New South Wales

CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Phuoc Van Nguyen
Hearing date:	22 January 2026
Date of Findings:	30 January 2026
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death, Parklea Correctional Centres, searching of inmates prior to internal transfer, assessment of inmates for risk of suicide or self-harm, Instruction PKL 025, reduction and elimination of ligature points
File number:	2023/171059
Representation:	Ms A Storm, Coronial Advocate Assisting the Coroner Mr S Bailey for Management & Training Corporation Australia Ms K Llewellyn for the Commissioner of Corrective Services New South Wales
Findings:	Phuoc Van Nguyen died on 27 or 28 May 2023 at Parklea Correctional Centre, Parklea NSW 2768. The cause of Mr Nguyen's death was hanging. Mr Nguyen died as a result of actions taken by him with the intention of ending his life. Mr Nguyen's death was therefore intentionally self-inflicted.
Non-publication orders:	See Annexure A

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1. Introduction

1.1 Phuoc Van Nguyen was a 51-year-old man who was serving a custodial sentence at Parklea Correctional Centre. On the morning of 27 May 2023, Mr Nguyen was involved in a physical altercation with another inmate. Following enquiries made by correctional officers, Mr Nguyen asked to be transferred to a different area within the correctional centre. This request was approved and later that evening Mr Nguyen was escorted to another area and placed in a new cell. He was last seen alive and well at around 7:46pm.

1.2 At around 8:26am on 28 May 2023, correctional officers conducted a routine morning check. When Mr Nguyen's cell was opened he was found suspended from a ligature made from fabric material which had been tied around his neck and attached to the cell window. Mr Nguyen was unresponsive and showed no signs of life.

1.3 An emergency medical response was initiated and resuscitation efforts were commenced. However, Mr Nguyen could not be revived and was later pronounced life extinct.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

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

2.3 A coronial investigation and inquest seek to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. This type of examination typically involves consideration of, where relevant, the conduct of correctional staff.

2.4 In Mr Nguyen's case, the circumstances of his death raised a number of questions regarding the origin of the ligature used by him, whether there was any missed opportunity to identify that Mr Nguyen was at risk of self-harm at the time of his internal transfer, and whether appropriate remedial action has been taken by Management & Training Corporation Australia (**MTC**), the operator of Parklea Correctional Centre, since Mr Nguyen's death.

2.5 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very

nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

3. Mr Nguyen's life

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

3.2 Mr Nguyen was born in Vietnam. When he was approximately 17 years old, Mr Nguyen moved to Australia and lived in Perth. He formed a relationship with Lily Kwan and had two children, Barry and Paula. Sadly, Mr Nguyen later became estranged from his children.

3.3 In 1997, Mr Nguyen moved to Sydney without informing his partner or children. He later formed a relationship with Kim Huynh and began living with her and her two daughters. Sometime during the mid-2000s, Mr Nguyen returned to Perth where he reconnected with Ms Kwan. He remained there for nearly a year before returning to Sydney.

3.4 Upon his return, Mr Nguyen reconnected with Ms Huynh and they lived together, although there were periods where Mr Nguyen's interactions with the criminal justice and correctional systems separated him from Ms Huynh. Despite these challenges, Mr Nguyen maintained his relationship with Ms Huynh and they remained close.

3.5 Mr Nguyen helped to look after Ms Huynh's daughters and had a particularly good relationship with one of them. Mr Nguyen was also close to Ms Huynh's grandchildren.

3.6 Despite his personal challenges, Mr Nguyen sought to maintain relationships with those closest to him. They are no doubt saddened by Mr Nguyen's tragic death and continue to miss him.

4. Mr Nguyen's custodial history

4.1 Mr Nguyen had a lengthy history with the criminal justice systems in both NSW and Western Australia. He first entered custody in April 1999 and spent various periods in custody since that date.

4.2 On 23 April 2023, Mr Nguyen was arrested for a shoplifting offence in Cabramatta. He was later convicted and sentenced to 7 months imprisonment, with a two-month non-parole period commencing on 23 April 2023 and concluding on 22 June 2023.

