CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Darren Higgins
Hearing dates:	7-11 November 2022 7 February 2023
Date of findings:	3 March 2023
Place of findings:	Lidcombe
Findings of:	Magistrate Kennedy, Deputy State Coroner
Catchwords:	CORONIAL LAW – Cause and manner of death, missing persons, cross border police communication in missing persons, interstate search for missing persons, mental health, mentally ill person, missing persons search across border, involuntary patient, false reported sightings and impact on search, use of ACLO in missing persons, communication with First Nations family and community during a missing persons search, risk assessments of location suitability in the granting of leave for mentally ill persons
File number:	2017/270415

Representation:	**Mr P Aitken, Counsel assisting, instructed by Ms R Muniz and Ms S Crellin (Crown Solicitor's Office)** **Mr De Brennan Counsel for the Commissioner of New South Wales Police instructed by New South Police, Office of the General Counsel.** **Ms Hodgson Counsel for the Chief Commissioner of Victoria Police instructed by Maddocks** **Ms McFee Counsel for Bendigo Health instructed by MinterEllison** **Ms Mendes Counsel for Emily Higgins, instructed by D Captain-Webb of Legal Aid NSW.**

Findings:	***The identity of the deceased*** The deceased person was Darren Higgins ***Date of death*** *Between 11 and 12 February 2017* ***Place of death*** Moira State Forrest, Barham, New South Wales ***Cause of death*** The death was caused by Dehydration with contributory causes of severe mental health conditions and hyperthermia ***Manner of death*** Misadventure
Recommendations:	To the Commissioner of Police, New South Wales AND to the Commissioner of Police, Victoria: a. To give consideration to developing a memorandum of understanding between the two Police forces, applying to circumstances where a person goes missing in a border region adjacent to the Murray River in either New South Wales or Victoria AND that person is considered by either a New South Wales or Victorian missing person risk assessment to be a high risk of misadventure or death if not located as soon as possible, addressing: b. the exchange of information obtained by each Police force in relation to that person; and c. co-ordination between the two Police forces of search and investigative resources, where feasible;

	d. In addressing point (a) above, to consider including as part of that information exchange process, a requirement that an officer of Inspector level or higher in each relevantly adjoining New South Wales and Victorian local regional command have direct oversight of the information exchange; and that the officer in charge of the New South Wales missing person investigation and their Victorian counterpart immediately liaise and continue to directly liaise as part of that information exchange; e. To consequently update the relevant NEW SOUTH WALES and Victorian Missing Persons Standard Operating Procedures and Polices should any of proposed recommendation 1(a) and/or (b) be implemented; f. To give consideration to identifying in such Standard Operating Procedures and Policies (as referred to in (c) above) how an Aboriginal Community Liaison Officer may be used to help provide a culturally safe context when dealing with families and relevant extended kin of a missing First Nations person, including when obtaining information to assist in a missing person investigation and when conducting a land or water search. 2. To the New South Wales Commissioner of Police: a. To give consideration to arranging and offering currently available New South Wales Police training, in cultural safety and cultural awareness when dealing with First Nations persons, to officers within the New South Wales Missing Persons Unit. 3. To the Chief Psychiatrist, Department of Health Victoria

	a. That the medical evidence of Dr Mathew, Dr Eagle and Dr O'Neill together with the Bendigo Health medical records, statements of treating medical practitioners and practitioners be forwarded for consideration as to whether arising from this matter there should be a review of policy, forms or procedures in respect of the grant of extended leave to involuntary patients.

The Coroners Act 2009 (NSW) in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

INTRODUCTION

2. It is important to reflect on the person that Mr Darren Higgins was. He was only 25 years of age when he died. The following is a summary of the factual background, before turning to the specific facts of the matter, analysis of evidence finally followed by recommendations and formal findings.

Outline of this inquest

3. Darren was a much-loved son, nephew, brother and friend. He loved to sing and dance, had a sense of humour and above all he loved his family. He was a proud Wiradjuri man with strong connections to the Yorta Yorta nation. He was educated in Echuca at Echuca South Primary School and then Echuca College High School. He left school and spent some time with the Baroona Healing Centre and later worked with the Njernda Cooperative and the Moama Local Aboriginal Land Council. He was talented and had a respectful nature and was able to connect with many within his community.

4. Darren was also one of the most vulnerable among us. He was suffering from schizophrenia and was treatment resistant. He was also suffering with a long-term substance abuse disorder. As a result of his psychological health he was found to be a mentally ill person. This led to his involuntary detention in Victoria. This meant that he lost his freedom to make choices for himself. Just prior to his death a decision was made by health care providers to allow Darren weekend leave from the facility where he had been involuntarily detained for approximately 12 months.

5. Darren's psychological diagnosis meant that he was someone who was often psychotic, he was difficult for the staff at the psychiatric facility to manage, prone to outbursts and sometimes very defiant, all symptoms of his unwellness.

6. It was decided to allow him to spend the weekend away with his mother and a family friend, Pastor Day. Pastor Day is a respected elder, well known and familiar to Echuca Police. He held recognised social justice roles in the community and had experience in assisting in such situations as this, and he was well regarded and well connected in relation to access to community resources. He had access to Njernda personnel and services. He was also very well-liked by Darren.

7. It was however decided that Darren was not allowed to return home to his beloved hometown Echuca, because too much concern existed over his desire to obtain illicit substances and going home would enable him a better chance of obtaining these.

8. Instead, a plan was put in place that they would initially go to one caravan park which then changed later to allow him to attend Mathoura, a border town on the river, backing onto a national park. There were limited resources for access to mental health care in the area. Darren's mother did not have the support of community around her in that area, nor was she well-resourced to obtain assistance if she needed to. She had no medical or other training to assist her in managing Darren's psychological condition.

9. In the days leading up to his planned leave staff raised some concerns about Darren and his ability to attend on leave. This was raised with his psychiatrist Dr Mathew who decided to grant the leave nonetheless. Dr Mathew was not informed of the ultimate location of his intended leave.

10. Darren did not last very long on the leave. When they arrived at Mathoura he almost immediately absconded and had to be located. A phone call was made to the institution from where he had been granted conditional leave, still being subject to the involuntary order. After being spoken to by a staff member he agreed to stay

with his mother. He then abruptly went and retrieved his belongings and told his mother he was leaving, jumping in the water and swimming back to the Victorian side of the river. She watched him go, she could not swim herself.

11. He was immediately reported missing to both Victorian Police and New South Wales Police. Victorian Police very quickly resourced a full-scale search for him the next day on 11 February 2017.

12. In the meantime, at a nearby caravan park Darren was witnessed swimming back to New South Wales, walking out of the water and wandering off. The following day when Victoria Police Airwing was canvassing the area a caravan park owner who had seen him return to New South Wales the previous day called the Echuca Police and reported that a person had come out of the river wearing only underwear and a singlet, and sounded like the person that they were in the air searching for. She was told that she should contact New South Wales Police. She did so. This evidence was explored at inquest. No statement was taken from her until 28 February by New South Wales Police.

13. By 8 pm on 10 February representatives from both New South Wales and Victoria had received a report that Darren was missing. New South Wales determined that as he was last seen swimming over and exiting the river in Victoria, and so therefore this was a Victorian Police missing person investigation.

14. An extensive search was conducted in Victoria, however even given the reported sighting back in New South Wales on the day he went missing it took ten days for the matter to be transferred to New South Wales Police. No search was conducted in New South Wales until 3 March 2017 being 20 days after Darren first went missing. That search commenced at 8.40 am with a briefing to the searches and concluded at 1 pm.

