CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Mark LEWIS
Hearing dates:	19 November 2025
Date of findings:	19 November 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, natural causes
File number:	2024/65322
Representation:	Coronial Advocate Assisting: Danny Winter-Mirenzi NSW Department of Corrective Services: Mr Dinjar Justice Health Forensic Mental Health Network: Ms Guildford

Findings:

Identity: The person who died is Mark Lewis

Date: Mr Lewis died on 19 February 2024

Place: Mr Lewis died in Cell 6, Long Bay Hospital Aged Care Unit, NSW

Cause: The cause of Mr Lewis' death was end-stage congestive cardiac failure on a background of dilated cardiomyopathy

Manner: The manner of Mr Lewis' death was natural causes.

Non-publication order:

Orders pursuant to section 74(1)(b) of the Coroners Act 2009 prohibiting the publication of certain evidence have been made in this inquest. Orders have also been made pursuant to section 65(4) of the Coroners Act 2009. A copy of the orders can be found on the Registry file.

INTRODUCTION

1 Mr Mark Lewis died on 19 February 2024 in custody at Long Bay Hospital Aged Care Rehabilitation Unit.

2 When a person sentenced after being convicted of a criminal offence is detained in lawful custody they are deprived of their liberty, and the state assumes responsibility for the care of that person. Section 23 of the Coroners Act 2009 makes an inquest mandatory in cases where a person dies whilst in lawful custody. In Mr Lewis' case, the family and the supportive next of kin did not ask that an inquest be conducted. Nevertheless, as I have indicated, the legislation makes an inquest mandatory.

3 In such cases, the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seek to

examine the circumstances surrounding the person's death in order to ensure that the State discharges its responsibility appropriately and adequately. This is so even where the death of the person in lawful custody was due to suspected natural causes.

4 In Mr Lewis' case, the coronial investigation was conducted by Detective Senior Constable Ward. He has conducted a thorough investigation, his investigation being supplemented by the serious incident report by a Corrective Services New South Wales investigator, Mr Jesse Choy. I am satisfied, on the material, that Mr Lewis was indeed well cared for with his multiple health problems whilst in custody, and that the care delivered to him in the final stages of his life was appropriate.

BACKGROUND

5 Mr Lewis was born in the Bondi area on 17 October 1937. He had two brothers and a sister. In the 1960s, he married a woman called Mary. They had two daughters. Mr Lewis and Mary divorced in 2001. Mr Lewis' first job was working for Woolworths. He was one of the youngest store managers in Australia, at the age of 17. He is said to have had a strong work ethic and good communications skills. After a period of time, he left Woolworths and then opened a number of brothels in Sydney, ultimately owning seven.

6 On 14 February 1994, two women were murdered inside a brothel which was owned by Mr Lewis. Subsequently, Mr Lewis and two co-accused were arrested on 16 April 1997. Mr Lewis was charged with two counts of murder and sentenced on 9 June 2000 at the Supreme Court of New South Wales to one sentence of life imprisonment, and on the other count, 18 years imprisonment. The sentences commenced on 28 April 1999.

7 Mr Lewis was incarcerated at Lithgow Correctional Centre for just over 22 years.

8 Mr Lewis' health conditions included heart failure, chronic kidney disease, gastroesophageal reflux disease, type 2 diabetes, hypertension, ischemic heart disease and anxiety. Mr Lewis had a pacemaker inserted in 2012 to treat a complete atrioventricular block. He had surgery at Nepean Hospital in June 2021 to change his pacemaker box. Mr Lewis had also suffered a stroke in 2014.

9 On 23 November 2023, Mr Lewis was transferred from Lithgow Correctional Centre to Long Bay Correctional Complex in order to better manage his health problems.

10 Prior to that move, Mr Lewis had signed a New South Wales Health Advanced Care Directive on 10 November 2023. In that Advanced Care Directive, Mr Lewis indicated that he would not accept cardiopulmonary resuscitation. Separately, Mr Lewis also signed a Resuscitation Plan-Adult on 23 January 2024, in which he indicated that no CPR was to be undertaken in the event of cardiopulmonary arrest.

EVENTS AFTER TRANSFER TO LONG BAY

11 On 7 December 2023, Mr Lewis was admitted to Prince of Wales Hospital for management of his decompensating heart failure. He was discharged to the Aged Care Rehabilitation Unit at Long Bay Hospital within the Long Bay Correctional Complex on 30 December 2023, in keeping with his wish to return there for end-of-life care. He then spent some time in the Kevin Waller Unit, before returning to the Aged Care Rehabilitation Unit on 22 January 2024.

