QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Ashley Thomas Horne**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2018/1459
DELIVERED ON:	9 March 2021
DELIVERED AT:	Toowoomba
HEARING DATE(s):	20 January 2021, 8-9 March 2021
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, self-inflicted stab wound, police dog, Taser, first aid response.

REPRESENTATION:

Counsel Assisting:	Sarah Lio-Willie, Coroners Court
Snr Constable Wagstaff Constable Maloy Snr Constable Giuliano:	Stephen Hollands, instructed by Gilshenan and Luton
Commissioner of Police:	Ian Fraser, Office of the QPS Solicitor

Contents

Introduction

1. Ashley Thomas Horne died at the Toowoomba Hospital at 12:17am on 31 March 2018. Earlier that night, police had responded to a triple zero call from Mr Horne's former partner who was in the process of taking out a Domestic Violence Order against him. She told police that he was in her backyard and was potentially violent. A police dog tracked Mr Horne to a nearby street.

2. After he was confronted by police, Mr Horne did not comply with their directions and stabbed himself in the chest. He later died of his injuries in hospital. He was aged 49 years. Only sixty seconds had passed between Mr Horne being located by police and his handcuffing after he had stabbed himself.

The investigation

3. As Mr Horne's death was classed as a death in custody, the investigation into the circumstances leading to his death was conducted by Detective Sergeant Detective Senior Sergeant Naomi Lockhart from the Queensland Police Service, Ethical Standards Command (ESC), Internal Investigations Group (IIG).

4. After being notified of Mr Horne's death, the ESC was tasked to attend, and their investigation ensued. The investigation was informed by statements and recorded interviews with:

    - police officers involved;
    - attending Queensland Ambulance Service (QAS) staff;
    - Mr Horne's former partner; and
    - Mr Horne's next of kin.

5. Relevant sections of the QPS Operational Procedures Manual were examined. Forensic analysis was conducted, and photographs were taken. All the police investigation material was tendered at the inquest.

6. A full internal autopsy examination, with associated testing, was conducted by Forensic Pathologist, Dr Andrew Reid. Further photographs were taken during this examination.

7. I am satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed.

The Inquest

8. An inquest was held in Toowoomba on 8-9 March 2021. All statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. The following issues were considered:

    1. The findings required by s45(2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death.

    2. Whether the actions of the attending police officers were appropriate in the circumstances.

3. The adequacy of training and auditing of QPS officers with respect to:
    i. First aid regarding penetrating trauma.
    ii. Training in night-time/ unlit scenarios, with and without the use of a torch.

9. Oral evidence was heard from the following witnesses:

    i. Detective Senior Sergeant (DSS) Naomi Lockhart (IO)
    ii. Senior Constable (SC) Jeffrey Wagstaff
    iii. Constable Lauren Maloy
    iv. SC Simon Giuliano
    v. Sergeant (Sgt) Lucas Finney
    vi. Doctor Stephen Rashford.

10. The evidence tendered in addition to the oral evidence from these witnesses was sufficient for me to make the requisite findings. I received helpful submissions from counsel assisting, Mr Fraser and Mr Hollands.

The evidence

11. Mr Horne was the youngest of four sons born to Annette Menelaws and Colin Horne. Mr Horne is survived by a son, who was aged 8 years at the time of his death.[1]

12. Mr Horne was a career truck driver. He and his ex-wife had relocated to America to live and run their own delivery truck business. However, at the time of his death, he was working as an interstate truck driver.

13. In response to concerns from Mr Horne's family, IIG investigators travelled to Perth and showed his brother the body worn camera footage of the events leading up to the death. After this his family informed police that they felt further informed about events leading up to and during the death and raised no further concerns.[2]

Criminal history

14. Mr Horne had no declarable criminal history. He had a single, dated, summary conviction from 1988 for consuming liquor on the road for which he was convicted and fined $20. He did not appear to be known to police until the night of his death.

