CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the disappearance of CD
Hearing dates:	12-14 September 2022
Date of findings:	16 September 2022
Place of findings:	Coroners Court of New South Wales - Lidcombe
Findings of:	Magistrate Erin Kennedy, Deputy State Coroner
Catchwords:	CORONIAL LAW – Missing person – manner of death – Police Investigation – Appropriateness and adequacy of police response – Appropriateness of legislative interpretation of legislation relating to triangulation – construction of s 287, *Telecommunications Act 1987*
File number:	2019/00306113
Representation:	**Counsel Assisting the Coroner:** Ms Emma Sullivan **Solicitor Assisting the Coroner:** Mr Valentino Musico, NSW Department of Communities & Justice **NSW Commissioner of Police:** Ms Gillian Mahoney, with Elizabeth Lambert instructed by Sgt Stephen Davis of the Office of General Counsel (NSW Police Force) **Chief Inspector Gary Charlesworth:** Mr Brent Haverfield instructed by Mr Matthew Treharne of Walter Madden Jenkins

Findings:

I make the following findings pursuant to section 81 of the *Coroners Act 2009* (NSW):

Identity of the deceased:
The person who died is CD.

Date of Death:
On or after 17 June 2019.

Place of Death:
Based on the evidence place of death cannot be ascertained

Cause of Death:
Based on the evidence, cause of death cannot be determined

Manner of Death:
Based on the evidence, manner of death cannot be determined

Recommendations

The recommendations made are as follows:

1. **To the Commissioner of the NSW Police Force:** That the Commissioner of Police of the NSW Police Force review the Missing Persons Standard Operating Procedures 2022 (Version 3.0) to clarify, state or otherwise include reference to the following matters:

    a. That the first 24 to 72 hours of a missing person investigation are usually the most critical, particularly so for missing persons in the high-risk category; during this period, continuity and intensity in the investigation are important;

    b. For high-risk missing person investigations, consideration should be given to immediate allocation of the investigation to an investigator (a designated Detective) with capacity to provide continuity and expertise for the critical 24 to 72 hour period (rather than General Duties officers);

    c. In relation to triangulation procedure (Chapter 17.0):

        i. Requests for triangulation should be made by a Duty Officer or Supervisor (except in remote areas); and

        ii. If a request for triangulation is declined - there is a review procedure pursuant to which the Duty Officer or Supervisor can escalate the matter (and specify that procedure);

    d. In Annexure A – 'Initial Response – Missing Persons Checklist', reference to canvassing the area/last place the missing person was seen for witnesses (for example, street neighbours).

2. **To the Minister of Communications (Cth):** That the Minister for Communications (Cth) be provided with the findings from this inquest and the evidence of Chief Inspector Gary Charlesworth, together with the findings in the *Inquest into the death of Thomas James Hunt* (dated 4 September 2020) regarding issues as to the interpretation and practical operation of s 287 the *Telecommunications Act 1997* in relation to missing person investigations, with a view to considering urgent reform of that provision, including as to whether to:

a. remove the qualifier of an “imminent” threat (consistent with the Australian Law Reform Commission Report 108 (2010), Recommendation 72-7); and

b. change the requirement of ‘belief’ to ‘suspicion’.

3. **To the Commissioner of the NSW Police Force:** That the Commissioner of Police of the NSW Police Force:

   a. be provided with the transcript of the evidence of CI Charlesworth in this inquest; and

   b. give consideration to obtaining an urgent advice to provide authoritative guidance to the NSW Police Force as to the construction of s 287 of the *Telecommunications Act 1997* (including for example from an appropriate senior counsel or from the Crown Solicitor’s Office), in light of the remedial purpose of that provision and noting evidence that the decision whether to triangulate can be a matter of life and death.

Non-publication orders:

1. Pursuant to s 74 of the *Coroners Act 2009* (**the Act**), there be no publication of the names of CD, his family and his friends, and any information tending to identify them.

2. Pursuant to s 74 of the Act, and the Court's inherent jurisdiction, and subject to Order 4, there be no disclosure of the information contained within paragraph 16 of the un-redacted statement of Sergeant Ross Veltman dated 26 August 2022 (**the Unredacted Statement**).

3. Pursuant to s 65(4) of the Act the Unredacted Statement is not supplied to any party, without prior notification to the Commissioner of Police's (**the Commissioner**) legal representatives.

4. Pursuant to the Court's inherent powers:

    a. One copy of the Unredacted Statement is only to be provided to the legal representatives of those granted leave to appear in this inquest. In the case of a party being represented by a solicitor and barrister, each of those persons can have one copy.

    b. The Unredacted Statement can be viewed by the family of CD in the presence of their legal representatives (if represented) or in the presence of those assisting the Deputy State Coroner where the family of CD is not represented.

    c. The Unredacted Statement is not to be copied save for the purpose of 4(a) above.

    d. All copies of the Unredacted Statement are to be returned to the Commissioner's legal representatives with 7 days of the delivery of findings in this matter.

5. The Court be closed for the hearing of any evidence or submissions to be made in respect of the Unredacted Statement, save for the following persons being present:

    a. The Deputy State Coroner and her staff;

    b. Those assisting the Deputy State Coroner;

    c. The Commissioner's legal representatives;

    d. The parties and legal representatives granted leave to appear to appear in this inquest; and

    e. The family of CD and if represented, their legal representatives.

INTRODUCTION

1. CD was 36 years old when he disappeared from his home at Little Bay around 7.20am on Monday, 17 June 2019. Since that time, there have been no signs of life, nor any credible sightings of CD.

2. When he initially went missing on 16 June 2019, his mother who had flown over from New Zealand given the serious concern for welfare that she held, reported CD missing within hours of him leaving her company. She was later joined in Australia by his sister and brother both from New Zealand as they attempted to find him. He has not been seen since.

The purpose of the inquest

3. The Inquest was mandatory as it was not sufficiently disclosed whether CD had died pursuant to s 27(1)(c) of the *Coroners Act 2009* (**the Act**). If it is found that he has since died, further issues are left to be determined in the nature of the manner and cause of death pursuant to 27(1)(d).

4. In addition to examining issues relating to the statutory findings under s 81 of the Act, the Inquest considered the adequacy of the police investigation into CD's disappearance. The Court heard evidence from CD's family – CD's mother, CD's brother and CD's sister, in addition to evidence taken from six officers from the NSW Police Force.

REFLECTION ON THE LIFE OF CD

5. CD was a young man, a new father and husband and very much loved by his family, wife and baby son. Known to be intelligent and funny, CD was an active person who loved trail running, tennis and skiing and who gave everything his all. He regarded his wife, and his son, as his whole world. In a letter to CD's wife written just one day prior to his disappearance, CD wrote, "I love you two more than you will ever know (I know you've always said it wasn't possible to love too much, but I disagree)."

6. CD's sister said in evidence in the proceedings that she thinks of him every day. She described him as fun, witty and brilliant with accents, and that he was full of life and a great uncle to her kids. She described how he would often ring her up, putting on an accent pretending to be someone else, and he was so good she would fall for it every time.

7. CD's brother described his brother as highly intelligent, witty, and very quick thinking, someone who could think of every option. He also thought of him as kind hearted and well-meaning, the sort of person who would do anything for

anyone. CD's brother described a very close and strong relationship with CD, speaking almost daily to each other from New Zealand. He explained the enthusiasm CD had in all things. Even when CD was helping him with a business interest, CD was fully committed and determined to help his brother by getting the job done for him.

8. CD's mother always had a lovely relationship with her son, and was clearly very close to him. The terrible pain from his disappearance was patent as she gave evidence. In doing so, she was dignified and gracious. It was evident that CD was deeply loved by all his family, and that his absence had left a huge hole in their lives.

9. The description of CD was that he was a lively, funny, intelligent and fun person. He was described by his family as being able to talk to anyone, anywhere. The story told about CD approaching an ex-prime minister when he saw her overseas, just to have a chat, provides an excellent illustration of the type of person he always has been.

10. In the weeks before his disappearance CD was exhibiting signs of a person who was struggling with mental health issues. His drinking had increased perhaps as a way to self-medicate or cope with the mental stress he was under. He had made some poor decisions in relation to his partner and son and was at risk of losing his relationship. He was becoming irrational and paranoid. He was a person that needed psychological support and help, which was exactly what his mother flew to Australia to achieve.

Events Surrounding the disappearance of CD

11. During the period 1 June 2017 until 14 June 2019 (that is, just days prior to his disappearance), CD saw his psychologist, Ms Fiona Green. In general terms, her notes record stressors in CD's life including his career direction, financial position and the prospect of being a "house husband".

Drink driving offence and first disappearance

12. The days prior to CD's disappearance suggested his mental health was in steep decline.

13. On 7 June 2019, there was a domestic altercation between CD and CD's wife, which resulted in CD's wife leaving CD and their son, and reporting the circumstances to Maroubra Police Station.

14. Around 10pm that evening, Police caught CD driving under the influence of alcohol with CD's son in the back seat. CD was arrested and charged with a high range PCA offence.

15. On 8 June 2019, CD's wife contacted Maroubra Police to report certain concerning texts she had received from CD. When police attended, CD's wife expressed concerns for CD's mental health, given his erratic and unusual behaviour. Police tried to locate CD at his Little Bay residence, without success. When police managed to contact CD that afternoon, he said he was having "suicidal thoughts", but also said "we are all going to die eventually", and was seemingly laughing and joking throughout the call." An entry on the police COPS system noted that CD had "undiagnosed mental health conditions".

16. At this time, it appears that CD had booked himself into the Pullman Sydney Airport Hotel, at Mascot for two nights, from 8 to 10 June 2019.

17. On Sunday, 9 June 2019 whilst CD was staying at the Pullman Hotel he contacted his mother and made suicidal threats, saying he wanted to die "either by taking numerous back pain pills" or jumping off a cliff. In response, police patrolled various areas, and deployed triangulation to try and ascertain CD's location.

