

INQUEST INTO THE DEATH OF SARAH ANNE RAWSON

FILE 262/2006

CORAM HIS HONOUR MAGISTRATE CARL MILOVANOVICH, NSW
DEPUTY STATE CORONER.

VENUE CORONERS COURT OF NEW SOUTH WALES SITTING AT PENRITH.

DATES 14TH MAY 2009 TO 28TH MAY 2009

APPEARANCES

Kristina Stern of Counsel with Joanna Murray instructed by the Crown Solicitor of New South Wales, assisting the Coroner.

David Hillard and Callan O'Neill, Solicitors of Clayton Utz for Wayne and Margaret Rawson (parents of the deceased).

Christopher H Watson, Solicitor of Watson's Solicitors for Shawn John Mullen.

Patrick Saidi of Counsel instructed by Kate Dobbie, Solicitor of Moray & Agnew Solicitors for the NSW Commissioner of Police.

R A Hewson of Counsel instructed by John Kamaras, Solicitor for Doctor Tim Schindler.

INTRODUCTION

1. The death of Sarah Anne Rawson was reported to me in my capacity as the NSW Deputy State Coroner on the Monday 13th March 2006 following her death on Saturday the 11th March 2006.
2. Sarah's death was a reportable death to a Coroner by virtue of Section 12 and 13 of the Coroners Act 1980 for the following reasons;
 - (a) Her death was sudden and unexpected.
 - (b) The manner and cause of her death was unknown.
 - (c) Her death was, on the known facts, a violent and unnatural death.
 - (d) A medical practitioner was prohibited from issuing a death certificate.
 - (e) Her death was being treated as suspicious.
3. On the 13th March 2006 I issued an order in writing to Doctor Peter Ellis, Senior Forensic Specialist at the Institute of Clinical Pathology and Medical Research, Westmead Hospital to conduct a post mortem examination on the body of Sarah Rawson. I directed that that a final report be submitted to the Coroner in writing.
4. The formal documents which have been tendered at this Inquest and which are now marked as Exhibit "1" include the following:-
 - (a) Report of Death to the Corner (P.79A)
 - (b) Identification Statement by William James Beekman.
 - (c) Certificate by Herim Kang dated 12/3/06 certifying life extinct.
 - (d) Final Post Mortem Report of Dr Ellis together with X Ray report.
 - (e) Report of Maree Coulter, (BSc) as to toxicology examinations.
5. The role of the Coroner is to investigate and examine the evidence surrounding the circumstances of a death. A Coroner has a statutory obligation pursuant to Section 22 of the Coroners Act 1980, to return a finding (where possible) as to the identity of the deceased, the date and place of death and the manner and cause of death.
6. A Coroner also has an obligation pursuant to Section 19 of the Coroners Act 1980 to examine the evidence to determine whether a known person or persons

may have committed an indictable offence in relation to the death of the deceased. In so doing a Coroner has a responsibility to examine the admissible evidence to determine whether (a) the evidence is capable of satisfying a jury beyond reasonable doubt that a known person or persons have committed an indictable offence and (b) make a determination as to the prospect of whether a jury would convict a known person or persons of an indictable offence in relation to the death of the deceased.

7. If a Coroner forms the view under Section 19 that a known person has committed an indictable offence in relation to the death of the deceased and that the Coroner is of the view that there is a reasonable prospect that a jury would convict, the Coroner is then required to return a finding limited to that of identity, date and place of death. The Coroner is then required to suspend the Inquest and inform the Director of Public Prosecutions that he has reached a view pursuant to Section 19 and also advise the Director of Public Prosecutions the name or names of the known person or persons and the indictable offence that the evidence supports.
8. A Coroner also has power under Section 22A of the Coroners Act 1980 to make recommendations. Recommendations are ordinarily made on issues of public health and safety.

ESTABLISHED FACTS

9. Sarah Rawson died on 11 March 2006 when she is known to have gone over a cliff at Hargrave's Lookout in the Blue Mountains. She fell approximately 70 metres and sustained serious head and other injuries. She is likely to have died almost immediately, and most probably sustained a number of impacts in the fall.

