JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	19 - 20 JUNE 2025
DELIVERED	**:**	2 JULY 2025
FILE NO/S	**:**	CORC 1 of 2023
DECEASED	**:**	WARD, DONALD JOSEPH HEMARA

Cases:

Briginshaw v Briginshaw (1938) 60 CLR 336

Counsel Appearing:

Ms T Weston appeared to assist the coroner.

Ms R Panetta (State Solicitor's Office) appeared on behalf of the Western Australian Police Force.

Mr T Pontre (of counsel, instructed by Moray & Agnew Lawyers) and Ms A Miolin appeared on behalf of St John Ambulance Western Australia Ltd, Ms S Bradley and Ms R Ambrosius.

SUPPRESSION ORDER

On the basis it would be contrary to the public interest, I make an Order under s49(1)(b) *Coroners Act 1996* that that there be no reporting or publication of the details of or discussion surrounding operational aspects of WA Police urgent duty/emergency driving policies and procedures, including any cap on the speed at which police officers are authorised to drive.

Order made by Coroner MAG Jenkin (19.06.25)

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of **Donald Joseph Hemara WARD** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 19 June 2025 - 20 June 2025, find that the identity of the deceased person was **Donald Joseph Hemara WARD** and that death occurred on 4 March 2023 at De Witt Road, Karratha, from multiple injuries in the following circumstances:*

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1

INTRODUCTION

1. Donald Joseph Hemara Ward (Don)[1] was 50 years of age when he died in bushland adjacent to De Witt Road in Karratha on 4 March 2023 from multiple injuries.[2,3,4,5,6,7]

2. Shortly before his death, Don had been riding at high speed on his Harley Davidson motorcycle (the Motorcycle). Don was travelling south on De Witt Road, having been briefly pursued by police. The intercept had been terminated and police lost sight of Don. A short time later Don left the roadway and rode onto a parallel bush track, before he lost control and was flung off the Motorcycle. Don sustained very serious injuries and despite the efforts of attending police and paramedics, he died at the scene.

3. Pursuant to the *Coroners Act 1996* (WA) (the Act) Don's death was a "*reportable death*".[8] Further, pursuant to section 22(1)(b) of the Act, because of the possibility that Don's death may have been caused or contributed to by a member of the Western Australia Police Force (WA Police), a coronial inquest was mandatory.[9]

4. I held an inquest into Don's death in Perth on 19 - 20 June 2025, which was attended by members of his family. The documentary evidence adduced at the inquest comprised one volume, and included a report by WA Police's Major Crash Investigation Section concerning the circumstances of Don's death,[10] and expert reports from St John Ambulance Western Australia (SJA)[11] and Dr H Rockley.[12]

5. The inquest focussed on the conduct of the police officers involved in the attempted intercept, and the circumstances of Don's death.

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[1] At the request of his family, Mr Ward was referred to as "*Don*" at the inquest, and in this finding. No disrespect is intended.
[2] Exhibit 1, Vol.1, Tab 1, P100 - Report of Death (10.05.24)
[3] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. S Malcolm, Major Crash Investigation Section (10.05.24)
[4] Exhibit 1, Vol.1, Tab 3, Life Extinct Form & Life Extinct Certification (04.03.23)
[5] Exhibit 1, Vol.1, Tab 4, P92 - Identification of Deceased Person by Visual Means (10.03.23)
[6] Exhibit 1, Vol.1, Tab 5, P98 - Mortuary Admission Form (04.03.23)
[7] Exhibit 1, Vol.1, Tab 6, Supplementary Post Mortem Report (13.04.23)
[8] Section 3, *Coroners Act 1996* (WA)
[9] Section 22(1)(b), *Coroners Act 1996* (WA)
[10] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. S Malcolm, Major Crash Investigation Section (10.05.24)
[11] Exhibit 1, Vol.1, Tab 35, Report - Mr A Bell, St John Ambulance Western Australia Ltd (16.06.25)
[12] Exhibit 1, Vol. 1, Tab 25, Report - Dr H Rockley (27.02.25)

6. The following witnesses gave oral evidence at the inquest:

a. Sgt. A Keogh, (Officer Keogh);[13]
b. Sen. Const. A Mitchell, (Officer Mitchell);[14]
c. Const. S Whiteford, (Officer Whiteford);[15,16]
d. Const. R House, (Officer House);[17]
e. Ms S Bradley, (Ms Bradley);[18]
f. Ms R Ambrosius, (Ms Ambrosius);[19] and
g. Dr H Rockley, (Emergency Medicine Physician);[20]

7. When assessing the evidence in this matter and deciding whether to make any adverse findings, I have applied the standard of proof as set out in the High Court's decision in the case of ***Briginshaw v Briginshaw***[21] which requires a consideration of the nature and gravity of the conduct when deciding whether a finding adverse in nature has been proven on the balance of probabilities.

