CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Gregory Ronald Merriman
Hearing dates:	29 September – 1 October 2025, 3 October 2025
Date of Findings:	6 March 2026
Place of Findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – mandatory inquest – death of a First Nations man in custody – use of force event in response to other inmates fighting in a POD – deployment of chemical agent Orthochlorobenzalmalononitrile (CS gas) – was the deployment a reasonably necessary use of force – whether a reasonable and adequate process was undertaken to subsequently check inmates' welfare – compliance with policies and procedures – appropriateness of cell placement and whether a chronic disease screen should have been performed during final period of custody – recommendation
File number:	2022/00391153
Representation:	Counsel Assisting the Inquest: J Harris of Counsel i/b Solicitor, Coroners Court Secondment Unit. Solicitor Advocates for Shannon Merriman, Senior Next of Kin: E Parker & F Al Majed, Aboriginal Legal Service. Commissioner of Corrective Services NSW: William de Mars of Counsel i/b Department of Communities and Justice Legal. Chief Executive of the Justice Health and Forensic Mental Health Network: Kate Holcombe of Counsel i/b Hicksons, Hunt & Hunt.
Non publication orders:	Non-publication orders made on 30 September 2025 and 6 March 2026. A copy of the orders can be obtained on application to the Coroners Court of New South Wales registry.

Findings:

Identity
The person who died was Gregory Ronald Merriman.

Date of death
Greg died on 27 December 2022.

Place of death
Greg died at the Metropolitan Reception and Remand Centre, Silverwater NSW.

Cause of death
Greg died from acute myocardial infarction caused by ischaemic heart disease.

Manner of death
Greg died while he was lawfully detained as an inmate in a correctional centre. Following a lawful use of force, where Orthochlorobenzalmalononitrile (CS gas) was deployed against other inmates, Greg was locked inside his cell. He was discovered unresponsive about 30 minutes later. His death was a result of natural causes.

Recommendations:

To the Commissioner of Corrective Services NSW (**CSNSW**):

1. CSNSW to consider amending Custodial Operations Policy and Procedures 13.7 – *Use of Force*, to include further instructions on action to be taken by correctional officers following the deployment of chemical munitions, including:

    a) identifying inmates who are affected by gas or are otherwise in need of medical attention,

    b) contact required with Justice Health staff,

    c) first aid and personal decontamination, and

    d) decontamination of areas affected by chemical munitions.

Circulation of findings

A copy of the findings should be provided to the NSW Minister for Health and Minister for Regional Health and the NSW Minister for Aboriginal Affairs and Treaty.

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Introduction

1. This inquest concerns the death of Gregory Ronald Merriman. At the time of his death, Greg was 58 years of age. He was a proud First Nations man of Yuin heritage and a direct descendant of Umbarra (King Merriman). Greg had deep connections to the Gadigal Land and the 29 tribes of the Eora nation where he was raised.

2. Greg died on 27 December 2022 at the Metropolitan Reception and Remand Centre (**MRRC**) in Silverwater.

3. Greg is survived by his daughter, Shannon, his older brother, Mark, his grandchildren and great-grand-daughter, along with many other relatives and friends. Shannon attended the inquest each day, and Mark joined remotely on the final day when his health permitted.

4. Greg and his siblings were removed from their family under the now-repealed *Aborigines Protection Act 1909* (NSW). This legislation empowered the NSW Aborigines Protection Board to remove indigenous children in wide ranging circumstances. Greg, like his siblings, spent much of his childhood navigating the trauma of being taken from his family, being told that he had been neglected, and being placed in boys' homes and custodial institutions. His family described how the very systems supposedly created to protect him ultimately failed and traumatised him. He experienced great harm in those settings, but he survived them.

5. Both Greg and his older brother Mark, gave evidence before the Royal Commission into Institutional Responses to Child Sexual Abuse.

6. Mark observed that although both he and Greg spent time in custody, he had been able to eventually break free from that cycle, while Greg had remained caught in what he described as a "revolving door", until his passing.

7. In a CSNSW Case Note dated 13 April 2021, it was recorded that Greg "*would often talk about his child hood trauma which he said attributed to his mental health, drug use and his offending… He reported being at peace in his life and wants to put his offending behind him and become a mentor for young indigenous people*."[1]

8. Greg's life was not an easy one, but his family was clear that he was never short of love. Mark described him as a "larrikin" who was preparing to take on a greater role as an Elder prior to his death. His daughter, Shannon said that Greg would "*give you the shirt off his back if he could*".

[1] BOE, Tab 49, Folio 7(a) (Vol 3) p.1045.

9. While in custody, he served as the Koori delegate and was clearly well respected. Evidence from GW, a friend and former inmate housed in the same POD at the MRRC as Greg, highlighted that Greg helped anyone and everyone.[2] He was regarded as a peacemaker, tutor, mentor and friend. The witnesses who knew Greg painted a consistent picture of a man who was kind, respected and trusted.

10. Greg held a long-term aspiration of securing a place on the Central Coast with a granny flat where he could live close to Shannon and remain within reach of his family.

11. Although the inquest necessarily focussed on the events of 27 December 2022, the day of Greg's passing, and the care and treatment he received during his final period of incarceration, his family shared reflections on the profound meaning he brought to their lives.

12. I acknowledge and respect the family's participation in these difficult proceedings. Greg's family emphasised that there are far too many First Nations people who share similar histories, reflecting the continuing impacts of colonisation, intergenerational trauma and social exclusion on daily life. I share their concerns. His family wished for Greg's story to be heard and hoped that the system Greg spent his life struggling against might change so that other families do not experience a similar loss. Greg's family sought clarity regarding the circumstances of his death and expressed a clear desire to contribute to systemic improvements that might prevent future harm. I extend to them my sincere condolences and gratitude for their attendance and contributions to this inquest.

The role of the coroner and the scope of the inquest

13. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also required to address issues concerning the manner and cause of the person's death.[3] A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[4]

14. When a person dies in custody in NSW, it is mandatory that an inquest is held.[5] The inquest must be conducted by a senior coroner. When a person is detained, the State assumes responsibility for that person's safety and for the provision of appropriate medical treatment. As inmates are not free to seek out or obtain their own healthcare, it is particularly important

[2] T25: 10-14 (29/09/2025).
[3] Section 81 *Coroners Act 2009* (NSW).
[4] Section 82 *Coroners Act 2009* (NSW).
[5] Section 27 *Coroners Act 2009* (NSW).

that the treatment available to them meets an appropriate standard. Inmates should be provided with healthcare of a standard that is equivalent to what is available in the community.

15. On 15 October 2025, the State Coroner issued an open letter, identifying that 12 Aboriginal and Torres Strait Islander people had died in custody in New South Wales in 2025 – the highest number ever recorded in a single year. The State Coroner also noted that in the preceding 5 years, the number of Aboriginal people in custody had increased by 18.9 per cent while the non-Aboriginal prison population had declined by 12.5 per cent. Nearly half of Aboriginal adults in custody (45.6 per cent) were on remand or refused bail awaiting further court outcomes. The number of Aboriginal people on remand had surged by 63 per cent over the same five-year period. These figures reflect – consistently with the sentiments expressed by Greg's family – that the entrenched over-representation of First Nations people in the criminal justice system is a systemic issue. I accept that this issue is grounded in the ongoing effects of colonisation. Until the broad causes of over-representation are properly addressed, the disproportionate number of First Nations deaths in custody will not reduce.

16. First Nations people are also known to experience inadequate health care and poorer health outcomes. This issue is well recognised by the government and certain measures have been adopted to "close the gap". The gap has not closed. In this context, the importance of health screening and culturally safe care for all First Nations inmates cannot be overstated.

17. The Coroners Court of NSW remains committed to investigating every death in custody independently and thoroughly, in line with its statutory responsibilities. Inquests will continue to be conducted with impartiality, transparency and cultural sensitivity, ensuring that the voices of affected families and communities are heard and respected.

The evidence

18. The Court took evidence over four hearing days. It also received extensive documentary material contained within twelve volumes. This material included witness statements, medical and custodial records, photographs, audio calls and video footage, operational documents, and policies and procedures.

19. While it is not possible to refer to all of the material in detail within these reasons, I confirm the entirety of the evidence has been carefully reviewed and considered.

20. Prior to the commencement of the proceedings, a list of issues was prepared to guide the investigation.[6] As is often the case, the inquest process served to crystallise the matters requiring closer examination. I intend to address the most significant issues that emerged during the evidence under broad headings below.

Background and brief chronology

21. In addition to preparing submissions summarising much of the oral evidence, Counsel Assisting has prepared a chronological overview of the key events from the available documentary evidence. I have relied on these documents in recording my written reasons, at times adopting the submissions put forward. I have reviewed the evidence carefully where differences in fact, emphasis or recommendation are noted by the parties and in all matters the conclusions are my own.

22. I attach Counsel Assisting's chronology as an annexure to these reasons. In my view it accurately sets out, in brief terms, Greg's medical and custodial history as it was disclosed in the available documentary evidence before me.

23. The circumstances leading up to Greg's death were not in dispute during these proceedings and the court had the benefit of CCTV footage as well as witness accounts.

24. On 27 December 2022 around 1pm a fight broke out between inmates in the common area of the MRRC wing where Greg was accommodated. Greg was not involved in the fight, and it is likely that he made verbal attempts to calm others as he is seen on the CCTV footage approaching the vicinity of the inmates who were fighting and then moving away as they moved towards him.

25. Several inmates became involved in the altercation, and one armed himself with a vacuum cleaner pole and began striking out. Tuna cans were thrown. Officers had legitimate concerns that someone could be seriously hurt. The Immediate Action Team, a tactical response team in the gaol, was summoned by correctional officers and arrived at the door of the POD at 1.08pm. CO Litasi Ma'u knocked on a window to the day room. He says he told the inmates to return to their cells. Shortly afterwards another officer opened the door to the POD and CO Ma'u discharged spray from a Magnum Fogger, while shouting at the inmates to return to their cells. In all there were three bursts of spray, which appeared to affect some inmates and staff in the direct vicinity. Greg was standing a few metres away. The CCTV footage shows

[6] Issues List dated 6 March 2025.

Greg returning to his cell seconds after the spray was deployed. In a short period of time the inmates had all dispersed and were then locked into their cells by correctional staff.

26. At 1.09 pm CO Satnam Singh looked into Greg's cell and shut the door which was later locked by another officer. At 1.15pm CO Meznaric opened the hatch to Greg's cell and looked inside. He said he saw Greg "*pacing and standing in the cell*".

27. At 1.40pm RN Harman arrived at Greg's cell as part of a welfare check operation that nurses were conducting on all inmates. She saw Greg lying unresponsive in the shower area and she called for help.

28. Correctional Officers opened the cell. CPR was commenced and an ambulance called. Tragically Greg could not be revived and was pronounced deceased at 2.30pm. There has been no submission that the medical response, once Greg was discovered unresponsive, was inappropriate or inadequate.

29. An autopsy was conducted by Dr Elsie Burger on 30 December 2022.

Greg's physical health and management in custody

Management of modifiable risk factors for myocardial infarction

30. Greg's post-mortem examination determined his cause of death to be an "acute myocardial infarction" with the antecedent cause identified as "ischaemic heart disease".[7]

31. Associate Professor Mark Adams, Court-appointed Cardiologist, opined that at the time of death, Greg had advanced coronary artery disease, had sustained a previous myocardial infarction and likely had asymptomatic ischaemic heart disease. He noted that Greg was receiving no treatment for these conditions and had ongoing risk factors – particularly cigarette smoking, that predisposed him to a further myocardial infarction.[8]

32. In his view, the major factor contributing to Greg's fatal myocardial infarction was his pre-existing severe coronary artery disease which had likely been present for some time and resulted from a combination of modifiable and non-modifiable risk factors.[9]

[7] BOE, Tab 3 (Vol 1) p.11.
[8] BOE, Tab 5 (Vol 1) p.51.
[9] BOE, Tab 5 (Vol 1) p.50.

33. A/Professor Adams considered that Greg received reasonable care for his cardiac condition, both in the community and custody. He observed that the first clinical manifestation of Greg's cardiovascular conditions was the fatal myocardial infarction itself, and it did not seem that he had any cardiac symptoms beforehand. In such circumstances, the usual care would focus on controlling cardiovascular risk factors. For Greg, the most significant modifiable factors were smoking and long-standing hypertension, both of which are among the most important risk factors for the development of coronary artery disease. [10]

34. During Greg's last period in custody (24 November – 27 December 2022), he was prescribed the medication perindopril, aimed at reducing blood pressure.[11] In A/Professor Adam's view, this was reasonable.[12]

35. Greg had blood tests, in custody and the community, which revealed he had slightly raised cholesterol levels (other than an aberrant reading in April 2020). Hyperlipidaemia is a risk factor for a heart attack. A/Professor Adams opined that in that circumstance, it may have been advantageous to commence Greg on a statin, but it would have had a minimal effect on his overall risk of a heart attack.[13] Greg was commenced on a statin during his earlier period in custody, although this was ceased in the community.[14]

36. Dr Sasanka Dissanayake, Staff Specialist in Primary Care, Justice Health & Forensic Mental Health Network (**Justice Health**) commented that she considered management of cholesterol to be a long-term management issue. When she reviewed Greg on 8 December 2022, she was aware he had slightly raised cholesterol levels.[15] She knew he was Aboriginal, but nothing else of his family history. At the time, she was focussed on addressing his hypertension. She expected to see him again, when she said consideration would have been given to commencing statins. Why these tasks could not be done at the same time remains unclear to me. Dr Dissanayake accepted she did not make a note in Greg's Justice Health records, to consider statins. At the time, she was relatively new to Justice Health systems and stated that she did not know how to make a note on the Patient Administration System (**PAS**).[16] Counsel Assisting submitted that considering the limited impact this would have had on Greg's risk factors, there would not be criticism of Dr Dissanayake's approach.

