JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN
HEARD	**:**	6 - 7 MAY 2025
DELIVERED	**:**	8 JULY 2025
FILE NO/S	**:**	CORC 1 of 2023
DECEASED	**:**	HART, TRAVIS BARRY MARK KIMBERLY

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S Tyler appeared to assist the coroner.

Ms K Niclair (State Solicitor's Office) appeared on behalf of the Western Australia Police Force.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Travis Barry Mark Kimberley HART*** with *an inquest held at the Kalgoorlie Courthouse, 208 Hannan Street, Kalgoorlie on 6 - 7 May 2025, find that the identity of the deceased person was* ***Travis Barry Mark Kimberley HART*** *and that death occurred on or about 25 December 2022 in bushland in Kalgoorlie, from heat stroke (environmental exposure) in a man with methylamphetamine effect, in the following circumstances:*

Table of Contents

INTRODUCTION

1. Travis Barry Mark Kimberley Hart (Mr Hart) was 33 years of age[1] when he died in bushland outside Kalgoorlie on or about 25 December 2022 from heat stroke (environmental exposure) with methylamphetamine effect.[2,3,4,5,6,7,8]

2. Shortly before his death, Mr Hart was the passenger in a vehicle (the Vehicle) with three friends that was being pursued by police. The police intercept was terminated when police lost sight of the Vehicle. Mr Hart and his friends abandoned the Vehicle after it had become damaged, and walked off in separate directions. Although three of the men in the Vehicle made it home safely Mr Hart did not, and his body was discovered on 30 December 2022.

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

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

5. I held an inquest into Mr Hart's death in Kalgoorlie on 6 - 7 May 2025 that was attended by members of his family. The documentary evidence tendered at the inquest comprised one volume, and the inquest focussed on the conduct of the police officers involved in the attempted intercept, and the circumstances of Mr Hart's death.

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

[1] Mr Hart would have been 33 years and 11 months if (as I have found) he died on or about 25 December 2022
[2] Exhibit 1, Vol.1, Tab 1, P100 - Report of Death (21.11.24)
[3] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24)
[4] Exhibit 1, Vol.1, Tab 3, P92 - Identification of Deceased Person Other than by Visual Means (02.01.23)
[5] Exhibit 1, Vol.1, Tab 3, Affidavit - Sgt. M Lee (02.01.23)
[6] Exhibit 1, Vol.1, Tab 3, Affidavit - Sgt. A McCulloch (30.12.22)
[7] Exhibit 1, Vol.1, Tab 3, Coronial Identification Report (30.12.22)
[8] Exhibit 1, Vol.1, Tab 4, Supplementary Post Mortem Report (30.08.23)
[9] Sections 3 & 22(1)(b), *Coroners Act 1996* (WA)

a. Det. Sgt. J Hannan, Investigating Officer (Officer Hannan);[10]
b. Mr R Lynch, Vehicle occupant (Mr Lynch);[11]
c. Const. S Vuleta, Passenger in intercept vehicle (Officer Vuleta);[12]
d. Sgt. K Rae, Driver of intercept vehicle (Officer Rae);[13]
e. Mr B Wells, Vehicle occupant (Mr Wells);[14]
g. Sgt. D Saunders, Kalgoorlie police station (Officer Rae);[15] and
h. Acting Insp. R Bove, Internal Affairs Unit (Officer Bove).[16,17]

7. When assessing the evidence in this matter, I have been mindful not to insert any hindsight bias into my assessment of the actions taken by members of the WA Police. Hindsight bias is the well-known tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[18]

8. In this case, after careful consideration of the available evidence, I concluded that none of the actions of any of the attending police caused or contributed to Mr Hart's death. Instead, it is my view that Mr Hart died from heat stroke after the vehicle he was travelling in broke down and was abandoned.

[10] ts 06.05.25 (Hannan), pp12-27
[11] ts 06.05.25 (Lynch), pp39-60
[12] ts 06.05.25 (Vuleta), pp72-87
[13] ts 06.05.25 (Rae), pp88-102
[14] ts 07.05.25 (Wells), pp106-119
[15] ts 07.05.25 (Saunders), pp119-135
[16] ts 07.05.25 (Bove), pp135-144
[17] At the time he authored his Internal Affairs Unit Report, Officer Bove held the police rank of Senior Sergeant
[18] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015), p10

MR HART

Background[19,20,21]

9. Mr Hart was born in Kalgoorlie on 28 December 1988, and he had four siblings. Mr Hart and his partner had three children, one of whom was still-born. Mr Hart enjoyed playing Australian Rules football, and he assisted in umpiring matches for younger players. He also enjoyed music and was a talented singer, and at one point, he was the lead singer in a local band.