8. I have also been mindful not to insert any hindsight bias into my assessment of the actions taken by members of the WA Police. Hindsight bias is the well-known tendency, after an event, to assume the event was more predictable or foreseeable than it was at the time.[22]

9. I also note that section 22(1)(b) of the Act is enlivened whenever the issue of causation or contribution in relation to a death arises as a question of fact, irrespective of whether there is fault or error on the part of any member of WA Police.

10. After careful consideration of the available evidence, I concluded that none of the actions of any of the attending police or paramedics caused or contributed to Don's death. Instead, it is my view that Don's decision to ride the Motorcycle in circumstances where he was intoxicated by alcohol and cannabis led to the fatal outcome in this case.

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[13] ts 19.06.25 (Keogh), pp9-32
[14] ts 19.06.25 (Mitchell), pp33-47
[15] ts 19.06.25 (Whiteford), pp48-55
[16] Note: At the relevant time Officer Whiteford was known as Officer Ingram
[17] ts 19.06.25 (House), pp56-67
[18] ts 20.06.25 (Bradley), pp71-85
[19] ts 20.06.25 (Ambrosius), pp86-90
[20] ts 20.06.25 (Rockley), pp90-102
[21] (1938) 60 CLR 336, per Dixon J at pp361-362
[22] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015), p10

DON

Background

11. Don was born in New Zealand on 10 May 1972, and he had three children, two of whom live with his ex-partner. Don was employed as a truck driver, and was in Karratha for work on 3 March 2023. Don was staying at his employer's depot which was in Karratha's light industrial area (LIA) located off De Witt Road.[23,24]

EVENTS LEADING TO DON'S DEATH[25,26,27,28,29,30]

Don's decision to ride the Motorcycle

12. Close circuit TV camera footage (CCTV) at the Evolution Night Club (the Club) in Karratha shows that Don arrived at the Club at 10.29 pm on 3 March 2023. CCTV shows Don rode out of the Club carpark on the Motorcycle at 1.19 am on 4 March 2023.

13. At 1.16 am, CCTV shows Don make several attempts to place a sock over the Motorcycle's rear number plate before success. His movements appeared uncoordinated and it seems likely he was obscuring the number plate because as he was aware he was intoxicated. After the crash, the number plate was recovered and the sock was still in place.[31,32]

Police attempt to intercept Don[33,34,35]

14. Shortly after Don rode out of the Club carpark, he came to the attention of Officer Keogh and Officer Mitchell, who were travelling towards him while conducting a routine patrol on Balmoral Road, Karratha in an unmarked police vehicle.

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[23] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. S Malcolm, Major Crash Investigation Section (10.05.24), p9
[24] Exhibit 1, Vol.1, Tab 1, P100 - Report of Death (10.05.24)
[25] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. S Malcolm, Major Crash Investigation Section (10.05.24)
[26] Exhibit 1, Vol.1, Tab 8, Major Crash Investigation Section - Initial Collision Assessment Report (03.05.23)
[27] Exhibit 1, Vol.1, Tab 8.1, Major Crash Investigation Section - Forensic Crash Reconstruction Scene Notes (04.03.23)
[28] Exhibit 1, Vol.1, Tabs 26-28, Various photographs - numberplate, crash scene & Don's motorcycle
[29] Exhibit 1, Vol.1, Tab 29, Main Roads WA Preliminary Crash Investigation and scene photographs (22.03.23)
[30] Exhibit 1, Vol.1, Tab 30, POCC EDIP Return Template
[31] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. S Malcolm, Major Crash Investigation Section (10.05.24), p4
[32] See: Exhibit 1, Vol.1, Tab 7, Toxicology Report (27.03.23) which shows Don had a blood alcohol level of 0.186%
[33] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. S Malcolm, Major Crash Investigation Section (10.05.24)
[34] Exhibit 1, Vol.1, Tab 10, Statement - Sgt. A Keogh (27.03.23), paras 6-16 and ts 19.06.25 (Keogh), pp9-32
[35] Exhibit 1, Vol.1, Tab 11, Statement - Sen. Const. A Mitchell (01.04.23) and ts 19.06.25 (Mitchell), pp33-47

15. Don appeared to be exceeding the posted speed limit, and Officer Keogh suspected he may be a member of an outlaw motorcycle club who had come from the Club and was possibly in possession of illicit drugs.

