CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of John Aramathuparambil John
Hearing dates:	24 November 2025-27 November 2025
Date of findings:	17 July 2026
Place of findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Judge Kasey Pearce, Deputy State Coroner
Catchwords:	CORONIAL LAW – unascertained cause of death – recent release from police custody – cause and manner of death – whether police cared for person in custody reasonably and appropriately
File number:	2023/00185279
Representation:	W de Mars, Counsel Assisting the Coroner, instructed by J Prindiville of the Crown Solicitor's Office K Burke, instructed by A Wooldridge of the Office of the General Counsel for the Commissioner of the New South Wales Police Force D Carroll instructed by D Longhurst of Longhurst & Associates for Senior Constable Hodder R Deppeler instructed by C Hatzigeorgiou of the Police Association of NSW for Senior Constable Cole
Non publication order:	A non-publication order has been made pursuant to section 74(1)(b) of the Coroners Act 2009 (NSW) in relation to parts of the brief of evidence.
Findings:	**The identity of the deceased** The person who died was John Aramathuparambil John **Date of death** John died on 6 June 2023 **Place of death** He died in Riverstone NSW **Cause of death**

	The cause of John's death was complications of chronic alcohol misuse and olanzapine toxicity. **Manner of death** John died due to misadventure resulting from the supratherapeutic self-administration of prescription medication in the context of his cessation of alcohol use.
Recommendations	**To the Commissioner of the NSW Police Force (NSWPF):** 1. The Charge Room and Custody Management Standard Operating Procedures and the NSWPF Handbook Chapter 'Custody' should be amended to provide additional guidance to custody officers in relation to allowing persons in custody to access a telephone in the station or charge room for the purpose of arranging post-release transport. 2. Without diminishing from or replacing any of the requirements under existing NSWPF policies and guidelines relating to the safe care and custody of detainees at police stations (including in respect of adequate recognition and assessment of health issues), a requirement should be implemented whereby at the point of a person's release from custody at a police station into the community: (a) the custody manager is to make a record of the following: i. the distance between the police station and the person's place of residence or other location to which they intend travelling (if not the person's place of residence); and ii. the means by which the person intends to travel to their intended destination; and (b) if the custody manager is concerned about the person's capacity to travel to their intended destination by the person's intended means of travelling and police assistance cannot be provided, the custody manager is to: i. attempt to contact an appropriate family member, friend, or other responsible person to assist the person in travelling to their intended destination; and ii. where it has not been possible to contact such a person or arrange such assistance, record the reason for this.

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1 Introduction

1.1 John Amarathuparambil John **(John**) died on 6 June 2023 in the Sydney suburb of Riverstone. He was 62 years old.

1.2 At around 11:23am on 6 June, John was arrested at a house in Lalor Park by police officers from Riverstone police station. The officers were attending in response to a triple zero call from a woman who reported that she had encountered a stranger in the kitchen area of her home. Attending police located John still in the woman's kitchen and arrested him. He was confused, unkempt, wore no shoes and had dirt caked on his feet. He appeared to believe, wrongly, that he had previously, or currently, lived at the house.

1.3 John remained at the scene for 35 minutes before police transported him to Riverstone Police Station. He was charged with trespass and was released shortly after 2:00pm, having been at the police station for about 90 minutes.

1.4 John was found deceased at around 7:00am on the morning of Wednesday 7 June 2023 in a vacant lot in Garfield Rd East, in Riverstone. CCTV footage obtained by police indicated that he had collapsed at about 5:30pm on the evening of 6 June in the same location where his body was found.

1.5 In making these findings, I acknowledge the profound impact that John's death has had, and will continue to have, on his family and friends, and on behalf of the Coroners Court of NSW, I extend to them my sympathies for their loss.

2 Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a coroner is responsible for investigating all reportable deaths. This investigation is conducted primarily so that a coroner can answer questions that are required to be answered pursuant to section 81 of the Act, namely, the identity of the person who died, when and where they died, and the cause and the manner of that person's death. A secondary function of a coroner is to make recommendations, when considered necessary or desirable, in relation to any matter connected with the death.

2.2 The focus of this inquest was on the manner and cause of John's death. A wide range of material was obtained during the coronial investigation that went towards exploring

these two central issues. This material was tendered at the commencement of the inquest in the form of a seven-volume brief of evidence. Several witnesses who had provided statements during the coronial investigation also gave oral evidence.

2.3 An issues list was developed to guide the coronial investigation and the conduct of the inquest. These issues were:

1. *What was the cause of John's death.*
2. *In relation to police interaction with John at 2a Swan St, Lalor Park:*
    a) *Should the officer in charge at the scene have sought medical assistance for John while at that location?*
    (b) *More generally, should police have identified and acted on potential concerns relating to John's health and welfare while at 2a Swan St? If so, does any failure to do so give rise to any police training and education issues?*
3. *In relation to John's custodial status:*
    a) *What was the basis for John's ongoing arrest and/or detention when transported to Riverstone police station?*
    b) *Was it necessary or appropriate for John to have been entered into custody at Riverstone police station and released on bail as opposed to being issued a Field Court Attendance Notice and/or being provided with assistance in relation to his health and welfare?*
4. *What options were available to A/Sgt Hodder to arrange for a health or mental health assessment of John and should he have made any such arrangement?*
5. *In relation to John's release from custody:*
    a) *Was it appropriate for police to release John onto the street in Riverstone, bearing in mind the distance from his home address?*
    b) *Was it open to police at either Riverstone Station or earlier at 2a Swan St Lalor Park, to provide John with assistance to return home, or to contact his next of kin? If so, should they have done so?*
6. *In relation to other training and policy issues:*

a) *What, if any, training do police receive to help them consider the possibility that someone thought to be intoxicated may, in fact, be suffering from a significant medical episode?*

b) *Are there any other policy and training issues arising from police interactions with John?*

7. *Are there any recommendations that should be made?*

2.4 As is often the case, during the inquest some issues assumed greater significance, while others receded in importance. While it has not been possible to address all the evidence adduced as part of the inquest in these findings, I have outlined what I consider to be the key evidence, and the most important issues, under the headings below.

3 John's life

3.1 While any inquest inevitably focuses on the circumstances of a death, it is important to recognise and acknowledge the life of the person the subject of the inquest in a brief and hopefully meaningful way, to appreciate what their life, and their loss, meant to those who knew and loved them.

3.2 John was born and raised in Kerala, in southern India. He obtained a qualification in mechanical engineering in Bombay (now Mumbai), after which he moved to Oman in the Middle East, where he worked for 15 years. In 1997 John married Lincy. The couple's son, Jobin, was born in 1998, and their daughter, Jewel, in 2002. John and his family moved to England in 2004, and then to Australia in 2007. John worked in Australia up until about 3 years prior to his death.

3.3 The accounts of John's family members and others who knew him indicate that John was generally well-liked and sociable, and that when he was sober, he would be highly organised in his approach to life. However, over time John developed a significant problem with alcohol. His alcoholism occasionally gave rise to violence and ultimately played a part in his separation from Lincy in 2017.

3.4 After John moved out of the family home he lived alone. For roughly two years prior to his death, John was living in a flat at 17/67 Hefron Rd in Lalor Park. He maintained ongoing contact with his family, who from time to time provided him with assistance.

John's son Jobin described providing practical assistance to his father with matters such as moving house and transport, and Jobin and Jewel had visited John while he was undergoing treatment for his alcoholism. Lincy John maintained ongoing phone contact with him in the interests of his general welfare.