10. Mr Hart had an extensive criminal history and by the time of his death, he had accumulated over 120 convictions for various offences including unlawful assault, aggravated burglary, breaches of various community based orders, and stealing.[22] Mr Hart had been the subject of a number of violence restraining orders, but none were current at the time of his death. The WA Police database included warnings in relation to Mr Hart for: "*for talk of self-harm, suffers from depression and may inflict self-injury*".[23]

11. Mr Hart's partner says that although Mr Hart was never formally diagnosed with any mental health conditions, following the death of their third child Mr Hart "*developed depression*" and started using illicit drugs. Mr Hart's polysubstance use reportedly included methylamphetamine, alcohol, cannabis, heroin, and cocaine.[24,25,26]

12. Mr Hart's medical history included: asthma, obstructive sleep apnoea, gastroesophageal reflux, and high cholesterol.[27] On 5 September 2022, Mr Hart presented at the emergency department at Kalgoorlie Health Campus feeling dizzy and unwell. He complained of shortness of breath, central chest tightness, and a cough and it was thought Mr Hart had a chest infection or an exacerbation of his asthma.[28,29]

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[19] Exhibit 1, Vol.1, Tab 6, Statement - Ms K Cooper (03.01.23)
[20] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24), pp3-5 & 29
[21] Exhibit 1, Vol.1, Tab 1, P100 - Report of Death (10.05.24)
[22] Exhibit 1, Vol.1, Tab 28, Mr Hart - Court Outcomes History - Criminal & Traffic
[23] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24), p5
[24] Exhibit 1, Vol.1, Tab 6, Statement - Ms K Cooper (03.01.23), para 19
[25] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24), p4
[26] Exhibit 1, Vol.1, Tab 6, Statement - Ms K Cooper (03.01.23), paras 17-21
[27] Exhibit 1, Vol.1, Tab 31, Medical records - Bega Gambirringu Health Service
[28] Exhibit 1, Vol.1, Tab 30, Kalgoorlie Health Campus Emergency Department Notes (11.27 pm, 05.09.22)

EVENTS LEADING TO MR HART'S DEATH[30,31,32,33,34,35,36,37,38,39]

Mr Hart's movements on 25 December 2022

13. Mr Hart and two friends (Mr Richard Lynch and Mr Brendon Wells), were at Mr Hart's house. The men were under the influence of drugs. Mr Lynch said he was in the midst of a five or six day "*methylamphetamine bender without any sleep*", while Mr Wells said: "*we were all shooting up speed*", and that Mr Hart looked "*pretty wasted like he had not slept for days*".[40,41]

14. At about 6.00 am, Mr Hart, Mr Lynch, and Mr Wells went to Ms Kitty Wells house, and while they were there, Mr Kaiden Smith arrived driving a black Alfa Romeo hatchback (the Alfa Romeo). At about 7.00 am, Mr Hart, Mr Wells, Mr Lynch, and Mr Smith (the Men) went for a drive in the Alfa Romeo.

15. Mr Smith was driving, and in his statement, Mr Wells says they "*were all drinking and had music going*" and were "*all high on speed*". The Men were driving around Kalgoorlie and Mr Wells says that when they were in Williamstown (a suburb of Kalgoorlie) a police vehicle started following them.[42]

16. The police vehicle (which was a marked Toyota Hilux fitted with a passenger pod) was being driven by Officer Rae, and Officer Vuleta was on duty in the passenger seat (the Officers). The Officers had been patrolling nearby in the vicinity of the Mount Charlotte Lookout and Reservoir trying to locate a high-risk offender who had removed an ankle monitoring bracelet that morning.

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[29] Exhibit 1, Vol.1, Tab 30, Kalgoorlie Health Campus Emergency Department Continuation Notes (05.09.22)
[30] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24), pp6-8 and ts 06.05.25 (Hannan), pp12-27
[31] Exhibit 1, Vol.1, Tab 2.1, Marked aerial photograph showing relevant locations
[32] Exhibit 1, Vol.1, Tabs 8 & 8.1, Statements - Mr K Smith (02.01.23 & 05.01.23)
[33] Exhibit 1, Vol.1, Tab 9, Statement - Mr B Wells (02.01.23) and ts 07.05.25 (Wells), pp106-119
[34] Exhibit 1, Vol.1, Tab 10, Statement - Mr T Lynch (30.12.22) and ts 06.05.25 (Lynch), pp39-60
[35] Exhibit 1, Vol.1, Tab 9, Statement - Mr B Wells (02.01.23) and ts 07.05.25 (Wells), pp106-119
[36] Exhibit 1, Vol.1, Tab 21, Statement - Sgt. K Rae (05.01.23) and ts 06.05.25 (Rae), pp88-102
[37] Exhibit 1, Vol.1, Tab 22, Statement - Const. S Vuleta (05.01.23) and ts 06.05.25 (Vuleta), pp72-87
[38] Exhibit 1, Vol.1, Tab 23, Statement - Sgt. D Saunders (05.01.23) and ts 07.05.25 (Saunders), pp119-135
[39] Exhibit 1, Vol.1, Tab 29, CCTV footage timeline (25.12.22)
[40] Exhibit 1, Vol.1, Tab 10, Statement - Mr T Lynch (30.12.22), paras 2-7
[41] Exhibit 1, Vol.1, Tab 9, Statement - Mr B Wells (02.01.23), paras 6-7
[42] Exhibit 1, Vol.1, Tab 9, Statement - Mr B Wells (02.01.23), paras 23-25

