CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Thomas James Hunt
Hearing dates:	6-8 July 2020
Date of findings:	**4 September 2020**
Place of findings:	State Coroner's Court, Lidcombe
Findings of:	**State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – missing person investigation; Missing Persons Standard Operating Procedures; interpretation of s. 287 of *Telecommunications Act* 1997; attendance by paramedics at a mental health emergency
File number:	2017/102894
Representation:	Ms C Melis, Counsel Assisting, instructed by Ms G Gutmann, Crown Solicitor's Office Mr M Hutchings instructed by Ms K Parmaxidis, Makinson d'Apice Lawyers, for NSW Commissioner of Police and involved officers Mr B Bradley instructed by Ms O Sclavenitis, McCabe Curwood, for NSW Ambulance, Jillian Eve and George Mutton

Findings:	The *Coroners Act 2009* in s. 81(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 or suspected death. These are the findings of an inquest into the death of Thomas James Hunt. **Identity**: The deceased person was Thomas James Hunt. **Date of death**: Thomas died on or shortly after 23 March 2017. **Place of death**: I am unable to determine the precise place of death. It is however likely that Thomas died in the water in the immediate proximity of Bondi Beach. **Cause of death:** I am unable to determine the cause of Thomas's death. **Manner of death:** I am unable to determine the precise manner of death. It is however likely that Thomas died after entering the water in the immediate proximity of Bondi Beach by an unknown means, in the context of suffering a significant decline in his mental health.
Recommendations:	***To the Commissioner of the NSW Police Force*** 1. That the Missing Persons Registry be directed to liaise with the State Coordination Unit to consider and implement a protocol whereby the information available in support of an application to the State Coordination Unit to access the location of a mobile telephone device under s. 287 of the *Telecommunications Act 1997* be recorded and the reasons for that application decision be recorded.

Non-publication orders	1. Pursuant to implied power, the Court orders that the information marked in green in the attached statement of Detective Senior Constable Sarah Etournaud dated 2 April 2019, (the green portions together, the "Sensitive Information") be redacted in any brief of evidence disclosed or supplied to any person except: a. the Court and court staff; b. the counsel and solicitors assisting the State Coroner in this inquest; c. the Commissioner of Police, New South Wales Police Force officers, and legal representatives of the Commissioner; and d. the New South Wales Ambulance and the legal representatives of the New South Wales Ambulance. Sensitive information includes: a. Paragraph 19, page 4, of the Statement of Detective Senior Constable Sarah Etournaud dated 2 April 2019; b. Annexure B, Yates Alarm Response: i. Reference to "HELLPOINT CAMERA NEED CLEANING" in entry dated 26/03 Sun at 11:29:22; ii. Reference to "SOUTH HELLPOINT ACTIVATED" in entry dated 01/04 Sat 08:46:48; c. Annexure E, Maps and descriptions of The Gap: iii. Any reference to or descriptions of the five significant areas of The Gap for responding police and where a majority of suicides occur; iv. Any reference to areas of The Gap monitored by CCTV cameras and alarm systems and any references to where those CCTV cameras and alarm systems are located; v. Any diagrams depicting the significant areas for responding police and where a majority of suicides occur; vi. Any camera or CCTV footage stills of the The Gap; vii. Any reference to or description of known suicide locations near to the Hotel Bondi, including The Gap, North Bondi Headland, Marks Park, Bronte Beach,

	Dolphins Point, Mistral Point, Malabar Headland National Park; viii. Any camera or CCTV footage stills of known suicide locations near to the Hotel Bondi, including The Gap, North Bondi Headland, Marks Park, Bronte Beach, Dolphins Point, Mistral Point, Malabar Headland National Park. 2. Pursuant to s. 65(4) of the *Coroners Act 2009*, the Court orders that the Sensitive Information be redacted in any part of the coronial file that is supplied to or accessed by any person except: a. the Court and court staff; b. the counsel and solicitors assisting the State Coroner in this inquest; c. the Commissioner of Police, New South Wales Police Force officers, and legal representatives of the Commissioner; and d. the New South Wales Ambulance and the legal representatives of the New South Wales Ambulance. 3. Pursuant to s. 74(1)(b) of the *Coroners Act 2009*, the Court orders that the Sensitive Information is not to be published in any medium.

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The Coroner's Act 2009 (NSW) in s. 81(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.

These are the findings of an inquest into the death of Thomas James Hunt.

Introduction

1. Thomas James Hunt was 27 years old when he went missing from his parents' home on 22 March 2017. At the time, he lived with his mother, Amanda Hunt, his partner, Natasha Mills, and their two young children.

2. Though Thomas had no documented history of mental illness, in March 2017 he experienced a serious decline in his mental health, suffering from paranoid delusions and exhibiting increasingly erratic behaviour. Thomas had quit his job, and was diagnosed with chronic depression by his general practitioner. By 22 March 2017, Thomas's mental state had markedly deteriorated, and Amanda made a triple zero call for an ambulance, telling the operator her son was mentally ill and needed to be "scheduled". Paramedics attended the premises but following a conversation with Amanda left without undertaking a mental health assessment of Thomas.

3. Thomas's concerning behaviour continued throughout the early morning of 22 March 2017. That morning he drove Natasha to work and his children to school and day care. Thomas's brother, Daniel Hunt, informed Amanda that he had spoken with Thomas who told him he was hearing voices and was going to Newcastle for the day. Thomas later told Natasha he would not be coming back and to look after the kids. Amanda reported Thomas as a missing person at 11:18am.

4. The evidence indicates that Thomas travelled up the north coast of NSW before turning back and arriving in the Bondi area on the evening of 22 March 2017. There he checked himself into the Hotel Bondi. Thomas was allocated Room 209.

5. On 23 March 2017 at 9:15am, Thomas called his father, Graham Hunt. Amanda answered the call and recalled that Thomas's mental state was deteriorating and that he was out of touch with reality. Amanda updated Penrith Local Area Command with this information at 9:18am. Later, Amanda realised the call from Thomas had come from a landline number and was able to ascertain that the call had come from Hotel Bondi. At 11:00am, Amanda again updated Penrith Local Area Command with this information.

6. Graham and Amanda did not receive any updates from Penrith Local Area Command following Amanda's second call, and Graham decided to travel to

Bondi to speak with police, arriving at approximately 2:00pm. At 3:11pm, Bondi LAC broadcast a Concern for Welfare job in relation to Thomas.

7. At 3:16pm, Fire and Rescue NSW received a notification of an automatic fire alarm at Hotel Bondi. Firefighters discovered that a fire had been lit on the mattress in Room 209 and the window had been smashed out prior to their arrival. Some of Thomas's belongings were located within Room 209 but there was no sign of Thomas.

8. Police attended Hotel Bondi and reviewed CCTV footage and conducted a search for Thomas but were unable to locate him. Further searches and enquiries were conducted in the following days without success.

9. At approximately 9:00pm on 4 April 2017, human remains were discovered on the shoreline at Bondi Beach by a passer-by. The remains consisted of all the vertebrae, some ribs, the left humerus and scapula, both femurs, both tibia and the pelvis. There was minimal soft tissue and muscle left. Land, air and water searches were conducted on 5 April 2017 but did not locate anything of significance relating to the remains.

10. On 13 April 2017, a DNA match confirmed that the remains could have originated from a biological child of Amanda and Graham, and that the profile was greater than 100 billion times more likely to have been obtained from a biological child of Amanda and Graham than an unknown individual in the Australian population.

The role of the Coroner

11. The role of a Coroner, as set out in s. 81 of the *Coroners Act 2009* (NSW) ("the Act"), is to make findings as to the:

    a. Identity of the deceased;
    b. Date and place of the person's death;
    c. Physical or medical cause of death; and
    d. The manner of death, in other words, the circumstances surrounding the death.

12. Pursuant to s. 27 of the Act, an inquest is required when the manner and cause of a person's death have not been sufficiently disclosed. In this case, neither the exact cause nor the circumstances of Thomas's death could be readily ascertained.

The proceedings

13. The inquest into Thomas's death was held at the State Coroners Court in Lidcombe from 6-8 July 2020.

14. An issues list was distributed in advance of the inquest, which included the following:

    1. When Thomas died.
    2. How Thomas died.
    3. The nature of Thomas's mental health issues.
    4. The actions of NSW Ambulance Service Officers during their attendance at Amanda Hunt's home on 22 March 2017, including the interpretation and application of Schedule 1 of the *Mental Health Act 2007* (NSW) to the circumstances of the case.
    5. The adequacy of the NSW police investigation, including
        a. The response to the missing persons report between 22 March 2017 and the fire at Hotel Bondi on 23 March 2017;
        b. The search for Thomas conducted in the period between the fire at Hotel Bondi on 23 March 2017 and the discovery of his remains on 4 April 2017.
    6. Whether there are any recommendations that are "necessary or desirable to make in relation to any matter connected with the death" arising from the evidence and findings at the inquest, pursuant to s. 82 of the *Coroners Act 2009* (NSW)

15. In making these findings, I extend my sincere condolences to Thomas's family, in particular to Amanda and Daniel Hunt, who attended each day of the inquest in person, and to Thomas's sister Bethany, who listened to the conduct of the proceedings each day via audio-visual-link from New Zealand.

Factual background

Thomas's personal circumstances

16. Thomas was born on 13 March 1990 in Leicestershire, United Kingdom. Thomas and his family, consisting of his parents, Amanda and Graham, his brother Daniel, and sister Bethany, immigrated to New Zealand in 2003, when Thomas was aged 13.

17. In 2007, Thomas met and entered into a relationship with Natasha Mills. There are two children of the relationship, Ella, born in 2009 and Marcus, born in 2013.[1]

18. In 2011, Thomas was awarded the New Zealand Certificate of Flooring, and in 2013 started his own business providing flooring services. In the same year,

[1] Tab 8, [4].

