Special Commission of Inquiry into LGBTIQ hate crimes

Volume 2

Commissioner, The Honourable Justice John Sackar

December 2023

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CATEGORY A

Introduction

5.1. In the Terms of Reference, I was authorised as Commissioner "to inquire into and report and make recommendations" to the Governor in relation to two categories of unsolved deaths, Categories A and B. My consideration of Category B deaths is contained in **Chapter 6** of this Report.

5.2. Category A is expressed as follows:

> *A. The manner and cause of death in all cases that remain unsolved from the 88 deaths or suspected deaths of men potentially motivated by gay hate bias that were considered by Strike Force Parrabell.*

5.3. The significance of several aspects of the language used in Category A is addressed at **Chapter 1** of this Report. I reiterate some aspects of that discussion here.

5.4. First, Category A refers to deaths that were "potentially motivated by gay hate bias", while Category B refers to "suspected hate crime deaths … where … the victim was … a member of the [LGBTIQ] community" (emphasis added).

5.5. I have treated those two different verbal formulations as referring to what is substantially the same concept or criterion. I have generally adopted the language of "LGBTIQ hate crime death" as reflecting this one criterion.

5.6. For the purposes of the Inquiry, as I have explained in **Chapter 1** of this Report, an unsolved death is regarded as a suspected LGBTIQ hate crime death, and thus prima facie within one or both of Categories A and B of the Terms of Reference, in circumstances where there is, objectively, reason to suspect both that the death was a homicide, and that membership or perceived membership of the LGBTIQ community was a factor in the commission of the crime.

5.7. Accordingly, for example, deaths associated with attacks on people who may not themselves have been members of the LGBTIQ community, but who are wrongly perceived by their assailants in such a way, would come within the meaning of "LGBTIQ hate crime deaths". Further, the Terms of Reference direct me to inquire into and report only on "deaths", not on crimes such as assaults which may have been LGBTIQ bias crimes but did not result in death.

5.8. Secondly, Category A refers to 88 deaths of *"men"* that were *"considered by Strike Force Parrabell"* whereas in Category B, the reference is to the deaths of people described as *"victims"*. In fact, some of the deaths considered by Strike Force Parrabell were not of men. In order to recognise and acknowledge the gender identity of all those persons considered by Strike Force Parrabell, I have interpreted the word "men" in Category A as referring generally to "people".

Deaths considered "unsolved" by Strike Force Parrabell

5.9. The origins of Strike Force Parrabell are set out in detail in **Chapter 13**.

5.10. Strike Force Parrabell was established by the NSWPF in about August 2015. It was a review, on the papers, of a list of 88 deaths which had been the subject of media attention since at least 2013. The 88 deaths occurred in a 23-year period between 1976 and 1999.[1] All 88 names are listed at the commencement of the Parrabell Report.

5.11. That list had been developed over many years, since about 1990, principally by Ms Sue Thompson, who was the NSWPF Gay and Lesbian Client Consultant from 1990 to 2002. Ms Thompson was assisted by others in developing the list, including Professor Stephen Tomsen.

5.12. Strike Force Parrabell reviewed only 86 of the 88 deaths. One of the deaths occurred in Tasmania and was not examined.[2] Another death, that of "David Williams", although it was one of the 24 described as "unsolved" in the Case Summaries, was actually not examined at all, because Strike Force Parrabell was unable to locate any records relating to the death.[3]

5.13. In the Case Summaries prepared by Strike Force Parrabell, 24 cases are described as "unsolved", whereas in the Parrabell Report itself, the number of "unsolved" cases is said to be 23.

5.14. The explanation for the discrepancy between 23 and 24 unsolved cases was, as the Inquiry ascertained, that the person noted as "David Williams" was actually named "David Lloyd-Williams".[4] The Inquiry's consideration of the death of Mr Lloyd-Williams is included below.

5.15. In my view, the Parrabell Report did not identify any criterion or criteria used in designating cases as "solved" or "unsolved". None of the three Strike Force Parrabell officers who gave evidence to the Inquiry addressed the topic of what criterion, if any, was used by the Strike Force in describing a case as "unsolved".

5.16. The 24 deaths described as "unsolved" in the Strike Force Parrabell Case Summaries were as follows (in chronological order):

(1) Mark Stewart (aka Mark Spanswick) (1976);

(2) David Williams (1979);

(3) Walter John Bedser (1980);

(4) Richard Slater (1980);

(5) Gerald Leslie Cuthbert[5] (1981);

[1] Exhibit 6, Tab 56A, Document from Sue Thompson titled 'Brief: Likely NSW Gay Hate Murders from Late 70s to Late 90s', undated (SCOI.77314).

[2] Exhibit 1, Tab 2, NSW Police Force, *Strike Force Parrabell Final Report*, 23, 69 (Report, June 2018) (SCOI.02632).

[3] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries, undated, 2 (SCOI.76961.00014).

[4] Exhibit 12, Tab 6, Death Certificate for David Lloyd-Williams, 9 November 1978 (SCOI.74028).

[5] Incorrectly identified as "Gerard Leslie Cuthbert" in the Strike Force Parrabell Report: see Exhibit 1, Tab 2, NSW Police Force, *Strike Force Parrabell Final Report*, 7 (Report, June 2018) (SCOI.02632).

(6) Peter Sheil (1983);

(7) Wendy Waine (1985);

(8) Gilles Mattaini (1985);

(9) William Antony Rooney (1986);

(10) Raymond Frederick Keam (1987);

(11) Scott Johnson (1988);

(12) William Emmanuel Allen (1988);

(13) Ross Bradley Warren (1989);

(14) Graham Paynter (1989);

(15) John Russell (1989);

(16) Michael John Swaczak (1991);

(17) William Dutfield (1991);

(18) Cyril Olsen (1992);

(19) Crispin Wilson Dye (1993);

(20) James William Meek (1995);

(21) Kenneth Brennan (1995);

(22) Carl Stockton (1996);

(23) Scott Stuart Miller (1997); and

(24) Samantha Rose (1997).

Deaths considered "unsolved" by ACON

5.17. In its report, *In Pursuit of Truth and Justice*, published in May 2018 (one month prior to the report of Strike Force Parrabell) (the **ACON Report**), ACON referred to "approximately 30" of the 88 deaths as unsolved.[6] The ACON Report did not identify those 30 by name.

5.18. However, in July 2016, ACON provided Strike Force Parrabell with a document titled, "ACON Gay Hate Murders List as at 18 July 2016".[7] Based on that list, it seems that, in addition to the 24 deaths described by Strike Force Parrabell as "unsolved", ACON considered the following deaths to also be unsolved:

(1) Paul Rath (1977);

(2) Andrew Currie (1988);

[6] Exhibit 1, Tab 1, ACON, In Pursuit of Truth and Justice: Documenting Gay and Transgender Prejudice Killings in NSW in the Late 20th Century, 6 (Report, 26 May 2018) (SCOI.03667).

[7] Exhibit 6, Tab 67A, ACON Gay Hate Murders List, 18 July 2016 (SCOI.74278).

(3) Russell Payne (1989);

(4) Samantha Raye (1989);

(5) John Gordon Hughes (1989);

(6) Blair Wark (1990); and

(7) Gerard Fleming (2007).

5.19. Mr Fleming died in 2007, and his death was therefore outside the timeframe being considered by Strike Force Parrabell.[8] I note that on 30 August 2008 a teenager was convicted of manslaughter in relation to the death of Mr Fleming, and consequently I do not consider that his death was unsolved for the purposes of the Inquiry.[9]

Deaths considered "unsolved" by the Inquiry

5.20. As I observed in **Chapter 1**, a key preliminary step in the Inquiry's work was for me to reach a determination as to which deaths were "unsolved". The Terms of Reference did not define the term "unsolved".

5.21. I did not simply proceed on the footing that the "unsolved" cases referred to in Category A of the Terms of Reference were the 23 (or 24) so described by Strike Force Parrabell. Rather, it was necessary for me to make my own assessment as to how many of the 88 Parrabell cases should be regarded as having "remained unsolved", as at the inception of the Inquiry in April 2022.

5.22. From May 2022 onwards, the Inquiry embarked on its own assessment of which of the 88 deaths reviewed by Strike Force Parrabell should properly be regarded as having "remained unsolved" as at the date of the Terms of Reference. That process involved, *inter alia*, consideration of publicly available information, including court judgments, and all the material eventually produced by the NSWPF. One resource, among many, considered by the Inquiry was the SBS "Gay Hate Decades" website.[10]

5.23. The Inquiry also took into consideration concerns expressed by some community groups, academics and activists, that some deaths of LGBTIQ persons had been inadequately investigated, sometimes leading to precipitate findings of suicide or misadventure.[11]

5.24. I concluded that a case was "unsolved" where, upon a preliminary review of the material available to me, it was either apparent that a case was not solved (see below), or where the primary theory advanced in the material was attended by sufficient doubt for me to consider that the case was prima facie unsolved.

[8] Exhibit 6, Tab 85, Email from Craig Middleton to Jacqueline Braw re: ACON Gay Hate Murders List, 9 February 2017 (SCOI.74437).

[9] AAP, 'Manslaughter verdict in stabbing case', The Sydney Morning Herald (online, 30 August 2008) <https://www.smh.com.au/national/manslaughter-verdict-in-stabbing-case-20080830-gdsswu.html>.

[10] Exhibit 6, Tab 223, Rick Feneley, 'The Gay Hate Decades', SBS (online) <https://www.sbs.com.au/gayhatedecades/> (SCOI.82033).

[11] Exhibit 1, Tab 1, ACON, In Pursuit of Truth and Justice: Documenting Gay and Transgender Prejudice Killings in NSW in the Late 20th Century, 4-5, 31 (Report, 26 May 2018) (SCOI.03667).

5.25. The assessment of the status of a case depended on the circumstances of each case. For example, among the circumstances in which a case might be regarded as "solved" would be cases where:

a. One or more persons have been charged and convicted in connection with the death, and all appeals have been finalised;

b. Such a person has been acquitted, despite having been the perpetrator, on grounds such as self-defence;

c. The evidence available to me at this preliminary stage established that the death was not a homicide but a suicide or misadventure.

5.26. Conversely, among the cases which might be regarded as "unsolved" would be, for example, cases where although the death was a homicide (or the possibility of homicide could not be ruled out):

a. No person of interest had been identified;

b. One or more persons of interest were identified, but no person had ever been charged;

c. A person was charged, but the prosecution was discontinued, or the charges were dismissed at a committal hearing, or the accused was acquitted at trial for reasons other than self-defence;

d. A conviction was overturned by a higher court.

5.27. Other cases which might be regarded as "unsolved" were those where a deceased was found in circumstances where what actually happened (the manner of death) was simply unknown, even where the cause of death might be sufficiently clear (e.g., injuries caused by a blow to the head, or injuries consistent with a fall from height).

5.28. Of the 88 Parrabell cases, I identified eight described as "solved" which I considered warranted close attention as possibly also being "unsolved" (in addition to the 24 so described by Strike Force Parrabell). These cases were:

(1) Paul Rath (1977);

(2) Andrew Currie (1978);

(3) Russell Payne (1989);

(4) Samantha Raye (1989);

(5) John Gordon Hughes (1989);

(6) Simon 'Blair' Wark (1990);

(7) Robert Malcolm (1992); and

(8) Brian Walker (1992).

5.29. However, two of that total of 32 cases, namely the deaths of Raymond Keam in 1987 and Scott Johnson in 1988, were the subject of ongoing criminal proceedings. Accordingly, having regard in particular to Paragraph E of the Terms of Reference, the Inquiry did not investigate those two deaths. In 2023, as events transpired, in both of those cases, offenders were convicted of homicide (murder in the case of Mr Keam and manslaughter in the case of Scott Johnson).

5.30. To the extent that Public Hearing 2 touched upon the investigative history of the Scott Johnson matter, the basis for the Inquiry doing so is referred to in my judgment delivered on 18 July 2023.[12]

5.31. The Inquiry thereafter took steps to inquire into that total of 30 deaths. This involved obtaining and reviewing all available historical material, as well as all further information that could be obtained by way of present-day forensic testing and/or by other means including expert review. Those 30 deaths then proceeded through the Case Review and Documentary Tender processes outlined below. Each death is considered in turn in this Chapter.

5.32. For completeness, I note that two of the deaths which I have considered pursuant to Category A, namely the deaths of Cyril Olsen and Michael Swaczak, were not presented in a public hearing and are addressed in the confidential volume of this Report. For the public record, I note that in my view both those deaths were homicides, and that in both cases there is objectively reason to suspect that LGBTIQ bias was a factor in the death.

5.33. Over the course of the Inquiry's work, I had the benefit of submissions addressing the topic of how I should understand the word "unsolved" in the Terms of Reference, and whether specific matters were "unsolved" for the purposes of the Terms of Reference. However, those submissions did not cause me to depart from the approach I took initially (as outlined above) to the question of which matters were unsolved.

Other introductory matters

5.34. The Terms of Reference required me to report on the manner and cause of death and on the question of LGBTIQ bias, in relation to particular unsolved cases. However, part of the broader utility of the Inquiry's work in investigating deaths falling within the Terms of Reference lies in what was revealed concerning the investigative practices, and attitudinal responses, of those responsible for investigating deaths that may be LGBTIQ hate crimes. This is true at both the initial investigatory stage, and at the stage of any subsequent review of that investigation (for example, by the UHT). I have expressed opinions on such matters in the course of my discussion of particular deaths.

5.35. As noted below, issues relating to investigative practices generally were explored in the separate Investigative Practices Hearing that is the subject of **Chapter 8**. Both the subject matter of that hearing, and the need for such a hearing, arose substantially from the Inquiry's consideration of the individual Category A deaths.

[12] Judgment of the Inquiry, 18 July 2023, [74]–[114] (ORD.00012).

5.36. Issues relating to the varying and changing approaches adopted by NSWPF officers in relation to their dealings and association with the LGBTIQ community were explored in the first public hearing (the Context Hearing). That hearing provided me with both documentary and oral evidence about the social and cultural contexts of the period under examination, namely the 40 years from 1970 to 2010, especially as to the lived experience of members of the LGBTIQ community during those years.

5.37. The Inquiry also examined aspects of Strike Forces Macnamir, Parrabell and Neiwand, and the BCU, in the course of Public Hearing 2. This has contributed to the acquisition of a baseline of information concerning the culture, practices and approaches of the NSWPF in relation to the investigation of homicides where LGBTIQ bias was or may have been a factor. That has also assisted me in the task of examining the individual deaths, as I observed in my judgment of 18 July 2023 concerning the Terms of Reference, including at [84]–[86].

5.38. There is also an important matter of terminology to address before I address the individual cases. Much of the underlying evidentiary material refers to the targeting of gay men in particular locations, refers to specific venues as being frequented by gay men, and/or assumes that all users of beats were gay men. This evidentiary material frequently proceeds on an underlying assumption – explicit or implicit – that any man who sought or engaged in sexual activity with other men was gay.

5.39. For reasons explained in the Terminology section of this Report, that assumption is erroneous. It erases the experience of many people who may have used beats, or been present in LGBTIQ-friendly venues. However, it is an assumption that, having regard to the evidence I received in the Context Hearing, may well have been shared by the perpetrators of bias crimes (in addition to many in the NSWPF and more broadly in the community), and it is important that I acknowledge that reality.

5.40. There is a tension between acknowledging that cisgender gay men, and those who were assumed, rightly or wrongly, to be cisgender gay men, were specific targets of some types of violence, while also seeking to ensure that misconceptions concerning sexuality and gender are not perpetuated. For example, in some instances, if I were to say that a perpetrator had assumed a person was "a member of the LGBTIQ community", this may obscure the different experiences of violence by different aspects of the LGBTIQ community, and the underlying animus of a perpetrator of violence.

5.41. There is no perfect approach to this issue. In general, where violence may have been connected to a beat, I have used the language of "beat user" to reflect the diversity of people who used beats. Where underlying documents or the submissions before the Inquiry refer to the targeting of gay men, I have often retained that language when summarising that evidence or those submissions, even though that language is likely to be overly simplistic. In doing so, I seek to acknowledge that cisgender gay men (or those assumed to be cisgender gay men) were specific targets of violence, and comprise many of the cases before the Inquiry, but should not be understood as overlooking the fact that many men who were not cisgender gay men used beats, and that other parts of the LGBTIQ community also experienced significant violence.

5.42. Further, in relation to some deaths, Counsel Assisting recommended that I make a finding that the person died by suicide. Whether or not that finding was appropriate in each case was the subject of submissions from both Counsel Assisting and the NSWPF.

5.43. Counsel Assisting drew my attention to the lack of a single settled definition of suicide, or test to be applied at common law in Australia.[13] Moreover, none of the Coroners Acts in Australia requires coroners to make an explicit determination of suicide or of a deceased's intent.[14]

5.44. The long-accepted principle in Australia is that a finding of death by suicide should not be made lightly.[15] Historically, there were significant consequences of a finding of death by suicide, including for religious burial and life insurance policies, and coroners have traditionally employed a high standard of proof on this issue, usually encapsulated by reference to the *Briginshaw* principle.[16]

5.45. However, as Counsel Assisting observed, social attitudes towards suicide have changed over time.[17] Thus, for example in *Clark v NZI Life Ltd* (1991) 2 Qd R 11 at 16, Thomas J suggested that a finding of suicide may no longer be one of such gravity as to "bring it toward the top of the range of what is sometimes called the *Briginshaw* test".[18] Nevertheless, it remains the case that Australian coroners continue to employ a high standard of proof in suicide determinations.[19]

[13] See Stephanie Jowett, Belinda Carpenter and Gordon Tait, 'Determining a Suicide under Australian Law' (2018) 41(2) *UNSW Law Journal* 355, 363.

[14] See Stephanie Jowett, Belinda Carpenter and Gordon Tait, 'Determining a Suicide under Australian Law' (2018) 41(2) *UNSW Law Journal* 355, 360ff.

[15] *American Home Assurance Company v King* [2001] NSWCA 201, [10]–[13] (Stein JA, Handley JA and Beazley JA agreeing); *Australian Associated Motor Insurers Ltd v Elmore Haulage Pty Ltd* (2013) 39 VR 365, [55]. For an overview of English authorities on suicide see *Breganza v BP Shipping Ltd* [2015] UKSC 17, [33]–[36] (Lady Hale, Lord Kerr agreeing), [61]–[62] (Lord Hodge, Lord Kerr agreeing).

[16] *Briginshaw v Briginshaw* (1938) 60 CLR 336, 361-2 (Dixon J).

[17] Stephanie Jowett, Belinda Carpenter and Gordon Tait, 'Determining a Suicide under Australian Law' (2018) 41(2) *UNSW Law Journal* 355, 364.

[18] *Clark v NZI Life Ltd* (1991) 2 Qd R 11, 16.

[19] Stephanie Jowett, Belinda Carpenter and Gordon Tait, 'Determining a Suicide under Australian Law' (2018) 41(2) *UNSW Law Journal* 355, 370-373; Senate Community Affairs References Committee, Parliament of Australia, *The Hidden Toll: Suicide in Australia* (2010) 26.

5.46. Counsel Assisting drew my attention to one formulation, proposed by Coroner Coate in the Coroners Court of Victoria, namely that the appropriate question to be asked is "whether or not, in doing what [the deceased] did on that [occasion], [the deceased] was engaged in a voluntary or deliberate course of conduct or act or acts in which [the deceased] consciously intended at the moment of engagement in the acts, by those acts, to end [their] own life".[20]

5.47. On that formulation, suicide comprises three elements:[21]

a. A voluntary or deliberate act of the deceased, where

b. The intent behind the act was to end their own life, with

c. A conscious understanding, at the moment of engagement in the act, that such an act would necessarily result in death.

5.48. Accordingly, I adopt and apply that formulation in respect of the cases in which the possibility of suicide is raised.

Case Review Process

5.49. The Inquiry sought and received a very large volume of documents and records of various kinds, primarily from two main sources: the NSWPF and the Coroners Court. However, many records were incomplete and some NSWPF files were missing or lost, in whole or in part. Other materials were also sought from and provided by numerous bodies, both in NSW and elsewhere, including the ODPP, the Supreme Court, the District Court, the Local Court, and other government agencies to assist in the consideration of these deaths.

5.50. The Inquiry conducted a detailed review of the material received in relation to each death (or disappearance where the person was presumed deceased) and produced a "Case Summary" with a preliminary analysis of the death. The analysis included, among other things:

a. An account of the known facts surrounding the death;

b. Details of the initial police investigation and any subsequent investigation (for example by the UHT);

c. Consideration of whether witnesses and persons of interest were still alive and whether exhibits were available; and

d. Initial observations as to possible avenues of fresh investigation.

[20] Findings of Coate J, Inquest into the Death of Tyler Jordan Cassidy, 11 November 2011, 52 [244].

[21] See Stephanie Jowett, Belinda Carpenter and Gordon Tait, 'Determining a Suicide under Australian Law' (2018) 41(2) *UNSW Law Journal* 355, 364.

5.51. The next step was the completion of a separate and more focused document, identifying specific "Factors for Decision". One of those factors was whether I ought to regard a death as solved or unsolved. This document also included recommendations as to what investigative steps should be taken, including any expert opinions to be obtained, and a preliminary assessment as to the possible presence of LGBTIQ bias.

5.52. The Case Summary and Factors for Decision documents were then discussed in a "First Case Review Meeting", with myself, Counsel Assisting and relevant staff of the Inquiry. At that meeting, decisions were made as to which, if any, of the recommendations for further investigation should be implemented. A First Case Review "Outcomes" document was prepared, recording the provisional views reached and the investigative steps which needed to be taken.

5.53. The Inquiry pursued a wide variety of investigative avenues as appropriate to each death. These avenues included: conducting witness conferences, holding private hearings with witnesses and persons of interest, issuing summonses to various courts, agencies and organisations for additional records, reviewing information provided by members of the public via the Inquiry's contact webpage and phone number, media reviews and scene visits.

5.54. Having regard to significant advances in science and technology, the Inquiry also issued summonses to the NSWPF for the production of the relevant physical exhibits. Unfortunately, what all too frequently emerged was that exhibits could not be found. Where exhibits had been lost or destroyed, in some instances a statement was sought from a forensic biologist at FASS as to the forensic analysis that could have been pursued if the exhibits had been retained. Where the NSWPF was able to locate and produce exhibits, in appropriate cases, the Inquiry arranged for various forms of modern forensic testing and checking, including for example DNA analysis through FASS and by requesting the assistance of the NSWPF to re-run fingerprints taken from crime scenes against the current national fingerprint database to identify any matches.

5.55. The Inquiry also sought and obtained advice and reports from a wide variety of expert consultants from various specialist fields, including forensic pathology, cardiology, neurosurgery, forensic psychiatry, toxicology, bloodstain pattern analysis, botany, and coastal geomorphology.

5.56. Once the investigative steps had been progressed for a particular case, a second "Factors for Decision" document was prepared, with the outcome of the steps taken to date, any revised assessments or analyses, and any recommendations as to further investigative steps.

5.57. A "Second Case Review Meeting" was then convened to discuss the progress and recommendations made in relation to the case. At that meeting, final decisions were made, firstly as to whether the death was considered to fall within the Terms of Reference or not and, if so, as to any further avenues of inquiry to be pursued. If all investigations were complete, a decision was made as to whether the case should be prepared for a documentary tender. Following that meeting, a Second Case Review "Outcomes" document was prepared to record the decisions made.

Family Involvement

5.58. The Inquiry also sought to contact family members in relation to each of the deaths considered as possibly falling within Category A. In some cases, families contacted the Inquiry directly in response to publicity about the Inquiry. Such publicity included advertising and public notices in newspapers and regional publications, LGBTIQ publications, on the radio and online, as well as media reporting of the Inquiry's public hearings.

5.59. The Inquiry also obtained the postal addresses, and in certain cases, mobile telephone numbers for family members via interagency cooperation. Journalists who had reported on certain deaths also assisted the Inquiry in locating families.

5.60. I wrote to all identified family members (or where no family could be identified, a close friend or loved one) explaining the nature and purpose of the Inquiry and inviting them to participate. A text message was also sent to the mobile phone numbers of many family members to ensure all possible efforts were made to contact families. Sadly, many of the family members, partners, friends and loved ones are deceased, in failing health, or no longer able to be found.

5.61. Family members and loved ones who expressed a willingness to participate in the Inquiry variously provided witness statements and/or copies of their own records, and participated in conferences with staff of the Inquiry. Families were also provided with the opportunity to read the evidentiary bundle prepared in relation to the death of their family member or loved one in advance of the relevant public hearing and could seek leave pursuant to Practice Guideline 1 to appear and be legally represented if they so wished.

Procedural fairness

5.62. In **Chapter 1** of this Report, I considered the principles of procedural fairness. I now turn to the Inquiry's contact with OICs, and persons suspected of having had involvement in a death under consideration by the Inquiry.

Contact with OICs

5.63. A common theme which emerged from the submissions of the NSWPF in relation to the public documentary tender of the Category A and B deaths is that it was unjust to make criticisms of historical criminal investigations when the OICs of those investigations had not been called to give evidence. Moreover, the NSWPF advised that it would not act for any of those officers before the Inquiry.

5.64. I am not persuaded by the NSWPF's submission that any criticism of historical investigations would be unjust without hearing from the OICs, given the nature of my inquiries and the focus for the most part on investigative practices rather than on whether individuals should be criticised. Nevertheless, out of abundant caution, this Inquiry has sought to identify and contact almost every living OIC from those investigations it has been able to identify. To this end, from 13 June 2023 the Inquiry made attempts to contact over 40 living OICs. Very few wished to be heard. Many indicated they did not wish to make submissions, and many more did not reply at all. Several were deceased, and some could not be safely contacted (or further contacted) due to significant trauma.

5.65. Notwithstanding that approach, it is appropriate to make the following comment. In some cases, I have considered it appropriate to discuss the specific conduct of named officers in conducting historical investigations. However, most of my adverse comments are in the nature of general critiques as to the manner in which an investigation was conducted. They should not, for that reason alone, be understood as specific adverse comment on the officer or officers in charge of that investigation.

5.66. It is not always possible, particularly given incomplete records, to assign specific conduct to specific officers. Some investigations are "products of their time", in terms of cultural attitudes to the LGBTIQ community and approaches to policing, and no single officer can appropriately bear the weight of that criticism. I do not intend every critique of a previous investigation to indicate a moral or professional shortfall of the relevant OIC, or other officers involved, that sets them apart from their colleagues in that period.

5.67. That does not mean that those investigations cannot and should not be critiqued in a general sense, regardless of whether the Inquiry has heard from each OIC or each individual officer involved. To take that view would be to promulgate the myth that historical failures of policing can be explained by a few "bad apples" who must personally answer for any shortcoming. It would also unfairly shield historical policing practices and systemic deficiencies from criticism unless the Inquiry were to embark on a task that was near impossible with the time assigned to it (and certainly in the timeframes originally assigned to it prior to the extensions granted).

5.68. Accordingly, while this Inquiry has taken as cautious an approach as possible with respect to seeking the views of OICs in the time available to it, that should not be understood as accepting the various NSWPF submissions that the Inquiry's criticisms of those investigations are necessarily "adverse findings" with respect to each of those officers, or that a duty of procedural fairness was in fact owed to every such officer under the principles set out above.

Notification of potential adverse comment

5.69. Where Counsel Assisting made a submission, or intended to make a submission, in respect of persons of interest suspected of having had involvement in a death under consideration by the Inquiry, that person—or any close family members if that person was now deceased—was contacted by the Inquiry and invited to make a submission.

5.70. In relevant instances, the Inquiry, through interagency cooperation obtained the postal address for the person of interest (or their next of kin). A letter was then sent notifying the person of interest (or their next of kin) that the Inquiry was in receipt of information which suggested that they (or their relative) may have been involved in the particular death within the Inquiry's Terms of Reference, and that Counsel Assisting may submit that I should reach such a conclusion. That letter also informed the person of interest (or their next of kin) of the date of the public hearing and provided a timeframe for them to contact the Inquiry to provide information and/or make submissions.

Documentary Tenders

5.71. Public hearings by way of documentary tender were conducted in relation to Category A and B deaths on 22 separate days between February and August 2023 in respect of 32 individual deaths. As discussed above, public hearings did not take place in relation to the deaths of Cyril Olsen and Michael Swaczak.

5.72. From the totality of the material obtained by the Inquiry with respect to each death within the Terms of Reference, the Inquiry marshalled and selected those documents which needed to be tendered in evidence. For each death a tender bundle of such documents was compiled and tendered in a public hearing. Such tender bundles typically included:

a. Documents relating to the circumstances of the death itself;

b. Documents relating to previous investigations of that death, whether by the police or the Coroner. The nature and extent of material derived from past police investigations of each death varied significantly from case to case, depending on the nature and extent of those investigations;

c. Documents relating to the various steps taken by this Inquiry in relation to that death, and the results and conclusions flowing from those steps; and

d. Statements made by family members and loved ones, outlining their memories and the impact that the death has had on their lives, if they had been provided.

5.73. At those public hearings, Counsel Assisting also provided me with written submissions and made oral submissions.

5.74. Counsel Assisting's submissions addressed, *inter alia*, both the manner and cause of death, and the question of whether the death involved LGBTIQ bias. Further, Counsel Assisting made submissions as to whether I should make any recommendations in connection with the death.

5.75. In the course of their submissions, Counsel Assisting in some instances made observations on matters such as police investigative practices. While these, for the most part, did not give rise to recommendations being suggested in respect of individual cases, I have taken such observations into account in my consideration of recommendations that I consider are appropriate more broadly concerning police investigatory practices. So too have I taken into account any responsive submissions made on behalf of interested parties that concern investigative practices. Those are addressed in **Chapter 8** of this Report.

5.76. In the majority of deaths, parties granted authorisation to appear in individual matters (principally, the NSWPF and some family members), chose to reserve their position at the public hearings of those matters, and later provided written submissions in accordance with Practice Guideline 3.

Steps after documentary tender

5.77. Following the written and oral submissions of Counsel Assisting, and receipt of submissions from interested parties, in some deaths I considered that additional investigative steps should be taken. In such cases, I gave instructions for further inquiries to be made, including obtaining additional expert reports, contacting additional witnesses and issuing further summonses for records.

5.78. Where additional information was obtained in a case, Counsel Assisting supplemented the tender bundle for that case by tendering additional documents in chambers and preparing supplementary written submissions where appropriate. The additional evidence and supplementary submissions were then served on the interested parties, who were invited to provide further submissions in reply.

Findings

5.79. An overview of my findings as to manner and/or cause (where appropriate) in each of the Category A deaths appears in my consideration of the individual deaths in this Chapter. I have also included my views as to whether or not there is objectively reason to suspect that LGBTIQ bias was a factor in the relevant death. Of the 30 deaths I considered pursuant to Category A, I ultimately formed the view that there was objectively reason to suspect that LGBTIQ bias was a factor in 21 deaths.

5.80. I outlined the approach I have taken in relation to the standard of proof at **Chapter 1** of this Report.

Divergence from coronial findings

5.81. In relation to some deaths, I have made findings or conclusions as to manner and cause which diverge from earlier findings made by a Coroner. This divergence varies in degree and is in most instances attributable to the existence of fresh evidence derived using the evidence-gathering powers provided for by the *SCOI Act*. That fresh evidence was unavailable to the Coroner at the time of the initial inquest and has shed light on matters including the timing, cause and manner of deaths being considered by the Inquiry.

5.82. On 14 July 2023, I convened a meeting with the State Coroner, Magistrate Teresa O'Sullivan, to discuss the potential implications of any findings I make as to manner and cause of death on the coronial jurisdiction more broadly.

5.83. In my view, it is generally undesirable for there to be a divergence between earlier coronial findings and any findings I make as to manner and cause of death. With a view to providing a pathway to reach consistency on the record, in some matters I have recommended that the Commissioner of the NSWPF or a serving NSWPF officer apply for a fresh inquest.

Applications for a fresh inquest

5.84. At common law, it is well established that once an inquest has been held, a coroner is *functus officio*, such that there is no power to hold a fresh inquest unless permitted by a specific legislative provision or until the first finding has been set aside by a Court.[22] This common law principle is also reflected in various provisions under the *Coroners Act*.

