MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

RECORD OF INVESTIGATION INTO DEATH (WITH INQUEST)
Coroners Act 1995
Coroners Rules 2006
Rule 11

(*These findings have been partially de-identified in relation to the names of family members by direction of the Coroner pursuant to s. 57(1)(c) of the Coroners Act 1995.*)

I, Olivia McTaggart, Coroner, having investigated the death of Jasmine Rose Pearce

WITH AN INQUEST HELD in the Launceston Magistrates Court (Coronial Division) on 26, 27, 28 November, and in the Hobart Magistrates Court (Coronial Division) on 1 and 15 December 2014

REPRESENTATION:

Counsel Assisting	M Allen
Child Protection Services	K Brown

FIND THAT:

(a) The identity of the deceased is Jasmine Rose Pearce;

(b) Jasmine died in the circumstances set out in this finding;

(c) Jasmine died on 27 January 2013 in Launceston, Tasmania;

(d) The cause of Jasmine's death was suffocation under bedding; and

(e) Jasmine was born on 5 February 2012 to Leslie Gordon Pearce and Helen Margaret Howell, and was an infant aged 11 months.

INTRODUCTION

Jasmine was born on 5 February 2012. She was 11 months old when she died on 27 January 2013 in her family residence in Launceston. She is the sixth child of Helen Howell. She is the second child of both Ms Howell and her partner Leslie Gordon Pearce. At the time of Jasmine's death Ms Howell was aged 39 years and Mr Pearce was aged 49 years. The two eldest children of Ms Howell, "J" and "K", did not live with Ms Howell at the time of Jasmine's death. The other four children, including Jasmine, lived with Ms Howell. At the time of Jasmine's death child "A" was nine years of age, child "R" was six years of age and child "D" (the other daughter of Mr Pearce) was two years of age.

The relationship between Ms Howell and Mr Pearce commenced in 2009 and was characterised by instability and family violence perpetrated by Mr Pearce upon Ms Howell. The relationship was, correctly, categorised as a "significant relationship" by police for the purpose of their actions pursuant to the *Family Violence Act 2004*.

At the time of Jasmine's death Mr Pearce was subject to a protective family violence order which did not prohibit him from entering Ms Howell's address. On the evidence, Mr Pearce spent significant time at her address and with the children despite maintaining his own home in Invermay. The children were regularly exposed to family violence. The Police Family Violence Management System ("FVMS") records 13 incidents of family violence between Ms Howell and Mr Pearce before Jasmine's death. There were 11 reported incidents of family violence since Jasmine's death, being 24 incidents in total. Most of the incidents occurred at Ms Howell's residence and Mr Pearce was always recorded as the offender. Of the total incidents, 19 recorded that one or more of the children were present. Of the total incidents, police submitted 12 Child Protection Services referrals, with six of these before Jasmine's death when Ms Howell was either pregnant with Jasmine or during Jasmine's life. Both Ms Howell and Mr Pearce are also recorded on police family violence records as being involved in incidents with previous partners.

Ms Howell has a history of mental health issues, drug use, and disengagement with supports and services. Child "A" suffers Down Syndrome, has an intellectual disability and physical illnesses, and requires intense support. Records tendered in evidence state that "A" was mostly not engaged in the specialist schooling and services required. Ms Howell's child "R" displayed behavioural difficulties. Their two bedroom residential unit had inadequate space for a family of one adult and four children. Ms Howell was not organised or able to keep up with the demands of the family. As detailed further in this finding, the unit was usually dirty and disorganised. All of the evidence shows that, during Jasmine's life, Ms Howell was not able to adequately cope with the needs of the children.

The evidence shows a history of child protection notifications regarding Ms Howell's children, primarily concerning the impact of the family violence upon the children and Ms Howell's alleged neglect of the children. Neither Jasmine nor the other siblings had been the subject of formal orders under the *Children, Young Persons, and Their Families Act* 1997. However, as a result of Ms Howell's need for support, she was referred by Child Protection Services ("CPS") to Gateway Services, being non-government support services linked to CPS and providing support to vulnerable families.

CIRCUMSTANCES SURROUNDING JASMINE'S DEATH

At about 10.37am on Sunday 27 January 2013, Mr Pearce called Ambulance Tasmania as Jasmine had been found in bed with no signs of life. At 10.41am ambulance personnel and police officers attended. They observed Ms Howell and Mr Pearce to be hysterical. Neighbours were assisting them, including attempting CPR upon Jasmine. Paramedics noted that Jasmine was not breathing and was without a pulse. They immediately provided advanced cardiac life support, until 11.08am, when they arrived with Jasmine at the Launceston General Hospital. This included adrenaline and a laryngeal mask for ventilation. Paramedics observed no change to Jasmine's condition during these attempts at resuscitation. On Jasmine's transfer to the Emergency Department at the Launceston General Hospital ("LGH") the treatment continued. Two further doses of adrenaline were administered. However at no time was there any spontaneous respiration, pulse or cardiac

rhythm. Resuscitation was stopped and Jasmine's life was declared extinct at 11.26am in the presence of her parents.

Initial investigations by attending police officers did not reveal any obvious injury or marks on Jasmine, nor any apparent cause of death. On that day both Ms Howell and Mr Pearce provided affidavits to police regarding the circumstances surrounding Jasmine's death. In the affidavits they stated that they were both present in the unit for the whole evening with the four children. They stated that Jasmine was placed onto a fold-out double bed in the lounge room the previous evening, being 26 January 2013. They stated that the bed contained their bedding and cushions. Cushions were also placed under the sides of the mattress and on top of the mattress to prevent Jasmine rolling off the bed. They stated that they went to sleep with Jasmine in the bed. They stated that they had smoked cannabis for an extended period in the house before going to bed. Whilst their accounts in their affidavits contained significant discrepancies, both initially stated that they found Jasmine in the bed in the morning with no signs of life, and did not know how Jasmine died. They denied that they accidentally rolled upon her and suggested that she may have died as a result of child "A's" actions of placing doonas on Jasmine or lying or jumping on her in the morning.

However, in a subsequent statement made to police recorded on 20 March 2013 and in their evidence at the inquest they gave a differing account. They stated that at a time after Jasmine had fallen asleep in the bed they both smoked cannabis and commenced sexual activity in the bathroom of the house. They stated that the sexual activity continued into the lounge room and onto the fold-out bed upon which Jasmine was sleeping. During the sexual activity in the bed Mr Pearce said he felt Jasmine's body under the doona and under him on the bed. At this time he made a statement to Ms Howell to the effect that he thought he was squashing Jasmine. They both stated that the sexual activity continued with neither of them checking upon her. They stated that she did not cry or wake during this time. They stated that they believed Jasmine may have died whilst this occurred and as a result of it. However, they did not discover that she was deceased until the morning, at a time after about 9.30am.

I have referred in basic terms to these two differing accounts in order to highlight the issue of the circumstances of death that must be determined. In actual fact, both Ms Howell and Mr Pearce each gave further accounts to police officers and others that conflict in many details with each other's statements, and also with their own accounts on other occasions. I will analyse them further in this finding to determine whether any or which of those statements are credible and reliable. This task is important as Ms Howell and Mr Pearce were the only persons in a position to assist with the truth regarding the circumstances of Jasmine's death.

FOCUS OF THE INQUEST

The evidence at the inquest focussed upon determination of the cause of Jasmine's death - in particular, whether she died as a result of suffocation in the bedding and/or by the bodies of her parents, or as a result of natural causes (Sudden Infant Death Syndrome) unrelated to her sleeping environment. The evidence does not support that there was any intention to deliberately harm Jasmine.

The inquest also focussed upon whether the risk to Jasmine was adequately assessed by CPS. In particular, the issue arose as to whether the response to the notifications whilst

Jasmine was *in utero* and during her life was adequate, and if not, the procedures and actions that should have been adopted.

Although I have made some critical comments about CPS in respect of Jasmine's care and protection, it was not envisaged prior to commencement of the inquest that a finding of contribution to death would be made on the basis that a formal order should have been applied for, or that if it had, an order would have been made removing Jasmine from the care of Ms Howell. After the evidence was heard I am not satisfied that such a finding can be made.

I am satisfied that Jasmine's safety and the manner in which it could have been enhanced by CPS is a proper matter for comment and recommendations (where appropriate) pursuant to section 28(2) and 28(3) of the *Coroners Act 1995*. Jasmine was a vulnerable infant who lived her short life as a child at risk, was known to CPS and died in circumstances attendant with risk. By virtue of the *Children, Young Persons, and Their Families Act 1997*, CPS is mandated to protect children at risk of harm in circumstances where notifications have been made.

Therefore the focus of the inquest was around the following issues:

(a) The circumstances of Jasmine's death and the credibility of the accounts of Ms Howell and Mr Pearce;
(b) The ultimate cause of Jasmine's death;
(c) Whether Mr Pearce and Ms Howell contributed to the cause of Jasmine's death; and
(d) The response of CPS to the notifications whilst Jasmine was *in utero* and during her life.

LEGAL PRINCIPLES TO BE APPLIED

Contribution to cause of death

When this inquest was heard in December 2014, section 28(1)(f) required a coroner investigating a death to find, if possible, the identity of any person who contributed to the cause of death.

Some of the relevant principles relating to contribution to death are as follows;

- The test of contribution is solely whether a person's conduct caused the death: *Keown v Khan* [1999] I VR 69 per Callaway JA at p76.

- The actions of the person must be a substantial contributing cause of death. The concept of "substantial" means an operative cause - not too remote, not merely part of the history of events, and more than *de minimis*; *Royall v The Queen* [1991] HCA 27; (1991) 172 CLR 378 per McHugh J at 442*; R v Smith* (1959) 2 QB 35.

- The actions of the person need not be the sole, direct or immediate cause of death; *Keown v Khan,* (supra); *Royall v The Queen* (supra). However, when the death is not caused directly by the actions of the person there is a question of

whether the chain of causation has been broken. *Pagett* [1983] EWCA Crim 1; (1983) 76 Cr App R 279.

- The question of causation is determined by applying common sense to the facts as found, not resolved by philosophical or scientific theories and bearing in mind the serious nature of a finding that a person contributed to death; *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.

However, on 21 April 2015, the *Coroners Amendment Act 2015* repealed section 28(1)(f).

A question arises in this inquest regarding whether I am required to specifically make a finding under section 28(1)(f) given that both the death occurred and the inquest was held when the provision was in existence.

In the joint judgment of the High Court in *Rodway v R* [1990] HCA 19; (1990) 169 CLR 515 at 518 the court stated:

> *"The rule at common law is that a statute ought not be given a retrospective operation where to do so would affect an existing right or obligation unless the language of the statute expressly or by necessary implication requires such construction. It is said that statutes dealing with procedure are an exception to the rule and that they should be given a retrospective operation. It would, we think, be more accurate to say that there is no presumption against retrospectivity in the case of statutes which affect mere matters of procedure. Indeed, strictly speaking, where procedure alone is involved, a statute will invariably operate prospectively and there is no room for the application of such a presumption. It will operate prospectively because it will prescribe the manner in which something may or must be done in the future, even if what is to be done relates to, or is based upon, past events. A statute which prescribes the manner in which the trial of a past offence is to be conducted is one instance."*

Section 16 of the *Acts Interpretation Act 1931* provides that where an Act repeals any other enactment then, unless the contrary is expressly provided, such repeal shall not affect any right, privilege, obligation, or liability acquired, accrued, or incurred under any enactment so repealed.

In *State of Tasmania v Thorpe* [2011] TASSC 18, Evans J applied the principles in *Rodway* in respect of a change to the provisions of the *Sentencing Act 1997* relating to the activation of breaches of suspended sentences. His Honour held that a person did not have a right to the proceedings brought against him for breaching the condition of his suspended sentence being conducted in any particular way. His right was for these proceedings to be conducted in accordance with the practice and procedure prevailing at the time of the hearing. His Honour stated that had the legislature intended otherwise when it amended the *Sentencing Act* it could have so provided.

