JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	29 JANUARY 2025
DELIVERED	**:**	3 FEBRUARY 2025
FILE NO/S	**:**	CORC 2269 of 2022 & CORC 2267 of 2022
DECEASED	**:**	RANDALL, NATHAN ALAN DIXON, JESSE KYEL

Cases:

Briginshaw v Briginshaw (1938) 60 CLR 336

Legislation:

Coroners Act 1996 (WA)

Counsel Appearing:

Mr J Tiller appeared to assist the coroner.

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

SUPPRESSION ORDER

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

Order made by: MAG Jenkin, Coroner (20.01.25)

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Nathan Alan Randall*** *and* ***Jesse Kyel Dixon*** *(together referred to as the deceased persons) with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 29 January 2025, find that the identity of the deceased persons was as follows:*

Nathan Alan Randall *and that death occurred in the vicinity of the intersection between Ennis Avenue and Patterson Road in East Rockingham on 18 August 2022 from head injury; and*

Jesse Kyel Dixon *and that death occurred in the vicinity of the intersection between Ennis Avenue and Patterson Road in East Rockingham on 18 August 2022 from multiple injuries; in the following circumstances:*

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INTRODUCTION

1. At about 2.10 am on 18 August 2022, Nathan Alan Randall (Nathan)[1] was riding a motorcycle north along Ennis Avenue in East Rockingham and Jesse Kyel Dixon (Jesse)[2] was his pillion passenger. As Nathan rode through the intersection of Ennis Avenue and Dixon Road, he passed a marked police car driven by Senior Constable Wigger (Officer Wigger).

2. For reasons I will explain, Officer Wigger decided to follow the motorcycle to conduct further enquiries, but Nathan accelerated away and Officer Wigger lost sight of the motorcycle. A short time later, Nathan collided with a tree and died from head injury. His passenger Jesse died from multiple injuries.[3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19]

3. Under the terms of the *Coroners Act 1996* (the Act), the deaths of both Nathan and Jesse were "*reportable deaths*". Further, on the basis that there was a possibility that a member of the Western Australian Police Force (the Police) may have caused or contributed to these deaths, a coronial inquest was mandatory.[20]

4. I wish to make it clear that section 22(1)(b) of the Act is enlivened whenever the issue of causation or contribution in relation to a death arises as a question of fact, irrespective of whether there is any fault on the part of any member of the Police.[21]

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[1] Mr Randall's family requested that he be referred to as "Nathan" at the inquest and in this finding
[2] Mr Dixon's family requested that he be referred to as "Jesse" at the inquest and in this finding
[3] Exhibit 1, Vol. 1, Tab 1.1, P100 - Report of Death - Mr N Randall (18.08.22)
[4] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death - Mr J Dixon (18.08.22)
[5] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sgt. S Malcolm (15.02.24)
[6] Exhibit 1, Vol. 1, Tab 3, P92 - Identification of Deceased Person - Mr J Dixon (18.08.22)
[7] Exhibit 1, Vol. 1, Tab 3, Affidavit - Sen. Const. S Durka (18.08.22)
[8] Exhibit 1, Vol. 1, Tab 3, Affidavit - Sen. Const. D Forbes (16.09.22)
[9] Exhibit 1, Vol. 1, Tab 3, Coronial Identification Report - Mr J Dixon (18.08.22)
[10] Exhibit 1, Vol. 1, Tab 3.1, P92 - Identification of Deceased Person - Mr N Randall (18.08.22)
[11] Exhibit 1, Vol. 1, Tab 3.1, Affidavit - Sen. Const. R Allison (18.08.22)
[12] Exhibit 1, Vol. 1, Tab 3.1, Affidavit - Sen. Const. D Forbes (16.09.22)
[13] Exhibit 1, Vol. 1, Tab 3.1, Coronial Identification Report - Mr N Randall (18.08.22)
[14] Exhibit 1, Vol. 1, Tab 4, Life Extinct Form Report - Mr J Dixon (18.08.22)
[15] Exhibit 1, Vol. 1, Tab 4.1, Life Extinct Form Report - Mr N Randall (18.08.22)
[16] Exhibit 1, Vol. 1, Tab 5, Post Mortem Report - Mr J Dixon (22.08.22)
[17] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report - Mr J Dixon (28.09.22)
[18] Exhibit 1, Vol. 1, Tab 5.1, Post Mortem Report - Mr N Randall (01.09.22)
[19] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report - Mr N Randall (14.10.22)
[20] Sections 3 & 22(1)(b), *Coroners Act 1996* (WA)
[21] Section 22(1)(b), *Coroners Act 1996* (WA)

