JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, ACTING STATE CORONER
HEARD	**:**	31 MARCH 2025
DELIVERED	**:**	8 JANUARY 2026
FILE NO/S	**:**	CORC 2099 of 2023
DECEASED	**:**	WARD, LEWIS WALTER

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Sergeant Craig Martin assisted the Coroner

Ms O Roberts (ALSWA) appeared for Ms Beverley Ward, mother of Mr Ward

Ms T Wilker (SSO) appeared for the Department of Justice and also filed submissions on behalf of the WA Country Health Service (WACHS)

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Acting State Coroner, having investigated the death of ***Lewis Walter WARD*** *with an inquest held at* ***Broome Courthouse***, ***Broome*** *on 31 March 2025, find that the identity of the deceased person was* ***Lewis Walter WARD*** *and that death occurred on or about 25 July 2023 at Royal Perth Hospital, Victoria Square, Perth, from complications of out of hospital cardiac arrest in a man with atherosclerotic cardiovascular disease and diabetes mellitus in the following circumstances:*

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INTRODUCTION

1. Mr Ward was a Ngarinyin, Woddorda and Wunumbal man who grew up in communities across the West Kimberley region. He had lived in Derby, Mt Barnett and Mowanjum Community amongst other places. Mr Ward also spent a brief period of time in Perth attending boarding school, but he had been homesick and eventually left school so he could return to his home and family in the north. Mr Ward was raised by his mother and grandmother.[1]

2. Other than the couple of years when Mr Ward attended boarding school in Perth, he had always lived and worked in the West Kimberley. He worked as a community worker and then later as an Aboriginal Ranger, caring for country around Mt Barnett and the surrounding land. He also obtained his white card in construction, concreting and bricklaying.[2]

3. Mr Ward was a loved member of his extended family and he made some significant contributions to his community. Unfortunately, it appears Mr Ward was also an alcoholic, having begun drinking heavily from the age of 17 years. I understand that heavy use of alcohol was common amongst his social circle as well, including his partner, and their mutual alcoholism impacted negatively upon their relationship. Mr Ward's drinking had led to him commit acts of family and domestic violence against his partner on occasion.[3]

4. In August 2021, Mr Ward was sentenced in the District Court to a term of five years' imprisonment for a serious act of violence involving his baby daughter. She had been the unintended victim of an act of violence directed towards his partner and the baby had suffered a brain injury as a result. Mr Ward was eligible to be considered for release on parole in September 2023.[4]

5. Mr Ward was serving his sentence at the West Kimberley Regional Prison in Derby when he collapsed while playing sport on 15 July 2023. Prison staff commenced CPR and he was then taken by ambulance to Derby Hospital for medical treatment. Mr Ward was then transferred, via Royal Flying Doctor Service (RFDS), to Perth where he was treated in the Intensive Care Unit at Royal Perth Hospital (RPH). A CT head scan conducted on 24 July 2023 confirmed a hypoxic brain injury and brain death. Following discussions with Mr Ward's family it was decided that treatment would be withdrawn on 25 July 2023, when his family could be with him.

6. The cause of Mr Ward's out of hospital cardiac arrest was not clear, but it was identified that he had been referred for cardiac testing and for various reasons the scheduling of that appointment had been delayed. In the end, Mr Ward collapsed three days before his first heart clinic appointment.

7. As Mr Ward was a serving prisoner at the time of his death, he came within the definition of a 'person held in care' under the *Coroners Act 1996* (WA) and a

[1] Submissions filed on behalf of Beverley Ward dated 31 October 2025.
[2] Exhibit 2, Tab 1.
[3] Exhibit 1, Tab 10, p. 16 - 17.
[4] Exhibit 1, Tab 10, p. 14 - 15.

coronial inquest into his death is, therefore, mandatory. I held an inquest on 31 March 2025. The inquest was heard on Yawuru-Djukun country at the Broome Courthouse. A number of Mr Ward's family, including his mother Beverley Ward and her son Harrison, travelled from their community to Broome for the inquest, for which I express my gratitude as there were logistical issues holding the inquest in Derby, which would have been closer to their home.

8. I am required to comment on the quality of Mr Ward's treatment, supervision and care while in custody prior to his death. Given Mr Ward died from a cardiac event in the context of a long delay for him to see a cardiologist while in prison, that was a primary focus of the evidence at the inquest. In particular, evidence was led to assist me to understand whether earlier cardiology review might have prevented Mr Ward's death, and whether his medical care could be said to be reasonable and commensurate with what he would have been expected to receive in the community or whether the care was below that standard.[5]

BRIEF BACKGROUND

9. Mr Ward was born in Derby. His mother Beverley lives in Mowanjum Aboriginal community, just outside of Derby in Western Australia. Beverley's family are Ngarinyin, Wunumbal and Woddorda people from the Beverley Spring (Charnley River) area. Mr Ward's father was from Mowanjum. Mr Ward's father experienced problems with alcohol and his parents separated when he was small. He was subsequently raised primarily by his mother and grandmother. His grandmother taught him language, song time corroboree, bush tools and dreaming stories. I understand Mr Ward spoke Ngarinyin fluently and considered it to be his first language.[6]

10. Mr Ward spent time at school at Mt Barnett station and in Mowanjum before transitioning to school, including high school, in Derby. He moved to Perth to attend Kingsway College in Years 11 and 12 as a boarding student for a period, before returning to Derby due to homesickness. Mr Ward reported he had a happy childhood.[7]

11. Beverley recalls her son was a sensible, gentle boy with good manners. He loved to play football and was a very good player. Mr Ward attained a number of qualifications and engaged in work opportunities with the Community and Development Program, including work as community worker and an Aboriginal ranger, caring for country around the Mount Barnett area.[8]

12. Mr Ward had a partner, Nelita, and they had three children together. The oldest was 17 years old at the time of the inquest and the youngest was six years old. Mr Ward's mother recalled he had liked looking after his children when he was home.[9]

[5] Sections 22(1)(a) and 25(3) *Coroners Act 1996* (WA).
[6] Exhibit 1, Tab 20; Exhibit 2, Tab 1 and Tab 2.
[7] Exhibit 1, Tab 16; Exhibit 2, Tab 1.
[8] Exhibit 2, Tab 1.
[9] Exhibit 1, Tab 20.

13. Unfortunately, from about the age of 17 years, Mr Ward began drinking alcohol and that appears to have impacted on his family life. His ongoing issues with alcohol led him into violence and other criminal offending and he spent a number of periods in prison.

14. On 2 August 2021, Mr Ward was convicted on his early plea of guilty in the District Court, sitting in Derby, of one count of unlawfully doing grievous bodily harm to his baby daughter in the context of a drunken argument with his partner, who is the child's mother. While violently striking his partner, he unintentionally struck his infant daughter to the head as she was being held by her mother. She suffered a brain injury that caused seizures. The State sought, and was granted, a serial family violence offender declaration as Mr Ward had a history of other convictions for family violence related offending.[10]

15. Mr Ward had experienced trauma in his own childhood as a result of alcohol-induced violence perpetrated by his father against his mother when he was a young child, before his mother left and took him to live with his grandmother in the Mt Barnett Community. There he lived a more stable and safe life, supported by his mother and maternal grandmother. However, as he reached adulthood, Mr Ward succumbed to alcoholism himself and, sadly, the pattern repeated. I understand from the records there was violence on both sides of his relationship, noting that shortly before he was incarcerated for the last time Mr Ward presented to hospital for medical treatment after allegedly being hit in the head with a bottle by his partner and it was indicated he had been granted a violence restraining order against her.[11]

16. It was made clear in sentencing that Mr Ward loved his partner and his children, including the victim in the most recent offence, and his behaviour when intoxicated was not reflective of the person he was when sober. Nevertheless, it had resulted in very serious consequences for his family. Mr Ward was sentenced to a term of five years' imprisonment and was made eligible for parole. The sentence was backdated to reflect the time he had spent in custody on remand and his earliest eligibility date for release was 8 September 2023.[12] He was initially placed at West Kimberley Regional Prison. He was noted to be remorseful, and while in custody he began to engage in drug and alcohol programmes to try to change his future path when released.[13]

MEDICAL HISTORY

17. At the time of his last admission to prison in August 2020 as a remand prisoner, Mr Ward had known diagnoses of Type 2 diabetes, high cholesterol, high blood pressure and he had been successfully treated for other diseases such as hepatitis. He was prescribed a number of medications for his high cholesterol, high blood pressure and diabetes on an ongoing basis. Notes were made on his admission to prison on

[10] Exhibit 1, Tab 16.
[11] Exhibit 1, Tab 16 and Tab 17 - ED Triage Notes 30.3.2020.
[12] Exhibit 1, Tab 16; Exhibit 2, Tab 1.
[13] Exhibit 1, Tab 16.

23 August 2020 that he usually took his medication when in prison, but he was generally non-compliant with his medication regime when in the community.[14]

18. Mr Ward had last been released from prison in January 2019 and when he was seen in hospital in March 2020, he self-reported that he was on no regular medications, so it is likely he had not been taking regular medication for about 18 months at the time he went back into prison.[15] On admission to prison in August 2020, Mr Ward's blood sugar reading was very high at 25.3 and his blood pressure was also high at 151/93, both of which were indicators that his conditions were not well managed as he hadn't been taking his prescribed medications. His oral diabetic medications metformin and empagliflozin were restarted. Mr Ward had no recorded cardiac issues at that time and was noted as fit for sport, work and an upper bunk.[16]

19. Blood tests on 1 September 2020 confirmed very poor blood sugar control over the previous three months, as well as high cholesterol and triglycerides, abnormal liver function and a small amount of protein in the urine. Mr Ward had a medical admission review with a prison doctor on 8 September 2020 and statin therapy to lower his cholesterol levels was commenced. The notes record that there were no respiratory or cardiovascular symptoms, and that Mr Ward had good exercise tolerance. Auscultation of the chest was unremarkable.[17]

20. Nursing notes from 8 October 2020 record that chronic disease management education was provided and at that time Mr Ward reported feeling well. It was also noted he was still smoking cigarettes. He was also seen by an optometrist and podiatrist in October, as is standard practice for a person on a diabetes management plan.[18]

21. In November 2020, Mr Ward was reviewed by a dentist, who noted rampant cavities and suggested there was a case for removal of all Mr Ward's teeth. It seems Mr Ward wished to manage his dental issues conservatively. On 8 December 2020, Mr Ward attended a Diabetes Care Plan nurse appointment. His blood pressure was noted to now be well controlled, and it was recorded that Mr Ward reported he ate a good diet and exercised daily, with good exercise tolerance. He was still smoking and was reportedly keen to quit one day, understanding the risks of smoking to his health, but he was not willing to try to cease smoking yet. No other diabetic concerns were noted at the nursing review.[19]

22. On 16 February 2021, Mr Ward had further blood tests, which showed an improvement in his overall health. There was a marked improvement in his blood sugar control over the previous three months, now that he was taking regular medication. He also had reduced protein in the urine, his liver function had normalised, and his cholesterol had much improved.[20]

[14] Exhibit 1, Tab 17 - ED Triage Notes 16.3.2020; Exhibit 2, Tab 2.
[15] Exhibit 1, Tab 17 - ED Triage Notes 16.3.2020; Exhibit 2, Tab 2.
[16] Exhibit 1, Tab 19; Exhibit 2, Tab 1.
[17] Exhibit 1, Tab 19.
[18] Exhibit 1, Tab 19.
[19] Exhibit 1, Tab 19.
[20] Exhibit 1, Tab 19.

