
# CORONERS COURT

# OF NEW SOUTH WALES

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| **Inquest:** | Into the death of John Pocklington |
| **File number:** | 2015/141693 |
| **Hearing dates:** | 13 July 2020 |
| **Date of findings:** | 29 July 2020 |
| **Place of findings:** | Coroners Court, Lidcombe |
| **Findings of:** | Deputy State Coroner E. Truscott |
| **Catchwords:** | Coronial Law - Death in Custody - Natural Causes - Care and Treatment - Resuscitation |
| **Representation:** | **Counsel Assisting**: Jason Downing instructed by Ms S Najjar, Crown Solicitors Office<br>**Pocklington Family**: Ms J Finlay, Legal Aid Commission, NSW<br>**Commissioner Corrective Services**: Ms J de Castro Lopo<br>**Justice Health Forensic Mental Health Network**: Mr Rooney instructed by Ms K Hinchcliffe, Makinson d'Apice Lawyers<br>**Mr Mariner and Mr Dally**: Mr J Kellaway instructed by Mr M Jaloussis, McNally Jones Staff Lawyers |
| **Findings:** | **Identity** John Pocklington<br>**Date of Death** 12 May 2015<br>**Place of Death** Metropolitan Remand & Reception Centre Silverwater NSW 2128<br>**Cause of death** Acute Myocardial Infarction<br>**Manner of death** Natural |
| **Non-publication Orders**<br>**S 65 & 74 Orders** | See Orders made under sections 74 and 65 on 15 July 2020 |

IN THE CORONERS COURT

LIDCOMBE

NSW

Section 81 *Coroners Act 2009*

**REASONS FOR DECISION**

1. This is an inquest into the death of John Pocklington as required under sections 23(d) (ii) and 27(1) (b) of the *Coroners Act* 2009 as Mr Pocklington died whilst in the lawful custody of New South Wales Corrective Services.

**Introduction**

2. John Pocklington was born on 31 July 1983 and was 31 years of age at the date of his death. John was one of six children to Vicki and Greg Pocklington. Vicki and Greg met during their teenage years and were married at the age of 18. They had four sons and two daughters and John was their fourth child.

3. The family initially lived in Revesby then moved to Padstow. Vicki and Greg separated in about 2000. After the separation, Vicki remained in the then family home in Padstow which remained John's home address up to the time of his death. John was very close to his family particularly his mother who imagined that he would be living with her always. His early death has taken a terrible toll on Vicki and all of John's family members.

4. John started his schooling at Revesby South Public School. However, his mother identifies a violent incident which occurred at the school when John was about 7 years of age. Vicki said John was left highly traumatised and since that time he would refuse to attend school. Although John enrolled at other schools Vicki indicates that nothing either she or the schools could do would assist to ensure John's attendance and consequently, John did not complete primary school.

5. Vicki describes that John taught himself to read sufficiently. She said that John was very skilful and had intuitive skills with his hands. He learned mechanics from his father and was adept at most tasks involving mechanics and building. He built his own motorised scooter when he was a teenager and could fix almost anything. John loved music, loved riding his bike and found freedom being alone. He was always very well groomed and very tidy. He was strong-willed, pushed boundaries and was a non-conformist. He was tremendously loyal to his family and friends and he is of course much missed.

6. Vicki indicates that when John was about 15 years of age, he began associating with various boys who were involved in juvenile crime, which led to John going down a similar path.

**Offending**

7. On 31 May 2001, when John was 17, he was charged with multiple drug-related and firearm offences. In July he was charged with goods in custody offence and in March 2003 he was placed on an 18 month supervised bond and to undergo urinalysis. In June 2002 the drug and firearm matters were finalised with John being convicted and placed on similar bonds.

8. On 11 March 2004, John was charged with drug offences for which he was sentenced in December of that year to community service and a suspended sentence supervised bond to attend drug and alcohol rehabilitation and education.

9. When John was about 21 he began a relationship with a girl who lived with John at his mother's house but the relationship ended in October 2005 in an incident where John committed offences including detaining her in his car. In August 2007 John was sentenced to imprisonment. He served 15 months in prison and was released in June 2008.

10. Vicki Pocklington indicates that this period of imprisonment was a turning point in John's life. She indicates that because the girl was under 18 years of age, John was placed on the Child Protection Register offender's register, which disturbed him considerably. Vicki states that it was during that sentence when John was first diagnosed as suffering from schizophrenia and paranoia.

11. At the end of 2008 John was charged with failing to comply with the CPR obligations and remanded in custody and in June 2009 he received a concurrent sentence with offences of intimidate police. He was released on 13 September 2009.

12. In 2011, John was placed on supervised suspended sentence bonds for intimidate police and assault. In 2013, he was sentenced to Intensive Correction Orders for assaults. Those orders were called up by the parole board in May 2014 and John re-entered custody until his release on 3 January 2015.

13. John continued living with his mum in Revesby. On 14 April 2014, he was charged with further assault offences, damage property and offensive behaviour offences arising out of an incident at the Wood Chop Bar at the Easter Show. He was granted conditional bail with a restriction that he not be in a public place whilst affected by alcohol.

14. A few days later John was charged with intimidate police after saying something to a police officer when he attended the station to report on bail. He was granted bail in Parramatta Court but on 25 April 2014, whilst playing "two-up" at a pub, he became intoxicated and involved in an incident from which he was charged and refused bail. He

was also apparently in breach of his parole. It was whilst on remand for those matters that John died in custody.

**Mental Health and Drug Use**

15. On 31 May 2004, when John was 20 years of age, his Probation and Parole Officer Anne McCarthy conveyed him to Bankstown Mental Health Service because as she was interviewing John to prepare a pre-sentence report for John for a conviction of cultivation and possession of cannabis she became concerned about his welfare and mental state. The records indicate that John had been depressed and had thoughts of suicide. The attending mental health nurse recorded that John appeared angry and agitated at times, with "*vague suicide threats*".

16. The mental health nurse arranged a review which was performed by Dr Ali, a psychiatric registrar. From Dr Ali's notes of the afternoon of 31 May 2004, it appears that he obtained a history of John having some suicidal ideas in the past, though he had not made any clear attempt. Apparently Dr Ali found no evidence of psychosis or any perceptual disturbance. He raised a diagnosis of a personality disorder or some form of situational reactive depression.

