NSW POLICE FORCE P190B

STATEMENT OF POLICE

In the matter of:	Special Commission of Inquiry into LGBTIQ Hate Crimes
Place:	Parramatta
Date:	22 May 2023

Name:	Glen Browne	Tel. No:	[redacted]
Rank:	Detective Chief Inspector		
Station/Unit:	Homicide Squad		

STATES:

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give in court as a witness. The statement is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I will be liable to prosecution if I have wilfully stated in it anything that I know to be false, or do not believe to be true. In this statement, if there is any information I have obtained from a particular source, I set out the source of that information.

2. I am 57 years of age.

3. I make this statement in respect of the Request for Statement issued by the Special Commission of Inquiry into LGBTIQ Hate Crimes (**Inquiry**) on 13 April 2023, specifically requesting information concerning the recommendations of Deputy State Coroner Milledge in the context of the inquest into the deaths of Ross Warren, John Russell and Gilles Mattaini in 2003-2005 (**Taradale Inquest**) (**Request for Statement**). A copy of the Request for Statement is attached as '**Annexure 1**'.

4. In this statement, I specifically address the following three recommendations made in the Taradale Inquest:

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a. Ensure that all Missing Person reports are investigated in a timely and proper manner (**Recommendation 1**);

b. Ensure that Missing Person cases considered 'suspicious' deaths are to be referred for criminal investigation (**Recommendation 2**); and

c. Ensure that all Missing Persons be reported to the State Coroner after a reasonable period of time after all routine investigations have been undertaken (**Recommendation 3**).

5. This is the first statement I have made in the context of the Inquiry. I set out detail about my qualifications and experience in **Section A** below.

6. At the time of signing this statement, I have been shown a zipfile of electronic documents marked with electronic document IDs in the format '**NPL.XXXX.XXXX.XXXX**'. Where I refer to a document in this statement, I refer to it by its document ID.

7. In the course of preparing this statement, I have reviewed the oral submissions made by Counsel Assisting the Taradale Inquest. I make some observations about the nature of Recommendations 1 – 3 in the context of those submissions in **Section B** below.

8. I then respond to each of the Inquiry's questions in the Request for Statement in the following sections of my statement below:

a. **Section C**: addresses Recommendation 1 and questions 1 – 5 in the Request for Statement concerning this recommendation;

b. **Section D**: addresses Recommendation 2 and questions 1 – 5 in the Request for Statement concerning this recommendation;

c. **Section E**: addresses Recommendation 3 and questions 1 – 5 in the Request for Statement concerning this recommendation.

9. As will become clear through my statement, there have been significant improvements in the way in which missing persons cases are dealt with at NSWPF over the approximately 20 years since the Taradale Inquest. Two of these changes are of particular importance:

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a. development of the Missing Persons Registry (**MPR**), replacing the former Missing Persons Unit (**MPU**). For the reasons I set out at paragraph 48 below, this represented a fundamental shift in NSWPF's approach to the investigation of missing persons cases as they were dealt with as part of NSWPF's investigative functions, because it relocated the MPU from the Operational Communications and Information Command (**OCIC)** to the State Crime Command (**SCC**). As a result of this shift, and the associated personnel changes, the MPR has far greater investigative expertise than the MPU (see further [16] below); and

b. allocation of an experienced investigator, an MPR 'consultant', to every case involving a missing person.

10. I also describe in detail below the functions of the MPR, and the process through which the current standard operating procedures for missing persons investigations (**2023 MP SOPS**) came to be updated. Today, the MPR comprises 16 specialist members, including a Manager (Detective Inspector), Co-ordinator (Detective Senior Sergeant), Team Leaders (Detective Sergeants), Investigators (Detective Senior Constables), Analyst Team Leader (Sergeant), Analysts (Senior Constable or Clerk grade 5/6), and Clerical Officer (Grade ½). MPR members are assigned immediately to new missing persons cases and provide assistance to investigating officers. More recently, the MPR also includes a three-person 'response team', who are able to be deployed to high risk missing persons reports. The response team is on call for deployment 24 hours a day, at the discretion of the Manager of the MPR.

11. In particular, some of the features of the NSWPF's approach to missing persons cases (reflected in the 2023 MP SOPS) include:

a. Mandatory training for all NSW police officers regarding responsibilities associated with missing persons investigations.

b. Police Area Command (**PAC**) or Police District (**PD**) retain responsibility for investigation of missing person matters, subject to the advice and oversight of members of the MPR;

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c. All officers involved in a missing persons investigation are required to be aware of the roles and responsibilities explained in detail in the 2023 MP SOPS (for example, the person taking the report, the Shift Supervisor, the Duty Officer, Crime Managers, Crime Coordinators, and others); thus, each officer has a clear understanding of their role in progressing the investigation. Officers also have access to detail about the investigative tools available to assist police with missing persons investigations set out in the 2023 MP SOPS;

d. Specialist MPR consultants ensure that (1) the 2023 MP SOPS are being followed, and (2) provide specialist advice and expertise to investigative teams at the PAC / PD;

e. All officers are required to adhere to the mandatory reporting timeframes (including reporting to the NSW Coroner) regarding missing persons cases;

f. Multiple layers of oversight and responsibility (by virtue of the number of officers, with varying levels of seniority, given defined roles within a missing persons investigation) to ensure investigations are conducted thoroughly;

g. Mandatory reviews conducted of all outstanding missing person investigations at three, six and nine months.