23. In May 2021, Mr Ward commenced drug and alcohol counselling, which was an important step given the factual circumstances of his previous offending.[21]

24. On 10 May 2021, Mr Ward saw a clinical nurse and complained of shoulder pain. He told the nurse he had a sore shoulder from playing football the day before. He had good range of movement but said he sometimes got shoulder pain when lifting. It was noted he worked in the kitchen, which he wanted to keep doing, so he was told to avoid heavy lifting while performing his duties. He was given some Metsal rub to apply to his sore shoulder, as needed. It was planned that he would be reviewed again if the pain did not improve. The assessment appears to be in keeping with pain from a shoulder injury, but it is also noteworthy that left arm/shoulder pain, especially on exertion, can be a symptom of myocardial ischaemia (heart pain), so it could have been an early warning sign of what was to come. On 11 May 2021, Mr Ward had some more blood tests, which were satisfactory.[22]

25. On 8 June 2021, Mr Ward had another diabetic review with a nurse and indicated he was compliant with his medications, he had good exercise tolerance, and he was currently trying to quit smoking. However, he wasn't keen to participate in the diabetic review and refused to have a foot check. He continued to have chronic disease management appointments monthly to check his observations and no concerns were recorded. He was reviewed in June and July by a doctor due to knee pain following an injury but otherwise required no medical attention.[23]

26. After Mr Ward was sentenced in August 2021, he was upgraded to maximum security rating, but he was allowed to stay at West Kimberley Regional Prison to facilitate social contact with family. Records show he had regular visits, including e-visits, with his family throughout his time in custody Mr Ward indicated some interest in attending education classes to obtain his driver's licence permit and was found suitable for inclusion in some programs to manage his outstanding treatment needs. It does not appear these were actioned prior to his death.[24] He had a job in the kitchen as a general worker and was considered to be an above average worker with a great work ethic and he was respectful and considerate towards others.[25]

REFERRAL TO CARDIOLOGIST

27. On 9 August 2021, Mr Ward had an ECG performed as part of his monthly chronic disease management review. The ECG was noted to be 'borderline' and was reviewed by a prison doctor, who made a plan that it would be repeated in one month. The ECG was repeated on 14 September 2021, and it was again found to be abnormal in the same way as the test from the previous month. Mr Ward was noted to be asymptomatic, and his observations were within normal range. The results of the ECG appeared to show signs of a previous inferior myocardial infarction (heart

[21] Exhibit 1, Tab 19.
[22] Exhibit 1, Tab 19.
[23] Exhibit 1, Tab 19.
[24] T 29 - 30.
[25] Exhibit 2, Tab 1.

attack on the underside of the heart). An EConsult was sent to the prison medical officer and after reviewing the result, the medical officer, Dr Roger Todd (Dr Todd), recommended the test be repeated in a month.[26]

28. Mr Ward was seen again by a clinical nurse for a diabetes care plan review on 14 September 2021 and the repeat ECG was performed. The clinical nurse again noted that the ECG was abnormal, with the result the same as the one the month before. It appeared to suggest a previous inferior myocardial infarction (heart attack). An EConsult was again sent to a medical officer. It was noted that at the time of the review Mr Ward was asymptomatic and his observations were within normal range.[27]

29. Dr Todd reviewed Mr Ward's blood results and other test results on 5 October 2021. The results showed mild abnormal liver and thyroid function but were otherwise generally good. About a week later, on 11 October 2021, Dr Todd then reviewed the ECG result and noted that the ECG showed an inferior infarct, but Mr Ward was symptom free. Dr Todd made a cardiology referral to Derby Hospital on that date. The referral requested an exercise stress test and cardiology appointment. An exercise stress test is performed to see if there are ECG changes of myocardial ischaemia with exertion.[28]

30. The referral noted Mr Ward was a non-insulin dependent diabetic and he was symptom free in relation to cardiac issues. The request was marked as semi-urgent for an appointment within 31 to 90 days (with the next option routine, 91 to 365 days). Unfortunately, this did not occur.[29]

31. Mr Ward was seen by a clinical nurse for an Annual Health Assessment on 2 December 2021 and he seemed generally well. He indicated he exercised daily and was now a light smoker. He had a Diabetes Care Plan review two weeks later on 14 December 2021 and again seemed well, although his blood sugar levels were elevated so a doctor's review was scheduled. He had blood tests on 4 January 2022 which showed his average three monthly blood sugar level was just above target and he still had a small amount of protein in his urine. His cholesterol levels were well controlled, thyroid function was normal and his liver function tests had improved, although mild abnormality was still present. He was reviewed by a doctor on 18 January 2022 and an additional diabetes medication called gliclazide was added.[30]

32. Mr Ward was given approval to attend a family funeral on 4 March 2022, but the approval was dependent on the availability of contractor Ventia security officers to escort him. It appears that in the end he did not attend the funeral.[31]

33. Mr Ward continued to have ongoing chronic disease management appointments and diabetic reviews. He was generally managing well but was noted still to be smoking. He was booked for a non-urgent ECG on 14 March 2022, which was performed on

[26] Exhibit 1, Tab 19.
[27] Exhibit 1, Tab 19.
[28] Exhibit 1, Tab 19 and Tab 22.
[29] Exhibit 1, Tab 19 and Tab 22.
[30] Exhibit 1, Tab 19.
[31] Exhibit 2, Tab 1.

17 March 2022 and showed a similar abnormal result to the previous ECG. It was noted he had no chest pains and no problems eating or sleeping.[32]

34. Mr Ward continued to be proactively managed for his diabetes and was also seen for minor ailments and received flu and COVID-19 vaccinations from March until July 2022.[33]

35. On 25 August 2022, Mr Ward was transferred from West Kimberley Regional Prison to Albany Prison. He transitioned through Broome Regional Prison and Casuarina Prison in Perth for a couple of weeks later before he arrived in Albany on 5 September 2022. The transfer out summary records that there were no external appointments expected or existing, despite the fact he still had not undergone the cardiology review that was requested in October 2021, nearly a year before.[34]

36. Mr Ward's mother understood her son was moved to Albany in order to undertake a course that wasn't available in the Kimberley.[35] However, evidence before me indicated that he was actually moved for prison population management purposes. It was understood that Mr Ward preferred to be at West Kimberley Regional Prison, close to his country and his family, so it was understood that his return to West Kimberley Regional Prison should be facilitated when it was possible.[36]

37. Mr Ward continued to have annual health assessments and diabetes care plan reviews in Albany and his blood pressure and blood sugars were well controlled. An ECG was performed as part of his annual health assessment on 20 September 2022 and had similar findings to the previous ECG's, suggestive of a previous heart attack; it was again marked for medical officer review. Mr Ward was noted to still be smoking at this time.[37]

38. The same medical officer, Dr Todd, appears to have reviewed Mr Ward's test results on 28 September 2022 but no note was made in relation to the ECG result.[38]

39. In early October 2022 Mr Ward was transferred back to West Kimberley Regional Prison, via Acacia Prison, acknowledging West Kimberley Regional Prison was his preferred placement. He was reviewed by prison medical officer Dr Todd following his return to West Kimberley Regional Prison on 17 October 2022 and was started on a new blood pressure medication. Mr Ward apparently expressed some reluctance to add more medications to his regime as he didn't want to take so many tablets. However, Dr Todd strongly encouraged him to at least take two essential medications, ramipril (for blood pressure and to protect kidney function) and empagliflozin (for his diabetes).[39]

[32] Exhibit 1, Tab 19.
[33] Exhibit 1, Tab 19.
[34] Exhibit 1, Tab 19; Exhibit 2, Tab 1.
[35] Exhibit 1, Tab 20.
[36] T 14; Exhibit 2, Tab 1.
[37] Exhibit 1, Tab 19.
[38] Exhibit 1, Tab 19.
[39] Exhibit 1, Tab 19; Exhibit 2, Tab 1.

40. Mr Ward continued to be regularly reviewed for his diabetes, and he reported no concerns. He indicated his energy when playing sports was good. He had successfully ceased smoking by 1 November 2022, which was a significant step for him. However, he later returned to smoking.[40]

41. On 6 December 2022 Mr Ward complained to health staff about dental pain on the left side of his face. He was placed on the dental list and saw a dentist two days later on 8 December 2022. Mr Ward attended the appointment but reportedly told the dentist he needed to go back to work and did not want any dental treatment that day. Nevertheless, the dentist obtained his consent to perform an examination and application of fluoride on his caries (decaying teeth). The exam revealed heavy inflammation and plaque and generalised caries, but no dental abscess was noted at the time.[41]

42. Mr Ward continued to be seen regularly by health staff from December 2022 through to early 2023 and appeared to be doing well, although a dental review had again identified significant issues that Mr Ward seemed reluctant to address.[42]

43. Throughout this time, the lack of a new cardiology appointment seems to have been overlooked by the various health staff involved in his care.

EVENTS IN EARLY 2023

44. On 7 February 2023, Mr Ward was seen at Derby Hospital ED due to left-sided facial swelling. He was diagnosed with a periodontal abscess, which was spreading. He was admitted to the ward and given pain relief and commenced on intravenous antibiotics to treat the infection. He was discharged back to prison on 9 February 2023 with a direction he continues on a course of oral antibiotics for five more days.[43]

45. A week or so later, Mr Ward was involved in an incident with another prisoner and reported that he had sustained an injury to his mouth. He was encouraged to continue on the antibiotics that he had been taking for his dental abscess, as they would also be effective against any new infection. After dental review in March 2023, a plan was made for a tooth extraction after the swelling resolved, with the hope this would ease some of his dental pain.[44]

46. On 24 March 2023, Mr Ward received treatment after a goanna bit him on the thumb while he was trying to remove it from the house. He sustained a small cut, which was cleaned and glued back together.

