QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Shaun Charles COOLWELL**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2015/3877
DELIVERED ON:	10 June 2019
DELIVEED AT:	BRISBANE
HEARING DATE(s):	5-7 March 2018, Written submissions 21 March – 11 May 2018.
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, police restraint, amphetamine use, administration of sedative during restraint, restraint asphyxia.

REPRESENTATION:

Counsel Assisting:	Mr Daniel Bartlett
Ms Shontay Coolwell:	Mr Michael de Waard, instructed by Anderson Fredericks Turner Lawyers
Qld Ambulance Service:	Ms Melinda Zerner, instructed by QAS
Constable Truter and Constable Zarzycki:	Mr Troy Schmidt

Critical Care Paramedic Mathew Anderson:	Ms Sally Robb, instructed by Corrs Chambers Westgarth
Commissioner of Police and Snr Sgt Hayden:	Ms Belinda Wadley, QPS Legal Unit

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Introduction

1. On 2 October 2015, police and ambulance officers were called to 62 Clare Road, Kingston in response to a call that indicated that Shaun Coolwell was affected by drugs and was at significant risk of harming himself. Queensland Police Service (QPS) officers attended the residence and restrained Mr Coolwell. Shortly afterwards, Queensland Ambulance Service (QAS) officers administered first aid, including a sedative.

2. Mr Coolwell rapidly deteriorated during the restraint and police and ambulance officers commenced attempts to resuscitate him. Mr Coolwell was then taken to the Logan Hospital where resuscitation attempts were continued. Those attempts were unsuccessful, and Mr Coolwell was declared deceased on the afternoon of 2 October 2015.

3. The investigation into Mr Coolwell's death was conducted under the *Coroners Act 2003*. As the death occurred in the course of a police operation, the *Coroners Act* presumes that an inquest will be held, unless the coroner is satisfied the circumstances of the death do not require the holding of an inquest.

4. The purpose of a coronial investigation into a reportable death is to ascertain the identity of the deceased person, when, where and how he died and what caused his death. It is not a function of an inquest to make findings that a person has committed a crime or is civilly liable. The inquest also considered the following issues that were determined to be within scope:

    - Whether the administration of midazolam by Queensland Ambulance Service officers was appropriate.

    - Whether the restraint of Mr Coolwell was appropriate.

    - Whether any further recommendations can be made to prevent a death in similar circumstances from happening in the future.

5. It was submitted on behalf of the QAS and CCP Anderson that Ms Coolwell's right to make submissions was confined to matters which may be the subject of adverse findings against her or her brother. I have previously considered this issue in findings delivered after those submissions were received[1], and concluded that the limitation on a family's right to make submissions that was held to exist in *Annetts v McCann*[2] does not apply to an inquest under the *Coroners Act 2003*.

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[1] *Inquest into the death of Hamid Khazaei*, 30 July 2018

[2] (1990) 170 CLR 596

The investigation

6. Before Mr Coolwell was declared deceased an investigation into the incident was started by the QPS' District Duty Officer and Regional Duty Officer as an injury in police custody. A forensic examination of the scene was undertaken and a detailed set of photographs taken. A clip seal bag found in the bathroom at the premises was subsequently found to contain traces of methylamphetamine.

7. An investigation into Mr Coolwell's death was then taken over by the QPS Ethical Standards Command (ESC) and a report was prepared by Detective Senior Sergeant Lisa Scully.

8. Senior Sergeant Scully oversaw the ESC investigations into Mr Coolwell's background and relevant aspects of QPS training and policy. Interviews were conducted with neighbours, and the attending police and ambulance officers who interacted with Mr Coolwell on the day of his death. Body worn camera footage from the attending QPS officers was obtained together with records from the QAS and the Logan Hospital. Statements from QAS paramedics in attendance were also supplied.

9. Senior Sergeant Scully's investigation into the death found the police officers involved acted lawfully in the execution of their duty when they restrained Mr Coolwell to allow QAS paramedics to provide medical attention. She found that the officers applied the skills and knowledge obtained through training when dealing with persons exhibiting signs of excited delirium.

10. Senior Sergeant Scully concluded that Constable Truter had identified the risk of positional asphyxia due to restraint under bodyweight and attempted to put Mr Coolwell into a position where his breathing was not restricted. She found that Mr Coolwell was monitored throughout the restraint process by QPS and QAS officers and medical attention was provided as soon as he was adequately contained.

11. Senior Sergeant Scully also concluded the police officers use of force was necessary to contain Mr Coolwell to prevent him further harming himself and to allow a medical assessment. She found that the application of handcuffs was solely to assist the paramedics. The attending police officers involved provided assistance to Mr Coolwell and supported the paramedics as required. Senior Sergeant Scully submitted that the investigation indicated the officers acted appropriately in an attempt to avert Mr Coolwell's death.

12. I am satisfied this matter was thoroughly and professionally investigated and all sources of relevant information have been accessed and analysed.

The inquest

13. Following a pre-inquest conference on 25 January 2018, the inquest was held in Brisbane from 5-7 March 2018. Thirteen persons were called to give oral evidence at the inquest:

- Detective Senior Sergeant Lisa Scully
- William Knight – neighbour
- Krish Wadiwell – neighbour
- Constable Tamzin Zarzycki
- Constable Barend Truter
- Alexandra Prescott – Advanced Care Paramedic
- Renee Thorley– Advanced Care Paramedic
- Mathew Anderson – Critical Care Paramedic
- Dr Philip Storey – forensic pathologist
- Dr Johan Duflou – forensic pathologist
- Senior Sergeant Damien Hayden
- Professor Peter Pillans - specialist in clinical pharmacology
- Dr Stephen Rashford, Medical Director, QAS

The evidence

Social History

14. Mr Coolwell was a 33 year old Indigenous man who, at the time of his death, resided with his twin sister, Shontay, at 62 Clare Road, Kingston. Mr Coolwell was a single man who was the youngest of six children. He is survived by four siblings and his son, Sebastian.

15. Mr Coolwell's older brother, Bradley, died on 12 September 2013 as a consequence of combined effects of respiratory and cardiac failure after he was restrained by security officers at the Logan Hospital, where he had been admitted on an emergency examination order under the *Mental Health Act 2000*.

16. Mr Coolwell's sister, Nancy, told police that she thought Mr Coolwell had been depressed due to ongoing family arguments that occurred after Bradley's death. Shontay indicated he had a lot of "bottled up emotions".

17. Mr Coolwell commenced offending in his early teens and his criminal history involved several periods of incarceration. He was last sentenced to a term of imprisonment on 24 March 2015. On that date he was sentenced to two years imprisonment and various suspended sentences were imposed cumulatively.

18. Having been in custody since 12 December 2014, Mr Coolwell was granted court ordered parole from 11 September 2015. A condition of his parole was that he reside with his sister at Kingston.

19. Mr Coolwell's compliance with his parole obligations was mostly satisfactory. He did not comply with his curfew soon after he was released and, on 15 September 2015, a urine sample contained presumptive indications of cannabis and methylamphetamine. Further curfew checks were conducted on 19, 20, 22, 25 and 29 September 2015 and Mr Coolwell was at home complying with his curfew on each occasion.

