QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Ashley Charles Washington**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2020/5290
DELIVERED ON:	18 November 2024
DELIVERED AT:	Brisbane
HEARING DATE(s):	26 June 2023, 29-31 August 2023
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, First Nations man, Taser, police dog, police restraint, administration of sedative, ambulance response, failure to recognise rapid deterioration.

REPRESENTATION:

Counsel Assisting:	Ms S Lio-Willie
Coral Washington:	Ms A Taylor, ATSILS
Queensland Ambulance Service:	Mr D Schneidewin, instructed by QAS

Officers Williams, Colman, Gregory, Emes and Ridge:	Ms C McGhee, Gilshenan and Luton
Commissioner of Police:	Mr J Paratz, QPS Legal Services
ACP McCasker:	Mr L Tiley, Hall Payne Lawyers

Contents

Introduction

1. Ashley Washington was aged 31 years when he passed away on 13 December 2020 at Toowoomba.[1] Ashley had been found on the veranda of a Mount Lofty home with property from inside the home. He had an altercation with the homeowner and ran away.

2. The Queensland Police Service (QPS) was called and a dog squad officer located Ashley on a nearby street. After Ashley did not comply with police directions to "get on the ground" the police dog was released. He stabbed the police dog and was then Tasered by the dog squad officer.

3. Ashley then stabbed the dog squad officer before again being incapacitated by the Taser and restrained by police. Ashley was restrained on the ground for about 20 minutes and was administered a sedative by an ambulance paramedic. He went into cardiac arrest in the ambulance and later died at the Toowoomba Base Hospital. The cause of his passing was undetermined.

The investigation

4. Ashley was detained under an arrest by a police officer before he passed. In accordance with s 10(2)(a) of the *Coroners Act* 2003 his passing was a 'death in custody' and an inquest was required.[2]

5. Senior Sergeant Perry of the Internal Investigations Group, Ethical Standards Command, investigated the circumstances surrounding Ashley's passing. A coronial report was provided to the Coroners Court in December 2022 with various annexures, including witness statements, body worn camera (BWC) recordings, QPS records and medical records.[3]

6. The investigation concluded that all QPS officers involved complied with relevant legislation, policy and procedures, and should not be subject to any criminal or disciplinary action for their conduct. The investigation did not make any recommendations. Snr Sgt Perry recommended that QPS Frontline Skills Training review this matter and consideration for ongoing training considerations.

7. An autopsy examination was conducted on Ashley's body by Senior Forensic Pathologist, Dr Milne, at Forensic and Scientific Services at Coopers Plains on 15 December 2020. Blood and urine samples were obtained and subject to further toxicological testing.

The inquest

8. A pre-inquest conference was held in Brisbane on 26 June 2023. Ms Lio-Willie was appointed counsel assisting. Leave to appear was granted to Ashley's family, the Commissioner of the QPS, the police officers who first attended the scene, the Queensland Ambulance Service (QAS) and the paramedics who attended the scene.

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[1] Ashley's family asked that he be referred to by name
[2] *Coroners Act 2003*, s 27(1)(a)(i)
[3] Ex A6 – Coronial Report

9. The inquest was held over three days in Toowoomba from 29 to 31 August 2023. Over 200 exhibits were tendered and the following witnesses were called to give oral evidence:

    - Snr Sgt Perry – investigating officer;
    - SC Williams – dog squad officer;
    - SC Colman – first attending officer;
    - Sgt Gregory – second responding officer;
    - SC Emes – second responding officer;
    - Sgt James Souilijaert – QPS Frontline Skills Training
    - ACP McCasker – QAS
    - CCP Crooks – QAS
    - Dr Rashford – QAS Medical Director
    - Dr Milne – Forensic Pathologist

10. I am satisfied that all information relevant to and necessary for my findings was made available at the inquest, which considered the following issues:

    - The findings required by s. 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death;

    - Whether the actions of Senior Constable Williams were appropriate in the circumstances;

    - Whether the actions of attending Queensland Police Service officers were appropriate in the circumstances,

    - Whether the actions of the attending Queensland Ambulance Service officers were appropriate in the circumstances.

The Evidence

Personal History[4]

11. Ashley was a proud Kamilaroi man who was born at Toowoomba. His mother is Coral Washington. He is the stepson of Paul Henningsen. He was an older brother to his four siblings Shanon, Cody, Jamara, and Tyler. At the time of his death Ashley lived in Toowoomba. He was unemployed.

12. Ashley was a father to his daughter, Ashleigh, and stepfather to her five older siblings.

13. Ashley and his siblings were a close-knit family and the four boys looked out for their sister. He was close to his mother, with Coral describing him as a ‘mum’s boy’.

[4] Taken from the family statement

14. Coral described Ashley as a happy go lucky person with a big heart who loved his family and always used his manners. He had a caring nature and was happiest in a father/caretake role always looking out for his younger siblings and others around him.

