CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Taulima Parker
Hearing date:	19 February 2026
Date of findings:	19 February 2026
Place of findings:	State Coroners Court, Lidcombe
Findings of:	State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – Cause and manner of death – death in custody
File number:	2025/00164977
Representation:	Advocate Assisting – Sam Chahrouk, Coronial Advocate Commissioner for CSNSW – Lily Chester, Solicitor Justice Health NSW – Katharine Guildford, Solicitor
Non publication orders:	Non publication orders were made on 19 February 2026. A copy of the orders can be obtained on application to the Coroners Court Registry.

Findings:	**Identity of deceased**: The deceased person was Taulima Parker **Date of death**: Taulima Parker died on the 29th of April 2025 **Place of death**: He died at Prince of Wales Hospital, 320/346 Barker St, Randwick, NSW, 2031 **Manner of death:** He died from natural causes while he was in lawful custody **Cause of death:** The medical cause of death was metastatic pancreatic cancer

Table of Contents

Introduction: 1

The Inquest: 1

The Evidence: 2

- Mr Parker’s background: 2
- Mr Parker's medical history........ 2
- Mr Parker’s incarceration: 2
- The events leading up to Mr Parker's death........ 3
- Investigation following Mr Parker's death........ 5

Findings required by s81(1)........ 6

- The identity of the deceased........ 6
- Date of death 6
- Place of death........ 6
- Cause of death 6
- Manner of death........ 6

The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of Taulima Parker.

Introduction:

1. At the time of his death, Mr Taulima Parker was 75 years of age and in lawful custody.

2. On the morning of the 29th of April 2025, Mr Parker died in the end-of-life care ward at Prince of Wales Hospital; he was pronounced deceased at 3:30am.

The Inquest:

3. 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.

4. When a person is bail refused or sentenced to a term of imprisonment, they are lawfully detained in the custody of Corrective Services NSW (‘CSNSW’). 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 the person in custody has been cared for in an appropriate way.

5. This inquest took place on Thursday the 19th of February 2026. A brief of evidence was tendered in the proceedings. The brief included police and witness statements, extensive medical and custodial records, and the post-mortem examination report.

6. All of the evidence within the brief of evidence has been taken into account in coming to the findings set out below. I would like to offer my sincere condolences to Mr Parker’s family.

The Evidence:

Mr Parker's background:

7. Mr Taulima Parker was born on the 31st of January 1950 in Lepea, Samoa. In 1972, he relocated to New Zealand, where he spent several years before migrating to Australia in 1980 to begin a new chapter in his life.

8. During his time in Australia, Mr Parker entered into a long-term relationship, during which three children were born between 1986 and 1989.

9. Mr Parker later formed a subsequent relationship, and that partnership resulted in two further children. That relationship ended in 2002.

10. Mr Parker's most recent relationship occurred later in life and represented the last significant personal partnership before his death

Mr Parker's Medical History

11. Mr Parker's medical history included ischaemic heart disease, asthma, paroxysmal atrial fibrillation and osteoarthritis. His family also believe he experienced a heart attack in 1986; however, the details surrounding this event are limited.

Mr Parker's incarceration:

12. On the 3rd of November 2016, Mr Parker was arrested and charged with a series of sexual offences. He was remanded in custody at Parklea Correctional Centre. He remained there until his release on bail on the 24th of January 2017.

13. In May 2018, Mr Parker was convicted of eight of the offences. He was taken back into custody on the 16th of May 2018 and was subsequently held at the Metropolitan Reception and Remand Centre (MRRC).

14. On the 20th of July 2018, while still on remand, Mr Parker appeared before the Downing Centre District Court for sentencing. He received an aggregate sentence of 14 years and 6 months imprisonment, with a non-parole period of nine years, scheduled to expire on the 20th of February 2027.

15. Following sentencing, Mr Parker was transferred from the MRRC to the Hunter Correctional Centre. He was later moved to the Kirkconnell Correctional Centre, where he continued to serve his sentence.

The events leading up to Mr Parker's death:

16. On the 24th of February 2025, while housed at Kirkconnell Correctional Centre, Mr Parker experienced an episode of abdominal pain. He reported upper right-sided abdominal pain radiating into the rib and chest regions, accompanied by lower back pain. Associated symptoms included shortness of breath, dizziness, unsteady gait, lethargy, and tiredness.

17. He was assessed by the on-site Nurse Practitioner, who determined that his condition required transfer to hospital for further assessment.

18. On the 25th of February 2025, Mr Parker was admitted to Bathurst Base Hospital.

19. On the 26th of February 2025, imaging and clinical investigations identified multiple lesions on both the pancreas and liver. A biopsy was scheduled and subsequently performed on the 28th of February 2025.

