STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of George Campbell
Hearing dates:	7-10 February 2023
Date of findings:	22 August 2023
Place of findings:	Batemans Bay Local Court
Findings of:	**State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – volatile substance use – First Nations death – death of a child in care
File number:	2018/00080916
Representation:	Counsel Assisting the Coroner: Chris McGorey instructed by Rebecca Campbell (Crown Solicitor's Office) Family (Karen Campbell): Julie Buxton instructed by Katrina Hawtrey (National Justice Project) Family (Paul and Marion Campbell): Bridget Kennedy (Legal Aid NSW) Department of Communities and Justice: Simeon Beckett SC and Dr Katherine Fallah instructed by Rachel Garrett (Wotton Kearney)
Non publication order:	Non publication orders apply to the evidence in this inquest, prohibiting the publication of certain evidence contained in the coronial brief of evidence, with a particular reference to media guidelines for the reporting of Volatile Substance Misuse. A copy of the orders made by State Coroner O'Sullivan is available upon request from the Court Registry.

Findings:	**Identity:** The person who died was George Joseph Charles Campbell. **Date of death:** George died on 9 or 10 March 2018. **Place of death:** George died at Wallaga Lake, New South Wales. **Cause of death:** The cause of George's death was hydrocarbon toxicity. **Manner of death:** George died whilst under the parental responsibility of the Minister, after ingesting or inhaling a petroleum product. The evidence does not establish that he ingested or inhaled the petroleum products with the intention of ending his life.

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The Coroners Act 2009 (NSW), s. 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of George Campbell.

Introduction

1. George Joseph Charles Campbell (**George**) was a Yuin, Dunghutti and Tharawal man and of Black Duck and Black Swan totem. George was just 17 years of age when he died sometime between 9 and 10 March 2018, at the Wallaga Lake Koori Village (**Wallaga Lake**).

2. Before I go further in these findings, I want to again extend my sincere condolences to George's family, a large number of whom attended each day of the inquest, both in person and via the audio-visual link. In particular, I acknowledge George's mother, Karen; brother, LC; sister, EC; Great Uncles, Paul and Gary; Great Aunt, Marion; Grandmother, Fay; Aunt, Belinda; and Uncle, Rodney. It is very clear to me that George was loved deeply by his family.

3. George's death was tragic and premature. The passing of a young indigenous man, not yet 18, in these circumstances is devastating and I acknowledge the trauma and loss that continue to be felt by George's family and the community. George's family were united in their desire to fully understand all the events leading up to his death.

The role of the coroner and the scope of the inquest

4. This inquest is held for the purposes of a public examination into the circumstances of George's death. Unlike some other proceedings, the purpose of an inquest is not to blame or punish anyone for a death. Instead, a coronial inquest is an inquisitorial process, in the nature of a fact-finding and truth-telling exercise.

5. The role of a Coroner, as set out in s. 81(1) of the *Coroners Act 2009* (NSW) (**the Act**), is to make findings as to the:

   (a) The person's identity;

   (b) The date and place of the person's death;

   (c) The manner (or surrounding circumstances) of the death; and

   (d) The medical cause of death.

6. Pursuant to s. 82(1) of the Act, the Coroner may also make any recommendations that the Coroner considers "necessary or desirable to make in relation to any matter connected with the death". This involves consideration of whether anything should or

could be done to prevent a death in similar circumstances in the future. These recommendations are made, usually to government and non-government organisations, to address systemic issues that are revealed in an inquest.

7. A coronial inquest takes places, necessarily, after the event. It follows that, unavoidably, a coronial inquest is conducted with the benefit of hindsight.

8. When considering the reasonableness of decisions or actions in real time, I must judge the appropriateness considering what was known or reasonably able to have been known to the relevant individual or organisation at the time. Reasonableness cannot be evaluated through the prism of the tragic outcome of the case.

Issues considered in this inquest

9. Simply put the matters examined in this inquest focused on (1) what was the cause of George's death and (2) the reasonableness of the Department of Communities and Justice (**DCJ**)[1] casework for George in the two years preceding his death.

10. A significant amount of documentary material was received in evidence. I have been greatly assisted in my consideration of that material by the careful and thorough submissions of the legal representatives.

11. I was also assisted to receive expert opinion from Emertius Professor Judith Irwin[2] and Ms Kate Alexander, the Senior Practitioner of the Office of the Senior Practitioner for DCJ, about DCJ's case management in George's case.[3] Both experts prepared separate statements or reports and gave oral evidence concurrently in the hearing.

12. Some of the documentary evidence before the Court touches on casework carried out earlier in George's childhood. To understand George's circumstances and needs in the two years preceding his death, it is necessary to understand some past events and experiences. These findings, therefore, outline certain events in George's early life and casework decisions.

13. I acknowledge the understandable concern that George's family has regarding past casework decisions and the distress they experience about those concerns.

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1 DCJ has been previously known as the Department of Families and Community Services (FACS) and the Department of Community Services (DOCS). In these findings it is simply referred to by its current name (DCJ).

2 Professor Irwin is an Emeritus Professor Social Work and Social Justice at the University of Sydney. She is a qualified social worker and has a Bachelor of Social Work, a Master of Arts (Counselling) and a PHD.

3 Ms Alexander is also the Chair of DCJ's Serious Case Review Panel. Ms Alexander has been a social worker in the area of child protection for 30 years; she has worked with DCJ for over 26 years in a variety of roles. Ms Alexander also holds a Master of Social Work and a number of post graduate qualifications.

Regrettably, it was beyond the scope of this inquest to properly examine the reasonableness of past casework actions and decisions. A proper examination of those issues would necessitate the calling of numerous individuals to examine them on events dating as far back as 15 or more years ago.

14. I also note the evidence given by Ms Alexander in her evidence in this inquest that touched on George's original removal. Ms Alexander said earlier in her evidence:

> *"The first point I want to make really goes back to the early years of our involvement with George and his family when he was brought into care in 2008, and I – I want to comment on that time with the benefit of everything we've done more recently that has really changed and challenged our thinking and approach to working with children that we consider at risk.*
>
> *It's about safety in family and the importance of really strong skills in our workforce in the way they assess the safety of children, and then really strong skills at working with families and the community around them to keep those children in families and lower the risk. So, ideally, back in 2008, and I do believe we do a much better job of this now, it was about harnessing all of the strengths in the family and all of the people who loved and cared about George and – and getting those people literally around a table and family group conferencing, family-led decision making, family action planning.*
>
> *There's a whole lot of ways that we should have been able to harness that love and that care for George and his brother at that time. I'm not sure what the outcome would have been if we'd done that, whether they would have needed to enter care or whether they would have been able to stay in care of family more informally, but it's about giving the power, the expertise and the respect to the family to organise safety for their child, and we've done a lot of work and really improved our processes to be much better at that. So, for me, those early years were very, very important."*

15. Ms Alexander also gave evidence about the initiatives being implemented by DCJ concerning the potential removal and placement of an Aboriginal child into statutory out of home care. This involves a regional panel which will include input from Aboriginal communities' members on removal and placement of Aboriginal children. Ms Alexander's evidence reveals a change in DCJ's approach to cases such as that of George. I hope it provides a measure of solace to George's loved ones.

16. I also note the submissions made by the DCJ as to changes being implemented in response to the *Family Culture Review*'s recommendations delivered on 7 November 2019.

17. *The Children and Young Persons (Care and Protection) Amendment (Family is Culture) Bill 2022* was introduced in response to *Family Culture Review* and assented to on 25 November 2022.

18. *The Children and Young Persons (Care and Protection) Amendment (Family is Culture) Act 2022 (***the amending Act***)* introduces a new section 12A into the *Children and Young Persons (Care and Protection) Act 1998* (**CYP Act**), with section 12 setting out the Aboriginal and Torres Strait Islander Children and Young Persons Placement Principles that apply to the administration of the CYP Act in relation to Aboriginal and Torres Strait Islander children and young persons. This new section consists of five elements, namely:

> *"In application of this Act to matters involving Aboriginal or Torres Strait Islander children and young people, all decision makers must apply each of the following elements of Aboriginal and Torres Strait Islander Child and Young Person Placement Principles that are relevant to the decision being made –*
>
> a. ***prevention****, recognising that a child or young person has a right to be brought up within the child's or young person's own family, community and culture,*
>
> b. ***partnership****, recognising that Aboriginal and Torres Strait Islander community representatives should participate in the design and delivery of services for children and young persons and in individual decisions about children and young persons,*
>
> c. ***placement****, recognising that, if a child is to be placed in out-of-home care, the child's placement is to be in accordance with the placement principles for Aboriginal and Torres Strait Islander children and young persons in section 13,*
>
> d. ***participation****, recognising that a child or young person, and the child's or young person's parents and family members, should participate in decisions about the care and protection of the child or young person,*
>
> e. ***connection****, recognising that a child or young person, and the child's or young person's parents and family members, should participate in decisions about the care and protection of the child or young person."*

19. The amending Act introduced other changes such as a new section 63 to the CYP Act, which places an onus on the Secretary to make active efforts to provide, facilitate, or assist with support for the safety, welfare, and wellbeing of the children or young persons, including support for the parents of the children or young persons before making a care application, and section 78(2A) which requires care plans for Aboriginal or Torres Strait Islander children or young persons to include a cultural plan that must adhere to specific requirements.