4.3 Mr Nguyen was subsequently transferred to Parklea Correctional Centre to serve his custodial sentence. Following a placement assessment, Mr Nguyen was accommodated in Area 4, a minimum security section where inmates are permitted to move around common areas and interact with one another, with individual cells not locked.

5. Mr Nguyen's medical history

5.1 Available medical records portray a conflicting medical history for Mr Nguyen particularly with respect to his mental health. For example, during an intake assessment in February 2021, Mr Nguyen reported a history of depression and schizophrenia. However, when a similar screen questionnaire was completed in February 2022, Mr Nguyen denied any mental health issues. During another questionnaire in October 2022, Mr Nguyen again referred to a history of mental health issues including depression and anxiety.

5.2 During his various periods in custody, Mr Nguyen was only referred for psychological assessment on one occasion in February 2019. At that time, Mr Nguyen reported no history of mental illness, denied any thoughts of suicide or self-harm, and demonstrated that he was future-focused with support from his partner and family.

5.3 Most recently, on 25 April 2023, Mr Nguyen underwent an intake screening assessment at Parklea Correctional Centre. He reported using alprazolam daily for anxiety and depression and experiencing seizures relating to withdrawal from heroin use. Mr Nguyen was referred to the clinic for management of his withdrawal symptoms.

5.4 On 26 April 2023, correctional officers completed an intake screening questionnaire with Mr Nguyen. He denied having a history of self-harm or any mental health issues. The following day, Mr Nguyen was cleared for normal cell placement.

6. The events of 27 and 28 May 2023

6.1 At around 10:36 AM on 27 May 2023, Mr Nguyen was in an outdoor common area within Area 4 when he approached another inmate. After speaking for a short period of time, Mr Nguyen allegedly struck the other inmate in the face unexpectedly. A short physical altercation followed with both Mr Nguyen and the other inmate sustaining minor injuries. Mr Nguyen did not initially seek medical attention or report the incident.

6.2 At around 10:50am, the other inmate approached Correctional Officer (**CO**) Gregory Appiah and alleged that he had been assaulted by Mr Nguyen. CO Appiah told Correctional Supervisor (**CS**) Lesley Zbrog about the allegation. CS Zbrog called Mr Nguyen to the office but he did not respond and arrangements were made for him to be escorted there.

6.3 On arrival, CS Zbrog observed that Mr Nguyen had minor facial injuries. When asked about the injuries, Mr Nguyen initially claimed that he had fallen and denied any alleged assault occurring. CS Zbrog completed an injury questionnaire with Mr Nguyen and arranged for him to be seen by a nurse and to be moved to a different cell location within Area 4.

6.4 CS Zbrog subsequently received a call to attend the Area 4 clinic as Mr Nguyen had expressed fears for his safety and requested to be moved out of Area 4. CS Zbrog completed an Assessment Tool: Inmate Under Threat (**Threat Assessment**) with Mr Nguyen and asked him to explain what had occurred with other inmate. Mr Nguyen said that he needed to leave Area 4 and enter protective custody because he was afraid of the other inmate but declined to provide any other details.

6.5 CS Zbrog considered it was appropriate to move Mr Nguyen from Area 4 to a Special Management Area Placement (**SMAP**) in Area 2 and made a recommendation for this to occur. Area Manager (**AM**) Sue Price spoke to Mr Nguyen who indicated that he had been

struck by the other inmate because he owed the inmate "*a lot of money*". AM Price agreed with CS Zbrog's assessment and approved Mr Nguyen's transfer from Area 4 to SMAP in Area 2. In preparation for this move, Mr Nguyen's property was packed in plastic bags. CO Appiah searched the property prior to Mr Nguyen's transfer.

