CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Stephen John Burt
Hearing dates:	18 and 19 November 2024
Date of findings:	18 December 2024
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Rebecca Hosking, Deputy State Coroner
Catchwords:	CORONIAL LAW – identification of a missing person; NSW police application of policies and procedures in relation to missing persons and fingerprinting.
File number:	2021/321968
Representation	Counsel Assisting the Inquest: Claire Palmer of Counsel, instructed by Leanne Kohler, NSW Crown Solicitor's Office. Commissioner of Police, NSW Police Force: Christine Melis of Counsel instructed by Craig Norman of the Office of General Counsel, NSW Police Force. Kathryn Jagot: Emma Sullivan of Counsel.

Findings	**Identity** The person who has died is Stephen John Burt **Place of death** Unascertained **Date of death** Between 22 and 26 January 1985 **Cause of death** Drowning **Manner of death** Unascertained
Recommendations	Not applicable.

Contents

Introduction

1. Section 81(1) of the *Coroners Act 2009* (NSW) (**the Act**) requires that when an inquest is held, the coroner must record in writing their findings as to various aspects of the death.

2. These are the findings of an inquest into the death of Stephen John Burt, much loved and missed brother, brother-in-law, uncle, nephew, son, grandson and friend.

The role of the coroner

3. Pursuant to section 81 of the Act, a coroner holding an inquest concerning the suspected death of a person must make findings as to whether the person has died and if so, the date and place of the person's death, and the cause and manner of their death.

4. In addition, the coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

5. A previous inquest took place on 3 May 1985 before Coroner B. Cleary at the City Coroner's Court in Glebe (**1985 Inquest**). At that time, Coroner Cleary was unable to identify the body of a deceased man reported to have been found by members of the NSW Police Force (**NSWPF**) on 26 January 1985. Coroner Cleary found that the unknown male:

> *Died about 27 January, 1985[1] most likely of drowning the evidence adduced does not enable me to say the exact time and place of death or the identity of the body.*

6. We now know that the body which was the subject of that inquest was Stephen's body. Acknowledging that fact, when I am referring to the body which was, prior to March 2021 unidentified, I will refer to it as Stephen's body as it always was.

The issues examined at the inquest

7. An inquest was held on 18 and 19 November 2024 in circumstances where the male who was the subject of the 1985 Inquest was identified by reference to his fingerprints to be Stephen John Burt, who had been missing since January 1985.

8. Tendered to the court was an electronic brief of evidence compiled by the Officer in Charge of the coronial investigation, Detective Sergeant Jennifer Ross.

9. At the inquest the court received evidence from:

   a. DS Ross

   b. Detective Chief Inspector Ian Rowney of Fingerprint Operations, Police Headquarters

   c. Dr Lorraine Du Toit-Prinsloo, Chief Forensic Pathologist and Clinical Director of Forensic Medicine NSW

   d. Lloyd Mulholland, former Detective Senior Constable, Police Fingerprint Bureau

   e. Detective Inspector Ritchie Sim, former Manager of Missing Persons Registry (**MPR**), State Crime Command, NSWPF

[1] It is unclear why Coroner Cleary determined the date of death to be 27 January 1985. The evidence before the court indicated that the body we now know to be Stephen, was retrieved from the water at 10.15am on 26 January 1985, that he was deceased when he was recovered, and that he was transported to Royal Prince Alfred Hospital Camperdown on 26 January 1985.

f. Kathryn Jagot, Stephen's sister.

10. The inquest considered the following issues:

a. What factor(s) contributed to the inability in 1985 to match/identify the fingerprints taken from Stephen's body on 26 January 1985 with the fingerprints of Stephen Burt, which had been available in the NSWPF records since 1982?

b. What factor(s) contributed to the Missing Person's report, photograph and diary given to the NSWPF in early 1985, and other records associated with Stephen's file:

i. not being able to be located by the NSWPF; and

ii. not being transferred to the NSWPF Computerised Operational Policing System (**COPS**) in 1993/1994.

c. Did the absence of any transfer to COPS in 1993/1994 materially affect whether Stephen was listed on the Missing Persons Database used by the NSWPF Missing Persons Unit (**MPU**)?

d. Was a fingerprint search carried out by NSWPF Fingerprint Operations in response to the email request made by Senior Constable Adam Marsh of the NSWPF MPU on 16 July 2009?

e. If a search of the kind referred to above had been carried out using the National Automated Fingerprint Identification System (**NAFIS**), is it likely that it would have produced a positive match?

f. What were the circumstances which resulted in a NAFIS search in May 2021 of the fingerprints of Stephen obtained on 26 January 1985, and why did the search produce a positive result?

g. Did the steps taken by the NSWPF to:

i. identify Stephen following his death; and

ii. investigate the report of Stephen as a missing person;

comply with the relevant NSWPF policies and procedures applicable at the time?

h. What was the date and place, manner and cause of Stephen's death?

i. Is it necessary or desirable to make any recommendations in relation to any matter connected with Mr Steven Burt's death pursuant to s. 82 of the Act?

