New South Wales

CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into death of Rohan Lloyd
Hearing dates:	14 to 17 April 2025; 2 June 2025
Date of Findings:	8 September 2025
Place of Findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, date of death, missing person, schizophrenia diagnosis, antipsychotic medication, Missing Persons, Unidentified Bodies & Human Remains Standard Operating Procedures, missing person risk assessment, severe mental health condition, vulnerable persons, Land Search and Rescue, suspension of missing person search, lost person behaviour, communication with family of missing person
File number:	2020/00268222
Representation:	Ms T Power, Counsel Assisting, instructed by Ms F Lilly (Crown Solicitor's Office) Ms K Burke for the Acting Commissioner of the New South Wales Force, instructed by Mr S Robinson (New South Wales Police Force Office of the General Counsel)

Findings:

Rohan Lloyd died between about 14 and 18 August 2020 at Whiteman Creek NSW 2460.

The cause of Rohan's death was the combined effects of presumed heavy metal poisoning from an unknown material and freshwater drowning.

Rohan was most likely experiencing a psychotic episode related to his schizophrenia diagnosis which caused him to become lost in bushland and unable to seek assistance or self-rescue. Whilst the mechanics of how Rohan came to enter the pool of water where he was found are not entirely clear, it is likely that dehydration and hypothermia contributed to his collapse. It is not possible to conclude from the available evidence how Rohan came to ingest the material found post-mortem in his stomach and oesophagus, or where the material came from.

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1. Introduction

1.1 On 15 August 2020, Deborah Lloyd attended Sutherland Police Station to report that her son, Rohan Lloyd, a 37-year-old man, was missing.

1.2 On 3 September 2020, Rohan's car was found near Whiteman Creek in Copmanhurst. A search operation conducted by the New South Wales Police Force (**NSWPF**), with assistance from Rural Fire Service (**RFS**) and State Emergency Service (**SES**) volunteers, was conducted over the next three days. The search operation was unable to locate Rohan before being suspended on 6 September 2020.

1.3 On 12 September 2020, a group of local residents organised their own search of Whiteman Creek. After walking upstream for about an hour, the search party found Rohan lying face down in a pool of water with no signs of life some 1.84 kilometres from where his car had been found.

2. Why was an inquest held?

2.1 Rohan's death was considered a reportable death in accordance with the *Coroners Act 2009* (**the Act**) because the cause of his death was not immediately known, with the possibility that he had not died of natural causes. For every reportable death, a Coroner has an obligation to determine whether the identity of the person who died, the date and place of their death, and the cause and manner of their death have been sufficiently disclosed. The manner of a person's death means the circumstances in which that person died. If the coroner is unable to answer these questions then an inquest must be held.[1]

2.2 As Rohan was found in a rural area away from his home, and some 28 days after he had been reported as a missing person, the date and place of his death were not immediately apparent. How Rohan came to be at the location he was found and whether he died of natural causes given he was found in an outdoor environment were also unclear.

2.3 In addition, the timing of when Rohan was found and when his death was reported to the Coroner raised several questions about aspects of the NSWPF missing person investigation. Further, it became apparent that Rohan's medical history was likely relevant to the circumstances in which he went missing. This also raised questions regarding the nature of the health care provided to Rohan in the period shortly before he was reported as missing.

2.4 For all of the above reasons, an inquest was required to be held.

2.5 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the coronial jurisdiction and inquest process into what is usually one of the most traumatic events in the lives of family members who have reported a loved one as missing. At such times, it is reasonably expected that families will wish to attempt to cope with the consequences of such a traumatic event in private. The sense of loss experienced by family

[1] *Coroners Act 2009*, section 27.

members does not diminish significantly over time. Therefore, it should be acknowledged that both the coronial process and an inquest by their very nature unfortunately compel a family to re-live distressing memories and to do so in a public forum.

3. Rohan's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. It is hoped that what is set out briefly below acknowledges Rohan's life in a meaningful way.

3.2 Rohan was born to Deborah Lloyd and Arnen Parker. He had two younger siblings, his sister, Meredith, and his brother, Tai.

3.3 Ms Lloyd describes Rohan was a considerate and gentle man who trod lightly upon the Earth and was tender with other people. He lived simply, was not materialistic and was more interested in developing a rich, interior life. Rohan had a scientific curiosity, and loved being with nature. Tai describes Rohan as having an explorer's spirit who revelled in nature's beauty. He read widely and in depth and celebrated other's achievements. Rohan would often mention how proud he was of people in his life, expressing admiration for a quirk or skill that they had.

3.4 Rohan created music and loved art. At the time of his passing, Rohan had recently completed an album and had been offered to go on tour to the United States as a supporting act but turned it down.

3.5 Rohan brought much joy to the lives of his family and those he loved. He put others first, often to his own detriment. His life was very much about caring for others and he had an enormous capacity for empathy. He cared for his father, driving him to medical appointments following a serious medical diagnosis and helped with managing his father's farm so that his father could continue living there despite increasing infirmity. Rohan also cared for his grandfather, managing his accounts and taking him out for lunch, shopping trips and visiting treasured places.

3.6 Rohan's mother describes him as nurturing, perceptive, full of wisdom, responsible and respectful. Rohan was known to have an amazing, broad sense of humour and as someone who could joke about anything and everything. He was always present in the moment and someone who gave you his full attention and took in every word. Tai describes him as a rare soul in today's world.

3.7 Rohan touched the lives of many people and they all have stories about how he profoundly helped to better their lives. Rohan's loss is felt not just by his family but also by the community he created. There is no doubt that Rohan is deeply missed every day by those who loved him.

4. Summary of relevant factual background[2]

Medical history

4.1 Rohan was diagnosed with schizophrenia around July 2004 when he was 21 years old. He reportedly experienced a mental health episode about every two years. According to his mother, during these episodes Rohan would stop eating and drinking, would become unable to talk, and would become physically stiff and dehydrated. From about 2014 to 2015, Rohan was seen by a psychiatrist, Dr Harry Freeman.

4.2 Between August 2004 and October 2018, Rohan was admitted to hospital on five occasions after exhibiting suicidal thinking and agitation, and experiencing auditory hallucinations, anxiety, paranoia, and other symptoms consistent with psychotic episodes. On each occasion, Rohan was recommenced on antipsychotic medication resulting in improvement in Rohan's mental state. He was discharged for mental health follow up in the community, mostly with review by Dr Freeman.

Social history

4.3 In August 2020, Rohan was living in shared unit with two roommates, Mark Finch and Kristian Hatton. Rohan previously worked two or three days per week as a peer support worker for people with disabilities. Due to the COVID-19 pandemic, Rohan lost his job. According to Mr Finch, Rohan had regular severe panic attacks and was known to calm himself down by driving to Chinamans Beach in Evans Head or an isolated place around Kyogle or Nimbin. Rohan reportedly would just sit in his car all night but would not be gone for more than 24 hours at a time.

4.4 Although Ms Lloyd lived in Sydney, she and Rohan spoke on the phone every week.

Events of August 2020

4.5 On 8 August 2020, Rohan attended a birthday party where he asked to play a set of music. However, during the set, Rohan's demeanour changed and he became "*very panicky*" and apologetic.

4.6 On 10 August 2020, Ms Lloyd called Rohan and left a message which was not returned, something that was out of character for Rohan. Mr Finch saw Rohan on this day and noticed that he was "*really withdrawn*".

4.7 On the morning of 11 August 2020, Mr Hatton saw Rohan at home and noticed that he seemed unable to speak, despite encouragement from Mr Hatton.

4.8 On the evening of 12 August 2020, Rohan called his father sounding distressed and reporting that he did not feel safe. At around 8:00pm, a 20-minute voicemail was left on Ms Lloyd's phone following a call made from Rohan's phone which appeared to be a pocket dial (**12 August 2020 Voicemail**). Mr Parker and his daughter, Annike, drove to Kyogle to pick up Rohan at around 10:00pm. They took Rohan back to Mr Parker's home in Barkers Vale where Rohan slept in his vehicle.

[2] Much of this background has been drawn from the helpful submissions of Counsel Assisting.

4.9 On the morning of 13 August 2020, Rohan had coffee with his father. Later at around 11:13am, Rohan borrowed a phone from a member of the public and used it to call his father, telling him that he needed his father's credit card details because of a medical emergency and that he was going to Casino. The person who lent his phone to Rohan noticed that he was shaking and sweating, appearing to be experiencing anxiety or under the influence of drugs.

4.10 At around 8:25pm on 13 August 2020, Rohan made a call to Triple Zero which lasted 23 seconds (**Triple Zero Call**). In the audio recording of this the sound of heavy breathing and possibly someone trying to speak towards the end of the call at Rohan's end can be heard. The call connected to a cellular tower located in Mylenford near Copmanhurst (**Copmanhurst Cell Tower**).

Last confirmed sighting of Rohan

4.11 At around 6:00am on 14 August 2020, Ben Grebert was driving to work when he saw Rohan sitting near the intersection of Clarence Way and Whiteman Creek Road in Copmanhurst (**Grebert Encounter**). Mr Grebert stopped and spoke to Rohan, noticing that Rohan had no shoes on, that he appeared "dishevelled and wet/shivering", that the tracksuit pants he was wearing were wet and "*shredded*", and that Rohan's legs were cut up as if he had been running through the bush. Mr Grebert observed that Rohan was "really quiet" but that he repeatedly said that he could not return to Lismore.

4.12 Mr Grebert gave Rohan a fluorescent yellow work jacket and offered to give me a lift to the police station or hospital in Grafton. Rohan accepted and got into Mr Grebert's car. However, after driving past Rohan's car (a blue Hyundai Getz), Rohan got out to get something and told Mr Grebert that he was happy to stay there. Mr Grebert drove away but drove past the location later at around 3:00pm when he saw that Rohan's car was gone.

Report of Rohan as a missing person

4.13 On 15 August 2020, Ms Lloyd attended Sutherland Police Station and reported Rohan as missing due to her belief that he was experiencing a mental health episode. Since 10 August 2020, Ms Lloyd had called Rohan's phone multiple time and left voicemail messages, none of which were returned, which was out of character for Rohan. Ms Lloyd had also spoken to Mr Parker on 14 August 2020, learning about Rohan's unusual behaviour on 13 August 2020 which made her more concerned for Rohan's welfare.

NSWPF investigation between 15 August 2020 and 2 September 2020

4.14 On the afternoon of 15 August 2020, NSWPF officers attended Rohan's home and spoke to his roommates. NSWPF officers also spoke to Deborah Ray, Rohan's best friend, who advised that she had not seen Rohan since 8 August 2020. That evening, NSWPF officers patrolled Chinamans Beach and areas in and around Evans township. NSWPF officers also spoke to Mr Parker and learned that:

(a) Rohan was being treated by Dr Freeman for anxiety disorder;

(b) about once a year Rohan became crippled with anxiety to the point of being unable to speak and would disappear to get his thoughts together;

(c) that Rohan had previously presented to Tweed Heads Hospital because he did not want his work colleagues to know that he was unwell.

4.15 On 15 August 2020, Ms Lloyd provided a photo of Rohan to Sutherland Police Station. Authority was also given for the photo to be used as part of any media release to seek information from the public.

4.16 On 17 August 2020, Rohan's case was allocated to Detective Senior Constable Daniel Fisher from the NSWPF Missing Persons Registry (**MPR**). His role was to review the investigation, act as a consultant for investigators, and make recommendations to the Officer-in-charge (**OIC**) to assist the search efforts for Rohan.

4.17 Over the following days, the NSWPF:

(a) made multiple appeals for community assistance through regional and national media outlets;

(b) conducted follow-up enquiries with Rohan's roommates and Ms Ray who all reported that they had not had any contact with Rohan;

(c) searched Rohan's unit;

(d) requested Rohan's Medicare and Pharmaceutical Benefits Scheme (**PBS**) records;

(e) conducted enquiries with Lismore Base Hospital;

(f) conducted enquiries with the Registry of Births, Deaths and Marriages;

(g) submitted iAsk requests for Rohan's mobile phone records from Vodafone and information regarding Rohan's accounts held with financial institutions.

4.18 On 2 September 2020, following analysis of Rohan's mobile phone records, it was recognised that Rohan's mobile phone had last been active in the vicinity of the Copmanhurst Cell Tower on 13 and 14 August 2020.

Discovery of Rohan's car

4.19 At 11:16am on 3 September 2020, resources from the NSWPF Aviation Command (**Polair**) were utilised to search the Copmanhurst area. At 12:16pm, Rohan's car was found down an embankment near a bridge on Whiteman Creek Road.

