



**CORONER'S COURT
OF NEW SOUTH WALES**

Inquest:	Inquest into the death of Meirion Thomas Morris
Hearing dates:	14 May 2026
Date of findings:	14 May 2026
Place of findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Judge Kasey Pearce, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in Corrective Services NSW custody – natural causes – whether care and treatment appropriate and reasonable
File number:	2024/00371857
Representation:	Durand Welsh, Advocate Assisting the Coroner G Amal on behalf of the Justice Health and Forensic Mental Health Network H Short of the Department of Communities and Justice, Legal, on behalf of the Commissioner of Corrective Services NSW
Non-publication order	A non-publication order has been made pursuant to section 74(1)(b) of the <i>Coroners Act 2009</i> (NSW) in relation to material contained within the brief of evidence. A copy of this order is on the Registry file.
Findings:	Meirion Thomas Morris died on 7 October 2024 at the Prince of Wales Hospital, Randwick, NSW 2031 The cause of Mr Morris's death was complications of chronic obstructive pulmonary disease. Mr Morris died of natural causes while in the lawful custody of Corrective Services New South Wales

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1 Introduction

- 1.1 At the time of his death, Mr Morris was serving a lengthy sentence of imprisonment. He had been in the custody of Corrective Services NSW (**CSNSW**) since 1 December 2014.
- 1.2 Mr Morris was diagnosed with several life limiting health conditions. Shortly before his death, he had been advised that his prognosis was poor and had determined not to seek further treatment.
- 1.3 Mr Morris suffered a stroke on 4 October 2024. He was taken by ambulance to Prince of Wales Hospital (**POWH**) where he was transitioned to end of life care. He died on 7 October. He was 67 years old.
- 1.4 Although Mr Morris was estranged from most of his family, he enjoyed the long term and ongoing support of his nephew, Martyn Williams. On behalf of the Coroners Court of NSW, I extend my condolences to Mr Morris' family, and to Mr Williams in particular, for their loss.

2 Why was an inquest held?

- 2.1 Under the Coroners Act 2009 (**the Act**) a Coroner is responsible for investigating all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to be answered pursuant to section 81 of the Act, namely, the identity of the person who died, when and where they died, and the cause and the manner of that person's death.
- 2.2 When a person is sentenced to a term of imprisonment, they are lawfully detained in the custody of CSNSW until their sentence has been served. By depriving that person of their liberty, CSNSW assumes responsibility for the care of that person as the person is unable to independently take steps to seek medical assistance or other care. The combined effect of sections 23 and 27 of the Act is that it is mandatory for a Senior Coroner to hold an inquest where a person dies while in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated to ensure that CSNSW has cared for a person in its custody in a reasonable and appropriate way. In this case, there is no suggestion that CSNSW cared for Mr Morris in anything other than a reasonable and appropriate way.

3 Mr Morris' life

- 3.1 Before moving to a consideration of the circumstances of Mr Morris' death, it is important to acknowledge the facts of his life.
- 3.2 Meirion Thomas Morris was born on 24 January 1957 in Barmouth, Wales, one of 5 children born to his parents. His family migrated to Australia in 1960 when he was 3 years old, and Mr Morris spent his early childhood years in Rozelle, NSW. The family returned to Wales in 1970. Mr Morris completed his education in North Wales and later studied computing at university.
- 3.3 In 1984 Mr Morris married, though the marriage ended in divorce in 1993. He had no children.
- 3.4 Mr Morris returned to Australia in 1992. His mental health deteriorated during the following years, and he was diagnosed with schizophrenic/schizoid personality disorder believed to have been brought on by significant cannabis and hallucinogenic substance usage in his early 20s. Although his nephew, Mr Williams, attempted to assist Mr Morris with both his physical and mental health issues, Mr Morris became estranged from his family.
- 3.5 Mr Morris had an extensive history of alcohol abuse and hallucinogenic drug use dating back to 1980. He was using drugs daily until his arrest. He used methamphetamine for the first and last time at the time of his offence.
- 3.6 Mr Morris resumed contact with his nephew after his incarceration, after which the pair spoke almost daily.

4 Mr Morris' time in CSNSW custody

- 4.1 Mr Morris entered CSNSW custody after he was arrested on 1 December 2014 and charged with murder. He was initially housed at the Metropolitan Remand and Reception Centre (**MRRC**).
- 4.2 In May 2017, Mr Morris was convicted of murder. He was ultimately sentenced to 17 years imprisonment with a non-parole period of 12 years expiring on 30 November 2026.
- 4.3 Mr Morris was classified as a C2 minimum security inmate. During his imprisonment,

he was held at Lithgow and Macquarie Correctional Centres, although he stayed for extended periods at Long Bay Hospital when he required treatment for his medical conditions.

- 4.4 At the time of his death, which occurred on 7 October 2024, Mr Morris was an inmate at Long Bay Hospital Aged Care and Rehabilitation Unit (**ACRU**).