15. Coral said they would do everything together, especially shopping. When Ashley and Shanon were young Coral met Paul, who became a father to Ashley. The family lived between Toowoomba and Kingaroy. They moved back to Toowoomba after Ashley finished school. While living in Kingaroy, Paul ran his own business in vegetation management. Ashley and his brothers would go to work with their father when they were not at school. After he finished school, Ashley spent several years working with Paul.

16. Ashley reconnected with his paternal family in the last few years of his life. He spent time with his paternal family doing things like working on motorbikes and scrap metal hunting. His grandmother described him as someone who was kind-hearted and would do anything for you. His paternal family were involved in the coronial investigation and inquest process, alongside Coral and Paul.

17. As a teenager Ashley engaged with his Aboriginal culture and learnt dancing, painting, and the didgeridoo. He would busk locally with a cousin and was even offered an opportunity to play in China. He was very spiritual and aware of the spirits around him.

18. Ashley was in a relationship with the mother of his daughter, Shiralee, for several years but the relationship broke down when they both were in prison, and the children went on to live with a maternal aunt. He became a lost soul when the relationship broke down and he lost contact with his daughter. His family are still in contact with his former partner and spend time with his daughter and stepchildren.

19. He struggled with drug use over the years but was always there for his family. The loss of Ashely continues to have a significant impact on his family.

Medical History

20. Ashley was first prescribed diazepam for anxiety in 2017 and quetiapine (antipsychotic) in 2019. In 2020 he was prescribed the following medications:

    - Quetiapine (antipsychotic)
    - Tramadol (opioid treatment)
    - Oxycodone (pain relief)
    - Celecoxib (anti-inflammatory)
    - Pregabalin (anti-epileptic)
    - Ibuprofen (anti-inflammatory)

21. His last prescription of quetiapine was dispensed on 6 October 2020.

22. Ashley's mother told police that he had a long history of drug use. He suffered from depression and anxiety and was being medicated for those conditions. She said that when she saw Ashley two days before his death, he was in a state of psychosis. On the day of his death he had been kicked out of the home he was staying at with relatives.

23. Ashley was hit by a car in 2019 and required steel rods and plates to be inserted in his leg. This resulted in him being in constant pain, and he relied on oxycodone for pain relief.

Criminal history

24. Ashley's adult criminal history commenced in 2009 and consisted of offences of burglary, entering premises, fraud, stealing, trespass, drug possession, public nuisance, obstruct police, assaults, and breach of bail.

25. Ashley's last court appearance was on 7 December 2020 at the Toowoomba Magistrates Court. He was sentenced for breach of bail, possessing a knife in public and failing to dispose of a syringe. At the time of the commission of those offences he was also subject to a 9-month imprisonment suspended sentence. That order was fully invoked, and Ashley was released on parole on 7 December 2020.

Circumstances of the Death

26. On 13 December 2020 shortly after 6.35pm, Ashley was found hiding behind a barbecue on the veranda of a home at Mt Lofty. Ashley was wearing blue shorts, a grey jumper, but no shoes. Ashley had his left hand behind his back and when the homeowner asked what he was hiding he revealed he was holding an iPad and iPhone.

27. The homeowner identified those items as belonging to his wife from their distinctive cases. He told Ashley that if he returned all the items taken from his home, he would not call police. Ashley returned the devices and the BMW car keys.

28. Ashley was also wearing the homeowner's sunglasses and was holding a sum of cash. The homeowner told him to return the sunglasses and the money.[5] Ashley said words to the effect of "*boss, you can afford it*".

29. The homeowner tried to manoeuvre Ashley into a chair to get him to sit down. However, following a brief struggle in which he lost his jumper Ashley ran down the stairs and walked away on Mackenzie Street. He was waving his hands in the air, shouting out something incoherent. The homeowner followed him and asked for his sunglasses and money back. Ashley broke the sunglasses, threw them on the ground, and became aggressive. A neighbour called triple zero, and the homeowner reported to the operator that he had been robbed.[6] He told police that Ashley needed assistance as he was walking on the road, it was getting dark and he was incoherent.

30. Senior Constable Williams told the inquest he was a member of the Toowoomba Dog Squad and was working alone with a Police Dog, Turbo. He responded to the Police Communications tasking and proceeded to the incident location with emergency lights activated. At about 6.55pm, SC Williams came across Ashley on Jellicoe Street. He matched the description of the person who was reported to have stolen property from Warana Avenue.

[5] D1 - $405 was found in Ashley's possession.
[6] B22 – Statement of the homeowner

31. SC Williams got out of his marked police vehicle and called out to Ashley to "*get on the ground*". Ashley was making unintelligible noises and kept walking away. SC Williams deployed PD Turbo and followed Ashley, repeatedly yelling "*get on the ground*".

32. SC Williams told the inquest that the dog was deployed because Ashley had committed an indictable offence and a possible assault. The police dog was "*chosen to apprehend him based on his behaviour, the fact that he was clearly not willing to engage, and that he matched the description of the offender*".

