CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ivan Milat
Hearing dates:	16 February 2021
Date of findings:	16 February 2021
Place of findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death, notification to next of kin of death in custody
File number:	2019/337389
Representation:	Ms B Notley, Coronial Advocate Assisting the Coroner Mr A Jobe for the Commissioner of Corrective Services New South Wales Mr H Norris for Justice Health & Forensic Mental Health Network
Findings:	I find that Ivan Milat died on 27 October 2019 at the Long Bay Hospital Medical Subacute Unit, Long Bay Correctional Centre, Malabar NSW 2036. The cause of Mr Milat's death was metastatic gastro-oesophageal adenocarcinoma. Mr Milat died from natural causes whilst in lawful custody, serving a sentence of imprisonment.
Non-publication orders:	See Annexure A

Table of Contents

1. Introduction

1.1 At the time of his death, Mr Ivan Milat was 74 years old and was being held in lawful custody at Long Bay Hospital, within Long Bay Correctional Centre. He was serving a custodial sentence of life imprisonment for a number of extremely serious offences which had been imposed on 27 July 1996.

1.2 In the early hours of the morning on 27 October 2019 Mr Milat was found unresponsive in his cell with no signs of life. In accordance with standing not for resuscitation orders, no cardiopulmonary resuscitation was initiated and Mr Milat was later pronounced life extinct.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of 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.

2.3 A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr Milat was not appropriately cared for and treated whilst in custody.

3. Mr Milat's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.2 Mr Milat was one of 14 children to his parents, Steven and Margaret Milat. He was born and raised in Liverpool, New South Wales and later attended high school in the Fairfield area. Mr Milat left high school at the end of Year 8 and commenced casual welding work.

3.3 Mr Milat subsequently formed several temporary relationships during his adult years. After travelling to New Zealand, Mr Milat later returned to Australia and worked for different state government agencies.

3.4 According to his brother, William, Mr Milat enjoyed a number of hobbies including camping, target shooting, motorbike riding and reading.

3.5 William maintained contact with Mr Milat after he went into custody, and describes having a close relationship with him. In this context, William has no doubt been greatly affected by Mr Milat's passing.

4. Mr Milat's custodial history

4.1 Mr Milat's first interaction with the police occurred in 1962. Between this date and 1974 Mr Milat was charged with a number of property offences and offences of a sexual nature. On 22 May 1994 Mr Milat was arrested and charged with nine offences, including seven offences of murder. He was subsequently refused bail and remanded into the custody of Corrective Services New South Wales (**CSNSW**). On 27 July 1996 Mr Milat was convicted at the Supreme Court of New South Wales and sentenced to life imprisonment.

4.2 Following his arrest, Mr Milat was housed at a number of correctional centres throughout New South Wales. However, up until 2019 Mr Milat spent most of his time in custody at Goulburn Correctional Centre.

4.3 On 13 May 2019 Mr Milat was transferred to Long Bay Hospital following a deterioration in his health.

5. Mr Milat's medical history

5.1 Upon his reception into custody Mr Milat was noted to have no major medical concerns. Indeed, William reported that his brother had no relevant medical history.

5.2 On 5 October 2018 Mr Milat presented with gastrointestinal symptoms including intermittent painful swallowing. He was reviewed by a general practitioner (**GP**) and commenced on medication to help treat upper gastrointestinal symptoms. Mr Milat subsequently tested positive for Helicobacter pylori (a common type of microorganism usually found in the stomach) and was treated with appropriate medications on 30 November 2018. Following this Mr Milat was regularly reviewed by nursing and medical staff at Goulburn Correctional Centre.

5.3 Mr Milat's symptoms remained ongoing and he was referred to gastroenterology for further investigations, including a colonoscopy (which Mr Milat refused) and a gastroscopy (which Mr Milat agreed to). However on 18 January 2019 Mr Milat declined, against medical advice, to go to Sydney for the gastroscopy investigation. Records kept by Justice Health & Forensic Mental Health Network (**Justice Health**) indicate that Mr Milat had previously been known to cancel investigations against medical advice. As a result, Mr Milat remained at Goulburn Correctional

Centre where he was monitored and showed progressive symptoms of weight loss and swallowing difficulties.

5.4 On 1 February 2019 an advanced care directive was discussed, and later completed, with Mr Milat. On 21 August 2019 the directive was updated to indicate that Mr Milat did not wish for any active or surgical intervention, transfer to intensive care, or for cardiopulmonary resuscitation to be initiated. On 1 February 2019 Mr Milat was also again referred by a GP to Prince of Wales Hospital for a gastroenterology consultation. However on 25 February 2019 it was documented that Mr Milat refused to go to Sydney for this consultation, against medical advice.