Amanda and Graham moved to Australia with Bethany to support her attendance at a performing arts school.[2]

19. In December 2015, Thomas, Natasha, and their children moved to Australia and lived with Amanda and Graham at their home in Jordan Springs. Thomas immediately gained employment with Choices Flooring in Blacktown, where he continued to work until 20 March 2017.[3]

Thomas's declining mental health

20. Prior to March 2017, Thomas did not have a history of mental health issues, nor had he ever been diagnosed with any mental health conditions.[4] Amanda did however note in retrospect that, from about 2013, there were certain peculiarities about Thomas's behaviour that may have indicated all was not well with his mental health, such as his occasional paranoia about being pursued by the police and biker gangs, his preoccupation with conspiracy theories, and on one occasion checking Daniel's car for "bugs".[5]

21. Amanda identified that 11 March 2017 was the first time she recognised signs of Thomas's potential depression, whilst on a family trip to the beach. She observed Thomas to be noticeably withdrawn and not connecting with the rest of the family.[6]

22. On 15 March 2017, Thomas travelled to New Zealand to organise to have a number of his household effects shipped to Australia. He stayed with Bethany and her partner. Thomas discovered that most of his belongings had gone mouldy whilst in storage. He disposed of a number of sentimental items. Amanda believes this event was the catalyst for what followed.[7] The evidence indicates that Thomas experienced a serious decline in his mental health after he returned from New Zealand on 18 March 2017.

23. On 20 March 2017 at approximately 8:00am, Thomas sent a text message to Amanda expressing that he was not feeling well and that he was unsure he wanted to continue on with floor-laying.[8] Later that day, Graham returned home to find Thomas standing in the driveway with a golf club, stating that Graham was a member of the Ku Klux Klan and that he was going to kill him. Graham left and returned later to find the home ransacked, sending a text message to Amanda stating that Thomas had "gone mad".[9]

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[2] Ibid, [6].
[3] Ibid, [8]-[9].
[4] Ibid, [10].
[5] Tab 9, [13].
[6] Ibid, [15].
[7] Ibid, [16].
[8] Ibid, [17].
[9] Ibid.

24. Amanda was able to contact Thomas and arranged for him to see a general practitioner, Dr Catherine Tan, that afternoon. Amanda met with Thomas at the shopping centre where Dr Tan's practice was located. She noticed he had an old family computer in his truck and that he was convinced Graham had been watching secret videos on their VHS player.[10]

25. Thomas attended his appointment with Dr Tan at 2:50pm for approximately 20 minutes.[11] Dr Tan notes that Thomas, whilst presenting as calm and not at risk to himself or others at the time, did speak of issues with Graham and exhibited signs of chronic depression.[12] Dr Tan prepared a mental health care plan and provided referrals for Thomas to see a psychologist and a psychiatrist. Dr Tan also provided Thomas with crisis numbers to contact, including Lifeline.[13] Dr Tan noted that Thomas was agreeable to all the proposed treatments and was willing to attend the arranged appointments. A follow-up appointment with Dr Tan was also arranged for the following week.[14]

26. Following the appointment, Amanda drove Thomas home. During the drive, Thomas mentioned to Amanda that he thought he was being watched, and that there were white people in Penrith that were out to get him.[15] When they arrived home, Thomas was remorseful for the damage he had caused at the house and helped Amanda to tidy up. He had also punched his fist through the wall in the hall. He put a piece of paper over the hole with a smiley face and "Be happy" written on it. [16]

27. At 10:45pm, Amanda awoke to find Thomas had re-arranged much of the furniture in the living room, and had been collecting scraps of paper with notes made by Graham, convinced that Graham was hiding something from his past and was part of a white supremacist group. Thomas expressed various other delusions about Graham, including:[17]

    a. That he was having conversations with a brother in Scotland using a piece of computer cable;
    b. The he caused a red-back spider infestation in the garden;
    c. That he was part of the Ku Klux Klan because he had worked for QEK, a vehicle freight management company, in the United Kingdom;
    d. The he was responsible for water build-up in his truck's tray; and

[10] Ibid, [18].
[11] Tab 56, [4].
[12] Ibid, [5], [7].
[13] Ibid, [10].
[14] Ibid, [11].
[15] Tab 9, [20].
[16] Ibid, [21].
[17] Ibid, [23].

e. That he had put cameras around the house.

21 March 2017

28. On 21 March 2017 at 7:21am, Thomas's manager received a text message from Thomas stating "I quit".[18] At 7:33am, Thomas sent a text message to Amanda stating that he had quit his job, and was unable to get an appointment to see a psychiatrist until May 2017.[19] Amanda was concerned by this information and spoke with Dr Tan, who advised that if Amanda was concerned that Thomas was at risk of causing harm to himself or others, she should immediately telephone an ambulance and the police.[20] Dr Tan prepared a letter to Nepean Hospital that Amanda could pick up and present should Thomas be willing to attend hospital voluntarily.[21] The letter stated that Thomas had struggled with depression and traumatic events as a child, as well at PTSD, and would need a full mental-health assessment. It also mentioned Amanda's concerns about Thomas' ongoing paranoia ideations.[22]

29. Dr Tan later contacted psychiatrist Dr Benjamin Samir and was able to secure an appointment for Thomas on 24 March 2017.[23] Dr Tan attempted to contact Thomas on his mobile but was unable to do so, and left a voicemail asking that he present to hospital.[24]

Attendance of NSW Ambulance

30. Late in the evening of 21 March 2017, Thomas's behaviour continued to deteriorate. At 11:56pm, Amanda entered the spare room of their home and found Thomas sitting on the ground with a torch, attempting to piece together shredded paper from their shredding machine.[25] Thomas was convinced that there was evidence against Graham contained in the shredded material.[26]

31. Amanda was extremely concerned about Thomas's mental state, and at 12:06am on 22 March 2017, she called "000" to request an ambulance,[27] expressing to the operator that it was time that Thomas was taken into care.[28] By this Amanda meant, she wanted Thomas to be "scheduled" or "sectioned" under the *Mental Health Act*. Amanda understood this to mean being taken to

[18] Tab 59
[19] Tab 9, [24].
[20] Tab 56A, [21].
[21] Ibid, [22], [27].
[22] Tab 9, p. 11 and tab 56B.
[23] Tab 56A, [26].
[24] Ibid, [24].
[25] Tab 9, [25].
[26] Ibid.
[27] Tab 60, p. 3.
[28] Tab 70.

a hospital or mental health facility to be assessed.[29] At 12:31pm, paramedics Jillian Eve and George Mutton attended the Hunt residence.[30]

32. Section 20 of the *Mental Health Act* reads as follows:

> (1) An ambulance officer who provides ambulance services in relation to a person may take the person to a declared mental health facility if the officer believes on reasonable grounds that the person appears to be mentally ill or mentally disturbed and that it would be beneficial to the person's welfare to be dealt with in accordance with this Act.
>
> (2) An ambulance officer may request police assistance if of the opinion that there are serious concerns relating to the safety of the person or other persons if the person is taken to a mental health facility without the assistance of a police officer.

33. The New South Wales Department of Health has created its own form in compliance with s. 20 of the *Mental Health Act* titled "Request by member of NSW Ambulance for the assessment of a mentally ill or mentally disturbed person at a declared mental health facility".[31] This form was not completed in Thomas's case because Thomas was not ultimately assessed by paramedics after they attended on the Hunt residence.

34. Ms Eve said in her evidence that in a situation like the present where there is a patient, parent and paramedics, the paramedics have the decision making role with consideration being given to what the parent may say along with what the patient may say. The patient has the right to refuse assistance if they are mentally sound at the time.[32] I accept this to be the case.

35. The inquest heard evidence from Amanda, as well as both Ms Eve and Mr Mutton, as to their attendance that evening. The inquest had before it written statements of both paramedics.

36. Amanda said in her evidence that she would have been very anxious, concerned, desperate when the paramedics attended.[33] It was agreed that Amanda met Ms Eve and Mr Mutton at the front door upon their arrival. Amanda's evidence is that she did so because Thomas had significant trust issues, and she was worried that if he thought she had called the police, his trust in her would be broken and she would be unable to assist him in getting treatment.

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[29] TS p.34:38.
[30] Tab 68.
[31] Exhibit #7.
[32] TS p. 54:36.
[33] TS p34:44.

37. Amanda's interaction that evening was primarily with Ms Eve.

38. The consolidated copy of the Ambulance Electronic Medical Record ("the Consolidated Copy") records a summary of the attendance of paramedics at the Hunt home that night. Ms Eve completed it. Amanda does not dispute the summary.[34] The case description in the Consolidated Copy reads as follows:

> "o/a met outside by pt parent who advises pt does not know we are attending tonight, pt parent advises pt has been behaving strangely for a long time but is gradually gotten worse, pt is moving furniture and ransacking draws and reassembling shredded paper, pt is acting paranoid and thinks he is being followed, pt attended GP with his mother earlier in the week and GP recommended psychiatric assessment for pt, pt parent advises pt ha an appointment in 3 days time which parent will take him to. Pt is not threatening self harm or harm to his mother whom he lives with and nil hx of same, pt has a problem with his father and threatened him in the past but not tonight, father is not living here, pt eventually realised paramedics were at the door and advised from the background that he was going to bed and didn't want to talk, pt appeared agitated and animated but not threatening, pt parent wanted pt scheduled as GP told her to call ambulance and take pt to hospital if concerned, explained to pt mother that unless pt is threatening to harm himself or her we don't have grounds to take him and if he won't come along we may need to get Police to help restrain pt, pt parent did not want this to occur and I advised we would have no choice if pt became violent when approached, pt parent decided not to pursue hospital tonight as pt not a danger and will be going to psychiatrist on Friday, pt mother then went back into house advising our services no longer required."

39. Absent from the summary is Amanda's evidence that she handed Ms Eve a copy of the letter provided to her by Dr Tan to be presented at the hospital. It will be remembered that this letter included Dr Tan's opinion that Thomas would need a full mental-health assessment. Ms Eve gave evidence that she did not specifically recall Amanda handing her a letter nor whether she read it but she could not say that she did not receive it nor that she did not read it.[35] Mr Mutton said he had a vague recollection of Amanda presenting a letter, and that it was Ms Eve who read it. Amanda said that when she handed Ms Eve the letter she only cursively looked at it and handed it back. Amanda felt Ms Eve was dismissive of it.[36]

40. I note further that the Consolidated Copy relating to the incident, records information that Amanda says she did not tell the paramedics, namely that Thomas had a history of PTSD, but that was contained in Dr Tan's letter.[37] This is further support that Amanda did hand the letter to Ms Eve and Ms Eve reading

[34] TS p.37:15.
[35] TS p.55:1 and p.55:33.
[36] TS p.40:4.
[37] Tab 67.

it, at least to the extent that she noted a history of PTSD. On the basis of the evidence available I accept that Amanda did hand Ms Eve the letter from Dr Tan.

