STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	**Inquest into the death of Madeline Rose Duffy.**
Hearing dates:	9 July 2015 and 23 November 2015;
Date of findings:	27 November 2015
Place of findings:	State Coroner's Court, Glebe
Findings of:	Magistrate Sharon Freund, Deputy State Coroner
File numbers:	2014/04099
Findings:	I find that Madeleine Rose Duffy died on 6 April 2014 at Cerebral Palsy Alliance, 3 Belvedere Avenue, Castle Hill 2154 and that her cause of death was asphyxiation and respiratory failure on a background of severe dystonic quadriplegia. The manner of her death was misadventure
Catchwords:	CORONIAL LAW – Cerebral Palsy, Respite Care, Care and Treatment;
Representation:	Mr S. Kelly advocate assisting the Coroner; Mr W. de Mars, Legal Aid for Ms Maree Duffy; Mr N Chen instructed by Williamson Legal for Cerebral Palsy Alliance;

FINDINGS

Introduction

1. Madeline ("Maddy") Rose Duffy was just 18 years age when she passed away on 6 April 2014. She is survived and clearly very much missed by her parents Anne Maree Duffy, Gary Duffy and her twin sister Bridget.

2. As an infant Maddy was diagnosed with and suffered from severe dystonic quadriplegic cerebral palsy and as a consequence she experienced a very severe movement and muscle disorder affecting her whole body. She was on all accounts dependent on her mother and/or her carers for most, if not all of her needs.

3. Maddy died while she was in respite care with the Cerebral Palsy Alliance at their facility at 3 Belvedere Avenue, Castle Hill.

The function of the Coroner

4. The usual role of a Coroner as set out in s. 81 of the *Coroners Act 2009* is to make findings as to:
   a. the identity of the deceased;
   b. the date and place of a person's death;
   c. the physical or medical cause of death; and
   d. the manner of death; in other words, the circumstances surrounding the death.

5. A Coroner, pursuant to s. 82 of the *Coroners Act 2009*, also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

6. It is convenient to note at this juncture the comments of the then State Coroner, Derek Hand, in the *Inquest into the Thredbo Landslide* at p.10[1]:

   > *"The inquest plays an important function as a fact finding exercise, essential to investigate and answer the relatives' and public's need to know the cause*

[1] 19 June 2000, unreported

of death free from the constraints of inter partes litigation. It does not apportion guilt. Although not expressly prohibited by the Act, it is not the function of the inquest to determine any question of civil, let alone, criminal liability."

7. Similar observations were made by his Honour Justice Hedigan in *Chief Commissioner of Police v Hallenstein*[2] at [15].

8. As indicated by Counsel Assisting at the outset of this inquest, as Maddy was healthy prior to attending respite the day prior to her death this inquest examined a number of issues, including:
   a. What was the "cause" of Madeline's death?
   b. Were there any factors or circumstances during her respite at the Cerebral Palsy Alliance that may have "contributed" to either the "manner" or "cause" of her death?
   c. Are there any recommendations which, if made, might reduce the likelihood of a similar death occurring or might otherwise contribute to an improvement of public health and safety.

9. I will deal with each of these issues in turn.

Background

10. Cerebral Palsy is an umbrella term that is used to describe a group of disorders that result in a life long physical disability due to damage to the developing brain as either a foetus or infant.

11. There are several different forms and different degrees of Cerebral Palsy. The evidence indicates that Maddy was classified as having the most severe form of cerebral palsy namely, she:

    a. was classified as having GMFCS 5 as she was unable to sit or stand independently even with equipment. Maddy was confined to a wheelchair all the time. Her wheelchair supported her to sit upright, be safe and allowed her the opportunity to interact with her environment. It was often in a tilt position to assist her in feeling secure and in control.

