



**CORONERS COURT
OF NEW SOUTH WALES**

Inquest:	Inquest into the death of Mr Stephen JOHN
Hearing dates:	10 July 2018
Date of findings:	10 July 2018
Place of findings:	State Coroner's Court, Glebe
Findings of:	State Coroner Les Mabbutt
File number:	17/358109
Catchwords	CORONIAL – Death in lawful custody, natural causes
Representation:	Coronial Advocate assisting the Coroner Mr Peter Bain Mr Alexander Jobe Officer of General Counsel for Corrective Services NSW

Non publication order pursuant to s 74(1) of the Coroners Act 2009

1. *That the following information contained in the brief of evidence tendered in the proceedings not be published under section 74(1)(b) of the Coroners Act 2009 (NSW):*
 - a. *The names, addresses, phone numbers and other personal information that might identify:*
 - i. *Any member of Mr John's family; and*
 - ii. *Any person who visited Mr John while in custody (other than legal representatives or visitors acting in a professional capacity).*
 - b. *The names, personal information and Master Index Numbers (MIN) of any persons in the custody of Corrective Services New South Wales ("CSNSW"), other than Mr John.*
 - c. *Direct contact details of CSNSW Officers not otherwise publicly available.*

- d. The serial numbers and identifying details of CSNSW security equipment such as revolvers, handcuffs, ankle cuffs and keys*
2. *Pursuant to section 65(4) of the Coroners Act 2009 (NSW), a notation be placed on the Court file that if an application is made under s.65(2) of that Act for access to CSNSW documents on the Court file, that material shall not be provided until CSNSW has had an opportunity to make submissions in respect of that application.*

Introduction

Mr Stephen John died at Fairfield nursing home on 26 November 2017. Mr John was 68 years old. At the time of his death Mr John was detained in the lawful custody of the Department of Home Affairs at the nursing home.

Why was an inquest held?

In accordance with s 23 and s 27 of the *Coroners Act* 2009, an inquest is mandatory where a person's death occurs whilst in lawful custody. Mr John was in lawful custody of the Department of Home Affairs at the time of his death

The role of the Coroner pursuant to s 81 of the *Coroners Act* 2009 is to make findings regarding:

- The identity of the deceased
- The date and place of that person's death
- The cause and manner of that person's death

A Coroner may also make recommendations in accordance with s 82 of the Act concerning any public health or safety issues arising out of the death.

Background

Mr John was born in England in 1949, and arrived with his family in Australia at the age of nine. He became a permanent resident of Australia. Mr John married and raised three children however he was separated at the time of his death.

Mr John joined the railways at age 18 and worked in south west Sydney for 47 years before retiring. Despite spending most of his life in Australia, Mr John never became an Australian citizen. At the time of his death he was detained by the Department of Home Affairs, awaiting deportation to his birth country of England.

The imprisonment of Mr John on criminal charges

In June 2012, Mr John was charged with multiple child sex and child pornography offences. Mr John was sentenced at the Downing Centre District Court on 6 December 2013 and received several terms of full time imprisonment in excess of 12 months.

The detention of Mr John under the *Migration Act 1958* (Cth)

Whilst in Corrective Services custody and as result of his convictions, Mr John's residency was reviewed and Mr John's permanent residency visa was cancelled by the then Department of Immigration and Border Protection. That decision was on character grounds and due to his criminal convictions. Accordingly Mr John was classified as an unlawful non citizen.

On 18 December 2016, Mr John was released from corrective services custody and detained in the custody of Immigration and Border Force officials in accordance with s189 of the *Migration Act 1958*. Mr John was detained initially in Villawood Detention Centre, pending his deportation to England.

However, Mr John's medical condition prevented his deportation from Australia. Mr John's health declined to the extent he was transferred for medical treatment to Liverpool Hospital on 10 July 2017 and on 24 July 2017 he was transferred to Fairfield Nursing Home, where he remained until his death.