20. Further, a new section 83A will be added to the CYP Act in addition to section 83 relating to permanency planning for Aboriginal and Torres Strait Islander children and

young persons. This section places an onus on the Secretary to make active efforts to determine: if children or young persons can be placed with a relative, a member of kin or community, or another suitable person; that the permanency plan complies with the permanent placement principles, the Aboriginal and Torres Strait Islander Children and Young Persons Principle, the placement principles for Aboriginal and Torres Strait Islander children and young persons as set out in section 13 and that the plan includes a cultural plan.

21. The emphasis given to the recognition of an Aboriginal and Torres Strait Islander child's right to be brought up within his or her own family, community and culture, and the recognition given to "family member" participating in decisions about the child's care and protection, is significant. It may be thought that these provisions would have significant work to do in the future for a child who finds him or herself in similar circumstances to that which George did in his early childhood.

GEORGE

22. Before I go on to discuss the circumstances of George's death, I recognise and reflect on who George was and the impact that his young life had on his friends and family.

23. George was born in Bega, New South Wales on 4 August 2000 to Karen Campbell and Michael Darcy. He had two siblings: his older half maternal sister, EC; and his younger brother, LC.

24. George was named after his maternal grandfather.

25. George grew up in the South NSW region, including Bega, Beauty Point Dalmeny,and around the Wallaga Lake area in early childhood. He attended school at Bermagui, Moruya, and Narooma.

26. George came from a large family and many of his relatives also lived on the NSW South Coast, including those whom I have already mentioned. George and his siblings, EC and LC, lived with their parents until 2007. In mid-2007 they went to live with their maternal grandparents, George (Wally) and Lillian (Fay) Campbell.

27. Towards the end of the inquest, George's family shared with the Court some of the joyous moments of George's life. What they shared helps to remember George as the dearly loved young man he was.

28. George's mother, Karen, told the Court of her extreme pain since her son's death. She continues to pray and hope that this has all just been a dream. She told the Court that George was a "mummy's boy" and as a small child never left her side. When

George was born it was the biggest and happiest news for the family, she felt blessed. George meant the world to her.

29. George's younger brother, LC told the Court how George was a "funny fella" who made everyone laugh. George brought joy to his life. He told the Court how they would go fishing and motorbike riding together and go out bush. They had a special bond. He told the Court how the death of their Dad and Pop affected them both greatly and that he didn't get to see George as much as he wanted to.

30. George's grandmother, Fay, told the Court how George meant everything to her. Fay remembered George telling her that he loved her and going to the football together with the family. She remembered the close bond George shared with his cousins and his Pop, the birthdays they shared and the time they spent at Wallaga Lake and the beach. George's nickname, given to him by his Pop, was "Pooples". George liked fishing but he didn't like eating fish. He liked prawns and oysters.

31. George's uncle, Rodney, described George as a fun-loving, caring and kind boy. He told the Court George's family will forever cherish the great moments they had with him.

32. George's Great Uncle, Paul and Great Aunt, Marion, who were also George's carers at the time of his death, told the Court how George was an energetic boy who always kept everyone entertained. Paul and Marion also read out a statement from their son Paul Junior who spoke about taking George out to activities organised through the Wandarma Program (a men's group). Paul Junior told the Court how everyone loved George's energy and how the camps aren't the same without him.

33. Paul and Marion described George as a "funny little lad who loved camping, fishing and learning about culture". He also loved spending time with his uncles and in 2017 asked to be baptised. Paul spoke of how George's school friends at Narooma High School had organised for a plaque to be made in George's memory and how Paul planned to place this in a special section of his garden to remember George. The plaque read: "*George Campbell, a larrikin in every sense. Once met, never forgotten and gone too soon.*"

34. It is important to look at George's life in context. Since the colonisation of this country, First Nations peoples have experienced extreme hardships, ranging from the loss of country to the forced removal of children and the denial of citizenship rights.

35. The impact of colonisation is still felt today. The history of the Wallaga Lake community, where George lived for a time with Paul and Marion, is but one example of that history.

36. The Wallaga Lake community is situated in strikingly beautiful country beneath the Gulaga Mountain. The lake itself contains an abundance of seafood. I heard how the Wallaga Lake community was historically part of an Aboriginal reserve or mission (previously known as Wallaga Lake Aboriginal station).

37. To this day there are residents (including Paul) who remember living at Wallaga Lake when it operated as a Mission, when Aboriginal residents required the approval of a superintendent to be able to come and go from the Mission. The relic of a boom gate, which in the mission days Aboriginal residents were prevented from passing without the permission of the Mission's administrator, remains in place as a powerful reminder of the treatment of First Nations peoples.

OVERVIEW

38. In submissions, Counsel Assisting summarised what might be thought of as the non-contentious evidence and matters. Most if not all of Counsel Assisting's submissions about this were not disputed by the other parties. I accept Counsel Assisting's summary of the evidence as accurate and reproduce much of it below.

DCJ's involvement in 2008

39. In mid-2008, the DCJ concluded it was not safe for George and his siblings to remain in their parents' or maternal grandparents' care. As indicated earlier in these findings, the reasonableness or correctness of that conclusion is not a matter that has been examined in this inquest.

40. On 4 June 2008, when George was 8, he and his siblings were removed from their parents' care by DCJ caseworkers under the CYP Act.

41. A care application was then made to the Children's Court of NSW (**CCNSW**) and interim orders were made vesting all aspects of parental responsibility to the Minister. Parental responsibility was exercised on the Minister's behalf by the Secretary for the DCJ. This was done primarily through DCJ caseworkers assigned to George's case acting under the supervision of Manager Caseworkers (**MCW**) who in turn were supervised by Manager Client Services (**MCS**) within DCJ Community Service Centres (**CSC**).

42. George and LC were initially placed with emergency authorised carers, before being placed with their aunt and uncle (not Paul and Marion). During this second placement

they were also placed with several respite carers on four occasions for periods ranging from a weekend to a month.

43. On 6 March 2009, DCJ placed George in the care of GK. GK was an authorised carer under the CYP Act and DCJ considered her an "experienced Aboriginal carer" who would be able to encourage and facilitate George and LC's cultural heritage and identity. LC joined that placement in June 2009, while EC returned to the care of her maternal grandparents. LC and George resided with GK at Dalmeny, NSW.

44. On 16 March 2011, the CCNSW made a final order vesting parental responsibility for George and LC to the Minister until each attained the age of 18. The Minister would have ceased to be George's legal parent upon George turning 18, on 4 August 2018. George died about 5 months shy of his 18th birthday.

45. George resided with GK continuously for approximately 7 years until early to mid-2016. During that time, he attended Moruya Primary School and later Moruya High School. GK also provided care to other children in a statutory out of home care context as well as to her own daughter.

46. Between February and March 2016, George's placement with GK broke down and their relationship became fractured. GK advised DCJ she was no longer able to take care of George. The reasons underlying the breakdown of their relationship are complex and traumatic and not something that can reasonably be examined in this inquest.

47. Following that breakdown, George spent some time at the Moruya Youth Refuge as well as in a residential care placement with 'Youth off the Streets' (a non-for-profit youth organisation).

48. On 21 July 2016, George was arrested following an altercation at GK's house. He was taken to Nowra Police Station. George asked police to contact his grand uncle, Paul Campbell and asked if he could stay with him. Paul agreed and collected George.

49. This was the first occasion George had stayed with Paul and his family. However, from that date onwards George lived with Paul and his great aunt, Marion and their three children, AC, ZA and WC, at their home in Wallaga Lake, until his death in March 2018. LC continued residing with GK during this period and up until her death in 2019.

Diagnosis in 2011

50. By about 2011, George had been diagnosed with an Attention Deficit and Hyperactivity Disorder (**ADHD**) and (possible) intellectual delay.

Events 2015

51. Leading up and into 2015, it is possible George's difficulties intensified after the passing of his father in April 2014 and then his paternal grandfather in May 2014.

52. I heard evidence about what George may have been told by GK which differed from the true circumstances of his father's passing. An understandable concern of George's mother is whether that information was or should have been corrected by DCJ caseworkers. While it is beyond the reasonable scope of this inquest to thoroughly examine what occurred in this respect, I acknowledge the pain and difficulty this may have caused George.

53. In Professor Irwin's view, George's behaviour had deteriorated to a significant degree by the beginning in 2015 onwards. This manifested in numerous ways including alleged behaviours in the home towards GK and others which resulted in police being called and difficulties at Moruya High School and consequent several short-term suspensions.

54. During these difficulties, on 25 May 2015, GK advised a DCJ caseworker that she thought George may have been inhaling deodorant that morning. The caseworker suggested GK buy roll on deodorant for George and to monitor the behaviour to ensure it was not George simply using too much deodorant. This was the first documented report of George's suspected volatile substance (**VS**) use.

Early to mid-2016

55. On 19 January 2016, Ms Sally Johnson, a Social Worker with the Child Protection Counselling Service (**CPCS**), Southern NSW Local Health District (**SNSWLHD**), spoke with GK by phone. This followed Louise Tompsett, George's assigned DCJ caseworker, requesting a counselling contact by Ms Johnson owing to GK's reports about his disruptive behaviours.

56. During her call with Ms Johnson, GK stated various concerns including about George's behaviours in the home and her suspicion that he was misusing inhalants. Ms Johnson noted "*[GK thinks] that he might be inhaling some volatile substance – referred to George disappearing for long periods, returning with red eyes, he has referred to going to buy petrol from IGA*". This was the second documented report of George's suspected volatile substance use.

