Deaths in Custody/Police Operations Report

REPORT BY THE NEW SOUTH WALES STATE CORONER

for the year

2025

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A REPORT PREPARED PURSUANT TO S 37(1) OF THE *CORONERS ACT 2009* (NSW)
OFFICE OF THE NSW STATE CORONER
NSW DEPARTMENT OF COMMUNITIES AND JUSTICE
ISSN NO: 1323-6423

Aboriginal and Torres Strait Islander peoples should be aware that this publication contains the names of deceased persons.

The NSW Coroners Court acknowledges Australia's First Nations peoples as the Traditional Custodians of the lands, waters and seas of Australia.

We pay our respects to ancestors and Elders, past and present, and recognise the strength, resilience, and diversity of First Nations peoples of this land.

HELP AND SUPPORT

Condolences

The Coroners Court NSW wishes to offer its sincere and respectful condolences to the families and loved ones of all the people whose coronial matters are referred to in this report. We recognise their lives and convey our appreciation to their families and loved ones for their participation in the coronial process.

Content warning

This report contains information about the circumstances and cause of death of persons who have died in custody or as a result of a police operation. Some people may find the content of this report confronting or distressing.

First Nations readers should be aware that this report contains information, including in some cases the names, of First Nations people who have passed away.

If you need support, please contact one of the support services listed. In an emergency, dial 000.

Lifeline: 24/7 crisis support and suicide prevention services.
Call: **13 11 14** Web: **https://www.lifeline.org.au/about/our-services/**

13YARN Crisis support for Aboriginal & Torres Strait Islander people: 24/7 confidential one-on-one over the phone yarning opportunity and support for mob who are feeling overwhelmed or having difficulty coping.
Call: **13 92 76** Web: **https://www.13yarn.org.au**

Beyond Blue: 24/7 advice, referral and support from trained mental health professionals.
Call: **1300 22 4636** Web: **https://www.beyondblue.org.au/**

Suicide Call Back Service: 24/7 counselling and support for people at risk of suicide, carers and bereaved.
Call: **1300 659 467** Web: **https://www.suicidecallbackservice.org.au/**

Griefline: Operates 9am to 8pm 7 days a week. Phone and online counselling for people experiencing loss or grief.
Call: **1300 845 745** Web: **https://www.griefline.org.au**

Blue Knot Helpline: Operates 9am- 5pm, Monday to Friday. All Blue Knot counsellors are experienced trauma counsellors. Call: **1300 657 380** Web: **https://www.blueknot.org.au**

NSW Mental Health Line: 24/7 telephone helpline available to everyone in NSW.
Call: **1800 011 511** Web: **https://www.health.nsw.gov.au/mentalhealth/Pages/mental-health-line.aspx**

The National Indigenous Postvention Service: 24/7 after suicide support for Aboriginal and Torres Strait Islander individuals and families impacted by suicide.
Call: **1800 805 801** Web: **https://thirrili.com.au/postvention-response-service**

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TERMINOLOGY

This report adopts the terminology of First Nations people in recognition that Aboriginal and Torres Strait Islander people are the sovereign people of Australia. This term also recognises the various language groups as separate and unique sovereign nations. (Common Ground, 2020).[1]

1 At https://www.commonground.org.au/learn/aboriginal-or-indigenous.

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The Hon. Michael Daley MP
Attorney General
GPO Box 5341
Sydney NSW 2001

30 April 2026

Dear Attorney General,

Section 37(1) of the *Coroners Act 2009* ('the Act') requires that I provide to you annually, a summary of all deaths in custody and deaths that are the result of police operations that were reported to the Coroner in the previous year. Inquests are mandatory in such cases but the coronial investigation into most of the deaths that occurred last year have not yet been finalised. I have also included information about inquests into deaths that were reported in earlier years and finalised in the past year.

I attach a hard copy and an electronic copy of the 2025 report.

Section 37(3) requires that you cause a copy of the report to be tabled in each House of Parliament within 21 days of receipt.

The deaths in question are defined in section 23 of the Act, and include deaths that occur:

- While the deceased person is in the custody of a police officer or in other lawful custody,
- While the person is attempting to escape from lawful custody,
- While the person is in or temporarily absent from a juvenile detention centre or an adult correctional centre, or
- As a result of a police operation.

As you would appreciate, deaths in prisons have for centuries been recognised as sensitive matters warranting independent scrutiny. Similarly, deaths occurring as a result of police operations also warrant independent scrutiny and attract significant public and media attention.

Inquest findings for those matters that were finalised in 2025 and are referred to in this report are available on the Coroners Court New South Wales webpage at: https://www.coroners.nsw.gov.au/coronial-findings-search.html.

A register of coronial recommendations directed to government agencies and responses to those recommendations is maintained by the Department of Communities and Justice is available at: https://dcj.nsw.gov.au/legal-and-justice/laws-and-legislation/legal-assistance-and-applications/responses-to-coronial-recommendations.html

I would like to recognise and acknowledge the lives of the people whose deaths are reported herein and extend my sincere condolences to their families and loved ones for their passing.

Please do not hesitate to contact me if you wish to discuss any of the matters contained in the report or would like further details of any of the matters referred to.

Yours faithfully,

Judge Teresa O'Sullivan
NSW State Coroner

ACKNOWLEDGEMENTS

Acknowledgement of Country

The Coroners Court NSW acknowledges Australia's First Nations peoples as the Traditional Custodians of the lands, waters and seas of Australia. We pay our respects to ancestors and Elders, past and present, and recognise the strength, resilience and diversity of First Nations peoples of this land.

"Cultivating Healing" By Wodi Wodi Walbunja Artist Lauren Henry ©Yirra Miya 2023

This artwork tells part of our story, journey, and purpose of the Coroners Court. The artwork embodies the notion of supported healing for individuals, families, and communities through their loss. This artwork also highlights the importance of recognising that healing is not a linear process and that collaboratively the Coroners Court is a safe and respectful space.

This artwork represents the significance of the Coroners Court as a space integral to the healing journey for those who enter its doors. Supporting people through the loss of a loved one while creating a space where everyone can grieve in their own way, with cultural understanding and support.

At the centre of the artwork is a yarning circle, symbolising community, and the importance that community holds for the Coroners Court. This yarning circle represents a sense of belonging, kinship and unity which are held in high regard by the

court. This sense of community is reflective of the community-based approach taken by the court in walking alongside families in the midst of a dark and painful time in their lives.

Journey lines extend from this yarning circle to two gathering places which reflect a safe space for all community members to feel supported during their journey within the court process. These gathering places highlight the start of inner healing with the knowledge sticks within representing the sharing of knowledge to assist people on their healing journey with their grief, as shown by the journey lines extending off the canvas.

The yarning circle centred at the bottom is surrounded by people and knowledge sticks. This meeting place represents truth telling and is where we acknowledge the events of the past and empower people to be fearless in their pursuit of understanding and obtaining the knowledge behind the loss of a loved one. This space represents and reflects the understanding of trauma that families and communities go through and the importance of providing tailored, culturally safe support for people to start on their healing journey.

On either side of the central yarning circle are elements that represents the diverse paths of healing that the court supports with individuals, families, and communities. The journey lines make their way off the canvas to represent that healing is a non-linear process, unique to each individual. The knowledge sticks symbolise the sharing of resources and support provided by the court, while acknowledging the weight carried by the findings surrounding a loved one's passing.

Directly beneath the central yarning circle are three interconnected meeting places, symbolising how the past and present are connected in order to impact and influence the future. You cannot have one without the other. These connected meeting places reflect the courts ongoing process of listening, learning, and reflecting, emphasising that moving forward requires understanding of the past. The court strives to leave a legacy of hope, where the knowledge gained from the findings of a passed loved one can help prevent other families from feeling a similar loss and pain.

Above the central yarning circle are stars to represent the guidance provided by our Ancestors, that they are always with us, watching and leading us in the space and journey of navigating loss and grief. From our Ancestors, we draw strength to persevere and continue to learn from those around us in order to heal.

At the top of the artwork are connected watering holes to represent the sharing of knowledge but also the continuous efforts by the court to improve in providing culturally safe and appropriate ways of working with people. The court is committed to listening, reflecting, and growing, both within itself and in its broader impact in community. The kangaroo tracks signify progress and movement, reflecting the ongoing journey of uncovering the truth behind a person's passing.

The different Country Lines acknowledge the diverse lands across this nation, honour the fact that this land Always Was and Always Will Be Aboriginal Land.

2025 SUMMARY IN BRIEF

Deaths reported to the Coroner in 2025

- In the calendar year 2025, **66** deaths were reported to the Coroner as occurring in custody or as a result of a police operation.
  - This is an overall increase of **18** deaths from the number reported in 2024.
  - **39** deaths were reported as occurring in custody.
  - This is an increase of **9** deaths in custody from the number reported in 2024.
  - **27** deaths were reported as occurring as a result of a police operation.
  - This is an increase of **9** deaths occurring as a result of a police operation from the number reported in 2024.
- These figures represent the highest number of deaths in custody or as a result of a police operation ever recorded in a single year.
- The Coroners Court of NSW remains committed to investigating every death in custody or as a result of a police operation independently and thoroughly, in line with its statutory responsibilities. Inquests will be conducted with impartiality, transparency and cultural sensitivity, ensuring that the voices of affected families and communities are heard and respected.

Overrepresentation of First Nations peoples

- **17** of the **66** deaths reported to the Coroner in 2025 as occurring in custody or as a result of a police operation were First Nations peoples. This represents 26% of all deaths reported to have occurred in custody or as a result of a police operation, despite First Nations peoples comprising only 3.4% of the NSW population (ABS Census, 2021).
- Of these **17** First Nations deaths, **12** First Nations deaths occurred in custody, the highest number ever recorded in a single year.
- This is a profoundly distressing milestone. Each of these deaths represents a person whose life mattered and whose loss is felt deeply by families, loved ones and communities across the state. They are individuals whose deaths demand independent and rigorous scrutiny, respect and accountability.
- Recent data from the NSW Bureau of Crime Statistics and Research (BOCSAR) underscores the scale of the issue. As of March 2025, there were 4,244 First Nations adults in custody, representing 32.4% of the total adult prison population – despite First Nations people comprising only a small proportion of the NSW population.
- Over the past five years, the number of First Nations people in custody has increased by 18.9%, while the non-Aboriginal prison population has declined by 12.5%.
- The number of First Nations people on remand has surged by 63% over the same five-year period. These figures reflect the entrenched over-representation of First Nations peoples in the criminal justice system – a systemic issue that compounds the risks and vulnerabilities contributing to the rising number of deaths in custody.
- More than 30 years have passed since the Royal Commission into Aboriginal Deaths in Custody handed down its recommendations to address these systemic failures and yet the number of First Nations peoples dying in custody continues to rise.
- Importantly, the overrepresentation of First Nations people is not limited to deaths in custody, nor is it unique to New South Wales. Across Australia, First Nations people are disproportionately represented in all deaths reported to coroners. This national pattern reflects broader systemic inequities and highlights the need for urgent, coordinated, cross-jurisdictional reform[2].

2 https://www.aic.gov.au/publications/sr/sr57

This element represents healing – this can be individual healing and collective healing journeys that require deep understanding about how their family member lived their life, and how their passing has impacted their family and those who knew them. This element highlights the importance of receiving culturally appropriate supports, acknowledging their loss, being heard, and showing compassion. The grieving process is an individual thing that must be respected and for some, healing can be a lifelong journey.

Deaths in custody in 2025

- **39** deaths were reported to the Coroner as having occurred in custody. Of these, 12 deaths (31%) were of First Nations peoples.
- All of these deaths (39) occurred in Corrective Services custody:
  - **24** (61.5%) of those persons who died were serving a full-time sentence, and
  - **15** (38.5%) of those persons who died were being held on remand.
- For the purposes of this report, deaths occurring during, or as a consequence of, police arrests have been classified as deaths as a result of a police operation. Deaths occurring in a police cell, however, would be classified as a death in custody. No deaths in police custody were recorded in 2025.
- In most cases reported to the Coroner in 2025, information about the circumstances of the person's death, including the medical cause of death, is still under investigation. However, at the time of writing:
  - **22** (56.4%) deaths were reported as a result of natural causes*,
  - **9** (23.1%) deaths were reported as a result of intentional self-harm,
  - **5** (12.8%) deaths were reported unascertained and
  - In **3** (7.7%) deaths, the manner was reported as 'external causes – accident' or 'external causes- multiple'.

* *Where a death appears to be due to natural causes, a Coroner may still find that the death may have been caused or contributed to by preventable issues such as the quality of care, treatment and/or supervision received by the person prior to their death, including a lack of culturally appropriate care. These issues will be addressed by the Coroner in the inquest and/or the recommendations made at inquest.*

- A significant number of unascertained deaths in custody were reported in the first half of 2025, occurring at a small number of correctional facilities. Chief Health Officer, Dr Kerry Chant, sought the State Coroner's approval to undertake additional toxicology testing of coronial samples to determine if a public health investigation was warranted. NSW Justice Health staff were concerned there may be a link between these cases, potentially related to illicit substances.
- Closer investigation of these deaths and additional toxicology screening did not reveal any new drug trends or issues of concern. It is notable that the cause of **5** deaths in custody remained unascertained,

even after the completion of the final post-mortem report by NSW Health Pathology. This is a concerning increase.

- Of the **12** deaths of First Nations peoples in custody, **6** deaths (50%) were reported as having occurred due to an external cause, either intentional self-harm or accidental overdose. **6** deaths (50%) were reported as natural causes (5 deaths) or unascertained (1 death).
- Of the **27** other reported deaths in custody, **6** deaths (22%) were reported as having occurred due to an external cause, either intentional self-harm or accident. The remaining **21** deaths (78%) were reported to have been due to natural causes (18 deaths) or unascertained (6 deaths).

Deaths as a result of a police operation in 2025

- **27** deaths were reported to the Coroner as occurring as a result of a police operation. Of these, **5** (18%) involved the death of a First Nations person.
- The deaths were reported to have occurred in the following types of police operations:
  - **9** (33.3%) deaths occurred in connection with a police motor vehicle pursuit,
  - **5** (18.5%) deaths occurred in the course of a police operation to contain or restrain the person,
  - **5** (18.5%) deaths occurred in the course of an operation to engage a person,
  - **3** (11.1%) deaths occurred in the course of an operation to apprehend a person,
  - **3** (11.1%) deaths occurred in connection to an operation to assist the person,
  - **2** (7.5%) deaths occurred in the execution of other police activities.
- Notably in 2025, there were **3** deaths that were reported to have occurred in the context of the administration of sedation for agitation management. Acute sedation by NSW Health practitioners is a last resort that is used where a person puts others at immediate risk of serious harm. These were reported to have occurred during an operation to apprehend a person, and during operations to contain/restrain persons.
- Also observable is the continuing growth in percentage of deaths reported as a result of a police operation which occur in connection with a police motor vehicle pursuit. Deaths reported to have occurred in the context of a police motor vehicle pursuit accounted for **9** (33%) of the **27** deaths reported in 2025.
- In most cases reported to the Coroner in 2025, information about the circumstances of the person's death, including the medical cause of death, is still under investigation. However, at the time of writing:
  - **9** (33.3%) deaths were reported to have been as a result of a motor vehicle collision,
  - **7** (25.9%) deaths were reported to have been as a result of intentional self-harm,
  - **3** (11.1%) deaths were reported to have been as a result of Police discharge of a firearm,
  - **3** (11.1%) deaths were reported to have been as a result of an accident,
  - **2** (7.5%) deaths were reported to have been as a result of Police restraint/ sedation,
  - **1** (3.7%) death was reported to have been as a result of assault,
  - **1** (3.7%) death was reported to have been as a result of an accidental overdose,
  - **1** (3.7%) death was reported to have a pending cause.
- All deaths except for **1** (cause pending) were reported as being due external causes.

