CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Kai McEwan
Hearing dates:	22 November 2022
Date of Findings:	22 November 2022
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, ruptured aneurysm, subarachnoid haemorrhage, undiagnosed hypertension, administration of aspirin, Adult Nurse Initiated Medication Protocols
File number:	2019/218076
Representation:	Ms K Boyd, Counsel Assisting, instructed by Ms H Fitzsimmons (Crown Solicitor's Office) Mr B Ferguson for Justice Health & Forensic Mental Health Network Ms S Pickard for the Commissioner of Corrective Services New South Wales Mr S Rees for Ms M Brown

Findings:

Kai McEwan died on 12 July 2019 at Westmead Hospital, Westmead NSW 2145.

The cause of Kai's death was a ruptured berry aneurysm and sequelae. The aneurysm was undiagnosed and its rupture resulted in a catastrophic subarachnoid and intracerebral haemorrhage. This led to overwhelming elevation of intracranial pressure, brain shift with uncal herniation, brain stem haemorrhage and compression, eventually causing brain death.

Kai died of natural causes whilst on remand in lawful custody. Kai suffered from undiagnosed significant hypertension and had previously engaged in lifestyle habits of cigarette smoking and substance abuse. These were all significant risk factors in the development of his cerebral aneurysm. Although Kai had previously complained of headaches in the period preceding his death, there was nothing to indicate that any further investigation was warranted, or any good reason to suspect that Kai was at risk of imminent intracranial aneurysm rupture. The overwhelming nature of Kai's intracranial pathology was inevitably fatal and, tragically, no medical treatment could have altered the eventual clinical outcome.

Non-publication orders: See Annexure A

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1. Introduction

1.1 Kai McEwan was a 25 year old indigenous man who died on 12 July 2019. At the time of his death, Kai was on remand in lawful custody. Whilst taking a shower in his cell on the morning of 11 July 2019, Kai suddenly collapsed. His cellmate was alerted to his collapse and called for medical assistance.

1.2 Kai was taken to hospital where it was found that he had experienced a catastrophic subarachnoid haemorrhage. The significant extent of this haemorrhage and its effects meant that there was no prospect of survival for Kai and brain death was certified on 12 July 2019. This was followed by the withdrawal of advanced life support measures due to Kai's poor prognosis.

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 charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

2.3 A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. This type of examination typically involves consideration of, where relevant, the conduct of staff from Corrective Services New South Wales (**CSNSW**) and Justice Health & Forensic Mental Health Network (**Justice Health**).

2.4 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

2.5 It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated.

3. Kai's personal background

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.2 Kai was born to Michael Hamilton and Sue-Anne McEwan at Campbelltown Hospital. Kai's father was not involved in his upbringing. Kai had three siblings: an older and a younger sister, and a younger brother.

3.3 In around 1999, when Kai was approximately six years old, he and his siblings were removed from Sue-Anne's care. At the time, Kai was experiencing issues with prohibited drugs. Following this, Kai lived with various family members in Ambervale, Airds, Edgeworth and, eventually, Sydney. When Kai was about 16 years old he moved out on his own. At the time he has been living with his mother's older sister and was in Year 9 at school. Kai later completed a Certificate III in Warehouse Operations but did not find employment.

3.4 Kai was proud of his Aboriginal heritage and felt a strong connection to his culture and community, both of which were important parts of his identity. Kai's mob is Wailwan from Gulargambone. He enjoyed being out in nature and pursuing outdoor activities. He played a number of sports well and was a particularly talented football and soccer player. Kai was known to be somewhat of a larrikin at school, had a daring sense of adventure and was popular amongst his many friends.

