CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the Death of Ruth McKay**
Citation:	**[2023] ACTCD 7**
Hearing Date(s):	10-14 February 2020, 5 June 2020, 3 July 2020, 11 October 2021, 16-17 March 2022
Decision Date:	6 April 2023
Before:	**Coroner Taylor**
Decision:	See [196]-[199]
Catchwords:	**CORONIAL LAW** – cause and manner of death – acute bronchopneumonia – death in care - no criticism of treating clinicians – matters of public safety in relation to operation of aged care facility - delay in coronial proceedings – non-publication order
Legislation Cited:	*Coroners Act 1997* (ACT) sections 3BA, 13, 34, 40, 52, 55
Cases Cited:	*R v Doogan; Ex Parte Lucas Smith & Ors* [2005] ACTSC 74 *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506 *Briginshaw v Briginshaw* (1938) 60 CLR 336
Texts Cited:	Royal Commission into Aged Care Quality and Safety, Final Report, Care, Dignity and Respect, Volume 1: www.agedcare.royalcommission.gov.au.
Representation:	**Counsel Assisting** Ms M Jones SC together with Ms S Baker-Goldsmith **Solicitor for Goodwin Aged Care Services** Mr V Harcourt **Counsel for Goodwin Aged Care Services** Ms D Foy **Solicitor for the Australian Capital Territory** Ms J Newman **Counsel for the Australian Capital Territory** Ms K Musgrove
File Number(s):	CD 19 of 2015

CORONER TAYLOR:

Introduction

1. Our old people are an important part of our community. It is through the elderly we chart our family history and importantly, our own place in that history. Through our old people we identify our connections to kin, place and culture. Old people are a rich source of wisdom, possessing knowledge and experience that only old age can generate. Our families and communities benefit socially, politically and economically from the ongoing participation of old people in our society. Getting old is a privilege and it should be attended to by high standards of support and care. In my culture our old people, our Elders, occupy a special place of reverence. So too Mrs Ruth McKay in her family. The circumstances of her death are sad and distressing – they bear no resemblance to the full life she led nor the love and high esteem in which she was held. The following report is the result of an inquiry into her death. It is by no means a reflection of the complete impact of her life.

Background summary

2. Mrs Ruth McKay (**Mrs McKay**) died on 23 January 2015 at The Canberra Hospital (**TCH**). She was 90 years of age.

3. On 17 January 2015, Mrs McKay was found at around 8am lying on her back under an ornamental antique car in an external courtyard at the aged care facility where she lived, Goodwin House Ainslie (**Goodwin**), bleeding from a head injury. She was dressed in a light night gown. Prior to this incident Mrs McKay had been observed to wander at night. When she was discovered, it was not known for how long she had been under the car or outside in the courtyard. She was found there after it was discovered she was not in her bedroom. A staff member called “000” and an ambulance attended the scene and transported her to TCH. She developed an infection and died at TCH on 23 January 2015.

4. Mrs McKay was born Ruth Allison Irwin on 5 August 1924. She lived her early life in Marrickville, Sydney, where she attended Marrickville Girls High School, she then completed a secretarial course and went on to be employed by a newspaper. Mrs McKay married Douglas Henry McKay in 1947. They moved to Canberra and had three children - Robyn born in 1948, Julienne born in 1951 and Wendy born in 1953. Mr McKay was an economist who became a senior public servant. Mrs McKay was at home with their girls full time. Mrs McKay actively played golf until 2009 when she was in her mid-80s and was involved in the golf club as treasurer. Due to Mr McKay’s declining physical health and Mrs McKay’s advancing dementia, in 2009 they moved into the independent living section at Goodwin. Mr McKay died on 7 July 2012. In July 2013, Mrs McKay moved to the Memory Support Unit (**MSU**) due to her more advanced dementia.

5. The MSU is a secure unit designed for residents of Goodwin with dementia and for other residents at risk when unsupervised or when the facility is left unattended. The MSU has an external, secure courtyard area accessible to residents. Mrs McKay gained access to the MSU courtyard where at some point, for reasons unknown, she pulled herself under the stationary, antique car.

6. It is clear from the evidence before me, and from the statement of Mrs McKay's daughter, Ms Wendy McKay, at the hearing on 14 February 2020, that Mrs McKay was deeply loved by her family. She was a wife, a mother and grandmother who lived a life characterised by close connection with her family and an abiding loyalty that has endured after her death. It is clear that Mrs McKay's death was a profound loss for her family. It is also clear that her life was much more than her death which, while obviously the subject of these proceedings, should not take away from the loving, rich and full life she led for the 90 long years that she lived.

Delay

7. Section 3BA of the of the *Coroners Act 1997* ("the Act") requires inquests to be carried out in a way that recognises that the death of a person and an inquest into the person's death, has a significant impact on the person's family and friends. In my view, that obligation has not been satisfactorily discharged in this case.

8. It is plain that the prolonged history of this coronial process has had a significant impact on Mrs McKay's family. The delay that has attached to this process since Mrs McKay's death in 2015 is indefensible and I will not attempt to explain it away. I will note that since I became responsible for the coronial proceedings, a substantial delay occurred in 2021 awaiting the provision of further material from Goodwin. The final day of hearing was set in March 2022, after material was provided by Goodwin in October 2021.

9. Ms Sarah Campbell, Mrs McKay's granddaughter gave a statement on behalf of the family at the hearing on 16 March 2022 which addressed, in part, the impact the delay has had on her family. It is entirely appropriate that an apology be extended on behalf of the Coroners Court to the family for that delay which was at times accompanied by very poor levels of communication and initially, an indication that coronial proceedings would not eventuate. Ms Wendy McKay travelled to Canberra in July 2019 expecting a hearing to commence as she had not been informed that the matter would be adjourned. This reflects very poorly on the Coroner's Office and would have undoubtedly been a source of more distress and frustration. The Coroners Court must always be mindful that its operation has real life impacts for those unfortunately swept up in our remit and every attempt should be made to reduce the impact of coronial proceedings on grieving family members. I am not confident that was always the case in this matter. I apologise to Mrs McKay's family for the delay and the, at times, poor communication. I acknowledge the ache in their hearts created by the circumstances of Mrs McKay's death, and I acknowledge the ongoing negative impact these protracted proceedings have had on their experience of grief.

Timeline of proceedings

10. Following Mrs McKay's death in January 2015, the police informed the family that they would be taking no further action.

11. A decision was made pursuant to section 34 of the Act to hold a hearing and in March 2019, the Coroners Court advised the family that an inquest would be held into Mrs McKay's death in July 2019.

12. The hearing was originally scheduled to begin in July 2019. The hearing was adjourned and subsequently, late in 2019, carriage of the proceedings was transferred to me from the Chief Coroner. The hearing first commenced before me on 10 February 2020. Leave was granted to Goodwin and the Territory to appear at the inquest and both parties were represented by counsel. The Territory's appearance was on the basis that Mrs McKay had passed away at TCH and one of the issues for consideration is to what extent, if any, Mrs McKay's treatment at TCH, contributed to her death.

13. A view of Goodwin Ainslie was conducted on the first day of the hearing. Evidence was heard on five days from 10 February 2020 to 14 February 2020. On 5 June 2020 an application was made by Counsel Assisting to re-open the inquest to hear evidence from two further witnesses, TL and HY. Leave was granted.

14. TL's grandmother, Resident 1, was a resident at the MSU at the same time as Mrs McKay. HY's wife, Resident 2, was a resident in the MSU from 19 February 2014.

15. The further evidence was heard on 16 March 2022. Final submissions were received in July 2022.

16. In February 2023, I issued a notice pursuant to section 55 of the Act annexed hereto.[1] In response, pursuant to s 55 (1)(b), Goodwin provided a statement annexed hereto.[2] See paragraph 22 for further reference.

Submissions

17. I received the following submissions in this matter;

    (a) Submissions on behalf of Counsel Assisting filed 9 May 2022;
    (b) Submissions in reply on behalf of Goodwin dated 31 May 2022;
    (c) Submissions on behalf of Canberra Health Services (**CHS**) dated 20 May 2022;
    (d) Supplementary submissions on behalf of CHS dated 17 June 2022;
    (e) Letter from Goodwin's legal representatives dated 23 June 2022 indicating an amendment to paragraph [76] Goodwin's submissions;
    (f) Amended submissions on behalf of Goodwin to reflect the change to paragraph [76] received on 27 June 2022;
    (g) Further supplementary submissions on behalf of CHS dated 27 June 2022 (responding to the changes flagged in Goodwin's letter of 23 June 2022); and
    (h) Counsel Assisting's submissions in reply dated 2 July 2022.

Jurisdiction

18. Mrs McKay died after an accident and her death is directly attributable to the accident. Section 13 (1)(g) of the Act relevantly provides:

[1] Notice Pursuant to Section 55 of the *Coroners Act 1997* to Goodwin Aged Care Services dated 21 February 2023.
[2] Statement of Goodwin Aged Care Services in response to Notice Pursuant to Section 55 of the *Coroners Act 1997* dated 3 March 2023.

13 Coroner's jurisdiction in relation to deaths

(1) A coroner must hold an inquest into the manner and cause of death of a person who—

(g) dies after an accident where the cause of death appears to be directly attributable to the accident

19. Section 52 of the Act relevantly provides:

52 Coroner's findings

(1) A coroner holding an inquest must find, if possible -
(a) the identity of the deceased; and
(b) when and where the death happened; and
(c) the manner and cause of death; and
(d) in the case of the suspected death of a person—that the person has died.

……

(3) At the conclusion of an inquest or inquiry the coroner must record the coroner's findings in writing.

(4) The coroner, in the coroner's findings—

(a) must—

(i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and

(ii) if a matter of public safety is found to arise—comment on the matter and

(b) may comment on any matter about the administration of justice connected with the inquest or inquiry.

Issues

20. There is no issue in relation to sections 52 (1)(a) and (b). There is no dispute as to the medical cause of Mrs McKay's death. There is no dispute as between experts Drs Milne, Brock and Professor Pain that the cause of Mrs McKay's death was pneumonic illness caused either by aspiration and/or infection.

21. The five issues that I will consider are:

A. Mrs McKay leaving her room in the MSU at Goodwin and entering the MSU courtyard undetected;

B. The length of time Mrs McKay was in the courtyard before she was found. This will include consideration of staffing at Goodwin and the particular circumstances of the shift on 16-17 January 2015;

C. Medical treatment and care at TCH from 17 January 2015 when Mrs McKay was an inpatient at TCH until her death on 23 January 2015, including the issue of aspiration;

D. Goodwin action, investigation, reporting processes and previous relevant incidents; and

E. Matters connected to public safety.

Section 55 Notice

22. The section 55 notice I issued to Goodwin in February 2023 contained numerous comments which I considered including in this report. In the notice I indicated I was considering making the following comment "*bed and room sensors were often switched off in the MSU*". Arising from Goodwin's response to that notice, and having reflected on the nature and extent of the evidence before me on the issue, I determined to alter the terms of the comment to now read *"as at January 2015 bed and room sensors were not consistently operated in the MSU*".

Relevant Legal Principles

23. It is appropriate to identify the relevant legal principles that attach to these proceedings. In *R v Doogan; Ex Parte Lucas Smith & Ors* [2005] ACTSC 74 ("*Doogan*") the Full Court of the ACT Supreme Court stated in relation to the nature of a coroner's inquiry, at [12] and [15]:

> The task of a coroner is not to determine whether anyone is entitled to some legal remedy, is liable to another or is guilty of an offence. The Coroner's task is to inquire into the matters specified in the relevant section of the Coroners Act 1997 and make, if possible, the required findings and any comments that may be appropriate…
>
> The [Coroners] Act is generally concerned with the resolution of relatively straightforward questions such as "what was the cause of this death?" or "what caused this fire?". It does not provide a general mechanism for an open-ended inquiry into the merits of government policy, the performance of government agencies or private institutions, or the conduct of individuals, even if apparently related in some way to the circumstances in which the death or fire occurred.

24. The Full Court in *Doogan* further observed that coroners should not conduct "*a wide-ranging inquiry akin to that of a Royal Commission*" (at [28]) using this example to demonstrate the limits of a coronial enquiry at [31]:

> ... a coroner might well hear evidence suggesting that a cyclist's death had been caused not merely by a collision with a motor vehicle, but also by the antecedent conduct of the driver of that vehicle in failing to stop at a stop sign adjacent to an intersection. However, the limited jurisdiction conferred ... would not authorise the coroner to inquire into any perceived failures in relation to general policy relating to the siting of stop signs or the enforcement of traffic regulations. The particular siting and design of the relevant intersection may be a different matter. The application of the common-sense test of causation will normally exclude a quest to apportion blame or a wide-ranging investigation into antecedent policies and practices.

25. The Full Court endorsed, at [29], the common-sense test of causation laid down by the High Court in *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506:

> A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative … in the context of a coronial inquiry, [the common sense test of causation] may be influenced by the limited scope of the inquiry which, as we have mentioned, does not extend to the resolution of collateral issues relating to compensation or the attribution of blame.

26. Findings may be made provided the requisite standard of satisfaction is met. A Coroner is to have regard to the principle laid down in *Briginshaw v Briginshaw* (1938) 60 CLR 336 as stated by Dixon J at 361-2:

> The truth is that, when the law requires the proof of any fact, the tribunal must feel an actual persuasion of its occurrence or existence before it can be found. ...The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal.

27. The Full Court in *Doogan*, commenting in relation to the coroner's power to make comment under section 52 of the Act, said [41]-[42]:

> Subsection 52(4) also provides that a coroner "may comment on any matter connected with the death, fire or disaster including public health or safety or the administration of justice." Comments may obviously extend beyond the scope of "findings". The latter term refers to judicial satisfaction that facts have been proven to the requisite standard or that legal principles have been established. The former refers to observations about the relevant issues and may extend to recommendations intended to reduce the risk of similar fires, deaths or disasters occurring in the future. However, conferral of the power to make comments does not enlarge the scope of the coroner's jurisdiction to conduct an inquiry. As Nathan J said, albeit in a somewhat different context, in Harmsworth v The State Coroner at 996:
>
> > The power to comment, arises as a consequence of the obligation to make findings…It is not free-ranging…The powers to…are inextricably connected with, but not independent of the power to enquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation. It arises as a consequence of the exercise of a coroner's prime function, that is to make "findings"
>
> If a coroner decides to pursue this course, he or she is subject to the requirement in section 55 of the Act that any party who may be adversely affected by such a comment be given due warning that it may be made, as well as the opportunity to make a written statement in relation to the comment or make a submission to the coroner in relation to the proposed comment.

Non-publication Order

28. I make an order pursuant to section 40 (2)(b) of the Act directing that the publication of the names of any employee of Goodwin (except senior managers Mr Jeffrey Shelley and Ms Robyn Boyd) and the names of any of the treating doctors and nurses of Mrs McKay at TCH is prohibited. In addition, the names of other residents of the MSU and their family members who gave evidence in these proceedings are also prohibited from publication. In each case I consider that it is in the public interest to make a non-publication order.

Evidence

29. The findings that follow are based on the evidence received during this inquest.

30. A view of Goodwin was conducted on the first day of hearing, 10 February 2020. Counsel assisting helpfully provided Attachment A, a list of all the witnesses called in the proceedings (annexed hereto)[3] and Attachment B a timeline of events (annexed hereto).[4]

[3] Attachment A – List of Witnesses called.