57. Ms Johnson subsequently communicated with DCJ caseworker Louise Tompsett about her contact with GK. Ms Johnson reported that George presented (to her in sessions) in a "very flat mood" and that he found it difficult to articulate his thoughts and feelings. George denied he used 'anything' (it appears on its face George denied either to Ms Johnson or GK he was misusing VS). Ms Johnson considered that continued counselling with her was unlikely to be helpful for George at that time. Ms Johnson also noted, "*I have observed a communication dynamic between [GK] and George that leaves both of them feeling very frustrated—and it seems to be repeating itself in ever decreasing circles*.*"*

58. DCJ caseworker Louise Tompsett also had phone conversations with GK between 18 and 20 January 2016, during which GK said she "*thinks [George is] doing something like 'chroming' maybe…or sniffing petrol.*"

59. A Child Assessment Tool report dated 31 May 2016, completed by a DCJ caseworker, stated "*Whilst there are no indicators that George is using alcohol or other drugs, George has stated to the carer that he has smoked bongs and sniffed paint or petrol.*" There is no record available showing if, and when, George might have made this statement. A file note of Ms Tompsett's conversations with GK about this between 18 and 20 January 2016 (Exhibit 4) record GK reporting her suspicion about these matters (not that GK knew for fact it had occurred). I cannot discount the possibility that what the report references is GK's suspicions as opposed to what George had in fact reported to her firsthand.

60. On 10 February 2016, police were contacted by GK who alleged difficult behaviours by George. This led to the making of an apprehended violence order (**AVO**), for the protection of GK and others living in the home against George, and his removal from GK's home.

61. At about this time, DCJ caseworker Louise Tompsett consulted with a DCJ psychologist (Karen Charlton-Owen) which led to a review of DCJ's management plan for George. Ms Tompsett also made a referral requesting a Child and Adolescent Mental Health Service (**CAMHS**) assessment. CAMHS is part of the Southern NSW Local Health District (**SNSWLHD**). Ms Tompsett advised, as part of that referral, that:

    (1) George had been showing erratic behaviours in his home which resulted in the involvement of police the day before.

    (2) George was angry and aggressive towards his carer and his behaviour was "*escalating*" and his carer was not able to adequately manage that.

(3) George had been arrested and removed from the premises the day before (10 February 2016) by police and had disclosed to police that he "*would kill himself by using a rope*" and that he had "*attempted suicide before several times*."

(4) George had experienced "significant loss in his life" with his "*father and grandfather passed away in last one year which he was close with grandfather"* (sic).

(5) When he became angry, George sometimes experienced "*angry feelings of suicidal, (sic) wanting to end his life with a knife or other means."*

(6) George denied alcohol or drug use (admitted to smoking cigarettes).

62. On 1 March 2016, police reported to DCJ that GK had contacted police advising she no longer could care for George due to his behaviours and police later found him walking the streets. He was returned to GK's home that night, but she had advised he could not stay there beyond that one night.

63. On 3 March 2016, George was placed temporarily at the Moruya Youth Refuge.

64. On 7 March 2016, Ms Charlton-Owen (DCJ psychologist) and DCJ caseworker Louise Tompsett completed a review of George's Behaviour Management Plan. The strategy listed three behaviours of concern: suicidal ideation; emotional dysregulation; and other inappropriate behaviours. The following strategies were identified for managing or preventing the behaviours of concern:

(1) Providing George with opportunities to develop a healthy sense of agency, autonomy, and cultural belonging through his engagement with Katungul Aboriginal Services Social Workers.

(2) George to be engaged with CAMHS to develop skills in recognising and regulating distressing and overwhelming emotions, and to explore patterns of thinking that may be contributing to negative thoughts about himself and his circumstances.

(3) George and his [carers] to have a clear response in place for if George becomes distressed, such as an agreed space that George can go to without further argument, and contact numbers to call if George's distress continues to elevate.

65. At around this time, George reported his wish to stay with his brother (LC) and GK. He also asked to stay with his sister, EC, however DCJ assessed that was not viable owing to George's behaviours and mental health difficulties.

66. The following observations are made regarding the review of George's Behaviour Management Plan and the strategies that were identified:

    (1) The assistance George received from the Katungul Aboriginal Health Service appears to have been limited to occasional General Practitioner sessions. This may have resulted, in part, from the limited funding and services Katungul was able to provide at that time.

    (2) George's engagement with CAMHS, ultimately, did not involve the development of skills in recognising and regulating distressing and overwhelming emotions, and to explore patterns of negative thinking patterns. The focus of CAMHS reviews of George was on his medication and general wellbeing. George declined counselling through CAMHS.

67. As observed by Emeritus Professor Irwin, the plan focused on managing suicidal ideation, emotional dysregulation, and inappropriate sexualised behaviour. Suspected drug or inhalant misuse was not an identified concern or focus of the plan.

68. On 14 March 2016, George had his first face to face consultation with Dr Steven Spielman, Consultant Psychiatrist, CAMHS. Dr Spielman saw George on 6 or 7 separate occasions up until 23 October 2017.

69. According to Ms Janine Zideluns, a CAMHS registered psychologist, George was a client of CAMHS between July 2016 and March 2018. From the initial contact, he declined assistance from CAMHS services including counselling apart from psychiatry. Ms Zideluns attended Dr Spielman's sessions with George. Records made by Ms Zideluns noted George's 'complex trauma history' and listed an 'associated diagnosis' as "*Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence*."

70. In Dr Spielman's view, at the time of his first or early reviews, George:

    (1) Presented with a transgenerational background of parental loss, trauma, abuse, and neglect.

    (2) Had suffered psychosocial trauma which manifested in difficult behaviours although there appeared to be some improvement before death.

(3) Presented with irritability, low mood, auditory perceptual abnormalities, impulsivity, and poor attention span.

(4) Was being treated with antidepressant and stimulant medication to improve his psychological and academic wellbeing.

71. Dr Spielman's impression of George was that of a young man who typically presented as polite, reserved, somewhat shy, but whom at times of stress had difficulties with his emotional dysregulation. In large part these difficulties stemmed from the early childhood trauma George had experienced.

72. As of 14 March 2016, George had been residing at the Moruya Refuge for the preceding 11 days at the time of this consultation. Dr Spielman recorded following their consultation:

(1) George reported being angry for an extended period worsening over the last year. He also reported being worried at some of his behaviours and "*thinking frequently about his father.*"

(2) GK reported difficulties in George's behaviours in the home including his anger at 'limit setting'. There had been increasingly verbal and at times physical violent incidents culminating in his recent shift to a refuge.

(3) George had reportedly undergone psychometric assessment which possibly indicated moderate intellectual impairment however those results were not available to Dr Spielman at the time of assessment.

(4) George received paediatric treatment from Dr Paul Jenkins and had been diagnosed with ADHD and was prescribed Concerta (36 mg mane), Ritalin (10 mg mane) and Catapres (100mcg each morning).

(5) In relation to ongoing treatment, the plan was to explore possible anger management programs options for George and the addition of Fluoxetine medication (*antidepressant medication used in treatment of depression and other disorders*).

73. On 17 March 2016, DCJ psychologist Ms Charlton-Owen recommended to DCJ caseworker Louise Tompsett, amongst other things, that Ms Tompsett continue to build on her relationship with George to begin to support him to be re-engaged with his family with whom he had limited contact.

74. On 11 May 2016, DCJ Caseworker Louise Tompsett consulted with psychologist DCJ Karen Charlton-Owen. The latter recorded (amongst other things):

(1) Ms Tompsett had '*recently been contacted by the carer regarding George's behaviour towards animals and George possibly injuring a dog*.'

(2) '*Fire lighting was occurring'* at the refuge.

(3) Although George is '*continuing to have some burn marks on his clothes*,' he was not lighting fires (Ms Charlton-Owen noted that burn marks were '*discussed as being possible examples of self-harm behaviours*.')

75. On 13 May 2016, Ms Zideluns emailed DCJ caseworker Louise Tompsett advising, amongst other matters, that:

> *"Just want to clarify CAMHS role in working with George. At this time George is listed with our service for Psychiatry reviews only. Counselling for George with the CAMHS team or other services has been discussed with George however he is adamant he does not want to attend counselling. Connecting George to a mentor, anger management and support for GK and George in their relationship have been identified as priorities and I understand were to be explored further with the family and service providers by Community Services. Please review Dr Spielman's letter re. his recommendations for supports for George.*
>
> *At our last review with George fire lighting was not identified, however I am aware from discussions with Refuge staff following the Psychiatry review that this is an area of concern.*
>
> *George presents with a complex history and presentation and as such further discussions regarding support services is required."*

76. On 30 May 2016, Ms Tompsett (DCJ caseworker) advised Ms Zideluns that the preceding Sunday, GK reported that George had a knife, made threats to others, and threatened to burn down the house (police were not contacted on this occasion).

77. On 31 May 2016, a DCJ placement needs assessment was completed. The assessment recommended "residential care" placement for George, noting amongst other matters:

(1) It was DCJ's assessment that George required "*intensive residential services to support his current placement and assist in addressing his specific needs*.*"*

(2) George reportedly wanted to stay with GK and his brother, LC, but his escalating behaviours made that unsuitable.