Inquests finalised in 2025

- In 2025, the State Coroner and Deputy State Coroners delivered findings in **44** inquests involving the death of a person in custody or as a result of a police operation. Of the **44** inquests that were finalised, **32** involved a death in custody, and **12** involved a death as a result of a police operation. This represents an increase of **11** inquest findings handed down in the 2025 calendar year, compared to 2024.
- This is the largest number of section 23 inquest findings handed down in a calendar year.

Overrepresentation of First Nations peoples

- **9** of the **44** finalised inquests involved a First Nations person. This represents 20% of all finalised inquests, despite First Nations peoples comprising only 3.4% of the NSW population (ABS Census, 2021).
- It is necessary to place these deaths in the wider social context. In NSW, First Nations peoples make up around 25% of the adult prison population compared to around 3% of the general population. It follows that First Nations peoples are also more likely to be detained or held in police cells/correctional services custody.

Deaths in custody

- **32** of the inquests that were finalised involved the death of a person in custody.
- **16** of these inquests made recommendations to improve public health and safety.
    - **7** inquests (22%) involved the death of a First Nations person,
    - **19** inquests (59.3%) involved the death of a person serving a full-time custodial sentence, **6** inquests (18.8%) involved the death of a person being held on remand, **3** inquests (9.4%) involved the death of person in immigration detention, **2** inquests (6.3%) involved the death of a person in other lawful custody, and **1** inquest involved the death of a person in forensic mental health custody.
- Further information regarding the **9** (28.1%) deaths determined to have been as a result of intentional self-harm was collated from the inquest findings. From the information presented at inquest, **8** people had a mental health diagnosis known to Corrective Services NSW, **6** of whom were receiving medication.
- Observation and monitoring failures within custodial settings were a continued theme of recommendations handed down in these finalised inquests, highlighting significant issues with frequency, modality and documentation of observations, increasing the risk of harm for inmates. These recommendations were based on instances where physical observations were missed or insufficient, particularly overnight or after-hours, and often in the context of inadequate responses to 'knock-up' calls.
- **1** person was found to have died as a result of natural causes following a medical emergency. However, due to issues with communication with his next of kin during the emergency, his family was unable to see him before his passing, causing profound distress. To address these failures, the coroner recommended urgent amendment to Corrective Services NSW's policies to ensure families receive timely, accurate and compassionate communication when an inmate's death may be imminent.

Deaths as a result of police operations

- **12** of those inquests that were finalised involved the death of a person as a result of a police operation.
    - **2** inquests (16.7%) involved the death of a First Nations person,
    - **5** inquests (41.7%) found that the death occurred due to the discharge of a firearm by police as a result of/in the course of a police operation,
    - **3** inquests (25%) found that the death was due to intentional self-harm,
    - **2** inquests (16.7%) found that the death was due to a police motor vehicle pursuit,
    - **1** inquest (8.3%) found that the death was due to an accident and
    - **1** inquest (8.3%) found the death was due to natural causes.
- These finalised inquests revealed the continuing growth in matters involving the intersection of policing and mental illness, and often concerning the death of a mentally ill person after a knife or bladed weapon was produced or used.
- In a number of previous inquest matters, Coroners have made recommendations aimed at improving mental health training and assistance for Police when they encounter a person experiencing a mental health crisis. The need for a health led co-responder approach when Police encounter a person experiencing a mental health crisis has been raised in multiple inquests. This remains a concerning issue in need of urgent attention.

STATUTORY APPOINTMENTS

Under the *Coroners Act 2009*, all Judges of the Local Court in New South Wales are Coroners by virtue of their office. However, under section 22, only a Senior Coroner who has been appointed as the State Coroner or a Deputy State Coroner is permitted to hold an inquest into the death of a person occurring in custody or as a result of a police operation.

The inquests detailed in this report were conducted before the following Senior Coroners:

NSW State Coroner

Her Honour Judge Teresa O'Sullivan (appointed 2019)

Deputy State Coroners

Her Honour Judge Joan Baptie (appointed 2021)

His Honour Judge Stuart Devine (appointed 2025)

Her Honour Judge Carmel Forbes (appointed 2011)

His Honour Judge Caleb Franklin (appointed 2022)

Her Honour Judge Harriet Grahame (appointed 2015)

Her Honour Judge Rebecca Hosking (appointed 2024)

Her Honour Judge Erin Kennedy (appointed 2023)

His Honour Judge Derek Lee (appointed 2016)

His Honour Judge David O'Neil (appointed 2023)

Her Honour Judge Kasey Pearce (appointed 2024)

Her Honour Judge Elizabeth Ryan (appointed 2017)

This element represents learning. The three connected meeting places represent how the past and present are connected in order to impact and influence the future. This element highlights the importance of honouring those who have passed and the creation of an ongoing legacy through systemic change and improvement. By listening, reflecting and growing we can focus on the future and make sure similar deaths are prevented.

01.
INTRODUCTION

Pursuant to sections 22 and 23 of the *Coroners Act 2009*, a death must be reviewed by a Senior Coroner (the State Coroner or a Deputy State Coroner) if it appears to have occurred while the person is in custody or as a result of a police operation, and an inquest must be conducted into the circumstances of that death.

The requirement for a Senior Coroner to hold a public inquest in relation to a death in custody or as a result of a police operation pursuant to section 27 of the *Coroners Act 2009,* reflects the important role of coronial investigations in monitoring standards of custodial care or police operations. The inquest process provides an opportunity for the Senior Coroner to make carefully considered recommendations with the objective of preventing deaths occurring in similar circumstances in the future.

INTRODUCTION BY THE STATE CORONER

Pursuant to sections 22 and 23 of the *Coroners Act 2009*, a death must be reviewed by a Senior Coroner (the State Coroner or a Deputy State Coroner) if it appears to have occurred while the person is in custody or as a result of a police operation, and an inquest must be conducted into the circumstances of that death.

Section 27 1(b) of the *Coroners Act 2009* provides that if jurisdiction arises under section 23 an Inquest must be held in relation to that death. The requirement for a Senior Coroner to hold a public inquest in relation to a death in custody or as a result of a police operation reflects the important role of coronial investigations in monitoring standards of custodial care and police operations. The inquest process provides an opportunity for the Senior Coroner to make carefully considered recommendations with the objective of preventing deaths occurring in similar circumstances in the future.

What is a death in custody?

Sections 22 and 23 of the *Coroners Act 2009* provide a Senior Coroner with jurisdiction to hold an inquest into a death where it appears that the person has died while:

- In the custody of a police officer, in prison custody or in other lawful custody including detention pursuant to the *Migration Act 1958* (Cth),
- Escaping, or attempting to escape, from the custody of a police officer, prison custody or other lawful custody,
- In or temporarily absent from a detention centre, prison or lock-up where the person was an inmate, or
- Travelling to a detention centre, prison or lock-up for the purpose of being admitted there as an inmate and while in the company of a police officer or other official charged with the person's care or custody.

These categories broadly align with the range of circumstances that were agreed by all mainland State and Territory governments as constituting deaths in custody in their responses to recommendations of the Royal Commission into Aboriginal Deaths in Custody (1991).

Deaths occurring in other circumstances may also be investigated by the Senior Coroner as if they are deaths in custody, including where:

- A person is serving a custodial sentence in the community (e.g. an Intensive Correction Order), or
- A prisoner has been released from custody by Corrective Services NSW prior to death (e.g. where hospitalised for the remainder of their life).

The decision as to whether a death has occurred 'in custody' is made by the Senior Coroner on careful consideration of all the evidence.

What is a death as a result of a police operation?

Sections 22 and 23 of the *Coroners Act 2009* provides a Senior Coroner with jurisdiction to hold an inquest into a death where it appears that the person has died as a result of a police operation.

A 'police operation' is defined broadly to mean:

any activity engaged in by a police officer while exercising the functions of police officer other than an activity for the purpose of a search and rescue operation.

In practice, this definition has been interpreted broadly by Senior Coroners. It can include:

- An operation to apprehend a person, or to contain/ detain a person.
- An operation to engage a person, or an operation to assist a person.
- A police motor vehicle pursuit or other pursuit.
- Any operation in which police discharge a firearm.
- Execution of a writ or service of process.
- A police siege.
- An evacuation.
- A traffic control or enforcement operation.

- A roadblock.
- Any other circumstance considered applicable by the Senior Coroner.

The reason for a broad approach is to enable the adequacy and appropriateness of police processes and conduct to be investigated where it appears necessary, and provide the family of the deceased, the New South Wales Police Force and the public with the opportunity to be made aware (as far as possible) of the circumstances surrounding the death.

It is important to note that for matters where an inquest is yet to be heard and completed, no conclusion can be drawn that the death occurred in custody or as a result of police operations until the Coroner, having considered all the evidence and submissions presented at the inquest, has made such a determination.

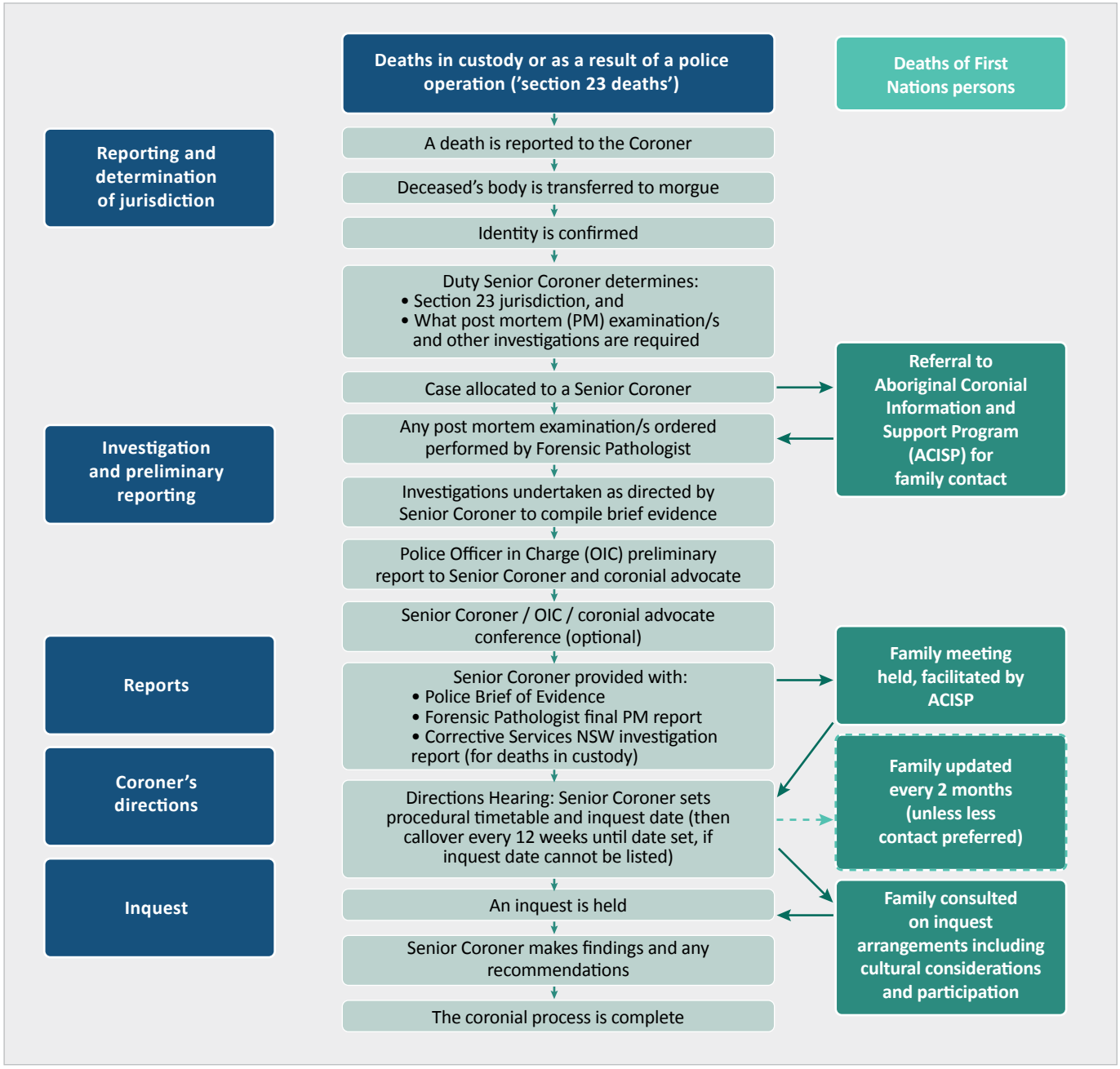
Conversely, a matter that was not initially reported as having occurred in custody or as a result of a police operation may be determined not to be so after the Coroner has reviewed all the evidence.

For the purposes of this report, the following is used to classify types of police operations:

- Operation to apprehend- situations where police are attempting to arrest the deceased.
- Operation to contain/restrain – situations where police are responding to an incident report indicating the deceased may be acting violently towards others.
- Operation to engage – situations where police are responding to an incident report indicating the deceased may intend self-harm or is experiencing a mental health crisis.
- Operation to assist – situations (not covered above) where police are responding to a call for assistance, or on the scene of an incident, such as a welfare check.
- Police motor vehicle pursuit – situations where police are or had been pursuing, or the person believes police to be pursuing, the deceased in a motor vehicle.
- Execution of a writ/service of process – situations where police are attempting to execute a writ, such as a search warrant or other service of process.
- Police siege – situations where police are attempting to negotiate a resolution to a siege.
- Roadblock – situations where police are utilising roadblock techniques for policing purposes.
- Traffic control/enforcement – situations where police are engaged in traffic control or enforcement, including random breath testing or speed detection.

THE CORONIAL PROCESS

The following diagram provides an overview of the coronial process when a death occurring in custody or as a result of police operations is reported to the Coroner, as outlined in Coronial Practice Note 3 of 2021 and where applicable, the First Nations Protocol (see below).



This diagram is not exhaustive and does not capture all interactions between the Coroner, parties who assist the Coroner and the family of the deceased person that are integral to the completion of the coronial process.

Notification of deaths in custody or police operations

When a death occurs in custody or as a result of a police operation in New South Wales, local police are to promptly inform the State Operations Co-ordinator (SOC) at VKG, the Police communications centre in Sydney. The SOC is to immediately notify the on-call duty Senior Coroner.

Once informed, the duty Senior Coroner will assume responsibility for supervising the initial investigation into the death, a critical part of any coronial inquiry. The Senior Coroner will:

- Give directions to police.
- Check that arrangements have been made to notify the relatives and, if necessary, the deceased person's legal representatives. If the deceased person is identified as a First Nations person, the Aboriginal Legal Service is contacted by NSW Police.
- If warranted, inspect the scene where the death occurred. Later, the Senior Coroner may also inspect the scene of death before commencing or during the inquest.
- Give directions for any post-mortem examinations to determine the deceased person's cause of death. All post-mortem examinations are conducted by experienced Forensic Pathologists at specialist forensic medicine facilities.

A high standard of investigation is expected in all coronial cases. Investigations into a death in custody or police operation are approached on the basis that the death may be a homicide. Suicide should never be presumed.

In cases involving the NSW Police

When notified of a death in police custody or as a result of a police operation, the Senior Coroner may request the NSW Crown Solicitor's Office to instruct independent legal counsel to assist the Coroner with the investigation into the death. Counsel, in consultation with the Senior Coroner, will:

- Oversee the conduct of the investigation,
- Oversee the preparation of the brief of evidence,
- Confer with the deceased person's family members and witnesses,
- Prior to the inquest, appear at directions hearings and participate in conferences with the Coroner, legal representatives, interested parties and the deceased person's family members, to ensure that all relevant issues for the inquest are identified, and
- Appear as Counsel assisting the Coroner at the inquest, to ensure that all relevant evidence is brought to the attention of the Coroner to enable them to make proper findings and appropriate recommendations.

