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

**Rhiannon Pearl Vanessa Pitchford**

# Record of Investigation into Death (With Inquest)

*Coroners Act* 1995
*Coroners Rules* 2006
*Rule 11*

I, Olivia McTaggart, Coroner, have investigated the death of Rhiannon Pearl Vanessa Pitchford, with an inquest held in Burnie on 29 and 30 August 2018 and Hobart on 12 October 2018.

**Appearances**

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| Counsel Assisting | Ms C Schokman |
| Counsel for Child Safety Services | Ms G Chen |

**Introduction**

Rhiannon Pitchford was an infant born on 25 September 2014 who died suddenly overnight between 18 and 19 November 2014, at the age of 55 days. She died whilst sleeping in the bed of her parents, with her mother in bed with her. Her death was reported to the coroner as required by the *Coroners Act* 1995 ("the Act"), it being a sudden and unexpected death of a child under the age of one year. A coronial investigation commenced into the cause of Rhiannon's death and the circumstances surrounding it. An autopsy performed by the forensic pathologist did not reveal any medical cause of death.

The coronial investigation was somewhat protracted due to difficulty obtaining evidence from Rhiannon's parents. Some time into the investigation, it also became apparent that Child Protection Services (now Child Safety Services and referred to as "CSS") had involvement with Rhiannon's siblings. In particular, that Rhiannon's brother, W, had been placed by CSS into foster care as a result of suffering apparently serious non-accidental injuries in the home. Further, there was an "unborn baby notification" to CSS regarding Rhiannon whilst she was *in utero*, made by staff at the Mersey Community Hospital (MCH) who were concerned about risk to her once she was born.

CSS is part of Child and Youth Services (CYS) which was formerly a division of the Department of Health and Human Services (DHHS) and now a division of the Department of Communities. The role of CSS is to protect children and young people who are at risk of abuse or neglect. Under the *Children, Young Persons and their Families Act* 1997 ("CYPTF Act") its functions are to respond to notifications in respect of children by assessing risk and,

where required, taking steps to protect children from that risk. Such steps may range from voluntary referral of families to support services to seeking a care and protection order from a Magistrate and placing the child in foster care.

I decided to hold an inquest into Rhiannon's death, although an inquest is not mandatory under the Act. There were two reasons for the desirability of a public inquest. Firstly, the affidavit evidence of Rhiannon's parents, Kylie Haywood and Joshua Pitchford, regarding the circumstances and events prior to her death, including their use of drugs, was inconsistent and incomplete. Secondly, this case raised the issue of whether CSS had adequately performed its statutory function in assessing and responding to the risk to Rhiannon and her brother, in circumstances where recent coronial inquests and findings have revealed issues relating to similar deficits in child protection procedures.

Counsel for CSS, Ms Chen, submitted that the inquest ought not be directed towards inadequacies in CSS systems and decision-making. Counsel assisting the coroner, Ms Schokman, submitted that there must be a nexus between the matters about which recommendations are made and the findings required under s28(2) of the Act. Nevertheless, she submitted that in this case the facts around CSS involvement with Rhiannon, her parents and siblings was an inextricable part of consideration of the findings of *"how death occurred"* and *"the cause of death"* in the broad construction required of s28(2).

In *Conway v Jerram*[1], the members of the New South Wales Court of Appeal observed that the scope of an inquest is a matter for the coroner to determine using both proper discretion and common sense. Campbell JA referred to *Harmsworth v State Coroner*[2] in which Nathan J discussed the fact that the enquiry must be relevant in the legal sense to the death and that a coroner is not permitted to conduct a "wide, prolix and indeterminate" inquest surrounding remote issues.

The judgments of *Re State Coroner; Ex parte Minister for Health*[3] *and R v Doogan; Ex parte Lucas-Smith*[4] also emphasise that the coroner is not authorised within his or her proper limits to undertake a roving enquiry into any possible causal connection, no matter how tenuous, between a particular fact or circumstance and the death of the deceased.

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[1] [2011] NSWCA 319 at [47-48]
[2] [1989] VR 989
[3] [2009] WASCA 165
[4] [2005] ACTSC 74

The coroner's function of finding *"how death occurred"* usually requires the coroner to make an assessment for the purposes of scope of the enquiry as to the substantial or operating causes of the death that are not merely part of the background or too remote. The question of causation should be determined by applying common sense to the facts and not resolved by speculative or hypothetical theories.[5]

In *Re the State Coroner; Ex Parte the Minister for Health,* Buss JA stated at [42]:

> *"…In my opinion, a construction of s25(1)(b) which entitles and requires the coroner to find, if possible, by what means and in what circumstances the death occurred reflects the public interest which is protected and advanced by a coronial investigation…Also, this construction is consistent with the decision of the Court of Appeal of Queensland in Atkinson on a comparable statutory provision...*
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> *44. The coroner, in finding, if possible 'the cause of death', is not confined or restricted by concepts such as 'direct cause', 'direct manner', 'direct and natural cause', 'proximate cause' or the 'real or effective cause'. Similarly, a coroner is not confined or restricted to a cause that was reasonably foreseeable…*
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> *47. It will be necessary, in each inquest, to delineate those acts, omissions and circumstances which are, at least potentially, to be characterised as causing or a cause of death of the deceased. This is to be undertaken by applying ordinary common sense and experience to the facts of the particular case."*

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

The facts around CSS involvement with Rhiannon, her parents and siblings are, in my view, an inextricable part of the *"how death occurred"* and *"the cause of death"* in the broad

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[5] See for example: *E & MH March v Stramare Pty Ltd* (1991) 171 CLR 506; *Campbell v The Queen* (1981) WAR 286; *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1; and *Atkinson v Morrow and Anor* [2005] QCA 353.

construction required of s28(2) of the Act and therefore appropriate for examination. The reasons for this conclusion should be clear from the following discussion surrounding the circumstances of Rhiannon's death set out chronologically below. However, put simply, there was an inadequate assessment of risk to Rhiannon upon receipt by CSS of the unborn baby notification and inadequate action in responding to that risk. These failures in statutory function resulted in Rhiannon, once born, living in the home unprotected from the significant risks inherent in that situation and risks that were contributory factors in her death.

**The scope of the inquest**

The inquest focused upon the following principal issues:

1. The movements of Kylie Haywood and Joshua Pitchford in the hours before Rhiannon's death, including in respect of drug use;
2. The cause of Rhiannon's death - whether natural causes, accidental suffocation by a parent ("overlay") or a result of an unsafe sleeping environment;
3. The capacity of Ms Haywood and Mr Pitchford to be fit and proper parents, including an examination of the injuries to W;
4. The response by CSS to the notification in respect of W;
5. The response by CSS to the unborn baby notification in respect of Rhiannon;
6. The inadequacies in child protection practice relating to Rhiannon, and whether those inadequacies were a contributing factor in her remaining in the family home and subject to risk and/or sudden death;
7. The processes of review by CSS concerning the death of Rhiannon;
8. CSS processes of review of child deaths, in particular sudden and unexpected deaths in infancy; and
9. The response by CSS to the coronial recommendations in the cases of Pearce[6], Johnstone[7] and Hayes[8].

The evidence at inquest comprised documentary and oral evidence. The documentary exhibits included the police report of death, an opinion of the forensic pathologist, police and civilian affidavits, medical, nursing and ambulance records, CSS records and expert opinion

[6] 2015 TASCD 075
[7] 2017 TASCD 248
[8] 2018 TASCD 208

regarding CSS decision-making.

The witnesses called to give evidence at inquest were the investigating officer, Kylie Haywood, Joshua Pitchford, Deborah Randall, Mark Lowrey, the State Forensic Pathologist and ambulance officer, Steven Brownrigg. The witnesses called to give evidence concerning the CSS issues were Suzanne Botak, (independent reviewer), Gail Eaton-Briggs (Deputy Secretary Children), and Claire Gray (CSS reviewer).

It should be noted that CYS and CSS have themselves acknowledged that many aspects of CSS decision-making surrounding Rhiannon and her siblings were inconsistent with proper policy and procedure. CYS authorised a review of the decision-making by its Serious Events Review Team (“SERT Review”/“the Review”). The Review culminated in a lengthy document setting out the manner in which risk assessment in respect of Rhiannon and her siblings was absent, incomplete or inconsistent throughout the relevant time period, contributing to poor decision-making and safety planning, which was inadequate to address the risks. The Review concluded that if the proper procedure had been followed, it is likely that the notification in relation to Rhiannon would have been responded to by CSS in a different manner and with a higher level of protection from the risks at home.

**Background and events leading to Rhiannon's death**

Kylie Haywood (formerly Kylie Heather) was aged 31 years when Rhiannon died. Joshua Pitchford was also aged 31 years. Ms Haywood had previously been married to Dean Heather and had three children with him: L, born in April 2005; B, born in August 2006 and; a boy, W, born in February 2012.