15. Darren was found deceased by a witness collecting firewood on 2 September 2017, and on 3 September Police went in to collect his remains and some clothing however

that search was cut short due to sudden flooding. DNA confirmed that Police had located the final resting place of Darren. Further attempts were made to organise a more thorough search and this did occur but not until 5 April 2018 when further remains were located.

16. This inquest considered issues important to Darren and his family about the subjective experience had by them in trying to locate Darren and bring him home. There were wider issues for the community and in particular border town missing persons issues. Communication between New South Wales and Victoria Police was considered together with the attitude and treatment of a young man who was a mentally ill person and therefore, by definition, unable to safely make decisions for himself.

17. The issues for consideration in this inquest involve determining the date, place and cause of death, including the following issues:

    <u>As to the manner of his death</u>:

    a. The appropriateness of the decision to grant Darren escorted leave from Vahland House at the Alexander Bayne Mental Health Facility, including whether a further risk assessment should have been conducted shortly before allowing Mr Darren escorted leave from Vahland House.
    b. The adequacy of the search for Darren conducted by the Victoria Police.
    c. The adequacy and timing of the handover of the search responsibility from Victoria Police to New South Wales Police.
    d. The adequacy of communication between Victoria Police and New South Wales Police, including during the initial week of the search.
    e. The adequacy, timing and co-ordination of the New South Wales Police search for Darren, including whether particular measures, such as cultural training, education and community engagement, be capable of improving New South Wales Police response to missing First Nations people.

Matters arising under s. 82 of the Coroners Act 2009:

f. Whether any of the above matters reveal inadequacies or deficiencies in training, policies or guidelines such that recommendations pursuant to s. 82 of *the Coroners Act 2009* (NEW SOUTH WALES) would be considered necessary or desirable.

18. Darren at the time was subject to an inpatient treatment order, made by the Victorian Mental Health Tribunal. The Victorian mental health legislation (the *Mental Health Act 2014*) provides that:

> S 10(1)(b): to provide for persons to receive assessment and treatment in the least restrictive way possible with the least possible restrictions on human rights and human dignity
>
> S 11(1)(a): persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred;
>
> The Victorian *Mental Health Act* also provides at s 11(1)(h) that:
>
> Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to.
>
> Leave of absence is provided for in s 64, which does not appear to place either time or geographic restrictions on such leave and provides as follows:
>
> s64 Leave of absence with approval
>
> (1) Subject to subsections (2) and (3), an authorised psychiatrist may grant a leave of absence from a designated mental health service to a person who is subject to an Inpatient Assessment Order, Inpatient Court Assessment Order, Inpatient Temporary Treatment Order or Inpatient Treatment Order—
>
> (a) for the purpose of receiving treatment or medical treatment; or
>
> (b) for any other purpose that the authorised psychiatrist is satisfied is appropriate.
>
> (2) The authorised psychiatrist may grant a leave of absence for any period and subject to any conditions that he or she is

satisfied are necessary or vary the conditions or duration of the leave of absence—

(a) having regard to the purpose of the leave; and

(b) if satisfied on the evidence available that the health and safety of the person or the safety of any other person will not be seriously endangered as a result.

(3) In determining whether to grant a leave of absence to a person, to grant a leave of absence subject to conditions or to vary its conditions or duration under this section, the authorised psychiatrist must, to the extent that is reasonable in the circumstances, have regard to all of the following—

(a) the person's views and preferences about the leave of absence and the reasons for those views and preferences, including the recovery outcomes that the person would like to achieve;

(b) the views and preferences of the person expressed in his or her advance statement;

(c) the views of the person's nominated person;

(d) the views of a guardian of the person;

(e) the views of the person's carer, if the authorised psychiatrist is satisfied that the decision will directly affect the carer and the care relationship;

(f) the views of a parent of the person if the person is under the age of 16 years;

(g) the views of the Secretary, if the person is the subject of a family reunification order or a care by Secretary order.

The factual background

19. Counsel Assisting helpfully set out the factual matrix in submissions, the chronology of events being mostly agreed by all interested parties, and are extracted in part below.

20. Darren had a long history of schizophrenia and polysubstance abuse possibly related to self-medicating for his serious medical condition. He first experienced psychosis at a very young age. He had been an involuntary inpatient at Vahland House on and off since 24 June 2016 when the Victorian Mental Health Tribunal imposed an

Involuntary Treatment Order. Before that, he had had multiple admissions to inpatient units since 2013. He had been admitted to the Adult Acute Unit in 2015 and trialled with olanzapine and paliperidone but still had behavioural difficulties and was trialled on clozapine and transferred to the Secure Extended Care unit, Vahland House in February 2016.

21. Whilst Vahland House was a secure unit, Darren had leave for supervised walks regularly and gradually was given leave to spend time with his mother. On 4 May 2016, an attempt was made to discharge him to the care and supervision of Echuca Community Mental Health Services, however due to non-compliance with medication and use of amphetamine, he was re-admitted to the acute adult unit two weeks later.

22. Darren was transferred back to the secure unit on 24 June 2016 and managed to settle his behaviour. Abilify was added as a medication which at the time was reported as having controlled his illness, with only residual symptoms. After this improvement he was again allowed to use escorted leave with staff for recreational purposes. Darren expressed intense desire to be with his mother and to be released back into the community. He was taken by an Aboriginal service in Bendigo to spend time with his family, but was then very reluctant to come back.

23. On two occasions during escorted leave with his mother in December 2016, Darren absconded however, and was brought back by Police. Darren did not like being an involuntary inpatient and in January 2017 after a court appearance he even expressed a desire to be sent to prison instead, reportedly so he could more readily access illicit drugs. Darren was also very agitated that he couldn't be with his extended family. On 23 January 2017 he cut both his cubital veins and required emergency management.

24. On 31 January 2017, Dr Teslin Mathew, consultant psychiatrist and treating doctor at Bendigo Health Care Group examined Darren, and he told her that he wanted to go home. He was happy about a plan for leave that was discussed. He reported still

hearing ongoing voices, but they were less intense. His insight was described by Dr Mathew as 'partial'. Darren was repeatedly counselled about the need to take medications and remain under supervision while on leave with his family. The notes of that date indicate an intention to obtain some leave for Darren to go to Echuca, Victoria to 'relieve some of the agitation and tension'.

25. On 7 February 2017, a discussion took place between Ms Higgins, Darren and Pastor Day where the option of Darren taking three days of leave under their supervision was discussed. The aim of this leave was to support a gradual transition back into the community, where he would be in contact with his own culture and extended family. It was discussed whether his mother, Ms Emily Higgins, would have capacity to support Darren at Echuca given his desire to acquire illicit substances, and it was suggested by Njernda Aboriginal Corporation that they stay at a resort motel in Moama on the Murray River. There were plans to take part in a healing ceremony. Plans to progress the leave for 10 February were put in place.

26. On 7 February, Darren was assessed by a psychiatric registrar, Dr Tim Vandenberg, who noted that Darren felt people in the afterlife were wanting to kill him. Darren asked to see a psychiatrist and was more agitated. As a consequence, he was given an injection of 50mg Acuphase.

27. On 9 February 2017, Dr Mathew assessed Darren to be very settled and calm and looking forward to his leave the next day.

