
**CORONER'S COURT**
**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of Barry Faulkner |
| **Hearing dates:** | 24 July 2023 |
| **Date of Findings:** | 24 July 2023 |
| **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 |
| **File number:** | 2020/26654 |
| **Representation:** | Dr C Palmer, Counsel Assisting, instructed by Ms S Crellin (Crown Solicitor's Office)<br><br>Ms C Dunn for the Commissioner of Corrective Services New South Wales<br><br>Ms K Guilford for Justice Health & Forensic Mental Health Network |
| **Findings:** | Barry Faulkner died on 25 January 2020 at Long Bay Correctional Complex, Matraville NSW 2036.<br><br>The cause of Mr Faulkner's death was ischaemic and valvular heart disease with chronic pulmonary disease being a significant condition contributing to the death.<br><br>Mr Faulkner died from natural causes, whilst in lawful custody on remand. |
| **Non-publication orders:** | See Annexure A |

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## 1. Introduction

1.1 Barry Faulkner was in lawful custody at a correctional centre at the time of his death on 25 January 2020. After collecting his lunch on that day, Mr Faulkner returned to his cell and lay down on his bed. Mr Faulkner was later heard and seen to be in distress and in need of medical assistance. Mr Faulkner's cellmate requested this assistance and correctional and nursing staff attended the cell immediately, followed by NSW Ambulance paramedics a short time later. Resuscitation efforts were initiated but Mr Faulkner could not be revived and was, tragically, 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. This type of examination typically involves consideration of, where relevant, the conduct of staff from Corrective Services New South Wales (**CSNSW**) and Justice Health & Forensic Mental Health Network (**Justice Health**). It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr Faulkner was not appropriately cared for and treated whilst in custody.

2.4 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

## 3. Mr Faulkner'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 Faulkner was born in Sydney to Geoffrey Faulkner and Lillian Maude Faulkner. He was the youngest of nine siblings. Sadly, as a child, Mr Faulkner had no fixed place of abode. Mr Faulkner also did not have permanent accommodation prior to entering custody.

3.3 It does not appear that Mr Faulkner ever married. However, at some stage Mr Faulkner formed a relationship with Renee Hunter. In addition, at some stage Mr Faulkner had a daughter named Nicole. The New South Wales Police Force have been unable to locate either Ms Hunter or Nicole.

3.4 One of Mr Faulkner's sisters, Cheryl, has expressed the view that Mr Faulkner may have been adopted and describes a family history of myotonic dystrophy. Some information available to the inquest indicates that Mr Faulkner identified as an indigenous man. Conversely, other information indicates that Mr Faulkner did not identify as Aboriginal or Torres Strait Islander. Sadly, little else is known about Mr Faulkner's family history and personal background.

3.5 There is no doubt that Mr Faulkner's family members and loved ones still feel his loss most deeply.

## 4. Mr Faulkner's custodial history

4.1 Between the ages of 16 and 70, Mr Faulkner was convicted of a number of criminal offences, many of which resulted in custodial sentences. These offences related to dishonesty offences, sexual assault offences and offences of violence.

4.2 On 30 April 2018, Mr Faulkner was charged with an offence of using a carriage service for child pornography. He was initially granted bail but later breached bail by allegedly committing a further identical offence on 6 May 2019. Following this, Mr Faulkner was bail refused and remanded in custody at Long Bay Correctional Centre. Trial and sentence proceedings for these two offences were listed for 19 March 2020 in the District Court.

## 5. Mr Faulkner's medical history

5.1 Mr Faulkner had a complex medical history, including cerebrovascular accident, deep vein thrombosis, asthma, osteoarthritis, pulmonary emphysema, cardiovascular disease, chronic obstructive pulmonary disease, type II diabetes, depression and anxiety. Mr Faulkner also previously had a carotid artery stent inserted in 2010 and was a known falls risk. Some entries in Mr Faulkner's medical records refer to symptoms of epilepsy, myotonic dystrophy, extreme clubbing in both hands and feet, numerous blood clots in his right leg, and an ulcerated lower right leg.

5.2 Due to his mobility issues, Mr Faulkner used a walking frame to move around. In addition, is poor lung capacity made walking or standing for short periods of time difficult.

5.3 On 1 August 2018, Mr Faulkner was hospitalised due to a suspected medullary infarcts. He received thrombolysis and was monitored before being cleared and discharged. Five days later, on 6 August

2018, Mr Faulkner returned to hospital complaining of chest pain. He was subsequently assessed and cleared as medically fit.

