FINDINGS, COMMENTS and RECOMMENDATIONS of Coroner Olivia McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Six Infants and One Child

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the names of the deceased, family, friends and others by direction of the Coroner pursuant to s57(1)(c) of the *Coroners Act* 1995)

I, Olivia McTaggart, Coroner, having investigated the death of six infants and one child, with an inquest held at Hobart in Tasmania, make the following findings.

Hearing Dates

24 - 26 August 2020 and final submissions received by 7 December 2020

Representation

Counsel Assisting the Coroner: C Schokman

Counsel for Child Safety Services: G Chen

Abbreviations and acronyms

In this finding, the following acronyms and abbreviations are used.

A&OD – Alcohol & other drugs

CAAG – Court Application Advisory Group

CAMHS – Child and Adolescent Mental Health Services

CFR/SERT – Critical File Review/Serious Event Review Report

CHaPS – Child Health and Parenting Service

CPIS – Child protection information system

CSLO – Child Safety Liaison Officer

CSS – Child Safety Service (formerly Child Protective Service)

CU@Home - a program offered by CHaPS for young first-time parents 15 to 19 years of age involving regular home visits by nurses in the antenatal period until the child's second birthday.

CYPTF Act – Children, Young Persons and their Families Act 1997

CYS – Child and Youth Services

Department – Department of Communities Tasmania

DoE – Department of Education

ED – Emergency Department

FADV - Family and Domestic Violence

FVCSS – Family Violence Counselling and Support Service

FVO – Family Violence Order

"Ice" – The illicit drug methamphetamine

IFES – Intensive Family Engagement Service

LGH – Launceston General Hospital

NWPH – North West Private Hospital

NWRH – North West Regional Hospital

PFVO – Police Family Violence Order

RHH - Royal Hobart Hospital

SUDI or SUID – Sudden Unexpected Death in Infancy or Sudden Unexpected Infant Death

The Act – *Coroners Act* 1995

TRF – Tasmanian Risk Framework

Descriptions

I set out below abbreviations and descriptions of the key CSS processes that are referred to throughout the finding.

Intake – A CSS service which receives notifications concerning the wellbeing of children and unborn infants and provides advice and referrals relating to these notifications. An initial risk assessment is carried out by Intake staff following a notification, and, depending upon the extent of the assessed risk, referrals may follow to other CSS services, including Response. Intake is now known as the Advice and Referral Line (ARL).

Response – The process carried out to comprehensively assess risk, safety and judgements about harm, future harm and persons responsible for harm in relation to a child or unborn infant and involves a Child Safety Assessment usually conducted by the Response Team.

Child Safety Assessment – The process of conducting an assessment to determine whether a child or young person has been abused or neglected or is at risk of abuse and neglect to determine what response is needed for the child's immediate and long term safety and wellbeing.

Three and Under Panel – A panel comprising CSS and Stakeholders who review CSS notifications involving children aged three and under.

Introduction

The joint inquest

1. I held a joint inquest pursuant to section 50 of the *Coroners Act* 1995 ("the Act") into the deaths of seven children between 2014 and 2018. Of the seven children, six were infants under the age of seven months. The seventh child was 16 years of age when she died and was the mother of one of the six infants.

2. Of the six infants, five were under the age of 4 months. In the case of four of these infants, their death occurred suddenly and unexpectedly during apparent sleep. In three of these cases, the circumstances surrounding death involved an unsafe sleeping environment and I cannot determine the cause of death. The fourth infant died as a result of natural causes, being bronchopneumonia. An older infant, aged seven months, died as a result of drowning in the bath. The final infant and his mother, being the 16-year-old child, died as a result of injuries sustained in a vehicle crash.

3. Each of the seven deaths was a reportable death within the meaning of section 3 of the Act and therefore I was required to investigate the deaths in accordance with the provisions of the Act.

   In respect of one of the infants, a mandatory public inquest was required by the Act as, at the time of his death, he was in the custody of the Secretary pursuant to an order under the CYPTF Act.[1]

4. In relation to the remaining six deaths, I considered that it was desirable to hold an inquest.[2]

5. As the formal delegate of the Chief Magistrate under the Act I directed that all seven deaths be investigated at the one inquest because each child and/or their family had a history of involvement with the child protection system. Child Safety Services (CSS) is responsible for child protection in this state. CSS sits within Children, Youth and Families (CYF) (formerly Children and Youth Services) and is part of the Department of Communities Tasmania.

6. It appeared in each case that there were risk factors associated with each child requiring their protection and that in each case there were deficits in child protection practice that may have been connected with the deaths. Specifically, it appeared that a failure on the part of CSS to recognise the extent of the risk to the child and to act in accordance with that risk may have

[1] Section 3 (definition of "person held in care") and section 24(1)(b) of the Act.
[2] Section 24 (2) of the Act.

either been causally related to cause of death or at least represented a missed opportunity to prevent death.

7. The role of CSS is to protect children and young people who are at risk of abuse or neglect. Under the CYPTF Act, its functions are to respond to notifications in respect of children by assessing risk and, where required, taking steps to protect children from that risk. Such steps may range from voluntary referral of families to support services to seeking a long-term care and protection order from a magistrate and placing the child in foster care.

Family members

8. The senior next of kin and/or involved family members of each child were contacted by the coroner's associate to advise that I had decided to hold an inquest and, in the period leading up to the inquest, were invited to participate. They were advised that the primary focus of the oral evidence would be the adequacy of the decision-making and actions of CSS in response to notifications involving their child. They were advised, however, that they would not be required by summons to give oral testimony at inquest. One family member made a submission regarding non-publication of details of the inquest. Otherwise none of the family members attended the inquest or made written submissions to the inquest. All were given the opportunity to consider the evidence in relation to their child and kept informed of the progress of the inquest, the child protection issues to be considered and the proposed witnesses to be called. None of the family members sought to challenge the evidence regarding circumstances and cause of death. [3]

Non-publication order

9. At the commencement of the inquest hearing I made an order, unopposed, under s57(1)(c) prohibiting the publication of:

   a) The name of each deceased;
   b) The name of the parent and close family members of the deceased and any civilian witnesses in the investigation;
   c) The address at which each death occurred;
   d) Any home address of each deceased;
   e) The identity of a notifier within the meaning of the *Children, Young Persons and their Families Act* 1997 or evidence from which the identity of a notifier could be determined.

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[3] The relevant family members were initially contacted in November 2019 to advise of the proposed inquest. Three further updates by letter were forwarded on 15 February 2020, 29 May 2020 and 5 August 2020 (personally delivered).

Required findings under the Act

10. The findings under the Act required to be made in respect of each child are stipulated by section 28 and are as follows:

    (1) A coroner investigating a death must find, if possible –

        (a) The identity of the deceased; and
        (b) How death occurred; and
        (c) The cause of death; and
        (d) When and where death occurred; and
        (e) The particulars needed to register the death under the *Births, Deaths and Marriages Registration Act* 1999.

    (2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.

    (3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

11. In relation to section 28(1)(e), neither the *Births, Deaths and Marriages Registration Act* 1999, nor the regulations made thereunder, provide for which particulars must be found. As observed by coroners in several previous findings, this legislative gap requires attention.[4]

12. I will deal with the power to make recommendations and comment further on, as this was the subject of detailed submissions by counsel assisting and counsel for CSS.

Scope of inquest

13. The focus of the inquest was, firstly, the issue of whether, and the extent to which, CSS action or inaction formed part of the relevant circumstances or played a causal role in the death of the child for the purposes of findings required to be made under section 28(1)(b) and (c) of the Act.

14. Secondly, evidence was adduced to enable me to fulfil my functions under section 28 (2) and (3) of the Act; being to make recommendations, if appropriate, with respect to ways of preventing further deaths and on any other matter that is appropriate; and also to consider appropriate comments on any matter connected with the deaths.

[4] For example *Mansell* 2016 TASCD 001 and *BJay Johnstone* 2017 TASCD 248.

Investigation of the deaths and evidence at inquest

Police investigation

15. Each of the seven deaths was investigated in the first instance by an allocated police officer, acting as a coroner's officer under section 16 of the Act. I will refer in this finding to each such officer as "the investigating officer". The documentary evidence compiled by the investigating officer in each case to assist in determining cause of death and how death occurred included the following;[5]

- The Police Reports of Death;
- Affidavits confirming life extinct and identification;
- Affidavits by the forensic pathologist who conducted an autopsy and provided an opinion as to the cause of death;
- Affidavits of a forensic toxicologist regarding the results of toxicological testing of the post-mortem blood sample;
- Ambulance Tasmania records of attendance and the 000 recording;
- Medical and hospital records for the child;
- Affidavits of the parent/parents and family members;
- Affidavits of witnesses relevant to circumstances of death and police video interviews;
- Affidavits of attending and investigating police officers, including Forensic Services officers and CIB officers;
- SUDI checklist compiled by the attending officers;
- CHaPS records for the child;
- Police information reports, family violence and conviction records;
- Analysis of mobile phones and electronic devices: and
- In the case of Infant 6 and his Mother, a crash investigation analysis report and court documentation regarding criminal conviction of the Father.

Serious Event Review Team (SERT) reports

16. Following the death of each child the Department undertook a critical review of CSS involvement with the child or family, including compliance with policy and procedure. The team undertaking the review was positioned outside of the service delivery operations of CSS

[5] The exhibit lists for each investigation itemise the full documentary exhibits tendered at inquest, although I have not attached them to this finding because they may tend to identify the deceased child.

but still within the Department. It produced a report which is referred to as a Serious Events Review Team report (SERT).

17. Copies of the SERT reports for each of the children were provided by the Department to the Coroners' Office during the course of the investigations. These reviews represent a very detailed summary and analysis of the involvement of CSS with the child and the child's family, including during the critical periods in the lead up to the death. Each of the SERT reports was tendered as an exhibit together with the original Departmental case records.

Expert opinion of Professor Robert Lonne

18. Expert opinion was sought to assist in determining whether and to what extent CSS action or inaction formed part of the causal circumstances attending the death of the child and for the purposes of informing the exercise of the function under s28(2) and (3), being to make recommendations and comments if appropriate.

19. The expert, Professor Robert Lonne, was well qualified to provide his opinion. He obtained his Bachelor of Social Work in 1981 and his Doctor of Philosophy in Social Work in 2002. He currently works as the Social Work Discipline Lead in the School of Health, Faculty of Medicine and Health in the University of New England. He is also Adjunct Professor of Social Work in the School of Public Health and Social Work in Queensland, having previously held the role of foundation Professor at that institution.

20. Professor Lonne's fields of expertise include systemic reform in child protection systems, community services workforce development, ethical practice in child protection and family support, policy formulation and development, and service and program evaluation. He is the author of a significant body of work including four books, 14 book chapters, 46 refereed journal articles and five government reports. He has also held national leadership roles and many other positions in his field of expertise. He has been engaged as an expert witness in child protection systems in several jurisdictions, including being heavily cited in the Carmody Commission of Inquiry involving reforms to Queensland's child protection system.[6]

21. Professor Lonne was asked to provide a report addressing the following:

    a) Do the SERT reports appear to be an honest and frank assessment of the failings in each case? (To address the cogency of the evidence in the SERT report)

[6] Queensland Child Protection Commission of Inquiry – Taking Responsibility: A Roadmap for Queensland Child Protection – June 2013.

b) If the failings appear to be correctly specified, have they contributed to a death and if so how? (To address the matters the Coroner is required to find under s28(1) of the Act).

To assist in the exercise of my functions under s28(2) and (3) of the Act, Professor Lonne was asked:

a) To identify common systems failings and the likely causes of them;
b) What issues appear to be persistent regarding practice and policy which may be connected to the deaths?
c) What reforms have been made in response to the risks in these cases?
d) Assess the efficacy or likely efficacy of these reforms.

As requested, Professor Lonne provided a detailed report in January 2020 containing his analysis and response to the questions posed. He also provided an addendum report in August 2020, before the inquest, after receiving further evidence from the Department.

Oral testimony at inquest

At the inquest itself, three witnesses gave oral evidence:

(a) Professor Lonne, whose role is described above;
(b) Ms Claire Lovell, Director of Children, Youth and Families; and
(c) Ms Mandy Clarke, Deputy Secretary, Children, Youth and Families.

Findings under s28(1) of the Act

22. My findings in respect of each child required by s28(1) of the Act are set out at Appendices A-F. The findings set out in detail the circumstances of their death and incorporate details of CSS's involvement with the child or their family. I have also set out in each finding Professor Lonne's opinion on the response by CSS to relevant notifications and his views on the relationship between CSS involvement and the death of each child.

23. Prior to the inquest, counsel assisting provided summaries to counsel for CSS at my request of proposed factual findings drawn from the documentary exhibits and the SERT reports. The purpose of providing these summaries was to assist the efficient conduct of the inquest, reduce the number of witnesses called, narrow the issues for ventilation and give notice of likely findings regarding the circumstances in respect of each death. The summaries set out the circumstances of the child's death, the relevant involvement of CSS with each child and their family, and the basic conclusions and recommendations taken from the individual SERT reports.

24. Counsel for CSS did not challenge the facts contained in the summaries that were derived from the police investigation and not related to CSS. She also did not submit that the summaries incorrectly represented the factual chronology of CSS action taken from the SERT report, nor incorrectly represented the conclusions contained within it. However, counsel for CSS submitted that the conclusions in the SERT reports should not be relied upon in the coronial process for a number of reasons, primarily due to their deliberately self-critical nature.

25. For the reasons discussed below, I do not accept that the SERT reports, when used in the coronial process, suffer from the numerous flaws asserted by the Department.

26. In each finding, the content under the headings Background, Circumstances of Death, Cause of Death, History of CSS Involvement and CSS Issues Identified in SERT Reports, is largely unchanged in substance from that provided by counsel assisting to the Department prior to the hearing.

27. It will be seen that I have concluded in respect of all deaths that, despite significant CSS deficiencies in responding to notifications, I am not able to determine to the requisite standard that the deficiencies played a causal role in the child's death.

28. I set out below in brief form my findings under s28(1) with respect to the death of each child.

Infant 1[7]

a) The identity of the deceased: *Infant 1.*
b) How the death occurred: *Co-sleeping with his mother and sibling in an unsafe sleeping environment.*
c) The cause of death: *Undetermined and described as Sudden Unexpected Death in Infancy.*
d) When and where the death occurred: *In 25 January 2013 in Northern Tasmania.*

Infant 2[8]

a) The identity of the deceased: *Infant 2.*
b) How the death occurred: *Whilst co-sleeping with his twin brother.*
c) The cause of death: *Acute pneumonia and premature birth.*

[7] Full finding attached as Appendix A.
[8] Full finding attached as Appendix B.

d) When and where the death occurred: In *August 2016 in North-West Tasmania.*

Infant 3[9]

a) The identity of the deceased: *Infant 3.*
b) How the death occurred: *Co-sleeping with his mother in an unsafe sleeping environment.*
c) The cause of death: *Undetermined and described as Sudden Unexplained Death in Infancy.*
d) When and where the death occurred: In *March 2017 in North-West Tasmania.*

Infant 4[10]

a) The identity of the deceased: *Infant 4.*
a) How the death occurred: As *a consequence of becoming submerged in water when left unattended by her mother in a child-seat in a bath.*
b) The cause of death: *Drowning.*
c) When and where the death occurred: *In September 2017 in Northern Tasmania.*

Infant 5[11]

a) The identity of the deceased: *Infant 5.*
b) How the death occurred: W*hilst sleeping on the couch with his mother in an unsafe sleeping environment.*
c) The cause of death: B*ronchopneumonia following a viral infection.*
d) When and where the death occurred: In *December 2018 in Northern Tasmania.*

The Mother of Infant 6[12]

a) The identity of the deceased: *The Mother of Infant 6.*
b) How the death occurred: W*hilst travelling as a passenger in a motor-vehicle driven by her partner.*
c) The cause of death: M*ultiple blunt injuries of the chest, abdomen and pelvis sustained in the crash.*
d) When and where the death occurred: In *June 2017 in North-West Tasmania.*

[9] Full finding attached as Appendix C.
[10] Full finding attached as Appendix D.
[11] Full finding attached as Appendix E.
[12] Full finding attached as Appendix F.

<u>Infant 6</u>[13]

a) The identity of the deceased: *Infant 6.*

b) How the death occurred: *In a crash whilst travelling as a passenger in a motor vehicle driven by his father.*

c) The cause of death: *Blunt injuries of the head and chest, sustained in the crash.*

d) When and where the death occurred: *In June 2017 in North-West Tasmania.*

General principles applied in the findings

Standard of proof

29. The standard of proof at an inquest is the civil standard. In practical terms, this means that where findings of fact are required to be made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon a person or organisation, it is well-settled that the standard applicable is that articulated in *Briginshaw v Briginshaw,* that is, that the task of deciding whether a serious allegation is proved should be approached with great caution.[14] I have been particularly mindful of applying this standard in the finding of whether any deficits in practices or actions on the part of CSS played a causative role in the death.

Causation

30. In her final submissions, counsel for the State, Ms Chen, submitted that the requisite nexus between CSS action and the causal circumstances of each death does not exist such that I not have jurisdiction to consider (to any degree) CSS compliance with policy and procedure, identification of systems failings and their likely causes, operations of CSS and reforms to CSS since the deaths.

31. Such a submission entails the adoption of an overly narrow interpretation of the circumstances surrounding and causes of the deaths. Ms Chen previously made exactly the same submission in the inquest of *Rhiannon Pitchford 2018 TASCD 511.*

32. The *Pitchford* inquest involved an infant aged 55 days who died as a result of an unsafe sleeping environment in her parent's bed. The infant had been the subject of an unborn baby notification to CSS due to concerns about the high level of risk to her as a result of multiple factors. Her sibling had been placed by CSS into foster care as a result of suffering apparently

[13] Full finding attached as Appendix F.
[14] (1938) 60 CLR 336 (see in particular Dixon J at p362).

serious non-accidental injuries in the home. In that case, I found that proper CSS practice demanded action to remove her from her parents at birth. I found that, if she had been so removed in accordance with statutory duty of CSS, she would not have died. I found that, therefore, there was a direct causative link between CSS deficits and the infant's death.

33. It is relevant to set out my reasoning in that inquest, together with the authorities, where I held that it *was* permissible for me to examine the involvement of CSS as being an inextricable part of the circumstances of death.

34. In *Conway v Jerram*, the members of the New South Wales Court of Appeal observed that the scope of an inquest is a matter for the coroner to determine using both proper discretion and common sense.[15] Campbell JA referred to *Harmsworth v State Coroner* in which Nathan J discussed the fact that the enquiry must be relevant in the legal sense to the death and that a coroner is not permitted to conduct a "*wide, prolix and indeterminate*" inquest surrounding remote issues.[16]

35. The judgments of *Re State Coroner; Ex parte Minister for Health*[17] *and R v Doogan; Ex parte Lucas-Smith*[18] also emphasise that the coroner is not authorised within his or her proper limits to undertake a roving enquiry into any possible causal connection, no matter how tenuous, between a particular fact or circumstance and the death of the deceased.

36. The coroner's function of finding *"how death occurred"* usually requires the coroner to make an assessment for the purposes of scope of the enquiry as to the substantial or operating causes of the death that are not merely part of the background or too remote. The question of causation should be determined by applying common sense to the facts and not resolved by speculative or hypothetical theories.[19]

In *Re the State Coroner; Ex Parte the Minister for Health,* Buss JA stated:[20]

> *"...In my opinion, a construction of s25(1)(b) which entitles and requires the coroner to find, if possible, by what means and in what circumstances the death occurred reflects the public interest which is protected and advanced by a coronial investigation...Also, this construction is consistent with the decision of the Court of Appeal of Queensland in Atkinson on a comparable*

[15] [2011] NSWCA 319 at [47-48].
[16] [1989] VR 989.
[17] [2009] WASCA 165.
[18] [2005] ACTSC 74.
[19] See for example: *E & MH March v Stramare Pty Ltd* (1991) 171 CLR 506; *Campbell v The Queen* (1981) WAR 286; *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1; and *Atkinson v Morrow and Anor* [2005] QCA 353.
[20] At [42].

statutory provision...

44. The coroner, in finding, if possible 'the cause of death', is not confined or restricted by concepts such as 'direct cause', 'direct manner', 'direct and natural cause', 'proximate cause' or the 'real or effective cause'. Similarly, a coroner is not confined or restricted to a cause that was reasonably foreseeable...

47. It will be necessary, in each inquest, to delineate those acts, omissions and circumstances which are, at least potentially, to be characterised as causing or a cause of death of the deceased. This is to be undertaken by applying ordinary common sense and experience to the facts of the particular case."

37. Additionally, the wide powers given to a coroner in this state under s28(2) to make recommendations *"with respect to ways of preventing further deaths"* also support a broad construction of powers to make findings under s28(1) as to *"how death occurred"* and the *"cause of death"* within the parameters of the authorities, such as those cited above.

38. I have not found that CSS played a causal role in any of the seven deaths in this inquest, although this finding was not without difficulty in respect of six of the deaths, particularly the death of Infant 6. As is seen from the individual findings, the circumstances surrounding all but the death of Infant 1 involved CSS having an active statutory responsibility to take steps to mitigate risk to the child in response to a notification. In the case of Infant 3, the Secretary had custody at the time of his death and was therefore responsible for the daily care and control of the infant.[21] As explained in the finding, Infant 3 was therefore 'held in care' and I am mandated by the Act to comment upon the care, supervision and treatment by CSS. In the case of Infant 1, it appeared from the investigation that CSS was unaware of his birth because of a failure to respond adequately to multiple previous notifications in respect of his siblings advising of serious risk.

39. In all cases, it appeared that there were deficits in CSS exercising its statutory responsibility and, in six cases, at a time proximate to the death. I therefore reject the submission, as I did in the *Pitchford* inquest, that there is insufficient nexus between the deaths and the role of CSS. In one case, I was bound to consider it. In all cases, it appeared that incorrect practice may have contributed to death or, as I have ultimately found, resulted in a missed opportunity to protect the child to a significantly greater degree.

[21] Section 6 of the CYPTF Act.

The approach to the involvement of CSS in the circumstances of the deaths

40. Below, I set out a number of overarching matters I have taken into account in considering, in each case, the role of CSS in the circumstances of the death and in reasoning to my conclusions regarding causation. These are to be read in conjunction with my reasoning contained in the individual findings.

a) The parents of each child had the primary responsibility for the care of the child.[22] In the context of the six vulnerable infants this entailed, relevantly, the need to provide the infant with timely medical and nursing care, a safe sleeping environment, a safe bathing environment, and due care and attention when transporting the infant in a vehicle. These obvious protective measures were known, or should have been known, to the parents of the infants.

b) Correct safe sleeping practices had been discussed with the parents by CHaPS nurses and other health professionals in respect of the deceased infant and in some cases, on multiple occasions after the birth of older children. This advice included that the infant should sleep on his/her own sleep surface on his/her back and clear of adult bedding. Contrary to this advice, unsafe sleeping environments attended the death of three infants, and the environments were created by their parent, albeit not expecting the infant's death.

c) CSS, in six cases, was actively engaged in its statutory function to respond to a notification or notifications and in five of these cases the child was an infant unable to protect itself. Despite the failures in practice, I am conscious of the statutory requirements imposed upon CSS that: (a) a child should only be removed from his or her family if there is no other reasonable way to safeguard his or her well-being,[23] and: (b) if a child is removed, the child should continue to have contact with his or her family and eventually be returned to reside within the family (as far as is practicable and consistent with the best interests of the child).[24] I therefore do not underestimate the influence of this requirement in the CSS decision-making. In this regard, I also bear in mind Professor Lonne's evidence that the research in Australia indicates that the process of removal has clear, demonstrable harms for many children and that the decision to remove an infant should be taken "*very seriously*" because of that fact. He said that it is preferable that, in the first instance, the parents are provided with

[22] Also note section 10C(1)(a) of the CYPTF Act.
[23] Section 10C(3).
[24] Section 10C(4).

intensive support and assistance to enable the standard of parenting to be good enough for the child to remain safely at home.[25]

d) In coming to the findings in the individual cases, I have accepted for the large part the analysis of Professor Lonne. His reports were thorough, analytical and responsive to the issues being examined. His expertise was impressive. His oral evidence was measured, kind and understanding of the workload and pressures associated with the child protection system. He was able to conduct his analyses without unrealistic hindsight loading and was able to provide good reasons why CSS had performed well in some instances and how that work had reduced risk to the infant.

e) Determination of a causative link in the six cases in which the Secretary did not have custody of the child involves making an assessment of whether a court would grant a particular order removing a child from home. In some cases, such as in the inquests of *Pitchford* and *Johnstone*, such a conclusion is not difficult.[26] However, bearing in mind the standard of proof, I have not been able to make this finding in any of the cases in this inquest.

f) I have been strongly guided by Professor Lonne's expertise in child protection regarding whether CSS's action or inaction has contributed to any of the deaths. I have accepted his opinion on all except the deaths of Infant 6 and his Mother. I have given my reasons for this conclusion in the finding. My duty as coroner is to form my own view with due regard to his conclusions. Upon my consideration of the circumstances of all of the deaths, it is difficult to make the distinction between contribution for the death of Infant 6 and the death of, say, Infant 3. In respect of Infant 3, the Secretary had the responsibility of custody and was aware of the high level of risk. A good case could also be made for the removal by CSS of Infant 5 from his home for the reasons contained in his finding. However, I do not consider that the causal role is made out, particularly in comparison to the factual circumstances of the previous inquests to which I have referred to above.

g) I bear steadily in mind that hindsight analysis provides 'clarity' not available at the time of the occurrence of the relevant event. In *Rosenberg v Percival* Gleeson CJ stated:[27]

[25] Transcript 24 August 2020 page 50 to 51.
[26] See also *Hayes* 2018 TASCD 208.
[27] [2001] HCA 18; (2001) 75 ALJR 734.

> *"In the way in which litigation proceeds, the conduct of the parties is seen through the prism of hindsight. A foreseeable risk has eventuated, and harm has resulted. The particular risk becomes the focus of attention. But at the time of the allegedly tortious conduct, there may have been no reason to single it out from a number of adverse contingencies, or to attach to it the significance it later assumed. Recent judgments in this Court have drawn attention to the danger of a failure, after the event, to take account of the context, before or at the time of the event, in which a contingency was to be evaluated."*[28]

41. The above passage is particularly relevant to my consideration of causation and contribution. It addresses the issue of too-easily constructing a 'systems failure' chain of causation in deaths of the type I am investigating in this inquest.

Value of the SERT Reports

42. In the investigations and inquest, I have placed significant reliance upon the contents of the SERT reports as accurately recording the facts of CSS involvement and providing a frank and thorough analysis of CSS practice. The reports employ clear language and helpful explanations, have a logical structure, are detailed in content and contain carefully reasoned opinions.

43. The Serious Event Review Team (SERT) commenced operation in 2017 with the aim of creating a standardised approach to serious event review and promoting continuous quality improvement within CYS/CYF. The Team undertakes reviews of cases where a child has died or suffered a serious injury and has been involved in the CYS/CYF system within the preceding three years. The team comprises two or more full-time staff, including reviewers.[29] The SERT is positioned outside the service delivery operations of CYS/CYF and maintains independence from it. The SERT reports directly to the Deputy Secretary Children. Referrals may come from the Deputy Secretary Children or a range of other sources.

44. Procedures have been developed for conducting the SERT review process including the triage of referrals, the interviewing and supporting of relevant staff members, moderation of draft SERT reports, feedback to staff after the SERT report and consideration by the Serious Event Review Committee (SERC). I note that SERC is an independent, multiagency committee comprising senior representatives of government agencies external to CYS/CYF. The role of the SERC focuses upon consideration of the SERT reports to identify systemic issues.

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[28] At para [16].
[29] Exhibit G2 Affidavit of Gail Eaton-Briggs, former Deputy Secretary Children.

45. As noted above, Ms Lovell on behalf of CSS, was critical of the SERT reports in coronial proceedings, stating that they could not be considered credible or reliable for the purpose of an inquest. She made numerous criticisms of the reports, all of which I have carefully considered. The main grounds of her criticisms involve the reports being prepared from a perspective of "*theoretical best practice with the benefit of hindsight*", represent the subjective opinion of the Reviewer and do not reflect the reality of casework. She also criticised the SERT reviews for being overly focused on procedural compliance, not dealing with the difficult consequences of tightening processes and procedures, and failing to focus upon the quality of the approach used by caseworkers. She further stated that the reviews were overly narrow in several respects – not covering the conduct or practice of other services outside CYF, having inadequate reliance upon conversations and interviews, the lack of comparison to other cases and themes within the state, country or internationally. She criticised the process for taking a "*simplistic*" view of risk assessment and the consequences, leading to a lack of confidence in decision-making.[30]

46. In his report of August 2020 Professor Lonne responded to each of Ms Lovell's criticisms in a logical and credible manner based upon the research and breadth of experience in this area.[31] Whilst I do not set out his response to every criticism, I am persuaded by his reasoning and prefer his evidence over that of Ms Lovell in this regard. In his report, he stated:

"*...What the research evidence shows is that despite the advantages of using risk assessment in child protection, it remains prone to practitioner error and that this is influenced by the organisational context and culture in which it occurs.*

For these reasons, retrospective case reviews in Australia typically involve experienced senior practitioners re-examining the facts with fresh eyes in those cases where there has been child deaths or serious injuries and undertaking a further risk assessment as part of the review process. There are potential limitations due to the retrospectivity necessarily involved in this but these can be managed with proper oversight of the review process and through other measures that promote objective analysis. It is important for child protection agencies to have knowledge about the reliability of their staff risk assessments both in general practice, and when tragedies have occurred. In my view this is being thorough and ethical because if things are going awry the agency needs to know about it, and understand what is going wrong and why this is happening, and then gather the information that will aid the development of remedies."

47. He further stated in conclusion:[32]

[30] Exhibit G3.
[31] Exhibit G5.
[32] Exhibit G5 page 15.

"I remain unconvinced by the rationale provided in Ms Lovell's affidavit for her conclusion that the SERT reports lacked credibility and reliability for their use as sources of information for the initial analysis I undertook of departmental actions with respect to the 7 children who died. All sources of information and research/analytical methods have their limitations but this does not equate, in my view, to the SERT reports having no use or legitimacy in assessing the adequacy or otherwise of Department actions. Moreover, case review methodologies such as the SERT reports are utilised around the Anglophone world as strategies for learning and program development."

48. It is important to note that Professor Lonne specifically addressed Ms Lovell's opinion that the risk assessments undertaken in the SERT reports relating to the seven children provided that, on some occasions, a protective response was warranted in the face of a generalised set of risk factors when, in real practice, this would be unethical and an overreach of power. Professor Lonne stated that Ms Lovell's deduction was erroneous because it was clear from the reports that the Reviewer *was* dealing with matters specific to the case at hand and he could not discern in the SERT reports any unethical assessments or recommendations made about risk.