5.5 Between February and May 2019 Mr Milat had progressive symptoms of weight loss, throat pain, difficulty swallowing and reflux. He was given symptomatic treatment and offered a soft food diet, but declined the latter. On 1 May 2019 Mr Milat agreed to a gastroscopy and arrangements were made for further pathology tests in preparation for an appointment with a GP on 8 May 2019. At this appointment Mr Milat's progressive symptoms were noted and he was referred urgently to Prince of Wales Hospital for further investigations.

5.6 Mr Milat was subsequently transferred to Sydney and admitted to Prince of Wales Hospital between 13 and 27 May 2019 for further investigation of his weight loss and progressive swallowing difficulties. Mr Milat underwent a diagnostic gastroscopy on 14 May 2019 and other investigations including computed tomography (**CT**) scans of the neck, chest, abdomen and pelvis, and a positron emission tomography (**PET**) scan. He had a lymph node biopsy on 17 May 2019 that indicated metastatic poorly differentiated adenocarcinoma.

5.7 On 21 May 2019 Mr Milat underwent a palliative oesophageal stent in order to ease his swallowing difficulties. Following this, Mr Milat was referred to radiation oncology and underwent palliative radiation treatment which was later completed on 7 June 2019.

5.8 On 6 June 2019 Mr Milat was reviewed by the palliative care team at the Long Bay Correctional Centre Medical Subacute Unit (**MSU**). The MSU worked collaboratively with Prince of Wales Hospital to support comfort measures during Mr Milat's oncology treatment.

5.9 On 27 June 2019 Mr Milat was seen by the oncology department at Prince of Wales Hospital and offered palliative chemotherapy for the metastatic oesophageal cancer. It was explained to Mr Milat that the metastatic cancer was incurable and that chemotherapy treatment was offered only with the aim of prolonging life and maintaining quality of life. Mr Milat was advised that the treatment had a response rate of 30 to 40 percent and a life gain measured in months.

5.10 Between May and October 2019 Mr Milat was admitted to the MSU on six occasions. Between these admissions Mr Milat continued to be treated at Prince of Wales Hospital. Mr Milat's last admission to the MSU was between 22 and 27 October 2019.

6. The events of 27 October 2019

6.1 During the morning of 26 October 2019 Mr Milat was observed hourly by nursing staff in the MSU. The cell in which he was housed was located directly opposite the nurse's station. During the

evening medication round Mr Milat indicated that he sought medication to assist with anxiety and pain relief. Mr Milat was administered these medications at about 9:30pm, and he was then left by nursing staff sitting up in bed with the light on.

6.2 Following this, visual observations of Mr Milat were performed hourly. At 3:00am on 27 October 2019 Mr Milat was checked on by CSNSW and Justice Health staff and appeared to be asleep in bed. However, during a subsequent visual observation performed at around 4:05am Mr Milat was seen to be not breathing.

6.3 Justice Health nursing staff performed investigations using an oxygen saturation machine which recorded no heartbeat or oxygen level. A palpable carotid pulse could not be found and Mr Milat showed no heart sounds or breathing. There was no response to centralised stimuli and it was noted that Mr Milat's pupils were fixed and dilated. As Mr Milat had a standing not for resuscitation order, cardiopulmonary resuscitation was not commenced and Mr Milat was subsequently pronounced life extinct at 4:07am.

7. What was the cause of Mr Milat's death?

7.1 Mr Milat was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Rianie Janse Van Vuuren on 30 October 2019. Postmortem imaging showed large pericardial and pleural effusions with single vessel coronary artery calcification. Features suggestive of lymphangitis carcinomatosa were present in the sub pleural septal area. Multiple sclerotic bone metastases were also noted.

7.2 Ultimately, in the autopsy reported dated 8 July 2020, Dr Van Vuuren opined that the cause of Mr Milat's death was metastatic gastro-oesophageal adenocarcinoma.

8. Other matters considered during the coronial investigation

8.1 As part of the coronial investigation a statement was obtained from Mr Milat's brother, William. In his statement William Milat expressed no concerns with the care and treatment provided to his brother whilst in custody. However William raised a concern that on 27 October 2019 he first learned of his brother's death when representatives from media organisations contacted him at around 5:00am. It was not until around 7:00am that an officer from the New South Wales Police Force (**NSWPF**) attended William's house and formally notify him of his brother's death.

8.2 The coronial investigation revealed that on 27 October 2019 NSWPF officers from Eastern Beaches Police Area Command (**PAC**) received a message at around 4:40am advising of Mr Milat's death. NSWPF officers subsequently attended the MSU at around 5:05am. One of the attending officers spoke to the Governor of Long Bay Correctional Centre and enquired whether Mr Milat's next of kin had been notified of the death. It was indicated that notification had not yet occurred and William's details were provided. At around 5:45am arrangements were made for NSWPF officers at Camden PAC to notify William of his brother's death. At around 7:00am a NSWPF officer attended William's residence and notified him of Mr Milat's death and passed on her condolences.

