CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Bernard Gore
Hearing dates:	4 to 8 November 2019; 27 to 31 July 2020
Date of findings:	18 December 2020
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – missing person investigation, Westfield Bondi Junction, Missing Persons Standard Operating Procedures, risk assessment, CCTV footage review, communication between Police and community partners, land search coordinator
File number:	2017/29406
Representation:	Ms A Mitchelmore SC & Ms C Trahanas, Counsel Assisting, instructed by Ms E McGee & Ms J Hoy of the Crown Solicitor's Office Mr K Andrews for the family of Bernard Gore, instructed by Wyatt's Lawyers & Advisors Mr M Cahill for Scentre Group Pty Ltd, instructed by Holding Redlich Ms M England & Mr R Coffey for New South Wales Commissioner of Police, instructed by Office of General Counsel, New South Wales Police Force Ms T Power for SecureCorp Limited, instructed by Bartier Perry Lawyers

Findings:

Identity

The person who died was Bernard Gore.

Date of death

It is more probable than not that Bernard died between about 6 and 9 January 2017.

Place of death

Bernard died inside a fire stairwell at Westfield Bondi Junction, Bondi Junction NSW 2022.

Cause of death

The available evidence does not allow for any finding to be made as to the cause of Bernard's death.

Manner of death

Bernard died inside a fire stairwell within Westfield Bondi Junction in circumstances where he was not initially found and, for reasons which are not well understood, did not, or was unable to, exit the fire stairwell. The pre-existing comorbidities that were identified at autopsy, and the absence of any evidence as to traumatic injury or direct third party involvement, therefore raise the possibility that the manner of Bernard's death was due to natural causes. However, the peri-mortem psychological, environmental and physiological stressors that Bernard would have experienced as a result of being within the stairwell were possible significant contributors to his death. When these matters are taken into account, together with certain identified shortcomings and inadequacies associated with the efforts to locate Bernard, it cannot be said that Bernard's death was entirely due to natural causes. Therefore, it is more appropriate to conclude that the manner of Bernard's death was as a result of misadventure.

Recommendations: See Appendix A

Non-publication orders: See Appendix B

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1. Introduction

1.1 On 6 January 2017 Bernard Gore left his daughter's apartment in Woollahra and walked to Westfield Bondi Junction (**Westfield**). He planned to meet his wife, Angela, there and have lunch together. Bernard and Angela had done this several times before. When Angela arrived at Westfield a short time later she could not find Bernard. Several hours later Bernard was reported missing to the New South Wales Police Force (**Police**).

1.2 Despite a number of electronic and physical searches that were conducted by Police and security personnel at Westfield (**Security**), Bernard was initially not found in the hours and days after he was reported missing. On 27 January 2017, 21 days after he was reported missing, Bernard was, tragically, found deceased in a fire stairwell within Westfield.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death. All reportable deaths must be reported to a Coroner or to a police officer.

2.2 Section 27(1)(d) of the Act provides that an inquest must be held if the manner and cause of a person's death has not been sufficiently disclosed. The postmortem examination that was conducted in Bernard's case was unable to ascertain a cause of death. Further, the period between 6 and 27 January 2017 raised questions about the adequacy of the searches for Bernard that were conducted by Police and Security, and therefore the manner of his death. For these reasons, an inquest was required to be held.

2.3 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents a public intrusion into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

2.4 It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated.

2.5 Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These

recommendations are made to organisations and individuals in order to draw attention to systemic issues that are identified during a coronial investigation, and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable. Where an inquest is able to identify issues that may potentially adversely impact upon the safety and well-being of the wider community, recommendations are made in the hope that, if implemented after careful consideration, they will reduce the likelihood of other adverse or life-threatening outcomes.

3. Bernard's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

3.2 Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Bernard's life in a brief, but hopefully meaningful, way.

3.3 Bernard and his wife, Angela, lived in Mornington, Tasmania, in the same house that they had lived in since around 1968. They had three children: Mark, Melinda and Rachel. Bernard and Angela celebrated their 50th wedding anniversary on 8 October 2016.

3.4 Bernard used to work as a bread delivery driver and barber. In around 2008 Bernard ceased full time work, but continued to cut the hair of his friends and acquaintances. Bernard loved walking. He was known to be a fast walker and would often walk to his local shopping centre in the morning.

3.5 Whilst Mark lived in Tasmania, both Melinda and Rachel lived in Sydney. Accordingly, Bernard and Angela travelled to Sydney two or three times a year to visit their daughters. Bernard and Angela would often stay with Melinda during these visits and, indeed, were staying with her on 6 January 2017.

3.6 There cannot be any doubt that Bernard is greatly missed by his family, loved ones, and friends, and that his untimely loss has caused them immeasurable grief and distress. It is particularly devastating to know that Bernard died so unexpectedly, and in circumstances where 6 January 2017 appeared to be a day no different than any other that Bernard and Angela had experienced during their trip to Sydney.

4. Background to the events of 6 January 2017 and after[1]

4.1 At the time of his death, Bernard had been prescribed medication for hypertension and for a cognitive impairment. In early 2016 Angela noticed that Bernard was sleeping excessively and not taking his hypertension medication as prescribed. Melinda and Mark also noticed that Bernard seemed to be more tired than usual and was not as involved in conversation.

4.2 On the afternoon of 17 June 2016 Bernard and Angela went to a shopping area in Moonah, a suburb of Hobart. They separated to run their own errands and arranged to meet back at their car later. However, when Angela returned to their car she was unable to find Bernard. After waiting for a short period of time, Angela returned home and reported Bernard as missing to local police at around 6:20pm.

4.3 Bernard was later found at around 10:00pm in the Hobart CBD. He was in good spirits and good physical health. When Bernard was asked about his whereabouts over the preceding hours, it was noted that he was quiet and vague in his answers. When police officers asked Bernard where Angela was, he told them that she was at the hospital and that he was waiting for her. Following this incident, police advised Bernard's family that Bernard should carry a location tracker or have a mobile phone. Mark subsequently bought Bernard a watch with GPS capability.

4.4 Angela subsequently took Bernard to see a general practitioner on 1 July 2016. At a subsequent appointment on 10 August 2016 a mini mental state examination was conducted. The results indicated a moderate cognitive impairment. Bernard was prescribed medication (donepezil) used to treat dementia in persons with Alzheimer's disease.

4.5 Once Bernard commenced taking his medication on the prescribed daily basis, Angela observed a noticeable difference. At a subsequent mini mental state examination conducted on 5 December 2016 there was an improvement in Bernard's score. On this occasion the result indicated a mild, as opposed to moderate, cognitive impairment.

4.6 On 16 December 2016 Bernard and Angela travelled to Sydney to visit Melinda over Christmas, staying with her in her apartment on Ocean Street, Woollahra. They intended to return to Tasmania on 11 January 2017.

4.7 During their stay, Bernard went for a walk on most days, often by himself. These walks would usually take between one and three hours. One of Bernard's frequent walks involved walking to Westfield usually with Angela. Bernard typically took a route which involved walking from Melinda's apartment on Ocean Street to Wallis Street, turning left and taking the footbridge over Syd Einfeld Drive to Oxford Street, and walking through the Oxford Street mall to Westfield (**Bernard's Route**).

[1] The factual background concerning events before, on, and after 6 January 2017 have been drawn from the helpful opening and closing submissions of Counsel Assisting.

5. Layout of Westfield

5.1 Before going on, it is useful to describe the layout of Westfield, which is one large shopping complex comprised of two zones:

(a) **Zone A** is on the northern side of Oxford Street and is bounded by Adelaide Street, Grafton Street, Grosvenor Street and Oxford Street. Woolworths is located on Level 3 of Zone A.

(b) **Zone B** is on the southern side of Oxford Street and is bound by Bronte Road, Hollywood Avenue and Gray Street. Coles is located on Level 1 of Zone B.

5.2 Zone A and Zone B are interconnected with underground connections via interconnected car park levels, an underground shopping level, a street level crossing between both zones, sky bridge connections above street level and two office towers situated above Zone A.

5.3 Zone A has a total of six pedestrian entrances, that are accessible from the street and not via a car park level or retail premises:

(a) An entrance on Grosvenor Street, which takes visitors to Level 2 of Zone A;

(b) An entrance on the corner of Grosvenor Street and Oxford Street (**the Revolving Door Entrance**), which takes visitors to Level 3 of Zone A;

(c) An entrance on Oxford Street to the lobby one of the office towers above Zone A;

(d) An entrance on Oxford Street near the Luxe Café (**the Luxe Entrance**), which takes visitors to Level 3 of Zone A;

(e) An entrance on Oxford Street along a short lane, near Luxe Café and the Eastern Hotel (**the Eastern Hotel Entrance**), which takes visitors to Level 3 of Zone A;

(f) An entrance at the corner of Oxford Street and Adelaide Street near Zara (**the Zara Entrance**), which takes visitors to Level 4 of Zone A.

5.4 In addition to the above there is an additional street level entrance on Grafton Street, near the corner of Grosvenor Street, that provides access to David Jones[2], which occupies a multi-storey tenancy within Zone A.

5.5 Zone B has a number of pedestrian entrances at street level, including:

(a) An entrance on Bronte Road, between Oxford Street and Gray Street (**the Bronte Road Entrance**);

(b) An entrance off Hollywood Avenue into Myer (**the Myer Entrance**), which occupies a multi-storey tenancy within Zone B;

[2] 31/7/20 at T16.40.

(c) A split entrance from Oxford Street opposite the Luxe Entrance.

6. Events of 5 January 2017

6.1 On 5 January 2017 Bernard walked to Westfield. CCTV footage from this day indicates that Bernard crossed from the Oxford Street mall towards Westfield, and entered Westfield using the Zara Entrance at about 11:03am. At around 11:23am, Bernard left Westfield, again using the Zara Entrance.

6.2 On their frequent trips to Westfield, Bernard and Angela followed a typical routine. They only visited Zone A, although the pedestrian entrance they used varied. Whilst inside Westfield Angela would visit a number of shops. Whilst Bernard would walk around with Angela he would not go into the shops. They often ate together in the food court on Level 5, and picked up groceries from Woolworths on Level 3. Bernard was known to visit the toilets located near Woolworths before leaving. They would then walk back to Melinda's apartment using the same route they had taken to Westfield.

7. Events of 6 January 2017

Bernard walks to Westfield

7.1 On the morning of 6 January 2017 Bernard woke between 6:00am and 7:00am. He had at least toast for breakfast, and then watched TV with Angela as it was raining. After the sun came out, Bernard said that he wanted to go to Westfield. Angela said that she would accompany him but as Bernard was keen to get going, it was decided that Bernard would leave first.

7.2 Bernard left Melinda's apartment alone at around 12:30pm. He made arrangements to meet Angela outside Woolworths at around 1:15pm. Angela planned to leave about 20 minutes after Bernard. Bernard was not wearing his GPS watch on this day as it was not working. Angela and Melinda made a card for Bernard which contained his details and Melinda's address. Bernard was wearing a black and red checked shirt, a t-shirt singlet, grey skivvy, dark long pants with a pair of pyjama pants underneath, black socks, white shoes, and a white hat with black trim.

7.3 CCTV footage revealed that Bernard took the following route to Westfield:

(a) At about 12:40pm, Bernard walked past The Meat Store at 262 Oxford Street;

(b) Approximately two minutes later, Bernard walked past Taylors Property Management (**Taylors**) at 282 Oxford Street;

(c) By 12:47pm Bernard was walking along Oxford Street, next to Zone A of Westfield;

(d) At about 12:48pm Bernard entered Zone A using the Zara Entrance;

(e) Bernard walked along Level 4 to door L407, which is located near the Chanel store; and

(f) At about 12:50pm Bernard entered door L407. There is no further CCTV footage of Bernard after 12:50pm.

7.4 The above path is consistent with Bernard walking to Westfield on 6 January 2017 using Bernard's Route.

7.5 Also at around 12:50pm Angela left Melinda's apartment and walked to Westfield. She arrived at Woolworths and waited for Bernard. When he did not arrive Angela searched the areas that she and the Bernard usually frequented but was unable to find him. Sometime after 2:00pm Angela returned to Melinda's home.

Report of Bernard as missing to Police

7.6 As it became dark, Angela and Melinda became increasingly worried. Angela called Police at 7:59pm and told them that Bernard was missing, having last been seen at 12:30pm before going to Bondi Junction. Melinda advised that Bernard suffered from dementia and provided a description of the clothes that Bernard was wearing when he left her apartment. This information was broadcast to police in a computer aided dispatch.

7.7 At about 8:18pm, Constable Sebastien Clavel and Constable Eloise Arnold went to Melinda's home, where they spoke to Melinda and Angela. Melinda and/or Angela informed Constables Clavel and Arnold about Bernard leaving the apartment bound for Westfield and his plans to meet Angela there. They also provided a photograph and description of Bernard, including that he had early onset dementia but appeared to be mentally well earlier that day.

7.8 At about 8:50pm Constable Clavel broadcast a description of Bernard. He and Constable Arnold then attended to other jobs.

Report of Bernard as missing to Security

7.9 At around 9:30pm Melinda attended Westfield and met with Rui Macarico and Michael Attenborough, two security officers who were rostered on as rovers. The role of a rover is to secure and patrol Westfield, and to assist customers and contractors. Melinda told Mr Macarico and Mr Attenborough that Bernard was supposed to meet Angela outside Woolworths at around lunchtime but that he had been missing since around 12:30pm. Melinda also provided a description of Bernard, including the clothes that he was wearing and that he had early onset dementia. Melinda also informed them that Bernard had been reported as missing to Police.

7.10 Mr Macarico and Mr Attenborough later passed on the information that Melinda had provided to Thomas Murphy, who was the security supervisor from 6:00pm during that shift. Mr Murphy then began checking the CCTV footage from the camera that captured the foyer outside the entrance to Woolworths (**the Woolworths Camera**).

7.11 Mr Macarcio and Mr Attenborough returned to their ordinary duties, such as barricading Zone A of Westfield. As they completed their task they kept a lookout for Bernard, checking the mall area including the lifts, escalators and toilets, and the back of house. This area includes the goods lift areas, the dock areas and garbage rooms. They did not, however, check the fire stairs or fire corridors.

8. Events of 7 January 2017

Initial Police request for Security to review CCTV footage

8.1 At around 1:00am on 7 January 2017 Constable Clavel called Security and spoke to Mr Murphy about the review of CCTV footage at Westfield (**the Clavel-Murphy Call**). Constable Clavel and Mr Murphy gave different accounts of this conversation:

(a) According to Constable Clavel, he told Mr Murphy that all entrances to Westfield had to be checked to ascertain whether Bernard had arrived there. Mr Murphy indicated that Security would review CCTV footage of all entrances and exits at Westfield and would notify the Police if they located Bernard.[3] Constable Clavel acknowledged that it was possible that Mr Murphy said that the CCTV review would focus on Woolworths, but that was not his recollection.[4]

(b) According to Mr Murphy, he told Constable Clavel that he would check CCTV footage of the areas near Woolworths from around 12:30pm to the time when Bernard was reported missing to Security.[5] Mr Murphy did not tell Constable Clavel that he would check all entrances to Westfield.[6]

Creation of the missing person report on the Computerised Operational Policing System

8.2 At about 1:30am, after he returned to Rose Bay Local Area Command (**LAC**), Constable Clavel created a missing persons event on the Police Computerised Operational Policing System (**COPS**) for Bernard (**the Bernard COPS Report**). As the officer who took the missing person report regarding Bernard and who created the Bernard COPS Report, Constable Clavel was the Investigating Officer for the purposes of the 2016 Missing Persons SOPs. This was the first time that Constable Clavel had held such a role.[7]

Initial review of CCTV footage by Security

8.3 That evening, Mr Murphy and Mr Attenborough checked CCTV footage of Level 3 of Zone A from 12:30pm. The cameras they checked were the Woolworths Camera and four ID cameras: two at the Luxe Entrance, one at the Eastern Entrance and one at the revolving door entrance.[8] They did not check the ID camera at the Zara Entrance. By the end of their shifts, Mr Murphy and Mr Attenborough had not located Bernard on the CCTV footage they had reviewed.

8.4 At around 6:00am Peter Bonhs took over from Mr Murphy as control room operator. As part of handover Mr Murphy created Shift Handover Report for Mr Bonhs regarding his previous shift in which he wrote: "I *tracked CCTV and could not locate [Bernard]*".[9] Mr Murphy did not identify in his Shift Handover Report the CCTV footage that had been reviewed.

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[3] 7/11/19 at T27.18.
[4] 7/11/19 at T17.39.
[5] 5/11/19 at T36.3.
[6] 5/11/19 at T37.32; T55.36.
[7] 7/11/19 at T18.27.
[8] 5/11/19 at T40.40.
[9] Exhibit 1, TS Documents Bundle, Tab 32 at 1387.