4.20 At around 12:40pm, NSWPF officers from Grafton Police Station arrived on scene and confirmed that the car was registered to Rohan. The car was found to be 20 or 30 metres down an embankment with the key still in the ignition. The front end had been damaged due to a collision with a bridge pylon but the airbags had not been deployed. The bonnet was open and the car battery had been removed.

Search efforts between 3 and 6 September 2020

4.21 On the afternoon of 3 September 2020, a Command Post was set up at the intersection of Whiteman Creek Road and Clarence Way. The location of Rohan's car was deemed the last known point (**LKP**). A search effort was initiated under the direction of Senor Constable Bryce Jeffcoat, a Land Search and Rescue (**LANDSAR**) Coordinator. A small search team was deployed to search The Whiteman Creek bed, both north and south of the Command Post. Other searchers were deployed to an area on the western side of Whiteman Creek adjacent to Whiteman Creek Road.

4.22 That afternoon, barefoot prints were found approximately 845 metres north of the LKP. The barefoot prints went around in circles and there appeared to be more than one set at different locations next to Whiteman Creek.

4.23 Rohan's car was later towed from its position and a more thorough search was conducted. Rohan's wallet, prescription glasses, keys and items of clothing were found in the car. The fluorescent yellow work jacket given to Rohan by Mr Grebert on the morning of 14 August 2020 was also found near the car in a clean condition.

4.24 At around 4:35pm, Rohan's mobile phone and a blue fabric mask were located in the long grass on Whiteman Creek Road, about 250 metres south of Clarence way.

4.25 Over the next three days, a LANDSAR was conducted with the assistance of the Rescue and Bomb Disposal Unit (**RBDU**), Polair, and RFS and SES volunteers. Crews of local NSWPF officers were tasked with canvassing surrounding properties.

4.26 Shortly after 12:45pm on 6 September 2020, the LANDSAR was suspended. This occurred after the NSWPF received information regarding reported sightings of persons who may have been Rohan in the surrounding area.

Civilian search efforts

4.27 On the afternoon of 11 September 2020, a vigil involving members of the local community was held for Rohan at Whiteman Creek. Following this, Kelly Beneke, a local resident and administrator of a Copmanhurst community Facebook group, decided to organise a search of Whiteman Creek. This was due to a belief that those involved in the LANDSAR effort had not searched far enough up Whiteman Creek.

4.28 At 8:30am on 12 September 2020, a group of civilians consisting of Ms Beneke, Russell Arthurson (a local resident who lived on a property near Whiteman Creek), Mr Parker and his partner, Emma Farmer, Ms Beneke's family members and friends met at the LKP. Three members of the group travelled down Whiteman Creek in kayaks. The remaining six members (including Ms Beneke, Mr Parker, Mr Arthurson and Ms Farmer) walked upstream along the creek bed.

4.29 At first, the search party walked slowly, taking photos and leaving markers of the any footprints they identified. After the footprints stopped, they walked at a faster pace until reaching a point 1.84 km upstream from the LKP at around 9:33am. This location was at the back of Mr Arthurson's

neighbour's property. At this location, Rohan was found lying face down in a pool water, fully clothed and deceased. NSWPF officers were called and arrived on the scene at around 11:30am.

5. What issues did the inquest consider?

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

(1) The cause and date of Mr Lloyd's death.

(2) The appropriateness of the initial risk assessment, and subsequent reassessment on 2 September 2020, conducted by the NSWPF including by reference to the NSWPF Missing Persons Standard Operating Procedures in place at the relevant time. In particular:

(a) whether appropriate regard was had to Rohan's history of mental illness; and

(b) whether timely reassessments of Rohan's level of risk were conducted

(3) The adequacy and appropriateness of actions taken by the NSWPF between 15 August 2020 and 12 September 2020, including by reference to the NSWPF Missing Persons Standard Operating Procedures in place at the relevant time.

(4) The adequacy of the LANDSAR efforts between 3 and 6 September 2020, including the appropriateness of the decision to call off the LANDSAR on 6 September 2020.

(5) The timing and efficacy of the handover of the carriage of the investigation from Richmond Police District to Coffs/Clarence Police District, including any delay in the search for Rohan's car battery and taking of witness statements.

(6) The adequacy and appropriateness of the care and treatment of Mr Lloyd by Dr Harry Freeman.

5.1 As part of the coronial investigation, the following independent experts were instructed to provide reports addressing a number of questions regarding the circumstances of Rohan's death:

(a) Dr Kerri Eagle, forensic psychiatrist;

(b) Dr Paul Luckin, specialist anaesthetist specialist anaesthetist and expert in search and rescue and survivability;

(c) David Marston, master automotive mechanic; and

(d) Dr James Whitehead, expert in search and rescue activities.

5.2 For convenience, the issues have been dealt with in chronological order below.

6. The post-mortem examination

6.1 A post-mortem examination was performed by Dr Allan Cala, forensic pathologist, on 21 September 2020 at Newcastle. The significant findings from the examination can be summarised as follows:

(a) The post-mortem computed tomography (**CT**) identified a radiopaque substance within the stomach.

(b) Internal examination revealed a jet black and odourless liquid material found lining the stomach and oesophagus. Although the material was submitted for toxicological analysis, the forensic laboratory was unable to perform any testing as to its nature. Dr Cala expressed the view that the substance was some type of heavy metal such as arsenic or cadmium.

(c) Moderate decomposition was identified with extensive skin slippage following prolonged immersion in water over at least several days.

(d) No signs of drowning were identified although Dr Cala noted that these changes likely dissipated due to decomposition.

6.2 In the post-mortem examination report dated 1 February 2021, Dr Cala opined that the cause of Rohan's death was the combined effects of presumed heavy metal poisoning and fresh water drowning.

7. What was the cause and manner of Rohan's death?

7.1 The unusual findings from the post-mortem examination were explored with Dr Cala in oral evidence in an attempt to identify the date, case and manner of Rohan's death. Initially, Dr Cala gave evidence about the challenges associated with identifying the material found in Rohan's stomach and oesophagus:

> Part of this material, that is the jet-black substance, was submitted for toxicological analysis; however, the laboratory was unable to test for it as to its nature or test it as to its nature. The substance was odourless at autopsy. In other words, there was no smell to it or distinctive odour such that I might be able to form a view as to what its nature was, for example, cyanide, cyanide has a distinctive bitter almond smell. There was no odour attached to this, so. That's not to say I discounted cyanide, but I didn't - there was nothing to support it being a substance like cyanide.

7.2 Dr Cala went on to describe the post-mortem CT findings in this way:

> No normal natural food substance, or item that anyone would normally ingest looks like this on CT scan. It is only, only caused by the presence of a very dense substance like I've said, arsenic or something similar which has this appearance on CT scan and to the naked eye as well. There is no other, I can think of no biological material, no food stuff that looks like this at all. This was a very unusual finding.

7.3 Dr Cala described the substance found in Rohan's stomach and oesophagus as being a large volume of material, and that it was "*particulate material*" with particles that were of a "*sand-like size, but jet-black and not brown*". Dr Cala also gave evidence that ingestion of the material may have been independently fatal, irrespective of any effects of drowning. Equally, Dr Cala explained that the possibility that Rohan had ingested a sublethal level of the unidentified material and then collapsed into the water and drowned could not be excluded.

7.4 Dr Luckin gave evidence that dehydration degrades a person's cognition "*quite significantly and quite early*". Dr Luckin expressed the view that Rohan may actually have already been significantly dehydrated before entering the Whiteman Creek area. Dr Luckin also gave evidence as to the likely effects of dehydration and hypothermia on Rohan in this way:

> [H]ypothermia and dehydration would contribute to his being in the water in the first place. To falling into the water, falling face down would contribute to him having difficulty getting out, and also would contribute to the risk of all of those things that I have mentioned; they are all potentiated by being both dehydrated and hypothermic. So I think that by the time he reached the water he would have been extremely cold. Whether he meets the scientific definition of hypothermia or not I think is irrelevant; the fact is I believe he would have been very cold by the time he got there. We know that he was poorly clothed, he was wet, he was in a shaded environment, low down where the temperature would have been much lower than at ground level, and when he fell into cold water I think he would have died very quickly in that position.

7.5 **Conclusions:** Having regard to the opinions expressed by Dr Cala, the cause of Rohan's death is best described as set out in the post-mortem examination report; that is, the combined effects of presumed heavy metal poisoning and freshwater drowning.

7.6 One question relevant to the manner of Rohan's death is how the substance found in Rohan's stomach and oesophagus came to be ingested. Two hypotheses emerged from the evidence gathered:

(a) The material is battery acid ingested by Rohan; or

(b) The material is heavy metal byproduct found in the waters of Whiteman Creek.

7.7 As to the first hypothesis, Mr Marston gave evidence that it is most likely that Rohan's car had a flooded lead acid (wet cell) battery. The main components of a car battery include an electrolyte solution (battery fluid) which is a mixture of sulfuric acid and distilled water. It is odourless with a consistency similar to water, and with a quantity of lead (a heavy metal) within it. Mr Marston explained that cadmium and arsenic are agents which are found in small amounts in modern day car batteries.

7.8 Specific tools would have been required to remove the battery. The search of Rohan's car found "*tools, oil bottles and the usual things found in cars for general service or breakdowns*". However, it is unclear whether any of these tools could have been used to remove the battery. Ms Lloyd gave evidence that Rohan had no interest in doing "*mechanical things*" and that it was an "*utter*

impossibility" that Rohan would have been able to remove a car battery given that he could not even undo the lid of a water bottle when experiencing a psychotic episode.

7.9 Mr Marston gave evidence that the description given by Dr Cala of the substance being particulate material was consistent with "*lead paste breaking down*" inside a battery. However, Dr Cala gave evidence that ingestion of an electrolyte solution consisting of sulfuric acid would result in acute severe corrosion occurring to the upper gastrointestinal tract. This can cause perforation of the oesophagus and stomach with leakage of gastric comments into the abdomen. The post-mortem examination did not identify any such findings.

7.10 Therefore, there is no reliable evidence that Rohan had the ability to remove the battery from the car, and no evidence from the post-mortem examination that indicates that the material found in Rohan's stomach and oesophagus was acid that is found in battery fluid.

7.11 As to the second hypothesis, Dr Luckin gave evidence that if Rohan had fallen into water he would have stirred up sediment in the water. Dr Luckin explained that water enters a person's mouth in pre-drowning scenario and is swallowed when the person attempts to clear their airway. Dr Luckin expressed the belief that in such a scenario Rohan ingested black silt from the sediment of the creek which contained heavy metals.

7.12 Dr Luckin referred to a peer reviewed academic journal article which referred to the presence of heavy metal byproducts in river sediments in areas where mining activity had been conducted in parts of Europe. Dr Luckin went on to give this evidence:

> So when [Rohan] fell in to the stagnant pool I have no doubt he would have stirred up the sediment on the bottom, and being a stagnant pool I would suspect that it had at the bottom a significant layer of sediment from the previous mine activity of over a hundred years, and that that was the contributor of the heavy metals in his oesophagus and trachea.

7.13 However, beyond Dr Luckin's own research, the inquest did not receive any evidence regarding the extent of mining activity in the Copmanhurst area or the likelihood of heavy metals from such activity being found in waterways in the area. Dr Cala gave evidence that he found no positive evidence of silt in Rohan's upper gastrointestinal tract.

7.14 **Conclusions:** The evidence establishes that Rohan was most likely experiencing a psychotic episode related to his schizophrenia diagnosis which caused him to become lost in bushland and unable to seek assistance or self-rescue. Whilst the mechanics of how Rohan came to enter the pool of water where he was found are not entirely clear, it is likely that dehydration and hypothermia contributed to his collapse. It is not possible to conclude from the available evidence how Rohan came to ingest the material found in his stomach and oesophagus, or where the material came from.

Date of death

7.15 Dr Cala gave evidence that it is possible that Rohan had been in the pool of water where he was found for "*many days*" due to the amount of skin slippages seen at the post-mortem examination and the very low temperatures and absence of sunlight at the scene. When asked if this timeframe

could be narrowed any more precisely, Dr Cala gave evidence that he thought it was "*more than about four days, and it's possibly up to several weeks*". Dr Cala went on to explain that there is no post-mortem examination "*under those conditions that could narrow it down further unfortunately*".

7.16 Dr Luckin gave evidence that Rohan most probably "*died within the first 24 hours, or possibly 48 hours*" due to the poor weather conditions, cold temperatures and effects of dehydration and hypothermia. Dr Luckin expressed doubt that Rohan had survived longer than three or four days, and expressed the view that he most likely died on either 14 or 15 August 2020.