5.85. The statutory duty to hold a fresh inquest or inquiry is enshrined in s. 83(4) of the *Coroners Act*, which is in the following terms:[23]

> *(4) A fresh inquest or inquiry must be held if:*
>
> *(a) an application for a fresh inquest or inquiry is made under this section, and*
>
> *(b) on the basis of the application, the State Coroner is of the opinion that the discovery of new evidence or facts makes it necessary or desirable in the interests of justice to hold a fresh inquest or inquiry.*

5.86. The term "fresh inquest" is a reference to a new inquest concerning the death or suspected death of a person.

5.87. The mandatory duty to hold a fresh inquest or inquiry is conditional upon the State Coroner forming the opinion set out in s. 83(4)(b) of the *Coroners Act*. This opinion amounts to a subjective jurisdictional fact.[24] To be validly held, the opinion formed by the State Coroner must, amongst other things, be such that it can be formed "by a reasonable [person] who correctly understands the meaning of the law under which [the person] acts".[25]

5.88. Pursuant to s. 83(5) of the *Coroners Act*, an application for a fresh inquest or inquiry may only be made by a police officer or a person who has been granted leave to appear or be represented at a previous inquest or inquiry. Accordingly, limited persons have standing to make an application under s. 83 of the *Coroners Act*.

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[22] R *v West Yorkshire Coroner; Ex parte Smith* [1983] QB 335 at 359, [1982] 3 All ER 1098 at 1108, CA per Donaldson LJ.

[23] The requirement to hold a fresh inquest may also arise by way of an order of the Supreme Court pursuant to Chapter 7 of the *Coroners Act*. I further note that a discretionary power to hold a fresh inquest, in certain proscribed circumstances, is enshrined in ss. 83(2)-(3) of the *Coroners Act*.

[24] *Minister for Multicultural and Indigenous Affairs v SGLB* (2004) 207 ALR 12 at 20.

[25] R *v Connell; Ex parte Hetton Bellbird Collieries Ltd* (1944) 69 CLR 407 at 430.

5.89. Whilst the term "police officer" is not defined in the *Coroners Act*, it is defined in s. 3 of the *Police Act* as "a member of the NSWPF *holding* a position which is designated under this Act as a position to be held by a police officer". The functions of police officers which are set out in the *Police Act* include the exercise of functions conferred on members of the police force under other legislation. This would include functions conferred upon police officers pursuant to the *Coroners Act*. A retired police officer would clearly be precluded from exercising such functions and could not be regarded as holding a relevant position under the *Police Act* as described above. A retired officer would therefore not have standing to make an application under s. 83(5) of the *Coroners Act*, unless the officer was individually granted leave to appear or to be represented in the relevant inquest.[26]

5.90. Since only serving police officers will have standing to bring an application for a fresh inquest, a previous OIC would be precluded from doing so if no longer a serving officer. In many cases considered by the Inquiry, the OIC is no longer a member of the NSWPF by reason of retirement or otherwise.

5.91. Further, although s. 57(3) of the *Coroners Act* creates a strong presumption that a family member will be granted leave to appear or be represented in an inquest, it does not operate so as to confer such leave automatically. During the course of coronial proceedings, many family members may be actively involved without formally seeking leave to appear or to be represented. As a result, many family members will not have standing to bring an application for a fresh inquest under s. 83 (but may make an application for a fresh inquest to the Supreme Court under Chapter 7 of the *Coroners Act*). Given the period captured by the Terms of Reference, in several matters I have considered, there are no living relatives.

5.92. Accordingly, in the following matters I recommend that the NSWPF (the Commissioner of the NSWPF or a serving police officer) make an application for a fresh inquest, having regard to additional evidence obtained by the Inquiry and the findings and conclusions I have reached as to manner and cause of death:

a. Scott Miller;

b. Paul Rath;

c. Richard Slater; and

d. Carl Stockton.

Correction to Births, Deaths and Marriages Register

5.93. In some instances, where I did not consider there to be a material divergence between an earlier coronial finding and my finding as to manner and cause, I have included a recommendation to the Registrar of Births, Deaths and Marriages. Pursuant to s. 45(1)(b) of the *Births, Deaths and Marriages Registration Act 1995*, the Registrar has the power to correct the Register to bring an entry about a particular registrable event into conformity with the most reliable information available to the Registrar of the registrable event.

[26] See *Police Act 1990* (NSW), ss. 6(2)(a) and (4).

Common themes raised by the NSWPF

5.94. In the course of considering the submissions on behalf of the NSWPF, I identified a number of common themes. Several of these themes relate to the absence or loss of records and the investigative practices of the NSWPF. In particular, these themes include: historical vs modern day investigative standards; improvements in forensics and technology; and changes to exhibit management and archiving standards. As noted above, these matters are addressed in detail in **Chapter 8**.

5.95. Against that background, I now turn to my consideration of the Category A deaths.

IN THE MATTER OF MARK STEWART

Factual background

Date and location of death

5.96. Mark Stewart (formerly Mark Spanswick) died on 10 or 11 May 1976 at a headland near Shelly Beach in Manly.

5.97. The headland at which Mr Stewart died was sometimes referred to as "the Fairy Bower headland", and this name is used in this Report.[27]

Circumstances of death

5.98. At around 10:00 am on 11 May 1976, Mr Stewart's body was discovered lying on the rocks at the base of a cliff about 250 metres south of the Fairy Bower headland.[28] He had last been seen at 9:30pm on 9 May 1976 at the Hilton Hotel on George Street in the Sydney Central Business District (**CBD**), where he had booked a hotel room for two nights.[29]

5.99. Mr Stewart was 18 years old at the time of his death.

Previous investigations

Original police investigation

5.100. The original police investigation into Mr Stewart's death was overseen by Manly Police. Senior Constable Keith Thoms was the OIC of the investigation.

5.101. At 11:00am on 11 May 1976, Senior Constable Thoms and Constable Ronald Fyson of Manly Police attended the Fairy Bower headland and were taken to the location of the body by Colin McGuire (the local fisherman who had found Mr Stewart's body earlier that morning).[30]

5.102. A third officer, Constable Christopher Ure, appears to have arrived shortly after these two officers "in company with other police from the Manly detectives office".[31]

[27] As outlined in Counsel Assisting's submissions, the headland was referred to as the "Fairy Bower headland" in much of the material relating to Mr Stewart's death despite the fact that the headland is much closer to Shelly Beach in Manly, than to Fairy Bower beach, which is some distance away and further west.

[28] Exhibit 19, Tab 8, Statement of Colin Richard McGuire, undated (SCOI.02724.00018).

[29] Exhibit 19, Tab 9, Statement of Patricia Cupitt, 7 July 1976(SCOI.02724.00012).

[30] Exhibit 19, Tab 12, Statement of Senior Constable Keith Thoms, undated (SCOI.02724.00019); Exhibit 19, Tab 14, Statement of Constable Ronald Fyson, Undated 1 (SCOI.02724.00017).

[31] Exhibit 19, Tab 15, Statement of Constable Christopher John Ure, 4 July 1976 (SCOI.O2724.00016).

5.103. Senior Constable Thoms, Constable Fyson and Constable Ure made statements concerning their attendance at the scene. The statements record that Mr Stewart's body was located on rocks about 250 metres south of either "Fairy Bower headland" or "Fairy Bower", and that Mr Stewart was lying face down on rocks about 20 feet from the cliff face.[32]

5.104. In Senior Constable Thoms' view, "[i]t was apparent that the body had fallen from the cliff top".[33]

5.105. According to Constable Ure:[34]

> *We then made an extensive search of the headland near to where it would appear the deceased had fallen from. This area is dense bushland with very rocky sections jutting out of the bush, there are a number of small trails leading from the roadway to the edge of the cliff. A further search was made of the edge of the cliff and this area is also overgrown with dense bush and it was noticed that there is no safety fence or any other facility to prevent persons from losing there (sic) footing and falling to their deaths.*
>
> *A thorough search of the whole area by police for any signs which explain how the deceased came to fall to his death was made and no sign of the persons [sic] prior presence was found. I then returned to the bottom of the cliff where I viewed the body of the deceased…*

5.106. The only property found on Mr Stewart's body was a small piece of notepaper with the name and telephone number of a hotel on one corner. According to the statement of the OIC, the hotel name on the notepaper was the "Chevron Hotel, Sydney". The notation "7.20 11.5.76" was written in biro on the paper.[35]

5.107. Other physical evidence found near Mr Stewart's body included a piece of Banksia tree, which was similar to the trees growing at the top of the cliff about 150 feet above.[36] A men's Seiko wristwatch was also recovered about 21 feet further east of the body. The watch had stopped at "8.02 TUE 11".[37]

[32] Exhibit 19, Tab 12, Statement of Senior Constable Keith Thoms, undated(SCOI.02724.00019); Exhibit 19, Tab 14, Statement of Constable Ronald Fyson, undated (SCOI.02724.00017); Exhibit 19, Tab 15, Statement of Constable Christopher John Ure, 4 July 1976(SCOI.O2724.00016).

[33] Exhibit 19, Tab 12, Statement of Senior Constable Keith Thoms, undated (SCOI.02724.00019).

[34] Exhibit 19, Tab 15, Statement of Constable Christopher John Ure, 4 July 1976, 1 (SCOI.O2724.00016).

[35] Exhibit 19, Tab 12, Statement of Senior Constable Keith Thoms, undated (SCOI.02724.00019).

[36] Exhibit 19, Tab 12, Statement of Senior Constable Keith Thoms, undated (SCOI.02724.00019); Exhibit 19, Tab 14, Statement of Constable Ronald Fyson, undated (SCOI.02724.00017).

[37] Exhibit 19, Tab 12, Statement of Senior Constable Keith Thoms, undated (SCOI.02724.00019); Exhibit 19, Tab 14, Statement of Constable Ronald Fyson, undated (SCOI.02724.00017).

5.108. Although not mentioned in any police statement, the Report of Death to Coroner dated 13 May 1976 refers to the clothing worn by Mr Stewart as pale green slacks, a bone-coloured belt, bright green sneakers, a cream body shirt, blue denim jacket, white cotton singlet and blue floral briefs.[38] His shoes were off but still laced and were in close proximity to the body.[39] The report also mentions a cigarette lighter, stainless-steel comb and $15.27 as property that was found with Mr Stewart's body.[40] A description of the clothing in similar terms appears in a local newspaper article published on 14 May 1976, adding the detail that the bright green sneakers had yellow stripes and describing the shirt as fawn coloured.[41]

5.109. There was no evidence before the Inquiry that there was ever any forensic testing of these items. The present location of the items, including the notepaper, was not known by the NSWPF and therefore no testing of them was possible.[42] There was no evidence that any photographs were taken of any of the items.

5.110. The immediate focus of the police investigation was on identifying Mr Stewart's body. This included fingerprinting and photographing the body,[43] circulating a description of the body via the police radio network and news media,[44] making enquiries with the local Water Board depot (situated at North Head) in case someone fitting Mr Stewart's description was an employee, and checking at a "local employment office".[45] According to the statement made by the OIC in 1976, he also contacted the "Chevron Hotel" on 11 or 12 May 1976 and left information there concerning the (then still unidentified) deceased.[46]

5.111. In the Report of Death to Coroner, the OIC stated that inquiries were being made in Brisbane regarding the deceased, and that a description of Mr Stewart had been circulated via the police radio network and the news media "but to date has been unsuccessful in assisting with identification".[47]

5.112. Mr Stewart was identified in the evening of 13 May 1976, when police searched Mr Stewart's hotel room (room 3117 at the Hilton Hotel) and identified the body as that of Mr Stewart, from the passport located in the room. How police came to attend the Hilton Hotel is not entirely clear. Mr Stewart's body was subsequently identified by Constable Fyson, Patricia Cupitt (the Hilton Hotel receptionist who checked Mr Stewart in on 9 May 1976) and Mr Stewart's father John Spanswick.[48]

[38] Exhibit 19, Tab 2, Report of Death to Coroner, 13 May 1976, 1 (SCOI.82449).

[39] Exhibit 19, Tab 2, Report of Death to Coroner, 13 May 1976, 1 (SCOI.82449).

[40] Exhibit 19, Tab 2, Report of Death to Coroner, 13 May 1976, 1 (SCOI.82449).

[41] Exhibit 19, Tab 27, 'No clue to dead youth', *The Manly Daily,* 14 May 1976 (SCOI.82452).

[42] Exhibit 19, Tab 23B, Statement of Detective Sergeant Neil Sheldon, 16 March 2023, [10] (SCOI.82812).

[43] Exhibit 19, Tab 12, Statement of Senior Constable Keith Thoms, undated (SCOI.02724.00019).

[44] Exhibit 19, Tab 13, Letter from Senior Constable Keith Thoms to Coroner, 29 May 1976 (SCOI.02724.00011).

[45] Exhibit 19, Tab 23, NSWPF Report of Occurrence, 'Further information re unidentified male person found on rocks at Fairy Bower on 11.5.76', 12 May 1976, 2 (SCOI.82810)

[46] Exhibit 19, Tab 12, Statement of Senior Constable Keith Thoms, undated (SCOI.02724.00019).

[47] Exhibit 19, Tab 2, Report of death to Coroner, 13 May 1976, 1-2 (SCOI.82449).

[48] Exhibit 19, Tab 14, Statement of Constable Ronald Fyson, undated (SCOI.02724.00017); Exhibit 19, Tab 9, Statement of Patricia Cupitt, 7 July 1976, 1 (SCOI.02724.00012); Exhibit 19, Tab 7, Statement of John Spanswick, 28 May 1976, 2(SCOI.02724.00015); Exhibit 19, Tab 15, Statement of Constable Christopher John Ure, 4 July 1976(SCOI.O2724.00016).

5.113. Mr Stewart's personal effects were located by police in his room at the Hilton Hotel. These included his British passport, an old driver's license, an electric hair brush, a toiletry bag, various items of clothing, two packets of cigarettes, and a red canvas hand bag.[49]

5.114. Police took possession of the property from the hotel room and returned with it to Manly Police Station where it was entered into the Property Book held there.[50]

5.115. Notably, no wallet or money was found in Mr Stewart's room. At the time, no observation of this fact was made by police or the Coroner.

5.116. Once Mr Stewart was identified, police obtained a statement from Ms Cupitt about her interaction with Mr Stewart on 9 May 1976, as well as from two Hilton Hotel employees who assisted police with the recovery of Mr Stewart's personal belongings from his room.[51] They also took a statement from Mr Stewart's father, John Spanswick.[52]

5.117. Based on two entries in the Special Crime Squad synopsis books produced to the Inquiry, it is apparent that two detectives from the Special Crimes Squad came to have some involvement in the investigation. A synopsis extract dated 24 May 1976 notes, "[a]t this stage reason for being at Fairy Bower not known, but there is no evidence to suggest foul play."[53] Ms Cupitt also refers to the two detectives attending the Hilton Hotel on 20 May 1976 and escorting her to the City Morgue to identify the body of Mr Stewart.[54] A third detective is described as having spoken with John Spanswick after he approached police on 28 May 1976.[55]

5.118. As submitted by Counsel Assisting, the limited reference to the involvement of the officers from the Special Crime Squad, and the fact that the OIC at the inquest was the local Manly officer, Senior Constable Thoms, suggests that the involvement of the Squad did not yield information that was regarded as being of particular significance at the time. However, it appears that Special Crime Squad officers ascertained the relevant information from the operator of a boarding house in Brisbane, where Mr Stewart lived until 6 May 1976 just a few days before he died.[56]

Persons of interest

5.119. No persons of interest in relation to the death were identified at the time of Mr Stewart's death, nor subsequently.

[49] Exhibit 19, Tab 16, Personal effects of Mark Stewart – Room 3117, undated (SCOI.02724.00020).

[50] Exhibit 19, Tab 14, Statement of Constable Ronald Fyson, undated (SCOI.02724.00017).).

[51] See Exhibit 19, Tab 9, Statement of Patricia Cupitt, 7 July 1976 (SCOI.02724.00012); Exhibit 19, Tab 10, Statement of William Eugene Muirhead, 7 July 1976 (SCOI.02724.00013); Exhibit 19, Tab 11, Statement of David John Ford, 7 July 1976 (SCOI.02724.00014) .

[52] See Exhibit 19, Tab 7, Statement of John Spanswick, 28 May 29176 (SCOI.02724.00015).

[53] Exhibit 19, Tab 18, Special Crime Squad synopsis extract, 24 May 1976 (SCOI.47557).

[54] Exhibit 19, Tab 9, Statement of Patricia Cupitt, 7 July 1976 (SCOI.02724.00012).

[55] Exhibit 19, Tab 13, Letter from Senior Constable Keith Thoms to Coroner, 29 May 1976 [2] (SCOI.02724.00011).

[56] Exhibit 19, Tab 17, Special Crime Squad synopsis extract, 21 May 1976 (SCOI.47558).

Post-mortem examination

5.120. Forensic pathologist Dr Thomas Oettle conducted a post-mortem examination at 11:00am on 14 May 1976. In a post-mortem report dated 3 June 1976, Dr Oettle recorded the direct cause of death as "multiple injuries" and estimated that death had taken place three to four days prior to the post-mortem (i.e., 10 or 11 May 1976).[57]

5.121. Dr Oettle recorded numerous injuries, including splitting on the left side of the scalp in the parietal region; extensive shattering to the skull; gross laceration of the brain and a thin extradural and subdural haemorrhage; several parchment scrape abrasions on the back left side of the body; fracturing of the left humerus, pelvis, left femur, left tibia and fibula; fracturing of the C3 spine with a small amount of surrounding haemorrhage; mediastinal haemorrhage (in the thoracic cavity); and tearing of the trachea.[58]

5.122. In relation to Mr Stewart's organs, Dr Oettle found extensive tearing in both lung hilar regions, with small amounts of blood inhaled and in air passages; tearing and a small blood clot in the pericardial sac of the heart, and occasional flecks of fibrous change in the myocardium; gross tearing through the centre of the liver, extending into the left and right sides; extensive tearing of the spleen; and 100ml of free blood present in the abdomen, 450ml present in the left chest cavity and 100ml in the right chest cavity.[59]

5.123. Toxicology testing was limited to testing for the presence of alcohol. No alcohol was found in Mr Stewart's blood.[60]

Findings at inquest

5.124. An inquest was conducted by City Coroner John Goldrick on 16 July 1976. The Coroner found that Mr Stewart died on 11 May 1976 at Manly, [61]

> *of multiple injuries sustained then and there as the result of falling from the clifftop of Fairy Bower Headland but whether such fall was accidental or otherwise the evidence adduced does not enable me to say.*

5.125. The Coroner also found:[62]

> *I am satisfied there are no circumstances giving rise to suspicion of foul play but whether or not the fall which caused the death was accidental or was intended by the [deceased] I am not able to determine on the evidence, I will make an open finding as to that.*

[57] Exhibit 19, Tab 4, Post-mortem report of Dr Thomas Oettle, 3 June 1976, 1 (SCOI.02724.00009).

[58] Exhibit 19, Tab 4, Post-mortem report of Dr Thomas Oettle, 3 June 1976, 1 (SCOI.02724.00009).

[59] Exhibit 19, Tab 4, Post-mortem report of Dr Thomas Oettle, 3 June 1976, 1-2 (SCOI.02724.00009).

[60] Exhibit 19, Tab 3, Toxicology report, 20 May 1976, 1 (SCOI.02724.00010).

[61] Exhibit 19, Tab 5, Findings of City Coroner John Brian Goldrick, 16 July 1976 (SCOI.02724.00001).

[62] Exhibit 19, Tab 36, Extract of transcript of Coronial Inquest into the death of Mark Stewart, undated (SCOI.02724.00007).

Strike Force Parrabell

Bias Crimes Indicators Form

5.126. A BCIF was completed in this case by Strike Force Parrabell.

5.127. All ten indicators in the BCIF were answered "Insufficient Information".[63]

5.128. The BCIF was completed, it seems, under the misapprehension that the Hilton Hotel (in the CBD) and the Chevron Hotel (in Potts Point) were one and the same. The form appears to conflate the two hotels on four separate occasions.[64] In one instance it states, "[t]he Chevron Hotel is in fact the Hilton Hotel, the place that STEWART had stayed at for two nights before his death."[65] In another instance it states, "STEWART stayed at the Chevron Hotel (also known as the Hilton Hotel), for two nights prior to his death."[66]

5.129. As was submitted by Counsel Assisting, the two hotels are not the same. While it is clear that Mr Stewart checked in to the Hilton Hotel (in the CBD) on 9 May 1976, and that his personal belongings were located there, the possibility exists that he may have separately visited the Chevron Hotel (in Potts Point) while in Sydney. The likelihood of this turns on whether or not police investigating the matter correctly recorded the Chevron Hotel (as opposed to the Hilton Hotel) as the hotel name on the notepaper found on Mr Stewart. The conflicting evidence on this matter is discussed below.

5.130. The BCIF also states as fact that Mr Stewart stayed at the Hilton Hotel on the night of 10 May 1976.[67] Although he was booked to do so, there is no clear evidence that he was seen at the Hilton Hotel after checking in at 9:30pm on 9 May 1976.

5.131. One consequence of the assumption in the BCIF that the two hotels were one and the same is that Strike Force Parrabell officers did not turn their minds to the possibility that Mr Stewart may have attended the Chevron Hotel, the bar of which was known as a popular venue for gay men, at some time proximate to his death.[68]

[63] Exhibit 19, Tab 19, Strike Force Parrabell Bias Crimes Indicators Review Form – Mark Stewart, Undated 4, 6-7, 9-15 (NPL.0115.0002.3655).

[64] Exhibit 19, Tab 19, Strike Force Parrabell Bias Crimes Indicators Review Form – Mark Stewart, Undated 5, 6, 16 (NPL.0115.0002.3655).

[65] Exhibit 19, Tab 19, Strike Force Parrabell Bias Crimes Indicators Review Form – Mark Stewart, Undated 6 (NPL.0115.0002.3655).

[66] Exhibit 19, Tab 19, Strike Force Parrabell Bias Crimes Indicators Review Form – Mark Stewart, Undated 16 (NPL.0115.0002.3655).

[67] Exhibit 19, Tab 19, Strike Force Parrabell Bias Crimes Indicators Review Form – Mark Stewart, Undated 1, 16 (NPL.0115.0002.3655).

[68] Exhibit 2, Tab 1, Statement of Garry Wotherspoon, 14 November 2022, [45] (SCOI.77300).

5.132. The "Summary of Findings" categorises the case overall as "Insufficient Information", and concludes that:[69]

> *[b]ecause of the lack of evidence in being able to determine how STEWART died, there is also insufficient information available to determine whether bias motivation was involved in his death.*

5.133. The NSWPF submitted that, in the absence of any evidence to establish that Mr Stewart's death was a homicide, a finding by Strike Force Parrabell of "insufficient information to establish a bias crime" was appropriate.[70]

Results of Strike Force Parrabell

5.134. Strike Force Parrabell categorised the case as "Insufficient Information".[71]

5.135. The academic review also categorised it as "Insufficient Information".[72]

5.136. The matter was categorised as "unsolved" by Strike Force Parrabell.[73]

Review by the Inquiry

5.137. The Inquiry took the following steps in the course of examining the matter.

Summonses

5.138. A summons to the NSWPF was issued on 18 May 2022 for, relevantly, all documents relating to investigations by the NSWPF of the death of Mr Stewart, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Stewart. No investigative file was produced for Mr Stewart's matter. Nor were any Report of Occurrence entries produced. However, a number of Special Crime Squad synopsis books were provided to the Inquiry on 23 August 2022 in an archive box labelled "Investigations – Unsolved murders – 1977 – (Box 1)".

5.139. A further summons (dated 13 February 2023) was issued to the NSWPF on 16 February 2023 requesting any Report of Occurrence at Manly Police Station dated between 10 and 31 May 1976, relating to the discovery of a body at or around Fairy Bower or North Head, Manly, or any subsequent investigation of such a matter (NSWPF61).[74] On 22 February 2023, the NSWPF produced four Report of Occurrence entries dated 11, 12, 13 and 28 May 1976 relating to Mr Stewart's death.[75]

[69] Exhibit 19, Tab 19, Strike Force Parrabell Bias Crimes Indicators Review Form – Mark Stewart, Undated (NPL.0115.0002.3655).

[70] Submissions of NSWPF, 12 April 2023, [63] (SCOI.45187).

[71] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Mark Stewart, Undated 1 (SCOI.76961.00014).

[72] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Mark Stewart, Undated 1 (SCOI.76961.00014).

[73] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Mark Stewart, Undated 1 (SCOI.76961.00014).

[74] Exhibit 19, Tab 22A, Summons to NSWPF (NSWPF61), 13 February 2023 (SCOI.82450).

[75] Exhibit 19, Tab 23, NSWPF Report of Occurrence, 11-13 and 28 May 1976, 1-4 (SCOI.82810).

5.140. These Report of Occurrence entries are of some significance in relation to the question of whether or not the note in Mr Stewart's possession was accurately recorded by the OIC as bearing the name of the Chevron Hotel. A reference in one of these entries lends weight to the suggestion that the OIC is likely to have mistakenly recorded the name as the Chevron Hotel, instead of the Hilton Hotel. As submitted by Counsel Assisting, it is regrettable that these Report of Occurrence entries were not produced to the Inquiry in answer to its very first summons, issued nine months earlier, which explicitly sought such documents.

5.141. A summons to DOFM was issued on 22 August 2022 for all records held in relation to Mr Stewart, including photographs, CT images and/or notes relevant to his post-mortem on 14 May 1976 (DOFM1).[76] An 18-page electronic file relating to Mr Stewart was produced on 30 August 2022. Significantly, the file contained a complete copy of the report of death to Coroner, which had not previously been provided to the Inquiry by the NSWPF or the Coroners Court.

5.142. A summons to BDM was issued on 23 August 2022 in respect of Mr Stewart (BDM2). Mr Stewart's death certificate was produced on 25 August 2022,[77] along with certificates recording that a change of name search and birth search yielded no result.

5.143. A summons was issued to the Hilton Sydney Hotel on 10 October 2022 for any records relating to Mr Stewart as a hotel guest in May 1976 (HSH1).[78] On 11 October 2022, Hilton Sydney Hotel advised by email that no records were available, as guest records and records of security incidents are destroyed after 10 years.[79]

5.144. A summons was also issued to the Queensland Police Service on 20 December 2022 requesting any criminal history and intelligence holdings (including last known address) for Mr Stewart (QLDPS3).[80] By a return letter of 11 January 2023, the Queensland Police Service advised that no such documents had been located.[81]

Interagency cooperation

5.145. The Inquiry requested, and received, Mr Stewart's coronial file in May 2022. The coronial file consisted of 34 pages of material, including witness statements, post-mortem and toxicology reports, and records relating to the inquest proceedings that took place on 16 July 1976.

5.146. Subsequent to submissions being filed, the Inquiry was also able to obtain records from the New Zealand Defence Force relating to Mr Stewart's naval service, which are relevantly summarised below.

[76] Exhibit 19, Tab 29A, Summons to Department of Forensic Medicine (DOFM1), 22 August 2022 (SCOI.82536).

[77] See Exhibit 19, Tab 6, Death Certificate for Mark Stewart, 21 July 1976 (SCOI.73994).

[78] Exhibit 19, Tab 30A, Summons to Hilton Sydney Hotel (HSH1), 10 October 2022 (SCOI.82453).

[79] Exhibit 19, Tab 31, Email from Amelia Benjamin to Caitlin Healey-Nash, 11 October 2022 (SCOI.82438).

[80] Exhibit 19, Tab 32A, Summons to Queensland Police Service (QLDPS3), 20 December 2022 (SCOI.82463).

[81] Exhibit 19, Tab 33, Letter from Queensland Police Service to Caitlin Healey-Nash, 11 January 2023 (SCOI.82456.00001).

Family members

5.147. Efforts were made to contact surviving family members of Mr Stewart. The Inquiry made contact with Mr Stewart's younger sister. Although Mr Stewart's sister could shed little light on the likely manner of his death, she was able to provide some information about the family's visits to Sydney in the years prior to Mr Stewart's death.[82]

Searches for exhibits

5.148. A summons was issued to the NSWPF on 28 September 2022 requesting the exhibit book entries for Mr Stewart's watch and the handwritten note, to ascertain whether the exhibits had been retained and their current location (NSWPF22).[83] On 11 October 2022, the NSWPF advised that it had not located any documents responsive to the request and that the May 1976 Manly Police Station Exhibit Book was unable to be located.[84]

5.149. On 3 March 2023, the Inquiry requested a formal statement from the NSWPF regarding the status of all exhibits identified in connection with Mr Stewart's matter, including the Seiko wristwatch and the notepaper, along with a gold cigarette lighter and steel comb listed in the *Manly Daily* article dated 14 May 1976.[85]

5.150. On 16 March 2023, the NSWPF provided a statement from Detective Sergeant Neil Sheldon, which outlined that, following extensive searches and enquiries within the NSWPF, no exhibits or records of the exhibits could be located.[86] Detective Sergeant Sheldon also considered that no further avenues of enquiry were available to locate the exhibits.[87]

Further forensic examinations

5.151. None of the exhibits identified in connection with Mr Stewart's matter are available for testing.

Professional opinions

5.152. By letter dated 5 October 2022, an expert opinion was sought from Dr Linda Iles.[88] On 15 December 2022, Dr Iles provided a report to the Inquiry.[89]

5.153. Dr Iles noted the absence of a number of matters from the original post-mortem report that made review of Mr Stewart's death challenging. These included:[90]

a. The lack of detailed description of external injuries;

[82] See Exhibit 19, Tab 43, Statement of Caitlin Healey-Nash, 21 March 2023, [4]–[7] (SCOI.82814).

[83] Exhibit 19, Tab 20A, Summons to NSWPF (NSWPF22), 28 September 2022 (SCOI.82448).

[84] Exhibit 19, Tab 21, Email from Patrick Hodgetts to Caitlin Healey-Nash 11 October 2022 (SCOI.82446).

[85] Exhibit 19, Tab 23A, Letter from Caitlin Healey-Nash to Patrick Hodgetts, 3 March 2023 (SCOI.82813).

[86] Exhibit 19, Tab 23B, Statement of Detective Sergeant Neil Sheldon, 16 March 2023, [9] (SCOI.82812).

[87] Exhibit 19, Tab 23B, Statement of Detective Sergeant Neil Sheldon, 16 March 2023, [10] (SCOI.82812).

[88] Exhibit 19, Tab 38A, Letter of instruction from Caitlin Healey-Nash to Dr Linda Iles, 5 October 2022 (SCOI.82462).

[89] Exhibit 19, Tab 38, Expert report of Dr Linda Iles, 15 December 2022 (SCOI.82457).

[90] Exhibit 19, Tab 38, Expert report of Dr Linda Iles, 15 December 2022, 4 (SCOI.82457).

b. No comment on the presence or absence of injury to the aorta, larynx, ribs, sternal and lumbar areas;

c. No description of the presence of anogenital injuries or pathology;

d. Toxicology analysis being limited to testing for alcohol only; and

e. No photo documentation of external features.

5.154. There were no recorded medical observations to allow Dr Iles to consider a likely time of death, or to understand how Dr Oettle was able to estimate that it had occurred three to four days prior to 14 May 1976. The only indicator available to Dr Iles was the circumstantial evidence such as the time of last sighting, the time at which the body was found and the time on his watch. In relation to the latter, Dr Iles urged caution in relation to assuming that the watch was accurate and had necessarily stopped at the time of death.[91]

5.155. Dr Iles agreed with Dr Oettle that the cause of Mr Stewart's death was "multiple injuries".[92] She considered that Mr Stewart's injuries were consistent with a fall from a height of around 50 metres.[93] Dr Iles noted that the cause of death might be more "fulsomely" described as "multiple injuries sustained in a fall from a height".[94]

5.156. However, Dr Iles was unable to determine the manner of Mr Stewart's death. She found that the documentation of external injuries and marks in the post-mortem report was insufficient to address the presence or absence of subtle injuries that might assist consideration of the possibility of trauma having been inflicted prior to the fall.[95]

5.157. Dr Iles was of the view that there were no further medical investigations that would help to determine the manner of Mr Stewart's death.[96]

Witness statements

5.158. The Inquiry made contact with Keith Thoms, the OIC of the original investigation, as a result of which he provided a brief statement to the Inquiry.[97] Given the length of time that has elapsed since Mr Stewart's death, the statement is ultimately of limited assistance. Mr Thoms had been stationed in Manly for no more than 12 months prior to Mr Stewart's death.[98] He recalled that there was nothing on Mr Stewart's body except the piece of notepad paper, and that a Seiko wristwatch was found nearby. His recollection is that he was able to identify the body as Mr Stewart through the "jeweller's mark" in the Seiko wristwatch.[99]

[91] Exhibit 19, Tab 38, Expert report of Dr Linda Iles, 15 December 2022, 5 (SCOI.82457).

[92] Exhibit 19, Tab 38, Expert report of Dr Linda Iles, 15 December 2022, 6 (SCOI.82457).

[93] Exhibit 19, Tab 38, Expert report of Dr Linda Iles, 15 December 2022, 4 (SCOI.82457).