[10] BOE, Tab 5 (Vol 1) p.50, 53.
[11] BOE, (Vol 9) Tab 78 p.2996; Tab 79 p.3086.
[12] T285: 3-25 (3.10.2025).
[13] BOE, Tab 124 (Vol 2) p.3819.
[14] Justice Health Records: BOE, Tab 78 (Vol 9) p.3705 (Crestor was commenced on 18 May 2020); Community GP Records from Pyrmont Medical Centre, Tab 71 (Vol 6) p. 1785 (Lipitor was ceased on 17 December 2020).
[15] BOE, Tab 78 (Vol 9) p.3065 (Results).
[16] T86:15 – 88:49 (29.09.2025).

37. While I find it hard to understand why Dr Dissanayake chose to delay consideration of a statin medication, I accept Professor Adam's view that it would have had minimal impact on his overall risk of a heart attack. Nevertheless, given that inmates are routinely moved across the system and Dr Dissanayake may never have seen Greg again, her thinking in this regard should, at the very least, have been recorded in the record for future care givers.

38. A/Professor Adams raised an issue regarding the content of the discharge summary from St Vincent's Hospital Sydney,[17] which could have usefully commented on cardiac investigations undertaken during Greg's admission there in November 2022.[18] St Vincent's Hospital acknowledged that ideally, the discharge summary would have referred to Greg having undertaken an ECG during the admission and recorded those results.[19]

39. In my view this was an appropriate concession. The ECG result should have been disclosed on the discharge summary so that later medical professionals would have been alert to the potentially significant issues raised.

Should Greg have received a Chronic Disease Screen during his final period of custody?

40. At the time of Greg's final period of custody, a Chronic Disease Screen (**CDS**; now called a Chronic Condition Assessment (**CCA**)) was to be performed on all Aboriginal patients aged 45 and over, within 30 days of the Reception Screening Assessment (**RSA**) (or otherwise identified as meeting criteria).[20]

41. On 24 November 2022, following his RSA, Greg was placed on the waitlist for a CDS.[21] It follows that Greg ought to have had a CDS performed prior to his death on 27 December 2022. This did not occur, and that was not consistent with policy.

42. Greg last received a CDS during a previous period in custody, on 22 January 2019 while housed at Parklea Correctional Centre (**PCC**). From April 2019, Justice Health ceased providing health services to patients at PCC and those services were subsequently provided by St Vincent's Correctional Health (**SVCH**).[22] The CDS identified that he had a chronic

[17] BOE, Tab 78 (Vol 9) p.2804.
[18] BOE, Tab 5 (Vol 1) p.53. A/Professor Adams commented that it was recognised that Greg's ECG showed a Wellen's pattern consistent with possible significant coronary artery disease. Two further ECGs showed a similar pattern and a bedside echocardiogram in the emergency department is described as showing "global hypokinesis" suggesting significant underlying cardiac disease. Ideally this might have been further investigated, however, Mr Merriman was discharged against medical advice.
[19] BOE, Tab 98 (Vol 10) p.3524 [20].
[20] BOE, Tab 83, Annexure A (Vol 10) p.3110 [3.3].
[21] BOE, Tab 81, line 18 (PAS excel spreadsheet).
[22] BOE, Tab 78 (Vol 9) p.2854.

condition – arthritis. He was due to have a further CDS 12 months after that date. That did not occur.[23] Counsel Assisting observed that there is a draft CDS in the Justice Health records said to have been completed on 1 December 2019 and deleted on 18 June 2022 with comment "error", when Greg was discharged from custody.[24] Again, that was not consistent with policy. Deb Little, Director of Nursing Regional – Primary Care, Justice Health, observed that Greg had nonetheless been reviewed by medical staff at SVCH and Justice Health on multiple occasions during his earlier period in custody which concluded on 12 June 2020.[25] While I accept that this is correct, treatment for particular issues involves a different approach to the more wide ranging assessment which is required by a CDS.

Changes to Justice Health policy

43. Since Greg's death, the policy regarding CDSs has been revised. The current policy is that a CCA is to be performed for all patients who have an identified chronic condition and is to occur within 30 days of identification of that condition, with at least 12-monthly follow up.[26]

44. All adult Aboriginal patients (and non-Aboriginal patients over 55) are also offered a Preventative Health Screen (**PHS**), within 12 months of the RSA. The PHS includes a screening process, with education health promotion. It can be opportunistic, and occur at the same time as another intervention, although is to occur within the timeframes above.

45. It was explained that the two pathways, namely the Chronic Condition Model and the PHS Model, separate patients into two categories:[27]

    (a) patients who have been diagnosed with a chronic condition, who require management / monitoring / treatment; and

    (b) patients who are considered to be at risk of developing a chronic condition, who may benefit from screening and the initiation of intervention strategies to prevent the development of chronic conditions.

46. Counsel Assisting commented that the net result appears to be that, while previously Aboriginal patients ought to have had a CDS within 30 days of the RSA, now the minimum requirement is a PHS within 12 months. Counsel for the Chief Executive of Justice Health submitted that these changes were made to reflect evidence based best practice, to place

[23] BOE, Tab 124 (Vol 12) p.3865. On 16 December 2019, Greg was transferred from PCC to the Metropolitan Special Programs Centre where health services were provided by Justice Health.
[24] BOE, Tab 78 (Vol 9) p.2879.
[25] BOE, Tab 125 (Vol 12) p.3865 [16].
[26] Exhibit 5, Letter from Hicksons Hunt and Hunt dated 14 October 2025.
[27] Exhibit 5, Letter from Hicksons Hunt and Hunt dated 14 October 2025 [1.11].

increased focus on the prevention of chronic conditions, and to improve consistency of screening within existing resourcing constraints.

47. I am very troubled by the new time frame. The provision of adequate health screening is one of the very few possible positive outcomes for those who are incarcerated. Many Aboriginal inmates serve short sentences. If PHS is set to occurs towards the end of the 12 month window, many inmates will be released before it takes place. I am concerned the new policy constitutes a decrease in the level of service rather than a clear improvement.

48. Justice Health also identified further strategies to improve Aboriginal Health. Increasing the number of CCAs for Aboriginal patients who have been diagnosed with a chronic condition is one of the strategic goals of the Justice Health "10 Year Strategic Plan – 2023-32". The implementation of the strategic outcomes outlined in *Together for Healthier Tomorrows* is being cascaded into a series of delivery plans with those plans being developed across five-time horizons for each outcome. *Horizon One* is the initial set of actions within the broader 10-year vision to fundamentally rethink and improve healthcare in the custodial setting. The core objective is to transform service delivery to ensure safe, holistic, and equitable care, optimising patient health and wellbeing. A key activity for *Horizon One* is developing metrics to measure progress towards the strategic goals, ensuring accountability. To that end, Justice Health is in the process of designing and implementing an interactive dashboard which identifies patients who are due to undergo a CCA. It is envisaged that the dashboard will provide real time metrics in relation to CCAs, to the extent that patients who are due or overdue for their scheduled CCA will be more easily identified and prioritised.[28]

49. Further, Justice Health is in the process of developing a Primary Health Model of Care for patients that is culturally safe and mindful of the needs of the Aboriginal cohort of patients within the NSW custodial setting. Subject to resourcing constraints, the intention is for Aboriginal patients to undergo a health check performed by an Aboriginal Health Worker or Aboriginal Health Practitioner "within weeks" of the RSA, akin to the "Health Assessment for Aboriginal and Torres Strait Islander People" that is funded by Medicare [Medicare Benefits Schedule item 715] and performed for Aboriginal patients in the community.[29] Counsel for the Chief Executive of Justice Health submitted that while Justice Health does not have an update regarding the above strategies since its letter dated 14 October 2025, including on the resourcing necessary to implement those strategies, Justice Health affirms its continuous commitment to seeking to provide evidence based best practice to Aboriginal people in custody.

[28] Exhibit 5, Letter from Hicksons Hunt and Hunt dated 14 October 2025 [4.1] – [4.4].
[29] Exhibit 5, Letter from Hicksons Hunt and Hunt dated 14 October 2025 [4.5] – [4.8].

50. Counsel Assisting submitted given that Justice Health policy on this topic is in the process of development, a specific recommendation is not called for. While I accept that Justice Health have a plan to provide health checks by an Aboriginal Health Worker or Aboriginal Health Practitioner "within weeks" of the RSA, I remain concerned that this important plan is not yet operational. It is clear that further funds should be released for this purpose and I intend to send a copy of these findings to the relevant ministers for their information.

Was Greg's cell placement appropriate during his final period of custody? What factors affected the cell placement decision?

51. I accept Counsel Assisting's overview of the events and evidence relating to Greg's cell placement and re-produce it below:

- On Greg's arrival at MRRC, RN Seok Yun performed an RSA.[30] She explained her practice in evidence, including to build a rapport, ask open questions and then ask in plain English, whether the patient had any relevant conditions.[31] Among other things, RN Yun made PAS waitlist entries, for drug and alcohol, mental health, methadone maintenance, blood pressure reviews and a CDS for hypertension and hyperlipidaemia.[32]

- RN Yun also completed a Health Problem Notification Form (**HPNF**). She recommended normal cell placement (**NCP**), meaning no specific clinical recommendation was given regarding cell placement. Although RN Yun had no recollection about completing the HPNF, she assumed she gave that recommendation because Greg looked well, was not exhibiting any distress, and had previous experience in custody. While he had raised blood pressure and a history of hypertension, he was not showing any symptoms.[33]

- Deb Little stated that, in her view, Greg met criteria for a shared or group cell placement, as this was clinically recommended when human contact and support are identified as being important requirements.[34] She identified in evidence that it was Greg's history of anxiety and seizures, as well as his recent head injury, which would have led to this recommendation. However, this was at the outset, when little was known about the impact of those recommendations; Ms Little anticipated that this would have been reviewed during Greg's time in custody.[35]

[30] BOE, Tab 78 (Vol 9) p. 2889.
[31] T52:24 – 53:41 (29/09/2025).
[32] BOE, Tab 81, lines 14-18 (PAS excel spreadsheet).
[33] T57:14 – 61:13 (29/09/2025).
[34] BOE, Tab 83 (Vol 10) p.3104 [34].
[35] T217:35 – 219:25 (1/10/2025).

52. Counsel Assisting submitted that the recommendation that Greg be placed NCP could have resulted in him being placed either one- or two-out (that is, housed alone or within with another inmate). It is probable that Greg's one-out placement reflected his own preference. While his role as Aboriginal Delegate did not necessarily require him to be one-out, it was generally the case that the role meant he had access to a more desirable cell.[36] While it may have been an advantage to consider a two-out placement at the outset, given Greg's head injury, RN Yun's decision was reasonable in the circumstances known to her. It is also likely that this would have been reviewed at some point prior to Greg's death.[37] Counsel Assisting submitted accordingly, Greg's cell placement was appropriate.

53. The Solicitor Advocates on behalf of Shannon and Greg's broader family, adopted the submissions of Counsel Assisting in this respect.

54. Decisions in relation to cell placement must weigh up a variety of factors, including the strong and understandable preference of some inmates for privacy. In all the circumstances, given the information known to RN Yun at the time of the RSA, I accept the decision to recommend Greg for NCP was one reasonably open to her.

Whether the deployment of CS spray on 27 December 2022 was a reasonably necessary use of force and in accordance with CSNSW policy?

55. The available video evidence demonstrates that Senior Correctional Officer (**SCO**) Litasi Ma'u, then-Correctional Officer of the Immediate Action Team, discharged 3 short bursts of Mace CS Fogger in POD 26 on 27 December 2022. This agent is Orthochlorobenzalmalononitrile and is commonly known as CS (named after the inventors Corson & Stoughton) (**CS gas**).[38]

56. SCO Ma'u gave evidence regarding his decision to use the Mace CS Fogger. He referred to the governing legislation, clause 131 of the *Crimes (Administration of Sentences) Regulation 2014* (NSW) (**CAS Regulation**) relating to the use of force in dealing with inmates. He acknowledged that he was permitted to use no more force than was reasonably necessary in the circumstances, for one of 16 identified purposes. He identified the following items from cl 131(4) as being relevant (for completeness cl 131(1) – (3) has been included in full):[39]

[36] T240:20– 242:28 (1/10/2025).
[37] There was a further HPNF completed on 1 December 2022, when Greg left COVID-19 quarantine. It recommended "*Normal cell placement- lower bunk*". See BOE Tab 49, Folio 5(g) (Vol 3) p.957.
[38] BOE, Tab 111 (Vol 10) p.3399 [8].
[39] T146: 33-40 (30/09/2025).