Medical history

15. Mr Horne suffered from anxiety and depression. In June 2017, he was referred to Dr Marshall at Magnolia House Psychology and Therapies Centre, for an opinion and management regarding the acute exacerbation of his anxiety and depression in the context of work stress, where he alleged he was the subject of bullying.[3]

16. Mr Horne attended six appointments with Dr Marshall between July 2017 and February 2018. After his final appointment, Dr Marshall wrote to Mr Horne's GP and

[1] Ex B18 – Mr Horne's wife was granted a DVO against him in 2015, following their separation.
[2] Ex A5 – Coronial Report, para.11.
[3] Ex F2, p.38.

advised that his depressive scores remained in the mid-range and he would benefit from more sessions with her.[4]

17. Mr Horne returned to his GP on 9 February 2018 to review his mental health plan. He reported being in a better place mentally and was responding well to the prescribed antidepressants.[5] Mr Horne's GP described him as a man who had gone through a tough few years with a divorce and significant work stressors but appeared to be coming out of the worst of it.[6]

Relationship with Silvia[7]

18. In March 2016, Mr Horne commenced a relationship with Silvia. Silvia had five children living with her. Mr Horne lived with Silvia for a few months from about April 2017. Silvia described Mr Horne as a jealous partner who often accused her of cheating on him. Their arguments became more frequent and Mr Horne progressively became more paranoid and threatening. As a result of the arguments, Silvia moved to West Toowoomba with her children.

19. Her relationship with Mr Horne was strained and was on and off from January 2018. In the beginning of March 2018, they agreed to end their relationship. DSS Lockhart told the inquest that she had formed the view, based on interviews with Silvia and other family members, that Mr Horne and Silvia both wanted the relationship to work but that was not tenable.

20. On 24 March 2018, Mr Horne took Silvia out for dinner. Silvia told him about a humorous text message she received from a male friend. Mr Horne became angry and accused her of having a relationship with this man. He walked out of the restaurant. Silvia went outside to look for Mr Horne. He came back a few minutes later and took her phone and ordered them an Uber to his home. He refused to give Silvia her phone back during the trip home.

21. Once at Mr Horne's house, he threw Silvia's phone against the fence causing the screen to crack. Silvia retrieved her phone and went home. She sent him a message telling him there was no need to break her phone and he needed to fix it. She also told him their relationship was completely over.

22. From that night until 29 March 2018, Mr Horne constantly sent offensive Facebook messages to Silvia.[8] He also called her numerous times. Silvia did not answer his calls and only sporadically replied to these messages telling him to stop contacting her.

23. On 27 March 2018 after 5.54pm, in response to Silvia not answering his calls, Mr Horne sent the following string of messages:

    - *You are what they call toast*
    - *TOAST*
    - *BURNT*

[4] Ex F2, p.112.
[5] Ex F2, p.1.
[6] Ex F2, p.2.
[7] A pseudonym has been used to protect the identity of Mr Horne's partner.
[8] Ex E8 – Facebook messages between Silvia and Mr Horne, p.123.

- *Good that's going to give me more time to think!!! And you do know "CUNT" I DON'T GIVE A FUCK ANYMORE. So have a hard think about what you've done slut.!!!!*
- *Sweet fucking dreams. So you better be quick to get [name] cock into you ok*
- *No more!!!! All the talking is done from here cunt.*

24. On 29 March 2018, Silvia attended the Toowoomba Police Station and applied for a protection order against Mr Horne. Police completed the Police Protection Notice (PPN) and were advised that Mr Horne was not due to return home until 30 March 2018 as he was away driving. Police attended Mr Horne's address twice on the afternoon of 30 March 2018, but he was not home and the PPN was not served on him.[9] There is nothing to suggest that Mr Horne was aware Silvia was seeking assistance from QPS or applying for a DVO at the time of his death.

Events Leading up to the Death

25. At 12.05am on 30 March 2018, Mr Horne sent a further batch of messages to Silvia:

- *Do you want to talk at all?*
- *?*
- *Your all I got ...*
- *And all I want* 💔
- *Do you hate me? And is your heart with someone else?*
- *I'm a mess darl!!!!*

Silvia did not respond to any of the messages.

26. That evening sometime after 10.30pm, Silvia was painting at home and went outside for a cigarette. When she went into the backyard, she saw that some furniture had been moved. She had arranged the furniture to alert her if Mr Horne came over unannounced, which he had done on occasion since they separated. Some children's toys had also been taken from the shed and placed in the yard. Silvia returned inside and locked the door. She then saw Mr Horne walk past one of the bedroom windows.[10]

27. Silvia rang police at 11.09pm. Two police crews and a Dog Squad officer responded to the job. At 11.17pm the Dog Squad Officer, SC Wagstaff with Police Dog (PD) Agro, arrived at the address. He was told by Silvia that she had applied for a DVO and he searched the back yard and shed. PD Agro gave a strong indication that there had been a person in the shed.

