CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Benjamin Cullen
Hearing Dates:	11-18 October 2024
Date of Findings:	8 December 2025
Place of Findings:	Coroners Court of New South Wales at Lidcombe
Findings of:	Magistrate David O'Neil, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody – Parklea Correctional Centre – provision of medication – health care in custody—obligations at time of release from custody—provision of medication upon release from custody
File Number:	2023/55427
Representation:	Mr M Robinson, Counsel Assisting the Coroner instructed by Ms F Lilly of the Crown Solicitor's Office Mr Greg James SC, instructed by A Reslan of King's Law, for the family of Mr Cullen Mr M Windsor SC, instructed by Ms S Idowu of Hall & Wilcox, for St Vincent's Correctional Health Mr Wilcox, instructed by Ms Holmes of the Department of Communities and Justice, for The Commissioner, Corrective Services NSW Mr T Hackett, instructed by Mr S Bailey of Ash Street Partners, for MTC- Broadspectrum

Findings:

Identity:

The person who died was Benjamin Nathan Cullen

Date of death:

Mr Cullen died on 25 February 2021 at 5:23pm

Place of death:

Mr Cullen died at John Hunter Hospital

Cause of death:

The cause of Mr Cullen's death was acute, severe hydrocephalus. Mr Cullen's death was contributed to by longstanding chronic hydrocephalus caused by a tumour abutting the cerebral aqueduct.

Manner of death:

Mr Cullen died from natural causes

Recommendations

To **St Vincents Correctional Health**

*1.*That St Vincent's Correctional Health, in consultation with MTC, the Justice Health, and Forensic Mental Health Network and Corrective Services New South Wales, explore options for real time documentation of medication, administration, and or supply in the electronic medication administration record;

To **MTC Broadspectrum**

2.That MTC Broadspectrum, in consultation with St Vincent's Correctional Health, review its processes at discharge, including the terms of the discharge checklist completed with inmates shortly prior to their release from custody to ensure its discharge processes are compliant with Corrective Services New South Wales's policies and procedures, including

but not limited to COPP 23.2

Non-publication orders: Orders pursuant to section 74(1)(b) of the Coroners Act 2009 prohibiting the publication of certain evidence have been made in this inquest. Orders have also been made pursuant to section 65(4) of the Coroners Act 2009.

A copy of the orders can be found on the Registry file.

Introduction

1 Mr Benjamin Cullen who I shall refer to as Benjamin died on 25 February 2021 at 5:23pm at John Hunter Hospital. Benjamin, who was then aged 41 had been pronounced brain dead after a series of seizures on 23 February 2021, and his life support systems were turned off with the agreement of, and in the presence of, his mother.

2 Because Benjamin died so soon after his release from custody on 22 February 2021, an inquest was conducted under the Coroners Act 2009 NSW (the Act).

3 When someone is in lawful custody they are deprived of their liberty, and the State (and in this case, its contractors) assumes responsibility for the care and treatment of that person. In such cases including when a person's death occurs shortly after release from custody the community has an expectation that the death will be properly and independently investigated.

4 Due to the similarities in issues, this matter was heard in tandem with the inquest into the death of Robert Bickerstaff. Findings for that matter will be delivered separately.

The Coroner's role

5 An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death.

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, namely;

- the person's identity;

- the date and place of the person's death; and

- the manner and cause of the person's 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 an inquest, a detailed coronial investigation was undertaken. The Investigating Police Officer in Charge Detective Senior Constable Counsell compiled a brief of evidence and a report was obtained from a forensic pathologist as to the cause of death. The brief included statements from correctional, St Vincent's pharmacy and nursing staff and CCTV footage.

9 During the Coronial investigation relevant policy documents and a Serious Incident Report undertaken by a senior investigator from the Corrective Services' Investigation Branch were also obtained.

10 All the documents and witness statements obtained during the investigation formed part of the brief of evidence tendered during the Inquest. All that material has been considered in making the findings detailed below.

Witnesses

11 The following witnesses gave evidence at the hearing:

a. Caroline Basaly, Senior/Chief Pharmacist at St Vincent's Correctional Health;

b. Wendy Adair, Pharmacy Technician at St Vincent's Correctional Health;

c. Professor John Watson, expert neurologist;

d. Katya Issa, Operations Manager at St Vincent's Correctional Health; and

e. Brian Gurney, Deputy Governor of Parklea Correctional Centre.

Issues

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 – Determination of the statutory findings required under s. 81 of the Coroners Act 2009 (NSW), including manner and cause of death.

- Issue 2 – Whether, during Mr Cullen's incarceration at Parklea Correctional Centre, there were occasions on which he did not receive his prescribed levetiracetam (Keppra). If there were such occasions

    a) When was his Keppra not administered or supplied?

    b) Why was his Keppra not administered or supplied?

- Issue 3 – If it be the case that there were occasions on which Mr Cullen did not receive his Keppra, whether the failure to administer Keppra which had been prescribed to Mr Cullen caused or contributed to:

    a) The occurrence of his seizures on 23 February 2021; and/or

    b) His death.