47. On 6 April 2023, Mr Ward was seen by prison medical officer Dr Todd in relation to his other thumb, which he had injured playing football. He had an x-ray but nothing

[40] Exhibit 1, Tab 19.
[41] Exhibit 2, Tab 3.
[42] Exhibit 1, Tab 19.
[43] Exhibit 1, Tab 17 – Discharge Summary 9.2.2023.
[44] Exhibit 1, Tab 19; Exhibit 2, Tab 2.

more was raised. Nothing seems to have been reported about any other issues while exercising at that time.[45]

48. On 12 April 2023, Mr Ward was given approval to attend the funeral of his biological grandmother. He attended the funeral in Mowanjum Uniting Church and Derby cemetery on 28 April 2023.[46]

49. He was seen by a nurse a few weeks later for treatment for a knee injury, also sustained while playing football. Again, no cardiac symptoms seem to have been raised at that time.[47]

50. On 6 June 2023, Mr Ward was transferred to Derby Prison so he could be seen at Derby Hospital ED in relation to his injured thumb. He was diagnosed with a sprained ligament. The thumb was strapped, and he was advised not to play footy again for three weeks to allow the injury to repair. It seems then that due to this injury Mr Ward had a few weeks off football, prior to the game that then led to his collapse.[48]

51. On 8 June 2023 the Parole Review Report indicated that Mr Ward had requested not to be considered for parole, and a recommendation was made that Mr Ward be denied release on parole at his own request until he had prepared a viable parole plan. He was aware he could apply for parole in the future.[49]

52. Mr Ward was referred back to the dentist in June 2023 as he reported worsening pain in his front teeth.[50] Mr Ward was reviewed by a nurse on 30 June 2023 and reported his thumb was much better and he had regained full movement. He did mention continued dental pain, so a new referral was generated to see the dentist again and he was given some mouthwash and oral gel for the pain. His dental issue had developed into another dental abscess a week later on 7 July 2023. His face was visibly swollen, and he was in pain, so he was recommenced on antibiotics and given pain relief.[51]

53. On 3 July 2023, West Kimberley Regional Prison staff were notified that a booking had been made for Mr Ward to see a cardiologist in Derby on 17 July 2023. However, he collapsed two days before this appointment.[52]

54. On 7 July 2023, Mr Ward had his last diabetes care plan visit. No new signs or symptoms were raised aside from more frequent urination at night. It was noted that Mr Ward had no issue with energy or exercise tolerance, but it doesn't appear another ECG was performed.[53]

[45] Exhibit 1, Tab 19.
[46] Exhibit 2, Tab 1.
[47] Exhibit 1, Tab 19.
[48] Exhibit 1, Tab 17 - ED Triage Form 6.6.2023 and Tab 19.
[49] Exhibit 1, Tab 15; Exhibit 2, Tab 1.19.
[50] Exhibit 2, Tab 2.
[51] Exhibit 1, Tab 17 - ED Triage Form 6.6.2023 and Tab 19.
[52] Exhibit 1, Tab 17 - Outpatient Booking Form.
[53] Exhibit 1, Tab 19.

55. A few days before his death, Mr Ward rang his mother and told her he had a toothache and his face was swollen. She recalled he told her he wasn't getting any help from the prison officers, although he was being given Panadol. The notes show Mr Ward was seen by a clinical nurse on 30 June 2023 and then again on 7 July 2023 in relation to his dental pain. The nurse had consulted a medical officer and Mr Ward had been commenced on antibiotics and prescribed Panadol and ibuprofen for 7 days from that date while he remained on the list for a dental appointment. Mr Ward was aware he was on the waitlist to see a dentist, but it seems he was still suffering with pain and discomfort in the meantime. His partner Nelita also noticed his face was swollen and he had a tooth sticking out when she visited him around this time.[54]

56. Mr Ward was otherwise feeling reasonably well by all accounts, and he was ready to get back to playing footy.

COLLAPSE ON 15 JULY 2023

57. On the morning of Saturday, 15 July 2023, Mr Ward was playing football on the oval at the prison in a regular game with other prisoners. During the second quarter at 9.44 am, Mr Ward was near the centre of the oval without anyone close to him and when the ball was not in play when he suddenly collapsed. Aspects of the incident are captured on CCTV footage, but the footage is grainy and slightly obscured by vegetation, so Mr Ward's collapse cannot be seen. However, the footage does show other inmates immediately going to his aid. Prison officers, who were nearby, were alerted and they drove a buggy onto the oval and went to where Mr Ward was lying. When they arrived, some of the prisoners said they had seen Mr Ward 'fitting' so they had put him in the recovery position.[55]

58. The prison officers observed that Mr Ward did not appear to be breathing. Prison Officer Denise Fletcher called a Code Red Medical Emergency over the radio, indicating medical help was needed on the oval, and then she called for an ambulance to attend. Meanwhile, three other prison officers moved Mr Ward onto his back and commenced CPR, while others went to get some resuscitation equipment from a nearby building. The other prisoners were directed to return to their respective accommodation but it seems many of the prisoners, including some prisoners who were related to Mr Ward, remained nearby.[56]

59. Mr Ward had a number of relatives at West Kimberley Regional Prison, including several cousins. They later told Mr Ward's mother that they were told to go back to their accommodation while Mr Ward was being resuscitated, but culturally they felt they needed to remain there so they could speak to him and call out his name to wake him up.[57] I understand that for security purposes it is standard protocol for prisoners to be sent back to their accommodation during an incident. However, I can understand Mr Ward's family members' strong desire to stay with him, particularly when the cultural basis of that desire is explained.

[54] Exhibit 1, Tab 19 and Tab 20; Exhibit 2, Tab 2.
[55] Exhibit 1, Tab 2 and Tab 5.
[56] Exhibit 1, Tab 5.
[57] Exhibit 1, Tab 20.

60. I understand the prison officers were aware some of Mr Ward's relatives were present and were watching as the resuscitation efforts were performed. Some of the officers guided the relatives away from Mr Ward, explaining they did so to ensure the prisoners did not hinder the CPR. However, they were allowed to stay nearby for a period during the resuscitation efforts, which did allow them an opportunity to try to call him back. However, once the prison officers were advised the ambulance was ready to come through to the oval, the prisoners had to leave for security reasons. Prison Officer Katy Johnson (Prison Officer Johnson) stated that she heard the radio call from the prison gate advising that the ambulance had arrived onsite, so she explained to the remaining prisoners, who were family members, that they would have to head to one of the houses nearby and be secured for the safety of the ambulance officers. The family members then left as requested.[58]

61. Prison Officer Johnson indicated in her report that she obtained permission from her senior officer to later relay some information about Mr Ward's state to the family members. She explained to them that Mr Ward was breathing, and he was going to be taken to hospital soon. She then ensured the prisoners in the remaining units were advised of his status, so that they were all aware that Mr Ward appeared to be responding to initial resuscitation efforts and was going to hospital to receive further help.[59] This does not, of course, replace the cultural requirement family members felt to be near to Mr Ward, but I accept the prison officers did what they could to alleviate Mr Ward's relatives understandable distress while following safety protocols.

62. The prison officers took turns continuing CPR. They were joined by prison health staff, who assisted with resuscitation efforts. They applied a defibrillator, which indicated one shock, which was delivered. No further shock was advised by the device. Further CPR then continued to be delivered by prison health staff and prison officers working together in turns to manage fatigue.[60]

63. The ambulance arrived at the prison at 10.07 am and was quickly let through, arriving at the oval at approximately 10.10 am. The ambulance officers observed CPR still in progress. The ambulance staff took over management of Mr Ward's airway and they also connected him to the ambulance defibrillator. They gained intravenous access and administered intravenous medications while CPR was continued by prison staff. The ambulance staff then instructed them to cease CPR as Mr Ward's pulse had returned. Further care was given onsite by ambulance officers before Mr Ward was put on to a stretcher and taken to the ambulance. The ambulance left the prison oval at approximately 10.28 am and left the prison at 10.30 am.[61]

64. Mr Ward was transported by ambulance to Derby Hospital, arriving at 10.42 am. He was noted to be unconscious but breathing following out of hospital cardiac arrest.[62]

[58] T 12; Exhibit 1, Tab 20.
[59] Exhibit 1, Tab 5.5.
[60] Exhibit 1, Tab 5.
[61] Exhibit 1, Tab 5 and Tab 19; Exhibit 2, Tab 2.
[62] Exhibit 1, Tab 17.

65. Some of Mr Ward's family, including his mother Beverley and partner Nelita, came to the hospital after being informed by family he had collapsed and was at the hospital receiving treatment. They were permitted to go in, one at a time, to see him before he was transferred by RFDS to Perth for further medical treatment. There was evidence that a security decision was made for Mr Ward to have restraints applied during the RFDS flight, given the safety issues involved as there was only one escorting officer.[63]

TREATMENT AT RPH

66. Mr Ward arrived at RPH at approximately 7.00 pm on the same day he collapsed, and I am told his restraints had been removed immediately upon his arrival into the RPH ED.[64] He was admitted to the Intensive Care Unit. Mr Ward remained a patient at RPH and continued to be managed in the ICU thereafter. He never regained consciousness and developed complications, including aspiration pneumonia and liver dysfunction, during his hospital stay. He was supervised by staff from a security contractor, Ventia and was added to the Casuarina Prison muster. It was noted that the Casuarina Prison Deputy Superintendent had approved Mr Ward have no restraints applied while he remained in a critical condition on life support in hospital. Permission was also granted for Ventia staff to sit outside Mr Ward's room when required, so long as they had him in their sight at all times.[65]

67. The Department's Director of Medical Services contacted RPH ICU staff on 16 July 2023 to obtain an update on Mr Ward's medical condition. She was advised that he was still intubated and sedated. The hospital staff were still unsure as to the cause of the medical event and it was not clear that the cause was primarily cardiac.[66]

68. Notes indicate that Mr Ward was taken off sedation for two hours on the morning of 18 July 2023, but he then developed seizure activity, so sedation was recommenced. Mr Ward's mother was contacted by the Department that day and advised of her son's condition and poor prognosis. Approval was given for family members to visit Mr Ward once they were able to get to Perth. This included Mr Ward's children, at the discretion of his partner.[67]

69. I am advised that on 19 July 2023 the Department recommended that Mr Ward should not be released via the Royal prerogative of Mercy provisions due to the lack of clarity around his medial prognosis, the serious natures of his offences, his history of family violence and his unaddressed treatment needs. It was noted Mr Ward had recently decided to decline his own parole consideration and there was no information available regarding a suitable release plan and community supports.[68]

[63] T 11, 26 - 27; Exhibit 1, Tab 5.14 and Tab 7.
[64] T 27.
[65] Exhibit 1, Tab 6 and Tab 8; Exhibit 2, Tab 1.24.1.
[66] Exhibit 2, Tab 2.
[67] Exhibit 2, Tab 1.
[68] Exhibit 2, Tab 1.