12. I consider these changes, together with the other changes considered below, have had a very positive impact on the ability of NSWPF to effectively investigate missing person matters. The improved process associated with the implementation of the MPR are reflected in the statistics mentioned later in this statement.

A. ROLE AND POLICING EXPERIENCE / QUALIFICATIONS & TRAINING

13. I am a Detective Chief Inspector. I am currently an Investigations Coordinator at the Homicide Squad, overseeing multiple current homicide investigations.

14. I have been a member of the NSWPF since July 1988. From approximately 1988 to 1994 I worked in General Duties in South Western Sydney. From 1994 to 2001 I worked in various detectives' offices within police districts. From 2001 to 2015, I worked within the Homicide

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Squad at State Crime Command (**SCC**). From February 2015 to February 2019, I was an Investigations Coordinator at the Professional Standards Command. From February 2019 to August 2019, I was an Investigations Coordinator at the Financial Crimes Squad, SCC. On 5 August 2019, I was selected by the Commander SCC to become the inaugural Manager of the new MPR. As part of this role, I was instructed to review the organisations response to both missing persons and unidentified bodies and human remains investigations and to create new systems and processes to ensure those investigations are conducted in an appropriate manner.

15. The MPR sits within the SCC. While Manager of the new MPR, I reported to the Director, Crime Operations, SCC. I finished in that role in November of 2022 and returned to the Homicide Squad where I currently hold the role of Detective Chief Inspector.

16. Prior to the introduction of the MPR, the NSWPF response to missing persons, unidentified bodies and human remains investigations was guided by the MPU which sat within the OCIC of the NSWPF. The NSWPF has had a MPU, in various forms since the 1940's. While undertaking the role of Manager of the MPR, I searched for all available literature relating to previous forms of NSWPF MPUs. I did not locate information about the structure of the previous forms of the MPU. My understanding is that former iterations of the MPU were staffed by general duties police officers rather than criminal investigators. The focus on criminal investigation and investigative expertise is one of the reasons in my view that the new MPR represents a significant improvement in NSWPF's management of missing persons cases.

B. TARADALE RECOMMENDATIONS

17. The recommendations made in the Taradale inquest concerning missing persons are in broad terms. Recommendation 1 in particular was extremely broad and it is difficult, on the face of it, to identify what exactly was intended by that recommendation.

18. In an effort to understand the terms of the recommendations, I have reviewed the submissions of Counsel Assisting the Taradale Inquest.

19. I set out part of the transcript of submissions of Counsel Assisting, and an exchange with the Deputy State Coroner Milledge, below:

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> *LAKATOS: The sixth then is possible recommendations. Your Honour one of the problems with this inquiry is, of course, that it deals with events which have occurred more than a decade ago.*
> *HER HONOUR: That's exactly right.*
> *LAKATOS: Accordingly, much of it is historical and accordingly, some of the general areas of recommendations that I'd urge your Honour to consider have probably been dealt with and therefore it may be that strict recommendations may not be necessary. It is also the case that my learned friend, Mr Saidi, has provided material, in written form, as to the present procedures.*
> *HER HONOUR: Good, that's excellent.*
> *LAKATOS: And I will go to those very briefly. In effect, your Honour, the recommendations will be that these things need to be looked at, not because the systems on paper appear to be deficient but simply in order to audit or monitor how the systems are working.*

20. The findings of Deputy State Coroner Milledge do not themselves explain what is intended by the recommendations.

21. While I cannot be certain what was intended, the above paragraphs of Counsel Assisting's submissions suggest to me that what the Coroner likely had in mind was some form of assessment to check that the systems in place were resulting in timely and proper investigations of missing persons cases, appropriate referrals for criminal investigations, and appropriate reports of missing persons to the State Coroner.

22. I also refer to page 13 of the submissions, and in particular, the paragraph which states:

> Your Honour as to what recommendations might usefully be made. Your Honour would be well aware that in July of 2002 the State Coroner, Mr Abernethy, made full recommendations in relation to the investigation of deaths of young women, Goodall, Robinson and Hickey. Those recommendations in broad terms your Honour related to a recommendation that the Police Force ensure its systems in relation to missing persons are linked to criminal investigations, so that in every case, unresolved missing person case, after a finite period an analysis is carried out in order to decide whether to formally treat and deal with the matter as a criminal investigation. The second was a suggestion that a systematic audit into old missing persons cases be undertaken and reported to the Coroner. The third was the New South Wales Police Force carry out similar audits in relation to no body investigations . And the fourth is additional staffing to the various agencies concerned with these matters. It may be timely that your Honour simply say that these things ought to perhaps be, attention be drawn to those.

23. I have been advised that NSWPF have conducted searches of the Ministerial and Executive Services holdings to identify how the 2002 Inquest into the deaths of Goodall, Robinson and Hickey was dealt with by NSWPF.