[4] Attachment B – Timeline of Events.

31. During the hearing, evidence was heard from staff who were working at Goodwin on 16 and 17 January 2015, Goodwin management staff, medical staff at TCH, the forensic pathologist who conducted the autopsy, Associate Professor Dr Nathan Milne. Two expert medical witnesses, Professor Michael Pain, a consultant thoracic physician engaged by Goodwin, and Dr Jeffrey Brock, a specialist in exposure and hypothermia also gave evidence at the hearing.

The Autopsy

32. After Mrs McKay's death at TCH on 23 January 2015, an autopsy was performed by Associate Professor Dr Nathan Milne on 27 January 2015. He produced a report dated 16 March 2015. He gave evidence at the hearing. He identified that the histology of Mrs McKay's brain demonstrated signs of Alzheimer disease, and her dementia was noted to be advanced and deteriorating. The lung histology identified acute bronchitis and bronchopneumonia of a significant degree.

33. The autopsy report includes the following findings:

    (a) Mrs McKay was very physically fit for her age;
    (b) The brain showed signs of Alzheimer's disease;
    (c) There were no internal injuries;
    (d) There was pus in the upper airways and both lungs showed features of bronchopneumonia. There was a suggestion that some areas of pneumonia were older;
    (e) There were no internal findings to suggest hypothermia, however this is complicated by the period of survival in hospital noting changes of hypothermia can be difficult to identify even without such a survival period;
    (f) Histology confirmed acute bronchopneumonia in the lungs and some older areas of pneumonia; and
    (g) The pus from the trachea identified a heavy growth of the bacterium Staphylococcus aureus.

34. The report concluded that the cause of death was acute bronchopneumonia, a bacterial infection. Dr Milne identified the infectious organism as Staphylococcus aureus. He opined *"the most likely condition predisposing her to the development of bronchopneumonia is Alzheimer's disease."* This opinion was consistent with the evidence he gave in the hearing before me, that is, Alzheimer's disease elevated Mrs McKay's risk of any infection, including bronchopneumonia. His evidence was that the bronchopneumonia likely developed after Mrs McKay fell, the fall arising from her Alzheimer's disease.

35. He goes on in his report to note *"she survived in hospital for 6 days after being found near the car. The acute bronchopneumonia would have developed after this time. However, as areas of bronchopneumonia were older, it is possible that she already had a degree of bronchopneumonia prior to hospital admission."*

36. Dr Milne notes in the report that the circumstances prior to the admission to hospital were uncertain. He notes the fall and the resulting soft tissue injury to Mrs McKay's head. He opines that if the fall was accompanied by any reduced level of consciousness this could have seen Mrs McKay predisposed to aspirating. Dr Milne notes that no aspirated material was seen in the lungs but concludes it cannot be

excluded that the bronchopneumonia resulted from aspiration. He identifies that hypothermia may have also contributed to her death.

37. In evidence Dr Milne said bronchopneumonia was evident in both lungs and described it as *"quite significant"*. He identified that while potentially bronchopneumonia can be attributed to Alzheimer's alone, it likely developed after Mrs McKay fell, her fall being attributable to Alzheimer's disease. He reiterated the difficulty in assessing the role of hyperthermia, noting Mrs McKay's death six days after the event, but nonetheless considered it was a factor to be considered as *"part of the whole process and the way she ended up getting pneumonia as well."*

38. The prospect and potential timing of aspiration was the subject of evidence during the hearing. Professor Milne's evidence was that the cause of the bronchopneumonia may have been the aspiration of foreign material – there being signs that foreign material had been aspirated in the past being inflamed cells contained old debris. He opined that it appeared foreign material had been present for many days and possibly a longer period – *"months or longer"*. He said that there was no sign of fresh foreign material, although noted Mrs McKay may have aspirated some fluid from her stomach saying:

> *Well, there was some sign that she had aspirated or breathed contents down her lungs in the past, with inflammatory cells that contained old debris. Now, that looked like that had been present for many days at least, so it could have been present for months or longer. There wasn't any fresh foreign material in the airways to confirm that but it doesn't mean she didn't' aspirate some fluid be that fluid from the stomach or from the head injury potentially. So aspiration pneumonia I couldn't confirm microscopically. From the circumstances it seems most likely.*

39. He said an elderly person suffering from Alzheimer's was at greater risk of both aspiration and independent of this, developing an infection, as compared to a person of the same age but not suffering from Alzheimer's disease.

40. As I have already noted, upon discovering Mrs McKay under the car vomit was observed near her head. The evidence also established that she vomited while immobile in a cervical brace at TCH. She also had a coughing fit while drinking water while in the emergency department.

The MSU

41. It is essential to understand the physical layout of the area where Mrs McKay lived at Goodwin, in particular the MSU.

42. The MSU is a secure area of Goodwin located on the ground floor of the three-story facility. This secure area is designed for residents at risk of leaving the facility such as those like Mrs McKay with dementia. Access to the MSU requires entry from the main lobby of Goodwin. The MSU has secure doors operated by swipe card access or by staff pressing a button to allow entry or exit. The hub of the MSU is the common area where the nurse's station is located as well as areas for eating and socialising. There are two wings off the common area where resident's bedrooms are located. One wing is referred to as the green corridor and the other as the gold corridor. The MSU has its own outdoor courtyard area that can only be accessed via the MSU. Mrs McKay's bedroom, number 15, was located toward the end, closer to the courtyard area, of the

gold corridor. The MSU courtyard can be accessed by residents from the nurse's station/common/dining room area and at the end of each of the corridors.

43. The doors at the end of each corridor do not require a key to lock or unlock them. In January 2015, they opened from the inside by turning the snib and pushing the door forward. From the outside a key was required to gain access to the corridor if the doors were locked. These doors could be opened from the inside at any time of the day or night without a key by turning a snib style lock. Mrs McKay's room was close to the external door at the end of the gold corridor.

44. Unlike the doors at the end of each corridor, the glass doors off the common area were fitted from the inside with mesh screen doors. Those doors were able to be locked from the inside with a key and as part of an evening lockdown procedure these doors were locked with a key.

45. I had the benefit of attending upon Goodwin to see the general layout of the MSU for myself. It was of assistance in terms of orienting some of the evidence given in the hearing from various witnesses. Floor plans and video footage were also of use. At the outset I note that there is no direct evidence of how or when Mrs McKay went out into the courtyard. There is no CCTV footage or any kind of electronic record of the MSU courtyard doors or dining room opening or closing that might assist. Unfortunately, Mrs McKay herself was not able to provide any information that assists any aspect of this inquiry.

46. ACT ambulance service (**ACTAS**) was called to attend Goodwin at 8.10am. ACTAS officers Greg Addison and Nicole Price arrived at 8.15am. Mrs McKay was observed to be conscious and alert on her back under the car. Substantial blood was observed near the car. The incident report records that Mrs McKay had no recollection of the event. Mrs McKay's Glasgow Coma Score was measured at 14. She had a large haematoma to her left forehead with swelling and congealed blood. She was extracted from under the car and arrived at TCH at 9.11am.

47. At 8.25am, Mrs McKay's tympanic temperature was recorded as 31 degrees. A space blanket was used and by 9am en route to hospital her temperature had risen to 32.9 degrees and at 9.10am to 33.9 degrees.

48. Mrs McKay arrived at TCH Emergency Department (**TCH ED**) at 9.16am. At 8.20pm she was admitted to the geriatric ward.

A. How did Mrs McKay get outside to the MSU courtyard undetected?

Security of the external door at the end of the gold corridor

49. The simple answer to this question is that absent a physical inability to operate the snib lock that was in the place on the door at the end of the gold corridor, there was no physical impediment to Mrs McKay gaining access to the outside courtyard area at any time of the day or night. There was no alarm or other kind of notification to alert staff that the doors to the outside area had been or were in operation. Mrs McKay was independently mobile though did use a wheelie walker. There was no evidence before me upon which I could conclude that the task of unlocking and opening the door by

pushing it forward was physically beyond Mrs McKay. Indeed, as will become clear I am satisfied on the evidence that she was capable of turning the lock and pushing the door at the end of the gold corridor forward, thereby gaining access to the courtyard. I am satisfied that this is precisely what she did to access the courtyard where she was ultimately found on 17 January 2015. The video footage and the view I attended demonstrated that the turning of the snib and the pushing of the door was not a particularly onerous physical task. The statement of Ms Boyd dated 23 November 2018 (exhibit 6) confirms this view where she states:

> *Residents have free egress from the corridor to the courtyard area during the day. At night the outside door is locked but can be unlocked from the inside by residents.*

50. There was a standard practice in place that the doors to the courtyard were to be locked every night. There was evidence from JL, the Team Leader for the night shift on 16-17 January 2015 about the practice required whereby a lockdown checklist was completed to confirm that doors had been locked. The checklist from 16-17 January 2015 reflected that the doors were locked at 7pm and rechecked sometime before 11.30pm.

51. In my view despite this lockdown practice, having seen them in operation myself, the snib locks on the doors at the end of each corridor were capable of being easily accessed and operated. They did not require a key to lock or unlock. This meant that while staff would turn the snib to lock the doors, any resident capable of turning the snib could come along and unlock the corridor doors after the lockdown checklist had been completed.

52. Mrs McKay's care plan required her to have a sensor mat due to concerns about wandering at night. The care plan under the heading "Sleep & Resting" records this as part of the "observations"; "*Ruth has been observed wandering at night and falling asleep in the lounge*." The care plan records that observation as having been added on 27 December 2014 by Deputy Care Manager RN, VC.

53. The intervention recorded to address that observation is recorded as "*sensor mat in place and staff to monitor Ruth during the night-time*". Again, in the care plan under the heading "Cognitive and Mental Health Behaviour" it is observed that "*Ruth has been observed wandering*". Indeed, it is recorded in this part of the plan that "*Ruth has been moved to the memory support unit due to her previous behaviours of wandering*".

54. There was no evidence that an alert or alarm was triggered in Mrs McKay's room by either a bed sensor mat or a room sensor when she left it to access the courtyard on 16-17 January 2015.

55. I am satisfied on the evidence before me that Mrs McKay exited the MSU to the courtyard area through the door at the end of the gold corridor by turning the snib and pushing the door open.

56. It is plain from the evidence that Mrs McKay moved from her room in the gold corridor to the outside courtyard area undetected. There was no electronic record of her movement (through electronic monitoring of external doors or room doors) and there was no direct observation by any staff of her movement (whether by chance doing rounds, via CCTV, or as a result of the sensor mat or room alarm triggering enquiry).

A number of factors combined allowed Mrs McKay to access the courtyard undetected such as room sensors being inoperative, the ease of the corridor door being unlocked, as well as, less significantly in my view, the 16-17 January shift being particularly busy.

Bed sensor mat and room alarm

57. As I have already observed, Mrs McKay's care plan identified that she had been observed wandering at night. The intervention to address that behaviour was a bed sensor mat to provide a way, outside of observing the behaviour directly, for staff to be alerted when she had moved from the bed. In addition, the care plan identifies that Mrs McKay was to be monitored through the night.

58. The evidence from the Goodwin Nurse Call Access logs is that there were no alarms for room 15, Mrs McKay's room for the night of the 16-17 January 2015. The only available inference from this is that the bed sensor mat was not turned on or not working at that time, because it is clear that Mrs McKay moved from her room at some point.

59. HY and TL had family members who were residents at the MSU at the same time that Mrs McKay was a resident at the MSU. They gave evidence in the hearing that it was their experience that bed sensor mats were often not switched on. HY gave evidence in relation to his wife and TL gave evidence in relation to her grandmother. TL said her grandmother was required to have a bed sensor mat on her bed at various times and on many occasions, she would check, and it would not be switched on. HY gave similar evidence in relation to his wife, Resident 2 and the use of bed sensor mats.

60. I accept their evidence in relation to their experience of the use of bed sensor mats. Firstly, because in addition to being witnesses who presented as careful and considered they impressed as particularly invested in the day to day lives of their family members. Secondly, the issue with the bed sensors was clearly of interest to them as a matter directly relevant to the wellbeing of their loved ones and I am satisfied they recalled the concern accurately. And finally, because it is entirely consistent with what must have been the case on the evening of 16-17 January 2015 when Mrs McKay successfully made her way out to the courtyard area without detection through the bed sensor mat which, according to her care plan, should have been in use and was not. I infer from the evidence that the use of such sensor mats may have been quite burdensome for staff to manage because they sounded an alert for every occasion where there is movement off the bed including occasions for instance where there may be no risk to the resident such as going to the bathroom or getting off their bed to retrieve something from inside their room.

61. In addition, there is no evidence of any process or procedure that strengthened the approach to the use of bed sensors in terms of identifying responsibility for ensuring ongoing operation upon a change of shift or after an alarm had sounded and staff had responded. Likewise, there was no record or log of when a bed sensor was turned off or on, who turned it off or on or why it was turned off or on to strengthen ongoing compliance with care plans such as the one that informed the care provided to Mrs McKay. The evidence supports the view that bed sensor could be turned on or off by anyone, at any time.

62. Mr Jeffrey Shelley, the Residential Manager of Operations at Goodwin, said in evidence that each room was fitted with room sensors to monitor resident movement and as a matter of standard practice the sensors were activated when a resident was in their room. The sensor had the capacity to alert staff about resident movement by sending an alert through to staff phones. Ms Robyn Boyd, Deputy Executive Manager, at Goodwin gave evidence that an internal review after this incident with Mrs McKay revealed that all the sensors were working. Ms Boyd's evidence was that sensors were not activated as a matter of standard practice but rather they were used as required. Ms Boyd's evidence was that a room sensor was not necessary for Mrs McKay. This view, though clearly inconsistent with Mr Shelley's description of their use, is consistent with there being no evidence of any alarm or alert from room sensors for Mrs McKay's room for 16-17 January 2015 on the basis that they were not in use for whatever reason on that evening.

63. JL gave evidence that sensor mats are turned off in the morning when staff assist a resident out of bed. GB, a carer on night shift on 16-17 January 2015 did not consider that he had any responsibility in relation to checking or ensuring that sensors were in operation.

64. A record of a staff meeting on 23 January 2015, produced as part of Ms Boyd's evidence, indicates that staff were advised that room sensors were to be on all night in all rooms.

65. The evidence paints something of a confused picture about what the approach was to bed sensor mats as at 16-17 January 2015. The difference in approach articulated in the evidence of Mr Shelley and Ms Boyd, reflected in the experience of HY and TL as well as what happened in Mrs McKay's case, provides a strong basis to infer that staff may well have been confused about the use of sensors as a risk mitigator and that their use was inconsistent.

Supervision in the MSU

66. Goodwin is a residential aged care facility. The evidence suggests this is distinct from a nursing home. Ms Boyd was clear in her evidence that while the MSU, by its very nature, was a place that provided some restraint on the capacity of residents to determine their movements, it was not a place where constant supervision was implemented. Ms Boyd said in evidence:

> *I think what we're trying to promote is quality of life and as much independence as possible, our philosophy is not to restrain people in any way and so the idea is that we supervise and support, not restrict and retain – or restrain.*

67. She went on:

> *Living in residential aged care doesn't mean you have 24 hour one to one supervision. That's not what residential aged care is about. That's not what it is. It's to support people to live as independently as they possibly can. We couldn't possibly provide one to one support to every single resident, 108 residents, 24 hours a day. That is not what the care is.*

68. Goodwin highlighted, consistent with the evidence of Ms Boyd, that their facilities are required to impose as little restriction on the dignity and autonomy of an individual as possible in the circumstances and residential aged care facilities are required to give

real meaning to those concepts. I note, as emphasised by Goodwin, that The Charter of Rights of Care Recipients – Residential Care provided in 2015 that a resident in residential care was entitled "*to live in a safe, secure and homelike environment and to move freely both within and outside the resident care service without undue restriction*".

