



# MAGISTRATES COURT of TASMANIA

## CORONIAL DIVISION



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### **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Teegan Rose Hayes

**Find, pursuant to Section 28(1) of the *Coroners Act 1995*, that**

- a) The identity of the deceased infant is Teegan Rose Hayes;
- b) Teegan was accidentally suffocated whilst sleeping with her parents on 4 November 2011 which caused her subsequent death on 6 November 2011, the circumstances of which are further set out in this finding;
- c) The cause of Teegan's death was hypoxic brain injury; and
- d) Teegan died on 6 November 2011 at the Royal Hobart Hospital in Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Teegan's death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; affidavits from Teegan's parents; police and witness affidavits; medical records; child protection records and reports; forensic evidence; a report from an independent expert regarding the actions and decisions of Child Protection Services ("CPS") (now Child Safety Services); and a comprehensive review document prepared by Children and Youth Services.

Teegan Rose Hayes was born in Devonport, Tasmania on 13 October 2011 and was aged 24 days. Her parents are Robert William Hayes and Kim Maree Fox. At the time of Teegan's death Ms Fox was aged 39 years and Mr Hayes was aged 44 years.

Ms Fox and Mr Hayes commenced a relationship in approximately 2006. They have four children; Breanna Kathleen Hayes - born 15 May 2007, Ethan William Hayes - born 10 April 2008, Shanae Phyllis Hayes - born 8 January 2010, and Teegan. Ms Fox also has three other children from a prior relationship; Chloe Blacker - born 27 April 1996, Olivia Blacker - born 22 May 2002, and Jayden Blacker - born 8 July 2004. At the time of Teegan's death, Chloe stayed with Ms Fox and Mr Hayes every second weekend and had done so for several years. Olivia and Jayden were in the full custody of their father but visited Ms Fox fortnightly.

Ms Fox and Mr Hayes lived at 59 Canning Drive, East Devonport and had lived at that address since the commencement of their relationship.

Teegan Rose Hayes was born on 13 October 2011. At this time the youngest of Ms Fox's other children, Shanae, was aged 22 months. Teegan was Ms Fox's seventh child, four of whom (including Teegan) were residing with her at that time.

Teegan was delivered by caesarean section. The evidence indicates that Teegan was a normal, healthy baby. In her affidavit made for the coronial investigation, Ms Fox stated that Teegan was slow to drink her formula but healthy in all respects.

There is ample evidence that Ms Fox and Mr Hayes both suffered deficits in intellectual functioning, and that Ms Fox had a lower level of functioning than Mr Hayes. It does not appear that a formal assessment in respect of Ms Fox's disability was conducted. There is reference in the evidence to her IQ being in the borderline range and that her level of disability was "moderate".

Ms Fox had been declared a Ward of the State at the age of 14 years due to "neglect" and the order was discharged at the age of 18 years. As a parent herself, Ms Fox had been the subject of a long history of child protection notifications dating back to 1997. The notifications continued during the course of the relationship between Ms Fox and Mr Hayes in respect of risk to their children and their ability to adequately care for them. I will discuss these notifications in more detail later in this finding. Their ability to care for and protect Breanna was a central issue in this investigation, as was the adequacy of the CPS response to the notifications.

For the reasons further expressed, I find that Teegan should not have been in the care of her parents at the time of her death due to the high level of risk to her.

### **Circumstances of death**

The direct evidence surrounding the incident leading to Teegan's death comes principally from the affidavits of Ms Fox and Mr Hayes. I have real concerns that neither are credible or accurate historians. However, there is sufficient corroborating evidence from other sources that I am able to accept in general terms the correctness of their account. That is as follows.

At about 6.00pm on Thursday 3 November 2011, Ms Fox and Mr Hayes went shopping, leaving Teegan in the care of Ms Fox's cousin who lived next door at 61 Canning Drive. They collected Teegan from that address about an hour later and returned to their home.

Ms Fox put Teegan to bed in her bassinet at a time between 7.30pm and 8.30pm on 3 November 2011 after giving her a bottle. She was wearing a disposable nappy, a singlet and yellow jumpsuit. Teegan's bassinet was located beside her parents' bed.

At about 10.30pm Ms Fox and Mr Hayes went to bed. Ms Fox stated that before she went to bed both her and Mr Hayes consumed one full strength beer. I am not able to fully assess the accuracy of Ms Fox's statement that she only had one beer. Given the reported patterns of her alcohol consumption and the nurses' observations regarding the

smell of alcohol on her breath later that day, she may well have consumed a very significant quantity of alcohol.

