CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of CG
Hearing dates:	4, 5, 9,10,11,12, 25 June 2026
Date of Findings:	10 July 2026
Place of Findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Judge David O'Neil, Deputy State Coroner of NSW
Catchwords:	CORONIAL LAW – Parklea Correctional Centre - St Vincents Correctional Health - communication between correctional officers and St Vincent's Correctional Health at Parklea Correctional Centre --
File number:	2024/1164074
Representation	Mr M Robinson as Counsel assisting, instructed by Ms L Shepherd of the Crown Solicitor's Office Mr A Mykkeltvedt for Office of the General Counsel Mr T Hackett for MTC Broadspectrum M J Harris for St Vincent's Correctional Health Ms M O'Brien for Corrective Services New South Wales Mr M Bradley for Dr J Kim Mr D Nagle for Correctional Officers S Alkhamees, A Tahir and R Sarin
Non-publication orders	Non-publication orders made pursuant to s 74 of the *Coroners Act 2009* and/or the incidental powers of the Court apply in this matter and are available on the Court file. Copies are also annexed to these findings.

Findings:

The identity of the deceased
The person who died was CG
Time of Death
CG died at approximately 10pm on 18 May 2024.
Place of Death
CG died at Parklea Correctional Centre, Parklea, New South Wales.
Cause of death
Exsanguination from sharp force injuries to both arms, dissecting the veins of the right elbow and the artery of the left wrist.
Manner of Death
Deliberately self-inflicted

Recommendations

I make the following recommendation pursuant to s 82 of the Coroners Act 2009 (NSW)

To Corrective Services New South Wales and Justice Health Forensic Mental Health Network:

I recommend that Corrective Services NSW and Justice Health and Forensic Mental Health Network review their training and consider jointly developing and implementing situation-based simulation training for medical emergencies in custody, conducted so far as practicable in the actual custodial environment, incorporating both correctional and health staff training together, and directed not only to the administration of first aid and resuscitation but also to communication between correctional and health staff at the point of notification of the emergency and through to communication during the emergency.

To MTC-Broadspectrum:

I recommend that MTC-Broadspectrum take steps to reinforce to correctional officers that a cell may be opened in a medical emergency on the responding officer's assessment that it is safe and necessary to do so, including where only one officer is present, consistently with the Custodial Operations Policy and Procedures.

Introduction

1 CG died at approximately 10pm on 18 May 2024 at Parklea Correctional Centre, Parklea, New South Wales.

2 CG died from exsanguination caused by sharp force injuries to both arms; dissecting the veins of his right elbow and the artery of his left wrist. Mr CG' injuries were self-inflicted. CG was 61 years of age at the time of his death. He had been in custody for 19 days.

3 CG died while in custody, an inquest was required by ss 23 and 27 of the *Coroners Act 2009* NSW (the Act). When someone is in lawful custody they are deprived of their liberty, and the State assumes responsibility for the care and treatment of that person. In such cases the community has an expectation that the death will be properly and independently investigated.

The Inquest and the Coroner's role

4 An inquest was held between 4 and 12 June 2026, at the Coroners Court of New South Wales, Lidcombe. The inquest was partly concurrent and partly consecutive with the inquest into the death of Mr Fred Elrezz.

5 An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death. It is not the primary purpose of an inquest to blame or punish anyone for the death. The process of holding an inquest does not imply that anyone is guilty of wrongdoing. Despite this there may nevertheless be factual findings which necessitate an adverse comment or criticism to be made.

6 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the Act being, the person's identity, the date and place of the person's death, and the manner and cause of death.

7 Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

8 Prior to holding the inquest, a detailed coronial investigation was undertaken and the Officer in Charge of the investigation (OIC), Plain Clothes Senior Constable Alex Townend compiled an initial brief of evidence comprising a number of documents, including a report by a forensic pathologist as to the cause of death. The court also received extensive documentary material which included witness statements, medical records, policies and procedures, and expert reports by emergency physician Professor Anne-Maree Kelly, and expert general practitioner, Dr Hester Wilson

9 All the documents including witness statements and expert reports obtained during the coronial investigation formed part of the seven-volume brief of evidence that was tendered at the commencement of the inquest. Material was also received and tendered throughout the inquest. All of that material, and the oral evidence at the inquest, have been considered in making the findings detailed below.

Sufficient Interest Parties

10 The following agencies and individuals were identified as having a sufficient interest in the proceedings and received notification:

(1) The son of CG

(2) The Commissioner, Corrective Services New South Wales

(3) MTC-Broadspectrum

(4) Justice Health and Forensic Mental Health Network (did not seek leave to appear)

(5) St Vincent's Correctional Health

(6) Dr Jun Kim

(7) Officer Lachlan Fryer

(8) Officer Sam Alkhamees

(9) Officer Abdul Tahir

(10) Officer Ravinder Sarin

Witnesses

11 The following witnesses gave evidence at the hearing:

(1) Leek Marial

(2) St Vincent's Correctional Health Nurse, Arlene Yaranon

(3) St Vincent's Correctional Health Nurse, Thanh Nhi Tran Le

(4) St Vincent's Correctional Health Nurse, Armita Oli

(5) St Vincent's Correctional Health Nurse, Oge Ishiekwene

(6) St Vincent's Correctional Health Nurse, Mithila Bhogadi

(7) Correctional Officer Sam Alkhamees

(8) Correctional Officer Abdul Tahir

(9) Correctional Officer Lachlan Fryer

(10) Correctional Officer Michael Tago

(11) Correctional Officer Ravinder Sarin

(12) Dr Hester Wilson, general practitioner

(13) Professor Anne-Maree Kelly, emergency physician

(14) General Manager Statewide Operations Security and Custody for Corrective Services New South Wales, Malcolm Brown