16. Officer Keogh decided it was necessary to conduct a traffic stop, so he activated the police vehicle's emergency lights and sirens before executing a U-turn for that purpose. Officer Keogh activated his body worn camera (BWC), and at the time visibility under street lighting was "*reasonable*" and there were no other vehicles on the road.

17. Despite being followed by an unmarked police vehicle with its emergency lights and sirens on, Don did not stop and instead he turned left onto Dampier Road (also known as Dampier Highway), before accelerating heavily away.

18. As a result of Don's actions, Officer Keogh formed the belief that he (Don) was not going to stop. Officer Keogh told Officer Mitchell to "*call the matter in to Karratha base*", which Officer Mitchell did.

19. Officer Keogh continued to follow the Motorcycle and Don turned right onto De Witt Road. Officer Keogh noticed Don was travelling at speed in the centre of the road, and that he was pulling away from the police vehicle. A short time later, at 1.21 am, the Karratha Police Operational Command Centre (POCC) instructed Officer Keogh to terminate the intercept.[36,37]

20. Moments later, Officer Mitchell acknowledged POCC's direction and Officer Keogh immediately complied and terminated the attempted intercept by slowing the police vehicle. Although the police vehicle's emergency sirens were switched off, Officer Mitchell left the vehicle's emergency lights switched on for safety reasons given that the officers were travelling slowly on a pitch black road.[38,39]

[36] See: Audio recording of Karratha POCC's interactions with Officers Keogh and Mitchell (04.03.23)
[37] See: Footage from Officer Keogh's and Officer Mitchell's body worn cameras
[38] Exhibit 1, Vol.1, Tab 11, Statement - Sen. Const. A Mitchell (01.04.23), para 19
[39] ts 19.06.25 (Keogh), pp24-26 and ts 19.06.25 (Mitchell), pp40-41

Police lose sight of Don[40,41,42]

21. Officer Keogh continued travelling south on De Witt Road and as he travelled around a bend in the road, he realised he could no longer see the Motorcycle's rear taillight. Officer Keogh assumed Don must have crashed and called out "*he's crashed, he's crashed*". The driver of an oncoming vehicle (the Witness) stopped and spoke to Officer Keogh, and told him he had seen the Motorcycle "*go off into the bush*".[43]

22. Officer Mitchell got out of the police vehicle and began searching the side of De Witt Road and the bush track which runs parallel to the roadway and which serves as a short cut to the LIA. In this section of De Witt Road there is no street lighting, so Officer Keogh drove the police vehicle slowly behind Officer Mitchell to provide additional lighting with the vehicle's headlights.

Don is located and resuscitation efforts[44,45,46,47,48,49,50,51,52,53,54,55,56,57,58,59]

23. A short time later, Officer Mitchell used his police radio to advise that he had located Don and the Motorcycle in bushland a few metres from the bush track. While Officer Mitchell provided first aid to Don, Officer Keogh requested an ambulance on a "*Priority 1*" basis, and then briefly spoke with the Witness to obtain their details.

24. A short time later, other police officers (i.e.: Officers House, Whiteford,[60] Connor, Ta'ala, Barndon, Watson, and Kaminski) arrived at the scene, and these officers assisted with resuscitation efforts.