Cl 131 of the CAS Regulation: Use of force in dealing with inmates

(1) In dealing with an inmate, a correctional officer may use no more force than is reasonably necessary in the circumstances, and the infliction of injury on the inmate is to be avoided if at all possible.

(2) The nature and extent of the force that may be used in relation to an inmate are to be dictated by circumstances, but must not exceed the force that is necessary for control and protection, having due regard to the personal safety of correctional officers and others.

(3) If an inmate is satisfactorily restrained, the only force that may be used against the inmate is the force that is necessary to maintain that restraint.

(4) Subject to subclauses (1)–(3), a correctional officer may have recourse to force for the following purposes—

…

(h) to ensure compliance with a proper order, or maintenance of discipline, but only if an inmate is failing to co-operate with a lawful correctional centre requirement in a way that cannot otherwise be adequately controlled,

…

(l) to restrain violence directed towards the correctional officer or other persons by an uncontrollable or disturbed inmate,

(m) to prevent or quell a riot or other disturbance,

(n) to deal with any other situation that has a degree of seriousness comparable to that of the situations referred to in paragraphs (a)–(m).

…

57. SCO Ma'u said on arrival to the POD, he "*tapped on the clear Perspex window and instructed the involved inmates to cease combat and return to their cells*".[40] He accepted in evidence he did not specifically think about giving a warning to inmates that they should get back to the cells or he would use CS gas.[41]

[40] BOE, Tab 106 (Vol 10) p.3353 [9].
[41] T148: 13-14 (30/09/2025).

58. CSNSW Custodial Operations Policy and Procedure (**COPP**) 13.7 *Use of Force*, sub-sections 2.2 – 2.4, requires officers, *where possible*, to give non-compliant inmates reasonable opportunities to comply with directions, and to use de-escalation strategies. Force must only be used as a last resort to control or restrain inmates and other persons. Reasonable attempts must be made to resolve a situation without using force unless doing so would place persons, property or correctional centre security at risk of harm. [42]

59. There is an obligation on officers to give a warning prior to the discharge of CS gas. I refer to the *Warning chemical aids* below: [43]

Instructions

Prior to the use of chemical aids these are the warnings that should be given to the inmates:

Warning 1

"This is *(say your name and rank)*. I am ordering you to move to *(state the location)*. If you do not comply with my order chemical aids and or force may be used against you. You have *(state minutes)* to comply with my order."

Warning 2

"This is *(say your name and rank)*. I am ordering you to move to *(state the location)*. If you do not comply with my order chemical aids and or force may be used against you. I am ordering you to move now."

Note: A warning does not have to be given if:

- Personnel are at immediate risk of death or serious injury;
- Communication with the inmate is not possible (E.g. in a barricaded situation);
- There is a hostage or siege situation;
- The Governor or Supervising officer believes that a proclamation would have an adverse effect.

These are the warnings referred to in **COPP section *13.7 Use of force.***

60. SCO Ma'u gave evidence that in his experience, the mere presence of IAT members often had the effect of de-escalating a situation. On 27 December 2022, that did not occur, and the inmates continued to fight. Some had weapons, including a vacuum cleaner and tuna cans. He saw one of the inmates make a gesture which caused him to be concerned that he may have a blade. As a result, he did not give any warning.[44]

61. Kevin Pese, the General Manager, Security Operations Group at CSNSW, gave evidence on this topic. In his view, while a warning was generally required in both planned and unplanned use of CS gas, it was not required where personnel are at immediate risk of death or serious injury. There could be disadvantages to giving a warning (allowing inmates time to prepare

[42] BOE, Tab 54 (Vol 4) p.1306.
[43] BOE, COPP 13.7, Tab 54 (Vol 4) p.1317 [7.5]; Warnings, Tab 61 (Vol 5) p. 1502; Tab 112 (Vol 5) p.3482.
[44] T127:31 – 129:36; 148:18 – 149:8 (30/09/2025).

for it) and advantages (it may result in compliance). In the present matter, the circumstances showed an immediate risk of serious injury, with the result that no warning was required. Mr Pese noted that, if force had been delayed, that may also have resulted in criticism.[45]

62. Counsel Assisting submitted, in light of that evidence, the use of force was reasonably necessary and was in accordance with CSNSW policy. Counsel for the Commissioner of CSNSW agreed with the submissions of Counsel Assisting on this matter.

63. The Solicitor Advocates on behalf of Shannon and Greg's broader family, accepted that SCO Ma'u's decision to use the Mace CS Fogger was reasonable with respect to the first two bursts but maintained that more should have been done in accordance with CSNSW policy to give a warning so that innocent bystanders could have had an opportunity to avoid the effects of CS gas. The Solicitor Advocates drew on the evidence Professor Alison Jones, Court-appointed Toxicologist and Specialist Physician Expert. Professor Jones commented that CS gas is more potent than OC spray, but both chemicals are broadly similar; they are designed to incapacitate people by making their eyes very sore and their skin sore to stop them from continuing with an aggressive type of behaviour.[46]

64. The Solicitor Advocates further submitted that the exceptions to giving a warning as set out in the excerpt at paragraph [59] above, did not apply in this situation, as the fight at the time of entry had decreased in its level of seriousness, was only a physical fight between two inmates, and did not reach the threshold of "*personnel* are at an immediate risk of death or serious injury." The Solicitor Advocates asserted that the effect of SCO Mau's evidence, is that he did not think about giving a warning to the inmates,[47] and that he held a misapprehension that a warning was only required if the use of force was planned,[48] not that he made a specific decision not to give a warning due to the level of seriousness he perceived.

65. The Solicitor Advocates commented that Mr Pese agreed in his evidence that there was an opportunity for a warning to be given,[49] and only saw a "snippet" of the video evidence and wasn't part of the review of the use of force. They maintained he does not have a thorough understanding of what occurred.

66. Additionally, the Solicitor Advocates noted that SCO Ma'u accepted in his evidence, that the third burst of CS gas was to get inmates to move out of the way, even though the first two bursts had the desired effect of stopping the fight and getting the inmates to comply with his direction to go back to their cells. The Solicitor Advocates submitted that the third burst of CS

[45] T268:32 – 272:13 (1/10/2025).
[46] T305: 9 (3/10/2025).
[47] T143: 13-14 (30/09/2025).
[48] T132:34 – 133:8 (30/09/2025).
[49] T271: 22-25 (1/10/2025).

gas was not reasonable and did not comply with cl 131(2) of the CAS Regulation, as it exceeded what was necessary for control and protection in the circumstances.

67. Counsel for the Commissioner of CSNSW contended that it is evident from the video evidence that SCO Ma'u was leading the way in entering a highly volatile and dangerous setting. In those circumstances, the three short bursts of CS spray were limited, and ceased upon their deployment having the desired effect. It was submitted that given the challenging and dynamic setting and the very short duration of the deployment of all three bursts, it would not be reasonable to draw a distinction between deployment of the first two bursts, and the third. Further, SCO Ma'u and the IAT more generally, as seen in the video evidence appear to act decisively and responsibly in bringing the violent event to a conclusion effectively and with minimal application of force, limited to the three short bursts.

68. On the topic of whether or not any warning should have been given by IAT officers concerning their intention to deploy CS gas prior to entry, in addition to the matters referred to by Counsel Assisting, Counsel for the Commissioner drew the following matters to the Court's attention:

- Both of the CSNSW institutional witnesses, namely Mr Pese and Adam Riddell, A/General Manager of State-wide Operations, CSNSW, were of the view that in the circumstances, there was an imminent risk of serious injury or death and that in those circumstances a warning did not have to be given, in keeping with the first dot-point exception to the warning that otherwise "*should be given*"). While the Solicitor Advocates suggested that the exception did not apply to inmates; both of these witnesses gave evidence that the exception as apposite to the circumstances confronting the officers.[50]

- It would be perverse if IAT officers were not permitted to enter urgently, absent a warning, in circumstances where they held a concern about imminent risk of serious injury or death to an inmate (as distinct from themselves). On the interpretation sought by the Solicitor Advocates, the potential corollary would be that, in order to protect the safety of inmates, officers may feel compelled to enter without the aid of chemical munitions, in which circumstances they would potentially expose themselves to risk of serious injury.

[50] T253: 19, T269: 8 (1/10/2025).

- Mr Riddell confirmed that relevant warnings are to be given only if time and circumstances allow.[51] Further under COPP 13.7, *Use of Force*, the requirement to give warnings in the case of planned use of forces generally is qualified by the proviso that this is the case "*unless urgent intervention is required*."[52]

69. Ultimately, Counsel for the Commissioner submitted that in the circumstances, no criticism is warranted of the actions of the IAT officers on the basis that they did not give a formal warning concerning the deployment of chemical munitions.

70. I have considered the matter carefully and am persuaded the use of CS spray was broadly consistent with the relevant policies. I accept, given the large number of prisoners present, that officers had a legitimate concern that the situation could escalate quickly and that serious injury or death could result. A verbal warning was not given, but as the IAT officers burst into the common area, shouting at inmates to return to their cells it would have been immediately clear that SCO Ma'u was holding a spray cannister ready to use. It is well known within the prison system that IAT officers have the capacity to use spray in circumstances where serious harm is contemplated. While the threat may have decreased after the second spray, the third use of spray follows almost immediately and in my view occurred at a time when it was open to the relevant officer to hold the view that risk of serious harm remained. I accept there may have been an opportunity for the Correctional Officer (**CO**) to pause and warn before the third spray, or to make a decision that two sprays were sufficient for the threat encountered, but I am not critical of the officer in this regard. In the spur of the moment risk of this sort may be assessed differently by individual officers tasked with the decision of whether or not to use force.

Was a reasonable and adequate process undertaken to check inmates' welfare, following the use of force incident which occurred on 27 December 2022?

71. Counsel Assisting submitted:

    (a) COPP 13.7, *Use of Force*, requires staff to request Justice Health NSW to medically assess or treat an inmate who is subject to a use of force, regardless of the presence or absence of injury.[53] There is also guidance and training for chemical munitions operators on personal and area decontamination.[54] There is no specific guidance or policy on medical or welfare checks on bystanders, following deployment of CS gas.

[51] T225: 8-19 (1/10/2025).
[52] BOE, Tab 114 (Vol 10) p.3502.
[53] BOE, Tab 52 (Vol 4) p.1313 [6.1].
[54] BOE, Tab 111 (Vol 12) p.3466-3468.

(b) The process that was adopted in the present case was that the POD was placed into lock down, and a request was made to Justice Health to attend to check inmates. No immediate steps were taken to identify or decontaminate affected inmates other than those directly targeted in the use of force. A head check was performed, and none of the inmates checked appear to have raised any concern.

72. I accept Counsel Assisting's overview of the events and the evidence concerning the period following the deployment of the CS gas, and I reproduce that overview below:[55]

- The CCTV shows that Greg returned to his cell about 4 seconds after the CS gas was deployed. CO Satnam Singh then looked into the cell briefly and shut the door. The door was locked by Functional Manager (**FM**) Daniel Hewson, at 1.09pm. Neither CO Singh nor FM Hewson had a particular memory of Greg's condition at that point.

- At 1.15pm, CO Meznaric attended Greg's cell, opened the hatch and briefly looked inside. He described this as a "head check", which FM Hewson had asked him to perform. He recalled seeing Greg "*pacing and standing*". He was 100% confident about this; if he had seen something wrong, he would have taken action.[56]

- By 1.18pm, the IAT had completed processing inmates in the dayroom and the yard, and all inmates had been locked in their cells. All officers then left the day room. No-one re-entered the day room until 1.38pm, 20 minutes later.

- Meanwhile, CO Pradap, in the clinic, received a call requesting a medical check. It is uncertain when this call was made. He then attended the POD with two nurses, RN Ian and RN Harman.

- RN Ian can be seen for the first time on the video at 1.26pm. She appears to be looking into the day room, to observe the state of the POD.[57]

- The evidence does not reveal precisely why there was a delay between the attendance of the nurses and their entry into the POD. At least some of the time was taken up with a handover, and some required for RN Ian to attend the clinic to obtain a third nurse. All three nurses and CO Pradap entered the day room.

[55] BOE, Tab 48 Folio 6(b)(i); Exhibit 2, Bodyworn camera footage "UOF_GAS_Pod_26_R_block_IAT".
[56] T194:42 – 195:23 (30/09/2025).
[57] T110: 1-27 (30/09/2025).