In a similar vein, the former section 28(1)(f) of the *Coroners Act* is a procedural provision relating to matter for mandatory inclusion in a coroner's finding. Its repeal does not affect any right, privilege, obligation, or liability acquired, accrued, or incurred by any person.

I note that there is no provision that provides for the retrospective operation of section 28(1)(f) of the *Coroners Act.*

I therefore conclude that the repeal of s. 28(1)(f) operates prospectively from the date of the repeal, and that I am not required to make a specific finding as to the identity of any persons who contributed to the death.

Standard of proof

The standard of proof in coronial inquiries is the civil standard of the balance of probabilities. However, where the findings may reflect adversely on an individual, such as in this inquest, the standard is to be applied in accordance with the principle in *Briginshaw v Briginshaw* (1938) 60 CLR 336. In that case, Dixon J (as he then was) stated:

> *"…reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"*

Similarly in *Chief Commissioner of Police v Hallenstein* (supra), Hedigan J said at p19:

> *"The identification of appropriate standards of proof and satisfaction is important, a matter that at all times must be borne in mind by any coroner who has to consider findings of contribution which must not lightly be made and only be made when there has been established the necessary degree of satisfaction of mind."*

I apply the above principles in this finding.

ACCOUNTS OF MS HOWELL AND MR PEARCE OF THE CIRCUMSTANCES OF JASMINE'S DEATH

It is appropriate to set out the accounts by Ms Howell and Mr Pearce regarding the circumstances surrounding Jasmine's death. They are the only persons who were in a position to have direct knowledge. I have been assisted by the investigating officer, Constable Scott Templar, in such analysis.

Accounts provided on day of Jasmine's death

1. At about 11.00am Ms Howell spoke to Luke Finau, paramedic, whilst travelling in the ambulance. Ms Howell sat in passenger seat of ambulance. She told Mr Finau that:

- She woke at 9.30 am in bed with Jasmine, who normally sleeps with her;
- She woke to find Jasmine on her tummy and facing the opposite head/feet position in the bed. She took blankets from Jasmine's face;

- After a period of time she went to check on Jasmine and rubbed her feet which were cold; and
- She turned Jasmine over and she was grey.

Mr Finau's notes in the ambulance report to the above effect were recorded immediately after his attendance upon Jasmine. He was a clear witness and I fully accept that his notes are an accurate representation of what Ms Howell told him at that time.

2. Shortly after 11.26am Ms Howell and Mr Pearce both spoke to Dr Karen Richards, the staff specialist in the Emergency Department of the LGH. They were in the same room. Dr Richards was a clear, impressive witness and I accept her evidence without hesitation. Both parents gave lucid accounts at a time when Jasmine's resuscitation was still occurring. Their joint account is summarised as follows:

- Ms Howell stated that Jasmine had been asleep face down, with her feet on the pillow and face in the middle of the bed;
- Mr Pearce stated that he gave a bottle to Jasmine at 6.15am and left her in the bed alive and well; she fed well at that time;
- Ms Howell stated that she awoke at 9.30am with Jasmine face down with feet on the pillow and face in the middle of the bed, and feet cold;
- Ms Howell stated that she went out for a cigarette, returned, noticed her feet were in the same position and still cold; and
- She rubbed Jasmine's feet to warm them and when this was not successful she turned her over.

Both Ms Howell and Mr Pearce did not dissent from each other's account. I note that in this account that neither parent told Dr Richards that Jasmine's face was covered when they discovered her. This fact would clearly be one that Dr Richards would need to know in her urgent attempts to revive Jasmine. In her statement to Mr Finau, Ms Howell mentions nothing of Mr Pearce giving Jasmine a bottle at 6.15am.

3. At about 12.00pm Constable Templar interviewed Ms Howell for the making of her sworn affidavit. He stated that her account was given with no apparent memory problems. I accept his evidence. Ms Howell stated, *inter alia*, in her affidavit that:

- She put Jasmine to bed at about 10.00pm;
- She placed her on the bed in the lounge room, on her back;
- Jasmine was wearing a disposable nappy and silky pajama top;
- She gave Jasmine a 200ml bottle of cow's milk with added penta-vite due to constipation;
- She put a doona over her;
- Jasmine had a play before she went to sleep;
- She went to sleep on the bed with Jasmine and Mr Pearce at about 2.00am, blaming neighborhood noise for the late bed time;
- She thought that Jasmine was between them in bed;
- She woke up on the next day at about 10.30am;
- She noticed Jasmine lying on top of the doona; could see her right side and part of her face;
- She thought Jasmine was asleep;

- She got up, had coffee and a cigarette, watched other children play with Lego;
- On returning to Jasmine, she felt her feet and noticed they were cold;
- She laid next to Jasmine to keep her warm;
- She observed the other children go to toilet/fight with each other;
- She mentioned to Mr Pearce that Jasmine had been asleep for some time;
- Mr Pearce responded "is she alright?";
- She turned Jasmine over and observed her lips were blue;
- She screamed for Pearce to call an ambulance;
- She attempted CPR and sought assistance of neighbours;
- She and Mr Pearce smoked a $25 deal of cannabis the previous day, and stated that she had smoked "a fair bit lately";
- She didn't think she rolled on Jasmine;
- She had been sleeping with Jasmine for about a month; and
- She had previously caught her nine year old son, "A", lying on top of Jasmine on three occasions.

I note in this account Ms Howell stated nothing about Mr Pearce giving Jasmine a bottle at approximately 6.00am. Her previous accounts earlier that day mention nothing about Jasmine lying on her side with her face partly visible or that she laid next to Jasmine after feeling that her feet were cold. Although she suggested that the children may be responsible for accidentally hurting Jasmine, she had not stated this earlier to Mr Finau or Dr Richards.

4. An affidavit was also taken separately by Constable Templar from Mr Pearce in which he stated, *inter alia*, that:

- He spends most of his time at Ms Howell's home;
- All the children except Jasmine were in bed by 9.30pm on Saturday 26 January 2013;
- "A" and "R" sleep in one bedroom and "D" in a cot in another bedroom;
- He and Ms Howell smoked a few cones (cannabis) in the bathroom at about 10.00pm;
- They also smoked cigarettes in the kitchen throughout the night;
- He gave Jasmine a 250ml bottle of cow's milk at about 10.50pm;
- Jasmine went to sleep on the bed in the lounge room at about 11.30pm;
- He and Ms Howell placed pillows around the bed and under the mattress to prevent Jasmine from falling out;
- When he and Ms Howell went to sleep he told Ms Howell to put Jasmine in her cot but Ms Howell said "she would be okay";
- Jasmine slept on the side closest to the heater, Ms Howell in the middle, and he was closest to the kitchen;
- He woke at about 5.40am to "A" going to the toilet, and then spoke to both boys about staying in their room; he went to the toilet and returned to the lounge;
- Jasmine was awake, as he saw the doona move; went over and gave her a kiss;
- He told Jasmine *"Dad will get you a bottle"*;
- He retrieved a bottle already made up in the fridge, warmed it in the microwave;
- He checked the temperature and gave it to Jasmine;

- He observed that Jasmine looked "pretty tired", stating that Jasmine normally sleeps until 8.30-9.00am;
- He cleaned up the kitchen and made the boys breakfast;
- Ms Howell got up at about 8.30am ("D" woke too);
- Mr Pearce and Ms Howell had breakfast and a cigarette at the kitchen table;
- He observed the boys get into bed with Jasmine (under the covers) for about 45 minutes;
- He told "A" off a few times due to him jumping off the bed onto the bed;
- Ms Howell told him to check Jasmine;
- He went over to the bed and observed Jasmine laying on her stomach, facing the end of the bed (when he gave her the bottle she was facing the other way);
- He felt Jasmine and realised she wasn't moving and said *"she's not moving"*;
- Ms Howell picked her up and called the ambulance;
- Neighbours assisted with CPR attempts;
- "A" had previously (a few months ago) placed doonas on top of "D" until she turned blue; and
- He did not know how Jasmine may have died, possibly by Ms Howell throwing her leg over her thinking it was him.

This account by Mr Pearce sought to maximize the possible responsibility of the other children and Ms Howell for Jasmine's death. He later became uncertain on the fact of the boys being in bed with Jasmine. He emphasizes that Jasmine was alive and reacting when he gave her an early morning bottle, an occurrence that he was later to largely retract.

Accounts provided after the day of Jasmine's death

1. On 8 February 2013 Ms Howell telephoned the police and spoke to Constable Timothy Watson. I infer that the purpose of this call was to correct inaccuracies in her initial accounts. I accept Constable Watson's evidence that Ms Howell's account to him was clear and frank. He recorded the contents in an email to Constable Templar for when he returned to the office. I accept that he recorded it accurately. Ms Howell stated that:

    - Between 1.30-2.00am she and Mr Pearce started having sex in the bathroom;
    - Both were consuming a lot of marijuana during the course of the night;
    - The sex moved from the bathroom and ended up in the lounge room on the end of the bed;
    - Jasmine had previously been left at the top end of the bed and pillows had been placed near the bottom of the bed to stop her from rolling off the end;
    - She believed Jasmine moved herself down the end of the bed, towards the pillows;
    - She believed they both squashed Jasmine towards the end of the intercourse; and
    - She believed Jasmine's head, and/or body may have moved under the pillows on the end of the bed, which is why they "did not feel her", but was not certain on that point.

2. On 5 March 2013 Constable Templar took a further affidavit from Ms Howell after receiving the email from Constable Watson. In the affidavit she stated that:

    - She missed some details in her initial statement due to being in shock at the time;

- At around 2.30am on 27 January 2013, she and Mr Pearce had sex in the bathroom of the home;
- They finished the sex on the bed where Jasmine was sleeping;
- At about 6.30am Mr Pearce said *"I am squishing her and she hasn't ever cried"*, and then he checked her feet;
- She asked Mr Pearce if she was alright and he replied *"it's only her feet"*;
- When they finished having sex she (Ms Howell) crawled from the end of the bed to the top;
- She noticed Jasmine lying three-quarters down the bed with her head facing the end and her feet the top;
- Jasmine was lying on her stomach and her face was pressed into the doona;
- Mr Pearce got out of bed but did not get the bottle as he previously alleged;
- She thought he said that he gave Jasmine a bottle at about 6.00am because he did not want to admit he didn't check on Jasmine on the day;
- Mr Pearce said he was going to make a bottle but he did not do so;
- She was going to pick Jasmine up but thought she was heading to the head of the bed and was going to be okay; and
- She thought she had been up about 40 minutes prior to the ambulance arriving.

In these two accounts by Ms Howell, she proposed for the first time that the possible explanation for Jasmine's death was suffocation under bedding whilst she and Mr Pearce were engaging in sexual intercourse. The affidavit is again vague, and she indicates that the time of sexual intercourse was about 6.30am. The description of why Mr Pearce stated he gave Jasmine a bottle is self-serving and implausible, in keeping with her whole evidence.

