QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Betty Christine Quayle**
TITLE OF COURT:	Coroners Court
JURISDICTION:	CAIRNS
DATE:	12 February 2019
FILE NO(s):	2013/1946
FINDINGS OF:	Nerida Wilson, Northern Coroner
CATCHWORDS:	Aged care; aged care provider; nursing home; death in care; assault; manslaughter; risk assessment of residents; response by aged care regulators; referrals to the Department of Health (Cth) and to the Royal Commission into Aged Care Quality and Safety, referral to Aged care Quality and Safety Commission; and Aged Care Quality Agency

Contents

Background

1. Betty Christine Quayle was 89 years of age when she died on 31 May 2013.

2. Mrs Quayle was fragile and experiencing functional decline. She resided in Kingfisher Lodge at the Glenmead Village aged care facility in Cairns. Mrs Quayle's adult children visited her at the facility and kept in contact with their mother by telephone.

3. At the time of Mrs Quayle's death the facility was owned by Blue Care Queensland. It is now owned and operated by Regis Aged Care.

4. [redacted] (hereinafter referred to as Resident A) was also a resident of Glenmead Village although in a different wing to Mrs Quayle. He was admitted into care in June 2011. Resident A was 74 years of age and he suffered from cognitive impairment, consistent with alcohol related dementia.

5. At about 3:00am on 30 May 2013, Resident A wandered from his wing and inadvertently into Mrs Quayle's room. Resident A, believing he was in his room, told Mrs Quayle to wake up and get out of his bed. Mrs Quayle was unable to respond to him. Resident A then attempted to remove her from the bed. He assaulted Mrs Quayle a number of times causing a number of visible injuries to her, before leaving the room.

6. A nurse saw Resident A with blood on his clothing and hands. Resident A took the nurse to Mrs Quayle's room, where she found Mrs Quayle seriously injured. Amongst her injuries she had a deep skin tear to her left forearm, the only explanation for which, was the assault upon her by Resident A.

7. Mrs Quayle was transported to the Cairns Base Hospital. She was pronounced deceased at 2:30pm on 31 May 2013.

Autopsy results

8. A forensic pathologist performed an external and internal autopsy on 3 June 2013. An autopsy report was produced on 23 April 2014.

9. The forensic pathologist was of the opinion that the medical cause of Mrs Quayle's death was a blunt force head injury.

10. Although the extent of Mrs Quayle's brain injury was less than would usually be expected to cause death, the forensic pathologist was of the opinion that it was likely that Mrs Quayle's death was the consequence of a background of severe heart and lung compromise, with superimposed consequences of blunt force tissue injury and subdural bleeding.

11. It was also noted that Mrs Quayle had suffered other injuries particularly to her left arm and chin. It was noted that she had "*bruising over both sides of the chin and the right side of the face and nose, multiple areas of bruising over the front of the trunk, the arms, both forearms and both legs, tearing of fragile skin of both forearms and associated treatment of those*".

12. The autopsy report also noted that "*the general fragility of her body tissue [meant] that only minimal force*" may have been required to cause her injuries.

13. I am of the view that the general fragility of Mrs Quayle's body tissue clearly indicates

her particular vulnerability, and her requirement for care and protection.

14. I accept the forensic pathologist's opinion as to the medical cause of Mrs Quayle's death.

Resident A's Admission and Behavioural History at Glenmead Village

15. Prior to his admission Resident A was assessed by the Aged Care Assessment Team (ACAT) at the Cairns Hospital in May 2011. That assessment noted the following matters:

    - He had episodes of restlessness and aggression; and
    - He required a high level of care at a secure facility.

16. The Client Transfer Summary from the Cairns Hospital noted that Resident A "*can abscond or be aggressive*".

17. During Resident A's residence at Glenmead Village routine notes were made about his care and behavior. Those notes were disclosed as part of this investigation.

18. The Blue Care admission documentation noted that Resident A wandered frequently and required a secure environment. Although there was a tick box for the recording of "*physical aggression*", that part of the form was not completed. It was recommended that Resident A be placed in a locked, secure unit, because of his tendency to wander. It was not recommended that he be restrained in any way.

