CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of John Cribb
Hearing dates:	28 April 2023
Date of findings:	5 May 2023
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate David O'Neil, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, natural causes
File number:	2018/60363
Representation:	Coronial Advocate Assisting Kai Jiang Ms Dunn for the Commissioner of Corrective Services NSW Ms Guilford for the Justice Health Forensic Mental Health Network.

Findings:

Identity:	The person who died is John Cribb
Date:	John Cribb died on 21 February 2018
Place:	John Cribb died in Cell 3 of Unit 2, Goulburn Correctional Centre NSW
Cause:	Haemopericardium arising from a ruptured Aorta
Manner:	Natural Causes

Non-publication order:	A Non-publication order pursuant to section 74(1)(b) of the Coroners Act 2009 (NSW) has been made in this inquest. A copy of the orders can be found on the registry file.

Introduction

1 Mr John Cribb died at the Goulburn Correctional Centre on 21 February 2018.

2 Because Mr Cribb died while in custody, an inquest is required by the Coroners Act 2009 NSW (the Act).

3 When someone is in lawful custody they are deprived of their liberty, and the State assumes responsibility for the care and treatment of that person. In such cases the community has an expectation that the death will be properly and independently investigated.

The Coroner's role

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

5 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the Act; namely

- the person's identity;
- the date and place of the person's death; and
- the manner and cause of death of the person's death.

6 Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

7 Prior to holding an Inquest a detailed coronial investigation is undertaken. Investigating Police compile a brief of evidence and a report is obtained from a forensic pathologist as to the cause of death. Given that Mr Cribb's death occurred whilst he was in custody in a correctional facility it was thoroughly investigated by Detective Senior Constable Coorey, who obtained correctional centre records, including medical records. The Police also interviewed correctional officers, medical staff and Mr Cribb's sister.

8 The Coronial investigation also obtained relevant policy documents, CCTV footage and received a Serious Incident Report undertaken by a senior investigator from the Corrective Services' Investigation Branch.

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

BACKGROUND

10 Mr John Cribb was born on 5 August 1950 and was 67 years of age at the time of his death. He has three sisters, one of whom is the Senior Next of Kin. The family lived in the Baulkham Hills area and later moved to the mid north of NSW. Mr Cribb was educated in the Marist Brother's catholic school at Parramatta.

11 Mr Cribb had a troubled youth. He had a criminal history dating back to 1968 for property offences, armed robberies, and escape lawful custody. On 14 August 1978, Mr Cribb was charged with a number of serious offences (including rape and murder of a mother and her two children) and was sentenced on 22 May 1979 to three terms of life imprisonment. Soon after entering custody, Mr Cribb managed to escape on two occasions but was subsequently recaptured and remained in custody from at least September 1985.

12 Whilst in custody, Mr Cribb received visits from his mother, his sister, friends, and legal representatives. Whilst in custody, Mr Cribb married a female prison visitor, who unfortunately passed away a few years after their marriage due to a brain tumour.

13 After being housed at various correctional centres within the state, in July 2017, Mr Cribb was transferred to the Goulburn Correctional Centre where he was placed in a one out cell. He had one out cell placements for most of his time in custody for his own protection. Mr Cribb was classified as A2 maximum security and was lawfully detained in custody at the time of his death.

Medical History

14 Prior to incarceration, Mr Cribb was a heavy drug user. At the age of 14, he began smoking cannabis and consuming alcohol. He commenced using LSD (Lysergic Acid Diethylamide) when he was 17.

15 In the early years of his imprisonment, Mr Cribb was regularly reviewed by psychiatrists due to violent outbursts and possible psychosis. He was treated with anti-psychotic medications and was prescribed lithium carbonate for manic depressive disorder. There were expressions of suicidal thoughts, and he was provided psychiatric consultations and anti-depressant medications. Over time, it appears that with the acceptance of his situation, Mr Cribb's mental health conditions improved, and his medications were ultimately ceased.

16 In February 2012, Mr Cribb was diagnosed with moderate non-obstructive coronary disease, coronary artery insufficiency, aortic regurgitation and hypertension. Relevantly, Mr Cribb has a family history of heart related issues. His conditions were appropriately managed by Justice Health and treated with prescription medication.

17 In August 2017, due to his age and existing cardiac conditions, Mr Cribb was referred to Justice Health for his ongoing health care planning. He was reviewed and had a consultation with a medical officer. Mr Cribb was described as "world weary" and clearly indicated that he did not wish for his life to be prolonged with medical intervention. In accordance with his wishes, a not for resuscitation plan and advanced care directive were signed on 29 August 2017. Mr Cribb thereafter declined to be transferred to other correctional centres where his heart issue and other medical issues could be better managed. He also cancelled medical referrals, including a cardiology appointment on 20 February 2018. Despite the cancellation, a physical examination and an ECG was still conducted which showed no changes in his cardiology status since 2016.