8.5 Mr Murphy also gave Mr Bonhs a verbal briefing in relation to Bernard, and asked him to recheck the CCTV footage. Mr Murphy told Mr Bonhs that he had checked the entrances onto Level 3 and the area surrounding Woolworths from around 12:00pm on 6 January 2017.[10]

8.6 Following this handover, Mr Bonhs reviewed CCTV footage around the Woolworths area during his shift. Mr Bonhs gave evidence that Woolworths was the "*focal point*" of his CCTV review because that was where Bernard was supposed to meet Angela.[11] However, Mr Bonhs accepted that his CCTV review would not show whether Bernard had actually arrived at Westfield.[12] During his review Mr Bonhs did not consider the possibility that Bernard may have entered through the Zara Entrance but not made it to Woolworths.[13]

8.7 Following a briefing at Rose Bay LAC on the morning of 7 January 2017, Sergeant Matthew Hall, the Shift Supervisor, tasked Constable Rebecca Daniels and Constable Owen Sharman (as he then was) to make enquiries as to whether Bernard had attended any local hospital. More relevantly, Sergeant Hall also tasked Constables Daniels and Sharman to follow up on the review of CCTV footage that Constable Clavel had requested of Mr Murphy and Security earlier that morning. Constables Daniels and Sharman later attended Westfield where they gave Mr Bonhs a photo of Bernard and asked about the progress of the CCTV review by Security. The evidence of their conversation is as follows:

(a) Mr Bonhs gave evidence that he told Constable Daniels that Security was reviewing CCTV footage around Woolworths "*to identify where [Bernard] was, if he attended the centre*" and that those searches had not identified Bernard.[14] Mr Bonhs had no recollection of Constable Daniels requesting Security to review particular CCTV footage.[15]

(b) Constable Daniels gave evidence that, based on the briefing she received from Sergeant Hall at the beginning of her shift, she understood that Security had reviewed CCTV for entrances and exits to Westfield.[16] However, Mr Bonhs did not provide Constable Daniels with details as to exactly what CCTV footage Security had reviewed, and Constable Daniels did not ask for these details.[17] Constable Daniels gave evidence that she asked Mr Bonhs to ensure that CCTV continue to be monitored.[18]

(c) Mr Sharman gave evidence that he and Constable Daniels asked Security to review CCTV footage of all entrances to Westfield. Mr Sharman assumed that Security would review all pedestrian entrances.[19]

[10] 5/11/19 at T48.7; T87.48; T90.1.
[11] 5/11/19 at T80.6.
[12] 5/11/19 at T113.1.
[13] 5/11/19 at T93.16.
[14] 5/11/19 at T89.15.
[15] 5/11/19 at T92.19.
[16] 8/11/19 at T82.3.
[17] 8/11/19 at T81.37; T82.50.
[18] 8/11/19 at T83.18.
[19] 8/11/19 at T5.13.

8.8 After attending Westfield Constable Daniels recorded in the Bernard COPS Report that she had "*attended Westfield security – CCTV was reviewed last night with nil find of MP*".[20] Constable Daniels gave evidence that the reference to "*nil find*" was intended to convey that Bernard had not been seen on the CCTV footage that had been reviewed by Security.[21] In the Bernard COPS Report Constable Daniels did not identify the CCTV footage had been reviewed by Security. She also did not indicate her understanding of what had been reviewed.[22]

8.9 At 6:00pm Mr Murphy took over from Mr Bonhs, who gave Mr Murphy the photo of Bernard, and told Mr Murphy that his CCTV review was "*inconclusive*".[23] Mr Bonhs did not tell Mr Murphy what cameras he had checked. Similarly, Mr Murphy did not ask Mr Bonhs for these details.[24] Mr Bonhs did not refer to his CCTV review in the Shift Handover Note which was provided to Mr Murphy. Mr Bonhs acknowledged that it would have been useful to have a written record of the CCTV footage that he had reviewed so that Security on subsequent shifts knew exactly what had been reviewed.[25]

8.10 During the overnight shift on 7 to 8 January 2017 Mr Murphy re-reviewed the CCTV footage that he had reviewed the previous evening, but this time with the photo of Bernard.[26] Mr Murphy later completed a Shift Handover Note in which no entry was made about the CCTV review he had undertaken, or about Bernard.

[20] Bernard COPS Report at 7.
[21] 8/11/19 at T85.26.
[22] 8/11/19 at T85.31.
[23] 7/11/19 at T48.16.
[24] 7/11/19 at T48.30; T49.16.
[25] 5/11/19 at T92.14.
[26] 5/11/19 at T48.41.

9. Events of 9 January 2017

Review of progress of Police investigation

9.1 On the morning of 9 January 2017 a meeting occurred involving a number of senior police officers at Rose Bay LAC. At 8:20am Superintendent Bradley Hodder, Detective Sergeant Peter Wirth (the relieving Crime Manager), Acting Lindsay Inspector McDonald (Duty Officer) and Sergeant Ray Pratt (Shift Supervisor) met. Detective Sergeant Wirth and Sergeant Pratt gave evidence that the purpose of the meeting was to discuss the status of the investigation relating to Bernard – that is, efforts made to locate him – and to identify possible enquiries to be undertaken in order to progress the investigation.[27]

9.2 At about 5:30pm a shift change over at Rose Bay LAC occurred. Sergeant Pratt and Sergeant Matthew Hall (the incoming Shift Supervisor) discussed conducting a search of Westfield which focused on stairwells and more inaccessible areas where Bernard could have gone.[28] Inspector Tracy Trevallion (Duty Officer for the incoming shift) was also present at the meeting. Although each of the officers agreed that a search of Westfield was discussed, their recollections differ as to the details of the discussion:

(a) Sergeant Hall gave evidence that Sergeant Pratt referred to another incident where a person had gone missing in a shopping centre, perhaps in the Northern Beaches area, and that he thought it was pertinent to search stairwells and other places where Bernard could have gone within Westfield.[29]

(b) Sergeant Pratt gave evidence that he suggested a further search of Westfield because it extended over a large distance and several blocks, and described it as an "*absolute rabbit warren*" with several access points and areas for someone to hide.[30]

(c) Inspector Trevallion gave evidence that they discussed tasking a car crew to look through the stairwells or discuss with Security a search of stairwells at Westfield.[31] Inspector Trevallion explained the reason for this was because Sergeant Pratt had a prior experience in the Northern Beaches where a missing person had been located in a locked fire stairwell.[32] Additionally given that there was no indication that Bernard had used public transport or a taxi, a check needed to be done to confirm whether the Police had missed anything.

Request for CCTV footage

9.3 That evening, Sergeant Hall tasked Constable Daniels and Constable Ramon Gilarte with requesting CCTV footage from Westfield and conducting a patrol of Westfield.[33] Constable Gilarte gave evidence that Sergeant Hall requested the CCTV footage of all entrances to Westfield, and

[27] 28/7/20 at T82.1; 29/7/20 at T13.42.
[28] 30/7/20 at T9.35; 28/7/20 at 85.1.
[29] 30/7/20 at T9.35.
[30] 28/7/20 at T85.12.
[31] 29/7/20 at 62.24.
[32] 29/7/20 at 62.35.
[33] 30/7/20 at T11.5; 27/7/20, T57.30.

CCTV footage of the entrances surrounding Woolworths.[34] However, Constable Daniels could not recall Sergeant Hall identifying CCTV footage for specific areas.[35]

9.4 Sergeant Hall gave evidence that he asked the two officers to conduct a "*full and comprehensive search*" of Westfield, including checking fire stairs, with the assistance of Security.[36] Constable Daniels agreed with this description.[37] However, Constable Gilarte gave evidence that Sergeant Hall asked for a foot patrol to be performed, which Constable Gilarte understood to be a general search to ascertain whether Bernard was at Westfield.[38]

9.5 Constables Daniels and Gilarte went to Westfield later that evening and spoke to Mr Bonhs, who was the outgoing control room operator. Mr Ghani, who was the incoming control room operator, was also present for part of the conversation.

9.6 Constable Daniels asked Mr Bonhs for CCTV footage. Again, there is a difference in the accounts as to what specifically was requested. Constables Daniel and Gilarte gave evidence that the request was for CCTV footage of all entrances to Westfield, and for the entrances surrounding Woolworths from midday to midnight on 6 January 2017.[39] Mr Bonhs and Mr Ghani gave evidence that the request was for CCTV footage of entrances or entry points to Woolworths from midday to midnight on 6 January 2017.[40] Ultimately, this was the CCTV footage that was given to police by Security on 10 January 2017. However, it is likely that the police did not start reviewing this footage until 13 January 2017 and ultimately did not complete the review.[41]

Search of Westfield

9.7 Constable Daniels and Mr Bonhs discussed searching Westfield. Constable Daniels, at the least, told Mr Bonhs that she and Constable Gilarte would walk through Westfield. From this point the evidence diverges. Constable Daniels gave evidence that she asked Mr Bonhs to assist by having security check the fire stairs. She said that she clearly recall saying to Mr Bonhs that "*every nook and cranny*" of Westfield was to be checked that evening.[42] Constable Gilarte gave evidence that Security actually searched the car park and perhaps some of the retail areas.[43]

9.8 Mr Bonhs gave evidence that Constable Daniels did not ask for assistance from Security to search Westfield. He gave evidence that Constable Daniels also did not ask Security to patrol all the fire stairs.[44] Mr Ghani also said that he could not recall Constable Daniels making such a request, but acknowledged that he was not in the room for the whole of the conversation. Notwithstanding, both Mr Bonhs and Mr Ghani gave evidence that if Constable Daniels had asked Security for

[34] 27/7/20 at T57.30.
[35] 8/11/19 at T87.7.
[36] 30/7/20 at T11.5.
[37] 8/11/19 at T86.15.
[38] 27/7/20 at T58.8.
[39] 8/11/19 at T90.3; 30/7/20 at T60.38.
[40] 5/11/19 at T95.33; 6/11/19 at T47.1.
[41] 7/11/19 at T29.46; T45.24.
[42] 8/11/19 at T92.33.
[43] 27/7/20 at T65.47.
[44] 5/11/19 at T104.25; 6/11/19 at T19.29.

assistance or to search Westfield, that they would have contacted Mr Shirin. Mr Shirin also gave evidence that he would have expected a call in these circumstances.[45]

9.9 Constables Daniels and Gilarte, and Mr Bonhs, all agreed that Mr Bonhs said, or would have said, that there were regular or routine checks of the fire stairs.[46] However, even if Mr Bonhs said this, Constable Daniels did not ask any questions about what was involved in checking areas like stairwells.[47] Instead, Constable Daniels said that she assumed that such checks involved Security walking up and down the fire stairs.[48]

9.10 Constables Daniels and Gilarte both said that Mr Bonhs was adamant that Bernard was not at Westfield.[49] However neither Mr Bonhs nor Mr Ghani recalled this being said.[50]

9.11 Following this conversation, Constables Daniels and Gilarte walked through the carpark and the mall area of Westfield. They did not check the fire stairs because they believed that Security was checking them. However, they did not follow up with Mr Bonhs or anyone else as to whether this had occurred.

9.12 After performing their check within Westfield and the carpark areas, Constables Daniels and Gilarte walked the streets and alleys around Westfield, looking for Bernard and CCTV cameras. Constable Daniels subsequently updated the Bernard COPS Report and debriefed Sergeant Hall.

9.13 The walk-through that Constables Daniels and Gilarte performed on 9 January 2017 is the only Police search of Westfield that was conducted between 6 and 27 January 2017.

[45] 29/7/20 at T64.26.
[46] 8/11/19 at 92.45; 5/11/19 at 102.15; 27/7/20 at 68.1.
[47] 8/11/19 at T94.5.
[48] 8/11/19 at T93.14.
[49] 8/11/19 at T96.6; 27/7/20 at T64.1.
[50] 5/11/19 at T103.42; 6/11/19 at T52.10.

10. Other investigations between 9 and 27 January 2017

10.1 Between 9 and 27 January a number of enquiries and searches were conducted in an attempt to locate Bernard. Police engaged in searching for Bernard in the Eastern Suburbs, including at Woolworths Bondi Beach (based on a belief that Bernard had travelled to this Woolworths and not the one at Westfield), Centennial Park (which was located near Melinda's home), and the wider Sydney area. It should be noted that these searches were not the focus of the inquest, and therefore they will not be discussed in detail.

10.2 However, an important event occurred on 19 January 2017. During that evening Zachariah North, a Security rover, was tasked with completing a monthly check of fire stairs for Levels 3 and 4 of Zone A. Mr North completed a *Security Fire Corridor and Stairs Check* form for Level 4 of Zone A in which he marks that he checked Door L407. Mr North said this check involved walking inside door L407, looking up and down, and then walking out again.[51] Door L407 leads to door L306, which opens onto Oxford Street. However, Mr North did not check Door L306. The corresponding *Security Fire Corridor and Stairs Check* form for Level 3 of Zone A contains no entry for Door L306.

11. Events of 27 January 2017

11.1 At around 8:00am on 27 January 2017 a maintenance worker entered Door L407 to investigate the report of a bad smell in the area. The maintenance worker walked to the bottom of the stairwell and found Bernard lying in a semi-kneeling position on the ground with no signs of life. It appeared that Bernard had been sitting on a chair that was found near his body, and that at some point he had fallen forward and off the chair.

11.2 After entering through Door L407 and once inside the fire stairwell, Door L407 can only be opened from within with a key. There is no suggestion that the operation of the door in this manner was anything other than compliant with building code requirements in relation to fire stairs.

11.3 Once inside the stairwell there is a door to the rear of a commercial premises which also cannot be opened without a key. To the left of this door is a set of stairs going up and down. Within the stairwell there is a large exit sign painted in red, together with an arrow pointing downwards, which is clearly visible from Door L407. A green exit sign is also located in the Level 4 stairwell landing area.

11.4 Another large exit sign painted in red, and corresponding arrow pointing downwards, is located in the stairwell leading from Level 4 to Level 3. A similar sign is painted in the Level 3 stairwell landing area.

11.5 At the base of the stairwell there is a painted exit sign pointing in the direction of a corridor which proceeds east for approximately 10 metres. This section of the corridor contains two fluorescent lights on the northern wall (one of which was not operating when Police examined the area after Bernard was found). A green illuminated exit sign and another red painted sign, both pointing south, are located at the end of the corridor.

[51] Exhibit 1, Tab 31 at [9] to [12].

11.6 Following the corridor south leads to three steps down, and then to a further corridor, approximately nine metres in length. This corridor also contains two fluorescent lights (with, again, one light not operating when Police examined the area after Bernard was found). Located at the end of this corridor is Door L306, which contains a push bar, with a green exit sign located above the door (with the sign not being illuminated when Police examined the area after Bernard was found). When pushed Door L306 opens and leads to an undercover paved area on Oxford Street. When Door L306 is opened an audible alarm sounds. Westfield keeps records as to when such doors are opened and an alarm is triggered. These records reveal that Door L306 was not opened between 6 and 27 January 2017.

12. What issues did the inquest examine?

12.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the matters that the inquest would examine and consider. Bernard's Family, the Police, Scentre Group Limited (**Scentre Group**) (the operator of Westfield) and SecureCorp Pty Ltd[52] (**SecureCorp**) were identified as sufficiently interested parties in the inquest.

12.2 The list of issues set out the following:

(1) Determination of the statutory findings required under section 81 of the Act, including as to manner and cause of Bernard's death.

(2) In so far as Police formed the view that Bernard never arrived at Westfield, when did Police form that view and on the basis of what information and/or material did they form that view.

(3) In so far as Security who were rostered to perform duties at Westfield formed the view that Bernard never arrived at Westfield, when did Security form that view and on the basis of what information and/or material did they form that view.

(4) The adequacy of the timing and extent of the review of the available CCTV footage of Westfield undertaken by Security and Police, including:

(a) the areas of Westfield for which CCTV footage was reviewed, when that footage was reviewed and the reasons why those areas were chosen for review; and

(b) the planning and documentation of CCTV footage checks made by both Security and Police; and

(c) the allocation of responsibility for CCTV footage checks between Police and Security and the appropriateness of that allocation.

(5) The adequacy of the timing and extent of physical searches of Westfield conducted by Security and Police, including:

(a) the areas of Westfield physically searched, when those searches were undertaken and the reasons why those areas were chosen for searches;

(b) the planning and documentation of foot searches undertaken; and

(c) the allocation of responsibility for physical searches of Westfield between Police and Security and the appropriateness of that allocation.

[52] The ultimate holding company of various subsidiaries that at different times were the employer of Security.

(6) The adequacy of communications between Police and Security in relation to the searches undertaken for Bernard, in particular, the review of CCTV footage and physical searches of the fire door and fire stairwells areas of Westfield.

(7) The adequacy of the timing and extent of searches conducted by Police for CCTV cameras along the route Bernard habitually took to Westfield.

(8) The frequency and extent of checks of the fire stairwells and fire doors by Security as at January 2017, including:

(a) whether additional or different fire stairwell and fire door checks were conducted following the missing persons report of Bernard and the reasons why/why not; and

(b) whether the practice and procedure of Security in relation to fire stairwell checks was in compliance with the relevant Scentre Group policies and procedures.

(9) The adequacy of the signage in the fire stairwells in Westfield.