(3) George had indicated a desire to live with his sister, EC, but this option was not considered suitable owing to his '*current behaviours.'*

(4) George identified strongly as a young Aboriginal man but was '*struggling with his sense of personal identity since the passing of his father and maternal grandfather 2 years ago*.*'*

(5) George was smoking cigarettes, and often made reference to drug taking behaviours, however it was not known at that time if he was "*drinking alcohol or using any substances.*"

78. On 16 June 2016, George moved to a residential care placement with Youth off the Streets which offered accommodation in the Sydney Metropolitan area. This followed George being prohibited from staying at the Moruya Youth Refuge as he had, reportedly, tried to light fires at those premises.

79. In July 2016, George left his placement with the Youth off the Streets and returned to GK's home. After returning he allegedly damaged property and committed an assault.

80. On 15 July 2016, Youth off the Streets staff travelled to Dalmeny and met with George to return him to their refuge. George was adamant he would not return to the refuge or accompany them.

Placement with Paul and Marion Campbell (Wallaga Lake)

81. On 31 July 2016, George was arrested and taken to Narooma Police Station. While there he contacted Paul and asked if he could come and stay with Paul and his family. George was released on bail to reside at Wallaga Lake with Paul, Marion and their three children.

82. Paul and Marion were authorised as kinship carers. George continued to attend Moruya High School at this time.

83. On 8 August 2016, Dr Spielman noted George's report that he was staying with his great uncle, and this had had "*a beneficial impact on his mood and behaviour*" and that he felt calmer and less stressed.

84. Dr Spielman recommended that George maintain Concerta 36mg daily, Ritalin 10mg each morning and Fluoxetine 20mg daily. Dr Spielman noted George was not "*keen on any particularly psychological therapies and believes that more practical measures such as helping him to transfer to Narooma High and involvement in work based programs are more beneficial.*"

85. Although George's circumstances improved after his placement with Paul in August 2016, he continued to have difficulties with his behaviour and consistency maintaining

his prescribed medications. On 14 September 2016, a learning support teacher at Moruya Highschool advised DCJ of the school's concern that George **'***may be affected by an unknown substance.***'** His behaviour at school was reported to be erratic and included occasional threatening and verbal abuse towards school staff. In an assessment with Dr Spielman on 10 October 2016, George reported he had not taken his prescribed Concerta in the preceding weeks and felt more irritable and angrier.

86. On 12 October 2016, DCJ caseworker Louise Tompsett stated the following in a statement prepared for George's criminal proceedings, (amongst other things):

(1) Paul had been able to establish a strong 'fatherly' relationship with George.

(2) George was beginning to develop greater insight into his inappropriate and aggressive behaviours.

(3) George had been attending a local Men's Group (Wallaga Lake) regularly with Paul.

(4) George had said he enjoyed spending a few hours with the elders in his community.

(5) George was 'eagerly participating in outdoor, 'hands on' activities with Paul around cars and motor bikes.

(6) George was continuing to attend Moruya High School.

(7) Paul and Marion are also exploring further options in work experience for George.

87. On 13 October 2016, George appeared before Narooma CCNSW for his outstanding criminal charges. He was supported by his mother, Karen Campbell, and Paul, Marion, and cousins. George received a 12-month good behaviour bond. It appears the outcome reflected, in part, the CCNSW's view that George's situation had stabilised and was making progress.

88. On 26 to 27 October 2016, a Moruya High School teacher notified a DCJ Caseworker that George had been suspended for 5 days owing to aggressive and unpredictable behaviour, including verbal threats to staff and students and him sniffing 'whiteout' (the third documented report of suspected VS misuse by George). On the face of the records, it does not appear that the DCJ caseworker specifically inquired with George or his teachers about the possibility of him sniffing white out in response to this report.

89. On 28 November 2016, George, Paul, and Marion attended a review with Dr Spielman. CAMHS had received information emailed by Stefan Ziolo about "*George at school.*" Amongst other matters, Marion and Paul voiced their commitment to George but also mentioned some of the challenges with George's behaviour for them and their family. George advised that he has not had contact with his younger brother, LC, for about 4 months (George voiced that he would like to see LC).

90. I pause here to note that in November 2016, George's DCJ caseworker, Ms Louise Tompsett, ceased to be assigned to his matter. Ms Tompsett had been George's caseworker since about November 2015. Her involvement with George occurred in a particularly tumultuous period for him. The evidence demonstrates that Ms Tompsett was very diligent in trying to support George through this period to achieve a stable placement. Her efforts were commendable.

Events in 2017

91. On 18 January 2017, George reported that he had suffered an alleged sexual assault. He identified the perpetrator as a child/teenage friend of a relative. This was investigated by the Joint Child Protection Response Program (**JCPRP**) (involving NSW Police and DCJ) and included an 'Aboriginal consultation'. Following an interview with George the allegations were found not to be substantiated. A subsequent referral was made for George to attend sexual assault counselling, but he indicated he did not wish to engage in that therapy.

92. In late January or February 2017, George began attending Narooma High School. A summary of George's enrolment at Moruya High School was sent to Narooma High School. Amongst other matters, the summary noted:

    (1) George had significant behavioural issues and needs supervision.

    (2) He has suffered trauma and shows responses to perceived threats.

    (3) George was considered a safety risk because of his behavioural difficulties and impaired cognitive functioning.

    (4) George had trouble in a classroom setting with his behaviour and would get angry, yells and can sometimes hit other students, especially when his medication is not managed properly.

93. On 27 February 2017, a case plan review was carried out. In that review a goal identified was George's eventual departure from statutory care. George's progress was summarised at the time as:

> *"…George, Paul and Marion all report to be happy with George living with them. George has recently changed schools from Moruya High School to Narooma High. George is much happier going to Narooma High with his brother, Uncles and Aunties and cousins. George stated that he plans to stay at school and complete Year 11 and 12. He enjoys wood tech and metal tech and is keen to participate in work place type activities/experiences as soon as he is able (possibly working as a motorbike mechanic or working on small motors).*
>
> *George is engaged with the Men's Shed at Wallaga and works on cars there with his uncle Paul and other Aboriginal Mentors in the community.*
>
> *George is happy to have birth family contact with his mother and cousins, however he is strongly reluctant to resume any contact with his maternal grandmother, Fay.*
>
> *George was assessed and prescribed further medication (Fluoxetine) to assist George in dealing with long-term grief and possible depressive illness. It was recommended also currently remain on the Concerta, Catapre and Ritalin for ADHD."*

94. On 7 March 2017, DCJ caseworker, Andrew Grady met with George at Narooma High School. Mr Grady also met with Paul and Marion. Mr Grady recorded (amongst other matters):

    (1) George reported he was happy living with Paul and Marion.

    (2) Paul and Marion confirmed they were happy having George living with them.

    (3) George had been involved in discussions about leaving care and would be provided ongoing support.

95. In March or April 2017, George was assigned a new DCJ caseworker (Arthur Brain, Batemans Bay CSC). It appears Mr Brain was on leave at or about this time. He did not meet with George and the Campbells until May 2017.

96. In May 2017, after a consult with George and Paul, Dr Spielman noted George's report that he felt 'well' and his belief that he had 'settled in reasonably well' at Narooma High School. Dr Spielman also noted:

> *"…Paul tells me that there have been fewer behavioural difficulties at school and George agrees with this. He feels more supported by having family in the local area and is enjoying being at the same school as his brother LC. This term, he has been moved into the ED class, the same class as LC, and as such the brothers now spend significantly more time together than previously. Paul tells me that George's school attendance has been sufficient. Hopefully, in a few weeks, he may have a job working two days a week on an oyster lease, ·and in combination with his day a week working with Paul at the Men's Shed, he will have three days of work related activity and two days of school based learning."*

97. Dr Spielman also noted that:

> *"…There have been frequent changes of his case manager with Family and Community Services, to the point that George now feels disengaged from his support services. Hopefully, he will have a much more stable case manager in the coming months, given the anticipated stress and number of agencies involved in his care in the future. We will continue to liaise with other services, and I will review George again later this year."*

98. At about this time, records refer to concerns with George's education progress in May 2017, with it being noted on 11 May 2017 by NSW Health that: "*CAMHS psychologist noted a conversation Narooma High school. Advised mainstream classes are not appropriate for George and a meeting was planned to discuss this with his carer. It was likely that a support class was going to be proposed. Has been close to suspension due to behaviour, Post school options are also being explored*."

99. In the second half of 2017, George received three short suspensions from school for aggressive behaviours. It does not appear from DCJ records that DCJ caseworkers had contact with Narooma Highschool during this period.

100. On 24 August 2017, DCJ caseworker Arthur Brain visited Paul and George at their home at Wallaga Lake, during which they discussed George's plan to return to school after his recent suspension, George's new job, driving lessons, and family visits.

101. On 23 October 2017, Dr Spielman had his last consultation with George (before George's death). George was accompanied by his DCJ caseworker Arthur Brain, Paul and Marion. Dr Spielman reported after this consult:

> *"All report that George is managing well. He is attending school as. much as possible and his behaviour has been settled. He is participating in family activities and feeling happy and productive. He is hopeful of getting his driver's licence, and has been studying for his learners permit. He worries about his brother, LC, whom he finds is somewhat shut-down and less communicative than previously. He recently had contact with his mother and grandmother and found this difficult however managed interaction in an appropriate way. He is sleeping and eating well…His concentration, attention span, memory and organisation are unchanged…I have suggested that he continue on Concerta 54mgs and have given him a script with 5 repeats. He will also continue on Fluoxetine for the time being and we will reassess these as he progresses further into Year 12. I will review him again during Term One of next year."*

102. By late October 2017, preparations were underway to finalise a NDIS application before George reached 18 and left statutory out of home care.