- Issue 4 – The adequacy of release planning in Mr Cullen's circumstances, including:

a) Whether MTC-Broadspectrum promptly informed St Vincent's Correctional Health of Mr Cullen's pending release;

b) Whether St Vincent's Correctional Health had sufficient opportunity to engage in planning for Mr Cullen's release;

c) Whether, upon his release, Mr Cullen was provided his evening dose of Keppra;

d) Whether Mr Cullen was provided a supply of his prescription medication (beyond the evening dose of Keppra) upon release or otherwise provided with advice in respect of the requirement to obtain medication for his medical conditions, including epilepsy.

Background

14 Much of the following background is gratefully drawn from the opening of Counsel Assisting.

15 Benjamin was born on 8 December 1979. He was the son of Gaylene and Michael Cullen and brother of Sharney Cullen. Benjamin's father is deceased. Benjamin was raised in the Newcastle area in a loving and stable environment. He had one son. Benjamin worked variously as a chef, having successfully completed an apprenticeship and later for Foxtel performing installations. Prior to entering custody, Benjamin was a demolition and asbestos removalist.

16 Benjamin was known to regularly consume alcohol and was believed to consume recreational drugs on a casual basis. He suffered a head injury approximately 20 years before his death and in his late teens he was diagnosed with epilepsy. He was prescribed Keppra to manage his epilepsy. He'd reliably taken Keppra in the years preceding his death, together with Zonisamide, sold under the brand name Zonegran and Rosuvastatin, sold under the brand name Crestor. Benjamin had adhered to his medication regime and had not experienced a seizure since 2017. That seizure was while he was in custody in Tamworth.

17 On 12 December 2020, Benjamin was arrested and charged in relation to a domestic violence offence. He was granted bail that day, breached that bail and returned to custody on 1 January 2021, granted bail on 8 January and again breached bail and returned to custody on 11 January 2021. He was refused bail by the Local Court at Belmont and transferred to Kariong Correctional Centre before ultimately being transferred to the Metropolitan Remand and Reception Centre, MRRC, on 13 January 2021.

18 Upon his intake on 13 January 2021, it was noted that he took Zonisamide (the active ingredient of Zonegran) and Keppra for epilepsy. He remained at MRRC until 5 February 2021. The records disclosed that during Benjamin's custody at MRRC, and with perhaps one exception, his medication was administered as prescribed. On 1 February 2021, while at MRRC, Benjamin appropriately underwent a chronic disease screen, which recorded the following in respect of his epilepsy:

> History of epilepsy since age 18. Has been on meds. Was under specialist care from John Hunter Hospital, hasn't had follow up for years. Currently under GPs care in community. Last recorded seizure was from 2017, see ROI (release of information). Reported its [epilepsy] under good control, hasn't had seizure for about four years with current meds. Happy with current meds."

19 On 5 February 2021, Benjamin was transferred from MRRC to Parklea Correctional Centre (Parklea). Parklea is a private prison operated by MTC Broadspectrum pursuant to a joint venture arrangement. At some stage MTC Broadspectrum's name changed to MTC. MTC Broadspectrum, and subsequently MTC, both contracted St Vincent's Correctional Health (SVCH) to provide healthcare services at Parklea Correctional Centre. For convenience "MTC Broadspectrum" and "MTC" shall be referred to interchangeably in these findings.

20 On 6 February 2021 Benjamin said the following to his mother on a telephone call: "*They didn't give me meds last night. Wouldn't give it to me this morning*". In another call to his mother that day he said, "*I asked the nurse this morning. I*

said, 'I need medication." He further advised his mother that he threatened that if he did not get his medication he would have a seizure. In a more prescient observation to his mother later that day he observed, "*I'm gunna do an inquest when I get out of here.*"

21 On 8 February 2021 Benjamin said to his mother, "*So, and last night I didn't get any medication and um I'll make it quick, but anyway, they didn't give me medication*". He then recounted using the knock up system to request the medication and, although it's not entirely clear, I am satisfied on balance that he then received his medication.

22 On 9 February 2021, Benjamin attended upon Dr Michael Novy, a specialist emergency physician performing a general medicine type role within Parklea Correctional Centre's main clinic. During Benjamin's consultation with Dr Novy, a medical review of Benjamin was performed. As a result of the review it was recommended that medical staff "*continue anti-epileptic medication as charted. Cease Nurofen and provide Panadol Osteo, two tabs for two weeks*". In addition to his diagnosis of epilepsy, Benjamin was known to suffer from obstructive sleep apnoea (OSA).

23 The 9th of February was the only occasion on which Benjamin was seen by a doctor whilst at Parklea Correctional Centre.

24 The administration of Benjamin's Keppra was required to be supervised. That meant that the nurse or pharmacy technician giving the medication to Benjamin had to witness him swallow it.

25 With respect to the administration of Benjamin's Keppra there was no signature to confirm that Benjamin had taken the morning dose on 7 February, the evening dose on 9 February or the morning doses on 10, 12, 17, 18, 19, 20 and 21 February 2021.

