These Reasons were prepared without the benefit of a transcript.

STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of William John Torrens
Hearing dates:	29-30 June 2023
Date of findings:	14 July 2023
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – missing person, LANDSAR search, risks for aged care residents with dementia
File numbers:	2019/00007049
Representation:	Mr Jake Harris, counsel assisting instructed by Mr Gareth Martin of the Crown Solicitor's Office Ms Kim Burke of counsel instructed by Sergeant Stephen Davis of the Office of the General Counsel for the Commissioner of Police Mr Joshua Raftery of counsel instructed by Ms Jessica Crollos for Brett Arthur (former CEO of Fairview Retirement Village)

Findings: I make the following findings pursuant to section 81(1) of the *Coroners Act* 2009 (NSW),

Identity

William John Torrens is dead.

Date of death

He died on or about 5 January 2018.

Place of death

He died at Moree, NSW.

Cause of death

His cause of death is unknown.

Manner of death

His manner of death is unknown.

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Introduction

1. William John Torrens ("John") was 73 years of age when he went missing from his nursing home on 5 January 2018. He had been living at Fairview Retirement Village at Moree since August 2017. Almost a year later his partial remains were found on the banks of the Mehi River, only a short distance from the nursing home.

2. Unfortunately, exactly what had happened was not disclosed during the subsequent police investigation.

3. John was a well-loved man. He was hard working and capable. His daughter Renae and her husband attended the inquest and their affection for John was evident. At the time of his death, plans were being made so that John could live with his daughter at Deepwater, NSW. I offer Renae and her family my heartfelt condolences.

4. At the family's request Mr Torrens will be referred to as John in these proceedings.

The role of the coroner and the scope of the inquest

5. The role of the coroner in a case such as this is to make findings pursuant to section 81 of the Coroners Act.[1] At the conclusion of an inquest the court is required to record in writing the fact that a person has died and also to record:

    a. the person's identity;
    b. the date and place of the person's death; and
    c. the manner and cause of death.

6. In addition to deciding these questions, at the conclusion of proceedings, the coroner may, if necessary, make recommendations in relation to matters arising directly from the evidence.[2]

7. An issues list was circulated prior to the inquest commencing.

The evidence

8. The inquest was held at the State Coroners Court in Lidcombe on 29-30 June 2023.

[1] Section 81 *Coroners Act* 2009 (NSW)
[2] Section 82 *Coroners Act* 2009 (NSW)

9. A nine-volume brief was tendered, including witness statements, police reports, photographs and maps. It contained the records of many days of investigative work and searching. I will only refer to these detailed records briefly within the scope of these written reasons, however I have had the opportunity to review all the documents provided.

10. The court also heard oral evidence from two police officers involved in the search for John, the Chief Executive Officer of Fairview Retirement Village at the time of John's disappearance, the general practitioner who cared for John in Moree, and the head of the NSW Missing Persons Registry. A senior independent geriatrician, Professor Susan Kurrle also attended to provide the court with information about the nature of dementia and how it can be managed in a residential care setting.

Background

11. William John Torrens was known to his friends as "John" or "Torro". He was born on 18 May 1944. He was a boilermaker by trade, and that work took him around Australia during his working life. He had a daughter, Renae; and although he separated from Renae's mother when she was a child, he retained great affection for Renae and had even tried to get custody of her when she was young. There appears to have been a period of estrangement between them during the 1990s, but at the time of John's disappearance there was a strong bond and great affection.

12. For some years, John lived in Collarenebri, a town about 140 km west of Moree. He got a job with the local council and purchased a home for himself in Narran Street.

13. He was known in the community as a hardworking man, who took pride in his work. He also did a lot of work for the community.

14. His neighbours, Toni McCarthy and Don Timmins, became his friends. He met Don at the pub, and later became friends with Toni, too. John was reportedly a big drinker. He liked to make his own home brew.

15. John was a perfectionist; his friends describe him as "OCD". He normally kept his home and garden very clean and tidy and was very punctual with his financial affairs.