4 John's physical and mental health

4.1 John had frequent contact with his General Practitioner (**GP**), Dr Seelan, from the Bridgeview Medical Practice in Toongabbie. In his statement, Dr Seelan explained that John suffered from chronic depression and chronic alcohol dependence, and that he also had type 2 diabetes mellitus, hypertension, dyslipidaemia (high cholesterol) and benign prostate enlargement.

4.2 At the time of his death John was prescribed medication for his physical health conditions, which included metformin (for diabetes), rosuvastatin (a cholesterol lowering medication) and atenolol (a beta blocker used to treat high blood pressure). Lincy John described John as very good in managing his health conditions, explaining that he took his medication regularly and that he regularly attended his GP for check-ups.

4.3 In relation to his treatment of John, Dr Seelan observed:

> *John had insight regarding his conditions and he always wanted to get professional help for his alcohol dependency. On his request I referred him to inhouse detoxification and rehabilitation facilities. Many of his admissions were self-referred. I was involved with follow-up care such as medication management, review of progress and support counselling*.

4.4 In the 17 months preceding John's death, his self-admissions to alcohol detoxification and treatment clinics were frequent. Most commonly he would spend periods of time of 3-5 weeks at either The Ramsay Clinic in Wentworthville or The Hills Private Hospital in Baulkham Hills. Prior to his death, John's most recent admission was from 20 April to 27 May 2023 at The Hills Private Hospital.

4.5 Evidence from Dr Samir Benjamin, a psychiatrist who cared for John at The Hills Private Hospital, was that during his last admission, John was prescribed the psychotropic medications Aropax (an anti-depressant), Seroquel (anti-psychotic and mood stabilising medication) and Melatonin (hypnotic medication). He explained that

antipsychotic medications are commonly used as an adjunctive treatment for chronic depression, particularly when patients do not respond to antidepressant medications alone.

4.6 One of the significant features to emerge from the evidence about the circumstances of John's death was that postmortem toxicological analysis of John's blood detected a toxic level of the prescription medication olanzapine (an antipsychotic commonly sold as Zyprexa). Although John had been prescribed olanzapine in the past, this medication had not been prescribed to him for nearly 12 months prior to his death.

4.7 Dr Benjamin's evidence was that at the time of his discharge from The Hills Private Hospital on 27 May 2023, John was *euthymic* (meaning that he had a stable mood), and he was optimistic that he would stay sober and improve his relationship with his family. He also planned to continue to attend Alcoholics Anonymous meetings at least three times weekly.

5 Events early on 6 June 2023

5.1 John's family members and a neighbour provided helpful evidence about John's presentation in the hours preceding his interaction with police at Lalor Park on the morning of 6 June. From this information the following is known.

- At 1:05am on 6 June, John phoned Lincy John and accused her of coming to his home and stealing his suitcases and hiding in his house.
- At around 2:00am John knocked on the door of his neighbour, Geoffrey Cole. Mr Cole told John to go back to bed. Mr Cole thought that John did not know where he was or what he was doing, but he did not consider this to be unusual for John, as he assumed that John was intoxicated.
- At 7:27am Lincy John phoned John. He said something to her about working at Woolworths.
- At 8:09am John called Lincy and told her that he was unable to remember things and said something about going to school.
- At 9:35am John called his son Jobin, who did not answer.

- At 10:17am Jobin phoned John. John said he was in Toongabbie. He seemed confused and said something to the effect that someone was at their house and queried why Jobin had let someone in the house. He sounded distressed and concerned. Jobin assumed he was intoxicated.
- At 10:54am John called Jobin again, but Jobin was unable to answer.

6 John's interaction with police at 2a Swan Pl Lalor Park

6.1 At 11:17am on 6 June a woman living in the granny flat of a house at 2a Swan Place, Lalor Park called police, alleging that a man was in her house.

6.2 In her statement, the resident of the granny flat said that she had heard her front door open and found a man, who she did not know, standing in her kitchen. He said to her *I'm here to eat* and put his keys on her table. He had a drink in his hand that he had brought with him. He also asked *Where are the two people that were here last night*? She locked herself in a bedroom and called triple zero. While she was on the phone with the triple zero operator, the woman could hear the man in the loungeroom talking on the phone and moving dishes around. She later found his drink in her fridge.

6.3 There is no issue that the man in the woman's house was John, as he was still in the kitchen of the granny flat when police arrived. John's flat in Heffron Road Lalor Park was 1km by road from the Swan Pl address. As his car remained at his home address, it appears likely that John had walked to Swan Pl.

6.4 Police arrived on scene at about 11:23am. The two officers first to arrive were Senior Constable (**SC**) Emma Cole and her partner Constable (**Con**) Mark Darley from Riverstone Police Station. They were followed by Con Jermayne Starr and Con Timothy Rodriguez, also from Riverstone Police Station. Soon after, two further officers attended from Blacktown Police Station, Sergeant (**Sgt**) Wendy Johnson and Con Jaye Hinkley. Sgt Johnson and Con Hinkley had very little to do with the incident and left less than 10 minutes after they arrived.

6.5 SC Cole assumed the role of officer in charge (**OIC**). In her statement, SC Cole recounted a conversation with John at the scene in which she asked him *Why are you here?* to which he replied *To collect my stuff, in the room. I was here.* She adds:

JOHN was hard to understand, so I asked him if he had anything to drink or did he take any prohibited drugs? To which JOHN said he had not. JOHN's eyes appeared to be glazed, almost with a film over them and was appeared to somewhat [sic] under the influence of something.

And later:

At the time JOHN's speech, I was just able to understand, and he was unsteady on his feet. He was very dishevelled and appeared to be affected by something.

6.6 Con Darley echoed SC Cole's observations:

...JOHN appeared as though he was under the influence of an intoxicating substance. JOHN appeared dishevelled in appearance at the time and his eyes were glassy. There were times that JOHN spoke incoherently at the scene.

6.7 SC Cole and Con Darley were only intermittently involved directly with John. The officers who had the most contact with John were Con Starr and Con Rodriguez, who assumed responsibility for guarding John after his arrest. These two officers stayed close to John, observing him and communicating with him over the course of 35 minutes prior to him being transported back to Riverstone Police Station. Both also recorded their interaction with John on body worn video (**BWV**). Con Starr kept his BWV running from the time of his arrival until John was locked in the back of the caged police vehicle, resulting in continuous footage of John over the period from 11:23am until 11:58am. Con Rodriguez' BWV captures the first 6 minutes of this period, at which time he turned off his BWV.

6.8 Officer Rodriguez comments in relation to John's appearance, that he *was not wearing shoes and he had dirt marks around his feet and legs. It was apparent to me that the Deceased had not bathed in a few days due to his dishevelled appearance and odour.*

6.9 In both his written statement and oral evidence, Con Starr explained that at an early point he began to form a suspicion that John may have suffered from *some manner of altered mind*. It was apparent to Con Starr that John did not have the capacity to understand the explanation he had to give concerning the reason for searching him. He said:

I listened to Mr John speak although I thought it was incoherent, I saw that he held his eyes wide open when focused on a person, I saw his hair appeared dirty

or sweaty. I thought he was inappropriately dressed wearing shorts and a T-shirt in June, which is winter. I formed a view considering what I was seeing in terms of his behaviour it was more likely than not that he was drug affected in some manner or suffering from some manner of delusion due to a mental illness or disorder.