[94] Exhibit 19, Tab 38, Expert report of Dr Linda Iles, 15 December 2022, 4, 6 (SCOI.82457).

[95] Exhibit 19, Tab 38, Expert report of Dr Linda Iles, 15 December 2022, 5 (SCOI.82457).

[96] Exhibit 19, Tab 38, Expert report of Dr Linda Iles, 15 December 2022, 4 (SCOI.82457).

[97] Exhibit 19, Tab 39, Further statement of Senior Constable Keith Thoms, 28 February 2023 (SCOI.82809).

[98] Exhibit 19, Tab 39, Further statement of Senior Constable Keith Thoms, 28 February 2023, [6] (SCOI.82809).

[99] Exhibit 19, Tab 39, Further statement of Senior Constable Keith Thoms, 28 February 2023, [9]–[11] (SCOI.82809).

5.159. Mr Thoms did not have an independent recollection of the name of the hotel that appeared on the notepaper.[100] While he suggests that he made contact with the hotel where Mr Stewart had been staying from a phone number which appeared on the notepaper, the reliability of this recollection is uncertain, as in other respects his recollection of contact with the hotel appears to be mistaken.[101]

Contact with OIC

5.160. Further to the contact outlined above, on 23 August 2023 and 20 September 2023, the Inquiry wrote to Mr Thoms enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Stewart. The Inquiry did not receive a response from Mr Thoms.[102]

Other

5.161. The Inquiry undertook a manual search of the *Manly Daily*, *Sydney Morning Herald*, *Daily Telegraph*, *Daily Mirror* and *Sun* newspapers for the period 10 to 16 May 1976. The following articles were identified:

a. On 12 May 1976, the discovery of Mr Stewart's body was referenced in the *Sydney Morning Herald,* which described the body of an unidentified boy "aged about 15" located on rocks "below a 15-metre cliff at Fairy Bower, near Manly".[103] An article in the *Manly Daily* on the same day stated that police had to carry the body "several hundred metres to a steep track leading" to the Fairy Bower headland.[104]

b. On 13 May 1976, the *Manly Daily* noted that Mr Stewart's body had not been identified and that "photographs and fingerprints of the dead youth are expected to be circulated" that day.[105]

c. On 14 May 1976, the *Manly Daily* noted that Mr Stewart had still not been identified, but that it was thought that he had fallen from "a 50 metre cliff at 8am" on 11 May.[106]

d. On 18 May 1976, the *Manly Daily* noted that police had identified Mr Stewart's body and "established that the youth had been staying at a Kings Cross hotel". The article also stated that Manly detectives have been in contact with "a Brisbane solicitor and officials at the British High Commission in Canberra".[107]

5.162. The Inquiry also sought and obtained weather data from the BOM for 10 and 11 May 1976.

[100] Exhibit 19, Tab 39, Further statement of Senior Constable Keith Thoms, 28 February 2023, [9] (SCOI.82809).

[101] Exhibit 19, Tab 39, Further statement of Senior Constable Keith Thoms, 28 February 2023, [9]–[12] (SCOI.82809). Mr Thoms suggests that the Hotel contacted police after a period of two weeks, whereas this contact appears to have occurred after only two days.

[102] Exhibit 66, Tabs 76-77, Letters to Keith Thoms, 23 August 2023 and 20 September 2023 (SCOI.86333; SCOI.86334).

[103] Exhibit 19, Tab 25, 'Body found', *Sydney Morning Herald,* 12 May 1976, 14 (SCOI.82455).

[104] Exhibit 19, Tab 24, 'Mystery boy dies in cliff plunge', *The Manly Daily*, 12 May 1976, 1 (SCOI.82459).

[105] Exhibit 19, Tab 26, 'Body not identified', *The Manly Daily,* 13 May 1976(SCOI.82458).

[106] Exhibit 19, Tab 27, 'No clue to dead youth', *The Manly Daily,* 14 May 1976 (SCOI.82452).

[107] Exhibit 19, Tab 28, 'Cliff body identified', *The Manly Daily,* 18 May 1976 (SCOI.82454).

Consideration of the evidence

Mark Stewart's background

5.163. Mr Stewart was born on 18 July 1957 in Port Moresby, Papua New Guinea. He was the second of three children.[108]

5.164. In 1962, the Spanswick family moved to Fiji due to Mr Stewart's father John Spanswick's work with the company Burns Philp. While living in Fiji, the family visited Sydney on holiday on at least three occasions for periods of six to seven weeks at a time. Mr Stewart's sister confirmed to the Inquiry that the family would visit Sydney for extended holidays from Fiji. She stated that they would stay in either Manly or Kings Cross.[109] Mr Stewart's past familiarity with Kings Cross is of note in the context of conflicting evidence that he may have visited the Chevron Hotel, which was located in the Kings Cross area.

5.165. Mr Stewart attended school in Fiji until he was 13-14 years old. He was then sent to college in Masterton, New Zealand.[110] Following a recruitment visit to his school, in September 1973, Mr Stewart (then aged 16) joined the Royal New Zealand Navy as a cadet. He was stationed at Training College in Devonport. During this time, Mr Stewart's parents received regular correspondence from him. However, after some time, Mr Stewart's letters indicated that he had become disenchanted with navy life, and he sought permission from his father to resign. In August 1974, the Royal New Zealand Navy advised Mr Stewart's parents that Mr Stewart had apparently deserted and was absent without leave.[111]

5.166. Records obtained from the Royal New Zealand Navy subsequent to submissions being made shed some further light on the background to Mr Stewart's desertion from the Navy.

5.167. In the latter part of 1974, John Spanswick wrote to his son's superior officers advising them that it would not be in his son's best interests for him to be permitted to visit his family in Fiji during the upcoming Christmas holidays, due to:[112]

> *the current wave of hooliganism and assaults in the streets of Suva … it is hardly a situation for a young lad from overseas to face, unless he wants to spend his leave without leaving the house.*

5.168. In a letter to a senior naval officer dated 6 October 1974, John Spanswick expressed similar sentiments. He stated that:[113]

> *During his last visit Mark spent the whole of his leave in various bars, poolrooms and guesthouses and showed not the slightest interest in entertainment we offered such as a stay at an outer island copra plantation,*

[108] Exhibit 19, Tab 7, Statement of John Spanswick, 28 May 1976, 1 (SCOI.02724.00015).

[109] Exhibit 19, Tab 43, Statement of Caitlin Healey-Nash, 21 March 2023, [5]–[6] (SCOI.82814).

[110] Exhibit 19, Tab 7, Statement of John Spanswick, 28 May 1976, 1 (SCOI.02724.00015).

[111] Exhibit 19, Tab 7, Statement of John Spanswick, 28 May 1976, 1 (SCOI.02724.00015).

[112] Exhibit 13, Tab 45, Letter from John Spanswick to The Commanding Officer, HMNZS Philomel, 9 September 1974 (SCOI.84778).

[113] Exhibit 13, Tab 46, Letter from John Spanswick to The Commanding Officer, HMNZS Waikato, 6 October 1974 (SCOI.84785).

> *sea fishing trip, hikes through the bush or even a lengthy stay at some of our resort hotels, to assist in breaking his constant association with, frankly, the louts of the town.*

5.169. He said that he and his wife were in the process of considering a move to New Zealand for the benefit of their son and daughter.[114]

5.170. The records also indicate that Mr Stewart then wrote to his parents complaining about the contact that his father had made with his superior officers and indicating that he wanted to be discharged from the Navy.[115] In a letter to the Navy dated 12 November 1974 Mr Stewart's mother wrote:[116]

> 5.171. *Obviously Mark is all bitter and twisted with us and I very much doubt that we shall hear from him, that is assuming he is alive and has not done anything silly. You can imagine our worry and concern over the boy at the present time.*

5.172. Mr Stewart's parents emigrated to New Zealand in December 1974. They made extensive inquiries to locate Mr Stewart but to no avail. In mid-1975, John Spanswick received a telephone call from his old employer in Fiji. Mr Stewart was there and spoke with his father. Mr Stewart then flew to New Zealand and stayed with his parents for a few days.[117]

5.173. Following the short stay with his parents in mid-1975, Mr Stewart's father drove him to Christchurch where he caught a flight to Brisbane for "an appointment".[118] Mr Stewart's parents did not know what their son did while in Australia or where he may have lived. Mr Stewart wrote to his parents shortly after his arrival in Brisbane. According to Mr Spanswick, Mr Stewart said that "he had arrived safely, got a job and that everything was O.K.".[119] Mr Stewart's parents did not hear from him thereafter.[120]

5.174. It appears that Mr Stewart lived at a boarding house in Brisbane from around Christmas 1975 until 6 May 1976, just a few days before he died.[121] This information came from the operator of the boarding house, who was interviewed by Brisbane detectives once Mr Stewart's identity had been established.[122]

[114] Exhibit 13, Tab 46, Letter from John Spanswick to The Commanding Officer, HMNZS Waikato, 6 October 1974 (SCOI.84785).

[115] Exhibit 13, Tab 47, Letter from PL Spanswick to The Commanding Officer, HMNZS Waikato, 12 November 1974, 1 (SCOI.84783).

[116] Exhibit 13, Tab 47, Letter from PL Spanswick to The Commanding Officer, HMNZS Waikato, 12 November 1974, 1 (SCOI.84783).

[117] Exhibit 19, Tab 7, Statement of John Spanswick, 28 May 1976, 1 (SCOI.02724.00015).

[118] Exhibit 19, Tab 7, Statement of John Spanswick, 28 May 1976, 1-2 (SCOI.02724.00015).

[119] Exhibit 19, Tab 7, Statement of John Spanswick, 28 May 1976, 2 (SCOI.02724.00015).

[120] Exhibit 19, Tab 7, Statement of John Spanswick, 28 May 1976, 1-2 (SCOI.02724.00015).

[121] Exhibit 19, Tab 17, Special Crime Squad synopsis extract, 21 May 1976 (SCOI.47558).

[122] Exhibit 19, Tab 17, Special Crime Squad synopsis extract, 21 May 1976 (SCOI.47558).

5.175. Some time prior to his death, Mr Stewart changed his name by deed poll from Mark Spanswick to Mark Stewart. There is conflicting evidence as to whether this occurred in 1974 (based on a notation in a Special Crime Squad synopsis extract),[123] or in the early part of 1976 (as suggested by the OIC, based on inquiries made with the British consulate).[124] Mr Stewart's parents were not aware of the name change. They later assumed that Mr Stewart had taken this action because of his desertion from the Navy.[125]

Movements prior to death

5.176. As noted above, the operator of the boarding house where Mr Stewart had been living in Brisbane indicated that Mr Stewart had stayed there until 6 May 1976. At some point between 6 and 9 May 1976, evidently Mr Stewart travelled to Sydney.

5.177. At 9:30pm on Sunday, 9 May 1976, Mr Stewart checked into room 3117 at the Hilton Hotel. It is possible, therefore, that he may have stayed elsewhere in Sydney for one or two nights prior to this. He advised the Hilton Hotel receptionist, Ms Cupitt, that he intended to stay for two nights. Ms Cupitt did not see Mr Stewart after that time.[126]

5.178. Mr Stewart showed Ms Cupitt a driver's licence (later found in his belongings in the hotel room) as identification.[127] Registration details recorded by the hotel indicate Mr Stewart's address as a property on Upper Edward Street, Brisbane, consistent with the later enquiries that were made at that address.

5.179. Ms Cupitt described Mr Stewart as slightly built, with long curly unruly shoulder length fair hair.[128] She said he had a commanding and very self-confident manner, speaking what she described as "well-educated Public School English".[129] In her view his manner and speech were not in keeping with his appearance.[130]

5.180. There is no evidence as to Mr Stewart's movements after 9:30pm on 9 May 1976 when he checked into the hotel.

Location of death

5.181. John Spanswick said that Mr Stewart knew the Fairy Bower area fairly well as the family holidayed in Manly on at least three occasions from Fiji when Mr Stewart was a child.[131] He said that Mr Stewart loved the walk from Shelly Beach to Fairy Bower and that he loved "climbing the rocks and going for walks".[132] Whether by "Fairy Bower" Mr Spanswick meant to refer to the headland or not is unclear.

[123] The extract suggested that this had occurred through the Supreme Court of Queensland, via a firm of solicitors: Exhibit 19, Tab 17, Special Crime Squad synopsis extract, 21 May 1976 (SCOI.47558).

[124] Exhibit 19, Tab 13, Letter from Senior Constable Keith Thoms to Coroner, 29 May 1976 (SCOI.02724.00011).

[125] Exhibit 19, Tab 7, Statement of John Spanswick, 28 May 1976, 2 (SCOI.02724.00015).

[126] Exhibit 19, Tab 9, Statement of Patricia Cupitt, 7 July 1976 (SCOI.02724.00012).

[127] Described as "old" in a property inventory from a search of Mr Stewart's room on 13 May 1976: Exhibit 19, Tab 16, List of personal effects from room 3117, Undated 1 (SCOI.02724.00020).

[128] Exhibit 19, Tab 9, Statement of Patricia Cupitt, 7 July 1976 (SCOI.02724.00012).

[129] Exhibit 19, Tab 9, Statement of Patricia Cupitt, 7 July 1976 (SCOI.02724.00012).

[130] Exhibit 19, Tab 9, Statement of Patricia Cupitt, 7 July 1976 (SCOI.02724.00012).

[131] Exhibit 19, Tab 7, Statement of John Spanswick, 28 May 1976, 2 (SCOI.02724.00015).

[132] Exhibit 19, Tab 7, Statement of John Spanswick, 28 May 1976, 2 (SCOI.02724.00015).

5.182. Similarly, Mr Stewart's younger sister stated that Mr Stewart enjoyed the Shelly Beach area and would go exploring up into the rocks and headlands above Shelly Beach.[133]

5.183. The precise location where Mr Stewart's body was found has not been pinpointed beyond the description given by police that it was 250 metres south of the "Fairy Bower Headland" or of "Fairy Bower". Given the shape of the relevant landmass, this leaves some imprecision as to the starting point for measuring the 250 metres. Counsel Assisting submitted that, nevertheless, the description places it either within or very close to an area now known to have been a beat from at least some point in the 1970s until the 1990s. The type of terrain described by police at the clifftop is similar to that known to have been used as part of the beat.

5.184. The general description in the police statements suggests that the area from which Mr Stewart fell is likely to have been somewhere in the vicinity of "Shelley Headland Upper Lookout", although it may have been somewhat to the north or south of that location. The location in question is very close to the spot from which it appears that Paul Rath fell, approximately 12 months later, this being another death considered by the Inquiry.

Weather conditions

5.185. The weather data indicates that it did not rain in the week prior to 10 May 1976. The weather conditions in Sydney on 10 and 11 May 1976 were overcast, with some rain overnight. There appeared to be little wind and good visibility. The temperatures were mild.[134]

Time of death

5.186. Theoretically, Mr Stewart's death may have occurred any time after around 10:00pm on 9 May 1976, shortly after he checked into the Hilton Hotel. If he had intended to take his life, it would seem that he was not intending to do so until at least late on 10 May or on 11 May, given that he had booked a room for two nights.

5.187. The notation displayed on the Seiko wristwatch ("8.02 TUE 11"), suggests that Mr Stewart may have fallen to his death at 8:02am on 11 May 1976, and that the watch stopped because of the force of Mr Stewart's impact on the rocks. However, it is also possible that:

a. Mr Stewart's watch continued operating for some time after he had fallen;

b. Mr Stewart's watch stopped some time before he had fallen; or

c. Mr Stewart's watch did not display the accurate time.

[133] Exhibit 19, Tab 43, Statement of Caitlin Healey-Nash, 21 March 2023, [6] (SCOI.82814).

[134] Exhibit 19, Tab 37, Bureau of Meteorology Data Document CAS-37787-S5G0Y9-4, 20 October 2022 (SCOI.74836).

Evaluation and significance of references in the evidence to the 'Chevron Hotel'

Two distinct hotels

5.188. Contrary to the assumption in the BCIF that the Hilton and Chevron Hotels were one and the same, they were distinct hotels in different locations, the former in George Street in the Sydney CBD (where it still is), and the latter in Macleay Street Potts Point / Kings Cross.[135] For a period after its opening in September 1960, the Chevron Hotel was known as the 'Chevron Hilton' Hotel under a failed management deal with Hilton International.[136] However, from 1965 until its closure in 1985 it was simply the 'Chevron Hotel'.[137]

Potential relevance of the notepaper being from the Chevron Hotel

5.189. The downstairs bar at the Chevron Hotel, known as the 'Quarter Deck', was a well-known gay venue. The historian Gary Wotherspoon, in his book *Gay Sydney: A History,* states:[138]

> *When the new Chevron Hotel in Macleay Street opened in the early 1960s, its downstairs bar, 'The Quarter Deck', soon became another favoured drinking place for camps, not least because of the large number of young sailors among its patrons.*

5.190. In evidence to the Inquiry given in November 2022, Mr Wotherspoon stated, when referring to Kings Cross venues:[139]

> *I think in the early 1960s, the Chevron Hotel opened there and it had a Quarter Deck Bar, another place you could go. A lot of young sailors would go there for a free drink, a bit of sex later and then a bashing.*

Conflicting references in the police statements

5.191. The earliest reference in the evidence to "the Chevron Hotel" is in the undated statement of the OIC. The statement appears to have been made prior to the contact that police received from the Hilton Hotel on 13 May 1976, as no reference is made to this. The concluding portion of the OIC's statement reads as follows:[140]

> *… The body was then removed to the City Mortuary. On searching the body the only property found was a small piece of note paper with the telephone number of the Chevron Hotel, Sydney on it one corner and written in biro was 7.20 11.5.76.*

[135] Noting that Kings Cross in not a "suburb", but a descriptor of the locality in the vicinity of the junction of William Street, Darlinghurst Road and Victoria Street. Most of the Kings Cross area falls within the suburb Potts Point.

[136] See Exhibit 19, Tab 42, Donald McNeilland and Kim McNamara, 'Hotels as Civil Landmarks, Hotels as Assets: the case of Sydney's Hilton' (2009) 40(3) *Australian Geographer*, 374 (SCOI.82609).

[137] See Chevron Hotel advertisements in *The Bulletin* dated 20 February and 11 September 1965 demonstrating the change, (Exhibit 19, Tab 40, 'Chevron Hotel' advertisement, *The Bulletin,* 20 February 1965 (SCOI.82607), Tab 41, 'Chevron Hotel' advertisement, *The Bulletin,* 11 September 1965(SCOI.82609)).

[138] Exhibit 3, Garry Wotherspoon, *Gay Sydney: A History* (New South Printing, 1st edition, 2016) 158 (SCOI.03677).

[139] Transcript of the Inquiry, 21 November 2022, T191.42 (TRA.00004.00001).

[140] Exhibit 19, Tab 12, Statement of Senior Constable Keith Thoms, undated (SCOI.02724.00019).

> *The Chevron Hotel Sydney was contacted and information left there regarding the deceased. On the 12th May, 1976, I caused the deceased to be fingerprinted and photographed.*

5.192. Counsel Assisting submitted that it seems distinctly possible that the OIC erroneously recorded the name of the hotel on the notepaper as "the Chevron Hotel", instead of "the Hilton Hotel", possibly because there was an association in his mind between the two hotels due to the fact that the Chevron Hotel had been known as the "Chevron Hilton" in the 1960s, but then nevertheless he or another officer telephoned the actual number on the notepaper, being the number for the Hilton Hotel. This might explain how it was that police were in contact with the Hilton Hotel on 11 May 1976.

5.193. The evidence relating to contact between the police and the Hilton Hotel is as follows:

a. Constable Fyson says that at 6:30pm on 13 May 1976, he had a conversation with William Muirhead, a Hilton Hotel security officer, as a result of which he went to the Hilton Hotel (which he describes as the "Hilton Hotel, Sydney") and was shown into room 3117, in which Mr Stewart's property, including his passport, were located.[141]

b. David Ford, another security officer at the Hilton (whose statement was not made until two months later), indicates that after 6:45pm on 13 May 1976, he searched room 3117 "as a result of information received". After locating Mr Stewart's personal effects and passport, "some time later that evening" he made a phone call to Manly Police Station and had a conversation with Constable Fyson, and he later issued "certain instructions" to the other security officer, Mr Muirhead.[142]

c. In his statement (also made two months later), the security officer Mr Muirhead makes no mention of a conversation with Constable Fyson at around 6:30pm on 13 May 1976. He says that he received instructions from Mr Ford at about 7:30pm on that day regarding the occupant of room 3117. He says that at about 8:10pm he was then approached by Constable Fyson and his partner from Manly Police Station and gave them access to room 3117, after which an inventory was made of the property in the room and the officers departed with a suitcase packed with the personal effects that had been located in the room.[143]

d. A NSWPF Report of Occurrence entry for 13 May 1976 made by Constable Fyson commences as follows:[144]

> *From inquiries made on 11.5.76 at the Sydney Hilton Hotel re unidentified male person found at Fairy Bower on 11.5.76, I received a telephone call from Mr David Ford Security Control Officer at the Hilton*

[141] Exhibit 19, Tab 14, Statement of Constable Ronald Fyson, undated (SCOI.02724.00017).

[142] Exhibit 19, Tab 11, Statement of David John Ford, 7 July 1976 (SCOI.02724.000114).

[143] Exhibit 19, Tab 10, Statement of William Eugene Muirhead, 7 July 1976 (SCOI.02724.00013).

[144] Exhibit 19, Tab 23, NSWPF Report of Occurrence, 'Further information re unidentified male person found on rocks at Fairy Bower on 11.5.76', 13 May 1976, 3 (SCOI.82810).

> *Hotel, stating that a young male person answering the description of the above had booked into the Hotel on 9.5.76, but had not been seen since the 10.5.76.*

5.194. Counsel Assisting submitted that this entry indicates that on some basis, the "Sydney Hilton Hotel" had been contacted by police on 11 May 1976. In Counsel Assisting's submission, this appears to strengthen the inference that the OIC erroneously recorded the name of the hotel that appeared on the notepaper, and that in fact the notepaper bore the name of the Hilton Hotel.

5.195. As set out by Counsel Assisting in submissions, there was clearly some conflation in the minds of officers between the two hotels, given the number of references that are made to the Chevron Hotel. Constable Fyson refers to Mr Muirhead as the security officer of the "Chevron Hotel",[145] when in fact he was the security officer of the Hilton Hotel. Similarly, in the Report of Death to Coroner, the OIC describes the notepaper as bearing the name of the "Chevron Hilton Hotel", and says that it had been ascertained that Mr Stewart had booked into this hotel, when in fact he had not.[146]

5.196. Counsel Assisting submitted that, on the other hand, it is possible that the notepaper did in fact refer to the name and number of the Chevron Hotel and that the officer who contacted the Hilton Hotel on 11 May 1976 did so after looking up the number for the Hilton Hotel. However, on that hypothesis, how such an officer would have arrived at a belief or understanding that the Hilton Hotel should be contacted is unclear.

5.197. Potentially telling in favour of the possibility that the notepaper did refer to the Chevron Hotel is the fact that the *Manly Daily* records that Mr Stewart had been staying at Kings Cross,[147] suggesting that information provided to the newspaper (presumably by police) linked Mr Stewart to the Chevron Hotel at Potts Point/Kings Cross.

5.198. Adding to the uncertainty is that where Mr Stewart stayed on 7 and 8 May 1976 is not known, and that Kings Cross and Manly were the two locations in Sydney that he had visited on family holidays in the past. Those factors may lend some weight to the possibility that the OIC had accurately recorded the name of the hotel written on the notepaper as the Chevron.

5.199. Counsel Assisting submitted that, on balance, it is more likely that the OIC wrongly recorded the name that appeared on the notepaper, and that the name on the notepaper was in fact that of the Hilton Hotel. Counsel Assisting further submitted, however, that there remains some uncertainty about this, and the possibility undoubtedly remains that it was notepaper from the Chevron Hotel. The uncertainty around the issue serves to highlight that it is regrettable that that notepaper was not retained or photographed, and that there are no records available that enable it to now be located.

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[145] Exhibit 19, Tab 14, Statement of Constable Ronald Fyson, undated (SCOI.02724.00017).

[146] Exhibit 19, Tab 2, Report of Death to Coroner, 13 May 1976, 1 (SCOI.82449).

[147] Exhibit 19, Tab 28, 'Cliff body identified', *The Manly Daily,* 18 May 1976, 1 (SCOI.82454).

5.200. The NSWPF submitted that "the evidence supports the conclusion that the officer in charge wrongly recorded the name of the hotel as the 'Chevron Hotel', and that the name on the notepaper was in fact the Hilton Hotel in George Street where Mr Stewart had been staying".[148] In any event the NSWPF discounted the relevance of the notepaper being from the Chevron Hotel to the circumstances of Mr Stewart's death. I accept the submission of Counsel Assisting and the NSWPF that the more likely explanation is that the OIC wrongly recorded the hotel name. However, the question is attended by real doubt and there is a real possibility that the notepaper referred to the Chevron Hotel. I do not accept the NSWPF's attempt to discount the relevance of the notepaper being from the Chevron Hotel. If that were so I consider it would be a material matter for this Inquiry, especially given the evidence I have received about the Quarter Deck Bar. I return to this matter below.

Police investigation

LGBTIQ hate crime on the Northern Beaches in the 1970s

5.201. Counsel Assisting submitted that an evaluation of the nature of the police investigation of this matter requires some broader consideration of the policing and social context of the era, now over 45 years ago.

5.202. Evidence in other matters being considered by the Inquiry suggests that some police officers investigating deaths in the late 1980s and early 1990s at times gave little or no attention to the possibility that they may have been homicides motivated by LGBTIQ bias, notwithstanding that, based on the circumstances, there was reason to suspect that they were, or may have been, homicides of that nature. It was suggested by Counsel Assisting that this has particularly been the case for deaths that have involved a fall from a cliff, where the death may have been too readily assumed to have been an accident or suicide.

5.203. Counsel Assisting submitted that, if this was the position in the late 1980s, there is even more reason to expect that it was also often a feature of the approach of police to such deaths in the 1970s. The Inquiry has heard ample evidence of the historically low levels of awareness and acceptance of the LGBTIQ community in the general community in that era, as well as evidence of low levels of awareness and acknowledgement at that time of crimes committed against members of the LGBTIQ community. The environment in which policing occurred in the 1970s, it was submitted by Counsel Assisting, was not conducive to the detection of such crimes.

[148] Submissions of NSWPF, 12 April 2023, [62] (SCOI.45187).

5.204. Counsel Assisting noted that, undoubtedly, assaults of men who were perceived to be gay occurred in areas of the northern beaches of Sydney during the 1970s, and referred to a documented instance of "gay murders" in a suburb near Manly in late October 1975, less than seven months prior to Mr Stewart's death. That matter involved a number of young navy recruits who were convicted of the murder of a man at Curl Curl Beach, having met the victim (Phillip Jones) and his friend at a hotel in Manly Vale earlier in the evening. Perceiving the men to be gay, the sailors lured them to the beach and assaulted both of them, resulting in the death of Mr Jones.[149]

Extent of awareness among police of the possible relevance of proximity to the North Head beat

5.205. The OIC in relation to Mr Stewart's death told the Inquiry that he had not been aware of the existence of the beat in 1976, and it is not mentioned in the documentary record of the investigation. However, the OIC had not been stationed at Manly for a lengthy period at the time of Mr Stewart's death. The Strike Force Parrabell review of the matter acknowledged the beat's existence, which has been well documented elsewhere, both in evidence before the Inquiry and in other proceedings.

5.206. Moreover, contemporaneous material suggests that at least some Manly police must have been aware of it by the mid-1970s. For example, a *Manly Daily* newspaper article published on 27 April 1977, less than 12 months after Mr Stewart's death, refers to a "'Starsky and Hutch' beach patrol" policing crime in the beach areas of Manly and that the patrol featured plain clothes officers who had, among other things, "busted homosexual activities at North Head".[150]

5.207. Further, in the matter of Paul Rath, a young man who died as a result of a fall from the same headland one year later, evidence before the Inquiry demonstrated an awareness on the part of the OIC of investigating that matter that the area in question was a beat. In that matter, reference was made by police, in the Report of Death to Coroner, to the status of the area as a beat.

The possibility of homicide was not seriously countenanced

5.208. Counsel Assisting submitted that the police investigation of Mr Stewart's death never appears to have seriously countenanced the possibility that the death may have been a homicide. Rather, its focus was on identifying the body and identifying someone who knew Mr Stewart. This included making enquires at the local Water Board depot (situated at North Head) in case someone fitting Mr Stewart's description was an employee and checking at a "local employment office".[151]

[149] See Exhibit 2, Tab 98, Lex Watson, 'Australian Gays Murdered in 1975', *Campaign* (Sydney), February 1976, 3 (SCOI.76852); Exhibit 2, Tab 30, Thomas Poberezny-Lynch, *'We All Thought They Were Poofters': Anti-Homosexual Murder and Violence in Australia, 1970–1980* (Honours Thesis, University of Sydney, 2014), 6-8 (SCOI.76829).

[150] Exhibit 12, Tab 27, '90 arrested by new police beach unit', *The Manly Daily*, 27 April 1977, 1 (SCOI.82350).

[151] Exhibit 19, Tab 23, NSWPF Report of Occurrence, 'Further to unidentified male person found on rocks at Fairy Bower', 12 May 1976, 2 (SCOI.82810).

5.209. Counsel Assisting noted that police made observations of items in the vicinity of the body and conducted a search of at least a part of the Fairy Bower headland. They made observations of the terrain at the top of the cliff and the lack of any obvious disturbance in the clifftop area. Beyond this, Counsel Assisting submitted, there appears to have been little investigation by police into the circumstances of Mr Stewart's death. There are no photographs or other documents relating to the location and position of the body, or of Mr Stewart's possessions. As a result, it is difficult now to accurately identify the location where the body was found.

5.210. Counsel Assisting submitted that although the timing of Mr Stewart's death cannot be pinpointed with certainty, there was good reason for police to suspect that Mr Stewart had met his fate earlier that morning, potentially only two hours prior to discovery of his body at 10:00am. This is based on the state of the body, the time at which the Seiko watch appeared to have stopped (8:02am on 11 May) and the time written on the notepaper (7.20 on the 11th).

5.211. In oral submissions Counsel Assisting observed that in the occurrence entry made just five hours after Mr Stewart's body was located, the conclusion had already been reached that there were "no suspicious circumstances".[152]

5.212. I accept Counsel Assisting's submission that had there been an openness to the possibility that Mr Stewart's death may have involved another party, there may have been opportunities for police to immediately canvas for information, based on Mr Stewart's young age, distinctive clothing and physical appearance. Once Ms Cupitt had been spoken to, such canvassing could have taken account of the distinctive accent that she had noticed Mr Stewart to have. Such canvassing could have involved residents of houses on the walk between Manly Beach and Shelly Beach, and those houses closest to the Fairy Bower headland at the end of Bower Street, as well as Manly ferry staff and ticket sellers who were on duty early on 11 May. Obvious questions may have included whether, if noticed, Mr Stewart had been accompanied by anyone, and whether anyone was observed in his vicinity or otherwise noticed to have been acting in a manner that aroused suspicion.

5.213. I also note that there appears to have been no attempt made to speak with hotel staff (other than the receptionist, Ms Cupitt) to obtain information about anything that may have been known of Mr Stewart's movements at any time after he checked in, including all day on 10 May and the morning of 11 May.

5.214. The OIC has provided the Inquiry with his limited recollection of his involvement in this matter. Counsel Assisting did not suggest that criticism should be made of him or other individual police officers who were involved in the investigation. Rather, Counsel Assisting submitted that the point is to observe that the social environment and policing practices of the era do not appear to have been conducive to considering and detecting whether a death in these circumstances may have been an LGBTIQ bias homicide. I accept this submission.

[152] Exhibit 19, Tab 23, NSWPF Report of Occurrence, 'Unidentified youth found at the foot of Fairy Bower headland', 11 May 1976, 1 (SCOI.82810).