28. In the clinical note of Nicole Davis, Acting Nurse Unit Manager dated 9 February 2017, concern was expressed that Darren was having leave over the weekend for a number of reasons, including the fact that he was expressing a desire to return to prison to access ice and heroin. There was also concern that there would be a lack of on call psychiatric services available on the weekend, should they be required.

29. Dr Mathew was made aware of this information and confirmed that the leave should go ahead. A clinical concern about going to the resort that was planned was also

considered, as a ski racing festival on that weekend nearby raised the possibility of further stimulation, and possible increased risk of drug exposure. Separately, it appears that all accommodation was booked out. It is not entirely clear what were the ultimate reasons for choosing Mathoura. Pastor Day was also made aware of this information and confirmed that leave could go ahead at a caravan park at Mathoura. There was a note about an alternate plan for Darren to take the leave in Bendigo instead of the Murray River so that he remained in close proximity to Vahland House in Bendigo and could easily return should the need arise. This was to be revisited on 10 February 2017 but it does not appear that this occurred.

30. Darren was ultimately permitted the three day escorted leave with his mother and Pastor Day. On Saturday afternoon 10 February Darren attended Picnic Point Caravan Park, Mathoura, New South Wales with his mother and Pastor Day. After checking into the caravan park around 5:00pm, Darren went for a walk with his mother and Mr Day to the edge of the Murray River and then returned to the cabin. Darren became agitated, saying that he would rather be in Echuca with his Aunt Louise and Uncle Roy who lived there.

31. That day the temperature had reached over 40 degrees. Weather readings from Deniliquin airport show that it reached 44.9 degrees at 4.30pm. By 8.30pm on the 10th it was still 36.9 degrees, passed below 30 degrees at 1.00am and got to a low of 26.1 degrees at 6.30am the morning of the 11th. The temperature on the 11th peaked at 41.8 degrees at 4.30pm.

32. Darren told his mother that he wanted to walk to the shop. His mother asked him to wait for her while she went inside the cabin to get something but when she came out Darren had left. Ms Higgins and Mr Day drove out of the caravan park along Picnic Point Road towards Mathoura in search of Darren. A witness observed Darren walking along the side of the road. That witness informed Ms Higgins of this sighting and Ms Higgins and Pastor Day successfully located Darren.

33. Once finding him, Pastor Day phoned Mr Martin Cliff, a nursing staff member at Vahland House. Nurse Cliff gave evidence that he spoke to Darren and advised him that he needed to stay with Pastor Day and his mother and not go to Echuca. Darren agreed. Despite this, Darren again stated that he wanted to see his Aunt Louise, so Pastor Day agreed that he would the next day drive to Echuca and bring his Aunt Louise to Picnic Point.

34. At about 7:30pm, Darren went inside the cabin and came out holding a plastic bag with his tracksuit pants, shirt and shoes and stated "I'm going" before proceeding to walk to the edge of the Murray River. Ms Higgins reports that when he left, Darren did not have a wallet or any money with him. Darren got into the river and swam to the Victorian side before walking into the bush. He entered the Barmah Forest, part of the traditional lands of the Yorta Yorta Nation. At about 7:50pm, Ms Higgins phoned triple zero for assistance and reported Darren missing and at about 9:00pm, Pastor Day used his boat to look for Darren along the river. Ms Higgins and Pastor Day then drove to Echuca, searching the roads for Darren until the early hours of the next morning.

35. A witness, Mr Cotton, observed Darren get out of the Murray River at about 6:30pm on the Victorian side of the river. Given the time of the 000 call made by Darren's mother, this estimate may be out by at least an hour and it may have been closer to 8 or 8.30pm. Mr Cotton then observed Darren to remove his tracksuit pants and then swim towards the New South Wales side of the river before getting out and walking back towards the Murraybank caravan park office at the west end of the park. This was a different caravan park from the one that they were staying.

36. At 8pm on 10 February, Pastor Day again rang Nurse Cliff and told him that Darren had crossed the Murray and was last seen heading into the Barmah Forest. Neither Pastor Day nor Ms Emily Higgins were aware that Darren had swum back across to the New South Wales side.

37. At about 8:30pm, the owners of Murraybank Caravan Park, Annette and Michael Kimberlin observed Darren walk through the park towards the entrance wearing a singlet or a t-shirt and underpants but no footwear, but were not aware at the time that he was missing. Mr Kimberlin asked Darren if he was alright and he responded that yes, he was "fine thanks".

38. Both the Kimberlins and Mr Cotton only became aware of media reports the next day that Darren was missing. They also saw helicopters in the air over the caravan park, and recognised that the unusual sighting from the day previous was probably the missing person. As a result Ms Annette Kimberlin reported their sightings and in evidence Ms Kimberlin recalled that she rang Echuca Police and spoke to an officer, who we now know was Leading Senior Constable Johnson. She recalled in evidence that Officer Johnson told her that was a New South Wales issue and she was told to also report the sighting to Moama Police on the New South Wales side given he was on the New South Wales side.

39. Officer Johnson didn't appreciate the significance of the report until the 12th, when she informed her sergeant on duty. A formal statement wasn't taken from Ms Kimberlin until 28 February, by the then New South Wales investigator, Senior Constable Raison. There was no attempt to take a statement from Ms Kimberlin by Victoria Police.

40. By 8:00pm on the 10th, representatives of both New South Wales and Victorian Police were aware that Darren was missing. At 8:08pm, Moama Police (New South Wales) indicated that if he had swum to the Victorian side of the Murray River then this would be a matter for the Victorian Police. Something to that effect appears on the New South Wales Police radio broadcast at shortly after 9pm. The New South Wales Police officers from Moama were informed that the matter had been transferred to Victorian Police and returned to their duties. Senior Constable Aston of the New South Wales Police Force stated that he understood Victorian Police were searching for Darren and continued to do so on the 11th and 12th of February 2017. On one of

these days, he understood that Victorian Police asked the New South Wales Police for any information they may have received.

41. At 9.15pm on the evening of the 10th, Nurse Cliff was called by Nathalia Police. Nurse Cliff believes that he would have given details to Police of Darren's psychiatric history and factors reflective of his mental state such as poor judgment and impulsive behaviour and risk of substance abuse. Nurse Cliff made other calls, including to Darren's mother, to Bendigo health psychiatric Triage, and to the on call psychiatrist.

42. On 10 February 2017, Victorian Police officers Senior Constable Bernard O'Dwyer and Senior Constable Kerry-Anne Rappell conducted a search of the Sandridge Track and River Track of the Barmah National Park on the Victorian side. The search began at 11pm and concluded at approximately 1:00am. Darren was not located. The Sandridge Track continues through the forest all the way to Moira Lakes Rd, which leads into the small settlement of Barmah. The search started at Moira Lakes Rd. A report suggested that if Darren had not been picked up by a 4WD it would take 'days' to walk out of the national park. Police also spoke to Pastor Day at about midnight on the 10th, who continued searching in the park for a few hours.

43. Police spoke to Ms Emily Higgins at her Echuca address on the morning of the 11th. They spoke to Pastor Day who said that he would call the Cummeragunja mission to see if anyone had seen Darren. They spoke to a close family and friends in Moama who had not seen Darren and who reported that members of the Aboriginal community were also searching for him.

