



STATE CORONER'S COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of Malcolm George BAKER
Hearing Dates:	29 October 2025
Date of Findings:	1 December 2025
Place of Findings:	Coroner's Court of New South Wales at Lidcombe
Findings of:	Magistrate Joan Baptie, Deputy State Coroner
Catchwords:	CORONIAL LAW - death in custody, cause and manner of death
File Number:	2024/00232255
Representation:	Mr Samer Chahrouk, Coronial Advocate Assisting the Coroner Ms L Ovens for the Commissioner of Corrective Services, New South Wales Ms G Amal for Justice Health and Forensic Mental Health Network
Findings	Malcolm George Baker died on 23 June 2024 at the Acute Stroke Ward, Prince of Wales Hospital, Randwick, New South Wales. The cause of Mr Baker's death were complications of cerebrovascular accident on a background of atrial fibrillation. Mr Baker died from natural causes, whilst in lawful custody serving a sentence of imprisonment.
Non-publication order	See Annexure "A"

Introduction

- 1 At the time of his death, Mr Malcolm George Baker was 76 years of age and was in lawful custody, serving a sentence of imprisonment.
- 2 Mr Baker had a medical history which was significant for hypertension, hypercholesterolemia, deafness and glaucoma. He had chronic back pain and developed a dependence on benzodiazepines to alleviate his chronic discomfort.
- 3 He suffered a posterior cerebral artery stroke in 2020 and 2021. He was also diagnosed with schizophrenia, schizo-affective disorder, a Delusional Disorder and a paranoid personality disorder.
- 4 Since suffering the stroke in 2020, Mr Baker had limited mobility and required ongoing medical treatment and daily assistance. He was bed bound and on percutaneous endoscopic gastrostomy (PEG) feeds due to the earlier strokes.
- 5 On 10 June 2024, nursing staff at Long Bay Hospital noticed the onset of increased drowsiness and gaze deviation in Mr Baker and he was transferred to the Prince of Wales Hospital Emergency Department. After being clinically assessed, he was transferred to the Acute Stroke Ward, where he received palliative care.
- 6 Mr Baker's condition continued to deteriorate, and he was declared deceased at 5.41am on 23 June 2024.

The role of the Coroner and the scope of the inquest

- 7 A coroner is required to investigate all reportable deaths and to make findings as to the person's identity; as well as when and how the person died. A coroner is also required to identify the manner and cause of the person's death. In addition, a coroner may make recommendations, based on the evidence adduced during the inquest, which may improve public health and safety.
- 8 A person can be detained in lawful custody either as a result of the refusal of bail pending the determination of alleged criminal charges, or as a sentenced prisoner after conviction.

- 9 In circumstances where Mr Baker's death occurred whilst he was in lawful custody, an inquest is mandatory pursuant to sections 23 and 27 of the *Coroners Act 2009* ("the Act"). Parliament recognised the importance of conducting a mandatory inquest into the death of an inmate who has been deprived of their liberty. A person in custody is necessarily reliant on the State, and the facility in which they are incarcerated, to provide an adequate level of care during their incarceration. A mandatory review of the circumstances of Mr Baker's death is an important safeguard for persons incarcerated in New South Wales.
- 10 During these proceedings, a brief of evidence containing statements, photographs and other documentation, was tendered in court and admitted into evidence. In addition, oral evidence was received from the officer in charge of the Police investigation, Detective Amy Gerrish.
- 11 All the material placed before the Court has been thoroughly reviewed and considered. I have been greatly assisted by the written and oral submissions prepared by the Coronial Advocate assisting the Coroner, Senior Constable Samer Chahrouk. At times I have embraced his descriptions in these findings.
- 12 Non-publication orders have been made in accordance with an application made on behalf of the Commissioner of Corrective Services NSW pertaining to the evidence tendered in the proceedings.

Mr Baker's life

- 13 Mr Baker was born on 13 August 1947. He resided with his parents and two sisters in the Penrith area. He later reported that he was exposed to significant domestic violence from both of his parents.
- 14 Mr Baker left school at the age of 15. He was admitted to the Parramatta Psychiatry Unit at the age of 15 years due to an overdose of sleeping tablets. He moved out of the family home when he was 17 years of age and relocated to the Central Coast. He worked in several occupations, including as a mechanic and a panel beater. He made a steady income from renting out his caravan.
- 15 Mr Baker sustained an injury to his back, which resulted in him having to cease work. He developed a dependence on benzodiazepines at this time, to assist with pain management.

