CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Chin Hung HO
Hearing dates:	7 February 2022
Date of findings:	7 February 2022
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate Brett Shields, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death
File number:	2021/00081529
Representation:	Mr. K. Jiang, Solicitor and Coronial Advocate Assisting the Coroner Ms A. Heritage, Solicitor, for Corrective Services New South Wales Ms. N. Szulgit, Solicitor, for Justice Health
Findings:	
Recommendations:	Nil
Non-publication orders:	See Annexure A

Table of Contents

Contents

Introduction

1.1. At the time of his death, Chin Hung Ho was 64 years old and in lawful custody at the Macquarie Correctional Centre facility at Wellington in New South Wales ('MCC'), serving a sentence of imprisonment.

1.2. Mr. Ho was a Chinese National from Hong Kong and he entered Australia on a tourist visa on 26 November 2015. Mr. Ho was subsequently found to be involved in the manufacture and production of prohibited drugs and he was arrested on 1 December 2015, charged with offences and ultimately sentenced to a significant term of imprisonment.

1.3. On the evening of 21 March 2021 Mr. Ho appeared at the nightly muster before going to his bed, where he read and watched television, later falling asleep. Mr. Ho left his bed twice during the night and went to the toilets. The following morning, 22 March 2021, Mr. Ho gets out of his bed at 06.10 a.m. and walks to the morning muster line at marker 135. CCTV footage shows what then occurred including Mr. Ho falling backwards onto the concrete floor and striking his head on the ground.

1.4. Correctional Officers radioed for a medical assistance and provided first aid to Mr. Ho, who was breathing but unresponsive. An Ambulance was called and the assistance to Mr. Ho continued until the Paramedics arrived and transported Mr. Ho to Dubbo Base Hospital ('the Hospital').

1.5. On admission to Hospital CT imaging studies showed extensive skull fractures with extensive subarachnoid and subdural haemorrhages. Mr. Ho was assessed as unsuitable for neurosurgical intervention and with no possible chance of recovery. After consultation with Mr. Ho's family, life support was withdrawn on 22 March 2021 and he died at 12 p.m. that day.

Reason for the inquest

1.6. The *Coroners Act* 2009 ('the Act') requires a Coroner to investigate a 'reportable death', as that term is defined in the Act, to enable a Coroner to the make the findings required by sec. 81 of the Act. The findings concern the identity of the person who died, when and where they died, and the cause and the manner of their death. In this context the manner means the circumstances in which they died.

1.7. A person charged with a criminal offence, or who is sentenced to a term of imprisonment upon conviction, can be detained in lawful custody and, in so doing, the State assumes responsibility for the care of that person. Sec. 23 of the Act makes an inquest mandatory in cases where a person dies while in the custody of the State. The open administration of justice requires, and the community appropriately expects, that the death of a person in the custody of the State will be properly and independently investigated to ensure that the State met its responsibility for the care of that person.

1.8. The coronial investigation into the death of Mr. Ho did not identify any evidence to suggest that he was not appropriately cared for and treated while in custody.

Mr. Ho's life and background

1.9. Regrettably, very little is known about Mr. Ho's life and background prior to his arrival in Australia in November 2015. Mr. Ho was born on 23 October 1956, although the place of his birth is not known. He was a Chinese National, apparently from Hong Kong, and he spoke Mandarin however he did not speak English. Mr. Ho's known family is his son Mr. Jason Zhi Ho and his sister, Ms Wei Fong Ho, who reside in Hong Kong.

1.10. In Australia Mr. Ho was classified as a non-lawful citizen and if released from criminal custody he was liable to be held in immigration detention for deportation.

Mr. Ho's custodial history

1.11. Mr. Ho first appeared before Fairfield Local Court on 2 December 2015 where he was refused bail and thereafter held on remand at the Metropolitan Remand and Reception Centre.

1.12. On 9 February 2018, Mr. Ho appeared before the District Court at Sydney for sentence for offences concerning the manufacture of prohibited drugs. He was convicted and sentenced to a term of imprisonment of 13 years and 6 months commencing on 1 December 2015 with a non-parole period of 10 years. Mr. Ho's earliest possible date for release was 30 November 2025.

1.13. Mr. Ho was given a 'B Medium' classification and he was transferred to MCC on 16 February 2018. He reclassified as 'C1 Minimum Security' on 19 March 2021, shortly before his death.

1.14. Mr. Ho had difficulties communicating with other inmates and staff at MCC and most communication occurred with the assistance of a Mandarin interpreter or other inmates who also spoke Mandarin. During 2019 Mr. Ho experienced difficulties with other inmates because of his personal practices and on 3 December 2020 he was moved to Area B, Dormitory 2, Cubicle 135, when a bed became available, and he remained there until his death. That area is dormitory style accommodation with no physical barriers between inmates who are only separated by partitions.