5. When assessing the available evidence and considering whether to make any adverse findings or comments, I have been mindful of the "*Briginshaw test*". This principle is derived from a High Court judgment of the same name, in which Justice Dixon said:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "*reasonable satisfaction*" should not be produced by inexact proofs, indefinite testimony, or indirect inferences.[22]

6. Essentially the Briginshaw test provides that the more serious the allegation, the higher the degree of probability that is required before I can be satisfied as to the truth of the allegation.

7. For reasons I will explain, after carefully considering the available evidence I have been unable to conclude, to the relevant standard, that any member of the Police caused or contributed to the deaths of either Jesse or Nathan. I have also concluded that there is no basis for me to make any adverse finding or comment against any person.

[22] *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 362

BACKGROUND

Nathan[23]

8. Nathan was born on 19 December 2004, and was 17 years of age when he died.[24] Although Nathan's mother declined the opportunity to provide police with any background information about her son, police enquiries established that Nathan had four siblings, and that he was in a relationship at the time of his death.

9. When speaking with investigating police, Nathan's mother emphasised that although Nathan had never held a Western Australian driver's licence, Nathan "*was an experienced motorcycle rider, having ridden trail bikes most of his life*.[25]

Jesse[26]

10. Jesse was born on 14 January 2000, and was 22 years of age when he died.[27] Jesse was described by his mother as a "*gentle giant*", and as a humble person "*who tried never to disappoint anyone*". Jesse had been diagnosed with a mild form of autism which affected his social interactions, but he had a very strong sense of empathy and social justice, and was always willing to help others.

11. Jesse enjoyed sports, including golf, and he "*was good at anything he did with his hands*". Jesse had completed courses in landscaping and horticulture and he was actively seeking work in these fields. Jesse had a sister, and he was said to have a particularly close relationship with his grandmother.

[23] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sgt. S Malcolm (15.02.24), p8
[24] Exhibit 1, Vol. 1, Tab 1.1, P100 - Report of Death - Mr N Randall (18.08.22)
[25] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sgt. S Malcolm (15.02.24), p8
[26] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sgt. S Malcolm (15.02.24), p8
[27] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death - Mr J Dixon (18.08.22)

EVENTS ON 18 AUGUST 2022

Jesse and Nathan are observed[28,29,30,31,32]

12. At about 2.10 am on 18 August 2022, Nathan was riding a Honda motorcycle (the Motorcycle) north along Ennis Avenue in East Rockingham, with Jesse as his pillion passenger. This area is a light industrial zone, and there was no traffic on the road at the relevant time. The weather was cold, and drizzly rain had left a film of water on the road. The roadway was lit by street lights but a heavy fog affected visibility.[33,34]

13. As Nathan rode through the intersection of Ennis Avenue and Dixon Road, he passed a marked police car being driven by Officer Wigger, who was on patrol with his police dog "*Digga*" as part of the Police Canine Section. Officer Wigger had been in the turning lane and had been intending to turn right onto Dixon Road in order to head home at the end of his shift.[35]

14. As Officer Wigger explained in his statement, he decided to follow the Motorcycle to conduct further enquiries because:

> As the motorbike passed a few things caught my attention regarding it. It seemed an odd time for two people to be going for a motorbike ride and the weather wasn't ideal. The rider and passenger glanced at me and it looked like they had their faces covered. The number plate attached to the bike looked oddly shaped and possibly altered.[36]