17. Dr Ali offered to admit John to Bankstown Hospital which John declined. John also refused a prescription of antidepressants. Dr Ali was of the opinion that there were insufficient grounds to admit John as an involuntary patient.

18. However, about two weeks later John was admitted to Bankstown/Lidcombe Hospital for three days after being brought in by Police and scheduled as a mentally disordered person on 15 June 2004. The hospital notes indicate that the admission followed an incident where John, whilst intoxicated, assaulted his mother and possibly his sister and threatened to kill himself. The hospital records include a history of recent substance use, including three to four cans of beer per day, regular cannabis use and ecstasy use.

19. On 22 July 2004, John was referred to the Bankstown Mental Health Service for an assessment under s. 32 of the *Mental Health (Forensic Provisions) Act* 1990. The records refer to an admission to Bankstown Hospital five months previously for a drug induced psychosis. According to the records, John had reported a four-year history of amphetamine, cannabis and ecstasy use, though he apparently stated that he'd stopped cannabis use about five weeks ago.

20. The report created on 22 July 2004 indicates that John was high functioning, had a supportive family, was pleasant, cooperative and appropriate during the assessment and had a reactive affect. He was assessed as being at no risk for suicide, harm to self or harm to others and he was not diagnosed with any condition under DSM-IV.

21. On 26 September 2005, John attended the Padstow Parade Clinic, where he saw a Dr T Quach. Mr Pocklington presented with anxiety, major depression and a history of drug abuse and in that regard, he told Dr Quach he was a heavy smoker of cannabis and

occasional user of amphetamine. Three days later John was admitted to Bankstown/Lidcombe Hospital after being brought in by Police for a mental health assessment under s. 22 *Mental Health Act* 2007 because of threats to kill himself on 29 September 2005. The Emergency Department record refers to John having a background four-year history of polysubstance abuse, with cannabis, amphetamine and ecstasy.

22. During 2006, John was admitted to Bankstown/Lidcombe Hospital as an involuntary patient 24 -26 May 2006, due to experiencing an acute psychosis. At the time, John described urges to harm him-self and others. He had a further one-day admission on 31 May 2006 with feelings of irritation, racing thoughts and urges to harm himself and others.

23. John's mental health condition may then reasonably have been well controlled for a period, before another series of hospital admissions commencing in early 2011. He was admitted as an involuntary patient between 1- 2 March 2011 suffering acute psychosis.

24. John remained under the treatment of the community team of Bankstown Mental Health Service from 2011 – 2015, where he came under the care of Dr Casimir Liber, psychiatrist. Dr Liber notes that when she first saw John in May 2011, he had already been diagnosed with chronic schizophrenia and paranoia.

25. Dr Liber has indicated that John required high doses of medication to help him sleep and calm his levels of distress and paranoia. She treated him with high doses of Seroquel and Zyprexa (both antipsychotics). Dr Liber has indicated that over the period she saw him, John was a difficult patient, who was frequently non-compliant with his medication which would result in a deterioration of his mental health marked by increased paranoia and distress.

26. Vicki says in her statement that John was introduced to methamphetamine or "ice" when he was about 28 years old. This would be about 2011 and may account for some of the presentations of psychosis. On 26 February 2012, John presented to the Emergency Department (ED) at Bankstown/Lidcombe hospital complaining that he had shortness of breath following taking amphetamine that night and claiming someone had spiked his drinks. Handwritten notes record that a drug screen showed presence of amphetamines, benzodiazepine and cocaine.

27. On 24 May 2012, John again presented to the ED at Bankstown/Lidcombe Hospital stating that he had body aches all over, numb fingers and complained of vomiting and stiffness in his arms and legs and that he had been taking speed/ice for 2 days and had no sleep. An ECG was performed and it was queried whether "patient was contracting arms and queried a spasm". Another ECG was performed on 3 June 2012 when John attended the same hospital complaining that when he sat on his bed his heart was racing o/e febrile and this time he denied taking illicit medication but John discharged himself rather than wait for medical review.

28. On 13 October 2012, John was taken by police to Bankstown/Lidcombe Hospital under s. 22 of the *Mental Health Act* after becoming involved in a fight with three people at an

engagement party, apparently after someone said something derogatory about his sister. John was not admitted as the medical review determined that John was neither mentally ill nor mentally disordered presenting a serious risk of harm to himself or others. The records indicate that Mr Pocklington was under the care of Dr Liber at the time and as part of the discharge plan, he agreed to remain under Dr Liber's follow up care. Also recorded as part of the drug and alcohol history is that John had a history of polysubstance abuse and that he was positive for THC on the urine drug screen done in the ED. He was noted to be taking Seroquel, but with "*spasmodic compliance*".

29. On 13 March 2014 John was again taken by police to Bankstown/Lidcombe Hospital under s. 22 of the *Mental Health Act* to Bankstown/Lidcombe Hospital following an argument with staff and patrons at a hotel and making a threat to drive his utility through the front door. He was admitted as he was found to be aggressive and intoxicated and scheduled as a mentally disordered person. He was discharged the following day.

30. From reading the notes written by various Probation and Parole personnel who supervised John it is apparent that when in the community John disclosed that he would binge drink but denied illicit drug use sometimes saying that if he disclosed such they would only want him to stop or change which he was not interested in doing. He appeared selective in what he would disclose to Corrections staff and was only slightly more forthcoming when speaking to health professionals in a custodial setting.

**Final Period of Incarceration**

31. On 25 April 2015, John was arrested at a hotel after he apparently approached other patrons threatening to kill them and their families and blow up the pub. The police took John to the Redfern Police Station but shortly thereafter they called for an ambulance and John was conveyed to Royal Prince Alfred Hospital for a mental health assessment.

32. The ambulance record indicates that when paramedics arrived at Redfern Police Station, John was naked in the police cells. The records note that though John was able to initially respond to questions in an ordered fashion, his thoughts quickly changed to irrational and disordered and he expressed suicidal ideations and homicidal thoughts. John told ambulance officers that he had been non-compliant with his medications. The ambulance officers completed a request for a mental health assessment under s. 20 of the *Mental Health Act*.