11. I reached the conclusions that follow.

a. The failure of Mulholland to identify the correct fingers when taking fingerprints from Stephen's remains on 26 January 1985 was catastrophic in that it precluded those prints from being matched to the fingerprints taken from Stephen on 3 March 1982 at the time of his death in late January 1985 and, ultimately, until May 2021.

b. This error was compounded by the absence of 'plain' or 'slap' prints which may well have enabled the error to be rectified and a contemporaneous identification made.

c. While they may not have impacted the outcome, other inadequacies in the fingerprinting analysis process in 1985 included:

i. that the forms were not completed, and significant information was routinely not recorded – including why only 9 prints were taken/available to be taken

ii. that there was no process by which updated information – such as regarding the estimated age of an unidentified body – was reported to the fingerprinting analysis team so that further searches could be undertaken.

d. The evidence adduced at the inquest does not enable a finding as to what factors may have contributed to Stephen's missing person's file being lost and not being transferred to the COPS system in 1993/1994.

e. The Missing Person's database is populated by COPS. Given there was no Missing Person's report recorded on COPS for Stephen, the Missing Person's database held no record of him.

f. There was no evidence adduced at the inquest which was consistent with there having been a search carried out by NSWPF Fingerprint Operations in response to the email request made by Senior Constable Adam Marsh of NSWPF MPU on 16 July 2009.

g. If a search of the fingerprints taken from Stephen's body had been undertaken in NAFIS in 2009 it would not have produced a positive match because of the incorrect sequencing.

h. Between 2010 and 2013 NAFIS underwent a significant capability upgrade making it more accurate and less reliant on sequencing. The system adjusted for error including searching on the assumption that all prints were incorrectly sequenced.

i. Project Aletheia was an initiative of the MPR following its commencement in 2019. The purpose of the project was to review holdings for all outstanding long-term missing persons cases together with outstanding unidentified bodies and human remains cases.

j. During phase 2 of Project Aletheia, a decision was made in 2021 to request NSWPF Fingerprint Operations to conduct a search of NAFIS for all unidentified bodies and human remains where fingerprints had been taken. From the search, a total of 16 persons were identified within NSW and interstate. Six of these persons related to long term missing persons investigations. One of the six was Stephen. The capability upgrade and lack of reliance on sequencing produced a positive result.

12. The steps taken by NSWPF to identify Stephen following his death and to investigate Stephen as a missing person were not in accordance with NSWPF policies and procedures in place at the time in that the Commander's instructions required "every effort" to be made to locate a missing person and to document their efforts. In Stephen's case:

a. catastrophic errors were made in the investigative steps that were undertaken including:

i. the incorrect sequencing of fingerprinting

ii. the failure to update the estimated age of Stephen's body, and

iii. the inadequacy of the inquiry with Kathryn Jagot to ascertain whether the body found could belong to Stephen. In the course of that inquiry, a comparison was rejected on the basis that Stephen's boots were found with his belongings in his apartment. Further inquiries which were available to Love at the time included a comparison of his fingerprints from the copy held on file by the NSWPF or potentially a comparison from dental records.

b. Stephen's missing person's file including his photograph and his diary were lost.

c. there appears to have been no attempt to identify Stephen by searching NAFIS between 2013 and 2021 – if there had been a search, Stephen may have been identified as early as 2013 notwithstanding the errors in the initial investigation.

13. I find that Stephen died between 22 and 26 January 1985 as a consequence of drowning. The evidence adduced at the inquest does not enable me to make a finding as to the place or manner of death.

14. In circumstances where the NSWPF policies, procedures and systems which are currently in place do not reflect those that were in place in 1985, I make no recommendations as a consequence of this inquest.

Background

15. Much of the facts of this matter are not in dispute and I am grateful for submissions by counsel assisting from which I have drawn extensively and, in relation to non-contentious issues, directly at times.

16. Stephen was born on 8 January 1962 to William and June Burt. He was the older brother of Kathryn Jagot (nee Burt), brother-in-law of Simon Jagot, grandson of Murial and Fred and nephew to Robyn Weaver. He was the uncle of Emma and Thomas, whom he did not get to meet.

17. Stephen was described by his sister as a shy, softly spoken and sensitive man. He was intelligent and good at school though had difficulty with the social aspects. He was musically talented and taught himself to play guitar. He enjoyed his motorcycle which he bought with his own money, fitness and watching television with his sister and their cousin. He was a gentle soul.

18. Stephen had a difficult childhood. His father suffered from alcoholism. Stephen began to drink in his early teens. At around age 18 or 19, he attempted suicide by overdosing on prescription medicine. He was admitted to the mental health unit of Westmead Hospital where he stayed for at least 2 weeks. At some stage later, aged around 21, he was admitted to St John of God Hospital at Burwood where he remained for several weeks. Stephen also attended Alcoholics Anonymous around this time.