20. On 21 September 2015, Mr Coolwell was interviewed by the Parole Board's Show Cause Panel about his non-compliance. He was reported as engaging well and understanding the expectations placed upon him. No recommendation was made that his parole be revoked but he was given a final warning in relation to noncompliance with the parole order.

21. Mr Coolwell's family has endured significant trauma as a result of the untimely deaths of Mr Coolwell and his brother in similar circumstances. I extend to them my condolences.

Medical history

22. The court received Mr Coolwell's medical file from Queensland Corrective Services. Mr Coolwell did not have a significant history of mental illness or suicidal ideation. Mr Coolwell's general health was consistent with his use of drugs and heavy smoking. He reported that he was a regular user of alcohol, cannabis, amphetamines and heroin. He also had severe coronary disease, which was detailed in the autopsy reports following his death.

Events leading up to the death

23. Nancy Coolwell told investigators that Mr Coolwell went to her home at Annerley at about 6:00am on 2 October 2015. Her daughter answered the door and told him Nancy was sleeping. Mr Coolwell said he would come back later.

24. At around 10:30am on 2 October 2015, a neighbour, Ms Danielle Knight, saw Mr Coolwell walking along the footpath to 62 Clare Road, Kingston, which is a highset timber residence with a small landing facing the street. Ms Knight said that Mr Coolwell appeared to be affected by drugs because he was weaving from side to side.[3] About 30 minutes later she and her husband, William, noticed all the children from the Coolwell residence at the front of the property. She said that they all looked "really worried". She then

[3] Ex B7

asked the children what was happening, and they told her that Mr Coolwell was “smashing the house up”. Ms Knight then called 000 for assistance.

25. Mr Coolwell’s sister, Shontay, was at the back of the premises hanging out washing when she saw her brother return home. Mr Coolwell went upstairs to have a shower. He was home for about 30 minutes when he had a violent episode which she thought was likely to be drug induced. She went to assist her brother but could not settle him.

26. Shontay said that she found her brother lying in a tub of hot water. She tried to turn off the tap but he kept turning on the hot water. He was continually yelling and calling for his mother and his deceased brother, saying “forgive me for my sins”. Soon after, she saw he was lying naked in the bathroom banging his head on the floor and door frame. He was also bleeding profusely from a very deep cut to his ankle which likely resulted from his kicking the bathroom vanity.

27. Shontay made a 000 call at 11:22am. She told the call taker that her brother was going crazy in the shower, he was naked and screaming that something was on him. She also said that he was bleeding from his feet and was hysterical and lashing out, kicking and throwing his arms about and injuring himself. Shontay told the call taker that her brother was possibly under the influence of drugs. She said that a neighbour had called the QAS for assistance but that the QPS would also be required to calm her brother down. The QAS had also called the QPS for assistance to attend at the address at 11:22am.

28. Mr William Knight heard the commotion and went into the house with Ms Coolwell to assist after being told that Mr Coolwell had stabbed himself. He told the inquest that he saw Mr Coolwell on the floor of the bathroom where there was lots of blood and the sink was broken. Mr Knight said that Mr Coolwell was moving uncontrollably, flailing his limbs and head-butting the door. He said that it was like he was in a state of psychosis.[4] Mr Knight said that although he and another neighbour, Mr Wadiwell, could get into the bathroom, he did not see the point in trying to restrain Mr Coolwell because “*he was just uncontrollable …he’s quite a large lad too… There was blood on the floor, water all over the floor, the bath was full of water*.” He said that he then waited for the QPS and paramedics to arrive.

[4] Ex B8, p4

29. Mr Knight said that it was a significant challenge for the QPS officers to restrain Mr Coolwell because he kept flailing around. He said that he saw a QPS officer drag Mr Coolwell out of the bathroom by his legs and then restrain Mr Coolwell with the help of a female officer. Mr Coolwell remained lying on his stomach after he was restrained with the police officers crouching over him. He did not witness the entire restraint but could not see any knees or elbows being applied to Mr Coolwell. He had no concerns about the way in which he was restrained.

30. Another neighbour, Mr Krish Wadiwell, also went to assist after his wife drew his attention to the commotion at the Coolwell residence. Mr Wadiwell saw Shontay, who told him that her brother was pouring hot water on himself in the bathroom and "he's not quite there and he might be hurting himself".[5]

31. Mr Wadiwell went to the bathroom where he found Mr Coolwell lying naked on the floor in apparent excruciating pain; twisting and hitting his head. Mr Wadiwell was concerned that Mr Coolwell would cause a serious injury to himself. He called 000 and was told the QPS and QAS were on the way to the address. Mr Wadiwell also asked Shontay to retrieve a mattress that might be placed on top of Mr Coolwell in order to prevent him from further injuring himself. The mattress was then placed in the hallway outside the bathroom.

32. Mr Wadiwell told the inquest that after the QPS arrived he saw a male police officer pull Mr Coolwell out of the bathroom by his ankles and across the mattress in the hallway. He said that Mr Coolwell was moving less at that time and appeared to be very tired as he had been thrashing about for five minutes.

33. Mr Wadiwell told the inquest that he saw the male police officer put a knee on Mr Coolwell's back to prevent him from moving. He also saw a female officer place a boot on his back or knee. However, Mr Wadiwell did not consider that the QPS officers were "rough" and he agreed that Mr Coolwell needed to be restrained as he thought it was a medical emergency. He thought that the QPS officers were "cool, calm and orderly". Mr Wadiwell then heard a QPS officer ask a paramedic if Mr Coolwell could be sedated. The paramedic's response was that she needed a more senior officer's authorisation. Mr Wadiwell said that he then left the house. He later heard that Mr Coolwell had died.

[5] Ex B15, p4

Circumstances of the death

34. Constable Barend Truter and Constable Tamzin Zarzycki were performing traffic patrols when tasked with the job at 11:27am. The job codes were "QAS assist" and "attempted suicide". They arrived at 62 Clare Road at around 11:32am. QAS Advanced Care Paramedics (ACP) Alexandra Prescott and Renee Thorley arrived at the same time. Constable Truter said he was not wearing a body worn camera as they were not issued by the QPS and were not compulsory at that time.

35. Constable Truter went to the bathroom with Shontay. He saw blood on the bathroom door. He asked Mr Coolwell to open the door but was then able to open the door himself. He saw that Mr Coolwell was naked on the floor, face down with his head towards the sink and feet just inside the door. There was blood and water everywhere and Mr Coolwell's ankles were covered in blood. Mr Coolwell kicked the door closed so Constable Truter pushed it open. Constable Truter said that Mr Coolwell was waving his fists on the ground, wriggling around and making noises. He was screaming and yelling out but not using specific words. The vanity door had been ripped off and there was a large hole in the wall near the vanity.

36. Constable Truter said he pulled Mr Coolwell into the hallway to allow more room for the paramedics to provide treatment. Officers Truter and Zarzycki restrained Mr Coolwell in a prone position across the hallway. Constable Truter stated he placed his knee on the back of Mr Coolwell's hamstrings to stop his kicking, which was causing blood to spray into the hallway. The officers attempted to calm Mr Coolwell, telling him they were there to help him. He was not responding verbally, and continued to violently thrash around, kicking his legs with his arms tucked underneath his body.