33. At Royal Prince Alfred Hospital, John was found to be heavily intoxicated and/or sedated and incapable of engaging in a full mental health assessment. The psychiatric registrar telephoned John's mother on the morning of 26 April 2015. Vicki informed him that John had gone to the pub to play two up and that as far as she was aware he was compliant with Olanzapine and was seeing Dr Liber at the Bankstown Community Health Centre. Vicki expressed no concern about John being at risk of serious harm to himself or others.

34. John was discharged from Royal Prince Alfred Hospital on 26 April 2015 back into police custody who then returned to Redfern station at 7.00 am where he was charged with

offences arising from the pub incident. John was then conveyed to the Surry Hills Police Cells which is a transit corrections centre pending transfer to and placement in a reception prison. It is run by Corrections NSW and the Justice Health and Forensic Mental Health Network (the Network) provide medical services. He remained there for 2 nights.

35. The "New Inmate Lodgement & Special Instruction Sheet" and the "Inmate Identification & Observation Form" (IIO) were completed at 07:45 am on that day. Section 2 of the IIO contains questions about health and each box is ticked *"No"* relating to whether John used non-prescribed drugs, whether he had consumed alcohol in the last 24 hours and whether he had received any psychological or psychiatric treatment. Presumably either John responded to the officer's questions in that way or the officer took any refusal to answer as a "no". Whatever the case the answers recorded for those matters are not correct.

36. On 27 April John appeared by video-link before the Local Court and he was bail refused and he was remanded in custody to 11 May 2015.

37. Whilst John was at the Surry Hills police cells on 28 April 2015 he was attended to by a Registered Nurse McCann who was the Nurse Unit Manager. A statement has not been obtained from Ms McCann as she has left Australia and returned to live in Ireland. However, Ms McCann's Progress Notes records *"Pt (patient) knocking up stating "heart pain" – called up for triage. Allergic to Fish/prawns – throat swelling. states has been having this pain for a few months especially after taking drugs, he rates this pain 4/10 – nil travelling down arms ect (sic). States he hx (history) of schizophrenia on Zyprexa 30 mg nocte last taken 3/7 (days) ago. Nil TOSH (Threats of Self Harm) guarantees safety. ROI (release of information) signed and sent to records. Pt states drinks socially & uses drugs fortnightly, anything barr (sic) heroin"*.

38. Ms McCann performed standard observations and recorded John's Blood Pressure as 121/80, Oxygen Saturations at 99% respiratory rate as 16 breaths per minute and heart rates at 74 beats per minute. Ms McCann wrote *"Pt advised to rest & knock up if pain worsens. reassurance given".*

39. RN McCann arranged for Dr Liber to release information to the Network. John's medication was then recommenced and he continued to take the Olanzapine each evening while in custody.

40. Later that day John was transferred to the Metropolitan Reception and Remand Centre, (MRRC) in Silverwater. John was interviewed in what is called a "Reception Intake and Screening Process" which involves a prisoner being separately and respectively interviewed by a nurse from Justice Health and a corrections officer from the DCSNSW. They would have had the forms that had been completed on intake at the Surry Hills cells. Presumably the progress note completed by RN McCann also was available.

41. RN Anna Grigore completed the Justice Health "Reception Screening Assessment" commencing at 4:11 pm concluding at 4.23 pm on 28 April 2015. She sought a detailed history of recent alcohol and drug use. John told her that he used alcohol less than weekly

and had last used it 5 days ago. He said that in the last four weeks prior to his incarceration he had used methamphetamine and that he had used it once a month and he had last used it a week ago. He said he smokes it. He denied using cannabis in the last 4 weeks.

42. It is unclear whether the Progress Note completed by RN McCann was forwarded to MRRC for the Reception Screening. Though John disclosed a history of drug use and schizophrenia there is no reference to any cardiac issues other than RN Grigore recording "No" under the heading of Cardiovascular Condition(s). There is no reference to any cardiac issues during the remainder of John's incarceration.

43. Likewise, there is no entry in any Corrective Services records to suggest that John reported any heart or chest pain or dissatisfaction about the review by RN McCann at the Surry Hills cells on 28 April 2015. John was interviewed by the corrections officer for his Intake Screening commencing 5.15 pm and concluded 5.45 pm.

44. While at the MRRC, John was reviewed by the Risk Intervention Team (RIT) on 29 April and 1 May 2015. The CSNSW records for 1 May 2015 indicate that John "acknowledged that he had used ice about once a month and denied any other illicit drug use". His main concern at the time was to not share a cell with any inmate who smoked.

45. On 28 April 2015, John was placed in the Darcy Wing, Pod 2, in a one out cell number 92. In classification terms, John was a special management area placement (SMAP) prisoner in light of his history and on his request. On 3 May 2015, John refused to sign Child Protection documents and on 8 May 2015, he declined a psychology referral. Throughout his two weeks at the MRRC, John telephoned his mother but he apparently did not mention to her that he had experienced or was experiencing any heart problems.

46. On 11 May 2015, John appeared via AVL in the Central Local Court and pleaded guilty to the charges and was adjourned to 18 May 2015 for sentence. That day he was also reviewed by Clinical Nurse Consultation (CNC) Marco Rec. CNC Rec completed a Health Problem Notification Form which stated that John "*must be one out cell. Holding Darcy until R/V by psychiatrist*". That day he moved from Cell 92 to Cell 81 still on his own.

47. Clinical notes made by CNC Rec on 11 May 2015 contain a useful history John gave about his alcohol and drug intake with notes as follows: *"ETOH (alcohol) : Binge – 1-x2/week, THC (cannabis) last several weeks ago : as much as I can get". Amphetamine: last (used) "months ago". If it's there I will use it – both speed/ice "smoke" or eat it", XTC (ecstasy) x10/day "occasionally cocaine but it's too expensive. Inhalants: not used. Hallucinogens "when I was young it was good stuff it's hard to get. Benzo (benzodiazepine) Rx (review) in past but refuses it'.*

**12 May 2015**

48. The events of 12 May 2015 are captured in large part by footage on a Darcy Pod 2 CCTV camera and later in addition by a hand-held camera operated by Corrective Services Officer Brent Samyia.

49. Corrective Services Officer Medhurst was tasked to conduct a head count of prisoners in the pod. At 6.18 am he came to John's cell, he unlocked the door, opened it and briefly looked inside then closed and relocked it moving on to the next cell to do the same. Though Officer Medhurst stated in his Incident Report written on that day, that John responded to him, he had not recorded what response John had given.

