
JURISDICTION : CORONER'S COURT OF WESTERN AUSTRALIA
ACT : CORONERS ACT 1996
CORONER : Rosalinda Vincenza Clorinda Fogliani, State Coroner
HEARD : 16 - 27 SEPTEMBER 2024
DELIVERED : 4 JUNE 2026
FILE NO/S : CORC 5 of 2010
DECEASED : WARNEKE, JOSHUA TIMOTHY

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms R Young SC assisted by J Tiller assisted the State Coroner

Mr T Percy KC and Ms K Zhang and Ms C Bass (instructed by Jeremy Quan-Sing, Allens) appeared for Mrs Bishop, mother of the deceased

Mr G Stockton and Mr A Gibson (State Solicitors Office) appeared for the Western Australia Police Force

Ms A Owen (Tindall Gask Bentley Lawyers) appeared for Detective Senior Constable P Gazzone and Detective Senior Constable R Shannon and Detective Senior Sergeant C Western

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Rosalinda Vincenza Clorinda Fogliani, State Coroner, having investigated the death of **Joshua Timothy WARNEKE** with an inquest held at Broome Courthouse, Hamersley Street, Broome, on 16 - 18 September 2024, and Perth Coroners Court, Central Law Courts, Court 51, 501 Hay Street, Perth, on 19 - 27 September 2024, find that the identity of the deceased person was **Joshua Timothy WARNEKE** and that death occurred on 26 February 2010 on Old Broome Road, Broome, about 490 metres north of Bagot Street, from head injury in the following circumstances:*

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SUPPRESSION ORDERS

There are non-publication orders made under s 49(1) of the Coroners Act 1996, which are Suppression Orders, over evidentiary material that relates to the potential identification of, and/or exclusion of, persons who may have been responsible for Josh's death.

That evidentiary material is not outlined in this finding.

INTRODUCTION

1. On 26 February 2010 in the early hours of the morning, an emergency call was made by Broome taxi driver, Mr Jim McCall (Mr McCall), reporting a man lying on Old Broome Road. The caller was not sure if he had been hit or not and said there was quite a lot of blood around him. Emergency services were dispatched to the scene and confirmed that the man was dead.
2. It was later identified that it was the body of Mr Joshua Warneke. At the request of his family, he is referred to in this finding as Josh. Josh was 21 years old. He was found deceased at the side of Old Broome Road, partially on the road, with a severe head injury. There was no obvious line of inquiry. Initial thoughts were that he may have been a victim of a hit and run incident involving a motor vehicle, or that he may have been assaulted and left there.
3. A criminal investigation into Josh's death commenced, and it was beset by numerous problems, some of which are outlined later in this finding.
4. Josh's death was a reportable death within the meaning of s 3 of the *Coroners Act 1996* (Coroners Act). It was reported to the coroner as required. By reason of s 19(1) of the Coroners Act I have jurisdiction to investigate the death.
5. My primary function is to investigate the death. It is a fact-finding function. Pursuant to s 25(1)(b) and (c) of the Coroners Act I must find, if possible, how the death occurred and the cause of the death. Pursuant to s 25(2) of the Coroners Act, in this finding I may comment on any matter connected

with the death including public health, safety or the administration of justice. This is the ancillary function.

6. I held an inquest at Broome Courthouse between 16 and 18 September 2024 and at Perth Courthouse between 19 and 27 September 2024.
7. I heard from 29 witnesses. I received 21 exhibits into evidence. Investigations continued and after the close of the inquest, between 20 October 2025 and 28 April 2026 I received a further four exhibits into evidence.
8. The focus of the inquest was on the expert evidence relating to the cause and manner of Josh's death, with particular attention given to what may have caused his head injury.
9. In making my findings I have applied the standard of proof of the balance of probabilities taking into account the considerations as set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 361 - 362 which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proved on the balance of probabilities. The more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.
10. My findings appear below.

MR WARNEKE (JOSH)

11. Josh was born in the rural town of Millicent, South Australia on 27 December 1988. He was the eldest son of Mr Timothy Charles Warneke and Ms Ingrid Bishop (Ms Bishop) and had a brother, Matthew Charles Warneke who was two years younger than him.¹
12. Josh's mother and father separated in 1998. Josh relocated to Broome WA in 2007 with his mother and brother and commenced his carpentry apprenticeship. He worked as a labourer on a number of sites, including at

¹ Exhibit 3, tab 1.1.

Karijini and Mill Stream National Parks in the early stages, and then also within Broome, including at the Cable Beach Club Resort.²

13. Josh was an organised young man, he worked, saved money, rented a residence with some friends, and enjoyed his life. He maintained a close and loving relationship with his mother and sought her out for guidance and support.³
14. Josh was well known around Broome and was described as a confident young man with an outgoing personality who enjoyed numerous circles of friends. The witnesses who knew him and who gave evidence at the inquest described a good-natured young man, and many remained upset about his death.
15. Josh was a much-loved son and brother. His mother described him as an incredible young man who brought energy, kindness, humour, generosity and love into their lives and to those that knew him.⁴
16. Ms Bishop attested to his integrity and loyalty and said that as a family, they are continuing to learn how to live without him.⁵
17. Ms Bishop has been unwavering in her focus on seeking to know how Josh died, and has spoken movingly of the impact this has had on her and her family.⁶

BACKGROUND TO THE EVENTS

18. In 2010, Josh Warneke was a 21-year-old labourer, living in the Roebuck Estate, about three kilometres from the centre of Broome. During the wet season, he worked with other tradespeople on jobs around the Broome area. Through that work, and through socialising like any other young adult, he came to meet, and become friendly with, other people in Broome.

² Exhibit 3, tab 1.1.

³ Exhibit 3, tab 1.1 and 1.2.

⁴ ts-873.

⁵ ts-873.

⁶ ts-873-875.

19. They described Josh as a very friendly, polite, helpful and calm person. Josh's friends observed that his personality after a few drinks did not change much – he was “*always just friendly*”. He was not described by anyone as being disagreeable or having tension with anyone. He was a very likeable person.⁷
20. This was relevant within the context of whether Josh was likely to have gotten into a fight with someone at some stage prior to his death, who may later have come to assault him. As will be seen later in this finding, Josh did not get into a fight before heading home along Old Broome Road, and there would have been no apparent cause for any person to follow him or seek him out, with the intent of assaulting him.
21. On Thursday, 25 February 2010, Josh had three work friends around to his house at Broome for some drinks after work. At about 10.20 pm they headed into town to the Oasis Bar. A couple of hours later, at around 12.35 am on 26 February 2010, Josh entered the Bungalow Bar, a few metres down from the Oasis Bar.
22. At about 2.13 am, Josh left the Bungalow Bar, with three Mangrove Resort workers that he had met that night. Together, they walked through the Roebuck Bay Hotel drive-thru bottle shop, then across Male Oval.
23. His new friends walked towards the Mangrove Hotel staff house. Josh parted ways with them to order food at the nearby McDonald's, expressing his intent to meet up with them at the staff house for a swim later.
24. At around 2.27 am, Josh was seen at the McDonald's. The time of night meant that only “*drive-thru*” customers were able to purchase food. Josh arranged with two overseas nationals, who were in a vehicle, to purchase three cheeseburgers for him.
25. At around 2.29 am, a taxi driver was driving through the McDonald's drive-thru. Josh appeared to be urinating on the McDonald's speaker box.
26. Eventually, Josh obtained his three cheeseburgers, and was witnessed by Ryan Thompson (Mr Thompson) walking up Old Broome Road towards the Roebuck Estate at about 2.45 am. That was in the direction of Josh's home.

⁷ ts-124.

- 27.** Sadly, Josh never made it home. At about 3.02 am, Josh was found dead on the side of Old Broome Road. He was lying on the north bound lane, at a right angle to the direction of the road, with his head partially on the road. He was wearing a pair of dark shorts with an unbuckled belt, and was shirtless. A t-shirt was tucked into the right side of his shorts. His thongs were on his right side, near him. This was consistent with the taxi driver Mr McCall stating that he had passed what seemed to him to be a person lying on the side of the road at about 2.50 am.
- 28.** The positioning of Josh's body was unusual and I address this in more detail later in this finding.
- 29.** At 3.10 a.m., local police officers Sergeant Andrew Henshaw and Constable Damian Webb arrived on the scene. Officer Henshaw examined Josh's body for signs of life and formed the view that Josh had passed away. This was confirmed by St John of God ambulance officers who attended at about 3.18 am.
- 30.** Josh had a deep laceration to the scalp at the back of the head and two lacerations or abrasions above his right eye. He had numerous other abrasions, bruising and lacerations to the face, particularly on his right side.
- 31.** The forensic pathologist who made the post mortem examination formed the view that the cause of death was a head injury. I address this in more detail later in this finding.
- 32.** In the few minutes between Mr Thompson seeing Josh walking up Old Broome Road towards his home, and Mr McCall seeing a person lying on the side of Old Broome Road, something significant happened to Josh, resulting in his death.
- 33.** This matter took some time to come to inquest, principally because the Court was not able to investigate and hear the matter while criminal proceedings in connection with Josh's death were under way as specified by s 53 of the Coroners Act.

KEY FACTUAL FINDINGS

34. In making the factual findings I record below, I note that I was assisted by my site visit on 16 September 2024, the first day of the inquest, walking the route that Josh took in the early hours of 26 February 2010, from the old location of the Oasis Bar, to the Bungalow Bar, and then across to Male Oval, observing the McDonald's, and walking up Old Broome Road to the location where Josh's body was located.
35. The key factual findings appear below.

Earlier car accident on 20 February 2010

36. Late on 20 February 2010, Josh rolled his car about 50 km north of Roebuck Road House. This is relevant as it occurred some five days prior to his death, and it is important to understand whether any injuries he sustained in this incident impact upon the analysis of the head injury that caused his death.⁸
37. Josh was promptly transported by his friends to Broome Hospital. He was examined. He had a superficial laceration to the back of his head about 10 cents in size (two centimetres) and a seat belt mark across his chest and lower abdomen. His neck was sore. The findings were of a laceration to the occiput (back of the head), and a minor head injury with no adverse neurological findings.⁹
38. He was released but then called back to the Broome Hospital the next day, after his cervical X-ray had been reviewed by Royal Perth Hospital, who were concerned about an impression of a transverse lucency through the anterior arch of his C1 vertebra. Consequently, a plan was made for further imaging with CT and he was put in a cervical collar.¹⁰
39. On 22 February 2010, Josh was flown by Royal Flying Doctor Service from Broome to Royal Perth Hospital for medical examination for his spine. He was given 5 mg of diazepam just prior to entering the flight as he had an anxiety attack.¹¹

⁸ Ex 1.11, p. 1; Ex 3.1.1 [40].

⁹ Ex 1.11, p. 1-2.

¹⁰ Ex 3.1.1 [41]-[42]; Ex 1.11, p. 2.

¹¹ Ex 1.11, p. 2.

40. After two detailed examinations, including a consultation with a spinal surgeon, there were no findings of concern and he was discharged.¹²
41. Subsequent review of those medical findings by the forensic pathologists and forensic anthropologist who gave evidence at the inquest identified that there was nothing in those medical findings that suggested Josh had a skull fracture or skull injury from the 20 February 2010 car accident, and nothing to suggest he would have been predisposed to a skull fracture by reason of the accident. I accept these opinions.¹³
42. Josh returned to Broome at about 6.00 pm on 23 February 2010. He had no neck collar and no need for any further follow up.¹⁴

Drinks at Josh's house on 25 February 2010

43. A few days later, after work at about 9.30 pm on Thursday, 25 February 2010, Josh had friends Graham Cockman, Corin Lowe and Clint Gibson over to his house at 27 Greenshank Drive, Roebuck Estate, for drinks. Josh had become friendly with Mr Cockman, Mr Lowe and Mr Gibson through working together on a renovation on the Cable Beach Club in about 2008.¹⁵
44. That night at Josh's house, they each had about two to four beers.¹⁶ Conscious of his prior car accident, Mr Cockman asked Josh if he was okay to go out that night. Mr Gibson was aware that Josh had a sore neck.¹⁷ Josh said he was fine, and he did indeed seem fine to Mr Cockman.¹⁸ They recalled calling a taxi to take them into town.¹⁹
45. At about 10.20 pm they were transported into town by taxi driver Minwoo Park, known as Mike, and dropped off about 50 metres from the Oasis Bar.²⁰

¹² Ex 1.11, p. 3.

¹³ ts-655.

¹⁴ Ex 1.11; Ex 3.1.1 [46].

¹⁵ ts-127; ts-185; Ex 2.1; Ex 2.2; Ex 2.3

¹⁶ ts-127, ts-187

¹⁷ Ex 2.3.1 [16].

¹⁸ ts-128.

¹⁹ ts-129.

²⁰ Ex 2.23.2 [11]-[28].