33. After PD Turbo made contact with Ashley's arm and chest area, Ashley stabbed the dog with a pair of surgical scissors. PD Turbo audibly yelped and returned to his cage in the police vehicle. The surgical scissors were around 13cm long with a sharp point.[7] SC Williams attempted to arrest Ashley but was stabbed in the face with the scissors. At that time he was not aware that Ashley had possession of the scissors.

34. SC Williams then deployed his Taser, which caused Ashley to fall to the ground briefly. After SC Williams directed him to put his hands behind his back, Ashley stood back up and ran to the other side of the road. SC Williams attempted to restrain him, and Ashley fell onto the curb. SC Williams had his hands on the back of Ashley's neck. During a struggle on the road, Ashley stabbed SC Williams in the arm and the leg.

35. Ashley got up and walked away down Jellicoe Street, making incoherent noises. A member of the public attempted to help SC Williams but was told to get away. SC Williams continued to tell Ashley to get on the ground. As he reached the intersection with Glendower Street, SC Williams deployed his Taser again, causing Ashley to fall to the ground. The fall caused one of Ashley's teeth to fall out.

36. At 6.56pm, SC Williams notified Police Communications that he had been stabbed and requested assistance. SC Williams continued to cycle the Taser for four rounds. He told the inquest that he used the Taser again in an effort "*to use the minimum amount of force possible and to resolve it using force that wasn't likely to cause his death or grievous bodily harm*".

37. SC Williams told the inquest that he used continuous cycles because Ashley had tried to kill him. He needed to preserve his life and was aware that there were other people on the street that needed to be kept safe. His dog had been incapacitated and he was alone. Ashley was incredibly strong and he was not able to physically restrain him. He said the other use of force option was the firearm. He was not aware that other crews were on the way. The Taser was the absolute last resort before he had to use potentially lethal force. SC Williams said that QPS training was to draw his firearm for a bladed weapon to preserve his life and stop that threat.

38. At 6.57pm, SC Colman and Constable Ridge were the first police officers to respond. They tried to restrain Ashley while SC Williams attended to PD Turbo. Constable Ridge said that she was not able to move his arm behind his back and he was combative and strong.

[7] Ex D1, page 18

39. Soon after, a second unit of responding officers – SC Emes, Sergeant Gregory, and SC Timm arrived and assisted with restraining Ashley in handcuffs. There was blood on Ashley's face and around him on the road. By this time, it had started raining heavily.

40. SC Colman told the inquest he had been tasked to proceed Code 2 to a cordon point at the intersection of Mary and North Streets due to the dog squad responding to a break and entry in the area. Multiple crews were attending. On the way to the cordon he was informed that SC Williams had been stabbed.

41. On arrival at Jellicoe Street, SC Colman saw SC Williams standing with his Taser out. Ashley was on his side on the ground in front of him with his back towards SC Williams. SC Williams alerted him to the presence of blood. He saw the blood covered scissors on the ground between SC Williams and Ashley.

42. SC Colman said he used a three point pin to restrain Ashley. While he was holding his left arm behind his back, he had one knee on his shoulder and one on his hip. SC Timm was able to handcuff him at that time.

43. Ashley remained agitated and continued to yell. He was kicking his legs and spitting as well. Officers held his head down. Officer Colman applied a leg restraint by flexing his legs towards his buttocks. He said he did not apply pressure to Ashley's back during the restraint. He and SC Emes were trying to roll Ashley to the right side to relieve any pressure that he may have on his chest. Both officers said they were conscious of the risk of positional asphyxia and excited delirium and were able to monitor his breathing at all times.

44. Sgt Gregory said he assisted in the restraint by placing his left knee high up on Ashley's shoulder, and holding his arms while the cuffs were applied. His right knee was on the ground. He then moved his knee to Ashley's buttocks. He said he was concerned about the restraint and wanted to move Ashley, but it was not safe to due to his demeanour and the amount of blood. He said it was QPS practice to monitor restrained persons. He said he was clenching his jaw and grinding his teeth which he thought were symptoms of excited delirium. He withdrew from the restraint when SC Colman and SC Emes were able to restrain him and started to collect exhibits.

45. The restraint by SC Colman and SC Emes continued until the Queensland Ambulance Service (QAS) arrived on scene. Officers had called for the QAS and advised that Ashley would require sedation. SC Colman said when the QAS arrived he was "*yelling out, still sort of thrashing about, still trying to kick his legs backwards".*

46. At 7.11pm, the QAS arrived and administered droperidol (a sedative) at 7.13pm. SC Colman told the inquest Ashley slowly started to calm down and began providing less resistance. He was not concerned about this change as he thought it was directly related to the sedation. Within five minutes Ashley was unresponsive. He remained handcuffed behind his back and was transferred to the stretcher and placed in the ambulance at 7.18pm.

47. ACP McCasker and CCP Crooks told the inquest that the tasking they received was to attend to a police officer who had been stabbed. This had not been updated when they arrived at the scene.

48. ACP McCasker said it was dark and raining and he recalled that he was driving the ambulance. On arrival he retrieved the equipment and readied the dose of droperidol while CCP Crooks interacted with the police officers and Ashley. He could see that Ashley was being restrained with his legs flexed behind him.