- 16 Mr Baker had six significant personal relationships from which he fathered nine children.
- 17 His last personal relationship was with Ms KG. That relationship ended in September 1992. On 19 October 1992, Mr Baker was served with an Apprehended Domestic Violence Order (ADVO), after it was alleged that he had assaulted Ms KG. Mr Baker was required to surrender all firearms to the police, pursuant to the interim ADVO. Mr Baker surrendered five of the six firearms that he possessed, retaining a 12-gauge double-barrel shotgun.
- 18 On 27 October 1992, Mr Baker shot and killed Ms KG, and two of her family members, in addition, he seriously wounded another person at the same premises. He then shot and killed his son and two others, before surrendering to Police.
- 19 Mr Baker was charged with six counts of murder and one count of attempted murder. On 6 August 1993, he was sentenced to a period of imprisonment of life without parole for the six murders and a fixed term of 12 years for the attempted murder.
- 20 Mr Baker was held in custody at eight different Correctional Centres at various times during his incarceration.
- 21 Mr Baker was designated as an Extreme High Security inmate from 23 April 1997 until 3 June 2013, and a High-Risk inmate from 3 June 2013 until 25 August 2016. He spent a significant period of time in segregated custody between 31 July 1996 and 18 August 2012.

Medical Interventions whilst in custody

- 22 Justice Health medical records disclose that Mr Baker received treatment both within his custodial settings, as well as at the Prince of Wales Hospital.
- 23 Mr Baker was diagnosed with a psychotic illness in 2005, after two admissions to the psychiatric unit. At different times, Mr Baker was diagnosed with schizophrenia, schizo-affective disorder and a delusional order. He was prescribed Olanzapine and Paliperidone, although it was noted that he was not compliant with his medications. He spent periods of time as an involuntary patient in the Long Bay Prison Hospital and was reviewed by the Mental Health Review Tribunal.

- 24 In 2018, he received an alternative diagnosis of paranoid personality disorder, although it was determined that he was still a mentally ill person in terms of the *Mental Health Act* NSW 2007, requiring ongoing treatment in hospital.
- 25 In May 2018, he complained of slurred speech and temporary memory loss and a brain CT was undertaken on 28 May 2018, with “nil acute intracranial pathology” being noted.
- 26 On 19 May 2020, Mr Baker was transported by ambulance to the Prince of Wales Hospital and diagnosed with a hyperdense right fetal posterior cerebral artery infarction involving the right occipital lobe, the right temporal lobe posteriorly, the right thalamus and posterior aspect of the right basal ganglia.
- 27 Mr Baker was assessed as having a “severe disability secondary to the recent cerebral vascular accident with minimal neurological recovery” and was a poor candidate for rehabilitation.
- 28 He was eventually returned to the Medical Subacute Unit and provided with ongoing care and treatment within his custodial setting.
- 29 In 2021, Mr Baker suffered another stroke and was placed in full-time respite care, where he was fully dependent on staff and received ongoing daily assistance. He was bed bound and fed via a percutaneous endoscopic gastrostomy (**PEG**).

Events on 10 June 2024

- 30 At 11.30am nursing staff noticed that Mr Baker had become increasingly drowsy. His Glasgow Coma Scale (**GCS**) reading was assessed as being 12-13 out of a total score of 15. He was noted to be drooling more than usual on his left side, with both eyes deviating to the left. Mr Baker was transferred from the Long Bay Prison Hospital to Prince of Wales Emergency Department.
- 31 An electrocardiogram (**ECG**) was performed and identified atrial fibrillation and ventricular couplets, suggesting an irregular heartbeat. A CT of his brain revealed no acute bleed or infarction. His GCS was now assessed at 11.
- 32 On 12 June 2024, Mr Baker was assessed as being Not for CPR (being cardiopulmonary resuscitation), as it would have negligible clinical benefit in the event of a cardiac arrest.

