New South Wales

CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of John Denham
Hearing dates:	29 October 2026
Date of Findings:	29 October 2026
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Judge Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death
File number:	2025/00341622
Representation:	Mr D Winter-Mirenzi, Coronial Advocate Assisting the Coroner Ms G Amal for Justice Health & Forensic Mental Health Network Ms S Walsh for the Commissioner of Corrective Services New South Wales
Findings:	John Sidney Denham died on 5 September 2025 at the Aged Care and Rehabilitation Unit at Long Bay Correctional Centre, Malabar NSW 2046. The cause of Mr Denham's death was acute pneumonia with type II diabetes mellitus, recent urosepsis, and the combined effects of hypertensive, arrhythmogenic and atherosclerotic cardiovascular disease being other significant conditions contributing to the death but not relating to the disease or condition causing it. Mr Denham died from natural causes, whilst in lawful custody serving a sentence of imprisonment.
Non-publication orders:	See Annexure A

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1. Introduction

1.1 John Denham was an 82-year-old man who had been serving custodial sentences following convictions for criminal offences. Mr Denham had been in lawful custody since 2008 and was most recently housed within an aged care unit at Long Bay Correctional Centre.

1.2 In June 2025, Mr Denham became ill and was transferred to hospital where he remained admitted for approximately two and a half months. Despite treatment, Mr Denham's condition declined over the next three months and he was eventually transitioned to end of life care.

1.3 In the early hours of the morning on 5 September 2025, Mr Denham was observed to be asleep during a routine nursing check. A short time later, Mr Denham was checked on again and found to be unresponsive and not breathing. In accordance with this and advance care directive, no resuscitation efforts were initiated and Mr Denham 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 be answered 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 seek 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 Corrective Services New South Wales (**CSNSW**) and Justice Health and Forensic Mental Health Network (**Justice Health**) staff. It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr Denham 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 Denham'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 Denham never married and had no children. Apart from a brother, Mr Denham did not remain in contact with any family members. Mr Denham's brother died in May 2025.

3.3 Mr Denham was a Catholic priest who worked in the Taree parish within the Maitland/Newcastle Diocese. He commenced as a deacon in the Mayfield parish in 1972 and worked throughout the Hunter Region until 1994.

3.4 Unfortunately, little else is known about Mr Denham's personal background.

4. Mr Denham's custodial history

4.1 On 14 August 2008, Mr Denham first entered lawful custody after being arrested and charged with numerous offences. In 2010, Mr Denham was convicted and sentenced.

4.2 On 30 November 2011, Mr Denham was charged with further offences. He later pleaded guilty to multiple offences and was convicted and sentenced to an aggregate term of 18 years imprisonment commencing on 23 January 2015 with a non-parole period of 13 years expiring on January 2028.

4.3 On 27 November 2024, Mr Denham was transferred from Bathurst Correctional Centre where he was housed at the time to the Metropolitan Remand and Reception Centre.

5. Mr Denham's medical history

5.1 Mr Denham had a history of atrial fibrillation, gout, hypertension, high cholesterol, type II diabetes mellitus and recurrent urinary tract infections. He had previously been assessed for oropharyngeal dysphagia secondary to delirium on a background of generalised acute deterioration and rhinovirus infection. Mr Denham was diagnosed with ongoing aspiration risk and was unsafe to continue with oral intake.

5.2 On 14 June 2025, Mr Denham became ill with pneumonia and was transferred to Westmead Hospital. During his admission, Mr Denham experienced prolonged delirium, raised inflammatory markers of unclear cause but thought to be most likely due to aspiration pneumonia, recurrent urinary tract infections, functional decline, worsening psychotic symptoms (paranoia and auditory hallucinations), and hypercalcaemia and hyperparathyroidism.

5.3 On 1 September 2025, Mr Denham was transferred from Westmead Hospital to Long Bay Hospital where he was housed in the Aged Care and Rehabilitation Unit (**ARU**). Mr Denham's condition continued to deteriorate.