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[2] [1996] 2 VR 1

b. Level 5 pursuant to the MACS classification range as she could not handle objects and had a severely limited capacity to perform even simple hand actions[3]; and

c. level 4 according to the Communication Function Classification System ("CFCS") which is a tool used to classify everyday communication of a person with cerebral palsy, in that she had inconsistent communication with familiar people. In order to communicate, Maddy would use a combination of vocalisations, facial expressions and body language to communicate. She would indicated 'yes' by saying 'yeh' or smiling. She would indicate 'no' by saying or mouthing 'no' (with her tongue). As such, it was necessary to ask Maddy questions that had a yes or no answer for clear communication[4].

12. Overall the degree of Maddy's disability was severe and as a consequence she was totally dependent on mother / carers for all her needs. To assist her at home, she had a hoist, an electric bed, wheelchair and a shower chair.

13. However, notwithstanding the severity of her condition Maddy on all accounts lived a full life, attended school[5] and was described as a "*good kid, and so smart. She knew what was going on around her, she knew who everyone was*". According to her carers, "*Madeline was funny, always smiled and was full of life*"[6].

14. It was the evidence of Mrs Duffy that: "*Madeline was always happy and smiling. She loved people and shopping. She liked going out to dinner and we would do everything together*". According to Mrs Duffy, Maddy was not a sickly little girl, "*she ate everything, and loved food. She ate lots of cake and yoghurt, she ate mash potato and pumpkin. She would have 4 peg feeds a day*".

15. As a consequence of her disability, Maddy suffered from dystonic hypertonia or increased tone, which caused a significant degree of discomfort and pain as a result of uncontrollable muscle spasms, stiffening or straightening out of muscles, shock like contractions of all or part of a group of muscles and abnormal muscle tone. Accordingly to ease her pain and

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[3] Exhibit 1, Tab 30 Report of Michelle Cohen 13 September 2011;

[4] Ibid

[5] She was at the time of her death a year 12 student at Cherrybrook Technology High School;

[6] Exhibit 1, Tab 8 – Statement of Teaghanne Serina dated 28 June 2014 at paragraph 6;

help control the muscle spasms, she was prescribed Baclofen and Diazepam in an attempt to reduce this muscle tone.

16. To assist her, calorie intake, Maddy had a gastrostomy tube that was used to supplement her daily oral food in-take, these were also known as “Peg Feeds”/ Gastronomy Feeds. At the time of her death Maddy required four Peg Feeds a day. These feeds consisted of 170ml of Ensure Plus through her tummy button which assisted in increasing her weight. Her other medications at this time included Losec for gastro-oesophageal reflux, Valium 2.5mg twice a day & Baclofen 3 times a day as well as paracetamol for pain. She was also prescribed (Antenex) (Diazepam) to assist settling her if required.

17. Maddy was also asthmatic.

18. At home, Mrs Duffy and Madeleine usually shared the same bed[7]. It was the evidence of Mrs Duffy that Maddy:

    a. usually slept on her side with a pillow – or pillows – behind her back and under her legs[8], and a pillow under her head[9]; and
    b. slept “like everyone else really”.

    Mrs Duffy considered that this position of sleeping was both safe and comfortable for Madeleine[10].

The Weekend of 5 April 2014

19. Maddy first attended respite care with the Cerebral Palsy Alliance (“**CPA**”) from about April 2007, when she was about 12 years old, at their respite care home at Castle Hill, NSW. She initially attended once a week, and these attendances increased. In 2014, Maddy would stay one weekend a term and on 3 days during the school holidays. She also attended one afternoon a week.

20. Through the CPA Maddy also received the assistance of Occupational Therapist, Speech Pathologist and was provided other specialist services to assist her in her daily living.

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[7] Mrs Duffy, 9 July 2015 – Transcript page16.5;

[8] T25.25

[9] T26.10

[10] T25.15-25.20

21. The CPA home at Castle Hill was a dwelling with four bedrooms and six beds[11].

22. On 4 April 2014, Maddy was taken by Mrs Duffy to the CPA respite facility at Castle Hill for respite care between Friday evening and Sunday.