69. I am not satisfied that staffing numbers can be identified as a factor that contributed, either directly or indirectly, to the circumstances of Mrs McKay going out into the courtyard undetected. The reality of the needs of residents in a facility like the MSU is that staff attention may be required to meet those needs in a way that sees other residents unattended. More staff covering the 16-17 January 2015 shift may not have ensured that Mrs McKay remained in her room given the demands of the shift. This is why, in my view, it is important to ensure in so far as is possible that the safety and security of residents does not rely entirely on staff.

70. The MSU is the home of the residents who live there. That said, MSU residents are restricted because of their needs. They cannot roam freely or independently around the Goodwin facility as they might wish to because a decision is made that it is not in their best interest. Restricting their movements is a protective measure. It is a reasonable measure in the circumstances. It is not at all controversial to acknowledge that the autonomy and liberty of residents should be promoted.

71. That said, the promotion of autonomy and liberty cannot be at a cost to the safety and security of those residents. Where policies, procedures, practices and/or physical accommodations present obvious risk to residents, those risks should be mitigated. Mitigation of risk as a matter of common sense may well intrude upon autonomy or liberty but that intrusion, in my view, is justified where safety and/or security are at risk and the action taken to mitigate risk is carefully and appropriately measured against the promotion of independence and liberty in so far as it is possible.

Findings about how Mrs McKay got outside to the MSU courtyard undetected

72. In January 2015, there was nothing other than the practice of staff checking that the doors at the end of the gold and green corridors were locked and observing the movements of residents, preventing residents from tuning the snib lock and pushing open the doors to the MSU external courtyard at any time of the day or night. As at January 2015, bed and room sensors were not consistently operated in the MSU. Mrs McKay was known to be prone to wandering. Indeed, her Goodwin care plan required that she have a sensor mat in place at night to guard against that risk. Had sensor mats in Mrs McKay's room been switched on, it is likely staff would have responded to the alert when Mrs McKay left her bed to access the courtyard. It is also likely that Mrs McKay would not have remained undetected outside for an extended period.

73. A resident inside the facility as at January 2015, using the external doors at the end of the gold corridor nearest to where Mrs McKay's room was located, could simply turn the snib, push open the door and gain access to the courtyard, to exit the facility. This allowed residents to access the courtyard at any time of the day or night.

74. Goodwin's approach to ensuring the security of these doors relied entirely on staff compliance and intervention. Even then, once locked by staff, the doors at the end of corridor could be unlocked, without detection, by any resident capable of turning the snib. The doors could then be opened, without detection, by any resident capable of pushing the door forward. The failure by Goodwin to adequately protect the safety and security of residents by ensuring that they were not able to access the courtyard through those doors, in particular at night, was a matter of public safety, and represented a risk to the residents. It was an obvious and straightforward risk of which Goodwin should have been aware. This failure led to Mrs McKay accessing the courtyard undetected and ultimately, to her death.

75. There was confusion in the evidence given by Goodwin managers as to whether sensor mats were used routinely, as standard, or used only as required at the discretion of staff. This confusion may well have affected staff attitudes to, and understanding of, the use of sensors and the role of Goodwin care plans in guiding the approach to risk mitigation. In any event, Mrs McKay's care plan required the use of a sensor mat and, consistent with that, at least one ought to have been in place and switched on in accordance with that care plan.

76. Goodwin's reliance solely on staff to ensure that doors remained locked, and that residents were not attempting to leave the facility using the corridor doors, provided the environment for undetected courtyard access to occur. If there had been an alert or alarm system on corridor doors which notified staff that doors had been opened, and/or if sensor mats had been operational in Mrs McKay's room, it is highly likely that:

    i. Mrs McKay's absence from her room would have been detected earlier than it was; and
    ii. Mrs McKay would have been located in the courtyard much sooner than she was.

77. I find that Mrs McKay went outside to the MSU courtyard through the gold corridor external door. I find that she did so by turning the snib lock on the door and pushing the door forward. I find that Mrs McKay was able to do so because the door did not require a key to unlock it.

78. I find that on the evening of 16-17 January 2015, neither bed nor room sensors were in use in Mrs McKay's bedroom at the MSU.

79. I find that Mrs McKay was able to access the courtyard undetected because of the absence of sensor mats anywhere in her room, including on her bed. The absence of sensor mats in use resulted in her leaving her room without staff being alerted to her movement. I find that the absence of electronic monitoring, including alerts or alarms, of the gold corridor external doors meant Mrs McKay's use of the door to enter the courtyard went undetected for some time.

80. The circumstances of residents in aged care facilities being able to unlock doors to areas outside undetected at night is a matter of public safety as contemplated by section 52 (4)(a). I will address this at (E).

B. How long was Mrs McKay outside undetected in the MSU courtyard

81. The evidence demonstrates that Mrs McKay's absence from her room was not discovered until just before 8am. Dr Brock opined that Mrs McKay was likely to have been under the car for no more than 2-3 hours, but she may have been outside, but not under the car for up to five hours.

82. There are a number of aspects of the evidence to consider that informs the finding I make in relation to this question.

Staffing

83. Ms Boyd's evidence sets out the staffing structure and regime in place at Goodwin in January 2015. They operated on a 1 carer to 11 residents ratio. In summary, there was a morning, an afternoon and a night shift. Staffing levels varied over the three shifts.

84. Morning shift saw a Team Leader and four carers for each floor.

85. Team Leaders have Certificate IV qualifications while other carers have Certificate III qualifications. The day shift also saw an enrolled or registered nurse on shift. Evening shifts were led by one Team Leader for all three floors supported by an unspecified number of carers.

86. Night shifts were staffed by a Team Leader for three floors and one carer per floor. There was an additional carer who was referred to as a 'floater'. There was no enrolled or registered nurse on shift at the facility for overnight periods. If the assistance of a nurse was required overnight, the Team Leader would contact an 'agency' nurse.

The 16-17 January 2015 night shift

87. JL was the Team Leader on duty on the night shift for 16-17 January 2015. GB was a carer on duty. SE was the 'floater' for the shift. She did not have any interaction with Mrs McKay during her shift.

88. JL's evidence consistent with the statutory declaration that he completed on 18 January 2015 is that he checked on Mrs McKay at 2.10am and saw her sleeping in her bed. He called GB at 5.20am and requested a check of all MSU residents be conducted. GB reported back that all was well with residents except for a male resident who was wandering.

89. JL said he checked the MSU doors leading out to the courtyard including the door nearest Mrs McKay's room by "*turning the lock not with a key*".

90. JL described Mrs McKay being known to wander. He said she would wander into other resident's rooms, the pan and utility rooms, the garden, and would try to open doors within that wing. Staff would attempt to divert her and on occasion she would be administered a sleeping tablet.

91. JL described an incident in January 2015 where Mrs McKay was concerned about her car. JL made notes about this in the electronic recording system at 3am on 4 January 2015.

92. The note is comprehensive stating:

> *Resident came up to care office and asked me I could start up her car and looking for her mother and father at around 0240. Resident was guided back to her room and assisted to settle back into bed. A couple of minutes later resident got up and came back to care office with the same reason as above. Resident was directed back to her room again and declined to settle in bed. Resident was trying to get through the fire exit door as well. Advised staff on duty to keep an eye on resident.*

93. I observe here that the note makes no reference to implementing or ensuring the use of sensors consistent with Mrs McKay's care plan to assist with monitoring Mrs McKay in these circumstances.

94. JL maintained that as part of his checking of all residents on 17 January 2015, at 2.10am he saw Mrs McKay in her room, asleep in her bed. He described there being enough light for him to satisfy himself that she was where she should be. He did not make a note of this observation but recalled it occurring. JL then described attending to other duties including the death of another resident overnight. He asked GB to perform a check. GB reported that apart from a male resident who was wandering, all was well. This is consistent with progress notes relevant to Mrs McKay recording at 5.26am that she had been checked and was sleeping. JL said it was an unusually busy shift. He had nothing further to do with Mrs McKay. The Cardox logs which recorded movements in and out of the MSU from the main reception of Goodwin were consistent with the evidence JL gave about his movements and the timing of when he said he checked on Mrs McKay.

95. JL agreed that if the doors at the end of the corridor were locked anyone could open them. He also described that while resident's individual rooms were locked from the outside with a key, they could be opened from the inside without a key. This is consistent with the observations of First Constable Callum Hughes. A room door would lock itself upon closing behind a resident, preventing re-entry.

96. There is no basis for me to reject the evidence from JL about what he did and observed during his shift as Team Leader when this incident occurred.

97. GB also completed a statutory declaration on 18 January 2015. He was a carer on the night shift of 16-17 January 2015. He declared that at 11.30pm on 16 January and again at 5am on 17 January 2015 he checked on residents. In an interview with police on 25 January 2015, he said checks were supposed to happen hourly but that he had been busy with other duties. He said during the first check where the bathroom light was on and he saw Mrs McKay in her bed, he was careful not to wake Mrs McKay because if she woke up, she would wander, waking other residents and this would create difficulty because he was the only carer on the floor that night to care for 20 residents.

98. GB said he checked on Mrs McKay at 5am and saw her lying in bed. He had no role in relation to checking whether external doors were locked. He generally described Mrs McKay as a wanderer saying, "*she is saying all the time looking for the car on the street*". He said he did not know of her going outside at night.

99. He said Mrs McKay liked the garden and could operate the external doors to the garden noting those doors did not require a key.

100. GB did not believe Mrs McKay's room had a sensor mat but he was not entirely certain. As I have already noted, he did not have any responsibility in this regard. He said this evening represented one of the busiest shifts he had worked and that this was why he had not been able to get to making notes of his duties for the earlier check he conducted. His evidence about the demands of the shift are reflected in the nurse call logs which recorded 15 alarms in the green corridor between 4.15am and 4.45am.

101. When giving evidence, GB expressed some hesitation about whether he could in fact recall going into Mrs McKay's room. This is unsurprising given the passage of time. The version he gave in the statutory declaration and in his interview with police occurred within days of the incident. They are consistent with the progress note entry of there being a check of Mrs McKay at 5.26am. There is no basis for me to reject the evidence of GB about what he did and saw during his night shift when this incident occurred.

102. While there was evidence in relation to staffing ratios, ultimately it is not possible for me to determine that the number of staff allocated to a night shift led to Mrs McKay entering the courtyard undetected. The evidence suggests that night shift staff assist and support residents with an array of needs and requirements, consistent with the vulnerabilities of those residents, in addition to attending to their administrative and record keeping duties. It is entirely possible, noting the particular demands of that shift, that more staff would have only impacted capacity to respond to those needs in a timelier fashion, rather than successfully guarding against resident movement out into the courtyard. An increased staffing ratio, given the approach in place to ensuring the security of the corridor doors was entirely based on staff compliance and the opportunity for staff intervention, would not have guaranteed Mrs McKay remained inside. By this I mean, for example, had there been ten carers on shift for the MSU that night, it is quite possible that all ten could have been attending to other residents inside their rooms and not have noticed Mrs McKay accessing the courtyard when she did. Absent any monitoring that did not rely entirely on staff (door alarms or alerts, room sensors, CCTV monitoring and alerts) this scenario, in my view, was a real possibility.

The Discovery of Mrs McKay

103. The three staff members involved in finding Mrs McKay all noted that her bed was neatly made, and her room was locked from the outside when they discovered her missing.

104. Carers, CF and PW gave statements four and a half years after the incident. In those statements, they detailed conducting a head count of residents in the gold corridor after beginning their shift on 17 January 2015.

105. They noted that Mrs McKay's bed was made. PW observed that the bed appeared not to have been slept in. PW told RD that Mrs McKay was not in her room. PW looked for Mrs McKay in other resident rooms and the dining/TV room before she unlocked and opened the door at the end of the gold corridor by turning the lock to open the door

and saw Mrs McKay outside under the car. CF retrieved blankets to keep her warm until the ambulance arrived.

106. Neither PW nor CF gave evidence at the hearing. Their statements were tendered.

107. RD was the Team Leader at the MSU on the morning shift. He was also an enrolled nurse. He described Mrs McKay as a wanderer. He gave evidence that the doors at the end of the corridors which opened into the courtyard could be locked from inside by turning a latch or with a universal key. RD is wrong about the use of a universal key as there was no keyhole on the inside of the doors at the end of corridors out to the courtyard.

108. RD gave evidence that he was administering medicines to residents in the gold corridor from about 7:40am. He said Mrs McKay's room was locked when he reached it, he unlocked it and entered. Consistent with PW and CF, he said the bed was made neatly. RD observed that it was made in a way that Mrs McKay could not have achieved herself. Consistent with PW, he said the bed appeared not to have been slept in.

109. RD gave evidence that he was on his way back to the care office when PW called out to him pointing in the direction of the gold corridor. RD said that door was locked when he tried to open it.

110. RD said Mrs McKay told him that she was cold and that she had been outside all night, he also observed here that she had dementia, a concession from him in my view about the reliability of that assertion.

111. RD called "000" at 8.10am moments after entering the courtyard and discovering Mrs McKay. He said he observed vomit on the concrete by her mouth.

112. RD recorded a version of events within a few hours of the incident in a typed document which was attached to his police statement.

113. RD's version is inconsistent with PW about who discovered that Mrs McKay was missing. PW's statement is corroborated by CF's. That said, PW and CF's statements were made four and a half years later, a long time after the incident, in comparison to RD's version which was within hours of the incident occurring. Enrolled nurse, VT, in a statement made four and half years after the incident, described "*carers*" noticing Mrs McKay was not in her room. There is, on either version, the possibility that both RD and PW made the discovery at different times not realising the other had already observed her bed empty. In any event, I do not consider the inconsistency about who discovered Mrs McKay missing to be a significant matter that provides a basis to reject any evidence given by these witnesses.

114. I am of the view that I cannot conclusively determine whether the gold corridor external door was locked when Mrs McKay was discovered thus preventing re-entry. I am satisfied it was unlocked by Mrs McKay when she moved out into the courtyard, JL having checked and locked it at 11pm. There is the real possibility that a staff member who was not a witness in these proceedings locked it after Mrs McKay went into the courtyard but prior to RD, PW and CF moving out into the courtyard to assist Mrs

McKay. Again, in my view, this is not a significant matter that materially effects the findings I make.

115. I accept the evidence from all three witnesses that when they entered Mrs McKay's room the bed was made. Photographs taken by police sometime after they arrived at 10am are consistent with that evidence. In the photos of the room, the bed does appear to have been neatly put together. In the corner of the room, next to the head of the bed, some sheets appear to be piled up as if the bed had been recently stripped. There is no real explanation on the evidence before me about that. It is important to note that there was no log or record kept of who entered Mrs McKay's room after she was discovered under the car in the courtyard. There is no record of whether any other staff entered her room after she had entered the courtyard but before she was determined to be missing by PW and/or RD. This raises the possibility that a staff member who was not asked to give any information about this matter to Goodwin management or the police investigating on behalf of the coroner, entered Mrs McKay's room prior to her discovery, incorrectly assumed that she was up and about for the day, and made the bed. As will become clear, I do not consider that the fact that the bed was neatly made is evidence that can be relied upon to determine that Mrs McKay had not slept in her bed.