49. Upon my consideration of the SERT reports, I am in full agreement with Professor Lonne. I also add that I found the SERT reports to recognise good practice at appropriate times and generally focused upon deficiencies in procedure rather than reasoning to the 'correct' outcome. Coroners regularly receive internal reviews of systems in a variety of cases and are required to assess their utility in the investigation. Appropriate weight may then be given to such reviews in light of all of the evidence received in the investigation.

50. I am satisfied, however, that the SERT reports relating to the seven children are of high quality notwithstanding that I should approach opinions contained in them with due care. The SERT reports have assisted me considerably in performing my functions in this inquest as they have in numerous other cases since the implementation of the SERT process.

51. I note Ms Lovell's evidence that the issues with the SERT process as she described in her affidavit led to the commissioning of an external review of the process and, as a result, the process was terminated shortly before the holding of this inquest. The senior staff members of the SERT were relocated to another area. The new review process, the Signs of Safety Quality Improvement System is intended to overcome the perceived limitations of the previous process.

Recommendations and Comments pursuant to section 28(2) and (3) of the Act

Power to make recommendations and comments

52. Whilst I have not found that CSS action or inaction played a causal role in the deaths of the children, I am nevertheless empowered to make comments and recommendations within the limits specified by the Act.

53. In the decision of *Thales Australia Limited v The Coroner's Court of Victoria*[33] the Victorian Supreme Court rejected a submission, similar to that made by counsel for CSS, that if the coroner were unable to make a finding on the cause of death the coroner would have no power to comment or make recommendations. Beach J stated:[34]

"This submission was without substance. To the extent that it was pursued in these proceedings, I reject it. There may be many cases where the cause of death is uncertain, but that the circumstances in which the death occurred give rise to significant and substantial matters relating to public health and safety or the administration of justice. Neither the text of s 67 of the Coroners Act, nor the Act when read as a whole, limit the power of the Coroner to comment on such matters provided they are "connected with the death" which is being investigated. The same may be said of s 72(2). To hold otherwise would be contrary to the text of ss 67 and 72 and the purpose of the Act when read as a whole."

54. I respectfully follow His Honour's reasoning. The degree to which CSS was involved with the children and their families in its statutory capacity, together with the practice issues leading to missed opportunities to have changed the ultimate outcome, provides the requisite connection with the deaths to enable comment.

55. In the following section of this finding, I make the following comments pursuant to my power to do so.

Professor Lonne's brief

56. When Professor Lonne was briefed to provide a report in respect of each of the children he was also asked to look at my findings made following inquests into the deaths of *BJay Johnstone* and *Rhiannon Pitchford*.

57. Professor Lonne used the nine cases to study and report on:

[33] [2011] VSC 133.
[34] At para [71].

a) Common systems failings and the likely causes of them;

b) What issues appear to be persistent regarding practice and policy which may be connected to the deaths;

c) What reforms have been made in response to the risks in these cases;

d) Assess the efficacy or likely efficacy of these reforms.

58 Professor Lonne reviewed and summarised information in chronological order of the date of death of each child. Professor Lonne set out in detail certain characteristics of each of the cases examined in order to gain insights into how system responses altered over time.

Common systems failings – Professor Lonne's opinion

59 He identified broadly the risk factors common to some of the cases including the vulnerability of infants, the economic/social disadvantage of their families, the young age of some of the parents, the involvement of family and domestic violence and illicit drugs. He said:

"The characteristics outlined above are clearly identified in the research and literature as being associated with a higher likelihood for child maltreatment. Most cases had a number of these factors present. Cumulative harm was generally identified to be characteristic for these children."[35]

60 He went on to examine the characteristics of CSS involvement, examining factors central to the legislative responsibilities and policy framework of CYS/CSS. These included:

- The extent to which the Intake process met organisational standards;
- The adequacy of Response processes meeting organisational standards;
- The timely use of the Tasmanian Risk Framework (TRF);
- Whether the child was sighted;
- The extent to which the reports indicated that the recording of information collected was adequate;
- The adequacy of Safety Planning;
- How many of the cases had cumulative harm specifically addressed;
- The adequacy of the CYS/CSS and other agencies' communication with the family;
- Responding in a timely fashion to notified concerns;
- The adequacy of CYS/CSS communication internally and with external agencies;
- the adequacy of supervision provided to CYS/CSS staff;
- Whether workforce issues impacted on each case.

[35] Report Professor Lonne para 5.23 – p12.

61 Against most of these indicators Professor Lonne identified steady or slow improvement in practice over the course of CSS involvement with these families. However, in the area of risk assessment, he described the progress as "*patchy*". In the area of dealing with cumulative harm, he formed the view that there was "*significant space for improvement in practice regarding the routine assessment of cumulative harm and future risks of harm.*"[36] Professor Lonne also noted that there was inadequate information in many of the SERT reports to determine the adequacy of staff supervision and, in the earlier reports, the impact of workforce issues.

62 Professor Lonne then identified more broadly that system failings in these cases included the following:[37]

a) Intake process responses have been deficient, (and in some cases defective) and in particular:

- Collection of information was not timely;
- Not all relevant historical information was accessed leading to an inadequate assessment of family history;
- A systems tendency towards transfer of risk to other agencies;
- Workplace staffing issues appearing to affect intake processes including the collection of information and causing delays in referral to Response.

b) Response processes were overloaded and problematic, as evidenced by delays in transfer from Intake and delayed processing by Response;

c) Risk assessment quality was significantly defective in 6 out of the 9 cases examined. There was variable quality evident in the risk assessments which, in some respects, reflected information collection issues. In particular:

- Information sources crucial to the child's involvement with CYS/CSS or other agencies was not sought or gained;
- The risk assessment did not include important information from earlier risk assessments and events including information in CPIS;
- The assessment of cumulative harm was not adequately addressed;
- The Tasmanian Risk Framework (TRF) was not completed or not completed in a timely fashion in accordance with policy timeframes; and
- The risk assessment did not take into account the full risks to the child.

[36] Professor Lonne report 27 January 2020 para 6.14.
[37] Professor Lonne report 27 January 2020 page 22ff.

d) Safety planning was inadequate;

e) Assessment of cumulative harm was frequently absent;

f) Workplace issues impacted upon performance at critical times, notably, high workloads and inadequate supervision; and

g) Workforce issues such as recruitment, retention and training of staff impacted on the practice standards.

What issues appear to be persistent regarding practice and policy which may be connected to the deaths?

63 In relation to this issue, Professor Lonne said:[38]

"The crucial issues found in these cases entailed the apparent inconsistency in:

- *The thoroughness of the information collected regarding the child's current situation and family's history of care providing, including utilising earlier risk assessments, and information concerning the associated social problems of FADV and the use of A&OD, and involvement with police concerning criminal offending;*
- *The adequacy and timeliness of the completion of risk assessments of the children at the initial phases, but also in subsequent circumstances where new information came to light that ought to have caused a revision of the nature and level of identified risks;*
- *The propensity to prematurely close cases under the assumptions that other agencies were continuing to work closely and effectively with the family;*
- *The lack of attention to the issues and assessment of cumulative harm;*
- *The quality of the Safety Planning undertaken; and*
- *Poor internal communications with colleagues including of the oversight of case-related decision making.*

These issues in Intake and Response and case work were identified in most cases to a greater or lesser degree. In this sense they were persistent, although as outlined earlier, there was emerging evidence in the cases studied of gradual improvements in these areas. Two broader systemic issues that appear to be persistent relate to the problems identified regarding:

- *Workplace issues including supervision and dealing with periods of work overload; and*
- *Workforce issues including training, staff turnover, recruitment and retention.*

[38] Professor Lonne report 27 January 2020 p32ff.

These latter aspects are likely to be impacting on service delivery consistency and the ongoing attainment of quality service delivery."

Professor Lonne's view of recent CSS reforms in response to the issues, and the likely efficacy of the reforms

64 In his report, Professor Lonne set out the main aspects of the Department's 2016 *Redesign of Child Protection Services Tasmania "Strong Families – Safe Kids"* reform agenda and other associated reforms. I will deal in more detail with these below, as I received significant evidence from the Department about these reforms. Professor Lonne formed the opinion that the "*overall thrust*" of these reforms appears in line with trends towards a public health approach in Australia and overseas.[39]

Recommendations proposed by Professor Lonne

65 Professor Lonne suggested 11 recommendations following his examination of these cases. They are as follows:[40]

a) That a policy and procedure be developed to enable a process for staff to access real-time assessment information concerning risk of significant harm for existing cases so that identified high-risk cases are able to be quickly identified, particularly in situations where new cases are arriving and/or high demand work periods occur.

b) That an accessible procedure/directive is developed to require CSS Managers to notify in a timely way the CYS Executive about situations where workload demands are not able to be satisfactorily addressed with current resources and thereby significantly restrict compliance with policy and procedural requirements.

c) That a statewide system for ongoing auditing of compliance with policy and procedural requirements be developed and implemented, with annual reports available regarding outcomes.

d) That SERT reports include consideration of the contributions that workplace climate, culture and the quality of supervision, management and leadership make in achieving required practice standards.

e) That, if not yet available, the CSS undertake a comprehensive workforce analysis and finalise the development of the Workforce Development Strategy in consultation with other relevant stakeholders.

f) That CYS/CSS develop, if not yet available, a comprehensive Workforce Training and Professional Development Plan as part of the recommended Workforce Development Strategy.

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[39] Professor Lonne report 27 January 2020 p38–39.
[40] Professor Lonne report 27 January 2020 p46-47.

g) That a meta-analysis of the issues, failings and learnings identified in SERT examinations be conducted on a regular basis and these be accessible to all CYS/CSS staff and inform the recommended Workforce Training and Professional Development Plan.

h) That a robust evaluation of the efficacy of CYS/CSS and joint training programs and packages be undertaken on a regular basis with results/learnings used to review the CYS/CSS Workforce Training and Professional Development Plan.

i) That the Monitoring and Evaluation Framework concerning the *'Strong Families, Safe Kids'* reforms be finalised and publicly released.

j) That surveys of client experiences of CSS services be a measure considered as part of the Monitoring and Evaluation Framework.

k) The effectiveness of the Advice and Referral Line (a key reform of the front door) and the initial assessments of children and family's risk and well-being, and needs for support, be measures considered as part of the Monitoring and Evaluation Framework.

The Department's response to Professor Lonne's first report

66 Ms Claire Lovell, Director of Children and Family Services and Ms Mandy Clarke, Deputy Secretary, CYF, provided evidence by way of affidavits and gave oral evidence at the hearing, and responded to the evidence of Professor Lonne. I deal with their evidence below.

67 I also had the benefit of an affidavit filed in the *Pitchford* inquest in 2018 sworn by the then Deputy Secretary Children, Ms Gail Eaton-Briggs, who provided evidence of the commencement of systemic reforms since 2015 to redesign the child protection system in Tasmania. She stated that these were the result of *Strong Families, Safe Kids* Project (SFSK). She said that the changes were being made partly in response to the findings in the inquests of BJay Johnstone in June 2017 and Teegan Hayes in May 2018.[41]

68 Ms Eaton-Briggs described a key part of the SFSK project as being the establishment of the Children's Advice and Referral Service representing a single point of entry for people seeking information, advice and communicating concerns for the safety and well-being of children. She stated that the new service would replace the current dual pathway provided by CSS and Gateway (non-government support services). Ms Eaton-Briggs also described the introduction of Intensive Family Engagement Services (IFES) to provide early and intensive support to vulnerable families and children to prevent the need for statutory intervention.

69 These reforms are now in operation and will be discussed further.

[41] Exhibit G3C Annexure A and Exhibit G2C Annexure B.

Ms Lovell's evidence

70 I set out below Ms Lovell's response in respect of the areas of common systemic failure identified by Professor Lonne and the way in which reforms were addressing those issues.

71 With respect to Professor Lonne's findings about deficiencies in the intake processes, Ms Lovell said:[42]

"The relevant procedures and practice of advice (ARL) were updated to coincide with the opening of the service. These processes are much improved to the processes being used at the time of each of the six deaths the subject of this inquest (noting the seventh death, that of [Infant 5], occurred only weeks after the ARL commenced on 3 December 2018).

Information is more readily accessible via systems and other information sharing arrangements with key services.

Consultation and support is also more readily available. The current location of government and non-government staff within one service allows expertise relating to family support options and more forensic aspects of, and response to child abuse and severe neglect, to be readily shared between staff.

ARL now routinely make contact directly with families very early on following the receipt of a concern.

Liaisons are available in the regions to undertake face-to-face assessment if necessary, to assist with referrals and to carry out and role model more conservative approaches to engagement with families where necessary.

Decision-making is concluded in a more transparent and collaborative way and does not rely on one person.

Referrals and handovers to other services are conducted in a more collaborative way to ensure that assumptions are not made about the acceptance of another service, its capacity to respond and achieve necessary goals, and its timeframe for doing so."

72 With respect to deficiencies outlined by Professor Lonne in the CSS Response processes Ms Lovell said:[43]

"CSS has introduced a variety of ways to mitigate the risk of delay in allocation; and to reduce the likelihood of harm occurring when delay cannot be avoided.

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[42] Exhibit G3 p12.
[43] Exhibit G3 p12 para 65.

The hand-over process from ARL to CSS Response has improved with briefings and being a feature of transfers.

Risk assessments undertaken by ARL are comprehensive and of a consistently higher standard than those conducted by the former intake services. This is because of the different approaches to gather information, the consistency of training and the quality assurance measures built into the process when cases transfer to CSS response, there is generally very little "unknown" information which needs to be gathered ahead of commencing direct family engagement.

A new procedure was implemented in 2018 to coincide with the commencement of ARL to clarify responsibilities and steps to be taken when new issues are reported for children who are already allocated or who are awaiting allocation at CSS. When cases can't be allocated immediately this process is used to continuously adjust the risk assessment accordingly and triage for priority allocation.

Priority tasks, including visits are undertaken as required until the case can be formally allocated to a lead worker.

CSS also has processes in place to respond better to periods of peak demand. It is normal for qualified staff from liaison positions to be mobilised to assist CSS Response."

73 Ms Lovell then addressed Professor Lonne's findings about deficiencies in CSS risk assessments, stating as follows:[44]

"As mentioned, risk assessment practice has improved, with all staff now being trained in the use of relevant frameworks, and having Clinical Practice Consultants and Educator's (CPCEs), and other senior staff available to provide support and guidance as staff are still learning, and/or as they face a new or complex scenario.

Where risk assessment was often previously a solitary activity, and sometimes only completed to enable a workflow, the process has been "opened up" in recent years with consultations and collaborative case review and case decision-making forums being the norm in both ARL and CSS.

Risk assessments have been enriched by the dual use of the Signs of Safety Approach, and more recently the use of the Child and Youth Wellbeing Framework. Each of these approaches, and frameworks can help to gather, analyse and make sense of available information to inform plans and decisions.

Most reviews and audits draw into question the quality practitioner skill in analysis of material gained through assessments, and the judgement used to inform decision making. Taking action to improve

[44] Exhibit G3 p13 paras 66-73.

worker capability in analysis and decision making cannot be left to the creation of all procedures or to subjecting staff to more training. This has been tried before, with uncertain outcomes.

Work is progressing now to achieve an improvement in the level and timeliness of direct practice leadership and guidance to improve child safety assessment and decision making, at the time the guidance is required by the practitioner, the care team and the child and the family.

Focus is being placed on enabling a broader collection of psychosocial material to inform the assessment process, greater transparency to the analysis and decision-making process and the ongoing case management of children and families through collaborative decision-making forums, and a team approach to case planning.

Reform work will further strengthen these commonly referred to weaknesses in practice, by supporting the workforce to recognise the impact of the normative views on how they construct meaning about parenting, risk and safety, and the tension between structural and individual responsibilities.

Success in the application of this more direct approach on improving practice will be monitored through the implementation of the Signs of Safety Quality Assurance System which will bring together collaborative case audits, family and workforce feedback and core data to create a continuous learning cycle and a system for continuous growth."

74 With respect to Professor Lonne's criticisms of the inadequacy of Safety Planning processes Ms Lovell said:[45]

"Safety planning in relation to child abuse is one of the most complex and high-risk social work tasks. It is made most difficult when faced with denial, hostility and refusal by parents and other important people to engage with the process.

Staff are trained and provided tools and avenues for guidance and support to undertake safety planning. However, no two cases are ever the same. Safety planning is an iterative process. It works best when staff are guided by experienced practitioners, and have the support of the organisation and other key stakeholders in the community, as they attempt to navigate a family away from danger and towards safer outcomes.

CSS is continuing to embed the Signs of Safety Approach, and is gradually developing the skills and confidence of the workforce to apply it well.

Mastering Safety Planning is a long-term goal for CSS. It is difficult and requires an appetite for sensible risk practice, not only within CYF but within the community. It is, however, essential as a

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[45] Exhibit G3 p14 paras 74-77.

reliance on point-in-time risk assessment, without equal focus on risk assessment during safety planning processes, will limit the ability of CSS to safely preserve families and reunify children."

75 With respect to Professor Lonne's findings about the failure in the cases to recognise cumulative harm in risk assessments, Ms Lovell responded:[46]

"Cumulative Harm procedures and practice advice were revised in 2018 to coincide with the commencement of ARL. The current practice advice is more contemporary than the original 2000 version, which was current at the time of all except [Infant 5's] death in December 2018.

The current advice is heavily based on the work of Leah Bromfield and Robyn Miller's 2010 Specialist Practice Resource titled Cumulative Harm – Best Interests case practice model. This work is still used by the State Government of Victoria to guide practice. That research and practice advice formed the basis of current training delivered to the child safety workforce (including non-government staff in ARL) and all new staff as part of the induction program."

76 Workplace Issues were also addressed by Ms Lovell in response to Professor Lonne's findings on problems identified from the cases: [47]

"CYF carefully monitors workload data and attempts to balance the desire for smaller workloads against the need to be responsive to incoming demand. Increasing use of the Care Team approach and the introduction of many new positions within the service through the Safe Families Safe Kids project and other initiatives has helped to improve workplace issues.

Unit Coordinators provide much needed administrative support; course coordinators in each region assist with legal work; Family Law Court Liaisons have recently been appointed to help facilitate joint work across the Federal Court and Child Safety Service/ARL; Hospital/CSS liaison officers are now appointed in each region; Support Workers whose role was previously to facilitate contacts now offer broad case aid support to CSS; Assistant Managers were appointed in the North and North-west and a second manager in the South; Intensive Family Engagement Service and Out of Home Care were also allocated their own management oversight. The Clinical Support Team has grown and currently comprises two Managers (North and South) and nine Clinical Practice Consultant and Educators, and Senior Quality Practice Advisors to support improved clinical practice within the Child Safety Service and ARL.

Time limited projects are currently in place to focus on restoration, interstate and intrastate case transfers and casework and progressing third party guardianship arrangements. This assistance is

[46] Exhibit G3 p14 paras 78-79.
[47] Exhibit G3 p14 paras 80-86.

reducing pressure in case management teams and creating capacity for work flow and work allocation in the Response and short-term child safety teams.

Professor Lonne outlines the different forms of supervision that are essential in assisting staff to deal with the complex matters they face. Formal professional supervision has improved in recent years with all supervisors being trained in and supported to apply the Excellence in Supervisory Practice Excellence (PASE model of supervision) through Amovita International.

PASE provides a formal and structured opportunity for staff to explore practice issues, receive education, guidance on tasks and support from the supervisor. A recent staff survey indicated that staff report benefit in the use of four domains.

Importantly, though, since 2017 opportunities for practice supervision and on-the-job education have been bolstered by the introduction of Clinical Practice Consultant Educators (CPCE). As discussed in the affidavit of Gail Eaton-Briggs. CPCE's use every interaction as an opportunity to increase the confidence and competence of child safety practitioners in understanding and applying quality practice.

CPCEs provide opportunities for live and practical advice and support; targeted mentoring sessions; formal consultation around complex matters; and group opportunities for practice exploration, reflection and learning."

77 In response to the workforce issues identified by Professor Lonne, Ms Lovell said:[48]

"CYF has made great gains in workforce development in recent years with the new and revised training packages being finalised and implemented. Formal training is now supported by other learning strategies to ensure that staff are supported to apply the learning through watching, doing and reflecting. Each new package is developed to achieve this, and some functions require evidence of completion before an employee is deemed competent. In addition to in-house training, the CYF Workforce Development team collate and share other relevant training opportunities. Annexure B is a copy of a (sic) July's Professional Development opportunities provided to staff.

In 2017 improvements were made to staff induction and orientation processes with a formal program of l:l introductory sessions, including practice and well-being sessions occurring for each new staff member, along with the induction program of training.

The new positions created in recent years have assisted in maintaining strong experience within CSS. Senior staff educate others, and can be mobilised where assistance is needed most during periods of high demand and unplanned leave. Professional expertise is also harnessed through the competency-

[48] Exhibit G3 p15 paras 87-90.

based Allied Health Professional progression process where experienced and high performing staff are assessed for promotion.

CYF is currently reviewing workforce management strategies to ensure that the Agency maintains its low rate of front-line vacancy and continues to increase flexibility in the workforce to be responsive at times of high demand or service stress."

Ms Clarke's evidence

78 The affidavit of Ms Clarke addressed at a broader level the reforms which have been made by the Department since a review was initiated in August 2015.[49]

79 Annexed to the affidavit of Ms Clarke was a report of a reference group led by Professor Maria Harries.[50] This report was commissioned by the Minister to inform the redesign of child protection services in Tasmania. The report, published in March 2016, entitled *Redesign of Child Protection Services: Strong Families, Safe Kids* (SFSK), made a number of recommendations including, relevantly to this inquest:[51]

- The promotion of child safety as shared community responsibility and to articulate the role of CSS within that broader service system for child safety (Recommendation 1);
- Working towards a common approach to define and respond to risk across that wider service system (Recommendation 2);
- Education and training across the multiple providers of primary and secondary support for children to promote shared understanding of and effective response to need for supports for children and families (Recommendation 3);
- A review of the effectiveness of arrangements between CSS and Community Based Intake Services to optimise efficiency and accessibility (Recommendation 8);
- Transitioning the existing regional Intake services to an Advice and Referral Service managed under a single state wide structure, with expertise to assess needs identified by notifiers and other skills for building strength in children and families (Recommendations 7 and 16); and
- The development, in conjunction with the non-government sector, of an assertive family support service and review the range of services to determine whether further evidence based interventions could be introduced (Recommendation 17).

[49] Exhibit G2.
[50] Exhibit G2a Annexure C.
[51] Exhibit G2a Annexure C p8.

80 Ms Clarke stated that the Intensive Family Engagement Service (IFES) was introduced as part of the SFSK redesign project to provide practical and therapeutic support for families with significant levels of risk. The service is provided by a number of non-government organisations and is designed for early engagement with vulnerable families and children, "*with the aim of building parental capacity and addressing risks to prevent the need for statutory intervention and allow children to remain safely in the family home*".[52]

81 Ms Clarke noted that after the initial 12 month trial period, the IFES services was reviewed by the University of Tasmania and she annexed to her affidavit a copy of that evaluation of February 2019.[53]

82 Ms Clarke gave evidence that the SFSK project is underpinned by the Child and Youth Wellbeing Framework which creates a common language for child and youth wellbeing in this State.[54] She annexed the Framework to her affidavit. The document itself states its aim as providing a contemporary definition of child and youth well-being with the aim of ensuring that personnel in all parts of Tasmania's service system and in the broader community have a strong, common understanding of child and youth well-being. The Framework incorporates a Child and Family Well-being Assessment Tool.

83 Ms Clarke attested that the Advice and Referral Line (ARL) was set up in response to the recommendations of the SFSK project.

84 Ms Clarke outlined in her affidavit the workings of the ARL and Child Safety Response and set out the current policies and procedures in the CYS Practice Manual.[55]

85 In respect of the ARL, an Initial Assessment (being a preliminary safety assessment), is undertaken by the staff member involved in a contact or conversation with a caller. During this stage, ARL staff members gather appropriate information about the child, the family, the concerns and current safety issues sufficient to inform the assessment. If there is insufficient information to demonstrate reasonable grounds that a child requires statutory intervention, the matter may be referred for other services or not pursued further. If the information suggests a further assessment is required and possible intervention, the ARL will transfer the case (classifying it as having priority 1, 2 or 3) to the CSS Response teams for a Child Safety

[52] Exhibit G2 p2 paras 14 and 15.
[53] Exhibit G2 p2 para 16 and G2b Annexure E.
[54] Exhibit G2 p3 para 19 and G2c Annexure F.
[55] Exhibit G2 p3 para 25.

Assessment. The procedures applicable to a Child Safety Assessment at Response then apply.

86 Ms Clarke also described an information system developed in 2018 which integrates with the existing CPIS system and used by CSS officers. The system is known as the Children's Advice and Referral Digital Interface (CARDI).[56]

87 Ms Clarke then outlined the implementation of quality and practice improvement plans, the introduction of a new Quality and Performance Team within CYF and the Quality Improvement System which will formalise the cycle of practice improvement.[57]

88 Ms Clarke advised that the new Terms of Reference had been implemented for the Three and Under Panel to include a broader range of expertise. The purpose of these changes was to fully harness the expertise of the panel and empower them to provide practice advice rather than simply endorsing case closure or not.[58]

89 Ms Clarke outlined staff training and induction processes developed since 2018 and noted that a specific training package for team leaders is under development.[59]

90 With respect to improvement in risk assessment, she advised that the Child Safety Assessment and Decision Making Codesign Group commenced work in July 2020. She stated that the group will build on the reform agenda established through SFSK and recommendations from the March 2019 audit and review of several practice areas.[60]

Ms Clarke's responses to Professor Lonne's recommendations

91 I replicate below Ms Clarke's comments in her affidavit responding to Professor Lonne's suggested recommendations for addressing the deficiencies he found in his assessment of the cases:[61]

a) That a policy and procedure be developed to enable a process for staff to access real-time assessment information of risk of significant harm for existing cases so that identified high-risk cases are able to be quickly identified particularly in situations where new cases are arriving and/or high demand work periods occur.

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[56] Exhibit G2 p8 para 30.
[57] Exhibit G2 p8 para 35.
[58] Exhibit G2 p8 para 36.
[59] Exhibit G2 p8 paras 39-41.
[60] Exhibit G2 p10 para 53.
[61] Exhibit G2 p12ff.

"It is not disputed that staff must have timely access to relevant information to inform risk assessments and the triaging of those cases for response.

The SFSK Advice and Referral Line and CSS now has access to integrated client information reports which are run overnight and will return a snapshot of involvement information from all relevant Tasmanian services.

Our agency staff have access to relevant information systems relating to family violence and seek priority access to necessary information by the Safe Families Coordination Unit at any time. Our agency staff also have access to medical information systems and have in place relationships with other agencies to facilitate the sharing of information as necessary.

Capacity for improved data-sharing is ever-evolving with many agencies, both in Tasmania and nationally, undertaking projects and legislative reform work to allow more seamless and integrated data sharing.

Communities Tasmania is currently in the process of scoping legislative change required to allow for CYF to participate in a national child safety data linkage system with interstate Child Welfare Agencies."

b) That an accessible procedure/directive is developed to require CSS Managers to notify, in a timely way, the CYS Executive about situations where workload demands are not able to be satisfactorily addressed in current resources, and thereby significantly restricts compliance with policy and procedural requirements.

"ARL and CSS are each demand driven services which can be susceptible to pressure at times of high and unexpected demand. CYF has implemented a procedure which sets out a process for the identification, escalation and coordination of a response by the division when issues which impact the ability of CYS to deliver services arise."

c) That a state-wide system for ongoing auditing of compliance with policy and procedural requirements be developed and implemented, with annual reports available regarding outcomes.

"It is not disputed that a quality assurance process is important.

CYF currently uses performance data and audits to examine performance. However, CYF strives to focus as much on outcomes as on compliance with procedure. For this reason, a new quality improvement system is currently under development. This system will be applied to review how effective the Agency's services are. Effectiveness will be measured in a range of ways against agreed indicators. Some indicators relate to compliance (e.g., are we achieving our

targets in relation to child visits and assessment timeframes?); some relate to the quality of services which can only be determined by file review and/or surveying staff and service recipients. Detailed data from this process will be made available within CYF, and some performance data will be made available to the public."

d) That SERT reports include consideration of the contributions that workplace climate, culture and the quality of supervision, management and leadership make in achieving required practice standards.

"The impact of workplace culture on practice cannot be underestimated. Since Communities Tasmania formed in 2018, it has held a strong focus on establishing and maintaining a positive workplace culture, including safety, well-being, leadership and the demonstration of behaviours which reflect our values at every level of our organisation. Initiatives have been introduced to recognise and celebrate good practice and good conduct, including sharing excellence in processes, a values recognition and award program, leadership forums and the use of inspiring and supportive communication by all leaders within CYF.

All supervisory staff are now trained in the PASE model of supervision; and an evaluation is in process currently to assess how staff use and view this model and to identify opportunities for improvement.

Health and Wellbeing Officers positions were created to provide additional support to staff within the Child Safety Service. These staff have implemented strategies to improve health and wellbeing, including the creation of groups in each region which focus on responding to health, wellbeing, human resource and injury management issues in that area.

We monitor the Agency's progress in a range of ways, including through the Annual State Service Employee Survey, regular Agency Culture Pulse check surveys of our workforce, reporting via supervisory structures, and local health and wellbeing groups.

Work is progressing to achieve an improvement in the level and timeliness of direct practice, leadership and guidance, to improve child safety assessment and decision-making, at the time the guidance is required.

Success in the application of this more direct approach on improving practice will be monitored through the implementation of the Signs of Safety Quality Assurance System which will bring together collaborative case audit, family and workforce feedback and core data to create a continuous learning cycle and a system for continuous growth."

e) That, if not yet available, the CSS undertake a comprehensive workforce analysis and finalise the development of Workforce Development Strategy in consultation with other relevant stakeholders.

"This recommendation is not disputed and analysis to inform this strategy is underway."

g)[62] That a meta-analysis of the issues, failings and learnings identified in the SERT examinations be conducted on a regular basis and these be accessible to all CYS/CSS staff and inform the recommended Workforce Training and Professional Development Plan.

"The CYF Workforce Development Committee currently uses material available through review and relevant research to identify and prioritise areas for professional development within the Agency.

CYF will soon implement a Quality Improvement System. Findings from case studies and reviews of both adverse events and practices which have achieved positive outcomes, and feedback from service users will be used by the Quality and Performance team to progress improvements. These improvements may relate to areas for training, but may also relate to procedural issues, system improvements or availability of services and resources to support improved outcomes."

h) That a robust evaluation of the efficacy of CYS/CSS and joint training programs and packages be undertaken on a regular basis with results/learnings used to review the CYS/CSS Workforce Training and Professional Development Plan.