19. A further review of notes made during Resident A's residence at Glenmead Village indicates he engaged in a number of behaviours that were consistent with the ACAT assessment and the Client Transfer Summary. Whilst there may have been consistent behaviours there is no suggestion of any escalation of behaviours although the response received from Blue Care in relation to the draft findings raises the possibility of further incidents being undocumented.

20. The following table provides a history of incidents involving Resident A and decisions taken to manage his behaviours.

2011

Date	Event
3 June 2011	Blue Care File Notes stated that Resident A: • Definitely needed dementia secure accommodation, even though he had settled little in hospital; • Gets very upset and aggressive if he does not get what he wants; and • Is inclined to wander and get lost.
30 June 2011	Resident A was admitted to the Kingfisher Lodge 'Memory Support Area' at Glenmead Village. The Memory Support Area offered a higher level of care to residents who suffered from significant cognitive and memory deficit and it was a secure unit.

Date	Event
13 July 2011	A review noted that Resident A was verbally aggressive.
16 July 2011	Resident A picked up a dining chair in an attempt to throw the chair at another resident.
27 July 2011	Altercation between Resident A and another male resident almost resulting in a "*fist fight*".
12 August 2011	Resident A had a verbal altercation with another male resident and had to be separated from him.
20 August 2011	Resident A became very upset when another resident mistakenly walked into his room.
25 August 2011	A review noted that Resident A: • Wandered; • Could become verbally/physically aggressive; and • Was easily distracted.
2 October 2011	A review recommended that Resident A continue to be accommodated in a "*locked unit*".
14 October 2011	Resident A struck a female resident on the hand, causing bruising. He was later remorseful and concerned that his behaviour would result in him having to stay in the secure unit.
20 October 2011	A case note indicates that the Medical Officer would discuss with Resident A's son the possibility of Resident A being transferred to a low care unit in order to decrease his frustration and aggression.
20 October 2011	File note indicates that staff on Resident A's lodge had phoned his son to ask for permission to relocate him to the non-secure 'Heliconia Lodge'. It was noted that Resident A's General Practitioner had suggested the relocation after having a conference with Resident A and his carers.
21 October 2011	Six days after he struck another resident (14 October 2011), Resident A was moved to the non-secure unit, Heliconia Lodge.
26 October 2011	Resident A "*absconded*" from the facility. Staff were not alerted until dinner time. Resident A was later found by a staff member outside of the facility.
4 November 2011	Resident A absconded from the facility. When he returned, he thought he was residing at the Kingfisher Lodge rather than the Heliconia Lodge.
19 November 2011	After returning from a trip, Resident A said that he had gone to the local hotel for a couple of beers. He went to the hotel again later that evening.

21 November 2011	Resident A absconded from the facility and he was located at the local hotel.
28 November 2011	Resident A yelled at kitchen staff.

2012

Date	Event
11 January 2012	A Residential Care Plan noted that Resident A: • Became verbally and physically aggressive and abusive when he missed his son or when he was unable to exit the lodge or run errands; and • Had physical altercations with co-residents. The strategies recommended to deal with Resident A's behaviour included: • To remove him to a place with fewer or no people; • To take him for a walk; and • To offer him reading material or TV.
7 May 2012	Resident A was found wandering around the lodge trying to get out.
21 May 2012	Resident A refused his medication and he came out from his room in his underwear.
24 June 2012	Resident A was easily annoyed and short-tempered to a severe level. 'Severe level' was defined in the notes as a level that was a major interference with his everyday life and where symptoms occurred often.
1 September 2012	Resident A was wandering. He then wanted to return to his room, which he believed to be room 19 at Kingfisher Lodge (rather than Heliconia Lodge). He became upset because he thought there was somebody else in his bed.
18 September 2012	Resident A was aggressive and swearing at staff in the dining room.
21 September 2012	Resident A was absent most of the shift and he was later located in his room intoxicated.
28 September 2012	Resident A was observed returning to the facility until 11:45pm. It was unclear what time he had left as there had not been a handover with night staff at the commencement of their shift. It was noted on Resident A's return that he smelt of alcohol.