And later

Mr John continued ranting incoherently, I couldn't really understand a word that he was saying, although I was satisfied that it appeared to my eyes to be English.

6.10 These increasing concerns prompted Con Starr to ask the question *You got any mental health conditions, diagnoses*? to which John replied *Yeah.* Unfortunately, any further answer was interrupted by SC Coles laughing and saying *Oh so your name is John John…Psych*.

6.11 Soon after this exchange, SC Cole is recorded laughing again with other officers in relation to a person referred to as [redacted] who she describes as a *friend* of John. According to Con Daley [redacted] lived nearby and was known as *a fairly prolific offender*. The tone adopted by SC Cole at this and other points seems to have provided a distraction from the attempts by other officers to garner information from John about his health. The brief of evidence includes all past holdings on the NSWPF Computerised Operational System (**COPS**) in relation to John. Notably, the only association of John's name with any female with the surname [redacted] is in an entry where both are separately listed as witnesses to a matter involving other parties. There is no suggestion of any sort of adverse link between the two.

6.12 Soon after he raised the question about mental health diagnoses, Con Starr asked SC Cole *You want an ambo, Cole, for a mental health*. Con Starr gave evidence that SC Cole's response was a dismissive hand gesture accompanied by her saying *no, he's just off his face.* Con Starr's evidence was that although he remained very concerned about John's mental state, he did not feel able to raise the question again with SC Cole who was his superior and the OIC. He said that he did not think asking SC Cole the same question again would result in a different response from her.

6.13 Another instance demonstrating the unfortunate approach taken by SC Cole to considering John's condition arose at the time Con Hinkley tried to determine whether language might be a factor in relation to the way John was communicating. He asked John what languages he spoke, although John's answers were interrupted by SC Cole twice, saying somewhat derisively *drunk, drunk*, apparently suggesting that this was the language John spoke.

6.14 There are several further aspects of John's presentation during the 35 minutes of the BWV that are notable. For example, John expresses on several occasions, his belief that he has some connection with the house that he entered and that his belongings are inside the house. Further, at the 21-minute mark of Con Starr's BWV footage John is observed to be talking to someone in the glass reflection of the door he is sitting next to. Officer Rodriguez remarks that *he's seeing things and hearing things. There's no man there*.

6.15 Police appear to believe that John to be drug or alcohol affected. However, in response to repeated inquiries as to whether he had consumed alcohol or taken illicit drugs, John repeatedly denies that he has consumed alcohol (although he admits that he does consume alcohol habitually) and states that he has never consumed illicit drugs.

6.16 Con Starr observed that John appeared to have yellowish patches in the white parts of his eyes, which he understood could be a symptom of liver disease. He says to John, [*y]our eyes look a bit jaundiced, you got any liver issues going on?* To which John replies *I didn't sleep yesterday or tonight*. Con Starr later observed that at the point of entering the caged vehicle John *appeared to stare at us with his eyes wide open*.

7 How should police have dealt with John at Swan Pl?

Section 22 of the Mental Health Act 2007 (**MHA**)

7.1 It was suggested that it was open to police officers when dealing with John at the Swan Pl address to deal with him pursuant to s22 of the MHA.

7.2 This section gives power to police in circumstances where a person is committing or has recently committed an offence or where they pose a risk to themselves or others, to take a mentally ill or mentally disturbed person to a hospital for assessment if it would be beneficial to the person's welfare to be dealt with in accordance with the MHA, rather than in accordance with law.

7.3 The terms *mentally ill* and *mentally disordered* are defined in the MHA by reference to a belief on reasonable grounds that the person is at risk to themself or others. Although the term *mentally disturbed* is not defined in the MHA, it is difficult to imagine that it should not be interpreted in a similar fashion, given that the powers granted to police by s22 enable the forcible apprehension of a person and the taking of them, not to a hospital, but to a declared mental health facility, that is, a psychiatric hospital.

7.4 Evidence given by NSWPF Acting Superintendent of the Mental Health Command, Kirsty Hales is that:

> *Fundamentally, officers are required to form a subjective 'lay person' assessment of the consumers presentation at the time, and to consider that presentation in the context of the specific elements of section 22 of the Mental Health Act.*

7.5 Superintendent Stynes' evidence was *that a section 22 threshold for the police is, we have to - if they're threatening self-harm or harm to others, or suicide, that's the threshold that we have to meet. If they're - if they're reaching that threshold, we'll do a section - we'll implement a section 22.*

Alternatives to s22 MHA

7.6 The chapter of the NSW Police Force Handbook (**The Handbook**) relating to *Mentally Ill People* (both the versions in force in June 2023 and currently) sets out a broad range of options for police to use, as *alternative options for mental health intervention*. These alternatives recognise that there may be situations in which a person's behaviour raises

concerns but does not reach the section 22 threshold. According to Acting Superintendent (**A/Supt**) Hales, *it is at the discretion of an officer and dependant on the circumstances as to whether a person's behaviour raises sufficient and ongoing concerns about the person's mental state such that some kind of alternative option is appropriate to manage those concerns.* Some of these options include:

- contacting the Mental Health Hotline number;
- engaging with the person's family or primary carer to take responsibility for the wellbeing of the person;
- referral to the Community Mental Health Team;
- where possible, making an effort to contact the person's treating clinician or care coordinator; and
- engaging the services of Ambulance NSW who may detain the person and take them for assessment.

Powers under the *Law Enforcement (Powers and Responsibilities) Act* 2002 (**LEPRA**)

7.7 Part 16 of LEPRA gives police powers in certain circumstances to detain an intoxicated person until such time as a *responsible person* can be found into whose care the intoxicated person can be released.

7.8 Section 6 of the NSWPF *Charge Room and Custody Management Standard Operating Procedures* (**Custody SOPs**) provides that an intoxicated person may be taken to a police station, or authorised place of detention, if

- *It is necessary in order to find a responsible person, or*
- *A responsible person cannot be found, or*
- *The IP is not willing to be released into the care of a responsible person, and it is impracticable to take the IP home, or*
- *The IP is behaving, or likely to behave, so violently that the responsible person would not be capable of taking care and controlling the IP.*

7.9 In his evidence, institutional witness for NSWPF, Superintendent (**Supt**) Raymond Stynes, clarified that this was the case if *they're being detained as an... intoxicated person...if they haven't committed any other offence*. This position seems to reflect

s206(2) of LEPRA which provides that *[a] police officer is not to detain a person under this section because of behaviour that constitutes an offence under any law*.

Other provisions relating to intoxicated persons

7.10 The *Intoxicated People* chapter of The Handbook (both the version in force in June 2023 and currently) provides as follows:

> *Police should be mindful that an intoxicated person seriously affected by alcohol or other drugs may require immediate medical attention. Medical assessments of people who appear to be intoxicated are to be conducted by a doctor or a registered nurse at a public hospital.*
>
> *Be alert to the possibility that some people who appear to be intoxicated may in fact be ill or injured.*

7.11 The Custody SOPs were expressed by Supt Stynes to be the principal policy document concerning the management of persons in custody or who are otherwise detained under Part 16 of LEPRA. Section 5 of the version of this document in force in June 2023 relates to the roles and responsibilities of arresting/escorting police. Section 5.1 provides that:

> *Arresting/escorting police are responsible for the care, control and safely of PICs[1] until they are formally handed over to the Custody Manger or another officer (including Corrective Services NSW).*
>
> *This responsibility includes seeking medical attention if the PIC needs or requests it, on reasonable grounds. Any police officer regardless of their role or rank has the authority to call an ambulance.*

7.12 In addition, section 6 of the Custody Management SOPs provides that:

> *Police should always consider the safely of an intoxicated person (IP) and are reminded to seek urgent medical attention where appropriate.*

7.13 Conclusion

- There was no suggestion in the evidence that John had ever been diagnosed with a serious mental illness, nor that he posed a risk to himself or others. While police possessed the

[1] person in custody

power under s22 of the MHA to take John to a *declared mental health facility* for a mental health assessment, the failure to do so was not unreasonable in the circumstances, given what was known of John and his presentation at the scene.