"This recommendation is not disputed. The CYF workforce development team has a process for identifying areas where additional training would be beneficial and either sourcing or developing that training.

The Workforce Development Committee endorses new or adjusted learning pathways and designs and implements new packages.

Each training package is evaluated. Participants are obliged to provide feedback on content and delivery. This data is collated for evaluation by the Learning and Development Committee and often needs adjustments."

i) That the Monitoring and Evaluation Framework concerning the 'Strong Families, Safe Kids' reforms be finalised and publicly released.

[62] No separate response to recommendation (f).

"This recommendation is not disputed. The initial review of SFSK by the University of Tasmania has been finalised and will be publicly released (Annexure D)

In future, evaluation of the operational service delivery aspects of SFSK which are within control of CYF, and service delivery outcomes by CYF in general, will occur, through the Quality Improvement System. Relevant information of public interest, including operational performance and client outcomes data, will be made available periodically."

j) That surveys of client experience of CSS services be a measure considered as part of the Monitoring and Evaluation Framework.

"This recommendation is not disputed. Service user experiences are an essential measure of effectiveness. Surveys have been designed for users of the Advice and Referral Line and will also be developed for the Child Safety Service. Use of these surveys will be implemented as part of the new quality improvement system."

k) The effectiveness of the Advice and Referral Line, a key reform of the front door and the initial assessments of children and family's risk and well-being, and needs for support, be measures considered as part of the Monitoring and Evaluation Framework.

"This recommendation is not disputed."

General comments by Professor Lonne

92. I now summarise under individual headings further pertinent points from Professor Lonne's reports and evidence.

The public health approach to child protection reform

93. Professor Lonne supported the direction of the Department's SFSK reforms as moving towards an overall public health approach as has been operating in jurisdictions internationally. He stated that public health approaches emphasise earlier intervention and prevention strategies that minimise the prevalence of maltreatment, and offer more than merely responding once harm has occurred.[63]

94. Professor Lonne explained in his report the main elements of the public health approach to child protection:

[63] Professor Lonne report 27 January 2020 page 48.

"Essentially, a public health approach to prevention of child maltreatment utilises population-level strategies using three approaches:

- *Primary preventions are targeted towards the (sic) reducing the risks that the whole population faces and services are delivered through universal services such as health and education departments that do not stigmatise service users. Examples include public information strategies that help people identify maltreatment, and promotion of lifestyle principles that are child focused and relationship-based, and which assist families to deal appropriately with the stresses and strains that all families deal with at some times in their lives;*
- *Secondary preventions are targeted to those groups and communities who are at identifiable higher risk of experiencing child maltreatment, and includes (sic) the provision of programs and services that provide support, material assistance and guidance. The aim is to prevent the accumulation of risk factors affecting families. Interventions are shaped to be culturally diverse and appropriate. Examples would be the PPP Positive Parenting program to assist parents in their familial responsibilities and behaviour management, and health programs that enable parents to reduce the risks of mental ill health that may impact upon their children;*
- *Tertiary preventions focus upon ameliorating the environment/conditions for families where maltreatment has already been identified. For example, anger management programs or sex offender treatment programs that aim to prevent repeated maltreatment. Child protection is a tertiary prevention as is removal and placement into out-of-home care."*[64]

95. He stated in respect of the CSS reforms:

"Taken overall, there are a number of positive and worthy initiatives, within the overall SFSK which is attempting to realign the service approach to reducing child maltreatment and its impacts through increased use of prevention strategies as part of an overall public health approach. The reform agenda is multi-layered and in line with worldwide trends in western countries' child protection systems. The overall SFSK design is sound." [65]

Intensive Family Engagement Services (IFES)

96. Professor Lonne considered the development and operation of IFES as part of the CSS reform structure. He noted this as a positive development and in line with the desired public health approach. However, he also noted that there were issues identified with the IFES rollout in the University of Tasmania evaluation in February 2019.[66] These included:

[64] Professor Lonne report 27 January 2020 para 7.6.7.
[65] Professor Lonne report 13 August 2020 para 3.2 p12.
[66] Exhibit G2b Annexure E.

- Difficulties in comparing different programs;
- Adherence to program fidelity;
- Referral process delays;
- Lack of program capability to specifically address family violence; and
- Issues for CSS in managing the risks inherent in IFES cases.[67]

97. The evaluation report contains significant detail in its analysis of the programs delivered to the participants in the review period. Recommendations were made for improving programs, tailoring programs to needs and adding further programs to ensure evidence-based outcomes. The authors of the review confirmed the effectiveness of similar programs internationally in reducing risk to children and that, despite the challenges, the IFES program should not be discontinued in Tasmania.[68]

98. Professor Lonne noted that as part of a further review in May 2020 by the University of Tasmania of the SFKS reforms, the issues identified with the IFES program included linking and connecting the IFES program and the pre-existing Integrated Family Support Services (IFSS).[69] He said that it is important to address these issues quickly because one of the shortcomings of complex systems can be difficulties in collaborating and coordinating service delivery when people are unclear about program requirements for referral, service and user eligibility and the intended program outcomes. Further, he noted that the different risk thresholds applicable to each program affect how voluntary or involuntary the services are perceived to be by their users. He stated that this fact goes to the "*very heart of public health approaches and program integration*" so it is potentially a very big issue to address.[70]

99. With respect to the University of Tasmania's May 2020 evaluation, Professor Lonne commented that he would have expected there to have been more quantitative evaluation of the efficacy of the reforms. Ms Clarke in oral evidence said more data based quantitative evaluation would be included in future evaluations.

Child and Youth Wellbeing Framework

100. Professor Lonne commented favourably on the development of the Wellbeing Framework and Tool but noted the issues identified by the May 2020 evaluation of SFSK by the University of Tasmania which included the comment that, as a result of the introduction of the Framework, there was "*confusion and frustration around the concepts of safety, risk, notifications and mandatory*

[67] Professor Lonne report 13 August 2020 para 3.3 p12.
[68] Exhibit G2 p2 para 16 and Exhibit G2b Annexure E p92.
[69] Exhibit G2c Annexure I.
[70] Professor Lonne report 13 August 2020 para 3.4 p12.

reporting and the changing responsibilities of practitioners".[71] He said that it is imperative that these matters be addressed quickly because uncertainty about these concepts can quickly transition to disputes about roles and responsibilities. He suggested the institution of regular and ongoing cross-agency forums to discuss specific case studies and unpack the broader concepts as they relate to real situations.[72]

101. Professor Lonne also noted the lack of clarity about how the use of the Tasmanian Risk Framework fits with the Wellbeing Framework – noting the Wellbeing Framework is "*strengths-based*" while the TRF is "*deficit-oriented*". He stated, and I agree, that the differing emphasis has real potential to be confusing to practitioners with regards to the approaches to be taken with children and families. Professor Lonne noted that the evaluation report identified positively that a common understanding and knowledge about children's wellbeing is being built, which he stated is foundational to changing collaborative practice for the better. [73]

The Advice and Referral Line (ARL)

102. Professor Lonne was positive about the introduction of the ARL in terms of addressing some of the issues he had identified in his examination of the cases. He stated that this development is particularly important in CSS reform because many of the problematic and defective practices seen in the cases at inquest occurred during the Intake process. He said that, whilst the history of centralised Intake systems in other locations is "*mixed*", the Tasmanian population should be sufficiently contained to ensure that staff have up to date information regarding localised services and supports across the state.

103. I note that Professor David Thorpe, the expert involved in the reform, conducted a review of the ARL, published March 2021, comparing data from CSS operations for 12 months before the service commenced in December 2018 with data from the first 12 months of the ARL service in operation.[74] The review determined that the ARL has succeeded in meeting its objectives in this period. Specifically, the review concluded:

- The amount of advice and support provided to callers has gradually increased since the service went live in December 2018;
- Matters referred to other services for help have increased considerably;

[71] Exhibit G2c Annexure I p6.
[72] Professor Lonne report 13 August 2020 para 3.5 p13.
[73] Professor Lonne report 13 August 2020 para 3.6 p13.
[74] https://www.communities.tas.gov.au/__data/assets/pdf_file/0023/153941/Summary-Report-1-Year-of-SFSK-ARL-Accessible.pdf

- There was an overall decrease in matters requiring a child safety response during the year following the introduction of the new conversational methodology; and
- The rate of the continuing rise in the number of children in out of home care has halved.[75]

104. The review stated that the *Strong Families Safe Kids Next Steps Action Plan 2021-2023* includes actions to support the ongoing development of the ARL. This plan was not tendered in evidence at the inquest and I am unaware of whether it is complete.

Training

105. Professor Lonne considered that the roll-out of training programs seemed well-conceived and appropriate. He reiterated the need for training programs to:

- Be evaluated in robust and ongoing fashion;
- Be developed and delivered by people with learning design qualification;
- Include assessments for staff competence in knowledge and skills; and
- Be integrated with staff career progression systems and standards.[76]

Comments on Professor Lonne's proposed recommendations from CPSU

106. The Community and Public sector Union (CPSU) were provided with an opportunity to comment on Professor Lonne's proposed recommendations without being provided with any of the evidence presented to the hearing. I saw it fit to invite comment in light of the extent to which workforce issues were linked in the evidence to deficient practice. The CPSU provided a comprehensive and informative written submission dated 6 August 2020.[77] It supported the recommendations of Professor Lonne and, in general terms, appeared to support the redesign of the system.

107. The CPSU recorded concerns from CSS staff regarding difficulties accessing information in CPIS and CARDI. Issues concerning systems were also referred to in the University of Tasmania May 2020 evaluation. Ms Lovell did not agree that there were restrictions in access to information that hindered practice.[78] The evidence at inquest was insufficient to allow me to make any informed comment about issues with systems. However, given the critical role played by information technology in child protection practice, I would expect that the

[75] p12.
[76] Professor Lonne report 13 August 2020 para 3.9 p14.
[77] Exhibit G6.
[78] Transcript 25 August p38 lines 20-25.

functionality of systems would be the subject of ongoing review by the Department.

108. Importantly, the CPSU identified retention and recruitment of staff as a major issue in CSS and described a state of chronic understaffing which had been brought to the attention of the Department on repeated occasions since 2015 by way of industrial action. It also reported excessively high workloads with staff being compromised in their ability to follow practice standards and address the needs of children. These submission referred to team leaders carrying caseloads at the expense of their important tasks of supervision, clinical practice development and compliance with policy and procedure. The CPSU also stated that ARL calls have exceeded what had been expected with an increase in staffing required to manage this additional demand.

109. Workforce issues were reported in the University of Tasmania May 2020 review as follows:

> *"Despite the introduction of new support roles, widespread workforce issues in CSS were nevertheless reported. High turnover of staff and the subsequent challenges to building trust for families, along with attracting and retaining the right staff remained. The high caseload for frontline staff was seen as preventing collaboration with other professionals and impeding access to training and implementing learnings from training into practice."*[79]

110. It is unclear upon the evidence the extent of any staffing deficits in the current reform environment. My findings in at least two of the deaths starkly illustrate how staffing inadequacies, in terms of numbers and expertise, translate into unacceptable delays and poor practice. In turn, these issues directly impact upon protecting children at risk. Certainly, I have received significant evidence about the creation of new positions and additional staff since the commencement of the reform. The reforms require appropriate staffing for success. A continual review of staffing is and must be central to the ongoing reform.

Response by Council of Obstetric and Paediatric Mortality and Morbidity (COPMM) to recommendations of Professor Lonne

111. COPMM (the Council) were provided with Professor Lonne's recommendations and copies of the SERT reports. One function of the Council under its Act is to investigate and report upon child deaths.[80] The Council provided a written submission dated 9 September 2020 signed by

[79] SFSK Evaluation Summary Report University of Tasmania May 2020 – Exhibit G2c - Annexure I Affidavit of M Clarke p30.

[80] Obstetric and Paediatric Mortality and Morbidity Act 1994, section 6.

the Chair, Dr Michelle Williams.[81]

112. The Council supported the recommendations of Professor Lonne and went on to note:

"In many of these cases, the dead infant's parent (or parents) were also known to Child Protection through notification that occurred in their own childhoods. Childhood disadvantage, neglect and abuse can cause lifelong disadvantage and increased risk of intergenerational transmission of abuse. These vulnerable young parents were known to come from families who had also experienced difficulty in parenting and yet the increased risk to the infants and to the parents themselves seem not to have been recognised, prioritised or acted upon in a timely matter.

There is clear evidence that intervention and support for parents from the time of conception or before, is more likely to be beneficial than support being provided when child safety concerns start to be reported. The process of 'unborn alerts' provides an opportunity for support to be provided to future vulnerable parents. Children identified as being 'at risk' during their own childhoods are more likely to require targeted rather than universal support services when they themselves become parents.

These children all came from families experiencing disadvantage. Each case had at least one risk factor of parental involvement as a child with child protection, exposure to family violence, parental substance abuse and misuse, parental mental health problems and poverty. Every one of these risks has a significant negative effect on the safety of the infants and children in these families."

113. The Council went on to make comment on these risk factors in more detail. I summarise its comments relevant to this inquest in terms of its support for the public health approach to CSS reform and the availability of and requirements for support services to reduce risk.

Parental Substance Abuse/Misuse: Drug and alcohol treatment services are not readily accessible, especially in regional areas of Tasmania. Services are often generic, and not designed for young people, parents-to-be and families. The ability to refer to an effective, affordable and accessible service for parents and families affected by drug and alcohol issues would be beneficial for child safety officers and others providing support to vulnerable families.

Family Violence: It is important that services are tailored to families' needs and encompass more than one service stream. Most organisations do not provide integrated services, resulting in vulnerable parents needing appointments with a range of different providers such as drug counselling, housing and family violence counsellors. Making services more family focused and providing a 'wrapped up' service model will decrease the risk of non-engagement

[81] Exhibit G8.

or disengagement, which occurs frequently. Services such as the Tasmanian Child and Family Centres, where a number of services specifically designed for families are available in one location close to the family's community, are an excellent model of ways to provide accessible care and support to vulnerable families. Such centres could offer hubs to provide both universal services for families, as well as more targeted services for families at higher risk.

Mental Health Issues: Good mental health of parents is important for effective and safe parenting and conducive to good child development. The proposal to establish perinatal mental health services statewide, and to establish new statewide teams to treat young people who have been subject to developmental trauma or involved in the forensic system would be of clear benefit to many higher risk families. COPMM strongly supports the adequate resourcing of these additions to the statewide CAMHS service.

114. COPMM further considered that the following matters should be given consideration in light of the care issues raised by the deaths of the seven children. Briefly, these were as follows:

- Provision of safe, portable infant sleeping pods to "*at risk*" families;
- Strengthening the role of visiting child health nurses to vulnerable families, by increasing the frequency and period of home visits;
- That CSS should give priority to ensuring that, in the case of vulnerable infants, there is no delay in taking appropriate protective action once a family disengages with a voluntary service provider; noting that significant delays occurred in the inquest cases which created risk; and
- An independent body should conduct reviews into the deaths of infants and children known to CSS.

115. I urge the Department to consider the matters raised in the full submission by COPMM. Certainly, the first three points above align with the CSS reforms.

Conclusion

116. In this inquest, I have investigated the deaths of six infants and one child occurring between 2014 and 2018, whose families were known to CSS. In the case of six deaths, CSS was exercising its statutory responsibility in responding to notifications at the time of or just before the death. The Secretary of the Department had custody of one child at the time of death and therefore, in that case, I was mandated to hold an inquest and report upon his care. I have found that CSS's potential role in the question of 'how death occurred' was appropriate for examination in each case pursuant to my functions under the Act.

117. I determined to hold a joint inquest because of the common features of the circumstances of death in the cases of the infants in an apparently unsafe sleeping environment; and, in respect of all seven children, the apparent deficits in the CSS response.

118. In the inquest, I examined the question of whether the extent of the CSS deficits in practice were such that CSS could be found to have played a causal role in the child's death. I have not made this finding in respect of any of the deaths. I have, however, found that there were significant inadequacies in decision-making by CSS, with many decisions made contrary to procedure or good practice. As a result, there were lost opportunities to protect the vulnerable infants which, if they had been taken, may have resulted in a different outcome.

119. I have been guided in my conclusions by the expertise of Professor Lonne and the SERT reports, being the Department's own review process. I have also been assisted by comprehensive evidence provided by Ms Lovell and Ms Clarke. Except where I have specifically indicated, I accept the evidence given by Professor Lonne, Ms Lovell and Ms Clarke. I recognise the difficult work undertaken by Ms Clarke and Ms Lovell, both of whom appeared knowledgeable and dedicated to child protection and the reform of the system.

120. I find that the common and persistent issues in CSS practice were generally:

- Inadequate information collected to inform sound risk assessments;
- Unacceptably lengthy delays in risk assessments;
- A propensity to prematurely close cases under the assumptions that other agencies were continuing to work closely and effectively with the family;
- A lack of attention to the issues and assessment of cumulative harm;
- Deficiencies in Safety Planning; and
- Poor internal communications with colleagues, including of the oversight of case-related decision making.

121. I specifically add two persistent issues to the above list - problematic decision-making by the Three and Under Panel, at times, in closing infant notifications prematurely; and insufficient appreciation by CSS practitioners regarding the risk of infant death caused by unsafe sleeping environments.

122. All of the above issues have repeatedly arisen in previous investigations and inquests.[82] I have made previous recommendations to address these matters, as has the Serious Event Review

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[82] For example, BJay Johnstone, Pitchford and Hayes.

Team. In response, CSS and the Department have made efforts to improve practice.

123. It is apparent that, during the years in which these deaths occurred, issues associated with the CSS workforce in the face of very high demand played a very significant role in these practice deficits. Good child protection practice cannot occur consistently in a workplace not properly staffed or resourced.

124. The SFSK reform of the child protection system towards a public health approach is a major development and a very positive one. The redesign of the system has the potential to improve child protection in this State. The reform work is not yet complete but reasonable progress is being made. The expert evidence strongly emphasises the need for continued and renewed commitment and engagement with the redesign process. I therefore urge the Tasmanian Government to fully support the completion of the reforms. It is this reform that may address the multiplicity of issues seen in this inquest and result in the decrease in risk to vulnerable infants and children.

125. I have dealt in this finding with some issues emerging as a result of the reforms. These include the need to ensure that the ARL operates as intended; that IFES is effective; and that concepts of 'risk' are made consistently clear across many services. Professor Lonne has also made sound recommendations that should be used to guide the reform, together with the many recommendations from the existing reports, reviews and evaluations. Significant evaluations and reviews of the process should, in my view, be made publicly available by the Department in the interests of accountability and public confidence.

126. In her affidavit, Ms Clarke described CSS as perhaps the most frequently reviewed and highly scrutinised service in Tasmania. She described the public nature of the reviews as a challenge in realising change. She said that the volume of reform recommendations requiring attention is "*ever-present and immense*". She said "*Reform is difficult in the context of eroded public confidence, and it can be easy for progress to be hindered by a defensive stance when a brave one is what's needed.*"

127. Ms Clarke's statement is valid and, in holding this inquest, I am conscious that scrutiny of CSS has consequences, including to members of its workforce, who have performed their work diligently and to the best of their ability.

128. I do not consider that it is appropriate to make recommendations. However, I urge the Tasmanian Government, the Department and CSS to consider the issues contained in this finding.

Acknowledgements

I thank Professor Lonne for his comprehensive review of the evidence in this inquest.

I extend my appreciation to the investigating officers in each investigation.

I also appreciate the assistance of Sergeant Genevieve Hickman, Coroner's Associate; and Ms Laura Harle, intern within the Coroner's Office, who competently assisted with preparation of the investigation summaries.

I am particularly grateful to counsel assisting, Ms Schokman, who performed her role to a high level.

I convey my condolences to the families and loved ones of each of the deceased children.

Dated: 17 September 2021 in the State of Tasmania

Olivia McTaggart
Coroner

Appendix A

Infant I

Introduction

1. Infant I was born in October 2013 and died suddenly during the early morning of a day in late January 2014 at the age of 3 months. He died whilst sleeping in the bed of his mother, with her and another sibling in the bed with him. His death was reported to the coroner as required by the Act, being a sudden and unexpected death of a child under the age of one year.

Background and family history

2. At Infant I's birth, the Mother was 27 years of age and the Father was 29 years of age. The Mother had three older children: Sibling A, Sibling B and Sibling C.[1] The Mother has since had another child. The Father is also the father of two of the Mother's older children.[2]

3. The Mother and the Father had been involved in a sporadic relationship since 2007. It was volatile and characterised by episodes of verbal abuse, physical assaults, drug use and criminal activity, as well as periods of separation.[3]

4. The Father reportedly had a difficult childhood, suffering violence from his father. He was known to police from 2001 in relation to a wide range of offences, particularly the use, sale and distribution of drugs but also including motor vehicle theft, burglaries and fire related offences. The Mother was exposed to domestic violence as a child and was known to police from 2002 in relation to heavy drug use – subsequent reports from after she entered the relationship with the Father indicate that the couple were at times dealing and selling drugs.[4]

5. The Mother's older children were known to CSS through a series of notifications and assessments relating to parental drug use, family violence and inappropriate parenting. The involvement of CSS with the family is covered in more detail below.

6. During the Mother's pregnancy with Infant I, the 30-week scan discovered a 'questionable cardiopulmonary abnormality', which was of concern as two of the older children had a

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[1] Exhibit A11.
[2] Exhibit A27 p10.
[3] Exhibit A26 p4, A27 p2.
[4] Exhibit A27 p4-10.

history of congenital heart defects.[5] However, subsequent scans showed nothing out of the ordinary.[6] Infant I was born at the LGH in October 2013 with no complications.

7. At the time of Infant I's birth, the Mother lived in a town in Northern Tasmania. Mother and baby spent extra time in the hospital after the birth due to concerns about Infant I suffering symptoms of opiate withdrawal, the Mother having taken morphine and smoked marijuana throughout the pregnancy. The town was considered too far away to return to the LGH if any withdrawal symptoms such as seizures should appear.[7] Despite a minimum five day stay being advised, the Mother wished to leave sooner and was discharged with Infant I after only three days..[8]

8. By November 2013, the Mother changed her mobile phone number to avoid the Father 'hassling' her. This made it difficult for CHaPS nurses to get in contact with her following Infant I's birth.[9] In addition, just before Christmas 2013 the Mother and her four children moved into a hotel in the area where her mother, Ms L, worked and lived. They moved because of fears related to the Father's involvement with drugs.[10] The Mother and her children moved into the hotel's accommodation, which had three separate bedrooms. The Mother slept in one of these bedrooms in a double bed and Sibling A slept in another in a single bed.[11] The third bedroom was not used for sleeping. The boys usually slept with The Mother and, according to Ms L, Sibling B and Sibling C had done this since they were born. Ms L herself slept in a bedroom at the other end of the hallway from the Mother's accommodation.[12] The Father did not reside with them and was not present on the night of Infant I's death.

9. In December 2013, the Mother and Infant I visited the Scottsdale Doctors Surgery for Infant I's 6-week check. He was seen by Dr Qiong Yue Teo who noted that he was a "*normal healthy baby*". Infant I was given his 6-week vaccinations and coloxyl drops for suspected constipation. In her statement to police, the Mother said that she had asked Dr Teo about Infant I's irregular breathing and heart at this appointment and was told that neither were an issue, although this is not reflected in the Scottsdale Doctors Surgery medical records.[13]

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[5] Exhibit A25.
[6] Exhibit A1 p1, A9, A20 p3.
[7] Exhibit A9, A11 p1.
[8] Exhibit A9, A23.
[9] Exhibit A23.
[10] Exhibit A11, A12.
[11] The Mother refers to an older child going back to his bed in another child's room on the night of Infant I's death suggesting he also had a bed in that second bedroom. A11 p2
[12] Exhibit A12.
[13] Exhibit A10, A11 p1.

Circumstances of death

10. In January 2014, the Mother and her four children travelled to spend two nights with the Mother's friends, Friend A and Friend B.[14]

11. On one of the evenings at approximately 10.00pm, the Mother left her children in Friend A's care while she went for a drive. During this time Friend A gave Infant I a bottle that the Mother had made up for him. While drinking from the bottle, Infant I began to choke and stopped breathing for a period of about 30 seconds. Friend A considered calling an ambulance but did not do so as Infant I began to breathe again on his own after she removed the bottle from his mouth.[15] Friend A believed a large hole in the teat of the bottle caused Infant I to choke as he had no problems finishing the milk when it was placed in another bottle.[16]

12. The Mother was not overly concerned by this incident as Infant I appeared fine by the time she returned and she knew Friend A tended to exaggerate from time to time.[17]

13. During the next morning the Mother and Friend A went out for a short time, leaving their children in the care of Friend B and Friend A's friend, 14-year-old Ms K. During this time, Sibling C hit Infant I in the stomach while Infant I was lying on a mattress. The force of the hit caused Infant I to bounce in the air and hit his head on floorboards. Ms K checked his head for any marks or lumps but could find nothing, and Infant I had stopped crying and seemed happy when the Mother arrived back 5 minutes later.[18]

14. At 6.15pm that evening the Mother returned to the hotel and took the children upstairs to the accommodation, prepared a bottle for Infant I which Sibling A fed him in her bedroom. The Mother worked in the hotel with Ms L, returning to check on the children several times during the night.[19] At approximately 8.20pm, the Mother returned upstairs to find Sibling B and Sibling C asleep in her bed and Infant I asleep in Sibling A's bed. Sibling A accompanied the Mother downstairs for about half an hour and they returned upstairs at approximately 9.00pm. At this time, Sibling A wanted to go to bed and the Mother decided to leave Infant I in Sibling A's bed until she came to bed herself. Sibling A got into bed with Infant I, who was still asleep.[20]

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[14] Exhibit A11.
[15] Exhibit A11, A13.
[16] Exhibit A13.
[17] Exhibit A11 p3, A15 p4.
[18] Exhibit A14 p2.
[19] Exhibit A11, A12.
[20] Exhibit A11 p2.

15. The Mother returned to the bar and consumed 3 'Black Russian' alcoholic drinks between 9.00pm and approximately 1.15am on 25 Jan 2014. She did not consider herself drunk when she went to bed after the last patrons left the hotel at 1.20am.[21]

16. The Mother moved Infant I into her own bed and gave him another bottle. Sibling C was also in the bed. Infant I was lying on his back without a pillow. Once he was settled, she went into the unoccupied third bedroom and smoked four cones of marijuana, which she did every night to help her sleep. She stayed awake until about 4.00am texting the Father.[22]

17. At some point between 4.00am and 5.30am,[23] Infant I woke and the Mother fed him another bottle while holding him in her bed. After this, she fell asleep next to Infant I with him on her left side, closest to the door of the room. Sibling C was lying down near her feet on her right side.

18. When the Mother woke, Infant I was still lying on the bed on her left side. She noticed blood under his nostrils and, listening to his chest, realised he was not breathing. She picked him up and ran to Ms L's room.[24]

19. The Mother stated this to have occurred at 7.15am, and this time was recorded in a number of statements made by police responders after the fact.[25] However, Ms L estimated the time to be 6.40am and this seems more likely as the initial 000 call was made at 6.46am.[26]

20. Ms L woke up when the Mother entered her room "screaming and yelling that Infant I was not breathing". She took Infant I from the Mother and noted that he was warm, his skin colour appeared normal and he had a small drip of blood coming out of his right nostril. Ms L began CPR on Infant I and told the Mother to call an ambulance.[27]

21. The records from Ambulance Tasmania record a call between the Mother/Ms L and the operator commencing at 6.46am and ending shortly after 7.11am, when the paramedics arrived. The Mother was clearly distraught during this call and found it difficult to communicate with the operator. Ms L was able to remain calm and provide CPR to Infant I in accordance with the operator's instructions.[28]

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[21] Exhibit A11, A12.
[22] Exhibit A11 p2.
[23] In the Mother's statement, she says this happened at 4.00am; in Constable Salter's statement he says that the Mother told him it was between 5-5.30 am: Exhibits A11, A15
[24] Exhibit A11 p2
[25] Exhibit A15 p4, A17 p1, A11 p2.
[26] Exhibit A21, A8.
[27] Exhibit A12 p2.
[28] Exhibit A21.

22. It is apparent from the recording of the 000 call that this was a highly distressing time for both women. Ms L said afterwards she felt as though she performed CPR for what seemed like an hour before the ambulance arrived.[29] Paramedics continued CPR but, sadly, Infant I could not be revived.

23. Police officers attended the hotel and noted both the Mother and Ms L's bedrooms were dirty, smelled strongly of cigarettes, and were cluttered with clothes and rubbish, including food scraps. The Mother's bedroom was noted to also smell of cannabis. The bed in the Mother's room, where Infant I had been sleeping, had no sheets or mattress protector.[30]

Cause of death

24. On 28 January 2014 an autopsy upon Infant I was carried out by State Forensic Pathologist, Dr Christopher Lawrence, at the RHH. No obvious traumatic injuries were discovered. Dr Lawrence observed petechiae (bleeding caused by broken capillaries) on the lungs and lividity on Infant I's back. The presence of Rhinovirus suggested Infant I had a cold.[31]

25. On review, Dr Lawrence confirmed that there was no convincing evidence of structural or congenital heart disease that may have caused death and no evidence that the episode of apnoea while feeding with Friend A contributed to death. He noted that there were risk factors in Infant I's sleeping environment, including co-sleeping with his mother and brother in adult bedding, the Mother's high body mass index, and the fact that she had consumed alcohol and cannabis on the night of the death. While there was no evidence to determine whether overlying had occurred, he considered the case at the very least to represent an unsafe sleeping environment.[32]

26. The toxicology report showed no significant results in Infant I's blood sample. No alcohol or drugs were detected.[33]

27. Ultimately, Dr Lawrence described Infant I's death as sudden infant death while bed-sharing.[34] This description means that Dr Lawrence was unable to determine a medical cause of death but that the unsafe sleeping environment may well have contributed to death. For example, Infant I might have died as a result of suffocation in the adult bedding or as a result of unintentional overlying by another occupant of the bed, more likely his mother. Bearing in mind the standard of proof, I am not able to make a positive finding to this effect even though

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[29] Exhibit A12.
[30] Exhibit A15, A17, A18, A19.
[31] Exhibit A6.
[32] Exhibit A28.
[33] Exhibit A7.
[34] Exhibit A6.

unintentional suffocation is the more likely scenario. A less likely scenario is that Infant I died as a result of an undetected natural cause.