16. It was in late 2016 that Don and Toni began to notice some changes in John's behaviour. Don noticed the garden and home was untidy. Toni recalls John stopped

making home brew, and began making unusual purchases, like the occasion be bought 20 empty milk crates.

17. In June 2017, Toni recorded a few bizarre incidents that had occurred in her diary. For example, John asked her for some dog food, but – as she reminded him – he had plenty in his spare room. He would also forget where he had left his keys. This kind of behaviour appeared out of character.

18. On 14 June 2017, John called Toni at 4.15 am, asking for the fuel key. She called an ambulance, and when they attended, John was threatening self-harm with an axe. Police attended to assist.

19. John was transferred by ambulance to hospital, and subsequently conveyed to Dubbo Hospital for a CT scan.

20. On 17 June 2017, Toni received a call from John. It transpired that he had signed himself out of Dubbo Hospital, caught a bus to Walgett, and needed a lift back home to Collarenebri.

21. A few days later, on 22 June 2017, Toni and Don took John to a solicitor, where he executed an Enduring Power of Attorney, and appointed them his Enduring Guardians.

22. On 29 June 2017, John was admitted to the Collarenebri Multi-Purpose Service ("Collarenebri MPS"). That was a medical facility that had some limited capacity for Aged Care. John remained there until August 2017. During his admission, some erratic behaviour was recorded; for example, he put cutlery down the toilet. He was also noted to be wandering around the facility at times.

23. An Aged Care Assessment was completed, and John was referred to a geriatrician, Dr William Thoo, who reviewed him by telehealth on 19 July 2017. Dr Thoo administered a formal test, the Montreal Cognitive Assessment. He identified that John had deficits in frontal and executive function. He prepared a report, recording his diagnosis as "*dementia with frontal lobe impairments".*

24. Ultimately, Collarenebri MPS was not able to continue accommodating John. Instead, enquiries were made with a nursing home at Moree, Fairview Retirement Village ("Fairview"). A place was available, and John was accepted there on 8 August 2017.

25. Toni recalls a conversation about whether John would be placed in a secure area of Fairview, on 4 August 2017. However, the Director of Care, Jenny Baker, told her he was "*not that bad yet."*

Fairview Retirement Village

26. Fairview was a community aged care facility with a 95-bed capacity. It had three units: Perry James, a low care unit; Federation Lodge, a high care unit; and Nan Crane, a secure unit for residents with dementia and those who wander.

27. Ordinarily, a resident who is to be admitted to Fairview would have been reviewed by a local GP on a rostered basis. In John's case, that was Dr Maelle Morgan. The court was told that a review did not occur initially, probably because John was transferred directly from Collarenebri MPS to Fairview.

28. On 4 August 2017, a request was made for the previous GP's records to be transferred to Dr Morgan's practice. Those records were not received, and nor were the notes from Collarenebri MPS, until sometime later. Critically, this meant that the report from Dr Thoo, which recorded the diagnosis of dementia, was not received by Fairview until after John's disappearance. Dr Morgan confirmed in court that she had never seen this report.

29. As part of the admission process, in the absence of other records, Dr Morgan asked a nurse to complete a Comprehensive Medical Assessment. It recorded that John was "*alert and oriented but suffers from STML* [short-term memory loss]." It also stated John had started to "wander". It did not make any reference to dementia.

30. Dr Morgan told the court that she thinks she must have glossed over the reference to "STML" or did not recognise what those letters meant. She also does not think she noticed the reference to John wandering when she reviewed the report in 2017.

31. A few days later, on 19 August 2017, a Psychogeriatric Assessment Scale was completed. John scored 1, indicating he had minimal cognitive impairment.

32. John did not settle into Fairview well. He was frustrated about living in the home. He felt he did not need care like the other residents. He liked to keep his room tidy and organised, and he refused assistance with his personal care from staff. He was initially allowed to keep his budgie, Georgia, although he was not able to look after her

and another resident complained. John liked to have a beer every day and Fairview wanted to accommodate this wish. An Esky was prepared with XXXX Gold at 3.30pm, daily. John became upset if it was not ready on time.