26 On 13 February 2021 Benjamin said to his mother in a telephone call, " *Then it'll be good for a week or two I've been here for five weeks, and they've missed my night medication probably six times. I don't carry on about it. I just say, 'Well, you*

know, I didn't get my night medication last night.' And they say, 'Sorry, I'll note it.' and then bang, doesn't come".

Release and events leading up to death

27 On 22 February 2021, Benjamin, appeared in the Local Court of New South Wales by audio visual link from Parklea Correctional Centre and was sentenced to a two-year Community Correction Order (CCO).

28 He was on bail in respect of other charges. Consequently, Benjamin was to be released from Parklea Correctional Centre as soon as was practicable. His release was categorised as an unplanned release in the sense that he had not reached the end of a fixed non parole period or custodial term such that it was anticipated and could be planned for.

29 As with any person released from custody, Benjamin required continuity of medical care and a supply of medication to ensure he did not go without important medication until such time as he could attend upon a GP in the community or access an existing supply of medication.

30 Upon his release, Benjamin returned to Newcastle by train on the evening of 22 February 2021 or the morning of 23 February. At about 1pm on 23 February, Benjamin collected his phone from a solicitor in Lake Macquarie. At 2.02pm, he suffered a seizure and fell from a bus stop seat in front of a shop at Belmont in Newcastle.

31 New South Wales Ambulance was called, with two crews attending. Paramedics found Benjamin to be confused. Initially, he declined to go to hospital with them. Benjamin was ultimately, conveyed by paramedics to Belmont Hospital, from where he soon discharged himself against medical advice.

32 During the afternoon of 23 February Benjamin spoke with his employer. The employer indicated that Benjamin appeared to be *delusional and out of it.* The employer told Benjamin to get on a bus and return to his accommodation. The

employer spoke to Benjamin's mother who told him that Benjamin had experienced a seizure earlier in the day.

33 At around 5pm on 23 February, Benjamin suffered a second seizure whilst travelling on a public bus. The bus driver was alerted to Benjamin's condition by a passenger. Triple 000 was contacted and an ambulance requested. Paramedics attended and attempted to treat Benjamin at a bus stop in Belmont North. Paramedic Joel Mayhew observed Benjamin to be alert and speaking in full sentences; however, he appeared to be confused. Benjamin resisted being conveyed to hospital. Paramedic Mayhew used Benjamin's phone to speak with Benjamin's mother, Gaylene. Gaylene advised Mr Mayhew that Benjamin had, by that stage, had two seizures, and he had not been taking his medication. Benjamin refused treatment and began walking towards the suburb of Redhead.

34 As such, at 5.20pm, police were called to assist. Paramedics and police spoke to Benjamin for a prolonged period, and ultimately Mr Mayhew indicated to Benjamin that, if he did not get into the ambulance, he would be sectioned (detained and taken to hospital). Mr Mayhew was of the view that Benjamin appeared to understand what this meant. Benjamin voluntarily walked towards the ambulance and acceded to transport to John Hunter Hospital.

35 Paramedics Andrews and Jones indicated that, once they opened the ambulance doors at John Hunter Hospital, Benjamin said either "Thanks, heaps, fellows" or "See you, fellows" and walked towards the exit and absconded. Security was called to retrieve Benjamin; however, upon Paramedic Jones asking Benjamin a series of questions and, based on his answers and his ability to walk on the footpath unaided, he formed the view that Benjamin had emerged from the post ictal (recovery) phase of the seizure. He told Benjamin that he should be assessed in the hospital, but that he could not stop Benjamin from leaving. Benjamin left.

36 At around 6.44pm, Benjamin booked a taxi. The taxi was dispatched to Charlestown; however, the driver cancelled the booking, as Benjamin could not be found. At 6.51, Benjamin called 13CABS, but he did not connect with the driver.

37 At around 7.05pm, Roslyn Hollott observed Benjamin lying on the footpath in front of a house at Russell Street in New Lambton. Benjamin had facial injuries. Upon attending upon Benjamin, Ms Hollott observed that Benjamin was unresponsive. She called triple 000 and her friend Lucy van Baalen, a GP. Dr van Baalen arrived at the scene prior to paramedics. She found Benjamin to have a Glasgow Coma Score of 3. He was not breathing, and she could not find a pulse. She commenced compression only CPR. She continued CPR for approximately five minutes until paramedics arrived and took over.

38 Paramedics, utilising a defibrillator and an automated CPR machine, continued CPR. Benjamin was conveyed to John Hunter Hospital. CPR was continued for 36 minutes by paramedics and medical staff before circulation resumed. A CT scan was undertaken, which indicated a significant hypoxic brain injury. Medical staff determined to monitor Benjamin for a 24-hour period to determine if he regained any brain function. On 25 February 2021, Benjamin was pronounced brain dead, it having been determined that he had regained no brain function. With the agreement of his mother, Gaylene, and in her presence, life support systems were turned off. Benjamin was pronounced deceased at 5.23pm.