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24. I have been provided with a document titled 'Response January 2003', available at NPL.0100.0011.0438. This document sets out the following in respect of Recommendations One and Two of the 2002 Inquest, noting Recommendations Three and Four deal with no body investigations and resources at Homicide and Serial Violent Crime:

> ### *Recommendation One*
> *That the New South Wales Police Force ensures that its systems in relation to "missing persons" are linked to criminal investigation so that in every unresolved missing person case, after a finite period, an analysis is carried out in order to decide whether to formally treat and deal with the matter as a criminal investigation.*
>
> ### *Recommendation Two*
> *That the New South Wales Police Force carries out a systematic audit into "old missing persons" registered with police in order to ensure that there are no further cases that need to be reported to a Coroner.*
>
> *The Missing Persons Application (MPA), maintained on the NSW Police intranet, provides a central database on missing person cases and is available to all operational police. The MPA system is particularly effective when utilised as a tool in 'unidentified body' and other homicide investigations, facilitating the expedient search and comparison of physical descriptions and other relevant information.*
>
> *The Missing Persons Unit systematically reviews all long term (in excess of 365 days) matters and identifies those that should be reported to the Coroner. The Missing Persons Unit also retrieves and reviews, on a daily basis, missing person reports and additional information on existing matters that are entered into the COPS system by Local Area Command and specialist police. Missing Persons Unit investigators evaluate, enter and maintain this information in the Missing Persons Application.*
>
> *In 2001, the revised and enhanced NSW Police Missing Persons Policy and Procedures was released. These guidelines, developed by the Missing Persons Unit in consultation with, amongst others, the NSW State Coroner, the then Crime Agencies (now the State Crime Command) and the National Missing Persons Unit, Australian Bureau of Criminal Intelligence, are readily accessible to all police via the NSW Police intranet. The guidelines comprehensively address all aspects of the investigation of missing persons and clearly describe when and how a missing person investigation is to be intensified. The following excerpts from the NSW Police Missing Persons Policy and Procedures are attached for further information:*
> - *Tab A – Initial Response Checklist for the investigation of missing person reports.*
> - *Tab B – The role of Local Area Command police during the investigation stage.*
> - *Tab C - The role of Local Area Command police in the management of long term matters.*
> - *Tab D - The role of Local Area Command police during the finalisation process.*

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> *In 2002 an education and training program, focusing on the use of the Missing Person Application and reinforcing the updated procedures, was delivered to Local Area Commands state-wide by the Missing Persons Unit.*

25. This document refers to attachments, being excerpts from the 2001 policy described in the document. I have not reviewed these materials in connection with the preparation of this statement.

26. I take from this document that NSWPF updated its policy documents regarding missing persons in 2001 and delivered an education and training program in 2002.

27. I am presently unable to comment further on the content of that policy.

28. Further, as I set out in more detail below, the Missing Persons Unit (as it then was) has been the subject of many reviews and recommendations and has changed considerably since the Taradale Inquest.

C. RECOMMENDATION 1

29. In this section of my statement I address Recommendation 1 which recommended the Minister for Police and the Police Commissioner:

> *Ensure that all Missing Person reports are investigated in a timely and proper manner*

(a) Whether and by what means the NSWPF accepted the recommendation

30. As at the time of the Inquest, I was a Detective Sergeant with the Homicide Squad. I have no personal knowledge about whether or by what means NSWPF accepted Recommendation 1. In Part B and C below, I make a number of comments regarding the extent to which the practice of the NSWPF is reflective of, and consistent with, the recommendations made in connection with the Taradale Inquest.

31. I have been shown a document marked NPL.0100.0009.0066 (**Note to Minister**). The document states under the heading '*Issue*', '*Response to the recommendations of the State Coroner following the inquest into the deaths of Gilles Mattaini, John Russell and Ross Warren*'.

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32. On the second page of the Note to Minister, Recommendations 1, 2 and 3 are set out. The document then states:

> *The NSW Police Missing Persons Procedures require Investigation Managers to:*
>
> - *Liaise with Crime Coordinators and obtain all information relating to suspicious missing person cases*
> - *Ensure that all suspicious missing person cases are appropriately investigated; and*
> - *If 'foul play is strongly suspected', to immediately contact the Homicide Squad, State Crime Command through the Duty Operations Inspector.*
>
> *Crime Managers are required to make available criminal investigators to immediately respond to missing person cases where suspicious circumstances exist, manage suspicious missing person cases and maintain liaison with the Homicide Squad.*
>
> *If a matter remains outstanding the Crime Manager is required to meet with the Investigating Officer, Investigations and Crime Coordinator and Local Area Commander to ensure that all appropriate resources have been assigned to the case.*
>
> *Prior to finalising a missing person case the Investigation Officer is required to consult with the Duty Officer and seek advice from the Investigations Manager and Crime Manager as to whether the matter should be placed before the Coroner.*
>
> *The procedures remind police of their responsibilities under the Coroners Act 1980, No 27, Part 2A [sic] – Reporting of Deaths*
>
> *12A. Obligation to Report death*
>
> ...

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A police officer to whom a death or suspected death is reported as provided by subsection (1) or by Section 12B(5), is required to report the death or suspected death to the Coroner or Assistant Coroner as soon as possible

The Local Area Commander has overall responsibility to ensure that the guidelines are being complied with.