116. The expert medical evidence which I will come to in a moment does not support the finding that Mrs McKay was outside all night. The evidence from GB and JL, which I have already indicated I cannot reject, is inconsistent with Mrs McKay having not slept in her bed.

Expert medical evidence on the length of time Mrs McKay was outside in the courtyard

117. Dr Jeffrey Brock is a medical practitioner with specialist expertise and experience in aviation medicine, aerospace medicine and extreme weather survival on land. He was an impressive and helpful witness. Dr Brock said that Mrs McKay's temperature recorded by ambulance officers, recording the tympanic (ear) temperature, must be treated with caution. He said that a body temperature of 31 degrees on rescue, as was recorded by ambulance officers, alongside Mrs McKay's medical conditions and frailty would not be compatible with life. Dr Brock noted that when she was found she was still conscious and rewarmed quickly after rescue. Dr Brock observed that the first rectal temperature at 9.20am which was recorded as 34.9 degrees was likely more reliable than those recorded by ambulance officers.

118. Dr Brock said that Mrs McKay was "*significantly hypothermic at the time of her discovery and initial assessment*" although her temperature would have been higher than 31 degrees. Hypothermia, he explained, being when an individual reaches a core temperature of 35 degrees or less.

119. Dr Brock described the role hypothermia played in Mrs McKay's decline as "*the beginning of a journey*" saying this about the role of hypothermia in her decline:

> *Hypothermia of itself can set in train a sequence of events that may lead to complications that seemingly are – you survive the hypothermia event but other things – in the case of Mrs McKay other things have become apparent or occurred that might not necessarily be directly connected to the event itself or hypothermia per se. But it's the beginning of a journey*

…Healthy people do better. Unhealthy people or injured people do not necessarily have the same outcome.

120. He said that Mrs McKay was more likely to experience hypothermia because of her age, low BMI, her medication, her dementia and likely Alzheimer's disease. He said that someone who has got dementia and who becomes hypothermic is less able to protect their airway.

> *These are – all these factors that I'm discussing increase the likelihood of hypothermia and its complications. So her age. She was 90. She had a low BMI, body mass index. Put in lay speak, essentially she was lightly built and did not have much fat tissue to provide insulation to her in the cold threat. She was on a group of medications, some of which would have increased her risk of hypothermia. Particularly she was taking – she'd had – she was on Amitriptyline, which is used for several reasons. It can be used to assist with sleep, it can be – larger doses of Amitriptyline – it's an old antidepressant but in lover doses it's used to improve sleep and to deal with chronic pain. She was taking a blood thinner called Plavix. Of itself Plavix is used – she had a – and taking – why was she taking Plavix? Well she had a predilection I believe to cardiac arrythmia called atrial fibrillation. There's no evidence that atrial fibrillation has a role in this matter but she was put on Metoprolol – a low dose of Metoprolol which is a beta blocker which is a drug that's used to reduce her likelihood of having runs of atrial fibrillation. But Plavix and – sorry – having a beta blocker onboard does reduce your response to thermal stress, particularly – even in a healthy person. But in a less healthy person such as she was that would predispose her to a faster cooling rate. She suffered with dementia. That's – I don't think there is any doubt about that. The autopsy report from a colleague indicated that, you know there were good evidence of Alzheimer's disease I've seen her CT scan of her brain and I agree that's very likely. So because she suffered with dementia that is an independent risk factor for hypothermia and aspiration. Not all the mechanisms are clearly understood but essentially someone who has got dementia and who becomes hypothermic they are less able to protect their airway they are more – they may be unconscious but they are less able to, as I said, protect their airway or to do things for themselves that might actually save themselves*

121. In addition, he noted the suggestion in the hospital notes that Mrs McKay was suffering from a urinary tract infection saying that it would have increased her risk of hypothermia. Additionally, Mrs McKay may have had an undiagnosed long-standing low-grade chest infection prior to her admission which could lead to mild hypothermia even before she went outside.

122. Dr Brock identified that the weather conditions at 5am on the morning of 17 January 2015 being 12 degrees posed a "*significant hypothermic threat".* He said that where Mrs McKay was positioned acted as a heatsink and her ongoing blood loss also meant heat loss noting she was wearing a light nightgown and she was immobile underneath the vehicle.

123. Ultimately it was Dr Brock's view that Mrs McKay was outside of the building for 2-3 hours at most. This view was influenced by his expectation that had it been any longer, she would have been profoundly unconscious or deceased. He could not rule out the possibility that Mrs McKay had been outside for longer than 2-3 hours but said that given her Glasgow Coma Score of 14 at 8am, it was "*much less likely that she was outside for more than a couple of hours*".

124. There is no basis for me to reject the opinion of Dr Brock. Indeed, it is consistent with the timing of the observations which JL and significantly GB made of Mrs McKay in her room in bed.

Findings about how long Mrs McKay was outside undetected in the MSU courtyard

125. I find that Mrs McKay entered the courtyard through the gold corridor external door sometime after 5am on 17 January 2015. I find that she was outside in the MSU courtyard until she was discovered around 8am. I find that she was undetected outside in the MSU courtyard for between 2 to 3 hours.

126. It is difficult to determine with any certainty the extent to which Mrs McKay was suffering hypothermia and if she was, the extent to which it contributed to her death. It is clear that she had a number of factors personal to her that elevated the risk of and susceptibility to hypothermia. While I am satisfied she did indeed suffer a degree of hypothermia from the time she spent outside in the courtyard, in particular under the stationary vehicle, I cannot make any definitive finding about the role it played in her decline and ultimately in her death.

C. Medical treatment and care at TCH including the question of aspiration

Care on arrival – removal of the cervical spine collar

127. As I have already noted, Mrs McKay arrived at TCH at 9.11am. BH was the Senior Registrar who cared for Mrs McKay at TCH ED. BH gave evidence before me. He had no independent recall of treating Mrs McKay and relied on hospital notes. Given the significant passage of time there can be no criticism of him for this.

128. BH noted that Mrs McKay was in a cervical spine collar and no airway issues were noted with oxygen levels at 96%. He ordered a CT scan of the brain/cervical spine, chest and the abdomen/pelvis area and an x-ray.

129. At 12.50pm the hospital notes record Mrs McKay having a large brown liquid vomit while lying on her back with the collar on. Suctioning commenced within seconds as AR was with Mrs McKay when the vomiting occurred.

130. After a CT report confirmed the left front soft tissue haematoma and no other traumatic injury, BH notes at 1.20pm that the cervical spine collar was removed. BH ordered antibiotics along with a repeat chest x-ray.

131. BH's view was that the cervical spine collar was to remain in place until the results of a CT scan. To remove it before the results of such a scan in the circumstances I am satisfied created a risk of injury to the spinal column. There was no challenge to his evidence that to have removed it earlier would go against standard practice and treatment. Indeed, it was consistent with Professor Pain's evidence. Agreeing with Professor Pain, Dr Brock articulated the balancing exercise underpinning Mrs McKay's treatment in those first hours of her care noting that the priority was to ensure that a c-spine injury was not missed which could have been the difference between life and death. While Dr Brock noted a CT scan earlier could have seen the removal of the collar, he also observed that emergency departments are routinely prioritising patient care. Dr Brock offered this observation:

> *It's a trade off between the risk of missing – until you absolutely should and she doesn't have a significant neck fracture. It's that versus the risk of anything else – any other complications*

going like, I'm sure you, the obvious one is whether or not if she vomits and she's got a collar on whether you can – she can protect her airway with by herself or with help adequately while wearing a cervical collar. But as Professor Pain and I agree the priority is to get, is to ensure that we don't miss a c-spine injury which could be, you know, catastrophic if they took the collar off and something happened, she had a disc – or she had a serious spinal injury that was missed. That might be the difference between life and death at the time. The only thing I might say, is, well, given all – it's great looking backwards, but given all of the circumstances at the time they could have done – the only thing I can think of is could they have done the CT scan earlier and made the, and cleared the requirement for her to maintain the c-spine - or maintain the wearing of the neck guard. The sooner it was removed, perhaps the more comfortable she would have been.

132. Dr Brock did not identify any concerns with, or criticisms of the care Mrs McKay received at TCH. The above extract from his evidence demonstrates that his view about earlier removal of the collar was expressed with the benefit of hindsight. I am affirmed in that view because of his specific use of the term "*looking backwards*" and this further evidence where he said:

I think realistically – I don't know how busy it was. It was a Saturday. ED departments are crazy. It's prioritisation. And, you know, in the whole mix of what was going on in the ED, it might be that getting her trauma, whatever. The only thing I would say optimally was to have got maybe a CT earlier.

133. Professor Pain made clear, having reviewed the treatment provided to Mrs McKay at the TCH that he had no concerns about that treatment responding when asked "*none whatsoever*". He went on to offer "*if the event hadn't occurred in the courtyard, none of this will be initiated*".

134. In my view there can be no criticism of the decision to await the results of a CT scan before the collar was removed from Mrs McKay. There is no evidence before me that the performance of the CT scan was unusually or unnecessarily delayed. BH did not express any concern about the time taken for the CT scan to be performed in the context of his experience as an emergency doctor. The time it did take for a CT scan to be performed was not, in my view, a failing, nor did it represent inappropriate, or an unsatisfactory level of care. BH did not assess the need for a CT scan as urgent. That assessment was not challenged or undermined by any of the other expert medical evidence.

Aspiration

135. Mrs McKay's cause of death as determined by Dr Milne was acute bronchopneumonia. There was no contest to the cause of Mrs McKay's death. The issue to resolve here is whether the acute bronchopneumonia was caused by aspiration of foreign material. If aspiration did occur there is also a question of when and how it occurred.

136. Variously described by the medical experts, aspiration is the inhalation into the airways of something that should not be inhaled – typically food, saliva and stomach contents. A consequence of aspiration can be inflammation and infection.

137. The question of whether or not Mrs McKay vomited while she was laying under the car was raised during the course of this inquiry. RD said he saw vomit on the concrete near Mrs McKay's mouth when he observed her in situ under the car. Goodwin identified that the presence of vomit was not included in the ambulance officer records.

The absence of an observation by the ambulance officers that vomit was near Mrs McKay when they attended to her was said by Goodwin to provide a basis to reject entirely the observation that RD said he made. The evidence demonstrates that while the ambulance officers may not have specifically noted vomit in their notes, RD was not the only person who recorded observing vomit near Mrs McKay at the scene when she was under the stationary vehicle.

138. Annexed to the statement of Jeffrey Shelley (exhibit 19), is a document he produced entitled "*Ruth McKay Incident – Ongoing Review Following Fall*" dated 17 January 2015. That report details versions of the incident from Goodwin staff who were immediately on the scene. One of those staff members is VT, an enrolled nurse. VT also provided a statement, and it is exhibit 25. In both the version she gave detailed in Mr Shelley's report and in exhibit 25, VT specifically notes observing vomit near Mrs McKay when she was under the vehicle saying, "*there was vomit around down the left-hand side of her face and on the concrete*".

139. While VT did not give sworn evidence, there is nothing on the face of her documented, consistent versions that would cause me to have concern about relying on her version. RD made contemporaneous notes about the incident on the day soon after it occurred which included his observations of Mrs McKay while she was under the vehicle. Those contemporaneous observations include that he saw vomit on the concrete near her mouth.

140. The absence of vomit being recorded in the observations made by the ambulance officers does not cause me to reject the observations of RD and VT. I am satisfied there was vomit on the concrete near Mrs McKay and down the left-hand side of her face.

141. The significance of this is that I am satisfied Mrs McKay may have aspirated while trapped under the vehicle.

142. As I have already noted, at 12.50pm Mrs McKay vomited while lying on her back with the collar on at TCH. Suctioning commenced within seconds as a nurse was close by to Mrs McKay.

143. At 2.30pm, BH records there is "*likely aspiration*" and identifies "*aspiration pneumonia*" as a possible issue. BH, noting he had no independent recall and there being no notes of his reasoning, gave evidence that it was likely he came to that view after seeing signs of aspiration on the CT scan and the prescribing of antibiotics could have covered that possibility.

144. BH agreed aspiration could have been possible while Mrs McKay was on her back under the car.

145. DB was the medical assessment and planning unit registrar on 17 January 2015 and admitted Mrs McKay under the Geriatric Team. After examining Mrs McKay, DB noted "*lots of upper airway transmitted noise. Difficult to assess clearly…subtle crep right base, no wheeze*". Upon being told that Mrs McKay had a coughing episode in the ED, DB queried if there was a risk of aspiration.

146. At 4:45am on 18 January 2015 while Mrs McKay was under TC's care, she noted that she was "*very chesty and gurgly*" so she placed her in a semi-sitting position. At 7:40am she noticed that Mrs McKay was "*more chesty and gurgly*" and she was worried that she "*may have become a bit fluid overloaded*". TC notified the after-hours doctor who did not arrive before she finished shift.

147. WH, a radiologist reviewed the CT images and X-Ray images of Mrs McKay and noted that her lungs were "*grossly clear*", and no evidence of aspiration was visible on the x-ray or the CT scan as would normally be the case if it were present. WH said this in evidence:

> *Does an x-ray always pick up evidence of aspiration? As I said, this is also, once again we are back to square one where we started in regards to the CT and aspiration. This all depends on the amount – about the amount of the aspirate, compilation of the aspirate, time between aspiration is going to happen and examination to occur, so there are many factors which influence this. So yes ma'am, if there is content most of the time we should be able to see if it's already unless enough time has elapsed between the event and the examination, patient has responded and aspirated of such nature, the chemical composition and the age of the contents, size of the particle and material which has been aspirated. So they always get – I mean, not always we can detect but most of the time we are able to see aspiration.*

148. This opinion is consistent with Dr Milne who also identified how much is aspirated as a factor influencing whether aspiration would be revealed in a CT scan or an x-ray. He went on:

> *If someone aspirates particulate food matter, that might be really obvious sitting in the airway. It they're only aspirating a bit of fluid and we're then relying on a secondary inflammatory process, I can't really say how long it's going to take on an x-ray, it not being my field, but it takes hours to see microscopically, so I would think usually it would take longer on an x-ray to see those changes.*

149. Dr Milne gave evidence that he could not confirm aspiration pneumonia microscopically although he did say from the circumstances known to him it seemed likely.

150. Professor Pain was of the view that up until Mrs McKay vomited an amount of gastric juice, her lungs were "*in pretty good condition*". Aspiration pneumonitis he said causes irritation of lung tissue that can develop into an infection. Professor Pain explained that where the foreign body is fluid and not a significant amount it takes about 24 hours for clinical and radiological evidence of aspiration. He said:

> *The amount you aspirate is proportionate to the severity of the aspirational event, the pneumonitis. So I guess it's possible that she aspirated some fluid under the car, or at some time before she went to hospital which had not demonstrated itself radiologically. That is possible.*

151. Helpfully, Professor Pain explained the difference between aspiration pneumonia and bronchopneumonia:

> *Aspiration pneumonia is an acute --- it produces an acute inflammatory response which goes to a diffuse pneumonitis. It's an acute inflammatory reaction. Of itself it is sometimes self-limiting, but it is in some sense a medical emergency. It's a very serious event carrying a high mortality, unless it is actively treated. And there is treatment for it. Bacterial pneumonia is an infection with organisms often beginning in the upper respiratory tract, but then descending down into the lower part where it develops pneumonia, which is an inflammatory*

reaction usually localised, in the sense that it's patchy and not as diffuse as pneumonitis. But it can meld into one another making the separation very difficult.