George's assigned DCJ caseworkers

103. In the period January 2015 and March 2018, George had 6 different DCJ caseworkers from the Bateman Bay CSC assigned to him between:

Jan 2015 – Sept 2015	Caseworker Hal Butterfield (Batemans Bay CSC)
Sept 2015 – Nov 2015	Caseworker Gregg Hendry (Batemans Bay CSC)
Nov 2015 to Nov 2016	Caseworker Louise Tompsett (Batemans Bay CSC)
Nov 2016 to Dec 2016	Caseworker Danny Hamer (Batemans Bay CSC)
Nov 2016 to Apr 2017	Caseworker Andrew Grady (Batemans Bay CSC)
Apr 2017 to Mar 2018	Caseworker Arthur Brain (Batemans Bay CSC) (*Caroline Doherty was the MCW supervising Arthur Brain for short period in 2018 before George's passing*).

104. This is a matter that I will return to later in these findings.

Early 2018

105. In early 2018, George commenced school at Narooma High School in a supported class.

106. On 8 February 2018, George was suspended from Narooma High School for 10 days (possession of cannabis).

107. On 19 February 2018, a school meeting took place to determine the way forward for George's return to school. This included a plan for Katungul and DCJ to meet to discuss a support plan with the NDIS support planner.

108. On 5 March 2018, George was due to attend a boot camp, but he did not attend.

Events on 9 to 10 March 2018

109. On 9 March 2018, Paul Campbell left Wallaga Lake to go shopping with his wife and daughter. When he left, George was with Paul's son, ZC, and his 16 year-old nephew, NC. When Paul returned later that day he saw the white Mitsubishi Magna, which George was known to drive around, parked by the side of Umbarra Road. After returning Paul sent ZC and NC to go look for George but they did not find him. Paul called family and friends that evening trying to locate George.

110. NC later told police that he was driving with George around the Village in the white Mitsubishi Magna. They were driving up the hill to get some tyres and petrol from one of the car yards situated near the Wallaga Lake entrance. The car ran out of petrol by the side of the road, about 100 metres from Paul's home (where it was found by police the following day). George walked away from the car, leaving NC, saying he

was going to get fuel from "*one of the yards down the bottom of the hill.*" NC didn't see which way George went and walked back to Paul's residence. This was the last sighting of George alive.

111. The following day, on 10 March 2018, Paul and his family attended a church service at the Village hall. After the service, Paul, Gary, and members of the church group began looking around the Village for George. Church member, Malcolm Murchison and his 19 year-old brother Codie Hodge, walked together down a dirt track off Umbarra Road, where they found a clearing adjacent to approximately 20 to 30 abandoned and rusting cars.

112. Malcolm found George lying deceased on the ground near some cars. Malcolm and Codie ran to Paul's house to tell them that they had found George deceased. Paul returned with Malcolm to where George's body was found. There was a siphon hose sticking out of a car nearby.

113. At 1:24pm, Narooma Police Officers responded to a radio message that there was an apparent deceased person at the Village on Umbarra Road.

114. Police attended at approximately 1:40pm. Police observed a 10-litre red plastic fuel can located about 7 metres away from where George was lying and a siphon hose protruding from the fuel door of an abandoned red station wagon (registration XCR602).

Post-mortem examination and pathologist's opinion as to cause of death

115. An autopsy was performed by Dr Bernard l'Ons on 14 March 2018. Dr l'Ons made the following observations:

(1) Scattered evidence of animal predation

(2) Haemorrhage of the right sclera (white part of the eye surrounding the cornea) with no associated petechiae of the eyelids or other evidence of inflicted injury.

(3) Two puncture marks on the right 4th fingertip (suspected snake bite), however urine and serum testing revealed no traces of snake venom (*Dr l'Ons did not consider a snake bite to be a possible cause of death*).

(4) Other surface injuries namely a right upper eyelid contusion, abrasion to the right posterior elbow and an abrasion to the right patellar.

(5) Nothing otherwise remarkable in the internal examination or the whole of body CT scan.

(6) No indications of a scalp injury, skull fractures, or haemorrhage within the extradural or subdural, nor signs of any neck injury (e.g., thyroid and hyoid cartilage).

116. A small sample of George's blood was retained following the autopsy, as is standard practice, along with a small sample of lung tissue.

117. Toxicology testing showed a therapeutic level of fluoxetine (antidepressant (0.21 mg/L) and Paracetamol (< 5mg/L). Alcohol was not detected and nor were illicit drugs.

ISSUES

George's needs

118. George clearly experienced several traumatic events in his childhood including:

(1) Possible exposure to neglect and abuse.

(2) Lack of stability of placements in his early childhood.

(3) Removal from parental and family care, after which his contact with his mother and other birth family members became increasingly more and more limited.

(4) Loss of important family members (e.g., passing of his father in April 2014 and his grandfather in May 2014).

(5) Escalating difficulties in his relationship with his carer, GK, which appear to have contributed, in part, to instances of aggression, impulsive, and self-destructive behaviours by George in the first half of 2016.

(6) Limited contact with his brother LC after he left GK's placement other than contact taking place at school in 2017.

(7) Difficulties in his schooling experience and educational attainment.

119. It is reasonable to assume these experiences contributed to the difficulties George had with some behaviours in later adolescence.

120. An additional challenge in George's case was his reluctance to engage with professional supports such as counselling and alcohol and other drug (**AOD**) programs.

121. Ms Zideluns gave evidence that herself and Dr Spielman were mindful not to push George about topics he appeared reluctant to discuss and engaging with AOD programs or therapies as doing so might result in George refusing to engage.

Whether George's reluctance was the consequence of him dealing with numerous care, educational and health professionals throughout his life is not known.

122. I accept the submission that, unsurprisingly given his traumatic background, George's case was one of complexity. George required culturally appropriate, careful, and intensive supervision if he was to have a reasonable chance of successfully achieving some measure of stability in adult life. His difficulties also underscored the importance of constructive relationships between caseworkers, George, and George's carers to meet his needs and support his development.

123. I also accept the submission that George's placement with the Campbells was a positive development in his life. I am impressed by Paul and Marion and their commitment and devotion to George. Paul and Paul's brother, Gary, offered strong male role models for George. The Campbells had considerable experience raising children including under fostering arrangements and they are respected Elders both in their community and church. George's placement with the Campbells at Wallaga Lake gave him extensive opportunities for outdoor activities and engagement in his culture. Although he continued to exhibit difficulties with behaviours (e.g., school suspensions), George was happier and presented as more settled in their care. One manifestation of that improvement in George was that he no longer came to the attention of police. This of course did not mean that George ceased to have complex needs for which he required careful supervision and support.

Cause of death

124. In his pathology report, dated 16 May 2017, Dr I'Ons' opinion was that the cause of death was hydrocarbon toxicity.

125. At hearing, Dr I'Ons gave evidence that at that time, this opinion was based upon the absence of any other findings to explain death (nothing was seen externally or internally during autopsy) coupled with the circumstances of where George was found, and information obtained from Paul Campbell that he suspected George may have been sniffing petrol.

126. In January 2023, Dr I'Ons arranged for a sample of George's blood, taken during autopsy, to be forwarded to the Queensland Forensic and Scientific Services for testing. The testing involved the chromatographic separation and identification of compounds within the blood sample and comparison of those results with controlled samples. The compounds detected in the sample were consistent with petrol although the possibility these results might be caused by exposure to other substances could not be excluded.

127. At hearing Dr l'Ons gave evidence that:

> *"…that sample detected the presence of substances with the same pattern chemically as petroleum products, so that test is not saying that petroleum products from a vehicle was the only place where you could get a similar signal, it's just saying the signal that they got on that blood sample, is completely consistent with what you would find with another sample of blood which we know had petrol exposed to it.*
>
> *So, his signal was identical to another specimen of blood which they exposed to petrol. But there are other compounds which also would give a similar signal which he might have been exposed to. So, it's not – it's not a - this is the only place where you could get a similar signal, but he's certainly been exposed to a product that is very similar to a petrol product."*

128. Dr l'Ons also confirmed in his evidence that:

(1) Petrol will rapidly enter a person's blood system through the lungs when fumes are inhaled.

(2) The amount of petrol inhalation necessary to produce toxicity and death cannot be defined; there does not appear to be an exact correlation between concentration and toxicity.

(3) The recent testing results are consistent with petrol entering George's blood system before his death. On its own it does not indicate the means of ingestion or inhalation, nor the amount inhaled/ingested or the exact timing of that relative to George's death.

(4) The recent testing confirmed the opinion he gave in the autopsy report that the cause of death was hydrocarbon toxicity.

129. Given that no cup or container was located at the scene, any ingestion of petrol likely occurred by inhaling.

130. I note Counsel Assisting sets out a basis for the finding being made that George's cause of death was hydrocarbon toxicity at [94] of his submissions (this is not disputed by the other parties) as below:

(1) George was 17. There is no evidence he suffered or had symptoms of a major illness or physical health condition that might account for death.

(2) The last known sighting of George alive was on 9 March 2018, when he reportedly told NC that he was going to get petrol for his car.

