IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 6552

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Amended pursuant to s76 of the *Coroners Act 2008*

Findings of:	**CORONER CARLIN**
Deceased:	Matthew Williams
Delivered on:	10 March 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	21 & 22 September 2016
Counsel assisting the Coroner:	Ms Jessica Wilby, Principal In House Solicitor
Representation:	Mr Paul Lawrie, Counsel for the Chief Commissioner of Police, instructed by Russell Kennedy Lawyers

Background

1. Matthew Williams was born on 3 June 1977 in Sale, Victoria to Anne and Christopher Williams. He had two younger brothers, Jeremy and Andrew. His parents divorced when Matthew was young.

2. Matthew attended Catholic primary and secondary school in Sale and left in Year 10. At approximately 16 years of age Matthew obtained an apprenticeship as a boilermaker.

3. At the time of his death Matthew was working full-time as a boilermaker at Doan Pacific in Braeside. During the week he lived in Frankston with his brother, Andrew, and on weekends he lived with his partner, Sara Okerstrom, and their son Aarre, in Blackwood. Sara described their relationship as wonderful, close and that of being the best of friends.[1]

4. Matthew was close to his family. According to Andrew '*Matt was never a violent person. Matt never exploited anyone. Matt was a big, scary longhaired lout but he never used his intimidation to victimise anyone. Matt was a hard worker and he took pride in his work. Matt would always help out a mate. He wasn't a saint. In our younger years we got up to more than our fair share of mischief, but he never intentionally hurt anyone. Matt was a good man, and he loved his son Aarre.*'[2]

5. Andrew described Matthew as being 'bush savvy' from his years in the Blackwood area going out into the bush. He also said he was not a social person and liked to do things on his own.[3]

6. Matthew had a love of gold prospecting, a hobby he commenced in about 2008, and he often prospected in the Blackwood area. While Andrew had never been prospecting with Matthew, Sara had gone with him on occasions.

7. On Sunday morning 21 December 2014 Matthew left his Blackwood home to go prospecting. He was due home about lunch time, but never returned. Despite a coordinated search Matthew was not found until some civilians chanced upon his car, in the bush, six days later. Matthew was lying next to his car, obviously deceased. He was 37 years old.

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[1] Statement of Sara Okerstrom, p 2 of coronial brief

[2] Letter to the Court, July 2016

[3] Statement of Andrew Williams, p 68 of coronial brief

The Purpose of a Coronial Investigation

8. Matthew's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as his death occurred in Victoria and was unexpected.[4]

9. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[5] Coroners independently investigate reportable deaths to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

10. It is not the role of a coroner to lay or apportion blame, but to establish facts.[6] It is not the role of a coroner to determine criminal or civil liability arising from the death under investigation, nor to determine disciplinary matters.

11. For coronial purposes, the 'cause of death' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

12. The 'circumstances in which death occurred' refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

13. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations. This is generally referred to as the 'prevention' role.

14. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.

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[4] Section 4 *Coroners Act 2008*.

[5] Section 89(4) *Coroners Act 2008*.

[6] *Keown v Khan* (1999) 1 VR 69.

15. All coronial findings must be based on proof of relevant facts on the balance of probabilities with due regard to the principles enunciated in the case of *Briginshaw* v *Briginshaw*.[7] The effect of this and similar decisions is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

16. The circumstances of Matthew's death were initially investigated on my behalf by the appointed Coroner's Investigator, Sergeant Nathan Parker. He prepared a coronial brief of evidence comprising a range of evidentiary material including witness statements and visual material.

17. After considering the material contained within the coronial brief and correspondence from Matthew's family I determined to obtain additional material to assist me further in the investigation of Matthew's death.

18. This finding is based on the entirety of the investigation material including the coronial brief of evidence, additional material gathered at my request, family correspondence and the statements and evidence of those witnesses who appeared at the inquest.

Identity of the Deceased

19. On 30 December 2014, the identity of the deceased was determined to be Matthew Williams, born 3 June 1977, by means of fingerprint comparison. I was satisfied as to Matthew's identification and decided that further investigation was not required.

Forensic Medical Examinations

Relevant Medical history

20. Shortly after Matthew's death his mother, Anne Williams, provided a statement outlining a family medical history that included high blood pressure, circulatory problems, high cholesterol, cerebral aneurysm, stroke and heart attack at a young age. All three of her sons had suffered from high blood pressure, but she did not think Matthew had ever been medicated.

21. The only recorded blood pressure for Matthew was 140/90 taken on 3 May 2013. Matthew had visited his General Practitioner, Dr Lee, at that time with concerns about his circulation due to

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[7] (1938) 60 CLR 336.

pins and needles over his right anterior thigh, worse upon standing. The doctor advised him that the sensation was likely nerve related.

22. In the months leading up to his death Matthew reportedly complained of reflux and pain in his arm and shoulder.[8] His last recorded visit to Dr Lee, was on 14 April 2014. At that time he complained of left shoulder pain for 6 weeks, which he described as 'something slipping over inside'. Dr Lee considered this was likely a ligament tear. An x-ray and ultrasound of his left shoulder on 15 April 2014 revealed no abnormality. No bony injury or lesion was identified and no significant changes of inflammatory or non-inflammatory arthritis were noted.

23. Matthew was prescribed Escitalopram (Lexapro) an antidepressant, and he last filled his prescription in November 2014.

Autopsy

24. On 2 January 2015, Dr Jacqueline Lee, a Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on Matthew's body. She provided a written report, dated 16 March 2015.

25. Matthew's body had signs of early to advanced decomposition, his stomach was empty and there was no evidence of injury. A post-mortem tomography scan showed no evidence of skeletal trauma and no fractures to the skull.

26. Dr Lee did not detect any suspicious skin lesions suggestive of a snakebite. Nevertheless, she discussed the case with Dr Winkel, director of the Australian Venom Research Unit at the University of Melbourne. He indicated that the sequence of events following snake envenomation is variable with prognosis depending on the type of snake and quantity of venom. Symptoms range from acute deterioration over 5 minutes with a Brown snakebite to limb and respiratory muscle paralysis leading to respiratory failure in excess of 3 hours. In addition, haemotoxic venom from certain snakes can cause coagulopathy (excessive bleeding). Death due to bleeding would be likely to occur after 3 hours. In such a case evidence of bleeding would be seen in the tissues and organs, but there was no such evidence here.[9]

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[8] Second statement of Andrew Williams, dated 21 May 2015, p 71 of coronial brief

[9] Autopsy report, paragraphs 14-15

27. Dr Lee noted that Matthew's medical history did not include allergies. She commented that in the absence of a previous history, it is unlikely that a severe allergic or anaphylactic reaction was the cause of death.

28. Dr Lee also noted the history of cerebral aneurysm on Matthew's mother's side, but found no evidence of haemorrhage at autopsy. Dr O'Donnell, Consultant Radiologist at VIFM, was of the opinion that hyperdensity in the lateral ventricles was suggestive of blood, but was not definitive.