33. John's friends, Don and Toni, were able to drive over from Collarenebri to visit him most weeks to take him out for lunch. He enjoyed going out for a Chinese meal. He also liked to attend outings into the town at Moree, and to go shopping. He was otherwise known to be quiet, and he mostly kept to himself.

34. Dr Morgan reviewed John for the first time on 31 August 2017. She noted that the medical records from John's former GP and Collarenebri MPS were still not available, and she asked staff for these to be obtained. John told her that he did not know why he was there, did not feel like he needed care, and was frustrated with his position. Dr Morgan ordered blood tests and further screening. She understood that he had been placed in the home due to assistance he required with self-care, including with medication. She did not note any obvious cognitive impairment, and she told the court that their conversation flowed freely. However, she did consider that he may have some degree of memory impairment or dementia.

35. Dr Morgan reviewed John again a week later, on 7 September 2017. He told her he wanted to go home. However, she still had not received John's medical records from his former GP or Collarenebri MPS, and so she again asked Fairview staff to contact the former GP and hospital for his history and records. She gave John some ointment for dermatitis.

36. Dr Morgan told the court that if she had seen a copy of Dr Thoo's report at the time of her treatment of John, she would have had a better understanding of John's cognitive capacity. However, she said that she did not know how much it would have affected the care she provided. She did not think it would have caused her to undertake or refer John for any further assessment given the thoroughness of the assessment Dr Thoo had already undertaken. In her view a further assessment would not offer any more assistance in managing him at that stage.

Wandering

37. A significant issue in this inquest is the extent to which John wandered out of the home, and the response that was taken by Fairview staff to that behaviour.

38. It seems concerns about him wandering were identified at an early stage. On 23 August 2017, a 24-hour monitoring chart was introduced by nurse Suzanne Bouliopoulos. This required staff to observe John every hour throughout the day, to check where he was. He reportedly found this intrusive, and it made him anxious.

39. There are differing accounts as to whether John was able to leave the facility, and how often he did so. Assistant in Nursing Sue Sampson ("AIN Sampson"), for example, recalls that he was able to go out and get himself a newspaper, and sit in the sun and read it, and that he did this just about every morning. Others recall this only occurred on one or two occasions. Another resident, Bill Murray, recalled that John liked to go along the banks of the river, to collect golf balls around the Moree Golf Club which was located nearby along the Mehi River.

40. There are also differing accounts in the material as to whether Fairview utilised bracelets in 2017 for wandering patients. These bracelets would sound an alarm if a resident left the facility. At least one staff member believes John used a bracelet, although the strap was damaged or broken. He was not wearing one at the time of his disappearance. There are no records indicating that this was a consistent strategy and it seems unlikely that it was.

41. There were two recorded incidents of John absconding from the facility, on 10 September 2017 and 16 October 2017.

42. On 10 September 2017, John left the home in the morning. He could not be located, and police were called, although he returned prior to police arrival. The police CAD message referred to John having "*memory issues*". As John returned on his own, police took no further action.

43. John was briefly taken into the dementia unit, Nan Crane, for a period. However, he soon returned to his normal room in Federation Lodge.

44. Dr Morgan reviewed John on 5 October 2017. It was reported to her that he had been agitated, but redirectable. She was not informed about the absconding incident. She planned for staff to implement behaviour techniques but did not think sedative medication was appropriate at that stage.

45. Dr Morgan reviewed John again the following week, on 12 October 2017. John appeared depressed, and he was still upset about moving into Fairview. He was teary

and agitated at times. She thought he had memory problems, and so considered counselling was unlikely to be beneficial. She prescribed an antidepressant, sertraline, and asked for a further Aged Care Funding Instrument ("ACFI") Cognitive and Depressive assessment to be performed. The results of that assessment, completed on 26 October 2017, were indicative of mild cognitive impairment and minimal depression.