Police attempt to intercept Mr Hart[43,44,45,46,47]

17. At about 7.20 am, the Officers saw the Alfa Romeo driving on Sutherland Street, which is an unsealed road that heads east away from the town centre. The Alfa Romeo had no front number plate, and three of the occupants had bandanas across their faces. Mr Wells says that Mr Smith "*took off from the police*", and although Mr Wells did not know why, he says he was aware that Mr Smith did not have a driver's licence.[48]

18. Officer Rae says he suspected that the high-risk offender that he and Officer Vuleta had been looking for may be in the Alfa Romeo, and so he did a U turn and began following the vehicle. Despite the fact that Officer Rae had activated the police vehicle's emergency lights and sirens briefly the Alfa Romeo did not stop and accelerated away.

19. The Alfa Romeo travelled along Goldfields Highway before turning onto a dirt track behind Hannans Estate. Officer Rae's police vehicle was not authorized to conduct police pursuits, so he turned off the vehicle's emergency lights and sirens and terminated the intercept.

20. The Officers lost sight of the Alfa Romeo, but minutes later they saw it turn off Hawkins Street onto a dirt track. The Officers followed the dust trail thrown up by the Alfa Romeo, but lost sight of the vehicle again. After several subsequent sightings, the Officers headed towards Kurrawang, an Aboriginal community about 12 km south of Kalgoorlie, where they suspected the Alfa Romeo may be heading.

21. The Officers spotted a vehicle that appeared to be the Alfa Romeo driving out of Kurrawang, and followed it as it drove along a bush track. The Officers agreed that if the vehicle did not turn down Coolgardie North Road and head back towards Great Eastern Highway, they would stop following it. At about 8.10 am, the vehicle the Officers were following continued past the Coolgardie North Road, and the Officers turned back to Kalgoorlie.

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[43] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24), pp10-15 and ts 06.05.25 (Hannan), pp12-27
[44] Exhibit 1, Vol.1, Tab 2.1, Marked aerial photograph showing relevant locations
[45] Exhibit 1, Vol.1, Tab 21, Statement - Sgt. K Rae (05.01.23) and ts 06.05.25 (Rae), pp88-102
[46] Exhibit 1, Vol.1, Tab 22, Statement - Const. S Vuleta (05.01.23) and ts 06.05.25 (Vuleta), pp72-87
[47] Exhibit 1, Vol.1, Tab 23, Statement - Sgt. D Saunders (05.01.23) and ts 07.05.25 (Saunders), pp119-135
[48] Exhibit 1, Vol.1, Tab 9, Statement - Mr B Wells (02.01.23), paras 12-24 and ts 20.06.25 (Wells), pp106-119

22. In passing, I note that in his statement, Mr Wells says that Mr Hart and Mr Lynch "*had a little scruff up*" in the Alfa Romeo. Mr Wells says that Mr Lynch slapped Mr Hart to the side of the head with "*a good enough slap*" and that after Mr Hart began swearing at Mr Lynch, the Alfa Romeo stopped and Mr Lynch (who had been in one of the rear passenger seats) got into the front and Mr Hart sat in back.[49,50]

23. At the inquest, Mr Lynch denied this incident had occurred, and said the only argument between the Men related to them being pursued by police.[51] In any case Mr Wells thought the "*scruff up*" related to a scooter, and that:

> Apart from the slap, Richard did not do anything else to Travis. Apart from the swearing, Travis did not do anything else to Richard. There was no punches or kicks. No one else got involved. There was no more arguing after this point. I did not see any injuries on (Mr Hart) after (Mr Lynch) slapped (Mr Hart).[52]

The Alfa Romeo is abandoned[53,54,55,56,57]

24. Meanwhile, the Alfa Romeo continued along "*back tracks*" towards Coolgardie. The Alfa Romeo hit bumps and small trees which caused a flat tyre and significant damage to the vehicle's oil sump. As a result, the Alfa Romeo came to a stop in a ditch about 4.2 km down the track.

