[2026] WACOR 4

JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, ACTING DEPUTY STATE CORONER
HEARD	**:**	14 - 15 JANUARY 2026
DELIVERED	**:**	2 FEBRUARY 2026
FILE NO/S	**:**	CORC 1666 of 2023
DECEASED	**:**	VAN MALSSEN, JOSHUA FREDRIK

Cases:

Briginshaw v Briginshaw (1938) 60 CLR 336

Legislation:

Coroners Act 1996 (WA)
Criminal Code (WA)
Government Railways Act 1904 (WA)
Public Transport Authority Act 2003 (WA)
Public Transport Authority Regulations 2003 (WA)

Counsel Appearing:

Mr D McDonald appeared to assist the coroner.

Ms R Panetta (State Solicitor's Office) appeared on behalf of the Public Transit Authority.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Acting Deputy State Coroner, having investigated the death of ***Joshua Fredrik VAN MALSSEN*** *with an inquest held at Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth, on 14 -15 January 2026, find that the identity of the deceased person was* ***Joshua Fredrik VAN MALSSEN*** *and that death occurred on 16 June 2023 at Royal Perth Hospital from cardiac arrest in a man with Sotos syndrome and multiple comorbidities, including, complex heart disease, asthma, early bronchopneumonia and obesity, while being restrained in a prone position, with alcohol effect, in the following circumstances:*

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INTRODUCTION

1. Joshua Fredrik Van Malssen (Josh)[1,2] was 24-years of age when he died on 16 June 2023 from cardiac arrest.[3,4,5,6,7,8,9,10] Immediately before his death, Josh was behaving in a disorderly manner in the Perth Underground Train Station (the Station) and had been shouting and swearing. As a result of his behaviour, Josh was spoken to by Public Transit Authority (PTA) transit officers before being arrested.

2. After his arrest, Josh was placed on his stomach on the ground in the prone position and handcuffs were applied to his wrists. Josh was then moved into the recovery position and a short time later it was realised he had stopped breathing. Josh's handcuffs were removed and PTA transit officers started CPR and called emergency services.

3. Ambulance officers arrived at the Station and took over resuscitation efforts, and Josh was taken to Royal Perth Hospital (RPH). Josh could not be revived and he was declared deceased.

4. Members of Josh's family attended the inquest I conducted from 14 -15 January 2026 in Perth. The documentary evidence tendered at the inquest comprised two volumes, and the inquest focused on the cause of, and the circumstances surrounding Josh's death.

5. The following witnesses gave evidence at the inquest:

a. Dr Jodi White (Forensic Pathologist);
b. Mr Reece Turner (Attending PTA transit officer);
c. Mr Christopher Stow (Attending PTA transit officer);
d. Mr Brett Parker (Attending PTA transit officer);
e. Mr Craig Nichols (Attending PTA transit officer);
f. Mr Chris Markham (Use of Force expert, Western Australia Police Force); and
g. Mr Peter Armstrong (Acting Director of Security, PTA).

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[1] At the request of his family, Mr Van Malssen was referred to as "Josh" at the inquest and in this finding
[2] Email - Registry of Births, Deaths and Marriages (30.01.26) confirming Josh's middle name is spelt "Fredrik"
[3] Exhibit 1, Vol. 1, Tab 1, P100: Report of Death (16.06.23)
[4] Exhibit 1, Vol. 1, Tab 2, Homicide Squad Report, Det. Sgt. L McKnight (19.04.24)
[5] Exhibit 1, Vol. 1, Tab 3, RPH Death in Hospital Form (16.06.23)
[6] Exhibit 1, Vol. 1, Tab 4, P92: Identification of Deceased Person - Visual Means (20.06.23)
[7] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (29.03.24)
[8] Exhibit 1, Vol. 1, Tab 6, Supplementary Toxicology Report (31.01.24)
[9] Exhibit 1, Vol. 1, Tabs 7 & 7.1, Neuropathology Reports (31.01.24 & 03.07.23)
[10] Exhibit 1, Vol. 1, Tab 8, P98: Mortuary Admission Report (17.06.23)

6. In cases where a death occurs in the presence of a member of the Western Australia Police Force (WA Police), a coronial inquest is mandatory. Further, in such cases section 22 of the *Coroners Act 1996* (WA) (the Act) requires a consideration of whether the relevant death may have been caused or contributed to by a member of WA Police.

7. Although PTA transit officers are not members of WA Police, I have decided that it is appropriate for me to make a similar assessment in this case. That is because Josh died after he was restrained in the prone position, and the question that arises is whether the actions of any of the attending PTA transit officers caused or contributed to Josh's death. I have also decided that is it appropriate for me to assess the quality of the supervision, treatment, and care that Josh received whilst he was in the custody of PTA transit officers.

8. When assessing the available evidence and deciding whether to make any adverse findings, I have applied the standard of proof set out in the High Court's decision in the case known as ***Briginshaw v Briginshaw***[11] (the Briginshaw case).

9. The Briginshaw case is authority for the proposition that a consideration of the nature and gravity of the relevant conduct is required when deciding whether a finding adverse in nature has been proven on the balance of probabilities.

10. I have also been mindful not to insert any "*hindsight bias*" into my assessment of the actions taken by members of the PTA. Hindsight bias is the well-known tendency after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[12] In this case the relevant event is Josh's death whilst he was being restrained in the prone position.

[11] (1938) 60 CLR 336, per Dixon J at pp361-362
[12] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015), p10

JOSH

Background[13,14,15]

11. Josh was born in Perth on 6 January 1999 and was the eldest of two siblings. In a moving statement provided to the Court, Josh's mother (Ms Fisher) said this about her beloved son:

> My son Josh was 24 years old. He was a happy chap most of the time, liked a chat and to tell a joke. He could talk crap for hours ha-ha. He liked a drive along the coast, and I would pick him up every Saturday or Sunday for a drive along the coast and a coffee. He would often catch the bus to Scarborough for his favourite, fish and chips.
>
> He enjoyed playing video games, riding his bike and loved seeing his brothers Ashley and Luke. He had just moved into a unit only 10 minutes' drive from us and Ashley had his licence and was starting to go and visit Josh at his unit and take him out for a drive.[16]

12. When Josh was 18-years of age, he moved into shared and supported accommodation in Shenton Park that was run by a disability service provider. Josh remained in this accommodation until May 2023, when he moved into shared and supported accommodation in Balga, run by a different disability service provider.

13. Josh received a funding package from the National Disability Insurance Scheme (NDIS). Josh's NDIS funding package included funding for a support worker to visit Josh in his accommodation and assist with cooking, cleaning, and outings. However, Josh's NDIS funding package did not provide for full time in-house support.

14. Josh was otherwise independent, and he was free to come and go from his accommodation as he pleased. I note that Josh's mother continued to provide him with significant assistance including helping Josh to arrange and attend medical and other appointments.

