JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	27 MAY 2025
DELIVERED	**:**	3 JULY 2025
FILE NO/S	**:**	CORC 73 of 2023
DECEASED	**:**	SEXTON, NATHAN BARRETO

Legislation:

Nil

Counsel Appearing:

Mr D McDonald appeared to assist the coroner.

Ms K Niclair (State Solicitor's Office) appeared on behalf of the Western Australia 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 that there be no reporting or publication of the details of or discussion surrounding operational aspects of Western Australia 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 Coroner MAG Jenkin (27.05.25)

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Nathan Barreto SEXTON*** with *an inquest held at the Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, Perth on 27 May 2025 find that the identity of the deceased person was* ***Nathan Barreto SEXTON*** *and that death occurred on 21 October 2023 near the intersection of O'Connor Street and Great Eastern Highway, Merredin from a gunshot injury to the head and neck in the following circumstances:*

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INTRODUCTION

1. Nathan Barreto Sexton (Mr Sexton) was 31 years of age when he died near the intersection of O'Connor Street and Great Eastern Highway, Merredin on 21 October 2023 from head and neck injuries, after shooting himself with a double-barrelled shotgun.[1,2,3,4,5,6,7]

2. Prior to his death, Police had been attempting to intercept Mr Sexton, and were following his vehicle at low speed. Shortly before 12.00 am on 22 October 2023, Mr Sexton slowed his vehicle to a stop and pulled to the side of Great Eastern Highway in Merredin. Police found Mr Sexton sitting, unresponsive, in the driver's seat of his car. Police removed Mr Sexton and started CPR, but he could not be revived.

3. Pursuant to the *Coroners Act 1996* (WA) (the Act) Mr Sexton's death was a "*reportable death*". Further, pursuant to section 22(1)(b) of the Act, because of the possibility that Mr Sexton'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.[8]

4. I held an inquest into Mr Sexton's death on 27 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 Sexton's death. The following witnesses gave evidence:

a. Const. M Bol, Attending police officer (Officer Bol);[9]
b. Const. J Pomroy, Attending police officer (Officer Pomroy);[10] and
c. Det. Sgt. A Xu, Author, Internal Affairs Unit Report (Officer Xu).[11]

[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (16.12.24)
[2] Exhibit 1, Vol. 1, Tab 2, P98 - Mortuary Admission Form (21.10.23)
[3] Exhibit 1, Vol. 1, Tab 3, P92 - Identification of Deceased Person by Other than Visual Means (23.10.23)
[4] Exhibit 1, Vol. 1, Tab 3, Affidavit - Sen. Const. D Robertshaw (23.10.23)
[5] Exhibit 1, Vol. 1, Tab 3, Affidavit - A'Sgt. S Ryan (23.10.23)
[6] Exhibit 1, Vol. 1, Tab 4, Life Extinct Certification (22.10.23)
[7] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (24.01.24)
[8] Sections 3& 22(1)(b), *Coroners Act 1996* (WA)
[9] ts 27.05.25 (Bol), pp4-17
[10] ts 27.05.25 (Pomroy), pp18-24
[11] ts 27.05.25 (Xu), pp25-34

5. When assessing the evidence in this matter and deciding whether to make any adverse findings, I have applied the standard of proof as set out in the High Court's decision in the case of ***Briginshaw v Briginshaw***[12] which requires a consideration of the nature and gravity of the conduct when deciding whether a finding adverse in nature has been proven on the balance of probabilities.

6. I have also been mindful not to insert any hindsight bias into my assessment of the actions taken by members of the WA Police. Hindsight bias is the well-known tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[13]

7. In passing, 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 WA Police.

8. In this case, after careful consideration of the available evidence, I concluded that none of the actions of any of the attending police (Attending Police Officers)[14] caused or contributed to Mr Sexton's death. Instead, it is my view that for reasons unknown, Mr Sexton took his life by shooting himself in the head.