15. Officer Wigger turned onto Ennis Avenue (a manoeuvre officers are authorised to perform in these circumstances) and as he did so, the Motorcycle sped away from the intersection and Officer Wigger briefly accelerated to 100 km per hour. At that time, the Motorcycle was travelling at a much faster speed (estimated to be about 115 km per hour on average).[37,38]

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[28] Exhibit 1, Vol. 1, Tab 11, Statement - Sen. Const. F Wigger (15.09.22) and ts 29.01.25 (Wigger), pp9-29
[29] Exhibit 1, Vol. 1, Tab 20, Report - Det. Sgt. S Perejmibida (02.03.23) and ts 29.01.25 (Perejmibida), pp29-40
[30] Exhibit 1, Vol. 1, Tab 11.1 & Exhibit 2, Dash-cam footage from TK102 (18.08.22)
[31] Exhibit 1, Vol. 1, Tab 11.2 & Exhibit 3, Vehicle location data from TK102 (18.08.22)
[32] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sgt. S Malcolm (15.02.24)
[33] Exhibit 1, Vol. 1, Tab 11, Statement - Sen. Const. F Wigger (15.09.22), para 10 and ts 29.01.25 (Wigger), pp12-13
[34] Exhibit 1, Vol. 1, Tab 20, Report - Det. Sgt. S Perejmibida (02.03.23), p9
[35] 29.01.25 (Wigger), pp9-10 & 13-14
[36] Exhibit 1, Vol. 1, Tab 11, Statement - Sen. Const. F Wigger (15.09.22), paras 16-19 and 29.01.25 (Wigger), pp14-16
[37] Exhibit 1, Vol. 1, Tab 11, Statement - Sen. Const. F Wigger (15.09.22), paras 24-27 and ts 29.01.25 (Wigger), pp13-18
[38] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sgt. S Malcolm (15.02.24), p9 and ts 29.01.25 (Perejmibida), pp33-34

16. As Officer Wigger drove through a slight left-hand bend in Ennis Avenue, he realised that the Motorcycle was "*a long way*" in front of him and made the decision to "*just let it go*".[39]

17. In his statement, Officer Wigger said he did not activate his vehicle's emergency lights and/or siren, and that: "*at no point did I engage the motorbike or have any intention to stop it*". At the inquest Officer Wigger said it would not have been safe for him to have attempted to stop the Motorcycle because he was patrolling alone. In his statement, Officer Wigger confirmed that at the relevant time, his intention was to: "*[S]imply garner more information, assess its speed and if possible, obtain a registration before deciding what to do next*".[40]

18. At the point he lost sight of the Motorcycle, Officer Wigger was about 500 m from the intersection of Ennis Avenue and Patterson Road (the Intersection). In his statement, Officer Wigger says he "*had no idea*" where the Motorcycle had gone and there was a "*significant fog*" in the road in front of him. Officer Wigger also said: "*At no point did I engage with the motorbike or have any intention to stop it*".[41]

19. As he approached the Intersection, Officer Wigger saw an unidentified male emerge from the shadows on the opposite side of Ennis Avenue. Officer Wigger said he thought this person may have been the rider or passenger of the Motorcycle, and that it was "*not uncommon for a rear passenger to be dropped off or for a vehicle to be dumped and for the occupants to flee on foot*".[42]

20. Officer Wigger stopped and spoke with the male at the Intersection who told him he had seen "*sparks*", and that a motorbike had ridden off to the left (i.e.: along Patterson Road towards Rockingham). Officer Wigger asked the male to remain in the vicinity of the Intersection and although he conducted a patrol towards Rockingham along Patterson Road, Officer Wigger was unable to locate the Motorcycle.[43]

