



**CORONERS COURT
OF NEW SOUTH WALES**

Inquest:	Inquest into the suspected deaths of missing persons Ursula Barwick, Lionel Daveson, Gary Jones & Christof Meier
Hearing dates:	18, 19 & 20 May 2020; 22 to 25 February 2021; 1 to 4 March 2021; 8 to 10 March 2021
Date of findings:	2 November 2021
Place of findings:	Coroner's Court of New South Wales at Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – missing person investigations, unidentified bodies and human remains, long term missing person, Missing Persons Unit, Missing Persons Registry, Missing Persons Standard Operating Procedures, NSW DNA Database, National Criminal Investigation DNA Database, NCIDD-Integrated Forensic Analysis, Human Skeletal Remains Initiative, Bones Project
File numbers:	Ursula Barwick (2016/190872); Gary Jones (2018/197922); Lionel Daveson (2018/382225); Christof Meier (2002/123035 & 2006/364681)
Representation:	Mr A Casselden SC & Dr C Palmer, Counsel Assisting, instructed by Mr J Loosley & Ms C Potocki (Crown Solicitor's Office) Ms J Needham SC & Mr R Coffey, instructed by the New South Wales Police Force Office of General Counsel, for the New South Wales Commissioner of Police, Sergeant J Dean, Sergeant V McKell, Detective Sergeant K Whiting, Senior Constable J Williams, Senior Constable FD Makhoul, Senior Constable A Marsh, Senior Constable J Campbell, Former Superintendent J Cobbin, Retired Detective Sergeant P Fenwick, Former Detective Sergeant J Noble Ms R Mathur, instructed by Makinson d'Apice Lawyers, for Forensic and Analytical Science Service, NSW Health Pathology

Findings:**Ursula Barwick**

I find that Ursula Barwick died on 27 October 1987 at Keajura NSW 2652. The cause of Ursula's death was cerebral contusions and lacerations due to head injury, with a ruptured aorta, ruptured liver and multiple injuries all being significant conditions which contributed to death. Ursula sustained these fatal injuries when a vehicle that she was travelling in was involved in a collision with another vehicle.

Gary Jones

I find that Gary Jones died between 9 and 24 November 1990 in or around Little Bay NSW 2036. However, the limited available evidence, and the absence of any postmortem examination, does not allow for any finding to be made as to the cause or manner of Gary's death.

Lionel Daveson

Lionel Daveson died on, or sometime after, 24 August 2007. However, the limited available evidence does not allow for any finding to be made as to the place of Lionel's death. Lionel died as a result of actions taken by him to intentionally inflict his own death. The limited available evidence, and the absence of any postmortem examination, does not allow for any finding to be made as to the cause of Lionel's death.

Christof Meier

Christof Meier died on 1 April 2002 at Broken Head NSW 2481. The cause of Christof's death was drowning. Christof drowned whilst swimming in the surf off Broken Head beach. The manner of death is, therefore, misadventure.

Recommendations:

See Appendix A

Table of Contents

1.	Introduction	1
2.	Why were these inquests held?	1
3.	Procedural background	4
4.	What issues did the inquests examine?	5
5.	Factual background in relation to Ursula Barwick	7
	Personal history	7
	Events of September 1987	8
	Ursula is reported as missing	8
	Possible sightings of Ursula	9
	Investigation between 1988 and 1994	10
	Transfer of Ursula's file to COPS	11
	Initial enquiries between 1999 and 2001	11
	Cheree provides a DNA sample	11
	Investigation between 2002 and 2013	12
	Death of Cheree	15
	Review of Ursula's file	15
	Creation of Facebook page	16
	Age progression photographic technology	16
	Further activity at Kings Cross LAC	16
	Detective Senior Constable Noble is transferred to the Homicide Squad	17
	Investigations between 2014 to 2016	17
	Amendments to Missing Persons website	18
	Creation of Strike Force Hemingway	18
	Missing Persons Week	19
	Report of David King	19
	Review of unidentified remains	20
	Inquest into the death of a person believed to be "Jessica Pearce"	20
6.	The statutory requirements of the Act regarding Ursula Barwick	28
7.	The adequacy of the police investigation in relation to Ursula as a missing person	28
8.	Factual background in relation to Gary Jones	30
	Personal history	30
	Gary is reported as missing	30
	Investigation between 1992 and 2010	31
	Enquiries made by the MPU	31
	Death of Gary's mother	32
	DNA sample located in Victoria	32
	Notification regarding Merrilee's estate	33
	Investigation between 2010 and 2011	33
	Daily Telegraph article	33
	Investigation between 2012 and 2015	33
	Investigation between 2017 and 2019	35
	Connection with unidentified human remains located at Little Bay	36
9.	The statutory requirements of the Act regarding Gary Jones	38
10.	The adequacy of the police investigation in relation to Gary as a missing person	38
11.	Factual background in relation to Lionel Daveson	39
	Personal history	39
	Medical history	39
	Lionel goes missing in the United Kingdom	39

Lionel travels to Brisbane	40
Lionel returns to Sydney	40
Lionel is reported as missing	41
Investigation between 2007 and 2009.....	41
Enquires made in Queensland.....	43
Further investigations.....	44
Contact made with Brian Hull of the Red Cross.....	44
Lionel is listed as located.....	45
Investigation between 2018 and 2019.....	46
Case returned to Botany Bay	46
Forensic investigation.....	47
Contact with Major Gary Masters	48
12. The statutory requirements of the Act regarding Lionel Daveson	49
13. The adequacy of the police investigation in relation to Lionel as a missing person.....	49
14. Factual background in relation to Christof Meier	51
Personal history	51
Christof goes missing.....	51
2002 Inquest	52
Discovery of tibia bone on Cabarita Beach	52
Initial forensic examination	53
Further forensic examination	53
Detective Senior Constable Sheehan becomes aware of Christof Meier	53
2010 Inquest	54
Forensic and DNA samples taken from Christof's parents	54
DNA profile received from Orchid Cellmark.....	54
DNA profile placed on Unknown Deceased Person index	54
15. The statutory requirements of the Act regarding Christof Meier	56
16. The adequacy of the police investigation in relation to Christof as a missing person.....	56
17. Overview of the New South Wales Missing Person Unit	57
Operations Support Team	58
Investigation Support Team.....	58
Databases	58
NSWPF Missing Persons Database	58
Unidentified Bodies and Remains Database	59
NSW DNA Database	59
National Missing Persons & Victim Services Database (previously PlassData)	60
National Missing Persons Database	60
Safely Home Database.....	61
Other Functions – DNA Collection	61
Nine Network Missing Persons Television Show	62
18. Reviews of the Missing Persons Unit	63
The Walton Review.....	63
Operation Firenze	67
Beresford Review	69
An absence of improvement.....	71
Flogel Review	72
19. Functionality and effective use of relevant DNA databases.....	74
20. The Missing Persons Registry	77
Revision of Standard Operating Procedures	77
Missing Persons Coordinator.....	79
Day to day work undertaken by the MPR	79
The Bones Project/Human Skeletal Remains Initiative.....	80

21. Recommendations pursuant to section 82 of the Act	81
22. Findings pursuant to section 81 of the <i>Coroners Act 2009</i>	85
Ursula Barwick: Identity.....	85
Ursula Barwick: Date of death	85
Ursula Barwick: Place of death.....	85
Ursula Barwick: Cause of death.....	85
Ursula Barwick: Manner of death	85
Gary Jones: Identity.....	85
Gary Jones: Date of death.....	85
Gary Jones: Place of death	85
Gary Jones: Cause of death	86
Gary Jones: Manner of death.....	86
Lionel Daveson: Identity	86
Lionel Daveson: Date of death.....	86
Lionel Daveson: Place of death	86
Lionel Daveson: Cause of death	86
Lionel Daveson: Manner of death.....	86
Christof Meier: Identity	86
Christof Meier: Date of death	86
Christof Meier: Place of death.....	86
Christof Meier: Cause of death.....	86
Christof Meier: Manner of death	86
23. Epilogue.....	87

1. Introduction

- 1.1 In 2020 and 2021 four inquests were held concurrently to examine four long-term missing person cases. These four persons were not related in any way, and the circumstances in which they were reported missing occurred at different points over a 15 year period. Despite this, the subsequent respective coronial investigations revealed a number of concerning features common to each case. These common features centred around the adequacy, timeliness and efficacy of the missing persons investigations conducted by the New South Wales Police Force in each case, and the procedural framework, governance and investigative methodology underpinning missing persons investigations more broadly.
- 1.2 Ursula Barwick was last seen alive in September 1987. A previous inquest in December 2018 determined that Ursula died in a motor vehicle collision on 27 October 1987, only three to four weeks after leaving the home of her father and stepmother. Despite police being aware of both Ursula being reported missing and the motor vehicle collision, for 31 years Ursula's family were left without answers as to their many questions regarding what happened to Ursula.
- 1.3 Gary Jones was last seen alive on 9 November 1990. Fifteen days later unidentified human remains were found in Little Bay on 24 November 1990. However, it was not until 10 January 2019 that forensic examination was able to identify the remains as belonging to Gary.
- 1.4 Lionel Daveson was last seen alive on 23 August 2007 and later reported as a missing person. In June 2009 Lionel was incorrectly determined to be located and no longer missing. For a period of nine years no further investigation was conducted until enquiries from Lionel's sister resulted in the case being reopened.
- 1.5 Christof Meier was reported as missing while swimming at a beach on 1 April 2002. A previous inquest in July 2002 determined that Christof died as a result of drowning. A tibia bone found at Cabarita Beach in April 2006 was later identified in April 2019 as belonging to Christof. However, in the 10 years prior to this discovery, neither the police officer in charge nor Christof's parents were aware that any active investigation was still being conducted regarding the tibia bone and Christof's case.

2. Why were these inquests held?

- 2.1 Between 2008 and 2015 more than 305,000 persons were reported as missing in Australia, an average of 38,159 reports per year.¹ Approximately 94,000 of these reports were made in NSW. In 2020, over 51,000 missing person reports were made to police in Australia.
- 2.2 More than two-thirds of persons reported missing in NSW are located in less than 48 hours. Nationally, approximately 98 percent of missing person are ultimately located, with the majority (at least 93 percent nationally) found alive.

¹ Bricknell S & Renshaw L, (2016) *Missing persons in Australia, 2008–2015*, Statistical Bulletins No. 1, Canberra: Australian Institute of Criminology.

- 2.3 According to the National Missing Persons Coordination Centre (NMPCC) a missing person is defined in Australia as: “*Anyone who is reported missing to police, whose whereabouts are unknown, and there are fears for the safety or concern for the welfare of that person*”. A long-term missing person refers to persons who remain missing after a sustained period of time with the standard definition of a long-term missing person in Australia referring to those missing for more than three months.² Nationally, there are approximately 2,600 long-term missing persons. The NMPCC relevantly notes that “*when a relative or friend is reported missing, the emotional impact on families and friends can be considerable*”.
- 2.4 In cases involving long-term missing persons it is sometimes suspected, for various reasons, that the person is deceased. When the police suspect that a missing person may have died, that suspected death becomes reportable to a Coroner. This is typically done by a police officer completing what is known as a *P79B Report of Suspected Death to the Coroner*, which sets out relevant personal details and a narrative regarding the background and circumstances in which a person is reported to have gone missing.
- 2.5 Once such a report has been made a Coroner then has an obligation to conduct an investigation in order to answer a number of questions. The primary question which a Coroner seeks to answer is whether the person is, in fact, deceased. If that conclusion is reached then, pursuant to a Coroner’s statutory duties pursuant to the *Coroners Act 2009 (the Act)*, the Coroner must also seek to answer questions about where and when the person died, and what was the cause and manner of their death. The manner of a person’s death means the circumstances surrounding their death and the events leading up to it. If any of these questions cannot be answered then a Coroner must hold an inquest. Sadly, due to the passage of time in long-term missing person cases and limited evidence, it is often the case that even after an inquest a Coroner is unable to answer all, or most, of these questions.
- 2.6 It should be recognised at the outset that missing person cases which proceed to an inquest often represent, from a procedural point of view, the final stages of a lengthy and traumatic experience for relatives and friends of a missing person. In this context, the inability to answer certain questions which relatives and friends may consider to be most pressing only serves, regrettably, to add to the grief and trauma which they have experienced, and continue to experience.
- 2.7 It should therefore also be recognised that whilst an inquest represents the conclusion of a coronial investigation, the grief and trauma experienced by relatives and friends of missing persons, and the unbearable uncertainty associated with the cases of many missing persons, will remain with them. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has gone missing cannot be overstated.
- 2.8 Finally, it should be acknowledged that any form of delay in the conduct of a missing person investigation only serves to compound the grief and trauma which the relatives and friends of that missing person are experiencing. The four inquests that have been conducted have highlighted

² Bricknell S, (2017) *Missing persons: Who is at risk?*, Research Reports No. 8, Canberra: Australian Institute of Criminology.

particular delays involving the police investigations, which in some cases have been extraordinarily lengthy. In addition, the impact of the COVID-19 pandemic, and consequent public health orders that have been instituted in response to this pandemic, resulted in the inquests being conducted in two tranches during 2020 and 2021 which, again, has also added to the traumatic experience of all family members affected by the inquests.

- 2.9 Importantly, it should be noted that Ursula's mother passed away prior to the 2018 inquest concerning Ursula, without ever knowing what happened to her daughter. Further, Ursula's father passed away in late 2020, before the evidence in the most recent inquests concluded. Finally, Gary's mother also passed away in 2005, also without ever knowing what happened to her son.
- 2.10 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. Procedural background

- 3.1 The *Inquest into the death of a person believed to be Jessica Pearce* was previously held on 21 December 2018 (**the Jessica Pearce Inquest**) with findings delivered on the same day. These findings concluded that a person believed to be Jessica Pearce, who had died in a motor vehicle collision at Keajura on 27 October 1987, was in fact, Ursula Barwick.
- 3.2 Prior to the findings being delivered, Ursula had been a missing person for 31 years. For the majority of that very lengthy period of time, Ursula's family had received no reliable information as to what happened to her after she had been reported as missing. Therefore, although the coronial investigation into the report of Ursula going missing identified a number of systemic issues in relation to missing person investigations in general which warranted consideration at an inquest, it was considered important to provide Ursula's family with answers to some of their questions and some degree of certainty. Therefore, the Jessica Pearce Inquest was held for this primary purpose, with the understanding that the systemic issues would be considered in a later inquest.
- 3.3 In the intervening almost three year period, further coronial investigation has been conducted seeking to understand the underlying systemic issues contributing to many other missing person investigations. During the same period, three other long term missing person matters were identified which had not yet proceeded to inquest, and where no coronial findings had yet been made as to whether the persons are now deceased and, if so, as to the other statutory requirements of the Act. Further, these other matters also highlighted a number of systemic issues relating to missing person investigations which, individually and collectively, warranted consideration at inquest.
- 3.4 For the reasons set out above, it was determined that concurrent inquests would be held in relation to the missing person matters of Ursula Barwick, Lionel Daveson, Gary Jones and Christof Meier. It was also determined that the evidence adduced in one inquest would be considered as being adduced in all four inquests.
- 3.5 In these findings, it is proposed to set out the factual background relating to the circumstances in which Ursula, Lionel, Gary and Christof all went missing. Then, it is proposed to consider the discrete issues examined by the collective inquests.

4. What issues did the inquests examine?

4.1 Prior to the commencement of the inquests a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquests and the issues to be considered. That list identified the following issues:

- (1) The adequacy or otherwise of the NSW Police Force's investigations into the disappearances of Ursula Barwick, Gary Jones, Christof Meier and Lionel Daveson, including (without limitation):
 - (a) The delays and missed opportunities associated with each investigation;
 - (b) The level and appropriateness of resources allocated to each investigation;
 - (c) The sufficiency of record keeping by investigating officers;
 - (d) The scope and frequency of supervision performed by senior officers within Local Area Commands;
 - (e) The utility of any assistance provided by the Missing Persons Unit; and
 - (f) The use of specialist DNA techniques and (where relevant) their effectiveness in advancing the investigations.
- (2) The extent to which the NSW Police Force's new Standard Operating Procedures for Missing Persons, Unidentified Bodies and Human Remains address systemic deficiencies evident from the investigations into the disappearances of Ursula Barwick, Gary Jones, Christof Meier and Lionel Daveson, including in relation to:
 - (a) Training and supervision provided to investigating officers based within Local/Police Area Commands;
 - (b) Reporting, tracking and evaluating the progress of missing persons investigations within all Police Area Commands;
 - (c) The role of the Missing Persons Registry and its relationship with Police Area Commands;
 - (d) Encouraging greater and earlier uptake of specialist DNA techniques to assist missing persons investigations; and
 - (e) Information sharing between the NSW Police Force, Forensic Analytical Science Services and other interstate, national and international law enforcement agencies;
- (3) Whether legislative and/or regulatory settings effectively promote and facilitate the use of DNA identification techniques in missing persons investigations in New South Wales. This includes (but is not limited to) consideration of the Human Skeletal Remains Initiative (previously known as the Bones Project).
- (4) Whether practices established in other jurisdictions (in Australia or internationally) offer opportunities to improve the conduct and resolution of missing persons investigations in New South Wales.

5. Factual background in relation to Ursula Barwick³

Personal history

- 5.1 Ursula was born to Peter Barwick and Cheree Barwick (née Holland) on 14 August 1970. Ursula was Peter and Cheree's second child with their son, Lee, having been born in January 1968. Peter and Cheree's third child, Christopher, was born in 1972. Tragically, Christopher developed organ failure and died only two days following his birth. Equally tragically, Lee passed away in 1976 as a result of a rare kidney disease.
- 5.2 Peter describes Ursula as a bright, happy and healthy child who was always smiling and who loved to play dress ups. Ursula attended Willow Tree Primary School as a young girl. Around this time Peter and Cheree separated, and later divorced. Upon separating, Cheree and Ursula moved to Wallabadah in the New England Region of northern NSW. A short time later, Cheree and Ursula moved to Manilla, north of Tamworth. Whilst in Manilla, Cheree formed a new relationship with Laurie Murtagh. Ursula remained in primary school in Quirindi even through Cheree and Laurie moved again, first to Braefield and eventually to Pine Ridge.
- 5.3 Peter later formed a new relationship with Elizabeth Turner and they married in 1978. They moved to Caroon, about 14 kilometres from Pine Ridge. Whilst Ursula lived with Cheree and Laurie in Pine Ridge, she would see Peter and Elizabeth about once per fortnight.
- 5.4 In 1984 Peter and Elizabeth, and their children, Andrew and Katelyn, moved to Long Jetty on the NSW Central Coast. Consequently, Peter and Elizabeth saw less of Ursula, usually only seeing her during school holidays. Peter and Elizabeth also sent Andrew and Katelyn to Quirindi to visit Ursula and Cheree during school holidays.
- 5.5 In 1986 or early 1987, Ursula first began to travel to Sydney by herself to look for work. It is possible that Ursula may have completed her year 10 work experience at a police station in Sydney in March 1986. In early February 1987 Ursula may have travelled to Sydney in order to babysit the twins of a police officer, Denis Percy, who was travelling interstate with his wife. Ursula may also have worked at a closed shop in Sydney in 1986 or 1987.
- 5.6 Ursula finished Year 10 in 1987 and it was around this time that Cheree noticed that Ursula's behaviour was worsening. It appeared that Ursula had been using illicit drugs and that she was frequently lying in an attempt to avoid getting into trouble. In order to remove Ursula from negative peer influences in Quirindi, Cheree asked Peter if Ursula could move to live with him and Elizabeth.
- 5.7 On 4 September 1987 Ursula moved to Long Jetty to live with Peter, Elizabeth and their children for about four to six weeks. Two days later, on 6 September 1987, Ursula wrote two letters to her friend, Melissa Cooper, in which she spoke about missing her friends, her intentions to return to Quirindi in October 1987 and an alleged pregnancy.

³ The factual backgrounds set out in these findings has been drawn from the comprehensive and helpful submissions of Counsel Assisting.

- 5.8 During her time in Long Jetty, Ursula largely kept to herself even though she got on well with Andrew and Katelyn. Indeed, Elizabeth describes Ursula as being a wonderful big sister to Andrew and Katelyn. Similarly, Peter recalls that Ursula loved looking after Andrew and Katelyn, and that they in turn loved her.

Events of September 1987

- 5.9 Around 16 September 1987, Ursula told Elizabeth that she was pregnant. Elizabeth took Ursula to see a local doctor who confirmed that Ursula was not, in fact, pregnant. Medical records indicate that on 1 and 16 September 1987 Ursula attended upon medical practitioners in relation to blood tests for pregnancy.
- 5.10 In late September 1987 Ursula told Peter that she was going to a job interview at a jewellery store in Hornsby. There is some difference between the recollections of Peter and Elizabeth regarding this period of time. On Peter's account, he drove Ursula to Tuggerah station so that she could travel to Hornsby for her interview. Ursula was expected to return home to Long Jetty later that same day. However, she did not return until the afternoon of the following day. At that time, Peter found Ursula in a dishevelled state, smelling of alcohol and cannabis. Peter recalls that Ursula told him that she had gotten the job in Hornsby and would be leaving for Sydney the following week.
- 5.11 According to Elizabeth, Ursula got the job in Hornsby and worked there for about two weeks. It appears that she commuted from Long Jetty to Hornsby during this time. However, towards the end of this period she did not return home for about two days. This of course made both Peter and Elizabeth concerned and Peter planned to report Ursula as missing to The Entrance police station. As he was on his way to do so, Peter saw Ursula walking home in a dishevelled state. This prompted an argument between Peter and Ursula about Ursula's responsibilities.
- 5.12 Elizabeth recalls that shortly after this Ursula returned to live with Cheree and Laurie in Pine Ridge. However Ursula did not stay there long and soon decided that she did not want to return to school for Year 11. Instead, she decided to get a job in Sydney and move there. Elizabeth believes that Ursula may have decided to return to work at the same jewellery store in Hornsby.
- 5.13 Despite the differences in the recollections of Peter and Elizabeth it is clear that in mid-September 1987 Ursula decided to move to Sydney. Ursula told Peter that she was moving into a unit in the Hornsby area with some friends and that she would call him later to give him the address and phone number.

Ursula is reported as missing

- 5.14 On a Wednesday during the school holidays at the end of September 1987 Elizabeth's father, Leo John Turner, drove Ursula to Tuggerah station. Ursula had with her a suitcase containing most of her belongings, with the remainder left at Peter and Elizabeth's house. Ursula had made arrangements with Peter and Elizabeth for them to deliver the rest of her belongings to her in Sydney once she was settled.

- 5.15 After Ursula's departure, Peter and Elizabeth packed up Ursula's belongings, planning to deliver them to her that same weekend, and waited for Ursula to call with details of her new address. However, Ursula did not call. Peter and Elizabeth were initially not overly concerned, believing that Ursula had simply reverted to her former behaviour of not being overly communicative with them. Further, they believed that she would call eventually when she needed her belongings. However, after about two or three weeks Peter and Elizabeth became concerned when Ursula had still not made contact.
- 5.16 Peter and Elizabeth travelled to Hornsby and, based on a description previously given by Ursula, attempted to locate the jewellery store where she had her job interview, but were unable to do so. Peter and Elizabeth also made enquiries with the Commonwealth Bank, where Ursula held an account, and the Department of Social Security (as it then was) but were unable to gather any information as to her whereabouts due to privacy restrictions. According to Cheree's sister, Dianne, Cheree also contacted a police officer from Quirindi whose children were supposed to be living with Ursula in Sydney. The police officer reportedly advised that his children had not yet moved out of home.
- 5.17 Eventually Peter and Elizabeth formed the view that they needed to report Ursula as missing. Some friends informed Peter and Elizabeth that the best place to make a missing person report was at the Police Headquarters in Sydney.
- 5.18 According to Peter, "*about a week or 10 days*" after Ursula left Long Jetty (or around two weeks after Ursula went missing, according to Elizabeth), he travelled to Sydney with Elizabeth's mother, Joy Turner. They went to the former New South Wales Police Force (NSWPF) Missing Persons Unit (MPU), located in College Street, Sydney, where Ursula was reported as a missing person. Peter provided the police with Ursula's particulars and also a photograph of her. According to Elizabeth, Joy later told her that the police officer behind the desk "*showed very little interest and seem to treat it as just another runaway. [They said] if they find Ursula, they didn't have to inform us as she was over 16*". Following this report, Peter and Elizabeth considered that Ursula would make contact with them at Christmas, but she never did. According to a NSWPF missing person event record, Cheree also reported Ursula as missing at The Entrance police station on 8 March 1988.
- 5.19 Two weeks after Ursula left for Sydney, Cheree became extremely worried and may have contacted the Dart family. According to Cheree's sister, Dianne Panov, Mr Dart informed Cheree that Ursula had not stayed with them or contacted them, and that his children had not even moved out of home. Diane describes that from this point in time it was "a waiting game".

