CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 20th, 21st, 22nd, 23rd and 24th days of May 2019 and the 28th day of February 2020, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Sophia Alessia Nisco.

The said Court finds that Sophia Alessia Nisco aged 16 years, late of 9 Highbury Drive, Highbury, South Australia died at disAbility Living Riverside Respite, 7 Riverside Drive, Felixstowe, South Australia, South Australia on the 11th day of February 2017 as a result of upper airway occlusion due to the aspiration of a foreign body with contributing cerebral palsy. The said Court finds that the circumstances of her death were as follows:

1. Introduction and background

1.1. Sophia Alessia Nisco was 16 years of age when she died on 11 February 2017. She died at the disAbility Living Riverside respite facility after she aspirated a disposable latex glove at that facility. The glove is the foreign body recited in the cause of death described above. Resuscitation efforts performed in the first instance by staff of the facility and then by paramedics of the South Australian Ambulance Service (SAAS) were unsuccessful. There is no evidence that Sophia's possession of the glove or its aspiration was witnessed by any person. In the course of these findings I will discuss the circumstances surrounding Sophia's aspiration of the glove.

1.2. Sophia had a past medical history of cerebral palsy. It appears that this diagnosis was made when she was three months of age. Sophia also had an intellectual disability. It is said that Sophia had the mental abilities of an infant. She could not communicate by

way of speech. There were other diagnoses including autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD). Sophia also had a gastronomy tube in place, known as a PEG. This device enabled the provision of nourishment via a tube in the abdomen. The ongoing risk of aspiration was the reason for the placement of the PEG. The PEG was used in respect of Sophia's consumption of fluids and medication. As far as food was concerned, she was able to tolerate a mashed diet by mouth. Sofia was partial to marshmallows. There does not appear to be any suggestion that the eating and swallowing of marshmallows posed any danger of choking or aspiration. Indeed, as will be seen, Sophia's mother encouraged the use of marshmallows as an inducement or reward for compliant behaviour. Sophia was able to mobilise by walking until she was about 13. However, by the age of 16 her ability to move by this method was severely limited to the point where for the most part she was in a wheelchair. Out of the wheelchair she was able to crawl and propel herself reasonably effectively. The evidence suggested that Sophia was able to mobilise in this fashion quite quickly and had little hesitation in doing so when out of the wheelchair. Evidence also established that out of the wheelchair Sophia could pull herself up alongside furniture and reach for things that were situated at a reasonable height, for example from a bathroom vanity unit. Her mother was enthusiastic about the notion that Sophia should be out of the wheelchair as much as possible and not be perpetually wheelchair bound.

1.3. Notwithstanding her disabilities Sophia appears to have been a gregarious and playful child. It is plain that she was much loved and well cared for. Her mother was Ms Nella Nisco. In his witness statement Dr Andrew Tidemann, the paediatrician who provided clinical care to Sophia over her entire life, says this about Sophia's parental care:

> 'I was always struck by the quality of care and supervision that Nella provided. She was always there for Sophia and was very patient with her. She would react very quickly if she had any concerns regarding Sophia's health. Nella was a very attentive mother. I think this was one of the reasons she held off accessing respite care for Sophia for so long was because she didn't think the level of care and supervision could be as good as what she could provide.' [1]

1.4. Sophia resided with her mother, her mother's partner Ms Dalton and with other children of both her mother and Ms Dalton. Sophia was provided with respite care every second weekend at the disAbility Living Riverside facility where she would die in February

[1] Exhibit C5

2017. Sophia attended a school from which she would be picked up by facility staff during a Friday afternoon. She would be delivered back to the school on the Monday morning. Thus the facility's carers would be responsible for Sophia's safety and care during those weekends.

1.5. The facility consisted of an ordinary suburban house that included four bedrooms, two bathrooms (one being an ensuite), living and play areas, a kitchen and laundry.

2. Cause of death

2.1. Following Sophia's death her remains were subjected to a post mortem examination by Dr Cheryl Charlwood, a forensic pathologist at Forensic Science South Australia. Dr Charlwood's post mortem report was tendered to the Inquest[2]. The report expresses the cause of Sophia's death as:

i a) upper airway occlusion; aspiration of foreign body;

ii. cerebral palsy.

2.2. Dr Charlwood further reports as follows:

> 'In conclusion, given the above circumstances and findings, particularly those of SA Ambulance Service at resuscitation, the death in my opinion has resulted from the occlusion of the upper airway subsequent to aspiration of a foreign body. Due to the intellectual disability, the cerebral palsy is considered an intrinsic disease process underlying the death.'

2.3. In her report Dr Charlwood notes that during Sophia's attempted resuscitation at the facility, paramedics removed a disposable medical glove from her throat. The evidence from SAAS confirms this[3]. It also establishes that upon the arrival of the paramedics Sophia was in cardiac arrest and was totally unresponsive. I accept Dr Charlwood's opinions and conclusions and find that the cause of Sophia's death was upper airway occlusion due to aspiration of a foreign body with contributing cerebral palsy.

2.4. Sophia did not have any significant injuries at post mortem. Toxicological analysis revealed the presence of her medications only.

2.5. As earlier alluded to, Sophia's aspiration of the glove was not witnessed by any other person, or at least by any of the carers present within the facility at the time. At around the time of the incident it is clear that two carers were on the premises, although it is

[2] Exhibit C1a
[3] Exhibit C4 – Statement of Garth Gill

possible that at the time Sophia aspirated the glove a third carer was in the process of leaving the premises, or had just left the premises, at the end of his shift. Certainly there were only the two carers present when Sophia's collapse was discovered. There were four children on the premises including Sophia. One of those children, a 10 year old boy whom I will refer to as H, also suffered a disability that at times confined him to a chair. I was told that this boy was prone to agitated behaviour. The other two children, R and E, then aged approximately 16 and 12 respectively, had disabilities that are not relevant for these purposes. These children were mobile. It was at approximately 3.30pm that the third carer was leaving the premises at the end of his shift. Another carer was due to commence her shift at 4pm. The incident involving Sophia occurred prior to her arrival. Thus the incident that accounted for Sophia's death occurred sometime between 3.30pm and 4pm on the afternoon in question.

2.6. The level of vigilance that was required in respect of the facility's carers' supervision of Sophia, and whether that level of vigilance was adhered to, were naturally matters that were examined in the inquest. This evidence was not entirely consistent. It also seems from the evidence that in this regard the expectations of Sophia's mother, Ms Nella Nisco, and her partner, Ms Nichole Dalton, may have exceeded those of the staff and management of the facility and indeed may have exceeded the level of vigilance that was actually maintained in respect of Sophia. These are matters that I will examine in the course of these findings.

2.7. The principal issue that this inquest investigated was how it had come to pass that Sophia had been provided with the opportunity to locate and aspirate a disposable glove and whether a greater degree of vigilance on the part of carers could have and should have prevented the aspiration of the object and her consequent death.

3. The evidence of Dr Andrew Tidemann

3.1. I have already referred to Dr Tidemann. He is a Senior Staff Specialist and Paediatric Rehabilitation Specialist at the Child Development Unit at the Women's & Children's Hospital. He was involved in the provision of clinical care to Sophia Nisco from 2001 when she was born until the time of her death in February 2017. He conducted approximately 60 consultations with Sophia.

3.2. In Dr Tidemann's statement he recites Sophia's medical history, the salient features of which I have already mentioned. Of particular relevance is the PEG that was inserted

in her abdomen for the purpose of feeding and for the provision of medications due to issues associated with aspiration. Dr Tidemann explains that Sophia was not able to protect her airway which increased the risk of her inhaling liquids and food. He also explains her history in mobilising and her regression to a point where she was unable to take more than a few steps. Although she was disabled, Dr Tidemann felt that Sophia's life expectancy would reasonably be estimated to be to middle age or even beyond. He believed that at the time of her death she was functioning at a mental level of an infant of less than 12 months of age. She could not speak words that could be understood.

3.3. Dr Tidemann was made aware of the circumstances of Sophia's death and offered certain insights into those circumstances taking into account her developmental and intellectual ability. Dr Tidemann states that Sophia was quite mobile when crawling and was able to propel herself effectively. He believed that it was realistic for Sophia to travel 8 to 12 metres in 4 to 5 minutes and would not have been overly taxed or exhausted in crawling that distance in such a timeframe. He doubts that she would have made a lot of noise in this process. I am not certain why the distance of 8 to 12 metres and the timeframe of 4 to 5 minutes was selected as measuring sticks of mobility. I suspect it is because on one view this might be the distance Sophia covered from the location at which she was last seen to the location where she was found collapsed and that 4 to 5 minutes was an estimate of the duration since she was last seen. The evidence suggested that Sophia could move at a pace much quicker than 12 metres in 5 minutes.

3.4. In any event Dr Tidemann states that Sophia was mobile, had the ability to climb to a high kneeling position and that her field of interaction with objects was not limited to floor level. A bathroom vanity unit for example could be well within her reach. Though Sophia had no ability to pincer grip, that is to say by gripping an object between thumb and forefinger, she used a palmar grasp to take hold of objects. Dr Tidemann opines that it would have been perfectly feasible for Sophia to have removed a glove from a box of gloves using these limited grasping abilities.

3.5. Dr Tidemann states that like a baby Sophia explored much of her world through the use of her mouth as distinct from her ability to touch and to see. He said '*she would put anything in her mouth*'. He explains this is a trait common in children with an intellectual disability and/or ASD. In view of this, an object such as a glove would have been be particularly dangerous to Sophia, not only because it could block her

airway, but also because her lack of fine motor skills as described would have rendered her unable to use her fingers to pull the glove from her throat.