Case management of the coronial process

The Senior Coroner will case manage the coronial investigation and preparations for the holding of an inquest into a death in custody or as a result of a police operation in accordance with formal arrangements that aim to foster consistency, timeliness and inclusiveness of the family in the coronial process. This includes providing culturally appropriate support for First Nations families.

Coronial Practice Note 3 of 2021 - Case Management of Mandatory Inquests Involving section 23 Deaths

On 24 September 2021, the State Coroner, with the approval of the Chief Judge, issued Coronial Practice Note 3 of 2021, containing revised guidelines for Senior Coroners for the case management of deaths in custody or deaths as a result of police operations ('s 23 deaths'). The practice note aims to improve the timeliness of coronial investigations in these mandatory inquests, irrespective of the background of the deceased.

State Coroner's Protocol - Supplementary arrangements applicable to section 23 deaths involving First Nations People ('First Nations Protocol')

On 11 April 2023, the State Coroner issued the First Nations Protocol, which works in conjunction with Coronial Practice Note 3 of 2021, which sets out supplementary arrangements where a First Nations person has died in custody or as a result of a police operation. The aim of the Protocol is to ensure that each stage of the coronial

process is managed in a culturally sensitive and appropriate manner and is established in recognition that every First Nations death in custody represents the loss of a valued individual, family and community member, and needs to be understood in the context of the history and harmful results of dispossession and colonisation that continue to be experienced by First Nations peoples today.

Coronial Practice Note 3 of 2021 – Review

A review of the timeframes set out in Coronial Practice Note 3 of 2021 was undertaken in 2025, in consultation with stakeholders, to ensure that they were appropriate and continuing to serve the purpose of improving timeliness of coronial investigations in mandatory inquests.

Commencing on 9 May 2025, the revised Practice Note extends the timeframe for Corrective Services NSW and NSW Police to provide their investigation reports to the coroner to 16 weeks from determination of jurisdiction. The variation represents a 4 week increase on the previous timeframe, to allow adequate time for Corrective Services NSW and NSW Police to conduct necessary investigations and present probative evidence of the highest quality to the coroner.

The timeframe for NSW Health Pathology (Forensic Medicine) to provide the final post-mortem report to the coroner was also extended to 16 weeks to align with the above timeframes.

The inquest

An inquest is a public hearing held in court by a Senior Coroner into the circumstances of a particular death. Coroners are concerned not only with how the person died, but also the circumstances of their death. The Objects in section 3 of the *Coroners Act 2009*, enable the Coroner to investigate a death to determine the identity of the deceased person, the time and date of their death, and the manner and cause of their death and to make recommendations in relation to matters in connection with the inquest.

Deaths occurring in custody or police operations are personal tragedies that rightly continue to attract significant public attention and require thorough consideration by the Senior Coroner.

When inquiring into a death in custody, the Senior Coroner's investigation of the cause and circumstances of the death will include the quality of care, treatment and supervision of the person before their death, and whether custodial officers observed all relevant policies and instructions.

For example, at an inquest into a suspected death by suicide occurring in custody, the Senior Coroner will typically examine the circumstances to identify any improvements in the psychological/psychiatric care provided as well as the physical surroundings, with a view to reducing the risk of deaths by suicide in the future.

When inquiring into a death as a result of a police operation or in another form of detention, the Senior Coroner will investigate the appropriateness of actions of police or other officers and review standard operating procedures. The Senior Coroner will critically examine each case in order to identify whether shortcomings exist and if so, to ensure (as far as possible) that remedial action is taken and appropriate recommendations made.

Role of the Coroner

The purpose of an inquest into a death in custody or police operation is to enable the Senior Coroner, at the end of the inquest process, to make findings about the death and any recommendations about issues connected with the death. The *Coroners Act 2009* outlines a number of responsibilities of the Coroner in the inquest process, including:

Written findings: At the conclusion of the inquest, the Coroner must provide written findings as to whether a person has died, their identity, the time and date of their death, and the manner and cause of their death. However, the findings must not indicate or suggest that an offence has been committed by any person (s 81).

Suspension in the event of criminal charges: If it appears that a person has been charged with an indictable (serious) offence or on the evidence that a jury would convict a known person of an indictable offence in relation to the death, the Coroner is to suspend the inquest and, if applicable, refer the matter to the Director of Public Prosecutions for consideration of criminal proceedings (s 78). For inquests into deaths in custody or police operations, the inquest process will not resume until after the conclusion of any criminal proceedings (s_79).

Recommendations: The Coroner may make such recommendations as they consider necessary or desirable in relation to any matter connected with the death the subject of the inquest. The purpose of any recommendations is to prevent, if possible, other deaths from occurring in similar circumstances in the future. There is no limit on the subject matter of recommendations, although issues of public health and safety are specifically indicated (s 82). A copy of any recommendation is to be provided to the State Coroner, the person or body to whom the recommendation is directed, and the relevant Minister/s.

Responses to recommendations

The *Coroners Act 2009* does not contain formal mechanism for monitoring responses to coronial recommendations. A Coroner may request but is not empowered to require that a response to a recommendation be provided by the person or body to whom it is directed.

However, a government agency to whom a recommendation is directed is required to adhere to the Department of Premier and Cabinet Memorandum 2009-12 Responding to Coronial Recommendations, which generally provides for:

- Acknowledgment of receipt of a recommendation to be provided to the State Coroner within 21 days, and
- Relevant Ministers to write to the Attorney General within 6 months to outline action being taken to implement a recommendation, and provide further progress updates as needed.

Government agency responses to coronial recommendations are compiled by the Department of Communities and Justice and published at:

https://dcj.nsw.gov.au/legal-and-justice/laws-and-legislation/legal-assistance-and-applications/responses-to-coronial-recommendations.html

For recommendations and responses for coronial inquests between 2009 and 2022, these are hosted on the Responses to Coronial Recommendations Archive and published at:

https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx.

Timeframe for hearing of inquests

Before any inquest into a death can be held, the coronial investigation must be conducted. The Coroner supervises the investigation of any death from beginning to end. The time taken for this process to occur will vary considerably depending on the circumstances of the case.

Investigations into deaths in custody or police operations can take many months and up to several years to complete, due to the importance of ensuring cases are fully and properly investigated and a comprehensive brief of evidence is provided to the Senior Coroner. This typically involves a large number of witnesses being spoken to and statements being obtained. A comprehensive investigation process assists to ensure all relevant issues are identified and evidence is sought to address those issues, so that the conduct of the inquest is as efficient as possible.

The interaction of other processes can also affect the timeframe in which an inquest can be held. In some cases, concurrent investigations into a death may occur (for example, by the Professional Standards Command of NSW Police or the Investigations Branch of Corrective Services NSW). The Senior Coroner may need to wait and give consideration to the results of those investigations, which in turn may raise further issues for investigation and/or consideration at the inquest.

ABOUT THIS REPORT

This report provides information about:

- Deaths occurring in custody or as a result of police operations in NSW that were reported to the Coroner between 1 January 2025 and 31 December 2025, and
- Inquests into deaths occurring in custody or as a result of police operations in NSW that were finalised by a Senior Coroner between 1 January 2025 and 31 December 2025 (regardless of the date that the death occurred and/or was reported to the Coroner).

The cases comprising each dataset have been extracted from JusticeLink, the electronic case management system used by the Department of Communities and Justice for the collection of court data, and cross-checked against physical files managed by court staff. This process was undertaken to ensure that for each dataset:

- All cases meeting the inclusion criteria were identified and included, and
- Any cases that did not meet the inclusion criteria were excluded.

The aggregate data presented in relation to each dataset has been manually collected for each case within the dataset from sources including:

- Data fields in JusticeLink, which contain information manually entered into the system from original documents provided to the Coroner, original documents, including the police report of death and the Forensic Pathologist's postmortem report, and
- The Coroner's written findings, if applicable.

Data indicating a person's First Nations status is drawn from JusticeLink. This information is reported in the police report of death to the Coroner where known, and/or is subsequently confirmed or identified by the Court's Aboriginal Coronial Information and Support Program (ACISP) officers or other coronial family liaison staff. All cases identified as relating to First Nations persons included in this report have been confirmed by ACISP staff.

OVERVIEW OF DEATHS IN CUSTODY AND POLICE OPERATIONS, 2005-2025

The following material provides an overview of all deaths that were reported to the Coroner, within the relevant year, as deaths occurring in custody or as a result of police operations.

This is a compilation of annual reported deaths and is not indicative of Coroners' final findings as to whether or not the deaths in fact occurred in custody or as a result of police operations.

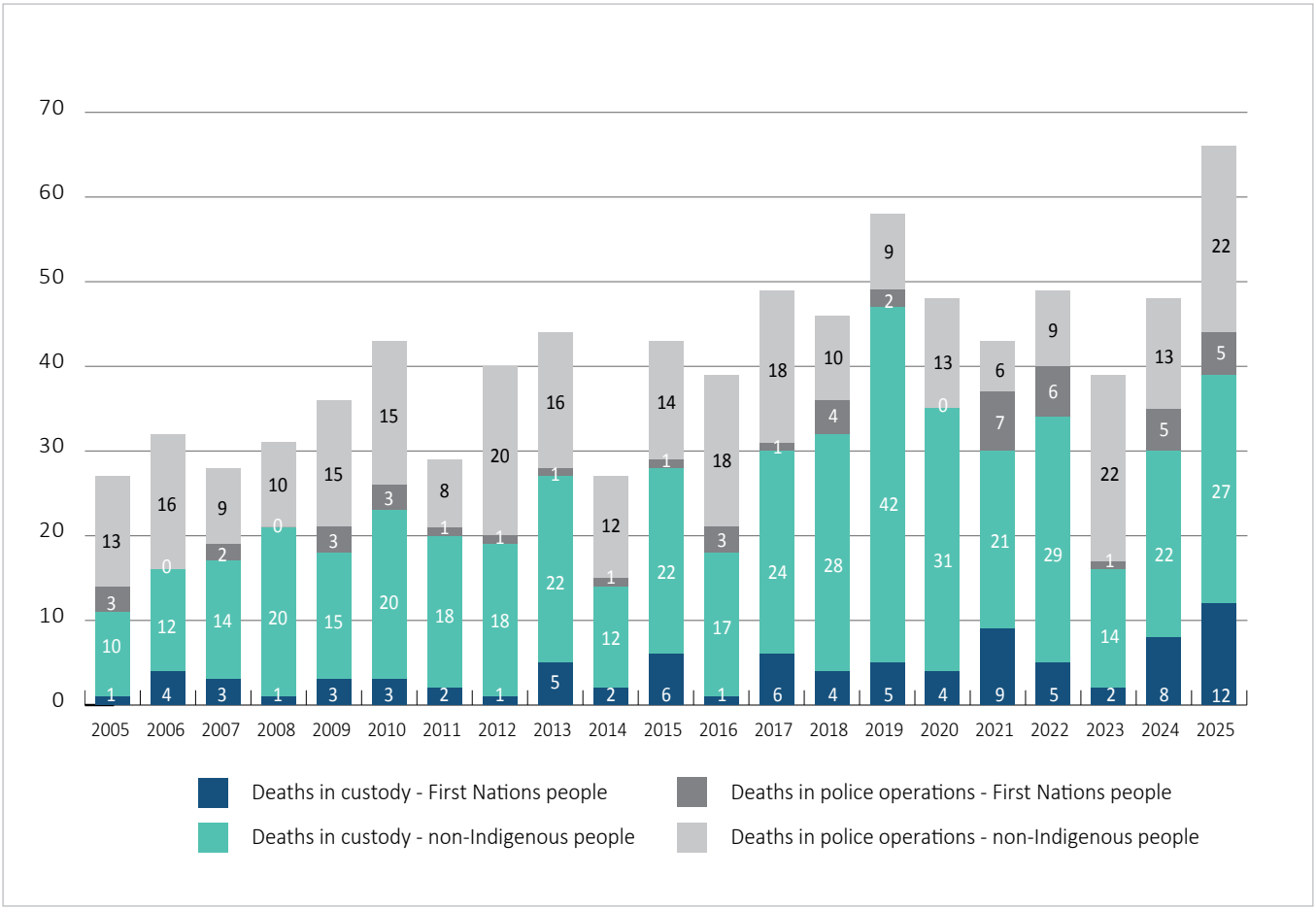


Figure 1: Deaths reported to the Coroner as occurring in custody and as a result of police operations in NSW, by First Nations status and year (2005-2025).

Deaths in custody

Year	Total	First Nations people	Non-Indigenous people
2005	11	1	10
2006	16	4	12
2007	17	3	14
2008	21	1	20
2009	18	3	15
2010	23	3	20
2011	20	2	18
2012	19	1	18
2013	27	5	22
2014	14	2	12
2015	28	6	22
2016	18	1	17
2017	30	6	24
2018	32	4	28
2019	47	5	42
2020	35	4	31
2021	30	9	21
2022	34	5	29
2023	16	2	14
2024	30	8	22
2025	39	12	27
TOTAL	**525**	**87**	**438**

Figure 2: Table of deaths reported to the Coroner as occurring in custody in NSW, by First Nations status and year (2005-2025).

Deaths as a result of police operations

Year	Total	First Nations people	Non-Indigenous people
2005	16	3	13
2006	16	0	16
2007	11	2	9
2008	10	0	10
2009	18	3	15
2010	18	3	15
2011	9	1	8
2012	21	1	20
2013	17	1	16
2014	13	1	12
2015	15	1	14
2016	21	3	18
2017	19	1	18
2018	14	4	10
2019	11	2	9
2020	13	0	13
2021	13	7	6
2022	15	6	9
2023	23	1	22
2024	18	5	13
2025	27	5	22
TOTAL	**338**	**50**	**288**

Figure 3: Table of deaths reported to the Coroner as occurring in police operations in NSW, by First Nations status and year (2005-2025).

REPORTED DEATHS IN 2025

This section provides information about deaths reported to a Senior Coroner in 2025 as having occurred in custody or as a result of a police operation. In most of these cases, an inquest had not yet been held at the date of this report. As a result:

- Only limited information is available about deaths which have been reported as the matters are not yet finalised, and
- Information is provisional in nature. No conclusion can be drawn that a death occurred in custody or as a result of a police operation until this is determined by the Senior Coroner after hearing all the evidence and submissions presented at an inquest.

For the purposes of this report, deaths occurring during, or in the course of, police arrests have been classified as deaths as a result of a police operation. Deaths occurring in a police cell, however, are classified as deaths in custody. No deaths in police custody were recorded in 2025.

Deaths in custody

39 deaths reported to the Coroner in 2025
↑ **9** deaths from 2024

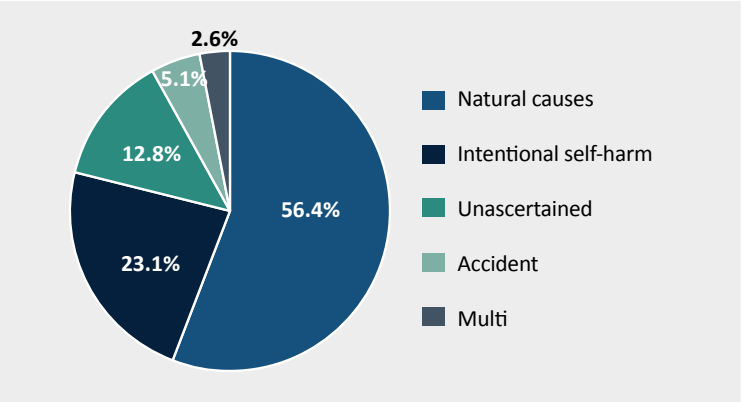
36 Male
3 Female

12 First Nations persons

12 First Nations deaths occurred in custody; the highest number ever recorded in a single year.

This is a profoundly distressing milestone. Each of these deaths represents a person whose life mattered and whose loss is felt deeply by families, loved ones and communities across the state. They are individuals whose deaths demand independent scrutiny, respect and accountability.