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[13] Exhibit 1, Vol. 1, Tab 9, Statement - Ms D Fisher (20.06.23)
[14] Exhibit 1, Vol. 1, Tab 24, Statement - Mr S Cronsaye (27.06.23)
[15] Exhibit 1, Vol. 1, Tab 2, Homicide Squad Report, Det. Sgt. L McKnight (19.04.24), pp2-3
[16] Exhibit 1, Vol. 2, Tab 49, Statement - Ms D Fisher (14.01.26)

Medical history[17,18,19,20,21,22,23,24]

15. Josh's medical history included: Sotos Syndrome (a rare genetic disorder characterised by excessive growth in early childhood, distinctive facial features, learning disabilities and developmental delays), moderate intellectual disability, autism spectrum disorder, anxiety, depression, obstructive sleep apnoea, asthma, obstructive lung disease, and dilated cardiomyopathy.

16. Josh first attended the Cardiology clinic at Fiona Stanley Hospital (FSH) on 25 May 2020. An echocardiogram (ECG) performed that day showed "*mild ventricular systolic failure*", and this was consistent with an ECG performed 18 months previously. Josh's condition was regarded as "*stable*", and he was compliant with his medication regime.[25]

17. Josh's last appointment with the Cardiology clinic at FSH was on 2 August 2022, when he saw Dr Baumwol (Consultant cardiologist). Josh reported feeling well, and did not complain of shortness of breath as he had done at previous appointments. A recent ECG confirmed stable cardiac function with a mildly impaired ejection fraction. No changes were made to his medication, and Josh was advised to reduce his weight and to exercise.

18. Josh was referred to the Respiratory Clinic at FSH after he presented to the emergency department at FSH in July 2020. Josh described a history of paroxysmal nocturnal dyspnoea (where shortness of breath wakes the patient), and he was treated for asthma. Following various pulmonary tests, Josh was diagnosed with "*mild obstructive lung disease*". Josh was last seen in the Respiratory Clinic on 6 April 2023, when he was reviewed by Professor Moodley. At that time Josh's asthma was "*stable*" and his condition "*was well controlled*".[26]

[17] Exhibit 1, Vol. 1, Tab 25, Report - Dr J Baumwol, Consultant Cardiologist, (09.12.24)
[18] Exhibit 1, Vol. 1, Tab 25.1, Report - Prof. Y Moodley, Consultant Cardiologist, (12.11.24)
[19] Exhibit 1, Vol. 1, Tab 26, Report - Dr C Acacio, Consultant Psychiatrist, (08.08.24)
[20] Exhibit 1, Vol. 1, Tab 27, Report - Mr J Couglan, Headspace, Early Psychosis (undated)
[21] Exhibit 1, Vol. 1, Tab 28, NDIS Plan
[22] Exhibit 1, Vol. 1, Tab 29, Medical records - Dianella Medical Centre
[23] Exhibit 1, Vol. 1, Tab 30, Day to Day Behaviour Support Plan (20.05.22)
[24] Exhibit 1, Vol. 2, Tab 31, Medical records - Sir Charles Gairdner Hospital
[25] Exhibit 1, Vol. 1, Tab 25, Report - Dr J Baumwol, Consultant Cardiologist, (09.12.24), pp1-2
[26] Exhibit 1, Vol. 1, Tab 25.1, Report - Prof. Y Moodley, Consultant Cardiologist, (12.11.24), p2

19. Pulmonary function testing on 6 April 2023 found Josh had "*moderately severe airways obstruction*", and this limitation in his lung function was said to make Josh "*vulnerable to any stress on his respiratory system*".[27]

20. On 29 August 2022, Josh was referred to Headspace's Early Psychosis service (the Service) following a presentation to the emergency department at Sir Charles Gairdner Hospital in the context of "*suicidal ideation and perceptual disturbances, namely paranoia and hallucinatory experiences*". Josh was diagnosed with a brief episode of psychosis, and he was managed by the Service until his death.[28]

21. At the relevant time, Josh was 204 cm tall and he weighed about 174 kg. His body mass index BMI was calculated as 40.6,[29] and the short point is that Josh was a large man. As I shall explain, Josh's physical size was to have significant consequences when he interacted with and was subsequently arrested by PTA transit officers.

[27] Exhibit 1, Vol. 1, Tab 25.1, Report - Prof. Y Moodley, Consultant Cardiologist, (12.11.24), pp2-3
[28] Exhibit 1, Vol. 1, Tab 27, Report - Mr J Couglan, Headspace, Early Psychosis (undated)
[29] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (29.03.24) and ts 14.01.26 (White), pp6-19

EVENTS LEADING TO JOSH'S DEATH

Josh's conduct at the Station[30,31,32,33,34,35,36,37,38,39,40,41,42,43,44,45,46,47,48,49]

22. At about 8.00 pm on 16 June 2023, Josh walked around the Perth Train Station before heading towards the Yagan Square exit. At the exit, Josh laughed and joked with PTA transit officers for several minutes, before walking off towards the Perth Underground Station (the Station). At about 8.07 pm, Josh used a lift to enter the Station, and CCTV footage shows he was sweating profusely, and appeared to be out of breath. Josh also seemed to be fatigued and he leaned against a wall before walking along the concourse and stopping to rest up against a wall.

23. At about 8.10 pm, Josh had a brief interaction with some juveniles who were being spoken to by two police officers. Josh repeatedly shouted abuse at the police officers including "*you pig dogs*" before asking the juveniles: "*Are you OK*" and "*What do these dogs want with you*"? The juveniles did not know Josh and the police officers told Josh to "*move along*", which he did. One of the officers described Josh's demeanour at the time as "*heightened agitation*".[50]

24. As Josh exited through the ticket gates at the Muray Street Mall exit, he began shouting and swearing at the on-duty ticketing assistants. One of the ticketing assistants asked Josh to "*watch his language*" and Josh pointed at him and said: "*Fuck off*".[51]

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[30] Exhibit 1, Vol. 1, Tab 2, Homicide Squad Report, Det. Sgt. L McKnight (19.04.24), pp1-2, 3-10 & 12
[31] Exhibit 1, Vol. 1, Tab 10, Statement - Sgt. J Orre (23.06.23)
[32] Exhibit 1, Vol. 1, Tab 11, Statement - Const. J Petrie (23.08.23)
[33] Exhibit 1, Vol. 1, Tab 12, Statement - Mr M Halid (22.06.23)
[34] Exhibit 1, Vol. 1, Tab 13, Statement - Mr S Kong (21.06.23)
[35] Exhibit 1, Vol. 1, Tab 14, Statement - PTA Officer C Nichols (17.06.23) & ts 14.01.26 (Nicholls), pp106-117
[36] Exhibit 1, Vol. 1, Tab 15, Statement - PTA Officer B Parker (17.06.23) & ts 14.01.26 (Parker), pp53-73
[37] Exhibit 1, Vol. 1, Tab 16, Statement - PTA Officer C Stow (17.06.23) & ts 14.01.26 (Stow), pp73-94
[38] Exhibit 1, Vol. 1, Tab 17, Statement - PTA Officer R Turner (17.06.23) & ts 14.01.26 (Turner), pp95-105
[39] Exhibit 1, Vol. 1, Tab 18, Statement - Const. T Rutter (20.06.23)
[40] Exhibit 1, Vol. 1, Tab 19, Statement - Sgt. I Lyon (18.10.23)
[41] Exhibit 1, Vol. 1, Tab 20, Statement - Det. Sen. Const. M Ripp (20.06.23)
[42] Exhibit 1, Vol. 1, Tab 21, Statement - Det. FC Const. L Whittam (25.06.23)
[43] Exhibit 1, Vol. 1, Tab 22, Statement - Det. Sen. Const. A Ingram (25.06.23)
[44] Exhibit 1, Vol. 1, Tab 23, Statement - Const. R Woolgar (05.07.23)
[45] Exhibit 1, Vol. 2, Tabs 32 & 32.1, CCTV Footage (16.06.23)
[46] Exhibit 1, Vol. 2, Tabs 33, 33.1-33.3, WAPOL Runnings sheets (16.06.23)
[47] Exhibit 1, Vol. 2, Tabs 34 WAPOL Incident Report 16062023-2010-87303 (16.06.23)
[48] Exhibit 1, Vol. 2, Tabs 36-38, PTA Action Reports (17.06.23, 09.09.22 & 24.09.21)
[49] Exhibit 1, Vol. 2, Tab 41, Transperth Incident Reports (12.08.22 & 10.03.23)
[50] Exhibit 1, Vol. 1, Tab 10, Statement - Sgt. J Orre (23.06.23) & Exhibit 1, Vol. 1, Tab 11, Statement - Const. J Petrie (23.08.23)
[51] Exhibit 1, Vol. 1, Tab 12, Statement - Mr M Halid (22.06.23) & Exhibit 1, Vol. 1, Tab 13, Statement - Mr S Kong (21.06.23)