3.6. Unsurprisingly given her mental age, Dr Tidemann also states that Sophia had no understanding of risk. He suggested that she would have required close, rather than constant supervision, depending on the safety of the environment. He says that she was like an infant and that if there were small objects around that could be mouthed, then she would need to be watched. Otherwise she could quite easily swallow things. I have concluded that Sophia's environment at Riverside did in fact dictate constant supervision. Dr Tidemann states that Sophia's mother, Ms Nella Nisco, was very aware of choking hazards. Evidence was given by Ms Nisco herself which confirms that observation. During Sophia's appointments with Dr Tidemann he noted that her mother was always quick to remove from Sophia things that could be put into her mouth.

3.7. To my mind, Dr Tidemann's statement provided clear and persuasive independent evidence of Sophia's disabilities. In my opinion it goes without saying that her disabilities would have been obvious to any reasonable adult. In her evidence before the Court Ms Nella Nisco corroborated nearly everything that Dr Tidemann said. However, Ms Nisco was of the view that when her daughter was out of her wheelchair or on the floor she needed '*one on one*' attention. Ms Nisco confirmed that Sophia would put '*everything*' in her mouth and was never left alone out of her wheelchair. There were other descriptions that involved people saying that Sophia put '*everything*' or *'anything'* in her mouth. Clearly this could not literally be true, but in my view what people were intending to convey by this observation was that Sophia had a demonstrated propensity to put objects into her mouth and to do so indiscriminately. To this end, an object called a '*chewy tube*' was provided to Sophia. This was a plastic object that could be hung around her neck and which was available for Sophia to chew on. I understood from the evidence that she did so habitually[4].

3.8. Other significant matters arising from Dr Tidemann's statement included Ms Nisco's stated concern about the need to prevent Sophia from having access to choking hazards and her mother's haste to remove from Sophia items that would present as such a hazard. Ms Nisco's own evidence confirmed this. It would therefore not be surprising for Ms Nisco to have endeavoured to make it plain to staff at her daughter's respite

[4] Transcript, page 29

facility that there was a risk of Sophia choking on objects that she might possess and that there was a need for those objects to be removed from her environment. It would also not be surprising if Ms Nisco were to have urged Sophia's carers to keep a very close eye on her for those reasons.

3.9. Dr Tidemann's statement does not contain any suggestion that his views about Sophia's abilities, disabilities and risks were conveyed in a direct way to management or staff at her respite facility. It would have been highly beneficial from the point of view of Sophia's safety if they had been. This of course is no criticism of anyone. But this is not the first time that this Court has made an observation along these lines. I here refer to this Court's findings in the matter of **Lawrence Betts**, Inquest Number 11 of 2013, delivered 29 November 2013. I will mention more of this finding and its key recommendation in due course.

4. The incident leading to Sophia's death

4.1. The day on which Sophia died was Saturday 11 February 2017. At about 1pm that day Ms Sandeep Mangat, one of the disAbility Living carers, began her shift. She was rostered to work until 7.30pm. Ms Mangat holds a Certificate III in Disability, a Certificate III in Aged Care, a Certificate III in Home and Community Care and a Certificate III in Childrens' Services. She had various other qualifications including for Cardio Pulmonary Resuscitation (CPR). Ms Mangat gave a statement and also gave oral evidence at the inquest. She had been interviewed by investigators of the DCSI. She described the scenario at the facility on the afternoon in question.

4.2. Ms Mangat commenced her employment with disAbility Living as a community support worker in 2013, that is to say before Sophia commenced respite care at the facility in 2015.

4.3. Although there had been excursions conducted out of the facility earlier in the day, there were four children present at the facility during relevant periods in the afternoon. Two of the children, R and E, did not require one on one care. Another child, whom I have already mentioned as H, did require one on one care and that care was to be provided by Ms Mangat. Sophia was also present on the premises. According to Ms Mangat's evidence, she believed that Sophia did not require one on one care within the facility premises, but only required that level of care when on excursions. An issue was ventilated in the inquest as to whether one on one care was funded and should have

been provided within the premises. It was certainly the case that there was an expectation that such a level of care would be afforded outside the premises. I will deal with that issue in another section of these findings.

4.4. So, until approximately 3.30pm there were three carers on the premises and four children and, as indicated earlier, one of those carers, a person by the name of Nuwan, left at about 3.30pm.

4.5. In due course that afternoon Ms Mangat was tasked with showering Sophia and also with preparing the evening meal for the four children. It is evident from Ms Mangat's statement that she was familiar with Sophia's feeding requirements. She asserts that Sophia could feed herself small pieces of finger food but that all liquid had to be given through her PEG. Her statement indicates that she believed that was so because there were '*issues with her swallowing*'. Ms Mangat also knew that she had been assigned to work with the child H on a one on one basis. There seems little doubt that this was the case as the facility's records bear that out. In her statement Ms Mangat asserts that the child H was quiet and sitting on his chair in a TV room which was located at the front of the residence. At that point Ms Mangat showered Sophia which appears to have taken some time.

4.6. Ms Mangat's duties in showering Sophia and then having to attend to the evening meal seem somewhat inconsistent with her duties to provide one on one care with the child H. However, at the time at which Ms Mangat showered Sophia, Ms Mangat was the only female carer on the premises and it had been made clear by Sophia's mother that Sophia's personal care should only be administered by female staff. This understandable request had, among other aspects of Sophia's care, been the subject of a recent staff meeting at which Ms Nella Nisco had been present and had made that request. The requirement was documented in minutes that I will discuss in another context in due course.

4.7. Ms Mangat's evidence was that at the time she showered Sophia another male carer by the name of Charanjit Singh, aka Chad, was looking after the child H.

4.8. Ms Mangat showered Sophia in the main bathroom of the premises. The showering of Sophia was unremarkable except for the need to induce her to get down from her wheelchair by giving her marshmallows. As alluded to earlier, the giving of marshmallows was a routine inducement for Sophia to co-operate with carers.

Ms Mangat sat with Sophia during the showering process. Sophia sat on the shower floor. After the showering process concluded Sophia crawled out and was dried and dressed. Once dressed, Sophia crawled out to the dining area of the premises. Ms Mangat attended to the tidying up of the bathroom. In her oral evidence Ms Mangat described a situation where after the shower Sophia repeatedly kept coming back to the bathroom and, again, had to be induced with marshmallows to co-operate. Ultimately Sophia settled in the playroom.

4.9. Sophia seemed to be attracted to the bathroom although the evidence was unclear as to the nature of the attraction. As will be seen, disposable gloves were present in a dispenser situated on the bathroom vanity unit. Ms Mangat had worn gloves during the showering process. Having regard to the fact that Sophia would ultimately be found collapsed in the bathroom having aspirated a disposable glove, one is left with the suspicion that Sophia had developed a fixation in relation to disposable gloves and it was this that led her to return to the bathroom both immediately after her shower and then ultimately before her collapse. However, the evidence is not capable of giving rise to that finding. As well, there is no evidence to suggest that in this particular instance staff were aware that Sophia was attracted to the bathroom and its contents for this reason.

4.10. In her oral evidence Ms Mangat described her use of gloves in connection with the showering of Sophia. Ms Mangat said that she always wore gloves around Sophia. Disposable gloves were for the most part kept in a cupboard in the hallway. The cupboard was opposite the doorway to the bathroom. The gloves were retrieved from a dispenser. There were other places within the premises where gloves were either habitually located or in any event located that day by investigating police. Ms Mangat did say that boxes of gloves were also kept in the bathroom at '*certain times*'[5]. Later that afternoon police would locate and photograph a box of gloves, as I say, on the bathroom vanity unit. Ms Mangat at first told the Court that she used the one glove in this process[6] but then said that she had worn them on both hands. The gloves could be put on either hand interchangeably. Ms Mangat said that she obtained the gloves from the hallway cupboard, but is clear in my view that at the time the shower took place

[5] Transcript, page 124
[6] Transcript, page 134

there was a box of gloves on a vanity unit in that bathroom. I so find. I also find that the box of gloves remained on the bathroom vanity unit thereafter.

4.11. There was much evidence, chiefly of a speculative kind, given about the various locations of gloves within the house and where conceivably Ms Mangat obtained gloves during the showering process and from where Sophia obtained the glove that caused her death. The issues are moot as it is apparent that there were gloves in different places in the house and that Sophia, if left to her own devices, would find them.

4.12. Ms Mangat told the Court that after the showering process she cleaned the bathroom still wearing the gloves that she had originally put on prior to the shower. She said that having cleaned the bathroom she put Sophia's clothes in the laundry and took the gloves off. She said that she put the gloves in a bin but could not remember whether she placed them in a bin situated in the laundry or in the bin situated in the bathroom[7]. She states that she usually places one glove inside the other and creates a small ball out of them before placing them in the bin. Ms Mangat states that once she had attended to the laundry she went into the kitchen to start dinner preparations.

4.13. Ms Mangat told the Court that from her position in the kitchen she could see into the playroom where Sophia was through its open double doors. It is clear that the whole of that room could not have been seen from the kitchen even with the doors open.