3.5 Kai enjoyed a close relationship with his older sister and other siblings, his mother's cousin, Melinda Brown, and his many cousins. To them he was known as "Kai Kai". Kai's older sister was a mother figure to him and they were inseparable, always looking out for each other from their childhood to adulthood. Kai was also a loving and devoted uncle to his nieces and nephews, and a role model to his cousins; they all looked up to him. Kai spent many holidays with his nieces and nephews, taking them on outings and building lifelong memories with them. He loved them like his own children and enjoyed a special bond with them. Kai was always determined to make sure that their lives were better than his own. Throughout his life, Kai always placed family first and spent much of his time attending family events and looking after the well-being of family members.

3.6 At the conclusion of the inquest, Melinda shared her personal memories of Kai, who he was as a person and how his loss has been deeply felt by his loved ones. Melinda described Kai as a cheeky, kind and loving young soul who was a big kid at heart, and who touched the hearts of many people.

3.7 It was a great privilege to hear about these memories and to be provided with a brief, but important, glimpse into Kai's life. At the same time, it is heartbreaking to know that Kai died as a young man, with his future ahead of him and his dreams and aspirations unfulfilled. It is equally devastating to know that Kai died whilst in custody, separated from his family and many friends and loved ones.

4. Kai's medical history

4.1 Apart from being treated for tuberculosis in 2009, Kai's medical history was unremarkable except for his substance abuse. Since the age of 13, Kai had engaged in illicit drug use, including heroin, methylamphetamine and smoking cannabis. He had also consumed alcohol and engaged in heavy nicotine cigarette smoking from this time.

4.2 In the months before Kai was remanded in custody in May 2019, he reportedly complained of constant headaches. However, he did not seek medical attention.

5. Kai's custodial history

5.1 From the age of 13, Kai had numerous interactions with police and the criminal justice system. Some of these interactions involved Kai being convicted of a number of criminal offences, resulting in recurring periods in custody between 2010 and 2019.

5.2 On 2 May 2019, Kai was charged with an alleged offence of driving whilst disqualified. He had been charged with an identical alleged offence only a month earlier. After being refused bail, Kai was transferred from the cells at the Surry Hills Police Centre to Parklea Correctional Centre where he remained until 22 May 2019. At that time, Kai was transferred to Dawn De Loas Correctional Centre which is located within the Silverwater Complex.

5.3 After appearing at Parramatta Drug Court on 25 June 2019, Kai was found eligible for the Drug Court Program. Kai was encouraged by his acceptance into this program and saw it as an opportunity to make some positive changes in his life. He was transferred to the Metropolitan Remand and Reception Centre (**MRRC**) and initially housed within Pod 13.

5.4 On 9 July 2019, Kai was transferred to the Detox Unit within the MRRC. This unit is used for inmates who are participating in the Drug Court Program. Kai was initially housed with another inmate, but was moved to a different cell the following day which he shared with a third inmate.

6. Background to the events of 11 July 2019

6.1 At around 1:45pm on 9 July 2019, Kai was seen by a Justice Health nurse in relation to drug and alcohol substance withdrawal monitoring. Notes from the consultation indicate that Kai reported having a headache at the time, with his pain recorded as being "*mild*".

6.2 The following day, on 10 July 2019, Kai complained to one of his cellmates that he had a "*really bad headache*". According to Kai's cellmate, Kai indicated that he did not want to leave the cell and instead just wanted to lie down.

6.3 At around 9:00am, Kai presented to the Justice Health Nurse Unit Manager. He complained of a headache behind his right eye, which reportedly had been there for the past three days. Kai also reported that the headache was related to a cough and runny nose, and that it had not responded to paracetamol. Records from the consultation indicate that the pain was described as "*moderate*".

6.4 Kai's vital signs, including his blood pressure, were taken. They were all noted to be within normal limits. At around 9:30am, Kai was provided with 300mg of aspirin for his headache and 10mg of phenylephrine hydrochloride for his nasal congestion.

6.5 Following this presentation, and prior to being transferred to a different cell, Kai reportedly told his cellmate that he was feeling much better.