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[39] Exhibit 1, Vol. 1, Tab 11, Statement - Sen. Const. F Wigger (15.09.22), paras 24-27 and 29.01.25 (Wigger), pp19-20
[40] Exhibit 1, Vol. 1, Tab 11, Statement - Sen. Const. F Wigger (15.09.22), paras 24 & 32
[41] Exhibit 1, Vol. 1, Tab 11, Statement - Sen. Const. F Wigger (15.09.22), paras 29-32 and ts 29.01.25 (Wigger), pp19-20
[42] Exhibit 1, Vol. 1, Tab 11, Statement - Sen. Const. F Wigger (15.09.22), paras 33-35
[43] Exhibit 1, Vol. 1, Tab 11, Statement - Sen. Const. F Wigger (15.09.22), paras 36-44 and 29.01.25 (Wigger), pp20-21

21. Officer Wigger says he told the "*police radio operator*" that the Motorcycle's "*last known direction of travel*" was towards Rockingham. A few minutes later Officer Wigger spoke briefly with police officers in another vehicle travelling in the opposite direction, and he told them about his earlier conversation with the male at the Intersection. Officer Wigger also told the officers he had no idea where the Motorcycle was.[44]

22. A short time later, Officer Wigger heard a police radio call requesting assistance for two males who were "*in a critical condition*". After receiving further information, Officer Wigger realised the location of this task was near where he had last seen the Motorcycle. Officer Wigger asked to be assigned to the task, and he proceeded directly to the crash scene. By the time Officer Wigger arrived, ambulances and police vehicles were already there.[45,46]

Evidence from Ms Lavering[47,48]

23. For the sake of completeness, I note that in his Major Crash Investigation report, Detective Sergeant Malcolm (Officer Malcolm) refers to evidence from a witness called Ms Lavering, who says that at the relevant time she was riding an electric bicycle on Ennis Avenue. In her unsigned statement, Ms Lavering says the Motorcycle passed her "*very fast*" and she believed it was travelling too fast for the foggy conditions at the time.

24. Ms Lavering then says she saw a police car, that did not have its emergency lights and siren activated, follow the Motorcycle. Given the available evidence, this police vehicle must have been Officer Wigger's police car (i.e.: "TK102").

25. Ms Lavering says after the Motorcycle had passed her, TK102 followed behind it and was "*getting faster and changing lanes a few times*". Ms Lavering also says that "*the bike was going fast but the police car was gaining on it*", and "*the police car must have been going fast because it was gaining on the bike*".[49,50]

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[44] Exhibit 1, Vol. 1, Tab 11, Statement - Sen. Const. F Wigger (15.09.22), paras 44-45 and 29.01.25 (Wigger), pp21-22
[45] Exhibit 1, Vol. 1, Tab 11, Statement - Sen. Const. F Wigger (15.09.22), paras 47-50 and 29.01.25 (Wigger), pp21-24
[46] Exhibit 1, Vol. 1, Tab 11.2 & Exhibit 3, Vehicle location data from TK102 (18.08.22)
[47] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sgt. S Malcolm (15.02.24), p6
[48] Exhibit 1, Vol. 1, Tab 20, Report - Det. Sgt. S Perejmibida (02.03.23), pp24-26 and 29.01.25 (Perejmibida), pp37-37
[49] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sgt. S Malcolm (15.02.24), p6
[50] Exhibit 1, Vol. 1, Tab 20, Report - Det. Sgt. S Perejmibida (02.03.23), pp24-25

26. In his Internal Affairs Unit report, Detective Sergeant Perejmibida (Officer Perejmibida) makes the following observation about Ms Lavering's recollections about TK102's speed and proximity to the Motorcycle:

> (Ms Lavering's) recollections regarding speeds and distances are inconsistent with evidence obtained from dash cam and CCTV footage, and ARL[51] data. Portions of (Ms Lavering's) statement pertaining to these portions cannot be relied upon.[52]

27. The Dashcam footage from TK102 clearly shows that as the Motorcycle passes TK102 at the intersection of Ennis Avenue and Dixon Road, TK102 briefly accelerates and follows the Motorcycle, before the Motorcycle disappears into heavy fog and TK102 decelerates.[53,54]

28. Having carefully reviewed dashcam footage from TK102, I have concluded that Ms Lavering's evidence about TK102's speed and proximity to the Motorcycle is unreliable and cannot be correct.