5.215. The NSWPF accepted that societal attitudes and policing practices in the 1970s were not conducive to recognising the possibility that crimes may have been motivated by LGBTIQ bias. However, the NSWPF submitted that a finding that the identification of the body was quickly the "sole" concern of the police investigation is not open on the evidence.[153]

5.216. The NSWPF pointed to the following inquiries as "clearly extend[ing] beyond the identification of the body":[154]

a. The Special Crime Squad synopsis dated 24 May 1976, which included the observation:[155]

> *Death obviously caused by falling over cliff. No member of family yet located to establish whether possible suicide or drug involvement. His passport was issued at Fiji in 1970 and a telex was sent there on 21-5-76 to ascertain relatives but no reply as yet. As this stage reason for being at Fairy Bower not known, but there is no evidence to suggest foul play.*

b. The statement taken from John Spanswick, with notes from the officer taking the statement recording the following:[156]

> *Mr Spanswick suggested that the reason his son was in Manly could have been the fact that whilst they resided in Fiji the family had a number of holidays in Manly and the Shelley Beach-Fairy Bower area was frequently visited by the deceased and family. The deceased was also very keen on rock climbing. The father had no knowledge of suicidal tendencies by his son and undoubtedly Mark was walking around the cliff face area and probably slipped and fell.*

5.217. The NSWPF submitted that the focus of investigations on possible suicide or accidental death is unsurprising in light of the fact that there was and remains no positive evidence of foul play or, indeed, evidence of anyone being present at or shortly before Mr Stewart's death.[157] In those circumstances, the NSWPF submitted, it was reasonable for police to arrive at a hypothesis that Mr Stewart's death was either an accident or suicide.[158]

5.218. It was also submitted that the NSWPF cannot reasonably be criticised for the fact that the clothing worn by Mr Stewart and the items found with his body, including the handwritten note, are now not available for forensic testing almost 47 years later.[159]

[153] Submissions of NSWPF, 12 April 2023, [49] (SCOI.45187).

[154] Submissions of NSWPF, 12 April 2023, [52] (SCOI.45187).

[155] Exhibit 19, Tab 18, Special Crime Squad synopsis extract, 24 May 1976 (SCOI.47557).

[156] Exhibit 19, Tab 23, NSWPF Report of Occurrence, 'Mark Stewart @ Spanswick – identified', 28 May 1976, 4 (SCOI.82810).

[157] Submissions of NSWPF, 12 April 2023, [53] (SCOI.45187).

[158] Submissions of NSWPF, 12 April 2023, [53] (SCOI.45187).

[159] Submissions of NSWPF, 12 April 2023, [54] (SCOI.45187).

5.219. The NSWPF also considered it relevant to note that there was no suggestion that the Coroner considered the investigation to be in any way deficient.[160] Had Coroner Goldrick considered further investigations to be warranted, recommendations in that respect could have been made. The NSWPF submitted that:[161]

> *The absence of recommendations or directions in relation to the conduct of further investigative steps gives rise to a clear inference that the investigation was regarded as at least adequate, having regard to police practice at the time.*

5.220. During the Investigative Practices Hearing, Detective Inspector Warren agreed with Counsel Assisting's suggestion that it is difficult to accurately identify the location of Mr Stewart's body absent any photographs or other documents relating to the location and position of his body or possessions. Detective Inspector Warren told the Inquiry that there is no record of any such photographs or other documentation being taken, notwithstanding the fact that the requisite technology was available in 1976. Detective Inspector Warren accepted that it was important in an investigation to have a photograph or other reliable record of the location of a body and personal effects. Detective Inspector Warren also agreed that the importance of such steps was appreciated in the mid-1970s. He could not offer any reason why photographs were not taken.[162]

5.221. As indicated above, there is some doubt on the evidence as to whether Mr Stewart was in fact staying at the Chevron Hotel prior to his death. Detective Inspector Warren acknowledged that the bar located within the hotel was a popular venue for gay men in 1976. He gave evidence that he would expect, and proper police procedures would require, investigating police in the mid-1970s to have taken steps to contact hotel staff to obtain information about Mr Stewart's movements at any time after he checked in. Detective Inspector Warren accepted that these steps should have extended beyond taking a statement from the receptionist at the Hilton Hotel.[163]

5.222. In these circumstances, Counsel Assisting submitted, in the context of the Investigative Practices Hearing, that police can reasonably be criticised for the failure to take at least those steps set out above. They fell short of the standard the public had a right to expect from the NSWPF. Counsel Assisting submitted that the failure to retain the handwritten note means that it is not clear whether the steps referred to at [5.220] should have been taken, but the failure to retain the note in and of itself is a serious matter.

5.223. In written submissions filed by the NSWPF in response to the Investigative Practices Hearing, the NSWPF accepted that if photographs were not taken of Mr Stewart's body or his possession this fell short of accepted investigative standards in the 1970s.

[160] Submissions of NSWPF, 12 April 2023, [56] (SCOI.45187).

[161] Submissions of NSWPF, 12 April 2023, [56] (SCOI.45187).

[162] Transcript of the Inquiry, 5 July 2023, T4974.18-4975.47 (TRA.00073.00001).

[163] Transcript of the Inquiry, 5 July 2023, T4974.47-4975.22 (TRA.00073.00001).

5.224. In respect of Detective Inspector Warren's evidence concerning the failure of the NSWPF to take a statement from hotel staff about Mr Stewart's movements after he checked in, the NSWPF suggested that there was some ambiguity in Detective Inspector Warren's evidence as to whether he was referring to the Hilton Hotel or the Chevron Hotel. The NSWPF submitted that, considering the quick contact made by police with the Hilton Hotel, it is unlikely police overlooked contacting the Chevron Hotel.[164]

5.225. In reply submissions in the context of the Investigative Practices Hearing, Counsel Assisting contended at [106] that the inference sought by the NSWPF could not be drawn (that it is unlikely that police overlooked contacting the Chevron Hotel, if that hotel's name did appear on the notepaper). Rather, the inability to reach a conclusion about this is one of the reasons why the failure to retain the handwritten note was serious. I accept the submissions of Counsel Assisting.

Loss or destruction of exhibits

5.226. In relation to the failure of the NSWPF to locate the exhibits referred to above, the NSWPF submitted that, "[p]olice cannot reasonably be criticised for the fact that the clothing worn by Mr Stewart and the items found with his body, including the handwritten note, are now not available for forensic testing almost 47 years later".[165] The NSWPF submitted that, as has been repeatedly identified, police exhibit management practices have changed dramatically in that intervening period. Mr Stewart died roughly 10 years before DNA testing was used anywhere in the world, and almost 30 years prior to the formation of the UHT.

5.227. In evidence given during the Investigative Practices Hearing, Assistant Commissioner Conroy conceded that these exhibits were "significant" and could not possibly have been consumed by forensic testing. Assistant Commissioner Conroy accepted that if the exhibits were destroyed, disposed of or otherwise returned to somebody, there ought to have been a record to that effect. Despite making enquiries, Assistant Commissioner Conroy could not point to such a record existing and conceded that the absence of documentation is indicative that "there's possibly been a breach of a police policy or procedure".[166] In these circumstances, Counsel Assisting submitted that criticism of the NSWPF is entirely reasonable.

[164] Submissions of NSWPF, 10 October 2023, [303] (SCOI.86127).

[165] Submissions of NSWPF, 12 April 2023, [54] (SCOI.45187).

[166] Transcript of the Inquiry, 4 July 2023, T4847.44-4848.19 (TRA.00072.00001).

5.228. The NSWPF acknowledged, in written submissions filed in the context of the Investigative Practices Hearing, that a record ought to have been created of whether the exhibits were destroyed, disposed of or returned to the family. However, the NSWPF submitted that whether the failure to locate such a record is indicative of a breach of procedure cannot be determined by the Inquiry. This is because Mr Stewart's death occurred in 1976, during which time it is not apparent for what period such records were required to be retained.[167] As to whether it was reasonable for the NSWPF to retain the exhibits, the NSWPF noted that the relevant police instruction required the retention of exhibits until "all possible Court action has been finalised".[168] Given the Coroner and the Special Crime Squad had found no evidence to suggest foul play, the NSWPF submitted that it would be "surprising" if the exhibits had been retained till present day.[169]

5.229. In reply submissions in the context of the Investigative Practices Hearing, Counsel Assisting made the point, which I accept, that if records were disposed of in accordance with an applicable police instruction there should be a record to that effect. Such a record, it appears, did not exist as the NSWPF were not able to furnish me with evidence that the exhibits in Mr Stewart's case were destroyed with appropriate authorisation (or any policy or procedure document to explain why that record, in turn, would not exist or have been retained).

Consideration of submissions

5.230. I agree with the submission of Counsel Assisting that the primary focus of the police investigation into Mr Stewart's death was the identification of the body. No criticism is made of this being an important matter to determine in the early stages of the investigation. However, in my view, the police investigation prematurely ruled out the possibility that Mr Stewart's death may have involved an act of foul play and that more could have, and should have, been done to pursue lines of inquiry covering the range of alternative hypotheses that may have explained Mr Stewart's death both prior to and once Mr Stewart had been identified.

5.231. The inquiries made by the investigating officers showed little consideration of Mr Stewart's last movements, any evidence of the involvement of another party, or any potential factors of LGBTIQ bias (such as the location of his death at a beat, a potential connection to the Chevron Hotel and/or that he attended Fairy Bower Headland as a result of a prearranged meeting).

[167] Submissions of NSWPF, 10 October 2023, [299] (SCOI.86127).

[168] Submissions of NSWPF, 10 October 2023, [300] (SCOI.86127).

[169] Submissions of NSWPF, 10 October 2023, [300] (SCOI.86127).

5.232. As noted above, the NSWPF submitted that there were investigative steps taken by police that demonstrated that inquiries "quite clearly extended beyond the identification of the body".[170] The inquiries that the NSWPF pointed to, were, in effect:[171]

a. To try to make contact with relatives and to ask them about "possible suicide or drug involvement" and Mr Stewart's reasons for being at Fairy Bower in circumstances where the police had already concluded that there was "no evidence to suggest foul play"; and

b. Taking a statement from Mr Stewart's father, John Spanswick, who gave evidence as to why Mr Stewart could have been at Manly and that he was keen on rock climbing. John Spanswick also told police that he had "no knowledge of suicidal tendencies by his son and undoubtedly [Mr Stewart] was walking around the cliff face area and probably slipped and fell".

5.233. I do not consider that these inquiries demonstrate that the police investigations went far beyond the identification of the body. In fact, they tend to confirm the limited nature of any substantive investigation of possible causes of Mr Stewart's death.

5.234. I observe that given the lack of evidence as to manner of death at the time of Mr Stewart's death, police could have and should have queried certain issues (such as the lack of a wallet and the existence of a note suggesting a potential arrangement for a meeting) and taken additional steps (such as canvassing in relation to sightings of Mr Stewart) and other steps outlined by Counsel Assisting as noted above.

5.235. I do not accept the submission made by the NSWPF that a lack of criticism by the Coroner in relation to the police investigation can be taken to indicate that it was sufficient. The Coroner should be entitled to assume that police investigating a death will have approached a matter with a certain degree of thoroughness before an investigative officer expresses a view that a death has not involved foul play. In any event, by the time a coroner may be in a position to examine a coronial brief that has been sent to the Court, opportunities for more thorough scene examination and early canvassing of eyewitnesses are likely to have been lost.

5.236. I am satisfied on the evidence of Detective Inspector Warren that it fell short of the policing standards of the day for police to have failed to take a photograph or make an accurate record of where Mr Stewart's body and personal effects were found. Moreover, if the notepaper did in fact refer to the Chevron Hotel, then that would have been a significant matter warranting investigation, especially noting the status of the Quarter Deck Bar as a venue frequented by gay men. As to this last matter, in fairness I refer to the view I have expressed above that on balance the notepaper is more likely to have referred to the Hilton Hotel. However, the uncertainty about this makes it even more regrettable that the notepaper has been lost.

[170] Submissions of NSWPF, 12 April 2023, [52] (SCOI.45187).

[171] Submissions of NSWPF, 12 April 2023, [50]–[51] (SCOI.45187).

Manner and cause of death

Cause of death

5.237. Counsel Assisting noted that while the Coroner's finding of "multiple injuries" is consistent both with Dr Oettle's original post-mortem report and Dr Iles' review of the forensic materials, Dr Iles' recommendation is that the cause of death be more specifically described as "multiple injuries sustained in a fall from a height".[172] Counsel Assisting submitted that this more specific cause of death should be adopted by the Inquiry.

5.238. The NSWPF did not make any specific submissions regarding cause of death, beyond submitting that they agreed with the ultimate finding as to manner and cause of death proposed by Counsel Assisting.

Manner of death

5.239. Counsel Assisting submitted that the evidence before the Inquiry does not enable any formal finding to be made that would distinguish between the possibilities of suicide, accident or foul play.

5.240. While the Coroner's principal finding that it is not possible to determine the manner of death is supported, it was submitted by Counsel Assisting that the secondary finding that foul play could be ruled out, should not be adopted by the Inquiry.

5.241. I therefore turn to consider the evidence relating to each potential manner of death, and the parties' submissions in relation to the alternative hypotheses.

The possibility of suicide

5.242. Counsel Assisting submitted that the absence of relevant evidence in the police material makes it difficult to evaluate the likelihood of suicide, and noted the following matters:

a. Mr Stewart's father told police that he could not offer any reason or explanation as to why Mr Stewart would be at Fairy Bower at that time of day (it is unclear what "time of day" he is referring to), and that he did not know of anything that would cause Mr Stewart to take his own life.[173] Counsel Assisting noted that that opinion needs to be understood in the context of the very limited contact between Mr Stewart and his father in the 18 months prior to his death. Mr Stewart's sister was of the view that her brother's past associations with the area were happy ones, in the context of their childhood holidays.[174]

b. Other evidence that would assist in evaluating the likelihood of suicide would include any further information regarding Mr Stewart's life in Brisbane or elsewhere in the months preceding his death. However, other than the fact

[172] Exhibit 19, Tab 38, Expert report of Dr Linda Iles, 15 December 2022, 6 (SCOI.82457).

[173] Exhibit 19, Tab 7, Statement of John Spanswick, 28 May 1976, 2 (SCOI.02724.00015).

[174] Exhibit 19, Tab 43, Statement of Caitlin Healey-Nash, 21 March 2023, [7] (SCOI.82814).

that he resided at a boarding house for around five months leading up to his death, there is no evidence of about Mr Stewart's personal relationships, health, employment, or any personal difficulties in that period which might assist in revealing his state of mind.

c. Mr Stewart's two-day booking at the Hilton Hotel could perhaps be consistent with his having intended to end his life on 10 or 11 May 1976. Similarly, the notepaper and notation could be viewed as a record intentionally left by Mr Stewart to indicate where he had been staying and the time at which he was about to take his life. (However, this seems unlikely given the bare nature of the notation and there being no indication that a pen was located at the scene.) Conversely, the existence of the note indicating a potential arrangement or plan for the time of 7:20 (whether am or pm) on 11 May might be thought inconsistent with any suicidal intention.

5.243. I observe that the records recently obtained from the Royal New Zealand Navy shed some light, albeit inconclusively, on Mr Stewart's mental state as of May 1976. They reinforce the evidence of an estrangement between Mr Stewart and his parents. From Mr Spanswick's perspective, this appears to have been referable at least in part to Mr Stewart attending "various bars, poolrooms and guesthouses" and associating with "louts". The possibility of suicide might also be what Mr Stewart's mother had in mind when she said, "assuming he is alive and has not done anything silly".

5.244. It was submitted by Counsel Assisting that the possibility that Mr Stewart may have intentionally taken his own life has little support in the evidence, but cannot be ruled out entirely.

5.245. In submissions, the NSWPF stated:[175]

> *It is unclear why Counsel Assisting so significantly discounts the possibility of suicide. It should be recalled in this respect that deaths by suicide are vastly more common than deaths by homicide. This probabilistic disparity is only heightened when one considers that the bulk of homicides occur in a residential setting.*

5.246. The evidence cited by the NSWPF in support of this submission was the following footnote:[176]

> *In 2021, for example, there were 3,144 suicides recorded in Australia (https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/2021#australia-s-leading-causes-ofdeath-2021), but only 370 homicides — 193 of which were recorded as murders (https://www.abs.gov.au/statistics/people/crime-and-justice/recorded-crime-victims/latest-release).*

[175] Submissions of NSWPF, 12 April 2023, [65] (SCOI.45187).

[176] Submissions of NSWPF, 12 April 2023, [65] (SCOI.45187).

5.247. At no point prior to, or at, the documentary tender into Mr Stewart's death or the filing of written submissions, did the NSWPF seek for these ABS statistics to be tendered into evidence. It was only after the Inquiry wrote to the NSWPF regarding the several online articles and other ABS statistics cited by the NSWPF in its submissions — but which had not been tendered into evidence — did the NSWPF seek for these statistics to be tendered.

5.248. The NSWPF submitted that there is admittedly a paucity of evidence as to Mr Stewart's mental state, but that there are at least some matters that might be consistent with suicide:[177]

> *Indeed, it is clear is that the period prior to Mr Stewart's death was one of significant upheaval in his life: he deserted the New Zealand navy, moved to Brisbane where he lived in a boarding house, became estranged from his family, and changed his name. Moreover, it was at least highly unusual that Mr Stewart, an 18-year- old who had resided in a boarding house for some months, reserved two nights at a luxury hotel immediately prior to his death.*

The possibility of accident

5.249. Counsel Assisting submitted that the terrain in the vicinity of the cliff edge as described by Constable Ure suggests the possibility that Mr Stewart could have fallen accidentally, bearing in mind his father's account that he used to love climbing around the rocks in the area on past family holidays.

5.250. Further, Counsel Assisting submitted that the presence of the broken off Banksia branch at the base of the cliff may be more consistent with either an accident or foul play rather than suicide, as its presence may indicate an attempt to grasp at a branch in circumstances where the fall was not an intentional act.

5.251. The NSWPF did not make any specific submissions regarding the possibility of accident.

The possibility of foul play

5.252. Both the Coroner and the Special Crime Squad found no evidence to suggest foul play.[178]

5.253. No evidence appears to have been located at the clifftop indicative of a struggle or assault having taken place there. Counsel Assisting submitted that limited weight can be given to the absence of such evidence in circumstances where such a death can be effected by a push and where the post-mortem report may not have adequately documented any external injury. The NSWPF submitted that:[179]

> *the hypothetical scenario of a push that was not associated with any other form of struggle proposed by Counsel Assisting … is difficult to reconcile*

[177] Submissions of NSWPF, 12 April 2023, [66] (SCOI.45187).

[178] Exhibit 19, Tab 36, Extract of transcript of Coronial Inquest into the death of Mark Stewart, undated (SCOI.02724.00007); Exhibit 19, Tab 17, Special Crime Squad synopsis extract, 21 May 1976 (SCOI.47558); Exhibit 19, Tab 18, Special Crime Squad synopsis extract, 24 May 1976 (SCOI.47557).

[179] Submissions of NSWPF, 12 April 2023, [70] (SCOI.45187).

> *with ordinary human behaviour; it would have required Mr Stewart to be standing on or near the edge of the cliff and for someone to approach him unnoticed such that they were able to push him over the edge before he could offer any meaningful resistance.*

5.254. Counsel Assisting submitted that although a sum of money ($15.27) is noted as having been found on Mr Stewart, the absence of any wallet having been found on his person or in the vicinity at the time of death, or in his hotel room, is potentially consistent with Mr Stewart having been the victim of robbery, although it must be borne in mind that it is not known whether it was his practice to carry a wallet.

5.255. Counsel Assisting further submitted that, in summary, features of this matter that suggest the possibility that Mr Stewart may have been the victim of foul play are as follows.

5.256. First, the absence of particularly compelling evidence in support of alternative hypotheses. The NSWPF submitted that this cannot, without more, support a finding of possible foul play and stated that "this analysis fails to recognise the statistical reality that both suicide and accidental deaths are vastly more common than homicides".[180]

5.257. Secondly, the fact that the death occurred in the vicinity of a beat. The NSWPF submitted that the mere fact that a death occurred in the vicinity of a beat cannot, without more, give rise to a realistic suggestion that Mr Stewart was the victim of a homicide. The NSWPF stated:[181]

> *In particular, Fairy Bower is an attractive coastal location, and the vast majority of visitors to it were likely there for reasons other than the pursuit of sexual relations.*

5.258. Thirdly, the possibility that Mr Stewart may have attended the Chevron Hotel, the bar of which was a well-known gay venue, and the potential consistency of this with his visit to a known beat location. By contrast, the NSWPF submitted that even if the notepaper found with Mr Stewart's body did refer to the Chevron Hotel in Potts Point, this "does not advance the inquiry into either Mr Stewart's sexuality or the cause of his death", and cannot be attributed any real weight.[182]

5.259. Fourthly, the hypothesis that Mr Stewart was a member of the LGBTIQ community or questioning his sexuality being potentially consistent with his apparent estrangement from family and his departure from the New Zealand Navy. The NSWPF submission on this point is outlined below.

[180] Submissions of NSWPF, 12 April 2023, [71] (SCOI.45187).

[181] Submissions of NSWPF, 12 April 2023, [68] (SCOI.45187).

[182] Submissions of NSWPF, 12 April 2023, [67] (SCOI.45187).

5.260. Fifthly, the absence of a wallet in his hotel room, or at the scene at Fairy Bower. By contrast, the NSWPF submitted that the absence of a wallet does not provide meaningful support for a homicide finding, and pointed to the following matters:[183]

a. It is not known whether Mr Stewart habitually carried a wallet.

b. If Mr Stewart died by way of suicide, he may have given his wallet away, or left it somewhere (other than his hotel room) prior to doing so.

c. Mr Stewart had a reasonable sum of money in his possession (relative to the average earnings of the time), suggesting he was not likely the victim of a robbery.

d. There were no other indications consistent with robbery or attack of any kind.

5.261. Sixthly, the possibility that the notation on the notepaper was a reference to an arrangement to meet another person. Counsel Assisting submitted that if this were the case, bearing in mind the time that was noted, it suggests that Mr Stewart may have been with someone in the lead up to his death.

5.262. The NSWPF submitted that while the possibility of foul play cannot be entirely excluded, it finds little support in the evidence.

Consideration of submissions as to manner of death

5.263. Concerning the manner of Mr Stewart's death, both Counsel Assisting and the NSWPF made submissions as to the relative likelihood of suicide, accident and foul play. While the absence of relevant evidence makes it difficult to determine the likelihood of each alternative, I have reached the following conclusions:

a. I place little weight on the general assertions by the NSWPF "that deaths by suicide are vastly more common than deaths by homicide" and "that the bulk of homicides occur in a residential setting".[184] Such generalisations are of little assistance in considering the particular known circumstances of this case.

b. Further, accepting the assertion made by the NSWPF that the majority of homicides occur in a residential setting, Mr Stewart was found at or near the location of other suspicious deaths in the time period the subject of this Inquiry, one of which is known to have been an act of homicide. To "assume" the likelihood of suicide by virtue of the type of generalisation referred to by the NSWPF risks the adoption of erroneous assumptions that are known to have hampered past police investigations such as that which occurred in relation to the death of Scott Johnson.

c. The presence of the Banskia branch near to Mr Stewart's body to be a feature that is potentially more consistent with misadventure or foul play, rather than with suicide.

[183] Submissions of NSWPF, 12 April 2023, [69] (SCOI.45187).

[184] Submissions of NSWPF, 12 April 2023, [65] (SCOI.45187).

d. Further, while it was evident that Mr Stewart had experienced some significant changes to his life in the 18 months prior to his death, without evidence as to his mental health and life circumstances at the time, I do not consider it appropriate to assume a link between those changes and potential suicidal ideation.

e. I agree with the submission of Counsel Assisting that homicide cannot be discounted, and accept that there are features of this matter which suggest the possibility that Mr Stewart may have been the victim of foul play.

f. The submission made by the NSWPF clearly seeks to diminish the likelihood that foul play may have been involved in the death. I reject those submissions entirely on the question of foul play.

g. In particular, I note that the submissions of the NSWPF in this respect rely in part on the lack of "indications consistent with … an attack of any kind". It is alarming to see such a submission being advanced in relation to a potential act of foul play at a clifftop setting, even putting to one side the evidence of the Banksia branch.

5.264. As I indicate above, the recently obtained material from the Royal New Zealand Navy might lend some support to the possibility of suicide.

Time of death

5.265. Counsel Assisting submitted that the Coroner's finding that Mr Stewart died on 11 May 1976, too narrowly confines the potential time of death, in the absence of evidence as to Mr Stewart's movements between 9:30pm on 9 May 1976 and the discovery of his body at 10:00am on 11 May 1976.

5.266. Accordingly, Counsel Assisting submitted that the Inquiry should find that Mr Stewart died on 10 or 11 May 1976 as a result of multiple injuries sustained in a fall from a height, the cause of which cannot be determined.

5.267. The NSWPF did not make any specific submissions regarding time of death beyond agreeing with the finding as to manner and cause of death proposed by Counsel Assisting (see [5.279] below).

5.268. In these circumstances, and noting the expert evidence of Dr Iles at [5.154] above, I accept the submissions of Counsel Assisting as to time of death.

Bias

5.269. Counsel Assisting submitted, and the NSWPF agreed, that the evidence does not disclose whether Mr Stewart was a member of the LGBTIQ community.

5.270. In addition, both Counsel Assisting and the NSWPF acknowledged that the area where Mr Stewart's body was found, the headland area rising to the south of Shelly Beach, was adjacent to, or part of, a known beat. However, while Counsel Assisting submitted that this was a matter that should be taken into account in the consideration of both manner of death and possibility of bias, the NSWPF submitted that there is no evidence to suggest that the beat was in any way related to Mr Stewart's death.

5.271. Counsel Assisting noted the potential significance of the notepaper bearing the handwritten notation consistent with a potential meeting or appointment time of 7:00am on 11 May 1976, found on Mr Stewart's body with the name and telephone number of a hotel on one corner. Counsel Assisting submitted that if the notepaper was indeed from the Chevron Hotel (in Macleay Street in Potts Point), it may be of relevance that in the 1970s the Chevron Hotel had a popular bar called the Quarter Deck Bar that was frequented by gay men. If Mr Stewart visited the Chevron Hotel at some time proximate to his death, that may provide some support for the possibility that he was or was perceived to be a member of the LGBTIQ community.

5.272. Counsel Assisting acknowledged that evidence that Mr Stewart had stayed at or visited the Chevron Hotel, and/or used its notepaper to record a future time and date would not of course conclusively prove either his sexuality or the circumstances of his death. However, Counsel Assisting submitted that when combined with other evidence, it would potentially lend support to a hypothesis that Mr Stewart was visiting the Fairy Bower headland area in connection with it being a beat and/or as part of a pre-arranged meeting with another person.

5.273. By contrast, the NSWPF submitted that this analysis "does not in any way advance the position as to Mr Stewart's sexuality, or whether his death was motivated by gay hate bias".[185] The NSWPF submitted that the evidence supports the conclusion that the OIC recorded the wrong hotel name, and that, even if the OIC did correctly record the "Chevron Hotel", that this could not sensibly lead to any reliable inferences about Mr Stewart's sexuality or, in turn, the circumstances surrounding his death.[186]

5.274. Further, Counsel Assisting submitted that, although involving some speculation, Mr Stewart's desertion from the New Zealand Navy at an early age and his apparent estrangement from his family may also be consistent with him being a young man who was coming to terms with his sexuality in a challenging environment in the 1970s. The NSWPF submitted that this "is entirely speculative and cannot be given any weight", stating that "[s]elf-evidently there could be many reasons why an 18-year-old man is not in contact with his family, having recently deserted the navy without his father's permission."[187]

[185] Submissions of NSWPF, 12 April 2023, [62] (SCOI.45187).

[186] Submissions of NSWPF, 12 April 2023, [62] (SCOI.45187).

[187] Submissions of NSWPF, 12 April 2023, [60] (SCOI.45187) citing Exhibit 19, Tab 7, Statement of John Spanswick, 28 May 1976 (SCOI.02724.00015).

5.275. In summary, Counsel Assisting submitted that, in light of the uncertain state of the evidence as to the circumstances of Mr Stewart's death, it is not possible to determine whether Mr Stewart's death was a homicide, and therefore it is not possible to determine whether it was an LGBTIQ hate crime, although it is possible that it may have been.

5.276. The NSWPF similarly submitted that in the absence of any evidence to establish that Mr Stewart's death was a homicide, Strike Force Parrabell's finding of "insufficient evidence to establish a bias crime" was entirely appropriate.[188]

Consideration of submissions

5.277. I accept the submission of Counsel Assisting, in effect agreed with by the NSWPF, that it is not possible to determine whether Mr Stewart's death was an LGBTIQ hate crime, although it is possible that it may have been.

5.278. I also find that the location of Mr Stewart's death at the Fairy Bower beat, a possible connection that he may have had to the Chevron Hotel, and the notepaper notation indicating a possible rendezvous are relevant factors supporting the possibility that Mr Stewart may have had a connection to the LGBTIQ community and that his death may have involved LGBTIQ bias.

Conclusions and Recommendations

5.279. I find that:

> *Mr Stewart died on 10 or 11 May 1976 as a result of multiple injuries sustained in a fall from a height, the cause of which cannot be determined.*

5.280. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in Mr Stewart's death.

5.281. I do not propose to make any recommendations arising from the Inquiry's consideration of Mr Stewart's death.

[188] Submissions of NSWPF, 12 April 2023, [63] (SCOI.45187).

IN THE MATTER OF PAUL EDWARD RATH

Factual background

Date and location of death

5.282. Paul Edward Rath died on 15 or 16 June 1977 at a headland on North Head, south of Shelly Beach in Manly. Mr Rath was 27 years old at the time of his death.

5.283. As has been explained previously in this Chapter, the headland at which Mr Rath died was sometimes referred to in documents relating to this case, somewhat inaccurately, as "the Fairy Bower headland".[189]

Circumstances of death

5.284. At around 7:20am on Thursday, 16 June 1977, Mr Rath's body was discovered wedged between rocks some distance from the base of the cliffs. He had last been seen in the early evening of 15 June 1977 by Helen Colman, his sister, at her flat in Denison Street in Manly.[190] Ms Colman recalls that Mr Rath indicated to her, on leaving her flat, that he was due to meet someone, but that he would not tell her who this person was.[191]

5.285. Injuries to Mr Rath's body were consistent with a fall from height. Whether or not he may have received any injuries prior to such a fall is the subject of further discussion below.

[189] As outlined in Counsel Assisting's submissions, the headland was referred to as the "Fairy Bower headland" in much of the material relating to Mr Rath's death despite the fact that the headland is much closer to Shelly Beach in Manly than to Fairy Bower Beach, which is some distance away and further to the north-west.

[190] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [14]–[15] (SCOI.82919).

[191] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [22] (SCOI.82919).

Previous investigations

Original police investigation

5.286. The original police investigation into Mr Rath's death was overseen by Manly Police. Senior Constable Ross Parry was the OIC of the investigation.[192]

Discovery and retrieval of body

5.287. At 7:20am on 16 June 1977, Senior Constable Parry received a call from Alfred Barrett, a fisherman, who reported sighting a body wedged between rocks at the base of the cliff at Fairy Bower.[193] At about 7:30am, Senior Constable Parry arrived at the parking area at the end of Bower Street.[194]

5.288. Mr Barrett led him to the base of the cliffs, approximately 300 metres south of the parking area, where Mr Rath's body was located. Senior Constable Parry saw "the body of a male person, wedged between rocks, in a sitting position with his head between his legs, at the foot of a 150 foot ledge".[195] Senior Constable Parry examined the ledge from which Mr Rath had apparently fallen and reported seeing "no notes left by the deceased or signs of a struggle".[196]

5.289. Detective Sergeant Ezart of the Scientific Branch of the NSWPF attended to examine and take photographs of Mr Rath's body. The Police Rescue Squad were then called to recover Mr Rath's body and it was conveyed to Manly District Hospital, where he was pronounced dead.[197] Mr Rath's body was identified by his brother-in-law, Peter Rowan, at the City Morgue in Glebe.[198]

Discovery of property

5.290. Upon the discovery of his body, Mr Rath was observed to be dressed in a suit, the trousers of which were down at approximately mid-thigh level, exposing his underpants and upper thighs. One of his shoes, and a set of rosary beads that belonged to him, were located on the rocks nearby. A piece of paper with writing on it of a religious nature, signed by Mr Rath, was found in his coat pocket.[199]

[192] Exhibit 26, Tab 11, Statement of Senior Constable Ross Parry, 10 August 1977, 1 (SCOI.02734.00009).

[193] Exhibit 26, Tab 1, P79A Report of Death to Coroner, 17 June 1977, 1 (SCOI.82905).

[194] Exhibit 26, Tab 11, Statement of Senior Constable Ross Parry, 10 August 1977, 1 (SCOI.02734.00009).

[195] Exhibit 26, Tab 11, Statement of Senior Constable Ross Parry, 10 August 1977, 1 (SCOI.02734.00009).

[196] Exhibit 26, Tab 11, Statement of Senior Constable Ross Parry, 10 August 1977, 1 (SCOI.02734.00009).