Oasis Bar

46. At about 10.30 pm, the group arrived at the Oasis Bar, on Dampier Terrace in Broome. There they had drinks and socialised.
47. As was seemingly the practice, at about midnight, the patrons of the Oasis Bar moved to the nearby nightclub, the Bungalow Bar, also on Dampier Terrace.
48. Josh walked from the Oasis Bar with his friend, Erin Parke, to the Bungalow Bar, telling her about his car accident of a few days ago.²¹
49. Josh entered the Bungalow Bar at about 12.35 am and 49 seconds, on Friday, 26 February 2010, based on the CCTV.²²

Bungalow Bar

50. At the Bungalow Bar, Josh, Mr Cockman, Mr Lowe and Mr Gibson, had a few more drinks and danced. Ms Parke saw him on the dance floor, joking and dancing like a robot because of his stiff neck.²³
51. Josh can be seen on the CCTV inside at about 12.40 am and 44 seconds.²⁴
52. Josh also spent time in the beer garden, speaking with other patrons. There he met Megan Tilbrook (then Megan Patterson), Shaye Clark and Natasha Duffy (then Natasha Binns). They were workers at the Mangrove hotel in Broome.
53. In the short 10 to 20 minutes they spoke with Josh, they thought he was polite and friendly and a “*really top bloke*”. They were comfortable with inviting him back to the Mangrove staff house at 6 Bagot Road, near the Broome airport, for a swim.²⁵
54. Ms Duffy did not think Josh was overly affected by alcohol, but he seemed to her to be moderately intoxicated and seemed tired.²⁶

²¹ ts-24-25; Ex 2.4.1 [29].

²² Ex 7.1.

²³ Ex 2.4.1 [40].

²⁴ Ex 7.2.

²⁵ ts-205-206; ts-225-227.

²⁶ ts-205, 212, 217; ts-226.

55. None of the witnesses thought Josh was so badly affected by alcohol that he had trouble walking or functioning.²⁷ At no point did any of the witnesses observe Josh being in any fights or disagreements that night at either the Oasis Bar or the Bungalow Bar.²⁸

Leaving Bungalow Bar in the early hours of 26 February 2010

56. Josh, Mr Cockman, Mr Lowe and Mr Gibson did not leave the Bungalow Bar together.
57. Mr Cockman left first, after midnight, taking a taxi to his accommodation at the Cable Beach Club, likely arriving there at about 1.00 am.²⁹
58. About 2.00 am Mr Gibson was glassed in the back of the head and was conveyed by ambulance to Broome Hospital. Mr Lowe called Mr Cockman to let him know that Mr Gibson had fallen over or had been glassed and Mr Gibson was going to hospital. There did not appear to be any discussion about Josh in that call.³⁰
59. Not long after Mr Gibson was taken away in the ambulance, Mr Lowe left via a taxi to his accommodation at the Cable Beach Club.³¹
60. The evidence at the inquest, including the CCTV footage, reflects that at about 2.13 am and 27 seconds, Josh began to leave the Bungalow Bar, first chatting to others, and then exiting at 2.15 am on foot, with the Mangrove hotel workers, Ms Tilbrook, Mr Clark and Ms Duffy.³²
61. Together they walked through the Roebuck Bay Hotel “*drive thru*” bottle shop, then across Male Oval.³³
62. Ms Tilbrook’s evidence was that after walking across Male Oval, Josh said he knew someone who worked at McDonald’s and so he would see if he was working and could get a feed, but he would meet them at the Mangrove

²⁷ ts-29; ts-53-54.

²⁸ ts-49; ts-135; ts-188; ts-207; ts-231.

²⁹ ts-134.

³⁰ ts-134-135.

³¹ ts-191.

³² Ex 7.3.

³³ ts-228.

Resort staff house later.³⁴ The Broome McDonald's is on the road opposite Male Oval.

63. As will be seen, Josh did indeed pick up some food from the McDonald's, and it would appear to have been three serves of food, but he then headed towards his home, and not in the direction of the Mangrove Resort staff house.
64. I am satisfied that Josh did not go to the Mangrove Resort staff house.

Attending McDonald's

65. The practice of the Broome McDonald's in February 2010 was that in the early hours of the morning, only "*drive thru*" customers were served. Josh knew that, but as he told Ms Tilbrook, he thought his friend might be working at McDonald's that night, so he went to McDonald's and tried anyway.³⁵
66. Ms Tilbrook and Ms Duffy walked back towards their staff accommodation. Mr Clark walked across the road from Male Oval towards the McDonald's with Josh and spoke with him for about five minutes. In response to Josh's offer, he asked Josh to order him a burger and gave Josh the directions to the Mangrove Resort staff house, which was close by.³⁶
67. Josh continued towards the McDonald's. Mr Clark then walked off in the direction of Ms Tilbrook and Ms Duffy, possibly to check that they were alright. The three of them expected Josh to come to the Mangrove Resort Staff House after he got the food from McDonald's.³⁷
68. The CCTV shows Josh at about 2.27 am at the McDonald's.³⁸
69. As it transpired, the usual rules applied and Josh was not able to order food from McDonald's without going through the "*drive thru*" (in a vehicle). He spoke to another patron at McDonald's, Andrew McDonald, about how he could order food. Mr McDonald was sitting on a traffic island in the McDonald's carpark, with some food. To him Josh seemed upbeat, light-

³⁴ Ex 2.6 [47]-[48].

³⁵ ts-52; ts-229.

³⁶ ts-229.

³⁷ Ibid.

³⁸ Ex 7.4.

hearted and positive. From his observations, Josh was not unsteady on his feet or slurring.³⁹

70. Josh then spoke to Vincent Vigoroux and Guillaume Callot, who were travelling in one car through the “*drive thru*.” Josh gave them money for three cheeseburgers. Their evidence was also that at one stage they saw Josh urinating on the McDonald’s speaker box, and one of them told him not to do that. They proceeded to order for him and shortly afterwards gave him his food.⁴⁰
71. Close to this time, at about 2.29 am, Philip Nordfelt, a taxi driver, was driving through the McDonald’s “*drive thru*,” with his passenger who wished to order McDonald’s on her way home.⁴¹
72. Mr Norfeldt also saw Josh urinating on the McDonald’s speaker as he pulled up to the “*drive thru*,” and this is consistent with the CCTV footage at 2.29 am. Mr Norfeldt nudged Josh with his taxi as he arrived, and Josh reacted and moved away from the speaker. He did not appear to be injured by the slight nudge. At the inquest Mr Norfeldt denied nudging Josh with his taxi, but the CCTV shows this.⁴²
73. Although at the inquest Mr Nordfelt could not recall speaking to Josh, Mr Nordfelt’s police statement from 2010 identifies that he and Josh spoke briefly, with Mr Nordfelt, in connection with Josh urinating, saying words to the effect that: “*This is no good mate.*” Josh responded saying words to the effect: “*They won’t serve me.*”⁴³
74. Also, in his 2010 police statement, Mr Nordfelt described Josh as mildly drunk. At the inquest it became apparent that this was Mr Nordfelt’s assumption based upon his experience of Bungalow Bar patrons at that hour of the night or early morning. However, Mr Nordfelt did not smell alcohol on Josh’s breath, and to him Josh seemed steady on his feet.⁴⁴

³⁹ ts-87-88; Ex 2.10 [25].

⁴⁰ Ex 2.12 [58]-[67]; Ex 2.13 [37]-[55].

⁴¹ Ex 2.16 [10].

⁴² ts 172; Ex 7.6; Ex 7.7.

⁴³ ts-154; Ex 2.14 [21]-[22].

⁴⁴ Ex 2.14 [23]; ts-156-157.

75. The CCTV of the conversation between Mr Nordfelt and Josh reflects that it does not appear to be heated. Mr Nordfelt confirmed that Josh did not display signs of aggression to him. Mr Nordfelt drove his taxi out of the speaker area of the McDonald's at 2.31 am.⁴⁵

Walking along Old Broome Road

76. At about 2.45 am on 26 February 2010, Josh was seen by Mr Thompson and Bradley Henry walking up Old Broome Road towards the Roebuck Estate, positioned on the roundabout and then walking along the side of the road. Mr Thompson did not know Josh but recognised him from earlier that night. Josh appeared to be alert and did not seem to be excessively drunk or in any distress. He had no visible injuries on him.⁴⁶
77. It would appear, by this stage, that Josh had decided not to go to the Mangrove Hotel staff house, but instead was planning to walk back to his residence on the Roebuck Estate.
78. Old Broome Road was a relatively straight, flat, level, single two-lane, bitumen carriageway with vehicles travelling in both directions and the two lanes separated by a single broken white line. On either side of the carriageway are verges constructed from compacted gravel.⁴⁷
79. At the time there were no overhead lights on the side of the road where Josh was found.⁴⁸
80. At around 2.50 am, Broome taxi driver, Mr McCall, was driving with three passengers (Kelvin Jones, Michelle Coates and Daniel McQuiggin) from the McDonald's to Roebuck Estate. As Mr McCall was driving north on Old Broome Road, he saw what looked like a person lying on the side of the road with the head pointing in a southerly direction. The person was later identified to be Josh. This sighting occurred very shortly after Josh had been seen by Mr Thompson and Mr Henry walking along Old Broome Road.⁴⁹

⁴⁵ ts-157; Ex 7.6.

⁴⁶ Ex 2.8 [53]-[60]; Ex 2.17 [30]-[31].

⁴⁷ Ex 1.20.

⁴⁸ ts-112; Ex 1.20.

⁴⁹ Ex 2.19.1 [17].

81. Mr McCall did not stop. He swerved around the person he saw lying on the road, and continued along Old Broome Road.⁵⁰
82. Mr McQuiggin looked out the rear window to see why the taxi swerved. He saw a person lying on the side of the road, which he described as a white skinned, young and quite skinny male without a shirt, but wearing shorts. Mr McQuiggin saw that he was lying on his back with his hands covering his face. Mr McQuiggin explained at the inquest that what really stuck in his memory was the taxi swerving and seeing someone lying on the side of the road with their hands on their face, though he also accepted the person's face could have been turned to the side, with his hands on the side of his head. Either way, he thought the placement of the hands meant that Josh was alive.⁵¹
83. Mr McQuiggin could not recall seeing blood on Josh. His sighting of Josh occurred over a matter of seconds.⁵²
84. Ms Coates did not see the person lying by the side of the road but thought that Mr McQuiggin said something like "*he is still alive*" as he looked back.⁵³
85. Mr Jones was in the rear passenger seat. His 2010 police statement identifies that after the taxi passed the person lying on the road, Mr Jones turned back and saw what looked like the silhouette of a man lying motionless on the road, from about 50 metres by the time he turned.⁵⁴
86. Mr McCall continued driving and dropped off Mr Jones, Ms Coates and Mr McQuiggin at Roebuck Estate.⁵⁵
87. Sometime shortly after 2.58 am, Mr McCall drove back down Old Broome Road in a southerly direction, and he decided to stop to see if the person he had seen previously lying by the road was okay. He pulled up and parked his taxi half on the road and half on the gravel.⁵⁶

⁵⁰ Ex 2.19.1 [18].

⁵¹ ts-715-716; ts-720; Ex 2.21 [31]-[34].

⁵² Ex 2.21 [30]-[33].

⁵³ Ex 2.22 [48].

⁵⁴ Ex 2.20 [28]-[29].

⁵⁵ Ex 2.19.1 [18].

⁵⁶ Ex 2.19.1 [19]-[22].

88. Just before Mr McCall pulled up, another taxi driver, Mr Park, had already pulled up. At around 3.02 am, Mr Park had been driving in a northerly direction along Old Broome Road, with a passenger. When he had driven about 300 or 400 metres past the roundabout, he saw something on the road, and put his high beam on. In the light of his high beam, he noticed a person lying down, half on the bitumen and half on the gravel shoulder. He described the person, later identified to be Josh, as being shirtless with quite long blonde hair.⁵⁷
89. Mr Park decided to stop upon seeing the person lying down. He drove around the person and pulled up about 20 to 30 metres past him. He said to his passenger something to the effect of: “*what was that?*” and she responded with a similar question, and indicated that they should call the police. Mr Park did a u-turn and pulled up next to the person.⁵⁸
90. Mr Park exited his taxi and attempted to rouse the person by saying: “*hey hey.*” The person was unresponsive. Mr Park observed blood around his head and something red coming out of his mouth. The person looked dead to Mr Park.⁵⁹
91. Shortly afterwards, Mr McCall arrived on the scene. Mr Park was standing near Josh. Mr Park told Mr McCall he thought the person was dead and to call the Police.⁶⁰
92. At about 3.03 am, Mr McCall called the emergency services line.⁶¹ He reported that he thought: “*this guy’s dead*” but added that he had not: “*had a good look at him yet.*”⁶² He informed the call taker that: “*there’s quite a lot of blood around him*” and thought that someone could have hit him. Mr McCall observed Josh was lying face down, had no t-shirt on, a t-shirt appeared to be tucked under his stomach, he was wearing shorts and his thongs were placed near his feet. Mr McCall said it looked like Josh had been hit.⁶³

⁵⁷ Ex 2.23.1 [8]-[12].