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[40] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. S Malcolm, Major Crash Investigation Section (10.05.24)
[41] Exhibit 1, Vol.1, Tab 10, Statement - Sgt. A Keogh (27.03.23), paras 17-20 and ts 19.06.25 (Keogh), pp21-26
[42] Exhibit 1, Vol.1, Tab 11, Statement - Sen. Const. A Mitchell (01.04.23) and ts 19.06.25 (Mitchell), pp39-41
[43] Exhibit 1, Vol.1, Tab 10, Statement - Sgt. A Keogh (27.03.23), para 19
[44] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. S Malcolm, Major Crash Investigation Section (10.05.24)
[45] Exhibit 1, Vol.1, Tab 10, Statement - Sgt. A Keogh (27.03.23), paras 22-28 and ts 19.06.25 (Keogh), pp26-31
[46] Exhibit 1, Vol.1, Tab 11, Statement - Sen. Const. A Mitchell (01.04.23), paras 22-34 and ts 19.06.25 (Mitchell), pp41-47
[47] Exhibit 1, Vol. 1, Tab 12, Statement - Const. R House (06.04.23) and ts 19.06.25 (House), pp58-65
[48] Exhibit 1, Vol. 1, Tab 13, Statement - Const. M Ingram (07.04.23) and ts 19.06.25 (Whiteford), pp50-54
[49] Exhibit 1, Vol.1, Tab 13.1, Statement - Const. M Ingram (04.04.25)
[50] Exhibit 1, Vol.1, Tab 14, Statement - Sen. Const. W Barndon (25.03.23)
[51] Exhibit 1, Vol.1, Tab 15, Statement - Sen. Const. J O'Connor (undated)
[52] Exhibit 1, Vol.1, Tab 16, Statement - Const. M Ta'ala (24.03.23)
[53] Exhibit 1, Vol.1, Tab 17, Statement - Const. S Watson (29.03.23)
[54] Exhibit 1, Vol.1, Tab 18, Statement - Sen. Const. E Kaminski Barndon (04.05.24)
[55] Exhibit 1, Vol.1, Tab 19, Statement - Sen. Const. W Merrick (11.04.23)
[56] Exhibit 1, Vol.1, Tab 20, Statement - Sen. Const. D Walker (10.04.23)
[57] Exhibit 1, Vol.1, Tabs 21 & 21.1, Statements - Paramedic S Bradley (28.02.25 & 16.06.25) and ts 20.06.25 (Bradley), pp71-85
[58] Exhibit 1, Vol.1, Tab 22, Statement - Volunteer Paramedic R Ambrosius (02.03.25) and ts 20.06.25 (Ambrosius), pp86-90
[59] Exhibit 1, Vol. 1, Tab 32, SJA Patient Care Record 22364304 (04.03.23)
[60] Note: At the relevant time Officer Whiteford was known as Officer Ingram

25. A defibrillator that was brought from the Karratha police station by Officers Barndon and Ta'ala, was handed to Officer House, who attached both defibrillator pads to Don's body. The defibrillator would not function, and it appears one of the pads had been placed incorrectly.[61,62] In his statement, Officer House noted:

> I heard the defibrillator continue to repeat the same instructions. I pulled one of the pads off to check it however I couldn't notice anything wrong with it. I checked to see that the wires connecting the pads to the machine weren't broken. I went through the zip-up pocket on the defibrillator to see if there were any spare pads. I was unable to locate them.[63]

26. Following the inquest, WA Police confirmed the defibrillator used on Don is stored in a soft case with adult pads, and that paediatric pads are stored in a separate rear pocket.[64] WA Police also confirmed their defibrillators are checked biannually, and this includes "*checking the pads expiry date along with the device. The pads are not activated in live test as they are a single use item*.[65]

27. At about 1.32 am, an ambulance arrived and Ms Bradley (a career paramedic) and Ms Ambrosius (a volunteer paramedic) took over resuscitation efforts. Ms Bradley attached pads from a St John Ambulance (SJA) defibrillator, which showed that Don's heart was in pulseless electrical activity (PEA), which is a non-shockable rhythm.

28. Ms Bradley conducted a brief assessment and noted Don's injuries, and that he: "*was not breathing and there was no detectable pulse or other signs of life*". In her statement, Ms Bradley said: "*Based on the lack of signs of life, the observed injuries and fact that the patient had already arrested I was able to conclude that the patient was deceased and any possible treatments would have been futile. I provided police with a Life Extinct Certificate which I signed at 1.42am on 4 March 2023*".[66,67,68]

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[61] Exhibit 1, Vol. 1, Tab 12, Statement - Const. R House (06.04.23), paras 19-25 and ts 19.06.25 (House), pp61-64
[62] ts 20.06.25 (Rockley), pp92-93 & 97
[63] Exhibit 1, Vol. 1, Tab 12, Statement - Const. R House (06.04.23), paras 26-31
[64] Email: Ms R Panetta to Ms T Weston (23.06.25)
[65] Email: Acting Insp. J Liddelow to Principal Registrar (30.06.25)
[66] Exhibit 1, Vol.1, Tab 21, Statement - Paramedic S Bradley (28.02.25), paras 20-21
[67] See also: Exhibit 1, Vol.1, Tab 21.1, Statement - Paramedic S Bradley (16.06.25), paras 21-38
[68] See also: Exhibit 1, Vol.1, Tab 3, Life Extinct Form & Life Extinct Certification (04.03.23)