(15) Executive Director, Strategy, Contracts and Commissioning for Corrective Services New South Wales, Craig Mason

(16) Former Governor of Parklea Correctional Centre, Wayne Taylor

(17) Representative for St Vincents Correctional Health, Nicola Smith

Issues considered in the Inquest

12 An issues list was distributed to the parties as guidance as to the issues to be considered at inquest.

13 An issues list is neither determinative nor limiting. In the inquest further issues arose which will be dealt with later in these findings. The issues set out in the issues list were:

Issue 1

Whether CG' pain medication was adequately managed from his reception into custody on 29 April 2024 until his death, and in particular whether adequate clinical arrangements were in place to ensure that the expiry of his opioid prescription did not leave him without any pain relief

Issue 2

Whether the repeated requests CG made on 18 May 2024 via the cell call alarm system for pain relief were communicated to St Vincents Correctional Health, and whether any nursing response to those requests was adequate

Issue 3

Whether the response by MTC correctional officers to the notification by CG' cellmate at approximately 9:30 pm on 18 May 2024 that CG was "bleeding out" was adequate, including in relation to the classification of the initial call, the time taken to open the cell door, and the failure to call an ambulance promptly

Issue 4

Whether the CPR performed on CG was adequate, and whether earlier or more effective haemorrhage control might have saved his life

Issue 5

Whether any recommendations are necessary or desirable in relation to any matter connected with the death.

Factual Background

14 CG was arrested by NSW Police on 28 April 2024 in connection with an alleged domestic violence incident. He had been intoxicated at the time of his arrest. While in police custody, he was transported to Northern Beaches Hospital where a seven-day supply of oxycodone 20 milligram twice daily and diazepam was prescribed. He was bail refused at the Manly Local Court on 29 April 2024 and remanded to Parklea Correctional Centre (Parklea) that same day.

15 Parklea was at the time of CG arrest a privately operated New South Wales prison. Parklea was run by MTC-Broadspectrum (MTC) pursuant to contractual arrangements with Corrective Services NSW (CSNSW). Nursing services at Parklea were provided by St Vincent's Correctional Health (SVCH), again pursuant to contract.

16 CG Intake Screening Questionnaire (ISQ) was conducted by a MTC staff member. When the ISQ was completed on 1 May 2024 it recorded Mr CG was suffering from multiple mental health conditions, including PTSD, OCD, ADHD, major depressive disorder, psychosis, bipolar disorder, schizophrenia and a prior history of self-harm by slashing. However, it was also recorded that CG *'denied suicidal ideation and denied current self-harm thoughts'.*

17 The reception screening assessment (RSA), which is the principal clinical screening tool employed by SVCH on reception was also completed on 1 May 2024. The assessment recorded CG regular use of oxycodone and diazepam in the community. A mental health referral was made. He denied suicidal ideation. He was placed on GP hold in the main clinic, given the perceived complexity of his presentation.

18 On 2 May 2024, a Thursday, CG was reviewed by Dr Kim, a general practitioner at Parklea. Dr Kim noted CG claimed history of multiple health conditions, including long term Oxycontin use. The Doctor did not have access to SafeScript NSW, the government's real time prescription monitoring system for high-risk medications, including opioids, because access requires two factor authentication by a mobile

phone, and staff were not permitted to bring mobile phones into the facility. In addition, Dr Kim could not access CG' My Health record for the same reason.

19 In the absence of any verified prescription history, and consistent with the centre's usual protocol of not charting high risk medications without clear, clinical indication, Dr Kim prescribed Panadeine Forte, two tablets twice daily, pending further information from CG' community GP. Dr Kim also charted 10 milligrams of olanzapine at night.

20 On the next day, 3 May, a Friday, Dr Kim reviewed CG for the second time, having that day received the health summary from CG' GP. The summary confirmed a prescription for Oxycontin 20 milligram twice daily, but in Dr Kim's assessment, offered limited clinical justification beyond a reference to a prolapsed L5 S1 disc. There were, Dr Kim noted, no specific mentions of chronic pain.

21 Dr Kim discussed the matter with CG. He then prescribed Endone, or 10 milligram of oxycodone twice daily for two weeks to assess how CG managed on a lower opioid dose, with an intention to titrate accordingly at review. Dr Kim ceased the Panadeine Forte. He planned to review CG in two weeks at the end of the prescription period

22 Dr Kim's clinical note relevantly read, "*Endone 10 milligram BD for 2/52 at this stage*" and "*change patient over to Endone 10 milligram BD for now*". The note did not expressly state the intended end point of the prescription, the titration doctor had in mind, or the review that was to occur at its expiry.