- While there is no expectation that police should be able to exercise clinical skills, it is important that they have a level of concern for those in their custody if they are to make reasonable decisions in relation to the wellbeing of individuals to whom they owe a duty of care. While some aspects of her behaviour indicated that SC Cole evidenced her concern for John's welfare, the comments made by SC Cole at various points in her interaction with John gave the appearance that she did not have an appropriate level of concern for his welfare.
- Associate Professor Sullivan stated *[i]t remains unclear that there was clear evidence of physical concerns which a layperson (such as police) would or should have identified and which clearly warranted medical assessment*. There were challenges in interpreting John's presentation at the Swan Pl address. Although the decision of attending police not to seek medical attention or mental health assistance for John was a missed opportunity, I am not satisfied that this decision was unreasonable in the circumstances or contrary to policy and procedure.

8 Why was John detained and transported to Riverstone police station?

8.1 There is some ambiguity in the evidence in relation to the basis upon which John was detained and transported back to Riverstone Police Station, that is, whether he was detained as an intoxicated person under Part 16 of LEPRA or whether he was arrested.

8.2 At the point at which John was handcuffed at 2a Swan Place he was told by Con Starr that he was arrested for Break and Enter. At that time officers had no understanding of the circumstances in which John had entered the house and his mental state. Seven minutes later, at 11.30, SC Cole again advises John that he is under arrest. She cautions him, although she gives no reason for the arrest. Arrangements are then made for a car crew to attend to transport John to Riverstone Police Station. At 11.38am SC Cole asked John if anyone lived at home with him or whether he house-shares. John advised that he lived alone.

8.3 The two officers involved in transporting John back to Riverstone police station were Con Sophia Fenech, and Con Joshua Peppin. Officers Fenech and Peppin appear to have

understood from SC Cole that John was being taken to the station as an *intoxicated person*, and that SC Cole was concerned about John's welfare were he simply to be dropped home. According to Con Peppin, SC Cole said *If we just let him go he will probably die and it will be a critical incident*. Officer Fenech recalls SC Cole saying *I don't want to drop him home and for it to be a critical incident*. Officers Fenech and Peppin understood that any charge would proceed by way of the later issue of a Future Court Attendance Notice.

8.4 The evidence of the Custody Manager at Riverstone Police Station, Acting Sergeant (**A/Sgt**) Christopher Hodder, was that the conveying police told him that John *had been detained as an intoxicated person and was to be issued a Future CAN or Field CAN for the offence of trespass when he was deemed suitable for release.* A/Sgt Hodder explained

> *There's separate reasons to detain someone, however, if they have committed an offence, we don't arrest them, like, we don't detain them as an intoxicated person, we detain them as an arrested person and they're in a time out for intoxication. So it would be a different reason to detain the person.*

8.5 According to SC Cole she informed officers Fenech and Peppin that *JOHN was under arrest and was going back for a trespass and intoxication/being under the influence of something*.

8.6 When it was put to Con Darley that consideration might have been given to whether it might have been appropriate to take John to his home from Swan Pl, he replied *I believe with the offences, we, at the time, believed it happened, that it wasn't appropriate….it may have been a consideration for later on after the custody process, but possibly not at the time*. Con Darley did not believe that John was to be taken back to the police station as an intoxicated person.

8.7 On Con Darley's evidence, when he and SC Cole returned to Riverstone Police Station, both Con Darley, SC Cole, and the proactive team leader, Sgt Winter, discussed whether they could prove a charge of Break and Enter against John. According to Con Darley, the view of Sgt Winter was that they could not. There was a further discussion as to what charge was available, ultimately resulting in the laying of a charge of Unlawful Entry onto Enclosed Lands.

8.8 When Superintendent Stynes was asked how he would respond to a scenario similar to that involving John, he replied *personally I would more than likely take that person into custody and remove them from the area to…make sure there's no repetition of any offence, take them back to the police station, and then deal with things following there.*

8.9 Conclusion

- The officers who attended the incident at Swan Pl clearly believed that John had committed an offence that necessitated his arrest.
- Despite the understanding of Con Fenech and Con Peppin (who did not attend the incident at Swan Pl except for the purposes of conveying John to Riverstone Police Station), the evidence does not suggest that the sole reason for John's detention and transport back to Riverstone Police Station was pursuant to Part 16 of LEPRA, that is, that John was detained solely as an intoxicated person.
- I am satisfied that SC Cole's decision to transport John back to Riverstone Police Station and formally charge him was motivated in part to ensure his removal from the Swan Pl address and allow for the imposition of bail conditions that would prevent him from returning to that address.
- While there may have been alternatives open to SC Cole to deal with John, such as taking John home and sending him a Future Court Attendance Notice, this option also carried risks, given her belief that John was intoxicated. The fact that she chose to arrest John and charge him was neither unreasonable in all the circumstances nor contrary to NSWPF policy and procedures.

9 Was A/Sgt Hodder's assessment of John at Riverstone Police Station adequate?

9.1 It was clear that Con Fenech was concerned about John's welfare during the drive from Swan Pl to Riverstone Police Station.

> *Due to the state that I observed JOHN to be in I believed that JOHN was intoxicated by some sort of drug or alcohol. Due to this, I sat in the back seat of the caged vehicle to ensure I could clearly see into the cage area where JOHN was sitting. I did this as I was concerned for his welfare as he appeared intoxicated and I wanted to make sure I could constantly monitor him to ensure he remained alert and conscious.*

9.2 According to Con Peppin, after he and Con Fenech had arrived at Riverstone Police Station, but before A/Sgt Hodder had seen or met John, A/Sgt Hodder said *Is this guy intoxicated or is it just mental health*. Con Peppin's evidence was that in response to this comment, he explained the circumstances of John's arrest and conveyed his belief to A/Sgt Hodder that John was drug affected. The account given by A/Sgt Hodder was somewhat different. He agreed he made the comment *Is this guy intoxicated or is it just mental health?* but said that he had made that comment as John *was mumbling to himself as he came through*.

9.3 A/Sgt Hodder placed John in a dock where he was able to have a continuous view of him. His evidence was that he spoke to John to assess his sobriety. According to Con Peppin:

> *LSC HODDER spoke with JOHN whilst he sat in the dock. JOHN would go off on short tangents where he would say sentences in gibberish before returning to normal speech. JOHN still continued to keep his eyes wide open and look around aimlessly. LSC HODDER asked "Where do you live" and JOHN said "90 Heffron Road, unit 17".*

9.4 John did not in fact live at 17/90 Heffron Rd, but instead at 17/67 Heffron Rd. It seems that he also believed that he was at Blacktown Police Station as opposed to Riverstone.

