STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Kerry Forrest
Hearing dates:	6 July 2017
Date of findings:	6 July 2017
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, natural cause, terminal illness
File number:	2016/26063
Representation:	Ms L Green, Coronial Advocate Assisting the Coroner
	Mr R Donnelly (Justice Health & Forensic Mental Health Network)
	Mr A Jobe (Corrective Services NSW)

Non-publication order: I direct that, pursuant to section 74(1)(b) of the *Coroners Act 2009*, the following material is not to be published:

1. The names, addresses, phone numbers and any other personal information that might identify:

   (a) any member of Ms Forrest's family;
   (b) any person who visited Ms Forrest whilst he was in custody (other than legal representatives or visitors acting in a professional capacity);
   (c) any Corrective Services NSW employee; and
   (d) any victim of the offence for which Ms Forrest was serving a custodial sentence.

2. The names and Master Index Numbers of any persons in Corrective Services NSW custody, other than Ms Forrest, that are contained in the brief of evidence (Exhibit 1).

3. The Employee Daily Schedule dated 26 January 2016.

Findings: I find that Kerry Forrest died on 26 January 2016 whilst she was a patient in the Secure Unit Annex of the Prince of Wales Hospital, Randwick NSW. At the time of her death Ms Forrest was serving a custodial sentence. Ms Forrest died of natural causes due to complications of cervical cancer.

Table of Contents

Introduction

1. Kerry Forrest died on 26 January 2016. At the time of her death Ms Forrest was serving a custodial sentence that had been imposed in November 2014. Two years prior to being sentenced Ms Forrest had been diagnosed with a terminal illness. Much of Ms Forrest's time in custody following her sentence was spent in different hospitals where she was admitted due to the effects of her terminal illness, and to the decline in Ms Forrest's general health.

Why was an inquest held?

2. When a person's death is reported to a Coroner, there is an obligation on the Coroner to investigate matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it. If any of these questions cannot be answered then a Coroner must hold an inquest.

3. Section 23 of the *Coroners Act 2009* (the Act) makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. This is because when a person is imprisoned or held in lawful custody as a result of breaching a law, the State, by depriving that person of their liberty, assumes responsibility for the care of that person. It is necessary to ensure that the State discharges its responsibility appropriately by examining the circumstances surrounding that person's death.

What is known about Ms Forrest's personal and custodial history?

4. Ms Forrest was born in Sydney on 20 October 1959. Ms Forrest's parents separated shortly after her birth and she was raised by her paternal grandparents. Ms Forrest finished year 12 at school but had not been working for many years prior to when she last entered custody in 2014. Ms Forrest was married for 26 years from 1981 and has 2 adult daughters.

5. Ms Forrest first came to the attention of police in 1974 for a dishonesty offence. Her criminal history reveals that, regrettably, Ms Forrest repeatedly appeared before the courts, mostly for dishonesty-related offences, in the years that followed. The outcome of some of these court appearances resulted in Ms Forrest spending various periods in custody at different times.

6. On 14 February 2011 Ms Forrest was arrested and charged with a murder committed in April 2010. Following her arrest Ms Forrest was held on remand pending her trial. Ms Forrest was later found guilty of murder following a judge-alone trial. On 27 November 2014 Ms Forrest was convicted and sentenced to a term of imprisonment of 25 years with a non-parole period of 19 years dating from 14 February 2011 and expiring on 13 February 2030.

7. At the time of her sentencing, information was provided to the sentencing court that Ms Forrest was suffering from a terminal illness. In October 2012 Ms Forrest was diagnosed with advanced stage cancer of the cervix. She also suffered from a number other conditions including swelling of the left kidney (hydronephrosis), chronic regional pain syndrome, and required insertion of uretic stents. During an application in 2013 to permanently stay Ms Forrest's criminal

proceedings, evidence was provided to the Supreme Court that there was only a low possibility that Ms Forrest's life expectancy would extend beyond 2 years.

8. Ms Forrest was initially treated with radiation therapy. However, by August 2014 Ms Forrest's radiation oncologist noted that any further radiotherapy or chemotherapy treatment would be counterproductive and recommended that Ms Forrest be provided with palliative care only. In a medical report written shortly during Ms Forrest's November 2014 sentencing proceedings Ms Forrest's oncologist noted that Ms Forrest had recently been admitted to Prince of Wales Hospital, following a collapse whilst in gaol because of low haemoglobin. Ms Forrest's oncologist indicted that the best estimate of Ms Forrest's life expectancy at that time was between 6 to 18 months.