- 33 On 15 June 2024, Mr Baker was transitioned to “end-of-life-care”, as his condition had continued to deteriorate. His breathing was irregular, he was non-verbal, and he was increasingly drowsy and non-responsive.
- 34 Mr Baker had a noted intolerance to oral anticoagulants, and as such, was assessed to be at an elevated risk for a recurrent stroke, or cerebrovascular accident.
- 35 On 18 June 2024, Mr Baker was provided with palliative care.
- 36 On 23 June 2024, his condition continued to deteriorate until he was declared deceased at 5.41am.
- 37 Mr Baker’s death was referred to the State Coroner on 23 June 2024, due to his death occurring whilst in custody.

Cause of Death

- 38 Mr Baker was later transported to the Department of Forensic Medicine where an external examination was performed by Dr Kendall Bailey, forensic pathologist, on 27 June 2024.
- 39 Dr Bailey noted that on Mr Baker’s presentation to the Prince of Wales Hospital Emergency Department on 10 June 2024, the “onset of his increased drowsiness and gaze deviation, on a background of previous posterior cerebral artery stroke (2020) with a dense left hemiparesis” was unclear.
- 40 Dr Bailey noted that Mr Baker “was considered unlikely to benefit from significant investigations given (his) poor baseline. The cause of deterioration was unclear and there was a decision to admit for 24 hours of observation to ascertain a narrower differential or for a reversible cause to declare itself. An EEG did not identify a non-convulsive state/status epilepticus, and the most likely aetiology was thought to be ischaemic, however the deceased was not considered stable enough to perform an MRI to confirm the diagnosis.”
- 41 Dr Bailey opined that the “cause of death will be recommended to be recorded as complications of cerebrovascular accident on a background of atrial fibrillation.”

Conclusions

- 42 A careful review of the relevant records held by Corrective Services NSW and Justice Health, together with the postmortem report prepared by Dr Bailey, the evidence permits a conclusion that Mr Baker died from natural causes.
- 43 Mr Baker had suffered two prior strokes whilst in custody which had rendered him frail and susceptible to further episodes.
- 44 On 10 June 2024, Mr Baker was admitted to the Prince of Wales Hospital, and his presenting condition and his medical history were reviewed by the admitting medical staff. It became apparent that Mr Baker's condition was terminal. He was afforded palliative treatment until his death.
- 45 Overall, it would appear that Mr Baker was provided with appropriate medical care to deal with a number of significant medical conditions while he was in custody. It is clear that no medical intervention would have changed the outcome experienced by Mr Baker on 23 June 2024, nor did any staff employed by CSNSW or Justice Health, contribute to his death.
- 46 The evidence confirms that at the time of his death, Mr Baker was lawfully incarcerated in an NSW correctional facility.
- 47 Mr Baker's daughter, Ms B, indicated to Detective Gerrish that she had a "good relationship" with her father, "although I struggled with his actions for so many years. I often wanted to reach out to the families to express my sincere condolences. My father could be quite intimidating at times and there are many incidents that occurred prior to this event."
- 48 Ms B was a minor at the time of the murders. It is acknowledged that she must have been exposed to significant trauma and public condemnation due to her father's actions. Her co-operation with Detective Gerrish and the police investigation is gratefully acknowledged.
- 49 I would like to acknowledge and thank Mr Samer Chahrouk, Coronial Advocate, for his assistance in preparing, assisting and presenting the evidence in this case. I would also like to acknowledge and thank the Officer in Charge of this case, Detective Senior Constable Amy Gerrish, for her investigation and collation of the brief of evidence.

Findings

The findings I make pursuant to section 81 (1) of the Act are:

Identity

The person who died was Malcolm George Baker

Date of Death

Mr Baker died on 23 June 2024

Place of Death

Mr Baker died at the Prince of Wales Hospital, Randwick

Cause of Death

The cause of Mr Baker's death was complications of cerebrovascular accident on a background of atrial fibrillation

Manner of Death

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

I now close this inquest

A handwritten signature in black ink, appearing to read 'Joan Baptie', written in a cursive style.

Magistrate Joan Baptie

Deputy State Coroner

Coroners Court of New South Wales