28. Just prior to the SC Wagstaff's arrival, SC Giuliano and Constable Maloy had driven past Silvia's home in an unmarked police vehicle. They staged nearby so as not to interfere with the police dog's tracking. They had responded to the job as they were returning from Westbrook to Toowoomba. They saw a silhouette running on Friend Street. After confirming that this was not SC Wagstaff, they informed him that an unknown person was in the vicinity of 28 Friend Street. They reversed back to enable PD Agro to track in that location.

[9] Ex C14 – Occurrence Enquiry Log.
[10] Ex B16 – Statement of Silvia .

29. After SC Wagstaff was informed that Mr Horne had likely jumped over the back fence PD Agro was deployed. He ran a track across several properties and into the adjacent street at the rear of Silvia's address.[11]

30. At the inquest, SC Wagstaff recalled that it was very dark and windy. PD Agro initially lost the track, but soon tracked to the front a house at 28 Friend Street, which had a garden bed and was lined by a hedge. There were no house or street-lights illuminating the yard.

31. SC Wagstaff told the inquest that he heard a noise in the bushes and then observed Mr Horne wearing a backpack and holding onto the straps in front of him. He repeatedly directed Mr Horne, "*get here and get on the ground. Police with a police dog, get on the ground*." SC Wagstaff radioed for other units to respond to his location. Mr Horne stepped towards SC Wagstaff with both hands against his chest and fell forward face onto the ground.

32. Mr Horne then rose to his knees, at which point SC Wagstaff saw the knife and directed him again to "*get on the ground*." At this point, Mr Horne can be seen on body worn camera (BWC) footage on his knees, hunched over with his hands to his chest and audibly groaning.[12] He then falls forward onto his left elbow. At this time SC Wagstaff produced his taser and the laser LED light shone on Mr Horne. SC Wagstaff told Mr Horne he had produced his taser. Until this time, Mr Horne was not clearly visible on the BWC footage.

33. SC Wagstaff discharged his taser, the probes penetrated Mr Horne's back and he fell forward face down onto the ground, before rolling onto his left side. Constable Maloy ran towards Mr Horne, as SC Wagstaff yelled "*move in, he's got a knife, he's got a knife".*

34. Upon hearing Mr Horne had a knife, Constable Maloy took three steps back. She had not produced her firearm or taser. Mr Horne then rolled onto his back, at this time the knife can be seen on the BWC penetrating the left side of Mr Horne's chest, with the handle sticking out.

35. At around the same time, SC Giuliano arrived and had his firearm produced and aimed at Mr Horne. All three officers directed Mr Horne to "*drop the knife*", "*armed police, get rid of the knife*". Mr Horne had both hands on the handle of the knife, and appeared to hold it in place or push it further into his chest. SC Giuliano said that he had deployed his hand held torch, although his pistol was also equipped with a lighting device. In hindsight, he thought deployment of the light on his weapon may have illuminated the scene a few seconds earlier.

36. SC Wagstaff yelled "*taser again*", causing Mr Horne to roll over once to his right, face down, then landing on his back with his left arm beside his body and his right arm above his head. He was not moving.[13] Mr Horne's position was illuminated by the LED light of SC Wagstaff's taser, and the knife handle was visible protruding from his chest. The officers continued to yell at Mr Horne to drop the knife.

[11] Ex B39 – ROI of Constable Maloy.
[12] Ex D6 – SC Wagstaff BWC – enhanced at 8.50mins.
[13] Ex D6 – SC Wagstaff BWC – enhanced at 9.17mins.

37. SC Wagstaff said that he deployed the Taser as it was the least lethal use of force option available where an officer is confronted with a person with an edged weapon. He was concerned for the safety of the police dog and himself and considered it was necessary to taser Mr Horne to prevent him from self-harming. Mr Horne was on the ground moving his arms and still able to access the knife. He said he had not used a torch in tracking Mr Horne as this may have distracted the dog as well as given away his location.