49. CCP Crooks' recollection was that he was the driver of the ambulance vehicle and therefore ACP McCasker was the primary care provider. He had no concerns about the restraint when he arrived at the scene. Ashley was moving his head around and was talking.

50. ACP McCasker was concerned about the restraint, but CCP Crooks told him that the police officers reassured him that there was not any pressure on Ashley's chest and they were holding him up as they were restraining him. ACP McCasker said that it was CCP Crooks' role as the primary officer to carry out the assessment of Ashley.

51. ACP McCasker told the inquest that he considered Ashley's score on the Sedation Assessment Tool (SAT) would have been 3 because he was being restrained and yelling – "*it was quite obvious*". He did not administer the droperidol. After Ashley was placed on the stretcher it was apparent to him that he was docile and flat. He agreed that it was his experience that the droperidol would usually take effect within 10 minutes of being administered.

52. CCP Crooks recalled that it was jointly decided with ACP McCasker that Ashley's agitation and behavioural disturbance warranted sedation as he was 3+ on the SAT. He did not recall that police asked for Ashley to be sedated. He did not monitor Ashley and considered that ACP McCasker was doing so. He ultimately accepted that he was the primary caregiver and ACP McCasker was the secondary caregiver during this incident.

53. Once inside the ambulance, Ashley's heart rate rapidly declined, and he went into cardiac arrest. Paramedics commenced CPR with the assistance of Queensland Police Service (QPS) officers. He was transported to the Toowoomba Base Hospital where he was declared life extinct at 8.01pm.

Autopsy Results [8]

54. On 15 December 2020, Senior Forensic Pathologist, Dr Milne, conducted an autopsy consisting of an external and full internal examination of the body.

55. The external examination showed:

- Lacerations to the scalp, left eyebrow and lip, indicative of blunt force trauma;
- Numerous abrasions consistent with a struggle on the road;
- Puncture-like defects on the back of the neck, right upper arm, left upper buttock and right thigh consistent with the Taser injuries;
- Injuries to the left elbow and forearm consistent with dog bites;

[8] A4 – Autopsy report

- Injuries to the right wrist, possibly related to the handcuffs;
- An incised wound on the left middle finger, possibly related to the scissors.

56. The internal examination findings included:

- Areas of subcutaneous haemorrhage, including at the sites thought to be Taser injuries;
- Sternal and rib fractures, consistent with resuscitation injuries;
- Aspiration of stomach contents into the upper airways and lungs;
- Significant heart disease, with severe narrowing of two of the arteries of the heart (coronary atherosclerosis). There was no evidence of old or recent heart attack;
- A tumour in the right adrenal gland;
- No evidence of a severe acute allergic reaction; and
- No neck injuries.

57. The full body CT scan showed a left frontal contusion and changes of aspiration in the lungs.

58. Toxicology results showed:

- Methylamphetamine at a level that falls within the overlap of the non-toxic, toxic and lethal ranges;
- Amphetamine at a non-toxic level;
- Quetiapine at a non-toxic level;
- Droperidol at a level of 0.09mg/L. Little is known about blood levels of this drug. Studies vary between, up to 0.05mg/L as therapeutic levels, and 0.0224 – 0.215mg/L as being the peak, occurring about 10minutes after administration;
- Tetrahydrocannabinol (THC)
- No alcohol was detected.

59. Dr Milne concluded that the cause of death was 'undetermined'. He opined that the death was very likely the combined result of multiple factors including the pre-existing natural disease (coronary atherosclerosis), physical and psychological stress, and the effects of drugs (methylamphetamine and droperidol). The relative weight each of these factors had in relation to death could not be determined. However, he said that almost any level of methylamphetamine can potentially increase the risk of a cardiac event.

60. Dr Milne also explained that the degree of coronary atherosclerosis was such that it could have caused myocardial infarction or sudden death at any time. Sudden cardiac death is more likely to occur at times when there is additional psychological and physical stress on the body.

QPS injuries

61. PD Turbo was stabbed twice in the chest and SC Williams rushed him to a veterinary surgeon for surgery. PD Turbo recovered from his injuries.

62. SC Williams sustained a stab wound to the right side of his face, and to his right bicep. He was treated at hospital after PD Turbo was admitted into the care of the vet.

The Investigation

63. The conclusions of ESC Investigators were based on a review conducted by Sergeant Souilijaert, Training Officer from Frontline Skills Training. Ultimately, the ESC investigation found there was insufficient evidence to support a criminal prosecution or any breach of discipline or misconduct by any police officer with respect to Ashley's passing.

64. During his record of interview, SC Williams had explained that he did not know Ashley was armed until after he himself was stabbed. When PD Turbo yelped and returned to the police vehicle, SC Williams believed the dog was injured. As noted previously, after SC Williams was stabbed, he considered drawing his firearm but was satisfied that Ashley was walking away from him (not attacking him) and deploying his Taser a second time was a sufficient use of force.

