CITATION: *Inquest into the death of Steven Andrew Forbes* [2011] NTMC 52

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0177/2010
DELIVERED ON:	3 January 2012
DELIVERED AT:	Darwin
HEARING DATE(s):	23 September and 30 November 2011
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Death in custody, natural causes, adequacy of custodial medical attention, rheumatic heart disease, swine flu.

REPRESENTATION:

Counsel Assisting:	Ms Elisabeth Armitage
Department of Health and Corrections:	Mr Tim Barrett
Family of the Deceased:	Ms Philippa Martin of NAAJA

Judgment category classification:	A
Judgement ID number:	[2011] NTMC 52
Number of paragraphs:	52
Number of pages:	14

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0177/2011

In the matter of an Inquest into the death of
Steven Andrew Forbes

ON 8 OCTOBER 2010
AT ROYAL DARWIN HOSPITAL

FINDINGS

(Delivered)

Mr Greg Cavanagh SM:

Introduction

1. The Deceased, Mr Steven Andrew Forbes ("the young man"), was 37 years old when he died of acute viral pneumonia secondary to a swine flu infection of the lungs. The course of his viral condition was exacerbated by his long standing rheumatic heart disease. He died on 8 October 2010 in Royal Darwin Hospital.

2. At the time of his death, the young man was in custody at the Darwin Correctional Centre. As he died in custody an inquest was mandatory. Pursuant to section 26(1)(a) of the Coroners Act when considering a death in custody I am further required to investigate and report on the care, supervision and treatment of the young man while he was held in custody. Accordingly, although the young man died of natural causes, I have considered whether the medical attention provided to him whilst he was imprisoned was appropriate and adequate to his needs.

3. The young man was taken into custody on 5 October 2010 following his discharge from Royal Darwin Hospital. He had been in hospital for five days for treatment of an abscess on his left hip. He was discharged with a course of oral antibiotics and analgesia into police custody on a warrant. He was

received into the Darwin Watchhouse with his medication. However, there is no record of his medication accompanying him to the Darwin Correctional Centre later that day. As it turned out, the loss of this medication was not a factor in this young man's death. But it is of serious concern to me that the prescribed medication of a prisoner was lost. Accordingly, I recommend that a policy concerning the receipt, custody, and administration of prisoners' prescribed medications be developed and implemented.

4. During the evening of 6 October 2010, the young man's cell-mate used the intercom to let prison officers know that the young man was not well. Prison officers attended the cell. Given the information known to the prison officers about the young man in my opinion the on-call nurse should have been called by them. I have recently recommended the development of guidelines to assist prison officers in the exercise of their discretion concerning the use of the on-call nurse. I reiterate that recommendation.

5. Ms Elisabeth Armitage appeared as Counsel Assisting. Mr Tim Barrett appeared for the Department of Health and Corrections and Ms Philippa Martin of NAAJA appeared for the young man's family. The death was investigated by Detective Sergeant Isobel Cummins. I received into evidence her detailed investigation brief and the young man's medical files. I also heard evidence from Forensic Pathologist Terence Sinton, Mr Kenneth Baker-Joe, Registered Nurses Bernard Egan and Margaret Jones (nee Campbell-Lowe), Corrections Officers Connell Brannelly and Peter Douglas, and Doctors Michael Kulisiewicz, Robert McNamara and Peter Harbison.

6. Pursuant to section 34 of the Coroners Act, I am required to make the following findings:

> "(1) A coroner investigating –
>
> > (a) a death shall, if possible, find –

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

(iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

7. Section 34(2) of the Act operates to extend my function as follows:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

8. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.
>
> (3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

Background

9. The young man was born on 11 June 1973 in Katherine and lived in the Territory his entire life. His mother, Ms Joanne Bowden, is deceased. He is survived by his father, Mr Kevin Forbes, his adult son, Dewayne, and his five brothers and sisters, Sharon, Dudley, Patricia, Patrina and Constantin. At the time of his death the young man's long term partner was Ms Sharon Campion and he was a father figure to her daughter, Shauna.

10. The young man grew up in Bulman where he enjoyed fishing, hunting and buffalo mustering. One of his favourite spots was the Wilton River. He

enjoyed gospel music and played the keyboards for the Bulman church. He was a recognised artist and designed the logo for Sunrise Health Service.

11. Unfortunately the young man's adult life was marred by alcohol abuse. He came into regular conflict with the law and received numerous sentences of imprisonment.