3. On 20 March 2013 Ms Howell was interviewed by Detective Jarrod Lightfoot and Constable Olivia Eldershaw. In that interview she stated that:

- She put Jasmine to bed as stated in her other affidavit;
- She didn't go to sleep until 2.00am;
- She "forgot about having sex" when making her initial affidavit;
- She smoked cannabis and cigarettes in the bathroom with Mr Pearce (half to full deal);
- Cannabis made her tired and sluggish;
- She had sex with Mr Pearce in the bathroom; she did not think it went for long but must have been hours;
- They finished up sitting on the end of the bed kissing and cuddling;
- She noticed that Jasmine's doona/pillows were in the same position as when she put her to bed. She observed Jasmine's face, and saw no reason to check her;
- She and Mr Pearce laid across the end of the bed (opposite ways);
- They did not have sexual intercourse on the bed;
- She heard the other children stir and realised she did not get much sleep;
- Mr Pearce said *"I'll get up and make her a bottle"*;
- She crawled up to the head of the bed and observed Jasmine facing the other way and she thought she was awake;
- She thought she would grab her but thought "*bugger her, Leckie's getting the bottle*" and went to sleep;
- She doesn't recall when or how Jasmine turned around;

- She woke no more than one hour before the ambulance was called;
- She saw Jasmine's feet uncovered and felt them;
- Jasmine's feet were cold and so she pulled the doona over her;
- She had a coffee and went to the bathroom, presuming that Jasmine was still asleep;
- She commented that Jasmine had been asleep for a long time, turned her over and observed her lips were blue;
- She attempted CPR and sought assistance from neighbours;
- The comment made by Leslie *"I am squishing her and she hasn't even cried"* happened at about 6.30am (just before she went to sleep);
- She responded *"is she all right"* and Mr Pearce replied *"it's only her feet"*. She then said *"are you sure?"*
- She was not concerned by his statement;
- She did not check on Jasmine because "couldn't be bothered taking the time to turn around to look";
- She denied that she was lying on top of Jasmine and denied that they had sex on the bed, and that they were "kissing and cuddling, not humping"*;*
- Perhaps they were on top of Jasmine, stating *"I think we squished her";*
- She believed her initial statement had been "a little chopped around";
- She did not have a lot of time for Jasmine over the last few days, not playing with her as normally she would;
- Mr Pearce did not make Jasmine a bottle that morning;
- She was unable to explain why she originally said she went to sleep with Jasmine in the middle, but it was what she thought at the time; and
- Her variation in events was due to stress caused by school holidays, postnatal depression, and being tired.

4. On 20 March 2013 in a separate recorded interview with the same police officers, Mr Pearce stated that:

- Ms Howell put Jasmine in bed in the lounge at around 11.00pm;
- Ms Howell stacked pillows under the mattress with Jasmine in the middle;
- Both were in and out of bathroom that night smoking marijuana ($35 worth) for one to two hours;
- After smoking cones they decided to go to bed (both in the bed);
- Whilst in bathroom he told Ms Howell to put Jasmine in the cot but Ms Howell said she would be okay;
- Both were pretty stoned that night but he was still able to function;
- Both sat on the end of the bed and started having sex after a couple of minutes (on top of doona);
- He did not see Jasmine before sitting on the end of bed/having sex;
- He had sexual intercourse with Ms Howell;
- He was "on top" first whilst lying across end of bed;
- Rolled off Ms Howell then she had sex "on top" of him;
- At some point during sexual intercourse he said, *"I think I'm squashing Jazzie"*; he felt Jasmine's leg and said *"no it's just her leg"* thinking her head was up the other way;
- He did not remember what Ms Howell said in response;

- He did not check Jasmine and did not know why he did not do so;
- Ms Howell did not check her either;
- They finished having sex (lasted about 20 minutes) Ms Howell went to the bathroom; he went to the kitchen;
- Ms Howell got onto the bed, he got in behind her and they both went to sleep (around 3.00am), commenting that Jasmine would normally be between them (but wasn't);
- He woke to the noise of the other children at about 6.30am, but did not check on Jasmine or see her;
- Believed Ms Howell got out of bed at 8.30am, went to bathroom and had a cigarette;
- Ms Howell asked him to check Jasmine;
- When he checked Jasmine he sung out *"you've got to come"* and called the ambulance.
- **When discussing his affidavit made on 27 January he stated:**
    - That he presumed that Jasmine was awake when he woke at 5.40am because he saw the doona move, but it could have been Ms Howell;
    - He was confused about whether he gave Jasmine a bottle, kissed her or spoke to her that morning, believing he may have been thinking about what he did the day before;
    - All sex occurred on the bed. However, when it was put that Ms Howell had stated that sex occurred in the bathroom he agreed they had sex in both locations (bathroom first, then on bed); and
    - He was not sure whether the doona was on Jasmine when he checked her.

Ms Howell's evidence at the inquest

In evidence Ms Howell stated that she put Jasmine to bed on the fold-out bed. There were pillows to lift the sides. She was put to bed at the top of the bed with the bedding up to her chest. She was feeling stressed by the children being on school holidays. She stated that she and Mr Pearce started smoking cannabis, and continued doing so for about four hours. They then commenced sexual intercourse in the bathroom, which lasted about an hour (and not 20 minutes). They then commenced sexual activity on the bed. This did not involve intercourse, but her masturbating whilst sitting on top of Mr Pearce who was lying on the bed at the end. She remembers Jasmine moving down the bed and leaned forward so Jasmine could not see her. She stated to Mr Pearce that "we must have disturbed her". Jasmine's head was facing the bottom of the bed but Ms Howell did not check her. About 40 minutes later Mr Pearce stated *"I am squashing Jazzy but it's only her feet"*. Ms Howell then dozed off. She did not think the doona was covering Jasmine's face.

At about 9.45am she remembers hearing children and waking up. She did not see Jasmine alive between the time of her moving in the bed and when she found her deceased. She does not remember having a bath or shower and stated she was "out of it" with the marijuana. She stated that she didn't remember at the time of talking to Dr Richards that Mr Pearce made the statement concerning squashing Jasmine. In an exhaustive cross-examination by counsel assisting, Ms Howell acknowledged that she gave differing accounts, but could not explain why. She stated that she did not give the account of smoking cannabis and possibly squashing Jasmine during sexual activity to Constable Templar on the day of Jasmine's

death because she didn't remember it. However, on 27 January she did have a clear thought that rolling on Jasmine was an explanation for her death.

Ms Howell gave embellished reasons for not giving consistent evidence that were verbose, changeable and implausible. She denied concocting with Mr Pearce the initial accounts to ambulance officers, police and the doctor to avoid mentioning that they feared they had squashed Jasmine with their bodies. Her ultimate position in evidence was that Jasmine was likely to have been squashed by Mr Pearce's body at the bottom of the bed as Jasmine's head must have been down near the foot of the bed under the doona. She does not remember any of the other children on the bed until the morning. The witnesses' accounts of Ms Howell in the morning were that she did not appear affected by drugs and was lucid. Although understandably distraught, I do not accept that she would have no memory of an event that occurred during the evening that could have resulted in Jasmine's death. I agree with Mr Allen's submission that her answers were reconstructed and over-argued for effect, and that the discrepancies are not adequately explained by the stress of the situation.

Mr Pearce's evidence at Inquest

In evidence to the inquest Mr Pearce gave a similar account as he did to police. He stated that Ms Howell placed Jasmine onto the bed, which had cushions placed around it. She was placed on her back with the doona only reaching to her stomach. When all children were asleep he and Ms Howell started smoking cannabis, and smoked seven to eight cones in about two hours. During this time they did some chores. Ms Howell had a bath. The cannabis had little negative effect except to make him tired. They then commenced sexual activity in the bathroom for about 20 minutes before continuing that activity on the bed where Jasmine was sleeping. He thought that they had sexual intercourse on the bed. Whilst this was occurring he stated he could feel Jasmine under him as he was lying on his back with Ms Howell on top of him. He said to Ms Howell *"I think I am squashing Jazzy and she hasn't even cried"*. He stated that he thought it was just her leg, and he did not desist or move and was in this position for 10 minutes. He stated that he swapped positions and subsequently was in the top position. He said that in total they were engaged in sexual intercourse towards the bottom of the bed for about half-an-hour. He later stated that he was not sure that the sexual activity on the bed was actually sexual intercourse. This was a reconstructed statement at the end of his evidence, presumably made to conform to the statement of Ms Howell. He said he had his body weight on Jasmine but that he thought it was her leg. He stated that both he and Ms Howell believe that they squashed Jasmine. He stated that "we should have stopped". He stated that when sexual intercourse had finished both he and Ms Howell went to bed in the usual sleeping position for the bed. He was not aware of Jasmine's presence and fell asleep. He awoke early with "A" taking Jasmine's bottle and he took it off "A". He stated he thought he gave Jasmine a bottle but then stated it may have been "D". He then stated he definitely did not give Jasmine a bottle and was incorrect in stating this to Dr Richards. He does not have a clear memory of Jasmine being alive after she was put into bed. He did not at any time clear the blankets from her face. He found Jasmine half way down the bed in the middle with her head down towards the bottom of the bed. She was lying face down with the doona fully covering her.

Summary of accounts

The array of accounts of both Ms Howell and Mr Pearce are inconsistent, changeable and imprecise in important respects. They have modified their statements in an attempt to

conform with each other's accounts even to the point of directly contradicting their own accounts. Initially, there was no mention by either that they believed they had squashed Jasmine during sexual activity. The omission and then subsequent confession by both is explicable only on the grounds that they colluded not to reveal the true state of their knowledge as it would implicate them in conduct that may attract condemnation or criminal liability. Even though both provided a generally similar account in their recorded interview there were still obvious attempts to modify to conform to the other's account. For example, Mr Pearce in his video interview gave a very detailed and deliberate account of sexual intercourse occurring on the bed and only on the bed during which he became concerned about the effect of those actions upon Jasmine. It wasn't until very late in that interview that it was suggested to Mr Pearce that Ms Howell had provided a different account, at which point Mr Pearce modified his account to coincide with that of Ms Howell who describes sexual intercourse also occurring in the bathroom. Similarly, Ms Howell's account of the type of sexual activity on the bed - once it was disclosed - changed from sexual intercourse, to kissing and cuddling to masturbation.

The sequence of events provided by Ms Howell and Mr Pearce also contained serious inconsistencies. Mr Pearce initially stated that he gave Jasmine a bottle at 5.40am and kissed her and talked to her. His final account in evidence was that he did not give her a bottle at all, but awoke at 6.30am, but did not check her. Quite incredibly, he stated that he first became aware of something wrong at about 10.30am when Ms Howell discovered Jasmine lifeless. It is almost inconceivable that he could not have been aware of Jasmine for a period of four hours. This defies common sense and natural parenting tendencies. However, having heard the volatile manner in which he gave evidence and having studied the voluminous CPS and police files concerning Mr Pearce, there is little that would give the Court confidence that he is fit to care for and protect a child. I am suspicious that he was aware of Jasmine being deceased at about 6.00am when he woke, but did nothing until Ms Howell awoke and discovered Jasmine deceased. However I cannot make a positive finding to this effect.

Ms Howell stated that she was up about 40 minutes before the ambulance arrived. Again, it is incredible that she took no steps to check Jasmine who was occupying the same bed as herself.

The explanation by Ms Howell that she "forgot" about having sex, and the possibility of suffocation during intercourse as an explanation for Jasmine's death, is simply implausible. The effects of the cannabis were not apparent to those witnesses in the morning. When questioned in the inquest, her attempts to put forward a credible, consistent account failed. I found her to be very articulate, and yet evasive, inconsistent and unhelpful in her long-winded and unresponsive explanations. Mr Pearce presented as angry, irrational and unhelpful. It was apparent that he was giving evidence for effect rather than to assist the inquest. His cross-examination was lengthy and skilful but Mr Pearce did not assist the Court. Notwithstanding these comments, both Mr Pearce and Ms Howell ultimately did not resile from their view that they believed that Jasmine may have suffocated due to the pressure exerted by their bodies, and that their failure to check her was inexcusable.

Whilst the temptation is to reject almost all of what has been stated by Ms Howell and Mr Pearce, it appears that Ms Howell was motivated by genuine guilt in disclosing to Constable Watson that the sexual activity on top of Jasmine may have suffocated her. Both Ms Howell

and Mr Pearce showed real emotion that their actions were likely to have contributed to her death.

This account is quite extraordinary and must be shocking to most members of the community. It portrays neglectful and shameful disregard for their vulnerable infant child's safety in circumstances where any protective parent would have taken steps to check her. A fabrication of such an account is unlikely, particularly given that it coincides with the objective evidence as to time of death. Fabrication could be only to cover up more serious deliberate actions, as there would be nothing else that could render them more blameworthy.