Manner of death		
Natural causes	22*	56.4%
Intentional self-harm	9	23.1%
Unascertained	5	12.8%
Accident	2	5.1%
Multi	1	2.6%
TOTAL	**39**	**100.0%**



**Where a death appears to be due to natural causes, a Coroner may still find that the death may have been caused or contributed to by preventable issues such as the quality of care, treatment and/or supervision received by the person prior to their death, including a lack of culturally appropriate care. These issues will be addressed by the Coroner in the inquest and/or the recommendations made at inquest.*

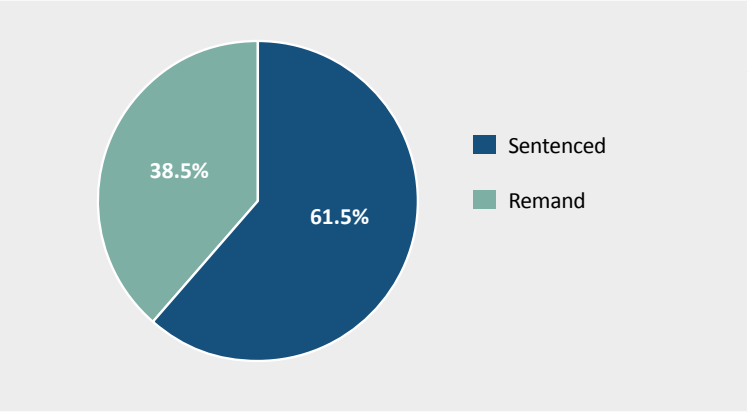
8 of the 9 (22.1%) deaths in custody reported as intentional self-harm were recorded as hangings. A review of the information currently available for these reported matters appears to show the continuing increasing numbers of intentional, self-inflicted deaths involving hanging points, despite the recommendations to remove all hanging points

in correctional centres having been made by the Royal Commission into Aboriginal Deaths in Custody 35 years ago and recommendations made by coroners in numerous inquests.

5 (12.8%) deaths in custody were reported as due to unascertained causes. This is a significant increase in the number of unascertained deaths in custody, and prompted further investigation of this cluster of deaths, including additional toxicology testing of coronial samples. Whilst closer investigation of these deaths and additional toxicology screening did not reveal any new drug trends or issues of concern, it is notable that the cause of these 5 deaths in custody remained unascertained even after the completion of the final post-mortem report by NSW Health Pathology.

2 (5.1%) deaths in custody were reported as having occurred as a result of the administration of an approved Voluntary Assisted Dying medication. These deaths represent the first deaths in custody to occur under the Voluntary Assisted Dying legislation since its commencement in late 2023.

Custodial status		
Sentenced	24	61.5%
Remand*	15	38.5%
TOTAL	**39**	**100.0%**



**Being held on remand means that a person has been charged with a criminal offence but has been refused bail, or cannot meet bail conditions. They are held in custody while waiting for their trial or sentencing. Not all people who are held on remand are found guilty nor do they always receive a custodial sentence.*

15 (38.5%) people who died in custody were reported to have been on remand.

In NSW, the number of people on remand has reached record highs, partly driven by stricter bail laws, according to data released in February 2026 by the NSW Bureau of Crime Statistics and Research ('BOCSAR').

Between December 2023 and December 2025, the remand population increased by 1,016 people (up 20.1 per cent) to a record 6,081. As a result, people on remand now make up 46% of the adult prison population, the highest proportion ever recorded[3].

3 https://bocsar.nsw.gov.au/research-evaluations/2026/nsw-custody-statistics-quarterly-update-dec-2025.html

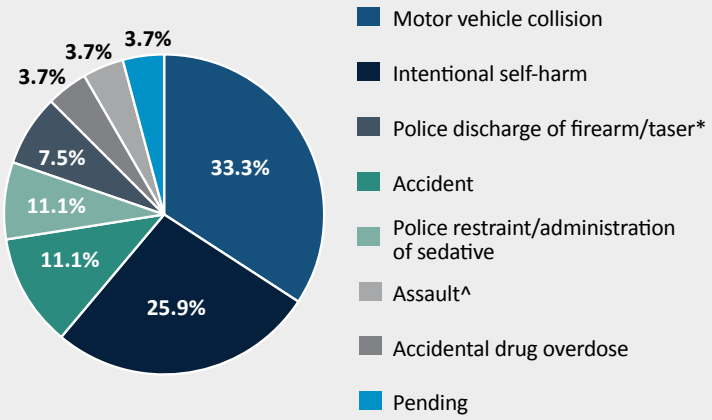
Deaths as a result of police operations

27 deaths reported to the Coroner in 2025
↑ **9** deaths from 2024

24 Male
3 Female

5 First Nations persons

Manner of death		
Motor vehicle collision/pursuit	9	33.3%
Intentional self-harm	7	25.9%
Police discharge of firearm*	3	11.1%
Accident	3	11.1%
Police restraint/administration of sedative	2	7.5%
Assault^	1	3.7%
Accidental overdose	1	3.7%
Pending	1	3.7%
TOTAL	**27**	**100.0%**



* *Police discharge of firearm refers to a death occurring in a police operation where the deceased was shot by police. It makes no assessment as to whether or not the discharge of the firearm by police occurred in lawful circumstances.*

^ *Assault here refers to an assault that occurred prior to NSW Police arriving, however has been determined to be as a result of a police operation as NSW Police did not respond to the 000 calls for assistance from members of the public who witnessed the assault.*

9 (33%) deaths were reported as a result of a police operation which occurred in connection with a police motor vehicle pursuit. This represents an increasing trend in the number of deaths reported to have occurred in the context of a police motor vehicle pursuit. This figure also includes the deaths of victims who were killed as a collateral result of a pursuit but were not being pursued, such as innocent bystanders or pedestrians.

All police pursuits pose a risk to human life – the need for safeguards or qualifiers before police engage in a pursuit has been raised by Coroners, including in an Inquest finalised in 2025, to ensure that the community is not placed at a greater risk of harm when compared to the harm that the police are trying to prevent when they engage in a pursuit[4].

4 https://coroners.nsw.gov.au/documents/findings/2025/Inquest_into_the_death_of_Harri_Tapani_Jokinen.pdf

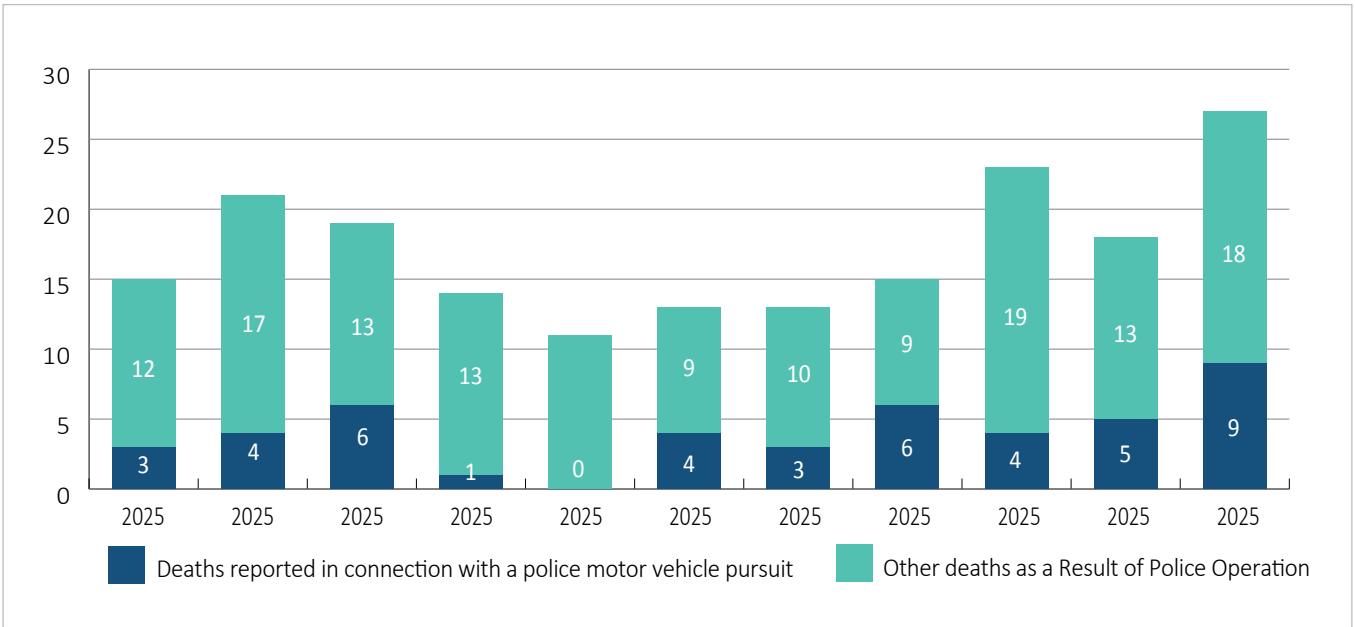
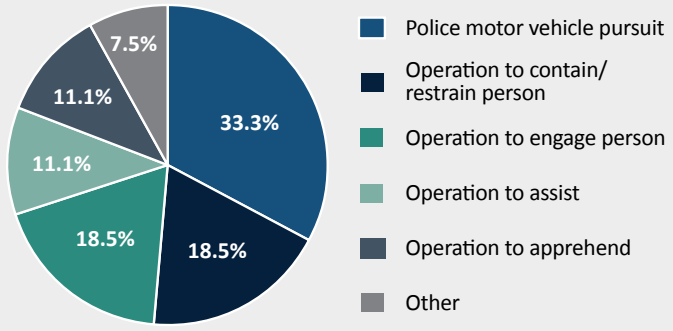


Figure 4: Deaths reported in connection with a motor vehicle pursuit, compared against deaths reported to the Coroner as a result of a police operation by year (2015- 2025)

3 (11%) deaths were reported to have occurred in the context of the administration of sedation for agitation management. Acute sedation by NSW Health practitioners is a last resort that is used where a person puts others at immediate risk of serious harm. NSW Health's Agitation Management and Restrictive Practice Working Group are reviewing the deaths and any relationship to NSW Ambulance's Agitation Management protocols.

Type of police operation		
Police motor vehicle pursuit	9	33.3%
Operation to contain/ restrain person	5	18.5%
Operation to engage person	5	18.5%
Operation to assist person	3	11.1%
Operation to apprehend	3	11.1%
Other	2	7.5%
TOTAL	**27**	**100.0%**



INQUESTS FINALISED IN 2025

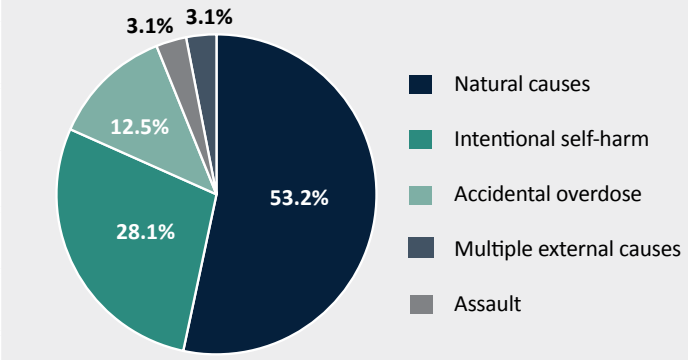
In 2025, **44** inquests were finalised in relation to deaths occurring in custody (**32** inquests) or as a result of police operations (**12** inquests).

Deaths in custody

32 inquests finalised by a Senior Coroner in 2025
16 of these inquests made recommendations

30 Male
2 Female
7 First Nations persons

Manner of death		
Natural causes*	17	53.2%
Intentional self-harm#	9	28.1%
Accidental overdose	4	12.5%
Multiple external causes	1	3.1%
Assault	1	3.1%
TOTAL	**32**	**100.0%**



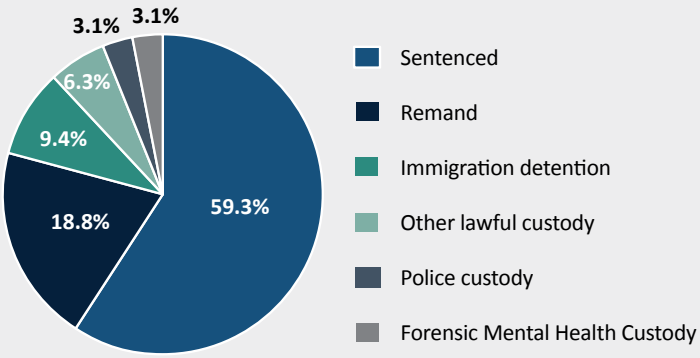
* *Note: where the Coroner has found that a death was due to natural causes, they may have also identified causal or contributory issues regarding the quality of care, treatment and/or supervision of the person prior to their death that may be the subject of recommendations aimed at preventing similar deaths in the future. These recommendations are contained in the Coroner's written findings, which are accessible as outlined below. A key theme in these findings was ensuring those people with a chronic or acute medical condition received timely healthcare, including access to specialist care during palliative or advanced illnesses and improvements in the quality of head-check processes and wellness confirmations to ensure officers verify responses.*

Further information regarding the **9** (28.1%) deaths determined to have been as a result of intentional self-harm was collated from the inquest findings. From the information presented at inquest, **7** people had a mental health diagnosis known to Corrective Services NSW, including a person who died from hyponatraemia, following the excessive consumption of water, in the context of psychogenic polydipsia and schizophrenia.

Coronial inquests examine the circumstances surrounding the person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibilities appropriately and adequately. In some inquests, issues in relation to the nature and adequacy of the deceased mental health management by Corrective Services NSW (CSNSW) and/or Justice Health may be examined.

In relation to the **4** (12.5%) deaths as a result of an accidental drug overdose, coroners made important recommendations regarding the need to expand access to Opioid Agonist Treatment program, as one of the strongest protective factors against opioid overdoses for adults in custody. Recommendations also called for improvements in after-hours clinical support to reduce gaps in crisis management as well as improved observation protocols.

Custodial status		
Sentenced	19	59.3%
Remand	6	18.8%
Immigration detention	3	9.4%
Other lawful custody	2	6.3%
Police custody	1	3.1%
Forensic Mental Health Custody	1	3.1%
TOTAL	**32**	**100.0%**

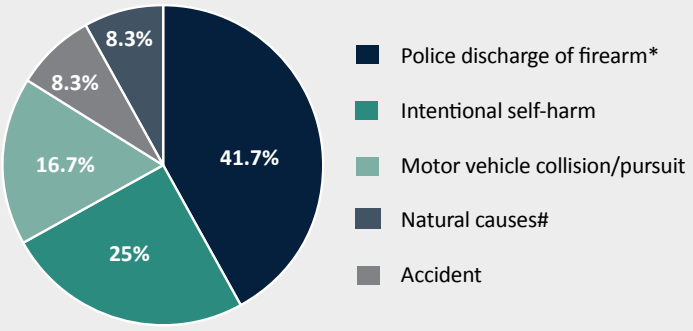


Deaths as a result of a police operation

12 inquests finalised by a Senior Coroner in 2025
4 of these inquests made recommendations

10 Male
2 Female
2 First Nations persons

Manner of death		
Police discharge of firearm*	5	41.7%
Intentional self-harm	3	25.0%
Motor vehicle collision/ pursuit	2	16.7%
Natural causes#	1	8.3%
Accident	1	8.3%
TOTAL	**12**	**100.0%**



Police discharge of firearm: Five deaths were found to have occurred when the deceased person was shot by police as a result of a police operation. The circumstances of each death in this category varied, occurring in the following situations where police officers:

- were provoked to discharge their weapon when threatened with a weapon by a person acting with the intention to end their own life.
- were threatened by a mentally ill person after a knife was produced.
- attempting to arrest a person when a knife was produced, and police officers were injured.

- attempting to arrest a person, when a knife was produced and the person advanced towards police.
- defending a police officer following an earlier unjustified roadside detention of the deceased.

