CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Bernard Greenwell
Hearing dates:	25 March 2025
Date of Findings:	25 March 2025
Place of Findings:	Coroner's Court of New South Wales, Newcastle
Findings of:	Magistrate Caleb Franklin, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death
File number:	2023/134439
Representation:	Ms Alison Storm, Coronial Advocate assisting the inquest Ms Janet de Castro Lopo for Department of Communities and Justice appearing on behalf of the Commissioner of Corrective Services New South Wales Mr Hugh Norris for Justice Health & Forensic Mental Health Network
Findings:	Bernard Greenwell died on 25 April 2023 at John Hunter Hospital, Lookout Road, New Lambton NSW 2305 The cause of Mr Greenwell's death was haemoperitoneum due to ruptured abdominal aortic aneurysm. Mr Greenwell 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 Bernard Greenwell was in lawful custody at a correctional centre on the date of his death on 25 April 2023. At approximately 11:30am on 25 April 2023, Mr Greenwell experienced the sudden onset of severe pain in his left groin. Correctional Officers and nurses came to his cell to assist him. He was transferred by NSW Ambulance to Cessnock District Hospital, and later to John Hunter Hospital. Investigations revealed a ruptured abdominal aortic aneurysm. Despite the care and treatment provided, Mr Greenwell's condition deteriorated rapidly, and further treatment was considered futile. He was transitioned to palliative care and died later that same day.

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 in lawful custody, they are deprived of their liberty and the State assumes responsibility for the care and treatment of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody, reflecting the community expectation that such a death will be properly and independently investigated.

2.3 A coronial investigation and inquest involves the public examination of the circumstances surrounding that person's death to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. This type of examination often involves consideration of the conduct of staff from Corrective Services New South Wales (**CSNSW**) and Justice Health & Forensic Mental Health Network (**Justice Health**). Mr Greenwell's coronial investigation and inquest did not identify any evidence to suggest that Mr Greenwell was not appropriately cared for and treated whilst in custody.

3. Mr Greenwell's life

3.1 Mr Bernard Greenwell was born in Australia on 26 February 1939. At the time of his death, he was 84 years old.

3.2 Sadly, very little is known about Mr Greenwell's family history and personal background. Records reflect that prior to entering custody, Mr Greenwell was a single man who had been living alone and independently in the community in Forster NSW. He had previously married but was divorced. He reported an employment history working as a truck driver. He self-reported being a regular smoker for over 65 years and at times consuming between 15 to 30 standard drinks of alcohol per week. He described being unable to read and considered himself illiterate. At the time of his death, he was serving a sentence of imprisonment for historical child sex offences committed against his stepdaughter.

3.3 Corrective Services NSW records show that while Mr Greenwell was in custody he did not receive any visits or have any contact from family or friends throughout the time he was in custody.

3.4 When Mr Greenwell first came into police custody following his arrest for his most recent charges, he refused to provide a next of kin details to police. When he entered Corrective Services NSW custody, the only listed next of kin provided was a person described as a friend. When that named friend was contacted following Mr Greenwell's death, that person declined to take responsibility for funeral and burial arrangements.

3.5 Mr Greenwell had a destitute burial.

4. Mr Greenwell's criminal and custodial history

4.1 Mr Greenwell was first convicted of a criminal offence, on 9 November 1961 when he was 22 years old. He was convicted of numerous offences throughout the following decades, some of which resulted in custodial sentences. His convictions history included offences of wilful and obscene exposure, committing acts of indecency and indecent assaults, and alcohol related driving offences.

4.2 At the time of his death, Mr Greenwell was an inmate at Cessnock Correctional Centre, within the Cessnock Correctional Complex, Lindsay Street, Cessnock. Mr Greenwell was in prison following convictions for a number of criminal offences, including "Carnal knowledge of a girl aged between 10 and 16 years" and 15 counts of "Assault Female and Commit Act of Indecency". He was serving a total effective sentence of imprisonment of 9 years and 6 months, with an effective non-parole period of 7 years and 6 months, that commenced on 25 April 2018. His earliest possible date of release to parole would have been 24 October 2025.

4.3 After entering full time custody, Mr Greenwell was transferred between various Correctional Centres around NSW until he was transferred to Cessnock Correctional Centre on 3 September 2020. Apart from a brief transfer to the Metropolitan Reception and Remand Centre in Sydney from 30 July 2022 until 9 August 2022, for isolation purposes after testing positive to COVID, he remained housed at the Cessnock Correctional Centre until his death.

4.4 While at Cessnock Correctional Centre, Mr Greenwell was a minimum security Special Management and Placement (SMAP) inmate, and was essentially housed with other convicted child sex offenders that require protection from other inmates. He was on protection at his own request. At the time of his death, he was housed in a one-person cell being Room 6108 in Area 2, which is a small unit where inmates are housed in dormitory style accommodation and their individual cells are referred to as rooms.