4.14. Ms Mangat told the Court that the carer, Nuwan, finished his shift at about 3.30pm. At that time she was still in the kitchen preparing dinner. Ms Mangat told the Court that in order to let a person out of the house at the front door, the door needed to be unlocked by another person. In this instance that person was the other carer, Chad. Ms Mangat then stated that after Chad had let Nuwan out of the house she heard H apparently banging his head. She was still in the kitchen at that stage[8]. Ms Mangat added that H started screaming so she went to the lounge area at the front of the house. She believed that Sophia was still in the playroom at that time but she would not have been able to see her from the lounge area. Ms Mangat said that she assisted in unbuckling the child H from his chair. H then ran straight to the playroom and Ms Mangat followed. It was there that she observed that Sophia was no longer in the playroom and so she and Chad commenced looking for Sophia. Ultimately she was found lying on the bathroom floor. Sophia was unresponsive. There was no indication that Sophia was breathing but when

[7] Transcript, page 138
[8] Transcript, page 140

her mouth was checked no obstruction could be seen. Sophia had to be brought into the hallway for CPR to be commenced. Chad commenced CPR while Ms Mangat rang an ambulance using her personal phone.

4.15. When Ms Mangat spoke on the phone with the ambulance service a female representative instructed them what to do. Ms Mangat at some point took over CPR. She explained to the Court that she had undertaken a CPR course. The evidence to my mind was not clear as to whether as part of CPR breaths as well as chest compressions were administered to Sophia. The point is academic because at that stage Sophia's airway was virtually completed occluded such that the administration of breaths would not have assisted. The disposable glove would not be identified as that obstruction until after the arrival of the ambulance service.

4.16. Ultimately paramedics arrived and took over resuscitation. During the course of the resuscitation efforts the disposable glove was seen and removed by paramedics.

4.17. Charanjit (Chad) Singh was the other carer on the premises. Mr Singh had similar qualifications to those of Ms Mangat.

4.18. Mr Singh commenced his employment with disAbility Living in August of 2016. This was at a time after Sophia commenced respite care at the facility.

4.19. Mr Singh told the Court that he was aware that Sophia was being showered by Ms Mangat. He knew that Sophia's mother had indicated that she only wanted female staff to provide personal care including showering to Sophia. Mr Singh told the Court that he was aware that Ms Mangat was trying to induce Sophia to leave the bathroom and so he went to the bathroom to assist. To begin with his own inducements were all verbal but he then obtained some marshmallows which he '*used as a bribe*'[9]. In the event he put some marshmallows on the benchtop of the kitchen. Sophia crawled up to that level and obtained them. Mr Singh believed that the carer Nuwan was still at the premises at that point.

4.20. According to Mr Singh, in the end Sophia crawled towards the playroom where, as was her habit, she was hitting the door with her feet. He believed that the playroom door was closed at that juncture.

[9] Transcript, page 244

4.21. Mr Singh said that after this Ms Mangat was attending to the preparation of the evening meal. He said that the child H was in the loungeroom at the front of the premises. H was in what Mr Singh described as a '*pram*' and was buckled into it.

4.22. Mr Singh said that Nuwan then left the premises through the front door where they chatted for a period. At that stage he still believed Sophia was still in the playroom and that the child H was in the loungeroom area. He then described what happened as follows:

> 'So H has a very hard behaviour. When Nuwan left within probably 10 minutes he started playing up. He has a very hard behaviour, hitting his head, biting his hand, more biting, crying and hitting his back on the pram, so very hard behaviour. He started doing all that.' [10]

4.23. Mr Singh told the Court that he thought that the child H may have just wanted to get out of his pram. He said that although he did not know from where Ms Mangat had come, she was then in the loungeroom to attend to H. At that stage Mr Singh told the Court:

> 'So when Nuwan left and H started playing up we both were trying to settle him down. So we was doing our thing, you know, like do this and this and so food or whatever, we tried all the strategies to calm him down, then Sandeep told me maybe he want to get up. I was pretty new with him I think and she told me to - because his buckle, he had a special buckle you can't - it's not button, it's like a hole and you need something sharp to unbuckle him so she said to me use something sharp. So I used my car key to unbuckle him.'[11]

4.24. Mr Singh told the Court that after the child H was unbuckled he got out of his chair and went towards the playroom. Mr Singh followed. Sophia was not in the playroom at that time and so he and Ms Mangat started looking for her. Sophia was found in the bathroom. Both Ms Mangat and Mr Singh said that the sliding door to the bathroom was closed. Sophia was on the floor. Mr Singh's initial thought was that she was sleeping there but it was soon ascertained that she had collapsed. He checked her vital signs. He could not detect a heartbeat. She was not breathing. He said that he checked Sophia's mouth to see if there was anything in it. He put his finger in her mouth but could not detect anything.[12] He commenced CPR while Ms Mangat called 000.

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[10] Transcript, page 247
[11] Transcript, page 248
[12] Transcript, page 251

4.25. Mr Singh told the Court that CPR was continued until the ambulance arrived. Ambulance officers were able to extract the glove with an instrument. Mr Singh told the Court that he had no idea where the glove had come from.

4.26. I have accepted the evidence of Ms Mangat and Mr Singh as to the manner in which the incident unfolded. I have found that Sophia was left on her own in the playroom while both Ms Mangat and Mr Singh attended to the child H in another area of the house, being an area from which the playroom could not be seen. While the two carers were attending to H, Sophia left the playroom and moved to the bathroom. At some point she took possession of a disposal glove and aspirated it. It is not possible to conclude with certainty where she obtained the glove. In my view a number of possible sources have not been eliminated including a bin, the kitchen benchtop and the bathroom vanity unit. The exact source does not particularly matter.

5. Sophia's propensities to place things in her mouth

5.1. In this regard I have already referred to the evidence of Dr Tidemann. Sophia's propensities to place things in her mouth were well known to Dr Tidemann. Ms Nella Nisco confirmed this in her evidence, as did her partner Ms Dalton.

5.2. Ms Nisco gave evidence in some detail about this topic. She said that she would not leave Sophia's side once she was out of her wheelchair because '*she was very oral, everything was put in her mouth*'[13]. Ms Nisco told the Court that Sophia would fixate on something and would go to it and so she was never left alone out of her wheelchair. If she was alone with Sophia and she had other tasks to perform, she always put her into her wheelchair. For similar reasons Sophia had what was described as a '*safe surround bed*' which was fully enclosed. Indeed, such a bed was provided for her at the facility in question. This meant that she did not need to be watched when she was in bed. For all these reasons Ms Nisco said she had presumed that Sophia was '*one on one at respite*'[14]. Later in her evidence Ms Nisco was asked this question:

> 'Q. What was your expectation then of the facility, what they would do.
>
> A. That she would be watched one-on-one or watched, that she wouldn't have anything when she was out of her wheelchair.'[15]

[13] Transcript, page 26
[14] Transcript, page 26
[15] Transcript, page 33

5.3. Ms Nisco gave examples as to the kind of objects that Sophia would place in her mouth. These included her hearing aids and also an object (referred to as a 'button') that was connected with her gastronomy tube. When asked by counsel assisting Ms Waite as to the extent of Sophia's oral fixations, Ms Nisco gave this evidence:

> 'Everything, including gloves. There was a situation at Modbury Special School where a support worker had changed her using gloves, actually tossed the glove, she thought, in the bin, but it was actually on the edge of the bin and dropped to the floor and Sophia saw it, crawled to it and tried to put it in her mouth, but she was right there, she actually stopped. Support workers at home wore gloves constantly and she would put a finger underneath the gloves and just thought it was funny because she tried to take them off. I hardly wore gloves at home because I don't like the risk of anything going in her mouth. It was that - with food, you know, the consistency of her food had to be the right consistency otherwise she would choke.' [16]

5.4. It was for these reasons that Sophia was provided with the chewy tube which Ms Nisco said was constantly in her mouth from the time that she rose in the morning until the time that she went to bed.

5.5. Ms Nisco told the Court that Sophia had been receiving respite care at disAbility Living for about three years. She said that when Sophia had been inducted into the facility, a document known as a **'Participant Profile 2015'** was completed. Although this document was not completed by Ms Nisco herself it was prepared on information that she provided. The document was tendered to the inquest.[17] The date of the document is 7 April 2014. The document is a proforma document consisting of eleven pages. The document provides for a description of the client's disability, a list of the desired activities while inside the facility and in the community, food preferences and the manner of feeding and medical information. This was a document that was made available to the facility staff and was expected to be read by facility staff. I was satisfied that this document had been read by staff. However, this document does not of itself provide for any description of a child's risk profile. As a care plan for a severely disabled and vulnerable child it left much to be desired.

5.6. Within Sophia's Participant Profile 2015 her disabilities are described as physical, intellectual, learning and sensory. Under a general heading entitled '**About Your Child**', and within a sub-heading entitled '**What activities do you think your child**

[16] Transcript, pages 27- 28
[17] Exhibit C9k

might enjoy participating inside the house and in the community?', the following is recorded:

> ' • Not in chair all the time, but watch as will put everything in mouth'

The document does not specify what object or objects Sophia would place in her mouth, and certainly the recorded observation about that subject is not confined to food. Again, this description insofar as it refers to Sophia putting *'everything'* in her mouth, should have been taken as a reference to a tendency on her part to put things in her mouth indiscriminately and that the objects that she did put in her mouth would not be confined to food or any other specific type of object. This warning was a matter that should have been more prominently displayed in the document, and although it could be inferred that Sophia's propensities to put things in her mouth carried a risk of aspiration or choking, this risk should have been spelt out.