41. After handing the letter to Ms Eve, Amanda recalls Ms Eve telling her words to the effect that the paramedics were just the "transport crew" or "transport service".[38] Amanda explained that by this she assumed the paramedics were a transport service that took a patient from A to B. Her assumption was also based, in part, on the situation in England, where Amanda is originally from, where they have two ambulance services and a distinction is apparently made between the service that treats and the service that transports.[39] Ms Eve could not recall specifically saying that. Rather, she thinks she may have mentioned that she was in charge of transporting Thomas to hospital, but it would be up to the hospital what went on beyond that.[40] Amanda said nothing like that was said to her.[41]

42. It is concerning that, even accepting Ms Eve's version, that Amanda, who, at the time, was anxious, concerned, and desperate to seek help for Thomas, was left with a false impression of the role of the paramedics who had attended her home to assist with obtaining treatment for Thomas.

43. Ms Eve said that even if she had read the letter from the GP she would have needed to assess Thomas and assess her need to get him to hospital voluntarily or involuntarily. On the question of assessment, Amanda did not agree, contrary to Ms Eve's evidence, that three offers to assess Thomas were made by Ms Eve. Amanda says only one offer was made.[42] I note that the Consolidated Copy only records one offer to assess Thomas. Mr Sean Mutchmor, General Manager of Quality and Safety at the Australian College of Rural and Remote Medicine and a previous critical care paramedic himself with Queensland Ambulance Service, gave evidence before the inquest. He observed that it may have been more beneficial in this matter if the fact that there were a number of offers made had been recorded in the Consolidated Copy.[43] I accept however that at least one offer to assess Thomas was made by Ms Eve.

44. Amanda said that when making that offer to assess Thomas, Ms Eve said that if Thomas did not want to go with the paramedics to the hospital the paramedics would need the assistance of police.[44] Amanda later accepted that Ms Eve said

[38] TS p.40:4.
[39] TS p.40:38.
[40] TS p.55:16.
[41] TS p.47:46.
[42] TS p.38:50.
[43] TS 7/7/20, p.5:25.
[44] TS p.39:31.

that police *may* need to be involved.[45] Amanda said in her oral evidence that if she had understood the legislation and understood that paramedics could not actually contact the police unless they had a concern for their safety, she may have changed her opinion and allowed them to asses Thomas. Ultimately however Amanda did not think Ms Eve would be able to communicate with Thomas. She formed the impression overall that Ms Eve came across as somebody who was "matter of fact", "cold" and "didn't show any empathy to the situation."[46] Ms Eve did not think there was anything about her communication that could have been improved.[47]

45. I understand from Amanda's evidence that the real issue she had with the paramedics attendance at her home was the *way* in which Ms Eve communicated with her which left her thinking Ms Eve would not be able to communicate with Thomas effectively enough to have him transported without police assistance. Amanda did not want police attending for reasons that are understandable. On that basis, she thanked the paramedics and sent them away, confident she could get Thomas to attend his upcoming appointment with the psychiatrist, and so as not to avoid losing his trust.[48]

46. Mr Mutchmor had the benefit of listening to the evidence of Amanda, Ms Eve and Mr Mutton as well as to review the relevant portions of the Brief of Evidence. He was of the overall opinion that the paramedics acted appropriately in their interactions with Thomas and his mother and they acted in accordance with what would be widely accepted in Australia by peer professional opinion as competent professional practice.[49]

47. Mr Mutchmor agreed that optimal communication with family and patient is critical for the safe management of the scene and to ensure the best outcome for the patient's welfare.[50] He also said he would expect that the paramedic should explain matters to the best of their ability given the situation and the level of comprehension that they may deem that the person they are speaking to may or may not have.[51]

48. In this case, Amanda's interaction with Ms Eve left her genuinely feeling, to use her words, "that something was wrong with that evening."[52] In the spirit of ensuring optimal communication as between paramedics and third parties, including parents of patients, Mr Mutchmor agreed that a scenario like the one

[45] TS p.41:22.
[46] TS p.40:7.
[47] TS p60:6.
[48] Tab 9, [26].
[49] TS 7/7/20, p.2:43
[50] TS, 7/7/20, p.3:44-48.
[51] TS, 7/7/20, p.4:32.
[52] TS, 7/7/20, p.42:37.

that this inquest presents would be a useful one in communication training for paramedics responding to a mental health emergency.[53]

49. The brief of evidence contains materials relating to communication training undertaken by paramedics. A component of training includes scenario based role playing. I consider that a scenario based on the factual matrix of this inquest would go some way in assisting paramedics in their communication with parents of patients. This case, in particular, presents a mother who has taken the step to call for an ambulance because she believes it is time for her son to be taken into care and her desire is to have her son scheduled under the *Mental Health Act*. She does not have a working understanding of section 20 of the *Mental Health Act* and she does not want police to be involved because her son has an issue with trust and she does not want to break that trust. She has a letter from the GP to the hospital that says he will really need a full mental health assessment. She is anxious, concerned and desperate.

50. Mr Kevin McLaughlin, Director of Mental Health NSW Ambulance, indicated at the inquest that he had spoken with Mr Mike Richer, Assistant to the Director Education at NSW Ambulance, who agreed to take the factual scenario that this inquest presents to the next clinical review committee with the possibility of informing the educational program and scenario training in the future. The clinical review committee sits every month.

51. I do not consider the need for a formal recommendation in this regard, confident that NSW Ambulance will take these findings and, where necessary, apply any learnings to its educational program.

Events following the ambulance departure – 22 March 2017

52. Thomas continued to exhibit concerning behaviour after the ambulance's departure. At 2:25am, Amanda heard Thomas retching in the kitchen sink, and he told her Graham had poisoned his food or drink.[54] Thomas later positioned a number of plates on the floor of the spare room and was sorting shredded paper into groups, convinced that Graham was a terrorist and requesting Amanda's assistance as it needed solving that night.[55] He also said to Amanda that someone should kill Graham.[56]

53. At 2:45am, Amanda heard Thomas talking to himself and saying that he could hear voices. Amanda later entered the kitchen hoping to take a photo of the shredded paper on the floor. When Thomas noticed Amanda holding her

[53] TS, 7/7/20, p5:2.
[54] Tab 9, [28].
[55] Ibid, [29].
[56] Ibid.

phone, his demeanour changed and he began cleaning everything up. From this point on, Amanda believes Thomas no longer trusted her and that she was "in on whatever Graham was in on".[57] At 4:51pm, Thomas was still awake and could hear plates clashing. When Amanda woke up, Thomas had cleared everything away, however he remained suspicious of Amanda and was increasingly aggressive towards her.[58]

Thomas's disappearance

54. Later that morning, Thomas drove Natasha to work and took his children to school and day-care.[59] This was the last time anyone in the family saw Thomas.

55. Daniel made a phone call to Thomas and asked him about his plans for the day. Thomas told Daniel that he was going to Newcastle for the day, and spoke of Maori spirits that had "told him what to do" and that "the truth would set me free".[60] Thomas also informed Daniel that he had quit his job. Daniel was concerned for Thomas and suggested that he take Amanda with him, and asked specifically where in Newcastle he was going; however, Thomas became suspicious and ended the call.[61]

56. At 9:39am, Daniel contacted Amanda informing her that Thomas had told him that he was hearing voices. [62] At around 10:15am, Natasha contacted Amanda to tell her that Thomas had contacted her saying that he was not coming back, and to look after their children.

Thomas is reported as a missing person

57. At 11:18am, Amanda reported Thomas as a missing person. The Computer Aided Dispatch ("CAD") message created in response to Amanda's call was allocated a priority 3 "concern for welfare keep lookout" and broadcast as:

> "INFT CONCERNED FOR HER SON THOMAS HUNT 13031990 HAVING A PSYCHOTIC EPISODE, HISTORY OF MENTAL HEALTH, HAS SAID GOODBYE TO HIS PARTNER AND TOLD HER TO LOOK AFTER THE CHILDREN AND DECAMPED AFTER 0900, INFT SPOKE TO HIM AT 1021 AND IS VERY ANGRY WITH EVERYONE, HAS NOT SLEPT IN 24 HOURS, HASN'T MADE SPECIFIC THREAT OF SUICIDE, SAID IS ON HIS WAY TO GOSFORD, POI MOBILE 0424993693 CHKS OTW".[63]

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[57] Ibid, [30]-[31].
[58] Ibid, [31].
[59] Ibid, [32].
[60] Tab 10, [16].
[61] Ibid.
[62] Tab 9, [33].
[63] Tab 8, CAD message dated 22 March 2017, 11.18am.

58. At around 11:24am, Senior Constable Brian Tulk ("SC Tulk") and Senior Constable Jason Hattch ("SC Hattch") attended the Hunt residence and spoke with Amanda.[64] Amanda provided information about Thomas's mental state and his recent behaviour and her concerns for his welfare, as well as a photograph of Thomas. SC Tulk and SC Haatch subsequently requested that their external supervisor, Sergeant John Janovsky ("Sergeant Janovsky") attend the Hunt residence.[65] Sergeant Janovsky arrived at approximately 11:40am.