18. After use of triangulation, just after 3am on 10 June 2019, Police located CD at the Pullman Hotel in Mascot. CD was scheduled by police under s 22 of the *Mental Health Act 2007* (NSW) and taken in an ambulance to the Prince of Wales Hospital in Randwick (**POWH**). Soon after, CD's mother arrived from New Zealand and immediately attended the hospital to be with CD.

19. Whilst in hospital, CD denied any thoughts of self-harm. He told staff his threats were empty and that he never had a plan to hurt himself. He was discharged later that day, the view having been formed that he could not be detained. CD also wanted to leave. He declined Acute Care Team follow-up and was discharged into the care of his GP, leaving the hospital with his mother.

20. Dr Kerri Eagle, forensic psychiatrist, in her expert report received into evidence, reviewed the care and treatment CD received at POWH. She opined that overall, it was adequate and reasonable. Accordingly, no issues arise in that regard for this Inquest.

Post-release from POWH

21. Following his release, CD showed a renewed vigour and determination to tackle the various issues in his life and his relationship.

22. On 12 June 2019, CD saw a psychologist, Daniel Herman. His mental state at that time was unremarkable, notwithstanding the tumultuous events he had been through in recent times. CD denied any current suicidal ideation.

23. On Friday, 14 June 2019, CD attended more appointments, including with a lawyer, a counsellor at Relationships Australia and with Ms Green. In the appointment with Ms Green, CD described his drink driving and domestic issues, and admission to POWH. Ms Green noted that although anxious and overwhelmed, CD was attempting to solve his difficulties. She saw the letter of apology CD had written to CD's wife. Ms Green thought that he was attempting to solve his issues and reconcile with his wife. Certainly, there was no cause for concern as to potential suicidal ideation.

24. However, around 6.30pm that evening, CD was arrested at his Little Bay residence, and charged with certain offences contrary to the *Criminal Code Act 1995* (Cth) and the *Crimes Act 1900* (NSW) relating to use of his phone. He was also served with an Apprehended Domestic Violence Order that named his wife and son as persons in need of protection. CD was released from custody around midnight.

Trip to the Central Coast

25. Early the next morning, Saturday, 15 June 2019, CD's mother and CD went for a drive up to the Central Coast, staying overnight at a hotel in Yarramalong. That night CD was focussed on completing his letter of apology to CD's wife. However, at this time, CD's mother particularly noted that the degree of paranoia was not normal.

26. CD was very open with CD's mother; not only did he tell her what he was experiencing, but he confided in her about his wishes. He allowed her to attend all the psychologist and legal appointments. He clearly trusted his mother and welcomed her involvement in his recovery.

CD disappears on 16 June, reported missing

27. On the afternoon of Sunday, 16 June 2019, CD's mother and CD returned to Little Bay. CD's mother dropped CD at St Michael's Golf Course near his home. CD's mother said that his paranoia was increasing, and he wanted her to drop him there because he was convinced the police would be waiting for him at home. She was to wave to him to tell him that they were not there (that the "coast was clear"), and then he would come home. After leaving CD sometime around 2.30pm, by 4.30pm CD's mother was sufficiently concerned to contact police with concerns as to his welfare.

28. Around 5.30pm, Senior Constable Daniel Invernon (together with another more junior police officer) attended the Little Bay residence to obtain the missing person report from CD's mother. CD's mother told police that CD was "not mentally well as he was rambling and she found it hard to get him to listen." She reported that CD had not made threats of self-harm. She also said that CD might keep his phone off to prevent police from tracking it, and that he "does not like police and would probably hide" from them. In taking this report, under the relevant missing person (**MP**) police policy SC Invernon became the Officer in Charge (**OIC**) of the investigation into CD's disappearance.

29. No risk assessment was undertaken by SC Invernon during that shift (which concluded at midnight), nor the following day.

CD returns home for the last time

30. CD stayed away overnight, returning to his Little Bay apartment around 4am on Monday 17 June 2019 to his mother's relief. He was calm, but was soaking wet and dishevelled. He was still paranoid. In her statement closer to the time, CD's mother had reported that he was intoxicated; however, in evidence she couldn't recall that fact. He was compliant for the most part. She talked to him about the need to go to Hospital and get help for himself. He listened to her, as she explained that his sister was on her way from New Zealand and that his sister also thought it a good idea to go to the hospital.

31. He said that he was tired and would go with them later in the morning. CD's mother told him to have a shower and get warm. She became aware that he vomited in the bathroom and was able to discern that there was what appeared to be red wine and what looked like pills (white crumbles) in the vomit.

32. She felt reassured by this because she thought that if he had consumed anything that he had expelled it from his body. She reflected in evidence that he may have been intoxicated, that he could drink quite a lot and not necessarily show the effects.

33. It is a good time to reflect on the position CD's mother found herself in. She had flown over with no prior understanding of mental health generally nor awareness of any such signs exhibited by her son. She had travelled with him and supported him but gradually then formed the view that he was very unwell and not behaving rationally. She knew he needed help. She reported him missing and wanted the police to find and help her son. She was in an unfamiliar environment, alone in another country. Albeit the close relationship New Zealand and Australia enjoy, nevertheless she was not in her usual environment and was faced with a serious situation.

34. She did not alert police that he had returned; however, he was a mentally unwell person, stumbling in wet and dishevelled. She could not place a call to police without CD hearing that call, potentially increasing his paranoia and driving him away. She had him safe for that time.

35. He was compliant with her requests and after considering an ambulance, she made the difficult decision to trust that she could get him help later that morning. Any suggestion that she should contact the police at that point is to misunderstand the significantly precarious situation that she faced, her focus being to keep her son safe however she could. Telephone conversation at that critical point had the real potential to drive CD away, from her safety.

36. At about 7.20am, CD left the unit, telling his mother that he wanted to get rid of a bong. This was more evidence of his increasing paranoia, thinking that the police would be around to search his home and might find it. This was the very last time CD was seen alive.

Investigation by police

37. Before finishing his shift around 6.30am on 17 June 2019 (the morning of CD's final disappearance) the Duty Officer, Acting Inspector Matthew Magee, left a handover note for the incoming Duty Officer, Inspector Aaron Wunderlich. This note included an informal risk assessment of CD's disappearance, which assessed the risk as 'High'.

38. At 7.30am, Senior Constable Petrina Price and Constable Dean Hodges attended the Little Bay apartment and spoke with CD's mother. SC Price later noted in the COPS system that CD's mother (the Next of Kin) had reported that CD had returned home at around 4.30am that morning. He was intoxicated after consuming a bottle of wine and he was soaking wet. CD was sick and possibly physically ill in the bathroom before showering.

39. The COPS entry goes on to state:

> "About 7:20am the MP left the address wearing a navy and white [striped] jumper and navy/dark colour pants. NOK believes the MP left and went to St Michels Golf Club/Botany National Park area.
>
> The MP left on foot with no car keys, no wallet, possibly has his mobile phone".

40. Soon after, Officers Price and Hodges were directed to return to Maroubra Police Station for the 8am morning briefing, at the request of Acting Sergeant Rabiye Arslan (now Sergeant). They later returned around 10am to continue foot and vehicle patrols of the golf course and national park area; they attempted to call CD's phone but it was switched off.

41. Notably, in the shift handover between the Duty Officers that day, the 'Handover' document assessed the risk as 'High', due to domestic violence (**DV**) history, recent MP report, recent charges, recent mental health Act admission and alcohol use.

42. At 11.55pm night, police attended the Little Bay apartment, and spoke with CD's mother, who had no news. Police searched the surrounding area but found nothing. They attempted to call CD's mobile, which rang several times, suggesting that it was active.

43. The following day, on Tuesday, 18 June 2019, Senior Constable Benjamin O'Reilly (SC O'Reilly) continued inquiries, including contacting CD's wife and undertaking foot patrols of the area.

44. That evening at 7.06pm, SC Invernon (who had started an evening shift at 6pm) completed a formal risk assessment. In doing so, he used a non-approved risk assessment guideline, which was not entered into the COPS system. The risk was assessed as 'Low'. This assessment was approved by the shift supervisor, Leading Senior Constable James Smith.

45. At the conclusion of the day shift on 18 June 2019, the Duty Officer completed the handover document assessing the risk as 'High'. In contrast, it appears that the shift sergeant handover document downgraded the risk assessment to 'Medium'.

46. From 19 to 20 June 2019 the investigation remained with 'General Duties' Police officers. Amongst other things, it appears patrols of the Little Bay area were conducted, and there were continued attempts to contact CD's mobile phone.

Detective Cigana assigned carriage of the investigation

47. On the morning of Friday 21 June 2019, CD's case was reviewed by the Investigations Manager, Detective Sergeant Michael Capon. He was sufficiently concerned about the matter to allocate it to Detective Cigana.

48. Detective Cigana immediately commenced a range of inquiries. At midday he made contact with the Duty Operations Inspector, Chief Inspector Gary Charlesworth, requesting triangulation of CD's phone. This request was declined by CI Charlesworth on the basis there was no 'serious or imminent threat to the life or health' of CD within the meaning of s 287 of the *Telecommunications Act 1997* (Cth).

49. That same afternoon DS Capon contacted the POLAIR wing to request a helicopter patrol of the Eastern Suburbs, and particularly the Little Bay area, to see if a deceased body could be seen. This patrol took place on 22 June and again on 23 June 2019, but nothing was found.

50. On 27 and 28 June 2019, Police conducted an intensive search of a 3.5 acre dense area of bushland close to CD's Little Bay residence. Nothing of interest was found.

51. On 19 September 2019, Detective Cigana, together with a number of police from the then newly established Missing Persons Registry, conducted a review into CD's case to identify any further leads. Relevant lines of inquiry were then promptly followed up by Detective Cigana.

52. On 23 September 2019 an Interpol Missing Persons request was placed.

53. From June 2019 to present day, police have undertaken numerous 'proof of life' checks with various agencies including banks, government organisations, interstate police and Interpol. No reliable evidence has been uncovered that would suggest CD is still alive.

