New South Wales

CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Raeputa Tangatapoto
Hearing date:	11 August 2026
Date of Findings:	11 August 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, detainment of patient at Forensic Hospital
File number:	2024/00481240
Representation:	Mr S Chahrouk, Coronial Advocate Assisting the Coroner
Findings:	Raeputa Tangatapoto died on 26 December 2024 at Forensic Hospital, Malabar NSW 2036 where he was lawfully detained. The cause of Mr Tangatapoto's death cannot be ascertained. Mr Tangatapoto died of natural causes.
Non-publication orders:	See Annexure A

1. Introduction

1.1 Raeputa Tangatapoto was a 55-year-old man who was a long-term lawfully detained patient at the Forensic Hospital. On the evening of 25 December 2024, Mr Tangatapoto was found on the floor of his room complaining of chest pain.

1.2 After being taken to a treatment room and given medication to alleviate his symptoms, Mr Tangatapoto began vomiting and lost consciousness. Resuscitation efforts were commenced and advanced life support measures were provided. However, Mr Tangatapoto could not be revived and was pronounced life extinct in the early hours of the morning on 26 December 2024.

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. In Mr Tangatapoto's case he was lawfully detained at the Forensic Hospital at the time of his death. 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 staff from Corrective Services New South Wales and Justice Health & Forensic Mental Health Network. It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr Tangatapoto 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 Tangatapoto'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 Mr Tangatapoto's life in a brief, but hopefully meaningful, way.

3.2 Mr Tangatapoto was born on the island of Mitiaro in the Cook Islands. He was one of 12 children and born prematurely. He previously worked as a labourer in plantations and as a garden cleaner. In the late 1990s, Mr Tangatapoto moved to Australia.

3.3 Mr Tangatapoto was reportedly cared for by his brother in Minto for a period of time. He later lived on his own in Campbelltown.

3.4 There are differing reports regarding Mr Tangatapoto's connections with other family members. Unfortunately, little else is known about Mr Tangatapoto's life.

3.5 Mr Tangatapoto is no doubt greatly missed by his loved ones and those closest to him.

4. Mr Tangatapoto's medical history

4.1 Mr Tangatapoto had a history of previous head injuries, pneumonia, hyponatraemia, mild left ventricular hypertrophy, chest pain, heavy alcohol use, impaired glucose tolerance and obesity.

4.2 Between September 2000 and September 2002, Mr Tangatapoto had frequent contact with mental health services both in the community and in custody. He presented with disordered thought, mute and withdrawn behaviour, persecutory and bizarre delusions, and appeared to respond to internal stimuli.

4.3 Mr Tangatapoto was diagnosed with chronic treatment-resistant schizophrenia, paraphilic disorder and cognitive impairment. It was noted that his mental illness was characterised by ongoing severe thought disorder, bizarre and grandiose delusions and ongoing auditory hallucinations. Past treatment providers have noted that the extent of Mr Tangatapoto's thought disorder has limited rehabilitative attempts.

5. Mr Tangatapoto's custodial history

5.1 On 14 October 2002, Mr Tangatapoto was charged with a serious offence and refused bail. On 19 November 2002, Mr Tangatapoto was remanded at the Metropolitan Remand and Reception Centre (**MRRC**).

5.2 On 13 May 2003, Mr Tangatapoto was found unfit to be tried. On 6 April 2004 at a Special Hearing in the District Court, Mr Tangatapoto was found not guilty by reason of mental illness

of the offence he had been charged with pursuant to section 39 of the *Mental Health Act*. An order was made for Mr Tangatapoto to be detained at Long Bay Hospital (**LBH**).

5.3 Whilst at LBH, Mr Tangatapoto was noted to be withdrawn and very thought disordered. He was observed to respond to auditory hallucinations and to express persecutory beliefs about other inmates. He also had other delusions that were difficult to follow.

5.4 On 1 September 2004, Mr Tangatapoto was transferred to LBH for specialist psychiatric management after setting fire to his cell. By November 2004, some improvement in Mr Tangatapoto's condition was noted. In January 2005, Mr Tangatapoto was observed to be less withdrawn and spent more time playing the guitar in the courtyard and singing songs. It was also noted that his self-care had improved although he experienced ongoing delusions.