37. Constables Truter and Zarzycki considered it was necessary to restrain Mr Coolwell with handcuffs to prevent him further injuring himself, for the safety of the officers involved, and to allow paramedics to provide him with medical treatment. Constable Truter stated he took out his handcuffs and grabbed Mr Coolwell's left arm and placed the handcuffs on. Assisted by Constable Zarzycki, Constable Truter struggled to get Mr Coolwell's second arm, which was tensed, but eventually managed to cuff Mr Coolwell's arms behind his back. Constable Truter told the inquest that he also lifted Mr Coolwell's shoulder to aid his breathing while he was on floor.

38. Constable Zarzycki told the inquest that after Mr Coolwell was restrained initially, she continued to update the paramedics stationed in the adjacent lounge room. She said that Constable Wallis secured Mr Coolwell's head to prevent him from hitting it against the bathroom doorway. Constable Zarzycki said that it was not until after the QAS paramedic administered a sedative that Mr Coolwell experienced breathing difficulties. The handcuffs were then removed and Mr Coolwell was relocated to the lounge room.

39. Constable Zarzycki was unable to recall the exact conversation she had with paramedics in relation to the sedation of Mr Coolwell but she said that it was not unusual for her to request that persons be sedated. Her objective was to calm Mr Coolwell down. She accepted that she asked for him to be sedated and that she was initially told a more senior paramedic was required to administer a sedative.

40. Constable Zarzycki said that whether a person was sedated was ultimately a question for the QAS. She said that if she was presented with the same circumstances she would not act differently. She agreed that the QPS policy in relation to handcuffs was to keep them on because of the risk a restrained person posed to officers once cuffs were removed.

41. Constable Truter later indicated that he had restrained Mr Coolwell under the provisions of the *Mental Health Act 2000* (as it then was) concerning emergency examination orders. He told the inquest that the legal basis for his actions was s 609 of the *Police Powers and Responsibilities Act 2000 (PPRA),* which entitles police officers to enter places and detain persons to prevent injury to persons and property.

42. Police officers Jennifer Wallis and Nathan Armstrong arrived while Mr Coolwell was being restrained in the hall. They were both wearing body worn cameras. The time coding on Officer Armstrong's body worn camera indicates they walked into the premises at 11:33am. Mr Coolwell can be seen struggling with officers and vigorously moving his head at this time.

43. Constable Truter's evidence was that he did not discuss sedation with paramedics. However, he agreed that Mr Coolwell needed sedation because after he was cuffed, he continued to be tense and was still knocking his head against the door frame. Shortly after he was sedated Constable Truter felt Mr Coolwell's muscles relax.

44. Constable Truter told the inquest that soon after Constable Wallis arrived, Shontay Coolwell asked him to remove the handcuffs but he declined because Mr Coolwell had been acting violently. He said that he was monitoring Mr Coolwell's pulse at that time. Constable Truter declined two further requests from Shontay Coolwell to remove Mr Coolwell's restraints over a period of two minutes. He said that Mr Coolwell was very strong and he was informed by Constable Wallis that he was still breathing. During this period, he noticed brown phlegm and water coming from Mr Coolwell's mouth and his level of concern increased.

The decision to sedate Mr Coolwell

45. ACP Thorley provided several statements and gave evidence at the inquest.[6] The second statement was provided after ACP Thorley had the benefit of viewing the body worn camera footage. The case had been allocated as a Code 25 Bravo – suspected mental health case. ACP Thorley said that the paramedics were advised to wait for the QPS to arrive before entering the residence. They went to the residence and waited on the front landing for around 90 seconds before a police officer asked them to enter. ACP Thorley said that as soon as she entered, she was asked by a female police officer to sedate Mr Coolwell. She told the officer that a more senior paramedic would have to attend to administer sedation.

46. From the front landing, ACP Thorley thought she could hear Mr Coolwell yelling and he was very agitated. On entry to the hallway she could see that he was being restrained by police officers. ACP Thorley said that she was able to visualise Mr Coolwell and noticed he had scratches to both arms and wounds to both feet. He appeared normal in colour and was conscious and breathing. When she attended to his feet, she saw that Mr Coolwell had multiple deep lacerations. One laceration on his ankle appeared to be down to the bone with Achilles tendon involvement and was actively bleeding.

47. In her initial statement[7] ACP Thorley said she had completed an assessment and noted that Mr Coolwell had a good pedal pulse on his left foot but it was hard to get a pulse on his right foot. Her focus was on treating Mr Coolwell's feet and the significant injury to his ankle. However, in her subsequent statement and at the inquest she conceded that paramedics had not checked Mr Coolwell's blood pressure, heart rate or ECG. Nor did they check his airway.

48. Critical Care Paramedic (CCP) Mathew Anderson attended the scene at about 11:36am. ACP Thorley's initial evidence was that at that time Mr Coolwell was still SAT +3 (Sedation Assessment Tool) and he was still resisting the handcuffs. A SAT score of +3 is based on the patient being assessed by a QAS officer as "combative, violent, out of control" with "continual loud outbursts".[8]

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[6] Ex B12-B12.1

[7] Ex B12

[8] Ex C9. This document notes that "A SAT score of +2 or +3 is a good predictor of the need to administer sedation and should prompt the ACP to consider requesting CCP backup for assessment and management."

49. However, ACP Thorley later acknowledged this was based on her perceptions at the time of arrival, the information given by QPS officers and the fact Mr Coolwell was restrained. As she was focussed on treating his feet, she was reliant on the QPS officers to alert her to a change in Mr Coolwell's presentation. She also acknowledged that, in hindsight, Mr Coolwell should have been repositioned and a full assessment undertaken to determine his SAT score before midazolam was administered. At the inquest she conceded that it was not possible to conduct a SAT assessment while located at a person's feet and that, in hindsight, she did not think that Mr Coolwell required sedation.

50. ACP Thorley also said that if similar circumstances arose again, the patient would not be given midazolam. Instead, in accordance with revised QAS guidelines they would be given droperidol and moved from the prone position.

51. ACP Prescott said that after ACP Thorley went to attend to Mr Coolwell, she went outside to request the attendance of a critical care paramedic for sedation. As she was doing so, CCP Anderson arrived at the scene. ACP Prescott told CCP Anderson that the QPS were restraining Mr Coolwell, and that he was quite aggressive and likely to require sedation.[9]

52. ACP Prescott said that when she and CCP Anderson went inside the residence Mr Coolwell was still lying on the floor being restrained by police officers. In her statement ACP Prescott said that paramedics discussed sedation and determined it was best to sedate Mr Coolwell before the handcuffs were removed. However, at the inquest she clarified that this discussion did not take place but she recalled briefing CCP Anderson about the situation. ACP Prescott agreed that she noticed that Mr Coolwell had become quiet and less resistant before the midazolam was administered.

53. In her initial statement, ACP Prescott said that as CCP Anderson administered the midazolam she saw Mr Coolwell vomit a large amount of clear fluid. However, in a subsequent statement, completed following a review of the body worn camera footage, she acknowledged that he had also vomited before he was given midazolam. The footage records that she informed CCP Anderson before the administration of midazolam that Mr Coolwell had become "somewhat unresponsive". The footage also records that ACP Prescott informed CCP Anderson that there was a significant amount of vomiting occurring after the administration of midazolam.