Background

10. Sarah was born on 3 April 1980 and was aged nearly 26 when she died.
11. She is described as a very happy and popular girl, and very independent. She was well travelled and clearly had a strong sense of adventure. She had had a number of jobs, including working with the disabled.
12. She had a history of fainting.
13. She was recovering from the effects of a serious road traffic accident which had occurred on 16 December 2005. In this accident Sarah had suffered serious orthopaedic and other injuries. She was undergoing occupational therapy, and was still mobilising in a wheelchair, although on occasion she had been observed taking a few steps out of her wheelchair.
14. Sarah had also suffered some depression after the road traffic accident. Anti-depressants were prescribed to her on 14 February 2006 with good effect. She was not in any way suicidal or expressing thoughts of self harm.
15. Sarah met Shawn Mullen on 24 February 2006 when they met at the King of the Mountain hotel. Sarah was flattered by his attention, although indicated to her friends and family that she was not interested in a long term or serious relationship.
16. Sarah and Shawn had seen each other on 26 February at the Log Cabin where they lunched together, and on 3 March in the evening at Gael's Nightclub. They had previously kissed when driving home from lunch at the Log Cabin.
17. Shawn has a history of psychiatric presentations dating from around 2001. These have included drug induced psychosis and possibly schizophrenia. In around 2001 – 2003 he had been noted during two separate episodes of deterioration of his mental state

necessitating admission to hospital to have had delusions including that he had a gift of a religious nature, and that he could cure or heal people, including by touching them.

18. Shawn was on long term psychiatric medication, Lovan 20 mg per day, and Seroquel 100 mg per day. This is indicative of a background psychiatric illness rather than active presentation.
19. As at 11 March 2006, Shawn had not had any admission for psychiatric presentation, or at which psychiatric symptoms had been noted, since 29 October 2004. His most recent GP attendance was with Dr Chau on 18 February 2006 when Dr Chau noted that he needed a script for Lovan as he was going away on a cruise in June 2006. According to Dr Parmegiani, Consultant Psychiatrist, this indicated that there were at that time no concerns about Shawn's mental state. Dr Chau had previously noted in October 2005 that Shawn's mood was stable and that he was enjoying work and had no psychotic symptoms.
20. Shawn's friend Jason Davis also noted that he seemed happy in the period leading up to 11 March 2006.

Events on 11 March 2006

21. As at 11 March 2006 Sarah's mobility was still very restricted, and she was able to walk only slowly and with difficulty. Her ability to use her arms to weight bear was very restricted. She could possibly have squatted, but it is likely to have been awkward for her, and getting up from that position is likely to have been difficult, and probably would have caused her some pain. However, her pain threshold may have been affected by alcohol.
22. Lesley Radbron, Sarah's occupational therapist, stated that she would not expect Sarah to have been able to squat, and would not expect her to have been able to get up from a squat, as she was unable to fully weight-bear on both legs. Ms Radbron said that the CCTV footage from Gearins Hotel looked like Sarah was not weight-bearing on both legs.
23. Sarah and Shawn had arranged to have lunch in the Blue Mountains on 11 March 2006. Sarah was wearing new clothes, and new shoes which are known to have had slippery soles.
24. Sarah and Shawn were captured by CCTV footage at 2.48 pm at Gearins Hotel in Katoomba. They can be seen kissing, with Sarah sitting on Shawn's knee in the

wheelchair. Sarah then walks approximately 2 metres from the chair to the steps, and Shawn helps her up the steps.