OST review[9]

65. Sergeant Souilijaert reviewed the BWC footage of Officers Williams, Colman, Emes, and Timm and the records of interview of those officers, in conjunction with the ESC Coronial report, Computer Aided Dispatch records, and Taser download information.

66. The Taser download information from SC Williams revealed:

Time	State of Taser
18:55:55	Armed
18:55:56	Trigger pulled for a 5 second cycle
18:56:04	Reset *This can occur if there is a momentary loss of battery power, a disconnect between the battery pack and battery contacts of the Taser*
18:56:23	Armed
18:56:38	Trigger pulled for a 5 second cycle
18:56:44	Trigger pulled for a 5 second cycle
18:56:50	Trigger pulled for a 5 second cycle
18:56:58	Trigger pulled for a 5 second cycle
18:58:44	Taser made safe

67. Sergeant Souilijaert explained that additional Taser cycles may be applied in exceptional circumstances after the officer has reassessed the situation prior to each additional cycle. He accepted that these were exceptional circumstances. However, he said it would have been preferable to provide a greater gap between each cycle to establish whether compliance was forthcoming.

68. Sergeant Souilijaert explained that the first Taser cartridge may have failed through the wires being damaged by Ashley and that this was SC Williams' second and therefore last cartridge. This may have contributed to his decision to keep cycling his Taser. Sergeant Souilijaert said the repeat Taser cycles were justified given:

[9] B20 – Statement of Sgt Souilijaert

- Ashley appeared affected by drugs;
- Ashley had stabbed SC Williams and PD Turbo; and
- SC Williams was alone without the immediate assistance of other officers to restrain Ashley.

69. Sergeant Souilijaert ultimately concluded that SC Williams' use of the Taser (a less lethal use of force option) and closed hand strikes were authorised, justified, reasonable, proportionate, legally defensible, tactically sound, and effective.

Restraint and control by other QPS officers

70. In his record of interview, Sergeant Gregory explained that he held Ashley's head to the side on the road because he was spitting blood. The primary reason he did not want to sit Ashley up was the risk to police if he continued to spit blood.[10]

71. Sergeant Souilijaert said that good practice for handcuffed subjects is for them to be either stood up or placed in the lateral recovery position. At that point, a CARE assessment should be conducted and, if required, QAS assistance sought. The lateral recovery position minimises compression of the chest and maintains a clear airway thereby reducing the risk of positional asphyxia. Sergeant Souilijaert thought responding officers initially attempted this position when they rolled Ashley onto his left-hand side after being handcuffed.

72. SC Colman told investigators Ashley was extremely strong and was kicking out at officers. He crossed Ashley's legs over and lifted them to his buttocks and held them there to minimise the risk of being kicked.

73. Sergeant Souilijaert stated that this form of leg control is not a technique currently taught to general duties officers in the OST curriculum. However, he said this does not mean its use is not permitted. Officers need sufficient reasons for using it and adequate consideration of the circumstances in which it is applied. The crossed leg position keeps the subjects' hips flat to the ground, limiting the capacity of the subject to achieve a lateral recovery position depending on their flexibility. Sergeant Souilijaert said that this did not constitute a pain compliance technique, and would have served only to control Ashley's legs and hips.

74. Sergeant Souilijaert said good practice would have been to move Ashley into a full lateral recovery position without that method of leg control. He qualified his opinion by saying that had the leg control not been used, Ashley could have been difficult to control and exposed the officers to increased risk of injury and blood borne disease.

75. Ultimately, while he was not critical of the other responding police officers, Sergeant Souilijaert opined that the positioning of Ashley in the prone position for a prolonged period was not consistent with the QPS' operational skills and tactics curriculum, and more effort to employ a different position could have been attempted.

[10] E9 – ROI of Sergeant Gregory

Queensland Ambulance Service Review[11]

76. QAS Medical Director, Dr Rashford, reviewed the BWC footage of Officers Williams, Colman, Emes, and Timm in conjunction with the QAS electronic Ambulance Report Form (eARF) and the Incident Detail Report (IDR).

77. Dr Rashford reported that Ashley was restrained for approximately 20 minutes, with pressure continually applied on both his arms and legs, which were purposely positioned behind his back. There was also intermittent pressure applied to his posterior chest. Dr Rashford explained that this positioning and pressure potentially effects the work of breathing, increasing the energy required for chest expansion due to less effective mechanical advantage.

78. Dr Rashford's opinion was that prolonged restraint such as this results in significant muscular effort. Ashley's resistance against his positioning and restraint force, coupled with his initial agitated state and physical exertion before restraint, likely resulted in Ashley developing severe metabolic acidosis.

79. Dr Rashford said Ashley's condition significantly changed before he was placed on the ambulance stretcher. He was unresponsive with ineffective breathing at this time. Dr Rashford said that Ashley was in a peri-arrest state at this point. His heart rate was 75bpm when placed in the ambulance. Dr Rashford would have expected a rate well over 100 bpm in an individual who was severely agitated and had just experienced significant exertional stress complicated by metabolic acidosis.