5.7. The evidence adduced before me was that until only recently Novita Children's Services had been the entity that was instrumental in the funding of Sophia's respite care at the facility. As I understood the evidence that funding role had been, or at least was to be, taken over by the National Disability Insurance Scheme (the NDIS). The funding for Sophia's care had been transitioned as of 6 January 2017. A document had been crated in relation to Novita's purposes. The Court was informed that the Novita document had been provided to the management of the facility but I understood from the evidence that it would not have been seen by the facility staff. The document appears to relate mostly to questions of finance, although it does make provision for identification of risk. The information within a section of the document entitled '**Identification of Risk**' is recorded as follows:

> 'Sophia does not understand the outcome of her behaviour. She may bite without realising others will be hurt, and needs adults to monitor her environment. Sophia may bite or pull hair if touched around her head/mouth. Sophia had an extremely short attention span and is constantly looking for change in activity. Sophia currently drops to the ground if she does not want to do something. If in wheel chair Sophia will scream/cry out if she is distressed by something. **Sophia requires constant supervision as she is able to access items in the home and poses a choking/safety risk. Care worker to follow parent's instructions**'.[18] (emphasis added)

5.8. This document should have been made available to the facility's staff. The emboldened section of the above passage was information that was fundamental to Sophia's

[18] Exhibit C9k

continued safety in the facility. Certainly in my view, the facility's management were cloaked with that knowledge.

5.9. Neither the Participant Profile 2015 nor the Novita document contain anything about gloves presenting as a specific choking risk for Sophia. Indeed, I have seen nothing at all recorded about Sophia's propensity in relation to disposable gloves.

5.10. On 25 January 2017, only a few weeks before Sophia's death, a staff meeting was held at the facility. This meeting was attended by Ms Nisco and her partner Ms Dalton. Minutes of the meeting were kept by Mr Pushpesh (aka Peter) Bishnoi, a team leader employed at the facility. Tendered to the Court were two versions of the minutes that were prepared. The first version consisted of a typed document that began life as a list of the agenda items to be discussed at the meeting together with Mr Bishnoi's handwritten notes as to the discussion that took place at the meeting. The second document is a completely type-written version of the minutes.

5.11. The meeting canvassed a number of matters that did not concern Sophia. However, it is plain from the minutes that there was discussion about Sophia and also about Ms Dalton's child S. I will come those minutes in a moment.

5.12. Prior to the meeting, Ms Dalton prepared her own handwritten agenda that covered items both relating to her child S and Ms Nisco's child Sophia. This document of some four pages bears ticks alongside each agenda item that were intended to signify that each item had been covered at the meeting. Regarding the items relating to Sophia, as set out in Ms Dalton's agenda, they are in summary as follows:

- Sophia being taken to the wrong school;
- Female staff only to change or shower Sophia;
- Sophia's 'onesie', which is a garment that she habitually wore, should be worn back to front, the purpose being to prevent Sophia accessing her gastrostomy button and choking on it;
- Marshmallows can be used to motivate Sophia as 'Sophia loves these';
- Sophia needs to be properly hydrated;
- Sophia's mashed diet;
- Sophia's toileting;

- ‘Time of out wheelchair - Encourage time out of wheelchair. Helps keep her muscles active. Must be supervised at all times when out of wheelchair. She will put anything in her mouth’;
- The use of lifters for transferring Sophia;
- Sophia’s missing clothes;
- Sophia’s excursions.

5.13. It will be observed that Ms Dalton’s agenda refers to two separate issues involving Sophia putting things in her mouth. The first involved the need for Sophia’s onesie to be worn back to front so that she could not pull her gastronomy button out and put it in her mouth and choke. The second involved the need for Sophia to be supervised at all times when out of her wheelchair as she would put anything in her mouth.

5.14. Both Ms Nisco and Ms Dalton gave evidence to the effect that these topics were mentioned at the meeting. Both women assert that notes were written in the margin of the agenda suggesting that the issues to which the marginal notes relate were in fact discussed, that certain risks were pointed out to staff in attendance and were acknowledged by staff.

5.15. In Ms Dalton’s handwritten agenda, alongside the item concerning Sophia’s onesie, the following has been written:

> ‘Very important –
> risk of choking
> while driving!!
>
> Peter will remind all staff.’

5.16. Against the item regarding Sophia’s time out of the wheelchair, the following has been written:

> ‘Staff well aware
> of what she is capable of. Risks
> Staff said she will
> try to crawl everywhere
> fast’

5.17. A number of staff members were present at the meeting. They included Ms Sandeep Mangat, Mr Charanjit (Chad) Singh and Mr Pushpesh (Peter) Bishnoi. None of those three individuals acknowledged in their evidence before the Court that there had been

discussion at the meeting about Sophia's propensities to put things in her mouth or about her resultant risk of choking[19].

5.18. In addition to what has been recorded in Ms Dalton's handwritten agenda, both Ms Nisco and Ms Dalton gave evidence that in discussing the need for Sophia to be out of her wheelchair staff were informed that Sophia needed to be watched one on one because she could crawl and get into situations where she could put something into her mouth[20]. Ms Nisco told the Court that she also informed staff that she and her partner never left Sophia alone at home and that they wanted the same level of scrutiny at respite. She said that at the meeting she made it quite clear that Sophia was never to be out of her wheelchair unless someone was with her.[21] In addition to all of that, and in respect of the advice that she said she imparted during the meeting, she said that Sophia would put anything in her mouth and gave examples. She said:

> 'Yes, I actually mentioned latex gloves because we actually noticed that her fascination with gloves were actually increasing or balloons. I remember saying things like balloons she'll actually put in her mouth and pop so, anything with texture on it.' [22]

5.19. When Ms Waite of counsel assisting pointed out to Ms Nisco that nothing had been specifically written about gloves or balloons in the handwritten agenda, Ms Nisco said that gloves represented simply one example of what she was describing at the meeting. She asserted categorically that she had specifically raised the topic of gloves at the meeting. In respect of the note that was written onto the agenda to the effect that staff were well aware of what Sophia was capable of, Ms Nisco said:

> ''Well aware' meant that anything when she was out of her wheelchair she could get onto anything, she could climb. She was at risk of falling, she could climb up on anything and grab anything. They were aware that she was not to be left alone out of her wheelchair.'[23]

5.20. When Ms Nisco was asked by me whether any staff member at the meeting acknowledged Sophia's ability and propensity to put anything in her mouth, Ms Nisco said '*I think they all just agreed. I don't remember anyone individually saying*

[19] Transcript, pages 186 (Ms Mangat), 416-417 (Mr Bishnoi)
[20] Transcript, page 45
[21] Transcript, page 45
[22] Transcript, page 46
[23] Transcript, page 46

anything'.[24] When asked as to whether she could have been mistaken about specifically mentioning gloves at this meeting, Ms Nisco denied that.[25]

5.21. In her evidence Ms Dalton asserted that at the meeting they reiterated to staff that Sophia must be watched at all times. She said that she and her partner would never leave Sophia alone. She said that staff were well aware of these issues and '*how tricky Sophia is out of her wheelchair*'.[26] Ms Dalton said that staff seemed to express some good natured amusement at Sophia's capabilities in this regard and in particular at how quick she was. Ms Dalton also said that the topic of Sophia putting things into her mouth was definitely raised in the meeting, saying that it was said that Sophia was a '*massive risk*' of putting things in her mouth and choking.[27] Specifically, they spoke about the PEG button and of Sophia's ability and propensity to open her onesie to access it.

5.22. Ms Dalton said in her evidence that Ms Nisco reminded staff about gloves and Sophia's fascination with them when being changed. Ms Dalton said that the Modbury Special School incident was mentioned, as was the fact that every time they changed her at school Sophia would pull at their gloves and try to put them in her mouth. She said that at the meeting staff were told that anything that was on the floor including balloons would present as a risk to Sophia. As far as the staff response to these issues was concerned, Ms Dalton told the Court that their response was that they were aware that Sophia was a massive risk of putting things in her mouth, '*but not particularly to the gloves and balloons but Nella did mention that, you know, with other things as well, not just the gloves and balloons, but she did mention with other things as well.*'[28]

5.23. Mr Bishnoi's handwritten draft minutes of the meeting refer to the following issues:

- Sophia's need for the use of a lifter;
- Sophia's signal of putting her thumb in her eye when she needs to go to the toilet;
- Her missing items of clothing;
- That Sophia should be showered and changed only by female staff;

[24] Transcript, page 52
[25] Transcript, page 53
[26] Transcript, page 95
[27] Transcript, page 95
[28] Transcript, page 97

- Sophia's preferred foods including shepherds pie, soup and pasta;
- The need for Sophia to consume 1100mls of water a day.

5.24. Mr Bishnoi's handwritten draft minutes do not record anything about the potential of Sophia putting the gastrostomy button in her mouth and the consequent need for Sophia's onesie to be worn back to front. The topic involving encouragement for Sophia to spend time out of her wheelchair and that when out of the wheelchair she should be supervised at all times as she puts anything in her mouth is also not mentioned.

5.25. As far as the type written minutes are concerned, they record the matters that the handwritten draft minutes record in respect of Sophia. Additionally, the typed version records '*Onesie should be backwards for school, sleep and outing due to the risk of her pulling the gastro plug*'. It says nothing in that context about Sophia's tendency to put it in her mouth with the possibility of choking.

5.26. The evidence of staff members who were called to give oral evidence was unanimously to the effect that nothing was mentioned at the meeting about gloves and Sophia's fascination with them. In particular the evidence of Ms Hugo who was the Manager of the facility and who was in my assessment a patently honest witness said that she knew nothing about gloves posing a risk to Sophia. I deal with Ms Hugo's evidence in greater detail below. When it was put to Ms Dalton in cross-examination that there had been no mention at the meeting about Sophia's fascination in respect of gloves or balloons, Ms Dalton said that the subject was in fact mentioned, as was the risk of putting things in her mouth when she was out of her wheelchair and the consequent need for Sophia to be watched. She told the Court that the suggestion that Ms Nisco had not said anything about Sophia's propensity to put things in her mouth was incorrect.[29]

5.27. Ms Mangat, one of the carers who was present at the facility on the afternoon of Sophia's death, was closely questioned during her evidence about her knowledge of Sophia's tendency to put things into her mouth. At first Ms Mangat was only prepared to agree that her experience with Sophia was that she would grab things and put them in her mouth, but that the things were limited to food items[30]. She said that she only saw Sophia putting food into her mouth, but did not see her putting any other object in

[29] Transcript, page 108
[30] Transcript, page 172

her mouth. She conceded however that she knew or had heard that Sophia had placed small toys such as marbles into her mouth, or small things that may have been on the floor[31]. Ms Mangat said that she had seen something to that effect in Sophia's care plan.