12.3 Each of these issues is discussed in further detail below.

13. Issue 1: Statutory Findings required by section 81 *Coroners Act 2009*

Identity and place of death

13.1 It is not in issue that the deceased person found in the fire stairwell by a maintenance worker at around 8:00am on 27 January 2017 was Bernard Gore.

13.2 It is also not in issue that after entering door L407 at Westfield, Bernard did not leave the fire stairs. The place of Bernard's death is therefore Westfield, Bondi Junction NSW 2022.

Date of death

13.3 After Bernard was discovered he was taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Sarita Maistry, forensic pathologist, on 31 January 2017. Dr Maistry subsequently prepared an autopsy report dated 30 January 2018. The postmortem examination demonstrated relevant findings and pathology. However in the autopsy report Dr Maistry ultimately opined that the cause of Bernard's death could not be ascertained.

13.4 It is evident that Bernard's death was not immediate. He was found at the bottom of the stairwell from door L407, three flights of stairs from where he entered and in an alcove under the last flight of stairs. At the time that he was found it was evident that Bernard had removed some items of clothing: his hat, shirt, skivvy and T-shirt. In addition, a number of personal items were found on the ground near Bernard's body: a handkerchief wrapped around a set of upper and lower dentures and a men's wristwatch.

13.5 Expert evidence was gathered over the course of the coronial investigation which established the following:

(a) Dr Maistry was unable to establish a precise date of death, other than noting that death occurred sometime between 6 and 27 January 2017;[53]

(b) Associate Professor James Wallman, forensic entomologist, analysed entomological evidence collected on 31 January 2017 to provide an estimate as to the minimum time since Bernard's death. Associate Professor Wallman considered that the available evidence did not provide for a precise time of death. However, he considered that Bernard had died a minimum of one to two weeks before his body was found.[54]

(c) Associate Professor John Raftos, emergency physician, was instructed by Scentre Group to also provide an opinion as to the timing of Bernard's death. Associate Professor Raftos opined that Bernard could not have survived for more than three days without water in the stairwell. Further, Associate Professor Raftos considered that, due to Bernard's pre-existing comorbidities (hypertension, hypertensive heart disease and generalised atherosclerosis) the likely survival period was considerably less than three days. Indeed, Associate Professor Rafter

[53] Exhibit 1, Tab 3, page 2.
[54] Exhibit 1, Tab 45, page 4.

considered that the absence of faeces being found in the stairwell "*strongly suggests*" that Bernard died within 24 hours of entering the stairwell, or that he may have died "*within minutes or hours*" of entering the stairwell "*because of symptoms of an acute illness*".[55]

13.6 There is no evidence that any food or water was available to Bernard within the stairwell, or that he brought any food or water with him into the stairwell. No food or water was found near Bernard when he was discovered on 27 January 2017. Whilst a fire hydrant is located at the landing between Levels 3 and 4 of the stairwell there is no evidence that Bernard accessed it.

13.7 Having regard to these matters, and to the opinion expressed by Associate Professor Raftos as to the maximum survival period in the absence of water, it is most likely that Bernard survived for up to three days from the time that he entered the stairwell. Whilst the available expert evidence does not allow a precise finding to be made as the date of Bernard's death it is more probable than not that Bernard died sometime between about 6 and 9 January 2017. It is noted that the outside date range takes into account the opinion expressed by Associate Professor Raftos, and is broadly consistent with the opinion expressed by Associate Professor Wallman that Bernard may have been deceased for up to approximately two weeks (that is, by at least 13 January 2017) before he was found.

Cause and manner of death

13.8 Dr Maistry considered that the cause of Bernard's death could not be ascertained with certainty. However, Dr Maistry noted the following:

(a) The autopsy demonstrated that Bernard had evidence of hypertensive cardiovascular disease with sites of myocardial fibrosis/scarring and coronary artery disease. Dr Maistry considered that these abnormalities would have compromised the heart's ability to function optimally and made Bernard "*especially susceptible to the generation of fatal cardiac arrhythmias and sudden death*".[56] In addition, Dr Maistry noted that this could have been further exacerbated by physiological stressors associated with being confined in a stairwell for a period of time.

(b) Food and water deprivation would have resulted in dehydration with ensuing electrolyte and metabolic derangements with the potential to cause death. Dr Maistry again noted that Bernard's cardiac pathology may have made him especially susceptible in this regard.

(c) As the incident occurred in January, during the height of summer, Bernard may have been exposed to temperatures and humidity which he may not have been acclimatised or accustomed to. Dr Maistry noted that high environmental temperatures can cause physiological changes (increased core body temperature, dehydration, tachycardia) which can predispose a person to cardiac arrhythmias, loss of consciousness and even death. Dr Maistry also considered that if lower temperatures existed in the concrete stairwell the possibility of hypothermia as a contributor could not be entirely excluded.

[55] Exhibit 1, Tab 45A, page 5.
[56] Exhibit 1, Tab 3, page 6.

(d) Histological examination of the brain revealed features strongly suggestive of Alzheimer's disease. Dr Maistry noted that this and other dementias can cause unpredictable behaviour, which can in turn be heightened by stress, anxiety, confusion, hunger, thirst and environmental factors. It is possible that these matters prevented Bernard from being able to self-rescue once inside the stairwell.

13.9 Associate Professor Raftos considered that the two most likely scenarios are that:

(a) Bernard developed chest pain because of his pre-existing cardiac disease, entered the stairwell and died shortly afterwards because of a fatal cardiac arrhythmia; or

(b) Bernard suffered a stroke and the initial symptoms caused him to seek refuge in fire stairwell.[57]

13.10 Counsel for Scentre Group submitted that, having regard to the absence of food and water, the time of year, Bernard's age and the autopsy findings, it is open to find that the cause of Bernard's death "*was cardiac arrhythmia which resulted in or caused cardiac arrest*".[58]

13.11 **Conclusions:** It is acknowledged that cardiac arrhythmia can only be diagnosed in a living person, and cannot be demonstrated at autopsy. Notwithstanding, there is no evidence that Bernard was experiencing chest pain, or that he suffered a stroke, on 6 January 2017. In addition, the autopsy report raised the possibility that Bernard could have died from electrolyte and metabolic derangements following dehydration as a result of food and water deprivation. Further, Dr Maistry noted that the possibility of hypothermia as a contributor could not be excluded. Having regard to these matters, the available evidence does not allow for a precise finding to be made as to the cause of Bernard's death.

13.12 As to the manner of death, there is no evidence that Bernard sustained any injury or trauma. Equally, there is no evidence of any third party involvement in Bernard's death. With these potential causes of death excluded, the postmortem findings as to Bernard's pre-existing comorbidities raise the possibility that Bernard's was due to natural disease process. However, the circumstances in which Bernard was found obviously cannot be ignored. Relevantly, Dr Maistry noted that the "*peri-mortem stressors*" (psychological, environmental and physiological from dehydration) that Bernard would have experienced as a result of being within the stairwell "*possibly played a significant role in leading to death*".[59]

13.13 From the bottom of the stairwell, two corridors connected by three steps and a distance of around 20 metres leads to Door L306, a fire exit onto Oxford Street. A number of signs, including painting on the wall, within the stairwell indicated the direction of this exit. There is no suggestion that Door L306 was not functioning properly. It is not clear why Bernard did not exit through Door L306 after he found himself in the stairwell.

[57] Exhibit 1, Tab 45A, page 5.
[58] Submissions on behalf of Scentre Group at [25].
[59] Exhibit 1, Tab 3, page 7.

13.14 However, as noted above, Bernard's symptoms that were characteristic of Alzheimer's dementia and the unfamiliar surroundings that he found himself in may have contributed to his inability to self-rescue. When these matters are taken into account, together with certain shortcomings and inadequacies associated with the concerted Police and Security attempts to locate Bernard, it cannot be said that Bernard's death was entirely due to natural causes. Therefore, it is more appropriate to conclude that the manner of Bernard's death should be considered to be as a result of misadventure.

14. Relevant policy considerations

14.1 Before going on to consider each of the issues individually, it is useful to set out the relevant Police and Westfield policies that were applicable as at January 2017.

Police Missing Persons Standard Operating Procedures

14.2 In 2013 the Police published the *Missing Persons Standard Operating Procedures*. They were reviewed and updated in June 2014 and June 2016, with this third version (**the 2016 Missing Persons SOPs**) being in force at the time that Bernard was reported missing.

14.3 The 2016 Missing Persons SOPs established "*the minimum standards for NSWPF officers in their day-to-day management of [missing person] matters*".[60] A missing person was defined to mean "*anyone who was reported missing to police, his whereabouts are unknown, and there are fears for the safety or concern for the welfare of that person*".[61]

14.4 In responding to a report of a missing person the 2016 Missing Persons SOPs relevantly set out a number of steps that the Police were to take, including:

(a) conducting "*a risk assessment to inform the appropriate level of investigative response*"; and

(b) continuing "*with the enquiries, maintaining regular investigative activity to pursue resolution of the [missing person] matter*".[62]

14.5 The 2016 Missing Persons SOPs also identified a number of key roles in a missing person investigation, including:

(a) The Local Area Command (**LAC**) where the missing person was last seen or went missing from was responsible for the missing person investigation. Even though Westfield was within Waverley LAC, the LAC for Bernard's investigation was Rose Bay LAC.

(b) The Local Area Commander had overall responsibility for ensuring compliance with the 2016 Missing Persons SOPs.

(c) The Investigating Officer (also known as the Officer-in-Charge (**OIC**)) was the officer who took the missing person report. The OIC was "*responsible for exhausting all avenues of enquiry until the [missing person] is located or the investigating role is transferred to, and accepted by, another LAC or specialist unit*".[63]

(d) The Supervisor was responsible for ensuring "that the investigating officer [took] all relevant information and [pursued] investigation appropriately".[64] They had to "ensure the police

[60] 2016 Missing Persons SOPs at 1.
[61] 2016 Missing Persons SOPs at 2.
[62] 2016 Missing Persons SOPs at 2.
[63] 2016 Missing Persons SOPs at 3.
[64] 2016 Missing Persons SOPs at 3.

response [was] commensurate with the risk assessment outcome and support the Investigating Officer".[65] At Rose Bay LAC the Supervisors held the rank of Sergeant.

(e) The duty officer was "responsible for ensuring and being accountable for the assessment of, and initial response to, all [missing person] incidents".[66] At Rose Bay LAC the Duty Officers held the rank of Inspector.

(f) The Missing Persons Unit had a "coordination, quality assurance, education, information management and investigative support" function.[67] It did not have "direct investigative capacity".[68]

14.6 The 2016 Missing Persons SOPs organised a missing persons investigation into three stages: (a) initial reporting; (b) investigation; and (c) finalisation. It provided that there was "*no 'one size fits all' approach*" in missing persons investigations".[69] Relevantly, it provided:

(a) The Investigating Officer had to perform a risk assessment and implement "Risk Mitigation Actions, in line with the Risk Rating". Annexure 2 of the 2016 Missing Persons SOPs contained a questionnaire to determine an appropriate Risk Rating and Mitigation Actions. The Supervisor had to ensure completion of this assessment and that "the resulting police actions are commensurate with the Risk Rating".[70] It also noted that the "Risk Rating should be continually reviewed and re-evaluated throughout the course of the investigation, as long as the person remains missing".[71] Where a missing person was assessed to be at a "high" or "very high" risk, Annexure 2 listed the following Risk Mitigation actions: "Refer MP SOPs. Monitor and reassess each shift. Follow up actions on the event daily. Inform Investigator. Contact [Missing Persons Unit]. Engage Police Radio & Media Assistance". [72]

(b) The Investigating Officer should consult the Initial Response Checklist at Annexure 3 "as a guide for other actions".[73] The tasks at Annexure 3 included completing a risk assessment, obtaining permission to search where the incident took place and conducting a search to include all surrounding areas.

(c) If and when a decision is made to conduct a land search then a "*qualified Land Search Coordinator must be nominated to undertake the actual search operation planning and coordination function*".[74] This was also provided for in a Memorandum dated 9 July 2013.[75]

[65] 2016 Missing Persons SOPs at 3.
[66] 2016 Missing Persons SOPs at 3.
[67] 2016 Missing Persons SOPs at 4.
[68] 2016 Missing Persons SOPs at 4.
[69] 2016 Missing Persons SOPs at 12.
[70] 2016 Missing Persons SOPs at 8-10.
[71] 2016 Missing Persons SOPs at 10.
[72] 2016 Missing Persons SOPs at 34-35.
[73] 2016 Missing Persons SOPs at 8, 39.
[74] 2016 Missing Persons SOPs at 10.
[75] Exhibit 1, Tab 25Y(B).

Risk Assessment

14.7 Before going on to consider the further issues which the inquest examined, it is convenient to say something at this point about the risk assessment conducted by Police. As noted above the 2016 Missing Person SOPs required a risk assessment to be performed in order to inform the appropriate level of response to a missing person report. Constable Clavel gave evidence that he was unfamiliar with the 2016 Missing Person SOPs and did not review it after becoming the Investigating Officer. As at January 2017 Constable Clavel had never previously acting as the Investigating Officer for a missing persons investigation. He gave evidence that he was unaware of risk assessments having been performed in any other missing persons investigation. As a result Constable Clavel did not appreciate that he was required to perform a risk assessment in accordance with the 2016 Missing Person SOPs.[76] Instead, Constable Clavel said that he conducted an "*informal*" risk assessment, which led him to conclude that Bernard was "*high risk*". However, this assessment was not recorded in the Bernard COPS Report.[77]

14.8 Instead, the Missing Persons Unit performed a risk assessment on 9 January 2017. It also concluded that Bernard was "*high risk*". Constable Clavel received this assessment via email when he returned to work on 11 January 2017. Despite reading this assessment, Constable Clavel did not do anything with it because he saw that it had also been sent to one of his superiors.[78] However, Constable Clavel acknowledged that he made no entry in the Bernard COPS Report to indicate that he understood that Bernard was high risk.

14.9 Constable Clavel gave evidence that he did not know what types of activities were identified as risk mitigation actions for high-risk missing persons in the 2016 Missing Person SOPs. Notwithstanding, he considered the types of actions so identified to be "*common sense*" and that his own actions were consistent with his assessment of Bernard being a high risk missing person.[79]

14.10 The 2016 Missing Person SOPs provided that, for high and very high risk missing persons, consideration ought to be given to informing an Investigator: in other words, a detective. By 12 January 2017, Constable Clavel advised his superiors that it would be challenging for him to manage his tasks in relation to the missing person investigation concerning Bernard, whilst also maintaining his regular workload as a general duties officer.[80] However, it was not until 22 January 2017 that a suggestion was made that an Investigator be allocated to Bernard's case. Further, it was not until 25 January 2017 that Detective senior Constable Bell was appointed to the case as an Investigator.

14.11 In January 2020 the 2016 Missing Persons SOPs were replaced by the *Standard Operating Procedures – Missing Persons, Unidentified Bodies and Human Remains* (**the 2020 Missing Persons SOPs**) which are intended to be a "*one stop shop*" for missing persons investigations.[81]

[76] 7/11/19 at T19.12; T21.32.
[77] 7/11/19 at T50.12.
[78] 7/11/19 at T24.1; T48.27.
[79] 7/11/19 at T24.42; T67.11.
[80] 7/11/19 at T37.39.
[81] 28/7/20 at T40.21.

14.12 As to the issue of risk assessment, the 2020 Missing Persons SOPs contains a chapter on risk assessment (**Risk Assessment Chapter**) which emphasises that it is critical to conduct a risk assessment early in a missing person investigation, and that risk to that person should be regularly reviewed. This risk assessment is to be undertaken by the officer taking missing person report, with verification provided by the shift supervisor as to whether they are in agreement with the assessment. The Risk Assessment Chapter sets out questions to be asked for the purpose of assessing whether a missing person is high risk and that person's vulnerabilities in order to assist police officers to locate that person.[82] The Risk Assessment Chapter also describes the various risk ratings (such as high risk, medium risk and limited risk) and the types of actions that should be taken. For the category of high risk missing persons the Risk Assessment Chapter relevantly provides that immediate notification to a Supervisor/Duty officer/Sector Supervisor is required. Further, "*[i]f the missing person is lost, an immediate search and rescue response is required. Immediate consideration should be given to utilising all investigative tools to locate the missing person*".[83] Detective Inspector Browne gave evidence that new risk assessments should be undertaken whenever new information is gathered that could impact on the previous risk assessment.[84]

14.13 In submissions, counsel for SecureCorp drew attention[85] to the fact that Detective Sergeant Wirth appeared to consider that Bernard was "*vulnerable*" but not "*high risk*" as he had "*mild dementia*".[86] Counsel for SecureCorp submitted that this informal risk assessment might explain why the response by Police on 9 January 2017 was not commensurate with a missing person who was assessed as high risk. To this extent, it was further submitted that it is necessary or desirable to make a recommendation that the 2020 Missing Person SOPs be amended to include a specific section which addresses specific considerations that apply in cases involving missing persons who are vulnerable, elderly and have dementia.[87]

14.14 As noted above, the Risk Assessment Chapter already provides for a number of questions to be asked so that the particular vulnerabilities of a missing person can be identified and assessed in order to inform the level of Police response. It is accepted that this process is likely to capture the particular considerations that may apply for elderly missing persons who have dementia. Therefore, it is not necessary or desirable to make a recommendation in this regard.