19 December 2012	Resident A was noted to have continued to go out to local hotels.

2013

Date	Event
17 February 2013	A Residential Care Plan again noted that Resident A had physical altercations with other residents. The same care strategies were recommended as the Care Plan dated January 2012. They were to: • Remove him to a place with fewer or no people; • Take him for a walk; and • Offer him reading material or TV.
18 February 2013	It was noted that Resident A's "physical altercations with co-residents" was a behavior that needed to be addressed. This was to be addressed by: • Taking Resident A to a place with fewer people; • Offering him reassurance and comfort; and • Taking him for a walk or otherwise distracting him.
2 March 2013	Case notes recorded that Resident A: • Did not like people in his personal space; and • May become verbally or physically aggressive. The same strategies were recommended as in the previous Care Plans. They were to: • Remove him to a place with fewer or no people; • Take him for a walk; and • Offer him reading material or TV.
13 March 2013	Resident A went missing from his unit. His whereabouts was unknown between 9:45am and 1:00pm.
27 March 2013	Resident A left the facility and did not sign himself out. He returned at 1:30pm that day.
1 April 2013	Resident A left the facility and informed staff he was heading to the Redlynch Shopping Centre. There was no notation as to what time he left. At 3:20pm a member of the public called the facility and reported they had located Resident A on Reservoir Road, he was described as appearing "*lost and tired*". A staff member collected him. When he was collected Resident A informed the staff member that he had "*taken a wrong turn and become lost*".

9 April 2013	Resident A was not in his room when the doctor visited. He "*became very angry*" when he later realised that he had missed his appointment.
10 April 2013	Resident A was found on Lake Street in Cairns after having a seizure and fallen. He had sustained a laceration to his forehead that was treated at the Cairns Hospital. At 3:45pm a staff member of the Hospital notified the facility of Resident A's admission. There is no notation from the facility as to when Resident A had left the facility or any conversations he may have had with staff members prior to his departure.
17 April 2013	Resident A "*became very angry*" and he "*began yelling at staff*". He then left the facility and caught a bus to a hotel.
19 April 2013	A review of Resident A's behaviour noted concerns regarding his "*physical altercations with others*". However, the review stated that no new strategies were required.
1 May 2013	Resident A refused his medications at 9:00pm and it was noted that he was drunk and that he had become angry. He later had a seizure and he was put back in bed. However, he refused his sleeping medication.
2 May 2013	Resident A became aggressive when he was requested to take his evening medication.
15 May 2013	Resident A was outside the lounge room playing music on a device. Another resident approached him and asked him to turn it off. Resident A refused and the other resident "*hit out at him*". Resident A "*retaliated*" and "*hit back*". Neither Resident A nor the other resident sustained any injuries from this incident.
30 May 2013	At around 3:00am, Resident A entered Mrs Quayle's room and struck her a number of times with a pillow.

21. In addition to the above incidents, a "Behaviour Monitoring Tool" recorded 24 occasions between 3 July 2011 and 18 September 2012 where Resident A had acted aggressively or where he was agitated. The document was not continued after December 2012.

22. There was also a general trend in the records of Resident A refusing his mood stabilizing and sleeping medication.

Outcome of criminal proceedings against Resident A

23. Resident A was initially charged by the police with unlawfully doing grievous bodily harm to Mrs Quayle. This was later upgraded to a charge of manslaughter.

24. On 16 June 2016, the Mental Health Court found that Resident A was of unsound mind at the time of Mrs Quayle's death and manslaughter charge was discontinued.

Blue Care's review of the circumstances of Mrs Quayle's death

25. Blue Care Queensland advised me that they conducted a thorough investigation into the circumstances of Mrs Quayle's death. In response to my request for information, Blue Care advised me (through their legal representatives) by letter dated 31 October 2017 that:

    - Although Resident A had been aggressive in the past, it was believed that his aggressive behaviour was being adequately responded to, and it was "*wholly unexpected*" that he would assault another patient;

    - Resident A was not returned to the facility following Mrs Quayle's death. He spent the following year as an inpatient at the Cairns Hospital;

    - On the day of Mrs Quayle's death, Blue Care reported the incident to its accreditation body (the Australian Aged Care Standards and Accreditation Agency);

    - Glenmead Village was audited (for the purposes of accreditation) by the Australian Standards and Accreditation Agency in March 2013, September 2013, and September 2014. Each time, the facility was found to be meeting all of the expected outcomes; and

    - Glenmead Village was sold by Blue Care to Regis Aged Care in 2015.