6.6 At around 6:00pm, Mr Nguyen was transferred from area 4 to the Main Area reception. Mr Nguyen was allocated to reception cell 5 pending allocation of a cell in Area 2 SMAP. At around 7:26pm, correctional officers escorted Mr Nguyen to cell 5. At this time, Mr Nguyen was carrying a plastic bag with his property, whilst one of the correctional officers was carrying two additional plastic bags containing Mr Nguyen's property. Mr Nguyen was secured inside his cell and the correctional officers departed.

6.7 At around 8:26am on 28 May 2023, correctional officers conducted a routine morning head check. Cell 5 was opened and Mr Nguyen was found suspended from a ligature which had been tied around his neck and attached to the structures of the cell window. Mr Nguyen was unresponsive and showed no signs of life.

6.8 An emergency call was made for medical personnel to attend. Resuscitation efforts were initiated. However, Mr Nguyen could not be revived and was later pronounced life extinct at the scene

6.9 Attending New South Wales Police Force (**NSWPF**) officers later found a piece of green coloured fabric attached to the window structure and another piece of green coloured fabric which had been removed from Mr Nguyen's neck beside Mr Nguyen.

7. What was the cause and manner of Mr Nguyen's death?

7.1 Mr Nguyen was subsequently taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Kendall Bailey, forensic pathologist, on 31 May 2023. This identified the following relevant findings:

(a) a semi-circumferential ligature mark encircling the neck with some relative sparing of the left posterior aspect;

(b) generalised swelling with bruising and small laceration is present over the left side of the face, and bruises and small lacerations of the lips in keeping with the history of recent altercation; and

(c) the presence of methylamphetamine and its metabolite amphetamine from toxicological analysis.

7.2 In the autopsy report dated 21 August 2023, Dr Bailey opined that the cause of Mr Nguyen's death was hanging.

7.3 Mr Nguyen's apparently unprovoked and unexpected physical altercation with the other inmate on 27 May 2023 suggests that he may have used the incident as a reason to request a transfer from Area 4 to Area 2. This in turn raises the possibility that Mr Nguyen may have planned what was to occur following his transfer. This tends to be supported by Mr Nguyen's request that he be placed in protective custody where he is likely to have been afforded more privacy than when accommodated in Area 4. Given these matters, and the circumstances in

which Mr Nguyen was found on 28 May 2023, the evidence establishes that Mr Nguyen took actions with the intention of ending his life.

8. What issues did the inquest examine?

8.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficient interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues for consideration:

(1) What was the nature and extent of the assessment of Mr Nguyen performed on 27 May 2023 prior to his transfer from the Area 4 Minimum Security to the Maximum Security Centre/Main Centre?

(2) Was the assessment performed on 27 May 2023 adequate and appropriate having regard to Mr Nguyen's personal and medical history?

(3) As at 27 May 2023, what procedures, if any, were in place at Parklea Correctional Centre regarding the searching of an inmate's property:

(a) prior to their transfer from the Area 4 Minimum Security to the Maximum Security Centre/Main Centre; and

(b) upon their reception in the Maximum Security Centre/Main Centre.

(4) Currently, what procedures, if any, are in place at Parklea Correctional Centre regarding the searching of an inmate's property:

(a) prior to their transfer from the Area 4 Minimum Security to the Maximum Security Centre/Main Centre; and

(b) upon their reception in the Maximum Security Centre/Main Centre.

(5) What assessment, if any, has been performed regarding the cell in which Mr Nguyen was housed on 27 and 28 May 2023 as part of any cell refurbishment program to remove any obvious ligature points?

(6) What review, if any, has been performed regarding Instruction No: PKL 025, Inmates Moved into the Main Centre from Area 4, issued on 15 June 2023?

8.2 For convenience, some of the issues have been dealt with together below.

9. What was the nature and extent of the assessment of Mr Nguyen on 27 May 2023 and was it adequate and appropriate?

9.1 CS Zbrog assessed Mr Nguyen twice on 27 May 2023: initially when Mr Nguyen was called to the office, and again after he had been assessed in the clinic. On each occasion, CS Zbrog took particular notice of whether there was any change in Mr Nguyen's behaviour, attitude and overall presentation. CS Zbrog noticed no such changes.