25. At 3.16 pm Shawn went to Katoomba Fair shopping centre, where he purchased some food, and to Liquorland where he purchased a bottle of Omni Pink Sparkling Wine at 3.23 pm.
26. Sarah spoke to her friend Lucy Macdonald at 3.17 pm and indicated that she was on the way to a lookout that she had previously been to with friends. She also spoke of a party to be held that evening at Sarah's mother's house, to which Shawn was invited. Lucy says that Sarah seemed really happy. Shawn also spoke to his friend Jason Davis in the early hours of the afternoon and told him that he was going to a party with Sarah that evening, and with Sarah's agreement he invited Jason to come along.
27. At 3.45 pm CCTV footage shows Shawn's car crossing the Blackheath level crossing in Govetts Leap Road, missing the turn to Shipley Road and then taking that turning at 3.46 pm, having turned around. This is on the way from Katoomba to Hargrave's Lookout.
28. The weather is recorded as being warm and calm on that day in Katoomba, although the wind was noted to be rising in the later afternoon.
29. Bradley Stroop was at the lookout and saw Sarah and Shawn arrive. He noticed that Sarah was having trouble walking and appeared to want to walk on her own without assistance. Linette Davies recalled Shawn saying to Sarah "are you sure you want to walk down there". A similar impression of Sarah wanting to walk unaided, and appearing to want to walk to the rock ledge on her own was formed by others who saw them then. All who saw them walk from the car to the ledge noticed that Sarah appeared to be walking with difficulty, but that she was walking with Shawn's assistance. They were seen on the ledge with wine and some food, on what appeared to be a blanket.
30. The rock ledge was approximately 30 centimetres high, and approximately one metre back from the cliff edge. Shawn's car was parked behind a tree approximately 5 metres from where they had set up the picnic. There was no safety fence between the car park and where they had set up the picnic, although there were a number of low, wooden bollards. One of those bollards displayed a small cliff warning pictogram.
31. Although there was a toilet at the lookout, it was locked at the time, and would have involved a prohibitive distance over uneven ground for Sarah to have walked or be wheeled.

32. They were seen looking romantic, sitting together. At one point Sarah was sitting effectively between Shawn's legs. At another he was lying between Sarah and the edge of the cliff. The last person to see Sarah and Shawn together at the lookout was Anissa Bakker who left shortly after 5 pm.
33. There were no other persons at the lookout at the time when Sarah fell to her death.
34. Shawn's account is that he got up to take some stuff to the car, and Sarah got up to urinate, then he heard her fall. On one account, he looked over a couple of times and saw her about to urinate, and then whilst she was urinating. He says he heard her scream and then ran over to try to find her. Shawn estimated to Police that Sarah took "roughly five seconds" to urinate and be seen starting to pull her pants up.
35. A patch of urine was identified by police by smell next to the rock ledge, and just adjacent to a dangerous chute which, on close observation, involved a sheer drop down the cliff. This wet patch is described as being about 30 cm x 50 cm and positioned about 1 metre from a steep incline. The steep incline, or chute, was deceptively dangerous as the drop was masked by the contours. It formed a kind of funnel towards a sheer drop. The surface was uneven at the top of the chute.
36. Sarah had drunk a lot of alcohol, as her blood alcohol at the time of her death was in the region of 0.15 g/100 ml. This amount of alcohol is likely to have affected her stability and judgment. It may have made lead to a release of inhibitions. Her antidepressant medication may have exacerbated the effect of alcohol.
37. Shawn Mullen made a 000 call at 5.45 pm. During the call, he expressed concern that he might be "going to go to gaol for this" and might be "done for manslaughter". He said once that he had seen Sarah Rawson's body "in four pieces, I think" and "mangled". He said that he had tried to get down to get to her but had not been able to. He had seen her body when he went down the cliff and she appeared dead.
38. Between 5.30 and 6 pm Shawn was seen by the Mr and Mrs Caucino who drove up and found him on the telephone and agitated and crying. He told them that his girlfriend had fallen off the cliff a few minutes earlier, and that she was dead. He was crying and seemed to be heaving as if throwing up.
39. An ambulance was booked at 5.45 and arrived at 6.13 pm. The ambulance attendants described Shawn as clearly agitated and upset but nothing out of what might have been expected. They did not identify any signs of symptoms of mental illness. Police then

arrived. Harry Gatt, a paramedic, was winched down to where Sarah was found and tested for signs of life. He did not attempt to rescue her body.

