CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 30th day of June and the 30th day of August 2023, by the Coroner's Court of the said State, constituted of Ian Lansell White, Deputy State Coroner, into the death of Barbara Ann Haynes.

The said Court finds that Barbara Ann Haynes aged 89 years, late of Gawler Grande Views, 3 Duffield Street, Gawler East, South Australia died at the Angaston District Hospital, Schilling Street, Angaston, South Australia on the 11th day of April 2020 as a result of a head injury. The said Court finds that the circumstances of her death were as follows:

1. Introduction and cause of death

1.1. Barbara Ann Haynes was born in Reading, England in 1930. She was 89 years of age when she died on 11 April 2020 at the Angaston District Hospital.

1.2. A pathology review into her death was conducted by Forensic Science South Australia.[1] Mrs Haynes' medical history included Alzheimer's dementia, hypertension, hypothyroidism, osteoporosis and PTSD.[2]

1.3. Based on the pathology review, FSSA found her cause of death to be 'head injury'.[3] I accept the opinion of FSSA and make a finding accordingly.

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[1] FSSA
[2] Exhibit C2a
[3] Exhibit C2a

2. Reason for Inquest

2.1. On 19 March 2019, an order was made by the South Australian Civil and Administrative Tribunal[4] under the Guardianship and Administration Act 1993, Sections 32 and 57 confirming Mrs Haynes' son, Mark Haynes, as her limited guardian with roles and duties limited to those concerning accommodation.

2.2. SACAT confirmed that order on 4 December 2019. It was due for review on 3 December 2020.

2.3. Mrs Haynes was subject to a Section 32(1)(b) guardianship order. Her cause of death given by pathology review was head injury.[5] This is not a natural cause of death. Therefore, her death must be subject of a mandatory inquest pursuant to Section 21 of the Coroners Act 2003.

3. Mrs Haynes' personal matters

3.1. Following completion of secondary school, Mrs Haynes worked in the public service in administration. She met her husband John in England. Together they had four sons, all born in England – Peter, Paul (now deceased), Michael and Mark. The family migrated to Australia via ship in 1963.

3.2. Mrs Haynes established a very successful business as an interior decorator in Adelaide during the 1960s and 1970s. Mrs Haynes later became the publican of the Policeman's Point Hotel in the Coorong. In her retirement, she and her husband John lived in the Para Hills and Salisbury area. She was a member of the Rotary Club in Salisbury. Mrs Haynes was also proudly involved in the development of the Paddocks at Para Hills.

4. The events leading to Mrs Haynes' death

4.1. Mrs Haynes was admitted to the Gawler Grande Views Aged Care facility[6] at Gawler East on 16 May 2019. On this date Mr Haynes signed a copy of the residential care service agreement.[7]

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[4] SACAT
[5] Exhibit C2a
[6] Gawler Grande Views
[7] Exhibit C3

4.2. During her time at Gawler Grande Views Aged Care, Mrs Haynes was unfortunately involved in a number of incidents that resulted in physical injuries, some of which occurred as a result of altercations with other patients with dementia.

4.3. On 22 February 2020 a physical assault resulted in soft tissue injury to her cheek and lip. Mrs Haynes suffered a witnessed fall on 7 March 2020 with no serious injuries occurring, but which did result in minor abrasions to her arm and head. Multiple physical altercations are recorded on incident forms in the notes from the aged care facility.

4.4. It is also noted in documentation from the facility that Mrs Haynes had a tendency to wander and was under a behaviour management plan.

4.5. On the 29 March 2020 Mrs Haynes was admitted to the Lyell McEwin Hospital[8] following an unwitnessed fall with a head-strike at the aged care facility. Staff reported hearing a loud bang. When they attended to the sound, Mrs Haynes was located on the hallway floor, with no other residents in proximity. Staff reported that she was unconscious for about one minute and fluid was leaking from her right ear.

4.6. When SAAS were called they found her conscious but disorientated with asymmetric pupils. She was reported as hemodynamically stable and afebrile with no signs of injury other than to her head and face. Mrs Haynes was transferred by SAAS to the LMH.

4.7. Her assessment in the Emergency Department at LMH included routine blood tests and CT scans which revealed a right subdural haematoma, temporal lobe contusion and subarachnoid haemorrhage. A cervical spine CT scan showed an old fracture. Nasal bone fractures were also noted, also of indeterminate age.

4.8. Mrs Haynes was not considered to be a candidate for surgery due to the severity of the brain damage and her underlying co-morbidities.

4.9. Her condition did not improve. She was subject to conservative management and care. After discussion with her son and allied health professionals, goals of her care were explored.

4.10. Palliative care medications and management plans were drawn up to control symptoms, including agitation and pain. Mrs Haynes was transferred to Angaston Hospital on 7 April 2020 for comfort care.