9.2 CS Zbrog gave evidence that he reviewed Mr Nguyen's records in the Offender Integrated Management System (**OIMS**) and was aware that he had a self-harm alert from 2016 but

could not recall any other matters related to Mr Nguyen's mental health history. Notwithstanding, CS Zbrog gave evidence that he did not observe anything about Mr Nguyen's demeanour that gave rise to a suspicion or belief that Mr Nguyen was at risk of self-harm.

9.3 Completion of the Threat Assessment did not require specific consideration of any possible risk of self-harm. Rather, in its terms, the Threat Assessment required consideration of whether there is a reason to transfer an inmate from one area to another because of a possible risk to their safety, typically from another inmate. When completing the Threat Assessment, CS Zbrog assessed the overall likelihood of a threat to Mr Nguyen as "*High*", meaning that a "*general threat of violence exists*" with "*no overt or intention to carry out the threat*".

9.4 Part D of the Threat Assessment deals with assessment of an inmate's vulnerabilities. Under the subheading, "*Additional factors*" is a checkbox labelled "*Mental illness*". Although CS Zbrog did not tick this checkbox he gave evidence that it is factor to be weighed up in the overall matrix in determining whether the transfer of an inmate due to a possible threat is warranted or not.

9.5 Part 3.7 of the CSNSW Custodial Operations Policy and Procedures (**COPP**) generally provides for the management of inmates at risk of self-harm or suicide. Section 1.1 of COPP Part 3.7 provides that *"[p]revention of suicide and self-harm is the responsibility of all staff as part of their duty of care to inmates*". Section 2.1 of COPP Part 3.7 goes on to provide

> The identification and assessment of risk factors for suicide or self-harm begins when an inmate is received into the custody of CSNSW. As risk levels can change rapidly, risk factors need to be assessed on an ongoing basis. Risk factors will be present in a large number of the inmate population.

9.6 COPP Part 3.7 also sets out the action to be taken following identification of risk of suicide or self-harm in an inmate, commencing with making a mandatory notification about the risk by completing a Mandatory Notification Form (**MNF**), developing an Immediate Support Plan (**ISP**), convening a Risk Intervention Team (**RIT**), and developing a RIT Management Plan.

9.7 CS Zbrog gave evidence that he did not think that he had completed the online e-learning module *Awareness of Managing At-Risk Offenders* referred to in section 2.1 of COPP Part 3.7. However, CS Zbrog gave evidence that he was aware of the actions to be taken in accordance with COPP Part 3.7 following identification of risk of suicide or self-harm in an inmate.

9.8 **Conclusions:** The assessments of Mr Nguyen on 27 May 2023 were primarily directed towards whether his expressed fears for his safety were warranted and whether Mr Nguyen was at risk of violence from another inmate. Whilst the Threat Assessment did not explicitly require CS Zbrog to consider Mr Nguyen's risk of suicide or self-harm it is evident that he did so. This consideration was in accordance with COPP 3.7 and demonstrated good practice. On the limited information available to CS Zbrog there was no evidence to indicate that Mr Nguyen was at risk of suicide or self-harm. The assessment was therefore adequate and appropriate in the circumstances.

10. What procedures were in place in May 2023, and are in place currently, regarding searching an inmate's property prior to internal transfer?

