STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of 'Becky'
Hearing dates:	10-12 November 2020 Armidale Local Court NSW
Date of findings:	17 March 2021
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	**Deputy State Coroner Carmel Forbes**
File number:	2016/94536
Catchwords	CORONIAL – death of young person, in state care, of drug overdose in suspicious circumstances - inadequate evidence to suspend the inquest and refer the matter pursuant to s.78 *Coroners Act 2009*-inadequate care of a child in the parental responsibility of the Department of Family and Community Services
Representation:	Ms R Mathur Counsel Assisting, instructed by Ms A Doyle, NSW

	Crown Solicitors Office Ms K Burke representing the NSW Police Commissioner, instructed by Mr C Norman, Office of General Counsel New South Wales Mr B Fogarty representing the NSW Department of Communities and Justice, instructed by Mr D Jackman, Department of Communities and Justice Mr B Kelleher representing Life Without Barriers instructed by Ms S Sackville, Colin Biggers and Paisley Lawyers.
Findings:	***Identity*** The person who died was Becky ***Date of death*** Becky died on 26 March 2016 ***Place of death*** Becky died at 245 Brown Street, Armidale, NSW ***Cause of death*** Becky died as a result of a combination of methyl amphetamine and methadone toxicity ***Manner of death*** Becky died as a result of an accidental drug overdose in suspicious circumstances

Recommendations:	**To the Secretary of the Department of Communities and Justice, I make the following recommendations:** **1.** that the Secretary of the Department of Communities and Justice should consider a review of its internal practices and policies (and also those applicable to private out of home care providers) in relation to expressing the frequency of face-to-face contacts expected to be provided by a case manager, and when it is appropriate to increase or decrease the frequency of such contacts. **2.** that the Secretary of the Department of Communities and Justice should consider a review of policies surrounding Child Assessment Tool assessments, with a review to removing barriers (formal or informal) to re-assessment of a child if their circumstances or needs have changed. Further, the Secretary of the Department of Communities and Justice should review whether there is sufficient evidence that support at least one mandated review between the years of 13 and 15, a period in which young people commence their entry into adolescence and routinely experience upheaval, transformation, hormonal irregularities, and defiance with authorities that can result in pressure on placements and disengagement with known stabilizing factors.

INTRODUCTION

1. This is an inquest into the very sad death of Becky. Becky died in Armidale on 26 March 2016. She was only 15 years of age. Becky was found deceased from the combined effects of methadone and methylamphetamine in the home of a 42 year-old man, Mr Damien Dawson. The level of methadone alone could have been fatal. She was not on the methadone program and not known to have ever used methadone. She was not known to use drugs intravenously. A recent needle injection site was found at autopsy on her right wrist. Police found a bottle of methadone in Mr Dawson's bedroom.

2. At the time of her death Becky was in the parental responsibility of the Department of Family and Community Services ("**FACS**").[1] Between February 2013 and January 2016 her case was managed by Life Without Barriers (LWB), an out of home care service provider.

3. An inquest is a public examination of the circumstances of a death. This inquest is being conducted in accordance with the *Coroners Act 2009 NSW* ("Act"). Section 81 of the Act requires a Coroner, at the conclusion of the inquest, to make findings as to:

    a. The identity of the deceased person;

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

    c. The manner and cause of the person's death.

4. Section 78 of the Act requires a Coroner who forms an opinion that the evidence is capable of satisfying a jury beyond reasonable doubt that a known person has

[1] Subsequent to Becky's death FACS has been subsumed within the Department of Communities and Justice. For the purposes of my findings I will refer to the Department in whose care Becky was placed as "FACS". I will address any recommendations to the Secretary of the Department of Communities and Justice.

committed an indictable offence in respect of the death, to refer the matter to the Director of Public Prosecutions.

5. During an inquest a coroner is also to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This will involve considerations of whether anything more could be done to prevent a similar death in similar circumstances in the future.

6. The issues in this inquest in broad terms are as follows:
    a. How and when did Becky ingest the drugs that caused her death. How did she come to ingest the methadone, a drug she was not known to use before? How did she come to have a recent needle injection site on her right wrist as she was not known to use drugs intravenously?

    b. Did the State appropriately care for Becky and if not have any inadequacies in their care been addressed

Becky

7. Becky was much loved. Her mother battled with physical abuse, mental illness and drug addiction. She suffered from episodes of acute psychosis that resulted in her involuntary admission into mental health units.

8. It was against this backdrop that her mother was incapable of being able to properly care for Becky. Becky was first removed from her mother before she turned one and then again some eight years later.

9. Becky was also loved by her father. As a result of a long history of criminal offending, resulting in lengthy terms of imprisonment, he too was unable to provide her with the parental care and attention she needed. He was in gaol at the time of her placement in care in 2008 and was in fact unaware of the court proceedings until sometime later. During his time in custody he kept all of his

scheduled phone contact with Becky. He had indicated that upon his release in 2013 he wanted as much contact as possible with his daughter.

10. Becky's father's large extended family in Sydney wanted Becky in their life and had contact with her right up to her death. They paid for Becky's private high school fees in Armidale. She was by all account a highly intelligent young girl. At age seven she ranked in the top 99% percentile range on IQ testing placing her in the gifted and talented classification. In stark contrast, her emotional maturity placed her as far younger.

11. Becky's stepfather also loved and cared about her, having been in her life since when she was a toddler. He battled with addiction and periods of incarceration so unfortunately was not in a position to care for her himself. It was his parents, in whose care Becky was placed in early 2008, and where she officially remained until January 2015, when her first cousin took over her care.

12. Records indicate that no case worker visited Becky regularly at the time she entered into the care of her step grandparents. Across her first two years in care there was no evidence of caseworkers visiting Becky at the home to talk with her, to see how she was living, or whether she was happy. It is unclear whether Becky even knew she had a caseworker, who was responsible for supporting her and advocating on her behalf.

13. In 2013 Becky's care was transferred to LWB an out of home care provider. This was part of a broader government policy to transition case management of children in out of home care to non-government agencies. Angela Walsh, her most recent case worker appears to have approached her job as case manager with a greater level of supervision and engagement than what had been afforded to Becky previously.

14. In early 2015, LWB placed Becky in the care of her maternal cousin, who it appears, took over her care with love, dedication and commitment.

15. But by mid-2015 Becky was skipping school, refusing to remain at her private high school, and ultimately also refusing to attend the local high school. She obtained a traineeship at McDonalds where she had been working for some time- but by early 2016 -she was fired, having failed to turn up to work- one too many times.

16. All the hallmarks of a young teenager spiralling out of control were present.

17. By January 2016 Becky was refusing to stay at any one fixed place of abode. She no longer wished to live with her cousin, or her step-father telling LWB and later FACS that she wanted to make her own decisions about where she lived. She preferred to roam freely, between the homes of her new transient acquaintances and new older adult friends who were less than suitable and exposed her to many risks, primarily the insidious risks involved in heavy drug use.

18. During the latter part of 2015 and until her death, Becky continued to assert her independence from LWB and then FACS, providing limited information about which she was staying with and where and only accepting occasional offers of support from her caseworker.

19. She was a head strong 15 year old teenager who knew her mind; she refused to accept the advice of those around her while she was battling her inner demons.

20. Her diary entries from 2013 three years before her death paint a picture of a young girl, then 12 or 13 years of age, who was desperately unhappy and vulnerable. Across the ten months that are reflected in her diary entries Becky detailed her loneliness, her self-loathing about her body image, her experience of cutting her arms and body, taking pills and bulimic behaviours. At times Becky detailed plans about how and where she intended to kill herself and made short lists of the positives of staying alive and long lists of the reasons she should die.

21. At autopsy a number of linear scars were noted on her upper chest; her left upper arm and around her left antecubital fossa- that area around the inside

crease of the elbow. These scars are consistent with a young teenage girl self-harming.

22. There was a failure at the time to recognise those diary entries for what they were- namely evidence of a highly vulnerable, damaged, very alone and troubled young mind. Becky was in need of urgent and professional support. The diary entries made that crystal clear.

23. The support was arguably needed from the moment she went into care in early 2008, if not then, then surely after she lost her mother to suicide in September 2008.