44. Victorian Police conducted a further search from 11:40am to 8:00pm on 11 February 2017 through the Barmah National Park. Involved in the search was Search and Rescue, Police Airwing, State Emergency Service and Parks Victoria. A witness saw a helicopter over the river near the Picnic Point caravan Park on the 11th, which was part of that search. Mr and Ms Kimberlin also saw it. That air search is followed the Murray River from Picnic Point to Barmah. The ground search patrolled the River Rd, Sandridge Rd and

McDonalds track from Picnic Point to Barmah and camp sites. SES boats also patrolled between Picnic Point and Barmah, as it was thought that Darren would most likely swim with the current downstream. The air and ground search failed to locate Darren or any signs of his movements.

45. Hospital records checked by Nurse Cliff also show that Bianca from Numurkah Police rang at 12.40pm and spoke to a social worker at the hospital, wanting to know the status of Darren if they found him in New South Wales. They were advised that he could be brought back to Victoria.

46. Leading Senior Constable Rappell said that she handed over responsibility at the end of her shift on the 11th to search and rescue. In his second statement, Nurse Cliff says that he believes that before 8am on the 11th, Officer Bruce Rigoni rang and advised that they were going to escalate the search and engage Airwing assistance.

47. Sergeant Kervin from Victoria Police at Echuca provided a statement summarising the search efforts. He was given the responsibility for the search for Darren on 14 February. He was also involved in the transfer of the search to New South Wales Police to Inspector Hayes of Deniliquin Local Area Command on 20 February 2017. After the search on the 11th, a representative of Victoria Police concluded that Darren had been known to go missing before, that he was likely eluding searchers, that he had numerous associates in the area and knew the Barmah Forest well. Accordingly no concern for welfare was concluded in that report.

48. Media circulars were provided to outlets on the 12th and as a consequence, reports of sightings were made. On 12 February 2017, at least one sighting was reported to Police of Darren. It came from a juvenile, who claimed to have seen and recognised Darren in Echuca at about 9pm the evening of the 11th. Mr Martin Cliff also received phone calls from both Darren's mother and Pastor Day on the 12th, reporting they had had various reports of Darren being seen in Echuca on the previous evening and afternoon of the 11th and the morning of the 12th. Sergeant Kervin's records also show a witness from Moama had apparently told Pastor Day of seeing Darren at an

IGA (apparently in Echuca) the morning of the 11th. This was subsequently proved to be mistaken. Police attended the IGA on the 12th and spoke to staff.

49. As a consequence, the focus of the investigation shifted to Echuca. It was where Darren had lived, where his mother and community lived and it was where he had said he wanted to go to. Sergeant Kervin took responsibility for the matter on 14 February. Victorian Police also spoke to an unknown doctor on the 12th who advised that the only concerns would be heat exposure, despite Police concerns about dehydration.

50. Various enquiries were made on 15th February by Victorian Police. This included further visits to Ms Emily Higgins and her sister and checking bank activity. Those notes suggest Police were thinking that Darren was avoiding Police. This reasoning is also set out in a Victorian Police incident report dated 11 February 2017 made by Officer Bruce Rigoni. A note from 12 February in the running sheets notes Ms Kimberlin's sighting on the evening of the 10th of someone resembling Darren on the Mathoura side of the river, wet, and picking up clothing items, but is then followed by a note suggesting that Police thought Darren was avoiding Police and at that stage they had "nil concerns for welfare". Nurse Cliff says that it was proposed to put an article in the Bendigo Advertiser on the 13th regarding Darren going missing.

51. After taking over the investigation, Sergeant Kervin had someone recontact Darren's credit union and was advised that he had not been seen and no withdrawals were made. He planned a media investigation strategy to ensure that all reasonable avenues were explored. It appears that he started revisiting the potential leads.

52. On 16 February Police phoned to speak to the man who had apparently made the IGA sighting and were told that it was a juvenile who had sighted Darren on the 11th, but he was asleep and couldn't speak to them. They attended his home but were told he was still asleep. The same day Darren' mother reported her continued concern that it was out of character that he had not made contact. Ms Emily Higgins

was actively searching for her son, and attended the mission to make further enquiries, and told Police on the 17th that nothing had come from it. The same day Victorian Police spoke to the Kimberlins and ascertained that Mr Cotton had seen the man swim across the Murray on the 10th from the Victorian side. Ms Kimberlin said she was 100% certain it was Darren. Mr Cotton was then spoken to and also had the same certainty. It seems that it was after this that Police attempted to visit and speak to the juvenile. They also looked at IGA and Australia Post closed circuit television to satisfy themselves that he had not attended these places. Ms Emily Higgins was again spoken to and the running sheet entry suggests that Police still felt sure that Darren was in Echuca.

53. On 17 February Police again attended the juvenile's residence and formed the view that this report was questionable, as he indicated he was unsure of whom he had seen. The focus then shifted back to the Murraybank Caravan Park sighting. A request was made to the Victoria Police Airwing for a further urgent search of that area at 7.40am on 19 February. It was noted that the search area was in NEW SOUTH WALES, which meant that New South Wales Police may need to be involved. Police again spoke to Ms Emily Higgins who had grave concerns at this point. They spoke to other community members with no fresh information about sightings. They then contacted local National Parks, to advise of the shift of focus back into New South Wales.

54. A call was made to the Airwing at 11.50am, who advised that they would consider the request on the 20th. On 20 February Airwing advised that they would not be attending and undertaking a search of New South Wales due to the scale and complexity of the search area.

55. On 20 February a New South Wales Parks and Wildlife representative was spoken to by Sergeant Kervin and he advised that they did weekly sweeps of the park and would keep an eye out. The same day Sergeant Kervin received advice from a nurse at Bendigo Health familiar with Darren, Mr Liam Thorpe, who said that without medication, Darren would be obviously talking to himself and would be in a very

agitated state, that is, would not "be under the radar". A check of a further vague sighting in Echuca was also found to be unlikely.

56. On 20 February 2017 Victoria Police spoke to the Pastoral Times in Deniliquin, to try and get some more New South Wales media coverage. Google searches show a media release appearing in that publication online on 21 February. Mr Liam Thorpe, a mental health nurse at Bendigo, was also called to get an understanding of Darren's likely declining mental health. A Victorian Police media release update was proposed. A check of a New South Wales crime stoppers sighting was followed up, as was a possible further sighting at a house in Echuca.

57. The same day as Darren's investigation was transferred to Deniliquin Local Area Command (New South Wales) as it was deemed by Victorian Police that the last credible sighting of Darren was in New South Wales when he was seen by Annette and Michael Kimberlin to walk through the Murraybank Caravan Park towards the entrance. Sergeant Kervin's notes suggest that the intention was for New South Wales Police to co-ordinate a search.

58. Senior Constable Raison's movements have been reconstructed from his handwritten duty books. On 21 February he went to Mathoura and spoke to people at Murraybank caravan park. On 22 February he met with Pastor Day at Moama Police station and obtained a statement. It appears that he also spoke to two Victorian Police officers who attended Moama and that he spoke to Senior Constable Aston, who advised that it was considered Victoria's job to search on the 10th as Darren had last been seen on that side of the Murray. It appears he went to Ms Emily Higgins' address in Echuca. The same day his duty book records that "spoke with Sergeant Kirk re requirements to commence land search for MP". The note appears to continue: "provided with criteria forms, completed same for submission 23/2".

59. On 23 February, he added statements to the COPS event, went to Picnic Point caravan park and spoke to staff there. He examined Darren's cabin there and then

went to Murraybank Caravan park and conducted a canvass of the cabins and area where Darren had been seen and took photos. He then appears to have conducted a patrol via Forestry point Rd through Moira National Park with no find and then to the Cobb Highway. He submitted a land search request and report to the chain of command.