25. As Josh rode the escalator leading to Murray Street Mall he continued swearing and shouting threats and abuse at the ticketing assistants. Although PTA transit officers heard Josh shouting, they did not engage with him at that stage. When Josh got to the top of the escalator he turned around and travelled back down the escalator and into the Station.

26. As Josh rode down the escalator he continued to shout and swear, and he was also making threats aimed at the ticketing assistants. Four PTA transit officers, namely Officers Stow, Parker, Turner and Nichols (the Officers) left their office near the ticketing gates at the bottom of the escalator and approached him.

27. One of the Officers (Officer Stow) knew Josh from previous encounters and had some rapport with him. As Officer Stow tried to reason with Josh, Officer Turner stood to his right, and Officer Nichols stood to the left. Officer Parker (who also knew Josh from previous interactions with him) stood about one metre to behind the group.

28. For some time the Officers made numerous attempts to deescalate the situation. Further, Officer Parker could see Josh was sweating profusely and he suggested Josh leave the Station to get some fresh air. Despite these attempts by the Officers, Josh continued to hurl abuse and make threats to the ticketing assistants, and he tried to push past the Officers on numerous occasions and move towards them (the ticketing assistants). Each time Josh did so, the Officers blocked his path with an outstretched hand.

29. On two occasions, Officer Stow told Josh that because of his disorderly behaviour he would not be allowed to travel on a train and he would have to leave the Station. Several of the other officers also directed Josh to leave the station, but Josh continued to refuse to do so. Eventually, when all attempts to reason with Josh had failed, Officer Stow warned Josh that if he did not leave the Station, he would be arrested.

Josh's arrest[52,53,54,55,56,57,58]

30. When Josh tried to push past the Officers again, Officers Turner and Stow took hold of his arms in a "*two on one*" escort manoeuvre.[59] Officer Parker called the nearby lift so that Josh could be removed from the Station safely. Despite being restrained, Josh continued to resist and he began thrashing his arms about and dropping his weight.

31. Officer Stow asked Officer Nichols to take Josh to the ground using a "*harness takedown*", a manoeuvre typically performed by two officers which PTA transit officers are trained to do.[60] Officer Nichols walked behind Josh and placed one arm over Josh's right shoulder and one under his left armpit before clasping his hands in front of Josh's body. Officers Turner, Stow and Nichols then lowered Josh to the ground in a seated position, before rolling him into the prone position.

32. Officer Parker had returned from the lift, and he used his hands to restrain Josh's legs while Officers Turner and Stow began placing Josh into handcuffs. Meanwhile, Officer Nichols (who was not involved in the restraint process) stood nearby apparently monitoring Josh.

33. CCTV footage shows it took 46 seconds for handcuffs to be applied to Josh's wrists, and part of this delay was caused by the Officers trying to locate a set of handcuffs large enough for Josh's wrists. Although a larger set of handcuffs could not be found, Officer Stow eventually managed to get his handcuffs onto Josh's wrists, although the handcuffs would only secure to the "*first click*" which was not usual.

34. CCTV footage shows Josh stopped resisting shortly after he was restrained on the ground, and appears to take several short, deep breaths before becoming unconscious. All of this appears to have gone unnoticed by the Officers until after Josh's handcuffs had been secured.

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[52] Exhibit 1, Vol. 1, Tab 12, Statement - Mr M Halid (22.06.23)
[53] Exhibit 1, Vol. 1, Tab 13, Statement - Mr S Kong (21.06.23)
[54] Exhibit 1, Vol. 1, Tab 14, Statement - PTA Officer C Nichols (17.06.23) & ts 14.01.26 (Nicholls), pp106-117
[55] Exhibit 1, Vol. 1, Tab 15, Statement - PTA Officer B Parker (17.06.23) & ts 14.01.26 (Parker), pp52-73
[56] Exhibit 1, Vol. 1, Tab 16, Statement - PTA Officer C Stow (17.06.23) & ts 14.01.26 (Stow), pp73-94
[57] Exhibit 1, Vol. 1, Tab 17, Statement - PTA Officer R Turner (17.06.23) & ts 14.01.26 (Turner), pp94-105
[58] Exhibit 1, Vol. 2, Tabs 32 & 32.1, CCTV Footage (16.06.23)
[59] Exhibit 1, Vol. 2, Tab 40, Extract: PTA Defensive Tactics Manual (v.2.0), p64
[60] Exhibit 1, Vol. 2, Tab 40, Extract: PTA Defensive Tactics Manual (v.2.0), p63

35. In any case, Officer Parker eventually noticed that Josh was unresponsive and his face had changed colour, and he (Officer Parker) ordered Josh's handcuffs be removed. As Officer Turner began trying to remove the handcuffs, Officer Stow used his PTA radio to call a medical emergency and request an ambulance.

36. At the inquest, Officer Nichols said that as Josh was being restrained, he took on a "*monitoring role*" and that every time he looked at Josh's face, he (Josh) was breathing. Officer Nichols also says he noticed Josh's wrists had changed colour at about the same time Officer Parker noticed the same about Josh's face. Meanwhile, Officer Stow realised Officer Turner was struggling to remove Josh's handcuffs and went to assist. CCTV footage shows the removal process took about 36 seconds.