46. Four days later, on 16 October 2017, another resident reported John had left Fairview via the rear exit. The CEO, Brett Arthur, went to look for him. John was located at the tourist information office that afternoon.

47. A month later, on 16 November 2017, John's 24-hour monitoring chart was ceased. Fairview Care Manager, Maria Woods, considered that John had not been displaying signs of wandering for some time. In a statement to this inquest, she says he was removed from the hourly sight chart because he was capable of going to the shops and coming back to Fairview, and he wasn't at risk.

48. There are other events recorded in the progress notes of a less serious nature. For example, he wandered into other residents' rooms, or outside but within the grounds of the home. On one occasion, he wandered off from a group outing at an RSL, although the nurse recalls he said he was looking for the toilets.

49. At Christmas in 2017, John went out with Don and Toni for a meal. On Boxing Day, they took him to see his daughter, Renae, at Deepwater in NSW. He stayed there overnight. There was a plan to sell John's home in Collarenebri, and build a cabin for him on Renae's property at Deepwater. The local council approved the plans on the day of John's disappearance.

50. On 3 January 2018, Toni and Don took John shopping in Moree for some socks. He asked them if they would take him out for a Chinese meal the following week; this was scheduled for 10 January 2018.

51. On 4 January, he went shopping with a Fairview activities officer and had some photos printed of friends and family at the Harvey Norman Shop in Moree.

Was John's cognitive impairment adequately managed by Fairview?

52. John was admitted to Fairview without Dr Thoo's report outlining his diagnosis of dementia with frontal lobe impairment. On admission, in August 2017, Fairview completed a Psychogeriatric Assessment Scale, which indicated John had minimal cognitive impairment. A reassessment on 17 October 2017 scored John within a mild range of cognitive impairment. Nevertheless, the lack of records and particularly the fact that an existing and important specialist report was not obtained in a timely manner is disappointing. It was a missed opportunity for those caring for John to understand the complete picture.

53. After reviewing all the available records Professor Kurrle was not critical of the care John received. She did not consider John's condition in 2017 was severe enough to warrant placement in Fairview's Nan Crane secure unit for people with dementia. She noted that he had demonstrated an ability to leave the facility and return safely. She drew a distinction between John's purposeful journeys outside the centre and the kind of aimless or obsessive wandering that can be a behavioural feature of dementia. She spoke of the balance that caregivers needed to strike between safety and allowing residents some autonomy.

54. Professor Kurrle told the court that placing John in Nan Crane, where he was unable to leave when he wished would have been likely to have caused him to become extremely distressed and depressed and possibly agitated and aggressive. She also observed that when John was subject to it, he found hourly monitoring somewhat intrusive.

55. An alternative mode of monitoring John, suggested by Professor Kurrle, would have been a tracking bracelet; though, she also notes that many people with mild to moderate dementia find these tracking bracelets to be intrusive and will try and remove them. As discussed earlier in these reasons, while the evidence is equivocal as to whether John had such a bracelet at some point in 2017, he certainly did not have one at the time of his disappearance.

56. Professor Kurrle identified that a referral to the Dementia Behaviour Management Advisory Service ("the DBMA Service") through Dementia Support Australia, a freely available service which could have provided assessment and management strategies for John, would have been appropriate.

57. Dr Morgan agreed the DBMA Service may have been beneficial to John, but at that time, it did not occur to her that John had that degree of memory impairment or dementia.

58. Professor Kurrle told the court that dementia can be very variable in presentation, particularly in the early stages. This was demonstrated in John's case, where on some days he coped reasonably well, while on other days he did not. She cited as examples the day he rang Toni and Don at 4 am because he could not find his fuel key, and the occasion where he tipped cutlery down the toilet at Collarenebri MPS. Given his inability to live independently due to his cognitive impairment from his dementia, she considered a move to supported accommodation was necessary and appropriate.