Ms Haywood and Mr Heather separated in about June 2013. By October 2013, Ms Haywood had entered into a relationship with Mr Pitchford and they had begun cohabiting by November 2013.

L, B and W resided primarily with Ms Haywood at 1 Kiah Place, East Devonport ("the Kiah Place residence") with fortnightly weekend access visits to Mr Heather's house.

Mr Pitchford had a child, C, born in August 2010 to a prior relationship. On 5 September 2013, CSS received a notification regarding C following a family violence incident between Mr Pitchford and C's mother.

Ms Haywood's children were not known to CSS before Mr Pitchford moved into the Kiah Place residence.

I set out now, chronologically, the significant events (including main aspects of CSS involvement) before Rhiannon's death based upon the evidence presented in the documentary exhibits and at inquest.

On 13 November 2013 Ms Haywood took W, then 20 months, to the MCH reporting that he had woken extremely distressed with swollen hands and swelling on the left side of his face. It was reported by Ms Haywood that W had had a cold for three weeks and still had a runny nose. W was medically examined and found to have swelling on the left side of his face and bruising on his right forehead and behind his left ear, on both sides of his trunk and at the base of his testicles. It was noted that the bruises were of different ages. Ms Haywood told hospital staff that W bruised easily and he may have received the bruises on his testicles while bathing with his sisters and falling on a toy. The doctors expressed concern that W's presentation was in keeping with non-accidental injuries and intended to inform CSS of this fact but suggested he first be seen by a paediatrician.

W was seen by a paediatrician who diagnosed him with Henoch Schoenlein Purpura (HSP) and discharged him. HSP is a disease of the skin, mucous membranes, and sometimes other organs, that most commonly affects children. In the skin, the disease causes palpable purpura (small, raised areas of bleeding underneath the skin), often with joint pain and abdominal pain.

On 14 November 2013 Ms Haywood reported W's injuries to police. She told police that she had been advised by the hospital that CSS would be notified and she was attending to report the injuries. She said that she did not suspect child abuse although the tenor of her reporting is that the injuries occurred whilst in Mr Heather's care. She also reported concerning interactions between Mr Heather and L and B. Tasmania Police reported these matters to CSS later that day. CSS then spoke with Mr Heather on 15 November 2013. Mr Heather advised CSS that he had seen bruising to W's penis and also expressed concerns about Mr Pitchford having moved into Ms Haywood's home.

On 16 November 2013 Ms Haywood again took W to the MCH, with further swelling to his fingers and a bruise on his left eye. He was again diagnosed with HSP and sent home.

On 21 November 2013, W was seen again by a paediatric registrar at the MCH. Ms Haywood reported that W had new bruises on his elbows and lower limbs and that his fingers, which had improved since the last visit, were swollen again. The doctor who examined W noted that the *"HSP was settling"*.

On 25 November 2013 an ambulance was called by Ms Haywood and Mr Pitchford to the Kiah Place residence to attend to W. Ms Haywood and Mr Pitchford reported that W was unsteady on his feet on getting out of bed in the morning. However, W was observed by ambulance officers to be walking normally, mobile, happy and alert. Ms Haywood and Mr Pitchford were offered transport for W to hospital, but indicated that they would take him to the hospital after dropping the other children at school. The evidence discloses that they did not take him to the hospital.

On 30 November 2013 W attended the MCH. Ms Haywood reported to hospital staff that Mr Pitchford had been changing W's nappy and holding his left foot when W twisted and Mr Pitchford heard a "crack". Ms Haywood reported that W was not weight bearing on his left leg. The doctor examined W and noted bruising on his right temple, left forehead, and abdomen as well as his left lower leg. W's scrotum was still swollen but he now had a wound on the dorsum of his penis. An x-ray of W's leg showed a spiral fracture just above the middle of his left tibia. The doctor examining W was concerned that the injuries were non-accidental and telephoned the on-call paediatrician. W was then transferred to the North-West Regional Hospital and his leg placed in a plaster cast. When asked about the wound on W's penis Ms Haywood stated that it happened in the bath and attributed its cause to her daughter, L. Ms Haywood and Mr Pitchford were asked about W's broken fingers and Mr Pitchford said that W may have fallen from the bed – clearly an implausible explanation.

On 1 December 2013 W was reviewed by a paediatric registrar at the North-West Regional Hospital and by a paediatrician. They documented bruising on W's face and bruises under the ribs (said by Mr Pitchford to have been caused by him holding W). His hands and feet were slightly swollen. A skeletal survey was arranged for W the following day.

On 2 December 2013 the skeletal survey results indicated that W had healing fractures to his fingers of differing ages. An MCH Emergency Department doctor notified CSS of his concerns that W had sustained non-accidental injuries. On this day CSS assessed the notification as "Priority 1", being an incident assessed as having a ‘Very High Risk’ and requiring CSS response within half a day.

On 3 December 2013 a CSS caseworker attended the family at the Kiah Place residence, during which Mr Pitchford provided a different explanation for W's leg fracture. On this occasion, he told the case worker that W was throwing a tantrum but

not mentioning that it occurred whilst changing his nappy.

On 4 December 2013, L and B were interviewed by CSS and expressed fear about Mr Pitchford holding them upside down, threatening to flush their heads in the toilet, throwing balls at them, punching them hard in the arm and waving his hands in front of their face pretending he would hit them. Mr Pitchford had been living in the home for two months at that time.

On 6 December 2013 CSS workers visited the family again and were told by Ms Haywood and Mr Pitchford that on 10 November W had been sitting on the back doorstep and fell forward onto his hands and his face contacting the ground.

On the same day, orders were made under section 20 of the *CYPTF Act* removing W, L and B from the custody of Ms Haywood and Mr Pitchford under a 120-hour order.

On 10 December 2013 the CSS Court Application Advisory Group recommended that further orders be sought in respect of W but not for L and B while they were in the care of Mr Heather.

On 11 December 2013 an interim assessment order was made for W requiring him to leave the care of Ms Haywood and Mr Pitchford. CSS also advised Mr Heather not to allow Ms Haywood to have unsupervised access to L and B and that they should not have contact with Mr Pitchford. The Review noted that CSS did not have lawful grounds to make these requirements of Mr Heather.

On 16 December 2013 CSS visited Mr Heather's home where L and B again told workers that they did not feel safe around Mr Pitchford. Mr Heather told CSS that Ms Haywood was threatening to take the girls back into her care and CSS advised him that if this occurred, legal action to remove them from Ms Haywood's care would be considered.

The following day, 17 December 2013, a four-week assessment order was made in respect of W to protect him whilst CSS continued to assess risk. Following this, Mr Heather returned L and B to Ms Haywood and Mr Pitchford.

By 23 December 2013 CSS had become aware of the family violence incident involving Mr Pitchford occurring in September 2013.

On 6 January 2014 CSS closed its files for L and B. No orders had been sought to protect

them, notwithstanding their apparent fear of Mr Pitchford and W's injuries. The CSS risk assessment was inadequate in numerous respects. No further action was taken by CSS to protect L and B until August 2015, well after Rhiannon's death.

On 14 January 2014 an extension of the assessment order for W was made for 8 weeks.

In January or February 2014, Ms Haywood became pregnant with Rhiannon.

On 21 March 2014 Ms Haywood attended the MCH for an antenatal check-up. As a result of this attendance, hospital staff made an "unborn baby notification" to CSS. The notification, entered into the CSS system on 24 March 2014, provided as follows:

> *"Has had three children under care. Has gained custody back of 2 older girls, but the son born 2012 is still in care. She is currently working with CPS to gain custody back. Is pregnant with 4th child, booking in at 11 weeks gestation."*

On 26 March 2014 CSS records note a discussion between the intake worker, W's child protection worker and case manager. It was agreed that as W's child protection worker was already working with Ms Haywood, the unborn baby notification could be closed with an understanding that another notification would occur if concerns were raised in the future. This decision to close the notification meant that no initial risk assessment or information-gathering occurred in respect of Rhiannon's safety once born.

On 1 April 2014 W's child protection worker was advised of drug charges against Mr Pitchford, but there was no discussion or further investigation by CSS with a view to ascertaining the extent of any drug use by Mr Pitchford which might affect the risk to W or to unborn Rhiannon.

On 4 April 2014 the unborn baby notification in respect of Rhiannon was tabled at the "Three and Under Panel", a review body established by CSS in 2013 to review decisions and actions taken by CSS for notifications involving infants under 3 years of age, including decisions in respect of unborn baby notifications. In this case, the panel assessed the future risk to the baby as *high* because W had recently been placed in care. Harm consequences were rated as *concerning* but harm probability *unlikely* as the baby was only 11 weeks in utero and there was no evidence of Ms Haywood misusing alcohol or drugs at the time. The panel approved the decision to leave W's child protection worker to continue to monitor the family situation during her work with W with the expectation that she would re-notify if there were concerns later in the pregnancy.