[197] Exhibit 26, Tab 11, Statement of Senior Constable Ross Parry, 10 August 1977, 1 (SCOI.02734.00009); Exhibit 26, Tab 1, P79A Report of Death to Coroner, 17 June 1977, 1 (SCOI.82905).

[198] Exhibit 26, Tab 11, Statement of Senior Constable Ross Parry, 10 August 1977, 1 (SCOI.02734.00009); Exhibit 26, Tab 8, Statement of Peter Gregory Rowan, 10 August 1977, 1 (SCOI.02734.00013).

[199] Exhibit 26, Tab 11, Statement of Senior Constable Ross Parry, 10 August 1977, 1 (SCOI.02734.00009); Exhibit 26, Tab 1, P79A Report of Death to Coroner, 17 June 1977, 1 (SCOI.82905).

Investigative steps by OIC

5.291. Senior Constable Parry obtained statements from family members of Mr Rath, being Elwyn Rath, his father, Gregory Rath (**Gregory**), one of his younger brothers, and Peter Rowan, his brother-in-law. A statement was also taken from Mr Barrett, who discovered Mr Rath's body, and a note was obtained from Mr Rath's treating psychiatrist, "Dr Reichard".[200]

5.292. In the Report of Death to Coroner, Senior Constable Parry noted that a "precautionary" anal swab was taken on 16 June 1977 at the city morgue because Mr Rath was found with his trousers partially removed and the scene of Mr Rath's death was known to be "frequented by homosexuals".[201]

Persons of interest

5.293. No persons of interest in relation to the death were identified at the time. Accordingly, no person was ever charged with any offence in relation to Mr Rath's death.

5.294. Ms Colman, Mr Rath's sister, expressed a concern to the Inquiry that there may be some possibility that a male person known to her could have been involved in some way in Mr Rath's death.[202] This is explored further below.

Post-mortem examination

5.295. Forensic pathologist Dr Peter Russell conducted a post-mortem examination on 18 June 1977.[203]

5.296. Dr Russell noted that there were "numerous externally obvious injuries" including:

a. A large contusion (bruise) with "good deal of superficial oedema" overlying the right eye and cheek;

b. "[O]ld" blood issuing from both nostrils;

c. A small amount of blood present in the right ear which appeared to be "passive" in nature and not associated with skull fracture;

d. Bruising to the right upper arm;

e. Bilateral compound comminuted fractures (bone broken in at least two places) on the lower ends of the tibia and fibula (lower legs); and extensive bruising of the anterior chest wall.[204]

5.297. Other significant injuries were fracturing of the sternum and a number of ribs and spinal fractures at the C7 level (near the base of the neck) and at the L1 level (the top of the lumbar spine/lower back). No skull fracture was observed.[205]

[200] Exhibit 26, Tab 11, Statement of Senior Constable Ross Parry, 10 August 1977, 1 (SCOI.02734.00009); Exhibit 26, Tab 1, P79A Report of Death to Coroner, 17 June 1977, 1 (SCOI.82905).

[201] Exhibit 26, Tab 1, P79A Report of Death to Coroner, 17 June 1977, 1 (SCOI.82905).

[202] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [42] (SCOI.82919).

[203] Exhibit 26, Tab 4, Post-mortem Report of Dr Peter Russell, 30 June 1977 (SCOI.02734.00010).

[204] Exhibit 26, Tab 4, Post-mortem Report of Dr Peter Russell, 30 June 1977, 1 (SCOI.02734.00010).

[205] Exhibit 26, Tab 4, Post-mortem Report of Dr Peter Russell, 30 June 1977, 2 (SCOI.02734.00010).

5.298. Blood testing was negative for alcohol. It does not appear that blood was tested for any other substances.[206]

5.299. It also appears that on 16 June 1977, a number of bodily swabs were taken, prior to the post-mortem, when Mr Rath's body was at the City Morgue.[207]

5.300. A one-page forensic biology report dated 21 June 1977 records that four items were received from police on 16 June 1977 (one anal smear, one anal swab, one penile smear and one penile swab). Semen was detected on the two penile samples but not on the anal samples.[208]

5.301. Dr Russell described the cause of death as "multiple injuries".[209]

Exhibits: Availability and testing

5.302. The Report of Death to Coroner dated 17 June 1977 describes the clothing found on Mr Rath (a suit, jumper, shirt, socks, shoes, underpants and singlet). It also states that property and clothing was destroyed on the authority of Mr Rath's mother.[210]

5.303. Black and white photographs taken at the crime scene show staining, which may or may not have been blood, on several distinct areas of the clothing.

5.304. As noted above, the forensic biology report of 21 June 1977 refers to penile and anal swabs having been taken and tested, with the penile swabs testing positive for the presence of semen. These samples have not been retained.[211]

5.305. At the time of Mr Rath's death, there was no DNA testing capacity available to the NSWPF. Had either the swabs or the clothing been retained, it now would be possible to conduct DNA testing of these items, to determine whether any other person's DNA could be detected. However, that possibility no longer exists.

Findings at inquest

5.306. In his Report of Death to Coroner the OIC stated that there were "NO SUSPICIOUS CIRCUMSTANCES".[212] No other hypothesis as to the manner or death was advanced at that stage.

5.307. In his statement to the Coroner of 10 August 1977, the OIC expressed the following conclusion:[213]

> *I could find no evidence that the deceased had taken his life. In view of all the circumstances, in my opinion the deceased went to the Fairy Bower area*

[206] Exhibit 26, Tab 3, Toxicology Report of Rodney Reece, 23 June 1977, 1 (SCOI.02734.00011).

[207] See Exhibit 26, Tab 1, P79A Report of Death to Coroner, 17 June 1977, 1 (SCOI.82905).

[208] Exhibit 26, Tab 2, Forensic Biology Report of Dr Robert John Goetz, 21 June 1977, 1 (SCOI.02734.00012).

[209] Exhibit 26, Tab 4, Post-mortem Report of Dr Peter Russell, 30 June 1977, 1 (SCOI.02734.00010).

[210] Exhibit 26, Tab 1, P79A Report of Death to Coroner, 17 June 1977, 1 (SCOI.82905).

[211] Exhibit 26, Tab 19B, Letter from Katherine Garaty to Enzo Camporeale, 16 May 2023 (SCOI.83235); Exhibit 26, Tab 29B, Statement of Carol Field, 10 May 2023 (SCOI.83234).

[212] Exhibit 26, Tab 1, P79A Report of Death to Coroner, 17 June 1977, 1 (SCOI.82905).

[213] Exhibit 26, Tab 11, Statement of Senior Constable Ross Parry, 10 August 1977, 1 (SCOI.02734.00009).

> *at a time when it was almost dark and whilst on the ledge apparently lost his footing and fell to his death.*

5.308. The inquest was conducted by Coroner Henry on 16 September 1977. The Coroner's finding was that Mr Rath died:

> *between the fifteenth and the sixteenth day of June, 1977, at Fairy Bower, Manly … of the effects of multiple injuries sustained then and there when he fell accidentally onto rocks at the foot of a cliff.*[214]

5.309. The Coroner also stated:[215]

> *On the evidence, there are no suspicious circumstances, and I formally find there is no prima facie case, against any person for an indictable offence. Whilst on the one hand there is evidence to dec'd under tretment [sic] from Dr. Richardt, the Drs. evidence is that earlier that month, the dec'd was quite normal, this situation is conformed [sic] by relatives and there is other evidence, it was not unsual [sic] for the dec'd to walk in this area.*

Strike Force Parrabell

Bias Crimes Indicators Form

5.310. In the BCIF completed by Strike Force Parrabell, the case was categorised as "No Evidence of Bias Crime", even though all ten indicators in the BCIF were answered "Insufficient Information".[216]

5.311. I agree with the submission made by Counsel Assisting that this inconsistency points to the likelihood of classificatory confusion on the part of Strike Force Parrabell.

Case Summary

5.312. The Strike Force Parrabell Case Summary reads as follows:[217]

> ***Identity:*** *Paul Edward Rath was 27 years old at the time of his death.*
>
> ***Personal History:*** *Mr Rath was last seen alive by his brother at their family home the day before his death. He was in a happy mood and had never previously indicated suicidal tendencies. Mr Rath was a religious person, working as a catechist at local public schools and devoting much of his time to the Catholic Church. He worked at the 'House with no steps' three years before leaving with pension entitlements. Mr Rath's parents stated that Paul often went for walks along the Fairy Bower area to calm himself and would often sit on the cliff tops to relax.*

[214] Exhibit 26, Tab 27, Findings of Coroner Ray William Henry, Inquest into the death of Paul Rath, 16 September 1977, 1 (SCOI.02734.00001)

[215] Exhibit 26, Tab 26, Extract of Transcript of Coronial Inquest into the death of Paul Rath, undated (SCOI.02734.00007).

[216] Exhibit 26, Tab 17, Strike Force Parrabell, Bias Crimes Indicators Review Form – Paul Rath, 28 February 2017 (SCOI.32131).

[217] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Paul Rath, Undated 1 (SCOI.76961.00014).

> ***Location of Body/Circumstances of Death:*** *Mr Rath's body was found between rocks at the base of the Fairy Bower cliffs, Manly about 300 metres south of a parking area. A handwritten note signed by Mr Rath was located in his pocket which read: 'God loves little children. 'Children love God with your whole heart and whole soul. Let God's light shine upon you from day to day. Let your little hearts become a replica of His. Place your faith and love in his sacred heart. And he will find a special place in heaven where you will be with Him for eternity.'*
>
> ***Sexual Orientation/Psychological Health:*** *Mr Rath's sexual orientation at the time of his death could not be confirmed. Mr Rath suffered from schizophrenia and was taking medication up until the time of his death.*
>
> ***Coronial/Court Findings****: The Coroner found Mr Rath, 'died of the effects of multiple injuries sustained then and there when he fell accidentally onto rocks at the foot of a cliff.... on the evidence, there are no suspicious circumstances, and I formally find there is no prima facie case, against any person, for an indictable offence.'*
>
> ***SF Parrabell concluded there was no evidence of a bias crime***

5.313. The Case Summary is broadly consistent with the contents of the BCIF.

5.314. It is apparent, from the material produced to the Inquiry by the NSWPF, that the NSWPF, and Strike Force Parrabell, were aware of Ms Colman's concerns about the potential involvement in Mr Rath's death of a man known to her, and the possibility that this was an LGBTIQ hate crime. However:

a. Strike Force Parrabell made no reference to those concerns in the BCIF or the Case Summary; and

b. it would seem (on the material produced to the Inquiry) that neither Strike Force Parrabell nor the NSWPF generally took, or have ever taken, any steps to investigate or pursue them.

Academic review

5.315. The academic review categorised the case as "Insufficient Information".[218]

[218] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Paul Rath, Undated 1 (SCOI.76961.00014).

Review by the Inquiry

5.316. The Inquiry took the following steps in the course of examining the matter.

Summonses

5.317. A summons was issued to the NSWPF on 18 May 2022 for, all documents relating to investigations by the NSWPF of the death of Mr Rath, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Rath.[219]

5.318. On 8 June 2022, the NSWPF produced a hard copy file purportedly in relation to Mr Rath, but which erroneously was a file relating to a different deceased person.

5.319. On 21 July 2022, the NSWPF produced a number of electronic documents relating to Mr Rath's death, in response to a different summons (NSWPF3), all of which were duplicates of material in the coronial file.

5.320. On 9 August 2022, the NSWPF produced a Manly Occurrence Pad entry in relation to Mr Rath's death.[220] On 6 September 2022, the legal representative for the NSWPF informed the Inquiry that there were no further holdings in relation to Mr Rath.[221]

5.321. On 23 August 2022, the Inquiry issued a summons to BDM requesting Mr Rath's birth and death certificates (BDM2), both of which were produced on 26 August 2022.[222]

5.322. On 22 August 2022, the Inquiry issued a summons to DOFM requesting all records (including photography, CT images or notes) relating to Mr Rath's post-mortem on 18 June 1977 (DOFM1).[223] On 30 August 2022, the Inquiry received a USB containing a single 18-page electronic file in relation to Mr Rath, which comprised the post-mortem report, toxicology report, forensic biologist report and the Report of Death to Coroner.

Interagency cooperation

5.323. On 11 May 2022, the Inquiry requested the coronial file in relation to Mr Rath's death. A file of 44 pages was produced on 26 May 2022.

[219] Exhibit 26, Tab 18A, Summons to NSWPF (NSWPF1), 18 May 2022 (SCOI.82904).

[220] Exhibit 26, Tab 14, NSWPF Report of Occurrence, 'Death of Paul Edward Rath, 27 Old at Rocks at Foot of Cliff at Fairy Bower', 16 June 1977 (SCOI.82907).

[221] Exhibit 26, Tab 19, Email from Patrick Hodgetts to Kate Lockery, 6 September 2022, 1 (SCOI.82896).

[222] See Exhibit 26, Tab 5, Death Certificate of Paul Rath, 6 October 1977 (SCOI.73988).

[223] Exhibit 26, Tab 28A, Summons to NSW Health Pathology – Forensic Medicine (DOFM1), 22 August 2022 (SCOI.82536).

Family members

5.324. On 30 November 2022, after making contact with some of Mr Rath's siblings, members of the Inquiry's legal team held a conference with five of Mr Rath's seven siblings: Chris, Liz and Helen (in person), and Gregory and Rosemary (over the phone).

5.325. On 14 December 2022, a separate conference was held with Ms Colman. Ms Colman later provided a statement which includes her recollections of the last occasion she saw Mr Rath and the events following his death.[224]

5.326. On 16 March 2023, the Inquiry's legal team also held a separate conference with Mr Rath's brother Gregory. Gregory later provided a statement containing his own recollections of his last meeting with Paul and related matters.[225]

Searches for exhibits

5.327. On 8 May 2023, the Inquiry wrote to DOFM and the NSWPF to request a formal written response regarding the status of the four biological items taken from Mr Rath, including their current location and whether they were available for further testing.[226]

5.328. On 10 May 2023, FASS provided a statement from Carole Field which advised that:[227]

> *According to laboratory records, two swabs and two smears for this matter were received on 16 June 1977.*
>
> …
>
> *In 1977, the laboratory did not retain swabs and/or smears for long term storage.*
>
> *There are no records retained relating to the disposal or dispatch [of the items].*

5.329. On 16 May 2023, the NSWPF provided a written response in similar terms.[228]

Professional opinions

Dr Linda Iles (First Report)

5.330. The Inquiry sought the opinion of expert forensic pathologist Dr Linda Iles. Dr Iles' first report was dated 26 October 2022.

[224] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023 (SCOI.82919).

[225] Exhibit 26, Tab 37, Statement of Gregory Rath, 16 May 2023 (SCOI.82920).

[226] Exhibit 26, Tab 19A, Letter from Enzo Camporeale to Patrick Hodgetts, 8 May 2023 (SCOI.83236); Exhibit 26, Tab 29A, Letter from Cailin Healey-Nash to Dr Isabel Brouwer, 8 May 2023 (SCOI.83237).

[227] Exhibit 26, Tab 29B, Statement of Carol Field, 10 May 2023 (SCOI.83234),

[228] Exhibit 26, Tab 19B, Letter from Katherine Garaty to Enzo Camporeale, 16 May 2023 (SCOI.83235).

5.331. While allowing for changes in post-mortem practices that have occurred over time, Dr Iles noted the absence of a number of matters from the original post-mortem report that made review of the matter challenging.[229] These included:

a. The limited description of external injuries, including ambiguity as to what was meant by the expression "old blood" issuing from the nostrils, and there being no indication of the origin of the "passive blood" identified in the right ear;

b. That there was no description of any injuries to the fingers of both hands, despite scene photographs appearing to suggest such injuries;

c. That there was no description of cutaneous injuries to the lower legs, the absence of which is unusual given the description of extensive comminuted fractures as described in the post-mortem report;

d. The specific location of bruising to the right upper arm not being indicated;

e. No description of the presence or absence of anogenital injuries, or of the presence or absence of scalp bruising; and

f. There being no comment regarding whether there was spinal injury associated with the C7 and L1 spinal fractures, this being the most serious of the injuries described.[230]

5.332. More generally, Dr Iles observed that accurate external and internal injury descriptions, ideally documented by photos, along with relevant negative observations, would be needed in order to correlate injury patterns with scene findings, and thereby to test propositions relating to injury causation and event reconstruction.[231] She also observed that, given that Mr Rath was prescribed two antipsychotic medications that may cause sedation, toxicological analysis for drugs other than alcohol would have been advisable.[232]

5.333. Dr Iles expressed the view that the nature of the lower leg fractures was in keeping with a fall from a height, with primary impact forces being directed through the feet.[233] The absence of any associated pelvic injuries was surprising and may have been overlooked.[234]

5.334. Dr Iles commented on the significance of the distinctive position in which Mr Rath's body was found. She considered it extremely unlikely that the body would have been placed in its position by persons unknown, given that Mr Rath had injuries in keeping with a fall from height and the apparent difficulty in accessing the site where he was found. Absent her own analysis of the topography, she was unable to say whether Mr Rath might have landed directly in the position. A fall onto the grassy area above the rocks, followed by the body then tumbling, could have accounted for the position.[235]

[229] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 4 (SCOI.82906).

[230] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 5 (SCOI.82906).

[231] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 6 (SCOI.82906).

[232] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 5 (SCOI.82906).

[233] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 6, 8 (SCOI.82906).

[234] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 8 (SCOI.82906).

[235] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 6 (SCOI.82906).

5.335. Dr Iles did not consider it likely that Mr Rath could have fallen and then moved himself into his final position, as his injuries were such that he would not have had the capacity to do so after the initial impact.[236]

5.336. Although qualified by whether or not the remainder of the post-mortem report could be considered accurate, it appeared to Dr Iles that the spinal injuries would have been the cause of Mr Rath's death (particularly in the absence of any documented head injury other than bruising). The nature of the spinal dislocations described in the post-mortem report potentially may have left Mr Rath with some degree of upper body movement. However, Dr Iles was of the view that the lack of any described intracavitary haemorrhage associated with fractures suggested that "death was rapid in onset".[237]

5.337. Dr Iles cautioned that the emission of semen after death is a "relatively common post mortem phenomenon", and that the detection of semen from a penile swab during post-mortem investigations (unless it is demonstrated by DNA analysis to have come from another individual) should not be interpreted as evidence of recent sexual activity.[238]

5.338. What Dr Russell meant by "old blood" issuing from the nostrils was not clear to Dr Iles. She considered it possible that it was a reference to dried blood, which could have issued as a result of injuries sustained either during or prior to the fall.[239] Dr Iles was of the view that the bruising to Mr Rath's right eye, cheek and upper arm could have been sustained in the fall, particularly if there were "secondary impacts" in addition to the primary impact.[240] Without knowing the particular location of the upper arm bruising, it was not possible for her to reach a view as to whether or not this could be considered suspicious.[241]

5.339. Dr Iles observed that the lowered trouser position may have been a prompt for the penile and anal swabbing that occurred, but that the incomplete nature of the post-mortem examination made it difficult to determine the significance of the trouser position. In particular, there was no recorded observation as to whether the trousers were fastened or loose or tight fitting. Nor was there any documented detailed anogenital examination. She expressed the view that on first principles, the trouser position should have been a prompt for a more thorough examination at the scene and at the post-mortem.[242]

5.340. Dr Iles also made note of the fact that the photographs of the scene appear to indicate a degree of injury to Mr Rath's fingers. While she acknowledged that a spectrum of injuries could occur in a fall, she again observed that the lack of any detailed documentation of the nature of these injuries made it difficult for her to make any meaningful comment on them.[243]

[236] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 6 (SCOI.82906).
[237] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 7 (SCOI.82906).
[238] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 8 (SCOI.82906).
[239] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 9 (SCOI.82906).
[240] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 9 (SCOI.82906).
[241] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 9 (SCOI.82906).
[242] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 9–10 (SCOI.82906).
[243] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 10 (SCOI.82906).

5.341. Apart from the very limited nature of the documented post-mortem examination, the primary matter of concern noted by Dr Iles was the staining visible in the scene photographs of various areas of Mr Rath's clothing, which she regarded as likely to be blood, dirt, or a combination of both. She expressed that view as follows:[244]

> *The staining of Mr Rath's clothing, in my view, particularly if the staining is due to blood, is the most concerning element of the materials under review. It is out of keeping with the scene and circumstances as described, along with autopsy findings as documented. As above, it is strongly recommended that these photographs be reviewed by a forensic biologist.*

5.342. Consequently, the Inquiry obtained a report from Jae Gerhard in order to address the concern identified by Dr Iles.

5.343. Dr Iles was of the view that the cause of death could reasonably be described as "spinal injuries sustained in a fall from a height".[245] However, she noted that cause of death does not imply manner of death. Based on the medical evidence, it was not possible to distinguish between whether the fall was due to accident, suicide or homicide.[246]

Jae Gerhard

5.344. Ms Gerhard is a forensic scientist whose experience and training includes blood pattern analysis.[247]

5.345. Ms Gerhard was asked to consider whether the staining on Mr Rath's clothing, evident in the black and white scene photographs, can be identified as blood and/or another substance, with reference to a number of different areas including Mr Rath's trousers, coat jacket cuffs and the back of his jacket, as well as his lower arms and hands.[248] Ms Gerhard was also asked whether, on the assumption that such staining was blood, she considered it to be suspicious.[249]

5.346. In Ms Gerhard's opinion, the photographs did not enable her to determine whether the staining arose from an assault, or by virtue of a tumbling action after falling.[250] Her reasons were twofold: that she could not conclude whether or not some of the staining may have been either mud or dirt rather than blood; and even on the assumption that it was blood, it could have been deposited either in the course of an assault, or as a result of tumbling while bleeding.[251]

[244] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 8 (SCOI.82906).

[245] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 10 (SCOI.82906).

[246] Exhibit 26, Tab 34, Expert report of Dr Linda Iles, 24 October 2022, 10 (SCOI.82906).

[247] Exhibit 26, Tab 39, Expert report of Jae Gerhard, 7 July 2023, [1.4] (SCOI.85458).

[248] Exhibit 26, Tab 39A, Letter of Instruction from Caitlin Healey-Nash to Jae Gerhard, 9 May 2023, 4 (SCOI.83087).

[249] Exhibit 26, Tab 39A, Letter of Instruction from Caitlin Healey-Nash to Jae Gerhard, 9 May 2023, 4 (SCOI.83087).

[250] Exhibit 26, Tab 39, Expert report of Jae Gerhard, 7 July 2023, [9.1] (SCOI.85458).

[251] Exhibit 26, Tab 39, Expert report of Jae Gerhard, 7 July 2023, [9.1] (SCOI.85458).

Dr Linda Iles (Second Report)

5.347. Following receipt of Ms Gerhard's report, a supplementary report was sought from Dr Iles. She was asked, on the assumption that all the relevant staining was blood, for elaboration of her opinion that the staining was "the most concerning element" of the materials that she had reviewed.[252]

5.348. Dr Iles noted that based on the post-mortem report, the only identifiable source of blood loss was from Mr Rath's nose. Dr Iles expressed the view that if the staining on the clothing is blood, its extent cannot be accounted for by the dripping and/or smearing of blood originating from his nose following primary impact from his fall. In particular, small separate rounded areas of staining on Mr Rath's coat sleeves and left trouser leg, if blood, could not be accounted for in this manner, nor by passive dripping once he was in his final resting place.

5.349. Dr Iles said that "this therefore accommodates a scenario where this staining, if blood, may be the result of an injury to Mr Rath's nose *prior* to his descent from the top of the cliff".[253]

5.350. The more diffuse staining on the trouser legs, if blood, also could not be accounted for by the dripping or smearing of blood from Mr Rath's nose, given its location, extent and the post-mortem findings.

5.351. Dr Iles observed that if none of the staining was blood, and was instead mud or dirt, this could be accounted for by the primary impact followed by a tumbling action.[254]

5.352. In conclusion, Dr Iles restated her concerns about the thoroughness and adequacy of the original post-mortem report, the deficiencies of which placed a limitation on her opinions. With this qualification, she stated that "the following elements are of concern" (emphasis in original):[255]

> *a. Lack of documentation of apparent injuries to the fingers of both Mr Rath's hands as observable in scene photographs.*
>
> *b. The pattern of staining on Mr Rath's clothes. If this is blood, in my view it cannot be accounted for by blood loss from Mr Rath's nose following his primary impact, with the staining occurring during tumbling following primary impact.*
>
> *c. The manner of Mr Rath's fall death having been ascribed as accident with apparent minimal investigation, given he was located in an area in which he appears to have been very familiar, and that he was not intoxicated by alcohol.*

[252] Exhibit 26, Tab 40A, Letter of Instruction from Caitlin Healey-Nash to Dr Linda Iles, 11 August 2023, 2 (SCOI.85460).

[253] Exhibit 26, Tab 40, Supplementary Expert report of Dr Linda Iles, 16 August 2023, 2 (SCOI.85459).

[254] Exhibit 26, Tab 40, Supplementary Expert report of Dr Linda Iles, 16 August 2023, 2–3 (SCOI.85459).

[255] Exhibit 26, Tab 40, Supplementary Expert report of Dr Linda Iles, 16 August 2023, 3 (SCOI.85459).

Dr Danny Sullivan

5.353. The Inquiry also sought the opinion of expert forensic psychiatrist Dr Danny Sullivan as to Mr Rath's psychiatric history and state at the time of his death.[256]

5.354. Dr Sullivan's report, dated 24 October 2022, expressed his opinion in relation to Mr Rath's diagnosis, medications and likely cause of death. Dr Sullivan noted that information in relation to Mr Rath's condition was sparse and lacked detail. He had no basis to dispute Mr Rath's treating psychiatrist's diagnosis of schizophrenia.[257]

5.355. Dr Sullivan observed that Mr Rath's antipsychotic medications (haloperidol and thioridazine) had been prescribed in moderate and low doses respectively, which would have been considered effective dosages for schizophrenia at the time.[258] He noted that the side effect of "restless legs" can be a common effect of haloperidol in particular, and that the medications would have led to stability in mood and functioning.[259] They would have also resulted in a degree of sedation and reduced facial movement, and would possibly have slowed Mr Rath's reactions. However, without reference to Mr Rath's symptoms, Dr Sullivan could not comment further on the likely effect of the medications.[260]

5.356. Dr Sullivan noted that observations about Mr Rath's behaviour at the time of his death are "highly speculative" and limited by the paucity of relevant material. As a consequence, his discussion of the possible alternative causes of death is necessarily limited and inconclusive. He did not think that any particular conclusions could be drawn from the presence of the rosary beads or the note in Mr Rath's pocket, as the presence of such items would appear to have been usual for Mr Rath.[261]

Witness Statements

5.357. The Inquiry obtained statements from the following members of Mr Rath's family:

a. Mr Rath's sister Helen Colman (née Rath);

b. Mr Rath's brother Gregory Rath;

c. Mr Rath's sister Janice Rowan (née Rath); and

d. Mr Rath's sister Rosemary Rath.

5.358. The content of these statements is discussed further below.

[256] Exhibit 26, Tab 33A, Letter of Instruction from Caitlin Healey-Nash to Dr Danny Sullivan, 30 September 2022 (SCOI.82912).

[257] Exhibit 26, Tab 33, Expert report of Dr Danny Sullivan, 24 October 2022, [19]–[21] (SCOI.82895).

[258] Exhibit 26, Tab 33, Expert report of Dr Danny Sullivan, 24 October 2022, [22] (SCOI.82895).

[259] Exhibit 26, Tab 33, Expert report of Dr Danny Sullivan, 24 October 2022, [23] (SCOI.82895).

[260] Exhibit 26, Tab 33, Expert report of Dr Danny Sullivan, 24 October 2022, [23] (SCOI.82895).

[261] Exhibit 26, Tab 33, Expert report of Dr Danny Sullivan, 24 October 2022, [28] (SCOI.82895).

5.359. The Inquiry also made attempts to locate "Dr O Reichard" (believed to be Dr Otto Reichard), Mr Rath's treating psychiatrist before his death. However, a death certificate for Dr Reichard was produced on 19 September 2022 in response to summons BDM3, stating that Dr Reichard had died on or about 2 October 2005.[262]

Contact with OIC

5.360. On 11 May 2023, the Inquiry spoke with the OIC of the original investigation into Mr Rath's death, former Senior Constable Parry. He had no independent recollection of Mr Rath's death or of the investigation. He did confirm his understanding of the area in question being a location for gay men to meet in the 1970s and 1980s.[263]

5.361. On 23 August 2023 and 20 September 2023, the Inquiry wrote to former Senior Constable Parry enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Rath. Mr Parry advised that he did not wish to participate in the Inquiry any further.[264]

Other

Scene visit by Inquiry personnel

5.362. On 2 August 2022, lawyers assisting the Inquiry visited the Fairy Bower headland and North Head, with a view to pinpointing the location where Mr Rath's body was found using scene photographs taken at the time of the original investigation. It was possible to pinpoint the precise crevice, between rocks at the base of the headland, where Mr Rath's body was found. This was of assistance in the consideration of evidence relating to the likelihood or otherwise of Mr Rath falling from the cliff above this particular site.[265]

Bureau of Meteorology

5.363. On 19 September 2022, a request was submitted to the Bureau of Meteorology (**BOM**) for information about the weather conditions in the Manly area from 8 to 16 June 1977. On 20 October 2022, the Inquiry received daily weather and rainfall observations for that period, as well as synoptic observations for 15 and 16 June 1977.[266]

Media

5.364. By searching historical copies of the *Manly Daily* newspaper, the Inquiry obtained a copy of a newspaper report published at the time of Mr Rath's death.[267]

[262] Exhibit 26, Tab 38, Statement of Caitlin Healey-Nash, 18 May 2023, [11]–[12] (SCOI.82921).

[263] Exhibit 26, Tab 38, Statement of Caitlin Healey-Nash, 18 May 2023, [13]–[15] (SCOI.82921).

[264] Exhibit 66, Tabs 61-62, Letters to Ross Parry, 23 August 2023 and 20 September 2023 (SCOI.86321; SCOI.86321).

[265] Exhibit 26, Tab 38, Statement of Caitlin Healey-Nash, 18 May 2023, [4]–[8] (SCOI.82921).

[266] Exhibit 26, Tab 30, Bureau of Meteorology Data Document CAS-37787-S5G0Y9-9, 26 September 2022 (SCOI.82913).

[267] Exhibit 26, Tab 31C, 'Man, 27, Dies in Cliff Plunge', *Manly Daily* (Sydney, 17 June 1977) 1 (SCOI.83078).

Consideration of the evidence

Paul Rath's background and mental health

5.365. Mr Rath was 27 years old when he died, having been born on 18 January 1980.

5.366. Mr Rath came from a large and close family of eight siblings who were brought up by their parents in the Sydney suburb of Manly, on Pittwater Road. Mr Rath was still living in the family home. Mr Rath was the eldest of the siblings, all of whom attended local Catholic high schools.[268]

5.367. Mr Rath left school in Fourth Form (Year 10), when aged 15, at which time he was described as suffering from a "nervous breakdown".[269] According to his treating psychiatrist, Dr Reichard, Mr Rath had a schizophrenic disorder which was treated with medication and in the months leading up to his death he had been "fairly well".[270]

5.368. After Mr Rath left school, he worked for three years at the "House with No Steps". However, he left this work as he found the conditions depressing, and thereafter he was on a pension.[271] At the time of his death, Mr Rath was not in paid employment and received a sickness pension.[272]

5.369. Elwyn Rath, Mr Rath's father, described him as "deeply religious", and stated that he devoted himself to the Catholic Church. At the time of his death, he was doing voluntary work as a catechist at local schools "where he would write small pieces of prose for the children" and he regularly attended church.[273] He was known to go on walks from the family home around the local area, including sometimes to the Fairy Bower headland.[274]

5.370. Mr Rath's psychiatrist, Dr Reichard, provided a very brief report to the Coroner.[275] He had been Mr Rath's treating psychiatrist since January 1971 (when Mr Rath would have been either 20 or 21). He said that "long before" then, Mr Rath was being treated by another psychiatrist.[276] After referring to Mr Rath's "schizophrenic disorder"[277] Dr Reichard stated:[278]

[268] Exhibit 26, Tab 7, Statement of Elwyn Walter Rath, 10 August 1977, 1 (SCOI.02734.00016).
[269] Exhibit 26, Tab 7, Statement of Elwyn Walter Rath, 10 August 1977, 1 (SCOI.02734.00016).
[270] Exhibit 26, Tab 10, Statement of Dr O Reichard, 23 June 1977, 1 (SCOl.02734.00018).
[271] Exhibit 26, Tab 7, Statement of Elwyn Walter Rath, 10 August 1977, 1 (SCOI.02734.00016).
[272] Exhibit 26, Tab 7, Statement of Elwyn Walter Rath, 10 August 1977, 1 (SCOI.02734.00016).
[273] Exhibit 26, Tab 7, Statement of Elwyn Walter Rath, 10 August 1977, 1 (SCOI.02734.00016).
[274] Exhibit 26, Tab 7, Statement of Elwyn Walter Rath, 10 August 1977, 1 (SCOI.02734.00016).
[275] Exhibit 26, Tab 10, Statement of Dr O Reichard, 23 June 1977, 1 (SCOI.02734.00018).
[276] Exhibit 26, Tab 10, Statement of Dr O Reichard, 23 June 1977, 1 (SCOI.02734.00018).
[277] Exhibit 26, Tab 10, Statement of Dr O Reichard, 23 June 1977, 1 (SCOI.02734.00018).
[278] Exhibit 26, Tab 10, Statement of Dr O Reichard, 23 June 1977, 1 (SCOI.02734.00018).