60. Senior Constable Raison then appears to have had days off until 28 February, when he was back on duty. He had a conversation with Sergeant Kirk about co-ordinating the search and involvement of search groups. He took statements from Mr and Mrs Kimberlin and obtained details for the witness Mr Cotton. He patrolled along Poverty Pt Rd to Cobb highway with no sign of Darren.

61. Later on the 20th February Detective Sergeant Rogers from Deniliquin advised Sergeant Kervin that the investigation was being assigned to Senior Constable Raison. On 24 February VicPol followed up with Deniliquin detectives and were informed that a ground search was being co-ordinated for the week beginning 27 February. Sergeant Walker from Victorian Police was to be kept informed as Sergeant Kervin would be away for two weeks.

62. On 3 March 2017, a search was conducted of the Moira State Forest by New South Wales Police. Involved in the search were National Parks Officers, State Emergency Service volunteers and a New South Wales Police cadaver dog and handler and it was conducted by vehicle and boat; there was also a search on foot of an area of light bushland about 150 metres west of the roadway adjacent to where Darren had last been seen. The search failed to locate Darren or any signs of his movements. It lasted from about 8.40am (briefing) to 1pm. Given that Darren was not located on either side of the Murray River, that he had removed all clothes other than his underwear and t-shirt, that he had not contacted his family or accessed his bank accounts and as he had not means to sustain life in the national park, Sergeant Kirk formed the view that Darren was deceased most likely in the Murray River.

63. Victorian Police continued to receive reports of sightings which turned out to be unreliable, and on 5 April an email was sent to Deniliquin Police suggesting a search around the Murraybank Caravan Park and if New South Wales Police were not going to search then perhaps Victorian Police should.

64. A follow-up report was sent through chain of command requesting 'conversations" between Police management concerning the decision by New South Wales Police not to conduct a further search. The Victorian file suggests that the search described as occurring on 3 March in an area on the New South Wales side "highly suspected" of being where the body of Darren may be located had not gone ahead as Police resources were diverted to a murder/attempt murder that occurred in Moama on 2 March, but a further entry notes that this was incorrect and the search on 3 March had in fact gone ahead, but with some Police resources diverted. Victorian Police has operated on the wrong assumption that no New South Wales search had been conducted on 3 March which seemed to be a communication error.

65. Detective Sergeant Rogers indicated on 20 April to Sergeant Kervin that they were still waiting on a statement from the search co-ordinator and would be forwarding a report to the coroner.

66. At about 5:30pm on Saturday 2 September 2017, Mr Damon Williamson was in the Moira State Forest cutting firewood when he discovered what he believed to be a human skull. Mr Williamson travelled to Moama Police Station and alerted Police. Mr Williamson and Senior Constables Pollock and Matthew returned to the location and a crime scene was established.

67. In the morning of Sunday 3 September 2017, an examination of the crime scene was commenced by Police officers from Deniliquin and Albury, as well as volunteers from the State Emergency Service. In addition to his remains, several items of clothing were located. Police had located what is believed to be the final resting place of Darren. On 17 October 2017, the remains were confirmed as those of Darren by DNA comparison.

68. On 5 April 2018, a further search of Moira State Forest was arranged by Detective Senior Constable Phillips and conducted by Deniliquin Police. During this search another two bones were located. On 8 May 2018, it was confirmed that the DNA extracted from the remains matched the DNA for Darren.

Analysis of the evidence, Date, Place and Cause of Darren's death

69. The evidence in the inquest established that Darren had travelled some substantial distance in land from the Murray River, the direction in which he travelled was consistent with his intention to make his way to family in Echuca. There was some conjecture in evidence that Darren may have attempted to float down the river and drowned as a result, washing up as a result of floodwaters where his remains were found. However there was an absence of evidence relating to recent flooding that could support that suggested theory. Darren's remains were found approximately 1.8 kilometres from the river and there was no evidence to support that Barmah Forrest had been subjected to flooding at that time.

70. Doctor Luckin was a survival expert and was able to give very helpful and considered views on the last few days of life of Darren. He carefully considered the material before him and he was able to postulate that Darren most likely would have passed away from hyperthermia as early as the day or evening of 11 February 2017 into 12 February 2017. Based that on information he had about Darren, his diagnosis, medications, very high temperatures on those days, lack of drinkable water supply available, distance travelled and terrain, he agreed that it was likely that Darren was heading south through the forest heading towards Echuca. The heat on those days was unfortunately so high, being above 40 degrees.

71. He did not agree with the suggestion that Darren had a considerable amount of water supply available to him. If Darren had consumed the Murray River Water Dr Luckin noted that it would have only added to his poor state of dehydration. The Murray water is not good for consumption and would have caused further illness.

The stagnant pools in the area would most likely deter drinking, and although there were small creeks, finding those in the darkness would have been difficult. The hyperthermia would have resulted in an increased body temperature, therefore further affecting dehydration and further contributing to the impact of his medication clozapine. Clozapine itself contributes to a raised body temperature. The hyperthermia has a paradoxical effect meaning that Darren would have lost the feeling of thirst or even remember that he had a need to drink, and as time progressed Darren's thinking would have become further disordered.

72. Council Assisting explored other possibilities of cause of death, such as snake bite, or significant physical injury. Dr Luckin thought this unlikely in Darren's case, given the heat, the distance travelled and the lack of water. Dr Luckin's evidence allows me to be satisfied of the cause of Darren's death, and the date range.

Appropriateness of the decision to grant leave from Vahland House

73. Doctor Matthew was the treating psychiatrist for Darren in Bendigo. Darren had a most complex mental health diagnosis, as acknowledged by the experts in this inquest. As a result, he was at times unable to be managed by trained mental health staff. He was attached to his family and constantly expressed a strong desire to return home to family in Echuca. On one occasion when he absconded, he indicated later that he had intended to walk to Echuca from Bendigo, some 82 kilometres away.

74. Doctor Mathew says that Darren sometimes could be very aggressive and would need seclusion. He was noted to have a blunted affect and was muttering to himself on 9 February 2017 but this was consistent with his usual presentation. She said that he was never free of psychotic symptoms, was always unstable and would exhibit poor judgment. Dr Mathew agreed with the description that Darren had partially treatment resistant schizophrenia. This is not to detract from the fact that at times Darren was happy, he would sing and whistle and communicate well however there was never a series of days where he could be predicted to stay the same.

75. Dr Mathew said that Darren had been receiving multiple medications including Olanzapine PRN doses, 1g sodium valproate x 2 a day (used as a mood stabiliser), 10mg diazepam (a benzodiazepine) daily as well as breakthrough PRN doses, 200mg Clopixol-Acuphase depot injection (a change in January 2017 from Abilify/Aripiprazole), Lorazepam 1mg, Clonazepam 200mg nocte and Clozapine (an anti-psychotic). Dr Mathew's concern about return of psychosis would only have arisen if Darren was without medication for 3-4 days. She considered that if Darren became non-compliant with his regular antipsychotic Clozapine medication while on the three-day leave, the slow-acting Acuphase injection administered on 7 February 2017 would have been operating as a backup to stabilise Darren and would moderate any arising agitation. The list of medications gives some indication of the depth of Darren's complex mental health issues.