I have given considerable thought as to whether the account of accidentally suffocating Jasmine during sexual activity was given to conceal a more sinister explanation, such as a deliberate act by her parents or a child to Jasmine causing her death. Deliberate suffocation may not exhibit external signs of trauma. However, the investigation has uncovered no motive, nor would it be likely that spontaneous abuse would be directed towards Jasmine whilst she was sleeping. There is no evidence from close neighbours that there was any noise indicating hostility between Mr Pearce and Ms Howell the evening before or in the very early hours of the morning. It is apparent from the statements of neighbours that they would regularly hear shouting and arguments between Ms Howell and Mr Pearce.

Therefore none of the evidence suggests that a deliberate act of abuse is a plausible reason for her death. I do accept that their account of sexual activity and Jasmine being covered with the doona is correct. However, I cannot rule out that one or both knew much earlier that Jasmine had died. The untrue story of the bottle being given by Mr Pearce was an attempt to portray that he knew she was alive at about 6.00am when he may well have already known upon waking that she had died. As stated, it is difficult to believe that he did not check Jasmine at all after rising early. Similarly, the time gap between Ms Howell waking and calling the police, where Jasmine was not checked indicates the possibility of Ms Howell and Mr Pearce using this period to collude to omit details of their belief that they had accidentally suffocated Jasmine in the early hours of the morning and had not checked her subsequently. The proposition that both purported to simultaneously retrieve a memory of possibly the most significant event to contribute to her death is fanciful. I do not accept that this occurred. I find that they both, by prior agreement with each other, deliberately omitted to tell police the full account of the evening.

Expert evidence as to time of death and cause of death

Dr Richards was surprised by the history given by Mr Pearce that Jasmine was alive at 6.15am. Dr Richards stated that it appeared that Jasmine had been deceased for more than five hours. This was due to her cold temperature and the mottling on her body. Dr Richards stated that she had expected to hear that Jasmine had died during the night. She stated there was no trauma seen on her body. She stated that the account of Jasmine being overlain at 2.00am is more plausible given that the mottling was on the front of her body consistent with her being found on her stomach.

On 29 January 2013 Dr Chris Lawrence, State Forensic Pathologist, performed an autopsy upon Jasmine. He swore an affidavit with his conclusions and gave evidence at the inquest. In his affidavit, sworn 26 April 2013, he concluded that the likely cause of death was "sudden infant death whilst bed-sharing". He saw no clear traumatic injuries upon Jasmine and no natural disease process that would positively indicate death from natural causes. In

that affidavit he commented that the lividity present on the front of Jasmine's body suggested that she had been dead for a number of hours before the ambulance attended. The cause of death provided by him, being "sudden infant death by bed-sharing" is a differential diagnosis that would capture both SIDS and suffocation depending upon the determined circumstances of death. In this regard SIDS is a diagnosis of a natural death defined as follows:

> *"the sudden and unexpected death of an infant under one year of age, with the onset of the lethal episode apparently occurring during sleep, that remains unexplained after a thorough investigation including the performance of a complete autopsy and review of the circumstances of death and the clinical history."*

In evidence at the inquest, Dr Lawrence stated that he would have been surprised if Jasmine died later in the morning, for example at 8.30am. His opinion, given the mottling on her face that did not shift, was that it was more likely to have occurred during the night and that she had been in a face down position for several hours.

He stated that, assuming that Jasmine was found face down and completely covered in the blankets, he would not give the cause of death as SIDS. He stated that the design of the bed was dangerous, particularly with the pillows at the edges "pushing everything into the middle". Further, he stated that the majority of SIDS cases occur at around three months of age. He stated that Jasmine was "a little bit old" at 11 months, at which age the SIDS cases tail off to almost none for such a diagnosis.

Dr Lawrence also stated that a child trapped under an adult would probably not be capable of making much noise and would not necessarily cry before suffocation. He further stated that the child would need to first wake. This may not have occurred in Jasmine's case. This absence of crying is not indicative that suffocation did not occur.

After being requested to review the evidence, Dr Lawrence stated that he could not determine cause of death, as it depended upon factual findings being made on the circumstances of death. He stated that if Jasmine's head was under the doona, even if not in proximity to adult bodies, she may have suffocated by re-breathing carbon dioxide. She may well not have been sufficiently mobile to extricate herself. If she was under the doona with adult bodies on top of her she could have also suffocated under the pressure from those bodies.

Other evidence as to time of death and cause of death

Marilyn Howell, Ms Howell's mother, gave evidence that "R" told her that he had seen Mr Pearce, early in the morning of Jasmine's death, rubbing Jasmine's back saying *"oh my God, oh my God"* before going back to sleep. If this is correct then it would indicate that Mr Pearce knew that Jasmine was dead early in the morning when he and the children woke, being some hours before the alarm was raised. Marilyn Howell, I perceived, was a reasonably sound witness who cared for her daughter and tried to give an accurate account. I accept that "R" did make a statement to Marilyn Howell. However, as "R" did not give evidence, I cannot determine the context and cannot give weight to this statement. I note also that Ms Howell told her mother various matters about events before Jasmine died - such as that Mr Pearce had squashed her leg, that Mr Pearce did not give her a bottle at 6.00am, and that she didn't remember much about the night because she was tired and she had been

drinking. Mrs Howell thought that it was unusual that her daughter was drinking, as she is not a big drinker. I accept Mrs Howell's evidence that Ms Howell told her that she had been drinking, but this was untrue. Again, this was another example of an untruth to attempt to abdicate her own responsibility for Jasmine's death.

Summary of factual findings

- Jasmine was a healthy 11 month old child with no physical impairment.

- Jasmine died in the early hours of the morning on 27 January 2013, likely between about 2.00am - 3.00am.

- Before and at the time of her death, Jasmine's head and body were fully under the bedding, with her head at the end of the bed, for a significant period of time.

- Jasmine died as a result of suffocation under the bedding.

- During a portion of the time that Jasmine was under the bedding, Mr Pearce and Ms Howell engaged in sexual activity of some description on top of part of Jasmine's covered body.

- I cannot determine to the requisite standard whether Jasmine's death occurred before, during or after the sexual activity. Common sense would suggest that the suffocation was more likely to have occurred whilst she was trapped under the bedding, by or in proximity to adult bodies. However, it is also feasible that Jasmine had herself become covered in the bedding in the face down position at the foot end of the bed and died before her parents were on or in the bed.

- The sleeping environment was dangerous for an infant. The mattress rolled inwards due to the presence of the cushions under the mattress. The dip in the middle of the mattress, the external cushions and adult doona presented suffocation hazards.

- Neither Ms Howell nor Mr Pearce took any adequate steps to check Jasmine and to ensure her safety from the time that they put her to bed. They became aware that they had likely rolled onto Jasmine while engaged in sexual activity. This likelihood was vocalised by Mr Pearce and acknowledged by Ms Howell. Even then, neither of them took steps to check Jasmine and subsequently went to sleep. Ultimately they both conceded their general responsibility. Their actions were uncaring and irresponsible in the extreme. They were fully aware of a potentially dangerous situation created solely by their own actions and blatantly ignored her safety.

- Jasmine was not given a bottle in the morning, and no one saw Jasmine alive in the morning.

- Mr Pearce and Ms Howell colluded, on the morning of Jasmine's death, to omit to tell initial police, ambulance and doctors that Jasmine's head was fully covered by the bedding, and that a likely explanation for her death was due to suffocation by their bodies whilst in the same bed.

- Ms Howell and Mr Pearce did not deliberately cause the death of Jasmine.

- The unsatisfactory involvement of Ms Howell and Mr Pearce in the investigation into the death of their infant daughter is a matter for criticism. The accounts of the two people who could reasonably be expected to be in the best position to assist in accurate findings about the death of their infant daughter were inconsistent, contrived and, in many respects, fanciful.

- It is possible that Mr Pearce or Ms Howell may have knowledge that Jasmine had died much earlier than when they stated that she was discovered. This would be consistent with the assertion that they did not check her at any relevant time later in the morning, their changing accounts and attempts to fabricate an account giving her a bottle at 6.00am. However, prior knowledge of her death cannot be proved.

Provisional conclusion as to identity of persons who contributed to the cause of death

I have already concluded that I am not required to make a finding pursuant to the former section 28(1)(f) of the *Coroners Act*. However, in the event that such conclusion is not correct, it is appropriate to record that I would find that Mr Pearce and Ms Howell contributed to Jasmine's cause of death for the following reasons:

(a) As her parents and responsible for her safety, they placed her to sleep in an unsafe sleeping environment on an inwards-rolling adult bed covered with an adult doona; and

(b) Allowed her to be fully covered with the doona in the bed for a lengthy period, such that her air was restricted and she suffocated under the bedding.

CHILD PROTECTION ISSUES

Legislative framework of Child Protection Services

The *Children, Young Persons and Their Families Act* 1997 *("CYPF Act")* provides the framework and mandate for notifications of harm to and response by CPS. The mandate of CPS to protect children at risk of harm from abuse and/or neglect arises from the reporting of notifications in respect of children. The Act, sections 13-16 provides for confidential notifications, including mandatory notifications in respect of risk to a child. The powers under the Act are reposed in the Secretary of the Department.

By section 8, the *CYPF Act* is founded upon the following principles:

(a) the primary responsibility for a child's care and protection lies with the child's family;

(b) a high priority is to be given to supporting and assisting the family to carry out that primary responsibility in preference to the Secretary commencing proceedings for a care and protection order in respect of the child;

(c) if a family is not able to meet its responsibilities to the child and the child is at risk, the Secretary may accept those responsibilities.

Under the Act a child is "***at risk***" if:

(a) the child has been, is being, or is likely to be, abused or neglected; or

(b) any person with whom the child resides or who has frequent contact with the child (whether the person is or is not a guardian of the child):

(i) has threatened to kill or abuse or neglect the child and there is a reasonable likelihood of the threat being carried out; or

(ii) has killed or abused or neglected some other child or an adult and there is a reasonable likelihood of the child in question being killed, abused or neglected by that person; or

(ba) the child is an ***affected child*** within the meaning of the *Family Violence Act* 2004 (***affected child*** means a child whose safety, psychological wellbeing or interests are affected or likely to be affected by family violence); or

(c) the guardians of the child are:

(i) unable to maintain the child; or

(ii) unable to exercise adequate supervision and control over the child; or

(iii) unwilling to maintain the child; or

(iv) unwilling to exercise adequate supervision and control over the child; or

(v) dead, have abandoned the child or cannot be found after reasonable inquiry; or

(vi) are unwilling or unable to prevent the child from suffering abuse or neglect; or

(d) the child is under 16 years of age and does not, without lawful excuse, attend a school, or other educational or training institution, regularly.

Section 17 provides that nothing in the Act requires the Secretary or a Community-Based Intake Service to take or initiate any action under this Act in respect of a risk notification if the Secretary or a Community-Based Intake Service is satisfied –

(a) that the information or observations on which the notification was based were not sufficient to constitute reasonable grounds for the belief or suspicion contained in the notification; or

(b) that, while there are reasonable grounds for the notification, proper arrangements exist for the care and protection of the child, and the matter of the apparent abuse or neglect or the likelihood of the child being killed or abused or neglected has been or is being adequately dealt with; or

(c) that no further action is required in respect of the notification.

The Secretary may refer a risk notification received by the Secretary to a Community-Based Intake Service if satisfied that the Community-Based Intake Service is an appropriate organisation to take action in respect of the notification (section 17A).