⁵⁸ Ex 2.23.1 [13]-[16]; Ex 2.23.3 [8]-[9]; Ex 2.24.1.

⁵⁹ Ex 2.23.1 [19]-[25].

⁶⁰ Ex 2.19.1 [23]-[24]; Ex 2.23.1 [27]-[28].

⁶¹ Ex 7.8; Ex 1.2.

⁶² Ex 7.8; Ex 1.2.

⁶³ Ex 2.19.3 [16].

93. At about 3.07 am, a Police vehicle and an ambulance were dispatched to the scene. Police records at this stage reflect that a hit and run was considered a possibility, as do the ambulance records.⁶⁴
94. Before emergency vehicles arrived, Mr Nordfelt, who was still on his shift, came across the scene. He spoke to the other taxi drivers and enquired whether they had called emergency services. They indicated that they had, so Mr Nordfelt continued up Old Broome Road to the Roebuck Estate to pick up his next passenger.⁶⁵
95. At about 3.10 am, Officer Henshaw and Officer Webb arrived on the scene, at Old Broome Road, almost directly opposite the Bristow helicopter hangars. Officer Henshaw and Officer Webb examined for signs of life and formed the view that the person had passed away. While the person was warm to the touch, indicating he was recently deceased, he was not breathing.⁶⁶
96. At about 3.18 am St John of God Ambulance officers arrived. Volunteer Ambulance Officer Linley Cilia checked for signs of life and could not find any. There was a pool of congealed blood around his head and shoulder. His head was turned right side down. His left eye was swollen and closed. Officer Cilia certified him life extinct at 3.20 am.⁶⁷
97. Officer Cilia observed some darkness on Josh's right outer forearm, which, with her pen light at about 3.00 am in the morning, she thought was a sign of lividity.⁶⁸
98. This became a focus at the inquest as it was subsequently posited that the dark mark on Josh's right outer forearm was made by the tyre of a vehicle, that came into contact with him.
99. To preserve Josh's dignity, Officer Cilia covered Josh with a non-sterile sheet from the ambulance. At the inquest Officer Cilia's evidence was that this was done after consulting with one of the police officers present.⁶⁹

⁶⁴ Ex 1.3; Ex 12.

⁶⁵ ts-164; Ex 14.

⁶⁶ Ex 2.25 [11]-[16]; Ex 2.26.1 [13]-[15].

⁶⁷ Ex 2.27.1 [14]-[15]; Ex 1.4.

⁶⁸ ts-102-103.

⁶⁹ ts-104; Ex 2.27.1 [15].

100. This became a focus at the inquest as it was subsequently outlined that the placement of a non-sterile sheet over Josh could have compromised the evidence.
101. Around this time, Senior Constable, Forensic Investigation Officer, Julie Ann Walters had also attended the scene, in her capacity as crime scene examiner, photographer and exhibits officer.⁷⁰ By the time Officer Walters came to do her examination of Josh, he was already covered with the sheet.⁷¹

Initial police observations at scene

102. Josh's body was examined and photographed by attending Police in the early hours of 26 February 2010. He was lying on the north bound lane of Old Broome Road, at right angles to the direction of the road. He was wearing a pair of dark shorts with an unbuckled belt, and was shirtless. A t-shirt was tucked into the back side of his shorts.⁷²
103. Josh was lying on Old Broome Road about 490 metres north of Bagot Street (where the Mangrove Resort staff house was located), which is consistent with him having determined to walk home after McDonald's, rather than meet up with his new companions at the Mangrove Resort staff house.⁷³
104. Josh's head and the upper part of his body were on the sealed bitumen surface of the road in a pool of blood. His thighs and legs were on the gravel shoulder. The blood pooled under Josh and appeared to originate from his head area and flowed in the direction of the gravel verge.⁷⁴
105. There appeared to be no signs of disturbance in the gravel verge. Nor did Josh seem to be obviously injured on his legs, back or arms.⁷⁵
106. A wallet and a cheeseburger were in his left rear pocket. The other two cheeseburgers, that he bought, were not located with or near his body.

⁷⁰ Ex 1.26.1 [7].
⁷¹ Ex 1.26.1 [14].
⁷² Ex 1.26.1 [14]-[18].
⁷³ Ex 1.20.
⁷⁴ Ex 1.26.1 [14]-[18].
⁷⁵ Ex 1.26.1 [17], [19].

Subsequent forensic examinations suggest he may have eaten two of the cheeseburgers.⁷⁶

107. Josh's head was turned so that the right side of the face was on the road with his head facing towards his left. His body was chest down on the road.
108. His right arm was extended out at a right angle from his body with his elbow being in line with his head. His left arm was also bent.
109. He had several small fine hairs in the palms of his hands.⁷⁷
110. His legs were relatively straight with both soles of his feet facing upward. His thongs "*appeared to be positioned*" neatly together on the gravel verge about 30 centimetres from his right leg.⁷⁸
111. This became a point of interest at the inquest, as it was not clear why the thongs were relatively neatly positioned in that way. They did not appear to have been removed as though during an altercation, or while fleeing. Nor did they appear to come off his feet in the course of being hit by a vehicle.⁷⁹

Initial criminal investigation

112. About 3.55 am, when the Officer in Charge of the Broome Police Station, Brett Baddock, attended at the scene after being contacted at 3.20 am by Officer Henshaw for assistance, Officer Henshaw had already advised him that he believed the matter was a hit and run.⁸⁰
113. Officer Baddock was the head of the West Kimberley District Forensic Investigation Office. When he examined the scene, he was not satisfied it was a traffic crash, taking account of Josh's thongs that seemed to be positioned perfectly parallel to each other at a 90-degree angle to the road (which he says was different to the position in which they were later photographed). Officer Baddock also thought that if it were a traffic crash,

⁷⁶ Ex 1.6.1, p. 6; Ex 1.26.2, p. 6; Ex 1.28, p.8.

⁷⁷ Ex 1.26.1 [31].

⁷⁸ Ex 1.26.1 [16].

⁷⁹ Exhibit 1.28, p.52.

⁸⁰ Ex 1.25 [3].

there would be momentum injuries to Josh and gravel disturbance, but he could see none.⁸¹

114. It was initially planned to treat the matter as a hit and run traffic crash with Officer Henshaw as investigator, and that Officer Baddock would assist and run a parallel investigation into a possible homicide.⁸²
115. Senior Constable Adrian Callaghan of the Major Crash Investigation Section of WA Police attended at the scene during the afternoon of 26 February 2010.
116. Like Officer Baddock, Officer Callaghan thought that the injuries were not typical of the severe head trauma commonly found in collisions involving pedestrians and vehicles, in his experience. Further, he thought that the positioning of Josh's body was inconsistent with him having been hit by a passing vehicle or protruding object. In Officer Callaghan's experience, when a vehicle collides with a pedestrian, some momentum of the vehicle will usually be imparted to them (meaning they are thrown for some distance and will suffer secondary injuries from the road surface and/or there will be imparted some degree of rotation).⁸³
117. That said, Officer Callaghan could not exclude a collision having occurred; he could not "*discount it 100%*."⁸⁴
118. Following Officer Callaghan's opinion, expressed to Officer Baddock on the evening of 26 February 2010, Josh's death was treated as a suspected homicide.⁸⁵

Operation Aviemore established

119. The investigation was subsequently given the name Operation Aviemore. Over the course of its life, that operation identified 738 witnesses.⁸⁶

⁸¹ Ex 1.25 [6]-[9].

⁸² Ex 1.25 [10].

⁸³ Ex 1.16.

⁸⁴ Ex 1.16.1.

⁸⁵ Ex 1.16.1.

⁸⁶ Ex 1.27, p. 9.

120. On 4 March 2010, Detective Sergeant Cameron Western assumed the role of the Investigating Officer, and on 3 August 2011, he became the Senior Investigating Officer.⁸⁷

Post Mortem Examination

121. On 4 March 2010, the forensic pathologist Dr Clive Cooke performed the post mortem examination. He identified that Josh had a severe head injury with damage evident both externally and internally but was not, on that date, able to form a view on the cause of death.⁸⁸

122. Dr Cooke recorded that Josh had a widely gaping, upwardly shelved laceration to the scalp at the back of the head, located approximately at the level of the tops of the ears, five centimetres below the top of the head. At the inquest Dr Cooke explained that it was a complex laceration. There was a large component and then extending from the large component towards the centre of it were two extensions. The deep laceration to the back of the head was about 9.5 centimetres long and had, in Dr Cooke's opinion, an avulsion pocket, or a "*degloving*," meaning an undercutting of the scalp extending towards the top of the head for a further two and a half centimetres. The blow or force causing the injury appeared to have been made in an upwards direction, or from horizontal to upwards.⁸⁹

123. Josh had two lacerations or abrasions above his right eye.⁹⁰

124. Josh had numerous other abrasions, bruising and lacerations to the face, particularly on his right side.⁹¹

125. Josh had severe internal injuries to his head. He had fractures on both sides of his skull, particularly the right side of the skull vault, extending as two linear fractures to the top of the forehead, and of the skull base. There was bleeding around the brain (subdural haemorrhage) and bruising and injury to the brain.⁹²

⁸⁷ ts-723-724.

⁸⁸ Ex 1.6.1, p. 1.

⁸⁹ Ex 1.6.1, p. 5; Ex 15; ts-578-581.

⁹⁰ Ex 1.6.1, p. 5.

⁹¹ Ex 1.6.1, pp. 1-5.

⁹² Ex 1.6.1, pp. 1-5; Ex 1.6.4 [2.1].

126. The pooling of blood around and under Josh’s body, extending along the left side of the body to the edge of the bitumen surface, appears to have come from Josh’s head, most likely from his nose, right ear, and the injury to the scalp of the head.⁹³
127. Dr Cooke ordered further investigations that were carried out. Toxicological analysis showed a high level of alcohol (0.183%) and neuropathology examination confirmed the presence of traumatic brain injury. Following receipt of results of the further investigations, on 29 April 2010 Dr Cooke formed the opinion that Josh’s cause of death was 1a, head injury with 2, acute alcohol intoxication. At the inquest Dr Cooke was questioned about the inclusion of the reference to alcohol intoxication. He explained that in his opinion, it could be argued that the alcohol level was a factor in the final mechanism of death (hence his reference to it).⁹⁴
128. Toxicological testing did not reveal any illicit drugs in Josh’s system.⁹⁵
129. Eyebrow and scalp hairs were found in Josh’s hands at the post mortem examination.⁹⁶
130. The hairs on the left hand appeared to be associated with the blood staining on the ulnar aspect of the hand.⁹⁷ Dr Cooke posited that it was possible they had been transferred there by blood flow. Josh’s left hand was in an area of pooled blood. They may also be explained by Josh having touched his head with his left hand after he was injured.⁹⁸ The hairs on the palm of the right hand were shorter in length than those on the left hand and were not associated with blood staining (save for a very small number).⁹⁹ Dr Cooke posited that if they are eyebrow hairs, and had been transferred by contact with the injury to the right eyebrow, then the absence of blood staining is not explained. Overall, Dr Cooke considered the source of those hairs in the palm of the right hand as “*puzzling.*” He would not have expected Josh to have been conscious so as to be able to touch his head, after having sustained his head injury.¹⁰⁰

⁹³ Ex 1.6.4 [1.1].

⁹⁴ Ex 1.6.3, p. 1; ts 576.

⁹⁵ Ex 1.7.1; Ex 1.7.2.

⁹⁶ Exhibit 1.6.1.

⁹⁷ Ex 1.15.2, p. 6 [2.8].

⁹⁸ ts-611.

⁹⁹ Ex 1.15.2, p. 6 [2.8].

¹⁰⁰ Ex 1.6.4 [1.2]; ts-611.

131. The hairs found in Josh’s hands were not shed naturally. A subsequent report prepared in 2012 by Elizabeth Brooks, the Senior Forensic Scientist with the Australian Federal Police, reflects that the hairs could be attributed to Josh’s scalp or eyebrows, and that they were consistent with being cut, broken or sliced, by a sharp object or instrument, as evidenced by breakage, cuts or oblique angle cuts through the proximal hair shafts. The Australian Federal Police Report also addressed blood adhering to the hair shaft of some of the hairs.¹⁰¹
132. Later still, in 2018, the DNA profiles on the hairs were compared to the mitochondrial DNA profile of Josh by the Victorian Institute of Forensic Medicine, and a report was produced. To the extent that DNA mitochondrial analysis was able to be done, some of the hairs in Josh’s hands were found to match his hair.¹⁰² No results could be obtained from others of the hairs in Josh’s hands.¹⁰³
133. Turning back to the period of the post mortem examination, a discrepancy in the evidence regarding an important meeting arose at the inquest, that has led me to adopt a recommendation proposed by Ms Bishop and referred to later in this finding, concerning the WA Police review of expert witness briefing practices.
134. Specifically, on 15 April 2010, it appears Officer Western met with Dr Cooke at the State Mortuary, in the company of other WA Police officers. A WA Police record from this meeting reflects that Dr Cooke opined that based on the crime scene photographs and lack of evidence of any momentum being present at the time the blow was inflicted, it would appear not to be consistent with a vehicle crash. However, Dr Cooke did not recall this conversation by the time of the inquest and testified that it did not represent his opinion as at the time of giving his evidence.¹⁰⁴
135. I have treated Dr Cooke’s opinions, below, as being the ones he expressed at the inquest.