26. In response to Mrs Quayle's death, Glenmead Village:

    - Counselled nursing staff on the relevant policies and procedures, including how to respond to an emergency; and

    - Provided refresher training to staff on missing resident procedures.

27. A 'Riskman System' has also been introduced since Mrs Quayle's death. The system captures trends and near misses, such as aggressive behaviour. If there is a potential for harm, the service manager will conduct a review and investigation.

Audit of Glenmead Village by the Australian Aged Care Standards and Accreditation Agency

28. On 15 May 2018 a request was sent to the Aged Care Complaints Commission (Qld) requesting a review of draft findings, which at that time looked solely at the conduct of Blue Care in relation to this matter.

29. That request was subsequently referred to the Department of Health (Cth) as they held

the relevant records. The Department of health responded on 29 June 2018 noting that at the time of Mrs Quayle death the agency responsible for the accreditation of Glenmead Village was the Australian Aged Care Standards and Accreditation Agency (AACSAA).

30. AACSAA is now known as the Australian Aged Care Quality Agency (AACQA) hereafter referred to as 'the Agency'.

31. For the purpose of these findings any reference to 'the Agency' is a reference to both the current and former entity.

32. In its response the Department of Health provided four documents:

    a. A copy of the correspondence from the Northern Coroner's office on 15 May 2018;
    b. A copy of the Residential Care Plan for Resident A dated 2 March 2013;
    c. A copy of an 'Assessment Contact Report' by the Agency dated 4 July 2013; and
    d. A response from the Department of Health dated 28 June 2018.

33. The response from the Department included an attachment (Attachment A) that was in effect a chronology of internal processes that occurred after the assault of Mrs Quayle.

34. The Residential Care Plan noted that Resident A "*doesn't like people in his personal space, he may become verbally or physically aggressive*". The Plan also noted he had a "*lack of inhibitations [sic] r/t cognitive impairment*".

35. I note the care strategies were focused on Resident A, and did not consider safety strategies with respect to other residents.

36. The Assessment Contact Report, a report on the Glenmead facility, was completed by the Agency on 4 July 2013.

37. It was not initially obvious to me that the report was triggered by Mrs Quayle's death as it does not refer to her or the circumstances directly relating to her death. The report nonetheless noted that Glenmead Village:

    - Met the expected outcomes for 'behavioural management'; and
    - Met the expected outcomes for "physical environment and safety management".

38. In their report the Agency concluded that:

    - The environment was monitored;
    - Problems were identified; and
    - Problems were actioned to ensure that the facility was safe and secure.

39. With regard to the issues in paragraphs 37 and 38 I note those observations were made within 5 weeks of Resident A wandering without impediment into Mrs Quayle's room at approximately 3am.

40. The Agency reported that 17 of the 18 care recipients they interviewed as part of their Assessment Contact Report felt safe and secure at Glenmead Village.

41. The Agency identified that there were inconsistencies at Glenmead Village in terms of the recording of triggers and causes of residents' challenging behaviours in Care

Plans. It was suggested that Glenmead Village might benefit from reviewing its processes to ensure there was a shared understanding of causes and triggers of challenging behaviours.

42. Although the Agency identified that incidents were not consistently recorded in the Glenmead Village incident management system and subsequently not entered into Care Plans, it found action was being taken to address challenging behavior incidents.

43. Having regard to Attachment A to the response from the Department of Health it appears they conducted their own assessment on 19 July 2013. The Departmental assessment had access to the Assessment Contact Report produced by the Agency.

44. On 23 July 2013 the Department wrote to Glenmead Village advising to the effect:

    "*the Department would take no further action relating to the incident, as it was satisfied the provider had complied with its reporting obligations and reasonable actions had been taken in relation to the incident*".

45. I conclude from that and a subsequent letter from the Agency dated 2 November 2018, that the Assessment Contact Report was triggered by the death of Mrs Quayle.