38. After Mr Horne released the knife, SC Wagstaff told the other officers to move in. While the knife was visible, Constable Maloy ran in and grabbed the handle of the knife and threw it away.[14] She then handcuffed Mr Horne in front of his chest., at which time there was no visible light on Mr Horne. SC Wagstaff called for Queensland Ambulance assistance and maintained hold of PD Agro.[15]

39. SC Giuliano told the inquest that he did not recall any directions being given by SC Wagstaff in relation to the knife. He said that he was stunned when he saw the knife in Mr Horne's chest and Constable Maloy had removed it before he was able to comprehend the situation.

40. SC Giuliano said that with the benefit of hindsight, he was not certain he would have indicated that the knife should have been left in situ in Mr Horne's chest before paramedics arrived. However, he understood from general first aid training that it was preferable not to remove a knife from a penetrating wound. He said that this scenario was not dealt with in tactical first aid training by the QPS. He agreed that the first response to meet the threat posed by a bladed weapon was to produce a firearm.

41. As police officers rendered first aid, Mr Horne told them to "*let me die, tell my boy I love him*". Constable Maloy said that she maintained pressure on the wound after moving Mr Horne into the recovery position.

42. The first QAS unit arrived at 11.36pm. Paramedics observed Mr Horne shirtless, handcuffed and unresponsive, with taser prongs on his back and shoulders.[16] Paramedics were advised that Mr Horne had stabbed himself in the chest. Mr Horne went into cardiac arrest at the scene, he was subsequently transported Code 1 to the Toowoomba Base Hospital, arriving at 11.56pm. Resuscitation efforts ceased at 12.17am and Mr Horne was declared life extinct.

The knife

43. The knife was identified as a CRKT brand, M16-14LEK Tanto Large knife with triple point serrations. It was a folding knife with a locking liner. The blade was 95.25mm in length.

The backpack

44. Mr Horne's backpack was searched and found to contain:

- a hammer,
- 2 x trucking ropes,
- 2 x gas cannisters,

[14] Ex D6 – SC Wagstaff BWC – enhanced at 9.20mins.
[15] QAS received the call to attend at 11.27pm.
[16] Ex B25 – Statement of Katrina Nixon.

- a blow torch,
- a pair of secateurs, and
- alcohol.

45. Given the domestic violence background, police inferred that the items in Mr Horne's backpack may have been for the purpose of scaring or harming Silvia. While only Mr Horne knew what his intentions were when he went Silvia's house that night, I agree that it is likely that he had planned some form of retaliation in response to her decision to finally end the relationship.

Autopsy Results[17]

46. An external and partial internal post-mortem examination was performed by Dr Andrew Reid at the Queensland Health Forensic and Scientific Services on 3 April 2018.

47. The external examination revealed a stab wound measuring 36 x 4mm of the left upper anterior chest. There were two single puncture wounds with surrounding blue bruising on the lateral aspect of the left arm and left lateral posterior chest. A less obvious puncture wound was also located above the stab wound on the anterior chest.

48. The internal examination showed an oblique penetrating stab wound, at a shallow angle above the horizontal plane, through the skin, subcutaneous tissue, superficial muscles of the chest wall and intercostal muscles of the fourth intercostal space of the left side of the chest and into the left pleural cavity. There was a large left sided haemopneumothorax and the left lung was collapsed but had not been stabbed or penetrated. There was a stab wound of the left anterior side of the pericardium with an associated small volume haemopericardium.

49. The stab wound was consistent with having been made by the knife seized by police. The knife was single edged.

50. The toxicology test revealed a post-mortem BAC of 0.028%. Concentrations of the antidepressant drugs sertraline and desmethyl sertraline were within a therapeutic range.

51. There was no evidence that the significant injuries from the taser barbs or the low voltage electrical discharge either caused or contributed to Mr Horne's death, especially in the presence of a severe penetrating chest injury and bloody loss.

52. Dr Reid concluded that the cause of death was a stab wound to the chest.

Assessment of the QPS Response

Use of taser

53. Sgt Lucas Finney, QPS Operational Skills and Tactics (OST) training officer, reviewed the BWC and relevant statements and provided an opinion as to the response by QPS officers, specifically SC Wagstaff, SC Giuliano and Constable Maloy.

[17] Ex A3 – Autopsy report.