History of CSS involvement

28. CSS had never received a notification in relation to Infant I himself.[35] However, the Mother had been known to CSS from her own childhood and 7 notifications in relation to Infant I's older siblings were received by CSS before his birth as follows:[36]

a) 17 March 2008: unborn notification regarding Sibling C whereby the Mother fell while drunk and broke her ankle while 25 weeks pregnant. The notification recognised her history of continuing drug and alcohol abuse.

b) 31 March 2008: notification regarding both Sibling A and unborn Sibling C, being a family violence incident involving the Father smashing a car window with the Mother and Sibling A inside, causing glass to spray over them. This was considered a 'minimal' risk as Sibling A was not harmed. The notification was closed for Sibling A on 19 May and for Sibling C on 21 August because "based on the mother's report"future incidents were unlikely, and because a third further notification had been received.

c) 4 August 2008: notification regarding Sibling C whereby police attended the home due to the Father "*going off*" at the Mother and leaving with her phone. The Mother told police there were no problems and refused to cooperate. Enquiries were made with CHaPS who had no concerns, but a home visit was recommended.

d) 24 December 2008: notification regarding Sibling A whereby Sibling A witnessed the Mother being verbally abused by the Father and there was concern about her repeat exposure to family violence. A CHaPS enquiry indicated the family was engaging with the service and the notification was closed on 15 January 2009.

e) 1 April 2009: notification regarding Sibling C from Victoria as the Father had taken Sibling C interstate. A home visit was carried out by DHS (Vic) and a number of concerns in relation to the Father's care of Sibling C were noted. This was followed up by CSS by 9 April and Sibling C was confirmed to be back with the Mother on 15 April. CHaPS attempted several times to conduct a home visit but were unsuccessful and the matter was referred for assessment.

[35] Exhibit A26, A25.
[36] Exhibit A25.

f) 29 May 2009: notification regarding Sibling A whereby Sibling A was forced to stay home from school and witnessed an assault upon the Mother by the Father.

g) 2 November 2011: notification regarding Sibling B where Sibling B was admitted to hospital after suffering convulsions and requiring CPR from the Father. In response to follow-up enquiries, the childcare service that Sibling B attended reported a number of risk issues (including cleanliness, parental drug use and neglect) and finding marijuana buds in the nappy bag left with Sibling B at the childcare centre.

29. Two notifications were referred for assessment in the same period:

a) Notification (c) was referred for assessment but was closed without follow-up on 6 November 2008 due to family engagement with CHaPS. This closure was supposedly given approval by the Service Centre Manager, but there is no record of this approval.

b) Notification (e) was referred for assessment and a home visit was carried out during which the Mother confirmed the family violence. None of the children were sighted during this visit. The matter was closed on 6 October 2009 with a statement to the effect that there were no concerns for Sibling C's health, even though he was not examined by a health professional or directly observed. Sibling C had not, at this point, been seen by CHaPS or CSS since December 2008.

30. Following Infant I's birth, a discharge report was provided to CHaPS on 28 October 2013. CHaPS attempted to contact the Mother on 6 occasions between 1 November 2013 and 17 January 2014 but, as described above, found it difficult to get in touch with her as she had changed her phone number. The service obtained her correct number from her mother, Ms L, on 15 November 2013 and attempted calling and texting that number, as well as sending a letter on 17 January 2014 offering a home visit or an appointment at the Scottsdale CHC.[37]

CSS issues from Critical File Review

31. CSS was not notified of Infant I's birth and the most recent prior notification had been two years previous. However, the notifications that were received before Infant I's birth and death regarding his siblings consistently raised concerns about the Mother's care of young children and substance use. Repeated and escalating risk relating to Sibling A, Sibling B and Sibling C were clearly identified and documented in the case file and effective intervention in regard to these earlier notifications may have reduced the environmental risks to Infant I. Of substantial

[37] Exhibit A23.

note was the missing of a strong and long-lasting pattern of parental drug use and serious family violence.[38]

32. CSS reviewed its intervention related to Infant I's family and acknowledged that a number of the responses to notifications or assessment matters prior to Infant I's were not dealt with in line with established procedures and were not adequate. A number of deficits/areas for improvement were identified in the Review report:[39]

- Adding additional or new information as case notes to existing notification or assessment records (rather than recording a discrete notification for each report).
- Closing notifications with a note that the matter is undergoing assessment rather than linking notifications to incidents or assessments to ensure a clear reflection of current risks.
- Closing notifications based on the premise that it may affect a police investigation when there is still risk present that requires further CSS consideration.
- Failure to consider all children in the household when a notification was received – individual notifications were received for the three older children when the issues were in fact applicable to all of the siblings.
- Failure to ensure closure rationales were consistent with information gathered and analysed.
- Failure to ensure substantiation decisions about notifications were made in accordance with policy.
- Deficits in documentation of information, analysis and risk assessments prior to cases being closed without assessment – a substantiated/unsubstantiated outcome not being appropriate where there has been no assessment.
- Failure to consider pattern and history, for example, the Mother's pattern of denying concerns, drug use and non-engagement with services.
- Failure to follow basic investigation requirements – interviewing both parents and interviewing children, sighting children too young to be interviewed and documenting observations of their development and interaction with caregivers.

[38] Exhibit A25.
[39] Exhibit A25.

- Insufficient care taken to distinguish between an accepted referral to Gateway or other services and a genuine family engagement with Gateway or other services to address and resolve risks. Non-engagement by families can result in a high level of re-notification and children remaining at risk.

33. Specific recommendations made in the Review report included:

    - Sharing of the findings of the review to CSS Intake and Response teams to strengthen future work.

    - Sharing of the findings of the review specifically with CSS staff currently engaged with the family to contribute to current intervention.

    - A continued consultative role for Quality Improvement and Workforce Development (the internal CYS review team) in regard to current intervention.

34. Infant I's death caused CSS staff to approach the family with a high level of sensitivity, which contributed to a level of non-recognition of the significant risk that his older siblings were facing at the time. It was noted that current and ongoing CSS intervention with the family is reflective of practice in line with established policy and procedure, well-documented and with increased rapport and engagement with the Mother.

35. Professor Lonne was asked to assess whether, in his opinion:

    If correct practice had been adopted by CSS would there have been a significant reduction in risk to Infant I?

    and

    Does the case contain deficiencies in the CSS that are more serious and which involve an identifiable increase in risk to Infant I before death?

36. In his response, Professor Lonne identified the issues and risks as:

    - Alcohol and drug misuse by both parents, including illicit drugs cannabis, morphine, opiates and potentially methamphetamines. There was associated police involvement, particularly with the Father;

    - Domestic violence perpetrated by the Father upon the Mother, with strangulation mentioned;

- Primary issues of neglect of children (emotionally and relationally) with evidence of behavioural problems being experienced with the children; and

- The Mother being very difficult to engage with a range of services, and her being hostile toward CSS involvement.

37. However, Professor Lonne went on to say:

"While there are some noted criticisms of the overall case management outlined in the CFR, such as poor assessments conducted prior to Infant I's death, there was no contact work with the family for an extended period prior to Infant I's birth. For all intents and purposes, as far as CYS was concerned, the family appears to have been flying under their radar with respect to Infant I, and with his siblings.

I found, on the basis of the CFR that while there were ongoing concerns with respect to Infant I's siblings and shortcomings concerning the quality of risk assessments, I could not identify any particular actions regarding these shortcomings directly affecting Infant I following his birth, or when he was in utero. I did note that following his birth Infant I was identified as having withdrawal symptoms, but there appears to be no record of health personnel having advised CYS of this.

Hence with respect to Infant I I have concluded the following:

If correct practice had been adopted by CYS/CSS would there have been a significant reduction in risk to the child?

Response: While there were identified deficiencies with regard to departmental involvement with the family prior to Infant I's birth, I could not identify that if there had been ongoing contact about the risks and issues that this would have led to a significant reduction in risk to Infant I. I base this primarily upon the Mother's apparent low motivation in addressing her A&OD issues and the Father not being around the family during the period of Infant I's life, and therefore the immediate risk of FADV being low.

Does the case contain deficiencies in the CYS/CSS that are more serious and which involve an identifiable increase in risk to the child before death?

Response: I could not identify any particular aspects of the CYS involvement that were more serious deficiencies that could be attributed to having a resultant significant increase in risk of harm to Infant I."[40]

[40] Exhibit G1 Appendix E p 2-3

Conclusion

38. There were serious and entrenched deficits in CSS practice over a period of several years before Infant I's birth. The notifications in respect of Infant I's siblings showed that they were subject to a high degree of risk that required thorough and correct assessment and appropriate action to protect them as a response to that assessment. The children were exposed to a high level of family violence, parental drug-taking and neglect. They were not adequately supported by community services because of their parents' consistent failure to engage with those services.

39. It is not helpful to speculate whether the proper response to the serious and persistent risk was that the children be removed from the home pursuant to an order under the CYPF Act. However, it is likely that if proper procedures had been followed, there would have been ongoing involvement of CSS with this high-risk family for the children's care and protection. If this had been the case, CSS would have had knowledge of Infant I's impending birth and the risks to him as a vulnerable infant. CSS could therefore have been immediately prepared to take appropriate action. Alternatively, CSS involvement or monitoring from the time of the initial notifications may have resulted in improved parenting capacity and reduction in risk, which in turn may have changed the course for Infant I.

40. Such reasoning, however, requires considerable retrospective reconstruction of events occurring over a number of years before Infant I's birth. For that reason, I do not consider that there can be said to be sufficient causal nexus between the deficiencies in CSS involvement with Infant I's siblings and Infant I's death. I agree with Professor Lonne's view in this regard.

41. This family most obviously required a great deal of support for the care and protection of the children. The continued closure of notifications by CSS without proper assessment or action contributed to the family remaining "under the radar", not engaging with services and the risks remaining present. These were missed opportunities which, had they been taken, may have resulted in Infant I having a greater level of protection from the time of his birth.

Appendix B

Infant 2

Introduction

1. Infant 2 was born in late June 2016 and died suddenly in the early morning of late August 2016 at the age of 2 months. He died whilst sleeping in the same bed as his twin.

2. I reopened this investigation on 31 October 2019. It had been completed by Coroner Chandler with an in-chambers finding on 27 November 2017. However, at that time, Coroner Chandler did not have evidence before him that there were likely deficiencies in CSS procedures relating to a failure to appropriately assess risk to Infant 2 in his home environment. He also did not have available to him evidence that Infant 2's mother had resumed her use of the drug crystal methamphetamine ('ice') after Infant 2's birth. This new evidence required investigation in the context of the circumstances of death.

Background and family history

3. At Infant 2's birth, the Mother was 29 years of age and the Father was 42 years of age. The Mother and the Father had two other children together: Sibling A and Sibling B, Infant 2's twin. The Mother had a third child, Sibling C. At the time of the birth of the twins, Sibling C was living with her father, Mr M.[1]

4. The Mother and the Father had entered into a relationship in approximately 2012. The Mother and the Father's relationship was turbulent and marked by drug use, physical abuse and controlling behaviour by the Father against the Mother. They separated in December 2016, four months after Infant 2's death.[2]

5. The Mother's older children were known to CSS through a number of notifications and assessments relating to parental drug and alcohol use and incapacity for appropriate parenting. Infant 2 was subsequently the subject of notification and assessment from birth. The involvement of CSS with the family is covered in more detail below.

6. At the time of Infant 2's birth, the Mother was living with the Father and Sibling A. An FVO was in place between them at this time.[3]

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[1] Exhibit E18 p7-8.
[2] Exhibit E11, E20.
[3] Exhibit E20.

7. The Mother stated that she was not aware that she was pregnant with the twins until 29 weeks into the pregnancy as her menstrual cycle had not stopped. However, the CSS records include unborn baby notifications relating to this pregnancy in January 2016. The Mother reported that she continued to drink alcohol, smoke about 20 cigarettes a day and use ice until she discovered the pregnancy, after which she stopped drinking completely and reduced her consumption of cigarettes.[4]

8. The Mother went into labour at her home in June 2016 and called an ambulance to take her to the NWRH. The twins were born very shortly after her arrival at the hospital and were 6 weeks premature. Sibling B was born first and did not require any special care, but Infant 2 required resuscitation. Both boys were taken to the Special Care Unit before being transferred to the RHH neonatal unit the same day. The twins spent two weeks in the RHH before being transferred back to Burnie and spending an additional one and a half weeks in the NWRH.[5]

9. The Mother became very stressed and anxious during the time that the twins were in Hobart and returned to smoking about 20 cigarettes a day. Neither she nor the Father smoked inside the house. After the twins returned home, she stopped breastfeeding and began feeding them formula. At home, the twins shared a regular sized (single) cot in the same room where the Mother and the Father slept. The cot had a rolled-up towel placed under the sheets between the twins so that they would not roll. They would sleep side by side on their backs dressed in singlets, a body suit and a onesie jumpsuit, and wrapped in a blanket. The house was heated by a heat pump but additionally had an electric heater in the bedroom.[6]

10. At around this time, the relationship between the Mother and the Father began to break down. The Father had been using ice heavily and his usage was costing the couple $100-$300 per day. This cost led him to take measures such as turning down the heaters in the twins' bedroom (which the Mother had set to be the same temperature as the hospital) in order to reduce their electricity bill. He became controlling and abusive and the Mother was forced to hide money at her mother's house for nappies and baby formula to prevent him from spending it on drugs. The Father would frequently disappear with the car for three to four days at a time. The Mother did not have a driver's licence and the twins missed medical appointments due to these absences. She also began using ice to stay awake, keep up with housework and care for her children. The Mother did not believe that her drug use affected her care of her children.[7]

[4] Exhibit E10, E11.
[5] Exhibit E10, E9a.
[6] Exhibit E10.
[7] Exhibit E10, E11, E19 (18/10/17).

Circumstances of death

11. During the day on 20 August 2016, the Mother noticed that Infant 2 appeared to have a cold and did not seem quite like himself. He fed as normal before he was put to bed between 10.00pm and 10.30pm. At 4.00am on 21 August, the Mother woke to feed the twins. She gave Sibling B a bottle of formula but Infant 2 did not seem interested. She thought he felt cooler than when she had put him to bed and he fell asleep again easily.

12. When she woke again at about 8.30am, the Mother thought both twins were still asleep so left the room to prepare their bath and bottles. When she returned to the bedroom, she noticed that Infant 2 was not his normal colour and she was unable to wake him. She woke the Father and asked him to wake Infant 2. The Father found Infant 2 pale and cold to the touch and appeared deceased. The Mother and the Father called 000 and followed the operator's instructions to provide CPR until the ambulance arrived.[8] Ambulance Tasmania records show the call was received at 9.12am and the ambulance arrived at 9.23am.[9]

13. Infant 2 continued to receive CPR in the ambulance and at the NWRH ED. The Father praised the paramedics for their attempts to save Infant 2, but sadly he could not be revived and was pronounced dead at the hospital.[10]

14. Police officers attended the home and observed it to be clean and tidy. The bedroom was neat and warm with good ventilation. There was no evidence of smoking inside.[11]

Cause of death

15. On 23 August 2016 an autopsy upon Infant 2 was carried out by forensic pathologist, Dr Donald Ritchey, at the RHH. No evidence of any traumatic injury was found and bed-sharing was not considered a factor. Infant 2 was found to have pneumonia. Dr Ritchey noted Infant 2's prematurity as a significant contributing factor, as premature infants are at increased risk of death due to pulmonary infections.[12]

16. The toxicology report showed no apparent significant toxicology.[13]

17. Ultimately, Dr Ritchey opined that Infant 2's cause of death was due to acute pneumonia, contributed to by premature birth.[14]

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[8] Exhibit E10, E12.
[9] Exhibit E7.
[10] Exhibit E2, E9, E10, E12.
[11] Exhibit E14, E15.
[12] Exhibit E5.
[13] Exhibit E6.
[14] Exhibit E5.

History of CSS involvement

18. CSS became involved with Infant 2's siblings in 2011 when two notifications were received: one in relation to a historical family violence incident between the Mother and Sibling C's father, Mr M, and the other in relation to the Mother's alcohol abuse while Sibling C was in her care (Mr M was in prison at this time). CSS made enquiries of the Family Violence and Counselling Support Service (FVCSS) and were told that the Mother was not a client of FVCSS. CSS contacted CHaPS, which reported that Sibling C had not been seen by CHaPS nurses. There is no record that CSS discussed the allegation of alcohol abuse with the Mother. The notification was closed at Intake despite the TRF identifying Sibling C as a child at risk and despite the child protection worker recommending that the matter be assessed by Response. CSS considered that the Family Court and CHaPS would monitor the family.[15]

19. Further notifications in 2013 and 2014 made by family members related to poor parenting capacity, drug abuse by the Mother and the Father, and allegations about the Father's history of sexually abusing girls. The Father was reported to be aggressive and the Mother to have cut contact with family members when they raised their concerns with her. A file review was conducted. CSS learned that the family had had no contact with FVCSS; that Sibling C, then aged 5 years, was not enrolled in school; and CHaPS had had only one contact with Sibling A. The parents were not contacted and these notifications were all closed at Intake without the allegations being fully assessed or discussed with the parents. This outcome was supported by the Three and Under Panel.[16]

20. A further notification was received from CHaPs in January 2014 when Sibling A was aged eight months. CHaPS reported the Mother had left Sibling A in the care of the Father for a period of time; that Sibling A had not had newborn screenings or vaccinations; and that there were concerns about his development. CSS reviewed Sibling A's file but there is no evidence that it also reviewed Sibling C's file. The matter was closed at Intake on the basis that the Father was appropriately caring for Sibling A with the support of extended family and CHaPS monitoring. The Three and Under Panel supported the closure on 14 February 2014.[17]

21. Infant 2 and Sibling B first came to CSS's notice on 18 January 2016 before the birth when a notification was received from Tasmania Police about a domestic violence incident in which the Father choked the Mother and carried her several metres with his hands around her neck. Infant 2 and Sibling B were included on the notification as unborn babies. The Mother also reported two previous family violence incidents which had resulted in a broken wrist and having the broken wrist further injured. The Mother also reported the Father's drug use

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[15] Exhibit E18, p8.
[16] Exhibit E18, p8-9.
[17] Exhibit E18, p9.

costing $100-$300 per week. The Father was charged with assault as a result of this incident and an FVO was issued. CSS called the Mother, who advised that she had separated from the Father, had no further concerns about family violence and declined a referral to the Intensive Family Support Service (IFSS). The case was presented to the Three and Under Review Panel twice and was closed after repeated attempts to contact the Father were unsuccessful. Risk analysis rated the harm consequence as 'concerning' due to the children being exposed to emotional harm as a result of witnessing the family violence, the harm likelihood as 'unlikely' due to the FVO and identified no immediate safety issues.[18]

22. Another notification was received from Sibling C's school on 24 February regarding disclosures she had made about the Father's presence at their house and ongoing violence against the Mother. This notification was added to the 18 January notification rather than being assessed individually, and was not included in the risk analysis.[19]

23. The NWRH notified CSS on 24 June that the Mother had missed a complex care appointment, was not answering her phone, and that family members had raised concerns about drug-taking by the Mother and the Father and their ability to care for the twins. An assessment was commenced by Intake. CSS was notified of the twins' premature birth and the case remained open, but no action was taken until 25 July when a number of unsuccessful attempts were made to contact the Mother, the NWRH and the RHH Child Protection Liaison Officer (CPLO).[20]

24. On 29 July, the CPLO contacted CSS to advise that they held no significant concerns related to the parents of the twins. Despite this, Intake made a number of attempts to contact the Mother and the Father on 9 August. On 18 August CSS received information from CHaPS about the twins' birth, their transfer to RHH for post-natal care, and return to NWRH on 7 July. On 8 August the twins' Paediatric Specialist reported to CHaPS that the twins had not been presented for their follow up appointment. CHaPS reported that its last contact with the family was in December 2013.[21]

25. A file review was conducted by CSS on 26 August that included the family violence incident from January 2016 and the June 2016 notification, but no other notifications or the previous history regarding Sibling C and Sibling A. Also on 26 August, CSS contacted Tasmania Police to obtain an update about the family's situation and were informed that Infant 2 had passed away. Tasmania Police informed CSS that they had no concerns for Sibling B at that time. A TRF assessment continued. Although Infant 2 had died, the risks to Sibling B required

[18] Exhibit E18, p10.
[19] Exhibit E18, p10.
[20] Exhibit E18, p11.
[21] Exhibit E18, p12.

assessing. This assessment found the harm consequence 'concerning' because of the history of drugs and violence but identified safety factors as the absence of reports of family violence since January 2016 and the existence of an FVO . The harm probability was assessed as 'unlikely' as the concerns regarding drugs and violence were considered historical. The future risk was assessed as 'medium'. The Mother could not be contacted. The Three and Under Panel supported the closure of the notification.[22]

CSS issues identified in SERT report

26. Deficiencies noted in the SERT report included:

- Regarding the assessments conducted between 2011 and 2014 in relation to Sibling C and Sibling A: failure to sufficiently gather information and contact key individuals, leading to missed opportunities to address the concerns and create safety, inaccurate risk assessments and poorly informed decisions.
- Regarding the January and June 2016 notifications: incomplete file reviews and failure to understand the importance of pattern and history as a predictor of future risk of harm.
- Adding additional or new information received on 24 February as case notes to the existing January notification (rather than recording a discrete notification for each report), against accepted practice.
- Failure to complete the Tasmanian Risk Framework in accordance with guidelines and to register an Unborn Alert with the NWRH.
- Failure to engage the family and offer support or intervention while the twins were in hospital.
- Failure to consider cumulative harm or capture the full pattern and history of CSS involvement prior to the August 2016 file review.
- Failure to give consideration to or comply with several policies when conducting assessments.
- Lack of effective communication between stakeholders (including the RHH, the NWRH and Tasmania Police), and lack of engagement with the parents. More meaningful engagement may have created the opportunity to provide the family with information and support.

[22] Exhibit E18, p12-13.

27. The specific recommendations made in the SERT report for improvement by CSS were:

- Regular state-wide auditing of cumulative harm assessments, unborn baby alerts, the TRF and supervision of staff against the CYS Practice Manual.
- Mandatory information sessions in relation to new policies, procedures and practice guides to be led by CYS Planning and Program Development.
- Regular review and discussion of new and existing policies, procedures and practice guides via CSS staff meetings and staff supervision.
- Consideration to be given to implementing a strategy to address any reluctance on the part of staff to consult, and be guided by, policy, procedures and practice guides.
- Development of policies, procedures and practice guides in relation to the assessment of and response to family violence, including the engagement of family violence offenders.
- Training and mentoring of staff in: the preparation and application of the TRF; assessments at Intake; family violence, its impact on children and families and the engagement of family violence offenders; safety planning; the assessment of unborn babies and infants; the use of client information systems; the use and application of the CYS Practice Manual; and ongoing information sessions for the external members of the Three and Under Review Panel with regards to the Tasmanian Risk Framework and risk assessment practice in CSS.
- Delivery of formal training compulsory for all staff in relation to risk assessment, the assessment and impact of cumulative harm and the Tasmanian Risk Framework, and continued delivery of formal training compulsory to all staff in relation to safety planning.
- Consideration to be given to developing a strategy to address the identified issues with CPIS in relation to the automatic linking of file information for all children in a family.

Professor Lonne's assessment

28. Professor Lonne was asked to assess whether, in his opinion:

If correct practice had been adopted by CSS would there have been a significant reduction in risk to Infant 2?

and

Does the case contain deficiencies in the CSS that are more serious and which involve an identifiable increase in risk to the child before death?

29. Professor Lonne said:[23]

> *"I concluded from my examination of the case materials that while there were deficiencies identified in the handling of the assessments, the risks identified above were less critical because the children's mother...had ceased misuse of A&OD during the pregnancy, and there was regular and intensive contact with health authorities who were closely attending to the matters at hand. The police report concluded that given the circumstances no person was believed to have "contributed to the death" (Taspol Coronial file, p. 4).*
>
> *Based upon the information provided I was unable to identify any particular significant risk that contributed to the death of Infant 2. That is, CYS/CSS involvement, despite its shortcomings in adequacy of assessment and intervention, could <u>not</u> be attributed a high level of responsibility for his death from SUID. With respect to the key questions, my responses are:*
>
> *If correct practice had been adopted by CYS/CSS would there have been a significant reduction in risk to the child?*
>
> *Response: An adequate level of service and practice standards would have reduced the risks to the children, but not to a significant degree.*
>
> *Does the case contain deficiencies in the CYS/CSS that are more serious and which involve an identifiable increase in risk to the child before death?*
>
> *Response: The deficiencies identified in the SERT report were sufficient to mean that the assessments were inadequate (and did not meet departmental requirements). However, these failings could not be identified as being contributors to the death of Infant 2 from SUID. I concluded that a more adequate assessment and increased intervention and support would have been unlikely to prevent his passing in these circumstances."*

30. In the course of his oral evidence, the admission of the Mother (made by affidavit sworn on 18 October 2017), that she had commenced using ice again when the twins were about 4-5 weeks old, was put to Professor Lonne. He had previously said in evidence that the cessation of substance use by the Mother during pregnancy was a pivotal fact in relation to contribution issues by CSS.[24] His assumption in this regard was that she had not resumed substance use. He was asked whether this resumption altered his opinion about the connection between the deficiencies in CSS's involvement and Infant 2's death. Professor Lonne emphasised, as he did a

[23] Exhibit G1 Appendix E p6

[24] Transcript 24 August 2020 p34.

number of times in the course of his oral evidence, that the long-term risk to a child of removing the child from its mother as an infant must be weighed against risks to the infant of immediate removal. He noted the inherent health risks of infancy and he declined to alter his opinion about the CSS contribution to risk to Infant 2.[25] It is plain from his evidence, however, that he was of the view that intensive support, observation and monitoring of families involved in misuse of substances is crucial for protection of the children.

31. Nevertheless, the information concerning the Mother's resumption of ice use was not a matter which had come to the attention of CSS prior to Infant 2's death. Even if it had, Professor Lonne could not assess that this fact, combined with the other risk factors, would have warranted Infant 2's removal from his parents or that a greater level of intervention would have avoided his death.

Conclusion

32. Infant 2 was a particularly vulnerable premature infant and at risk from a myriad of parenting issues – severe family violence, drug and alcohol abuse, cumulative harm, financial hardship and non-engagement with key services.[26] He was the subject of a current CSS notification at the time of his death. CSS did not correctly assess the risk to him nor the risk to his siblings over several previous years of notifications. If the notifications received by CSS before and shortly after Infant 2's birth had been assessed and responded to in accordance with correct practice, there may have been an early and accurate identification of risk. This may have led to proactive monitoring and provision of support for Infant 2 in his home, and if his parents did not engage, informed decisions could have been made to consider interventions involving his removal, and presumably that of his twin, from the home to a safe environment.

33. Infant 2 died as a result of acute pneumonia, being a death by natural causes. I am not able to find that his sleeping environment itself was unsafe. He was laid on his back to sleep next to his twin and was found deceased in the same position. I find that his pneumonia, being a lung infection, developed as a result of the virus he had been suffering. It appears that other members of the family had also been suffering from a head cold at the time.[27]

34. He was physically vulnerable due to his premature birth and weighed only 2.9 kilograms at his death. His vulnerability must have been obvious to his parents after his lengthy period of hospitalisation. He had been unwell for about two days and it appears that the Mother perceived he had a raised temperature during the evening before his death.[28]

[25] Transcript 24 August 2020 p52.
[26] Exhibit E18 p24.
[27] Exhibit E14a.
[28] Exhibit E10, p4

35. Despite his vulnerability and his illness, Infant 2 was not taken to a medical practitioner. He had not been to a doctor in at least the preceding two weeks, and he had not been taken to an important scheduled paediatrics appointment earlier in the month. His mother was using ice, a fact that may have been discovered by CSS if there had been appropriate risk assessment and monitoring subsequent to the notification. Infant 2's mother and father, both of whom lived in the house, had a relationship marked by family violence. The financial strain caused by his parents' drug use affected the family's living conditions.

36. The important issue, therefore, for my consideration was whether CSS should have taken action to have Infant 2 removed from the home to a safe environment. I take into account the expert view of Professor Lonne, who did not consider that the lack of proper CSS action in response to the notifications played a causative role in Infant 2's death. Bearing in mind the standard of proof, I accept his opinion and acknowledge that there was a good chance that reasonable decision-making on the part of CSS may have still seen Infant 2 at home being cared for by his parents but being monitored and supported and with a requirement for full engagement with CSS and appropriate services. In this scenario, a greater level of support in the home may well have ensured that Infant 2 was attended to regularly by nurses and presented at his doctor's appointments. It may also have resulted in greater awareness on the part of Infant 2's parents about his need for medical treatment. In such a situation, he may have been treated successfully in a timely manner.

37. Even if a court had granted an order involving removal of Infant 2 from the home in response to a CSS application, he still may have succumbed to pneumonia in a safe environment. However, it is more likely that the greater vigilance to his health would have resulted in successful emergency treatment with antibiotics.

38. In conclusion, I can only find that the serious deficits in child protection practice in respect of responding to notifications for this family, and most relevantly, in respect of Infant 2, resulted in missed opportunities to afford him greater care and protection.

Appendix C

Infant 3

Introduction

1. Infant 3 was born in late November 2016 and died suddenly overnight in early March 2017 at the age of 14 weeks. He died whilst sleeping in the bed of his mother, with his mother in the bed with him. His death was reported to the coroner as required by the Act, being a sudden and unexpected death of a child under the age of one year.

Background and family history

2. Infant 3's reported father was not involved in a relationship with the Mother when Infant 3 was born.[1] At Infant 3's birth, the Mother was 33 years of age and the Father was 32 years of age. The Mother had two older children: Sibling A and Sibling B. Both Sibling A and Sibling B had been diagnosed with ADHD.[2]

3. The Mother had two older sisters and grew up in a strongly Christian family. She described herself as the "*black sheep*" of the family and ran away when she was 17 years of age. She felt loved by her parents growing up but was exposed to her mother's self-harm and heavy alcohol use. She described her father as a "*hard, very angry man, but strong*" and had a strong bond with him, but had grown apart from her mother. The Mother considered her mother to be over-powering and blamed her for saying things that had resulted in Sibling A and Sibling B being removed from the Mother's care.[3]

4. The Father was known to police for a number of offences between 1997 and 2016 involving alcohol, firearms, drug use, supply and cultivation, sexual offences and a breach of an FVO.[4]

5. The Mother had natural births and experienced quick labour times with all three of her children. She, her mother and one of her sisters had a history of miscarriages. The Mother suffered a bout of cervical cancer in 2006. She was diagnosed with bipolar disorder as a teenager and was prescribed medication (Pristiq and Zeldox). She also took Desfax to treat her anxiety and Ventolin for asthma. At the time of Infant 3's birth she smoked cigarettes but said that she did not drink alcohol.[5]

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[1] Exhibit D18 p8-9.
[2] Exhibit D11, D18 p8.
[3] Exhibit D18 p12.
[4] Exhibit D18 p17.
[5] Exhibit D11 p3.

6. The Mother's older children were known to CSS through a number of notifications and care and protection orders relating to parental drug use, mental health issues, and incapacity for appropriate parenting. Infant 3 was subsequently the subject of notification and assessment from birth. The involvement of CSS with the family is covered in more detail below.