25. The Men were unable to get the Alfa Romeo to start, and abandoned the vehicle. Although the police had not been following the Alfa Romeo for some minutes by this stage, it appears the Men were worried police were still looking for them, and they ran into the bush to hide. In his statement, Mr Wells says: "*We ran over the railway line away from the Kalgoorlie side. We ran for a good enough while, then split up*".[58]

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[49] Exhibit 1, Vol.1, Tab 9, Statement - Mr B Wells (02.01.23), paras 133-137 and ts 07.05.25 (Wells), p109
[50] See also: Exhibit 1, Vol.1, Tab 8, Statement - Mr K Smith (02.01.23), paras 17-25
[51] ts 06.05.25 (Lynch), pp50-51
[52] Exhibit 1, Vol.1, Tab 9, Statement - Mr B Wells (02.01.23), paras 138-139
[53] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24), pp10-15
[54] Exhibit 1, Vol.1, Tab 2.1, Marked aerial photograph showing relevant locations
[55] Exhibit 1, Vol.1, Tabs 8 & 8.1, Statements - Mr K Smith (02.01.23 & 05.01.23)
[56] Exhibit 1, Vol.1, Tab 9, Statement - Mr B Wells (02.01.23) and ts 07.05.25 (Wells), pp106-119
[57] Exhibit 1, Vol.1, Tab 10, Statement - Mr T Lynch (30.12.22) and ts 06.05.25 (Lynch), pp39-60
[58] Exhibit 1, Vol.1, Tab 9, Statement - Mr B Wells (02.01.23), para 35

26. The daytime temperature in the general area was about 39°C on 25 December 2022, and 41.4°C on 26 December 2022.[59]

27. The available evidence also suggests that the Men had consumed limited amounts of food and water in the days leading up to them abandoning the Alfa Romeo, and that there was no food or water in the vehicle.[60]

Three of the occupants return to safety[61,62,63,64,65]

28. The precise details of what happened next is difficult to determine. The accounts of Mr Smith, Mr Lynch, and Mr Wells are inconsistent, and this appears to be a result of their illicit drug use.[66] Nevertheless, what is clear is that although Mr Hart, Mr Smith, Mr Lynch, and Mr Wells were initially together, they eventually separated, and whilst Mr Smith, Mr Lynch, and Mr Wells all made it back to Kalgoorlie safely, Mr Hart did not.

29. In his statement, Mr Lynch says he walked off on his own, and made it back to Kalgoorlie at about 3.00 pm on 25 December 2022.[67] Meanwhile, Mr Hart, Mr Smith and Mr Wells walked off in a different direction, and Mr Hart was described as looking "*dehydrated*" and "*stressed out*".[68]

30. Mr Wells says that Mr Lynch went off on his own and he (Mr Wells) stayed with Mr Hart and Mr Smith. Mr Wells says he was walking in front of Mr Hart and Mr Smith, who he thought were "*about two houses*" behind him. Mr Wells says that he came upon a dirt road after passing a dry creek with "*some little crosses*" and sat down to wait for Mr Smith and Mr Hart, however neither Mr Smith nor Mr Hart ever arrived.[69]

[59] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24), p29
[60] See for example: Exhibit 1, Vol.1, Tab 9, Statement - Mr B Wells (02.01.23), paras 41 & 61 and ts 07.05.25 (Wells), pp112-113
[61] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24), pp10-15 and ts 06.05.25 (Hannan), pp12-27
[62] Exhibit 1, Vol.1, Tabs 8 & 8.1, Statements - Mr K Smith (02.01.23 & 05.01.23)
[63] Exhibit 1, Vol.1, Tab 9, Statement - Mr B Wells (02.01.23)
[64] Exhibit 1, Vol.1, Tab 10, Statement - Mr T Lynch (30.12.22)
[65] Exhibit 1, Vol.1, Tab 12, Statement - Ms K Wells (02.01.23)
[66] ts 06.05.25 (Hannan), pp24-25
[67] Exhibit 1, Vol.1, Tab 10, Statement - Mr T Lynch (30.12.22), paras 27-42
[68] Exhibit 1, Vol.1, Tab 8, Statement - Mr K Smith (02.01.23)
[69] Exhibit 1, Vol.1, Tab 9, Statement - Mr B Wells (02.01.23), paras 36 & 62-65

31. Mr Wells says he "*was singing out*" to Mr Smith and Mr Hart and trying to look for them, but "*had no idea where they were*". Mr Wells thinks he last saw Mr Hart and Mr Smith at about 2.00 pm on 25 December 2022, but he did not have a watch or mobile phone with him so this is really a guess. In any case, Mr Wells says he made his way into Coolgardie, where he arranged a lift into Kalgoorlie, arriving there at about 7.30 pm.[70,71]

32. Mr Wells says that when he got to Coolgardie, he did not alert anyone about Mr Hart, Mr Smith or Mr Lynch "*being out in the bush*" because:

> (Mr Wells) thought everybody would have got back to Kalgoorlie and I just got left out there. I thought they took off before me and I was the only one left out there. I just thought they had been picked up before me but I did not see any cars pick them up.[72]

33. Mr Wells says that when he woke up on 26 December 2022, he did not try to find Mr Hart because his sister told him Mr Hart was in hospital. In his statement Mr Wells also says he retrieved his mobile phone from Mr Smith on 28 December 2022. On 29 December 2022, Mr Wells saw Mr Lynch and told him that Mr Hart "*was still out there somewhere*" because "*by this time nobody had seen (Mr Hart)*".[73]

34. In his statement Mr Smith says he walked off on his own for a while, leaving Mr Hart and Mr Wells behind him. Mr Smith says he looked at Mr Wells' mobile phone (which he had taken) at around 12.00 noon, and did not see Mr Hart again after that. Mr Smith used Mr Wells' mobile phone to call family members and friends, and at about 6.00 pm, the mobile phone's battery was at 3%.[74]

35. That evening, family members found Mr Smith, lying on his back in the dirt in front of Cairns Road, several kilometres from where Mr Hart's body was later found.