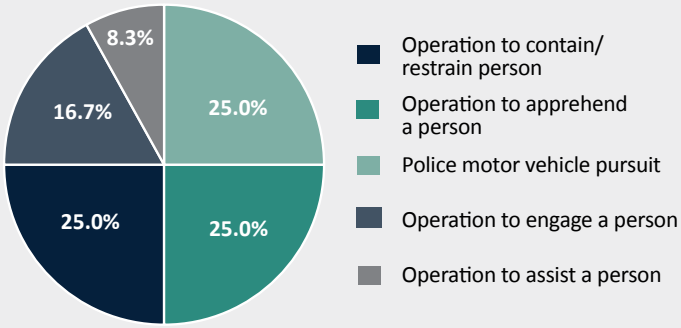
Natural causes: One death was found to have occurred as a result of natural causes in a situation where a report regarding the person's welfare was made to NSW Police, but no appropriate response initiated until a follow up report of concern was made a day later. However, it was not possible to conclude whether the death would have been prevented if an appropriate response had been initiated when the concern for welfare was first reported.

In **7** (58.3%) of these 12 inquests, the Coroner noted evidence that the deceased had a diagnosis of mental illness.

A number of the inquests involved the intersection of policing and mental illness/drug abuse, and coroners made a number of recommendations aimed at improving mental health-related training for police and recommending that a health-led model of response be explored.

In particular, knife-threat dynamics were noted as leaving extremely limited time for negotiation or retreat, and the need for improved mental health training and assistance for police when they encounter a person experiencing a mental health crisis or are drug-affected remains an issue in need of urgent attention. Whilst a police response will almost always be required where there is a threat to public safety, police are not always well placed to be the only first responders for people who are suffering severe emotional distress or experiencing a mental health crisis.

Type of police operation		
Operation to contain/restrain person	3	25.0%
Operation to apprehend a person	3	25.0%
Police motor vehicle pursuit	3	25.0%
Operation to engage a person	2	16.7%
Operation to assist a person	1	8.3%
TOTAL	**12**	**100.0%**



Written findings

The electronic version of this report contains a link to the written findings made in each finalised inquest in the tables below. Written findings are published on the NSW Coroner's Court website at:

https://www.coroners.nsw.gov.au/coroners-court/coronial-findings-search.html

The written findings set out the Coroner's determinations about the deceased person's identity and the date, time, manner and cause of death. They include a description of the circumstances surrounding the death and any recommendations that were made.

Where the Coroner makes a finding that a person's death was self-inflicted, section 75 of the *Coroners Act 2009* prevents the person's name from being published unless the Coroner directs otherwise. In the tables below and in the written findings for such cases, the names of deceased persons have been replaced with pseudonyms.

Due to the increase in deaths reported to the Coroner generally, the time required to complete the coronial investigation to inform the inquest process, and the impact of the COVID-19 pandemic, the substantial majority of cases in the lists below were reported to the Coroner in years prior to 2025.

Deaths in custody

	Case number	Inquest into the death of	Senior Coroner
1	201800400495	Hayden DAWES	Judge K. Pearce
2	201900028070	Moses KELLIE	Judge E. Ryan
3	201900407715	James Joseph CUNNEEN	Judge D. O'Neil
4	201900302386	Dushyanthan VISVANATHAN	Judge D. O'Neil
5	202000352738	Muhammad HAFIZUDDIN BIN ZAINI	Judge E. Ryan
6	202000121160	Michael BLACK	Judge H. Grahame
7	202100261563	Alfonso CENICCOLA	Judge E. Ryan
8	202100205817	'BQ'	Judge D. O'Neil
9	202100339279	'RD'	Judge K. Pearce
10	202100004815	Matthew Richard LOTHIAN	Judge T. O'Sullivan

	Case number	Inquest into the death of	Senior Coroner
11	202100196736	Frank Dwayne COLEMAN	Judge T. O'Sullivan
12	202100055427	Benjamin CULLEN	Judge D. O'Neil
13	202200317333	Daniel Munro Lewis TURNBULL	Judge E. Kennedy
14	202200375404	Emmett BROWN	Judge H. Grahame
15	202200318454	Michael SANDERSON	Judge R. Hosking
16	202200148393	Leah Jane PORTER	Judge E. Ryan
17	202200189166	Roland ASHBOLT	Judge D. Lee
18	202200273459	Francis William Athol CABLE	Judge D. Lee
19	202200218649	'SF'	Judge J. Baptie
20	202200367479	Shane MCMILLAN	Judge R. Hosking
21	202300229298	Stephen Paul BOURKE	Judge D. O'Neil

22	202300134439	Bernard GREENWELL	Judge C. Franklin
23	202300298225	'PF'	Judge R. Hosking
24	202300155101	Robert SIEVERS	Judge H. Grahame
25	202300296564	'JSZ'	Judge R. Hosking
26	202400394631	Colin James WHALEY	Judge S. Devine
27	202400292825	Frank VALENTINE	Judge S. Devine
28	20240008248	Lathan BROWN	Judge S. Devine
29	202400119476	Daniel LEEHY	Judge D. Lee
30	202400051676	Philip William WALKER	Judge K. Pearce
31	202400232255	Malcolm BAKER	Judge J. Baptie
32	202400065322	Mark LEWIS	Judge D. O'Neil

Deaths as a result of police operations

	Case number	Inquest into the death of	Senior Coroner
1	202000365139	Bradley Vincent BALZAN	Judge T. O'Sullivan
2	202100355435	Alan James GREEN	Judge R. Hosking
3	202200002500	Harri Tapani JOKINEN	Judge R. Hosking
4	202200190663	Malcolm BROWN	Judge D. Lee
5	202200123358	Dima THOMSON	Judge D. Lee
6	202300066886	Mohamed Rahmathullah Syed AHAMED	Judge E. Ryan
7	202300115388	Warren Matthew SIMON	Judge K. Pearce
8	202300154615	Brent Reginald POTTINGER	Judge H. Grahame
9	202300074085	Hillal BARBOUR	Judge D. Lee
10	202300074236	'MQ'	Judge D. Lee
11	202300051396	'DE'	Judge K. Pearce
12	202400057088	'JF'	Judge K. Pearce

CORONIAL INQUEST RECOMMENDATIONS DELIVERED IN 2025

In accordance with section 81 of the *Coroners Act 2009*, written findings are published after the conclusion of coronial inquests held by the NSW Coroners Court. The written findings set out the Coroner's determinations about the deceased person's identity and the date, time, manner and cause of death, as well as a description of the circumstances surrounding their death and any recommendations that were made. Recommendations related to the circumstances of the matter may be made pursuant to section 82 of the *Coroners Act 2009* where they are deemed to be necessary or desirable.

A mandatory coronial inquest, held in accordance with section 27 1(b) of the *Coroners Act 2009*, will necessarily involve examination of the conduct of staff predominantly from Corrective Services New South Wales, Justice Health and Forensic Mental Health Network and the New South Wales Police Force; and will often involve an examination of the adequacy of health care, including mental health care, provided to those detained in the State's care.

Of the **44** inquests finalised in 2025, **20** matters had recommendations delivered. **16** of these matters were deaths in custody, and **4** of these matters were deaths as a result of a Police operation.

Importantly these recommendations seek to prevent future deaths and improve public safety. Recommendations across finalised inquests in 2025 highlighted persistent gaps in observation practices, communication and training, clinical care pathways and policy clarity across Corrective Services NSW ('CSNSW'), Justice Health NSW, NSW Police Force and the Commonwealth Detention system.

Observation, Monitoring & Welfare Checks

Coroners repeatedly emphasise failures in head-check and confirmation of physical wellbeing processes; timeliness and quality of welfare checks; observation cell supervision, including camera use and physical rounds; clear instruction on what a check requires (verbal vs physical responses)- all contributing factors to preventable deaths.

Communication & Information-Sharing Failures

Coroners noted areas of concerns including poor transfer of critical clinical risk information between agencies; unclear handover processes across shifts; inconsistent notification and liaison with next-of-kin during deterioration or palliative care; weak communication pathways in immigration detention and between hospitals and custodial facilities. Breakdowns in communications were often noted as causing delayed responses to emerging or escalating health concerns.

Training Gaps in High-Risk Operational Domains

Several recommendations also called for expanded or revised training on areas including mental health recognition, welfare checks, observation requirements, protection request triage, police pursuits, radio communication standards, and management of excessive water ingestion.

Training gaps repeatedly appeared as causative or contributing factors across multiple inquests, signalling a systemic need for structured, scenario-based capability development.

Environmental & Infrastructure Safety Risks

Coroners highlighted continuing concerns about ligature points and unsafe physical infrastructure in detention centres; inadequate clinical environments and observation cells in correctional centres and faulty or unclear emergency communication hardware (e.g. knock-up audio systems).

Safety hazards in cells and clinical areas were identified as creating predictable risks of self-harm and hindering emergency responses.

Delays and Gaps in Clinical Care Pathways

Multiple recommendations were directed at improving drug and alcohol assessments and improving access to Opioid Agonist Treatment; rectifying insufficient after-hours mental health support in detention; improving

a lack of timely medical reviews after acute prescribing and the need for clearer withdrawal monitoring requirements (e.g. observation frequency).

Timely clinical intervention, particularly in relation to withdrawal, mental health crises, and palliative care, was identified as central to preventing avoidable deaths in custodial settings.

Policy Ambiguity in High-Risk Operational Areas

Coroners also highlighted the need for clearer custody procedures (head-checks, protection requests, end-of-life liaison), stronger frameworks for incident reporting integrity, review of pursuit thresholds and documentation requirements and firearm and holster serviceability criteria and mandatory audits.

Ambiguous or outdated policies were identified as contributing to inconsistent and unsafe practices, particularly in relation to police pursuits, firearm handling, and custodial supervision.

Inquest Recommendations of particular note:

In the **Inquest into the death of Harri Tapani Jokinen**, the Coroner recommended strengthening NSW Police's pursuit policy, to ensure that pursuits are only commenced where there is a serious pre-existing threat to safety, and a mandatory radio articulation of this threat by officers and supervisors is made. NSW Police have accepted the principle that community safety must be the overriding priority in any pursuit, and have advised that they have commenced work to align policy, training and communication protocols.

In the **Inquest into the death of MQ**, the Coroner found that the call to police expressing welfare concerns was not entered into the Police Computer-Aided Dispatch (CAD) system, contrary to NSWPF Handbook requirements The Coroner recommended a review of procedures, training and systems to ensure all such calls were promptly converted to CAD jobs, a recommendation that NSW Police have accepted and advised that a review of call-taking and CAD entry processes is underway.

In the **Inquest into the death of SF**, the Coroner found systemic failures in relation to CSNSW consideration of requests for alternative cell placement due to a threat to the personal safety of inmates, and recommended that CSNSW review its policies and consider imposing a requirement that where it is determined that an inmate may be at risk from others, or requires alternative cell placement due to a threat or due to fears for their personal safety, that completion of the Assessment Tool, Inmate under Threat, occur within four hours unless there are exceptional circumstances.

In the **Inquest into the death of Lathan Brown**, the Coroner found that CSNSW needed to urgently implement procedures to improve emergency responses to 'knock-up' calls as well as ensure timely and accurate family liaison during medical emergencies, particularly where end of life care is being given. The Coroner recommended changes to the 'knock-up' systems, emergency response protocols and amendment to the policies for medical emergencies to provide clear and accurate information to inmates families.

In the **Inquest into the death of Daniel Munro Lewis Turnbull**, the Coroner found that Daniel died from hyponatraemia caused by psychogenic polydipsia, a condition linked to his schizophrenia, despite being in a 24-hour surveillance cell. The Coroner recommended that CSNSW and Justice Health review and revise relevant policies, including the Health Problem Notification Form, to include excessive water consumption as a life-threatening condition, and that any signs or symptoms of excessive water intake trigger immediate intervention even when the inmate themselves does not report a problem, and that there be improved understanding between CSNSW and Justice Health regarding the level of monitoring that must occur when an inmate is in an observation cell.

Responses to Recommendations

Recommendations can be made around issues of public health and safety or can be aimed specifically at a person or agency to recommend a matter or issue be investigated or reviewed. The majority of recommendations made in inquests finalised in 2025 were aimed at a specific agency, head of agency or Minister responsible for the specific agency. It is a legislative requirement that the coroner making the recommendations provide a copy of the recommendations to the State Coroner, the person or agency to whom the recommendation is directed, the Minister, and any other Minister responsible for the person or agency, or responsible for the administration of the legislation to which the recommendation relates.

However, there is no reciprocal legislation that requires or compels the persons, agencies or Ministers responsible to respond to, nor implement these recommendations. It is considered standard practice for responses to recommendations to be provided to the NSW Attorney General's Office within 6 months of the recommendation being received. Reponses to coronial recommendations from 2009 onwards are publicly available on the Government Responses to Coronial Recommendations webpage on the Department of Communities and Justice website: https://dcj.nsw.gov.au/legal-and-justice/laws-and-legislation/legal-assistance-and-applications/response-to-coronial-recommendations-archive.html

02.

RECOMMENDATIONS MADE IN 2025 AND RESPONSES

All recommendations delivered in 2025 are outlined in the tables below. This information includes the agency or agencies to which the recommendations were addressed to, and any responses received by 3 April 2025. Where the response recorded is noted as 'awaiting', the agency has not yet responded to the recommendation but is still within the timeframe for response as set out in the Premier's Memorandum on Responding to Coronial Recommendations. Where the response recorded is noted as 'overdue' the agency has not responded within the timeframe set out in the Premier's Memorandum on Responding to Coronial Recommendations.

Inquest into the death of Daniel Turnbull (Ref: 202200317333)

Recommendation

To the Commissioner of Corrective Services NSW

1. That correctional officers in correctional settings are informed and education is provided that:
   - excessive water intake, particularly in a short period of time, can be life threatening,
   - intervention should occur before a person shows signs or complains of symptoms, and
   - if the person does develop symptoms and/or signs, it is a medical emergency.

To the Commissioner of Corrective Services NSW and to the Justice Health and Forensic Mental Health Network

2. That CSNSW and Justice Health and Forensic Mental Health Network policies, and the HPNF, be revised to reflect the fact that excessive water ingestion, particularly over a short period, can be life threatening, and any symptoms and/or signs that suggest excessive water ingestion require immediate intervention regardless of whether an inmate identifies it as a concern.

3. That the Commissioner of Corrective Services NSW consider the production of a memorandum outlining what level of supervision/observation service is provided by CSNSW staff of any inmate placed in an observation cell (including a 24-hour surveillance cell) to clearly identify and communicate to Justice Health what types of physical checks will occur, how often these can reasonably be performed, how often the surveillance camera is expected to be on, who is watching that camera and how regularly it will be staffed and viewed, whether officers are aware/instructed about why an inmate has been placed in an observation cell, how this information is passed across shifts to new officers, and what the officers are instructed to look for. That memorandum is to be provided to Justice Health for circulation to clinical staff to enable the development and management of appropriate inmate treatment plans.

Agency/Organisation

Corrective Services NSW
Justice Health and Forensic Mental Health Network

Response

Corrective Services NSW

1. A new policy is in development which outlines the circumstances where water restrictions may be applied for inmates. This includes where recommendations are made by Justice Health & Forensic Mental Health Network (JHFMN) in relation to self-harm issues linked to excessive water consumption. The policy is currently being reviewed by CSNSW and external stakeholders.

2. A new policy is in development which outlines the circumstances where water restrictions may be applied for inmates. This includes where recommendations are made by Justice Health & Forensic Mental Health Network (JHFMN) in relation to self-harm issues linked to excessive water consumption. The policy is currently being reviewed by CSNSW and external stakeholders.

3. CSNSW and Justice Health & Forensic Mental Health Network (JHFMN) have both agreed to support the development of a joint Memorandum of Understanding (MOU).