Possible sightings of Ursula

- 5.20 Angelique Miller knew Ursula from Quirindi High School, being in the year below her. Sometime in 1987 Ms Miller travelled to Sydney to visit family. Although Ms Miller is unable to recall precisely when she visited Sydney, she believes it was in the school holidays and in the warmer months. This period of time is, therefore, consistent with late 1987.
- 5.21 Whilst in Sydney Ms Miller went to Kings Cross one morning. As she was walking through the area, Ms Miller reported seeing three girls, who she describes as being well-dressed, approaching from

the opposite direction. Ms Miller recognised one of the girls as Ursula, called out, “*Hi Ursula*”, and waved. According to Ms Miller, the girl that she recognised as Ursula turned, smiled, waved back and said, “*Oh hi*”. The three girls continued walking, crossed the road, and walked in the opposite direction away from Ms Miller.

- 5.22 When Ms Miller later returned to Quirindi she told her mother, Carol Ashworth, that she had seen Ursula in Kings Cross. Ms Ashworth in turn told Cheree about the sighting.
- 5.23 On 31 July 2015 investigating police conducted a walkthrough of Kings Cross with Ms Miller. Ms Miller remained uncertain as to exactly when in 1987 she had seen Ursula. However, Ms Miller was able to identify the intersection of Darlinghurst Road and Macleay Street as being the location where she saw Ursula.
- 5.24 On 6 November 2008 Angus McInnes posted an entry on a Facebook page created for Ursula by an old school friend. Mr McInnes grew up in Quirindi and went to school with Ursula. Mr McInnes wrote in his post that he was one of the last persons to see Ursula, having seen her at Central train station.
- 5.25 On 27 July 2015 Mr McInnes told police that one afternoon, at around 3:00pm, in mid-September 1987 he saw a girl who he recognised as Ursula walking along the concourse at Central station. Mr McInnes called out to Ursula and they went to a nearby pub to sit down and have a chat for about 10 to 15 minutes. Mr McInnes reported that his sister, Kylie Cotton, was also present and that she bought them each a beer. According to Mr McInnes, Ursula said that she was unemployed and living at a location called the People’s Palace in the city.
- 5.26 It is not clear that Ursula was already missing at the time of this encounter. Further, Ms Cotton had no recollection of ever meeting Ursula, or buying her brother a beer at the train station.
- 5.27 Sometime in 1988, Cheree reportedly contacted Denis Percy (a police officer for whom Ursula had previously performed casual babysitting work in February 1987) to enquire if he had seen Ursula. Mr Percy told Cheree that Ursula had visited him at his workplace in College Street, Sydney, asking for work as she had no money and in need of accommodation. Mr Percy describes Ursula as appearing dishevelled and suggested that she may have been working as a sex worker. Mr Percy reported that he took Ursula to the Young Women’s Christian Association (YWCA) where he arranged accommodation for her.

Investigation between 1988 and 1994

- 5.28 No original record of a missing person report made in relation to Ursula, either at the former MPU by Peter or at The Entrance police station by Cheree, has been found. Therefore, it is not clear precisely when Ursula was reported missing to police. Further, it is also not clear that any steps were taken in the missing person investigation between 1988 and 1994. As the original report or file has not been able to be located there are no records to explain what (if any) police investigations were conducted during this period.

Transfer of Ursula's file to COPS

- 5.29 In 1994 the NSWPF began a process of transferring paper files to a new computerised program known as the Computerised Operational Policing System (**COPS**). During this file transfer process, many missing person reports were entered with the reported missing person being marked as "Located" within COPS. Ursula's file, together with the files of other missing persons, was transferred to COPS on 21 March 1994. However, the new electronic file within COPS relating to Ursula incorrectly stated that she had been located on the same day.
- 5.30 On 9 February 1999 Constable Karen Karakaya, a former police officer who worked at the MPU at the relevant time, identified the error involving Ursula's missing person report being mistakenly marked as "Located". It is likely that the error was identified at this time as the MPU had embarked upon a manual reconciliation of all missing person files in preparation for data being uploaded to a new NSWPF Missing Persons Database in 1999.

Initial enquiries between 1999 and 2001

- 5.31 Following discovery of the error, Constable Karakaya created a new COPS Event and, over the next two days, made relevant enquiries with the Department of Immigration (as it then was), Centrelink and the Registry of Births, Deaths and Marriages (**the BDM Registry**). However, it is not clear whether searches were undertaken to locate the microfilm record of the original COPS Event. On 21 October 1999 Centrelink and the BDM Registry confirmed that their records contained no sign of Ursula.
- 5.32 On 3 November 1999 Constable Karakaya called Cheree to enquire about the status of Ursula. Cheree confirmed that Ursula was still missing and provided Constable Karakaya with information not previously recorded regarding Ms Miller, Mr Percy and Ursula's banking records. Cheree also informed Constable Karakaya that Ursula had withdrawn nine dollars from her Commonwealth Bank account in the days after she arrived in Sydney. Constable Karakaya entered this information into COPS and made a new request with the Commonwealth Bank for information connected to Ursula. On 11 November 1999 the Commonwealth Bank advised Constable Karakaya that Ursula's bank account had been closed by the bank on 16 November 1992 following the absence of any transaction activity.
- 5.33 On 20 December 2001 Constable Karakaya spoke to Cheree again and was informed that Ursula had completed work experience with police in 1986, and that she had worked as a babysitter for Mr Percy in 1987. Cheree also informed Constable Karakaya of the enquiries that she made with Mr Percy in 1987 after Ursula went missing.

Cheree provides a DNA sample

- 5.34 On 19 February 2002, Cheree provided a DNA sample to Tamworth police station for the purposes of obtaining a mitochondrial DNA profile for potential comparison against DNA profiles taken from unidentified human remains in order to identify whether a missing person was, in fact, deceased.

- 5.35 At this time, the process by which comparison of such DNA profiles was conducted was limited in nature. DNA profiles, such as the one obtained from Cheree, were not randomly compared against profiles obtained from all unidentified human remains which existed at the time. Instead, such a comparison would only be performed involving a profile obtained from a specific set of unidentified human remains for a particular reason. Usually, this reason would be if some feature of the remains suggested that it was likely they belonged to a particular missing person.

Investigation between 2002 and 2013

- 5.36 On 12 April 2002, Ursula's file was transferred to Kings Cross Local Area Command (**LAC**) for reasons which are not entirely clear. Although procedure at the time dictated that a missing person file would be transferred to the LAC where the missing person was last seen, it is not evident on the face of the relevant case report why MPU personnel considered that Ursula had been last seen in Kings Cross. It is possible that at the time, there was a practice of allocating missing persons files involving young persons to Kings Cross LAC. Detective Sergeant Peter Fenwick held the position of Investigation Supervisor at Kings Cross LAC from 2006. His main duties were to supervise all criminal investigation staff, and allocate and oversee all cases being undertaken by all Kings Cross police officers, particularly investigators. Detective Sergeant Fenwick gave evidence that, in his experience, this was a practice that seemed to be followed, although one which he queried:

Yes, that's a nice - yes, they used to do that a lot, last seen in our command. And missing persons, a lot of them would go to Kings Cross. I had very strong - so just because it's seen last in Kings Cross, why are we getting it? You know, like, why can't the - the local area commands are trying to pull it on all the time. But I suppose there's a valid reason, if the last - person was seen in Kings Cross, but you know, that was two years ago, before we got it. You know, like, come on.

- 5.37 Detective Sergeant Fenwick also gave evidence that he did not consider Ursula's case to be suitable for a LAC to investigate and that it should instead have been transferred to State Crime Command.
- 5.38 On 2 July 2002, Detective Sergeant Fenwick allocated Ursula's case to Detective David Richards. Two days later, the case was reallocated to Detective Senior Constable Jarrod Noble. Like Detective Sergeant Fenwick, Detective Senior Constable Noble gave evidence that he was unsure why the case had been transferred to Kings Cross LAC, particularly given that it was known to be a very busy LAC.
- 5.39 On 9 July 2002 Detective Senior Constable Noble spoke with Senior Constable Jane Sutcliffe from the MPU. Over the next two days, Senior Constable Sutcliffe conducted name change and record checks for Ursula with all Australian Police services, Centrelink, Department of Immigration, the NSW Electoral Roll, the BDM Registry and a range of financial institutions. On or around 29 July 2002, similar enquiries were also made with the Roads and Traffic Authority (**RTA**) (as it then was). None of these enquiries returned any trace of Ursula. Such enquiries are commonly known within the NSWPF as **signs of life checks**, and are conducted with the understanding that, in the ordinary course of everyday life, members of the community will frequently interact with the agencies and organisations described above.

- 5.40 On 11 July 2002, Detective Senior Constable Noble spoke with Cheree and advised that he was now the new Officer in Charge (**OIC**) of the investigation into the missing person report for Ursula. On 17 August 2002, Detective Senior Constable Noble had a similar conversation with Peter and provided his contact details. In the intervening period, on 8 August 2002, Detective Senior Constable Noble sent a request for advice to the Coroner's office. The evidence indicates that during this period, Ursula's file may have moved back and forth between Kings Cross LAC and the MPU, before finally being allocated back to Detective Senior Constable Noble at Kings Cross in 2003. Detective Sergeant Fenwick gave evidence that he may have attempted to send the case back to the MPU.
- 5.41 On 23 March 2003, Detective Senior Constable Noble again spoke to Cheree who informed him that a woman named Kelly Shields may have information in relation to Ursula. Detective Senior Constable Noble later spoke with Ms Shields who told him that a person named Peter Galpin had seen Ursula in Kings Cross at some point in the early 1990s. However, Ms Shields indicated that she believed that Mr Galpin was lying but did not say why. Detective Senior Constable Noble gave evidence that some "*general checks by police*" and a check with the RTA were unsuccessful in locating Mr Galpin.
- 5.42 On 8 April 2003 Detective Senior Constable Noble spoke with Cheree again, who told him that a local paper was planning to publish a story on Ursula having gone missing. Detective Senior Constable Noble asked Cheree to tell the newspaper to include his contact details in the story so that readers could contact him with any information in relation to Ursula. However, Detective Senior Constable Noble gave evidence that he was unaware of any public response to the story.
- 5.43 On 17 August 2004 Detective Senior Constable Noble received an email indicating that Cheree was in hospital with cancer. Despite this, Detective Senior Constable Noble gave evidence that this news did not prompt him to consider taking a statement from Cheree. Significantly, Detective Senior Constable Noble also gave evidence that given the workload at Kings Cross LAC, Ursula's case was not considered to be a priority. Further, he indicated that given that he was investigating a historical missing person case, with no access to evidentiary material such CCTV footage, this influenced how he approached the investigation. Finally, Detective Senior Constable Noble's evidence highlighted a degree of confusion regarding the respective roles of Kings Cross LAC and the MPU. Whilst Detective Senior Constable Noble expressed the belief that the MPU was an investigative body, he also agreed that he knew it was his responsibility to exhaust all avenues of inquiry.
- 5.44 Detective Senior Constable Noble had no recollection of asking either Peter or Cheree for a photograph of Ursula in 2002 or 2003. It is entirely possible that there was no such photo on Ursula's file. Detective Senior Constable Noble also could not recall whether he asked them where they had made their original missing person reports, or whether he made enquiries regarding the location of any such report. Detective Senior Constable Noble gave evidence that he did not contact any of the police officers mentioned in the report (namely Barry Traynor, Ian Campbell and Denis Percy), and that he had not taken any of the steps due to other work commitments at the time.
- 5.45 Further, Detective Senior Constable Noble agreed in evidence that he did not take any of the following investigative steps:

- (a) Travel to Quirindi in order to meet and interview Ursula's family and friends;
- (b) Obtain a photograph of Ursula from her family;
- (c) Speak to any person at Ursula's school or the local media in relation to Ursula going missing;
- (d) Make any enquiries with local health care professionals who may have been in contact with Ursula, and held medical or dental records for her;
- (e) Follow-up to confirm whether the DNA profile provided by Cheree at Tamworth in 2002 had ever been compared against any unidentified human remains; or
- (f) Keep in contact with Ursula's family.

5.46 Overall, Detective Senior Constable Noble acknowledged that, without the above investigative steps having been taken, he saw no way of progressing the investigation. When asked why he did not perform any of the above investigative steps, Detective Senior Constable Noble frankly acknowledged:

It's - unfortunately, it was the prioritising against other work at the time and unfortunately, during the years - that I did not do that activity.

5.47 Relevantly, Detective Sergeant Fenwick gave evidence that investigative steps such as circulating a photo of a missing person, taking statements from the person's family members and obtaining DNA samples were standard steps that ought to be completed in any missing person investigation. Notwithstanding, Detective Sergeant Fenwick could not explain why such steps were not taken in Ursula's case.

5.48 Detective Senior Constable Noble said that he could not recall speaking with his supervisors about Ursula's matter but that they were "*well aware of the workload*", meaning that there was no point in raising the possibility of having Ursula's file reallocated given that other police officers were equally busy. When asked whether he gave any consideration to making the request for Ursula's matter to be reallocated, Detective Senior Constable Noble indicated:

Hindsight, perhaps I should have, and documented it, but from my recollection, I didn't.

5.49 Although case reviews were conducted by supervisors 3 to 4 times per year, these reviews were not necessarily focused on individual cases. Rather, such reviews often involved a general discussion of workload and cases still in the investigation stage at the time. Detective Senior Constable Noble gave evidence that he had some recollection of discussing with his supervisors the possible reason(s) for Ursula's file having been transferred to Kings Cross LAC, and what would be required in order to prepare a brief for the Coroner. However, he had no recollection of any discussion regarding the progress of the matter, or his supervisors independently offering him advice regarding the investigation.

5.50 Detective Sergeant Fenwick gave evidence that he had a practice of checking the records of each case, including missing persons cases, on a monthly basis to ensure there had been activity on them. He described this as a form of “*case management*” to prevent cases from otherwise “*falling through the cracks*”.

5.51 However, in evidence Detective Sergeant Fenwick was taken to relevant entries in the COPS record which demonstrated that in 2002 and 2003 a review of Ursula’s case had not been conducted on a monthly basis. Further, the COPS record also demonstrated that there appeared to be an absence of any investigative activity between 2004 and 2011. In response to these records, Detective Sergeant Fenwick stated:

Looking at this, I don't understand it but yes, apparently. But that - yes, I don't know. I mean, I mightn't have been there. I was often taken away. But I can't comment - I don't know.

5.52 Detective Sergeant Fenwick considered that the absence of activity may have been due to the LAC awaiting advice from the Coroner on 9 November 2011. Detective Sergeant Fenwick acknowledged that such advice would usually only be sought when all avenues of investigation had been exhausted. However, he was unable to explain why this was considered to be the situation in Ursula’s case.

5.53 In summary, Detective Sergeant Fenwick explained:

You know, as far as going - I just didn't have the luxury on really focusing on a lot of missing persons cases, unless we had some sort of evidence that was suspicious, they were a juvenile or they were - medical attention, or something like that, because my staff would be busy on other - I just didn't have the resources, you know. Yes, I admit, a lot of missing person cases would given the full attention but I didn't have resources to put a missing person's case over the top of the homicide, you know, so - and I'd be losing police all the time to different inquiries. We average homicide a year, or to homicide is a year, so there goes half your staff on the investigation. So it was - as I keep saying, it's a juggling act. You do a value judgement. If there's there something that you feel warrants further investigation in the missing persons, I would, yes, get onto it and have a look at it and a lot of a missing persons turned up after 48 hours, a lot of them didn't want to be found, a lot - you know, like, what do you do, you know, you just don't have the resources to focus on all of them.

Death of Cheree

5.54 On 23 September 2004 Laurie Murtagh, Cheree’s partner, informed Detective Senior Constable Noble that Cheree had, tragically, died from cancer at Randwick Hospital. Mr Murtagh advised that Woman’s Day magazine was planning to publish an article in relation to the missing person report for Ursula, and Detective Senior Constable Noble again asked that the contact details for Kings Cross detectives be provided to the magazine so that they could be included in the article.

Review of Ursula’s file

5.55 As part of a periodic review, Detective Sergeant Fenwick reviewed Ursula’s file on 28 January 2005 and sought an update from Detective Senior Constable Noble. On 2 July 2005, Detective Sergeant Fenwick reopened Ursula’s case and attempted to re-classify it as “Investigation Complete” and

then reallocate case to himself so that it could be re-categorised as “Suspended”. However, it appears that this re-categorisation attempt was refused by Inspector Stephen Fowler on 5 July 2005 for reasons which Detective Sergeant Fenwick could not recall.

- 5.56 However, on 16 September 2005 Detective Sergeant Fenwick subsequently received approval to categorise the case as “Suspended”, indicating that all avenues of investigation had been exhausted. Detective Sergeant Fenwick gave evidence as to the rationale for this approach:

So for the sake of, like, getting a case off the books, if [investigators] could tell me that there was no further investigation required, that they - or I was satisfied that - at that stage that they had conducted all they could, I would [suspend] the case. But it's not finished; it was just to get off the books but it was still current. Does that make sense? It's just the title. "Suspend" doesn't mean the case was ever finalised. You know, like, we can always reopen it again, if there's further inquiries coming forward or - a lot of the times, I would take them off staff workload because they may have been transferred to a strike force. It was a juggling effect of cases and staff at Kings Cross.

- 5.57 Detective Sergeant Fenwick went on to explain that the reason for getting a case “*off the books*”:

It was just purely to assist the investigators, so they don't feel overloaded. Like, you get an investigator that has 30 or 40 cases, which isn't unusual at Kings Cross, if we could keep them down a bit - and also the commander would like you to cut them down a bit - it would just, sort of, appease them a bit, just to take the stress levels off them.

- 5.58 On 25 January 2006 police eventually contacted Mr Murtagh in order to request a photo of Ursula. This photo was provided and uploaded onto the database by Sergeant Vanessa Rolfe.

Creation of Facebook page

- 5.59 On 6 November 2008, Heidi Porter-Williams, an old school friend of Ursula's, created a Facebook page titled, “*Missing Person – Ursula Barwick*”. Mr McInnis posted on this page that he was one of the last people to see Ursula at the time that she was reported missing. He indicated that he had seen Ursula at Central station and that she had been residing at the People's Palace, which was a type of backpackers accommodation at the time.

Age progression photographic technology

- 5.60 In March 2010 the Australian Federal Police (AFP) released new technology, called age progression technology, which had the ability to aesthetically re-render the face of a missing person from a photograph to show how that person's face might appear at any future age. Ursula was one of six people profiled with an age progression photo released to the public.

Further activity at Kings Cross LAC

- 5.61 On 11 October 2010 Detective Senior Constable Noble conducted further signs of life checks with the BDM registry which revealed there had been no name changes made from the name Ursula Barwick to any other identity during the period from 1996 to 2010.

- 5.62 On 19 May 2011, Detective Senior Constable Noble spoke with Andrew, and was advised that Peter still lived on the Central Coast. Detective Senior Constable Noble gave evidence that he intended speaking with both Andrew and Peter, with a view to possibly obtaining a statement from them regarding the circumstances of Ursula being reported missing. However, Detective Senior Constable Noble did not eventually meet with, or obtain statements, from Andrew and Peter as intended. This was primarily due to other work commitments with the NSWPF Homicide Squad at the time.
- 5.63 On 12 September 2011, 7 October 2011 and 9 November 2011, Detective Sergeant Fenwick “actioned” the case, recording in each instance that King’s Cross was awaiting advice from the Coroner. Detective Sergeant Fenwick indicated that in order for this to occur on each of these occasions he would have re-opened the case.

Detective Senior Constable Noble is transferred to the Homicide Squad

- 5.64 On 5 January 2012, Detective Sergeant Fenwick suspended the case once again. Around this time, Detective Senior Constable Noble was transferred to the Homicide Squad. Ursula’s file indicates that the case remained with Detective Senior Constable Noble following his transfer. However, evidence given during the inquest established that this should not have occurred, and that the file should have remained at Kings Cross LAC.
- 5.65 On 9 January 2012, Detective Senior Constable Noble spoke with Sergeant Vicki McKell from the MPU. Sergeant McKell informed Detective Senior Constable Noble that no action had been taken regarding the case due to extensive trial commitments, and that further actions on the case would need to occur at a later date.
- 5.66 On 21 February 2012, Detective Senior Constable Noble spoke with Inspector David Laidlaw, the Homicide Squad Coordinator, in relation to Ursula’s case and his existing caseload. A determination was made that further investigation into Ursula’s case would not commence until a coronial review for another unrelated matter had been completed.
- 5.67 On 9 July 2013 information was provided to Crime Stoppers suggesting that remains found in Belanglo Forest may belong to Ursula. This information was forwarded to the Homicide Squad, however it was later confirmed that the remains did not belong to Ursula.

Investigations between 2014 to 2016

- 5.68 In July 2014 the case was reallocated to Detective Senior Constable Amy Scott (now Sergeant Amy Scott) and Detective Sergeant Kurt Hayward for the purpose of gathering as much evidence as possible regarding the circumstances of Ursula going missing, and to prepare a brief of evidence for the Coroner. Detective Sergeant Hayward contacted both Peter and Elizabeth to advise them that the investigation was being reopened.
- 5.69 In early August 2014, Detective Sergeant Hayward took the following steps to progress the investigation:

- (a) He travelled to Quirindi and attended a missing person's picnic in order to speak with Ursula's friends and acquaintances and identify various lines of enquiry.
- (b) Ursula's school records from Quirindi High School between 1976 and 1987 were obtained, and information was sought from parents of students during a school assembly.
- (c) Detective Sergeant Hayward appeared in an interview which aired on local Prime Tamworth news on 1 August 2014.
- (d) Detective Sergeant Hayward spoke with Melissa Pouliot, Ursula's cousin, who had written a fictional novel titled, "*Write About Me*", based on the circumstances of Ursula going missing. Ms Pouliot herself had made many enquiries with families and friends and, as a Missing Person's Ambassador, had arranged the Missing Persons Picnic in Quirindi to raise awareness around the issue.

5.70 Also during August 2014, Detective Senior Constable Scott conducted a review of the investigation to date. Ursula's file indicated that basic signs of life checks with various government and financial institutions had been completed, and that Ursula's description had been compared against every unidentified human remains in Australia with no match.

Amendments to Missing Persons website

5.71 On 26 August 2014, a request was made to the AFP to amend a number of incorrect details regarding Ursula on the Australian Missing Persons website. These amendments included:

- (a) The descriptor "brown eyes" was changed to "blue eyes";
- (b) The descriptor "brown hair" was changed to "blonde/light brown hair";
- (c) The entry for "last seen date" was changed from 14 August 1987 to September 1987; and
- (d) The entry for "last known sighting" was changed from "Long Jetty" to "Tuggerah Railway Station".

5.72 On 2 September 2014, Detective Senior Constable Scott made several enquiries with the MPU in relation to the original missing person report for Ursula. Several discrepancies regarding the date Ursula was first reported missing were identified, as described above.

Creation of Strike Force Hemingway

5.73 On 5 December 2014 Strike Force Hemingway was created to investigate the circumstances of Ursula going missing. Over the next six months, Detective Senior Constable Scott investigated the possibility of conducting comparative testing of mitochondrial DNA profiles against profiles obtained from unidentified human remains. Senior Constable Joanne Williams advised at the time that the process of having all DNA samples of unidentified human remains uploaded to one system for comparison purposes had been put on hold due to staffing and resourcing issues.

Notwithstanding, Senior Constable Williams advised Detective Senior Constable Scott that she would search the records of unidentified human remains (which numbered approximately 200 at that time) for any that appeared to match Ursula's description. No match was identified.

5.74 Detective Senior Constable Scott also conducted the following further enquiries:

- (a) On 2 July 2015 a request was sent to Centrelink for any records in relation to Ursula;
- (b) On 15 August 2015 a request was sent to the Passports Office for an Australian Facial Recognition Check, with no record being found;
- (c) On 27 October 2015 a check was conducted with the Australian Taxation Office, with no record relating to Ursula identified.

Missing Persons Week

5.75 National Missing Persons Week is an annual event held in the first week of August. It has two purposes: to raise awareness of the issues associated with missing persons, and to help reduce the incidence and impact of missing persons in Australia. In 2015, Ursula was selected as a focal missing person. As part of National Missing Persons Week 2015 the following actions were taken:

- (a) On 17 July 2015 Detective Senior Constable Scott attended Tuggerah train station with a multimedia unit in order to film a re-enactment of Ursula being dropped at the station by Mr Turner and boarding the train. This re-enactment was later incorporated into the media release for National Missing Persons Week.
- (b) On 1 August 2015 a "*Picnic for Ursula*" was held outside Kings Cross police station for family and friends. The following day, Ursula's details were displayed on a billboard at ANZ Stadium during the halftime break of an NRL game in an attempt to seek information from the public.
- (c) On 3 August 2015 National Missing Persons Week was officially launched at Customs House, Circular Quay, with Ursula being the focal missing person at launch. Peter and Elizabeth, together with Ms Pouliot, spoke at the event.