[12] (1938) 60 CLR 336, per Dixon J at pp361-362
[13] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015), p10
[14] Const. B Lengen, Const. C Turner, FC Const. Wood, Const. J Peters, Const. J Pomroy, Const. M Bol, Const. M Burns & Const. P Dhue

MR SEXTON

Background[15,16,17]

9. Mr Sexton was born in Perth on 31 May 1992. Mr Sexton had one sibling and he and his partner had one child together. As a child, Mr Sexton took prescribed medication after being diagnosed with Attention Deficit Hyperactivity disorder, and as an adult, he had a polysubstance use history, including methylamphetamine and cannabis.

10. In his IAU report, Officer XU notes that Mr Sexton had numerous criminal and traffic convictions, and that he had "*extensive warnings" on WA Police's Incident Management System, including: "talk of self-harm, known prohibited drug user, suffers from depression, and may suffer epileptic fits*".[18]

EVENTS LEADING TO MR SEXTON'S DEATH

Mr Sexton's prior interactions[19,20,21]

11. At about 5.15 pm on 21 October 2023, Mr Sexton [and a female passenger (Ms H)] were driving south on Albany Highway in North Bannister, when Mr Sexton crashed his car and collided with a tree near the Threeways Roadhouse (the Roadhouse).

12. Mr S (who was in a vehicle with three others) saw the crash and stopped to help. As he did so, Mr Sexton suddenly appeared and pointed a double-barrel shotgun (the Shotgun)[22,23] through the window of Mr S's car. Mr S accelerated away heavily, and as he did so, Mr Sexton fired a round through the car's rear window, smashing it and showering the occupants of Mr S's car in glass. Mr Sexton fired several more rounds at

[15] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (10.05.24)
[16] Exhibit 1, Vol. 1, Tab 7, Report - Det. Sgt. L McKnight, Homicide Squad (06.12.24), pp2-3
[17] Exhibit 1, Vol. 1, Tab 8, Report - Det. Sgt. A Xu, Internal Affairs Unit (31.01.24), p1
[18] Exhibit 1, Vol. 1, Tab 8, Report - Det. Sgt. A Xu, Internal Affairs Unit (31.01.24), p1
[19] Exhibit 1, Vol. 1, Tab 7, Report - Det. Sgt. L McKnight, Homicide Squad (06.12.24), pp1-8
[20] Exhibit 1, Vol. 1, Tab 26, Statement - Mr S (21.10.23)
[21] Exhibit 1, Vol. 1, Tab 27, Statement - Mr F (21.10.23)
[22] The Shotgun was described as a: Falco Arms 410 bore, break action, double-barrel, side by side shotgun
[23] See: Exhibit 1, Vol. 1, Tab 8, Report - Det. Sgt. A Xu, Internal Affairs Unit (31.01.24), pp25-26

Mr S's car, and when it was safe to do so, Mr S pulled over and called police.[24]

13. At about 5.30 pm, Mr F and his wife were driving their Volvo wagon (the Volvo) past the Roadhouse when they saw Mr Sexton's crashed car. They pulled over to help and Ms H, who had blood running down the side of her head, walked out from some bushes and asked Mr F to get out of the Volvo. As he was doing so, Mr F felt what he thought was a shotgun being pushed into the back of his head, and heard Mr Sexton tell him to get out of the vehicle.[25]

14. When Mr F got out of the Volvo he saw that Mr Sexton was holding the Shotgun. Meanwhile, Ms H "helped" Mr F's wife out of the Volvo's front passenger seat, before she (Ms H) and Mr Sexton got into the Volvo and drove off south on Albany Highway. A short time later, Mr F's wife called emergency services and reported the incident to the Police.[26]

15. Mr Sexton and Ms H drove to Merredin (about 180 km away), and at about 10.30 pm, they followed a vehicle driven by Mr FB on Kitchener Road in Merredin. As Mr FB was pulling into the driveway of his home, Mr Sexton got out of the Volvo with the Shotgun in his hand. Mr FB reversed and sped off, and his passenger called emergency services.