23. When they arrived, Mrs Duffy spoke with the respite centre manager, Mr Ashkan Ajiri and provided him with the following instructions/ information, including:

   a) how Maddy was to be positioned during sleep[12], in short, the instruction was that Maddy was to be positioned on her left side;
   b) that she was to have a "tummy feed" before she goes to bed; and
   c) that she goes to bed late;

24. Mr Ajiri recorded Mrs Duffy's instructions in the communications book, which stated:

"*Maddy's mum asked that when we put her to bed, lay her on her left side with pillows behind her back. Her back to be propped up against the bed rails.*
Please also only give her small sips of drink as per mums request
Thanks Ash"[13]

25. The evidence indicates that on Friday 4 April 2014, sometime after 8pm Maddy was put to bed by Clodagh Deignon, another carer and Mr Ajiri who stated:

"*I placed Maddy into her bed the way that her mum asked us to. Maddy's [sic] appeared to be her normal self… and when she went to be this evening see [sic] appeared to be the same as another evening..*"[14]

26. It was the evidence of Ms Nicole Daniel[15], who started her shift at 10pm on 4 April 2014, inter-alia that:

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[11] see the statement from Jo-Anne Hewitt dated 2 July 2015 at [17]

[12] Oral evidence of Mrs Duffy 9 July 2015 at T19.50;

[13] Exhibit 1, Tab 24 – Annexure – copy of communications book 5/04/14;

[14] Exhibit 1, Tab 24 – Statement of Mr Ajiri at paragraph 10;

[15] Exhbit 1, Tab 22 – Statement of Nicole Daniel;

a. When she started her shift she spoke with Clodagh who told her about the change of sleeping position of Maddy at her mother's request;

b. She then went with Clodagh to check on Maddy "who was on her side in fetal position with knees tucked up and a pillow supporting her back. She was still awake."

c. she then commenced 10 minute checks on Maddy because she didn't think her breathing sounded right as normally Maddy makes noises when she is asleep;

d. at about 10.30pm, she asked Maddy whether she wanted to be repositioned into her old position on her back which she said she responded with a 'yes';

e. She then repositioned Maddy onto her back;

f. not long after doing this, Maddy appeared comfortable and went to sleep.

g. Thereafter, Maddy did not have any problems for the rest of the evening and she conducted regular checks on her about every 15 minutes.

27. On Saturday 5 April 2014, the notes from CPA record that Maddy went to the movies to see the movie 'The Lego' with the other children. The shift book entry for that date stated:

"*A busy morning all children up and ready by 9.00am to go to the movies supplied by kids flix. All children happy and well. Left Respite to go to Castle Hill Towers to watch the lego movie. Joel, Madeleine, Nicolas and Mark brought and ate lunch after movies*".

28. At 7.00pm on 5 April 2014, Maddy received a phone call from her mother. It was the evidence of Mrs Duffy that:

she sounded happy but very tired. Our conversation lasted for 2 minutes. I just wanted her to know I was thinking of her. I spoke to Grace. I told her she sounds tired. Grace said "She slept well last night"…"[16].

29. That evening Maddy and Brianna (another client of CPA who was staying in the same room as Maddy) watched the movie Spiderman in the lounge room and Maddy was given a Tummy feed.

30. It was the evidence of Grace Gatdula[17] inter- alia that:

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[16] Exhibit 1, Tab 18 – Statement of Mrs Duffy dated 27 May 2014 at paragraph 11;

[17] Exhibit 1, Tab 11 – Statement of Grace Gatdula dated 6 April 2014 and oral evidence of 23 November 2015;

a) At about 8.35pm she Maddy her nightly medication with a Milo mouse;

b) At about 8.50pm she put Maddy to bed on her side, as was stipulated in the communication book). She said she put two pillows up against her back and she was lying on her left side. There was a pillow underneath her head, and her own pillow from home. Her face was facing the wall. She was in the middle of the bed.

c) She was checked at 9.30pm and noted to be quiet and at 10.30pm when she was noted to be asleep;

d) That she asked Padmawati Pillay, who was on night shift that evening to:
"*please watch Maddy, because I never put her on her side and wan't feeling comfortable just make sure she's alright…*"[18]

31. On this evening, there were 6 children in total sleeping at the CPA facility.

32. On 5 April 2015 namely the Saturday night, Padmawati Pillay was working the night shift. She commenced work at about 9.40pm and recalls having a conversation with Ms Gatdula about Brianna and Maddy, who were both staying in the one room.