[9] Ex B11, p2

54. ACP Prescott said that ACP Thorley checked for a pedal pulse but was unable to feel one. CCP Anderson then directed that the handcuffs be removed and ACP Prescott noted that Mr Coolwell did not react. Mr Coolwell was then moved to the lounge room where resuscitation efforts were commenced.

55. The supplementary statement of ACP Prescott indicates that following a review of the video footage she considered that the tension present in Mr Coolwell's arms and shoulders may have been indicative of a hypoxic seizure, and that she should have reported this to CCP Anderson and undertaken an assessment of Mr Coolwell. In hindsight, she considered that her clinical judgement was clouded by the circumstances in which Mr Coolwell was being restrained.[10]

56. ACP Prescott said that following Mr Coolwell's death several training packages were provided to advanced care paramedics regarding agitated patients, acute behavioural disturbance and the implementation of the sedation drug droperidol. She had attended at two cases in which droperidol had been administered successfully. She had also received training in relation to the appropriate positioning of patients who were agitated and experiencing excited delirium secondary to drug intoxication.

57. CCP Anderson informed the inquest that he had been a paramedic for 28 years and a mobile CCP for over 16 years. He was employed as a clinical support officer with the clinical education unit in the Metro South local ambulance service network. This role involved attaching himself to cases and attending for the purpose of field coaching and auditing of other paramedics.[11]

58. CCP Anderson said that in hindsight he would not have sedated Mr Coolwell but did so because he was led to believe that he was SAT +3 and experiencing an acute behavioural disturbance. He said that he had examined Mr Coolwell and saw that he was struggling and agitated. His eyes were open and he was breathing and he had multiple injuries. He considered that the sedation would be useful to "switch off" what he thought were the effects of a drug induced psychosis which may have led to serotonin syndrome or excited delirium. He was concerned about Mr Coolwell's safety and the safety of the QPS officers and paramedics.

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[10] Ex B11.1, p4

[11] Ex B1, p1

59. CCP Anderson said that his plan was to move Mr Coolwell from the confined hallway into the lounge room after he had administered midazolam in order to undertake an assessment and provide treatment. He briefly left the hallway to draw up the midazolam and returned to administer it into his right deltoid muscle. At the same time, he was informed that clear fluid was coming out of Mr Coolwell's mouth. Mr Coolwell became unresponsive soon after, and resuscitation commenced when a pulse was unable to be detected.

60. CCP Anderson frankly acknowledged that on reviewing the body worn camera footage it was apparent that while he was drawing up the midazolam Mr Coolwell deteriorated, and he was showing signs of respiratory compromise. He agreed that in those circumstances midazolam should not have been administered and that he should have undertaken a complete assessment himself. He said the case highlighted the risks associated with acting on assumptions over assessment, and the importance of following QAS guidelines and procedures in emergency situations.[12]

61. At the inquest, CCP Anderson's attention was drawn to a portion of body worn a camera footage where, before he administers midazolam, a male remarked "*so he's awake and everything?*" He was unable to recall making that remark and agreed that it would be inappropriate to administer midazolam to an unconscious patient. He agreed that the QAS team could have worked better together at the scene, including attending to basic matters such as establishing that Mr Coolwell's airway was clear, that he was breathing and had circulation.

62. By around 12:30pm Mr Coolwell had not regained consciousness, but return of spontaneous circulation had been achieved, and Mr Coolwell was transferred to the Logan Hospital. Mr Coolwell was admitted to the Logan Emergency Department at 12:50pm. Resuscitation attempts were continued unsuccessfully and at 1:36pm Mr Coolwell was declared deceased.

[12] Ex B1, p3

Review of QPS Use of Force

63. I heard evidence on the appropriateness of the use of force applied to Mr Coolwell by the attending QPS officers from Senior Sergeant Damien Hayden, Officer in Charge of the QPS Operational Skills Training Unit (OSTU). As part of the investigation conducted by the Ethical Standards Command, Senior Sergeant Hayden conducted a review of the body-worn camera footage and the interviews of each police officer. He provided a statement and gave evidence at the inquest.[13]

64. Senior Sergeant Hayden considered that the entry to Mr Coolwell's residence by police was justified as an attempt to render assistance to paramedics under s 609 of the PPRA - 'Entry to prevent offence, injury or domestic violence'. He also considered that the QPS officers made a justifiable decision to restrain and handcuff Mr Coolwell. I also note that Ms Shontay Coolwell had invited the first responders into her home to assist Mr Coolwell.

65. Senior Sergeant Hayden said that having regard to all the circumstances, the level of force used by the QPS officers "*was a reasonable response to a confronting and chaotic health crisis. Physical force was used to bring Mr Coolwell under control, so Queensland Ambulance could address his injuries and medical condition*."[14] He said that the application of the handcuffs was required given that Mr Coolwell was thrashing around and bleeding freely from the wound to his foot. The officers were trying to ensure that Mr Coolwell received the necessary medical attention to his wounds. Senior Sergeant Hayden said that the response of the operational police was in accordance with the following QPS policies and procedures:

    - *Operational Procedures Manual Section 14.3.6 Acute psychostimulant-induced episode and excited delirium*
    - *Operational Procedure Manual Section 14.3.7 Post arrest collapse (medical risk factors)*
    - *Operational Procedures manual Section 14.3.8 Monitoring restrained prisoners (positional asphyxia)*

[13] Ex B19

[14] Ex B19, p9

66. Senior Sergeant Hayden said that officers are trained that:

> *"the safest and most effective way to establish control over a resisting subject is to have the subject person pinned face down on the ground, with their hands behind their back. This position maximizes the tactical advantage to the restraining officer by being in a superior position, minimises the risk of injury to the officer by limiting the movement of the subject as well and reducing the ability of the subject to strike/kick out at the officer."*

67. However, officers are also instructed not to unnecessarily maintain this position once the subject is compliant due to the risk of injury. Senior Sergeant Hayden was not concerned about the application of force to Mr Coolwell as Constable Truter applied bodyweight to the rear of the upper legs and Constable Wallis secured Mr Coolwell's head. He noted that Constable Truter lifted Mr Coolwell's shoulder to facilitate his respiration. Senior Sergeant Hayden said that he observed on the camera footage that police and paramedics in attendance were monitoring Mr Coolwell throughout the restraint.

68. Senior Sergeant Hayden said that since 2008 QPS officers have been given yearly instruction in relation to 'Sudden In-Custody Death Syndrome'. This is conducted with the view of minimising the risk of sudden in-custody deaths generally, especially arising from use of force situations; including Restraint Asphyxia, Positional Asphyxia and Excited Delirium (Psychotic or psychostimulant induced episodes). [15]

69. In his evidence at the inquest Senior Sergeant Hayden said that he did not consider the fact that Mr Coolwell was restrained on top of a mattress was a factor QPS officers should have considered as it was a thin mattress and not "splinted against" his diaphragm. He agreed that Mr Coolwell should have been moved to a lateral position as soon as it was safe to do so. He said that after the initial struggle Mr Coolwell became calm and that may have been an opportunity to assess his position, and that QPS officers were not trained in the recognition of agonal breathing.