Issues List

54. Firstly, the Inquest examined whether there is sufficient evidence to find that CD is deceased, and if so, the place and date, and manner and cause of his death, to the extent the evidence permits.

55. Secondly, the Inquest examined the adequacy of aspects of the police investigation into CD's disappearance. This is an important opportunity to review and reflect upon police practice, and to consider whether there is scope for improvement or for lessons to be learned.

56. Thirdly, the Inquest considered whether any changes to the NSW Police Force's Missing Persons Standard Operating Procedures (**MP SOPS)** arise.

57. Finally, the Inquest considered whether any recommendations are necessary or desirable.

DETERMINATION OF STATUTORY FINDINGS

Is CD deceased?

58. The facts are unequivocal that CD has not been sighted since the morning of 17 June 2019. Whether CD is deceased is a matter to be determined on the

balance of probabilities. Of course, a finding that a person is deceased is a serious one, with important legal, administrative, and emotional ramifications. Noting *Briginshaw* (1938) 60 CLR 336, any finding of death must be supported by cogent evidence that the person is no longer alive.

Background to events surrounding his disappearance

59. In the days immediately following his disappearance on 17 June 2019, CD's family and police officers made numerous attempts to contact CD via his mobile phone. None of these calls were answered, and police reported that the phone was mostly switched off. However, it appears that at some stage on 17 June, CD's phone was turned back on again. The evidence regarding attempts to reach CD on the phone disclosed that he had it off on 17 June, but then after 11.55 pm it was called and rang. On 18 June 2019 it was active for periods of time. The last online activity was with CD's wife at 7.12 am on 17 June 2019.

60. His mother believed in his paranoia he may have turned it off to prevent being found by police. His brother said it was so unusual for CD not to be constantly on the phone using it, looking at it or on social media.

61. There is no evidence that he had his phone with him, other than his phone not being located at home or in his car. There were in fact two phones that he had access to, that the police were attempting to contact. There is no evidence to say at what point he was with those phones, or what happened to those phones.

Signs of life in the community

62. The inquest heard from Detective Sergeant Peter Daley, the current OIC of the investigation into CD's disappearance. He confirmed that having regard to the various proof of life checks, there have been no signs of activity by CD since his disappearance on 17 June 2019. DS Daley has undertaken an admirable investigation and as a result confidence can be had in that regard.

63. On 21 June 2019 Detective Cigana moved to conduct significant and extensive enquiries in relation to any intelligence or information to suggest CD may have left an actual or electronic footprint anywhere.

64. Since 17 June 2019, other than some possibility that his phone remained on still on 18 June 2019, there are no signs of life in the community. There has been no social media activity, other than one small entry which I accept is consistent with someone accessing his account, rather than CD being active. He was an avid phone and social media user. It would be unlikely that he has not done so for 3 years.

65. Given the investigation spanned multiple jurisdictions, including New Zealand, it is unlikely that CD would have disguised his identity and left the jurisdiction. He was in an unhealthy psychological state making it even less likely that he would traverse the difficult terrain of trying to reinvent himself and start again.

66. DS Daley summarised it well in his evidence, when he discussed the strength and bond he observed in the CD's family. CD had the support and love of a strong caring family; he would not choose to leave them. Equally, in his final letter to his partner and son, he expressed such great love for them that it is inconceivable that he would choose to remain hidden from them for over 3 years.

67. Tragically, I am satisfied on the balance of probabilities that CD is now deceased.

Place and date of death

68. The evidence does not permit any finding as to the place of CD's death.

69. As to the date of CD's death, the evidence permits a finding that he died some time on or after 17 June 2019 (being the last time he was seen).

What was the manner and cause of CD's death?

70. The Court received into evidence an expert report from forensic psychiatrist, Dr Kerri Eagle. She noted that CD had a documented history of depressive and anxiety symptoms associated with persistent sleep disturbance and alcohol use. His depressive symptoms appeared to occur in the context of stressors, excessive alcohol consumption and disrupted sleep. He was also described as having changeable moods.

71. As to the issue of whether CD may have taken his own life, Dr Eagle provided a supplementary report (emphasis added):

> "… CD had some risk factors known to be associated with suicide at the time of his suspected death including, for instance, depressive symptoms and substance intoxication. He was also experiencing major life stressors (marriage breakdown and separation from his son). He displayed an increasing level of distress in response to these stressors. He had recently expressed suicidal ideation in the context of alcohol intoxication. On the other hand, as noted at paragraph 118.3.1, CD had been described as hopeful he would reunite with his wife, was preparing a letter hoping to facilitate a reconciliation and was engaged with his GP and his psychologist. Prediction of suicide risk is unreliable. On the basis of the available information, I am unable to conclude with any reliability whether CD, on a balance of probabilities, was likely to have

> committed suicide on 17 June 2019. It is possible that in the context of intoxication and heightened distress he impulsively took his own life, but it is also possible he was subject to some unknown misadventure."

72. CD had the history of threatening self-harm a little over a week prior to going missing. He was exhibiting very concerning behaviour and clearly was in need of psychological assistance. CD's mother noted that he appeared to have over consumed medication that morning, was dishevelled, wet and perhaps intoxicated. He was at high risk of self-harm. The previous risk of self-harm (as reported to police on 9 June 2019) was as follows:

> "Inf states POI CD has said he does not want to be here anymore and has consumed lots of alcohol told his mother that he wants to die either by taking numerous back pain pills or jump off a cliff…"

73. CD's mother recalled speaking to CD about these threats of self-harm; she also recalled him indicating he had been stock-piling oxycontin, so he had access to an excessive amount of medication.

74. Counteracting this evidence is the fact that the letter written to his wife was full of hope and future plans. There were indications of deciding to try and address his drinking, and plans for self-improvement.

75. DS Daley considered that it was more likely that CD had fallen into the water near his home, rather than taking his own life. Importantly, those who knew him best do not consider it likely that he would self-harm. The evidence of his hopefulness, seeing his sister, picking her up from the airport that morning, hoping to try to reunite with his little son and wife, and sharing this with his mother, is inconsistent with a positive finding of self-harm.

76. Thus, accidental death by some other misadventure is a reasonable possibility which cannot be ruled out on the available evidence. The expert opinion supports the fact that after a professional review of the material, it is not possible to determine whether CD took his own life.

77. The evidence does not allow any finding to be made as to the manner and cause of CD's death.

ADEQUACY OF POLICE INVESTIGATION

78. Beyond the statutory findings, the key focus of the inquest was whether the actions of police, in attempting to locate CD on 16 June 2019 and following, were reasonable and appropriate in the circumstances (having regard to the applicable NSW Police Force policies and procedures), including:

a. the adequacy of the initial general duties investigation;

b. the appropriateness of the risk assessment process;

c. whether the "triangulation" process ought to have been used to ascertain CD's location; and

d. the adequacy of the searches undertaken (including on 27 and 28 June 2019).

a. Adequacy of general duties investigation

General duties investigation on 16 June 2019

79. SC Daniel Invernon was the officer responding to CD's mother's 'Concern 4 welfare' report in the afternoon on 16 June 2019. As a result, he became the OIC of the investigation. According to the 2016 Missing Persons Standard Operating Procedures (**2016 MP SOPs**), he was then responsible for "exhausting all avenues of inquiry until the MP is located or the investigating role is transferred."

80. SC Invernon spoke to CD's mother and then patrolled the area for about an hour. He broadcast a 'keep a lookout' message for him.

81. In evidence SC Invernon was insightful as to the tone of certain entries that he made into the COPS system regarding CD and the circumstances of his disappearance, and agreed there was a better approach. In oral evidence, SC Invernon told the Court he could not recall missing person investigation training at the Academy, nor could he recall being taken through the 2016 MP SOPS. He readily accepted that he should have completed the risk assessment as soon as possible and should have done it earlier than the evening of 18 June 2019. He did not at the time appreciate the urgency of it, but understands now. He did not complete the risk assessment on the COPS system as required. The risk assessment guideline he in fact completed should have led to a high risk outcome, as opposed to low.

82. The 2016 MP SOPS also required the OIC of the Missing Person investigation to consult an 'initial response checklist,' That checklist included a number of suggested tasks, such as:

a. Identifying and interviewing persons at the scene;

b. Obtaining the contact details of the missing person's friends and associates, and other relatives and friends of the family (and interviewing those people);

c. Conducting a search where the incident took place and all surrounding areas;

d. Sealing and protecting the scene and area of the missing person's home;

e. Evaluating the contents of the missing person's room or residence; and

f. Securing the missing person's medical and dental records.

83. Whilst the checklist was not intended to be a step-by-step guide for police officers, it was meant to "offer a framework of actions, considerations and activities that can support competent, productive and successful missing persons investigations." It appears that a number of these tasks were not completed by SC Invernon as the OIC, nor by incoming general duties officers on 17 June 2019.

84. Amongst other things, an opportunity was missed to interview those who might have recently seen CD, such as his neighbours, to develop a better understanding of his movements and his mental/physical state. Attempts by Detective Cigana to canvass CD's neighbours years after the event yielded some helpful information. A proper canvass of the area in the hours after CD's disappearance may have revealed important information.

85. Notably, the 'Initial Response – Missing Persons Checklist' at Annexure A to the 2022 Missing Persons, Unidentified Bodies and Human Remains Standard Operating Procedures (**2022 MP SOPs**) does not contain any reference to canvassing the area where the missing person was last seen for potential witnesses. As this case demonstrates, this is an important step to be taken early in missing persons investigations, before witnesses depart from the scene or lose recollection. In oral evidence, Detective Chief Inspector Glen Browne, the current Manager of the Missing Persons Registry at the NSW Police Force, agreed that this requirement could usefully be added to the 2022 MP SOPS 'checklist'. This matter is the subject of a recommendation below.