24. At the time of her death there were no indicators that Becky was contemplating suicide. In fact, she had plans to travel to Sydney to visit her father's family. Becky was no doubt not old enough or experienced enough to truly appreciate the dangers of drug use.

Issues

a. **How did she come to ingest the methadone on 26 March 2016, a drug she was not known to use before? How did she come to have a recent needle injection site on her right wrist as she was not known to use drugs intravenously?**

25. At approximately 8pm on Friday, 25 March 2016, Becky attended her step-grandparents' house to collect some clothes.

26. She then went to a friend's house. That friend believes that Becky was under the influence of drugs when she arrived at her house and that her level of

intoxication increased as the night wore on. She states: "she looked more high every time I looked at her sort of thing."[2]

27. Shortly thereafter, both girls walked back to Becky's step grandfather's house. He didn't notice anything different about Becky's demeanour. Becky informed him that she had returned to get a coat. After finding a coat and a cardigan, Becky asked if he could take them to a party.[3]

28. He drove them to a party in Evangelene Crescent, Armidale. Becky's friend states that en route to the party, they stopped at Mr Dawson's house at Brown Street briefly. She and Becky went inside.

29. As to what happened there, her friend states:

> "Um, I don't know. I went in there and I was in the lounge room and they went up into the room for a short, I don't know, it was very short but, and then yeah, I just said, "Can we go?" She was just talking to him in the lounge room when they came out and then I said can we go?" and we left. Jumped in the car and that's when we went to the party."[4]

30. Mr Dawson never makes reference in his statement and record of interview to the fact that Becky and her friend stopped at his home earlier in the evening before she went to the party.

31. According to her friend, Becky was not a big drinker and only had one or two drinks during the evening.[5] About two hours after they arrived at the party, Becky and her friend left and attended a house at 4 Alexander Street, Armidale. Her friend there engaged in a prolonged argument with the person who lived at that house. It does not appear that Becky was involved in the argument; what she did while the argument occurred is not clear.

32. At about 3.30am, Becky and her friend got a lift to Mr Dawson's house on Brown Street.

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[2] Ex 1 Vol 1 Tab 24 p 129.

[3] Ex 1 Vol 1 Tab 28

[4] Ex 1 Vol 1 Tab 24 p 130.

[5] Ex 1 Vol 1 Tab 24 p 134

33. Mr David Garland who lived next door to Mr Dawson on Brown Street recalls that he was having a cigarette outside his house at about 3.30am when he saw two skinny girls about 16 years old get out of a grey/silver coloured car and walk over to 245 Brown Street. They let themselves in. He heard a male voice say something similar to "Where ya been".[6]

34. Becky's friend said Mr Dawson was drinking a glass of wine on arrival. He offered a glass to her friend, but she did not drink it. After five minutes or so, her friend was bored so left Mr Dawson's house. About 20 minutes after she left, Becky and her friend had a phone conversation. At that time, Becky "seemed fine" though she did "show a few signs that she was on drugs and she did mention at one point of the night that she had taken ice".[7]

35. Mr Dawson gave the following evidence[8] :

    a. He noticed that Becky "had eyes like sources [sic], they were wide open and large. As she spoke I could see she was distant and spaced out. She did not really understand what was being said. I said "look at the state of you'se [sic]'".

    b. Becky's friend left while he was in the toilet. When he returned from the toilet he saw Becky texting someone.

    c. He then had a conversation with Becky. His account of that conversation was as follows:

        "I said to Becky "if you have had something you can tell me"

        Becky said "While I was at the party I was offered something that was yellow in a bag, I tasted it and it tasted like curry powder". We continued to have a conversation and I could tell she was not listening I said "I might as well be talking to myself", Becky said "what".

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[6] Ex 1 Vol 1 Tab 26

[7] Ex 1 Vol 1 Tab 24 p 128.

[8] Ex 1 Vol 1 Tab 22

I said "Becky you can tell me, what else did you have anything else at the party"

Becky said "I had some ICE and a shit load of alcohol"

Becky said "have you got any smokes"

I said "no I've got some tallyo's, fuck it I might go across the road and find some butts over at the train station".

d. At about 4am, the two then walked over to the train station. Mr Dawson states: "she could not walk properly I had to help her along. I grabbed a couple of butts and we walked back home".

e. When they returned, Mr Dawson stated he rolled a cigarette. Becky "still had those big eyes and looked spaced out".

f. He then went to get more cigarette butts from the train station. When he returned five to ten minutes later, Becky was stumbling down the hallway. She said she was looking for him. He states that he helped her to the double lounge in the lounge room and she lay down. "As soon as her head hit the pillow she was out to it and I went back to my bedroom".

g. About ten minutes after going to his room, he heard her snoring very loudly. He said he was then "online on facebook using my Xbox for about 390 [sic]9 minutes and I must have fallen asleep. Prior to falling asleep I could still hear her snoring causing [sic] it was driving me nuts".

h. About 2pm, he woke up and went to the kitchen. He yelled out to Becky, who did not respond. He found her lying on the lounge room on her left side. He grabbed her by the shoulders to wake her up. He ran outside and told a man in a white van that he needed him to call the ambulance straight away.

36. Mr Garland, the neighbour, states that in the afternoon of 26 March 2019, the next day, he heard Mr Dawson screaming from inside his house "Wake up, fuckin

[9] Ex 1 Vol 1 Tab 25

wake up".[10] He then heard him say "Oh fuck. Not again".[11] He then recalled Mr Dawson running out of his house straight towards a salesman's van yelling "Ring 000. Ring the fuckin Ambulance. There's a fuckin girl unconscious. I can't wake her up."

37. Mr Garland's partner, Tracey Kliendienst stated that after Becky was discovered, Mr Dawson told Ms Kliendienst that Becky was "fine when she got here" repeatedly. He also said that Becky had told her she had been to a party and put her finger in a bag of yellow powder and had tasted it and it had tasted like mustard.[12]

38. The ambulance report describes Becky as "poorly perfused but warm to touch." It states that no CPR had been attempted prior to ambulance officers' arrival. Becky was by then asystole and no response was seen to IV adrenaline or IV Naloxone.[13]

39. Professor Alison Jones, toxicologist, was asked to provide a report in relation to time of Becky's death. Professor Jones observed:

> "The most likely clinical scenario, however, given her age of 15, is that she was relatively opiod naïve. According the [sic] Dr Rexson's report, "the deceased was known to be a frequent user of recreational drugs including amphetamines, cannabis and "LSD". Deaths from methadone in opioid naïve users, in my clinical experience, tend to occur within a few hours of administration. This is because methadone is rapidly absorbed and at peak blood concentration the CNS and respiratory depression is at its highest – and this is the commonest mechanism of death. If Becky had been a regular user of methadone then the death could have occurred due to accumulation of multiple methadone doses over several days, but this is considered the less likely scenario in this case. The post-mortem concentration of

[10] Ex 1 Vol 1 Tab 26 para 10

[11] Ex 1 Vol 1 Tab 26 para 10

[12] Ex 1 Vol 1 Tab 27 para 22

[13] Ex 1 Vol 1 Tab 41

methadone at 0.43mg/L, was present in the toxic to potentially fatal concentration range." [14]

40. Notably, Professor Jones takes the view that Becky likely ingested the relevant drugs not at the party on 25 May 2016, but sometime afterwards. She stated:

> "Both methylamphetamine and methadone cause coma in overdose and so respiratory depression is the most likely mechanism of death in this case, though cardiac arrhythmias are also possible due to methylamphetamine. The autopsy finding (Dr Rexson) of neutrophilic lung infiltrate suggestive of early aspiration pneumonia is consistent with a reduced conscious [sic] level and respiratory aspiration due to an unprotected airway. Methylamphetamine and methadone have an additive effect causing coma and death in overdose. Thus, death has occurred most likely to a combination of the two drugs. Methadone and methylamphetamine are most likely to have been taken in the same timescale (i.e. within a few hours) of death i.e. not at the party on the evening of the 25th March 2016. According to Dr Rexson's pathology report the deceased's friend noted that Becky was under the influence of drugs "had taken "ice" at 0300 at Dawson's house. She had passed away due to drug toxicity and was found "lifeless" by the early afternoon on the 26th March 2016. From a single post-mortem blood sample I cannot determine whether methylamphetamine or methadone was taken earlier than the other drug, or if the two drugs were taken concurrently. In my opinion Becky died due to a combination of methylamphetamine and methadone overdose." [15]

41. Although there was evidence of Becky using both marijuana and ice in the past, none of the statements taken refer to Becky ever using methadone. The friend who accompanied Becky to Mr Dawson's home expressed her surprise that Becky had used methadone on this evening.