Relevant improvements in procedures

14.15 Further, the 2020 Missing Persons SOPs have made a number of additional improvements over its 2016 counterpart:

(a) It refers to the Missing Persons Registry which was established on 1 July 2019 within State Crime Command and which replaced the former Missing Persons Unit. State Crime Command houses specialist investigative units of the Police.[88] Unlike the Missing Persons Unit the Missing

[82] 2020 Missing Person SOPs at 34-35.
[83] 2020 Missing Person SOPs at 35.
[84] 28/7/20 at T52.38.
[85] Submissions on behalf of SecureCorp at [23].
[86] 29/7/20 at T32.26.
[87] Submissions on behalf of SecureCorp at [29(a)].
[88] 28/7/20 at 32.22.

Persons Registry has an investigative function and is staffed by investigators who specialise in missing persons investigations.[89] The Missing Persons Registry has direct involvement in missing persons investigations through the review of risk assessments, the monitoring of missing persons events on COPS, and by providing support to police officers at a local level.[90]

(b) Missing Person Coordinators have been introduced to LACs and Police Districts. This role is often performed by the Investigations Manager, and includes providing guidance about missing persons investigations to Supervisors and Duty Officers, monitoring and reviewing missing persons cases, and ensuring that missing persons cases are appropriately investigated, with sufficient resources being allocated to such investigations.[91]

(c) The role of Shift Supervisors, Duty Officers and Officers in Charge of a missing persons investigation are defined. The 2020 Missing Persons SOPs provide that "*it is possible and often appropriate for the officer who takes the report to be the OIC*".[92] However, even if this is not the case, it is intended that this report-taking officer needs to initiate inquiries for the missing person investigation.

(d) The Missing Persons Checklist at Annexure A provides guidance to the Police as to the inquiries to be a made in a missing persons investigation in the following ways:

(i) Lists information that should be included in the official police notebook in relation to the missing person report;

(ii) Alerts the police officer taking the report that they should notify a Supervisor;

(iii) States that a risk assessment should be done to assess the safety of the missing person and lists the types of questions that should be asked for this purpose;

(iv) Prompts police officers to assess the need for specialist resources, such as Bomb and Rescue for Land Search Coordination, and to commence absurd operations soon as practicable, if the search is required; and

(v) States that areas should be canvassed for CCTV footage and relevant CCTV footage should be obtained, with records kept in COPS.[93]

(e) It contains a dedicated chapter on land and marine searches (**Land Search Chapter**) and states that "land searches should be considered as a priority" and "land searches do not only relate to bushland areas, they also include urban areas or large buildings/structures that require a coordinated response".[94] The Land Search Chapter also alerts police officers to

[89] 28/7/20 at 32.32.
[90] 28/7/20 at 33.9.
[91] 2020 Missing Person SOPs at 15; 28/7/20 at 41.50.
[92] 2020 Missing Person SOPs at 20.
[93] 2020 Missing Person SOPs at 65-66; 28/7/20 at T53.6.
[94] 2020 Missing Person SOPs at 43.

resources available for land searches, including the Rescue and Bomb Disposal Unit (**LandSAR Coordinators**).[95]

14.16 Section 9.1 of the 2020 Missing Persons SOPs outlines the responsibilities of the police officer who receives a report for a missing person. One procedure that is immediately required to be undertaken by such an officer is to "*[i]nitiate enquiries aimed at locating the Missing Person and enter the result of those enquiries and other relevant information in the COPS Event*".[96] Detective Inspector Browne gave evidence that the officer initiating such enquires is required to refer to the Missing Persons Checklist, until such time as they may be replaced as the officer in charge of the investigation, and that this ought to be clarified in the 2020 Missing Persons SOPs.[97]

14.17 In submissions, counsel for SecureCorp drew attention to the fact that the 2020 Missing Person SOPs provide that where a missing person is assessed as high risk, immediate consideration should be given to utilising "*all investigative tools*" to locate the missing person. On this basis counsel for SecureCorp submitted that it is necessary or desirable to make a recommendation that the 2020 Missing Person SOPs be amended to clearly identify what specific tools are available (including the appointment of a specialist Land Search and Rescue (**LandSAR**) coordinator, and the appointment of a full-time investigator), and to address what investigative steps ought to be taken in the event that a vulnerable or high risk person is reported missing when there is no investigator on duty.[98]

14.18 Counsel for SecureCorp also submitted that for investigations of missing persons assessed to be low or medium risk, it is necessary or desirable to make a recommendation for the 2020 Missing Person SOPs to clarify the way in which the roles and responsibilities of police officers (both at an investigatory and supervisory level) operate in the context of absences (due to, for example, leave) or rotating shifts, and any consequences in terms of investigation continuity and management.[99]

14.19 **Conclusions:** After Bernard was reported missing, no risk assessment was initially undertaken as contemplated by the 2016 Missing Person SOPs. Even after a risk assessment was completed by the Missing Persons Unit, three days after Bernard had been reported missing, it appears that the outcome of the assessment did not materially inform the direction of the investigation. The performance of an initial risk assessment, and applying the results of such an assessment to the investigation itself, would likely have resulted in the involvement of an investigator (detective) at a much earlier point in time.

14.20 The new 2020 Missing Person SOPs have introduced a number of welcome improvements regarding the risk assessment process in missing persons investigations. Relevantly, greater support is provided to police officers at the local level by staff from the Missing Persons Registry with an investigative background and focus. This has resulted in an increased likelihood that appropriate police resources are deployed commensurate with the level of risk identified in a particular missing persons matter.

[95] 2020 Missing Person SOPs at 43.
[96] 2020 Missing Person SOPs at 19.
[97] 28/7/20 at T55.18.
[98] Submissions on behalf of SecureCorp at [29(b)].
[99] Submissions on behalf of SecureCorp at [29(c)].

14.21 The Missing Persons Checklist now provides a step-by-step guide to a police officer taking a missing person report as to the necessary enquiries to be made, particularly during the initial stages of the investigation. In order to reinforce the importance of such enquiries it is desirable to make the following recommendation.

14.22 **Recommendation 1:** I recommend to the NSW Commissioner of Police that the *Standard Operating Procedures – Missing Persons, Unidentified Bodies and Human Remains* (**the Missing Persons SOPs**) be clarified to provide that when a police officer takes a missing person report aimed at locating a missing person, that police officer should refer to the Missing Persons Checklist contained in the Missing Persons SOPs. I further recommend that consideration be given to including a reference to the Missing Persons Checklist in Section 9.1 of the Missing Person SOPs which deals with the initiation of enquiries aimed at locating a missing person.

14.23 Having regard to the recommendation above, it is not considered necessary or desirable to make a further recommendation of the kind which counsel for SecureCorp submitted ought to be made as to identification of the investigative tools available to a missing person investigation. It is noted that the Missing Persons Checklist already identifies the investigative tools available, including specialist resources such as a LandSAR coordinator, to assist with locating a high risk missing person. Further, the function of Missing Persons Coordinators at a local level, and the Missing Persons Registry at a broader level, already provides for appropriate supervision of a missing person investigation.

14.24 The 2020 Missing Persons SOPs already define the roles of investigatory and supervisory officers in the context of a missing person investigation. Further, as noted above, the 2020 Missing Person SOPs also provide for investigative review to be conducted by Missing Persons Coordinators, and assistance to be provided by the Missing Persons Registry. On this basis, it is not considered necessary or desirable to make any further recommendation, as submitted by counsel for SecureCorp, in relation to the roles and responsibilities of officers involved in a missing person investigation.

15. Issue 2: When, and on what basis, did Police form the view that Bernard never arrived at Westfield?

15.1 As noted above, there is disagreement between Constable Clavel and Mr Murphy as to precisely what was discussed during the Clavel-Murphy call on 7 January 2017. However what is clear is that at the time of the Clavel-Murphy call it was critical for Police to determine whether Bernard had in fact arrived at Westfield.[100]

15.2 Inspector Paul Sly was the Duty Officer for the evening shift on 6 to 7 January 2017. He gave evidence that at this time Police were still considering a number of possibilities (for example, bus terminals, train stations, Centennial Park) as to where Bernard may be, including Westfield. Inspector Sly said that that he could not recall whether he considered that Police should have positively eliminated Westfield as a location where Bernard might be, before going on to consider other possible locations.[101] However, he explained that Westfield was still in play and had not been ruled out, and that due to Bernard's age and condition, concurrent consideration needed to be given to other possible locations.[102] However, Inspector Sly also gave evidence that if Bernard was at Westfield he would be identified because Security were monitoring CCTV footage.[103] Inspector Sly accepted that he assumed that Bernard would be in an area that was covered by CCTV.[104]

15.3 It appears that between 7 to 12 January 2017 it is likely that the Police formed the view that Bernard never arrived at Westfield for the following reasons.

15.4 First, Police assumed that Security had reviewed CCTV footage of all entrances to Westfield for Bernard and he had not been identified. Police also assumed that Security were searching, or had performed a search, for Bernard at Westfield in the same manner that Police might conduct such a search. As Bernard had not been found as a result of this review and search process, the Police reached the mistaken conclusion that he had not arrived at Westfield.

15.5 It appears that this conclusion was possibly reached as early as 9 January 2017, and at least by 11 January 2017. Sergeant Pratt gave evidence that by 9 January 2017 the Police had no information that Bernard had ever arrived at Westfield. He said that, following the apparent review by Security of the CCTV footage, the Police began to focus their attention on other areas. This is also supported by the evidence of Constable Clavel. He said that when he returned to work on 11 January 2017 he felt that the direction of the investigation had moved away from Westfield. This impression was based on the Bernard COPS Report and from communication with other police officers. Both of these sources of information indicated that that Security had reviewed the CCTV footage for the entrances and exits and Westfield, and were conducting patrols to look for Bernard.[105]

15.6 Second, documentation used by senior officers to convey information during handovers, and from shift to shift, also gave the impression that Bernard had not arrived at Westfield:

[100] 7/11/19 at T18.13.
[101] 8/11/19 at T27.39.
[102] 8/11/19 at T27.29.
[103] 8/11/19 at T22.43.
[104] 8/11/19 at T23.6.
[105] 7/11/19 at T34.35; T68.17; T74.33.

(a) In the Duty Officer Handover Sheet for the overnight shift from 6-7 January 2017, Inspector Sly wrote that Bernard "*[l]eft at 12:30pm to meet wife at Bondi Westfield and did not show up and has not returned to the location*" (**6 January 2017 Handover Note**).[106] This statement was repeated in the Duty Officer Handover Sheets for the day and night shifts on 7 January 2017.[107] Inspector Sly gave evidence that there was no basis for making the statement that Bernard "*did not show up*". This is because Inspector Sly acknowledged he was still waiting for further information from Westfield, including as to whether Bernard had been seen on CCTV footage.[108]

(b) Similarly, Sergeant Pratt gave evidence that, having reviewed the Bernard COPS Report, including the Nil Find COPS Entry from 7 January 2017, he turned his mind to places other than Westfield where Bernard may be.[109]

(c) Detective Sergeant Wirth gave evidence that, relying on the Bernard COPS Report and handover notes prepared by Duty Officers and Shift Supervisors, he believed that Security and Police had searched Westfield, and that CCTV footage had been reviewed. On this basis he considered that there was no indication that Bernard was at Westfield.[110] It is most likely that Detective Sergeant Wirth formed this belief around 9 to 10 January 2017 when he reviewed the Bernard COPS Report and handover notes.[111]

15.7 Third, Sergeant Hall tasked Constables Daniels and Gilarte with conducting a search of Westfield on 9 January 2017 in order to exclude it at a location where Bernard might be. It appears that this led Police to assume, together with the nil result returned from the review of CCTV footage by Security, that Bernard had not arrived at Westfield. For example, Inspector Trevallion gave evidence that she assumed that once Security and the Police had searched the stairwells at Westfield, they were clear.[112] Further, as noted above, after 9 January 2017 Police did not search Westfield again up to 27 January 2017.

15.8 **Conclusions:** It is most likely that by 9 January 2017, and at least by 11 January 2017, Police formed the view that Bernard had not arrived at Westfield. This view was informed by assumptions made about the nature and extent of searches conducted by Security, and the nature and extent of the CCTV review performed by Security. No actual clarification was sought by the Police as to the precise details of this search and review. As a result, the assumptions came to be documented in the Bernard COPS Report and handover sheets which, in turn, only served to perpetuate such assumptions. In this sense there were several missed opportunities for the Police to independently verify that the information which had been provided by Security, and upon which Police relied to direct the investigation, was actually correct.

[106] Exhibit 1, Tab 25R at 1910.
[107] Exhibit 1, Tab 25R at 1920, 1932.
[108] 8/11/19 at T25.16.
[109] 28/7/20 at T87.45.
[110] 29/7/20 at T5.43; T20.6, T22.46.
[111] 29/7/20 at T5.21; T6.7, T6.33, T8.39.
[112] 29/7/20 at T63.44.

15.9 One additional matter should be mentioned here. In submissions, counsel for SecureCorp submitted that mention should be made of the fact that mobile phones (and associated GPS tracking technology) are used by police "*very regularly*" in missing persons cases, but unfortunately that valuable tool was on available to police in this investigation.[113] Counsel for SecureCorp submits that such a finding would be aimed at raising "*public awareness of the importance of GPS tracking technology in preventing similar tragedies and to encourage families to think of strategies or search for options to combat any resistance from a loved one with dementia refuses to carry or where such a device*".[114]

15.10 Whilst it is obviously important for Police in any missing person investigation to identify investigative tools which may assist with locating a missing person it is not considered that the circumstances of Bernard's case give rise to a specific finding being made of the kind for which is submitted by counsel for SecureCorp. This is because, as noted above, the evidence establishes that although Bernard had a watch with GPS capability, he was not wearing it on 6 January 2017 because it was not working. Even if Bernard had been wearing a functioning watch on 6 January 2017 it is not known the extent to which, if any, its GPS capability may have assisted the missing person investigation.

[113] Submissions on behalf of SecureCorp at [10].
[114] Submissions on behalf of SecureCorp at [10].

16. Issue 3: When, and on what basis, did Security form the view that Bernard never arrived at Westfield?

Scentre Group Lost and Found Children or Vulnerable People Policy

16.1 In January 2017, the Scentre Group *Lost and Found Children or Vulnerable People Policy* dated March 2015 (**the 2015 Lost & Found Policy**) was in operation at Westfield. It set out the procedures for locating a lost child or vulnerable person, with the latter including any person aged 65 years or older.

16.2 Robert Sanderson, the Director of Risk and Internal Audit at Scentre Group, gave evidence that the 2015 Lost & Found Policy was aimed at missing persons who were, or who had at some stage, been at a Scentre Group shopping centre.[115] Mr Yigal Shirin, the Senior Risk and Security Manager at Westfield at the time, gave evidence that this was also his understanding and that of other Security personnel.[116]

16.3 The 2015 Lost & Found Policy set out the steps to be followed in, relevantly, locating a vulnerable person who had been in a Scentre shopping centre and was reported missing which included:

(a) Obtaining certain information from the person reporting the vulnerable person is missing, including how the vulnerable person attended the shopping centre and the entry point into the shopping centre;

(b) Notifying the duty manager, who was to broadcast a message for all staff which included the phrase, "*Code Grey*" (the code for a missing person procedure), a description of the missing person, the last known location of the missing person and directed staff to cover public exits on the level whether missing person was last seen;

(c) Searching the CCTV system "*starting at the time and location where the [missing person] was last seen*"; and

(d) Once a Code Grey had been broadcast, all available staff undertaking a systematic search "*starting from the last known point the lost [person] was sighted*".[117]

16.4 The 2015 Lost & Found Policy also outlined the Duty Manager's responsibilities, which included to commence a running log of events, "*deploy[ing] all other available staff to conduct a systematic and coordinated search of the Centre"* and, *"where an initial search was unable to locate the [missing person]", "broaden[ing] the search area*".[118]

16.5 The evidence establishes that Security did not consider that Bernard had arrived at Westfield on 6 January 2017 for the following reasons:

[115] 4/11/190 at T32.13; T33.35.
[116] 30/7/20 at T61.41.
[117] 2015 Lost & Found Policy at 21-22.
[118] 2015 Lost & Found Policy at 22.