40. Sarah was found at the bottom of the cliff, in an unnatural position. She could be seen from some points at the lookout, but not from the chute area, and not from the area where the picnic took place.
41. She was found with her jeans open but pulled up. The zip was torn towards the bottom but there was no sign that the buttons of her jeans had been ripped open. Her underpants were rolled down. It is likely that her jeans buttons were undone when she fell, but it is not possible to know whether or not her jeans were in that position when she fell. Leaf matter was found on her bottom, but that may have occurred during her fall.
42. Remnants of a picnic were found on a cliff top at the lookout – half a strawberry, a packet of Longreach cigarettes, an open pack of table water crackers and an empty 750 ml bottle of Omni Pink wine. These were positioned on a rock platform about a foot higher than the cliffs edge. They were later blown around a little by the wind from the helicopter.
43. Shawn was taken to Katoomba Police Station where he was interviewed by police in a lengthy interview (without caution) in the evening of 11 March 2006. Senior Constable Howe described him as cooperative, with normal affect and not displaying anything which Senior Constable Howe would have recognised as a sign or symptom of mental illness.
44. Shawn's injuries were photographed that night.
45. Sarah's body was recovered on the morning of 12 March 2006. Senior Constable Peters abseiled down the cliff that morning looking for information. He identified a shoe some distance down in the chute, and a further shoe, sunglasses and a Liquorland paper bag further down the cliff. He did not see signs of disturbance in the first section of the chute, but saw what he identified as points of impact in other locations down the cliff face.
46. It is likely that Sarah fell down the chute, given the physical indicators of impact, the evidence of her shoe, and the location where her body was found.
47. A life extinct certificate was issued by Dr Kang about 3.30 pm on 12 March 2006.
48. Sarah was identified by her uncle, William Beekman on 14 March 2006 at Westmead Hospital.

Events on 12 March 2006

49. On the morning of 12 March 2006 Shawn attended his general practitioner, Dr Schindler. He was in grief. Dr Schindler recommended counselling.
50. Shawn later broke a glass window at his home. At 2.15 pm he was brought in by ambulance to the Blacktown Hospital. He was initially noted to be softly spoken and grieving. His parents were concerned that he might kill himself. He wanted tranquillisers and wanted to leave after his initial assessment. However, he was told that he had to wait to see the psychiatrist. He was seen by Dr Arghandewal at some time around 5.30 pm. For some reason he then attempted to leave, and was chased by security guards. There was then an altercation with a security guard. There are competing accounts as to this. Following this Shawn was detained under powers in the Mental Health Act, anti-psychotic medication was administered, and he was transferred to Cumberland Hospital. He was discharged from Cumberland Hospital the following day on the basis that he could not be detained as he was not mentally ill. The diagnosis was situational crisis. The discharge summary noted that he did not show any psychotic or mood disorders. The discharge summary noted that he did not show any psychotic or mood disorders. The Cumberland Hospital notes record that Shawn had been "frustrated and punched glass window" and had been upset at the "manner of interrogation" by Dr Arghandewal and "snapped".

Shawn's psychiatric state as at 11-12 March 2006

51. In the light of the evidence of Dr Parmegiani, it is unlikely that Shawn was suffering from any delusions or psychotic symptoms on 11 or 12 March 2006.
52. Dr Parmegiani's evidence was that Shawn has experienced a prolonged emotional response to Sarah's death, which is not a mental health issue. Dr Parmegiani's evidence was that this emotional response was outside the normal range to be expected.

SUMMARY AND FINDINGS

53. The Inquest into the death of Sarah Anne Rawson commenced with the taking of oral evidence at Katoomba Court on Monday 11th May 2009 followed by a site view at Hargraves Lookout, which was attended by the Coroner, Counsel assisting and the legal representatives of the interested parties. Over the ensuing two weeks oral evidence was taken from some 33 witnesses and a comprehensive brief of evidence was tendered (Exhibit 2) together with a further 24 Exhibits.
54. This Court has now had the opportunity of hearing the final submissions and reading the written submissions presented by all interested parties.
55. As correctly outlined in her opening address, Counsel Assisting the Coroner, has identified the issues in this Inquest and the statutory obligations placed on a Coroner pursuant to Section 22 of the Coroners Act 1980 in examining the evidence and returning findings as to the identity of the deceased, the date and place of death and the manner and cause of death. It goes without saying that the question of identity, date and place of death are well established from the evidence. It is also clear from the evidence that the cause of Sarah's death was due to multiple injuries sustained as a result of impact with terrain when her body fell a distance of some 70 metres.
56. The primary focus of this Inquest has been to try to determine the manner of death, in other words and put simply, how did Sarah come to fall, was it a tragic accident, was there any involvement by any other person or is there any other possible explanation which might explain her death that is supported by the presented evidence.
57. It should perhaps be firmly stated at the outset, that while speculation and various hypothesis as to the manner of death can be entertained and considered through the inquisitorial process, ultimately a Coroner's findings must be based on the factual evidence as presented during the Inquest. The evidentiary test applied to Coronial proceedings is equivalent to the civil test, being on the balance of probabilities and a Coroner in reaching a finding need not apply the more stringent test, beyond reasonable doubt, applicable in criminal proceedings.
58. It has been established from the evidence that Sarah Rawson first met Shawn Mullen on the 24th February 2006 at a Hotel. At this meeting personal details were exchanged and

