The Hon Ryan Park MP
Minister for Health
Minister for Regional Health
Minister for the Illawarra and the South Coast

The Hon Rose Jackson MLC
Minister for Water, Minister for Housing, Minister for Homelessness,
Minister for Mental Health, Minister for Youth, Minister for the North Coast

Your Ref: 2018/180472
Our Ref: COR23/13

The Hon. Michael Daley, MP
Attorney General
52 Martin Place
SYDNEY NSW 2000
office@daley.minister.nsw.gov.au

Coronial inquest into the death of JY

Dear Attorney General Michael

I write in relation to the findings and recommendations made on 5 July 2023 by State Coroner Teresa O'Sullivan regarding the death of JY.

JY died aged 5 years on 8 June 2018 as a consequence of the acts of his father. The cause of death was multiple stab wounds.

JY's father, BS, was diagnosed with schizophrenia, and had extensive interactions with hospitals and health agencies for many years. In April 2018, BS was admitted to Hornsby Hospital following a deterioration in mental state. He was discharged on 16 May 2018 with referral to a community mental health team. BS engaged with the community mental health team from May to June 2018.

Following JY's death, BS was arrested and tried for murder. On 24 July 2019, BS was found not guilty by reason of mental illness. The judgement described BS' actions in killing JY as having occurred during a psychotic episode.

The State Coroner directed one recommendation to all the Chief Executives of all Local Health Districts (LHDs) and to the Ministry of Health, that is supported.

Recommendation

The State Coroner recommended:

> *That consideration be given to expanding the REACH program to Community Mental Health settings, with appropriate information being provided to consumers, families, and other carers on how to use the program in that setting.*

The Ministry of Health Mental Health Branch advises that a state-wide response is warranted and all LHDs should be consider implementing REACH in Community Mental Health settings. Further, the Mental Health Branch noted that REACH is an initiative of the Clinical Excellence Commission.

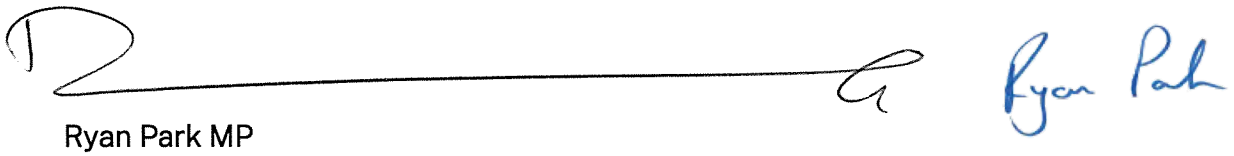
All fifteen LHDs advised they have embedded or are progressing REACH or an equivalent escalation process in their Community Mental Health settings. District responses have been shared with the Mental Health Branch and the Clinical Excellence Commission.

Common elements of LHDs' approaches are identifying opportunities to enhance embedded processes; developing action plans and communication strategies; establishing working parties with governance oversight; developing or amending local procedure documents; and broad stakeholder engagement to support effective local solutions and change management.

I trust that this response confirms NSW Health's commitment to a process of continuous improvement and delivering safe and high-quality care to all patients of the NSW health system.

For more information, please contact Joanne Edwards, Executive Director, System Management Branch, NSW Ministry of Health at moh-systemmanagementbranch@health.nsw.gov.au.

Yours sincerely



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CC: NSW Coroner's Court

Encl. Coroner's report – *Inquest into the death of JY*