Consideration of Issues

39 I shall deal with issue 1 after the other issues.

40 It is convenient to deal with issues 2 and 3 together

Issue Two – Whether, during Mr Cullen's incarceration at Parklea Correctional Centre, there were occasions on which he did not receive his prescribed keppra (Keppra)

If there were such occasions: (a) When was Mr Cullen's keppra not administered or supplied? (b) Why was Mr Cullen's keppra not administered or supplied?

Issue Three – If it be the case that there were occasions on which Mr Cullen did not receive his keppra, whether the failure to administer keppra which had been prescribed to Mr Cullen caused or contributed to (a) The occurrence of his seizures on 23 February 2021; and/or (b) His death.

41 The evidence in the inquest establishes that Benjamin was not given his medication on the 7th of February 2021 and was not given his Keppra on the 12th of February 2021.

42 The reason Keppra was not given on those days is unclear beyond the explanation of "human error".

43 As there is no dispute that Keppra was not given on those dates there is no need to go into the mechanism as to how medication was administered.

44 It is equally clear that the failure to give Benjamin his Keppra on the above dates did not contribute to his seizures on the 23rd of February and did not contribute in any way to his death.

45 An ancillary issue arising in relation to the administration of medications generally and Keppra in particular is that the record keeping in relation to the administration was inadequate.

46 On a number of occasions, the sheets which should have been signed to indicate that medication had been administered ("signing sheets') were in fact not signed.

47 Evidence from the now chief pharmacist at Saint Vincent's Correctional Health, Ms Caroline Basaly, together with two other pharmacists confirmed that it was not unusual for signing sheets to not be correctly completed. The failure to make appropriate entries was attributed to human error.

48 Whilst this evidence from the pharmacist was commendably frank it is trite to point out that the signing sheets should have been signed to provide a record that medication had been administered. There is no evidentiary dispute that on a number of occasions despite the signing sheets not being signed, I can be

satisfied that Keppra was in fact administered on those days (other than 7 and 12 February).

49 The documentation error is a significant one. It is common sense that signing sheets ought to have been consistently completed so that a person reviewing the signing sheets could make a reliable assessment as to whether Benjamin's medication had been supplied to him.

50 The evidence indicated that a variety of steps have been taken to reduce the incidence of medication errors, including documentation errors, since Benjamin's death. The steps taken include recruiting a Medication Management Pharmacist in July 2022. The role of the Medication Management Pharmacist is to "*actively, and on a daily basis, undertake a review, audit, support, backup of the clinicians on the floor providing medication, to trace any patterns or themes that are emerging and provide direct support to the clinicians on the floor so that patients are receiving medication in a timely way*".

51 Additionally, there are now a number of audits which are designed to identify medication errors, including documentation errors, including a spot observational audit and a medication chart audit. Responsibility for overseeing the performance of those audits rests with the Medication Management Pharmacist.

52 I accept these steps are part of a positive effort towards better administration of medicine and record keeping, in relation thereto, at Parklea.

Issue Four – The adequacy of release planning in Mr Cullen's circumstances, including topics set out below

(a) Whether MTC-Broadspectrum promptly informed St Vincent's Correctional Health of Mr Cullen's pending release

(b) Whether St Vincent's Correctional Health had sufficient opportunity to engage in planning for Mr Cullen's release

(c) Whether, upon his release, Mr Cullen was provided his evening dose of keppra

(d) Whether Mr Cullen was provided a supply of his prescription medication (beyond the evening dose of keppra) upon release, or otherwise provided with advice in respect of the requirement to obtain medication for his medical conditions, including epilepsy

53 It is convenient to deal with issues 4 a, b, c and d together.

54 As set out above Benjamin was placed on a CCO after appearing in Court by AVL on 22 February. Benjamin was to be released as soon as practicable that same day.

55 At 1:01 pm, the MTC Sentence Administration Team sent an email to 'Parklea Intake', 'Parklea Daily Movement Alerts', and 'a common SVCH email address to which SVCH employees and the Parklea Shift Manager had access (the 1:01 email).

56 The 1:01 email subject line read "Release - Cullen, Benjamin", followed by Benjamin's MIN (Master Index Number) and his location within Parklea. The body of the email read: "*The above listed inmate is to be released on a CCO. Please arrange all money and property accordingly*".

57 Upon learning that Benjamin had been placed on a CCO both MTC and SVCH had obligations in relation to Benjamin's pending release.

58 There was an obligation to ensure continuous healthcare, including providing Benjamin with his prescribed antiepileptic medication.

59 The relevant SVCH policy was titled *'St Vincent's Correctional Health – Transfer and Release from Custody Procedure.'* The aim of this policy was to ensure that "*all custodial patients will have continuity of health care when transferred to and from the Parklea Correctional Centre or released/discharged from custody*," and included mandating the provision of prescribed medication at discharge to prevent gaps in healthcare.

