**If you need crisis support, call Lifeline on 13 11 14, or call Kids Helpline on 1800 55 1800, 24 hours a day. For general support, talk to your GP or local health professional.**

# 1 Executive Summary

## 1.1 About the investigation

### 1.1.1 Functions of the Ombudsman

The Ombudsman has four principal functions derived from his governing legislation, the *Parliamentary Commissioner Act 1971* (**the Act**), and other legislation, codes and service delivery arrangements, as follows:

- Receiving, investigating and resolving complaints about State government agencies, local governments and universities;
- Reviewing certain child deaths and family and domestic violence fatalities;
- Improving public administration for the benefit of all Western Australians through own motion investigations, and education and liaison programs with public authorities; and
- Undertaking a range of additional functions.

### 1.1.2 The Ombudsman's Child Death Review function

The Ombudsman commenced the review of certain child deaths on 30 June 2009, following the passage of the *Parliamentary Commissioner Amendment Act 2009*. The Ombudsman reviews investigable child deaths. Section 19A(3) of the Act defines an investigable death. For these investigable deaths, the Ombudsman's functions are outlined in section 19B(3) of the Act, as follows:

> (a) to review the circumstances in which and why the deaths occurred;
>
> (b) to identify any patterns or trends in relation to the deaths;
>
> (c) to make recommendations to any department or authority about ways to prevent or reduce investigable deaths.

To facilitate the review of investigable child deaths, the Department for Child Protection and Family Support receives information from the State Coroner on reportable deaths of children and notifies the Ombudsman of these deaths. The notification provides the Ombudsman with a copy of the information provided to the Department for Child Protection and Family Support by the State Coroner about the circumstances of the child's death together with a summary outlining the Department for Child Protection and Family Support's past involvement with the child.

Through the review of the circumstances in which and why child deaths occurred, the Ombudsman identified a pattern of cases in which young people appeared to have died by suicide (in this report, young people are defined as those under 18 years of age). The Ombudsman decided to undertake an investigation into these deaths with a view to determining whether it may be appropriate to make recommendations to any State government department or authority about ways to prevent or reduce such deaths.

## 1.2 Characteristics of the young people who died by suicide

### 1.2.1 Young people whose deaths were notified to the Ombudsman

- Suicide is defined as the intentional taking of one's own life.[1] This investigation considers young people who died by suicide who were aged between 13 and 17 years.
- The Office of the Ombudsman (**the Office**) analysed 36 deaths in which a young person had either died by suicide (for those deaths where the State Coroner has completed an investigation and found that the cause of death was suicide) or was suspected of having died by suicide (for those deaths where the State Coroner has not yet completed an investigation). In this report, these young people are referred to as **the 36 young people**.

### 1.2.2 Demographic characteristics of the 36 young people

- The 36 young people ranged in age from 14 to 17 years at time of death. Four young people were aged 14 years, 10 were aged 15 years, 11 were aged 16 years and 11 were aged 17 years at time of death.
- Among the 36 young people, 22 (61 per cent) were male and 14 (39 per cent) were female.
- Thirty-three (92 per cent) of the 36 young people were born in Australia. Three young people were born outside Australia.
- Aboriginal young people were significantly over-represented among the 36 young people. Thirteen (36 per cent) of the 36 young people were identified as Aboriginal and 23 (64 per cent) young people were identified as non-Aboriginal. For comparison, six per cent of children and young people aged 0 to 17 years in Western Australia are Aboriginal.[2]
- The majority of the 36 young people were residing in the metropolitan area of Perth at the time of their death. Using regions defined by the Australian Bureau of Statistics,[3] 21 young people were residing in a major city, six young people were residing in an inner regional area, three young people were residing in an outer regional area and six young people were residing in a remote or very remote region. Taking into account the numbers of young people residing in each of these regions, the mortality rates for the 36 young people who died by suicide were as follows:
    - 2.4 per 10 000 young people resided in a major city;
    - 5.4 per 10 000 young people resided in an inner regional area;
    - 3.2 per 10 000 young people resided in an outer regional area; and
    - 10.6 per 10 000 young people resided in a remote or very remote region.

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[1] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 12.
[2] Commissioner for Children and Young People, *Groups of children and young people in Western Australia: Wellbeing monitoring framework*, viewed 26 September 2013, <http://www.ccyp.wa.gov.au/maps/map.php>.
[3] Australian Bureau of Statistics, *2011 Census of Population and Housing*, cat. no. 2049.0, ABS, Canberra, 2011.