Resuscitation efforts[61,62,63,64,65,66,67,68,69,70,71,72]

37. As Josh's handcuffs were being removed, the Officers rolled Josh onto his back and Officer Parker started CPR. Meanwhile, another PTA staff member fetched a defibrillator and handed it to Officer Nichols. Officer Stow then placed the defibrillator's pads on Josh's chest, but at no stage was a shock advised meaning Josh's heart was in asystole.[73,74]

38. The Officers continued performing CPR until paramedics from St John Ambulance arrived at 8.24 pm and took over resuscitation efforts. A LUCAS Machine[75] was applied to Josh's chest and he was given oxygen, and five injections of adrenaline before being transported to RPH by ambulance.[76] Despite further resuscitation efforts, Josh could not be revived and he was declared deceased at 9.15pm on 16 June 2023.[77]

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[61] Exhibit 1, Vol. 1, Tab 2, Homicide Squad Report, Det. Sgt. L McKnight (19.04.24), p10
[62] ts 14.01.26 (White), pp16-19
[63] Exhibit 1, Vol. 1, Tab 12, Statement - Mr M Halid (22.06.23)
[64] Exhibit 1, Vol. 1, Tab 13, Statement - Mr S Kong (21.06.23)
[65] Exhibit 1, Vol. 1, Tab 14, Statement - PTA Officer C Nichols (17.06.23) & ts 14.01.26 (Nicholls), pp106-117
[66] Exhibit 1, Vol. 1, Tab 15, Statement - PTA Officer B Parker (17.06.23) & ts 14.01.26 (Parker), pp52-73
[67] Exhibit 1, Vol. 1, Tab 16, Statement - PTA Officer C Stow (17.06.23) & ts 14.01.26 (Stow), pp73-94
[68] Exhibit 1, Vol. 1, Tab 17, Statement - PTA Officer R Turner (17.06.23) & ts 14.01.26 (Turner), pp94-105
[69] Exhibit 1, Vol. 2, Tabs 35, 35.1 & 35.2, SJA Patient Care Records KEW21N2, CSE01N2 & MID22N2 (16.06.23)
[70] Exhibit 1, Vol. 2, Tabs 32 & 32.1, CCTV Footage (16.06.23)
[71] Exhibit 1, Vol. 2, Tab 35.1, SJA Patient Care Record 22526489 (16.06.23)
[72] Exhibit 1, Vol. 2, Tab 35.2, SJA Patient Care Record 22526488 (16.06.23)
[73] ts 14.01.26 (Parker), p62
[74] Asystole is the complete cessation of the heart's electrical and mechanical activity
[75] A LUCAS machine (Lund University Cardiac Assist System) is a device that provides chest compressions for cardiac arrest patients
[76] Exhibit 1, Vol. 2, Tab 35.2, SJA Patient Care Record MID22N2 (16.06.23), p5
[77] Exhibit 1, Vol. 1, Tab 3, RPH Death in Hospital Form (16.06.23)

CAUSE AND MANNER OF DEATH

Post mortem examination[78,79,80,81,82]

39. On 21 June 2023, two forensic pathologists (Dr White and Dr Grewal) conducted a post mortem examination of Josh's body, and they also reviewed CT scans, and toxicology and neuropathology reports.

40. Dr White and Dr Grewal found that Josh had a high body mass index (40.6) and was 207 cm tall and weighed 174 kg. There was evidence of medical intervention, including cardiopulmonary resuscitation, consistent with his recent history. Josh had soft tissue injuries to his face, torso and limbs, and his lungs were heavy and fluid laden, which is a non-specific finding.

41. Josh's heart was enlarged, and the arteries supplying his heart were narrowed (coronary artery atherosclerosis). Microscopic examination of tissues confirmed these findings noting moderate plaque build-up, and there was severe fat accumulation in Josh's liver (macrovesicular steatosis), but his kidneys appeared normal.

42. A higher number of inflammatory cells were found in Josh's left lung (eosinophils and neutrophils) along with Group A *Streptococcus pyogenes*, suggesting a possible early stage lung infection (pneumonia). Specialist examination of Josh's brain noted a thin corpus callosum, and although this is a non-specific finding, it has been described in patients with Sotos syndrome.

43. Toxicological analysis detected loratadine, along with therapeutic levels of paroxetine and quetiapine. Low levels of gamma-hydroxybutyric acid (GHB) were also noted, but Dr White and Dr Grewal expressed the opinion that this finding was likely due to natural post mortem changes rather than consumption. Post mortem analysis also detected a blood alcohol level of 0.174%, and a urine alcohol level of 0.215%.[83,84]

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[78] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (29.03.24) and ts 14.01.26(White), pp6-19
[79] Exhibit 1, Vol. 1, Tab 5.1, Post Mortem Report (21.06.23)
[80] Exhibit 1, Vol. 1, Tab 6, Supplementary Toxicology Report (31.01.24)
[81] Exhibit 1, Vol. 1, Tabs 7 & 7.1, Neuropathology Reports (31.01.24 & 03.07.23)
[82] See also: Exhibit 1, Vol. 1, Tab 2, Homicide Squad Report, Det. Sgt. L McKnight (19.04.24), pp13-14
[83] Exhibit 1, Vol. 1, Tab 6, Supplementary Toxicology Report (31.01.24)
[84] I note that analysis of blood samples taken on Josh's admission to RPH detected a blood alcohol level of 0.139%

Cause and manner of death

44. Following their post mortem examination, Dr White and Dr Grewal made the following observations about the circumstances which led to Josh's death:

> In our opinion, the physical stress of the altercation between (Josh) and the security staff, given his significant heart and lung conditions and WHO class 111 obesity (BMI - 40.6 kg/m^2), combined with his alcohol consumption, overwhelmed his physiological reserve and resulted in cardiac arrest and death. Additionally, no other factors that significantly contributed to the death were found on neuropathology and biochemical analysis.[85]

45. At the conclusion of their post mortem examination, Dr White and Dr Grewal expressed the opinion that the cause of Josh's death was:

> Cardiac arrest in a man with Sotos syndrome and multiple comorbidities, including, complex heart disease, asthma, early bronchopneumonia and obesity, while being restrained in a prone position, with alcohol effect.[86]

46. I respectfully accept and adopt the conclusion Dr White and Dr Grewal expressed as to the cause of Josh's death.

47. Further, given that Josh was being lawfully restrained at the time of his death, I find that Josh's death occurred by way of misadventure.

[85] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (29.03.24), p1
[86] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (29.03.24), p1

COMMENTS ON THE ACTIONS OF PTA OFFICERS[87]

Relevant considerations

48. As noted, when assessing the conduct of the PTA transit officers who interacted with Josh on 16 June 2023, I have applied the standard of proof set out in the Briginshaw case. I have also been mindful not to insert "*hindsight bias*" into my assessment.[88,89]

Training provided to PTA transit guards[90,91,92,93,94]

49. PTA transit officers must complete a Certificate III in Security Operations, which is delivered during a 14 week Transit Officer Recruit Training course (TORT course). The TORT course includes units dealing with managing conflict, controlling individual and crowd behaviour, and the correct use of handcuffs and force options (i.e.: baton and Oleoresin capsicum (OC) spray).

50. Training on the TORT course is delivered in classroom based sessions and by way of simulations, realistic scenario based assessments, and on-the-job-training. In the six months after they graduate, PTA transit officers must also complete an evidence record book covering practical and theoretical skills and they receive "*on-the-job consolidation under supervision and mentoring*".