19. At some point between the ages of 18 and 21, Stephen left home unannounced for a period of four months and went to Melbourne, before returning to his family. Kathryn Jagot recalls that Stephen seemed to improve somewhat in Melbourne but then deteriorated when he returned home. Kathryn Jagot was not certain whether Stephen had been reported missing when he went to Melbourne, but she assumed not.

20. On 5 March 1982, Stephen's fingerprints were taken at Parramatta Police station in relation to minor charges. As a consequence, Stephen's fingerprints were available to police from that date.

21. Stephen eventually moved out to a unit in Harris Park around 1983. He spent a significant amount of time with his maternal aunt, Robyn, who would take him to see his mother's parents in Katoomba and on outings to concerts and the theatre.

22. In the summer of 1985, Stephen disappeared, aged 23. Kathryn Jagot thinks that she became aware that her brother was missing after her mother was contacted by Stephen's real estate agent, who informed her that Stephen was behind on his rent. She said that Stephen would not have had a job at this time; he would have been on a Centrelink benefit. He did not have a car, but he had a bike.

23. Kathryn Jagot and her mother went to the unit to collect Stephen's belongings, and it appeared neat and tidy. Stephen's wallet, watch and personal belongings were still in the unit. They also found Stephen's diary open on the kitchen table, in which he had written words to the effect of, 'They are after me. They're coming to get me.' Kathryn Jagot recalled that her mother thought that Stephen would be 'all right' and that he would 'come back'. Kathryn Jagot thought the situation was different to when Stephen had previously travelled to Melbourne for several months without telling his family. In that case, Stephen had packed his belongings and taken them with him.

24. Kathryn Jagot went to Parramatta Police station to report her brother missing. She was accompanied by her then boyfriend, now-husband, Simon Jagot. Kathryn Jagot brought Stephen's diary and a recent polaroid photo of him and made a report. She informed police that her brother had a history of mental illness, that he had attempted to commit suicide in the past, and that she feared for his safety. She is unsure of precisely when she made this report, but she recalled it was summer, perhaps February or March, because of the clothes she was wearing. Simon Jagot recalled that he felt that he and Kathryn Jagot were not taken seriously by the police due to their age, Stephen's age, and Stephen's mental health history.

25. Kathryn Jagot stated in her interview with DS Ross that she did not have any further contact with NSWPF after this time. She also thinks that if the NSWPF had contacted her mother or father instead, her parents would have discussed that contact with her.

26. The events involving Stephen affected Kathryn Jagot's life and the lives of her entire family, significantly. She eventually completed a degree in counselling and even worked with homeless men at one stage at a refuge in Granville. She recalls always thinking, 'Is he going to turn up? Is he here?'. Her aunt Robyn had night terrors worrying about what might have happened to Stephen. Her father and grandparents died not knowing what had happened to Stephen. Their mother found out that Stephen had died while suffering from dementia and was confused as to whether he had been alive all this time. This suffering was exacerbated by not being able to identify Stephen's grave and provide him with a proper burial. It was also exacerbated by delays in the coronial process.

The discovery of Stephen's body

27. About 7.55pm on 25 January 1985, a telephone message was received at the Sydney Water Police station stating that a body had been seen floating off the Gap, in the Tasman Sea. A search was carried out by police vessels and Polair 1 but, due to the failing light, the body was unable to be located.

28. The following morning, the search resumed at 9.30am assisted by police divers. At 10.15am, remains were discovered by Senior Constable Martin Kelly and Constable Richard Worrad of Sydney Water Police in an advanced state of decomposition. They appeared to have been in the water for some time and were located about 40 metres east of Jacobs Ladder, an area of two clefts in the cliff face under the Gap Park. Clothing found with the remains included a black shirt, blue denim jeans, boots with zips on the sides and white socks. No identification was found with Stephen's body. Stephen's body was taken to Sydney Water Police where it was viewed by Detective Sergeant Williams from the Pillage Unit, who observed that there were no apparent signs of violence. Government contractors conveyed Stephen's body to the Royal Prince Alfred Hospital, Camperdown where Doctors Paton and McLean pronounced life extinct.

29. Stephen's body was taken to the City Morgue at Glebe and admitted as "E21997". In the afternoon of 26 January 1985, Wireless Message no. 14 was circulated to all

stations with a description of Stephen's body. This message appears to have indicated that the deceased was in his late 30s or early 40s and that he was bald.

30. Also on 27 January 1985, Detective Sergeant Heslop of the Crime Scene Unit, Scientific Investigation Section attended the City Morgue and took a series of photographs of Stephen's body.

31. On 29 January 1985, the Division of Analytical Laboratories received items for biological testing. Some alcohol (00.27g/100mL) was found in the blood specimen but the certificate indicated that this result should be interpreted with caution due to the decomposed nature of the specimen. Examination of the remaining biological fluids yielded no significant results.