59. Professor Kurrle described John's case as one which highlights the tension that exists between duty of care to a person and allowing them some autonomy and the ability to make their own decisions. It can be a difficult balance. She discussed the principles that a person is deemed to have capacity unless proven otherwise, and that capacity is task-specific – and, in this case, she could not see any evidence that showed John was incapable of coming and going to and from the facility for short errands. She also observed that, while John had expressed on a number of occasions that he wished to go home, it appears that this would have been very difficult for him and supported accommodation was appropriate. There is no doubt that being able to leave the facility and return when he wished would have made supported accommodation much more acceptable to him.

60. I accept her view that John required some freedom. However, it appears that more could have been done to ensure that his absences from the facility were supervised more closely. In particular, I note there had been incidences of some alarm on both 10 September 2017 and 16 October 2017 already. In addition, one of the difficulties with the eventual search was that NSW Police were not contacted for many hours. It appears that nobody was responsible for monitoring John's return to Fairview and there was no checking process when he was absent at mealtimes or at handover.

The events of 5 January 2018

61. On 5 January 2018, the day of John's disappearance, the weather was hot, reaching 37 degrees Celsius. There had also been significant rainfall at some stage, and the

Mehi River was higher than usual and flowing quickly. The river runs nearby to the nursing home, heading west through the town and onwards towards Collarenebri.

62. At around 7am, AIN Sampson, who was allocated care for John's group, saw him in his room. He told her he did not need any help at that time.

63. At 7.30am, John went for breakfast. Enrolled Nurse Ida Johnston ("EN Johnston") saw him and said he was a bit early for breakfast. He told her he was having breakfast early because he was going out for lunch. He had said this to a number of staff members that week, saying he was going out for a Chinese meal. EN Johnston made a note of what John was wearing – "*blue/green cotton shirt, black shorts, shoes, black socks*." She underlined shoes. She indicates in her statement that she could not recall exactly why, but perhaps it was because she found it unusual because John always wore slippers, bare feet or thongs.

64. John was given breakfast: Weetbix, toast and a cup of tea. AIN Sampson saw him in his room at about 9am. She was going to change his sheets.

65. Mr Murray, a fellow resident, saw John about the same time. John told him that he was going into town to buy a budgie.

66. At 9:18am, John left the home via the front doors. It appears none of the staff saw him leaving. The time and means by which he left the facility was only discovered later, by reviewing the CCTV. He was carrying a plastic bag with some unknown belongings in it. Where he went is not known.

67. At about 10am, morning tea was served. Morning Hostess Judith Raveneau ("Ms Raveneau") went to John's room, but the door was shut. This was not unusual, and she just continued on.

68. At lunchtime, John was not present. Staff, including Ms Raveneau, asked where he was. Other staff mentioned that he had been talking of going for a Chinese meal. No-one made any checks at that point.

69. A nursing handover occurred at 2pm. Outgoing Registered Nurse Jacob Thomas ("RN Thomas"), and incoming Registered Nurse Jay Bernal ("RN Bernal"), discussed all the residents. Nothing of note was raised regarding John. Again, no checks were made.

70. At 3pm, Mr Murray asked a nurse where John was, as he had not seen him. The nurse suggested he might have gone out with Toni and Don. Again, no checks were made.

71. Soon after, Activity Officer Meleena Smith ("Ms Smith") went to John's room, to give him his afternoon beers. She found he was not there. This was significant, as he would always take his beers in the afternoon. She alerted other staff, and in turn, Care Manager Maria Woods ("Ms Woods"), Director of Care Jenny Baker ("Ms Baker"), and CEO Brett Arthur ("Mr Arthur") were informed.

72. A number of staff members began looking around the home, and outside, along the riverbank. Don and Toni were contacted. Mr Arthur told the court that he joined the initial efforts, firstly driving in the nearby streets and then along the river. He also visited licensed premises in town to look for John. John could not be located. At around 4:15pm, Mr Arthur went to Moree police station to report John missing.

73. As a result of that timeline, there was a delay of about 6 hours before the home even appreciated John was missing, and 7 hours before police were informed. That was a critical delay and Mr Arthur accepted staff missed opportunities to take earlier action. The systems were vulnerable, there was no regular headcount even at mealtimes or during nursing handover, no system of signing out and no CCTV that would assist with the general direction John took after leaving the main building.