54. Consistent with his evidence at the inquest, SC Wagstaff had explained to investigators his decision to deploy his taser as opposed to using his baton, OC spray or firearm. Upon locating Mr Horne in the front yard, SC Wagstaff transferred PD Agro to his left hand and decided the most appropriate use of force was his taser, for the safety of himself, PD Agro and other officers.

55. Sgt Finney considered that the first deployment of the taser was justifiable. Although the knife was already embedded in Mr Horne's chest, he had risen to his knees and still had at least one hand on the handle of the knife with the capacity to pull the knife out and use it as a weapon.

56. Sgt Finney also concluded the second deployment of the taser was justifiable. Although Mr Horne was lying on his back, he appeared conscious and moving with both his hands on the knife embedded in his chest. It continued to pose a serious risk to Constable Maloy and other QPS officers.

57. Sgt Finney concluded that the decision to deploy the taser on both occasions was a reasonable response and proportionate use of force. I agree with those conclusions.

Tactical first aid

58. Constable Maloy told the inquest that she saw SC Wagstaff deploy the first cycle of his taser and ran towards Mr Horne with her handcuffs. She heard SC Wagstaff yell "*knife*" and she stepped backwards. She did not use her torch when she approached Mr Horne. SC Wagstaff said he was going to taser Mr Horne again, and Constable Maloy observed SC Giuliano had presented his firearm.

59. After SC Wagstaff tasered Mr Horne a second time, he rolled over before resting on his back. Constable Maloy ran up to Mr Horne and had "*thrown the knife*" away. She thought the knife was on his left hand. She did not assess or realise the knife was in Mr Horne's chest. Then she handcuffed him, put gloves on and rendered first aid to Mr Horne.[18]

60. Another QPS crew attended. They provided a tactical first aid kit and assisted with first aid. SC Angus attempted to apply a chest seal to Mr Horne's wound but there was too much blood and the seal did not take effect. SC Giuliano recalled that blood was spouting out of the wound at times.[19]

61. Sgt Finney stated the basic rule in first aid for penetrating trauma was to leave the object in place as it could be slowing the bleeding. A 'donut' bandage should be applied around the object. Officers are instructed about penetrating trauma during OST and tactical first aid training.[20] However, that training is based on best practice medical interventions where there is good light and the patient is not combative. Before administering first aid, any provider must be aware of potential dangers that exist and take appropriate actions to render the scene safe.

[18] Ex B39 – ROI of Constable Maloy.
[19] Ex B41 – ROI of SC Giuliano.
[20] Ex B25, statement of SC Osbourne.

62. Sgt Finney believed Mr Horne was not incapacitated and the knife, although embedded in his chest, was still within reach. This presented a threat to the responding police and moving forward to control Mr Horne and apply first aid while the knife was in his chest and unsecured would have unnecessarily placed police at risk. Even if restrained, Mr Horne would still have been able to grab the knife.

63. Sgt Finney considered that the decision by Constable Maloy to remove the knife was appropriate in the circumstances to ensure, as far as possible, the safety of the responding police and paramedics.[21] After hearing the evidence from the officers, Sgt Finney and Dr Rashford, I also agree with that conclusion.

64. At the inquest, Sgt Finney said that this was a rare occurrence and he was not persuaded that it was necessary to incorporate more penetrating knife trauma responses in the tactical first aid training offered by the QPS. He said that QPS officers should consider safety as a priority and on this occasion the officers had acted correctly to remove the threat by securing the weapon and then controlling Mr Horne.

First aid training

65. SC Wagstaff did not assist in the provision of first aid as he was handling PD Agro and there were enough officers to assist. He told investigators he had completed first aid and tactical first aid training in 2017.

66. Constable Maloy believed she had completed tactical first aid training in 2017, but at the time of the incident she was not certified in first aid.

67. SC Giuliano believed he was first aid certified and completed tactical first aid training within the six months prior to the incident.

Body worn camera

68. SC Wagstaff activated his BWC before getting out of his car at the incident location. His actions on the night and the critical incident were all captured on BWC.[22]

69. Both SC Giuliano and Constable Maloy were equipped with QPS issued BWCs. However, neither activated their BWCs correctly or in accordance with the Operational Procedures Manual.