10.1 The evidence from CO Appiah and CS Zbrog established the following general procedures regarding the searching of an inmate's property prior to transfer from Area 4 to Area 2, both in May 2023 and currently:

(a) in the majority of circumstances, once a determination has been made that an inmate is to be transferred, a CO will attend the inmate's cell to pack up their property and place it in plastic bags;

(b) typically, an inmate's existing linen will be packed as part of their belongings unless it is unavailable because, for example, it is linen day;

(c) in some instances, an inmate will present to a CO requesting immediate internal transfer with their property already packed by the inmate;

(d) if an inmate packs their own property, it is unclear whether they will also pack their own linen;

(e) regardless of whether property is packed by a CO or an inmate, a CO will search the property to identify whether it contains any contraband or any items which do not match what is recorded on the inmate's property card;

(f) a CO will question an inmate about any items which do not appear on the inmate's property card and a determination will be made regarding whether the item can be kept or surrendered;

(g) if any damaged linen is discovered during a search it is removed and the inmate is typically issued with a "charge package" for damaging property, with the "charge package" to be heard and determined at a later date;

(h) if an inmate arrives in Area 2 without linen, they will be issued with a fresh linen pack; and

(i) it is not usual practice for an inmate's property to be searched again upon arriving in Area 2.

10.2 CO Appiah gave evidence that he had no specific recollection of Mr Nguyen or attending his cell on 27 May 2023 to pack up his property prior to transfer. However, CS Zbrog gave evidence that he instructed CO Appiah to pack and search Mr Nguyen's property. It is therefore most likely that Mr Nguyen did not pack his own property and that it was instead packed, and later searched, by CO Appiah. At the time, Mr Nguyen was housed alone in a two-out cell. It therefore appears that the property in his cell could not be mistaken as belonging to another inmate.

10.3 Detective Senior Constable Luke Burdekin, the Officer-in-Charge of the NSWPF investigation, gave evidence that on his first review of Mr Nguyen's cell in Area 2 he saw no evidence of any torn material or fabric of any kind. Detective Senior Constable Burdekin also gave evidence that Mr Nguyen's cell was later searched by a NSWPF scene of crime officer who informed Detective Senior Constable Burdekin that, similarly, no torn fabric or material

was found. Detective Senior Constable Burdekin acknowledged in evidence that this conversation was not documented.

10.4 Notwithstanding, Detective Senior Constable Burdekin expressed the view that Mr Nguyen likely brought with him from Area 4 the material that was used as a ligature given that no torn material was found in Area 2. Conversely, it was submitted on behalf of MTC that the evidence in support of the ligature being fashioned is "*not strong*". This is because, it was submitted, there is no reliable evidence of any torn material being found in Area 2 and Mr Nguyen's property was searched in Area 4 prior to his transfer.

10.5 Although CO Appiah had no recollection of searching Mr Nguyen's property he gave evidence as to his usual practice when searching an inmate's property prior to internal transfer. There is no evidence to suggest that he did not follow this practice. It is therefore likely that if Mr Nguyen had attempted to bring with him from Area 4 any torn material he intended to use as a ligature it would have been discovered during a search by CO Appiah and confiscated. Equally, the absence of any torn material being found in Mr Nguyen's Area 2 cell tends to suggest that the ligature was not fashioned in that location. However, it may have been the case that that there was simply no leftover torn material to be found after the ligature was fashioned.

10.6 The CSNSW Serious Incident Report Death in Custody refers to the material as a "*piece of ripped bed sheet*". Detective Senior Constable Burdekin described the material as matching "*multiple items of clothing and linen used within*" Parklea Correctional Centre. However, there is no evidence that the material used to fashion the ligature was ever compared with the clothing and linen available to Mr Nguyen in order to determine its origin.

10.7 **Conclusions:** Ultimately, the available evidence does not allow for a conclusion to be reached regarding the origin of the ligature used by Mr Nguyen, or when and where it was fashioned. Whilst the ligature material matched clothing and linen available to Mr Nguyen, there is no evidence of any torn remnants having been found either in Area 4 or Area 2.

10.8 It is most likely that Mr Nguyen's belongings were searched appropriately in Area 4 in accordance with usual practice prior to his transfer. There is no evidence to suggest that any additional search ought to have been performed upon Mr Nguyen's arrival at the Reception area or after he had been moved to his cell in Area 2.

11. What cell assessment has been performed since May 2023?

11.1 Brian Gurney, Governor of Parklea Correctional Centre, gave evidence that there are presently (as at January 2026) no upgrade works planned for Area 2 to reduce or eliminate potential ligature points in cells. Such a systemic works program is subject to capital funding which has not been made available to MTC.