5.5 Following this, little improvement in Mr Tangatapoto's mental state was noted. He continued to present with severe thought disorder, delusions and hallucinations.

5.6 On 24 March 2009, the Mental Health Review Tribunal (**MHRT**) ordered that Mr Tangatapoto be transferred from LBH to the Forensic Hospital pursuant to section 76E of the former *Mental Health (Forensic Provisions) Act 1990*. Orders were also made by the MHRT for Mr Tangatapoto to be detained at the Forensic Hospital for care and treatment.

5.7 During his time in the Forensic Hospital, Mr Tangatapoto appeared superficially settled without obvious external signs of psychosis. However, whenever he was interviewed he presented with severe thought disorder, reported auditory hallucinations and expressed a desire persecutory and grandiose delusions. At regular intervals, Mr Tangatapoto reported heightened paranoia about other patients trying to harm him and the possibility that his food or water might be poisoned.

5.8 During his time in the Forensic Hospital Mr Tangatapoto remained on clozapine at doses between 400mg to 500mg daily and it was noted that these were always maintained at a dose to achieve maximum safe blood levels. Mr Tangatapoto's clozapine was augmented with amisulpride between 2012 and 2016 with little benefit. In 2013, sertraline was commenced in the context of his depressive symptoms. In late 2016, aripiprazole was commenced in the context of low mood and lack of motivation with notable benefit in engagement and activity levels. In 2017, sertraline was changed to venlafaxine which brought about considerable improvement in Mr Tangatapoto's mood.

5.9 In a report prepared for the MHRT on 28 November 2024 by Mr Tangatapoto's treating psychiatrist, it was noted that:

(a) Mr Tangatapoto continued to suffer from a mental health impairment, namely chronic treatment-resistant schizophrenia characterised by ongoing and clinically significant disturbance of thought (delusions), mood and perception (auditory hallucinations);

(b) there was no form of safe and effective care available that was less restrictive; and

(c) release into the community at that time would pose an unacceptable risk of endangerment to the community.

6. The events of December 2024

6.1 On 17 December 2024, Mr Tangatapoto was transferred from the Forensic Hospital to Prince of Wales Hospital (**POWH**) with chest pain, light headedness and postural hypotension. He was found to have prolonged unexplained sinus tachycardia. Investigations were performed including a CT pulmonary angiogram which found no evidence of pulmonary embolism or right heart strain. It was also noted that Mr Tangatapoto had normal electrolytes and no signs of infection, and that his initial postural drop in blood pressure resolved with intravenous therapy. Mr Tangatapoto's tachycardia eventually settled.

6.2 Following assessment and treatment and given that Mr Tangatapoto's symptoms resolved after intravenous therapy, it was considered that his presentation may be hydration related. Mr Tangatapoto was later transferred back to the Forensic Hospital.

6.3 On the evening of 25 December 2024, Mr Tangatapoto was found lying on the floor of his room complaining of chest pain. Nursing staff assisted Mr Tangatapoto to the medical bay for treatment. An echocardiogram was performed and Mr Tangatapoto was given medication to alleviate his chest pain. However, Mr Tangatapoto began vomiting and his condition rapidly deteriorated before losing consciousness.

6.4 Resuscitation efforts were initiated and emergency services were contacted. Paramedics arrived on scene at around 11:15pm and provided advanced life support. A defibrillator was applied but Mr Tangatapoto was found to have no shockable rhythm throughout.

6.5 Resuscitation efforts continued for approximately one hour and included the use of a LUCAS (Lund University Cardiopulmonary Assist System) mechanical chest compression device. However, Mr Tangatapoto could not be revived and was pronounced life extinct at 12:23am on 26 December 2024.