Events leading up to death

18 On 19 February 2018, Mr Cribb complained about vomiting and diarrhoea. He was assessed by a Justice Health nurse and was given Panadol for his stomach cramps. A review was scheduled for Mr Cribb to be assessed again the following day.

19 About 10:15am on 20 February 2018, Mr Cribb was observed by a corrective officer to be lying down in the yard. He was sent to the medical clinic for assessment. A "sick in cell" certificate was issued by a Justice Health nurse which allowed him to remain in his cell. There was an apparent heatwave on the day, and Mr Cribb was not physically well enough to be out in the yard. He was escorted back to his cell. At 2:34pm, Mr Cribb was observed by corrective officers without any issues. This was the last time Mr Cribb was seen alive.

20 At 8:28am on 21 February 2018, during the morning "let go", the door of Mr Cribb's cell was briefly unlocked, but not opened, by a corrective officer who then resecured the cell to attend to other duties. Mr Cribb was not checked upon at this time. About 10:25am on the same day, Mr Cribb was found unresponsive inside his cell by another inmate who was conducting "sweeper" duties. Corrective officers were alerted and attended the cell. Mr Cribb was observed to be on his side on the cell floor. He was positioned slightly under the storage shelves with his feet to the rear of the cell. His body was cold and stiff to touch.

21 Corrective officers immediately removed Mr Cribb's body from the cell and commenced CPR until the arrival of Justice Health staff. Resuscitation efforts eventually ceased due to confirmation of the not for resuscitation plan.

22 Mr Cribb was pronounced deceased at 10:40am on 21 February 2018.

Investigation following the death

23 After Mr Cribb's death, his cell was cleared and secured by corrective officers. NSW Police were contacted and attended at 11:59am on 21 February 2018. An investigation was conducted in relation to Mr Cribb's death.

24 Cell 3 was forensically examined and searched with photographs taken. Police spoke to all corrective services and justice health staff present. Mr Cribb's medical and custodial records were obtained and reviewed. The inmate who discovered Mr Cribb was interviewed. All CCTV footage available at the time was analysed. After assessment by detectives, Mr Cribb's death was not treated as suspicious.

25 Investigation found no evidence of foul play or self-harm regarding Mr Cribb's death. The duress button in the cell was checked and was confirmed to be operational. The responses from Corrective services officers were appropriate and in accordance with relevant policies and procedures.

26 Medical records show that on 29 August 2017, Mr Cribb was assessed by a Justice health nurse. His cardiac conditions were stable. There had been no significant changes to his clinical state after that date. As such, his one out cell placement at the Goulburn Correctional Centre was appropriate in accordance with Justice Health policies applicable at the time.

27 Mr Cribb was positively identified by corrective officer who had known him for over one year. A statement was obtained from his sister. The statement provided background information.

28 An external post-mortem examination was conducted and found that Mr Cribb died due to Hemopericardium (build-up of blood in the sac that surrounds the heart) with a ruptured aortic dissection (tear in the inner layer of the large blood vessel branching off the heart). There were no external or internal injuries of concern.

29 The Serious Incident Report referred to the fact that Mr Cribb should have been observed at the "let go" on the morning of his death and noted that the probability is that Mr Crib had been dead for some time at that stage and that, in any event Mr Cribb had signed a no CPR resuscitation plan. I am satisfied on the balance of probabilities that the failure to observe Mr Cribb at the "let go" did not play any role in his passing, given he suffered a ruptured aortic dissection and given his desire to not be resuscitated.

30 The Serious Incident Report found that overall management of Mr Cribb and the response to the fatal incident were both compliant with departmental policies. I am satisfied those findings are correct.

Whether any recommendations required pursuant to s82 of the Coroners Act

31 On the evidence in this matter there are no recommendations to be made. Applicable policies were not identified to be deficient or requiring change. The failure of the officer to observe Mr Cribb at "let go" is not a matter which requires a recommendation. The officer was well aware of the requirements in place but was distracted on this occasion from doing a head check. The failure was one of human error due to circumstances and as such no recommendation is required.

Findings under s81 of the Coroner's Act:

32 For all the above detailed reasons I make the following findings:

33 Identity: The person who died is John Cribb

34 Date: John Cribb died on 21 February 2018

35 Place: Cell 3 of Unit 2, Goulburn Correctional Centre NSW

Cause: Haemopericardium arising from a ruptured Aorta

36 Manner: Natural Causes

Closing

37 I acknowledge and express my gratitude to the Coronial Advocate assisting the Coroner, Mr Kai Jiang, for his assistance both before and during the inquest. I also thank the Officer-in-Charge of the investigation, Detective Senior Constable Coorey, for his work in the Police and Coronial investigation and compiling the evidence for the inquest.

38 On behalf of the Coroners Court of New South Wales, I offer condolences to the family and friends of Mr Cribb

39 I close this inquest.

Magistrate David O'Neil

Deputy State Coroner

Coroners Court of New South Wales