On 24 April 2014 CSS visited Ms Haywood and Mr Pitchford at their home with a view to commencing safety planning for W.

On 2 May 2014 Ms Haywood reported to CSS that she was suffering some anxiety and would be attending her general practitioner.

On 5 May 2014 CSS met with C's mother and approved continuing visits by C to the Kiah Place residence. This was apparently done without any adequate assessment of the risk to C.

On 12 May 2014 a family member reported to CSS that L and B were making complaints that Mr Pitchford was threatening to flush their heads in the toilet. CSS made a decision to deal with this notification as part of “W's file” and did not complete an independent risk assessment.

On 15 May 2014 a 12-month care and protection order was made for W with custody granted to the Secretary. W resided in foster care during the currency of the order. Mr Heather had been assessed as not being able to care for W due to several circumstances including his work commitments, housing issues and physical injuries. Mr Heather himself accepted that foster care was a better option than him being responsible for W’s full-time care.

On 20 May 2014 a further notification was made regarding L and B about what was said to be the "toilet game", likely being the alleged threats by Mr Pitchford to flush their heads in the toilet. CSS responded by indicating to the notifier that it would schedule time to speak with the girls. However, this did not happen, nor were these matters discussed with Mr Pitchford or Ms Haywood.

In June 2014 CSS commenced planning to re-unify W with Ms Haywood and Mr Pitchford at the conclusion of the care and protection order.

On 11 June 2014 a family member raised concerns with CSS regarding the impending birth of Rhiannon. CSS advised the notifier that workers had spoken with the parents about getting ready for the birth. Any such discussion by CSS with the parents was not adequate to address the serious risk issues of which CSS were aware.

On 10 July 2014 Ms Haywood reported to CSS that she had arranged counselling in family dynamics and for her own well-being for 24 July 2014. She later cancelled this

counselling session.

On 11 July 2014 CSS met with L and B as part of W's safety planning process. However, a discussion with them about Mr Pitchford's alleged treatment was not initiated by the workers.

On 18 July 2014 Ms Haywood telephoned CSS to ask whether it was suitable for the baby, when it was born, to sleep in the lounge room. CSS provided a letter of support for an application for housing to be made.

In July 2014 Ms Haywood and Mr Pitchford commenced contact visits with W at the East Devonport Child and Family Centre. CSS notes regarding these contact visits record some problematic issues regarding the interaction between Mr Pitchford, Ms Haywood and W.

On 3 September 2014 Ms Haywood advised CSS that she had commenced taking the anti-depressant, Effexor. However, her medical records record that she had been taking anti-depressant medication dating back to the time of her relationship with Mr Heather.

On 24 September 2014, five days before Rhiannon's birth, a CSS Senior Quality Practice Advisor (SQPA) reviewed the CSS worker's reunification readiness assessment for W and reported:

> *"I note that the reunification plan commenced in June 2014 and according to the plan it appears that unsupervised overnight access is taking place…I am not comfortable with providing endorsement on this reunification at this stage for the following reasons:*
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> - *Because I have been unaware of this case until now, I have not had the opportunity to fully familiarise myself with the issues but from my quick review of CPIS today there are significant risk factors present, including: young age of the child; severity of the injuries; absence of any plausible explanation or admission with regard to how W sustained the injuries; an unborn baby alert in place for the new baby that is due any day.*
> - *I have not been asked to review this case prior to now, despite policy requirements that SQPA's endorse all reunification plans and this plan appears to have been in place for some months.*
> - *I can find no evidence on file that the reunification plan has been approved by the*

*manager.*

- *I could not locate a completed reunification readiness assessment or other written risk assessment available on file and, as such, I am unable to make a determination if the risk issues have been adequately addressed to the point where W would be safe to return home or even have unsupervised contact*."

Despite the above advice, W's case worker continued steps to reunify W with his family. Supervised and then unsupervised visits for W at the home of Ms Haywood and Mr Pitchford were arranged.

Rhiannon was born on 25 September 2014. The fact of her birth was not recorded on the CSS file.

On 30 September 2014 Rhiannon was noted at a Child Health Clinic check to be in good health, as she also was at her clinic check of 7 October.

On 6 October 2014 a Reunification Readiness Assessment was prepared. As part of this assessment, W's CSS case worker documented that she had formed the view that W's injuries were the result of *"careless distracted parenting by adults preoccupied with their own problems to the extent that care of the children was rushed and/or unsupervised".* Such a benign conclusion regarding W's injuries was quite patently erroneous. The conclusion should have been that the injuries were most likely deliberately inflicted upon W from within the home.

On 8 October 2014 the SQPA consulted with the same case worker about the reunification plan and noted concerns regarding the case worker's non-acceptance of medical opinion and the acceptance of the parent's explanation for injuries. However, it appears that the SPQA (possibly appropriately for her advice role) took the view that the question of reunification would be for the case worker. The notes record that the case worker held the view that pressing the parents further on the cause of W's injuries would not be productive for reunification plans. Again, such an approach represented very poor practice and resulted in a lost opportunity for assessment of risk to W and, consequently, to Rhiannon.

On 22 October 2014 Rhiannon was taken to the East Devonport Medical Centre with suspected oral thrush. Ms Haywood reported that she had been treating the suspected thrush with Nilstat. It was noted that this medication was not recommended to be used without a doctor's approval. The doctor concluded that Rhiannon did not have oral thrush

and recommended that Ms Haywood cease the use of Nilstat. Rhiannon was noted to have a possible tongue-tie that was not interfering with her ability to suck/feed. There were no other recording about Rhiannon's health or care.

On 15 November 2014, Ms Haywood took Rhiannon to the MCH with a complaint about a "wet mucousy cough". Rhiannon was diagnosed with suspected bronchiolitis and returned home with her parents. The advice from the hospital was that they should use Vicks rub and a vaporiser and, if the condition worsened, to go to the North West Regional Hospital. Ms Haywood reported that she subsequently contacted the hospital to advise them that she was giving Rhiannon "Little Coughs" syrup. There is no record of this contact in the hospital records and I doubt that Ms Haywood made such contact. The administration of inappropriate medication to Rhiannon, a very small infant, does not appear to have caused any harm but shows a lack of understanding on Ms Haywood's part of the medical needs of an infant.

On 17 November 2014 Ms Haywood and Mr Pitchford took Rhiannon to the Child Health Clinic for her 8-week health check. She was recorded as having gained weight and was being bottle-fed with formula. The child health nurse notes indicate that risks associated with sudden infant death syndrome were discussed with Ms Haywood. The risks and recommendations are set out in the blue child health book belonging to the parents. Relevantly, the standard advice likely given by the nurse would have included a caution against sharing a sleep surface with Rhiannon due to the increased risk of sudden unexpected death in infancy. The file also noted that Rhiannon had bronchiolitis and had not had a general practitioner check-up or her immunisations. Her length was below the third percentile and she had short femurs. Her length was to be reviewed at the 3-month check. There was also a note in Rhiannon's blue book that Rhiannon, *"rolls front to back, very bright and alert!"*. This information was provided by either Ms Haywood or Mr Pitchford. The State Forensic Pathologist, in evidence at inquest, stated that it is very unlikely that Rhiannon at this age could roll as described. I find that the statement made to the nurse was incorrect.

On the same day, 17 November 2014, W spent his first unsupervised night at the Kiah Place residence with Ms Haywood and Mr Pitchford pursuant to the reunification plan. On the following day a CSS support worker attending to collect W raised concerns with CSS about the state of the home describing an unpleasant odour of animal faeces in the house, noting the sister was feeding Rhiannon a bottle and that W was taken to the car by his

sisters. The worker also raised concerns about Ms Haywood's apparent detachment from W.

**Circumstances surrounding Rhiannon's death**

The evidence at inquest concerning the immediate circumstances surrounding Rhiannon's death came from Ms Haywood and Mr Pitchford as well as their friends, Deborah Randall and Mark Lowrey, who were present at the Kiah Place residence during the evening. The evidence of Ms Haywood and Mr Pitchford is not, for reasons further discussed, credible or reliable in many important respects. Both presented as unwilling to assist the Court and persistently gave self-serving, contradictory and untruthful answers to important questions. In a further part of this finding, I discuss in more detail my reasons for this conclusion.

By contrast, the evidence of Ms Randall, and to a lesser extent Mr Lowrey, was helpful and reliable. Whilst they had an illicit drug addiction at the relevant time, both have since rehabilitated, removed themselves from Ms Haywood and Mr Pitchford and were able to provide objective evidence.

From a time shortly after Rhiannon's birth, Mr Pitchford, Ms Randall and Mr Lowrey commenced together to inject morphine at the Kiah Place residence on a daily basis. Ms Randall and Mr Lowrey gave evidence that they were friends of Mr Pitchford and Ms Haywood and had been regular visitors to the Kiah Place residence since October 2014. They gave evidence that they were addicted to morphine, as was Mr Pitchford, and they would visit the residence to receive morphine illicitly from Mr Pitchford and inject it.