> *He had ups and downs in his mood and condition but over the last several months he was fairly well and when last seen on 1st June, 1977, he appeared in quite good spirits and gave no special indication of any current suicidal tendencies. He has been on a moderate amount of tranquillizers as follows: HALOPERIDOL 1.5mg. 3 times per day and MELLERIL 25mg. 3 times per day.*

5.371. Mr Rath's brother Gregory recalls that there was a belief by some of his family that Mr Rath's "breakdown" may have come about as a result of some form of trauma suffered while at school.[279] He describes his brother's walking gait as unusual. He would keep his head down and look like he was on a mission, and for this reason people would view him as different.[280]

Indicators of LGBTIQ bias

5.372. At the time of Mr Rath's death, the evidence that was gathered gave no indication of Mr Rath's sexuality. However, evidence obtained by the Inquiry from one of Mr Rath's siblings indicates that he had been involved in a romantic and/or sexual relationship with a man.

5.373. Mr Rath's youngest brother, Gregory, recalls a conversation he had with Mr Rath a year or so prior to Mr Rath's death which involved discussion of sexual matters. Gregory asked his brother whether he was gay. Mr Rath told Gregory that he was. He added some remarks about a male friend who he had worked with at the "House with No Steps", which may have been a reference to sexual activity with that friend.[281]

Movements prior to death

5.374. In his statement, Elwyn Rath said that he last saw his son during the day on 14 June 1977, when he seemed "normal and happy".[282] He said that on 15 June 1977, Mr Rath was due to attend a church meeting at 7:30pm, and that it was not uncommon for him to sit on the clifftop at either day or night and say the rosary with his beads prior to going to church, or otherwise just to relax.[283]

5.375. A brief note of Elwyn Rath's oral evidence at the inquest records him as stating that, on the day of his death, Mr Rath went down to the Corso (Manly's pedestrian mall) and "did a couple of messages".[284] The source of Elwyn Rath's knowledge about these movements is not known.

[279] Exhibit 26, Tab 37, Statement of Gregory Rath, 16 May 2023, [13] (SCOI.82920).

[280] Exhibit 26, Tab 37, Statement of Gregory Rath, 16 May 2023, [14] (SCOI.82920).

[281] Exhibit 26, Tab 37, Statement of Gregory Rath, 16 May 2023, [17]–[18], [20] (SCOI.82920).

[282] Exhibit 26, Tab 7, Statement of Elwyn Walter Rath, 10 August 1977, 1 (SCOI.02734.00016).

[283] Exhibit 26, Tab 7, Statement of Elwyn Walter Rath, 10 August 1977, 1 (SCOI.02734.00016).

[284] Exhibit 26, Tab 24, Deposition of Elwyn Walter Rath, Inquest into the death of Paul Rath, 16 September 1977 (SCOI.02734.00006).

5.376. At around 4:30pm on Wednesday, 15 June 1977, Gregory saw and briefly spoke with Mr Rath at the family home on Pittwater Road in Manly (where they both lived) when Gregory returned home from surfing.[285] He went into Mr Rath's bedroom to get his assistance to remove his wetsuit. Mr Rath was playing records when Gregory left his room.[286] He was wearing a jumper and trousers.[287] At the time of the inquest in September 1977, this was the last known sighting of Mr Rath.

5.377. In his 1977 statement, Gregory described his brother as being in a "happy mood" when he last saw him.[288] However, as noted below, Gregory told the Inquiry that he only said that because he felt some pressure from his mother to do so, whereas it actually "felt like something was wrong" and Gregory's impression was "that Paul just wasn't right".

Account given by Helen Colman

5.378. At the time of her brother's death, in June 1977, Ms Colman was 18 years of age. She had finished her HSC at the end of 1976.[289]

5.379. Ms Colman was at that time in a relationship with I266 (a pseudonym), a man who was about 15 years older than she was, and was then a teacher at the school that her brothers had attended.[290] In February or March 1977, three or four months prior to Mr Rath's death, Ms Colman had moved into a flat with I266, in Denison Street in Manly, a distance of only about 300 metres from her family home on Pittwater Road.[291]

5.380. Ms Colman told the Inquiry that on the evening of 15 June 1977, Mr Rath visited her at the Denison Street flat, the first time that he had done so. They sat together in the loungeroom, and Mr Rath told her that I266 had phoned the Rath family home and asked that Mr Rath pass on a message to Ms Colman that he (I266) would be staying an extra night in the country town he was visiting with a friend, and that he would therefore not be home that evening as anticipated.[292] It was necessary to have the message relayed this way as there was no phone at the Denison Street flat.

5.381. Ms Colman said that Mr Rath also told her that during his phone conversation with I266, I266 had said that he wanted to meet with him (Mr Rath). She said that her brother seemed somewhat puzzled by this and told her that he did not like I266 and did not trust I266. At the time, Ms Colman thought nothing of I266's suggestion to meet, and considered that it was probably a friendly suggestion of a casual catch-up.[293]

[285] Exhibit 26, Tab 6, Statement of Gregory John Rath, 10 August 1977, 1 (SCOI.02734.00015); Exhibit 26, Tab 37, Statement of Gregory Rath, 16 May 2023, [4] (SCOI.82920).

[286] Exhibit 26, Tab 6, Statement of Gregory John Rath, 10 August 1977, 1 (SCOI.02734.00015).

[287] When his body was found, Mr Rath was wearing a brown suit and a jumper: Exhibit 26, Tab 1, P79A Report of Death to Coroner, 17 June 1977, 1 (SCOI.82905); Exhibit 26, Tab 11, Statement of Senior Constable Ross Parry, 10 August 1977, 1 (SCOI.02734.00009).

[288] Exhibit 26, Tab 6, Statement of Gregory John Rath, 10 August 1977, 1 (SCOI.02734.00015).

[289] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [4] (SCOI.82919).

[290] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [6]–[7] (SCOI.82919).

[291] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [4] (SCOI.82919).

[292] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [18] (SCOI.82919).

[293] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [19] (SCOI.82919).

5.382. Ms Colman was not sure what time it was on 15 June 1977 when her brother visited, but said that when he left it was "very dark". He was wearing a suit and closed shoes, as he usually did when attending church, but she recalled thinking that it was quite late for him to be going to church.[294]

5.383. As noted above, Mr Rath's father said in 1977 that Mr Rath had been going to attend a "church meeting" at 7:30pm.

5.384. Ms Colman described her brother as being in a reflective mood, discussing his desire to get a job and move out of home so that he could attain some independence.[295] He was there for around 20 minutes. Ms Colman asked him where he was going and he said that he was going to meet someone. When Ms Colman asked who this was, Mr Rath told her that the person had asked him to keep it confidential.[296] She went to bed soon after her brother left, as she had to make an early start in her waitressing job the next morning.[297]

5.385. Ms Colman learned of her brother's death the next morning, 16 June 1977. Later that day, her partner I266 returned home and she shared the terrible news with him. I266 asked her not to say anything about her interaction with Mr Rath on the night of 15 June 1977, or about I266's phone conversation with him earlier on that day.[298] I266 said this was because he was concerned that if these matters came to light in a police or coronial investigation, they would draw attention to the fact of his relationship with her and this might jeopardise his job (bearing in mind their age difference, her relatively young age and the fact that I266 was a teacher at a school that two of her brothers attended).[299]

5.386. Ms Colman subsequently did not feel comfortable withholding information about her conversation with her brother. She did tell her mother about the conversation, but was told by her parents that the there was "no need to stir anything else up".[300]

5.387. I266's fears of losing his job seem to have been well-founded, as he did lose his job later in 1977 when, for other reasons, their relationship became known to the school where he taught.[301]

5.388. At the time of her brother's death in June 1977, Ms Colman was not interviewed by police or approached to make any statement to the police. The original investigation was thus unaware of Mr Rath's visit to her on the evening of 15 June 1977.

[294] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [17] (SCOI.82919).
[295] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [20] (SCOI.82919).
[296] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [22] (SCOI.82919).
[297] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [24] (SCOI.82919).
[298] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [30]–[31] (SCOI.82919).
[299] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [31] (SCOI.82919).
[300] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [35] (SCOI.82919).
[301] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [10] (SCOI.82919).

5.389. In February 2013, Ms Colman contacted the family members of another man who had died at a similar location to Mr Rath in the 1980s. She passed on her concerns that the area was a beat and that Mr Rath's pants were found down, and provided the name of I266.[302] This information was forwarded to Sue Thompson (former NSWPF Gay and Lesbian Client Consultant) that same month, and was included in a spreadsheet provided by Ms Thompson to Mr Willing at some point in 2013, as well as to Strike Force Parrabell in 2015.[303]

5.390. It was not until Ms Colman was contacted by this Inquiry, some 45 years after the death of Mr Rath, that her recollection of relevant events was recorded in the form of a statement. Such a lengthy passage of time necessarily means, without any reflection whatsoever on Ms Colman, that her 2023 evidence needs to be considered with an appropriate degree of caution.

5.391. Since approximately 2013, as noted above, the NSWPF (and in due course Strike Force Parrabell) have been aware that Ms Colman may have had relevant information concerning I266 and events surrounding her brother's death.[304] However, the NSWPF has never sought to speak to her or question her about such matters.[305]

Location and body position

5.392. The scene visit made by the Inquiry, which enabled the precise spot where Mr Rath's body was found to be pinpointed, was of assistance in assessing how Mr Rath's body came to be in its resting position. Mr Rath's body position in the scene photos is distinctive.

5.393. At first it may seem curious that a person would land in a seated position after a fall of this nature. However, having regard to the precise location where the body was found, and its lateral distance from the ledge above, it seems likely that Mr Rath may have first impacted a sloping area of vegetation near the base of the cliff, before tumbling further to his position in the rocks adjacent to the vegetation. This would account for his body's resting position, as well as the fact that his body was some distance from the cliff face. Dr Iles expressed a similar view as outlined above.

5.394. Further, the nature of the injuries, which is discussed further below, appears to be consistent with Mr Rath's legs having taken the initial impact of the fall, onto the sloped area of vegetation, before the body came to its resting position in the rocks near the vegetation.

5.395. For these reasons, the distinctive body position is not of itself a cause of suspicion. Moreover, it is difficult to see how or why a third party would have altered Mr Rath's body position after the fall had occurred, particularly given how difficult the area would have been to access in the dark.

[302] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [44] (SCOI.82919).

[303] Exhibit 6, Tab 56, Email from John Lehmann to Craig Middleton, 16 June 2015, 1 (SCOI.74113); Exhibit 6, Tab 56B, Sue Thompson, 'Possible Gay Hate Murders List' (SCOI.77315).

[304] Exhibit 6, Tab 56, Email from John Lehmann to Craig Middleton, 16 June 2015, 1 (SCOI.74113); Exhibit 6, Tab 56B, Sue Thompson, 'Possible Gay Hate Murders List' (SCOI.77315).

[305] Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023, [46] (SCOI.82919).

Weather conditions and lighting

5.396. 15 June is close to the shortest day of the year. Records indicate that sunset on 15 June 1977 was 4:53pm and sunrise on 16 June was 6:58am.[306] Temperatures in Sydney appear to have been in a range of approximately 17 degrees Celsius at 5:00pm on 15 June 1977, dropping to 13 degrees Celsius overnight, and 15 degrees Celsius at 7:30am on 16 June 1977.[307] No rain was recorded at North Head over this period.[308] The moon was a waning crescent moon (3%), suggesting it would have been a dark night.[309]

Police investigation

LGBTIQ hate crime on the Northern Beaches in the 1970s

5.397. As Counsel Assisting submitted, an evaluation of the police investigation in this matter requires some broader consideration of the policing and social context of the era, now over 45 years ago. Similar factors affect the cases of Mark Stewart (1976) and David Lloyd-Williams (1979). Both of those deaths also occurred at North Head, and in both those cases police also concluded within a short time that there were no suspicious circumstances.

5.398. Consistent with the submissions made in some other cases before the Inquiry, Counsel Assisting observed, and I agree, that evidence in other matters being considered by the Inquiry suggests that some NSWPF officers investigating deaths in the late 1980s and early 1990s at times gave little or no attention to the possibility that they may have been homicides motivated by LGBTIQ bias, notwithstanding that, based on the circumstances, there was reason to suspect that they were, or may have been, homicides of that nature. Some notable examples are deaths that involved a fall from a cliff, where the death may have been too readily assumed to have been an accident or suicide.

[306] Exhibit 26, Tab 31, Geoscience Australia, 'Sunrise, Sunset and Twilight Times –Manly, 15 June 1977 (Webpage, 21 September 2022) <https://geodesyapps.ga.gov.au/sunrise> (SCOI.82911); Exhibit 26, Tab 31A, Geoscience Australia, 'Sunrise, Sunset and Twilight Times – Manly, 16 June 1977 (Webpage, 10 May 2023) (SCOI.83085).

[307] Exhibit 26, Tab 30, Bureau of Meteorology Data Document CAS-37787-S5G0Y9-9, 26 September 2022, 8–9 (SCOI.82913).

[308] Exhibit 26, Tab 30, Bureau of Meteorology Data Document CAS-37787-S5G0Y9-9, 26 September 2022, 15 (SCOI.82913).

[309] Exhibit 26, Tab 31B, US Naval Observatory Astronomical Applications Department, 'Dates of Primary Phases of the Moon – 1977', (Webpage, 10 May 2023) <https://aa.usno.navy.mil/calculated/moon/phases?date=1977-01-01&nump=50&format=p&submit=Get+Data> (SCOI.83086).

5.399. I also agree with Counsel Assisting that, if this was the position in the late 1980s, there is even more reason to expect that it was also often a feature of the approach of police to such deaths in the 1970s. The Inquiry has received an abundance of evidence of the historically low levels of acceptance of the LGBTIQ community in that era, and of the dramatic upsurge at that time of crimes committed against members of the LGBTIQ community.[310] As was acknowledged by the NSWPF, "societal attitudes and policing practices in the 1970s, were not conducive to recognising the possibility that crimes may have been motivated by LGBTIQ bias."[311]

5.400. It is undoubtedly the case that assaults on gay men and beat users, or those assumed to be gay and/or beat users, occurred in various parts of the northern beaches of Sydney during the 1970s. One example was the death of Phillip Jones (a gay hate homicide) at Curl Curl Beach in late October 1975, about 19 months prior to Mr Rath's death.[312]

5.401. Contrary to a suggestion in the submissions for the NSWPF, Counsel Assisting did not submit that there was a direct parallel between the death of Mr Jones and that of Mr Rath, nor that in isolation Mr Jones' death provided a basis for suspecting that Mr Rath's death was a hate crime. However, the whole of the evidence available to the Inquiry indicates in my view that police officers in the Northern Beaches of Sydney in the 1970s should have been alive to the possibility that deaths such as those of Mr Stewart, Mr Rath and Mr Lloyd-Williams may have been homicides affected by LGBTIQ bias, occurring as they did at or near a well-known beat in an era when violence against men who were or were perceived to be members of the LGBTIQ community was also well-known.

5.402. In the case of Mark Stewart, the investigating officer professed not to be aware of the beat. By contrast, the OIC in the present matter frankly acknowledged that the scene of Mr Rath's death was "frequented by homosexuals".

5.403. Further, however, as Counsel Assisting noted, contemporaneous material suggests that many if not all Manly police must have been aware of the beat as of 1977. For example, a *Manly Daily* newspaper article published on 27 April 1977, about seven weeks before Mr Rath's death, refers to a "'Starsky and Hutch' beach patrol" which was policing crime in the beach areas of Manly, and describes how the patrol featured plain clothes officers who had, among other things, "busted homosexual activities at North Head".[313]

[310] See, eg, Exhibit 1, Tab 1, ACON, In Pursuit of Truth & Justice: Documenting Gay and Transgender Prejudice Killings in NSW in the Late 20th Century (Report, May 2018), 14–15 (SCOI.03667); Exhibit 2, Tab 1, Statement of Garry Wotherspoon, 14 November 2022, [107]–[118], [128] (SCOI.77300); Exhibit 2, Tab 5, Statement of Barry Charles, 14 November 2022, [25], [44]–[52], [61]–[76], [118]–[128] (SCOI.77304).

[311] Submissions of NSWPF, 1 June 2023, [6] (SCOI.83645).

[312] See above in relation to the death of Mr Stewart; see also Exhibit 2, Tab 98, Lex Watson, 'Australian Gays Murdered in 1975', *Campaign* (Sydney, February 1976) 3 (SCOI.76852); Exhibit 2, Tab 30, Thomas Poberezny-Lynch, '"We All Thought They Were Poofters": Anti-Homosexual Murder and Violence in Australia, 1970–1980' (Honours Thesis, University of Sydney, 2014) 6–8 (SCOI.76829); 'Beach Body Identified', *Manly Daily* (Sydney, 6 March 1976) (SCOI.83240); '5 Men Jailed for "Cowardly" Beach Death', *Daily Telegraph* (Sydney, 6 April 1976) 15 (SCOI.83241).

[313] Exhibit 12, Tab 27, Doug Ryan, '90 Arrested by New Police Beach Unit', *Manly Daily* (Sydney, 27 April 1977) 1 (SCOI.82350).

Exhibits

5.404. The question of the availability and testing of exhibits is referred to above. None of the exhibits (in particular the swabs taken from Mr Rath's body, and his clothing) were retained.

5.405. In addition, Mr Rath's case was the subject of further evidence and written submissions by both Counsel Assisting and the NSWPF in connection with the Investigative Practices Hearing.

5.406. During the course of oral evidence, Detective Inspector Warren accepted that the penile swabs, which returned a positive result for the presence of semen, were not retained. Detective Inspector Warren accepted that whilst the emission of semen is relatively common post-mortem, it is nevertheless a matter which ought to have prompted investigating officers to make enquiries. In that regard, Detective Inspector Warren stated that the determination by police that Mr Rath's death was "non-suspicious" may have influenced subsequent investigative steps.[314]

5.407. The NSWPF accepted that it is unfortunate that neither DOFM or the NSWPF made (or, at least, retained) a record in relation to the consumption or disposal of the swabs. However, the NSWPF note that this failure needs to be understood in light of the coronial determination that Mr Rath's death was not suspicious.

5.408. I accept that, given relevant retention policies, the fact that this death occurred now over 45 years ago, and the coronial finding of accident, it is unsurprising that the relevant exhibits were not retained beyond a certain period following the coronial finding.

5.409. However, I also accept that as certain indicators of LGBTIQ bias do not appear to have been explored by the NSWPF, they may not have been brought to the attention of the Coroner, which in turn was likely to have causatively contributed to the coronial finding. While it is true a Coroner's decision will not be affected by "hindsight bias", it will necessarily be dependent on the information before the Coroner at that time.[315] In this case, the Coroner's decision to treat Mr Rath's death as "non-suspicious" could only have been made in light of the information before them at that time.

5.410. Mr Rath's clothing appears to have been either returned to his family,[316] or destroyed on his mother's authority at a very early stage (within a day or two of his death),[317] apparently before results had been obtained from the penile and anal swabs and smears.

5.411. It would have been extremely helpful had the original investigation and forensic examination identified the nature of the staining that was evident on Mr Rath's clothing and/or taken swabs from it. There is now no way of conclusively determining whether those stains were blood, a matter that assumes some significance.

[314] Transcript of the Inquiry, 5 July 2023, T4976.8-25 (TRA.00073.00001).

[315] Submissions of NSWPF, 10 October 2023, [324] (SCOI.86127).

[316] Exhibit 60, Tab 41, Statement of Rosemary Rath, 22 October 2023, [5]–[6] (SCOI.85461).

[317] Exhibit 26, Tab 1, P79A Report of Death to Coroner, 17 June 1977, 1 (SCOI.82905).

5.412. Relevant to the stains on Mr Rath's clothing, I received supplementary submissions from both Counsel Assisting and the NSWPF arising from evidence that was tendered subsequent to the initial submissions, which included the report of Ms Gerhard and the additional report of Dr Iles.

5.413. The NSWPF took issue with Counsel Assisting's submission that Dr Iles' opinion, that blood emanating from Mr Rath's nose could not account for the staining having been the product of secondary tumbling impacts, lent weight to the possibility that the injury to Mr Rath's nose had occurred prior to the fall. Counsel Assisting appropriately qualified their submission, however, by recognising that significant uncertainty unfortunately remains concerning the matter due to the limitations on the quality of the original post-mortem report, and uncertainty regarding whether or not the relevant staining was in fact blood.

5.414. With that qualification, I accept Counsel Assisting's submission. I also acknowledge the possibilities, raised by the NSWPF supplementary submission, that the relevant staining could predate any event related to Mr Rath's death, or that it may have emanated from injuries caused in the course of Mr Rath's fall. The former I regard as unlikely, and the latter possibility was considered by Dr Iles in the course of giving her opinion.

The extent of consideration given to the possibility of foul play

5.415. The early return of the clothing is consistent with the limited consideration that appears to have been given to the possibility of foul play having been involved in the death.

5.416. As Counsel Assisting observed, although there initially appears to have been some degree of suspicion that Mr Rath's death may have had some connection to the fact that the area was a beat, by 17 June 1977 (the day after the body was found), the OIC emphasised the words "NO SUSPICIOUS CIRCUMSTANCES", capitalised, at the end of his Report to the Coroner.[318] This seems quite premature given that as of 17 June it would appear that the results of the penile and anal swabs taken on 16 June had not yet been obtained, nor had the post-mortem been conducted.

5.417. In his statement for the coronial brief, the OIC said that he "made an examination of the ledge from where the deceased apparently fell, however, I found no notes left by the deceased or signs of a struggle".[319] That is the extent of any attempt, so far as is documented, to search or inspect the vicinity of the clifftop. As Counsel Assisting observed however, where a death resulting from a fall from a clifftop had involved foul play, one would not necessarily expect to find positive evidence indicating that a struggle had taken place.

5.418. In addition, Counsel Assisting noted that there does not appear to have been any canvassing of local residents, even though the location was not far from local streets including Bower Street.[320]

[318] Exhibit 26, Tab 1, P79A Report of Death to Coroner, 17 June 1977, 1 (SCOI.82905).

[319] Exhibit 26, Tab 11, Statement of Senior Constable Ross Parry, 10 August 1977, 1 (SCOI.02734.00009).

[320] Exhibit 26, Tab 11, Statement of Senior Constable Ross Parry, 10 August 1977, 1 (SCOI.02734.00009).

5.419. Bearing in mind that Mr Rath's father was of the view that his son was due to attend church at 7:30pm,[321] it is also notable that there is no indication as to whether any enquiries were made at the church to see if Mr Rath had attended.

5.420. The NSWPF accepted that it is "regrettable" if the investigation did not include such steps being taken, but suggested that "the information available to the Inquiry does not appear to include a comprehensive account of all investigative steps undertaken".[322]

5.421. That latter suggestion is one that was made in submissions on behalf of the NSWPF in a number of the cases considered by the Inquiry. It is, in my view, unhelpful if not disingenuous. The Inquiry sought, by summons and by repeated correspondence, in every case, all relevant material held by the NSWPF. The NSWPF, in every case, produced what it said was the totality of such material that could be located. For the NSWPF then to submit (as it has done in this case and numerous others) that certain conclusions should not be reached because other records (not produced, and either non-existent or lost) might have cast a different light, in my view borders on sophistry. Further consideration of this aspect appears in **Chapter 15.**

5.422. Again, this is an unsatisfactory situation where the internal records give limited, if any, insight into the disposal or otherwise of the records.

5.423. Counsel Assisting pointed to various steps which could have been taken, but were not, including:

a. Taking statements from a broader number of family members and friends of Mr Rath, concerning any understanding they may have had of his sexuality and any habit he may have had of visiting the Fairy Bower headland as a beat.

b. Requesting the forensic pathologist for an assessment of the significance, if any, of the nature, particular locations and patterns of the stains on Mr Rath's clothing, and for an assessment as to whether any of the recorded injuries may have been caused other than by a fall.

5.424. The steps canvassed above were also considered in connection with the Investigative Practices Hearing.

5.425. In relation to Mr Rath's stained clothing, Detective Inspector Warren accepted that blood type analysis, specifically blood grouping, was an important forensic technique in the 1970s.[323] However, Detective Inspector Warren could not say whether it was police practice to see whether all of the blood on relevant items was that of a deceased person.[324] Detective Inspector Warren acknowledged that where one was asking whether or not to dismiss a death as suspicious or potentially suspicious it would be a highly significant enquiry to make.[325]

[321] Exhibit 26, Tab 7, Statement of Elwyn Walter Rath, 10 August 1977, 1 (SCOI.02734.00016).

[322] Submissions of NSWPF, 1 June 2023, [17] (SCOI.83645).

[323] Transcript of the Inquiry, 5 July 2023, T4976.27–34 (TRA.00073.00001).

[324] Transcript of the Inquiry, 5 July 2023, T4977.17–35 (TRA.00073.00001).

[325] Transcript of the Inquiry, 5 July 2023, T4977.41–45 (TRA.00073.00001).

5.426. As to the matters raised at [5.417]-[5.419] and [5.423], Detective Inspector Warren indicated that all of the steps were available to investigating officers in the mid-1970s and would assist in forming a view about whether or not a death was suspicious.[326] Detective Inspector Warren said he would expect an investigating officer today to make those enquiries and could not offer any reason as to why that was not equally so in 1977.[327] Counsel Assisting submitted that the ready inference from Detective Inspector Warren's evidence is that there were investigative steps and enquiries which were available at the time, and which could and should have been taken.

5.427. As I have explained earlier, in making observations as to investigative steps which could have been taken, it was not the purpose of Counsel Assisting, nor is it mine, to direct criticism towards any particular officer. Rather, my concern is with what such examples indicate about the systemic attitudes and approaches of the time.

5.428. For the NSWPF, reliance was sought to be placed on the fact that the Coroner was satisfied that the death was accidental, and did not express any concerns with the police investigation or require any further investigations to be conducted. However, the absence of such requests or concerns by a coroner cannot be taken as demonstrating that an investigation has necessarily been adequate. Coroners rely on the work of investigating police to uncover all relevant matters, and should be able to assume that an appropriate standard of investigation has occurred. A coroner will not be in a position to ask for relevant further steps to be taken if initial investigations do not uncover the details they might be expected to, including, for example, by scene preservation, early appropriate canvassing, and the retention and examination of exhibits.

5.429. The NSWPF submitted that the fact that LGBTIQ bias was not independently explored during an investigation does not, without more, justify a conclusion that the possibility of foul play was "readily dismissed".[328] That may be so, as a matter of logic. However, on the evidence, it is in my view inescapable both that such a possibility was in fact dismissed at a very early stage, and that the possibility of LGBTIQ bias was also not pursued beyond the taking of the penile and anal samples.

5.430. In circumstances where the OIC had entertained the possibility that Mr Rath's death was connected with the status of the Fairy Bower headland as a beat, such that the OIC arranged for penile and anal swabs to be taken, it was premature to conclude at such an early stage, and to convey to the Coroner, without caveat, that there were no suspicious circumstances in relation to Mr Rath's death.

[326] Transcript of the Inquiry, 5 July 2023, T4978.4–25 (TRA.00073.00001).

[327] Transcript of the Inquiry, 5 July 2023, T4978.27–34 (TRA.00073.00001).

[328] Submissions of NSWPF, 1 June 2023, 20 (SCOI.83645).

The extent of consideration given to the possibility of suicide

5.431. There is evidence, as Counsel Assisting submitted, suggesting that the conclusion reached by police (that the death was the result of an accidental fall rather than either suicide or foul play), may have been influenced by a sensitivity to the concerns of Mr Rath's parents in relation to at least the suicide possibility.

5.432. Mr Rath's parents, as devout practicing Catholics, do appear, on the evidence, to have been anxious to avoid the possibility that their son's death might be regarded as a suicide.

5.433. Counsel Assisting observed that Gregory was only 14 years old in 1977. At the time, he was understood to have been the last person who had contact with Mr Rath. Investigating police were not aware of the later contact between Mr Rath and his sister Helen (now Ms Colman), set out above.

5.434. As noted above, at 4:30pm on 15 June 1977, Gregory spoke to Mr Rath.[329] Gregory considers that when his mother told him to tell the police that Mr Rath was in a good frame of mind when he last saw him and that there was no reason to worry about his behaviour, she did so in order to "protect Catholic values".[330]

5.435. Gregory told the Inquiry that in fact, in his view, his brother was not in a good frame of mind when he last saw him. He said that his brother did not make eye contact with him and that he appeared to "have something on his mind" and be "in a deep place".[331]

5.436. Gregory also noted that he and his mother became concerned about Mr Rath's failure to return home later that night, as he would sometimes go missing for periods of time when he had depressive episodes.[332] Gregory is of the belief that at the time his parents in fact thought it likely that Mr Rath had taken his own life.[333]

5.437. Mr Rath's father, Elwyn Rath, stressed to police that he was of the view that his son was in a good mood when he last saw him, that Mr Rath was clumsy, and that his reactions were affected by the medication that he took.[334] Elwyn Rath explicitly stated:[335]

> *[b]oth my wife and I are certain beyond doubt that our son would not take his life as he never said or did anything to indicate this. While he did suffer from nerves he was never really depressed and being a very devoted Catholic person, to take his life, would be contrary to his religious beliefs.*

[329] Exhibit 26, Tab 6, Statement of Gregory John Rath, 10 August 1977, 1 (SCOI.02734.00015).

[330] Exhibit 26, Tab 37, Statement of Gregory Rath, 16 May 2023, [7] (SCOI.82920).

[331] Exhibit 26, Tab 37, Statement of Gregory Rath, 16 May 2023, [8] (SCOI.82920).

[332] Exhibit 26, Tab 37, Statement of Gregory Rath, 16 May 2023, [11] (SCOI.82920).

[333] Exhibit 26, Tab 37, Statement of Gregory Rath, 16 May 2023, [9] (SCOI.82920).

[334] Exhibit 26, Tab 7, Statement of Elwyn Walter Rath, 10 August 1977, 1 (SCOI.02734.00016).

[335] Exhibit 26, Tab 7, Statement of Elwyn Walter Rath, 10 August 1977, 1–2 (SCOI.02734.00016).

5.438. Given the police's limited consideration of the possibilities of foul play and suicide, it is perhaps not surprising that the police also supported the view proffered by Mr Rath's parents, that Mr Rath's death was an accident. In his statement, the OIC said that he could find no evidence that Mr Rath had taken his own life, and concluded that "in my opinion the deceased went to the Fairy Bower area at a time when it was almost dark and whilst on the ledge apparently lost his footing and fell to his death."[336]

5.439. As Counsel Assisting submitted, objectively there seems to be little basis for favouring a theory of misadventure over one of suicide. The evidence is capable of supporting either. I would not regard it as surprising if the strong terms in which Mr Rath's father refuted the possibility that his son may have died by way of suicide played a part in the investigating police coming to the view that Mr Rath's fall was not suicide but an accident. More fundamentally, however, in my view, as discussed below, it is simply not possible, on the evidence, to arrive at a positive conclusion as to which of the three possibilities (homicide, suicide or misadventure) led to Mr Rath's death.

Manner and cause of death

Cause of death

5.440. As to the cause of Mr Rath's death, Counsel Assisting submitted that I should adopt Dr Iles' opinion that an appropriate description would be "spinal injuries sustained in a fall from a height", as opposed to the Coroner's more general finding of "multiple injuries". The NSWPF supported this formulation, and I adopt it.

Manner of death

5.441. As to the manner of Mr Rath's death, I agree with Counsel Assisting that the evidence available to the Inquiry is insufficient to permit a positive finding of either suicide, misadventure or homicide. Nor does the evidence enable any of those possibilities to be ruled out.

5.442. Consequently, as proposed by Counsel Assisting (with whose submission in this regard the NSWPF agreed), I do not adopt the Coroner's finding that Mr Rath's fall was "accidental". Instead, I find that Mr Rath died on 15 or 16 June 1977 as a result of spinal injuries sustained in a fall from a height, the cause of which cannot be determined.