86. In this case it is not suggested that the police did nothing. To the contrary, steps were taken to search for CD, and he was discussed at a higher level of command. However, clearly not enough was done in keeping with the 2016 MP

SOPS, nor to a standard that would be expected from any member of the public seeking help to find a missing person.

87. I take a step back to again reflect on the enormity of the actions of CD's mother, who put her life on hold, got on a plane and flew to Australia to assist her son. CD's brother and sister followed soon after. It is a curiosity that this important fact did not make its way into the COPS entries nor into the communications in the handovers.

88. A reflection of the inadequacy was highlighted by the picture painted in evidence by CD's family. CD's mother getting in her car, driving around in the dark in unfamiliar territory calling out the window for her son, activating her horn. CD's sister turning up at the police station, to wait to be served along with those on bail report, as she tried to get information from the police. Getting help from family in New Zealand to create flyers and being grateful to a neighbour who offered to print them, but who didn't have access to a colour copier and so they were black and white only.

89. CD's brother described putting on his boots and heavy farm jacket and walking in the freezing windy conditions from one end of a coastal track to the other. He said he couldn't stop himself - he had to keep going, keep looking. He then recalled that he saw a neighbour's bicycle and so asked to borrow that and was able to travel further on his searches in the cold. The family reported not knowing if they were covering areas the police were also covering. They reported the desperation of trying to beg for an air search to be undertaken to no avail, although one company said they would look out for them when they were in the air.

90. They spoke to rangers, canvassed neighbours, shops, asked for CCTV, and even mentioned going into the local chemist and trying to enquire whether he had been filling a script, and being told privacy issues prevented them from helping, but also being assured that he had not been seen in the few days that he had been missing.

91. Frustrated, they reached out to police friends and contacts in New Zealand, and tried to pass on the suggestions to local police. They had a friend attend from Western Australia, and that friend came to bring his drone. CD's brother described in evidence he and that friend flying the drone along the cliffs and trying to zoom in on a small screen to examine any anomaly they thought they saw.

92. At times the family felt they were met with a lack of compassion, being told that they couldn't take certain steps because of lack of funding, or resources. Careless comments were made to them about how many people are missing

generally and how resources can't extend that far. These careless comments and apparent lack of empathy has stayed with CD's family and the hurt was still evident at the Inquest.

93. In saying that, CD's mother, sister and brother conducted themselves with grace and dignity, even when listening to difficult evidence from that particularly traumatic part of their lives. They reiterated a desire to ensure that although others will lose loved ones, and will need to look for them, that at least they shouldn't have to endure the treatment they received while searching for CD. They felt alone.

Expert opinion of Detective Chief Inspector Glen Browne

94. DCI Glen Browne, the current Manager of the Missing Persons Registry at the NSW Police Force, reviewed the investigation into CD's disappearance, including statements from police officers who investigated CD's disappearance on 16 and 17 June 2019. Ultimately, he formed the following opinion:

> "It is my opinion that more should have been done to locate CD on the afternoon/evening of 16 June and the following day, including the use of additional resources… I also believe a triangulation should have been requested to discover the location of CD's phone."

95. DCI Browne believes that the triangulation tool should be used for all 'high risk' missing person investigations.

96. Further to DCI Browne's evidence, a report by the Australian Institute of Criminology (AIC Report) in 2015 identified that 64% of missing persons were located within 48 hours, and a further 22.1% were located within 1 week. Notably, 97.5% of missing persons were later found alive. The AIC Report highlighted a UK Missing Person Behaviour study, which found that in 2011, the highest fatality rates were "among the so-called 'despondents' (i.e. persons with depression, experiencing stress/distress and/or with the intention to suicide)." The AIC Report concluded that middle aged men with mental illness or the intent to commit suicide were one of the two demographic groups most vulnerable to adverse outcomes. It bears repeating that middle aged men suffering from a mental illness but without any stated *intent* to suicide are still among the most vulnerable. CD falls into this category.

97. Sergeant Arslan's second statement in these coronial proceedings demonstrated insight. Clearly, however, the fact that Officers Price and Hodges were directed to return to the station to attend a meeting instead of looking for CD some minutes after he had disappeared, was a missed opportunity.

98. It is also apparent from the chronology described above that at the critical time, that is, within the first 24 to 72 hours of CD's disappearance, there was a clear lack of continuity or intensity to the investigation. The investigation was disjointed, lacking both focus and direction and was conducted by junior officers with limited investigative experience. By the time the case was ultimately allocated to Detective Cigana, it may be thought that the trail had gone cold.

99. This evidences the need for ownership of the search for a missing person. There was no one person, or indeed no one rank, responsible for CD nor responsible to CD's family. This was an example of lack of communication internally. I am careful not to cast individual criticism; the work of the duty officer and general duties officer is taxing and hard. The pressure and pull in unpredictable different ways during a shift is difficult. This highlights the need for thought to be given to the first critical 24 to 72 hours, and the need for a system that allows ownership, attention, responsibility and continuity.

Adequacy of the risk assessment process

100. The risk assessment process serves an important function. In short – it directly informs the appropriate level of investigative response, including whether specialist resources are used.

101. DCI Browne believes that a 'High' risk rating should have prompted additional searches of the Botany Bay National Park and the coastal cliff faces. DCI Browne stated:

> "…a request could have been made to the Police Aviation Branch (POLAIR) for air searches to commence and potentially the Marine Area Command for coastal water searches. At daylight on the 17 June, a co-ordinated and documented search program should have been commenced."

102. DCI Browne further opined:

> "When a high-risk rating is attributed to a missing person report, all available tools and resources should be considered, and Requests for Assistance (RA's) submitted to the specialist resource providers such as the State Coordination Unit (triangulation), Police Aviation Support Branch, Marine Area Command, Bomb & Rescue Unit (LANDSAR) and Police Media Unit. Local police resources should also be used for searching and canvassing, including CCTV canvassing to try and track the movements of the missing person."

103. The facts that we have heard in relation to the risk assessment for CD are troubling. The initial OIC did not undertake one at all for a period of two days; when he did, he did not have the right tool at hand and the calculations were made in error, putting CD at low risk. At the same time, his superior officers put

CD in the high risk category but that did not change what happened in relation to escalating the search for CD. Later on another officer downgraded his risk to medium. There is little wonder why there was confusion and inaction.

104. The valuable evidence of three senior officers was that CD easily fell within the high risk category. Warning bells should have been ringing given the matrix of complex facts that presented in CD's case. These included the serious and drastic steps taken by his family to attend Australia given the fear they held for his welfare; the mental health behaviour demonstrated by CD, including paranoia and recent threat of self-harm; the recent separation from his partner; recent charges; the alcohol abuse problems; and finally the disappearance from his home taking nothing with him, after presenting to his mother dishevelled, and vomiting possible pill products.

105. In summary, the essential failing in relation to the risk assessment process included:

    a. a failure to conduct a risk assessment upon receipt of the missing persons report;

    b. a failure to conduct a risk assessment in a timely manner;

    c. a failure to complete the risk assessment in the COPS system (so that it would be visible to other police);

    d. a failure to conduct ongoing risk assessments, upon receipt of new information; and

    e. discrepancies in the risk assessment amongst the various ranks, with the duty officers consistently rating the matter high – as compared with the low rating assigned by the OIC, an approved by the supervisor.

106. The positive thing that arose from the evidence of the police witnesses was the insight demonstrated by many. It is powerful to hear that "yes, mistakes were made" and "yes, we can do better". This cooperative approach and honest assistance in this Inquest is to be commended.

Should the "triangulation" process have been used to attempt to ascertain CD's location?

107. Having been assigned to CD's case on 21 June 2019, Detective Cigana immediately contacted the Duty Operations Inspector, Chief Inspector Gary Charlesworth to request triangulation of CD's phone. CI Charlesworth was

stationed at the State Coordination Unit, Communications and Security Command. CI Charlesworth refused the request, stating that it did not meet the threshold set out in s 287 of the *Telecommunications Act 1997* (Cth). That section provides:

"Division 2 does not prohibit a disclosure or use by a person (the ***first person*** of information or a document if:

(a) the information or document relates to the affairs or personal particulars (including any unlisted telephone number or any address) of another person; and

(b) the first person believes on reasonable grounds that the disclosure or use is reasonably necessary to prevent or lessen a serious and imminent threat to the life or health of a person."

108. The exchange between CI Charlesworth and Detective Cigana was relevantly as follows:

Charlesworth: State Coordinator, Chief Inspector Charlesworth.

Cigana: Yeah, g'day sir, just Steve Cigana from Maroubra Detectives. How you going?

Charlesworth: Very well. What's your name mate?

Cigana: Steve Cigana from Maroubra Detectives

Charlesworth: Yep.

Cigana: Um, I was just enquiring about the possibility of getting a triangulation on a missing person who hasn't been sighted since the 16th June.

Charlesworth: Oh very unlikely.

Cigana: Yeah? It's not going to happen?

Charlesworth: Ah, mate, is there a serious [and] imminent risk to the health and safety of that person?

Cigana: Well he is mentally unstable and has made previous threats of self-harm, just no one has seen or heard from him since the 16th. Um, he has two phones. One's ringing, um we can confirm that earlier this after-, this morning, sorry. So, one's ringing and one's definitely switched off.

Um, he is known to have extreme paranoia. We've just exhausted all avenues at the moment and we're just not too sure what other, we've tried to get an LS-

> sorry LBS, but that was obviously knocked back given that it was not a criminal offence we're investigating.
>
> **Charlesworth**: Mate, there is no serious and imminent threat.
>
> **Cigana**: Yeah, well, none that we can give definitively, no.

109. CI Charlesworth has explained his reasoning for declining Detective Cigana's triangulation request as follows:

> "Based on the evidence presented to me I did not have the requisite belief that reasonable grounds existed that there was a serious and imminent threat to the life or health of a person."