(a) Security had received no confirmation that Bernard had made it to Westfield on this day;

(b) Melinda's initial report to Mr Attenborough and Mr Macarico of Bernard being missing was made about eight hours after Bernard's scheduled meeting time with Angela, in circumstances where Bernard needed to walk some distance in order to reach Westfield;

(c) The Police did not on 6 January 2017, or subsequently, convey to Security a belief that Bernard was likely to have attended, or had actually attended, Westfield on 6 January 2017. Indeed, during the Clavel-Murphy call Constable Clavel indicated that the purpose of the call was to determine whether Bernard had actually arrived at Westfield.[119] Further, at 12:52pm on 7 January 2017 Constable Daniels sent Mr Bonhs an email which included a photo of Bernard and stated that Bernard "*has been reported missing to police, and was last seen 12:30pm on 6 January 2017 when he said he was going to walk to Woolworths Bondi Junction*".[120] Later on 7 January 2017, whilst at Westfield, Constable Daniels told Mr Bonhs that police were unsure which Woolworths Bernard was headed to after he left Melinda's house, and that Police were also planning to check Woolworths Bondi Beach (on the basis that Bernard may have caught a taxi to travel there).[121]

(d) Bernard was not found by Mr Attenborough and Mr Macarico on 6 January 2017 as they completed their physical checks during the course of their shift, and also not found between 7 and 9 January 2017 as Security routinely patrolled house areas and conducted daily perimeter checks.[122]

16.6 This view that Security held that Bernard had not arrived at Westfield is reflected in the fact that Mr Murphy did not initiate a Code Grey pursuant to the 2015 Lost and Found Policy on 6 January 2017.[123] Instead he only recorded a "*possible Code Grey*" (together with a brief description of Bernard and the fact that Security had been looking out for him) in the Security control room log for 6 January 2017.[124] Mr Murphy's understanding was that a Code Grey was not initiated unless there was confirmation that a missing person was onsite at a shopping centre. Mr Murphy gave evidence that he considered calling a Code Grey. However, two factors operated against this in his mind: the fact it had not been confirmed that Bernard was onsite, and the time that had elapsed between when Bernard was last seen and the initial report made by Melinda to Security.[125]

16.7 Although he was not on shift on 6 January 2017, Mr Bonhs gave evidence that the absence of any confirmation that Bernard had arrived at Westfield was relevant to the decision not to call a Code Grey.[126] Mr Mawassi also gave evidence that Security had no confirmation that Bernard had arrived at Westfield.[127] Notwithstanding, Mr Bonhs acknowledged that the 2015 Lost & Found Policy did

[119] 7/11/19 at T18.11.
[120] Exhibit 1, Tab 16, Annexure C.
[121] 27/7/20 at T34.50.
[122] Exhibit 1, TS Documents Bundle, Tab 7 at 359.
[123] 5/11/19 at T77.21.
[124] Exhibit 1, TS Documents Bundle, Tab 31 at 1363.
[125] 5/11/19 at T39.1.
[126] 5/11/19 at T79.5.
[127] 6/11/19 at T87.35.

not explicitly refer to the fact that a Code Grey was only initiated if a missing person had last been seen at Westfield.[128]

Relevant improvements in policies

16.8 Scentre Group subsequently updated the 2015 Lost & Found Policy with the current version dated May 2019 (**the 2019 Lost & Found Policy**). Relevantly, there are two key differences between the 2015 and 2019 versions of the Lost & Found Policy:

(a) Whilst both versions provided for all available staff to join a systematic search in response to a Code Grey, the 2019 Lost & Found Policy states that such a search should include "*Back of House & Fire Corridors*".[129] Fire corridors were not part of the initial systematic search in response to a code Grey under the 2015 Lost & Found Policy.

(b) The 2019 Lost & Found Policy contains a section on responding to "*reports of a lost child or vulnerable person from external sources located in the Centre*" (**External Reports Section**).[130] The 2015 Lost & Found Policy contained no such equivalent section. The External Reports Section was introduced to make it explicitly clear that the policy relating to lost children and vulnerable persons applied to reports of persons in respect of whom it could not be confirmed had arrived at the centre.[131] It states that it is "*crucial to treat all external reports with due diligence and where reasonable in the circumstances, conduct a full CCTV and Centre search for the lost person*".[132] Mr Sanderson gave evidence that what was "*reasonable in the circumstances*" depended on the discretion of individuals, guided by other policies including Scentre Group's Hazard Identification, Risk Assessment and Control Policy.[133]

16.9 The 2019 Lost & Found Policy set out the following steps to respond to external reports of lost persons, including:[134]

(a) The person receiving a report of a lost person from an external source should ask questions, including how the lost person attended the centre on the last visit or the lost person's usual entry point (**Last Visit/Entry Point Questions**). There is also a "*lost person checklist*" to be completed by the report taker, which includes some of the questions to be asked by staff but does not expressly refer to Last Visit/Entry Point Questions.

(b) The report taker should ask the person making the report if the police have been notified;

(c) The report taker should notify the Duty Manager and the Risk and Security Manager, with the latter reviewing the report and ascertaining the likelihood of the loss person visiting the centre.

[128] 5/11/19 at T110.48
[129] 2019 Lost & Found Policy at 91.
[130] 2019 Lost & Found Policy at 96.
[131] 4/11/190 at T35.35.
[132] 2019 Lost & Found Policy at 96.
[133] 4/11/190 at 43.21; Exhibit 1, Tab 53.
[134] 2019 Lost & Found Policy at 96-99.

(d) If there is an indication that the loss person may have entered the centre at a certain time or through a certain entry, the Risk and Security Manager will direct Security to search CCTV starting at the time and location provided.

(e) If requested by the police or if deemed appropriate in the circumstances by the report taker, all available staff should undertake a systematic search (**Initial Search**). If there is doubt about whether such a search should be conducted, the Duty Manager or the Risk and Security Manager must be consulted.

(f) If the lost person is not located in the Initial Search or if the Duty Manager or the Risk and Security Manager believe the lost person may still visit the centre, the Duty Manager should (a) review and assess the information that gave rise to the Initial Search; (b) review and assess the areas the subject of an earlier physical or CCTV search; and (c) arranger for a search by Security to be undertaken, including of fire corridors.

16.10 **Conclusions**: It is most likely that by 9 January 2017 Security had formed the view, like Police, that Bernard had not arrived at Westfield. This view was based on the reviews of CCTV footage, and the searches for Westfield, that have been performed up to this point in time. Importantly, no Code Grey was initiated on 6 January 2017 on the basis that Security had not received confirmation that Bernard was onsite. However, the 2015 Lost & Found Policy did not preclude a code Grey from being initiated in such circumstances.[135]

16.11 Counsel of Scentre Group submitted that, having regard to the information known to Security on 6 January 2017, it was reasonable for a Code Grey not to have been called.[136] Of course, caution must always be exercised in not permitting hindsight bias to colour any assessment of decision-making at a particular point in time. However, to the extent that any decision-making regarding the calling of a Code Grey was based on a correct interpretation of the 2015 Lost & Found Policy, that decision-making process was flawed. It is acknowledged that, for reasons discussed further below, the calling of a Code Grey on 6 January 2017 may not have resulted in Bernard being found.

16.12 The 2019 Lost & Found Policy is a more robust document in two relevant ways. First, it now, unlike the 2015 equivalent policy, includes the searching of fire corridors as part of a Code Grey response. Second, it specifically deals with external reports of missing persons and provides for critical questions in order to elicit information regarding the missing person's likely entry point into a centre.

[135] 31/7/20 at T32.45.
[136] Submissions on behalf of Scentre Group at [19].

17. Issue 4: Was the review of CCTV footage by Security and Police adequate?

Identification of the entrance used by Bernard

17.1 The CCTV footage establishes that Bernard entered Westfield on 6 January 2017 via the Zara entrance. However, neither Security nor the Police reviewed the CCTV footage for this entrance. Instead, the review of CCTV footage concentrated on the pedestrian entrances on Level 3 of Zone A. It appears that this occurred because of the location known to Security and Police regarding where he had arranged to meet Angela, namely Woolworths on Level 3 of Zone A.

17.2 On the evening of 6 January 2017 Mr Macarico asked Melinda a number of "*usual questions*" in response to a missing person report regarding Bernard's name, his appearance, what clothes he was wearing, where he was last seen, his favourite areas within Westfield, and any areas which Bernard usually avoided.[137] However, Mr Macarico gave evidence that asking about Bernard's possible points of entry into Westfield was not part of the set of "*usual questions*". Similarly, Mr Attenborough could not recall whether he asked Melinda about this issue, or whether such a question was part of the "usual questions" to ask when a person was reported missing.[138]

17.3 Further, Mr Macarico gave evidence that it was his usual practice to record information of the kind provided by Melinda in a notebook. However, Mr Macarico did not have his notebook with him on 6 January 2017. Instead, Mr Macarico recorded the information provided by Melinda on a timesheet. However Mr Macarico gave evidence that he could not recall what, if anything, he subsequently did with the timesheet.[139]

17.4 The 2015 Lost & Found Policy provided that a staff member obtaining information about a missing person should ask how the child or vulnerable person attended Westfield, and the entry point into Westfield.[140] The 2019 Lost & Found Policy contains a similar provision.

17.5 **Conclusions:** On the evening of 6 January 2017 it is most likely that neither Mr Macarico or Mr Attenborough elicited critical information from Melinda as to Bernard's usual points of entry into Westfield, and when Bernard was last at Westfield. This appears to be inconsistent with the provisions of the 2015 Lost & Found Policy. Equally importantly, Mr Macarico did not document information provided by Melinda in his notebook, or any other record which might have been reviewed by subsequent Security staff. There is no evidence that the timesheet used by Mr Macarico to record this information was ever seen by any other member of Security.

17.6 It is not possible to be definitive as to what might have occurred if information had been elicited as to Bernard's usual points of entry into Westfield. However, it is most likely that if Melinda had been asked about Bernard's usual points of entry into Westfield, his use of the Zara Entrance would have been elicited. This in turn may have led Security to review CCTV footage of the Zara Entrance. Having regard to the above matters it is necessary to make the following recommendation.

[137] 4/11/19 at T67.43.
[138] 5/11/19 at T8.13.
[139] 4/11/19 at T68.26; T69.41.
[140] Exhibit 1, TS Documents Bundle Tab 1 at 20.

17.7 **Recommendation 2:** I recommend the Chief Executive Officer, Scentre Group Pty Ltd that the 2019 *Lost and Found Children or Vulnerable People Policy* be amended so as to include in the lost person checklist the questions to be asked in order to elicit information as to how a lost person attended Westfield and that person's entry point into Westfield. I further recommend that (a) the lost person checklist be made readily available to security staff and independent security contractors when taking a report of a lost person; and (b) training be provided to security staff and independent security contractors during their induction process as to the types of questions to ask when taking a report of a lost person.

Review methodology employed by Security

17.8 In order to properly understand the methodology employed by Security in conducting the review of CCTV footage the following matters should be noted:

(a) Review of the CCTV footage at Westfield required the physical monitoring of a screen by human operators. As at January 2017 facial recognition technology was not available to either Security or Police as part of the review process.

(b) The review process could occur in one of two ways depending on the information available. First, in the case of a person who had become separated from another person who had reported them as missing, CCTV footage could be reviewed by tracking backwards to identify the point of separation, and then tracking forwards to follow the missing person. Second, in the case where a point of separation or a location where the missing person was last seen was unconfirmed, Security would begin a review at the location where the missing person was meant to be, and then broaden the search from this point.[141] This second scenario is what occurred in Bernard's case.

(c) The review of 12 hours of CCTV footage (from 12:00pm to 12:00am on 6 January 2017) from a total of nine cameras (the entrance to Woolworths, the pedestrian entrances to Westfield, and two internal cameras on Level 3 of Zone A) amounted to a total of 108 hours of footage in real-time. Although it was possible to increase the playback speed of the footage during review, even a review of footage played at four times normal speed would require a minimum of 27 hours real-time review.

(d) Apart from being time-consuming, the review process also depended on human factors such as the ability of reviewers to maintain concentration and cope with mental fatigue and eye strain for extended periods of time. Mr Bonhs gave evidence that he could only review CCTV footage for about 20 minutes before losing concentration. He also explained that it was not possible review CCTV footage continuously throughout a shift because of his competing duties, and that he routinely only reviewed periods of CCTV footage of less than one hour.

(e) Although up to January 2017 Security had routinely received requests from police for the review, and copying, of CCTV footage, these requests typically related to footage of relatively

[141] 6/11/19 a T28.31.

short duration, up to a couple of hours.[142] Further, these requests typically related to circumstances involving a person confirmed to be onsite, and a known entrance or exit points, or the known location of an incident.[143] Mr Shirin gave evidence that in his experience Westfield had never previously received a request for footage from every entrance to a centre.[144]

17.9 Mr Attenborough gave evidence that after speaking to Melinda on 6 January 2017 he began by reviewing CCTV footage from the Revolving Door Entrance. He explained that he chose this entrance because it was on the same level as Woolworths. Using the methodology described above, Mr Attenborough started the footage from 3:30pm and worked backwards to 12:30pm, watching the footage at double speed in reverse. At the time of this review Mr Attenborough did not have a photo of Bernard to assist him (as this was only provided to Security the following day) but considered that one would have been of assistance.

17.10 Mr Murphy acknowledged that the Zara Entrance was reasonably proximate to Woolworths. However, he gave evidence that he did not consider checking CCTV footage from the Zara Entrance for the following reasons:

(a) In his experience, it was most common for visitors to enter Westfield via the Luxe Entrance, Revolving Door Entrance or the Eastern Hotel Entrance in order to attend Westfield. Mr Bonhs considered it to be uncommon for visitors to enter via the Zara Entrance and then take an escalator down to Level 3 where Woolworths was located.

(b) In order to attend Woolworths via the Zara Entrance, a visitor would need to walk past three other entrances on the same level as Woolworths.

(c) If Bernard had used the Zara Entrance to enter Westfield and then took the escalator from Level 4 to Level 3, he would have been seen on the camera outside Woolworths.

17.11 Notwithstanding the above, Mr Murphy agreed in evidence that on 7 January 2017 it would have been appropriate to review CCTV footage from the Zara Entrance.[145]

17.12 Counsel for SecureCorp submitted that Security did "*an acceptable job and the best job they could*" given the information, skills and resources available to them, and that it was inappropriate for Police to wholly delegate the complex task of CCTV footage review "*without any input, supervision or strategic oversight whatsoever*".[146] There is some force to this submission given that it appears that Police wholly relied on the review of CCTV footage of Westfield by Security. This is evident from both the outcome of the Clavel-Murphy Call, and the attendance of Constables Daniels and Sharman at Westfield later the same morning. In taking this approach Police made assumptions about the extent of the review of CCTV footage, and in particular that it included all entrances to Westfield.

[142] 31/7/20 at T19.44.
[143] 31/7/20 at T19.48.
[144] 31/7/20 at T20.9.
[145] 5/11/19 at T57.19.
[146] Submission on behalf of SecureCorp at [98].

17.13 **Conclusions:** The request made by Police for Security to conduct a review of CCTV footage was atypical, both in its size and scope. It is evident that the size and scope of the review required was dependent on identifying a reliable starting point, or points, to commence any CCTV footage review. However, unlike requests for CCTV footage review made to Security prior to January 2017, Security did not have available to them a known starting point, or one which could be reliably inferred from the information provided. Of course, it has already been noted above that had further information been elicited on 6 January 2017 this may in turn have elicited further information that would have assisted any such CCTV footage review.

17.14 Given the matters referred to by Mr Murphy as to the most common entrances that visitors to Westfield used in order to attend Woolworths, it is reasonable at that time for the Zara Entrance to not have been considered a likely entrance used by Bernard. However by 7 January 2017, when an initial review of the most likely entrances had been conducted, it was unreasonable not to extend the review to the Zara Entrance given its proximity to Woolworths.

Communication within Security regarding CCTV review

17.15 Whilst the entrance to Westfield that Bernard had actually used had not been reviewed by Security, it was commonly understood by members of Security that CCTV footage of entrances to Westfield on 6 January 2017 had been reviewed, and that Bernard had not been identified. For example:

(a) Hasan Mawassi was the security supervisor or second-in-charge of Security, and was on shift on 7 January 2017. He gave evidence that at the beginning of his shift, Mr Bonhs told him that the CCTV footage for the cameras in the direct vicinity of Woolworths and the entrances to Westfield had been checked. Mr Mawassi understood this check to have included the CCTV footage of the Zara Entrance.[147] Mr Mawassi asked Mr Bonhs to continue reviewing Level 3, the centre entrances and ID cameras to double check the work done the previous night.[148]

(b) Mr Ghani and Mr Bonhs gave evidence that on 9 January 2017, Mr Bonhs told Mr Ghani that the CCTV footage of cameras in front of Woolworths, Coles and entrances to Westfield had been checked by Mr Murphy, Mr Attenborough and Mr Bonhs.[149] Although Mr Bonhs said that he did not specify what entrances had been reviewed, Mr Ghani understood the description of the CCTV review to include the footage of the Zara Entrance.[150] Mr Ghani also gave evidence that on 10 January 2017 he understood that Security had finished reviewing CCTV footage.[151]

(c) Dragana Jakovljevic worked as a rover on 7 January 2017. She gave evidence that Mr Bonhs and Mr Murphy told her that they had checked the CCTV footage of cameras around Woolworths and the entrances to Westfield. Ms Jakovljevic interpreted this to mean that this check included all entrances in Zones A and B.[152]

[147] 6/11/19 at T84.50.
[148] 6/11/19 at T88.1.
[149] 5/11/19 at T94.33; 6/11/19 at T7.35, T45.18;
[150] 6/11/19 at T46.11.
[151] 6/11/19 at T65.4.
[152] 6/11/19 at T6.9.