12 On 2 February 2024, Mr Lewis was transferred to Prince of Wales Hospital following an unwitnessed fall with head strike. A CT of the brain and Cervical spine demonstrated no acute abnormalities.

13 Mr Lewis declined to be admitted to cardiology and decided to return to Long Bay Hospital.

14 He was discharged but readmitted to Prince of Wales Hospital the following day in relation to bilateral lower limb cellulitis (a bacterial skin infection).

15 He was treated under the care of an infectious diseases expert and was discharged from Prince of Wales back to Long Bay Hospital on 8 February.

16 On 18 February 2024, a registered nurse recorded in her clinical entry that Mr Lewis was found to be drowsy, moaning, could no longer tolerate oral intake, and was oedematous (bodily swelling).

17 The next morning, observations were made by a registered nurse at 6.50am. Mr Lewis was unsettled and agitated. He was provided with his medication.

18 At 7.30 a registered nurse again attended upon Mr Lewis and found him to be more settled and comfortable.

19 At 7.56am the same registered nurse again attended upon Mr Lewis and found that he was pale, did not have any breath sounds, did not have any heart sounds, his pupils were fixed and dilated, he was non-responsive to centralised stimulus and did not have a palpable carotid pulse.

20 A form recording the observations and declaring Mr Lewis to be life extinct was completed on that day, 19 February 2024, confirming the results of the examination of Mr Lewis which had occurred at 7.56am.

INVESTIGATION FOLLOWING DEATH

21 Following Mr Lewis' death, detectives attached to the Eastern Beaches Police Station arrived at Long Bay Hospital at 10am. A crime scene officer examined Mr Lewis' cell and found there to be nothing unusual. At 12.38pm Detective

Senior Constable Ward and other officers searched the cell and found that the duress alarms were working correctly, and that they were positioned within reach of Mr Lewis. CCTV footage was examined and was found to be consistent with the account supplied by the correctional officers who had attended upon Mr Lewis after he was found deceased.

22 Mr Lewis' family and next of kin have raised no issues in relation to Mr Lewis' care and treatment in custody, and as I have already said, I am satisfied it was adequate. A serious incident report compiled by a principal investigator with Corrective Services New South Wales Professional Standards and Investigation section, Mr Choy, found that:

1. Mr Lewis was lawfully detained, appropriately classified and placed prior to and at the time of his death;

2. There were no issues or concerns regarding the management of Mr Lewis during his period of incarceration, or at the time of his death at Long Bay Hospital;

3. The overall response of Corrective Services New South Wales officers to the death in custody of Mr Lewis was appropriate and in accordance with departmental policies and procedures.

23 I am satisfied Corrective Services New South Wales officers acted appropriately in the period up to and after Mr Lewis' death. I am satisfied there are no suspicious circumstances at all in relation to Mr Lewis' death.

24 At post-mortem examination, pathologist Dr Sairita Maistry reported that there was no evidence of trauma externally. Post-mortem CT imaging showed an enlarged heart, coronary artery and valvular calcification, congested lungs, bilateral pleural effusions and an implanted medical device (the pacemaker). There was no acute skeletal trauma. The toxicology was non-contributory to death. Dr Maistry concluded that the cause of death was in keeping with end stage congestive cardiac failure on a background of dilated cardiomyopathy

with significant contributing conditions noted as cerebrovascular accident, hypertension, chronic renal disease and diabetes mellitus type 2.

FINDINGS UNDER s81 OF THE CORONERS ACT

25 For the above reasons, having considered all the material in the brief of evidence I make the following findings:

Identity: The person who died is Mark Lewis

Date: Mr Lewis died on 19 February 2024

Place: Mr Lewis died in Cell 6, Long Bay Hospital Aged Care Unit, NSW

Cause: The cause of Mr Lewis' death was end-stage congestive cardiac failure on a background of dilated cardiomyopathy

Manner: The manner of Mr Lewis' death was natural causes.

CLOSING

26 I thank Mr Lewis' medical next of kin for taking the role of medical next of kin and for attending the inquest. Mr Lewis appeared to be a person who was quite isolated in prison, perhaps for understandable reasons, and the medical next of kin is to be commended for the role he played in relation to Mr Lewis. I

express my sympathies to Mr Lewis' family and associates. I thank the lawyers who appeared at inquest on behalf of the institutions. It is worth noting that both agencies' staff acted commendably in relation to Mr Lewis.

27 My thanks to Detective Senior Constable Ward for his coronial investigation, followed through from beginning to end, and to Mr Winter Mirenzi, coronial advocate, for preparing the matter for inquest, assisting me in getting ready for this inquest and at inquest.

28 I close this inquest.

Magistrate David O'Neil

Deputy State Coroner

Coroners Court of New South Wales