51. The TORT course includes the Initial Defensive Tactics Training program comprised of 22 x four-hour sessions, and five, eight-hour scenario-based training days covering the following competencies:[95,96]

- CPPSEC3103 Determine and implement response to security risk situation;
- CPPSEC3110 Control persons using baton;
- CPPSEC3111 Restrain persons using handcuffs;
- CPPSEC3121 Control persons using empty hand control; and
- CPPSEC3126 Defend persons using spray.

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[87] Exhibit 1, Vol. 1, Tab 2, Homicide Squad Report, Det. Sgt. L McKnight (19.04.24), pp14-15
[88] (1938) 60 CLR 336, per Dixon J at pp361-362
[89] Dillon H and Hadley M, *The Australasian Coroner's Manual (2015)*, p10
[90] Exhibit 1, Vol. 2, Tab 46, Report - Mr P Armstrong (22.05.25) and ts 15.01.26 (Armstrong), pp121-125
[91] Exhibit 1, Vol. 2, Tab 47, Report - Mr C Markham (19.09.25) & ts 14.01.26 (Markham), pp23-51
[92] Exhibit 1, Vol. 2, Tab 48, Memorandum - Mr J Apai (17.12.25)
[93] Exhibit 1, Vol. 2, Tab 48.1, Photos depicting PTA Handcuffs (Saflock Mk IV & ASP Ultracuffs)
[94] Exhibit 1, Vol. 2, Tabs 42, Record of the Officers' training qualifications
[95] Exhibit 1, Vol. 2, Tab 47, Report - Mr C Markham (19.09.25), p50
[96] See also: Exhibit 1, Vol. 2, Tab 48, Memorandum - Mr J Apai (17.12.25), pp2-3

52. During the TORT course, participants are required to undertake theoretical and practical assessments in relation to empty hand tactics, a term which refers to specific techniques designed to control aggressive or violent persons without causing injury or harm.[97]

53. PTA Transit Officers are then required to attend an annual eight-hour defensive tactics "*Refresher Training*" day, which includes 2.5 hours of empty hand tactics training.[98]

54. PTA's Defensive Tactics Manual (the Manual) provides guidance to transit officers and is the document against which an officer's competency is assessed. Set out below are three sections of the Manual which are relevant to Josh's detention and restraint:

> *Symptoms of restrained person may include:*
> Having difficulty breathing; suddenly stopping breathing; a change in their aggression levels; being sick; becoming unresponsive; swelling of the face and neck, and expansion of veins in the neck.
>
> *People at High Risk of suffering Positional Asphyxia:* It has been identified that some people are at higher risk then others from suffering from Positional Asphyxia. High-risk individuals include people who: are extremely obese; have high blood pressure; are diabetics; are suffering from cocaine psychosis; and are suffering from excited delirium syndrome.
>
> *Risk Reduction*: All subjects held in any form of restraint must be closely monitored and kept in a position not likely to cause asphyxiation. Once the subject is restrained and handcuffed you must:
>
> Continuously monitor the subject for symptoms of breathing difficulty, including checking that they respond verbally to you; and provide immediate medical attention if a problem appears…Once a person has been placed in handcuffs, it is the responsibility of the Officer who affected the arrest to ensure that the person in custody is actively observed and controlled in order to minimise the risk of positional asphyxia.[99]

[97] Exhibit 1, Vol. 2, Tab 47, Report - Mr C Markham (19.09.25), p53
[98] Exhibit 1, Vol. 2, Tab 47, Report - Mr C Markham (19.09.25), p54
[99] Exhibit 1, Vol. 2, Tab 40, Extract: PTA Defensive Tactics Manual (v.2.0), sections 11.1-11.3, pp72-73

55. In addition to their annual mandatory training, PTA transit guards are also required to maintain a current first aid qualification (which is valid for three years). The first aid qualification is said to include information relating to breathing emergencies, and agonal breathing.[100]

56. I refer to the sections of the Manual I have just set out, the content of the TORT course, and the mandatory annual refresher training PTA transit officers must undergo. In that context, I consider that all of the PTA transit officers who gave evidence at the inquest displayed an inadequate understanding of positional asphyxia, and the significant risks associated with restraining a person in the prone position. In his evidence, Mr Armstrong agreed that this apparent knowledge deficit required attention.[101,102,103]

Josh's arrest and restraint[104,105]

57. Having carefully considered the available evidence and the relevant policy and legislative framework PTA transit officers operate in, I have concluded that the decision of the Officers to arrest Josh and restrain him with handcuffs was both justified and appropriate.

58. The Officers made numerous attempts to deescalate the situation and Josh was directed to leave the Station on a number of occasions. Despite these directions, Josh refused to leave the Station, and he continued to swear and abuse the ticketing assistants as he attempted to move towards them.

59. In these circumstances, and given Josh's physical size and intoxication, arresting and restraining him was necessary for his safety, and the safety of the Officers and potentially also safety of members of the public. A minimal amount of force was used to take Josh to the ground, and the CCTV footage confirms this was done in a careful and controlled manner using the harness takedown.

[100] Exhibit 1, Vol. 2, Tab 48, Memorandum - Mr J Apai (17.12.25), pp1-3
[101] ts 14.01.26 (Parker), pp64-66 & ts 14.01.26 (Stow), pp84-85 & 88-89
[102] ts 14.01.26 (Turner), pp101-102; & ts 14.01.26 (Nicholls), pp112-114
[103] ts 15.01.26 (Armstrong), p126-128
[104] Exhibit 1, Vol. 2, Tab 39, Summary of the powers of PTA transit officers
[105] Exhibit 1, Vol. 2, Tab 47, Report - Mr C Markham (19.09.25), pp11-26 & 39-49 and ts 14.01.26 (Markham), pp20-23

60. Although I accept that Josh needed to be restrained with handcuffs, it is regrettable that it took some time to apply them, due to the size of Josh's wrists. The delay in applying handcuffs to Josh's wrists meant that he was restrained in the prone position for a longer period than he should have been. It is also the case that there were similar delays in removing Josh's handcuffs when it was realised he had stopped breathing.

61. At the inquest, Officer Stow expressed the opinion that the ASP Hinged Ultra-Cuff handcuffs (ASP handcuffs) now used by the PTA were inferior to the models they replaced (i.e.: Saflock Mk IV & V). At the inquest Mr Armstrong confirmed there had been a consultation process before the ASP handcuffs were introduced, and this model is appropriate for juveniles who PTA transit guards regularly have to deal with.[106]

62. Nevertheless, given the concerns expressed by Officer Stow (an experienced PTA transit officer) and my assessment of photographs of ASP handcuffs and Saflock Mk IV handcuffs (which were tendered into evidence),[107] I have recommended that the PTA reassess the ASP handcuffs to determine whether they are fit for purpose when detaining persons of large build, and if not, whether an alternative type of restraint device should be made available.