(d) Mr Shirin gave evidence that on 10 January 2017 Mr Bonhs told him that Security had been reviewing CCTV footage of all entrances and the Woolworths area. He said that he instructed Mr Bonhs that the control room operators should continue reviewing CCTV footage of entrance cameras.[153] His expectation was that this would include a review of CCTV footage from before 6 January 2017.[154] Mr Shirin accepted that these instructions should have been documented and that he should have checked whether his instructions had been carried out.[155]

17.16 Counsel for Scentre Group submitted that the absence of a robust documentation process for what was described as a generalised, multi-camera search conducted over multiple days needed to be understood against the matters relevant to the methodology employed by Security as described above.[156] Counsel for Scentre Group also submitted that in the experience of Scentre Group a CCTV review of the complexity that was requested of Security had never before been required.

17.17 **Conclusions:** It is apparent from the above that members of Security did not have a uniform understanding of the nature and extent of the CCTV review. Instead, members of Security had differences in understanding as to what had been reviewed by other members, which in turn was different from what actually had been reviewed. These differences were a result of ineffective communication between members of Security.

17.18 The primary reason for this ineffectiveness was the absence of precise and comprehensive documentation of the CCTV review process. Mr Shirin, Mr Bonhs and Mr Ghani all acknowledged that it was useful to document the CCTV footage that had been reviewed. This would have allowed Security staff on subsequent shifts to be made aware of what CCTV footage had actually been reviewed, and what further review was required.[157]

17.19 It is acknowledged that the task faced by Security as to the CCTV review process was an unusual and complex one. However, the very complexity and extent of the task only serves to reinforce that it was critical for the review process to be properly documented. This is especially so given that a number of members of Security engaged in the process over a number of days. It was therefore imperative that clear information be provided from shift to shift as to the precise nature of what had been reviewed, and what was still to be reviewed.

17.20 One welcome improvement made since January 2017 is that, for any CCTV review process, Security now follows a more robust practice involving the documentation of all CCTV footage that has been reviewed.[158]

[153] 30/7/20 at T68.5.
[154] 30/7/20 at T68.10.
[155] 30/7/20 at T71.13.
[156] Submissions on behalf of Scentre Group at [81].
[157] 5/11/19 at T92.7, T 94.4; 6/11/19 at T64.6; 30/7/20 at T69.40.
[158] 30/7/20 at T63.34; T71.26.

Communication between Police and Security

17.21 Sergeant Hall acknowledged that in asking Constables Daniels and Sharman to follow-up the review of CCTV footage on 7 January 2017, he should have contacted Security to obtain information as to the location and number of CCTV cameras at Westfield. This would have assisted the constables with their enquiries. Sergeant Hall also agreed that it would have been helpful to make a record of the assistance that had been requested from, and provided by, Security.[159] Constable Gilarte similarly agreed that it was important to record what Westfield had undertaken to provide to the police in terms of the CCTV footage.[160]

17.22 Inspector Sly gave evidence that if police intended to rely on an external party to conduct a review of CCTV footage, it was important for Police to know precisely what footage was being reviewed. He also acknowledged that it was important for Police to confirm that the external party had reviewed everything that the Police had requested be reviewed.[161]

17.23 Counsel for the Police submitted that the circumstances in which Bernard went missing, and subsequently died, "*had a profound effect on those officers involved in searching for him*".[162] In support of this submission Counsel for the Police drew attention to aspects of the evidence in which certain police officers expressed the ways in which the investigation affected them and their colleagues. For example, Inspector Sly gave evidence that the investigation, and the consequences for Bernard, "*consumed the [LAC] at the time*".[163] A number of police officers gave evidence that the desire to locate Bernard consumed the entire LAC. There is no reason to doubt that the description given by Inspector Sly is reflective of the collective concern that the Police had for Bernard's welfare. However, notwithstanding this concern, it is clear that Police relied on the review conducted by Security without a proper understanding, or audit, of what that review entailed.

17.24 The 2020 Missing Person SOPs provide that an objective is to ensure that "*detailed records are kept of all information gathered, inquiries conducted, and investigative functions undertaken*".[164] Detective Inspector Browne gave evidence that, under the 2020 Missing Person SOPs, he would expect that in any CCTV review records would be kept regarding the areas that had been reviewed, and the cameras accessed in order to conduct such a review.[165] The 2020 Missing Persons SOPs also provide that relevant areas should be canvassed for CCTV footage, such footage should be obtained, and corresponding records should be kept in COPS. Detective Inspector Browne gave evidence of an intention by Police to update the 2020 Missing Person SOPS with further guidance on the gathering of CCTV footage in a missing person investigation.[166]

[159] 30/7/20 at T6.13.
[160] 5/11/19 at T62.15.
[161] 8/11/19 at T36.11; T40.49.
[162] Submissions on behalf of Police at [17].
[163] 8/11/19 at T67.43.
[164] 2020 Missing Person SOPs at 12.
[165] 28/7/20 at T44.20.
[166] 28/7/20 at T72.45.

17.25 **Conclusions:** The absence of appropriate documentation of the CCTV footage review that Security had been requested to conduct left Police with an inaccurate understanding of the nature and extent of this review. Police did not seek to confirm that their requests had been carried out accurately and effectively. Since January 2017 more robust procedures have been introduced to ensure that there is appropriate documentation of such CCTV review processes. However, it appears that these procedures can be reinforced further with the following recommendation.

17.26 **Recommendation 3:** I recommend to the NSW Commissioner of Police that the *Standard Operating Procedures – Missing Persons, Unidentified Bodies and Human Remains* be updated to identify and emphasise the following matters: (a) the purpose and importance of canvassing for, and gathering, CCTV footage in the context of a missing person investigation; (b) the timing of when, and extent to which, such CCTV footage is to be reviewed; and (c) the need for comprehensive and accurate communication between Police and community partners who are requested to engage in the provision and review of such CCTV footage.

18. Issues 5 and 8: Were the physical searches of Westfield, including of fire stairs and fire corridors, adequate?

18.1 Due to a number of common issues, it is convenient to deal with Issues 5 and 8 together.

No physical search of the fire stairs and fire corridors at Westfield

18.2 As noted by Counsel for Scentre Group[167], it is important to bear in mind the following relevant factors in any assessment of the adequacy of the physical searches conducted at Westfield:

(a) Between 2009 to 2018 approximately 20 to 21 million persons attended or otherwise passed through Westfield each year.[168]

(b) Before 6 January 2017 Scentre Group had no experience of an incident where a person reported missing at one of its centres had not been resolved. Instead, the experience of Scentre Group was that reports of missing persons (most commonly children) were typically resolved within approximately 10 minutes following the initial report of a missing person to security.

(c) Before 6 January 2017 Scentre Group also had no experience of any incident where a person had sustained a serious injury, or had been found deceased, in a fire stairwell or fire corridor at a centre.

(d) The 2015 Lost & Found Policy was directed at locating persons who were reported as having been lost or gone missing at a Scentre Group centre. As a result, searches for a missing person typically commenced from a known starting point: either the location in or about the centre where the missing person was last seen or the place of the report.

18.3 As noted above, Mr Murphy did not call a Code Grey on 6 January 2017. Even if a Code Grey had been called and a systematic search of Westfield had been conducted by security in accordance with the 2015 Lost & Found Policy, the fire stairs and fire corridors may not have been checked in a manner that would have resulted in Bernard being located. This is because, as Mr Bonhs explained, a Code Grey differed from what was described as a white level search. This is a search commonly used by Security in response to a bomb threat in order to identify suspicious persons and packages, and used less commonly in missing person cases. This type of search, once escalated to, and approved by, a Duty Manager, includes back of house corridors, tenancies, fire stairs, loading docks, and carparks. Mr Bonhs explained such a search would include searching fire exits, and that it would least require walking up and down the stairs to the next immediate landing.

18.4 Between 6 and 27 January 2017 neither police nor Security conducted a physical search of the fire stairs and fire corridors in Zone A. It is likely that any physical search of Westfield performed by Security during this period was limited to keeping a lookout for Bernard in the course of Security conducting their routine patrols in and around the perimeter of Westfield. For example, Mr Macarico and Mr Attenborough kept a lookout for Bernard as they completed their usual tasks on 6 June 2017.

[167] Submissions on behalf of Scentre Group at [35]-[40].
[168] Exhibit 1, Tab 33D at 2.

18.5 The 2019 Lost & Found Policy states that a full search after an Initial Search in response to an external report should include a search of the fire corridors. Mr Shirin gave evidence that had this policy been in place in January 2017 it is likely that the fire stairs would have been checked by Security.[169]

18.6 The 2019 Lost & Found Policy now states that a systematic sweep in response to a Code Grey should include the fire corridors.[170] It states that the systematic sweep should include "*Back of House & Fire Corridors plus Loading Docks, starting from last known location radiating outwards following the Centre's Back of House Policy inspection methodology*".[171] Mr Sanderson gave evidence that the inspection methodology was the "*inspection checklist*" attached to the Back of House Corridors, Fire Doors & Plant Rooms Inspection Policy dated September 2019.[172] However, Mr Sanderson acknowledged that whilst areas of inspection are identified, there are no instructions about the order in which fire corridors are to be searched in the "*inspection checklist*".[173]

18.7 **Conclusions:** No physical search of the fire stairs at Westfield was conducted by either Security or Police in the period between 6 and 27 January 2017. This is because no Code Grey was ever initiated. Even if one had been initiated, it would have required a Duty Manager to exercise discretion to extend such a search to include fire stairs and fire corridors. Further, it appears unlikely that such discretion would have been exercised given the past experience of Westfield (and Scentre Group more broadly) as to the typical types of missing person matters that were usually resolved in a relatively short period of time.

18.8 The 2019 Lost & Found Policy now removes any such discretion being exercised and includes the searching of fire stairs and fire corridors as part of a Code Grey response. However, no guidance is given as to the order in which this type of search is to be conducted so as to give full effect to the utility and goals of such a search. Therefore the following recommendation is necessary.

18.9 **Recommendation 4:** I recommend to the Chief Executive Officer, Scentre Group Pty Ltd that the 2019 *Lost and Found Children or Vulnerable People Policy* be amended to provide clarification regarding the order in which fire stairs and fire corridors should be searched in response to a Code Grey.

Lack of understanding by Security about monthly fire stair and fire corridor checks

18.10 As at January 2017 Security were meant to check the fire stairs at Westfield once per month on a rolling basis.[174] In other words, no set date was allocated for the monthly check of each fire stair and fire corridor. These checks involved the walking up and down the fire stairs and along the full length of the fire corridors. These checks were to ensure that the fire corridors and fire stairs were in good working order, were not blocked and did not have anything suspicious in them. In

[169] 30/7/20 at T73.22.
[170] 2019 Lost & Found Policy at 91.
[171] Exhibit 1, TS Documents Bundle Tab 2 at 91.
[172] 4/11/190 at T38.25.
[173] 4/11/190 at T39.38.
[174] 4/11/19 at T68.12; 5/11/19 at T8.45, T86.20; 30/7/20 at T57.50; Exhibit 1, Tab 33I at [25]-[26].

addition, Security also had an informal practice during routine patrols of Westfield of checking the fire corridors at the rear of commercial tenancies. This is because some tenants at Westfield were known to use the fire stairs and back of house corridors to store extra stock.

18.11 Mr Shirin gave evidence that a security officer, who was tasked to check a fire door, would also walk the fire corridors to the exit associated with that door, even if that involved walking down the fire stairs.[175] However, despite Mr Shirin's expectation this is not the manner in which Mr North conducted a monthly check of Doors L407 and L306, and the associated fire corridor, on 19 January 2017. Instead, as noted above, Mr North walked inside door L407, looked up and down and then walked out. He did not check door L306. On 23 December 2016 Mr North was also tasked with checking the same doors. He again checked door L407 in the same manner but did not check door L306. Mr North gave evidence that on the basis of his training, his checks involved looking up and down on each level, but not walking up and down the fire stairs.[176]

18.12 Therefore, Mr Shirin's expectation as to how fire stairs and corridors should be checked, and how these checks were in fact carried out, were incongruous. Mr Shirin acknowledged that Mr North did not appear to understand the nature of the check that he was tasked to perform.[177] Mr Shirin was unaware that door L306 had not been properly checked. He accepted that either he, or the control room operators, should have been aware of this.[178] To this extent, Mr Shirin acknowledged that if door L306 had been checked on 19 January 2017, Bernard would have been found.[179]

18.13 As noted above, a finding has already been made that Bernard most likely died sometime between 6 and 9 January 2017. This means that even if door L306 had been properly checked on 19 January 2017 it would not have altered the eventual outcome. However, there are two critical considerations. First, if Bernard had been found on 19 January 2017 his family would have been spared an additional week of distress in not knowing his whereabouts. Second, Bernard's earlier discovery may have enabled more conclusive findings to be made following the postmortem examination. Counsel for SecureCorp submitted that the second matter is one of "*pure speculation*".[180] However, it should be noted that the postmortem examination revealed evidence of significant decompositional changes to the body, and that "*post-mortem lividity was difficult to discern due to the level of decomposition*".[181] On this basis, it is reasonable to conclude that limiting the extent of decompositional changes might *possibly* have allowed for more precise pathological findings to be identified postmortem.

18.14 Since 2017 Scentre Group has increased the frequency of checks of fire stairs and fire corridors. In accordance with the Back of House policy they are now checked weekly by Security, Scentre Group staff and cleaning contractors.[182] Whilst there is some evidence that Security now walks from the top to bottom of fire stairs it is important for Scentre Group to ensure that appropriate training is provided to Security to ensure that these checking tasks are correctly performed. Further, as such

[175] 30/7/20 at T59.11; 4/11/190 at T26.33.
[176] 5/11/19 at T69.30.
[177] 4/11/190 at T28.41.
[178] 4/11/190 at T27.38; T28.46.
[179] 4/11/190 at T28.46.
[180] Submissions on behalf of SecureCorp at [101].
[181] Exhibit 1, Tab 3, page 9.
[182] Exhibit 1, TS Documents Bundle, Tab 10.

checks are performed by non-Security personnel it is equally important that these persons understand the nature of their tasks.[183]

18.15 The Back of House Policy lists documentation that is completed in connection with the checks of the fire stairs and fire corridors by Security, Scentre staff and cleaning contractors.[184] However, it is equally important to that this documentation is reviewed to ensure that any omissions or inquiries are followed up.

18.16 **Conclusions:** As at January 2017 checks of fire stairs and fire corridors at Westfield were performed monthly on a rolling basis, together with informal checks during routine Security patrols. These checks included external fire exit doors. The purpose of such checks was to ensure that the fire stairs were in good working order and free of obstructions, and to ensure that external perimeter doors were operating as intended.

18.17 As the relevant fire stairs and fire corridors were maintained in accordance with applicable building regulations, and in good working order, counsel for Scentre Group submitted that there is no evidence that, as at January 2017, these types of checks were required to be performed more frequently.[185] Whilst this submission is accepted, it is evident that regardless of the frequency of the checks, there were identified deficiencies in the quality of checks of fire corridors, and whether perimeter exit doors were checked at all.

18.18 Since January 2017 the frequency of checks of fire stairs and fire corridors has been increased. However, in order to give effect to the quality of such checks the following recommendation is necessary.

18.19 **Recommendation 5:** I recommend to the Chief Executive Officer, Scentre Group Pty Ltd that the training provided to Scentre Group Pty Ltd security staff and independent security contractors be reviewed in relation to the checking of fire stairs and fire corridors to ensure that the nature of such tasks are effectively communicated and properly understood. I further recommend that measures be put in place to ensure that documentation in relation to such checks is reviewed to identify the need for any follow-up.

Police reliance on Security in relation to the physical search of fire stairs and fire corridors

18.20 Constable Clavel gave evidence that on 6 January 2017 he did not consider undertaking a systematic search of Westfield because it was closed and he was confident that Security would be able to identify Bernard (if he had arrived at Westfield) from a review of CCTV footage.[186] Similarly, Inspector Sly gave evidence that he considered whether a search of Westfield should be conducted, but thought that if Bernard was at Westfield he would be easily identified because Westfield was closed and Security was reviewing CCTV footage.[187] Inspector Sly acknowledged that

[183] 30/7/20 at T86.20.
[184] Exhibit 1, TS Documents Bundle, Tab 10 at 504-506.
[185] Submissions on behalf of Scentre Group at [97].
[186] 7/11/19 at T64.1.
[187] 7/11/19 at T22.47.

if Police had spoken to Security directly, this would have clarified the nature and extent of the physical checks that they had undertaken.[188]

18.21 By 9 January 2017, Police assumed or understood that the fire stairs and fire corridors had been checked.[189] The Bernard COPS Report for 9 January 2017 stated: "*Security staff conduct regular patrols around the centre, including patrolling all toilets, garbage rooms, loading docks and fire stairwells*".[190] It appears that this assumption or understanding occurred because:

(a) Security did not complete the request made by Police to check the fire stairs and fire corridors, and Police did not follow this up; or

(b) The Police interpreted information received from Security to mean that the fire stairs and fire corridors were checked more regularly than once per month.