5. Mr Greenwell's medical history

5.1 Prior to entering custody, Mr Greenwell was a heavy smoker with a medical history of smoking related lung disease. He had a known history of chronic alcohol use.

5.2 In April 2016 Mr Greenwell had a fall at home and dislocated his right shoulder.

5.3 On 22 August 2016 he presented to Manning Base Hospital suffering a traumatic pneumothorax after he had another fall at home, where he tripped on slippers and fell into a wardrobe. It was noted at the

time that he had a least three fractured ribs on the right side and a medium sized right sided pneumothorax. A chest drain was inserted, and he was treated with antibiotics and analgesia.

5.4 Mr Greenwell originally entered custody on 20 September 2016, after being charged with the offences for which he was serving a sentence at the time of his death. During his Reception Screening Assessment he complained of "chronic back and right shoulder pain" and sore ribs from the two recent falls he had suffered earlier that year. He was noted to be frail and walked slowly. He was noted to wear bifocals. He denied any other health issues. Mr Greenwell's medical history during this initial entry into custody on his most recent charges is limited, as he only remained in custody for a short period as he was granted bail on 28 September 2016.

5.5 On 3 May 2018 Mr Greenwell underwent an intake assessment when he again entered custody after his bail was revoked. During this intake assessment he denied any physical or mental health issues, denied any allergies, denied any drug use and reported that he was not on any medications. He reported at that time that he was an occasional drinker only, despite his chronic alcohol history. His observations were noted to be within normal limits. He was later screened for chronic diseases on 20 June 2018 which did not identify any health issues, and no medications were prescribed.

5.6 When Mr Greenwell entered custody, he was assessed as being a high falls risk, consistent with his reported medical history of falls in the community. It was recommended that he be housed in a shared cell ("two-out cell") and only to use the lower bunk. This was later reviewed and changed at the request of Mr Greenwell after he had been in custody for a number of months.

5.7 Mr Greenwell wore bifocal glasses that were noted to be badly scratched. He was assessed by an optometrist on 25 September 2018 and was prescribed new bifocals. At the time he was also diagnosed with diffuse cataracts in both the left and right eyes and an advanced pterygium in left eye. However, he was strongly opposed to treatment for the pterygium.

5.8 On 18 May 2019, Mr Greenwell was seen in the clinic. Although he had made a self-referral for painful left hip and knee, when seen at the clinic he was treated for a minor injury, being a graze to his lower left leg, that he reported he sustained after hitting his leg on furniture following an assault by another inmate on 17 May 2019. During that presentation, he was also treated for a small superficial wound on his right ankle that he reported was unrelated to the assault incident.

5.9 On 29 May 2019 Mr Greenwell underwent an aged care health assessment. During that presentation he reported dry skin on his legs for which it was recommended he use sorbolene. He also reported difficulty lifting with his left arm due to an old shoulder injury. No other health concerns were raised by Mr Greenwell or identified by nursing staff following his assessment which included blood tests, spirometry and electrocardiogram.

5.10 On 6 June 2019 Mr Greenwell presented to the clinic with a small skin tear to his right elbow, sustained whilst pushing a trolley. Bleeding from the wound was minimal and the wound was cleaned and dressed.

5.11 On 4 September 2019 Mr Greenwell had an aged care health assessment. He reported at that time a history of smoking related lung disease and a history of chronic alcohol intake. He described his memory as terrible. The clinical impression following cognitive screening was that he was suffering mild cognitive impairment with deficits in short term memory but was still able to meet his own daily needs. It was also noted that he may need further review in future for smoking related lung disease.

5.12 Mr Greenwell received a total of three COVID-19 vaccinations which were administered on 15 September 2021, 12 October 2021 and 17 May 2022. On 27 July 2022 Mr Greenwell tested positive to COVID-19 and was treated with oral anti-viral medication given his age. He was briefly transferred to the Metropolitan Reception and Remand Centre in Sydney. He was noted to be afebrile and a symptomatic by 4 August 2022.

5.13 On 9 August 2022 Mr Greenwell was transferred back to the Cessnock Correctional Centre.

5.14 On 18 August 2022 Mr Greenwell attended his first case management interview with his case manager. In a follow-up case management interview on 23 August 2022, his Case Management Officer discussed with Mr Greenwell whether he had any health issues of concern. Mr Greenwell advised that he was not on any medications. He did admit that he was "hard of hearing", however, he did not raise any other health issues.

5.15 Significantly, when a history was taken from Mr Greenwell on 25 April 2023 by NSW Ambulance staff who transferred him from the correctional centre to the hospital on the day of his death, he denied any pain in the days leading up to his death and denied any history of similar events.