The police search

74. Police broadcast a report that John was missing at 4:15pm. Two police officers, Constable Emma Gately ("Constable Gately") and Senior Constable Bree Hampson ("Senior Constable Hampson"), attended Fairview to speak to staff. Among other things, Mr Arthur told police he was reviewing CCTV, to identify which direction John had gone after he left. Unfortunately, the CCTV did not show this, although it did depict John leaving at about 9:18am. Mr Arthur told the court he supplied a photograph and description of John to assist in the search.

75. At 5:25pm, police left to perform searches. As they did so, Constable Gately made a further broadcast, asking other police to keep a look out for John.

76. Constable Gately and Senior Constable Hampson conducted vehicle and foot patrols, Constable Gately told the court that her initial patrol included benches in the local park

near the river. She also went to licenced premises and bottle shops, the main street and to the Aquatic Centre.

77. As it became dark, they returned to the police station.

78. That evening, Constable Gately prepared a Missing Persons Risk Assessment. She rated the risk as “Very High”, the highest category, because John was resident at a care home, was taking medication, and had previously gone missing. In all the circumstances it was, in my view, an appropriate assessment of the grave situation unfolding.

79. That evening, Inspector on Duty for the Barwon Local Area Command, Martin Burke (“Inspector Burke”), was informed of the incident. He directed various checks, including local hospitals, bus and rail companies, banks, canvasses for CCTV, and he also made posts to local police social media.

80. The following day, 6 January 2018, police continued their enquiries. This included a search by a police dog handler along the river and the golf course, contact with the state police media unit, and a similar request to QLD police, and Constable Gately searched John’s room at Fairview.

81. On 8 January 2018, Acting Crime Manager for the Moree Local Area Command, Detective Sergeant Brent Falkiner (“Detective Sergeant Falkiner”), received a handover from Inspector Burke. He reviewed the relevant COPS event, attended Fairview and met with the board of directors. Mr Arthur was on scheduled leave that day.

82. The court heard evidence from Detective Sergeant Falkiner. He told the court that his primary goal was to find out as much information as he could. His enquiries of Fairview staff about John’s health disclosed he had type 2 diabetes and a heart condition for which he required daily medication. He told the court that, on police information he had reviewed, he initially believed John may have some memory loss or dementia, and so he specifically asked Fairview about any cognitive issues. No cognitive issues were raised, though he was informed that John had a history of leaving the facility. As a result, he treated John as a missing person who did not have his heart medication, not as someone with dementia.

83. Detective Sergeant Falkiner contacted the local newspaper and radio station. He contacted the local taxi company. He asked for a further CCTV canvass. He tasked two police officers to perform bike patrols along the river and golf course. Those police officers found a bag containing toiletries and a razor, but after checking with the home this was excluded as not relevant.

84. Detective Sergeant Falkiner confirmed with the Duty Operations Inspector in Sydney that John's mobile phone had not been active since 20 November 2017.

85. Detective Sergeant Falkiner also tried to organise a Land Search and Rescue ("LandSAR") Coordinator. He contacted Western Regions Operations and NSW Police Force Rescue Squad in Sydney. He spoke with NSW Police Rescue Unit Operations Co-ordinator, Senior Sergeant Smith in regard to a LandSAR and search resources. He told the court he spoke with the Rescue and Bomb Disposal Unit, which he indicated was the central number to call to obtain a LandSAR, and he got a list of all the names of the LandSAR Co-ordinators in the western region. He exhausted that list, and called random Police Districts, but none were available, all being either on annual leave or outside the district and all unable to provide assistance.

86. At about 3pm, he got in contact with one LandSAR Co-ordinator, Sergeant Tim Connolly, who was based at Nyngan. Sergeant Connolly could not attend, as he was five or six hours away, but Detective Sergeant Falkiner told the court he was able to provide very valuable advice. They discussed the approach, and how the local State Emergency Service ("SES") could be involved in the search. Detective Sergeant Falkiner gave evidence before me, and I accept that he was highly motivated to find John.