18.22 As noted above, there is a divergence in the evidence as to whether Police requested Security on 9 January 2017 to search the fire stairs at Westfield. It is most likely that this request was not made. Mr Bonhs and Mr Ghani both gave evidence that performing such a task would have required Security deviating from their usual patrol routine.[191] If this was to occur it would have required authorisation from Mr Shirin or another Duty Manager. There is no evidence that authorisation of this kind was sought or obtained.

18.23 There are two other matters to note. First, the total length of all the fire corridors in Westfield was approximately 10 kilometres (although this was not a matter known to Police). Second, when Constables Daniels and Gilarte attended Security later on 10 January 2017 no specific enquiry was made as to the outcome of any purported check of the fire corridors.

18.24 Inspector Trevallion accepted that it was important for the Police to understand the nature and extent of the checks of stairwells that had been performed by Security. She also accepted that she assumed that a check of the stairwell involved a top to bottom check without confirming whether this was actually the case.[192]

18.25 Constable Gilarte gave evidence that it was important to understand how Security conducted their searches. However he could not recall that Constable Daniels asked Mr Bonhs about this.[193] Constable Gilarte also accepted that he and Constable Daniels should have confirmed the searches that security had performed, or obtained information about the protocols used to conduct their searches.[194]

18.26 On the issue of any request made by Police of Security for the fire stairs and fire corridors to be searched, counsel for the Gore Family submitted that "*the conversation between the police and Secure Corp wherein the police had been sent to Westfield/Scentre Group for the purpose of*

[188] 8/11/19 at T34.50.
[189] 29/7/20 at T63.25.
[190] Bernard COPS Report at 14.
[191] Day 2 at T104.25; Day 3 at T52.17.
[192] 29/7/20 at T63.50.
[193] 27/7/20 at T63.43.
[194] 27/7/20 at T70.48.

conducting the search and then informed by employees of Secure Corp that the fire stairs have been searched must be found to be nothing short of a lie".[195]

18.27 **Conclusions:** There is no evidence that any member of Security was deliberately untruthful in providing information to police regarding the nature and extent of any check that had been performed in relation to the fire stairs and fire corridors at Westfield. Instead, the evidence establishes that it is most likely that Police made no specific request for security to conduct such a search on 9 January 2017. This is primarily due to the absence of any authorisation by a senior member of Security which would have been required and sought before such a search was conducted, and the absence of any specific follow-up by Police on 10 January 2017. Therefore, it is most likely that from 9 January 2017 Police proceeded on the assumption that checks of the fire stairs and fire corridors were conducted more regularly than once per month.

18.28 Whilst it was important for Police to understand the nature, extent and frequency of any searches performed by Security, it is clear from the evidence that precise details about these matters were not sought by Police. The inaccurate entry contained in the Bernard COPS Report for 9 January 2017 explains why this issue was not revisited after this date.

Adequacy of planning and resources

18.29 Inspector Trevallion and Sergeant Hall agreed that a full and comprehensive search of Westfield by Police required careful planning, sufficient resources and liaison with Westfield.[196] However, the Police did not undertake any planning prior to the walk-through of Westfield conducted by Constables Daniels and Gilarte on 9 January 2017, or allocate sufficient resources to this task.

18.30 Sergeant Hall accepted that when he tasked Constables Daniels and Gilarte to search Westfield on 9 January 2017 he had no real understanding as to the following matters:

(a) what such a search would entail;

(b) the layout and size of Westfield, including back of house areas;

(c) the number and scope of fire doors and fire stairwells;

(d) how many members of Security were onsite and their capacity to assist.[197]

18.31 Before assigning Constables Daniels and Gilarte to this task, Sergeant Hall recognised that he ought to have informed himself about the above matters, and obtained confirmation from Security as to the availability of resources for such a task.[198]

18.32 Given the size of Westfield, two police officers in the form of Constables Daniels and Gilarte were insufficient to perform the type of search requested by Sergeant Hall.[199] They also had no maps of

[195] Submissions on behalf of the Gore Family at [9].
[196] 29/7/20 at T64.39; 30/7/20 at T13.36.
[197] 27/7/20 at T12.33, T13.26, T13.31.
[198] 27/7/20 at T13.10, T66.49; 8/11/19 at T93.44.

Westfield and no checklist.[200] Both would have been useful tools in ensuring that areas were not missed.[201] Overall, Constable Gilarte considered that a more thorough search could have been carried out by Police if proper resources and maps were available.[202]

18.33 Inspector Trevallion agreed that something akin to a land search and rescue operation involving LandSAR coordinators was required for a full and comprehensive search of Westfield.[203] Indeed, such a search was undertaken at Centennial Park on 11 January 2017. Detective Senior Constable Agostino expressed the view that such a search should have been conducted of Westfield.[204] Whilst acknowledging that he did not have the benefit of the full details relating to Bernard's matter, Detective Inspector Browne also expressed the view that rapid engagement with LandSAR coordinators to search Westfield would have been beneficial.[205]

18.34 Since 2017 improvement action has been taken by Police to address the above issues, namely:

(a) The 2020 Missing Person SOPs make land searches using LandSAR coordinators a more prominent feature of missing persons investigations, and makes clear that land searches to not only relate to rural areas; they also relate to urban areas and large buildings. This is relevant because as at January 2017 many police officers did not appreciate that these types of searches could be undertaken in non-rural and non-outdoor areas.[206]

(b) The Missing Persons Registry is proactive about the use of land searches and LandSAR coordinators in missing persons investigations. If it is considered that LandSAR coordinators should be used for a land search, staff from the Missing Person Registry will provide advice to police at the local level about such a search. If a LandSAR coordinator is ultimately not engaged the matter will be escalated with their supervisors and, if necessary, with Detective Inspector Browne. This will result in follow-up on the search and engagement of a LandSAR coordinator.[207]

18.35 In addition, both Detective Inspector Browne and Detective Senior Constable Agostino recognised that education and training regarding the use of land searches in urban environments would be valuable.[208] Some measures have already been taken by Police to provide education and training to officers regarding the 2020 Missing Person SOPs, and to use them when conducting a missing person investigation.[209]

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[199] 27/7/20 at T64.50; T67.3, T69.40.
[200] 27/7/20 at T68.41; T69.40.
[201] 27/7/20 at T68.48.
[202] 27/7/20 at T70.25.
[203] 29/7/20 at T65.1.
[204] 4/11/19 at T40.16.
[205] 28/7/20 at T47.35; T55.38.
[206] Day at T19.45; 28/7/20 at T48.24; T76.37.
[207] 28/7/20 at T33.15; T48.4, T48.39, T77.36.
[208] 4/11/19 at T57.36; 28/7/20 at T78.8.
[209] 28/7/20 at T38.40, T40.44, T48.4, T78.8.

18.36 **Conclusions:** Police properly considered that a comprehensive and systematic search of Westfield was required by at least 9 January 2017. However, the actual search conducted on this date can more accurately be described as a walk-through, rendering it largely ineffective in confirming whether Bernard had arrived at Westfield, and was still there. In order to give full effect to the intent of such a search Police needed to inform themselves of the intricacies of the search location, the scale of the search and the resources required to undertake it. Regrettably, this did not occur.

18.37 Appropriate resources and expertise were available to Police to conduct a search at Westfield of the type and nature conducted at Centennial Park on 11 January 2017. However, these resources and expertise were not called upon due to a misapprehension regarding the availability of a LandSAR coordinator to become involved. It appears that this misapprehension has been addressed in the 2020 Missing Persons SOPs which emphasises the availability of land searches using a LandSAR coordinator, and input provided by the Missing Persons Registry to the same effect. However, it appears prudent to reinforce the provisions of the 2020 Missing Persons SOPs with specific training as to this issue. Therefore it is desirable that the following recommendation be made.

18.38 **Recommendation 6:** I recommend to the NSW Commissioner of Police that specific training and education be provided to police officers in relation to the *Standard Operating Procedures – Missing Persons, Unidentified Bodies and Human Remains* as to the availability of land searches and the engagement of Land Search and Rescue coordinators for searches of urban areas and commercial premises.

19. Issue 6: Was there adequate communication between the Police and Security?

19.1 Counsel Assisting has correctly described that there was a decision-making loop between the Police and Security. That is, the decisions of the Police, which were communicated to Security, were actually informed by information that the Police had received from Security. The effect of this loop was that information shared by Police and Security was open to misinterpretation, and incorrect assumptions were made about aspects of the investigation, such as whether the fire stairs and fire corridors had been checked by Security, and the extent of the CCTV review and physical searches of Westfield.

19.2 For example, and as already noted above, the understanding that Police had of the extent of CCTV review that had been performed by Security was materially different from what had actually been done. The records kept by Security of the CCTV review process did not identify in unambiguous terms what CCTV footage had been reviewed. Some members of Security understood that all entrances to Westfield had been checked, even though this is not occurred. The same ambiguity was apparent verbal communications between Security staff during shift handovers. The result was that Security staff from shift to shift did not have a clear understanding of what CCTV footage had been reviewed, and therefore made incorrect assumptions about this. These assumptions and misunderstandings were then conveyed to Police who in turn used the information as part of their investigative decision-making processes.

19.3 The Police communicated with each other through verbal briefings and electronically via the COPS system. Duty Officers and Shift Supervisors communicated with each other via handover notes. The manner in which this communication occurred was also upon to misinterpretation, as critically occurred regarding the extent of the review of CCTV footage and the searches of Westfield.[210] For example:

(a) In his shift summary for the evening shift on 6 January 2017, Inspector Sly wrote: "*Westfield contacted and reviewing footage. Nil result*".[211] Inspector Sly explained that the reference to "*nil result*" meant that Security had not confirmed whether Bernard had been identified during the review of the CCTV footage. However, Inspector Sly acknowledged that his entry could be interpreted to mean that Security had not found or located Bernard during the review of the CCTV footage.[212]

(b) In his handover notes for the evening shift on 9 January 2017, Sergeant Hall wrote: "*Police attended Bondi Junction Westfields. Full search of premises conducted with Westfield Security…*".[213] Sergeant Hall agreed that this was not an accurate description of what occurred on the evening of 9 January 2017, despite his instructions to Constable Daniels and Gilarte to perform a full and comprehensive search.[214] It is evident that information such as this was relied upon by other senior officers. For example, Inspector Fenwick gave evidence that she

[210] 28/7/20 at T87.34.
[211] Exhibit 1, Tab 25R at 1910.
[212] 8/11/19 at T25.43.
[213] Exhibit 1, Tab 25R at 1970.
[214] 30/7/20 at T15.21.

understood that a coordinated search of Westfield, including the stairwells, had been conducted.[215]

19.4 Detective Inspector Browne gave evidence that, having regard to the record-keeping objective in the 2020 Missing Persons SOPs, he would expect that if a search was conducted, accurate records would be kept of what area was searched, what resources were used to search it and when it was searched.[216]

19.5 On 12 January 2017, Inspector Fenwick and Constable Clavel compiled a spreadsheet of police activities in relation to the search for Bernard (**the Bernard Spreadsheet**). This was intended to be a simple way for the Police to see what had, and had not been done, during the investigation.[217] Inspector Fenwick said that she envisaged that the Bernard Spreadsheet would be a tool to ensure accountability, with Bernard's case updated as the investigation continued. Inspector Fenwick gave evidence that the intention was to create a system to allow Police to be confident that all lines of enquiry had been followed, and to include all information from the date that Bernard was reported missing. However, it appears that there was a difference of opinion amongst Police as to the way in which the Bernard spreadsheet was to be used. Constable Clavel considered that it would be used instead of COPS.[218] However, Inspector Fenwick and Inspector Sly gave evidence to the contrary.[219]

19.6 As the investigation unfolded, the Bernard Spreadsheet was updated by Police. However, when this occurred new information was simply added to the bottom of the spreadsheet and a new version was not created.[220]

19.7 The Bernard Spreadsheet had the capacity to create confusion. The Police have since identified "*duplication and unnecessary functions*" is a risk in missing persons investigations.[221] As a result the Missing Persons Registry is taking measures to enable COPS to communicate with the Missing Persons Database to avoid duplication of data, and to make sure that one system is not missing data. It is also working to update COPS to provide a better resource to manage missing persons investigations.[222]

19.8 **Conclusions:** The communication between Police and Security was inadequate and ineffective. This inadequacy and ineffectiveness was a product of information being communicated from shift to shift, and day to day, both at the Police and at Security, which was inaccurate and unclear. Further, the ways in which information was conveyed in documentary form internally by Police and Security lacked required precision and accuracy. This in turn resulted in misconstruction of two critical components of the investigation: the electronic and physical searches which were necessary in order to confirm or exclude that Bernard had arrived at Westfield.

[215] 7/11/19 at T94.40; T96.30.
[216] .28/7/20 at T43.44.
[217] 7/11/19 at T35.38; T85.13; T88.14.
[218] 7/11/19 at T36.35.
[219] 7/11/19 at T86.42; 8/11/19 at T32.21.
[220] 7/11/19 at T41.48; T88.32.
[221] Statement of Detective Inspector Browne at [8(c)].
[222] 28/7/20 at T30.36.

20. Issue 7: Was the canvass conducted by Police for CCTV cameras along Bernard's route to Westfield adequate?

20.1 When Constable Clavel took the missing person report from Melinda and Angela on 6 January 2017, there is no evidence that information about Bernard's Route was documented. Constable Clavel acknowledged that the route that Bernard may have taken to Westfield was important information. However, he could not recall whether Melinda and Angela spoke about the route, or whether he asked them about this.[223] It is therefore most likely that Constable Clavel did not obtain information about Bernard's Route on 6 January 2017.

20.2 Instead, it is most likely that it was not until 9 January 2017, when Inspector Trevallion spoke to Melinda about possible routes that Bernard might take, that Police enquired about Bernard's usual route to Westfield.[224] Although Inspector Trevallion marked up these routes onto Google maps, it does not appear that any records were kept of these routes. Further, it does not appear that Police referred to these routes in subsequent investigations.[225] Constable Clavel agreed that it would be good practice for a map of the likely routes that had been canvassed by police to be recorded on COPS.

20.3 There is some evidence that the Police canvassed areas around Woollahra and Westfield for CCTV footage.[226] However, the Police did not identify the CCTV footage available from The Meat Store or Taylors. This suggests that the Police either did not canvass Bernard's Route for CCTV footage, or that a canvass was conducted and that the CCTV cameras at The Meat Store and Taylors were missed.

20.4 Similar to the review of CCTV footage and searches of Westfield, Police communications about what areas had been canvassed for CCTV footage were imprecise. For example, the Bernard COPS Report recorded on 9 January 2017 that Rose Bay Detectives "*conducted a canvass of the likely routes from the premises at Ocean Street seeking witnesses and CCTV with a negative result*".[227] Constable Clavel interpreted this entry to mean that a canvass had been conducted along Bernard's probable route from Melinda's to Westfield and no CCTV footage or witnesses had been located.[228] However, Constable Clavel acknowledged that this entry did not state that the "*likely routes*" canvassed included the routes from Melinda's apartment to Westfield.[229]

20.5 Detective Inspector Browne gave evidence regarding the importance of obtaining information as to the likely routes a missing person may have taken, and then to canvass such routes.[230] It is also important to record if a canvas of the routes has been undertaken.[231] This is so that, over the course of an ongoing investigation, police officers can check what has been done from shift to shift.

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[223] 7/11/19 at T10.53.
[224] 29/7/20 at T57.16.
[225] 29/7/20 at T57.44.
[226] 30/7/20 at T16.30; Exhibit 1, Tab 21 at [6]-[12]; Exhibit 1, Tab 20 at [6]-[14].
[227] Bernard COPS Report at 13.
[228] Exhibit 1, Tab 12 at [20].
[229] 7/11/19 at T30.34; 30/7/20 at T17.39.
[230] 28/7/20 at T44.39; 8/11/19 at T78.39; 28/7/20 at T93.33; 29/7/20 at T15.36.
[231] 28/7/20 at T45.4.

20.6 **Conclusions:** The canvass conducted by Police for available CCTV footage which captured Bernard's route to Westfield on 6 January 2017 was inadequate. It is mostly likely that critical information about this route, which would have allowed for an effective canvass to be conducted, was not sought at the first available opportunity on the evening of 6 January 2017. Three days later, there was a further missed opportunity for Police to gather information regarding Bernard's likely route to information and to document it. Much like the review of CCTV footage and physical searches of Westfield, the records kept by Police were imprecise and open to misinterpretation.