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[14] Ex 1 Vol 1 Tab 8

[15] Ex 1 Vol 1 Tab 8 p 39

42. There is evidence that Mr Dawson was a regular drug-user.[16] Mr Dawson confirmed that he had a methadone prescription, and in oral evidence stated that he kept methadone in the bedroom, and that he had needles in his home.

43. Further, in the days prior to Becky's death, Becky and Mr Dawson engaged in a series of Facebook messenger exchanges, some of which made reference to drug use.

44. Around 2.24pm on 23 March 2016, Mr Dawson and Becky had an exchange during which Mr Dawson indicated that he was at the chemist to "get my done."[17] The only conceivable inference is that "done" refers to methadone.

45. Shortly after midnight on 24 March 2016, Mr Dawson sent Becky a message asking: "You still need a pipe?" She responded: "yeah but don't have money for one yet", to which he replied: "got something 4 you shorty come over at like 1-30, 2-00 tomorrow I will be only one here give it to you. She then responds "okay? We can get mad shit when my money comes through too ahhah" and then follows up with "btw would you know anyone on now? Only got 50 but can grab a 50 bag. He responded: "delete those txtss give me 5 mins."[18] They then arranged to meet at the train station across the road from Mr Dawson's house.

46. The messages they exchanged suggest that this occurred. It appears that one of Becky's friends was present at the time. The type of drug Becky purchased is not clear on the face of the exchange. In oral evidence, Mr Dawson insisted it was "pot". However, this seems inconsistent with the text exchange that follows. Becky told Mr Dawson that her friend did not know what she was getting and instructed Mr Dawson to "pretend it's sesh for my friend". Mr Dawson confirmed in oral evidence that the word "sesh" referred to pot. This suggests that Becky was purchasing something else – on balance, (given the drugs found in her system and the ice pipe found in her bag), ice.

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[16] Ex 1 Vol 1 Tabs 26 and 27

[17] Ex 1 Phone/ SIM examination E60742303, Tab 11A, p 100.

[18] Ex 1 Phone/ SIM examination E60742303, Tab 11A, p 104.

47. Mr Dawson continued to insist in oral evidence that the exchange was about "pot" and denied ever supplying Becky a drug other than pot. He further gave evidence that when she returned to his house on the morning of 26 March 2016, the two of them were smoking pot together. This is entirely inconsistent and plainly contradicted by the toxicology report that showed no cannabinoids in her system.

48. Having assessed Mr Dawson demeanour in the witness box, and portions of his evidence which are clearly contradicted by other objective evidence tendered in this inquest, in my opinion Mr Dawson was being dishonest about the drugs he was supplying to Becky. This affects the credibility of the totality of his evidence – most particularly, his evidence on whether Becky obtained the methadone from him.

49. Adding to this suspicion is Mr Dawson's history. In 2000, Mr Dawson had been investigated for having a sexual relationship with a 14-year-old child-in-care, Amber Stewart.[19] Mr Dawson admitted in his oral evidence that he used heroin with Amber during their intimate relationship. Tragically, Amber also died of a drug overdose.

50. Becky was noted to have a recent needle injection site on the right wrist which was not attributable to ambulance intervention.[20] This is consistent with drugs having been administered by injection.

51. The most likely scenario is that Becky ingested the methadone and methylamphetamine within a few hours of her death. While she may well have taken some methylamphetamine prior to or at the party I am satisfied on balance, she took methadone and perhaps more methylamphetamine at Mr. Dawson's home when she returned there after the party.

52. I am satisfied on balance that the drugs were obtained at Mr Dawson's home.

53. While there are suspicions that arise from the injection site that was found at autopsy on Becky's right wrist, at this stage, there is no evidence that the drugs

[19] Ex 1 Vol 1 Tab 9 and 21

[20] Ex 1 Vol 1 Tab 5B

were not voluntarily ingested or injected by Becky and accordingly I am not in a position to make a referral under s 78 of the *Coroners Act 2009*.

54. The early stage of the police investigation into Becky's death was unfortunate. The officer in charge formed the opinion that the more likely source of drugs was at the party Becky had been to. The death of a 15-year-old girl by drug overdose in the house of a 42-year-old man who was known to police for: heroin addiction, amphetamine supply, being involved in a relationship with an underage girl who was found overdosed on heroin, ought to have immediately indicated the need for a more careful and thorough investigation of Mr Dawson and his house.

b. Did the State appropriately care for Becky and if not have the inadequacies in her care been addressed?

55. There were many indications that Becky was deeply unhappy, and that she was struggling with depression, anxiety, loneliness and self-loathing. She was an extremely vulnerable young person.

56. Her diary entries between June 2012 and April 2013 included disclosures of self-harm and a previous suicide attempt, detailed suicide plans (including a suicide note to a friend), and lists weighing the positives of staying alive against the reasons she should die.[21] LWB and FACS knew of these diary entries.

57. There are reported incidents of Becky possessing blades and medication[22] and of self-harming by cutting.[23] Becky was also recorded to have had difficulty in expressing normal emotions such as happiness, sadness and excitement, and difficulties expressing empathy for others.[24] Becky was prescribed Cymbalata for

[21] Ex 1 Vol 3 Tab 45 pp 135-186

[22] Ex 1 Vol 3 Tab 45 pp 25, 84

[23] Ex 1 Vol 3 Tab 45 Walsh, [43]-[44]

[24] Ex 1 Vol 3 Tab 45 p 162

anxiety and Circadin for insomnia.[25] There is limited evidence regarding the extent of her compliance with these prescribed medications.

58. In November 2014, Becky had contacted Eheadspace, an online counseling service, expressing suicidal ideation of increasing intensity.[26] These concerns were referred to LWB.

59. Her placement with her step-grandparents became increasingly strained and "close to breaking point."[27]

60. The statement of Ms Walsh sets out in detail the history of LWB's involvement with Becky.[28]

61. There were some attempts by LWB to engage Becky with counseling in this period. A list of interventions is located at paragraph 164 of Ms Walsh's statement. However, Becky withdrew from the professional help she was receiving. In June 2014, Becky cancelled her appointment with private psychologist Dr Kilpatrick.[29] In December 2014, after having reached out to Eheadspace, Becky refused any further services with them.[30]

62. In oral evidence, Ms Walsh stated that there were "not a lot of options" when a young person does not agree to attend counseling. She described Becky as discovering her voice, not thinking she needed help, and being stubborn.

63. It is recognised that navigating the care relationship with an adolescent who is starting to assert their independence is difficult. There are no special powers available to FACS or LWB to compel a young person to access therapeutic services, short of intervention under the *Mental Health Act 2007* or pursuant to the Supreme Court's parens patriae jurisdiction.[31]

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[25] Ex 1 Vol 3 Tab 45 p 96

[26] Ex 1 Vol 3 Tab 45 p 75

[27] Ex 1 Vol 3 Tab 45 pp 26, 52, 72

[28] Ex 1 Vol 3 Tab 45

[29] Ex 1 Vol 3 Tab 45 p 60

[30] Ex 1 Vol 3 Tab 45 p 83

[31] Ex 1 Vol 2 Tab 44 pp 11-12

64. In June 2013, Clinical Psychologist Phil Screen recommended family therapy for Becky.[32] In April 2014 a Psychological Assessment Report prepared by the University of New England[33] noted the difference in the reported behaviours of Becky between home and school. The report recommended family therapy, in addition to ongoing individual psychological treatment, to help address the "apparent incongruence in Becky's behaviours."[34] These recommendations for family therapy were not pursued by LWB and no such therapy was provided.

65. Given the strain on the relationship within the care placement, it is difficult to justify why family therapy in line with this recommendation was not attempted, notwithstanding a risk that Becky would not have engaged.