- Applying the Australian Bureau of Statistics' definition of homelessness,[4] eight (22 per cent) of the 36 young people experienced at least one form of homelessness at some time in their lives. For comparison, Australian Bureau of Statistics census data reports that in 2011 less than 0.6 per cent of children aged 12 to 18 years were homeless at the census date.[5]

### 1.2.3 Factors associated with suicide for the 36 young people

- The research literature identifies a range of risk factors, warning signs and precipitating events associated with suicide by young people. These are referred to here as **factors associated with suicide**. While no single cause of suicide has been identified,[6] the factors associated with suicide have been shown to increase the risk of suicide, particularly when multiple factors are present and interact with each other.[7] It is important to note that these factors are considered to be correlative, not causal.

- Several factors associated with suicide have already been discussed above as demographic characteristics of the 36 young people, namely, being male and experiencing homelessness. This section discusses the remaining factors associated with suicide experienced by the 36 young people.

- Records indicate that mental health problems were prevalent among the 36 young people:
  - twelve (33 per cent) young people were recorded as having had a diagnosis of mental illness; and
  - fifteen (42 per cent) young people were recorded as having demonstrated self-harming behaviour.
- Records indicate that suicidal ideation and behaviour were also prevalent among the 36 young people:
  - twenty two (61 per cent) young people were recorded as having had thoughts about attempting or completing suicide;
  - twenty (56 per cent) young people were recorded as having communicated their intention to commit suicide to a friend, family member or health professional; and
  - sixteen (44 per cent) young people were recorded as having previously attempted suicide, with six of these young people recorded as having attempted suicide on more than one occasion.

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[4] Australian Government, Department of Health and Ageing, *Homelessness and mental health linkages: review of national and international literature,* Department of Health and Ageing, Canberra, 2005, viewed 26 September 2013, <http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-homeless-toc~mental-homeless-1~mental-homeless-1-2>.

[5] Australian Bureau of Statistics, *2011 Census of Population and Housing: Estimating homelessness*, cat. no. 2049.0, ABS, Canberra, 2011.

[6] Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's business,* Department of Health, Perth, 2009.

[7] Australian Government, Department of Health and Ageing, *Living Is For Everyone: Research and Evidence in Suicide Prevention*, Australian Government Publishing Services, Canberra, 2008, p. 12.

- Child maltreatment consists of any act of commission or omission by a parent or caregiver that results in harm, the potential for harm or the threat of harm to a child, even if the harm is unintentional.[8] The Office examined allegations of child maltreatment of the 36 young people and found:
  - sixteen (44 per cent) young people were said to have experienced family and domestic violence;
  - nine (25 per cent) young people were recorded as having allegedly experienced sexual abuse;
  - eight (22 per cent) young people were recorded as having allegedly experienced physical abuse; and
  - twelve (33 per cent) young people were recorded as having allegedly experienced one or more elements of neglect during their childhood.
- Records indicate that, among the 36 young people, the frequency of adverse family experiences was:
  - thirteen (33 per cent) young people were recorded as having a parent who had been diagnosed with a mental illness;
  - eight (22 per cent) young people were recorded as having a parent with alleged problematic alcohol or other drug use;
  - five (14 per cent) young people were recorded as having a parent who had been imprisoned; and
  - three (eight per cent) young people were recorded as having a family member who died by suicide and four (11 per cent) had a friend who died by suicide or knew a person who had died by suicide.

## 1.3 Among the 36 young people who died by suicide, the Office identified four distinct groups of young people

- To analyse the factors associated with suicide, the Office grouped them into the following categories:
  - **Mental health problems**, which included having a diagnosed mental illness and/or self-harming behaviour;
  - **Suicidal ideation and behaviour**, which included suicidal ideation, previous suicide attempts or communicated suicidal intent;
  - **Substance use**, which included alcohol or other drug use;
  - **Experiencing child maltreatment**, which included family and domestic violence, sexual abuse, physical abuse and neglect; and
  - **Adverse family experiences**, which included having a parent with a mental illness, having a parent with alleged problematic alcohol or other drug use, having

[8] Australian Institute of Family Studies, *Effects of child abuse and neglect for children and adolescents*, Australian Institute of Family Studies, Melbourne, 2010, viewed 25 February 2014, <http://www.aifs.gov.au/cfca/pubs/factsheets/a146141/index.html>.

a parent who had been imprisoned and having a family member, friend or person known to the young person who died by suicide.

- Through the analysis of the factors associated with suicide experienced by the 36 young people, the Office identified four groupings of young people, distinguished from each other by patterns in the factors associated with suicide that each group experienced. The four groups of young people also demonstrated distinct patterns of contact with State government departments and authorities. In brief, the four groups of young people are:
  - **Group 1** - 20 young people who all were recorded as having allegedly experienced one or more forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse or neglect. Most of the 20 young people in Group 1 were also recorded as having experienced mental health problems and/or suicidal ideation and behaviour.