59. At 11:48am, SC Tulk provided Penrith VKG with the information to broadcast a "keep a look out for" Thomas, and requested that the information be broadcast to both Gosford and Wollongong channels also. The message was broadcast at 11:50am[66] and recorded as:

> "KLO4 VOI AZS73J MAZDA BRAVO SILVER C4W OF DRIVER THOMAS HUNT DOB 13031990 DESC AS M 5FT 10 CAUC APPEAL SOLID BLD SHAVED HEAD STRONG CONCERNS WITH MENTAL STATE PARANOID THOUGHTS NEEDS TO BE ASSESSED POSS RISK TO HIMSELF OR OTHERS".[67]

60. Sergeant Janovsky provided advice to SC Tulk and SC Haatch about the appropriate investigative steps that could be taken in seeking to locate Thomas.[68] This advice included circulating a "keep a lookout for" for Thomas and his car, that warnings be placed on both Thomas and his vehicle and that a mental health assessment was to be conducted if he was located.[69]

61. The evidence indicates that SC Haatch raised with Sergeant Janovsky the possibility of organising the triangulation (now called "emergency mobile location") of Thomas's phone.[70] Sergeant Janovsky gave evidence that at that time, despite concerns about Thomas's mental health, he had not made specific threats of self-harm or threats of serious harm to another person, was not taking any medication, there was nothing to suggest he had been taken against his will and he had not missed any pre-arranged appointments. On that basis, Sergeant Janovsky's view was that the threshold set out in s. 287 of the *Telecommunications Act 1997* (Cth) for the triangulation of Thomas's phone had not been met. In his evidence Sergeant Janovsky accepted that he also knew at that time that Thomas had said something similar to "his father should

[64] Tab 15, [5], Tab 15A, [3].
[65] Tab 15C, [9].
[66] Tab 8, CAD messaged dated 22 March 2017, 11:50am.
[67] Tab 15, [9].
[68] Ibid, [12].
[69] Ibid.
[70] Ibid, [15], Tab 15A, [11].

be killed". Sergeant Janovsky said however there was nothing imminent about that threat to his father.[71]

62. Having formed the view that the threshold for the triangulation of Thomas's phone had not been met, Sergeant Janovsky did not contact the duty operations inspector to organise a triangulation, which was the practice, nor did he contact the duty operations inspector to seek advice about whether there were reasonable grounds for a triangulation.[72] The duty operations inspector retained a discretion as to whether the triangulation would be performed.[73] For Sergeant Janovsky, this was a very clear case that had not reached the threshold.[74]

63. Amanda was made aware of this police view, later sending a text message to Daniel stating, "unless he said he was going to kill himself they can't do triangulation".[75] It is not clear on the evidence who told Amanda this. Both SC Tulk and Sergeant Janovsky gave evidence that it could have been them. Either way, Amanda understood from what police told her that Thomas's phone could only be accessed if there was a threat to his life. This is not only an incorrect interpretation of the power under the *Telecommunications Act* but also an undesirable way in which to communicate the power to a family member of a missing person.

64. I pause here to make some observations about the power that arises under s. 287 of the *Telecommunications Act*. The section provides that:

> "*Police may access Telecommunications information of a person if Police believe on reasonable grounds that the disclosure or use is reasonably necessary to prevent or lesson a serious and imminent threat to the life or health of a person."*

65. The Missing Persons Standard Operation Procedures ("MP SOPS") that applied at the time of Thomas's disappearance gave police no guidance on the application of s. 287. It became apparent during the evidence that police were, and still are, interpreting and applying the test under s. 287 differently, meaning where the threshold may be met for one officer for the triangulation of the phone of a missing person, it may not be met for another. This was made stark as between the evidence of Sergeant Janovsky and Detective Inspector Glenn Browne ("DI Browne"), Manager of the Missing Persons Registry ("MPR") at State Crime Command. Sergeant Janovsky understood the words "to prevent or lessen a serious and imminent threat to the health of a person" to apply to

[71] TS, 8/7/20, p.7:44.
[72] TS 8/7/20. P.6
[73] TS 8/7/20, p.15:28.
[74] TS, 8/7/20, p. 10:26.
[75] Exhibit 6.

the physical health of a person and not the mental health of a person.[76] DI Browne was of a different view. He said that a fair majority of missing persons are more related to mental health than physical health.[77] DI Browne was of the opinion that the information relayed to police and contained in the CAD updates at 11.18am and 11.48am on 22 March 2017 raised reasonable grounds to make an application for triangulation.[78] The aspect that brought him to that belief is that there was potentially an imminent threat to the life of the person reported missing as well as to his health.[79]

66. The new MP SOPS that came into effect on 1 January 2020 dedicate a section to using mobile phones to urgently locate someone at risk. Some examples of appropriate circumstances in which a request for triangulation should be made are given. However, the section is still scant on how officers should interpret s. 287. When asked about this DI Browne said that he is cognisant that there are varying interpretations of s. 287. He said he had recently submitted a report to the Office of General Counsel trying to get a clearer interpretation of the section so that better guidance could be provided to the field. Additionally, the State Coordination Unit that controls applications for triangulation have concern over the use of the word "belief" in s. 287; they would like that changed to "suspicion". Meanwhile, they set the bar fairly high for applications for triangulation. In DI Browne's own personal view the bar is much lower than the Unit's interpretation.

67. As DI Browne said in evidence, the reality is triangulation is an incredibly useful tool for missing persons investigations. These days most people are carrying a mobile phone or some other device that can be located using triangulation. Certainly as Manager of the MPR, DI Browne would like to see police using it more often. It is therefore of some concern that the bar is set high for applications under s. 287 by the State Coordination Unit.

68. At the close of the oral evidence, Mr Hutchings, for the Commissioner of Police, filed written submissions on the interpretation of s. 287. The submissions urge this Court to find that the threshold test contained in s. 287 is not a high bar that can only be met where proof of a missing person's intentions are available. The community would expect that where the NSWPF is in possession of credible information concerning a threat to a missing person's health or safety all available action ought to be taken. That is plainly so and I accept that this is how the section ought to be read; proof is not required.

[76] TS 8/7/20, p.9:13.
[77] TS 8/7/20, p30:13.
[78] TS 8/7/20, p.33:45.
[79] Ibid, p33:49.

69. DI Browne also raised in his evidence the need to change the processes around the application for a triangulation so it becomes more formalised. At the moment it is administered through phone calls. He would like to see the application process embedded into an IT system so that the information that is provided in the application is recorded and the decision and the reasons for those decisions are also recorded so that the MPR can keep a better eye on how s. 287 is being interpreted and administered. I am of the view that the ability of the MPR to track applications for triangulation is in the public interest and goes to matters of public health and safety. Accordingly, I make a recommendation in this regard, explained further below.

70. There were hallmarks in Thomas's disappearance that at the very least should have elicited a conversation between Sergeant Janovsky and the duty operations inspector about whether the threshold under s. 287 had been met. Those hallmarks were:

a. Concern by Amanda that Thomas was having a psychotic episode;
b. A history of mental health;
c. Thomas saying goodbye to his partner and asking her to take care of the children;
d. A view formed by police that there was a clear need for Thomas to be assessed; and
e. Thomas had mentioned that his father should be killed or something similar.

71. Sergeant Janovsky said that if faced with the same scenario today he would contact the duty operations inspector and run through the information he had.[80]

72. At 1:48pm, SC Tulk completed COPS Event E63550724 in relation to Thomas,[81] and uploaded the photo of Thomas provided to him by Amanda to what is known as the VIEW IMS system - a database that gave the COPS system the capability to store documents. The MP SOPS in force at the time of Thomas's disappearance required the investigating officer to conduct a risk assessment regarding the missing person, and upload that assessment to COPS.[82] This risk assessment would then inform the investigative response with regard to the missing person. Equally, supervisors had the responsibility to ensure that risk assessments were completed and recorded, and that police action related to the level of risk assessed.

73. SC Tulk gave evidence that he could not recall whether he had completed a risk assessment in relation to Thomas, and that his assumption is that at the

[80] TS 8/7/20, p.10:40.
[81] Tab 62.
[82] Tab 72, Annexure A, p. 8-10.

time he completed the Event he was not aware that the MP SOPS required a risk assessment to be completed. SC Tulk further explained that he had a habit of detailed record keeping and accepted that if a risk assessment was not recorded in the Event, then it was likely that one had not been done.[83] I accept SC Tulk's characterisation of his record-keeping, given the level of detail evident in the Event, and that in relation to Thomas's case, a risk assessment was not completed.

74. SC Tulk also gave evidence that at that time at Penrith police station, he was unaware of any process for uploading risk assessments to an online system, and that they were instead stored in a hard-copy folder near the supervisor's office.[84] According to the evidence of DI Browne risk assessments ought to have been uploaded to VIEW IMS not kept in hard copy folders. Either way, this coronial investigation did not uncover a risk assessment in Thomas's case.

75. On 22 March 2017, Sergeant Robert Creamer performed duties as the internal supervisor attached to the Penrith Local Area Command. In his statement Sergeant Creamer said that he could not recall verifying the Event on 22 March 2107, nor did he remember if a risk assessment was completed in respect of that Event or whether he had verified the risk assessment.

76. Sergeant Creamer said that he was unaware of any requirement to complete a risk assessment and for that risk assessment to be verified in accordance with the MP SOPS. Ordinarily, the risk assessment would be verified if it was uploaded onto the COPS system. Sergeant Creamer could not remember being provided with any actual training on preparing or verifying missing persons risk assessment forms.

77. DI Browne gave evidence that according to the old MP SOPS, the risk assessment should have been sighted by the supervisor prior to the Event being verified. This is because the supervisor needed to be satisfied that the risk assessment was appropriate and that the investigative functions that were to inform the investigation were commensurate with that risk rating.[85]

78. DI Browne was asked to look at Thomas's case and give it a risk rating as against the MP SOPS and risk assessment questionnaire that applied at the time. He said that this was a clear case of a "high" risk. Sergeant Janovsky disagreed, saying that to his mind, it was a "medium" risk. This is another example of where minds might have differed under the old MP SOPS. The new MP SOPS enhance consistency with the respect to risk assessments and investigative functions that might follow. This is explained further below.

[83] TS, 7/7/20, p.21:14ff
[84] TS, 7/7/20, p.22:36.
[85] TS, 8/7/20, p.26:34.