76. Dr Mathew was concerned that if the leave was refused at that late stage Darren might self-harm or become very aggressive. She said that he did not react well generally to "no" and that Darren would become very aggressive. Dr Mathew took into account that she observed that he was respectful to family and his mother and that he had a high regard for Pastor Day. She said that while Darren did not display or express suicidal or self-harm ideation prior to the scheduled leave, on a previous occasion when leave had been cancelled, he had self-harmed. When questioned about the appropriateness of a period of three days leave, she said that Darren had been locked up for twelve months and she felt that he wanted to be with family and her approach was to ensure the least restrictive care on to Darren and to get him back into the community.

77. Dr Mathew acknowledged Darren's significant drug misuse disorder and recognised that pull of drugs was something in the forefront of his mind being so great that he was a significant flight risk. She described him as having a "huge" drug misuse disorder.

78. Thought was given to the appropriateness of location for leave. It was decided that Darren should not go back to Echuca, given that he had potential contacts to obtain drugs. He was even known to share his own prescription drugs with his friends. It was decided for the same reason that Moama was not a suitable location given its proximity to Echuca. It was surprising that Dr Mathew was not part of the decision making in deciding to allow release to the location that he was taken. The location in Darren's case was a very important factor given the need to access Police by family if needed, access to medical help and services available to locate him if he did abscond. The process of identification of a suitable location involved a real consideration of access to drugs but appeared to overlook other potential risk factors.

79. In this case, those additional factors included the river, the fact that a major boating event was taking place, there would be limited Police available given the large number of visitors to the area, the fact that there were no mental health services in the vicinity, and the close proximity of a national park. Dr Mathew said that she would do nothing different in retrospect, and that having regard to the least restrictive environment in a situation where he had the care of Pastor Day and his mum that it was best to permit the leave.

Expert view of Doctors Eagle and O'Neill

80. These experts differed in their opinions. Dr O'Neill considered it appropriate to grant the leave. Dr Eagle did not. They both agreed that the mental health medical team's motivation to promote reintegration into the community was commendable. Dr Eagle commented upon the poly-pharmacology of Darren's medications, and that he was still partly in transition giving rise to increasing concern around his stability. She summarized that given his history he was prone to impulsivity. She considered that delay in leave would have been a better course

81. Dr O'Neill's view was that delay would not have made a significant difference. Dr Eagle was concerned that there were no meaningful supports in place during

Darren's leave and although the leave was very well intentioned including from a cultural perspective, in her view where there was no safe pathway leave should have been reconsidered. Dr Eagle also opined that with the serious and significant diagnosis, that potentially Darren would not have been able to absent himself from the facility at all, at least for some time.

82. The inquest is always conducted with the benefit of hindsight. Getting all of the facts before making a decision to release Darren into his mother's care in my view was most critical feature in this matter. There did not seem to be a proper understanding of where he was in fact going. He was not easily being managed at the facility while in the care of experts. Darren's mother was a mother keen to see him understandably, but when faced with no support structures around her by community, no psychological support close by, limited Police ability given the ski racing festival, and Darren's presentation as partially treatment resistant, it was a big responsibility for her to be given in a situation where other mental health professionals were also concerned about his capacity to safely navigate leave at that time.

83. Dr Mathew did what she believed clinically correct at the time, she was in the difficult position of balancing his risks of self-harm and harm to others if she cancelled leave at the last moment. She was obliged to consider culturally appropriate options, as per the legislation and her role was to try and help Darren reintegrate back into the community. She was also conscious of his love for family, knew that Pastor Day was experienced, well respected and not unfamiliar to these types of situations. She also felt that his connection to his home would mean that he would not stay missing for long, as previously in Bendigo he was easily found.

84. Although Dr Mathew didn't necessarily agree that she needed to know his precise location, or details such as the national park nearby, it seems in a case such as Darren being one of the most difficult patients to treat making it essential that a thorough a risk assessment of location or destination was completed as part of the

process.

85. The evidence of Dr Eagle was very compelling, her view was that leave could have been delayed although she expressed a view that it was open to Dr Mathew to approve it.

86. However, I agree that this was a clinical decision made by Dr Mathew and she was entitled as an experienced psychiatrist to make the determination in the circumstances. It is a difficult tightrope to walk, to try and promote reintegration and freedom for Darren while mindful of his serious condition. I accept that decisions that were made were believed to be in his best interests.

87. In relation to any recommendations, I received supplementary submissions that were most helpful from Bendigo health. After comparing very carefully the old and new Acts, Ms McFee commends no recommendations relating to documenting details of the evidence relied upon when granting leave, given all other factors pursuant to the Act now required to be considered by the treating specialist prior to the grant of leave.

88. I agree with these sentiments, although I am of the view that Darren's case does provide some areas of special consideration, and warrants consideration of whether anything coming arising from these facts and evidence would prompt consideration of a further review of policy and forms. As such I will make the recommendation promoted on behalf of Ms Emily Higgins.

Discussion of Police Communication between New South Wales and Victoria in Darren's border town missing person cases

89. There are a number of identifiable areas where communication opportunities were lost. Some can be identified as individual policing errors, and for that reason I will not dwell on those, because it is inevitable that individual human errors will be made or protocol will not be followed. Firstly, it should be noted however that the fact

that Ms Kimberlin's reported sighting was not forwarded to the relevant searching Victoria Police the very day of the air search was very unfortunate. Officer Johnson from Echuca Police was not even aware that a search was occurring for Darren when she received the report from Ms Kimberlin, which was additionally surprisingly because in evidence she also indicated that she knew Darren from previous dealings. Where Officer's Johnson's evidence differed from Ms Kimberlin's evidence I accepted Ms Kimberlin's recollection. To Ms Kimberlin who had observed something unusual reported it to two police stations and was interviewed in the weeks following, this was an event that was memorable. Officer Johnson had not thought it significant enough to pass on the report until the following day, and her recollection of events did not appear to be as clear as that of Ms Kimberlin. There were some inconsistencies in the Officer's recollection and documentation that could be attributable to the passage of time.

90. Secondly the missing persons' report made to New South Wales was not treated as a missing person's report and it should have been instead a decision was made that it left to Victoria to search for Darren. Chief Inspector Browne gave evidence that it should have been treated as a New South Wales matter also.

91. Finally, the report that I accept Ms Kimberlin made to New South Wales was not even recorded by New South Wales Police at all. The explanation was that it was a very busy weekend, that was true however with so many visitors to the region one would hope that in relation to the missing persons protocols and practices police would be hypervigilant in those circumstances, where a large number of people had gathered in the region. These were all missed opportunities that may have turned the spotlight on New South Wales much sooner.

92. The Victorian search was very impressive. It was quickly set up with a comprehensive search including air and river searches.

93. After the initial search did not prove successful, the attention was drawn to Echuca, on an assumption that Darren had managed to obtain transport home from the Barmah Forest. There were also a number of reports of sightings in that area.

94. Once the reliable information of a sighting was brought to Victorian Police it is inexplicable on these facts why someone didn't immediately arrange to speak to this witness. Ms Kimberlin was a caravan park owner who described a man coming out of the river shortly after Darren was last seen. Her description of his behaviour was very unusual, underwear and singlet walking off with nothing in effect to nowhere. Nevertheless, Victoria maintained its sights on Echuca. Having the benefit of seeing Ms Kimberlin in the witness box it is important to describe the articulate, informed, and caring individual that she was. She bothered to become involved, to attempt to help with what she had seen and yet no one followed her up until 17 February 2017.