7.17 Dr Whitehead similarly expressed the view that Rohan died sometime between 14 and 20 August 2020. Dr Whitehead explained his reasoning in evidence in this way:

> That's based on my experience with survival for people who are reported lost. I'd say that would be the extreme, the 18th and 20th. I would put it a little bit closer to the 14th, but that's based on hypothermia, the fact that Mr Lloyd had difficulty with vision, and from his wanderings, and the footprints, and the other information, I suggest that he actually didn't know where he was going. Plus, he had the other comorbidities of the mental illnesses there, the lack of sleep, and probably not looking after himself and having adequate food for the period that he had left his home to when the - when this occurred. I would say all that would restrict his survival time to a matter of days at best.

7.18 **Conclusions:** The available evidence establishes that is most likely that Rohan died on 14 August 2020, when he was last seen alive during the Grebert Encounter, or within four days of this date. Rohan therefore died between about 14 and 18 August 2020.

8. Adequacy and appropriateness of treatment provided by Dr Freeman

Formulation of diagnosis

8.1 Rohan first met Dr Freeman during an involuntary admission to Lismore Base Hospital in September 2016. Dr Freeman later agreed to see Rohan for follow-up care as a private patient. Dr Freeman gave evidence that when he first saw Rohan he considered that in addition to a diagnosis of schizophrenia, Rohan might also have a diagnosis of autism. Dr Freeman explained it in this way:

> At the time, you know, in saying that I felt that he was autistic, certainly in much of my thinking, I would've been thinking, "This is not schizophrenia. He's done things that are absolutely too extraordinary for somebody who has schizophrenia."

8.2 At some point during his treatment Rohan, Dr Freeman formed the view that Rohan did not actually have schizophrenia. There is support for this from other sources:

(a) Rohan told his family and friends that his psychiatrist had "*reversed*" his long-standing schizophrenia diagnosis, and had given him a possible new diagnosis of anxiety or autism;

(b) Dr Freeman stated that Rohan was "*satisfied and relieved*" at the suggestion that he was actually autistic;

(c) Alice Robertson, Rohan's psychologist, stated that about a year or so before Rohan died, Dr Freeman had given Rohan "*a new diagnosis of a panic disorder or something like this, rather than schizophrenia*". As part of this diagnosis, Dr Freeman had taken Rohan of his medication. Ms Robinson stated that she expressed her concerns to Rohan about ceasing his medication but Rohan decided to follow Dr Freeman's approach.

8.3 Dr Eagle explained that Autism Spectrum Disorder (**ASD**) was a new diagnostic label introduced by the American Psychiatric Association for the 5th Edition of the Diagnostic and Statistical Manual of Mental Disorders (**DSM-5**). ASD encompassed a range of pervasive developmental disorders such as, relevantly, autistic disorder and Aspergers syndrome.

8.4 When asked about his understanding of the objective diagnostic criteria for autism, Dr Freeman gave this evidence:

> I'm not going to answer your question because as far as I'm concerned, diagnosis, as in DSM-5, is a lot of absolute nonsense, and there's a heavy number of psychiatrists who agree with me, and indeed, there is a movement at the moment to have DSM banned. So if we're going to get into talk about diagnosis, you will hear my suspicion that such a conversation is unhelpful.

8.5 Dr Eagle explained that schizophrenia is regarded as a neurodevelopmental disorder and a lifelong condition, which can "*vary significantly in presentation and severity*". Dr Eagle could not identify anything in the material she was briefed with which would cause her to doubt Rohan's long standing diagnosis of schizophrenia. Dr Eagle also expressed the view that:

(a) there was no clear basis for a diagnosis of Autism Spectrum disorder (**ASD**);

(b) even if Rohan satisfied the diagnostic criteria for ASD "*this did not explain his relapses of psychosis*"; and

(c) a diagnosis of ASD *"would not have justified a reformulation of his schizophrenia diagnosis or the cessation of biological treatment*".

8.6 Ultimately, Dr Eagle opined that any decision to "*reverse*" Rohan's schizophrenia diagnosis "*would appear to be unsupported by his documented clinical history of psychotic relapses*" and "*would arguably not be a decision made by a reasonably competent psychiatrist in the circumstances*".

Cessation of antipsychotic medication

8.7 Dr Freeman stated that he did not tell Rohan to cease his antipsychotic medication. However, Dr Freeman said that when Rohan told him that he was planning to do so, Dr Freeman told him that "*if he was going to do so do it slowly*". Between January and September 2018, available medical records establish the following:

(a) On 17 January 2018, Rohan told Dr Freeman that he felt that he would like to "*go off the meds after 15 years*". Dr Freeman advised Rohan to try lowering his daily dose of risperidone;

(b) On 19 January 2018, according to Dr Gunn, Rohan's general practitioner (**GP**), Dr Freeman told Rohan to try stopping his antipsychotic because "*he feels he may have autism/Asperger's rather than schizophrenia*";

(c) On 18 April 2018, Dr Freeman's notes record that risperidone was decreased to 1 mg (from 1.5 mg in January 2018);

(d) On 24 April 2018, Dr Gunn reported that Rohan was meeting his risperidone dose with his psychiatrist;

(e) On 6 June 2018, Dr Freeman recorded that Rohan's dose of risperidone was reduced to 0.5 mg daily; and

(f) On 5 September 2018, Dr Freeman noted that Rohan was "*right off the [risperidone]*" with references made to dread, existential anxiety, paranoid/voices, anxiety and hopelessness.

8.8 On 20 October 2018, Rohan was admitted to hospital due to a relapse of psychosis. At the time, he was not speaking, eating, or drinking, and showed signs of dehydration, psychomotor agitation, and features of catatonia. He was discharged on 31 October 2018. During his stay, he was gradually taken off risperidone under the guidance of Dr Freeman, due to adverse side effects and to allow for further diagnostic clarity. His antipsychotic medication was changed from olanzapine to paliperidone, with good clinical response.

8.9 On 7 November 2018, Dr Freeman reviewed Rohan and noted his recent hospitalisation following a psychotic episode, which occurred after discontinuing risperidone. It was also recorded that it had taken several months to stop risperidone completely.

8.10 On 10 February 2019, Rohan informed Dr Gunn that he had been reassessing his long-standing diagnosis of paranoid schizophrenia with Dr Freeman. Dr Freeman had indicated that his current working diagnosis was a "*severe lifelong panic disorder and generalised anxiety disorder*".

8.11 On 15 February 2019, Rohan saw Dr Gunn again, who noted that Rohan had experienced an acute psychotic episode but was now stable on his medication. Dr Gunn also recorded that Rohan was hopeful about receiving a new diagnosis, as Dr Freeman had suggested he may have Asperger's syndrome, and that his acute episodes could be related to this.

8.12 PBS records show that between February and August 2019, Rohan filled a prescription for risperidone each month that had been prescribed by Dr Freeman. However, Dr Freeman's notes only refer to consultations with Rohan on 20 February 2019, 22 May 2019 and 7 August 2019. On this last occasion, Dr Freeman provided Rohan with a prescription for risperidone although this is not reflected in his notes.

8.13 PBS records indicate that between February and August 2019, Rohan consistently filled monthly prescriptions for risperidone, all prescribed by Dr Freeman. However, Dr Freeman's clinical notes only document consultations on 20 February, 22 May, and 7 August 2019. On the latter date, a risperidone prescription was issued, although this is not recorded in his notes.

8.14 After this period, PBS data confirms that no prescriptions for antipsychotic medication were filled by Rohan from September 2019 until the time of his death.

8.15 The broader medication history indicates that:

(a) Rohan had been prescribed risperidone from November 2007 to 2017;

(b) From early November 2018 to 7 August 2019, he regularly filled prescriptions for antipsychotic medication on an almost monthly basis;

(c) Rohan's last recorded prescription for antipsychotic medication was filled on 7 August 2019.

8.16 Accordingly, at the time Rohan was reported missing in mid-August 2020, he had not taken antipsychotic medication for approximately one year.

8.17 It appears that at least two factors which contributed to Rohan's desire to cease his antipsychotic medication: his schizophrenia diagnosis and the adverse side-effects that he experienced. Dr Eagle explained that it is common for patients with schizophrenia to struggle with having to continue to take their medication. Further, Dr Eagle noted that antipsychotic medications can also have significant adverse effects which can be unpleasant and contribute to a desire to cease treatment.

8.18 Dr Eagle also explained that the main effect of a person with a psychotic illness ceasing risperidone is the risk of relapse of psychosis. The evidence demonstrates that Rohan's gradual weaning off of risperidone over a period of months in 2018 culminated in his admission to hospital in October 2018 for acute psychotic relapse.

8.19 Dr Eagle expressed the view that if Rohan had told Dr Freeman that he intended to stop taking antipsychotic medication, there were a range of steps that Dr Freeman should have taken, including:

(a) counselling Rohan against ceasing medication;

(b) providing education regarding the risks of ceasing medication compared to the perceived benefits; and

(c) informing Rohan's family and providing them with information about how to access mental health support if needed.

8.20 Dr Freeman gave evidence that the only option available to him to ensure that Rohan took his medication was to seek a community treatment order which he sought to avoid. Dr Freeman also gave evidence that he and Rohan often discussed the risks of ceasing medication, and that he never had a chance to talk to Rohan's family because this was not something that Rohan wanted or felt was necessary.

8.21 Dr Freeman also gave evidence that schizophrenia is "*usually fairly treatment unresponsive*", expressed scepticism as to the effectiveness of mainstream antipsychotic prescriptions for schizophrenia, and considered that Rohan had on many occasions been on a "*poisonous dose*" of the medication (4 mg). Dr Freeman also considered that Rohan had improved during his admission to hospital because of the admission itself and not because he resumed antipsychotic medication, explaining:

> It's not my experience as a psychiatrist that somebody who comes in with all the symptoms of so-called schizophrenia gets better in seven days because he's had some pills.

8.22 Overall, Dr Freeman gave evidence that Rohan was frequently "*overdosed*" when in hospital and that "*medicalising the mind is nonsense*". Dr Freeman acknowledged that this view would possibly not be alignment with mainstream medical advice at the time and that many of his views in general could be counter to mainstream medical advice.

8.23 **Conclusions:** The evidence establishes that there was no clinical basis for Dr Freeman to doubt Rohan's diagnosis of chronic schizophrenia. Equally, there was no clinical basis to support a diagnosis of Autism Spectrum Disorder for Rohan. Even if such a diagnostic formulation had been available it would have provided no justification for Dr Freeman to reformulate Rohan's schizophrenia diagnosis.

8.24 Dr Freeman expressed scepticism about the efficacy of antipsychotic medication for treatment of schizophrenia that was unsupported by established and accepted medical practice. When Rohan decided in 2018 to wean himself off his antipsychotic mediation Dr Freeman supervised this process and provided Rohan with certain advice about how to do so. The expert evidence establishes that instead Dr Freeman ought to have counselled Rohan against following such a course and explained the risks of ceasing his medication against the perceived benefits.

8.25 However, there is no evidence that Dr Freeman advised or encouraged Rohan to cease taking this medication in the 12 months before his death. In fact, during their final consultation, Dr Freeman issued Rohan a prescription for risperidone.

8.26 It is also noted that Dr Freeman retired from medical practice during the COVID-19 pandemic due to personal health reasons.

9. Appropriateness of the risk assessments performed in relation to Rohan

9.1 Ms Lloyd gave the following evidence regarding what she told Probationary Constable White on 15 August 2020 when she reported Rohan as missing:

> I told her that he was schizophrenic, I told her that he was extremely vulnerable and withdrawn; he would have - be possibly athetotic, he would not respond, so normally if you - police would say, "what is your name" he would not respond, he would not able capable of putting together "my name is Rohan Lloyd and I live at". He might be able to respond with a yes/no answer, and I gave her an elaborate explanation of how to communicate with him when he was in those conditions.

9.2 In her statement dated 17 February 2025, Ms Lloyd also indicated that she told Probationary Constable White that Rohan was taking antidepressant medication, and medication for anxiety and insomnia.

9.3 Ms Lloyd gave evidence that she spoke to Probationary Constable White for around 20 to 25 minutes, emphasising Rohan's mental health concerns because of his "*extreme vulnerability crisis*". However, Ms Lloyd expressed the view that the level of her concern was not reflected in how the NSWPF prioritised their response. Ms Lloyd explained her views in this way:

> I just felt that […] as soon as I said mental illness, there was some sort of discounting of Rohan as a person as somewhat less worthy of attention and that was reflected in several conversations I had with officers at the Lismore Police Station over the telephone over - over time and I - - that - that really worried me. You know, that's the stigma about having a mental health condition should not play a part in deciding not to help someone who was seeking help or needing help.