9.5 According to A/Sgt Hodder, although he initially found it difficult to understand what John was saying, when he requested that John speak more slowly, he was better able to understand him. A/Sgt Hodder also asked that John read from the Part 9 document,[2] which he *read fluently with nil issues*. A/Sgt Hodder added:

> *John had red eyes and went off on tangents when speaking, however showed no other signs that would indicate being affected by a drug or alcohol There was no smell of intoxicating liquor, JOHN was able to follow instructions and could walk in a straight line. He was not swaying or slurring his speech. JOHN stated he did not use drugs and though he did have an issue with alcohol, had not consumed alcohol since the previous Sunday, being the 28th of May 2023. The accused knew the day to be Tuesday.*

[2] This is the document given to persons in custody which outlines their rights

9.6 In his oral evidence, A/Sgt Hodder explained that *John just appeared to be a regular person. Like, he would talk, he could answer questions and then he would keep talking about other things, which I didn't take as very uncommon for someone who enters custody*.

9.7 On the face of it, there appears to be considerable difference between how John is described by police at Swan Pl, and how he is behaviour is perceived in the charge room at Riverstone Police Station. However, Con Darley, who was present with John at Swan Pl and in the charge room, commented in his statement:

> *While he was in custody, I took custody fingerprints and photographs of JOHN. During this process, JOHN spoke to me normally and appeared to be more coherent than at the scene, although his eyes were now bloodshot.*

9.8 Con Darley expanded upon this in his oral evidence.

> *He did appear a bit confused at times with what I was asking him to do or - or things I was saying. And he was a - at times he was a bit uneasy on his feet but at - at - sometimes as well, he was very understanding and at other times he was walking perfectly normal as well, or normally.*

He added

> *I think he was generally steady but you can see in the footage a few times, obviously there are some moments of unsteadiness but he never, from my memory, he never fell over, he never had any major stumbles or trips or anything like that. And I also don't know what his normal is, so that very well might have been what was normal for him, so it's hard for me to say.*

And later

> *My baseline was, I guess, the - the scene when I originally met Mr John where he, like I said, he was in probably a - a bit more of a confused state at that time and then at the station was far more coherent and appeared much more, what I would describe as, baseline normal.*

9.9 Con Darley's oral evidence was that he was speaking to John throughout the whole process in the charge room. He accepted that there were some times in the custody room when John may not have understood fully what was being said to him, once when

John went to walk out of the custody room and perhaps another time when Con Darley was taking a photograph of him and he had to ask John to put his hands down. He concluded:

> *…he certainly at that time in custody, he was much more coherent and much more, like, talkative and that sort of stuff, than he was at the scene. So it appeared like his condition had…improved to me from what I had observed because, like I said, he was - he was much more - like, you can see in the footage that he can understand what I'm - I guess, to a degree, what I'm asking him to do and he is complying with those things even if he does get a bit confused at times. But throughout the whole process, he was very talkative and chatty and jokey and all that sort of stuff.*

9.10 Given the absence of any audio on the charge room CCTV, it is not possible to independently verify what John's speech was like while he was in custody at Riverstone Police Station, nor the extent to which he was confused in his communication.

9.11 As part of his assessment of John A/Sgt Hodder used a straight-line walking test and another physical test involving asking John to put feet his feet together and close his eyes. There was some focus in the inquest on the appropriateness of such tests as a means of assessing intoxication or its absence. Superintendent Stynes' evidence was that he had no opinion on whether a custody manager should ask someone to walk a straight line or close their eyes and put their feet together to assess their sobriety. He suggested that a Custody Manager might consider *their breath smelling of intoxicating liquor, slurred speech, bloodshot eyes, and…there's also visual and - a visual assessment and a questionnaire that is in the custody management record that they have to ask and - and complete during the custody process.* The unchallenged evidence of A/Sgt Hodder was that he had conducted these assessments in addition to the physical tests he asked John to undertake to assess his balance and coordination.

9.12 A/Sgt Hodder concluded that in his view John was not affected by either drugs or alcohol. His evidence was that he advised the escorting police that he would speak to the OIC to clarify whether John was brought to the police station due to intoxication. He then spoke to SC Cole, who by that time had returned to the police station. According to A/Sgt Hodder, he was advised by SC Cole that John was in fact arrested *to stop the continuation and repetition of the offence, not intoxication*…as *JOHN had said*

he would return to the area he was trespassing, as he believed he had a right to be there. SC Cole's account of this conversation with A/Sgt Hodder was that she:

> *explained to him that I believed that he was under the influence of something and was unable to drop him home as he was living by himself. I explained that he was under arrest for an offence of trespass and that he was here in relation to being under the influence of something.*

9.13 Con Darley photographed and fingerprinted John. SC Cole booked him into the Custody Management System (**CMS**) and completed the *Field Arrest Report* (reflected in the *Brief Assessment* on the CMR) in which she describes John's intoxication level as *slightly affected*. Under *comments* she recorded *affected by something. Confused and kept changing his story*. While this was occurring, A/Sgt Hodder continued to talk to John. Once John was entered on the CMS, A/Sgt Hodder completed the *Visual Assessment*, *Vulnerability Assessment* and *Questionnaire* parts of the CMR.

9.14 The *Custody* chapter of The Handbook in force in June 2023 provides that *[p]olice are not expected to diagnose people's conditions.* However, they must '*immediately call for medical assistance by calling an ambulance* if a person in custody:

- appears to be ill;
- is injured;
- drifts in and out of being awake (semi-conscious) or unable to be woken up (unconscious);
- fails to respond normally to questions or conversation;
- is severely affected by alcohol or other drugs or withdrawing;
- is an intoxicated person who also has diabetes;
- cannot walk without assistance;
- cannot talk coherently;
- cannot sit upright without assistance;
- requires medical attention, and the grounds on which the request is made appear reasonable; and
- otherwise appears to be in need of medical attention.

9.15 During his assessment of John, A/Sgt Hodder noticed a cut on John's forehead and asked whether he wanted an ambulance to be called to assess him. John indicated he may have an injury to his side, although when he lifted his shirt A/Sgt Hodder was unable to see any mark on his side. John declined the services of an ambulance.

9.16 Relevant to the issue of whether or not A/Sgt Hodder should have called an ambulance for John is Associate Professor (**A/Prof**) Sullivan's comment: *in my review of the footage in the custody suite, and when he was seated at the house into which he had intruded, I didn't see that John appeared very tremulous. I didn't see that. And I think had that been present, then the police may have made, had more suspicions that he was unwell, as opposed to just a bit odd. So in the absence of really clear indicators, I can appreciate that the police may not have formed a view that he was medically unwell and, you know, not needing to have an ambulance called.*

9.17 However, Associate Professor Sullivan also noted: *… delirium, by definition tends to be fluctuating. So you can have periods of lucidity or clarity of thought and orientation which can last for minutes or, you know, up to a few hours before the person returns to a more delirious state. So it's not a static state and consequently, in a particular situation, such as when being interviewed by police, you know, a person may be able to muster some rationality and provide plausible or cogent explanations.*

9.18 Conclusions

- A/Sgt Hodder's assessment of John in the charge room at Riverstone Police Station did not only include requests for John to perform certain actions in order to assess his balance and coordination, but also included visual observation of him over a 90 minute period, conversation with him, asking him to read passages from the Part 9 document and completion of the Visual Assessment, Vulnerability Assessment and Questionnaire parts of the CMR.
- The evidence of Associate Professor Sullivan was that there could be fluctuations in confusion and delirium. In this context, I accept the evidence of Con Darley, who had been with John at both the Swan Pl address and in the custody room at Riverstone Police Station, that John was considerably more coherent at the police station than he was when he was arrested.