Positional asphyxia and the risks of the prone position[108,109,110]

63. The PTA has recently made changes to the Manual, which now states that there are "*techniques of restraint*" that have been associated with "*sudden, unexpected deaths*". The Manual also requires security personnel (i.e.: PTA transit officers) to "*take every precaution to ensure they adopt safe practice*", and defines positional asphyxia in these terms:

> Positional Asphyxia (restraint asphyxia) can be defined as obstruction of breathing because of restraint techniques. It occurs when the position of a person's body interferes with their ability to breath. If this is not recognised, death can occur from asphyxia or suffocation. A body position that interferes with breathing can cause death.[111]

[106] ts 14.01.26 (Stow), pp80-81 & ts 15.01.26 (Armstrong), pp131-134
[107] Exhibit 1, Vol. 2, Tab 48.1, Photos depicting PTA Handcuffs (Saflock Mk IV & ASP Ultracuffs)
[108] Exhibit 1, Vol. 2, Tab 47, Report - Mr C Markham (19.09.25)
[109] Exhibit 1, Vol. 2, Tab 48, Memorandum - Mr J Apai (17.12.25)
[110] ts 14.01.26 (Markham), pp29-39 & ts 14.01.26(White), pp13-16
[111] Exhibit 1, Vol. 2, Tab 48, Memorandum - Mr J Apai (17.12.25), p4

64. The Brief contains PTA training material which sets out four risk factors which can contribute to positional asphyxia deaths, namely: obesity, psychosis, pre-existing physical conditions, and pressure on the abdomen.[112] With the benefit of hindsight, it seems clear that Josh displayed three, and possibly all four of these risk factors.

65. At the inquest Dr White explained that breathing, cardiac output (i.e.: how much blood the heart pumps out each minute), and heart rate can be adversely affected by being in the prone position, and noted that:

> [W]hen you lie flat and you have the pressure on your chest and the diaphragm pushing up and your abdomen is a bit squashed, the amount of blood that comes up in your venous return…so it's coming in through your liver, from your limbs is reduced...so the amount of blood that's…put into the heart and is ready to come out with each beat of your heart, is less. So your stroke volume is low and your heart rate is up. But you're in a position where your body can't compensate for that. So you tend to build up a lot of acid in the blood, so you get a metabolic acidosis because you can't remove toxins and acids from your muscles…because your heart's not pushing enough blood around to clear all this…and you can't get enough oxygen. So that's the…main…physiological problem for some people.[113]

66. Dr White also confirmed that various factors can make the effect of being in the prone position worse. Relevantly in Josh's case, these factors include: obesity, heart issues (including coronary artery disease and a large heart), asthma, chest infection, agitation, and intoxication with alcohol.[114]

Conclusions regarding the actions of the Officers

67. After carefully considering the available evidence, I have concluded that the interaction between Josh and the Officers was appropriate, and in accordance with PTA policies and training. Josh was treated in a respectful and courteous manner, and numerous efforts were made to deescalate the situation and have him to leave the Station voluntarily.

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[112] Exhibit 1, Vol. 2, Tab 48, Memorandum - Mr J Apai (17.12.25), p4
[113] ts 14.01.26(White), p9
[114] ts 14.01.26(White), pp9-13

68. I am also satisfied that the decision to arrest Josh was in accordance with PTA's policy and legislative framework, and was justified given his disorderly behaviour, and his persistent refusal to comply with directions by the Officers that he leave the Station.

69. It is possible that Josh's intoxication and intellectual disability meant that his decision-making capacity was diminished to the point where he was simply unable to comply with the Officers' reasonable requests. In any case, given Josh's size and his continued resistance and agitation, the decision to lower him to the ground using the harness takedown and then to apply handcuffs to his wrists was both justified and reasonable.

70. At the inquest, Mr McDonald (Counsel Assisting) asked Mr Markham (WAPOL's subject matter expert in the use of force) for his assessment of the Officers' conduct in restraining Josh. Mr Markham said:

> I think their…use of force and the application of force was entirely appropriate and justified in the circumstances. It was lawful, it was in accordance with the…training and the guidelines that they are provided. So…there's no issues with the use of force and the application of handcuffs. I think what I've identified in my report were some concerns around the practicalities of those handcuffs,…with…somebody of (Josh's) size. Given that that is very unusual to be dealing with a male person of those sort of dimensions, with his risk. And perhaps there was a missed opportunity in terms of monitoring (Josh)…after he had been taken to the ground and…the handcuffs had been applied. I think they had become, like I said, task-orientated, task-focused because of the complications they had in applying the handcuffs.
>
> It appeared to me that (Officer Nichols) was monitoring, but it…just seems that…if there was a recognition of the issues that perhaps (Josh) was experiencing with his breathing…and he…appeared to be experiencing breathing difficulties, then there didn't seem to be any urgency around that earlier on in the piece. Once they recognised it, once it was identified then, again, their…actions were in accordance with their training and in the administering CPR.[115]

[115] ts 14.01.26 (Markham), p46

71. I agree with Mr Markham's assessment, and as I noted earlier, the delay in applying handcuffs to Josh's wrists was very unfortunate because it meant that he spent more time in the prone position than should have necessary. That said, I do not attribute this delay to the actions of any particular officer, but rather to the types of handcuffs which the Officers had access to at the relevant time.

72. However, with due regard to both the Briginshaw case and the concept of hindsight bias, I have concluded that the standard of monitoring by the Officers while Josh was restrained in the prone position was **poor**. There was also no communication between the Officers as to who was monitoring Josh or about Josh's welfare.[116] There should have been.

73. I have also concluded that Officer Nichols (who was not involved in either applying handcuffs to Josh's wrists or restraining his feet) should have been more vigilant while monitoring Josh and should have noticed that Josh had stopped breathing before Officer Parker (who was restraining Josh's feet) realised that his (Josh's) face had changed colour.

74. At the inquest, Officers Stow, Turner, and Nichols each conceded that, with the benefit of hindsight, Josh had not been effectively monitored while he was being restrained in the prone position.[117,118] The concessions by these officers are both welcome and appropriate.

75. In accordance with section 44(2) of the Act, Mr McDonald wrote to Mr Nichols on 23 January 2026 to advise him that I intended to make the adverse finding set out in paragraph 72 above. Mr Nichols was asked to advise if he intended to make any submissions by 4.00 pm on 30 January 2026, in which case further guidance about the timeframe for the making of any such submissions would be provided to him.[119]

76. As no communication was received from Mr Nichols prior to 4.00 pm on 1 February 2026, I concluded that Mr Nichols did not intend to make any submissions about the finding set out in paragraph 73 above.

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[116] ts 14.01.26 (Parker), pp67-70; ts 14.01.26 (Stow), pp78-81; ts 14.01.26 (Turner), p99 & ts 14.01.26 (Nicholls), p114
[117] ts 14.01.26 (Stow), pp90-91; ts 14.01.26 (Turner), pp104-105 & ts 14.01.26 (Nicholls), p116
[118] See also: ts 15.01.26 (Armstong), pp136-137
[119] Letter - Mr D McDonald to Mr C Nicholls (23.01.26)

Did the actions of the Officers cause or contribute to Josh's death?

77. In the coronial context, issues of causation and contribution are determined in a common-sense manner. Further, in this case, I have approached the issue of contribution on the basis that a factor must have made a material contribution to death in order for it to be said to have contributed to that death.