5.28. The care plan that was being referred to was Sophia's Participant Profile. Ms Waite cross-examined Ms Mangat about the document. Ms Mangat acknowledged that she had read the document and from it knew, generally, that Sophia would put everything in her mouth if she had the opportunity[32], and that for that reason she needed to be watched when she was out of her chair[33]. As far as gloves were concerned Ms Mangat said at first that she had never thought that gloves could present as a choking risk. However, a passage from her record of interview with the Department of Communities and Social Inclusion (now the Department of Human Services) on 5 December 2017 suggests that Ms Mangat did have some knowledge of gloves presenting as a choking risk. Asked by the DCSI interviewer whether new gloves were in the bathroom of the premises Ms Mangat had said as follows:

> 'No. There wasn't any gloves. I just take the gloves from the – on the top, and put two gloves on, and then give her shower. There wasn't any glove or any – we're not keeping in – in the - - - bathroom, because we've got a – lots of kids coming to choking risk and all that stuff.' [34]

This passage in my view was somewhat ambiguous because the interviewer did not establish whether Ms Mangat was speaking about the situation prior to Sophia's death or since Sophia's death. However, in cross-examination by Ms Waite of counsel assisting, Ms Mangat appeared to concede that it had occurred to her that gloves presented as a choking risk to children, not necessarily to any specific child but to children in general[35]. I made due allowance for the fact that English is not Ms Mangat's first language, but her English was quite good. In the event I was unable to place complete reliance on Ms Mangat's evidence, particularly in relation to Sophia's tendency to put things into her mouth other than food and where her evidence differed from others on the same subject, I preferred the evidence of those others, in particular the evidence of Ms Nisco and Ms Dalton in respect of what was said at the meeting of 25 January 2017.

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[31] Transcript, pages 173-174
[32] Transcript, page 223
[33] Transcript, page 223
[34] Exhibit C18c, page 36
[35] Transcript, page 208

5.29. Mr Singh was also examined about the same issues. He told the Court that he did not believe that Ms Nisco had said anything about Sophia's fascination with gloves at the meeting of 25 January 2017[36]. He did not remember Ms Nisco making any mention of Sophia needing to spend more time out of her wheelchair[37]. As far as Sophia's Participant Profile was concerned Mr Singh acknowledged that before starting work with a new child they would read the profile to ascertain the child's likes and dislikes and other matters. In respect of the passage in Sophia's profile where it was stipulated that she should not be in her chair all the time but needed watching as she would put everything in her mouth, Mr Singh said that he could not really remember that, but that he probably would have read it[38]. Asked whether he was aware that Sophia would often put items in her mouth he said '*I don't know which items. Like she put – I don't know, I don't remember very well now*'[39]. In a further passage of Ms Waite's cross-examination on the same subject matter Mr Singh was conspicuously evasive, even allowing for the fact that English was not his first language[40]. In the event I had to insist that Mr Singh directly answer the question as to whether he knew from his own observation or otherwise that Sophia had a tendency to put things other than food into her mouth. His response was:

> 'Yeah I would say - care plans, yes. I would say yes.' [41]

Asked about whether Sophia presented as a choking risk having regard to matters such as her special diet and her PEG, Mr Singh did not acknowledge that. In re-examination by his counsel, Mr Tilley, he agreed that it was known among staff that Sophia had a tendency to put items into her mouth such as grass and bark[42]. On the whole Mr Singh was not a satisfactory witness.

5.30. I have referred to Mr Bishnoi. Mr Bishnoi was a team leader. He was not present at the facility on the day of Sophia's death. Mr Bishnoi gave oral evidence. He told the Court that he never had to pull anything that was non-edible out of Sophia's mouth[43]. His evidence was to the effect that the only substance that Sophia would have a tendency to grab and put in her mouth was food and that the only risk that this presented

[36] Transcript, page 263
[37] Transcript, page 264
[38] Transcript, page 264
[39] Transcript, page 265
[40] Transcript, pages 278-279
[41] Transcript, page 279
[42] Transcript, page 304
[43] Transcript, page 376

was spillage[44]. As a team leader Mr Bishnoi acknowledged that he was required to read the Participant Profile[45]. He also acknowledged that there was an expectation that staff were to refer to that document and even went so far as to describe it as '*the bible they have to go by*'[46]. As far as Sophia's profile was concerned, and in particular the entry that she needed to be watched when not in her chair as she would put everything in her mouth, and whether that was consistent with his own observations of Sophia, he said:

> 'Usually it was, I would say yes, usually it would be the food items which I've seen, had seen.' [47]

Mr Bishnoi reiterated that although the document did not specify food items, he had seen food items and the chewy as being the items that would be placed in her mouth. He said that he did not remember Sophia having opportunities to grab other things and put them in her mouth[48]. He also told the Court that he knew nothing about Sophia in respect of gloves or any special risk presented thereby[49].

5.31. Mr Bishnoi also said that Sophia played on her own. He suggested that she did not need to be observed at all times out of the wheelchair because she would love to go to the play room and play on her own. He said:

> 'There wasn't any risk where you'll be worried that you left her alone in her room and you have to be there with her. So I wouldn't say 24/7 or all the time.' [50]

He implied on a number of occasions in his evidence that Sophia was like any other child in respect of her need to be watched in that one would keep an eye open and see what all the children were doing[51]. Asked specifically whether he denied that there was a need to supervise Sophia all the time when she was out of the chair, Mr Bishnoi said that he did not deny that and again suggested that staff would keep an eye on all children who were in their care, as if to say that there was nothing particularly special about Sophia. I rejected that characterisation of Sophia's need for supervision. It was well documented that Sophia needed to be watched because she put 'everything' in her mouth and that everything was not restricted simply to food.

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[44] Transcript, page 378
[45] Transcript, page 395
[46] Transcript, page 380
[47] Transcript, page 380
[48] Transcript, page 380
[49] Transcript, page 455
[50] Transcript, page 384
[51] Transcript, page 385

5.32. Mr Bishnoi, as with the other witnesses, stated that he knew nothing about gloves posing a risk and that gloves were not mentioned at the staff meeting of 25 January 2017. As far as other topics were concerned, and in particular Ms Nisco's discussion about Sophia needing to be out of her wheelchair, he said he did not remember and would just be guessing about that[52]

6. The evidence of Ms Amy Rowe

6.1. Ms Amy Rowe is a special education teacher with Autism Queensland. She told the Court that she has had several roles in the disability industry. She had been employed as a child support worker with disAbility Living at Riverside. She was employed there from 2014 to the end of 2016. Her resignation from that organisation occurred in 2017.

6.2. Ms Rowe was no longer working at Riverside in February 2017 when Sophia met her death. Ms Rowe was not present at the staff meeting of 25 January 2017.

6.3. Ms Rowe gave her evidence by way of video conference from Queensland. Ms Rowe told the Court that she had cared for Sophia Nisco on many occasions at the facility. She was working at the facility when Sophia first started attending there. Ms Rowe told the Court that at one stage she was working every weekend. Thus for a period she saw Sophia fortnightly. The essential feature of her evidence was that the risk of Sophia choking on a glove was well understood at the facility. In due course Ms Rowe would contact police about the matter.

6.4. Ms Rowe told the Court that she learnt of Sophia's death the day after she died. On that day she was phoned by Ms Cheryl Hugo who was the senior manager of development and specialist support at disAbility Living. The conversation gives some but not a complete insight into who knew what about Sophia's alleged fascination with disposal gloves. Ms Hugo told Ms Rowe that Sophia had died after choking on a glove. Ms Rowe said that her reaction to that information was one of absolute shock because, so she asserts, the risk of death by that method was '*so well known*'[53]. Asked by me as to whether she had said anything to Ms Hugo about the fact that gloves had presented

[52] Transcript, pages 415-416
[53] Transcript, page 335

a risk to Sophia and that the risk had been identified at a time prior to Sophia's death, Ms Rowe said:

> 'Yes, I believe I did in that conversation. I've thought a lot about that phone conversation recently. Yes, I said 'How could this happen? This was known, this is - yes, this should not have happened because it was predictable'. It was, yes, just the client should not pass away due to a choking hazard and it be predictable, that's not okay.' [54]

Asked whether Ms Hugo responded to those observations, Ms Rowe said that she had not. Ms Hugo had simply wanted to talk about how the staff had responded to the crisis that had presented itself at the time of Sophia's death. Ms Hugo confirmed in her evidence that she had telephoned Ms Rowe to let her know that Sophia had died. Ms Hugo told Ms Rowe that a glove had been responsible for Sophia's death. She said that Ms Rowe's reaction to that was one of shock. Ms Rowe had seemed shocked that a glove had been involved. She said that Ms Rowe was:

> '… crying a lot. She was very shocked. All of the staff that I spoke with, we talked about gloves and all of the staff including Amy and I said 'Did you know anything about the gloves' and everyone has said no to me.' [55]

When asked by me about what if anything she had asked Ms Rowe about gloves, Ms Hugo said:

> 'Well, I don't know - when I was talking with all of the staff it was I spoke with around about half of the staff about that Sophia had passed away and I said that she had choked on gloves and I would have been rambling. So I would have been saying - and I recall saying pretty much the same sort of thing to everyone, 'I can't believe this has happened', about the gloves, 'Did you know anything about the gloves?', that kind of thing and there was no reaction around that from Amy.' [56]

I asked Ms Hugo whether Ms Rowe at any stage after Sophia's death had asserted that she herself had identified a choking risk associated with gloves. Ms Hugo said that Ms Rowe had not, but that if Ms Rowe had known about a risk involving gloves her obligation would have been to update Sophia's profile[57].