29. Finally, Dr Lee noted the family history of heart disease and hypertension. Microscopic examination of Matthew's heart showed no evidence of old or acute myocardial infarction (such as, for example, might have been expected if his shoulder pain had been cardiac in nature). However, Matthew's heart did weigh more than normal for a man of his height.

30. The expected mean heart weight for a 182cm man was 336g with an upper limit of normal of 475g. Matthew's heart weighed 479g. Dr Lee commented that as decomposition decreases the weight of organs, 479g reflected an enlarged heart (cardiomegaly). Possible causes for cardiomegaly include valvular heart disease and hypertension. The autopsy did not reveal any evidence of heart valve disease and Dr Lee could not determine the underlying cause for the enlargement in Matthew's case.

31. Dr Lee commented that death due to the enlargement of the heart may be the result of an abnormal cardiac rhythm due to an inadequate supply of blood to the heart muscle.

32. Whilst noting that cardiomegaly can cause sudden death, Dr Lee was unwilling to attribute Matthew's death to cardiomegaly as the circumstances of his death were unclear and there was *'no known history of the symptoms of heart disease'*, In all the circumstances she determined that the cause of death was 1(a) Unascertained.

Time of death

33. Dr Lee did not collect insect samples from Matthew's body at autopsy as her primary concern was to determine if there was evidence of foul play or a catastrophic natural event. She later asked Dr Archer, forensic entomologist, to conduct a retrospective review of the role that forensic entomology might have played in evaluating time of death had she done so.

34. Dr Archer explained that ideally insect evidence needs to be collected at the site of body discovery and at the mortuary. If insects had been collected from Matthew at autopsy, the

absence of evidence from the site of discovery of his body and the delay to autopsy would have meant that any opinion Dr Archer might have proffered would been so heavily qualified as to be unhelpful in providing an estimate of the minimum time that Matthew had been dead.

35. Dr Archer could not provide any useful conclusions from the information that was available to her in Matthew's case, including photographic and CT imaging. Dr Archer noted that in the vast majority of cases she cannot provide an actual time of death even with ideal evidence collection.[10]

Toxicology

36. Toxicological analysis of Matthew's blood revealed ethanol (alcohol) at 0.08g/100mL and citalopram, Matthew's prescribed antidepressant at ~0.3mg/L. As ethanol may form by fermentation during decomposition, it was not possible to draw any conclusions as to antemortem ingestion of alcohol.

Initial reporting of Matthew's disappearance

37. On the evening of Saturday 20 December 2014 Matthew told Sara that the next day he would go gold detecting for a couple of hours before it got too hot and he would then come back and take their son swimming. He said he would prospect in the Blackwood area, but did not state an exact location.

38. At approximately 11:30am the next morning Matthew left his Blackwood home in an unregistered dark red 1992 Toyota Forerunner. He was due home at approximately 1pm.

39. Sara was out for the morning and returned home at approximately 1 o'clock. She had not had any contact with Matthew throughout the morning and expected that he would be home upon her return.

40. When Matthew had still not arrived by 2:30pm, Sara started to become concerned. She called Matthew's mobile telephone and it went straight to voicemail. An hour later she called Matthew's mobile telephone again and left a message.

41. At approximately 8pm Sara called Bacchus Marsh police station to report Matthew missing. She spoke to Senior Constable (**SC**) Roy Owen, who discussed Matthew's movements and obtained a description of his clothing, car and supplies.

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[10] Forensic Entomology Report, p 138 of coronial brief

42. Sara said the car was a red unregistered Toyota Hilux and described mechanical problems[11]. She said she believed Matthew may have gone to the Whale Bone Road, Skinners Road or Old Golden Point Road areas in Blackwood, as they were popular prospecting sites for him. She indicated that Matthew took two to four litres of water with him, four cans of beer and possibly some beef jerky and salted nuts. She said he had a 'bit of a pot belly' and smoked, but otherwise had no medical problems although she worried about snakes as he often detected near creeks. Sara said that Matthew did not take his wallet with him, that he had not been withdrawn in any way and had not been acting out of the ordinary[12].

43. After speaking to Sara, SC Owen completed an 'Incident Field Report' and a 'Missing Person & Risk Assessment' Form and notified the Sergeant in charge, Sergeant Barry Hills, who was the Moorabool area Patrol supervisor. Sergeant Hills was originally responsible for handling the incident.

44. Acting Sergeant Beel took further information from Sara Okerstrom at approximately 9:00am on 22 December 2014 and then attended Sara and Matthew's house. At the house an old gold mining book was located with some handwritten notes in it, which he provided to the search coordinators.

45. Sergeant Wayne Gatt, who was Station Commander of the Trentham Uniform police station, took control of the search on Monday 22 December 2014. The next morning (23 December) he took a formal statement from Sara which was signed at 11.28 am. In that statement Sara indicated that Matthew mainly prospected in the Blackwood area and that she regularly went with him. He often went down the track behind the house – Skinners Road. He sometimes went to Greendale in the 'B' Track area. To the best of her knowledge he did not prospect in any other place. When Matthew went prospecting he did not conceal his behaviour and normally parked his car in plain view.[13]

46. Sergeant Gatt reported that based on the information initially provided to police '*...it was difficult to determine a likely location for the deceased other than areas commonly known by*

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[11] SC Owen recorded that the vehicle had "a canopy", although it did not.

[12] Statement of SC Owen, p 6 of coronial brief

[13] Statement of Sara Okerstrom, p 2 of coronial brief

the deceased's family to have prospecting significance and that family knowledge of these areas did not extend beyond 'possible' names of areas frequented.'[14]

47. Sergeant Gatt considered that the information provided to him did not place Matthew in a high risk category. That is, he was in reasonably good health, was not known to have a medical condition that would cause immediate concern for his welfare, there were no suspicious circumstances surrounding his disappearance and his actions were consistent with him intending to return home. There were also no identified relationship, social or psychological issues.[15]

The search for Matthew

Overview

48. Information provided to me during my investigation indicated that searching for Matthew commenced on 21 December 2014. A full scale search was conducted on 22 December 2014 utilising various resources including local police, the Victoria Police Air Wing (**VPAW**), Solo Units, Search and Rescue (**SAR**), State Emergency Service (**SES**), Parks Victoria and many civilian searchers.

49. Investigations and searching continued over the following days. In the evening of 24 December 2014 it was decided to scale back the search - pending new information - as it was believed all likely areas had been searched without any sign of Matthew or his car.