5.443. I add the following observations in relation to each of the three possibilities.

The possibility of suicide

5.444. As Counsel Assisting submitted, there is no evidence that Mr Rath was actually contemplating suicide in the lead-up to his death. I do accept, however, that as submitted by both Counsel Assisting and the NSWPF, the possibility of suicide cannot be ruled out.

[336] Exhibit 26, Tab 11, Statement of Senior Constable Ross Parry, 10 August 1977, 1 (SCOI.02734.00009).

The possibility of accident

5.445. There is also no compelling evidence pointing to the likelihood that Mr Rath's death was an accident. Elwyn Rath's references to his son being clumsy, complaining of aching legs and having slowed reactions find support in the observations Dr Sullivan has made about the potential effects of the anti-psychotic medication that Mr Rath took. On the other hand, his father also observed that it was a location that his son was familiar with and would regularly visit, and so the terrain was familiar to him.

5.446. As with any fall from a height in respect of which there are no witnesses, and no conclusive indications of either suicide or foul play, the possibility of misadventure cannot be ruled out.

The possibility of foul play

5.447. No evidence was located at the clifftop indicative of a struggle or assault having taken place there. However, the absence of such evidence is unremarkable, in circumstances where such a death can readily be effected by a simple push and where the post-mortem report may not have adequately documented any external injury.

5.448. Counsel Assisting noted a number of aspects of the evidence that are relevant to the possibility that Mr Rath was the victim of foul play:

a. The fact that the death occurred in the vicinity of a beat;

b. The evidence concerning Mr Rath's sexuality, which raises the possibility that Mr Rath may have been visiting the location because it was a beat;

c. The possibility, based on Ms Colman's account, that Mr Rath had arranged to meet a person at or near the location;

d. The possibility, based on the position of his trousers where he came to rest, that Mr Rath may have had his pants lowered prior to falling from the cliff, and the further possibility either that this occurred while he was present with another person, or that someone approached him having seen Mr Rath in that state of undress; and

e. The many uncertainties concerning the pattern of stains which may have been blood) on Mr Rath's clothing, and the possibility that these were the product of an act of violence that occurred prior to Mr Rath falling from the cliff.

5.449. The NSWPF acknowledged that homicide cannot be ruled out as a possibility, but submitted that such a possibility was unlikely, having regard in particular to the following matters:[337]

a. What was said to be a "statistical reality" (not the subject of any evidence before me) that "suicide and accidental deaths are vastly more common than homicides";

[337] Submissions of NSWPF, 1 June 2023, 27 (SCOI.83645).

b. The fact that a death occurred in the vicinity of a beat did not of itself give rise to a realistic suggestion that Mr Rath was a homicide victim;

c. Ms Colman's recent evidence that Mr Rath was due to meet someone on leaving her flat on 15 June 1977 needed to be considered with caution, given the passage of time, and was in any event inconclusive; and

d. There were a range of explanations, other than foul play, for the positioning of Mr Rath's trousers.

5.450. In my view, the evidence is simply not such as to permit these various possibilities to be resolved. I agree that each of the factors noted by Counsel Assisting is consistent with the possibility of homicide. However, none of them—either separately or in combination—provides any sufficient basis for such a finding.

5.451. The supplementary submission of the NSWPF asserted that there was no evidence to positively suggest Mr Rath's death was the result of a homicide while there are a number of matters suggestive of the possibility that Mr Rath died by way of suicide. I do not agree with the distinction that the NSWPF draws between the two possibilities. Both rest on relevant circumstantial evidence that I refer to above.

5.452. The evidence of Dr Iles as to the staining on Mr Rath's clothes does tend to leave open the possibility that Mr Rath was the victim of an assault shortly prior to his fall, and that his fall may thereby have been occasioned by a deliberate act of another person or persons. However, as explained above, that evidence is necessarily inconclusive because of the uncertainty as to whether the stains are blood (an uncertainty which cannot now be clarified), and the inadequacies of the post-mortem.

5.453. Ms Colman's recent statement to the Inquiry includes the suspicion on her part that I266 may have come back to Sydney earlier than he had suggested, and that he might have been the person whom Mr Rath had said he was going to meet on the evening of 15 June 1977.

5.454. As Counsel Assisting submitted, however, these suspicions on the part of Ms Colman do not provide any sufficient basis for a conclusion that I266 had any involvement in the circumstances of Mr Rath's death. There is no evidence available to the Inquiry which in any way supports such suspicions.

Bias

5.455. For the reasons outlined above, it is not possible to determine whether Mr Rath's death was a homicide. Neither suicide nor misadventure can be ruled out. Accordingly, it is also not possible to reach a concluded view as to whether LGBTIQ bias was or was not a factor in Mr Rath's death.

5.456. However, if Mr Rath's death was indeed a homicide, then there is undoubtedly evidence which tends to indicate the possibility of LGBTIQ bias having been a factor. Such evidence includes:

a. The evidence of Gregory Rath that Mr Rath told him he was gay;[338]

b. The location where Mr Rath's body was found, close to a known beat;

c. Although there is no direct evidence that Mr Rath's practice of visiting the headland area was related to its being a beat, it does appear to be a location that he frequently visited;

d. The position of Mr Rath's trousers; and

e. The presence of semen on the penile sample.

5.457. None of these features is conclusive. They do not, either jointly or severally, establish the presence of LGBTIQ bias in connection with Mr Rath's death.

5.458. For the reasons outlined above, while the evidence does not permit a finding of homicide, that possibility cannot be ruled out. That is to say, there is, objectively, reason to suspect that the death was a homicide.

5.459. In my view, that being so, the presence of the factors identified above means that there is also, objectively, reason to suspect that LGBTIQ bias was a factor in the death of Mr Rath.

Conclusions and Recommendations

5.460. As to manner and cause of death, I find as follows:

> *Mr Rath died on 15 or 16 June 1977 as a result of spinal injuries sustained in a fall from a height at North Head, the cause of which cannot be determined.*

5.461. On the evidence available to the Inquiry, there is objectively reason to suspect both that the death of Mr Rath was a homicide and that LGBTIQ bias was a factor in Mr Rath's death.

Recommendation 1

I recommend that the Commissioner of the NSWPF or a serving police officer make an application for a fresh inquest, in relation to the death of Mr Rath, having regard to the evidence considered by the Inquiry and the findings and conclusions I have made in relation to manner and cause of death.

[338] Exhibit 26, Tab 37, Statement of Gregory Rath, 16 May 2023, [20]–[21] (SCOI.82920).

IN THE MATTER OF DAVID LLOYD-WILLIAMS

Factual background

Date and location of death

5.462. David Lloyd-Williams died between 8:30am and 11:45am on 24 August 1978 at North Head, in the suburb of Manly in Sydney.

Circumstances of death

5.463. Mr Lloyd-Williams was 32 years old at the time of his death.

5.464. In the months before his death, Mr Lloyd-Williams was suffering significantly from ongoing depression, for which he was receiving treatment. He had also recently been an inpatient at a mental health facility.

5.465. On the morning of his death, 24 August 1978, Mr Lloyd-Williams travelled to North Head near Manly, where he took his own life by jumping from a cliff. At around 11:45am, Mr Lloyd-Williams' body was discovered on the rocks by a member of the public.[339]

Previous investigations

Original police investigation

5.466. The original police investigation was overseen by Manly Police. Constable John Mortimer was the OIC of the investigation of the death. In his statement, he reported having attended the location at 3:30pm.[340] By this stage other police were already in attendance and the body of Mr Lloyd-Williams had been recovered by the Police Rescue Squad and conveyed to Manly District Hospital.[341]

[339] Exhibit 12, Tab 11, Statement of Robert Steele, 9 October 1978 (SCOI.73571.00008).

[340] Exhibit 12, Tab 12, Statement of Constable John Charles Mortimer, 24 August 1978 (SCOI.73571.00013).

[341] Exhibit 12, Tab 2, Certificate of life extinct, 24 August 1978 (SCOI.73571.00007).

5.467. It appears that statements were obtained from family members and colleagues of Mr Lloyd-Williams, as well as his treating psychiatrist, as part of the police investigation. However, although the Coroners Court produced to the Inquiry some statements and other documentation which had been provided to the Coroner by the police in 1978, no police investigation file was located or produced to the Inquiry by the NSWPF.

5.468. Dr Grace Higgins conducted a post-mortem on 26 August 1978. Multiple injuries to Mr Lloyd-Williams were found, consistent with a fall from a significant height. A blood sample was taken with no alcohol found. The cause of death was recorded as "multiple injuries".[342]

5.469. Apart from the blood alcohol test that was conducted at the time of the post-mortem, there is no record of any exhibits having been collected or retained.

5.470. No persons of interest in relation to Mr Lloyd-Williams' death were identified, at the time or subsequently.

Findings at inquest

5.471. At an inquest held on 23 October 1978, City Coroner Nash found that:[343]

> *On the 24th of August 1978 at North Head, he [Mr Lloyd-Williams] died from multiple injuries received when he cast himself from a cliff with the intention of taking his own life whilst in a state of mental depression.*

Strike Force Parrabell

Bias Crimes Indicators Form

5.472. A BCIF was only partially completed by Strike Force Parrabell in this case.[344] That was because Strike Force Parrabell was unable to locate any records of the death, including the coronial file ultimately obtained by the Inquiry.

5.473. Mr Lloyd-Williams is referred to in the BCIF as both "David Williams" and "David Lloyd WILLIAMS". In the latter case, the name "David Lloyd WILLIAMS" is set out in a manner that suggests that police were proceeding on the basis that rather than comprising a hyphenated surname (Lloyd-Williams), the name consisted of a middle name "Lloyd" and a surname "Williams".

5.474. The BCIF contained an assertion that the body of Mr "Williams" was found naked "in the Manly cliff area in 1979" and that his clothes were left neatly folded.[345] In this respect, a comparison was drawn in the BCIF with the circumstances of another death (i.e., that of Scott Johnson) that had occurred in the North Head area in 1988.

[342] Exhibit 12, Tab 4, Post-mortem report of Dr Grace Higgins, 13 September 1978, 1 (SCOI.73571.00014).

[343] Exhibit 12, Tab 5, Findings of City Coroner Leonard James Nash, Inquest into the death of Lloyd Williams, 23 October 1978 (SCOI.73571.00004)

[344] Exhibit 12, Tab 16, Bias Crimes Indicators Review Form – David Williams, 9 March 2017 (SCOI.82180).

[345] Exhibit 12, Tab 16, Bias Crimes Indicators Review Form – David Williams, 9 March 2017, 1 (SCOI.82180).

5.475. It is evident from the content of the BCIF that the basis for this assertion by the police was, at least in part, notes in the spreadsheet created by Sue Thompson and referred to earlier in this Report.[346] In the BCIF, it was said that the spreadsheet indicated that the source of the content of these notes was a friend of Mr "Williams" named Dave Davies.

5.476. The BCIF indicated that unsuccessful attempts had been made to obtain a death certificate and that no relevant information could be found through searches of the COPS database, the Ryerson Index (an online index of death and funeral notices from Australian newspapers), and the media.[347] It was observed in the form that the "only other option" for police would be to identify the person "Dave Davies".[348]

5.477. The BCIF concluded with the observation that "[s]earches were completed on any possible date of birth, possible misspelling of [the] name and date of death of Williams" and that "[c]urrently no information has been located".[349]

5.478. In short, Strike Force Parrabell did not uncover any information of substance about the death upon which they could base any opinion, and the BCIF was not completed in any substantive fashion.

Case Summary

5.479. Strike Force Parrabell did not review this matter as details of the death could not be confirmed.[350] The matter was categorised as "unsolved" and "not reviewed" by Strike Force Parrabell.

5.480. The Case Summary for this matter reads as follows:[351]

> ***Identity:*** *The only information available is within a spreadsheet prepared by a former NSW police employee indicating that David Lloyd Williams was found naked at the bottom of a cliff at Manly in 1979. The person who provided the information was only known as 'Dave Davies', who could not be located without further details. Investigators were unable to locate any records relating to this matter despite extensive searches including all possible dates of birth; dates of death; and/or misspelling of names. Database searches including: COPS; Ryerson Index; Media Archives; Coroner; GRR; Police and State Archives were also unsuccessful.*
>
> ***Sexual Orientation/Psychological Health:*** *Mr Williams' personal history; body location; sexual orientation; psychological health; coronial or court findings could not be confirmed.*
>
> ***Coronial/Court Findings:*** *The death of Mr Williams is noted in academic reports indicating its occurrence in the same 'gay beat' area as Mr*

[346] See generally Exhibit 6, Tab 56B, Excel spreadsheet titled 'Possible Gay Hate Murders List' provided to Michael Willing by Sue Thompson in about 2013 (SCOI.77315).

[347] Exhibit 12, Tab 16, Bias Crimes Indicators Review Form – David Williams, 9 March 2017, 1 (SCOI.82180).

[348] Exhibit 12, Tab 16, Bias Crimes Indicators Review Form – David Williams, 9 March 2017, 1 (SCOI.82180).

[349] Exhibit 12, Tab 16, Bias Crimes Indicators Review Form – David Williams, 9 March 2017, 3 (SCOI.82180).

[350] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – David Williams, 2 (SCOI.76961.00014).

[351] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – David Williams, 2 (SCOl.76961.00014).

Stewart (Parrabell Case 1); Mr Rath (Parrabell Case 2); and Mr Johnson (Parrabell Case 29). SF Parrabell did not review this matter as details of the death could not be confirmed.

5.481. The content of the case summary for Mr Lloyd-Williams is in keeping with the contents of the BCIF. The reference to reports indicating that it occurred in the same beat area as certain other deaths was evidently made in the absence of accurate detail as to precisely where at North Head the death occurred. Based upon evidence gathered by the Inquiry, while the death occurred at North Head, it does not appear to have occurred in the particular area of North Head that was best known as a site for beat activity (where other deaths considered by Strike Force Parrabell occurred).[352]

5.482. I do not regard Strike Force Parrabell's treatment of Mr Lloyd-Williams' death as adequate or satisfactory and accept Counsel Assisting's submission that its efforts to identify the circumstances of the death should have been more thorough. While it may be (as the NSWPF submitted was possible) that the original police records had already been lost by 2016/17 when Strike Force Parrabell was in existence,[353] that submission is no more than speculation. Moreover, Strike Force Parrabell did have access to information that could have been considered further, including:

a. Information from Ms Thompson, as to her source "Dave Davies";

b. The statement of Detective Chief Inspector Pamela Young in relation to the death of Scott Johnson at North Head in 1988, being one of the matters reviewed by Strike Force Parrabell, which refers to David Davies; and

c. Media reports from the time, including the *Manly Daily* articles identified by the Inquiry.

5.483. While it is true (as the NSWPF also submitted) that the Terms of Reference for Strike Force Parrabell did not include taking active investigative steps in a matter (such as interviewing friends or family members about the death), this was predicated on Strike Force Parrabell having gathered all available materials relating to the investigation of that death. Logically, it cannot have been beyond the remit of Strike Force Parrabell to contact known sources of information so as at least to clarify the name and identity of the deceased person in question, so that all available material (including relevant coronial and investigative files) could be sought and obtained.

Academic review

5.484. The academic review categorised the matter as "insufficient information".

[352] See Exhibit 2, Tab 8, Statement of Ulo Klemmer, 11 November 2022, [18] (SCOI.77307); Exhibit 2, Tab 1, Statement of Gary Wotherspoon, 14 November 2022, [40]-[42] (SCOI 77300); Exhibit 6, Tab 252F, Statement of Detective Chief Inspector Pamela Young, 13 July 2014, [1223], [1238]-[1239], [1254]-[12561, [1269] (SCOI.83088).

[353] Submissions of NSWPF, 21 February 2023, [96] (SCOI.82560).

Review by the Inquiry

5.485. The Inquiry took the following steps in the course of examining the matter.

Summonses

5.486. On 25 August 2022, as a result of a summons issued by the Inquiry to BDM, BDM produced a death certificate for Mr Lloyd-Williams (BDM2).[354] The summons had asked for any relevant certificates, including death certificates, for "WILLIAMS, David Lloyd", and also provided the name of his wife and the fact that he had been born in England. His wife's name and his place of birth were information that by that stage had been provided to the Inquiry by Dr Neil McEwan.

5.487. The description of the circumstances of death in the certificate made it apparent that this death was the subject of the information that had been provided to Ms Thompson, and subsequently identified by in Strike Force Parrabell.

5.488. On 26 August 2022, a summons was issued to the NSWPF for all documents relating to investigations by the NSWPF of the death of Mr Lloyd-Williams, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF13). That summons was issued using his name and dates of birth and death, as they appeared in the death certificate.[355]

5.489. On 9 September 2022, the legal representative for the NSWPF advised by email that the only information or holdings of the NSWPF in relation to the matter were the Strike Force Parrabell Case Summary and BCIF, and that any further information or holdings could not be identified.[356]

5.490. However, the coronial file produced to the Inquiry contained various statements and documentation which had been provided to the Coroner by the NSWPF at the time of Mr Lloyd-Williams' death. No explanation was provided to the Inquiry as to what may have happened to the actual NSWPF investigation file.

5.491. On 28 September 2022, the Inquiry issued a summons to DOFM, seeking all records held by DOFM relevant to the post-mortem of Mr Lloyd-Williams (DOFM2).[357] On 11 October 2022, DOFM produced an electronic file. This consisted of 12 pages of documents comprising copies of the post-mortem report, the Report of Death to Coroner, the blood alcohol test results, and the formal order for the post-mortem. It did not include any evidence of substance not otherwise contained in the coronial file.

[354] Exhibit 12, Tab 6, Death certificate of David Lloyd-Williams, 9 November 1978 (SCOI.74028).

[355] Exhibit 12, Tab 17A, Summons to NSWPF (NSWPF13), 26 August 2022 (SCOI.82178).

[356] Exhibit 12, Tab 18, Email from Patrick Hodgetts to Caitlin Healey-Nash, 9 September 2022, 1 (SCOI.82176).

[357] Exhibit 12, Tab 23, Letter from Caitlin Healey-Nash to Dr Isabel Brouwer, 28 September 2022 (SCOI.82175).

Interagency cooperation

5.492. On 26 August 2022, following receipt of Mr Lloyd-Williams' death certificate from BDM, the Inquiry requested any coronial file related to the death. On 2 September 2022, the Coroners Court provided a file that consisted of 22 pages of material, including a number of witness statements, post-mortem and toxicology reports, and a very brief record of the inquest proceedings that took place on 23 October 1978.

5.493. In his statement to the Coroner, the OIC outlined his views as to the manner of Mr Lloyd-Williams' death as follows:[358]

> *It is my opinion that David LLOYD-WILLIAMS had a deep bout of depression and sadness over the breakup of his marriage [sic] driven his car to North Head and whilst in a state of depression jumped from the cliff to end his life. Inquiries had also revealed that the Deceased had previuosly [sic] contemplated taking his own life as he had expressed his desire not to go on without his wife. There are no suspicious circumstances and no notes were found at his home or in his motor vehicle at the scene where the body was recovered.*

Family members

5.494. The Inquiry ascertained that the "Dave Davies", referred to in Ms Thompson's spreadsheet as a source of her information about Mr Lloyd-Williams' death, was likely to have been Justice David Davies of the Supreme Court.

5.495. Justice Davies was contacted by the Inquiry, and provided the details of another friend of Mr Lloyd-Williams, Dr Neil McEwan, whom Justice Davies thought may have had more information concerning Mr Lloyd-Williams. A meeting was held with Dr McEwan, who did provide the Inquiry with some additional information concerning Mr Lloyd-Williams.

5.496. In the course of its work, the Inquiry also made contact with Mr Lloyd-Williams' sister, with whom he was in close contact around the time of his death, and with his daughter (who was an infant at that time).

Professional opinions

5.497. By letter dated 19 December 2022,[359] an expert opinion was sought from Dr Linda Iles. On 11 January 2023, Dr Iles provided a report to the Inquiry.

5.498. Dr Iles was of the view that a reasonable statement of the cause of Mr Lloyd-Williams' death was "multiple injuries sustained in a fall from height" and noted that this was not materially different from the original opinion of Dr Higgins.[360]

[358] Exhibit 12, Tab 12, Statement of Constable John Charles Mortimer, 24 August 1978, 3 (SCOI.73571.00013).

[359] Exhibit 12, Tab 22A, Letter of Instruction from Caitlin Healey-Nash to Dr Linda Iles, 19 December 2022 (SCOI.82318).

[360] Exhibit 12, Tab 22, Expert report of Dr Linda Iles, 11 January 2023, 4 (SCOI.82316).

5.499. Dr Iles considered that the forensic pathology alone could not determine whether the death might have involved foul play or misadventure, as opposed to an act of suicide. This was because the available material was insufficient in relation to determining the presence or absence of any subtle injury. As a result, she concluded that:[361]

> *circumstantial findings best inform the manner of Mr Lloyd-Williams' death. The circumstances as described in the materials available, suggest that suicide was most likely.*

5.500. Dr Iles was of the view that there were no further medical investigations that would help to determine the manner of Mr Lloyd-Williams' death.[362]

Contact with OIC

5.501. On 23 August 2023 and 20 September 2023, the Inquiry wrote to John Mortimer enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Lloyd-Williams. Mr Mortimer advised that he did not wish to participate in the Inquiry.[363]

Other

5.502. The Inquiry searched for media articles relating to the death of Mr Lloyd-Williams. Two articles were found in the *Manly Daily* newspaper, dated 25 and 26 August 1978.[364]

Consideration of the evidence

Personal background

5.503. Mr Lloyd-Williams was born in Barnhurst, England on 20 June 1946. He had been living in Australia for seven years at the time of his death.[365]

5.504. Mr Lloyd-Williams had an interest in music and worked as a Concert Manager with the ABC.[366] On the afternoon of his death, Mr Lloyd-Williams' body was identified by a friend and work colleague, Herbert Russell, who had worked with Mr Lloyd-Williams for five or six years at the ABC. Mr Russell provided a statement that was tendered at the inquest.[367]

[361] Exhibit 12, Tab 22, Expert report of Dr Linda Iles, 11 January 2023, 4 (SCOI.82316).

[362] Exhibit 12, Tab 22, Expert report of Dr Linda Iles, 11 January 2023, 5 (SCOI.82316).

[363] Exhibit 66, Tabs 43-44, Letters to John Mortimer, 23 August 2023 and 20 September 2023 (SCOI.86301; SCOI.86302).

[364] Exhibit 12, Tab 25, 'Cliff Death Fall', *Manly Daily* (Sydney, 25 August 1978), 1 (SCOI.82319); Exhibit 12, Tab 26, 'Victim named', *Manly Daily*, (Sydney, 26 August 1978), 1 (SCOI.82317).

[365] Exhibit 12, Tab 6, Death certificate of David Lloyd-Williams, 9 November 1978 (SCOI.74028).

[366] Exhibit 12, Tab 1, Report of Death to Coroner, 24 August 1978 (SCOI.73571.00002); Exhibit 12, Tab 24, Statement of Caitlin Healey-Nash, 5 February 2023, [6]–[11] (SCOI.82364).

[367] Exhibit 12, Tab 9, Statement of Herbert Charles Russell, 24 August 1978 (SCOI.73571.00012).

5.505. Dr McEwan told the Inquiry that he had shared a flat with Mr Lloyd-Williams prior to Mr Lloyd-Williams' marriage.[368] They had a mutual interest in music and Dr McEwan had first met Mr Lloyd-Williams when Mr Lloyd-Williams had auditioned for a church choir in Mosman.[369]

5.506. The evidence available to the Inquiry did not suggest that Mr Lloyd-Williams was a member of the LGBTIQ community. Dr McEwan told the Inquiry that he did not understand Mr Lloyd-Williams to be gay.[370]

Mental health

5.507. The inquest exhibits included a brief report by Dr J E Hoult, psychiatrist, dated 29 August 1978. Dr Hoult was treating Mr Lloyd-Williams at the time of his death. The report indicated that Mr Lloyd-Williams had spent time as an inpatient at North Ryde Psychiatric Centre. Dr Hoult was asked to see Mr Lloyd-Williams on 16 August 1978, eight days prior to his death, due to reports from the Centre's social worker that while at home, Mr Lloyd-Williams had been staying in his room all day, not answering the door and not attending work.[371]

5.508. This is consistent with observations made in a statement by Mr Lloyd-Williams' sister in 1978. She stated that she had seen her brother two days prior to his death, when she had gone to his flat to make sure that he was going to keep an appointment with the Welfare Officer at the ABC at 10:30am that day.[372] She indicated that he seemed to be in a very depressed state. She stayed with him for some time, until she had to leave. She made contact with Mr Lloyd-Williams' mother-in-law to see if she could come over and talk with him.[373]

5.509. More generally his sister observed that her brother had always been in good health and spirits, but that this had changed in April 1978. His wife left him at that time and he had seemed to "go down hill quickly with fits of depression" and he had seemed to get worse over the last three weeks of his life.[374]

5.510. In his statement, Mr Russell said that six months prior to Mr Lloyd-Williams' death (i.e., in the early months of 1978), he noticed that Mr Lloyd-Williams was going through "fits of depression caused by marital problems".[375] He said that he had last seen Mr Lloyd-Williams three weeks prior to his death, at which time he did not seem to be himself as he was restless and agitated.[376]

[368] Exhibit 12, Tab 24, Statement of Caitlin Healey-Nash, 5 February 2023, [8] (SCOI.82364).
[369] Exhibit 12, Tab 24, Statement of Caitlin Healey-Nash, 5 February 2023, [8] (SCOI.82364).
[370] Exhibit 12, Tab 24, Statement of Caitlin Healey-Nash, 5 February 2023, [11] (SCOI.82364).
[371] Exhibit 12, Tab 10, Report of Dr JE Hoult, 29 August 1978 (SCOI.73571.00016).
[372] Exhibit 12, Tab 7, Statement of Elizabeth Lloyd-Williams, 24 August 1978 (SCOI.73571.00011).
[373] Exhibit 12, Tab 7, Statement of Elizabeth Lloyd-Williams, 24 August 1978 (SCOI.73571.00011).
[374] Exhibit 12, Tab 7, Statement of Elizabeth Lloyd-Williams, 24 August 1978 (SCOI.73571.00011).
[375] Exhibit 12, Tab 9, Statement of Herbert Charles Russell, 24 August 1978 (SCOI.73571.00012).
[376] Exhibit 12, Tab 9, Statement of Herbert Charles Russell, 24 August 1978 (SCOI.73571.00012).

5.511. Mr Lloyd-Williams' mother-in-law, Ms Worton, also provided a statement to the police. Consistent with the observations made by his sister, Ms Worton described Mr Lloyd-Williams as having been in "good health and spirits" up until April 1978, which coincided with his marriage breaking down.[377] She stated that he then started to have fits of depression.[378] During this period, she would see Mr Lloyd-Williams every weekend and, over the two weeks prior to his death, he had been visiting her place a couple of nights a week. Over the two days and nights prior to his death, he had been staying at the house of his parents-in-law, but had remained agitated.[379]

5.512. At his appointment with Dr Hoult on 16 August 1978 at North Ryde Psychiatric Centre, Mr Lloyd-Williams told the psychiatrist that he was feeling very depressed and that he no longer felt that he had anything to live for since his wife had left him.[380] He was having difficulty getting to sleep and had lost his appetite. He told Dr Hoult that he had recently seriously considered suicide, but that he was now past this. Dr Hoult was of the view that Mr Lloyd-Williams was suffering a depressive neurosis as a result of his marriage break-up.[381] He prescribed an anti-depressant to last three days and made a further appointment for two days' time, on 18 August 1978, which Mr Lloyd-Williams did not keep.[382]

5.513. Dr Hoult reported that Ms Worton had then brought Mr Lloyd-Williams to see him on 21 August 1978, five days after the initial consultation, and three days before his death.[383] She was concerned that Mr Lloyd-Williams was remaining in his room and not adequately caring for himself. The report concludes as follows:[384]

> *It was agreed that he should not stay alone and he consented to go and stay with his mother-in-law [name]. I prescribed increased quantities of Nortriptyline, but requested that [his mother-in-law] control the medication and dispense each dose to Mr Lloyd-Williams. The need for hospitalisation was considered but Mr Lloyd-Williams was opposed to it and there were insufficient grounds for compulsory admission. An appointment was made to see Mr Lloyd-Williams on Friday 25th August.*

Last known movements

5.514. In accordance with Dr Hoult's advice, Mr Lloyd-Williams stayed with his parents-in-law over the two days preceding his death.[385]

[377] Exhibit 12, Tab 8, Statement of Anna Louisa Worton, 24 August 1978 (SCOI.73571.00010).
[378] Exhibit 12, Tab 8, Statement of Anna Louisa Worton, 24 August 1978 (SCOI.73571.00010).
[379] Exhibit 12, Tab 8, Statement of Anna Louisa Worton, 24 August 1978 (SCOI.73571.00010).
[380] Exhibit 12, Tab 10, Report of Dr JE Hoult, 29 August 1978 (SCOI.73571.00016).
[381] Exhibit 12, Tab 10, Report of Dr JE Hoult, 29 August 1978 (SCOI.73571.00016).
[382] Exhibit 12, Tab 10, Report of Dr JE Hoult, 29 August 1978 (SCOI.73571.00016).
[383] Exhibit 12, Tab 10, Report of Dr JE Hoult, 29 August 1978 (SCOI.73571.00016).
[384] Exhibit 12, Tab 10, Report of Dr JE Hoult, 29 August 1978 (SCOI.73571.00016).
[385] Exhibit 12, Tab 8, Statement of Anna Louisa Worton, 24 August 1978 (SCOI.73571.00010).

5.515. Mr Lloyd-Williams was last seen alive at around 8:30am on the morning of his death, 24 August 1978, by his mother-in-law, Ms Worton. She made Mr Lloyd-Williams breakfast and described him as feeling better. Mr Lloyd-Williams said he was going home to Mosman to clean up his flat and that he would phone her to arrange a time to come over to her place to have lunch. Ms Worton did not hear from him again.[386]

5.516. It appears that, at some point after 8:30am on 24 August 1978, Mr Lloyd-Williams travelled to North Head at Manly.

5.517. At 11:45am on that day, 24 August 1978, Robert Steele was standing at the edge of the cliff at North Head and observed a body on the rocks below, and waves crashing over the body.[387] Mr Steele remained at the location in order to show the police where the body was, before returning to work.[388] In an article that appeared in the *Manly Daily* the following day, Mr Steele added that he was looking for a fishing spot when he observed the body.[389]

The cliff location

5.518. According to a newspaper report of 25 August 1978, investigating police described the cliff location as at the "south-eastern point" of North Head, and said that the base of the cliff from which the body was recovered was about 300 feet (or roughly 90 metres) below the top.[390] A white Volkswagen station sedan, which appeared to belong to Mr Lloyd-Williams, was also found parked at the southern end of Scenic Drive with the "keys … in the ignition".[391]

5.519. While there was no diagram of the location of Mr Lloyd-Williams' body in the documentation before the Inquiry, these descriptions were sufficient for the Inquiry to establish in general terms the area of North Head where the car and body were located.

5.520. North Head is known to have had a well-used beat area, often visited by men to sunbake and/or engage in sexual activity, during the era in which the death occurred, the late 1970s.[392] There is also some evidence that attacks on men who were using the area as a beat may have occurred during this period.[393]

[386] Exhibit 12, Tab 8, Statement of Anna Louisa Worton, 24 August 1978 (SCOI.73571.00010).

[387] Exhibit 12, Tab 11, Statement of Robert Steele, 9 October 1978 (SCOI.73571.00008).

[388] Exhibit 12, Tab 11, Statement of Robert Steele, 9 October 1978 (SCOI.73571.00008).

[389] Exhibit 12, Tab 25, 'Cliff Death Fall', *Manly Daily* (Sydney, 25 August 1978), 1 (SCOI.82319).

[390] Exhibit 12, Tab 12, Statement of Constable John Charles Mortimer, 24 August 1978, 1 (SCOI.73571.00013).

[391] Exhibit 12, Tab 25, 'Cliff Death Fall', *Manly Daily* (Sydney, 25 August 1978), 1 (SCOI.82319); Exhibit 12, Tab 12, Statement of Constable John Charles Mortimer, 24 August 1978 (SCOI.73571.00013).

[392] See generally Exhibit 2, Tab 8, Statement of Ulo Klemmer, 11 November 2022, [18] (SCOI. 77307); Exhibit 2, Tab 1, Statement of Gary Wotherspoon, 14 November 2022, [40]–[42] (SCOI.77300).