Report of David King

5.76 On 5 August 2015 David King reported to Crime Stoppers that on 24 June 1989 he and his brother had seen Ursula working at the Coach and Horses, a hotel in Randwick. This report prompted further investigations which revealed that the King brothers had likely confused Ursula with Megan Clarke, another girl from Quirindi who worked at the hotel in June 1989 before returning to the Quirindi. Indeed, Ms Clarke was the principal of Quirindi High School when Detective Sergeant Hayward visited the area in 2014. A statement was later taken from Ms Clarke on 13 January 2016 confirming that Ursula had not worked at the hotel in June 1989.

Review of unidentified remains

- 5.77 In September 2015, Detective Senior Constable Scott commenced a process to gather a list of unidentified human female remains in New South Wales. Four months later, the MPU provided Detective Senior Constable Scott with a list of such remains from the relevant database where this information was stored.
- 5.78 On 17 February 2016, Detective Senior Constable Scott conducted a review of all female and unknown unidentified human remains in New South Wales. From this review it became apparent that the list was outdated as several of the listed unidentified human remains had in fact been identified.
- 5.79 From the review, two sets of remains were identified as potentially suitable for mitochondrial DNA comparison testing: one set of remains located at Wallsend in 2005 and another set remains located at Wyong in 2006. However, on 29 June 2016 this testing was put on hold pending the outcome of a new line of enquiry which suggested that a deceased female person known as “Jessica Pearce” was in fact Ursula.

Inquest into the death of a person believed to be “Jessica Pearce”

- 5.80 On 20 November 2018 the then State Coroner authorised the resumption of a previous inquest from 1988 into the death of “Jessica Pearce”. This inquest was held at the former Coroner’s Court in Glebe on 21 December 2018, with findings delivered on the same day. By way of introduction, the findings noted the following:

In late 1987 two events took place. The events were seemingly unconnected, except for the fact that they occurred approximately one month apart.

The first event was a missing person report made in relation to Ursula Barwick in September 1987. Ursula was 17 years old at the time that she was reported missing. She has not been seen alive by her family for more than 31 years. In the years that have passed since that report was made Ursula’s parents and family have had to endure not only the immeasurable loss caused by her separation from them, but also the painful and distressing uncertainty of not knowing what happened to her.

The second event occurred on 27 October 1987. In the early hours of the morning on that day a young lady was fatally injured in a motor vehicle collision. Evidence gathered at the time was unable to establish her true identity, only that she was known as Jessica Pearce.

Apart from proximity in time, the missing person report in relation to Ursula and the fatal motor vehicle collision did not, at first, appear to be connected in any way. However, the totality of evidence that has now been gathered in relation to both incidents indicates that they are indeed connected in a most critical and meaningful way. That evidence indicates that the person who died in the motor vehicle collision, and who was known as Jessica Pearce, is, in fact, Ursula Barwick.

5.81 Findings were also made in relation to the factual background concerning the death of the person believed to be “Jessica Pearce”:

At about 7:00am on 27 October 1987 Robert House was driving a Holden Commodore, registration NYY-490, in a southerly direction on the Hume Highway at Keajura. Hans Tangen, Marco Ilardi and a young lady were travelling in the vehicle with Mr House. Mr Tangen was seated in the front passenger seat whilst Mr Ilardi and the young lady were lying down in the rear seat. Approximately 1.3 kilometres south of Kilgowah Creek, the Commodore veered to the incorrect side of the road and collided with a Volvo semi-trailer, registration NV-15-AP, being driven in the opposite direction by Graeme Hills (**the 1987 collision**).

Police arrived on the scene at about 7:15am and discovered that the young lady had been ejected from the vehicle and was located about four metres from it, with no signs of life. Mr House and the other passengers were found trapped within the significantly damaged vehicle, having sustained injuries of varying degrees. Arrangements were made for the young lady, Mr House and Mr Tangen to be taken to Wagga Wagga Base Hospital. Due to the extent of his injuries Mr Ilardi was taken by air ambulance to St Vincent’s Hospital in Sydney for treatment. It appears that, based on information possibly gathered from the occupants of the Commodore, investigating police were able to determine that the name of the young lady was believed to be “Jessie” or “Jessica”.

At 9:50am Dr Robert Porter examined Jessica and pronounced her life extinct. It was noted that the name “Sue Latham” was written on the inside of Jessica’s left palm in pen. The Notification to the Coroner form completed by Dr Porter stated: “*I have examined to-day a body identified to me by UNKNOWN FEMALE as (NAME) ? Jessica of (ADDRESS) NOT KNOWN*”.⁴ Jessica’s death was reported to the Coroner at Wagga Wagga on the same day. The field to record the name of the deceased person was left blank on the P79A Report of Death to Coroner.

On 27 October 1987 Mr Severin Hill, Coroner at Wagga Wagga Court, made an order that a postmortem examination be conducted. This examination was later conducted by Dr Michael Lennon on 31 October 1987. It was noted during the examination that Jessica had a tattoo of a multi-coloured bird above her left breast. Dr Lennon later completed a document titled “*Medical Report upon Examination of the Dead Body of Unidentified Female Perhaps ‘Jessie’*” in which he opined that the cause of Jessica’s death was cerebral contusions and lacerations due to head injury. Dr Lennon also noted that a ruptured aorta, ruptured liver, and multiple injuries were all significant conditions which had contributed to Jessica’s death.

Mr House was subsequently charged with a number of offences in relation to the 1987 collision, including: driving in a manner dangerous occasioning death, driving in a manner dangerous occasioning grievous bodily harm, and stealing a motor vehicle.

5.82 Against the above background, an initial police investigation was conducted during 1987 and 1988. The findings relevantly noted the following:

It is apparent from the above that following the 1987 collision a question remained over the identity over the female person known as Jessica. The police officer-in-charge of the investigation, Sergeant Lindsay Becroft, made a number of enquiries to gather evidence about Jessica’s true identity. Sergeant Becroft conducted checks with a number of government departments, the NSW Police Missing Persons Bureau (as it then was), and with interstate law enforcement agencies.

⁴ Exhibit 1, Tab 18.

None of these enquiries was able to produce information that was able to answer the question of Jessica's true identity.

Sometime prior to February 1988, Sergeant Becroft was eventually able to gather information (possibly from the Bureau of Crime Intelligence in Victoria⁵) that a person named Ginera Michaelles knew Jessica. It appears that the information gathered by Sergeant Becroft indicated that Ms Michaelles was known to frequent the Kings Cross area. With the assistance of officers from Kings Cross police station, Ms Michaelles was eventually found.

On 17 February 1988 Sergeant Becroft met with Ms Michaelles at the (then) City Mortuary in Glebe. Ms Michaelles identified the body of Jessica as Jessica Pearce. Ms Michaelles signed an identification statement which recorded that she had known Jessica for about 3½ years as a friend, and that Jessica was about 25½ years old and that she was a dancer.

In a statement sworn on the same day Ms Michaelles provided the following information regarding Jessica:

- (a) she first met Jessica in Hamilton, New Zealand sometime in around 1984;
- (b) a couple of months later she ran into Jessica in Kings Cross in Sydney;
- (c) at that time, Jessica was working as a sex worker;
- (d) she came to know Jessica quite well over the next three years and lived with her from time to time;
- (e) in late October 1987 Jessica told Ms Michaelles that she was going to Melbourne with Mr Ilardi, Mr House, Mr Tangen, and another person named Kyle Mitchell;
- (f) Jessica told her that she had divorced her ex-husband about 12 months prior to October 1987;
- (g) Jessica told her that she had a five year old son who lived with his father; and Jessica had recently been granted custody of her son.

5.83 On 1 June 1998, an inquest into the death of "Jessica Pearce" proceeded before Corner Hill at Wagga Wagga Local Court. The findings noted the following:

An inquest into the death of the unidentified female person known as Jessica Pearce was listed before Coroner Hill at Wagga Wagga Court on 1 June 1998. On that day, the Sergeant Assisting the Coroner advised that attempts were still being made to positively identify Jessica. These attempts included enquiries with Interpol which suggested that Jessica might possibly identified by family residing in England. On that basis Coroner Hill made a determination to "*leave the matter in abeyance for the time being*"⁶ until further information could be gathered to positively identify Jessica.

⁵ Exhibit 1, Tab 21, page 4.

⁶ Exhibit 1, Tab 20.

On 16 December 1988 Coroner Hill made an order pursuant to s 16(1)(c) of the *Coroners Act 1980* (**the 1980 Act**) transferring the inquest into the death of Jessica to another coroner having jurisdiction at Wagga Wagga.

On the same day, an inquest into Jessica's death commenced before Coroner Ronald Gentle at Wagga Wagga (**the 1988 inquest**). A number of documentary exhibits were tendered at the commencement of the inquest, including the statement of Ms Michaelles and the report of Dr Lennon. Sergeant Becroft and Mr House were the only two witnesses called to give oral evidence.

In his evidence Sergeant Becroft indicated that he had cross-referenced fingerprints taken from Jessica against records held by NSW and interstate law enforcement agencies, together with Interpol, in an attempt to determine Jessica's true identity. Further, Sergeant Becroft said that he had also made enquiries with other police stations, the Department of Immigration (as it then was), the Registry of Births, Deaths and Marriages (**the BDM Registry**) and the Missing Persons Bureau, in an attempt to positively identify Jessica. All of these enquiries had failed to elicit any information as to Jessica's true identity.

During the course of Sergeant Becroft's evidence, he was asked questions about the information provided by Ms Michaelles and, in particular, Ms Michaelle's belief as to Jessica's employment. Sergeant Becroft was asked the following question⁷:

Coroner: *And I would think Sergeant from your experience and background that it wouldn't be uncommon to find young females using all strange or assume [sic] names in the Cross in view of their undertaking the occupation of a prostitute?*

Sergeant Becroft: *That's right.*

Later, during Sergeant Becroft's evidence the following exchange took place⁸:

Coroner: *I take it Sergeant that you continued at the search because in the circumstances it seemed that perhaps Jessica Pearce was not her real name.*

Sergeant Becroft: *Yes.*

Mr House gave evidence that he knew Jessica as a friend, that he only knew her by her first name, and that he had known her for about three months prior to the 1987 collision. Mr House also said that Jessica had told her that she was originally from New Zealand and that he had never discussed with her anything to do with her family.

At the conclusion of Mr House's evidence the inquest was stood down temporarily. Coroner Gentle then turned his attention to the criminal offences that Mr House had been charged with which, it appears, had been listed for hearing on the same day (although this is not entirely clear from the transcript of the proceedings). Mr House was not legally represented in relation to these matters. As a result, Coroner Gentle also temporarily stood down the criminal proceedings in order to give Mr House an opportunity to obtain legal advice.

⁷ Exhibit 1, Tab 21, page 5.

⁸ Exhibit 1, Tab 21, page 4.

Coroner Gentle later returned to the 1988 inquest. Coroner Gentle noted that “*a known person has been charged with an indictable offence as a result of [Jessica’s] death*” and that “*prior to her death [Jessica] was a prostitute and used the name Jessica Pearce*”.⁹ Further, Coroner Gentle noted that “*the means by which [Jessica] has been identified and the evidence suggests that perhaps this is not her correct name but an assumed name for the purpose of her profession. It is however possible that it is her correct name or part of it*”.¹⁰ After referring to a number of circumstances surrounding Jessica’s death, Coroner Gentle said this:

“...it also seems little is to be served by further prolonging this inquest. Indeed other proceedings are waiting for conclusion of this inquiry...the matter will need to be returned to the Court for further consideration through the usual channels if further evidence be available of identification. But on the evidence before me I find –

THAT A FEMALE KNOWN AS JESSICA PEARCE DIED ON 27TH OCTOBER 1987 AT KEAJURA IN THE STATE OF NEW SOUTH WALES AND HAVING BEEN INFORMED THAT A KNOWN PERSON HAS BEEN CHARGED WITH AN INDICTABLE OFFENCE IN RELATION TO SUCH DEATH I NOW TERMINATE THIS INQUEST”.¹¹

On 28 February 1989 the death of Jessica Pearce was registered with the BDM Registry. It was noted that Jessica had died on 27 October 1987 at the Hume Highway at Keajura and that the cause of her death was as set out by Dr Lennon in his report. Details of Jessica’s usual residence, place of birth, parents, and marital status were all recorded as being “*Unknown*”.¹²

By letter dated 22 March 1991 Coroner Hill wrote to the Officer-in-Charge of the Missing Persons Bureau in Victoria advising that Coroner Gentle had made a finding that a female person known as Jessica Pearce had died on 27 October 1987 at Keajura. The letter went on to state:

“While the Coroner made a formal finding as to the identity of the deceased person, the true identity of that person is still unknown i.e. the proper name of that person, her date of birth and family background”.¹³

It should also be noted that the criminal offences which Mr House was charged with were later dealt with to finality in 1991 in the District Court.

5.84 Following the 1988 inquest, it was not until December 2010 that a possible connection between Ursula and the person known as “Jessica Pearce” was drawn. The findings describe the nature of this connection:

Senior Constable Adam Marsh was attached to the MPU between 2008 and 2012. In 2010 Senior Constable Marsh worked on Operation Firenze, an operation assembled to collect and collate data relating to ongoing missing person investigations and unidentified human remains. In December 2010 Senior Constable Marsh was provided with records relating to Jessica’s death which had been given a reference number of “*Unidentified #216*”. Over the next several months Senior Constable Marsh obtained a copy of the original coronial brief of evidence, and other documents,

⁹ Exhibit 1, Tab 21, page 11.

¹⁰ Ibid.

¹¹ Ibid.

¹² Exhibit 1, Tab 25.

¹³ Exhibit 1, Tab 26.

relating to Jessica. In the course of reviewing this material, and making further enquiries in an attempt to ascertain Jessica's true identity, Senior Constable Marsh formed the view that there were a number of factual similarities between what was known about Jessica prior to the 1987 collision, and the circumstances surrounding when Ursula went missing.

Senior Constable Marsh was later transferred from the MPU to a different location within the NSW Police Force. However, in November 2015 Senior Constable Marsh saw a photo of Ursula which strengthened his views about the similarities between the cases of Jessica and Ursula. As a result, Senior Constable Marsh compiled a report regarding the history of both matters and emailed it to Sergeant Kylie Whiting, an officer working within MPU. Following receipt of this email, Sergeant Whiting contacted Detective Sergeant Kurt Hayward, of Kings Cross Police Station, on 28 April 2016.

As a result of the communication from Senior Constable Marsh and Sergeant Whiting, Detective Sergeant Hayward and Sergeant Amy Scott began making further enquiries regarding the cases of both Ursula and Jessica.

- 5.85 During the 2021 Inquest, Senior Constable Marsh gave evidence describing the circumstances in which he realised the possibility of a connection between Ursula and "Jessica Pearce". Prior to working at the MPU, Senior Constable Marsh worked at Eastwood LAC with Andrew, Ursula's brother. Due to his connection with Andrew, and having formed a particular interest in missing persons matters generally, Senior Constable Marsh already had some familiarity with Ursula's case by the time he commenced work at the MPU.
- 5.86 Senior Constable Marsh may have printed a photo of Ursula on 28 December 2010, and again on 25 May 2011. However, despite having a "*gut feeling*" that Ursula and "Jessica" might be the same person, Senior Constable Marsh did not try to contact Detective Senior Constable Noble to advise of the possibility that there was a connection between Ursula and "Jessica". Further, Senior Constable Marsh also did not add any narrative to the COPS database regarding the possible connection. However, Senior Constable Marsh gave evidence that he attempted to obtain DNA, dental records and fingerprints for "Jessica" in the first part of 2011, and that he approached his supervisor, Sergeant McKell, in relation to the issue. Sergeant McKell described this event in the following way:

[The role of the MPU] was not an investigative role, the responsibility to investigate missing persons and unidentified cases remained with the officer in the field, known as the [OIC]. When Senior Constable Marsh approached me, he stated the photographs were similar in appearance but he didn't have any other evidence to support a positive identification of Ursula. He advised that he had reviewed all the information available to him and had been unsuccessful in obtaining any further material that would allow him to move forward. Due to the overwhelming amount of cases to be reviewed and work to be done in the unit, I advised Senior Constable Marsh to put the file aside for now and continue working on files where we did have further information that would allow him to move forward with a possible identification.

- 5.87 Senior Constable Marsh gave evidence that he considered the advice from Sergeant McKell to be "*reasonable*" because he "*knew how busy we were*". However, despite acknowledging that it was standard practice at the time to add a short narrative to the relevant COPS Event regarding the

possibility of a match in relation to identifying a missing person, Senior Constable Marsh expressed the opinion that “*it wasn’t enough evidence to say it is a match*”.

5.88 Although the 2018 inquest did not have available to it forensic evidence which irrefutably established a connection between Ursula and “Jessica”, the available circumstantial evidence allowed for such a conclusion to be reached. In particular, the findings noted the following:

- (a) Ursula being sighted and recognised in Kings Cross and central Sydney by Ms Miller and Mr McInnes, both of whom knew her well;
- (b) The proximity of the sightings made by Ms Miller and Mr McInnes to the time that Ursula was last seen by her family in the Central Coast;
- (c) The location of the sightings being consistent with the intention expressed by Ursula to move to Sydney;
- (d) The corroborated accounts of Mr Tangen, Mr House, and Mr Mitchell of the intention of Mr Tangen, Mr House, Mr Ilardi and the person known as Jessica to drive to Melbourne;
- (e) The positive identifications made by Mr House, Mr Tangen and Mr Mitchell that the person known to them as Jessica is in fact Ursula;
- (f) The similarly positive identifications made by Peter and Elizabeth, to the extent of about 75% certainty, that the photos of Jessica shown to them are in fact photos of Ursula;
- (g) The absence of any evidence to corroborate the account provided by Ms Michaelles that the person known to her as Jessica was originally from New Zealand, was previously married, and had a son;
- (h) Other evidence indicating that aspects of Ursula’s life (such as her fondness for the name Jessica, her stepfather, Laurie, being originally from New Zealand, and her propensity for lying and exaggeration at the time she went missing) could have provided a basis for her to have fabricated an account which she related to Ms Michaelles;
- (i) The absence of any evidence demonstrating that any missing person report made at about the time of the 1987 collision, apart from the report made in relation to Ursula, could positively relate to Jessica;
- (j) The photographic similarities in the maxillary dentition¹⁴ between that of Jessica and Ursula suggesting consistency to Professor Griffiths, albeit not positive identification; and
- (k) The absence of any evidence suggesting to Dr Mallett that the antemortem photos of Ursula and the postmortem photos of Jessica are not of the same person, with the number of anatomical similarities between both sets of photos suggesting that Ursula is the subject of both sets of photos.

¹⁴ The arrangement of teeth in the upper jaw.

5.89 Ultimately, the 2018 inquest determined that “Jessica” is in fact, Ursula, with the findings noting the following:

It is not possible to know precisely what occurred after Ursula boarded a train at Tuggerah station in September 1987. However, the available evidence suggests that she travelled to Sydney and eventually made her way to Kings Cross where she met Mr Ilardi. As Mr Ilardi has limited recollection of this period of time, the precise circumstances in which Ursula met Mr Ilardi is not known. However, on the accounts provided by Mr Ilardi and Mr Mitchell their arrival in Sydney from Victoria coincided with Ursula’s arrival in Sydney. It appears that Ursula was either sleeping rough or sleeping in temporary accommodation for a short time before she met Mr Tangen and Mr House. There is no credible evidence to establish that Ursula worked at any time in the sex industry. Indeed, to the contrary, both Mr House and Mr Tangen specifically state that they had no knowledge of this. The assumption that this was the case is based only on the assertion made by Ms Michaelles. Like many other aspects of Ms Michaelles’ 1988 statement, there is no corroborating evidence to support such an assertion.

Having regard to the entirety of the evidence now available, the conclusion that must be reached, on the balance of probabilities, is that Jessica Pearce is, in fact, Ursula Barwick.

6. The statutory requirements of the Act regarding Ursula Barwick

- 6.1 As noted at the outset, in any missing person case the provisions of the Act require a Coroner to make a finding as to whether the missing person is now deceased. If such a finding is made, then the Coroner is also required to make findings, if the available evidence allows, as to when and where the missing person died, and as to the cause and manner of their death.
- 6.2 Consistent with the findings already made in December 2018 in the *Inquest into the death of a person believed to be Jessica Pearce*, the available evidence establishes that Ursula died on 27 October 1987 at Keajura NSW 2652. The cause of Ursula's death was cerebral contusions and lacerations due to head injury, with a ruptured aorta, ruptured liver and multiple injuries all being significant conditions which contributed to death. Ursula sustained these fatal injuries when a vehicle that she was travelling in was involved in a collision with another vehicle.

7. The adequacy of the police investigation in relation to Ursula as a missing person

- 7.1 Overall, the NSWPF investigation into the report of Ursula having gone missing was inadequate, ineffective, and occasioned further and unnecessary trauma upon Ursula's family members beyond that which families ordinarily experience when a loved one goes missing in sudden and unexplained circumstances. In many ways, the investigation reflects a number of significant and systemic deficiencies associated with missing person investigations more broadly, and that have persisted for over three decades.
- 7.2 The inadequacies of the NSWPF investigation may be summarised as follows:
- (a) First, the investigation failed to gather and retain basic, yet critical, pieces of evidence such as a photograph of Ursula.
 - (b) Second, during the initial stages of the investigation, which is commonly acknowledged as the most critical period during a missing person investigation, the significance of Ursula having gone missing was either minimised or given inadequate attention; put simply, Ursula was apparently treated as "*just another runaway*".
 - (c) Third, in the first four years after Ursula was reported as missing there is little to no evidence that the police investigation was progressed in any meaningful way, seemingly reflective of the fact that little importance was placed on the fact of her having gone missing.
 - (d) Fourth, there was an absence of ownership of the investigation between Kings Cross LAC and the then MPU, resulting in a lack of direction so far as advancing the investigation was concerned.
 - (e) Fifth, being a historical missing person case it was not seen as a priority, or assigned appropriate importance, compared to criminal investigation cases in a busy LAC such as Kings Cross which was already struggling with finite resources.

- (f) Sixth, up until 2014, the investigative steps largely consisted of performing routine signs of life checks at regular intervals without further consideration given as to how the investigation could be more effectively advanced.
- (g) Seventh, basic investigative steps such as initiating and maintaining contact with Ursula's family members and members of her local community, obtaining relevant dental and medical records, and identifying whether suitable biological samples had been collected for forensic comparison purposes were not followed.
- (h) Eighth, there was an absence of oversight and supervision by senior police officers regarding the investigation. Case reviews conducted at periodic intervals were done at a superficial level with little to no direction provided as to ways in which investigation should be progressed.
- (i) Ninth, investigation was either inappropriately closed (with Ursula incorrectly designated as having been located) or suspended at different intervals when all avenues of investigation had not been exhausted. This appears to have been a result of the resource limitations within Kings Cross LAC and done at the convenience of investigators so that they did not feel "*overloaded*".
- (j) Tenth, even when a possible connection was identified between Ursula and "Jessica Pearce" in 2010 and 2011, important steps to verify this possibility were not taken, such as contacting the OIC and documenting the evidence giving rise to this connection.

8. Factual background in relation to Gary Jones

Personal history

- 8.1 Gary was born to Robert Jones and Merrilee Jones (nee Wills) in 1963. He grew up in Clovelly, in Sydney's eastern suburbs, and lived with his mother and grandmother, Grace Wills. After finishing school, Gary enrolled in an electrical engineering degree at the University of New South Wales (UNSW). In 1981 Gary met Jillian Hallam, who was also studying at UNSW at the time. Gary and Jillian married on 30 November 1985. Three years later, in 1988, they purchased a home in Rockdale together with the assistance of a loan from Gary's grandmother.
- 8.2 The following year was a challenging one for the couple. In around May 1989, Gary's grandmother discovered that Gary had been using cheques from her cheque-book, and forging her signature. When this became known to Jillian the following year, it resulted in the breakdown of her relationship with Gary. Jillian also discovered that Gary had not completed his university degree, as he had led Jillian to believe. The couple later divorced on 16 September 1990 but continued living in the same house in Rockdale.
- 8.3 A short time later, Gary formed a new relationship with a girlfriend known only as "Amelia". Jillian observed that Gary made a number of what she perceived to be extravagant expenses associated with the relationship, and later confronted Gary about his spending habits. This made Gary extremely upset, and Jillian did not raise the issue with Gary again, as she was still studying and living with him in the same house.
- 8.4 By around November 1990, Jillian noticed that "Amelia" stopped coming to her house. Around this time, in late October or November 1990, Jillian and Gary had a drink together one Sunday, and Jillian observed that Gary appeared to be depressed.
- 8.5 On the morning of 9 November 1990, Gary left home to go to work at Ocean Trading, an importing/exporting company based in Alexandria, Sydney. This was the last time that Gary had contact with Jillian. Later that day at around 2:30pm investigators from Westpac contacted Gary's employer to advise that cheques had been drawn from the company's account and credited to an account in Gary's name. It was subsequently discovered that between 31 July 1990 and 5 November 1990 Gary had allegedly fraudulently obtained \$140,937.07 by forging a signature on nine blank cheques belonging to his employer.