Further contact with Thomas

79. In the afternoon of 22 March 2017 at approximately 1:54pm, Thomas called and spoke with Bethany for approximately 30 minutes.[86] Bethany could tell Thomas was not his usual self – he mentioned Graham being a member of the Ku Klux Klan and how he heard Maori spirits talking to him.[87] Thomas also told Bethany that he was driving to Gosford, and she encouraged him to go home, however he resisted stating that he would be sent to hospital and treated "as a psycho".[88] Towards the end of the call, Thomas become almost silent and unresponsive, and said he had to go as his phone was going flat. Bethany attempted to call and text Thomas later that day however his phone had been turned off.[89]

80. At 4:12pm, Thomas sent Amanda a text message that said "thunder and lightning in bond".[90] Amanda responded asking "Where's bond" however Thomas did not reply. At 4:33pm Thomas replied to another message stating that he would not be home for dinner.[91] At about 4:38pm, Natasha sent a text message asking Thomas when he would be coming home, to which Thomas replied "Never".[92]

Thomas's arrival at Hotel Bondi

81. Though Thomas's precise movements on 22 March 2017 are unclear, call charge records indicate that Thomas travelled from the Penrith area to the Central Coast area before returning to Sydney later that afternoon.[93]

82. CCTV footage captured Thomas arriving and checking himself into Hotel Bondi at approximately 5:07pm, and entering Room 209 at approximately 5:24pm.[94] Thomas left his room at 5:42pm and returned at 5:51pm, carrying with him a shopping bag and other items.[95]

83. At 6:20pm, Amanda called Penrith police station and spoke with Senior Constable Andrew Burden ("SC Burden").[96] Amanda informed SC Burden of

[86] Tab 11, [20], Tab 34, Annexure B.
[87] Tab 11, [21].
[88] Ibid, [22].
[89] Ibid, [23].
[90] Tab 9, Annexure 2
[91] Ibid.
[92] Tab 14, [7].
[93] Tab 34.
[94] Tab 38B, Annexure A.
[95] Tab 28, [6].
[96] Tab 14, [4].

the contact Thomas had had with Bethany and Natasha that day, and the text message she received stating "thunder and lightning in bond", which she believed could have been referring to the Sydney suburb of Bondi.[97]

84. SC Burden updated the Event with the information provided by Amanda, and discussed this information with his supervisor, Sergeant Creamer.[98] Some consideration was given to liaising with Eastern Suburbs Police Area Command following Amanda's phone call,[99] however this was not done, as both SC Burden[100] and Sergeant Creamer[101] formed the view that creating a CAD job for the Eastern Suburbs Local Area Command was not appropriate at that time. A number of considerations informed this view including that the term "bond" could have been a misspelling/auto correction for any number of words; Amanda gave no reason for Thomas going to Bondi; Bondi is a large geographical area and without more specific information to direct Eastern Suburbs Police where to search, it gave police little assistance in locating Thomas.[102]

85. Sergeant Janovsky was asked hypothetically what further enquiries, if any, he would have requested SC Burden to make in respect of the new information if he had been the internal supervisor and he said that he would have had him contact Bondi police to let them know about the missing person and that a call had been received that indicated he might be in the area.[103] DI Brown also opined that this was an investigative function that should have been pursued. As an investigator he said he would have at least considered that "bond" was a reference to Bondi and that there may be a possibility that Thomas was at Bondi. He would have alerted Bondi to the fact that a missing person at risk may have been in their area. Alerting them in this way would also have meant that Thomas's case would have been on their "radar" and on their CAD.

86. Moreover, as DI Browne said in evidence, risk should continually be reassessed during an investigation; any new information should cause a new risk assessment to be conducted. The information relayed in this call ought to have caused a reassessment of the risk and a consideration of whether there were other investigative functions open, including the use of triangulation. SC Burden said in his statement that SC Creamer did not think the threshold had been met. DI Browne disagreed; in his view the threshold had been met. In fairness to the supervisor, DI Browne said that he has, in his experience, seen numerous examples where applications have been made and knocked back in similar

[97] Ibid, [5]-[7].
[98] Tab 14, [9].
[99] Tab 14A, [8].
[100] Ibid, [9]-[13]
[101] Tab 15B, [14]-[15].
[102] Tab 14A [9]-[11].
[103] TS, 8/7/20, p.15:11.

circumstances. It is understandable therefore why supervisors form a view that their applications would not meet the threshold.[104]

87. At 6:24pm, Thomas sent a text message to Amanda that stated "memories are flooding back".[105] Multiple further text messages sent by Amanda that evening to Thomas were not responded to.

88. At 7:30pm, CCTV captured a Hotel Bondi staff member attending to Room 209 with a room service trolley, delivering food items and a bottle of wine.[106]

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89. On 23 March 2017 at 12:54am, Thomas sent a text message to Bethany saying that he loved her, and would talk soon as his phone was flat.[107]

90. Thomas was captured on CCTV leaving Room 209 at 8:36am carrying a shopping bag, and returning with the bag and other items at 8:42am.[108] During the course of the investigation into Thomas's disappearance, a Hotel Bondi receptionist informed Detective Senior Constable Lucy Stansfield that Thomas had attended reception at approximately 8:40am and extended his stay by one night.[109] This was the last sighting of Thomas recorded on CCTV at Hotel Bondi.

91. At around 9:00am, Thomas sent three text messages to Graham. The content of these messages was nonsensical, referencing a "listening device", "white hair" and saying to "tell your short English looking mate with the Makita grinds and utensils he better bring his A game".[110]

92. At 9:15am, Thomas called Graham's phone. Amanda answered the call as Graham was driving and spoke with Thomas. Amanda observed from the call that Thomas's mental state was deteriorating and that he was out of touch with reality. He was ranting about nonsensical things, saying words to the effect of "Bandidos, we must unite together. Women killers, white haired people…". Thomas then said "I shouldn't be talking to you" and hung up the phone.[111]

93. At 9:18am, Amanda telephoned Penrith Local Area Command to update the police regarding her contact with Thomas.[112] A CAD message was created in response to Amanda's call at 9:18am.

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[104] TS, 8/7/20, p.35:5.
[105] Tab 9, Annexure 2.
[106] Tab 28, [6]
[107] Tab 34, Tab 11, Annexure 2.
[108] Tab 28A [6].
[109] Ibid, [7].
[110] Tab 9, Annexure 5.
[111] Tab 9, [37].
[112] Tab 60.

94. Other than the creation of the CAD message, no other action was taken by police in response to this call by Amanda. I find however that it was an opportunity to reassess risk and revisit the question of whether the threshold for triangulation had been met. Sergeant Janovsky and Inspector Kai Pennikalampi ("Inspector Penninkilampi") agreed. Inspector Pennikalampi's involvement in this matter is introduced further below.

95. Later that morning, Amanda noticed that the earlier phone call from Thomas had originated from a landline number rather than Thomas's mobile. After undertaking a Google search, Amanda discovered that the number Thomas had called from was in fact from Hotel Bondi. Amanda immediately called Penrith Local Area Command to provide them with this information, her call charge records indicating that this occurred at 11:00am.[113] Amanda gave evidence that at this point, she was relieved and let her guard down, believing that since Thomas's whereabouts were known, the police would be able to locate him and bring him to safety.

96. In a most unfortunate turn of events, there is no evidence that any action was taken in relation to Amanda's call to Penrith Local Area Command at 11:00am, and the identity of the person who received the call could not be positively identified following police inquiries.[114]

97. The inquest heard evidence from Inspector Penninkilampi from Nepean Police Area Command in relation to Amanda's 11:00am call. Inspector Penninkilampi prepared an Investigator's Report in relation to the failure to take appropriate action in response to Amanda's call. In the course of investigations, an email was circulated to staff present on 23 March 2017 that asked whether any individual recalled taking a call from a woman calling with information about her son, a missing person.[115] All officers responded in the negative, except for General Administrative Support Officer Annette Chappell ("GASO Chappell"), who stated:

> "*Yes I was on the counter that day… Very, very, vaguely, I do remember a call relating to the MP being seen in a hotel in Bondi… I honestly cannot remember who took that call but for some reason I feel that info was acted on, I'm feeling to the Supervisor, or maybe a note in the CAD, however I'm not 100% sure"*[116]

98. In giving his evidence, Inspector Penninkilampi agreed when it was put to him that GASO Chappell's response in fact conflates the content of both Amanda's

[113] Tab 60.
[114] Tab 12B.
[115] Tab 53AA, p. 3.
[116] Ibid.

9:18am and 11:00am call. Inspector Penninkilampi also gave evidence that GASO Chappell was the only person captured on CCTV at Penrith Police Station answering a call at both 9:18am and 11:00am. Inspector Penninkilampi also agreed that ultimately, he did not believe any action had been taken within their command in response to Amanda's 11:00am call. He said he would have expected the internal supervisor at Penrith to be advised and subsequently the information relayed to the relevant command, namely Bondi.[117]

99. On the basis of the available evidence, I accept that it was GASO Chappell who answered Amanda's 11:00 call, and that no further action was taken as a result of receiving this information. Whilst I also accept Inspector Penninkilampi's evidence that Penrith Police Station is extremely busy and receives a consistently high volume of calls, it is of serious concern that a phone call containing crucial information regarding the location of Thomas, a missing person experiencing a mental health crisis, was not passed on in any form, whether to an internal supervisor, via an update to the CAD, or in a referral to the Eastern Suburbs Local Area Command. Inspector Penninkalampi accepted that the 11am call presented an opportunity for police action.[118]

100. Of further concern is that it was put against GASO Chappell that she failed to update the CAD system in respect of the 9.18am call and that this was the subject of disciplinary action, namely, she was referred to the Professional Standards Command ("PSC"). Of course, the CAD clearly shows that the 9.18am call was recorded at 10.40am. When taken to the record, Inspector Penninkalampi said he could not recall seeing this entry during his investigation.

101. The outcome of the PSC referral is unknown. Regardless, the referral to the PSC was unnecessary. On the evidence, the information Amanda gave police in the 9.18am call was not relayed to the internal supervisor at the time. It was eventually relayed to SC Tulk when he came on shift at 3pm. That the information was not relayed to the supervisor was not the subject of investigation or referral to the PSC.

Other investigative functions not undertaken

102. As mentioned, DI Browne was asked to look at Thomas's case and, in circumstances where there was no risk assessment conducted in compliance with the MP SOPS, he was asked to give a risk rating and outline what the police response should have been commensurate with that rating.

103. Based on the information available to him and specifically:

[117] TS, 8/7/20, p.22:15.
[118] TS, 8/7/20, p22:38.

a. The current mental state of Thomas;
b. Thomas had contacted his partner to say he was not coming back and to look after the kids; and
c. Thomas was reported to be highly agitated and paranoid,

DI Browne was of the view that that the risk rating at the time would have been assessed as High.