50. In his statement dated 21 December 2018, Officer Medhurst stated that it was his practice that he would never leave a cell door unless he received a response. In his evidence before the Inquest he said such a response might be verbal or a physical one.

51. Around this time breakfast is left at each prisoner cell. At 6.23 am, John's breakfast was left outside the door to his cell. At 8.27 am, Senior Correctional Officer (SCO) Peter Dally unlocked the door to John's cell and with his leg pushed the breakfast inside. SCO Dally has confirmed in his statement that as he did so, John approached the cell door, bent down and collected his breakfast. This is captured on the CCTV footage. SCO Dally then relocked the cell door and left. It is unknown what, if any of the breakfast John consumed.

52. At 9.13 SCO Dally returned to John's cell and unlocked the door. The CCTV footage shows that no-one approached John's door during the period 8.27 - 9.13. The CCTV footage shows some movement of prisoners through the cell window but there is no such movement evident through the limited window view into John's cell after the time he collected his breakfast. After SCO Dally unlocked the cell door at 9.13 am John did not appear.

53. SCO Dally gave evidence and said that when he unlocked the door he called out "let go" to indicate that the occupant was free to leave the cell. He said that it is not his practice to check the inmate at "let go" as the head count has already been completed and he does not interrupt what a prisoner is doing in their cell or disturb their privacy.

54. A viewing of the Darcy Pod 2 CCTV footage confirms that through the course of the morning, inmates were let out of their cells and a number of them exercised in the large area in front of cell 81. Relevantly about a dozen inmates, including an inmate who I will refer to as "TS" and his cellmate, were exercising. No-one approached John's cell other than an inmate who had been at the door of the next door cell and when he walks away he appears to look into John's cell through the door window at about 9:19:26. Nothing about his demeanour or later demeanour raises any suggestion that what he saw gave him cause for concern.

55. At 10.08 am, inmate TS walked up to John's cell and looked inside the door. TS knew John as they had shared a cell at a previous time. TS saw that John was lying in bed and appeared unresponsive. He closed the door and walked to the Corrective Services Officers' station in D2 block. He told SCO Dally that John did not look too good. SCO Dally requested Senior Assistant Superintendent (SAS) Sampson Mariner, who was at the time the Acting Manager of Security for the entire centre, to accompany him to cell 81.

56. At 10.10 am, SCO Dally and SAS Mariner walked to the cell and opened the door. They saw that John was lying supine in bed. They both described him as pale and

unresponsive. In his initial statement, SCO Dally stated that: "*I could tell straight away the inmate was deceased as he was pale in colour, his eyes were wide open and he was non-responsive*". SAS Mariner directed SCO Dally to call for medical services and SCO Dally immediately did so by radio.

57. Neither officer entered John's cell at that time. SAS Mariner left the cell and directed that the area be secured and he walked away from the cell directing the same as he walked. Inmates who had been in the open area quickly complied with the direction. A third officer, CO Carlsson, had followed SCO Dally and SAS Mariner to the cell and he assisted by following prisoners returning to their cells and locking the cell doors. It is evident from CCTV footage that at least ten inmates who had been in the area, quickly complied with the direction to vacate the area. One inmate can be seen to remain in the area which apparently did not give any concern to the officers. I think it likely that he was the "head sweeper" and positioned himself visibly to assist in the orderly compliance.

58. SCO Dally remained at John's cell door. After SAS Mariner left the area and inmates were vacating the area, SCO Daly entered the cell and touched John's neck very briefly. The time was 10:10:42. He left the cell again, leaving the door opened and unattended at 10:10:52.

59. At 10:11:05 Nurse Fagaloa entered the pod area and she is then joined by Assistant Superintendent Ms Witt. They walk to John's cell and enter it and at 10:11:30. Nurse Fagaloa checked John's neck for a pulse and pulled the covers down to feel his chest and she commenced CPR at 10:11:30.

60. Ms Witt says in her statement that she was at her desk in Darcy 2 when she heard someone say *"He appears to be in a very bad way".* Nurse Fagaloa happened to be in the area as she was a mental health nurse carrying out other duties and Ms Witt asked her to accompany her to John's cell. It would appear that neither attended in answer to the radio call transmitted by SCO Dally. Neither had with them any medical equipment such as a defibrillator or oxygen.

61. Ms Witt says in her statement that when she entered John's cell she saw that he was *"lying straight on top of the bed with the covers up to his chin. His face was very pale, his eyes and mouth were open".*

62. The Pocklington family are concerned that SCO Dally did not commence CPR either as soon as he discovered John or once he had called for medical assistance on his radio. About 1 ½ minutes had elapsed between the Corrective Services Officers seeing John and Nurse Fagaloa commencing CPR. It is the family position that Corrective Services should not wait for medical staff.

63. Both SCO Dally and SAS Mariner wrote in their respective Incident Reports that day that SCO Dally on arriving at the cell entered it and after finding John pale and unresponsive, checked for signs of life and called a medical response. However, having viewed the CCTV footage they later made statements correcting that. Each was questioned in the inquest about why CPR was not commenced immediately.

64. Registered Nurse Lauren Lennon and Enrolled Nurse Debbie Wood responded to SCO Dally's radio call of 10:10:04. They arrived at the cell door at 10.12.18, bringing with them a trolley on which was the emergency bag, which contained an automatic defibrillator, oxygen and other airway management and emergency equipment.

65. Nurses Lennon and Wood prepared the defibrillator and placed the defibrillator pads on John's chest however John's heart was asystole and the defibrillator at no time picked up a shockable rhythm at any point.

66. Shortly prior to the arrival of Nurses Lennon and Wood, Corrective Officer Samyia attended and began filming events with a hand-held video camera.

67. At about 10.20 am, one of the attending nurses asked why the doctor working in the MRRC that day, Dr Annette Bemand, had not attended in response to the medical call made by SCO Dally. It appears that a Corrective Services Officer then yelled out for someone to fetch Dr Bemand.

68. At about 10:22, Corrective Service officers carried John from the cell and placed him on the floor in the open area of the pod to allow for more medical access as the first ambulance crew of 2 paramedics had arrived as had Dr Bemand. She took over the airway management with bag and mask.

69. The paramedics asked how long John had been unresponsive and RN Lennon says words to the effect of "*he was still warm*", presumably meaning that John was still warm when CPR commenced.