152. I asked this question:

So something could begin as aspiration? Yes

Pneumonia and become bronchopneumonia?------ Exactly so, Your Honour.

153. Professor Pain found that Mrs McKay could not have had pneumonia prior to 17 January 2015 as Goodwin did not note any concerns for her health in the week prior. In his report he said that it was unlikely that aspiration occurred while she was outside as he would have expected Mrs McKay to show increased signs of stress on admission and abnormalities in chest radiology. He said that the most likely scenario is that Mrs McKay developed pneumonia after vomiting in the ED. In evidence at the hearing, Professor Pain retreated from this definitive position adding the following evidence to his view that aspiration had most likely occurred after admission to hospital:

I'd like to modify that I think. I think it's possible that radiology may not have detected anything so shortly after the possible event. But certainly I would expect Mrs McKay to be very distressed if she had significant aspiration in the courtyard.

154. Professor Pain was asked to comment on the observations of DB. Professor Pain's opinion was that DB's observations were more consistent with aspiration pneumonitis than bronchopneumonia. He gave the following evidence:

Question: So can I take you to the section where it says 'chest' and DB gave evidence yesterday afternoon. He says 'lots of upper airway transmitted noise. Difficult to assess clearly. Subtle creps right base. No wheeze. Not dull to percussion'. Could you tell her Honour whether or not that picture of those symptoms is consistent with a diagnosis of pneumonia or aspiration pneumonitis? Or is there any difference?

Answer: I don't think what he said there allows a clear distinction. 'Not dull to percussion' is against pneumonia in the sense that significant pneumonia often produces dullness when you percuss the chest. That was not present, so that's one point against this being pneumonia. 'No wheeze' is slightly against this being an aspiration pneumonitis because commonly there is a wheeze because the airways get irritated as well as the lung tissue, so you commonly hear a wheeze in early aspirational pneumonia. Subtle creps at the right base is a very non-specific finding and is equally applicable to aspiration pneumonitis and pneumonia. 'Difficult to assess clearly'. Well that doesn't help much at all. So I think these findings are more – to my mind are more consistent with aspiration pneumonitis but they certainly don't – they're a bit against pneumonia. But you couldn't put a lot of money on it either way.

155. He went on:

He (DB) was obviously concerned about the episode of coughing and sputtering and he wondered – he has a question mark, 'Query aspiration'. So, I think it's certainly in his mind as a diagnosis, but he wasn't totally convinced.

156. Significantly, Professor Pain was not able to exclude the contribution of aspiration of gastric juices while Mrs McKay was under the car as contributing to aspiration pneumonia. Professor Pain identified that it was possible radiology may not have detected anything so shortly after a possible event of aspiration. While Mrs McKay was not in respiratory distress when she arrived at hospital, Professor Pain could not exclude the possibility of aspiration while she was trapped under the vehicle. Dr Milne

did not see any microscopic evidence of foreign material that was fresh and could not confirm aspiration pneumonia microscopically.

157. On the evidence before me, it is not possible to determine to the requisite standard whether aspiration did in fact occur. It is similarly not possible to determine if aspiration did occur, when it occurred and how it occurred. On the evidence before me I am not able to determine the cause of the bronchopneumonia infection.

Findings on medical treatment and care at TCH

158. I find that while at TCH, Mrs McKay received appropriate treatment and care.

159. Mrs McKay may have aspirated foreign material either while she was trapped under the vehicle in the MSU courtyard or at TCH when she vomited or after drinking water and coughing. It is not possible to make a positive finding that the acute bronchopneumonia was caused by aspiration. Mrs McKay's pre-existing medical conditions, including Alzheimer's, made her more vulnerable to this infection with or without aspiration. I am unable to find to the requisite standard that she did in fact aspirate foreign material, or did not, and if she did, where that occurred.

D. Goodwin actions on 17 January 2015, internal investigation, reporting processes and previous incidents

160. I deal first with the credibility of RD. I formed the view that RD presented as a responsible, thoughtful, diligent carer who operated with the wellbeing of residents in his care at the forefront of his practice. In my view, attempts to undermine his credibility were misguided. RD almost immediately identified the seriousness of the incident involving Mrs McKay and took the time to record his involvement contemporaneously. That approach reflects the view I have taken of him which is also reflected in the time he took to comprehensively record his concerns about Resident 3 (see Resident 3 Icare record 26 December 2014). That RD was mistaken about some matters, like whether a key was required to operate the gold corridor door, or that he believed Mrs McKay had not slept in her bed all night, which I am satisfied was not the case, does not in my view provide a basis to reject his evidence or cause me to hesitate about relying upon it.

161. I reiterate my view that I do not consider there to be any real basis upon which I could reject the evidence of HY and TL. It is entirely unsurprising that they could not provide specific dates and times given they gave evidence some years after the events. TL's evidence that at times her mother's sensor mats were switched off is not undermined by the records establishing that at other times it was turned on. Indeed, the picture painted by the combination of that evidence is consistent with the confusion as between Mr Shelley and Ms Boyd about the use of sensors, the finding in Mr Shelley's report about the robustness of their use and the fact that Mrs McKay left her room undetected to get to the courtyard despite her care plan instructing otherwise.

162. On 17 January 2015, Mr Shelley and Ms Boyd arrived on the scene after Mrs McKay had been taken to hospital via ambulance. There was a significant amount of evidence of what happened at Goodwin in the immediate aftermath. There was conflicting evidence about the precise detail of what was said and done by Mr Shelley, Ms Boyd

and RD. I accept RD formed the view arising from his engagement with Goodwin management that he was, at the very least, to be careful about his engagement with police. RD's commitment to capturing his version of events as quickly as possible is to be commended, in my view.

163. I am not in a position, based on the evidence, to make any definitive findings about exactly what was said by Goodwin staff and ultimately, I do not consider what occurred in the immediate aftermath to be relevant to the findings I am required to make. I take the opportunity to make clear though, as a matter of common sense and good practice, all staff in facilities such as Goodwin, particularly senior staff, should be well versed in the response and approach to be taken after a serious incident such as the one Mrs McKay's situation presented. Certainty in approach provides a basis for clear, consistent leadership so that all staff understand the requirements and their role in responding to a serious incident such as the one subject to this inquiry which could include cooperation with police investigations.

164. Ms Boyd gave evidence that the incident involving Mrs McKay did not need to be reported to the Department of Health or the Aged Care Quality and Safety Commissioner, but internal Goodwin procedures required an investigation to be undertaken. Consequently, Mr Shelley was instructed to conduct the investigation he did resulting in the document "*Ruth McKay Incident - Ongoing Review Following Fall*".

165. The document noted the following actions to be taken following the incident; a request that external doors be alarmed, an audit of bed sensors, staff training on documentation, staff reminding of checking and staff discussion of behaviour management.

166. An audit of the bed sensors, crash mats and room sensors revealed, according to Mr Shelley, the technology was not being used as robustly as Goodwin had hoped. This view is entirely consistent with Mrs McKay's room not having sensors switched on and the experience described by TL and HY. Mr Shelley gave evidence that every room was fitted with sensors which staff were required to turn on when residents were in their rooms. The sensors would detect movement, send an alarm to DECT phones and if they were not responded to in a certain time, there was an escalation process.

167. Despite the review conducted by Mr Shelley, he was not aware of whether a sensor mat was in Mrs McKay's room nor that there was no alarm set off during the night of the incident. He accepted that the absence of any nurse calls from Mrs McKay's room on the night in question would tend to indicate that there was no sensor operative in Mrs McKay's room and as such, no precise time of Mrs McKay exiting the room could be ascertained.

168. Ms Boyd gave evidence that the MSU courtyard was designed for dementia patients so that all paths lead back to the doors inside. She did not accept that the lack of any restriction, other than locking the doors, was a deficiency or obvious risk, instead describing it as a "*problem*".

169. Contrary to Mr Shelley's view that the use of sensors was standard procedure, Ms Boyd was of the view that they were only to be used as required. Confusion amongst senior management, which is clear on their evidence, provides a basis to infer that

confusion existed amongst caring staff about their use and a basis to determine that their use was not consistent.

170. The Australian Aged Care Quality Agency (**AACQA**) was responsible for managing the accreditation and ongoing supervision of all Commonwealth funded aged care facilities. Goodwin was accredited on 16 August 2012 and 6 August 2015.

171. The 2012 accreditation found that Goodwin met all expected outcomes. In relation to the physical environment, safe systems and living environment, the audit report found that the outside courtyard areas provided a secure environment for those residents inclined to wander. Additionally, regular audits and environmental inspections monitor the internal and external environments, risk assessments are conducted, and residents' rooms are monitored.

172. The 2015 audit also found that Goodwin met all expected outcomes and noted that the system of monitoring and reporting on internal and external living environments provided a safe and comfortable environment for care recipients. In relation to Standard 44 – physical environment and safe systems, living environment – the audit notes the following:

> *The home has a system for monitoring the external and internal living environment including hazard and incident reporting and conducting regular inspections to provide a safe and comfortable environment for care recipients. The home is on three levels and includes a memory support unit on the ground floor with a separate secure garden*.

173. It is not clear that the AACQA was aware of the incident involving Mrs McKay when completing the 2015 audit. However, the *Aged Care Act 1997* (Cth) ("the Aged Care Act"), as it applied at the time of Mrs McKay's death, did not require Goodwin to report the incident to an external agency.

174. Since 2021, the Aged Care Act provides for a Serious Incident Response Scheme which requires a number of serious incidents, including an unexpected death, to be reported to the Aged Care Quality and Safety Commission.

175. The Icare record in relation to Resident 3 was produced at exhibit 63. On 26 December 2014, three weeks before Mrs McKay was found under the vehicle in the courtyard, a note was entered into that record by RD in the following terms:

> *Hazard report has been completed and sent to management – resident continues to get outside to courtyard via the gold corridor doors unsupervised. Resident is an extreme high risk of falls and injury, resident has been seen attempting to stand out of wheelchair unassisted and get into the parked old car in the courtyard. This has happened 4 times this shift, raising alarms because resident needs to be supervised constantly as the doors are unable to be locked from the inside. Resident is able to unlock the door. Due to risk, we had had to block the entrance to the door as resident continues to try and get into the car by himself. It was reported that this is happening during the night, and staff have reported that the resident has been getting out through the gold corridor door and was found during the night sitting in the driver's seat of the car. I have reported this to management and completed a hazard report so that more secure locks can be put in place.*

176. There was no sworn evidence given about this note either by RD or any other Goodwin staff member. It is beyond doubt that this entry exists in Resident 3's notes. RD clearly mentions both the making of a hazard report *and* reporting to management.

177. Goodwin highlights that they do not hold any record of the hazard report RD said that he made. This does not exclude the possibility that RD told someone in a management position about his concerns. That prospect was not explored in evidence at the hearing and RD does not identify who in management he informed. I do not consider that the absence of a hazard report in Goodwin records necessarily means that RD did not complete one. While I accept the possibility exists that he simply did not complete the hazard report in the way he said he did that is not consistent with the general approach he was clearly taking to the risk he identified. The approach he described in the note including making the hazard report, informing management and creating the comprehensive progress note, is entirely consistent with my strong impression of him in terms of the seriousness with which he took his role caring for residents.

178. On the evidence before me, the utility of the Icare record in the ongoing identification by management of resident needs and challenges remains unclear, if they are not reviewed or scrutinised after a record or note is added. RD made the entry as the staff member identifying the concern. It is unclear whether there was any process of review or supervisory scrutiny of the content on those progress notes, and, if so, when and how, in the context of ongoing resident care. On the evidence before me I cannot be satisfied that Goodwin management were, in fact, aware of the specific risk presented by Resident 3's conduct as at 16 January 2015.

179. What is clear is that the note entered by RD corroborates HY's evidence about finding Resident 3 outside in the MSU courtyard at around midnight. I accept his evidence about that. I accept TL's evidence that HY told her about this incident. I accept HY's evidence about the incident where his wife became locked outside after accidentally finding herself in the fire stairs.

180. I am satisfied that even without management being made specifically aware through the report of RD of the risk in relation to Resident 3 accessing the courtyard at night, the risk presented by the security of the locking mechanism on the gold corridor door in relation to all residents of the MSU was obvious and capable of being identified, given the needs and challenges of the residents living at the MSU.

181. It is unclear why the entry from RD on 26 December 2014 identifying the risk in the context of the behaviour of Resident 3 did not feature in the report produced on behalf of Goodwin.

182. Evidence was given regarding two incidents at Goodwin prior to Mrs McKay's death involving residents being able to exit the facility at night, and then having difficulty coming back inside. In the case of one of these residents, this occurred in the MSU. It is regrettable that Goodwin's management were not able to identify the obvious risk to its vulnerable residents posed by access to the courtyard by residents prior to 17 January 2015. It is also unclear how and whether the hazard report addressing the accessibility of the courtyard from the MSU (the existence of which is recorded in the progress notes of Resident 3 on 26 December 2014) was, could or should have been brought to the attention of Goodwin's management, putting them on further notice of the existence of the already evident risk. It is also unfortunate that it took until September 2020 for more appropriate safeguards to be put in place, noting that while alarms on the MSU doors were installed very soon after Ms McKay was found in the

courtyard, it was not until September 2020 that magnetic door locks were installed which directly addressed the issue concerning residents being able to leave the facility.

183. Ms Wendy McKay described members of their family feeling unwelcome at Goodwin in the days after Mrs McKay's death when they went to collect her personal belongings. She also described feeling a lack of communication. This was most unfortunate and undoubtedly added to the shock and distress at the circumstances of Mrs McKay's death. It was very unfortunate that upon their return to Goodwin to collect Mrs McKay's belongings her family were required to walk through the MSU courtyard, the very place where Mrs McKay had been found trapped under the vehicle. There was no evidence that any Goodwin staff member in particular was responsible for this being the case or indeed, that there had been a decision made by anyone at Goodwin that this was to occur. However, I acknowledge that it was certainly a factor that contributed to the negative experience of Mrs McKay's family.

184. There was evidence about the periods where the MSU was not attended to by staff. TL and HY both gave evidence of their concern and frustration in relation to staff availability. While I am of the view that I cannot reject that evidence, ultimately, I cannot determine that staff ratios had any impact on Mrs McKay's capacity to move out into the courtyard undetected as she did. It is beyond the particular scope of this inquest to delve in any detail into staffing ratios or levels. This was an issue within the scope of the *Royal Commission into Aged Care Quality and Safety* ("the Royal Commission") established on 8 October 2018. The Royal Commission made numerous (though not all unanimous) recommendations in their final report. I will come more to the Royal Commission in a moment. It seems to me to be a matter of common sense that where staff are routinely attending to vulnerable residents with varying needs and risk profiles (including wandering, falling, confusion, emotional dysregulation) that may require the time, care and attention of staff it heightens the need to ensure that direct staff supervision is supported by other methods of supervision, such as electronic monitoring.