23 CG was transferred from the main clinic on 6 May 24 to Area 5. Before any inmate can be placed in a cell (other than in the clinic), or if his placement status is to change, a clinician, usually a nurse, must complete a health problem notification form (HPNF). The HPNF dated 6 May 2024 for CG read as follows:

> "Sign symptoms to look for in the inmate:
>
> *First time in custody. Medical watch for signs of pain. Mental health issues. Watch for signs of low mood, isolative behaviour, inappropriate talking/laughing, mood swings, D&A issues. Watch for signs of excessive sweating, tremors, goosebumps, stomach cramps, diarrhoea."*

24 There was then set out, "*Nil current TOSH or harm to others.*" TOSH stands for "thoughts of self-harm." Under the header "what the CSNSW officers need to do" was entered "*clear from main clinic on shared cell placement.*"

25 Sharing a cell was thought to be a protective factor in terms of inmates who it was thought may be at some risk of suffering mental health issues. Between 6 May and 17 May, the only clinical entries in relation to CG related to weekly taking of his weight on 7 and 14 May. In oral evidence, CG was described to be a compliant and well-respected inmate.

17 and 18 May 2024

26 On 17 May 2024, CG learned that his Endone had ended. He attended the clinic. On the return escort, Correctional Officer Craig overheard him tell another inmate that he had not been given his pain relief because it was charted only for short-term use. Officer Craig believed CG' Endone had stopped some days earlier and that the centre was awaiting further guidance from a doctor.

27 Despite attending the clinic on 17 May, CG was not seen by Doctor Kim or any other doctor and there is no clinical entry indicating he was seen by a nurse.

28 The fact that the very topic CG mentioned to another inmate related to him not being given his pain relief suggests that very issue was discussed with someone in the clinic on the morning of the 17th.

29 Dr Kim explained in oral evidence that he and other medical officers were engaged that week in transferring paper medication charts to the electronic medication management system and the administrative task consumed his clinical time.

30 There was a doctor available in the clinic on 17 May, however CG was not seen by that doctor, nor was a doctor consulted in respect of CG.

31 On 18 May 2024, a Saturday, CG 'knocked-up' repeatedly for pain relief. The knock-up calls are recorded and were tendered in evidence.The first call was at 10.05am in which he described being in "excruciating pain." Officer Craig answered and told him the nurses had arrived on post and to go and speak with them.

32 I note that no nurse in this inquest received a sufficient interest letter. In circumstances where some of what follows may be read as critical of aspects of the care delivered by nurses, I will refer to nurses by number, where necessary.

33 Returning to 18 May, I am satisfied that CG did see a nurse in his area that morning. The nurse CG saw shall be referred as Registered Nurse 1 (RN1).

34 The handover booklet for the morning nursing shift's handover to the afternoon shift that day contains entries in RN1's handwriting.

35 One of those entries referred to CG and contained the word "pain" followed by a dash and then a single vertical entry which bears some resemblance to the number "1". There was some focus in evidence on that entry.

36 RN1 was clear in her evidence that she could not recall what that entry indicated and she was not prepared to speculate as to its meaning.

37 In my view, the least likely of the possible explanations of the single "1", was that it was meant to indicate a pain level of 1 out of 10. This contention was raised in some questions of RN1, however given CG' earlier indication that he was in "excruciating pain" that morning, my view is that is the least likely of any of the possibilities attendant that entry. The entry for example, may have been an incomplete entry.

38 RN1 gave two versions as to what her practice was in regard to completing the handover sheet. One was that she completed it at the time of handover. That is, when the morning shift overlapped with the afternoon shift and a handover discussion took place. The second version, which RN1 seemed to embrace more fully, was that she made the entries contemporaneously.

39 Nothing turns on when the entry was made. It was accepted by RN1 that the very purpose of the entries on the handover sheet was to inform the afternoon shift of matters that had been raised by patients during the course of the morning shift. It served as an indication that the issue raised needed some attention.

40 At 12.50pm, CG made another knock-up call. CG said "*I don't know what's going on. I've been cut off my medication of Endone two days ago. I saw the nurse.*"

41 Officer Craig said to him, "*CG, you've buzzed the office. You spoke to the nurses. You've just got to wait for the doctor, okay?*" CG replied, "*Alright, I'm still waiting, that's all, I'm in pain.*" At 2.49pm, CG made a third knock-up call. He asked whether medical staff would get back to him regarding his pain medication.

42 He told the officer that the nurses had said they would "*ring it through to the doctor because it was urgent.*" He explicitly asked for "*paracetamol, or anything*" and said he was buzzing up because "*it is worse*". He was told that nurses would do their rounds later in the afternoon, and that no doctor was on-site on the weekend.

43 Officer Craig, who received the 2.49pm call, then sent a direct email to St Vincent's Correctional Health staff at 2.55pm. It read;

> "*Good afternoon, can you please get a nurse to check on CG? He has buzzed up a few times after lock-in about getting meds. I have told him there is no doctor today and there has been two emergencies. He just keeps buzzing up. If a nurse can talk to him on the afternoon pill run, that would be much appreciated.*"

44 There is no evidence from any St Vincent's Correctional Health nurse concerning receipt of that email or establishing that it was actioned in any way. At approximately 6;30pm, CG again used the intercom to ask about his medication. He was told by an officer that it was not ready, and that the officer could not assist him.

45 At 7:10pm, CCTV footage SVCH captured nurses walking past CG' cell on their evening medication round without administering anything to him.

46 At 8:05pm, CG made a further knock-up call to ask when medical staff would attend his cell. He was told by the officer that the nurses had already been through, the conversation went as follows:

> CG: " *I was wondering if medications have come around yet?*"
>
> Officer: "*I believe it has already, Area 5, but I can double check. Why? What did you miss?*"
>
> CG: *"Ah, well, I put a request form in for some painkillers. It's all right. I'll catch up tomorrow."*

47 Dr Wilson, expert general practitioner, noted that this final response does not suggest a person in severe pain, but as she also observed, a person in the custodial setting who has been repeatedly told to wait for a doctor and the doctor has not come, and no nurse had come, may have simply felt he may have exhausted the available avenues of complaint.