33. The evidence of Ms Pillay can be summarised as follows:

a) she initially checked Madeleine at around 10.30 pm and she was asleep[19];

b) She checked Maddy at half hourly intervals during the night[20];

c) That she was aware that daylight savings time ended that evening and she did the additional checks that morning although those checks were not accounted for in the "sleep chart";

d) She last saw/ checked Maddy at about 6.35 am or 6.40 am as she was attending to Briana Hamnett who required medication at that particular time, but she also checked on Madeleine. Her evidence was that Madeleine was:

i. "*…on the side. She wasn't lying on a pillow. I could see a bit of movement like her lungs were expanding and contracting, she was lying on the left side facing the wall. I am facing Brianna, I finished giving the medication and feed*

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[18] Exhibit 1, Tab 11 – Statement of Ms Gatdula dated 6 April 2014 at paragraph 13;

[19] Exhibit 1, Tab 10 -statement of Padmawati Pillay dated 6 April 2014 at paragraph 5; see also the sleep chart which is annexure 'A' Exhibit 1, Tab 27 - statement of Melissa Hammel dated 1 July 2015;

[20] see also the sleep chart which is annexure 'A' to the statement of Melissa Hammel dated 1 July 2015

around 6.40 am. I turned around and saw Maddy again, she was sleeping and I could see her still moving. The bed was elevated slightly at the head.

ii. *There was a pillow near her head up against the wall and another pillow near her back. The pillow was next to the bed rail. Her face was facing the wall and there was a gap between her face and the pillow. Maddy was uncovered and I covered her again…up until her legs...'*[21].

e) She finished her shift at about 7.00 am and the 'day' roster staff took over at that time, namely Teaghanne Sarina, Kastra McCreadie and Jasna Yellachich.

34. There was no report or indication of any problem with Maddy during the night of 5-6 April 2014. The shift entry diary for the night recorded:

'*Luke, Mark, Joel and Madeleine slept well. Brianna hot and sweaty in the night. Nicolas awake at 4.30am knocking. Brianna meds and formula administered. Nil Issues'.*[22]

35. The following morning, Sunday 6 April 2014, Daylight Saving had finished and all clocks were put back an extra hour.

36. Ms Teaghanne Sarina, disability support worker, arrived at work at about 6.30am on Sunday 6 April 2014. Her evidence was inter- alia that:

a) one of the male clients was already up while two of the boys in one room were yelling and knocking on their beds;
b) Accordingly she first started getting the male clients ready that morning.
c) by 7.30am all four male clients were dressed and she took two of the clients into the computer room to give them breakfast;
d) She had no contact with Maddy until she was called by Jasna to provide assistance.

37. Ms Jasna Yellachich, manager who was not rostered to work on the morning on 6 April 2014, however was at the residence to offer assistance and arrived at about 8 am. She also had no contact with Maddy prior to when she was called to assist.

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[21] Exhibit 1, Tab 19 – Statement of Ms Pillay dated 6 April 2014 at paragraphs 9 and 10;

[22] Exhibit 1, Tab 39;

38. Similarly, it was the evidence of Kastra McCreadie, community health worker that she arrived at about 7 am on 6 April 2014, and attended to administering medication to the boys and then feedings them breakfast. She had no contact with Maddy until she went to check on her and Brianna at about 8.15am[23], it is then:

"…*I went over to check on Maddy and noticed that she was in an unusual position on her left side and her face closest to the right hand side of the bed railing where the pillow was. I could see half her face, I couldn't see her nose and mouth. I could see the right side of her face. Her face was pressed up against her pillow. The pillow was wedged in the railing. Her face was facing the wall. There was a long sausage pillow on both sides. She had her head pillow but was not lying on it. The other pillow was underneath her legs in between her legs. The head piece area was elevated*"[24].