[8] LMH

4.11. Mrs Haynes was declared life extinct on 11 April 2020 at 3:40pm.

5. Cause of the fall on 29 March 2020

5.1. The incident report of this fall records that no other resident was in the proximity of Mrs Haynes at the time of the fall.[9] Inquiries have been made as to the existence of any CCTV footage, however, Gawler Grande Views Aged Care does not retain CCTV for longer than seven days. Thus, by the time of Mrs Haynes' death being reported to the Coroner (noting that her death was 11 days post fall), there was no CCTV footage that could be ascertained in order to further explore the circumstance of this fall.

5.2. Dr Alderman, who completed the pathology review for FSSA,[10] noted that it is not possible to differentiate between a fall and an assault, particularly an assault occasioning a fall with a head-strike, from a review of the records. However, Dr Alderman also noted that determination was unlikely to be possible by a post-mortem examination given her 13-day survival period and the subsequent post-mortem interval in which any other injuries present at the time may be healed or disguised. A post-mortem was never performed as it was not recommended post pathology review, given the cause of death was determined with certainty from the case notes. Dr Alderman also noted that, other than the head injury, no other injuries were reported at the time of the incident on 29 March 2020.

6. Concerns raised by Mrs Haynes' son

6.1. Mr Mark Haynes provided an affidavit to the Court.[11] In this he asserts that he withdrew his consent, as the guardian responsible for accommodation, for Mrs Haynes to remain at Gawler Grande Views on 19 March 2020. He stated that on that day he was contacted by a male from the home who informed him that Mrs Haynes had been the subject of an assault by another resident. An incident report from 19 March 2020 records that Mrs Haynes was sitting next to another resident who punched her to the chest.[12]

6.2. As a result of being advised of that assault, Mr Haynes presented to the aged care facility later that evening. He indicated the doors were locked and keypad access was denied.

[9] Exhibit C6
[10] Exhibit C2a
[11] Exhibit C8
[12] Exhibit C6

6.3. It is important to note that on the previous day, 18 March 2020, restrictions related to Covid-19 had been put in place relating to visits to residents at residential care facilities.

6.4. Mr Haynes stated he was told he could not see his mother and he needed to leave the premises for the protection of other residents.

6.5. Mr Haynes stated that same day he wrote a letter to Ms Nicole King, who was at the time of Mrs Haynes' admission and death the Director of Care and Services at Gawler Grande Views.[13] Mr Haynes' affidavit stated that was hand-delivered to the letterbox of the nursing home. That letter requested that Mrs Haynes be released from the nursing home.

6.6. Mr Haynes indicated he wrote a number of other letters on 27 March, 5 April, 6 April and 20 April 2020 alleging his mother was being unlawfully detained.[14]

6.7. Ms Nicole King stated that she has checked records and at no time while Mrs Haynes was at the home did she or any person from the facility receive any correspondence from Mr Haynes revoking his permission for Mrs Haynes to be a resident at the facility.[15]

6.8. Ms King has annexed to her affidavit two letters dated 27 and 29 March 2020 from Mr Haynes which were received by her head office on 1 April 2020, by which time Mrs Haynes had already left the facility and was in the hospital.

6.9. Ms King stated in her addendum affidavit[16] that, after speaking to a detective on 14 October 2021, she checked with the head office in relation to any other letters that had been received by Mr Haynes. Following such, she received copies of letters dated 5 April, 6 April, 28 April, 3 June, 9 June and 25 November 2020. However, all these letters are stamped as having been received after Mrs Haynes passed away.

6.10. Ms King also detailed in her affidavit what would be undertaken if a family member requested the removal of a resident from the facility. At the time of Mrs Haynes residency, a request to terminate the arrangement would have included a meeting where it would have been discussed whether the resident was to return home or be transferred to another aged care facility. If the family member was going from long-term home, a

[13] Exhibit C8b
[14] Exhibit C8
[15] Exhibit C3
[16] Exhibit C3a

request would have been made for the resident's general practitioner to attend the facility and undertake an assessment of the resident and their care plan.

6.11. Ms King stated that normally residents are only discharged if their care needs are simple, but she recalled Mrs Haynes' care needs as being complex. Approval for home care would also require approval for government funding. Ms King stated, that:

> 'If at any time a family member or guardian attended the facility and physically removed a resident, we would not stop them. If a person has guardianship of a person in this sort of instance there is nothing we can do.' [17]

6.12. Ms King stated that an assessment and action plan were not put into place for Mrs Haynes to leave the facility because the staff were not aware a request had been made while Mrs Haynes was a resident.

7. <u>Conclusions</u>

7.1. This is a very tragic set of circumstances, particularly for Mr Haynes whose mother suffered an injury that led to her death at a time he says he no longer wanted nor consented to her remaining in the facility. However, there is no indication any of the letters were received until after the final fall which led to her death.

7.2. I find Mrs Haynes was subject to lawful detention at all times prior to her death.

7.3. I find the care of Mrs Haynes at Gawler Grande Views and LMH was appropriate.

7.4. I make no recommendations.

Key Words: Death in Custody; Section 32 Powers; Nursing Care

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 30th day of August, 2023.

Deputy State Coroner

Inquest Number 09/2022 (0747/2020)

[17] Exhibit C3, paragraph 11