this recommendation is unworkable. One of the significant errors in SG 's case related to a critical email communication to two of the most senior leadership team members being missed. It is easy to envisage in workplaces where many people are performing a part-time role, things can be missed. Opportunity to speak directly is not always easy if people are away, working away from the school or unwell. However, a modified recommendation will be made to reflect the concerns raised. SG 's case relates to human error in part, and it is this system that needs repair. It was submitted to be unworkable, but the modified recommendation leaves it to the Department of Education to determine the most suitable system. It could be as simple as a read receipt, a high alert being required to be added to such emails, or a specific email address for the ROSH reports to be sent to as a further back up.

172. Recommendation 3 is supported, and the Department of Education is willing to develop a training package to support staff in supporting students.

B. Discussion of proposed recommendations to CAMHS

173. Counsel assisting proposed the following recommendations be made to CAMHS:

To the Child and Adolescent Mental Health Services, Hunter New England Local Health District:

4. *Consideration be given to implementing a policy to ensure all reasonable efforts are made to contact an adolescent/young person directly when a referral is received, in addition to the parents/carers, unless contraindicated, especially before closing a file or referral. Consideration be given to ensuring this contact can*

occur by phone call, in-person contact, home visits, text messages, emails, online messaging services or other outreach services.

5. *If no action taken or referrals are implemented before a file is closed, that CAHMS staff provide a report to the original referrer about the outcome.*
6. *That a review is undertaken to improve current communication methods for when correspondence is mailed to a young person or their parent when a file is closed, including providing additional contact phone numbers for alternative supports (for example, Lifeline, Kids Helpline, Headspace), in addition to providing a copy of the education package recommended in [8] below. It is submitted that a separate letter should be sent to the young person and their parent/carer with this information.*

174. CAMHS does not support the making of recommendations 4 and 5. It was submitted that these steps have already been undertaken. I accept that I have been provided with evidence to this effect and am satisfied that these important changes have been incorporated into practice.

175. CAMHS does not support recommendation 6, and submitted that it has addressed this issue. A letter that is suggested to be a current example of this was provided in evidence. This letter is to either the child or the parent, it is lengthy, and complex. It does not extend to enclosing the information package suggested to be developed in recommendation 8 at this stage. It would appear that a version for both parent and child should be developed in easy plain language.

C. Discussion of proposed recommendation jointly to DCJ, the Department of Education and CAMHS

176. Counsel assisting proposed the following recommendation be made jointly to DCJ, the NSW Department of Education, and CAMHS:

Jointly to the Department of Communities and Justice, NSW Department of Education and the Child and Adolescent Mental Health Service, Hunter New England Local Health District:

7. *Consideration be given to developing a joint agreement between the Department of Communities and Justice, NSW Department of Education and the Child and Adolescent Mental Health Service, Hunter New England Local Health District so as to ensure mandatory cooperation, coordination, communication and information sharing takes places 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 a 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.*

177. Recommendation 7 is not supported. The evidence would suggest that this is the most important and critical step that needs to be taken. DCJ have recognised this in their submissions. I agree with the submission relating to the word "mandatory", and it will be removed. In SG 's case there was no, or very limited inter-agency sharing of information. This alone may have altered the outcome for SG , and sadly SG 's story is not alone. The 2020 report highlights some 42 children who have been lost to intentional self-harm.

178. I agree that this is not for the purposes of passing on responsibility to another agency. Each have their role, and DCJ maintains a position in child protection, and it may be these discussions result in DCJ bearing more responsibility to ensure the information, which is more often than not within their domain, is provided to others when the need arises, such as in SG 's case.

179. CAMHS also does not support recommendation 7, however I repeat the observations above. CAMHS made lengthy submissions that the existence of section 16A and sections 245D and 245E would lead to this recommendation being unnecessary. The power to request information is set out in those sections, however the cooperation and determination to ensure the information actually is transmitted is the aim of this recommendation. The recommendation will require communication and collaboration between agencies. In this space, CAMHS is perhaps the most important of the three departments in relation to mental health of children. CAMHS did not obtain any additional information about SG from other agencies, nor was any additional information about SG provided to CAMHS. Communication and

further detail about SG could have changed his outcome, and even with the improvements made unless more is known about a child at risk they might not qualify for outreach or additional action.

D. Discussion of proposed recommendation jointly to the Department of Education and CAMHS

180. Counsel assisting proposed the following recommendation be made jointly to the NSW Department of Education, and CAMHS:

Jointly to the NSW Department of Education and the Child and Adolescent Mental Health Service, Hunter New England Local Health District:

8. That an education package is developed by the above agencies to provide to parents and carers of children or young people who have attempted suicide or expressed suicidal behaviour. The package is to provide guidance in relation to dealing with suicide attempts, suicidal behaviour, initiating appropriate conversations with young people in relation to same, and general suicide and wellbeing education for parents, particularly around the possibility of any further attempts of suicide and risk factors. Such a package should be provided to parents following a report to a school counsellor or a referral to CAHMS about such behaviours.

181. I note that recommendation 8 is not opposed by CAMHS. It is opposed by the Department of Education. It would seem appropriate that this tool is available both through schools and CAMHS to reach parents and carers as a protective measure. This was a request by [redacted], and it is one that might save a life through the education of parents and carers. It also sits with the Government intention to work to prevent suicide in our young.