70. Notes made of a discussion with Mr Ward's treating ICU consultant on 23 July 2023 indicated that no acute ischaemia had been identified on his ECG, only old changes of inferior infarction. There was nothing to suggest a recent myocardial infarction (heart attack). It was felt that his collapse was probably an isolated cardiac event due to scar-related arrhythmia. Hypoxic ischaemic changes had been noted on his brain CT scan, taken on arrival, and his pupils had become fixed and dilated and spinal reflex had ceased, suggesting brain death. However, more testing would be performed.[69]

71. Further testing on 24 July 2023 led to a certification of brain death, noting he had sustained hypoxic ischaemic encephalopathy secondary to cardiac arrest.[70] Dr Alasdair Burns (Dr Burns), a Consultant Intensive Care Specialist, called the WA Police Coronial Inquest Squad at 4.30 pm on 24 July 2023 to advise that Mr Ward's death was imminent. Dr Burns advised Mr Ward had been assessed at 1.13 pm that same day and brain death had been confirmed. He remained on life support as the doctors were waiting for his family to attend before his life support would be ceased. His mother, partner and two daughters and brother were able to visit him on 25 July 2023 and after a discussion between his treating doctors and family members, Mr Ward's ventilator was turned off that afternoon with family members by his bedside. After doctors confirmed that Mr Ward had passed away, the room was cleared and closed to allow police officers to attend and commence the coronial investigation into his death.[71]

CAUSE AND MANNER OF DEATH

72. Forensic Pathologist Dr Nina Vagaja, performed a post-examination on 7 August 2023. The post-mortem examination showed signs of recent medical intervention, consistent with his known medical care. There was severe narrowing of arteries which supplied the heart (coronary artery atherosclerosis). The heart muscle was scarred in areas, as may occur with diminished blood supply to the heart muscle in the setting of coronary artery disease. There was some pigment staining of lung tissue, which is typically observed in smokers, and the lungs were congested, which is a non-specific finding.[72]

73. Tissue microscopy showed abundant scarring in the heart in keeping with at least two foci of previous infarctions (heart attacks). Widespread calcified coronary atherosclerosis was also confirmed, with multifocal severe narrowing (stenosis) of the coronary arteries, including evidence of an older bleed into the atherosclerotic plaque. Mild fatty change was present in the liver and kidney tissues showed some scarring as may occur with chronic diabetes and cardiovascular disease. Neuropathology examination of the brain showed global cerebral ischaemia.[73]

[69] Exhibit 1, Tab 19; Exhibit 2, Tab 2.
[70] Exhibit 1, Tab 11.
[71] Exhibit 1, Tab 2, Tab 6, Tab 11.2, Tabs 12 to 14, Tab 18 and Tab 19; Exhibit 2, Tab 24.8.
[72] Exhibit 1, Tab 8.1.
[73] Exhibit 1, Tab 8.1 and Tab 9.

74. Dr Vagaja had noted that Mr Ward had been receiving treatment for a dental infection prior to his collapse. Dental examination during the post-mortem examination showed a neglected dentition with generalised destruction due to dental caries (cavities) and there were signs of the known dental abscess for which he had been receiving treatment. Toxicology analysis did not show anything of relevance.[74]

75. Dr Vagaja reviewed Mr Ward's clinical notes and noted his history of arterial hypertension, dyslipidaemia and Type 2 diabetes mellitus, for which he was managed on medications. Dr Vagaja observed that long term diabetes mellitus is a significant risk factor for cardiovascular disease and may impair healing response of the body to illness and injury. In view of the presence of severe coronary artery disease in a relatively young man, Dr Vagaja also considered there was a possibility of hereditary cardiovascular disease.[75]

76. In conclusion, Dr Vagaja expressed the opinion the collapse and cardiac arrest occurred most likely due to atherosclerotic heart disease, which was severe. The underlying diabetes mellitus, although relatively well controlled, would have represented a chronic physiological burden to Mr Ward's body and would have contributed to his overall risk of cardiovascular disease and imminent death. Dr Vagaja expressed the opinion Mr Ward's death was consistent with natural causes.[76]

77. I accept and adopt Dr Vagaja's opinion as to the cause and manner of death. I find Mr Ward passed away as a result of complications of out of hospital cardiac arrest in a man with atherosclerotic cardiovascular disease and diabetes mellitus. The manner of his passing was by way of natural causes.[77]

EXPERT CARDIOLOGY OPINION

78. Dr Alan Whelan (Dr Whelan) is an Interventional Cardiologist who practises at Fiona Stanley Hospital and Advara Heart Care. At the request of the Court, Dr Whelan reviewed Mr Ward's medical records and provided an expert opinion in relation to Mr Ward's known cardiac issues and his cause of death. This included an opinion as to whether Mr Ward's death might have been prevented if he had been reviewed by a cardiologist prior to his death. Dr Whelan provided a written report and also gave evidence at the inquest.

79. Dr Whelan was able to make a very realistic assessment of the kind of health issues Mr Ward faced and the services that would have been available to Mr Ward in the Kimberley, as Dr Whelan regularly provides cardiology services to patients in the Pilbara region of Western Australia. He observed the Pilbara region experiences many of the same challenges in providing specialist healthcare as the far north of the state.[78]

[74] Exhibit 1, Tab 8.1, 8.2 and Tab 10.
[75] Exhibit 1, Tab 8.1.
[76] Exhibit 1, Tab 8.2.
[77] Exhibit 1, Tab 8.2.
[78] T 40; Exhibit 1, Tab 21.

80. From his review of the records, Dr Whelan observed that Mr Ward was "a patient at increased cardiovascular risk (Indigenous, Type 2 Diabetes, Hypertension, Hypercholesterolaemia, Smoking and Family History ….)."[79] Dr Whelan noted that a routine health check at West Kimberley Regional Prison identified Mr Ward's increased cardiovascular risk and a routine ECG reportedly demonstrated evidence of a prior inferior myocardial infarction (heart attack - commonly a blockage of a heart artery causing heart muscle damage), although the ECG was not available for Dr Whelan to review.[80]

81. The heart attack would have occurred sometime before it was detected on Mr Ward's ECG and it seems Mr Ward was unaware it had occurred. Dr Whelan explained at the inquest that the symptoms of a heart attack commonly last from some hours to typically at most six to 12 hours. He noted that symptoms in diabetics are often atypical, and Mr Ward had a longstanding history of diabetes. Mr Ward may have simply dismissed his heart attack symptoms at the time as being indigestion or nonspecific chest discomfort. Dr Whelan commented that unfortunately many people having a myocardial infarction may not seek medical attention at the time, for a variety of reasons, as seems to have occurred with Mr Ward. Therefore, what was picked up on the ECG was the signs that Mr Ward had experienced a heart attack in the past, and his heart muscle had suffered some damage as a result. As to when the heart attack may have occurred, Dr Whelan gave evidence the event could have occurred anytime from days to years prior to the ECG.[81]

82. Dr Whelan noted that Mr Ward was appropriately referred for an exercise stress test (EST) and cardiology review on a semi-urgent basis on 10 October 2021. Dr Whelan explained at the inquest that the purpose of the EST is that when the heart is under load, if the blood supply is inadequate (reflecting narrowing/blockages) the doctors may see changes on an ECG or the patient may volunteer symptoms suspicious for angina (inadequate blood supply). Dr Whelan suggested the EST may have been normal or abnormal, by which he meant it may well have shown evidence of a prior inferior myocardial infarction. It may also have shown changes when the heart was under load suggesting inducible myocardial ischaemia, but it was also possible that Mr Ward may have not had any ECG changes or symptoms raising concern.[82]

83. Dr Whelan also observed Mr Ward was on reasonable medical therapy for cardiovascular risk, namely treatment for his diabetes, hypertension and hypercholesterolaemia. Dr Whelan gave evidence Mr Ward could also have been put on regular aspirin, but if he had no symptoms whilst playing regular football, then he could see why no additional medication had been provided.[83]

84. Dr Whelan noted the referral was received and then triaged as a Category 3 for an EST and possibly a clinic appointment on the same day at Derby Hospital. Dr Whelan understood this process would have been overseen by Perth

[79] Exhibit 1, Tab 21, p. 1.
[80] T 40.
[81] T 40 - 41.
[82] T 40 - 41; Exhibit 1, Tab 21.
[83] T 40 - 41, 50; Exhibit 1, Tab 21.

Cardiovascular Institute. From the records, Dr Whelan established that a booking for an EST at Derby Hospital was made for Mr Ward for 22 February 2022. The evidence indicates that Mr Ward did not attend the appointment and Dr Whelan's enquiries established that Derby Hospital staff were advised that Mr Ward would not be attending due to the prevalence of COVID-19 in West Kimberley Regional Prison at the time. However, it was then incorrectly marked as 'attended', rather than 'non-attendance'.[84]

85. Dr Whelan's enquiries established that Perth Cardiovascular Institute (PCI) eventually identified through its own internal processes that the EST had not occurred within the recommended period for a Category 3 triage (a period of 12 months). It appears this prompted staff from PCI to contact Derby Hospital advising that the test had not occurred, which led to the test being rebooked for 18 July 2023. This booking was approximately 21 months after the initial referral was made.[85]

86. Although this was a lengthy period Dr Whelan noted that Mr Ward was seen for other health issues in the intervening period. This included an admission at Derby Hospital on 7 February 2023 for treatment for his dental abscess. There were no concerns volunteered regarding Mr Ward's cardiovascular health during this admission, and he continued to be prescribed appropriate medical therapy for his identified cardiovascular risk factors at this time.[86] Mr Ward was also seen again at the Derby Hospital ED on 6 June 2023 for treatment for his injury sustained while playing football. Once again, no concerns were volunteered regarding his cardiovascular health, and specifically Mr Ward made no comments regarding experiencing any exercise-induced cardiovascular symptoms whilst playing football.[87]

87. In the materials provided to Dr Whelan, there was no information as to whether Mr Ward had complained of any cardiac issues or symptoms of concern immediately prior to his collapse, so he assumed he had not been feeling significant chest discomfort. There is evidence after Mr Ward's collapse the Security Manager interviewed some of Mr Ward's cellmates to ascertain if he had said or done anything to indicate he was unwell before the football game. They reported they had not noticed any uncharacteristic behaviour or any signs he might be unwell in the days leading up to the event. They only thing they could recall of significance was that he had not taken his morning medication as he had not presented to the medication parade, despite being called over the PA system.[88]

88. The bystander accounts of Mr Ward's collapse also suggest the event occurred suddenly and without any warning. Although the timings were not clear from the information provided, Dr Whelan observed that there appeared to have been a quick response by prison staff to commence CPR, which continued for a prolonged period of approximately 20 minutes before Mr Ward had a return of spontaneous circulation

[84] Exhibit 1, Tab 21.
[85] T 42; Exhibit 1, Tab 21.
[86] Exhibit 1, Tab 21.
[87] Exhibit 1, Tab 21.
[88] Exhibit 1, Tab 5.14 and Tab 21.