    Records indicate that, as a group, the 20 young people in Group 1 had extensive contact with State government departments and authorities, schools and registered training organisations. All of the young people in Group 1 were known to the Department for Child Protection and Family Support. All had contact with WA Health, with eight young people having contact with the Child and Adolescent Mental Health Service.[9] Eighteen of the young people had contact with a government school and seven had contact with a registered training organisation. The 20 young people in Group 1 had significant contact with the State government departments and authorities associated with the justice system. The majority also had contact with the Department of Housing.
  - **Group 2** - five young people who were recorded as having been diagnosed with one or more mental illnesses, as having a parent who had been diagnosed with a mental illness and/or demonstrated significant planning of their suicide. None of the five young people were recorded as having allegedly experienced child maltreatment.

    Records indicate that four out of the five young people in Group 2 had contact with WA Health and Child and Adolescent Mental Health Service. Three of the five young people had contact with a government school and two had contact with a registered training organisation. Records indicate that none of the young people in Group 2 had contact with the Department for Child Protection and Family Support, Department of Corrective Services, Department of Housing, Department of the Attorney General or Western Australia Police.
  - **Group 3** – six young people who were recorded as having experienced few factors associated with suicide. None of these six young people were recorded as having allegedly experienced any element of child maltreatment, a mental health problem or adverse family experiences. All six young people were recorded as being highly engaged in school and highly involved in sport.

[9] Child and Adolescent Mental Health Service is a service administered by the Department of Health. For the purposes of this investigation, contact with Child and Adolescent Mental Health Service has been considered separately from other services administered by the Department of Health to identify access to specialised mental health services.

Records indicate that the six young people in Group 3 had minimal contact with State government departments and authorities. Four young people in Group 3 had contact with one State government department, namely WA Health. One young person had contact with a government school and three had contact with registered training organisations. None of the young people in Group 3 had contact with Child and Adolescent Mental Health Service, Department for Child Protection and Family Support, Department of Corrective Services, Department of Housing, Department of the Attorney General or Western Australia Police.

- **Group 4** - five young people who, like the young people in Group 3, were recorded as having experienced few factors associated with suicide, except for four young people who were recorded as having demonstrated suicidal ideation and behaviour and/or engaged in substance use. Although none of the five young people were recorded as having allegedly experienced any elements of child maltreatment, a mental health problem or adverse family experiences, the Office observed that all five young people were recorded as having demonstrated impulsive or risk taking behaviour.

  Records indicate that the five young people in Group 4 all had contact with WA Health, plus government schools. Four young people had contact with the Department for Child Protection and Family Support and registered training organisations. As a group, the five young people in Group 4 had some contact with the State government departments and authorities associated with the justice system. Two young people had contact with the Department of Housing. None of the five young people in Group 4 had contact with Child and Adolescent Mental Health Service.

## 1.4 The patterns identified by the Office may have implications for Western Australia's suicide prevention framework

### 1.4.1 Different suicide prevention activities may be relevant to each of the four groups of young people

- The research literature refers to a model of interventions for mental health problems developed by Mrazek and Haggerty in 1994 entitled *The spectrum of interventions for mental health problems and mental disorders* (**the Mrazek and Haggerty model**).[10] This model continues to underpin current thinking about suicide prevention strategies. The Mrazek and Haggerty model divides interventions for mental health problems into three categories - Prevention, Treatment and Continuing Care – and further into eight domains within these categories. The Western Australian *Suicide Prevention Strategy 2009-2013: Everybody's Business* (**the State Strategy**) is informed by the Mrazek and Haggerty model.
- The Office analysed how the patterns in the factors associated with suicide experienced by the 36 young people aligned with the categories and domains of suicide prevention activities as set out in the State Strategy. The Office found that the patterns in the factors associated with suicide experienced by each of the four groups

[10] P Mrazek & R Haggerty (eds), *Reducing risks for mental disorders: Frontiers for preventative intervention research*, National Academy Press, Washington, 1994.

of young people may be aligned with different, albeit overlapping domains of suicide prevention activities. This means that different suicide prevention activities may be relevant to each of the four groups of young people.

**Recommendation 1:** As part of the development of the State Strategy past 2013, the Mental Health Commission considers developing differentiated strategies relevant to each of the four groups of young people, taking into account the findings of the investigation regarding the demographic characteristics of the 36 young people who died by suicide, the factors associated with suicide they experienced, and their contact with State government departments and authorities.