[24] Exhibit 1, Vol. 1, Tab 26, Statement - Mr S (21.10.23), pp2-6
[25] Exhibit 1, Vol. 1, Tab 27, Statement - Mr F (21.10.23), paras 13-25
[26] Exhibit 1, Vol. 1, Tab 27, Statement - Mr F (21.10.23), paras 26-34

Police attempt to intercept Mr Sexton[27,28,29,30,31,32,33,34,35,36,37,38,39,40,41,42,43]

16. Police conducted patrols in Merredin, and just before 11.00 pm, the Volvo was seen speeding off from a service station in Merredin. At 11.17 am, Officers Bol, Pomroy and Dhue, were in Tammin when they were advised to proceed to Merredin. Meanwhile, police in Merredin had spotted the Volvo on Great Eastern Highway at about 11.25 pm, they followed the vehicle as it drove around Merredin.

17. At about 11.45 pm, the Volvo stopped on Bates Street in Merredin, where Ms H got out and sat down on the side of the road, where she was arrested by police. Meanwhile, several police vehicles followed the Volvo at speeds of around 60 km per hour as it drove around the Merredin area. Police did not switch on the emergency lights and sirens on their vehicles.

18. At about 11.54 pm, Mr Sexton drove the Volvo around a police road block before heading east, and then west on Great Eastern Highway at about 60 km per hour. Mr Sexton was occasionally driving on the wrong side of the roadway, and although consideration was given to using tyre deflators (i.e.: Stingers), it was decided that this was not practicable.[44]

19. Shortly before 12.00 am on 22 October 2023, Mr Sexton slowed the Volvo and pulled up on the side of Great Eastern Highway near the intersection of O'Connor Street. Officer Bol parked his police vehicle in front of the Volvo, and several police vehicles parked behind the Volvo.

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[27] Exhibit 1, Vol. 1, Tab 7, Report - Det. Sgt. L McKnight, Homicide Squad (06.12.24), pp8-15
[28] Exhibit 1, Vol. 1, Tab 8, Report - Det. Sgt. A Xu, Internal Affairs Unit (31.01.24), pp1-28 and ts 27.05.25 (Xu), pp25-34
[29] Exhibit 1, Vol. 1, Tab 9, Statement - Const. B Lengen (22.10.23)
[30] Exhibit 1, Vol. 1, Tab 10, Statement - Const. C Douglas (22.10.23)
[31] Exhibit 1, Vol. 1, Tab 11, Statement - Sen. Const. P Hege (21.10.23)
[32] Exhibit 1, Vol. 1, Tab 12, Statement - FC Const. G Wood (22.10.23)
[33] Exhibit 1, Vol. 1, Tab 13, Statement - Const. J Peters (22.10.23)
[34] Exhibit 1, Vol. 1, Tab 14, Statement - Const. J Pomroy (22.10.23) and ts 27.05.25 (Pomroy), pp18-24
[35] Exhibit 1, Vol. 1, Tab 15, Statement - Const. M Bol (22.10.23) and ts 27.05.25 (Bol), pp4-17
[36] Exhibit 1, Vol. 1, Tab 16, Statement - Const. M Burns (22.10.23)
[37] Exhibit 1, Vol. 1, Tab 17, Statement - Const. P Dhue (22.10.23)
[38] Exhibit 1, Vol. 1, Tabs 21 & 21.1-21.2, Incident Reports 1720 15470, 1720 15470 & 2235 16928 (21.10.23)
[39] Exhibit 1, Vol. 1, Tab 21.3, WAPOL Person Summary - Deceased
[40] Exhibit 1, Vol. 1, Tab 22, Incident Report LWP 00744306 1720 (21-23.10.23)
[41] Exhibit 1, Vol. 1, Tab 23, Police Forensic Division Register (20.05.24)
[42] Exhibit 1, Vol. 1, Tab 24, Transcript - Police interview with Ms H (21.10.23)
[43] Exhibit 1, Vol. 1, Tab 28, Police BWC footage (22.10.23)
[44] ts 27.05.25 (Bol), pp5-6 & 13-14 and ts 27.05.25 (Pomroy), pp22-23

20. Attending Police Officers (several of whom had drawn their pistols) cautiously approached the Volvo. Initially police could not see anyone in the Volvo, but as Officer Pomroy got to the driver's door of the vehicle he found Mr Sexton sitting, unresponsive, in the Volvo's driver's seat.