At about midnight, Teegan awoke. Ms Fox took Teegan out of the bassinet, changed her wet nappy and brought her into the double bed (upon which she and Mr Hayes slept) to give her a bottle. After drinking about 60 mls of formula, Teegan fell asleep in Ms Fox's arms. Ms Fox stated in her affidavit that she herself then fell asleep. She further stated that when Teegan fell asleep with her in bed she was cuddled into Ms Fox's left shoulder on her right side. There was an adult-sized oversheet and quilt on the bed and multiple adult pillows at the head of the bed.

After a period of time Ms Fox stated that she heard the dog barking and awoke. The evidence indicates that the time then was about 3.30am on 4 November 2011. Ms Fox turned on her bedside light and found Teegan in her arms with a small amount of blood around her nose but a normal colour in her face. However, she had only faint breaths. Ms Fox woke Mr Hayes who took Teegan and commenced CPR upon her. Ms Fox tried to ring 000 for an ambulance but was too upset to do so successfully.

Ms Fox alerted the next door neighbours and one of them provided information about Teegan's condition on the telephone to Ambulance Tasmania personnel. This call was registered by Ambulance Tasmania as being received at 3.34am. In response, an ambulance arrived at the scene at 3.48am.

Ambulance officers took over CPR upon Teegan from Mr Hayes and transported her to the Mersey Hospital at 4.05am where she was assessed as being critically unwell, with no electrical activity in her heart, no breaths and fixed pupils. She was noted to be pale and floppy with constant seizure activity. Shortly after her arrival, adrenaline and fluid were administered. She regained electrical and mechanical activity to her heart some minutes later. Resuscitation efforts continued which included intubation and ventilation.

Arrangements were then made for Teegan to be transported urgently to the Royal Hobart Hospital ("RHH") by air. She arrived at the RHH neonatal intensive care unit at 11.00am on 4 November 2011 where she was medically managed and her medical state investigated. She was noted to be relatively stable but exhibiting seizure activity with no spontaneous movement.

At 4.30am on 5 November 2011 Dr Christopher Williams, experienced intensive care paediatrician, recorded that Teegan's seizures were unresponsive to medication and the prognosis for her brain was very grave. Throughout the day Teegan's condition remained critical, with an MRI showing multiple infarcts (areas of tissue death) throughout the brain. This finding indicated severe brain damage with a very poor neurological outcome. Dr Williams consulted with Dr Mark Pascoe and Dr Peter Dargaville, also experienced paediatricians, who agreed that Teegan's prognosis was poor. In consultation with Ms Fox and Mr Hayes, it was decided to withdraw active treatment to Teegan and provide her with palliative care.

At 12.00pm on 6 November 2011 Teegan was removed from the ventilator. Her breath and pulse then ceased. She was declared deceased at 12.22pm.

Upon Teegan's death, the coronial investigation commenced. On 6 November 2011 police officers attended the RHH, spoke with doctors and obtained an affidavit from Mr Hayes. On that day a CIB officer attended the address of Ms Fox and Mr Hayes, observing a clean and tidy three-bedroom residence containing a bassinet in the master bedroom.

The following day, 7 November 2011, Forensic Services officers attended the address to examine and photograph the scene. There was blood on the under sheet of the bed near the pillows at the point where Teegan was likely lying cradled in her mother's arms, suggesting that blood from her nose had been deposited in that area.

On the same date an autopsy was performed upon Teegan by Dr Donald Ritchey, forensic pathologist. Dr Ritchey, in his report dated 29 March 2012, determined that Teegan died as a result of hypoxic brain injury following respiratory arrest. He noted that the two possibilities for the cause of Teegan's brain injury were overlay (suffocation) by a sleeping adult or Sudden Infant Death Syndrome (natural causes). He observed that often infants who have either been suffocated by the body of a sleeping adult or who have suffered a natural causes medical event (SIDS) are discovered deceased. However, he states that cases are recorded when unresponsive infants may be found prior to death. In these cases, such infants may be resuscitated or may later die as a result of hypoxic injury that occurs to the brain caused by lack of oxygen due to respiratory arrest (cessation of breathing). Sadly, the latter scenario occurred in Teegan's case.

At the time of Dr Ritchey's original report, the full coronial investigation file had not been completed. Upon the evidence being complete, the file was again forwarded to Dr Ritchey to determine whether the further evidence could assist his opinion. In his amended report dated 5 December 2017, Dr Ritchey stated that *"on the balance of probabilities overlay by a sleeping adult seems the most likely scenario leading to this child's respiratory arrest and death by hypoxic brain injury."* I accept the opinion of Dr Ritchey. Teegan was a healthy baby during her life and there was no evidence at autopsy of natural disease or condition. Conversely, there was evidence that Teegan was sleeping next to the chest of Ms Fox and remained in this position when Ms Fox awoke.