9.4 Ms Lloyd's missing person report was recorded as an entry in the NSWPF Computerised Operational Policing System (**COPS**) database. The relevant COPS entry for 15 August 2020 is consistent with Ms Lloyd's evidence regarding what she reported. The COPS entry also records the following:

> A Missing Person Risk Assessment was completed on Saturday 15th August 2020 and was rated as Medium Risk.

9.5 Section 11 of the 2020 version of the NSWPF Missing Persons, Unidentified Bodies & Human Remains Standard Operating Procedures (**2020 MPUBHR SOP**) provided the following in relation to risk assessment procedures for missing persons:

> A Risk Assessment is required for each missing person. An early assessment of a Missing Person report to determine the urgency of investigative functions is critical. This can be compared to the triage used in assessing casualties and the speed of response needed to save lives. Core to this process is assessment of the level of risk to the Missing Person and how immediate that risk is. The assessment and categorisation of risk and the circumstances of the case should shape the police response, informing the investigative and search strategies. Risk should also be regularly reviewed to consider new information and evolving circumstances. The first step in the process requires gathering of all information that might impact upon the risk assessment.

9.6 Section 11.1 of the 2020 MPUBHR SOP provided that for a missing person risk assessment:

(a) a missing person report taker was required to select a risk rating, record their rationale for their decision, and how they intend to address the NSWPF response to the incident; and

(b) a supervisor verifying a missing person event was required to review the risk assessment, allocate a risk rating (including if and why they rate the risk differently to the report taker) and record their rationale for their decision and how they how they intend to address the NSWPF response to the incident.

9.7 Section 11.1 also emphasises that "*[i]t is important to remember that risk assessment is an ongoing process*", that NSWPF officers will be prompted to consider whether a new risk assessment should be conducted, and that, if necessary, multiple risk assessments can be conducted and recorded within COPS.

9.8 On 17 August 2020, Rohan's case was allocated to Detective Senior Constable Daniel Fisher from the MPR. He stated that although the risk assessment documentation from 15 August 2020 was not attached to the relevant COPS event, it is most likely that he saw it. Detective Inspector Ritchie Sim, the MPR Manager during the currency of the coronial investigation, stated that COPS record indicated that the risk assessment was incomplete and that he could not provide a reason why the report taker did not complete the risk assessment process on COPS.

9.9 Section 11.2 of the 2020 MPUBHR SOP describes three categories of risk ratings for missing persons: limited, medium and high. It provides that for the high risk category might include where "*answers to any of the 'Red Flag' questions […] indicate a high risk*".

9.10 Section 11.1.1 sets out a list of five *High Risk 'Red Flag' questions* and provides that if the answer is "yes" to any of the questions "*this would indicate the need for an immediate high level police response*". Relevantly, Question 4 asks:

> Is the Missing Person particularly vulnerable due to age / disability? (i.e. child, elderly, autistic)

9.11 This should be contrasted with the equivalent section 11.1.1 of the 2024 MPUBHR SOP which sets out Question 4 in this way:

> Is the missing person particularly vulnerable due to age / disability? (e.g., child, elderly, dementia, autistic, **severe mental health condition**) [emphasis added]

9.12 Section 11.1.2 of the 2020 MPHBHR SOP sets out, relevantly, further questions "*regarding the Missing Persons [sic] vulnerabilities*", namely:

> Does the Missing Person need essential medication or treatment that is not likely to be available to them? (e.g. mental health, diabetic etc)
>
> Does the Missing Person have a mental health diagnosis? (are they currently unwell? currently taking medication?)
>
> Was the Missing Person recently exhibiting behaviour that is considered out of character?

9.13 It should be noted that although the words "*severe mental health condition*" were added to section 11.1.1 of the 2024 MPUBHR SOP, they are not found in section 9.2.12 which describes vulnerable groups within the community "*such as those with dementia, autism, cognitive impairment, or other medical related impairments*". Similarly, Annexure A of the 2024 MPUBHR SOP, which is the *Initial Response – Missing Persons Checklist*, repeats the *High Risk 'Red Flag' questions* without making any reference to persons with a "*severe mental health condition*".

9.14 Detective Inspector Sim gave evidence that he considered the assessment of Rohan being in the medium risk category to be reasonable based on the information available at the time. Detective Inspector Sim noted that Rohan's demeanour and behaviour were described as "*not unusual*" and that he was known to "*often disappear*" for short periods of time. Notwithstanding, Detective Inspector Sim accepted that the concern for Rohan's welfare was based on the fact that it was "*highly unusual for him to be gone for this long*".

9.15 In oral evidence, Detective Inspector Sim disagreed with the general proposition that a person who suffered from schizophrenia would typically be considered as particularly vulnerable for the purposes of section 11.1.1 of the 2020 MPUBHR SOP. He explained:

> There'd be more questions which you should ask. Are they medicated? People with mental health conditions can be medicated, and be - well, I'm hesitant to use the word "normal", because it implies they're not normal. Everyone's normal. But someone suffering that - a condition of that nature can be within the community, and no one knows that they're taking medication with regards to mental health. So on the surface, yes. But further questions should be asked. And again, I'm not saying they were or they weren't. But in that environment generally, yes, further questions should definitely be asked around that, to establish the full circumstances. The more information you have, the more reliable decisions you can make.

9.16 As noted already above, Dr Eagle described schizophrenia as an illness that can vary significantly in presentation and severity. Dr Eagle went on to explain that "*[i]ndividuals with milder forms of the illness could potentially function without treatment in some circumstances*".

9.17 During his oral evidence, Detective Inspector Sim was asked whether the information provided by Ms Lloyd on 15 August 2020 should have resulted in the assignment of a different risk category to Rohan. Detective Inspector Sim gave this evidence:

> Look, if you're asking if I was working on the front station front counter of a police station and someone came in with a mental health a missing person who suffered a mental health condition, I would certainly ask sufficient questions to be able to establish whether or not there needs to be an urgent response. Would I be considering a high risk response? Absolutely, and I'm not saying this police officer did not. In my experience in obtaining information from family, and I do not want to be disrespectful to Ms Lloyd, is the ability and the capability of obtaining information from, certainly, loving parents, can be very difficult and less experienced police may struggle in doing that. I don't know and this is where it's important to consider the environment these police are working in. You're talking about COVID pandemic and you're talking about Sutherland Police Station.
>
> So at the time it's a strongly likelihood, if we're assuming facts, staffing shortages at the police station, she's a probationary constable, not necessarily as experienced, may not be as supervised as closely as we had liked, I don't know, but these are all considerations we need to consider when making these assumptions and that's why I don't like considering assumptions. What's happened to Rohan is horrific and I don't think there's any police officer who would want to try who would not want to try and stop that. Can we do our business better? Always. In 37 years of policing, I've never done one investigation where I couldn't think, "Yeah, I should have done that better". That's always a consideration. I'll accept that.

9.18 Later in his evidence, Detective Inspector Sim acknowledged that he was unable to assess whether an appropriate risk assessment had been performed on 15 August 20202 without knowing whether the report taker had conducted appropriate enquiries to make a thorough and accurate risk assessment. Detective Inspector Sim acknowledged that he had formulated his own assessment based on content of the COPS narrative alone.

9.19 As at 15 August 2020, the following information was available to inform the assessment of the risk posed to Rohan, noting of course that the 2020 MPUBHR SOP provided that risk assessment is an ongoing process:

(a) The information about Rohan provided by Ms Lloyd;

(b) Information obtained from Rohan's roommates who described him as being a bit "*out of sorts*" and that it was "*highly unusual*" for him to be gone for the period of time that he had not been seen;

(c) Information from Ms Ray who said that she was "quite concerned" about Rohan and that she had made several attempts to contact him without success; and

(d) Information from Mr Parker who indicated that Rohan had told him on 12 August 2020 that he was "*not safe*" and that when Rohan was unable to be around other people he was known to become crippled with anxiety and be unable to speak.

9.20 Paragraph 11.2 of the 2020 MPHBHR SOP provides that:

(a) a medium risk category rating "*requires an active and ongoing response by police and other agencies in order to locate the missing person*" and that "*[a]ll investigative tools should be considered to locate the missing person*"; and

(b) a high risk category rating requires immediate notification to a supervisor, a crime scene/forensic response, an immediate search and rescue response, and immediate consideration to be given to "*utilising all investigative tools to locate the missing person*".

9.21 Between 15 August 2020 and 2 September 2020, when Rohan's risk category was upgraded from medium to high, the following steps were taken by the NSWPF:

(a) as noted above, enquiries were made of Rohan's father, best friend, and roommates;

(b) patrols were conducted in locations where Rohan was known to frequent;

(c) various enquiries were made to obtain relevant records, including Rohan's mobile phone records; and

(d) once Rohan's car was found an immediate LANDSAR effort was initiated.

9.22 One further matter to note is that section 7.0 of the 2024 MBUBHR SOP provides that a NSWPF officer who takes a missing person report is to submit an iAsk request for the missing person's mobile phone records within 72 hours, and within 24 hours if the missing person falls within the high risk category. In Rohan's case, his mobile phone records were sought and obtained by 18 August 2020, within 72 hours after he was reported missing. This would have therefore been consistent with a medium risk category response pursuant to the 2024 MPUBHR SOP.

9.23 The final matter to consider is that section 7.0 of the 2020 MPUBHR SOP provided that within four weeks of a missing person report the case should be transferred to an experienced investigator within the Police Area Command (**PAC**) or Police District (**PD**), and that in most circumstances this should be a designated detective. In contrast, the equivalent section of the 2024 MPUBHR SOP provides that this should occur within one week of a missing person report, and that assistance/guidance should be sought from an experienced investigator immediately for high risk missing person incidents.

9.24 On 31 August 2020, Detective Sergeant Bernadette Ingram, the Richmond PD Investigations Manager and Missing Persons Coordinator, recorded the following COPS entry:

> SOPS recommendation to transfer to an experienced investigator considered: In the last two weeks Richmond PD has responded to two violent homicides that occurred within 5 days of each other. As a result, CI resources have been significantly impacted, including the Investigations Manager/Missing Persons Coordinator. A/Sgt Cooper has maintained carriage of this matter and all actions and enquiries have been overseen by the SMT including the Crime Manager. The matter is

regularly addressed in the morning SARS briefing. Missing Persons unit has also been contributing to coordinating enquiries.

Due to the current live homicide investigations taking precedence, an investigator can not be assigned to this matter at this stage. The above enquiries are to continue as recommended. The matter will continue to be reviewed daily and recommended actions undertaken. A detective will be assigned if the MP is not located in within coming weeks.

9.25 Detective Senior Constable Thompson was assigned as the OIC on 2 September 2020 after Rohan's risk category was upgraded from medium to high.

9.26 **Conclusions:** By 15 August 2020, the NSWPF possessed sufficient information to answer the "Red Flag" question of whether Rohan was particularly vulnerable in the affirmative. The information relevant to this question was Rohan's medical history including his previous suicidality, admissions to hospital, tendency to withdraw from social contact, and inability to interact socially; his behaviour in the days preceding 15 August 2020 being a departure from his usual behaviour even when experiencing anxiety; and his report to his father of not feeling safe. In this regard, the relevant provisions of the 2020 MPUBHR SOP were not complied with. There is no evidence as to whether the relative experience of the report taker, the degree of supervision that may have been exercised following the missing person report, or the impact of the COVID-19 pandemic had any bearing on this risk assessment noting that it is a mandatory ongoing process.

9.27 On 2 September 2020, when Detective Sergeant Ingram read Detective Senior Constable Fisher's email from the previous day regarding the location where Rohan's mobile phone was last active, it was recognised that the risk to Rohan was immediate. An adequate risk assessment was performed and the risk to Rohan was appropriately elevated to high.

9.28 Counsel for the Acting Commissioner submitted that any evaluation of the adequacy of any risk assessment performed must be *"based on the context of the time of the event*". That is accepted. Counsel for the Acting Commissioner also submitted that in her first statement dated 5 September 2020, Ms Lloyd provided no detail of what she reported to Probationary Constable White on 15 August 2020, and that in her second statement dated 17 February 2025, Ms Lloyd only described the medication that Rohan was taking without making any reference to antipsychotic medication. These submissions are also accepted. However, Ms Lloyd's evidence of the more fulsome description of what she told Probationary Constable White was unchallenged. It is otherwise not inconsistent with the contents of Ms Lloyd's statement and there is no basis to doubt the reliability of her account.