Autopsy

32. On 27 January 1985, an autopsy was conducted by Dr Leng Chai Jimmy Yong. Dr Yong determined that the body was that of a Caucasian male aged between 25 and 35, weighing 66kg and measuring 185cm in height. Dr Yong stated that the body showed 'no evidence of any violence or injury'. He wrote:

> *'The exact cause of death is difficult to ascertain due to decomposition. The most likely cause is drowning.*

33. Dr Yong recorded:

> *evidence of water immersion especially the skin of the hands and feet which were considerably wrinkled and had started to slough off from the respective parts.*
>
> *there was a large quantity of gravel in the bronchial tree*
>
> *a considerable amount of gravel in the oesophagus and also in the gastric region*
>
> *estimation of alcohol and blood, liver, stomach and contents, urine and bile and blody [sic] fluids sent for chemical analysis via Const. Cleary. History being performed'.*

34. Importantly, Dr Yong did not state in his report that any finger was missing. Nor did he note the presence of rigor mortis.

Fingerprints are obtained

35. On 28 January 1985, Lloyd Mulholland took a set of nine (9) fingerprint impressions from Stephen's body. In a statement dated 21 March 1985, Mullholland wrote that he:

> *took a set of inked fingerprint impressions from the body and upon return to the Central Fingerprint Bureau I carried out a thorough search.*

36. These fingerprints will be discussed in greater detail below.

37. At Fingerprint Operations, Mulholland classified the fingerprint card using the Modified Henry Classification System (**MHCS**), which was the fingerprint identification process in operation at the time. This included a manual search being performed by a fingerprint expert against the hardcopy ten print fingerprint records held by the NSWPF. The fingerprint card indicates that the deceased's fingerprints were searched and determined to be 'Not Known'. This means that no existing fingerprint record could be located within NSWPF records as at 7 February 1985 (despite Stephen's fingerprints having been taken by the police on 5 March 1982 – this will be revisited below).

38. DCI Rowney indicated that once the manual search of the subject fingerprint card was finalised, the forensic investigation would have been closed and the fingerprint card placed into a file, prior to its eventual archiving.

Dental Examination

39. On 1 February 1985, Dr Christopher Griffiths, Forensic Dentist of Westmead Hospital completed an examination of Stephen's body. Dr Griffiths' report of 26 February 1985 stated that there were no dental records available for comparison. Dr Griffiths suggested that the Mandible and Maxilla be removed prior to interment, which in turn would give them the flexibility of being able to take post mortem radiographs to match any ante-mortem files which may become available in the future. The Mandible and Maxilla would be stored at the Dental school, Westmead Centre, and this would save having to exhume the body at a later date. However, this suggestion was not endorsed by the coroner, and so did not go ahead.

40. On 5 February 1985, Constable Worrad spoke with Dr Griffiths on the telephone. Dr Griffiths told Constable Worrad that based on his assessment, the body was of someone 18-20 years old. This was younger than the age range determined in the Autopsy Report, which was 25-35 years. It was also younger than the initial age range estimated by the police officers involved in the retrieval of Stephen's body (late 30s to early 40s).

41. Later that day, Wireless Message no. 39 was circulated to all stations amending the previous Wireless Message no. 14 with respect to age (18-20) and hair (that he was not bald). Wireless Message no. 39 also noted that recent dental work had been undertaken. Significantly, this information was not conveyed to Mulholland or Fingerprint Operations. As such, a further search with the adjusted age range was not performed.

Contact with Vaucluse Police Station & Statement of Robin Edward Connelly

42. Constable Worrad contacted Vaucluse Police Station and was informed that on 22 January 1985, at 5.35pm, a young man behaving unusually had been sighted by Robin Connelly near the Gap.

43. On 30 March 1985, Connolly prepared a statement indicating that he was walking with his family in Watsons Bay on 22 January 1985. A young male walked past him with his hands shaking in a strange way. Connelly later gave evidence during the 1985 inquest that his wife had mentioned that:

> *she thought he was conducting an orchestra, in the way young people do when they have stereos, head sets, because his arm action was very striking.*

44. This is consistent with Stephen's interest in and talent for music.

45. Connelly said that he saw the male climb through a fence and onto a ledge near the Dunbar Anchor. Connelly described the male as aged about 20, wearing a black shirt with short sleeves and a red and yellow emblem on one side of the chest. The male was wearing shiny boots and navy or black jeans. He was of slim build, pale, with medium length dark hair and acne on his face. Connelly waited to see if the man returned, being concerned by the strong winds blowing at the time. When the male did not return, Connelly returned to the area to see if he could find him. When he could not, he reported the incident to Vaucluse Police Station. Connolly returned with police to the area. Police also called the police helicopter, which searched the cliffs unsuccessfully. Connolly notes in his statement that he did not see the male jump, and he may have taken another track away from the cliff.

46. A review of the clothing held at the City Morgue revealed that it appeared to be identical to the description of clothing provided by Connelly to Vaucluse Police on 22 January 1985.

Letter from Sydney Water Police to the Missing Persons' Unit

47. Around 22 March 1985, a Memorandum was sent to the MPU from Sydney Water Police attaching a letter prepared by Senior Constable M J Kelly dated 21 March 1985 (**MPU Memo**). Senior Constable Kelly's letter outlined the circumstances around the discovery of Stephen's body and enquiries made by Sydney Water Police to date.