50. Many family members, community members and travellers in the area engaged in the search. There were also media alerts and a KALOF issued by police.[16]

51. Acting Sergeant Beel described it as more difficult than other searches he had been involved in due to the following:

- No destination was specified and Matthew's behaviour was not out of character;
- No high-risk factors or family issues were identified to account for his longer than expected absence;

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[14] Ibid, p 25 of coronial brief

[15] Statement of Sergeant Gatt, p 24 of coronial brief

[16] P 217 of coronial brief

- On 22 December 2014 Matthew's vehicle was not located in the expected search area and there was no further intelligence or sightings;

- Information from the general public in and around parks was less likely due to the quiet period just before Christmas; and

- In the absence of 'passer-by' calls, a located item or vehicle or other intelligence, there was no anchor point to narrow the search down. This meant that a large search radius had to be considered and the area covered a challenging variety of terrain.[17]

Co-ordination of ground resources

52. At 9pm on the 21 December 2014, when Matthew had still not returned home, Sergeant Hills requested members of the local SES to assist with the search. A ground search continued until 12:30am, when it was suspended due to the darkness and terrain. Four wheel drive (**4WD**) tracks were also patrolled for three and a half hours before visibility became poor.[18]

53. Sergeant Gatt commenced duties as Patrol Supervisor at 6:20am on 22 December 2014 and was made aware of Matthew's disappearance. After familiarising himself with the search efforts so far, he assumed carriage of the matter including co-ordinating resources. At 7:00am he met with Acting Inspector Lappin, who was on temporary assignment as the Moorabool Local Area Commander and Sergeant Bartlett, a specialist search co-ordinator from SAR. They determined that search activities would utilise local police resources together with Parks Victoria members.

54. Searching continued that day until light failed at approximately 8:30pm that evening. At 6.40pm Sergeant Gatt was advised of a possible sighting of Matthew. Investigations into that sighting on the night were inconclusive.[19]

55. On 23 December 2014 searching continued throughout the day using local police units and Parks Victoria. Later that afternoon arrangements were made for the 4x4 club to provide civilian searchers for areas that Matthew might be. At approximately 4:20pm Sergeant Gatt received information that excluded the possible sighting from the day before.

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[17] Statement of A/Sgt Beel, p 36 of coronial brief

[18] Statement of SC Martin, p 13 of coronial brief

[19] Statement of Sgt Gatt, p 28 of coronial brief

56. On 24 December 2014 Sergeant Gatt met with new police and civilian searchers and a collective decision was made by the search managers to re-search areas previously visited, in case some details were clearer in different conditions. There was to be a particular focus on gullies and burnt out creeks based on further information from the family.

57. Leading Senior Constable Ball from SAR co-ordinated the search on 24 December 2014 and determined that there should be another full scale search of the Blackwood area with the major objective of locating Matthew's car. All SAR members' activities were GPS recorded and logged.

58. The search continued throughout the day and into the evening. Leading Constable Ball stated that not a single clue was uncovered, and in spite of intensive media coverage not a single reliable sighting was reported.[20]

59. At approximately 8:20pm, after consultation with all police and SES members, a decision was made to scale down the search with members provided with specific tasks of patrolling specific areas.[21]

60. Between 25 and 26 December 2014 local police and Parks Victoria continued to patrol identified areas and on the afternoon of 26 December 2014 all information was passed to the Moorabool Criminal Investigation Unit to further investigate Matthew's disappearance.

The Victoria Police Air Wing

61. VPAW was first requested to assist in the search for Matthew by the Rescue Co-ordination Centre at approximately 9pm on 21 December 2014 (the night Matthew was reported missing).

62. Acting Senior Sergeant Grenfell who was in charge of VPAW between 21 and 27 December 2014 provided a statement as to VPAW's assistance in the search for Matthew. A VPAW helicopter crew performed searches on 21 December 2014 until approximately 10pm and then on 22 and 24 December 2014.[22]

63. The tactical flight officer attached to VPAW, Acting Sergeant Pascoe, stated that Sergeant Gatt briefed him and allocated an initial search area of the forest within a 15km radius of the Blackwood Township.

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[20] Statement of LSC Ball, p 85 of coronial brief

[21] Statement of Sgt Hills, p 10 of coronial brief

[22] Statement of A/Snr Sgt Grenfell, p 17 of coronial brief

64. The Forward Looking Infrared (**FLIR**) was also utilised to search for Matthew in the dark with the pilot and searchers wearing Aviation Night Vision googles. Leading Senior Constable Weekley indicated that a thorough FLIR search was conducted on 21 December 2014 of the entire length of Whalebone Road, the entire length of Simmons Reef Road and the entire length of Golden Point Road to Morning Star Road. A requested search of Skinners Road was then made, but the terrain was difficult to penetrate with the thermal camera as high winds were making it difficult to hold the helicopter level. [23]

65. A VPAW helicopter departed at 11:15am on 22 December 2014 for a visual search utilising the aircraft camera only to verify any points of interest. Acting Sergeant Pascoe stated that searching bush and forest areas can be difficult due to environmental factors such as steep terrain, tree canopy and light conditions, particularly the casting of shadows which can camouflage persons or vehicles underneath. On this day the VPAW helicopter utilised an east west and north south sweep pattern.

66. At 1:25pm the helicopter landed to refuel and Acting Sergeant Pascoe contacted Sergeant Gatt to discuss further search areas and '*...he [Sergeant Gatt] advised that Williams was secretive about his gold prospecting sites, but they had some information that he had previously frequented Shaws Lake and Yankee Track which are located North of Blackwood'.*

67. At 2.30pm VPAW commenced searching around Shaws Lake, Shaws Track, Yankee Creek and Old Blackwood Road. The area had a heavy tree canopy and steep terrain making it difficult to see through to the forest floor and detect any minor tracks.

68. At approximately 3:45pm Acting Sergeant Pascoe spoke to Sergeant Gatt again, who said they had information that Matthew had previously frequented areas to the south of Blackwood. Sergeant Gatt allocated two further search areas south of Blackwood near Greendale and east of Blackwood near Golden Point.

69. At 4.55pm VPAW arrived in the allocated area and searched an area bounded by Greenhills Road to the north, Greendale township to the east, Greendale-Ballan Road to the south and Blakeville Road to the west. Significantly this was the area in which Matthew's body was later found.

70. After that VPAW searched an area between Chettle Road, Amblers Track, O'Brien's Road and Greendale-Trentham Road. Search conditions then became difficult because of the heavy tree

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[23] Statement of LSC Weekley, p 21 of coronial brief

canopy and afternoon shadows. At 6:30pm Sergeant Gatt informed the VPAW crew the search was being scaled back.

71. The total flight time during this shift search was 364 minutes and Acting Sergeant Pascoe produced screenshots of the aircraft mapping computer displaying the areas searched by the crew. These screenshots were included in the coronial brief. [24]

72. On 24 December 2014 VPAW was again deployed to re-search parts of Blackwood that had already been searched on 22 December 2014 with a particular focus on waterways and creeks inaccessible to other vehicles.[25]

73. On 26 December 2014 Sergeant Gatt attended Matthew's home and provided his family with all of the aerial mapping provided by Air Wing on their final day of searching. [26]

The family's searches

74. On 22 December 2014 when Andrew Williams discovered Matthew was missing he went straight to Blackwood and headed out on the tracks. Andrew asked Sara to direct him to the places that Matt frequented, but they could not find him.[27]

75. Matthew's cousin Emma Silberstein is a qualified pilot and on 23 December 2014 she contacted a fellow pilot, Gerard Lappin, and asked him to conduct an aerial search for Matthew. They determined the search area based on information given to the family by police. They did not include the regions close to town (identified as the VPAW search area) as '*...we had been informed by the police that these locations had been thoroughly searched and our time would be better spent searching outside these areas'.*

76. This private aerial search was conducted on 24 December 2014 and was funded by the family.[28] Gerard had been flying for three hours with Emma's father as a spotter when Emma joined the search and requested Gerard to fly over the remainder of the state forests surrounding the Blackwood area.