9.29 All that said, it is not possible to determine what practical difference the assignment of a high risk category is likely to have had on the missing person investigation between 15 August 2020 and 2 September 2020. During that period, investigative steps were taken consistent with a response to a high risk category incident.

9.30 The two matters which are likely to have influenced the missing person investigation during this period are the obtaining of Rohan's mobile phone records and the matter being assigned to an experienced investigator or detective at an earlier stage. However, whilst these matters are provided for by the 2024 MPUBHR SOP for high risk category incidents, they did not feature in the 2020 version of the MPUBHR SOP in force at the time. Further, the evidence establishes that by at least 31 August 2020 appropriate consideration had been given to allocating Rohan's case to an experienced investigator. However, due to resource constraints centred around two active homicide investigations at the time, this allocation could not occur. Overall, it cannot be said that the provisions of the relevant SOP at the time regarding these two matters were not complied with.

9.31 As noted above, the reference to a person with a "*severe mental health condition*" being a particularly vulnerable person is reflected in Section 11.1.1 of the 2024 MPUBHR SOP but not elsewhere in the SOP which deals with vulnerable groups of persons, or particularly vulnerable persons. To ensure consistency and clarity, the addition of these words should be reflected in all relevant provisions within the current version of the MPUBHR SOP. It is therefore necessary to make the following recommendation.

9.32 **Recommendation:** I recommend to the Acting Commissioner of the New South Wales Police Force that Section 9.2.12 and Annexure A of the current version of the Missing Persons, Unidentified Bodies & Human Remains Standard Operating Procedures be amended to include reference to a person with a "*severe mental health condition*" as being a vulnerable, or a particularly vulnerable, person.

9.33 Ms Lloyd submitted on behalf of Rohan's family that more experienced NSWPF officers should take missing person reports and conduct interviews with report makers in a more secure location. Whilst the inquest did not receive any specific evidence regarding these matters, it is noted that section 8.7 of the 2024 MPUBHR SOP provides that one of the responsibilities of the PAC/PD Shift Supervisor is to ensure that the COPS risk assessment has been completed and that NSWPF actions/responses are appropriate to the circumstances.

9.34 Ms Lloyd also submitted that Annexure A to the 2024 MPUBHR SOP, which is the *Initial Response – Missing Persons Checklist*, ought to be formatted as an infographic with a series of questions and displayed within the waiting area of a police station to assist persons making a missing person report. Again, the inquest did not receive any evidence regarding this specific issue. However, it is noted that Annexure A is a checklist for NSWPF officers and not members of the public. Notwithstanding, Counsel for the Assistant Commissioner has indicated that the submission made by Ms Lloyd has been noted.

9.35 Finally, Ms Lloyd submitted that the term "mental illness" as it appears in the current version of the MPUBHR SOP be "*further refined as it covers a broad range of conditions, with widely varying symptoms and different active and passive risks*". At a high level, this submission can be accepted and it is recognised that "mental illness" is not defined in the 2024 MPUBHR SOP. Again, the inquest did not receive any evidence regarding this specific issue. However, it is noted that sections 11.1.2 and 11.1.3 of the 2024 MPUBHR SOP set out, respectively, lists of questions directed to understanding a missing person's vulnerabilities and the context in which a person has gone missing. It is considered that these types of questions are likely to provide NSWPF officers a better understanding of persons falling within the broad category of having a mental illness. In addition, Counsel for the Assistant Commissioner has indicated that the submission made by Ms Lloyd has been noted.

10. Adequacy of the NSWPF investigation between 15 August 2020 and 2 September 2020

10.1 Several of the investigative steps taken by the NSWPF between 15 August 2020 and 2 September 2020 have already been described above. Set out below are a number of additional, relevant investigative steps taken during this period.

Interpretation of mobile phone records

10.2 On 16 August 2020, Ms Lloyd spoke to Sergeant Adam Cooper, who was the OIC at the time, and told him about the 12 August 2020 Voicemail. She also advised that the mobile phone carrier had told her that the voicemail message could be reinstated if an iAsk request was submitted. According to Ms Lloyd, Sergeant Cooper indicated that he would access and examine Rohan's mobile phone records as a matter of urgency. However, when Ms Lloyd spoke to Sergeant Cooper on 24 August 2020, he told her he was going on leave and said that he would "*have to get onto that*". A COPS entry for 24 August 2020 records the following:

> The NOK advised that she will forward some information in relation to a message that she received, but deleted. This information was conveyed in an earlier narrative. At this stage it is unsure if this information will convey any further information of the whereabouts of the MP.

10.3 On 18 August 2020, Rohan's mobile phone records from Vodafone were obtained and reviewed by Senior Constable Suzanne Nall. At 12:37pm, Senior Constable Nall recorded the following narrative in the COPS record:

> [Reverse call charge records] results show that from 13/08/2020 the [missing person] travelled from Lismore > Casino > Kyogle > Grafton > Copmanhurst. His last record was at 5.30pm 17/08/2020 in Brunswick North area and then nothing further.

10.4 Regrettably, this review did not identify the Triple Zero Call. Rohan's mobile phone records indicate that the Triple Zero Call was one of 837 entries for the period between 11 and 18 August 2020. In addition, the location of the call made to Rohan's mobile phone on 17 August 2020 was misidentified.

10.5 The mobile phone records were interpreted to mean that Rohan had received the 17 August 2020 call in the vicinity of Brunswick Heads. Instead, the records showed that the person who called Rohan's mobile phone on this date was located in Brunswick North in Victoria (**Brunswick North Record**). It was subsequently discovered that because the caller was also a Vodafone subscriber, their location appears on Rohan's mobile phone records.

10.6 The misidentification of Rohan's location resulted in a Computer Aided Despatch (**CAD**) job being broadcast over NSWPF radio for NSWPF officers to keep a lookout for Rohan in the Tweed and Richmond PDs. Rohan's father stated that because of this misinformation, friends and family spent days travelling through the Brunswick Heads region looking for Rohan.

10.7 Close inspection of Rohan's mobile phone records shows:

(a) that on 13 August 2020, his mobile phone connected with cell towers in Nimbin, Lismore, Casino, Kyogle, Grafton and then Copmanhurst as set out in Senior Constable Nall's COPS entry above;

(b) numerous data transmissions involving Rohan's mobile phone in the Copmanhurst area between 5:57pm on 13 August 2020 and 6:43am on 14 August 2020;

(c) no further entries of any outgoing calls, text messages or data transmissions from Rohan's mobile phone; and

(d) the Brunswick North Record does not appear until six pages later at 5:31pm on 17 August 2020.

10.8 Acting Sergeant Cooper gave evidence that he did not speak with Senior Constable Nall regarding her review of Rohan's mobile phone records, that it was not the practice of supervisors to conduct a secondary review of such records in missing persons cases, and that the "*information was just passed on through the actual shift supervisor*".

10.9 Detective Inspector Sim stated that the best practice is to "*clean*" mobile phone records which involves an analyst "*formatting the information"* and "*standardise the format to assist the reader*". Detective Inspector Sim also stated that given the workload at Richmond PD at the time it is "*very likely*" that an analyst or intelligence officer would not have been available to perform this "*clean*".

10.10 Rohan's mobile phone records were not correctly interpreted until1 September 2020 when Detective Senior Constable Fisher identified the Triple Zero Call. Further enquiries revealed that there was no record of any CAD job or NSWPF attendance created as a result of the Triple Zero Call.

10.11 At 12:19pm on 1 September 2020, Detective Senior Constable Fisher sent an email to Lismore Police with his analysis of Rohan's mobile phone records. He advised that the Triple Zero Call appeared to have been made in the Copmanhurst area and that the Copmanhurst cell tower was the last cell tower which Rohan's phone appeared to have connected with until 6:43am on 14 August 2020. Detective Senior Constable Fisher further advised that he would enquire whether Vodafone was able to provide information to more precisely identify Rohan's location at the time the Triple Zero Call.

10.12 At 7:00am on 2 September 2020, Detective Sergeant Ingram read the email sent by Detective Senior Constable Fisher the previous day and recognised the need to upgrade Rohan's risk category to high. At 9:35am, Detective Sergeant Ingram removed Acting Sergeant Cooper and all the other General Duties officers as case officers and reallocated the case to Detective Senior Constable Douglas Thompson. Detective Sergeant Ingram also undertook various other steps including enquiries to initiate a LANDSAR effort in the Copmanhurst area later that day.

10.13 At 8:27 AM on 2 September 2020, Detective Senior Constable Fisher sent an email to Lismore Police and advising:

> [U]nfortunately, all signs at the moment are pointing towards the MP possibly coming to some kind of harm at/near Copmanhurst (within the cell tower connection area) from 13/8 into the early morning of 14/08 … [A] co-ordinated search may need to be commenced there.

10.14 Later that day, NSWPF officers attended the property where the Copmanhurst Cell Tower was located and spoke to the owner who advised that it was common for people to stop on the land to access phone reception but that she had not seen Rohan or his car. Detective Senior Constable Thompson also began arranging for an aerial search of the Copmanhurst area to be performed the following morning.

10.15 Annexure K of the 2020 MPUBHR SOP provided practical information regarding the submission of an iAsk request to a telecommunications service provider in order to obtain mobile phone records. It also stipulated a number of questions to ask such as:

> Where is the Cell Tower Located (Cell ID Location)
> What phone numbers to they own?

10.16 However, Annexure K provides no information or guidance regarding how mobile phone records, once received, are to be analysed and interpreted.

10.17 In this regard, information regarding the availability of training for General Duties NSWPF officers in interpreting iAsk records was sought from Sergeant Renae Power, the Education and Development Officer for Coffs/Clarence PD. Sergeant Power stated that she received advice to the following effect:

> [T]raining does exist however it is delivered on an ad hoc basis when requested by an Education and Development Officer. The training that is available is not specific in its content but more a generalised presentation from Information Services where questions from the class are encouraged and can be answered by staff. [The Systems Administrator] was unaware of any of this type of training being delivered.

10.18 One final matter concerns whether mobile phone triangulation was available in August 2020 to assist efforts to locate Rohan. Section 17.3 of the 2020 MPUBHR SOP provides that a request for triangulation can be used where there is a "*reasonable belief that accessing a person's information will prevent or lesson a serious and imminent threat to the life or health of a person*". In contrast, the equivalent section in the 2024 MPUBHR SOP provides:

> A request for a triangulation to locate a missing person should only be made in those instances where there is a reasonable belief there is a serious threat to a person's life or health. If a person is reported missing and the risk has been determined to be high (having completed the formal risk assessment), there is a very strong likelihood the request will be supported and **should be** applied for in these instances. [original emphasis]

10.19 Detective Senior Sergeant Ian Corcoran, the OIC of the matter at the time of the inquest, gave evidence that amendments to the *Telecommunications Act 1997 (Cth)* had effectively lowered the

threshold to request a mobile phone triangulation for a missing person investigation with an imminent threat to the life of that person no longer being required. Regardless, even if such a lowered threshold had existed as at 15 August 2020, it is likely that triangulation would not have been possible because Rohan's mobile phone had run out of battery early in the morning on 14 August 2020. Therefore, in the absence of triangulation, reliance would still have been placed on correct interpretation of Rohan's mobile phone records in order to identify the last known location where his mobile phone connected to a cell tower.

10.20 **Conclusions:** The regrettable omission in identifying the Triple Zero Call and the misidentification of the location of the last cell tower that Rohan's mobile phone connected with delayed provision of critical information to the missing person investigation. Correct interpretation of Rohan's mobile phone records led to discovery of Rohan's car and the starting point for the subsequent LANDSAR effort. However, it is not possible to measure the effect of this delay on the overall missing person investigation, including the subsequent search operation.

10.21 Counsel for the Acting Commissioner submitted that the likely unavailability of an analyst or intelligence officer at Richmond PD to perform a "*clean*" of Rohan's mobile phone records of the kind described by Detective Inspector Sim "*provides a reasonable explanation as to the error made by Senior Constable Nall*". Whilst this matter was not explored during the inquest, it is accepted that this may have contributed to the misidentification that was made without being able to reach a more precise conclusion about its cause. However, if this is indeed what occurred then it raises a question as to why certain investigative steps were taken in reliance on a record that was not able to be formatted in accordance with best practice. That said, the evidence in this regard rises no higher than a possibility with insufficient evidence available to reach a conclusion as what factor, or factors, contributed to misinterpretation of Rohan's mobile phone records.