48. Senior Constable Kelly wrote:

> *At this time all avenues of inquiries have been exhausted, and an application will be made to the coroner for burial of the remains as a destitute person.*

49. The letter from Senior Constable Kelly notes that the deceased was 180cm which is inconsistent with the Autopsy Report, which states the height of the deceased as being 185cm.

50. The third page of the MPU Memo is a covering sheet signed by an 'Inspector dga'. There is a handwritten note underneath initialled DHL and dated 27 March 1985. That note reads:

> *Check of [unreadable] on this date for comparison. Only likely comparison appears to be 850667, Stephen John Burt. I contacted his sister this date and confirmed height definitely 6'2". Last seen on 6.1.85. Has black zip boots but she checked his property and boots are still there. Rejected comparison.*

51. Detective Sergeant Ross has established that 'DHL' are the initials of former Senior Constable Donald Hugh Love, who was previously attached to the MPU and passed away in 1990. In her evidence, Kathryn Jagot did not recall a conversation with Love. She was asked whether the conversation would have been significant and one which she would expect to remember and she said yes. Notwithstanding that, given the note, I consider it more likely that there was a conversation between Love and Kathryn Jagot which she does not recall likely because of the passage of time and potentially because a conversation which did not locate Stephen may well have been traumatic.

52. The existence of the note does suggest that the Missing Person's Report made by Kathryn Jagot to Parramatta Police station was forwarded to the MPU prior to 27 March 1985.

53. The rejection of a comparison on the basis that Stephen's boots were found at his residence is highly problematic.

Burial of remains at Emu Plains Cemetery

54. On 6 February 1986, Stephen was buried in a destitute grave in the Catholic section at Emu Plains Cemetery. Stephen's exact location is unknown.

Enquiries in 2009

55. On 15 July 2009, MPU's Senior Constable Adam Marsh began a review of the file relating to Stephen's body. The following day, he sent an email to then Sergeant Tony Bush at Fingerprint Operations to re-search the fingerprint card taken of Stephen's body to "see if there is any match". Senior Constable Marsh indicated that "strong possibilities" were two specific persons, Jeffrey Hines and Christopher

Howse. It appears unlikely that Sergeant Bush read the email; Sergeant Bush considers that it is likely that he "missed the email from Constable Marsh initially which would have eventually dropped to the bottom of [his] email inbox, having never been read".

56. There is no record indicating that the fingerprints taken from Stephen's body were openly searched against the electronic national database at this time. Nor it is likely that Senior Constable Marsh followed up his original request. Senior Constable Marsh said that it would have been common practice for him to follow up fingerprint search requests but he has not been able to locate any replies or other correspondence for these inquiries.

Project Aletheia and the identification of Stephen

57. On 5 May 2021, the fingerprints taken from Stephen's body were searched against records contained on NAFIS at the request of the MPR. This request was made as a result of 'Project Aletheia', a project commenced by the MPR following its commencement in 2019. The purpose of the project was to review holdings for all outstanding long-term missing persons cases together with outstanding unidentified bodies and human remains cases.

58. The request resulted in a match to fingerprints held on file taken on 5 March 1982. As noted above, it appears that Stephen's fingerprints would have been available on hardcopy file when Detective Mulholland undertook his search at the Central Fingerprint Bureau in 1985.

Issues

What factor(s) contributed to the inability in 1985 to match/identify the fingerprints taken from Stephen's remains on 26 January 1985 with the set of Stephen's fingerprints which had been available in the NSWPF records since 1982?

59. On or about 26 January 1985, Mulholland attended the City Morgue for the purpose of taking fingerprints from the body now known to be Stephen. In doing so, Mulholland:

    a. took 9 ink prints

    b. mis-sequenced the prints he took of the left hand: the left index finger impression was not recorded at all, the left middle finger impression was recorded in the left index finger space on the form, the left ring finger impression was recorded in the left middle finger space on the form, and in the left ring finger space on the form the left little finger impression was recorded.

    c. did not take 'plain' or 'slap' prints of either hand

    d. did not complete the form on which the fingerprints were taken, despite the following notation on the form:

       This form must be completed in every detail before the officer concerned begins to take the fingerprints of another person.

    e. did not indicate why only 9 prints were taken or complete the section of the form which states:

       When a finger is missing, or so injured that the impression cannot be obtained or is deformed and yields a bad print, the particulars of the date of loss of finger or injury must be stated.

60. Mulholland conceded that the incorrect sequencing of the fingerprints was a result of his error.

61. In his statement dated 13 March 2024, Mulholland stated that the reason only 9 prints were taken is because:

> *The tenth finger was missing from the body.*

62. At the inquest, Mulholland's evidence was that he did not recall taking fingerprints from Stephen's body. To that extent, his evidence was reconstructed. We heard from Dr Lorraine Du Toit-Prinsloo, Chief Forensic Pathologist and Clinical Director of Forensic Medicine NSW. While she was not qualified in 1985, she considers the loss of a finger to be a relevant feature to note in performing a post-mortem examination.