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[24] Statement of A/Sgt Pascoe, p 54 of coronial brief

[25] Statement of Sergeant Ball from SAR, pp 84-86 of coronial brief

[26] Statement of Sgt Gatt, p 11 of coronial brief

[27] Statement of Andrew Williams, p 72 of coronial brief

[28] Letter to the Coroners Court dated 1 January 2015

77. Emma estimated the flight was conducted at approximately 500 feet (the helicopter did not have an instrument panel). There was no aerial footage and maps of the search have since been destroyed. There were clear visuals to the ground in most places but less so when flying over dense gullies. The ground terrain was dense in most areas, but consisted of thin trees which allowed for a '*...relatively clear view to the ground in most places.*'[29] They did not find Matthew.

78. After this, Matthew's mother decided to continue with the aerial searches and privately engaged the services of a specialised search and rescue helicopter from Altitude Aviation for 4 hours on 27 December 2014.

79. At approximately 8:00am on 27 December 2014 pilot Peter Nelson met Andrew Williams who advised that Matthew had turned left out of his driveway. They checked north of the house and to the east of Lederberg State Forest. The search was guided by a friend of Andrew's as to the places Matthew frequented. [30]

80. The total flight time was approximately 4 hours and 30 minutes around the search area and the path was plotted on the aircraft's GPS and videotaped. The maps of the GPS plotting of the flight path and the video were provided to me during my investigation.

The discovery of Matthew's body

81. On 26 and 27 December 2014, three men travelled to Greenhills Road, Blackwood to camp and go four-wheel driving for the weekend. On Friday 26 December 2014 two of the males came across a woman who stated that her cousin had been missing for a week and gave them a flyer.

82. Late in the afternoon of 27 December 2014 the group revisited the Bee Track, Blackwood to try and find an original track which was shown on their GPS. Giles Richardson recalled: '*We got approximately 900m down the track to where the GPS took us earlier and the actual road on the map had stopped, to see where the original track went. We walked in about 5 metres and saw a crushed log where a car had driven over it. It was obvious that the log had been crushed within a week or so, we figured that we would head down and have a look.*'[31]

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[29] Statement of Emma Silberstein, March 2016

[30] Statement of Peter Nelson, p 90 of coronial brief

[31] Statement of Giles Richardson, p 98 of coronial brief

83. Another of the group, Michael Collins, stated they went one and a half kms down the Bee Track to an area that was overgrown and a dead end. They then drove though the overgrown area and found a burgundy Toyota.[32]

84. The car was not visible from the existing extension of the Bee Track.

85. Once they saw the car the third member of the group, Edison Lau, started recording with his mobile telephone. They approached and saw that the driver's door was open and a person was lying face down next to the car. Edison reported *'We weren't to[sic] close and we didn't touch anything'*. They realised that the person was dead, returned to their car and attempted to call 000. There was no reception so the group marked their location on their GPS, drove until they got to a mobile service area and called 000 again.

86. Leading Senior Constable Young attended that evening and walked with Giles Richardson down what appeared to be the Old Bee Track. He states that it appeared that Parks Victoria had disused this track quite a few years ago by the significant trees growing along it.[33]

87. Sergeant Glenn Saw was the patrol supervisor at Bacchus Marsh that night and attended the scene. He observed marks consistent with finger marks on the rear driver's side door which looked to him as if Matthew had tried to grab the door and his fingers ran down the door as he fell.

88. Sergeant Saw also noted that the driver's door was open and that Matthew had '*...seemingly been gathering his belongings to leave the vehicle, there was a gold pan with a full beer can in a stubby holder located on the driver's seat and the keys were in the ignition.*'[34]

89. Matthew's mobile telephone was located in the pocket of his jeans.

90. The video taken by Edison was provided to me during my investigation[35] and photographs of Matthew's body in situ form part of the coronial brief. The photographs depict Matthew lying partly on his left side, face down, next to the driver's side of the car. His left arm is outstretched next to him and his right arm is folded at the elbow and under his body.

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[32] Statement of Michael Collins, p 93 of coronial brief

[33] Statement of LSC Young, p 110 of coronial brief

[34] Statement of Sgt Saw, p 113 of coronial brief

[35] Video in additional material, Misc – video taken by Lau

The Bee Track

91. Matthew's car was *'possibly 300 metres or more'* from the Bee Track.[36] Sara's signed statement of 23 December 2014 indicated Matthew sometimes went to the 'B' Track in Greendale.

92. At approximately 5-6 pm on 22 December 2014 *'Bee Track'* was reported as an area mentioned by Matthew in the past and at around 7 pm Leading Senior Constable Beel and Senior Constable Radau drove the entire length of that track, not finding any trace of Matthew.

93. Leading Senior Constable Beel described the Bee Track as follows: *'It runs from Paradise track North/South towards the Greendale Township. It ends on a small feeder track about 1 km from the very Southern end of Greenhills road. It's a moderate track up to about the ½ way point, where a small creek crosses it at a clearing, then becomes very steep and broken from that point on. From memory we got stuck exiting the climb out from the creek and had to chainsaw a path to continue.'*[37]

94. At approximately 8:30am on 28 December 2014, the day after Matthew's body was discovered Scott Nicholson, Parks Victoria, drove out to the location for his *'own peace of mind'* as he wanted to know if it was in the original search areas and had been missed.

95. Mr Nicholson noticed the area was not on a track, rather it was down a gully and hidden from the nearest track, being the Bee Track. He remarked: *'...the area is so remote due to being a heavily mined area and heavily treed, particularly regarding fallen trees. It was a difficult place to get into even for me in my four wheel drive.'*[38]

96. On 14 January 2015, Sergeant Gatt, Acting Inspector Lappin and Senior Constable Radau attended the area to observe where Matthew had been located. Sergeant Gatt described it thus: *'The area was on a disused and very overgrown track that was not visible from the Bee Track. The deceased's vehicle would not have been visible from the track known as Bee Track and I believe that it would be highly unlikely that passing searchers would have observed any evidence that a vehicle had passed in that location. My observation of the area was some time after the location of the deceased, and even after significant disruption by attending vehicles, I found it hard to locate the old Bee Track entrance. The area is well vegetated and while not*

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[36] Statement of SC Owen, p 6

[37] Information contained in email from LSC Beel to DS Parker.