From the evidence, I find that Teegan fell asleep after drinking her formula. Ms Fox then fell asleep still cradling Teegan in her arms. Sometime between the time of Teegan's feed at approximately midnight on 3 November 2011 and the time she was found by Ms Fox with blood coming from her nose at approximately 3.30am on 4 November 2011, Teegan was suffocated by the body of Ms Fox, possibly sleeping under the influence of alcohol. Due to this suffocation, Teegan suffered irreparable brain damage from which she could not survive despite the efforts of her parents and paramedics in resuscitating her and the intensive treatment provided by doctors at the Mersey Community Hospital and the RHH.

I am satisfied, based upon all of the evidence in the investigation, that neither parent did any deliberate act with an intent to harm Teegan, and that her death was accidental.

I note that on 25 October 2011, a child and family health nurse, Suzanne Luke, examined Teegan for her two week assessment. Nurse Luke noted that Teegan was healthy. Relevantly, she discussed safe sleeping practices with Ms Fox on this date, being standard practice for such a visit. The safe sleeping recommendations were further outlined in Teegan's personal health record. One of those recommendations indicated that bed sharing with an infant may be unsafe. I find that Ms Fox was fully aware of appropriate safe sleeping practices, particularly the importance of a separate sleep surface for an infant. These consistent messages would have also been relayed to her at the birth and early infancy of her other six children.

### **Child protection issues**

Whilst living in Tasmania, the children of Ms Fox came to the attention of this state's child protection service on many occasions due to an alleged inability of Ms Fox, and subsequently Mr Hayes, to adequately care for the children. Although there were many notifications alleging risk to the children, the notifications did not lead to CPS performing any thorough assessment of risk or to make application for protective court orders, including for further assessment or for their care and protection. The last notification was closed by CPS in March 2012.

Ms Fox, Mr Hayes and their children subsequently left Tasmania and relocated to New South Wales. In about 2014, they became known to the child protection authority in that state.

On 16 March 2015 Breanna, Ethan and Shanae Hayes were each made subject to a Care and Protection Order in the Children's Court of New South Wales until each attained the age of 18 years. As part of this order, parental responsibility was allocated to the Minister administering the *Children and Young Persons (Care and Protection) Act 1998* (NSW). This order entailed a finding of the court that the children were in need of care and protection, that there was no realistic possibility of the children being restored to the care of Mr Hayes or Ms Fox and that permanency planning with foster placements had been adequately addressed.

The CPS records in Tasmania reveal that there were 15 notifications made in respect of the family before the birth of Teegan. The first of these was in 1997 when Chloe, the eldest child, was aged 13 months. A number of risk factors were repeatedly identified in the notifications. These were primarily as follows: the incapacity of the parents to adequately care for the children by virtue of their intellectual disabilities; alcohol abuse by the parents, particularly Ms Fox; violent and aggressive behaviour of Ms Fox, including towards the children, when intoxicated; parental neglect and lack of supervision of the children; inappropriate methods of discipline of the children; and displays of sexualised behaviours by the children.

Two of the total notifications were purportedly investigated by CPS and found to be unsubstantiated. All of the remaining notifications were closed at Intake, "Intake" being the first stage in the CPS investigation process relating to a notification.

As will be further discussed, CPS did not adequately respond to the numerous notifications in respect of the family before the death of Teegan. I do not intend in this finding to set out in any detail the deficits in the CPS response to many of the very early notifications, even though it might be said that had CPS properly assessed and acted upon those notifications (in respect of Chloe, for example), the outcome for Teegan may have changed because a correct risk assessment would have informed a comprehensive and assertive strategy for protection of all of Ms Fox's younger (and future) children, including a likely application for the removal of Teegan from the family at birth.

I set out and discuss below the final series of notifications received by CPS from January 2009 until Teegan's death. These are the most relevant, temporally, in respect of action that might have been taken by CPS that could have prevented Teegan's death.

The question also arises whether CPS should have, in investigating these notifications, become aware of the impending birth of Teegan and intervened to protect her at the time of her birth. CPS was not in fact aware of Teegan's birth until 4 November 2011 when she was admitted to hospital in a critical condition.

### **The final CPS notifications**

In making the following comments I have relied upon a report provided at my request by Mr Damien Minehan, an experienced forensic psychologist, with knowledge of the child protection system and legislation. In his report Mr Minehan has carefully analysed the content of the notifications and the CPS decision-making and actions in response to them.