78. A cascade of events led to Josh's death, and the evidence establishes he developed a fatal cardiac arrhythmia due to a combination of factors including: his pre-existing medical conditions; his exertion; his intoxication with alcohol; and his restraint in the prone position.

79. Josh's treating specialists were whether Josh's medical conditions meant he was more vulnerable in the context of restraint and alcohol use. In his report, Dr Baumwol (Josh's cardiologist) confirmed that Josh had been diagnosed with mild ventricular systolic dysfunction, and expressed the following opinion:

> I do not think that Joshua's cardiac condition made him more vulnerable. As noted above, on last review in August 2022 his heart function was only mildly impaired and quite stable on echocardiography, clinical examination, and on blood tests.[120]

80. In his report, Professor Moodley noted pulmonary function testing suggested Josh had moderately severe airways obstruction, and this "*limitation in Josh's lung function does make him vulnerable to any stress on his respiratory system*". Professor Moodley also expressed the following opinion:

> Restraint applied to the neck would be more hazardous for Joshua since he is asthmatic. His SOTOS syndrome and high BMI could result in increased tissue around his airway which could also predispose him to danger during restraint. I am unable to provide an opinion in relation to his combined risks, or vulnerabilities due to his other medical conditions as that is outside of my area of expertise.[121]

[120] Exhibit 1, Vol. 1, Tab 25, Report - Dr J Baumwol, Consultant Cardiologist, (09.12.24), p3
[121] Exhibit 1, Vol. 1, Tab 25.1, Report - Prof. Y Moodley, Consultant Cardiologist, (12.11.24), p3

81. Whilst I respect Professor Moodley's expertise, I wish to make it clear that in Josh's case, the evidence (and in particular the CCTV footage) makes it clear that **no** restraint was applied to Josh's neck at any stage.[122]

82. Given the clinical complexities in Josh's case, and paying careful regard to the available evidence, I have decided it is not possible to conclude (to the relevant standard) that the outcome in Josh's case would necessarily have been any different had CPR had been initiated earlier than it was.[123]

83. At the inquest, Dr White outlined the combination of factors which led to Josh's death, one of which was Josh's restraint in the prone position. Dr White also agreed that it was not possible to identify any particular factor as being more relevant than any other.[124]

84. After carefully considering the available evidence, I have been unable to conclude (to the relevant standard) that the acts or omissions of any of the Officers caused Josh's death. However, Josh's restraint in the prone position was one of the factors that contributed to his cardiac arrest, and therefore his death. In that context, the act of restraining Josh in the prone position contributed to his death, but only because of the physical and physiological factors that were affecting Josh at the relevant time.

Critical incident review

85. At the inquest, Mr Armstrong confirmed that the PTA did not conduct a formal review of the actions of the Officers following Josh's death.[125] Instead, Mr Armstrong said the Officers had been spoken to, and informal feedback had been given to them. In my view, this was a missed opportunity to examine the lawfulness of the conduct of the Officers and to identify "*lessons learned*".

86. I am mindful of the recommendations that were made by the Corruption and Crime Commission (the Commission) in 2024, following the Commission's review of a use of force incident by PTA transit officers. The Commission recommended the PTA:

[122] Exhibit 1, Vol. 2, Tabs 32 & 32.1, CCTV Footage (16.06.23)
[123] See also: ts 14.01.26 (White), p18
[124] ts 14.01.26(White), p9
[125] ts 15.01.26 (Armstrong), pp128-130

> Review, update, and implement policies and procedures associated with managing use of force incidents including, but not limited to:
>
> i. maintaining transparent oversight over incidents where Transit Officers have used their powers;
>
> ii. monitoring, identifying, and investigating any breaches of policy; and
>
> iii. ensuring use of force reporting and any review, aligns the justification for the force used with legislative power(s) and PTA policy.[126]

87. The Commission noted that the PTA was "*making changes to its systems dealing with use of force incidents*", but that it (i.e.: the Commission) would review the PTA's "*response to the recommendations in 12 months' time*".[127]

88. At the inquest, Mr Armstrong said that once the inquest had concluded, "*There will be a review of the process, we will decide the appropriate communication with the officers, yes*".[128] Whilst this is a welcome development, I remain concerned that the formal review proposed by Mr Armstrong is occurring several years after Josh's death. Given that memories tend to dim over time, there is a very real risk that valuable insights may be lost if a formal review is not conducted as soon as possible after the relevant incident.

89. I have therefore recommended that the PTA conduct a formal review following **all** critical incidents involving PTA transit officers where death or serious injury occurs. I have also recommended the PTA ensure that any "*lessons learned*" from such reviews are provided to all PTA transit officers.

[126] Exhibit 1, Vol. 2, Tab 43, Review of a PTA Use of Force Incident, Corruption & Crime Commission (17.09.24), p2 (para 12)
[127] Exhibit 1, Vol. 2, Tab 43, Review of a PTA Use of Force Incident, Corruption & Crime Commission (17.09.24), p2 (paras 13-14)
[128] ts 15.01.26 (Armstrong), p137

OPPORTUNITIES FOR IMPROVEMENT[129,130]

90. The available evidence identifies several opportunities for improvements which, if implemented, may reduce the risk of adverse outcomes to people in a similar situation to Josh. These opportunities include:

a. *Awareness of the risks associated with the prone position*: as I have noted, the level of understanding of the risks associated with the prone position which was displayed by the PTA transit officers who gave evidence at the inquest was below the level I would have expected. This is concerning as three of these officers are experienced officers, and one is now a PTA trainer, and I have recommended the PTA:

> Take immediate steps to ensure that transit officers are keenly aware that persons being detained in the prone position are at grave risk of experiencing positional asphyxia, and the need to minimise the time people spend in that position.

b. *Changes to Defensive Tactics manual and training methods*: in order to ensure that PTA transit officers are provided with the most appropriate guidance about the risks associated with positional asphyxia and the risks of detaining persons in the prone position, I have recommended further amendments to the Manual, including:

- More detailed and prescriptive guidance relating to monitoring persons being detained in the prone position;
- the inclusion of concrete examples of factors which may place a person at greater risk of experiencing positional asphyxia;
- more detailed information about the signs and symptoms to look for when monitoring a person detained in the prone position;
- the inclusion of the circumstances of Josh's case and the lessons learnt from his death; and
- the inclusion of a section emphasising that persons should be restrained in the prone position for as short a time as possible, and that given the risks associated with this position, literally every second counts.

[129] Exhibit 1, Vol. 2, Tab 46, Report - Mr P Armstrong (22.05.25) & ts 15.01.26 (Armstrong), pp131-138
[130] Exhibit 1, Vol. 2, Tab 48, Memorandum - Mr J Apai (17.12.25)

c. *Body worn cameras*: although Josh's interactions with the PTA transit officers were captured by overhead CCTV cameras, this footage did not include any audio of their interactions with him and was obviously not taken from the Officers' perspective.

Had the PTA transit officers who interacted with Josh been wearing body worn cameras (BWC), it would have been possible to make a more detailed assessment of their interactions with him. In addition, the signs and symptoms Josh was displaying could have been assessed from the perspective of the Officers who were restraining him.

The benefits of officers wearing BWC has been clearly demonstrated by WAPOL, and it is therefore unsurprising that the PTA have made the sensible decision to roll out BWC to all PTA transit officers.