Recommendations

182. I make the following recommendations:

To the NSW Department of Education ("DOE"):

1. That the DOE implements a policy to ensure that a copy of any prior child protection history is accessed by school counsellors at the time of, or shortly after, meeting with suicidal students so that an assessment of cumulative trauma and post-traumatic stress can be more accurately obtained at the time of presentation to a counsellor.

2. That the DOE undertake a comprehensive review of current policies across all schools and implement a clear suicide and wellbeing policy, ensuring that the policy considers the following:

    a. the mandatory delivery of a suicide prevention or safety plan for all students reporting suicide attempts be implemented as soon as possible after a suicide attempt;

    b. if a safety plan is not developed or implemented for any reason, the reasons for this decision are documented and signed off jointly by the school principal and school counsellor, and parents/carers and other agencies (if involved) are informed;

    c. a mandatory checklist be developed to ensure all school staff are clear on the precise steps required, and the allocation of roles and responsibilities when there is a suicide attempt;

    d. provide information and adequate resources to provide immediate support to staff, parents and students in the event of suicide attempts or suicidal behaviour;

    e. ensure that steps required under the policies of the DOE are enacted at the local level;

    f. implement a mandated and automatic system for follow-up by school counsellors, which is not dependent upon individual capacity or memory; and

    g. implement an additional level of oversight for when a mandatory report or e-referral to DCJ is sent to the principal and deputy principal which does not permit human error to allow the child or young person to be unsupported.

3. That an education and training package be delivered to school staff (including principals, deputy principals, teachers and school counsellors) to ensure policies relating to student wellbeing and suicide at a local and state level are being followed; and provide comprehensive and practical training on responding to a suicide attempt or suicidal behaviours.

Jointly to the Department of Communities and Justice, NSW Department of Education and the Child and Adolescent Mental Health Service, Hunter New England Local Health District:

4. Consideration be given to developing a joint agreement between the Department of Communities and Justice, NSW Department of Education and the Child and Adolescent Mental Health Service, Hunter New England Local Health District so as to ensure cooperation, coordination, communication and information sharing takes places 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 a 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.

Jointly to the NSW Department of Education and the Child and Adolescent Mental Health Service, Hunter New England Local Health District:

5. That an education package is developed by the above agencies to provide to parents and carers of children or young people who have attempted suicide or expressed suicidal behaviour. The package is to provide guidance in relation to dealing with suicide attempts, suicidal behaviour, initiating appropriate conversations with young people in relation to same, and general suicide and wellbeing education for parents, particularly around the possibility of any further attempts of suicide and risk factors. Such a package should be provided to parents following a report to a school counsellor or a referral to CAHMS about such behaviours.

To the Department of Communities and Justice:

6. 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.

Concluding Remarks:

183. There were a number of missed opportunities to ensure that SG received assistance. Most of the knowledge was within the records of DCJ and failed to make its way to DOE or CAMHS. Each of these agencies have a different role to play, and this in no way suggests either step into the obligations or role of another. SG 's case was one where it did appear on the evidence that each agency thought another was assisting, and each closed his file. If it had been made apparent to each that the file was closed, this might have prompted different action.

184. As was submitted by counsel assisting, youth suicide is a major public health issue, and sufficient resources should be allocated to prevention strategies:

> *"to increase successful attempt to address youth suicide in the future, further unravelling of the complex suicide process must be accompanied by sustained and substantial effort in scientifically underpinning and (re) evaluating ongoing and new prevention strategy plans, and this is largely a matter of policy priorities and commitment."* (see article "Suicide and Youth: Risk Factors" – Tab 84A)

185. It might be thought that SG then chose not to engage, however, he was a 15-year-old boy carrying the burden of life experience that many adults would not know how to deal with. Encouraging agencies to work together in such circumstances might increase overall engagement with mental health services by teenagers. This inquest also highlighted the power of verbal communication, inter-agency and intra-agency alike.

186. Each agency participated so helpfully in these proceedings, impressive representatives attended from each and it is hoped that those with the internal knowledge of each

agency can formulate a helpful plan to implement discussion and sharing between agencies to promote the wellbeing of children.

187. It is hoped that these recommendations might assist in improving communication, especially to assist those special vulnerable children when they are brave enough to speak out and share their struggles.

Acknowledgments

I. To the cooperation of all legal representatives that represented the parties in the proceedings in ensuring the inquest was a useful and productive analysis of the loss of SG . Also to the diligent attendance, time and consideration each of the Departments gave to addressing the issues in this matter and searching for improvement in systems.

II. Importantly to SG 's family who contributed to inform us about SG 's life, and work graciously and generously through this process in the hope of system improvements.

III. To the team assisting the Coroner. Counsel Assisting Mr Anderson for such a thorough preparation and presentation of the inquest. The written submissions together with proposed recommendation has prompted engagement by the agencies and prompted improvement. Ms Hubbard for her organisation of the brief, preparation and ensuring the inquest proceeded with ease. Ms Petch for also assisting in those tasks, and assisting me in the presentation of the findings. To Nicolle Lowe for her invaluable support throughout the inquest.

Findings required by s81(1)

188. As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it:

The identity of the deceased

The deceased person was SG

Date of death

13 May 2020

Place of death

East Maitland, New South Wales

Cause of death

Hanging

Manner of death

Intentionally self-inflicted

189. I again extend my most sincere condolences to SG 's family, especially to his father and brothers, grandmother and aunt as a result of the loss of such a significant person from their lives.

190. I close this inquest.

Magistrate E Kennedy
Deputy State Coroner
25 August 2023