110. In oral evidence, CI Charlesworth reiterated this view: as a matter of statutory construction, given the prescriptive requirements of s 287, there was no imminence to any threat; he described the "imminence" requirement as a "hurdle" that needed to be cleared. Differently put, he gave evidence to the effect that there were "four different fences to climb over [in s 287] to get to triangulation … if you know you can't get over one fence you don't need to get information on the other fences".

111. CI Charlesworth accepted, however, that there were different definitions that could be given to the word imminent (including "likely to happen soon"). CI Charlesworth understood it to mean "about to happen". In his view, there could be no "imminency" for any threat after five days had passed unless there was other information such as a call or threat. CI Charlesworth rejected the contention that he should have obtained further information, including by asking any of the questions contained in the Local Operating Procedures, 'Information required by the DOI for consideration of activating a triangulation'.

112. Although agreeing he had not asked a substantive question of Detective Cigana, nor followed up any of the information provided, he did not accept there was any requirement to obtain further information, stating: "I asked him the statutory test". CI Charlesworth did not accept that he was unduly dismissive of the request to triangulate. CI Charlesworth did accept, however that the issue of whether to triangulate was a decision that may literally be one of life or death; he agreed it was critical to have all the facts relevant to that decision.

113. CI Charlesworth was not able to explain where the 'cut-off' for a lack of imminency would be - whether it was 48 to 72 hours, for example: rather, it would "depend on the circumstances". As to whether it would change if a 13 year old was lost after five days that would "depend on the circumstances"; a person suffering Alzheimer's disease who was missing after 5 days would be

an “ongoing threat”, but mental illness would not pose the same risk. CI Charlesworth stated words to the effect: “The more time that passes the more serious, but it is also less imminent. The section is incredibly prescriptive”.

114. Although this aspect was not explored in evidence, CI Charlesworth referred to his construction of s 287 as being informed by certain internal ‘advice’ (which was not called for or explored in evidence, nor is there any suggestion as to waiver of privilege over same). CI Charlesworth indicated his view that his construction of s 287 was shared within the State Coordination Unit. He held this view notwithstanding the revised local operating procedures for the DOI/State Coordinator now include examples of guidance on instances that may justify approval of triangulation such as: “The missing person has made actual or implied threats of self harm;” or “The missing person has not made threats of self-harm and has no history of self-harm but is known to have serious mental health issues or mental health issues that have escalated in recent times resulting in serious concerns for their safety”. There is clearly an ambiguity between the two positions.

115. CI Charlesworth confirmed he would make the same decision today, on the same facts. Listening to the call today and looking back with hindsight, he told the Court he would do nothing differently, stating “it would not satisfy the criteria as it lacked imminency”.

116. DCI Browne disagrees with CI Charlesworth’s declining of the triangulation request. Similarly, he disagrees with the decision of police officers not to pursue triangulation of CD’s phone on 17 June 2019 (as noted above). Commenting on s 287 of the *Telecommunications Act*, DCI Browne stated:

> “I interpret that to be quite a low bar when considering the use of that section to try and locate a missing person. Bearing in mind there must be a fear for the safety or concern for the welfare of a person for them to be considered as missing (ANZPAA definition of a missing person)… I believe this tool should automatically be used for all ‘high risk’ missing person investigations where there is reason to believe the missing person has with them a mobile telephone (or other mobile device).”

117. Quite extraordinarily, the same day that the triangulation request was made and refused, DS Capon contacted the Police Air Wing and requested a helicopter to fly over the coastline of the Eastern Suburbs and particularly the area of Little Bay to see if they could see a deceased body on the cliffs or in the water. Clearly then DS Capon had grave fears for CD’s life.

118. Importantly, s 287 has been the focus of a previous inquest, where similarly a narrow view was taken of the section. A detailed analysis of the provision was

provided by State Coroner O'Sullivan in the *Inquest into the Death of Thomas Hunt* in 2020, an inquest known to CI Charlesworth. Concerns as to the interpretation of the provision and the need for legislative reform was raised at that time.

119. The public interest very much favours urgent resolution of the tension that exists within the NSW Police Force as to the proper construction of this provision, noting that DCI Browne disagrees with CI Charlesworth's approach to the provision. He considers that s 287 presents a low bar (a view also stated in the *Hunt* inquest matter); he also stated that in his view, risk and the imminence of it, increases over time.

120. Importantly, the construction of "about to happen" is not the only available meaning of "imminent": it can also mean, as a matter of ordinary language, "impending threateningly; close at hand in its incidence; coming on shortly" (per the Oxford English Dictionary); or "coming or likely to happen very soon" (per the Cambridge English Dictionary).

121. As the purpose of the provision is plain and that is to provide an 'emergency' exception to the ordinary 'privacy' constraints posed in relation to use of the information, the objective is a beneficial or remedial one. It is inconsistent with that purpose to construe it so narrowly; basic principles of statutory construction tend in favour of a broad construction. Moreover, as a matter of common sense there is obvious force in the proposition that where there has been no contact with a missing person for 5 days that any threat to the life or health of a person increases, particularly against the backdrop of pre-existing risk factors of mental health issues and previous threats of self-harm.

122. In this respect, there was a tension in CI Charlesworth's position of being unable to articulate what the parameters of imminent risk might be (that is – whether something stops being imminent after 24, 48 or 72 hours), and contending that it would "depend on the circumstances", yet also being very resistant to the notion that it was incumbent upon him to elicit relevant information. Certainly, the relevant State Coordination Unit procedures do not provide any such prescriptive guidelines (for example, that after 3 to 5 days, absent further information, there can be no imminent threat); instead, the emphasis is upon the need to obtain relevant information to inform the decision whether to triangulate.

123. CI Charlesworth was undertaking his role, and applying the law as he perceived it to be when he rejected the triangulation request. It appears he has informed himself of his obligations, and been provided with guidance by way of legal advice in the interpretation of section 287. It was apparent that he felt somewhat hamstrung by the wording of the section, and would prefer it to be relaxed so

he could provide more people with the use of triangulation. CI Charlesworth clearly also wants to see lives saved. He walks a tightrope in that role, providing a very useful policing tool while at the same time having regard to the considerations of personal privacy. He expressed his frustration in that position, and articulated the need for legislative change.

124. Listening to the recording, it did seem that in this case, CI Charlesworth was far too quick to form a negative view of the request. It appeared to be a case where he perhaps has forgotten the impact of a very senior and respected officer firmly shutting down a much more junior officer. He was commanding in knowledge and tone, and it was the case that I thought it impressive that the far junior officer was able to get out the information that he did. From the evidence I heard it seems the expectation of officers generally is that they will have difficulty obtaining triangulation, and as a result go into the request with low expectations. The exchange I listened to on this occasion was unfortunate.

125. It was also the case that the factors that the Chief Inspector should have explored according to the guidelines were not considered. The story was barely explained to him. He put the legal test to the officer, and was not interested in elucidating the full story.

126. The interpretation is also somewhat curious. The choice to make such a narrow interpretation is hard to understand from a legal perspective. Every single case will turn on its facts, but importantly it must turn on its complete facts, to be properly understood and analysed to be able to then apply the term “imminent”. This is protective legislation; this is lifesaving legislation. I agree with DCI Browne that imminence increases every moment that CD was not found. I found it concerning that one would distinguish Alzheimers from a vulnerable child, or for that point, a person suffering mental illness. They are all amongst the most vulnerable people in our community. The imminent threat was alive the moment CD walked out the door, and until he could be found and his mental state be confirmed safe, he remained at imminent risk.

127. All senior police, that is DS Daley, DS Capon, DCI Browne and CI Charlesworth, agreed that the decision whether to triangulate can be a matter of life and death. All promote the change of the legislative wording if that will improve the outcome to allow triangulation to occur much more readily.

128. It is also troubling that State Coroner O’Sullivan echoed these concerns two years ago, and there is an absence of evidence to suggest anyone has done anything about this. To have listened to all officers, senior, respected and currently performing their roles, saying that this change is long overdue is unacceptable. To hear CI Charlesworth say that he would dearly like to help

more people but feels he cannot due to the constrains of the legislation, is disappointing and concerning for the community.

129. CI Charlesworth was honest and open in evidence. He explained how he felt legally obliged to decline to triangulate in this case. He highlights the need for reform, and, in the interim, for further legal advice to be given to assist these officers performing their difficult role. He receives 15-20 such requests each day he works, approximately two thirds of those are directly from the police force. Potentially, with the success rate of triangulation, so many missing persons could be located quickly and potentially lives saved, also saving police resources, public money and family distress.

130. Submissions were helpfully made on CI Charlesworth's behalf indicating that the legislation is that from 1997, a lifetime ago in relation to electronic devices. Our information is out there, in the public domain constantly. Apps track our locations, the concept of privacy has changed considerably, as should the interpretation of the section, and the section itself.

Reform of s 287 of the Telecommunications Act 1997 and guidance as to interpretation of section

Commonwealth agency guidelines to assist with interpreting s 287 of the Telecommunications Act *1997*

131. On 29 April 2022, those assisting me wrote to the Commonwealth Deputy Secretaries of the Department of Infrastructure, Transport, Regional Development and Communications (**DITRDC**) and the Department of Home Affairs to provide a further example about how s 287 is being construed operationally, in the context of missing persons investigations. That step was taken with the consent of the NSW Commissioner of Police (whose legal representatives - it should be noted - have been extremely helpful throughout the entirety of the inquest). In response, a letter from Deputy Secretaries Richard Windeyer and Marc Ablong PSM noted:

> "DITRDC and Home Affairs recognise the need for greater clarity in the interpretation of section 287, and appreciate the difficult and complex nature of the circumstances relating to the disappearances of CD and Mr Thomas Hunt. A consistent and uniform understanding of this provision across Australian policing agencies would support considered and timely decision-making in future situations involving public heathland safety risks.
>
> A draft of this information sheet has been provided for feedback to Commonwealth, state and territory police forces, including NSW South Wales Police, through the Interception Consultative Committee (ICC). The ICC is a long-standing government consultative committee chaired by Home Affairs,

which is comprised of interception agencies, criminal law enforcement, and enforcement agencies. Once finalised, this information sheet will be distributed to police agencies and service providers. We would also be happy to share a copy of the finalised guidance with the NSW Department of Communities and Justice to help inform help recommendations that may be made as a result of the current coronial inquest".