7. Post-mortem examination

7.1 Mr Tangatapoto was later taken to Forensic Medicine Sydney. His family expressed their wishes for no invasive internal examination to be performed. Therefore, the post-mortem examination was limited to an external examination only and performed by Dr Issabella Brouwer, forensic pathologist on 3 January 2025. This identified the following relevant findings:

(a) post-mortem imaging identified evidence of single vessel coronary artery calcification;

(b) evidence of hiatus hernia and distension of the lower oesophagus with mottled density material were also identified, likely reflecting gastric contents in the oesophagus; and

(c) toxicological analysis detected a potentially toxic level of clozapine (antipsychotic medication), although Dr Brouwer noted that interpretation of this level is limited in the absence of an internal post-mortem examination. Non-toxic levels of aripiprazole (also antipsychotic medication) and sertraline (antidepressant medication) were also detected.

7.2 In the post-mortem examination report dated 22 February 2025, Dr Brouwer opined that the cause of Mr Tangatapoto's death could not be ascertained.

7.3 It should be noted that following Mr Tangatapoto's death a CT scan was performed at Forensic Medicine Sydney. This scan was reviewed by a radiographer who formed the impression that the scan showed a possible bowel obstruction. However, the CT scan was subsequently reviewed by a specialist radiologist who noted that it showed relative gaseous distension of small bowel compared to colon but without a well-defined transition point. The radiologist expressed the view that the small bowel distension could reasonably be attributed to decomposition only, with no evidence of bowel obstruction or perforation.

8. What was the cause and manner of Mr Tangatapoto's death?

8.1 The post-mortem examination did not identify any convincing evidence that any non-natural factor contributed to Mr Tangatapoto's death. Although a potentially elevated level of clozapine was detected, it has not been possible to interpret this finding in the absence of an internal examination. Given that the other medications detected were all within the therapeutic ranges, it is most likely that the level of clozapine also was within this range. It is also noted that Mr Tangatapoto had been on clozapine for a long period of time since 2004 without any previous incident. Further, Mr Tangatapoto's complaints of chest pain on 17 and 25 December 2024 appeared to be consistent with a medical episode.

8.2 Therefore, the available evidence indicates that it is most likely that Mr Tangatapoto died of natural causes. Although the post-mortem examination identified some pathology (coronary artery calcification) which may have contributed to death, a precise cause of death could not be ascertained without an internal examination.

8.3 Having regard to these matters, the cause and manner of Mr Tangatapoto's death is best described as due to unascertained natural causes.

8.4 It should also be noted that the coronial investigation did not identify any evidence to indicate that the care provided to Mr Tangatapoto whilst he was in lawful custody or at the Forensic Hospital and POWH was inadequate or contributed to his death in any way.

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 Mr Sam Chahrouk, Coronial Advocate Assisting the Coroner for the assistance provided throughout the coronial investigation and inquest, and the sensitivity shown to Mr Tangatapoto's family.

9.2 I also thank Tiarne Jolly for her role in the New South Wales Police Force 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 Raeputa Tangatapoto.

Date of death
Mr Tangatapoto died on 26 December 2024.

Place of death
Mr Tangatapoto died at The Forensic Hospital, Malabar NSW 2036 where he was lawfully detained.

Cause of death
The cause of Mr Tangatapoto's death cannot be ascertained.

Manner of death
Mr Tangatapoto died of natural causes.

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

9.5 I close this inquest.

Judge Derek Lee
Deputy State Coroner
11 August 2026

Inquest into the death of Raeputa Tangatapoto

Annexure A: Non-publication orders

1. Pursuant to section 74(1)(b) of the *Coroners Act 2009* (**the Act**), the following material contained within the brief of evidence tendered in the proceedings is not to be published:

   a) The names, Visitor Index Numbers, telephone numbers, addresses, and any other identifying information of any member of the inmate's family, friends, and/or visitors, other than legal representatives or visitors acting in a professional capacity.

   b) The names, Master Index Numbers, and other personal information of any persons currently or previously in the custody of Corrective Services New South Wales (**CSNSW**), including any case notes concerning inmates other than the deceased.

   c) The direct contact details, including OIMS usernames, internal emails and telephone numbers and personal information of CSNSW staff and business units that are not publicly available.

2. Pursuant to section 65(4) of the Act, 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
11 August 2026