The Hon Ryan Park MP
Minister for Health
Minister for Regional Health
Minister for the Illawarra and the South Coast

Your Ref: 2019/00256729
Our Ref: COR23/28

The Hon. Michael Daley, MP
Attorney General
52 Martin Place
SYDNEY NSW 2000
office@daley.minister.nsw.gov.au

Coronial inquest into the death of Jacob Carr

Michael

Dear Attorney General

I write in relation to the findings and recommendations made on 30 November 2023 by Deputy State Coroner Joan Baptie regarding the death of Jacob Carr.

Mr Carr was a 53-year-old male who died on 17 August 2019 of a gunshot wound to the leg sustained during a police operation. The Deputy State Coroner described the manner of death as misadventure. Mr Carr's death was reportable to the Coroner because it was both an unnatural and sudden death and occurred as a result of the direct involvement of police officers.

Mr Carr had a history of medical and mental health issues, and the Deputy State Coroner noted a prior history of criminal offending.

The inquest considered a range of issues regarding NSW Police Force officers and NSW Ambulance service officers. The focus in relation to NSW Ambulance was adequacy of care and treatment including pain relief, use of space blanket, tourniquet, having one paramedic in the rear of the ambulance, and escalation.

Magistrate Baptie directed one recommendation to NSW Ambulance, which is supported. The Deputy State Coroner also made one recommendation to NSW Police.

Recommendation

The Deputy State Coroner recommended:

That consideration be given to improving Incident Reporting concerning any equipment failures to ensure they are communicated to a specified person within each directorate using the particular equipment who has responsibility for the monitoring of the continued efficacy of the directorate's equipment.

NSW Ambulance supports the recommendation and has taken the following actions in relation to improving incident reporting for equipment failures.

In July 2020, NSW Ambulance introduced the new state-wide incident information system, ims+. The system is for notification and management of clinical and corporate incidents and enables the tracking of clinical equipment issues across the organisation.

NSW Ambulance established a funded role of Coordinator Clinical Consumables & Equipment within the Clinical Capability, Safety & Quality directorate. The role will support several system wide activities relating to clinical equipment and consumables. NSW Ambulance advises that the successful applicant has verbally accepted the role.

The NSW Ambulance Clinical Equipment Sub Committee undertakes important functions regarding new or existing equipment. Clinician members of the Sub Committee support communication about clinical equipment and ensure end users are involved in risk assessment, options and solutions.

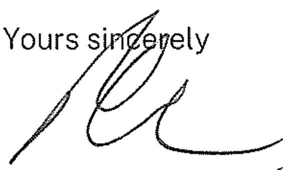
Sub Committee functions include:

- Reviewing devices, consumables or non-consumables that relate to patient care or staff safety
- Determining methods to pilot and evaluate of new or replacement clinical equipment
- Approving additions or changes to clinical equipment or recommending new equipment.
- Monitor clinical incidents that relate to clinical equipment and consumables.

I trust that this response confirms NSW Health's commitment to a process of continuous improvement and delivering safe and high-quality care to all patients of the NSW health system.

For more information, please contact Joanne Edwards, Executive Director, System Management Branch, NSW Ministry of Health at moh-systemmanagementbranch@health.nsw.gov.au.

Yours sincerely



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CC: NSW Coroner's Court

Encl. Coroner's report – *Inquest into the death of Jacob Carr*