CAUSE OF DEATH[69,70]

29. A forensic pathologist (Dr C. Cooke) conducted a post mortem examination of Don's body at the State Mortuary and reviewed CT scans. Dr Cooke noted that Don had sustained multiple injuries including: fractures of his nose and part of his skull, as well as his ribs, spine, and right hip. There was also bleeding into the right side of Don's chest (haemothorax), and bruising of part of Don's brain.

30. Toxicological analysis detected tetrahydrocannabinol in Don's system at levels indicating recent cannabis use. Don also had a blood alcohol level of 0.186%, and a urine alcohol level of 0.200%. Other common drugs were not detected.[71] In his post mortem report, Dr Cooke noted that alcohol and cannabis can have a combined intoxicating effect.[72]

31. At the conclusion of his post mortem examination, Dr Cooke expressed the opinion that the cause of Don's death was multiple injuries.[73]

32. I accept and adopt Dr Cooke's opinion and find that Don died from the injuries he sustained when he lost control of his motorcycle in the early hours of 4 March 2023.

33. Further, given the circumstances of the crash, I find that Don's death occurred by way of accident.

[69] Exhibit 1, Vol.1, Tab 6.1, Post Mortem Report (15.03.23)
[70] Exhibit 1, Vol.1, Tab 6, Supplementary Post Mortem Report (13.04.23)
[71] Exhibit 1, Vol.1, Tab 7, Toxicology Report (27.03.23)
[72] Exhibit 1, Vol.1, Tab 6, Supplementary Post Mortem Report (13.04.23)
[73] Exhibit 1, Vol.1, Tab 6, Supplementary Post Mortem Report (13.04.23)

SUBSEQUENT INVESTIGATIONS

Police intercept driving policy[74]

34. Members of WA Police are required to comply with policies and procedures relating to urgent duty and emergency driving. At the start of the inquest I made a non-publication order relating to the operational aspects of WA Police urgent duty/emergency driving policies and procedures, including any cap on the speed at which police officers are authorised to drive.

35. For that reason, I do not intend to do more than briefly outline key provisions of those policies in this finding. For a start, I note that police officers engaged in intercepts are required to undertake a risk assessment before and during the intercept, and to consider relevant factors when deciding whether to initiate and/or continue with the intercept.

36. Officers engaged in an intercept must also provide regular updates to the POCC (in this case the Desk Sergeant at the Karratha police station), and an intercept may be terminated by POCC (or the supervising officer), the intercept vehicle driver, an intercept vehicle passenger, or by one of a range of authorised officers.

37. When an intercept has been terminated, the driver of the police vehicle must switch off emergency warning equipment, reduce speed, and comply with applicable speed limits. An intercept which results in a serious injury or death must be investigated by WA Police's Internal Affairs Unit (IAU), and that investigation must consider if relevant policies and legislation have been complied with, and the appropriateness of the actions of police.

Drug and alcohol testing

38. Following Don's death, Officers Keogh and Mitchell underwent drug and alcohol testing. The results of these tests established that neither officer had consumed alcohol or common drugs prior to the commencement of their shift.[75,76,77]

[74] Exhibit 1, Vol.1, Tab 31, WAPOL Emergency & Response Driving Policies
[75] Exhibit 1, Vol.1, Tab 10, Statement - Sgt. A Keogh (27.03.23), para 29

Major Crash Investigation Section investigation[78]

39. Detective Sergeant Stephen Malcolm (Officer Malcolm) from the Major Crash Investigation Section attended the scene and conducted an investigation. Officer Malcolm established that immediately before the crash, Don had been riding south on De Witt Road at high speed, before he crossed onto a bush track running parallel to the carriageway.