6.5. Ms Hugo told the Court that she herself had not known anything about risk associated with gloves. She had asked Ms Mangat and Mr Singh as to whether they had known anything about a risk associated with gloves and their response was that they had not.

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[54] Transcript, page 336
[55] Transcript, page 515
[56] Transcript, page 515
[57] Transcript, page 516

6.6. If Ms Rowe had identified disposable gloves as having presented as a choking hazard to Sophia it would have been odd for Ms Rowe not to have mentioned this when she had an opportunity to do so when speaking with Ms Hugo. As seen, Ms Hugo asserts that Ms Rowe in effect said nothing about that to her.

6.7. Yet Ms Rowe in her extensive evidence had much to say about the risk that disposable gloves presented to Sophia and how widely that was known at the facility. Ms Rowe told the Court that Sophia put everything in her mouth and that everything was a risk to Sophia. All small objects presented risks[58]. She said it was also well known that Sophia, in spite of her disability, had great mobility and that although she was free to roam the house, she had to have staff supervision[59]. Asked as to whether staff would have had that same understanding, Ms Rowe said:

> 'Definitely. It was so obvious. It was clear as day. Yeah, she was very quick, very quick and she was very cheeky, so even if you were with her if you weren't watching and she wasn't listening she could do things that you asked her not to do so you had to watch her and you had to make sure her environment was safe.' [60]

She went on to say that it was constantly discussed that Sophia needed to be watched all the time and that if Sophia left a room someone needed to have eyes on her. Ms Rowe believed that Sophia needed the absolute maximum funding to facilitate constant observation of her. Ms Rowe said that all staff at the facility had an obligation to read client profiles[61]. So much was not in dispute. Ms Rowe herself had read Sophia's profile including the entry that stated that Sophia was not to be in her chair constantly but needed to be watched as she would put everything in her mouth. Ms Rowe was of the view that '*everything*' really did mean everything. Ms Rowe also said that she believed that this entry had been sufficient to identify a choking risk even though the word choking was not mentioned[62]. Ms Rowe also said that Sophia's restricted diet also illustrated the need to watch Sophia and what went into her mouth. It was also to be identified from such a diet that choking was to be seen as a large risk. She said:

> 'All these factors illustrate quite a complex disability and quite a complex need for feeding and therefore, a large risk of choking.' [63]

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[58] Transcript, page 311
[59] Transcript, page 314
[60] Transcript, page 314
[61] Transcript, page 317
[62] Transcript, page 319
[63] Transcript, page 320

6.8. Ms Rowe was naturally aware of the presence of disposable gloves in the Riverside premises. She said that they were kept in the ensuite bathroom of the main bedroom, in the pantry in the kitchen and in the linen closet in the hallway. Ms Rowe told the Court that she would find gloves in places and put them away. There was no instruction from management to keep gloves off benches[64]. She was concerned about gloves because she thought that they presented as a choking risk to many clients. Asked whether she had specific concerns about Sophia and gloves, she said that she did because Sophia loved plastic gloves and would put them in her mouth. She said that she sought out gloves. Ms Rowe said that for some reason gloves were attractive to Sophia and that this was well known[65]. Ms Rowe believed that the issue of gloves was the subject of constant discussion and that she was sure it would have been mentioned at staff meetings.

6.9. Ms Rowe stated in evidence that at one stage she had asked Peter Bishnoi for a safe to be installed in the bathroom so that all liquids and gloves could be locked within it. A 'wish list' had been prepared in respect of the facility as a whole. She said that she had included the provision of such a safe on that wish list. I would pause here to observe that there was a wish list prepared and it did include a request for a bigger medications safe or lockable draw for the staff room, as well as a lockable draw or vanity for the bathroom in which items could be stored. However, aside from Ms Rowe's assertions, there was no evidence that a safe or lockable receptacle was ever intended or contemplated for the storage of disposable gloves. As well, there was no evidence that the question of gloves, the risk presented by gloves or the need to keep them under lock and key was recorded in the minutes of staff meetings, including of course the meeting of 25 January 2017.

6.10. Ms Rowe was extensively cross-examined by Mr Tilley of counsel for disAbility Living. He attempted to build a case through his cross-examination of Ms Rowe that her evidence was coloured by hidden resentment on her part in relation to the manner in which she had been treated after she had ceased work at the facility. Ms Rowe had become a figure of controversy before Sophia had died. In particular it was suggested that she was resentful about the fact that in 2017 she had not been given any shifts at the facility and that in 2017 she had borne an attitude of hostility towards disAbility

[64] Transcript, page 321
[65] Transcript, page 322

Living in respect of that issue as well as in respect of the facility's tardiness in paying Ms Rowe monies owed in respect of the use of her private vehicle.

6.11. Ms Rowe had approached the police in relation to her concerns after she had learnt of Sophia's death. She told the Court that she had not been motivated by any ulterior consideration in doing so. She said that she did not have any grudge against disAbility Living. She said that she was motivated by the fact that Sophia had passed away in a manner that was, to use her expression, '*absolutely predictable*'. She said that Sophia would put everything in her mouth, that she would seek out gloves, seize things off tables and pick up whatever was on the ground. She believed that it was unacceptable that Sophia had passed away when she should have been under the care of paid staff. This had been her motivation. When it was put to her in cross examination that in going to the police she had been motivated by a desire to get disAbility Living in trouble she flatly denied it [66].

6.12. There was another issue about which Ms Rowe was cross-examined extensively. This concerned an amount of money that Ms Rowe believed she was owed by disAbility Living to compensate for the use of her private vehicle in connection with her employment. The suggestion in effect was that this issue had also fomented resentment on her part towards disAbility Living. Ms Rowe told the Court that on several occasions she had sought this reimbursement but that ultimately the matter was settled. She believed that the sum of money had been outstanding for some months. When asked how much money had been involved in her claim she said that she could not remember exactly but it was probably in the vicinity of $50. She said '*this was not a massive issue, this did not create big drama*'[67]. Asked by Mr Tilley to confirm that it was only a small amount in issue, she said it was not hundreds and hundreds of dollars, but that it involved a reimbursement to which she was entitled.

6.13. I would have regarded the suggestion that Ms Rowe had been motivated to give false evidence against her former employer over such a small sum of money as completely fanciful were it not for the following revelation. During her cross-examination it was

[66] Transcript, page 352
[67] Transcript, page 349

revealed that the amount in question in fact had been $765. Ms Rowe's reaction to this was as follows:

> 'Well there you go. I cannot remember. I honestly I cannot remember, hand on Bible.' [68]

She accepted that the figure could have been $765 but said that she had not been lying when she had mentioned the much lesser figure of $50. There is a significant difference between the sum of $50 and the sum of $765. The greater figure is one that ought to have been remembered. The revelation of that difference caused me to question Ms Rowe's evidence that to her the money had not been a massive issue or a big drama in her mind, in other words that the sum of money that was outstanding had not affected her attitude towards her former employer. It was a small point, but a point which made me question whether or not Ms Rowe was totally reliable. It made me question whether her evidence could be relied upon where it differed from the evidence of others. It also made me hesitate in accepting Ms Rowe's evidence as to fine detail.

6.14. As to her evidence that she suggested that a safe was needed to store toiletries and specifically gloves, there was no documentary or other evidence within disAbility Living to support her assertion that gloves being an item that needed to be kept locked away had ever been a subject of discussion. Any documented material that there was in relation to the acquiring of a locked container did not mention anything about gloves. Assertions that this issue may have been mentioned at a staff meeting were also not supported by documentary evidence that was tendered to the inquest.

7. <u>The evidence of Ms Cheryl Hugo</u>

7.1. Between 2012 and 2018 Ms Hugo was Senior Manager of Development and Specialist Support for disAbility Living. She was in essence the manager of Riverside. In February 2017 which was the month in which Sophia died, she was the General Manager based at the company's head office in Stepney. As such she oversaw the service that was provided at the Riverside facility.

7.2. Ms Hugo gave oral evidence in the inquest. I found Ms Hugo to be an impressive and truthful witness.

[68] Transcript, page 361

7.3. In her evidence Ms Waite of counsel assisting drew Ms Hugo's attention to the Novita document mentioned earlier in which it was stated that Sophia required constant supervision as she was able to access items in the home and that this posed a choking/safety risk. Ms Hugo told the Court that disAbility Living would have received that document, although it would not have been seen by staff[69]. However, Ms Hugo told the Court that the information the document contained would have been communicated to the staff either by way of entering into the client's profile or spoken of at a staff meeting, so that the information that Sophia required constant supervision and the choking risk would have been discussed with staff[70]. Constant supervision in Ms Hugo's eyes meant that staff would have had to watch the relevant child all of the time[71]. This did not necessarily translate into one-on-one supervision. Ms Hugo said that leaving a child in a room on his or her own for several minutes out of the sight of the carer was not consistent with the notion of constant supervision. In regard to the situation that applied in this particular case where a staff member was called away to attend to another child, Ms Hugo said that the staff member should have had an awareness of what was happening in respect of the children and that rather than leaving the child, the alternative would have been to take the child with the carer. Ms Waite pointedly asked Ms Hugo as to what she would say to the asserted claims that staff were not aware that Sophia required constant supervision and that she posed a choking/safety risk. To this proposition Ms Hugo said:

> 'Well, that that's untrue because, you know, the staff meetings that I attended we talked about, you know, safety for children and risk and choking was talked about at staff meetings.' [72]

She also said that any child with an eating or drinking plan such the one that Sophia had would indicate a risk of choking or aspiration. The propensity for her to put things into her mouth also signified a choking risk[73].