- I accept the evidence of Associate Professor Sullivan who had reviewed the BWV footage of John from the Swan Pl premises and the CCTV footage from the custody area, that he did not observe any evidence of tremulousness or any of what he described as *really clear indicators* to suggest that John was medically unwell, such that he needed to have an ambulance called.
- While I accept that there were some instances where John was confused, such as in relation to his address or as to whether he was at Blacktown or Riverstone Police Station, I am not satisfied that while he was in the custody room, there was clear evidence of John's need for assistance with his physical or mental health such that the failure by A/Sgt Hodder to contact an ambulance or seek other assistance for John was a breach of his duty of care towards John.
- I am satisfied that in his dealings with John while he was in the charge room at Riverstone Police Station, A/Sgt Hodder behaved reasonably and in accordance with NSWPF policy and procedures.

10 Was it appropriate for John to be released from custody in the way he was?

10.1 Once the charge, bail and other paperwork was completed, at about 2:05pm, John was allowed to leave Riverstone Police station. According to A/Sgt Hodder John asked him *if we have tokens or similar so he could get home, as he had previously been given travel passes from Blacktown Hospital*. According to A/Sgt Hodder he advised John that they did not have tokens and that John could call a taxi himself or one could be arranged at the police station foyer if he could not do so. After John said he would walk home, as it was not far, A/Sgt Hodder's evidence was that he reminded John that he was at Riverstone, not Blacktown. A/Sgt Hodder's evidence was that John advised that he would catch a taxi and left via the exit gate.

10.2 In his oral evidence A/Sgt Hodder explained that it was only when John was being released from custody that he had any concern about him, because John had said that he was going to walk back to his car. His evidence was that he became concerned about the injury to John's head that he had observed and again offered to call an ambulance He then recounted the following conversation:

> *And at that point, he said, "No, I can call a, a taxi." I said, "Do you have a phone that works?" He pulled out his phone, and I remember that it worked. And I said, "What's the taxi number?" and he repeated two numbers. And the following day, I think one was a taxi number and another one was a 1300 number, and I looked that up the following day and that was a Transport Info number.*

10.3 Supt Stynes was taken to policies that deal with procedures at the point of release from custody. Section 7 of the current Custody SOPS deal with *Release/Transfer*. Although they address distinct circumstances such as Corrective Services Prisoners and Medical Escorts, they do not deal with the responsibilities of Custody Managers generally upon release of a person from custody at a police station and any transport or welfare considerations that might arise at that point. The custody chapter of The Handbook contains a brief section headed *Releasing People from Custody*. It indicates that when a person who is ill is to be released, reasonable steps should be taken to obtain appropriate treatment by notifying a doctor, relative or friend. It also states:

> *Remember, your duty of care requires reasonable steps be taken to ensure the ongoing safety and welfare of a person released from custody. The person must*

be capable of caring for themselves or arrangements made for a person to care for them.

10.4 The guidance in the Handbook is very general and limited. The Custody SOPS do not appear to contain any guidance at all.

10.5 The point of release provides a valuable opportunity for the development of a procedure or protocol to be applied by police prior to releasing someone from custody, that serves to ensure police have adequately turned their minds to the question of risks that might be associated with someone leaving a police station without adequate arrangements in place to ensure their safe return to their home or some alternate address.

10.6 Conclusions

- At the time of his release from custody, having spent 90 minutes with John, A/Sgt Hodder did not believe that John was intoxicated or otherwise unwell. Irrespective of this, A/Sgt Hodder turned his mind to how John was to make his way home after his release from custody.
- When John said he would walk home, A/Sgt Hodder reminded John that he was at Riverstone Police Station not Blacktown and again offered to call him an ambulance and when he declined the services of an ambulance, to call a taxi. When John said that he would call the taxi himself, A/Sgt Hodder ensured that John had the ability to call a taxi (a functioning mobile phone), information about the number to call, and the funds to pay for a taxi (he knew John had $75.00 in cash in his possession).
- I am satisfied that in the context of his subjective belief that John was neither mentally nor physically unwell, A/Sgt Hodder acted reasonably and in accordance with NSWPF policy and procedures when he released John from Riverstone Police Station.

11 What is known of John's movements after leaving Riverstone police station?

11.1 Part of the investigation into John's death involved the compilation of information derived from CCTV of the local Riverstone area, as well as John's phone records and details related to purchases that he made.

11.2 It appears that John spent much of the three hours and twenty minutes following his release from Riverstone Police Station on foot wandering around the Riverstone shopping and business area. He passed the police station on several occasions.

11.3 John's phone records indicate that he called a taxi company with an Indian country code at 3:32pm, the call being of nearly 5 minutes duration. In the following twenty minutes he sent two text messages to Indian phone numbers, the content of which is unknown.

11.4 Sometime after 4:00pm John bought a loaf of bread from a bakery. At 4:25pm he entered a *Subway*. He took a seat with some food and drink items that he was already carrying. The Subway staff member, Mr Kaur, observed that John had a bag containing five Powerade bottles containing different coloured liquid. He drank from one while he ate some food. After sitting at a table for 25 to 30 minutes John came to the counter and bought a chicken schnitzel *sub*. Mr Kaur describes John as follows:

> *He walked up to the counter and I took his order. I noticed the man had very red eyes. I saw that his hands were vibrating and had small shakes constantly. The man didn't talk properly he used hand signs to point at the salad items that he wanted.*

11.5 John left Subway at 4:53pm. By this time almost 3 hours had passed since his release from Riverstone Police Station.

11.6 CCTV footage indicates that at 5:34pm John collapsed as he neared the boundary fence at Lot 1 Garfield Rd East. This location is 1.5km southeast of the Subway premises. It appears that John walked to the location. His body is not seen to move after that time. John was found deceased at approximately 7:20am the following morning.

12 What was the cause of John's death?

<u>Autopsy</u>

12.1 On 13 June 2023 Forensic Pathologist Dr Rianie Van Vuuren conducted a coronial postmortem examination.

12.2 Dr Van Vuuren found that the heart was unremarkable with mild coronary atherosclerosis. The liver was markedly fatty with early nodular changes. Microscopic examination showed mild coronary atherosclerosis with focal areas of fibrosis in the heart. The liver tissue was essentially replaced by fat.

12.3 Biochemistry examination showed a low glucose level and a raised beta hydroxybutyrate level of 1451umol/L.

12.4 Toxicology showed a low alcohol level in the blood and no alcohol in the urine. Atenolol, diazepam and its metabolites, nordiazepam and metformin were present in non-toxic levels. Olanzapine was present in a toxic level.

12.5 Dr Van Vuuren commented that acute olanzapine toxicity can cause various extrapyramidal symptoms, increased motor tone, changes in movement and involuntary motor activity. Effects of toxicity are convulsions, respiratory depression, hypertension or hypotension, or cardiac arrhythmias. Olanzapine can also have profound cardiometabolic problems, including obesity, hyperglycaemia, hypertension and dyslipidaemia, all factors associated with sudden death.

12.6 While Dr Van Vuuren was unable to conclusively determine a cause of death, she commented that the cause of John's death was most likely an acute cardiac arrythmia.