Gary is reported as missing

- 8.6 It is most likely that Gary left work on 9 November 1990 after overhearing the conversation between Westpac investigators and his employer. Later that evening, at 10:20pm, the allegations of fraud were reported to Ultimo police station. A crime information report was prepared, stating that Gary was suspected of committing nine counts of larceny as a clerk and nine counts of making false instruments. A warrant was later issued for his arrest.
- 8.7 The same day, Gary was reported as a missing person to Waterloo police station by his mother. It was considered that Gary may be at risk of self-harm, and an intelligence report was later

completed by Constable Murray Wiley. Notwithstanding, Gary's mother and family believed at the time that Gary had likely relocated in order to avoid the consequences of the fraud charges.

8.8 It appears that the following steps were taken in the initial investigation period:

- (a) On 14 November 1990 the NSWPF requested the AFP to place a restriction on Gary from leaving the country due to his outstanding arrest warrant;
- (b) On 10 May 1991, an outstanding missing person's report was completed at Redfern police station, confirming that Gary was still missing;
- (c) On 15 January 1992 a letter was prepared recommending that Gary's file be forwarded to Detective Senior Constable Paul Thomas at Redfern Detectives as the OIC of the matter.

Investigation between 1992 and 2010

8.9 On 19 February 1992 Detective Senior Constable Thomas prepared a continuation report to be sent to the MPU confirming that Gary was still reported as missing. At that time, there had been no contact between Gary and Jillian or Merrilee. Detective Senior Constable Thomas informed the MPU of the address of Gary's dentist, and that it was his understanding that a photo of Gary had previously been submitted to the MPU with the original missing person report.

Enquiries made by the MPU

8.10 Between 1992 and 2004 the MPU made the following enquiries:

- (a) On 21 December 1992 the MPU made enquiries with the RTA and NSW Electoral Roll, with neither enquiry revealing any information about Gary.
- (b) On 25 February 1993 the MPU made enquiries with the Department of Immigration, which revealed no record of Gary having travelled after 9 November 1990;
- (c) On 6 February 1997 the MPU conducted further enquiries with the RTA, together with COPS and the National Names Index (**NNI**), with no new information uncovered;
- (d) On 4 February 1999 the MPU made enquiries with Centrelink, which revealed that it had no current record for Gary, and none had existed since 9 November 1990;
- (e) On 30 March 2004 the MPU attempted to obtain Gary's dental records but was unable to do so due to the time that had elapsed since Gary was reported missing. In evidence, Detective Senior Constable Cary could offer no explanation as to why attempts were not made to obtain Gary's dental and medical records closer to the time that he was reported as missing.
- (f) On 30 March 2004, microfilm records relating to Gary's alleged offences were also obtained;

- (g) On 6 April 2004 new enquiries were made with State and Territory Missing Person Units, the BDM registry, Centrelink, Department of immigration and the NSW Electoral Roll, none of which revealed any further information regarding Gary's whereabouts.
- (h) On 28 June 2004 enquiries were made with the ATO, Medicare and a number of financial institutions, none of which produced any further information.
- (i) Also on 28 June 2004, Gary's details were compared against identified human remains located throughout New South Wales. It was identified that Gary's description was possibly matched to unidentified human remains located near Echo Point, Katoomba on 27 November 1991 (**the Echo Point remains**). However, a comparison was not able to be completed in the absence of dental records. Further enquiries were made in relation to the possibility of obtaining a DNA sample from Gary's family for comparison purposes.

Death of Gary's mother

- 8.11 On 16 February 2005 Merrilee tragically died of a brain tumour. Prior to her death she had reportedly been very distressed regarding Gary having been reported as missing, and remained of the belief that he had relocated in order to avoid apprehension by police.
- 8.12 Merrilee's passing came to the attention of Sergeant Stephen Kos on 29 June 2006 who was at the time making enquiries regarding obtaining a DNA sample from a member of Gary's family in order to further investigate the Echo Point remains. After obtaining further information, on 30 June 2006 Sergeant Kos lodged an iASK request for Merrilee's birth certificate to identify any siblings who could be contacted for the purpose of providing a DNA sample. On 17 July 2006 Sergeant Kos received Merrilee's birth certificate, but it did not identify any relatives from whom a DNA comparison sample could be taken. Douglas Wills, a cousin of Merrilee, was listed as a contact on the Merrilee's death certificate.

DNA sample located in Victoria

- 8.13 On 12 February 2007 Sergeant Kos contacted Mr Wills and discovered that Merrilee had stored a DNA sample before her death with a laboratory in Victoria called Silbase Scientific Lab (**Silbase**) for the purpose of identifying Gary if he was found. Sergeant Kos noted in a relevant COPS entry that the MPU would have to determine whether Merrilee's DNA sample was sufficient to compare against the Echo Point remains, and that Constable Joanne Williams from the MPU would follow up this matter.
- 8.14 On 1 February 2008 Senior Constable Williams contacted Mr Wills, who confirmed that he was arranging for a DNA sample from Silbase to be sent to the MPU. This sample was later provided to the MPU on 1 May 2008. The following day, the sample was conveyed to Orchid Cellmark, a DNA and the forensic testing company which was located in the United States at the time.
- 8.15 On 31 July 2009 the mitochondrial DNA profile for Merrilee was received and entered into the Missing Persons database for comparison against unidentified human remains.

Notification regarding Merrilee's estate

- 8.16 On 22 April 2008, Bartier Perry Legal sent a letter stating that the firm acted for the executor of Merrilee's estate, Mr Wills. Merrilee had left an estate of \$6,243,309.77 which she wanted to be split into three equal portions between Gary, the Cancer Council NSW and the National Heart Foundation of Australia.

Investigation between 2010 and 2011

- 8.17 Between 2 December 2010 and 16 August 2011, Detective Senior Constable Adnan Daye was the OIC of the investigation. He undertook the following investigative steps:
- (a) On 2 July 2010, he spoke with Jillian who provided him with four colour photographs of Gary;
 - (b) On 21 December 2010, he contacted Gary's aunt, Vivienne Russell and made arrangements for her to provide a buccal swab at Redfern police station;
 - (c) On 25 May 2011, Vivienne informed Detective Senior Constable Daye that she had visited a psychic who informed her that Gary was alive and living in Western Australia. Vivienne further stated that Gary had reportedly remarried a woman named Andrea who worked in Geraldton. Vivienne made her own enquiries and located a woman named Andrea Jones working in the library run by Geraldton Local Council. Detective Senior Constable Daye eventually contacted Andrea Jones and a person named Gary Stephen Jones, who was confirmed not to be the missing person.

Daily Telegraph article

- 8.18 On 3 June 2011 a media release in relation to Gary was prepared, with a photo attached. An article was subsequently published in the Daily Telegraph inviting members of the public with any information regarding Gary's whereabouts to contact the police. This publicity did not generate any further information.
- 8.19 On 9 June 2011, Detective Senior Constable Daye spoke to a former employee of Ocean Trading and obtained the names of several people who were working at the company in November 1990. Detective Senior Constable Daye gave evidence that he did not conduct any investigation in relation to these names because he subsequently moved overseas and the case was transferred to another detective.

Investigation between 2012 and 2015

- 8.20 Detective Sergeant Nicholas Walker was designated as the OIC of the investigation between 30 July 2012 and 30 March 2015. Upon commencing as OIC, Detective Sergeant Walker conducted a review of the investigations to date and noted that no signs of life for Gary had been recorded since 9 November 1990.

8.21 During the period that Detective Sergeant Walker was the OIC, the investigation progressed in the following ways:

- (a) On 2 August 2012, Senior Constable Campbell from the MPU sent Detective Sergeant Walker an email confirming that the Echo Point remains did not belong to Gary;
- (b) On 19 April 2013 Vivienne provided a statement indicating that she had visited two clairvoyants over the years, with one indicating that Gary was alive and living in Broome Western Australia, with the other indicating that Gary was living in a suburb south of Melbourne;
- (c) On 7 February 2014 the Department of Immigration informed police that there was no record of Gary having departed Australia;
- (d) On 29 May 2014 checks conducted with the Queensland Department of Natural Resources and Mines (Land Titles) identified no records in relation to Gary owning land in Queensland, as previously suspected; and
- (e) On 6 August 2014 the BDM registry in Queensland indicated that there was no record of any relevant change of name for Gary.

8.22 On 16 June 2014 Detective Sergeant Walker spoke with Detective Senior Constable Murray Wylie, one of the original investigators relating to the fraud investigation involving Gary, who indicated the following:

- (a) He recalled interviewing “Amelia” shortly after Gary was reported as missing;
- (b) “Amelia” worked as a sex worker at the Golden Apple in Kings Cross;
- (c) Gary was paying “Amelia” \$700 per night;
- (d) Gary’s car was found near The Gap in Sydney’s eastern suburbs shortly after he was reported as missing; and
- (e) He could not recall any mention of Gary being in Queensland.

8.23 Following this conversation Detective Sergeant Walker contacted several Sydney brothels for the purpose of identifying “Amelia”, without success. However, Detective Sergeant Walker could not recall taking any steps to ascertain whether any unidentified human remains had been found near The Gap around 9 November 1990. Detective Sergeant Walker gave evidence that in his dealings with the MPU, his recollection was that his attention was only drawn to the Echo Point remains.

8.24 Between June 2014 and March 2015 a number of further investigations were performed:

- (a) On 27 June 2014 a facial recognition scan for Gary was performed in the Suspect Identification System, with no result;

- (b) On 8 July 2014 Jillian provided a statement to police;
- (c) On 22 December 2014 police contacted Forensic Analytical Science Service (**FASS**) regarding a familial comparison between Merrilee's DNA against profiles of convicted offenders. However, FASS indicated that it had no DNA sample in the Merrilee's name. Police subsequently arranged for the relevant sample to be delivered to FASS (who later confirmed that the sample were stored on file), however the comparison was never completed.
- (d) On 12 March 2015 Orchid Cellmark provided a report confirming that Merrilee's DNA sample and the Echo Point remains were excluded as originating from the same maternal lineage.

Investigation between 2017 and 2019

8.25 On 30 July 2017, Detective Senior Constable Amanda Cary from Redfern police station became officer in charge of the investigation. Further steps in the investigation may be summarised as follows:

- (a) On 30 July 2017, Detective Senior Constable Cary made a number of enquiries with Centrelink, the BDM registry and a number of financial institutions, but no activity in relation to Gary was identified.
- (b) Also on 30 July 2017, a request was sent to FASS for all unidentified human remains to be checked against Merrilee's DNA sample. The MPU provided Detective Senior Constable Cary with a list of unidentified human remains on their files since 1990, and this list was in turn forwarded to FASS to assist with the comparison process.
- (c) In August and September 2017 signs of life checks were conducted with the following agencies: Centrelink, the BDM registry, Medicare, and interstate police databases in Western Australia, Tasmania, Queensland, Victoria, the Northern Territory and the Australian Capital Territory. None of these enquiries produced any records in relation to Gary.
- (d) An information request was also made regarding a prescription that appeared to have been issued by a Dr Peterson to Gary on 19 July 1981 and was filled at a pharmacy in Elizabeth Street, Sydney on 23 July 1991.
- (e) On 26 October 2017, Detective Senior Constable Cary sent another request to FASS for Merrilee's DNA sample to be placed on the FASS database and compared against all unidentified human remains in New South Wales.
- (f) On 13 April 2018 FASS prepared a report stating that it had completed the familial history search on all DNA samples for unidentified human remains held on record, with no match for Gary having been found.

Connection with unidentified human remains located at Little Bay

- 8.26 On 15 May 2018, Detective Senior Constable Cary sent an email to Carole Field, the Unit Manager of the Database and Case Management Unit at the Forensic Biology/DNA Laboratory of the NSW Health Pathology Forensic & Analytical Science Service. In the email, Detective Senior Constable Cary advised that she had “*stumbled across*” records in relation to unidentified human remains found at Little Bay on 24 November 1990 (**the Little Bay remains**), just 15 days after Gary was reported as missing. The Little Bay remains related to a male person, about 30 to 40 years old, 170 to 180 cm tall, and with a fair complexion and build. They were partially decomposed and wedged under a rock with a wheel and axle of a motor vehicle, which were determined to have been there for some time and unrelated to the death. However, as the Little Bay remains were found with the head upwards from the bottom jaw missing, hair and facial features were not able to be identified.
- 8.27 An autopsy was conducted on 26 November 1990 which determined the cause of death to be injuries received from a fall from a great height. As the Little Bay remains could not be identified, a destitute burial was held in February 1992.
- 8.28 Detective Senior Constable Cary gave evidence that she located the reference to the Little Bay remains by performing a COPS search for the incident “*Unidentified Remains*” in relation to each of the LACs in the central metro regions. When asked about the search methodology that she used, and her understanding of available search methodology at the time the first tranche of the inquest (in May 2020), Detective Senior Constable Cary indicated that she was the only police officer undertaking this task, and gave the following evidence:
- Unfortunately as far as I know that’s the only that we could do it and the same thing would happen with current cases at the moment, you’d have to search the areas.
[...]
[The search] would have stemmed over a few days to maybe a few hours each day, like it wasn’t I sat down solid for 12 hours and just reviewed COPS entries because as you’re working you’ve still got other jobs coming in so it would have gone over a few days and taken a few hours each day.
- 8.29 In her email to Ms Field, Detective Senior Constable Cary enquired whether there was a DNA profile available from the Little Bay remains to allow for it to be compared against Merrilee’s DNA sample. Ms Field advised that FASS had no record of any such DNA profile for the little Bay remains. This was later confirmed by Associate Professor Jodie Ward (who at the time was the Team Leader – Specialist DNA Laboratory at FASS), who also indicated that she had no further information on the FASS laboratory system.
- 8.30 As a result of the above, Detective Senior Constable Cary submitted an initial P79B report on 27 June 2018. Then, in July 2018, Detective Senior Constable Cary sought approval from the Coroner to obtain wax tissue blocks from the Little Bay remains. This was later approved and on 6 September 2018, Detective Senior Constable Cary delivered the wax tissue blocks to FASS for examination.
- 8.31 On 10 January 2019 Associate Professor Ward completed an expert certificate indicating that she had analysed seven wax tissue blocks and extracted a mitochondrial DNA profile which had the

same mitochondrial profile as Merrilee. This confirmed that the profile from the Little Bay remains could not be excluded as originating from the same maternal lineage as Merrilee. This would be expected to occur in approximately one in 13,815 unrelated individuals in the general population, thereby confirming Detective Senior Constable Cary's suspicion that the Little Bay remains were likely those of Gary.

8.32 An updated P79B report was subsequently submitted to the Coroner on 17 January 2019.

9. The statutory requirements of the Act regarding Gary Jones

- 9.1 The available forensic evidence establishes that Gary is now deceased, and that the previously unidentified Little Bay remains are those of Gary. This conclusion is supported by the consistency in physical appearance between Gary and the Little Bay remains, as well as the temporal connection between when Gary was last seen alive and when the Little Bay remains were located.
- 9.2 The other evidence establishes that Gary died between 9 November 1990 (when he was last seen alive) and 24 November 1990 (when the Little Bay remains were found). Given the location of the Little Bay remains, it can also be concluded that Gary died in or around Little Bay. Further, it is also evident that Gary died from multiple injuries as a result of a fall from height.
- 9.3 However, as to the manner of Gary's death, it is unclear whether the fall from height was the result of an intentional act or, for example, a result of misadventure by way of an accidental fall. In certain cases conclusions can be reached that the death of a person from a fall from height was the result of an intentional act. However, in such cases there is typically an established body of evidence which demonstrates that the person had, for example, previously attempted self-harm, voiced suicidal ideation proximate to the time of their death or left behind a note containing content consistent with an intention to self-harm or instructions for the disbursement of their property and management of their affairs following their death.
- 9.4 It is evident that at the time he was reported as missing, Gary was experiencing significant personal difficulties associated with the allegations of fraudulent conduct. Whilst the possibility of self-harm was raised at the time, it was also considered, by Gary's family, that Gary may have simply relocated in order to avoid apprehension. Therefore, whilst self-harm might be suspected, a sufficiently clear and cogent evidentiary basis must exist before a conclusion can be reached that a person intentionally inflicted their own death. In Gary's case, due to the passage of time and the absence of any relevant investigation conducted at the time that he was reported as missing, there is insufficient evidence upon which a conclusion can be reached as to the manner of Gary's death.

10. The adequacy of the police investigation in relation to Gary as a missing person

- 10.1 Although the discovery of the Little Bay remains on 24 November 1990 would obviously have been known to police at the time, it is unclear why any cross-referencing between this event and the circumstances of Gary being reported as missing did not occur until almost 28 years later when it was performed by Detective Senior Constable Cary. Prior to 2018, no formal system existed that allowed for such cross-referencing to be conducted.
- 10.2 Instead, in Gary's case, it relied upon the initiative and dedication demonstrated by Detective Senior Constable Cary over a number of days to identify the connection between the two events. This identification occurred 13 years after the death of Gary's mother, Merrilee. Therefore, much like the case of Ursula Barwick where Ursula's mother died without knowing what happened to her daughter, so too did Merrilee die without knowing what happened to her son. Given that Merrilee was understandably very distressed regarding the circumstances in which Gary went missing and the unbearable uncertainty of not knowing what happened to him, it is devastating to know that an opportunity existed to provide this certainty to Merrilee before her passing.

11. Factual background in relation to Lionel Daveson

Personal history

- 11.1 Lionel Daveson was born in Queensland on 8 January 1982 to Lionel William Daveson (Senior) and Thelma Bartlett. Lionel grew up in the Silkwood area in far North Queensland with his parents, who are now deceased.
- 11.2 After suffering a stroke when Lionel was only two years old, Thelma was frequently ill during Lionel's childhood. As a result, Lionel lived with his sister, Lynette Oswald, in Townsville throughout his teenage years. Lynette was 15 years older than Lionel and contributed significantly to his early upbringing. When Lionel's father died in 1994, Lynette assumed full custody of Lionel.
- 11.3 In around 1999, when Lionel was 19 years old, he moved to Sydney. Lionel found work in the hospitality industry, and also as a sex worker in a brothel in Kings cross. This occupation appeared to cause Lionel significant stress and anxiety.

Medical history

- 11.4 Lionel sadly suffered from a multitude of mental health issues, and was admitted to hospital for treatment on a number of occasions. The following provides a brief summary of Lionel's relevant medical history:
- (a) On 3 September 1999, shortly after his move to Sydney, Lionel was admitted to the psychiatric ward at Prince of Wales Hospital, suffering from drug-induced psychosis, paranoia and exhibiting suicidal ideation. He was later discharged on 7 October 1999.
 - (b) On 7 November 2000, Lionel was admitted to the Kiloh Centre, an acute mental health inpatient service at Prince of Wales Hospital. He was diagnosed with schizoaffective disorder and paranoia, and discharged on the same day.
 - (c) On 30 January 2001, Lionel was again admitted to the Kiloh Centre following a further psychotic episode and expressions of suicidal ideation. On 12 February 2001, Lionel was discharged into accommodation provided by Bondi Youth.
 - (d) On 7 November 2001 Lionel was admitted to the Kiloh Centre again for a chronic paranoid schizophrenia, and later discharged on 11 December 2001.
 - (e) On 23 May 2002, Lionel returned to the Kiloh Centre for schizoaffective disorder and polysubstance abuse. Following treatment and medication, Lionel was discharged on 3 June 2002.

Lionel goes missing in the United Kingdom

- 11.5 In 2003 Lionel moved into the house of a friend, Michael Butterworth, in Mascot. Sometime in 2005 or 2006 Lionel relocated with Mr Butterworth to Perth.

- 11.6 In late 2006 Lionel travelled to England with another friend, Michael Board. During this period Lionel's mother died, and Mr Board expressed the belief that Lionel would have been extremely affected by this event. Whilst overseas, Lionel went missing for a period of time. In mid-2007 Mr Board made plans to travel to England to locate Lionel, when Lionel unexpectedly made contact with him. At this stage, Lionel was living in a hostel in England. Mr Board subsequently contacted the Australian Consulate and paid for a flight so that Lionel could return home to Sydney.
- 11.7 Lionel arrived at Sydney in June 2007 where he was met by Mr Board who describes Lionel as being "*extremely agitated and anxious*" upon his arrival. Lionel indicated that he did not want to return to his old house in Mascot, and instead wanted to travel to Brisbane to see a childhood friend, Quinn Woodhall. Mr Board subsequently booked a flight to Brisbane for Lionel, and took him to the airport that night.

Lionel travels to Brisbane

- 11.8 Upon arriving in Brisbane, Lionel stayed with Mr Woodhall, who observed that Lionel was acting strangely at the time. Mr Woodhall said that it appeared that Lionel "*was running from someone*", and behaving unusually. For example, Lionel reportedly stayed up watching the news on repeat and did not sleep at all. This behaviour continued over a number of days until Mr Woodhall and his partner decided that they were unable to look after Lionel.
- 11.9 Mr Woodhall made arrangements for Lionel to go to the Pindari Men's Homeless Shelter (**the Pindari Shelter**) in Spring Hill, Queensland. Mr Woodhall also contacted Lionel's family in Townsville, but they were too far away to assist. Lionel made it clear to Mr Woodhall that he did not want to go to the shelter and, on the day that Mr Woodhall drove him there, he jumped out of the car as it was moving at slow speed. Mr Woodhall was able to persuade Lionel to get back into the car, and drive him to the Pindari Shelter.
- 11.10 Between 2 June 2007 and 5 July 2007 Lionel resided at the Pindari Shelter. On 6 July 2007 Lionel was admitted to Royal Brisbane Hospital following self-harming behaviour. Lionel was later discharged on 27 July 2007, with his discharge details faxed by Dr Merrilee O'Donnell to Royal Prince Alfred hospital in Sydney. The discharge summary set out the circumstances of Lionel's admission and suggested that he reconnect with some mental health services in Sydney.

Lionel returns to Sydney

- 11.11 Sometime in August 2007, Lionel returned to Sydney, although his means of travel is not known. Upon arrival, Lionel stayed at Foster House, a homeless shelter in Surry Hills for a week, and then went to stay with a friend in Maroubra. Around this time, Lionel was visited by the Acute Mental Health Team from Randwick Hospital, and diagnosed as being in a psychotic state of mind. Arrangements were made for Lionel to be admitted to hospital pursuant to the *Mental Health Act (NSW)*. Despite this, no records were located in relation to this admission.
- 11.12 On 13 August 2007, a cash withdrawal was made from Lionel's account in the sum of \$430 from the ANZ branch in George Street, Haymarket.

- 11.13 On 23 August 2007, Lionel arrived unannounced at the home of Mr Butterworth, who was living in Rosebery at the time. Mr Butterworth's daughter, Rachel, was at home at the time and observed that Lionel appeared agitated, and said that he wanted to go for a walk. Lionel asked Rachel to fill the bottle with white wine and give him some cigarettes, which she did. Lionel told Rachel that he was going for a walk and that he would be back, and left his bag at Mr Butterworth's house. Mr Butterworth returned home between 7:30pm and 8:00pm and waited up for Lionel, but he did not return.
- 11.14 Later that evening, at around 10:50pm, Leading Senior Constable Bradley Rodwell saw Lionel near a charity bin in Vaucluse, where he appeared to be sifting through clothes on the ground. This location is across from walking trails that lead to The Gap, an ocean cliff on the South Head peninsular in Eastern Sydney. Lionel told Leading Senior Constable Rodwell that he had come to drop off clothes from Surry Hills, but could not explain why he had travelled from Vaucluse to do so. Leading Senior Constable Rodwell noted that Lionel appeared to be slightly drug affected.
- 11.15 In relation to his interaction with Lionel, Leading Senior Constable Rodwell gave evidence that he "*more than likely would have*" asked Lionel some questions in relation to possible self-harm (as it was "*something that [he] would have done up around the area quite often*"), but acknowledged that there was no record in his notebook of having asked Lionel any questions regarding his mental health. Lionel told Leading Senior Constable Rodwell that he planned to catch the next bus back to Surry Hills, and provided a home address in Merrilee Street, Surry Hills. After being searched, with nothing located, Lionel was permitted to leave and Leading Senior Constable Rodwell subsequently completed a COPS report regarding the interaction.

Lionel is reported as missing

- 11.16 On 24 August 2007 an email (**the August 2007 Email**) was sent to Mr Butterworth's work email address from Lionel's Hotmail account which stated, "*I don't need my stuff, you can get rid of it*". Mr Butterworth did not see the email at the time it was sent.
- 11.17 On 28 August 2007 Mr Butterworth attended Mascot police station where he reported Lionel as missing to Senior Constable Joseph Halloran. At the time, Senior Constable Halloran had only been a police officer for three months, and could not recall receiving any training in relation to missing persons investigations. Senior Constable Halloran agreed in evidence that any training which he might have received was "*in effect on-the-job training*".
- 11.18 Mr Butterworth later saw the August 2007 Email after 28 August 2007. As he knew Lionel's password, Mr Butterworth logged into Lionel's Hotmail account and saw that the August 2007 Email was the last email sent from the account. It appeared to Mr Butterworth as though Lionel had deleted all his contacts and his email history.