**Recommendation 2:** The Mental Health Commission, in collaboration with relevant stakeholders, considers whether it may be appropriate to undertake, or facilitate the undertaking of, mental health literacy and suicide prevention activities for those young people who demonstrate few factors associated with suicide, as identified by the investigation.

### 1.4.2 Preventing and reducing suicide by young people may involve symptom identification, treatment and continuing care for young people who have experienced child maltreatment and mental health problems

- The State Strategy identifies that it is focused on the Prevention category of the Mrazek and Haggerty model, which comprises activities that '… can be targeted universally at the general population, they can focus on selective at-risk groups or they can be directed to those at risk as required.'[11] The Office's analysis also indicates that suicide prevention activities in the Prevention category may be important and should continue.

- In addition, the Office found that the factors associated with suicide experienced by 25 (69 per cent) of the 36 young people may align with the Treatment and Continuing Care categories of the Mrazek and Haggerty model.

### 1.4.3 State government departments and authorities potentially have an important role to play in preventing suicide by young people, including the Department of Health, the Department for Child Protection and Family Support and the Department of Education

- Records indicate that all of the 36 young people had contact with State government departments and authorities at some point in their lives. Records indicate that 31 of the 36 young people (86 per cent) had contact with multiple State government departments and authorities. These 31 young people were across Groups 1 to 4.

- Chapters 7 to 9 of this report contain detailed analysis of the contact by the 36 young people with three State government departments and authorities. These are the Department of Health's Child and Adolescent Mental Health Service, the Department for Child Protection and Family Support and the Department of Education. The

[11] Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 30.

findings and recommendations in these chapters largely concern activities that align with the Treatment and Continuing Care categories of the Mrazek and Haggerty model. These recommendations could be considered as part of the development of the State Strategy past 2013.

**Recommendation 3:** As part of the development of the State Strategy past 2013, the Mental Health Commission gives consideration to whether the scope of the State Strategy should be expanded to encompass the Treatment and Continuing Care categories of suicide prevention, by incorporating the investigation's recommendations about ways that State government departments can prevent or reduce suicide by young people.

## 1.5 The patterns identified by the Office may have implications for the Department of Health

### 1.5.1 Twelve of the 36 young people were recorded as having been diagnosed with a mental illness and all were referred for assessment by the Child and Adolescent Mental Health Service at some point in their lives

- The research literature identifies mental illness as a factor associated with suicide. Twelve of the 36 young people were recorded as having been diagnosed with a mental illness. All 12 young people were referred to the Child and Adolescent Mental Health Service (**CAMHS**) at some point in their lives. This contact presents an important opportunity to identify and treat mental illness and, in doing so, assist in preventing and reducing suicide by young people.

- Eight of the 12 young people were also recorded as having allegedly experienced at least one form of child maltreatment. These young people have been included in Group 1. The remaining four young people who were recorded as having been diagnosed with a mental illness were also recorded as having experienced self-harming behaviour, suicidal ideation and previous suicide attempts. However, none of these four young people were recorded as having allegedly experienced child maltreatment or any adverse family experiences other than a parent with a mental illness. These young people have been included in Group 2.

- The Office examined referrals to CAMHS, acceptance of referrals by CAMHS, risk assessments, treatment and discharge planning for the 12 young people who were recorded as having been diagnosed with a mental illness. The Office found differences between the experiences of the young people in Group 1 and Group 2, particularly with respect to acceptance of referrals by CAMHS and risk assessments. These patterns are discussed below.

### 1.5.2 By ensuring that the priorities for acceptance of referrals by CAMHS are applied more consistently for all young people, the Department of Health can assist in preventing and reducing youth suicide

- Of the 20 young people in Group 1, eight young people were recorded as having been diagnosed with a mental illness. All eight young people had been referred to CAMHS and, for six young people, these referrals had been accepted by CAMHS at some point in their lives.

- During the last year of their lives, six of the eight young people were referred to CAMHS again. However, three young people were not accepted by CAMHS even though they met the priorities for acceptance set out in the *WA Country Health Service Child and Adolescent Mental Health Services Access Criteria Policy.* The remaining three young people either received services from CAMHS or were waitlisted.Of the five young people in Group 2, four were recorded as having been diagnosed with a mental illness. Records indicate that, these four young people were diagnosed with a mental illness during the last two years of their lives. All four of these young people were referred to CAMHS. All referrals were accepted by CAMHS and the young people referred received services from CAMHS or were waitlisted to receive CAMHS services.

**Recommendation 4:** The Department of Health considers the findings of this investigation in determining their state-wide provision of mental health services for young people.