70. Constable Maloy thought she turned her BWC on before getting out of the car on Friend Street but when she returned to the police car after the incident and went to turn off her BWC she realised it was not on or recording.[23] SC Giuliano did not turn his BWC on while he was in the car staging. He only thought to turn on his BWC after the incident.[24]

Use of the torch

71. Sgt Finney considered that SC Wagstaff's intermittent use of his torch while tracking and attempting to detain Mr Horne was appropriate in the circumstances.

[21] Ex B14 – Statement of Sergeant Finney.
[22] Ex D3 – BWC of SC Wagstaff.
[23] Ex B39 – ROI of Constable Maloy.
[24] Ex B41 – ROI of SC Giuliano.

Expert Opinion[25]

72. An opinion was sought from Dr Stephen Rashford, Emergency Medicine Specialist and Medical Director of the Queensland Ambulance Service (QAS), in relation to:

    - whether the removal of the knife from Mr Horne's chest at the scene contributed to his death;
    - whether leaving the knife in situ until the QAS arrived would have been outcome changing; and
    - whether the delay in the removing the handcuffs until the critical care paramedic (CCP) arrived contributed to Mr Horne's death.

73. Dr Rashford said that where there was penetrating trauma with an implement in situ, the usual practice was not to remove the implement. He said that as there would usually be a degree of direct pressure exerted by the implement, it will to an extent to slow the loss of blood from any vessel organ injured by the implement. He said that although this was a well-accepted principle of trauma care, it was "more paradigm rather than evidence based".

74. Dr Rashford said that the only circumstances where he would advise diverting from this practice was when the patient was in cardiac arrest and removal of the implement was necessary to allow resuscitation efforts to safely occur.

75. He agreed that if the officers considered that Mr Horne was in cardiac arrest it would have been necessary to remove the knife to commence chest compressions. Dr Rashford also said that in the circumstances of Mr Horne's case he could appreciate the rationale behind the split-second decision that was made to remove the knife. He said that on the balance of risks and with the benefit of hindsight, it was difficult to criticise that decision.

76. Dr Rashford noted that Mr Horne had suffered a penetrating injury to the pericardial and right ventricle of the heart. He said that this was a critical injury that is associated with an exceptionally high mortality rate irrespective of the geographic location of the patient. He considered that Mr Horne had suffered a nonsurvivable injury based on the nature of his injuries and the distance from advanced resuscitative care once he developed a cardiac arrest scenario.

77. Dr Rashford said that after reviewing the BWC in detail the most likely acute cause of death was a cardiac tamponade, which Mr Horne suffered because of the right ventricular wound. He noted that cardiac arrest due to cardiac tamponade is a form of obstructive shock. Blood gathers under pressure within the pericardial cavity, ultimately compressing the low-pressure right side of the heart, resulting in no inward or outward blood flow. It is a rapidly fatal condition unless treated. Contemporary opinion is that this injury requires emergency resuscitative thoracotomy - the opening of the chest cavity to directly decompress the blood collection and definitively address the bleeding site in the heart. Such a procedure was beyond the scope of practice for any paramedic.

[25] Ex F5 – Report of Dr Stephen Rashford.

78. In those circumstances, Dr Rashford said that Mr Horne's injury was always going to result in his death, regardless of whether the knife was removed by the QPS officer or remained in situ until his cardiac arrest. He concluded that the overwhelming determinant of survival in this case was the severity of the injury complex, the rapidity of deterioration to cardiac arrest, and the distance to hospital once this deterioration occurred. Those factors conspired to represent a zero chance of survival.

79. Dr Rashford said that by the time the first QAS officers arrived Mr Horne was unconscious and verging on cardiac arrest. Prior to this he had stated several times that he found it difficult to breathe and wanted to sit up. He then became drowsy and unconscious. The negative response to the request to remove the handcuffs because Mr Horne was violent demonstrated that the deterioration in his condition was missed or misinterpreted as behavioural when in fact his sudden compliance was directly due to his clinical deterioration.

80. Dr Rashford said that a complaint by an individual about not being able to breathe was the first sign of clinical deterioration. This should be a "red flag event" and will predate eventual deterioration. Often the individual will be agitated and combative due to oxygenation levels. In the context of an arrest situation, nonclinical law enforcement officers are often unable to differentiate this behaviour from previous aggressive behavioural disturbance. He said that this is a very difficult scenario for law enforcement personnel, but the body worn camera clearly demonstrated the scenario presenting to attending QPS officers.