12. The young man had a history of rheumatic heart disease.

Relevant circumstances surrounding the death

13. On 1 October 2010, the young man was admitted to Royal Darwin Hospital for a surgical procedure for an abscess on his left hip. In the hospital discharge summary he was described as being "systemically well and afebrile at the time of presentation". He remained in hospital until 5 October 2010. On discharge his recovery from surgery was described as "rapid" and "uncomplicated" and he was considered to be well.

14. At that time of his discharge from hospital, the young man was sought by police in relation to an outstanding warrant. Members of the Domestic Violence Unit learned of his hospitalisation and made enquiries as to his whereabouts through the hospital based Constable, Robin Kidney. Constable Kidney confirmed the young man had been discharged but was waiting for his medications. At approximately 12.00 pm the young man was arrested at the hospital and taken to Darwin Watchhouse in police custody.

15. The young man was discharged from hospital with a course of oral Dicloxacillin, to be taken four times daily on an empty stomach, and paracetamol, to be taken four times a day. I am told that Dicloxacillin is an oral antibiotic for treating or preventing bacterial infections and was prescribed to prevent infection of the abscess.

16. The Darwin Watchouse Arrest Card and the police IJIS system record the young man's medications. However, the police Property Receipt Form completed at 12.54 pm makes no reference to them. It appears that the young

man's medicine might have been separated from his other property at the Watchhouse. Although the young man was at the Watchhouse for about six hours, there is no record of him receiving his medication whilst held there.

17. On the evening of 5 October 2010, the young man was taken from the Watchhouse to the Darwin Correctional Centre. The Property Transaction record created upon the young man's reception into the prison at 7.24 pm does not document the young man's medications. Nor is there any reference to his medications in any of the intake documentation produced to me at the inquest. I can only conclude that the prison staff were not advised by police about the medication and that it did not accompany the young man to the prison.

18. Further investigation undertaken at my request failed to discover what happened to the medication.

19. During the prison reception process, the young man was seen briefly by a registered nurse who completed a Patient Reception Report (the "Report"). The Report was completed during a short question and answer interview and contained information provided by the young man. At least some of the information provided by the young man was inaccurate. For example, the young man incorrectly reported that he had never been in prison before and that he was not on any medication. Furthermore, the information provided by the young man justified some further inquiry in that the Report also documents a "recent hospitalisation" and that the young man complained he was "unhealthy" and in pain.

20. The reception nurse told me that he did not access any prison or medical records to confirm or refute the accuracy of the information provided by the young man, nor asked further questions. I accept the reception nurse asked no further questions, in circumstances which warranted further questions being asked. I am not persuaded that that the nurse did not access prison records. I was told by another nurse that the electronic records must

necessarily be accessed in order to create the Report. Clearly this must be correct as the Report contains references to the young man's identification numbers created by IJIS (Department of Justice), HRN (Department of Health) and DCC (Darwin Correctional Centre). Furthermore, the Report contains a reference to the young man's "right inguinal hernia repair 20/06/2005", information in my view which can only have come from prison medical records.

21. Although the reception nurse must have had access to the young man's prison medical records, it appears these were not considered, and the inaccurate and concerning reporting by the young man passed unnoticed. That is unfortunate as further inquiry could easily have confirmed the young man's recent stint in hospital and ought to have uncovered the missing medication. Priority might then have been given to ensuring his review by a prison doctor.

22. Normally, following an interview with a nurse, new prisoners are assessed by a doctor. However, I was told that as the young man's reception was late in the day, a medical appointment would be booked for the following morning. Again, this evidence was inconsistent with the prison records. The Patient Appointment List shows the only doctor's appointment booked for the young man's "reception and chronic disease check" was on 8 October 2010.

23. On the morning of 6 October 2010, the young man was taken to Darwin Magistrates Court in relation to his warrant and sentenced to 14 days imprisonment. He was returned to the Darwin Correctional Centre as a sentenced prisoner and again reviewed by a nurse as a "court return".

24. I am informed that reviews following court returns are normally short and focus on the mental health of a prisoner. The process involves showing the prisoner a series of faces from happy "1" to sad "5" in an effort to quickly identify prisoners who might be at risk. The young man reported feeling like

a “3”. There was no evidence produced at the inquest of any further inquiry being made as to the young man’s mental or physical health during the court return review.

25. The young man was then placed in a cell with one other male, Mr Kenneth Baker-Joe.

26. On the evening of the 6 October 2010, at 10.07 pm, Mr Baker-Joe pressed the intercom in the cell, and reported that the young man was “crook”. As a result four officers attended the cell and spoke to the young man and Mr Baker-Joe. Mr Baker- Joe gave evidence that he told the prison officers that the young man was crook and they should get him to hospital.