70. At approximately 10.24, a second ambulance crew arrived, with two further paramedics. They assisted with the CPR and relieved the Justice Health nurses of some tasks. At about 10:27 am one of the paramedics suctioned vomitus from John's airway.

71. At 10:30 a third ambulance crew arrived with a further two paramedics. CPR continued and the defibrillator indicated continued absence of any shockable rhythm.

72. At approximately 10.39, John is intubated to further assist with management of his airways beyond the valve bag mask. Unfortunately, despite the prolonged efforts of the Justice Health staff and paramedics, John could not be revived. At approximately 10.45, the paramedics ceased CPR and declared John deceased. Dr Bemand prepared a Life Extinct Form at 10.50.

73. The initial officer in charge of the Coronial investigation was Detective Inspector Garry James. He arrived at Darcy 2 at about 11.29 am. He inspected the scene, both outside and inside cell 81. He also viewed the CCTV and requested that it be retained and spoke to a number of Correctional Officers.

74. Vicki Pocklington was informed of John's sad death at approximately 13.40 on 12 May 2015.

**Autopsy**

75. Dr Jennifer Pokorny, forensic pathologist, conducted an autopsy at the Glebe Morgue on 13 May 2015 and provided a Post Mortem Examination Report. Relevantly, she concluded that the direct cause of death was Acute Myocardial Infarction and she did not identify any antecedent causes. She did however identify the following:-

    (i) a vague blue bruise in the upper left thigh/groin surround by three possible puncture marks;

    (ii) areas of scarring, pallor, mottling and softening in the interventricular septum and free wall of the left ventricle of the heart, in keeping with recent and remote ischemic injury, varying in age from hours to at least several weeks;

    (iii) the presence of cannabinoids on toxicological examination of the blood, in keeping with recent cannabis use, as well as Olanzapine at therapeutic levels.

76. Dr Pokorny indicated that narrowing of the coronary arteries was normally present in severe ischemic heart disease, but was not present in John. She raised an issue as to whether John's long history of methamphetamine use may be associated with this and previous myocardial infarction. She described that no methamphetamine was detected in the blood toxicology analysis.

Issues for Consideration

77. The following matters were raised in the inquest:

    (a) the cause of death and in particular, whether the use of methamphetamine and/or Olanzapine may have contributed to Mr Pocklington's death;

    (b) the manner of Mr Pocklington's death, including:

        (i) the adequacy of the response to the report of "heart pain" on 28 April 2015;

        (ii) the adequacy of medical care provided to Mr Pocklington from 28 April to 12 May 2015;

    (c) observations made of Mr Pocklington on 12 May 2015;

    (d) any recommendations considered necessary or desirable pursuant to Section 82 of the *Coroners Act* 2009.

**Cause of Death**

78. In light of Dr Pokorny's comments in her report, an expert report from Associate Professor Mark Adams, consultant cardiologist and head of cardiology at Royal Prince Alfred Hospital, has been obtained.

79. Associate Professor Adams described that the post mortem examination findings demonstrate that John had experienced multiple small myocardial infarctions, likely brought about by coronary artery spasm arising secondary to methamphetamine or cocaine ingestion.

80. In his evidence, Associate Professor Adams provided helpful explanations consistent with his report and Dr Pokorny's findings. He described that John had suffered myocardial infarction/s in the week to days prior to and/or leading up to 12 May 2015 and that this in turn led to John suffering a fatal arrhythmia on 12 May 2015 (either a ventricular tachycardia or ventricular fibrillation).

81. Associate Professor Adams considered it likely that the "*heart pains*" John complained about to RN McCann on 28 April 2015 were likely the result of coronary artery spasm caused possibly from the recent use of methamphetamine or from having suffered previous damage to his heart.

82. He also explained that methamphetamine use can cause cardiac damage regardless of dose and frequency of use. It is not clear when John last consumed methamphetamine because of the variance in the history he gave different people - on 28 April 2015 he told RN Grigore that he had used methamphetamine *"a week ago",* but on 11 May 2015 he told CNC Rec that it was "*months ago"*. In terms of frequency, on 28 April 2015 he told RN McCann that he had been having heart pains for a few months especially after taking drugs and on 1 May 2015 he told the Risk Intervention Team he had used ice once per month.

83. The possible puncture marks in John's upper thigh/groin raises the possibility of him having injected some form of illicit drug but in the absence of any such drug being detected on post mortem toxicological assessment, the relevance of it is unclear, particularly in light of John claiming to ingest or smoke methamphetamine rather than inject it. Associate Professor Adams' evidence explains that John's fatal heart attack, in the absence of clear evidence of recent methamphetamine use, was likely due to cardiac damage from earlier and smaller infarcts.

84. Associate Professor Adams' gave evidence that John's use of methamphetamine would have led to recurrent coronary artery spasm and consequently, multiple myocardial infarctions (over months, if not years). He said that methamphetamine caused a vaso-constriction and cardiovascular spasms which would create scar tissue.

85. He said that each small cardiac infarction would leave further scarring or damage on the heart and each would have cumulative effects causing repeated cardiac infarctions leading to the fatal arrhythmia which occurred on 12 May 2015. Associate Professor Adams thought that this one was more likely to have been caused by an earlier infarction,

occurring in the week to days prior to 12 May 2015. In the absence of John having any methamphetamine in his blood at autopsy it seems clear that John did not use methamphetamine within 48 hours of his death.

86. Associate Professor Adams explained that John did not have coronary artery disease nor a spontaneous artery dissection and there was no evidence of embolization so it is clear that methamphetamine usage over time was the precipitating factor.

87. Associate Professor Adams explained that fatal arrhythmias, whether due to ventricular tachycardia or ventricular fibrillation, typically occur without warning or other symptoms such as chest pain and instead present with loss of consciousness and sudden death. Given that Associate Professor Adams explained methamphetamine use can cause cardiac damage regardless of dose and frequency of use and that it is not possible to accurately determine John's use of methamphetamine given the inconsistent accounts contained in the medical records, Ms Finlay submits that there are insufficient findings that John was a chronic methamphetamine user. Whether John used methamphetamine once a month or sporadically, he identified that his binge drinking was more problematic though he was sufficiently aware to tell RN McCann that he had begun experiencing heart pain after he used drugs over the recent few months.