39. Ms McCreadie on locating Maddie, called for assistance. CPR was commenced, an ambulance was called however Maddy tragically was unable to be revived.

What was the Cause of Maddy's death?

40. It was submitted by Mr Chen, Counsel for the CPA that in relation to the cause of Maddy's death "*the Court should find, consistent with the opinions of Dr Montgomery, Dr Ashford and Dr Irvine – viz., [be recorded as] undetermined or unascertained but most likely a consequence of Madeleine having cerebral palsy*"[25], for the following reasons:

    a. That I had the benefit of the opinions of three pathologists, namely Doctors Montgomery, Ashford and Irvine and none of them were prepared to advance an identifiable cause of death, accordingly there is no reason, it is submitted, to move beyond this.

    b. Dr Allen's view should be disregarded as:

        (i) he only expressed a theoretical view based on a reconstruction of events, namely, that if Madeleine found her way on to the pillow and if that position

[23] Exhibit 1, Tab 9 – Statemtent of Ms McCreadie dated 6 April 2014 at paragraph 6;

[24] Ibid at paragraph 6;

[25] Submissions of CPA dated ** at paragraph **;

compromised her ability to breathe (an issue not quantitatively explored) then that could have resulted in her demise; or

In the alternative it can equally be said that if Madeleine had a respiratory event and if her ability to breathe was compromised and if she made her way on to the pillow and if that position compromised her ability to breathe (again, an issue not quantitatively explored) then that could have resulted in her demise.

(ii) the epidemiology actually posited the most likely cause of death – complications of cerebral palsy. Dr Allen's oral evidence was: "*the more severe the cerebral palsy the – the greater the mortality and the morbidity…So the studies…show that children who have severe spastic quadriparesis and cerebral palsy ie cerebral palsy involving four limbs, have a quite significant mortality up to 50% by the age of 15 or – in the later teenage years…*"[26] ;

41. I do not agree.

42. It was the evidence of Dr Irvine that

"*there was no gross finding at the time of autopsy that would explain her sudden unexpected demise. There's nothing that appeared to be acute at autopsy that was subsequently confirmed during examination of the glass slides and with the return of all the extra testing.*"

43. In giving that oral evidence Dr Irvine was specifically referring to fatal chronic conditions such as pneumonia, aspiration, seizure that would explain Maddy's death.

44. Dr Irvine also stated in evidence inter-alia that:

"*The lack of such findings renders an unnatural cause of asphyxiation (in respect of which no physical findings would be present) more, rather than less likely, as opposed to other possible "natural" causes*"

[26] Oral evidence of Dr Allen on 9 July 2015 at T75.10 and exhibit 1, Tab 21- report dated 1 May 2015 at page 5;

45. She also indicated that "*It would be unusual to find any physical findings at all*"[27] in the case of suffocation or rebreathing particularly in Maddys death, where you would not expect to see the possible signs when someone has the ability to fight against the deliberate suffocation as Maddie was unable to do this[28].

46. It is convenient at this point to make reference to the observations and evidence of Dr Mary-Clare Anne Waugh, paediatric and rehabilitation physician who was Maddy's treating doctor who stated inter- alia that:

    a. "I have observed Madeleine unrestrained in a bed. She would often adopt and move into awkward dystonic postures and had extreme difficulty moving out of voluntarily"[29];

    b. I uncomfortable or distressed her movement difficulty would have worsened[30];

    c. That in the event that Maddy was unsupervised in her bed and her movement difficulties let her to becoming in a posture that was awkward, uncomfortable or obstructed her airway, that she would have great difficulty in being able to get out of this posture[31];

47. This evidence coupled with the evidence from Ms McCreadie as to the position Maddie was found:

    "I couldn't see her nose and her mouth … Her face was pressed up against her pillow. The pillow was wedged in the railing. Her face was facing the wall."[32]

48. In my view, lack of physical findings in this case is consistent with asphyxia or rebreathing as described by Dr Irvine.

49. Accordingly, I am satisfied on the balance of probabilities that the cause of Maddy's death was asphyxiation and respiratory failure on a background of severe dystonic quadriplegia. The manner of her death was misadventure.