21. Mr Sexton did not appear to be breathing, and although he was bleeding from the mouth, he did not appear to have any other injuries. The Shotgun, which had been leaning against the vehicle's dashboard, was removed by Officer Pomroy and secured. In his statement, Officer Pomroy says he could smell gunpowder inside the Volvo, and that he removed one spent cartridge and one live cartridge from the firearm.[45]

22. Mr Sexton was removed from the Volvo, and Attending Police Officers started CPR and requested an ambulance. Ambulance officers arrived at the scene at about 12.15 am, and after conducting an assessment, Mr Sexton was declared deceased.[46,47]

CAUSE OF DEATH

Post mortem examination

23. Two forensic pathologists (Dr R Junckerstorff and Dr J Grewal) reviewed CT scans and conducted a post mortem examination of Mr Sexton's body at the State Mortuary on 26 October 2023.[48,49]

24. Dr Junckerstorff and Dr Grewal found Mr Sexton had superficial injuries to his forehead, both upper limbs, and his back, and there was "*deep bruising*" to his left leg. There were signs of medical intervention, including previous surgery to Mr Sexton's left leg, and his lungs were congested which is considered to be a non-specific finding.[50]

[45] Exhibit 1, Vol. 1, Tab 14, Statement - Const. J Pomroy (22.10.23), paras 42-50 and ts 27.05.25 (Pomroy), pp20-24
[46] Exhibit 1, Vol. 1, Tab 25, SJA Patient Care Record 23179981 (22.10.23)
[47] Exhibit 1, Vol. 1, Tab 4, Life Extinct Certification (22.10.23)
[48] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (24.01.24)
[49] Exhibit 1, Vol. 1, Tab 5.1, Post Mortem Report (26.10.23)
[50] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (24.01.24)

The injuries to Mr Sexton's head and neck

25. Dr Junckerstorff and Dr Grewal found Mr Sexton had an "*intra-oral gunshot wound and disruption of the cervical spine and cervical spinal cord*". Dr Junckerstorff and Dr Grewal said this about the gunshot wound, and the projectiles which were located in Mr Sexton's body:

> The entrance perforation is on the posterior wall of the pharynx, approximately 40mm x 40mm, with ragged edges and 156 cm above the left heel, in the midline. There is no abrasion collar, muzzle stamp or stippling. At the posterior pharyngeal wall there is soot staining and adherent propellant powder around the entrance perforation. The parapharyngeal soft tissues have patchy bruising. The wound track passes through the posterior wall of the pharynx, prevertebral soft tissues, the anterior part of the 2nd to 4th cervical vertebrae (C2-4), the cervical spinal cord, the posterior part of the C2-4 vertebrae (spinous processes) and the paraspinal and posterior cervical skeletal muscles. There is no exit perforation. **Multiple round to oval, grey-coloured metal pellets, each 4 mm - 6 mm in diameter**, are retrieved along the wound track. These pellets are predominantly centered in the paraspinal and posterior cervical skeletal muscles. **Two pieces of pale-blue, plastic blood-stained wadding**, the largest up to 45mm, are seen at the posterior pharyngeal wall around the entrance perforation and retrieved.[51] [Emphasis added]

26. On 4 June 2025, Mr Sexton's sister sent an email to Mr D McDonald (Counsel Assisting) on 4 June 2025, in which she raised concerns about how the injuries to Mr Sexton's head and neck were caused. In her email, Mr Sexton's sister says: "*The gun Nathan had would of (blown) his head off his shoulders not a little blood*".[52]