81. Inevitably the patient becomes unconscious but still exhibits breathing activity, often initially at a normal or elevated rate. This breathing is falsely reassuring to non-clinical personnel. This represents another "red flag" event. The individual's breathing pattern will deteriorate to agonal breathing patterns over time, but all should be considered ineffective. Unfortunately, these reoccurring themes occur as human factors are at play. The attending law enforcement officers have just experienced an extremely confronting, often strenuous and stressful event, which may result in them being blinded to these changes.

82. Dr Rashford said that the QAS was committed to ongoing education and simulation training the QPS and QAS officers. He said that these scenarios will continue to confront officers in acute operations.

83. The persisting focus on the violent events that had just occurred resulted in a delay to removal of the restraint, which potentially complicated and delayed QAS assessment and/or treatment. While in this case the outcome would not have been altered by earlier removal of handcuffs, it was worth highlighting as it occurs relatively frequently in these confronting situations.

84. Sgt Finney told the inquest that the QPS and QAS had commenced negotiations in early 2020 on joint training in relation to officer awareness of deteriorating levels of consciousness and identifying breathing patterns. This was in response to previous coronial recommendations but was interrupted by the exigencies of the Covid-19 response. As such, face to face training was not able to be implemented. Officers are being trained in relation to the AVPU scale to ensure that where a person is unresponsive, they are afforded medical treatment as a matter of urgency. The AVPU scale has also been incorporated into the First Responders Handbook.

Queensland Ambulance Service Response

85. The QAS received the call to attend at 11.27pm and dispatched the first unit and the CCP at 11.29pm. At 11.30pm the first unit was on the way to the scene, arriving at 11.36pm and the CCP arrived at 11.38pm.

86. Paramedics observed Mr Horne lying on the ground in the left lateral position, with his hands cuffed across his chest. He was rolled onto his back and paramedics visualised a deep puncture wound on the left side of his chest. There was nil active bleeding but there was excessive blood loss on and around him. Paramedics asked QPS officers to remove the handcuffs so Mr Horne could be treated but officers stated that as he was violent, they would prefer not to remove them.[26]

87. Paramedics continued their initial assessment of Mr Horne and identified that he was:

- Unresponsive with a Glasgow Coma Score of 3.
- Airway partially obstructed.
- Respirations inadequate at a rate of 4 and shallow.
- Circulation inadequate with a weak carotid radial pulse; and
- Skin pale and cool to touch.

88. Mr Horne began vomiting and immediate airway management and suction was provided. After the CCP arrived, paramedics again requested police remove the handcuffs so that Mr Horne could be treated. Paramedics advised that he was deteriorating rapidly and was too unwell to be violent. Police then removed the handcuffs.[27]

89. Mr Horne went into cardiac arrest and CPR was commenced. Given the proximity to the Toowoomba Hospital, paramedics loaded Mr Horne into the ambulance and all three paramedics remained with him. A police officer drove the ambulance to the hospital to allow paramedics to continue working on Mr Horne.[28] Paramedics believed the stab wound was to the heart. It began actively bleeding and 'spurting' multiple times during CPR and was difficult to manage.[29] The ambulance arrived at the hospital at 11.56pm.[30]

90. A Clinical Review was undertaken by the QAS, which did not result in any adverse comments about the QAS response to Mr Horne nor offer recommendations about alternative management or treatment offered to him by paramedics.[31]

[26] Ex B13 – Statement of Sebastian Erdelyi; Ex C20 – QAS electronic ambulance report form, p2.
[27] Ex B13 – Statement of Sebastian Erdelyi; Ex C20– QAS electronic ambulance report form, p2, handcuffs removed at 11.40pm.
[28] Ex B3; Ex B10, Ex B13; Ex B25.
[29] Ex B13 – Statement of Sebastian Erdelyi.
[30] 4 minutes after leaving the scene.
[31] Ex C22 – QAS Operational Incident Review.

Investigation Findings

91. The Internal Investigations Group report found no evidence to support any criminal offence, breach of discipline or misconduct against any police officer regarding Mr Horne's death.

92. The investigation observed that the actions of police following Mr Horne's self-harming were worthy of recognition in the way that Tactical First Aid was administered.