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[70] Exhibit 1, Vol.1, Tab 9, Statement - Mr B Wells (02.01.23), paras 71-101
[71] See also: Exhibit 1, Vol.1, Tab 17, Statement - Ms M Kartinyeri (09.01.23)
[72] Exhibit 1, Vol.1, Tab 9, Statement - Mr B Wells (02.01.23), para 102
[73] Exhibit 1, Vol.1, Tab 9, Statement - Mr B Wells (02.01.23), paras 106-122
[74] Exhibit 1, Vol.1, Tab 8, Statement - Mr K Smith (02.01.23), paras 90-116

36. In his statement, Mr Smith says he did not tell anyone that Mr Hart had been picked up by "*any person*" and he also said: "*I didn't report (Mr Hart) missing to police as I didn't know he was missing*".[75]

Reports to police[76,77,78,79]

37. At 7.52 pm on 29 December 2022, Mr Wells' mother (Ms B Wells) called emergency services to report that her son had been a passenger in a small black car involved in a high-speed chase that morning. Ms B Wells told police that Mr Smith was the driver, and that apart from Mr Wells, there were two passengers who she named as Mr Lynch and "*Trevor*" Hart, although clearly, she meant Mr Travis Hart.[80]

38. Ms B Wells also told police that Mr Lynch and Mr Smith had made their way back to Kalgoorlie, but that Mr Wells and Mr Hart the other two were unaccounted for and "*in the bush somewhere*". It appears Mr Wells' mother was unaware that in fact, Mr Wells had returned to Kalgoorlie safely about 20 minutes earlier.[81]

39. As a result of the call from Ms B Wells, Officer Saunders created a Computer Aided Despatch task (the CAD task), which he designated as a "Priority 3" task, meaning a response was expected within 60 minutes.

40. At 8.32 pm, Mr Wells' cousin (Ms C Wells) went to Kalgoorlie police station after she had also become concerned for Mr Wells' welfare. Ms C Wells spoke with Officer Saunders, and while she was at the station, she received a phone call from her partner saying Mr Wells had "*been located and was fine*".[82]

41. After Ms C Wells' phone conversation with her partner, Officer Saunders understood that all four people who had been reported missing had now been accounted for, and he closed the CAD task.[83]

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[75] Exhibit 1, Vol.1, Tab 8, Statement - Mr K Smith (02.01.23), paras 133-134
[76] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24), pp1-2 & 17
[77] Exhibit 1, Vol.1, Tab 23, Statement - Sgt. D Saunders (05.01.23) and ts 07.05.25 (Saunders), pp119-135
[78] Exhibit 1, Vol.1, Tab 11, Statement - Ms C Wells (0.02.23)
[79] See also: Exhibit 1, Vol.1, Tab 20.1, Report - Det. Sgt. R Bove, Internal Affairs Unit (24.01.24)
[80] Exhibit 1, Vol.1, Tab 26, Incident Report LWP221222500880964 (7.52 pm, 25.12.22), p1
[81] Exhibit 1, Vol.1, Tab 26, Incident Report LWP221222500880964 (7.52 pm, 25.12.22), p1
[82] Exhibit 1, Vol.1, Tab 26, Incident Report LWP221222500880964 (8.32 pm, 25.12.22), p2
[83] ts 06.05.25 (Hannan), pp24-25

42. However, at the time he closed the CAD task Officer Saunders had not spoken with anyone other than Ms C Wells nor had he confirmed that all of the men mentioned in that task were safe and well. In fact, at the time the CAD task was closed, Mr Hart had not returned to Kalgoorlie and was still missing.[84]

Mr Hart is located[85,86,87,88,89,90,91,92]

43. Over the next few days, Mr Hart's family became increasingly concerned when they realised that Mr Hart was not in hospital, as they had been assumed.[93] On 29 December 2022, several members of Mr Hart's family contacted the Kalgoorlie police station to report their concerns for Mr Hart's welfare.[94,95,96]

44. As a result of these reports, police undertook a land search operation with the help from the State Emergency Service, members of Mr Hart's family, and community members. The Alfa Romeo was located on its roof 29 December 2022, although it had reportedly been "*on its wheels*" when the Men abandoned it on 25 December 2022. Police noted that the Alfa Romeo's three functioning tyres had been removed, along with the vehicle's catalytic converter.[97,98,99]