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[27] Transcript 9 July2015 p60.39;

[28] Oral evidence of Dr Irvine of 9 July 2015 at T59.45

[29] Exhibit 1, Tab 23 - Statement of Dr Waugh dated 19 June 2015 at paragraph 18;

[30] Ibid at paragraph 20;

[31] Ibid at paragraph 22;

[32] Exhibit 1, Tab 9 – Statement of Ms McCreadie at paragraph 6;

Were there any factors or circumstances during her respite at the Cerebral Palsy Alliance that may have "contributed" to either the "manner" or "cause" of her death?

50. The evidence before me indicates that Maddy was last checked and seen to be breathing between 6 and 6.30am on 6 April 2014. Thereafter the evidence clearly indicates the staff at the Castle Hill facility, did not check on Maddy until she was found unresponsive in bed by Ms McCreadie at about 8.15am, which was at least one and half hours since she was last checked/ observed.

51. I accept the submissions of Mr De Mars on behalf of Mrs Duffy that the potential significance of this failure to check on Maddy that morning becomes apparent when one considers:
    a. Maddy appears to have been breathing when the last check was performed at either 6 or 6.30am;
    b. Maddy was normally expected to wake at around 7am-7.30am;
    c. Maddy's propensity to get herself into postures while in bed from which she could not extract herself, particularly if she were to become upset or distressed; and
    d. The position and state Maddy was ultimately found in, at the time which would have been equivalent for her of 9.20am as the clocks had been turned back the previous night;

52. Accordingly, I accept that Maddy's death may have been avoided had she been checked on regularly during the morning period. Firstly, as staff may have then noticed that she was awake and then commenced to positively engage with her and assist her and secondly, there is possibility, that had she been found earlier, albeit in a compromised state of health, she could have been given life-saving attention.

53. The evidence indicates that an important part of Maddy's care was ensuring that she received adequate nutrition. The evidence of Dr Waugh and Mrs Duffy was that because of her extreme level of involuntary movement, Maddy required a very high level of calorie intake in order to maintain a reasonable weight. For this reason, she received "bolus" feeds through a "gastronomy button"[33].

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[33] oral evidence of Dr Waugh, 23 November 2015

54. The proforma documentation in use by the CPA indicates that it recognises the importance of these feeds for their clients, by providing for a "gastronomy plan" that specifically outlines the regime for these feeds, in terms of timing, frequency and quantity. However, these plans only have utility, if they are both up to date and followed by staff.

55. Unfortunately the following evidence demonstrates that Maddy's gastronomy plan was niether up to date nor complied with on the day preceding her death:

  a. Gastronomy plans are developed from advice from the "Nutrition Review Clinic" ("**the Nutrition Clinic**") at the Children's Hospital. The most recent advice to the CPA from the Nutrition Clinic was dated 7 August 2013[34] and it refers to Maddy receiving 4 daily bolus feeds of 170 mls of the "ensure" supplement a day[35];
  b. Despite this, the most recent "individual needs information" sheet on Maddy's file[36] indicates that Maddy was to receive 2 bolus feeds per day[37]. It also indicated that staff should refer to her "gastronomy procedure" document for further details.
  c. Moreover, the "gastronomy plan" on file[38] also indicated that Maddy was to be given 3 bolus feeds per day;
  d. Mrs Duffy gave evidence that she recalls going to the respite house when Maddy had had her most recent nutrition review and telling someone there that she was to have four feeds per day including one in the morning and one in the evening[39]. I have no reason to disbelieve the evidence of Mrs Duffy; and
  e. The feeding record on file, indicated that Maddy had only received 2 peg feeds on the 5th of April, when she should have received four and there was no evidence before me that she indicated that she was asked or refused a Peg Feed the day prior to her death[40];

[34] Exhibit 1, Tab 35;

[35] It was the oral evidence of Ashkan Ajiri on 9 July 2015 at T54.39-T55.36 that CPA would have received this advice and I note that the document itself refers to the respite home and was cc'ed to the CPA.