(3) *George was found deceased near a car which had a hose protruding from its petrol tank next to a plastic jerry can. The same type of hose was later found in the white Mitsubishi vehicle driven by George around the community.*

(4) *The recent testing which detected compounds consistent with petrol in George's blood system.*

(5) *The absence of other discernible injuries or findings to account for his death (e.g. blunt force trauma or suffocation injuries).*

(6) *The evidence of past reports and suspicions that George had deliberately inhaled petrol in the past including suspected inhalation by him in the months before his death.*

131. I accept Counsel Assisting's submissions that the cause of George's death was hydrocarbon toxicity.

George's intentions

132. An issue I have considered is whether George may have inhaled petrol intending to take his own life.

133. This is owing to some handwritten notes that were located by Paul Campbell after George's death.

134. Paul gave evidence that he located a notebook in the caravan used by George at the time of his passing. The notebook contained handwritten notes with a date at the top of the page of "23\2\18" (this date being a couple of weeks before George's passing).

135. Noted in the book in handwriting are statements "*I hate my - - - I am gonna - - hang – myself – tomorrow morning – on – the swings –"; "I need to die right now"; "I am useless to everyone of (sic) the earth I need to die"* and "*I need to put a bullet in my [heart].*"

136. The date and location of this notebook (in George's caravan) point to George being the author of these statements.

137. It is confronting to read such statements by George and to think about the extent to which these possibly reflected the thoughts and feelings he was experiencing.

138. The submissions made on behalf of Paul and Marion regarding this issue at [7] of Ms Kennedy's submissions are extracted below:

(1) Even if George had ingested the petrol intentionally, there is no evidence that he did so with suicidal intent. Indeed, the balance of the evidence points away from such a conclusion. Specifically, I note the following:

a. Although there is some evidence that suggests George had in the past engaged in self-harm and experienced suicidal ideation, this evidence is equivocal and limited;

b. In the months leading up to his death, George's personal circumstances, emotional stability, and overall mood appeared to be substantially improved, and he was making plans for his future including getting his licence, a job, addressing his health needs, and living independently in Wallaga Lake;

c. By contrast, there are several instances of adults suspecting that George was using some unknown substance, and some specifically that he was engaging in recreational "volatile substance use" (sniffing of petrol or, at p3. other inhalants causing a "high"), as far back as 25 May 2015.

139. I accept these submissions. The evidence does not establish that George ingested or inhaled the petroleum products with the intention of ending his life.

The reasonableness of DCJ's casework in the two years preceding George's death

Concessions of DCJ

140. The written submissions for DCJ helpfully identified a number of matters in respect of which DCJ acknowledged there were deficiencies in its casework for George.

141. The submissions referred to the Internal Child Death Review (**ICDR**) and the evidence of Ms Alexander (both in her oral evidence and written statement).

142. The ICDR made the following findings:

(1) Casework throughout 2016 should have included addressing GK's parenting style and whether any education or support could have been provided to improve the placement. Instead, the responsibility for behaviour change was placed on George.

(2) George's case plan should have been reviewed within three weeks of his move to Paul and Marion's care. It should have included family and representatives from the services engaged with George. The services George was engaged with, including his psychiatrist, his mentor, Katungul

Aboriginal Corporation, and the local Men's Shed, were not included in case planning, nor were they aware of their respective roles within the plan.

(3) DCJ agreed to follow up with the National Disability Insurance Scheme (**NDIS**) to engage George in other activities and support in 2018, but there were no records to evidence that this occurred.

(4) George's 'leaving care' case plan was to be reviewed in 2018, but this did not occur. Critically, this meant that it was unclear where George would live once he turned 18. There was inadequate purposeful planning regarding what was required in the months before George's birthday by those supporting him to clarify what would happen in August 2018 and beyond.

143. Ms Alexander, in her evidence, opined that:

(1) DCJ caseworkers did not seem to speak to George about volatile substance use during September 2016: '*DCJ records do not indicate that George was spoken to by his DCJ caseworker or other DCJ staff about volatile substance or other drug use during September 2016*.'

(2) Casework was not strong during 2017 and early 2018, in comparison with the casework undertaken in 2016: '*I agree with Professor Irwin and note the support of George and his carers during 2017 and in early 2018 was not as strong, consistent or beneficial as it should have been*.'

(3) Casework visits were not regular: '*I note the DCJ records reflect that the DCJ caseworker visits with George were not regular and there were no records of the DCJ caseworker visiting George in the months of April, June, and December 2017*.'

(4) The number of caseworkers responsible for George over a short period was not ideal, as it "*did not provide George and his carers with continuity of service and would have impacted on George's engagement with his caseworkers*."

(5) '*Despite best efforts to manage [the] handover process, time constraints and demands on the [Community Services Centre] resources, continuity of casework did not occur in accordance with best practice*.'

144. In her oral evidence, Ms Alexander accepted further examples of where George's casework did not reflect best practice namely:

(1) DCJ would have ideally arranged family conferencing and action planning for George from 2008.[13]

(2) More curiosity or support could have been provided to George in relation to his experiences of trauma, PTSD and ADHD.[14]

(3) DCJ should have conducted annual case planning that was clear on roles, requirements, desired changes, and concerns.[15]

(4) DCJ should have arranged for more 'alone time' for George with his caseworker (during 2017 and 2018) to enable his caseworker to have a better sense of what was going on for him.[16]

(5) George's carers (Paul and Marion) should have been made to feel they could call on caseworkers about issues.[17]

145. Ms Alexander presented as a thoughtful, frank witness. She was readily prepared to accept, explain, and analyse errors made by DCJ in the standard of their care and casework provided to George, necessarily with the benefit of hindsight. I commend Ms Alexander and DCJ for their constructive approach to this inquest and preparedness to acknowledge the above matters. I also accept that DCJ has carefully considered the issues and shortcoming identified in their casework for George.

146. In accepting the submissions on behalf of DCJ about the quality of its casework, it is necessary to address certain factual issues and appropriate that I elaborate further on some of the matters canvassed above.

Caseworker continuity

147. There was a lack of case worker continuity at least between 2015 and 2018 and an absence of intensive engagement with George and the Campbells (at least between 2017 and early 2018).

148. With regards to continuity, George had 6 assigned DCJ caseworkers between January 2015 and March 2018

149. The frequent changes in caseworkers was remarked upon by Dr Spielman in his letter dated May 2017 where he wrote:

> *"…There have been frequent changes of his case manager with Family and Community Services, to the point that George now feels disengaged from his support services. Hopefully, he will have a much more stable case manager in the coming months, given the anticipated stress and number of agencies involved in his care in the future. We will continue to liaise with other services, and I will review George again later this year."*

150. The new DCJ caseworker assigned to George's case in about March to May 2017 did not have contact with the Campbells until 13 June 2017 (when he spoke with them by phone). That caseworker's first home visit did not occur until 19 July 2017 (at which time George was not present). The earliest known meeting between that caseworker and George did not occur until on 24 August 2017 (during a home visit).

151. Although the Campbells were generally positive in their reports about George, on occasion they did indicate they were finding some behaviours challenging. It does not appear from the records that the offer of additional supports was contemplated or discussed with the Campbells owing to these reports.

152. The frequent changes in George's assigned casework must have hindered the potential for himself, and Paul and Marion, to form a relationship of trust with the caseworker and to see him or her as a support to turn to in times of difficulty.

153. Ms Alexander acknowledged that handovers to newly assigned caseworkers did not occur in accordance with best practice because of the "*time constraints and demands on the CSC's resources.*" Ms Alexander also commented on the importance of caseworkers spending time with a child and developing that relationship (if possible) with the child and the child's carers, giving evidence that:

> *"…there's a very heavy focus through [DCJ's] standards about the importance of our caseworkers spending individual time with children in care. So it's not so much about regulating a set period and a set frequency, because it's very variable on the needs of the young person, but it is an emphasis on they need to spend time alone, away from the carers, and that's not any disrespect to the carers; it's just the importance of building those relationships alone.*
>
> *So, ideally, George would have spent more time alone with his caseworker over those years and we would have had a better sense through that relationship, ideally, of what was going on for him. At the same time, his carer should have been able to call on that caseworker whenever they wanted to talk about what they were worried about as issues arose and as well as having regular times that were really focused on what they were noticing about George, what they were worried about. Listening to Mr Campbell speak earlier, I was struck by the amount of support that was put around George through the family, the Men's Shed and the camping and all of that. Opportunities to check in with how that was going and how we as the department could support as much of that as possible if is ideal."*

154. There is no basis to find that responsibility for the continuity issue should be attributed to the individual caseworkers involved. Nor is there any basis to think that the

individual caseworkers involved weren't genuinely motivated and concerned for George's wellbeing.

155. I make further comments on this issue under the recommendations section commencing at [198].

Suspicion by the Campbells about George misusing solvents

156. After his death, Paul described occasions that he was also told or suspected that George had sniffed petrol when living with them. When Paul confronted George about his suspicions, George denied sniffing petrol.