(ROSC). Dr Whelan observed that the "prolonged period of CPR prior to ROSC in the context of an out of hospital cardiac arrest, unfortunately is typically associated with a very poor clinical and neurological outcome."[89]

89. At the time of his arrival at Derby Hospital at 10.42 am, around an hour after he first collapsed, Mr Ward was haemodynamically stable but with a GCS of 3 and a lactate of 12.7, which suggests a poor prognosis. The ECG's done on, or near, his arrival at the hospital suggested a prior inferior myocardial infarction (as previously recorded on the prison ECG's) and some non-specific ECG changes were noted, but there were no changes to suggest an acute myocardial infarction. It seemed most likely that his collapse was due to ischaemia.[90]

90. In Dr Whelan's opinion, all of the care provided at Derby Hospital prior to his transfer to Perth was consistent with expected practices and standards of care, and there was nothing to suggest the care provided by RFDS and RPH was anything other than appropriate and in keeping with Mr Ward's clinical presentation, although Dr Whelan did not review those records.[91]

91. Of relevance, an echocardiogram done at RPH after Mr Ward's admission was noted to demonstrate an ejection fraction of ˜45% (mild to moderately impaired) with regional variability consistent with ischaemic heart disease and prior inferior myocardial infarction.[92] I will return to this later.

92. Based on the information provided, Dr Whelan expressed the opinion the initial referral for an EST and cardiology opinion was appropriate and it was also appropriate that Mr Ward was established on standard medical therapy for his identified risk factors in the interim. Dr Whelan observed that the plan it to optimise management of those risk factors, which "reduces risk but never negates risk."[93] Dr Whelan was aware of the cause of death and he noted that the post-mortem revealed Mr Ward had "fairly established cardiovascular disease at a very young age,"[94] which could have been explained by his number of risk factors, as well as possibly a genetic component.

93. Dr Whelan also considered the triage process was reasonable, given Mr Ward was asymptomatic and already received medications for his risk factors. Dr Whelan observed the timing of an EST around four months after the receipt of the referral (noting the original February 2022 booking) was well within the recommended timeframe for a patient triaged to a Category 3 appointment and nears the timeframe recommended for a patient triaged to a Category 2 appointment (within 90 days).[95]

94. The issue in this case arose when the 22 February 2022 appointment was marked as having been 'attended' when it had not. Dr Whelan commented that this "is an error

[89] Exhibit 1, Tab 21, p. 2.
[90] T 47; Exhibit 1, Tab 21.
[91] Exhibit 1, Tab 21.
[92] Exhibit 1, Tab 21.
[93] T 44.
[94] T 46.
[95] T 43; Exhibit 1, Tab 21.

and presumably resulted in a further appointment not being scheduled at that time."[96] It took some time for the error to be identified, but PCI processes did appropriately identify that the test had not taken place within one year and PCI then alerted Derby Hospital, so that a further appointment could be scheduled. This new booking was made for 18 July 2023. Regrettably, this appointment was scheduled for three days after Mr Ward's collapse.[97]

95. Dr Whelan observed that Mr Ward had presented to Derby Hospital twice in the lead up to his collapse for other issues, in February and again in June. No issues were raised at the time regarding any cardiac symptoms that may have raised concerns, which suggests he remained asymptomatic. Dr Whelan observed that being a diabetic, it is possible Mr Ward did not have typical symptoms. Dr Whelan explained that absence of chest discomfort is a well-described phenomenon in long term diabetics if they are getting angina; they are more troubled by shortness of breath as a symptom, rather than the symptom of chest pain that we are taught to look for in such cases. Also, associated autonomic neuropathy may also mean that chest discomfort is less prevalent in some diabetics.[98]

96. The collapse occurred whilst Mr Ward was playing football and Dr Whelan noted it was of uncertain mechanism. Dr Whelan explained that "hearts that have been scarred always have the potential to trigger heart rhythm disturbances that can translate into collapse. A heart muscle territory that is deprived of … blood and oxygen, acutely also has the potential to trigger a heart rhythm disturbance that would lead to collapse."[99] In this case, Dr Whelan felt it was difficult to say whether it was the former or the latter, but it would probably have been one or the other. Dr Whelan noted that the post mortem report indicated that Mr Ward's arteries were significantly narrowed, suggesting ischaemia was the more likely cause.[100]

97. While it is unclear whether he had symptoms of concern immediately prior to his collapse, information now provided indicates he had not mentioned any concerns to any of his associates in the days or hours leading up to the game. This included some of his relatives who were also in the prison with him. After the event, the echocardiogram performed at RPH demonstrated an ejection fraction of around 45%, (normal being 55% or greater) with some regional variability. This result is consistent with a prior inferior myocardial infarction, which is the same result that was identified on the ECG's taken in the prison.[101]

98. Considering the above, Dr Whelan was asked to comment on whether it was likely an earlier EST, either in February 2022 or sometime before July 2023, might have changed the outcome for Mr Ward. Dr Whelan acknowledged that one can only speculate on this matter but noted that Mr Ward was asymptomatic at the time of the referral, and he continued to play football without volunteering any symptoms of concern. Therefore, Dr Whelan expressed the opinion, "it is entirely possible the EST

[96] Exhibit 1, Tab 21, p. 3.
[97] Exhibit 1, Tab 21.
[98] T 43, 48 - 49; Exhibit 1, Tab 21.
[99] T 43.
[100] T 43, 47.
[101] Exhibit 1, Tab 21.

would have been "negative" and not shown evidence of 'ischaemic burden' when he exerted himself. That is, he may not have had any ECG changes raising concern or any other symptoms raising concern.[102]

99. If the EST had been normal, the focus would have continued to be on modifiable cardiovascular risk factors and likely addition of aspirin to the current medical therapy. A diagnosis of underlying ischaemic heart disease being likely, Mr Ward already appears to have been on reasonable preventative medical therapy (assuming a negative EST).[103]

100. If, however, the EST had been abnormal then further assessment would likely have been arranged. Dr Whelan explained this would likely have been an echocardiogram, which is an ultrasound of the heart showing overall function, or else a coronary angiogram. The echocardiogram would be readily available in the Kimberley, but an angiogram would have required Mr Ward to be sent to Perth as it is not available in the north of the state.[104]

101. Any assessment on whether the EST not occurring altered the outcome is speculative. However, the EST occurring as scheduled, would of course, have been ideal."[105] Nevertheless, based upon the later findings of the echocardiogram performed at RPH shortly before Mr Ward's death, Dr Whelan considered the ejection fraction of 45% (assuming the ejection fraction was similar previously) meant Mr Ward would not have been considered for an internal defibrillator had he had an echocardiogram at an earlier stage.[106]

102. Dr Whelan explained at the inquest that in reaching this conclusion, he was trying to understand what might have been done differently had medical care been provided differently. So, if, theoretically, Mr Ward had undergone the stress test and then had an echocardiogram performed and his ejection fraction is less than 35% (indicating more damaged heart muscles) despite optimal medical therapy, patients can be considered for internal defibrillators, which are there to treat acute rhythm disturbances. However, given his ejection fraction was higher (around 45%) then he would not have had a defibrillator put in place. So, although a defibrillator would have protected him from a sudden cardiac arrhythmia whilst out in the community, it can be concluded that Mr Ward would not likely have had such a defibrillator even if the echocardiogram was performed at an earlier time.[107]

103. An angiogram would have shown the state of Mr Ward's coronary arteries, and would definitely have shown some ischaemia, but Dr Whelan noted that the arteries may not appeared the same as they did at the time of his collapse (as identified in the post mortem examination) as things evolve. If an angiogram had been performed, and ischaemia identified, it could have led to a stent being inserted to improve blood supply to the heart muscle. This can help ensure blood supply to the heart when the

[102] T 41, 53 -54; Exhibit 1, Tab 21.
[103] Exhibit 1, Tab 21, p. 4.
[104] T 41 - 42.
[105] Exhibit 1, Tab 21, p. 4.
[106] Exhibit 1, Tab 21.
[107] T 44.

heart is under load, such as when exercising. Nevertheless, Dr Whelan observed that "[a]dverse cardiovascular outcomes unfortunately still occur despite best medical practices and optimal management of cardiovascular risk factors."[108] Therefore, he could still experience an adverse cardiac event if a stent had been inserted.[109]

104. Dr Whelan also explained in his evidence that "[o]ut of hospital cardiac arrest, even with immediate bystander CPR of good quality, unfortunately has very adverse cardiovascular and neurological outcomes, and survival is uncommon."[110] Dr Whelan commented that "even within minutes of compromise of blood supply to the brain, [the brain] starts to suffer irreversible damage," and with CPR there will always be suboptimal brain perfusion. Therefore, it does not seem likely that any issues of timing/quality of CPR would have been an issue in this case, assuming that his assumptions about the quick response of prison officers was incorrect.[111]

105. Dr Whelan also did not find surprising or unusual the fact Mr Ward's originally booked EST in February 2022 may not have proceeded due to protocols in place for COVID, Dr Whelan commented that it "is well established that the protocols around COVID contributed to adverse health outcomes worldwide, especially cardiovascular outcomes."[112] However, he did concede that by that time he had thought lockdowns were less common.[113]

106. In summary, Dr Whelan considered the most significant issue was the error in identifying the EST appointment in February 2022 as having been attended, instead of recording a cancellation and then rescheduling promptly. However, due to the appropriate processes at PCI, this error was eventually identified, and Derby Hospital/WA Country Health Service (WACHS) were alerted to ensure that a further appointment was scheduled. Dr Whelan observed that had there been a high level of clinical concern regarding the delay in the interim, the prison health medical officers could have re-referred Mr Ward or contacted Derby Hospital. It appears that the missed appointment was simply overlooked, and because Mr Ward was asymptomatic, the issue did not arise. Dr Whelan also observed that Mr Ward had a potential opportunity to raise any health concerns himself on two occasions when he presented to Derby Hospital in 2023, including during a brief admission, but he expressed no concerns.[114]

107. Dr Whelan observed that "even patients in whom we do everything perfectly, adverse cardiovascular events still do occur,"[115] so he could not say that Mr Ward would not have suffered this event if the missed EST had not occurred. Put another way, Dr Whelan considered that "if the missed stress test had occurred when originally scheduled, there would have been a greater chance of a different outcome, but not a guarantee."[116]

[108] T 47.
[109] T 48.
[110] T 45.
[111] T 45.
[112] Exhibit 1, Tab 21, p. 4.
[113] T 49.
[114] Exhibit 1, Tab 21.
[115] T 44.
[116] T 55.