Justice Health and Forensic Mental Health Network

1. Justice Health NSW and CSNSW fully support that excessive water ingestion should be included in relevant policies and the Health Problem Notification Form (HPNF). The HPNF communicates Justice Health NSW advice and recommendations regarding an adult patient's clinical status to CSNSW. Excessive water ingestion has been highlighted in other coronial matters. The updated HPNF is in the final stages of development and consultation with CSNSW. The updated HPNF will be an electronic form within the electronic health record, to enable improved sharing and standardisation of information. The mental health section of the HPNF will now include a section on excessive water consumption and prompts to observe excessive thirst. The related Justice Health NSW internal policy on HPNF will be updated to reflect changes made to the HPNF.

2. Justice Health NSW and CSNSW support this joint recommendation and have commenced discussions at the Joint Recommendation Working Group and the Joint Executive Committee. It is agreed the HPNF is the communication tool between Justice Health NSW and CSNSW. When an inmate is being managed through a Risk Intervention Team (RIT), the communication between agencies will be outlined in the RIT plan. At all other times, communication will be via the HPNF. which provides information and direction on the type, duration and frequency of monitoring required, and by whom, for patients placed in camera cells for medical or at-risk reasons.

Inquest into the death of Alfonso Ceniccola (Ref: 202100261563)

Recommendation

To the Commissioner of Corrective Services NSW

That consideration be given to implementing a formal induction process for all officers working in the Complex Placement Unit at the Metropolitan Remand Reception Centre, which has replaced the Acute Care Management Unit. The induction should emphasise to officers the importance of familiarising themselves with the requirements of Risk Intervention Team management plan and other information about inmates, particularly regarding the requirements and frequency of physical observations.

Agency/Organisation

Corrective Services NSW

Response

CSNSW has developed a formal induction process to be used for all officers working at the Complex Placement Unit (CPU) at the Metropolitan Remand and Reception Centre (MRRC) which has been captured in a Staff Induction Checklist for officers working at the CPU. The checklist provides an overview of the purpose of the CPU as well as key areas of focus for induction which include IT Setup, Workspace, Welcome Session, Policies and Procedures, Health and Safety, Job-Specific Training, Social Integration and Ongoing Support. This ensures that all staff working at the CPU undertake an adequate induction that prepares them for working in this complex environment.

Inquest into the death of Alan Green (Ref: 202100355435)

Recommendation

To the Commissioner of New South Wales Police Force

That consideration be given to providing additional or updated or revised training to officers with designated category driving certification, who are permitted to conduct pursuits:

- of the difference between the police powers pursuant to sections 169A and 175 and Schedule 3 of the *Road Transport Act 2002* (NSW) and sections 36 and 36A of the *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) (LEPRA) and an understanding of the elements and objectives of those police powers.
- as to how information about "the speed of the offending vehicle" should be conveyed to NSW Police Force radio (VKG) and officers monitoring the pursuit, as referred to in Part 7.5.1(j) of the Safe Driving Policy (SDP), version 9.2, or in any future version of the SDP.
- as to what type of information constitutes "pertinent information" that should be conveyed to VKG and officers monitoring the pursuit, as referred to in Part 7.5.1 of the SDP, version 9.2, or in any future version of the SDP.

Agency/Organisation

NSW Police Force

Response

1. Supported

All police recruits receive in-depth training to ensure they understand the elements and objectives of police powers pursuant to:

- sections 169A and 175 and Schedule 3 of the *Road Transport Act 2002* (NSW), and
- sections 36 and 36A of the *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) (LEPRA).

All Highway Patrol trainees undergo extensive training in these areas to ensure they are well prepared for their duties. The NSWPF is developing a mandatory revisionary training package on the relevant topics. This package will ensure officers remain up-to-date with the latest legal requirements and best practices.

2. Not supported

The NSWPF Safe Driving Policy (SDP) was replaced by the Safe Driving Response and Operations Guideline (SDROG) on 01 July 2024. The previous SDP already required the speed of the offending vehicle to be conveyed. All NSWPF officers trained in pursuits completed relevant training. The SDROG (section 4.5.4), emphasises that the speed and manner of driving of the subject vehicle, location, traffic considerations, and the reason for pursuit are priority information to be relayed as soon as possible.

All NSWPF officers have completed an employee acknowledgment and mandatory training to understand the SDROG. NSWPF Commissioned Officers and Sergeants, including those relieving in these positions, completed training in relation to SDROG, to provide a strong framework for their leadership and management roles. The NSWPF Radio Operation Group is provided relevant information in relation to requesting appropriate information when receiving pursuit calls.

3. Supported

The NSWPF's Police Driver Training (PDT) contains examples of pertinent information. This material will be revised to include specific details on what constitutes pertinent information. The NSWPF will develop a training package for all NSWPF officers on pertinent information. Additionally, PDT will develop a PETE training package for all NSW police officers in relation to what constitute pertinent information.

Inquest into the death of Leah Porter (Ref: 202200148393)

Recommendation

To the Department of Home Affairs

1. That the Commonwealth revisit its processes for considering reviews of the immigration detention process commissioned by, or available to, the Commonwealth, and for implementing any recommendations made in such reviews and consider whether any improvements to those processes are required.

2. That the Commonwealth implement a specified timeframe for responding to any recommendations made in any review referred to in the recommendation above.

3. That the Commonwealth consider commissioning an independent study to identify the reasons why detainees in Villawood Immigration Detention Centre (VIDC) do not routinely take their mental health medication.

4. That an external auditor conducts an audit of VIDC with a view to ascertaining the existence of any hanging points or features in the physical design of the premises which could be used by detainees to self-harm.

5. That the Commonwealth ensure that, as far as is reasonably practicable, to the extent that any of the above recommendations are directed to Serco and/or International Health and Medical Services (IHMS), those measures are implemented by any organisation that may succeed Serco as Facilities and Detainee Services Provider (FDSP) and IHMS as Deployment Health Surveillance Program (DHSP).

To Serco Australia Pty Ltd, or the detention services provider which replaces Serco Australia Pty Ltd

6. That FDSP staff be trained:

    a. in their responsibilities pursuant to a Psychological Support Program (**PSP**) / Supportive Monitoring and Engagement (**SME**) Plan; and

    b. as to the recognition of signs and symptoms of mental health illness and/or deterioration

7. That FDSP staff whose role includes performing or supervising the performance of welfare checks undergo training as to best practice in performing welfare checks of persons in immigration detention.

8. That Serco Staff who undertake the role of a "Personal Officer" receive further training as to the requirements of fulfilling the role of a "Personal Officer" in the Personal Officer scheme referred to in Serco Policy and Procedure Manual 0001- Keep SAFE and PSP/SME, 30 April 2020.

The International Health and Medical Services Pty Ltd (IHMS) or the health services provider which replaces it

9. DHSP staff be trained as to best practice in preparing a PSP/SME Plan with such training covering, in particular, the following topics:

    a. the importance of tailoring an SME Plan to the specific circumstances of a detainee; and

    b. the importance of communicating clear instructions to FDSP Staff (and to other persons who have responsibilities for implementing the measures contained in a PSP/SME Plan)

Agency/Organisation

Department of Home Affairs
Serco Australia Pty Ltd
International Health and Medical Services Pty Ltd

Response

Serco Australia Pty Ltd

Serco no longer provides services to the ABF with regard to the management of the Immigration Detention Centres in Australia. Prior to the Coronial hearing Serco reviewed and developed three training modules to strengthen our training delivery and in readiness for changes proposed by the ABFs new Mental Health policy; however these modules were not fully implemented by Serco due to the transition of the Immigration contract to the new provider.

Serco strongly supports the intent of Recommendation 6, particularly the value of ensuring that FDSP staff are trained:

a. in their responsibilities pursuant to a PSP/SME Plan; and

b. in recognising signs and symptoms of mental health illness and/or deterioration.

As a result, Serco updated the below training methodologies and policies:

- Initial Training Course Update – comprehensive update of the Mental Health, PSP & Suicide Awareness for new staff subject to the ITC.
- The annual officer refresher Ongoing Security Training.
- A bridging training pack was developed to ensure staff were adequately trained to transition from current practice to the proposed new Mental Health policy. This training commenced at all sites prior to the transition out of the Immigration contract.
- The Keep SAFE policy was strengthened during a concurrent review with updates to the respective training material

Awaiting Responses from:

1. Department of Home Affairs
2. International Health and Medical Services Pty Ltd

Inquest into the death of Moses Kellie (Ref: 201900028070)

Recommendation

To the Department of Home Affairs

1. That the Commonwealth revisit its processes for considering reviews of the immigration detention process commissioned by, or available to, the Commonwealth, and for implementing any recommendations made in such reviews and consider whether any improvements to those processes are required.

2. That the Commonwealth implement a specified timeframe for responding to any recommendations made in any review referred to in the recommendation above.

3. That the Commonwealth amend the 2023 Procedural Instruction to require non-mental health clinicians employed by the Deployment Health Surveillance Program (DHSP) and employees of Facilities and Detainee Services Provider (FDSP) to have access to advice provided by a mental health clinician 24 hours per day and 7 days per week.

4. That the Commonwealth make a decision on the ASR submitted by International Health and Medical Services (IHMS) requesting funding for a mental health nurse to be available on the HAS line 24 hours per day (assuming that this has not already occurred).

5. That the Commonwealth ensure that, as far as is reasonably practicable, to the extent that any of the above recommendations are directed to Serco and/or IHMS, those measures are implemented by any organisation that may succeed Serco as FDSP and IHMS as DHSP.

6. That the Commonwealth consider commissioning an independent study to identify the reasons why detainees in Villawood Immigration Detention Centre (VIDC) do not routinely take their mental health medication.

7. That as a matter of priority, the Commonwealth:

   - extend its 'ligature review' (referred to in its submissions in the inquest into the death of Mr Moses Kellie) to all accommodation and bathroom areas within the VIDC as part of an Administrative Capital Works project; and
   - commit to taking reasonable steps to remove ligature points identified in the 'ligature review'

To Serco Australia Pty Ltd, or the detention service provider which replaces Serco Australia Pty Ltd

8. That FDSP staff be trained:

   - in their responsibilities pursuant to a PSP/SME Plan; and
   - as to the recognition of signs and symptoms of mental health illness and/or deterioration.

9. That FDSP staff whose role includes performing or supervising the performance of welfare checks undergo training as to best practice in performing welfare checks of persons in immigration detention.

10. That Serco Staff who undertake the role of a "Personal Officer" receive further training as to the requirements of fulfilling the role of a "Personal Officer" in the Personal Officer scheme referred to in Serco Policy and Procedure Manual 0001- Keep SAFE and PSP/SME, 30 April 2020.

11. That the training referred to in Recommendations 9 and 10 be provided by an external consultant.

To International Health and Medical Services Pty Ltd or the health services provider which replaces it

12. DHSP staff be trained as to best clinical practice in preparing a PSP/SME Plan with such training covering, in particular, the following topics:

    - the importance of tailoring an SME Plan to the specific circumstances of a detainee; and
    - the importance of communicating clear instructions to FDSP Staff (and to other persons who have responsibilities for implementing the measures contained in a PSP/SME Plan).

To the Department and IHMS or the health services provider which replaces it

13. That the Commonwealth and the DHSP expedite the development of a memorandum of understanding with South Western Sydney Local Health District regarding:

    - the process for admitting and discharging a detainee from hospital; and
    - the mental health care services that are to be provided to a detainee at VIDC.

Agency/Organisation
Department of Home Affairs Serco Australia Pty Ltd International Health and Medical Services Pty Ltd
Response

Serco Australia Pty Ltd

Serco no longer provides services to the ABF with regard to the management of the Immigration Detention Centres in Australia. Prior to the Coronial hearing Serco reviewed and developed three training modules to strengthen our training delivery and in readiness for changes proposed by the ABFs new Mental Health policy; however these modules were not fully implemented by Serco due to the transition of the Immigration contract to the new provider.

Serco strongly supports the intent of Recommendation 6, particularly the value of ensuring that FDSP staff are trained:

a. in their responsibilities pursuant to a PSP/SME Plan; and

b. in recognising signs and symptoms of mental health illness and/or deterioration.

As a result, Serco updated the below training methodologies and policies:

- Initial Training Course Update – comprehensive update of the Mental Health, PSP & Suicide Awareness for new staff subject to the ITC.
- The annual officer refresher Ongoing Security Training.
- A bridging training pack was developed to ensure staff were adequately trained to transition from current practice to the proposed new Mental Health policy. This training commenced at all sites prior to the transition out of the Immigration contract.
- The Keep SAFE policy was strengthened during a concurrent review with updates to the respective training material.

Awaiting Responses from:

1. Department of Home Affairs
2. International Health and Medical Services Pty Ltd

Inquest into the death of Muhammad Bin Zaini (Ref: 202000352738)

Recommendation

To the Commonwealth Government

1. That the Commonwealth review the role of a detainee's Status Resolution Officer under the 2023 Procedural Instruction with a view to considering whether there is an opportunity to improve the process concerning:

    a. the manner in which news or messages which, it might reasonably be expected, will be distressing to a detainee are communicated to that detainee; and

    b. the support provided to a detainee at a time when that detainee is delivered news or messages referred to in a paragraph (a) above.

2. That as a matter of priority, the Commonwealth:

    a. extend its 'ligature review' to all accommodation and bathroom areas within the Villawood Detention Immigration Centre (VIDC) as part of an Administrative Capital Works project; and

    b. commit to taking reasonable steps to remove ligature points identified in the ligature review.

Agency/Organisation

Commonwealth Government

Response

Awaiting Response

Inquest into the death of Michael Sanderson (Ref: 202200318454)

Recommendation

To Justice Health NSW, that consideration be given to:

1(a). A requirement that Justice Health NSW clinicians consult an inmate to see if they wish to provide a 'Consent to Liaise' with their next of kin concerning their health status, as soon as possible after an inmate receives an advanced cancer diagnosis and/or starts receiving palliative care; and

1(b). That actioning such a requirement should occur prior to an inmate's transfer to Long Bay Hospital, and that if not done prior to transfer, must occur at the time of reception at Long Bay Hospital; and

1(c). A requirement that consultation with an inmate to see if they wish to provide a 'Consent to Liaise' with next of kin must occur when an inmate is identified as suffering from a 'Chronic Condition' under JHNSW policy and updated at subsequent Chronic Condition reviews.

To the Commissioner of Corrective Services NSW, that consideration be given to:

1. Amending the final paragraph of Part 6.2 of the Custodial Operations Policy and Procedures (COPP) 19.6, concerning prohibitions on giving items to inmates, to refer to the potential for exceptions to be made in the case of end of life visits or palliative care visits; and

2. Ensuring there is consistency between COPP 19.6 and the current in so far as they relate to end of life/palliative care visits.

Agency

Justice Health NSW
Corrective Services NSW

Response

Justice Health NSW

Justice Health NSW fully supports 1(a) and 1(b) of this recommendation. Recommendation 1(c) is supported however will require further consideration due to the large number of patients with a chronic condition in custody. The recommendation will be implemented into policies and procedures that apply across all facilities and services within Justice Health NSW, including the Palliative Care Model of Care and Procedure 6.127 Managements of Patients with a Chronic Condition.

- In July 2025, the recommendation was tabled at the Justice Health NSW Close the Loop Committee for monitoring and tracking of completion. The Close the Loop Committee monitors and tracks progress of Serious Adverse Event Review and coronial recommendations.
- (Recommendation 1a and 1b) Complete current review of the Justice Health NSW Palliative Care Model of Care and ensure the coronial recommendation is incorporated.
- (Recommendation 1c) Conduct review of Justice Health NSW Procedure 6.127 Managements of Patients with a Chronic Condition for feasibility of inclusion of recommendation 1(c), and consideration of how this will be monitored. The Primary Care Directorate will complete the review, with oversight provided by the Close the Loop Committee. Status: in progress- anticipated completion date June 2026.