Responses to Draft Findings

46. Upon receiving the material from the Department of Health the draft findings were further revised to include that response.

47. The revised draft findings in relation to Mrs Quayle's death were provided to the Australian Aged Care Quality Agency (the Agency) and Blue Care in order to give them an opportunity to respond.

48. The Agency was provided a copy of the draft findings on 21 September 2018.

49. On 2 November 2018 the Agency provided a written response. They stated:

    - Their own investigation (into Mrs Quayle's death on 31 May 2013) was yet to be completed;
    - The Agency also confirmed that it conducted an accreditation audit of Glenmead Village on 5-7 March 2013;
    - They did not agree with the draft conclusion to the extent that "*Mrs Quayle's death was not investigated, examined or analysed*" by them;
    - In that regard they considered as inaccurate the implication that the Agency had a responsibility to investigate Mrs Quayle's death;
    - Instead they identified their role as to "*examine the operations of the residential aged care service under the Accreditation Standards, including, relevantly, standards relating to behaviour, facility safety and medication management*";
    - The Agency conducted such an examination on 7-8 May 2013 and did not identify any "*systemic issues*" with behaviour management at that time;

- The Agency acknowledged that prior to that Glenmead Village had conducted a behaviour management review of Resident A in April 2013;

- Following Mrs Quayle's death the Agency reassessed the facility on 4 July 2013. It concluded that the facility was compliant;

- The Agency noted Resident A had since been removed from Glenmead Village "*thus eliminating any ongoing risk he may have posed to the residents*"; and

- The Agency agrees it would have been "*preferable*" to have mentioned Mrs Quayle's death in their July 2013 report.

50. The reference to 7-8 May 2013 appeared incongruous with the chronology of events in relation to Mrs Quayle. Further clarification was then sought from the Agency in that regard. The Agency confirmed the 7-8 May visit (preceding Mrs Quayle's death and therefore unrelated) was an unannounced assessment contact visit. That assessment focussed on outcomes relevant to 'Standard 2 – Health and Personal Care'.

51. It is unclear to me whether this 7-8 May assessment contact visit was connected with Resident A and his behaviours or whether it focused on an unrelated issue. I therefore cannot have regard to it. Although it raises a matter of concern for the Agency's response on 2 November 2018 in that they have seemingly relied upon that assessment contact visit and the behaviour review from April 2013 to satisfy itself of Glenmead Village's compliance with standards for behaviour management.

52. Returning to their letter of 2 November 2018, the Agency requested I reconsider my initial statement in the draft report that "*Mrs Quayle's death was not investigated, examined on analysed*" by them. I decline to make any changes.

53. I am of the view that when a resident of a facility dies in circumstances such as these, and the death is not recorded by the accrediting body during a review conducted within weeks of the death; there must be reflection by the Agency about the lack of a death review process when considering behaviour management and facility safety. How could one be done without reference to the other?

54. I am of the view that the response received from the Agency was inadequate for the following reasons:

    a) It failed to identify whether specific or general regard was had to Resident A's behaviours during their contact with Glenmead Village in the months leading to Mrs Quayle's death particularly the March 2013 contact which had a broader scope given it was concerned with reaccreditation;

    b) I find this failure all the more egregious given the draft findings gave a clear account of Resident A's behaviours in the almost two years prior to March 2013;

    c) In that regard the response also failed to identify what other examinations were conducted by the Agency after Resident A was first admitted to the facility; and whether any behaviour management issues were identified on those occasions;

    d) The Agency's response also failed in that it placed undue weight on the behaviour review conducted by Glenmead Village on 19 April 2013, as a means of satisfying itself after that fact, that Glenmead Village was compliant; and

e) By highlighting Resident A's removal from the facility as a means of reducing risk, the Agency, whether consciously or not, unduly attributed responsibility to him individually, and failed to properly consider whether management practices concerning behaviour of all residents at the facility were adequate.