Emergency service response[55,56,57,58,59,60,61,62,63,64,65,66,67,68,69]

29. Meanwhile, members of the public who were in the relevant area heard what appeared to be a motorbike crashing, and called emergency services.[70] Ambulances and police vehicles responded to this call, and the first of three ambulances arrived at the scene at 2.25 am.[71]

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[51] ARL is the abbreviation for "automated resource location" and provides automatic vehicle location information
[52] Exhibit 1, Vol. 1, Tab 20, Report - Det. Sgt. S Perejmibida (02.03.23), p24
[53] Exhibit 1, Vol. 1, Tab 11.1 & Exhibit 2, Dash-cam footage from TK102 (18.08.22)
[54] See also: Exhibit 1, Vol. 1, Tab 11.2 & Exhibit 3, Vehicle location data from TK102 (18.08.22)
[55] Exhibit 1, Vol. 1, Tab 11, Statement - Sen. Const. F Wigger (15.09.22), paras 51-54 and ts 29.01.25 (Wigger), pp20-25
[56] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sgt. S Malcolm (15.02.24)
[57] Exhibit 1, Vol. 1, Tab 20, Report - Det. Sgt. S Perejmibida (02.03.23) and ts 29.01.25 (Perejmibida), pp29-40
[58] Exhibit 1, Vol. 1, Tabs 22.1 - 22.3, SJA Patient Care Records (22068783, 22068784 &22068785 - 18.08.22)
[59] Exhibit 1, Vol. 1, Tab 9, Preliminary crash investigation and scene photos (23.08.22)
[60] Exhibit 1, Vol. 1, Tab 9.1, Initial collision assessment report (23.08.22)
[61] Exhibit 1, Vol. 1, Tab 10, Vehicle examination summary report (07.09.22)
[62] Exhibit 1, Vol. 1, Tab 12, Statement - Const. M Henderson (09.09.22)
[63] Exhibit 1, Vol. 1, Tab 13, Statement - Const. A Boon (09.09.22) & scene photographs (18.08.22)
[64] Exhibit 1, Vol. 1, Tab 14, Statement - Sen. Const. P Mason (02.09.22)
[65] Exhibit 1, Vol. 1, Tab 15, Statement - Const. M Fahey (09.09.22)
[66] Exhibit 1, Vol. 1, Tab 16, Statement - Const. B Mitchell (11.09.22)
[67] Exhibit 1, Vol. 1, Tab 17, Statement - Sen. Const. B Coates (02.09.22)
[68] Exhibit 1, Vol. 1, Tab 18, Statement - Sen. Const. M Cook (05.09.22)
[69] Exhibit 1, Vol. 1, Tab 19, Statement - Const. D Fraser (09.09.22)
[70] Exhibit 1, Vol. 1, Tab 7, Statement - Mr C Turner (18.08.22)
[71] Exhibit 1, Vol. 1, Tab 22.1, SJA Patient Care Record (22068783 - 18.08.22)

30. After travelling through the Intersection, the Motorcycle had collided with trees and sustained serious damage. It was found on its side in a grassed area about 35 m from the Intersection. Ambulance and police officers were attending to Nathan and Jesse, who were both lying on the ground about 15 m in front of the Motorcycle. Both Nathan and Jesse had sustained very serious injuries. Despite resuscitation efforts Nathan and Jesse could not be revived, and they were each declared deceased at the scene.[72,73,74]

Inspection of Motorcycle[75,76]

31. Nathan purchased the Motorcycle on 6 August 2022.[77] Following the crash, the Motorcycle was inspected by a police vehicle examiner who noted that although its front tyre was "*low in thread depth condition to the centre area*", the tyre's shoulders were compliant and serviceable.

32. The vehicle examiner also stated it "*appears all damaged items are crash related*". Further, although the Motorcycle's front master cylinder was damaged rendering the front brakes inoperable, its rear brakes, and the remaining undamaged front brake components appeared to be "*serviceable in condition and operation pre-crash*".