48 A number of things flow from the foregoing.

49 Firstly, at no stage was anything done by any nurse in relation to CG' initial or repeated complaints about pain. That includes RN1 failing to effectively hand over the record of CG' report of pain to the afternoon staff. The very purpose of the handover notation was, as RN1 accepted in evidence, to inform afternoon staff of a patient who needed clinical attention.

50 Secondly, both CG and Correctional Officer Craig were of the view someone would raise with a medical officer the fact that CG' medication had ended and that he was complaining of pain. I note here the evidence was that one of the eight doctors who service Parklea, was *"on call 24/7"*. That is, day and night every day and night. Thus, if any nurse had bothered to do so, a doctor could have been contacted.

51 Thirdly, when Correctional Officer Craig realised verbal requests had not caused the situation to be addressed, she sent an email. The evidence was that the email went to all St Vincent's Correctional Health staff. Just as verbal requests had failed, so did the written request.

Events from 9pm on 18 May 2024

52 CG' cellmate, Mr Leek Marial, gave evidence at inquest. He indicated that CG had been in considerable pain throughout the day, moaning, using the bathroom frequently, and frustrated at the absence of medication. In the evening, Mr Marial watched a movie. Partway through, he heard noises. He checked on CG when he commenced to hear the noises. CG answered that he was "*all right.*" After approximately ten minutes of those noises, Mr Marial checked on CG again. He did so after having smelt that CG had defecated on himself.

53 He looked down from his top bunk and saw that CG had cut himself and was bleeding. Mr Marial knocked-up, doing so immediately upon smelling that CG had lost control of his bowels.

54 Mr Marial explained that CG attempted to dissuade him from knocking-up, but Mr Marial did so anyway. Although, Mr Marial's statement put the onset of the noises at about 9pm, in his oral evidence he tied their onset to about ten minutes before he knocked up. Accepting Mr Marial had no clock, I find the noises began at around 9.20pm.

55 On the evidence, CG was coherent and spoke firmly prior to the first knock up at 9.33pm intending to discourage Mr Marial from raising the alarm. By the second knock up at approximately 9.38pm, which ran for about four minutes, CG was saying to Mr Marial, "*It's an emergency,*" repeatedly with slurring and by that time, he had difficulty sitting up.

56 During helpful evidence, Professor Kelly was played the early knock-up calls and asked to provide comment on CG' state given what she could hear from CG in the background. Between 9.40 and 9.42pm, Professor Kelly heard groaning and identified what she perceived to be some attempt by CG to say words but those words were very difficult to make out.

57 The deterioration was readily apparent to Professor Kelly, the clear, purposeful speech of 9.33pm compared to "*It's an emergency*" slurring at 9.38pm and considerable groaning and moaning with incoherent speech or attempts at speech between 9.40pm and 9.42pm.

58 At 9.33pm Mr Marial activated the cell call alarm and told Control Room Fryer the following, "*My cellmate is bleeding out.*" Officer Fryer asked, "*What do you mean bleeding out?*" Mr Marial said he could see CG bleeding from his arm and asked for officers to come and look. CG could be heard in the background as I have set out immediately above. Officer Fryer did not treat this as a medical emergency. He organised a welfare check, telephoning Officer Alkhamees to attend.

59 Officer Fryer did not declare a "code blue" which required an immediate medical response. He made a "code blue" declaration after the second knock-up call at 9.38pm or 9.39pm, some six minutes later.

60 In the second knock-up call Mr Marial reported blood everywhere. Officer Fryer accepted on hearing the recording during his evidence that he had heard the words "*bleeding out*". It was clear he had done so because he repeated them back, "*What do you mean bleeding out?*" He reflected during his evidence that the appropriate response to a report that a cellmate was bleeding out was to call a "code blue". That concession accords with the evidence of Mr Taylor whose view was that the information conveyed by Mr Marial in the first knock-up warranted an immediate code blue.

Delay in opening the cell door

61 The code blue, having been called at approximately 9.39pm, the cell door was not opened until 9.57pm, some 24 minutes after the first knock up and some 18 minutes after the second knock up and the code blue call.

62 Officer Alkhamees had been contacted by Officer Fryer at 9.34pm. He did not arrive at the cell door until 9.43pm, four minutes after the code blue was called. Officer Tahir and Officer Sarin arrived at Area 5 at 9.47pm. Officer Tahir went to the cell door and Officer Sarin remained downstairs on the ground floor holding the security keys. This was an appropriate course. Accordingly, from 9.47pm, there were three officers deployed to the response; two at the cell door and one below holding the keys which is the compliment that Parklea Operating Procedure 408 required before a cell could be opened during lock in. The cell was nonetheless not opened until ten minutes later.

63 The reason it was not opened was that the officers were awaiting a nurse. Officer Tahir left at 9.48pm to collect RN1 who was on a double shift. Officer Tahir thought he was collecting a wheelchair as well as a nurse. That task took some ten minutes because of confusion as to where the nurse was located. At 9.52pm, Officer Fryer told Mr Marial through the knock up that the officers were waiting for the nurse before entering. All three officers thought they couldn't open the cell door unless three officers were in attendance at the area. All three officers were minded to await the attendance of a nurse before opening the cell door.