- There was no prioritisation for the review of the inmates, and the nurses simply commenced on the left and worked around. However, identifying any inmates who were at greater risk would have added further delay.[58] In any event, the lapse of time between the time when nurses attend the first cell and Mr Merriman's cell was about 2 minutes.

73. Counsel Assisting submitted that the evidence revealed an ad hoc system for checking the inmates' welfare. It was reasonable and appropriate in the circumstances, although ideally it would have commenced earlier. There is no evidence this would have made any difference to the outcome. CSNSW policy provides no specific guidance on how to respond to the deployment of CS gas inside a centre. Only chemical munitions operators have training and guidance on decontamination.[59] Accordingly, Counsel Assisting submitted it would be of benefit for there to be such guidance, including on the need to identify who is affected by gas, contact with Justice Health, and first aid and decontamination. Justice Health has already drafted relevant policy. It would be an advantage for CSNSW and Justice Health to ensure their policies align. This informs a proposed recommendation put forward by Counsel Assisting, which will be dealt with in the recommendations section below.

74. The Solicitor Advocates on behalf of Shannon and Greg's broader family, adopted the rationale in the closing submissions of Counsel Assisting for this issue, except to note that on the totality of the evidence, there was no identifiable reason for the delay in CSNSW officers facilitating the entry of Justice Health nurses into the POD for welfare checks. They commented that this was concerning and the lack of reasons for this means the delay was not reasonable.

75. Counsel for the Commissioner contended that the time between the arrival of Justice Health nursing staff in the POD at 1.26pm and their deployment on the floor for the purpose of conducting checks at 1.38pm was not inordinate, nor were the events over that 12 minute period fully explored in evidence, but it is known that at least some of the time was taken with a handover, and some required for Nurse Ian to attend the clinic to obtain a third nurse. It was submitted that there is not a sufficient basis to conclude that there was any delay that was "not reasonable".

76. In terms of the effects of the CS spray, the Solicitor Advocates referred to the evidence of GW, an inmate in R Block on 27 December 2022 who was not involved in the fight. From his recollection, the CS spray "*made it very hard to breathe. Tight chest … it wasn't nice. It was pretty horrible actually*." [60] SCO Ma'u also agreed that his and a female colleague's breathing

[58] T117:46 – 118:25 (30/09/2025).
[59] BOE, Tab 111 (Vol 10) p.3437.
[60] T27: 3-6 (29/09/2025)

was affected.[61] GW further gave evidence that if a warning had been issued, he would have gone outside as fresh air "*is the best way to stop the effects of the gas*."[62] Mr Pese outlined in his statement that chemical munitions operators are taught that "*the best first aid after being exposed to CS is fresh air/wind*."[63]

77. The Solicitor Advocates on behalf of Shannon and Greg's broader family, agreed with Counsel Assisting, that it would be advantageous for CSNSW and Justice Health to ensure their policies on how to respond to the deployment of CS gas inside a centre align to ensure that welfare checks of inmates are performed in a more timely manner in the future. While acknowledging that Greg's chance of survival was slim, they submitted it remains possible that if Greg was found earlier, first aid and the use of a defibrillator may have had a better outcome.[64]

78. On this matter, Counsel for the Commissioner of CSNSW submitted that a balanced appraisal of the extent of the impact of the spray on inmates generally, should take account of the evidence that no CS spray was detected on the swabs taken from Greg's hand and face. It should also take account of the objective evidence of Justice Health Nurse Ian, that in the course of the checks that she had conducted with inmates at their cell doors prior to the check on Greg's cell, no inmate had complained of suffering symptoms from the effects of CS gas.[65]

79. It is appropriate that a medical check took place. The evidence does not disclose why it did not take place sooner. In my view it is appropriate for the relevant agencies to review the relevant guidelines and I will deal with this matter below.

What factors contributed to Greg's acute myocardial infarction?

80. Greg presented with a number of recognised risk factors for myocardial infarction. These included non-modifiable factors such as his sex, age, and Aboriginal status. A/Professor Adams commented that Aboriginal people experience cardiovascular disease at significantly higher rates, often 10 to 20 years earlier than non-Aboriginal populations. In addition, Greg had several modifiable risk factors, namely tobacco use, hypertension and hyperlipidaemia.[66]

[61] T138:40 – 139:4 (30/09/2025)
[62] T32:25 – 33 (29/09/2025).
[63] BOE, Tab 53 (Vol 4) p.1098.
[64] T298: 34-50 (3/10/2025).
[65] T117: 24-33 (30/09/2025).
[66] BOE, Tab 5, (Vol 1) p.50-51.

81. The predominant factor contributing to Greg's myocardial infarction was his underlying severe coronary artery disease. This condition appears to have been asymptomatic, and Greg was not receiving treatment for it at the time of his death. The disease was sufficiently advanced that a cardiac event could have occurred at any time.[67]

82. A/Professor Adams observed that Greg's prior COVID-19 infection was associated with an increased risk of myocardial infarction. However, A/Professor Adams did not consider this to be a significant factor in Greg's case.[68] A/Professor Adams likewise did not consider any of Greg's prescribed medications or the substances detected post-mortem were likely to have contributed to the fatal event.[69]

83. A/Professor Adams commented that:

> "*Examining the video footage of this incident, Mr Merriman did not appear to be directly involved in any physical or verbal altercation, nor was any physical force required for him to return to his cell. Emotional distress or excitement has been recognised as a trigger for myocardial infarction (Chan et al, Emotional stress and physical exertion as triggers of acute myocardial infarction, JACC 2023, attachment 13). It is possible that the excitement involved in witnessing the use of force incident may have precipitated his cardiac event by causing emotional stress, however I think that this is unlikely as Mr Merriman did not seem distressed in any way by the events at that time. Nevertheless, if this myocardial infarction did not occur at this time, it was virtually inevitable that it was going to occur at some stage in the near future given the severity of his coronary artery disease.*"[70]

84. The Solicitor Advocates on behalf of Shannon and Greg's broader family, accepted Counsel Assisting's closing submissions on this issue, but wished for it to be recognised that A/Professor Adams and Professor Jones concurred that the use of force incident could have increased Greg's blood pressure, and/or heart rate which would have put him as an individual with significant coronary artery disease, at a higher risk of cardiac arrhythmias and myocardial infarction.[71]

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[67] T:299: 10-17 (3/10/2025).
[68] BOE, Tab 5, (Vol 1) p.52.
[69] BOE, Tab 5, (Vol 1) p.52.
[70] BOE, Tab 5, (Vol 1) p.53.
[71] T298: 17-21; T306: 22-25 (3/10/2025).

85. I accept Counsel Assisting's submissions on this issue. I also acknowledge that stress can certainly impact blood pressure and even the development of cardiac arrhythmias.

OC spray / CS gas

86. The evidence in relation to the discovery of traces of OC spray, rather than CS gas on Greg's body caused considerable confusion during these proceedings.

87. Swabs were taken of Greg's hands and face on 30 December 2022. Testing conducted on these swabs revealed traces of the main components of OC spray, on Greg's left hand and face. Testing did not reveal any exposure to CS gas.[72]

88. The canister deployed in the incident on 27 December 2022 has been tested, and it contained only CS gas (not OC spray).[73] No substances were detected on recent testing of Greg's shorts; it is possible that there had been some exposure to CS gas, which evaporated to undetectable levels, prior to testing in October 2025.[74] However, this is speculative.

89. OC spray was not used in CSNSW at the time of Greg's death, although it has been trialled for community escorts since that time. Counsel Assisting submitted that it is speculative to consider how traces of OC spray were detected on Greg's hand and face. It is possible that there was inadvertent transfer (either by police or paramedics, noting that OC spray is issued to police and deployed in the community, and that paramedics may attend such incidents). It is also possible that other substances could result in a positive result for the components of OC spray, including pain relief creams, food and personal care products.[75] Ultimately, no positive finding can be made as to the origin of the OC spray and frustratingly it remains a mystery.

90. There is, no evidence that Greg was exposed to any significant dose of CS gas during the use of force incident.

91. At the time of their reports, A/Professor Adams and Professor Alison Jones were each asked to consider whether exposure to OC spray contributed to Greg's heart attack. Neither considered it to have contributed to the death, because, on a review of the video evidence, Greg did not appear to have had a large exposure.[76]

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[72] BOE, Tab 4 (Vol 1) p.49.
[73] Exhibit 3, FASS Chemical Criminalistics Unit Report dated 30 September 2025.
[74] Exhibit 6, FASS Chemical Criminalistics Unit Report dated 30 October 2025 [8.14].
[75] Exhibit 6, FASS Chemical Criminalistics Unit Report dated 30 October 2025 [6.3].
[76] BOE, Tab 5 (Vol 1) p.53; Tab 101 (Vol 10) p.3276.

92. A/Professor Adams and Professor Jones maintained their views that, if CS gas were the substance deployed, it did not contribute to Greg's myocardial infarction.[77]

93. Counsel Assisting submitted that the only contributing condition to Greg's heart attack which is clearly supported by the evidence is Greg's pre-existing cardiovascular disease termed as "ischaemic heart disease" by the pathologist.

94. After listening to the experts I am confident that I can discount the CS spray as a direct factor in Greg's death. I have watched the CCTV footage a number of times and I accept that even if he was affected to some degree, he was not in the path of a direct blast.

95. While the stressful context of Greg's return to his cell may have raised his blood pressure and heart rate, it must be emphasised that Greg had significant pre-existing disease which is the root cause of his untimely death.

The need for Recommendations

96. Counsel Assisting put forward one recommendation arising from the evidence directed at CSNSW. The recommendation was drafted in these terms:

> ***To the Commissioner of Corrective Services NSW:***
>
> *1. CSNSW to consider amending Custodial Operations Policy and Procedures 13.7 – Use of Force, to include further instructions on action to be taken by correctional officers following the deployment of chemical munitions, including:*
>
> *a) identifying inmates who are affected by gas or are otherwise in need of medical attention,*
>
> *b) contact required with Justice Health staff,*
>
> *c) first aid and personal decontamination, and*
>
> *d) decontamination of areas affected by chemical munitions.*

97. The Solicitor Advocates on behalf of Shannon and Greg's broader family, supported this recommendation in principle, but sought the following specificity:

> "*That COPP 13.7 is amended to state that the best way to decontaminate inmates and provide first aid to who may have been exposed to CS gas is to give them access to fresh air/wind and not to lock them in their cells*".

[77] T293:34 – 294:5 (3/10/2025); T303:27 – 306:44 (3/10/2025).

98. The Solicitor Advocates advanced that this guidance was necessary, noting the general practice at the MRRC when IAT attends incidents like these is to lock inmates in their cells.[78]

99. Counsel for the Commissioner of CSNSW submitted that the Commissioner would support a recommendation being made in the terms put forward by Counsel Assisting. It would appropriately permit the Commissioner to consider the most effective manner in which the COPP might be amended, bearing in mind that flexibility in the terms of any amendment is necessary to ensure that:

- it is consistent with the approach taken by Justice Health;
- it accommodates the fact that there may not always be an on-site Justice Health presence, depending on location and timing; and
- it adequately accounts for the fact that the deployment of chemical munitions may occur in a range of different environments and circumstances and may or may not entail issues concerning possible effects on inmates who are "bystanders".

100. While understanding the intent behind the family's more prescriptive suggestion, the Commissioner resisted the terms put forward by the Solicitor Advocates. It was submitted that events giving rise to deployment of chemical munitions can occur in a variety of circumstances. A key consideration for officers in the relevant circumstances of 27 December 2022 included containment of the violence. Moving a large group of inmates into a single open area may significantly increase the chances of escalation. Providing individual medical attention to inmates in such a setting may also present operational challenges for officers. The circumstances must also be sufficiently secure so that Justice Health clinicians can safely provide assistance to inmates.

101. Having considered the submissions on this issue, it is in my view appropriate to make the recommendation in the terms suggested by Counsel Assisting.

102. The Solicitor Advocates on behalf of Shannon and Greg's broader family, put forward a draft recommendation arising from the evidence, directed at Justice Health. The recommendation was drafted in these terms:

[78] T142: 45-49 (30 September 2025).

To the Chief Executive of Justice Health & Forensic Mental Health Network:

Consider undertaking a review of its systems to ensure the following occurs, or otherwise, is implemented:

a) That information is obtained upon entry into custody from NSW Police and/or CSNSW of recent hospital admissions following arrest and reviewed prior to the RSA;

b) That health information is obtained from community and external healthcare providers early;

c) Health information is being reviewed by health staff regularly upon treatment of an inmate;

d) Previous health information that is known to Justice Health being populated into new systems; specifically, family history being auto populated into CCA's and PHS; and

e) Consideration be given to family history being included in the RSA and auto populating if known.