**Recommendation 5:** The Department of Health ensures that the Child and Adolescent Mental Health Service applies the priorities for acceptance of referrals set out in its policies.

**Recommendation 6:** The Department of Health, where services are available, assists with the coordination of services from other government and non-government mental health services for young people who have been placed on a waitlist for services from the Child and Adolescent Mental Health Service.

**Recommendation 7:** Where a young person is referred to the Child and Adolescent Mental Health Service but not accepted by the Child and Adolescent Mental Health Service, the Department of Health notifies the referrer that the young person has not been accepted.

### 1.5.3 By ensuring that risk assessments are conducted more consistently for all young people across WA Health's hospitals and health services, the Department of Health can assist in preventing and reducing youth suicide

- Risk assessments, including risk of harm to self (self-harm and suicide), are required by WA Health's *Clinical Risk Assessment and Management in Western Australian Mental Health Services: Policy and Standards* (**the CRAM Policy**).
- For the eight young people in Group 1 who had been recorded as having been diagnosed with a mental illness, risk assessments were not generally undertaken at the three points where they were required by the CRAM policy, as follows:
  - two risk assessments were undertaken as part of four admissions to an inpatient mental health unit; and
  - six risk assessments were undertaken on 14 presentations to an emergency department with self-harm, suicidal ideation and/or behaviour.

- For the four young people in Group 2 who had been recorded as having been diagnosed with a mental illness, risk assessments were generally undertaken in accordance with the CRAM policy, as follows:
  - three risk assessments were undertaken on four admissions to an inpatient mental health unit;
  - five risk assessments were undertaken for six presentations to an emergency department with self-harm, suicidal ideation and/or behaviour;
  - CAMHS undertook three risk assessments after accepting five referrals. These three risk assessments undertaken by CAMHS included a psychosocial and biological component. All three young people for whom a risk assessment had been conducted also had a risk management plan in place.

**Recommendation 8:** The Department of Health ensures that risk assessments undertaken by the Child and Adolescent Mental Health Service are conducted in accordance with the Clinical Risk Assessment and Management policy and the findings of the Chief Psychiatrist, including for young people who present with a history of child maltreatment.

### 1.5.4 Aboriginal young people

- Three of the eight young people in Group 1 who had been recorded as having been diagnosed with a mental health illness were Aboriginal. For these three young Aboriginal people:
  - all had been referred to CAMHS and for two young people the referral had been accepted by CAMHS, at some point in their lives;
  - all had been referred to CAMHS on more than one occasion, with a total of 11 referrals for the three young people; and
  - during the last year of their lives, two Aboriginal young people were referred again to CAMHS. Neither of these young people received services from CAMHS as a result of these referrals.
- The research literature has shown the effectiveness of culturally appropriate mental health services successfully engaging Aboriginal young people.[12] This was also recognised in the 2012 *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, which recommended that government:

[12] Australian Institute of Health and Welfare, *Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people*, Resource sheet No 19, Australian Institute of Health and Welfare, Canberra, 2013, viewed 24 February 2014,
<http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2013/ctgc-rs19.pdf>.

> Continue to resource the currently COAG Closing the Gap funded Specialist Aboriginal Mental Health Services to assist Aboriginal people to access culturally secure Mental Health Services.[13]

- The findings of this investigation support this recommendation.

## 1.6 The patterns identified by the Office may have implications for the Department for Child Protection and Family Support

### 1.6.1 Twenty of the 36 young people were recorded as having allegedly experienced one or more forms of child maltreatment, and all of these young people had contact with the Department for Child Protection and Family Support

- Twenty of the 36 young people were recorded as having allegedly experienced one or more forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse or neglect. On the basis of this distinguishing factor, for the purposes of further analysis, these 20 young people are referred to as Group 1.

- Child maltreatment, and its individual forms, has been identified in the research literature as a factor associated with suicide. All of the 20 young people in Group 1 had contact with the Department for Child Protection and Family Support (**DCPFS**). This contact provides DCPFS with opportunities to recognise and respond to child maltreatment and, in doing so, assist in preventing and reducing suicide by young people.

### 1.6.2 Seventeen of the 20 young people were recorded as having allegedly experienced more than one form of child maltreatment, and are therefore likely to have suffered cumulative harm

- Different forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse and neglect, often co-occur.[14] The effect of experiencing multiple forms of child maltreatment is referred to in the research literature as cumulative harm. Of the 20 young people in Group 1, 17 (85 per cent) were recorded as having allegedly experienced more than one form of child maltreatment, and are therefore likely to have suffered cumulative harm.