64 RN1 arrived at the cell door as the first nurse on the scene at 9.57pm, whereafter the cell door was opened. No call was made to the ambulance service until 9.57pm. At approximately 10.02pm, two other registered nurses arrived with the emergency trolley. CG was unresponsive and cold to the touch with dilated pupils.

65 CPR commenced and continued. At 10.20pm NSW Ambulance paramedics arrived. Paramedics assessed CG and at 10.23pm he was declared deceased.

Consideration of issues

66 I will now deal with the issues by reference to the issues list as styled by Counsel Assisting in his opening. Those issues were a refinement of the issues list that had been distributed to the parties. At inquest, no one took issue with the issues as articulated in counsel assisting's opening.

Issue 1: Whether CG' pain medication was adequately managed from this reception into custody on 29 April 2024 until his death, and in particular whether adequate clinical arrangements were in place to ensure that the expiry of his opioid prescription did not leave him without any pain relief

67 Dr Kim's initial role in prescribing pain medication was unquestionably appropriate. As Dr Wilson confirmed it was based on appropriate medical assessment on both 2 and 3 May. Whilst Dr Kim's note of 3 May was adequate, it in my view could have been more explicit. Nevertheless, it was not the cause of the issue that arose when Dr Kim's script expired.

68 The system at the time was for relevant expiring medications including oxycodone, to be flagged for a doctor to review. Any doctor could conduct the review under the shared care model in place at Parklea at the time. The expiring prescription should have been entered on the eMeds request board.

69 Ms Smith and Dr Kim both gave evidence that the system in place at that time for medication management review should have flagged CG' oxycodone script as expiring. The failure to do so represented a system failure. In circumstances where the prescription expiration was not flagged, it was somewhat ironic that Dr Kim was involved in the transfer of the medication charts on 17 May. It was most unfortunate that Dr Kim was not in the clinic that day. CG attended the clinic that morning and his oxycodone medication having ceased was clearly at the forefront of his thinking. If Dr Kim was in the clinic, CG' pain medication would likely have been assessed.

70 Dr Wilson, expert general practitioner, made clear that the assessment of CG following two weeks on oxycodone did not necessarily need to take place on 17 May and could

have been conducted early in the following week. What needed to happen as a minimum was any doctor who was advised on 17 May or 18 May that CG' script had expired, could have filled a script for painkillers pending full assessment the following week. Alternatively, as I shall touch upon shortly, nurses also could have provided some pain medication.

71 Dr Kim noted in his evidence that over the 12 months that followed CG' death, St Vincent's Correctional Health developed a new system to reduce the likelihood of another similar tragedy. As Dr Kim set out in his 28 May 2026 statement, every Monday and Thursday, pharmacists, generate a list of prescriptions that are expiring in the next seven days and provide the list to doctors on the floor to review. This allows the doctors on the floor to consider which medications need to be recharted and which should expire

Issue 2: Whether the repeated requests CG made on 18 May 2024 via the cell call alarm system for pain relief were communicated to St Vincent's Correctional Health and whether any nursing response to those requests was adequate.

72 There can be no doubt CG' complaints of pain were initially reported to RN1 on 18 May by CG personally and his ongoing complaints through the knock up system were reported by Correctional Officer Craig in her email at 2.49pm. Equally clearly, the report made to RN1 should have been communicated to afternoon shift staff at handover.

73 There was some evidence from nurses that email was not the preferred method of communicating an issue such as pain. It was said, such an issue was normally raised by a telephone call.

74 In circumstances where Correctional Officer Craig had knowledge of CG' concern regarding his oxycodone medication ending from when she accompanied him from the clinic on 17 May, and had told CG to raise his pain issue with the nurse who was in Area 5 during the morning of 18 May, and was aware CG had done so, it was not only reasonable but sensible for Officer Craig to raise the issue in an email sent to an email address which was available to all St Vincent's Correctional Health staff.

75 Ms Smith acknowledged that the email address received over 100 emails per day and all she could proffer in relation to the failure to act upon the email was that it must have

been missed. As at August 2025, the processes for raising medical concerns with St Vincent's Correctional Health was formalised as follows:

> "*For non-urgent health concerns including request for medication reviews. One, self-referral. Ensure that the custodial patient has submitted a self-referral form for review of the health team (completed self-referrals should not be sent by email, these forms are to be placed in envelopes and delivered to the St Vincent's Correctional Health team physically*)."

76 I note that in one of his knock-up calls, Mr Maggs indicated that he had completed a form. That may have been done on 17 May when he attended the clinic.

> "*Response 2. If self-referral has been completed and requires further escalation, raise concerns directly with the nurse allocated to the relevant area.*"

77 This is a step CG clearly took on 18 May.

> *"Response Three, if unable to raise concern for escalation, send an email.*"
>
> Then an email address is indicated and a suggestion or indication as to what to put in the subject line.

78 The similarity of that process with what occurred throughout 17 and 18 May, is striking. However, the steps taken on 17 and 18 May elicited no response.

79 Dr Wilson identified what the appropriate clinical response to Mr CG' repeated complaints should have been. One, a nurse review involving a proper clinical assessment of the pain, a telephone discussion with the on-call doctor, and the provision of short-term pain relief, paracetamol, which a nurse could administer, or potentially ibuprofen, until a comprehensive review could be conducted at the latest, early the next week.