they met again on the 26th February again at licensed premises and in the company of Sarah's friends. A further meeting took place on the 3rd March 2006 at a Nightclub and subsequently arrangements were made for an outing together which was planned for the 11th March 2006. The evidence would suggest that Mr Mullen had showed an interest in Sarah, they had kissed on one occasion and while Sarah had expressed to her friends that she was not interested in any long term relationship, it is apparent that she had agreed to the outing on the 11th March. The outing was originally planned as a drive to the Blue Mountains with lunch possibly at the 3 Sisters at Katoomba. There is no doubt on the evidence that it was at her suggestion that they drive to that area. It is known that on route they had stopped at a hotel and consumed alcoholic drinks and then stopped to purchase snacks and a bottle of wine before making their way to Hargraves Lookout.

59. The evidence would support that Sarah and Mr Mullen would have arrived at the Hargraves Lookout at approximately 4.00pm. This time frame can be determined from CCTV footage which shows Mr Mullen's vehicle entering Shipley Road at the level crossing at Blackheath at 3.46pm and taking into account the distance from that point to the Lookout, they would have arrived at around 4.00pm. A number of witnesses have given evidence of seeing Sarah and Mr Mullen between the approximate time frame of 4pm to 5pm. In short that evidence includes observing Mr Mullen assisting Sarah to the rock ledge, seeing them sitting together and observing that they appeared to be having a picnic and being affectionate to each other. While most of the witnesses who did see Sarah and Mr Mullen have had difficulty in remembering precise times, it would appear that Mrs Bakker may have been the last person to see both Sarah and Mr Mullen and she believed that the time was around 5.00pm.

60. Some time between this last sighting at around 5.00pm and prior to the arrival at the Lookout of Mr & Mrs Caucino, Sarah fell to her death. As to the precise time Sarah fell could not be determined from the evidence nor from the record of interview conducted with Mr Mullen. What is known however is that Mr Mullen phoned 000 at 5.45pm and when Mr & Mrs Caucino arrived at the Lookout, Mr Mullen was speaking to the 000 Operator. The evidence has also established that after Sarah fell, Mr Mullen climbed partially down the cliff face to a point where he could see Sarah's body. As to how Mr Mullen was able to climb down the cliff face and as to what route he took is not clear, however, his statement to the 000 operator that he could see Sarah together with the abrasions on Mr Mullen support the fact that he did in fact descend the cliff face. Having regard to the fact that when Mr & Mrs Caucino arrived at the Lookout, at a time which must have been after the commencement of the 000 call at 5.45pm and taking into

account the time that it would have taken for Mr Mullen to descend the cliff face and return, it is probable that Sarah fell to her death sometime between approximately 5.00pm and approximately 5.30pm.