63. Given the absence of a reference to a missing digit in the postmortem report of Dr Yong prepared on 27 January 1985, I reject the assertion by Mulholland that the tenth finger was missing from the body. The more likely scenario is that the finger was so deteriorated by decomposition that the print could not be taken.

64. The fingerprint form contains the following notations:

    a. 'Index checked by' – this was not completed

    b. ''Classified and searched by' – this was initialled by Mulholland

    c. 'Checked by' – this was initialled, Mulholland said by Ray Turner.

65. Mulholland indicated that the reason for not completing the form was that the form was linked to an index card containing all the relevant information – such cards no longer being available presumed to have been destroyed once the system was digitised.

66. Mulholland's evidence was that the supervisor who marked the, 'Checked by' box was reviewing the classification pursuant to the MHCS and was not otherwise checking that, for example, the form was correctly completed (or completed at all).

67. Mulholland stated that he didn't take 'plain' or 'slap' prints because it was not routinely done in the case of deceased persons. It was suggested that it can be difficult to obtain these prints in cases of rigor mortis. However, Dr Du Toit-Prinsloo confirmed that given the immersion in water, rigor mortis is likely to have passed by the time Stephen's fingerprints were taken and that the issue is more likely to have been decomposition.

68. The failure to take 'plain' or 'slap' prints was significant. These records are taken as a singular impression of all fingers captured simultaneously on the fingerprint form. According to DCI Rowney, they are a critical component of the quality control process. He stated:

> *'This step is essential to ensure that the individual (rolled) fingerprints have been captured in the correct sequence and in the correct spaces on the fingerprint form, eg: the right thumb is in the right thumb space, the right index finger is in the right index finger space, and so forth.*

69. DCI Rowney's evidence was that the Modified Henry Fingerprint System in use at the time is a complex alpha-numeric classification process based on the analysis of the fingerprint pattern type appearing in individual thumbs and fingers, combined with the distinctive friction ridge flow features contained within the different classified patterns in each individual thumb and finger.

70. DCI Rowney opined:

> *The system has in-built allowances to account for missing or badly damaged fingers, which often extend[s] the search criteria considerably along with the number of fingerprint records required to be manually examined by the searching fingerprint expert. In this particular case, in addition to the fingers being recorded in the wrong spaces on the form, the missing recording of the left index finger on the fingerprint form relating to the deceased resulted in an inaccurate Henry classification being made by the analysing and searching fingerprint expert in 1985. The resulting Henry search classification criteria that was applied by the analysing fingerprint expert in 1985 was not sufficiently broad enough to result in the deceased being identified as a result of that search. There are thousands of fingerprint records filed between the correct Henry classification and the erroneous Henry classification applied as a result of the incorrect finger sequence issue.* ***Of note the deceased record was searched in the age bracket of persons born 1921-1960, with the deceased's actual year of birth being 1962.*** *However, searching the 1960+ bracket would have made no difference due to the significant inaccuracy of the actual Henry classification search formula used by the searching fingerprint expert in 1985.*

Findings

71. The failure of Mulholland to identify the correct fingers when taking fingerprints from Stephen's remains on 26 January 1985 was catastrophic in that it precluded those prints from being matched to the fingerprints taken from Stephen on 3 March 1982 at the time of his death in late January 1985 and, ultimately, until May 2021.

72. This error was compounded by the absence of 'plain' or 'slap' prints which may well have enabled the error to be rectified and a contemporaneous identification made.

73. While they may not have impacted the outcome, other inadequacies in the fingerprinting analysis process in 1985 included:

    a. that the forms were not completed, and significant information was routinely not recorded – including why only 9 prints were taken/available to be taken.

    b. that there was no process by which updated information – such as regarding the estimated age of an unidentified body – was reported to the fingerprinting analysis team so that further searches could be undertaken.

What factor(s) contributed to the Missing Person's report, photograph and diary given to the NSWPF in early 1985, and other records associated with Stephen's file: not being able to be located by the NSWPF; and not being transferred to the COPS in 1993/1994.

74. There is no doubt that a missing person's report was made by Kathryn Jagot in 1985. I accept Kathryn Jagot's evidence in that regard and it is consistent with the note by Love recording the comparison undertaken as between Stephen's missing person's file and the file relating to his remains.

75. I am satisfied that the searches to find this file as reported by DS Ross were extensive and unsuccessful.

76. In his evidence, DI Sim confirmed that the diary and photograph Kathryn Jagot provided to the NSWPF were important documents which ought to have been maintained or copied and returned to Kathryn Jagot.

77. DI Sim considered it possible that these items were sent to the MPU.

Findings

78. The evidence adduced at the inquest does not enable a finding as to what factors may have contributed to Stephen's missing person's file being lost and not being transferred to the COPS system in 1993/1994.

Did the absence of any transfer to COPS in 1993/1994 materially affect whether Stephen was listed on the Missing Persons Database used by the NSWPF Missing Persons Unit (MPU)?