7. At the time of Infant 3's birth, the Mother was living alone in a rental unit. Sibling A was living with her boyfriend and Sibling B was living with the Mother's parents, Mr and Mrs B.[6] The Mother met and formed a friendship with her neighbours, Mr and Mrs E, in mid-2016 - about two months after Mr and Mrs E moved in to the neighbouring unit.[7]

8. The Mother did not know that she was pregnant until early November 2016. She had thought she may have been pregnant at an earlier time but had taken a number of home pregnancy tests that gave negative results. A blood test at the Wynyard Medical Centre finally confirmed the pregnancy and she was told at that time that she was 5-7 weeks pregnant.[8] The medical records indicate that her pregnancy was, in fact, well advanced. She said that as soon as she knew she was pregnant she stopped using cannabis, which she had previously used heavily. On the advice of her general practitioner (but against the recommendation of her treating psychiatrist) she also stopped taking the medication related to her mental health disorders.[9]

9. A few weeks later, on 28 November, Sibling A was visiting the Mother when she began to feel unwell and as though she would miscarry. She lay down and Infant 3 was delivered within 20 minutes with Sibling A's assistance. It was believed by hospital staff that Infant 3's gestation was between 34 and 36 weeks.[10] Sibling A ran next door to seek Mrs E's assistance and an ambulance was called to take the Mother and Infant 3 to the NWPH.[11]

10. At birth, Infant 3 had hypoglycaemia, hypothermia and jaundice and spent about two weeks in the hospital; the majority of that time in the Special Care Unit. He was fed expressed breastmilk through a tube.[12] The Mother consented to a drug screen which returned positive results for cannabinoids and benzodiazepine. This issue, combined with Infant 3's failure to gain weight, caused the paediatric doctors to recommend that Infant 3 be placed on formula. The Mother was opposed to this recommendation and was concerned that the results of the drug screen would result in CSS taking Infant 3 into care. She was particularly upset because

[6] Exhibit D11 p1.
[7] Exhibit D12.
[8] The Mother has given a different time frame to the NWPH saying she became aware of her pregnancy at 10 weeks gestation which was questioned by the NWPH. D18 p10.
[9] Exhibit D11 p3, D18 p9, 11.
[10] CHaPS at assessment on 22 February 2017 thought gestational age more likely 33-34 weeks D18 p19.
[11] Exhibit D11 p1, D18 p10.
[12] Exhibit D11 p1, D18 p10.

she had allegedly stopped using cannabis and her other medications as soon as she knew she was pregnant, albeit this had been only a short time before Infant 3's birth.[13]

11. Within a week after Infant 3's birth, the Mother resumed taking her bipolar medication. The hospital nursing staff and psychiatric team had no concerns regarding her interactions with Infant 3. Her mother, Mrs B, spoke to CSS at this time to emphasise that the Mother was "a good little mum when they're tiny" and that parenting issues had only arisen with Sibling A and Sibling B when they were older and needed "guidance and discipline".[14]

12. Before the Mother and Infant 3 left the NWPH, a CSS Initial Safety Planning Meeting was held. Mrs E, along with her husband, was a registered foster carer. She volunteered to provide guidance and care to the Mother and Infant 3. The resulting Safety Plan allowed the Mother and Infant 3 to return to the unit, with Mrs E to stay overnight with them between 7.00pm and 7.00am for a month.[15]

13. It is clear from this generous commitment that the Mother and Mrs E had a strong bond, despite having only met a few months before Infant 3's birth. The Mother referred to Mrs E as 'Mum'. Mrs E described Infant 3 as a beautiful baby who was easy to care for and said that the Mother took good care of him, always keeping him well dressed and fed.[16] Infant 3 usually slept in a bassinet in the Mother's bedroom and she also had a cot ready for him.[17]

14. The Mother resumed a relationship with Infant 3's father, the Father, in late January 2017. There was some question about Infant 3's paternity and CSS had arranged a paternity test to be undertaken. The Father intended to move in with the Mother and Infant 3 if the results showed that he was Infant 3's father.[18] However, it does not appear that the results of that test had been returned prior to Infant 3's death.

15. Infant 3 was admitted to the NWRH on 1 February after the Mother became concerned that he was in pain and not emptying his bowels.[19] He presented with a bowel motion that contained blood, but further motions were normal and he was discharged the following day with instructions for the Mother to trial avoidance of cow's milk, as an allergy was a possibility.[20]

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[13] Exhibit D18 p11.
[14] Exhibit D18 p11-13.
[15] Exhibit D12, D18 p14.
[16] Exhibit D12.
[17] Exhibit D11 p2.
[18] Exhibit D18 p17-18.
[19] Exhibit D11 p2.
[20] Exhibit D10, D11 p2.

16. On 6 February the Mother showed Infant 3's "puffy" stomach to the child health nurse who visited regularly. The nurse suspected an inguinal hernia and Infant 3 attended Wynyard Medical Centre. He was referred to the RHH the following day. He underwent a herniotomy on 9 February, recovered with no complications and was discharged the next day.[21]

Circumstances of death

17. During the day on 9 March, nothing seemed amiss with Infant 3 who appeared to be a "happy little baby". Mrs E thought that the Mother had come a long way and was doing everything she could to take care of Infant 3.[22]

18. The Mother fed Infant 3 at 9.30pm that night and took him to bed with her between 11.00pm and 11.30pm. She placed him on the left side of her bed, where he had slept for the previous few nights. Infant 3 was dressed in a grow suit and a romper suit and wrapped in what the Mother described as a muslin wrap (but police called a bunny rug), with his face uncovered.[23]

19. The Mother woke between 4.30am and 4.45am the following morning, surprised that Infant 3 had not woken during the night. She reached out and found him cold to the touch.[24] Distressed and hysterical, she called Mrs E who came in from next door to find the Mother carrying Infant 3 out of the bedroom.[25] The Mother gave Infant 3 to Mrs E and said "*Mum, is he alive?*" Mrs E told the Mother to call 000 and Mrs E followed the operator's instructions to provide CPR until the ambulance arrived.[26] Ambulance Tasmania records show the call was received at 4.47am and the ambulance arrived at 5.00am.[27]

20. Infant 3 continued to receive CPR in the ambulance and at the NWRH ED. Adrenaline was administered after arrival at the ED but, sadly, Infant 3 could not be revived and resuscitation attempts were stopped at 5.33am.[28]

21. Police officers attended the Mother's unit and observed it to be clean and well-kept. In the Mother's bedroom was a double bed, a bassinet and cot. Neither the bassinet nor the cot appeared to have been slept in. The double bed was fitted with a mattress topper, a fitted satin bottom sheet, two pillows and a quilt. The heat pump in the unit was set to 30 degrees Celsius and the temperature in the bedroom was measured to be 22.1 degrees Celsius. Empty alcohol containers were seen in the kitchen and in an outside bin. There were ashtrays,

[21] Exhibit D10, D11 p2.
[22] Exhibit D12.
[23] Exhibit D1, D5 p1, D11 p2.
[24] Exhibit D11 p2, D7.
[25] Exhibit D12, D14.
[26] Exhibit D12.
[27] Exhibit D7a.
[28] Exhibit D8.

cigarette butts and lighters outside the front door and living room sliding door, but no evidence of smoking inside.[29]

Cause of death

22. On 14 March 2017 an autopsy upon Infant 3 was carried out by State Forensic Pathologist, Dr Christopher Lawrence, at the RHH. No evidence of traumatic injury was found. A mass in the pleural cavity was initially thought to be a haematoma but after review of CT scans was concluded to be an infantile haemangioma.

23. Dr Lawrence noted Infant 3's prematurity as an increased risk factor in bed-sharing. He said that the haemangioma was unlikely to have contributed directly to death, but could have indirectly contributed to apnoea during sleep as it occupied space in the chest.[30]

24. The toxicology report showed sub-therapeutic levels of desvenlafaxine, an antidepressant probably received via breastmilk, and also paracetamol, possibly related to Infant 3's recovery from the herniotomy. Amiodarone given during resuscitation was also detected.[31]

25. Ultimately, Dr Lawrence did not determine a medical cause of death but described Infant 3's death as sudden infant death while bed-sharing.[32] In describing his death in that way, he stated that *"this appears to be an unsafe sleeping environment for a premature infant who has had some minor medical problems".* [33] No doubt, Dr Lawrence was primarily referring to the obviously unsafe practice of the Mother co-sleeping with Infant 3 in her bed and amongst adult bedding, particularly given that he was 6 to 8 weeks premature.

26. There is no clear evidence about Infant 3's position in the bed compared to that of the Mother when she discovered him unresponsive. Her affidavit suggests that there was space between them. Nevertheless, the unsafe sleeping environment means that Infant 3 might well have experienced suffocation in the adult bedding or died as a result of unintentional overlying by the Mother whilst she was sleeping. The Mother's cigarette smoking, even if it was done outside, nevertheless represented a risk factor to Infant 3. I cannot determine whether the Mother had consumed alcohol or cannabis before taking Infant 3 to bed with her, these being sedating substances. The evidence indicates that it is quite possible that she may have done. I accept Dr Lawrence's opinion that the haemangioma was unlikely to have caused Infant 3's death in itself but may have been a factor in his respiratory compromise. There were no other natural conditions that would obviously have caused his death, and therefore an undetected

[29] Exhibit D14, D15, D16.
[30] Exhibit D5.
[31] Exhibit D5, D6.
[32] Exhibit D5 p13.
[33] Exhibit D5.

natural cause alone is a far less likely cause of death than death contributed to by unsafe sleeping practices. However, I cannot make a final determination upon cause of death.

History of CSS involvement

27. CSS became involved with Infant 3's siblings in 2013 when care and protection orders were issued for both Sibling A and Sibling B for reasons including: the Mother's long-term mental health issues, drug use, criminal activity, aggressive behaviour towards the children, disengagement from support services, people of dubious character visiting the home and socialising with the children, and concerns about the children engaging in shoplifting and vandalism. From this time, Mrs B periodically left her living circumstances to assist in caring for her grandchildren and in 2016 took over full care of Sibling B. Further care and protection orders were issued for both children in 2014 and again for Sibling B in 2016.[34]

28. CSS received a notification from the NWPH the day after Infant 3's birth alerting them to his birth. Prematurity and the Mother's history of mental illness were identified as risk factors by the notifier. The notification was assessed within 24 hours of receipt and rated Infant 3's vulnerability as extreme with a high risk of future harm.[35]

29. On 30 November 2016, the day the notification assessment was completed, CSS attended the NWPH to meet with the Mother and medical professionals. After the results of the drug screen were known, CSS requested on 1 December that NWPH notify CSS if the Mother attempted to remove Infant 3 from hospital and to inform of a discharge date as soon as it was known. A foster carer was engaged on standby if out-of-home care for Infant 3 was required.[36]

30. On 5 December CSS notified the NWPH of CSS's intention to apply for a 4-week order in respect of Infant 3 and bring him into care upon discharge from the hospital. The midwife at the NWPH expressed opposition to this due to her observation and assessment of the Mother's appropriate care of Infant 3 in hospital. The midwife also advised that Infant 3 was expected to be discharged by 8 December.[37]

31. Infant 3's discharge was delayed due to his failure to gain weight. On 8 December the CSS Court Application and Advisory Group (CAAG) met, noted that a Safety Plan that would allow Infant 3 to go home with the Mother would need to include daily sighting, and recommended a 28-day assessment order to allow for immediate intervention by CSS if

[34] Exhibit D18 p9.
[35] Exhibit D18 p10.
[36] Exhibit D18 p10-11.
[37] Exhibit D18 p113-14.

required. The Mother, the NWPH midwife, Infant 3's paediatrician and Mrs and Mr E all met with CSS the same day for an Initial Safety Planning meeting. Infant 3 was allowed to go home with the Mother primarily due to the generous commitment of Mrs and Mr E to assisting and monitoring mother and baby.[38] However, steps were not taken to progress the application for the recommended assessment order.[39]

32. Infant 3 was kept in hospital for the weekend of 10 and 11 December. On 9 December the Mother accompanied CSS to have her unit assessed for Infant 3 to go home. As a result, the cot the Mother had purchased for Infant 3 was replaced by CSS with one that met safety standards. During this visit, the Safety Plan was discussed with Mrs E and the arrangement for her (or her husband if she was unavailable) to stay in the Mother's apartment each night between 7.00pm and 7.00am for the next month and to be available during the day to assist. Sibling A agreed to visit during daytime hours to spend time with Infant 3 and assist the Mother but not to live with the Mother at that time. Part of the reason for this appeared to be that Sibling A was using cannabis at this time and the Mother was trying not to do so.[40]

33. The Safety Plan included requirements for the Mother to take her medication, engage with relevant support services and not have people in her unit that were not part of the safety network. The safety and family network comprised the Mother, Sibling A and Sibling B, Mrs and Mr E, Mrs and Mr B and Friend A (a friend, described as Infant 3's 'kinship grandfather') as well as staff from support services. The Safety Plan was finalised on this day.[41]

34. Infant 3 was discharged to the Mother's care on 12 December without an assessment order. The Mother engaged well with support services and her network and, after the initial one month period for Mrs E's 'sleepovers' ended, CSS agreed not to enforce them any longer.

35. After further advice from CAAG, an interim assessment order was applied for and granted on 12 January, which gave custody of Infant 3 to the DHHS Secretary.[42] However, Infant 3 was permitted to remain at home in compliance with the Safety Plan.

36. The CSS case manager had no concerns for Infant 3 until 24 January. At this time, the Mother had re-entered a relationship with the Father, who was believed to be staying in her unit. Sibling A was also wanting to spend nights staying at the Mother's unit contrary to the Safety Plan. The Mother's history of becoming unstable in changing circumstances and when new relationships were established was again assessed and noted by CSS.[43]

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[38] Exhibit D18 p14-15.
[39] Exhibit D18, page 16
[40] Exhibit D17, D18 p15.
[41] Exhibit D17.
[42] Exhibit D18 p17.
[43] Exhibit D18 p17.

37. On 30 January the Safety Plan was reviewed with regard to concerns about the Father's criminal and family violence history and his presence in the Mother's unit. CSS decided to apply for funding to cover a paternity test for Infant 3 as it considered that there were two other potential fathers. Notwithstanding Infant 3's admission to NWRH on 1 February, CSS believed that over the following week Infant 3 and the Mother were doing well. When Infant 3 was transferred to the RHH for the herniotomy, Mrs E reported that the Mother stayed in constant phone contact with her.[44]

38. On 16 February the CAAG met to consider further legal orders as Infant 3's assessment period had expired. It was noted that there had been no reports of family violence between the Father and the Mother, but his history and plan to move in if the paternity test confirmed him to be Infant 3's father was of concern. It was planned to make an application for a 12-month care and protection order to enable ongoing custody to the Secretary of the Department to ensure continued monitoring, safety planning, and the Mother's compliance with service engagement.

39. An application for a 12-month care and protection order was made on 21 February, and on that day, the Court made an interim order on the application in the same terms as the assessment order until 21 March. A pre-court conference was held on 8 March, in which the Mother's legal representative informed CSS she would be opposing the proposed 12-month order. CSS was concerned that the Mother was "doing everything right" with regard to her mental health only because CSS was asking her to do so, not because she wanted to do it for herself, and considered the order necessary to ensure she did undertake the work needed to improve her mental health and stability. CSS expressed the view that it did not intend to take Infant 3 from the Mother at this stage. The Mother agreed to various things, including psychotherapy, parenting courses, appropriate access for Sibling B, and keeping CSS informed of any new partners or friends.[45]

40. CSS was advised of Infant 3's death on 10 March 2017.[46]

CSS issues identified in SERT report

41. CSS reviewed its intervention related to Infant 3 and acknowledged that there were deficiencies and areas for improvement in the case management, particularly relating to the Safety Plan.[47] It is noted that the Initial Assessment and subsequent Child Safety Assessment

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[44] Exhibit D18 p17-18.
[45] Exhibit D18 p19-20.
[46] Exhibit D18 p20.
[47] Exhibit D18 p20.

carried out while Infant 3 and the Mother were in hospital immediately after Infant 3's birth were appropriate, as was the initial decision that out-of-home care intervention would be necessary - but this did not eventuate.

42. The CSS deficiencies included:

- Failure to progress the decisions of the CAAG (senior and experienced CSS practitioners) with regard to Infant 3 and non-compliance with CAAG procedures relating to this failure – this usually would involve returning to CAAG with changed circumstances to revisit a decision.

- Failure in the case management process to acknowledge legal responsibilities associated with holding legal custody of a child. In particular, there was a heavy reliance on others – for example, failure to acknowledge visiting and sighting requirements from the date of custody (12 January 2017) and relying on reports of Infant 3's wellbeing from Mrs E and leaving Mrs E and CHaPS to take the primary role in monitoring Infant 3's post-surgery treatment.

- Failure to undertake a structured and comprehensive risk assessment for Infant 3's return home. The Safety Planning was done well as it was done in a timely manner with updates made following changes in Infant 3's circumstances and identified concerns and what was working well. However, it was seriously deficient as it was based on allowing a premature and vulnerable infant to return home in the absence of the required protections evidenced over time. The original Safety Plan was also insufficient as it relied on Mrs E's untested ability to provide the level of support required with no contingency plan and that it did not adequately address the Mother's considerable history and pattern of disengaging from services.

- Failure to discuss with the Mother the 'Infant Safe Sleeping Practices – DHHS Wide – Policy and Procedure 2013'.

43. The specific recommendations for improvements to be made by CSS were:

- Ongoing state-wide focus on staff training relating to the TRF and the application of the Signs of Safety Approach (particularly the use of Safety Plans).

- Annual audits of compliance with procedures.

- Reviews and updates, as required, of policy, procedures and practice requirements relating to the responsibilities attached to legal orders.

- Clear documentation of legal orders on CPIS.

- Staff attention to be drawn to the policy 'Infant Safe Sleeping Practices – DHHS Wide – Policy and Procedure 2013'.

Professor Lonne's assessment

44. Professor Lonne was asked to assess whether, in his opinion:

If correct practice had been adopted by CSS would there have been a significant reduction in risk to Infant 3?

and

Does the case contain deficiencies in CSS that are more serious and which involve an identifiable increase in risk to the child before death?

45. In his response he identified the following risks and issues for CSS:[48]

- An established history of emotional abuse and destructive mother/child relationships with the two older children;
- An established history of the mother's variable mental illness and her propensity at times to misuse alcohol and other drugs;
- The father's history of criminal offending including FADV, albeit that he was having little contact with Infant 3, but appeared interested in having increased contact;
- Some identified issues with the adequacy of CSS interventions; and
- The vulnerability of Infant 3 as an infant with acknowledged medical needs.

46. In his assessment of the work of CSS, Professor Lonne said:[49]

"The casework/case management of the situation following Infant 3's birth was intensive, highly supportive and coordinated. The Mother's mental health was stable and being well managed medically. There was very close supervision and support from (the foster parent and neighbour). The Mother was positively engaged with the support being provided. Moreover, the materials examined indicate that the Mother was a good enough mother of infants, but that when they got older and less dependent, the relationship problems with her children arose.

Nonetheless, the SERT report identified aspects where CSS practice did not meet with departmental requirements. For example, while ChaPS did discuss safe sleeping practices with the Mother, CSS staff did not. Issues were also raised about the risk analysis undertaken not being "comprehensive" nor "structured", and that its "sustainability" was questionable. It concluded that "The safety

[48] Exhibit G1 Appendix E p7.
[49] Exhibit G1 Appendix E p8.

planning was 'done' well, but the basis upon which it was conceived was seriously deficient." (SERT, p. 26). I did not concur with the SERT assessment that "the case management of Infant 3 from this date (12 January 2017) be appropriately regarded as confused and ad hoc, in which legal responsibility was inappropriately delegated in an approach that was (or) could be described as 'relaxed' and 'hands off'" (p. 27). Rather, in my view, it appeared to be well considered and coordinated, and involved a sound combination of formal and informal supports, close supervision and clear exercising of CYS/CSS case management and legal responsibility. There did not appear any work undertaken that could be attributable to the subsequent death of Infant 3 from SUID.

Having considered the material my responses to the questions are as follows:

If correct practice had been adopted by CYS/CSS would there have been a significant reduction in risk to the child?

Response: In my view the case management by CYS/CSS did lead to a demonstrable decrease in the risk of harm to Infant 3 by addressing and reducing known stressors, and providing intensive, multi-layered supports to the Mother.

Does the case contain deficiencies in the CYS/CSS that are more serious and which involve an identifiable increase in risk to the child before death?

Response: Notwithstanding the shortcomings in practice identified in the SERT report, when these are considered alongside the positives of the intervention, I could not identify an appreciable contribution CYS/CSS actions played in Infant 3's death from SUID."

In his evidence at inquest, Professor Lonne dealt with the issue of whether CSS should have sought to remove Infant 3 at birth. He stated:

"The removal of a child at birth has quiet (sic) significant implications in the longer term. Particularly around – because of the attachment. The attachment by parents of infants is really quite critical, and there are significant impacts if you disrupt that attachment or if that attachment is disrupted by ill health of a child, or ill health of a parent, or removal of a child. It is a quite significant decision to take. It is justified in some circumstances and certainly in cases where there is a propensity for physical abuse of children, but otherwise it nonetheless is a decision that needs to be taken with a lot of consideration and good evidence and information. In this case, I thought the decision they made to not remove was a correct one and the decision to provide a very strong support network was also the correct one."[50]

[50] Transcript 24 August 2020 p39-40.

Conclusion

47. Infant 3 was an infant at high risk requiring protection. This was reinforced by the fact that Infant 3's sibling, Sibling B, was subject to a care and protection order, and a recent independent forensic psychological assessment in respect of him concluded that he required CSS care in the long term due to the Mother's chronic mental health issues, concerns regarding recreational substance use, and difficulties complying with psychiatric treatment. The assessment recommended that Sibling B not be returned to the care of the Mother. [51]

48. CSS undertook a large amount of dedicated work in developing and implementing the Safety Plan for Infant 3. I accept Professor Lonne's view in this regard and acknowledge the efforts made by CSS. As to whether the Safety Plan was adequate to mitigate the risk involved, Professor Lonne made no criticism. To the contrary, the Reviewer considered that the basis for it was deficient in protecting Infant 3, particularly given the Secretary's responsibility of custody, and it was 'misaligned' with the high risk situation. The Reviewer also reasoned that it did not provide for sustainable intensive monitoring of a vulnerable infant nor contingency plans in the event that crucial supports, such as Mrs E, were lost.[52]

49. I found the Reviewer's detailed analysis of risk to Infant 3 and the deficiencies in the Safety Planning to be compelling, notwithstanding Professor Lonne's opinion. If Infant 3 was to remain at home, the plan required building into it a higher level of protection, particularly after Mrs E ceased overnight stays. As noted by the Reviewer, the only protective parenting observed by CSS from the Mother before she was allowed to take Infant 3 home was the two-week period in the supportive environment of the hospital - an environment in which parenting skills could not properly be assessed. Moreover, there was no initial protection of an assessment order for Infant 3 (with custody to the Secretary), as the CAAG decision had not been complied with by relevant CSS staff. It appears that the CSS staff involved were focused exclusively upon supporting Infant 3 at home with his mother rather than recognising the high risk situation.

50. Further, CSS did not take the opportunity to impose stricter conditions upon the Mother when later being granted the assessment order. Such strengthening should have been given consideration at this time as Mrs E had been relieved from sleeping the night at the Mother's unit, leaving Infant 3 exposed to additional risk. Mrs E's involvement in this regard had effectively been a precondition for allowing Infant 3 to be at home with his mother.

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[51] Exhibit D18 p13.
[52] Exhibit D18 p27.

51. Further, CSS did not take the opportunity to consider more assertive intervention upon the imposition of the interim care and protection order, which remained in existence at the time of his death. This was another obvious opportunity to reassess the degree of risk to which he was exposed.

52. Finally, there was no implementation of the CSS Infant Safe Sleeping Procedure which mandated CSS staff to inform and discuss with the Mother the critical safe sleeping messages, particularly emphasising that the infant should sleep in his/her own safe sleeping place and the dangers of co-sleeping. It would be apparent to CSS from experience, learnings and practice that death of an infant through unsafe sleeping practices is one of the highest risks to an infant particularly where the parent is unable or unwilling to adhere to safe sleeping practices.

53. It does not appear that Infant 3 regularly, if at all, slept in his own cot. Instead, the Mother chose to put Infant 3 to sleep in her bed with her. The child health nurse explained safe sleeping practices to the Mother, as would have occurred with her other children. It is well-known that such messages require repetition, particularly with high-risk parents. I consider that CSS had a particular responsibility, with the Secretary having custody, to ensure that Infant 3 was safe in this crucial respect.

54. The imposition of a requirement that Infant 3 sleep in his own safe cot could have been imposed and could have made a difference to the outcome. CSS could have and should also have conducted home visits and investigations regarding Infant 3's actual sleeping arrangements. In this case, such process was not undertaken.

55. Infant 3 was an infant at high risk and his risk was assessed as such in response to the notification. In retrospect, best CSS practice may have been that Infant 3 was removed from home and therefore not exposed to the numerous known risks, including an unsafe sleeping environment. If factors related to that unsafe sleeping environment were instrumental in his death, his death would likely not have occurred if he was removed from his mother and in care. Nevertheless, I am conscious of Professor Lonne's view that the situation did not require removal of Infant 3 from home. Although legal orders with custody to the Secretary were necessary, I accept that a suitable Safety Plan with Infant 3 remaining at home was within the realm of appropriate CSS practice.

56. Accepting Professor Lonne's view, therefore, the Safety Plan needed to be effective to mitigate the high level of risk to Infant 3. Notwithstanding the copious work by CSS staff members, the Safety Plan and its monitoring required significantly greater strengthening to mitigate the risks as outlined by the Reviewer.

57. Even with a stronger Safety Plan, more intensive monitoring and higher accountability on the part of the Mother, that plan may not have prevented her co-sleeping with Infant 3.

58. As previously outlined, it is also possible, but less likely, that the unsafe sleeping environment did not play a part in Infant 3's death, which may have been due to unknown natural causes.

59. In summary:

(a) I find that the Safety Plan, and its implementation and monitoring, was inadequate to ameliorate the high risk to Infant 3 in remaining at home.

(b) I find that there were other deficiencies in CSS practice as outlined in the SERT report.

(c) I cannot make a finding that Infant 3 should have been removed from the Mother.

(d) I cannot determine Infant 3's cause of death, although there is a very significant chance that the unsafe sleeping environment caused or contributed to death.

(e) I cannot make a finding that CSS deficiencies contributed to Infant 3's death, although there were opportunities to have protected him to a greater degree.

Report upon Infant 3's care, supervision or treatment pursuant to section 28 (5) of the Act

60. I was required pursuant to section 24(1) of the Act to hold a public inquest into Infant 3's death because he was a person 'held in care'. In section 3 of the Act that phrase includes a child within the meaning of the *Children, Young Persons and Their Families Act* 1997 in the custody of the Secretary. The Secretary therefore had the right to have, and the responsibility for, the daily care and control of Infant 3, and the right to make, and the responsibility for making, decisions concerning his daily care and control.[53]

61. Given Infant 3's status as a person 'held in care', I am required by section 28(5) of the Act to report upon his care, supervision and treatment whilst he was held in care – that is, for the period that the Secretary had custody by virtue of a court order.

62. I consider that I have discharged my obligation to report under section 28(5) in this finding.

[53] *Children, Young Persons and Their Families Act* 1997, section 6.

Appendix D

Infant 4

Introduction

1. Infant 4 was born in mid-February 2017 and died in mid-September 2017 at the age of 7 months. She drowned in the bath at home while in the care of her mother. Her death was reported to the coroner as required by the Act, being a sudden and unexpected death of a child under the age of one year. CSS had involvement with Infant 4 before her death.

Background and family history

2. At Infant 4's birth, the Mother was 18 years of age and the Father was 26 years of age.[1] Infant 4 was the first and only child to her parents, who were not in a relationship. She primarily lived with her mother but spent two days a week and every second weekend with her father.[2] The Mother and the Father were generally on good terms with regard to Infant 4, but the Mother did not get on well with some other members of the Father's family.[3]

3. The Mother was the third of six children and had three brothers and two sisters. She moved into a unit before Infant 4's birth. The Father lived not too far away. At the time of Infant 4's death, the Mother's mother was living and working in a town some distance away, but some of her siblings and her grandmother were living nearby.[4]

4. Infant 4 was born at the LGH in mid-February 2017. The birth involved no complications and Infant 4 was a healthy baby.[5] The Mother's family and acquaintances generally considered her to be a loving and caring mother to Infant 4.[6] The Father and his family were considered loving and competent carers.[7]

5. Infant 4 was known to CSS through several notifications relating to parental drug use, inappropriate relationships and lack of capacity for appropriate parenting. The involvement of CSS with the family is covered in more detail below.

6. About a month before Infant 4's death, Friend A (aged 16 years) moved into the unit with the Mother and Infant 4. Friend A and the Mother had known each other for five years.[8]

[1] Exhibit F34 p7.
[2] Exhibit F11 p2-3.
[3] Exhibit F15, F34 p8.
[4] Exhibit F15, F16.
[5] Exhibit F10, F35.
[6] Exhibit F14, F15, F16.
[7] Exhibit F25 p2, F27 p11.
[8] Exhibit F11, F12.

7. The Mother's mother, Ms J, held concerns about some of her daughter's friends, whom she considered to be unsafe, and who exhibited behaviours and made lifestyle choices associated with alcohol and drugs. Ms J understood these concerning behaviours to arise when the Mother was not with Infant 4, but that the Mother would sometimes leave Infant 4 with unsuitable carers, such as Friend A, when she went out to party. She would also take Infant 4 with her when visiting friends' homes where the environment was not suitable for an infant.[9]

8. The Mother and Infant 4 received home nurse visits through the CHaPS program 'CU@home'. The Mother cancelled or otherwise disregarded about half of the scheduled visits by this service, although the Father consistently took Infant 4 to the general practitioner and other medical appointments. At the time of Infant 4's death, the visiting nurse was Ms P.[10]

9. In June and August 2017 Infant 4 was unwell with croup and bronchiolitis.[11] The Mother had home visits by a general practitioner on 17 June and 15 August. The Mother asked Ms P's advice about care for Infant 4 for this condition during a scheduled visit on 21 August. However, as the Mother had forgotten about the appointment, Infant 4 had been left at a friend's house which was warmer and Ms P was not able to see her or examine her. The Mother did not respond to Ms P's requests to make an alternative appointment later in that week and Ms P did not see Infant 4 again until 11 September. This appointment took place at a friend's house and Ms P discussed safe sleeping practices, treatment for Infant 4's eczema, and a squint that she was developing (for which she was supposed to attend appointments with an eye specialist, the next one being the next day on 12 September). Infant 4 still had a wheeze at this time. Ms P also noticed that the back of Infant 4's head was flat and that she would transition from lying to standing without bending into a sitting position when being picked up, which together indicated that she was likely spending a lot of time lying on her back. Ms P discussed this with the Mother and told her that Infant 4 needed more supported sitting and playing time.[12]

Circumstances of death

10. On 19 September 2017, the Mother awoke with Infant 4 at around 7.00am. She gave Infant 4 a bottle, placed her in a rocker baby chair and had a coffee and cigarette outside with Friend A. The Mother then ran a bath for Infant 4.[13]

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[9] Exhibit F15 p2, F27 p9.
[10] Exhibit F25.
[11] Exhibit F10, F11 p14-15.
[12] Exhibit F25 p2-4.
[13] Exhibit F11 p4-6.