7.4. I did not see any written evidence of references to Sophia's choking risk in any documentation that was tendered to the Court, but I have little doubt that Ms Hugo was accurate when she said that choking risks would be mentioned routinely in staff meetings. I have also found in any event that at the meeting of 25 January 2017,

[69] Transcript, page 477
[70] Transcript, page 478
[71] Transcript, page 478
[72] Transcript, page 479
[73] Transcript, page 479

choking risks were specifically mentioned in relation to Sophia and that despite this nothing was recorded in the minutes of that meeting about it. To my mind the staff meeting minutes were not necessarily a reliable source of information.

7.5. Ms Hugo also gave convincing evidence that there was no specified requirement in respect of Sophia that she was to have one-on-one care at all times. Ms Hugo said that she was not asked to quote for one-on-one care. She did not believe that Sophia needed one-on-one care as such, other than for excursions for which one-on-one care was funded. Ms Hugo believed that Sophia would receive constant supervision with two-to-one care which was adequate if the children were being watched[74].

7.6. As to the Participant Profile relating to Sophia, Ms Hugo agreed that it should have included reference to risk. She did not recall whether she had participated in the compilation of this document, but acknowledged that the reference in the document to Sophia not being in her chair all the time but that she needed to be watched as she would put anything in her mouth, had not been written in an appropriate place. She said that this information related to a risk in respect of Sophia and that normally matters pertaining to risk should be on the front page. For example, risk of anaphylaxis or epilepsy or choking would be entered on the front page[75].

7.7. Ms Hugo also said that if any staff member identified a particular choking risk they were under an obligation to update the information in the profile. She said that it was '*everybody's responsibility*' to do so[76].

7.8. Ms Hugo candidly acknowledged that she had recognised from her personal dealings with Sophia that Sophia was at risk of choking. She was asked to explain this. She said:

> 'Well I knew that she had an eating and drinking plan, which is a key in understanding that there may be a risk of choking, because I know that all children are at risk of choking, and you know, first aid training has a choking component to it. But also, developmentally, Sophia, in putting things in her mouth at that time is a risk of choking, so I'm aware of that.' [77]

[74] Transcript, page 485
[75] Transcript, page 493
[76] Transcript, page 495
[77] Transcript, page 496

Ms Hugo herself had observed Sophia putting things into her mouth such as toys. She acknowledged that Sophia would put things other than food into her mouth[78]. Specifically, she had seen Sophia in the play room putting toys in her mouth. Ms Hugo also acknowledged that it was very likely that if Sophia tipped over a bin she would put the contents into her mouth.

7.9. Ms Hugo said, however, that she had not been told anything about Sophia having a fascination with gloves. If she had been told anything about that she would have locked them away. She had been aware of the '*wish list*' that included the stated need for a lockable drawer in a bathroom. She recalled discussion about this at a meeting. Her recollection was that this was contemplated for the storage of such things as shampoo that could be ingested. She had no recollection that such things as gloves and nappy bags were specifically mentioned as items that needed to be kept in a lockable container. She said that having regard to the circumstances of Sophia's death she would have remembered if such discussion had taken place[79]. She said that in any event she did not believe that staff would be viewing gloves as posing a particular risk. Ms Hugo herself had never heard anything about the risk of choking on gloves[80].

7.10. Ms Hugo spoke of her interaction with Ms Amy Rowe. She had been made aware of a complaint made by Ms Rowe in relation to her not being provided with any shifts and described in brief terms an unpleasant conversation with her. However, Ms Hugo denied that Ms Rowe had raised anything with her about Sophia's access to gloves or any need for one-on-one care[81].

7.11. Ms Hugo also said that she had asked Ms Mangat and Mr Singh as to whether they had known anything about a risk associated with Sophia having access to gloves and both of them had said they had not.

7.12. Ms Hugo was closely cross-examined by Mr Tilley of counsel for disAbility Living. Asked by Mr Tilley as to whether at any stage Ms Hugo had told staff members that Sophia would put things into her mouth other than food, she said that she believed that when Sophia was entering into the service there was discussion with staff in which she spoke about Sophia putting toys into her mouth and that periodically the toys were gone through to make sure there were no pieces broken off. Asked as to what Ms Hugo

[78] Transcript, page 496
[79] Transcript, page 500
[80] Transcript, page 500
[81] Transcript, pages 513-514

would say to the suggestion that a significant proportion of the facility's carers were ignorant of the fact that Sophia would put things into her mouth other than food, she said the staff who worked with Sophia would have seen her put things into her mouth such as toys. They would have also understood Sophia's liking for marshmallows and that she could not have too many at a time[82].

8. Discussion

8.1. In my view it is highly unlikely that at the meeting on 25 January 2017 both Ms Nisco and Ms Dalton neglected to mention the two subjects involving Sophia placing things into her mouth. It will be remembered that this issue was documented in the handwritten agenda prepared by Ms Dalton, both in respect of Sophia's tendency to pull the button on the gastrostomy tube out and put it in her mouth with the possibility of choking and, secondly, the need for her to be supervised at all times when out of her wheelchair because she would put anything in her mouth. In my view it is unthinkable that having gone to all of the trouble of compiling this agenda neither woman raised either subject.

8.2. The fact that marginal notes were written against both of those entries in the agenda supports the fact that they were mentioned at the meeting. I am mindful of the evidence of Ms Mangat, Mr Singh and Mr Bishnoi that the subject of Sophia's tendency to put things into her mouth was not mentioned at the meeting and I am also mindful of the fact that neither the handwritten minutes taken by Mr Bishnoi, nor the typed version of the minutes, say anything about that issue save and except for a notation that Sophia's onesie should be placed on backwards for school due to the risk of her pulling out the '*gastro plug*'.

8.3. However, I preferred the evidence of Ms Nisco and Ms Dalton to that of Ms Mangat, Mr Singh and Mr Bishnoi and find that at the meeting of 25 January 2017 at which those three staff members were present there was discussion to the effect:

- that Sophia's onesie must be placed on her with the zip at the back to prevent her from pulling out the gastrostomy button;
- that the underlying reason for preventing this was because of Sophia's tendency to put the button in her mouth with the possibility that she might choke on it;

[82] Transcript, pages 543-544

- that in this context there was a risk of Sophia choking while being driven;
- that Mr Bishnoi (Peter) would remind all staff to ensure that Sophia's onesie was worn back to front with the zip at the back;
- that Sophia should be encouraged to spend time out of her wheelchair;
- that when Sophia was out of her wheelchair she must be supervised at all times as she would put anything in her mouth;
- that it was acknowledged by staff at the meeting that staff were well aware of Sophia's capabilities in this regard and of the risks that this presents to her. It was also acknowledged that Sophia did try to crawl everywhere and that she was fast.

In coming to those conclusions I have relied on the accuracy of the written agenda that had been prepared by Ms Dalton and the accuracy of the marginal notes that were placed on the document as a result of the meeting. I do not believe they are a fabrication. It was not suggested to Ms Nisco nor Ms Dalton in cross-examination that either the original handwritten agenda or the marginal entries were a fabrication. I do not believe that Ms Nisco and Ms Dalton had formed any type of understanding whether express or complicit to deceive the Court in respect of these issues.

8.4. However, I was not persuaded that the issue of Sophia's propensities in respect of gloves and the risks that might thereby be presented to her as far as choking was concerned was mentioned at this meeting. There is no documentation to this effect either within the handwritten agenda or its marginal notes, or in the handwritten or typewritten versions of the minutes. In short, I was unable to determine where the truth lies in relation to this issue. It is possible that neither Ms Nisco nor Ms Dalton mentioned the issue of gloves at the meeting. It is possible that they are mistaken about this issue in the light of the fact that as things transpired Sophia choked on a glove.

8.5. I have accepted Ms Rowe's evidence that Sophia had a well-known tendency within the facility to place items in her mouth and that it was understood that this would present as a choking risk. I have also accepted Ms Hugo's evidence in this regard. I was unable to conclude from Ms Rowe's evidence that she had specifically drawn to the attention of staff or management of the facility the need for Sophia to be kept away from the disposable gloves that were used within the facility. In respect of the matter involving the amount of money that Ms Rowe said she was owed by the management of the facility she demonstrated that she could be unreliable in respect of detail. This is not to say, however, that I concluded that Ms Rowe was lying about the question of gloves.

It is simply a case of me not being satisfied to the necessary degree that she was accurate about that issue.

8.6. I have also found that as at the day of Sophia's death both Ms Mangat and Mr Singh were both aware of a number of behavioural issues that applied to Sophia, namely:

- that despite her disability Sophia was able to move about the house quickly;
- that Sophia had a tendency to place objects in her mouth that were not restricted to food items;
- that Sophia's tendency to place things in her mouth would have presented as a choking risk for her;
- that for those reasons Sophia needed to be watched at all times.

8.7. Supporting these findings is the fact that Sophia's profile document made specific reference to Sophia's tendencies to place things in her mouth. I was satisfied that both Ms Mangat and Mr Singh had access to that document and would have read it at some point in time, and in particular had read that entry.