A room that had been Mr Pitchford and Ms Haywood's bedroom had been converted into an "adult room", used for injecting morphine. Although Ms Haywood was accepting of the injection of drugs in the house, it does not appear that she injected morphine regularly or at all at that time. The double bed had been moved into the open plan kitchen and lounge room area of the house and a bassinet for Rhiannon was also in that area. There were various accounts of when the double bed had been moved into the lounge area. I find that it had been in that area for at least a number of days prior to 18 November 2014. Ms Randall gave evidence that she sometimes saw Rhiannon in bed with Ms Haywood, sometimes with both Ms Haywood and Mr Pitchford, and often in her own bassinet.

Ms Randall and Mr Lowrey gave evidence that they had gone to the Kiah Place residence on the afternoon of 18 November 2014 and used morphine.

Ms Haywood, in her affidavit sworn on 19 November 2014, provided very little detail as to the events of the night and following morning. She stated that the family went to KFC for dinner between 7.30pm and 8.30pm that evening. In evidence, however, she said that she had no memory of this event. It is clear that Ms Randall and Mr Lowrey did not go with them, although they returned to the Kiah Place residence later that evening at about 10.00pm where they used more morphine. Mr Pitchford was unable to recall the trip to KFC or the presence of Mr Lowrey and Ms Randall in the house.

Ms Randall gave evidence that after she had used morphine she sat with Ms Haywood on the double bed. Rhiannon was in the bassinet in that room. Mr Pitchford was cleaning and moving furniture in the "adult room". Ms Randall said that Mr Pitchford was in a very active mood consistent, in her experience, with him having used “ice” (methamphetamine) that evening.

The evidence of Mr Lowrey and Ms Randall allows me to find that Rhiannon woke from her bassinet at about 11.00pm and was picked up and held by Mr Lowrey, while Mr Pitchford prepared a bottle for her. Mr Lowrey then handed Rhiannon to Mr Pitchford before leaving at around 11.00pm. Mr Lowrey and Ms Randall did not see Mr Pitchford putting Rhiannon on the bed or feeding her.

Ms Haywood’s evidence that she last fed Rhiannon between 7.00pm and 8.00pm does accord with the other evidence, as does her statement that Mr Pitchford fed Rhiannon at around 11.00pm. Ms Haywood herself was in the bed by this stage, still awake, and remained there.

Mr Pitchford also said that he fed Rhiannon at about 11.00pm. This time is consistent with the evidence of Ms Randall and Mr Lowrey.

After Mr Lowrey and Ms Randall left the residence, the circumstances surrounding Rhiannon’s death were then only known to Mr Pitchford and Ms Haywood.

L and B, both aged under 10 years, were present in the house but there is no evidence about their movements at the house that evening.

Mr Pitchford said Rhiannon only took “a bit” of formula and she then fell asleep. He said that he put Rhiannon on the bed to feed her. In his initial affidavit, sworn on 19 November 2014, Mr Pitchford said that he placed her in bed with her head on a pillow. However, Mr Pitchford's evidence at inquest was very different, being that he placed Rhiannon

lengthways on her back on a memory foam pillow with a blue dragon patterned pillowcase (“the dragon pillow)” and that she fell asleep on that pillow in the same position. He said that Rhiannon was on his side of the bed (the left side when facing the bedhead) and Ms Haywood was on the other side of the bed. He said that there was a space between them.

Ms Haywood, in her evidence at the inquest, supported Mr Pitchford's statement that Rhiannon had been placed lengthways upon the dragon pillow. However, this was an account that she had never previously given at any time during the investigation.

In their evidence at inquest Mr Pitchford and Ms Haywood both asserted that they had no recollection of that evening other than Rhiannon being put in the bed to feed and then sleep at about 11.00pm. According to Mr Pitchford, he did not sleep or lie upon the bed at all during the evening or following morning at any time. Instead, he stayed up, moving items around the house. In particular, it appears from Ms Randall’s evidence that he was rearranging items in the adult room. Mr Pitchford was consistent in providing this unusual account of his movements. I find that he was under the influence of drugs, most likely morphine and methamphetamine.

Ms Haywood, in her initial affidavit sworn on 19 November 2014, said that she awoke at about 3.30am and found Rhiannon lying on her side and not moving.

In her evidence at inquest, Ms Haywood insisted that Rhiannon was never lying on her side but was on her back. She admitted, however, that she may have said this to the police officer taking the affidavit. Her affidavit was made shortly after Rhiannon’s death and it is more likely to be accurate. Further, Ms Haywood gave evidence at inquest that she liked to cuddle Rhiannon in bed, which may suggest that she was placed on her side for this purpose.

Mr Pitchford, in his affidavit, said that between 3.00am and 4.00am he was in the kitchen rolling a cigarette when Ms Haywood woke and started shouting "Bub!” Ms Haywood said in her affidavit that she did not know why she woke but had “this horrible feeling”. She said that she was facing the hallway (away from Rhiannon) and “quickly spun around” to see Rhiannon on her side and not moving. I do not accept at face value this self-serving evidence of Ms Haywood.  She said that she then shook Rhiannon and lifted her up. Mr Pitchford, in his affidavit, said that he ran over and found Rhiannon in the same spot on the bed in the same blanket, blue in colour and not breathing. He did not refer to her lying on the dragon pillow. He said that he started CPR upon Rhiannon on the end of the bed.

Mr Lowrey, in his affidavit sworn in August 2016, stated that he received a phone call from Mr Pitchford between 3.00am and 3.30am who said, "Bubby's dead". He and Ms Randall went back to the Kiah Place residence and found Ms Haywood on the front step, Rhiannon on the bed and Mr Pitchford in the kitchen, screaming. Mr Lowrey stated that he and Ms Randall performed CPR upon Rhiannon and told Mr Pitchford and Ms Haywood to ring an ambulance and the police. Ms Randall, in her affidavit, said that when they arrived at the residence between 3.00am and 3.30am the ambulance had not been called.

At the inquest, Ms Haywood gave evidence that she called Ms Randall and Mr Lowrey and then called an ambulance. She said that Mr Pitchford was trying to resuscitate Rhiannon and that he then phoned his mother.

The records from Ambulance Tasmania record a call between Ms Haywood and the operator commencing at 3.39am and ending shortly after 3.46am. In that call Ms Haywood was clearly distressed and volunteered to the operator on two occasions that she did not “lay on the baby”.

In summary, the evidence indicates that between 3.00am and 3.30am, several hours after Rhiannon was placed on the bed, she was found unresponsive whilst still in the bed with Ms Haywood.

The ambulance and paramedics arrived at the residence at about 3.50am and arrived at the MCH at about 4.10am on 19 November 2014. Rhiannon was transported on her back in the ambulance with paramedics continuing to attempt resuscitation. The ambulance records note that there was no CPR in place prior to Ambulance Tasmania arriving. One of the attending paramedics, Mr Stephen Brownrigg, gave evidence that that information would have come from questioning the occupants of the house when they arrived.

I find that Mr Pitchford did not perform CPR on Rhiannon, likely due to his highly emotional state. It is possible that Ms Randall and Mr Lowrey did so but that they were not questioned by the ambulance personnel. Notwithstanding any delay by the parents in performing CPR it is likely that Rhiannon was deceased and not able to be revived at the time she was discovered. The evidence indicates that neither parent, by reason of temperament, inadequate knowledge and (in Mr Pitchford’s case) drug intoxication was equipped to effectively try and revive their daughter.

It is also possible that there was a delay, possibly of up to 40 minutes, between the time Rhiannon was discovered deceased and the time that the ambulance was called. However, I

am satisfied that there was no intentional act done by either Ms Haywood or Mr Pitchford to cause Rhiannon's death. There was no detectable motivation or reason for them to deliberately hurt Rhiannon, their joint child for whom they had affection. Further, the circumstances and their accounts do not indicate homicide as much as accidental overlay.

Mr Pitchford and Ms Haywood went with Ms Randall and Mr Lowrey to the MCH where Rhiannon was formally pronounced deceased.

On the morning of 19 November 2014 both Senior Constable Woodrow, investigating officer, and forensics officers conducted a walk-through of the Kiah Place residence. Senior Constable Woodrow gave evidence that he observed a queen-sized bed in the lounge room (although the forensics officer reported it as a double bed) which had obvious signs of having been slept in. He observed a large number of cigarette butts on the kitchen floor outside the front door and several full ashtrays in the lounge room and kitchen. He also located syringes, a syringe disposal container and a cannabis-smoking pipe in the bedside drawer, attached to the bedhead of the bed in the lounge room. The drawer was unlocked and accessible to children. He said that when he went into a rear bedroom of the property he noticed a strong smell of smoked cannabis. The photographs taken by the forensics officer depict an unkempt and dirty house consistent with Senior Constable Woodrow's observations.