66. In oral evidence, Maggie Van Den Berg, Therapeutic Specialist, Intensive Therapeutic Care, Northern Area, LWB spoke of the more recent introduction of family group conferencing, being a service run by a specialist family therapist or facilitator, in the New England area. It is a form of alternate dispute resolution organized and facilitated by a trained facilitator whose role is to mediate issues within the family unit. This may well have been beneficial in bringing together all of Becky's extended family. Ms Walsh accepted that such conferencing may have been of some benefit but did not think that that service was available in the region at the time that Becky was in the care of LWB.

67. Despite the indicia of Becky's unhappiness over this time, she was still attending school and by all accounts was a good student having received a scholarship for PLC in 2015.[35]

68. In early 2015 Becky began expressing unhappiness at PLC and a desire to move back to Armidale High School. One of the justifications provided for this desire was that she felt the girls at PLC were not really her friends.[36] She transitioned

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[32] Ex 1 Vol 3 p 234

[33] Ex 1 Vol 3 p 300

[34] Ex 1 Vol 3 p 300

[35] Ex 1 Vol 3 Tab 45 p 70

[36] Ex 1 Vol 3 Tab 45 p 71

out of full-time boarding and began spending more time on weekends and weeknights with her cousin, whilst still attending PLC throughout the day.[37]

69. The evidence suggests that Becky started using illicit drugs in the early stages of 2015. In February 2015, Becky is said to have told some other students at PLC that she had been smoking marijuana.[38] Becky's cousin found marijuana in Becky's bag in April 2015.[39] Stephanie Jackson states that Becky started smoking marijuana with a boyfriend, in 2015.[40]

70. On 8 May 2015, Becky was formally placed with her cousin.[41] Her cousin approached that role with dedication, and sought to provide Becky with a safe, secure and loving home.[42] She was assisting Becky to explore natural alternatives to anxiety medication, which Becky had stopped taking.[43]

71. However, not long after being placed with her cousin, difficulties with the placement commenced.

72. On 1 April, Becky's cousin found a small amount of marijuana sitting near Becky's bag. Becky denied it was hers.[44] Her cousin informed LWB.

73. In April 2015, her cousin told Ms Walsh that Becky no longer wanted to follow the rules that she had implemented and that she believed Becky intended to "self-place" after she turned 15.[45] In response to this, Ms Walsh agreed to submit a referral to the LWB Clinical Referral Team "to try and access some more support and get some direction on where to go from here."[46]

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[37] Ex 1 Vol 3 Tab 45 p 98

[38] Ex 1 Vol 3 Tab 45 p 91

[39] Ex 1 Vol 3 Tab 45 p 177

[40] Ex 1 Vol 1 Tab p 9

[41] Ex 1 Vol 3 Tab 45 p 99

[42] Ex 1 Vol 3 Tab 45 p 111 and oral evidence of Becky's cousin.

[43] Ex 1 Vol 3 Tab 45 p 100

[44] Ex 1 Vol 3 Tab 45 p 105

[45] Ex 1 Vol 3 Tab 45 p 106

[46] Ex 1 Vol 3 Tab 45 p 106

74. On 26 April 2015, Becky's cousin told LWB that when Becky returned home on 26 April 2015, she appeared to be under the influence of something like methamphetamines.[47] Her cousin was concerned about the friends that Becky was spending time with.

75. On 22 May 2015, Becky was accepted for clinical referral at LWB.[48] Maggie Van Den Berg, who at the time was the LWB Northern Area Clinical Services Manager, allocated Sarah Taylor as the Clinician to Becky.[49] Ms Taylor never met with Becky and her support appears to have been limited to supporting Becky's cousin in her role as carer.[50] Ms Van Den Berg acknowledged in her statement and oral evidence that there were resource constraints on this relationship, as Ms Taylor was in a dual role so only provided clinical services two days per week, and was the only clinician employed by LWB in the region at the time.[51]

76. On 26 June 2015, Becky became involved in an argument with her cousin around the choices Becky was making. Becky had said that school was a waste of time and that she wanted to live in a flat with her friends. Becky left her cousin's house and went to stay at her stepfather's house. In turn, her stepfather informed LWB of this and Becky returned to her cousin's care the next day.[52]

77. In early July 2015, Becky began working at McDonalds.[53]

78. In mid-July 2015, Becky and her cousin reached an agreement in relation to the time Becky could spend with her friends on weekends. Her cousin expressed concerns about the types of friends Becky had to LWB, noting that they were known to shoplift and take drugs.[54]

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[47] Ex 1 Vol 3 Tab 45 p 109

[48] Ex 1 Vol 3 Tab 45 p 115

[49] Ex 1 Vol 4 Tab 48 pp 57, 58

[50] Ex 1 Vol 4 Tab 49 pp 62- 70

[51] Ex 1 Vol 4 Tab 48 p 59

[52] Ex 1 Vol 3 Tab 45 p 116

[53] Ex 1 Vol 3 Tab 45 p 119

[54] Ex 1 Vol 3 p 120

79. Around the same time, Becky began self-placing with her stepfather, and 'couch-surfing'. Her stepfather reports, similarly to her cousin, that he was unable to enforce the rules of his house upon Becky.[55] He reports observing Becky being stoned or high, likely from 'ice'.[56]

80. On 6 August 2015, Becky informed Ms Walsh that she was not going back to school and would not be returning to her cousin's house. Despite this, Becky returned to that house on 10 August 2015.[57]

81. On 17 August 2015, Becky started as a full-time trainee at McDonalds.[58]

82. Stephanie Jackson states that in or about August or September 2015, she received a call and was told that Becky had tried ice. When Ms Jackson asked Becky about this, she denied it.[59]

83. On 2 September 2015 Ms Walsh conducted a home visit with Becky's cousin. Becky wasn't home. Her cousin informed Ms Walsh that she was talking to or seeing Becky on an almost daily basis.

84. On 1 October 2015, Becky and Ms Walsh had a brief face-to-face meeting at a train station. Ms Walsh states that Becky presented well and said that everything was going well. Ms Walsh had further conversations with Becky's cousin as well as her step-grandparents, all of whom "agreed that this was the happiest and settled they had seen Becky".[60] It appears that this was the last face to face contact between Ms Walsh and Becky.

85. On 19 October 2015, Becky's cousin expressed concern to Ms Walsh about the fact that another relative had provided Becky with $2000 and the fact that she had learned via a friend of Becky's that Becky had smoked some marijuana.[61]

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[55] Ex 1 Vol 1 Tab 37

[56] Ex 1 Vol 1 Tab 37 pp 7, 10

[57] Ex 1 Vol 3 Tab 45 p 125

[58] Ex 1 Vol 3 Tab 45 p 126

[59] Ex 1 Vol 1 Tab 29 p 13

[60] Ex 1 Vol 3 Tab 45 p 128

[61] Ex 1 Vol 3 Tab 45 p 130

86. On 30 October 2015 Ms Walsh requested a change to her casework arrangements with Becky such that a home visit would be scheduled once every two months, rather than once a month. The reasons cited for that request were: that there were regular communications with Becky's cousin; that Becky does not want to feel like a young person in care and wanted less LWB interference in her life; that her step-grandparents and cousin were happy with the present arrangement; and, that the her step-grandparents and her cousin were also willing to communicate with each other. This request was approved.[62] Reducing face to face contact at this point is difficult to reconcile with the suspected presence of increasing drug use and itinerant lifestyle Becky appeared to be leading, as discussed below.

87. On 24 November 2015, Becky's cousin advised Ms Walsh that Becky had not been at her place for two weeks and had moved her things to her stepfather's place. Her cousin stated that she felt the placement had ended.[63] The following day, Ms Walsh spoke to Becky and asked what she was planning to do. Becky said she was happy staying with friends and her stepfather. Although there is some record of LWB communicating with her stepfather earlier in the year and undertaking risk assessments in relation to him,[64] there was no *direct* contact with him at this critical time when Becky had started self-placing with him seemingly on a full-time basis.