Motorcycle licence[78,79]

33. Although Nathan had never held a driver's licence of any kind, according to his mother, he was "*an experienced motorcycle rider*".[80] In his report, Officer Malcolm made the following observation:

> The level of experience and proficiency (Nathan) had as a motorcyclist is unknown as he had never held a Drivers Licence. The Honda he was riding is not considered to be a vehicle suitable for an inexperienced rider and it has legal licencing restrictions placed on it to prevent this from occurring. Further to this carrying a pillion passenger typically alters the normal handling characteristics of a motorcycle.[81]

[72] Exhibit 1, Vol. 1, Tab 22.1, SJA Patient Care Record (22068783 - 18.08.22)
[73] Exhibit 1, Vol. 1, Tab 4, Life Extinct Form Report - Mr J Dixon (18.08.22)
[74] Exhibit 1, Vol. 1, Tab 4.1, Life Extinct Form Report - Mr N Randall (18.08.22)
[75] Exhibit 1, Vol. 1, Tab 10, Vehicle examination summary report (07.09.22)
[76] Exhibit 1, Vol. 1, Tab 10.1, Statement - Mr P Willsher (22.11.22)
[77] Exhibit 1, Vol. 1, Tab 8, Statement - Mr K Hood (19.09.22)
[78] Exhibit 1, Vol. 1, Tab 10, Vehicle examination summary report (07.09.22)
[79] Exhibit 1, Vol. 1, Tab 10.1, Statement - Mr P Willsher (22.11.22)
[80] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sgt. S Malcolm (15.02.24), p8
[81] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sgt. S Malcolm (15.02.24), p8

CAUSE AND MANNER OF DEATH - NATHAN[82,83]

34. A forensic pathologist (Dr Junckerstorff) conducted a post mortem examination of Nathan's body on 1 September 2022 at the State Mortuary and reviewed post mortem CT scans.

35. Dr Junckerstorff noted a laceration to the back of Nathan's head, and bruises and abrasions on his limbs. Post mortem CT scans showed Nathan had sustained skull fractures and there was bleeding on the surface of his brain (subarachnoid haemorrhage). Fractures of Nathan's left shoulder blade, left collarbone, breast bone and thoracic vertebrae were also noted.

36. Nathan tested negative to the COVID-19 virus, and toxicological analysis detected tetrahydrocannabinol in his system, indicating recent use of cannabis.[84,85]

37. Nathan had a blood alcohol level of 0.099% in one sample and 0.13% in another, and a urine alcohol level of 0.188%. Other common drugs were not detected.[86]

38. At the conclusion of his post mortem examination, Dr Junckerstorff expressed the opinion that the cause of Nathan's death was "*head injury*".[87]

39. I accept and adopt Dr Junckerstorff's conclusion as my finding in relation to the cause of Nathan's death, and I find that his death occurred by way of accident.

[82] Exhibit 1, Vol. 1, Tab 5.1, Post Mortem Report - Mr N Randall (01.09.22)
[83] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report - Mr N Randall (14.10.22)
[84] Exhibit 1, Vol. 1, Tab 6.2, COVID-19 Report - Mr N Randall (19.08.22)
[85] Exhibit 1, Vol. 1, Tab 6.2, Toxicology Report - Mr N Randall (04.10.22)
[86] Exhibit 1, Vol. 1, Tab 6.2, Toxicology Report - Mr N Randall (04.10.22)
[87] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report - Mr N Randall (14.10.22)

CAUSE AND MANNER OF DEATH - JESSE[88,89]

40. Dr Junckerstorff conducted a post mortem examination of Jesse's body at the State Mortuary on 23 August 2022, and reviewed post mortem CT scans.

41. Dr Junckerstorff noted that Jesse had sustained lacerations, abrasions and palpable fractures of his left collarbone, left shoulder blade, and the left side of his pelvis.

42. Post mortem CT scans showed that in addition to multiple rib fractures, Jesse had sustained tears to his lungs (traumatic pneumatoceles), air in the chest cavity (bilateral pneumothoraces), a laceration to his spleen, and there was blood in his abdomen and pelvis.