40. On 8 June 2023, the Motorcycle was inspected by a police vehicle examiner and was found to have no mechanical defects which would have contributed to the crash.[79] In his report, Officer Malcolm expressed the following conclusion, with which I agree:

> At the time of the crash the deceased had a blood alcohol level of 0.186%. At that level it is reasonable to conclude that the deceased was affected by alcohol intoxication adversely impacting his reaction time, judgement and coordination. The THC that was also detected in the deceased's system is likely to have contributed to this effect.[80] In this intoxicated condition, the deceased deprived himself of the capacity to properly control the Harley. The crash was caused by the deceased riding while impaired.[81]

Internal Affairs Unit investigation[82]

41. In accordance with WA Police policy, Detective Sergeant R Shelholt (Officer Shelholt) conducted an IAU investigation of the conduct of Officer Keogh and Officer Mitchell in relation to their attempt to intercept Don on 4 March 2023.

42. Officer Shelholt concluded that Officer Keogh had contravened the Police Code of Conduct by briefly exceeding the speed cap at which police are permitted to drive at during an attempted intercept. As a result, Officer Keogh was issued with a management notice. Officer Shelhot concluded that Officer Mitchell had not breached the Police Code of Conduct.[83]

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[76] Exhibit 1, Vol.1, Tab 11, Statement - Sen. Const. A Mitchell (01.04.23), paras 35-36
[77] Exhibit 1, Vol.1, Tab 14, Statement - Sen. Const. W Barndon (25.03.23), paras 17-18
[78] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. S Malcolm, Major Crash Investigation Section (10.05.24)
[79] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. S Malcolm, Major Crash Investigation Section (10.05.24), p5
[80] THC is the abbreviation for tetrahydrocannabinol, the primary psychoactive compound found in cannabis plants
[81] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. S Malcolm, Major Crash Investigation Section (10.05.24), p12
[82] Exhibit 1, Vol.1, Tab 23, Report - Det. Sgt. R Shelhot, Internal Affairs Unit (03.09.24)
[83] Exhibit 1, Vol.1, Tab 23, Report - Det. Sgt. R Shelhot, Internal Affairs Unit (03.09.24), p7

Resuscitation efforts[84]

43. At the Court's request, Dr Rockley (an emergency medicine consultant physician), conducted an assessment of the resuscitation efforts of the police officers and paramedics who attended to Don following the crash. Dr Rockley watched BWC footage from attending police officers, and reviewed the post mortem and toxicology reports, the MCIS report, witness statements, and the SJA patient care record. Following her review, Dr Rockley provided a helpful report to the Court, and she also gave evidence at the inquest.

44. Dr Hockley concluded that Don had been involved in a high speed motorcycle accident and that he had sustained "*multi-trauma to the right side of his body*". Dr Rockley also noted:

> (Don) was found soon after the accident and was attended to promptly by police officers, who appropriately diagnosed the breathing difficulties and cardiac arrests and provided timely CPR. Resuscitation efforts were terminated approximately 16 minutes from when he was first found, unconscious. Potentially reversible causes for the cardiac arrest, namely hypoxia and hypovolaemia were not addressed during this time.[85]

45. In a report provided to the Court, SJA's Deputy Director Paramedicine (Mr A Bell) noted that incidents such as the one involving Don are commonly referred to as HALO events, meaning "*high acuity, low occurrence*" events. Mr Bell also noted that in Karratha a "*hybrid service*" model is used, where a career paramedic is rostered on duty with a volunteer paramedic.[86]

46. Mr Bell reviewed police BWC footage and Dr Hockley's report, before making the following observations in his report:

> Having considered the footage, it does appear that the decision was made to cease resuscitation without attempting to address the potentially reversible causes. I agree with Dr Rockley's observations that there were no '*hard signs to indicate absolute futility of further resuscitation*'...

[84] Exhibit 1, Vol. 1, Tab 25, Report - Dr H Rockley (27.02.25) and ts 20.06.25 (Rockley), pp90-102
[85] Exhibit 1, Vol. 1, Tab 25, Report - Dr H Rockley (27.02.25), p13
[86] Exhibit 1, Vol. 1, Tab 35, Report - Mr A Bell St John Ambulance Western Australia Ltd. (16.06.25), p3

> However, as detailed above, (Don's) presentation had a number of less favourable features suggesting that interventions were more likely to be futile, including a traumatic aetiology and the fact that he had not received any defibrillation prior to (SJA) attendance and upon arrival of (SJA) was assessed as being in PEA (i.e.: pulseless electrical activity) which is a non-shockable rhythm.[87,88,89]