27. I heard evidence from Corrections Officer Connell Brannelly. He recalled the young man was lying on a mattress on the floor of the cell. The young man told him that he was having trouble breathing, he felt hot and sweaty, he was coughing and he felt a bit sore. Officer Brannelly recalled that the young man also told him that he had had an operation a couple of days ago. Officer Brannelly told me that he knew that the young man was a “new reception”.

28. Officer Brannelly offered to move the inmates to a better ventilated cell but the offer was declined. No further action or inquiries were undertaken by the prison officers. In particular the on-call nurse was not called. Officer Brannelly told me that he was aware the young man had returned from court that day, and that he assumed he had been seen by a nurse. That appears to have been a factor in his decision not to call the on-call nurse.

29. On the morning of 7 October 2010 corrections officers unlocked the cells. During “unlock” Corrections Officer Peter Douglas noticed that the young man appeared to be unwell and that he was wearing a hospital band. Officer Douglas recalled the young man saying he said he was sick and had pain in his hip. Officer Douglas noticed that he couldn’t stand up properly. Officer

Douglas requested that the young man wait while the "unlock" was completed.

30. Approximately five minutes later, Officer Douglas re-attended the cell. He saw that the young man looked very unwell, and needed a wheelchair to get to the prison clinic. Officer Douglas contacted the clinic to let them know he was bringing the young man in and requested that he be given immediate attention.

31. The young man was assessed by Doctor Michael Kulisiewic and Registered Nurse Margaret Jones (nee Campbell-Lowe). It was immediately obvious to Dr Kulisiewic that the young man was "visibly", "obviously" and "acutely" unwell. In evidence before me, Dr Kulisiewic described the young man. He said that the young man was breathing rapidly which indicated obvious respiratory distress, he was coughing, he had a fever (38.2), he was sweating, and he had an extremely high heart rate.

32. A prompt decision was made to transport the young man to hospital and the ambulance was called. At 10.44 am the ambulance departed the Darwin Correctional Facility and arrived at Royal Darwin Hospital at 11.02 am.

33. Medical staff at the Emergency Department provided initial treatment. At approximately 3.30 pm the young man was transferred to the short stay unit before being taken to the Intensive Care Unit. At approximately 10.50 pm the young man suffered a cardiac arrest. After numerous attempts to revive him, he was declared deceased at 2.25 am on 8 October 2010 by Dr Peter Harbison.

The autopsy

34. Later that same day, Forensic Pathologist Dr Terence Sinton performed an autopsy.

35. Dr Sinton's significant findings included:

(i) An abnormally enlarged heart, with moderately severe degenerative damage to the mitral valve, in a manner consistent with chronic rheumatic heart disease.

(ii) Moderately severe degenerative damage to the aortic valve in the heart.

(iii) Microscopically, changes in the lungs consistent with an acute viral infection.

(iv) Large volumes of fluid in the chest and abdominal cavities, consistent with chronic heart failure.

(v) A throat swab taken before death identified the presence of the H1N1 (swine flu) influenza virus.

36. Based on the history provided and his findings, Dr Sinton concluded that the young man died from acute viral pneumonia arising from a swine flu virus infection of the lungs. Dr Sinton considered that the course of the infection was profoundly exacerbated by the young man's longstanding rheumatic heart disease. I accept Dr Sinton's findings and find that the young man died of acute viral pneumonia. The young man died from natural causes.

Issues

Loss of medication

37. Although the loss of this young man's medication played no part in his death, I was most concerned by it. It is not difficult to imagine another scenario, one involving a prisoner dependent on life saving medication, and the consequences that might flow were these mistakes repeated.

38. It seems likely that the young man's medication was deliberately separated from his other property at the Watchhouse, but what happened to it then or later is uncertain. The investigating officer was not able to shed any light on what had occurred. More importantly, nor was she able to point me to any guideline or direction about the handling or documentation of prisoner medications. In my view, this is a real area of risk that demands clear guidelines and procedures.

Use of the on-call nurse

39. I have recently considered the use of on-call nurses in an inquest into the death of Daniel Johnson [2011] NTMC 048. I recommended that guidelines be developed to assist prison officers in the exercise of their discretion as to when it would be appropriate to call the on-call nurse. In my view this is another case in which corrections officers might have been assisted by guidelines and training on the exercise of this important discretion.

40. Prisoners cannot obtain their own medical assistance. They are dependent on prisoner officers facilitating access to medical care. In my view, to be denied access to medical care in circumstances of genuine need falls short of the duty of care owed by Correctional Services to their inmates.