70. Senior Sergeant Hayden said that in the context of Mr Coolwell's restraint, the primary role of the attending police officers was to obtain control in order to facilitate the administration of first aid. He noted that it generally takes some time for a restrained person to calm down, and that Mr Coolwell deteriorated in a matter of minutes.

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[15] Ex B19, p14

Review of the actions of QAS paramedics

71. At my request, the Medical Director for the Queensland Ambulance Service, Dr Stephen Rashford, provided a very helpful statement addressing a number of issues.[16] Dr Rashford is registered as an emergency medicine specialist in Australia and the United Kingdom. Dr Rashford has been engaged with the QAS since 1999 and has attended over 10,000 pre-hospital cases in his role.

72. Dr Rashford noted that the following clinical policies relating to the management of patients with acute behavioural disturbance and physical restraint were contained within the QAS Digital Clinical Practice Manual on 2 October 2015:

    - *Clinical Practice Guideline: Behavioural Disturbance/Acute Behavioural Disturbance (February 2015)*
    - *Clinical Practice Procedure: Assessment/Sedation Assessment Tool (February 2015)*
    - *Clinical Practice Procedure: Behavioural Disturbance/Sedation – Acute Behavioural Disturbance (February 2015)*
    - *Clinical Practice Guideline: Behavioural Disturbance / The Physically Restrained Patient (February 2015)*
    - *Drug Therapy Protocol: midazolam (February 2015)*

73. Dr Rashford said that these guidelines were comprehensive and evidence-based and provided a structured approach to the circumstances that presented QAS paramedics on 2 October 2015, which he described as a complex high-risk scenario. All attending paramedics had completed the relevant training prior to 2 October 2015.

74. Dr Rashford said that on review of the available information, the treatment provided to Mr Coolwell after he was moved into the lounge room appeared to be in keeping with expected practice by QAS paramedics. Return of spontaneous circulation was gained after a period of cardiopulmonary resuscitation and other advanced life-support measures.[17]

[16] Exhibit B20

[17] Ex B20, p5

75. A summary of Dr Rashford's comments on the footage, based on relevant timestamps (in minutes and seconds) from Constable Wallis' body worn camera footage, is as follows:

02:22 *Upon the arrival of Constable Wallis into the residence, it is apparent that Mr Coolwell is highly agitated, requiring restraint. He is astride a hallway with his head just inside the bathroom and his legs placed in an opposite room. There is no obvious pressure around his neck. It is apparent a male police officer is holding his arms in position, with Mr Coolwell in a prone position.*

03:12 *Soon after Constable Wallis places her hand on Mr Coolwell's head in an attempt to stop him thrashing around. Mr Coolwell then ceases his agitated activity. This is a crucial time stamp. It is highly unusual that agitated patients suddenly cease this activity. This is a very concerning feature.*

04:35 *Mr Coolwell is prone, his eyes are closed and he is not exhibiting any purposeful movements. The extent of the bruising, contusions and abrasions across the posterior torso and neck are overt. In layman's terms, Mr Coolwell looks completely fatigued and washed out. Mr Coolwell does not respond to stimulus from QPS officers.*

04:55 *Mr Coolwell was exhibiting Kussmaul's respirations - deep and laboured breaths most commonly seen in individuals with underlying metabolic acidosis. The vision was in keeping with Mr Coolwell being unconscious at that time.*

05:32 *Mr Coolwell has a period of apnoea. He stopped breathing until 05:43.*

05:53 *Mr Coolwell's breathing pattern changed altogether and he developed "head bobbing" - pronounced movement of the head with each respiration due to the use of accessory breathing muscles as a result of underlying severe respiratory embarrassment. This is ominous and reflects the continued deterioration in his condition.*

06:07 *A police officer vocalises that "some brown stuff is coming out of his chest". This most likely represented a loss of Mr Coolwell's gag reflex and he is aspirating gastric contents – he is not protecting his airway.*

07:40 *Agonal breathing is present.*

09:00 *Constable Wallis states "he is still breathing". Dr Rashford observed no evidence of that.*

09:47 *CCP Anderson[18] asks Constable Wallis if Mr Coolwell is "awake and everything" and Constable Wallis replies "yep, yep". Dr Rashford considered that Mr Coolwell was deeply unconscious and had ineffective breathing – he was almost certainly in cardiac arrest at this point.*

10:19 *CCP Anderson has administered the midazolam.*

10:37 *Mr Coolwell is turned to face left lateral.*

10:49 *Police officers attempt to rouse Mr Coolwell – there is no response. He is not breathing. Shortly after CCP Anderson requests the handcuffs be taken off. These are removed at 11:30.*

12:20 *CCP Anderson states he is not sure he can feel a pulse and asks that Mr Coolwell be moved to the lounge room*.

12:39 *Resuscitation begins in the lounge room.*

76. Dr Rashford said that the initial video evidence demonstrated that Mr Coolwell was still resisting restraint on the arrival of Constables Wallis and Armstrong. However, soon after their arrival he rapidly ceased this activity. Dr Rashford said that such a sudden change should always result in a very detailed review of the patient's condition. Although first responders often attributed this change in behaviour to the individual succumbing to the restraint, this may not be the case.

77. Consistent with Senior Sergeant Hayden's evidence, Dr Rashford considered that the attending QPS officers acted with care and concern for Mr Coolwell's condition at all times.

78. Dr Rashford said that shortly after ceasing resistance Mr Coolwell can be observed to be breathing very deeply. He said that this was a pattern in keeping with Kussmaul's respirations,[19] and that it is highly likely that Mr Coolwell developed a significant body acidosis from a combination of his physical activity, the oxygen debt that occurred during that activity and any possible toxidrome related to the amphetamines.[20] Dr Rashford said that this breathing pattern was the body's way of returning to normal homoeostasis.

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[18] This was disputed by CCP Anderson

[19] Hyperventilation found in patients with metabolic acidosis.

[20] Ex B20, p9

79. Dr Rashford said that the point that Mr Coolwell stopped breathing for 11 seconds was a critical point in his clinical trajectory. This change in the breathing pattern was pathological and was one of marked respiratory distress. Dr Rashford said that Mr Coolwell's subsequent head bobbing indicated that he was struggling to breathe and that from that point onwards (four minutes prior to the administration of the midazolam) Mr Coolwell was deeply unconscious/unresponsive.[21] Dr Rashford considered it almost certain that he developed a malignant cardiac dysrhythmia from this point.

80. In Dr Rashford's opinion, the midazolam was administered while Mr Coolwell was in cardiac arrest as he appeared lifeless and did not display any meaningful breathing efforts. However, Dr Rashford did not consider that midazolam contributed to Mr Coolwell's death for two reasons:

    - Mr Coolwell was already in cardiac arrest when it was administered. Accordingly, the drug did not affect his breathing pattern.
    - Even if Mr Coolwell was not in cardiac arrest he was in a state of reduced cardiac output and intramuscular midazolam normally takes between five and 10 minutes to take effect. In contrast, the first responders recognised Mr Coolwell's deterioration within 60 seconds of the administration of the midazolam.