61. The only person present and the only witness to see Sarah falling from the cliff face was Mr Mullen. Mr Mullen exercised his legal right, pursuant to Section 33 of the Coroners Act 1980, not to give evidence at this Inquest. He did however provide a voluntary record of interview without caution which forms part of the evidence tendered. In addition the tendered evidence also includes a transcript of the 000 call Mr Mullen made at 5.45pm on the 11th March 2006. I do not propose to go into detail as to what is contained in both a lengthy record of interview or the 000 transcript. By way of summary, however, Mr Mullen has stated that he was in the process of packing up his vehicle when Sarah indicated that she needed to urinate. In both his 000 call and the record of interview he has maintained a consistent version on one issue, that being that he did not actually see Sarah fall. While it is accepted that some minor inconsistencies exist, there is consistency in his assertions that he was some metres from her when he heard a muffled cry and then heard the sound of branches and turned to see that she was no longer on the cliff edge. Mr Mullen stated that Sarah had decided to urinate and he observed her taking her jeans down and that he then turned away.
62. The investigation of the crime scene detected what has been described as a wet patch in partly sandy and rocky soil close to the cliff edge. While no forensic testing was done of this wet patch for reasons already stated, Constable Peters, who first observed it, knelt down and smelt it and observed an indentation in the soil. He formed the view that it was a urine patch and most likely from a female. The existence of the wet patch, its smell and its location is consistent with the version given by Mr Mullen that Sarah indicated a desire to urinate and that urination had commenced.
63. The forensic evidence presented in regard to Sarah's clothing is of considerable relevance. The evidence has indicated that Sarah had purchased new jeans on the day prior to this outing. When Sarah's body was located and photographed in situ, her jeans are positioned around her hips. When her body was recovered and again photographed at both the cliff top and at Westmead Hospital, the jeans are in a similar position. The jeans are seen as being undone at the front, with the zipper fully extended in the downward position and a tear can be seen in the zipper at the extremity of the downward position. It is also apparent that what appear to be either brass or metal buttons (two) which would secure the jeans once the zipper was fully closed show no damage or strain on the material that attaches those buttons to the jeans. Similarly, the adjacent button

holes (two) which would accommodate the metal buttons show no evidence of fraying or damage that might be consistent with the buttons being dislodged during the fall.

64. While it is difficult to speculate whether the fall may have re-arranged Sarah's clothing and to what extent, the positioning of the jeans and her underwear is supportive of the fact that it is more probable that at the time Sarah fell, her jeans and underwear was not fully pulled up, zippered or buttoned.
65. If this evidence is accepted, as I believe it should, it does support and corroborate the version given by Mr Mullen that Sarah commenced to urinate and that she fell some time after urinating and before being able to fully adjust her panties and jeans.
66. The post mortem and toxicology examinations revealed that Sarah had a blood alcohol content of 0.150 ml/100 gms at the time of her death. Expert pharmacology evidence was not able to rationalise how Sarah would have had such a high alcohol level on the evidence presented regarding alcohol consumption on the day. The evidence of Mr Mullen was that Sarah consumed possibly two full strength beers, believed to be schooners at a Hotel before 3.00pm. Dr Allender, Pharmacologist stated that the Omni wine had an alcohol content of 11.5% and according to Mr Mullen he had consumed possibly two glasses and that Sarah had consumed the remainder. The only conclusion that can be drawn on the assumption that the alcohol reading is correct is that either more beer was consumed prior to 3.00pm by Sarah or that she had drunk the majority of the Omni wine to reach an alcohol level of 0.150 at the time of her death.
67. Blood alcohol readings are invariably reliable and on the basis of Sarah having a blood alcohol content of 0.150, which would be three times the legal limit for an unrestricted driver, there is little doubt that she would have been affected by this level of alcohol. Dr Allender has stated and this Court can take judicial notice that alcohol readings in the range of 0.150 will affect judgment, inhibition and motor skills, even in a person with a high tolerance for alcohol. Toxicology also found that Sarah had a blood sample in which Sertraline was detected at 0.2 milligrams per litre. Dr Allender has stated Sertraline is an anti depressant which can result in dizziness and drowsiness and that care should be taken with any activity which requires alertness and judgment, particularly early in the treatment.
68. If the account given by Mr Mullen is to be accepted, that being that Sarah intended to urinate close to the cliff edge, it is certainly possible that with her restricted mobility and

the affectation of alcohol and prescription medication, she may have lost her footing or fainted.