[38] Statement of Scott Nicholson, p 45 of coronial brief

dense in terms of tree canopy it certainly was well treed to an extent that would hamper aerial attempts to locate a vehicle.'[39]

The Inquest

97. Matthew's mother Anne, his brother Andrew, his Aunt Dr Trish Kerbi and his cousin, Emma Silberstein, all wrote to the Court in January 2015, expressing their discontent. This was followed by a formal submission by the family and email correspondence. The main issues raised by the family can be generalised as follows:

    That the police did not exercise a proper duty of care towards Matthew;

    That the police failed to search in an effective and appropriate manner;

    That the police called off the search on a false sighting;

    That the risk assessment conducted when Matthew was reported missing was not ranked 'high', when it should have been; and

    That judgements were made about Matthew due to his appearance that affected the police response.

98. As a result of my review of the coronial brief and the issues raised by Matthew's family, I decided to refer this matter to the Court's independent in-house legal service to provide assistance and conduct further investigations. Further statements and material including further maps and videos were obtained.

99. After considering this further material I exercised my discretion to conduct an inquest to clarify certain discrete matters, particularly the medical cause of death and the parameters of the search for Matthew. I determined that four witnesses should be called:

    Dr Iles, Head of Forensic Pathology at VIFM, to provide further analysis as to the possible causes of Matthew's death and the likelihood of prolonged survival after collapse.

    Acting Inspector Edward Lappin, the Moorabool Local Area Commander, who was involved in critical decision making about the search from the time that Matthew was first reported missing until he was found.

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[39] Statement of Sgt Gatt, p 12 of coronial brief

Sergeant Bartlett, who in his role with SAR provided specialist assistance to the local police; and

Inspector Brett Murphy who conducted an independent review of the search, its co-ordination and the risk assessment.

Likely cause of death

100. Dr Iles did not conduct Matthew's autopsy, but reviewed all of Dr Lee's notes, reports and observations as well as relevant correspondence, photographs and post-mortem CT scans, prior to giving evidence at the inquest.[40] She was satisfied that this was sufficient to allow her to express her opinions.

101. Dr Iles agreed with Dr Lee's medical examination report, saying it was very comprehensive.

102. Dr Iles confirmed that the decomposition process, which was well-advanced in Matthew's case, could limit interpretation of results of post mortem examination. However, she explained that an intracranial haemorrhage would still have been detected by the post mortem scans. She said that Dr Lee had specifically looked for intracranial haemorrhage as it is one of the more common causes of sudden collapse in a young person and there was no evidence of it. She concluded '*...so out of the things that we can definitively rule out, I am confident we can definitively say that has not occurred.*'[41]

103. Dr Iles regarded the fact that Matthew's heart was enlarged in the setting of decomposition (which causes the weight to decrease) as significant. She explained that one of the most common causes of cardiac enlargement, '*which may be relevant in this situation*', is hypertension. Whilst valvular heart disease and underlying coronary artery disease can cause cardiac enlargement there was no evidence of them in Matthew's case. Cardiomyopathy[42] is another cause of cardiac enlargement which was difficult to exclude. Dr Iles considered that Matthew's family history of high blood pressure added *'some weight'* to Matthew having an underlying hypertensive heart disease and that he '*may have died from it, he may have died with it.*'[43]

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[40] Transcript p 21. Dr Lee was no longer employed at VIFM at the time of the inquest.

[41] Transcript p 26.1

[42] Disease of the heart muscle

[43] Transcript p 30.31

104. Dr Iles elaborated on the effects of cardiomegaly saying: *'It is recognised that those with underlying heart disease, which might manifest as cardiac enlargement, can suffer sudden cardiac arrhythmias which may result in collapse and sudden death. ... So if someone has an enlarged heart, they could live for a long time with an enlarged heart and it may mean nothing, or conversely it is well-recognised that because of the fibrosis and underlying instability of the cells of the heart in a pathological state, that they can generate sudden cardiac arrhythmias which can present as shortness of breath and then rapidly deteriorate into a malignant heart rhythm and result in collapse and sudden death...just because somebody has a large heart, it doesn't mean they've died of it, they may have died with it, and so we would ascribe a cause of death to cardiac enlargement if we could exclude other causes, i.e. it may be a diagnosis of exclusion, or, for example, if someone's witnessed to clutch their chest before they collapse, then clearly that's – that's a useful piece of information, but clearly we don't have that in this instance.*[44]

105. Significantly Dr Iles explained that people with cardiomegaly do not necessarily have symptoms and that in her role as forensic pathologist dealing with unexpected deaths she frequently encountered people whose first presentation was sudden death. *'Just because Matthew didn't have symptoms, doesn't necessarily mean he didn't have an underlying significant problem.'*[45]

106. The family were particularly concerned that Matthew may have been alive for some time after becoming incapacitated and that his death could have been prevented by a timely rescue. At my request Dr Lee provided a supplementary report on this issue. She concluded that without knowing the cause of death, the length of time from collapse or final event to death could not be determined.[46] Dr Iles did not entirely agree with that assessment. She was of the view that even without knowing the cause of death there were still some things that could be gleaned from the post mortem examination and imaging, particularly in relation to the possibility of a prolonged survival.

107. Dr Iles explained that one of the most reliable indicators that someone has survived for a period of time in a semi-conscious state is the development of pneumonia, a respiratory tract infection. She noted there was no evidence of pneumonia on Matthew's CT scan, which is a useful device

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[44] Transcript p 23 - 24

[45] Transcript p 43 - 44

[46] Dr Lee supplementary report dated 4 February 2016

for detecting pneumonia. Further, significant microscopic sampling of Matthew's lungs did not reveal any inflammation, inflammation being an indication of breathing difficulties.

108. Dr Iles said: '*...whilst I can't give you a specific number in terms of hours, if somebody has survived for a period of six to twelve hours with a reduced conscious state, we will often see evidence of some inflammation around the airways so we specifically look for that and as I said Dr Lee's sampling has been quite comprehensive in this regard and there is no evidence of that.*'[47]

109. Dr Iles was satisfied that there was no evidence of any early developing pneumonia: '*...if there was a prolonged period of survival, which I believe is important in this case, that we would expect to see some signs of that and we have seen none, neither macroscopically at autopsy, on the post-mortem CT scan or under the microscope.*'[48]

110. When pressed for an outer limit of survival Dr Iles cautiously indicated 12 to 24 hours.[49] She confidently rejected a survival period of several days as 'highly improbable'.[50]

111. Dr Iles considered that the circumstantial evidence combined with the medical evidence pointed to *'a rapid, sudden event'*. She listed a number of possible causes of sudden collapse leading to death, however she excluded most as impossible, unlikely or very unlikely in Matthew's case.[51] She considered the three most likely causes of Matthew's collapse were a sudden cardiac event, snake bite and anaphylaxis, for example from an allergic reaction to an insect bite. Out of those three, she favoured cardiac event and snake bite, given Matthew had no known previous instance of allergy.