In his evidence at the inquest, Senior Constable Woodrow said that he had attended the MCH and had seen Rhiannon's body. He noted that she had lividity (pooling of blood close to the surface of the skin) on her front and back. As will be further explained with reference to the medical evidence, this lividity indicates that Rhiannon was in a facedown or largely facedown position at the time of her death.

I reject the evidence given at inquest by Mr Pitchford and Ms Haywood regarding the position in which Rhiannon was placed in the bed at 11.00pm on 18 November. The evidence that she was placed on the dragon pillow was very obviously a recent invention by both Mr Pitchford and Ms Haywood (in concert) in an attempt to portray that Rhiannon was not in an unsafe sleeping environment. Mr Pitchford is more likely to have given a more accurate account to police on 19 November 2014 in indicating that Rhiannon was placed on her side in the bed (implying directly onto the mattress) rather than lengthwise on the dragon pillow.

In this regard, the photographs taken by police on the morning of 19 November 2014 show

the dragon pillow on the right-hand side of the bed (when facing the bedhead) and a flower-patterned pillow (“the flower pillow”) on the left-hand side closest to the window. A bloody, "mucousy" stain was found on the flower pillow in a position consistent with where a baby’s head might be placed for the purpose of sleeping. Mr Pitchford's explanation at inquest for the fact that the dragon pillow was on the right-hand side when the police photographs were taken was that L and B must have swapped them around after Rhiannon’s death but before police attended the residence. This assertion was inherently implausible and represented a typical example of the propensity of Mr Pitchford and Ms Haywood to invent evidence that might assist their cause. Ms Haywood and Mr Pitchford were both at pains to name the dragon pillow a “memory foam” pillow, when in reality the photographic evidence showed that it comprised merely a pillowcase filled with what appeared to be small offcuts of foam. Again, I find that such evidence was deliberately and inaccurately given to attempt to convey that Rhiannon was in a safe sleeping environment.

Further, Senior Constable Woodrow, who attended the residence after Rhiannon’s death on 19 November, completed a Report of Death for the Coroner and completed a Sudden Unexpected Death in Infancy (SUDI) checklist in the days following death. He said the information used to complete this checklist would have been obtained from the parents and most likely from their affidavits prepared on 19 November 2014. The SUDI checklist included notes that the mattress was in good condition, that Rhiannon had been found deceased on her *left side* at 3.30am and that she had been placed to sleep on the *left side*.

Senior Constable Woodrow also gave evidence about the difficulties he had encountered in having Ms Haywood and Mr Pitchford co-operate with him in providing further information in the investigation. He gave evidence that even after speaking to them and assuring them that he was not conducting a criminal investigation they failed to attend planned meetings or return phone calls. Whilst grief manifests in many different ways, I would have expected Ms Haywood and Mr Pitchford to be concerned to find answers surrounding the death of their infant daughter and, to that end, provide the coronial process with important information known only to them to enable the cause of death to be determined. As discussed further in summarising my findings, it appears that Ms Haywood and Mr Pitchford may well be aware of matters of which they have not provided evidence.

**Medical evidence of the cause of death**

On 19 November 2014, an autopsy upon Rhiannon was conducted by State Forensic Pathologist, Dr Christopher Lawrence. In concluding his report, Dr Lawrence stated:

> *"Autopsy reveals no obvious cause of death. There is lividity on the anterior surface of the body consistent with being in a facedown position for some time. It is not clear whether this has occurred in the bed or during transport subsequently. It appears that she was sleeping in an unsafe sleeping environment. There is evidence of an upper respiratory infection with rhinovirus and bronchiolitis. Toxicology shows a 4% carbon monoxide level which suggests passive smoking."*

Thus, Dr Lawrence identified that, despite there being no obvious anatomical cause of death, the risk factors that may be contributors were Rhiannon's facedown position, bed sharing, environmental smoking and upper respiratory infection with rhinovirus and bronchiolitis.

Dr Lawrence also gave evidence at the inquest and noted a further risk factor to be that Rhiannon was a small baby for her age.

Dr Lawrence said that the actual cause of death is unclear in cases of this type but most of the research suggests cause of death arises from respiratory compromise.

He said that the level of carboxyhaemoglobin on the toxicological examination suggesting exposure to passive smoke is unlikely to have come from being held against clothing of a smoker, as suggested by Ms Haywood in evidence. He said that parental sedation or intoxication would also be a risk factor in bed-sharing. In this regard, it is well known that a parent affected by drugs or alcohol may not rouse upon accidentally smothering the infant. He said that he was not able to medically determine if an overlay occurred because of the lack of signs at autopsy. He said that, due to the risk factors in sudden infant death, the recommendations are that children do not use an adult pillow or bedding or sleep in an adult bed with an adult, and should not be exposed to smoking. These factors give rise to a high risk of breathing problems, particularly in a child with respiratory infection.

Ultimately, Dr Lawrence described Rhiannon's death as sudden infant death whilst bed-sharing with risk factors, reflecting the fact that the ultimate cause of death was undetermined but recognising the likely role of an unsafe sleeping environment.

Further, Dr Lawrence described the position of the lividity upon Rhiannon and gave evidence that, as she was transported to the hospital on her back, lividity formed in that area. He gave evidence that the lividity on Rhiannon's front prior to transport supports that she was lying face down or largely face down at her death.

I accept the opinions expressed by Dr Lawrence concerning Rhiannon's death.

**The lay witnesses**

The lay witnesses who gave evidence at the inquest were Ms Randall, Mr Lowrey, Ms Haywood and Mr Pitchford.

Mr Dean Heather, the father of L, B and W, was also called at short notice to give evidence, to be given an opportunity to answer suggestions by Ms Haywood that he had mistreated or abused L and B and may have been responsible for the injuries to W. It was not contemplated that Mr Heather would be subject to criticism in connection with Rhiannon's death.

The evidence of these witnesses covered the matters of circumstances of death, parental capacity and risk to Rhiannon. It is appropriate to discuss their evidence that has not already been dealt with and to make further findings relevant to the issues being considered in the inquest. I do so with particular reference to the evidence of Ms Haywood and Mr Pitchford.

I summarise the main factual findings surrounding Rhiannon's death at the conclusion of this discussion.

*Evidence of Joshua Pitchford*

Mr Pitchford was not a credible witness. His contradictory and fabricated evidence concerning important matters surrounding Rhiannon's death has already been discussed. On many wider issues, his evidence was equally implausible and unsatisfactory.

In oral evidence at inquest, Mr Pitchford was adamant that he was not responsible for W's injuries on the basis that he and Ms Haywood had been told by CSS that the fractures to W's fingers occurred prior to him moving into Ms Haywood's household. There is no evidence supporting the proposition that the injuries to W occurred before Mr Pitchford moved in with Ms Haywood. The reports of W's injuries by Ms Haywood to the hospital and the hospital records themselves support the injuries being close to the time of W's presentations. There were no similar injuries to W before Mr Pitchford moved into the household. Mr Pitchford's explanation at inquest of the cause of W's injuries varied, just as the hospital records also noted differing explanations given by him and Ms Haywood for W's injuries. As already noted, these accounts respectively included attributing blame to L and B, attributing them to W's behaviour and attributing them to when W was with Mr Heather.

Mr Pitchford also denied making threats to flush L and B's heads in the toilet but agreed he may have threatened it as part of a game. He did not believe he scared the children or at

least did not intend to do so.

It is not necessary or desirable to make a factual finding as to whether Mr Pitchford caused W's serious injuries. There is credible evidence from Ms Randall that Ms Haywood was rough and hostile to W whilst Mr Pitchford was loving and affectionate. The important fact is that CSS should have proceeded by recognising that the injuries were deliberately inflicted within the home of Ms Haywood, that Mr Pitchford was quite likely responsible and Ms Haywood unable to protect him.

Mr Pitchford admitted abusing drugs for many years, commencing with a heroin addiction at the age of 12 years. However, he denied that he was dealing in drugs. He said that he would pick up supplies of morphine for Ms Randall and Mr Lowrey who would pay him. He agreed that Ms Randall and Mr Lowrey started coming to the Kiah Place residence after Rhiannon's birth. He said that CSS had requested a third party to be present as part of the plan for W to stay overnight and that he and Ms Haywood asked Ms Randall and Mr Lowrey to perform that function, as they had no one else. He estimated that Ms Randall and Mr Lowrey were visiting the residence regularly for approximately five weeks before Rhiannon's death. He said that he used both morphine and cannabis on a daily basis. Mr Pitchford admitted using "ice" (methamphetamine) but only away from the house prior to Rhiannon's death.