8.3 As the above events were occurring, Jodie Minus, the on-call CSNSW Media Officer was notified of Mr Milat's death at 4:26am. Between 4:49am and 5:32am Ms Minus received a number of phone calls which she believed to be from various media organisations. Whilst Ms Minus was surprised at the number of phone calls so soon after Mr Milat's death, she noted that it was not uncommon for media organisations to quickly obtain information relating to Mr Milat given the high profile nature of the offences for which he had been imprisoned.

8.4 At 5:40am on 27 October 2019 an email statement was sent by the CSNSW media unit to a number of media organisations confirming that Mr Milat had died at about 4:07am earlier that morning. It is therefore evident that the CSNSW statement was issued before William had been notified of his brother's death by the NSWPF.

8.5 Section 13.3 of the CSNSW *Custodial Operations Policy and Procedures* (**COPP**) provided that a death in custody must be immediately reported by CSNSW to the nearest police station by telephone. Following this, the NSWPF is responsible for notifying the deceased inmate's next of kin or emergency contact person of the inmate's death. As at 27 October 2019 it was not CSNSW policy to confirm that the NSWPF had notified a next of kin of an inmate death prior to a media release being issued.

8.6 However, Michael Duffy, the Director of the CSNSW Media and Communications Unit, explained in his statement that to the best of his knowledge, CSNSW had not previously experienced a situation prior to 27 October 2019 where media organisations became aware of the death of an inmate so soon after it occurred. Mr Duffy explained that usual practice normally allowed for sufficient time between the death of an inmate and the media becoming aware of such a death for NSWPF officers to notify a next of kin of the death.

8.7 Since Mr Milat's death, CSNSW has amended the COPP to provide that if CSNSW are approached by the media about a death in custody, the death will only be confirmed after obtaining confirmation from the relevant authorities that the inmate's next of kin or emergency contact person has been notified of the death.

9. Conclusions

9.1 Having regard to the relevant Justice Health and CSNSW records regarding Mr Milat's incarceration, and the findings from the postmortem examination, it is evident that Mr Milat died as a result of natural disease process. From October 2018 appropriate investigations were conducted to investigate Mr Milat's symptoms and presenting complaints. When Mr Milat's condition deteriorated he was appropriately transferred to the MSU. Following investigations performed at Prince of Wales Hospital, which resulted in a terminal diagnosis, appropriate measures were put in place to provide palliative care for Mr Milat.

9.2 The evidence establishes that Mr Milat was provided with an adequate and appropriate level of medical care during his period in custody. There is no evidence to suggest that any aspect of Mr Milat's medical care, or the care provided by CSNSW staff, contributed in any way to his death.

9.3 In addition, there is demonstrated evidence that appropriate changes have been made by CSNSW to ensure that where a death in custody occurs, the next of kin or emergency contact person of the inmate who has died is appropriately notified before confirmation of the death is provided to any media organisation. This will avoid the regrettable consequence of an inmate's next of kin or emergency contact person being informed of the death through the media or a third party.

10. Findings

10.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Brooke Notley, Coronial Advocate, for her excellent assistance both before, and during, the inquest. I also thank Plain Clothes Senior Constable Luke McNaughton for his role in the police investigation and for compiling the initial brief of evidence.

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

Identity
The person who died was Ivan Milat.

Date of death
Mr Milat died on 27 October 2019.

Place of death
Mr Milat died at the Long Bay Hospital Medical Subacute Unit, Long Bay Correctional Centre, Malabar NSW 2036.

Cause of death
The cause of Milat's death was metastatic gastro-oesophageal adenocarcinoma.

Manner of death
Mr Milat died from natural causes, whilst in lawful custody serving a sentence of imprisonment.

10.3 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Mr Milat's family for their loss.

10.4 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
16 February 2021
Coroners Court of New South Wales

Inquest into the death of Ivan Milat

File Number: 2019/337389

Annexure A

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

1. The names, addresses, phone numbers and other personal information of any person who visited Mr Milat while in custody (other than legal representatives or visitors acting in a professional capacity).

2. 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 Milat.

3. Direct contact details and/or serial numbers of CSNSW Officers.

4. Notations on Mr Milat's Case Management File detailing security intelligence gathered by CSNSW's in respect of escape attempts.

5. Footage and still images taken from CCTV and hand-held video footage.

6. The following portions of the CSNSW Custodial Operations Policy and Procedures '13.3 Deaths in custody':

   (a) Page 6, sub-section 2.4, third sentence; and
   (b) Page 12, sub-section 6.1, the contact number of the Aboriginal Strategy and Policy Unit.

Pursuant to section 65(4) of the *Coroners Act 2009*, a notation is to 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.

Magistrate Derek Lee
Deputy State Coroner
16 February 2021
Coroners Court of New South Wales