Expert evidence

12.7 During the coronial investigation, several expert reports were obtained to assist in explaining the cause of John's death, the toxic levels of olanzapine found in his postmortem blood, and John's presentation to police. Reports were obtained from:

- Professor Alison Jones (**Prof Jones**), Toxicologist;
- Associate Professor (**A/Prof Adams**) Mark Adams, Cardiologist; and
- A/Prof Danny Sullivan (**A/Prof Sullivan**), Psychiatrist; and

These experts also gave oral evidence.

The evidence of Prof Alison Jones

12.8 Prof Alison Jones is a specialist general physician and clinical toxicologist.

12.9 Prof Jones noted that the most likely observable effects of olanzapine toxicity would have been drowsiness and slurred speech. She also observed that the CCTV footage at the time of Mr John's arrest appears to show him confused and slightly slurred in speech, though not overtly drowsy. She considered that the slurred speech was compatible with an olanzapine overdose, but not diagnostic of it (it could have been due to other substances not found at postmortem).

12.10 She considered it was possible that olanzapine toxicity in combination with other prescription medication in John's system meant that it was possible that John may have succumbed to the combination of depressive effects of those drugs, however she noted that it was also possible that John had suffered a sudden cardiac death.

12.11 She considered that with hindsight it may have been preferable for John to have been medically assessed when he was arrested by police and displaying features of being *rambling and intoxicated*, however she queried whether John's future risk of demise was foreseeable by police at the time of his arrest.

12.12 Prof Jones observed that even if John had taken one or more olanzapine overdose(s) prior to his arrest, and he was assessed medically at the time of his arrest, unless this overdose(s) was declared to medical staff and/or he had corroborating clinical features such as miosis and hypotension, then he might not have received close monitoring for overdose complications until one occurred, and his death might not therefore have been preventable. If John died of a sudden cardiac death unrelated to olanzapine, Prof Jones' view was that could have occurred at any time given his inherent risk factors.

The evidence of A/Prof Mark Adams

12.13 A/Prof Adams is a senior staff specialist the Royal Prince Alfred Hospital as a general and interventional cardiologist and an Associate Professor of Medicine at the University of Sydney.

12.14 The view of A/Prof Adams was that it was most likely that John died due to a cardiac arrhythmia and that the underlying cause of the arrhythmia may have been multifactorial, including olanzapine toxicity, ketosis, diabetes, cardiac fibrosis, alcohol abuse and obesity. John's obesity, diabetes, myocardial fibrosis and his alcohol abuse would all have predisposed him to developing an arrhythmia. There was mild atherosclerosis in two of John's coronary arteries, mild perivascular fibrosis and

extensive fibrosis in the papillary muscles of the heart. In addition, John's postmortem level of Beta Hydroxybutyrate (BHB) was extremely high at 1451mcmol/L (normal fasting level is 55-150 mcmol/L) indicating a high level of ketones at the time of death.

12.15 A/Prof Adams commented that In John's case, autopsy and toxicology results rule out all other causes of sudden cardiac related death other than arrhythmia. He commented that John had several factors that could have led to QT prolongation and that may have predisposed him to experience a fatal arrhythmia.

12.16 In relation to John's presentation to police, he observed that several factors may have contributed. These include the possibility that he was suffering from diabetic or alcohol related ketoacidosis, which can cause delirium, or that his state was related to toxic levels of olanzapine. He observed that olanzapine, even at normal doses has been associated with delirium and transient cognitive impairment. However, he commented in his oral evidence that olanzapine is not a big cause of sudden death other than by arrhythmia, and even then, it is not common unless it is in very high doses. He agreed with Prof Jones that death by olanzapine overdose might be expected to involve a person becoming drowsy and experiencing respiratory depression.

12.17 A/Prof Adams considered that John *may have had a chance* had medical attention been sought on 6 December 2023. However, on balance, he considered it more likely than not that John's death would not have been preventable even if police had sought medical attention at any stage during their interaction with him on 6 June 2023.

12.18 He observed that if John's confused state had been due solely to diabetic ketoacidosis, this would likely have been recognised and successfully treated. A/Prof Adams also noted that although Mr John's mental state did seem to have improved somewhat during his time at the Riverstone Police Station, he still seemed confused when he left. He observed that it would be ideal if it were possible to assess that a person is safe to be released.

The evidence of A/Prof Danny Sullivan

12.19 A/Prof Sullivan is a consultant adult and forensic psychiatrist. He described John's presentation to police on 6 June, and later, as follows:

> *Mr John was confused. He was disoriented to place. He appeared to be hallucinating or misinterpreting environmental stimuli. Body-worn video*

captured him appearing delirious, with restricted facial movement, confusion, perseveration, impaired attention and possible confabulation. He had no shoes. He was observed at Subway to be tremulous.

12.20 He considered these features to be consistent with delirium, or an acute confusional state. He observed that there are many potential causes of delirium., and that in this case the most likely possibilities include alcohol intoxication or withdrawal, diabetic complications, olanzapine overdose, infection, or cerebral hypoxaemia due to cardiac concerns. He observed that people with hypoglycaemia or hyperglycaemia related to diabetes may present with delirium.

12.21 A/Prof Sullivan felt that it was not obvious clinically that John was intoxicated with olanzapine, as this would more likely present as *overt sedation*.

12.22 A/Prof Sullivan considered that the most likely cause of John's confusion on 6 June 2023 was alcohol withdrawal. This was due to his history of severe alcohol dependence, a history of rapid relapse after detoxification, the evidence of recent alcohol use at his residence, Lincy John's observations about his confusion in the early hours of 6 June 2023, evidence of tremulousness at Subway, and his behaviour.

12.23 In A/Prof Sullivan's opinion John's death may have been preventable if he received a comprehensive medical assessment such as in an emergency department, including blood tests (to exclude metabolic disturbance or altered blood glucose levels) and breathalysing, although it is speculative as to whether investigations would have revealed a cause of the delirium and treatment for it. He felt it was unclear that police would, or should, have identified physical concerns which warranted medical assessment (although a nurse or GP may have assisted police with determining if further assessment/investigation was warranted).

12.24 Conclusions

- Although the evidence suggests that the terminal cause of John's death was cardiac-related, in my view, the recording of his death as *cardiac arrhythmia* or *acute cardiac arrythmia* alone, does not adequately reflect either John's behaviour and conduct on the day of his death or the ambit of the postmortem findings.

- Despite the postmortem findings of a toxic level of olanzapine in John's blood, observations made of John in the hours before his death were not consistent with olanzapine toxicity as the cause of death, although the olanzapine may have had some impact on John's cardiac functioning.
- The findings at postmortem that John's liver had essentially been replaced by fat and the frequent observations made by police officers on 6 June that John's eyes appeared yellow or jaundiced, suggest that his liver function was significantly impaired, likely due to chronic alcohol misuse.
- The findings that John had low alcohol in his blood at the time of his death and no alcohol detected in his urine, suggests that his intake of alcohol in the time leading to his death was negligible.
- The significantly high levels of beta hydroxybutyrate found at postmortem and John's observed behaviour at various points on the day of his death suggest that John was suffering from alcohol related ketoacidosis resulting from alcohol withdrawal immediately prior to his death.
- It is possible that John consumed olanzapine as a means of mitigating some of the symptoms associated with alcohol withdrawal.
- John's cause of death should reflect not only the terminal cause of his death, but the proximate cause of his death. I propose therefore to record the cause of John's death as *complications of chronic alcohol misuse and olanzapine toxicity*.