81. Dr Rashford said that in order to understand the actions of the QAS and QPS officers in this situation, it was necessary to consider the broader environment and human factors. In a highly charged situation such as Mr Coolwell's presentation with an acute behavioural disturbance, first responders are assured when they can take control, and the patient becomes compliant. However, where a patient becomes suddenly compliant after requiring significant restraint, they require very careful assessment to ensure another pathological event has not occurred.

82. Dr Rashford said that the other human factor was the vocal request by attending police officers for Mr Coolwell to be sedated. While Dr Rashford considered that sedation was an option for acute behavioural disturbance, the decision to sedate must be made after careful consideration of the individual scenario as sedation of acute behavioural disturbance patients carries risk, particularly in an out of a hospital environment. Dr Rashford considered that in this instance, paramedics responded to the requests of the attending police without the level of due diligence that was required.[22] The decision to sedate is a clinical one, best made after careful consideration of the situation and clinical observations and associated risk factors.

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[21] Ex B20, p9

[22] Ex B20, p11

Autopsy Results and Cause of death

83. On 3 October 2015, experienced forensic pathologist, Dr Philip Storey conducted an autopsy examination. He issued a comprehensive report on 24 May 2017. Dr Storey noted an incised wound to the right posterior ankle which had transected the Achilles tendon. Other sharp force injuries were confined to the lower limbs where there were scratches and superficial cuts. He also noted abrasions and bruises to the head region, back and limbs. There was also a series of lesions suggestive of burns on the left hip, buttock and thigh.

84. Dr Storey stated that this was an obviously complex death, and identified six potential factors requiring detailed consideration:

a) Drug toxicity

Mr Coolwell's antemortem blood had traces of cannabis (THC 0.004 mg/kg, amphetamine (0.03 mg/kg) and methylamphetamine (0.09 mg/kg) and midazolam (0.04mg/kg) in his body. While Dr Storey did not consider that the administration of midazolam was the underlying cause of death, it could not be discounted as having contributed. Dr Storey also said was not possible to discount a contribution to Mr Coolwell's death by acute methamphetamine intoxication, if not toxicity.

b) Physical injuries

These injuries included blunt force injuries, burns and superficial lacerations. These injuries may have been attributed to Mr Coolwell's conduct in the bathroom prior to his restraint. Dr Storey did not think the injuries per se were of sufficient severity to have had a material impact on the death. Blood loss may have contributed to the death but was of lesser importance than the other factors.

c) Natural pathologies

Mr Coolwell suffered from severe coronary atherosclerosis. There was 80% luminal narrowing at the point where the left main coronary artery divides to form the left anterior descending and left circumflex coronary arteries. This condition may lead the heart to enter an abnormal potentially fatal rhythm at any time under any circumstances of death. Under stress, the heart was more likely to enter into an abnormal, potentially fatal rhythm.

d) Inhalation of water

Dr Storey could not discount the inhalation of water at the scene. This has the potential to lower the threshold of abnormal cardiac rhythm in the presence of significant coronary artery disease.

e) Restraint

The handcuffing of Mr Coolwell in the prone position may have increased further the level of circulating stress hormones in the blood stream. However, Dr Storey noted that many people restrained in this way do not die, and the role of restraint in these deaths remains controversial.

f) Excited delirium

Dr Storey said that excited delirium is a controversial entity described as a state of acute extreme agitation during which the victim is irrational, exhibits superhuman strength and appears insensitive to pain and is subject to significant hyperthermia. Mr Coolwell displayed some features displayed in the syndrome. The mechanism of death in such cases is obscure. It may involve several factors such as higher stress hormones with the presence of stimulants, restraint and exhaustion following marked exertion.

85. Having considered all these factors, Dr Storey was unable to identify a single cause of death. He said that the following factors made a material contribution to Mr Coolwell's death: coronary atherosclerosis, methamphetamine toxicity, restraint, a situation of acute stress, use of midazolam and the likely aspiration of water. The physical injuries, with an unknown degree of blood loss, and excited delirium were of less significance.

86. On 21 October 2015, a second post mortem examination was conducted by Professor Johan Duflou, Consulting Forensic Pathologist. This was carried out following a request from Mr Coolwell's family. Dr Duflou said the original autopsy was performed in a highly competent manner. He raised the following major pathological entities in the formulation of the cause of death:

1. Atherosclerotic coronary artery disease – the extent of the coronary artery narrowing, absent the other circumstances, would have been enough to cause death. In a setting of significant stress and increased demand on the heart, sudden death in part as a result of heart muscle hypoxaemia caused by narrowing of the coronary arteries should be considered.

2. Methamphetamine toxicity - considered together with the presence of advanced coronary artery disease, a case could be made that Mr Coolwell could have died at any time if he took methamphetamine or other psychostimulants because of the severity of his heart disease.

3. Midazolam toxicity - sudden death following intramuscular administration of midazolam is rare, but in a patient who appears to be physically exhausted and who has significant cardiac disease there is a possibility that administration of this respiratory depressant drug could significantly contribute to the circumstances leading to the death.

4. Other chemical toxicity - this may be the cause of the burns as hot water from a domestic source would not normally inflict such a severe injury without a period of immersion.

5. Multiple incised and blunt force injuries – it was unlikely that the blunt force injuries contributed to the death in any significant way.

6. Restraint asphyxia – this is a controversial diagnosis and Dr Duflou considered the typical criteria used for diagnosing restraint asphyxia were not met as there did not appear to be significant downward force on the trunk of Mr Coolwell. His positioning may have resulted in increased anxiety and agitation with associated release of adrenaline type substances which could have a further deleterious effect on the heart.

7. Excited delirium - this could only be put forward as a possibility, because of the presence of the significant heart disease, methamphetamine levels and the restraint which could have caused death either instead or in combination with excited delirium. On balance, Dr Duflou was of the view that excited delirium "likely was present, and it may have caused or contributed to death in combination with the other factors described".

87. Like Dr Storey, Dr Duflou said it was not possible to give a discrete cause of death with any degree of certainty. He said that the cause of death was best given as "undetermined" and that the best description on the balance of probabilities was:

    "cardiorespiratory arrest during the restraint of a person who is predisposed to cardiac arrhythmia because of the effects of advanced coronary artery disease, methamphetamine use, midazolam administration, injuries, stress and excited delirium".

88. Dr Storey gave evidence at the inquest. He said that he had viewed the body worn camera footage of the events leading up to the death. With respect to the role that midazolam played in Mr Coolwell's death, Dr Storey noted that it was administered late in the QAS procedure and that Mr Coolwell was expiring before the midazolam was given. Dr Storey's evidence was that for at least 30 seconds prior to the administration of midazolam Mr Coolwell had ceased respiration.

89. Dr Storey confirmed that the extent of Mr Coolwell's coronary atheroma increased his risk of injury and predisposed him to death as a result of coronary syndromes. He noted that Mr Coolwell had been restrained in the prone position, which limited his capacity to breathe using his diaphragm. He agreed that this was not an optimal position.

90. Dr Storey said that Mr Coolwell's death was very complex and that it would be possible to remove any specific factor, such as midazolam or coronary atherosclerosis, and the outcome would be the same. It was not possible to give a relative weighting to the various contributory factors he had identified.