112. Whilst Dr Iles could not exclude a snake bite causing rapid death, the evidence did not support a snake bite causing a prolonged death by coagulopathy, as there was no bleeding within the body. This would have been detectable even with Matthew's level of decomposition.

113. After the inquest Anne Williams emailed Dr Iles directly with further questions. Dr Iles responded by letter dated 25 October 2016 and elaborated on her evidence as to survival time. She indicated that in her experience signs of lower respiratory tract infection in unconscious or

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[47] Transcript p 28.5

[48] Transcript p 29.9

[49] Transcript p 38

[50] Transcript p 39

[51] Transcript p 34

paralysed people appear, albeit at the microscopic level, after at least several hours. She would expect to see such signs in someone who had been unconscious for over 12 hours. Further, she would expect to see a full bladder in such a case, whereas Matthew's was empty. Finally tests on Matthew's kidneys showed no evidence of rhabdomyolysis (muscle breakdown) which develops in a person lying in the one position for a number of hours. In short *'there are no features to suggest that Matthew was lying unconscious for a prolonged period of time'.*

The search

114. Sergeant Gatt was initially responsible for co-ordinating the search effort with oversight from Acting Inspector Lappin.

115. Acting Inspector Lappin described the rationale for determining the search area. It was based on the fact Matthew had indicated that he would be home by one o'clock, with the focus on attempting to identify areas that may have been of interest to him that *'maybe only he knew that weren't necessarily local knowledge.'*[52]

116. As to the resources he said *'I was satisfied from the risk as well and obviously advice from Search and Rescue, that the resource in that area...that we had enough resources on the ground to patrol the areas that were considered to be where he was most likely to be.'*[53]

117. The search was enhanced by the utilisation of Parks Victoria, who had the advantage of knowing the area in detail and the ability to patrol off road. The search itself was based on expert advice from SAR, with the primary focus being on locating Matthew's car. The search included some recently burnt out areas behind Greendale (as advised by Parks Victoria), all of the areas south of Blackwood and within Blackwood that were the areas known as likely prospecting places.[54]

118. On the first day the areas searched were highlighted on a Parks Victoria map at the request of Acting Inspector Lappin, and subsequently SAR recorded their searches by GPS mapping.

119. In response to Counsel Assisting referring to the family's view that Matthew's appearance may have influenced how the search was conducted Acting Inspector Lappin said he was personally challenged that they would think that the desire to find their family member was lessened by the way someone looks; *'I'm sorry that they think that was the reason but I don't think we gave*

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[52] Transcript p 60

[53] Transcript p 48.24

[54] Transcript p 60

them any reason to think that. I think the level of um commitment that we showed, and the tasking that we showed and um support that we showed them was far from thinking that we were going to be flippant about the way we were going to try to find the deceased but I understand they're hurting.'[55]

120. Acting Inspector Lappin explained the difference between the Bee Track and the Old Bee Track where Matthew was found. He said that when he went out there with Sergeant Gatt two weeks later he understood why Matthew had not been seen from the Bee Track as *'it wasn't just a deviation off the track, you had to drive round some pre-laid logs because Parks didn't want that to be a track anymore and.there was nothing to discern that this was previously a track beforehand.'* In the circumstances he was satisfied that the police search of the Bee track had been '*reasonable*'.[56]

The Risk assessment

121. Acting Inspector Lappin gave evidence that during a search for a missing person the risk assessment level is continually re-assessed. In this case the risk assessment stayed 'low' throughout.[57] He acknowledged that the initial risk assessment report was not signed by the Sergeant (who was also the coordinator of the search that first afternoon) but did not agree that it was not 'filled in' or was 'incomplete'.[58] He said there was nothing in that risk assessment that the police did not already know, so there was no omission from the risk assessment itself: '*So the idea of having it checked by the supervisor is to make sure it's done correctly. Now Constable Owen is experienced and you're right, there could have been a risk in a risk assessment being inappropriately made or low levelled, but that wasn't the case at all.*'[59]

122. Acting Inspector Lappin explained that although there is no opportunity to revise the original risk assessment report, once completed it is uploaded onto LEAP[60], which becomes an electronic narrative of the investigation.[61] All officers involved in this incident had access to

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[55] Transcript p 64.23

[56] Transcript p 69.21 to 70

[57] Transcript p 52

[58] Transcript p 73

[59] Transcript p 51.12

[60] Law Enforcement Assistance Program, an online database which is continually updated.

[61] Transcript at p 49

the LEAP progress report, but it was through briefings that risk assessments are re-communicated to those participating in the search.[62]

123. Acting Inspector Lappin highlighted that the initial response on 21 December 2014 was disproportionate to the risk assessment as they had VPAW out there within moments of the matter being reported and there was a high level of local resources allocated: *'I thought the response relative to the way that it was appropriately risk assessed was disproportionate in the positive sense.'*[63]

124. Acting Inspector Lappin said that after speaking to Matthew's family *'we were confident that there was no medical issue, because that had been articulated to us, and his risk – the risk assessment – the risks that were predominant to the family was the – the manner in which he drives and the roadworthiness of his car and that he was laying under his car somewhere, waiting for someone to find him.'* He explained that *'foot and line'* searches were appropriate when there was an indication that a missing person had been in an area, such as some clothing or their car, but not otherwise.

125. Acting Inspector Lappin indicated that although there was an oversight in respect to the initial risk assessment document not being signed *'...in actual fact it's, um, expedited the report getting onto LEAP. So in relation to the risk assessment itself and there's no issue with the risk assessment but that lack of signature, if anything expedited the report getting onto LEAP and being visible to all of the Victoria Police force.'*[64]

Search and Rescue assistance

126. Sergeant Bartlett from SAR outlined that SAR's role is to provide specialist advice and enhance normal policing procedures. The assistance given is needs based. They have a comprehensive discussion with the search manager as to what has occurred, provide advice as to things that should be followed up, assets as required and assistance to search hard to access areas.