¹⁰¹ Ex 1.15.2.

¹⁰² Ex 19, p. 8 (conclusions on items 8, 9 and 14).

¹⁰³ Ex 19, p. 2 (conclusion on item 7).

¹⁰⁴ Ex 15; ts-638-639, 648-649.

Operation Aviemore continues – charging of Gene Gibson

136. On 21 July 2010, Officer Callaghan of the Major Crash Investigation Section issued a Forensic Road Collision Report, verified by Sergeant Magorian, confirming his initial view that the evidence was not consistent so as to confirm a collision between Josh and a passing vehicle or object, but he was not able to eliminate the possibility that a collision, however unlikely, did occur.¹⁰⁵
137. The absence of physical evidence consistent with a traffic collision, the position of Josh’s body and his footwear being located near his body all supported Officer Callaghan’s opinion, but it required further investigation to rule out vehicle involvement.¹⁰⁶
138. A question arose as to whether Josh’s body had been moved to the location where he was found, after suffering his injuries. Records reflect that Dr Cooke did not consider that Josh had been killed and then moved to the location where he was found, as there were no blood disturbance patterns consistent with such a scenario. The blood movement at the scene and on Josh indicates that he was struck and went straight to the position he was subsequently located in.¹⁰⁷ I accept this opinion.
139. In April 2011, testing was done at ChemCentre of various materials found in Josh’s hair near his scalp laceration and of white specks removed from the left side of his face, neck and shoulder. The black material in his hair was composed of polyethylene (but different to example scrapings taken from the front skirting of a Holden Commodore). The white specks on Josh were found to be fragments of silvery-white material composed of black acrylic with a thin layer of aluminium. No conclusive origin for those white specks could be identified.¹⁰⁸
140. Investigations led Police to consider the role of a Mr Gene Gibson. An interview plan was prepared for him, initially drafted to be an interview plan for Mr Gibson as a suspect in relation to a stolen motor vehicle and having no authority to drive. The plan was later amended so that he was merely to

¹⁰⁵ Ex 1.16.2.

¹⁰⁶ Ex 1.16.2.

¹⁰⁷ Ex 15.

¹⁰⁸ Ex 13.

be interviewed as a witness under s 28 of the *Criminal Investigation Act 2006* (WA).¹⁰⁹

141. That decision arose because there was no longer any intention to charge Mr Gibson with the suspected motor vehicle offences. Those preparing the plan (Detective Inspector Philip Gazzone and Detective Sergeant Rodney Shannon with Officer Western), testified at the inquest that they did not at that stage consider Mr Gibson a suspect in Josh's death.¹¹⁰
142. On 16 August 2012, Mr Gibson was located in the Kiwirrkurra community in the remote east Pilbara region.¹¹¹ Pintupi, and not English, was his first language.
143. Mr Gibson was interviewed by Officers Gazzone and Shannon and made admissions in an unrecorded interview, in effect, that he had hit Josh with a vehicle.¹¹² This surprised those officers. At the material time, Officers Gazzone and Shannon did not have experience in interviewing Aboriginal persons from remote locations, in respect of serious charges, where English was not their first language.¹¹³
144. Mr Gibson was formally arrested on suspicion of murder and an audio-visual recorded interview was commenced. Prior to that recorded interview, Mr Gibson had the opportunity to speak to a lawyer from the Aboriginal Legal Service, who then communicated to Officer Shannon that Mr Gibson did not wish to be interviewed. Despite that, the interview proceeded.¹¹⁴
145. Over the course of about six hours, accompanied by an interview friend (a senior member of the Kiwirrkurra community, and older relative of Mr Gibson (the Interview Friend)), but with no lawyer, Mr Gibson made further admissions regarding his involvement in Josh's death.¹¹⁵ The caution had been given to Mr Gibson, but he had not been asked to explain his understanding, in his own words, back to the interviewing police officers, as would have been consistent with WA Police practice.¹¹⁶

¹⁰⁹ ts-483.

¹¹⁰ ts-484, 532, 758-759.

¹¹¹ Ex 1.28, p. 9.

¹¹² *State of Western Australia v Gibson* [2014] WASC 240 [8]; ts-492.

¹¹³ ts-478, ts-530.

¹¹⁴ ts-492-493; ts 536.

¹¹⁵ *State of Western Australia v Gibson* [2014] WASC 240 [10].

¹¹⁶ ts-539.

146. Officer Shannon was unaware of the kinship relationship between the Interview Friend and Mr Gibson. He was also unaware of the limitations of having an interview friend who had a kinship relationship with the interviewee.¹¹⁷
147. On 17 August 2012, a further recorded interview occurred in which Mr Gibson was taken to relevant locations in Broome and further admissions made. Neither an interpreter nor an interview friend were used during the Broome interview.¹¹⁸ Mr Gibson was subsequently charged with the murder of Josh.
148. As outlined, prior to their involvement with Mr Gibson, Officers Gazzzone and Shannon had little or no experience with interviewing Aboriginal persons from remote locations. Specifically, the concept of “*gratuitous concurrence*” (an inclination to agree with questions in a felt oppressive environment) was unfamiliar to them. The concept of a senior kinship relationship between Aboriginal persons making it hard for a person to ignore a more senior person’s commands was not known to them either.¹¹⁹
149. Between the charging of Mr Gibson and his criminal prosecution, the investigation continued.
150. On 23 July 2013, Dr Mark Reynolds, former police officer and then forensic consultant to WA Police, prepared a report on the bloodstains and bloodstain patterns in relation to Josh’s death. His analysis identified that Josh assumed the position he was found in “*almost immediately*” after the infliction of the bleeding injuries; and that Josh was not moved after assuming the position in which he was found.¹²⁰
151. Following a request to consider the significance of there being no tyre scuff marks on Old Broome Road, Officer Callaghan prepared an Addendum Forensic Road Collision Report dated 18 December 2013. Officer Callaghan, who had attended and reviewed numerous collisions involving pedestrians and vehicles, confirmed his opinion that the available

¹¹⁷ ts-534.

¹¹⁸ *State of Western Australia v Gibson* [2014] WASC 240 [11].

¹¹⁹ ts-478; ts-530; ts-534.

¹²⁰ Ex 1.19.2 [6.0].

physical evidence did not indicate or support the involvement of a vehicle in Josh's death.¹²¹

152. In so concluding, Officer Callaghan had regard to the lack of tyre marks (for example if a driver were to have swerved suddenly in an avoidance manoeuvre) and to the nature of the trauma injuries sustained by Josh (which were not extensive in regards to what would typically be observed in pedestrian/vehicle collisions).¹²²

Prosecution of Gene Gibson

153. After Mr Gibson was charged with the murder of Josh, his electronic records of interview came under scrutiny.

154. On 4 July 2014, the Honourable Justice Hall excluded the electronic records of interview of Mr Gibson, on the basis that he was not satisfied that Mr Gibson's participation at any stage in the police interviews was voluntary, and that there were breaches of the *Criminal Investigation Act 2006* (WA), which rendered the interviews inadmissible. Further, the interview would be excluded on fairness grounds; Mr Gibson was at a serious disadvantage given his limited understanding of English, compounded by the power imbalance as between Mr Gibson on the one hand and several police officers and an older male relative on the other hand.¹²³

155. These errors could not be rectified:

*".... It is unlikely that the admissions of the accused would have been made at all if the interview had been properly conducted. All the indications are that if the accused had been treated as a suspect from the outset and had his rights explained to him by a qualified interpreter he would have exercised the right to silence."*¹²⁴

156. The charge of murder was downgraded to a charge of manslaughter to which Mr Gibson pleaded guilty. On 22 October 2014, Mr Gibson was sentenced to 7 years 6 months' imprisonment.¹²⁵

¹²¹ Ex 1.16.3.

¹²² Ex 1.16.3.

¹²³ *State of Western Australia v Gibson* [2014] WASC 240 [175]-[183].

¹²⁴ *State of Western Australia v Gibson* [2014] WASC 240 [181].

¹²⁵ *State of Western Australia v Gibson* [2014] WASC 203; Exhibit 1.28, p.47.

Operation Kvasir established

157. In about August 2015, a WA Police team reviewed aspects of Operation Aviemore.¹²⁶ This was known as Operation Kvasir, and it was initially planned as a desktop review. It was headed by Detective Inspector Mark Fyfe and Detective Senior Sergeant David Gorton.
158. As it transpired it was not undertaken as a desktop review. Nor was it intended to be a cold case homicide review.¹²⁷ It involved going out and reinterviewing persons.¹²⁸ It included consultation with a behavioural analyst from the Major Crime Division, and later consultation with an investigative psychology working group.¹²⁹ It also included cultural awareness revision, which involved the team travelling to Kiwirrkurra and other remote communities.¹³⁰
159. On 8 December 2015, Officers Fyfe and Gorton issued a report: *“Investigative review into aspects of Operation Aviemore.”* They considered that as at 2012, there may have been sufficient evidence to commence a prosecution of Mr Gibson, that following the exclusion of Mr Gibson’s electronic record of interview there may have been a case to answer, but had the matter gone to trial, they opined Mr Gibson could not have been convicted. They considered there was insufficient evidence to convict Mr Gibson of any offence in relation to the death of Josh.¹³¹

Operation Prolmar established

160. On 23 February 2016, Operation Prolmar commenced, led by Detective Senior Sergeant Geoffrey Cramp. It was an investigative desktop review into Operation Aviemore. It concluded on 10 June 2016, and a report was delivered on 22 June 2016: *“Operation Prolmar – Investigative desktop review into Operation Aviemore.”*¹³²

¹²⁶ Ex 1.28, p. 9-10.

¹²⁷ ts-813.

¹²⁸ ts-337, 813.

¹²⁹ ts-831, 851-853.

¹³⁰ ts-869-870.

¹³¹ Ex 1.23, p. 42.

¹³² Ex 1.27, p. 5.

161. In that time, the review team undertook a review of the thousands of running sheets, action items and exhibits and intelligence holdings.¹³³
162. Its terms of reference included undertaking a person of interest assessment and review (excluding Mr Gibson) and the preparation of investigative action registers where further work was required to eliminate or implicate persons of interest.¹³⁴
163. A number of investigative opportunities were identified.

Gene Gibson's acquittal

164. In June 2016, Mr Gibson appealed his conviction. It was ultimately heard in April 2017.
165. On 12 April 2017, the Court of Appeal set aside the conviction and entered a judgment of acquittal, and Mr Gibson was released from prison.¹³⁵

Operation Azurite - Report to the coroner

166. In April 2017, following Mr Gibson's acquittal, Operation Azurite was commenced, to re-reinvestigate Josh's death.¹³⁶ The senior investigating officer was Officer Cramp and Detective Sergeant David Palmer was the investigating officer.¹³⁷
167. The terms of reference were to do a review and reinvestigation into Josh's death. Officer Cramp delivered a report on 29 November 2018: "*Coronial Report*."¹³⁸
168. During the course of that operation, over 850 witnesses were identified and interviewed.¹³⁹

¹³³ Ex 1.27, p. 6.

¹³⁴ Ex 1.27, p. 5.

¹³⁵ *State of Western Australia v Gibson* [2017] WASCA 141.

¹³⁶ Ex 1.28, p. 9-10.

¹³⁷ ts-341-342.

¹³⁸ ts-344.

¹³⁹ Ex 1.28, p. 16.