104. If this determination had been made, several other investigative functions could have been considered including:

a. **A triangulation on Thomas's mobile**. In this regard it is noted that the Call Charge Records obtained later in the investigation indicate Thomas's mobile service was still communicating with the network at 9am on 23 March 2017. If a triangulation was requested, approved and undertaken on 22 March, it may have provided evidence that the relevant device was in the broader Bondi area.

b. **Consideration of a media release**. Sergeant Janovsky said a media release was not considered because Thomas was not a vulnerable person, had not made any direct threats to seriously harm or kill himself and he was not in the company of children. He did agree when questioned that a media release may have at the very least alerted staff at the Hotel Bondi that Thomas was a missing person as did DI Browne. DI Browne also said that today police try to engage all available tools more readily. Police are encouraged to consider the use of media releases, including through social media like Facebook.[119]

c. **Consideration to directly attempting to contact Thomas on his mobile**. Sergeant Janovsky assumed the investigating officers would have called the mobile phone. He could not recall discussing it with them on the day though but did agree that as the external supervisor, it was his duty to discuss investigative options with the officers.[120] He foresaw no risks in calling the phone or sending a text message.[121] SC Tulk similarly said it was open to him to directly call or text but this was not done.

It is relevant to note that the function of contacting someone directly or sending a text message to their phone is a pre-condition to making an application for triangulation under the new MP SOPS.[122]

[119] TS, 8/7/20. P.36:41.
[120] TS, 8/7/20, p14:33.
[121] TS, 8/7/20, p14:47.
[122] TS, 8/7/20, p.36:3.

DI Browne said that there is always the potential for a negative impact with any investigative function. However, in his view each of these things need to be considered, decisions made and documented.[123]

105. I note that other than a potential media release and triangulation, DI Browne was unaware of any other investigative function that is likely to have assisted in locating Thomas prior to him contacting his father's mobile telephone from Hotel Bondi on 23 March 2017.

The new MP SOPS and Thomas's case

106. DI Browne offered his views on how the new MP SOPS may have impacted the police response to the disappearance of Thomas if that event were to occur today. The salient factors include:

a. According to the new MP SOPS, risk assessments are mandatory. Work is almost complete to have initial risk assessments become a mandatory function built within the COPS system when a missing person report is created;

b. The initial risk assessment must be completed by the officer taking the report before a COPS Event can be submitted for verification. The risk assessment is focussed on asking the right questions at the initial stage of the investigation to identify the level of risk and comprises 26 questions. A supervisor cannot verify an Event until they have reviewed that risk assessment, attributed a risk rating to it, and detailed how they intend to respond to the identified risks. Additionally, the COPS system will prompt police to consider conducting further risk assessments each time new information is added to an Event to address changing risk;

c. There is a list of relevant iAsk requests to be submitted during the initial phase of a missing person investigation;

d. Specialist investigator attached to the MPR review all missing persons reports within 24 hours. During this initial review COPS Events are examined and risk assessments and actions undertaken are considered. Investigators will immediately contact the relevant command to notify them of additional things to be considered. All fresh missing persons matters are continually reviewed daily by the MPR until a formal 14 day MPR review is undertaken; and

[123] TS, 8/7/20, p.36:15.

e. Every Police Area Command and Police District now has a nominated Missing Persons Coordinator who provides early intervention and guidance for missing persons investigations. They have become the person that people within the command will know to go to whenever they engage in a missing person investigation. They are appropriately trained and funding has been received for a yearly conference for those coordinators for ongoing training.[124]

107. One of a number of initiatives being pursued by the MPR is the geographic targeting of SMS messages for high risk missing persons. The MPR has commenced consultation with Telstra to facilitate "geographic targeting" of SMS messages for high risk missing persons. Like the geographic targeting of SMS for bushfires, it is proposed that SMS messages, (containing photographs if their release is authorised) be sent to devices within a defined geographic area when someone goes missing in high risk circumstances.

Graham Hunt attends Bondi Police Station

108. Graham said in his statement that he expected further contact from Penrith Police Station after Amanda's 11:00 am call. When this did not occur, Graham drove to Bondi, arriving at approximately 2:00pm.[125] Graham immediately attended Hotel Bondi, where he spoke with a receptionist who advised him that Thomas was staying in Room 209.[126]

109. Graham's evidence is that he then attended Bondi Police station arriving at approximately 2:10pm.[127] When he arrived, he spoke with Senior Constable Vincent Ongsritrakul ("SC Ongsritrakul"). However, SC Ongsritrakul's recollection was that Graham attended shortly before 3:00pm.[128]

110. Graham informed SC Ongsritrakul about Thomas's disappearance, that he made enquiries and discovered that Thomas was staying at Hotel Bondi, and that there were concerns regarding Thomas's mental health.[129] SC Ongsritrakul made enquiries regarding the COPS Event and identified that the officer in charge of the investigation was SC Tulk.

111. SC Tulk was scheduled to commence his shift at 3:00pm on 23 March 2017.[130] SC Ongsritrakul was advised of this when he called Penrith. He told Graham as much and asked him to return at 3:00pm.

[124] TS, 8/7/20, p.27:20
[125] Tab 12AA, p. 2.
[126] Ibid.
[127] Ibid.
[128] Tab 16, [5].
[129] Ibid, [5]-[6].
[130] Tab 15, [13].

112. Further evidence received by the inquest in the form of an audit report[131] detailing SC Ongsritrakul's access to the COPS system, confirmed Graham's version of events.

113. SC Tulk gave evidence that his usual practice was to arrive at the station approximately 30 minutes prior to his shift starting in order to prepare himself. Prior to commencing his shift, SC Tulk was informed (likely by GASO Chappell) that Amanda had contacted Penrith Police and was given information regarding Thomas's behaviour as relayed in her 9:18am call. [132]

114. At some time prior to commencing his shift, SC Tulk called and spoke with SC Ongsritrakul, as he had been informed that SC Ongsritrakul had earlier attempted to speak with him.[133] SC Ongsritrakul informed SC Tulk that Graham had attended Bondi Police Station with information regarding Thomas's location and that he would be placing a job on the CAD for a car crew to attend the location and attempt to sight and speak to Thomas.[134] SC Tulk and SC Ongsritrakul also discussed whether an Apprehended Domestic Violence Order would be taken out against Thomas in favour of Graham. It had not been decided whether Penrith or Bondi would make the application. SC Tulk expressed in evidence that this consideration was secondary to finding, sighting and organising for paramedics to assess Thomas's mental health.[135] DI Browne agreed that that would have been his view also, particularly where there were concerns for Thomas's safety.

115. At 3:11pm, SC Ongsritrakul broadcast a Concern for Welfare job in relation to Thomas as follows:

> "MP: Thomas HUNT has been reported missing to Penrith Police Station yesterday, E63550724 relates. INF is the father of the MP. INF received a phone call from the MP this morning. The MP is staying at Hotel Bondi, possible room 209. The MP's vehicle was sighted by the hotel staff and it is confirmed that he got the room for tonight. The POI needs TO BE SIGHTED AND ASSESSED DUE TO serious MENTAL HEALTH CONCERNS. Please update event and inform OIC of the result at Penrith Police Station."[136]

116. At approximately 3:14pm, car crew ES141 manned by Constable Daniel Cameron and Plain Clothes Senior Constable Daniel Barling acknowledged the

[131] Exhibit 10.
[132] Tab 15, [14].
[133] Ibid, [15].
[134] Ibid.
[135] Ibid, [16].
[136] Tab 16, [7], Tab 8, CAD message 23 March 2017, 3.11pm.

Concern for Welfare job broadcast by SC Ongsritrakul.[137] Car crew ES141 was attending another Concern for Welfare job at this time.[138]

Fire at Hotel Bondi – Room 209

117. At 3:16pm, Fire and Rescue NSW Fire Communications received a notification of an automatic fire alarm at Hotel Bondi.[139] Fire fighter Robert Russell attended Hotel Bondi at 3:21pm and was informed by Bondi Hotel Manager Ms Sharon Coutman that the alarm had operated on Level 2, and that staff members had attempted to open the door to Room 209 but it could not fully be opened.[140]

118. Mr Russell and his colleagues were unable to access Room 209 via the door and searched for an alternate entry.[141] They then located a small window that had been blown or smashed out prior to their arrival, and gained entry to Room 209.[142] The glass had been smashed outward, as though it had been kicked from inside the room.[143]

119. Mr Russell discovered a small fire on a mattress had been extinguished by the building's fire sprinkler system.[144] Mr Russell also noted that furniture had been deliberately piled up against the door to prevent entry, and that power cords had been stripped back to expose the active circuit, and then attached to the bare metal door handle, both of which Mr Russell removed.[145] Thomas was not present in the room.

120. A police radio broadcast was received in relation to the fire in Room 209 at 3:29pm[146] and police arrived on the scene by 3:35pm.[147] At approximately 4:00pm, officers from Eastern Suburbs Local Area Command entered Room 209 and took a number of crime scene photographs.[148]

121. A search of Room 209 observed fire damage to both single beds. The word 'Bandidos' had been carved into a wooden wardrobe, and the stuffing had been removed from a blue teddy bear displaying Superman logos, which had

[137] Tab 23A, [6], Tab 23B, [6].
[138] Tab 16, [8].
[139] Tab 51, [4].
[140] Ibid, [6].
[141] Ibid, [10].
[142] Ibid, [11].
[143] Tab 20, [9].
[144] Tab 51, [12].
[145] Ibid, [13]-[16].
[146] Tab 23A, [7].
[147] See Tab 19, [5], Tab 23A, [8], Tab 23B, [7].
[148] Tab 20, [5]-[17].

belonged to Thomas.[149] Thomas's wallet containing his bank cards and identification, and his mobile phone, were also located.[150]

122. Upon entering Room 209, Sergeant Bradley Phillips noticed a manhole in the ceiling and requested the attendance of police rescue to search the void above the ceiling.[151] Upon their attendance, a search was conducted and Thomas was not located.[152] Constable Samuel Palfreyman ("Constable Palfreyman") conducted a review of CCTV footage capturing the hallway outside Room 209 from 1:45pm until 3:20pm, and of the fire escape exit from 2:00pm until 3:20pm but did not observe Thomas in the frame.[153] Further searches were conducted by police, including searches of Hotel Bondi's underground car park and the internal and external fire exits, as well as the surrounding streets, and making enquiries with shop owners.[154] Thomas was unable to be located.