132. The draft guidelines were not available for consideration during the Inquest hearing.

133. As noted above, the *Inquest into the death of Thomas James Hunt* (regarding a missing person investigation) squarely considered the operation of s 287 of the *Telecommunications Act 1997*. In her findings, State Coroner O'Sullivan noted:

> "I note the desirability advocated by DI Browne that s. 287 be interpreted more liberally so as to make way for a lower threshold to its use. One way this may be achieved is by a legislative change to the section to allow police to access telecommunications information of a person if police suspect (as opposed to believe) on reasonable grounds that the disclosure or use is reasonably necessary to prevent or lessen a serious and imminent threat to the life or health of a person. The most the coronial jurisdiction can do in that regard is to make comment directed to the Commonwealth that such an amendment is highly desirable so as to pave the way for a more consistent and accessible approach to s. 287 in missing person cases. Otherwise, I reiterate the comments made above that, in my view, it is open to police to apply a lower threshold to s. 287 so that proof of a missing person's intentions is not essential."

134. Relatedly, in 2010, the Australian Law Reform Commission (**ALRC**) made the following recommendation:

> "Sections 287 and 300 of the Telecommunications Act 1997 (Cth) should be amended to provide that a use or disclosure by a 'person', as defined under the Act, of information or a document is permitted if:
>
> (a) the information or document relates to the affairs or personal particulars
> (including any unlisted telephone number or any address) of another person; and
>
> (b) the person reasonably believes that the use or disclosure is necessary to lessen or prevent a serious threat to a person's life, health or safety."

135. Evidently, the ALRC recommended that the word "imminent" be removed and the word "safety" be added, effectively relaxing the triangulation threshold. Senior police who gave evidence at the inquest universally agreed with the need for urgent reform of s 287, including DS Daley, DI Browne and CI Charlesworth.

136. Legislative amendment is of course a matter solely within the province of Parliament. However, it is consistent with my death prevention role to highlight the urgent need for review given the current construction and operation of s 287 in the context of missing person investigations, as was highlighted by this Inquest and that of the *Thomas Hunt Inquest.*

137. Accordingly, a recommendation addressed to the Minister of Communications (Cth) regarding an urgent review of s 287 of the *Telecommunications Act* is noted below.

Adequacy of search conducted

138. Some of the criticism of the search was the issue of continuity, and communication with family or lack thereof. Having one person with carriage of the matter might have led to a very different search approach, and certainly from the early stages a different approach would have been expected.

139. As noted, on 27 and 28 June 2019, an area of Little Bay – namely, the corner of Jennifer and Harvey Streets – was searched by officers from the Central Metropolitan ODIN and Dog Unit. Detective Cigana stated that this area was:

> "… specifically targeted after CD's mother and CD's brother advised CD would possibly go running through this area also. CD's mother and CD's brother believe that this area would be a place CD would feel comfortable with, and also it was the belief he had slept the night her before he returned home on the morning of 17 June 2019."

140. The basis upon which this area was selected is not clear. Detective Cigana stated that he believed it was important to arrange a land search for CD, but that:

> "… we had no credible information to a specific area which made the determination difficult. CD's mother was unable to provide any specific location or information given that she did not know the area. CD's mother provided a possible location of Botany Bay National Park but couldn't narrow down a specific area, only noting this area as CD used to run through it prior to his back injury. CD's mother had no local knowledge of the area either given she resides in New Zealand."

141. Detective Cigana formed the view that CD's mother's identification of this area was "suspicious" (the meaning of which is a little unclear) because there was no other information suggesting that CD had frequented that particular area. On the second day of the search, he stated that he was "sceptical" as to how that location was nominated by CD's mother as it was "extremely dense, thick and impassable in certain [areas]". As Detective Cigana was not available to give evidence at the inquest, the precise basis for selection of this zone could not be further examined. The family – including CD's mother – had concerns about both the timing and scope of the search.

142. Senior Constable Adam Bateman was called to give evidence to assist with understanding as to how this zone was selected. The essential evidence he gave was that in this search (or request for assistance), he had no involvement in the identification of what area to search; he was just told by the investigator that this was an area the missing person used to frequent. Accordingly, he was instructed to execute the search in that zone. It follows from that evidence, that there was no independent assessment as to the utility or wisdom of that search zone.

143. It is clear from the evidence of DCI Browne and DS Daley, that there ought to have been an earlier coordinated land search, potentially involving the deployment of specialist resources (such as POLAIR and the Marine Area Command, and also drones).

144. I had the opportunity to attend the area CD disappeared, and the search zone, in the context of a view, led by the OIC, DS Daley, together with the team assisting me. The first question that comes to mind after seeing the search area is "Why?". The area is uninviting, almost impenetrable and doesn't lead anywhere in particular. Again, I cast no criticism on the searchers, they did a remarkable job with what they were given. However it was curious again why the expert, SC Bateman, was not consulted as to his views of the utility of the search in that area.

Reflections and concessions upon review of police investigation

145. The Commissioner of Police should be proud of the nature and quality of the reflections and concessions made by various officers regarding the deficiencies and shortcomings in the initial phase of the police investigation into CD's disappearance. Additionally and creditably, those officers indicated how the circumstances of this matter has impacted their approach to missing person investigations since that time.

146. The preparedness of those officers to proffer such concessions was of some solace to CD's family, and also served to truncate the scope and length of the

inquest hearing. I want to acknowledge the various concessions specifically. The loss of CD has made an impact, and he has brought change.

Detective Sergeant Anastasios Zervas

147. DS Zervas was an Acting Inspector and the Duty Officer for the Eastern Beaches Police Area Command from:

- 6am to 6.30pm on Sunday, 16 June 2019;
- 6am to 6.30pm on Tuesday, 18 June 2019;
- 6am to 6.30pm on Thursday, 20 June 2019; and
- 6am to 6.30pm on Saturday, 22 June 2019.

148. DS Zervas' reflections and concessions were to the following effect:

a. he could have made more communications with the supervisors during his shifts to follow up on what investigative steps were being taken to locate CD;

b. during the shift on 18 June 2019, DS Zervas could have queried why a triangulation had not occurred, and requested a triangulation; and

c. on 18 June 2019, DS Zervas could have informed a supervisor that a coordinated land search be organised and could have made inquiries with POLAIR, and conducted enquiries as to why a land search and the use of POLAIR had not yet been arranged.

149. As to his current practice for missing person matters, when managing or investigation 'High Risk' missing person matters as the OIC, DS Zervas now allocates tasks to specific officers through the eagle.i system. He also generally allocates tasks to a detective who has the required time to complete the tasks. This allows the officer to input data as to the progress of the task along with the end result, and enables oversight by supervisors.

Inspector Aaron Wunderlich

150. Inspector Wunderlich was the Duty Officer for the Eastern Beaches Police Area Command from:

- 6am to 6.30pm on Monday, 17 June 2019;
- 6pm to 6.30am, Tuesday, 18 June 2019; and
- 6pm to 6.30am, Wednesday, 19 June 2019.

151. Inspector Wunderlich acknowledged that this missing person case was recorded as ‘high risk’ on the Inspector’s handover document, and that he should have enquired as to the basis for that assessment and considered taking more action to locate CD.

152. On 17 June 2019, Inspector Wunderlich made the decision not to apply for a triangulation. However, as more time passed, he noted that it would have been appropriate to have made a triangulation request. This should have been done on 18 June 2019. He noted that a request for triangulation could also have been made on 17 June 2019.

153. After several investigative efforts to locate CD had failed, Inspector Wunderlich could have initiated a coordinated land search during the day shift on 19 June 2019, involving POLAIR, Water Police and a Search Coordinator.

154. Further, Inspector Wunderlich acknowledged that the issue in the inconsistency between the Sergeant’s handover and the Duty Officers’ handovers as to the level of risk (medium vs high) should have been identified and addressed.

155. Inspector Wunderlich now ensures that he makes thorough notes of what has occurred, and what should occur for follow-up on all missing person matters, particularly for medium to high-risk matters. He also noted that the new Missing Person SOPs have provided clarity over the risk assessment process and suggested actions.

Detective Sergeant Michael Capon

156. DS Capon gave oral evidence during the inquest. He was the Investigations Manager at Eastern Beaches Police Area Command, allocating the investigation to Detective Cigana on 21 June 2019; he is also the current Missing Persons Coordinator (under the new MP SOPS which commenced in 2020 and have been annually reviewed– see [171] below).

157. DS Capon made concessions to the effect that he ought to have challenged the triangulation refusal on 21 June 2019. As to lessons learned from this case, he thought that supervisors and duty officers needed to have a full understanding of what was happening, and not just leave it to constables to sort out. He considered the new MP SOPS have brought about a “massive improvement” in awareness. He proposed to use the circumstances of CD’s case as a case study to teach aspiring investigators (including in a training program with DI Browne as soon as next week).

158. DS Capon was a very impressive officer. His evidence was so helpful in this Inquest. Honest, raw and connected, he was able to give a practical opinion to

guide the Inquest and the ultimate recommendations. He was reflective of his own practices, insightful and committed to improvement of the process. In his view every missing person is a high risk, just by being missing, until proven otherwise by evidence. He encapsulated what the evidence promotes: it is the first crucial 48 hours that can change everything, take it seriously, give it resources and you are more likely to get results. It is little wonder that by DCI Browne he is recognised as one of the best Missing Persons Coordinators in the State.

Review of investigation by senior police

159. The coronial investigation and the Inquest hearing was greatly assisted by the comprehensive and candid review of the police investigation provided by DCI Browne (aspects of which have been noted above). A subsequent review by DS Daley – a highly experienced detective – was also very valuable. The respective opinions of those senior officers are summarised below.