CAUSE AND MANNER OF DEATH

The expert evidence

- 169.** I heard much evidence about the cause of Josh's death and received many reports offering different opinions as to how Josh died. I heard from and/or reviewed reports given to WA Police from preeminent experts. The expert evidence I received came from the following persons:
- (a) Dr Clive Cooke (forensic pathologist and Western Australia's former chief forensic pathologist);
 - (b) Dr Alanah Buck (State forensic anthropologist);
 - (c) Dr Michael Burke (senior forensic pathologist of the Victorian Institute of Forensic Pathology and of Monash University and author of *Forensic Medical Investigations of Motor Vehicle Incidents*);
 - (d) Professor Bryant Stokes (neurosurgeon);
 - (e) Professor Timothy Ackland (Winthrop Professor of Biomechanics; with a special research interest into the mechanics of human motion); and
 - (f) Professor Guy Rutty (UK forensic pathologist).
- 170.** I turn first to the written reports from the neuropathologist and the toxicologists.
- 171.** To begin with, a neuropathology examination of Josh's brain conducted by Dr Vicki Fabian revealed the presence of a traumatic brain injury. A written report to that effect was provided to the coroner, and was taken into account by the experts who opined on Josh's cause of death.¹⁴⁰
- 172.** Toxicological analysis was conducted which identified Josh's blood alcohol concentration was 0.183%. The evidence of Professor David Joyce (physician, clinical pharmacology and toxicology) was that based on the

¹⁴⁰ Ex 1.8.

alcohol concentration in his urine, it is safe to assume that the blood alcohol level was close to 0.183% at the time of the injury.¹⁴¹

173. Later toxicological analysis also revealed traces of diazepam and its metabolites, which may be explicable by the medications Josh received during his hospitalisation for the car crash on 20 February 2010. Those levels were so low that Professor Joyce considered they did not contribute to Josh’s state of intoxication prior to his death.¹⁴² Dr Cooke similarly thought the levels were extraordinarily low and unlikely to be additional factors in Josh’s death.¹⁴³
174. I now turn to the opinions of the forensic pathologists, who had regard to the above reports, on Josh’s cause of death.
175. As indicated previously in this finding, in his written post mortem report, Dr Cooke opined that the cause of death was 1a, head injury, with 2, acute alcohol intoxication. At the inquest he explained that he referred to the acute alcohol intoxication in his report because it was, arguably, a factor in the final mechanism of death (in that the respiratory depressant and sedating effects of a very high level of alcohol can contribute to respiratory impairment, being part of the mechanism of death).¹⁴⁴
176. Taking these factors into account, at the inquest Dr Cooke confirmed that his opinion on the cause of death was: “*head injury.*” By way of explanation, he referred to bleeding around the brain, bruising of the brain and possibly bleeding within the brain associated with those bruises, having regard to the neuropathology report’s findings of traumatic brain injury.¹⁴⁵
177. At the inquest, Dr Burke confirmed his prior written opinion, that the cause of death was “*a severe head injury.*” By way of explanation, he referred to the severe skull fractures that reflect the amount of force that has been applied to the brain. At the inquest Professor Stokes concurred, having regard to the extent of the brain injury and skull fracturing.¹⁴⁶

¹⁴¹ Ex 1.7; Ex 1.12 [20].

¹⁴² Ex 1.12 [23]-[29], [35]-[36].

¹⁴³ ts-589.

¹⁴⁴ ts-576, 612, 619.

¹⁴⁵ ts-574; ts-619; Exhibit 1, tab 8.

¹⁴⁶ ts-573-574.

178. Given the complexity of this case, none of the experts that gave evidence or whose reports I reviewed for this inquest, could offer a definitive opinion about the manner of Josh's death (as distinct from the cause of his death). That was a proper approach. They all recognised there is evidence which supports different theories as to how Josh died.

The scenarios I discount

179. Before turning to these different theories of how Josh died, which I consider are supported on the evidence, I first discount the scenarios which I do not think can reasonably be supported by the evidence.

180. First, no expert suggests Josh was struck by a vehicle while standing upright. This takes account of the opinions of Professor Stokes, Professor Ackland and Dr Cooke.¹⁴⁷ The expert evidence does not support such a scenario because of the absence of injury on Josh's body consistent with such a collision, the absence of momentum injuries and the absence of gravel disturbance. I exclude this scenario.

181. Second, Counsel Assisting and Ms Bishop submitted that the evidence did not support the scenario that the crushing injury resulted after Josh chose to lie down on the side of Old Broome Road or, being so intoxicated, that he effectively passed out in the position he was ultimately found.¹⁴⁸

182. Put another way, the evidence does not support a finding of accident arising from Josh innocently coming to lie on the side of Old Broome Road, whereupon he was later struck by an inadvertent driver or rider.

183. I accept those submissions for the following reasons.

184. While Josh had been drinking alcohol that evening and into the early morning and was intoxicated with his blood alcohol concentration measuring 0.183%, the expert evidence identified that the effect of alcohol on someone, even in a high concentration such as 0.183%, depends upon their experience with alcohol.¹⁴⁹

¹⁴⁷ Ex 1.6.4 [3].

¹⁴⁸ Counsel Assisting's submissions [7]; Senior next of kin's submissions [14].

¹⁴⁹ ts-590.

185. The traces of diazepam and its metabolites were, as referred to previously in this finding, extraordinarily low. I am satisfied that, notwithstanding Josh's blood alcohol level, they would not have combined so as to materially added to his intoxication.
186. The evidence of all the witnesses that saw Josh that night, including close to the time he was found deceased, described him in various states of intoxication, but no-one described him as severely intoxicated. He was not having difficulty walking or retaining his balance. He was not slurring his words. Having seen the CCTV of Josh leaving the Bungalow Bar and at the McDonald's, he does not appear to have any difficulties walking or remaining upright. Consistent evidence to this effect was given by witnesses who were with Josh and/or who saw him at his house, at the Oasis Bar, at the Bungalow Bar and at the McDonald's. These witnesses comprised existing friends, new acquaintances and persons who interacted with Josh that night.¹⁵⁰
187. He was about three kilometres from home by foot (had he planned to turn down Sandpiper Avenue).¹⁵¹ I find it improbable that Josh, even though intoxicated, would decide to lie down on a well traversed road in an unlit area, with the upper half of his body on the road itself, while relatively close to home.
188. Further, I do not consider that Josh was so intoxicated that he fell down and/or passed out, with the upper half of his body on the road.

The scenarios supported by the evidence

189. The different hypotheses which are supported by the evidence can be divided into two broad categories as follows.
190. The first scenario is of a **crushing injury from a vehicle**; namely, that Josh, while lying on the road (in an unexplained way but unlikely by an assault) suffered a glancing, but significant, blow from a vehicle, or was run over or partly run over by a vehicle.

¹⁵⁰ ts-25, 29, 30, 49, 53-54, 87, 88, 131, 156-157, 205, 212, 217, 226; Ex 7.1-7.7.

¹⁵¹ Ex 1.24.

191. The second scenario is of **blunt force trauma with a weapon**; namely, that Josh was hit in the head, one or more times, causing him to fall onto the road, and may have been hit again once he had fallen onto the road.
192. There is also the possibility of a **combination** of the two scenarios; namely that Josh came to be lying on the road by reason of the application of blunt force trauma and then was run over or glanced by a vehicle, although no expert put forward that theory expressly.
193. Before turning to the different evidence in support of each scenario, it is helpful to identify some key aspects of evidence which supports each scenario:
- (a) **the bloodstain pattern evidence**, as analysed by Dr Reynolds, and referred to previously in this finding, suggests Josh was not mobile after the head injury, howsoever caused. Dr Reynolds opined that Josh assumed the position he was found in, almost immediately after the infliction of the bleeding injuries. That suggests, consistent with all reasonable scenarios, that however Josh came to be lying on the road, he was not moved to that location. This is important, particularly given Mr McQuiggin’s memory of seeing Josh lying on his back with his hands on his face, although he accepted it was possible that Josh’s face was turned to the side with his hands on the side of his head;
 - (b) **the absence of any momentum injuries** was analysed in the Forensic Road Collision Report and its Addendum, referred to previously in this finding. This counters the theory that Josh was hit while walking on Old Broome Road, thrown some distance, and then landed in the position in which he was found;
 - (c) **injuries to the front of Josh’s face** are referred to previously in this finding. They were considered by Dr Cooke and Dr Buck to be consistent with “*collapse-type*” injuries to the prominent parts of the face. They are injuries sustained when the face makes a forceful impact onto a rough surface, which could be caused by either the face collapsing onto the ground from an upright position or if the face was already down, by impact(s) to the back of the head;¹⁵²

¹⁵² Ex 1.6.4 [2.3].

- (d) **the position of Josh's thongs** proved hard to explain. One explanation as posited by Professor Ruddy is that Josh could have been walking barefoot (as identified by the brown coloured dirt staining on the soles of his feet) and carrying his thongs and they were either dropped or placed where they were found.¹⁵³

The crushing injury from a vehicle theory

194. The first scenario of a crushing injury from a vehicle is supported by the following evidence:

- (a) **Josh's head injury was very severe.** It was of a greater severity than Dr Cooke, Dr Buck and Dr Burke expected of a head being hit in a non-supported position (for example while standing up) and was more consistent with Josh's head being hit and crushed while lying on the road.¹⁵⁴ Dr Cooke referred to the degree of fracturing, particularly to the front of the skull, which in his opinion is a transmitted force from the back of the head. He did not consider that Josh could have sustained this degree of crushing type injury from an unsupported head strike with a subsequent collapse to the ground.¹⁵⁵ While Dr Cooke and Dr Buck could not exclude the possibility of the head injury being caused by a hard, blunt object, they considered it was less likely given the severity of the crushing injury and the absence of blood splatter around Josh's body.¹⁵⁶ Dr Burke thought that the laceration and skull fracture to the rear of the head indicated the application of considerable blunt force and the degree of scalp bleeding was far beyond what he expected from a localised blow applied to the back of the head by a weapon, and was instead suggestive of a glancing but significant impact by a tyre or part of a motor vehicle, rather than an assault.¹⁵⁷ For Professor Ruddy, the injury, while severe, suggested the vehicle did not go over Josh's head, but that the injury was consistent with a glancing (not

¹⁵³ Ex 1.14.3, p. 5 [2].

¹⁵⁴ ts-578-579; ts-590; ts-597.

¹⁵⁵ ts-578; ts-597.

¹⁵⁶ Ex 1.6.4 [2.1], [4]; ts-595.

¹⁵⁷ Ex 1.13.1, p. 4; ts-590.

perpendicular), but significant, impact from a tyre or part of a motor vehicle to the back of the head while he was prone on the ground.¹⁵⁸

- (b) **the avulsion pocket on the back of the skull.** The large laceration on the back of Josh’s head is a complex angulated laceration of the scalp. The undercutting of the upper margin of the laceration has formed an “*avulsion pocket*” where the skin has separated from the underlying skull bone. The laceration could have been caused by one or two impacts, but the ragged skin margin, shelving (of the lower margin) and undercutting (of the upper margin) was suggestive for Dr Cooke and Dr Buck of an impact which was tangential and directed more to the top of the head. In their opinion, an impact from a moving and rotating vehicle tyre can cause that torsional-type of injury, although they both acknowledge it has also been seen with other blunt impacts with tangential trajectories. They did not believe it would have been caused by a cutting instrument;¹⁵⁹
- (c) **the injuries to Josh’s forehead** were considered by Dr Cooke to be abrasions, not lacerations, and could have been caused by force transmitted from the back through to the front of the skull when the two skull fractures were caused. Dr Buck’s analysis of the skull also was consistent with this;¹⁶⁰
- (d) **the absence of bleeding pattern suggestive of upright position.** Dr Cooke and Dr Buck noted that the blood staining on Josh’s body does not appear to have any downwards streaking of blood on the front of the right side of his chest, which may have been expected had Josh sustained any bleeding facial injuries in an upright position;¹⁶¹
- (e) **the absence of blood splatter** suggested for Dr Cooke and Dr Buck that it was less likely that there was an impact or impacts to the back of the head with a hard, blunt object;¹⁶²

¹⁵⁸ Ex 1.14.3, p. 7 [8]-[9].

¹⁵⁹ Ex 1.6.4 [2.2], [3]; ts-584, 596; Ex 16.

¹⁶⁰ Ex 1.6.4 [3]; ts-583; ts-586-588.

¹⁶¹ Ex 1.6.4 [1.1].

¹⁶² Ex 1.6.4 [4].

- (f) **the injuries to Josh’s face** had a mild “*sliding*” component to them, not just a collapse type mechanism. But the sliding component was mild only and had Josh been hit at the back of the head while upright then Dr Cooke and Dr Buck would have expected the injuries to show more evidence of sliding;¹⁶³
- (g) **the absence of disturbance around the body** suggested to Professor Ruty that there was no struggle, fight, or another party present at the time;¹⁶⁴
- (h) **the absence of momentum injuries** is not consistent with a typical traffic collision in Professor Ruty’s opinion, but with a glancing blow of some kind. That includes the absence of any fractures in the right arm. Dr Buck thought it may be possible for Josh to have been clipped by a vehicle or run over by a vehicle, depending on its weight and speed, and not have any forearm fractures;¹⁶⁵
- (i) **the marks on Josh’s right forearm** as referred to previously in this finding, were consistent with a tyre mark, or at least, not inconsistent with such;
- (j) **the dirt stains on Josh’s knees, toes and feet.** Dr Cooke and Dr Buck noted these dirt stains were consistent with the position in which Josh was found. Had Josh been kneeling for any length of time on the gravel, they might have expected dirt staining of the lower parts of his knees extending to the top of his shins.¹⁶⁶

The blunt force trauma with a weapon theory

195. The second scenario is of blunt force trauma with a weapon. That is, that Josh was struck (once or multiple times) by an unknown weapon while he was standing, stooping, or kneeling on the gravel verge facing the road, perpendicular to the carriageway)¹⁶⁷ This scenario posits that the major blow to the back of the head likely occurred after he came to rest on the ground. Prior to that he may also have been struck in the front of the head.

¹⁶³ Ex 1.6.4 [3]-[4].

¹⁶⁴ Ex 1.14.3, p. 7 [9].