47. Mr Bell also noted that HALO events place "*a significant amount of cognitive strain on an individual paramedic*", and are difficult to diagnose and manage, because "*complex and multifactorial aetiologies*" often occur concurrently. In his report, Mr Bell also noted that:

> The national data on out of hospital cardiac arrests (OHCA) indicates a survivability rate of around 10% (specifics vary depending on jurisdiction). It is well accepted that the survivability rate for a patient with an OHCA with traumatic aetiology is poorer. While the cited rates of survival vary (depending on study criteria), the survival rates for TCA with a favourable neurological outcome is around 1-2%.[90]

48. At the inquest, Dr Hockley noted that although the defibrillator pad Officer House placed in the centre of Don's chest was in the correct position, the other pad had been placed too low on Don's flank, and this may have been why the defibrillator repeated the automated instruction to place the pads on the casualty's chest. Dr Rockley also said she could readily understand why the defibrillator pad placement had proved to be difficult given Don's physical size, the fact he was sweating, and the available lighting at the crash location.[91,92]

49. However, there is no evidence before me as to whether, at the time police were placing their defibrillator on Don, his heart was in a "*shockable rhythm*". I also note that when SJA arrived a short time later and placed their defibrillator pad's on his chest, Don's heart was in PEA which is an unshockable rhythm.[93]

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[87] Exhibit 1, Vol. 1, Tab 35, Report - Mr A Bell St John Ambulance Western Australia Ltd. (16.06.25), p4
[88] Ms Bradley agreed with this assessment, see: Exhibit 1, Vol.1, Tab 21.1, Statement - Paramedic S Bradley (16.06.25), para 48
[89] See also: ts 20.06.25 (Bradley), pp76-77 & 82
[90] Exhibit 1, Vol. 1, Tab 35, Report - Mr A Bell, SJA Deputy Director Paramedicine (16.06.25)
[91] Exhibit 1, Vol. 1, Tab 12, Statement - Const. R House (06.04.23), paras 19-25 and ts 19.06.25 (House), pp61-64
[92] ts 20.06.25 (Rockley), pp92-93
[93] Exhibit 1, Vol. 1, Tab 32, SJA Patient Care Record 22364304 (04.03.23)

50. At the inquest, Ms Bradley (the career paramedic who attended Don), said she had reflected deeply on the care she had provided to Don after the crash. Ms Bradley said that with the benefit of hindsight, she should have applied an oxygen mask to Don's face, and that her assessment (including Don's airway, breathing, and circulation) could have been more comprehensive. Ms Bradley also said that had she conducted a "*systemic primary survey*" she may have considered "*chest decompression and the application of a pelvic binder*".[94,95]

51. In her report, Dr Rockley noted that splinting Don's right leg might have improved his blood pressure, as he was likely to have bleeding into his "*hip joint and thigh compartment*". In her supplementary statement, Ms Bradley said that she did not agree that splinting Don's leg would have been worthwhile. Ms Bradley had access to the necessary equipment to do this, but said: "*in my experience application can take a significant amount of time - up to ten minutes*".[96,97]

52. Dr Rockley also made the following observations about the possibility of transferring Don to Karratha Health Campus (KHC):

> With ongoing CPR and other resuscitation measures attempting to seek and treat potential reversible causes for the arrest, Mr Ward could possibly have been transferred within minutes to the nearby Karratha Health Campus. There, he would have been seen by a team of nurses and doctors and had ongoing resuscitation with further management of reversible injuries/causes for his presentation. Investigations could have been performed guiding further resuscitation efforts or its termination.[98]

53. In a supplementary statement, Ms Bradley said she accepted it may have been possible to extricate Don and transfer him to KHC, but that this would have required a backup crew, a process which can take 10-20 minutes. Further delays would have occurred because specialists from radiology, anaesthetics, and surgery would have to be called in.[99]

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[94] Exhibit 1, Vol.1, Tab 21.1, Statement - Paramedic S Bradley (16.06.25), paras 39-46 and ts 20.06.25 (Bradley), pp78-79
[95] See also: ts 20.06.25 (Ambrosius), p89
[96] Exhibit 1, Vol. 1, Tab 25, Report - Dr H Rockley (27.02.25), p12
[97] Exhibit 1, Vol.1, Tab 21.1, Statement - Paramedic S Bradley (16.06.25), para 49 and ts 20.06.25 (Bradley), p81
[98] Exhibit 1, Vol. 1, Tab 25, Report - Dr H Rockley (27.02.25), pp12-13 and ts 20.06.25 (Rockley), pp94-95 & 101-102
[99] Exhibit 1, Vol.1, Tab 21.1, Statement - Paramedic S Bradley (16.06.25), paras 51-54 and ts 20.06.25 (Bradley), pp80-81