80 CG expressly asked for paracetamol at 2.49pm on 18 May. He was not given it. Dr Wilson's evidence was that this simple intervention might have moderated his distress and that there was no clinical contraindication to administering paracetamol to CG.

81 As is often the case with missed opportunities, it cannot be known if, and if so, how, providing CG with pain medication at any time on 18 May might have changed subsequent events. What is inarguable is that systems and personal failings denied CG of any medication for his pain that day, his second day without pain medication.

Issue 3: Whether the response by MTC correctional officers to the notification by CG' cellmate at approximately 9.30pm on 18 May 2024, that CG was bleeding out, was adequate including in relation to the classification of the initial call, the time taken to open the cell door, and the failure to call an ambulance promptly.

82 Correctional Officer Fryer's response to the 9.33pm knock-up call from Mr Marial was wholly inadequate. The evidence revealed that Correctional Officer Fryer had, after an internal inquiry was conducted following CG death, received a written warning for failing to call a code blue following the knock-up call.

83 In his oral evidence, Correctional Officer Fryer accepted he should have called a code blue following the 9.33pm call.

84 One aspect of a code blue procedure was to immediately call for an ambulance. In his oral evidence, Correctional Officer Fryer adhered to the view that an ambulance should not have been called at that same time, as calling an ambulance would, in his view, have unnecessarily risked involving ambulance services inappropriately given the number of false self-harm and cellmate harm knock-up calls made daily during the afternoon shift at Parklea.

85 Despite the evidence of Mr Taylor that he was not aware of any complaint ever about inappropriate engagement of ambulance services as a result of calls from Parklea the weight of the evidence at inquest was, despite the code blue procedure, that it was reasonable to await confirmation of the severity of the situation, prior to calling an ambulance. That evidence could only be properly predicated, in my view, on a far more timely assessment of the situation than occurred on 18 May 2024 in relation to CG.

86 Given the content of what Mr Marial relayed to Correctional Officer Fryer, he should have called a code blue and made sure the response was urgent. However, if he had determined not to call a code blue, including not to call an ambulance, he should have ensured that he stressed that an urgent welfare check was required.

87 As I have set out above, Correctional Officer Alkhamees attended CG' cell ten minutes after the first request to conduct a welfare check. In the intervening period, Correctional Officer Fryer had called a code blue at 9.38pm to 9.39pm. Whilst Correctional Officer Alkhamees arrived at the cell door at 9.43pm, Correctional Officer Tahir did not arrive until 9.47. Correctional Officer Alkhamees was correct to await the arrival of Correctional Officer Tahir. As noted, he arrived at the same time as Correctional Officer Sarin, who appropriately remained on the ground floor, as he held the security keys.

88 The cell should have been opened when Correctional Officer Tahir arrived at the door, and he and Correctional Officer Alkhamees were both there together. However, instead of that, Correctional Officer Tahir left at 9.48pm to collect RN1 and a wheelchair. This decision reflected both an insufficient co-ordination of what was happening and the incorrect view of Correctional Officers Alkhamees and Tahir, that they needed a nurse to be present when they opened the cell door.

89 Some officer other than Correctional Officer Tahir should have been assigned to escort a nurse to the cell whilst Correctional Officers Tahir and Alkhamees entered the cell as soon as they determined it was safe to do so, upon Correctional Officer Tahir's arrival at the door at 9:47pm. They then should have assessed the situation inside the cell, removed Mr Marial to another cell and commenced first aid. As a result of the MTC internal investigation, Correctional Officers Tahir and Alkhamees each received a written warning for not having done so.

90 I note that each of the officers,Tahir and Alkhamees, were relatively junior officers with limited experience. They impressed as both desirous and capable of improving in their role as correctional officers. They both indicated, as did most witnesses who were asked, that they would like to transfer to Corrective Services NSW employment when Parklea returns to public hands in October 2026. The following findings substantially reflect counsel assisting submissions and flow from the factual matters I have just set out:

(a) Parklea operating procedures, POPs, were subservient to Corrective Services NSW Custodial Operations, Policies and Procedures (COPPs).

(b) The relevant COPP did not specify any minimum number of officers to be present to open the cell door, when assessed as safe to do so, in an emergency.

(c) Correctional Officer Alkhamees could have opened the cell door when he was there by himself, if he assessed it was safe to do so. Although he did not know that he could have opened the cell door, the fact was that Correctional Officer Alkhamees did not think it was safe to do so at that time. This was a reasonable position to take as he was concerned about the possibility that what was reported was not what it seemed, and of the prospect which the evidence shows that correctional officers are right to keep in mind of being lured into a cell or otherwise harmed. Those were not unreasonable concerns.

(d) The concerns were compounded by the fact that the configuration of the anti-ligature bed meant CG could not be clearly seen from the cell door.

(e) Once Correctional Officer Tahir arrived at the cell door, it should have been opened and first aid should have been commenced.

(f) It was clear from the evidence of Officers Alkhamees and Tahir that they did not know that they had the discretion to enter the cell without a nurse being present.

(g) If cell access was achieved at an earlier time, an ambulance would have been called sooner.

(h) It was clear that there was scope for MTC to better inform correctional officers of the discretion that exists in such medical emergencies.