91. Dr Duflou also gave evidence at the inquest and agreed with Dr Storey to a large extent. He also largely agreed with the conclusions in the reports of Dr Rashford and Professor Pillans but considered that midazolam may have been a contributing factor in the death.

92. Like Dr Storey, Dr Duflou said that it was not possible to rank the role played by the various pathological entities he had identified, and that any one of those may or may not have a role. Dr Duflou described the death as "an unusual outcome of a common event".

93. Dr Duflou agreed that if Mr Coolwell was already in cardiac arrest before midazolam was administered it likely played no role in his death. Alternatively, there was a question as to whether it contributed in the time available if it was able to reach the brain following administration. He said that if Dr Rashford's reasoning was correct, he accepted that midazolam played no role. However, he also said it was not possible to say post-mortem when cardiac arrest occurred.

94. Dr Duflou said that the human body should be able to handle prone restraint. However, if the person aspirates there is a decrease in reserves and an increase in the risk of hypoxia, as it is harder to take deep breaths as the splinting of respiratory muscles pushes up on the diaphragm.

Midazolam administration

95. A report with respect to events relevant to Mr Coolwell's cardiorespiratory arrest and the administration of midazolam was prepared by Professor Peter Pillans, Director of Clinical Pharmacology at Princess Alexandra Hospital (PAH). Professor Pillans also practises as a specialist physician in the PAH's Department of General Medicine. Professor Pillans also gave evidence at the inquest.

96. Professor Pillans had reviewed the relevant material including the two autopsy reports, the police investigation report and relevant QAS protocols. Professor Pillans considered that the forensic pathologists and Dr Rashford had each provided excellent overviews of the potential contributors to Mr Coolwell's death. He agreed that the following all had to be considered in the formulation of the cause of death: arrhythmia in the setting of severe atherosclerotic coronary artery disease, methamphetamine toxicity, aspiration, restraint asphyxia, excited delirium and midazolam toxicity.[23]

97. Professor Pillans noted that the measured level of midazolam in Mr Coolwell's blood was in keeping with the recent administration of a 5 mg dose. He said that the onset of the sedating effects of midazolam are of the order of 5 to 15 minutes. It was relevant that there was an evident deterioration in Mr Coolwell's condition before the midazolam was administered, and the further deterioration within two minutes appeared too rapid for the onset of the action of midazolam.

98. Professor Pillans said that midazolam was a short acting benzodiazepine like Valium. It depresses the central nervous system causing sedation, hypnosis and, at higher doses, anaesthesia. The most important effect is respiratory depression, particularly when associated with other depressants such as alcohol and narcotics, which were not evident in Mr Coolwell's toxicology results. Midazolam has a half-life of 1 ½ to 2 ½ hours, with duration of affect up to approximately 4 hours, depending on dose and whether other depressants have been administered.

99. Professor Pillans said that it was difficult to determine the effect of the administration of midazolam on Mr Coolwell because of the "confounding factors" and deterioration prior to administration. He considered that the cardiorespiratory arrest approximately 2 minutes after administration was more likely to be related to other factors. He said that midazolam does not cause cardiac excitation and would therefore not have predisposed to an arrhythmia.

100. Professor Pillans concluded that that the administration of midazolam did not contribute to Mr Coolwell's death. He said that after he became unresponsive, the CPR and assisted ventilation should have been sufficient to respond to the effects of midazolam alone.

[23] Ex B18, p2

101. Professor Pillans thought that the administration of midazolam was appropriate initially, but it was no longer indicated at the time it was injected into Mr Coolwell. He also noted that midazolam is no longer recommended for a sedation of persons with acute behavioural disturbance, and that droperidol has been assessed as equally effective, safer, with a shorter time to onset of sedation and a lower requirement for additional sedation.

102. After considering the evidence of Dr Storey and Dr Duflou, together with the evidence of Professor Pillans and Dr Rashford, I conclude that Mr Coolwells' death was not caused because of the administration of midazolam. In addition, having regard to the controversial nature of the diagnosis of excited delirium, the presence of the constellation of other significant factors in this case makes it unnecessary for me to include excited delirium among the factors that contributed to Mr Coolwell's death.

Conclusions on Issues

103. The circumstances that confronted QPS officers and paramedics on arrival at 62 Clare Street, Kingston on 2 October 2015 were undoubtedly challenging, dynamic and stressful.

104. The 000 call taker advised the officers on tasking that Mr Coolwell was reported to be extremely violent. He had locked himself in the bathroom, it was not known whether he was armed and there was a lot of blood. As Dr Rashford noted, the initial experience of first responders to these scenes is fear, as this is a dangerous situation until control is obtained.

105. The scene on arrival at the residence was consistent with the information conveyed by the call taker. Mr Coolwell was locked in the bathroom and there was yelling and banging. The first responders would have been understandably concerned for their own wellbeing, together with that of Mr Coolwell and other persons present. Unfortunately, Mr Coolwell was also restrained within the confines of a narrow hallway with his feet in a bedroom and his head at the entry to the bathroom.

106. Notwithstanding the confronting scene that the QPS officers and paramedics faced on arrival, as Dr Rashford noted first responders are trained and given procedures and guidelines to follow that provide a template for reducing risk to everyone present. While the paramedics attending to Mr Coolwell did not have sufficient regard to those guidelines, I am unable to find that his death was caused by any oversights on their part.

Was the administration of midazolam by Queensland Ambulance Service officers appropriate?

107. Midazolam was administered to Mr Coolwell by CCP Anderson after a request was made by attending QPS officers to have Mr Coolwell sedated. Consistent with the evidence of Dr Rashford, the submissions on behalf of each of the three attending paramedics and the QAS have frankly acknowledged that the administration of midazolam was inappropriate having regard to Mr Coolwell's presentation when it was injected. This was supported by the evidence of Professor Pillans. It was also accepted that responsibility for Mr Coolwell's medical treatment rested with the paramedics.

108. Paramedics had recorded in the electronic Ambulance Report Form (eARF) that Mr Coolwell's Glasgow Coma Score (GCS) was 15/15. As acknowledged by Dr Rashford, this was clearly incorrect and in the four minutes prior to the administration of midazolam his GCS score was 3/15 – "the lowest score indicating no response to painful stimuli and a deeply unconscious state".

109. I accept that when the QPS officers and QAS paramedics arrived at 62 Clare Road, Kingston Mr Coolwell was experiencing an acute behavioural disturbance and that the recording in the eARF of a SAT Score of plus (+) 3 was warranted. However, as Dr Rashford noted Mr Coolwell's score was minus (-) 3 in the four minutes before the administration of midazolam.

110. I do not accept the evidence of CCP Anderson that Mr Coolwell's SAT score was plus (+) 2 when he decided to administer the midazolam. He acknowledged, in hindsight, that he would not have sedated Mr Coolwell. Thirty seconds before injecting the midazolam into Mr Coolwell's shoulder someone asked, "so he's awake and everything?". Irrespective of who made the comment, it was clearly audible on the video tape and should have prompted a reconsideration of the pathway being followed. As Dr Rashford noted, at that time "Mr Coolwell was deeply unconscious and had ineffective breathing – he was almost certainly in cardiac arrest at this point".