108. As someone who has been providing cardiology services to the community of WA for a prolonged period of time, with particular reference to the Pilbara community, Dr Whelan also made some general comments relevant to this inquest. Dr Whelan commented that:[117]

> *Sudden cardiac death (SCD) unfortunately is a not infrequent cause of presentation to emergency departments. Out of hospital cardiac arrest due to ischaemic heart disease is the leading cause of SCD. SCD can occur in patients on optimal medical therapy and after all investigations and treatments have been implemented. It often occurs in patients that had been asymptomatic until that moment and cannot typically be predicted or necessarily prevented.*
>
> *Provision of Health Care to the Indigenous populations of the Pilbara (personal experience) and the Kimberly (presumed and from discussions with colleagues) presents unique challenges. There is a relatively high rate on non-attendance (DNA) of appointments (multiple reasons including communication, transport, contact, incarceration, itinerant population, remote locations/distance and more). Resources are sub-optimal (access to testing and consultation, hospital resources, general practitioners, etc.). The high "DNA rate", ˜30-40% for some clinics, also adds to the complexity of healthcare delivery. The combination of these factors and others, sadly leads to poor healthcare outcomes in a substantially at-risk population. How to address these issues is beyond the scope of this report however the very sad outcome relating to [Mr Ward] serves as another, most unfortunate reminder that the community, health care industry and as a nation, we have a long way to go and need to do better.*
>
> *May [Mr Ward] RIP.*

109. Dr Whelan emphasised in his evidence at the inquest that he is supportive of any steps that can be taken to improve health care delivery in the remote parts of Western Australia and the patients who attend clinics in those areas, in particular the many First Nations patients. In his view, people such as Mr Ward should not be dying of coronary artery disease and "[w]e need to do more" to ensure that there is good preventative care to reduce the risk factors that lead to a young man like Mr Ward suffering from significant coronary artery disease.[118]

110. Dr Whelan acknowledged that providing health care to prisoners is difficult, given the patients often move between prisons, as well as in and out of prison and the community. With specialist appointments often being scheduled some time in the future, missed appointments are not uncommon. Dr Whelan commented that there are "genuine barriers as to how adequate health care can be delivered"[119] in such circumstances. Nevertheless, with his considerable experience in this area, Dr Whelan suggested there needs to be a focus on how we can do it better and learn lessons from sad cases such as Mr Ward's.

[117] Exhibit 1, Tab 21, pp. 4 - 5.
[118] T 51 - 52.
[119] T 52.

PRISON HEALTH SERVICES SUMMARY

111. The Department's Deputy Director of Medical Services, Dr Catherine Gunson (Dr Gunson), authored a summary of the health care provided to Mr Ward while in custody, which was approved by the Director, Justice Health & Wellbeing Service, on 30 March 2025. Dr Gunson also spoke to the health record review at the inquest. The main focus of the review was, quite appropriately, Mr Ward's final term in custody, although earlier relevant periods were also referenced.[120]

112. It was noted that Mr Ward had several documented medical conditions, including Type 2 Diabetes, hypertension and dyslipidaemia. He was a known smoker with what he described as 'moderate' alcohol intake when he was out in the community. Mr Ward also reported that he would not take his prescribed medications when in the community, so it was recognised that the majority of his consistent health care was delivered when he was in custody. The prison's health care team were mindful of this, and they encouraged him to cease smoking and continue consistent health care both when incarcerated and out in the community. There was a strong focus by prison health staff on optimising the treatment of Mr Ward's chronic health conditions and minimising his risk factors for disease progression, including regular chronic disease care plan reviews. He also had allied health reviews such as podiatry and optometry as part of his routine preventative diabetes care.[121]

113. The primary issue identified in the Department's health care review was the cardiology review. It was noted that at his reception into prison on the last occasion, routine electrocardiograms (ECG's) were scheduled annually. Given Mr Ward's young age, he would not ordinarily have undergone an ECG on admission to prison. The practice was ordinarily reserved for Indigenous prisoners over the age of 35 years. However, given his background of diabetes and high blood pressure, Mr Ward was proactively included in the group. This enabled the medical officer to identify new changes in Mr Ward's ECG in 2021 and then refer him for testing and cardiologist review. Thereafter, his ECG's were scheduled to be done six monthly given his abnormal result. Unfortunately, whilst he was referred for an exercise stress test, it was accepted this had not been done before Mr Ward's sudden death. It was noted that the hospital team appeared to have changed the triage category from Category 2 (up to 90 days) to a Category 3 (up to 365 days), but the appointment was still scheduled in a timely manner for February 2022. However, he did not attend.[122]

114. Dr Gunson advised at the inquest that investigations by the Department's health staff identified the external appointment was not recorded in the custodial software and there was no note in the medical case notes to suggest a reason for non-attendance. Although lockdown for COVID had been earlier suggested by Derby Hospital as the reason for non-attendance, Dr Gunson found nothing in the Department's health records to indicate this had been the case. Dr Gunson gave evidence that in her experience there is usually a record of any such interaction with a hospital, but there was nothing in this case that showed any record of the external appointment. Dr Gunson speculated the appointment notification may have been sent to the

[120] Exhibit 2, Tab 2.
[121] Exhibit 2, Tab 2.
[122] T 58, 72; Exhibit 2, Tab 2.

incorrect address, which would have meant the Department was unaware it was booked.[123]

115. Dr Gunson accepted that the Department has not had a reliable system for tracking referrals in the past. In this case, if there had been a better referral tracking system in place, prison health staff would likely have been prompted to follow up with the hospital once around six months from the original referral had elapsed, which would have identified that they had not been informed of the February 2022 booking. This might have enabled Mr Ward to have a new appointment booked at a much earlier stage as the hospital would have become aware that he had not attended (contrary to their records) at that time, rather than when PCI identified the problem some 12 months down the track.[124]

116. In terms of the impact of the missed appointment, Dr Gunson noted Dr Whelan's opinion that the results of the exercise stress test may not have shown anything and may not have led to any major investigations. Although it is speculative, as the appointment was missed, Dr Gunson did observe that Mr Ward was playing sport every weekend and exercised daily, so "in a way, he was almost doing his own stress tests every day and every weekend."[125] Without an ECG monitoring his heart during this physical activity, the full impact of exercise on his heart can't be known, but he seemed generally to be coping with strenuous activity without symptoms. Dr Gunson commented that given his very young age and the fact he was on appropriate medical therapy, and generally a healthy weight and exercising, he may have flown a little under the radar in terms of his risk. Dr Gunson agreed with Dr Whelan that Mr Ward's lack of traditional symptom of chest pain may have been related to his diabetes.[126]

117. Dr Gunson advised that while it is still under development, the Justice and Health Wellbeing Service now uses a referral method that records and updates the status of patient referrals within the Electronic Health Record, which means that a practitioner can see at a glance if the referral has been accepted, the triage category and whether an appointment has been made (although the date of the appointment may not be shown). This allows better tracking of the referral and an opportunity to identify delays or missed appointments. Dr Gunson gave evidence the new referral process is in use but still being streamlined as they try to make it easy and fast to use.[127]

118. Additionally, as part of their onboarding education into the prison health system, medical officers are taught that when they send a specialist referral they should record the date of the referral next to the diagnosis on the patient's 'Problem List'. Medical officers are also asked to schedule a follow-up administrative intervention to check on the status of the referral, usually for two to three months after the referral has been sent. This ensures that if there is no appointment booked, it can be appropriately followed up.[128]

[123] T 58 - 59; Exhibit 2, Tab 2.
[124] T 61 - 62, 74.
[125] T 64 - 65.
[126] T 64 - 66.
[127] T 61 - 62; Exhibit 2, Tab 2.
[128] T 61 - 62; Exhibit 2, Tab 2.

119. In relation to the CPR provided to Mr Ward on the oval, Dr Gunson indicated she had not been able to view the CCTV footage, but I note that much of the relevant events was obscured by trees anyway. Dr Gunson did, however, note that Mr Ward had a return of spontaneous circulation recorded quite quickly with early defibrillation, which was a positive sign.[129]

120. Similar to some of the concerns raised by Dr Whelan about the challenges of providing health care in regional areas and the particular challenges for First Nations people, Dr Gunson noted that a study published in 2021 estimated that 37% of all deaths, and 50% of deaths in First Nations people aged 45 years or over, are caused by smoking. Even smoking at a 'light' level (1 to 14 cigarettes per day) triples the mortality risk compared to a person who has never smoked. Further, smoking for a person with diabetes, like Mr Ward, is an added risk.[130]

121. Mr Ward was regularly counselled and educated on smoking cessation, and he had been interested in doing so and sought support every now and then with that aim in mind. He did reduce his levels of smoking during his time in custody down to around five cigarettes per day at the time of his death, with some periods of total cessation. However, given his cardiovascular risk, any kind of smoking remained a major health risk for him.[131]

122. Dr Gunson observed that "cessation can be difficult to achieve in an environment where a person is surrounded by others who continue to smoke."[132] That is the case in Western Australian male prisons currently. Dr Gunson emphasised that while First Nations peoples form a small proportion (3.8%) of the Australian population, they are over-represented in the custodial system; they are incarcerated at much higher rates (more than 14 times higher) than non-Indigenous Australians and make up 35% of the total prison population overall. Western Australia has the second highest incarceration rate (44.9%) for First Nations people in Australia, after the Northern Territory. Therefore, when we consider that smoking is prevalent in prisons and is currently one of the only remaining places where it is permitted in confined communal spaces, it could be said to be a significant factor in poor health outcomes for Indigenous people in Western Australia. Accordingly, as Dr Gunson comments, any interventions which would improve health and [reduce] morbidity and mortality in this vulnerable population, are imperative. Encouragement and facilitation of smoking cessation is clearly one such intervention."[133]

123. The Department of Justice is currently in the process of phasing in smoke-free prisons, which would align Western Australia with all other Australian states and territories. Dr Gunson observed that it would be expected that the health impact from this strategy will be significant in terms of both prevention and management of major and minor health issues for all prisoners. However, at the time of the inquest the only two facilities in Western Australia operating smoke free were Melaleuca and

[129] T 65.
[130] T 63; Exhibit 2, Tab 2.
[131] T 63; Exhibit 2, Tab 2.
[132] Exhibit 2, Tab 2, p. 21.
[133] Exhibit , Tab 2, p. 22.

Bandyup Women's Prisons, and it had not been rolled out to any of the male prisons. Dr Gunson indicated it was forecast that by the end of 2025, all Department of Justice facilities, including all male prisons, would be smoke-free, but I understand that this is no longer the case, with the reasons set out below.