- The research literature also identifies that, when responding to child maltreatment, child protection authorities need to undertake holistic assessments so as to recognise cumulative harm.[15]

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[13] B Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, Western Australian Department of Health & Mental Health Commission, Perth, 2012, p. 14.
[14] Australian Institute of Family Studies, *Effects of child abuse and neglect for children and adolescents,* Australian Institute of Family Studies, Melbourne, 2010, viewed 26 September 2013, <http://www.aifs.gov.au/nch/pubs/sheets/rs17/rs17.html>.
[15] L Bromfield & D Higgins, 'Chronic and isolated maltreatment in a child protection sample', *Family Matters,* no. 70, 2005, pp. 38 – 45.

- Legislation and policies in some other states and territories explicitly identify that child protection authorities need to undertake holistic assessments so as to recognise cumulative harm. However, there are no explicit legislative requirements in Western Australia for undertaking holistic assessments so as to recognise cumulative harm.

- Some DCPFS policies for responding to child maltreatment address the need to undertake holistic assessments so as to recognise cumulative harm. DCPFS's *Policy on Neglect* explicitly identifies cumulative harm in its operational description of neglect[16] and two further elements of DCPFS's policy framework contain indirect references to cumulative harm. However, the explicit or indirect recognition of cumulative harm has not been extended to other relevant elements of the DCPFS's policy framework.

- DCPFS procedures for responding to information that raises concerns about a child's wellbeing make one direct reference to recognising and responding to cumulative harm. This is contained in DCPFS's Casework Practice Manual, which explicitly identifies that a Safety and Wellbeing Assessment should involve 'some or all' of a number of tasks, including 'assess(ing) for the presence or risk of cumulative harm.'[17]

**Recommendation 9:** The Department for Child Protection and Family Support considers whether an amendment to the *Children and Community Services Act 2004* should be made to explicitly identify the importance of considering the effects of cumulative patterns of harm on a child's safety and development.

**Recommendation 10:** The Department for Child Protection and Family Support considers the revision of its relevant policies and procedures to recognise, consider and appropriately respond to cumulative harm that is caused by child maltreatment.

### 1.6.3 By assessing the potential for cumulative harm more effectively, DCPFS can assist in preventing or reducing suicide by young people

- All of the 17 young people in Group 1 who were likely to have suffered cumulative harm were known to DCPFS, many through multiple interactions. The Office examined whether, for these 17 young people, DCPFS considered the potential for cumulative harm to have occurred by undertaking holistic assessments.

- The three key stages of DCPFS's procedures are: duty interactions; initial inquiries; and Safety and Wellbeing Assessments. The Office examined the assessments undertaken by DCPFS staff at each of these three stages and found:
    - For the 17 young people who were recorded as having allegedly experienced more than one form of maltreatment, DCPFS received information that raised

[16] Government of Western Australia, Department for Child Protection and Family Support, *Policy on neglect*, DCPFS, Perth, 2012, viewed 26 September 2013, <http://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/Neglect-PolicyOnNeglect.pdf>.
[17] Government of Western Australia, Department for Child Protection and Family Support, *Casework Practice Manual*, DCPFS, Perth, 2013, viewed 26 September, <http://manuals.dcp.wa.gov.au/manuals/cpm/Pages/01SafetyandWellbeingAssessment.aspx>.

concerns about the wellbeing of the young person through 257 duty interactions, and for 251 duty interactions, conducted an assessment of this information;

- It was not possible to examine whether DCPFS assessed the potential for cumulative harm during the duty interaction process as information which would allow such an assessment to take place is not recorded by DCPFS;
- For 12 young people in Group 1 there were 27 instances of intake and initial inquiries. During these initial inquiries there is evidence that DCPFS assessed the potential for cumulative harm, or progressed to a Safety and Wellbeing Assessment to enable this to be done, in 17 instances. DCPFS did not progress to a Safety and Wellbeing Assessment in two instances. In these two instances, DCPFS did not assess for the potential for cumulative harm; and
- As part of 25 Safety and Wellbeing Assessments, there is evidence that DCPFS assessed the potential for cumulative harm in two Safety and Wellbeing Assessments.

**Recommendation 11:** The Department for Child Protection and Family Support enables and strengthens staff compliance with the policies and procedures that are applicable to the duty interaction process.

**Recommendation 12:** The Department for Child Protection and Family Support enables and strengthens staff compliance with any revised policies and procedures which require them to assess the potential for cumulative harm to have occurred as a result of child maltreatment.