Detective Chief Inspector Browne (Manager of the Missing Persons Registry)

160. DCI Browne opined that although SC Invernon undertook some of his responsibilities, other important functions were not undertaken, including:

    a. an initial risk assessment this should have been contemporaneously recorded in the COPS event and the Shift Supervisor should have reviewed the risk assessment; and
    b. an appropriate policing response to address the identified risks.

161. More should have been done to locate CD on the afternoon/evening of 16 June and on 17 June 2019, including the use of additional resources.

162. DCI Browne supported the 'high risk rating' determined by Acting Inspector Magee at 12.38am on 17 June 2019 based on information at the time. This rating should have generated an urgent response, and consideration given to all available tools and resources. Requests for assistance could then be submitted to specialist resource providers (State Coordination Unit for triangulation; Police Aviation Support Branch; Marine Area Command; Bomb & Rescue Unit (LANDSAR); and Police Media Unit). Local police resources should also be used for searching and canvassing (including CCTV).

163. At daylight on 17 June 2019, a coordinated and documented search program should have been commenced. In oral evidence, DCI Browne did not think this position was affected by the return of CD to his home between 4.30 and 7.20am that morning. A triangulation should have been requested to discover the location of CD's phone (noting evidence that the phone was ringing on 17 June

2019). Triangulation should be automatically used for all 'high risk' missing person investigations where it is believed the person has a mobile phone with them.

164. There appeared from the evidence to be an attitude that because CD returned home for a few hours, that therefore lessened the urgency to find him. DCI Browne's opinion was that his return home changed nothing. If anything, he was in a worse state in many ways than when he first left.

Statement of Detective Sergeant Peter Daley

165. DS Daley agreed with DCI Browne in relation to the risk assessment being incorrectly recorded and triangulation being sought. DS Daley also agreed with DCI Browne that a more coordinated response and search could have been conducted on the day CD was reported missing (on 16 June 2019) and continued throughout the following shifts using resources such as POLAIR and Rescue and Marine Area Command.

166. DS Daley considered that the complex factual presentations in this case plainly meant that CD was in the high risk category, namely: the emails sent by CD's mother on 9 and 17 June 2019 expressing concern for her son; the fact that CD's mother had flown from New Zealand to take care of her son; CD's recent threats to jump from a cliff or overdose on pills; his marriage breakdown and financial issues; his arrest for DV offences; his separation from his wife and child; and his paranoia. DS Daley thought that this combination should have raised alarm bells for police.

167. On that basis, in DS Daley's view there were sufficient grounds on 16 June 2019 to request a triangulation of CD's phone, as it was reasonably necessary to prevent or lessen a serious and imminent threat to his life or health.

168. DS Daley referred to the current procedures in response to missing person cases, and noted that:

- high risk matters are allocated to detectives, as they have the time and resources to coordinate an appropriate response;
- the new MP SOPS have played a major role in assisting police progress and investigate missing persons in a timely and logical manner;
- since the introduction of those SOPs, there has been a greater emphasis on escalating and prioritising missing person cases. Duty officers and supervisors are aware of their responsibilities and the daily checks to ensure the necessary resources are assigned in a timely manner.

Summary of shortcomings in police investigation

169. Given the totality of the evidence there were significant deficiencies in the police investigation summarised as follows:

    a. Risk assessment processes and procedures were not adhered to:

        i. a formal risk assessment was not completed upon receipt of the missing person report, but two days later;
        ii. it was not completed on the COPS system and an outmoded Sutherland LAC Risk Assessment Guideline document was instead used and completed erroneously;
        iii. nor was there any 'ongoing' risk assessment as new information was received;
        iv. risk assessment ratings were inconsistent, ranging from 'High', 'Medium' and 'Low'.

    b. A formal risk assessment should have led to CD's disappearance being rated as 'High' given:

        i. CD's recent threats of self-harm, as made both to his family and to police;
        ii. CD suffering from mental health issues (both diagnosed and undiagnosed), and having recently been scheduled and admitted to POWH;
        iii. CD's behaviour being out of the ordinary and uncharacteristic, him being described as paranoid;
        iv. CD's relationship breaking down and him facing domestic violence charges and a Court date;
        v. CD having business and financial issues;

    c. The 'High' risk rating should have informed a commensurate police response, including greater urgency to find CD, and consideration as to the availability and deployment of specialist police resources.

    d. A triangulation request ought to have been made on 17 June 2019 (at least), given the phone was apparently ringing that evening.

    e. There was no proper or coordinated land, air or sea search using the available police resources, which should have included earlier use of drones and the police helicopter.

    f. The search conducted on 27 and 28 June 2019 was too late, and focused on a narrow and doubtful zone of interest.

g. There was no proper or coordinated canvassing of the Little Bay area (including neighbours).

h. There was no proper search of CD's home.

i. There was a lack of continuity and direction in the investigation whilst general duties had carriage of it – there was no officer with ownership in the investigation or the capacity to progress it; nor did SC Invernon have sufficient expertise or experience to conduct a high risk MP investigation.

j. There was generally poor communication and support for CD's family during the investigation and a lack of any 'family liaison' contact point. This was deeply upsetting and frustrating for the family, who felt particularly helpless given they had flown over from New Zealand. It is commendable that certain officers deeply reflected on their involvement in the police investigation, and sought to learn lessons from the failings identified above.

CHANGES TO NSWPF MISSING PERSONS STANDARD OPERATING PROCEDURES

170. The situation has changed since CD disappeared. Improvements have been made to counteract some of the deficiencies in this case.

171. At the time of CD's disappearance on 17 June 2019, the 2016 MP SOPS were applicable to the police investigation into his disappearance. On 1 January 2020, the new Missing Persons SOPS were introduced. There have since been two further updates to the NSW Police Force's Missing Persons SOPS (2021 and 2022). DCI Browne is currently drafting the 2023 MP SOPS. The relevant changes to the SOPs have been helpfully outlined by DCI Browne in both his statement, and also his oral evidence. Those changes are comprehensive and constructive.

172. DCI Browne currently manages the Missing Persons Registry (**MPR**), which commenced operation as a unit within the State Crime Command on 1 July 2019. The MPR is currently a team of 16 people that reviews an average of 28-35 missing persons reports per day.

173. As to recent changes to the risk assessment process, DCI Browne explained:

> "Under the current SOPS, a risk assessment is part of the OIC's initial response… The risk assessment tool for missing person matters is now embedded into the COPS system and is an automated process (rather than a

physical word document)… Included in the risk assessment are specific questions for officers to address."

174. In terms of CD's disappearance, an automated risk assessment tool would have ensured that a formal risk assessment was conducted upon entering information into the COPS system on 16 June 2019. That risk assessment would have been conducted in accordance with up-to-date policies. This a very important new change.

Triangulation and related tools

175. As to updated guidelines or advice regarding grounds for triangulation, DCI Browne noted that police officers are still expected to conduct at least a basic investigation before requesting triangulation. However, DCI Browne also stated:

> "Chapter 18.2 of the [2021] SOPs provides a list of examples that may justify use of triangulation which include:
>
> - The missing person has made actual or implied threats of self-harm;
> - The missing person has a history of self-harm although has not made threats in this instance;
> - The missing person has not made threats of self-harm and has no history of self-harm but is known to have serious mental health issues or mental health issues that have escalated in recent times resulting in serious concerns for their safety…".

176. These examples are also referred to in the State Coordination Unit operating procedures (as noted above). In addition, the 2022 MP SOPS state:

> "If deemed high-risk, consideration should immediately be given to utilising triangulation of a mobile telephone if applicable (See Chapter 17.3), the use of Live CAD (See Chapter 17.8) and geographic targeting of SMS messages (See Chapter 20.2)."

177. This aligns with the opinion of DCI Browne, as noted above. For completeness, Live CAD is described in the 2022 MP SOPS as follows:

> " 'CAD' is near to real time telecommunications call records. Section 287 of the *Telecommunications Act 1997* (Cth) also allows for the use of 'Live CAD' to assist in the location of Missing Persons if there is an imminent risk to the life or health of a person.
>
> Data obtained from the use of 'CAD' can include the time and date of activation of the telecommunications device, whether those activations consist of incoming or outgoing calls, and cell tower location. The data can also include

> the type of activation (e.g. phone call A and B Party, SMS and internet access). The data does not include the content of communications."

178. Further, 'geographic targeting of SMS messages' means that the NSWPF can send SMS messages to all devices within a defined geographical area to assist high-risk missing person investigations. DCI Browne has explained that "the message would generally include a brief description of the missing person and details of how to report any sighting." In oral evidence, DCI Browne told the Court that this method has been incredibly successful to date with a 60% success rate.

179. The 2022 MP SOPS also provide guidance for submitting emergency requests via Facebook/Instagram, Google, Apple and Twitter, amongst other social media platforms. This enables police to access data collected by those companies in relation to the missing person. For example, Facebook and Instagram collect data relating to:

> "…device attributes (signal strength, battery level, operating systems), device operations, identifiers (device IDs, games, apps), device signals, data from device settings, network and connections (IP address, time zone) and cookie data."

180. These are useful alternatives to triangulation. Ultimately of course, the extent to which they may have assisted the investigation into CD's disappearance is simply unknown.

Consideration of utility of new technology for use in investigation

181. Finally, it is noted that DS Daley revisited the issue of whether all available technological avenues had been pursued in relation to CD's disappearance. Given that the various methodologies cannot be used retrospectively, unfortunately, no new lines of inquiry were available.

Family liaison officers

182. In oral evidence, DCI Browne also noted in response to questioning as to concerns by CD's family about the lack of a family contact point, that the MPR had recently introduced new training for formal liaison officers (**FLOs**).He explained that there would need to be enough officers trained within each Police Area Command to make it effective there would be multiple FLOs.