E. Matters of Public Safety

185. In January 2015, as I have already found, Mrs McKay was able to let herself out into the MSU courtyard. The failure to ensure that residents could not go outside at night led to Mrs McKay's death. I am satisfied Goodwin rectified this situation entirely by September 2020 with the installation of a timed automatic door, locks and ultimately CCTV.

186. A matter of public safety arises in relation to aged care facilities more generally accommodating residents with dementia in circumstances where they can get access to outside areas at night or in dangerous weather conditions undetected.

187. It is true to say that there was no evidence from an independent aged-care expert about the nature of any risk, regarding the circumstances as I have found them to be, in relation to residents accessing the MSU courtyard in January 2015. That said it is surprising to me, given the view I have formed about the obvious nature of the risk presented by the security of the corridor doors, that the risk to MSU residents in that regard was not identified in either the 2012 or the 2015 accreditation process. It is clear that the accreditation process failed to identify the risk of undetected resident access

to the MSU courtyard. While the accreditation process in August 2015 saw the doors alarmed, they were nonetheless still able to be opened at any time of the day or night.

188. The Aged Care Act at the time of Mrs McKay's death did not require the reporting of an accidental death. Assaults, unlawful sexual contact and unreasonable use of force were reportable. Despite Mrs McKay dying as a result of the incident at Goodwin, there was no requirement or mandatory reporting that required any external agency to be informed of the circumstances of her death.

189. The Royal Commission operated under wide ranging terms of reference, including the quality of aged care services delivered in Australia, the best ways for aged care services to be delivered and future challenges and opportunities for delivering accessible, affordable and high-quality aged care services in Australia. The final report underscores the stake we all have in ensuring easily accessible, high quality aged care not only in the interests of our aging loved ones but in recognition that old age is hopefully, ahead of us all. As part of their final report the Royal Commission noted:

> *Residential aged care is often a person's final place of residence before they die. Palliative and end-of-life care, like dementia care, should be considered core business for aged care providers. People at the end of their lives should be treated with care and respect. Their pain must be minimised, their dignity maintained, and their wishes respected. Their families should be supported and informed.*

190. The final report of the Royal Commission includes recommendations giving more power to the Aged Care Quality and Safety Commissioner to conduct inquiries into issues relating to the quality and safety of aged care, including complaints and serious incidents. The Royal Commission, reflecting on the future of aged care services in Australia, observed:

> *The purpose of the aged care system must be to ensure that older people have an entitlement to high quality aged care and support and that they must receive it. Such care and support must be safe and timely and must assist older people to live an active, self-determined and meaningful life in a safe and caring environment that allows for dignified living in old age.*

191. In their final report, the Commissioners noted that shortcomings of the regulator, the Aged Care Quality and Safety Commission and its predecessor observing:

> *We both consider that the Aged Care Quality and Safety Commission and its predecessors have not demonstrated strong and effective regulation. The regulator adopted a light touch approach to regulation when a more rigorous system of continuous monitoring and investigation was required for aged care. Current regulation policies and processes have many deficiencies. The regulatory framework is overly concerned with processes, not focused enough on outcomes, and does not provide enough safeguards to protect older people and provide reassurance to their families that they will receive safe and high-quality aged care. The system is insufficiently responsive to the experiences of older people*.

192. The final report of the Royal Commission contains numerous recommendations. In particular, recommendation 10 of Commissioner Briggs specifically addresses strengthening the role of the regulator across the aged care sector to ensure the maintenance of an appropriate regulatory capability, including regulatory and investigatory skills, clinical skills, assessment skills, and enforcement skills.

193. It is a positive reform then, arising from the Aged Care Royal Commission, that from 2021 the Aged Care Act provides for a Serious Incident Response Scheme. This scheme requires certain serious incidents to be reported to the Aged Care Quality and Safety Commission. The Act identifies eight types of reportable incidents including unexpected death. It is clear that if circumstances arose in an aged care facility now, such as those that led to the death of Mrs McKay, there would be an obligation to report the incident to the scheme. In my view, that represents significant and positive progress from the position in 2015. It is a reform that provides increased scrutiny of individual experience in aged care services and an increased capacity to identity systemic challenges.

194. I acknowledge the improvements that Goodwin has made since Mrs McKay died. In particular, I note the high level of confidence expressed by Goodwin about there being no prospect now, of any MSU resident moving into the MSU courtyard without it being known to staff immediately. Some of those improvements occurred soon after Mrs McKay died and before this inquest began in 2019. Some have occurred in more recent years. These improvements include:

    (a) Removal of the stationary vehicle from the MSU courtyard – 18 January 2015;
    (b) In or around January 2015, Goodwin changed the operation of the alarms to 24-hour operation;
    (c) Installation of alarms on the MSU external doors, with doors alarmed at night only, then later alarmed 24 hours a day – 18 January 2015;
    (d) On 18 January 2015, Goodwin installed external lighting in the courtyard of the MSU which illuminates the area. The lighting is programmed to turn on automatically from dusk to dawn and remains on overnight;
    (e) Goodwin conducted an audit of the room motion sensors and validated that all motion sensors were working at the time of Mrs McKay's incident;
    (f) Training of staff and requirement that sensors be switched on;
    (g) From mid-2016, a full-time registered nurse is now employed by Goodwin and is on-site 24 hours a day;
    (h) In September 2020, Goodwin installed magnetic doors at end of each corridor that lock automatically between 7pm and 7am each night and can be opened by staff with a swipe card. In addition, a head count of residents is implemented at 7pm each night. Any alarm that is activated requires attention or action by staff;
    (i) In September 2020, Goodwin installed four closed-circuit television (CCTV) cameras with monitoring and recording capability operating CCTV inside the MSU gold and green corridors and outside across the full range of the MSU courtyard. CCTV screens can be monitored from the nurses' station;
    (j) In 2020, an additional carer was rostered on at night – this additional carer will ensure that all breaks taken by the carer in the MSU are covered;
    (k) Since 2017, the Team Leader position for the MSU is rostered consistently to ensure familiarity with residents and their needs;
    (l) In 2019, a new nurse-call system was installed which ensures alarms are triggered when a stairwell door is opened;

(m) Goodwin installed additional fencing with magnetic locks in the MSU courtyard which prevents access to the main switch room;
(n) Goodwin installed cladding on both sides of the internal entry/exit doors of the MSU with a print so that these doors do not appear as an exit door which residents can pass through. The doors appear to be a bookshelf;
(o) Goodwin implemented more focussed regular dementia training for staff in the MSU. This now includes training through a virtual reality platform called "EDIE" (Educational Dementia Immersive Experience) which is a tool created by Dementia Australia. This enables participants to see the world through the eyes of a person living with dementia utilising high quality virtual reality technology. It enhances knowledge of dementia whilst exploring a supportive approach to living more confidently with dementia. This was initially trialled in 2018 but rolled out to staff more broadly in 2020. Also in 2020, Goodwin implemented mandatory Positive Behaviour Support Training for all staff; and
(p) Changes to internal policies relating to the reporting of incidents, including specifying the responsibilities of carers or staff members who witnesses an incident, and management.

195. It was the installation of the magnetic door locks in September 2020 that directly addressed the specific problem that led to Mrs McKay's death. I acknowledge that the door alarms installed in January 2015 went some way to mitigating the risk realised by Mrs McKay's circumstances. The improvements in September 2020 came some five years after the incident involving Mrs McKay on any view, a long time. The internal review commissioned by Goodwin in the immediate aftermath of the incident involving Mrs McKay resulting in the report "*Ruth McKay Incident: Ongoing Review Following Fall"* was not as effective as it could have been in identifying the urgency of the risk presented by the locking mechanism and the shortcomings of a system relying entirely on staff practice and intervention to ensure the security of the corridor exits from the MSU. On 16 May 2022, the timing of the automatic lock doors was changed to unlock at 8am and to lock at 4pm each day throughout winter. Goodwin indicated that a review was to be undertaken before the summer of 2022/23 to determine the appropriate hours of operation. I am satisfied that this approach is appropriate in the circumstances and that, given the improvements that have now been made by Goodwin, there are no further recommendations that I am required to make.

Conclusion

196. In summary, I find that Ruth Allison McKay died in The Canberra Hospital on 23 January 2015

197. The direct cause of her death was acute bronchopneumonia with the infectious organism being *Staphylococcus aureus*.

198. Mrs McKay developed acute bronchopneumonia after accessing the external courtyard undetected at the Memory Support Unit at Good Aged Care Facility in Ainslie sometime after 5am on 17 January 2015. Mrs McKay was outside in the courtyard, undetected, for some hours before her discovery around 8am on 17 January 2015 where she was trapped under a stationary, antique vehicle in the courtyard. Mrs McKay also sustained a head injury while outside in the courtyard.

199. Mrs McKay accessed the courtyard undetected by turning the snib lock on the gold corridor door near her bedroom and pushing it forward. Mrs McKay's care plan identified the use of room sensors to mitigate the risk of her wandering in the context of her dementia. Bed and room sensors were not in operation in her room on the night of 16 and into the early hours of 17 January 2015 and staff did not observe her accessing the courtyard. There was no other mechanism in place in the MSU to detect Mrs McKay's movement into the courtyard. If there had been an alert or alarm system on corridor doors which notified staff that doors had been opened, and/or if sensor mats had been operational in Mrs McKay's room, it is highly likely that:

    i. Mrs McKay's absence from her room would have been detected earlier than it was; and
    ii. Mrs McKay would have been located in the courtyard much sooner than she was.

200. The death of a loved one is always a source of sorrow. I again acknowledge that the delay that regrettably attached to these proceedings has compounded that sorrow for the family members of Mrs McKay. Mrs McKay was a beloved matriarch and it is clear that her death has been deeply felt by her family. To reach 90 years of age is an extraordinary achievement and the circumstances of her death were a very unfortunate end to a rich life, well lived. I extend my sincere condolences to Mrs McKay's family and I thank them for the generous way in which they participated in these proceedings in the face of their grief and frustration.

201. I also extend my appreciation to counsel assisting Ms Jones SC, Ms Baker-Goldsmith, Ms Musgrove and Ms Foy for their helpful submissions and their conduct and assistance during the course of the proceedings.

I certify that the preceding two hundred and one [201] numbered paragraphs are a true copy of the Reasons for Decision of Her Honour Coroner Taylor.

Associate: L Corcoran

Date: 6 April 2023

LIST OF WITNESSES

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	WH		371-384
	DB		452-459
14/2/20	TC		478-482
	Dr Nathan MILNE		483-495
	Professor Michael PAIN		495-507, 538-540
	Dr Jeffrey BROCK		508-537
	Wendy McKAY	Daughter of deceased	540-544
16/3/2022	TL	Daughter of resident of MSU, Goodwin, Ainslie	
	HY	Husband of resident of MSU, Goodwin, Ainslie	

SELECTED TIMELINE – RUTH McKAY

Date & Time	Event	Source
5 August 1924	Ruth Allison Irwin is born	Police summary of circumstances
1939-1940	Ms Irwin graduates from Marrickville Girls High School with her leaving certificate	Police summary of circumstances
	Ms Irwin completes a secretarial course at Miss Hale's Business School – takes position with The Truth and Sportsman newspaper, working for Ezra Norton – Ms Irwin later works as the secretary to the secretary of Rupert Murdoch	Police summary of circumstances
1947	Ruth Allison Irwin marries Douglas Henry McKay – they subsequently relocate to Canberra as Mr McKay has a position with the Bureau of Agricultural Economics	Police summary of circumstances
13 December 1948	Robyn Godley is born – Mrs McKay does not return to work	Police summary of circumstances
11 March 1951	Julienne McKay is born	Police summary of circumstances
12 November 1953	Wendy McKay is born	Police summary of circumstances
~2005	Mrs McKay sustains a fractured arm	Police summary of circumstances
2009	Mrs McKay is playing three rounds of golf a week until this time	Police summary of circumstances
2009	Mr and Mrs McKay move into Goodwin Ainslie Aged Care Facility – accomodated in independent living section Mrs McKay is in good physical health but is displaying signs of dementia	Police summary of circumstances
7 July 2012	Mr McKay dies	Police summary of circumstances
~2012	Mrs McKay contracts shingles, which leaves her with some nerve damage to above her right eye	Police summary of circumstances
July 2013	Mrs McKay moves out of the independent living section of Goodwin Ainslie into the Memory Support Unit (MSU). Mrs McKay classed as having advanced state dementia. Good health generally apart from dementia symptoms.	Police summary of circumstances
2014	Marco Arquero begins working at Goodwin, employed as a Team Leader	Arquero statement

4 January 2015 3:00am	Mrs McKay appeared outside care office of Goodwin and asked Tju Poniman if he could start up her car. Was also observed trying to get through the fire exit.	Progress Notes- AFP file number 003
14 January 2015	Mrs McKay's medical notes record presence of a UTI	Boyd Statement
Friday 16 January 2015 – Cardex records		
4:04pm	Mrs McKay found in another resident's room, wanting to use their toilet	Progress Notes (Ex 12, page 27)
8:21pm	Sun sets	Hughes Review
8:51pm	Entry made on Mrs McKay's bowel chart by Carer Anil Acharya	Progress notes, (Ex 12, page 27)
8:46:10pm	Non-card door unlock, code only access granted, at ground floor Main Reception door	Cardax logs (Ex. E8)
8:49:15pm	Non-card door unlock, button release granted, at ground floor West (Gold) Wing door	Cardax logs (Ex. E8)
8:52:50pm	Non-card door unlock, code only access granted, at ground floor Main Reception door	Cardax logs (Ex. E8)
9:06:35pm	Non-card door unlock, button release granted, at ground floor Main Reception door	Cardax logs (Ex. E8)
9:22:11pm	Non-card door unlock, code only access granted, at ground floor Main Reception door	Cardax logs (Ex. E8)
9:25:25pm	Non-card door unlock, button release granted, at ground floor South (Green) Wing door	Cardax logs (Ex. E8)
9:26:54pm	Non-card door unlock, button release granted, at ground floor West (Gold) Wing door	Cardax logs (Ex. E8)
9:32:09pm	Non-card door unlock, button release granted, at ground floor West (Gold) Wing door	Cardax logs (Ex. E8)
10:17:39pm	Non-card door unlock, button release granted, at ground floor Kitchen corridor door	Cardax logs (Ex. E8)
10:22:41pm	Poniman Tju enters through the Main Reception door on the ground floor	Cardax logs (Ex. E8)
10:31:20pm	Piyush Shah enters through the North West Main Entry on the ground floor	Cardax logs (Ex. E8)
10:31:22pm	Eva Muthinji enters through the Main Reception door on the ground floor	Cardax logs (Ex. E8)
10:37:52pm	Eva Muthinji passes through the ground floor West (Gold) Wing door	Cardax logs (Ex. E8)
10:45pm	Night shift commences – Tju, Shah and Muthinja commence work Tju receives a handover from the Evening shift team leader	