1.15. During his time in custody Mr. Ho had no visitors, and only limited contact with his family by telephone and audio visual link, with the last contact occurring on 10 January 2021. A further AVL meeting with his family was scheduled for 7 March 2021 however Mr. Ho declined to join the meeting.

Mr. Ho's medical history

1.16. Mr. Ho's medical history prior to his arrival in Australia is limited other than a reported diagnosis of mental illness, including schizophrenia and depression, and significant illicit drug use.

1.17. On entry into custody Mr. Ho was assessed by Justice Health and was found to be withdrawing from the use of ICE and he was placed in a safe cell and monitored for suicidal ideation. Mr. Ho was resistant to medication for his mental health issues and was not prescribed any medication. Mr. Ho was considered 'At Risk' for suicide or self-harm and the subject of mandatory notifications to correctional centres while in custody and he was appropriately monitored and reviewed.

1.18. Mr. Ho was suffering Hepatitis at the time he was transferred to MCC and was treated at Long Bay Hospital on a number of occasions in 2018 and 2019.

1.19. In September 2020 Mr. Ho was admitted to Dubbo Base Hospital for blood tests, that the clinical staff at MCC was unable to perform, following a barium swallow test to investigate progressively worsening difficulty swallowing. He was referred for an Ear, Nose and Throat review in Sydney and discharged back to MCC under the care of Justice Health.

1.20. Overall, the available evidence shows that while in custody Mr. Ho was provided with appropriate medical care to address and treat his various chronic medical conditions.

What happened on 22 March 2021?

1.21. Mr. Ho's movements on the morning of 22 March 2021 were limited, and his fall was both captured on CCTV footage and contemporaneously observed by MCC correctional officers, who immediately responded to the incident.

1.22. The CCTV footage shows:

1.22.1. Mr. Ho sleeping in his bed in POD 125;

1.22.2. At 06.10, the time of morning muster for roll call, Mr. Ho gets out of his bed and appears to stumble forward slightly and he to rests his hands against the wall. At this point he appears to be slightly hunched over;

1.22.3. Mr. Ho then stands up straight and walks from his pod to his assigned marker on the floor for morning muster;

1.22.4. At 06.11 Mr. Ho puts his hands on his head before lowering them and crossing them in front of him;

1.22.5. At 06.12 Mr. Ho puts his hands into his pants pockets;

1.22.6. At 06.13 Mr. Ho's head appears to go limp and his chin hits his chest. He then appears to fall forward, straightens, appears rigid before going limp and falling backwards onto the concrete floor and his head collides heavily against the concrete;

1.22.7. As Mr. Ho hits the concrete his knees are bent and then slowly release to become straight.

1.23. CCTV footage tracking Mr. Ho's movements in the 24 hours prior to his death shows nothing adverse.

The cause Mr. Ho's death

1.24. Mr. Ho was taken to the Department of Forensic Medicine in Newcastle where a postmortem examination was performed by Dr. Allan Cala, forensic pathologist, on 25 March 2021. Examination revealed an extensive scalp haemorrhage, fractures to the base and vault of the skull, bilateral subdural and subarachnoid haemorrhages in the frontal and anterior temporal regions, bilateral cerebral cortical contusions and lacerations, a minor abrasion of the left occiput, pulmonary emphysema, moderate coronary artery disease, left ventricular hypertrophy, gallstones and oesophageal reflux.

1.25. In the autopsy report dated 23 June 2021 Dr. Calla opined that:

1.25.1. The cause of death is a closed head injury;

1.25.2. The overall pattern of the brain injuries was typical of a heavy fall onto the back of the head;

1.25.3. The enlarged heart with left ventricular hypertrophy, due to long standing hypertension, is sufficient to explain a sudden collapse but whether it actually caused the collapse cannot be confirmed; and

1.25.4. No other cause for the collapse could be identified with certainty on autopsy.

Conclusions

1.26. The evidence establishes on the balance of probabilities that:

1.26.1. Mr. Ho died from a closed head injury sustained when he collapsed and struck his head on the concrete floor; and

1.26.2. The cause of the collapse was Mr. Ho's cardiac abnormalities.

1.27. There is no evidence to suggest that any action could have been taken by CSNSW or Justice Health to potentially alter the outcome or that any aspect of the medical care provided to Mr. Ho while in custody contributed in any way to his death.

Findings

1.28. The findings I make under sec. 81(1) of the Act are:

Identity	Chin Hung Ho
Date of death	22 March 2021
Place of death	Dubbo Base Hospital, Dubbo, New South Wales
Cause of death	Closed Head Injury
Manner of death	Misadventure

Closing

1.29. I acknowledge and express my gratitude to Mr. K Liang, Solicitor and Coronial Advocate, for his assistance both before and during the inquest. I also thank Detective Mathew Roberts for his role in the Police investigations and for his work compiling the initial brief of evidence.

1.30. On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to Mr. Ho's family.

1.31. I close this inquest.

Magistrate B.J.A Shields
Deputy State Coroner
Coroners Court of New South Wales