95. An issue that arose was the usual and unfortunately often large number of false sightings coming from concerned members of the community trying to help. Detective Chief Inspector Browne made the important point that until the Police have satisfied themselves of the quality of the information, it remains just that. Unconfirmed sightings. Each lead should be investigated in relation to sightings as soon as possible by Police to ensure when a credible sighting is made it can then form the basis of additional search.

96. This leads to another issue in relation to Police generally when dealing with a vulnerable mentally ill person. Much of the communication and records relate to Darren trying to avoid Police, or Darren wanting to hide in Echuca in community to avoid apprehension and return to the facility. Darren was not of sound mind, and yet the way much of the reporting reads it is as though he was a criminal trying to avoid detection. That he was a person of sound mind making informed decisions to hide himself. The fact is that Darren was mentally ill. As his drugs wore off he would have become more delusional or psychotic, and even less rational. Having that as the profile of the person who was being searched for is critical. Dr Mathew was in fact

never spoken to by Police, and her input was critical in helping others understand the progressively worsening psychological state that he would have been in.

97. Overall, however, Victoria Police made decisions based on evidence they had, and importantly continued the search. There was one entry that he was of low risk and there was no concern for welfare. I accept submissions made that nothing turned on that unfortunate entry. I accept the submission that the search continued in spite of that entry.

98. Sergeant Kervin deserves a special mention and was a hero in this investigation. He was an impressive witness and a very impressive Police officer.

99. When he took over the search for Darren, he also took ownership and responsibility to try all he could to locate Darren. He liaised with family, organised investigation and leads were followed up, he had a lot to do, and he got on with doing all he could. He remained committed to his case. He utilised an aboriginal identified Police officer to speak to one of the leads and once he was satisfied this was not credible, looked towards the sighting in New South Wales. Rather than immediately transfer the matter he formed the view that an urgent search of the area in New South Wales needed to be undertaken. He was reluctant to pass Darren's matter over because he was concerned about the delay that would be occasioned in the process of handing the matter over the border. He decided to try and commission the appropriate search himself. He was right to worry, because what he feared came to pass.

100. He was off duty on 18th and on 19th he tried to arrange another urgent air search of New South Wales and contacted the Pastoral Times in Deniliquin to promote awareness that he was missing. He contacted the New South Wales National Parks and Wildlife Service to advise of the shift of focus back to the Murray Valley National Park and spoke to a mental health nurse at Bendigo Health. He kept the matter in Victoria before handing it over and requested that Victoria did an arial search over New South Wales. This was declined and so he organised to transfer the

matter. Importantly he was an excellent family communicator and kept Ms Emily Higgins informed.

101. During his evidence which was measured and thoughtful it was clear that he had nothing but the best interests of Darren in his mind as he looked for him. He understood his vulnerabilities, his mental health issue and the urgency of the need to find him even if that was not going to be alive.

102. He produced an excellent document succinctly summarising what had occurred in one and a half pages to his supervisors. That document incredibly never made its way over the border. The date of the document was 20 February 2017.

103. On that day 20 February 2017 there was an informal handover from the missing person investigation from Sergeant Kervin to Chief Inspector Hayes at Deniliquin Police.

104. Sergeant Kervin acknowledged the challenges generally with cross border issues, and spoke about the fact that those challenges still exist today. He said there are different systems used and acronyms used. He said he would welcome improvement.

105. Counsel assisting made the point in submissions that had there already been in place a cross-border communication protocol between relevant LAC or information sharing for missing persons in a non-urban setting there would have been no need to do a formal or even informal file handover. It would be hoped that such a protocol would encourage New South Wales searching alongside Victoria, Police may have borders but in border towns the river is merely just a river. Border towns rely on each other, people work, live and socialise together. Medical attention can be provided by one side or the other, they share essential services including hospitals, supermarkets, shops, schools, workplaces and the list goes on. COVID demonstrated to us that hard borders do not work for border towns and

indeed they needed to co-exist in their own bubble as a joint society.

106. Submissions were made that in essence this is a difficult political issue. That many have turned their minds to the problem and the solutions are not easy to find. That attitude is not helpful to those many (2.1 million) Australian people living in those towns. Improved communication systems is required between the two states. I note the positive improvements that were raised in submissions for the NSW Commissioner of Police, which is a step forward , but this inquest heard that communication is still not easily nor smoothly working in a practical sense between the two states in the area of missing persons. If Victoria Police is in the air or on the water undertaking a border search then New South Wales in that region should know who they are searching for and ensure that they shouldn't be searching too. With 10,000 missing persons a year in New South Wales alone, this communication issue becomes even more important to cure because the issue is bound to arise regularly. It would also seem that in cases where an intense urgent search is taking place, a simple communication agreement could resolve the deficiencies that have been identified in this inquest.

107. Turning then to what happened when Darren's case came to New South Wales the matter was given to Detective Constable Raison who was unavailable to give evidence and was excused. His notes and records were relied upon. From the notes we can see that there was activity, but it must be noted it was very limited in the attempts to locate Darren.

108. Sergeant Kirk was ultimately appointed the search coordinator. The search was not conducted until 3 March 2017. Sergeant Kirk's evidence highlighted the breakdown in communication between the states. He, as the land search coordinator, was unaware of the search in Victoria, or at least the extent of it. He did not have the missing persons file, but relied on the OIC. He used the despondent persons guide to orchestrate the search, because he had formed the view that Darren was suicidal from the very limited information available or given to him. There is no available evidence in this inquest to support that view. The excellent

summary prepared by Sergeant Kervin would have been an excellent start for the New South Wales to have absorbed and built upon. I will not extract it here but it would make a very useful training example to create a template document as a hand over tool. There was no evidence to even suggest that Sergeant Kervin was contacted by anyone in New South Wales to discuss the case prior to the search.

109. I should comment that Sergeant Kirk relied heavily on information provided to him by New South Wales Police to determine the parameters of the search. His role at that time as search coordinator was to plan the search with the material provided to him. He was tasked with an enormous job. It was clear in his evidence in which he provided helpful and frank evidence that he would also like to see improvements in communications between the States. He was a dedicated officer who wanted to find Darren.

110. Independent expert Senior Sergeant Whitehead gave evidence that the correct lost person's behaviour guide to use was that of the "person with a psychological illness," aided by the "hiker/walker" guidelines given the terrain where Darren went missing was situated. I accepted his analysis of why these were appropriate and should have been used.

111. Senior Sergeant Whitehead also said that the search and rescue expert should be having detailed conversations with family, who should be invited to the search. They were not in this case.

112. This was difficult and vast terrain to search, that should be acknowledged, it was a hard task for Sergeant Kirk. However, it would be hoped in future that at least in the planning stage all relevant critical important information would be gathered. There was a need to consult family. There was a need to gather an appropriate psychological and physical profile of Darren, so easily done by calling his treating psychiatrist. There was a need to communicate with Victoria Police directly to understand the extent of the investigation to the handover point.

113. I accept that the search for Darren was sub optimal. There was no urgency in New South Wales to get the search moving. He was a high risk vulnerable man in danger of losing his life or had already lost it.

114. Secondly I agree that there was a lack of detail obtained in New South Wales to create the search parameters, from family, doctors and Victoria Police.