43. Jesse tested negative to the COVID-19 virus, and toxicological analysis found he had a blood alcohol level of 0.060%, and a urine alcohol level of 0.083%. Other common drugs and cannabinoids were not detected.[90,91,92]

44. At the conclusion of his post mortem examination, Dr Junckerstorff expressed the opinion that the cause of Jesse's death was "*multiple injuries*".[93]

45. I accept and adopt Dr Junckerstorff's conclusion as my finding in relation to the cause of Jesse's death, and I find that death occurred by way of accident.

[88] Exhibit 1, Vol. 1, Tab 5, Post Mortem Report - Mr J Dixon (22.08.22)
[89] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report - Mr J Dixon (28.09.22)
[90] Exhibit 1, Vol. 1, Tab 6.1, Final Toxicology Report - Mr J Dixon (12.09.22)
[91] Exhibit 1, Vol. 1, Tab 6.1, Urgent Interim Toxicology Report - Mr J Dixon (25.08.22)
[92] Exhibit 1, Vol. 1, Tab 6.1, COVID-19 Report - Mr J Dixon (19.08.22)
[93] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report - Mr J Dixon (28.09.22)

ASSESSMENT OF POLICE CONDUCT

Relevant considerations[94,95]

46. At the conclusion of his investigation, Officer Malcolm concluded that the deaths of Nathan and Jesse should be investigated as a coronial matter on the basis that there had been no direct contact between TK102 and the Motorcycle at any time, and "*therefore there is no criminality in the actions of the police vehicle in relation to the crash*".[96]

47. Officer Malcolm's conclusion was supported by Inspector Brierley from State Traffic, who noted that Officer Wigger had not activated the TK102's emergency lights or siren, and had discontinued his attempt to follow the Motorcycle after about four seconds when the Motorcycle accelerated heavily away.[97]

48. After assessing the available evidence, Inspector Brierley noted that Officer Wigger had advised Police Communications of his intentions in a timely manner, and that dashcam footage, location data from TK102, and the "*initial scene account*" corroborated Officer Wigger' account.[98]

49. Inspector Brierley noted that TK102 was a significant distance from the Intersection when the crash occurred, and there had been no direct contact between TK102 and the Motorcycle at any time. Inspector Brierley concluded: "*The driver of the police vehicle (i.e.: Officer Wigger) has not breached policy and his actions throughout the incident are lawful*".[99]

50. The matter was referred to Officer Perejmibida at the Internal Affairs Unit, who conducted a managerial investigation to determine whether Officer Wigger had adhered to relevant Police policies on the morning of 18 August 2022. Officer Perejmibida assessed the available evidence including dashcam footage from TK102 and CCTV footage, the accounts of witnesses (including Mr Turner and Ms Lavering), and the contents of Officer Malcolm's report.

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[94] Exhibit 1, Vol. 1, Tab 20, Report - Det. Sgt. S Perejmibida (02.03.23) and ts 29.01.25 (Perejmibida), pp29-40
[95] ts 29.01.25 (Wigger), pp25-26
[96] Exhibit 1, Vol. 1, Tab 20, Report - Det. Sgt. S Perejmibida (02.03.23), p6
[97] Exhibit 1, Vol. 1, Tab 20, Report - Det. Sgt. S Perejmibida (02.03.23), pp6-8
[98] Exhibit 1, Vol. 1, Tab 20, Report - Det. Sgt. S Perejmibida (02.03.23), p7
[99] Exhibit 1, Vol. 1, Tab 20, Report - Det. Sgt. S Perejmibida (02.03.23), p7

IAU report findings[100]

51. Following the crash, Officer Wigger was taken to the Rockingham police station and at 6.17 am he underwent drug and alcohol testing, the results of which were negative.[101,102] Officer Perejmibida also noted that at the relevant time, Officer Wigger was a qualified pursuit driver (having gained that qualification in 2014) and at the inquest, Officer Wigger confirmed he had completed annual pursuit driver refresher training.[103,104]

52. After carefully reviewing the available evidence, Officer Perejmibida expressed the following conclusion (with which I agree) in relation to Officer Wigger's conduct:

> The managerial investigation concluded Wigger's driving was reasonably necessary to perform a function of his duty in the circumstances and no breach of policy was identified.[105]

Conclusions about the conduct of Officer Wigger

53. At the start of the inquest, I made a non-publication order in relation to any evidence relating to police policies concerning urgent duty/emergency driving procedures, including any cap on the speed at which police officers are authorised to drive. Therefore, I do not intend to canvas the relevant provisions of those policies in this finding.