103. The Solicitor Advocates on behalf of Shannon and Greg's broader family, noted that the St Vincent's Hospital's discharge summary relating to Greg's admission in November 2022, was not received by Nurse Yun, who performed Greg's RSA on 24 November 2022. This document *was,* however, available to NSW Police and CSNSW.[79]

104. Separately, the Solicitor Advocates identified that RN Yun had identified that the RSA has information which is auto populated from the system to include demographic details which is not available for the CCA where inmates have previously had a custodial experience.[80]

105. In respect of the CDS performed on 22 January 2019, the Solicitor Advocates observed that Greg's parents were identified as having a cardiovascular disease around Greg's age.[81] They submitted that if a CCA had been performed on Greg during his final period in custody, this would have assisted clinicians to consider his hypertension in the context of cardiovascular disease and in circumstances where he was previously commenced on statin medication during his earlier period in custody.[82]

[79] BOE, Tab 40 (Vol 2) p.440; Tab 49, Folio 4 (Vol 3) p.850.
[80] T52:44-50; T53:6-14 (29 September 2025); T53:6-14 (1 October 2025).
[81] BOE, Tab 78 (Vol 9) p.2857.
[82] BOE, Tab 78, (Vol 9) p.3705.

106. Additionally, Dr Dissanayake stated that if it had been known to her that Greg had a family history of cardiovascular disease, along with other risk factors, including his Aboriginality, she would have started him on statins.[83] The Solicitor Advocates submitted that it was concerning that the Justice Health records which would have been available to Dr Dissanayake through the Justice Health Electronic Health System (**JHeHS**), indicated that Greg had a family history of cardiovascular disease.[84]

107. Counsel for the Chief Executive of Justice Health, submitted that the proposed recommendation is not necessary nor appropriate, given the evidence adduced during the hearing of this inquest. Stated summarily, and adopting the numbering of the proposed recommendation, the following reasoning was provided:

a) The RSA contains a specific question asking to whether the patient has attended hospital in the past 6 months. Where the patient indicates that they have, the clinician is prompted – via embedded guidance to complete a release of information (**ROI**) form with the patient's consent, to obtain the hospital discharge summary. There is no evidence before the Court that obtaining information about hospitalisations from NSW Police and/or CSNSW offers a benefit to the existing processes and Justice Health cannot require those agencies to provide them with information nor compel information in a timeframe that would ensure that the information was reviewed prior to an RSA being performed within 24 hours of the patient entering a police cell / custody. In March 2024, HealtheNet was made available to Justice Health clinicians. This is a statewide clinical portal which provides clinicians with immediate access to an aggregated view of patient and clinical information from NSW Health clinical systems and My Health Record. The information available through HealtheNet includes but is not limited to discharge summaries from recent hospital admissions. Finally, timely access to information about recent hospitalisations will be further enhanced when the Single Digital Patient Record (**SDPR**) is rolled out. This is a platform that will provide NSW Health care teams access to an integrated all-in-one electronic medical record system, patient administration system and pathology laboratory information system. Handover documents from external hospitals and specialist health services will include admission and discharge documents recorded in the same record.

[83] T87: 1-10 (29/09/2025).
[84] BOE, Tab 78 (Vol 9) p. 2744-2745; 2782-2783, 2821, 2857, 2882.

b) Justice Health currently seeks information from community and external healthcare providers at an early stage in a patient's interaction with the criminal justice system through the ROI process. Further the HealtheNet is available to all Justice Health clinicians, and the SDPR will enhance timely access to relevant information.

c) Standard clinical practice requires practitioners to review the patient's health record when reviewing and treating the patient.

d) The evidence before the Court does not permit a conclusion that auto population of family history information would provide efficiencies or improvements in clinical practice, particularly given that the matter was not raised in evidence in terms of whether Justice Health has previously explored the use of auto population within JHeHS and whether it is possible and achievable from a resourcing and technology perspective.

e) Specific questions about family history are asked during a CCA or PHS assessment, family history may be captured opportunistically, or through material obtained through the ROI process. The RSA is a different process to a CCA or PHS. It is a screening tool for the purpose of identifying active health issues for a patient upon their entry into custody to ensure appropriate referrals are made, appropriate cell placement recommendations are made, and any immediate treatment needs are met. To achieve this objective, the RSA comprises a large number of screening questions and can take anywhere from 30 minutes to an hour and a half to complete. In those circumstances, and where Justice Health processes already seek to capture family history information, it was submitted that it is of limited benefit to add family history to the RSA process.

108. I have carefully considered the response provided by Justice Health in relation to the family's concerns. I accept that the system will be improved once the SDPR is rolled out. This appears to be a more appropriate way to obtain information than by requesting it through NSW Police or through CSNSW.

109. It appears to me that in the circumstances of this case, even under the current system, important information would have been provided to Justice Health at an early stage had the St Vincents Hospital discharge summary been a more robust document.

110. I am sympathetic to the family's concerns that had further information (including information about family history), been available or accessible to Justice Health a more complete picture of Greg's risk would have been available and as a result planning for his care may have been improved. It appears that a comprehensive PHS would satisfy some of these concerns. In

this regard I have already raised my concerns about the current timeframes for the completion of a PHS. I have also stated that resources to implement contact with Aboriginal Health workers within weeks of the RSA should be provided as soon as possible. It strikes me that Justice Health has appropriate plans and is keen to strengthen the service it provides for Aboriginal inmates, but is hampered by resourcing restraints. This is unacceptable.

111. I have decided not to make the recommendation, but will draw the issue to the attention of the relevant ministers by sending a copy of these reasons.

Findings and Recommendations

112. For reasons stated above, I make the following formal findings pursuant to section 81 of the Coroners Act:

Identity

The person who died was Gregory Ronald Merriman.

Date of death

Greg died on 27 December 2022.

Place of death

Greg died at the Metropolitan Reception and Remand Centre, Silverwater NSW.

Cause of death

Greg died from acute myocardial infarction caused by ischaemic heart disease.

Manner of death

Greg died while he was lawfully detained as an inmate in a correctional centre. Following a lawful use of force where Orthochlorobenzalmalononitrile (CS gas) was deployed against other inmates, Greg was locked inside his cell. He was discovered unresponsive about 30 minutes later. His death was a result of natural causes.

Recommendation pursuant to section 82 *Coroners Act 2009*

113. For the reasons stated above, I make the following recommendations pursuant to section 82 of the Coroners Act:

To the Commissioner of Corrective Services NSW

1. CSNSW to consider amending Custodial Operations Policy and Procedures 13.7 – *Use of Force*, to include further instructions on action to be taken by correctional officers following the deployment of chemical munitions, including:

    a) identifying inmates who are affected by gas or are otherwise in need of medical attention,

    b) contact required with Justice Health staff,

    c) first aid and personal decontamination, and

    d) decontamination of areas affected by chemical munitions.

Conclusion

114. I thank the OIC, Detective Senior Constable Jemima Brown for her assistance in these proceedings.

115. I thank Nicolle Lowe, Aboriginal Coronial Information and Support Program worker. Her role at this court is of the utmost importance and once again she has assisted a grieving family to make sense of these difficult proceedings. Her assistance to this Court is once again invaluable.

116. I thank Mr Jake Harris of counsel and his instructing solicitor, Ms Connie Livanos for their hard work in the preparation of this inquest.

117. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner,
Coroners Court of NSW, Lidcombe
6 March 2026

Attachment – Counsel Assisting Chronology

Date	Time	Event	Ref	e
4 Dec 1964	00:00	Greg is born (58 at death)	P79A 2	0002
1972		Greg is placed in Daruk Boys Home until he is 17 He is the victim of physical and sexual abuse		
1976		First criminal charge, stealing (aged 11)	OIC 8 [20] Crim hist 42	0206 0488
1977		Commences smoking cannabis, and later uses amphetamines, LSD and heroin (at 18)		
u/k		Greg is placed in Mount Penang Training School for Boys, where he suffers abuse. He later assisted police with an investigation into child abuse offences at that facility, and Dharruk	OIC 8 [20]	0206
1984		Greg is hit on head with sledgehammer. Following this, he experiences seizures		
1985		First enters custody (aged 21)	OIC 8 [20]	0206
1988		Commences methadone		
u/k		Father dies of CVD aged 49; mother also has CVD		
1985 to 2009		**Various prior periods in custody**	IPD 49 (2)	0624
9 Feb 2009		**Enters custody**		
7 Feb 2012		**Released from custody**		
2013		Commences methamphetamine use		
7 Nov 2013		Lipitor 20mg is first prescribed (for cholesterol)	Pyrmont 71	1748
10 Jan 2014		Greg falls and sustains a head injury		
12 Jan 2014		Greg has a seizure; he is treated at Wyong Hospital. No clear epileptic activity detected		
1 Sep 2014		Review by neurologist: *In view of the history, this man needs to be on an anti-epileptic drug long-term and he has agreed to go on Keppra building up to a dosage of 500mg b.d if tolerated*		
14 Mar 2016		**Enters custody at Surry Hills**	IPD 37	
15 Mar 2016		**Transferred to Parklea CC**	IPD 37	

Date	Time	Event	Ref	e
		RSA No history of cardiovascular issues or hypertension noted	JH 64	
12 Apr 2016		Blood tests Cholesterol 5.6 H 3.0-5.5 Triglycerides 1.98 N <=2.0 HDL 1.1 N >=0.9 LDL 3.6 H (<=3.5) Cholesterol total/cholesterol in HDL 3.7 Non-HDL cholesterol 3.8 (<=4.0) HB1AC 4.7 N 4.0-6.0	JH 78 Pathology	3069 3066
13 Apr 2016		ROI sent to Broadway Medical Centre	JH 78	2737
15 Apr 2016		ROI received from Broadway Medical Centre Patient records include that he is a smoker, Medication fluoxetine (Lovan), Valium and Panadeine Forte	JH 78	2739
2 May 2016		ECG – suggests Left Ventricular hypertrophy	JH 78	2744
15 Sep 2016		**Released from custody**	IPD 37	
		In community		
6 Oct 2016		**Enters custody at Surry Hills**	IPD 37	
		Has a seizure; taken to RPAH ED for assessment	JH 78	2761
7 Oct 2016		**Transferred to MRRC**	IPD 37	
7 Oct 2016		ROI sent to Pyrmont Medical Centre	JH 78	2746
		ROI received from Pyrmont Medical Centre Patient records include IV drug use, Hep C. Medication - methadone, Valium	JH 78	2748
28 Nov 2016		**Transferred to John Morony CC**	IPD 37	
1 Dec 2016		**Released from custody to CDTP**	IPD 37	
		Commences Compulsory Drug Treatment Program, Phase 1		
30 Mar 2017		Progresses to Phase 2		
18 Jul 2017		Dr Maria Li, GP	JH 78	2768

Date	Time	Event	Ref	e
		Has put on weight (100kg) and attributes it to Avanza. Blood tests requested including lipids		
3 Aug 2017		Progresses to Phase 3		
22 Jan 2018		Blood tests from GP T cholesterol 5.4 N Triglycerides 1.9 N HDL 0.8 L (>0.9) LDL 3.7 H (<3.5) Received in ROI 12 Feb 2018	JH 78	2775
		Just prior to completing the CDTP, Greg relapses, in the context of being interviewed by police in relation to an historic child abuse investigation (perpetrated against him)		
7 Feb 2018		**Charged** with Larceny, Entering premises without lawful excuse, Break and Enter		
		Enters custody at Surry Hills	IPD 37	
10 Feb 2018		**Transferred to MRRC**	IPD 37	
		RSA History of seizures and arthritis is noted Methadone use – last dose 7 Feb	JH 78	2822
12 Feb 2018		ROI sent to Pyrmont Medical Centre and Star Medical centre	JH 78	2765
		ROI received from Star Medical centre Includes blood tests from 22 Jan	JH 78	2771 2775
13 Mar 2018		**Transferred to Parklea CC**	IPD 37	
14 May 2018		ECG – *possible inferior myocardial infarction*	JH 78	2782
22 Jan 2019		Chronic Disease Screen (RN Foxhall) *Arthritis* *Seizures*	JH 78	2854
		Multidisciplinary Care Plan Arthritis – plan to review by GP after X rays	JH 78	2858

Date	Time	Event	Ref	e
23 Jan 2019		Blood tests Cholesterol 5.7 H 3.0-5.5 Triglycerides 2.86 H <=2.0 HDL 0.81 L >=0.9 LDL 3.6 H (<=3.5) Cholesterol total/Cholesterol in HDL 7.0 normal	JH 78 Pathology	3057
27 Sep 2019		Medication perindopril (for hypertension)	JH 123	3729
8 Mar 2019		**Sentenced to 3 years 4 months' custody**		
1 Dec 2019	11:11	Chronic Disease Screen (RN Divina Velasco) Deleted on 18 Jun 2022 Assessment date is 1 Dec 2019	JH 78	2879
16 Dec 2019		**Transferred to MSPC**	IPD 37	
21 Dec 2019		PAS waitlist *Requesting initial CDS* Priority 4 = Routine This line is still outstanding on 12 Jun 2020	PAS waitlist 81 Line 31	
Jan 2020		Chronic Disease Screen is due (12 months)		
18 Mar 2020		D&A review – methadone to be increased to 140mg max for pain management	JH 78	2961
27 Apr 2020		Blood tests Cholesterol 7.5 H 3.0-5.5 Triglycerides 5.7 H <=2.0 HDL 0.8 N 0.7-1.9 LDL 4.1 H (<=3.5)	JH 78 Pathology	3064
18 May 2020		Dr Miljan Vlahovic review *Lipid profile deranged - Fasting bloods confirmed with Pt.* *Pt is going home in 3/52,* *O/E* *Looks well* *BP 130/70 HR 68* *Hyperlipidaemia discussed.* *Adequate diet, exercise discussed* *Side effect of Crestor discussed* *Pt advised to see his GP as soon as he can.* *Reminded about his referral to POWH for Colonoscopy*	JH 78	2979