[36] Exhibit 1, Tab 30 at page 4;

[37] Ibid at page 5;

[38] Exhibit 1, Tab 30 p15

[39] Oral Evidence of Mrs Duffy on 9 July 2015 at T28.39;

[40] I note that in the past Maddy had received 4 gastronomy feeds in a day see Exhibit 1, Tab 33 – daily monitoring chart for 28/09/13 - at page 68

56. Mr Ajiri, the residential manager, acknowledged in his evidence that the documentation on file as to the gastronomy feeds differed and was out of date[41].

57. The records of the respite facility have as a result of Maddy's death been examined by her family very carefully. They have found another anomaly in the record keeping which can in my view not be ignored namely that her medication chart has three distinct and separately initialled entries indicating that she was given medication throughout on the morning of 6 April 2014[42] after Maddy had passed away. None of the staff were asked to explain this entry.

58. The fact that Maddy did not receive her required number of Gastronomy feeds on the day prior to her death has undoubtedly caused her family much concern and angst. However there is no evidence before me to indicate any causal nexus between Maddy not receiving the appropriate feeds and her death the following day.

Are there any recommendations which, if made, might reduce the likelihood of a similar death occurring or might otherwise contribute to an improvement of public health and safety?

59. In relation to the record keeping by the respite facility generally. Maddy's death has highlighted a number of concerns in particular:

    a. That files be updated regularly to reflect changes in regimes for clients as and when they occur; and
    b. That proper records be kept as to when clients are medicated and what medication they receive.

60. I accept that that CPA is not a health service provider. It is a not for profit organisation that provides an important and valuable service to those with Cerebral Palsy and their carers. However, this inquest has highlighted that communication is the key to ensure that all in their care are adequately cared for. I commend CPA for taking steps to formalise their new handover policy and training their staff in relation to this. A copy of the revised policy was forwarded to the court under email dated 24 November 2011 the revised policy now states:

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[41] Oral Evidence of Mr Ajiri on 9 July 2015 at T55.35-T56.6;

[42] Exhibit 1, Tab 30 at page 13;

“*18. Shift Handover Procedure- Respite*

This procedure is to ensure an efficient exchange of client health and wellbeing information between shifts for respite houses.
Staff instruction:

- *When arriving to shift, read all client progress notes and associated communications such as communication books/diaries*
- *Arriving and departing staff will together check each client and ensure they are safe and well, and departing staff will provide a verbal report on the client's previous shift.*
- *For awake night shift staff handing over to morning shift staff, this check is to be documented on the "awake night checklist" form. This check is to be documented with the letter 'H' beside the time the check took place to indicated it was a handover check. Both staff are to initial"*

61. However, it is of concern that the records that were maintained by CPA at its Castle Hill facility were also not up to date in relation to Maddy and contemporaneous records were not maintained as to her medication. There is no evidence before me that this is a systemic issue however no doubt it would be of concern for their clients and their carers that all records were kept up to date and staff understood that medication charts should only be completed contemporaneously. I will not make a formal recommendation in this regard however hope that CPA will take into consideration the anomalies discovered as a result of Maddy's passing and will take steps to ensure that its records are up to date and staff understand their obligations to take accurate and contemporaneous notes particularly in regards to the giving of medication.

Conclusion

62. Maddy's death is tragedy. Despite the challenges she was dealt with it seems that Maddy lived her short life to the fullest loving and being loved. Her smile lit up a room and she is clearly missed by all those who had the privilege of knowing her.

Accordingly, I now turn to the findings I am required to make pursuant to s. 81 of the *Coroners Act 2009*.

I find that Madeleine Rose Duffy died on 6 April 2014 at Cerebral Palsy Alliance, 3 Belvedere Avenue, Castle Hill 2154 and that her cause of death was was asphyxiation and respiratory failure on a background of severe dystonic quadriplegia. The manner of her death was misadventure

For the reasons set out in these findings I decline to make the following recommendations pursuant to s. 82 of the *Coroners Act 2009*:

I close this inquest

Magistrate Sharon Freund
Deputy State Coroner
27 November 2015