123. At 4:46pm, Fire and Rescue NSW restored the fire alarm systems and rendered the incident safe, handing the premises over to NSW Police.[155] At approximately 5:15pm, Plain Clothes Senior Constable Brendan Ruprecht and Plain Clothes Senior Constable Joshua Murphy attended Hotel Bondi and conducted a search of Thomas's vehicle.[156] Nothing adverse was located in the vehicle, and Thomas's mobile phones and wallet were collected as exhibits from Room 209.[157] As it was raining heavily, the officers conducted an extensive patrol of the Bondi Beach area in their police vehicle, however Thomas was not located.[158]

Thomas's disappearance from Hotel Bondi

124. The evidence is clear that by the time fire fighters attended Room 209, Thomas was nowhere to be found, nor were subsequent police searches on 23 March 2017 able to locate him. An issue that was explored at the inquest was the likely means by which Thomas exited Room 209 and subsequently evaded detection from police.

125. The window in Room 209 which fire fighters found had been blown or smashed out prior to their arrival opens onto external fire stairs that are no longer in

[149] Ibid.
[150] Ibid.
[151] Tab 19, [8].
[152] Ibid.
[153] Tab 17, [8].
[154] Tab 23A, [11]-[13].
[155] Tab 51, [21].
[156] Tab 23, [6].
[157] Ibid, [7].
[158] Ibid, [9].

use.[159] During investigations on 29 March 2017, Detective Acting Sergeant Amy Robertson (" D/AS Robertson") noted that though there were locked gates at each level of the external fire stairs, she believed they could be climbed over.[160] These external fire stairs led to a door that provided entry to a newer, internal fire escape, which led to Hotel Bondi's rooftop.[161] On the same date, a sim card was located inside the internal fire escape.[162] Officers submitted an iAsk request which confirmed that the sim card belonged Thomas's mobile service.[163]

126. The inquest heard evidence from Detective Senior Constable Sarah Etournaud ("DSC Etournaud"), the Officer in Charge of the investigation into Thomas's death. DSC Etournaud's evidence was that the only plausible conclusion is that Thomas exited from Room 209 via the window and ascended up the external fire stairs, before entering into the internal fire escape and ascending to the rooftop. DSC Etournaud noted that there were only very small gaps between the rooftop of Hotel Bondi and adjacent buildings that could have been "walked across", and indicated that there were many locations where Thomas could have hidden whilst waiting for the police presence to subside.[164]

127. DSC Etournaud also gave evidence that the sprinkler system had caused damage to some of the CCTV cameras at Hotel Bondi, and that the CCTV camera located at the gate of the external fire stairs was not operational. In those circumstances, DSC Etournaud's view was that it is plausible that Thomas could have left from Hotel Bondi without being captured on CCTV.

128. In light of DSC Etournaud's evidence, the location of a sim card registered in Thomas's name in the internal fire escape, and the fact that Constable Palfreyman did not sight Thomas in his review of CCTV footage on the date of the incident, I am prepared to accept DSC Etournaud's hypothesis as to Thomas's exit from Room 209 on the afternoon of 23 March 2017 after lighting the fire, and his subsequent disappearance from Hotel Bondi.

Searches for Thomas after 23 March 2017

129. In the days following the fire at Room 209, police made a number of efforts to attempt to locate Thomas. These included patrols in the Bondi Beach area and conversations with local residents,[165] police air searches, and returning to Hotel Bondi to make further enquiries and conduct further searches of the hotel and

[159] Tab 34, Annexure C, p. 24-37.
[160] Ibid, [6], Annexure C, p. 25.
[161] Ibid, [7].
[162] Ibid.
[163] Ibid, Annexure A.
[164] TS p.28:24.
[165] Tab 26, Tab 27.

surrounding buildings.[166] These enquiries failed to provide any further significant information.

130. Other routine enquiries were conducted in respect of Thomas's bank account activity and usage of his Opal card; however, no activity was detected.[167] Enquiries were also made with a number of hospitals and health clinics in the Sydney and the Blue Mountains, however Thomas was not located.[168] Homeless shelters in the Bondi, Surry Hills, and Sydney City area were also contacted without success.[169] DSC Etournaud also gave evidence that a police media release was issued on 28 March 2017, and Thomas's photo was posted to the NSW Police Facebook page.[170] A number of suspected sightings emerged as a result of these releases, however investigations concluded none of them were in fact Thomas.

Discovery of human remains on Bondi Beach and subsequent searches

131. On 4 April 2017 at approximately 9:00pm, Nicholas Polias came across what appeared to be a carcass whilst walking along the shoreline at South Bondi Beach.[171] Mr Polias ran to Bondi Police Station and informed officers that he believed he had found a human body on the beach, before returning to the location to wait for police to arrive.[172]

132. The remains, which were observed to consist of the buttocks with the vertebrae and some ribs attached, and the bones of both legs with no skin or flesh attached, were photographed by police in situ and then moved up the beach to avoid them being washed away by the incoming tide.[173] Acting Inspector Dean Richens requested that POLAIR conduct a flyover of Bondi Beach to search for any other body parts that may be in the water, however POLAIR was unavailable.[174] The remains were conveyed to Glebe Mortuary at approximately 11:40pm.[175]

133. On 5 April 2017 at 7:30am, Sydney Water Police conducted a search of the area off shore from Sydney Heads (South Head). Due to the advanced state of decomposition and the unknown elements relating to the body, a distinct search area was unable to be established.[176] A search was conducted tracking from

[166] Tab 34, Tab 28.
[167] Tab 29, [22]-[24].
[168] Ibid, [10]-[21], [26]-[29].
[169] Tab 34, [10].
[170] Exhibit 4.
[171] Tab 57, [5].
[172] Ibid, [6]-[9].
[173] Tab 41, [7]-[8].
[174] Ibid, [9].
[175] Tab 2, p. 3.
[176] Tab 46, [4].

South Head to Bronte Beach and then on a reciprocal course back to South Head 3-4 times, at all times venturing no further than approximately 800m from the shoreline.[177] Due to adverse conditions including low visibility and choppy waters, the search was concluded at 11:30am with nothing located.[178] A similar search was conducted the following day, 6 April 2017 at approximate 7:30am without success.[179]

134. On 5 April 2017 at approximately 9:00am, members of the NSW Public Order and Riot squad conducted a search of Bondi Beach and a section of the Bondi coastal walk, as well as the rock pool area, nearby streets and the coastal footpath.[180] These searches concluded at approximately 10:30am and nothing of interest was located.[181]

135. On 5 April 2017 at approximately 9:00am, members of NSW Police Aviation Support Branch undertook an air search for a missing person along the shoreline from Coogee Beach to Rose Bay.[182] No person of interest or clothing articles were located.[183]

Autopsy and identification of Thomas's remains

136. On 6 April 2017 at 9:00am, pathologist Dr Lorraine du Toit-Prinsloo conducted an autopsy on the remains. The autopsy included macroscopic dissection and histology as well as a review of radiology and anthropology investigations. A cause of death remained unascertained at autopsy alone.[184]

137. Police obtained DNA samples from Amanda on 5 April 2017 and from Graham on 10 April 2017.[185] On 11 April 2017, examination results were received that a DNA sample extracted from the thoracic vertebrae of the remains had a profile that could have originated from a biological child of Graham and Amanda, and that the profile was greater than 100 billion times more likely to have originated from a biological child of Graham and Amanda than from an unrelated individual in the Australian population.[186] The identification of the remains as belonging to Thomas was accepted by then NSW State Coroner Magistrate Barnes on 18 April 2017.[187]

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[177] Tab 43, [4],
[178] Ibid, [5].
[179] Ibid, [6]-[7].
[180] Tab 42, [5]-[10].
[181] Ibid, [11].
[182] Tab 48, [5].
[183] Tab 47, [4].
[184] Tab 7, p. 3.
[185] Tab 5.
[186] Ibid.
[187] Ibid.

Issues

Identity

138. The deceased is Thomas James Hunt.

When did Thomas die?

139. The autopsy findings note that the body consisted of partially skeletonised remains, with muscles showing severe decomposition, and had spent a "prolonged period" in the water.[188] The addendum to an anthropology report prepared by Dr Denise Donlan notes that in the circumstances in which the body was found, it is probable that Thomas was in the water for a period of time prior to being discovered.[189]

140. There is unfortunately a lack of evidence as to precisely when and how Thomas came to enter the waters off the coast from Bondi Beach. However, the medical evidence appears to indicate that prior to the discovery of Thomas's remains, his body had been in the water for some time. Additionally, police enquiries in the immediate aftermath of Thomas's disappearance from Hotel Bondi did not detect any possible activity that could suggest Thomas was alive after 23 March 2017. On the basis of the available evidence, I am prepared to make a finding that Thomas entered the water sometime in the evening of 23 March 2017 or shortly thereafter, and his death occurred in close proximity to that time.

Place of death?

141. The exact place of death is unknown. There is no conclusive evidence as to where Thomas entered the water, however consistent with the statement of Senior Sergeant Robert Trussell ("Senior Sergeant Trussell"), previously attached to Sydney Water Police, it is likely that Thomas entered the water close to where his remains washed up on Bondi beach.

How did Thomas die?

142. The cause of death is unknown.

143. As to the manner of death, the initial anthropology report provided by Dr Donlan on 7 April 2017 observed damage to some exposed bones, including abrasions to the left femur and left tibia, fractures and abrasions to the left ribs, fractures to the right ribs and a fracture to the superior border of the left scapula.[190] Following de-fleshing, a post-mortem break and abrasion was identified to the

[188] Tab 7, p. 5.
[189] Tab 6A.
[190] Tab 6.

superior border of the left scapula.[191] Damage to the right side of the C3 vertebrae and a fracture of the left rib were also observed and could have occurred post or peri-mortem.[192]

144. In respect of each instance of abrasion, fracture, break, or damage, Dr Donlan was subsequently asked, whether, in her opinion, the injury was more likely than not to have occurred post-mortem. Dr Donlan's conclusion was that it is probable that Thomas was in the water for a period of time and may have been subject to being dragged over the sand and/or rocks by waves. All of the abrasions identified were found to be post-mortem and likely to occur when the soft tissue protecting the bone had decomposed, however it was unclear whether the fractures occurred peri or post-mortem.[193]

145. Senior Sergeant Trussell, having over 30 years-experience with water police, and having dealt with numerous body recoveries and searches in the area, formed the view that it was likely that Thomas's body had been submerged and wedged under a rock or similar in the near vicinity prior to washing out.[194] This explanation would be consistent with the post-mortem nature of the abrasions identified by Dr Donlan.