111. In those circumstances, the administration of midazolam was clearly inappropriate, and followed the absence of an independent assessment of Mr Coolwell's condition immediately before it was administered. At its highest, the evidence suggests that the only observations carried out were radial/pedal pulse checks.

112. The attending paramedics also failed to comply with the QAS February 2015 Clinical Practice Guideline on the physically restrained patient. That Guideline required that there be continued careful assessment of the patient's airway[24] and breathing status, together with optimal positioning of the patient. The Guideline required:

> *"Continual visual observations including monitoring of the patient's face for signs of distress/difficulty. Vital sign monitoring, five minutely:*
>
> *- Respiration rate and pulse oximetry*
>
> *- Heart rate and blood pressure*
>
> *- Glasgow coma score assessment*
>
> *- Perfusion assessment distal to the mechanical restraint*
>
> *- Initial BGL*
>
> *- Temperature (taken initially then every fifteen minutes)"*

Was the restraint of Mr Coolwell appropriate?

113. Mr Coolwell was clearly in need of restraint for his own wellbeing when Constables Zarzycki and Truter arrived at 62 Clare Road, Kingston. He had injured himself during an acute behavioural disturbance in the bathroom of the residence and was lashing out with his arms and legs. He had suffered a severe cut to his right Achilles tendon, as well as apparent burns.

114. Mr Coolwell was not responding to verbal directions and resisted initial efforts to restrain him. I accept that the restraint was authorised and it was necessary to apply force to maintain the restraint in the interests of Mr Coolwell's safety and the safety of the first responders. Submissions on behalf of Mr Coolwell's sister acknowledged that the attending police officers seemed genuinely concerned for her brother's health and wellbeing, and that they tried to treat him with care and concern in a difficult situation.

115. It is clear from the review of the body worn camera footage that while Mr Coolwell was restrained in a prone position for almost 10 minutes, he only struggled for a very short time at the beginning of this period.

[24] At all times one officer was to be responsible for the supervision of the patient's airway.

116. The evidence of Dr Storey and Dr Duflou was that restraint of Mr Coolwell in a prone position was a factor that contributed to his death but having regard to the multifactorial causes of the death I cannot conclude that the restraint alone caused Mr Coolwell's death.

117. However, I agree with the submissions on behalf of Mr Coolwell's sister that restraint was not required from two minutes after Constable Wallis arrived. Instead, Mr Coolwell required urgent medical attention. I also agree that although the police officers were not the correct people to administer that medical attention, they should have recognised from their own observations in relation to Mr Coolwell's pulse, breathing and vomiting that restraint was no longer required.

118. The contribution of the restraint to the death could have been minimised if Mr Coolwell was moved from the prone position after he stopped resisting, and his vital signs were continuously monitored. While I acknowledge that Constable Truter made efforts to keep Mr Coolwell's shoulder off the floor, it should have been possible to roll him on to his side with the handcuffs in place. In addition, although the police officers were attempting to monitor his pulse and breathing, Mr Coolwell's vital signs were not adequately checked or monitored during the restraint despite the presence of two advanced care paramedics and a critical care paramedic.

119. As Dr Rashford noted in his report, the sudden change in Mr Coolwell's agitated state should have resulted in a very detailed review of his condition. The paramedics and police officers who were present interpreted Mr Coolwell's behaviour as compliance with the restraint. There was a basic failure to recognise and respond to his clinical deterioration.

Findings required by s. 45

120. I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. After considering all the evidence, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased - Shaun Charles Coolwell

How he died – Mr Coolwell died after he was physically restrained by police officers in a prone position in the hallway at his sister's residence. Police were called to help ambulance officers give first aid to Mr Coolwell after he had injured himself during a drug induced acute behavioural disturbance. After Mr Coolwell became unresponsive during the restraint, he was given a midazolam injection for sedation. At the time of his death he was affected by amphetamines and had severe coronary atherosclerosis. It was not possible to separate the various factors that contributed to Mr Coolwell's death.

Place of death – Logan Hospital, Logan in the State of Queensland

Date of death– 2 October 2015

Cause of death – Mr Coolwell died as a result of cardiorespiratory arrest during restraint, involving a predisposition to cardiac arrhythmia because of the effects of advanced coronary artery disease, methamphetamine use, injuries and stress.

Comments and recommendations

121. Section 46 of the *Coroners Act 2003* provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

122. Counsel assisting submitted that an area where consideration may be given to ways to prevent similar deaths concerned the inappropriate administration of midazolam. However, it was noted that the need for such a recommendation had been overtaken by a change in Queensland Ambulance Service practice.

123. As Dr Rashford noted in his report, midazolam is no longer used by QAS paramedics in sedating violent or aggressive patients. The drug now used is droperidol, which is not a respiratory suppressant. Permission may be sought to administer midazolam only in circumstances where a person with an acute behavioural disturbance with a SAT score of at least +2 is unresponsive to droperidol.[25]

124. The QAS has also revised its training on responding to patients with acute behavioural disturbance, and the relevant Clinical Practice Guidelines and Procedures have been reviewed and enhanced.

125. Counsel assisting also submitted that while the first responders to Mr Coolwell's predicament acted professionally and in good faith, that did not alleviate the fact that the police officers misunderstood his medical condition in that they interpreted his agonal breathing as mere compliance with the restraint. It was submitted that to prevent further misunderstandings the QPS should incorporate a practical understanding of agonal breathing in its first aid and restraint training to enable a better appreciation of the distinction between respiratory suppression and compliance.

126. Submissions on behalf of the QAS noted that the need for paramedics and police officers to attend presentations of acute behavioural disturbance are likely to increase with widespread use of illicit stimulant medication, excessive alcohol intoxication and mental illness. Dr Rashford agreed that there was a need for the QPS and QAS to better understand each other's roles, and to improve how they work together given that QPS officers are often first on the scene because of the safety issues that arise in these cases.

127. The QAS submissions also recommended that the QAS have access to police investigation material, such as body worn camera footage, in a timely manner to inform the QAS investigation of the actions of paramedics. It was apparent in this case that the paramedics failed to appreciate the extent to which Mr Coolwell had deteriorated during the restraint until they viewed the body worn camera footage of officers Wallis and Armstrong. There are existing mechanisms within the QPS to review critical incidents and it may be appropriate to use those forums for both agencies to enhance working relationships following an adverse event.

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[25] QAS Drug Therapy protocols: midazolam, January 2019. https://www.ambulance.qld.gov.au/docs/clinical/dtprotocols/DTP_Midazolam.pdf

Recommendations

I recommend that the Queensland Police Service and the Queensland Ambulance Service:

1. *work together in relation to the joint management of responses to acute behavioural disturbance, including physical restraint, to ensure that officers from both agencies are aware of the requirement for ongoing monitoring of restrained persons, the differential interpretation of observations and the importance of role clarity and teamwork.*

2. *develop a formal process to facilitate the early sharing of lessons learned from the investigations of both agencies into adverse events where QPS and QAS officers are co-responders, including access to relevant investigative materials.*

128. I close the inquest.

Terry Ryan
State Coroner
Brisbane
10 June 2019