60 This SVCH policy reads at 6.3.5:

When short notice is received for a patient's release, advice on the options available for release medication should be sought from the Pharmacist for patients who have been released, the clinical team primarily responsible for the patient's care must complete the SVCH Release Summary and Transfer of Care Form within JHeHS. In the event that this does not occur, the responsibility will fall to the evening RN to finalise and send a copy to the patient's nominated General Practitioner and their last known community address.

At 6.5, the policy provides that:

> "*patients receiving medications in custody will be supplied between 3-7 days of medication on release, i.e. the balance of their weekly medication order.*

61 The policy envisages that "*medications required by the patient are given to the patient as they are released from the prison reception area by MTC-BRS correctional officers*".

62 Paragraph 6.7 of the SVCH Administration of Medications Procedure in force at the time, and now, provides:

> *(i) MTC Officers complete correctional officer paperwork at release time, including asking the patient if they wish to see a nurse prior to being released, or if they are prescribed medications.*

63 While MTC was not obliged to comply with SVCH policies, the terms of the SVCH Administration of Medication Procedure appear to do little more than reflect MTC's own Operating Procedures, and its obligations under CSNSW's *Custodial*

Operations Policy and Procedure Section 23.2 'Release from Correctional Centres' (the COPP).

64 MTC's Operating Procedure 7.12 titled '*Release of Inmates*' provided, in respect of 'Final Checks', a range of matters for which the MTC Shift Manager was responsible, including "*Confirm with SVCH that the inmate has been assessed and provided with a Medical Discharge Summary*".

65 At paragraph 1.8 of COPP section 23.2, it is provided that 'Immediately prior to release', the *MOS/FM/OIC/Releasing* officer is to "*check that JH&FMHN has provided any required medication and/or referrals*".

66 In evidence to the Court, Mr Gurney, the Deputy Governor of PCC, appropriately accepted that the reference to 'JH&FHMN' is to be read as a reference to SVCH.

67 MTC did have a "Discharge Checklist" however it contained no mention of checking whether medication had been supplied, or referrals provided.

68 Both in the evidence of Mr Gurney and in written submissions MTC was reluctant to fully accept its obvious failure to adhere to its own policies. Firstly, Mr Gurney argued that the 1:01 email sufficed as a "final check" and then in written submissions MTC argued that the proposed approach would have required MTC to check if SVCH had done what it was supposed to do under SVCH policy and further that the question contained in the discharge checklist –"*Are you content that when you leave here you have everything in place for the next 24 hours*" was a prompt for Benjamin to mention he required his medication.

69 The initial evidence of Mr Gurney revealed an understanding that did not meet the responsibility of MTC to comply with its own policies.

70 The written submissions referred to above also sought to minimise MTC's failure to comply with its own policies by placing responsibility upon SVCH and Benjamin.

71 Whatever responsibilities SVCH had, MTC also had responsibilities. The responsibilities co-existed.

72 MTC's suggestion that Benjamin had an opportunity to mention his medication at the point of release denies the submission otherwise relied upon by MTC that "*critical factors (were identified by counsel assisting) that may lead to a reluctance of corrective staff to rely on inmate advice or requests regarding medication'* and is also at odds with Mr Gurney's evidence "*that (on the same topic) it is unwise for the onus to be on the custodial service provider or the inmate rather than the health service provider*".

73 On the evidence I am satisfied that MTC promptly informed SVCH of Benjamin's pending release (issue 4a) and that SVCH had sufficient opportunity to engage in planning for Benjamin's release which occurred at approximately 5pm (issue 4b). It is clear that sufficient notice was provided to SVCH however no advice was sought from the pharmacist in respect of discharge medication, nor was Bejamin provided with his medication, he was not provided with a SVCH Release Summary and Transfer of Care Form (which document operates as a discharge summary), nor was such document completed retrospectively (in order to send it to a nominated GP). For MTC's part whilst it had sent the 1:01 email to SVCH it at no stage checked that Benjamin had been provided with required medication and/or referrals.

74 The evidence made clear that Benjamin was given his morning dose of Keppra on the 22nd of February despite Nurse Alexander's initial evidence that it was given to him in the evening.

75 Benjamin was not given any medication when he was released and as such he was not provided with his evening dose of Keppra (issue 4c). It is also clear Benjamin was not provided a supply of prescription medication nor was he provided with advice in respect of the requirement to obtain medication for his medical conditions including epilepsy (issue 4d).

76 On an overall assessment of the adequacy of the release planning for Benjamin both SVCH and MTC failed to meet their obligations.

77 SVCH have made changes to its system. Now, when MTC provides SVCH notification of an impending release a SVCH pharmacy technician who has been allocated/rostered for the task (or nurse, if after hours) accesses the patient's chart and works with the pharmacist to ensure that the required medications are packed and a release summary created. The summary and the medications are then taken to the patient.

78 In relation to MTC Mr Gurney ultimately accepted there could be improvements in the approach of MTC. A recommendation which will be discussed below has the support of MTC.

Cause of death

79 There is no dispute that the direct cause of Benjamin's death was acute, severe hydrocephalus, and that his death was contributed to by longstanding chronic hydrocephalus caused by the presence of a tumour abutting a cerebral aqueduct.