6.6 At around midday, Kai was assessed by a psychiatrist with the Drug Court Program. It was noted that Kai had reported headaches "*but nil else*" for the previous four days. A treatment plan was formulated which focused on abstinence from all illicit substances and alcohol, regular drug counselling and prescription of suboxone.

6.7 At around 2:30pm, Kai was seen by a Justice Health nurse. He reported that he had no more pain from his headache, which is reflected in an entry in his observation chart which recorded his pain at the time as being "*nil*". Kai's vital signs were checked and again found to be within normal limits. Kai reportedly requested more pain relief for the night and was given 1mg of paracetamol.

6.8 Just before going to sleep, at around 10:30pm, Kai told one of his cellmates that he wanted to go to sleep "*before his headache returned*". At this time, neither of Kai's cellmates noted that Kai appeared to be sick or unwell.

7. What happened on 11 July 2019?

7.1 Between around 4:06am and 6:04am on 11 July 2019, CCTV footage from Kai's cell recorded Kai to be moving his legs at various times whilst in bed.

7.2 At around 6:04am, a CSNSW officer opened the door to Kai's cell to perform a head check and requested a verbal acknowledgement from Kai and his two cellmates. All three persons responded accordingly. CCTV footage shows Kai to be moving at this time.

7.3 Approximately four minutes later, Kai got out of bed and went to the toilet area within the cell. He later returned to bed at around 6:12am.

7.4 CCTV footage shows Kai to be moving in his bed from 6:12am to 6:50am. At 6:51am, one of Kai's cellmates was escorted from the cell by CSNSW staff to attend court.

7.5 At around 7:02am, Kai got out of bed again, collected a towel and walked towards the shower area of the cell. A minute later, Kai removed his clothes and entered the shower. Due to limited natural light at the time, the CCTV footage does not clearly show what was occurring. However, at 7:06am, the CCTV shows Kai appearing to collapse whilst in the shower area.

7.6 At around 7:10am, Kai's remaining cellmate woke up after hearing a noise from the shower area. He described it as a gargling noise, "*kind of like snoring*" but quite loud. Initially, the cellmate did not pay any attention to the noise, believing that it was Kai's other cellmate getting ready to attend court. However, after the noise continued, the cellmate sat up and looked towards the bathroom.

7.7 Kai was observed to be lying on the floor, face down and completely naked. His arms were by his side with his head pressed up against the toilet. The shower was not on but there was some water on the ground around Kai, who was noted to be making a "*gurgling or grunting noise*". Kai's cellmate described this as "*an unearthly noise*".

7.8 Kai's cellmate knelt down, and attempted to raise Kai by touching him and speaking to him. When Kai did not respond, his cellmate banged on the cell door and called for assistance. This call was answered by a CSNSW officer who was told that Kai was lying on the ground and unwell. The CSNSW officer proceeded to the cell, advising Justice Health staff of the situation.

7.9 At around 7:13am, Kai's cellmate dragged Kai away from the toilet towards the middle of the cell and placed him in the recovery position. At that time, it was noted that one of Kai's eyes was partially open with the pupil pointing straight up and not moving, and that Kai's breaths were very shallow and far apart.

7.10 When Justice Health staff arrived at the cell, Kai could be seen through the viewing panel in the cell door to be lying on the floor, naked and in the recovery position. They called out to him but Kai did not respond. After two CNSW officers arrived at the cell, the door was opened and the CNSW officers and Justice Health staff entered the cell. One of the CSNSW officers asked Kai's cellmate whether Kai had "*taken anything*" and was advised that Kai had been complaining of headaches for the last few days. This information was provided to the three Justice Health nurses who were attending to Kai.

7.11 The nurses found that Kai was unresponsive to verbal commands, but responded to painful stimuli by retracting his arms. No visible signs of trauma were noted on Kai's body. It was also noted that Kai was breathing on his own and making periodic gurgling and groaning noises. Kai was administered 0.4mg of naloxone (which is used to negate the effects of opioids) in accordance with standard protocol, without any effect. Kai's blood pressure could not be recorded and his pulse rate was noted to be 40bpm. Kai's pupils were also noted to be dilated to 6mm and not reacting to light. Kai was administered oxygen, his head was supported to maintain his airway and emergency services were contacted.