13 Conclusion

13.1 Police officers are not clinicians. They are often required to make difficult decisions in very short periods of time that frequently require a fine balancing of the needs of victims, presumed offenders, police, and the community more generally. In the course of their work, they encounter situations that are physically or psychologically confronting or confusing, or which involve people with mental illness, those who are drug or alcohol affected, or individuals who are violent, unpredictable, or emotionally heightened. By contrast, inquests are conducted in the calm of a courtroom, with the benefit of time and the clarity, and sometimes bias, brought by hindsight.

13.2 It is understandable for those who have lost a loved one or those who are tasked with investigating a death to reason back from a what ultimately occurs and criticize those who did not see it coming, to speculate whether if one thing or another had or had not occurred, whether the person at the heart of the inquest might still be alive. There must, of course, be oversight of the use of the considerable powers given to police to arrest and detain individuals, and examination of the use of those powers in the context of the responsibilities that police owe to those in their custody. However, the focus of an inquest is not to speculate about what could have happened if individuals had made different decisions, but to consider whether there has been a failure of policy or procedure, or non-compliance with policy and procedure and, if so, to make recommendations as to how best such failures can be remedied.

13.3 In this case I have concluded that although different decisions might have been made in relation to John while he was in police custody, the decisions that were made were both reasonable, and in compliance with NSWPF policy and procedure. That is not to say, however, that there is no room for policy and procedure to be improved in an effort to prevent deaths from occurring in the future in similar circumstances to that of John.

14 Recommendations pursuant to s82 of the Act

14.1 At the close of the evidence, counsel assisting foreshadowed the possibility of a recommendation being made to bring a greater focus to matters that might be considered by a Custody Manager at the point when an individual who has been in the custody of police is released.

14.2 Counsel assisting proposed the following recommendation which was circulated to the parties:

That the NSW Commissioner of Police implement a requirement (including relevant training) that mandates that a custody manager is to complete a checklist when a person is being released from custody at a police station that records the custody manager's consideration of:

a. the distance between the police station and the person's place of residence;

b. the availability of appropriate transportation (including public transportation, taxi, or ride share) for the person to return home;

c. the person's capacity to return home safely and unaided; and

d. where a concern is held about the person's capacity to return home safely and unaided:

i. attempts made by the custody manager to contact the person's family member, friend, or other responsible person to assist the person in returning to their home; and

ii. if it has not otherwise been possible to arrange for a family member, friend, or other responsible person to assist the person in returning to their home, the reason why.

14.3 In view of submissions received from the Commissioner of Police and from John's daughter, Jewel, amendments were made to the original proposed recommendation. I now intend to make recommendations in the following terms:

To the Commissioner of the NSW Police Force (NSWPF):

1. *The Charge Room and Custody Management Standard Operating Procedures and the NSWPF Handbook Chapter 'Custody' should be amended to provide additional guidance to custody officers in relation to allowing persons in custody to access a telephone in the station or charge room for the purpose of arranging post-release transport.*

2. *Without diminishing or replacing any of the requirements under existing NSWPF policies and guidelines relating to the safe care and custody of detainees at police stations (including in respect of adequate recognition and assessment of health issues), a requirement should be implemented whereby at the point of a person's release from custody at a police station into the community:*

   (a) the custody manager is to make a record of the following:

      i. the distance between the police station and the person's place of residence or other location to which they intend travelling (if not the person's place of residence); and

      ii. the means by which the person intends to travel to their intended destination; and

(b) if the custody manager is concerned about the person's capacity to travel to their intended destination by the person's intended means of travel and police assistance cannot be provided, the custody manager is to:

i. attempt to contact an appropriate family member, friend, or other responsible person to assist the person in travelling to their intended destination; and

ii. where it has not been possible to contact such a person or arrange such assistance, record the reason for this.

14.4 Proposed recommendation 1 takes up the indication made by the Commissioner that NSWPF would be supportive of relevant amendments being made to the Custody SOPs and The Handbook. This additional guidance can only be of potential benefit and should be provided to relevant officers. However, that proposal alone does not address the separate question of what might be put in place as a safeguard at the point of release of a person from police custody into the community, in relation to the distinct matter of their safety in travelling to their destination in the community.

14.5 The original proposed recommendation was not intended in any way to supplant or undermine current requirements concerning custody officers' responsibilities to ensure that those in their custody receive safe care, including appropriate assessment of their wellbeing and provision of medical or other assistance as may be appropriate for the duration of the time they are in custody. There is no reason why those requirements would or should be undermined. The wording in the first paragraph of proposed recommendation 2 seeks to make that clear.

14.6 The proposed recommendation seeks to ensure that in future when someone is released from police custody, particularly where this may be a considerable distance from their intended destination (noting that although John was apprehended approximately 1 km from his home, he was then taken to a police station 15 kms from his home), a custody officer has turned their mind to potential assistance that might be sought for the person, should they hold concerns about their intended means of travel. Such circumstances are not novel. In the *Inquest findings into the death of Ashley Paull* (18/8/25) Deputy State Coroner O'Neill observed that having been stopped by police near his home, Mr Paull later told police that he was going to walk home, a distance of some 50 kilometres from Kempsey police station where he had

been in custody. He was hit by a truck while walking along the Pacific Highway later that evening.

14.7 Concerns expressed by the Commissioner in relation to the varying locations to which someone may be released, have been addressed in the final proposed recommendation by indicating that it applies to persons being released *to the community* (as opposed to, for example, into the custody of Corrective Services NSW) and then referring more generally to their intended destination, rather than their home or residence.

14.8 More generally, the amended proposed recommendation is not now framed as a *checklist*, acknowledging the concern expressed by the Commissioner that custody officers might take a *one size fits all* approach to *the simplicity of a checklist*. Rather, as a safeguard that is in addition to present practices, it would require the recording of basic information particular to the circumstances of the person concerned (distance and intended means of travel), which ought then assist in prompting additional action that it may be appropriate for the officer to take.

14.9 The proposed process in no way suggests that officers should contact particular family members or other persons who it may not be appropriate to contact due to privacy or other considerations.

14.10 The response of Jewel John to the original proposed recommendation includes the suggestion that a detainee should be asked about their intended means of travel. That is a sensible suggestion that the proposed amended recommendation also adopts.

15 Findings required by s 81(1)

15.1 I make the following findings in relation to the matters listed in s 81(1) of the Act:

The identity of the deceased

The person who died was John Aramathuparambil John

Date of death

John died on 6 June 2023

Place of death

John died in Riverstone NSW 2765

Cause of death

The cause of John's death was complications of chronic alcohol misuse and olanzapine toxicity.

Manner of death

John died due to misadventure resulting from the supratherapeutic self-administration of prescription medication in the context of his cessation of alcohol use.

16 Close of Inquest

16.1 I thank counsel assisting, Bill de Mars, and his instructing solicitor, James Prindiville, from the Crown Solicitor's Office, for the assistance they have provided in preparing and conducting this inquest. I also thank Detective Inspector Darren Greaney for the work he did in investigating the circumstances of John's death.

16.2 Once again on behalf of the Coroners Court, I offer my sincere and respectful condolences to John's family and friends.

16.3 I close this inquest.

Judge Kasey Pearce
Deputy State Coroner
Coroner's Court of New South Wales
Date 17 July 2026