69. The Police and Coronial investigation also examined and investigated whether there was any evidence to suggest or support the possible involvement of Mr Mullen in Sarah's death. Mr Mullen was not treated as a suspect in the early stages of the investigation and it was for that reason that he was not cautioned when he gave his record of interview. Mr Mullen was co-operative with the Police and voluntarily provided a DNA sample as well as surrendering the clothing he was wearing on the day for forensic examination. Mr Mullen, the Court has been told, was prepared to participate in a re-enactment with Police, however, decided not to after a media article and following legal advice.
70. Mr Mullen was investigated by the Police for a number of reasons. Firstly and I believe correctly, Sarah's death, and any death in similar circumstances where there are no independent witnesses, needs to be thoroughly investigated. The presumption with a violent and unnatural death should always be to treat the matter as suspicious. Appropriate investigative techniques, crime scene preservation etc, are all important not only in trying to find the truth, but also to possibly exonerate a person of interest.
71. It became apparent in the early stages of the Police investigation that Mr Mullen had a psychiatric history and information provided to Police by some of Sarah's friends described Mr Mullen as being "strange" and perhaps obsessive about Sarah. A conversation that Mr Mullen had with an off duty Police Officer at the Log Cabin Hotel was perceived as unusual as was some of the comments he made to the 000 operator. Mr Mullen presented to Blacktown Hospital on the day following Sarah's death and was then scheduled under the Mental Health Act to Cumberland Hospital, but discharged on the following day on the basis that he was not mentally ill.
72. Mr Mullen's medical history has been subject to close scrutiny during the investigation and during this Inquest. Police, in my view appropriately wanted to examine whether Mr Mullen's may have been experiencing a recurrence of the psychosis he had exhibited during admissions in 2003 and 2004. A relevant feature of the 2003 and 2004 psychosis was a belief that Mr Mullen had that he had certain healing powers. This knowledge plus the known fact that Mr Mullen appeared attracted to Sarah who was wheelchair bound was considered an appropriate avenue for investigation.

73. The court has heard evidence from Mr Mullen's general practitioner Dr Schindler, who stated that he was aware of Mr Mullen's past medical history, however, was of the view that he was compliant with his medication and had not exhibited any signs of psychosis since 2004. Mr Mullen was spoken to and observed by a number of personnel from the Police and Ambulance at Hargraves Lookout. Their collective evidence was of observing a man who appeared upset and distressed but not of a man who was exhibiting behaviour that was bizarre or strange or indicative of a florid or acute mental disturbance. This evidence is relevant as it was made by personnel who would have some experience in dealing with persons suffering a mental illness and the observations were made within a relatively short time after Sarah fell from the cliff. Similarly, Dr Parmegiani, Psychiatrist, who thoroughly reviewed the medical records of Mr Mullen was firmly of the view that at the time of Sarah's death, Mr Mullen was not exhibiting any form of psychosis. Dr Parmegiani did express a view that the grief Mr Mullen exhibited regarding Sarah's death appeared disproportionate having regard to the shortness of their relationship.
74. The evidence presented at this Inquest does not suggest that Mr Mullen was mentally ill or suffering from any psychosis at the time of Sarah's death. Similarly his admission to Cumberland Hospital with assertions of aggressive behaviour should, in my view, be seen in the context of a man who had witnessed a violent death, followed by feelings of guilt and compounded by a confrontation with Security Staff at Blacktown Hospital. Sight should not be lost of the fact that he was discharged promptly after being examined by two Doctors at Cumberland Hospital.
75. A degree of attention was focused on two specific comments that Mullen made to the 000 operator. The first being his expression of concern that he would be "up for manslaughter" and the second his statement of seeing Sarah in four pieces. I believe these statements, particularly in view of the evidence of Dr Parmegiani that Mr Mullen was not psychotic, must be considered in the context of what took place on the 11th March. There is no doubt that when one reads the 000 transcript in its entirety, that Mr Mullen makes a number of references to a feeling of guilt and expresses concerns as to what Sarah's parents will think. Bearing in mind that the relationship was a relatively short one and that it was Mr Mullen's idea to take Sarah to the Blue Mountains, feelings of guilt or of responsibility should not in my view be seen as unusual. There is perhaps also some feeling of responsibility because it was Mr Mullen who assisted Sarah to get her to the cliff edge. Also if his version is to be accepted, he may also have feelings of guilt in not assisting Sarah when she wanted to urinate. The reference to seeing Sarah

in four pieces, I believe can properly be explained in the context of a man who would have been traumatised, saw a body from a distance, perhaps his view partially obstructed by foliage and seeing her limbs in an unnatural position. I do not believe the first statement imports and admission or inference to wrongdoing, nor does the second statement support that Mr Mullen was psychotic at the time he saw Sarah's body.