11. The Mother sat Infant 4 in the bath in a baby seat. The seat was an 'Ingenuity' unit from the brand 'Kids II', with leg holes, restraint straps and a small tray that would sit across an infant's lap, purchased from Target. The Mother's older brother had unpacked it from the box so she had not read any warning notices or labels in or on the box. The Mother used the seat regularly for Infant 4 and one of her friends had the same seat. However, this was the first time she had used it in the bath.[14] The warning label on the back of the seat stated, relevantly, "*Do not leave the child unattended*" and "*Never use this product near swimming pools or other bodies of water*".[15] Infant 4 was strapped into the seat around her waist and had a leg in each of the leg holes. The water in the bath covered Infant 4's legs but was below the level of the seat's tray.[16] The Mother had removed an insert from the seat before putting Infant 4 in the bath.[17]

12. The Mother played with Infant 4 in the bath for a few minutes and took some photos on her phone of Infant 4 in her "big girl seat" which she sent to a friend and her mother at 7.58 am.[18] She then washed Infant 4's hair and body and played with the toys that were floating in the bath. The Mother then left the bathroom to get a towel from the lounge room, where Friend A was watching television. The Mother had no towels washed that morning so had placed a used damp towel of Infant 4's under the heat pump in the lounge room to dry. She estimated she was out of the bathroom for three to four minutes.[19]

13. On her return to the bathroom, the Mother found that the chair had tipped over and Infant 4 was face down in the water. She pulled Infant 4 out of the bath and tried to resuscitate her, calling out for Friend A to call 000.[20]

14. Friend A made the 000 call at 8.20am from the Mother's phone.[21] Their neighbour, Mr N, heard the commotion and came next door to find Friend A outside on the phone. He could not understand what she was saying due to her distress and he entered the unit to find Infant 4 and a distraught the Mother in the bathroom. He returned to his unit to rouse his partner, Ms T, and came back to take the phone from Friend A to speak to the operator.[22] Ms T came into the unit to assist the Mother and moved Infant 4 from the bathroom floor to the lounge room because she was concerned that the bathroom floor was cold. She began performing

[14] Exhibit F11 p11, 12, 17.
[15] Exhibit F24.
[16] Exhibit F28.
[17] Exhibit F11 p11.
[18] Exhibit F11 p7, F28.
[19] Exhibit F11 p9, F12.
[20] Exhibit F11 p9-10, F12.
[21] Exhibit F11 p15, F12, F6 p2.
[22] Exhibit F13.

CPR according to the instructions of the operator, which were relayed to her by Mr N. Infant 4 did not respond during this time.[23]

15. The ambulance arrived at 8.32am and paramedics took over the resuscitation efforts. Sadly, Infant 4 could not be revived and CPR was stopped at 9.02am.[24]

16. Police attended the unit and observed it to be generally clean and tidy, with no evidence of smoking inside, although the area outside the external laundry door appeared to be a smoking area. The distance from the bathroom to the end of the lounge room was about five metres. The laundry door was also about 5 metres from the bathroom, through the kitchen of the unit. A small amount of cannabis was located in a bowl on the kitchen bench.[25]

17. During the 000 call, Friend A referred to being outside with the Mother having a smoke.[26] When directly asked about this, the Mother told police officers at the time and her mother a few days later that this was not the case.[27]

Cause of death

18. On 20 September 2017 an autopsy upon Infant 4 was carried out by forensic pathologist, Dr Donald Ritchey, at the RHH. No evidence of traumatic injury or neck compression was found. Faint contusions on Infant 4's chest correlated with the restraint straps on the Ingenuity seat.[28]

19. Toxicological analysis detected caffeine and nicotine in Infant 4's blood.[29] The presence of nicotine was considered likely the result of second-hand tobacco smoke exposure. Neither contributed to death, but are unexpected in seven-month old infants.[30]

20. Dr Ritchey formed the opinion that Infant 4 died by drowning.[31] I accept his opinion as to cause of death. I find that Infant 4 drowned because she toppled over in the seat into which she was strapped and her face became submerged in water. This occurred because the Mother left Infant 4 unattended, having placed her in the bath strapped into a seat not designed as a bath aid and which was unsuitable for water. I find that she left Infant 4 unattended for at least several minutes, during which time she may have gone outside to smoke or become otherwise distracted. For part of this time she may have been getting a

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[23] Exhibit F14.
[24] Exhibit F6, F8, F9.
[25] Exhibit F17.
[26] Exhibit F11, F17 p2, F6 audio.
[27] Exhibit F11 p17, F15 p3.
[28] Exhibit F4 p12.
[29] Exhibit F5.
[30] Exhibit F4 p12.
[31] Exhibit F5.

towel for Infant 4. Whilst she was out of the bathroom, Infant 4's face became submerged in the bath.

History of CSS Involvement

21. CSS became involved with Infant 4 when various notifications and information relating to concerns about her safety and wellbeing was received in the 12 days prior to her death.

22. A first notification was received from Ms P, Infant 4's CHaPS nurse, on 7 September 2017 following a conversation between Ms P and Ms J, who was caring for Infant 4 at the time. Ms J was concerned that it would cause conflict with the Mother if she personally were to contact CSS and this would affect the periodic care she was providing to her granddaughter.

23. Ms P notified CSS that Ms J had reported that the Mother was abusing drugs and alcohol, had been charged with driving under the influence, and was sometimes so "stoned" that she did not wake up to Infant 4 crying. Ms P also reported the Mother's low engagement with the CU@home program and that it was the Father who took Infant 4 to medical appointments.[32]

24. Infant 4's case was allocated the same day at Intake noting concerns of neglect. The allocated Intake worker requested information from Tasmania Police about the Mother's driving history and boyfriends/associates. It was confirmed that the Mother had been charged with driving with an illicit drug present in her blood which occurred at the beginning of September 2017, and which was listed in court in March 2018. It was also confirmed that the Mother had tested positive for cannabis at the time of apprehension. Tasmania Police also provided the identity of her current boyfriend – a male serving time in prison. The following day, 8 September, it was agreed that a referral to the Gateway service would be discussed with the Mother.[33]

25. At this time, the allocated Intake worker had just returned from a period of extended leave and had not had the benefit of refresher supervision. That worker was also having to manage phone calls in Intake on top of allocated cases as a result of staff illness.[34]

26. Following the visit with Infant 4 at the Mother's friend's house on 11 September, Ms P provided additional information to CSS via email. She described the various medical issues that were discussed with the Mother and the unsuitability of the sleeping arrangements at the friend's home for Infant 4. She also raised a domestic violence incident that had occurred the previous day, when the Mother had gone to pick up Infant 4 without warning from the paternal grandfather's house as she believed she was being looked after by a member of the Father's family that she did not like. The paternal grandfather and sister did not want her to

[32] Exhibit F34 p7.
[33] Exhibit F34 p8.
[34] Exhibit F34 p13.

take Infant 4. When the Mother arrived, she was allegedly pushed by both the paternal grandfather and sister while she was holding Infant 4. The Mother was consequently intending to deny the Father contact with Infant 4. Ms P suggested that now would be a good time for CSS to contact all the parties involved as the Mother had not been open to potential help, believing she was doing a good job of parenting on her own.[35]

27. A second notification was received from Ms J's sister-in-law, Ms U (Infant 4's great aunt). She raised concerns about the Mother's drug use and association with criminals; two incidents of Infant 4 falling from a bed and a pram after being left unattended and unrestrained; Infant 4 being left in the care of others; and the Mother's failure to follow medical advice in respect of Infant 4's eye problems. Ms U had largely gained the information she provided from conversations with Ms J.[36]

28. On 13 September CSS contacted Ms P by telephone regarding the 11 September visit. Ms P raised concern about the Father being prevented from having contact with Infant 4, as he was the only one taking her to appointments. This was a particular issue as the Mother had missed Infant 4's eye appointment the previous day, despite being reminded about it the day before. Ms P also expressed concern about Infant 4's late development, health issues, including the possibility that she might redevelop bronchiolitis through visiting homes of smokers with the Mother. She expressed that the Mother appeared to be consistently making choices based on herself rather than what was best for Infant 4.[37]

29. On the same day, Ms J contacted CSS to provide further information about the Mother's drug use and failure to address Infant 4's medical issues. She also raised that the Mother had some control issues and would prefer to resort to unsafe options for care for Infant 4 than ask herself or the Father to look after her. Ms J also indicated that she did not have any concerns about the Father and his family having contact with Infant 4 and she believed they loved Infant 4 very much. CSS told her that the intended plan was to call the Mother the next morning and offer her family support through Gateway. Ms J told CSS that she predicted the Mother would be hostile to their call and would not accept support because she did not believe she was doing anything wrong.[38]

30. Due to staff illness at CSS, no call was made to the Mother on 14 September. This was conveyed to Ms P when she again contacted CSS the following week on the morning of 19 September, advising that she had not been able to contact the Mother and requesting that the Father and Ms J be "kept in the loop". CSS staff said that CSS intended to try to make contact

[35] Exhibit F34 p8-9.
[36] Exhibit F34 p9.
[37] Exhibit F34 p10.
[38] Exhibit F15, F34 p10-11.

with the Mother "this week". During the afternoon of 19 September, CSS was advised that Infant 4 was deceased.[39]

CSS issues identified in SERT report

31. CSS has reviewed its actions related to Infant 4 and acknowledged that there were some deficiencies and areas for improvement in the case management, although Infant 4 was only a client of CSS for 12 days.[40]

32. Deficiencies noted included:

- A failure to comply with procedural timeframe requirements with regard to the Initial Assessment for a child aged 3 years or younger. The Initial Assessment should have been completed within three days of receipt of the notification, including a completed risk assessment under the Tasmanian Risk Framework. This would have enabled a clear rationale for the case direction and action to intervene, if necessary. Instead, the assessment remained incomplete at the time of Infant 4's death, 12 days after the notification.

- A failure to comprehend the accumulating information indicating a high likelihood of a 'serious to extreme' harm consequence to Infant 4 which should have caused priority intervention on or before 13 September 2017.

- Failure to comply with procedures relating to the Initial Assessment in that the intention to refer to Gateway Services was made prior to the completion of the assessment.

- CSS was experiencing significant resource constraints due to a number of factors. These included sick leave, unavailability of designated relief workers and the part-time hours of the relevant intake worker and team leader. These factors likely contributed to the Initial Assessment not being completed and no internal consultation on Infant 4's case being undertaken prior to her death.

33. The specific recommendations for improvement made by CSS were:

- Ongoing state-wide focus on refresher staff training regarding SIDS risk indicators and indicators of infant/young child neglect more generally, noting that a new procedure *'Assessing and Responding to Risks to Infants and Young Children'* came into effect in

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[39] Exhibit F34 p11-12.
[40] Exhibit F34.

October 2017 and is more comprehensive than previous procedures, devoting a special risk field to SIDS.

- Development of a formal policy and procedure for triage of existing cases to identify high-risk cases and ensure ongoing attention to such cases at times where staff are required to attend to alternative tasks and functions.

- Development of a procedure to compel CSS managers to formally notify the CYS Executive about episodes in which notable resourcing issues (such as periods of unplanned staff illness) are creating environments that restrict compliance with procedural requirements.

- Development of strategies by CYS Executive to ensure backfill is available in the episodes contemplated in the above point, particularly in high-risk areas of CSS such as Intake and Response.

- Development of a return-to-work procedure to assist staff to resume confidence and competence following an extensive absence from the workplace, including refresher training inclusive of risk assessment, familiarity with new policy and procedures and regular supervisory support and case consultation.

Professor Lonne's assessment

34. Professor Lonne was asked to assess whether, in his opinion:

If correct practice had been adopted by CSS would there have been a significant reduction in risk to Infant 4?

and

Does the case contain deficiencies in the CSS that are more serious and which involve an identifiable increase in risk to Infant 4 before death?

35. In his response Professor Lonne identified the following risks to Infant 4:[41]

- The Mother was a young, first time parent who was under some observable pressure with her parenting role and in dispute with Infant 4's father, from whom she was estranged;
- Infant 4 was a young infant;

[41] Exhibit G1 Appendix E p10.

- The allegations received by CSS concerned her misuse of alcohol and drugs, lack of bonding with Infant 4 and leaving her for extended periods in the charge of inappropriate others; and
- The Mother's support system was limited, she had only intermittent contact with the CHaPS nurse and was resistant toward receiving other assistance.

36. In his assessment of the contribution of the actions of CSS to Infant 4's death he stated:[42]

"The situation appears from the documents examined to be one of a young, immature mother who was stretched and stressed with her caring role for Infant 4, was 'self-medicating' and avoidant of her parenting situation and responsibilities. Yet, she was also apparently feeling threatened and defensive about the criticisms of her behaviour by the Father's relatives. That an intervention was required by CYS/CSS is not in dispute. What is apparent is that there were a number of factors at play which hindered this being actioned in a timely way. These include the reduced staffing numbers, a staff member recently returned to duties, and no access to supervision to the Team Leader during a critical period for Infant 4.

My conclusion from reading all the material is that even had CYS/CSS interviewed the Mother during the period from 7 September onward my assessment is that it would be unlikely that statutory action to remove Infant 4 from her care would be justified or taken. Rather, because of the predominant issues of neglect, it would be more than likely that the assessment would identify a stressed mother in need of immediate assistance, and this would be arranged through referral for support from Gateway and other community-based agencies. In my opinion, the death of Infant 4 through a drowning incident in the bath was not reasonably foreseeable but, rather, what was foreseeable was a continuation of the emotional/relational neglect by the Mother through A&OD misuse and lack of consistent caregiving.

My examination and assessment of the materials provided has led me to the following responses to the critical questions:

If correct practice had been adopted by CYS/CSS would there have been a significant reduction in risk to the child?

Response: A priority response was warranted in this situation, which involved a young, vulnerable infant and this ought to have entailed interviewing the Mother and sighting Infant 4 so that a full assessment could be completed in a timely way. Had this occurred there would have, in my view, been a significant reduction in risk to the child from the sorts of issues that were the substance of the notifications and other information received. There would likely have been an increase in the levels of support brought forward and voluntarily accepted.

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[42] Exhibit G1 Appendix E p10.

Does the case contain deficiencies in the CYS/CSS that are more serious and which involve an identifiable increase in risk to the child before death?

Response: My assessment has concluded that while a number of risks to Infant 4's safety and well-being were identified and identifiable in the period immediately before her passing, I did not deduce that Infant 4's death by drowning was reasonably foreseeable. I could not attribute the fatal outcome for Infant 4 to the deficiencies identified in the delayed intervention by CYS/CSS. My sense of these events is that even with a more timely intervention and assessment by CYS/CSS that the prevention of the drowning incident could not be guaranteed. The statement by Det Sgt Riley seemed apt to me: "While it is clear that parents should never leave children in baths unattended, such events do occur." Infant 4's death was genuinely tragic and must have had a terrible impact on all her family members."

37. In his oral evidence, Professor Lonne was asked whether the identified risk to Infant 4 involving neglect by her mother was the very risk which had materialised when she was left unattended in the bath. Professor Lonne noted that the nature of the risk of neglect in the notifications was the Mother's leaving Infant 4 with non-family members overnight. Professor Lonne said that the neglect reported in notifications was different qualitatively from the inattention resulting in Infant 4's death. He noted that placing an infant in such a seat in the bath and leaving her unattended, was inexplicable. However, he remained steadfast in his opinion that the risks identified in the Mother's parenting would not have warranted at that time the removal of Infant 4 from the Mother's care. He was also reluctant to indicate that any CSS intervention short of Infant 4's removal could have made a difference in preventing Infant 4's death in this manner. [43]

38. Professor Lonne said that increased intervention by the Department was in order, most likely by instituting safety planning and a support network, as well as putting significant pressure upon the Mother to comply with commitments.[44]

Conclusion

39. Infant 4 was an infant aged seven months who was subject to two child protection notifications in the 12 days before her death which were actively being investigated by CSS. There was reliable information in the notifications that the Mother was not engaging with the visiting nurse, not attending to Infant 4's medical needs, not bonding with her, neglecting her and exposing her to unsafe sleeping environments, using alcohol and drugs and associating with people of poor character, and in an acrimonious relationship with Infant 4's

[43] Transcript 24 August pp43-46.
[44] Transcript 24 August p43.

father and his family. She was in the category of having a high likelihood of a 'serious to extreme' harm consequence if such assessment had been completed.

40. Whilst CSS attempted to progress the assessment, it did not do so by 13 September as required by its own Initial Assessment procedure. It was essential that, with a vulnerable infant and such serious concerns, the assessment be completed within that timeframe. If it had, CSS would have had a chance, at the very least, to commence intensive engagement with the Mother and request that she comply with certain safety planning measures, failing which further intervention would be taken. The further measures would have been dictated by the risk assessment and planning, although an obvious protective intervention in this case would have involved an application for an assessment order. If successful, Infant 4 may well have been removed from the home whilst an assessment took place.

41. Nevertheless, and critically, CSS did not actually speak to the Mother, did not sight Infant 4 and did not visit the home in the 12 day period in question. I consider this to be a serious oversight in the risk assessment process. Similarly, the continued assumption (even before a completed risk assessment) that risk to Infant 4 may have been reduced by the involvement of Gateway Services was highly problematic in the face of such concerning notifications. It should be a well-entrenched principle within CSS that it should not acquit its statutory duty of responding to notifications by referral to non-government services alone, and without adequate and timely risk assessment.

42. In making such criticisms, I accept that the child protection resourcing environment at the time was particularly difficult. This is set out in detail in the SERT report and goes a significant way in explaining the pressure upon CSS at the time. The consequences of such staff shortages cannot be underestimated. I am sympathetic to the particularly difficult staff situation at the time.

43. Professor Lonne made the point that, even if Infant 4 remained at home with her mother with the required intervention and monitoring, CSS could not necessarily have foreseen that the Mother would leave her unattended in the bath in a dangerous situation, and this tragic event is likely to have still occurred. Immediate and assertive action by CSS to engage the Mother may have modified her risk-taking behaviour and improved her care of Infant 4.

44. Certainly, if Infant 4 had been removed from the home (assuming a timely risk assessment had taken place) before her death, she would not have drowned, unattended in a bath. However, I cannot make the finding that proper CSS practice would have required that intervention at that time. There may, however, have been an opportunity to make a successful application for an order if (a) a timely and thorough risk assessment had taken

place and determined the need for a court application, and/or (b) the Mother had shown CSS little cooperation or willingness to accept and engage in critical supports for Infant 4's protection.

45. I do not completely share the view of Professor Lonne, understandably sympathetic to CSS in this situation, that Infant 4's death in an unforeseeable manner could not necessarily have been prevented.

46. Infant 4 remained with her mother, was at high risk, and was without adequate care and protection. There was always an opportunity with immediate CSS engagement, monitoring and intensive support, to remediate the Mother's parenting capacity to a point where she may have been a more attentive parent, including in circumstances such as those surrounding Infant 4's death.

47. Although such an opportunity existed, it remained simply an opportunity. I cannot make a finding that CSS played a causative role in Infant 4's death.

Appendix E

Infant 5

Introduction

1. Infant 5 was born in mid-September 2018 and died suddenly overnight in late December 2018 at the age of 15 weeks and four days. He died whilst sleeping on the couch at his mother's house, with his mother also on the couch with him. His death was reported to the coroner as required by the Act as being a sudden and unexpected death of a child under the age of one year.

Background and family history

2. At Infant 5's birth, the Mother was 18 years of age and the Father was 20 years of age. Infant 5 was the first child of both his parents.[1]

3. The Mother was the youngest of three children and had two older brothers. She had a difficult relationship with her mother, Ms V. She was abusive towards her mother, who gave up her care when she was 15 years of age due to her behaviour.[2] She was diagnosed with Conduct Disorder and Obsessive Compulsive Disorder in 2014 and with cognitive and processing difficulties in 2015. The latter difficulties caused her to have trouble processing complex information and recalling information, particularly when under duress.[3]

4. The Mother and the Father were involved in an intermittent relationship for approximately three and a half years before Infant 5's death, separating about five weeks before Infant 5's birth.[4] Their relationship was difficult and marked by episodes of family violence by the Father against the Mother. FVOs were in place to prevent the Father contacting the Mother from July 2017 and an FVO was still in effect at the time of Infant 5's death. These orders were breached on a number of occasions by the Father.[5]

5. Infant 5 was known to CSS through a number of notifications and assessments relating to family violence, incapacity for appropriate parenting and parental drug use both before and after his birth. The involvement of CSS with the family is covered in more detail below.

6. At the time of Infant 5's birth, the Mother was living alone in a unit in Invermay provided by the Karinya Young Women's service (an independent service provider funded by both the

[1] Exhibit C23 p11.
[2] Exhibit C23 p12.
[3] Exhibit C p15.
[4] Exhibit C10 p3, 10, C12 p2.
[5] Exhibit C21.

State and Federal governments). Karinya staff conducted regular home visits.[6] Prior to this she was living with her mother and brother.[7] The Father had no fixed address at this time but was known to stay at Thyne House in Launceston.[8]

7. The Mother had gestational diabetes during her pregnancy. Her mother (Ms V), who had also had gestational diabetes during her own first pregnancy, felt that she did not manage it well initially but improved as the pregnancy progressed.[9]

8. Infant 5 was born on 12 September 2018 at the LGH about four weeks premature. The Father's mother and Ms V were present and the birth involved no complications.[10] Infant 5 spent some time in ICU with unstable blood sugar levels due to the Mother's gestational diabetes. He and the Mother were not discharged until 26 September due to the hospital's concerns that the Mother was not able to accurately identify when Infant 5 needed feeding and his consequential weight loss.[11]

9. After discharge from the hospital, the Mother began to feed Infant 5 with formula. He drank six to eight 150ml bottles per day and began to gain weight. The Mother received visits from CHaPS nurses, who reported Infant 5 as healthy and gaining weight.[12] Infant 5 slept in a bassinet in the Mother's bedroom during the night and a second bassinet with mesh sides in the lounge room for daytime naps.[13] The Mother also had a kelpie-cross dog aged around 12 months.[14]

10. Ms V described the Mother as very independent when looking after Infant 5 and that she would not allow anyone else to care for him – for example, a few days before Infant 5's death she requested that Ms V call to reschedule Infant 5's routine doctor's appointment as she had a migraine, and declined Ms V's offer to take Infant 5 to the doctor that day.[15]

Circumstances of death

11. Infant 5 woke and fed as normal on the morning of 29 December 2018. The Mother bathed him, gave him a second bottle and he seemed happy and content. They took a bus into the city and spent most of the day there, visiting various shops and returning to the unit at around

[6] Exhibit C23 p15.
[7] Exhibit C15.
[8] Exhibit C12 p1.
[9] Exhibit C15, C9, C10 p2.
[10] Exhibit C10 p2, C15, C9.
[11] Exhibit C23 p16, C9.
[12] Exhibit C10 p4, C23 p22, C24.
[13] Exhibit C10 p5.
[14] Exhibit C12 p8, C14.
[15] Exhibit C15 p2.

5.30pm. The weather was very warm. Infant 5 appeared well apart from a slightly runny nose and was content throughout the day.[16]

12. After returning home, the Mother placed Infant 5 on the three-seater couch in the lounge room of the unit. Infant 5 was lying on top of a soft folded blanket and his head and shoulders were propped between the back and arm of the couch so that his head was in the corner and that he would not roll. It was quite warm in the unit and the air conditioner had not cooled the air very much. Therefore, the Mother did not put any blankets on top of Infant 5, who was wearing just a nappy and top.[17]

13. The Mother joined Infant 5 on the couch to watch television, sitting at the other end. She was exhausted and unintentionally fell asleep. She woke at approximately 7.25pm, distressed that she had fallen asleep, and could see that Infant 5 was lying still and had blood and mucus under his nose. The blood made the Mother worry that she might have kicked Infant 5 in her sleep, but he was still in the same position as before and her legs did not reach as far as his head at the other end of the couch.[18]

14. The Mother was worried and called Infant 5's name but could not rouse him, finding him floppy. She moved him to the floor of the lounge room, called 000 and followed the operator's instructions to provide CPR until the ambulance arrived.[19] Ambulance Tasmania records show the call was received at 7.29pm and the ambulance arrived at 7.36pm.[20]

15. Infant 5 continued to receive CPR in the ambulance and at the LGH ED. Infant 5's heartbeat returned on its own after arrival at the hospital and he was given intense treatment. However, sadly, he died at 12.30am on 30 December 2018.[21]

16. Police officers attended the Mother's unit following Infant 5's death and observed its appearance to be unconcerning. There were no ashtrays or smell of cigarettes inside the unit. They found the unit to be still notably warm inside at 3.00am.[22]

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[16] Exhibit C10 p10-14.
[17] Exhibit C10 p14-19.
[18] Exhibit C10 p14-24.
[19] Exhibit C10 p19-20.
[20] Exhibit C7.
[21] Exhibit C8b, C14.
[22] Exhibit C18. This affidavit of the forensics officer, Senior Constable Rodney Walker, includes the following "mother has woken to find the infant was facing into the rear backrest of the couch and was unresponsive". In her interview at C10 the Mother says Infant 5 was in the same position when she woke as he was when she propped him on the couch. There is no other evidence to support a finding that Infant 5 was facing into the rear backrest of the couch. I suspect that this may have been incorrect or assumed information to Constable Walker.

Cause of death

17. On 31 December 2018 an autopsy upon Infant 5 was carried out by State Forensic Pathologist, Dr Christopher Lawrence at the RHH. No evidence of traumatic injury was found.[23] Histology showed bronchopneumonia in the lungs as a result of a viral infection (common cold).

18. The toxicology report showed levels of carbon monoxide in Infant 5's blood which were within the normal range but suggested passive exposure to cigarette smoke.[24]

19. Dr Lawrence attributed Infant 5's death to bronchopneumonia following a viral infection, although noted the unsafe sleeping environment and stated that it was difficult to assess the contribution of that environment to his death.

20. Dr Lawrence formulated his opinion as to cause of death on the basis of the evidence concerning the position in which Infant 5 was located when he was found unresponsive by his mother on the couch. This evidence was only from the Mother, who stated that she found him in the same position with his face clear of bedding. Dr Lawrence was therefore unable, for example, to assess the contribution to death of possible suffocation if Infant 5's face was covered by or very close to bedding. I do not accept without question the account of the Mother regarding the circumstances of sleeping with Infant 5 on the couch. It seems likely that she did fall asleep whilst at the other end of the couch. However, I cannot make a positive finding that when she awoke, Infant 5 was in the position indicated to police. In her video recorded interview with police officers, she said that when she awoke *"...his head was just more tilted back a little bit, to the side a little bit"*.[25] It is also apparent from the scene photographs that the blue blanket, upon which she said Infant 5 was laying, had blood upon it. This may well indicate that Infant 5's face was in contact with the blanket. Further, in her interview, the Mother suggested that Infant 5 had the ability at times to roll, indicating that he may have moved his face into the blanket and suffocated. It is possible, alternatively, that the blood on the blanket was caused by the Mother or another person later at the scene wiping Infant 5's face with the blanket after he was discovered to be unresponsive.

21. Given the uncertainty surrounding the circumstances of Infant 5's death, I am not able to find that the only cause of his death was bronchopneumonia as a result of his viral infection. A significant cause may well have been that his breathing was restricted by contact with the blanket or the couch structure in his unsafe sleeping environment. In this scenario, his

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[23] Exhibit C5.
[24] Exhibit C6 and C5.
[25] Exhibit C10 p16.

breathing would already have been compromised by having a cold and possibly exposure to cigarette smoke.

22. I am therefore not able to determine the cause of Infant 5's death.

History of CSS involvement

23. The Mother herself had an extensive CSS history between 2006 and 2016, with notifications received from relatives, school staff, hospital staff and Youth Justice services citing concerns. From 2014 these concerns included homelessness, placing herself at risk with older men and being on the streets, presenting to hospital with injuries, drug use, involvement in the Youth Justice system, neglect and refusing assistance from services. The Father did not have a history with CSS as a child.[26]

24. Infant 5 was first brought to the attention of CSS as an unborn baby on 27 April 2018 by Tasmania Police after an incident in which the Father arrived at the Mother's home to collect some clothing. At that time, he entered the property without her permission and pushed her backwards into a chair, breaching the FVO that had been in place between them since 15 November 2017.[27] The Mother was 16 weeks pregnant at this time. The notification also included the Father's prior police history of FVO breaches and assault.[28]

25. Upon receiving the notification, CSS Intake contacted the Child Safety Liaison Officer (CSLO) requesting information about the Mother's attendance at LGH appointments. It was reported that the Mother had gestational diabetes and that her general practitioner had identified that she would require support during her pregnancy and after the birth.[29]

26. No further action was taken until 5 July 2018, seven weeks later, when Intake again contacted the CSLO to confirm whether the required support identified by the Mother's general practitioner had been actioned. The CSLO responded the same day to report that Infant 5 was due in early October; that the Mother's attendance at appointments was poor; and that the Father had accompanied her to one appointment. Due to her low attendance, the LGH had been unable to undertake any significant psychosocial assessment and therefore could not provide any referrals for support. It was not clear why there was no communication between

[26] Exhibit C23 p12.
[27] CSS was later notified by the Department of Justice that the Father had not been in court when that order had been made and was not served with it until 15 May 2018, some weeks after the 27 April incident. However, previous orders were in place since July 2017. C21 and C23 p11
[28] Exhibit C23 p11.
[29] Exhibit C23 p11.

the CSLO and Intake to report this or to discuss the notification at all between April and July.[30]

27. A further notification from Tasmania Police was received on 10 July that the Mother's residence was entered and a flute was stolen from her bedroom. The Mother believed the Father to be the culprit as he had broken the lock on her bedroom window some months prior and had tried to sell a flute to a mutual acquaintance. It was noted that there was a current FVO in place that prevented the Father from entering the property and that he had current multiple breaches of the FVO. This notification was recorded as 'no risk to unborn identified'.[31]

28. On 2 August 2018 the case was transferred to Intake South for Initial Assessment due to high demand in the north. Intake South allocated the case immediately and sought more information about the backgrounds of the Mother and the Father, discovering the cognitive impairment diagnoses received by the Mother in 2014 and 2015 and her CSS history as a child.[32]

29. A third notification was received from Tasmania Police on 7 August regarding a family violence incident in which the Father entered the Mother's residence after she forgot to lock the front door after taking a dog outside. The Father aggressively confronted and frightened the Mother, who was in bed at the time, and physically assaulted her by pulling her hair, hitting her foot and throwing items from around the room at her. He also caused substantial damage to a number of items around the home - including a television, the Mother's mobile phone and the wall of her bedroom. The Father yelled at the Mother for the majority of the time that he was in the residence and threatened consequences if she stopped him from seeing Infant 5. The Mother was 30 weeks pregnant at this time.[33]

30. On 15 August Intake South completed the Initial Assessment and recommended that the case be submitted to Response North for a Child Safety Assessment, citing concerns about the Mother's neglect of her own health, her own extensive CSS history and the Father's continual FVO breaches as factors likely to impact upon Infant 5's safety and wellbeing. The risk to Infant 5 was rated as *likely* and *high*, with few safety factors in place that could reduce it. It was recommended that the Mother's cognitive capacity be reassessed with regard to her ability to parent. The referral was made on 16 August as a 'Priority 2' for response required within 5 days.[34]

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[30] Exhibit C23 p12.
[31] Exhibit C23 p12.
[32] Exhibit C23 p13.
[33] Exhibit C21, C23 p13.
[34] Exhibit C23 p13.