80 Benjamin had longstanding and progressively worsening hydrocephalus which is a buildup of excess cerebrospinal fluid in the brain. This was due to a tumour abutting the cerebral aqueduct. As Benjamin's hydrocephalus worsened, the pressure increased inside Benjamin's brain.

81 Professor Watson said, "Benjamin was on a knife's edge or precarious with respect to the lesion obstructing his cerebrospinal fluid and causing progressive hydrocephalus around the time of his death", and identified a number of factors present in Benjamin's circumstances that were capable of increasing Benjamin's intracranial pressure. These were (1) Benjamin's epileptic seizures, (2) Benjamin's obstructive sleep apnoea, (3) acute intoxication, (4) cannabis consumption, particularly in combination with alcohol.

82 Counsel Assisting submitted that, of these possible causes of the acute and ultimately fatal elevation of Benjamin's intracranial pressure, the most probable on the evidence of Professor Watson and Dr Du Toit-Prinsloo was the subtherapeutic level of Benjamin's Keppra which occasioned his seizures.

83 The submission on behalf of the family in relation to this was that the expert medical evidence established that the subtherapeutic level of Mr Cullen's Keppra caused his seizures which in turn triggered the fatal elevation of his intracranial pressure.

84 Senior Counsel for St Vincent's accepted that the direct cause of Benjamin's death was acute, severe hydrocephalus, and that his death was contributed to by longstanding chronic hydrocephalus caused by the presence of a tumour abutting the cerebral aqueduct but added that a finding that the subtherapeutic level of Keppra leading to Benjamin's seizures was the probable cause of the fatal elevation of the intracranial pressure was not available on the evidence.

85 Professor Watson clearly accepted that each of the factors set out above could have been a cause of the fatally raised intracranial pressure (emphasis added). Senior Counsel for St Vincent's highlighted, in submissions, Professor Watson's indication that he was uncertain as to the causative mechanism of Benjamin's death, placing reliance of the following passage.

> "Q. Can his Honour take it that, given your professional concern to attribute a causative element in a precise way as you possibly can, that you deliberately used those words (in the summary section of the report) to indicate a real uncertainty as to the causative mechanism of death in this instance?
>
> A. Yes. I am uncertain."

86 Senior Counsel also placed emphasis on Professor Watson's use of the expression, "they could have", during evidence in answer to questions as to whether the seizures "pushed Benjamin over the edge."

87 However, there was also the following evidence from Professor Watson. Firstly, the answer immediately following Professor Watson's expression of uncertainty set out above was as follows.

> "Q. And to the extent that you are uncertain, is it the situation that you can't say on the balance of probabilities that the absence of or subtherapeutic level of Keppra was causative or materially contributed to Mr Cullen's death?
>
> A. I'm of the opinion that it's a factor that cannot be ignored. But it may not, as it happens, have been the cause or the trigger for this man's death on this day with the mode of death being, well, the real - that's the wrong word, with what I believe was acute fatal raised intracranial pressure from hydrocephalus."

88 In further evidence, the following exchange occurred.

> "Q. Ultimately, it was going to take some kind of acute event to fatally raise this intracranial pressure. Is that right?
>
> A. Yes. Or, alternatively, he may have just been found dead in bed.
>
> Q. But, in this instance, it appears to have been the acute event of the seizures. Does it not?
>
> A. Yes. I think it's impossible to ignore the time relationship.

Q. That's right. It would be different plainly had he been found dead in bed, and, in that case, obstructive sleep apnoea, or the contribution of alcohol might have been the likely cause. Is that right?

A. Yeah. Or, alternatively, still quite plausibly a seizure in sleep.

Q. Indeed. But what we have here is three identified seizures.

A. Yeah.

Q. Are they more likely than not or did they more likely than not cause the fatal elevation in his intracranial pressure on 23 February?

A. I would have to say yes on the balance of probabilities. Not necessarily by a furlong that they were. They should be considered as the causative or triggering event or events."

In yet further evidence,

"Q. Certainly, is this right, acute alcohol consumption and sleep apnoea provide a plausible explanation for his seizures and death. But more likely, would you agree, the explanation is the subtherapeutic level of Keppra in his blood plasma?

A. On those terms, you'd have to say yes. But there's a parallel mechanism which you've elided, your Honour, with respect that acute alcoholism and sleep apnoea could directly lead to raised intracranial pressure without any seizures because that's what happens."

89 And finally, a question included,

> "Q. Of the factors that could have increased the intracranial pressure, the alcohol, the OSA, the cannabis, the seizures, in Benjamin's case, are you able to say that one or more of those factors are likely, is, or are more likely than the others to be the contributing factor to the increase intracranial pressure in the circumstances as you understand them?

In his answer, Professor Watson referred to the Munro-Kellie doctrine

> "where because the skull can't expand as the volume of the contents goes up, even by literally 0.2 of a millimetre, you run out of room, and the pressure goes up and up, and slowly, and then you reach this tipping point where the pressure goes like that. You only need that to happen for a short time in a situation such as Mr Cullen, in a sense, was primed to be in, for that to be the event."

