CORONER'S COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of Stephen Paul Bourke
Hearing dates:	3 February 2025
Date of findings:	3 February 2025
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate David O'Neil, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody – mandatory inquest – natural death
File number:	2023/00229298

Representation:

Mr Winter-Mirenzi; Coronial Advocate assisting

Ms Bellamy for the Commissioner of Corrective Services

Ms Guildford for the Justice Health and Forensic Mental Health Network

Findings:

I make the following findings in relation to the death of Mr Bourke, pursuant to s 81 of the *Coroners Act 2009* (NSW):

Identity:

The person who died is Stephen Paul Bourke

Date of death:

Mr Bourke died on the 18th of July 2023

Place of death:

Mr Bourke died at Prince of Wales Hospital Randwick, NSW

Cause of death:

Mr Bourke's death was caused by a liver abscess and the complications thereof on the background of a pancreatic adenocarcinoma

Manner of death:

Mr Bourke died of natural causes whilst in lawful custody

Non-Publication Orders

A non-publication order prohibiting the publication of certain evidence pursuant to the Coroners Act 2009 has been made in this inquest. A copy of these orders, and corresponding orders pursuant to section 65 of the Act, can be found on the Registry file.

Introduction

1 On the 3rd of February 2025 an inquest was held into the death of Mr Stephen Paul Bourke. Mr Bourke died on the 18th of July 2023 at the age of 67. At the time of his death, he was in the custody of Corrective Services NSW (CSNSW).

2 Because Mr Bourke was in custody at the time he died, this inquest is mandatory; (Coroners Act 2009 ("the Act"), s. 23(1)(d)(ii), s. 27(1)(b)).

3 When someone is in lawful custody they are deprived of their liberty, and the State assumes responsibility for the care and treatment of that person. In such cases the community has an expectation that the death will be properly and independently investigated.

The coroner's role

4 An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death. It is not the purpose of an inquest to blame or punish anyone for the death. The fact of holding an inquest does not imply that anyone is guilty of wrongdoing.

5 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the Act, namely;

(1) The person's identity;

(2) The date and place of the person's death; and

(3) The manner and cause of the person's death.

6 Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

7 Prior to holding the inquest a coronial investigation was undertaken. The OIC compiled a brief of evidence and a report was obtained from a forensic pathologist as to the cause of death, in addition an investigation into Mr Bourke's death was conducted on behalf of Corrective Services. The result of that was a Serious Incident Report which found that Mr Bourke was managed in accordance with Corrective Services NSW policy prior to and after his death.

8 The investigation conducted by Plain Clothes Senior Constable Jasmine McIlveen obtained documents which form part of the brief of evidence tendered during the inquest, including the OIC's statement, the Serious Incident Report, and medical records relating to Mr Bourke.

BACKGROUND

9 Mr Bourke was born on 24 February 1956 in Merewether, New South Wales. He was one of five children. When Mr Bourke was ten years old his eldest brother died in an automobile crash. This death impacted greatly upon all members of Mr Bourke's family. At some stage during his childhood Mr Bourke was sexually assaulted. This

assault was disclosed to his brother Robert, however further details of the assault are not known.

10 Mr Bourke worked as a chef, working predominantly in hospitality throughout his working life. He never married and his family was unaware of any partners he may have had. Later in life he purchased a motorhome and began travelling. In the late 1990s he worked as a caretaker on a large property in Dora Creek New South Wales. There were several dwellings on the property in which foster children would stay. Mr Bourke resided in his motorhome on the property.

CUSTODIAL HISTORY

11 Mr Bourke was charged between 1971 and 2010 on 30 occasions for various property, traffic, drug and violence offences. He spent time in custody from 14 December 1994 to 13 December 1995. On 30 April 2017 after a lengthy investigation Mr Bourke was arrested and charged with 15 offences of historic child sexual abuse. In August 2017 he was charged with a further 11 offences of the same nature. All offences were alleged to have been committed upon foster children who had resided at the Dora Creek property during the time he was the caretaker. On 12 April 2019 Mr Bourke was convicted of a number of these child sexual assault offences which had occurred between 1995 and 2010 at Dora Creek. He was sentenced to 12 years imprisonment commencing 30 April 2017 and to expire on 29 April 2029. The non-parole period for those offences was nine and a half years.

12 On 11 October 2019 Mr Bourke was sentenced for another sexual assault upon a foster child at Dora Creek. It is unclear why this matter was finished separately to his other matters. For this matter Mr Bourke was sentenced to four years and six months imprisonment commencing on 29 October 2025 and concluding on 28 April 2030. The non-parole period of 12 months was to end on 28 October 2026. Following his sentence being imposed Mr Bourke was moved from Parklea Correctional Centre where he had been as a remand inmate to Long Bay Correctional Centre. At his request Mr Bourke was a long-term protection inmate due to the nature of his offences. I am satisfied - as are Mr Bourke's family - that there are no care and treatment

concerns during Mr Bourke's period of incarceration. All the evidence suggests that he was cared for appropriately at all times.

MEDICAL HISTORY

13 Mr Bourke suffered longstanding coronary artery disease. He had a bypass graph in 1988, and a further procedure in 2009 to open blocked arteries. This procedure is known as a percutaneous coronary intervention. Mr Bourke was diagnosed with bladder cancer and type 2 diabetes in 2006. He suffered from a stroke in 2011, and a cyst on his spinal cord in 2012. He suffered from an anxiety disorder in 2016, and in 2017 prostate cancer was discovered. In 2023 a pancreatic adenocarcinoma was discovered. On 9 May 2023 a new abnormal abscess was located on his liver. On 22 June 2023 Mr Bourke was commenced on chemotherapy. The chemotherapy was not effective in slowing Mr Bourke's cancer. On 26 June 2023 Mr Bourke was admitted to Long Bay Hospital, and from there on 29 June he was transferred to the Prince of Wales Hospital at Randwick for palliative care. On 16 July 2023 Mr Bourke lost consciousness; he passed away on the morning of 18 July.

14 At autopsy it was confirmed that Mr Bourke died from a liver abscess and the complications thereof on a background of a pancreatic adenocarcinoma. He died at Prince of Wales Hospital, Randwick, New South Wales.

15 In the circumstances there is no need to make any recommendations.

Findings -- section 81 Coroners Act 2009

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Conclusion

16 I thank both the officer-in-charge Senior Constable McIlveen and the police advocate Mr Danny Winter-Mirenzi for their assistance in gathering and marshalling the

evidence, and in the conduct of the inquest. On behalf of the Coroner's Court of New South Wales I offer my sincere and respectful condolences to the family and associates of Mr Bourke.

17 I close this inquest.

Magistrate David O'Neil

Deputy State Coroner

Coroner's Court of New South Wales

3 February 2025