On 7 February 2018 I received from the Deputy Secretary, Children and Youth Services, Ms Ginna Webster, an extensive report ("the Review") compiled by the Serious Events Review team of Children and Youth Services ("the Reviewer"). The Review contained a comprehensive and forthright analysis of CPS decision-making and actions pertaining to Teegan and her siblings. The Review also responded to Mr Minehan's report and expressed substantial agreement with his conclusions. I am very grateful for the candid and helpful content in the Review. The factual background and analysis of the notifications has considerably assisted in my functions.

I have accepted and relied upon the conclusions of Mr Minehan and the Review in discussing the notifications to CPS below.

On 29 January 2009 a notification was made by a paediatrician in respect of Breanna, then aged two years, who was concerned with Breanna's disabilities, including her delayed speech and possible cognitive delay, issues with her sight, hip dysplasia requiring a harness and her need for grommets. The paediatrician stated that her parents

may be giving Breanna up to 20 bottles of cordial per day and had no understanding of appropriate nutrition. The paediatrician noted that the parents had a lack of understanding about appropriate discipline and behaviour management and that Breanna had very poor bedroom routine and sleep hygiene. The paediatrician was very concerned that this was the fourth child of Ms Fox and Mr Hayes and that they had such a lack of understanding.

On 18 February 2009 a notification was made by anonymous letter delivered to CPS which advised that Ms Fox's alcohol abuse was impacting upon her parenting. In response, CPS referred Ms Fox and Mr Hayes to an external organisation for assistance.

On 3 March 2009 a notification was received from a medical practitioner alleging alcohol abuse by Ms Fox and aggressive behaviour towards the children as well as concerns about Chloe caring for the younger children. As a result the family were referred to an external organisation for assistance.

On 5 January 2010 a notification was made by police in respect of Chloe alleging that Ms Fox had threatened to "discipline Chloe until her nose bled". This action was not said to have been carried out but Chloe was allegedly upset. This notification was closed at Intake with no further action by CPS. It is the Intake team within CPS that initially receives a notification and is responsible for assessing risk using the Tasmanian Risk Framework ("TRF"). The TRF is the process and documentation by which CPS is required to conduct a risk assessment in respect of a notification. If the notification is assessed as serious and requires further assessment it is referred to the Response team for further investigation, risk assessment and action. At Response level, the TRF is used more fully and the investigation is conducted in greater detail in order to determine risk response. For this particular notification regarding Chloe the harm consequence using the TRF was assessed at Intake as "concerning", the harm probability "likely" and future risk "medium".

On 8 January 2010 a notification was made by the children's maternal great aunt concerning inappropriate sexual behaviour within the family. Chloe, then aged 13 years, was alleged to be in a sexual relationship with a 13-year-old male. There was also information received that Jayden and Olivia (then aged 6 and 8 years respectively) were sharing a room, bathing together and going to the toilet together. This notification was closed at Intake with no further action by CPS. It appears that CPS took the view that the reports in relation to Jayden and Olivia were not a CPS concern but that CPS would further assess the matter relating to Chloe. However, there is no evidence that anything further was done by CPS to investigate the allegation. Moreover, the fact that a notification was not raised for Olivia and Jayden may have prevented a more comprehensive file review and assessment of parenting ability and risk to all of the children.

On 30 December 2010 a notification was made by a family member in respect of Breanna, then aged 3 years, Ethan, aged 2 years, and Shanae, aged 1 year, advising that Chloe was disciplining Ethan with a wooden spoon, Ms Fox was abusing alcohol and unable to care for the children, and that the children's physical needs were being

neglected. It was further advised that there was no food or money in the household, Breanna had headlice and the washing machine was broken down.

On 21 January 2011 the notification was referred for an investigation, which purportedly occurred. After the investigation, which included a home visit, the notification was found by CPS to be unsubstantiated and was closed on the basis that there was no evidence that the children were at risk and that there were some support services already involved with the family. It is likely that Ms Fox had just become pregnant with Teegan at this time but she may have been unaware of her own pregnancy. The TRF documentation was not updated by CPS in respect of this notification.

In respect of this notification, the Reviewer noted that the interview of the parents at the home visit by CPS workers relied on their own reporting of their alcohol use, that there was no exploration of the intellectual capacity of the parents and that no support services involved with the family (other than childcare) were contacted. The Reviewer further noted that the relevant CPS Response Assessment guide at the time required visual examination of the child, but in this case only Chloe was seen and Breanna was asleep. Importantly, there was no evidence that cumulative harm was considered as a possibility and incorporated into the assessment.