124. In another inquest into the death of Sam Lynch at Hakea Prison, which was heard and delivered earlier this year, the issue of smoking in prisons was considered in the context of a fire that caused the death of Mr Lynch. The presiding Coroner made a recommendation the Department should expedite a ban on smoking at Hakea Prison, with suitable measures to assist and support prisoners through the process of involuntary cessation of smoking. I understand the Department indicated it supported the recommendation in principle. The Commissioner's Operating Policy and Procedure (COPP) 6.7 Smoke Free Prisons is a procedure to assist each superintendent of the various custodial sites to develop a smoking cessation support strategy for their prison and there was a plan to commence with the women's prisons, then the mixed (women/men) regional facilities, then followed by the male estate, with all facilities having transitioned to smoke-free by 31 July 2025.[134]

125. However, in March 2025, the Deputy Commissioner (Operational Support) advised the Court that the Smoke-Free Policy was paused due to what was described as "unprecedented prisoner population pressures, which also saw a rapid rise in critical incidents."[135] As a result, the state-wide implementation was anticipated to be delayed by 12 months to May 2026 to ensure the safety and good order of prisons and manage the risk to staff and prisoner safety. His Honour Coroner Jenkin acknowledged the possible safety issues that the ban of smoking will raise but also observed that women's prisons in Western Australia have been smoke-free since 2024, and Western Australia remains the last state where smoking is permitted in male prisons. Smoking in prisons carries with it the additional risk that prisoners continue to have free access to cigarette lighters, which was relevant to the death in that inquest.[136]

126. I accept Dr Gunson's evidence that smoking is a relevant factor to consider in connection to Mr Ward's death, given his continued smoking would have contributed to his significant cardiovascular risk and his significant time in custody in a male prison made him vulnerable to exposure to smoking, even if he wanted to cease. However, I do not consider it is so sufficiently connected to the death that it is appropriate for me to make a specific recommendation in relation to banning smoking at West Kimberley Regional Prison. Nevertheless, the Department is on notice that this Court considers the risk to all prisoners, and particularly vulnerable people like Mr Ward and other First Nations people, has been clearly identified and needs to be addressed by proactive effort to make all prisons in Western Australia smoke-free on an urgent basis. The reasons given for the delay in the rollout of the Smoke-Free Policy beyond the female prisons are unlikely to change in the foreseeable future, so the Department will simply have to find a way to manage the

[134] *Inquest into the death of Sam Phillip Chisholm Lynch* [2025] WACOR 27, delivered 12 June 2025 (Coroner Jenkin) - Recommendation No 2; Exhibit 3.
[135] Exhibit 3, p. 4.
[136] *Inquest into the death of Sam Phillip Chisholm Lynch* [2025] WACOR 27, delivered 12 June 2025 - Recommendation No 2; Exhibit 3.

expected behavioural issues that may initially arise, as per the suggestions included in Coroner Jenkin's recommendation in the *Lynch* inquest matter.

127. I also note the submission made by Ms Ward that access to an Aboriginal Health Liaison Officer might have assisted her son to better understand, and engage with, some of the preventative health care options.[137]

128. The Department correctly noted in its responsive submissions that ultimately it is a matter for the prison whether they wish to stop smoking and there is no direct evidence that an AHLO would have impacted upon Mr Ward's view in this regard. However, the Department also advised (consistent with Dr Gunson's evidence) that it continues to actively try to recruit persons to fill AHLO roles, including at West Kimberley Regional Prison, to assist prisoners who would benefit from having a person in this role. Therefore, I do not consider I need to take this issue any further, other than to encourage the Department to continue to make all efforts to recruit Aboriginal health workers for this prison and others in the regions.[138]

129. Finally, in relation to smoking in prisons, until the bans come into place, I note that there have been issues around the cost of the medications available to assist with smoking cessation. Dr Gunson observed in her evidence that whilst these medications are provided by the Department at a subsidised rate, they still have to be self-funded by prisoners. Dr Gunson suggested this may present as a barrier to some prisoners, and it could be made easier to engage them if they did not have to set aside money for these medications. However, I note that in previous inquests I heard evidence from the former Director of Medical Services, Dr Joy Rowland, to the effect that it was considered that having to pay some money towards the medication would encourage those prisoners to follow through with the course of treatment as they had invested in it. I can see both schools of thought have some validity. I am not in a position to resolve it at this stage, but I raise it here as if the smoking ban comes into effect, I assume the Department will need to reconsider how it funds such medications as part of a general security and safety management issue.[139]

OTHER COMMENTS ON TREATMENT, SUPERVISION AND CARE

130. As part of the Death in Custody Review, consideration was given to the qualifications of the prison officers who provided CPR to Mr Ward. It was noted they all had appropriate training, and the majority were current. It appeared that all appropriate efforts were made to provide Mr Ward with timely and effective CPR, and it was noted in the records that the ambulance officers commended the prison staff on their efforts upon their arrival.[140]

131. I accept that during Mr Ward's time in custody, and particularly during his last period of incarceration, he received holistic and patient-centred care. By his own admission, he did not prioritise his health when in the community, so I accept that his

[137] Submissions filed on behalf of Beverley Ward dated 31 October 2025.
[138] T 74 - 75; Closing Submissions of the Department of justice and the WACHS filed 12 December 2025.
[139] T 79.
[140] Exhibit 1, Tab 19; Exhibit 2, Tab 3.

chronic health conditions were likely better managed in the last years before his death. He was generally taking his recommended medications for his most significant medical issues and he was receiving blood tests and nursing reviews, along with ongoing encouragement and support to cease smoking. It was through his regular health reviews and testing that his potential cardiac issues were identified, noting it appeared Mr Ward had unknowingly already experienced a cardiac event that was identified by the ECG, which prompted the cardiology referral.[141]

132. Unfortunately, a hospital clinic error meant that when Mr Ward did not attend his first scheduled appointment, it was erroneously noted in the hospital records that he had attended. This led to a significant delay until the error was identified through internal processes and a new appointment scheduled. As a result, Mr Ward did not undergo the testing and cardiology review that his doctor had through was necessary and appropriate. I accept that the Department's health team has now put in place better processes to ensure that such errors can be prevented or corrected in a timely fashion, but it is regrettable that at the time the systems were not in place, so the error was not picked up internally by the Department.

133. I note that Mr Ward did not proactively raise any cardiac concerns or query why he had not received the recommended exercise stress test and cardiology review. However, I also acknowledge that Mr Ward's level of literacy about his health seemed to be limited, so it was not reasonable to have expected him to identify the error on his own.

134. What is more important is that Mr Ward appears to have remained asymptomatic for any cardiac issues. He was proactive in seeking medical attention when he suffered from other injuries or pain, so it is reasonable to expect that if he had been experiencing cardiac symptoms that were troubling him, he would have mentioned it to prison health staff, whom he saw regularly.

135. As noted above, in Dr Whelan's expert opinion even if Mr Ward had an echocardiogram at an earlier stage, it is unlikely he would have been considered for an internal defibrillator, which might have prevented his heart event on the football field. In any event, Dr Whelan observed that adverse cardiovascular outcomes can occur even with optimal management, so further steps may not have prevented his collapse. Nevertheless, earlier testing would have been ideal and potentially could have led to action being taken to reduce Mr Ward's risk of a fatal cardiac event.

136. In that context, Mr Ward's mother Beverley Ward (Beverley) submitted that there were missed opportunities in the preventative medical care the Department of Justice provided to Mr Ward, and in particular a missed opportunity to investigate and treat his cardiac issues. Beverley also submitted that the WACHS failed to identify that the first cardiology appointment booked for 22 February 2022 was missed until 3 July 2023 (which was 630 days after the original referral and 496 days after the first appointment) and thus the WACHS did not meet the time limit required by its own policy. [142]

[141] T 40.
[142] Submissions filed on behalf of Beverley Ward dated 31 October 2025.

137. The WACHS and the Department "accept that an opportunity to take steps to seek [to] ensure Mr Ward's specialist appointment was rebooked and attended within the appropriate timeframe (12 months) was missed in light of absent and/or erroneous records."[143] While accepting this was a missed opportunity, the Department also points to Dr Whelan's independent opinion, as well as Dr Gunson's, that it is not clear that any earlier testing would have led to interventions that would have prevented Mr Ward's death, as I have noted above. Both doctors gave evidence that it was entirely possible an exercise stress test may not have evidenced any abnormalities, so Mr Ward's treatment may not have differed significantly, particularly noting Mr Ward was asymptomatic.

138. Taking the evidence before me at its highest, I am satisfied there was a missed opportunity to investigate Mr Ward's cardiovascular health through an exercise stress test, due to the failure by the Department and WACHS to identify the appointment had been missed for a lengthy period. Such testing *may* have identified that Mr Ward required further cardiovascular testing/intervention, but I cannot find conclusively that it would have prevented Mr Ward's death, given the many unknowns.

139. I note that following an inquest into the death of Seth Gregory Yeeda, who died in 2018 at West Kimberley Regional Prison from rheumatic heart disease, her Honour State Coroner Fogliani, made recommendations that the Department and WACHS work together to improve the referral system and implement a Referral Tracking System. The recommendations were delivered in July 2022 and the Minister for Corrective Services confirmed the Department of Justice was working to progress the recommendations in June 2023, shortly before Mr Ward's sudden death.[144] I am advised that the Department and WACHS have since taken steps to improve their referral processes, ensuring that the referrals are tracked within the Electronic Health Record at all prisons. In these circumstances, I do not consider it is necessary for me to make any further recommendation in this regard.[145]

OTHER FAMILY CONCERNS

140. The submissions filed on behalf of Beverley also raise concerns about the lack of footage capturing the immediate response of prison staff, in particular the performance of CPR on Mr Ward, on the oval and the fact that the reports by the prison officers were not sworn evidence. This was within the context that Mr Ward's family heard several rumours that it took some time for CPR to commence, and it is also suggested there were potential delays in the ambulance attending, although it is accepted that the SJA records show an ambulance was requested at 9.50 am and other evidence indicates he collapsed at 9.44 am. Given the prison officers had to make their way onto the oval and establish Mr Ward had collapsed, rather than

[143] Closing Submissions of the Department of Justice and the WA Country Health Service filed 12 December 2025.
[144] *Inquest into the death of Seth Gregory Victor Yeeda* [2022] WACOR 33; State Coroner Fogliani; Letter Minister for Corrective Services, 28 June 2023, https://www.coronerscourt.wa.gov.au/_files/Inquest_2023/recommendation%20yeeda.pdf.
[145] Closing Submissions of the Department of Justice and the WA Country Health Service filed 12 December 2025.

simply fallen and injured himself, I don't consider there is any evidentiary basis for me to conclude that CPR was not commenced as soon as possible. Whilst it would have been ideal if the CCTV footage captured all of the events, there were trees obscuring the view.