Mr John's medical history and the events leading to his death

Mr John was already frail upon entering into Corrective Services Custody in 2012, suffering diabetes and breathing difficulties from Chronic Obstructive Pulmonary Disease. Mr John was ultimately placed within a unit specifically for older inmates with a disability. Mr John was given a nebuliser in his cell. Mr John was seen by Justice Health staff daily prescribed medication and received treatment when health issues arose.

In January 2013, he was admitted to the Prince of Wales Hospital suffering from shortness of breath and respiratory distress. Upon discharge back into corrective services custody, Mr John was provided access to oxygen to assist with his breathing difficulties. Mr John's overall condition did not improve.

Upon his release from Corrective Services Custody and entering Immigration Detention on 18 December 2016 Mr John's Chronic Obstructive Pulmonary Disease had advanced to the point where he required aids for mobility, constant oxygen, and could only walk for a maximum of 10 metres at a time.

Whilst in Immigration detention, Mr John had access to care to assist with his showering, mobility and toileting and was supplied with oxygen and medication for his illnesses. Mr John's condition deteriorated whilst in detention. Whilst at Villawood Detention Centre Mr John was referred to Dr Keller a respiratory specialist. Dr Keller reviewed Mr John at Villawood Detention Centre on 3 July 2017. Dr Keller determined Mr John was in end stage Chronic Obstructive Pulmonary Disease and emphysema and had been on long term oxygen therapy for a number of years. Dr Keller discussed palliative care treatment with Mr John who agreed to a "not for resuscitation" status.

On 4 July 2017 the medical director at Villawood requested Mr John to be transferred to palliative care outside the Detention Centre. That request was approved on 6 July. Mr John was transferred on 10 July to Liverpool Hospital under the care of the Community Palliative Care Team. On 24 July Mr John was transferred to a placement at Fairfield Nursing Home.

Dr Peter Tieuw was Mr John's treating practitioner upon his admission to Fairfield Nursing Home. Dr Tieuw stated Mr John's illness was at a severe stage. Mr John was confused due to a lack of oxygen to his body and brain and spent most of his time in bed. Mr John needed assistance with all his activities of daily living.

By Saturday, 25th November 2017, Mr John's condition had declined to the point where his breathing became shallow and laboured and he fell into unconsciousness. His illnesses had reached end stage respiratory failure. Medical staff were notified and attempted to assist Mr John and make him comfortable. Dr Chiwara attended and pronounced that Mr John had died about 12.35am on 26 November 2017.

Police were notified of the death and attended shortly after. Constable Elise Ryan from Fairfield Local Area Command conducted the investigation.

Cause of death

A post mortem examination was conducted by Forensic Pathologist Dr Rebecca Irvine. Dr Irvine determined the cause of Mr John's death was chronic lung disease.

Was Mr John provided appropriate care and treatment whilst in custody?

When a person is detained in lawful custody, it is essential that person receives appropriate care and treatment. Even when a person in custody dies of apparent natural causes an inquest is required to independently assess that adequate care and treatment was provided to the person detained.

Records from Corrective Services NSW, Villawood Detention Centre and Fairfield nursing home have been reviewed. There is no evidence to suggest Mr John was assaulted or deliberately injured prior to his death. I am satisfied there are no suspicious circumstances. Mr John was transferred from Villawood Detention Centre to Liverpool hospital then to Fairfield nursing home when his medical condition required care above that available at Villawood Detention Centre.

The medical records reviewed reveal Mr John's care and treatment were appropriate. Mr John's family have raised no issues with his care and treatment.

Conclusion

I find that Mr John died of natural causes. I find Mr John received care and treatment of an appropriate standard whilst in lawful custody of the Department of Home Affairs. I find that Mr John died at Fairfield Nursing Home on 26 November 2017.

Findings Pursuant to s 81 of the Coroners Act 2009:

Identity

The person who died was Stephen John.

Date of death

26 November 2017.

Place of death

Fairfield Nursing Home, Fairfield, New South Wales.

Cause of death

Chronic lung disease.

Manner of death

Mr John died of natural causes whilst detained in lawful custody of the Department of Home Affairs.

Les Mabbutt
State Coroner
10 July 2018