A Community-Based Intake Service ("CBIS") means an organisation that has entered into an agreement with the Secretary under the Act. Part 5B of the Act deals with Community-Based Intake Services. Section 53E of the Act states that a CBIS has the following functions:

(a) providing a referral service for children and their families that –

(i) is readily accessible; and

(ii) enables early intervention in support of families;

(b) receiving referrals from the Secretary under section 17A;

(c) undertaking preliminary inquiries, in accordance with the CBIS guidelines, to determine –

(i) whether a child is at risk or in need; and

(ii) whether a child, once born, is likely to be at risk or in need; and

(iii) the most appropriate person or organisation to receive a referral from the Community-Based Intake Service;

(d) making referrals to other persons and organisations who provide services relevant to children and their families;

(e) providing the Secretary, in accordance with the CBIS guidelines, with a record of each determination of risk or need made under paragraph (c)(i) or (ii) and each referral made under paragraph (d);

In 2009, pursuant to the provisions of the *CYPF Act* governing a CBIS, "Gateway" sites were established across Tasmania with the primary purpose being to ensure that vulnerable children and their families are effectively linked into relevant services. Gateway was set up to accept referrals from CPS. At that time CPS was not able to cope with demand and there were a large number of unallocated notifications. This allowed CPS to manage notifications that met a threshold for intervention.

Gateway Services, being a CBIS, is funded by the Department of Health and Human Services. The funding is provided to Baptcare to deliver this service in conjunction with a number of other non-government organisations providing what is termed Integrated Family Support Services. For simplicity, I will use the generic term "Gateway" in this finding to refer to all aspects of the CBIS.

The legislative scheme governing a CBIS refers to its primary function of providing a referral service for children and their families. It also states that it has the function of making "preliminary enquiries" to determine risk to a child. The inquest did not focus upon the duty of Gateway to assess risk in relation to Jasmine or the scope of this legislative provision. Instead, the inquest proceeded properly on the basis that CPS had the duty to

assess risk in response to the notifications it received; and that once a notification had been received by CPS Intake, there was no ability or obligation upon Gateway to perform this function.

The issues in the inquest focused upon whether Jasmine was "at risk" as defined by the Act, the extent of the risk to Jasmine, whether the risk was properly assessed upon notification and whether the response in referring the family to Gateway was an adequate response.

Although the family, before Jasmine's birth, was the subject of many notifications, I will focus upon the notifications during the life of Jasmine (including *in utero*), of which I calculate there were four – these notifications arose from six family violence incidents reported by police on: 24 October 2011 (when Ms Howell was six months pregnant with Jasmine); on 27 and 30 December 2011 (when Ms Howell was eight months pregnant with Jasmine); on 7 April 2012 (when Jasmine was two months old) and; 21 September and 22 September 2012 (when Jasmine was aged seven months).

The practice of risk assessment by CPS

It is appropriate to describe in basic terms the processes for assessing notifications within CPS. These processes are undertaken by an Intake Team, a Response Team and a Case Management Team.

The CPS Intake team receives notifications in respect of a child. Intake workers use the Tasmanian Risk Framework ("TRF") and Risk Factor Warning list guidelines in this process. These guidelines are set out in the Child Protection Manual that governs child protection practice in Tasmania. The TRF provides an evidence-based set of guides to professional information-gathering, analysis and judgment regarding the impact and risk of abuse and/or neglect to children. The TRF is used to carry out an initial assessment of risk. Information is gathered from the notifier, other services and any previous records held within CPS to make a judgment about immediate safety issues and the need for further detailed assessment of the situation.

If the notification is assessed as serious and requires further assessment it is referred to the Response Team for an "investigation". If the initial assessment determines that there is no risk, or that the risk is being managed and the child is safe, referral can be made to other services and the notification is closed. A closed notification means that no further action is taken by CPS. In each of the notifications involving Jasmine, the notifications were closed without proceeding to further assessment by the Response Team, as CPS deemed that a sufficient response to the risk was that Ms Howell was engaged with Gateway.

The evidence provided by Ms Leonie Watson, Northern Area Director for Children and Youth Services, is that the Response Team carry out further detailed assessment in about 25% of all notifications received. At the response level, information is gathered from various sources including the child (if age appropriate), the parents, other significant family members and any other services involved. At response level, the TRF is used more fully and the investigation is more detailed in order to determine risk response. As a response to the risk, Voluntary Care agreements, Family Group Conferences, Assessment orders or Care and Protection Orders may be necessary to protect the child. CPS may also respond to the assessed risk by referral of the family to Gateway or support services. If an application for legal orders is necessary, then the Case Management Team receives the case from the

Response Team, who is responsible for ongoing further assessment and for the case and care planning for the child and family.

The purpose of risk assessment using the TRF guidelines assessment is firstly to determine whether the child is "at risk" (section 4 of the Act) of abuse and neglect (section 3 of the Act). The TRF analysis is recorded in the Child Protection Information System ("CPIS"). The TRF defines "risk" as the relationship between the degree of harm and the probability of the believed harm occurring (or of protection being provided).

Under the TRF the worker is required to analyse gathered information in terms of its significance in four areas – the severity of harm to the child or young person; the vulnerability of the child or young person to harm; the likelihood of harm to the child or young person; the safety of the child or young person.

A Risk Analysis guide provides the worker with items to consider in order to assess these factors. These items are: the consequence(s) of harm for the child; characteristics of the child; opportunity for harm; pattern and history of harm; beliefs and relationships; parenting characteristics affecting capacity to protect and care; isolation or supports affecting capacity to protect and care; strengths or protection(s) contributing to safety. Ms Watson stated that at intake the worker completing the initial assessments completes the "Harm consequence/Harm probability" section and "Future Risk" section in the notification form. However at response level there is a requirement to complete all sections. As I understand the evidence this would require completion of an assessment in respect of each of the matters stated above in this paragraph.

However the risk framework is applied, the investigation of a notification involves the determination of risk in accordance with the Act and an appropriate response in accordance with the provisions of the Act. Assessment of risk requires professional judgement based upon an analysis of factors relating to the child, his or her family and environmental factors. It also considers safety factors available that could decrease the risk to the child. Risk assessment, particularly for a small child, can be complex, particularly determining the interrelationships between risk factors rather than only the risk factors themselves.

In this inquest there was a particular focus upon whether CPS correctly assessed the impact of "cumulative harm" in Jasmine's case. 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 experience by a child of multiple continuing episodes of family violence is a clear situation for the consideration of whether the child is at risk as result of a cumulative harm.

The evidence at inquest from the child protection workers and from Ms Watson was that CPS does not "outsource" the responsibility of risk assessment to any other organisation. Risk assessment, whether this is an initial assessment of risk at intake, or a full assessment of risk at response level, is undertaken by CPS in accordance with the requirement to do so under the Act. After that assessment, some cases require consideration as to whether the family should be referred to Gateway for family support. In the event that the family are already engaged with Gateway, Ms Watson states that a conscious decision is made by

appropriate CPS workers as to whether the concerns arising from the notification are addressed by the provision of that existing support.

The Memorandum of Understanding between CPS and Gateway states that transfer of case responsibility occurs at the point Gateway confirms that the referral has been allocated, and that CPS may then close the case. The Memorandum states that "on a case-by-case basis, and not as a rule," open cases may be accepted by Gateway Services when consultation has occurred between Gateway Services and CPS. Where Gateway accepts this referral, case responsibility will remain with CPS until it becomes a closed case. The Memorandum of Understanding deals in detail with all aspects of the relationship between CPS and Gateway.

The inquest heard in some detail about the role of the Community Based Child Protection Team Leader ("CBTL"), being a CPS worker located in each of the Gateway sites. The role of the CBTL is to facilitate effective working relationships between the CPS and Gateway, to liaise on specific cases and to act on notifications of neglect and abuse. The CBTL provides consultation and advice on specific cases to Gateway, including safety planning, to enable Gateway's ongoing case management. The CBTL facilitates referrals from CPS to Gateway and from Gateway to CPS unless there are exceptional circumstances (immediate safety). In the event that Gateway has concerns for families that it is working with, the process is that Gateway will consult with the CBTL, and, if the CBTL believes CPS should be involved a notification is generated. The matter then automatically proceeds to Response for investigation. Gateway workers can also make a notification directly to CPS Intake.

Child Protection History

The Child Protection file for Ms Howell and her children shows a long history of notifications and dealings from 2004 onwards.

I will summarise them below, as they provide a very important context to the relevant decision–making relating to Jasmine.

Summary of notifications

2004

20 January	"A's" maternal grandmother reported "A" being cared for by inappropriate and intoxicated people.
28 May	"A's" maternal grandmother reported neglect, maternal amphetamine use, lack of supervision, unwillingness to maintain the child. She reported that Ms Howell left children in the care of others, and was using "speed".
18 November	A shelter worker reported an incident involving firearms. Ms Howell had previously self-reported to child protection when she admitted to hitting her child with a spoon. The notification was closed as no evidence to suggest children at immediate risk. There was no confirmation as to whether Ms Howell had returned to a domestic violence situation.
11 December	Police reported a family violence incident, being an argument.
29 December	Police reported that Ms Howell was assaulted and subjected to threats to kill by "K's" father, being a member of Outlaws; and that the children were not in school. This notification was overlooked in a

	'backlog' for six months and then closed without investigation as location of family could not be found.
2005	
5 February	"K's" father reported that Ms Howell was 'on the run' after setting the Outlaws Clubhouse on fire.
3 June	The Domestic Violence Counselling Service reported that Ms Howell was strangled at least twice in the previous year by the partner while the children were in her care.
2006	
16 January	"A's" father raised a concern of neglect after seeing Ms Howell on ABC TV complaining about lack of housing. No further action taken by CPS.
2007	
11 September	A neighbour reported "environmental neglect" by Ms Howell in throwing dirty nappies out of her window and other unhygienic household practices. The notification was viewed by CPS as malicious due to neighbourly dispute.
2009	
24 November	Police reported that two of Ms Howell's children were found naked in the street by neighbours. CPS noted that Ms Howell and maternal grandmother were unconcerned and suggested that the situation was commonplace.
2011	
24 July	Police reported a family violence incident, being an argument between Ms Howell and Mr Pearce about the care of "D". Children woken by arguing but not involved.
22 October	Police reported a family violence incident. Mr Pearce was staying with Ms Howell for a week after his diagnosis with cancer and there had been arguments during this time; Ms Howell was seven months pregnant with Jasmine. "R" was helping at the sink when Mr Pearce picked him up and 'plonked' him on floor. Ms Howell did not like this and an argument started. A little while later "D" fell from a chair and hit her teeth and started crying. Mr Pearce called Ms Howell a 'dog', 'bad mother' and 'tip rat'. Later, Ms Howell argued with "A" about going to the toilet. Mr Pearce stated *"I'd belt the little retard if he was mine"*. As Ms Howell left with "D" in her arms, Mr Pearce charged at Ms Howell and struck her on her top lip. Ms Howell believed "D" was hit too and put "D" down and hit Mr Pearce in the back. Two days later Ms Howell told police that Mr Pearce had not meant to strike her, and was only trying to get cigarettes from her. Mr Pearce was interviewed but not charged. The children were present. The **risk assessment of the notification** was that the harm consequence was "concerning" as children were witnessing family violence; the harm probability was "likely" if Mr Pearce stayed in the home as there is a history of family violence. The future risk was assessed as "low" as Ms Howell appeared protective and has

contacted police in regards to this incident. The comments made noted that Ms Howell had not been able to be contacted relating to any CPS requests. It is noted that *"given that the mother does appear to be protective and does not appear to want any assistance, it appears that there is no further role for Child Protection at this time."*

27 December — Police reported a family violence incident. Ms Howell was eight months pregnant with Jasmine. Mr Pearce had become abusive after not being able to find his wallet. He called Ms Howell a 'slut' and a 'toe rag'. The abuse went on for approximately 20 minutes before Ms Howell called police. The child "D" was present. Mr Pearce left over the fence. Mr Pearce was charged with breach of Family Violence Order.