6. What happened on 25 April 2023?

6.1 In the days and weeks leading up to the 25 April 2023, there were no signs or indications that there had been any changes to Mr Greenwell's heath or wellbeing.

6.2 At around 6:25am on 25 April 2022 the door to Mr Greenwell's cell was opened and at approximately 6:30am Mr Greenwell left his cell for the first time that day.

6.3 Throughout the course of the morning, Mr Greenwell went in and out of his cell on several occasions, moved about the unit, entered the kitchen area, used the amenities, talked to other inmates, entered the secure yard area attached to the unit, made drinks and collected food from the kitchen area. At approximately 11:24am, Mr Greenwell walked back into his cell.

6.4 Until approximately 11:47am on 25 April 2023, there was no indication that Mr Greenwell was experiencing any pain, distress or discomfort. During that period, there is no evidence from CCTV footage or otherwise of any apparent assaults or physical interactions between Mr Greenwell and other inmates or correctional officers nor any evidence of any apparent falls.

6.5 Mr Greenwell walked out of his cell at approximately 11:47am and approached the table in the dining area of the unit, leaned against a chair and talked to another inmate before later sitting down at the table. At this point in time, Mr Greenwell appeared to be in an amount of pain, rubbed his inner thigh area and his head tilted back.

6.6 At approximately 11:52 am Mr Greenwell walked back to his cell. At this stage he has his hand held against his abdominal region and he appeared to still be experiencing pain. At approximately 11:53am a call is made from Mr Greenwell's room via the cell call button (a "knock-up call") where a request is made for Mr Greenwell to be taken to the clinic as he has "extremely bad pain in the groin". At approximately 11:54am, two correctional officers attended the unit and entered Mr Greenwell's room. After observing Mr Greenwell's pain and discomfort, the officers called the clinic and advised Mr Greenwell was too unwell to walk to the clinic.

6.7 At approximately 11:58am, two nurses from Justice Health arrived at the unit with an emergency bag and wheelchair and attended upon Mr Greenwell in his room. Mr Greenwell reported to nurses feeling the sudden onset of pain in his left groin at about 11:30am but could not state the cause. He described the pain as 10 out of 10 on the pain scale. He was reviewed by the nursing staff and his vital observations were taken. During the review, he experienced apparent bouts of pain that would cause him to scream. No abnormalities were observed on palpitation of his abdomen and no visible abnormalities were observed to his abdomen, groin, or left leg. Given Mr Greenwell's age, the sudden onset of severe pain, and that he was not well known to clinic staff, a decision was made that he required transfer to hospital and NSW Ambulance were contacted at about 12:04pm.

6.8 At approximately 12:12pm, Mr Greenwell was wheeled out of his cell escorted by the nurses and correctional officers and taken to the clinic area to await the arrival of ambulance. At the clinic, his condition was further monitored by nursing staff as they waited for the ambulance to arrive. At about 12:21pm NSW Ambulance staff arrive at the clinic and a handover was conducted before Mr Greenwell was transferred by ambulance to Cessnock District Hospital, leaving the Correctional Centre at about 12:40pm.

6.9 Mr Greenwell arrived at Cessnock District Hospital at 12:47pm. Following his arrival, Mr Greenwell was triaged at 12:51pm and admitted to the Cessnock District Hospital Emergency Department at 12:55pm, with the presenting problem noted as acute sudden onset left groin pain.

6.10 At 1:45pm an urgent ultrasound was requested by emergency staff, and then subsequently performed at 2:00pm. The ultrasound revealed an enlarged abdominal aortic aneurysm measuring approximately 10cm in maximal anteroposterior dimension. Given the severity of his condition, arrangements were then made for a retrieval unit for urgent transfer to John Hunter Hospital.

6.11 Mr Greenwell received pain relief and was transfused with several blood products, both enroute and following arrival at John Hunter Hospital at 5:59pm on 25 April 2023. He was admitted to the John Hunter Hospital Emergency Department at 6:08pm. The treating team were concerned about a ruptured abdominal aortic aneurysm (AAA). Mr Greenwell was hypotensive, tachycardic and peripherally shut down. A bedside ultrasound showed a very large aorta with free fluid in the abdomen. The vascular team was consulted and requested a computerised tomography (CT) scan to confirm the diagnosis. The subsequent contrast CT angiogram confirmed a large abdominal aortic aneurysm and showed an area of rupture with active haemorrhage into the abdominal cavity.

6.12 Despite the poor prognosis for Mr Greenwell, the vascular team recommended active treatment and continued resuscitation while an operating theatre was prepared for an emergency surgical repair of the AAA. However, Mr Greenwell rapidly deteriorated and the consensus decision between consultants was that further active treatment was futile, and the decision was then made to transition Mr Greenwell to palliative/comfort care.