At the inquest, Mr Pitchford gave evidence that he never smoked cigarettes around Rhiannon. Instead, he stated that he smoked at the outside door. Like Ms Haywood, he said that the effects of passive smoking shown by the toxicology results would have been because Rhiannon had been held against their clothes. He said he smoked 20 to 30 cigarettes per day and would bring the butts inside to the ashtrays because those butts might be stolen. Again, this evidence was simply fanciful, although he appeared to genuinely believe that I would entertain it as plausible. Mr Pitchford said that he only smoked cannabis in the adult room with the door shut. I reject this evidence, and reject the evidence that he only smoked outside.

The evidence given by Mr Pitchford at the inquest as to the extent and nature of his drug use and smoking around Rhiannon was inconsistent with the credible evidence of Ms Randall and Mr Lowrey. Ms Randall stated that the house was filled with haze from cigarettes and cannabis smoking and there were no restrictions on smoking in the house. The evidence is also inconsistent with the evidence of cigarette butts and overflowing ashtrays in the house reported by Senior Constable Woodrow following his inspection of the house on 19 November 2014.

In his affidavit of 19 November 2014, Mr Pitchford stated that Ms Haywood was the mother of Rhiannon and that "*we are not really together any more*". In evidence at the inquest, he disputed that this was a reference to Ms Haywood, but rather to his former partner with whom he said he had argued a lot. I do not accept his explanation. It is clear that he was referring to Ms Haywood in his affidavit and for some reason he was not being truthful about their relationship. Ms Haywood gave evidence that Mr Pitchford received a carer's pension for looking after his mother in New Norfolk. This may be inconsistent with his living arrangements with Ms Haywood. The evidence from all of the CSS records is that he and Ms Haywood were a couple and that they have continued in this relationship.

This falsehood, again, demonstrates the tendency of Mr Pitchford to avoid giving an honest account of matters that he believed would reflect poorly on his character or which he believed might have repercussions for him.

*Evidence of Kylie Haywood*

The evidence of Ms Haywood, like that of Mr Pitchford, was unhelpful. In constantly attempting to deflect responsibility from herself, her evidence was at odds with the other objective or credible evidence.

Ms Haywood's evidence on several important points was given as a result of discussions with Mr Pitchford. For example, she also gave evidence that she and Mr Pitchford only smoked cigarettes outside, this evidence being patently untrue. The identical and false evidence given by both Ms Haywood and Mr Pitchford regarding Rhiannon sleeping on the dragon pillow is another example. Her evidence of a lack of memory of events before Rhiannon's death is a further example.

When questioned about the finances of the house, Ms Haywood said that Mr Pitchford spent about $30 per day on cigarettes, perhaps $50 a day on cannabis and $500 per week on morphine. She acknowledged that this would amount to around $1100 per week. She said that Mr Pitchford received his own separate payment from Centrelink because he was a carer for his mother and did not know where he found the additional money for his drug use. Nevertheless, she insisted that he was not dealing. She said that she had a household budget and always had enough money to feed and clothe the children.

Ms Haywood said that she smoked 15-25 cigarettes per day. She agreed she used over the counter pain medication but only in accordance with the instructions. At one stage, she was

tested positive for methamphetamine by CSS – stating that the ‘ice’ penetrated into her hair follicles by having been present in the house where others were smoking it.

Ms Randall gave evidence that Ms Haywood did not use morphine or ice, but would use Panadeine Forte or Panadol with a calmative and would take 4 to 5 tablets each time.

It does not make logical sense that the children’s needs were able to be satisfied, given the extremely large expenditure on tobacco and drugs.

Ms Randall gave evidence that Ms Haywood took a number of “calmative” tablets on the evening of 18 November. I accept her evidence.

When asked about saying to Ambulance Tasmania during the phone call after she found Rhiannon, "I didn't lay on her", Ms Haywood said that she made the statement because she did not want to get blamed for Rhiannon’s death - a most unusual statement to make in this emergency context concerning her own child. She gave evidence that she was always aware of the baby even when she was asleep. This is contrary to the research, as indicated by the evidence of Dr Lawrence.

Mr Lowrey also gave evidence that some months after Rhiannon's death, he and Ms Randall had visited Mr Pitchford and Ms Haywood and had used drugs. At one stage during that visit, they were all in the car when he heard Ms Haywood say, "I killed bubby". He did not know whether she meant it. Ms Haywood denied saying this, and none of the other witnesses could recall Ms Haywood saying those words that evening.

She acknowledged that she was aware from the time of first having her children of the dangers of co-sleeping but said that she had nevertheless co-slept with each of them as babies. It is apparent that she has not seriously reflected upon or accepted safe-sleeping recommendations, even after Rhiannon’s death.

Subsequent to Rhiannon’s death, Ms Haywood and Mr Pitchford have had two more children, M and D, who were subject of CSS notifications and who are now living in foster care pursuant to care and protection orders.

In relation to all of her five children not being in her own care she explained that this was due to her current homelessness, Mr Pitchford’s drug use and his mental health. Ms Haywood apparently had no insight into her own poor parenting skills, mental health issues and her dysfunctional relationship with Mr Pitchford.

Despite the commencement of W's physical injuries coinciding with Mr Pitchford moving into the family home and despite the lack of evidence of any concerns about L, B and W while she was with Mr Heather, Ms Haywood maintained that Mr Pitchford would not have caused any harm to W. She did, however, acknowledge that he was awake a lot at night and would have had the opportunity to interact with W whilst she was asleep.

Ms Haywood raised in her evidence that Mr Heather could have been to blame for W's injuries because he had not wanted a third child. Ms Haywood said she did not trust Mr Heather with the children because she had seen photos on a shared camera of L and B naked and in provocative sexual poses. She said that she had deleted the photographs and did not contact the police. She agreed that she did not tell the police about the photographs when she initiated contact with police on 14 November 2013 concerning potential abuse of W. She also stated in evidence that she reported to CSS that one of her daughters had a urinary tract infection but did not mentions the photographs.

In evidence, Mr Heather stated that he had thought that before W was born, two children were enough, but agreed to have a third child because Ms Haywood had wanted to do so. He said he was happy enough with the situation after W was born.

Mr Heather presented as a careful and candid witness and I accept his evidence in full. He said that he was aware, through CSS, of investigation into injuries to W. He did not recall any injuries to W while W was in his care, apart from once when putting a jumper on him and his fingers bent back on his right hand. He said W seemed unhurt after that event.

Mr Heather said L could be a bit boisterous in rough-and-tumble play with W but he would make sure he kept an eye on her.

He said he had been aware of allegations made by Ms Haywood about possible abuse when B had been diagnosed with a urinary tract infection. He said CSS came back to him eventually and said it was a hygiene problem and he realised then that the girls may not have been bathing while they were at his house.

Mr Heather said that he had not been aware before it was put to him at the inquest that he had taken photographs of L and B in sexually provocative poses. He denied having ever done so and said he felt uncomfortable even having photographs of his children as infants without clothes on. Ms Haywood herself said that in the 11-year relationship with Mr Heather, she had no concerns about his behaviour towards the children.

I fully accept Mr Heather's evidence. He was considered and rational. It does Ms Haywood no credit to make such damaging and completely false allegations in order to deflect responsibility from herself and Mr Pitchford.

All of the evidence (including CSS records of its dealings with Ms Haywood and Mr Pitchford) points to an unremitting, blind loyalty by Ms Haywood to Mr Pitchford, which has continuously impeded her from placing the safety of her children ahead of her relationship with him. This continues to be the case, as demonstrated by her evidence, even though Mr Pitchford is currently subject to a Police Family Violence Order protecting her. The inconsistencies and inherent implausibility in many parts of her evidence demonstrate the lengths to which she was prepared to go in her quest to deflect blame away from her actions and those of Mr Pitchford. Whilst the relationship continues and her lack of insight remains, she does not have the ability to provide adequate care or protection for her children. The evidence also contained a comprehensive assessment for CSS in 2016 by psychologist, Mr Damien Minehan, who notes the presence of serious parenting deficits on the part of Mr Pitchford and Ms Haywood. These include the continuing unsatisfactory accounts of W's injuries, violence in the relationship, drug use, lack of motivation and direction, an unhealthy lifestyle and poor co-operation with CSS.

**Summary of factual findings and immediate causes of Rhiannon's death**

I find that on the afternoon of 18 November 2014, Ms Randall and Mr Lowrey attended the Kiah Place residence for the purpose of injecting morphine provided by Mr Pitchford. Ms Haywood was present in the house, as were Rhiannon and her older sisters. At about 7:30pm the family, excluding Ms Randall and Mr Pitchford, went to KFC for dinner and returned at about 8:30pm. Ms Randall and Mr Lowrey returned to the residence at about 10.00pm where they used more morphine. Mr Pitchford quite possibly also injected methamphetamine. During the evening, Rhiannon had been in her bassinet in the main lounge room area but woke at about 11.00pm and Mr Pitchford prepared a bottle for her.