In his report, Mr Apai stated that the BWC rollout had commenced and was "*expected to be completed by February 2026*".[131] At the inquest, Mr Armstrong confirmed that this timeline remained accurate.[132]

[131] Exhibit 1, Vol. 2, Tab 48, Memorandum - Mr J Apai (17.12.25), p4
[132] ts 15.01.26 (Armstrong), pp127-128

RECOMMENDATIONS

91. In view of the observations I have made, I make the following recommendations:

Recommendation No. 1

The Public Transport Authority (PTA) should take immediate steps to ensure that transit officers are keenly aware that persons being detained in the prone position are at grave risk of experiencing positional asphyxia and the need to minimise the time people spend in that position. The measures taken by the PTA should include (but are not limited to):

a. Liaising with Western Australia Police Force (WAPOL) to determine whether any of WAPOL's resources and/or policies relating to positional asphyxia are applicable to the PTA;

b. Revising the Defensive Tactics manual (the Manual) so that the guidance offered to transit officers monitoring persons being detained in the prone position is more detailed and prescriptive, and further:

   i. the Manual should provide concrete examples of factors which can place a person at greater risk of experiencing positional asphyxia, and the signs and symptoms to look for when monitoring a person detained in the prone position;

   ii. the Manual should include information about the circumstances of Josh's case and the lessons learnt from his death; and

   iii. the Manual should emphasise that persons must only be restrained in the prone position for as short a time as possible, and that every second in the prone position exposes the person to the risk of death.

c. Provide transit officers with regular refresher training (including practical scenarios and exercises) aimed at ensuring transit guards understand how to effectively monitor persons being detained in the prone position, and how such monitoring should be undertaken.

Recommendation No. 2
The Public Transport Authority (PTA) should consider providing contextualised life support training to transit officers during their Transit Officer Recruit Training program, and then during annual refresher courses thereafter.

Recommendation No. 3
The Public Transport Authority (PTA) should reassess ASP Hinged Ultra-Cuff handcuffs (ASP) currently issued to transit officers to determine whether they are fit for purpose when detaining persons of large build, and if not, whether an alternative type of restraint device should also be made available to transit officers.

Recommendation No. 4
The Public Transport Authority (PTA) should liaise with Western Australia Police Force (WAPOL) to determine whether the type of leg strap restraint used by WAPOL would be suitable for use by PTA transit officers.

Recommendation No. 5
The Public Transport Authority (the PTA) should ensure that a formal review is conducted following any critical incident involving transit guards where death or serious injury occurs. Further the PTA should ensure that "*lessons learned*" from all such reviews are provided to all PTA transit officers.

Comments relating to Recommendations

92. On 16 January 2026, Mr McDonald emailed a draft of my proposed recommendations to Ms Panetta (counsel for the PTA). Any feedback on the proposed recommendations was requested by the close of business on 30 January 2026.[133]

93. On 30 January 2026, Ms Panetta advised that the PTA had accepted each of the recommendations I had drafted, and wished to make the following comments about Recommendations 1, and 2:

> *Recommendation 1*: the PTA **accepts** proposed recommendation 1 and adds that whilst the Defensive Tactics Manual (**DT Manual**) at page 72 of 146 (reproduced at Tab 40 of the Coroner's Brief) already provides prescription of matters to monitor in regards to positional asphyxiation (under the heading of "symptoms of a restrained person"), the PTA acknowledges that greater clarity can be provided to this section of the DT Manual by appropriately re-titling the heading and building upon the existing content regarding positional asphyxiation. Further, the PTA intends to supplement this, as recommended, with improvements to the DT training package, that is delivered to both new trainees and operational staff through annual refreshers, to ensure Transit Officers understand the risk factors and how to effectively monitor persons being detained in the prone position.[134] [Original emphasis]
>
> *Recommendation 2*: the PTA **accepts** proposed recommendation 2 and adds that the PTA is currently engaging with the WA Police Force to review its contextualised life-support training and assess how the PTA's existing first aid program may be adapted or supplemented to meet this requirement. Although full-day annual first aid refresher training presents logistical challenges, particularly given the PTA's operating model, critical shift-coverage requirements, and staffing impacts associated with the METRONET expansion, the PTA will review opportunities to enhance its program through improvements to the DT training package (as noted above in relation to Proposed Recommendation 1). The PTA will also explore the feasibility of incorporating a condensed, contextualised life-support refresher module into its annual rail safety refresher training.[135] [Original emphasis]

[133] Email - Mr D McDonald (16.01.26)
[134] Letter attached to email - Ms R Panetta (State Solicitors Office) to Counsel Assisting (30.01.26), p1
[135] Letter attached to email - Ms R Panetta (State Solicitors Office) to Counsel Assisting (30.01.26), pp1-2

CONCLUSION

94. The death of a loved one is a sad occasion, but Josh was only 24 years old when he died on 16 June 2023, after having been restrained by PTA transit guards. The death of such a young man in such circumstances is by definition, an unfathomable tragedy.

95. Although I am satisfied that Josh's arrest was lawful and justified by his disorderly conduct, I found the standard of monitoring Josh received whilst he was restrained in handcuffs in the prone position, was **poor**.

96. Had the Officers been monitoring Josh more effectively, there is little doubt they would have realised he had stopped breathing and they would have started CPR earlier. However, on the basis of the available evidence, I was unable to conclude that had CPR been started earlier, Josh would necessarily have survived.

97. After carefully considering the available evidence, I have made five recommendations which the PTA have accepted, and which I hope will be enthusiastically embraced.

98. It is a common misconception that at some point after a loved one's death there is "*closure*". Those who have experienced profound loss know this is not the case. The aching void left by a loved one's death does not get filled, nor do the feelings of grief and sadness disappear. However, with the passage of time, perhaps it may be that the sense of loss becomes a little easier to bear. As well, memories of happier times tend to emerge and these memories can help to deaden the ache. It is my sincere hope that Josh's family may have this experience.

99. I wish to acknowledge the members of Josh's family who attended the inquest, and I thank them for conducting themselves with impeccable composure in difficult and often painful circumstances.

100. I would also like to thank Josh's mother (Ms Fisher) for the moving statement she provided, in which she gave an insight into the person Josh was. It is very clear to me that despite his challenges, Josh was a much-loved family member who is sorely missed.

101. As I did at the conclusion of the inquest, I take this further opportunity to express my sincere condolences to Josh's family and friends on their terrible loss.

102. Finally, I wish to conclude this finding with the following quote from Ms Fisher's statement:

> Josh's death has devastated our family. It has also affected the Transperth guards, police officers, and emergency service workers who attended that day. No one involved set out to cause harm or loss of life. This should never have happened. With appropriate funding, proper supports, and better training, particularly around restraining and placing in the prone position those presenting with disability, mental health, overweight, and substance abuse, I believe Josh would still be alive. Our son deserved better. Our family deserved better. The system must do better.[136]

MAG Jenkin
Acting Deputy State Coroner

2 February 2026

[136] Exhibit 1, Vol. 2, Tab 49, Statement - Ms D Fisher (14.01.26)