The Professor went on,

> "Sorry. I'm sounding too much like a professor. You could get to there by any and all of these steps. And absolutely I think it's important and may well be the cause, if there is the cause, or the crucial cause, the seizures that were, in my opinion, likely to be related to the low and falling level of Keppra, although noting he did have another anticonvulsant on board with a longer half-life, Zonisamide. It seems to me that, you know, if you held a gun at my head, and said, give me one cause, it'd have to be that. But

you don't. Any and all of them could do it literally ten, 20, 30 seconds to set up this acute, fatal, raised intracranial pressure."

90 I have set out those questions and answers in some detail to provide a full indication of the answers provided by Professor Watson. Professor Watson was making clear that he is not certain as to the cause. Allowing for the professor's extravagant language in the final extracted passage, I am satisfied that, on his evidence, a number of factors, either alone or in combination, could have caused the final fatal increase in intracranial pressure. As I've said, Professor Watson was not prepared to express any certainty about which was the cause. However, as seen in the extracts above, Professor Watson, on a number of occasions, accepted that the subtherapeutic level of Keppra leading to Benjamin's three seizures was the most likely of the possible causes.

91 In further submissions, Senior Counsel for St Vincent's referred to the following causative uncertainties:

a) one cannot know with certainty the time all blood sampling was undertaken at John Hunter Hospital

b) not knowing the trajectory of enlargement of the brain tumour by 21 February 2021

c) not knowing the size of the tumour

d) not knowing the extent to which hydrocephalus had progressed by February 2021

e) the quantity of alcohol consumed by Benjamin during the evening and early morning following his discharge from Parklea. Professor Watson

notes that Benjamin reportedly had significant amounts of alcohol after discharge from Parklea and this can be a contributor to seizures occurring in a patient with epilepsy

f) the quantity and concentration of cannabis consumed by Benjamin during the evening or early morning of his discharge from Parklea

g) not knowing what the quantitative assessment of metabolised cannabis in postmortem blood would be (for Professor Watson accepted that he did not have expertise in that field)

h) Keppra does not prevent seizures. He described the situation of people with epilepsy who have therapeutic levels of Keppra who still have seizures

i) while Professor Watson acknowledges the absence of Keppra increased the risk of seizure occurring, an increase in risk in this instance does not equate with the requisite causative element

j) there is no clarity as to which one of the different but parallel pathways led to the fatal impact of the hydrocephalus.

92 As the submission was put, the causative uncertainties were multiplied by those listed uncertainties.

93 Aside from the time of the blood sampling, which was not an uncertainty as the time was established as set out in Dr Du Toit-Prinsloo's evidence, Professor Watson was aware of all the listed asserted uncertainties when he expressed his view several times as to the most likely cause of the fatal increase in intracranial pressure.

94 In relation to the trajectory of the enlargement of the tumour, its size, and the extent of the progression of the hydrocephalus, it is highly relevant that Professor Watson noted the lack of neurological symptoms such as headache and altered vision prior to the events that followed Benjamin's release from custody.

95 In relation to the unknown quantity of alcohol and cannabis Benjamin consumed and the unknown quality of the cannabis, I can only make my findings upon the evidence before me, I cannot speculate. There is nothing in the evidence upon which Professor Watson expressed his opinion that led him to the view that the amount of alcohol consumed or the amount and quality of the cannabis consumed made it more likely than note that they alone or in combination caused the fatal increase in intracranial pressure. Professor Watson's opinion was based upon the available evidence as must be my findings.

96 In relation to the evidence that Keppra does not prevent seizures, as correctly submitted by Senior Counsel for St Vincent's, Professor Watson made it clear that the absence of Keppra increased the risk of seizure occurring. I do not accept the submission that followed, asserting an increase in risk in this instance does not equate with the requisite causative element. In my view, the fact of Benjamin, who's epilepsy on the evidence was very well controlled when he was appropriately medicated, suffered three seizures whilst his Keppra levels were subtherapeutic, and that the fatal increase in intracranial pressure followed on from the third of those seizures points powerfully to the subtherapeutic levels of Keppra being the most likely cause. I accept, as Professor Watson pointed out on one occasion, the subtherapeutic level of Keppra "*cannot be ignored*", and on

another "*it's impossible to ignore the time relationship between the seizures and the fatal increase in intracranial pressure*".

97 Finally, in this part of submissions for St Vincent's, it was suggested there is no clarity as to which one of the different but parallel pathways led to the fatal impact of the hydrocephalus. Whilst Professor Watson made it clear, and I accept to be the case, there is no certainty as to the ultimate causative pathway, I'm satisfied on balance that the subtherapeutic levels of Keppra caused Benjamin's seizures, which caused the fatal increase in intracranial pressure.