Investigation between 2007 and 2009

- 11.19 On 29 August 2007, Senior Constable Halloran sent a photograph of Lionel to the MPU. On the same day, police officers attended the Surry Hills address which Lionel provided to Leading Senior

Constable Rodwell at Vacluse six days earlier, and discovered that it was not a residential address. Police did not make any further enquiries in relation to Lionel residing at Foster House.

- 11.20 Senior Constable Halloran gave evidence that he was aware that Lionel had spoken to police in Rose Bay, but was unaware that this interaction had occurred near The Gap. Further, Senior Constable Halloran also gave evidence that he spoke to Leading Senior Constable Rodwell regarding the interaction but was not told anything out of the ordinary about it. Senior Constable Halloran said that he had no recollection of having any sense at the time that Lionel was a vulnerable person. Further, he said that if the MPU had provided advice at the time to seek or obtain Lionel's personal belongings, he would have done so. Senior Constable Halloran denied receiving any advice at the time from the MPU to obtain a DNA sample from one of Lionel's relatives, and that if he had received such advice he would have done so.
- 11.21 CCTV cameras were not installed at The Gap until 2008. No search of The Gap area was ever conducted by police in Rose Bay to locate Lionel. Further, the case was never transferred to Rose Bay police.
- 11.22 By 12 September 2007, Senior Constable Jamie Smith from Mascot police station had been assigned as OIC of the matter. Senior Constable Halloran remained involved in elements of the investigation until he left Mascot police station. On 12 September 2007, Senior Constable Smith contacted all hospitals and homeless shelters in the Sydney area, but gathered no information that Lionel had attended any since 24 August 2007.
- 11.23 Mr Woodhall's mother, Lynne Woodhall, contacted police on 14 September 2007 to advise that she saw Lionel three days after he was released from Royal Brisbane Hospital. Ms Woodhall said that Lionel had been "*in the worst state that she [had] ever seen him, and that she couldn't believe that the hospital released him*".
- 11.24 During September and August 2007, police made various enquiries with Lionel's family members, financial institutions, Centrelink, Medicare, the Department of immigration and Missing Persons Units in other states and territories.
- 11.25 Senior Constable Smith gave evidence that he was generally reliant upon instruction from supervising officers as to what inquiries and next steps to take regarding the investigation. This was particularly so given that this was Senior Constable Smith's first missing persons investigation. He also gave evidence that if such a missing person investigation were to be allocated to him now, he would have followed up additional leads and stayed more in touch with relatives. However, at the relevant time, Senior Constable Smith frankly acknowledged:
- I'd have to say I didn't, at the time I didn't know any better. I thought I was doing, I thought I was doing what, what was expected.
- 11.26 Upon reflection, Senior Constable Smith considered that he could have conducted the investigation in a different manner between 2007 and 2009:

Well, I'm thinking now it could have been more following up leads, it's apparent I had information that he might have been seen in Queensland. They definitely could have been followed up better than maybe, maybe what I did...made inquiries or at least stayed in touch more with relatives and I'm probably thinking more better contact with interstate agencies that would be the Queensland Missing Person Unit or what it may have been.

- 11.27 Senior Constable Smith gave evidence that he would have been aware of the interaction between Lionel and police on 23 August 2007 near The Gap but could not offer any explanation as to why no steps were taken to search the surrounding area. Further, Senior Constable Smith said that he could not recall turning his mind to the possibility of gathering Lionel's personal effects from Mr Butterworth's house with a view to potentially obtaining a DNA profile for Lionel. This is despite Senior Constable Smith having some recollection of a discussion with an officer from the MPU regarding the possibility of obtaining a suitable DNA sample from a relative of Lionel. However, when asked why he never sought to obtain such a sample, despite this discussion, Senior Constable Smith could only explain:

Sorry, I do not really recall. I remember having the discussion and I feel that it was just more of a maybe if needed...I think that was maybe as far as it got.

- 11.28 On 3 January 2008, Senior Constable Halloran spoke with the MPU in relation to seeking advice and assistance. Further, he also contacted one of the police officers who spoke to Lionel near The Gap on 23 August 2007. Senior Constable Halloran also followed up with Mr Butterworth to confirm that Lionel had not been in contact with him.

Enquires made in Queensland

- 11.29 On 8 January 2008 Senior Constable Halloran spoke with Ms Woodhall who reported that Lionel may have been sighted in the South Bank area of Brisbane. Senior Constable Halloran contacted South Bank police station and arrangements were made for Lionel's name and photograph to be circulated to local police.
- 11.30 On 6 March 2008 Richard Pointing, an ex-partner of Lionel, advised Senior Constable Smith that he had received a bank statement for an account opened by Lionel on 4 December 2007 at the ANZ branch in Fortitude Valley, Queensland. This account was later closed on 27 February 2008. According to COPS records the "*bank statement was filed with case file items*", and it appears that no further enquiries were made regarding this bank account.
- 11.31 On 12 March 2008 the matter was referred to the Missing Persons Unit, Queensland (**the Queensland MPU**). Senior Constable Halloran spoke with Elizabeth Harris at the Queensland MPU and advised that Lionel was missing in New South Wales and that there had been reported sightings of him in the Brisbane area. Senior Constable Halloran was advised that a warning would be placed on the relevant Queensland computer system identifying Lionel as a missing person in New South Wales.
- 11.32 On 13 March 2008, Senior Constable Mandy Gayle of the MPU made further enquiries with Centrelink, the New South Wales Electoral Roll, a number of financial institutions.

Further investigations

- 11.33 On 2 April 2008, Senior Constable Williams from the MPU advised Senior Constable Smith that a search conducted of all unidentified human remains cases in New South Wales had returned no information consistent with Lionel's details.
- 11.34 On 20 June 2008, Senior Constable Gayle contacted Queensland Mental Health Branch to enquire if Lionel had engaged with any mental health facilities in Queensland since he had been reported as missing.
- 11.35 On 4 July 2008 Senior Constable Williams contacted Senior Constable Gayle to advise that a bailiff from Townsville Local Court had been tasked with locating Lionel, as he was the named beneficiary from a deceased estate in excess of \$45,000. This sum has never been claimed.
- 11.36 On 16 July 2008, police conducted further enquiries with the Department of Immigration, the MPU and Lionel's brother-in-law, Neville Oswald. These enquiries confirmed that after returning from England, Lionel had not departed Australia again. Further, Neville Oswald provided permission for a photo of Lionel to be released to the media as part of Missing Persons Week.
- 11.37 At the time of these enquiries, police did not consider that Lionel was deceased or that a P79B form was required. Instead, it was believed that Lionel was in or around the Brisbane area.
- 11.38 On 21 October 2008 Sergeant Fay Ambrose contacted Senior Constable Gayle to advise that Lionel's matter had been allocated to a new case officer at Botany Bay who were seeking guidance regarding next steps. Sergeant Ambrose suggested conducting checks with Centrelink and the New South Wales Electoral Roll, as well as enquiring whether Lionel had activated a mobile service with any of the major telecommunications carriers. Further, it was confirmed that Lionel had not been admitted to any mental health hospitals in Queensland since July 2007.
- 11.39 Also on 21 October 2008, Constable Smith contacted several homeless shelters in Brisbane. The two main shelters, the Salvation Army in Fortitude Valley and Aus Care in South Brisbane, advised that they had previously been aware of Lionel but had not seen him since July 2007. Further their records indicated that Lionel had not attended any homeless shelters under their control in the previous three months.

Contact made with Brian Hull of the Red Cross

- 11.40 On 5 November 2008 James Murray from the National Missing Persons Coordination Centre sent an email to Senior Constable Gayle advising that he had spoken to Brian Hull of the Red Cross. Mr Hull was a support worker and caseworker for the Salvation Army at the time and had worked at the Pindari Shelter between 2006 and 2007. Mr Hull was aware that Lionel was a tenant at the Pindari Shelter between around June and July 2007.
- 11.41 The COPS record describes this event in the following way:

Information received from James MURRAY, National Missing Persons Unit (AFP). The information was obtained from a Mr Brian HULL (Red Cross) who stated that he spoke with [Lionel] approx 2 weeks ago at Pindari Men's Hostel [...] when [Lionel] came to collect some mail. Mr HULL worked with [Lionel] previously and was aware that he was listed as a Missing Person. On the occasion two weeks ago when he saw [Lionel], Mr HULL said "Hi Lionel" and [Lionel] replied "Hi". He stated he may also have been seen by Major McLeod (Salvation Army) [...] Mr HULL suggested that [Lionel] has been in the area for some months.

- 11.42 On the same day, Senior Constable Gayle advised Senior Constable Smith that she had not contacted Lionel's family regarding the reported sighting as she did not want to raise their hopes. Senior Constable Gayle indicated that she planned to submit further bank and Centrelink checks in the same month. According to a case report, Senior Constable Amanda Weiling of the MPU spoke with Mr Hull on 6 November 2008.
- 11.43 On 3 February 2009, NSW Police attempted to transfer the case to the Queensland MPU. In March 2009 Senior Constable Gayle made further enquiries with Centrelink, Medicare and a number of financial institutions. A note on the case report indicated that Senior Constable Gayle is *"going through the process of having the case filmed for the TV show or at least having photo shown"*.
- 11.44 In June 2009 Senior Constable Gayle placed a National Missing Person Request for Information, and requested that warnings be put in place across all States and Territories.
- 11.45 According to a COPS entry, Mr Hull was contacted on 4 June 2009 and advised that the last time he saw Lionel was at the Pindari Shelter when Lionel appeared to be *"delusional"*. Mr Hull reportedly encouraged Lionel to go to the Fortitude Valley Mental Health Unit. Mr Hull indicated that he was no longer working for the Red Cross but suggested that police contact Major Russell McLeod, who was working at the Pindari Shelter at the time.
- 11.46 On same day, Major McLeod was contacted and advised that Lionel was not at the Pindari Shelter. However, there was a note on Lionel's file to contact police if he returned.
- 11.47 Senior Constable Gayle informed Senior Constable Smith that Neville Oswald had expressed the belief that Lionel was sighted in Brisbane shortly before Christmas 2008. Senior Constable Gayle contacted the Queensland MPU and advised that the case was likely to be referred to them in the near future.

Lionel is listed as located

- 11.48 On 13 June 2009 NSW Police discussed the matter and determined that Lionel should be listed as located. This decision was based on discussions with Mr Hull, reported sightings of Lionel in the Brisbane area, and the fact that a bank account in Lionel's name had been opened at the ANZ branch in Fortitude Valley on 4 December 2007 (after Lionel had been reported as missing). Detective Senior Constable (now Detective Sergeant) Luke Robertson, who became OIC of the matter in 2018, gave evidence that it was generally believed that Lionel was living on the streets in Queensland did not want to be located. Police advised Neville Oswald that if he still wanted Lionel

to be listed as missing then he ought to contact Queensland police. Accordingly, the case was closed in New South Wales.

- 11.49 On 29 July 2009 Senior Constable Vince Ahern (Brisbane City Station) advised Senior Constable Gayle that Lionel was an inpatient at Royal Brisbane Hospital (Mental Health) between 6 and 27 July 2007. Lionel reportedly told hospital staff that he was going to Sydney in August 2007, and an appointment had been made for him at a NSW hospital. There were no further records of Lionel attending Royal Brisbane Hospital after 27 July 2007.

Investigation between 2018 and 2019

- 11.50 On 20 April 2018 Lynette Oswald contacted the MPU seeking an update on investigation. Ms Oswald was informed that the case had been closed in 2009, which caused her considerable upset. This is because the alleged sighting of Lionel in Queensland had never been confirmed, and that Lionel's family had never been informed that the case would be closed. Lynette subsequently attended Albury police station and requested that the investigation be reopened for review.
- 11.51 On 24 April 2018 a meeting was held at Albury police station to discuss next steps in locating Lionel. Senior Constable Emma-Jane Musgrave was tasked with forwarding the relevant COPS event to Queensland police via iASK. It was intended that Queensland police would review the event for possible transfer of the case to Queensland.
- 11.52 On 27 April 2018 the Queensland MPU sent an email to NSW Police advising that the request to transfer Lionel's case had been rejected. This was based on the fact that staff at the Pindari Shelter had advised that Lionel was recorded on their system but the last engagement with him occurred on 1 July 2007, not 1 July 2008 as had been assumed by NSW Police.

Case returned to Botany Bay

- 11.53 On 23 May 2018, the case was returned to Botany Bay police for two reasons: first, Lionel had originally been reported as missing at Botany Bay police station; second, Lionel had left his possessions at Mr Butterworth's home in Rosebery, which was located within Botany Bay LAC.
- 11.54 Detective Senior Constable Robertson of Mascot detectives subsequently commenced a review of the file. He noted that all case file and brief items had been destroyed in 2013 due to Lionel having been listed as a located person. At the time, there was a requirement to retain briefs in relation to located persons for a period of two years. It was also noted that case files and brief items were not electronically scanned before they were destroyed. It should be noted that since mid-2020, all brief items are stored electronically before a matter is closed.
- 11.55 The destruction of relevant records meant that Detective Senior Constable Robertson had no information available to him apart from the COPS case report and event report. It was apparent from this information that no DNA sample had ever been obtained from Lionel's family members.

11.56 Detective Senior Constable Robertson subsequently completed signs of life checks with the Department of Home Affairs, the BDM registry, Centrelink, a number of financial institutions and police services in all States and Territories. These enquiries revealed the following :

- (a) Lionel had last received a Centrelink payment on 13 August 2007 and attended the Darlinghurst office on 24 August 2007;
- (b) The ANZ account in Lionel's name at the Fortitude Valley branch may have been re-opened by the bank in error, and that NSW Police had never conducted any follow-up to confirm whether there was ongoing activity on the ANZ account;
- (c) The last confirmed transaction by Lionel had occurred in 2007 at Haymarket;
- (d) There was no active account in Lionel's name with Westpac, CBA and NAB since he had been reported as missing.

11.57 Detective Senior Constable Robertson also contacted Mr Woodhall regarding his reported sighting of Lionel in South Brisbane in late 2007 or early 2008. Mr Woodhall indicated that the sighting had never been confirmed and that he simply believed that he may have seen Lionel and subsequently informed his mother of this possible sighting. Detective Senior Constable Robertson found no electronic record indicating that any NSW police officer had ever spoken directly with Mr Woodhall regarding the alleged sighting.

Forensic investigation

11.58 On 18 June 2018 NSW Police placed a request for an interstate DNA profile to be obtained from Henry Daveson (Lionel's half-brother) and Frank Daveson (Lionel's paternal uncle). A sample was subsequently obtained from Henry Daveson and transferred to FASS. On 26 October 2008 it was confirmed that, following the profile of Henry Daveson being searched against all profiles in the unknown deceased category of the New South Wales DNA database, no biological sibling relationship was identified.

11.59 In September 2018 DNA samples were obtained from Frank Daveson and Henry Daveson. A comparison search using these samples against the NSWPF unidentified human remains database yielded no results. In March 2019, permission was sought for a search to be performed on an Australia wide database. Detective Senior Constable Robertson wrote that "*the search is currently being conducted and there is no timeframe at this stage of when the search will be completed*". The delay was reportedly due to the system being "*new and complicated to operate*".

11.60 On 11 December 2018 Detective Senior Constable Robertson submitted a P79B report to the Coroner. On 13 December 2018 an order seeking production of relevant records was sent to the Kiloh Centre at Prince of Wales Hospital and to Royal Brisbane Hospital.

Contact with Major Gary Masters

11.61 On 6 February 2019 Detective Senior Constable Robertson contacted Major Gary Masters of the Salvation Army regarding Lionel's stay at the Pindari Shelter. Major Masters confirmed that Lionel only resided at Pindari between 2 June 2007 and 5 July 2007.

11.62 On 28 February 2019 Detective Senior Constable Robertson contacted Mr Hull, who subsequently provided a statement. Mr Hull had a vague recollection that Lionel did not seem very well whilst at the Pindari Shelter, that he did not mix well with the other residents, and that his mood and demeanour changed on a daily basis. Mr Hull recalled a Lionel as being "*a loner*" and "*very delusional*", and that he left without notice. Further, Mr Hull had no recollection of ever being approached by police regarding Lionel having been reported as missing.

11.63 Mr Hull also confirmed that he did not work at the Pindari Shelter in 2008, so he could not have sighted Lionel at that time. Further, Mr Hull stated the following in relation to the report of Lionel having been sighted at the Pindari Shelter in October 2008:

I believe that whoever made this report got the year wrong and it was around 2007 when Lionel was actually a resident at the Hostel. Detective Robertson is the only police officer that has made enquiries with me in relation to my alleged sighting in 2008.

11.64 On 11 March 2019, Senior Constable Danielle Woodroffe of the MPU confirmed that a search of the unidentified human remains database indicated that three sets of remains could not be excluded as being that of Lionel.

11.65 Following his investigations, Detective Senior Constable Robertson expressed the view (as at March 2019) that Lionel is deceased and intentionally caused his own death in the vicinity of The Gap within days of being sighted in the area at 11:00pm on 23 August 2007. Detective Senior Constable Robertson also expressed the view that Lionel had been experiencing adverse mental health after being non-compliant with his medications and that he had previously attempted self-harm on two occasions (by jumping out of a moving car in Queensland, and attempting to light fire to his hands and fingers which resulted in admission to hospital). Finally, Detective Senior Constable Robertson expressed the view that Lionel's remains have not been located as he "*may have been swept out to sea*".

12. The statutory requirements of the Act regarding Lionel Daveson

12.1 Since August 2007, a period of some 14 years, no evidence has been found that Lionel is still alive. The typical signs of life checks performed during this period have all returned negative results. Further, the evidence establishes that Lionel had a significant mental health history extending back to eight years before when he was last seen alive, and that this mental health history involved admissions to hospital associated with suicidal ideation. Finally, there is no evidence to explain why Lionel has not been seen alive since August 2007, or how he may have supported himself since then if he were still alive. Therefore, the conclusion that must be reached on the available evidence is that Lionel is now deceased.

12.2 Due to the limited available evidence, the only conclusion that can be reached as to the date of Lionel's death, is that he died on or sometime after 24 August 2007. In relation to the manner of Lionel's death, having regard to the evidence above as to Lionel's mental health history, there is a sufficient evidentiary basis to conclude that Lionel intentionally inflicted his own death. This is supported by two further pieces of evidence: Lionel having been seen in the vicinity of The Gap (an area known to be associated with intentional act of self-harm by persons) for no legitimate reason on 23 August 2007; and the email sent from Lionel's account to Mr Butterworth the following day which contained content suggestive of suicidal intent. Whilst this evidence also raises the possibility that the cause of Lionel's death was injuries sustained as a result of intentionally jumping from a height, in the absence of Lionel's remains being found and a postmortem examination being conducted, it is not possible to reach a conclusion regarding the cause of death. Similarly, it is also not possible to reach a conclusion as to the place of Lionel's death.

13. The adequacy of the police investigation in relation to Lionel as a missing person

13.1 Much like the case of Ursula Barwick, although to a lesser degree, the investigation into the report of Lionel having gone missing was inadequate and again demonstrated a number of systemic deficiencies associated with missing person investigations conducted by the NSWPF. These inadequacies may be summarised as follows:

- (a) First, police did not attribute sufficient significance to the sighting of Lionel on 23 August 2007 in the sense that Lionel was not identified as a vulnerable person at risk, and no investigation was conducted regarding the immediate circumstances which led up to Lionel having been seen that evening.
- (b) Second, despite contact having been made with the MPU, no attempt was made to seek or obtain Lionel's personal belongings, and it appears that no advice was given to obtain a suitable forensic sample for comparison purposes. Instead, this was considered to be an optional investigative step.
- (c) Third, no search was ever conducted of the area around The Gap in an attempt to locate Lionel, despite awareness of the nature of his interaction with police on 23 August 2007.
- (d) Fourth, and most significantly, it was incorrectly determined in June 2009 that Lionel had been located in Queensland, resulting in the closure of his missing person file. This determination

occurred in circumstances where police did not seek to confirm any of the following: the reported sightings of him in the Brisbane area, whether a bank account opened in Lionel's name four months after he was reported missing was legitimate, and any aspect of the reported sighting of Lionel by Mr Hull. It should be noted that if any enquiry had been made of Mr Hull in 2008 or 2009, of the kind made by Detective Senior Constable Robertson in 2019, it would have been immediately apparent that Lionel could not have been listed as located.

- (e) Fifth, and also most significantly, when the incorrect determination was made for Lionel's case to be closed, no contact was made with Lionel's family to advise them that this had occurred. Distressingly, Lynette Oswald only discovered this fact herself when she made contact with the MPU nine years later. In the intervening period, Lionel's family had operated under the mistaken assumption that the missing person investigation regarding Lionel was still active.

14. Factual background in relation to Christof Meier

Personal history

- 14.1 Christof Meier was born on 26 February 1972 to his parents Rudolf and Margaretha Meier, who reside in New Zealand.
- 14.2 Christof later travelled to Australia, and on 27 March 2002 Christof and a friend, Ben Garrett, travelled from Sydney towards Byron Bay. Their plan was to stay with friends at different addresses during their drive North along the coast, eventually planning to return to Sydney on 2 April 2002.
- 14.3 At around 11:00am on 1 April 2002, Christof and Ben left Goonengerry and drove towards Byron Bay, later arriving at the home of a friend, Nick Bladon, at around 11:30am. After being joined by Nick's flatmate, Jess Wagner, the group headed into town for lunch, before driving to Wategos Beach and then Broken Head, arriving at around 12:45pm, with the intention of going surfing.
- 14.4 Although Christof did not have his own surfboard, he anticipated borrowing one from his friends at some stage. The group went to the beach near the southern corner of the headland and Christof's friends paddled out into the water on their surfboards. Meanwhile, Christof went into the ocean a little further north, where a group of swimmers was in the area. Christof was reportedly in the water for about 45 minutes before he was seen to emerge from the water and sunbake on the sand.

Christof goes missing

- 14.5 Whilst Ben was surfing, his attention was drawn to a number of people on the beach who were screaming that someone was in the water and in trouble. Nick also recalled a man shouting that someone was in trouble and grabbing Nick's surfboard from him and running towards the surf with it. Ben, together with others on the beach, used his surfboard to paddle out through the waves to find the struggling swimmer. Nick began to swim to the area where he believed he had seen a person go under the surface. Ben reported that the visibility was very low and that he was unable to see anything underwater. After about 10 minutes of diving, Ben paddled back to the shore.
- 14.6 After being unable to find Christof on the beach, Ben asked Nick and Jess if they had seen him, with both indicating that they had not. The group searched the beach, the caravan park and checked the car but Christof was nowhere to be found. Ben subsequently checked the beach and found Christof's clothing and car keys where he had left them earlier. At this point, Ben formed the view that something was wrong as Christof would not have left his belongings on the beach if he went anywhere other than in the water.
- 14.7 Mark Thomson, a local photographer, was standing and talking with another local resident, Nigel Skyring, at the top of a track overlooking the beach. At the time, Mr Thomson recalled that there was a strong south east wind blowing and considerable swell in the ocean. Mr Thomson was also aware that the beach in this area had been cut down by several feet due to stormwater run-off from a pipe next to a boat ramp. This had created a deep trench in the ocean with either side of the trench only waist high. Whilst at the top of the track, Mr Skyring pointed to the beach in front of the storm water pipe and asked Mr Thomson if he thought that a swimmer was in trouble. Mr Thomson

saw a person in the water, some distance from the beach, swimming alone with no one else around him. Mr Thomson saw the person swimming towards the beach with what appeared to be a backstroke style and heard a clear, “*Help!*” come from the direction of the swimmer.

- 14.8 Mr Thomson instructed Mr Skyring to head down to the beach to assist the swimmer, whilst he stayed at the top of the track, with a good view of the beach and able to direct others to search the area. Mr Skyring grabbed a surfboard and ran down to the beach whilst Mr Thomson yelled at other people on the beach to help. As he was doing so, Mr Thomson saw a wave roll over the swimmer’s head, with the swimmer subsequent disappearing and failing to resurface.
- 14.9 Police and rescue services were subsequently notified. Upon attending the beach, police were informed that Christof had still not been seen for some time and that he had left his personal belongings on the beach which was highly unusual. At the time it was noted that surf conditions were rough and that there was a strong rip running to the north in the area. Despite extensive searches by police and rescue personnel, Christof could not be located. A P79A Report of Death to the Coroner was later submitted on 1 April 2002.

2002 Inquest

- 14.10 On 11 July 2002 Coroner Fleming held an inquest at Byron Bay Court into Christof’s suspected death. The Coroner concluded that Christof was deceased, and that he had died on 1 April 2002 at Broken Head beach as a result of “*drowning while swimming in the surf at the beach*”.