NSWP Missing Person policies and procedures are regularly reviewed and were last reviewed in September 2004. The State Coroner is consulted each time a review is conducted. The current procedures were publicised to all police via the Policing Issues and Practice Journal in October 2004 and made available on the Missing Persons Unit intranet site.

The Missing Persons Unit has undertaken an education and training program which involves meeting each Local Area Command Management Team throughout the state to discuss missing persons issues at a local and an organisational level. The Missing Persons Unit also conducts presentations to all new police recruits. A video presentation by the State Coroner is included in all training and available on the NSW Police Intranet.

33. On the last page of the Note to Minister, there is a '*recommendation*' that '*the Ministry be advised*'. I take this to mean that the Ministry, which I understand to be the Office of the Minister of Police, should be advised of the content of the document. The version of the document I have been shown has been endorsed up to Assistant Commissioner, Professional Standards level. It has not been endorsed all the way to Commissioner and Minister level. I do not know whether a version of the document endorsed by the Commissioner and Minister exists. I understand that inquiries have been made in an effort to locate a fully endorsed version but that those inquiries have not been successful.

34. Having reviewed the Note to the Minister, I have the following comments. I consider that it is apparent that the NSWPF appeared to accept the recommendation. That is to say, it is apparent from the terms of the briefing note that the NSWPF as at 16 September 2005 had a focus on ensuring that missing persons reports were investigated in a 'timely and proper

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manner'. As noted in Part B above, the recommendation appears to have been directed to drawing attention to recommendations made in a 2002 inquest and the steps implemented in response to them.

(b) Whether, by what means, and to what extent, the NSWPF has implemented the recommendation

35. Given the very broad terms of the recommendation, it is difficult to succinctly answer the question as to whether the recommendation was 'implemented'. Further, as I have identified at paragraph 16, I do not have any information about the historical structure of the MPU. I make the following comments based on my review of Commissioners Instructions, policies and SOPS, that I have described below.

36. For the purpose of preparing this statement, I have considered the NSWPF procedures and protocols about the investigation of missing persons, from around the time of the cases the subject of the Taradale Inquest to today. I set out some observations about those procedures and protocols below. I observe that there have been many advancements in the investigation of missing persons in NSW by the NSWPF, particularly in recent years. In general terms, although the advancements referred to do not appear to have flowed directly from the Taradale Inquest, they directly address the goal of Recommendation 1: that is, ensuring the timely investigation of missing person cases.

37. Prior to 2005, NSWPF were guided by 'Commissioner's Instructions', which were updated from time to time. The modern version of these documents is a Standard Operating Procedure. Between 1977 and 2005 (noting the last revision to the Commissioner's Instructions concerning missing persons was made in the 1994 revision), the Commissioner's Instructions contained limited guidance about conducting investigations concerning a missing person. For example, they did not provide guidance about investigative methods or tools specific to missing person cases, and contained very little guidance about the manner of supervision over missing persons' investigations. There was no guidance about when a long term missing person matter should be referred to the Coroner.

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38. From around 2004, as I detail below, the NSWPF issued a series of publications focused on specific procedure and expertise for missing person cases. The first of these that I have become aware of was a 2004 article published in the NSWPF Policing Issues and Practice Journal (**Journal**), which was titled 'The Missing Persons Unit', NPL.0100.0011.0001. Editions of the Journal were circulated to Police Stations across the State. This particular article provided an overview of the MPU, and the processes associated with missing persons investigations. I note that the article records that Deputy State Coroner Milledge herself played a role in the development of the policy and procedures set out in the article. It articulated roles of the investigating officer, supervisor, Duty Officer, Crime Co-ordinator, Investigations Manager, and Local Area Commander. Detailed role descriptions are set out in NPL.0100.0011.0001, by reference to each stage of the investigation (ie., initial reporting stage, investigation stage, and finalisation stage).

39. In my experience at NSWPF, it is rare for Commissioners Instructions, policy documents or SOPS to be updated every year. Historically, from time to time, individual units published articles in the Journal regarding their policies and practices, to keep them front of mind for the broader police force. The extent to which, and frequency, with which individual units published articles in the Journal was at the discretion of the unit.

40. In 2005, the NSWPF Handbook was developed. Each version of the Handbook refers to missing persons investigations. It did not contain a great level of detail. In my experience, that was not unusual: the Handbooks covered a very large range of investigation types, and often only a few sentences would be included on a particular topic. The Handbook was not intended to set out the NSWPF policy as concerns missing persons in full.

41. In 2007, a further article was published in the Journal, NPL.0100.0011.0427. It was similar to the 2004 article and in the context of missing persons investigations provided detail about the role of an investigating officer, and, the ongoing management of long term cases.

42. Also in 2007, a 32 page Missing Persons Policies and Procedures (**Policy**) document was released by the Operational and Information Agency of the NSWPF (NPL.0100.0011.0011). The Policy set out the role and functions of the MPU, and set out the roles and responsibilities of those involved in missing persons investigations. It introduced the requirement for a 'risk

assessment' to be conducted for all missing person cases. I do not know how the Policy was published or whether dedicated training was rolled out on it.