10.22 However, it is evident that whilst correct interpretation of mobile phone records is a fundamental step in a missing person investigation, previous versions of the MPUBHR SOP have provided little guidance regarding this task. Instead, non-specific training delivered on an ad hoc basis can be provided to General Duties NSWPF officers within Coffs/Clarence PD upon request. However, the inquest received no further evidence as to the nature and extent of any such training. It is therefore not possible to consider whether any gap in training exists within Coffs/Clarence PD or more broadly within the NSWPF, or whether a wider issue of misinterpretation of mobile phone records by General Duties NSWPF officers exists. To do so would amount to speculation and accordingly, it is not possible to advance this matter further.

10.23 Counsel for the Acting Commissioner submitted that in the absence of any issue relating to training provided to NSWPF officers being explicitly stated in the list of issues the inquest proposed to examine, it is "*procedurally unfair to use Sergeant Power's statement as a platform for raising an implied criticism of making a point or submission as to a perceived lack of training for general duties police officers*". No such implied criticism, point or submission has been made regarding any perceived lack of training in these findings or in Counsel Assisting's submissions. Indeed, Counsel Assisting fairly and properly submitted that "*any potential changes to the status quo by, for example, introducing a component of formal training to assist general duties police officers in reviewing [mobile phone records], were not explored at the hearing*".

Contact with the Officer-in-charge of the missing person investigation

10.24 On the morning of 18 August 2020, the Richmond PD Crime Coordinator allocated Rohan's case to Acting Sergent Cooper. On 31 August 2020, Detective Sergent Ingram made a COPS entry indicating that Acting Sergeant Cooper had maintained carriage of the matter and all actions and enquiries had ben overseen by the Senior Management Team, including the Richmond PD Crime Manager.

10.25 Ms Lloyd gave evidence that Acting Sergeant Cooper was either not available to be contacted or not on duty for several days after he was allocated as the OIC of the investigation. Mr Parker similarly stated that during August 2020, he had no access to a case officer due to NSWPF officers being on leave and the case being passed from officer to officer.

10.26 Acting Sergeant Cooper gave evidence that he was not "*the actual officer in charge*" but rather one of five shift supervisors who was responsible for providing updates and to allocating tasks to more junior officers on shift to carry out and follow-up. Acting Sergeant Cooper also gave evidence that he did not have any direct understanding of whether there was a single NSWPF officer responsible for day-to-day carriage of the investigation. Acting Sergent Copper explained that instead:

> [The shift supervisors] had access to the case itself. I'm not aware of any single one person who was allocated the case itself, like as in the OIC.

10.27 Section 9.2.1 of the 2020 MPUBHR SOP sets out the immediate responsibilities of the OIC for an adult missing person case and includes, relevantly, the following:

> Maintain regular contact with the informant/legal guardian/SNOK (where appropriate), at least weekly for the first two months of the investigation and then maintain contact at [specified] intervals […]. Record any contact as an Action Item;

10.28 The above provision is replicated in the 2024 MPUBHR SOP.

10.29 **Conclusions:** The available evidence indicates that there was no one NSWPF officer who was responsible for the day-to-day carriage of the missing person investigation between 15 August 2020 and 2 September 2020. Instead, it appears that the direction of the investigation was managed between five shift supervisors, including Acting Sergeant Cooper. Leaving aside the misinterpretation of Rohan's mobile phone records, it does not appear that the absence of a single OIC contributed adversely to the investigation itself.

10.30 However, it does appear that the absence of a single OIC and investigation management shared between different supervisors across shifts meant that Rohan's family did not have a single point of contact from whom they could seek updates regarding the investigation. At times, this appears to have led to difficulties in sharing and receiving information promptly. The impact, if any, on the investigation itself cannot be discerned. Both the 2020 and 2024 MPUBHR SOP prescribe that an OIC for a missing person investigation is to maintain regular contact with a missing person's senior next of kin on a weekly basis for the first two months of an investigation. Given these provisions, it is not necessary for any recommendation to be made.

11. Adequacy of the LANDSAR effort between 3 and 6 September 2020

Summary of LANDSAR effort

11.1 Senior Constable Jeffcoat was asked to coordinate the LANDSAR effort. He was a General Duties NSWPF officer at Yamba Police Station who had undertaken a two-week course in 2019 to be an accredited LANDSAR coordinator. At the time, Senior Constable Jeffcoat estimated that he had probably coordinated half a dozen searches for missing persons and been involved with more.

11.2 Senior Constable Jeffcoat was assisted by Leading Senior Constable Amanda Vidler (the Lismore Police Rescue Unit Search Coordinator) on 3 and 4 September 2020, and Sergeant Dallas Atkinson (a LANDSAR Coordinator since 2009 and a member of the Blue Mountains Police Rescue Squad). Sergeant Atkinson gave evidence that at the time it was a fairly new concept for a Senior LANDSAR Coordinator to be involved in reviewing or overseeing a LANDSAR operation.

11.3 Senior Constable Jeffcoat gave evidence that he did not read the COPS records for Rohan before commencing the search. Instead, he relied on a verbal briefing, together with information provided by Rohan's family and friends, at the scene. From these sources of information, Senior Constable Jeffcoat understood that Rohan had schizophrenia, was not taking his medication, and had history of suicidality, but was unaware that Rohan had previously experienced psychotic episodes.

11.4 At 12:45pm on 3 September 2020, the NSWPF Dog Unit was consulted but advised that there would be no benefit to deploying a dog due to the likely length of time that Rohan's car had been in the location where it was found. On 4 September 2020, a cadaver dog was requested but later redeployed to another job that was considered high priority. Therefore, neither a general purpose dog (to detect a live scent) or a cadaver dog were deployed as part of the LANDSAR effort.

11.5 Dr Whitehead expressed the view that a cadaver dog would have been unsuccessful in locating Rohan because he was found too far from the LKP. Dr Whitehead also expressed the view that a ground or air scent dog was unlikely to be of assistance given the time that had elapsed between when Rohan as reported missing and the commencement of the search.

11.6 On 4 September 2020:

(a) searchers were deployed to various sections of bushland in a southerly direction from where Rohan's mobile phone was located, parallel to Whiteman Creek and Whiteman Creek Road;

(b) search crews were deployed to the eastern and western side of Whiteman Creek Road.

(c) canvasses of the area identified that a local resident saw a blue car parked in a rest area at the intersection of Whiteman Creek Road and Clarence way about a week and half earlier with no one in the car;

(d) canvasses also identified that another local resident saw Rohan's car parked at the rest area on Whiteman Creek Road on 28 August 2020, and again on 30 August 2020 but in a different position;

(e) canvasses also identified that another resident had seen a person possibly matching Rohan's description walking along Whiteman Creek on the left side of the road appearing to be lost, but no photo of Rohan was shown to the resident to confirm whether this was in fact Rohan;

(f) enquiries were made to confirm that Rohan had not presented at any local hospitals; and

(g) a number of Rohan's friends attended the Command Post and told Senior Constable Jeffcoat that Rohan was no longer taking medication for schizophrenia, that his doctor had "*reversed*" his schizophrenia diagnosis, that Rohan had a previous suicide attempt, and that Rohan suffered from social anxiety.

11.7 On 5 September 2020:

(a) areas south of Clarence Way, either side of Whiteman Creek Road and two properties east and west of Whiteman Creek south of where Rohan's mobile phone had been located were searched;

(b) canvasses of the local area identified that on the evening of 1 September 2020 a taxi driver approached a resident regarding a booking for a pick up in the vicinity of Greberts Road due to a motor vehicle breakdown;

(c) canvasses of the local area identified that a local resident had found what was believed to be human faeces next to chicken coop on 27 August 2020;

(d) canvasses of the local area identified that Mr Arthurson had seen a small blue car around Whiteman Creek Road in early September 2020 with music coming from that direction. Mr Arthurson said that he told personnel at the Command Post that they should search Whiteman Creek heading upstream north of the bridge because in his opinion "*that would have been the more logical way for someone to travel through the bush*". Mr Arthurson said that soon afterwards an RFS officer drove around a clearing at his property. Although Mr Arthurson said that he told the RFS officer that he needed to go down the trail to the creek and walk upstream, the RFS officer reportedly "*said that he didn't feel like doing that and drove off*"; and

(e) Detective Senior Constable Thompson took a statement from Ms Lloyd at Lismore Police Station. Deborah described Rohan's mental health history and said that he experienced a mental health episode every two years or so when he would be unable to speak to people and would want to be alone. From the information provided, Detective Senior Constable Thompson formed the view that the circumstances in which Rohan went missing was similar to his previous behaviour when experiencing a mental health episode and likely related to such episodes. Detective Senior Constable Thompson also noted that the Triple Zero Call was consistent with Rohan having difficulty speaking when experiencing a mental health episode. It appears that neither Ms Lloyd's statement nor Detective Senior Constable Thompson's assessment were conveyed to Senior Constable Jeffcoat or any LANDSAR Coordinator involved in the search.

11.8 On 6 September 2020:

(a) search crews were tasked to conduct a close contact search of the area adjacent to the Command Post, south through to the area where Rohan's phone was found;

(b) search crews were deployed to bushland west of Whiteman Creek Road towards Copmanhurst.

(c) further canvassing of the local area identified a 13-year-old girl who reported that she saw a man dressed in a black or grey hooded jumper, wearing a beanie, walking towards Whiteman Creek Road at around 5:00pm on 2 September 2020. The girl's brother also reported seeing the same man near mango trees at 763 Clarence Way. This was considered unusual as they had lived in the area for many years and never seen anyone walking along the road; and

(a) canvassing also identified that a mental health nurse from Grafton reported seeing a man early in the morning on 2 September 2020 walking along Clarence Way towards Summerland Way being followed by a small blue car with someone attempting to have the man get into the car. The same man was reportedly seen later at 5:30pm walking in the opposite direction.

Search Urgency Assessment Form

11.9 As the LANDSAR coordinator, Senior Constable Jeffcoat was required to complete a Search Urgency Assessment (**SUA**) Form from the Australian Maritime Safety Authority National Search and Rescue Manual (**NATSAR Manual**). This was completed on the afternoon of 3 September 2020. Senior Constable Jeffcoat gave evidence that although he completed the form as if Rohan had just been reported missing, he took into account information obtained since 15 August 2020.

11.10 The SUA Form contains a series of questions designed to assess the level of risk to a missing person and determine which of three responses is required: Evaluate & Investigate, Measured Response and Emergency Response. Responses are allocated a score between 1 and 3 or 4, with 1 representing the highest level of risk. A note on the SUA Form states:

> Note: If any individual category above is rated as ONE (1), regardless of its total – the search could require an emergency response.

11.11 In contrast, paragraph 3.11.30 of the NATSAR Manual provides:

> [I]f there is a number 1 assigned to any of the categories then an immediate response is required.

11.12 In completing the SUA Form, Senior Constable Jeffcoat assigned a score of 1 in answer to six questions, with a total of 18 (although the correct total was actually 19). Both scores fell within the Measured Response category (which applies to scores between 18 and 27).

11.13 Senior Constable Jeffcoat stated that he believed that a measured response was the most appropriate given the following factors:

(a) the number of weeks that had passed since Rohan was last seen;

(b) there had been no recent sightings of Roman in the area although his car had been found at the bottom of the embankment; and

(c) that there was no evidence to suggest that Rohan had sustained any injury whilst in the car.

11.14 Senior Constable Jeffcoat stated that if an Emergency Response had been indicated, the search on 3 September 2020 would have most likely continued into the night with other assets such as a helicopter fitted with thermal imaging, a NSWPF Dog Unit, and additional NSWPF and volunteer search teams requested for an immediate response. Notwithstanding, Senior Constable Jeffcoat gave evidence that regardless of the response level indicated by the SUA Form:

(a) the actual LANDSAR effort was doing everything it could to find Rohan;

(b) he did not think there was much more that could have been done to elevate the LANDSAR effort to an emergency; and

(c) he could not be certain whether the search would have continued into the night even if an Emergency Response had been indicated.

11.15 Sergeant Atkinson gave the following evidence, based on his years of experience, as to the nature of the LANDSAR effort:

> I do note that the [NATSAR] manual does not provide any definition of what quantities an emergency response versus a measured response. It provides no guidance whatsoever in relation to the difference between those two terms. I've always just taken it to be a common-sense approach, and based on my opinion around that, I would consider that the response that was mounted to the report that the vehicle had been found at Whiteman's Creek Bridge on the afternoon of the 3rd was an emergency response. There was no notable delay in either a land SAR - a qualified land SAR attending the scene, nor was there a delay in getting volunteer resources to commence a land search at that time.