11.2 Governor Gurney gave evidence that instead, individual features of some cells in Area 2 have been "*replaced progressively during reactive maintenance of the cells*". Governor Gurney explained that reduction in potential ligature points (whether systemically or on a reactive maintenance basis) requires consideration of factors such as technical complexities, assessing the priority of which potential ligature points require modification, and avoiding creation of unintended risks such as interrupting sight lines from cell doors and observation hatches.

11.3 Craig Mason, CSNSW Assistant Commissioner of Contracts and Commissioning, provided a statement to the inquest indicating that CSNSW has a prioritised program of cell refurbishment to remove obvious ligature points. This program is premised on a risk assessment basis, which is funded through a Minor Capital Works budget and special capital funding allocations.

11.4 In the 2022/2023 and 2023/2024 financial years, funding was spent on cell refurbishment, including the location and removal of obvious ligature points, at Parklea Correctional Centre (as well as a number of other correctional centres). However, Parklea Correctional Centre is not scheduled for cell refurbishment in the 2025/2026 financial year. Assistant Commissioner Mason explained that Area 2 at Parklea "*will be refurbished as the anti-ligature program progresses, and the approved priority schedule brings Area 2 into [CSNSW's] delivery program*".

11.5 **Conclusions:** Whilst the individual features of some cells in Area 2 have been replaced progressively since May 2023, no dedicated program of ligature point reduction within Area 2 (apart from segregation areas) has been performed. Such a program is subject to capital works funding which has not been allocated to Parklea Correctional Centre since the 2023/2024 financial year.

11.6 Prioritisation of such programs is largely dependent on risk assessment. The inquest did not receive any evidence regarding any such assessment at Parklea Correctional Centre or at other correctional centres which have been allocated funding.

12. Has Instruction PKL025 been reviewed?

12.1 On 15 June 2023, Governor Gurney issued Instruction No: PKL 025 (**Instruction 25**) relating to "*Inmates Moved in the Main Centre from Area 4*". Instruction 25 appropriately recognises that movement of an inmate from Area 4 to the Main Centre, where Area 2 is located, "*presents a significant change in circumstances for inmates as it usually means a change of placement or regression in classification. As a result of this move, inmates may be at risk of self-harm*".

12.2 Instruction 25 relevantly goes on to provide that:

(a) inmates received into Main Centre from Area 4 during normal let-go hours "*are to undergo an at risk of self-harm assessment*" which is to be "*completed by a qualified RIT coordinator to determine if the inmate is at risk of self-harm or suicide*";

(b) if following assessment, a mandatory notification is deemed necessary then the procedure set out in COPP Part 3.7 is to be followed; and

(c) inmates received into the Main Centre from Area 4 outside of core business hours are to be assessed by RIT qualified Shift Managers.

12.3 Governor Gurney gave evidence that, in accordance with RIT protocols, the assessment to be performed by a qualified RIT coordinator or a RIT qualified Shift Manager is to occur within the first 24 hours of an inmate "*being housed in the main centre*". Governor Gurney also gave evidence that if neither a qualified RIT coordinator or a RIT qualified Shift Manager is

available to perform such an assessment an inmate is to remain "*housed in the clinic [overnight], under observation"* until the assessment is performed. Two issues arise in relation to this evidence.

12.4 First, Instruction 25 does not explicitly state the timeframe within which a risk of self-harm assessment is to be completed for an inmate upon their reception into the Main Area. Section 5 of COPP Part 3.7 provides that an "*inmate must be reviewed by the RIT within 24 hours of a mandatory notification being made and an ISP developed at a correctional centre*". This demonstrates that there is a defined process to follow, commencing with a mandatory notification and then development of an ISP, before an inmate is reviewed by a RIT within 24 hours.