91 The delays in accessing the cell were also contributed to by a failure of communication, which Mr Taylor emphasised in his evidence. Enquiries made by Correctional Officer

Fryer of Mr Marial during the first call were limited. The information passed onto the attending officers was limited. There was no detailed attempt by Officer Alkhamees to ascertain from Mr Marial what was occurring once he arrived at the cell door.

92 The problem was made worse by the fact that correctional officers and nurses operated on entirely separate radio channels with no relay between them. The officers could not communicate directly with the nurses, and the nurses' whereabouts were unclear to the correctional officers. Mr Taylor accepted that the communication was poor, that better interrogation from the control room was needed, and that with better communication between the main control room, the officers and nursing staff, the nurses should have arrived at the cell considerably earlier than they did.

93 An aspect of the communication failure was that some of the nurses and some of the correctional officers were operating on the basis that CG needed to be taken to the clinic in a wheelchair. The genesis of that erroneous understanding is not clear on the evidence. However, it is further evidence of poor communication and had the tendency to make those involved think that CG' injuries were less threatening than they actually were.

94 No nurse entered Area 5 until just before 9.57pm. The expectation of Ms Smith, supported by policy, was that two nurses attend a code blue. The belief that CG was to be brought to the clinic did not relieve St Vincent's Correctional Health of that obligation. Nurses were available in the main clinic who could have been deployed. Mr Taylor expected that if more nurses were needed to be escorted from the main clinic to Area 5, there were, on 18 May 2024, adequate correctional officers to facilitate cell access and nurse escorts.

95 When the cell was finally opened at 9.57pm when RN1 arrived at the cell door, RN1 seemed completely overwhelmed by what she saw when she entered the cell. Despite that, she did ensure an ambulance was called and arranged for further medical equipment to be taken to the cell.

Issue 4: Whether CPR performed on CG was adequate and whether earlier or more effective haemorrhage control might have saved his life.

96 The issue is best dealt with by reference to the evidence of Professor Kelly, who identified multiple deficiencies in the delivery of CPR. The most significant of these were:

1. There was no clear team leader.

2. The confined cell did not permit effective compression.

3. CG was not moved from the bed to the floor for some six minutes after the door was opened, during which time effective CPR could not be delivered.

4. RN1 entered and left the cell repeatedly to seek assistance and equipment because the response had not been resourced for what it was.

5. No effective tourniquet was applied to the wound at any stage.

97 I accept counsel assisting's submission that the multiple deficiencies revealed indicate a system wholly unprepared for the emergency they had responsibility to deal with on 18 May 2024 in relation to CG.

98 It is disturbing to make that finding against a background of the tragic history of deaths in custody in Australia. The circumstances of custody have resulted in many occasions of attempts at self-inflicted death over a very long period of time. The entities involved have an obligation to ensure their staff are well trained in what is to be done in such circumstances, and yet events on 18 May 2024 in relation to CG reveal the opposite.

99 Evidence was given during the inquest of emergency department staff in a hospital setting doing in situ simulation training of CPR at least once a week. Both correctional officers and nurses gave evidence that they had never done training together and that their training had never focused upon simulation or replicated the dimensions of a cell.

100 I have already referred to the relative inexperience of Correctional Officers Alkhamees and Tahir. In relation to the nurses, information was provided in the statement of Ms Smith as to the training required. She indicated nurses are required to complete an online basic life support training module every five years through the My Health

learning portal in addition to a practical basic life support (BLS) assessment every 12 months.

101 As at the date of CG' death, St Vincent's Correctional Health records show three of the nurses who were involved in delivery of the CPR had an online certificate and had their last BLS assessment respectively on 30 August 2023, 13 September 2023 and 8 February 2022 - so that in relation to that nurse the online portal was overdue as at 18 May 2024.

102 In relation to RN1, there was no online certificate. The indication from Ms Smith was a certificate may have been completed with her previous employer. And that nurse's last BLS assessment was in March 2022. The training status of RN1 may explain in part her reaction following entering the cell and her continual moving in and out of the cell throughout the CPR process.

103 I do not suggest that nurses in a correctional centre and correctional officers could have training anywhere near the frequency of that undertaken by those working in an emergency department. It is, however, instructive as to the frequency of that training.

104 The failings in relation to delivery of CPR in CG' case led to a recommendation being made as to training. I shall shortly return to that.

105 The second aspect of issue 4 brings focus upon the question of causation. In submissions, causation was addressed in terms of the entire correctional and health response to the first knock-up call, rather than being limited to haemorrhage control.

106 Had Officer Fryer declared a code blue at the first knock up call at 9.33pm rather than at 9.39pm, the entire response would have been brought forward by six minutes. Three officers were in position within some seven to eight minutes of the code blue being called. On that basis, if it had been called at 9.33pm, three officers would have been in a position to open the cell by approximately 9.41pm. They would have done so to enable them to render aid, and if two members of nursing staff were not already present at 9.41pm, they would have been present shortly thereafter, based on Mr Taylor's evidence that there was sufficient resourcing on that night for other guards, or correctional officers, to accompany nurses to the cell.

107 Professor Kelly's evidence establishes that at and shortly after 9.33pm, CG remained probably saveable. He was coherent with capacity to firmly discourage Mr Marial from knocking-up and seeking assistance. On her evidence, at a Glasgow Coma score of 14 or 15, there was adequate cerebral perfusion and therefore survivability. Her opinion was that if the bleeding had been effectively stopped at that point, CG would more likely than not have survived. There is no credible scenario however in which cell access at that time could have been achieved. Assuming cell access at 9.41pm, the evidence does not establish that the response actually available, would have resulted in survival.