As I stated in the finding of [Pearce, Jasmine Rose 2015 TASC 75](#):

*“The concept of cumulative harm refers to the effects of multiple adverse circumstances and events in a child’s life. Chronic child maltreatment causes children to experience harm, even when the individual circumstances of each incident or event do not, in themselves, suggest serious risk. It is well-known that evidence shows that ongoing low-level neglect or abuse can be more damaging to children’s well-being than sporadic or one-off incidents of significant violence”.*

The CPS practice guide entitled “Cumulative Harm: Identifying and Assessing” outlines the practice requirements for CPS case workers in assessing cumulative harm. There is a requirement that if two notifications are received within 12 months without assessment at Response, further notifications must be considered with specific reference to the concept of cumulative harm. The practice requirements also identify key indicators for a cumulative harm assessment - being multiple notifications, previous notifications relevant to other family members, previous substantiated notifications from multiple sources and professionals, evidence of a failure of a child to meet developmental milestones and allegations of inappropriate parenting in public. Where three or more of these indicators are present, the case should be referred to Response where an in-depth assessment is required. This will include a full review of the history of the child and siblings. In respect of this notification, this process should have taken place but did not.

On 15 July 2011 an anonymous notification was made in respect of Breanna, Ethan and Shanae, advising that they were being cared for by a neighbour whose capacity was described as limited. CPS records contain the comments that the children were going to childcare, the childcare facility did not have concerns, and that the children are often



sighted by other services with no issues noted. CPS further recorded that the parents denied the allegation and that the house was “faultlessly tidy”.

At this stage Ms Fox was six months pregnant with Teegan, although there is no evidence that CPS was aware of this fact. The assessment at Intake was that the harm consequence was “concerning”, the harm probability “unlikely” and future risk “low”. This notification was not assessed adequately. Importantly, the issue of cumulative harm was still not identified or assessed as required which would have, in accordance with practice requirements, demanded a full assessment of history and risk factors. The Reviewer stated in the Review *“it is noteworthy that this notification occurred only three months prior to Teegan’s birth. A different and more thorough response this time may have resulted in a different outcome for both Teegan and her siblings.”*

The final notification occurred on 4 November 2011 and was the first in respect of Teegan. By this time Teegan had been born, hospitalised and her death was, unfortunately, inevitable. Nevertheless, the CPS response in respect of this notification is emblematic of the inadequate manner in which the notifications generally were dealt with and the ongoing lack of appreciation of the serious risk to the children.

On 4 November 2011 nursing staff and police advised CPS that Teegan had been admitted to hospital in a critical condition due to “near cot death”. The notification involved a report that Ms Fox and Mr Hayes had been drinking heavily before going to bed and that Teegan was found by older siblings laying between her parents who were still asleep in a “concerning way”. It was reported that the children woke their parents and an ambulance was called. These are facts which cannot now be verified but nevertheless were reported at the time. It was further reported that Teegan was unlikely to survive and, if she did survive, would most likely have significant brain damage. It was reported that Ms Fox and Mr Hayes smelled strongly of alcohol and cigarette smoke at the Mersey and Royal Hobart Hospital.

Over the next several days CPS became aware of further relevant information. That information included the social worker’s belief that Ms Fox may have been drinking alcohol throughout the first day of Teegan’s hospitalisation and did not arrive at the RHH until after 4.00pm; that Ms Fox’s functioning appeared to be low; that her affect was flat and empathy limited; and that she had oily and dirty hair and ingrained dirt on her hands. Further, Ms Fox and Mr Hayes told hospital staff that they had found one of their previous babies in this same manner as Teegan and that she died in her father’s arms “just the same as Teegan”. This fact, on all the evidence, is incorrect, but, again, was critical information provided to CPS at the time.

On 7 November 2011 a paediatrician involved in Teegan’s care at the RHH contacted CPS to advise that Teegan had passed away and to express concerns regarding the remaining siblings. The paediatrician reported that Breanna had been admitted to the ICU about four years previously after “dying” and being resuscitated again. As a result of this incident, it was reported that Breanna suffered mild brain damage, developmental delays

and grand mal seizures. The paediatrician was unsure as to whether Breanna was the child that the parents previously reported as having died in her father's arms.

The notifications arising from Teegan's hospitalisation and subsequent death were referred to CPS Response for an assessment. The assessment included a home visit and a telephone call with a worker from a support organisation. As part of that assessment CPS noted that Breanna was already linked in with a support organisation, that the parents were accessing respite, that the Parenting Centre was involved, and that there was no evidence of alcohol misuse by Ms Fox and Mr Hayes.