45. Mr Hart's body was found on 30 December 2022, about 6 km south of where the Alfa Romeo had been abandoned. Mr Hart was lying, naked, under a tree and his clothing and wallet were found nearby. Mr Hart had "*no obvious injuries, violence, defensive wounds*", and there was no obvious "*vegetation or ground disturbance*" near his body. Further, no "*weapons or other articles*" were found in Mr Hart's vicinity.[100]

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[84] ts 06.05.25 (Hannan), pp24-25
[85] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24), pp21-25
[86] Exhibit 1, Vol.1, Tab 11, Statement - Ms C Wells (02.02.23)
[87] Exhibit 1, Vol.1, Tab 12, Statement - Ms K Wells (02.01.23)
[88] Exhibit 1, Vol.1, Tab 13, Statement - Ms J Spurling (31.12.22)
[89] Exhibit 1, Vol.1, Tab 19, Statement - Mr H Nelson (17.05.23)
[90] Exhibit 1, Vol.1, Tab 24, Statement - Sen. Const. M Lee (21.02.23)
[91] Exhibit 1, Vol.1, Tab 27, Report - Sen. Const. S Osborne (20.06.23)
[92] Exhibit 1, Vol.1, Tab 24, Statement - Sen. Const. M Lee (21.02.23)
[93] For example, see: Exhibit 1, Vol.1, Tab 7, Statement - Ms M Thomas (15.08.23)
[94] Exhibit 1, Vol.1, Tab 26.1, Incident Report LWP221222900890608 (12.56 pm, 29.12.22)
[95] Exhibit 1, Vol.1, Tab 26.2, Incident Report LWP221222900890741 (1.54 pm, 29.12.22)
[96] Exhibit 1, Vol.1, Tab 26.3, Incident Report LWP221222900890696(1.35 pm, 29.12.22)
[97] A catalytic converter is a device in a vehicle's exhaust system that reduces harmful emissions
[98] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24), pp21-22
[99] Exhibit 1, Vol.1, Tab 7, Statement - Ms M Thomas (15.08.23)
[100] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24), ppp22-23

CAUSE OF DEATH[101,102]

46. Two forensic pathologists (Dr D Moss and Dr K Patton) conducted a post mortem examination of Mr Hart's body at the State Mortuary, and reviewed CT scans. Dr Moss and Dr Patton noted Mr Hart had extensive internal and external post mortem changes. Although microscopic examination of tissues was limited by post mortem changes, the presence of mild to moderate coronary artery atherosclerosis was noted.

47. Dr Moss and Dr Patton found **no evidence** of any significant natural disease or injury, and noted that a post mortem CT scan showed "*no focal abnormality within the brain and no skull fracture or recent skeletal injury*".[103]

48. As for Mr Hart's musculoskeletal system, Dr Moss and Dr Patton noted:

> **There is no external evidence of recent injury to the bones of the limbs. The skull, ribcage, vertebral column and pelvis show no fracture. There is no bruising of the undersurface of the scalp**. An anterior neck dissection is performed in situ, showing no soft tissue injury, including no injuries to the strap muscles of the neck. The large vessels, cartilaginous and bony structures at the front of the neck are intact. There is no bruising of the soft tissues of the anterior chest or abdominal walls.[104] [Emphasis added]

49. Toxicological analysis detected methylamphetamine and its metabolite, amphetamine, in Mr Hart's system. Although alcohol was detected in Mr Hart's blood and bile, this was likely due to post mortem production, and the analyst noted that:

> The exhibits presented to the Laboratory displayed evidence of putrefaction, therefore the alcohol results should be interpreted with caution.[105]

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[101] Exhibit 1, Vol.1, Tab 4, Supplementary Post Mortem Report (30.08.23)
[102] Exhibit 1, Vol.1, Tab 4.1, Final Post Mortem Report (05.01.23)
[103] Exhibit 1, Vol.1, Tab 4.1, Final Post Mortem Report (05.01.23), p2
[104] Exhibit 1, Vol.1, Tab 4.1, Final Post Mortem Report (05.01.23), p6
[105] Exhibit 1, Vol.1, Tab 5, Toxicology Report (10.01.23), p1

50. As to the circumstances of Mr Hart's death, Dr Moss and Dr Patton made the following observations:

> Based on the information provided to us, the findings of the post mortem examination and the results of the ancillary investigations, it is most plausible that Mr Hart sustained heat stroke due to environmental exposure to elevated temperatures. Heat stroke may have been further exacerbated by the effects of methylamphetamine, a stimulant drug, which can cause hyperactivity, excessive sweating, and rapid breathing. Methylamphetamine is also known to have direct cardiotoxic effects and is associated with the development of potentially lethal cardiac arrythmias (irregular heartbeat - 'heart attack'), particularly in the presence of underlying heart disease, such as coronary artery atherosclerosis. Chronic methylamphetamine use has been associated with accelerated coronary artery atherosclerosis.[106]

51. At the conclusion of their post mortem examination, Dr Moss and Dr Patton expressed the opinion that the cause of Mr Hart's death was "*heat stroke (environmental exposure) in a man with methylamphetamine effect*".[107]

52. I accept and adopt Dr Moss' and Dr Patton's opinion, and I find that Mr Hart died from heatstroke after he had consumed methylamphetamine.