**Manner of death**

88. The manner of John's death involves a consideration of the way or circumstances in which it occurred and involves a focus on more than just the medical cause of death.

**The adequacy of the response of the report of "heart pain" on 28 April 2015**

89. Associate Professor Adams was asked to comment on RN McCann's review and response to John's complaint of "heart pains" on 28 April 2015 taking into account the clinical context in which it occurred. Namely, being that of a nurse working in a Justice Health Clinic in a correctional facility. Though he was not critical of RN McCann not organising an immediate medical review other evidence suggests that an ECG should have been considered.

90. Associate Professor Adams' acknowledged in his evidence that had John presented to a hospital or had been in the community a medical review could have been organised on the basis of the "heart pain" complaint however in John's circumstances he points to a number of important pieces of clinical information which mitigate against urgent or even prompt referral for medical review being necessary at the time.

91. In particular, the observations RN McCann recorded were all within normal limits. A pain of 4/10 is not severe and RN McCann appeared cognisant that John was complaining of heart pain rather than chest pain because she noted that it did not radiate to the arm.

92. EN Woods gave evidence that had an inmate complained to her that he was experiencing heart pain she would have organised and performed an ECG. She said that it is a readily

available test and that is a very simple procedure. She said she would also have considered whether to organise a medical review.

93. Associate Professor Adams said that a medical review could include an ECG and a blood test to examine Troponin levels which can indicate, depending on the timing of the test to the pain or cardiac event, whether there has likely been a release of a protein registering an elevated level consistent with demonstrating a cardiac event.

94. However, Associate Professor Adams, commented that had a medical review been undertaken on 28 April 2015 or shortly thereafter, it is unclear as to whether any therapeutic response would have ensued that would have averted John's death. Associate Professor Adams has suggested that an ECG might have shown some changes consistent with myocardial infarction, such as ST elevation of depression and that blood troponin levels would likely have been elevated due to the myocardial infarctions (identified on autopsy) but the previous infarctions were likely very small and even on a coronary angiogram being performed may not have been indicated and likewise an echocardiogram may have been within normal limits.

95. Associate Professor Adams indicated that had John undergone a urine/blood drug screen that he would have been likely advised to avoid using drugs, particularly amphetamines because of the high risk of causing further myocardial damage. He also suggested that a medical review could also have resulted in John being given aspirin and monitored for 48 hours. However, he noted in his evidence that many people would not have prescribed Aspirin and even if they had it would not have prevented the arrhythmia suffered on 12 May 2015.

96. RN McCann should have organised an ECG and a medical review if that was possible. However given that she saw John at 11 am and he was transferred from that location to the MRRC that day such an arrangement may have not been possible.

97. Associate Professor Adams said that if John had been in a tertiary hospital setting and reported that he was experiencing heart pain within a 4/10 range he would have been referred for a medical review. However, Associate Professor Adams said that the fact that John was in custody, had a psychiatric, criminal and drug history and was young would make a decision to refer him for a medical review not an "easy decision to make".

98. RN McCann could have completed a Health Problem Notification form advising the need for John to have an ECG and medical review which could have been followed up by the Justice Health staff at the MRRC. This would have been consistent with ensuring a continuity of care from one correction's facility to another. We do not know whether RN McCann considered doing so as she is not available. However, it should be noted that at the time John was screened at MRRC he did not apparently mention the pains to RN Grigore which suggests that they had either ceased or were significantly less than he reported five hours previously.

99. In the absence of evidence from RN McCann, Justice Health provided a document from the Adult Emergency Response Guidelines (2009) titled "Cardiac Pain Algorithm" which

provides a pathway to medical service personnel for treatment where a prisoner is experiencing Chest Pain/Angina/Possible Acute Myocardial Ischaemic/Infarction which indicates that if systolic Blood Pressure is greater than 90 mmHG then *half to one table of Glyceryl Trinitrate (GTN) and if the pain is relieved provided 300 mg Aspirin (oral). If possible perform an ECG, discuss with medical officer. If the ECG is abnormal or unclear then the prisoner should be transferred to hospital for further assessment if ECG changes are apparent.* John's systolic reading was 121 so had RN McCann approached his knocking up on his cell button and complaining of heart pain as an emergency those guidelines should have prevailed.

100. In the circumstances RN McCann should have indicated that John required both an ECG and a medical review so that bloods could be taken to measure his Troponin level. If she was unable to do this because John was about to transit to MRRC, then a Health Problem Notification Form should have been completed and highlighted so that John could receive this care.

101. Though John had an ECG on 25 April at the hospital which was normal and there was a possibility that the ECG if performed on 28 or 29 April may have also been normal, if blood had been taken there was a good chance that a rise in John's Troponin level would have been detected and further investigations could have followed.

102. However, had a medical review been arranged I accept that any follow up from investigations over the next 14 days would have not likely progressed to any effective treatment to prevent the acute myocardial infarction causing his death on 12 May 2015. That is likely to have been the case regardless of whether John was in custody or living in the community.

103. In the circumstances John's family feel aggrieved that John did not have the opportunity to have his heart pain further investigated after reporting it to RN McCann. I agree that a person's access to adequate health care should not be jeopardised because they are in a custodial setting.

**The adequacy of the medical care provided to Mr Pocklington from 28 April - 12 May 2015**

104. No criticism has been made of the medical/nursing care provided to John from 28 April 2015 through to him being found unresponsive on 12 May 2015. No cardiac condition was identified at the MRRC Reception Screening and there is no record of John raising the issue again with any member of Justice Health. His medical and nursing management was routine and largely focused on his mental health issues. Associate Professor Adams is clear that the Olanzapine John had recommenced had no role in his experiencing a heart attack.

105. In respect of 12 May 2015, expert opinion has been sought from an Accident and Emergency Physician, Professor Anthony Brown, a Senior Staff Specialist in Emergency Medicine at Royal Brisbane and Women's Hospital and a Professor of Emergency

Medicine at the University of Queensland, as to the adequacy of the medical response to Mr Pocklington being found unresponsive on 12 May 2015.

106. Professor Brown has provided a detailed report based on his review of relevant statements and in particular, the CCTV and hand-held camera footage.