43. A set of Standard Operating Procedures (**SOPS**) that covered missing persons]were released in 2013 (**2013 SOPS**) (NPL.0100.0011.0383).

44. The 2013 SOP identified that there are three major stages applicable to any MP investigation – initial reporting, investigation and finalisation. A 'process flow' is set out in Part 4 of the 2013 SOPS, identifying the focus areas within each investigative stage.

45. In particular, the 2013 SOPS identifies that for all MP investigations:

    a. 'local' review of the investigation at the Local Area Command (**LAC**) (now the PAC or PD). The 2013 SOPS did not provide detail about which specific points of the investigation this review should take place;;

    b. the MPU to follow up with the LAC and officer in charge (**OIC**) of the case at three, six and twelve month intervals. I do not know what processes were in place which assisted the MPU to follow up with the LAC or OIC;

    c. steps to be taken around the 72 hour mark of the investigation to gather fingerprints, dental records, charts and x-rays (as examples).

46. The 2013 SOP also identified at:

    a. Part 1, that the 2013 SOPS were designed to '*maximise the change that the MP is found safe and well', and provide 'clear direction to [NSWPF] officers at each stage of a MP Case*'. This is reflected for example in the 'process flow' that I have described above;

    b. Part 2, that reports must be taken 'without delay';

    c. Part 3, the key roles in managing missing person matters. This includes the relationship between local area commands (**LACs**) and the MPU.

    d. Part 3.8, that the main function of the MPU as involving the '*coordination, quality assurance, education, information management and investigative support. The*

MPU monitors all MP reports and assists investigations. They do not have a direct investigative capacity, but they can offer specialised advice and information'.

47. I am aware the Missing Persons capability of the NSWPF was subject to a series of reviews in 2017, 2018 and 2019.

48. Following those reviews, the MPR was established as a unit within SCC in 2019. It is a specialist unit that sits along other specialist units such as the Homicide Squad and Robbery Squad. The location of MPR within SCC signalled a clear intention that the new unit would be much more 'investigation' focused than the previous MPU. I have explained some of the key functions of the MPR at paragraphs 10 and 11 above.

49. When I commenced with the MPR in 2019, my priority as Manager of the new unit was the development of a revised set of SOPS to govern missing persons investigations (and unidentified bodies and human remains investigations). In reviewing the SOPS, I was seeking to improve the system of oversight and responsibility to ensure that the investigations were undertaken in an appropriate manner. It was also proposed (and has since been the case) that new SOPS would be released each year to deal with Coronial Recommendations from the previous twelve months, and to incorporate ongoing changes and improvements to systems and processes.

50. The SOPS that I initially developed are described in more detail below. The first revision of the SOPS that I prepared was released in 2020, titled the 'Missing Persons, Unidentified Bodies and Human Remains SOPS' (**MP SOPS**). In order to create the 2020 MP SOPS, I:

    a. spoke with the heads of Missing Persons Units in other Australian jurisdictions to examine their processes and procedures;

    b. researched international models and liaised with international contacts;

    c. as a member of the Australian New Zealand Policing Advisory Agency (**ANZPAA**) (in my role as manager of the MPR), formed part of the ANZPAA working group convened to create the 2020 ANZ Policy for Missing Persons Investigations, which was ultimately approved by the ANZPAA Board (which consists of Police Commissioners from all Australian and New Zealand jurisdictions). The 2020 MP

SOPS (and their revisions since) are guided by the ANZPAA policies, including through the use of consistent definitions;

d. met with the State Coroner (together with the Commander SCC and a representative from the OGC). During that meeting, Her Honour indicated her support for the implementation of both the 2020 MP SOPS and the broader work being undertaken to create the MPR (which I describe in more detail below from paragraph 55 below);

e. considered the recommendations from Coronial Inquests over the previous 10 years, to ensure all recommendations were captured.

51. The purpose of the MP SOPS is to guide NSWPF's responses to missing persons, unidentified bodies and human remains investigations. Importantly, the investigations themselves remain the responsibility of the relevant PAD or PD, subject to the oversight of, and advice from, the MPR. However, where PAC / PDs make reports, they are required to follow the requirements set out in the SOPS.

52. The SOPS contain detail about the responsibility of each person who might have a role in a missing person investigation, and, set out tools which are available to assist with missing person investigations.

53. An overview of the current functions of the MPR is described in paragraph 10 above, and I describe some of the functions of the current MPR in more detail in response to part (c) below.

(c) Whether the NSWPF's current practices are consistent with the recommendation

54. The policy documents I have described above, and in particular the development of the MPR, have, to my mind, the common goal of seeking to assist police to investigate missing persons matter in a timely and proper way I consider NSWPF's current practices governing investigation of missing persons (as set out in the 2023 Missing Persons SOPS (**2023 MP SOPS**)) are consistent with Recommendation 1 and advance the objective of ensuring that "*that all Missing Person reports are investigated in a timely and proper manner*". I provide further detail and explanation about this below.