7.12 NSW Ambulance paramedics arrived at the cell at 7:39am. Kai's airway was noted to be patent and a nasal tube was inserted to maintain his airway, as his jaw had locked up. Kai's heart rate was noted to be low and he was administered a dose of midazolam (used to treat seizure activity) as a precaution.

7.13 Intensive care paramedics arrived at the scene at 8:01am. Kai was administered atropine to increase his heart rate, with good effect. He was placed on a stretcher and removed from the cell to an ambulance so that he could be taken to Westmead Hospital.

7.14 Whilst en route, Kai was administered Hartmann's solution (to increase blood pressure with good effect), ondansetron (which is used to reduce vomiting), and midazolam (as it was noted that Kai's arms and hands began to curl back in apparent seizure-like activity). Kai's airway was also maintained, but overall there was no change to his condition.

7.15 Kai arrived at Westmead Hospital at 8:41am. He was noted to have fixed and dilated pupils with bilateral decorticate posturing as a result of brain stem compression. It was also noted that Kai was bradycardic and hypertensive, indicating raised intracranial pressure. A computed tomography (**CT**) brain scan was performed at 9:36am. This showed an extensive subarachnoid haemorrhage with a large intracerebral component. There was also evidence of uncal and tonsillar herniation resulting from mass effect and raised intracranial pressure. Kai was administered mannitol, an osmotic diuretic used to lower intracranial pressure.

7.16 A CT angiogram was also performed which revealed very little blood flow to the cerebral hemispheres. This indicated an ischaemic brain, which was an irretrievable situation with brain death imminent. This was confirmed following consultation with the on-call neurosurgeon, who opined that Kai had suffered a catastrophic brain haemorrhage and that the situation was non-survivable. As there had been no response to mannitol, the on-call neurosurgeon recommended supportive measures only.

7.17 Kai was maintained on ventilation and life support. At 12:30pm on 12 July 2019, an intensivist issued a certificate of brain death, with the time of death recorded as 1:14pm. Following discussions with Kai's family, advanced life support measures were withdrawn at 9:40pm.

8. The postmortem examination

8.1 Kai was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Bernard I'Ons, forensic pathologist, on 17 July 2019. That examination identified the following relevant findings:

(a) a large right-sided subarachnoid haemorrhage centred particularly on the right middle cerebral artery;

(b) moderate to severe hypertension, with myocyte hypertrophy in the heart muscle, and sections of the common carotid arteries showing intimal and medial thickening with focal calcification; and

(c) medium-sized blood vessels showing mild tunica media thickening in the kidneys.

8.2 Dr I'Ons noted the following:

> Most non-traumatic subarachnoid haemorrhages (SAH) are due to rupture of an intracranial aneurysm. Risk factors that are primarily associated with a formation of intracranial aneurysms are hypertension, cigarette smoking and family history. It is therefore significant that changes of moderate to severe hypertension were observed in the kidneys and heart of [Kai].
>
> The great majority of cases of subarachnoid haemorrhage resulting from ruptured cerebral arterial aneurysms have no associated history of concomitant or recent trauma.

8.3 Associate Professor Michael Buckland, a specialist neuropathologist, performed a macroscopic and microscopic examination of the brain. These examinations showed that the wall of the ruptured aneurysm was quite abnormal with both intima and media replaced by fibrous tissue. It was noted

that the ultimate agonal event that caused disruption of brain stem function was haemorrhage within the substance of the pons and herniation of the cerebella tonsils. The neuropathology examination did not identify any evidence of blunt force trauma.