12.5 However, it does not appear that COPP Part 3.7 provides, as Governor Gurney suggested in evidence, that an inmate is to undergo a risk of self-harm assessment by a qualified RIT Coordinator (or a RIT qualified Shift Manager) within 24 hours of reception in the main centre. Further, the 24 hour timeframe provided for by section 5 of COPP Part 3.7 is premised upon a MNF having been completed and an ISP developed. For an inmate arriving at the Main Area reception from Area 4 neither of these steps will have been completed.

12.6 Second, no mention is made in Instruction 25 regarding the third scenario referred to by Governor Gurney, namely that where a qualified RIT Coordinator or a RIT qualified Shift Manager is unavailable to conduct a risk of self-harm assessment, an inmate is to be housed overnight in the clinic until a suitably qualified person is available to perform such an assessment.

12.7 **Conclusions:** Instruction 25 has not been reviewed or amended since it was first issued in June 2023. It appropriately provides for two options to assess an inmate transferring from Area 4 to the Main Centre for the risk of suicide or self-harm. However, it does not provide for what is to occur if neither of these options is available despite Governor Gurney giving evidence regarding the availability of a third option.

12.8 In addition, Instruction 25 does not expressly provide for a timeframe within which a transferring inmate is to be assessed for risk of suicide or self-harm. COPP Part 3.7 does not appear to assist in this regard because the assessment timeframe it provides is not applicable to the scenarios contemplated by Instruction 25.

12.9 It was submitted on behalf of MTC that it will undertake to review Instruction 25 regarding the two issues identified above. It is nonetheless desirable to make the following recommendation.

12.10 **Recommendation:** I recommend to the Managing Director, Management & Training Corporation Australia, that Instruction No: PKL 025 "*Inmates Moved in the Main Centre from Area 4*" be reviewed and amended so that it expressly provides for: (a) a timeframe within which an inmate transferring from Area 4 to the Main Centre is to be assessed for risk of suicide and self-harm; and (b) what is to occur if a qualified RIT coordinator and a RIT qualified Shift Manager are unavailable to assess an inmate transferring from Area 4 to the Main Centre for risk of suicide or self-harm.

12.11 The inquest also received evidence that appeared to demonstrate a lack of awareness on the part of some correctional officers at Parklea Correctional Centre regarding the terms of Instruction 25.

12.12 First, in a statement dated 4 March 2024, AM Price stated that it was her understanding that inmates transferred from Area 4 to the Main Centre "*are moved through the Main Clinic for review by St Vincents Corrective Health before they arrive at their new placement*". There is no evidence that any person from St Vincents Corrective Health (the entity delivering health services to inmates at Parklea Correctional Centre) reviews a transferring inmate prior to their placement in a cell.

12.13 Rather, Instruction 25 provides for assessment by a qualified RIT coordinator or a RIT qualified Shift Manager in the terms described above. In evidence, Governor Gurney agreed that it was a matter of some concern that an AM appeared to not have an accurate understanding of the terms of Instruction 25.

12.14 Second, CO Scott Nehmer, who was acting as the Main Centre reception area supervisor on 28 May 2023, gave evidence that the first time he saw Instruction 25 was when it was shown to him in the witness box during the inquest. CO Nehmer gave evidence that despite being previously unaware of Instruction 25, the procedures it set out were being implemented in practice. Governor Gurney gave evidence that it was not entirely surprising to him that all correctional staff may not have read all email communications from him.

12.15 **Conclusions:** There is evidence that the procedures provided for by Instruction 25 are being implemented. However, the evidence available to the inquest indicates that there is a misunderstanding of Instruction 25 by correctional staff in one instance and complete ignorance of the terms of Instruction 25 in another instance. Neither represents sound correctional practice and may limit the efficacy of Instruction 25. It is therefore necessary to make the following recommendation.

12.16 **Recommendation:** I recommend to the Managing Director, Management & Training Corporation Australia, that any necessary steps be taken (whether by education, training or communication) to ensure that all correctional staff to which Instruction No: PKL 025 "*Inmates Moved in the Main Centre from Area 4*" applies are aware of its contents and understand accurately its terms.