CPS recorded the notification as "substantiated" with the consequence of harm being "extreme", the probability of harm, "likely", and the future risk being "high risk". Despite this result and despite the death of an infant in unclear circumstances, the notification was closed on 19 March 2012 with no further action or investigation undertaken by CPS. The Review detailed the inadequacies relating to this investigation and risk assessment. A very basic summary of those issues are as follows:

- There was not sufficient time spent by CPS workers to become acquainted with the family and the children to take the necessary action to ensure the future safety of the children.
- CPS was not compliant with the relevant practice guide for Response assessment and there were many respects in which that guide was not followed.
- There was no analysis of the pattern of cumulative harm or the history of notifications.
- The TRF was not fully completed with some sections left blank and some duplicated from the TRF completed by the Intake worker.
- There was no proper consideration of the reported alcohol abuse by Ms Fox and/or Mr Hayes in coming to the conclusion that there was no evidence of alcohol abuse. Inconsistently, alcohol abuse was recorded in the CPS notes as a major contributor to the death of Teegan.
- There were no enquiries made with the childcare centre where the children attended, or with support services involved with the family regarding risk factors.
- Breanna and Shanae were not considered as part of the notification, even though the parenting issues placed them at risk.
- There was no attention or analysis given to the inconsistent reports relating to Breanna's injury or the reported death of a previous child as a result of co-sleeping issues.

- Proper enquires would have revealed that there was only one support service involved with the family which was inadequate for their complex needs.
- Although the CPS notes indicated CPS would monitor the family, there was no further follow-up contact by CPS.
- The Director of CPS did not, in accordance with the guidelines, request a Critical Case Review upon Teegan's death.

As stated by the Reviewer *"the risk assessment process of gathering information, analysing that information and coming to a logical conclusion that enables the development of a safety plan does not seem to have occurred"*.

On a date unknown to CPS, Ms Fox, Mr Hayes, Breanna, Ethan and Shanae left Tasmania to live in New South Wales at an address unknown to CPS.

As discussed above, it seems that the family came to the attention of the New South Wales child protection authorities in 2014 and the three children were assumed into the care of the Minister (being placed in foster care) on 27 May 2014. Final care and protection orders were made in respect of the children on 16 March 2015.

It is unlikely, now that orders are in place in respect of the children, that they will come to harm by virtue of the risk factors existing whilst in the care of their biological parents.

### **Summary of risk factors and deficits in CPS response**

It is apparent that the children of Ms Fox were "at risk" in accordance with that definition in the *Children, Young Persons and their Families Act 1997*. Ms Fox and Mr Hayes, as guardians of the children, were unable to maintain the children, unable to exercise adequate supervision and control over the children and were unable to prevent the children from suffering abuse or neglect.

The particular factors indicative of risk to the children, and reported to or known by CPS as part of notification, can be summarised as follows:

- a) Severe alcohol abuse by both parents, particularly Ms Fox;
- b) History of poor supervision of the children by the parents;
- c) Neglect of the children by the parents;
- d) Lack of understanding of appropriate discipline for the children;
- e) The fact of multiple notifications indicating that the children had been subject to cumulative harm;

- f) Intellectual disability suffered by Ms Fox and Mr Hayes;
- g) Ms Fox's own dysfunctional childhood, including being in a sexual relationship at the age of 13 with a 32-year-old man whilst in her mother's care;
- h) Exposure to inappropriate sexual information and inappropriate sexual behaviours;
- i) Difficulty managing the behaviours of Breanna who suffered multiple issues including cognitive impairment, seizures, motor deficits and speech deficits; and
- j) Multiple individuals observed to be entering the home while parents are intoxicated.

Over many years, CPS did not recognise or adequately deal with the serious risk factors to the children. The Reviewer acknowledged this fact, stating *"when this evidence is considered, the involvement of CPS with this family was not sufficient to adequately address the issues, reduce the risk and create safety for the children. More timely, intensive involvement should have occurred which may have significantly altered the outcomes for these children"*.

In the examination of the notifications set out above, the inadequacies are clearly apparent. The Reviewer expressed the opinion that had the numerous notifications received prior to Teegan's birth been assessed and responded to in accordance with proper practices and procedures, an assessment of the family would have been comprehensive and ongoing with a planned strategy to protect the children. I agree with this statement. Such an assessment would almost certainly have led to the timely identification of the serious risk issues and the development of an assertive response. CPS would have not only known about Teegan's impending birth but would have been ready to take appropriate action, armed with a full risk assessment, at the time of her birth. This would likely have involved seeking and being granted a court order to remove her from the home to secure her care and protection.