80. Dr Rashford suspected that Ashley had suffered a cardiac arrest secondary to multiple factors. However, he did not believe that direct posterior chest pressure was the primary contributor. A number of circumstances existed that led to cardio-respiratory demise with his critical deterioration being missed by the attending QPS and QAS staff. This phenomena is common where undue emphasis is placed on positioning and the concept of 'excited delirium'.

81. Mr Washington's factors were:

    1. Prolonged exertion - initial physical interaction and prolonged restraint;
    2. Restraint positioning;
    3. Intoxicants (amphetamine and methylamphetamine);
    4. Presumed profound metabolic acidosis, as a consequence of 1 - 3;
    5. Medical comorbidity - primarily cardiovascular (Ashley, aged 31, had premature, severe multivessel coronary artery disease); and
    6. Use of sedative agents to control the agitation.

82. Dr Rashford said that this is a well-worn pathway.

> *When the factors combine, the patient will suffer a deterioration in their condition, most often evidenced by acute respiratory failure and inadequate ventilation. The presumed change in condition is either attributed to the sedative agent or the restrained patient settling, rather than a change in their "clinical" condition. Patients in these circumstances should be considered "patients" who are critically ill. Early objective vital signs monitoring is*

[11] B19 – Statement of Dr Rashford (QAS)

required, with very close ongoing physical assessment is a mandatory requirement to detect the deterioration.

83. Dr Rashford considered that the level of assessment conducted of Ashley by the paramedics was suboptimal. He said that CCP Crooks and ACP McCasker failed to appropriately initiate and continually assess and observe Ashley to the level required based on his clinical presentation. The mitigating circumstances were the rain and limited lighting at the time, which increased the degree of difficulty.

84. Dr Rashford considered the suboptimal level of assessment resulted in a delay in identifying Ashley's decline. However, he could not state with certainty that the outcome would have altered given the different factors that led to his cardiac arrest.

85. Dr Rashford considered Ashley could have been more effectively positioned on his left lateral side with the assistance of the paramedics before he was placed on the stretcher. He accepted that the heightened emotions at the scene, heavy rain, collateral information about Ashley having stabbed a police officer, and occasionally spitting blood, contributed to and may have complicated the paramedics' approach to this case and influenced their performance.

86. Dr Rashford agreed that sedation was indicated for Ashley. However, he said it would be unusual for the sedated person to slow down so quickly, but it could occur. The onus is then to reassess the patient. The QAS encourages staff to continually monitor these individuals because it's a very high-risk scenario.

Conclusions on Inquest Issues

87. The cause of Ashley's death was not determined. Dr Milne did not locate any injuries internal or external to the neck or chest area but also indicated that such injuries would not necessarily be present if someone were restrained in a prone position for a prolonged period of time. There were no injuries located consistent with positional asphyxia or a significant application of force on the chest identified as a contributing factor to the death.

88. Toxicology results revealed the presence of Methylamphetamine at a level that falls within the overlap of the non-toxic, toxic, and lethal ranges. Amphetamine and Quetiapine were found at a non-toxic level together with Droperidol and THC.

89. I accept that Ashley had a combination of vulnerabilities that all contributed to the stress placed on his heart when police restrained him. There was no single factor that could be said to be the sole or most likely contributor to his death.

90. Dr Milne also explained the severity of Ashley's heart disease was such that myocardial infarction or sudden death could have happened at any time in the absence of significant exertion. It was not expected that someone without a heart condition would decline in the manner Ashley did from the circumstances surrounding his arrest.

91. I accept that the preceding exertion, the physical and emotional stress of being restrained and resisting against it, and the presence of drugs, likely impacted Ashley's already diseased heart.

Findings required by s. 45

92. I am required to find, if possible, the 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 Charles Washington

How he died – Ashley died after being restrained for around 20 minutes by police officers who used force to arrest him after he was Tasered.

Police officers had responded to reports that Ashley had taken property from a private residence in Toowoomba. He was located on a nearby street.

Ashley had stabbed a police dog and a police officer. He became unresponsive after droperidol was administered to him by a paramedic. His clinical decline was not recognised until after he was placed in an ambulance, around eight minutes after paramedics arrived on the scene.

Place of death – Toowoomba Hospital, 154 West Street, Toowoomba

Date of death– 13 December 2020

Cause of death – Undetermined

Were the actions of Senior Constable Williams appropriate in the circumstances?

93. The inquest had the benefit of SC Williams BWC footage from when he was on the way to the reported "breakers on" job at Warana Avenue, Mt Lofty. SC Williams provided a narrative of the job he was responding to when he encountered Ashley on Jellicoe St.

94. In the two minute interaction between SC Williams and Ashley, he deployed his police dog, used closed hand strikes and deployed his Taser twice. Continual cycles of the Taser were deployed to control Ashley. In those two minutes, Ashley had stabbed PD Turbo three times and SC Williams three times.

95. At the inquest, SC Williams was taken through specific portions of his BWC footage. He gave a candid and well-reasoned account of his decision making at each of the relevant points.