107. Professor Brown was not critical of any aspect of the care and engagement of resuscitation procedures and timeliness. He described the CPR as being of a high standard, with appropriate use of a bag valve mask to provide breaths interspersed with 30 external cardiac compressions. He also noted that the person providing cardiac compressions was rotated at appropriate intervals. Professor Brown identified some small areas in which the CPR may not have been textbook, though he was not overtly critical and did not suggest that any variations in technique would have influenced the overall outcome of the CPR.

108. Professor Brown did not express any concerns regarding the initial performance of CPR on the cell bed and he had no criticism of the equipment used during CPR. He considered that the resuscitation attempts were ceased at an appropriate time.

109. Professor Brown was not of the view that any earlier attendance by Dr Bemand was required or would have changed the course of events as he was satisfied that those who were performing the CPR (Justice Health staff and then paramedics) possessed and performed the necessary skills.

110. Both Associate Professor Adams and Professor Brown agreed that in order to have some chance of survival from an acute heart attack that emergency first aid needs to be commenced within about four minutes of the patient's collapse.

111. The Polkington family have viewed the CCTV footage and are concerned about the response of the Corrective Services Officers towards finding John unresponsive. Whilst it is clear that SCO Dally immediately called for medical assistance, the time between that radio call and when that assistance arrived was a particularly difficult period for them to see because there was no checking of vital signs, urgency or provision of CPR.

112. SCO Dally and SAS Mariner both gave evidence that a priority in attending a medical emergency in a prison environment is to ensure the safety of the environment. They said it was not safe to enter the cell until the pod was secure from all the prisoners who had been 'at large' in the pod.

113. Whilst I accept that position, I do appreciate that from the Polkington family's perspective a viewing of the CCTV footage may not give the impression that John's situation was treated as "medical emergency" until after the nurses started CPR.

114. Inmate TS who first discovered John did not run to the officer's station and the officers did not run to John's cell carrying any medical apparatus. The officers stayed outside John's cell but for the briefest of moments when SCO Dally entered it and touched John's neck for a second and then went back outside. The first two nurses attended without

running and without medical equipment and it was not until the other nurses arrived with the emergency trolley that any equipment, particularly the defibrillator was available.

115. Two minutes elapsed between TS discovering John, fetching and bringing the officers back to the cell. Another one and half minutes elapsed before RN Fagaloa commenced CPR. For the family that is a long time to watch the CCTV particularly after hearing evidence from Associate Professor Adam and Professor Brown that time is of the essence.

116. Both experts agreed that given the descriptions of John having blue lips and cold extremities, very pale pallor, eyes and mouth open and non-responsive with cardiac asystole, that he was likely to have suffered collapse at least 30 minutes prior to TS discovering him. RN Lennon's report that he was warm is more likely due to the fact that John was in bed under covers rather than an indication that his collapse was more recent.

117. Professor Brown said that the outcome of an unwitnessed cardiac arrest where the patient is found to be in asystole is almost universally fatal and even in witnessed events with full tertiary hospital facilities the survival rate is as little as 7%. John's family acknowledges that given John's collapse was unwitnessed there was no opportunity for the resuscitation attempt to engage the defibrillator or CPR,

118. The Corrective Services Operations Policy (13.2.1.1) sets out what a First Responding Officer (FRO) should do upon discovering a death in custody: - 1. Determine and assess the situation for any risks or hazards including *"Prior to entering a scene to provide assistance, the FRO and all subsequent staff must make sure it is safe to do so…protecting people and providing the injured with first aid and medical care is the first priority.* 2 Establish and notify Communications – *call for assistance from other officers...it is the responsibility of all staff to provide first aid to injured people if in a position to do so and provided it can be administered safely. It is imperative that this is done as soon as possible to protect life. Once the FRO has determined it is safe to enter the scene the FRO must immediately check for signs of life and commence resuscitation….*

119. Though SCO Dally entered the cell after calling for assistance on the radio and he briefly checked for signs of life he did not commence resuscitation. His explanation was that it was not safe to do because the pod was still being made secure. SAS Mariner said that he would not have expected SCO Dally to enter the cell because there was no officer providing security for him.

120. I do not accept that it was not safe for SCO Dally to have commenced CPR after he entered the cell and felt John's neck. If it was unsafe he would not have re-entered the cell in any event. The CCTV shows that the immediate area was sufficiently vacated by prisoners who were compliant.

121. I accept the evidence from the officers that safety is particularly poignant in a remand wing because prisoners are not as settled as those who are sentenced and many prisoners on remand are not necessarily known by the officers and some have difficult behavioural concerns due to substance withdrawals, mental illness or gang affiliations.

122. However the CCTV footage would suggest that it was sufficiently safe for a corrections officer to have entered the cell and commenced CPR while the area was being secured and rather than wait for a complete lock down or for the medical staff to arrive.

123. Had RN Fagaloa not been in the pod at the time, CPR would not have been commenced as soon as it was as the corrections officers were waiting for medical staff to arrive rather than engaging in first aid as was required under the policy.

124. The nurses arrived with the medical equipment a little over 4 minutes after TS discovered John but within 45 seconds of RN Fagaloa commencing CPR. CSNSW has confirmed that every pod now has a defibrillator housed in it. This means that Corrections Officers are able to commence using that apparatus immediately rather than waiting for medical staff to bring the equipment into the pod from the clinic.

125. In regard to whether the response to John was treated as an emergency, I acknowledge the custodial setting is a relevant context and that due to the inmate population, particular in a remand wing, it was important for TS and the Corrections Officers and Health staff not to react or act in a way which could cause alarm, panic or unwanted involvement of other prisoners.

126. SCO Dally's said that he did not check for John's vital signs and commence CPR was due to security and believing that medical assistance was readily available. I think that this explanation is more given in hindsight because at the time SCO Dally genuinely thought John was deceased because he saw John had his eyes open and he was unresponsive and he was pale.

127. However, the policy relating to a Death in Custody makes it clear that *even if an officer finds an absence of signs of life in a person it does not necessarily man that a person had died and accordingly the FRO **must** check for the following signs of life: breathing, pulse, heartbeat and or pupil/contraction on exposure to light.*

128. SCO Dally did not do those things. The policy goes on *"If the inmate is not breathing or a heartbeat cannot be detected resuscitation **must** be started and first aid applied where necessary. Resuscitation attempts **must** continue until medical personnel arrive and take over…once health staff arrive CSNSW staff may withdraw unless they are requested by medical staff to assist in treating the inmate".*

129. In relation to SCO Dally not checking for signs of life (as set out in the policy) or providing CPR once he had called for medical assistance, Professor Brown indicated that it would have made no difference. He explained that he agreed with Associate Professor Adams' view that for John to have had some chance of survival, he would have needed to have been found within four minutes of his collapse.