5 Mr Morris' medical history

- 5.1 Mr Morris was a long-term heavy smoker of both tobacco and cannabis. He was diagnosed with severe chronic obstructive pulmonary disease (**COPD**) in February 2005, which became his primary and most limiting health condition.
- 5.2 In addition to his COPD, Mr Morris's medical history included hairy cell leukaemia (in remission), hypertension, dyslipidaemia, benign prostatic hyperplasia, gastro-oesophageal reflux disease, psychosis requiring antipsychotic medication, and benign paroxysmal positional vertigo. At the time of his death Mr Morris was prescribed multiple medications including MS Contin 5mg, Frusemide 40mg, Paracetamol 1g, Olanzapine 5mg, and Pantoprazole 40mg.
- 5.3 While he was in custody, the severity of Mr Morris' COPD progressed to end-stage disease. He required supplemental oxygen therapy and experienced severe breathlessness with minimal exertion. Medical assessment established that his baseline oxygen saturation was approximately 50–80% despite supplemental oxygen, significantly limiting his mobility and daily activities.
- 5.4 In August 2024, Dr Christopher Steen from the Colorectal Clinic at Prince of Wales Hospital reviewed Mr Morris following a positive faecal occult blood test. Dr Steen assessed Mr Morris as medically very comorbid with end-stage COPD and poor baseline function and estimated a life expectancy of approximately 12 months. Given his overall prognosis and quality of life, Mr Morris declined further invasive colorectal investigations.
- 5.5 In September 2024, Dr Shawna Koh, a staff specialist in Palliative Medicine, reviewed Mr Morris at the palliative care outpatient clinic. Dr Koh found that his COPD had progressed significantly over the preceding year, leaving him extremely breathless with minimal exertion and with very limited functional capacity. She assessed his prognosis

as very limited, likely less than 12 months, and potentially much shorter if he suffered any acute deterioration such as a respiratory infection.

6 Events preceding Mr Morris' death

- 6.1 About 7:50 am on 4 October 2024 Mr Morris experienced a stroke and was taken by ambulance to POWH where he was admitted at 10:38 am. A computed tomography (CT) scan of his brain showed a left M1 middle cerebral artery intracranial occlusion, causing a cerebrovascular accident (stroke). Medical staff treated him with thrombolytic therapy (Alteplase) to dissolve the blood clot causing the stroke. However, given Mr Morris' extensive comorbidities and poor baseline health, his prognosis remained very poor.
- 6.2 Following initial treatment in the Emergency Department, Mr Morris was transitioned to an end-of-life care pathway in the Clinical Neurosciences ward. Medical staff determined that aggressive interventions were not appropriate given his overall condition and established care goals. He was made comfortable with appropriate pain management and palliative care measures.
- 6.3 By 6 October Mr Morris was unable to move any limbs. It was believed that this was due to the work of breathing and respiratory deterioration rather than the stroke. He was transitioned to end of life care and prophylactic antibiotics were ceased.
- 6.4 On 7 October 2024, at approximately 3:55pm, CSNSW staff who were providing security observed that Mr Morris had stopped breathing. After approximately one minute of observation, they sought assistance from registered nurse Sareena Ghale and Dr Christian Pappas, who confirmed that Mr Morris had died. He was formally pronounced deceased at 4:17pm on 7 October 2024.

7 The postmortem examination

- 7.1 On 17 October 2024 Forensic Pathologist Dr Lena Quinto conducted an external postmortem examination. A postmortem CT scan showed hypodensity and possible oedema in the left parietal region, suggestive of a left middle cerebral artery stroke. Vascular calcification was identified affecting the coronaries, carotid, splenic arteries and aorta. The lungs showed features consistent with chronic obstructive pulmonary

disease, including bullae and areas suggestive of consolidation.

- 7.2 The pathologist determined the direct cause of death to be complications of chronic obstructive pulmonary disease. Contributing factors included the cerebrovascular accident (stroke), hypertension, and hypercholesterolaemia. The examination confirmed this to be a natural death resulting from Mr Morris' long-standing medical conditions, with the stroke serving as the immediate precipitating factor leading to his final decline.

8 Investigations after Mr Morris' death

- 8.1 CSNSW Senior Investigator, Anne Barudi, investigated Mr Morris' death. This involved a review of Mr Morris' Case Management File, Case Notes, and Warrant File, as well as various other documents. She concluded that the overall management of Mr Morris by CSNSW during his incarceration up to and including his death on 7 October 2024 complied with Departmental policies and procedures, and that existing departmental policies and procedures are considered appropriate.

9 Conclusion

- 9.1 An inquest is mandatory because Mr Morris died whilst in the custody of CSNSW. However, unlike most other inquests, no issues apart from the statutory requirements pursuant to section 81 of the Act were identified from the coronial investigation which required discrete examination during the inquest.

10 Consideration

- 10.1 Having regard to the above, the available evidence establishes the following:
- at the time of this death, Mr Morris was held in the lawful custody of CSNSW;
 - Mr Morris had a lengthy history of mental illness and multiple physical health issues;
 - Mr Morris deteriorated over time and was appropriately transferred to the ACRU at Long Bay Hospital to manage his ongoing medical conditions; and
 - Mr Morris was appropriately transferred to POWH when external medical attention was required

10.2 The evidence establishes that there was no issue or concern regarding the management of Mr Morris while at POWH or at the ACRU prior to his death.

11 Findings pursuant to s81(1) of the Act

11.1 I would like to express my thanks to the Officer in Charge, Detective Senior Constable Corey Hayward and Advocate, Durand Welsh, for all the work they have done in investigating this matter and preparing it for inquest.

11.2 The findings I make under section 81(1) of the Act are:

Identity

The person who died was Meirion Thomas Morris.

Date of death

Meirion Thomas Morris died on 7 October 2024

Place of death

Mr Morris died at the Prince of Wales Hospital, Randwick, NSW 2031

Cause of death

The cause of Mr Morris's death was complications of chronic obstructive pulmonary disease.

Manner of death

Mr Morris died of natural causes while in the lawful custody of Corrective Services New South Wales.

11.3 On behalf of the Coroner's Court of New South Wales, I offer my sincere and respectful condolences to Mr Morris' family.

11.4 I close this inquest.



Judge Kasey Pearce

Deputy State Coroner

14 May 2026