8.4 Dr I'Ons ultimately opined that the cause of Kai's death was a ruptured berry aneurysm and sequelae.

9. Outcome of the coronial investigation

9.1 As part of the coronial investigation, Professor Michael Besser AM, consultant neurosurgeon, was briefed to consider the circumstances leading up to and surrounding Kai's death, as well as the medical treatment provided to him. Professor Besser prepared a report dated 4 February 2022 in which he, relevantly, expressed the following opinions:

(a) Substance abuse, particularly cigarette smoking, is a known risk factor in the development of intracranial aneurysms. The risk of tobacco use in Kai's case is amplified by hypertension.

(b) Kai's aneurysm was asymptomatic. Although Kai had complained of headaches in the one to two months preceding his death, these complaints were likely due to his undiagnosed and untreated hypertension. Whilst 24-hour blood pressure monitoring would have diagnosed Kai's hypertension, there was no indication (apart from persistent headache) that this was indicated. Indeed, Kai's blood pressure was noted to be within normal limits when it had previously been measured on a number of occasions.

(c) It is possible that on 10 July 2019, Kai had a minor localised subarachnoid haemorrhage. This is known to occur in about half of the patients who subsequently have a major intracranial haemorrhage, and is often undiagnosed. This may have been the cause of Kai's more severe headache localised behind his right eye although the results of the CT brain scan from Westmead Hospital are inconclusive in this regard.

(d) The minor haemorrhage described above results in headache often accompanied by nausea, vomiting and neck stiffness, although one or more of these symptoms are not always present. In Kai's case, none of these symptoms were present. Further, Kai's symptoms quickly resolved with simple analgesia. Given this, and the absence of any accompanying relevant symptoms or signs, no further investigation or treatment was indicated in the days preceding 11 July 2019.

(e) On 11 July 2019, Justice Health staff were delayed from being able to immediately enter Kai's cell in order to provide treatment. This was due to the need to wait for the arrival of a second CSNSW officer so that the cell could be open in accordance with standard CSNSW policies and procedures. Whilst time is of the essence in the emergency treatment of an unconscious patient, Professor Besser opined that the impact on Kai's outcome "*was minimal in view of the overwhelming nature of his intracranial haemorrhage*". Ultimately, Kai's "*poor prognosis was set at the moment of his intracranial aneurysm rupture*".

(f) Whilst the nature and quality of medical treatment provided by Justice Health staff and ambulance personnel was appropriate and of good quality, no medical treatment on 11 July 2019 "*could have prevented the eventual clinical outcome*".

(g) The abnormal coagulation function in Kai's blood tests at Westmead Hospital indicates platelet dysfunction due to the administration of aspirin on 10 July 2019. The effect of aspirin on platelets lasts for 7 to 10 days and is well-known to cause untoward bleeding in a number of circumstances. In Kai's case this may have resulted in a more widespread and severe intracranial haemorrhage from his aneurysm rupture. Whilst Professor Besser expressed the view that aspirin should be avoided in treatment for headaches, he ultimately expressed doubt that the effect of aspirin administration "*had any major influence on the fatal outcome*".

9.2 In response to the opinion expressed by Professor Besser regarding the administration of aspirin to inmate patients, further information was sought from Justice Health. As at July 2019, and currently, the administration of aspirin to inmate patients was subject to the Justice Health *Adult Nurse Initiated Medication Protocols* (**the Protocols**). The Protocols provided the indications for the use of aspirin as follows:

> Symptomatic relief of fever, mild to moderate pain due to inflammation and tissue injury, migraine, toothache, headache, sore throat and period pain.

9.3 Relevantly, the Protocols also precautioned against the use of aspirin in patients with uncontrolled hypertension, with one of the possible side effects noted to be increased bleeding time.

9.4 Justice Health considered that Kai's presentation on 10 July 2019 appeared to be consistent with a migraine headache, noting that he had complained of a headache behind his right eye for the previous three days despite treatment with paracetamol. According to the Protocols, the first line of treatment for a migraine headache is simple analgesic such as paracetamol, with a nonsteroidal anti-inflammatory such as aspirin considered to be a second line of treatment that is regarded as offering therapeutic benefit to a patient.