¹⁶⁵ Ex 1.14.3, p. 5 [1], p. 7 [9]; ts-619.

¹⁶⁶ Ex 1.6.4 [1.3].

¹⁶⁷ Ex 1.9.1.

196. Ms Bishop submits that the evidence supports the second scenario of blunt force trauma. That is, that Josh's death came about as a result of blunt force trauma, from being hit in the head one or more times with a weapon, with one or more blows to Josh's head potentially occurring while he was lying on the ground. She submits the evidence supports this scenario over a scenario where the fatal injury was caused by a vehicle.¹⁶⁸
197. The blunt force trauma with a weapon scenario is supported by the following evidence:
- (a) **the absence of injuries to limbs and torso and momentum injuries to face**, suggested to Professor Ackland that Josh was not struck by a vehicle or any object protruding from a vehicle. In particular, the absence of injuries to Josh's arm or hand and the small abrasion injuries on the top of the right side of the forehead were not consistent with Josh having been run over by a car. He considered that the black marks on Josh's right forearm were not caused by a motor vehicle but could not discount that the impressions were made by contact with a bicycle tyre or a light motor bike tyre.¹⁶⁹ Similarly, the absence of momentum injuries suggested to Professor Stokes that he had not been struck by a motor vehicle.¹⁷⁰ This was also the view of Officer Magorian;¹⁷¹
 - (b) **the absence of scuff marks or debris in the vicinity of the body**, suggested to Professor Ackland that Josh was not struck by a vehicle or any object protruding from a vehicle;¹⁷²
 - (c) **the severity of the injury to the back of Josh's head** was considered by Professor Ackland and Professor Stokes to be consistent with being struck by a weapon (blunt force trauma). Professor Stokes opined that the shelving injuries could have been made by a small and solid instrument, and that the blow to the occipital region (back of the skull) was of such great severity as to have produced a massive skull fracturing. He believed Josh's

¹⁶⁸ Senior next of kin's submissions [2]-[3].

¹⁶⁹ Ex 1.9.1, p. 12; Ex 1.9.2, p. 7-9.

¹⁷⁰ Ex 1.10, p.1.

¹⁷¹ ts-286.

¹⁷² Ex 1.9.1, p. 12.

injuries were caused by an assault to the back of the skull with a sharp implement, and that they were not caused by a motor vehicle accident.¹⁷³ Further, Professor Rutty opined that, had the full weight of a vehicle gone over Josh’s head, he would have expected more extensive crushing than was seen on Josh;¹⁷⁴

- (d) **the injuries to Josh’s forehead** were considered by Professor Stokes to be lacerations, not abrasions, and in his opinion could not be explained by a force transmitted through the skull when the back of Josh’s head was struck. One of the lacerations in the frontal region appeared separate to Professor Stokes and in his opinion would not be produced by an anteroposterior injury and would be produced by a blow to the front of the head;¹⁷⁵
- (e) **the lacerations on the front of Josh’s head** were considered by Professor Stokes to be consistent with a further series of blows unrelated to the original blow to the back of Josh’s head;¹⁷⁶
- (f) **the injuries to Josh’s face** which had a mild sliding component to them were too small in Professor Ackland’s view to be caused by Josh being run over by a tyre;¹⁷⁷
- (g) **the hairs in Josh’s hand**, particularly his right hand, which are not apparently associated with any blood stains on the right palm are not explicable by the crushing injury from a vehicle theory. There are several features that have been previously addressed in this finding and summarised here: The hairs were not shed naturally – they were consistent with being partially cut through with a sharp object or instrument.¹⁷⁸ Both Dr Cooke and Dr Burke considered the eyebrow and scalp hairs in the right palm were a “*puzzling*” feature.¹⁷⁹ Some of the hairs in Josh’s hands appeared from DNA testing to be Josh’s hair but other hairs could not be identified.¹⁸⁰

¹⁷³ Ex 1.9.1, p. 12; Ex 1.10, p. 1; ts-660.

¹⁷⁴ Ex 1.14.3, p. 6 [7].

¹⁷⁵ ts-664-665.

¹⁷⁶ Ex 1.10, p. 2.

¹⁷⁷ ts-685.

¹⁷⁸ Ex 1.15.2, p. 7-8 [3].

¹⁷⁹ Ex 1.6.4 [4]; ts-611, ts-612, ts-635-636.

¹⁸⁰ Ex 19.

At the inquest Officer Western explained how the hairs were possibly interpreted during Operation Aviemore as suggesting Josh put his hands to the back of his head and to his face after he was injured.¹⁸¹ Officer Fyfe did not consider there was an explanation for the hairs in Josh's hands if his head was run over by a motor vehicle.¹⁸²

Professor Stokes posited that the hairs were cut by a sharp object such as a machete, an axe or a star picket or something of that nature. He agreed that the cuts to the hairs are inconsistent with a motor vehicle or part of a motor vehicle having cut that hair.¹⁸³

- (h) **the marks on Josh's right forearm** were not, to Officer Magorian, definitive enough to say that they were a tyre mark.¹⁸⁴ Further, the absence of associated friction and gravel marks suggests it may not have been a tyre.¹⁸⁵

On 13 March 2018, Senior Constable Stuart Byass was tasked to review photographs of Josh's right forearm which appeared to show a black impression of unknown origin. Whilst visible on the photographs, the black marks are not recorded as being apparent at the post mortem examination. At the inquest Dr Cooke confirmed he did not see them.¹⁸⁶

On 20 March 2018, Officer Byass produced a report in connection with the impression evidence located on Josh's right forearm. He had examined the photographs under different enhancements and opined that the impression appeared to be a transfer of an unknown black substance, located on the lateral side of Josh's right forearm. He opined that the object that came into contact with the skin produced more force in the back portion of the forearm, compared to the front portion.¹⁸⁷

181 ts-728

182 ts-831.

183 ts-668.

184 ts-299.

185 Ex 1.16.3.

186 Ex 1.18.1 [7]-[10]; ts-603.

187 Ex 1.18.2, p. 2-3.

Officer Byass concluded the impression, though very partial, may be suitable for comparison of possible tread element characteristics to a known tyre. The impression displayed a block pattern design with rectangle shapes separated by voids.¹⁸⁸ The uniformity and straight-line edges suggested it was created by a manmade object, and had visual characteristics more similar to a tyre, over any other man-made object.¹⁸⁹

He thought the impression appeared to be similar to a passenger vehicle tyre; it was too large to be a bicycle tyre, and not consistent with a motorcycle tyre.¹⁹⁰

There were no injuries to Josh's right arm to support an inference that a vehicle had run over it, or clipped it, though the absence of injuries does not exclude it.¹⁹¹

On this specific issue, Ms Bishop submits that the presence of the black impression mark is insufficient to implicate a vehicle in the cause of Josh's death, and refers to the limited utility of Officer Byass' analysis, without the exclusion of alternative possibilities.¹⁹²

Findings as to cause and manner of death

- 198.** I am required under s 25(1)(b) and (c) of the Coroners Act to find, if possible, how Josh's death occurred, and the cause of his death.
- 199.** I turn first to the cause of Josh's death.
- 200.** Having regard to the evidence of the experts referred to previously in this finding, I am satisfied that **the cause of Josh's death is Head Injury.**
- 201.** I turn now to how Josh's death occurred, which is the manner of his death.
- 202.** As to the manner of Josh's death, both Counsel Assisting and Ms Bishop submit that the evidence supports a finding that Josh was unlawfully killed.

¹⁸⁸ Ex 1.18.2, p. 4; Ex 9.

¹⁸⁹ Ex 1.18.2, p. 5; ts-407, ts-410, ts-432.

¹⁹⁰ ts-412, 430.

¹⁹¹ ts-599; ts-619.

¹⁹² Senior next of kin's submissions [45].

The Western Australia Police Force also agrees with Counsel Assisting's submission that the evidence supports a conclusion that Josh was unlawfully killed, rather than by accident.¹⁹³

203. I have had regard to the evidence outlined previously in this finding in support of the following scenarios: a crushing injury from a vehicle, blunt force trauma with a weapon, or a combination of the two. I am satisfied that, whether caused by a vehicle, or a weapon, or both, **the manner of Josh's death is Unlawful Homicide.**
204. I consider it more likely that Josh's fatal head injury was a result of blunt force trauma with a weapon given the following:
- (a) The nature and severity of the shelving injuries to the back of Josh's head, that produced massive skull fracturing, were likely inflicted by way of a blow to the back of Josh's skull with a sharp implement, while his head was on the ground (that is, supported). Prior to that, while upright, he may have been hit to the front of the head. The hairs in Josh's hands bore the marks of having been cut by an instrument, with the reasonable inference being that he was hit by a sharp object, following which he touched areas on his head with one or both hands.
 - (b) There was an absence of the common indicia of a motor vehicle collision. There were no marks suggesting a displacement of Josh's body. There was no evidence of Josh having been thrown any distance. There were no gravel injuries or scuff marks on Josh. There were no real indications that he was dragged, displaced or tumbled after being hit. There were no scuff marks or debris in the vicinity of his body. There was a general lack of injuries to his torso and limbs.

¹⁹³ Counsel Assisting's submissions [5]; Senior next of kin's submissions [4]; WA Police Force submissions [3].

REFERRAL TO DIRECTOR OF PUBLIC PROSECUTIONS

- 205.** Section 25(5) of the Coroners Act prevents me framing a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of any offence.
- 206.** For these reasons, I cannot make any finding as to who may have been responsible for the unlawful homicide of Josh. For similar reasons and because of issues of privilege against self-incrimination, during the inquest, I declined the application made on 18 September 2024 by Ms Bishop that certain persons be called to give evidence at the inquest.
- 207.** However, if I believe that an indictable offence has been committed in connection with Josh's death, s 27(5)(a) of the Coroners Act empowers me to report this to the Director of Public Prosecutions.
- 208.** It follows, from the finding I have made above as to Josh's death being the result of an unlawful homicide, that I am of the belief that an indictable offence has been committed in relation to Josh's death, namely an unlawful homicide as identified in s 277 of the Criminal Code, being murder or manslaughter.
- 209.** As I have formed this belief, I have a discretion to report the matter to the Director of Public Prosecutions.
- 210.** The discretion under s 27(5) is not limited by specific considerations. However, that discretion is guided by the object and purpose of the Coroners Act and ultimately, the interests of justice.
- 211.** Ms Bishop submits that I should exercise this discretion having regard to, amongst other things, the history of the matter, the outstanding investigative actions which warrant further attention and resources with oversight by the Director of Public Prosecutions and the continued treatment by WA Police of this case as a homicide.¹⁹⁴
- 212.** I have decided to exercise the discretion under s 27(5) to report this matter to the Director of Public Prosecutions, because I have formed the belief that an indictable offence has been committed, of a very serious nature, resulting

¹⁹⁴ Senior next of kin's submissions [83]-[86].

in the loss of Josh's life. It is not my role to review the evidence for the purpose of making a decision on whether an indictable offence has been committed, but having formed the belief, based upon the evidence before me, it is proper that such a review occurs, having regard to, amongst other things, any new and relevant information becoming available as a result of the inquest.

213. During the inquest, and after the close of the inquest between 20 October 2025 and 28 April 2026¹⁹⁵, WA Police provided evidentiary materials to the court, regarding their investigation, directed towards potentially identifying and/or excluding persons who may have been responsible for Josh's death. I received those materials into evidence and distributed them to the parties, along with non-publication orders, which are Suppression Orders, in respect of all such materials, made under s 49 of the Coroners Act, so as not to potentially prejudice the fair trial of any person in the future. These materials will be provided to the Director of Public Prosecutions as part of the s 27(5) report.
214. My findings on cause and manner of death are not inconsistent with these additional evidentiary materials. As they are suppressed, they are not referred to in this finding.

ADVERSE FINDINGS OR COMMENTS

Principles in making Findings or Comments

215. Section 25(2) of the Coroners Act empowers me to comment on any matter connected with the death including public health or safety or the administration of justice.
216. The power under s 25(2) is ancillary to my role to make relevant findings as to the death under s 25(1): *Re State Coroner; Ex parte Minister for Health* [2009] WASCA 165; 38 WAR 553 [52].
217. While the power under s 25(2) is ancillary, it does not diminish that power.

¹⁹⁵ Exhibits 22 to 25.

218. The s 25(2) power is governed by the statutory language. That expressly enables me to comment on “*any matter connected with the death*” (emphasis added). The test of “*connected with*” requires a material connection with the death, but it is not of itself limited to specific matters. Any matter with a material connection to the death may be commented upon. Section 25(2) gives examples of what may be connected with the death, but it is not exhaustive.
219. WA Police submit that for a matter to be connected with the death, it may occur prior to or subsequent to, or consequent upon the death, as long as a relationship exists between the death and the matter the subject of proposed comment. They urge me not to make adverse comments that are too remote from the circumstances of Josh’s death.¹⁹⁶
220. They accept that I can make comments in respect of matters relating to the circumstances surrounding Josh’s death, but also ask me to consider the utility of a comment if a failing, deficiency or wrong has already been exposed elsewhere (such as in another Court or by another body).¹⁹⁷
221. I am also conscious of s 53(2) of the Coroners Act which precludes me from making any finding on this inquest which is inconsistent with the result of any earlier proceedings where a person has been charged on indictment. In other words, I cannot make a finding inconsistent with Mr Gibson’s acquittal: see *Re the State Coroner* [2019] WASC 147 [32].
222. With those principles in mind, I deal now with the adverse findings or comments, taking into account submissions by Counsel Assisting and the interested parties.