31. On 4 September 2018 Response North allocated the case and made an assessment plan, noting Infant 5's due date in early October, the Mother's difficulties in processing information and the Father's FVO history. Contact was made with the Mother, her mother and the Karinya program worker the following day and a home visit was made on 10 September to discuss the Mother's support network and relationships, including with the Father. The Mother identified that she wanted to have the FVO varied so that the Father could have a relationship with Infant 5 and that she wanted the Father to be present at the birth.[35]

32. CSS was advised of Infant 5's birth on 12 September 2018 by the LGH. A Response team attended the hospital the following day and spoke with the Father and the Mother separately. The Father would not take full responsibility for his past behaviour towards the Mother, but committed to ceasing drug use and seeking drug, alcohol and anger management counselling in order to be a family with the Mother and Infant 5. It was discovered through discussion with the Mother that neither Ms V nor her Karinya worker knew about the FVO, and it became clear that Ms V had been largely unaware of the severity of the Father's violence towards the Mother. Ms V subsequently agreed to supervise and facilitate contact between the Father and Infant 5, and the Karinya worker agreed to increase unannounced visits to the Mother's unit once she was discharged. A referral to police was made to report the Father's presence at the hospital and breach of the FVO, noting that both parties would seek to change the order but had not yet applied.[36]

33. A meeting of the Mother's support network occurred on 19 September and included the Mother, Ms V, the LGH social worker, the nurse unit manager on the ward, Karinya worker, CSS and the CSLO. All parties were made aware of the FVO and it was agreed that safety planning for Infant 5 was the immediate priority, particularly with regard to interactions with the Father. CHaPS visits were arranged for the Mother and Infant 5.[37]

34. On 25 September the LGH social worker contacted CSS to advise of the hospital's concerns about the Mother's inability to identify when Infant 5 needed feeding and the possibility that her processing difficulties were likely to be worse than they appeared. The Mother did not understand the hospital's concerns and maintained that she had followed all instructions and was doing everything correctly. It was also reported that the Father, a former drug user, was suspected to be using ice. CSS contacted Ms V, who agreed to provide the Mother with practical parenting support. A home visit was also carried out and it was observed that the Mother was keeping note of feeding times.[38]

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[35] Exhibit C23 p15.
[36] Exhibit C23 p16.
[37] Exhibit C23 p16-17.
[38] Exhibit C23 p17.

35. As a result of the information received on 25 September, CSS completed an Assessment Report and referred the Mother to Intensive Family Engagement Service (IFES). IFES is designed as an intensive and specialised service capable of addressing higher-level, more complex issues and is premised upon assertive engagement and designed to present parents with a clear understanding that if they do not work with the service to address the concerns for their child, this will likely result in further intervention by CSS, including court orders.

36. The referral to IFES was approved by the Three and Under Panel and the case was closed at Response and forwarded to IFES on 15 October. The Mother was advised by CSS that if she did not engage with IFES, IFES would refer her case back to CSS. A handover with IFES occurred at the Mother's unit on 29 October.[39]

37. Anonymous notifiers contacted CSS on 31 October and 20 November concerned about the Mother using marijuana. These were not the subject of separate notifications but were dealt with only by CSS asking IFES to talk to the Mother.[40]

38. A second and new Initial Assessment was commenced by CSS Intake on 26 November 2018 in response to a notification received by Tasmania Police detailing a family violence incident in which the Father physically assaulted the Mother. The assault involved strangling her, causing her physical injury, throwing items, damaging a wall and breaking a window in the unit. Before leaving, he hid the Mother's phone so that she could not contact the police.[41] The Mother was very concerned that he would hurt Infant 5 during this incident. Intake requested an update from IFES. The organisation Key Assets (IFES's service provider managing the Mother's case) held a home visit the day after the notification and discussed safety planning with the Mother, reporting that her reluctance to involve services in the family violence incidents appeared to be related to her concern about the stability of her accommodation with Karinya.[42]

39. Intake transferred the case to Response for a second Child Safety Assessment on 30 November, citing concerns about the Mother's response to the most recent family violence incident, her alleged drug use, [43] and her ability to keep Infant 5 safe. The referral was made as a 'Priority 2' (response required within 5 days).[44]

40. No further entries were made on Infant 5's file until 14 December 2018 when a conversation report from the newly established Advice and Referral Line (ARL) was emailed to IFES. The

[39] Exhibit C23 p17-19.
[40] Exhibit C23 p19-20.
[41] Exhibit C21.
[42] Exhibit C23 p20-21.
[43] Apparently notified by a family member but denied by the Mother and not supported by the observations of Key Assets workers.
[44] Exhibit C23 p21.

ARL replaced the regional Intake services of the CSS. The report was in response to an electronic notification from one of the Mother's support workers, who had visited unannounced and had observed the unit to be in disarray, the Mother to appear to be under the influence of alcohol and Infant 5 possibly overheated or dehydrated on the couch under a heavy blanket. A neighbour complained about loud music late at night and it was suspected that the Father may have been hiding in the unit. CSS contacted the Mother's mother to discuss these concerns.[45] This report was not treated as a notification and notwithstanding the serious nature of the issues, ARL closed the case after emailing a summary report to the team leader of IFES.

41. In relation to this event, Key Assets advised CSS on 17 December that it had been contacted by Karinya who indicated it would change to a two-worker model for the Mother in future to address the concern that the Father had been in the unit, and that a joint visit had been conducted to discuss the safety plan for Infant 5's care when the Mother was using alcohol. CSS was also advised that Key Assets was closing for the Christmas break from 24 December to 2 January but would check in on the IFES families every second day and continue to run its afterhours service.[46]

42. CSS was advised of Infant 5's death on 30 December 2018. Key Assets and other services continued to provide support to the Mother after his passing.[47]

CSS issues identified in SERT report

43. CSS has reviewed its intervention related to Infant 5 and acknowledged that there were some deficiencies and areas for improvement in the case management. It was also noted by the reviewer that a number of aspects of the work associated with this case were of high quality, including the first Initial Assessment, the Response team's work with the Mother and ongoing assessment from CHaPS.[48]

44. Deficiencies noted included:

- Failure to meet the procedural timeframe for completion of the first Initial Assessment and allocation at Response North for both of the Child Safety Assessments.

- Lack of clarity about the role of the CSLO in the early stages of the case.

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[45] Exhibit C23 p22.
[46] Exhibit C23 p22.
[47] Exhibit C23 p23.
[48] Exhibit C23 p42-44.

- Failure to follow through on the recommendation to reassess the Mother's cognitive capacity.

- Failure of the newly-operational ARL to follow up notifications and to correctly record notifications.

- Failure to assess new information associated with the 30 November transfer to Response as indicative of ongoing and increasing high risk for Infant 5.

- Poor communication around the beginning and end of the case.

45. The specific recommendations for improvement made by CSS were:

- Undertaking a review of the role, functions and responsibilities of the CSLO position with particular reference to:

  a) Maximising the use of initiative and leadership in the development of case direction and planning in the earliest possible stages of a case.
  b) Providing direction regarding communication and collaboration with the ARL, Response Team and Case Management Team in cases of a common client.
  c) Specifying expectations for entering case notes and notifications onto CPIS.

- Ensuring procedures at the ARL are clearly developed in respect of appropriate follow-up with notifiers regarding IFES clients, determining when a contact is a notification and processes to follow in regard to incoming information in the case of an IFES client.

- Determining a position within the CSS relating to the circumstances in which a specialist assessment can and should be progressed (for instance, when legal orders are being pursued or during assessment at Response).

- Finalise IFES procedures and continue to conduct regular meetings to ensure that the final procedures (when established) are operating in the best interests of the client.

- CYS to review the extent of the issue of unallocated cases across the state in the past 12 months to develop an understanding of the ongoing high demand on the CSS system (particularly in Response); and a sustainable response to the inability to allocate cases for assessment to be developed.

- Implementation of a consultation point, involving the Clinical Practice Consultant and Educator, in cases where the risk to an IFES client is indicated to be increasing (through receipt of a new notification, a new Child Safety Assessment or client disengagement).

- Staff to be provided with clear instruction regarding case note entry into the CPIS with reference to the management of case notes that need to be entered after the day of the event.

Professor Lonne's assessment

46. Professor Lonne was asked to assess whether, in his opinion:

If correct practice had been adopted by CSS would there have been a significant reduction in risk to Infant 5?

and

Does the case contain deficiencies in the CSS that are more serious and which involve an identifiable increase in risk to Infant 5 before death?

47. In his response Professor Lonne identified the risks and issues for CSS as follows:[49]

- The Mother's history of being an at-risk teenager, coupled with her psychological assessments, left questions regarding her capacity to adequately and consistently care for her baby;
- The tardy and inadequate accessing of CSS records about her parents compromised the adequacy of the early assessments of risk;
- Infant 5 was a young infant;
- The Father had an extensive record of ongoing family and domestic violence toward the Mother, notwithstanding his later intentions to undertake counselling and play a part in Infant 5's life;
- The Mother's equivocal and changing views about pursuing her and Infant 5's relationship with the Father;
- The uncertainty that appeared to exist among those agencies involved about the nature of the FVO and its impacts upon the family relationships; and
- The communication necessary to maintain the number of active agencies involved in the Safety Planning and provision of support.

48. With respect to the connection between CSS involvement with Infant 5 and his family and Infant 5's death Professor Lonne said in his report:[50]

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[49] Exhibit G1 Appendix E p12-13.
[50] Exhibit G1 Appendix E p13.

"Taken overall, the CSS involvement in this matter was purposeful and usually timely, although work demands in the North did require some involvement by the South Response team. However, there was also evidence of patchy information gathering and assessment, particularly regarding the Mother's history and 2015 psychological assessments which were located by South in August. The SERT report also identifies some work was needed by the various agencies involved regarding their respective roles and responsibilities. Recommendations were made about this. Communication early on was also inadequate at times. Some of this might well be put down to 'teething problems' when new services, processes and positions are involved and trying to operationalise their responsibilities. Nonetheless, there was in place effective Safety Planning and Infant 5's health and well-being were ensured, and his progress maintained. In many senses Infant 5's death was quite unexpected and could not have been reasonably foreseen as a likely outcome.

Having closely examined the SERT report provided has led me to the following responses to the critical questions:

If correct practice had been adopted by CYS/CSS would there have been a significant reduction in risk to the child?

Response: The CSS involvement was not ideal but, taken overall, did prove to be engaged and generally timely with the need to respond to the dynamic nature of the case developments, particularly the ebbs and flows of the Father's and the Mother's relationship. The risks of FADV figured large in assessments. The development of the support network in response to the Safety Planning was well put together, despite some inter-agency issues. I concluded therefore that, taken overall, the practice of the CSS led to a tangible decrease in the risks to Infant 5.

Does the case contain deficiencies in the CYS/CSS that are more serious and which involve an identifiable increase in risk to the child before death?

Response: The risks in this case were significant due to the serious and ongoing violence by the Father toward the Mother, but generally well managed. I could not identify any aspect of the CSS practice which could be attributed toward the demise of Infant 5. Rather, their work (which did have shortcomings noted in the SERT report) did result in greater access to support services and a decrease in the risks to Infant 5's health and well-being."

Conclusion

49. Infant 5 was an infant at high risk who was the subject of at least 6 notifications from before his birth until two weeks before his death. It is quite plain that all of the known risk factors in his environment and associated with his parents meant that he was extremely vulnerable.

50. Even during the course of the intensive and dedicated support by IFES providers, notifications concerning serious risk to Infant 5 continued to be received by CSS.

51. As outlined above, the Mother's known inability to properly understand how to care for an infant, her cognitive deficits, poor lifestyle choices and her failure to take him to health appointments, were all alarming issues, particularly in light of his age and prematurity. Her inability to protect herself and Infant 5 from the repetitive episodes of physically violent and lawless behaviour from the Father, even despite FVOs and IFES support, presented a most serious situation.

52. A clear example of this danger came to the ARL on 14 December with the report of the Mother disheveled, her home in disarray and Infant 5 placed on the couch and overheating under a heavy blanket. This incident should have been recorded as a notification for Response to prioritise assessment and action. If it had been, Response may well have taken immediate action.

53. At that time, the previous notification involving the Father's violence on 26 November was already with Response but unallocated and therefore dormant. The report of 14 December was indicative of the increasing risk to Infant 5 due to the Mother's inability to keep him safe.

54. Unfortunately, serious resourcing constraints prevented the lack of progress by Response of the notification of 26 November. Even without the incident of 14 December, the situation required urgent assessment and decision-making regarding care and protection options, including whether Infant 5 should remain in his home.

55. It was not the role of IFES to make such decisions, although it appears that Response took the view that the involvement of IFES satisfactorily reduced Infant 5's risk for the time being. As it stood, both incidents were not assessed at the time of Infant 5's death.

56. The SERT report is lengthy, thorough and analytical in respect of the satisfactory and unsatisfactory CSS practices across all notifications. Some of the practice issues involved in earlier notifications likely affected the manner in which CSS approached Infant 5's care and protection closer to his death. However, the last two notifications, being 26 November and 14 December, represented a clear opportunity to recognise the high risk to Infant 5 and to protect him.

57. The Reviewer does not deal with what should have been the result of an assessment by Response, if it had been completed, but noted that the risk to Infant 5 was increasingly high.[51] A full assessment incorporating both of the final notifications may have resulted in action by CSS to remove Infant 5, for example, by way of a short-term assessment order. This assumes that such an order would be granted by the court. Alternatively, a significantly more assertive approach by IFES, with additional requirements upon the Mother, may have been formulated for Infant 5's safety. Regardless, an assessment of the risk to Infant 5 may have represented an opportunity to protect him from an unsafe environment.

I note Professor Lonne's views that the considerable safety planning and support by IFES operated to reduce Infant 5's risk. I accept his opinion and note the intensive involvement to help the Mother parent Infant 5 in a safe and appropriate way. Infant 5 was certainly in a safer parenting environment because of such supports than without them. But there were clear risks remaining which may or may not have been able to be further reduced with continued or more assertive IFES involvement.

Professor Lonne was of the view that Infant 5's death was unexpected and could not have been reasonably foreseen as a *likely* occurrence.

I accept that Infant 5's death could not have been foreseen as a *likely* occurrence but it was nevertheless a foreseeable occurrence. There were numerous known risks present in Infant 5's environment, an unsafe sleeping environment being one obvious risk. This is particularly the case with the information received two weeks before his death concerning him being placed on the couch under a heavy blanket. In general terms also, it is foreseeable that an infant inadequately cared for or protected may suffer the consequences of an untreated illness or be involved in an accident caused by serious parental failings.

Infant 5 was exposed to an unsafe sleeping environment at the time of his death – parental smoking, possible smothering in blankets, restriction of the airway by being propped up on the couch, and overly warm room temperature. All of these may well have contributed to his death. He should have been lying flat on his back in his own bassinet in a cooler room with no blankets around him. If this was the case, he may well not have died. However, I cannot determine the issue to the requisite standard.

58. Nevertheless, the fact that Infant 5's case remained unallocated with CSS Response and had not been progressed at the time of his death deprived him of an opportunity of additional care and protection that may have been warranted, after proper consideration, in light of his exposure to escalating risk.

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[51] Exhibit C23 p43.

59. Given the uncertainty regarding cause of death, and the inability to find that Infant 5 should have (and would successfully have been) removed from his home, I cannot find to the requisite standard of proof any causative connection between CSS practice and Infant 5's death.

Appendix F

Infant 6 and his Mother

Introduction

1. The Mother was born in mid-March 2000 and died in mid-June 2016 at the age of 16 years. Her son, Infant 6 was born in mid-April 2016 and died in mid-June 2016 at the age of 9 weeks. Their deaths were reported to the coroner as required by the Act, being unexpected deaths resulting from an accident and the unexpected death of a child under the age of one year.

2. CSS had involvement with both the Mother and Infant 6.

Background and family history

3. At Infant 6's birth, the Mother was 16 years of age and the Father was 18 years of age.

4. The Mother, her older siblings and the Father were all known to CSS through a series of notifications relating to parental alcohol and drug use, family violence and general neglect. The involvement of CSS with the Mother's family is covered in more detail below but, in summary, the notifications to and investigations by CSS indicate:

    a) The Father suffered physical abuse and neglect throughout his childhood and had a diagnosis of ADHD, which was not being managed with medication.[1] He was known to police from 2009 in relation to a range of offences and convictions, including driving offences (such as driving while unlicensed, unregistered and uninsured, and hooning), drug offences, burglary and assault.[2] The Father had a history of aggression towards both police and CSS, the latter of which he 'hated' due to negative experiences as a child.[3]

    b) The Mother was exposed to parental alcohol and drug use from an early age and was reported to be drinking alcohol by the age of 12 years.[4] Her father, Mr H, refused to have her in his care after 6 November 2012 due to her damaging his home in Devonport and, after this, she spent some time living with her 16-year-old brother, who was not able to appropriately care for her. When she returned to her mother's house

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[1] Exhibit B48 p11.
[2] Exhibit B50.
[3] Exhibit B47 p6.
[4] Exhibit B49 p10.

in Launceston, she witnessed verbal and physical abuse of her mother by her mother's then-partner. She attended school very little from 2013 onwards while in her mother's care despite assurances from her mother that she would support the Mother to continue to engage with the education system.[5]

5. The Mother and the Father had known each other for several years before beginning their relationship in April 2015. At this time, the Father was living with his grandparents in Wivenhoe and the Mother was living with her mother, Ms G, and her mother's then-partner, Mr I. When the Mother's family moved to a property, Ms G and Mr I allowed the Father to move in with them full-time from around May 2015, paying board and doing jobs around the farm. In July 2015, The Mother became pregnant with Infant 6.[6]

6. After the Father moved in with the Mother, his behaviour towards her became less caring and more aggressive. He was arrested and charged with assault against her on 19 September 2015 and was served with a PFVO. Further family violence incidents occurred on 4 and 28 October.[7]

7. In October 2015 they wanted to apply for a house together with Housing Tasmania, keeping this secret from Ms G.[8]

8. During an appointment at the NWRH on 12 April 2016, both presented with poor personal care and hygiene and the Father was agitated. He claimed to have stabbed his hand because he 'felt like it', although the Mother reported that he had injured himself while cutting meat. The Father made inappropriate comments to staff about 'no one else fingering the Mother' concerning the possibility of the Mother requiring an internal examination for the pregnancy. The NWRH staff were concerned that the Father was domineering and controlling towards the Mother and about potential future violent behaviour.[9]

9. Infant 6 was born in mid-April 2016. The NWPH staff maintained observations on the Father's behaviour towards Infant 6 until mother and baby were discharged. They were concerned that he did not engage with his son, was verbally abusive towards the Mother and Infant 6 and became easily agitated and aggressive when Infant 6 cried. The Mother was observed to be appropriately and competently caring for Infant 6 during this time.[10]

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[5] Exhibit B47 p56ff.
[6] Exhibit B47 p51, B48 p11.
[7] Exhibit B47 p47, B49 p12.
[8] Exhibit B49 p12.
[9] Exhibit B49 p13, B48 p12-13.
[10] Exhibit B46A p25 (of electronic file).

10. The Mother and the Father took over the lease on the property after Infant 6 was born, with Ms G and her partner moving to a property reasonably close by. Ms G reported that friends visited the property daily to feed the animals and checked on the couple. Ms G made some form of contact with the Mother every day. The property was isolated, had poor phone reception and would have no water supply if the power went out. Ms G did not like the Father and considered him unpredictable. She believed that the Father and his grandfather, Mr J, controlled the Mother. She said that the Mother usually called when the Father and Mr J had gone to the 'pokies'. If she called when the Father was around, the phone was put on speaker and the Father would listen and make comments in the background.[11]

11. There were varying reports from family members about the Mother and the Father's level of engagement with and appropriate care of Infant 6, including that the Father was doing most of the caring for Infant 6 and that his handling of Infant 6 was not especially gentle or entirely appropriate for a newborn. A family member described the couple as loving Infant 6 but needing parenting classes.[12]

12. The Father had a police history of driving without a licence and held an L1 licence. He purchased a 1989 white Toyota Corolla Seca hatchback from Ms G about three weeks before the crash that resulted in the death of the Mother and Infant 6.[13] Ms G offered to supervise the Father's driving multiple times, but he only accepted her offer on one occasion. During that occasion, she found his driving to be safe and sensible but also knew of numerous incidences of speeding and dangerous driving with the Mother, and later Infant 6, also in the car.[14]

13. Ms W (the ex-partner of the Mother's brother) described an incident in which the Father drove highly dangerously with the Mother in the car, only narrowly avoiding causing collisions with other road users and trying to ram her vehicle. On that occasion she called 000.[15] On another occasion he chased a herd of cattle around a paddock in his car.[16] Another local described being run off the road on Deep Creek Road on two occasions by a young man 'drifting' around corners and being passed by the same driver on several occasions speeding on Oldina Road – he recognised the Toyota Corolla from newspaper photographs of the crash as the same car he had seen in the past.[17]

[11] Exhibit B48 p14-15, B46A p36, B49 p13-14.
[12] Exhibit B48 p15-17.
[13] Exhibit B21, B37.
[14] Exhibit B37.
[15] Exhibit B36.
[16] Exhibit B23.
[17] Exhibit B24.

14. On the day before the crash, Ms G's partner, Mr A, drove past the property and saw the Father doing 'wheelies and hand brakies' in a paddock close to the highway with the Mother and Infant 6 in the car.[18]

Circumstances of death

15. At around 4.00pm on a day in June 2016, the Father, the Mother and Infant 6 travelled into Wynyard to sell a cot at Save-a-Buck. The Father was driving the Toyota Corolla, the Mother was in the front passenger seat and Infant 6 was in a baby capsule in the back left seat. They returned via Deep Creek Road, which intersects with the Bass Highway south-east of Wynyard.[19]

16. At the time that the Father, the Mother and Infant 6 were on the way into Wynyard, motorist Mr O was overtaken twice by a small white car between Yolla and Wynyard. The first incident occurred just outside Yolla, when Mr O was turning right from the slip lane from the Murchison Highway into Mt Hicks Road and was overtaken on the left by a car travelling well over the speed limit, which then braked hard and made a sharp right turn in front of him into the driveway of the Yolla shop. Mr O continued travelling north towards Wynyard on Deep Creek Road.

17. About fifteen minutes later the same car caught up to Mr O and tailgated him, with the bonnet under the rear tray of his utility for several minutes before trying and failing to overtake on a sharp right bend. Mr O was travelling at about 50-60km/h and considered the white car to be travelling fast, but possibly not over the speed limit of 100km/h. The car remained in the centre of the road until the next sharp bend where it overtook Mr O. Mr O observed the car maintain a line down the centre of the road into the next big bend, which provided only limited vision around the bend for the driver. He thought he would be 'picking [the driver] up from the gum trees' but the car successfully navigated the bend and disappeared. Mr O later saw photographs published on The Advocate's website of the crash and recognised the Toyota Corolla as the car that had overtaken him.[20]

18. Mr R, a machinery operator, was also on the road on this day, driving a Mack prime mover between Sisters Creek and Spreyton, transporting loads of carrots for his parents' business. Mr R assisted his parents in this way as required in their busy periods during his periods of time off from his work – he worked a four day on/four day off roster. He described a typical day of driving for his parents as being roughly 11 hours long but made up of short trips with

[18] Exhibit B23, B37.
[19] Exhibit B1 p3.
[20] Exhibit B25.

long breaks while the truck was loaded or unloaded. On this occasion he had spent the previous week driving the same route on the Bass Highway.[21]

19. Mr R held a number of vehicle and machinery licences and had been driving heavy combination vehicles for about 6 years. In addition to driving prime movers for his parents and during his work as a machinery operator, he had also spent a year driving prime movers in the Pilbara. He was familiar with each of the four prime movers owned by his parents and had had no difficulties driving the Mack he was using on the day on any of the previous trips he had made that day along the same route. The Mack was speed limited to 100km/h and would only reach approximately 98km/h on the flat.[22]

20. Mr R was returning to Sisters Creek with an empty trailer after delivering the fourth and last load of carrots for the day. The weather was overcast but dry.[23] It was close to dusk and the sun had set so was not causing any visibility problems.[24] It was still light enough for cars not to have their headlights on, but the Mack had both its headlights and five orange marker lights above the windscreen illuminated.[25]

21. At approximately 5.15pm,[26] Mr R approached the intersection with Deep Creek Road, travelling at about 95 km/h.[27] He was about 250 metres from the junction when he saw the Toyota Corolla approach from Wynyard. He saw it slow from a speed of approximately 50-60km/h to 15-30km/h - this gave him the impression it was going to stop at the intersection and he therefore maintained his speed. At the intersection, the Toyota Corolla faced two Give Way signs and holding lines, and was therefore required to give way to all vehicles on the highway before proceeding forward. Without giving way, the Toyota Corolla continued onto the Bass Highway, crossed the east-bound lane and continued into the west-bound lane. Mr R attempted to veer to the left and braked hard but was unable to avoid colliding with the passenger side of the Toyota Corolla. He judged that the Mack was travelling at about 90km/h when the collision occurred. The Toyota Corolla was pushed in front of the Mack for about 60 metres before Mr R was able to come to a stop.[28]

22. Mr Y and Ms Z were travelling east on the Bass Highway from Wynyard to Burnie. Mr Y was the passenger and saw the Toyota Corolla cross the highway at the Deep Creek Road intersection, travelling slowly. He was watching the car when it suddenly appeared to 'pop'

[21] Exhibit B22.
[22] Exhibit B22.
[23] Exhibit B22, B26, B28, B30, B31, B33.
[24] Exhibit B22, B27, B30, B31.
[25] Exhibit B22.
[26] Exhibit B27, B28, B33, B34.
[27] Exhibit B1 p26.
[28] Exhibit B1 p25, B22 p26.

and all the glass blew out. He then saw a truck appear which seemed to be pushing the car along the highway. He had not seen the truck before it hit the Toyota.[29]

23. Mr Y and Ms Z were the first on the scene. Mr Y observed the Father and Mr R to be apparently uninjured and the Mother to be initially unconscious. The Father was sitting in the driver's seat with the Mother in the front passenger seat. He described Infant 6 as looking like a 'Baby Born' doll, not moving or crying and with wide open eyes. The Mother shortly regained consciousness and was in significant pain but neither she nor the Father could be immediately extricated from the car.[30] Other witnesses who came upon the scene immediately after the crash described the Mother as being slumped across onto the lap of the driver.[31] The car was full of rubbish, cigarette butts and discarded food.[32]

24. A number of road users also stopped to assist, calling emergency services, stopping traffic, holding tarpaulins to protect the Mother and the Father when it began to rain and disconnecting the battery of the Toyota Corolla when smoke began to come from under the bonnet. The Mother was extremely distressed and screaming for her baby while in serious pain herself – Ms P was able to open the driver's side door and reassure her that Infant 6 was going to be fine, holding her hand until emergency services moved her away.[33]

25. Bystanders were able to remove Infant 6 from the car and began CPR. A nurse and doctor, arriving on the scene on their way back to Burnie from home visits in Smithton, also provided medical assistance until emergency services arrived. Defibrillation was also attempted.[34] Sadly, these efforts were unsuccessful. The Ambulance Tasmania crew attending Infant 6 could not resuscitate him and he was rushed to the NWRH. However, he was pronounced deceased soon after arrival at 6.15pm.[35]

26. The Mother and the Father were trapped in the wreckage of the Toyota Corolla for around 45 minutes, during which time the Mother gradually deteriorated and became less responsive. She became unconscious about five minutes before emergency services could extricate her. She was transported by ambulance to the NWRH and arrived in the ED at 6.20pm in a condition of haemorrhagic shock. She immediately underwent surgery which discovered severe internal abdominal bleeding. No source of the bleeding could be found but it was suspected to be retroperitoneal bleeding. The haemorrhagic shock worsened over the course of the night and the bleeding was determined to be surgically uncontrollable due to the

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[29] Exhibit B26.
[30] Exhibit B26.
[31] Exhibit B28, B29, B30, B33, B34.
[32] Exhibit B1 p10, B28.
[33] Exhibit B26, B27, B28, B29, B30, B31, B33, B34.
[34] Exhibit B34, B35.
[35] Exhibit B18, B2.

magnitude and likely location of her injuries. The Mother never regained consciousness and, after discussions with her family, medical treatment was not escalated and she died at 11.37pm.[36]

27. An inspection of both vehicles found that both would have been considered unroadworthy at the time of collision. Among other issues, the Toyota Corolla's steer tyres and the left rear tyre had no tread depth. Two tyres on the Mack had a non-compliant tread depth and its semitrailer was missing a mudflap. The brakes and the speed control on the Mack were found to be in good working order.[37] There is no evidence that any of these defects was a contributing factor to the collision. The collision was entirely caused by the Father, who did not give way to vehicles on the Bass Highway, as required, and failed to keep a proper lookout.

28. Blood tests were performed on both Mr R and the Father following the crash. No alcohol or drugs were detected in Mr R's blood.[38] Therapeutic levels of morphine and lignocaine were detected in the Father's blood, consistent with medical intervention post-crash.[39]

29. The Father declined to be interviewed about the crash. On 4 September 2017 he was sentenced upon his plea of guilty in the Burnie Magistrates Court to driving offences relating to the incident. These were two counts of causing the death of another person by negligent driving. In sentencing, Magistrate Jago described the Father's driving as inadvertent and the crash as resulting from a momentary lack of attention. Her Honour imposed a three-month period of imprisonment which was wholly suspended on the condition that he be of good behaviour for two years. He was also disqualified from holding or obtaining a driver's licence for a period of 18 months.