53. I am aware that members of Mr Hart's family have raised concerns that Mr Hart was assaulted and/or that a person or persons were involved in his death.[108,109] However, having carefully reviewed the available evidence, there is simply **no basis** for any such concerns.[110]

54. Mr Hart's body was examined at the scene, and he underwent a detailed post mortem examination which established Mr Hart did not sustain any lacerations or fractures, and I have concluded he was not bashed or attacked before his death.

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[106] Exhibit 1, Vol.1, Tab 4, Supplementary Post Mortem Report (30.08.23), p2
[107] Exhibit 1, Vol.1, Tab 4, Supplementary Post Mortem Report (30.08.23), p1
[108] Exhibit 1, Vol.1, Tab 34.1, Letter - Ms M Hart (05.05.25)
[109] Exhibit 1, Vol.1, Tab 34.2, Letter - Ms M Hart (undated)
[110] ts 06.05.25 (Hannan), pp114-16 & 26 and ts 07.05.25 (Wells), p118

55. Further, on the basis of evidence at other inquests I have presided over, the fact that Mr Hart was found naked is entirely consistent with him having consumed methylamphetamine, and experienced heatstroke.

56. On the basis that there is simply **no cogent evidence of any suspicious circumstances** in relation to the circumstances of his death, I find Mr Hart died from natural causes.

SUBSEQUENT INVESTIGATIONS

Police intercept driving policy[111,112]

57. WA police are required to comply with policies relating to urgent duty and emergency driving. Police officers engaged in an intercept must undertake a risk assessment before and during the intercept, and must consider relevant factors when deciding whether to initiate and/or continue with the intercept.

58. Officers engaged in an intercept must provide regular updates to the relevant supervising officer, and an intercept may be terminated by the supervising officer, the intercept vehicle driver, an intercept vehicle passenger, or by one of a range of authorised officers carrying out roles connected with the intercept.

59. When an intercept has been terminated, the driver of the police vehicle must switch off emergency warning equipment, reduce speed, and comply with applicable speed limits.

60. An intercept which results in a serious injury or death must be investigated by WA Police's Internal Affairs Unit (IAU). That investigation must consider if relevant policies and legislation has been complied with, and the appropriateness of the actions of police.

[111] Exhibit 1, Vol.1, Tab 32, TR-07.04 WAPOL Emergency Driving policy
[112] See also: Exhibit 1, Vol.1, Tab 33, EM-01.06 WAPOL Evade Police Intercept policy

Homicide Squad investigation[113],[114]

61. After Mr Hart's body was located, an investigation by the Homicide Squad was undertaken because of the inconsistencies in the accounts provided by the Men as to the circumstances that led to Mr Hart being left behind in the bush.

62. In her report, Officer Hannan noted that Mr Hart had been left alone in the bush by each of the other three occupants of the Alfa Romeo, and that:

> [O]n return to Kalgoorlie none of (Mr Hart's) associates raised concerns that (Mr Hart) had not returned and may have required assistance. It wasn't until four days later on the 29 December 2022 that concerns were officially reported to police regarding (Mr Hart's) welfare.[115]

63. Officer Hannan also noted that the delay in reporting Mr Hart as a missing person had "*inevitably hindered a timely response to take action to search for (Mr Hart)*".[116] At the end of her detailed and comprehensive investigation, Officer Hannan expressed the following conclusion in her report:

> Taking into consideration the above factors, in addition to (Mr Hart's) significant drug use in the lead up to his death, his prolonged lack of food and water, recent medical conditions, the harsh environment and hot temperatures; it is evident from the investigation that each of these factors have invariably contributed to his death. In accordance with legislative provisions, as a result of this investigation there is no evidence to indicate any criminality, either on the part of the involved officers, (Mr Hart's) associates or other person that can be attributed to the death.[117]

64. I agree with Officer Hannan's conclusion, and after carefully assessing the available evidence, I find there is **no evidence** of the involvement of any person or persons in relation to Mr Hart's death.

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[113] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24)
[114] ts 06.05.25 (Hannan), pp12-27
[115] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24), p31
[116] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24), p30
[117] Exhibit 1, Vol.1, Tab 2, Report - Det. Sgt. J Hannan, Homicide Squad (18.11.24), pp31-32

Internal Affairs Unit investigation[118]

65. In accordance with WA Police policy, Officer Bove from the Internal Affairs Unit (IAU) conducted an investigation of the conduct of Officers Rae and Vuleta in relation to their attempt to intercept Mr Hart, and into Officer Saunders in relation to his management of the CAD task created after Ms C Wells spoke with him.