157. In his first written statement to police shortly after George's death, Paul stated:

> *"It was a couple of months ago when I knew George was doing something because he'd come home with his eyes squinted all the time and I'd say to him "What's wrong? Are you tired?" He'd say "Nah it's okay I'm alright", but I could tell that there was something different about him. I had my suspicions that George might have been sniffing petrol and I think my boys ZC and AC must have known that he was doing it for a while but they wouldn't tell me, they wouldn't dob him in. Then one day around that same time a couple of months ago I said to my boys "You've gotta tell me what's going on", and AC said to me "Dad, I've gotta tell you, he's sniffing petrol you know". I said "What!", that's when I just freaked right out, I just didn't think he'd do that there with us.*
>
> *I tried talking to George about him doing that, but he denied it every time. I would say to him, "What are you doing this for? Why are you doing this? That shit will kill you, you've got to stay away from it"….He would tell me that he wasn't going to go sniffing petrol but I think then he would just go and do it when I wasn't there, and I just couldn't be with him all the time."*

158. Further in his 2018 statement, Paul stated:

> *"When we would bring the new cars in to the village, George would siphon all of the petrol out of them. While he was siphoning them, he was sniffing the fuel. Even my brother Gary said to George "Stay away from those cars mate".*
>
> *One day my wife and I came home and walked into the house with the grocery shopping and I could smell fuel. George was there and I said to him " What are you doing? Are you still mucking around with the fuel?" He said to me "I was siphoning it". I said "You wasn't siphoning it, where did you do it? You were sniffing petrol it's all over you". My wife got really angry with George and started yelling at him saying " How many times have we gotta tell you not to be doing that?" I told teachers what he was doing, I told [DCJ], I tried my best with him, but he just wouldn't listen."*

159. In a more recent statement, Paul also described:

(1) An occasion when Paul smelt petrol in the "*boy's room*" where the Campbell's two children and George slept in bunk beds. This was before George moved into a caravan next to their house.

(2) Occasions where he found his carpentry glues, and whiteout he kept in a car, went missing which he now suspects George might have taken.

160. George denied or never admitted to misusing petrol, glue, or whiteout when these matters were raised with him by Paul.

161. Paul in a recent statement described telling a DCJ caseworker, "*Andy*", about his concern that George was 'sniffing'. He did so proximate to when he smelt petrol in the boy's bedroom inside the house.

162. Andrew Grady, a DCJ caseworker based at the Batemans Bay CSC, was briefly assigned to George's case between November 2016 and April 2017. Mr Grady carried out at least one home visit on 7 March 2017 about which he completed an electronic record. That contact record contains largely positive details as to George's circumstances and progress.

163. There is no mention in the DCJ records, completed by Mr Grady or other caseworkers involved in George's case, that the Campbells had reported their suspicions or concerns regarding George's possible sniffing of petrol or glue.

164. Mr Grady gave evidence in the hearing that:

(1) Before his employment as a DCJ caseworker, he had worked with the Kimberley Community Alcohol and Drug Service for 4 years in roles of senior worker up to clinical coordinator. His responsibilities included program development and clinical supervision of staff. The clients this service engaged with included some with volatile substance misuse difficulties.

(2) He could only recall, now, "*having limited engagement*" with George while briefly his assigned caseworker. This happened at Narooma High School and Wallaga Lake. It involved "*limited verbal engagement"* from George.

(3) Based on his practice and experience, he believes that he would have made a record of being told that George was suspected of sniffing petrol or glue had he been told that: "*it's unlikely that if I was told about that that it wouldn't be in my case notes*".

165. The effect of Mr Grady's evidence is he was not told, or did not knowingly realise he was told, about the Campbell's suspicions that George was sniffing petrol, glue, or

whiteout. If he had been he would have noted that given his experience and his practices.

166. Counsel Assisting submitted that a positive finding ought not be made that Mr Grady or any other DCJ caseworker was told, or at least realised they were being told, between mid-2016 and March 2018 about the Campbell's suspicion that George was sniffing petrol and glue. That submission considers:

(1) Mr Grady's evidence.

(2) The absence of any contemporaneous record by a DCJ caseworker of that concern being raised with caseworkers.

(3) The absence of a record by teachers about that concern being raised with them by the Campbells during that same period.

(4) The absence of a record of that concern being raised with Dr Spielman in his reviews of George during that same period (noting that Paul attended some of those reviews).

(5) In his written statement made shortly after George's death, Paul indicated the events which gave rise to his suspicion of petrol sniffing occurred a few months prior to George's death. That timing comes after Mr Grady's involvement in George's case, which ceased by about March 2017.

167. There is force in DCJ's submission that, rather than to whom what was said, the most significant concern in this respect is the absence of effective communication operating between Paul and Marion, George and DCJ caseworkers. In my view this was primarily attributable to the lack of caseworker continuity. Had a collaborative relationship existed there would have been a greater likelihood that Paul's concerns would have been realised by the casework team.

168. I accept Counsel Assisting's submission regarding this issue. I don't doubt the honesty of Paul or Mr Grady, however it is possible that there may have been some miscommunication.

169. I also accept Counsel Assisting's submission that the reports caseworkers received about George's suspected abuse of petrol, or other solvent products, did not prompt appropriate curiosity by the casework team as to the possibility of George abusing petrol and or solvents. This is demonstrated by the absence of specific query or follow up by caseworkers with George or his carer(s) about the issue.

170. The general lack of awareness about this issue was demonstrated by Mr Grady's evidence. As best he recollected, upon being assigned George's case, Mr Grady understood the key issues in George's case had been his ADHD diagnosis, his recent placement with the Campbells, his contact with his brother LC, and his schooling. Mr Grady had no recollection of noting in the records or being told about the past reports of suspected sniffing of petrol, glue, or whiteout.

171. This absence of curiosity or awareness about George's possible solvent misuse also likely resulted from the lack of continuity in assigned caseworkers and the absence of a proper handover between caseworkers.

172. I have considered the submissions made on DCJ's behalf as to the impact of George's reticence to be open about his misuse with professionals and that an attempt to mandate George to engage in therapeutic program for VS may have jeopardised any trust and openness being achieved in George's relationship with caseworkers.

173. While I accept there is some force to those submissions, in my view these matters do not lessen the importance of the casework team maintaining reasonable curiosity and vigilance about the potential for him to misuse solvents. Caseworkers will not be able to implement a plan of action if they are not alive to the possible existence of an issue.

<u>George's birth family contact</u>

174. George had lived with his brother, since LC's birth in 2002, until his shift from GK's placement in about 2016.

175. This was a longstanding and important relationship in George's life.

176. I accept this was a difficult issue to manage as LC continued to reside with GK after George left that placement. There was also complexity arising around George's contact with his other biological family members.

177. Although George may have had some contact with LC when he shifted to Narooma High School after he began living with the Campbells, a plan was not implemented by DCJ to overcome difficulties to ensure meaningful contact between the brothers.

178. Some caseworkers noted this was a matter requiring attention, but it appears, likely owing to the lack of continuity of caseworkers, that this matter was not meaningfully progressed during the period George lived with the Campbells.

179. George's lack of contact with his brother likely had some impact on his emotional wellbeing as at early 2018.

Preparation of the Campbells to meet George's needs

180. Paul Campbell gave evidence that following George's placement with them, he and Marion were not told about the prior report of George's suspected petrol or solvent misuse, the past reports made to DCJ about the possibility of George having suffered various forms of abuse, and his engagement in risk taking behaviours such as lighting fires.

181. Although Paul and Marion became more familiar with these over time through their care of George and attendance at medical and education meetings, that does not lessen the importance of DCJ adequately informing and preparing persons who are taking on the care of young person such as George.

Cultural planning and considerations between 2016 and 2018

182. I have considered whether DCJ facilitated George to meaningfully engage with his culture in the two years preceding his death.

183. The submissions made by Karen Campbell on this issue were summarised at J to M of Ms Buxton's submissions. These were as follows:

(1) George's cultural plan was inadequate, simply listed activities he was already undertaking at a high level, undertaken as a part of creating his care plan and not as an independent process, and was lacking in meaningful contribution from his family, extended family, the Aboriginal community and George's support providers.

(2) A cultural plan for Aboriginal children in care should be more than just a section of their care plan and should involve input from the child or young person, their caseworker, their carer, their family, their extended family members and local Aboriginal community representatives and/or services. There needs to be accountability structures in place to ensure that this is followed and that the cultural plan is regularly reviewed.

(3) A cultural plan should centre the immediate and lifelong social and emotional wellbeing of Aboriginal and Torres Strait Islander children and young people and actively facilitate connections to family, kin, community, Country and culture.

(4) Further resourcing of Katungul Aboriginal Services should be considered moving forward and consideration of investment more broadly in Aboriginal Community Controlled Organisations to enable them to provide culturally safe support and consistent mentoring to Aboriginal and Torres Strait Islander children and young people in care.

184. I have also reflected upon the submissions made on DCJ's behalf regarding the services and cultural activities George was engaged with. DCJ provided the following examples (at [56] to [60] of their submissions):

(1) First and foremost, George was in the care of Paul and Marion Campbell and their children. That is, he lived with Aboriginal extended family and was supervised and guided by two very experienced Aboriginal parents and carers who had looked after many of their own children and foster children. As the report indicates, 'family is culture'; George was in a caring family of his own culture in an Aboriginal community.

(2) Being in such a community and with family, he was able to access Aboriginal support programs. For example, Paul Campbell's son, Paul Jnr, was working for Wandama Aboriginal Drug and Alcohol service and ran the Men's Shed which both Paul Snr and George attended. George attended once a week. George also went on a few camping trips with them.