### 1.6.4 Aboriginal young people

- Of the young people in Group 1, Aboriginal young people had higher levels of contact with DCPFS than non-Aboriginal young people, as follows:
  - of the 17 young people in Group 1 who were recorded as having allegedly experienced more than one form of child maltreatment, nine were Aboriginal and eight were non-Aboriginal;
  - 198 (77 per cent) of duty interactions for the young people in Group 1 concerned Aboriginal young people; and
  - of the 12 young people who were the subject of initial inquiries or a Safety and Wellbeing Assessment, seven were Aboriginal and five were non-Aboriginal.
- DCPFS currently engages as a specialist position, Aboriginal Practice Leaders to assist with matters relating to Aboriginal young people. The Case Work Practice Manual sets out specific requirements when the Aboriginal Practice Leader should be consulted. However, this requirement for consultation is generally limited to interactions involving children in the care of the Chief Executive Officer.
- The findings of this investigation indicate that it is also important that Aboriginal Practice Leaders are consulted when the potential for cumulative harm is being assessed for Aboriginal young people, to ensure responses to this are culturally appropriate.

**Recommendation 13:** In considering revisions to its policies and procedures to recognise cumulative harm, the Department for Child Protection and Family Support considers incorporating requirements to consult with Aboriginal Practice Leaders when the potential for cumulative harm is being assessed for Aboriginal young people.

**Recommendation 14:** The Department for Child Protection and Family Support uses information developed about young people who are likely to have experienced cumulative harm as a result of child maltreatment to identify young people whose risk of suicide will be further examined and addressed through the collaborative inter-agency approach discussed in Recommendation 22.

## 1.7 The patterns identified by the Office may have implications for the Department of Education

- The research literature identifies that educational institutions have an important role to play in reducing the incidence of suicide by young people as education professionals are in a unique position to identify and prevent the suicide of young people.[18] The research literature further identifies that educational institutions are particularly important for children and young people from certain groups, including young people who have experienced child maltreatment, and Aboriginal young people.

- All of the 20 young people in Group 1 were recorded as having allegedly experienced child maltreatment. Nineteen (95 per cent) of the 20 young people were enrolled in an educational program at the time of their death. Of these 19 young people, 17 young people were enrolled in government schools and two were enrolled in non-government schools at the time of their death.

### 1.7.1 By responding to persistent non-attendance and behaviour management problems more effectively, the Department of Education can assist in preventing or reducing suicide by young people

- During the last year of their lives, 14 of the 19 young people enrolled at school attended less than 60 per cent of the time.

- For the 14 young people who attended school less than 60 per cent of the time, limited actions pursuant to the *School Education Act 1999* and the *Student Attendance* policy were taken to remedy this persistent non-attendance. However a range of other actions, not required by the legislation or policy, were undertaken by schools.

**Recommendation 15:** The Department of Education ensures that schools comply with the requirements for addressing student non-attendance, as set out in the *School Education Act 1999* and the *Student Attendance* policy.

[18] S. Crawford & N Caltabiano, 'The School Professionals' Role in Identification of Youth at Risk of Suicide', *Australian Journal of Teacher Education*, vol. 34, no 23, 2009, p. 28.

**Recommendation 16:** The Department of Education considers expanding its *Student Attendance* policy to:
- recognise that persistent non-attendance by a student may be due to cumulative harm resulting from child maltreatment;
- recognise that these students may be at heightened risk of suicide;
- set out what additional steps will be taken in response to this risk, including working in coordination with other State government departments and authorities; and
- provide that, where this association is identified, it will be appropriately taken into account.

- Ten of the 19 young people enrolled at school had been suspended from school.
- Five of the 19 young people enrolled at school had been suspended from school for more than 10 days during a school year, and three young people went on to be suspended for more than 20 days during a school year.
- For the five young people who had been suspended from school for more than 10 days during a school year, the *Behaviour Management in Schools* policy was not consistently applied. However, a range of other actions, not required by policy were undertaken by schools.

**Recommendation 17:** The Department of Education ensures that schools comply with the requirements for managing student behaviour, as set out in its *Behaviour Management in Schools* policy.

**Recommendation 18:** The Department of Education considers the expansion of its *Behaviour Management in Schools* policy to:
- recognise that ongoing behavioural difficulties by a student resulting in multiple suspensions and exclusions may be due to cumulative harm resulting from child maltreatment;
- recognise that these students may be at heightened risk of suicide;
- set out what additional steps will be taken in response to this risk, including working in coordination with other State government departments and authorities; and
- provide that, where this association is identified, it will be appropriately taken into account.

### 1.7.2 Aboriginal young people

- Ten of the 20 young people in Group 1 were Aboriginal. Nine of the ten Aboriginal young people were enrolled with government schools at the time of their death.
- Nine of the ten Aboriginal young people attended school less than 60 per cent of the time in their last year of life. Attendance records for one young person were not available. The attendance patterns of the nine Aboriginal young people where records were available were as follows:
  - three effectively did not attend school in the last year of their life; and
  - six attended school less than 60 per cent of the time in the last year of their life.