93. DSS Lockhart recommended that the training of police in Operational Skills and Tactics continue to focus on the use of Body Worn Cameras in conjunction with torches and other operational police accoutrements.

Conclusions

94. The attending officers were responding to a complaint of trespass and domestic violence by Mr Horne's former partner. After considering the evidence, I conclude that Mr Horne died because of his own actions after he inflicted a stab wound to his chest. I do not consider that any of the police officers who attended Friend Street late on 30 March 2018 caused or contributed to his death in any way. I accept the submission of counsel assisting that no adverse comment should be made about the actions of the involved officers, who were acting in the execution of their duty.

95. I am satisfied that the actions and decisions made by the attending police officers in the immediate lead up to Mr Horne's death were appropriate and timely, and consistent with the requirements of Chapter 14.3 of the Operational Procedures Manual. His death could not have reasonably been prevented by the attending officers.

96. As previously noted, I have concluded that SC Wagstaff was justified in his deployment of the taser. The options of using a baton, closed hand tactics or capsicum spray were not practical for a dog handler to deploy when confronted with a person with a knife.

97. I accept the opinion of Dr Rashford that the removal of the knife by Constable Maloy did not change the outcome for Mr Horne. The nature of his injuries, the rapidity of his deterioration and the time to access advanced medical resuscitation techniques at the hospital were the primary determinants of his outcome. However, I also agree with Dr Rashford that this case serves to demonstrate system learnings in relation to scenarios where a person placed under arrest rapidly declines.

98. When the knife was removed from Mr Horne, it was reasonable for Constable Maloy to believe he was still potentially able to harm the officers. She was not aware of the precise location of the knife's entry point on his body. Her actions in those circumstances cannot be criticised.

99. I agree with Dr Rashford's assessment that the QPS officers were both compassionate and diligent in their attempts to treat and importantly, reassure Mr Horne during what was a very confronting scenario.

100. The inquest also considered the adequacy of QPS training in relation to first aid regarding penetrating trauma and training in night-time/ unlit scenarios, with and without the use of a torch.

101. I accept that responding to penetrative trauma is covered as part of tactical first aid training. Each of the involved officers was qualified in tactical first aid at the time of this incident. It is also a matter that the involved officers had a basic level of knowledge about from the general first aid training they are required to undertake prior to entry to the QPS. The circumstances that presented to the officers on 30 March 2018 were rare, and the need for more training in this area must be balanced against the need to train officers in situations they frequently encounter.

102. I am also satisfied from the evidence of the officers and Sgt Finney that adequate scenario based training is provided with respect to operating in night-time and unlit environments. In particular, the decision of SC Wagstaff to not use a light while PD Agro was tracking was tactically defensible. Each of the officers had access to torches and weapon mounted lights as part of their accoutrements.

103. I am satisfied that the investigation conducted into Mr Horne's death by the Ethical Standards Command was appropriate, thorough, and covered all relevant areas of investigation. I am satisfied that the protocols established to investigate deaths in custody in accordance with the *Coroners Act 2003*, and Queensland Police Operational Procedures Manual were complied with.

Findings required by s. 45

104. 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. As a result of considering all the evidence, including the material contained in the exhibits, I make the following findings:

Identity of the deceased – Ashley Thomas Horne.

How he died - Shortly before his death police had responded to a call from Mr Horne's former partner who had reported that Mr Horne was on her property and was potentially violent. Police attended with a police dog which located Mr Horne hiding in bushes at a nearby property. He was in possession of a backpack containing ropes, a hammer, gas cannisters, a blow torch, secateurs, and alcohol. After being challenged by police officers he intentionally stabbed himself in the chest.

Place of death – Toowoomba Hospital in the State of Queensland.

Date of death – 31 March 2018.

Cause of death – Stab wound to the chest.

Comments

105. Section 46 of the *Coroners Act*, insofar as it is relevant to this matter, 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.

106. While not the focus of this inquest, I accept that the QPS and the QAS are committed to further scenario-based training in relation to appropriate responses to rapidly deteriorating patients in custody.

107. In this case I have found that the police officers involved responded professionally, and in accordance with their training in relation to the appropriate use of force. I consider there are no recommendations connected with Mr Horne's death I could reasonably make to prevent a similar death from occurring in the future.

108. I close the inquest.

Terry Ryan
State Coroner
Toowoomba
9 March 2021