20. On the 1st of March 2025, Mr Parker was formally diagnosed with metastatic pancreatic adenocarcinoma with liver and lung metastases; his cancer was terminal. Due to the seriousness of his condition, he was deemed no longer suitable for continued placement at Kirkconnell Correctional Centre.

21. On the 12th of March 2025, he was transferred to Long Bay Hospital and admitted to the Medical Sub-Acute Unit (MSU) for pain management and oncology review through the Prince of Wales Hospital.

22. On the 27th of March 2025, Mr Parker was admitted to the Prince of Wales Hospital with a pain crisis related to his metastatic pancreatic cancer.

23. On the 31st March 2025, medical staff advised Mr Parker that the likelihood of deriving a meaningful response from systemic treatment of his pancreatic cancer was uncertain. He was informed that chemotherapy could offer only a modest extension of life and carried a significant risk of adverse side effects. Mr Parker demonstrated understanding that such treatment would not cure his disease and could only slow its progression. He nonetheless wished to proceed with chemotherapy.

24. On the 3rd of April 2025, he commenced his first cycle of gemcitabine and Abraxane chemotherapy, which he tolerated without issue. He received a second cycle on the 10th of April 2025, also without issue.

25. On the 11th of April 2025, he was discharged back to Long Bay Hospital MSU with plans for further chemotherapy, including a scheduled treatment for the 17th of April 2025.

26. On the 17th of April 2025, Mr Parker was readmitted to the Prince of Wales Hospital for review due to concerns of anorexia, nausea, and diarrhoea. Due to his clinical deterioration, palliative chemotherapy was not administered.

27. On the 18th of April 2025, a dietitian assessment of Mr Parker revealed a reduced oral intake and an estimated 10.8% loss of body weight over approximately two and a half weeks. A nutritional intervention plan was implemented, including close monitoring.

28. By the 24th of April 2025, medical staff documented a significant deterioration in Mr Parker's health.

29. On the 25th of April 2025, he was transferred to Bed 23 in the End-of-Life Care Ward.

30. On the 26th of April 2025, family members were present at his bedside. Mr Parker appeared weak but not in marked distress. He was non-verbal and unrousable, with no observable grimacing or agitation. His breathing remained comfortable, and he exhibited significant oedema of the upper limbs. Peripheral warmth was maintained, and his abdomen was noted to be soft on examination.

31. The treatment plan was to continue end-of-life care in accordance with palliative guidance, including mouth care and pressure area management.

32. Mr Parker's condition deteriorated further following a respiratory infection, he was then commenced on intravenous antibiotics.

33. Approximately 3:30am on the 29th of April 2025, medical staff attended to Mr Parker following a sudden and significant drop in his blood pressure. Despite treatment for a likely respiratory infection, his condition continued to decline.

34. Consistent with his documented resuscitation orders and discussions held with family, no resuscitative measures were undertaken. His care was transitioned to a comfort focused end-of-life approach with withdrawal of active treatments.

35. Mr Parker died at 3:55 am on the 29th of April 2025 under the supervision of the palliative care team.

Investigation following Mr Parker's death:

36. NSW Police were notified and attended Mr Parker's hospital room at Prince of Wales Hospital on the day of his death. Police commenced an investigation into the circumstances surrounding Mr Parker's death. Following their assessment, officers determined that Mr Parker's death was not suspicious. Mr Parker's body was transported to Forensic Medicine, Lidcombe.

37. A police brief of evidence was subsequently prepared and provided to the Court. The Officer in Charge, Plain Clothes Senior Constable Jazmin Tiller, formed the opinion that Mr Parker died from natural causes, consistent with complications of metastatic pancreatic cancer, while receiving treatment at the Prince of Wales Hospital

38. An autopsy conducted by pathologist Dr Rianie Janse Van Vuuren concluded that Mr Parker died as a result of metastatic pancreatic cancer. The examination identified no suspicious injuries. Post-mortem imaging showed a cystic mass in the pancreatic tail, consistent with the presumed primary tumour, as well as metastases within the lungs and multiple diffuse metastases throughout the liver.

Conclusion

39. Overall, the available evidence indicates that Mr Parker was in lawful custody and his medical conditions were appropriately managed whilst in custody. There is no evidence to suggest that any different management of Mr Parker's medical conditions, by CSNSW or Justice Health staff could have materially affected the eventual outcome.

40. I offer my sincere condolences to Mr Parker's family.

Findings required by s81(1)

41. As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The deceased person was Taulima Parker

Date of death

Mr Parker died on the 29th of April 2025

Place of death

He died at Prince of Wales Hospital, 320/346 Barker St, Randwick, NSW, 2031

Manner of death

He died from natural causes while he was in lawful custody

Cause of death

The medical cause of death was metastatic pancreatic cancer

42. I close this inquest.

Magistrate Teresa O’Sullivan
State Coroner

19 February 2026