88. Ms Walsh notified Becky that the supervision of her care would be transferred back to FACS as she had been out of the LWB-approved placement with her cousin for more than 4 weeks.[65]

89. At about that time, LWB submitted an application to FACS to request funding for Becky for the month of December, notwithstanding her self-placement. That application was not approved by FACS.[66]

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[62] Ex 1 Vol 3 Tab 45 pp 132 – 133

[63] Ex 1 Vol 3 Tab 45 p 135

[64] Ex 1 Vol 3 Tab 45 pp 90 and 104

[65] Ex 1 Vol 3 Tab 45 p 136

[66] Ex 1 Vol 3 Tab 45 p 138

90. On 28 November 2015, Ms Walsh and her supervisor, Ms Walters, spoke to Becky. During that conversation, Ms Walsh stated that LWB wanted Becky to go back to her cousin. Becky is said to have stated that she had no issues with her cousin but wanted to continue doing what she was doing. Ms Walsh interpreted this as meaning that Becky wanted to "do her own thing and live where she wanted with no rules".[67]

91. On 10 December 2015, Ms Walsh was informed by her step-grandmother that a friend, who worked at Centro Shopping Centre, had seen Becky hanging out down there with other teenagers and people in their twenties. Her step-grandmother indicated that police had caught some teenagers dealing drugs from that location the week prior.[68]

92. A few days later – on 14 December 2015 – Becky's cousin advised Ms Walsh that she seen Becky in the street and that she was starting to look unkempt.[69]

93. On 2 January 2016 and the morning of 4 January 2016, FACS received three reports to the Child Protection Helpline, which were not screened as meeting the Risk of Significant Harm threshold, on the basis of Becky having unsuitable accommodation for the night and not having stable accommodation.[70] The notifications emerged from the fact that Becky was living with a friend, at an address that was associated with significant drug taking activity.[71] Becky moved out of that place in the weeks prior to her death.

94. On 3 January 2016, LWB was notified via the FACS helpline that Becky was at an unsafe address. LWB contacted police about this, who advised that they had already received a call from Armidale Youth Refuge regarding Becky.[72]

95. On 4 January 2016, Ms Walsh contacted Becky, who indicated that she was arranging to move out with a friend but did not disclose where she was staying at

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[67] Ex 1 Vol 3 Tab 45 p 141

[68] Ex 1 Vol 3 Tab 45 p143

[69] Ex 1 Vol 3 Tab 45 p144

[70] Ex 1 Vol 2 Tab 44, p 4, [27]-[28].

[71] Ex 1 Vol 1 Tab 31 p 7

[72] Ex 1 Vol 3 Tab 45 p 148

that time. Ms Walsh advised Becky by text message that a case management transfer meeting was occurring that day and gave Becky the contact details for a new caseworker at FACS. Later that day, FACS contacted LWB to advise that the case management meeting needed to be rescheduled.[73]

96. On 5 January 2016, Ms Walsh spoke to Becky and told her that if she had nowhere to stay, she should contact Ms Walsh. Ms Walsh reiterated the availability of a placement with Becky's cousin. Becky stated that she had a place to stay but did not indicate where.

97. A case management meeting regarding the transfer of Becky's care to FACS took place on 7 January 2016. Ms Walsh does not recall being contacted by Becky or FACS after the date of her transfer.[74]

98. LWB records only indicate the following four face-to-face LWB contacts with Becky in 2015: 27 February, 1 July, 24 July and 1 October. The 27 February contact was in the context of a school meeting at PLC Armidale. The 24 July contact was in the context of a case plan review for Becky.

99. Ms Walsh states that not all face-to-face interactions have been recorded, and notes that she would often arrange brief meetings with Becky when Becky was in Tamworth. She estimated that occurred 6-8 times while she was a case manager.[75] These were described as brief catch ups, where Becky would be sighted to ensure she was OK.

100. Ms Walsh states that records exist in relation to the following other interactions with Becky:

    Phone calls: 19 May 2015; 5 August 2015; 6 August 2015; 25 November 2015, 28 November 2015; 5 January 2016

    Text messages: 2 December 2015; 15 December 2015; 23 December 2015; 4 January 2018

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[73] Ex 1 Vol 3 Tab 45 p 149

74 Ex 1 Vol 3 Tab 45, p 27 [152]

[75] Ex 1 Vol 3 Tab 45 p175

Emails: 11 February 2015; 12 February 2015; 13 February 2015; 17 February 2015; 18 February 2015; 19 February 2015; 25 February 2015; 1 March 2015; 2 March 2015; 5 March 2015; 12 March 2015; 13 March 2015; 18 March 2015; 25 May 2015; 16 July 2015; 5 August 2015; 6 August 2015; 13 November 2015.[76]

101. Again, Ms Walsh indicates there were other interactions that may not have been recorded.[77]

102. There were a number of limitations faced by Ms Walsh in trying to maintain contact with Becky. These included:

    a. Geography: Becky lived in Armidale, whereas LWB only had an office in Tamworth, over 112km away.[78]

    b. Caseload: Ms Walsh describes that her caseload was significant, with approximately 17 children, many of having highly complex needs. She describes "immense work pressure" as factoring into decisions to decrease contact with Becky.[79] The capacity constraints faced by LWB, particularly in regional areas, are also discussed by Ms Maggie Van Den Berg at [76]-[80] of her statement.

    c. Becky's own resistance to case management: Becky was a complex and developing young person. Ms Walsh believed that Becky did not want to feel as though she was "in care" and sought greater independence and freedom.[80] She did not want to feel monitored or supervised,[81] and disengaged from many services and professionals.[82] This perhaps was expressed most strongly by Becky's cousin in oral evidence, who described

[76] Ex 1 Vol 3 Tab 45 p176

[77] Ex 1 Vol 3 Tab 45 p174

[78] Ex 1 Vol 3 Tab 45 p172

[79] Ex 1 Vol 3 Tab 45 p134

[80] Ex 1 Vol 3 Tab 45, p227

[81] Ex 1 Vol 3 Tab 45, p175

[82] Ex 1 Vol 3 Tab 45 pp187, 218

Becky as "hating" FACS and LWB and their control over her. As her cousin put it, "if they suggested it, it was controlling."

103. Despite these challenges, it is nonetheless clear that Becky was a young person who needed more active case management. Almost all indications were that Becky's situation was worsening and that she required more active intervention. These indications include that:

    a. Becky had left PLC, and then left school altogether after multiple suspensions from Duval Public High School;[83]

    b. There were suspicions from April 2015 that Becky had commenced using illicit drugs;

    c. Becky was spending time with young people in relation to whom her cousin and stepfather had concerns of drug use and criminal behaviour;[84]

    d. Becky was receiving large sums of money from her paternal family, which posed a concern that she would be able to purchase drugs;[85]

    e. Becky was spending more and more nights away from her authorised placement with her cousin.[86] Initially she was self-placing with her stepfather, a relationship that LWB was happy to support.[87] However, by November 2015, she was effectively couch-surfing and staying with whoever would allow her to stay at the time.[88] There were indications that she was homeless, and refused to disclose to LWB the address that she would be staying at.[89]

104. Despite this, contact with Becky, even by way of emails, markedly dropped off in the latter half of 2015.

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[83] Ex 1 Vol 3 Tab 45 p121

[84] Ex 1 Vol 3 Tab 45, p109, 116, 120, 121, 143

[85] Ex 1 Vol 3 Tab 45, pp113, 146

[86] Ex 1 Vol 3 Tab 45, p197

[87] Ex 1 Vol 3 Tab 45 p194

[88] Ex 1 Vol 3 Tab 45, p198

[89] Ex 1 Vol 3 Tab 45, pp148-150

105. In October 2015, Ms Walsh received official approval from LWB to reduce her home visits from one every month to once every two months.[90] This approval would not have made a significant practical difference, given that it does not seem that home visits were in fact occurring monthly.

106. Ms Walsh describes that the approval was based in part on "how settled Becky had become at this point in time."[91] Despite the positive reports from and about Becky on 1 October 2015,[92] clearly this should also have been reassessed when, on 24 November 2015, Becky's cousin advised Ms Walsh that Becky had effectively moved out of her house, had been staying with friends, was only staying with her stepfather when he was in town, and that she felt "the placement had ended."[93]

107. Ms Walsh was engaged with Becky's cousin throughout this time. There was also some contact with her stepfather, although of a far more limited nature. However, there was likely an over-reliance on receiving and providing information through those people as intermediaries, rather than direct contact with Becky.