21. Issue 9: Was signage in the fire stairwells at Westfield adequate?

21.1 Edren Ravino, a Building Surveyor for Fire & Rescue NSW, gave evidence that establishes that the signage in the stairwells was complaint with relevant building requirements.[232] Mr Sanderson also gave evidence to the same effect.[233]

21.2 **Conclusion:** The signage contained in the fire stairwells at Westfield, and in particular the fire stairwell where Bernard was located, was adequate and in compliance with building regulations. There is no suggestion that the signage in the fire stairwells contributed to Bernard's inability to self-rescue and locate an exit via Door L306.

22. Acknowledgments

22.1 The coronial investigation, conduct of the inquest and preparation of these findings would not have been possible without the commitment of, and assistance provided by Ms Anna Mitchelmore SC and Ms Christina Trahanas, Counsel Assisting, and their instructing solicitors, Ms Ellyse McGee and Ms Jennifer Hoy of the NSW Crown Solicitor's Office. The Assisting Team has provided invaluable assistance and demonstrated exceptional dedication and professionalism in preparing for the inquest, and during the inquest itself. I am also extremely grateful for the sensitivity and empathy that they have shown throughout the course of this particularly distressing matter.

22.2 I also thank and commend Detective Senior Constable Agostino for conducting a thorough and independent coronial investigation into Bernard's death and for compiling a comprehensive initial brief of evidence.

23. Findings pursuant to section 81 of the *Coroners Act 2009*

23.1 The findings I make under section 81(1) of the Act are:

Identity
The person who died was Bernard Gore.

Date of death
It is more probable than not that Bernard died between about 6 and 9 January 2017.

[232] Exhibit 1, Tab 47 at [57]-[62].
[233] Exhibit 1, Tab 33D at [29].

Place of death

Bernard died inside a fire stairwell at Westfield Bondi Junction, Bondi Junction NSW 2022.

Cause of death

The available evidence does not allow for any finding to be made as to the cause of Bernard's death.

Manner of death

Bernard died inside a fire stairwell within Westfield Bondi Junction in circumstances where he was not initially found and, for reasons which are not well understood, did not, or was unable to, exit the fire stairwell. The pre-existing comorbidities that were identified at autopsy, and the absence of any evidence as to traumatic injury or direct third party involvement, therefore raise the possibility that the manner of Bernard's death was due to natural causes. However, the peri-mortem psychological, environmental and physiological stressors that Bernard would have experienced as a result of being within the stairwell were possible significant contributors to his death. When these matters are taken into account, together with certain identified shortcomings and inadequacies associated with the efforts to locate Bernard, it cannot be said that Bernard's death was entirely due to natural causes. Therefore, it is more appropriate to conclude that the manner of Bernard's death was as a result of misadventure.

24. Epilogue

24.1 The distress that Bernard must have felt after 12:50pm on 6 January 2017, and the uncertainty and anguish that his family must have felt in the hours, days and weeks that followed is unimaginable. It is hoped that the shortcomings that have been identified as part of the coronial process, the lessons that have been learned by individuals and organisations involved in the attempt to locate Bernard, and the recommendations that have been made following this inquest will mitigate the possibility of another family having to endure such a traumatic event.

24.2 On behalf of the Coroner's Court of NSW, I offer my deepest heartfelt sympathies and most respectful condolences to Angela, Melinda, Rachel and Mark, and Bernard's other family members and loved ones for their devastating loss.

24.3 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
18 December 2020
Coroner's Court of NSW

Inquest into the death of Bernard Gore

Appendix A: Recommendations made pursuant to section 82(1) *Coroners Act 2009*

To the New South Wales Commissioner of Police:

1. I recommend that the *Standard Operating Procedures – Missing Persons, Unidentified Bodies and Human Remains* (**the Missing Persons SOPs**) be clarified to provide that when a police officer takes a missing person report aimed at locating a missing person, that police officer should refer to the Missing Persons Checklist contained in the Missing Persons SOPs. I further recommend that consideration be given to including a reference to the Missing Persons Checklist in Section 9.1 of the Missing Person SOPs which deals with the initiation of enquiries aimed at locating a missing person.

2. I recommend that the *Standard Operating Procedures – Missing Persons, Unidentified Bodies and Human Remains* be updated to identify and emphasise the following matters:

   (a) the purpose and importance of canvassing for, and gathering, CCTV footage in the context of a missing person investigation;

   (b) the timing of when, and extent to which, such CCTV footage is to be reviewed; and

   (c) the need for comprehensive and accurate communication between Police and community partners who are requested to engage in the provision and review of such CCTV footage.

3. I recommend that specific training and education be provided to police officers in relation to the *Standard Operating Procedures – Missing Persons, Unidentified Bodies and Human Remains* as to the availability of land searches and the engagement of Land Search and Rescue coordinators for searches of urban areas and commercial premises.

Inquest into the death of Bernard Gore

Appendix A: Recommendations made pursuant to section 82(1) Coroners Act 2009

To the Chief Executive Officer, Scentre Group Pty Ltd:

1. I recommend that 2019 *Lost and Found Children or Vulnerable People Policy* be amended so as to include in the lost person checklist the questions to be asked in order to elicit information as to how a lost person attended Westfield and that person's entry point into Westfield. I further recommend that:

   (a) the lost person checklist be made readily available to security staff and independent security contractors when taking a report of a lost person; and

   (b) training be provided to security staff and independent security contractors during their induction process as to the types of questions to ask when taking a report of a lost person.

2. I recommend that Scentre Group Pty Ltd amend the 2019 *Lost and Found Children or Vulnerable People Policy* to provide clarification regarding the order in which fire stairs and fire corridors should be searched in response to a Code Grey.

3. I recommend that the training provided to Scentre Group Pty Ltd security staff and independent security contractors be reviewed in relation to the checking of fire stairs and fire corridors to ensure that the nature of such tasks are effectively communicated and properly understood. I further recommend that measures be put in place to ensure that documentation in relation to such checks is reviewed to identify the need for any follow-up.

Inquest into the death of Bernard Gore

Appendix B: Non-Publication Orders

Pursuant to ss 65 and 74 of the *Coroners Act 2009*, and the Coroner's incidental power, the Deputy State Coroner orders that:

1. In relation to the documents in Schedule A to these orders and information contained in those documents:

   (a) there shall be no publication of the information described in Schedule B.

   (b) the information described in Schedule B may be disclosed to the Deputy State Coroner, those assisting the Deputy State Coroner and the Officer in Charge of the coronial investigation and the legal representatives for the Commissioner of Police.

   (c) the documents described in Schedule A may be disclosed beyond the Deputy State Coroner to those assisting the Deputy State Coroner and the legal representatives of the interested parties to the inquest, provided that the documents have been redacted to remove the information described in Schedule B.

2. In the event that the oral evidence contains information identified in Schedule B there is to be no publication of that evidence.

3. Subject to Order 1, the documents listed in Schedule A are not to be supplied or copied to any person seeking access to the Coroner's file pursuant to s 65 of the *Coroners Act 2009*.

Schedule A

DOCUMENT		
1.	Statement of Inspector Allyson Fenwick	Tab 25
2.	Statement of Detective Sergeant Mark Carter	Tab 25N
3.	Statement of Senior Constable Melissa Brown	Tab 25PA
4.	Material pertaining to search of Centennial Park	Tab 25R
5.	Running sheets from Rose Bay LAC for the period 6/1/2017 to 27/01/2017	Tab 25R

Schedule B

DOCUMENT

1. Statement of Inspector Allyson Fenwick dated 19 March 2017

Annexure A - Spreadsheet of intelligence reports and actions

Page 2	The name and phone number of the informant/witness in I163425621
Page 6	The name and phone number of the informant/witness in E65133087
Page 7	The name and phone number of the informant/witness in I63435521
Page 8	The name and phone number of the informant/witness in I62962805
Page 11	The name and phone number of the informant/witness in the last row (no Event or Report number provided)
Page 14	The name and phone number of the informant/witness in I63570072

2. Statement of Detective Sergeant Mark Carter dated 13 March 2019

Annexure A – Table summarising crime stoppers reports

Page 6	The name and phone number of the informant/witness
Page 20	The name and phone number of the informant/witness
Page 24	The name and phone number of the informant/witness

Annexure B – 7 x CAD job numbers

CAD 811143-10012017	The name and phone number of the informant/witness
CAD 813794-11012017	The name and phone number of the informant/witness
CAD 874209-21012017	The name and phone number of the informant/witness

3. Statement of Senior Constable Melissa Brown dated 19 June 2019

Annexure – Land Search Operations Form

The mobile telephone numbers (which belong to Police officers)

4. Material pertaining to search of Centennial Park on 11 January 2017

Annexure B – Land Search Operations Form

Page 161	The mobile telephone numbers (which belong to Police officers)

5. Running sheets from Rose Bay LAC for the period 6/1/2017 to 27/01/2017

Redaction of the following items not connected with the missing person investigation of Bernard Gore:

(a) names of victims, witnesses, persons of interest, suspect, contacts of other agencies;
(b) street or building numbers, street names, but not suburbs;
(c) police methodology
(d) police resourcing information
(e) human resource/personnel/health information connected with NSWPF employees
(f) information about critical infrastructure or similar

Pursuant to s 74 of the *Coroners Act 2009*, and the Coroner's incidental power, the Deputy State Coroner orders that:

1. There shall be no publication of the information in annexure A to the Statement of Turgut Ercan dated 28 October 2019, being the SecureCorp Pty Ltd Industry Specific Procedures Manual – Retail- Shopping Centres ("**ISP Manual**").

2. The ISP Manual may be disclosed to the Deputy State Coroner, those assisting the Deputy State Coroner and the Officer in Charge of the coronial investigation, and the legal representatives of the persons with sufficient interest and granted leave to appear.

3. The ISP Manual may be inspected by the interested parties who have been granted leave to appear, in the presence of their legal representatives but they may not receive, copy or disseminate the ISP Manual.

4. The ISP Manual may be inspected by any unrepresented interested party to the inquest, who has been granted leave to appear, in the presence of those assisting the Deputy State Coroner but they may not receive, copy or disseminate the ISP Manual.

5. In the event that oral evidence given during the inquest contains details of the policies and procedures contained in the ISP Manual, the subject of this application, there shall be no publication of that evidence.

Pursuant to ss 65 and 74 of the *Coroners Act 2009*, and the Coroner's incidental power, the Deputy State Coroner orders that:

1. Pursuant to section 65(4) the *Coroners Act,* 2009, a direction be placed on the Coroner's file, together with a copy of the reasons for the direction, that the following parts of the Coroner's file are not be supplied in contravention of this direction:

   (a) the documents identified in Schedule A as attached to this order.

2. Pursuant to s. 74(1)(b) of the *Coroners Act,* 2009 that there be no publication of the documents identified in Schedule A as attached to this order.

SCHEDULE A

TAB 33D of Coroner's Brief of Evidence – Statement of Robert Talbot Sanderson dated 26 September 2019

1. **TAB 1: Customer Assistance Policies and Procedures Handbook (v/March 2015)**
   - Concierge Equipment, Lost and Found Children and Vulnerable People, Photography and Youth (Those matters and at those pages redacted at **Annexure A** only);
   - Political Candidate Visits (ALL – p37-38);
   - Conflict Management (ALL – p41-43);
   - Disorder Control (ALL – p42 - 43); and
   - Use of Force and Powers of Arrest (ALL – p50-52).

2. **TAB 2: Customer Assistance Policies and Procedures Handbook (as at 26 September 2019)**
   - Concierge Equipment, Lost and Found Children and Vulnerable People, Photography and Youth (Those matters and at those pages redacted at **Annexure B** only)
   - Back of House Corridors, Fire Doors & Plant Room Inspection (ALL – p53-54);
   - Conflict Management (ALL – p64-65);
   - Disorder Control (ALL – p74-76);
   - Political Candidate Visits (ALL – p109-110); and
   - Use of Force and Powers of Arrest (ALL – p120-122).

3. **TAB 3: Lost People Policy (v/March 2017)**
   - Those matters and at those pages redacted at **Annexure C.**

4. **TAB 4: Lost People Policy (v/April 2019)**
   - Those matters and at those pages redacted at **Annexure D.**

5. **TAB 5: Security Policies and Procedures (v/August 2015)**
    - Security Assessment – Mass Gathering Event (ALL – p206);
    - Counter Terrorism Planning and Training (ALL – p207);
    - Legal & Regulatory Notifications & Communication (ALL – p208);
    - Restrictions on search of People and Bags (ALL – p209);
    - Restrictions on Firearms or Weapons Possession (ALL – p210);
    - Restrictions on Chasing or Leaving Scentre Group Property (ALL – p211);
    - Plainclothes Deployment (ALL – p215);
    - Key System Management (ALL – p218-219);
    - Physical Barrier Management (ALL – p220-221);
    - Alarm System Management (ALL – p222-223); and
    - Cash in Transit (ALL – p229-237).

6. **TAB 6: Security Policies and Procedures (as at September 2019)**
    - Alarm System Management (ALL – p238-239);
    - Cash in Transit (ALL – p242-247);
    - Counter Terrorism Planning and Training (ALL – p266);
    - Key System Management (ALL – p275-276);
    - Legal and Regulatory Notification and Communication (ALL – p277-278);
    - Physical Barrier Management (ALL – p285-286);
    - Plainclothes Deployment (ALL – p287-288);
    - Restriction on Chasing and Leaving Scentre Group property (ALL – p291);
    - Restriction on Firearms or Weapons Possession (ALL – p292);
    - Restriction on Search of People and Bags (ALL – p293-294);
    - Security Assessment – Mass Gathering Event (ALL – p300);
    - Temporary Exclusion Notice (ALL – p320-329);
    - License Plate Recognition System Alerts & Privacy Management (ALL – p337-343); and
    - Repeat Offender and Graffiti (ROAG) Management System (ALL – p344-355).

7. **TAB 7: Security Site Orders (v/January 2017)**
    - Those matters and at those pages redacted at **Annexure E**.

8. **TAB 8: Security Site Orders (v/October 2018)**
    - Those matters and at those pages redacted at **Annexure F**.

9. **TAB 9: Bomb Threat and Search – Zone System**
    - ALL

10. **TAB 10: Back of House Corridors, Fire Doors & Plant Room Inspection Policy (v/September 2019)**
    - ALL

11. **TAB 12: Security Officer Induction Checklist**
    - Mobile telephone numbers of security officers (p509 and 515).

12. **TAB 15: Employee Induction File**
    - Date of birth of security officer (p525);
    - Home address of security officer (p525);
    - Mobile telephone numbers of security officer (p525);
    - Name of emergency contact (p525);
    - Phone number of emergency contact (p525); and
    - First Aid Certificate number and expiry date of security officer (p525).

13. **TAB 20: Pre-Response (Major Incident and Emergency Management Plan) (as at 6 January 2017)**
    - ALL, p697-745.

14. **TAB 21: Pre-Response (Major Incident and Emergency Management Plan) (as at 26 September 2019)**
    - ALL, p746-814.

15. **TAB 22: Immediate Response (Major Incident and Emergency Management Plan) (as at 6 January 2017)**
    - ALL, p815-992.

16. **TAB 23: Immediate Response (Major Incident and Emergency Management Plan) (as at 26 September 2019)**
    - ALL, p993-1229.

17. **TAB 24: Injury and Incident Notification and Administration Policy (v/May 2013)**
    - ALL, p1230-1253)

18. **TAB 30: External Perimeter Check Audit Document**
    - Westfield Bondi Junction Perimeter Door Audit (p1341 – 1352 only)

19. **TAB 31: Daily Control Room Logs**
    - Those matters and at those pages redacted at **Annexure G.**

20. **TAB 32: Control Room Handover Logs**
    - Those matters and at those pages redacted at **Annexure H.**

21. **TAB 35: Centre Monthly Life Safety Report January 2017**
    - Those matters and at those pages redacted at **Annexure I.**

22. **TAB 36: Centre Life Safety Report March 2019**
    - Those matters and at those pages redacted at **Annexure J.**

23. **TAB 37: Electronically Controlled Self-Assessment Reports, 2017 and 2019**
    - ALL p,1488-1502.

TAB 7 of Coroner's Brief of Evidence: Statement of Detective Senior Constable Bell dated 24 January 2018

1. **Exhibit AL**
    - Concierge Equipment, Lost and Found Children and Vulnerable People, Photography and Youth (Those matters redacted at **Annexure A** only);
    - Political Candidate Visits (ALL);
    - Conflict Management (ALL);
    - Disorder Control (ALL); and
    - Use of Force and Powers of Arrest (ALL).

2. **Exhibit AM**
    - Security Assessment – Mass Gathering Event (ALL);
    - Counter Terrorism Planning and Training (ALL);
    - Legal & Regulatory Notifications & Communication (ALL);
    - Restrictions on search of People and Bags (ALL);
    - Restrictions on Firearms or Weapons Possession (ALL);
    - Restrictions on Chasing or Leaving Scentre Group Property (ALL);
    - Plainclothes Deployment (ALL);
    - Key System Management (ALL);
    - Physical Barrier Management (ALL);
    - Alarm System Management (ALL); and
    - Cash in Transit (ALL).

3. **Exhibit AN**
    - Those matters redacted at **Annexure E.**