5.4 After entering custody in July 2019, Mr Faulkner was housed in a two-out cell after displaying symptoms associated with his diagnosed medical conditions. Mr Faulkner required a wheelchair for movement over distances of 50 metres. On 7 August 2019, Mr Faulkner was reviewed. Due to his continuing symptoms, he remained in a two-out cell.

5.5 Between 21 August 2019 and 6 September 2019, Mr Faulkner was hospitalised for flu-like symptoms, chest pain and symptoms related to cardiovascular accident.

5.6 On 6 September 2019, Mr Faulkner was reviewed again in light of his recent hospitalisation. It was noted that he was to be observed for signs of dizziness, shortness of breath and slurred speech and that any concerns should be raised with Justice Health nursing staff.

5.7 Between 7 September 2019 and 17 October 2019, Mr Faulkner experienced minor seizures resulting in brief confusion, disorientation and worsening chronic mild paralysis to the left side of his body.

5.8 On 18 October 2019, Mr Faulkner was taken to the Long Bay correctional Centre clinic. Whilst waiting to collect his medication, Mr Faulkner experienced a loss of consciousness and was taken to hospital. He was found to have symptoms including shortness of breath, chest pain, headaches and slurred speech. Following a period of admission, Mr Faulkner was discharged on 23 October 2019.

5.9 Following formal assessments, Mr Faulkner was transferred to the Kevin Waller Unit (a specialist unit for aged and frail inmates) on 17 December 2019. On 22 December 2019, arrangements were put in place for Mr Faulkner to not be housed alone in his cell.

5.10 On 20 January 2020, Mr Faulkner complained of throbbing leg pain and numbness from under his right knee. He was seen by nursing staff and referred for an ultrasound to investigate any difficulties with blood flow.

5.11 On 22 January 2020, a nurse reviewed Mr Faulkner for lower leg pain and oedema. Mr Faulkner's vital signs were found to be within normal limits. He was again referred for an urgent ultrasound to exclude the possibility of deep vein thrombosis.

5.12 On 23 January 2020, an ultrasound of Mr Faulkner's right leg was performed. Mr Faulkner was observed to comply and stable.

## 6. What happened on 25 January 2020?

6.1 In the week prior to 25 January 2020, Mr Faulkner cellmate observed that Mr Faulkner was coughing significantly more than usual. During this period Mr Faulkner also appeared to be more dependent upon oxygen therapy, which was administered from a machine next to his bed.

6.2 At around 9:35am on 25 January 2020, Mr Faulkner was reviewed and his vital signs were found to be within normal parameters. Nil changes were noted regarding his leg swelling and no signs of shortness of breath were observed.

6.3 At about 12:00pm on 25 January 2000, Mr Faulkner attended the lunch area in the Kevin Waller Unit with a number of other inmates. After collecting his lunch, Mr Faulkner returned to his cell. However on his way back, Mr Faulkner spoke with another inmate, indicated that he did not feel like eating and offered the inmate some of his lunch.

6.4 After returning to his cell, Mr Faulkner lay down on his bed. His cellmate was also lying on his bed and later fell asleep. Mr Faulkner's cellmate woke at around 1:33pm and heard Mr Faulkner "*gurgling*". Mr Faulkner's cellmate described Mr Faulkner as "*shaking like he was having a fit […] It was like he was choking on something*". Mr Faulkner's cellmate attempted to move Mr Faulkner onto his side but was unable to do so.

6.5 Realising that Mr Faulkner required medical assistance, the cellmate first attempted to use the cell call alarm and then sought the assistance of another inmate to call Justice Health. This inmate went to the clinic and notified the nurse on duty, Registered Nurse (**RN**) Scott Lea. The cellmate subsequently spoke to a CSNSW officer who answered the cell call arm and indicated that Mr Faulkner was unable to breathe properly and that he was "*having a fit*".

6.6 RN Lea and two CSNSW officers arrived at Mr Faulkner cell at 1:35pm. RN Lea left briefly to obtain an oxygen mask which was placed on Mr Faulkner's face. At 1:41pm, Mr Faulkner was taken out of the cell by wheelchair and transported to the satellite clinic within the Kevin Waller unit.