87. According to Sergeant Connolly, he would have been able to attend the following day, but he was not called on to do so.

88. Ultimately, no LandSAR Co-ordinator attended to assist with the search. Detective Sergeant Falkiner told the court he did all he could to get one to attend, and he is unable to explain why a search with a LandSAR Co-ordinator did not occur in January 2018, noting the decision was out of his control.

89. That afternoon, the SES attended and searched the river by boat. Some parts were unpassable, but they spent a few hours searching the area, commencing a few

kilometres downstream. They did not locate anything of interest, but the conditions were difficult. The river was fast-flowing, there was poor visibility and it had a lot of debris in it. Police divers were considered, but due to the conditions, they were not deployed.

90. Drone Operators from the Police Rescue Unit also attended, and surveyed the area from above. Again, nothing of interest was identified.

91. Searches continued onto 9 January 2018 and were then suspended. Detective Sergeant Falkiner told the court that he did not know who made the decision to suspend the search and it is certainly unclear from the records provided. Without a LandSAR trained co-ordinator involved some of the decision making is opaque.

92. Over the ensuing months, police repeated social media and regular media appeals, checked with friends and relatives, and continued patrols. At one point, a coordinated land search was again considered, although not undertaken.

93. The court heard from Detective Chief Inspector Richard Sim ("Detective Chief Inspector Sim"), Manager of the Missing Persons Registry ("MPR"). The MPR was established on 1 July 2019, following a restructure of the Missing Persons Unit. In January 2022, the MPR Response Team was established to assist Police Area Commands ("PACs") and Police Districts ("PDs") in the response to, and investigation of, high risk missing persons. The MPR Response Team is on-call for deployment 24 hours a day, seven days a week. While the MPR comprises investigators and analysts and has various responsibilities, including reviewing all missing persons investigations, the missing persons investigations remain the responsibility of the PACs and PDs. Missing Persons Coordinators have also been implemented in all PACs and PDs to provide early intervention and guidance for police.

94. On establishing the MPR in 2019, new Missing Persons and Unidentified Bodies and Human Remains Standard Operating Procedures ("SOPs") were drafted. The 2021 SOPs were released on 1 January 2021, with subsequent updated versions released on 1 January 2022 and in February 2023.

95. In his statement, Detective Chief Inspector Sim told the court that he believes the actions of police in this case, if undertaken today, would be similar, though more clearly

defined, structured and with defined roles, responsibilities and timeframes. Some aspects he specifically referred to include:

a. The MPR would review the incident and offer specialist advice where / if necessary (including analytical support if needed);

b. Consideration would have been given immediately to conducting a land search (as John would now be considered a vulnerable person under the current SOPs); and

c. The use of technology to locate missing persons would be further utilised. For example, geotargeted text messaging and social media emergency disclosure capabilities.

96. Detective Chief Inspector Sim told the court one issue with undertaking a formal land search for John in January 2018 was that there was no reference or starting point – police knew John left Fairview, but they did not know which direction he went, or where he was going. He drew a distinction between a formal land search, and the search undertaken and managed by Detective Sergeant Falkiner. He explained that kind of land search is basically to look for somewhere to start, and to exclude parts of the land. He used the example of sending bikes through a less dense area. He told the court that undertaking a formal land search, which requires the deployment of large amounts of resources to a relatively small area, without a reference point could be counter-productive and take resources away from investigating other lines of enquiry.

97. While I accept that NSW Police did not know which direction John took after he left Fairview, and thus did not have an accurate "start point", I do not accept that this ruled out a full and formal review by an appropriately trained LandSAR officer. It is true that Police were hampered by the number of hours it had taken to report John as missing, but a short and targeted LandSAR search should have been considered. I was heartened to find that the lengthy process of ringing around police stations that Detective Sergeant Falkiner undertook appears to have been streamlined with the oversight and support offered by the MPR.