8.8. I was not satisfied that Ms Mangat nor Mr Singh understood that the disposable gloves that were present in the facility presented as a particular risk to Sophia, either in terms of her tendency to place such an object in her mouth or in terms of the risk that this would have presented as far as choking is concerned. However, given Sophia's tendency generally to place items in her mouth, it was foreseeable that if gloves were left either on the floor, in rubbish bins or even in their original dispensers in places that Sophia could access, she might place such an item in her mouth and that this would present as a choking risk for her.

9. Did Sophia require one-on-one care?

9.1. A great deal of evidence and debate in respect of this issue was ventilated during the course of the inquest. The evidence was clear enough that when the Novita organisation had responsibility for the funding of Sophia's care that one-on-one care was funded for a period of five hours to cover excursions on the Saturday of any weekend during which Sophia was accommodated at Riverside. It was anticipated at the time of her death that six hours of one-on-one care would be funded through the NDIS in respect of excursions on both Saturdays and Sundays.

9.2. The evidence was less clear as to whether one-on-one was meant to be provided while Sophia was actually within the facility itself. I note that Ms Nisco's expectation was that one-on-one care would be provided to Sophia. However, it appears from the evidence as a whole that the facility and its staff and management did not understand that one-on-one care would be provided at all times within the facility itself.

9.3. However, regardless of whether one-on-one care was to be provided in the sense that Sophia would always have a dedicated carer whose sole responsibility was to supervise and care for Sophia, it was clear enough to staff that Sophia needed to be watched at all times.

9.4. At the time of the incident that led to her death, which was sometime between 3:30pm and 4pm on the afternoon in question, there were only two carers on the premises. They were Ms Mangat and Mr Singh. The third carer Mr Nuwan Somaratna, was in the process of leaving the facility or had left at the time of the incident. A replacement third carer was not due to start until 4pm, by which time the incident had occurred and Sophia had died. The reason for this half hour hiatus was not clearly explained in the course of the inquest. It is sufficient to say that it should not have occurred. I say this having regard to a number of factors that prevailed during the course of the afternoon in question. They were the fact that Ms Mangat was required to provide one-on-one care to the 10 year old boy H, that as the only female person on the premises she was required to attend to the showering needs of Sophia, that she was required to attend to the cooking of the evening meal, the fact that there was another severely disabled person, Sophia, on the premises and the fact that there were two other children on the premises. To my mind the number of carers present at the premises at the time of the fatal incident was manifestly insufficient. All that was needed for staff to be distracted from Sophia's needs was an incident that involved the child H whose propensities were well known. It was foreseeable that an occasion might arise where two people would be required to attend to his needs.

9.5. Therefore, regardless of whether Sophia required and was funded for one-on-one care, Sophia required constant scrutiny. The reason for this was her well known and documented tendency to put things in her mouth and her reasonable mobility despite her general disabilities. It is not possible to reconstruct the duration of the period in which Sophia was unseen prior to her discovery on the floor of the bathroom. I have accepted the evidence of Mr Singh that no heartbeat was detected when Sophia was discovered. Therefore all that can be said in relation to the duration in which Sophia

was unseen is that it was long enough for Sophia to have moved from the play room to the bathroom, for her to have located a disposable glove whether it be from the floor, a bin or a dispenser, and for her to aspirate it to the point where it obstructed her airway and ultimately cause a cardiac arrest. I do not believe that this could all have happened in an insignificant period of time.

10. Conclusions

10.1. The Court reached the following conclusions and made the following findings.

1. The cause of death of Sophia Nisco was upper airway occlusion due to the aspiration of a foreign body with contributing cerebral palsy. The object that caused her fatal airway obstruction was a disposable glove.

2. Sophia died at the Riverside disAbility Living premises sometime between 3:30pm and 4pm on 11 February 2017. Sophia had last been seen in the play room of the premises. At that time there were two carers on the premises and four children including Sophia. The attention of Ms Mangat, one of the carers, was drawn to the needs of another child who was situated in the lounge room. That afternoon Ms Mangat had the responsibility to provide one on one care to that child. Ms Mangat and Mr Singh, the other carer on the premises, tended to that child's needs. This meant that Sophia was left unobserved in the play room.

3. It is not possible to say with precision for how long Sophia was left unobserved, but it was long enough for her to move from the play room to the bathroom, to take possession of a glove and aspirate it. Furthermore, by the time that she was located she was in cardiac arrest.

4. Resuscitative measures were implemented in relation to Sophia. Unfortunately they were all unsuccessful.

5. I find that Sophia's propensity to put objects in her mouth indiscriminately, and that this posed a choking risk to her, was known to both management and staff of the Riverside facility. In particular, I find that these characteristics in respect of Sophia were known to the carers who were present on the premises on the afternoon in question. That knowledge in my assessment had been gleaned from a reading of Sophia's Participant Profile 2015 and also from statements that were made by Sophia's mother at a staff meeting that had taken place as recently as 25 January

2017. As well, it is idle to think that neither carer in their previous dealings with Sophia had gained an impression of Sophia's behaviours and characteristics. I make no finding as to whether or not Sophia's fascination with disposal gloves and whether they posed a particular risk of choking to Sophia was specifically understood by the management or staff members of disAbility Living.

6. Sophia required constant observation while on the Riverside premises. She did not receive constant observation. It was while she was unobserved that she was able to find a glove and aspirate it. Her death would have been prevented if she had been provided with the necessary level of supervision and observation.

7. I find that at the time Sophia was left in the play room and then aspirated the disposable glove the number of staff present at the facility was inadequate. There were two children on the premises whose needs were high. One of those children, H, was designated as requiring one-on-one care. The carer who was meant to be providing that one on one care to H was Ms Mangat. When Ms Mangat attended to the needs of that child Sophia was left unobserved by any carer. Sophia should not have been left alone and unobserved.

8. Sophia's written care plan being the Participant Profile 2015 was, of itself, a document that was inadequate as a means of identifying and managing risk of harm to Sophia.

11. Recommendations

11.1. Pursuant to section 25(2) of the Coroner's Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

11.2. Mr Tilley of counsel for disAbility Living tendered to the Court[83] a summary of the organisational actions and responses that were implemented by his client following the death of Sophia Nisco. These actions included a review of the risk that was presented by toys at Riverside, the institution of tamper proof rubbish bins, the placing of a poster regarding choking risks with staff being trained to respond to choking emergencies and to be made aware of all potential risks. Other measures have included waste bags to be

[83] Exhibit C27

used for disposable gloves, wipes and other items. Gloves will be locked in an office and are to be kept out of areas where a child could possibly access them. In addition, a measure was implemented whereby children at higher risk of choking would be identified and staff would be advised both verbally and in writing and as to the identities of those children. The information regarding children and their risk of choking would be highlighted in each individual's profile. Other initiatives have included measures relating to the supervision of children during meal time preparations and a review of the staff ratios.

11.3. DisAbility Living is to be commended for the implementation of those measures.

11.4. In my view there are other measures that should be contemplated. What constituted a care plan of sorts in respect of Sophia, namely the Participant Profile 2015, was an inadequate document insofar as it attempted to identify and address risks to a vulnerable individual such as Sophia. The information regarding Sophia's propensity to put things in her mouth and the risk that this posed to her was scant and inadequate. Such information should be prominently displayed in any care plan, as should the means by which the particular circumstances relating to a child should be addressed.

11.5. I would therefore recommend that disAbility Living revise their procedures in relation to the preparation of care plans for individual clients. The care plan should not be confined to a simple profile of the individual. The care plan should address such matters at the client's characteristic behaviours, the risks posed by those behaviours and should document the plan as to how those risks should be managed. Any care plan should be the subject of constant review. The care plan should also refer to the level of supervision and observation that an individual client requires. The identification of risk and the means by which risk should be managed should be prominently displayed on the first page of the plan. All such plans should be signed by staff members with a declaration that they have been read by those members. The same should apply to revised versions of any such plan. I recommend accordingly.

11.6. In my view there is a need, and I recommend accordingly, for management of and for carers within facilities such as the Riverside facility to have access to a client's medical history. In addition, Mr Tilley on behalf of Disability SA in his helpful submission referred to the desirability for an all-encompassing functional needs assessment to be undertaken in respect of all individual clients. I agree with that observation. In this

regard I have already referred in these findings to a previous inquest in the matter of **Lawrence Betts**. In that matter the Court recommended that disabled children be medically examined prior to their placement in institutions, including respite facilities, and that the resulting assessment be made available to the management and staff of respite facilities. Although the circumstances in **Betts** were different from those that prevailed in respect of Sophia, in that the **Betts** child was a child who was under the Guardianship of the Minister, there is a need for very detailed information to be made available to the management and staff of all facilities where disabled children are provided with respite care regardless of whether or not the child is under State care. A medical examination and assessment would be part of a functional needs assessment to be conducted prior to a child being admitted to an institution or respite facility. It is worthy of note that in this case a medical practitioner, Dr Tidemann, had been consulting with Sophia for her entire life. It appeared to me that the knowledge that Dr Tidemann had gained in respect of Sophia's abilities and risks would have been invaluable to the staff and management of disAbility Living.

11.7. Finally, the Court recommends that in respect of the care of disabled children in institutions and respite facilities that a dedicated '*key worker*' be assigned to each individual child. The key worker should be responsible for the oversight of the care provided to the child, for the education of other care workers in respect of the needs and safety of the child, to act as a focal point for the reception and recording of information relating to the needs and safety of the child and also be responsible for the upkeep of care plans and other documentation relating to that child.

Key Words: Choking; Respite Care; Children - leave unattended

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 28th day of February, 2020.

Deputy State Coroner