54. It is enough for me to say that after carefully considering the available evidence, I am satisfied that Officer Wigger's conduct was not in breach of any Police policies or procedures, and further that his actions were reasonable and appropriate in all of the circumstances.

55. Although Nathan sped off after seeing TK102, Officer Wigger did not activate TK102's emergency lights or sirens, nor did he pursue the Motorcycle for an extended period. Because of the speed Nathan was travelling, Officer Wigger lost sight of the Motorcycle moments after he had made the decision to follow it and conduct further enquiries.

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[100] Exhibit 1, Vol. 1, Tab 20, Report - Det. Sgt. S Perejmibida (02.03.23) and ts 29.01.25 (Perejmibida), pp29-40
[101] Exhibit 4, WA Police Alcohol and Drug Testing form 6243 (6.17 am, 18.08.23)
[102] The test includes alcohol, amphetamines, opiates, benzodiazepines, methylamphetamine, cocaine, and cannabis
[103] Exhibit 1, Vol. 1, Tab 20, Report - Det. Sgt. S Perejmibida (02.03.23), pp9, 13 & 31
[104] ts 29.01.25 (Wigger), pp10-11 & 25 and ts 29.01.25 (Perejmibida), pp30-31, 36 & 38-39
[105] Exhibit 1, Vol. 1, Tab 20, Report - Det. Sgt. S Perejmibida (02.03.23), p41

56. It follows that there was nothing about Officer Wigger's decision to conduct further enquiries, or his decision to follow the Motorcycle that was causally connected to Nathan's subsequent actions, and/or the collision between the Motorcycle and some trees which led to the deaths of Nathan and Jesse.

57. For the avoidance of doubt, I wish to make it clear that having carefully considered the available evidence, I find that the actions of Officer Wigger on 18 August 2022 did not contribute to, or cause the deaths of either Nathan or Jesse.

CONCLUSION

58. In this tragic case two young men (Nathan and his passenger Jesse) were killed, when Nathan collided with trees after deciding to ride his motorcycle well in excess of the posted speed limit whilst intoxicated by cannabis and alcohol.

59. It is impossible to know why Nathan decided to speed off on his motorcycle after seeing TK102. Nathan may have been motivated to evade police because he did not have a valid driver's licence. He would also have been aware that he had recently used cannabis and consumed alcohol, and may have been concerned that his intoxication would be detected if he were to be stopped by police.[106]

60. Whatever factors may have motivated Nathan to act as he did, after carefully considering the available evidence I concluded that the actions of Officer Wigger were reasonable and did not contribute to, or cause the deaths of either Nathan or Jesse.

61. At the inquest, Jesse's sister read out a letter from her mother setting out in loving terms who Jesse was, and what his loss has meant to his loved ones. I commend Jesse's sister for her bravery in reading out this beautiful tribute to her brother, and I sincerely thank her for doing so.

[106] Exhibit 1, Vol. 1, Tab 20, Report - Det. Sgt. S Perejmibida (02.03.23), p29

62. It is impossible for me to comprehend the impact that the deaths of Nathan and Jesse have had (and continue to have) on their respective families and friends. The lives of these two much loved men were snuffed out at a time when they were yet to realise their full potential, and to lose loved ones at such a young age is a truly awful thing.

63. As I did at the conclusion of the inquest, I wish to again extend, on behalf of the Court, my most sincere condolences to the families and loved ones of Nathan and Jesse for their terrible loss.

MAG Jenkin
Coroner
3 February 2025