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Current overarching MPR practices

55. I have set out some detail about the current structure of the MPR at paragraphs 10 and 11 above.

56. The purpose of the MPR, as articulated in the 2023 MP SOPS, is to coordinate the NSWPF response to missing person investigations, NPL.0100.0011.0157 at 0177. There are often a large number of people involved in the investigation of missing person matters and it is important that each individual understands their role and works in accordance with the established frameworks, in order for a matter to be investigated in a timely and proper manner. As a result of its coordination function, the MPR is able to monitor the conduct of missing persons cases and ensure that investigations are pursued in a timely and efficient fashion.

57. Of particular note, the 2023 MP SOPS also require that an experienced investigator from within the MPR is allocated to every missing person investigation. These allocations are made daily, at the commencement of every missing person investigation. The role of the MPR investigators as consultants to PAC / PD is a particularly important part of the MPR structure. It ensures that specialist advice and assistance is provided to investigating teams from PAC / PD. It also ensures that the Missing Persons SOPS are understood and followed. Consultants are also required to notify their supervisors if they consider their advice is not being followed by PAC / PD. Their supervisor then engages with the PAC / PD. This engagement has only ultimately been required in a small percentage of missing persons cases, and the interactions have generally been positive.

58. The MPR's responsibilities are set out in detail in the 2023 MP SOPs. Those responsibilities include monitoring adherence to the SOPS, reviewing risk assessment processes for missing persons, conducting reviews for all long-term missing persons cases at the three and six month stages, and reviewing all briefs to the Coroner in relation to missing persons prior to presentation to the Coroner, and reviewing and updating the MP SOPS, NPL.0100.0011.0157 at 0177.

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Day to day practices of MPR and PAC / PD personnel

59. The present approach to missing persons investigations is founded on a system of cooperation between the MPR and individual PAC / PD personnel who are allocated the day to day running of missing persons investigations. Noting the number of missing persons investigations, and the importance of having officers with local knowledge who are present in the relevant communities conducting investigations, the MPR does not conduct investigations in full themselves. As identified above, the current approach to missing persons cases is directed to ensuring prompt and proper investigation. There are a number of aspects of current missing persons arrangements directed to that end, including the following:

    a. Specialist MPR investigators review all missing persons reports from the previous 24 hours (an average of 28 – 35 cases per day);

    b. All fresh and outstanding missing persons matters are reviewed daily by the MPR until a formal seven-day MPR review is conducted, the results of which are disseminated to the PAC / PD OIC, MPC and Crime Manager to guide their response to the investigation;

    c. MPR conduct formal three, six and nine month reviews, which are attended by at least three MPR personnel (supervisor, investigator / consultant and analyst), the PAC / PD OIC, PAC / PD Missing Person Coordinator and the Crime Manager.

60. The 2023 MP SOPS continue to require (as has been the case since the 2020 MP SOPS) that every PAC and PD has a Missing Persons Coordinator (**MPC**): see section 8.2 of the 2023 MP SOPS. I describe the MPC role below. This role is usually performed by the PAC / PD Investigations Manager.

61. The MPC is responsible, among other things, for monitoring and reviewing all missing person cases within the PAC / PD, and providing advice and guidance to the OICs in relation to missing person investigations. The MPC is also responsible for ensuring that if a homicide is suspected, that it is immediately notified to the Homicide Squad. Similarly, if a kidnapping or abduction is suspected, the MPC is responsible for ensuring that it is notified to the Robbery and Serious Crime Squad. See NPL.0100.0011.0157 at .0178.

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Current approach to training

62. Aside from information being generally available in the 2023 MP SOPS to assist investigators, and enforcement of the requirements of the 2023 MP SOPS by the MPR, there is also mandatory and further optional training available in relation to missing persons investigations.

63. After the 2020 MP SOPS were created, mandatory training was rolled out to all sworn police. For MPCs, there is a specific training program which was initially rolled out and now comprises part of the yearly conference that MPR members and MPCs attend. Further, a missing persons training package has been added into the Academy, and to the Detective Education program. When the SOPS are updated, a message is sent to all members advising of the updates, and highlighting the changes to the previous version.

Trends in missing persons investigations over recent years

64. NSWPF collects statistics about the investigation of missing persons matters. I consider the trends in those statistics demonstrate that the approach to missing persons investigations has undergone significant improvement, leading to increased closure of missing person cases and fewer and fewer 'outstanding' missing persons investigations at the end of each year. In this regard, I observe that:

    a. As at 2023, there are more than 751 outstanding 'long-term' missing person cases (missing for 90 days or more). This has been consistent for the last two years. The total number of cases changes regularly as people either become designated as long-term, and, others are located. Of the 751 cases, approximately 50 are immigration related (visas expired).

    b. From 2016 to 2019, there was a yearly average of 147 missing people in NSW who became 'long term' missing, with an average of 26 missing people remaining outstanding each year: that is, unsolved / not yet located. The average is calculated across the five years prior to 2020, and utilised the number of outstanding missing persons as at the end of each year.

    c. In 2020, 18 people became long-term missing and 11 remained outstanding.

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d. In 2021, 16 people became long-term missing and 7 remained outstanding.

e. Of the 7 people for 2021 that remain outstanding, three are believed to be lost in coastal waters (snorkelling or floods), two walked from their homes suffering severe mental illness, and for two, the likely cause is unknown.