183. DCI Browne is a dedicated and impressive officer, who has brought extensive change to the world of missing persons. He is making a difference, together with his team. No criticism can be made of his continual updating and upgrading

of the MP SOPs; quite to the contrary, he is constantly looking to improve the system to find our missing people.

184. Yet it must be acknowledged that this reform is cold comfort to CD's family. It comes too late for CD.

RECOMMENDATIONS

185. Having regard to the evidence set out above, the following recommendations are both necessary and desirable, in accordance with s 82 of the Act:

1. That the Commissioner of Police of the NSW Police Force review the Missing Persons Standard Operating Procedures 2022 (Version 3.0) to clarify, state or otherwise include reference to the following matters:

    a. That the first 24 to 72 hours of a missing person investigation are usually the most critical, particularly so for missing persons in the high-risk category; during this period, continuity and intensity in the investigation are important;

    b. For high-risk missing person investigations, consideration should be given to immediate allocation of the investigation to an investigator (a designated Detective) with capacity to provide continuity and expertise for the critical 24 to 72 hour period (rather than General Duties officers);

    c. In relation to triangulation procedure (Chapter 17.0):

        i. Requests for triangulation should be made by a Duty Officer or Supervisor (except in remote areas); and

        ii. If a request for triangulation is declined - there is a review procedure pursuant to which the Duty Officer or Supervisor can escalate the matter (and specify that procedure);

    d. In Annexure A – 'Initial Response – Missing Persons Checklist', reference to canvassing the area/last place the missing person was seen for witnesses (for example, street neighbours).

2. That the Minister for Communications (Cth) be provided with the findings from this inquest and the evidence of Chief Inspector Gary Charlesworth, together with the findings in the *Inquest into the death of Thomas James Hunt* (dated 4 September 2020) regarding issues as to the interpretation and practical operation of s 287 the *Telecommunications Act 1997* in relation to missing person

investigations, with a view to considering urgent reform of that provision, including as to whether to:

a. remove the qualifier of an "imminent" threat (consistent with the Australian Law Reform Commission Report 108 (2010), Recommendation 72-7); and

b. change the requirement of 'belief' to 'suspicion'.

3. That the Commissioner of Police of the NSW Police Force:

a. be provided with the transcript of the evidence of CI Charlesworth in this inquest; and

b. give consideration to obtaining an urgent advice to provide authoritative guidance to the NSW Police Force as to the construction of s 287 of the *Telecommunications Act 1997* (including for example from an appropriate senior counsel or from the Crown Solicitor's Office), in light of the remedial purpose of that provision and noting evidence that the decision whether to triangulate can be a matter of life and death.

Evidentiary basis for recommendations.

186. These recommendations are made after hearing from impressive, senior, committed members of the NSW Police Force who are dedicated to making our State a safer place. They consistently want to guide and train new and upcoming officers to make the job streamlined and workable when it comes to dealing with missing persons.

Support for Recommendation 1(a)

187. There was general agreement amongst all police called, including DS Daley, DS Capon and DCI Browne, that the first 24 to 72 hour period is critical during a missing person investigation; further, that during this period, continuity and intensity in the investigation is important. That matter is not explicit in the current 2022 MP SOPS. There is merit in making it clear.

Support for Recommendation 1(b)

188. The evidence in this case indicated that generally there was a lack of responsibility, ownership or direction in the initial investigation into CD's disappearance. CD's case was passed between general duties officers across a number of shifts, with no real escalation in police effort nor any clear plan or direction. This occurred during the critical period, when it might be thought there is a higher window of 'solvability'. Relatedly, a key theme to be drawn from the

evidence is that general duties officers with many demands on their time as first responders are not well placed to investigate missing person matters.

189. Missing person investigations, and particularly those assessed as high risk, by their nature, require intensity and continuity. Moreover, the initial phase of such investigations – that is the 24 to 72 hour period is a critical period which may ultimately determine the success of the investigation. General duties officers are very poorly placed to undertake such investigations; nor do they have the requisite investigative training.

190. DS Daley agreed with the proposal to have a detective assigned.

191. DS Capon agreed with the notion that continuity and intensity is important in a high risk a missing person investigation; he also agreed that the first 24 to 72 hours is critical, and that you want the best people on the job during that time. However, he did not accept that detectives should always take on such cases, pointing out that detectives do not work 24/7 (in contrast to a duty officer and supervisor). He agreed that detectives have caseloads to juggle, and that requiring them to take high risk missing persons investigations might cause them to lose focus in other areas. In his view, supervisors are now more educated on missing persons urgency and believes that is a matter that has improved. He thought it was very difficult to say that every case should go to the detectives and rather, it has to be decided on a case by case basis.

192. His view has been the reason why it is accepted that only consideration should be given as to whether to hand it over. The value in consideration, however, is powerful: asking the question “should I hand this on or should I keep this?” creates a state of ownership which is much needed in these cases.

193. The issue of turning one’s mind to, or considering a detective, is consistent with DCI Browne’s evidence. He stated that in the current version of the MP SOPS, it is proposed that MP investigations go to a criminal investigator after 5 days, instead of the existing provision which provides for 4 weeks. His rationale for that was “in my experience, there are better results when [cases] go to criminal investigators quicker”. There will be exceptions, as he indicated for example in country locations, like Byron Bay police station, where there is only one detective in the office a few days a week.

194. Under examination from Ms Mahoney, DCI Browne reiterated his view that detectives achieve results quicker given the immediacy and reactive work in general duties. General duty officers for example, may start to write an MP report, and then get called to a DV matter, whereas an investigator is less likely to be distracted on shift. However, he also agreed that requiring investigators to take on high risk MP matters may detract from other investigations.

Support for Recommendation (1)(c) and (d)

195. As to Recommendations (1)(c) and (d), they were supported by DCI Browne's evidence .

Support for Recommendation (2)

196. In relation to Recommendation (2) – the evidence was highly concerning as to the manner in which that provision is being interpreted by senior police within the State Coordination Unit.

197. The need for potential amendment of s 287 and the "serious and imminent" threshold test requires urgent consideration. The necessity for such reform was supported by all senior police who gave evidence during the inquest, albeit that DCI Browne noted that his concern is primarily with the interpretation of the provision within the State Coordination Unit. It was again a privilege to be in the room while the evidence was given. I watched the faces of impressive and experienced on the job officers deflate at the thought that CD was still not considered eligible for triangulation at the point at which it was asked for, and that even in hindsight on the facts of this case the rejection of the request for triangulation would remain the same.

198. There was also the frustration of CI Charlesworth, who felt compelled to reject the application given the interpretation that has been promoted within the State Coordination Unit. There is no criticism of him made; he is trying to do his duty according to law, and advice has led him to form a certain view of how that duty is to be exercised.

Support for Recommendation (3)

199. Recommendation (3) is posed as a pragmatic measure that might be taken with urgency, with a view to addressing the very narrow construction ostensibly applied to s 287 by the State Coordination Unit. The suggestions as to the source of the proposed advice are provided by way of example only, but with a view to ensuring the requisite authority attaches to such advising. This is an important recommendation, which will take little time to obtain and hopefully begin the saving of lives quickly.

200. In summary - these recommendations are made to support the officers who gave of their time to the Inquest and themselves identified areas for change. They are also made for the family and in memory of CD, to improve future practice.

ACKNOWLEDGEMENTS

201. The first recognition needs to go to the family of CD, who participated in the investigation and proceedings. The family provided the Inquest with necessary insight into the life of CD. They are family to be admired, dropping everything, coming to Australia to try and save his life. They conducted themselves with dignity through this difficult process, and wanted to make our system work better, for those who have a future need. I thank them for all they have done. A special mention to his wife and son who will find these proceedings so very difficult.

202. The second is to the Officer in Charge – DS Peter Daley. His management of the matter was extraordinary. Having come into the matter late, he has quietly absorbed a huge amount of material and completed an enormous investigation (even undertaking ongoing inquiries during the Inquest, as they arose). He has given the family confidence, I am sure, to understand that no stone has been left unturned by him in trying to locate any sign of CD. I also had the privilege of watching him interact with the family in the proceedings, observing him give them support and comfort. I extend my gratitude to a very fine officer who brought a very empathetic touch to the proceedings which was much needed for the family.

203. To all the officers who gave statements and provided insightful and sometimes difficult evidence. It is not easy to admit mistakes in front of a grieving family in open court. It is a credit to them that they were of such character that they could do so.

204. To the legal representatives for the NSW Commissioner of Police and for the Chief Inspector for their helpful and sensitive approach to the proceedings. We all want to see change and improvement and that is only possible if the representatives are also committed to that outcome, which they were. It also saved the need for many witnesses to be called, and a narrowing down of the real issues to be carefully considered. Although I have had less interaction with these representatives, I want to particularly recognise them in assisting in achieving what are hopefully positive reforms.

205. Finally, to the team I was assisted by Mr Musico, for his commitment, dedication and compassion. I was regularly provided with detailed updates of important matters, and greatly appreciated his assistance. To Ms Sullivan I also extend my thanks. Her hard and thorough preparation and work undertaken was evident in every aspect of her role. The Inquest could not have come to such a useful and hopefully productive outcome had I not had the quality of her assistance.

FINDINGS REQUIRED BY SECTION 81(1)

206. As a result of considering all of the documentary evidence and the oral evidence heard at the Inquest, I am able to confirm that the death occurred and make the following findings under section 81 of the Act in relation to it:

Identity of the deceased:
The person who died is CD.

Date of Death:
On or after 17 June 2019

Place of Death:
Based on the evidence the place of death cannot be determined.

Cause of Death:
Based on the evidence the cause of death cannot be determined

Manner of Death:
Based on the evidence the manner of death cannot be determined.

FINAL REMARKS

207. To the family and friends of CD, I offer my sincere and respectful condolences for the difficult loss.

208. I close this inquest.

Magistrate E Kennedy
Deputy State Coroner
16 September 2022