Findings

79. The Missing Person's database is populated by COPS. Given there was no Missing Person's report recorded on COPS for Stephen, the Missing Person's database held no record of him.

Was a fingerprint search carried out by NSWPF Fingerprint Operations in response to the email request made by Adam Marsh of the NSWPF MPU on 16 July 2009?

Findings

80. There was no evidence adduced at the inquest which was consistent with there having been a search carried out by NSWPF Fingerprint Operations in response to the email request made by Senior Constable Adam Marsh of the NSWPF MPU on 16 July 2009.

If a search of the kind referred to above had been carried out using NAFIS, is it likely that it would have produced a positive match?

81. DCI Rowney opined that in 2009, NAFIS remained reliant on the correct sequencing of fingerprints such that if a search had been undertaken it is unlikely that the fingerprints taken from Stephen's remains would have matched the fingerprints on file taken from Stephen.

82. As outlined above, a secondary error in 1985 was the failure to notify Fingerprint Operations that Dr Griffith's analysis of the teeth from Stephen's remains indicated that he was between 18 and 20 at the time of his death. Mulholland indicated that even if the sequencing error had not been made, a match would not have occurred because the search parameters included the incorrect age range.

83. If not for the sequencing error, if no match had occurred in 1985 because of the incorrect age parameters being applied, this may have been rectified in 2009 as age parameters were no longer applied to searches in NAFIS.

Findings

84. If a search of the fingerprints taken from Stephen's body had been undertaken in NAFIS in 2009 it would not have produced a positive match because of the incorrect sequencing.

What were the circumstances which resulted in a NAFIS search in May 2021 of the fingerprints of Stephen obtained on 26 January 1985, and why did the search produce a positive result?

Findings

85. Between 2010 and 2013 NAFIS underwent a significant capability upgrade making it more accurate and less reliant on sequencing.

86. Project Aletheia was an initiative of the MPR following its commencement in 2019. The purpose of the project was to review holdings for all outstanding long-term missing persons cases together with outstanding unidentified bodies and human remains cases.

87. During phase 2 of Project Aletheia, a decision was made in 2021 to request NSWPF Fingerprint Operations to conduct a search of NAFIS for all unidentified bodies and human remains where fingerprints had been taken. From the search, a total of 16 persons were identified within NSW and interstate. Six of these persons related to long term missing persons investigations. One of the six was Stephen. The capability upgrade and lack of reliance on sequencing produced a positive result.

Did the steps taken by the NSWPF to: identify Stephen following his death, and investigate the report of Stephen as a missing person, comply with the relevant NSWPF policies and procedures applicable at the time?

88. Detective Senior Sergeant David Bennett, MPR, provided a statement dated 18 November 2022. He reported that in 1985 guidance as to how a missing persons investigations should operate could be found in the '1977 Commissioner's Instruction' which stated, amongst other things:

> *It is the responsibility of Police in charge of the matter to make every effort to locate the missing person and to endorse the appropriate place in the report of Missing Persons Book the result of their enquires.*
>
> *Upon receipt of a report of a missing person, it is the responsibility of the staff of the Missing Persons Section to take all necessary action to ensure the report is fully circulated by way of Special Missing Person Circulars to the Women Police Section, Vice Squad, Drug Squad, Criminal Investigation Branch and Police Station near to where the missing person may be found.*
>
> *The Missing Persons Unit will regularly "follow up" all reports of missing persons until such time as the persons concerned are located. When these "follow up' inquiries are received at Police Stations, any development since the initial report was furnished should be supplied by way of report to the Missing Persons Unit. This also applies in causes of deceased or unidentified Persons.*

89. The steps taken in 1985 to identify Stephen following his death included: the taking of the fingerprints, conducting an autopsy, conducting a dental examination and sending Wireless communications.

90. I accept that Love also spoke with Kathryn Jagot and, based on his note regarding the conversation, concluded that a comparison with Stephen could be rejected as Kathryn Jagot confirmed that she had "checked his property, boots are still there." This rejected comparison is, to my mind, almost as significant as the incorrect sequencing of the fingerprints. At this point, Love had available to him a next of kin, who could have potentially identified Stephen and the capability of identifying Stephen via his dental records. He could have also undertaken a search to obtain Stephen's criminal antecedents which, could have resulted in a fingerprint comparison being undertaken by an expert who may have identified the error in sequencing. The rejection of a comparison based on the likelihood that Stephen owned one pair of boots is inconceivable.

91. Kathryn Jagot recalls no further contact with NSWPF following her initial report. She felt she was not taken seriously, and she felt the NSWPF were dismissive of her. While I find that she was contacted by Love as above, it otherwise appears that the NSWPF were dismissive of her, did not take her seriously, did not take adequate steps to investigate her brother's disappearance or to engage with her as the next of kin of a missing person.

92. I do not consider the 2009 email submitted by Senior Constable Marsh of the MPU can be characterised as an attempt to identify Stephen in circumstances where two

other missing persons (and not Stephen) were listed as “strong possibilities.” The email makes no reference to Stephen.