96. Consistent with the QPS Situational Use of Force Model, SC Williams told the inquest he could have drawn his firearm because he had been stabbed, and Ashley was still armed with scissors. When asked why he decided to deploy his Taser a second time rather than engage his firearm, SC Williams said he did not want to use lethal force. The Taser was the last option available to him before using lethal force.

97. Officers are instructed that there must be a risk of serious injury to a person before an officer can use a Taser. While officers are not trained to deploy continuous cycles of the Taser, the inquest heard that a Taser cycle automatically cuts off after five seconds. There was a short break between each of the cycles. For a cycle to commence an officer needs to actively engage the trigger.

98. SC Williams said he continued the Taser cycles because he was stabbed. He was operating alone, he did not know where the police dog was, he did not know when backup would arrive and did not know if Ashley was still armed. For his safety and the safety of civilians on the street he continued the Taser cycles, not wanting to use lethal force.

99. I agree with the conclusions of the ESC investigation and Sgt Souilijaert that the decision of SC Williams to deploy the police dog to apprehend Ashley[12], use closed hand tactics, and then deploy the Taser were each an appropriate response to the incident as it evolved.

100. I note that the family accepted that SC Williams' actions were within QPS guidelines, policies and procedures.

101. I conclude that SC Williams' actions were appropriate in the circumstances.

[12] In accordance with the Police Dog Squad Capability Manual

Were the actions of other attending Queensland Police Service officers appropriate in the circumstances?

102. Each of the attending officers who assisted SC Williams were not aware Ashley was the alleged offender who they were trying to locate in response to the initial "breakers on" job. The responding crews were on the way to cordon points as they were aware SC Williams and the police dog had been tasked to look for Ashley.

103. After SC Williams reported over the police radio that that he had been stabbed and required assistance, the other police crews drove to Glendower St. Upon arrival, Officers Colman and Ridge attempted to handcuff Ashley. SC Colman did not initially recognise Ashley, although he had prior dealings with him. However, after Sgt Gregory, SC Emes and SC Timm arrived Ashley was identified.

104. SC Colman and Sgt Gregory had both had prior dealings with Ashley. Both officers told the inquest that his demeanour on 13 December 2020 was not typical. On previous occasions Ashley was not violent, and if he was agitated would calm down quickly when spoken to.

105. I agree with the submission from Counsel Assisting that this was not a situation where police were targeting a known violent offender. The job evolved quickly from a request to locate and establish cordons for a break and enter suspect to the serious assault of a police officer.

106. SC Colman, Sgt Gregory and SC Emes each said that after Ashley was handcuffed, he was rolled onto his left shoulder, semi prone and off the road. Each officer explained they did this to relieve pressure on his chest.

107. Ashley remained in this position for about 20 minutes. The attending officers each accepted at the inquest that this was not ideal and that they wanted to move him.

108. However, the consistent evidence of Officers Ridge, Colman, Gregory and Emes was that it was unsafe to move Ashley to a fully lateral, seated, or standing position. It was reiterated that it was not safe for Ashley, the police or the paramedics because Ashley was not complying with directions. He continued to kick out and was spitting blood (because his mouth was bleeding). He only briefly appeared to calm down when Sgt Gregory spoke with him early on in the restraint.

109. It was evident from comments of different officers that they were conscious of Ashley's breathing and continued efforts to manage his head and chest so his breathing was not compromised. SC Emes said he was 'heads down' and focused on Ashley. There did not appear to be direct pressure on Ashley's chest by any officer. When an officer applied pressure to Ashley's shoulder, buttocks, or legs it was not with their full body weight; but rather with at least one knee on the road.

110. Sgt Souilijaert reviewed the restraint utilised on Ashley. While he noted that the leg restraint used by SC Colman was not one instructed in police skills training, he considered the restraint appropriate in the circumstances. Sgt Souilijaert also concluded the involvement of Sgt Gregory, SC Emes and SC Timm in the restraint was appropriate in the circumstances.

111. Although Sgt Souilijaert identified it was not ideal for Ashley to be restrained semi-prone on the ground for such a lengthy period of time, he accepted that in the circumstances where Ashley was spitting blood, displaying great strength, and not appearing to comply, it would have been difficult for those officers to safely move and control Ashley in either a lateral recovery or standing position without exposing themselves to a degree of risk, either by exposure to infectious disease transmission from blood or by being kicked.

112. Officers are not expected to compromise their own safety when physically restraining a person, particularly where no other use of force options are available. Even though Sgt Gregory and SC Emes described Ashley as spitting at the ground, not necessarily at police officers, there was a real risk of transmission of infectious disease given the volume of blood.

113. I accept the conclusion of the ESC investigation and the opinion of Sgt Souilijaert that the actions of the restraining police officers were appropriate in the circumstances.

Were the actions of the attending Queensland Ambulance Service officers appropriate in the circumstances?

114. Neither QAS paramedic was concerned about the way Ashley was restrained. They each said they observed his head and chest were elevated in a way to relieve pressure on his breathing. Both paramedics indicated they would tell police to reposition Ashley if they thought his breathing was compromised.