98 The postmortem report under the hand of Dr Alison Ward with Dr Du Toit-Prinsloo as the supervising pathologist recorded the direct cause of death as hypoxic ischemic encephalopathy. Under the header, "Antecedent causes", with a subheading, "Morbid conditions, if any, giving rise to the above cause, stating the underlying condition, last", Dr Ward listed "epilepsy". In her written evidence, in exhibit 6, Dr Du Toit-Prinsloo expressed herself to be of the opinion that the cause of death is more likely due to hypoxic ischemic encephalopathy in the setting of epilepsy due to acute obstructive hydrocephalus, secondary to a probable tumour abutting the cerebral aqueduct.

99 I am satisfied Dr Du Toit-Prinsloo identified epilepsy as a causative factor contributing to Benjamin's death, as did Dr Ward. However, as Drs Du Toit-Prinsloo and Ward were not cross-examined, I do not propose to place any reliance upon their reports beyond recognising they do not in any way suggest Professor Watson's opinion is wrong.

100 I am satisfied the cause of Benjamin's death was acute, severe hydrocephalus. Benjamin's death was contributed to by longstanding chronic hydrocephalus caused by a tumour abutting the cerebral aqueduct.

101 Of the possible causes of the fatal elevation of Benjamin's intracranial pressure, the most likely cause was the subtherapeutic level of Benjamin's Keppra, which caused the three seizures, following his release from custody.

Whether any recommendations are required pursuant to s 82 of the Coroners Act

102 Counsel Assisting suggested two recommendations be made. The two recommendations involve both St Vincent's Correctional Health and MTC. Following their circulation, St Vincent's Correctional Health and MTC supported recommendation 1 in its entirety. In relation to recommendation 2, St Vincent's Correctional Health suggested an amendment, which Counsel Assisting accepted. MTC had no objection to recommendation 2.

103 I make the following recommendations:

1. *That St Vincent's Correctional Health, in consultation with MTC, the Justice Health, and Forensic Mental Health Network and Corrective Services New South Wales, explore options for real time documentation of medication, administration, and or supply in the electronic medication administration record;*

2. *That MTC, in consultation with St Vincent's Correctional Health, review its processes at discharge, including the terms of the discharge checklist completed with inmates shortly prior to their release from custody to ensure its discharge processes are compliant with Corrective Services New South Wales's policies and procedures, including but not limited to COPP 23.2*

104 Recommendation 2 is the recommendation I referred to above when indicating ultimate acceptance of possible improvements by Mr Gurney during his evidence.

105 I make these recommendations understanding that, as a result of a State Government decision, both MTC and St Vincent's Correctional Health will cease operating at Parklea in October 2026. Those entities will best know the current circumstances at Parklea. Their focus will no doubt be on the current functioning at Parklea and facilitating the ultimate handover. I understand, in making the

recommendations, that the entities will weigh the realities of the current situation at Parklea in determining their responses.

Findings

For all the above reasons I make the following findings:

Identity: The person who died was Benjamin Nathan Cullen.

Date of death: Mr Cullen died on 25 February 2021 at 5:23pm.

Place of death: Mr Cullen died at John Hunter Hospital.

Cause of death: The cause of Mr Cullen's death was acute, severe hydrocephalus. Benjamin's death was contributed to by longstanding chronic hydrocephalus caused by a tumour abutting the cerebral aqueduct.

Manner of death: Mr Cullen died from natural causes

Concluding Remarks

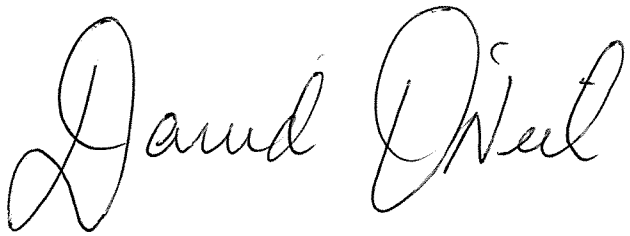
106 Before closing the inquest, I would firstly like to thank Benjamin's mother and his sister for their involvement in the inquest. Benjamin was a son, a brother, an uncle, and a father. After the tragedy of Benjamin's passing, his sister, Shani, became very active in seeking reform. The community should not accept the failings such as those revealed in Benjamin's circumstances. The family's attitude in expressing their desire that the identified failings not be repeated to save any other families having to go through what they have gone through is generous and to be admired. I thank them for that.

107 Benjamin was clearly loved very dearly, and, as expressed in the family statement, will be forever missed. I offer my sincere condolences to his

immediate family, extended family, and friends. I offer those condolences on behalf of the Coroner's Court of New South Wales and all those who have worked on this inquest both in the assisting team and at the Coroner's Court.

108 I thank the assisting team of Ms Lilly and Mr Robinson of counsel. Their dedication to their work and attention to detail has been of great assistance. I also thank the officer in charge of the coronial investigation, Detective Senior Constable Counsell, for his efforts in the investigation and work in compiling the police brief of evidence. I thank all the parties for their assistance during the inquest.

109 I close this inquest.



Magistrate David O'Neil
Deputy State Coroner
Coroners Court of New South Wales
12 December 2025