Ms Haywood was in a somewhat sedated state by virtue of taking several over-the-counter medications but she did not use drugs intravenously that evening. She had been lying in the bed awake during the time when Ms Randall and Mr Lowrey were present and was aware of Mr Pitchford feeding Rhiannon and then putting Rhiannon in bed beside her.

Mr Pitchford placed Rhiannon on her side with her head on the flower pillow to sleep on the left-hand side of the bed while Ms Haywood was on the right-hand side of the bed. Both Ms

Haywood and Rhiannon then fell asleep.

At some stage, most likely during the early hours of the morning, Rhiannon died in unwitnessed circumstances in the bed. Rhiannon's face was wholly or partly in contact with the flower pillow at the time of her death. She may also have been covered in other bedding or by the body of Ms Haywood.

I find that Ms Haywood was fully aware of the risk of death in sharing a sleeping surface with an infant. She was also aware that the supine position was the correct position for an infant to sleep safely, rather than the side sleeping or prone position.

I find that Mr Pitchford was not in the bed at any time during the evening but moved around the house in close proximity to where Ms Haywood and Rhiannon were sleeping. He was significantly under the influence of illicit intravenous drugs. He did not attempt at any time to place Rhiannon back into her bassinet where she would have been protected from the risks of being smothered by an adult body or adult bedding. He did not check, or at least adequately check, that Rhiannon was lying on her back in bed with her face free from obstruction.

I am able on the basis of the forensic evidence and lividity to find that Rhiannon's face down position compromised her breathing and was a direct contributor to her death. The movements of Ms Haywood in the bed and movement of the bedding is likely to have caused her face and body to turn into the pillow to a greater degree from a side-sleeping position. She did not have the physical ability to remove her face from this position. She is unlikely to have died if her face had been free from obstruction in this unsafe sleeping environment. Significant risk factors in her death were the high levels of smoking within the house, the level of sedation of Ms Haywood, the level of drug intoxication of Mr Pitchford and Rhiannon's mild bronchiolitis. In light of my finding regarding her respiratory compromise from contact with the bedding, I do not accept that Rhiannon died from purely natural causes.

Ms Haywood and Mr Pitchford did not attempt to perform CPR upon Rhiannon. They were ill-equipped to do so and likely realised that she was already deceased. It is possible that guilt concerning the circumstances surrounding her death, particularly drug use and condition of the house, may have been the reason for any significant delay in calling the ambulance.

Notwithstanding their responsibility for her death in an unsafe environment, I am satisfied

that there was no deliberate act by Ms Haywood or Mr Pitchford done to cause Rhiannon's death.

**Inaction of CSS as a factor in the death of Rhiannon**

As is apparent from the earlier chronological account of CSS involvement pertaining to Rhiannon, that there were critical failures in processes and decision-making leaving her exposed to the high risks that were associated with her death.

Unfortunately, there were lengthy delays in the provision by CSS of information for the coronial investigation and therefore took some time to ascertain the scope of the enquiry. It is appropriate now to discuss this issue.

*Provision of information to the Coroner*

It was apparent within several days of Rhiannon's death that CSS was involved with the family. Therefore, on 24 November 2014, a letter was sent from the Coroner's Office asking a CSS manager in Burnie to provide a report to the Coroner concerning CSS involvement with Rhiannon, her siblings, and Mr Pitchford and Ms Haywood. There was no response to that letter.

On 18 May 2016 a further letter was sent to the CYS office in Launceston requesting all protection records relating to Rhiannon or her parents.

On 1 June 2016 a response was received from CSS providing the Coroner's Office with 8 pages of records and a brief letter advising that CSS did not hold any file in relation to Ms Haywood or Mr Pitchford. The pages provided did not refer to the important matter of W sustaining injuries that were likely deliberately inflicted. The author (being the Director, Children and Family Services) advised that CSS did have files relating to Rhiannon's half siblings W, B and L and offered to provide those files if they were required. It should have been apparent to CSS at this point that there was a need to provide to the Coroner's Office all records of family members to assist the investigation.

On 20 January 2017 I exercised my powers under section 59 of the Act to require the production of all CSS records relating to Ms Haywood and Mr Pitchford.

In April 2017 these records were delivered to the Coroner's Office. They were contained in five lever-arch folders, in paper format and were difficult to interpret so as to properly understand CSS involvement with Rhiannon, her siblings, Ms Haywood and Mr Pitchford.

In order to progress this issue, I sought the opinion of consultant, Ms Suzanne Botak, a former senior practitioner with CSS. Ms Botak undertook a separate review of the CSS records and provided a report prior to the ultimate provision to me of the CSS Review. In her detailed report, she noted CSS failures to properly investigate, document and act upon the risks to Rhiannon prior to and at the time of her birth.

On 30 January 2018 the Coroner's Office, at my request, sent a letter to the Deputy Secretary of CYS outlining the scope of the coroner's investigation into Rhiannon's death, indicating that Ms Botak was conducting a review of CSS involvement with the family, noting that an inquest was likely to be held.

Ms Botak's report was provided to CYS on 24 April 2018 with a request for a response and a copy of any review that had been conducted by the Department.

On 14 June 2018 a follow-up email was sent requesting a response to the letter of 24 April 2018.

On 18 June 2018 the Coroner's Office received the Review and a response to Ms Botak's report.

Ms Schokman submitted that the difficulty in eliciting information from CSS indicated a failure to respect and support the functions of the coroner to investigate all relevant circumstances pertaining to Rhiannon's death. Ms Chen submitted that the delays arose out of a lack of proper processes. It seems, unfortunately, that both matters were contributors.

*Deficits in CSS practice*

The CSS Review provided a detailed analysis of the CSS failings in respect of Rhiannon. There was very little discrepancy between the views of Ms Botak and the conclusions of the Review as to the ways in which CSS failed to adhere to documented processes and policies.

Ms Botak gave evidence that the content and recommendations contained in the Review were very sound. I accept that this is the case. The Review is a clear, thorough, and well-reasoned document that provides a forthright analysis of the issues.

The Review included the following conclusions epitomising CSS inadequacies:

> *"At the time pre-birth notification was made, CSS had information known and information available to make a risk assessment. The recent history of multiple,*

*serious, non-accidental injuries to the (then) 20-month-o/d W, whilst in the care of his mother, Kylie Heather and her partner Joshua Pitchford, should have been central to the risk assessment. Neither adequate explanation nor responsibility for these injuries has been provided. In addition, there was relevant recent history regarding parental substance use, family violence, the notification history concerning sexual abuse and emotional abuse concerns. This indicated a high risk for this infant upon birth and formed the basis for the involvement of CSS both prior to and at the time of Rhiannon's birth for the purpose of completing an assessment under section 18 (1) of the CYPTF Act 1997. "*

And;

*"The application of risk assessment, using the Tasmanian Risk Framework, was absent, incomplete or inconsistent throughout the life of this case. Lack of, or poor information gathering with analysis and judgement not supported by the information known and/or available, is evident. Additionally, reported concerns were viewed in isolation and not considered as part of a broader picture of risk. Further, some concerns were never assessed. This has cascaded throughout the involvement of CSS with W and various siblings, including Rhiannon, and is found to have influenced and likely compounded poor decision-making at key points."*

Most relevantly, the issues directly impacting upon proper assessment of Rhiannon's unborn baby notification made in April 2014 can be summarised as follows;

- The child protection history for all siblings should have been documented and considered within a comprehensive cumulative harm framework, for which information-gathering guidance was provided in the CSS Practice Manual. The Initial Assessment document for Rhiannon contained no information about her siblings. Adequate review of the child protection history of Rhiannon's siblings would have identified substantiation of physical and emotional abuse, with Ms Haywood and/or Mr Pitchford being identified as likely being responsible for serious physical harm to W.
- Information should have been gathered and documented from a number of sources. In particular, the notifying staff in the ante-natal clinic were well-positioned to provide information about Ms Haywood's ante-natal care attendance and to communicate with CSS to assist in its assessment. Further, there is no evidence of any history checks being completed in relation to the parents or information gathered from them

in personal interviews. The Child Health and Parenting Service should have been contacted in relation to the pregnancy to provide any relevant information as well as to be provided with details of the possible risk to Rhiannon.