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[62] Transcript at p 51.22

[63] Transcript p 74.20

[64] Transcript at p 50.23

127. SAR may receive requests for assistance in up to 20 missing persons a day; *'So we will triage the most serious job that we need to attend on judging the terrain, the age, the conditions, health issues, things like that whether we attend or the local police are dealing with it.'*[65]

128. On 22 December 2014 Sergeant Bartlett considered the search for Matthew to be within the capabilities of the local police with only monitoring by SAR required: *'I had no general concerns for the health and well-being of the individual due to his age, he was in a vehicle, he knew the area, the search, the search assets that the local people have were Parks, which is one of the greatest assets you could have. Like, Parks, no one knows the area better than the local Parks guys. They had an air asset over the top, off road motorcycles by police and SES and it was a vehicle-based search, which means they had to eliminate roads in the search area.'*[66]

129. Sergeant Bartlett was of the view that the search had been well co-ordinated with SAR basically covering the same ground the police had originally searched. He explained the circuitous nature of a search which starts from the missing person's last known location, in this case Matthew's house, and moves outwards progressively eliminating areas.[67]

130. Sergeant Bartlett explained the reason the search on 24 December 2014 was over areas previously searched: '*We do a process of elimination so we know what has been eliminated and we electronically track that. So we will go over old ground with different people and overlay that on a map so we know what has been searched..*'[68]

131. In response to Counsel Assisting asking about the utilisation of VPAW Sergeant Bartlett said that a total of eight hours is a long time for an air asset. He described the challenges and limitations of VPAW searching: '*The problem with the, the Air Wing is to adequately search with it, you have to have the doors open and a harness on, you're leaning out of the aircraft for a start, which is quite taxing if you're buffeting quite a lot. The craft can only do a certain minimum speed, so it's travelling quite quick. If there's a high tree if there's a big tree canopy you've got like a split second to see in between the canopy and to continually be in the air for –*

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[65] Transcript p 89.15

[66] Transcript p 90.24

[67] Transcript p 98

[68] Transcript p 95.28

in the- circling, you'll always wander, you can't focus on one thing...looking for a person is really, really almost impossible in the bush.'[69]

132. Sergeant Bartlett said that you can see tracks through the canopy of the trees in this area and VPAW advised him they were confident that if the vehicle had been on a track they would have seen it.[70]

133. A search urgency assessment form was made available to me during my investigation and Sergeant Bartlett, who had completed that form for this search, explained that the assessment gives you a numerical figure and is a guide as to how you should conduct the search based on age, medical condition, physical condition and clothing profile. He outlined the matters he considered which included that Matthew was an experienced prospector who had been out in the bush quite a bit, he was appropriately dressed, the weather was fine and that a person can survive in a vehicle overnight and without food for three weeks.

The possible sighting on 22 December 2014

134. Acting Inspector Lappin said that whilst it was reasonable for the family to be concerned about the effect of the possible sighting of Matthew near Amblers Lane on 22 December 2014, it was not the reason the search was scaled down on 23 December 2014. Nor was lack of resources the reason. Rather, the search was scaled down on the advice of SAR, because of a dearth of information as to where to search. They had no new leads and no information to indicate the search area should be expanded.[71] The focus therefore shifted to investigation and intelligence gathering, whilst a scaled down version of the search continued.[72]

135. Acting Inspector Lappin explained that all incoming information had to be validated and verified so in respect to the Ambler's Lane sighting members were sent off to test the information that was received. That happened '*parallel to the search*', not instead of.

136. Sergeant Bartlett gave evidence that he thought the description of the vehicle was a good match: *'we actually though it was the missing person's vehicle'*. However, it changed nothing about the search from their perspective: *'[t]he search still continued because we still had to*

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[69] Transcript p 103.22

[70] Transcript p 104

[71] Transcript p 57 - 58

[72] Transcript p 80

find that car'[73]. He acknowledged that the search on 23 December 2014 was not as extensive as the search on 24 December 2014. Whilst that was not his decision, he was content with the way the search was conducted on that day. SAR were not utilised on 23 December 2014 but as no further intelligence was derived throughout the evening and the possible sighting was eliminated, they were sent out again on 24 December 2014.[74]

137. Acting Inspector Lappin explained that after three days have passed it is an automatic process for a missing person case to be referred to the criminal investigation unit, and passed to a detective.[75] In this case the detectives were engaged on the morning of 22 December 2014 in an oversight role, pending them taking control of the investigation (not the search) side of the case.

138. Other avenues of enquiry that were conducted included an analysis of Matthew's computer and checks of his bank account. Sergeant Bartlett indicated that 'proof of life' checks for example on a bank account may give you a last known point.

139. Call charge records (**CCR**) from Matthew's mobile telephone were analysed in an attempt to ascertain if the mobile had been used recently and to see if any information could be gleaned from the most recent calls that had been made. Acting Inspector Lappin explained that through the CCR the police were able to deduce that the telephone had not been used for some time, probably not since the day before Matthew went missing.

140. Telephone triangulation was considered but was not approved. Acting Inspector Lappin said at the inquest that he did everything in his power to try and have phone triangulation done.[76]

141. As Counsel for the Chief Commissioner of Police (**CCP**) highlighted this was a moot point as Matthew's telephone was likely turned off (and in an area without reception) so that telephone triangulation would not have been fruitful in any event.[77]

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[73] Transcript p 100

[74] Transcript 109

[75] Transcript p 53.29

[76] Transcript p 63

[77] Transcript p 131

Review of the search

142. Due to the various issues raised by the family and my review of the brief, a formal request was made through the Victoria Police Legal Services Department for an independent review of the search.

143. At the inquest Inspector Murphy outlined that he was assigned the task of conducting the review due to his emergency management experience and that he was the only member of the 20 strong search and rescue team who had not been involved in some way in the search for Matthew.

144. Inspector Murphy indicated that Victoria Police get approximately 8000 missing persons reported to them each year, approximately 22 per day.

145. Inspector Murphy outlined his review of the search: '*...so that was their objective, so then their tactics to actually achieve that objective, were then to use – utilise as many units as they can, both our own units, Victoria Police's and through our um partner agencies and people we have relationships with...whether it be Parks Victoria, whether it be four-wheel drive clubs, whether it be walker's clubs, whether it be hiking clubs, use those relationships to then do as much of that searching as you possibly can um try and record that search ah as best you can. So that's – that's one thing around the actual search, trying to search as wide an area as you can as quickly as you can because time is of the essence in most of these matters..*'[78]

146. As to the supervisor not signing the risk assessment report, Inspector Murphy said that from all of the material he had reviewed, including the material in the coronial brief, it was evident that the document not being signed did not practically impact on the search as the supervisor had been contacted straight away and the search commenced immediately.[79]

147. As to the risk assessment, Inspector Murphy said that he agreed with the classification of 'low'. He explained that there were no obvious risk factors that would have taken it to the next level: '*...there's not obvious mental health issues, no obvious signs they want to do self-harm...in this case he may have come - come off the side of the road.*'[80]

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[78] Transcript p 117.26

[79] Transcript p 114

[80] Transcript p 114 - 115

148. Further Inspector Murphy said '*I don't think we would have thrown more resources at it even if we'd graded it as medium because they were operating on a medium to high risk ah with our search we were throwing at this particular search, in any event.* '[81]

Submissions

149. At the conclusion of the evidence I foreshadowed that: '*based on the evidence of Dr Iles, and I know the family are anxious for me to make a finding that there was a contribution to Matthew's death because of the inadequacy of the search but the evidence from Dr Iles indicates there was no evidence of a prolonged survival so I cannot see how I can make that finding of contribution, irrespective of how the search was conducted on the 23rd for example, or the 24th.* '[82]

150. Counsel for the CCP, Mr Lawrie, conceded the search activities on 23 December 2014 had an increased focus on intelligence gathering, but submitted the change in emphasis was appropriate.[83] He acknowledged that there was a diversion, to some extent, to follow up the Amblers Lane sighting, but that as the sighting had a number of characteristics that were very close to the vehicle and description of Matthew the police would have been negligent not to do so.