11.16 Dr Whitehead, who is the author of the NATSAR Manual, initially gave evidence that he considered the NSWPF response from 3 September 2020 to be a measured response as he did not believe that "*all the evidence was used in identifying the areas needed to be searched*" and that the focus of the search should have been to the north of the LKP as there were no reported sightings of Rohan south of the LKP. However, Dr Whitehead later agreed that as the LANDSAR effort was performed with the assistance of RFS and SES volunteers (with a peak of 60 volunteers on 5 September 2020) over the course of three days it could described as an emergency level response.

11.17 Dr Whitehead also gave evidence that the next version of the NATSAR Manual will be updated to ensure consistency in language to make clear that an emergency response could be required for a particular SUA Form score threshold. Dr Whitehead also gave evidence that suggestions will be included in the NATSAR Manual as to what each level of response will entail.

Discovery of footprints on 3 September 2020

11.18 The footprints found by SES volunteers on the afternoon of 3 September 2002 were located at four discrete locations, all north of the LKP. Senior Constable Jeffcoat gave evidence that:

(a) he did not go to inspect the footprints for himself;

(b) he had been told that the SES volunteers could not go any further but could not be certain whether he enquired about the reason for this; and

(c) the footprints went around circles and there appeared to be more than one set.

11.19 In oral evidence, Senior Constable Jeffcoat was asked whether he considered whether Whiteman Creek should have been explored further at the time. Senior Constable Jeffcoat gave this evidence:

> Yeah, it's considered. When they tell me they can't go any further past that point, I've got to be guided by what they're telling me, and I can only be guided by what they're telling me. If they're – [searchers] are saying that they can't go any further, I can't really question it because I'm not there myself.

11.20 Sergeant Atkinson stated that on 6 September 2020 he spoke to the volunteer who had found the footprints and was told that multiple sets of footprints had been located in the creek bed and the footprints were present for several hundred metres but then stopped.

11.21 In his statement, Sergeant Atkinson described the consideration which he gave to the discovery of the footprints in this way:

> It could be suggested that the footprints located in the creek should have been given greater weight. And with hindsight, that proposition is hard to argue. However, based on the various pieces of information that was incoming during the course of the search, including the location of the mobile phone and the number of potential sightings, as well as the fact that search teams reported losing the footprints and not being able to locate them again, I suggest that the footprints were not a comparatively strong lead at that time. In my mind it could not be positively identified that the footprints were in fact belonging to the missing person. It could not be ruled out that, if they were in-fact the those of the missing person, that he did not walk along the creek, but then return to the bridge, a theory supported by the fact that there were reportedly multiple sets of footprints and they did not continue after a certain point.

Adequacy of the LANDSAR effort

11.22 Although Dr Whitehead acknowledged that the LANDSAR effort could be described as an emergency level response, he considered it demonstrated two errors of judgement:

(a) a failure to search Whiteman Creek in a 4.7 km radius from either side of the LKP; and

(b) the decision to cease the search on 6 September 2020 was premature and based on questionable reasoning.

11.23 The NATSAR Manual provides that a search response can be separated into two distinct actions: reflex or initial actions and a Formal Land Search. A reflex action is an "*instinctive search of those areas near the LKP*" where the missing person "*could have met with trouble*". The NATSAR Manual describes a reflex task as one that "*requires minimal planning, and it is used as a first response search*".

11.24 Dr Whitehead gave evidence that 81% of the time a reflex search will find the target of a search and rescue operation. Senior Constable Jeffcoat appears to have appreciated that searching Whiteman Creek in both directions was the easiest and most obvious starting point, given that he tasked a small search team to search the creek bed, both north and south of the Command Post, while he began preparations on 3 September 2020.

11.25 Dr Whitehead said that he would expect a LANDSAR coordinator to interrogate and explore the information provided by the searchers regarding the footprints for themself. Dr Whitehead gave this evidence:

> I would ask absolutely definitely which way were they going at what point, so identify the creek. Where they going northwards here, were they going southwards there, were they going westwards there, could you identify the stride length, because if the stride length is getting shorter and shorter then we know that Mr Lloyd was possibly getting tireder and tireder, which would have an effect on his ability to make a rational decision. So everything that somebody finds would require a lot of questioning to determine is it relevant, is it not relevant. If it is relevant, how is it relevant. Police ask questions all the time; that's their job, so one thing should lead to another; it's just natural SAR.

11.26 Dr Whitehead considered that that it would have taken a LANDSAR Coordinator a short time to walk to the location where the footprints were found. He gave evidence of this importance of this:

> And then as the search progressed there were footprints found, and they were only found on the northern side of the bridge. One part about SAR is you have to be very clue aware; as you find things it gives you directions of travel, probably ideas about intentions and things like that, so there is a lot of things that happen in that first day.

11.27 Dr Whitehead gave evidence that as Rohan was last seen on 14 August 2020 not wearing any shoes and in a distressed and dishevelled state, that his sneakers were found in his car, the presence of barefoot footprints was a possible link to Rohan until proven otherwise. Dr Whitehead also gave evidence that the footprints should have been investigated further in this way:

> [I]f they're still following footprints, continue to follow the footprints until you either come to the person who made them or there is no chance of following them any further.

11.28 The available evidence indicates that there was no difficult with continuing the search north along Whiteman Creek past the point where the footprints were found. It is clear that the civilian search party was able to travel about a further 1,000 metres although they had to navigate around a large tree blocking the path at one point. In this regard Sergeant Atkinson gave the following evidence as to what information had been provided by the searchers who found the footprints:

> What I took that to mean at the time is the footprints had been followed to a distance. Those footprints then were no longer present. I didn't take - my interpretation of the information I was given around that at the time wasn't that there was a physical barrier for them continuing. It was that they'd searched as far as the footprints went, and then some more, and the footprints were no longer present.

11.29 When asked whether he considered that the information provided suggested that the creek should have been searched further upstream Sergeant Atkinson gave this evidence:

> Look, I absolutely considered it, and as I said in my statement, you know, with the benefit of hindsight, it's easy for me to sit here and say we absolutely should have. Like with any search operation, you know, you don't have the luxury of a crystal ball, and we were - I say, "we". Obviously, you know, Senior Constable [Jeffcoat] and, certainly, my opinion was there were a number of different possibilities in relation to the highest - you know, the areas of highest probability of detection that we were exploring. I was satisfied at that time that the - you know, based on the information that had been given, the footprints were followed. They were - to a point where they weren't present any further, and that there was evidence of the footprints in both directions which could have indicated someone walking out, you know, walking along the creek in one direction, then turning around and coming back.

11.30 Dr Whitehead gave this evidence regarding the finding that the footprints appeared to go in different directions:

> To me that's a classic lost person characteristic of someone who is trying to go back to a place they think they can find. Where he's walking forward, realises "I'm lost", or "I want to go back to my car", turn around, walk back but probably not on the same track he was originally on and then stop at a point of time and think "well maybe I've overshot it" and turned back and walked back in the original direction. I found that occurs, yes.

11.31 The NATSAR Manual provides that Lost Person Behaviour (**LPB**) has been derived from many studies and statistics from search and rescue efforts globally and that "i*t has been found that certain categories of missing persons tend to have similar characteristics with respect to being lost*". These categories have been divided into several groups including, relevantly, persons with psychological illness. Sergeant Atkinson stated that this was the most appropriate behavioural category to provide statistical and guidance to LANDSAR Coordinators in Rohan's case.

11.32 The NATSAR Manual provides for a number of strategies to be employed when searching for missing persons who fall within the psychological illness group including:

> Check drains, streams and tracks.
> Obtain profile by talking to family, friends and medical experts.

11.33 The NATSAR Manual also provides statistical percentages of cases where missing persons with psychological illness have been found in terms of distances from the LKP. Using this calculation, Dr Whitehead explained that search and rescue operatives normally utilise the 80% mark which in this case was a radius of 4.7 kilometres from the LKP. Applying these two principles, Dr Whitehead

produced an annotated map which, in his view, identifies the area of highest probability in the search for Rohan.

11.34 Using this map, Dr Whitehead calculated that would have taken the 60 RFS and SES volunteers on 5 September 2023:

(a) 3 hours to cover the smaller 1.2 km radius (representing the 75% LPB boundary for persons who fall within the Aspergers and autism group); and

(b) 8.5 hours or a full day of searching to cover the larger 4.7 km radius (representing the 80% LPB boundary for psychological illness).

11.35 Dr Whitehead gave evidence that even if the footprints had not been found, the easiest and most obvious reflex response would have been to search either side of Whiteman Creek from the LKP up to a 4.7 km radius.

11.36 The available evidence indicates that further searching of Whiteman Creek upstream on 3 September 2020 or afterwards was warranted because:

(a) the search that had been performed fell well short (845 metres) of the 4.7km radius identified from the LKP in circumstances where a reflex search is successful in locating a missing person in 81% of cases;

(b) Senior Constable Jeffcoat appeared to appreciate that it was the most logical starting point having initiated a reflex action to search the location;

(c) the discovery of footprints was consistent with other evidence gathered that Rohan was last seen wearing no shoes and his sneakers were found in his car;

(d) Senior Constable Jeffcoat acknowledged in his evidence that his appreciation of the significance of the findings was limited by what the searchers had told him and that in order to sufficiently interrogate this information he needed to examine the scene himself which was relatively easy to do;

(e) the creek represented the only water source near the LKP with no evidence that Rohan had accessed any water source available from properties in the area; and

(f) there was no physical barrier to the search continuing upstream beyond the point where the footprints were found;

(g) the discovery of footprints going in different directions was consistent with classic lost person behaviour of a person retracing their steps after becoming lost and then continuing in the same direction;

(h) the LANDSAR effort had the capacity to search Whiteman Creek up to the LPB boundary; and

(i) searching Whiteman Creek up to the LPB boundary as part of a reflex response would have been relatively easy to accomplish compared to the time and resources required to search dense bushland in the area.

11.37 **Conclusions:** Although completion of the SUA Form on 3 September 2020 indicated that a measured response was required, the actual LANDSAR effort amounted to an emergency response with a large number of NSWPF and volunteer searchers deployed over three days. Appropriate efforts were made to search the areas around the LKP and to canvass local properties for further information and whether local residents might have sighted Rohan in the area.

11.38 The discovery of the footprints on the afternoon of 3 September 2020 represented a significant finding. Both Senior Constable Jeffcoat and Sergeant Atkinson gave consideration to whether further searching of Whiteman Creek upstream was warranted but ultimately decided that it was not. However, even on Senior Constable Jeffcoat's own evidence, it was recognised that properly interrogating what the searchers had found and reported required an inspection of the site where the footprints were located. This would have been a relatively easy task to perform but was not done. As Dr Whitehead explained, had this task been performed it is possible that it would have elicited relevant information to direct further investigative steps.

11.39 Even absent these types of enquiries the evidence suggests that further searching upstream of where the footprints were found was warranted and consistent with search methodology for missing persons with characteristics similar to Rohan's.

11.40 Counsel for the Acting Commissioner submitted that the evidence demonstrated that the LANDSAR effort extended beyond the 4.7km radius for roads, building habitats and areas of shelter and that the NATSAR Manual indicates that missing persons who fall within the psychological illness group are found in road, habitation and building/shelter areas combined 69% of the time. Whilst this is accepted, it remains the case that the instinctive reflex response which is successful in 81% of missing person cases only resulted in search efforts of Whiteman Creek 845 metres north of the LKP.

Suspension of the LANDSAR effort

11.41 At 12:10pm on 6 September 2020, Mr Grebert attended the Command Post and reported the Grebert Encounter. Shortly after information received from volunteers involved with searching on that day was recorded at 12:45pm, the volunteers were dismissed and the search was suspended. Sergeant Atkinson gave evidence that his recommendation to suspend the search was not "*suspending the search in the true sense of that term*". Sergeant Atkinson explained that instead:

> I felt it appropriate to take a pause for one, two, you know, days for the investigation side of the house to collect or, you know, to canvas further these number of informants that you've referred to because a lot of this information had kind of come either through volunteers who doorknocked or people had walked into the command post when there's a lot going on in that space. It's not the appropriate space to conduct a thorough interview with somebody and take a statement or what have you. Like, these people needed to be followed up by investigators so that the information could really be drilled into and the credibility of that information could be ascertained.
> […]

> I felt it appropriate that we just say stop, let's get our ducks in a row in terms of the information that's come in, work out what information we're actually relying on and then reassess whether Rohan has actually left the search area, whether he's still out there, for want of a better term […]

11.42 Sergeant Atkinson went on to explain:

> Now, whilst that doesn't mean the search automatically stops, it just means that the urgency of searching is not immediate and we would look at other resources, you know, to conduct further search activities in the area with the view of hopefully at least finding his body and obviously being able to deliver those answers to his family.