Corrective Services NSW

1. Corrective Services NSW supports the recommendation to amend the final paragraph of Part 6.2 of COPP 19.6 concerning prohibitions on the giving of items to inmates, to include reference to the potential for exceptions in cases involving end-of-life or palliative care visits. CSNSW is in the process of determining the most suitable way to implement this recommendation

2. Corrective Services NSW supports the recommendation to ensure consistency between COPP 19.6 and the current Local Operating Procedures (LOP), specifically in relation to the management of end-of-life and palliative care visits. CSNSW is in the process of determining the most suitable way to implement this recommendation

Inquest into the death of Emmett Brown (Ref: 202200375404)

Recommendation

To the Commissioner of Corrective Services NSW (CSNSW)

1. CSNSW review its written procedures and training concerning the confirmation of an inmate's physical wellbeing during the conduct of "head-check" procedures having regard to the findings made in this Inquest. This extends to:

   a. Reviewing Custodial Operation Policy and Procedure 5.3 – *Musters, Let-go and Lock-in*, to provide more detailed instruction about how an officer is to confirm an inmate's physical wellbeing during head-check. That includes ensuring clearer instruction as to whether a verbal and physical response is required from the inmate and how the officer can satisfy him or herself.

   b. Reviewing the sufficiency of the training provided to recruits and serving officers with respect to the procedure referred above in (a) and conducting refresher practical training for all custodial staff who conduct head-checks on inmates.

   c. Reviewing the Local Operating Procedures (LOPs) that concern the conduct of head-checks / let go procedures, applicable at the Shortland Correctional Centre and other Correctional Centres operated by CSNSW, to ensure there is consistency between the LOPs, Custodial Operations Policy and Procedures (COPP) 5.3 and the practices employed at those centres.

2. CSNSW review its written procedures and training concerning incident response and reporting in the event of medical emergencies and/or deaths in custody. That extends to:

   a. Requiring the separation of each involved officers, as soon as reasonably practicable and subject to operational considerations for the safety and security of the facility, until each officer has completed and submitted his or her incident report (including providing non-exhaustive guidance as to the type of instances in which operation considerations might prevail and what other arrangements might reasonably be effected to avoid that occurring).

   b. Mandating that, wherever possible, involved officers are not to discuss the event with each another or be present when others are discussing the event or reviewing any video evidence or be present when that evidence is being reviewed, until completion and submission of his or her incident report.

   c. Requiring a senior officer to assume responsibility for managing and supervising the initial incident reporting process.

   d. Ensuring there is clear guidance about what constitutes a medical emergency and when the abovementioned requirements are expected to be followed.

To the Chief Executive Officer, Justice Health and Forensic Mental Health Network

1. Justice Health examine the arrangements and resourcing regarding the wait times for Drug and Alcohol assessments and reviews with the aim of reducing wait times.

Agency

Corrective Services NSW
Justice Health Forensic Mental Health Network

Response

Corrective Services NSW

1. **(Recommendation 1(a))** Head-checks are conducted prior to 'let-go', during which inmates are identified using available records and staff confirm the inmate's wellbeing through verbal interaction and visual observation. Where an inmate displays signs of distress or harm, they must be assessed for risk of self-harm or suicide. Notwithstanding current practice, Corrective Services NSW is committed to reviewing the relevant policy to ensure clear guidance is provided to staff regarding head-check procedures. This includes instructions for confirming inmate health and wellbeing in circumstances where 'let-go' does not occur, such as during industrial action or when variable operating routines are in place.

2. **(Recommendation 1(b))** Corrective Services NSW supports the implementation of this recommendation. Once the policy is updated, CSNSW will notify staff and review primary training to ensure consistency with the policy update.

3. **(Recommendation 1(c))** Corrective Services NSW supports this recommendation and is currently considering how best to ensure procedural consistency across centres and alignment between LOPs, COPP 5.3, and operational practice.

4. **(Recommendation 2(a))** The COPP requires each officer to independently prepare reports for serious incidents and this practice is applied where there has been a death in custody. While every effort is made for staff members to prepare reports as soon as practicable, physical separation of staff members may not always be possible in all centres where staff need to consider the broader operational priorities involved in ensuring the correctional centre continues to operate at maximum capacity, while simultaneously managing a serious incident.

5. **(Recommendation 2(b))** Corrective Services NSW supports this recommendation, implementation of this recommendation is currently under consideration.

6. **(Recommendation 2(c))** Corrective Services NSW supports this recommendation, however, it is noted that senior officers must also manage broader operational priorities to ensure the continued safe and effective functioning of correctional centres. As such, direct supervision of the report-writing process may not always be practicable. Involved staff remain responsible for ensuring compliance with the Custodial Operations Policy and Procedures (COPP) incident reporting requirements, while also meeting the operational demands of the centre.

7. **(Recommendation 2(d))** The COPP 13.2 – Medical Emergencies already provides clear guidance on what constitutes a medical emergency and outlines the associated procedural requirements. As such, further amendment is not considered necessary.

Justice Health Forensic Mental Health Network

Justice Health NSW supports the recommendation and remains committed to ongoing service improvement aimed at supporting the better health outcomes for patients in custody. Justice Health NSW has made a concerted effort to respond to this recommendation through implementation of targeted strategies to improve access and reduce wait times for Drug and Alcohol Assessments, particularly in relation to Opioid Agonist Treatment (OAT):

- Established virtual care drop-in clinics to enable timely access to treatment and care, enhanced service flexibility and refined follow up review processes to ensure continuity and quality of care post-initiation

- Reviewed and implemented a more responsive OAT induction process, to initiate patients on a stable dose sooner
- Amended internal procedures and clinical guidelines to enable earlier OAT commencement in a patient's custodial journey, including enabling initiation shortly after reception into custody rather than waiting until sentencing
- Reviewed the Model of Care and enhanced service delivery of the drug and alcohol intake assessment processes. This led to an increase in the number of OAT assessments within the existing Drug and Alcohol Medical Officer and Nurse Practitioner clinic structure

Inquest into the death of Hari Tapani Jokinen (Ref: 2022000002500)

Recommendation

To the Commissioner of Police

1. Amend the Safe Driving Response and Operations Guideline (SDROG) to mandate that a pursuit can be commenced only if police are satisfied that a serious risk to the health and safety of a person existed before the decision to intercept or stop the vehicle.
2. Make clear in the terms of the SDROG, and in any relevant training, that the above test is the threshold for a police pursuit.
3. Amend the SDROG to expressly provide that upon a pursuit being called the relevant pursuit supervisor must, as soon as practicable, ask the pursuing officer to identify the serious risk to health or safety of a person that existed before the decision to intercept or stop the vehicle, and give independent consideration to whether that threshold is met.
4. Ensure that state-wide mandatory training be provided to all NSW Police Force officers on the threshold test for police pursuits.
5. Mandate that the serious risk to the health and safety of a person that existed before the decision to stop or intercept a vehicle be recorded for every police pursuit.

Agency

NSW Police Force

Response

Recommendation 1: The NSW Police Force (NSWPF) respects the intent of this recommendation and the Coroner's focus on public safety, especially in light of the tragic circumstances surrounding Mr Jokinen's death. The Safe Driving Response and Operations Guideline (SDROG) requires officers to undertake a dynamic risk assessment before and during any pursuit, weighing all known risk factors and the immediacy of the situation. This approach reflects significant policy reform, aiming to ensure that every decision is made with the utmost care for public and officer safety. It is accepted that further guidance and training can be given to officers in respect to the decision to initiate and continue a pursuit. The concerns highlighted by the Coroner in respect to the policy being subjectivity interpreted by officers is acknowledged. It is necessary to also appreciate that recommendations 2 to 5 are inextricably linked to the adoption of recommendation 1. The proposed threshold of requiring the existence of "a serious risk to the health and safety of a person" prior to a pursuit being initiated may have unintended adverse consequences. Several traffic offences may not meet this threshold for pursuits in every circumstance, however they still pose significant risks to the community and efforts should be made by police to stop drivers contravening the law. Due to the multitude of circumstances that exist when police attempt to stop vehicles there is a requirement to balance the need for operational flexibility with the imperative to minimise harm. The NSWPF is committed to the ongoing review and improvement of policies and will continue to consider the merits of any proposed recommendation as part of the continuous improvement process.

Recommendation 2: The NSW Police Force appreciates the Coroner's emphasis on clarity and consistency in pursuit policy and training and support that aspect. The current approach, as reflected in the updated Guidelines, emphasises the need for a dynamic risk assessment for each situation, rather than a single, fixed threshold. This model allows officers to continuously assess the unique and sometimes unpredictable circumstances of each pursuit, balancing the need for action with the imperative to minimise risk. The NSWPF is committed to ensuring that training and guidelines reinforce the importance of sound judgement, critical thinking, and ongoing evaluation. The requirement for ongoing investment in training, as highlighted in the Coroner's findings and Dr Adamson's letter is acknowledged. The NSWPF is exploring ways to further enhance training programs, including more comprehensive and scenario-based learning.

Recommendation 3: The NSW Police Force fully supports the principle of strong supervisory oversight during pursuits and recognises the value of independent review. As stated, the NSWPF has reservations in respect to the specific wording of recommendation 1. The updated Guideline requires supervisors to closely monitor pursuits and ensure that risk assessments are ongoing and informed by the best available information. Supervisory oversight is a requirement of the operational framework, promoting real-time, decision making by officers and supervisors. The NSWPF is mindful of the psychosocial impacts on officers involved in pursuits, as noted in the Coroner's findings. NSWPF agree that providing support and guidance in such circumstances is essential.

Recommendation 4: The NSW Police Force is committed to providing comprehensive, state-wide training on pursuit decision-making. This is a key component of current training programs. The issues raised in respect to the adequacy of training and the need for ongoing education, as highlighted in both the Coroner's findings and Dr Adamson's letter is acknowledged. Current training emphasises the need for critical thinking skills, dynamic risk assessment, and careful consideration of all relevant factors, including the seriousness of the offence, road and weather conditions, and available alternatives. The NSWPF is actively exploring opportunities to further enhance our training, including simulation-based programs and enhanced processes for the administration of pursuits.

Recommendation 5: The NSW Police Force strongly values accountability and thorough documentation in all aspects of policing. The need for clear and consistent record-keeping is acknowledged as part of the continuous improvement process. Requiring the recording of a "serious risk" as a prerequisite for every pursuit may not always align with the practical realities faced by officers in the field, particularly in dynamic and unpredictable situations. The NSWPF remain committed to the ongoing review of appropriate recording and documentation of incidents. The NSWPF continues to explore ways to enhance systems to ensure they are fit for purpose and support both public safety and officer accountability. We also acknowledge the importance of honest and respectful communication with families affected by critical incidents and are working to improve our practices in this area.

Inquest into the death of SF (Ref: 202200218649)

Recommendation

To the Commissioner of Corrective Services NSW

1. That CSNSW provide training to frontline correctional officers in respect of the management of an inmate's request for protection or alternative cell placement, including in respect of:
   - the applicable policies;
   - the persons authorised to administer the Assessment Tool – Inmates under Threat; and
   - the requirement or expectation that the Assessment Tool – Inmates under Threat be administered as soon as reasonably practicable or, in the event of policy amendment, within the stated period for completion.
2. That CSNSW reviews its policies and consider imposition of a requirement that where it is determined that an inmate:
   - may be at risk from others; or
   - requires alternative cell placement as a result of a threat to the personal safety of the inmate; or,
   - requires alternative cell placement as a result of a request by the inmate due to fears for their personal safety;

completion of the Assessment Tool – Inmate under Threat, occur within four hours unless in exceptional circumstances.

Agency

Corrective Services NSW

Response

Recommendation 1: Corrective Services NSW supports this recommendation. Relevant content is included in the Primary Training Program under "Duty of Care – Offender Management." SAS Quality Assurance and Continuous Improvement is reviewing whether the current training sufficiently addresses COPP 3.2 – Protective Custody, with initial analysis indicating that additional material may be required. E-Learning will work with the Custodial Training Unit to ensure appropriate online training is developed and delivered. While no formal training currently exists on the use of the Assessment Tool – Inmates Under Threat, CSNSW will work to develop suitable online training outlining the tool's purpose, function, and the roles authorised to administer it. While no current training addresses the timely administration of the Assessment Tool – Inmates Under Threat, CSNSW work to ensure updated online training includes clear guidance on timeframe expectations, consistent with policy requirements or future amendments.

Recommendation 2: Corrective Services NSW supports this recommendation and is in the process of determining the most suitable way to implement this recommendation.

Inquest into the death of James Joseph Cunneen (Ref: 201900407715)

Recommendation

1. The Inspector of Custodial Services and the Minister for Corrections be furnished with a copy of the transcript of these proceedings and the findings of the Coroner.

2. In tangent with Justice Health and Forensic Mental Health Network and considering existing Between the Flags guidelines, St Vincent's Correctional Health and other service providers operating in the custodial health space, including those for publicly and privately operated correctional centres, consider updating policy material to provide guidance regarding the timeframes required for medical practitioner review for a patient when medication has been prescribed for an acute condition.

3. The Commissioner of Corrective Services and the Minister for Corrections be furnished with a copy of the transcript of these proceedings and the findings of the Coroner.

4. The Commissioner of Corrective Services, having regard to input from Justice Health and Forensic Mental Health Network, take steps to ensure that Management and Training Corporation remains compliant with its contractual obligations with respect to the number of correctional and health staff it is contracted to provide.

5. The Commissioner of Corrective Services, and the State, give immediate consideration to the redevelopment of the Main Clinic at Parklea Correctional Centre, including the observation cells within the clinic, to ensure a clean, hygienic, and safe environment and one which is fit for the purpose of operating a medical clinic and accommodating patients in cells within the clinic.

Agency

Corrective Services NSW
Custodial Services NSW
Justice Health Forensic Mental Health Network

Response

Custodial Services NSW

The *Inspector of Custodial Services Act 2012* (s.6 (a)) requires each adult custodial centre to be inspected at least once every five years. The last inspection of Parklea CC took place in November/December 2020, almost one year after the death of Mr Cunneen on 28 December 2019, and the ICS made observations and 18 recommendations relating to the provision of health services at Parklea CC in the Inspection of Parklea Correctional Centre report tabled in 2022.

I am writing to inform you that I intend to conduct an inspection of Parklea Correctional Centre in accordance with the Terms of Reference. The inspection will commence in late 2025 and focus on the provision of health services during the transition phase, leading up to the expiration of the private contract with Management Training Corporation Pty Ltd (MTC Australia) and return of Parklea Correctional Centre to public hands in October 2026. It will also be an opportunity to assess whether the recommendations made following our last inspection have been implemented, and the systemic issues identified by the Coroner are being addressed. It is anticipated that findings and recommendations from this inspection will be relevant to both the private operators (MTC and St Vincent's Correctional Health) and the State (Corrective Servies NSW and Justice Health and Forensic Mental Health Network).

Justice Health Forensic Mental Health Network

Justice Health NSW fully supports this recommendation to consider updating policy material to provide guidance regarding the timeframes required for medical practitioner review for a patient when medication has been prescribed for an acute condition. Actions taken and planned by Justice Health NSW in response to the recommendation include:

- Policies for update have been identified for consideration, including Policy 6.138 *Recognition and Management of Patients who are Deteriorating;* Policy 4.032 *Prioritising Patients on Waitlist;* and Policy 6.049 *Medication guidelines*
- Recommendation for policy updates were tabled at Justice Health NSW Close the Loop Committee on 14 October 2025 for monitoring and tracking of completion. The Close the Loop Committee monitors and tracks progress of Serious Adverse Event Review and coronial recommendations
- Review of policies and consultation in consultation with stakeholders

Corrective Services NSW

To ensure compliance with contractual obligations, Management and Training Corporation (MTC) must maintain appropriate health services staffing levels to support holistic healthcare and timely access to required interventions. MTC is required to report monthly on its staffing profile, including health services. Where staffing concerns are identified—either through contractual review or raised by Justice Health—CSNSW will take appropriate action under the contract to ensure service delivery standards are met.