Cause of death

30. On 22 and 23 June 2016 autopsies upon Infant 6 and the Mother respectively were carried out by forensic pathologist, Dr Donald Ritchey, at the RHH. Both were found to have extensive injuries suffered in the crash. Infant 6 sustained a severe head injury, which caused multiple skull fractures and subarachnoid haemorrhage; and chest injuries including broken ribs and lung contusions. No healing injuries suggestive of abuse were found.[40] The Mother suffered from rib and pelvic fractures and severe internal bleeding.[41]

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[36] Exhibit B19, B20a, B34.
[37] Exhibit B41.
[38] Exhibit B22a
[39] Exhibit B21a.
[40] Exhibit B14.
[41] Exhibit B15, B20a.

31. The toxicology reports revealed no significant results. No alcohol or drugs were detected for Infant 6. Only midazolam administered in hospital to the Mother during surgery was detected in her blood.[42]

32. Dr Ritchey found Infant 6's cause of death to be blunt injuries of the head and chest sustained in the crash. The Mother's cause of death was found to be multiple blunt injuries of the chest, abdomen and pelvis sustained in the crash.[43] I accept Dr Ritchey's conclusions.

History of CSS Involvement

The Mother – before pregnancy

33. CSS was involved with the Mother's 3 older siblings from 1999 because of general neglect, parental gambling and alcohol use, family violence and disengagement from school. There were a number of notifications and two assessments in relation to the three older children between 1999 and 2012.[44]

34. The Mother first came to CSS's attention on 6 November 2012, when an unidentified woman took her to her school in Devonport and advised that the Mother would be leaving her father's house and moving to Launceston to live with her mother. Contact was made with Mr H, who said he didn't want the Mother living with him because she was damaging his house but expressed concerns for the Mother's well-being in the care of Ms G. These concerns included the crowded living conditions (five people in a one-bedroom unit), family violence, prioritisation of alcohol and drugs over food and electricity bills, and a lack of boundaries for the Mother's older siblings.

35. A further report on 29 November 2012 indicated that the Mother was living in Devonport with her brother (aged 16 years), and his girlfriend and was roaming the streets at night. CSS made contact with Ms G who advised that the Mother was only staying with the older brother in the short-term and would be returning to live with her. Ms G discussed the challenges of her living situation, including her partner's alcoholism, and accepted a Gateway referral. The matter was closed on 13 December with no confirmation that Ms G had engaged with any follow-up services.[45]

36. A notification on 10 December 2012 was received for a family violence incident against Ms G witnessed by the Mother, which brought to CSS's attention three further family violence incidents during which the Mother was present. CSS could not contact Ms G and closed the

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[42] Exhibit B16, B17.
[43] Exhibit B14, B15.
[44] Exhibit B49 p9-10.
[45] Exhibit B49 p10.

notification on 17 December after posting letters outlining family violence support and counselling programs. This was despite Ms G having not engaged with Gateway and the fact of 3 referrals in the previous 12 months.[46]

37. On 26 March 2014 CSS was notified by police that the Mother was in a sexual relationship with a 20-year-old man and was not regularly attending school. Centrelink also notified CSS on 9 April that the Mother had reported being kicked out of home. CSS made contact with Ms G, who advised that the Mother had returned home on 14 April, had been diagnosed with bipolar disorder and would be attending counselling appointments; and that she (Ms G) would be meeting with the Mother's school to discuss attendance. CSS also contacted the Mother and found her difficult to engage with, but identified no concerns due to the Mother's statement that she was happy at home and with the plans made for counselling and school attendance. The notification was closed on 23 April 2014.[47]

38. On 4 August CSS received a notification regarding the Mother's non-attendance at school and that Ms G had advised the school in June that the Mother was "no longer my problem". CSS called Ms G, who advised that the Mother would be attending sessions with a psychologist and would be home-schooled. The Mother could be heard in the background of the call. CSS requested Ms G contact the Department of Education and closed the notification on 6 August.[48]

39. On 2 December 2014 CSS was notified that the Mother had not attended scheduled appointments with CAMHS or attended school. Concerns for her mental health and the potential for self-harm were reported. The file history from the 4 August notification was duplicated and no further information-gathering occurred. The notification was closed on 8 December because it was said that the notification was not at a level that required further CSS intervention and the Mother had demonstrated previously that she was able to seek supports for herself.[49]

The Mother – pregnancy and after Infant 6's birth

40. CSS commenced an Initial Assessment on 23 September 2015 after a Tasmania Police notification of a family violence incident in which the Father assaulted the Mother, grabbing her wrists and pushing her to the ground. As mentioned above, this incident resulted in a PVFO.

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[46] Exhibit B49 p10.
[47] Exhibit B49 p11.
[48] Exhibit B49 p11.
[49] Exhibit B49 p11.

41. On the following day, a notification was recorded regarding the Mother's unborn child after she presented for her first ante-natal appointment at NWRH. While the Mother's young age and the existing PFVO in respect of the Father were reported, CSS only recorded Infant 6 as the subject child and did not list the Mother as a child at risk. The Initial Assessment was closed on 4 December 2015 due to police dealing with the family violence matters and the Mother attending all her antenatal appointments. These factors were considered 'evidence of safety' and the immediate safety of Infant 6 was assessed as 'low risk'.[50]

42. The NWRH notified CSS of the Mother and the Father's appointment on 12 April 2016 with concerns with respect to risks posed by the Father to the Mother, as mentioned above. It was identified by CSS that the Mother might be in need of support and a second Initial Assessment was commenced on 13 April. The Mother was not contacted by CSS until after Infant 6's birth on 27 April.[51] The Father could be heard in the background of the call demanding to know why CSS was asking questions. The Mother and the Father both declined support from CSS at this time.[52]

43. In 2015 and 2016, a number of further notifications were made that identified risks to both Infant 6 and the Mother. However, as CSS incorrectly identified only Infant 6 as the subject child in relation to these notifications, they are addressed in the section below relating to Infant 6.

44. The Initial Assessment of the 12 April notification began on 13 April 2016 and was completed on 24 May 2016, concluding that a full Child Safety Assessment was required for both the Mother and Infant 6. The Child Safety Assessment was still unallocated at the time of their deaths.[53]

Infant 6 – before birth

45. As mentioned above, Infant 6 first came to the attention of CSS when an unborn baby notification was made by the NWRH on 24 September 2015 due to the hospital's concerns about the young ages of his parents, the Father's lack of a driver's licence and the PFVO currently in place. An Initial Assessment with Infant 6 as the subject commenced but was closed on 4 December for the reasons detailed above.[54]

46. As above, a second Initial Assessment was commenced on 13 April 2016 after a notification of fresh concerns from the NWRH.

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[50] Exhibit B49 p12, B48 p12.
[51] Exhibit B49 p13.
[52] Exhibit B49 p13-14.
[53] Exhibit B48 p18-19, B49 p15.
[54] Exhibit B48 p12.

Infant 6 – after birth

47. Despite receiving notifications of concerns from the NWRH prior to Infant 6's birth and of Infant 6's birth in mid-April, CSS did not contact the Mother and the Father until 27 April. At this time it was acknowledged that CU@Home nurses were the only active support in place for the family. Feedback from home visits was subsequently provided to CSS from CU@Home nurses.[55]

48. On 3 May Ms G visited the CSS office on request and provided information about the isolation of the property and her concerns about the Father's behaviour and control of the Mother, as mentioned above.

49. The Mother, the Father and Infant 6 attended a safety planning meeting with CSS on 10 May. This meeting resulted in identification of risks and issues regarding the Mother and the Father's capacity to care for Infant 6, including their young ages and the Father's lack of control over his anger. This meeting was viewed by CSS as a positive experience and an assessment for the Three and Under Panel was completed with a view to process case closure.[56]

50. On 18 May a notification that had been received on 19 April but incorrectly entered under a second client ID by a locum CSS staff member was discovered. It recorded concerns from the NWRH about the Father's aggressive behaviour towards the Mother and Infant 6 prior to discharge from the hospital. This notification had not been previously addressed or considered.[57] On the same day, a further notification was received from a family member who had concerns about the potential case closure due to the Father driving with Infant 6 in the car, the parenting abilities of the Mother and the Father and their lack of ability to manage money. CSS subsequently decided to forward the case to Response for further investigation if the Father and the Mother would not accept additional parenting support.[58]

51. CSS informed Tasmania Police on 20 May that the Father was driving an unroadworthy vehicle while unlicensed and transporting Infant 6. Police attended the property but no-one was home and the car could not be located. Tasmania Police informed CSS that it would monitor and target the Father's car on public streets.[59]

52. CSS made contact with the Mother by phone on 23 May and attempted to convince the Father and the Mother to accept additional family support. The Father refused and threatened

[55] Exhibit B48 p13-15.
[56] Exhibit B48 p16.
[57] Exhibit B48 p16.
[58] Exhibit B48 p17.
[59] Exhibit B48 p18.

the staff member, telling her she would not get within 10 metres of their house. CSS Intake completed the second Initial Assessment and forwarded the case to Response for a Child Protection Assessment, which was accepted on 24 May as a Priority 2. Intake continued to forward information updates and subsequent notifications to Response.[60]

53. The case was closed at Response on 27 June 2016.[61]

CSS Issues identified in the SERT reports

The Mother

54. At the time that the Mother first came to CSS attention in 2012, there was already an existing history in relation to her older siblings that identified family violence, parenting issues with teenage children, irregular school attendance, risky relationships being formed by the children and parental alcoholism. Most of these issues were raised again in subsequent notifications relating to the Mother between 2012 and 2014, with escalating concerns over this time and consistent non-engagement by the Mother or her family with support services.[62]

55. CSS's interactions with the Mother showed that she was disengaged from school, exposed to family violence, socially isolated, had a history as a victim of abuse and exploitation and had potential mental health and emotional well-being issues.

56. CSS reviewed its intervention in respect of the Mother and identified some deficiencies in the handling of her notifications and case management.[63]

57. The deficiencies included:

- Failure to completely review and consider previous reports using a cumulative harm framework (for example, the closure of the 2 December 2014 notification without gathering any information additional to the previous notification in April 2014).

- Failure to further discuss concerns for the Mother with notifiers to better understand, given her age, what services could be utilised to address the concerns.

- Failure to freshly consider risk and safety on the presenting circumstances of the notification, rather than relying on prior assessments and circumstances.

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[60] Exhibit B48 p18.
[61] Exhibit B48 p19, B49 p15.
[62] Exhibit B49.
[63] Exhibit B49.

- Failure to negotiate for a more assertive effort at engagement by agencies such as DoE and CAMHS.

- Failure to make enquiries about the Mother's mental health or total disengagement from school after she became pregnant.

- Joining the Mother and Infant 6 in the same Initial Assessment case; and the related failure to recognise that the Mother's risk issues were different to Infant 6's and that they would be better managed through a separate case. It is noted that this approach is common practice for siblings who share the same reported concerns, and that at the time of review there were no CSS procedures guiding the use of a common case for a parent and child where both are subject children.

- Failure to undertake a thorough risk and safety assessment in relation to the 2015 Initial Assessment, which would likely have resulted in a full Child Safety Assessment before Infant 6's birth.

- Failure to identify the risk to the Mother arising from notifications in 2016 that included indications of family violence.

- The absence of notifications to CSS by Tasmania Police in relation to two serious family violence incidents by the Father against the Mother in 2015 – due to the Mother's young age, their relationship could not be considered a 'significant relationship' under the *Relationships Act* 2003 nor for protection under the *Family Violence Act* 2004. The Mother was not identified as a child for whom a notification was warranted in these incidents. This affected the Mother's ability to access services and protections in relation to family violence that would have been available had she been 16 years of age. The lack of notifications also meant that the serious nature of the family violence was not integrated into the CSS risk assessment completed for the 2015 Initial Assessment.

- It is noted that the management of the 2016 Initial Assessment was consistent with procedure with regard to the Mother and appropriately summarised risks to her independent of Infant 6. While CSS staff acknowledged that the focus of attention was on Infant 6, the risks to the Mother were identified and she was appropriately referred for a Child Safety Assessment as a client in her own right.[64]

[64] Exhibit B49.

58. Specific recommendations included:

- Addressing the service delivery restrictions created by legislative definitions on the Safe@Home service system for young people under the age of 16 years who experience family violence.

- Provision of a current and comprehensive guide to working with at-risk adolescents to CSS staff (including understanding adolescent development, recognising trauma and cumulative harm in adolescents and applying this in the context of a specific young person).

- The use of age-appropriate material for psycho-education and exploration of appropriate service delivery platforms to young people by the Family Violence Counselling and Support Service (for example, apps such as Daisy).

Infant 6

59. CSS reviewed its intervention with regard to Infant 6 and identified failures to follow proper procedures and policies and deficiencies in risk assessments for his case.[65]

60. Deficiencies noted included:

- Incorrect risk assessment and judgement about present and future risk with regard to the 2015 Initial Assessment – the 'evidence of safety' used as the rationale for closure was not sufficient to mitigate the risks known at the time.

- Failure to comply with procedural timeframe requirements with regard to the 2016 Initial Assessment for a child aged 3 years or younger.

- Infant 6 (and the Mother's) Initial Assessment was not completed within the 3-day timeframe required but remained with Intake for 6 weeks; the Child Safety Assessment was not allocated within the 5-day timeframe required but remained unallocated at Response for 21 days. The reasons for this delay were explored in the CSS review, which found that Intake staff experienced ongoing anxiety about the risk to Infant 6 during the Initial Assessment, but delayed the transfer due to the dynamic between Intake and Response, due primarily to a perceived high workload at Response. It is noted that the safety planning meeting that was conducted on 10 May, not the

[65] Exhibit B48.

responsibility of Intake, evidenced the concern that Intake staff had for Infant 6's safety and their desire to avoid adding to the workload pressure on Response by doing additional work at Intake. Notwithstanding the good intentions behind these decisions, it was concerning to the Reviewer that individuals within the service system disregarded critical evidence-based procedural guidelines that are specifically designed to promote safety for vulnerable infants.[66]

- It is further noted in the review that CSS communication with the CU@Home nurses and other stakeholders was of a high standard and that critical information throughout the two Initial Assessments was discovered and documented in accordance with procedural requirements and was of a high standard.[67]

62. Specific recommendations included:

- The development and/or review of standardised reporting and management to facilitate timely action in periods of constrained capacity.

- Staff at all levels to be reminded of their responsibility to escalate serious workload capacity issues that prevent compliance with policy and procedures.

Professor Lonne's assessment

63. Professor Lonne was asked to assess whether, in his opinion:

If correct practice had been adopted by CSS would there have been a significant reduction in risk to the Mother and Infant 6?

and

Does the case contain deficiencies in CSS practice that are more serious and which involve an identifiable increase in risk to the Mother and Infant 6 before death?

64. Professor Lonne identified the risks and issues for CSS as:

- Both parents were young and inexperienced;

- Both parents had histories entailing significant child maltreatment and CSS involvement during their own childhoods;

[66] Exhibit B48.
[67] Exhibit B48.

- There was significant FADV that was ongoing;
- Infant 6 was a vulnerable infant;
- Cumulative harm upon the Mother was not assessed;
- The Mother was a young person with significant needs and limited capabilities and supports;
- The Father had a long established propensity for interpersonal aggression and violence; and
- There were a range of inadequate service responses by CSS.[68]

65. With respect to the relationship between CSS deficiencies and the deaths of the Mother and Infant 6, Professor Lonne said:

"Police, health and CYS/CSS were involved with the Father and the Mother from October 2015 due to FADV and assault of the Mother. A referral was made to CHaPS CU@home program and CYS/CSS closed the case in December with support from the 3/U panel. In April the following year a notification was received from NWRH regarding their dishevelled presentation and continued aggression by the Father – this was shortly before Infant 6's birth. Safety planning took place in early May with the Father's anger being a central issue. The CU@home staff continued home visits and were generally positive. However, during this critical period the CYS/CSS Intake decided to hold responsibility for the case in an effort to "protect" an overloaded Response team, with a transfer occurring on 24 May, where it remained unallocated for 21 days. A critical period of non-attendance to the family and situation occurred. The SERT report concluded "new, incoming information, some of which was adding to the concerns for safety of Infant 6, did not cause allocation" (Infant 6's SERT, p. 26). It subsequently noted that "it is not acceptable for a small part of the service system, or individuals within it, to make the decision to disregard critical evidence-based required procedures" (Infant 6's SERT, p. 28).

Throughout the CYS/CSS involvement during 2015-16 there was a lack of recognition and focus upon the Mother who was also a child, albeit one in a co-habiting relationship with the Father. Her SERT report notes that she was an At-Risk Adolescent with many presenting factors (the Mother's SERT, p. 24). Yet, the focus of CYS/CSS decision making appears to be deficient with respect to her needs.

The two SERT reports identified that the initial case closure in 2015 was based on misunderstanding of 'safety'; risk assessment was inadequate and did not include prior information; there was no

[68] Exhibit G1 Appendix E p4.

evidence that FADV was integrated into risk assessment; cumulative harm was inadequately assessed; there was case drift; Safety Planning was too optimistic after discussion with parents; and while service referrals were made there was patchy engagement by family..."

"...I have concluded from the materials provided that the service delivery by CYS/CSS was manifestly deficient and failed to provide clear and focused intervention in a timely manner. At the very least, the assessments ought to have attended properly to the clear risk that the Father's ongoing aggression and propensity for violence presented to both Infant 6 and the Mother. Overall, the service response was haphazard and patchy, and this enabled the family situation to drift on without a definitive response to the high likelihood of the two children being significantly harmed.

While, in my view, the driving incident could not necessarily be foreseen, what is evident is that the historical and contemporary information which CYS/CSS had in their possession indicated an unacceptable level of risk that some sort of significantly harmful event would occur."[69]

66. Professor Lonne answered the questions proposed above as follows:

"1. *If correct practice had been adopted by CYS/CSS would there have been a significant reduction in risk to the child?*

Response: I have concluded that CYS/CSS involvement properly done would have entailed a far more directive approach to intervention and prevention, particularly regarding the ongoing FADV. Assessment was, however, deficient and tardy and misread the risk of aggression and violence at the hands of the Father. I therefore concluded that practice that meets professional and departmental standards would have been likely to have resulted in a significantly reduced level of risk to both children.

2. *Does the case contain deficiencies in the CYS/CSS that are more serious and which involve an identifiable increase in risk to the child before death?*

Response: In my view the level of risk of significant harm was very high and, in particular, the delay in referral to Response and its subsequent allocation was unacceptable. The Father presented a real and ongoing threat to the physical safety of these children that meant a preventive intervention was required, but instead there was 'case drift'. I therefore concluded that the departmental practice could be assessed as having contributed to the deaths of Infant 6 and the Mother. CYS/CSS intervention ought to have assessed and considered the risks to the children and the merits of removing both the Mother and Infant 6 to a place of safety. This would have provided space and opportunity to work intensively with the Father to reduce the risks he posed to them through his emotional dysregulation and propensity for violence and

[69] Exhibit G1 Appendix E p4.

dangerous risk-taking behaviours. Whether or not a more directive intervention with the Father would have meant a demonstrable change to his behaviour is difficult to determine from the documents examined. Nonetheless, the lack of a timely intervention denied the children and the Father opportunities to access needed support and to potentially avoid the displays of anger such as that which was evidenced in his driving on [the day].'[70]

67. Professor Lonne was cross-examined strongly by counsel for the Department regarding the specific actions of the Department in its involvement with the Mother and Infant 6. In the course of cross-examination Professor Lonne conceded the limitations in the jurisdiction of CSS, particularly with respect to protecting a partner from domestic violence.[71] He was pressed on the evidence held by the Department in April/May 2016 as to the level of Mr Sheal's continuing aggressive behaviour.[72] It was put to him that the contact the Department had with the Mother and the Father after the April 2016 notification was an appropriate response.[73] Professor Lonne's unshaken position was that there should have been more face to face contact with the Mother and the Father to better understand the dynamic of their relationship through non-verbal cues.[74]

68. It was put to Professor Lonne that the Father's driving immediately prior to the collision did not evidence angry or erratic driving, thus undermining his opinion.[75] It is certainly the case that in the seconds or even minutes before the collision, the Father was not travelling fast and, during this time, his behaviour could not be necessarily categorised in itself as "angry". The manoeuvre into the intersection causing the two deaths could properly be categorised as erratic when taken cumulatively with the whole course of his inappropriate and risky driving. Certainly, his prior course of driving as witnessed by Mr O and referred to by Professor Lonne appeared to be an exhibition of anger. Nevertheless, my findings concerning Departmental actions or inaction do not turn upon how the Father's driving might be categorised in the final moments before the crash. It is plain that, viewed as a whole, his driving was unsafe and reckless and placed his partner and infant son at high risk of injury or death.

Ms Lovell's evidence

69. Ms Lovell, Director of CYF, disagreed with Professor Lonne's opinion that the Department's practices played a causal role in the deaths of Infant 6 and the Mother.

[70] Exhibit G1 Appendix E p3 and 4.
[71] Transcript 25 August p32.
[72] Transcript 25 August p59-60.
[73] Transcript 25 August p53-57.
[74] Transcript 25 August p62.
[75] Transcript 25 August p34-39.

70. In both her affidavit evidence and court testimony, Ms Lovell initially outlined the difficulty in CSS implementing coercive intervention strategies in respect of a 16 year-old adolescent such as the Mother. She stated that attempts to take forceful action to make young people safe, even if it is possible in a legal or practical sense, can be just as likely to erode trust and destroy relationships with protective adults, thus placing the young person further at risk.[76]

71. Ms Lovell also said that it is impossible to determine whether the situation would have been different if CSS had correctly recorded a specific notification for the Mother and treated her as a child at risk in her own right. Again, she emphasised that CSS always seeks to minimise harm, although it cannot alone protect adolescents from violence or prevent them from perpetrating violence within relationships without a fully coordinated response using legal avenues and social services.

72. I accept the logic of Ms Lovell's evidence regarding the ability of CSS to prevent the Mother's movements and, in particular, associating with the Father. However, the Mother's risk might well have been significantly reduced if she was the subject of notifications in her own right, a comprehensive risk assessment in response to each notification and then appropriate CSS strategies and action. She possibly may have welcomed and benefitted by some or all of the protection initiatives.

73. In most other respects, Ms Lovell's affidavit and oral evidence about the cases of the Mother and Infant 6 was overly focussed upon defending the organisation from a finding that it played a contributory role in the deaths of the Mother and Infant 6, as opined by Professor Lonne.

74. Ms Lovell's evidence was protective of the organisation and the staff. She is clearly knowledgeable in CSS practice and procedure and fully conversant with the difficult decisions required to be made by CSS staff on a daily basis. However, I accept the submissions of counsel assisting that her interpretation of the CSS deficiencies did not accord with the reality of the seriousness of the risk factors that confronted CSS and the action that was required in response to the risk.

75. With respect to Infant 6, Ms Lovell said:

"With the benefit of hindsight, it is easy to say that CSS could or should have removed Infant 6 from the dangerous situation he was in. Indeed, the violent and controlling behaviour of his father and erratic driving habits posed immense risk to him. However, the reality of removing a young infant

[76] Exhibit G3 paras 33-38.

from the care of its parents due to the presence of untested risk factors is not a clear or simple decision.

These were first time parents. They had not harmed a child previously. There were no known or observed issues with the Mother's parenting capacity or attachment with her infant son. There were family members involved who had some visibility of the situation through their communication with and observation of the family. Despite their initial (negative) response to engaging with CSS and accepting help, both parents had begun to engage with CSS and had met to talk through the issues. There was an assessment, which needed to be built on, to determine what their actual willingness and capacity was to protect their son Infant 6.'[77]

76. Ms Lovell did not provide detailed analysis of CSS's involvement with the Mother and Infant 6.[78] In particular, her comments about CSS involvement with the Mother and Infant 6 did not satisfactorily address the very significant delay in the referral to Response – a delay of 21 days from the date of the already delayed referral to Response by Intake on 24 May 2016. Both the SERT reviewer and Professor Lonne regarded this issue as a serous deficit which allowed the continuation of significant risk to Infant 6.

77. Ms Lovell also did not provide evidence regarding the important issue of inadequate face-to-face contact between CSS and the Mother and the Father.

78. I accept the submission of counsel assisting that, in all circumstances known to CSS, the risk to both children was high. As indicated in the above passage, Ms Lovell somewhat hopefully relied upon there being no known issues with the Mother's parenting capacity and the fact that both parents had begun to engage with CSS. Nevertheless, in her affidavit, she recognised the "immense" risk to Infant 6 posed by the Father's violent and controlling behaviour and erratic driving habits.

79. In actual fact, the risk factors in respect of the Mother were multifactorial. There was a lengthy history of notifications in respect of her, involving substantial non-attendance at school, mental health and self-harm issues, inappropriate sexual behaviour, failing to attend psychological referrals or engage with supports, lack of an effective guardian, limited self-sufficiency and vulnerability. There is no evidence that her ability to protect and care for herself had improved in the lead up to and after Infant 6's birth. To the contrary, she was living with the Father in an isolated place and without protective adults. She was subject to his physical and emotional violence, under his control and had no safety networks. In light of her

[77] Exhibit G3 para 39-40.
[78] Transcript 26 August 2020 p43ff.

history and risks, together with the abusive and controlling relationship with the Father, she had very limited ability to protect Infant 6.

Conclusion

80. The Mother had been subject to many notifications during childhood with an escalation of risk as an adolescent. Unfortunately, there were deficits in assessing risk in response to notifications since 2012 which, in turn, contributed to a lack of appreciation of the risk to both herself and Infant 6 before and after his birth. Serious additional risk to the Mother arose upon the Mother entering the relationship with the Father. However, the Mother's notifications were not separately assessed in a framework of adolescent risk. Infant 6 was subject to an unborn baby notification and, despite numerous and serious risks to his safety pre and post-birth, it was closed at Intake. When further ongoing notifications pre and post-birth were made in respect of Infant 6 and the Mother, a second Initial Assessment occurred, causing a transfer to Response for a full Child Safety Assessment. Contrary to guidelines, the notifications were yet to be allocated in Response at the time of death.

81. The Reviewer found that capacity to allocate cases in Response was limited during this time. The SERT report commented:

"Following completion of the Initial Assessment, both Infant 6 and the Mother's Child Safety Assessments remained unallocated from 24 May 2016 until their death in June 2016. In interview, staff described this period of time as one where a number of cases were on the "waitlist" for allocation, due in part to the processing of a large number (approximately 150 cases) of previously unallocated Initial Assessments. This was described as a snowballing of cases over from Intake. New staff, including some who had not worked in the CSS before, and low staff numbers were described as additional pressures at the time for the Response team.

The Team Leader was available for interview and recalled looking at the case when it was first transferred, noting the teenage mother and infant, but did not see it was a high level of risk. It was acknowledged that, again, the focus was on Infant 6, with the Mother only being considered "in the context of a teen mum".

Further, as a priority two, it was not seen as high a priority as the priority one cases also being transferred. The Team Leader said that priority one matters were being allocated, and priority two's were being allocated "when possible".[79]

82. I accept that, unfortunately, a period of particularly heavy workload impacted significantly on decisions made by CSS regarding risk and the appropriate level of protection required for the

[79] Exhibit B49 p20-21.

Mother and Infant 6 in the critical period before their deaths. More timely and robust intervention was plainly warranted. I accept the opinions of the Reviewer and Professor Lonne in this regard.

83. It becomes an exercise in speculation with the wisdom of hindsight as to what would have been appropriate action to be taken by CSS. In terms of appreciation and assessment of the risks, the pre-birth notification should not have been closed at Intake but referred to Response. If that had been the case, an ongoing information gathering and assessment process would have occurred before Infant 6's birth; and upon his birth, an immediate further risk assessment, informed by the investigation prior to his birth, would have taken place to determine as a matter of urgency the protective interventions necessary.

84. Neither Professor Lonne nor the Reviewer engaged in the exercise of determining the appropriate trajectory for CSS interventions, although both were of the view that part of the pre-birth response should have been to have the Mother and the Father engage with CSS and in education and preparations for Infant 6's birth. If it had done so, it would have been in a position to assess their capacity for parenting and experienced firsthand any particular risks to Infant 6. From that point, protective interventions could follow.

85. By the time of their deaths, there was plainly risk to Infant 6 stemming from the Father's known controlling, abusive, lawless and immature behaviour, including driving unlawfully with Infant 6. There was known risk to Infant 6 because of the Mother's inability to prevent him from being exposed to these risks. There was also significant evidence from reliable notifiers that the Mother and the Father could not afford to feed Infant 6 at times, fed him with inappropriate food and did not clothe him adequately. Concerningly, notifications were also received that the Father handled Infant 6 roughly on occasions.

86. Obviously, the risk of harm to Infant 6 would have been greatly reduced if CSS had successfully applied for an Assessment Order. The operation of such an order would have required mandatory engagement by the Mother and Infant 6 and further assessment of risk by CSS. Additionally, if that order gave the Secretary custody of Infant 6, then he may have been in out-of-home care, with the Father having only short periods of supervised access. In such a case, the risk to Infant 6 from his father's actions would have been effectively eliminated. The same conclusion is reached if Infant 6 was subject to a Care and Protection Order with similar conditions.

87. In the nine months between Infant 6's unborn baby notification and his death, a very serious picture of risk to this vulnerable infant had emerged. The risk involved entrenched issues in respect of the Mother and the Father which would not be alleviated without significant

support, incentive and engagement.

88. If the shortcomings in CSS actions and practices had not occurred, there is a very good chance that Infant 6 would have been fully protected by an Order from the spectrum of the Father's behaviour that subjected him to risk. Driving unlawfully with Infant 6 had occurred previously, to CSS's knowledge, and was one such foreseeable risk.

89. As a less likely scenario, CSS may have appropriately responded to the high risk by requiring the Mother and the Father to engage in intensive supports, more suitable residential arrangements, careful safety planning and close monitoring. Even with this intensive input from CSS, Infant 6 and the Mother may still have died in the same manner. It would have been difficult to stop the Father driving with Infant 6, although additional CSS involvement and exertion of pressure may have improved the ability of the Mother and the Father to parent and protect their son.

90. Despite the shortcomings in CSS action and practice, and despite the understandable opinion of Professor Lonne, I do not consider that I can find that the actions or inactions of CSS played a causal role in the deaths of the Mother and Infant 6. The actions of the Father in driving as he did, and the actions of the Mother in failing to protect Infant 6 were causative in his death.

91. I have no hesitation in finding, however, that there were many opportunities for CSS to have properly assessed risk and to have taken timely action to protect the Mother and Infant 6. If this had occurred as it should have, CSS might well have changed the trajectory towards the tragic deaths of both the infant and child.