30 December — Police reported a family violence incident. Ms Howell was eight months pregnant with Jasmine and got up at 6.00am to feed "D". Mr Pearce yelled at her to be quiet. Ms Howell was angry at Mr Pearce for drinking all milk. Mr Pearce called Ms Howell 'dog' and 'slut' and threatened to slap her face. Ms Howell called police, Mr Pearce told Ms Howell to call police again and say that he had left, which she did. Mr Pearce then threatened Ms Howell again (as he did not believe she had called police as he told her to). Police arrived and Mr Pearce was arrested. "A" and "D" were present. While police were present, they observed no milk, cereal or toilet paper. In the presence of police, "A" stated to Ms Howell that there was no toilet paper. Ms Howell told "A" to use singlet instead of toilet paper. The home was found to be unclean, with a bad smell, and was considered unhygienic particularly for young children.

2012

5 January — Cindy Richards (CBTL) completes draft Initial Contact and Screening Tool for referral to Gateway. The summary included:

Ms Howell not coping with children and this will increase when baby is born; Ms Howell will need respite for children when baby born; Notification indicated Ms Howell had no bread, milk cereal for children and no toilet paper. Home described as unclean and smelling; Have been six FVMS (family violence) reports for Ms Howell and Mr Pearce although last four have been 'arguments only'. There were two occasions which lead to physical altercations in 2010; Mr Pearce does not live with Ms Howell however frequent visitor, often uninvited and Ms Howell may require assistance with setting boundaries with him; Mr Pearce is reportedly suffering from cancer and has made veiled threats to kill himself and Ms Howell. Ms Howell believes Mr Pearce is referring to when the cancer gets too bad to go on in these threats; Ms Howell has anxiety and feels may suffer post-natal depression after baby is born; Ms Howell has some support from mother but says her mother does not have the patience to care for children. The stress in the home will increase and Ms Howell's coping ability will decrease if she does not receive support which will impact on the safety and stability of the children.

	The **risk assessment of the notification** assessed the harm consequence as concerning, as Ms Howell was struggling at eight months pregnant with her fourth child and is a single mother. It was noted that she had limited supports and appeared to be disorganised. The harm probability was assessed as unlikely. It is noted that the home is unclean and Ms Howell is not organised with essential items but does not appear to be struggling financially to provide the items. The future risk was recorded as low risk and it was noted that even without supports the future risk would still appear to be low. **The notification was closed on the basis that there was no role for CPS at this time even if Ms Howell did not engage with Gateway.**
11 January	Ms Howell's case was allocated to Gateway. Gateway was requested to support the family in the following areas: respite care for "A"; parenting skills; household management skills and obtaining alternative housing; maintaining engagement with supports; counselling for Ms Howell for post-natal depression, low self-esteem and anxiety.
7 April	Police reported a family violence incident; Jasmine was eight weeks old. "D", (18 months), was upset as Mr Pearce told her to 'fuck off cunt'. Mr Pearce was abusing Ms Howell and children, calling them 'rats' and "D" a 'retard'. Mr Pearce stated to Ms Howell *"I hope you die and when you go I'm going to kick the fuck out of your kids"*. Mr Pearce sat next to Ms Howell and pushed her to the face causing her to head butt Jasmine whom she was holding. Mr Pearce had Ms Howell's mobile phone and prevented her from calling police. Mr Pearce prevented Ms Howell from leaving the home. She called out for help. On arrival of police, Mr Pearce had left. All four children were present. CPS records this notification being received on 11 April 2012.
13 April	Ms Richards contacted Katie Brook (Gateway worker) advising of the 7 April notification relating to family violence and emailed details to Ms Brook.
13 April	Ms Kuhlmann, Intake worker (CPS) wrote to Ms Richards – stated notification should be forwarded for investigation due to Jasmine being hurt in incident.
17 April	Ms Kuhlmann emailed Ms Richards requesting feedback from Gateway as to whether Ms Howell understood the seriousness of the incident, and that it was agreed that CPS would visit Ms Howell.
18 April	Ms Kuhlmann advised Ms Richards that she should speak with Ms Howell given the seriousness of family violence incident.
	The **risk assessment of the notification** completed by Ms Kuhlmann assessed the harm consequence as serious, the harm probability likely and the future risk to Jasmine as high. This was assessed as high as *"the father appears to have become agitated and threatening towards the mother, child and child's siblings for no clear reason. The situation appears to have escalated to a point*

	where the father has used physical violence towards the mother and in the process has caused Jasmine to be hit in the head. There is also a pattern and history of family argument and family violence between the mother and father which appears to be continuing. However the matter is being managed by Gateway services and it is agreed that the community based team leader will undertake visit at this time to address the concerns. The mother is reporting a willingness to protect the children and to engage with appropriate services". The rationale for closure was that the issues would be addressed by the Community Based Team Leader. Ms Kuhlmann recommended a full protective harm assessment to assess risk to Jasmine and her siblings in the care of her mother should any further incidents occur**.**
3 May	Ms Richards visited Ms Howell at home with Katie Brook.
21 September	Police referral of family violence incident. Ms Howell woke around 6.00am and checked on Jasmine. Mr Pearce woke 15 minutes later and complained he could not find his mobile phone. Ms Howell told him she had moved it and that he should put it up higher to stop children from getting it. Ms Howell told him to leave, as she didn't want to argue and he was not meant to be at unit with current order in place. Mr Pearce called Ms Howell 'slut' and 'dog', threw a hairbrush at her, that hits her in the back of the head. Police were called; found Mr Pearce short distance from unit and arrested him. All four children were present.
22 September	Police reported a family violence incident. Ms Howell was walking towards her residence with all four children. Mr Pearce approached Ms Howell and grabbed hold of the pram. Ms Howell told him to leave pram alone; Mr Pearce responded stating *"just shut up you goose"*. Ms Howell requested him to leave the pram or she would call police. Mr Pearce called Ms Howell a 'dickhead' and told her she 'deserved everything she got.' Ms Howell told him to leave pram and walked towards assistance. Mr Pearce let go of the pram and walked off. Ms Howell went home and called police. CPS worker Samantha Sturmer attempts to contact Ms Howell by phone and letter without success.
1 October	Ms Sturmer reported speaking with the Family Violence Counselling Service (FVCSS), who had not spoken to Ms Howell for a week and therefore had closed her case, but believed Ms Howell was possibly going to move into emergency accommodation.
2 October	Ms Sturmer emailed CPS worker who attends Safe at Home meetings and asked that person to raise the following: an inability to contact Ms Howell, that FVCSS were also concerned about Ms Howell not engaging, the risk involved with her allegedly continuing to have contact with Mr Pearce, and the vulnerability of the children due to family violence.
3 October	Ms Kuhlmann, as Acting CBTL, became aware of the two incidents of family violence.

4 October	Ms Sturmer received confirmation from Ms Kuhlmann (A/CBTL) that there was a worker from Gateway working with Ms Howell.
4 October	Ms Kuhlmann contacted Mission Team Leader Joyce Langmaid (Gateway), who advised that Ms Howell "was engaging in a positive way with Katie Brook, and was working to the safety measures that were in place."
4 October	Ms Kuhlmann consulted with Intake Team leader Melissa Kingston as she "was concerned about the notifications". Ms Kingston indicated to Ms Kuhlmann that she wanted "follow up".
5 October	Ms Kingston closed the notification with the comment: "*Family are engaged with gateway and CBTL is following up concerns raised in the notification. If matter requires intervention from Response team then a new notification will be generated and allocated for follow up. Thanks."*
12 October	Ms Kuhlmann contacted Ms Langmaid and Ms Brook by email. Ms Brook advised that she had been unable to contact Ms Howell since September. Ms Kuhlmann stated that Ms Brook told her that she did not have concerns about the family violence between Ms Howell and Mr Pearce, and stated that she was not concerned about him due to his size. Ms Brook also said to Ms Kuhlmann that she felt Ms Howell was a good parent. Ms Kuhlmann stated that Ms Brook had a good grasp on the situation which decreased her concern about the case and she finished a conversation with the belief that Ms Brook would consult further with any concerns. Ms Kuhlmann did not request follow up. **There is no evidence of an application of a risk assessment despite the recognition that a full protective harm assessment was required after the notification in April.**

After the death of Jasmine on 27 January 2013, CPS continued to receive notifications, all from police, until 26 May 2014. There were six notifications. Again these involved: family violence (verbal abuse, physical assaults), Mr Pearce attending the address uninvited, and breaches of the police family violence order with children present. Charges were laid on two of these occasions. Ms Richards, as Response Team Leader, stated that as at November 2014, there was an assessment open in relation to "A", "R", and "D" in which a CPS worker within the Response Team had been allocated. Ms Richards stated that the assessment would be assessing the concerns outlined in a notification which included the pattern and history of parental drug use and the impact of this on their parenting capacity, the ongoing concerns in relation to the home environment, the neglect concerns specifically relating to lack of supervision, the children not being cared for or fed appropriately along with the impact of the significant pattern and history of family violence which the children have witnessed.

Factual findings on risk

Jasmine and her siblings were "affected children" as defined under the *CYPF Act.* I fully accept the evidence of Mr Damien Minehan, forensic psychologist, that the child protection

history shows the following areas of risk – extensive documentation dating back to 2004 with Ms Howell involved in a pattern of violent relationships and exposing the children to high levels of severe family violence, both physical and psychological; extensive evidence of Ms Howell being unable to maintain her children over approximately 10 years; extensive evidence of inadequate supervision of the children in their parents care including the circumstances of Jasmine's death and the delay in them noticing that she was deceased; maternal and paternal use of cannabis and cigarettes in the home, including in the 24 hours prior to Jasmine's death where the effects of cannabis use were apparent and contributed to their actions of pressing on Jasmine's body during sexual activity in the bed for some period of time. The house was overcrowded, usually dirty and almost always messy. Additionally, Ms Howell bore the burden of caring for a child with Down Syndrome in addition to the arrival of another baby. I also accept Mr Minehan's categorisation of these areas of risk as he applies them to the various limbs of the definition within the Act.

Mr Minehan's report and evidence to the inquest was sound and based in logic. It was produced after a thorough review of the file in which he was able to effectively analyse and distil the actions of CPS. He is an experienced consultant psychologist who provides to CPS parental suitability assessments as well as clinical and risk assessments. He has also undertaken assessments in the Federal Court as the Single Expert. He is fully qualified to assess and manage risk to a child as that term is defined by the Act. His knowledge of the guidelines, procedures and data management system used by the CPS workers was challenged by Ms Brown. His evidence did not disclose an intimate knowledge of the data base or some of the risk assessment tools. I note, however, that the TRF is a tool that reflects known factors relating to risk that are well within the area of expertise of Mr Minehan.

I find that the unacceptable state of the home was a significant risk factor. The state of the home was an issue at the inquest. Constable Templar visited several times. He stated that there was, for the most part, rubbish on the ground, living areas untidy with unwashed clothing on the floor. He stated there was leftover food and unwashed dishes and cutlery in the kitchen. He stated that the unit had an unpleasant odour on the occasions he attended. Constable Watson attended on six occasions between July 2011 and September 2012. He noted the premises was always in an unkempt state with clothes, mattresses and food items found scattered over the premises including the living and bedroom areas. Marilyn Howell stated that Ms Howell "would not wash the children's clothes and she never cleaned up" and "her house is never clean as she didn't do housework". I accept the evidence of Constable Templar, Constable Watson and Mrs Howell. It was detailed evidence from persons with no motive to embellish who had regularly attended the home. Ms Howell herself stated that the queen mattress was unusable due to the difficulties with "A's" incontinence. Whilst there was one home visit on 3 May 2012 by the Community Based Team Leader who found the home messy but not dirty, the preponderance of evidence, including from CPS records, is overwhelmingly that the house was generally in an unacceptable state. The evidence indicated that Mr Pearce would often clean the house. I accept that during those times the home would not necessarily be in an unclean state.

Discussion of Risk Assessment

Mr Minehan reviewed the child protection files and provided a report and evidence for the inquest regarding the risk assessments relating to Jasmine. Similarly, Leonie Watson provided significant evidence of the structure and procedures in CPS and a helpful report and analysis of Jasmine's case.