CSNSW accepts the recommendation and will give consideration to refurbishment works at the Main Clinic at Parklea Correctional Centre, including the observation cells, in alignment with infrastructure priorities and available resources across the Corrective Services program of works. A new clinic, constructed under the Prison Bed Capacity Program, commenced operation in February 2020 and complements the existing Main Clinic.

Inquest into the death of Lathan Brown (Ref: 202400008248)

Recommendation

To the Commissioner of Corrective Services NSW

1. That consideration be given to adopting a procedure at Wellington Correctional Centre that would require at least one incoming and one outgoing officer to be present, so far as possible, in the J Block officers' station, during the handover period between A and C watches, in order to facilitate the timely response to knock-up calls requiring an urgent response.

2. That action be taken to investigate and, if appropriate, implement measures to improve the quality of the audio from knock-up calls heard in the monitoring room at Wellington Correctional Centre, including if appropriate by restoring the availability of a functioning handset, and take steps to ensure that monitor room staff are aware of the available hardware for answering knock-up calls.

3. The Custodial Operations Procedure and Policy (COPP) 13.2 be amended by the inclusion of a policy that addresses the following:

    a) A requirement for the Governor or OIC to delegate a sufficiently senior correctional officer or other staff member to liaise with the ECP in circumstances where the death of an inmate transferred to hospital may be imminent.

    b) The Governor or OIC or delegated officer must provide the inmate's Emergency Contact Person (ECP) with a contact name and telephone number of a medical professional at the hospital or medical facility to enable the ECP to have a point of contact with them for ongoing communication.

    c) The Governor or OIC or delegated officer being an ongoing point of contact for an inmate's ECP including in terms of any planned transfers.

    d) The Governor or OIC or delegate must otherwise facilitate contact and arrangements between hospital staff and the inmate's family.

Agency

Corrective Services NSW

Response

1. CSNSW acknowledges the recommendation and has discussed the proposal with local management. CSNSW is exploring the feasibility of assigning an identified position to remain at the J Block officers' station during shift handover to support timely responses to urgent knock-up calls. Implementation is subject to consultation with relevant unions, and if agreed, the change will be reflected in the Post Duties of the designated position.

2. CSNSW supports the recommendation. The contracted security company has investigated the audio quality of knock-up calls at Wellington Correctional Centre and identified issues with the existing handset. A replacement handset has been ordered and will be installed on a wall mounted bracket to prevent operational issues. All calls continue to be received correctly via the monitor room master station. Monitor room staff will be made aware of available hardware to ensure effective response to knock-up calls.

3. CSNSW supports the recommendation in principle. COPP 13.2 already provides for Emergency Contact Person (ECP) notification when an inmate's condition becomes life-threatening. It is proposed that section 2.2 be amended to require the Governor or Officer in Charge (OIC) to provide the ECP with a contact name and number for ongoing communication with the centre. While CSNSW cannot provide health updates, these remain the responsibility of NSW Health, the Governor or OIC can notify the ECP of transfers and visit arrangements. Appointment of a family liaison officer is supported in principle, with duties limited to facilitating contact and logistical arrangements, not medical updates.

Inquest into the death of Michael Black (Ref: 202000121160)

Recommendation

To the Chief Executive of MTC-Broadspectrum Pty Limited (MTC)

1. MTC review its procedures, instruction, and training as regards the conduct of Segregation Review Committee reviews and the formal lifting of segregation directions, having regard to the findings in these proceedings. This includes, but is not limited to, the importance of documenting reviews and the factors that were considered in determining whether or not to lift a segregation direction (including the appropriate record keeping and/or file management for that documentation).

2. MTC review its procedures, instruction, and training as regard when an inmate should be considered for referral to the High Security Inmate Management Committee for consideration of designation pursuant to Corrective Services NSW (CSNSW) Custodial Operations Policy and Procedure 3.5 (e.g., High Security or Extreme High Security), having regard to the findings in these proceedings.

3. MTC review its procedures with a view to expressly stipulating that specific correctional officers or supervisors who are working in the Reception Area in a given shift must expressly monitor the number of inmates placed in holding cells at a given time and to take steps to prevent unsafe numbers in these cells (including providing instruction on what action to take if an officer is concerned about cell numbers), having regard to the findings in these proceedings.

4. MTC urgently review its current limits on the maximum number of inmates that can be safely held in the cells within the Reception Area of Parklea Correctional Centre, having regard to the findings in these proceedings (this extends to potentially seeking advice from a work health and safety expert in this respect).

5. MTC review any training and instruction it provides Immediate Response Team members in responding to a violent encounter within a cell having regard to any lessons that might be drawn from the events on 22 April 2020 and the findings in this matter (separate to that provided externally by the Corrective Services Security Operations Group).

To the Commissioner of Corrective Services NSW and the Chief Executive of MTC

6. CSNSW and MTC review its arrangements concerning the provision of Serious Incident Reports completed by CSNSW into the death of an inmate at an MTC-operated correctional centre to MTC, having regard to the findings made in these proceedings.

Agency

MTC-Broadspectrum Pty Limited
Corrective Services NSW

Response

Corrective Services NSW

CSNSW supports the recommendation. A process is being finalised to provide MTC with the finalised Serious Incident Reports (SIRs) into deaths at MTC-operated centres, following submission to the Coroner.

Awaiting Response from MTC-Broadspectrum Pty Limited

Inquest into the death of Dushyanthan Visvanathan (Ref: 201900302386)

Recommendation

To Justice Health and Forensic Mental Health Network

1. That the drug and alcohol substance withdrawal monitoring form used by Justice Health be amended to incorporate, firstly, guidance regarding the frequency of observations recommended for patients in alcohol withdrawal, and secondly, a field which can be used by practitioners to indicate the plan for the frequency of observations for the patient.
2. That consideration be given to sending out or publishing a short communication to Justice Health staff which emphasises the importance of proper ventilation during CPR.
3. Consideration be given to seeking an allocation of funding from the Ministry of Health, for the staffing of drug and alcohol remote offsite and after-hours medical service shifts until 11pm with an on-call service to continue to be provided from 11pm onwards.

Agency

Justice Health and Forensic Mental Health Network

Response

1. Justice Health NSW supports this recommendation, with the following actions underway and planned:
   - Justice Health will transition to the Single Digital Patient Record (SDPR) in March 2026
   - On 23 October 2025, Justice Health made contact with the Secretariat for the SDPR, Alcohol & Other Drugs Steering Committee Group, to advise them of the recommendation
   - On 27 October 2025, advice was received that AWS form is currently undergoing validation by the Alcohol & Other Drugs Steering Committee Group, and will be accompanied by information to guide clinicians on how frequently vital observations and the Alcohol Withdrawal Scale should be completed based on patient withdrawal scores
2. Justice Health NSW supports and has actioned this recommendation to publish a communication to emphasise the importance of proper ventilation during cardiopulmonary resuscitation (CPR). This work was completed in alignment with the ongoing Emergency Response Initiatives currently underway, including roll out of revised emergency response guidelines and an updated emergency response form along with new emergency response bags and changes to equipment.
3. Justice Health NSW supports the intent of this recommendation, and is liaising with the NSW Ministry of Health, including the Centre for Alcohol and Other Drugs

Inquest into the death of Matthew Lothian (Ref: 202100004815)

Recommendation

To the Justice Health and Forensic Medicine Network and the Commissioner of Corrective Services NSW

1. Justice Health NSW and Corrective Services NSW consider the benefits of therapeutic psychological services being provided by Justice Health NSW, including how such services would be funded.

To the NSW Attorney General and to the NSW Minister for Corrections:

2. That there be an urgent review of the legislation and regulations relating to the use of firearms by officers of Corrective Services New South Wales, and, in particular, cl 299 of the Crimes (Administration of Sentences) Regulation 2014, having regard to the findings in the inquest into the death of Mathew Richard Lothian.

To the Commissioner of Corrective Services NSW:

3. That Corrective Services NSW urgently develop serviceability criteria for the assessment of whether holsters and associated equipment related to the retention of firearms are in proper operational condition and develop training for correctional officers in the assessment of the condition of that equipment according to that serviceability criteria.
4. That an urgent audit be undertaken of all armouries to identify and remove any holsters and associated equipment related to the retention of firearms that may not be in proper operational condition.

Agency

Corrective Services NSW / NSW Minister for Corrections
Justice Health and Forensic Mental Health Network

Response

Corrective Services NSW / NSW Minister for Corrections

1. CSNSW notes the recommendation to expand psychological services through Justice Health. CSNSW psychologists provide comprehensive, therapeutic care tailored to the correctional environment, with continuity between custody and community being critical to rehabilitation and public safety. All psychologists are bound by the same confidentiality standards, and refusal to engage with CSNSW psychologists is rare (approx. 0.5%). CSNSW will continue to strengthen its psychological services, including exploring supplementary support where appropriate, ensuring any expansion is properly funded and integrated.
2. CSNSW supports the recommendation. Serviceability checks for holsters and related equipment, as well as weapon retention procedures, have been incorporated into all weapons training courses. This includes primary training and firearm recertification for existing staff.
3. CSNSW supports the recommendation. An audit of all CSNSW armouries has commenced to identify and remove holsters and related equipment that are not in proper operational condition.

Justice Health and Forensic Mental Health Network

Justice Health NSW supports the recommendation and will work in partnership with Corrective Services NSW to explore options on how best to ensure inmates with health needs have access to psychological supports.

Inquest into the death of BQ (Ref: 202100205817)

Recommendation

1. That the Chief Executive Officer of the NSW Trustee and Guardian make arrangements to provide First Nation's cultural competency training to all NSW Trustee and Guardian staff with a priority to those working with Aboriginal and Torres Strait Islander clients (and with consideration to periodically repeating such training).
2. A copy of the Court's findings into the inquest into the death of BQ be referred to the New South Wales Attorney General.

Agency

NSW Trustee & Guardian

Response

Awaiting Response (not due until 29 March 2026, after time of printing of this report)

Inquest into the death of Frank Coleman (Ref: 202100196736)

Recommendation

To the Chief Executive, Justice Health and Forensic Mental Health Network NSW (Justice Health)/ the Commissioner, Corrective Services NSW:

1. Justice Health, in coordination with Corrective Services NSW, review the models of care and resourcing of Drug and Alcohol assessments for the commencement of opioid agonist therapy (OAT), with a view to increasing access and capacity, and:
    a) Produce a joint report estimating unmet need in the public jail system and outlining the optimum wait time
    b) Produce a joint mapping report indicating what resources would be necessary to achieve the optimum wait time (including staffing and infrastructure needs)
2. Justice Health, in coordination with Corrective Services NSW:
    a) Assess the viability of Drug and Alcohol reviews being conducted via telehealth, including in-cell, and if deemed viable
    b) Trial providing Drug and Alcohol reviews by in-cell telehealth

Agency

Justice Health and Forensic Mental Health Network
Corrective Services NSW

Response

Correctives Services NSW

1. CSNSW supports the recommendation in principle. CSNSW will contribute to the joint reporting process by providing input on the security and resourcing required to support timely access to health appointments, once optimum wait times are determined by Justice Health.
2. CSNSW notes the recommendation and is cognisant of significant technological, infrastructure, and security constraints in relation to implementation of this recommendation. In-cell telehealth for Drug and Alcohol reviews is currently impractical given privacy concerns, physical environment limitations, and lack of funding. CSNSW is not resourced to implement this model at this time.

Awaiting Response from Justice Health and Forensic Mental Health Network (not due until 22 April 2026)

Inquest into the death of Bradley Balzan (Ref: 202000365139)

Recommendation

To the Commissioner of Police, NSW Police Force

1. The NSW Police Force amend the Body Worn Video (BWV) Standard Operating Procedures to reflect that, in circumstances where BWV should have been activated but an officer failed to do so, the officer must record the reasons for non-activation, for example in the relevant COPS Event or in their police notebook.
2. The NSW Police Force:
    a) mandate that, at a minimum, officers must activate BWV when using statutory powers, or when it is likely that an interaction may lead to the exercise of statutory powers, and
    b) reflect this policy in any future Standard Operating Procedures or Guidelines that mention BWV use.
3. The NSW Police Force include in any future BWV Standard Operating Procedures or guidelines a 'definitions' section which defines directions (e.g. 'must') and key terms (e.g. 'operational policing').
4. The NSW Police Force consider developing a standard operating procedure for the conduct of Partnership Against Crime Taskforce (PACT) patrols, including with respect to:
    a) General directions or guidance about constructive detention, the exercise of s 21 powers (of the Law Enforcement (Powers and Responsibilities) Act 2002 (NSW)), and the use of reasonable force in proactive patrol situations (including identifying whether, in certain circumstances, people should be informed that they are not mandated by law to stop and answer questions if they do not wish).
    b) General directions or guidance as to possible techniques, language, and actions that can be appropriately utilised in approaching and engaging persons on PACT patrols when powers of detention are not enlivened or being exercised.
5. NSW Police Force review the training provided to officers assigned to PACT duties, and consider implementing training specifically for such officers, in relation to the conduct of PACT patrols, including with respect to:
    a) Instruction about constructive detention, use of reasonable force and the exercise of s 21 powers (of the Law Enforcement (Powers and Responsibilities) Act 2002 (NSW)) in proactive patrol situations.
    b) Instruction about how possible techniques or strategies in proactive patrol situations (language, approaches, etc) to minimise the risk of (i) constructive detention and (ii) escalation (including potential strategies to deescalate encounters).
    c) Use of practical scenario training in providing the above training, with consideration given to using scenarios where a person does not want to engage with police as part of scenario training. At the request of Bradley's family, the scenario which led to Bradley's death should not be used.
6. NSW Police Force consider reviewing all use of force manuals (including the Tactical Options Use of Force Manual and the Oleoresin Capsicum Defensive Spray Manual) to ensure consistency in the inclusion of a direction to use communication as a tactical option and issue a clear verbal warning before deployment of other tactical options which involve the application of force, where reasonably practicable.
7. NSW Police Force consider amending the relevant use of force manuals to authorise plain clothes police who have been trained in the use of tasers to carry and use tasers where appropriate, with specific consideration being given to the authorisation in this respect of officers assigned to PACT duties.

Agency
NSW Police Force
Response
Awaiting Response (not due until 13 May 2026, after time of printing of this report)

Inquest into the death of Benjamin Cullen (Ref: 202100055427)

Recommendation
To St Vincents Correctional Health 1. That St Vincent's Correctional Health, in consultation with MTC, the Justice Health, and Forensic Mental Health Network and Corrective Services New South Wales, explore options for real time documentation of medication, administration, and or supply in the electronic medication administration record **To MTC Broadspectrum** 2. That MTC Broadspectrum, in consultation with St Vincent's Correctional Health, review its processes at discharge, including the terms of the discharge checklist completed with inmates shortly prior to their release from custody to ensure its discharge processes are compliant with Corrective Services New South Wales's policies and procedures, including but not limited to COPP 23.2
Agency
St Vincent's Correctional Health MTC-Broadspectrum Pty Limited
Response
Awaiting Responses (not due until 8 June 2026, after time of printing of this report)

Inquest into the death of MQ (Ref: 202300074236)

Recommendation

To the Commissioner of the NSW Police Force

1. That consideration be given to having the St George Police Area Command review its practices, procedures and training regarding the taking of phone calls of matters which require a job to be created on the CAD system. This review should ensure that such processes are sufficiently robust and reliable, and that the New South Wales Police Force may respond appropriately to such jobs in accordance with its polices and standard operating procedures.

Agency

NSW Police Force

Response

Awaiting Responses (not due until 17 June 2026, after time of printing of this report)

Office of the NSW State Coroner
NSW Department of Communities and Justice