27. During his IAU investigation, Officer Xu reviewed body worn camera (BWC) footage from each of the officers who approached Mr Sexton's vehicle after it had stopped. At the inquest, Officer Xu confirmed that when an officer draws their 9mm service pistol, their BWC is automatically activated. In relation to whether any of the Attending Police Officers had discharged their pistols, Officer Xu's was as follows:

[51] Exhibit 1, Vol. 1, Tab 5.1, Post Mortem Report (26.10.23), p5
[52] Email - Mr Sexton's sister to Mr D McDonald (04.06.25)

> ***Mr McDonald***: So based on your review of the use of force reports and the body-worn camera footage, (and) bearing in mind what you've just told his Honour, was there any evidence of police discharging a firearm at Mr Sexton? ***Officer Xu***: No.[53,54]

28. Following Mr Sexton's death, the Shotgun was examined by police ballistics experts and found to be fully operational.[55] On the basis of all of the evidence from the Attending Officers and the observations of "*multiple round to oval, grey-coloured metal pellets*" and "*pale-blue, plastic blood-stained wadding*" in Mr Sexton's body (by Dr Junckerstorff and Dr Grewal),[56] I am satisfied that Mr Sexton's head and neck injuries are consistent with a shotgun cartridge, and were not caused by a bullet.

Toxicological analysis

29. Toxicological analysis noted tetrahydrocannabinol in Mr Sexton's system indicating recent cannabis use, along with methylamphetamine and its metabolite, amphetamine. The analysis also detected paracetamol and the stimulant, ephedrine. Although alcohol was not detected in Mr Sexton blood, he had a urine alcohol level of 0.0.15%. Other common drugs were not detected.[57,58]

Cause and manner of death

30. At the conclusion of their post mortem examination, Dr Junckerstorff and Dr Grewal expressed the opinion that the cause of Mr Sexton's death was "*gunshot injury to the head and neck*".[59]

31. I accept and adopt Dr Junckerstorff's and Dr Grewal's opinion and find that Mr Sexton died from the injuries he sustained when he shot himself in the head.

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[53] ts 27.05.25 (Xu), pp27-28 and see also: ts 27.05.25 (Xu), pp26-27 & 28-29
[54] See also: Exhibit 1, Vol. 1, Tab 8, Report - Det. Sgt. A Xu, Internal Affairs Unit (31.01.24), pp3-9 & 23-24
[55] Exhibit 1, Vol. 1, Tab 8, Report - Det. Sgt. A Xu, Internal Affairs Unit (31.01.24), pp25-26
[56] Exhibit 1, Vol. 1, Tab 5.1, Post Mortem Report (26.10.23), p5
[57] Exhibit 1, Vol. 1, Tab 6.1, Interim Toxicology Report (14.11.23)
[58] Exhibit 1, Vol. 1, Tab 6, Toxicology Report (24.11.23)
[59] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (24.01.24)

32. Further, on the basis of the available evidence, I find that Mr Sexton's death occurred by way of suicide.

SUBSEQUENT INVESTIGATIONS

Police intercept driving policy[60]

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

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

35. Officers engaged in an intercept must also provide regular updates to the Police Operations Coordination Centre (POCC), and an intercept may be terminated by POCC (or the supervising officer), the intercept vehicle driver, an intercept vehicle passenger, or by one of a range of authorised officers.

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

[60] Exhibit 1, Vol. 1, Tab 8, Report - Det. Sgt. A Xu, Internal Affairs Unit (31.01.24), pp27-28

Drug and alcohol testing

37. Following Mr Sexton's death, the Attending Police Officers involved in ther attempted intercept underwent drug and alcohol testing. The results of these tests established that none of the officers had consumed alcohol or common drugs prior to the commencement of their shift.[61]

Homicide Squad investigation

38. Detective Sergeant L McKnight (Officer McKnight), an officer attached to the Homicide Squad, conducted an investigation into Mr Sexton's death. At the conclusion of his investigation Officer McKnight expressed the following conclusion (with which I agree):