98. While a LandSAR review would have been best practice, I accept that, given the hours that had already passed by the time NSW Police were notified, there is no guarantee it would have changed the tragic outcome in this case.

The discovery of remains

99. On 1 January 2019, a member of the public, Cecil White, was walking through the bushland area near to the Mehi River. He found what appeared to be a skull, and on turning it over, realised it was human. He returned home and spoke to his housemate, who advised that he should report it to police. That afternoon, he did so, and led police to the location.

100. The following day, a coordinated Land Search was conducted by police, led by Detective Constable Ben King. It was a very detailed operation, and included police on foot and police divers, and it was conducted over the next three days. A number of bones were located, some of which were identified as human remains.

Autopsy and forensic anthropologist

101. An autopsy of the remains was conducted by Dr Alan Cala on 16 January 2019. He confirmed the death but was unable to identify a cause.

102. A forensic anthropologist, Dr Penny McCardle, also provided a report. She confirmed the remains to be of an adult male and could only date the remains as being one to ten years old. A small fracture was identified at the head of the right femur, which was possibly perimortem, but it could not be excluded as post-mortem. It was also consistent with age-related degenerative change.

103. A DNA profile was extracted from the remains. Comparison with a DNA sample from John's daughter, Renae later confirmed that these were indeed his bodily remains.

Time, cause and manner of death

104. It is impossible to accurately determine the cause or manner of John's death. It is certainly possible that he had a medical emergency, fell or had some other kind of accident while walking. Given where his remains were found, a short distance downstream from Fairview, I think it most likely he entered the water shortly after he left the home. Evidence before me indicated that the river was high at that time and the ground may well have been soft and unstable.

105. There is no evidence that John was suicidal or that his death was in any way suspicious. I accept that it is certainly possible that John simply fell into the river. He was known to collect golf balls around the riverbank and Professor Kurrle suggested that his ability to assess the risk the fast flowing river posed on this occasion could

have been affected by his cognitive impairment. However, the various theories put forward by those involved in the search and giving evidence are really no more than conjecture. I will record open findings in relation to the cause and manner of John's death.

Events since the disappearance

106. Following John's disappearance, changes were brought in at Fairview. A compulsory report was made to the Commonwealth Department of Health, and a complaint was also made to the Aged Care Quality and Safety Commission. The Quality and Safety Commission made a finding of Risk against Fairview. Fairview engaged a consultant, Pride Living, to help it improve its processes.

107. In his statement, Mr Arthur described some of the relevant improvements, including the introduction of further risk assessing of residents, improvements in security, and implementation of a meal tick sheet that ensured no residents could miss a mealtime without some explanation.

108. Perhaps most significantly, Fairview's assets were sold, and its aged care licences were transferred to another operator. The buildings and other assets were acquired by a separate Aged Care company, Frank Whiddon Masonic Homes ("Whiddon"), on 3 February 2020. Whiddon currently operates a care home on the site. It has no relationship with Fairview, and it operates completely different policies and processes. Fairview Care Limited, the company which previously operated Fairview, was dissolved in March 2021.

109. Given these changes, there are no necessary recommendations to consider.

Findings

110. For the reasons set out above, I make the following findings pursuant to section 81(1) of the Act,

Identity

William John Torrens is dead.

Date of death

He died on or about 5 January 2018.

Place of death

He died in Moree, NSW.

Cause of death

His cause of death is unknown.

Manner of death

His manner of death is unknown.

Conclusion

111. John was well loved by his daughter and was a valued friend to Don and Toni and others in the Collarenebri community. The circumstances of his disappearance and discovery were distressing and I have no doubt this compounded the distress those close to John continue to feel. Once again, I offer them my sincere condolences for their profound loss.

112. I thank the investigating officers and all those involved in the search. I thank the assisting team, Mr Jake Harris of counsel and his instructing solicitor, Mr Gareth Martin for their assistance in the preparation of this inquest.

113. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
14 July 2023
NSW State Coroner's Court, Lidcombe