130. Though there is no evidence of when it was during the period 8.27 to 10.08 am that John had become unconscious and unresponsive it is likely to have been at least 30 minutes prior to inmate TS seeing him. Given the descriptions of his skin pallor and extremities having a blue tinge that it is likely that John had collapsed at least half an hour prior to

inmate TS seeing him. Associate Professor Adams explained that the blue tinge of lips and hands is as a result of a lack of circulation of oxygenated blood. Professor Brown took into account that RN Lennon suggested that John was still warm when CPR began, noting that he was clothed and in bed and that it takes some time for a deceased's body to cool.

**Recommendations**

131. A Coroner has a statutory power to make recommendations under Section 82 of the *Coroners Act*. Counsel Assisting has put forward two recommendations for consideration.

132. The first relates to clarifying to the CSNSW officers that providing emergency first aid should not be compromised by an emphasis of dealing with risks and hazards over checking for signs of life and commencing first aid. Mr Downing queried whether the Operations Policy Manual which then applied or the Custodial Operations Policy and Procedures which now apply make it clear that security of the centre is the highest priority and everything else is secondary.

133. Counsel Assisting suggests that if it is the intent of the policy that corrections officers identify prisoners at large in the environment as a " risk and hazard" that must be dealt with prior to checking for signs of life then the policy should say so. Without such, he queries whether the steps a corrections officer should take and what those priorities are unclear. Counsel Assisting points out prompt steps are required when time is of the essence and if a prisoner is in tachycardia (rather than asystole) the quick use of a defibrillator is essential.

134. Ms Finlay agrees that an attempt to preserve life should be the primary focus though acknowledges the need to ensure security so that responders are safe to be able to respond to a medical emergency.

135. Ms de Castro Lopo does not support a change to the Operations Policy and Procedure because even if there is explicit reference to a hazard and risk being that of inmates being at large in the vicinity, it cannot always be predicted what the situation will be in a serious incident. For example, what might be done in a remand wing might be different to that done in a sentenced prisoner wing.

136. I accept that both SCO Dally and SAS Mariner were appropriately trained and experienced officers who were aware of their responsibilities as First Responding Officers. The first instruction from SAS Mariner was appropriate "radio for help" and his second response was to clear the area of inmates and enlist the assistance of other officers. That response was not essentially at the exclusion of SCO Dally being able to enter the cell and check for signs of life. Indeed both officers wrote in their respective Incident Reports filed that day that this had been done. It hadn't because they were both of the view that John was deceased. While SAS Mariner was organising other officers, Officer Carlsson had the security of the pod in hand leaving SCO Dally sufficiently safe to enter the cell. He in fact did enter the cell. The fact he did not properly check for signs of life and commence CPR was not because the area was not secured. It was because he believed the medical team

were soon to arrive and in any event John was deceased. It was not because there was a confusion or misunderstanding about prioritising security with first aid.

137. Mr Kellaway pointed out that SAS Mariner said that to render it safe to enter John's cell that the officers had to contain and isolate the area and he would not have directed SCO Dally to go into the cell alone because there was a need to maintain sight and sound of another officer. I note that SAS Mariner did not direct SCO Dally to go into the cell but SCO Dally did go in so he must have felt safe enough to do so. The CCTV footage indicates that the area appeared safe enough for him to have done so. In any event, there was nothing to stop one officer guarding the cell door while the other officer entered, checked for signs of life and commence CPR whilst medical support arrived.

138. Accordingly I do not propose to make a recommendation about identifying whether the presence of prisoners may present a specific hazard or risk when assessing an emergency situation. Further, I note that there are many everyday tasks, not just emergency situations, requiring corrections staff to always maintain an assessment of the hazard and risk prisoners provide to themselves and to each other and to the operation of the centre generally and given this explicit requirement there seems little to advance by making it implicit in an emergency environment.

139. The second recommendation Counsel Assisting suggested for consideration is put forward by Professor Brown's report that Justice Health and Corrective Services adopt a team structure and role delineation for cardiopulmonary arrests and the type of life support training that might be given to Correctional Officers might be appropriate.

140. The first aid support which was provided to John was performed by Justice Health personnel and the attending paramedics who did not call on CSNSW officers to assist. The policy in the CSNSW "Custodial Operations Policy & Procedures" for medical emergencies is at 13.2 and clearly sets out that: *"Correctional officers must provide first aid to inmates until medical personnel respond and commence treatment. Correctional officers must assist medical personnel if requested".*

141. The policy clearly sets out the role of the First Responding Officer (or officers and that the role can be shared) and other correctional officers. I am satisfied that policy adequately identifies and communicates the CSNSW officer's roles and I do not think the circumstances of this case warrant any recommendations in that regard.

142. Ms Finlay submitted that I consider a recommendation that Correctional Officers wear body video cameras citing that if SCO Dally or SAS Mariner had worn one, what they saw would be recorded. Whilst that issue is of interest, it was not ventilated with any of the witnesses and was not an issue about which I inquired so I am not now in a position to consider such a recommendation but I do note that most of what occurred is captured on the CCTV and shortly thereafter by the hand held camera so in this matter very little further evidence, if any would have been gained in any event.

143. The Polkington's grief for the loss of their beloved John is amplified by not only the fact that he died suddenly and so young but because he was in custody, away from those with

whom he was extremely close, particularly Vicki who had always given him unwavering love and support. John told Corrections officers repeatedly that his family was his protection and on his reception he was upset about how his incarceration would upset Vicki.

144. The family have been extremely patient and have pursued and ensured that John's death be properly investigated and understood and so over 5 years later and just 2 days before John's birthday which would have been his 37th, they can truly say that they have done everything they could to make sure that John's coronial process has been properly completed. I again pass on my sincere condolences to them.

145. The findings are formally entered:

Identity: John Pocklington
Date 12 May 2015
Place Metropolitan Reception and Remand Centre, Silverwater NSW 2128
Cause Acute Myocardial Infarction
Manner Natural

Magistrate E Truscott
Deputy State Coroner
29 July 2020