10:53:19pm	Non-card door unlock, button release granted, at ground floor West (Gold) Wing door	Cardax logs (Ex. E8)
10:54:07pm	Non-card door unlock, code only access granted, at ground floor North West Main Entry	Cardax logs (Ex. E8)
10:55:27pm	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)
~11:00pm	Poniman Tju checks on another resident on the middle floor and administers medication to them	Poniman Tju statement; also T
11:00:53pm	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)
11:00:59pm	Poniman Tju enters middle floor Carers Office	Cardax logs (Ex. E8)
11:07:28pm	Poniman Tju enters ground floor South (Green) Wing door	Cardax logs (Ex. E8)
11:07:41pm	Poniman Tju enters ground floor Treatment Office	Cardax logs (Ex. E8)
Shortly after 11:00pm	Poniman Tju checks both courtyard doors and found them to both be locked	Poniman Tju statement
11:26:19pm	Poniman Tju exits ground floor Dementia Wing by West (Gold) Wing door	Cardax logs (Ex. E8)
11:29:12pm	Eva Muthinji passes through the ground floor West (Gold) Wing door	Cardax logs (Ex. E8)
11:30pm	Poniman Tju signs off on the Lockdown Checklist for 16 January 2015	
11:30pm	Unrecorded check on Mrs McKay by Piyush Shah	Piyush Shah Stat Dec (Annexure D)
11:36:48pm	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)
11:41:53pm	Poniman Tju enters middle floor Carers Office	Cardax logs (Ex. E8)
11:43:36pm	Poniman Tju enters ground floor West (Gold) Wing door	Cardax logs (Ex. E8)
11:45:27pm	Poniman Tju exits ground floor Dementia Wing by West (Gold) Wing door	Cardax logs (Ex. E8)
11:46:20pm	Poniman Tju enters ground floor South (Green) Wing door	Cardax logs (Ex. E8)
11:49:57pm	Poniman Tju exits ground floor Dementia Wing by South (Green) Wing door	Cardax logs (Ex. E8)
11:52:18pm	Eva Muthinji exits ground floor Dementia Wing by West (Gold) Wing door	Cardax logs (Ex. E8)
11:59:03pm	Non-card door unlock, button release granted, at ground floor West (Gold) Wing door	Cardax logs (Ex. E8)
Saturday 17 January 2015		
12:13:58am	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)
12:16:16am	Poniman Tju enters ground floor West (Gold) Wing door	Cardax logs (Ex. E8)
12:16:30am	Poniman Tju enters ground floor Treatment Office	Cardax logs (Ex. E8)
12:18:40am	Poniman Tju exits ground floor Dementia Wing by West (Gold) Wing door	Cardax logs (Ex. E8)

12:32:04am	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)
1:08:32am	Piyush Shah enters ground floor Carers Office	Cardax logs (Ex. E8)
1:18:23am	Non-card door unlock, button release granted, at ground floor South (Green) Wing door	Cardax logs (Ex. E8)
1:18:32am	Piyush Shah enters through the North West Main Entry on the ground floor	Cardax logs (Ex. E8)
1:19:25am	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)
1:21:13am	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)
1:35:03am	Non-card door unlock, button release granted, at ground floor Kitchen corridor	Cardax logs (Ex. E8)
1:37:51am	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)
1:44:21am	Poniman Tju enters top floor Treatment Office	Cardax logs (Ex. E8)
1:51:41am	Poniman Tju enters ground floor West (Gold) Wing door	Cardax logs (Ex. E8)
~2:10am	Unrecorded ckeck on Mrs McKay by Poniman Tju- saw Mrs McKay lying under the sheets	Poniman Tju Stat Dec (Anenxure D)
2:19:54am	Poniman Tju exits ground floor Dementia Wing by West (Gold) Wing door	Cardax logs (Ex. E8)
2:20:43am	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)
2:23:41am	Poniman Tju enters ground floor West (Gold) Wing door	Cardax logs (Ex. E8)
2:23:53am	Poniman Tju enters ground floor Carers Office	Cardax logs (Ex. E8)
2:56:45am	Poniman Tju exits ground floor Dementia Wing by West (Gold) Wing door	Cardax logs (Ex. E8)
2:59:46am	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)
3:01:21am	Poniman Tju enters ground floor West (Gold) Wing door	Cardax logs (Ex. E8)
3:04:46am	Poniman Tju exits ground floor Dementia Wing by West (Gold) Wing door	Cardax logs (Ex. E8)
~3:00am	Poniman Tju attends to another resident on middle floor	Poniman Tju statement
3:06:19am	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)
3:59:55-4:46:41	Nurse alarm logs indicate alarms in green corridor – rooms 13, 6, and 9, being attended to	Nurse call logs (Ex 17)
3:49:04am	Eva Muthinji passes through ground floor West (Gold) Wing door	Cardax logs (Ex. E8)
4:20:10am	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)
3:04:46am	Eva Muthinji exits ground floor Dementia Wing by South (Green) Wing door	Cardax logs (Ex. E8)
4:24:02am	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)
4:27:11am	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)

4:51:39am	Poniman Tju enters top floor Treatment Office	Cardax logs (Ex. E8)
4:59:12am	Non-card door unlock, button release granted, at ground floor Main Reception door	Cardax logs (Ex. E8)
5:00am	Poniman Tju goes to care office to update progress notes	Poniman Tju statement
5:00am	Unrecorded ckeck on Mrs McKay by Piyush Shah	Piyush Shah Stat Dec (Annexure D)
5:14:06am	Piyush Shah exits ground floor Dementia Wing by South (Green) Wing door	Cardax logs (Ex. E8)
5:18:03am	Non-card door unlock, button release granted, at ground floor South (Green) Wing door	Cardax logs (Ex. E8)
5:18:16am	Piyush Shah enters ground floor Carers Office	Cardax logs (Ex. E8)
5:20am	Call made from Poniman Tju to Piyush Shah to check all the residents. Reported everyone was fine except one male resident wandering.	Poniman Tju Stat Dec (Anenxure D)
5:26am	Recorded as in bed by Poniman Tju with entry: “Checked on resident overnight, resident is asleep in bed and nil wandering behaviour occurred during the night”	Progress Notes- AFP file number 003
5:29:34am	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)
5:40:04am	Poniman Tju enters top floor Treatment Office	Cardax logs (Ex. E8)
~6:00am	Poniman Tju goes to check on other resident on level one	Poniman Tju statement
6:01:55am	Marco Arquero enters through ground floor Main Reception door	Cardax logs (Ex. E8)
6:02:13am	Non-card door unlock, button release granted, at ground floor South (Green) Wing door	Cardax logs (Ex. E8)
6:02:28am	Piyush Shah enters ground floor Carers Office	Cardax logs (Ex. E8)
6:02:50am	Piyush Shah enters ground floor Carers Office	Cardax logs (Ex. E8)
6:04:02am	Marco Arquero exits ground floor Dementia Wing by South (Green) Wing door	Cardax logs (Ex. E8)
6:05:17am	Piyush Shah passes through ground floor Carers Office door	Cardax logs (Ex. E8)
6:06:09am	Non-card door unlock, button release granted, at ground floor North West Main Entry	Cardax logs (Ex. E8)
6:08:19am	Non-card door unlock, button release granted, at ground floor Main Reception door	Cardax logs (Ex. E8)
6:14:42-6.16:46	Nurse alarm logs indicate alarms in green corridor – room 9, being attended to	Nurse call logs (Ex 17)
6:14:52am	Poniman Tju exits through ground floor Main Reception door	Cardax logs (Ex. E8)

6:15:02am	Poniman Tju enters through ground floor Main Reception door	Cardax logs (Ex. E8)
6:24:18	Nurse alarm logs indicate alarm in gold corridor – room 19 - being attended to	Nurse call logs (Ex 17)
6:25:13am	Poniman Tju enters middle floor Treatment Office	Cardax logs (Ex. E8)
6:25:19am	Poniman Tju enters middle floor Carers Office	Cardax logs (Ex. E8)
6:26:45am	Piyush Shah exits ground floor Dementia Wing by South (Green) Wing door	Cardax logs (Ex. E8)
6:27:16am	Piyush Shah exits ground floor by North West Main Entry	Cardax logs (Ex. E8)
6:28:20am	Piyush Shah enters ground floor by North West Main Entry	Cardax logs (Ex. E8)
6:30:02am	Non-card door unlock, button release granted, at ground floor West (Gold) Wing door	Cardax logs (Ex. E8)
6:30:27-6.33:27	Nurse alarm logs indicate alarm in green corridor – room 9 - being attended to	Nurse call logs (Ex 17)
6:31:56am	Piyush Shah passes through ground floor Carers Office door	Cardax logs (Ex. E8)
6:34:01am	Piyush Shah passes through ground floor Carers Office door	Cardax logs (Ex. E8)
6:45am	Marco Arquero starts shift at Goodwin	Annexure C
6:47:13am	Piyush Shah exits ground floor Dementia Wing by West (Gold) Wing door	Cardax logs (Ex. E8)
6:47:35am	Piyush Shah exits ground floor by North West Main Entry	Cardax logs (Ex. E8)
6:58.03-7:12:33	Nurse alarm logs indicate alarms in green corridor – rooms 9 and 10 - being attended to	Nurse call logs (Ex 17)
7:00am	Jelyn Maala begins shift at Goodwin	Maala Statement
7:00am	Maria Legarbes receive handover	Maria statement
After 7:10am	Jelyn Maala does a head count of residents in gold corridor and finds Ruth not to be in her room	Maala Statement
7:33:28-7:40:27	Nurse alarm logs indicate alarms in green corridor – rooms 10 and 8 - being attended to	Nurse call logs (Ex 17)
7:21:18-7:28:02	Nurse alarm logs indicate alarms in gold corridor – room 14 - being attended to	Nurse call logs (Ex 17)
7:40am	Arquero begins administering medications to residents in gold corridor	Arquero Statement
Saturday 17 January 2015 - Mrs McKay is found		
'shortly after' 7:40am*	Mrs McKay discovered not in her room rby Marco Arquero or Jelyn Maala (or both), found Mrs McKay's room locked and found bed made. Mrs McKay didn't usually make her bed. No beds should have been made by	Arquero Statement

	staff yet as no residents had appered for breakfast **Note: Marco Arquero made the first call to 000 at 8.10am so it is likely that Mrs McKay was discovered outside in the minutes prior to 8.10am rather than around 7.40am as suggested by Mr Arquero*	
	Jelyn Maala calls out and points to courtyard where they discover two legs coming out from under the car	Annexure C
	Marco Arquero attempts to enter courtyard through closest door to him and Mrs McKay's room- this door was locked. He unlocked door with universal key. Mrs McKay found conscious- told Arquero she was cold and in pain. She was cold to touch. Blood on car, concrete, forehead, hair, in mouth, on nightgown. Vomit observed on concrete next to mouth.	Arquero Statement
8:10am	Marco Arquero calls 000 and requests an ambulance	E1,000 call, E8, page 1-2
After calling ambulance	Arquero rang Jeffery Shelly (Goodwin Manager) and left several messages.	
While waiting for Ambulance to arrive	Mrs McKay continued to say she was cold and in pain. Arquero recalls her saying she had been there all night.	Arquero Statement
8.15am	Marco Arquero calls 000 and requests assistance to remove Mrs McKay from the car.	E1, 000 call
8:15am	Ambulance arrived at Goodwin (conscious, GCS 14, raised blood pressure, low temperature 31 degrees, reduced level of oxygen in blood, slightly raised blood glucose). Mrs McKay is placed in a brace.	PM Report
8:20am	ACT Fire and Rescue arrive at Goodwin	Arquero Statement
8:20am	Isanka Madawala attempts to contact Mrs McKay's primary contact- Julienne and no answer. Proceeds to contact Wendy who answered.	Annexure C
8.25am	Tympanic temperature – 31 degrees	ACTAS
8:51am	Ambulance departs Goodwin	ACTAS
9am	Tympanic temperature – 32.9 degrees	ACTAS
9.10am	Tympanic temperature – 33.9 degrees	ACTAS
Canberra Hospital – 17 January 2015		
9:11am	Mrs McKay arrives at Canberra Hospital. Hospital observations include large bruise on left forehead with swelling (haematoma), low temperature, break down of muscle (rhabdomyolysis), shrinkage of the brain, no injuries within skull. Blood tests showed mildly increased	PM Report

	inflammatory markers.	
9:17am	CIRT attend Canberra Hospital	Police summary of circumstances
9:20am	CIRT arrive at Goodwin and obtain photograph of state of Mrs McKay's bed	Hughes Review
9.20am	Rectal temperature – 34.9 degrees	Ex 28, page 98
9.57am	Mobile chest X-ray in ED	TS 383.33-36
10.30am	Rectal temperature – 35.2 degrees	Ex 28, page 98
No time noted	Dr Mak ED Registrar notes - no airways issues when Mrs McKay was first admitted and oxygen levels of 96%. Mrs McKay was in a cervical spine collar. Issues - left frontal haematoma/head injury, left hand injury, hypothermia and social?/neglect.[1] CT scan of the brain/cervical spine, chest, and the abdomen/pelvis area ordered.	Ex 37, statement of Dr Mak, ex 28, pp48-51
11.54am	CT scan	TS 383.33-36
12.50pm	Mrs McKay while in brace and lying on back had a "large brown liquid vomit" after being woken for observations. Suction was applied.	Ex 40, Nurse Bates statement, ex 28, page 97
12.59pm	CT scan results dictated by Dr Gupta. Noted that lungs were grossly clear.	Exhiibt 28, page 132
1.20pm	Dr Mak notes CT report indicated report indicated a left frontal soft tissue haematoma, and nil other traumatic injury. The cervical spine collar was removed. Dr Mak prescribed antibiotics and sought a referral to the geriatric ward. He ordered a repeat chest X-ray.	Ex 37, statement of Dr Mak, ex 28, pp48-51
1.35pm	Note made in hospital notes ""*very rattly chest and very wet cough since vomit. X-ray to be attended*"	Ex 28, page 97
2.30pm	Dr Mak notes "*likely aspiration*" and lists "*aspiration pneumonia*" as a possible issue	Ex 37, statement of Dr Mak, ex 28, pp48-51
2.57pm	Further chest X-ray taken. Noted by Dr Gupta that there was "*no pleural effusion or pneumothorax identified*"	TS 383.33-36, exhibit 28, page 81
3.50pm	Rectal temperature – 37.6 degrees	Ex 28, page 98
4.30pm	Dr Morgan Edwards, MAPU Registrar, sees Mrs McKay. Notes *lots of upper airway transmitted noise. Difficult to assess clearly…Subtle crep right base, no wheeze*."	Exhibit 28, page 54
No time	Dr Morgan Edwards notes Mrs McKay had an episode of coughing/spluttering when drinking in ED. He had queried	Exhibit 28, page 55

[1] Exhibit 37,at [5].

	if there was a risk of aspiration.	
8.20pm	Mrs McKay admitted to Geriatric Ward	Exhibit 28, page 81
Canberra Hospital - following		
18 January 2015 10am	Dr Donald Catino discussed treatment with family. A decision is made to provide “comfort care”.	Exhibit 28, hospital notes, p 7 (discharge summary), p 83-84 (notes)
23 January 2015, 8:13am	Pronounced dead- treated palliatively	PM Report

IN THE CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

CD 19 of 2015

IN THE MATTER OF AN INQUEST INTO THE DEATH OF RUTH ALLISON McKAY

TO: Goodwin Aged Care Services

NOTICE PURSUANT TO SECTION 55 *CORONERS ACT 1997*

Take notice that Coroner Taylor is considering including, in a finding or report under the *Coroners Act 1997*, the following comments which may be comments adverse to Goodwin Aged Care Services:

1. In January 2015, there was nothing other than the practice of staff checking that the doors at the end of the gold and green corridors were locked and observing the movements of residents, preventing residents from tuning the snib lock and pushing open the doors to the MSU external courtyard at any time of the day or night. Bed and room sensors were often switched off in the MSU. Mrs McKay was known to be prone to wandering. Indeed her Goodwin care plan required that she have a sensor mat in place at night to guard against that risk. Had sensor mats in Mrs McKay's room been switched on, it is likely staff would have responded to the alert when Mrs McKay left her bed to access the courtyard. It is also likely that Mrs McKay would not have remained undetected outside for an extended period.