Discovery of tibia bone on Cabarita Beach

- 14.11 On 13 April 2006, Bob Norris, a British resident on holiday in Australia, noticed a large bone wedged in the rocks at Cabarita Beach. Paul Bateman, Mr Norris’ travelling companion, showed the bone to his father (a paramedic) who expressed the belief that the bone was human. Mr Bateman subsequently took the bone to Kingscliff police station and made a report. The bone was later transported to Tweed Heads Hospital by NSW Police where it was confirmed to be a human tibia bone from an adult of average height.
- 14.12 On 14 April 2006, Detective Senior Constable Gary Sheehan was informed of the discovery of the tibia bone, and suspected that it may be related to two earlier missing person reports:
- (a) John Woodman and Chris Demmrich, two pilots who were reported as missing after their aircraft could not be located on radar screens approximately 16 km offshore from Byron Bay on 27 January 2004;
 - (b) Will Banks (pilot) and his son, Joel Banks, who were on board an ultralight aircraft when it crashed into the ocean off Tyagarah on 27 October 2005, with their bodies not being immediately located.

Initial forensic examination

- 14.13 On 18 April 2006, Detective Senior Constable Gary Sheehan sent the tibia bone to the DOFM in Newcastle, with the expectation that it may be matched to one of the four missing persons referred to above. He also contacted the MPU and obtained a list of 12 other persons that had been reported as missing in the Far North coast area between 1 April 2005 and 19 April 2006.
- 14.14 On 8 May 2006, Detective Senior Constable Sheehan contacted the DOFM and requested that the tibia bone be forwarded to the Department of Analytic Laboratories (**DAL**) for DNA analysis. On 31 May 2006, Detective Senior Constable Sheehan was advised by DAL that DNA analysis of the tibia bone had commenced with a view to extracting a DNA profile for comparison to other missing person profiles. On 26 July 2006 DAL confirmed that the tibia bone belonged to a male person.
- 14.15 On 1 September 2006 and 9 March 2007 DAL advised Detective Senior Constable Sheehan that a DNA profile had not been extracted from the tibia bone, but attempts were continuing. Eventually on 29 March 2007 DAL confirmed that a DNA profile could not be extracted. However, DAL also advised that a new process of DNA extraction was planned to be used in relation to the tibia bone in subsequent months. On 9 May 2007 Detective Senior Constable Sheehan was advised that extraction of a DNA profile had still been unsuccessful, although the new extraction process was still in progress.
- 14.16 On 4 June 2007, Detective Senior Constable Sheehan decided to suspend the investigation due to the inability of DAL to extract a DNA profile from the tibia bone.

Further forensic examination

- 14.17 On 12 December 2008 Constable Diana Makhoul of the MPU advised Detective Senior Constable Sheehan that the MPU had taken possession of the tibia bone. Constable Makhoul recommended having Dr Denise Donlon, a forensic anthropologist, examine the tibia bone to decide whether it should be sent to an overseas laboratory for further forensic testing. Detective Senior Constable Sheehan obtained approval to make such a request, and the investigation was again suspended pending the outcome of this request.
- 14.18 On 27 March 2009 an officer from the MPU retrieved the fragment of tibia bone from the DOFM in Sydney. The bone was marked up as an exhibit for transfer to Dallas, USA for mitochondrial DNA testing on 4 May 2009.

Detective Senior Constable Sheehan becomes aware of Christof Meier

- 14.19 On 9 July 2009 Detective Senior Constable Sheehan became aware of the police report regarding Christof being reported as a missing person. This information was added to the investigation regarding the tibia bone, but both matters remained suspended.
- 14.20 On 13 April 2010 Detective Senior Constable Sheehan contacted the MPU seeking an update in relation to the testing of the tibia bone. He was informed that a decision had been made not to

send a sample of the bone to the USA for testing because no maternal sample was available for comparison, and that the cost of testing was high.

- 14.21 Detective Senior Constable Sheehan subsequently wrote to the Assistant Coroner at Tweed heads to confirm that the sample had not been sent “*due to financial limitations*” and that the matter would remain suspended until a positive result was received in relation to DNA analysis.

2010 Inquest

- 14.22 On 13 July 2010, Coroner Linden held an inquest at Tweed Heads court in relation to the tibia bone. The Coroner found that the evidence did not allow for any determination to be made as to the identity of the person, or the cause or manner of death. Ultimately, the Coroner also concluded:

DNA has not been able to be extracted from the bone in Australia and because there is no suggestion as to who the bone belongs to, DNA testing in the USA would not further the matter. The bone is to be retained by [DAL] in the events that other forms of testing become available.

Forensic and DNA samples taken from Christof's parents

- 14.23 On 19 October 2010 forensic tests were conducted involving Christof's parents in New Zealand at the request of the MPU.
- 14.24 On 20 and 21 January 2011, buccal samples from Christof's parents were obtained via New Zealand police. Crucially, the DNA profiles obtained were categorised as “Volunteer (Limited Purpose)” samples which meant that they could not be compared against the Unknown Deceased Person index for legal reasons. This issue is discussed further below.

DNA profile received from Orchid Cellmark

- 14.25 On 3 January 2014 a mitochondrial DNA profile for Christof was received from Orchid Cellmark. The MPU noted that the profile could be stored for future comparisons with unidentified human remains, and was placed on the Unknown Deceased Person index.
- 14.26 On 16 July 2015, FASS attempted to match this profile against unidentified human remains located at Tallow Beach, Byron Bay. It was subsequently determined that the Tallow Beach remains could not have originated from a maternal relative of Christof's mother.

DNA profile placed on Unknown Deceased Person index

- 14.27 Over the course of 2017, further analysis was conducted on the tibia bone by FASS. The development of new technology enabled a profile to be extracted, and this profile was placed on the Unknown Deceased Person index.
- 14.28 On 22 October 2018, the DNA profiles for Christof's parents were re-categorised to a different index of the DNA database called “Volunteer MPU”. This transfer allowed their profiles to be compared to the Unknown Deceased Person index.

14.29 On 3 April 2019, FASS confirmed that the sample obtained from the tibia bone was “*34 billion times more likely*” to have originated from the biological child of Rudolph and Margaretha Meier than to have originated from an unknown individual in the Australian population.

14.30 After being informed of the positive identification, Detective Senior Constable Sheehan was unable to find any information that indicated Christof’s parents had been notified of the DNA match. Detective Senior Constable Sheehan also gave evidence that for a period of 10 years he was unaware that other personnel within NSW Police had taken any investigative role in relation to identifying the origins of the tibia bone. Following suspension of the investigation (when his request to have the tibia bone sent to the USA was declined), Detective Senior Constable Sheehan described his reaction when he received notification of the positive DNA match in April 2019 in this way:

The suspension of the case doesn’t mean that I can’t go back to it but I would only go back to it if there was a reason to do so. I didn’t do that and I have no clue that this was going on in the background. I was just getting on with other jobs that I had and it came as a complete surprise to me back in April 2019 that it had occurred.

14.31 Further, Detective Senior Constable Sheehan said in the 10 years leading up to April 2019 he would have expected someone from the MPU to have notified him as to the steps that were being taken regarding forensic examination of the tibia bone. Overall, Detective Senior Constable Sheehan expressed this view:

I just think that the Missing Persons Unit was quite ad hoc for a number of years in the way they went about things and especially in speaking to people like myself who are at the coalface trying to get some assistance or some results.

14.32 On 15 April 2019 Detective Senior Constable Sheehan sent a letter to the Commander, Forensic Evidence and Technical Services (**FETS**) Command which noted the following:

After receiving the Expert Certificate which identified the tibia bone as that of Mr Meier, I have not found anything that suggests that the parents of Mr Meier have been notified of his tibia bone being located and subsequently identified as belonging to their son, Christof Meier. I have not made any attempt to contact them.

This is a matter that has been in the hands of NSW Police for 17 years, and honestly one of a highly sensitive nature, given that it involves the death of Mr Christof Meier, a New Zealand national who was visiting Byron Bay at the time of his death.

I believe that the notification of the parents of Mr Meier should be made at a Senior level and it is for this reason that I am preparing this report.

14.33 On 24 July 2019, Deputy State Coroner Ryan determined, on the balance of probabilities, that the tibia bone belongs to Christof.

15. The statutory requirements of the Act regarding Christof Meier

- 15.1 The available evidence establishes that Christof is now deceased, and that the tibia bone located on 13 April 2006 belongs to Christof. Further, having regard to the factual circumstances surrounding the events of 1 April 2002, and the determination made at the July 2002 inquest, the conclusion that must be reached now is that Christof died on 1 April 2002 at Broken Head beach, with the cause of death being drowning due to misadventure.

16. The adequacy of the police investigation in relation to Christof as a missing person

- 16.1 The NSWPF investigation into the circumstances of Christof having been reported missing highlights certain procedural limitations associated with forensic, in particular DNA, examination used as part of missing person investigations. These limitations have compromised the efficacy and timeliness of such investigations, and are discussed in greater detail below.
- 16.2 Further, and more particularly to Christof's case, the investigation has also highlighted deficiencies in communication between the MPU and LACs. Despite the diligent attempts of Detective Senior Constable Sheehan to progress, from a forensic perspective, the suspected connection between the discovery of the tibia bone in 2006 and the circumstances in which Christof went missing four years earlier, it is evident that there was a significant communication gap between himself and the MPU. Indeed, as Detective Senior Constable Sheehan himself describes it, for a period of 10 years he was simply not notified of any of the investigative steps being taken in this regard. Even more significantly, during the same period of time, Christof's parents were not made aware of any active investigation being conducted.

17. Overview of the New South Wales Missing Person Unit

- 17.1 The MPU was formed in the early 1930s and originally operated under the name, “*Missing Friends Bureau*”. Until 1949, enquiries were carried out by two police officers attached to No. 20 Division, Police Headquarters. In 1947, the unit was renamed the “*Missing Persons Bureau*”. In 1974, the unit was again renamed the ‘*Missing Persons Section*’. In 1987, the section was relabelled the ‘*Missing Persons Unit*’ and was placed under the control of the Technical Support Group.
- 17.2 In 1997, the unit was realigned with the Information & Intelligence Centre and again in 2002 with the Operational Information Agency (OIA) within the Operation Communications & Information Command (OCIC). The purpose of the OIA is to deliver high quality operational information and services to support investigations and other operational decisions and purposes. It sits under the command of a Superintendent.
- 17.3 From 1997, the MPU was required to perform the following functions:
- (a) review, record and research all information in relation to missing persons (in 2008, for instance, this was approximately 9000 missing persons cases per year);
 - (b) maintain NSW Police Force policy and procedures on missing persons;
 - (c) coordinate the DNA Collection Program for missing persons;
 - (d) coordinate enquiries for interstate and international missing person cases and refer them to the LACs where appropriate;
 - (e) coordinate community awareness through internal and external media publications and promote National Missing Persons Week;
 - (f) provide education and training packages;
 - (g) provide lectures at police training days and other police courses;
 - (h) maintain the missing persons intranet application; and
 - (i) provide quality assurance in respect of over 100 unidentified bodies cases per year.
- 17.4 At the time that it was aligned with the OIA (that is, from 1997 to 2019), the MPU was under the command of an Inspector, who also had management responsibility for the OIA 24-hour service centre. During this period, the MPU was divided into two teams, known as the Investigation Support Team and the Operations Support Team. Each team was under the supervision and direction of a Sergeant.

Operations Support Team

17.5 The Operations Support Team was required to review all missing persons reports and provide quality assurance, coordination, and support to missing persons investigations. The primary functions of the Operations Support Team were as follows:

- (a) First, the Operations Support Team was required to provide specialist support and advice to LACs, which were responsible for the investigation of missing persons cases. Notably, MPU personnel were not required to proactively interrogate the COPS system to see how specific missing persons investigations were progressing. Further, there were no key performance indicators in place to ensure LACs were advancing investigations in a timely manner, or quarterly or six-monthly reviews conducted for the same purpose.
- (b) Second, the Operational Support Team completed signs of life checks, including checks with financial institutions, Centrelink, immigration, and interstate police checks.
- (c) Third, the Operational Support Team performed a quality assurance role by ensuring that the COPS data - as entered by the OIC at the relevant LAC - was complete. This data was then entered into the Missing Persons Database. A paper-based risk identification checklist was completed for each report to categorise it as low, medium, or high risk.

Senior Constable Williams, who was employed in the MPU from June 2004 until December 2016, indicated that each day data in connection to persons reported as missing to LACS was downloaded from COPS and uploaded to the MPU's standalone databases. Colloquially, staff referred to this process as the "*daily download*".

Investigation Support Team

17.6 The Investigation Support Team focused on identifying unidentified bodies and human remains (UBHR) and matching those remains to persons listed as missing. This team also maintained the records in relation to historical outstanding cases and provided oversight and management in connection to records concerning the long-term missing person (LTMP) cases.

Databases

17.7 The MPU has historically used several databases that are not integrated with the NSWPF COPS mainframe. The most relevant of these databases are described below.

NSWPF Missing Persons Database

17.8 The NSWPF Missing Persons Database went live to field in 2000. It includes information relating to missing persons cases dating back to 1967. The database was developed by the MPU and created by the NSWPF Digital Technology & Innovation Command (formerly Information Technology Services).

17.9 Historically, there has been three basic levels of access to the database including the following:

- (a) Field Officer access allowed the officer to search descriptions of located or missing persons; identify outstanding cases in the LAC and region; and identify cases with media publicity, DNA, or dental records available.
- (b) MPU Officer access was available only to MPU staff. It allowed them to update missing person cases and enter DNA data.
- (c) MPU Super User access was for Team Leaders of the MPU only. Super Users were able to conduct DNA searches.

17.10 The Missing Persons Database is currently the primary tool used by the NSWPF to manage information relating to missing persons and UBHR investigations. It is presently relied upon as the “*source of truth*” for missing persons statistical data. It has recently been upgraded and now works in conjunction with the e@gle.i management system.

17.11 Until recently, all information was manually entered into the Missing Persons Database by MPU personnel. Upgrades have since been made to both COPS and the Missing Persons Database so that the systems can communicate, thus reducing duplication of data entry. These upgrades have facilitated the anticipated introduction of a mandatory risk assessment tool into the COPS system. The database has a DNA search function which allows trained scientific staff to carry out a comparison on mitochondrial DNA samples obtained from the missing persons next of kin and unidentified bodies. It may be accessed at any time via the NSW Police Intranet and should be able to be migrated across to the new IPOS system when that is eventually launched.

Unidentified Bodies and Remains Database

17.12 The Unidentified Bodies and Remains Database is a stand-alone database which records known details of unidentified bodies and human remains. This includes physical description, age range, DNA profile, and other characteristics. The information in the database is manually entered from the case files to enable unit staff to cross reference the details of missing persons against unidentified bodies or remains with the objective of searching for a match. This database has been notoriously unstable.

17.13 Detective Sergeant Kylie Whiting gave evidence that two unsuccessful attempts were made in 2015 to 2016 to transfer the data within this database to the Missing Persons Database via FilePro. Both migration attempts were unsuccessful. The Unidentified Bodies and Remains Database does not currently have the capacity to record all the desired information.

NSW DNA Database

17.14 The Forensic Biology/DNA Laboratory at FASS receives exhibits (or sub-samples collected from exhibits) for both criminal and coronial cases from the NSWPF, examines the exhibits (if the complete exhibit is submitted) and collects a biological sample for DNA testing, conducts autosomal, Y chromosome and/or mitochondrial DNA testing, interprets the DNA results and

provides DNA test results back to the NSWPF electronically via the Exhibits Forensics Information and Miscellaneous Property System (**EFIMPS**).

- 17.15 The NSWPF may request an Expert Certificate be prepared by the reporting scientist if the case proceeds to court and they may subsequently be required to provide expert evidence during criminal or coronial court proceedings. The Forensic Biology/DNA Laboratory is also responsible for uploading DNA profiles to the NSW DNA Database, NCIDD and NCIDD-Integrated Forensic Analysis (**NIFA**) and reporting any DNA links to NSWPF.

National Missing Persons & Victim Services Database (previously PlassData)

- 17.16 The National Missing Persons & Victim Services Database (**NMPVS**) is a tool that was originally developed and used nationally for Disaster Victim Identification (**DVI**). It was developed by the Australian Criminal Intelligence Commission (**ACIC**), which still owns and operates this system in addition to the National Automated Fingerprint Identification System (**NAFIS**), the National Criminal Investigation DNA Database (**NCIDD**), and the NCIDD-Integrated Forensic Analysis (**NIFA**) Database. NIFA was deployed in 2018 to enable enhanced kinship matching, familial searching, and advanced direct matching.
- 17.17 The NMPVS now sits within a new National DNA Program for Unidentified and Missing Persons. This program, whilst housed within the AFP, is federally funded by proceeds of crime. Apart from the DVI function, the NMPVS provides police and other law enforcement agencies with the ability to undertake national searches on LTMP cases, unidentified human remains, and disaster victim identification. This function was previously limited due to the use of localised systems in each jurisdiction.
- 17.18 For missing person investigations, information must be entered into NMPVS by personnel from the former MPU. This is significant in considering how the NSWPF has engaged in recent months with the NMPVS.
- 17.19 The National DNA Program has requested that states audit their current holdings (in relation to both LTMP and UBHR data) and then upload this data to the NMPVS. On 18 September 2020, Associate Professor Ward was advised that the NSW LTMP audit was 95% complete and that there was a total of 754 LTMP cases in NSW. The report advised that of the 754 cases, 702 of these were recorded on NMPVS. However, many of these entries were “shells” only, that is, they contained little useful information for matching purposes. Detective Inspector Glen Browne, the Manager of the new Missing Persons Registry (discussed further below), acknowledged that there was still a substantial amount of work to do to upgrade NMPVS records, which had been ongoing since September 2020. He noted that there was a lot of information that was not collected, and that elements of the project will progress once cases are sent back to LACs.

National Missing Persons Database

- 17.20 The National Missing Persons database is owned and managed by the National Missing Persons Coordination Centre (**NMPCC**) within the AFP. This database is intended to be a national register of all LTMP cases within Australia. To add a person to the national database, MPU (now MPR)

personnel fill out the relevant form (including a photo), taking all the relevant data from the NSWPF Missing Persons Database. That document is then emailed to the NMPCC for inclusion in their database.

Safely Home Database

17.21 The Safely Home Program was a joint initiative between the NSWPF and Dementia Australia. This program allowed people to register their loved one suffering dementia or other related conditions. Registered persons were provided with a metal bracelet that contained an identification number. If a registered person is located wandering, the personal identification number allows police to search that number in the Safely Home database with a view to reuniting them with their family or care facility in a timely manner. When people were registered with the Safely Home Program, MPU (now MPR) personnel were required to manually enter data into that system.

17.22 Dementia Australia recently withdrew from the Safely Home Program, citing funding issues. The NSWPF still operates the Safely Home database to provide the service for all people previously registered, although no new registrations are being taken at this time.

Other Functions – DNA Collection

17.23 In or around 2006, the MPU introduced the DNA Collection Program. The aim of this program was to collect DNA samples from the relatives of missing persons to allow matching through DNA where circumstantial evidence was absent. Around this time, it was not usual practice for the belongings of missing persons to be obtained by police shortly after a person had been reported missing.

17.24 Initially, mitochondrial DNA samples were not able to be managed by DOFM (as FASS was until 2018). This meant that mitochondrial DNA profiles were stored on the standalone Missing Persons Database maintained by the MPU until DOFM developed the capability to store these in 2012. There was no formal information-sharing agreement between the MPU and DOFM at that time. Karen Karakaya, a former police officer who worked in the MPU between about 2008 and 2006 described the informal nature of the information sharing which occurred at the time:

So myself at the Missing Persons Unit had a relationship with some of the staff at the then Department of Forensic Medicine and so there was a microbiologist who would perform the mitochondrial DNA analysis for us and also the sergeants assisting the Coroner at the time and the manager of the Department of Forensic Medicine or the mortuary area, so it was as a result of myself building those relationships, trying to, I guess, streamline and facilitate a better sharing of information and that was obviously separate to whatever Local Area Commands might have been doing on their own.

17.25 Importantly, there is still no formal agreement between the MPR and FASS today.

17.26 Even though the task was time-consuming, required state-wide travel, and was arguably more closely aligned to the investigative function assigned to the LACs, MPU officers did collect a number of DNA samples. However, the DNA Collection Program was not as successful as hoped, largely due to the lack of staff and funding for DNA analysis. Ms Karakaya, who worked at the MPU from 1999 to 2006, gave evidence that the MPU developed some database capability from 2006 to

be able to have DNA samples obtained from families tested. However, at that time MPU personnel would not proactively obtain samples from unidentified bodies unless they were certain there was a good chance of a match (for example, due to a physical description). In addition, it was ultimately up to the responsible LAC to pay for the relevant testing. Ms Karakaya explained:

I do recall at the time - I can't recall the details but I know I have submitted some reports up the chain of command to ask to get some resources or funding to this project and at the time it wasn't heeded. It was - it was ultimately up to the Local Area Commands to pay for those testings so it is often difficult to get them across the line and agree to do that. So the Missing Persons Unit didn't own it but they would try to facilitate those checks as best they could.

17.27 In January 2013, funding was arranged for mitochondrial DNA analysis of previously held DNA samples at MPU to be performed by Orchid Cellmark in the USA. Approval was given for 10 samples to be sent each month and those samples were prioritised on a case-by-case basis

Nine Network Missing Persons Television Show

17.28 Around 2005, production began on an Australian television documentary series that focused on people who had gone missing in Australia and the police who investigated those cases. Senior Constable Williams gave evidence that the filming of this show added to the unit's workload dramatically. Senior Constable Diana Makhoul indicated that the MPU increasingly struggled with insufficient staff to work through the backlog of cases and new cases. She considered that this issue started when the MPU started filming the television series and noted:

This caused numerous staff [turnaround], officers beings conduct [sic] from PACs to assist with filming, these officers had no experience with the [MPU]. Therefore, caused extra workload and pressure on staff within the MPU.

18. Reviews of the Missing Persons Unit

- 18.1 It is apparent from the above that a number of system issues have been identified in relation to the general conduct of missing person investigations. Since 2008, several reviews have been conducted of the MPU. These reviews have highlighted these systemic issues and, to different degrees, sought to address them. However, despite the conduct of these reviews, the majority of the identified systemic issues were not substantially addressed prior to 2018.

The Walton Review

- 18.2 Inquests into the suspected deaths of missing persons Daniel Cumming, Graeme Taylor, and Mark Davis were previously held by (then) Deputy State Coroner Paul MacMahon. In each of these cases, an unidentified deceased body was not matched in a timely manner to a missing person case or report. Each of the deceased remained unidentified for between four and thirteen years, even though Daniel, Graeme, and Mark had all been reported as missing to police at some point in time.
- 18.3 In his findings, Deputy State Coroner MacMahon emphasised the following issues:
- (a) the structural deficiencies within NSWPF which create a disjointed approach to the investigation of missing persons cases;
 - (b) the lack of systems across investigative and specialist roles for the sharing of information related to missing persons; and
 - (c) the inordinate amount of time between initial reporting of a missing person, the recovery of unidentified remains, and subsequent cross referencing leading to identification.
- 18.4 Deputy State Coroner MacMahon recommended that the Commissioner of Police institute a thorough management review of the MPU. Superintendent Mark Walton was tasked to conduct this review, which occurred March and May 2008 (**the Walton Review**). The Walton Review relevantly identified the following matters:
- (a) As to the **role** of the MPU, the majority of officers could not clearly define the roles and functions of the MPU. The lack of role identification was largely concerned with the degree to which officers were involved in the investigation of cases. It had been caused by several factors, including the failure of LAC officers to appropriately respond to missing person cases within their LAC. The involvement of the MPU in the production of a Missing Persons television series had also contributed to the confusion, generating mixed messages amongst staff as to the priorities of the unit.
 - (b) As to **work flow**, the flow of information and in particular, “the matching of information concerning missing persons and located unidentified bodies” was the critical area of failure that led to the delayed identification of the cases under coronial review. The Walton Review identified that the risk assessment tool could be improved through alignment with the guiding principles of risk management as outlined in the Australian and New Zealand Risk

Management Standard 4360/1999, and that three-monthly review and evidence collection processes should be conducted in relation to outstanding cases located at LACs.

The Walton Review also noted that better information-sharing processes should be implemented between the NSWPF, the Office of the State Coroner and the DOFM. It was similarly advised that exhibit and record management required improvement.

- (c) As to **human resources**, the Walton Review found that the MPU was an attractive workplace to part-time workers but found that the MPU had difficulty recruiting police officers. To address this, it was suggested that the MPU be marketed as an opportunity for police officers to build on their investigative skills and that a mandatory Investigator's Course be required for attachment to the unit. It was also recommended that the OIA take recruitment action to fill the positions occupied by part-time employees to the highest occupancy rate.
- (d) As to **physical and technical resources**, the Walton Review recommended that the NSWPF install PlassData DVIAS¹⁵ as a matter of urgency and that information from the Unidentified Bodies and Remains Database be migrated immediately afterwards.