108. Ms Mattick's supplementary statement addresses the topic of working with adolescents who are non-compliant with their care plans and exhibiting challenging behaviours. Ms Mattick comments:

> "Young people in out of home care need caseworkers who are close enough to know them and can act with curiosity when they are not safe... It is important when adolescents are testing boundaries and asserting their independence that those around them continue to support them."[94]

109. Achieving the connection and relationship necessary to operate in this way is not possible when direct interactions are so infrequent.

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[90] Ex 1 Vol 3 Tab 45, pp132-133

[91] Ex 1 Vol 3 Tab 45, p133

[92] Ex 1 Vol 3 Tab 45, p128

[93] Ex 1 Vol 3 Tab 45, 135

[94] Ex 1Vol 2 Tab 44A, [7].

110. LWB did not have sufficient contact with Becky in the months prior to her death. Although Becky was 15 years of age and desperate for independence and autonomy, she was still a child and she was still under the Minister's care. As was noted at LWB school meeting at PLC in February 2015, although Becky was highly intelligent her emotional development was likened to that of a two year old.[95]

111. She was only 14 years old when news first circulated that she was using drugs or keeping the company of those who were involved in illicit drugs. She had only just turned 15 at the time she left school and, shortly thereafter, her approved accommodation. These were pivotal moments in Becky's life and close monitoring, increased support and regular face to face contact would ordinarily follow from a parent or carer at this critical juncture in a young person's life.

112. During the Inquest, there was general agreement, in hindsight, from FACS and LWB that it was unfortunate that the responsibility for Becky's care was transferred from LWB to FACS around this time.

113. The transfer was done pursuant to the FACS "Unplanned Absences policy."[96]

114. FACS' policy at the time was that, if a child or young person was absent from their authorised placement, the designated agency with case management responsibility was required to inform FACS. If the young person had left the placement and was not willing to return, funding for the placement would cease and case management responsibility would transfer back to FACS.[97]

115. The policy allowed for a placement to be held open for an additional four weeks, with the approval of the relevant District Director; however this required "strong evidence" that the young person was likely to return to the placement and that the provider was actively working with the young person.[98]

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[95] Ex 1 Vol 3 Tab 45 p74 and 407

[96] Ex 1 Vol 2, Tab 44, Annexures B and C.

[97] Ex 1 Vol 2, Tab 44, [19].

[98] Ex 1 Vol 2, Tab 44, [61].

116. LWB submitted a request for an additional four weeks of absence, but it was not approved by the District Director, on the basis that there was no evidence that Becky was likely to return to the placement.[99]

117. One of the consequences was that, at a critical and difficult time in her life, the relationship that LWB had built with her and her carers was severed. The depth of knowledge Ms Walsh had accumulated in her time working with Becky and her cousin was lost.

118. Ms Walsh describes the difficulty for her of returning case management for Becky because of her genuine care for Becky.[100] Becky's cousin also spoke of the change that she perceived when the transfer occurred, and the support that had been withdrawn from her.

119. The purpose of the Unplanned Absences policy was to ensure general foster care placements are not left vacant when children or young people leave. In general situations, it ensures the appropriate allocation of FACS resources. However, where Becky was placed with a family member who was specifically authorised to care for her, the rationale is less compelling.

120. It is clear that FACS have learnt from Becky's death and changed their policy to avoid repeat of some of the mistakes made.

121. In July 2018, FACS published a new Away from Placement policy. Significantly, under this policy case management is no longer required to be transferred to what is now DCJ when a young person is absent from their placement.[101]

122. The key features of the new policy are:

    a. A young person is deemed to be "not in placement" if they have not been residing in their authorised placement for a period of up to a maximum of eight weeks, or if there is immediate evidence that they will not return to their authorised placement.

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[99] Ex 1 Vol 2, Tab 44, [65].

[100] Ex 1 Vol 3 Tab 45, p228

[101] Ex 1 Vol 2, Tab 44, [68].

b. The Out of Home Care ("OOHC") service provider continues to have case management responsibility while the young person is "not in placement."

c. The service provider receives an alternative funding package for the purpose of "not in placement case coordination."

d. Transfer of case management back to FACS may occur in exceptional circumstances, including where the designated agency is no longer capable of protecting the young person, or if the young person is not in a placement for over 12 months.[102]

123. Had this policy been in place in December 2015, it is likely that LWB could have continued to have case management responsibility for Becky.[103]

124. The days surrounding the transfer of case management from LWB to FACS corresponded to a marked deterioration in Becky's presentation. Only days before the transfer, on 2 January 2016, FACS received a risk of significant harm report via the Child Protection Helpline about Becky being homeless.

125. The case management transfer meeting took place on 7 January 2016 at 2pm.[104] There was also a phone call between Ms Walsh and the incoming case manager on the same day. Ms Mattick provided a copy of the FACS notes from both that meeting and the phone call.[105] That document contains limited information about Becky's history of mental health issues and self-harm. It also does not refer to the suspicions of drug use by Becky or her associating with persons suspected of using drugs.[106]

126. Ms Walsh records that, on 13 January, she sent an email to Becky's new FACS caseworker, Emily Bullen, responding to a question she had about Becky and offering to be of assistance with any questions she may have regarding Becky's

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[102] Ex 1 Vol 2, Tab 44, [69]-[70].

[103] Ex 1 Vol 2, Tab 44, [70].

[104] Ex 1 Vol 2, Tab 44, [25].

[105] Ex 1 Vol 2, Tab 44A, [27]-[28]; Annexures E and F.

[106] Ex 1 Vol 2, Tab 44A, [29].

case to ensure that the transition was as smooth as possible for Becky.[107] However, Ms Walsh reports there were no further contact from FACS and no initial joint home visit.

127. An indication of the poor information held by FACS in relation to Becky is the revised Child Assessment Tool (CAT) report conducted by FACS on 23 March 2016.[108] That document records a number of comments relevant to the assessment of the level of care required by Becky, notably as follows:

    a. "Emotional adjustment: Child has occasional mood swings but does not affect functioning."

    b. "Depression and self-harm: Child has some depressive symptoms; may be some self-harm ideation, and/or suicidal ideation (ie thoughts about harming and/or killing oneself), but no history of any suicide attempt, no plans toward suicide."

    c. "Substance use/ misuse: Child gives no indication of any alcohol and/or drug use."

128. Their lack of information of significant mental health and substance use issues no doubt meant they were ill-equipped to assist Becky with those challenges.

129. The case management transfer meeting presented an opportunity for information to be shared between the two organisations, so that a clear plan could be developed to support Becky. It was also an opportunity for Becky to be involved in decisions that affected her life, with the intention of reengaging her with the supports that could be offered by FACS. Unfortunately, it appears neither of those opportunities was seized upon.

130. Ms Mattick gave evidence that :

> "...case management transfer from LWB to [FACS] on 7 January 2016 was insufficient. It was not child focused and did not consider Becky's strengths, needs and vulnerabilities. Becky was an extremely vulnerable young person, and during the meeting LWB should have been more forthcoming and [FACS]

[107] Ex 1 Vol 3 Tab 45, p215

[108] Ex 1 Vol 2, Tab 44A, Annexure H.

should have been more curious about Becky's experiences in the previous 12 months to ensure her needs were adequately understood and plans were developed to address the issues identified." [109]

131. While LWB do not accept this assessment of the handover, I note that Ms Walsh does not recollect the handover clearly and gave evidence her usual practice would have been to provide all the material she had relating to a child's health education and all other domains of care. She remembered offering her availability to answer any questions in relation to Becky.