93. It is impossible to precisely identify other steps taken because of the lack of records and a missing person’s file. Senior Constable Marsh gives evidence that he undertook a further review of Stephen’s case at least on 19 April 2010 and 29 December 2010.

94. The upgrade to NAFIS between 2010 and 2013 suggests that there was no attempt between 2013 and 2021 to search the prints taken from Stephen’s remains during that period. Given that this is likely a baseline step in the identification process, it suggests to me that there were no attempts during that period to identify Stephen.

95. While the Commander’s instructions are broad rather than specific, they indicate that “every effort” should be made to locate the missing person and to document their efforts.

96. In this case, significant steps that were taken, including fingerprinting and talking to Kathryn Jagot. However, they were performed so inadequately that they prevented a positive identification from being made. The investigation was wholly inadequate.

Findings

97. The steps taken by NSWPF to identify Stephen following his death and to investigate Stephen as a missing person were not in accordance with NSWPF policies and procedures in place at the time. This is because the Commander’s instructions required “every effort” to be made to locate a missing person and for those efforts to be documented. In Stephen’s case:

    a. catastrophic errors were made in the investigative steps that were undertaken including:

        i. the incorrect sequencing of fingerprinting

        ii. the failure to update the estimated age of Stephen’s body, and

        iii. the inadequacy of the inquiry with Kathryn Jagot to ascertain whether the body found could belong to Stephen. In the course of that inquiry, a comparison was rejected on the basis that Stephen’s boots were found with his belongings in his apartment. Further inquiries which were available to Love at the time included a comparison of his fingerprints from the copy held on file by the NSWPF or potentially a comparison from dental records.

    b. Stephen’s missing person’s file including his photograph and his diary were lost.

    c. there appears to have been no attempt to identify Stephen by searching NAFIS between 2013 and 2021 – if there had been a search, Stephen may have been identified as early as 2013 notwithstanding the errors in the initial investigation.

What was the time and place, manner and cause of Stephen’s death?

98. Stephen was last seen alive on 22 January 1985 and he was deceased when his body was retrieved on 26 January 1985. I find he died between 22 and 26 January 1985. His cause of death was drowning.

99. The evidence does not allow a finding as to the place of Stephen’s death or his manner of death. These will be recorded as ‘unascertained.’

Recommendations

100. There have been significant changes in NSWPF policies and procedures as well as technological advancements in respect of the identification of missing persons and the engagement with families about their missing loved ones. These developments indicate that the errors and inadequacies which arose in the identification of Stephen would not arise now.

101. In his statement of 17 October 2024, DI Sim outlines advances and improvements to processes which he opined would prevent reoccurrence of the circumstances surrounding Stephen's identification. Given the passage of time, these are extensive. The salient aspects include:

    a. the significantly enhanced capabilities of NAFIS which include the ability to override sequencing errors. This would enable an individual to be identified notwithstanding the incorrect sequencing of their fingerprints.

    b. formal 3, 6, 9 and 12 month reviews of missing person's cases that take place prior to the disappearance being reported to the coroner.

    c. the development of a detailed and directed Standard Operating Procedure in relation to Missing Persons, Unidentified Bodies and Human Remains (SOPs).

    d. advancements in DNA capabilities, including the professional and effective working relationship between the NSWPF and the Family Advocate and Support Service.

    e. the practice of obtaining phone and banking records and effective use of media.

    f. ongoing communication with the senior next of kin – in particular, regular contact for the initial seven days by the officer responsible during each shift .

    g. recording and maintaining records of exhibits.

    h. the establishment of an 'EFIMS' platform through which requests are made and such requests remain on the system until actioned to prevent emails such as the 2009 email from Senior Constable Marsh to then Sergeant Bush being overlooked.

102. In circumstances where the NSWPF policies, procedures and systems which are currently in place do not reflect those that were in place in 1985, I make no recommendations as a consequence of this inquest.

Conclusions

103. I will close by conveying to Stephen Burt's family my sympathy for the loss of Stephen and for the trauma caused by the delay in Stephen being identified. Stephen's family has suffered greatly due to the impact of not knowing what happened to him and this has been compounded by the family not being able to ascertain with any certainty where Stephen is buried. I also apologise for the trauma caused by delays in the inquest process.

104. I thank the Assisting team for their outstanding support in the conduct of this inquest and I thank the officer in charge, DS Ross, for her work in conducting the investigation and compiling the brief of evidence.

Findings required by s 81(1)

105. As a result of considering all the documentary and oral evidence heard at the inquest, I make the following findings:

Identity

The person who has died is Stephen John Burt.

Place of death

The evidence does not enable a finding as to the place of Stephen's death.

Date of death

Stephen died between 22 and 26 January 1985.

Cause of death

I find Stephen died from drowning.

Manner of death

The evidence does not enable a finding as to the manner of Stephen's death.

106. I close this inquest.

Magistrate R Hosking
Deputy State Coroner
Lidcombe
Date 18 December 2024