> The investigation into the death of the deceased is now concluded. Nil criminality was established into the cause of death and as such, this matter was not subject to any judicial proceedings. (Mr Sexton) was subject to an interaction/low speed pursuit with police officers (after committing multiple serious cross-district offences), in which he failed to stop, before committing suicide by way of discharging a firearm into his mouth/head. Despite resuscitation efforts, by both police officers and SJA, (Mr Sexton) could not be revived.[62]

Internal Affairs Unit investigation[63]

39. In accordance with WA Police policy, Officer Xu conducted an IAU investigation of the conduct of the actions of police officers involved in the attempted intercept of Mr Sexton. After reviewing the available evidence, Officer Xu did not identify any breaches of policy or legislation by any of the Attending Police Officers.

40. In his IAU report, Officer Xu also made the following observations, with which I agree:

> Police were justified to engage in a low-speed pursuit with (Mr Sexton) in an attempt to arrest him on suspicion of committing serious offences, prevent further offences occurring and protect the public from risk of ongoing harm. The enormity of the offending, his

[61] Exhibit 1, Vol. 1, Tab 8, Report - Det. Sgt. A Xu, Internal Affairs Unit (31.01.24), p23
[62] Exhibit 1, Vol. 1, Tab 7, Report - Det. Sgt. L McKnight, Homicide Squad (06.12.24), p15 and see: also ts 27.05.25 (Xu), p29
[63] Exhibit 1, Vol. 1, Tab 8, Report - Det. Sgt. A Xu, Internal Affairs Unit (31.01.24) and ts 27.05.25 (Xu), pp25-34

> methylamphetamine affected and altered state of mind and awareness of a likely extended time in custody if arrested and charged by police, appears to have influenced his decision making and choice to take his own life. The investigation concluded officers acted in a lawful and justified manner and adhered to legislation and training manuals whilst performing their duties in this circumstance. The acts undertaken by (Mr Sexton) could not have been prevented by officers.[64]

COMMENTS ON THE ACTIONS OF POLICE

41. The evidence before me establishes that in the period leading up to his death, Mr Sexton was armed with a double-barrel shotgun, and had allegedly committed very serious offences including being armed in a way to cause fear, robbery in circumstances of aggravation (car-jacking), and an attempt to unlawfully kill.

42. Mr Sexton was therefore a serious risk to road users and the general public, and the decision of police officers to attempt to intercept him was clearly justifiable and appropriate.

43. In my view the risk assessments conducted by the police officers took account of relevant factors, and their conduct while following Mr Sexton's vehicle was in accordance with relevant Police policy.

44. When Mr Sexton was removed from the Volvo after he had stopped the vehicle, police immediately started CPR and requested an ambulance. Despite the resuscitation efforts of police and ambulance officers, Mr Sexton could not be revived, and it seems very likely he was already deceased when he was removed from the Volvo.

45. After careful consideration of the available evidence, and with due regard to the Briginshaw principle, I am satisfied that neither the actions of the Attending Police Officers involved in the attempted intercept of

[64] Exhibit 1, Vol. 1, Tab 8, Report - Det. Sgt. A Xu, Internal Affairs Unit (31.01.24), p27

Mr Sexton, nor the resuscitation efforts by any of those officers caused or contributed to Mr Sexton's death.[65]

CONCLUSION

46. Mr Sexton died after shooting himself in the head and neck with a double-barrel shotgun. He had been pursued at low speed by police after allegedly committing very serious offences. After carefully reviewing the available evidence, I am satisfied that the actions of police involved in attempting to intercept Mr Sexton did not cause or contribute to his death.

47. As I did at the conclusion of the inquest, I wish to again convey to Mr Sexton's family and friends, on behalf of the Court, my very sincere condolences for your terrible loss.

MAG Jenkin
Coroner
3 July 2025

[65] See also: Exhibit 1, Vol. 1, Tab 8, Report - Det. Sgt. A Xu, Internal Affairs Unit (31.01.24), pp23 & 27-28