CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Lifa Faafete
Hearing dates:	25 March 2026
Date of findings:	25 March 2026
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate Carmel Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody-natural causes-use of interpreter in care and treatment
File number:	2025/00114625
Representation:	Coronial Advocate Assisting the Coroner: D Welsh
Findings:	**Identity of deceased**: The person who died was Mr Lifa Faafete **Date of death**: Mr Faafete died on 24 March 2025 **Place of death**: Mr Faafete died at the Prince of Wales Hospital, NSW **Cause of death**: Mr Faafete died from advanced cholangiocarcinoma **Manner of death**: Mr Faafete died of natural causes while in the lawful custody of Corrective Services NSW

Introduction

1 This inquest concerns the death of Mr Lifa Faafete at the Prince of Wales Hospital in Randwick on 24 March 2025. Mr Faafete was 69 years old.

2 At the time of his death, Mr Faafete was in the lawful custody of Corrective Services NSW ("CSNSW"), being held on remand at the Metropolitan Special Programs Centre. He had been transferred to hospital on 22 March 2025 pursuant to an order made under s 24(1) of the *Crimes (Administration of Sentences) Act 1999*.

The role of the coroner

3 A coroner is responsible for investigating all reportable deaths. An investigation is conducted primarily so that the coroner can make findings under s 81 of the *Coroners Act 2009* ("the Act") as to the identity of the deceased person and the date, place, manner and cause of their death. Under s 82 of the Act, a coroner may make recommendations in relation to any matter connected with the death if the coroner considers that it is necessary or desirable to do so. Typically, such recommendations address public health and safety issues and are aimed at preventing similar deaths from occurring in the future.

4 When a person dies in custody, ss 23 and 27 of the Act provide that an inquest is mandatory. The inquest must be held by a senior coroner. Prisoners are a vulnerable group in the community as Corrective Services NSW assumes responsibility for their care, and the person is unable to independently take steps to seek medical assistance or other care.

The evidence

5 A one volume brief of evidence was tendered at inquest which included witness statements, police reports, medical records and photographs. I will only refer to certain records in these reasons; however, I have reviewed all of the documents provided

Background

6 Mr Faafete was born in Samoa on 29 September 1955. In 1985, he moved to New Zealand with his partner, Aliitasi Faafete. They married in 1986. They moved to Australia in 1995 and had ten children.

7 Prior to being taken into custody, Mr Faafete resided at the Kilpatrick Aged Care Home in Toronto.

Medical history and treatment from Justice Health

8 Mr Faafete had an extensive medical history which included hypertension, hypercholesterolaemia, type 2 diabetes mellitus, gastroesophageal reflux disease, chronic kidney disease, advanced liver disease, alcohol dependence advanced cholangiocarcinoma, psoriasis and gout.

9 After being diagnosed with terminal cancer, on 1 August 2024, Mr Faafete was transferred from Shortland Correctional Centre to the Medical Surgery Unit at Long Bay Hospital. He was commenced on a palliative care pathway by clinicians from the Justice Health and Forensic Mental Health Network ("Justice Health").

10 On 23 January 2025, Mr Faafete was transferred to Metropolitan Special Programs Centre and continued to receive palliative care from Justice Health. He was frequently seen by social workers for end-of-life planning. The Justice Health progress notes indicate that Mr Faafete felt "well supported by [the] palliative care team".

11 On 22 March 2025, Mr Faafete's condition deteriorated and a decision was made to transfer him to the Prince of Wales Hospital.

Events between 22 March 2025 and 24 March 2025

12 At around 3:46pm on 22 March 2025, Mr Faafete was admitted to the Prince of Wales Hospital in Randwick for increased shortness of breath and for pain management.

13 On 24 March 2025 Dr Gazal attended and pronounced Mr Faafete life extinct at 9:54am. Dr Gazal opined that Mr Faafete died from progressive cholangiocarcinoma.

Post-mortem examination

14 An external post-mortem examination was conducted by Dr Brianna Thompson, Forensic Pathology Registrar, and Dr Issabella Gertruida Brouwer, Senior Staff Specialist Forensic Pathologist who determined that the cause of Mr Faafete's death was advanced cholangiocarcinoma.

Police and CSNSW investigation

15 The police investigation did not identify any issues relating to Mr Faafete's death.

16 Mrs Faafete raised a concern that there was a lack of communication when Mr Faafete was taken to hospital. Justice Health acknowledged this concern and explained that due to overarching security considerations it cannot inform next of kin of medical emergency transfers and there are procedures in place for Corrective Services to notify the patients emergency contact person.

17 A review by Justice Health of Mr Faafete's medical records identified that an interpreter could have been utilised more frequently in his care.

18 Policy 1.230 *Health Care Interpreter Services* governs the use of interpreters in health services provided by Justice Health NSW. Policy 1.230 provides that, to determine whether a patient requires the assistance of an interpreter, Justice Health NSW staff will need to assess if the patient can fully understand and communicate in a health care situation and establish if the patient would like to be assisted by an interpreter

19 The need of more frequent use of an interpreter in Mr Faafete's care was identified as an area of lessons learning by Justice Health NSW and this lesson was reported back to his treating team, noting the policy and highlighting that the use of ongoing interpreter services improves the provision of health care services to patients with limited English proficiency.

Conclusion

20 On behalf of the Court, I express my sincere and respectful condolences to Mr Faafete's family and friends for their loss.

21 I thank the officer in charge, Sergeant Elizabeth Toland, for the very thorough investigation and for preparing a detailed brief of evidence. I also express my gratitude to Ms Mackay and Mr Welsh, the coronial advocates assisting me throughout the inquest.

Findings

Having considered all the evidence, I make the following findings pursuant to section 81(1) of the Act:

Identity
The person who died was Mr Lifa Faafete

Date of death
Mr Faafete died on 24 March 2025

Place of death
Mr Faafete died at the Prince of Wales Hospital, NSW

Cause of death
Mr Faafete died from advanced cholangiocarcinoma

Manner of death
Mr Faafete died of natural causes while in the lawful custody of Corrective Services NSW

I close this inquest.

Magistrate Carmel Forbes
Deputy State Coroner
NSW State Coroner's Court, Lidcombe
25 March 2026

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