6.13 Mr Greenwell was pronounced life extinct at 7:32pm on 25 April 2023.

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

7.1 Mr Greenwell's body was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Donovan Loots, forensic pathologist, on 4 May 2023. This identified the following relevant findings:

(a) Postmortem computerised tomography (CT) scan showed a large haemoperitoneum due to a ruptured abdominal aortic aneurysm;

(b) The scan also showed calcifications of the coronary arteries and aorta and cystic lesions in the liver;

(c) Toxicological analysis of the samples taken at autopsy and antemortem blood samples detected only non-toxic levels of therapeutic drugs used in the treatment of Mr Greenwell while in hospital; and

(d) No traumatic injuries were noted.

7.2 In the autopsy report, Dr Loots concluded that in his opinion the cause of Mr Greenwell's death was haemoperitoneum, due to ruptured abdominal aortic aneurysm.

8. Care and treatment provided to Mr Greenwell

8.1 The relevant records from CSNSW, Justice Health, NSW Ambulance, Cessnock District Hospital and John Hunter Hospital, and the findings from the postmortem examination, establish that Mr Greenwell died from natural causes. When Mr Greenwell complained of experiencing significant pain on 25 April 2023, appropriate steps were taken by Corrective Service and Justice Health staff. There is no evidence to suggest that the emergency response to Mr Greenwell's sudden deterioration on 25 April 2023 was anything other than appropriate, or that any different treatment could have prevented his death.

8.2 Overall, the evidence indicates that Mr Greenwell was provided with appropriate medical care whilst in custody and whilst enroute and following his arrival at hospital. There is no evidence to suggest that any action could have been taken by CSNSW or Justice Health staff to potentially alter the eventual outcome. There is also no evidence to suggest that any aspect of Mr Greenwell's care provided by CSNSW and Justice Health staff, or the medical care he received through NSW Ambulance, at Cessnock District Hospital, or at John Hunter Hospital, contributed in any way to his death.

8.3 There are no significant concerns regarding the care and treatment provided to Mr Greenwell.

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 Ms Alison Storm, Coronial Advocate Assisting. I acknowledge the assistance provided throughout the coronial investigation, and the sensitivity and empathy shown during all stages of the coronial process.

9.2 I also thank Detective Senior Constable John Kaczmar-Bof for his role in the police 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 Bernard Greenwell.

Date of death

Mr Greenwell died on 25 April 2023.

Place of death

Mr Greenwell died at John Hunter Hospital, Lookout Road, New Lambton, NSW 2305.

Cause of death

The cause of Mr Greenwell's death was haemoperitoneum due to ruptured abdominal aortic aneurysm.

Manner of death

Mr Greenwell 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 Greenwell's family and friends for their loss.

9.5 I close this inquest.

Magistrate Caleb Franklin
Deputy State Coroner
25 March 2025
Coroners Court of New South Wales
Newcastle Courthouse

Inquest into the death of Bernard Greenwell
Number: 2023/134439

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, Master Index Numbers and other personal information of any persons in the custody of Corrective Services New South Wales (**CSNSW**), other than Bernard Greenwell.

   b) Portions of documents displaying the names, contact details, residential addresses and any other information that identifies, or tends to identify Bernard Greenwell's family, friends and visitors, other than legal or professional visitors.

   c) The names, telephone numbers, residential addresses, and any other information that identifies, or tends to identify any victim of Bernard Greenwell's offences.

   d) Portions of documents displaying the contact details of CSNSW staff that are not publicly available, including email addresses, telephone numbers and staff identification numbers.

   e) References to the current or former residential addresses of Bernard Greenwell.

   f) Photographs, CCTV footage, and body-worn camera footage, including any still images from that footage.

   g) References to the start and end times of the "Relieving D Watch" and the "Compound CO2" shifts.

   h) These Portions of the CSNSW *Custodial Operations Policy and Procedure* (**COPP**):

      (i) 13.1 *Serious Incident Reporting*, Version 1.2:
      - The contact numbers in the first and third paragraphs in subsection 2.5, page 5;
      - The email address in the second paragraph in subsection 2.6, page 6;
      - The contact number in the second paragraph in subsection 3.1, page 7;
      - The email address in the second paragraph in subsection 4.1, page 9.

      (ii) 13.3 *Death in Custody*, Version 1.7:
      - The third sentence commencing with 'Cellmates' in subsection 2.4, page 6;
      - The contact number in subsection 6.1, page 12.

      (iii) 13.8 *Crime Scene Preservation*, Version 1.1:
      - All of the first, second and fourth paragraphs in subsection 4.1, page 10.
      - The entire second column of the table in subsection 4.1, page 11.

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.

Magistrate Caleb Franklin
Deputy State Coroner
25 March 2025
Coroners Court of New South Wales