The extensive deficits in CPS practice and procedure can be summarised as follows:

1. Risk assessments in accordance with the TRF routinely fell short of accepted standards. The TRF documentation was in many instances either not completed at all or was left incomplete or duplicated from the previous notification rather than updated. The TRF, as the guiding document, was therefore inadequate to inform decision-making at critical points both for current and for future notifications. The quality of information-gathering and analysis of risk was poor. The Reviewer validly makes the point that there was a tendency to close notifications or take no further action on a notification on the basis of previous closed or unsubstantiated notifications. Further, the file reviews were inadequate and historical information was not accessed or incorporated into the

risk assessments. Conflicting information was not clarified, nor were gaps in information addressed. A heavy reliance upon Ms Fox's self-reporting was also identified by both Mr Minehan and the Reviewer. In the context of Ms Fox having a known intellectual disability, dependence upon alcohol and propensity to violence, her representations to CPS workers relating to risk should have been treated as highly unreliable.

2. There were obvious issues of cumulative harm apparent in the family prior to Teegan's birth. Cumulative harm was not considered or identified as a potential issue despite it being clearly stated in the practice guides and despite several indicators being present during most notifications. Most concerning, there were 13 notifications made in respect of the family before a referral to Response occurred. When an assessment did take place in Response on 21 January 2011 it was not conducted in line with the required practices and procedures; and therefore did not correctly identify the serious risk to the children necessitating intervention.
3. At the time of the notifications there were CPS guidelines in place for assessing notifications involving very young and infant children. These guidelines outlined particular assessment processes such as gathering information from multiple sources and services, assessing parental history and capacity and, conducting a comprehensive family history assessment. There is no evidence that the guidelines were followed or that correct process or analysis occurred in respect of applicable notifications.
4. There was, over the whole period in which notifications were made, poor communication by CPS with individuals and services who were reported to be involved with the family. Such communication was required to make properly informed assessments of risk, develop safety plans and achieve the best outcomes for children.
5. CPS performed unsatisfactorily in its contact with the parents. Ms Fox and Mr Hayes were not contacted in response to many notifications and the deliberations that occurred at Response were lacking in depth and inadequate to inform correct risk assessment.
6. There was no evidence of a systematic review of Ms Fox's parenting abilities and, in particular, a proper assessment of her intellectual disability and how it impacted upon her parenting. There was also no proper investigation of her use of alcohol, despite this being a repetitive theme in the notifications and obviously, if verified, an issue that significantly increased risk to the children.

I have no specific evidence in this investigation as to the reasons for such extensive failings over a lengthy period and I did not request such evidence. In the finding [Johnstone, BJay 2017 TASCD 248](#) relating to an infant death in 2012 where similar issues arose, I stated at page 70:

*“The unfortunate fact remains that.... there were extensive failings. Those failings reflect, in my view, entrenched systemic and cultural deficiencies in the context of inadequate resourcing. The evidence very strongly indicates that the pressure upon the individuals and the organisation, the inexperience and turnover of the workers, inadequate staff numbers and lack of training were constant issues preventing effective responses to the notifications. In such a context, the solution is not to criticise any individual, but to address those issues that impacted so strongly on the inability of proper decisions being made in accordance with correct practice.”*

Whilst I make no positive findings, it may be that some or all of the factors referred to above may have impacted upon the decision-making in respect of Teegan’s family.

### **Final comments**

The Review helpfully detailed some changes and refinements to CPS procedures since the notifications pertaining to Teegan’s family occurring prior to and in 2011. I note, in particular, that the Three and Under Panel has been established in respect of notifications involving children aged three years and under and which also includes assessment of Unborn Baby Alerts. In such cases, closure of a notification is only permitted upon approval by a panel comprising senior CPS staff, a Senior CHAPS nurse and Senior Counsellor. This development represents an important safeguard in respect of notifications involving vulnerable infants.

I also note that improvements to the CPS data management system, CPIS, have occurred since Teegan’s death by way of system releases, operational reports, templates and email alerts.

In his report Mr Minehan identified as a key issue apparent staff difficulties in using CPIS, which made keeping notifications in relation to each child and assessment of cumulative harm and risk over a time a very difficult task. Similar difficulties with CPIS were also apparent in the evidence received at the inquest into the death of BJay Johnstone. In that finding, I recommended that CPS implement a comprehensive independent review of the functionality and usage of CPIS. [The Tasmanian Government Response to Coroner’s Recommendations on the death of: BJay Adam Johnstone](#) (“the Government Response”) dated July 2017 sets out the Government’s commitment to replace CPIS and that funding has been provided in the 2017/2018 State Budget to develop a business case and requirements for the replacement of CPIS. Further, I am advised that substantial steps are already being taken to complete the project and work towards the requirements of the new system. The Government Response also provides that cultural change, including barriers to the system’s usage, is being addressed through the implementation of the Strong Families, Safe Kids project, including additional practice supports and a Systems Trainer position to support staff in their knowledge and use of CPIS.