Date	Time	Event	Ref	e
		Medication Crestor (rosuvastatin)	JH 78	3705
11 Jun 2020		Fax to Broadway General Practice Release Summary & transfer of care sent to GP	JH 78	2985
12 Jun 2020		**Released on parole**	IPD 37	
		Supervised by Community Corrections		
23 Nov 2020		**TTE performed at RPAH** Reveals aortic dilation and mild aortic regurgitation, and L ventricular hypertrophy		2637
17 Dec 2020		Dr Maria Li (GP) *Blood results given - after ringing RPAH pathology to fax to us. No diabetes, nor high lipids* Lipitor is ceased [for cholesterol]	Pyrmont 71	1785
18 Dec 2020		**Admission to RPAH**	RPAH 76	2450
		Admitted on an involuntary basis following assessment at Drug Health clinic		
19 Dec 2020		**Discharged**		
8 Jan 2021		Call from RPAH D&A to Dr Maria Li – re admission to RPAH over Christmas	Pyrmont 71	1786
12 Jan 2021		Dr Maria Li (GP) Attends re rectal bleeding and for Valium prescription *Brought up aortic root dilatation and concentric LV hypertrophy, which is related to his untreated hypertension. Pt recalls when his BP was checked in jail it was high too.* *D/W pt and needs cardiac assessment and treatment of his hypertension, monitoring of his aortic root dilatation* Greg is referred to cardiologist Prof I Wilcox	Pyrmont 71	1786
Mar 2021		**Greg receives compensation for historic abuse**	OIMS 49 Folio 7a	1043
12 Apr 2021		**Parole supervision ends**	SIR 49 [1]	

Date	Time	Event	Ref	e
13 Apr 2021		OIMS note: *Greg's response to supervision during his parole period was satisfactory … He has never missed an appointment and has maintained his methadone treatment at RPA. … He would often talk about his child hood trauma which he said attributed to his mental health, drug use and his offending… He reported being at peace in his life and wants to put his offending behind him and become a mentor for young indigenous people …*	SIR 49 [42] OIMS 49 Folio 7a	0603 1045
14 Apr 2021		**Admission to RPAH**	RPAH 76	2481
		Greg is hit by a reversing truck and sustains a head injury. Concussion, L frontal subdural haematoma, non-displaced fracture of occipital bone		
19 Apr 2021		**Discharged**		
26 Apr 2021		Dr Maria Li – review re head injury	Pyrmont 71	1788
13 May 2021		**Presentation to RPAH ED** - psychosis	RPAH 76	
14 May 2021		**Discharged**		
23 Jul 2021		**Charged** with custody of knife Fined $1,000	Criminal history 42	0554
28 Oct 2021		COVID vaccine given (first dose)	JH 78 Immunisation 70c	2931 1738
18 Nov 2021		COVID vaccine given (second dose)	JH 78 Immunisation 70c	2931 1738
15 Feb 2022		**Charged** with possess prohibited drug Fined $300	Criminal history 42	0554
11 May 2022		**Admission to RPAH**	RPAH 76	2663
		Involuntary admission in the context of auditory command hallucinations		
13 May 2022		**Discharged**		
23 May 2022		**Charged** with possess drugs, drive unlicenced Later withdrawn (deceased)	Criminal history 42	0554
25 May 2022		Dr Maria Li Attends for MHCP. <u>Last attendance on GP prior to death</u>	Pyrmont 71	1793

Date	Time	Event	Ref	e
5 Sep 2022		Dr Mark Lentham Greg is seeking diazepam BP 155/98 HT noted	Broadway 73	2196
11 Sep 2022		Dr Leilani Seeto Greg seeks a medical certificate for court	Star City 74	2355
21 Sep 2022		**Fails to attend court - Bench warrant issued**	CMR 40 p17	0443
2 Nov 2022		Greg is alleged to have entered a residence in Chatswood, and take multiple items He is connected to the scene by fingerprints	Facts sheet 41 p2	0458
4 Nov 2022		Greg is alleged to have entered a private property Lidcombe, where he took multiple items He is connected to the scene by fingerprints	Facts sheet 41 p8	0464
5 Nov 2022		Greg suffers a head injury		
		Greg is found by police slumped on a parked motorbike, intoxicated		
	15:51	**Admission to St Vincent's Hospital ED**	St Vincents 75 JH 78	2372 2809
	17:37	Drug screen – positive for benzodiazepines, amphetamines, cocaine, cannabis, alcohol, methadone – he admitted use	St Vincents 75 JH 78	2418 2806
		CT brain, spine, chest, abdomen, pelvis. Multiple facial fractures noted, no other acute injury. Not for immediate surgery – for follow up in plastics clinic	St Vincents 75	2418 2419
		ECGs – consistent with hypertension and old MI. The ECG is marked *? Wellen's syndrome Keep on monitor Rpt in 15/60*. However, Troponin tests do not reveal cardiac injury (13). No further cardiac investigations are undertaken or recommended	St Vincents 75 St Vincents 75	2383 2438
6 Nov 2022		**Discharged against medical advice**		

Date	Time	Event	Ref	e
		Discharge summary: 1. *Discharged against medical advice* 2. *Follow up with plastics Clinic as advised*	St Vincents 75 JH 78	2418
12 Nov 2022		Greg possibly suffers a further injury	JH 64 OIC 8 [21], [49]	
15 Nov 2022		Presents to RPAH D&A feeling dizzy, nauseous and with headache	RPAH 76	2813
		Presentation to RPAH ED	RPAH 76	2673
		Greg states he was assaulted 3 days prior. Diagnosed with post-concussion syndrome. Reviewed by D&A team, discharged to continue methadone as planned		
		CTB / CTX – discharged with head injury sheet		
		Discharged		
17- 21 Nov 2022		Methadone 140mg dispensed daily	Tab 64 p56	
22 Nov 2022	09:24	Methadone administered at RPAH	JH 78	2791
	14:40	**Arrested** at Ultimo	OIC 8 [1] SIR 36 [2]	0203
		Charged with break and enter offences, and outstanding warrants for possess drug, drive without licence, enter enclosed lands		
		Complains of pain and light-headedness following a previous head injury *Pinched nerve in back; 2 fractures in head from 11 days ago from assault* *Shaking, shielding face from light, states that he is suffering from pain and light headedness from an injury to skull a week ago – ambo called*	OIC 8 [2] CMR 40 CMR 40	
	15:33	Ambulance called, but cancelled due to wait, taken by police to St Vincent's	OIC 8 [2] CMR 40 p25	0203 0451
	16:31	**Presentation to St Vincent's Hospital ED**	St Vincents 75	2421
	17:42	Dr Rahul Santram (emergency physician) *Recent Zygomatic fractures and orbital floor# - uncomplicated -> has a plan to F/u in plastics clinic. Recent review at RP A and had CT brain – no intracranial pathology*	JH 78 CMR 40 p14	2804 0440

Date	Time	Event	Ref	e
		For simple analgesia (Paracetamol and Ibuprofen). Confirm F/u at Plastics Clinic (ph: 8382 3110) *Medically cleared for discharge into police / corrective services care*		
	18:49	Returned to police station	CMR 28	
	20:11	**Charged** with break and enter x 2, Dishonestly obtain financial advantage	CMR 28 CAN 29	
23 Nov 2022		Methadone is not dispensed on 23 Nov		
	04:01	**Refused bail**	CMR 40 p4	0431
		Enters custody at Surry Hills CC	IPD 37	
		NILSIS *Inmate shielding face from the light. Sensitivity due to head injury from a week ago. Treated at hospital. Clearance attached*	Case man 49 Folio	0860
		Downing Centre Local Court – refused bail Remanded to 7 Dec 2022	OIC 8 [3] Warrant 49 Folio 3(e)	0784
	11:16	Reviewed by NUM Thirak Keo	JH 78	
	19:49	ROI to RPAH for methadone dosing	JH 78 JH 79	2790 3089
24 Nov 2022		Section 23 Reception transfer checklist	Case man 39	
	08:28	ROI received from RPAH – last dose 140mg dispensed on 22 Nov at 9.24am	JH 78 JH 79	2791 3091
	09:27	Review by NUM Keo prior to transfer	JH 78	2989
	12:20	**Transferred to MRRC**	IPD 37	
		Placed in reception holding cell	OIMS housing 52	1096
		Inmate application form *I Gregory Merriman wish to remain on protection over my brother laws murder* [name intentionally omitted] *in long bat R wing*	Case man 49 Folio 4	0802
		Placed on SMAP	SIR 49 [4] Case man 49 Folio 4 Care 49 Folio 8e	0596 0794 1065
	13:19	EN Richards – review on intake. Greg says he hasn't received methadone since Monday	JH 78	2990

Date	Time	Event	Ref	e
	13:38 14:07	**Intake Screening Questionnaire** (Isabel Burns) *Head and back injury, recent head injury* *Contact established with inmate's sister Kerry ROBERTSON on* [number intentionally omitted]. *Inmate became emotional and cried, stating to his sister that he felt that he had not been taken care of in custody as he has not been dosed. Call appeared supportive and inmate ceased crying by its conclusion* *… (stated he has a head injury and is having headaches when looking at the light)* No issues raised, other than headache. Provided with handbook	Burns 22 Case man 49 Folio 4	0302 0850
	15:05	Methadone 140mg is dispensed	JH 79	3095
	16:39	HPNF (RN Seok Yun) *Previous experience in custody* *Chronic lower back pain* *On Methadone program* *Denies current thoughts of self-harm / harm to others and suicidal ideation* *Normal cell placement – lower bunk* *Quarantine until cleared by Justice Health*	SIR 49 folio 5(e) Case man Folio 4 JH 79	0955 0838 3079
	16:45	**Reception Screening Assessment** (RN Seok Yun) *Aboriginal* *Existing active health conditions* *Arthritis* *Physical disability* *Seizures* *History of Cardiovascular Condition* *No* *Methadone 140ml* *Current medication* *paracetamol, ibuprofen and diclofenac* BP 151/86 | HR 66 | SpO2 100% | T 36.2 | RR 16 BGL 7.9 | H 177cm | W 78kg | BMI 24	JH 78	2889

Date	Time	Event	Ref	e
		Admits smoking Ice, 1-2 points, 1-2 days per week, last used 2 weeks prior Reports depression and anxiety, but no report of heart problems or hypertension		
		D&A MH Summary provided to CSNSW	Case man 39	
		Consents obtained for St Vincent's, RPAH, Pyrmont	JH 79	3080
		PAS waitlist *Drug and Alcohol - New reception 24/11/22 - Recent head injury HTN, Hyperlipidaemia - currently a/w CDS blood. Epilepsy (seizure free for 5 years as per pt)* Priority 2 = semi-urgent *Adult Ambulatory Mental Health - Hx of dep but recent head injury/referred to GP* *Primary health - New reception 24/11/22 - on MMT 140mg. ICE smoke "here and there" 1-2points LUD 2/52 ago.* Priority 3 = non-urgent *Primary health - Repeat BP please. if possible please attend CDS blood/ECG* Priority 3 = non-urgent *Primary health - CDS - HTN/Hyperlipidaemia* Priority 3 = non-urgent	PAS waitlist 81 Line 14 Line 15 Line 16 Line 17 Line 18	
	PM	Medication Paracetamol, Ibuprofen	JH 79	3083
		Methadone prescribed by Dr Kehoe	OST 65	
		D&A OST Program details (RN Boorer) H 182cm | W 92kg [error?]	JH 64	
	17:05	**Placed in Darcy Unit 2 Cell 73**	OIMS housing 52	1096
25 Nov 2022		COVID quarantine checks commence (until 30 Nov)	JH 64	
	PM	Medication Paracetamol, Ibuprofen	JH 79	3083
		Methadone 140mg is dispensed	JH 79	3095
		PAS waitlist – PH nurse 4 (routine) *ECH post quarantine*	PAS Wait line 12	
		ROI sent to Pyrmont Medical Centre	JH 78	2795