Adverse Findings – WA Police

223. Josh’s family have lived through numerous investigative and judicial processes over the 16 years since his death. As outlined previously, Ms Bishop has described, in moving terms, her loving memories of Josh, and the angst that she and her family have suffered over the many years as they

¹⁹⁶ WA Police’s submissions [14]-[16].

¹⁹⁷ WA Police’s submissions [16]-[17].

endured legal processes, in various forums, and with varying outcomes, in connection with Josh's death.¹⁹⁸

224. It is important, for Josh's family, for WA Police, the community generally and most importantly, with respect for the memory of Josh himself, for me to examine what could have been done better and what further steps might be taken so that similar cases like Josh's can be better investigated and handled.
225. In saying all of that, I have also been conscious of not engaging in hindsight bias, being the tendency to perceive events that have occurred as being more predictable than they were at the time.
226. After the numerous investigations and reviews of the WA Police's conduct, commencing from the initial police investigation, followed by various WA Police reviews of the police investigation at varying stages, the criminal prosecution of Mr Gibson, the appeal process resulting in the acquittal, and the Corruption and Crime Commission investigation, there is a risk of the Court perceiving events very differently to how the police officers perceived them when they were working on the case, often in circumstances of long hours and in difficult conditions.
227. I turn now to the adverse findings.

WA Police did not have systems to investigate complex crimes regionally

228. Counsel Assisting submits that an adverse finding is open to me: that at the time of Josh's death in 2010, WA Police did not have systems to investigate complex crimes regionally and did not have resourcing strategies for protracted criminal investigations in regional Western Australia.¹⁹⁹
229. This adverse finding is supported by Ms Bishop.²⁰⁰
230. WA Police do not expressly submit whether I should make this finding or not, but point to several matters which they say, in effect, properly characterise the evidence given by the police officers at the inquest as to the

¹⁹⁸ ts-874.

¹⁹⁹ Counsel Assisting's submissions [49].

²⁰⁰ Senior next of kin's submissions [87].

lack of resourcing in the regions. Essentially, they submit that there was resourcing, but not to the same extent as in the metropolitan area.²⁰¹

231. I have had regard to Officer Western’s evidence concerning the lack of systems and structures, at the material time, to support complex protracted homicide investigations in the regions, and have also taken account of the WA Police submission not to take this evidence literally. However, Officer Western was not suggesting there was no resourcing, and WA Police concede it was not to the level of the metropolitan area. Officer Western gave evidence about the fragmented aspects of his involvement in the investigation and referred to the importance of gathering evidence during the “golden hour”:

“The first 24 to 48 hours of an investigation are the best opportunity to capture the best evidence, so it’s referred to regularly as the golden hour. So what it did mean was that the ability for those to be done as well as they might be done with a specialist and multidisciplinary approach in metropolitan Perth wasn’t as enhanced or as applicable in regional Western Australia. So the initial forensic and investigative response to this investigation was not the same as would have been applied in metropolitan Perth.”²⁰²

232. Officer Western gave evidence about a number of what he referred to as “suboptimal” aspects of the immediate forensic response, which he believed were due to a lack of multidisciplinary forensic knowledge on the part of the police officer who recorded the crime scene. He drew attention to there being no scaling and insufficient marking of particular spots, he was concerned about the quality of the photos, the angles at which they were taken, the lack of recording of the surrounding area, the lack of samples from the road surface and the premature movement of Josh’s body. Officer Western considered the capability was nowhere near what would be deployed within the metropolitan area, or its vicinity.²⁰³

233. At the inquest, Detective Superintendent Anthony Lee, who was appointed in charge of the Major Crime Division in 2012, agreed with Officer

²⁰¹ WA Police’s submissions [19].

²⁰² ts 786-787.

²⁰³ ts 731-736.

Western's evidence about the lack of systems and structures for regional areas. Officer Lee explained that the police response to Josh's death was not the same as would have been applied in the metropolitan area. In considering how a similar case would have been treated in the metropolitan area he referred to a greater level of resourcing being applied in a faster time frame, with greater access to an increased and broader range of skills, in particular the forensic area.²⁰⁴

234. Whilst I accept that, at the material time, some systems were in existence for the investigation of complex crimes regionally, and self-evidently there were resources allocated for the investigation into Josh's death, I am satisfied that they were not adequate, not to the level that would have been applied in the metropolitan area and, as the investigation became protracted, there was no evident resourcing strategy.

235. I note that there have been improvements in this area since that time:

(a) Officer Western explained that there is now a greater ability to deploy to regional Western Australia, and there are more police aircraft available for transport to such areas,²⁰⁵

(b) Officer Lee explained that WA Police now have a Forensic Field Operations Team with more capability, that runs 24/7, with five teams that can be deployed throughout the State. In a similar case now, the Homicide Squad would be deployed immediately, along with the Forensic Field Operations Team to assist with identifying and gathering the physical material at the primary crime scene and any subsequent crime scenes; the teams and the specialist resources are deployed more rapidly than before.²⁰⁶

Failures in forensic team

236. Counsel Assisting submits that an adverse finding is open to me: that the multidisciplinary forensic team was not called out to the scene on 26 February 2010 or shortly thereafter meaning that:²⁰⁷

²⁰⁴ ts 792-793.

²⁰⁵ ts-737.

²⁰⁶ ts-793; ts-807-808.

²⁰⁷ Counsel Assisting's submissions [51].

- (a) there was a failure to obtain samples from the scene for comparative testing; and
- (b) there was a failure to appreciate that the placement of the unsterile white sheet over Josh's body and the rolling of his body risked the forensic preservation of the scene and forensic evidence.

- 237.** This adverse finding is supported by Ms Bishop.²⁰⁸
- 238.** WA Police oppose this finding saying that it does not follow from the fact that a multidisciplinary forensic team was not called out to the scene on 26 February 2010 that the two asserted failures occurred.²⁰⁹
- 239.** The initial crime scene recording was described by Officers Western and Lee, and Dr Reynolds as disappointing, poor or suboptimal. The initial photographs from the scene were poor. The photographs lacked scales, were angular (rather than perpendicular and 90 degrees to the bloodstain) and there was insufficient marking of particular points, which made it challenging to engage in forensic analysis of those photographs many years later.²¹⁰
- 240.** I accept that there were challenges for local police officers attending the scene of Josh's death, and I make no criticism of the individual attending officers. In Officer Western's opinion, the District Forensic Investigation Officer did the best they could considering the circumstances, the limitations, and the training. However, he opined that the initial forensic response was suboptimal, there was a lack of multidisciplinary forensic knowledge of the different aspects of recording a crime scene, and overall, he was disappointed with its recording.²¹¹
- 241.** I have noted that the unsterile white sheet was placed over Josh's body with the intent of preserving his dignity and that it was done following consultation between the local police and the volunteer ambulance officers.²¹² The sheet was then removed, Josh's body was turned over (he was rolled onto his back) then the sheet was put back over him. At the

²⁰⁸ Senior next of kin's submissions [87].

²⁰⁹ WA Police's submissions [20].

²¹⁰ ts-555; ts-731-732; ts-793.

²¹¹ ts-731.

²¹² ts-103-104; ts-108; ts-112-113.

inquest, Officer Fyfe expressed his concern about this, noting that the road had items all over it. It cannot be known whether any such items were transferred onto Josh's body from this process.²¹³ Officer Western expressed his concern about Josh's body being turned over, referring to the risk of disturbance of the blood pattern on Josh and/or on his clothing, which could affect subsequent interpretations of the blood pattern analysis.²¹⁴

242. As a result of a number of concerns, once Officer Western came onto Operation Aviemore in early March 2010, he requested the deployment of a forensic team from Perth to review the initial attendance and see what could be done to capture any physical material evidence.²¹⁵
243. I am satisfied that, as a result of the multidisciplinary forensic team (or its equivalent) not being called out to the scene on 26 February 2010 or shortly thereafter, there was a failure to obtain samples from the scene for comparative testing and there was a failure to appreciate that the placement of the unsterile white sheet over Josh's body and the rolling of his body risked the forensic preservation of the scene and forensic evidence.

Failures with respect to the black marks

244. Counsel Assisting submits that an adverse finding is open to me: that with respect to the black mark or marks on Josh's right forearm, it was unfortunate that:²¹⁶
- (a) inadequate steps were taken to preserve evidence of that black mark or marks by taking any samples;
 - (b) inadequate steps were taken to effectively communicate the presence of the black mark or marks to the forensic pathologist;
 - (c) further investigations into the black mark or marks were not progressed until around May 2018, when Officer Byass was briefed to consider the matter.

²¹³ ts-824-825.

²¹⁴ ts-739.

²¹⁵ ts-731-732.

²¹⁶ Counsel Assisting's submissions [55].

245. This adverse finding is supported by Ms Bishop.²¹⁷
246. I heard evidence concerning the black marks on Josh’s right forearm at the inquest. The nature of the marks led some witnesses to question whether they were caused by the tread of a vehicle tyre.
247. The marks had been photographed at the scene, but without a scale being applied. Police did not draw the marks to the attention of the forensic pathologist undertaking the post mortem examination. No samples were taken of the marks and the forensic pathologist did not recall seeing them.
248. At the inquest Officer Western confirmed that, had a police officer understood the potential materiality of those marks, the usual practice would have been to draw this to the attention of the forensic pathologist at the time of the post mortem examination, who would have initiated a swabbing.²¹⁸
249. By the time Officer Byass was tasked with reviewing the black marks in May 2018, significant time had passed, he was only able to review them by reference to the unscaled scene photographs, and the black coloured material had not been sampled.
250. WA Police submit that I should make no adverse finding of a failure to “*effectively communicate*” and of “*inadequate steps*” given that is opaque and uncertain, relying on *Mead v Mulligan* [2013] WASC 460 [77(d)], [137] - [138] (Kenneth Martin J).²¹⁹ My adverse comment takes account of this.
251. I am satisfied that, as of February 2010, the potential materiality of the black marks on Josh’s right forearm were not recognised by attending police as being material when they should have been so recognised, which resulted in them not being drawn, by police, to the attention of the forensic pathologist. As a result, the black marks were not sampled and evidence of them was not preserved, when it should have been.

Failures with respect to training for interviewing Aboriginal persons

²¹⁷ Senior next of kin’s submissions [87].

²¹⁸ ts-734-735.

²¹⁹ WA Police’s submissions [21].

252. Counsel Assisting submits an adverse finding is open to me: that in 2012, there was insufficient training for police officers interviewing Aboriginal persons in remote communities including as to training as to an interviewee's potential vulnerabilities arising from language difficulties, substance abuse and in the use of interview friends.²²⁰
253. This adverse finding is supported by Ms Bishop.²²¹
254. WA Police say I should make no adverse finding as to the sufficiency of Police training in 2012 as it is not a matter connected with the death of Josh, arguing there should be "*some temporal limit*" to the matters relating to a police investigation which can be the subject of comment under s 25(2), positing that it ought to be limited to the immediate police response.²²²
255. Further, WA Police submit, amongst other things, that no adverse comment is necessary given similar comments have been made by the CCC in its public report entitled "*Report on Operation Aviemore: Major Crime Squad Investigation into the Unlawful Killing of Mr Joshua Warneke*" published on 5 November 2015 (CCC Report).²²³
256. The investigation of Josh's death is a matter connected with his death. Section 25(2) does not stipulate nor imply a temporal limit. Nor am I inhibited from making an adverse comment by reason of it having been made (or not made) in another forum, under separate and distinct proceedings. I am satisfied that I have jurisdiction for, and that there is utility in, making findings regarding training for police officers interviewing Aboriginal persons in remote communities, having regard to the impact of such systemic issues upon the administration of justice, specifically, the investigation of deaths of Aboriginal persons.
257. At the inquest Officers Gazzone, Western and Shannon, testified as to their training (or lack thereof) in respect of interviewing persons from remote communities or gratuitous concurrence. Taken together, while there was some relevant training at the recruitment stage, and access to computer-based material, their evidence reflected that there was an insufficient history of proactive refresher training on interview techniques such as may have

²²⁰ Counsel Assisting's submissions [58].

²²¹ Senior next of kin's submissions [87].

²²² WA Police's submissions [22.1].