The main child protection workers involved with the family gave evidence; they were Samantha Sturmer, Cindy Richards, Melissa Kingston and Melody Kuhlmann. The evidence of the workers was candid and helpful. Inadequate resourcing or lack of staff was not used as a reason for deficiencies in the way that decision-making occurred, although the evidence suggested at times there was a heavy work load. The workers that gave evidence also agreed in broad terms that there were certain deficiencies in the way that decision-making occurred in respect of Jasmine. They agreed with the areas of deficiency stated by Ms Watson. Although lack of time and resources for CPS was not an issue in the inquest, the manner in which serious notifications were dealt with and the lack of detailed assessments were characteristic of workers with limited time to devote to the task. This seems particularly to be the case given that these workers were all obviously diligent, experienced and devoted to their work.

Ultimately, both Ms Watson and Mr Minehan arrived at similar conclusions on two important points as to how the protection of Jasmine could have been improved. In simple terms they are:

(a) There was an over reliance by CPS on Gateway workers' statements about Ms Howell in the face of objective evidence of continuing serious risk to Jasmine; and

(b) There was a lack of consideration of the concept of cumulative harm in assessing the risk to Jasmine, based particularly upon the repeated episodes of family violence occurring in the presence of the children.

Both Mr Minehan and Ms Watson separately made other observations and suggestions that I will deal with further in this finding.

In assessing the actions and evidence of CPS I make the following observations;

(a) The task of assessing the risk in relation to notifications can be very difficult. In a setting such as an inquest, the process is analysed with the benefit of hindsight and with knowledge of the eventual outcome. As stated previously, caution is required in such circumstances before finding that a different decision should have been made. At the time of a decision being made there is a difficult weighing of risk and protective factors and a judgment made.

(b) The cooperation of CPS has been to a high standard in all aspects of this inquest. This was also the case with Baptcare and Mission Australia in relation to the material supplied for the inquest.

(c) I am not able to find that a different approach incorporating a more thorough risk assessment and application of the cumulative harm policy would necessarily have prevented Jasmine's death. However, in the context of the many serious risk factors, a higher level of intervention, and thus protection for Jasmine, should have occurred. This may have involved, after a full risk assessment by the Response Team, setting targeted goals to occur within a specified time for Gateway involvement, enhanced supervision of the

> Gateway progress by the CBTL, greater scrutiny of the home environment by the CBTL. Other avenues under the Act would have been the making of a Voluntary Care agreement, holding a Family Group Conference, and application for an Assessment order or Care and Protection Order (whether Jasmine was removed from the home or not). It is not possible to state, given these variables or the capacity for progress by Ms Howell when challenged, that it was inevitable that Jasmine would have been removed from Ms Howell's care, and therefore not have died.

Over reliance upon advice from Gateway Services

Ms Howell commenced involvement with Gateway in January 2012 just before Jasmine was born as shown in the summary set out above. She had, for the large part, one support worker, Katie Brook, who communicated Ms Howell's progress to the CBTL and other workers at CPS. The evidence indicates that Ms Howell made little progress over this time.

There was prolonged reliance over this period by CPS workers upon assertions from Ms Brook to the effect that Ms Howell intended to end the relationship with Mr Pearce, acted protectively towards her children and engages with support services. The above chronology demonstrates a pattern of acceptance by CPS of such assertions at face value with little questioning.

Ms Kuhlmann, for example, recounted a conversation with Ms Brook about the issues of family violence and parenting. Ms Brook said to Ms Kuhlmann that she was not concerned about Mr Pearce "due to his size" and that Ms Howell was a "good parent". Ms Kuhlmann concluded that Ms Brook appeared very familiar with Ms Howell and appeared to have a good grasp on the family situation. Such information provided by Ms Brook had the effect of decreasing Ms Kuhlmann's concern about the level of risk when it patently should not have done so. There was other overwhelming evidence of Ms Howell's inability to properly parent and Mr Pearce's violent behaviour and breach of orders. This conversation concluded with Ms Kuhlmann satisfying herself that Ms Brook would contact her if Ms Brook had any concerns. Such reliance on assurances by the Gateway worker was manifestly unreasonable. A longitudinal view of the case as a whole showing repeated notifications of neglect and family violence was simply inconsistent with the information that was coming directly from Gateway. CPS relied on the Gateway worker advising that Ms Howell was "engaged" or would imminently improve her engagement for various reasons. However, the indications from FVCSS and even CPS itself were that she was a very difficult person to contact. Since 2004 there had been a pattern of repeated non-engagement. In that context such assurances should not have been accepted at face value.

It should have been clear that no amount of verbal assurances by the Gateway worker ought of themselves to have allayed the concerns about family violence and the risk that it posed to the children. Mr Pearce would not obey court orders despite charges and convictions, and Ms Howell was complicit in the orders being routinely breached. Having heard Ms Howell give evidence, there is no doubt that she had a superficially convincing manner of presentation. However, it became plain very quickly that she was unreliable in her statements, her evidence given for effect and the content often bearing little resemblance to the reality of her situation. I am surprised that those involved with the support of her family and protection of her children could have relied on her assurances for such a long period of

time. For example, her assertions to Gateway and CPS that she was not intending to reconcile with Mr Pearce may have been expressed genuinely but the objective likelihood based on the history was that this would not occur. This cycle of violence and reconciliation should have been recognised as an entrenched, dysfunctional pattern in the relationship. Ms Kuhlmann frankly told the Court that Ms Howell was articulate, was loving to her children, and wanted to change. On that basis Ms Kuhlmann held the view that there were enough supports in place to keep risk in check. She noted that most of the family violence was emotional abuse and arguments rather than physical, and that fact played a part in her decision not to proceed further with investigation at a higher level.

It appears that one factor causing reliance on such statements was the professional courtesy extended by the CPS workers to the Gateway workers in being seen to trust their assertions and judgment. This was apparent in the evidence of both Ms Kuhlmann and Ms Richards. I note that the *CYPF Act* and Baptcare guidelines provide for a risk assessment role to be played by Gateway to inform notifications to CPS as mandatory notifiers. I detected that the CPS workers were somewhat reluctant to override or check the correctness of the advice as a matter of professional courtesy. As already mentioned it is apparent that workload issues likely played a role in the desire to close notifications as quickly as reasonably possible.

Neither the CPS workers nor Ms Watson in their evidence overtly sought to shift responsibility for risk assessment to Gateway. They were firm that the duty rested with CPS. However, in the notifications involving Jasmine there appeared to be a contentedness to rely on what Ms Brook told them to inform the decision-making without analysis of all objective risk factors. The CPS workers were not vigilant to the dangers in that approach - being that Ms Brook was not trained as a CPS worker; that Ms Brook had a very different relationship with Ms Howell, and may not see or report on matters as CPS would have liked to her do; and that her focus was necessarily different as a support for the family. While the information from Gateway is important it must be taken in that context. This is a case where there was clearly conflicting information weighing in favour of high risk to Jasmine as a vulnerable infant and the obligation was for CPS to assess that risk based upon all appropriate sources.

Mr Minehan states that brokerage of services for family intervention is distinct from outsourcing responsibility for risk assessment and management over time, and that risk management practices require consistent risk assessment tools and suitably qualified staff. Whilst this may be a trite statement, it highlights the different focus and responsibilities of CPS as compared with non-government support organisations. Indeed, the evidence was that many Gateway clients would engage because of the very fact that Gateway provided support and did not have the power to remove their children from the home.

As Mr Allen stated, this case illustrates is that it is always a matter of degree as to whether reliance amounts to “outsourcing” or “delegation”. In respect of the notifications in April 2012 and October 2012 the reliance upon the statements of a single Gateway worker to the exclusion of a full objective risk assessment did amount to overreliance and a failure to properly and independently assess the serious risk to Jasmine.

I acknowledge that the child protection system involves receiving notifications, assessing notifications, responding to notifications and, if appropriate, closing the notification. This is an established procedure. However in the higher risk cases referred by CPS to Gateway and then closed immediately by CPS the risk assessment role of the Intake team will not be

triggered again until there is a further notification. I acknowledge that Gateway is a mandatory notifier and the CBTL has the obligation to report on the recipients of Gateway services to CPS at regular meetings. These factors are important safeguards for Gateway referrals. In Ms Watson's view they work well to monitor Gateway clients. Ms Watson also is of the view that the CBTL role has sufficient support and mentoring from the CPS establishment to be an effective liaison.

The evidence suggests that it may be that the liaison procedures involving the CBTL are not always conducive to detailed risk assessment. Although there are regular meetings involving the CBTL and CPS to discuss Gateway clients, my impression from the evidence was that these meetings are unlikely to result in referrals of Gateway clients back to Intake or Response. In Jasmine's case, the two notifications before her death were closed due to Gateway support being a protective factor and yet noting current risk; however, once closed CPS Intake conducts no further formal risk assessment that incorporates an assessment of the efficacy of the Gateway support. In Ms Howell's case, Ms Howell made no progress with Gateway in the 12 months she was involved. There was evidence that there should have been progress seen after three months. CPS devised no targeted management plan for goals to be achieved by Ms Howell over time.

I consider that in cases at a nominated risk threshold it may be appropriate to keep notifications open for a specified period whilst Gateway progress is strictly monitored. Mr Minehan considers that this should occur. I consider that it would be appropriate for CPS to review their policy of file closure in the Gateway cases involving higher assessment of risk.

Mr Minehan states that, given the importance of the CBTL role, it should be strengthened Having heard the evidence, I agree that the CBTL's role is a crucial one, with a great deal of decision-making power and control of information reposed in one individual. I agree with Mr Minehan, who suggests that CPS re-examine the role of the CBTL with a view to clarifying its decision-making power and increasing its level of support.

Mr Minehan also indicated that pro-active regular home assessment by CPS particularly for safety of children under three was important. He noted that home visits for the purpose of a safety assessment are different to home visits by a Gateway worker in a therapeutic capacity. Ms Watson states that Gateway workers regularly visit clients' homes and if they have concerns they can request a consultation with their team leader or the CBTL. Again, this reflects the problem of reliance. Whilst in some cases the notification will be made to Child Protection in that way, it cannot always be assumed that it will for the reasons referred to earlier. Although Ms Brook visited Ms Howell on many occasions, and knew the home, the lack of bedding for Jasmine was not remedied.

Cumulative harm policy not followed

This case illustrates the lack of consideration given to cumulative harm, being the effects of all adverse circumstances and events in a child's life. The Child Protection Practice Manual states that a referral to the Response Team in regard to a concern about cumulative harm may be made even where the particular notification would not, of itself, warrant investigation. The indicators for an assessment of the risk of cumulative harm are, for example, multiple notifications (including family violence notifications), notifications by professionals, and allegations of inappropriate parenting in public.

The manual further notes that cumulative harm will not be observed if notifications are treated solely as events or incidents, and if patterns of notifications or events are not given consideration. The requirements under the manual for a notification at intake are as follows:

- For every notification, Intake workers must review the case history of previous notifications to ascertain if there is evidence to indicate possible cumulative harm to that child. Intake workers are also required to note reports in regard to the subject child's siblings or other members of the household.

- If two notifications about a child have been received but have not been investigated in the 12 months prior to a notification, any further notification must be considered with specific reference to the risk of cumulative harm. If referral to the Response Team is not warranted, the Intake worker must record explicit rationale for this decision on the electronic file.

- If a notification is the fifth consecutive report to be received about a child without investigation, the Intake worker, team leader and senior practice consultant should review the case history for that child. The review will be required to consider multiple reports, including family violence reports, previous reports relevant to other family members, previous substantiations, multiple sources, reports from professionals, evidence of failure of child to meet developmental milestones, and allegations of inappropriate parenting in public. Where three or more of these factors are present the matter should then be referred to the Response Team unless there is compelling evidence that such a referral is not warranted. If a referral is not made the reasons for this must be documented.