9.5 As noted already, Kai's hypertension was not diagnosed at any time before his death. In addition, after being prescribed aspirin on 10 July 2019, Kai reported to his cellmate that he was feeling much better. When seen by a Justice Health nurse later at around 2:30pm, Kai reported no further headache pain and his vital signs were found to be within normal parameters. In short, at the time that the aspirin was given to Kai, and shortly afterwards, there was no evidence to suggest, consistent with the guidance provided by the Protocols, that its administration was contraindicated. Further, given that previous administration of paracetamol had not resolved Kai's headache pain, the administration of aspirin was appropriate treatment for Kai's presentation.

10. Findings pursuant to section 81(1) of the Act

10.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Kate Boyd, Counsel Assisting, and her instructing solicitors, Ms Holly Fitzsimmons and Mr Hugh Gillespie from the Crown Solicitor's Office. The Assisting Team has provided enormous assistance during the conduct of the coronial investigation and throughout the course of the

inquest. I am extremely grateful for their meticulousness, and for the sensitivity and empathy that they have shown during all stages of the coronial process.

10.2 I also acknowledge the assistance of Detective Senior Constable Stewart Mortimer, the police officer-in-charge of the investigation, in compiling the initial brief of evidence.

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

Identity

The person who died was Kai McEwan.

Date of death

Kai died on 12 July 2019.

Place of death

Kai died at Westmead Hospital, Westmead NSW 2145.

Cause of death

The cause of Kai's death was a ruptured berry aneurysm and sequelae. The aneurysm was undiagnosed and its rupture resulted in a catastrophic subarachnoid and intracerebral haemorrhage. This led to overwhelming elevation of intracranial pressure, brain shift with uncal herniation, brain stem haemorrhage and compression, eventually causing brain death.

Manner of death

Kai died of natural causes whilst on remand in lawful custody. Kai suffered from undiagnosed significant hypertension and had previously engaged in lifestyle habits of cigarette smoking and substance abuse. These were all significant risk factors in the development of his cerebral aneurysm. Although Kai had previously complained of headaches in the period preceding his death, there was nothing to indicate that any further investigation was warranted, or any good reason to suspect that Kai was at risk of imminent intracranial aneurysm rupture. The overwhelming nature of Kai's intracranial pathology was inevitably fatal and, tragically, no medical treatment could have altered the eventual clinical outcome.

11. Epilogue

11.1 There is no doubt that Kai's family have lost a son, brother, nephew, uncle and cousin all too soon and with Kai's life very much ahead of him. It is distressing to know that Kai's passing came at a time when he had been accepted in the Drug Court Program and was determined to make positive changes in his life.

11.2 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Kai's family and loved ones for their tragic and heartbreaking loss.

11.3 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
22 November 2022
Coroners Court of New South Wales

Annexure A
Inquest into the death of Kai McEwan

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 as it is information that is not available to the public and, if released, has the potential to jeopardise CSNSW security arrangements and the safety of staff, inmates, family members and visitors:

   (a) Names, addresses, phone numbers, Visitor Index Numbers and other personal information that could tend to identify Kai McEwan's family, friends or visitors (other than legal representatives or visitors acting in a professional capacity).
   (b) The names, Master Index Numbers and other personal information of any persons in the custody of Corrective Services New South Wales (CSNSW), other than Kai McEwan.
   (c) The direct contact details of CSNSW staff that are not publicly available.
   (d) CCTV and handheld video camera footage, including any stills of that footage.
   (e) Maps and diagrams of correctional facilities.
   (f) CSNSW staffing rosters and daily schedules.
   (g) Portions of the Custodial Operations Policy and Procedure not publicly available
   (h) Local Operating Procedures for Metropolitan Remand and Reception Centre.

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 Derek Lee
Deputy State Coroner
22 November 2022
Coroners Court of New South Wales