STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Philip William WALKER
Hearing dates:	17 June 2025
Date of findings:	17 June 2025
Place of findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Kasey Pearce, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in Corrective Services NSW custody – whether care and treatment concerns
File number:	2024/00051676
Representation:	Sgt Scott Perry, Coronial Advocate Assisting the Coroner Ms T Nair of Department of Communities and Justice, Legal, for Corrective Services NSW Ms K Guilford for Justice Health and Forensic Mental Health Network
Non-publication order	A non-publication order has been made pursuant to section 74(1) of the Coroners Act 2009 (NSW) in relation to certain material contained within the brief of evidence. A copy of this order is on the Registry file.
Findings:	Philip William Walker died on 9 February 2024 at Prince of Wales Hospital, Randwick, NSW, 2031 The cause of Mr Walker's death was aspiration pneumonia complicating retropharyngeal plasmacytoma, cervical myelopathy, chronic obstructive pulmonary disease and atrial fibrillation. Mr Walker died of natural causes while in the lawful custody of Corrective Services New South Wales serving a sentence of imprisonment.

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1 Introduction

1.1 Philip Walker was in the lawful custody of Corrective Services NSW (**CSNSW**) serving a sentence of imprisonment at the time of his death on 9 February 2024. He had a complex medical background which meant that since 1 July 2019 he had been cared for at the Long Bay Hospital Aged Care and Rehabilitation Unit. On 6 February 2024 Mr Walker was transferred by ambulance to Prince of Wales Hospital (**POWH**) after he was 'seen to be unwell.'

1.2 On admission, Mr Walker was commenced on intravenous antibiotics and supported with oxygen. Unfortunately, his condition deteriorated, and he made it clear that he did not want any further investigations or treatment. At approximately 10:10 pm on 8 February he was noted to be unconscious with laboured breathing. He was provided with comfort care only in accordance with his existing end of life plan. Mr Walker was declared life extinct at 1:54 am on 9 February.

2 Why was an inquest held?

2.1 A coroner is responsible for investigating all reportable deaths. This investigation is conducted primarily so that a coroner can answer questions that are required to be answered pursuant to section 81 of the Coroners Act 2009 (**the Act**), namely, the identity of the person who died, when and where they died, and the cause and the manner of that person's death.

2.2 When a person is sentenced to a term of imprisonment, they are lawfully detained in the custody of CSNSW until their sentence has been served. By depriving that person of their liberty, CSNSW assumes responsibility for the care of that person as the person is unable to independently take steps to seek medical assistance or other care. The combined effect of sections 23 and 27 of the Act is that it is mandatory for a Senior Coroner to hold an inquest where a person dies while in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated to ensure that CSNSW has cared for a person in its custody in a reasonable and appropriate way. In this case, there is no suggestion that CSNSW cared for Mr Walker in anything other than a reasonable and appropriate way.

2.3 The coronial process represents an intrusion by the State into what is usually one of the most traumatic events in the lives of those who have lost someone close to them. An inquest by its very nature unfortunately compels the family and friends of a deceased person to re-live events often several years after their loved one's death, and to do so in a public forum. This is an entirely foreign, and sometimes distressing, experience for those who are dealing with the loss of a loved one.

3 Mr Walker's life

3.1 Coronial proceedings are as much about life as they are about death. The coronial system exists because as a society we acknowledge that all human life is both priceless and fragile. Before we move to a consideration of the circumstances of Mr Walker's death, it is therefore important to briefly acknowledge the facts of his life.

3.2 Philip Walker was born on 11 July 1946, in Arncliffe, the eldest of nine children. His father was a maintenance engineer, working on the railways around NSW. Because of this, Mr Walker's family moved often during his childhood.

3.3 Mr Walker had a long-standing interest in art, photography, and trains, and was actively involved in the Christian Brethren community, in teaching scripture and Sunday School.

3.4 He married in 1965 and had four children, although he became estranged from them following his divorce in 1986. In the late 1980s he began a long-term relationship with another woman. They remained living together until his arrest in 2016.

3.5 Mr Walker's brothers and sisters continued to support him after his arrest and during his time in CSNSW custody. He was visited regularly by several of his siblings and his brother-in-law over the years between his arrest in 2016 and his sentencing in 2019. It appears, however, that Mr Walker cut ties with most of his siblings in early 2020, although he seems to have maintained contact with two of his sisters.

4 Mr Walker's custodial history

4.1 Mr. Walker was arrested 16 June 2016 and charged with numerous historical child sexual offences and child abuse material offences. He was refused bail.

4.2 On 6 November 2019, Mr Walker was sentenced at the Downing Centre District Court to a term of imprisonment totalling 22 years, with a period of 16 years in full time custody before he was eligible to apply for parole. His earliest possible release date was 15 June 2032.