18.5 Across the four categories identified above the Walton Review made the following recommendations:

Role
1. That the role of the Missing Persons Unit is confirmed and marketed as one of coordination, quality assurance, information management and investigative support. 2. That the Missing Persons television series continues to be corporately supported. It is recommended, however, that the production of the program be more closely aligned with actual practice with a focus on the Local Area Command as undertaking the investigative function and the Missing Persons Unit performing the support function. That the core functions of the Missing Persons Unit are not diminished by the production of the television series. Should the series continue, the Missing Persons Unit should be supplemented from the field, which reaffirms recent practice.
Work Flow
1. That a risk assessment template that complies with the guiding principles of risk management, outlined in the Australian and New Zealand Risk Management Standard 4360/1999, is developed for use at the Missing Persons Unit. This template would replace the current subjective risk assessment tool utilised at the Missing Persons Unit. 2. That a joint working party be formed to rationalise the record holdings of the NSWPF, NSW Health Department and NSW Attorney Generals Department concerning unidentified remains. The purpose of the review would be to combine records and ensure accuracy and integrity of holdings. For NSWPF, this would also include the identification of physical exhibits and their location. The three agencies would require representation on this working party and access to the holdings of each of the agencies. 3. That the joint agency working party produce a comprehensive spreadsheet or other resource that

¹⁵ DVIAS is a system used to identify disaster victims and is built on the international Interpol Disaster Victim Identification Ante Mortem form and procedure.

is available for use by the three agencies.

4. That the NSWPF Missing Persons data base is updated with the revised records to provide an accurate data set for the management of missing persons cases.
5. That a case review of all unidentified remains be conducted by a suitably resourced and skilled group of police officers having regard to the experience of the Strike Force Belier conducted by the Victorian Police. This group would prioritise the allocation of cases for investigation by Local Area Commands and the Unsolved Homicide Unit.
6. That all missing persons cases are checked against the Unidentified Bodies and Remains Database when the person has been missing for three months.
7. That the Inspector in charge of the Missing Persons Unit issues a request for a status report to Local Area Commanders when missing persons cases when the cases reach the three, six and nine month status point via the corporate correspondence system (TRIM).
8. That the P79A form, 'Report of Death to the Coroner' is amended to allow the reporting of persons who have been missing for 12 months. Alternatively, a P79b could be developed to specifically incorporate this requirement which would further heighten the awareness of the need to report missing person cases that remain outstanding for more than twelve months to the Coroner where there are no signs of living.
9. That all missing persons cases outstanding for twelve months are reported to the Coroner utilising a revised P79A form which includes the capacity to report a long term missing person.
10. That all historical missing persons cases that have not been reported to the Coroner are reported to the Coroner utilising a revised P79A form which includes the capacity to report a long term missing person.
11. That a mandatory evidence collection process is undertaken when a missing person case is outstanding for three months unless it has been undertaken prior to that time. This would include obtaining relevant statements and DNA samples for both Nuclear and Mitochondrial (Maternal) DNA profiling.
12. That the Interpol Disaster Victim Identification (DVI) Ante Mortem Form is used as the template to record detailed information concerning outstanding missing persons.
13. That missing person cases are re-allocated or co-allocated to an appropriate officer performing criminal investigative duties when they remain outstanding for more than three months.
14. That consideration be given to utilising the skills of staff and students of the Detectives Education Program to reviewing and investigate historical high risk missing person cases.
15. That COPS multimedia is utilised to secure records relative to missing persons investigations.

Human Resources

1. That the full time equivalent authorised strength of the Missing Persons Unit be maintained as a priority.
2. That a review of the authorised strength of the Missing Persons Unit is undertaken by Work Force Planning to establish the required number of positions.
3. That Operational Information Agency take recruitment action to fill the positions occupied by part time employees to the highest occupancy rate.
4. That the Commander, Operational Information Agency consider impressing upon the NSWPF Executive the option of secondments as a short term means to fill critical vacancies.
5. That a formal induction package which includes a local training package be developed for Missing Persons Unit staff that incorporates the use of all Missing Persons Unit tools and systems.
6. That Missing Persons Unit staff complete the investigators course. A secondment into a Local Area Command Criminal Investigation office needs to be incorporated into this recommendation to ensure that Missing Persons Unit staff have the capacity to complete the practical component of this course.
7. That a mandatory continuing police education package be developed to promote investigative and management standards surrounding missing persons. The education package should also include enhancements following the outcome of this review. The Missing Persons Unit should work closely with Education Services to develop this package.

Physical and Technical Resources

1. That the NSWPF install PlassData DVIAS as a matter of urgency and that information from the Unidentified Bodies and Remains Database be migrated immediately following.
2. That in the absence of the capacity of COPS to accommodate automated access by Missing Persons Unit staff to missing persons cases that designated Missing Persons Unit staff be allocated as assisting officers to all missing persons cases.
3. Due to the current development of the national CRIMTRAC coordinated information technology data sharing it is not appropriate for NSWPF to further invest in missing persons related IT applications.
4. That NSWPF continue to support the development of CRIMTRAC.

18.6 Following completion of the Walton Review, it was envisaged that Assistant Commissioner Waites would establish a committee with representation from all relevant commands for the purpose of implementing the recommendations. On 1 June 2009, Deputy Commissioner Carey prepared a second memorandum and sent this to Acting Commander Chris Beaton of the OCIC. That memorandum indicated that a cross-command implementation committee, chaired by the Commander of the OIA, would be assembled to progress the implementation of the Walton Review recommendations.

18.7 However, it is not entirely clear from the evidence what steps were taken to implement the Walton Review recommendations. It appears that the Walton Review resulted in the following:

- (a) the Missing Persons television series was cancelled;
- (b) initial steps were taken towards a joint working party implementation committee;

- (c) LACs were requested to provide status updates in connection to each of their LTMP cases, resulting in the closure of some cases;
- (d) the MPU induction manual was updated; and
- (e) draft SOPS for mandatory DNA evidence collection were prepared.

Operation Firenze

- 18.8 In addition to authorising the Walton Review, the NSWPF responded to the recommendations of Deputy State Coroner MacMahon by launching Operation Firenze in January 2010. Operation Firenze was a joint operation between the MPU, Unsolved Homicide Squad, Forensic Services Group, DOFM, and the State Coroner's Office. Its aim was to obtain all missing information and forensic material in relation to the 587 LTMP cases (eventually 634 cases) and the 326 UBHR cases on file in January 2010 and reconcile as many cases as possible.
- 18.9 From its inception, Operation Firenze was to be conducted in three phases. Each phase was allocated approximately three months to be completed:
- (a) The **AM (antemortem) Phase**. This required the gathering of forensic information for each of the cases on hand in the MPU. Five hundred and sixty-seven requests (eventually 634 requests) for information were forwarded to OICs at various LACs so this information could be obtained. The OICs were asked to provide information such as mitochondrial DNA, nuclear DNA, medical records and x-rays, dental records and x-rays, DVI, missing persons identification form, photo, authority for publicity and a copy of the brief of evidence. They were allocated approximately 4 to 6 weeks to complete these tasks. However, it proved very difficult for Sergeant Dean and her team to persuade the OICs to gather the relevant forensic information within a reasonable timeframe.
 - (b) The **PM (postmortem) phase**. This required the conduct of an audit of unidentified bodies and associated files to determine the actual holdings (that is, the number of bodies) at DOFM. Phase 2 was also set down for three months. In practice, Phase 1 and 2 "morphed into each other." Sergeant Dean stated that locating and retrieving all paper-based files from DOFM was difficult due to the staffing of NSW Health and the age and location of the files. This phase took a great deal longer than anticipated due to the issues with collection of records in addition to inadequate staffing.
 - (c) Phase 3 was concerned with the **matching analysis of data and comparison** of the AM and PM files. This phase utilised the Plassdata software system. Sergeant Dean gave evidence that this system "had its own issues" as it was originally developed to assist with Disaster Victim Identification.
- 18.10 Sergeant Julie Dean, who worked consistently on the project since December 2009, gave evidence that the timeframe was "*extremely impracticable and there was no consultation with any member of the Missing Persons Unit [in arriving at] this estimate*".

18.11 Further, there were significant difficulties associated with the antemortem phases, as described by Inspector Paul Roussos:

[...] we were trying to collect information from LACs, investigators and [general duties officers], who had carriage [of a missing person matter]. Now, we couldn't - we couldn't say, "You must do this". All we could say was, "Please, go out and see the family, collect this information for us. Get something we can get a DNA example off" [...] but that was a huge frustration because no matter how good the database was and no matter how good we could do with it, if I couldn't get the information from the - from the field, cause we didn't have the resources - so we didn't have the resources to put people in a car and race out and do all those things cause that just wasn't possible, so we had to - and plus, our commander kept reminding us, we're a support unit, we don't do that. We ask people to do it for us and so that - to get that information back to us, so that was a huge frustration, if not disappointment.

18.12 Operation Firenze was designed to draw upon the experience of Strike Force Belier, which had been conducted by Victorian Police and addressed similar issues. Operation Belier commenced in January 2007 and engaged staff consisting of one sergeant, five constables, and one analyst. The operation was transitioned to a Strike Force in 2009 when the staffing strength was doubled to consist of one Senior sergeant, two sergeants, 10 constables, and one analyst. The Strike Force continued for at least another two years under this structure.

18.13 It was originally recommended that Operation Firenze commence with one sergeant, one analyst, and four constables. Instead, it commenced with one part-time sergeant (Sergeant Dean), one constable and one part-time analyst (on loan). By August 2012, the constable was transferred from the MPU, which left a part-time sergeant and part-time analyst working on the project. Staffing levels at Operation Firenze never reached the recommend levels, let alone the levels achieved in Victoria with Strike Force Belier. This comparison is illustrative because whilst Strike Force Belier focused on 525 LTMPs, Operation Firenze was dealing with approximately six hundred LTMP with a part-time analyst and sergeant.

18.14 Sometime around 30 April 2014, Sergeant Dean was advised that she was being moved from Operation Firenze to the Mapping Unit for reasons unknown to her. Senior Constable Williams and Senior Constable Makhoul also gave evidence that the project was terminated before Phase 3 was completed.

18.15 Superintendent Jodie Cobbin (née Shepherd) was appointed as the Commander of the OIA in January 2014. She remained in the position until September 2016 and stated that this period was *"the most challenging time in her career"*.

18.16 On 12 September 2014, Superintendent Shepherd wrote an email to former Inspector Victoria Beresford stating that *"the boss"*, Assistant Commissioner Barrie, wanted her to wrap up Operation Firenze. She gave evidence that if the Assistant Commissioner's plan was to shut down Operation Firenze, that decision would have been made in a context of the Assistant Commissioner having a broader strategic plan. On 6 May 2015, Superintendent Shepherd prepared a memo entitled, *"Conclusion of Operation Firenze"*. That memo indicated that the operation had concluded and that 82 of 634 requests to LACs remained outstanding.

18.17 Upon taking up the position of Commander, Superintendent Cobbin was required to do a functional review of the entire Command. She commented that the Command was “*such a diverse, complex regulatory environment, with so many disconnected pieces of moving parts that didn’t really belong anywhere else [...] It took a long time to understand how they worked*”.

18.18 In early 2014, the OIA faced several serious issues:

- (a) First, there was a “*revolving door*” of managers of the MPU for a period. This caused significant instability within the unit, partly because it seemed to MPU personnel that they were always “*starting over*”. At the time that Superintendent Cobbin started at the OIA, Detective Inspector Claude Biason had just become manager of the MPU after Inspector Paul Roussos left on long-term sick leave. Industrial requirements meant that it was not always possible to backfill the position of an officer on long-term sick leave. In addition, Superintendent Cobbin noted that neither of the MPU Sergeants ever applied to relieve as MPU Manager. On 31 May 2016, a substantive Inspector could be offered the role of MPU Manager from the Inspector’s promotion list.
- (b) Second, over half of the Command’s 160 officers were on either permanent or restricted duties, with a range of physical and psychological health issues. This meant that there were few officers who could be asked to relieve in a particular position.
- (c) Third, by this point, the OIA had been without a substantive Commander for approximately three years. During that period, Inspector Nada McDonald was fulfilling the role as acting Commander. This is significant because, in Superintendent Cobbin’s view, a Commander acts as a “*gatekeeper*”. She expressed the view that without anyone in that specific role:

[T]here is nobody there to really appropriately vet the number of staff or the capacity of staff that were coming to the Command. And obviously, every person has to have their place, but you would try to seek a balance [...] of gender and racial backgrounds, for example, and not necessarily have a topheavy command with so many restricted duty officers.

- (d) Fourth, Superintendent Cobbin gave evidence that she considered that in the MPU there was a culture of “*entitlement, resistance to change and self-importance*”. She described the human resource issues she encountered during this as ones that she “*ha[d] never seen before and have never seen since*.” Notably, a significant number of employees (approximately 25 out of 160) worked part-time, and Superintendent Cobbin considered that there were not enough “*bums on seats*”. Superintendent Cobbin assessed that the MPU, which was one component of the OIA, was working at 62% operational capacity. When Superintendent Cobbin took steps to move some of the MPU personnel from part-time to full-time arrangements, this was met with deep resentment by some of the staff.
- (e) Fifth, Superintendent Cobbin gave evidence that she discovered in July 2015 that exhibits taken from family members for matching purposes were not actually being sent to DOFM for analysis. She stated that she was informed that the MPU held 300 to 800 exhibits and that the MPU personnel were bringing these exhibits back to OIA for storage in case the investigating

officer failed to arrange for them to be analysed. Superintendent Cobbin said in relation to this that she was aware the MPU staff were well intentioned, but this step made it impossible for matching to occur because “*hundreds of exhibits were not being analysed*”.

- (f) Sixth, during this period general staff morale within the MPU was particularly low. The lack of leadership and support over previous years appeared to have taken its toll. The fact that the unit was subject to repeated reviews was also stressful for staff, who may have perceived this to be a sign that the unit was going to be shut down or moved to another command.

18.19 Against this backdrop, former Inspector Victoria Beresford and Sergeant Shantel Cogno were tasked with conducting a preliminary review between July 2014 and November 2014 (**the Beresford Review**). The overall purpose of the Beresford Review was to effectively manage the service “*output*” within the MPU, identify duplicating activities with other commands/business units, and provide factual evidence to support the necessity for creating, removing and/or realigning current functions/roles with the MPU. Ms Beresford recalled that “*the review was started to look at staffing numbers only, not really what they were doing.*”

18.20 Ms Beresford gave evidence that it was originally anticipated that she would complete a more substantial report following the preliminary report. However, she noted that it was “*impossible*” to do a full report without finding out where the failures were at the LACs. She said that she attempted to liaise with the different Assistant Commissioners for each LAC and submitted a report so this could occur. However, this request was declined. She agreed that if she had had more time, resources, and perhaps willingness from various parties, she would have spoken to various people at the LACs as well. No final report was ever completed.

18.21 The Beresford Review identified the following features of the MPU:

- (a) All the business plans in the OIA exhibited “poor metrics in place”;
- (b) MPU staff were stepping into risk assessment and investigatory roles in order to compensate for poor quality work at LACs, which was not being identified by supervising officers;
- (c) MPU staff would spend a substantial amount of time reviewing and updating risk assessments when many of those people would not be missing in 2-3 days’ time, resulting in core inefficiencies.

18.22 Ultimately, the Beresford Review produced the following recommendations:

Recommendation 1: The corporate responsibility for the overall management of Missing Persons needs to be led by Local Area Commands. It is recommended that corporate reporting processes be put into place to ensure regional accountability and effective management of Missing Persons cases and unidentified bodies/remains.
Recommendation 2: Establishment of a working party to review the current Missing Person SOPs and risk assessment tool [...].
Recommendation 3: Enhancement to COPS to improve reporting, case management and the collection of statistical data [...].

Recommendation 4: Development of a Missing Persons category in the e@gle.i investigation system to allow stakeholders in State Crime Command, particularly the Homicide Squad, access to long-term missing persons and unidentified bodies/remains case files.
Recommendation 5: Enhancements to the iAsk system to provide a set of tools to assist with the investigation of Missing Persons.
Recommendation 6: The adoption of DVI System International (here on referred to as PlassData) as a National Missing Persons Database.
Recommendation 7: Review of Disaster Victim Identification (DVI) procedures, in particularly the Ante Mortem phase, which OIA currently holds the corporate responsibility for managing in the event of a mass casualty incident.
Recommendation 8: Consideration given to reviewing the SOPs for Strike Force Eagle (NSWPF response to major terrorism investigation) particularly relating to DVI-AM procedures.

18.23 On 22 December 2014, the Acting Commander of the OIA, Helen Lawlor, supported Recommendation 2 and advised that “*further analysis was required for the remaining recommendations*”.

An absence of improvement

18.24 Despite the above reviews, and the recommendations made, the systemic issues described above remained largely unaddressed between 2015 and 2018.

18.25 On 21 July 2017, Detective Sergeant Kylie Whiting sent an email to Acting Commander Kristy Walters and former Inspector Kitley in relation to what Detective Sergeant Whiting perceived to be “*the risk*” to the NSWPF. She described that the situation was “*at a critical point where [the MPU was not] really not in a position to do their job accurately or effectively when servicing NSW Police, Interstate Stakeholders and the Coroner in relation to conducting unidentified bodies and remains checks*”. Further, Detective Sergeant Whiting described the following matters in her email:

We can no longer rely on NMPVS for accuracy during our searches, and according to NMPVS we have to find staff and resources, who, then have to put a substantial amount of time into fixing before it is accurate and can be searched confidently knowing all the data is correct and in there. We don't have the time or the staff to do this.

Not one of our databases are accurate and this significantly hinders us to do our job. We are unable to accurately match bodies/ remains with our long term missing in NSW and around Australia if the data in each of the databases is incorrect or missing without actually picking up the hard copy file and going /through it.

I shudder to think that for each signs of life check, where we have done the unidentified bodies and remains check, for a Coroners matter, we have overlooked a body or remains because of the missing or incorrect information and we actually have the body on hand. The Coroner may be able to deliver a finding that the person is deceased but in the case of a finding where the person is NOT deceased, we may very well have that body. Either way the Coroner is making that finding based on inaccurate information we are providing him/her [...]

This also applies to our interstate counterparts when they ask us to check our database. We may actually have a body of a missing interstate or international missing person and we've ruled it out based on wrong or incorrect information.

In short, each and every time we do a search of the unidentified bodies and remains data base of NMPVS for our State Police and our Interstate Police, we may be missing something or ruling a body/remain out as the data is not correct or hasn't migrated over.

Further forensic analysis will be conducted on all unidentified remains in the future. This may result in NSW Police re-analysing missing person records for comparison. The Missing Persons Unit will continue to periodically review this matter until such time that either (MP) is located or a match occurs through forensic analysis.”

This doesn't really happen and it hasn't happened for two years. We don't have DNA samples from all of our unidentified bodies and remains due to:

- No anthropology report
- A sample of tissue or bone has not been cut
- Or if it has it hasn't been forwarded to FASS to be added to the VOLMPU database (COPS has the samples, once taken recorded on the limited database, therefore FASS don't know about it)
- Numerous familial samples have been taken from the wrong family member because police in the field don't really understand DNA.

Diana has identified a further 50 unidentified bodies and remains that we have on our database that the morgue don't have on their spreadsheet. We have 194 on our database, however my estimates are that we should have around 350 unidentified bodies and remains.

Flogel Review

18.26 Following a review of the OCIC in 2017, a report submitted in December 2017 recommended ongoing assessment of the MPU with a view to developing future options as to where the MPU should sit within the NSWPF. The new review was allocated to Superintendent Philip Flogel.

18.27 Superintendent Flogel's review commenced in February 2018 and concluded with the submission of a 36-page “*Review of the Missing Persons Unit*” document in May 2018 (**the Flogel Review**). The Flogel Review highlighted particular risks associated with LTMP and UBHR cases, duplication and unnecessary functions, data and technology, and performance measures:

- (a) In relation to **long-term missing persons cases**, the MPU had not effectively managed the most complex missing persons cases. At the time of the review, there were 806 LTMP cases in need of review. It was found that the MPU had not: (i) consistently reviewed and updated their databases, including the NSW Missing Persons Database or the National Missing Persons and Victim System (**NMPVS**); (ii) established any measures concerning the review of LTMP cases (or other functions); or (iii) documented internal processes/procedures for assessing LTMP cases (or other functions). It was recommended that the corporate Missing Persons Standard Operating Procedures (**SOPs**) be revised.
- (b) In relation to **unidentified bones and human remains** cases, the MPU had not advanced the resolution of approximately 180 UBHR cases on hand at the DOFM Mortuary. There were failures to: (i) consult with key stakeholders; (ii) understand the underlying issues (one

presumption was that MPU would require approximately \$1 million in enhanced funding to resolve all these matters, but this was not the case); and (iii) coordinate and allocate an appropriate number of staff to the task. Superintendent Fogel further noted that there was an issue in connection to the consent forms used to take DNA samples voluntarily: “MPU currently has an index of 367 DNA profiles that cannot be shared with FASS for broader matching.” The review identified that an integrated approach was required and consequently a joint-agency project was established on 12 March 2018.

- (c) In relation to **duplication and unnecessary MPU functions**, the MPU carried out tasks that were already being undertaken by PACs and Districts. This involved staff conducting reviews and risk assessments on all missing persons cases daily (approximately 11,000pa). The review eliminated that function.
- (d) In relation to **data and technology**, the Fogel Review established that: (i) several internal and external databases were not integrated; (ii) outdated systems were in use that no longer supported and were at or near end-of-life; (iii) problems existed with uploading data to NMPVS (dental and other data) so that proper matching of candidates was not undertaken on a regular basis; and (iv) various forms of hardcopy files (many historic) had not been digitised or appropriately uploaded into relevant databases/systems. The review also indicated that an ICT strategy needed to be developed to establish a “single source of truth” for all missing persons cases and related data.
- (e) In relation to **performance measures**, it was noted that previous MPU reviews had reported that there were no performance measures in relation to MPU functions. The review indicated that this issue had been rectified in March 2018 and measures implemented to capture the tasks completed by all staff each month.
- (f) In relation to **comparison with other Australian Police Forces**, it was found that: (i) except for the NSW and ACT Police Forces, all Australian Police Forces at the time of the review had structured their MPUs under the crime portfolio (equivalents of NSW State Crime Command); (ii) all other Australian MPUs were staffed with a component of detectives; (iii) the NSW Police Force had the largest number of both long term missing persons (LTMP) and unidentified bodies and human remains (UBHR) cases; and (iv) NSW MPU actual strength is currently 50% below authorised strength (none of the other MPUs in Australia had a similar staffing issue).
- (g) The review also considered that there was a **poor organisational fit** between the MPU and the OCIC. It was that the MPU did not have a clear functional alignment with the broader goals and objectives of its current (or past) command structure within the OCIC. The review concluded that the MPU was “in urgent need” of realignment and that there was an ongoing risk of reputational damage to NSWPF if no action was taken. Three options were identified for realigning the MPU: either as a single business unit, or to be split and realigned into two separate command structures.

19. Functionality and effective use of relevant DNA databases

- 19.1 One of the primary matters considered by the inquests concerned the functionality of the NSW DNA Database and the NCIDD, and whether they have been effectively utilised in the course of missing persons investigations in New South Wales. Evidence adduced during the inquests established that there have been three significant factors impacting upon the efficacy of forensic investigation and use of the above two databases.
- 19.2 First, direct reference DNA samples are not available for every active long-term missing persons case. This is particularly so in relation to historical missing persons cases where it was not common practice to collect and preserve a direct reference DNA sample soon after a person was reported as missing. This is significant because direct reference DNA samples from missing persons (from the Missing Persons Index), as well as DNA profiles from unidentified human remains (from the Unknown Deceased Persons Index), are routinely uploaded to the NSW DNA Database and the NCIDD so that they can be directly searched against DNA profiles in all indexes of both databases. As at 31 March 2020, there were only 211 direct reference DNA samples on both databases associated with NSW missing person cases, in circumstances where at the same time there were approximately 769 active long-term missing person cases in NSW. It is evident that the relatively low percentage of available direct reference DNA samples compared to the number of active long-term missing person cases offers a lower likelihood of a positive identification result being achieved from a comparison search.
- 19.3 Second, DNA profiles from relatives of missing persons, known as family reference DNA samples, are not uploaded to the NSW DNA Database or NCIDD. Rather, such family reference DNA samples can be used in a local familial search against DNA profiles from unknown deceased persons stored on the NSW DNA Database. Although the NSW DNA Database had familial searching capabilities for missing and unidentified persons since 2016, the NSWPF did not grant FASS permission to routinely perform familial DNA searches for unidentified human remains cases in NSW until October 2018. Prior to this, the OIC of a missing person investigation needed to seek internal authorisation for this type of search to occur. In other words, although continuous searching of direct reference DNA profiles on the NSW DNA Database and NCIDD was available, familial searches were limited to a single initiated search at a point in time. This is significant because an autosomal DNA profile from a person will not match to an autosomal DNA profile from their relative. Instead, a familial comparison, rather than a direct comparison, is required to compare the DNA profiles from unknown deceased persons and relatives of missing persons. Further, actual routine familial DNA searching did not commence until March 2019 as there was a need by FASS to complete a series of associated tasks to increase the efficacy of searching.
- 19.4 Third, three DNA database indices have historically been used for family reference DNA samples from relatives of missing persons: Volunteer (Unlimited Purposes), Volunteer (Limited Purposes) and the Missing Persons Index. Of these, the majority of family reference DNA samples from relatives of missing persons have been collected under the Volunteer (Limited Purposes) and assigned the code, **VOL** for search purposes. This is significant because the same index is also used for other categories of volunteers such as victims of crime.