5.4 On 3 September 2025, Mr Denham was transferred to Prince of Wales Hospital for end-of-life care following a diagnosis of sepsis, likely urinary. It was indicated that no active treatment could be provided to Mr Denham.

5.5 Mr Denham was transitioned to a palliative care pathway and returned to the ARU on 4 September 2025. All active medications for Mr Denham were ceased and he was provided with medication for comfort only.

6. The events of 5 September 2025

6.1 At around 2:15am on 5 September 2025, a Justice Health nurse checked on Mr Denham as part of routine half hourly observations. Mr Denham was found to be asleep and breathing.

6.2 At around 2:38am, the same nurse checked on Mr Denham and found him to be unresponsive and with no signs of life. In accordance with an advance care directive which indicated that Mr Denham was not for resuscitation, no resuscitation efforts were initiated. Mr Denham was later pronounced life extinct.

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

7.1 Mr Denham was subsequently taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Istvan Szentmariay, forensic pathologist, on 11 September 2025. This identified patchy airspace opacity in the left upper and both lower lobes indicative of bilateral pneumonias.

7.2 In the autopsy report dated 28 December 2025, the finalising pathologist, Dr Isabella Brouwer, opined that the cause of Mr Denham's death was acute pneumonia with type II diabetes mellitus, recent urosepsis, and the combined effects of hypertensive, arrhythmogenic and atherosclerotic cardiovascular disease being other significant conditions contributing to the death but not relating to the disease or condition causing it.

8. Care and treatment provided to Mr Denham

8.1 The relevant records from CSNSW and Justice Health regarding Mr Denham's period in lawful custody, and the findings from the post-mortem examination, establish that Mr Denham died from progression of natural disease process. It is evident that Mr Denham had been diagnosed with ongoing aspiration risk and later developed pneumonia.

8.2 Despite treatment at hospital and in custody, Mr Denham's condition continued to deteriorate and it was later determined that no active treatment could be continued. Mr Denham was then appropriately transitioned to a palliative care pathway.

8.3 Overall, the available evidence indicates that Mr Denham's medical conditions were appropriately managed whilst in custody. There is no evidence to suggest that any different management of Mr

Denham's presentations and conditions by CSNSW or Justice Health staff could have materially affected the eventual outcome.

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 Danny Winter-Mirenzi, Coronial Advocate Assisting the Coroner, for the assistance provided throughout the coronial investigation and the inquest.

9.2 I also thank Sergeant Elizabeth Toland, the NSWPF officer in charge, for her role in the NSWPF 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 John Sidney Denham.

Date of death

Mr Denham died on 5 September 2025.

Place of death

Mr Denham died at the Aged Care and Rehabilitation Unit at Long Bay Correctional Centre, Malabar NSW 2046.

Cause of death

The cause of Mr Denham's death was acute pneumonia with type II diabetes mellitus, recent urosepsis, and the combined effects of hypertensive, arrhythmogenic and atherosclerotic cardiovascular disease being other significant conditions contributing to the death but not relating to the disease or condition causing it.

Manner of death

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

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

9.5 I close this inquest.

Judge Derek Lee
Deputy State Coroner
29 October 2026

Inquest into the death of John Denham
Coroner's Court File Number: 2025/00341622
Annexure A
Non-publication orders

1. Pursuant to section 74(1)(b) of the *Coroners Act 2009* (**the Act**), the following information and documents, and any evidence given about that information and those documents, are not to be published:

   (a) The names, addresses, phone numbers, Visitor Index Numbers and any other personal information that identifies or might identify any family member, friend or associate of John Denham (other than legal representatives or visitors acting in a professional capacity);
   (b) The names, Master Index Numbers and any other personal information of any person in the custody of Corrective Services New South Wales (**CSNSW**), other than John Denham.
   (c) The personal address of John Denham prior to entering custody.
   (d) The direct contact details, including telephone numbers and email addresses, of CSNSW staff and facilities that are not publicly available;
   (e) Offender Integrated Management System (**OIMS**) usernames, employee serial numbers and staff identification numbers of CSNSW staff;
   (f) Closed Circuit Television (**CCTV**), hand-held and body-worn video camera footage, photographs and still images, captured within Long Bay Hospital;
   (g) The following information relating to the security and good order of correctional facilities:
      i. specifications and details of security equipment, such as the calibre, capacity, model and make of firearms, and the quantity and location of weapons stored;
      ii. information which reveals the inventory or quantity of CSNSW security equipment including firearms;
      iii. serial numbers assigned to security equipment.
   (h) Portions of the documents set out in the Schedule appended to this Order that describe security checks undertaken by CSNSW staff, and any references to these security checks contained in the evidence;
   (i) COPP 19.6 *Medical Escorts*.

2. A notation is to be placed on the Court file that if an application is made under section 65(2) of the Act for access to CSNSW documents on the Court file, that material shall not be provided until the Commissioner of CSNSW has had an opportunity to make submissions in respect of that application.

Judge Derek Lee
Deputy State Coroner
29 October 2026

SCHEDULE TO NON-PUBLICATION ORDERS

Document	Portion of document over which a non-publication order is made
Folio 4: Case Management File 4	• At page 7: document entitled '*Section 24(1) – Transfer to hospital or other place specified order'*, the entire contents of the box in section 8 headed '*additional/special considerations'*
Folio 4: Case Management File 6	• At pages 29, 31, 33, 35, 37, 39, 40, 42, 44, 45, 47, 49, 53, 54, 56 and 58: document entitled '*Hospital escort daily log sheet'*, the entire contents in the section headed '*Escorting officer/s details* and 'time and date duty commenced' • At page 30, 32, 34, 36, 38, 41, 43, 46, 48, 50, 52, 55, 57 and 59: document entitled '*Running Sheet'*, the times and date duties commenced and of equipment security checks in the column entitled '*Event Time & Date'*. • At page 90: the security details under heading entitled '*additional/special conditions attached to Section 24(1) Order No'*
Folio 4: Case Management File 13	• At page 61: document entitled '*Section 24(1) – Transfer to hospital or other place specified in order'*the entire contents of the box in section 8 headed '*additional/special circumstances'* • At page 63: document entitled '*Escort Assessment'*the entire contents of the box in section Part 3A entitled '*summary'* • At page 65: document entitled '*Custodial patient information for NSWH'* the entire content of the box entitled '*Summary'*
Folio 4: Case Management File 14	• At page 40: document entitled '*Section 24(1) – Transfer to hospital or other place specified in order'*the entire contents of the box in section 8 headed '*additional/special circumstances'* • At page 42: document entitled '*Escort Assessment'*the entire contents in the section entitled '*Approving officer comment'*.
Folio 4: Case Management File 16	• At pages 78, 80, 81, 83, 84, 85, 86, 88, 90, 92. and 94: document entitled *'Hospital escort daily log sheet'*the entire contents in the section headed '*Escorting officer/s details'*and the information corresponding the table '*Time and date duty commenced'* • At page 90: document entitled '*Hospital escort daily log sheet'*the shift times in the column entitled '*Event time & date'*
Folio 4: Case Management File 17	• At pages 1, 2. 4, 6, 7, 10, 13, 15, 18, 21, 22, 24, 25, 26, 27, 28, 30, 32, 34, 47, 50, 53, 56, 59, 65, 67, 69, 71, 74, 76, 78, 80, 81, 83, 85, 86, 88, 89: document entitled *'Hospital escort daily log sheet'*the entire contents in the section headed '*Escorting officer/s details'*and the information corresponding the table '*Time and date duty commenced'* • At pages 3, 5, 8, 11, 16, 19, 29, 31, 48, 51, 54, 57, 60, 62, 64, 66, 68, 70, 72, 73, 75, 77, 79, 82, 87: document entitled '*Hospital escort daily log sheet'*the shift times in the column entitled '*Event time & date'*
Folio 5: DIC Package	• At pages 7 and 8: The times in the section headed '*occurrences / incidents / special instructions'*