2. A resident inside the facility as at January 2015, using the external doors at the end of the gold corridor nearest to where Mrs McKay's room was located, could simply turn the snib, push open the door and gain access to the courtyard, to exit the facility. This allowed residents to access the courtyard at any time of the day or night.

3. Goodwin's approach to ensuring the security of these doors relied entirely on staff compliance and intervention. Even then, once locked by staff the doors at the end of corridor could be unlocked, without detection, by any resident capable of turning the snib. The doors could then be opened, without detection, by any resident capable of pushing the door forward. The failure by Goodwin to adequately protect the safety and security of residents by ensuring that they were not able to access the courtyard through those doors, in particular at night, was a matter of public safety, and represented a risk to the residents. It was an obvious and straightforward risk of which Goodwin should have been aware. This failure led to Mrs McKay accessing the courtyard undetected and ultimately, to her death.

4. Evidence was given regarding two incidents at Goodwin prior to Mrs McKay's death involving residents being able to exit the facility at night, and then having difficulty coming back inside. In the case of one of these residents, this occurred in the MSU. It is regrettable that Goodwin's management were not able to identify the obvious risk to its vulnerable residents posed by the accessibility of the courtyard to residents prior to 17 January 2015. It is also unclear how and whether the hazard report addressing the accessibility of the courtyard from the MSU (the existence of which is recorded in the progress notes of Bill Ryan on 26 December 2014) was, could or should have been brought to the attention of Goodwin's management, putting them on further notice of the existence of the already evident risk. It is also unfortunate that it took until September 2020 for more appropriate safeguards to be put in

place, noting that while alarms on the MSU doors were installed very soon after Ms McKay was found in the courtyard, it was not until September 2020 that magnetic door locks were installed which directly addressed the issue around residents being able to leave the facility.

5. There was confusion in the evidence given by Goodwin managers as to whether sensor mats were used routinely as standard, or used only as required at the discretion of staff. This confusion may well have affected staff attitudes to, and understanding of, the use of sensors and the role of Goodwin care plans in guiding the approach to risk mitigation. In any event, Mrs McKay's care plan required the use of a sensor mat and, consistent with that, at least one ought to have been in place and switched on in accordance with that care plan.

6. The internal review commissioned by Goodwin resulting in the report "Ruth McKay Incident: Ongoing Review Following Fall" was not as effective as it could have been in identifying the urgency of the risk presented by the locking mechanism and the shortcomings of a system relying entirely on staff practice and intervention to ensure the security of the corridor exits from the MSU. It is unclear why the entry from Mr Arquero on 26 December 2014 identifying the risk in the context of the behaviour of Mr Bill Ryan did not feature in the report produced on behalf of Goodwin.

7. Goodwin's reliance solely on staff to ensure that doors remained locked, and that residents were not attempting to leave the facility using the corridor doors, provided the environment for undetected courtyard access to occur. If there had been an alert or alarm system on corridor doors which notified staff that doors had been opened, and/or if sensor mats had been operational in Mrs McKay's room, it is highly likely that

    (i) Mrs McKay's absence from her room would have been detected earlier than it was; and
    (ii) Mrs McKay would have been located in the courtyard much sooner than she was.

    I accept the opinion of Dr Brock that Mrs McKay was likely in the courtyard for between two and three hours.

And further take notice that you may, **within 14 days of the date of this notice**,

(a) make a submission to the Coroner in relation to the proposed comment; or

(b) give to the Coroner a written statement in relation to it.

The Coroner may, on application made to her, extend the period of time specified in this notice by not more than 28 days.

If you request, the Coroner must include in her report your written statement provided pursuant to s55(1)(b) in relation to the proposed comment, or a fair summary of it.

DATE OF NOTICE: 21 February 2023

IN THE CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY
CD 19 of 2015

IN THE MATTER OF AN INQUEST INTO THE DEATH OF RUTH ALLISON McKAY

STATEMENT OF GOODWIN AGED CARE SERVICES

I, **STEPHEN HOLMES** of 22 Marshall St, Farrer, Australian Capital Territory, state the following:

1 I am the Chief Executive Officer for Goodwin Aged Care Services Ltd (**Goodwin**), the approved provider of the residential aged care service known as Goodwin Ainslie (**Ainslie**) located at 35 Bonney Street, Ainslie in the Australian Capital Territory.

2 I make this statement pursuant to section 55(1)(b) of the *Coroners Act 1997* (ACT) (**Act**) in response to the Notice of Adverse Comment (**Notice**) issued to Goodwin on 21 February 2023. The Notice contains comments in relation to Goodwin that the Coroner proposes to include in her Findings in the Inquest into the Death of Ruth Allison McKay (**Inquest**).

3 If and to the extent that the comments included in the Notice are included in the Findings, I request the Coroner includes this statement, in accordance with section 55(3) of the Act.

4 I am authorised by Goodwin to provide a statement pursuant to section 55(1)(b) of the Act. The source of my knowledge of the matters contained in this statement concerning Mrs McKay is based on my reading of the records contained in Mrs McKay's resident file and speaking to staff involved in Mrs McKay's care. I have also had regard to the relevant records held by Goodwin including their policies and procedures.

5 I make this statement largely on the basis of the submissions made by Goodwin on 27 June 2022.

6 Goodwin wishes to reiterate its recognition that Mrs McKay's death has caused great distress to her children and extended family. Goodwin sincerely regrets the manner of Mrs McKay's fall and the incident that occurred, leading to her hospitalisation during which she subsequently died on 23 January 2015. It is also accepted by Goodwin that Mrs McKay should not have been able to enter the courtyard in the early morning without escort or without alarm.

7 Goodwin also wishes to acknowledge the length of time that has passed since Mrs McKay's death in 2015. Goodwin acknowledges the impact that the significant delays in this matter proceeding to Inquest including when it was re-opened in June 2020, and the additional stressors placed on Mrs McKay's family as a result. To the extent that these delays have involved Goodwin, Goodwin expresses its sincere apologies to the family of Mrs McKay.

8 In the eight years that have elapsed since Mrs McKay's death in January 2015, Goodwin has made significant improvements in relation to the care and services it provides to residents at Goodwin Ainslie. As set out below, some of these improvements occurred immediately after Mrs McKay's passing, and prior to the commencement of the Inquest in 2019. Goodwin has continued to make improvements to the Memory Support Unit (**MSU**) at Goodwin Ainslie to ensure that the circumstances that led to Mrs McKay's passing are now prevented.

9 Having regard to the improvements implemented immediately after Mrs McKay's death in 2015, along with the further improvements outlined in Ms Boyd's 2019 statement and those reflected in this statement, we are confident in stating that no resident at Goodwin Ainslie would be able to enter the MSU courtyard without it being known to staff immediately.

Improvements

10 Goodwin wishes to clarify the Coroner's proposed comment set out in the Notice that:

> *"It is also unfortunate that it took until September 2020 for more appropriate safeguards to be put in place, noting that while alarms on the MSU doors were installed very soon after Ms McKay was found in the courtyard, it was not until September 2020 that magnetic locks were installed which directly addressed the issue around residents being able to leave the facility."*

11 Goodwin acknowledges that the installation of magnetic locks occurred in September 2020. However, the installation of magnetic locks in September 2020 complemented improvements already made by Goodwin in 2015 following the death of Mrs McKay. For example, as set out in the statement of Robyn Boyd dated 17 June 2019:

(a) On 18 January 2015, Goodwin installed alarms on the external doors in the Memory Support Unit (**MSU**).

(b) In or around January 2015, Goodwin changed the operation of the alarms on the external doors of the MSU from 7:00 am to 7:00 pm, to 24-hour operation.

(c) On 18 January 2015, Goodwin installed external lighting in the courtyard of the MSU which illuminates this area. The lighting is programmed to turn on automatically from dusk to dawn and stays on overnight.

(d) Goodwin conducted an audit of the room motion sensors and validated that all motion sensors were working at the time of Mrs McKay's incident.

(e) On 23 January 2015, Goodwin conducted staff training on documentation, reminded staff of checking procedure, and discussed behaviour management at a staff meeting.

(f) Goodwin employed a Registered Nurse (**RN**) to ensure that an RN was rostered at Ainslie 24-hours per day.

12 The installation of magnetic locks on two doors in the MSU in September 2020 followed comprehensive improvements to the safety of the MSU courtyard which occurred as soon as the day after the incident involving Mrs McKay.

13 Goodwin also notes that it has implemented further improvements since the installation of the magnetic locks on the two doors which provide access to the MSU courtyard. For example, as set out in the statements of Tamra Macleod dated 24 August 2021 and 22 March 2022:

(a) In September 2020, Goodwin installed four Closed-Circuit Television (CCTV) cameras (with monitoring and recording capability). These cameras are located to capture the inside wing of the two corridors and to cover the full range of the outside courtyard.

(b) Goodwin installed additional fencing with magnetic locks in the MSU courtyard which prevents access to the main switch room.

(c) Goodwin installed cladding on both sides of the internal entry/exit doors of the MSU with a print so that these doors do not appear as an exit door which residents can pass through. The print on the doors makes the doors appear to be a bookshelf.

(d) Goodwin implemented more focussed regular dementia training for staff in the Memory Support Unit. This now includes training through a virtual reality platform called "EDIE" (Educational Dementia Immersive Experience) which is a tool created by Dementia Australia. This enables participants to see the world through the eyes of a person living with dementia utilising high quality virtual reality technology. It

enhances knowledge of dementia whilst exploring a supportive approach to living more confidently with dementia. This was initially trialled in 2018 but rolled out to staff more broadly in early 2020.

(e) Goodwin implemented mandatory Positive Behaviour Support training for all staff in 2020.

Proposed comments

14 Goodwin acknowledges the comments in the Notice which the Coroner proposes to include in her Findings. Goodwin has provided the Coroner with information pertaining to these comments throughout the course of this Inquest. Goodwin does not intend to restate its submissions dated 27 June 2022, save to note that aspects of Goodwin's submissions propose different Findings than those set out in the Notice.

15 For example, the Coroner proposes to include a comment in her Findings that:

> *Bed and room sensors were often switched off in the MSU.*

16 In respect of this proposed Finding, Goodwin refers to paragraphs [121] – [122] and [124] of its submissions dated 27 June 2022:

> *121. [Ms Spottiswood] also referred to her mother's sensor mat being turned off. The Court's attention is drawn to a random selection of her mother's notes tendered which indicate that considerable attention was paid by staff with respect to her mother's sensor mat.*
>
> *122. We particularly draw the Court's attention to pages 291-294 of 778 relating to this issue which demonstrate the efforts of staff to ensure that her bed sensor was on. The notes constitute clear evidence that bed sensors were checked and were not, "routinely switched off" as alleged in the Submissions of Counsel Assisting.*
>
> *…*
>
> *124. It is also clear from the Goodwin progress notes that Mrs Morgan's bed sensor was monitored on an almost daily basis and on an occasion when it was faulty, additional monitoring was undertaken by staff.*

17 While it is accepted that Mrs McKay's bed sensor was not activated on the night of 16 January 2015, there is insufficient evidence before the Coroner to make such a generalised finding in these terms. The evidence of Ms Spottiswood, concerning her mother's bed sensor, given some six years after Mrs McKay's death, is contradicted by the contemporaneous notes regarding the attention paid by staff to her mother's bed sensor. Given those notes and the absence of any accurate data regarding the use of bed sensors in the MSU, this generalised finding has no basis in evidence.

18 The Coroner also proposes to make a comment in her Findings that:

> *The failure by Goodwin to adequately protect the safety and security of residents by ensuring that they were not able to access the courtyard through those doors, in particular at night, was a matter of public safety, and represented a risk to the residents. It was an obvious and straightforward risk of which Goodwin should have been aware.*

19 Goodwin notes that no independent aged-care expert gave any opinion evidence about the nature of any risk regarding the circumstances pertaining to access to the courtyard in January 2015 during the hearing. Further, in respect of this proposed comment, Goodwin refers to paragraph [30] of its submissions dated 27 June 2022:

> *30. First, residential aged care facilities are not "nursing homes", nor are they services which provide constant supervision. Second, the Aged Care Act 1997 (Cth) provides that an aged care place is, and is intended, to be the "home" of a resident with all its connotations of*

> *autonomy and liberty from supervision. Such facilities are required to impose as little restriction on the dignity and autonomy of an individual as possible in the circumstances. Residential aged care facilities are required to give meaning to those concepts. The Charter of Rights of Care Recipients - Residential Care provided in 2015 that a resident in residential care was entitled "to live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction".* (Emphasis added)

20 The Coroner proposes to make comments in paragraph 6 of the Notice of her Findings that:

> *It is also unclear how and whether the hazard report addressing the accessibility of the courtyard from the MSU (the existence of which is recorded in the progress notes of Bill Ryan on 26 December 2014) was, could or should have been brought to the attention of Goodwin's management, putting them on further notice of the existence of the already evident risk.*
>
> *…*
>
> *It is unclear why the entry from Mr Arquero on 26 December 2014 identifying the risk in the context of behaviour of Mr Bill Ryan did not feature in the report produced on behalf of Goodwin.*

21 The likely reason for the absence of any comment regarding the risk referred to above is that no entry was made. Goodwin notes that there is no record of receipt of any Hazard Report by Mr Acquero in Goodwin's Hazard Register and accordingly, it is possible that a Hazard Report was never submitted as suggested in the progress note of 26 December 2014. Goodwin's submissions dated 27 June 2022 addressed this issue at paragraph [127]:

> *Goodwin has no record of such a report. Accordingly, management was not placed on notice of the alleged incident concerning Bill.*

22 Further in paragraph 6, the Coroner refers to the nature of the review undertaken by Goodwin, describing it as "ineffective". As the review occurred after Mrs McKay's death, it is unrelated to the "manner and cause" of her death and accordingly, does not fall within the meaning of "findings" under section 52 of the *Coroners Act* 1997 (ACT)

Conclusion

23 Goodwin is grateful for the opportunity to clarify the information relied upon by the Coroner in reaching her Findings.

24 Goodwin otherwise welcomes the Findings and is open to any other improvements which the Coroner recommends in respect of the care and services delivered to residents at Goodwin Ainslie.

25 Finally, Goodwin again expresses its sincere regret and remorse to Mrs McKay's family and friends in relation to the circumstances of her death. Goodwin particularly acknowledges the additional emotional toll caused by the delays in the finalisation of this Inquest. Goodwin hopes that the family of Mrs McKay can also be confident that the improvements made at Goodwin Ainslie immediately after Mrs McKay's death, and in the years following, have ensured that no such similar incident can again occur.

Dated: 3 March 2023

Signed: