



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 6th and 22nd days of December 2023, by the Coroner's Court of the said State, constituted of Ian Lansell White, Deputy State Coroner, into the death of John Michael Forrest.

The said Court finds that John Michael Forrest aged 68 years, late of Yatala Labour Prison, 1 Peter Brown Drive, Northfield, South Australia died at the Royal Adelaide Hospital, Port Road, Adelaide, South Australia on the 12th day of September 2020 as a result of multi-organ failure due to gram negative sepsis on a background of recent myocardial infarction and coronary artery bypass graft and end stage renal failure. The said Court finds that the circumstances of his death were as follows:

1. Introduction, cause of death and reason for Inquest

- 1.1. John Michael Forrest, born 16 May 1952, died on 12 September 2020 at the age of 68 years at the Royal Adelaide Hospital.¹
- 1.2. Mr Forrest's death was the subject of a mandatory Inquest pursuant to section 21(1)(a) of the Coroners Act as, at the time of his death, he was in the custody of the Department for Correctional Services.²
- 1.3. A pathology review³ was conducted by Dr Alexandra Yuill and Dr Karen Heath from Forensic Science South Australia.⁴ The review suggested that Mr Forrest's cause of

¹ RAH

² DCS

³ Exhibit C3

⁴ FSSA

death was multi-organ failure due to gram negative sepsis in a person with a recent myocardial infarction and coronary artery bypass graft and end stage renal failure. As the cause of death could be determined from the case notes, an autopsy was not recommended nor was one conducted. I accept FSSA's suggested cause of death.

2. Background and medical history

- 2.1. Mr Forrest was born in Broken Hill. His family moved to Adelaide when he was 12 years old. He completed Year 10 before leaving school to work in a factory. He worked in various jobs until he became unemployed in about 1980. He remained unemployed until 1987 when he began receiving the Disability Support Pension. He was granted a pension due to contracting the neurological condition Guillain Barre Syndrome, rendering him temporarily wheelchair-bound.
- 2.2. Mr Forrest married his wife Robyn in 1983 and they had six children.
- 2.3. Mr Forrest was diagnosed with diabetes aged 12, commencing medication at the age of 47 and insulin at the age of 57. He also suffered chronic kidney failure attributed to diabetes, hypertension, arthritis, asthma, chronic obstructive pulmonary disease, gout and was morbidly obese.

3. Mr Forrest's custody and his care and treatment

- 3.1. Mr Forrest had been in DCS custody since 19 April 2007.
- 3.2. On 2 October 2007, following being convicted at trial of sexual crimes, he was sentenced to 8 years imprisonment with a non-parole period of 4 years and 6 months, backdated to 18 April 2007.
- 3.3. Mr Forrest's sentence was due to expire on 18 April 2015, however on 15 April 2015 the Supreme Court declared him a person incapable of, or unwilling to, control his sexual instincts.
- 3.4. The Court authorised his release on licence with electronic monitoring on 2 November 2015.
- 3.5. Mr Forrest was readmitted into custody on 16 February 2016 after breaching conditions of his licence. The Parole Board revoked Mr Forrest's licence on 26 April 2016 and he remained in custody on an indeterminate sentence.

- 3.6. Having been moved around numerous correctional institutions during his periods of incarceration, Mr Forrest was transferred for the final time to the Yatala Labour Prison⁵ on 12 May 2020 where he was accommodated in E Division due to his status as a '*protected prisoner*'.
- 3.7. Mr Forrest's interactions with the South Australian Prison Health Service⁶ have been reviewed and summarised by Dr Daniel Pronk, Medical Director of SAPHS, who provided an affidavit to the Court.⁷ Mr Forrest's SAPHS notes comprise ten volumes. Dr Pronk reported that a review of the first eight volumes suggested nothing remarkable or significant. For simplicity, he focused on volumes nine and ten. I set out his medical history in brief based on this evidence.
- 3.8. On admission to the Adelaide Remand Centre⁸ Mr Forrest reported a history of diabetes requiring insulin, a history of chronic obstructive pulmonary disease dating back to the 1980s, a prior tonsillectomy and cholecystectomy and Guillain Barre Syndrome in 1987. A further prison medical officer review also listed a vitamin B12 deficiency, anaemia, hypertension, gout and a hearing impairment. No psychiatric history was reported or documented.
- 3.9. On 1 August 2018 Mr Forrest was taken to the RAH with uncontrolled hypertension which was treated with medication titration and he was discharged back to prison.
- 3.10. On 27 August 2018 Mr Forrest was reviewed by the RAH renal clinic.
- 3.11. On 16 October 2018 he had a hypertension outpatient specialist review follow-up, including an ECG review, with continuation of the same hypertension therapy recommended.
- 3.12. In June 2019 there was ongoing deterioration of his renal function, presumed secondary to long-term diabetes, despite blood tests indicating good diabetic control at the time. He had mild anaemia which was likely due to deteriorating renal ability to produce and release erythropoietin, a hormone that plays a key role in the production of red blood cells.

⁵ YLP

⁶ SAPHS

⁷ Exhibit C4

⁸ ARC

- 3.13. Throughout 2019 there was increasing difficulty managing Mr Forrest's hypertension fluctuating between high and low blood pressure.
- 3.14. On 13 August 2019 Mr Forrest had a medical officer review due to bilateral lower leg pain from multi-level lumbar spine degeneration as demonstrated on an MRI. Duloxetine was commenced and subsequent notes indicated it had good effect. Notes also indicate that he was suffering from bilateral cataracts and was referred for an ophthalmology review.
- 3.15. By December 2019 Mr Forrest was being reviewed by a renal physician every 6 months for ongoing input into his management. The review in December 2019 commenced the discussion about a requirement for future dialysis owing to the deterioration of Mr Forrest's renal function. At the time of his death, preparations were being put in place for him to commence dialysis treatment.
- 3.16. On 6 March 2020, as a result of the renal physician review, Mr Forrest underwent day surgery to create an arterial venous fistula in the wrist of his left hand to prepare him haemodialysis in the near future.
- 3.17. On 14 May 2020 Mr Forrest had day surgery at the RAH to correct cataracts.
- 3.18. On 18 May 2020, specialist renal review recommended a low potassium diet as his potassium levels were increasing with his reduced renal function.
- 3.19. On 22 May 2020 a prison medical officer noted that Mr Forrest was very short of breath on walking a few metres, and reported a history of intermittent chest pains upon exertion. An ECG was performed and showed no signs of acute ischaemia,⁹ or signs of high potassium impacting cardiac electrical activity. A referral was made for an urgent cardiology specialist review.
- 3.20. On 26 June 2020 Mr Forrest was reviewed by the RAH consultant renal physician who noted chronic kidney disease awaiting dialysis and ongoing slightly high potassium levels. Low kidney blood filtration was noted and his red blood cell count dropping below 100. A specialist script was issued for darbepoetin to promote production of red

⁹ Reduction of blood flow

blood cells, and ongoing monthly blood tests were recommended, along with weight loss. The need for a low potassium diet was reinforced.

- 3.21. On 17 July 2020 a prison medical officer review noted significant deterioration in renal function and clinical state, with Mr Forrest appearing pale and breathless after only small amounts of exertion. Mr Forrest denied chest pain at that time.
- 3.22. In light of his clinical deterioration a 7-step pathway was discussed and completed. Mr Forrest expressed a wish to be transferred to hospital if he deteriorated, but not to receive CPR, not to be treated in the ICU, nor to receive ventilation or intubation therapy.
- 3.23. On 10 August 2020, following a phone consultation with the RAH Cardiology Department, Mr Forrest was referred after a several-month history of worsening exertional breathlessness and chest pain, presumed to be cardiac ischaemia. The request was for Mr Forrest to have a dobutamine stress echocardiogram¹⁰ within the month.

4. Mr Forrest's admission and care at the RAH

- 4.1. On 5 September 2020 at 7:10am DCS staff attended Mr Forrest's cell in E Division after cellmates requested assistance via the cell intercom as Mr Forrest had woken with heavy pressure chest pain.
- 4.2. A '*Code Black*' was called which initiated a medical team response. Mr Forrest reported his chest pain as 10/10, which was reduced to 6-8/10 with multiple Glyceryl Trinitrate¹¹ sprays. His observations showed a high pulse rate and high blood pressure. He was transferred to the YLP Health Centre before being transported by ambulance to the RAH.
- 4.3. Dr Hugh Cullen, Head of Cardiothoracic Surgery at the RAH, provided an affidavit detailing the treatment that Mr Forrest received at the RAH.¹²
- 4.4. Dr Cullen detailed that Mr Forrest's chest pain was investigated via an angiogram, indicating that his coronary arteries were restricted.

¹⁰ DSE - Dobutamine is a medication that stimulates activity in the heart when it is not appropriate to stress the heart via activity

¹¹ GTN

¹² Exhibit C5

- 4.5. As a result, a coronary artery bypass grafting surgery of three vessels was performed on 8 September 2020. According to Dr Cullen, the operation was uneventful, routine and done in a timely manner.
- 4.6. Following the operation Mr Forrest was transferred to the ICU in a stable condition. Two or three days following surgery Mr Forrest was transferred to the Cardiothoracic Ward to complete his recovery.
- 4.7. Within 24 hours of being on the ward Mr Forrest started to develop an oxygen requirement, resulting in the use of nasal prongs and then a mask to deliver oxygen. Mr Forrest was promptly transferred back to the ICU.
- 4.8. Mr Forrest continued to deteriorate from a respiratory point of view and developed a hospital acquired post-operative pneumonia which was treated with antibiotics.
- 4.9. Dr Cullen explained that the pneumonia can be attributed to the fact that Mr Forrest underwent a long, complex operation involving two or three hours on a ventilator during the operation and then approximately 24 hours on a ventilator in the ICU. As a result his lungs were not under normal conditions, so a variety of bacteria had the opportunity to take hold and cause the infection that resulted in pneumonia.
- 4.10. Dr Cullen opined that, while it was not the first time a patient has died of post-operative pneumonia, it is unusual and not that common for someone of Mr Forrest's age. This led to the presumption that he had underlying lung disease. Additionally, Mr Forrest's renal situation was a marker for an unhealthy body and a generally unfit individual.
- 4.11. Dr Cullen asserted that Mr Forrest was not treated differently in any way due to his prisoner status. He advised that Mr Forrest received care equivalent to any other patient.
- 4.12. Mr Forrest died in the ICU at 9:41 pm on 12 September 2020.

5. Findings and conclusions

- 5.1. I find the cause of Mr Forrest's death to be multi-organ failure due to gram negative sepsis on a background of recent myocardial infarction and coronary artery bypass graft and end stage renal failure.

- 5.2. Consistent with the view expressed by the SA Police investigating officer, Detective Brevet Sergeant Jason Olsen, I find that Mr Forrest was in lawful custody at the time of his death and that there are no concerns with the medical care he received whilst incarcerated.
- 5.3. I have no recommendations to make in this matter.

Key Words: Death in Custody; Prison; Comorbidities; Sepsis; Multi-Organ Failure

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

Seal the 22nd day of December, 2023.

Deputy State Coroner