108 The nursing response actually undertaken was chaotic. A single nurse entering and exiting the cell to seek help with no team leader in a confined space seemingly unable to move the patient to the floor for some minutes and with no capacity demonstrated to hang intravenous fluids or to achieve and maintain effective haemorrhage control. Professor Kelly's evidence was that it was possible that CG might have survived had the cell been opened at that time, however that opinion depended on appropriate and effective efforts to stem further blood loss together with elevation of the legs and the administration of IV fluids. There is no evidence that IV fluids were available to Parklea, or that St Vincent's Correctional Health nurses had the capacity to administer them, and even putting the question of IV fluids to one side, survivability at that time assumes a quality of CPR that, on the evidence, was no more available then than it was at 9.57pm. Consequently, it cannot be said that the failure to call the code blue at 9.33 and the resultant delay was causative of CG' death.

109 Once again, it is necessary to observe that it cannot be known what the outcome would have been if the code blue was called at 9.33pm, officers and nurses attended expeditiously to the cell and soon after called for an ambulance to attend, and officers and nurses were effectively trained to attend appropriately to the emergency that confronted them and effectively stemmed the bleeding and commenced appropriate and effective CPR. What can be said is that the identified deficiencies and failings deprived Mr Maggs of whatever chance of survival those involved should have been armed to deliver.

Cause of Death and formal findings

110 In relation to the formal findings in relation to CG' death pursuant to s 81 of the Act there is no dispute that:

Identity	The person who died was CG
Time of death	CG died at approximately 10pm on 18 May 2024
Place of death	CG died at Parklea Correctional Centre, Parklea, New South Wales.
Cause of death	Exsanguination from sharp force injuries to both arms, dissecting the veins of the right elbow and the artery of the left wrist.
Manner of death	Deliberately self-inflicted.

Recommendations

111 Throughout these findings, I've acknowledged most of the system changes made since CG' death. The entities are to be complimented for those changes.

112 A further change, which should be acknowledged, relates to the use of radios in medical emergencies. It is now spelt out in the St Vincent's Correctional Health network communication pathway for patient health concerns, a document I have previously referred to in relation to health concerns.

113 The pathway provides a basis for custodial staff (MTC) to escalate custodial patient health concerns to St Vincent's Correctional Health. This document is designed to provide guidance in identifying the health concern priority and contact point to ensure that inquiries are acknowledged and responded to in a timely manner. In relation to urgent health concerns, the pathway now includes the following:

> *"An immediate critical incident response team response/emergency code should be initiated by the custodial team via radio communication. St Vincent's correctional health will attend response as per the CIRT protocol. Contact details. Radio channel 6. Ensure St Vincent's Correctional Health nurses are notified and respond."*

114 It was accepted by MTC representatives at inquest that the pathway included that nurses were notified on their radio channel when an emergency or critical incident arose. Again, the entities are complimented for that change.

115 Ultimately, the proposed recommendations were not contentious and readily flowed from the evidence. Corrective Services NSW made a suggestion of a minor alteration in relation to recommendation 1, which all parties agreed to.

116 I am indebted to the Justice Health and Forensic Mental Health Network who had a sufficient interest notification, and whilst not appearing, closely followed the inquest and gave a prompt and detailed supportive response in relation to recommendation1.

117 From 1 October 2026, correctional officers at Parklea will be in the employ of Corrective Services NSW, and nursing staff in the employ of the Justice Health and Forensic Mental Health Network.

118 It seems likely, based on the evidence given at this inquest, that many of the MTC staff and St Vincent's Correctional Health nurses will seek to stay on at Parklea following the 1 October 2026 handover. It is in that context that the evidence in this inquest leads to Recommendation 1 being directed at Corrective Services NSW and the Justice Health Forensic Mental Health Network.

119 I am also grateful to MTC for its acceptance of Recommendation 2, which again flows from the evidence. However, the context is different in that MTC leave PCC as at 30 September 2026. It barely needs to be said that it remains of paramount importance that MTC and St Vincent's Correctional Health make their best efforts to provide the best care they can for inmates right up until the point of handover, and it is in that context that I express my gratitude for MTC's acceptance of Recommendation 2.

120 Recommendation 1 to Corrective Services NSW and the Justice Health and Forensic Mental Health Network is:

> That Corrective Services NSW and the Justice Health and Forensic Mental Health Network review their training and consider jointly developing and implementing situation based simulation training for medical emergencies in custody conducted so far as practicable in the actual custodial environment, incorporating both correctional and health

staff training together, and directed not only to the administration of first aid and resuscitation but also to communication between correctional and health staff at the point of notification of the emergency and through to communication during the emergency.

121 Recommendation 2 to MTC -Broadspectrum is:

That MTC-Broadspectrum take steps to reinforce to correctional officers that a cell may be opened in a medical emergency on the responding officer's assessment that it is safe and necessary to do so, including where only one officer is present, consistently with the custodial operations policies and procedures.

Closing comments

122 I express my thanks to the officer in charge for the work in the investigation. My thanks also to the sufficient interest parties and their representatives for the manner in which the inquest has been conducted. My deepest gratitude goes to the assisting team for their invaluable assistance. I express my sincere sympathy to the family and associates of CG.

Judge David O'Neil

Deputy State Coroner

Coroner's Court of New South Wales

10 July 2026

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