Date	Time	Event	Ref	e
		ROI received from Pyrmont Medical Centre Medications: Celebrex 100mg (anti-inflammatory) Methadone 5mg/mL Nexium 40mg (heartburn) Valium 5mg No mention of hypertension/heart issue *On 12th November 2022, Greg sustained head injury and laceration to his brow from as alleged assault. He was seen in Emergency, RPAH and CT brain and spine revealed occipital skull fracture. No surgery was deemed necessary, but he was diagnosed with post-concussive syndrome.*	JH 78	2797
		ROI sent to St Vincent's	JH 78	2798
		ROI from St Vincent's Discharge summary from 6 Nov 2022 Check up 22 Nov 2022 Methadone dosing chart ECG not included - CT scan refers to dilated aorta	JH 78	2799
		ROI sent to RPAH	JH 78	2811
		ROI received from RPAH Discharge summary 15 Nov 2022 *Hypertension …* *Mild AR and aortic arch dilation*	JH 78	2813
	11:20	RN Bridget Musarurwa (D&A review) *Patient not intoxicated or withdrawing* *- Placed on waitlist for 3/12 MMT* *- Placed on waitlist for ECG post quarantine* *- Waitlist active in PAS for PH r/v of elevated BP* *- NIM as required* *- Advised to knock up if any issues or concerns arise*	JH 78	2991
26 Nov 2022	PM	Medication panadol, Ibuprofen	JH 79	3083
		Methadone 140mg is dispensed	JH 79	3095
27 Nov 2022		Methadone 140mg is dispensed	JH 79	3095
		OTS call to Kerry Robinson	OTS 49 Folio 8h	1075

Date	Time	Event	Ref	e
		Last successful call to Kerry-Anne		
28 Nov 2022		Classification and Placement Team meets to consider initial classification. Greg is not present. Hardeep Bhalla informs Greg of the outcome	OIC 8 [70] Bhalla 28 SIR 49 [31] OIMS 49 Folio 7b	0309 1048
		Initial classification: B (Unsentenced)	Case man 49 Folio 4	0826
		Methadone 140mg is dispensed	JH 79	3095
1 Dec 2022	08:51	HPNF (RN Laura McCarthy) *Previous experience in custody* *Chronic lower back pain* *On Methadone program* *Denies current thoughts of self-harm / harm to others and suicidal ideation* *Normal cell placement – lower bunk* *Cleared from quarantine by JH*	Case man 49 Folio 4 HPNF 49 Folio 5g	0792 0957
		Methadone 140mg is dispensed	JH 79	3093
	11:35	Review by CNC Tenille McDowell (MHN) *Reason for referral: Requesting to see MH team for his ?regular mirtazapine. pt reports pt was prescribed mirtazapine whilst in custody -unsure dosage …* *Pt complaining of recent head injury and main concern re: vision changes. Nil MH symptoms on background of depression hx. Not on mirtazapine for 2 years. Complaining of over sleeping since head injury.* *Plan* *1. Referrals: primary health/GP – follow up head injury* *2. Placement: NCP* *3. Discussed available services, Chaplin, Psychologist, Clinic Staff*	JH 78	2993
		PAS waitlist *Primary health - Recent head injury, experiencing slow motion at times if moves head, states had catscan at RPAH*	PAS Wait line 11	
		Interview by SCO Bove – does not raise issues or concerns.	OIC 8 [69]	
	12:14	**Placed in R Block POD 26 cell 788**	OIMS housing 52	1096

Date	Time	Event	Ref	e
	12:49	RN Gurung BP 141/78 | HR 62 | SpO2 99 | RR 18 | T36.1	JH 78	2995
2 Dec 2022		Methadone 140mg is dispensed	JH 79	3093
	09:38	NP Danielle Peel *RN attended ECG due to raised blood pressure* *Says previously on blood pressure medication - stopped taking it - unclear why…* *Obs:* *176/80* *161/85* *HSDNM ? aortic murmur* *ECG attended – NAD (static)* *Equal air entry bilaterally* *BS x 4* *Nil ankle oaedema* *IMP: to re-commence usual medications* *Plan:* *PHN to check BP daily for 2/52 – escalate to GP/NP if elevated*	JH 78	2996
		ECG *POSSIBLE LEFT ATRIAL ENLARGEMENT [-01mV P WAVE IN V1/V21* *LEFT VENTRICULAR HYPERTROPHY AND ST-T CHANGE [VOLT AGE CRITERIA PLUS ST/ ABNORMALITY]* *PROBABLE INFERIOR MYOCARDIAL INFARCTION [35 ms Q WAVE IN I/aVFl, OF INDETERMINATE AGE* *ABNORMAL ECG*	JH 78	2821
		Medication charted by NP Peel Panadol osteo 2 tabs BD Perindopril 5mg mane Rabeprazole 20mg daily Diclofenac PRN	JH 79	3086
	11:51	EN McNamara Note re BP review and ECG, reviewed by NP Booked on PAS for follow-up	JH 78	2998

Date	Time	Event	Ref	e
	13:30	RN Lucas – ECG attended	JH 78	2999
3 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
		EN Copeland Seen in clinic for BP check – BP 137/75 | HR 67 [Pt] *stated systolic normally sits around 170/80*	JH 78	3000
		PAS waitlist *Primary health - please attend CDS bloods* Priority 3 = non-urgent	PAS waitlist 81 Line 10	
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
	20:41	EN Ngalob – informed Greg would need to fast for blood tests the following morning	JH 78	3001
4 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
		Greg writes to his mother *… they have me on Blood Presher Tablets twice daily now and my level is back to 158, I am waiting to see the doctor about my head …* *I'm waiting for Ross Hill y get in contact with me as I want him to apply for parklea drug programme …* *I have no money at all that's why I havnt rang the only time I range was when welfare rang up for me and let me tak to Kerry*	Letter 6	0196
	13:09	EN Curtain – bloods taken	JH 78	3002
		Blood tests Cholesterol 5.2 N <=5.5 Triglycerides 1.3 N <=2.0 HDL 1.4 N >=1.0 LDL 3.2 H (<=3.0) Cholesterol total/cholesterol in HDL 3.7 Non-HDL cholesterol 3.8 (<=4.0) HB1AC 4.7 N 4.0-6.0	JH 78 Pathology	3065 3066
	13:44	RN Henry	JH 78	3003

Date	Time	Event	Ref	e
		BP check – BP 147/80 | HR 65		
		PAS waitlist *Adult Ambulatory Mental Health – looking for medication fro anxiety/dep. States he was on avanzas before* Priorty 3 = non-urgent	PAS waitlist 81 Line 10	
	PM	Medication panadol, perindopril, rabeprazole diclofenac	JH 79	3086
5 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
6 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
		Pfizer Comirnaty vaccine (3rd dose)	JH 78 Immunisation 70c	2930 1738
	13:46	RN Long BP check – BP 145/76 | HR 60	JH 78	3004
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
7 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	09:00	RN Maye *Pt seen in clinic for observation check post recent head injury…* *PEARL, left eye sensitive to light during review of pupil activity. Pt complaining of pain to behind eye and to brow bone…* *Pt reports headaches at time, HTN? recently commenced on perindopril 5mg…* *Education re medications given as pt was receiving DA'd medication but taken them at night instead of mane, pt now aware to keep medications until the next morning.* *... placed on GP list for r/v …* *BP:161/87mmgh, slightly elevated, pt asymptomatic to same ATOR.*	JH 78	3005

Date	Time	Event	Ref	e
		BP 161/87		
		PAS waitlist *Primary health - post head injury 15/11/22-ct brain and spine done showing occipital fracture, stilll experiencing dizziness/ lgiht headedness/head aches at times. Sensitive to light in left eye* Priority 3 = non-urgent *Primary health - requested by Dr. Grimsdale - HCV positive, ? PCR status, PCR requested* Priority 2 = semi-urgent	PAS Wait line 7 PAS Wait line 6	
		Downing Centre Local Court Remanded to 18 Jan 2023	SIR 49 [30] Warrant 49 Folio 3(f)	0602 0787
		Greg is interviewed by RAPO Belinda Hall They discuss Greg becoming Aboriginal Delegate – he was a delegate at Parklea	OIC 8 [68] Hall 10 OIMS 49 Folio 7b	 0287 1048
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
8 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	10:05	Dr Sasanka Dissanayake *Since yesterday, has a sharp headache 9/10 with postural dizziness and pain behind his eye…* *BP – 118/71* *PEARL, -3mm* *Shading his eyes* *Right eye sensitive to light…* *IMP- ongoing concussive symptoms* *Dehydration and vaccine related symptoms* *Plan* *Ondansetron* *Encourage oral fluids* *Review this afternoon - if still unwell, then ED for repeat CT brain*	JH 78 Dissanayake 35 [11]	3007 0407
		Medication charted Ondansetron (Maxolon is dispensed)	JH 79 Dissanayake 35 [26]	3085 0409

Date	Time	Event	Ref	e
		Medical officer/nursing certificate by CNE Clark *Suffering recent concussive symptoms. Headache, nausea, exhaustion, dizziness* *I recommend he has time in cell if feeling unwell/headache/nausea. Allow exercise if feeling well*	Certificate 49 Folio 5f	0956
	14:38	RN Long (with Dr Dissanayake) BP 119/65 | HR 98 (am) BP 126/78 | HR 78 (pm) *Dr.Sasanka also reviewed at this time and requested for patient to get another anti-emmitic and to wait and see if he improves.* *Did not want to transfer patient out at this time*	JH 78 Dissanayake 35 {31]	3009 0409
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
	20:57	RN Ngalob Welfare check	JH 78	3011
9 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	08:50	RN Fleming BP 141/74 | HR 63 | SPO2 78% (sic)	JH 78	3013
		Greg is interviewed by RAPO Belinda Hall for the Aboriginal Delegate position, and was successful	OIC 8 [68] Hall 7 Bove 31 OIMS 47	0287 0312
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
10 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	10:53	RN Mathew BP 151/84 | HR 65 | SPO2 97%	JH 78	3014
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
11 Dec 2022	AM	Medication panadol, perindopril, rabeprazole, diclofenac	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	09:17	Greg makes a call to JC (81 seconds)	OTS 49 Folio 8h	1073

Date	Time	Event	Ref	e
		Last successful call Greg made		
	11:57	RN Vora BP 145/88 | HR 86 Nil issues raised	JH 78	3015
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
12 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	08:40	RN Spriggs *Patient remains to feel slightly nauseous at time, nil vomiting* BP 154/86 |HR 78 *Patient requesting medical cert to remain inside, old cert has expired. Spoke with NUM re same, new cert issued for review in 3/7*	JH 78	3016
		Greg has an education assessment session. He is told there is no education program offered at MRRC, although there may be at his gaol of classification	Perry 11	0288
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
13 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	08:19	RN Maye *Pt reports headaches and dizziness has improved, still occurs at time. PEARL intact at size 3, left eye remains sensitive to light…* BP 153/81 | HR 66	JH 78	3017
	14:17	RN Maye *Discussed with GP Dr Hinder, nil requirement to alter antihypertensive at present.* *Continue to r/v, escalate if pt continuously elevated in BP.*	JH 78	3018
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
14 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086

Date	Time	Event	Ref	e
		Methadone 140mg is dispensed	JH 79	3093
	10:25	RN Honan BP 164/68 | HR 79	JH 78	3019
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
15 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	09:25	RN Maye *Nil headaches/dizziness or light headedness ATOR.* *Still experiencing same at times, improved as of recent.* *PEARL intact at size 3, sensitivity to light remains to left eye, same also improving, nil blurred vison associated with same.* BP 159/69 | HR 77 *Pt BP slightly elevated as of recent, as per pt he is more stressed at present, possible cause to elevated BP?. Pt on anti-hypertensive, compliant with taken same. Continue to monitor, if continued to be elevated, escalate to GP*	JH 78	3020
		Belinda Hall (RAPO) – discussion about a Yarning Circle and an art competition	OIC 8 [68] Hall 7 OIMS 49 Folio 7b	1049
	12:50	Sandra Anni helps Greg contact Centrelink, to correct the date when he entered custody	Anni 24 OIMS 49 Folio 7b	0304 1049
	13:26	**Placed R block POD 26 cell 784**	OIMS housing 52	1096
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
16 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	08:07	RN Honan BP 162/96 | HR 76 *…Reports he is anxious about his elderly mother who has just been released from hospital, reassurance offered. On GP waitlist regarding review of ongoing hypertension, compliant with anti-hypertensives. Nil other issues voiced.*	JH 78	3021
		PAS waitlist		

Date	Time	Event	Ref	e
		RAPO Belinda Hall speaks to Greg. Greg is asked to speak to other Aboriginal inmates about what they would like to see in the Yarning Circle, and the art competition	Hall 10	0287
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
17 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	08:49	RN Philip BP 152/84 | HR 74 *On GP waitlist to be review*	JH 78	3022
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
18 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	14:20	RN Zhang BP 160/87 | HR 68	JH 78	3023
		PAS waitlist *Primary health - Uncontrolled HT, please review medication dose* Priority 2 = semi-urgent	PAS Waitlist 81 Line 5	
19 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	08:32	RN Ziolkowski BP 159/82 | HR 77 *Pt was alert and orientated ATOR observed ambulating unaided around clinic and speaking in full sentences. Pt reported to be "bit stressed at the moment trying to get all this sorted" Pt on waitlist to be r/v by GP, Pt agreeable to same* Nil further concerns or complaints voices during interaction	JH 78	3024
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
20 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	08:29	RN Ziolkowski	JH 78	3025