6.7 Shortly after arriving at the clinic, Mr Faulkner went into cardiac arrest. RN Lea commenced cardiopulmonary resuscitation and an ambulance was called at 1:46pm. Two NSW Ambulance (**NSWA**) crews arrived at 2:04pm and 2:12pm, respectively. NSWA paramedics continued the resuscitation efforts. Mr Faulkner was intubated and administered adrenaline. An automated external defibrillator was applied which indicated that Mr Faulkner was in asystole with no shockable rhythm. Despite continued resuscitation efforts, Mr Faulkner could not be revived and was pronounced life extinct at 2:22pm.

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

7.1 Mr Faulkner was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Elsie Burger, forensic pathologist, on 3 February 2020. This identified the following relevant findings:

(a) severe calcification and narrowing of the aortic valve of the heart, with a small area in the valve where a clot may have dislodged;

(b) significant (70%) stenosis of all three coronary arteries due to calcified atherosclerosis with numerous foci of fibrosis in the myocardium;

(c) cardiomegaly (an enlarged heart) and myocyte hypertrophy (thickening of the heart muscle); and

(d) very significant emphysematous changes, together with fibrosis and changes suggestive of chronic bronchitis noted in the lungs.

7.2 In the autopsy report dated 21 December 2020, Dr Burger opined that the cause of Mr Faulkner's death was ischemic and valvular heart disease, with chronic pulmonary disease being a significant condition contributing to the death.

## 8. Care and treatment provided to Mr Faulkner

8.1 The relevant records from CSNSW and Justice Health regarding Mr Faulkner's time in custody, and the findings from the postmortem examination, establish that Mr Faulkner died from progression of a natural disease process. Given his frailty, Mr Faulkner was housed appropriately in a specialist unit and additional precautions were taken to have Mr Faulkner housed in a two-out cell. Indeed, when Mr Faulkner's cellmate observed that Mr Faulkner was displaying unusual symptoms on 25 January 2020, appropriate steps were taken to alert and seek assistance from Justice Health staff. There is no evidence to suggest that the emergency response to Mr Faulkner's cardiac arrest on 25 January 2020 was anything other than appropriate, or that any different treatment could have prevented Mr Faulkner's death.

8.2 Overall, the available evidence indicates that Mr Faulkner was provided with appropriate medical care, to address and treat his medical conditions, whilst in custody. There is no evidence to suggest that any action could have been taken by CSNSW or Justice Health staff to potentially alter the eventual outcome. There is also no evidence to suggest that any aspect of Mr Faulkner' medical care, or the care provided by CSNSW and Justice Health staff, contributed in any way to his death.

## 9. Findings

9.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Dr Claire Palmer, Counsel Assisting, and her instructing solicitors, Ms Sarah Crellin and Ms Avani Khandhar from the Crown Solicitor's Office. I acknowledge the assistance that they have provided throughout the coronial investigation, and the sensitivity and empathy that they have shown during all stages of the coronial process.

9.2 I also thank Plain Clothes Constable Kasey Watler for their role in the police investigation and for compiling the initial brief of evidence.

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

***Identity***

The person who died was Barry Faulkner.

***Date of death***

Mr Faulkner died on 25 January 2020.

***Place of death***

Mr Faulkner died at Long Bay Correctional Complex, Matraville NSW 2036.

***Cause of death***

The cause of Mr Faulkner's death was ischaemic and valvular heart disease with chronic pulmonary disease being a significant condition contributing to the death.

***Manner of death***

Mr Faulkner died from natural causes, whilst in lawful custody on remand.

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

9.5 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
24 July 2023
Coroners Court of New South Wale

**Inquest into the death of Barry Faulkner**
File Number: 2020/26654

**Annexure A**

**Non-Publication Orders**

1. Pursuant to section 74(1)(b) of the *Coroners Act 2009* (the Act), the following material contained within Exhibit 1 is not to be published:

   (a) the names, addresses, phone numbers and other personal information that identifies or might identify any family member or friend of Mr Faulkner's (other than legal representatives or persons acting in a professional capacity);

   (b) the names, Master Index Numbers and other personal information of any persons in the custody of Corrective Services New South Wales (CSNSW), other than Mr Faulkner;

   (c) stills of CCTV footage; and

   (d) portions of the Custodial Operations Policy and Procedure (COPP) as follows:

      (i) COPP - 3.10 Aged and frail inmates (version 1.1) – at [3.1] on page 8: email address of the Court Escort Security Unit; and

      (ii) COPP 6.1 JH&FMHN Notifications (version 1.0 and version 1.1) – at [3.1] on page 6: fourth dot point

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 section 65(2) of that Act for access to any 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
24 July 2023
Coroners Court of New South Wales