132. Upon her transfer into the care of FACS, Ms Bullen was allocated as Becky's caseworker. Her interactions with Becky were as follows:

    a. 7 January 2016 – meeting with Becky and home visit at the apartment of a young adult Becky had been staying with;[110]

    b. 5 February 2016 – meeting with Becky at a shopping centre. Becky raises issues about insufficient money, not seeing her family as often as usual, and being tired due to working full time;[111]

    c. 25 February 2016 – phone call with Becky about picking up food vouchers. Becky informs Ms Bullen that she does not want her family member involved in her case planning meeting;[112]

    d. 2 March 2016 – meeting with Becky for a pre-case plan discussion. Becky advises that she had a falling out with the young adult she had been staying with and has been "staying with various friends." She also says that she is sick and cannot afford to go to the doctor;[113]

    e. 4 March 2016 – case planning meeting at Armidale CSC. Becky agrees to trial a residential placement. She advises she has quit her job at McDonalds and wants to see a doctor about her anxiety;[114]

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[109] Ex 1 Vol 2, Tab 44A, [33].

[110] Ex 1 Vol 2, Tab 44, [37]-[41].

[111] Ex 1 Vol 2, Tab 44, [45]

[112] Ex 1 Vol 2, Tab 44, [46]

[113] Ex 1 Vol 2, Tab 44, [47]-[48].

[114] Ex 1 Vol 2, Tab 44, [49].

f. 11 March 2016 – meeting with Becky at Armidale CSC. Becky advises she is staying with a friend;[115]

g. 16 March 2016 – meeting with Becky at the supermarket to shop for groceries together;[116]

h. 23 March 2016 – text messages between Ms Bullen and Becky, enquiring about food vouchers.[117]

133. In her oral evidence, Ms Mattick gave a frank assessment of three related issues that emerged with the care provided to Becky in the period leading up to her death.

134. First, the intensity of support and frequency of contact was lower than indicated by Becky's circumstances, which was reaching a *crisis point*. The underlying reason for this appears to be that the new case worker provided Becky too much scope to govern the intensity of their relationship and the terms of their interaction. Particularly with an intelligent and headstrong young person like Becky, there is a risk of allowing too much latitude, despite the young person not having the emotional competence to recognise their own needs and vulnerabilities.

135. Secondly, the case worker failed to sufficiently engage Becky's care givers and network of supports. A critical moment in this period was when Becky instructed her case worker that she did not want any of her family members to be present at her case planning meeting on 4 March 2016. It is likely that her case worker was trying to engage and build trust with Becky, but did so at the expense of failing to involve those that loved and cared for Becky in decision making about her. This was a fundamental failure in the care given to Becky in the months preceding her death.

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[115] Ex 1 Vol 2, Tab 44, [50].

[116] Ex 1 Vol 2, Tab 44, [51].

[117] Ex 1 Vol 2, Tab 44, [52].

136. There was a real risk that, over this time period, Becky was isolating herself from her family. This may have been a symptom of the mental health struggles that she was facing.

137. Ms Mattick, reflecting on this in her oral evidence, noted that FACS, not the young person, has the responsibility to talk to the people that have an interest in the young person's life, and that that should be explained to the young person.

138. In addition to family not being present at the case planning meeting, there are almost no records that indicate that family was being contacted by FACS or kept informed about the issues being faced by Becky. This was echoed in the evidence of Becky's cousin, who recalls that she had no contact at all from FACS after case management was transferred, despite having previously had such a close relationship with LWB. While Becky was reporting feeling estranged from her family, there was no contact with them to determine their version.

139. There was a total absence of contact with Becky's previous carers, Becky's cousin and her step-grandparents, and also with the Becky's paternal family who had always shown an active interest in Becky (including welcoming her for holiday visits and paying for her education). While there can be no doubt that Becky *felt* lonely and isolated at times, she had considerable family support. This lack of contact was largely unexplained other than by a comment that the office had a high caseload.

140. Finally, FACS were not sufficiently proactive in meeting the urgent needs identified by Becky. Becky was reporting that she had financial issues and was unable to access the doctor. On 2 March, at the pre-case planning meeting, Becky indicated that she had been sick but unable to afford going to the doctor. This was repeated again on 4 March 2016, with Becky advising that she wanted to see a doctor about her anxiety, indicating some renewed willingness to seek professional help for her mental health issues.

141. No visit to a GP ever eventuated. This was a need that could have been met with relative ease, particularly bearing in mind that FACS had an office in Armidale.

142. This may have created an impression for Becky that she was not being supported. As Ms Mattick expressed in oral evidence, FACS lost the opportunity to "demonstrate that we could be useful." Delivery of practical assistance in a timely fashion, such as assistance accessing medical services, is a tool for engaging young people.

143. There was some more practical support by way of food vouchers and grocery shopping. However, there was a missed opportunity on those occasions to obtain a clearer understanding of Becky's financial position. It was concerning that her finances were so strained despite her working full-time at McDonalds and receiving additional funds from her paternal family. It may be that enquiries about her finances could have led to exploration about other aspects of her lifestyle, namely drug use.

144. The greatest omission in Becky's care appears to have occurred following her transfer back to FACS' care. It was incumbent on FACS to show more curiosity about the issues faced by Becky and take more proactive steps to ensure Becky's welfare upon resuming case management of her.

145. Becky's living circumstances were precarious from at least the time that FACS took over the management of her case. By the time FACS became involved, Becky did not have stable accommodation, was couch surfing with friends, and seeking accommodation with a shelter.[118] From at least 7 January 2016, Becky had been living with a particular young adult.[119] That young adult was known to FACS as she had a five-month-old son whom FACS had been concerned about due to the young adult's mental health and drug issues.[120] A friend of Becky's, describes the apartment as an entirely unsafe environment for a young person, being a place where drugs were regularly used and sold.[121] He also describes the deterioration in Becky's condition shortly after moving in:

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[118] Ex 1 Vol 2, Tab 44A, [72].

[119] Ex 1 Vol 2, Tab 44, [37].

[120] Ex 1 Vol 2, Tab 44, [41].

[121] Ex 1 Vol 1 Tab 31 p7

"Within a month of living in the unit across the hallway Becky started to look a little dead inside. Her skin was very pale and particularly around her face. The skin around Becky's eyes was puffy and purple in colour. She just looked like she was getting really run down."[122]

146. On 7 January 2016, at a meeting with her new case worker, Becky indicated that she did not want a placement and stated "I don't want to live with a random family." Notably, however, Becky was open to the option of a residential placement.[123]

147. By March, Becky had left the young adult's home and was staying with various friends.[124] Again, Becky indicated that she would consider residential placement options, and agreed to attend a residential care service provided by Pathways.[125] However, the Pathways referral failed on the basis that Armidale Pathways did not have any placements available.[126]

148. On 11 March 2016, Becky expressed a willingness to explore residential placement options in Sydney. In the meantime, she said she would live with the friend who would subsequently accompany Becky to Mr Dawson's house prior to her death.[127] There was no check of the suitability of that house.

149. On 16 March 2016, Becky again expressed agreement when Ms Bullen said she would continue to look for a placement for Becky.[128]

150. It was only on 23 March 2016, that Becky was first asked about where her relatives in Sydney lived, to enable the search for residential options in Sydney.[129]

151. Although Becky was frequently self-placing while with LWB, and seemed determined to live by her own rules, by the time that FACS was involved Becky

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[122] Ex 1 Vol 1 Tab 31 p7

[123] Ex 1 Vol 2, Tab 44, [40].

[124] Ex 1 Vol 2, Tab 44, [47].

[125] Ex 1 Vol 2, Tab 44, [47].

[126] Ex 1 Vol 2, Tab 44, [50].

[127] Ex 1 Vol 2, Tab 44, [50].

[128] Ex 1 Vol 2, Tab 44, [51].

[129] Ex 1 Vol 2, Tab 44, [52].

was expressing a willingness to consider a residential placement. Becky was demonstrating insight into her living circumstances being "not ideal."[130]

152. The period between January and March represented a lost opportunity to re-establish a safe placement for Becky. It does not appear that any enquiries were made about alternative accommodation until March 2016, despite Becky effectively being homeless from January and being open to the option of a residential placement. This was, in the circumstances, too late. It meant that FACS could not present any feasible options to Becky during planning meetings. FACS was failing to demonstrate that they could be of assistance to Becky.

153. Concerningly, there was no attempt to reengage Becky's family to find out what family placements could be available. Becky had a large and supportive family in Sydney who may have been able to offer new options that would remove Becky from her destructive social environment. Indeed, by March, it seems Becky was at least open to the possibility of living again with her cousin who had moved to Sydney.[131] Yet no contact, let alone immediate contact, was made with Becky's cousin by FACS over this period.