Date	Time	Event	Ref	e
		Seen for BP check BP 165/86 | HR 67 | SpO2 98% *nil concerns or complaints voiced during interaction*		
	09:48	Dr Dissanayake *Discussed with nurse and file review* *BG of head/facial injury with nasal, orbital floor and left occipital fractures on _____* *Was seen in clinic on 8/12 for headache and postural dizziness with dehydration* *BP at the time was _____* *Now has slowly rising HTN (currently on Perindoril 5mg mane)* *When seen in the clinic today denies any headaches, visual disturbances or light-headedness or any other symptoms Pt was alert and orientated* *BP 165/86* *HR 67bpm, Spo2 98%, Temp 35.8, RR 18* *Plan* *Cont thrice weekly BP check for the next 2 weeks* *If becomes hypertensive (BP > 140/90) then add to GP WL* *If develops headaches etc then for GP review /discuss with ROAMS GP earlier*	JH 78 Dissanayake 35 [36]	3026 0410
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
21 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	13:51	RN Maye *Pt seen in clinic for BP r/v, pt post head injury, consistently hypertensive for approx 1/52.* *Pt alert and orientated.* *Asymptomatic to elevated BP, nil dizziness/ light headedness or blurred vision.*	JH 78	3028

Date	Time	Event	Ref	e
		As per ROAMS GP note 20/12/22 pt for GP waitlist with systolic >140 … BP 166/87 | HR 76 | SpO2 99% *Pt admitted to author he has had increased levels of stress at present.* *Contributing to elevated BP?*		
		PAS waitlist – GP 3 (non-urgent) *BP >150 consistently for approx 1 week. On prindopril 5mg daily since 2/12/22*	PAS Wait line 4	
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
22 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	13:57	RN Long *Patient seen for BP check due to constant hypertensive episodes. Continues on anti-hypertensive and awaiting GP review for same. Patient reports feeling well ATOR, nil headache at this time. Mobilising with nil issues and nil dizziness noted. Observations stable but continues to be hypertensive.* BP 166/85 | HR 70 | SpO2 98% | T 36.2 | RR 17 *Patient agreed to knock up if any concerns*	JH 78	3029
		Appointment booked at St Vincent's	Appoint 65	
		PAS waitlist *St Vincents Hospital Plastic Clinic F/up Appointment history of Facial injury W/ nasal orbital Floor Discharge 25/11/22 in St Vincents- MRN- 07 33423- Tel: 8382 3110 L3 Ambulatory Care Outpatient* Priority 5 = follow-up	PAS Waitlist 81 Line 3	
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
23 Dec 2022	07:56	RN Harman BP 155/86 | HR 74 | SpO2 99% | T 36 | RR 17	JH 78	3030
	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
		PAS waitlist	PAS Waitlist 81	

Date	Time	Event	Ref	e
		Primary health - Daily BP until stable Priority 4 = routine	Line 2	
	08:00	Completes *Health Survival Tips* course	OIC 8 [72] Vosalotaki 25 OIMS 49 Folio 7b	0223 0305 1049
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
24 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	11:54	RN Yang *Alert and orientated, appears well. Patient stated that he experienced mild dizziness occasionally, denied headache* BP 146/91 | HR 98 | SpO2 96	JH 78	3031
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
26 Dec 2022	AM	Medication panadol, perindopril, rabeprazole	JH 79	3086
		Methadone 140mg is dispensed	JH 79	3093
	09:27	RN Philip BP 134/85 | HR 88 | SpO2 99% | T 35.9 | RR 18 *Denies headache, blurred vision and weakness at the time of review*	JH 78	3032
	PM	Medication panadol, perindopril, rabeprazole	JH 79	3086
27 Dec 2022	07:54	Methadone 140mg is dispensed	SIR 49 [5] JH 79	0596 3093
	AM	Medication is not dispensed	JH 79	3086
	09:20	RN Ian (written on account of RN Ha) BP 1385/80 (sic) | HR 81 | SpO2 96% | T 36.1 *Denies headache, blurry vision. Encouraged to knock up if any concern. Appointment booked for tomorrow for same*	JH 78 Ian 34 [6]	3035 0403
	09:51	Greg attempts to make a call – does not connect	OTS 49 Folio 8h	1071
	13:07	**A fight breaks out in POD 26** A group of inmates start fighting (the names of other inmates have been intentionally omitted)	Use of force 49 5(l) CCTV 49 Folio 6bi	0978

Date	Time	Event	Ref	e
	13:07	(The name of other inmate has been intentionally omitted) arms himself with a vacuum cleaner pole and strikes (the name of other inmate has been intentionally omitted) with it	CCTV 49 Folio 6bi	
	13:08	Immediate Action Team attends POD 26	OIC 8 [9] OIC 9 image 12 SIR 49 [74] Incident 49 Folio 5l Mau 106 [9]	 0239 0609 0979 3353
	13:08	CO Mau (IAT 5) knocks on window and directs inmates to stop fighting.	Mau 106 [9]	3353
	13:08	**Use of force - OC spray is deployed by CO Lau** CO Sioata Nau opens the door to the POD, and CO Mau deploys 2 x OC fogger bursts towards inmates (the names of other inmates have been intentionally omitted), and then 1 further burst after entering the POD. Greg is standing few metres away. Some spray contacts with his face and hand	Mau 106 [9] Nau 49 Folio 5l CCTV 49 Folio 6bi	3353 0987
	13:08	IAT enter the POD, followed by other officers	CCTV 49 Folio 6bi	
		CO Mau shouts "*Move, move back, get back to your fucking cells, move, move back, get in your fucking cell*"	BWV 49 6(p)	
	13:08	Greg returns to his cell (c. 4 seconds after OC spray is deployed)	SIR 49 [7] CCTV 49 Folio 6bi	
	13:09	POD 26 is placed into lock down		
	13:09	CO Satnam Singh looks into Greg's cell, and checks he is present, and shuts the door. He does not have a key to lock the cell, so asks FM Hewson to lock it	OIC 9 p17 Singh 105 [6] Hewson 15 Hewson 107 [7] CCTV 49 Folio 6bi	0244 3348 0293 3375
	13:09	**Greg's cell is locked** by FM Daniel Hewson	CCTV 49 Folio 6bi	
	13:10	Multiple other officers enter the POD	CCTV 49 Folio 6bi	
	13:11	IAT secure detain inmates in the yard	CCTV 49 Folio 6bi	
	13:12	(The name of other inmate has been intentionally omitted) is led back into the POD in handcuffs	CCTV 49 Folio 6bi	
	13:15	(The name of other inmate has been intentionally omitted) is taken away ? for a medical check	CCTV 49 Folio 6bi	

Date	Time	Event	Ref	e
	13:15	CO Meznaric goes to cell 784, opens the hatch and looks inside briefly. CO Meznaric believes he saw Greg "*pacing and standing in the cell*" Last confirmed sighting of Greg alive	Meznaric 109 [9] CCTV 49 Folio 6bi CCTV 49 Folio 6d	3382
	13:18	IAT and others leave the POD	CCTV 49 Folio 6bi	
		No-one enters the POD from 13:18 to 13:38	CCTV 49 Folio 6bi	
	u/k	FM MacFarlane asks FM Dorrans to go to each cell, to see if inmates were affected by gas	McFarlane 104 [6]	3346
	u/k	FM Dorrans and other officers go to POD office for a debrief. He checks the muster book to identify who was involved FM Dorrans may have called the clinic, to ask for nurses to attend to do a welfare check	Dorrans 99 [9]	3256
	u/k	CO Pradap receives a call from an unknown officer in the clinic, saying an incident had occurred, gas had been used, and JH nurses needed to attend to do a welfare check	Pratap 100 [6]	3259
	13:00	CO Pratap asks nurse to do a welfare check on inmates in R POD, as gas had been used	Ian 34 [8]	0404
	13:15	RN Ian and RN Harman arrive in POD office. POD 26 officers say the cells are not to be opened alone (only the hatches) RN Harman asks NUM to arrange additional staff. RN Ian goes to M Block clinic and returns with RN Ha	Ian 34 [9] Pradap 100 [14]	0404 3259
	13:26	A nurse (? RN Ian) can be seen in the POD office	CCTV 49 Folio 6bi	
	13:38	CO Pratap, with RN Harman, RN Ha and RN Ian enter POD 26 to conduct welfare checks. They commence on LHS of ground floor	OIC 9 p21 SIR 49 [10] Ian 34 [10]	0248 0404
	13:40	RN Ian goes upstairs to check top level cells	CCTV 49 Folio 6bi	
	13:40	RN Harman attends cell 784. She observes Greg unresponsive in shower area. She says "*man down"* About 31 minutes after cell was locked	OIC 9 p22 SIR 49 [80] Pradap 100 [9] CCTV 49 Folio 6bi CCTV 49 Folio 6d	0249 3259
	13:41	CO Pratap and RN Ha attend cell 784	OIC 9 p24 Pradap 100 [10]	0251 3259

Date	Time	Event	Ref	e
	13:41	CO Pratap goes to POD office and speaks to FM Dorrans	Pradap 100 [10] CCTV 49 Folio 6bi	3259
	13:41	RN Ian leaves the POD, and then attend returns with FM Dorrans and others	JH 78 (Ian) CCTV 49 Folio 6bi	3033
	13:42	FM Dorrans enters POD and goes to cell 784. He sees Greg crouched in the shower. He calls out to Greg but gets no response. He then opens the cell door	Dorrans 18 Dorrans 99 [13] CCTV 49 Folio 6bi	0298 3256
	13:42	**Greg's cell is opened** by FM Dorrans About 30 seconds after FM Dorrans arrives	OIC 9 p26 SIR 49 [9]	0253
	13:43	NUM Gonzalez calls ambulance	JH 78	3036
		Greg is moved from cell to corridor by Dorrans and Pratap	Dorrans 18	0298
		RN Dwyer attends with crash cart	JH 78 (Dwyer)	3034
	u/k	Meznaric commences using handheld camera, which is not working	Meznaric 12	0290
	13:44	**CPR is commenced** by FM Dorrans	Dorrans 18	0298
	13:45	CO Robinson attends and records list of names	Robinson 19	0299
	13:47	Meznaric obtains a new camera and starts recording events	Meznaric 12	0290
	14:05	Paramedics attend	SIR 49 [54]	0605
	14:30	CPR ceased		
	14:30	Time of death	Verification 1	0001
	14:33	Police broadcast *CONFRIMED DECD OF A MALE*	OIC 8 [27]	0208
	14:36	Cell secured		
	14:30	Police (Brown) attend	P79A 1 p7	
		A round orange tablet is found in Greg's pocket, within similar tablets and other drugs located in resealable bags in the cell Bags with the names (the names of other inmates have been intentionally omitted) also found in the cell	P79A 1 p7 OIC 8 [38]	0211
	18:40 19:20	After action review conducted in IAT office	Review 17	0296

Date	Time	Event	Ref	e
		Dorran, Meznaric, Pratap, Biala, Robinson, Warwick, Hristov, McFarlane, Hewson, Joseph, Brown are present All staff were given an opportunity to present actions and thoughts about the death		
	19:11	Cell call alarm test No other calls had been made from the cell	OIC 8 [44] SIR 49 [81] DIR 49 Folio 8g	 0616 1069
	22:00	OIC contacts Kerry-Anne	OIC 8 [48]	0213
29 Dec 2022		Use of Force Review	Use of force 40i	
		OIC speaks with Shannon	OIC 8 [52]	0214
30 Dec 2022		**Autopsy** (Dr Elsie Burger) *Direct cause: Acute myocardial infarction* *Antecedent causes: Ischaemic heart disease* BMI 27.3 kg/m2 (85.5kg) Concentration of methadone in the reported lethal range. However, tolerance can develop with prolonged use. COVID-19 infection is associated with increased risk of MI, even months after infection. No obvious signs of acute infection	PM 3	0011
	13:45	Alcohol wipes of Gregs hands and face – these later reveal OC spray	EFIMS 47	0554
		Neuropathology (A/Prof Buckland) - *Moderate small vessel disease…* - *Remote likely haemorrhagic infarcts…* - *No acute pathology*		
		Toxicology Alcohol ND Aripiprazole <0.05mg/L Not prescribed Mirtazapine 0.10mg/L Not prescribed Methadone 1.3mg/L Perindopril was not assayed	Tox 3	0040
		Virology *Sars-CoV-2 RNA DETECTED*	PM 3E	0044

Date	Time	Event	Ref	e
		Chemical analysis Components of OC spray are detected on wipe samples from face and left hand	Chemical 4	0049
5 Jan 2023		Planned appointment at St Vincent's plastics	JH 79	3097
18 Jan 2024		**Downing Centre Local Court** - next court date	OIC 8 [3]	0203