76. It has been submitted by Counsel Assisting, Ms Stern, Mr Saidi and Mr Watson that this Court should return a finding that Sarah's death was due to an accidental fall, albeit, that the Court can not determine the precise mechanisms that may have precipitated the fall. Mr O'Niell on behalf of the Rawson family has submitted that this Court should return an open finding. An open finding would be worded in the following manner;

"That Sarah Anne Rawson died on the 11th March 2006 at the Hargraves Lookout, Blackheath in the State of New South Wales, from multiple Injuries, sustained there and then when her body fell and impacted with Terrain. As to the manner in which Sarah Anne Rawson fell to her death, From the evidence adduced, I am unable to say"

77. A finding as suggested by Counsel Assisting, Mr Saidi and Mr Watson, would be worded in the following manner;

"That Sarah Anne Rawson died on the 11th March 2006 at Hargraves Lookout, Blackheath in the State of New South Wales from multiple Injuries sustained there and then when she accidentally fell from the Cliff edge."

78. In reaching a finding, a Coroner should make every endeavour to obtain evidence, which will allow him or her to come to a positive verdict. This court understands that these proceedings are particularly difficult for the Rawson family and the Court is well aware that the family looks to the Court to provide some answers. Sometimes, despite the best endeavours, all the answers are not there. This court also must acknowledge that these proceedings would have been particularly stressful to Mr Mullen and his family, particularly if his version of what happened is the correct version. While this court understands that Mr Mullen has been subject to innuendo and has had his personal life, as has

Sarah's, played out in a public arena, this court makes no apology for that burden. The reason for that, and I trust both families will understand, is that this Courts responsibility is to Sarah and I am sure every parent would want a Coroner to examine every possible avenue in relation to a death that, prima facie, may be suspicious, unusual or unexplained.

79. Relatives look to the learning and experience of a Coroner to solve what is a puzzle to them, and the Coroner should not shrink from bringing in a definite verdict out of mere timidity or excessive concern for their feelings. An open finding is satisfactory to no one and should only be returned where the evidence is of an uncertain character, or unreliable or insufficient. (Ref Jervis 9th Ed).

80. In this Inquest the evidence as to what happened at Hargraves Lookout consists of the version given by Mr Mullen, coupled with the forensic evidence. The forensic evidence is capable of corroborating the version given by Mr Mullen, in particular;

- (a) evidence of ground disturbance near the chute and impact points which are more consistent with an accidental fall, rather than a body leaving the edge with any degree of force;
- (b) location of shoes and sunglasses are consistent with the version given by Mr Mullen of where he last saw Sarah before hearing her fall;
- (c) evidence of a wet patch, determined to be urine which is consistent with the evidence of Mr Mullen that Sarah had indicated a desire to urinate
- (d) The positioning of Sarah's clothing, in particular he jeans and underwear, which is consistent with Sarah having urinated and perhaps in the process of adjusting her clothing when she fell;
- (e) DNA evidence, which supports Mr Mullen's version that some degree of intimacy took place; and
- (f) despite injuries sustained during the fall, forensic evidence did not locate any injuries on either Sarah or Mr Mullen that could be seen as supportive of any assault.

81. Having examined all the available evidence, it is the view of this Court that Sarah's death was a tragic accident. I propose to return a formal finding in the following terms.

FINDINGS

That Sarah Anne Rawson died on the 11th March 2006 at Hargraves Lookout, Blackheath, in the State of New South Wales, from multiple injuries following an accidental fall from the cliff edge.

RECOMMENDATIONS

This Court has been informed that Counsel Assisting contacted the Blue Mountains City Council, who it is understood are responsible for maintaining the Lookout and facilities at Hargraves Lookout. It has become apparent during this Inquest and during the site visit that the area where Sarah Rawson fell to her death is hazardous. While there is suitable fencing on the Lookout proper, the area, which is immediately to the north and with an easterly aspect, is directly adjacent to the car park. It was noted that timber bollards are erected there and what appeared to be a worn picture graph indicating a cliff edge. My concern is that this rock ledge is adjacent to the car park and young children could easily run out of vehicles or wander into this area, and not be aware of the potential danger. Similarly, adults may not be aware of the sudden cliff drop and the uneven surface.

I would recommend that the Council examine the site and give consideration to upgrading the signage in this area and also give consideration as to whether some form of fencing may be appropriate having regard to the proximity to the car park.

Magistrate Carl Milovanovich
NSW Deputy State Coroner
Findings handed down at Penrith Court on 28 May 2009

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