Inquest into the death of Shaun Charles Coolwell

Mr Coolwell died after he was physically restrained by police officers in a prone position and ambulance officers administered midazolam injection for sedation. At the time of his death Mr Coolwell was affected by amphetamines and had severe coronary atherosclerosis.

State Coroner Terry Ryan delivered his findings of inquest on 10 June 2019.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported.

The departments named in this response will provide implementation updates until the recommendation is delivered. Further information relating the implementation of recommendations can be obtained from the responsible minister named in the response.

**Recommendation 1**

The Queensland Police Service and the Queensland Ambulance Service 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.

Response and action: implementation of the recommendation is in progress.

Responsible agencies: Queensland Police Service (lead), supported by Queensland Health.

On 26 November 2019 the Minister for Police and Minister for Corrective Services and the Minister for Health and Minister for Ambulance Services responded:

An interagency working group with representation from the Queensland Police Service and Queensland Ambulance Service was previously established to implement the coronial recommendations arising from the inquest into the death of Pasquale Giorgio, which was delivered on 11 September 2018.

Given the linkages that exist between the findings arising from both inquests, the scope of this working group is currently being expanded to also address the implementation of the coroner’s findings relating to the death of Shaun Coolwell. The Queensland Ambulance Service will maintain its representation through this group.

**Recommendation 2**

The Queensland Police Service and the Queensland Ambulance Service 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.

Response and action: implementation of the recommendation is in progress.

Responsible agencies: Queensland Police Service (lead), supported by Queensland Health.

On 26 November 2019 the Minister for Police and Minister for Corrective Services and the Minister for Health and Minister for Ambulance Services responded:

The Queensland Police Service (QPS) is well advanced in developing a critical incident review framework to strategically manage the findings and recommendations of critical incident review matters and where appropriate, act consistently with the service’s continual improvement philosophy. A key element of the
framework involves the identification of key stakeholders to ensure relevant parties such as the Queensland Ambulance Service (QAS), are represented in the subsequent review process.

Senior officers from the QPS Operational Review Unit and the QAS Office of the Medical Director are meeting to discuss the integration of QAS into this framework, enabling shared analysis and learnings when the QPS and QAS are co-responders.