13. Findings

13.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Alison Storm, Coronial Advocate Assisting the Coroner, for the assistance provided throughout the coronial investigation and inquest, and the sensitivity shown to Mr Nguyen's relatives.

13.2 I also thank Detective Senior Constable Burdekin for his role in the NSWPF investigation and for compiling the initial brief of evidence.

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

Identity
The person who died was Phuoc Van Nguyen.

Date of death
Mr Nguyen died on 27 or 28 May 2023.

Place of death
Mr Nguyen died at Parklea Correctional Centre, Parklea NSW 2768.

Cause of death
The cause of Mr Nguyen's death was hanging.

Manner of death
Mr Nguyen died as a result of actions taken by him with the intention of ending his life. Mr Nguyen's death was therefore intentionally self-inflicted.

13.4 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to Mr Nguyen's family and loved ones for their loss.

13.5 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
30 January 2026

Inquest into the death of Phuoc Van Nguyen
Coroner's Court File Number: 2023/171059
Annexure A
Non-publication orders

1. Pursuant to section 74(1)(b) of the *Coroners Act 2009* (**the Act**), the following material contained within the brief of evidence (**BoE**) tendered in the proceedings is not to be published:

   (a) The names, residential addresses, telephone numbers, Visitor Index Numbers and any other information that identifies or is likely to lead to the identification of any family member, friend or person who visited Phuoc Nguyen while in custody (other than legal representatives or visitors acting in a professional capacity).
   (b) The names, dates of birth, Master Index Numbers, images and any other information that identifies or is likely to lead to the identification of any person formerly or currently in custody, other than Phuoc Nguyen.
   (c) The direct contact details and Offender Integrated Management System usernames (if applicable) of people employed by Corrective Services NSW (**CSNSW**), MTC Australia and other agencies, which are not publicly available.
   (d) The Parklea Correctional Centre Daily Operational Roster in Volume 2 of the BoE.
   (e) The Inmate Accommodation Area Journals in Volume 2 of the BoE.
   (f) The CERT Equipment Issue and Return Register – Parklea Correctional Centre in Volume 2 of the BoE.
   (g) All audio visual content captured within Parklea Correctional Centre, including photographs, video footage and audio recordings.
   (h) The following information revealing the internal layout of Parklea Correctional Centre and the location or absence of CCTV cameras:
      I. The diagram on page 25 of the CSNSW Serious Incident Report (**SIR**) at Tab 1 of Volume 2 of the BoE;
      II. The diagram of Cell Block 2A – First Floor on page 252, Tab 5 of Volume 2 of the BoE;
      III. Paragraph 140 of the SIR;
      IV. References in Volume 2 of the BoE to the location of CCTV cameras; and
      V. References in Volume 2 of the BoE to the absence of CCTV cameras.
   (i) The telephone numbers and email addresses of CSNSW, the NSW Department of Communities and Justice and the Australian Border Force, which are not publicly available, contained in the following sections of the CSNSW Custodial Operations Policy and Procedure (**COPP**) in Volume 4 of the BoE:

I. COPP 11.1 *Language services* – version 1.2;

II. COPP 13.1 *Serious incident reporting* – version 1.4;

III. COPP 13.2 *Medical emergencies* – version 1.5;

IV. COPP 13.3 *Death in custody* – version 1.9; and

V. COPP 13.9 *Video evidence* – version 2.0.

(j) The Parklea Operating Procedures in Volume 4 of the BoE.

(k) The Governor's Instruction *Inmates Moved From Area 4* in Volume 4 of the BoE.

2. Pursuant to section 65(4) of the Act, a notation is to be placed on the Court file that if an application is made under section 65(2) of the Act for access to CSNSW or MTC Australia documents on the Court file, that material shall not be provided until CSNSW and MTC Australia have had an opportunity to make submissions in respect of that application.

Magistrate Derek Lee
Deputy State Coroner
30 January 2026