(3) Third, George was engaged with the Katungul Aboriginal Corporation Aboriginal Youth Support program:

a. In 2016, he had an Aboriginal mentor, Todd Chatfield;

b. From 2016 onwards, he attended upon the paediatrician working out of Katungul;

c. His NDIS caseworker at Katungul, Deb Diggins, arranged in February 2018 for George to attend 'Workability', which saw him working in the canteen, and also working with Todd Chatfield or men's art classes; and

d. George was engaged with Katungul's physical, social and recreational activities.

(4) Fourth, in February 2018, Arthur Brain arranged for George to attend Tribal Warriors Boot Camp, facilitated and run by Col Watego, an Aboriginal man. George had attended and enjoyed the boot camp in 2016.70 While the camp was scheduled for 5 March 2018, George ultimately did not go as he did not return in time to attend the camp.

(5) Fifth, George also assisted Paul, his sons and other Aboriginal men to fix cars.

185. I acknowledge the concerns expressed on behalf of Karen and agree with the submission that a cultural plan is integral to the immediate and lifelong social and emotional wellbeing of Aboriginal and Torres Strait Islander children and young people and should actively facilitate their connections to family, kin, community, Country and culture.

186. I have also considered the submission made, on DCJ's behalf, that DCJ has taken some steps in providing culturally appropriate casework for First Nations children and their families since George's death. These changes include the following:

(1) The introduction of an Aboriginal Case Management Policy;

(2) The Caseworker Development Program 2021 which includes modules aimed at ensuring practice with families is culturally responsive,

(3) A new division called Transforming Aboriginal Outcomes, to focus on improving outcomes across the criminal justice system, child protection and housing;

(4) A dedicated leadership position known as the Director Aboriginal Culture in Practice; and

(5) The DCJ Practice Leadership Development Program which dedicates a number of places for emerging leaders including targeted roles for Aboriginal leaders.

187. I accept the submission and acknowledgement made on DCJ's behalf that the cultural planning (and the written plan) could have been more detailed and that Aboriginal supports could have been more intensive. I also accept DCJ's submission that the implementation of a cultural plan in the period 2016-2018 would have been impacted by resourcing and staffing constraints. Whilst a reality, this is, no doubt of little comfort to George's family.

Volatile substance misuse in the region

188. On the information presented in this inquest, it does not appear that VS misuse is a particularly prevalent issue in the South Coast region. The information provided on that issue came from the NSW Police Force through the Officer in Charge, Detective Senior Constable Ware, and non-government organisations Karralika and Katungul Aboriginal Corporation Regional Health and Community Service (**Katungul**). Although it is positive that such misuse is not prevalent, I accept Counsel Assisting's submission that its low prevalence does not diminish the seriousness of this issue. The limited programs available to support people who misuse VS in the South Coast region is concerning.

189. Ms Janine Zideluns from Southern New South Wales Local Health District gave evidence that the services available to support individuals like George, who misused, or were suspected of misusing, VS in 2016 would have been a drug and alcohol

service within NSW Health or Karralika, or a drug and alcohol counselling service specifically for young people in the area. Ms Zideluns noted that in 2016 the Karralika was the only residential rehabilitation service of its kind in the area. She said that a referral to an alcohol and other drugs service within NSW Health would likely involve a placement within a mental health service.

190. George received assistance from Katungul in 2016 and 2017.

191. Ms Kayeleen Brown, the Chief Executive Officer at Katungul, said that the service can, at present, provide a young person who needs ongoing assistance with dependency issues, with services ranging from group counselling, one on one counselling, support in recovery, transport to rehab and detox, and family support.

192. Ms Brown told the court that there was limited AOD programs offered through Katungul between 2012 and 2016 due to funding cuts. She said that Katungul only had two registered mental health nurses employed at that time and only one of those nurses did outreach work.

193. From Ms Brown's evidence, it appears that Katungul has recently received more funding, which has increased the team of clinicians. However, the service is still restricted in its ability to provide ongoing assistance to youth with AOD dependencies due to this limited funding.

194. Ms Brown estimated that in relation to its AOD services, Katungul presently is responsible for between 380 to 400 clients, with only 6 workers to share the load.

195. I acknowledge the important work the organisation does.

196. I accept that Katungul itself did not appear to be adequately resourced to provide consistent social work, Aboriginal mentorship, and support that George required in 2016 and 2017. However, I do not consider I can make a positive finding, or a recommendation, on this matter. It is outside the reasonable scope of this inquest to examine the funding arrangements and service gaps so as to permit the making of positive findings.

197. However, I have noted the above in the hope that those in the Executive that are responsible for the funding of rehabilitation services give appropriate attention to these matters.

RECOMMENDATIONS

198. I have considered the submissions of the parties as to what, if any, recommendations I ought to make in George's case.

199. I have given particular attention to the following submissions.

200. *First,* the submission on Karen Campbell's behalf regarding caseworker handovers:

> *"The high turnover of caseworkers in George's case serves as further evidence of the importance and need for there to be effective communication and handover between caseworkers during their frequent changeover to prevent important information about George's background and any issues of concern from being missed and allow George's new caseworker to be in the best position to support him going forward.*
>
> *We submit that a formal handover best practice procedure should be established by DCJ and implemented across NSW for the handover of cases between two caseworkers, including a verbal and written handover noting any issues of concern for each client, as well as a detailed review of each case file by the new caseworker. Barring extenuating circumstances, a formal handover should occur in most cases during the period of notice of a caseworker who has decided to leave the DCJ for whatever reason and would be expected to occur in similar circumstances in other fields."*

201. *Second*, the submission on behalf of the Campbells regarding, in part, the preparation of caseworkers to prepare them to care for a child with complex needs:

> *"…a recommendation be made to DCJ to develop a placement framework for use with carers, which allows caseworkers to:*
> *a. identify risky or problem behaviours;*
> *b. share such information prior to, or as soon as possible after, commencement of a placement;*
> *c. discuss with carers their capacity to manage those behaviours, identify gaps and areas where further support may be provided;*
> *d. where appropriate, refer both children and carers to external support services;*
> *e. record concerns raised by carers during the placement; and*
> *f. record actions taken in response to those concerns."*

202. I consider these submissions are reasonably made given my findings above concerning caseworker continuity, caseworker handovers and the preparation of the Campbells to care for George.

203. Additionally, I am concerned about the caseloads and turnover of staff at the Batemans Bay CSC during the relevant period, particularly 2016 to 2018. Ms Alexander gave evidence about the initiatives DCJ has implemented across the State in an effort to reduce attrition rates. While progress was being made in this respect, that progress has been undermined by COVID-19 and its ongoing impact on

workforce preferences (e.g., persons seeking employment that allow them to work for home).

204. I am mindful of the amount of time that has passed since the events in question. Over 5 years have passed since George's passing and more than seven years since he entered the care of the Campbells. In that time considerable change has occurred with DCJ's practices. These were briefly summarised by Counsel Assisting as including (non-exhaustively):

(1) The June 2018 supervision policy for child protection practitioners. Amongst other matters this provides for improved informal, individual and group supervision.

(2) The implementation of the NSW Practice Framework. The implementation began in about September 2017 and consolidates DCJ's practice approaches and priorities for child protection work. A key feature of the training of staff in this framework is attempting to "*improve caseworkers' skills and move from what was a procedurally driven, forensic, investigative approach to a relationship-based practice approach; with a child-centric focus.*"

a. The implementation of a new Caseworker Development Program.

b. Improved resources and training that is available to caseworkers and managers including with respect to practice guidance.

c. Improved practices to improve family engagement, including Family Group Conferencing.

d. Increased resourcing of early intervention and intensive family preservation services, with an aim at offering more therapeutic family support and interventions for vulnerable families.

e. The implementation of the Permanency Support Program (PSP), which began in October 2017. One of its key objectives is in reducing the number of children entering out of home care and reducing the time spent in out of home care. Amongst other initiatives, this has seen the introduction of 50 new permanency coordinators.

205. I cannot on the available evidence properly evaluate what difference (if any) these changes might have made to casework, assuming they were implemented before or during George's placement with the Campbells.

206. Whilst I do not propose to make any formal recommendations under s. 82 of the Coroners Act 2009, I trust that these findings will be brought to the attention the Secretary and the Minister responsible for DCJ.

FINDINGS

207. Pursuant to s 81(1) of the *Coroners Act 2009*, I make the following findings:

Identity

The person who died was George Joseph Charles Campbell.

Date of death

George died on 9 or 10 March 2018.

Place of death

George died at Wallaga Lake, New South Wales.

Cause of death

The cause of George's death was hydrocarbon toxicity.

Manner of death

George died whilst under the parental responsibility of the Minister, after ingesting or inhaling a petroleum product. The evidence does not establish that he ingested or inhaled the petroleum products with the intention of ending his life.

Concluding remarks

208. In closing, I would like to thank Nicolle Lowe for her guidance and compassion. I thank my counsel assisting, Chris McGorey and his instructing solicitor, Rebecca Campbell from the Crown Solicitor's Office.

209. I also thank the interested parties, their counsel and legal representatives and others involved in this inquest for their valuable participation and collaboration. The constructive approach of all parties involved is to be commended.

210. George's death is a heart-breaking tragedy that has affected many lives.

211. I again offer my heartfelt condolences and sympathy to George's family. I thank them for their generosity and courage in sharing their memories of George on the last day of the inquest. I especially want to thank them for sharing their culture and family history with us. Through sharing these stories and memories, it is very clear to me how much they loved George and how much they miss him.

212. I close this inquest.

Magistrate Teresa O'Sullivan

NSW State Coroner
22 August 2023