54. In relation to Don's likely outcome, Dr Rockley made the following observations in her report (with which Ms Bradley and Mr Bell agreed):[100,101]

> If the reversible causes had been addressed, Mr Ward had been without oxygen for more than 10 minutes and would have likely still suffered a hypoxic brain injury and death. In summary, I am unable to definitively comment on whether the management by police officers and paramedics of Mr Ward and if he had been transferred to Karratha Health Campus would have changed his outcome.[102]

Conclusions about resuscitation efforts

55. Don was involved in a high speed motorcycle accident, where his speed immediately prior to the crash was likely to have been in excess of 180 km per hour. In those circumstances, the injuries he sustained were almost inevitably going to prove fatal.

56. On the basis of the available evidence, I have concluded that the initial resuscitation efforts of Officer Mitchell assisted by Officer Keogh were timely and appropriate. Whilst it is of concern that the police defibrillator did not appear to function correctly, probably as a result of incorrect placement of one of the pads, there is no evidence that Don's heart was in a shockable rhythm at that time.

57. Obviously it is important that first responders, including police, who are using defibrillators during resuscitation efforts do so as competently as possible. I therefore **strongly recommend** that WA Police ask its first aid training provider to emphasise the importance of the correct placement of defibrillator pads, especially for patients who are obese.

58. As for the care provided to Don by Ms Bradley, I accept that her decision to cease resuscitation was made without an attempt to address potentially reversible causes for Don's cardiac arrest, namely hypoxia and hypovolaemia presentation.

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[100] Exhibit 1, Vol.1, Tab 21.1, Statement - Paramedic S Bradley (16.06.25), paras 55-57
[101] Exhibit 1, Vol.1, Tab 35, Report - Mr A Bell, St John Ambulance Western Australia Ltd (16.06.25), p4
[102] Exhibit 1, Vol. 1, Tab 25, Report - Dr H Rockley (27.02.25), p13 and ts 20.06.25 (Rockley), pp96 & 99

59. However, in my view the available evidence strongly suggests that even if this care had been attempted, Don would still have suffered a hypoxic brain injury, meaning that his death was inevitable.

60. I acknowledge Ms Bradley's capacity for self-reflection, and her willingness to retrospectively assess her actions and consider how she might improve the care she provides her patients. Too often witnesses before this Court are unwilling to undertake this often confronting and difficult exercise and Ms Bradley's willingness to do so is to be commended.

COMMENTS ON THE ACTIONS OF POLICE

61. The evidence before me establishes that at the relevant time, Don was riding the Motorcycle whilst he was intoxicated with alcohol and cannabis. Don was therefore a serious risk to road users, and in my view Officer Keogh's decision to attempt to intercept him was clearly justifiable and appropriate.

62. In my view the risk assessments conducted by Officer Keogh and Officer Mitchell prior to, and during the intercept took account of relevant factors, and the decision of the POCC to terminate the intercept shortly after it had begun was correct.

63. Don was found soon after he had lost control of the Motorcycle and crashed, and police immediately started CPR and requested an ambulance. The initial resuscitation efforts of police were appropriate, although as I have noted there were issues with the later placement of one of the defibrillator pads from the police defibrillator.

64. After careful consideration of the available evidence, and with due regard to the Briginshaw principle, I am satisfied that neither the actions of the Officers Keogh and Mitchell during the brief attempted intercept, nor the resuscitation efforts by attending police (and attending paramedics) caused or contributed to Don's death.

CONCLUSION

65. Don sustained very serious injuries after he rode the Motorcycle at high speed and lost control. Despite the efforts of police and paramedics Don could not be resuscitated, and died at the scene.

66. Police officers, career paramedics, and volunteer paramedics in regional areas are required to respond to serious vehicle accidents without the backup and support that is so freely available in the metropolitan area. The willingness of these people to do so is of great benefit to the people of Western Australia, and is to be warmly commended.

67. As I did at the conclusion of the inquest, I wish to again convey to Don's former partner, his family and his friends, on behalf of the Court, my very sincere condolences for your terrible loss.

MAG Jenkin
Coroner
17 JULY 2025