- 19.5 Section 94 of the *Crimes (Forensic Provisions) Act 2000* (**the CFP Act**) provides for the permissible matching of DNA profiles so that, relevantly, a VOL profile may only be matched against the relevant missing person database if it is “*within purpose*”. In contrast, a family reference DNA sample collected under the Volunteer (Unlimited Purposes) index contains no such limitation. The challenge has been that the origin of VOL reference DNA samples, and therefore the limited purpose for which such a sample was taken, was not known to FASS.
- 19.6 The fact that VOL reference DNA samples collected from a relative of a missing person were not uploaded to the NSW DNA database or the NCIDD was not well understood across the NSWPF. This lack of comprehension has adversely impacted:
- (a) how consent forms for family members have been drafted and executed;
 - (b) how requests for specific DNA testing have been framed to FASS by the NSWPF; and
 - (c) assumptions by individual NSWPF officers regarding which types of DNA searches are being performed when a request for a DNA sample to be searched against specific indices is made.
- 19.7 It appears that this misunderstanding first became apparent in April 2014. At that time Detective Chief Inspector Biason, Sergeant McKell, and Senior Constable Williams met with representatives of FASS in relation to the automatic DNA matching on FASS database. It became apparent during this meeting that automatic DNA matching between missing persons and unidentified human remains was not occurring as MPU personnel believed to be the case. Many of the consent forms obtained for reference DNA samples collected from a relative of a missing person had been given only for limited purposes. This meant that the reference DNA samples could not legally be uploaded to the unlimited purposes index on the database, which is essentially where DNA matching occurred.
- 19.8 Legal advice was provided to the MPU in June 2014 that new reference DNA samples ought to be collected (attached to different consent forms) or new consent should be obtained from previous donors. However, Senior Constable Williams gave evidence that this affected approximately 410 DNA samples and to revisit these would be time-consuming and, in some cases, impossible. Senior Constable Williams stated that over subsequent months, she requested direction from superiors including Superintendent Cobbin and Assistant Manager Sheree Windred (who was assigned to the MPU around early 2015). However, that direction was not forthcoming. Superintendent Cobbin gave evidence that she did not understand why Senior Constable Williams was waiting for further instruction and that Superintendent Cobbin understood the plan was to reobtain new consent forms from family members.
- 19.9 In November 2014, FASS and the NSWPF created a new code for VOL reference DNA samples collected from a relative of a missing person for the specific purpose of being compared to unidentified human remains. This new code – **VOLMPU** – means that the purpose for which such a DNA sample is taken is now known, so that it may be compared against the Missing Persons Index in accordance with the CFP Act. In January 2015 the NSWPF commenced the conversion of reference samples from missing persons from the VOL code to the VOLMPU code. Further, from 1

September 2019 all relatives of missing persons, from whom a DNA reference sample has been obtained, have provided written consent to the NSWPF to permit their sample being placed on the Missing Person Index. However, the use of family reference DNA samples taken prior to 1 September 2019 had not been addressed until recently. These matters are discussed in further detail below.

20. The Missing Persons Registry

- 20.1 Whilst these four inquests have identified and highlighted a number of systemic shortcomings related to the conduct of missing person investigations by the NSWPF in general, and the operation of the former MPU in particular, certain improvements have been made since 2018 to address these issues. These improvements, and further initiatives established to promote the efficacy of missing person investigations, are discussed below. Overall, it should be acknowledged that these improvements and initiatives now more appropriately recognise:
- (a) the devastating impact felt by members of our community when a loved one goes missing; and
 - (b) the importance of conducting timely, comprehensive and suitably resourced missing person investigations.
- 20.2 In November 2018, the Human Resources Manager at the Communications and Security Command (CSC), formerly the OCIC, submitted a report requesting to “*devolve the MPU and to re-establish the functions of the Unit within more appropriate areas of the NSWPF*”. Following the submission of this report, State Crime Command (SCC) implemented Project Alethia to prepare for the dissolution of the MPU and the creation of the Missing Persons Registry (MPR) within SCC.
- 20.3 On 1 July 2019, the MPR commenced operation as a unit within SCC. The operational structure of the MPR provides for: a Manager (Detective Inspector); a Co-ordinator (Detective Senior Sergeant); a Team Leader (Detective Sergeant); 5 Investigators (Detective Senior Constables); an Analyst Team Leader (Sergeant); 3 Analysts (Senior Constable/Clerk Grade 5/6); and a Clerical Officer (Grade 1/2).
- 20.4 The MPR currently also has two civilian contractors assisting with the digitisation of hard copy long-term missing person files (Project Alethia). Two sworn officers on Return-to-Work Programs are also assisting with that project.

Revision of Standard Operating Procedures

- 20.5 During August and September 2019 the MPR created entirely new draft Standard Operating Procedures (**the MPR SOP**) to guide the NSWPF response to Missing Persons, Unidentified Bodies and Human Remains investigations.
- 20.6 The MPR SOP introduced several new sections including:
- (a) the role and function of the MPR;
 - (b) the introduction of the role of Missing Persons Coordinator at each PAC;
 - (c) use of 'Live CAD' in missing persons investigations (it has recently been identified that section 287 of the *Telecommunications Act* (Cth) allows for the use of 'Live CAD' to assist in the location of missing persons if there is an imminent risk to the life or health of a person);

- (d) categories and associated risk factors to be built into the COPS system;
- (e) a mandatory risk assessment process to be built into the COPS system;
- (f) greater emphasis on searching procedures;
- (g) intelligence support for missing persons investigations; and
- (h) regular 'formal reviews' of all missing persons cases by the MPR.

20.7 A further revised version of the SOP was released on 1 January 2021 (**the 2021 MPR SOP**). The 2021 MPR SOP include: (i) a definition for a 'vulnerable person' (Chapter 5); (ii) the creation of generic 'corporate narratives' within COPS to assist officers taking reports of missing people (Chapter 9.0); (iii) clearer guidance regarding what is required when children or young people are reported missing (See Chapter 9.2.3 & 9.2.5); and (iv) more specific guidance on the collection of DNA for missing person investigations (Chapter 10.6 & Annexure C).

20.8 During the hearing, concurrent evidence was given by Associate Professor Ward, Mr Symonds and Detective Inspector Browne regarding a number of recommendations proposed by Associate Professor Ward. That evidence established the following:

- (a) It was accepted that ante-mortem information should be collected from a missing person's family within the first week of the person being reported missing. There was mixed discussion as to whether DNA obtained from a personal effect was sufficient, or whether a medical sample should always be obtained;
- (b) It was accepted that a committee should be established involving NSWPF, MPR, FASS, FETS and the NSW Coroner's Court in order to improve casework outcomes, turnaround times and communication between agencies in relation to UBHR cases. The importance of including forensic anthropologists and other forensic experts on the committee was emphasised;
- (c) It was accepted that it would be advantageous for NSW data to be entered into the NMPVS as soon as possible (on the NSWPF side, the view was also expressed that data entry is subject to resourcing constraints);
- (d) It was agreed that a more collaborative approach to obtaining DNA from family members should be undertaken, including via initiatives such as 'pop up' centres and designated Family Days in regional NSW;
- (e) It was agreed that unidentified human remains should not be buried prior to the collection and storage of all relevant forensic data (such as, DNA profile, dental chart, fingerprints, radiographs, archived biological sample); and
- (f) It was agreed that a policy should be devised detailing the process for the long-term retention of unidentified human remains (and archived biological samples) at FASS.

Missing Persons Coordinator

20.9 A Missing Persons Coordinator, to be appointed at each PAC, with the purpose of monitoring and reviewing all missing persons cases within the PAC, provide advice to OICs at a local level, and act as a point of contact between each PAC and the MPR. During the MPR SOP development process, several participants indicated that the appropriate person to perform this function would be the Investigations Manager or a Team Leader (Detective Sergeant) within the Detective's office. Detective Inspector Browne gave evidence that there have been 69 Missing Persons Coordinators appointed. All except one hold the rank of detective. Evidence was given that this system is presently working well and the intention is to provide training in the future.

Day to day work undertaken by the MPR

20.10 The inquests received the following evidence as to the day to day work undertaken by the MPR:

- (a) MPR personnel review every missing person report recorded on COPS from the previous day (an average of 28-35 cases per day). A quality review process identifies various errors. These are highlighted in a Case Review document that is sent to the OIC of the investigation.
- (b) The MPR Coordinator is tasked with reviewing all long-term missing persons digitised case files, updating the State Crime Command CORDS system, and categorising case file items on e@gle.i. The files are then forwarded to FETS for review and verification of forensic records, before being returned for further assessment by the MPR investigators to identify investigative deficiencies and outstanding enquiries.
- (c) MPR personnel have commenced conducting formal 3-month, 6-month and 9-month reviews for LTMP investigations. They are also actively scanning and digitising all hard copy LTMP files so they can be electronically searched in the future. As they are uploaded, they are reviewed to establish which records are available and which important functions have not been undertaken (i.e. collection of dental records or DNA). It is envisaged that once all of the historical LTMP files have been uploaded and the initial assessment is complete, a further review will be conducted before they are reallocated to responsible LACs. To date, about 30 to 40 LTMP cases out of 756 have been reallocated back to LACs.

20.11 One issue which arose during the inquests concerned the introduction of key performance indicators in relation to missing persons and engagement with Compass/Vortex. The latter is a mechanism by which all commanders are called before the NSWPF executive members and asked to explain any areas of low performance within their LACs. Detective Inspector Browne gave evidence that if Compass/Vortex applied to missing person investigations this "*would simply mean that commanders will want to know what [is] happening with missing person investigations within their command. They need to know because they are going to be asked about it when they appear at COMPASS*".

20.12 Another issue explored during evidence concerned whether it would be beneficial to put in place a formal working group involving NSWPF and FASS to encourage discussion of LTMP cases. This type

of model has been implemented in Victoria. Detective Inspector Browne gave evidence that although there is now a “*constant line of communication*” between the MPR and FASS, he was in principle “*supportive*” of the more formal meeting arrangements that are in place in Victoria. As noted above, it was generally accepted in evidence that a committee should be established involving NSWPF, MPR, FASS, FETS and NSW Coroner’s Court in order to improve casework outcomes, turnaround times and communication between agencies in relation to UBHR cases.

The Bones Project/Human Skeletal Remains Initiative

- 20.13 The Bones Project began in around 2010 when a post-mortem assistant commenced cataloguing skeletal remains at the former DOFM Morgue at Glebe. It became evident during this process that skeletal remains located during the 1960s, 1970s and 1980s had not always been catalogued or entered into a relevant database.
- 20.14 In 2014, the then-Director of DOFM formalised what was referred to as the Bones Project utilising the cataloguing completed by the post-mortem assistant. This occurred following an approach from the MPU.
- 20.15 In February 2018, Superintendent Flogel proposed a meeting with Superintendent Mark Sweeney, Commander of FETS, and Michael Symonds, Executive Director of FASS. The purpose of the meeting was to develop a plan for the management of UBHR. The original number of UBHR sets was 282. The meeting was convened in the week of 25 February 2018 and the following week a document of intent was developed by NSWPF proposing a commencement date for the Human Skeletal Remains Initiative (**the HSR Initiative**).
- 20.16 Since the commencement of the HSR Initiative, there has been a full inventory of all skeletal remains held at FASS. Categorisation of the remains (eg. Aboriginal and Ancient, Unidentified, Retained, Forensic Exhibits, and Teaching Specimens) has also occurred. Further, a new Forensic Medicine Information System (**FMIS**) is scheduled to be implemented in December 2021 and will identify and track skeletal remains throughout the process and ensure that component remains are reunited before release.

21. Recommendations pursuant to section 82 of the Act

21.1 As already discussed above, the NSWPF missing person investigations in relation to Ursula, Gary, Lionel and Christof all highlighted a single and recurring theme: the functional deficiencies associated with the former MPU, in its various forms prior to 2018, and the manner in which these shortcomings contributed to inadequate, inefficient and, in some cases, a complete absence of, investigation for extended periods of time at the LAC level. Equally concerning, despite a number of reviews having been conducted between 2008 and 2018, little was done to address these deficiencies.

21.2 The deficiencies described above can be divided into the following categories:

- (a) The role and functions of the MPU, and that of personnel working within the MPU, being ill-defined and misunderstood by police officers at the LAC level. This resulted in poor communication between the MPU and investigators, together with a lack of investigative ownership and direction in relation to missing person investigations.
- (b) The MPU being inadequately resourced to provide appropriate support to missing person investigations, with the role of the MPU largely perfunctory in nature and limited to performing superficial tasks (such as periodic signs of life checks) with few opportunities to conduct in-depth enquiries to meaningfully advance investigations, particularly into historic and long-term missing person cases.
- (c) A failure to recognise the importance of forensic evidence gathering and forensic examination techniques in furthering lines of inquiry, and a misunderstanding of how such techniques, in particular the use of comparison of direct and familial DNA reference samples against DNA profiles extracted from unidentified bodies and human remains, were actually being utilised. This resulted in missed opportunities to gather evidence which had the potential to assist missing person investigations, lengthy periods of inactivity during investigations and a failure to keep both officers-in-charge of missing person investigations and families of missing persons appropriately informed of investigative developments.
- (d) A lack of accountability within the MPU leading to the absence of both appropriate leadership and a collaborative approach between the MPU, NSWPF, and FASS in relation to the conduct of missing person investigations to enhance information sharing and casework outcomes.

21.3 These deficiencies have been recognised by the NSWPF Commissioner of Police (**the Commissioner**). Submissions prepared on behalf of the Commissioner noted the following:

[...] the Commissioner acknowledges that the investigation into each disappearance and suspected death [of Ursula Barwick, Gary Jones, Lionel Daveson and Christof Meier] involved substantial failings, that there was more generally a lack of oversight into the investigation of missing persons at both local and state level, and that the relevant procedures in force, over many years, have been inadequate.

21.4 The establishment of the MPR and the development of the MPR SOP has, in large part, addressed many of the deficiencies and shortcomings described above. Such changes have been positive and long overdue. Further, since the conclusion of the evidence in the inquests, other improvements relating to the conduct of missing person investigations have been made:

- (a) One issue which arose during the inquests concerned the necessity of adopting a model utilised in Victoria which provided for a multi-agency, multidisciplinary working group to improve communication, turnaround times and casework outcomes in missing person investigations. The Missing Persons, Unidentified, Destitute Review Committee (**the Committee**) has been jointly established between FASS and the NSWPF to ensure timely progression and finalisation of missing persons, unidentified and destitute cases.

Membership of the Committee includes Commanders from State Crime Command and Forensic Evidence and Technical Services Command, the Investigation Coordinator from the Unsolved Homicide team, the Manager, Missing Persons Registry, the Director and Operations Director, Criminalistics from FASS, the Chief Forensic Pathologist and Manager, Coronial Services. The Committee held its first meeting on 9 June 2021 with its Terms of Reference providing for meetings on a monthly basis (or more frequently if circumstances dictate upon agreement), and for the Committee to report on performance and outcomes to the Coronial Services Committee on a quarterly basis.

- (b) A review of the 2020 MPR SOP has been undertaken with proposed amendments circulated to stakeholders for consultation and feedback, with amendments incorporated in the next version of the MPR SOP to be released on 1 January 2022.
- (c) Amendments to Compass/Vortex have been implemented which require Police Area Commands and Police Districts to report on key performance indicators in respect of missing persons investigations. Key Performance Indicators for the MPR have also been identified but their development and implementation into Compass/Vortex remains a work in progress.
- (d) Training for Missing Persons Coordinators within three of the six Police Regions has been completed, and it is anticipated that training for the remaining three regions will be completed by the end of 2021.

21.5 One further issue which arose for consideration as a result of evidence given during the inquests concerned the necessity of DNA reference samples taken from relatives of missing persons prior to 1 September 2019 being able to be searched against relevant DNA indexes at both the NSW and national level. Ms Field gave evidence that continuous or “live” searching of familial DNA reference samples against unidentified human remains is not required:

All of the unidentified remains in, in forensic biology were searched against every relative sample and then any new sample from a relative that comes on - into our laboratory is searched against all the unidentified remains. So it actually doesn't need to be continuously searching, if that makes sense, because you're actually searching every unidentified remain against all of the relatives. Any new unidentified remain is searched against all of the relatives currently in New South Wales and then any new relative that comes into the laboratory is searched against all the

unidentified remains so we're covering it from both ends and you don't need continuous searching in New South Wales.

21.6 Prior to 4 March 2021, similar familial searches conducted at the national level have been limited to one-off, point-in-time searches. This was because of a technical barrier which prevented the searching of familial DNA reference samples being limited to the unknown deceased persons index, as required by the CFP Act. However, on 4 March 2021 (during the middle of the second tranche of evidence given during the inquests) a software solution was implemented in the NIFA database which now provides for such searching to be limited as required. Ms Field explained:

Yes, it actually provides a new index for the relatives of missing persons so it takes the legislation allows for the relatives of missing persons to go under either the volunteer limited purpose index or the missing persons index. But because the missing persons index searches against crime, having a new index for the relatives of missing persons that will not be allowed to search against crime, so will search only anything on the missing persons index or the unknown deceased person index, that actually will actually plug all the gaps, if you like, for the - missing persons identifications.

21.7 Whilst remedial action has been taken to address a number of systemic issues identified during the course of the inquests, there is still scope for further improvement. Having regard to the available evidence, it is necessary to make the following recommendations pursuant to section 82 of the Act:

21.8 **Recommendation 1:** I recommend to the New South Wales Commissioner of Police and Chief Executive, NSW Health Pathology that a Memorandum of Understanding be prepared and executed that defines the roles and responsibilities of each member of the Missing Persons, Unidentified, Destitute Review Committee.

21.9 **Recommendation 2:** I recommend to the New South Wales Commissioner of Police that reviews of the Missing Persons Standard Operating Procedures (**SOP**) are to be conducted on a 12-monthly basis, with reference to any recommendation made following a coronial inquest in connection to missing persons over the previous 12 months. During the revision process, a draft of the proposed changes to the SOP is to be given to members of the Missing Persons, Unidentified, Destitute Review Committee so that their input can be provided and considered by the Commissioner of Police.

21.10 **Recommendation 3:** I recommend to the New South Wales Commissioner of Police that:

- (a) Key Performance Indicators for: (i) the Missing Persons Registry; and (ii) Police Area Commands in relation to missing persons investigations be reviewed within 12 months to evaluate whether any improvements or additions to the Key Performance Indicators are necessary or desirable; and
- (b) The Missing Persons Registry Key Performance Indicators be integrated into the Compass/Vortex system as soon as practically possible.

21.11 **Recommendation 4:** I recommend to the New South Wales Commissioner of Police that ongoing training be provided to Missing Person Coordinators which includes specific information in relation to the operation of DNA databases (including the NSW DNA database and the National Criminal Investigation DNA Database-Integrated Forensic Analysis) relevant to missing persons investigations. In particular, Missing Persons Coordinators should have training in:

- (a) ensuring that the purpose of obtaining DNA reference samples from relatives of missing persons is clearly identified so as allow for appropriate comparison searching to be performed by Forensic and Analytical Science Service (FASS), and against relevant state and national missing person indices;
- (b) how to identify which family members are the most appropriate for the purpose of giving a DNA sample in the circumstances of a specific case; and
- (c) how requests for comparison DNA searches addressed to FASS should be made and how the most appropriate indices for search purposes should be selected.

21.12 **Recommendation 5:** I recommend to the New South Wales Commissioner of Police that consideration be given to engaging with the National DNA Program for Unidentified and Missing Persons in circumstances where the New South Wales Police Force consider that additional resources would assist in: (a) progressing outstanding Unidentified Bodies and Human Remains and Long Term Missing Persons cases; and (b) uploading substantive data to the National Missing Persons and Victim System in a timely manner.

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

- 22.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Adam Casselden SC and Dr Claire Palmer, Counsel Assisting, and their instructing solicitors, Mr James Loosley and Ms Clara Potocki of the NSW Crown Solicitor's Office. The entire Assisting Team has provided outstanding assistance during the course of the lengthy coronial investigations, as well as for the duration of the inquests. Their combined diligence, attention to detail, thoroughness and resolve has ensured that a comprehensive and effective coronial investigation has been conducted.
- 22.2 I also thank the respective officers-in-charge of each police investigation for their contributions and for preparing the initial briefs of evidence: Detective Sergeant Kurt Hayward and Detective Sergeant Amy Scott; Detective Senior Constable Amanda Cary; Detective Sergeant Luke Robertson; and Detective Senior Constable Gary Sheehan.
- 22.3 The findings I make under section 81(1) of the Act in relation **Ursula Barwick** are as follows.

Ursula Barwick: Identity

The missing person Ursula Barwick is now deceased.

Ursula Barwick: Date of death

Ursula died on 27 October 1987.

Ursula Barwick: Place of death

Ursula died at Keajura NSW 2652.

Ursula Barwick: Cause of death

The cause of Ursula's death was cerebral contusions and lacerations due to head injury, with a ruptured aorta, ruptured liver and multiple injuries all being significant conditions which contributed to death.

Ursula Barwick: Manner of death

Ursula sustained these fatal injuries when a vehicle that she was travelling in was involved in a collision with another vehicle.

- 22.4 The findings I make under section 81(1) of the Act in relation **Gary Jones** are as follows.

Gary Jones: Identity

The missing person Gary Jones is now deceased.

Gary Jones: Date of death

Gary died between 9 and 24 November 1990.

Gary Jones: Place of death

Gary died in or around Little Bay NSW 2036.

Gary Jones: Cause of death

The limited available evidence, and the absence of any postmortem examination, does not allow for any finding to be made as to the cause of Gary's death.

Gary Jones: Manner of death

The limited available evidence does not allow for any finding to be made as to the manner of Gary's death.

22.5 The findings I make under section 81(1) of the Act in relation **Lionel Daveson** are as follows.

Lionel Daveson: Identity

The missing person Lionel Daveson is now deceased.

Lionel Daveson: Date of death

Lionel died on, or sometime after, 24 August 2007.

Lionel Daveson: Place of death

The limited available evidence does not allow for any finding to be made as to the place of Lionel's death.

Lionel Daveson: Cause of death

The limited available evidence, and the absence of any postmortem examination, does not allow for any finding to be made as to the cause of Lionel's death.

Lionel Daveson: Manner of death

Lionel died as a result of actions taken by him to intentionally inflict his own death.

22.6 The findings I make under section 81(1) of the Act in relation **Christof Meier** are as follows.

Christof Meier: Identity

The missing person Christof Meier is now deceased.

Christof Meier: Date of death

Christof died on 1 April 2002.

Christof Meier: Place of death

Christof died at Broken Head NSW 2481.

Christof Meier: Cause of death

The cause of Christof's death was drowning.

Christof Meier: Manner of death

Christof drowned whilst swimming in the surf off Broken Head beach. The manner of death is, therefore, misadventure.

23. Epilogue

- 23.1 When a person goes missing many questions are raised by the family of that missing person. A coronial investigation and an inquest seeks, within the confines of the Act, to answer as many of these questions as possible. Through the dedication of individual police officers and, in some cases, through sheer serendipity, certain answers have been provided to the questions held by the families of Ursula Barwick, Gary Jones, Lionel Daveson and Christof Meier.
- 23.2 Some of these answers have, distressingly, have come too late for Cheree Barwick and Merrilee Jones. For other questions, the opportunity to now answer them has been lost, or the available evidence simply does not allow for these questions to be answered. The systemic issues examined by these inquests have identified further questions for which a family of a missing person should never have to seek answers. So whilst it is too simplistic to speak of certain answers providing closure for families who have had a loved one go missing, it is hoped that the answers that have been provided in these inquests do bring some measure of comfort and solace for the families of Ursula, Gary, Lionel and Christof.
- 23.3 It should also be recognised that many families of missing persons are never provided with the answers that they seek. This devastating uncertainty only serves to exacerbate the grief and trauma that is felt with being separated from a loved one, often for a period of many years. It is hoped that the issues which these inquests have highlighted continues to provide the impetus for improvement and change to ensure that the quality, adequacy and effectiveness of missing persons investigations appropriately reflects the importance of providing families of missing persons with the answers that they seek.
- 23.4 On behalf of the Coroner's Court of New South Wales, I offer my deepest sympathies, and most sincere and respectful condolences, to the family and friends of Ursula, Gary, Lionel and Christof.
- 23.5 I close these inquests.

Magistrate Derek Lee
Deputy State Coroner
2 November 2021
Coroner's Court of New South Wales

Inquest into the suspected deaths of missing persons Ursula Barwick, Lionel Daveson, Gary Jones & Christof Meier

Appendix A

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

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Magistrate Derek Lee
Deputy State Coroner
2 November 2021
Coroner's Court of New South Wales