146. Following the identification of Thomas's remains, Dr du Toit-Prinsloo expressed in an addendum to her autopsy report that:

> "*I am of the opinion that the injuries sustained could have been from entering the water (such as a fall into water, entering the water from the shore or entering the water from a vessel) and could thus have resulted from the body brushing against the rock surfaces in the water."*[195]

147. Given the state of decomposition of Thomas's remains, there is not sufficient evidence to make a definite finding as to how Thomas died, and it is apparent that many of the injuries identified are likely to have occurred post-mortem. What is likely, however, is that Thomas died as a result of entering into the water, either by a fall or entering from the shore.

What was the nature of Thomas's mental health issues?

148. Thomas had been suffering undiagnosed mental health problems for an undisclosed period of time. Thomas's consultation with Dr Tan on 20 March indicated a diagnosis of chronic depression and history of PTSD.

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[191] Ibid.
[192] Ibid.
[193] Tab 6A.
[194] Tab 46A, [7].
[195] Tab 7A.

149. In the days leading up to his disappearance from Hotel Bondi there was evidence of Thomas experiencing paranoid delusions and auditory hallucinations.

The immediate circumstances surrounding Thomas's death

150. In respect of the immediate circumstances surrounding Thomas's death, I find that Thomas exited room 219 of Hotel Bondi by kicking out the window in that room and proceeded to the decommissioned fire escape through to the internal fire escape where a SIM card belonging to him was located. He came out onto the roof of the hotel and most likely went over to one of the surrounding buildings where he likely laid low until the emergency response had subsided.

151. There is evidence that during his stay at the hotel, Thomas was experiencing a heightened level of paranoia and mental disturbance. This culminated in him setting fire to a mattress in his room after constructing three booby- traps. Whether he did this for what he believed necessary for his own protection or whether it is was an intentional act to harm others is not known. This heightened level of paranoia however makes it easier to accept that he did not want to be found and was possibly hiding somewhere undetected by the immediate police search that day.

152. The fact that there were no sightings of Thomas in the Bondi area suggests that he moved in an unknown direction, most likely at nightfall, undetected, and at some point thereafter entered the water.

The actions of NSW Ambulance Service Officers on 22 March 2017

153. I accept that Ms Eve offered to assess Thomas on at least one occasion and on that occasion mentioned that police may need to be involved to transport him. That is entirely consistent and appropriate with the duties of paramedics attending a mental health emergency.

154. Listening to Amanda's evidence, it was the manner in which Ms Eve communicated with her that left her with certain impressions about Ms Eve's demeanour and the role that paramedics had that night. Because of these impressions Amanda did not think that Ms Eve would be able to effectively engage with Thomas sufficient to have him transported to hospital voluntarily and without police assistance.

155. These were Amanda's impressions and feelings and these findings cannot dispute how someone felt. What I can say is that optimal communication is necessary in responding to a mental health emergency, not only with the patient but any third party like a parent who will obviously be distressed at what is

happening with their daughter or son. I acknowledge that paramedics have a difficult job.

156. The scenario that this inquest presented is real and no doubt paramedics will face many situations in which they are communicating with a parent in response to a mental health emergency. It is pleasing that NSW Ambulance are willing to consider whether this scenario might be used in its training package.

The adequacy of the NSW Police response to the missing persons report between 22 March 2017 and the fire at Hotel Bondi on 23 March 2017

157. In respect of the adequacy of the police response in the period between Thomas being reported missing and the fire at Hotel Bondi, I find as follows:

a. Contrary to the old MP SOPS no risk assessment was completed by the investigating officer, SC Tulk, and one should have been.

b. The risk assessment should have been sighted and approved by the internal supervisor, Sergeant Creamer, before verifying the Event. It was not. In fact, the evidence establishes it was not Sergeant Creamer's practise at the time to look at any risk assessment when verifying the Event. This demonstrates a lack of understanding of the MP SOPS at the time and a lack of oversight and supervision by Sergeant Creamer over the missing person investigation.

c. I accept DI Browne's opinion that Thomas's case had a high risk rating. On that basis I also accept that there were three further investigative functions that were open to the officers that were not implemented:

    i. Calling or sending a text to Thomas's phone;
    ii. Making an application for the triangulation of Thomas's phone; and
    iii. Issuing a media release.

d. The MP SOPS at the time gave officers no guidance around applying for triangulation of a mobile phone under s. 287 of the *Telecommunications Act.*

e. Whilst different minds might construe the threshold under s. 287 differently, I find that in this case, the threshold had been met and an application ought to have been made or, at least, Sergeant Janovsky ought to have spoken with the duty operations inspector about the matter.

f. When the call was received by Penrith police from Amanda at 6.20pm on 22 March 2017, Sergeant Creamer ought to have directed SC Burden to contact the Bondi LAC to alert them of the possibility of a missing person in their jurisdiction. Whilst there was no evidence about this, that action may have meant that when SC Ongsritrakul looked up the Event after Graham's attendance the next day he would have seen that Bondi had already been alerted to Thomas's case and may not have necessitated liaison with SC Tulk and a car crew may have been sent soon after Graham's attendance.

g. In respect of the 9.18am call received by Penrith police from Amanda, GASO Chappell was unnecessarily referred to the PSC for an alleged oversight by her in not updating the CAD. The evidence demonstrates otherwise and the CAD was updated.

h. The real issue in regard to that 9.18am call was that it was not escalated to a supervisor. If it had been, it would have necessitated a reassessment of the risk.

i. When Amanda called Penrith police at 11:00am she had, by her own means, identified the location of her son. It was a critical point in the chronology and an opportunity for police to respond. There was no police action on the 11:00am call; the CAD was never even updated. The lack of response was a failure in police process.

j. There is a strong inference on the evidence that GASO Chappell took the 11:00am call although I am unable to take it any higher on the evidence. I accept the evidence of Inspector Penninkilampi that the Penrith counter is a very busy counter. It is possible that because of this, the CAD was not updated and no other officer was alerted to the contents of that call. However that is only speculation.

k. I accept Graham's version of events when he attended the Bondi police station. I find that SC Ongsritrakul ought to have broadcast Thomas's possible location on the police radio and requested a car crew attend. Time was of the essence and Thomas's safety came before any other consideration. I make this finding appreciating that the police response was dependent on the availability of resources at the relevant time and also that if police had attended prior to the power having been cut at 3:00pm as a function of the fire at the hotel it is possible that harm may have come to those attending.

The adequacy of the NSW Police investigation regarding the search for Thomas between the fire at Hotel Bondi on 23 March 2017 and the discovery of his remains on 4 April 2017

158. There is nothing in the evidence to suggest that there were any inadequacies, in this respect.

Whether any recommendations are necessary or desirable

159. There have been vast and robust improvements made to the MP SOPS. I have previously commented in another inquest that the revisions are extremely thoughtful and impressive. [196]

160. A NSW Police intelligence bulletin dated 7 July 2020[197] recorded that from the implementation of the new MP SOPS on 1 January 2020, there has been substantial improvements in the location of missing persons:

- For 2020, there are 8 long term missing persons outstanding; four of which are misadventure and four that under investigation;
- For 2020, 99% of missing persons have been located prior to 90 days;
- From 2016-2019, there was an average of 147 long term missing persons per year (located after 90 days), with 26 missing persons remaining outstanding per year;
- For 2020, it is predicted that there will be 72 long term missing persons for the year (located after 90 days), with 16 missing persons remaining outstanding. This is predicted to be a 51% decrease in long term missing persons (located after 90 days), and a 39% decrease in outstanding missing persons from previous years.

161. I accept that these improved figures are due to the newly implemented MP SOPS and the increased accountability and enhanced review process conducted by the MPR as well as good police work. In considering this evidence, I find that the new procedures implemented by the 2020 MP SOPS give rise to a great deal of confidence in the real commitment within the NSWPF to improving investigations into missing persons.

162. DI Browne's statement helpfully provided an analysis of how the investigation into Thomas's disappearance would be different under the revised MP SOPs.

163. There is however scope for further guidance and training in respect of the interpretation of s. 287 of the *Telecommunications Act*. This inquest heard that

[196] Inquest into the Disappearance and Suspected Death of Bennett Dominic 25 June 2020
[197] Exhibit 11.

there are processes on foot to assist in getting a more consistent interpretation of that section. Until there is some further guidance or possible legislative change in this regard, it is difficult for updates to be made to the MP SOPS. 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.

164. There is also room for improvement in respect of having a more structured and electronic approach to requests for triangulation via the State Coordination Unit. In that regard I make the following recommendation:

To the Commissioner of NSW Police:

That the Missing Persons Registry be directed to liaise with the State Coordination Unit to consider and implement a protocol whereby the information available in support of an application to the State Coordination Unit to access the location of a mobile telephone device under s. 287 of the Telecommunications Act 1997 be recorded and the reasons for that application decision be recorded.

Conclusion

165. Thomas's death is a tragedy and his family has been deeply affected by his loss. At the hearing Amanda spoke of the enormous "ripple" effect Thomas's death had on the people in his life. I acknowledge the pain loved ones continue to feel at the loss of Thomas.

166. Accordingly, I offer my heartfelt condolences and sympathy to Thomas's family and thank them for participating in this inquest, when it has been so difficult and sad for them. I hope that the inquest has assisted them in some small way.

167. I would also like to extend my thanks to the officer in charge, Detective Senior Constable Sarah Etournaud and her predecessor, Detective Senior Constable Viviene Thomas for their very thorough investigation of this matter and DSC Etournaud's assistance at the inquest. I also thank the interested parties, in particular the Commissioner of Police and his legal representatives and NSW

Ambulance and its legal representatives for their co-operation and the constructive approach they took throughout this inquest.

168. Finally, I thank my counsel assisting, Ms Christine Melis, and her instructing solicitors from the Crown Solicitor's Office, Ms Gabrielle Gutmann and Mr Nick Geason, for their work in assisting me in this inquest.

I close this inquest.

Teresa O'Sullivan
State Coroner
Lidcombe

Date: 4 September 2020