11.43 In contrast to the explanation provided by Sergeant Atkinson, other evidence suggests that the decision made on 6 September 2020 was an indefinite suspension of the search and not a temporary one pending further investigations:

(a) At 5:22pm on 6 September 2020, Inspector Kingsley Chapman sent an email to the Crime Managers indicating that the search for Rohan had continued across the weekend and "*completed at 1pm today*"; and

(b) at 2:01 AM on 7 September 2020, Chief Inspector Susan Johnson sent an email advising that, after speaking with Inspector Chapman, they had agreed to a press release "*that the search had ceased in the area*".

11.44 For the reasons described already above, Dr Whitehead considered that suspension of the LANDSAR effort was premature because searching up to the LPB boundary as part of a reflex response had not been exhausted. Dr Whitehead also considered that the Grebert Encounter was the most probable reliable sighting of Rohan and that most of other reported sightings of Rohan were vague. For example, Dr Whitehead noted that the reported sightings disclosed on 6 September 2020 were in an area on Clarence Way, some distance from the LKP. In this regard, Dr Whitehead expressed disagreement with the assessment by the NSWPF of Rohan's capabilities in this way:

> Mr Lloyd would be hard pressed to do the things that I think they were relying on for the suspension, ie, survive for three weeks, move to a different location. He had no vehicle anymore. No one's come forward to say they picked him up. He wasn't seen on any of the roads leading out of the area. He wasn't seen by any of the farmers, or there's no reports of any person with any positive sighting after that one way back in August. Nothing is as good as something, in some cases, and particularly in SAR, if you find nothing after a really good search, then it's generally because there was nothing to find there. So in this case, going southwards, you know, nothing was found apart from, you know, once they got out past the mask and the telephone. So sometimes it's not about the finding things. It's a lot about the not finding stuff that has an impact on the search.

11.45 Notwithstanding, Dr Whitehead expressed the view that even if it was determined that the reported sightings needed to be pursued further, this did not warrant suspending the search. This is because the LANDSAR effort could have continued on 7 September 2020 concurrently with performing investigative steps of the kind described by Sergeant Atkinson. Dr Whitehead gave this evidence:

> [T]here is absolutely no problem with searching and doing inquiries at the time same time. You don't have to stop one to do the other, and if there's areas to search, you should just continue until your inquiries are out. If it turns out the inquiries find him, well that's great. If it turns out the inquiries don't find him and you haven't continued searching, you've put yourselves that many more days behind …

11.46 Relevantly, when Detective Senior Constable Thompson took Ms Lloyd's statement on 5 September 2020 it was noted that during previous mental health episodes Rohan typically displayed symptoms of catatonia, not drinking or eating, muteness, thought disorder, paranoia, auditory hallucinations, and suicidal ideation. Ms Lloyd's statement was not provided to Senior Constable Jeffcoat or Sergeant Atkinson at the time. There is also no evidence that either of them was made aware of its contents or of Detective Senior Constable Thompson's assessment that Rohan likely went missing in circumstances similar to previous mental health episodes he had experienced.

11.47 If this information had been available to Senior Constable Jeffcoat, Sergeant Atkinson or Leading Senior Constable Vidler (the other LANDSAR Coordinator involved in the search), it is likely that it would have informed the assessment of whether the reported sightings of Rohan were reliable, and whether Rohan was still alive and avoiding detection or had left the area.

11.48 Dr Whitehead expressed the view that by 3 September 2020, the timeframe for Rohan still being alive had likely already expired.

11.49 Senior Constable Jeffcoat gave evidence that, in hindsight, it would have been relatively easy to speak with Ms Lloyd on the phone. This likely would have allowed the eliciting of information that was provided to Detective Senior Constable Thompson. Such a step would have been consistent with the guidance provided by the NATSAR Manual that for missing persons who fall within the psychological illness group, an important investigative strategy is to obtain a profile of the person by speaking to family members.

11.50 Senior Constable Jeffcoat explained that there were a "*flurry of different things*" he was doing at the time, that he was trying to "*get this operation underway*" and that he believed that he had "*sufficient information to get things going*". Senior Constable Jeffcoat gave evidence that could not comment on whether he recalled the importance, as part of his LANDSAR Coordinator training, of consulting with family members before embarking upon a LANDSAR response. Senior Constable Jeffcoat also explained that he was not a fulltime LANDSAR Coordinator, that "*search requests come about at random times*", that he did not "*study these guides*", and that he did "*what [he] can with the training [he was] given*".

11.51 **Conclusions:** The decision to suspend the LANDSAR efforts on 6 September 2020 was made without a clear indication as to when the search might be resumed and in what circumstances. The expert evidence suggests that the information gathered up to that point in time did not support suspension of the search in order to further investigate the reported sightings of Rohan which were vague. There was also no reliable evidence that Rohan had departed the area of the LKP or that he had managed to survive in the area during the period from when his last mobile phone activity was identified.

11.52 Even if such further investigation was considered to be necessary, there was no impediment to the LANDSAR efforts continuing concurrently. This is particularly so in circumstances where the initial reflex response to search Whiteman Creek had elicited a significant finding and the search had not been completed up to the 80% LPB boundary.

11.53 Counsel for the Acting Commissioner submitted that the fact that Dr Whitehead was not provided with a copy of Sergeant Atkinson's statement before providing his report and giving evidence is regrettable "*as it was exceedingly unlikely that Dr Whitehead would ever alter his entrenched opinion about the search*". It was also submitted that Dr Whitehead's evidence "*demonstrated it was his opinion as to how he would conduct a search, rather than what is the appropriate standard*". However, Dr Whitehead's opinion was based on the fact that search and rescue operatives typically search up to 80% of the LPB boundary or, in this case, a 4.7 km radius from the LKP.

11.54 The lack of contact with Rohan's family prior to suspension of the search was both a missed opportunity and contrary to the provisions of the NATSAR Manual. It appears that Senior Constable Jeffcoat's relative inexperience as a LANDSAR Coordinator, his lack of familiarity with relevant aspects of the NATSAR Manual, and his belief that he was already in possession of sufficient information to commence and coordinate the search were all factors which continued to this missed opportunity. Had such contact occurred it is likely that important information would have been elicited regarding the circumstances in which Rohan went missing and their similarity to previous occasions when Rohan had experienced a mental health episode. Such information is also likely to have informed the focus of the LANDSAR efforts and whether suspension was in fact warranted.

12. Timing and efficacy of the handover from Richmond PD to Coffs/Clarence PD

12.1 On 7 September 2020, Detective Sergeant Ingram initiated Strikeforce Quia with Detective Senior Constable Thompson as the OIC and herself as the Investigations Supervisor. Various follow-up tasks were created. On 8 September 2020, a case review meeting was held involving personnel from Richmond PD, Coffs/Clarence PD and the MPR.

12.2 The meeting minutes record that Coffs/Clarence was to allocate an experienced investigator as OIC to take overall carriage of the investigation with assistance to be provided by Richmond PD, as well as engage the RBDU regarding searches. Richmond PAC was to complete allocated enquiries to date within Richmond PD and was to appoint a family liaison officer to provide updates around family.

12.3 On 9 September 2020, Grafton Detectives made enquiries with several potential witnesses who had been identified during the LANDSAR effort and who had reported apparent sightings of Rohan's car and/or male persons who may have been Rohan. These enquiries did not advance the investigation.

12.4 After Rohan was found on 12 September 2020, Detective Chief Inspector Guy Flaherty (Coffs/Clarence PD Crime Manager) said that a discussion took place between himself, Detective Sergeant Ingram and later, Detective Chief Inspector Lindsay, regarding the carriage of the matter and preparation of a brief of evidence for the Coroner. Detective Chief Inspector Flaherty said that it was decided that Detective Senior Constable Thompson would be responsible for compiling all enquiries made up to 2 September 2020, and that Coffs/Clarence PD would be responsible for completion of the brief of evidence, including making further enquiries regarding where Rohan was found.

12.5 On 19 September 2020, Detective Sergeant Ingram removed Detective Senior Constable Thompson as OIC and allocated Detective Sergeant Graham Burke from Grafton Detectives to this position. Detective Senior Constable Thompson was designated responsibility for liaising with the family and coordinating enquiries within Richmond PD at the Request of Coffs/Clarence PD which had taken over carriage of the investigation. Detective Sergeant Ingram also removed herself as Supervisor from Strike Force Quia and added Detective Chief Inspector Flaherty as the Investigations Supervisor.

12.6 Following the post-mortem examination 21 December 2020, it appears that the NSWPF took no further steps in the matter until April 2021 when Detective Chief Inspector Flaherty became aware that Rohan's family had expressed concerns about the lack of progress. Detective Chief Inspector Flaherty subsequently contacted Rohan's family and arranged to speak with Ms Lloyd via videoconference on 26 April 2021.

12.7 Following this meeting, two new OICs were allocated to the matter. On 7 May 2021, an order was issued from Grafton Court for a brief of evidence to be served by 21 June 2021. In response, several witness statements were obtained, Rohan's medical records were obtained, and a search of the Whiteman Creek area was arranged on 19 May 2022 for the missing car battery. However, as the area had been subject to flooding in the intervening period, no battery or any other items of interest were found.

12.8 As to the lack of communication with Rohan's family, Detective Chief Inspector Flaherty gave this evidence:

> [U]ltimately there was a downfall from our side where from a point of view in late 2020 we failed to maintain proper contact with family in terms of the progression of the matter.

12.9 Detective Chief Inspector Flaherty was unable to identify the cause of this breakdown in communication. When asked about his opinion as to why this occurred, Detective Chief Inspector Flaherty gave evidence that:

> There are a number of issues, and we could speculate and point blame and things like that. Ultimately, it's my responsibility to ensure that family are kept updated. For me to say person X or Y should've done A, B, or C is irrelevant. The fact is that we should've - the case officer at the various times should've kept the family updated. When I became aware of it, that's where we met to try and address some of the family's concerns.

12.10 **Conclusions:** It appears that the transfer of carriage of the investigation from Richmon PD (which included Lismore where Rohan lived) to Coffs/Clarence PD (which included Copmanhurst where Rohan was found) led to a breakdown in communication with Rohan's family, and delayed completion of the investigation so that a brief of evidence could be submitted to the Coroner. The precise reason for this is unclear although it is likely that the decision to initially keep Detective Senior Constable Thompson from Richmond PD as the liaison with Rohan's family whilst the investigation was managed at Coffs/Clarence PD contributed to this breakdown.

12.11 The result was that Rohan's family were regrettably not kept updated regarding the progress of the matter between September 2020 and April 2021. This lack of communication no doubt only added to the acute grief and uncertainty that they were collectively experiencing at the time. Once this issue was identified, immediate and appropriate steps were taken to restore timely and active communication with Rohan's family.

13. Findings pursuant to section 81(1) of the Act

13.1 Before turning to the findings that I am required to make, I would like to acknowledge, the efforts of Ms Theresa Power, Counsel Assisting, and her instructing solicitor, Ms Francesca Lilly of the Crown Solicitor's Office, and express my gratitude to them both. I am most appreciative of the assistance that the Assisting Team has provided throughout all stages of the coronial process, their thoroughness and diligence, and the sensitivity and empathy that they have shown, particularly in their communication and interactions with Rohan's family.

13.2 I also acknowledge the assistance of Detective Senior Sergeant Corcoran and his endeavours in advancing the coronial investigation.

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

Identity
The person who died is Rohan Lloyd.

Date of death
Rohan died between about 14 and 18 August 2020.

Place of death
Rohan died at Whiteman Creek NSW 2460.

Cause of death
The cause of Rohan's death was the combined effects of presumed heavy metal poisoning from an unknown material and freshwater drowning.

Manner of death
Rohan was most likely experiencing a psychotic episode related to his schizophrenia diagnosis which caused him to become lost in bushland and unable to seek assistance or self-rescue. Whilst the mechanics of how Rohan came to enter the pool of water where he was found are not entirely clear, it is likely that dehydration and hypothermia contributed to his collapse. It is not possible to conclude from the available evidence how Rohan came to ingest the material found post-mortem in his stomach and oesophagus, or where the material came from.

14. Epilogue

14.1 On behalf of the Coroner's Court of New South Wales I extend my most sincere and respectful condolences to Rohan's family and to his mother, Deborah; father, Arnen; sister, Meredith; brother, Tai; and his many loved ones and friends.

14.2 It is appropriate to close with Deborah's description of what she called he soundtrack of Rohan's life: diverse, discordant but heartfelt.

14.3 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
8 September 2025
Coroners Court of New South Wales