115. The evidence of both ACP McCasker and CCP Crooks contained some inconsistencies in relation to the sequence of events, and details such as who drove the ambulance to the job. It is not uncommon nor unreasonable that witnesses may have differing accounts of what occurred several years after an incident, given the position at which they witnessed things, when they became involved or what details were important to them compared to others. I note that the difficulties were not helped by delays in obtaining statements from the paramedics.

116. There can be no criticism of the decision to sedate Ashley. However, the evidence from ACP McCasker and CCP Crooks was that there was no hands-on medical assessment of Ashley or any vital signs taken at the roadside. ambulance. What was clear from the evidence was that Ashley was not monitored closely after the droperidol was administered.

117. I accept the opinion of Dr Rashford, who was forthcoming in his assessment of the actions of the paramedics on the night. He considered that the level of assessment conducted of Ashley was less than optimal, and the paramedics collectively failed to appropriately initiate and continually assess and observe Ashley to the requisite level based on his clinical presentation.

118. However, I agree that the actions of the paramedics did not represent wilful omissions of care. During his oral evidence Dr Rashford agreed that, whilst the identified matters were imperfections, on the whole the care provided by the paramedics was appropriate.

119. Dr Rashford opined that Ashley's condition significantly changed before he placed on the ambulance stretcher. It was at this point that Dr Rashford said that Ashley was in a peri-arrest state and his that critical deterioration was missed by the attending QAS and QPS staff.

120. Dr Rashford was unable to conclude that earlier assessments of Ashley would have been outcome changing, but he accepted the absence of constant monitoring resulted in a delay in identifying Ashley's decline.

121. Dr Rashford was not critical of the care provided to Ashley once he went into cardiac arrest.

122. The response of the paramedics can be explained in part by several environmental factors that informed their situational awareness. They both told the inquest:

- It was dark, wet and raining.
- There was a large amount of blood on the scene, and Ashley had Hepatitis C.
- Ashley was clearly agitated, affected by drugs and required restraint by at least two police officers. This informed their Sedation assessment.

123. Both ACP McCasker and CCP Crooks told the inquest that the situation unfolded quickly. A consideration in sedating Ashley was to enable him to be moved from the restraint for his safety and the safety of police and paramedics treating him. However, they mistakenly thought that Ashley's change in condition when he was placed on the stretcher was caused by the droperidol and were not alarmed at the time.

124. ACP McCasker and CCP Crooks both candidly accepted that with the benefit of hindsight they would have handled the situation differently. ACP McCasker said he would have attempted to deescalate Ashley before sedation. CCP Crooks said he would attach the monitoring equipment and go hands on much sooner.

Comments and recommendations

125. Section 46 of the *Coroners Act* 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.

126. After Ashley's death, all involved paramedics reviewed the QPS BWC footage with the QAS Professional Standards team.

127. Ashley's family submitted that there was a lack of leadership or ownership of the situation and how it was unfolding. This resulted in a lack of communication between the officers and the paramedics and limited exchange of information. While it is not clear that there were any impediments to communication on the night of Ashley's death, I am satisfied that the QPS and QAS are actively working together to address the concerns of the family.

128. In February 2021, the QAS revised its Clinical Practice Guideline (CPG) and Clinical Practice Procedure (CPP) with regards to the restrained patient requiring sedation. A "checklist" was introduced to be used by paramedics in every sedation case. The checklist outlines the specific steps to be taken and must be followed by every QAS clinician when undertaking sedation in these circumstances.

129. Interagency training continues between the QAS and QPS, including a revised education package that includes:

    - Detecting the signs of patient decline;
    - Recognising the '100 miles per hour to zero' syndrome;
    - Appropriate relocation of patients to facilitate clinical assessment;
    - A specific call sign when requesting the QAS to attend these patients;
    - A QPS Scene Supervisor role – where a dedicated officer stands back from the restraint overseeing the situation and being the QAS contact;
    - A signal to QAS upon their arrival, indicating that it is safe to assess the patient;
    - Considerations prior to sedation, which should include, comprehensive history and vital signs assessment.

130. The inquest explored the training provided to police and paramedics around restraint and rapid post arrest medical decline. From the evidence given by the police witnesses during the inquest, it is clear that they are aware of the risks and symptoms for decline from a person being restrained in a prone position, and that they are to call QAS to assess persons appearing in need of medical attention.

131. A jointly developed post arrest care and handover online learning product was available for all police and watchhouse officers from 9 December 2022. This learning product is mandatory training for all frontline police and watchhouse officers up to the rank of superintendent.

132. And an additional post arrest collapse scenario was featured in the annual OST dynamic interactive scenario training, which was an immersive learning environment.

133. I am satisfied that the QPS and QAS recognise the significance of sudden post arrest medical decline and the need for training about these scenarios, and are continuing collaborative development of training products for both agencies.

134. I extend my condolences to Ashley's family. I thank them for participating in the inquest, particularly as the circumstances of his death were most distressing. It was clear that he was loved and is missed by his family.

135. I close the inquest.

Terry Ryan
State Coroner
BRISBANE