There were six reported referrals of serious family violence incidents from police (being professional notifiers) from October 2011 (when Ms Howell was five months pregnant with Jasmine) until Jasmine's death. These notifications, of course, did not only relate to Jasmine but to her siblings. At no time was the cumulative harm policy applied, when in fact it should have been applied on all three of the above levels given the number of previous notifications in respect of the family. It may have been that the history of some notifications was reviewed by the Intake workers upon notification, but the documentation of any systematic application of cumulative harm principles was absent. In my view the repeated failure to apply a policy designed to protect children at high risk is a serious oversight. I note that the cumulative harm policy has been incorporated into the manual since at least 2009.

The failure to instigate the cumulative harm policy to its highest level of investigation meant that the notifications were not referred to the Response Team that would necessarily have been required to investigate the risk in detail and manage that risk with a detailed strategy.

I have some difficulty in respect of Ms Watson's statement that Jasmine was the subject of two notifications to CPS. CPS was aware that Ms Howell was pregnant at the time of the notification in October 2011. CPS in fact wrote to her in relation to concerns for her unborn baby. In keeping with the spirit of the cumulative harm policy, a proper assessment should have taken into account the total number of family violence incidents, all separately reported to CPS, including those incidents when Ms Howell was in the late stages of her pregnancy with Jasmine. It appears from the evidence of Ms Kuhlman and notes made on the CPS files

by workers that CPS distinguished risk markedly between those incidents that did not involve physical violence and those that did. As stated below, the term "argument only" is used commonly on the police FVMS. I infer that there is a specific reason relating to the type of police response for the use of this term. Unfortunately, the police referrals carry through this term onto the CPS files, which has the tendency of downplaying the seriousness of the incident. In the cases of Mr Pearce and Ms Howell, the incidents that did not involve actual violence nevertheless often involved intimidation, trespass and breach of family violence orders. Such incidents significantly affect the emotional well-being of the children and are prone to escalating to physical violence. These incidents were downplayed as a risk factor to Ms Howell's children.

The lack of documentation by CPS as to their CPIS searches of prior notifications is also noteworthy. CPIS searches are capable of searching under children and parents. Workers should ensure this occurs and is documented. I accept Ms Brown's submission that some searches may have occurred but were not documented. However, given that this type of search provides a necessary basis for a thorough cumulative harm assessment, it would be appropriate to set out in the risk assessment how the search is conducted, and the reasoning resulting from those searches.

Family Violence History

The circumstances of Jasmine's death did not involve Mr Pearce being in breach of his family violence order, or allegations of physical or verbal abuse. However, her death does arise out of her parents' inability to properly care for and protect her (including the provision of a safe sleeping environment) in the context of their dysfunctional relationship.

Constable Lisa Turner of the Northern Victim Safety Response Team has helpfully analysed their family violence history for the inquest. As is unfortunately often the case, Ms Howell would persistently return to the abusive relationship. Numerous charges (assault and breach of police/family violence order) were laid against Mr Pearce but many were either dismissed or withdrawn, presumably due to lack of cooperation from Ms Howell. It appears that from about December 2010 the interim or full family violence orders to which Mr Pearce was subject were in protective terms only, and did not prevent him from approaching Ms Howell or the children or being at Ms Howell's home. I can not rule out that on occasions he may have been subject to a full order prohibiting approaching her. However, ultimately it appears that Ms Howell did not seek a full order due to her wish to have a relationship with Mr Pearce.

The inquest did not examine the adequacy of the police decision-making in terms of: the charges laid against Mr Pearce and subsequently not proceeded with; the terms of the family violence orders and; the exercise of the police officers' discretion in not reporting some CPS referrals not involving physical abuse.

Attending police officers were diligent and timely in their recording of the incidents on the FVMS. In the context of the issues of Jasmine's care and protection it is important to mention and consider the family violence incidents that police attended but which police did not refer to CPS as notifications.

It is unnecessary to set out the history of all of the recordings between Ms Howell and Mr Pearce on the FVMS. Many allegations of family violence against Mr Pearce that were the

subject of referrals are set out above. However I note that the following reports by police on the FVMS were ***not*** the subject of referrals before Jasmine's death; 18 September 2010 (assault), 29 December 2010 (assault), 26 May 2011 (argument), 27 June 2011 (argument), 3 July 2011 (assault and argument), 21 January 2013 (argument).

The above incidents mostly occurred when the children or some of them were present. The theme of some of these incidents was that Mr Pearce was threatening in his behaviour and would not leave. For example, on the last occasion it would appear that the children were present when Mr Pearce attended Ms Howell's address and he became angry immediately, whereupon an argument commenced, and he refused to leave. It would appear that the word "argument only" is used in contradistinction to physical violence in the FVMS. I understand that the significance of this phrase is that it indicates to police that no further action is to be taken. It does not mean that the incident might not pose risk to the children. Whilst this phrase might possibly convey a harmless verbal exchange, the incidents between Ms Howell and Mr Pearce usually involved possibly threatening, abusive behaviour in front of their young and vulnerable children, accompanied by a refusal to leave when requested.

As already discussed in the police CPS referrals, the terminology of "argument only" is carried through to the CPS files. From the CPS viewpoint the categorisation of potentially serious and threatening confrontations in this manner does not encapsulate the potential for harm (both actual and emotional) to the children who are repeatedly forced to experience such distressing events. An argument can range in intensity and rationality. The arguments recorded where Ms Howell has felt the need to call the police are not in any sense incidents that are rational or controlled, but often prolonged incidents of intimidation and rage. The manner of recording, by these words, can tend to relegate these types of incidents to matters that may not represent significant risk to the children. The fact that a number of serious incidents, such as above, were not referred by police to CPS in their discretion, even though children were present, might indicate that in the scheme of the relationship between Ms Howell and Mr Pearce they were not thought to have presented a risk to the children. By not reporting many of them, CPS is not able to make a proper assessment of the risk of cumulative harm to the children. When they were reported, the phrase "argument only" is replicated in the CPIS records and, as the evidence shows, this tends to diminish their importance in the minds of the Intake workers in assessing risk to the children.

Constable Turner stated that in January 2014 FVMS was updated so that it now automatically generates a CPS referral from any report as long as the children are correctly entered in the relevant sections of the report. This is an important development. If this system was in place before Jasmine's death then there would have been six more reports to CPS from police in respect of family violence incidents. I can not determine whether this would have caused CPS to approach the issue of risk to Jasmine in any different manner.

Safe Sleeping Practices

Marilyn Howell stated that when the children were babies Ms Howell would often sleep with them, even though she had cots for them and was aware of the danger of sleeping with an infant.

Studies have shown that adult sleeping environments, such as adult beds and couches, may contain hazards that can be fatal for babies. The main hazards are accidental overlaying of the baby by an adult or suffocation from pillows, blankets or bedding.

As I have stated in previous findings, there remains an ongoing need for parental education in safe sleeping practices, particularly high risk sub-groups in the Tasmanian population, so that important messages for risk reduction in sudden infant death become entrenched.

Having investigated many sudden infant deaths with attendant risk factors, it is my view that relevant agencies and organisations should remain vigilant to ensure, where possible, they continue to incorporate into their operations, on an ongoing basis, effective strategies to reinforce safe sleeping messages. By this method similar deaths are likely to be prevented.

I acknowledge the efforts made by the Department of Health and Human Services ("DHHS") to educate high risk groups on the need for infant safe sleeping. The DHHS policy covering repetition of the advice to new parents by a number of organisations appears to have had a very significant effect in reducing sudden infant death. The Tasmanian coronial case management system shows that the number of sudden infant deaths has decreased from 19 in the three years 1 January 2009 to 31 December 2011, to 11 in the three years from 1 January 2012 to 31 December 2014.

In making the recommendations below I also acknowledge the other government policies and strategies to reduce risks to vulnerable babies that have been and are being developed as outlined by Ms Watson. In the context of this tragic case, the "Three and Under Policy" is a particularly welcome development. This was implemented in June 2013 and requires the approval of a multidisciplinary panel before closing a notification for a child aged 3 years or under.

RECOMMENDATIONS

Recommendations directed to CPS

I recommend:

1. 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, particularly in respect of cases where there are repeated notifications of family violence;

2. That the CPS Cumulative Harm Policy be amended to refer to the **number of separate incidents** reported to CPS as the trigger for the activation of the higher level of risk assessment rather than the **number of notifications** (noting in this case that one notification involved two separate family violence incidents).

3. That CPS continue to educate its workers on the cumulative harm policy and its practice, in particular education on the need for;

    (a) The risk assessment of cumulative harm to be applied strictly as required by the policy;

(b) Assessments of cumulative harm to occur additionally when the key indicators for cumulative harm are present;

(c) An extensive investigation as set out in the policy to properly assess cumulative harm;

(d) Analysis of the full content of a FVMS referral for risk factors indicating cumulative harm, and the fact that the police categorisation of the incident as an "argument only" may nevertheless mean that the incident is attendant with risk factors for the children and important in the assessment of cumulative harm to the child.

4. That CPS Intake workers, in assessing risk on any notification, routinely conduct CPIS searches of previous notifications in respect of the child, and of parents and siblings of the child, and document the searches undertaken to ensure that risk is considered across extended periods of time.

5. That the CPS Intake workers provide sufficient written reasoning on the risk assessment document in order that consistency is achieved in application of risk assessments.

6. That CPS conduct regular audits of files to determine whether the TRF is being routinely used, that CPIS searches are being routinely conducted and the TRF categories and reasoning processes are clearly exposed and documented on the file.

7. That when CPS make a referral to Gateway for family support as a result of a notification, then CPS should identify and document on the file a case plan for achievement of goals with Gateway.

8. That CPS consider whether the role of the CBTL should be strengthened to provide further supports and increased capacity, given the crucial nature of the role as a liaison between CPS and Gateway.

9. That CPS review the point of case closure of a notification from Intake where that notification involves referral of a high risk family to Gateway, to ensure that independent assessment of risk remains with CPS until the required progress has been made in Gateway.

10. That if no progress has been made by a family in Gateway in accordance with a case plan and strict time frames, the family be referred back to Intake for further investigation.

11. That home visits to those families involved with Gateway, attended by the CBTL and Gateway worker, be conducted regularly to ensure a robust investigation into risk.

12. That, where appropriate, a clause be included on government contract renewals and Memoranda of Understanding to require non-government organisations working with infants to discuss safe sleeping practices with families.

Recommendations directed to Tasmania Police affecting CPS risk assessment involving family violence incidents

I recommend:

13. That Tasmania Police, when training or educating officers in family violence practices and procedures, include training and education as to:

    (a) the need for reporting officers to elicit from the complainant, where possible, the full extent of the details of the interaction, including what was actually said by the parties to the interaction, and thus whether the incident may be properly categorised as an "argument only" incident, or whether the incident may attract charges;

    (b) the ascertainment by reporting officers of whether there are children to the relationship, even if they are not present at the incident;

    (c) the correct completion by reporting officers on the FVMS of the names of the children and whether they were present, so as to ensure that an automatic CPS referral is generated; and

    (d) that the supervising sergeant responsible for validating the FVMS report ensures as far as possible that the section for completion of the names of the children section is correctly completed, and that the incident details are as extensive as possible.

14. That Tasmania police conduct checks on a regular basis to confirm that the FVMS referrals to CPS are being forwarded to and received by CPS.

REFERRAL TO DIRECTOR OF PUBLIC PROSECUTIONS

I intend to forward this finding, together with the evidence at inquest, to the Director of Public Prosecutions to determine whether Ms Howell and/or Mr Pearce should be charged with any crime or offence, and in particular whether their omission to check that Jasmine was safe in the bed and able to breathe amounted to culpable negligence to perform a duty tending to the preservation of human life and therefore culpable homicide.

Dated: 27 May 2015 at Hobart in the State of Tasmania.

Olivia McTaggart
CORONER