141. I note in the matter of *Lynch* the Department provided evidence that body worn cameras (BWC) are slowly being rolled out to prison officers in custodial facilities throughout the State, starting with the 'youth estate', which is complete, and then with a plan to progress to Hakea Prison in Stage 2. The rollout will require significant investment in capital works by the Department. His Honour Coroner Jenkin made a recommendation that the Department should expedite the rollout of BWC for all custodial staff at Hakea.[146] This followed on from a previous recommendation of another Coroner in an inquest also related to a death of a prisoner at Hakea Prison.[147]

142. Based on the fact it seems the Hakea Prison rollout is still to occur, and that is Stage 2 of the planned rollout, I accept the submission of ALSWA that West Kimberley Regional Prison will likely be far down the list for the BWC technology rollout. In the meantime, it seems reasonable to me for the Department to consider what they can do to enhance the current monitoring of the oval by CCTV, to ensure that as much of the activity on the oval is captured as possible. Sadly, given there appear to be many prisons with cardiac issues in the West Kimberley, it may well be that other events may occur when prisoners are engaged in sport. Objective footage of events would be beneficial to prisoners, their families and also the prison officers themselves, as it will ensure that there is no room for confusion or rumours in circumstances like these.

Recommendation

I recommend that the Department of Justice consider improving the coverage of CCTV cameras over the football oval at West Kimberley Regional Prison. Further, I recommend the Department of Justice continue to work towards introducing body worn cameras in all prisons, including at West Kimberley Regional Prison.

143. Beverley Ward also raised a concern about how she was informed of her son's collapse. I understand one of hers nephews, who was in the prison with Mr Ward, rang his wife and told her about Mr Ward's situation. She then called Mr Ward's partner, Nelita, who then rang Beverley. That was how Mr Ward's mother found out about his collapse, rather than from a prison official. Other family members also became aware through the family network. They drove to Beverley's home and collected her and then went to the hospital together, where they found Mr Ward was unconscious and on life support.[148]

[146] *Lynch* (Ibid), Recommendation No. 6.
[147] *Inquest into the Death of Ricky-Lee Cound* [2025] WACOR 13, Recommendation 5.
[148] Exhibit 1, Tab 20.

144. The Department provided a supplementary report at the inquest addressing this issue and some other issues raised by the family, which are covered below. The Department explained that the Deputy Superintendent was not on site at the time of Mr Ward's collapse and was not on roster. She was notified by a telephone call. The Deputy Superintendent came to the prison as quickly as possible, but by the time she arrived the ambulance was already on its way to the hospital, and it appears family members inside the prison had already notified family members in the community. Beverley quickly made her way to the hospital, arriving within half an hour of Mr Ward's presentation by ambulance, and it was accepted that West Kimberley Regional Prison senior staff had not had an opportunity to contact her prior to her arrival.[149]

145. The Department noted that another senior staff member, Deputy Superintendent (Security), was at the hospital and he spoke to Mr Ward's family at the hospital. The Department acknowledged it was regrettable, and contrary to usual policy, that Mr Ward's family were not first notified by prison staff. However, the general view is that a prisoner should be admitted to hospital before a family member is notified, for security purposes. In this case, given family witnessed Mr Ward's collapse, the delay created a window for the information to be passed another way, as once those family members returned to their houses on the prison grounds, they had access to a telephone and understandably wanted to notify family members of what had occurred.[150] Ms Toni Palmer, on behalf of the Department, acknowledged it was unfortunate but understandable how it occurred on this occasion.[151]

146. Beverley, Nelita and two of Mr Ward's children flew to Perth and saw him at RPH before he was taken off life support. They were very upset and angry after he died. Their anger and grief were apparently exacerbated by previous experiences the family has had with medical care in prison.[152]

147. About a week after Beverley returned home, two Aboriginal Department of Justice staff came to Mowanjum to visit Beverley and her family. Beverley indicated in her statement that she felt let down that more senior officials from the prison had not come out to tell them what had happened.[153] It was agreed by the Department that two female indigenous staff members, Ms Buckle and Ms LeLievre, visited Beverley. Contrary to Beverley's understanding, both staff members were employed as part of the West Kimberley Regional Prison Senior Management Team, with one performing the role of Deputy Superintendent (Operations) and the other Facilities Manager. Therefore, the Senior Management Team had thought that they were suitably senior staff members to convey condolences to the family, whilst also being able to do so in a culturally sensitive manner. West Kimberley Regional Prison staff were said to be aware of the need for cultural sensitivity, and it was known that there had been some previously observed hostility between Mr Ward's family and West Kimberley Regional Prison staff. It became apparent to Ms Buckle and Ms Le Lievre

[149] T 25.
[150] T 12 - 14; Exhibit 2, Tab 3.
[151] T 25.
[152] Exhibit 1, Tab 20.
[153] Exhibit 1, Tab 20.

after they offered their condolences and the condolences of the prison management that there remained some hostility, so they withdrew and gave feedback to the West Kimberley Regional Prison Superintendent about the meeting. It was noted in the feedback that there appeared to have been some misinformation provided to Beverley and other family members from other sources that suggested prison staff had not done anything to assist Mr Ward when he collapsed, which had understandably caused considerable distress, although it was not borne out by the evidence.[154]

148. At the inquest evidence was led that the Department did engage with Mr Ward's family and West Kimberley Regional Prison prisoners to identify ways that Mr Ward's passing could be marked, and it was agreed that a smoking ceremony and a memorial footy game in his honour would be appropriate. I am informed they were held the week after Mr Ward's passing.[155]

149. In the supplementary report, the Department also referred to medical staffing at West Kimberley Regional Prison, noting that there were two agency nurses on duty at the time of the incident, who attended quickly and participated in the resuscitation efforts until ambulance officers arrived. They were both Registered Nurses and were well-qualified to assist. However, there were issues with recruiting full-time nursing staff to West Kimberley Regional Prison at the time, which remains an ongoing issue as many nurses are reluctant to relocate permanently to the Derby region. The Department continues to make all attempts to recruit permanent nursing staff to West Kimberley Regional Prison, including offering incentives, and since 2023 there has been some success accompanied by a boost in the number of positions available.[156]

150. I set out the above to explain how miscommunication can lead to a perception that things have been done in an insensitive way, even when the Department's staff are attempting to follow a process, they believe will be respectful and considerate of the feelings of family members. A sudden death of a person in custody will always be a difficult event for family members, who are not able to be with their loved one immediately and who will often receive differing accounts of what occurred from different sources. I accept the Department is aware of these issues and the senior management are doing their best to learn from cases such as this, to try to improve their communication with family members at such times.

151. Another, issue raised by Beverley related to the preventative medical care provided to her son. In my conclusions above, I have indicated that I am satisfied that overall, the health practitioners at West Kimberley Regional Prison were proactive in trying to help Mr Ward to manage his chronic health issues. In particular, there were some concerns raised about smoking in prisons and dental care. I have addressed the issue of smoking in prisons above.

152. As for the dental care issue, I note the Office of the Inspector of Custodial Services made a recommendation in a report delivered in May 2024 in relation to his

[154] Exhibit 2, Tab 3.
[155] T 16.
[156] Exhibit 2, Tab 3.

Inspection of West Kimberley Regional Prison[157] that the Department should develop and publish a plan to provide dental services in Derby. The Department noted the recommendation but made no further response. The recommendation was made in the context that the town of Derby had lost its only dentist, so the prison had lost access to dental services. The Inspector made some comments about the importance of dental services for overall health of prisoners, as well as pain management. Given there is no evidence Mr Ward's death was causally related to any dental issue, and also noting he declined an extraction at one stage and received appropriate hospital treatment when he had a dental abscess not long before his death, I do not consider it is appropriate to make any recommendation in that regard. However, I mention the Inspector's report to reassure Mr Ward's family that this issue has been identified and raised with the Department since Mr Ward's death.

CONCLUSION

153. Mr Ward was a very loved Ngarinyin, Woddorda and Wunumbal man who grew up in communities across the West Kimberley region. He passed away in hospital in the presence of his family on 25 July 2023, having collapsed some days earlier while exercising. He was less than two months away from his earliest release date at that time.

154. Mr Ward was in his early thirties and his sudden death was connected to an out of hospital cardiac arrest on a background of his cardiovascular disease and Type 2 Diabetes. He had been receiving treatment for diabetes for many years, but at the times of his passing his cardiac-condition was yet to be investigated. A referral to a cardiologist for an exercise stress test had been made in October 2021, and the appointment booked for February 2022, but due to some miscommunication issues Mr Ward was not sent to the external hospital appointment. The missed appointment was not identified until 3 July 2023, at which time another appointment was made for 18 July 2023, but sadly Mr Ward had already suffered a terminal event by that time and never got to attend the appointment.

155. The Department has accepted that the failure to identify that Mr Ward's cardiovascular investigation was not performed within a standard timeframe (12 months from the referral) was a missed opportunity to potentially identify and treat Mr Ward's cardiovascular disease. I am satisfied on the evidence before me that if Mr Ward had undergone the exercise stress test in February 2022, or any time prior to his collapse on 15 July 2023, it is possible his well-established cardiovascular disease would have been identified, and further investigations could have been undertaken and treatment options explored. However, based upon the expert evidence before me, I also accept that it is entirely possible that the exercise stress test may not have shown any abnormalities, in which case his treatment may not have altered from the medical therapies he was already receiving. Therefore, I can take it no further than a finding that the failure of the Department to follow up the referral within the appropriate timeframe was a missed opportunity, rather than being

[157] Office of the Inspector of Custodial Services 'Report *2023 Inspection of West Kimberley Prison'*, May 2024.

able to make a finding that Mr Ward's death could definitely have been prevented with better management.

156. Since Mr Ward's unexpected death, the Department has taken steps to improve its internal systems for managing external referrals, to ensure that referrals are tracked and followed up if appointments are either not made or missed for some reason.

157. In the broader sense of a consideration of treatment, supervision and care, I am also satisfied that the Department is working towards banning smoking in West Kimberley Regional Prison, as part of a state-wide rollout of the smoking ban in prisons, and also working at ways to improve preventative healthcare provision, including recruiting Aboriginal health workers to provide more culturally safe medical care and ensure better engagement of Aboriginal prisoners with the prison health services.

158. Mr Ward's sudden and unexpected death while in custody has caused his family immense grief and left them with many questions. I hope some of them have been answered through the evidence obtained during this inquest, although I acknowledge that they will always be left to wonder whether the missed appointment might have made the difference for him. Unfortunately, that is a question we will never know the answer to, but I hope they gain some comfort from the fact that the Department has reflected upon what has been learnt from his death, as well as others, and a new referral monitoring system is now in place.

159. I extend my condolences to Mr Ward's mother, Beverley, for the loss of her beloved son and to his extended family for their loss of a loved family member. I thank Beverley in particular for her willingness to engage wholeheartedly in the inquest process and work towards implementing change for the future.

S H Linton
Acting State Coroner
8 January 2026