66. After reviewing the available evidence, Officer Bove concluded that Officer Rae had breached WA Police policy in relation to emergency driving "*by engaging in an Evade Police Driving Incident in the wrong class of vehicle*" and by breaching the speed limit during the same incident. Officer Rae had thereby contravened the Police Code of Conduct, and he was served with a managerial notice.[119,120]

67. Officer Vuleta was also found to have breached the WA Police Force Intercept Driving Policy, "*by engaging in an Evade Police Driving Incident in the wrong class of vehicle*" and by breaching the speed limit during the same incident. Officer Vuleta was thereby said to have contravened the Police Code of Conduct, and she was served with a managerial notice.[121,122]

68. At the relevant time, Officer Vuleta was a passenger in the intercept vehicle. She was also a relatively junior officer. As noted the relevant policy provides that a passenger in an intercept vehicle can terminate an intercept at any time.

69. However, in my view it was unfair to expect that Officer Vuleta would have terminated the intercept in the circumstances she found herself in. In any case, the attempted intercept was brief, and was terminated without incident. It follows that in my view, the decision to find that Officer Vuleta breached the WA Police Code of Conduct was unreasonable, and in any event, given serving her with a managerial notice was excessive.

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[118] Exhibit 1, Vol.1, Tab 20.1, Report - Det. Sgt. R Bove, Internal Affairs Unit (24.01.24) and ts 07.05.25 (Bove), pp135-144
[119] Exhibit 1, Vol.1, Tab 20.1, Report - Det. Sgt. R Bove, Internal Affairs Unit (24.01.24), p6, 15 & 18-21
[120] ts 06.05.25 (Rae), pp94-95
[121] Exhibit 1, Vol.1, Tab 20.1, Report - Det. Sgt. R Bove, Internal Affairs Unit (24.01.24), p7, 16 & 18-21
[122] ts 06.05.25 (Vuleta), pp83-84

70. Officer Saunders was found to have breached the WA Police Force Code of Conduct by failing to adequately investigate the welfare check task relating to Mr Wells, after he closed the CAD task after speaking with Ms C Wells. Officer Saunders was served with a managerial notice.[123]

71. At the inquest, Officer Saunders acknowledged that he had been in error in not confirming that all of the Men referred to in the CAD task had in fact been accounted for.

72. Whilst Officer Saunders' actions are perhaps understandable in the context of a busy station, it is pleasing to note that he has reflected on his actions. At the inquest, Officer Saunders said that his approach to CAD tasks had changed as a result of Mr Hart's death, and that he has redoubled his efforts to adopt a "*very risk averse*" approach.[124]

COMMENTS ON THE ACTIONS OF POLICE

73. The evidence before me establishes that at the relevant time, Mr Hart was a passenger in the Alfa Romeo which was being driven in an erratic manner. The Alfa Romeo was therefore a potential danger to road users, and in my view Officer Rae's decision to attempt to intercept the vehicle was clearly justifiable.

74. In my view the decision by Officer Rae and Officer Vuleta to attempt to intercept the Alfa Romeo was clearly correct. When the Alfa Romeo failed to stop despite the fact that Officer Rae had activated the police vehicle's emergency lights and sirens, his decision to terminate the intercept was correct.

75. After careful consideration of the available evidence, I am satisfied that the actions of the Officers Rae and Vuleta during the brief attempted intercept did not cause or contribute to Mr Hart's death.

[123] Exhibit 1, Vol.1, Tab 20.1, Report - Det. Sgt. R Bove, Internal Affairs Unit (24.01.24), p7 & 17-21
[124] ts 07.05.25 (Saunders), p132

76. As I have explained, Officer Saunders closed the CAD task before conducting relevant enquiries. However, on the basis of the evidence of the forensic pathologists, and the extreme daytime temperatures, rugged terrain, and lack of water in the relevant area, I have concluded that by the time Ms C Wells raised her concerns with Officer Saunders (i.e.: 29 December 2022), Mr Hart was already dead.[125]

77. In those circumstances, it follows that the actions of Officer Saunders in closing the CAD task did not cause or contribute to Mr Hart's death.

CONCLUSION

78. Mr Hart died on or about 25 December 2022 from heatstroke, after using methylamphetamine. On the basis of the available evidence, I found that the manner of Mr Hart's death was natural causes, as there is no evidence of criminality or of the involvement of another person or persons in relation to Mr Hart's death.

79. Mr Hart was only 33 years old and the death of a young man in those circumstances has caused unfathomable grief and pain to his family and friends. As I did at the conclusion of the inquest, I wish to again convey to Mr Hart's family and friends, on behalf of the Court, my very sincere condolences for your terrible loss.

MAG Jenkin
Coroner
8 July 2025

[125] ts 06.05.25 (Hannan), pp16-18