41. In my view, on review of this matter, there was sufficient information available to the corrections officers attending the young man's cell to warrant calling the on-call nurse. The young man was a new reception who had recently undergone surgery. He was complaining of difficulty breathing, he expressed symptoms consistent with fever, he was coughing and in pain. This combination of elements ought to have flagged that a call to the on-call nurse was appropriate.

42. That the young man had been seen by a nurse on a court return did not justify the conclusion that his condition did not warrant a call to the on-call nurse. Court return assessments are often short, can be conducted in a group setting, and focus primarily on mental health. Corrections officers should be aware of this and ought not rely on them as necessarily involving an assessment of physical health.

43. On the evidence presented to me I do not find that a failure to call the on-call nurse contributed to this young man's death. However, with the benefit of hind sight it is clear that a call ought to have been made, and it might have resulted in some difference to the outcome.

Prison Reception Procedures

44. In recent inquests I have had the opportunity to hear evidence about the reception of prisoners into the Darwin Correctional Centre. On each occasion, I have noted problems with the process. There appears to be an over reliance on prisoners self-reporting information, in circumstances where it is (or should be) apparent that: misunderstandings might occur, that prisoner's might be motivated to mis-report, or prisoners might have little regard for the accuracy of the information requested from them. Not all information can be checked, but basics can be. An assertion by a prisoner that he has never been in custody, as was the case here, is one such matter. If an inaccuracy is identified further inquiries can be conducted. More care can be taken.

45. If a prisoner complains he is unwell, is in pain, and has recently been hospitalised, as was the case here, it would not be unreasonable to ensure he was promptly medically assessed. After all, Correctional Services owe a duty of care. Had a doctor's appointment occurred, in my view it is quite likely that Correctional Services would have been alerted to the lost medication, indeed a doctor might have discovered that the young man was not well. An appointment three days post reception, in the circumstances of this case, fell short of best practice.

46. Whilst there was nothing about the reception process which contributed to this young man's death, I consider that the lackadaisical approach to the completion of the Patient Reception Report, its inaccuracies and inconsistencies are matters that give rise to concern. I do not propose to make a recommendation about these matters as I did not hear sufficient evidence on them. However, I take this opportunity to draw them to the attention of Correctional Services.

Rheumatic Heart Disease

47. The young man's family was concerned that the young man's condition was exacerbated by his rheumatic heart disease. Counsel for the family, provided information about the Department of Health and Families Rheumatic Heart Disease Program. I was told that the Northern Territory has one of the highest rates of rheumatic heart disease in the world and that it is particularly prevalent in Aboriginal populations, including the prison population.

48. The family requested that I make the following recommendations:

> "That the Department of Health ensure SOS require that: all medical staff employed in the prison are aware of their responsibilities under the rheumatic heart disease program at the time of induction; SOS staff receive ongoing training both as to their responsibilities in relation to the condition (as described in the document the NT Department of Health and Families document "Rheumatic Heart Disease Program"), as well as its treatment and management; that all medical staff responsible for prisoner reception appointments have access to the rheumatic heart disease register and check it on prisoner reception; and that prisoners with rheumatic heart disease have appropriate prophylactic treatment, clinical care and follow up."

49. As the young man's underlying heart condition was not a cause of death, and as the matters raised on behalf of the young man's family were not the subject of evidence at the inquest, I decline to make those recommendations. However, I have extracted the request in full so that it may be considered by Correctional Services and the Department of Health.

Recommendations

50. That the Northern Territory Police Service develop and implement a policy addressing the receipt, custody and administration of prisoners' prescribed medications.

51. The Correctional Services develop and implement a policy as to the use of on-call nurses.

Formal Findings

52. Pursuant to section 34 of the Coroner's Act ("the Act"), I find, as a result of evidence adduced at the public inquest, as follows:

(i) The identity of the Deceased person was Steven Andrew Forbes born 11 June 1973. The Deceased resided at Darwin in the Northern Territory of Australia.

(ii) The time and place of death was 2.25 am on 8 October 2010 at Royal Darwin Hospital.

(iii) The cause of death was acute viral pneumonia secondary to a swine flu infection of the lungs

(iv) Particulars required to register the death:

1. The Deceased was Steven Andrew Forbes.

2. The Deceased was of Aboriginal descent.

3. The Deceased was unemployed.

4. The cause of death was reported to the coroner.

5. The cause of death was confirmed by post mortem examination carried out by Dr Sinton.

6. The Deceased's parents were Ms Joanne Bowden and Mr Kevin Forbes.

Dated this 3rd day of January 2012.

____

GREG CAVANAGH
TERRITORY CORONER