²²³ WA Police's submissions [22.2].

assisted them with Mr Gibson's interview. For example, refresher training within the context of the Anunga Rules²²⁴, the complexities of interviewing Aboriginal persons from remote communities, where English might not be their first language, who might suffer from cognitive impairments (for example Foetal Alcohol Spectrum Disorder) and/or who might provide answers within the context of gratuitous concurrence behaviour.²²⁵

- 258.** WA Police did not counter their evidence at the inquest concerning their felt lack of training.
- 259.** I am satisfied that as at 2012, there had been insufficient training, specifically, ongoing refresher training, for police officers interviewing Aboriginal persons in remote communities including training as to an interviewee's potential vulnerabilities arising from language difficulties, substance abuse and in the use of interview friends.
- 260.** I note that since that time, WA Police have reviewed existing guidelines in this area, there have been improvements in this area by way of refinements and more comprehensive guides:²²⁶
- (a) in 2017 a comprehensive Investigative Interviewing Guide was issued to assist interviewers who are required to interview an individual who is suspected of, or confirmed as having Foetal Alcohol Spectrum Disorder. This Investigative Interviewing Guide is reviewed and updated on an ongoing basis, as required.²²⁷
 - (b) In 2018 a comprehensive Investigative Interviewing Guide was issued to assist interviewers in the application of the Anunga Rules, to afford fairness and assess voluntariness, and include matters such as the provision of a qualified interpreter, the option of an interview friend for support, the care to be taken in administering the caution, the care to be taken in formulating questions, the importance of seeking corroboration in respect of admissions made, the offer of a meal, water and lavatory, the warning not to interview persons ill, intoxicated or tired and the facilitation of legal assistance. This

²²⁴ Derived from R v Anunga (1976) 11 ALR 412.

²²⁵ ts-478-479; ts-503-504; ts-530; ts-542.

²²⁶ Exhibit 21.

²²⁷ Exhibit 21.4.

Investigative Interviewing Guide is reviewed and updated on an ongoing basis, as required.²²⁸

Failures with respect to obtaining interpreters

261. Counsel Assisting submits an adverse finding is open to me: that in 2012, there was a problematic culture where interpreters were not often accessed to assist in the interview of Aboriginal persons.²²⁹
262. This adverse finding is supported by Ms Bishop.²³⁰
263. WA Police say I should make no adverse finding as to “*culture*” as to accessing interpreters as it is not a matter connected with the death of Josh.²³¹
264. I am satisfied that I have jurisdiction for, and that there is utility in, making findings regarding systemic practices, at the material time, where interpreters were not often accessed by police to assist in the interview of Aboriginal persons, having regard to the impact of such systemic practices upon the administration of justice, specifically, the investigation of deaths of Aboriginal persons.
265. At the inquest Officer Western testified that prior to 2012, during his four years in the Kimberley region, in his time in investigating serious crime, he could not think of any instance where an Aboriginal interpreter was engaged in relation to such.²³²
266. In his experience he considered that lack of availability of Aboriginal interpreters had an impact, but that the other part concerned what he referred to as a “*cultural belief*” of police officers in that region at the material time that, by speaking gently and explaining things thoroughly, this would be sufficient for the Aboriginal interviewee to understand the police questions and provide answers. At the inquest, he readily conceded that it clearly was not sufficient.²³³

²²⁸ Exhibit 21.5.

²²⁹ Counsel Assisting’s submissions [61].

²³⁰ Senior next of kin’s submissions [87].

²³¹ WA Police’s submissions [23.1].

²³² ts-769.

²³³ ts-769.

267. I accept the WA Police submission that the availability of Aboriginal interpreters is not a matter within their control. I note the WA Police submission that Officer Western's description is only evidence of his opinion regarding how certain police officers may have conducted themselves in this area. However, I bear in mind that Officer Western's evidence is based upon his investigations of serious crimes in the Kimberley over a period of four years and WA Police did not counter his evidence on this point at the inquest.
268. I am satisfied that as at 2012, there was a problematic culture within WA Police in the Kimberley region, where interpreters were not often accessed to assist in the interview of Aboriginal persons for serious crimes.
269. I note that since that time, WA Police have taken measures to ensure that interviewing police officers are aware of the need to consider the appropriateness of interpreters, and this includes addressing the issue in the 2018 comprehensive Investigative Interviewing Guide referred to previously in this finding.²³⁴
270. At the inquest Officer Lee confirmed that there is a greater awareness within WA Police of the need to consider English language capabilities of Aboriginal persons, as well as their cognitive capability and any impediments to their understanding of their rights and the interview process itself. I am confident that this has become well understood, and by way of comment add that there is no room for future complacency on this issue.²³⁵

No adverse findings in respect of individual police officers

271. Counsel Assisting submits a number of adverse findings are open against Officers Gazzone, Shannon and Western in connection with the interview of Mr Gibson, noting however that on each occasion they were acting honestly.²³⁶
272. The submitted adverse findings arise from interview actions that have previously been referred to in this finding.

²³⁴ Exhibit 21.5.

²³⁵ ts-799.

²³⁶ Counsel Assisting's submissions [63-80].

273. At the inquest each of Officers Gazzone, Shannon and Western with the benefit of hindsight, acknowledged their shortcomings in respect of the interview.²³⁷
274. The adverse findings are supported by Ms Bishop.²³⁸
275. WA Police, acknowledging that they do not act for Officers Gazzone, Shannon and Western, nonetheless oppose the making of the adverse findings on the basis that they are not matters “*connected with*” Josh’s death (within the meaning of s 25(2)), and refer to previous adverse comments or findings of a similar nature in respect of Officers Gazzone and Shannon already made in the CCC Report and, in respect of Officer Western, in the Supreme Court (which are a matter of public record).²³⁹
276. Officers Gazzone, Shannon and Western oppose the making of the adverse findings, drawing attention to the remoteness from the cause and circumstances of Josh’s death, and the findings in the CCC Report to the effect that errors of individual police officers are reflective of a deeper malaise and systemic weakness within WA Police.²⁴⁰
277. As previously stated, I am not inhibited from making an adverse comment by reason of it having been made (or not made) in another forum, under separate and distinct proceedings.
278. However, within the context of the connection to Josh’s death, the case of the individual police officers differs from that of WA Police. The evidence disclosed systemic issues within WA Police at the material time with respect to training for interviewing Aboriginal persons, and obtaining interpreters and I have made the adverse comments.
279. From the coronial perspective, the actions of individual officers are to be viewed within the context of the prevailing systemic issues within WA Police, that I have identified above. Having considered all of the submissions, I am satisfied that any further comment regarding individual police officers’ actions and/or omissions concerning the interview of Mr Gibson, in the course of investigating Josh’s death, potentially risks

²³⁷ ts-496-498, ts-523-524, ts-538, ts-771.

²³⁸ Senior next of kin’s submissions [87].

²³⁹ WA Police’s submissions [24].

²⁴⁰ Tindall Gask Bentley submissions; CCC Report [245].

conflating the coronial investigation with a disciplinary proceeding, the latter being outside my remit.

RECOMMENDATIONS

280. Various recommendations were submitted by Counsel Assisting and they were circulated, with the interested parties being given an opportunity to comment.
281. I commence with some general comments, then turn to the specific recommendations.
282. WA Police opposes the recommendations submitted by Counsel Assisting insofar as they relate to further training, on the basis that they are not “*connected with the death*” of Josh as they arose well after Josh’s death and primarily relate to matters internal to WA Police.²⁴¹
283. Opportunities for improvements have come to my attention in the course of the coronial investigation into Josh’s death. I am satisfied that recommendations directed towards supporting better outcomes in the area of the administration of justice are within my remit.
284. WA Police support a recommendation concerning the availability of interpreters in principle, with a qualification as outlined below.²⁴²
285. Ms Bishop supports the recommendations proposed by Counsel Assisting, and submitted further recommendations for my consideration.²⁴³
286. I have taken account of all submissions and this finding addresses the recommendations that I have decided to make.

Recommendation 1: Specific and refresher training – remote communities

²⁴¹ WA Police’s submissions [26].

²⁴² WA Police’s submissions [32].

²⁴³ Senior next of kin’s submissions [88].

287. Counsel Assisting submits that I make recommendations directed towards WA Police implementing specific training, and regular refresher training, for police officers who are, or who are to be deployed, to interview Aboriginal persons in remote communities.²⁴⁴
288. I have earlier referred to the WA Police 2017 and 2018 Investigative Interviewing Guides, which are comprehensive in their coverage of the application of the Anunga Rules to afford fairness and assess voluntariness, and which address considerations surrounding Foetal Alcohol Spectrum Disorder. I accept the WA Police submission that relevant training materials have been introduced, and are updated.
289. However, consistent with my view that there is no room for complacency in this area, the following recommendation is directed towards WA Police proactively seeking out and implementing specific training, notwithstanding that it is contained within written Guides, and to also implement refresher training.

I recommend that WA Police implement specific training and refresher training, for police officers who are, or who are to be deployed, to interview Aboriginal persons in remote communities, to cover areas including the Anunga Rules, English language competency issues, the use of interpreters, the suitability of interview friends and the effects of FASD.

Recommendation 2: Availability of interpreters – remote communities

290. Counsel Assisting submits that I make a recommendation directed towards WA Police making an assessment of the availability of culturally appropriate interpreters.²⁴⁵
291. WA Police support this recommendation in principle but say WA Police should not conduct or fund this assessment, as interpreters are independent of WA Police.²⁴⁶

²⁴⁴ Counsel Assisting's submissions [83], [84], [88].

²⁴⁵ Counsel Assisting's submissions [92].

²⁴⁶ WA Police's submissions [32].

292. WA Police draws my attention to the Common Use Arrangement provided by the Department of Finance, that is responsible for identifying preferred interpreter and translator services for use by WA Police.²⁴⁷

I recommend that WA Police liaise with the Department of Finance to outline any requests or concerns it may have regarding the availability of culturally appropriate interpreters and that they take steps towards supporting any assessment and/or feasibility study of such, including the provision of de-identified statistical information regarding the availability of interpreters, if requested.

Recommendation 3: Guidance on preservation of forensic evidence – regional and remote areas

293. Ms Bishop submits that I make a recommendation directed towards WA Police emphasising the need for preservation of forensic evidence by police in regional and remote communities.²⁴⁸
294. Examples of deficiencies in this area arose during the inquest and included Dr Reynolds' qualification to his Bloodstain Pattern Analysis Report, namely that there has been disturbance to original bloodstains and bloodstain patterns added to Josh's clothing and person due to poor crime scene maintenance.²⁴⁹
295. At the inquest Officer Lee confirmed that there is now a greater deployment capability within the Forensic Field Operations Team, and the matter would come under the responsibility of the Homicide Squad, but that it would of course be local police that would, again, respond initially.²⁵⁰
296. Whilst this is an area that does undergo review by WA Police, in light of the manifest impact of poor crime scene management in this case:

I recommend that WA Police conduct a review of the current internal guidelines and training modules for local police officers and detectives in regional and remote communities to emphasise the need for preservation

²⁴⁷ WA Police's submissions [32.2].

²⁴⁸ Senior next of kin's submissions [91].

²⁴⁹ Exhibit 1, tab 19.2.

²⁵⁰ ts-793.

of forensic evidence before the Forensic Field Operations and Homicide Squad teams (or their equivalents) have arrived at the scene.

Recommendation 4: Review of expert witness briefing practices

- 297.** Ms Bishop submits that I make a recommendation directed towards reviewing WA Police's record keeping practices when briefing expert witnesses.²⁵¹
- 298.** At the inquest discrepancies in the evidence arose due to there being an insufficiency in the records kept of a meeting between WA Police, Dr Cooke and Dr Buck such that it was unclear as to who attended and when, and whether expert opinions were based upon photographs provided and if so, which ones.²⁵²
- 299.** At the inquest it emerged that the police officer following up on briefing Professor Stokes had not been able to ascertain what evidentiary material had previously been provided to him, from internal records.²⁵³

I recommend that WA Police evaluate its practices for briefing and communicating with expert witnesses and consider implementing a specific expert evidence management protocol (to the extent one does not exist) that requires police officers to prepare briefing letters and keep detailed records of the information and materials provided to expert witnesses and responses from expert witnesses.

CONCLUSION

- 300.** Not every apparent crime can be solved within desirable timeframes.
- 301.** But many are eventually solved.
- 302.** The Coroners Act prohibits me from framing any finding or comment in such a way as to suggest that any person is guilty of an offence. I have made my findings on the cause and manner of Josh's death, as required. Having formed the belief that an indictable offence has been committed in

²⁵¹ Senior next of kin's submissions [102].

²⁵² Exhibit 15; ts-637, 639, 775.

²⁵³ ts-838-839.

connection with Josh's death, I have determined to report it to the Director of Public Prosecutions.

- 303.** Josh's mother Ms Bishop has shown courage and tenacity throughout her long and dignified search for the truth. The police investigation was beset with difficulties, many of which have been acknowledged. It is likely that critical evidence was lost due to some of the failures that I have outlined in this finding regarding forensic analyses.

- 304.** Nonetheless investigative methods continue to improve and there may be further avenues to explore. It is my hope, and expectation, that all efforts continue to be made to find out what happened.

R V C Fogliani
State Coroner
4 June 2026