65. Based on the above, and since the inception of the MPR and the new SOPS, I consider that fewer people are becoming 'long term missing'; and, fewer missing people remain outstanding each year. This trend suggests to me that a consequence of the reforms and enhanced practices and procedures that I have outlined above, missing people are being located more quickly which in turn leads to fewer people remaining outstanding each year. This is clearly consistent with the intent of Recommendation 1.

(d) Results of any reviews undertaken by the NSWPF as a result of the recommendation

66. As noted in Part B above, it appears that the extent to which the missing persons capabilities of the NSWPF complied with the recommendations was the subject of consideration after the Inquest. That consideration aside, I am not aware of a specific further review undertaken by NSWPF as a result of the recommendation. However I refer generally to my answer in response to paragraph (b) above regarding the past reviews of the 'structure' of the former MPU and, in particular, to my 2019 review of the appropriate SOPS that included, as noted above, a review of recommendations from Coronial Inquests over the 10 years prior to 2019.

(e) Any other action undertaken by the NSWPF as a result of the recommendation

67. I do not have anything further to add.

D. RECOMMENDATION 2

68. In this section of my statement I address Recommendation 2 which recommended the Minister for Police and the Police Commissioner:

> *Ensure that Missing Person cases considered 'suspicious' deaths are to be referred for criminal investigation.*

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(a) Whether and by what means the NSWPF accepted the recommendation

69. I refer to my answer in this section in Recommendation 1, at paragraphs 30 to 34 above.

(b) Whether, by what means, and to what extent, the NSWPF has implemented the recommendation

70. Recommendation 2 is focussed on referral of missing persons cases considered suspicious for criminal investigation. Again, I am not aware of a specific implementation program for the Taradale Inquest recommendations. However, as considered further below, the thrust of Recommendation 2 is captured in the policy and procedure documents that I have described above.

71. For example, the guidance material referred to above regarding the missing persons capability from 2004 indicates that the Missing Persons Unit was required to refer suspicious missing persons cases to "the State Crime Command, Homicide Squad, on-call officer" and made a number of other provisions as to what should occur in suspicious cases.

72. For its part, the 2007 Policy allocated responsibility for identification and action of missing persons cases with suspicious circumstances during the initial reporting stage to the Investigations Manager. That person was required to liaise with the Crime Coordinator to obtain all information relating to suspicious missing person cases, ensure all suspicious missing person cases are appropriately investigated, and immediately contact the Homicide Squad if 'foul play' is strongly suspected, NPL.0100.0011.0011 at 0023. During the investigation stage of such cases, it was the role of the Crime Manager to manage suspicious missing person cases and maintain a liaison with the Homicide Squad, NPL.0100.0011.0011 at 0025.

73. Also by way of example, the 2013 MP SOPS provided similar guidance. Specifically, it:

    a. Identified that the Crime Manager 'has an overview role in suspicious MP cases', including by facilitating specialist resources and guiding investigation strategy, NPL.0100.0011.0383 at 0390;

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b. Required that the MPU itself is to meet regularly with the Homicide Squad regarding suspicious cases, NPL.0100.0011.0383 at 0390; and

c. Allocated responsibility throughout the 'roles and responsibilities' defined for each investigation phase to specific individuals (see for example Crime Coordinator role described at NPL.0100.0011.0383 at 0394).

74. I describe NSWPF's current practices below.

(c) Whether the NSWPF's current practices are consistent with the recommendation

75. Recommendation 2 is focussed on referring 'suspicious' deaths for criminal investigation. For the reasons I explain below by reference to the 2023 MP SOPS, I consider current practices are consistent with the recommendation.

76. I observe that as set out above in relation to Recommendation 1, the MPR allocates an experienced investigator as a consultant to every missing person investigation within 24 hours, irrespective of whether the matter is considered suspicious or not. This ensures strong oversight and assists in the identification of any 'suspicious' circumstances.

77. Suspicious circumstances are defined in the 2023 MP SOPS as "*the possibility that the person is not voluntarily missing and may be detained and/or have come to harm by a person or persons, known or unknown*". This includes suspected homicides.

78. The 2023 MP SOPS requires that *"if suspicious circumstances exist"*, or, if the "*person is still missing at the four week mark*", then the PAC / PD Crime Manager must ensure that the case is transferred to an experienced investigator (often a designated detective) for attention, NPL.0100.0011.0157 at 0180.

79. In addition, the immediate responsibilities of the OIC of missing person investigations include to contact the Homicide Squad "*immediately*" if a homicide is suspected, and, to also contact the Homicide Squad as and when "*suspicious circumstances*" come to light during an investigation, NPL.0100.0011.0157 at .0186. Both in in my past experience as Manager at the MPR, and in my current role at Homicide, I have observed that there is a close and strong working relationship between the Homicide and MPR teams.

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(d) Results of any reviews undertaken by the NSWPF as a result of the recommendation

80. As noted at Part B above, it appears that the extent to which the missing persons capabilities of the NSWPF complied with the recommendations was the subject of consideration after the Inquest. That consideration aside, I am not aware of a specific further review undertaken by NSWPF as a result of the recommendation. However I refer generally to my answer in response to paragraph (b) and (c) above regarding in updates to the structure of the MP SOPS. I also refer to my review of recommendations made following Coronial Inquests in the 10 years prior to 2019.