- There is an absence of recorded risk assessment, contrary to the procedures set out in the CSS Practice Manual. The notification was prematurely closed without any assessment, with the notation that W's case manager would work with the parents in preparation for the birth and re-notify if repeated concerns presented. However, there was no record of clear agreements, guidance or a plan regarding what was required during this phase of work.
- There was a failure to appreciate that multiple risk factors were present when the notification was received. Apart from the parental abuse already referred to, these included poor parenting skills, Mr Pitchford's history of perpetrating family violence and recent history of drug use. There was a failure to appreciate the further signs of risk that subsequently arose – including Ms Haywood cancelling a counselling appointment, Mr Pitchford leaving supervised visits for extended periods of time before returning, reports that L and B's school attendance was poor and reports that participation of Ms Haywood and Mr Pitchford at playgroup with W was poor.
- The closure of the Initial Assessment was erroneously supported by the Three and Under Panel, in circumstances where the panel should have acted as an important and robust check in protecting a vulnerable infant from risk. Further, there are no recorded minutes of the panel meeting on the CSS file, representing poor practice.
- CSS did not initiate safe-sleeping discussions with the family, even when Ms Haywood directly raised Rhiannon's sleeping arrangements with CSS during a meeting on 18 July 2014.
- There was a failure of CSS to consider the state of the home or to conduct thorough home visits to inform itself of the suitability of the environment for a newborn infant. Even when concerns from a support worker about the extremely dirty state of the home were raised the day before Rhiannon's death, CSS was not prompted to assess Rhiannon's notification to take into account this serious risk factor.

The Review sets out numerous other failures by CSS to adhere to correct practice which related less directly to the unborn baby notification, although obviously still impacted upon the inadequate response to that notification. Some of the main issues in this category are as follows;

- Any safety planning by CSS for W which occurred prior to and following Rhiannon's birth was ineffective, not being grounded in comprehensive risk assessment and not addressing the risk presenting to any of the other children, including the expected infant, Rhiannon.
- The reunification plan for W did not follow the appropriate approval process. The reunification readiness assessment and the reunification plan were not approved by the SQPA and the relevant manager prior to reunification occurring. In the reunification plan safety is incorrectly equated with the absence of reported concerns.
- The notifications received about W, L and B (prior to Rhiannon's birth) were not managed consistently with CSS policy and procedure. There is no evidence that historical reports were considered as part of the full assessment relating to the children. Concerns in relation to L and B were not recorded appropriately and not properly assessed. Notably, there was little gathering of information from documentary records, outside sources and from the parents which could have assisted with an informed risk assessment.
- Contrary to correct procedure, the concerns notified about L and B on 4 May and 24 May 2014 were not recorded as notifications but rather within case notes on W's file. This practice allows important notifications to be minimised or overlooked.
- The Court Application Advisory Group (CAAG) procedures were not followed in that a risk and safety assessment was not completed for L and B in December 2013; and subsequently, when Mr Heather returned the girls to Ms Haywood, the CAAG did not reconsider the requirement for court intervention as was the originally intended course.
- Processes concerning the placement of W, L and B in December 2013 for the duration of the 120-hour order were confused and ad hoc and this record keeping and decision-making was inconsistent with CPS policy, procedure and guidelines.

Both Ms Gray (author of the Review) and Ms Botak gave evidence that had proper processes been followed and risk assessment undertaken in respect of the unborn baby notification, this would have likely resulted in CSS issuing an unborn baby alert for Rhiannon which, in turn, should have triggered an updated assessment at the time of her birth. They agreed that following any such assessment it was unlikely that she would have been released into the care of Ms Haywood and Mr Pitchford. I accept their evidence.

I find that if CSS had adhered to policies and procedures upon receipt of the unborn baby notification and undertaken a proper risk assessment at the time of her birth, Rhiannon

would not have been in the care of her parents at the time of her death. A court hearing an application for an assessment order almost certainly would have granted the order, particularly given the non-accidental injuries sustained by W and the other factors referred to above, all of which disclosed a very high risk to a new born infant.

If Rhiannon was subject to an assessment order and removed from the home, she would not have been exposed to three of the five factors which were found by Dr Lawrence to have been risk factors in the cause of her death – namely, bed sharing, being face down and environmental smoking. In particular, her face would not have been pressed into adult bedding restricting her respiration. In that case, I am satisfied that she would not have died.

I observe that, even after Rhiannon's death, there were delays by CSS in assessing the risk to L, B and W of remaining in the care of Ms Haywood and Mr Pitchford. Very surprisingly, arrangements for W's reunification with Ms Haywood and Mr Pitchford continued for a period of time after Rhiannon's death. The ongoing risk to L and B was not actioned until August 2015 when they were placed in care.

W is now subject to a guardianship order until 18 years under the CYPTF Act and resides with the same foster carer as his sisters.

L and B are also the subject of guardianship orders until the age of 18 years. In this regard, the Review summarises the matters that prompted this action under the CYPTF Act as:

> *"Risk of emotional and physical harm was the basis of the initial application with the following specific concerns identified: conflict within the family home; parental drug use; criminal activity including alleged drug dealing from the family home; lack of parental insight into the emotional care needs of L and B; neglect of physical and educational needs; refusal of Ms Haywood to prioritise the care and safety of the children over her relationship with Joshua".*

Upon hearing the evidence of Ms Haywood and Mr Pitchford at inquest, these issues are still clearly applicable in any further consideration by CSS of risk to the children.

The two younger children, M and D, remain in foster care under shorter-term care and protection orders. I understand that ongoing consideration by CSS is occurring as to the application for further orders.

*CSS Reform*

The Deputy Secretary Children, Ms Gail Eaton-Briggs, gave very helpful evidence at the inquest regarding significant policy and structural changes recently made and proposed to be made to CSS. She stated in her affidavit made for the inquest that over the last three years CYS has made these changes as a result of two things; firstly, the Tasmanian Government's *Strong Families, Safe Kids* project to redesign the CSS system; and secondly, as a result of implementing recommendations made in the coronial findings of *Johnstone* and *Hayes.*

In the findings of *Hayes* I discussed the comprehensive changes being implemented by the government to reform CSS. These include development of an effective audit and quality assurance system in respect of risk assessments, replacement of CPIS, and the recruitment of 10 Clinical Practice Consultant and Educator positions to assist implementation of a comprehensive training regime in all areas of CSS practice.

Of particular relevance to the systemic issues identified in this case are the following recent reforms:

- CYS has established a state wide "one-stop shop" for notifications, being the Children's Advice and Referral Service (CARS) which is a single point of entry for persons wishing to notify, seek information and advice, and service referral. CARS has recently commenced operation. Ms Eaton-Briggs gave evidence that this significant change is intended to streamline CSS operations, increase the accuracy of risk assessments and improve workforce training and mentoring;

- The placement of two additional hospital-based safety liaison officers in the north and northwest in February 2017. These positions, amongst other functions, provide important safeguards against the possibility of failure by CSS to undertake proper risk assessments following unborn baby notifications. Part of the role of the child safety liaison officers is to facilitate more effective working relationships between the relevant hospitals, CSS and the associated government and non-government organisations dealing with child protection issues.

- In 2017 the Three and Under Panel was also revised to include a clinical practice consultant and educator. It should be noted that this panel was in existence when the unborn baby notification was made for Rhiannon in April 2014. It sanctioned the CSS decision to close the notification at intake. It will need to be the subject

of auditing to ensure standards of risk assessment are maintained.

- The Serious Events Review Team was established in 2017. It is tasked with reviewing CYS processes and involvement in the death or serious injury to a child known to CYS or the sibling of a child known to CYS. SERT reports will be provided to a Serious Events Review Committee (SERC) whose role is to identify themes and common issues across child death and serious injury review reports and make recommendations to CYS to improve the quality and safety of CYS services. The SERC comprises senior representatives from government agencies external to CYS. CYS is to be commended for the implementation of these review processes.

In light of the major process of reform of CSS currently being undertaken in key areas, I do not consider it appropriate to make further substantive recommendations in this finding. I note also that the Review makes sound recommendations in respect of the issues concerning Rhiannon's death which will no doubt be considered and implemented by CSS.

Ms Gail Eaton-Briggs acknowledged in her evidence that the CSS response to coronial requests for information was less than adequate. I am of the view that CSS should provide early advice to the Coroner of its involvement upon becoming aware of the death of a child where that child or its siblings are known to CSS. Ms Gail Eaton-Briggs indicated that the CSS policy entitled *"Reporting the death of a child in care to the Coroner"* may undergo review to consider broadening the requirement for providing information to the Coroner.

**Recommendations:**

1. I **recommend** that upon CSS becoming aware of the death of a child where that child, his/her parents or siblings are known to CSS within 3 years prior to the date of the death, CSS advises the Coroner's Office of the death and provides a brief summary of its past and current involvement with the child and family members;

2. I **recommend** that CSS review its policy *"Reporting the death of a child in care to the Coroner"* with a view to including provisions to accord with the above recommendation;

3. I **recommend** that Tasmania Police notify CSS of the death of any child the subject of a report to the Coroner so as to enable CSS to provide the details referred to in the above recommendation;

4. I **recommend** that CYS and CSS provide to the Coroner a copy of any review undertaken by it or at its request in respect of a child whose death has been reported to the Coroner as soon as that review is completed or within a period of 90 days, whichever is the earlier;

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

I am particularly grateful for the assistance of counsel assisting, Ms Schokman, in this inquest.

**Dated:** 17 December 2018 at Hobart Coroners Court in the State of Tasmania.

**Olivia McTaggart**
**Coroner**