9. After her sentence was imposed Ms Forrest was primarily housed at Silverwater Women's Correctional Centre. On 27 June 2015 Ms Forrest was admitted to Long Bay Hospital following several earlier admissions to Westmead Hospital due to renal deterioration and a decline in her general health. On 8 October 2015, during one of these admissions, Ms Forrest signed a not for resuscitation order due to the grave nature of her illness.

10. On 29 December 2015 Ms Forrest was admitted to Prince of Wales Hospital where she was found to be acidotic secondary to acute renal failure. During this admission Ms Forrest confirmed the earlier not for resuscitation order.

11. Ms Forrest was later admitted to Long Bay Hospital on 19 January 2016 for palliative care but only a day later Ms Forrest was returned to Prince of Wales Hospital as her deteriorating condition made it difficult to administer her medication. At this time Ms Forrest decided that any treatment she was to be given would be limited to relieving her symptoms only. Ms Forrest told her treating physicians that she understood the consequences of her decision. Corrective Services NSW made appropriate arrangements for Ms Forrest's family to be able to visit her.

12. On 21 January 2016 a senior staff specialist in palliative medicine at Prince of Wales Hospital advised Corrective Services NSW that Ms Forrest was bed bound and intermittently unconscious.

13. At about 5:30am on 25 January 2016, during a routine observation check, a nurse and corrective services officer discovered that Ms Forrest was unresponsive in bed with nil vital signs. Ms Forrest had last been observed at 5:15am where she was noted to be breathing and not in any distress. Ms Forrest was subsequently pronounced deceased.

What was the cause of Ms Forrest's death?

14. Following the report of Ms Forrest's death to the Coroner's Court, Dr Riannie Van Vuuren, a forensic pathologist with the Department of Forensic Medicine, conducted a review of Ms Forrest's medical records. Dr Van Vuuren noted that on Ms Forrest's final admission to Prince of Wales Hospital Ms Forrest had acute kidney injury, severe metabolic acidosis secondary to renal dysfunction, nausea, a urinary tract infection and anaemia. Dr Van Vuuren also noted that management of Ms Forrest's pain was made difficult by her inability to have oral intake and that her wasting syndrome (cancer cachexia) meant that pain relief medication in the form of fentanyl patches was unlikely to be absorbed.

15. Having reviewed all of the relevant medical records Dr Van Vuuren recommended that the cause of Ms Forrest's death be recorded as complications of cervical cancer.

What conclusions can be reached?

16. Having considered the available records held by both Corrective Services NSW and Justice Health in relation to Ms Forrest, I cannot identify any matter associated with her care and treatment whilst in custody that contributed to her death. It is clear that Ms Forrest was diagnosed with terminal cervical cancer whilst she was in custody on remand pending her criminal trial. By the time of her sentencing, Ms Forrest's terminal illness was at such an advanced stage that active treatment was no longer being considered and her treating physicians regarded her prognosis as poor. It is evident that much of the treatment that Ms Forrest received after being sentenced was focused on palliative care only.

17. During the course of the police investigation following Ms Forrest's death the officer-in-charge, Inspector Ben Johnson, spoke to Ms Forrest's ex-husband. Mr Forrest informed Inspector Johnson that neither he, nor Ms Forrest's daughters, had any issues with, or concerns regarding, the care and treatment that Ms Forrest received from Corrective Services NSW and Justice Health.

18. In summary, the available evidence establishes that Ms Forrest received health care that was within an expected standard of care whilst in custody. There is no evidence to suggest that any action or inaction by either Corrective Services NSW or Justice Health contributed to Ms Forrest's death in any way. As already noted, much of the treatment that Ms Forrest received whilst in custody was palliative in nature only. Prior to this appropriate treatment was provided to Ms Forrest in an attempt to combat the terminal illness that Ms Forrest had been diagnosed with but this treatment was, ultimately, unsuccessful. There is no evidence to suggest that any other treatment or care afforded to Ms Forrest could have prevented her death.

Findings

19. The findings I make under section 81(1) of the Act are:

Identity
The person who died was Kerry Forrest.

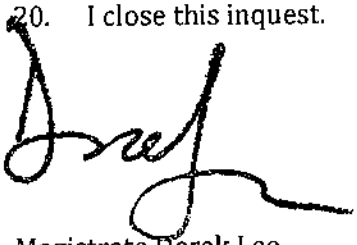
Date of death
Ms Forrest died on 26 January 2016.

Place of death
Ms Forrest died whilst she was a patient in the Secure Unit Annex of Prince of Wales Hospital, Randwick NSW. At the time Ms Forrest was serving a custodial sentence.

Cause of death
The cause of Ms Forrest's death was complications of cervical cancer.

Manner of death
Ms Forrest died of natural causes.

20. I close this inquest.



Magistrate Derek Lee
Deputy State Coroner
6 July 2017
NSW State Coroner's Court, Glebe