55. Blue Care was also provided with a copy of the draft findings on 21 September 2018.

56. On 16 November 2018 a response from was received from Blue Care via their legal representatives. In that response they:

- Sought to redefine Resident A's behaviour from what had been described as "*a clear history of violence*" in the conclusion of the draft findings but accepted that he engaged in aggressive behaviours;
- Raised limitations as to their ability to manage certain behaviours such as alcohol consumption by, and physical movement of, residents;
- Identified that Resident A's behaviour was not at a "*high risk*" threshold such that might see him placed in a psychiatric facility for the long-term;
- Identified they were unable to exclude Resident A from the facility in the absence of alternative arrangements;
- Accepted Resident A's "*dementia caused behaviours*" required high level care;
- Accepted decisions were made to manage his behaviours that saw him moved from a secure to an open unit;
- Acknowledged that residents in age care are more susceptible to serious injury from "*less than extreme force*";
- Notwithstanding that, they did not expect Resident A's behaviours might "*lead to the death of another resident*";
- Fully cooperated with regulatory bodies after the death of Mrs Quayle;
- Operated within a regulatory framework that required them to balance what they describe as "*competing obligations*" to provide a safe environment with residents personal, civic, legal and consumer rights;
- Have since 2013 introduced new methodologies to review, escalate and resolve behavioural incidents;
- Have since 2016 expanded their annual auditing system for residential services

57. I make the following observations with respect of the response from Blue Care:

a) The rights of residents to live in a safe and comfortable environment that ensures their quality of life should not be seen as "*competing*" with rights of residents to achieve control of their own lives within residential care. To say that, improperly suggests that from time to time one must take precedence over the other, or that one can only be provided at the expense of another. These rights should be seen as mutual, that is, in common with each other not in conflict.

58. I also raise the following specific concern with respect to the response from Blue Care. At paragraph 1.2 of their response they stated "***It is not uncommon*** *(emphasis added) for residents with dementia to display similar behaviour to that of Resident A*" and that staff manage complex behaviours including physical and verbal aggression on a "***regular basis***".

59. At paragraph 3.1 of their response Blue Care describe their record keeping model as "*exception based*", that is records are only made when something "*out of the ordinary occurs*".

60. Given Blue Care accept the physical and verbal behaviours of Resident A were not uncommon but would only be recorded if they were "*out of the ordinary*" the possibility is raised that there may have been further incidents by Resident A that were not documented. The response also suggests that certain behaviours may become 'normalized' over time such that certain risks may not be fully perceived or appreciated.

61. In their response Blue Care has also suggested that this matter should not be referred to the Aged Care Complaints Commissioner (ACCC) on the basis that it does not fall within the definition of a "*disciplinary body*" pursuant to s.48(5) of the *Coroners Act 2003*. I take a contrary view.

62. The s.48(5) definition of a "*disciplinary body*" includes a body that "*can sanction*" **or** "*recommend sanctions*". In that regard I note that s.65-1 of the *Aged Care Act 1997 (Cth)* expressly states that it is the Secretary (of the Department of Health) that can impose sanctions on an approved provider. However pursuant to s.95A-1 of the *Aged Care Act 1997 (Cth)* the functions of ACCC include those set out in the Complaints Principles contained in s.94A-1.

63. Specifically s.94A-1(2)(g) of the Complaints Principles provides a mechanism by which the ACCC can provide "*information relating to complaints and concerns*" to the Secretary (of the Department of Health). I read the words "*provision of information*" broadly to include recommending sanctions. To that effect I maintain my decision to refer this matter to the ACCC for further consideration (directed to the newly formed Aged Care Quality and Safety Commission).

64. To remove any doubt, I will also refer this matter to the Secretary of the Department Health (Cth).

Next of Kin Concerns

65. A copy of the draft findings was provided to Mrs Quayle's children, her next of kin.

66. The next of kin were understandably concerned that Blue Care regarded Resident A's assault of Mrs Quayle as "*wholly unexpected*" taking into account his known history of aggressive behavior, as documented in these findings. They were further concerned that whilst Blue Care had taken remedial action since Mrs Quayle's death, any systems failing prior to her death, were neither owned or acknowledged.