154. In the ten weeks that Becky was in FACS' care no real effort was made to locate an alternative placement for her and this was a serious deficiency in their obligations to provide her with appropriate care.

155. FACS and LWB have each undertaken their own internal reviews into the death of Becky.

156. Both organizations were honest and reflective in the approach they took to this inquest. The changes they have made to their practice are included in the statements of Ms Mattick and Mr Best.

157. Nonetheless, this inquest has highlighted a number of areas that are worthy of further consideration by FACS.

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[130] Ex 1 Vol 2, Tab 44, [47].

[131] Ex 1 Vol 2, Tab 44A, [72].

158. The infrequency of face-to-face contact with Becky is a significant source of concern.

159. It is accepted that face-to-face contact should be maintained on a regular basis – when any known risk factor emerges. The risk factors present in Becky's case included: suspected drug use, association with peers known to use or supply drugs, frequent absence from placement, loss of motivation with schooling and alternative training.

160. I have reviewed FACS' "Working with Young People" practice advice.[132] That document includes a number of relevant statements of principle that would support the need for regular contact, including:

    a. "Meaningful and positive relationships with young people lay the foundation for casework that is consistent, engaging and effective."[133]

    b. "Show the young people they are important by getting to know them."[134]

    c. "Do not rely on text or email to build a relationship or as the main way for keeping in touch or sharing information."[135]

    d. "Never use text or email to... replace face to face talks and visits."[136]

161. However, it appears from this document that the expected frequency of face-to-face contact is not expressed and there is no policy that sets a minimum number of contacts that should be provided. I am of the view that is desirable that FACS should consider a review of its internal practices and policies (and also those applicable to private OOHC providers) in relation to expressing the frequency of face-to-face contacts expected to be provided by a case manager, and when it is appropriate to increase or decrease the frequency of such contacts.

162. During the Inquest the use of the CAT categorisation system by FACS was investigated.

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[132] Ex 1 Vol 2, Tab 44A, Annexure A.

[133] Ex 1 Vol 2, Tab 44A, Annexure A, p 4.

[134] Ex 1 Vol 2, Tab 44A, Annexure A, p 4.

[135] Ex 1 Vol 2, Tab 44A, Annexure A, p 21.

[136] Ex 1 Vol 2, Tab 44A, Annexure A, p 21.

163. CAT was designed to assist placement matching of children and young people to carers, and to determine the level of funding to be provided for individual children or young people based on an assessment of their behaviour, health and development.[137]

164. Ms Van Den Berg explains that CAT was developed by a consortium of welfare providers in the USA, and was designed to assess a child and other young people in out of home care (rather than the general population).[138] CAT ranks young people from category 1 to category 6.

165. Only young persons categorized as CAT 4 and above are automatically entitled to specialist clinical input in foster care. For children with a categorisation less than CAT 4 (i.e. CAT 1 to 3), it would be necessary to make a special case to obtain access to clinician services.[139]

166. The CAT system would also dictate the formulation of LWB funding structures and staffing numbers – in particular, the number of regional clinicians depended on the number of CAT 4 or higher young persons in out of home care.[140]

167. The funded service provider was able to request a reassessment of CAT if there was a significant change in a young person's circumstances. Further, official policy says that CAT will be re-applied if specific triggers occur, including a pattern of escalating behaviours, or a significant change in the child or young person's behaviour or health.[141]

168. However, Ms Van Den Berg expressed the view that, in her experience, a CAT review would be approved by FACS only if there was a complete placement breakdown or a drastic change in circumstances.[142]

169. This observation is consistent with the oral evidence of Ms Walsh. When Becky's case management was transferred from FACS to LWB in 2013, an assessment

[137] Ex 1 Vol 2, Tab 44A, [95]. See Ex 1 Vol 4, Tab 48, Annexure 11.

[138] Ex 1 Vol 4 Tab 48 p36

[139] Ex 1 Vol 4 Tab 48 p40

[140] Ex 1 Vol 4 Tab 48 p41

[141] Ex 1 Vol 2, Tab 44A, [97]-[98].

[142] Ex 1 Vol 4 Tab 48 p44

was undertaken and Becky was assessed as CAT 1 (or "General Foster Care").[143] Ms Walsh expresses that, in hindsight, Becky was not a CAT 1 child at this time.[144] However, despite this, Ms Walsh expressed in oral evidence that she understood why LWB did not seek to have Becky reassessed, because LWB knew that there was insufficient evidence to require reassessment.

170. There was no further assessment of Becky until 23 March 2016, only days before her death. The result of this assessment was that Becky was entitled to receive a support package of "General Foster Care +2."[145]

171. Had she been re-assessed at an earlier time, it is possible that a higher level of funding may have made other therapeutic services available to her.

172. Ms Van Den Berg was of the view that CAT scores needed revision upon a young person entering their adolescence. She states:

> "It was not uncommon to observe challenging patterns of behaviour as clients entered puberty or adolescence who were assigned a GFC [general foster care] categorisation at the time their case management was transferred to LWB. The carers would often struggle to sustain the placement with the emerging behaviours. It is a pattern that is not unfamiliar, which I identified during my years of experience working with families and carers with children exhibiting challenging behaviours. Not dissimilar to the experience of parents in 'normal families' with children moving into adolescence. It was my opinion that more support was needed for adolescents and that their CAT assessments as children were redundant once they began to adolescence and started to become more aware of and understand, on higher level, their experiences of trauma."[146]

173. The CAT tool only breaks down children into 3 groups: under 5, 5 to 8, and 9 years and over. Ms Van Den Berg agreed with a suggestion that an additional age group of above 13 years would be a worthy addition.

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[143] Ex 1 Vol 3 Tab 45, [21].

[144] Ex 1 Vol 3 Tab 45, [21].

[145] Ex 1 Vol 2, Tab 44A, [32].

[146] Ex 1 Vol 4 Tab 48 p42

174. Ms Mattick disagreed that CAT scores automatically needed revision upon adolescence. She was of the view that the approach needed to be tailored to the individual child.

175. I am also of the opinion that it would be desirable for FACS to consider a review of policies surrounding CAT assessments, with a review to removing barriers (formal or informal) to re-assessment of a child if their circumstances or needs have changed. Further, FACS should review whether there is sufficient evidence that support at least one mandated review between the years of 13 and 15, a period in which young people commence their entry into adolescence and routinely experience upheaval, transformation, hormonal irregularities, and defiance with authorities that can result in pressure on placements and disengagement with known stabilizing factors.

176. I note that from July 2019 FACS are part of the Department of Communities and Justice. Accordingly, I address my recommendations to the Secretary of the Department of Communities and Justice.

Findings pursuant to s 81 (1) *Coroners Act 2009*

Identity

The person who died was Becky

Date of death

Becky died 26 March 2016

Place of death

Becky died at 245 Brown Street, Armidale, NSW

Cause of death

Becky died as a result of a combination of methylamphetamine and methadone toxicity

Manner of Death

Becky died of an accidental drug overdose in suspicious circumstances

Recommendations: s.82 Coroners Act 2009

To the Secretary of the Department of Communities and Justice, I make the following recommendations:

1. that the Secretary of the Department of Communities and Justice should consider a review of its internal practices and policies (and also those applicable to private OOHC providers) in relation to expressing the frequency of face-to-face contacts expected to be provided by a case manager, and when it is appropriate to increase or decrease the frequency of such contacts.
2. that the Secretary of the Department of Communities and Justice should consider a review of policies surrounding Child Assessment Tool assessments, with a review to removing barriers (formal or informal) to re-assessment of a child if their circumstances or needs have changed. Further, the Secretary of the Department of Communities and Justice should review whether there is sufficient evidence that support at least one mandated review between the years of 13 and 15, a period in which young people commence their entry into adolescence and routinely experience upheaval, transformation, hormonal irregularities, and defiance with authorities that can result in pressure on placements and disengagement with known stabilizing factors.

Magistrate Carmel Forbes
Deputy State Coroner
17 March 2021

NSW State Coroner's Court Lidcombe