- Of the nine Aboriginal young people who attended school less than 60 per cent of the time, limited action was taken to remedy this persistent non-attendance, pursuant to the *School Education Act 1999* and the *Student Attendance* policy. However, a range of other actions, not required by the legislation or policy were undertaken by schools.
- Of the ten Aboriginal young people in Group 1 who were enrolled at school or a relevant registered training organisation, two were suspended from school for more than 10 days in a school year or excluded from school and limited action was taken under the *Behaviour Management in Schools* policy.

**Recommendation 19:** The Department of Education ensures that schools comply with the additional requirements for addressing non-attendance by Aboriginal students, as set out in the *Student Attendance* policy.

**Recommendation 20:** The Department of Education identifies young people who are exhibiting difficulties by establishing internal procedures to track when:
- a young person's attendance has fallen below 60 per cent;
- a young person's name has been placed on the Students whose Whereabouts are Unknown list;
- a young person has been suspended from attendance at school on two or more occasions; and
- a young person has been excluded from school.

**Recommendation 21:** The Department of Education uses the information obtained through tracking attendance, suspensions and exclusions to identify young people whose risk of suicide will be further examined and addressed through the collaborative inter-agency approach discussed in Recommendation 22.

## 1.8 State government departments and authorities will need to work together, as well as separately, to prevent and reduce suicide by young people

### 1.8.1 The importance of sharing information to effective identification of young people at risk of suicide

- In Western Australia, the primary piece of legislation regarding the safety and wellbeing of children is the *Children and Community Services Act 2004* (**the CCS Act**). As identified in a review of the CCS Act, sections 23 and 24A of the CCS Act 'enable agencies to share information, without consent where necessary, in the interests of the wellbeing of a child or class or group of children.'[19]

[19] Government of Western Australia, Department for Child Protection, *Report of the Legislative Review of the Children and Community Services Act 2004,* DCPFS, Perth, 2012, p. 11.

- Some State government departments and authorities indicated that they were aware that information could be shared with DCPFS under the CCS Act and were cooperating with requests for information from DCPFS. However, some State government departments and authorities also reported that they believed the information sharing provisions of the CCS Act only related to exchanges with DCPFS.

- Action Area 4 of the State Strategy identifies the need for practical tools for information sharing. In implementing Action Area 4, the Mental Health Commission could bring together the Child and Adolescent Mental Health Service, the Department for Child Protection and Family Support and the Department of Education to develop a tool for identifying young people at risk of suicide, which involves the sharing of information between these three departments in particular, as well as other relevant State government departments and authorities.

### 1.8.2 The importance of inter-agency collaboration in preventing and reducing suicide by young people who experience multiple risk factors and have contact with multiple State government departments

- Nineteen of the 36 young people (53 per cent) were recorded as having experienced multiple factors associated with suicide and were recorded as having allegedly experienced one or more forms of child maltreatment. Most of these young people were also recorded as having experienced mental health problems and suicidal ideation and behaviour. These 19 young people were all in Group 1. The young people in this group had contact with multiple State government departments and authorities over their lifetime.

- The research literature identifies that young people who have multiple risk factors and a long history of involvement with multiple agencies are often 'hard to help',[20] and agencies face challenges in providing services to these young people.[21] The profile of 'hard to help' young people described in the research literature was similar to those young people in Group 1.

- Preventing or reducing suicide among young people, such as those in Group 1, who experience multiple risk factors is likely to involve a range of actions by a range of State government departments and authorities, which will need to be coordinated so that each action reinforces the others. One accepted way that such coordination can be achieved is through a case management approach. The young people in Group 1 had significant levels of contact with the Child and Adolescent Mental Health Service, the Department for Child Protection and Family Support and the Department of Education. These departments could be important parties to a case management approach.

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[20] M Brandon, P Belderson, C Warren, D Howe, R Gardner, J Dodsworth & J Black, *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003-05,* United Kingdom Department for Children, Schools and Families, London, 2008, p. 12.

[21] M Brandon, P Belderson, C Warren, D Howe, R Gardner, J Dodsworth & J Black, *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003-05*, United Kingdom Department for Children, Schools and Families, London, 2008, p. 12.

**Recommendation 22:** The Mental Health Commission, working together with the Department of Health, the Department for Child Protection and Family Support and the Department of Education, considers the development of a collaborative inter-agency approach, including consideration of a shared screening tool and a joint case management approach for young people with multiple risk factors for suicide.