151. Mr Lawrie highlighted that irrespective of the diversion, a complete re-search of the area was conducted on 24 December 2014 to no avail. Further, even those who rode along the Bee Track did not see the vehicle, for reasons explained by Acting Inspector Lappin.

152. Finally Counsel for the CCP submitted that I should not find adversely in respect to any of the police members involved in the search '*...one thing that's apparent right throughout the evidence is there's no starvation of resources and in my submission there is nothing to suggest that any member who's got involvement in this, whether it's at the start it's Owen, or through to Mr Gatt or Mr Bartlett, has got an insufficient motivation or desire to complete the search with a positive result. Far from it. It's simply that despite their efforts, they were unsuccessful.* '[84]

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[81] Transcript p 119.18

[82] Transcript p 126.18

[83] Transcript p 130.18

[84] Transcript p 134:19

Conclusions

Cause of death

153. I accept the evidence of Dr Iles. Based on her evidence I am satisfied that Matthew either died from a cardiac arrhythmia or the effects of a snake bite. There is evidence to support the former. There is no evidence to support the latter, but this does not mean it did not happen. Given I am not able to decide between the two possible causes of death, I formally find the cause of death to be unascertained.

154. As to the timing of his death, Matthew was found lying face down next to his car. The rear door had possible finger marks and the driver's door was open. His telephone was in his front pocket, albeit there was no reception. The circumstances suggest a sudden collapse with no return of capacity.

155. There is no evidence to indicate a prolonged survival, either circumstantially or medically. If anything, the various forensic medical examinations suggest that death quickly followed collapse in that certain expected findings in the case of a prolonged survival were absent. Further, the two likely causes of death proffered by Dr Iles were causes of sudden death.

156. In all the circumstances I am satisfied that it is likely Matthew's death was sudden. Even if this was not so, Dr Iles proffered an outer limit of survival of 12 to 24 hours, meaning he would not have survived beyond midday on 22 December 2014.

Risk assessment

157. The family believe that the Police failed to properly assess the risk to Matthew's health and safety after he was reported missing and that this influenced the adequacy of the search.

158. After receiving the telephone call from Sara, SC Owen completed an 'Incident Field Report' and a 'Missing Person & Risk Assessment' Form. The latter form required input from both the officer taking the report and a supervisor. In particular the supervisor was to assess the risk as either high, medium or low based on the information completed by the junior officer. The form then dictated a response, in very brief terms, depending on the category of risk.

159. In this case whilst SC Owen completed the Risk Assessment Form he did not show it to a supervisor. That part of the form remained blank.

160. I am satisfied that this fact was inconsequential for a number of reasons. First I accept the evidence of Acting Inspector Lappin and Inspector Murphy that the category of risk would have been low in any event. Secondly, it did not detract from the response, which was to conduct an immediate and comprehensive search that night and the next day. Acting Inspector Lappin described the search as more consistent with a higher level of risk. Thirdly, the exigencies of country policing meant that it was not possible for SC Owen, who was at the Bacchus Marsh Police Station, to present the form to a supervisor that night. He did however, immediately notify the regional Sergeant who was at the Daylesford Police Station. He also caused the information to be uploaded onto the Victoria Police LEAP system thereby making it widely available to police across all stations. In so doing he facilitated and expedited the search rather than hindering it. Finally the information obtained by SC Owen was independently assessed by Sergeant Gatt and Acting Inspector Lappin the next day.

Adequacy of the search

161. The family believed that the possible sighting of Matthew late on 22 December 2014 caused the search to be scaled back even though the sighting was quickly discounted by the family. Acting Inspector Lappin specifically denied that this was the case. Rather, he explained, after conducting a thorough search the day before, the police were at a loss to know where else to search. It was not for lack of resources - as plenty were on offer - that they changed the emphasis of their search on 23 December to intelligence gathering, it was because of a lack of 'leads'.

162. According to Acting Inspector Lappin, he did not place a great deal of credibility on the possible sighting and it was really a matter of coincidence that the search was scaled back shortly afterwards. He also said that he did not prioritise obtaining the statement from Claus Nygren (the 'sightor') as they had more important things to do in the search and it did not affect their decisions anyway.

163. Sergeant Bartlett appeared more optimistic about the sighting as he thought the car sounded like a good match. His advice was to get the local police members to take a statement from Mr Nygren and to find the car he described. However, he too denied that the sighting, including the investigation of the sighting, detracted from or unduly influenced the search. He believed the approach taken on 23 December 2014 was appropriate irrespective of the sighting. That said, his explanation for why the search was scaled up again on 24 December 2014 was because the sighting had proved false and there was no new intelligence.

164. Whatever influence the false sighting on 22 December 2014 did have on the search on the 23rd, I am satisfied that it had no influence on the outcome for Matthew. For the reasons outlined above, I am satisfied that by that stage Matthew had already died.

165. In a passionate plea to the Court Matthew's brother Andrew stated, the police can't just excuse their mistakes by saying that Matthew[85] was already dead. I agree with that sentiment, however I disagree that the direction the search took on the 23rd was necessarily a mistake. As Counsel for the police, Mr Lawrie, said, how to conduct the search on 23 December 2014 was an operational decision. It should not be judged with the benefit of hindsight. Although it could be argued that there should have been a full scale re-searching of the areas already searched the day before, I accept that it was legitimate decision to concentrate on intelligence gathering.

166. In any event, it is doubtful whether a different approach on the 23rd would have produced results. The limitations on searching from the air are possibly demonstrated by the fact that VPAW flew over the vicinity of the location of Matthew's car on 22 December 2014 yet failed to see it. All searches, including those conducted on 24 December 2014 and those conducted by or at the behest of the family failed to find Matthew.

167. I also disagree that the police were less than diligent in their search efforts because they were influenced by Matthew's appearance and were suspicious of him because of that. Believing they had conducted a thorough search on 22 December 2014, it is understandable that the police would be exploring other avenues. I am satisfied that at all times they were motivated by a genuine desire to find Matthew but were hampered by a lack of information.

FINDINGS

168. Having investigated the death of Matthew Williams and having held an Inquest in relation to his death on 21 to 22 September 2016, at Melbourne, I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the identity of the deceased was Matthew Williams, born 3 June 1977; and

(b) that Matthew died on 21 or 22 December 2014 at Blackwood from unascertained causes, in the circumstances set out above.

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[85] Amended

169. Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

170. I direct that a copy of this finding be provided to the following:

Mrs Anne Williams

Ms Sara Okerstrom

Mr Chris Williams

Russell Kennedy Lawyers, representatives for the Chief Commissioner of Police

Sergeant Nathan Parker, Coroner's Investigator

Signature:

Rosemary Carlin

CORONER

Date: 10 March 2017

Amended on 12 May 2017 at 4:40pm