(e) Any other action undertaken by the NSWPF as a result of the recommendation

81. I do not have anything further to add.

E. RECOMMENDATION 3

82. In this section of my statement I address Recommendation 10 which recommended the Minister for Police and the Police Commissioner:

> *Ensure that all Missing Persons be reported to the State Coroner after a reasonable period of time after all routine investigations have been undertaken*

(a) Whether and by what means the NSWPF accepted the recommendation

83. I refer to my answer in this section in Recommendation 1, at paragraphs 30 to 34 above.

(b) Whether, by what means, and to what extent, the NSWPF has implemented the recommendation

84. Recommendation 3 is focussed on the timely reporting of matters to the Coroner. The thrust of Recommendation 3 is captured in the policy and procedure documents that I have described above. I set out some examples of how this is the case.

85. For example, the 2007 Policy identifies that:

    a. one of the functions of the MPU is to ensure that, once a missing person matter has been outstanding for 12 months, the matter should be reported to the Local Area

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Commander. If there is no evidence of life, that report may include a recommendation that the Coroner be notified, NPL.0100.0011.0011 at 0014; and

b. one of the functions of the Investigating Officer, on finalisation of a missing persons case, was to consider and seek advice as to whether (at the 12 month mark) the matter should be placed before the Coroner, NPL.0100.0011.0011 at 0027.

86. The 2007 Policy (as did the 2004 policy recorded in the article described above) also sets out the responsibilities relating to the *Coroners Act 1980* No 27 Part 12A reporting of deaths.

87. The 2013 MP SOPS contain a specific section about placing matters before the Coroner (see section 6.2). Guidance in relation to which member of the investigative team is responsible for the parts of this process is set out in NPL.0100.0011.0383 at .0400. In the context of providing these instructions, the 2013 MP SOPS state that the matter should be placed before the Coroner if the person is still missing and there are no signs of life after 12 months, or, sooner, in the case of misadventure, NPL.0100.0011.0383 at .0400.

88. I describe NSWPF's current practices in part (c) below.

(c) Whether the NSWPF's current practices are consistent with the recommendation

89. Recommendation 3 is focussed on reporting Missing Persons to the State Coroner after a "*reasonable period of time*" after all routine investigations have been undertaken. For the reasons set out below, by reference to the 2023 MP SOPS, I consider current practices are consistent with the recommendation.

90. I have described at paragraph 50.d above discussions with the NSW Coroner prior to the finalisation of the 2020 MP SOPS. In my role as Manager at the MPR, I was also in regular contact with the NSW Coroner.

91. The 2023 MP SOPS continue to set out the NSWPF's expectations about liaison with the NSW State Coroner in the context of missing persons cases.

92. For example, the 2023 MP SOPS set out mandatory reporting time frames agreed between the NSWPF and the NSW State Coroner for reporting to the NSW State Coroner. The 2023 MP SOPS make clear that the timeframes set out in the document are maximum time frames, and

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that it will often be '*appropriate to perform relevant functions much earlier than the stated maximum time frames*', NPL.0100.0011.0157 at 0714. In this way, the 2023 MP SOPS remind investigators about their obligations to report matters to the Coroner and encourage them to keep this at the front of their minds through any investigation.

93. Examples of these timeframes in relation to this recommendation include, at nine months, the 2023 MP SOPS require that a "*coronial brief is to be forwarded to the Missing Persons Registry for Checking*" and at twelve months "*A completed brief of evidence is to be submitted to the Coroners Court Registry*", NPL.0100.0011.0157 at 0176.

94. In addition, the 2023 MP SOPS explain that "*the current protocol is that missing persons matters should be reported to the Coroner within 12 months of the report having been received by police in circumstances where no signs of life have been identified*". However, this *"does not prevent the police from making a report before 12 months has elapsed if they have formed the view that the missing person is likely to be deceased ('a suspected death'). An example of this would be where a person has gone missing in suspicious circumstances*", NPL.0100.0011.0157 at 0240. The intention in preparing this section of the MP SOPS was to reiterate that as soon as police formed a view that a person had died, a report should be made to the Coroner.

95. Once all routine investigations have been undertaken, the 2023 MP SOPS provide milestones and review processes for Long-Term Missing Persons (**LTMP**) investigations that must be satisfied prior to submitting a coronial brief to the coroner. These include periodic reviews such as 'Case Reviews' with OICs, MPCs and Crime Managers associated with the investigations at the three and six month mark, NPL.0100.0011.0157 at 0238.

(d) Results of any reviews undertaken by the NSWPF as a result of the recommendation

96. As noted at Part B above, it appears that the extent to which the missing persons capabilities of the NSWPF complied with the recommendations was the subject of consideration after the Inquest. That consideration aside, I am not aware of a specific further review undertaken by NSWPF as a result of the recommendation. However I refer generally to my answer in

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response to paragraph (b) and (c) above regarding in updates to the structure of the MP SOPS. I also refer to

(e) Any other action undertaken by the NSWPF as a result of the recommendation

97. I do not have anything further to add.

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