115. Finally the duration and extent of the search was inadequate with only several hours on one day to cover such a vast area. Sergeant Whitehead indicated that given 115 square kilometres it may have been unlikely to have been successful in locating Darren, however that did not reduce the need for a search to be conducted as a matter of urgency, and most likely would have resulted in traversing tracks south of Moira Lake if the correct lost persons behaviour guide had been used. Senior Sergeant Whitehead highlighted that even if Darren was believed deceased the search should have continued to find his remains.

116. It was raised that another urgent search was occurring in the region that same day, involving children. It was apparent from Sergeant Kirk's evidence that there was a desire by him to assist in that search, which is understandable. However, that does not explain why a further, more fulsome search was not completed at a later time in those circumstances.

117. The missing persons unit exists to find and save a person, or to find out what happened to that person. The role is for individual protection and safety and also for those looking for their loved one, often in anguish and despair at the loss. The longer the search delayed the harder it would become to find Darren's remains. It is acknowledged that a person suffering the pain and anxiety of the uncertainty of their loved one missing is a horrifying thought to all of us in the community.

118. Chief Inspector Browne has made sweeping reforms to the missing persons unit in New South Wales. He conceded that failings had occurred in this case, but said they ought not happen today. He felt that the cross-border communication had

improved, however the evidence of Sergeant Kirk and Sergeant Kervin was that there is more work to do in this communication space, and it is hoped that the Commissioners of Police will listen to two senior officers who shared current lived experiences. There is no doubt that both officers wanted to do the best job they could to find Darren, but described current cross border experiences as "ad hoc."

119. The inability to share policing electronic systems was raised as a bar to curing the communication issues, however in today's modern world of email, an ability to quickly share information on phones and technology generally it would seem a pathway or protocol should be able to be created to at least promote easy police cross border conversation and communications between these very important border towns.

Police communications with First Nations Families

120. This was a case that highlighted the need for focus to remain on improving awareness and communication between First Nations community and Police. Expert Psychologist Ms Edwige raised concern that Darren might not have presented as a worthy victim and queried whether cultural assumptions may have interfered with the investigation. She raised the issue of the delay in implementing search in New South Wales and the fact that Darren's significant mental illness was not featuring in the New South Wales investigation as a risk factor. Ms Edwidge raised that cultural awareness and culture responsiveness training was an important ongoing requirement for New South Wales Police in dealing with First Nations community members, and such training can assist in challenging erroneous assumptions and negative stereo typing.

121. Ms Edwige opined that it is important that Police consult with extended family given complex and sophisticated kinship systems that exist within First Nations community. The community itself is a powerful group to tap into to assist in finding a person. It also allows the community develop trust and credibility if they

are respectfully involved in the search.

122. In Darren's case his mother reached out to community to tap into this resource, but although family can help, in her own trauma the burden ought not have rested on her.

123. A statement was provided to the Inquest from New South Wales Police Assistant Commissioner McKenna dated 5 December 2022 setting out the good work that Police are doing in this area. Police have a large number of initiatives to promote culturally appropriate and sensitive services to and relationships with members of First Nations communities in New South Wales. The focus of the ACLO programs is to create open lines of communication between Police and Aboriginal people to interact with Police via the Police Aboriginal Consultative Committee.

124. Communication is key in missing persons, and when First Nations families are involved, it makes a great deal of sense to ensure the communication lines are easy, accessible and appropriate using such things as available ACLO officers. No such officer was used in this New South Wales, search for Darren, and the communication with Ms Emily Higgins could only said to be very poor once Sergeant Kervin handed the matter to New South Wales. Assistant Commissioner McKenna identifies that ACLOs may be involved in a missing persons investigation in a support role. The New South Wales Police is actively working to improve communication.

125. In relation to the evidence about consideration to be given to cultural awareness and training to officers within the Missing Persons Unit, Detective Chief Inspector Browne considered this a useful addition to the unit.

Concluding remarks

126. Finally, Chief Inspector Browne estimated that of the 10,000 cases about 100 each year occur in border towns. This is a significant number of individuals and families that are affected, and of course these towns are rural, creating different

challenges to other locations, often involving waterways and bushland. I hope that the Commissioner of Police both in New South Wales and Victoria see the need to improve on current communication practices to assist their respective officers in policing in a more satisfying way in in relation to finding missing persons. In turn this will give heightened confidence within our border town communities.

Acknowledgements

Firstly, to all representatives of the interested parties, for attending to travel, assisting the Coroner during the inquest particularly with the provision of very helpful submissions.

Secondly to the Officer in Charge Detective Senior Constable Casey Braz who not only collated a large amount of material across border, but also assisted in locating witnesses and assisting with the smooth running of the inquest. His dedication was obvious in his attention to detail and participation throughout the proceedings.

Thirdly to the team assisting the Coroner. There were many complex areas and components to this inquest, the team were thorough and well prepared and greatly assisted the process through the organisation and presentation of the matters relevant to the issues in Darren's case.

Finally, to Darren's family, in particular his mother Ms Emily Higgins. The family statement presented by his uncle assisted in a much better understanding of who Darren really was, and the loss to the community as a result of his passing. The stories told helped to understand further a young man who although was struggling with significant mental health issues was a treasured member of his family community.

Recommendations

To the Commissioner of Police, New South Wales AND to the Commissioner of Police, Victoria:

a. To give consideration to developing a memorandum of understanding between the two Police forces, applying to circumstances where a person

goes missing in a border region adjacent to the Murray River in either New South Wales or Victoria AND that person is considered by either a New South Wales or Victorian missing person risk assessment to be a high risk of misadventure or death if not located as soon as possible, addressing:

b. the exchange of information obtained by each Police force in relation to that person; and
c. co-ordination between the two Police forces of search and investigative resources, where feasible;

d. In addressing point (a) above, to consider including as part of that information exchange process, a requirement that an officer of Inspector level or higher in each relevantly adjoining New South Wales and Victorian local regional command have direct oversight of the information exchange; and that the officer in charge of the New South Wales missing person investigation and their Victorian counterpart immediately liaise and continue to directly liaise as part of that information exchange;

e. To consequently update the relevant New South Wales and Victorian Missing Persons Standard Operating Procedures and Polices should any of proposed recommendation 1(a) and/or (b) be implemented;

f. To give consideration to identifying in such Standard Operating Procedures and Policies (as referred to in (c) above) how an Aboriginal Community Liaison Officer may be used to help provide a culturally safe context when dealing with families and relevant extended kin of a missing First Nations person, including when obtaining information to assist in a missing person investigation and when conducting a land or water search.

4. To the New South Wales Commissioner of Police:

    a. To give consideration to arranging and offering currently available New South Wales Police training, in cultural safety and cultural awareness

when dealing with First Nations persons, to officers within the New South Wales Missing Persons Unit.

5. To the Chief Psychiatrist, Department of Health Victoria

    a. That the medical evidence of Dr Mathew, Dr Eagle and Dr O'Neill together with the Bendigo Health medical records, statements of treating medical practitioners and practitioners be forwarded for consideration as to whether arising from this matter there should be a review of policy, forms or procedures in respect of the grant of extended leave to involuntary patients.

Findings required by s81(1)

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 in relation to it.

The identity of the deceased

The deceased person was Darren Higgins

Date of death

Between 11 and 12 February 2017

Place of death

Moira State Forrest, Barham, New South Wales

Cause of death

The death was caused by Dehydration with contributory causes of severe mental health conditions and hyperthermia

Manner of death

Misadventure

I extend my sincere condolences to the family and friends and community of Mr Darren Higgins.

I now close this inquest.