67. In that regard I refer paragraph 8.3 of the Blue Response dated 16 November 2018, in which they stated:

    "*Blue Care accepts that Mrs Quayle's death should not have occurred, however at the time, it is difficult to see what could have been done differently or better, to manage*

the risk posed by [Resident A] in the context of the inability to forcibly restrain or detain him. His move to Heliconia from Kingfisher did in fact reduce the risk of harm by him to other residents and staff, and was in accordance with the medical advice provided by [his General Practitioner]"

68. Mrs Quayle's next of kin also raised a concern with respect of the response from the Agency. In particular the response by the Agency that Glenmead Village had met the expected outcomes for 'behavioural management' and 'physical environment and safety management'. Their concern being that if that is the case then the standards require change.

Conclusions and Findings

69. Mrs Quayle was a vulnerable resident. She, and all other residents, were entitled to live in a safe and comfortable environment that ensured their quality of life.

70. Resident A had a clear history of violence towards staff and other residents. He also regularly absconded from the aged care facility, consumed alcohol at local hotels, refused to take his sleeping and mood stabilizer medication, and entered other patients' rooms.

71. Glenmead Village made the decision to move Resident A from a secure unit to a non-secure unit six days after an altercation with a female resident, because Resident A's General Practitioner's suggested that it might 'decrease his frustration'.

72. General Practitioner had Resident A's best interests in mind, however that suggestion was only one of the many factors in the mix and should have been properly weighed against the safety, welfare and particular vulnerabilities of all other residents. That responsibility rests with the facility.

73. The safety and welfare of all residents at the facility was paramount against the background of the known risk of violent and aggressive behaviours exhibited by Resident A.

74. Resident A's behaviors continued in the non-secure environment where he remained for approximately 19 months, from October 2011 until Mrs Quayle's death in May 2013.

75. The Australian Aged Care Standards and Accreditation Agency (AACSAA) (now the Australian Aged Care Quality Agency) conducted an audit of Glenmead Village one month after the death of Mrs Quayle and essentially concluded that there were no systemic issues. Mrs Quayle's death was not investigated, examined or analysed by the agency.

76. Glenmead Village was assessed as fully compliant with the accreditation standards. No reference to Mrs Quayle's death, or the circumstances of her death, was made in the AACSAA report although they now acknowledge it would have been preferable to do so.

77. I find that Mrs Quayle died at the Cairns Base Hospital (renamed the Cairns Hospital on 31 May 2013).

78. I find the medical cause of Mrs Quayle's death was blunt force head injury.

79. It is alleged that a pillow may have been used during the assault however I have regard to the severity of her other injuries noting that she was particularly vulnerable to injury from minimal force. There were no direct witnesses to the event.

80. I find that Mrs Quayle's injuries were as a result of Resident A using a pillow and / or other means during the assault.

81. I find that if Glenmead Village had adequately managed the risk of harm posed by resident A, Mrs Quayle's death could have been prevented.

82. Blue Care have not acknowledged any systems or procedural failures on their part in this instance.

Referrals

83. I direct that a copy of my findings be provided to:

- The Secretary of the Department of Health (Cth);
- The Aged Care Quality and Safety Commission.

84. I further direct that a copy of these findings be provided to the Royal Commission into Aged Care Quality and Safety.

Conclusion

I do not intend to hold an Inquest into the death of Betty Quayle as I am satisfied I have sufficient information to enable me to make findings.

These are my findings and I direct that they be published on the website of the Coroners Court of Queensland as I consider it is in the public interest to do so.

I extend my sincerest condolences to Mrs Quayle's adult children on the death of their much loved mother in such tragic circumstances.

Findings required by s. 45

Identity of the deceased - Betty Christine Quayle

How she died - At approximately 3.00am on 30 May 2013, Betty Christine Quayle, an 89 year old woman and resident of Glenmead Nursing Home Cairns, a facility then operated by Blue Care Queensland, was assaulted in her bed by Resident A who mistakenly believed she was occupying his room. Resident A used a pillow and / or other means to inflict a head injury causing Mrs Quayle's death.

Place of death - Cairns Base Hospital Cairns QLD 4870

Date of death - 31 May 2013

Cause of death - 1(a) Blunt force head injury on a background of ischaemic and valvular heart disease

2. Dementia (Alzheimer and cerebrovascular disease)

Nerida Wilson
Northern Coroner
12 February 2019