4.3 Due to the nature of his offences, Mr Walker was classified as a Serious Offender and placed in Special Management Area Placement for his own protection.

4.4 Mr Walker had a complex medical background including oropharyngeal dysphasia with nasogastric feeds, chronic obstructive pulmonary disease, hypertension, ischaemic heart disease, osteoarthritis (with spinal canal stenosis), atrial fibrillation, and frailty. The dysphagia followed previous oropharyngeal carcinoma (retropharyngeal plasmacytoma) resection in 2012, followed by radiotherapy, recurrence, further resection and more radiotherapy.

4.5 These conditions required long-term, specialised care that could not be provided in a standard correctional facility. Mr Walker took a variety of medications to manage these conditions.

4.6 On 1 July 2019 Mr Walker was transferred to Long Bay Hospital Aged Care and Rehabilitation Unit for ongoing care, where he remained until his transfer to POWH shortly before his death. He was wheelchair dependent and described by CSNSW staff as 'an aged and frail inmate with numerous medical needs.'

5 The events of 6 February 2024 to 9 February 2024

5.1 About 10:04 am on 6 February 2024, Mr Walker was transported by ambulance from Long Bay Correctional Centre to POWH after suffering multiple episodes of vomiting and nausea.

5.2 On arrival, he was hypoxic and hypotensive and was diagnosed with aspiration pneumonia.

5.3 Despite treatment with intravenous antibiotics, oxygen, and cardiac medications, his condition continued to deteriorate.

5.4 On 8 February, a palliative care review was conducted. Mr Walker made it clear that he did not want any further investigations or treatment, and he was transitioned to comfort care only.

5.5 At approximately 10:10pm on 8 February, Mr Walker was noted to be unconscious with laboured breathing. At 12:02am on 9 February, CSNSW officers observed that he had stopped breathing. Medical staff were summoned, and he was formally declared deceased at 1:54am.

6 What was the cause of Mr Walker's death

6.1 Mr Walker was later taken to the Department of Forensic Medicine where a postmortem examination was performed on 19 February 2024 by forensic pathologist, Dr Issabella Brouwer. This identified the following relevant findings:

(a) no significant recent injuries
(b) an acute inflammatory process in the lungs;
(c) a single focus of calcification in the left anterior descending coronary artery;
(d) degenerative changes in the lumbar spine and hips;
(e) evidence of previous surgical intervention at the level of C2/3

6.2 In the autopsy report dated 3 March 2024 Dr Brouwer opined that the cause of Mr Walker's death was presumed aspiration pneumonia complicating retropharyngeal plasmacytoma and the treatment thereof, cervical myelopathy and the treatment thereof, chronic obstructive pulmonary diseases, and atrial fibrillation.

7 Care and treatment provided to Mr Walker

7.1 The relevant records from CSNSW and Justice Health regarding Mr Walker's time in custody, and the findings from the postmortem examination, establish that Mr Walker died from progression of a natural disease process. The records also establish that Mr Walker was appropriately transferred to POWH when it appeared that he had become acutely unwell.

7.2 During his final admission to POWH, Mr Walker's condition continued to deteriorate and, due to his poor prognosis, it was agreed that only comfort care measures would be put in place.

7.3 Overall, the available evidence indicates that while in custody, Mr Walker was provided with appropriate medical care to address and treat his medical conditions. 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 Walker's medical care, or the care provided by CSNSW and Justice Health staff, contributed in any way to his death.

7.4 An inquest is mandatory because Mr Walker died whilst in the custody of CSNSW. However, unlike most other inquests, no issues apart from the statutory requirements pursuant to section 81 of the Act were identified from the coronial investigation which required discrete examination during the inquest.

8 Findings

8.1 Before turning to the findings that I am required to make, I would like to acknowledge and express my gratitude to Coronial Advocate Assisting the Coroner, Scott Perry, for all the work he has done in investigating this matter and preparing it for inquest.

8.2 I also thank Detective Senior Constable Patrick Burns for his role in the police investigation and for compiling the initial brief of evidence.

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

Identity

The person who died was Philip William Walker.

Date of death

Mr Walker died on 9 February 2024.

Place of death

Mr Walker died at Prince of Wales Hospital, Randwick NSW 2031.

Cause of death

The cause of Mr Walker's death was aspiration pneumonia complicating retropharyngeal plasmacytoma, cervical myelopathy, chronic obstructive pulmonary disease and atrial fibrillation.

Manner of death

Mr Walker died of natural causes while in the lawful custody of Corrective Services New South Wales serving a sentence of imprisonment.

8.4 On behalf of the Coroner's Court of New South Wales I offer my sincere and respectful condolences to Mr Walker's family and loved ones for their loss.

8.5 I close this inquest.

Magistrate Kasey Pearce

Deputy State Coroner

17 June 2025

Coroners Court of New South Wales