In this case I have identified other similar deficits in CPS practice to those surrounding the death of BJay Johnstone. One particularly relevant recommendation from that finding is the implementation of an audit or quality assurance system to: (a) determine whether the TRF is being routinely and correctly used; (b) ensure that CPIS searches are being routinely and correctly conducted; and (c) ensure that risk assessments based upon the TRF accord with the statutory responsibilities of CPS and the CPS Practice Manual. In the *Jasmine Pearce* finding I also made recommendations that CPS conduct regular audits of its files to determine whether the cumulative harm policy in risk assessment of notifications at Intake is being routinely followed.

The CPS response to Teegan's death, again, raises the need for a comprehensive system of continuous file review and auditing to ensure adherence to correct CPS practice in all of its aspects. The system of auditing should involve strategies for quality improvement.

In the Government Response, the Government advised that it has instituted action to implement an audit and quality assurance system, which will involve case file audits conducted annually and will complement random review of files by line managers/team leaders as an ongoing part of supervision. The proposed system would appear to be responsive to the identified need and priority ought to be given to its full implementation.

With regard to training, I recommended in the *BJay Johnstone* finding that CPS implement a comprehensive training regime for all its workers in the application of the TRF, CPS Practice Manual and specialist guides and that the training be regularly updated to maintain the integrity of the risk assessment process and current learning in the field. In the *Jasmine Pearce* finding I recommended that CPS continue to educate its workers on the cumulative harm policy and its practice.

In the Government Response, the Government has advised that action is underway to implement a comprehensive training regime involving the recruitment of 10 Clinical Practice Consultant and Educator positions. The Government advised that it has also developed priority learning packages for risk assessment, particularly pertaining to infants, to be delivered by the first semester of 2018. The Government has also indicated that action is underway to implement regular training updates through the Clinical Practice Consultant and Educator positions to the CPS workers in order to maintain the integrity of the risk assessment process and current learning.

I note that in the Review, recommendations were also made by the Reviewer covering many areas discussed above. These included recommendations for improvements in risk assessment practice, procedure and auditing; supervision, mentoring and training; and, specifically, improvements in cumulative harm assessments and practice. These recommendations will no doubt be further considered by CPS in its quality improvement strategies.

Commendably, the Tasmanian Government has committed to developing and resourcing improvements to child protection practice in areas relevant to those surrounding Teegan's

death. For example, the replacement of CPIS, recruitment of Clinical Practice Consultant and Educators, recruitment of northern hospital Child Safety Liaison Officer positions and a system for auditing of files, will significantly improve the quality of child protection practice into the future.

The Government, through a cross agency working party, is also developing the Vulnerable Infants and Babies Strategy which intends to provide a comprehensive framework to enable a statewide and consistent response for vulnerable infants and babies and which delivers consistent policies and guidelines for use across child health, community, paediatric and obstetric services and clear notification criteria and referral pathways to other necessary services to support the families.

Given the Government's commitment to such significant reforms, it is unnecessary to repeat the comprehensive recommendations made previously, although I have made two recommendations below that I consider appropriate in the circumstances.

I have found that Teegan's death could have been prevented by appropriate CPS action. Nevertheless Teegan died ultimately as a result of suffocation in her parent's bed. Her parents, as her guardians, were directly responsible for her safety.

I take this opportunity to set out the main safe-sleeping recommendations promulgated by the Red Nose organisation (formerly Sids and Kids) to help prevent sudden unexpected death in infants. They are:

- Sleep baby on the back from birth, not on the stomach or side.
- Sleep baby with face uncovered, and not with doonas, pillows, bumpers or soft toys.
- Avoid exposing babies to tobacco smoke before or after birth.
- Provide a safe sleeping environment; a cot meeting Australian Standards, firm mattress, safe bedding, avoid over-heating.
- Sleep baby in his/her own safe sleep environment next to the parent's bed for the first six to 12 months of life; in a cot, bassinet or other safe sleep surface night and day.

## **Recommendations**

I **recommend** that CPS provide training on an ongoing basis to its child safety officers in effectively identifying and responding to situations where it is identified that an infant under the age of 12 months may be at risk due to unsafe sleeping practices.

I **recommend** that the Deputy Secretary, Child and Youth Services, provide the Chair of the working party for the Vulnerable Infants and Babies Strategy with this finding to assist



in informing the development of the Tasmanian Strategic Framework for Vulnerable Infants and Babies.

I express my appreciation to those who have assisted me in this investigation, including the investigating officer, coroner's associates, Mr Damien Minehan, Dr Donald Ritchey, Family and Community Services (NSW) and Child and Youth Services.

**Dated:** 31 May 2018 at Hobart in the State of Tasmania.

**Olivia McTaggart**  
**Coroner**