[393] Exhibit 6, Tab 232, Findings of State Coroner Barnes, 30 November 2017, [160]-[162] (SCOI.11064.00018).

5.521. The location where Mr Lloyd-Williams' body was found does not, however, appear to be in the particular area of North Head that was best known as the site of the beat.[394] That area is considerably further to the north, between Blue Fish Point and Shelly Beach.[395]

Clothing

5.522. The available material from the coronial file contains no information about any clothing worn by Mr Lloyd-Williams at the time of his death. There is nothing in the coronial file that suggests that Mr Lloyd-Williams' body was found naked or that his clothing was located at the top of the cliff. Although that material is limited, this may be because the circumstances of the death were assumed at the time to be quite clear (namely an assumption of suicide).

Police investigation

5.523. As outlined above, no police investigation file has been located or produced by the NSWPF. There is no document containing any description of the area from which Mr Lloyd-Williams fell, or of any search that was conducted of that area, or whether any clothing or personal items were located with his body.

5.524. Information in the statement of the OIC relating to the location is limited to the following:[396]

a. That Mr Lloyd-Williams' body was recovered "from the base of the cliff situated at the south eastern point of North Head from about 300 hundred feet below that cliff"; and

b. That he observed "a white volkswagon station sedan registered number AKP 007 which was parked at the southern end of the Scenic Drive".

5.525. Potentially significant matters, such as Mr Lloyd-Williams' ownership of the vehicle located near the cliff area from which he fell, and the fact that his keys remained in the ignition of the car, have been derived from a newspaper article found by the Inquiry, and do not appear in the police material.[397] Nor are there photographs of the area in that material. The only photograph of the relevant area appears in the newspaper article and is of limited assistance.

[394] See Exhibit 12, Tab 25, 'Cliff Death Fall', The Manly Daily, 25 August 1978 (SCOI.82319); Exhibit 12, Tab 12, Statement of Constable John Charles Mortimer, 16 October 1978 (SCOI.73751.00013).

[395] Exhibit 2, Tab 8, Statement of Ulo Klemmer, 11 November 2022, [18] (SCOI. 77307); Exhibit 2, Tab 1, Statement of Gary Wotherspoon, 14 November 2022, [40]–[42] (SCOI.77300).

[396] Exhibit 12, Tab 12, Statement of Constable John Charles Mortimer, 24 August 1978, 1 (SCOI.73571.00013).

[397] Exhibit 12, Tab 25, 'Cliff Death Fall', Manly Daily (Sydney, 25 August 1978), 1 (SCOI.82319).

5.526. The NSWPF accepted, and expressed regret for the fact, that the investigation file in relation to Mr Lloyd-Williams' death could not be found and appeared to have been lost.[398] The NSWPF submitted, however, that while the file's absence highlighted deficiencies in record keeping and archiving of such files at the time, there was little to be gained now from criticising the record-keeping practices of the NSWPF 44 years ago.[399] It was submitted that, in the absence of the file, it was not possible to confirm whether any other inquiries—not referenced in the Coroners Court holdings—were undertaken.[400]

5.527. In addition, the failure to locate the investigative file in relation to the death of Mr Lloyd-Williams was the subject of further evidence and submissions from both Counsel Assisting and the NSWPF in the context of the Investigative Practices Hearing.

5.528. During the course of oral evidence, Assistant Commissioner Conroy told the Inquiry that a coronial finding of suicide would have a bearing upon the appropriateness or otherwise of a decision to dispose of exhibits or investigative files. In particular, Assistant Commissioner Conroy indicated that exhibits would be disposed of upon receipt of written instructions from the Coroner.[401]

5.529. During the Investigative Practices Hearing, Detective Inspector Warren acknowledged that he would have expected documents to be created during the course of the police response into Mr Lloyd-Williams' death. Those records, according to practices of the day, would have been kept with the OIC at the police station where the incident occurred. Detective Inspector Warren accepted that even if a coroner formed the view that it was more likely, on the balance of probabilities, that a death was non-suspicious, proper police practice would require those records to be retained.[402]

5.530. In connection with the Investigative Practices Hearing, the NSWPF submitted that there is no evidence as to when and/or how the investigative file relating to Mr Lloyd-Williams' death came to be disposed of. Further, having regard to the status of the matter as a non-suspicious death, it may well be that the disposal of the file, after a given period of retention was authorised. If, of course, the relevant file was disposed of without authority or otherwise in contravention of the document management obligations of the NSWPF, the NSWPF submitted that would be "regrettable".[403]

[398] Submissions of NSWPF, 21 February 2023, [92] (SCOI.82560).

[399] Submissions of NSWPF, 21 February 2023, [93] (SCOI.82560).

[400] Submissions of NSWPF, 21 February 2023, [94] (SCOI.82560).

[401] Transcript of the Inquiry, 4 July 2023, T4865.26-46 (TRA.00072.00001)

[402] Transcript of the Inquiry, 5 July 2023, T4947.20-4948.39 (TRA.00073.00001).

[403] Submissions of NSWPF, 10 October 2023, [326]–[327] (SCOI.86127).

5.531. There is no evidence before the Inquiry as to whether the precise location from which Mr Lloyd-Williams fell was documented at the time of the initial investigation, or whether a search of the area surrounding the location of the body was conducted. This could be because these steps were not taken, or because they were taken but not recorded, or because they were taken and recorded, but these records have been lost. While the absence of records means that I am unable to make a definitive finding as to what occurred, I consider it unlikely that such steps were taken. If they had they been taken, one would logically expect them to have been referred to in the statement of the OIC or otherwise included in the coronial file.

Manner and cause of death

Location of death

5.532. There is no direct evidence before the Inquiry of the precise location where Mr Lloyd-Williams' body was found. However, on the basis of information in the OIC's statement and the *Manly Daily* article, I accept Counsel Assisting's submission that these descriptions are sufficient to establish in general terms that Mr Lloyd-Williams' body was located at the south-eastern point of North Head, in the vicinity of the carpark on Scenic Drive.

5.533. While there is clear evidence of the existence of a beat at North Head at the time of Mr Lloyd-Williams' death, the known beat area was significantly to the north of the part of North Head where it appears that the body of Mr Lloyd-Williams was located.[404]

5.534. I note and accept the evidence of the initial forensic pathologist Dr Higgins, and the Inquiry's expert pathologist Dr Iles, as to the cause of Mr Lloyd-Williams' death. Both pathologists were ultimately in agreement that Mr Lloyd-Williams died of multiple injuries consistent with a fall from a height.

Clothing

5.535. As to the assertion in the BCIF that Mr Lloyd-Williams was found naked, with his clothing left folded at the top of the cliff, Counsel Assisting submitted that these would have been distinctive and unusual features of the death and would have been likely to have been referred to in the statement of the OIC and/or the Report of Death to Coroner. However, there was nothing in the coronial file to suggest either of those matters.

[404] See Exhibit 2, Tab 8, Statement of Ulo Klemmer, 11 November 2022, [18] (SCOI. 77307); Exhibit 2, Tab 1, Statement of Gary Wotherspoon, 14 November 2022, [40]–[42] (SCOI.77300); Exhibit 12, Tab 12, Statement of Constable John Charles Mortimer, 16 October 1978 (SCOI.73751.00013).

5.536. Counsel Assisting made submissions concerning the reliability of the information provided to Ms Thompson, many years after Mr Lloyd-Williams' death. Both Justice Davies and Dr McEwan, who had heard at some stage that the clothes were folded at the top of the cliff, were uncertain as to when and from whom they had heard this.[405] Ms Thompson's recollection was that the matters attributed by her to Justice Davies had actually been passed on to her by the relatives of another man (Scott Johnson) whose body had been found at the base of a cliff at North Head.

5.537. I accept the submission of Counsel Assisting that it was not clear how Justice Davies and Dr McEwan came to the understanding they did in relation to way in which Mr Lloyd-Williams' clothes were said to have been folded. As Counsel Assisting submitted, it is possible that whatever was said to them, and whatever they subsequently said to others, had become confused over time with the reported circumstances of the other death at North Head where such circumstances (a naked body, folded clothes) did exist.

5.538. In my view, those submissions are likely to be correct. I afford little weight to the hearsay suggestion in the BCIF that Mr Lloyd-Williams' body was found naked and his clothes folded at the top of the cliff. There is no contemporaneous record to support this account, and it was first recorded decades after Mr Lloyd-Williams' death. Those witnesses who had heard of the clothes supposedly being folded could not precisely recall when or from whom they heard such a suggestion. Either of the two suggested factors, if they had existed, would have been likely to have been noted in the statement of the OIC and/or in other materials provided by police to the Coroner.

Psychological state

5.539. As Counsel Assisting submitted, the evidence clearly demonstrated that Mr Lloyd-Williams was suffering from severe depression at the time of his death.

5.540. That evidence included the accounts of the witnesses who had contact with him in the weeks and days prior to his death, including his psychiatrist. He had people around him, including his sister and mother-in-law, who were clearly very caring and were seeking to help Mr Lloyd-Williams as his condition appeared to worsen in the days leading up to his death.

5.541. The severity of his condition was reinforced by his indication to his psychiatrist that he had been contemplating suicide, his prior admission to an inpatient facility, the psychiatrist's suggestion that he admit himself as an inpatient, and the psychiatrist's requirement that he stay with his mother-in-law and that he not be permitted to administer his medication to himself.

5.542. Further, the particular location at North Head, to which Mr Lloyd-Williams drove, to and the fact that he left his keys in his car ignition, also appear to be consistent with an act of suicide.

[405] Exhibit 12, Tab 24, Statement of Caitlin Healey-Nash, 5 February 2023, [7]–[11] (SCOI.82364).

5.543. It was ultimately submitted by Counsel Assisting that, sadly, the evidence overwhelmingly supported the proposition that on the morning of 24 August 1978, while suffering from deep depression, Mr Lloyd-Williams travelled in his car from Mosman to North Head at Manly, where he deliberately ended his life by jumping from a cliff at the south-eastern end of North Head. I accept that submission, which the NSWPF also adopted.

Bias

5.544. As Counsel Assisting noted, there was no evidence to suggest that Mr Lloyd-Williams was a member of the LGBTIQ community.

5.545. Further, while North Head had a well-known beat area in the late 1970s, the location where Mr Lloyd-Williams' body was found was not in that area of North Head.[406]

5.546. Accordingly, it was submitted both by Counsel Assisting and by the NSWPF that this was not a death in which LGBTIQ bias was a factor.

Conclusions and Recommendations

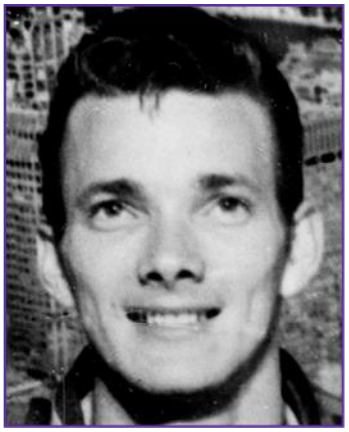
5.547. I find that Mr Lloyd-Williams died on 24 August 1978 of multiple injuries after deliberately jumping from a cliff at North Head in Manly. At the time of his death, Mr Lloyd-Williams was suffering from severe depression. I note that this does not differ in substance from the earlier coronial finding.

5.548. In my view, on the evidence available to the Inquiry, there is objectively no reason to suspect that LGBTIQ bias was a factor in the death of Mr Lloyd-Williams.

5.549. I do not propose to make any recommendations arising from the Inquiry's consideration of Mr Lloyd-Williams' death.

[406] See generally Exhibit 2, Tab 8, Statement of Ulo Klemmer, 11 November 2022, [18] (SCOI. 77307); Exhibit 2, Tab 1, Statement of Gary Wotherspoon, 14 November 2022, [40]–[42] (SCOI.77300).

IN THE MATTER OF WALTER BEDSER



Factual background

Date and location of death

5.550. At approximately 2:00pm on 2 December 1980, Walter Bedser was attacked and stabbed in the chest multiple times with a knife in his antique shop in Parramatta. He died in Parramatta Hospital shortly afterwards, at 2:15pm. He was 47 years old.

Circumstances of death

5.551. Mr Bedser, known more commonly by his middle name John or "Johnny", was an antique dealer in Parramatta. His shop was on the corner of an arcade at 4 Darcy Street, Parramatta.

5.552. On 2 December 1980, at approximately 2:00pm, Mr Bedser was fatally stabbed in his shop by a person who has never been identified. There were numerous witnesses to the immediate aftermath of the assault on Mr Bedser, who saw the injured Mr Bedser and/or another person emerge from the shop. However, there were also numerous differences in their respective accounts.

5.553. Clinical notes completed on Mr Bedser's arrival at hospital suggest Mr Bedser was unconscious on arrival and severely hypovolaemic. Initial examination identified two cuts lacerating his liver and lung, and four long slashes on Mr Bedser's left arm. Attempts at resuscitation failed and Mr Bedser was pronounced dead at 2:15pm, with the cause of death noted as "hypovolaemic shock" (referring to severe blood and fluid loss).[407]

5.554. The post-mortem concluded that the cause of death was blood loss from a lacerated liver and left lung.[408] The following injuries were identified:

a. 12 cm irregular laceration on the left forearm, more likely caused by glass;

[407] Exhibit 28, Tab 3, Synopsis of Clinical Notes, 2 December 1980, 2 (SCOI.00008.00012).

[408] Exhibit 28, Tab 4, Post-mortem report of Naaman Malouf, 3 December 1980, 1 (SCOI.00008.00017).

b. 8 cm regular laceration on the left arm, more likely caused by a knife;

c. 3 x 2 cm stab wound to the chest;

d. 7 cm stab wound to the chest, which lacerated the liver and diaphragm; and

e. Small abrasion on the left shoulder.

5.555. Various complexities surround the question of motive. At the time of the initial investigation, it would seem that there were three main possible case theories:

a. A revenge attack by a parent or family associate of a teenage boy (or possibly girl) with whom Mr Bedser was known or believed to have had, or to have sought to have, sexual interactions;

b. An attack by a member or associate of the family of NP58 (a pseudonym), a teenage boy who worked for Mr Bedser for several years prior to his death, as a result of acrimony flowing from various financial dealings between that family and Mr Bedser; or

c. An attack for other reasons altogether, such as a robbery or a dispute over jewellery or other property.

5.556. Those case theories are discussed in detail below. As will become apparent, the first two case theories may not be completely separable.

Mr Bedser's sexuality

5.557. It was well known among his friends and associates that Mr Bedser was gay.[409] One witness went so far as to say that Mr Bedser's sexuality was "common knowledge amongst local people".[410]

5.558. Soon after his death there were rumours circulating in the antique community that Mr Bedser was murdered due to his sexuality.[411]

5.559. His mother would not accept he was gay,[412] and his sister did not know he was gay.[413]

5.560. He had been given a warning in 1977, in a park in Parramatta, for "loitering" when in the company of another man. Police described that man in 1980 as "a dead set poofter", and Mr Bedser himself as "a cat": see below. There was also evidence that he had attended beats from time to time.

5.561. The Parramatta CBD near Mr Bedser's store included a number of known beats.[414]

[409] Exhibit 28, Tab 34, Statement of Raymond Morris Hadley, 2 December 1980 (SCOI.10058.00050); Exhibit 28, Tab 108, Report of interview with Maree Magers, 18 December 1980 (SCOI.45150).

[410] Exhibit 28, Tab 48, Report of interview with Emma Ellen Clarke, 3 December 1980 (SCOI.45115).

[411] Exhibit 28, Tab 125, Report of interview with John, Maree, Andrew and Elayne Margaret Magers, 25 January 1981 (SCOI.10061.00012).

[412] Exhibit 28, Tab 157, Jim Pollard, "The riddle of murder arcade", *Daily Mirror*, 27 October 1981 (SCOI.10064.00006).

[413] Exhibit 28, Tab 87, Report of interview with Shirley Driscoll (SCOI.00008.00113).

[414] Exhibit 28, Tab 164, Strike Force Parrabell Bias Crimes Indicators Review Form – Walter Bedser, Undated 16 (SCOI.49560).

5.562. It is clear that Mr Bedser had had sexual relations with, or had propositioned, a number of teenage boys, some of whom had at one time or another been employed by Mr Bedser in his shop. Most of those boys appear to have been from European, and especially Greek, backgrounds.

5.563. There is some evidence that Mr Bedser may have also had a sexual or romantic interest in women. One witness claimed that Mr Bedser had been having sex with a 16 year old girl,[415] while another claimed that he had found a ladies white slip in Mr Bedser's back room, and that Mr Bedser had said it belonged to a woman he was interested in. This latter witness also claimed that Mr Bedser had both heterosexual and gay pornographic magazines.[416]

Previous investigations

Original police investigation

Persons of interest

5.564. No persons of interest were identified in the initial police investigation, notwithstanding that numerous witnesses saw the presumed assailant running from the shop. The evidence gathered by the initial investigation, particularly with respect to the family of NP58, is considered below.

Exhibits

5.565. Some exhibits were recovered from the scene and some crime scene photographs taken, including photos of the knife used in the attack, which was found on the floor of the shop behind the counter.[417] The exhibits recovered included the knife, a blood sample from Mr Bedser, and blood swabs from various parts of the scene.

5.566. On 2 December 1980, the day of the murder, according to an occurrence entry of that day, the fingerprint section attended and obtained numerous prints for examination.[418] Fingerprints other than Mr Bedser's were found at his shop but were not matched with any known person.

5.567. Two of the prints were found on the top of the cash register, and one on the inside of a vase.[419] Another print, on a large bowl which had traces of blood nearby, was that of Mavis Turner, who was an employee of Mr Bedser. There were also some fragmented latent prints and a partial palm print not accounted for. Investigating police noted that they were not confined to a particular part of the shop and may have been those of customers.[420]

[415] Exhibit 28, Tab 44, Report of interview with Charles Joseph Duffield, 3 December 1980 (SCOI.82128).

[416] Exhibit 28, Tab 123, Report of interview with I40, 24 January 1981, 3 (SCOI.82143).

[417] Exhibit 28, Tab 10, Crime Scene and Post-mortem Photographs, Undated 32, 34, 35 (SCOI.82618).

[418] Exhibit 28, Tab 26, NSWPF Report of Occurrence, 'Police attendance at the crime scene', 2 December 1980 (SCOI.00008.00019).

[419] Exhibit 28, Tab 16, NSWPF Report of Occurrence, 'Report of fingerprint discovery', 4 December 1980 (SCOI.45108).

[420] Exhibit 28, Tab 17, NSWPF Report of Occurrence, 'Report of fingerprint examinations', 20 January 1981 (SCOI.45109).

5.568. Also on 2 December 1980, according to the same occurrence entry, Detective Sergeant Carter of the Parramatta Scientific Section took possession of the knife.[421] What Detective Sergeant Carter did with the knife is not recorded.

5.569. On 10 December 1980, Detectives McHugh and Smith are recorded as conveying the knife (along with the blood samples and swabs) to DAL, now known as the FASS, where they were received by P.A. Connellan, Forensic Biologist.[422]

5.570. On 24 December 1980, according to DAL records, the knife (and the blood sample and swabs) was removed from DAL by J Rheslop of Parramatta Police Station.[423]

5.571. There is no record, in any of the material produced to the Inquiry by the NSWPF, of any examination of the knife for fingerprints. However, at the inquest in 1983, the following exchange took place between the Coroner and the OIC, Detective Sergeant Hamilton:[424]

> *Q. You may have mentioned it but was the knife found?*
>
> *A. Yes the knife was found near the counter where the deceased was stabbed.*
>
> *Q. Obviously examined for fingerprints?*
>
> *A. Yes nothing at all.*
>
> *Q. Nothing at all?*
>
> *A. Nothing.*

5.572. That exchange clearly suggests both that the knife was examined for fingerprints, and that no fingerprints were found on it. However, as noted above, the NSWPF has produced no record of any such examination of the knife.

5.573. In fact, the NSWPF is unable to locate the knife (nor the blood sample, nor the blood swabs, nor Mr Bedser's clothing). On the evidence available to the Inquiry, at some point in time on or after 24 December 1980, the knife and the other items have been lost, whether by police or otherwise.[425]

[421] Exhibit 28, Tab 26, NSWPF Report of Occurrence, 'Police attendance at the crime scene', 2 December 1980 (SCOI.00008.00019).

[422] Exhibit 28, Tab 14, NSWPF Report of Occurrence, 'Record of exhibits sent for testing', 10 December 1980 (SCOI.82594); Exhibit 28, Tab 13, NSWPF Report of Occurrence, 'Specimen/Exhibit Examination Form', 8 December 1980 (SCOI.10284.00014); Exhibit 28, Tab 169, Statement of Detective Sergeant Neil Sheldon, 23 January 2023, [7] (SCOI.82591).

[423] Exhibit 28, Tab 169, Statement of Detective Sergeant Neil Sheldon, 23 January 2023, [7], Annexure A (SCOI.82591).

[424] Exhibit 28, Tab 8, Transcript of Coronial Inquest into the death of Walter Bedser, 11 July 1983, 4 (SCOI.00008.00139).

[425] Exhibit 28, Tab 169, Statement of Detective Sergeant Neil Sheldon, 23 January 2023 (SCOI.82591).

5.574. Assistant Commissioner Conroy stated that:[426]

> *Given that case is (and was) an unsolved homicide the disposal of the murder weapon (if that occurred) would very likely have breached Instruction 33 (1977). The disposal of such an exhibit would also likely have breached Instruction 78 (1977) (78-9) if it did not occur in accordance with a direction from a Coroner. While the material available to me does not indicate whether or not such a direction was issued, it seems very unlikely that such a direction would have been given in this case. Whether the murder weapon in Mr Bedser's case was disposed of or lost, the fact that it is unavailable is obviously unsatisfactory.*

5.575. The NSWPF accepted in submissions that this is "entirely unacceptable",[427] and that it "very likely involved a breach of policy at the relevant time".[428]

Missing documents

5.576. A considerable amount of material, at least some of which must have formed part of police records at an earlier time, has not been produced to the Inquiry by the NSWPF. In particular, the running sheets and occurrence entries produced to the Inquiry terminate abruptly in January 1981, whereas the investigation apparently continued for some considerable time after that and indeed the inquest did not take place until July 1983.

Findings at inquest

5.577. An inquest was held on 11 July 1983. The finding of Coroner Glass was that Mr Bedser died on 2 December 1980, "of the effects of blood loss due to a lacerated liver and a lacerated left lung inflicted earlier that day at the premises of 4 Darcy St, Parramatta, by a person unknown."[429]

Criminal proceedings

5.578. No criminal proceedings have ever been brought against anyone in relation to Mr Bedser's death.

[426] Exhibit 51, Tab 4, Second Statement of Assistance Commissioner Rashelle Conroy, 11 June 2023, [44] (NPL.9000.0008.1049).

[427] Submissions of NSWPF, 7 June 2023, [10] (SCOI.83644).

[428] Submissions of NSWPF, 10 October 2023, [329] (SCOI.86127).

[429] Exhibit 28, Tab 9, Findings of Gregory Charles Glass, Inquest into the death of Walter Bedser, 11 July 1983 (SCOI.00008.00003).

Subsequent police investigation

UHT Review

5.579. So far as can be ascertained from the material produced to the Inquiry by the NSWPF, the death of Mr Bedser has twice been the subject of student exercises at a "Senior Detectives Course" (one in 2005 and one in 2011), and has once been the subject of a review by the UHT (in 2008). Each review produced a "Screening Form" which provided information about the review.[430]

5.580. The usual UHT process involves: first, the "triage" of a matter (leading to a recommendation as to whether or not a review is warranted); next, depending on the outcome of the triage, a review to determine whether or not a matter should be reinvestigated;.[431] and finally, if a review does so recommend, an actual "reinvestigation".

5.581. In June 2022, the NSWPF produced a document which suggested that Mr Bedser's murder had been triaged again "recently."[432] However, no document recording or referring to the content or outcome of any such triage process, or any review flowing therefrom, has been produced to the Inquiry.

5.582. The UHT review in 2008 does not indicate which officer or officers carried out the review.[433] The form is undated and neither the "Reviewer's Certification" nor the "Co-ordinator's Certification" has been completed or signed. However, its notable features include:

a. No recommendation was made for reinvestigation, mainly because the critical exhibits (especially the knife and the blood samples and swabs) were missing, and because "some paperwork may be missing" — apparently a reference to the fact, noted elsewhere in the review, that the running sheets "abruptly terminate in January 1981"; and

b. The UHT's review of the fingerprint file (see further below) had identified I206 and I205 (who were not considered suspects), and Geoffrey Smith (in respect of whom some further enquiries were suggested).

[430] Exhibit 28, Tab 159, Senior Detectives Course review material – Walter Bedser, 10 May 2005 (SCOI.02915); Exhibit 28, Tab 160, Case Screening Form – Walter Bedser, 18 September 2008 (SCOI.02913); Exhibit 28, Tab 161, Senior Detectives Course review material – Walter Bedser, 4 August 2011 (SCOI.02914).

[431] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [86] (NPL.9000.0019.0001).

[432] Exhibit 28, Tab 162, Review Status Summary, 6 June 2022 (SCOI.83248).

[433] Exhibit 28, Tab 160, Case Screening Form, 18 September 2008 (SCOI.02913).

5.583. At the Investigative Practices Hearing, Detective Chief Inspector Laidlaw was asked by Senior Counsel Assisting whether it was possible to tell from the face of the document whether it was a review by the UHT or by the Detectives Course, and Detective Chief Inspector Laidlaw said it was not possible to tell.[434] The NSWPF submitted that it can be inferred that the 2008 Screening Form was prepared by the UHT rather than the Senior Detective Course because its contents records inquiries going beyond the apparent limitations of the Senior Detectives Course and the language used indicates that the author is not in such a course.[435]

5.584. Detective Chief Inspector Laidlaw informed Senior Counsel Assisting that while the 2008 screening form was not signed or dated, the Commissioner could nonetheless draw an inference that the form was completed.[436] The NSWPF conceded that, while the form is "detailed and it appears to be complete", in the absence of the certification of the reviewer or coordinator it is not possible to confirm that the form was completed. The NSWPF accepted that this was "unsatisfactory".[437]

5.585. The 2008 Bedser Case Screening Form records that "[t]his appears to have been a thorough investigation pursuing all lines of inquiry".[438] Senior Counsel Assisting drew Detective Chief Inspector Laidlaw's attention to the observation, also contained in the 2008 Bedser Case Screening Form, that "[i]t is unclear whether all running sheets are truly available as they finish abruptly in January 1981". Detective Chief Inspector Laidlaw agreed that it should have been obvious to the reviewer that they did not have complete information and that a reviewer could not form a view that a thorough investigation had been completed in those circumstances.[439]

5.586. Detective Chief Inspector Laidlaw agreed that language such as "[t]his appears to have been a thorough investigation pursuing all lines of inquiry" could affect the likelihood of a case being picked up and reviewed again in the future, and that this sort of statement may make a case less likely to be reviewed in the future.[440] In written submissions, the NSWPF contended that this language, read in the context of the further recommended inquiries and documentary limitations also set out in the "Recommendation" section of the 2008 form, does not appear to pose a significant risk of affecting the likelihood of further review in this case.[441]

5.587. As to the two reviews conducted during the Senior Detective Courses in 2005 and 2011:[442]

a. In 2005, the participating students recommended that consideration be given to reopening the case;

[434] Transcript of the Inquiry, 7 July 2023, T5218.1–5 (TRA.00075.00001).

[435] Submissions of NSWPF, 10 October 2023, [334] (SCOI.86127).

[436] Transcript of the Inquiry. 7 July 2023, T5216.37–42 (TRA.00075.00001).

[437] Submissions of NSWPF, 10 October 2023, [336] (SCOI.86127).

[438] Exhibit 28, Tab 160, Review of an Unsolved Homicide Case Screening Form – Walter Bedser, 18 September 2008, 17 (SCOI.02913).

[439] Transcript of the Inquiry, 7 July 2023, T5220.40–5221.33 (TRA.00075.00001).

[440] Transcript of the Inquiry, 7 July 2023, T5222.12–28 (TRA.00075.00001).

[441] Submissions of NSWPF, 10 October 2023, [337] (SCOI.86127).

[442] Exhibit 28, Tab 159, NSWPF, Senior Detectives Course review material, 10 May 2005 (SCOI.02915); Exhibit 28, Tab 161, Senior Detectives Course review material, 4 August 2011 (SCOI.02914).

b. In 2011, the participating students recommended that the case be reinvestigated;

c. Neither of those recommendations appears to have ever been adopted;

d. In each case the participating students appear to have assumed and accepted that any progress in any such reopening or reinvestigation would be dependent on locating the missing exhibits, especially the knife and the blood sample and swabs;

e. The 2011 students levelled various criticisms at the original investigating police, in particular in relation to the loss of the exhibits, "the fragmented style in which the information [gathered in relation to the case] was recorded and stored", and the absence of a comprehensive OIC statement.[443]

5.588. Detective Chief Inspector Laidlaw gave evidence that a Screening Form completed as part of the Senior Detectives Course was a serious review and undertaken under "strict" management, not just as a training exercise.[444]

5.589. The Case Screening Form dated 10 May 2005 is unsigned, undated and does not have a signature for the coordinator's certification. Detective Chief Inspector Laidlaw stated that the absence of a signature for the coordinator's certification appeared to be an oversight and was not an indication that the forms were incomplete as "if they're on our system, they wouldn't be [incomplete]."[445] In response to the Investigative Practices Hearing, the NSWPF have submitted that it was "unsurprising" that the form was unsigned because it was prepared by a "syndicate" in the context of a Senior Detectives Course rather than an individual reviewer.[446]

5.590. It appears that the recommended "phase 1" actions of the 2005 Screening Form were not carried out, as there is no record of the steps within the NSWPF records, which Detective Chief Inspector Laidlaw accepted would be expected if the recommendations had been actioned.[447]

5.591. The 2005 Case Screening Form records, under the "Exhibits Located" heading a "knife" which is identified as "to DAL on 10/12/1980".[448] In fact, by 2005 the knife had been lost. Detective Chief Inspector Laidlaw agreed that his ought to have been identified in the form, but conceded that the author may not have been aware of the loss of the knife.[449]

[443] Exhibit 28, Tab 161, NSWPF, Senior Detectives Course review material, 4 August 2011 (SCOI.02914).

[444] Transcript of the Inquiry, 7 July 2023, T5216.11–20 (TRA.00075.00001).

[445] Transcript of the Inquiry, 7 July 2023, T5212.38–5213.5, 5213.11–21 (TRA.00075.00001).

[446] Submissions of NSWPF, 10 October 2023, [332] (SCOI.86127).

[447] Transcript of the Inquiry, 7 July 2023, T5214.2–31 (TRA.00075.00001).

[448] Exhibit 28, Tab 159, Senior Detectives Course review material – Walter Bedser, 10 May 2005, 8 (SCOI.02915).

[449] Transcript of the Inquiry, 7 July 2023, T5214.44–5215.14 (TRA.00075.00001).

Fingerprint analysis

5.592. In about 2007-2008, as part of the UHT review at that time, further fingerprint analysis was conducted from prints which had been lifted from glass display cases at the crime scene. This produced matches with three persons: Mr Smith, I205 and I206.

5.593. Only one of those three persons, Mr Smith, was of an age and description (as at December 1980) possibly comparable to that of the person seen by several witnesses running from the shop at the time of the murder. Mr Smith died in custody in 2002. I accept the submission of Counsel Assisting that none of the material available to the Inquiry suggests any connection between Mr Smith and Mr Bedser that would link him to the homicide.

5.594. At the time of Mr Bedser's death, I205 would have been 15 years old, and I206 would have been 9 years old. None of the witnesses outside the shop in December 1980 suggested that any person of such an age was seen. Nor is there any indication in the available evidence that either I205 or I206 was one of the boys with whom Mr Bedser had any relevant association.

Strike Force Parrabell

Bias Crimes Indicators Form

5.595. A BCIF was completed by Strike Force Parrabell. Nine of the ten indicators were answered "Insufficient Information".[450] In the "Summary of Findings" box, the overall categorisation is also "Insufficient Information".[451]

5.596. For the first indicator, "Differences", the answer "No" was entered in respect of all four options at the conclusion of the section,. The NSWPF accepted that this was "clearly an error", but submitted that it had no bearing on the ultimate classification of Mr Bedser's matter by Strike Force Parrabell.[452]

Case Summary

5.597. In the Parrabell Report, six cases were referred to as "motivated by paedophilia".[453] In the accompanying pie chart, that group of cases is described as "Paedophile/revenge".[454] The Parrabell Report does not identify which individual cases fall into any particular category or classification.

5.598. Since the BCIF categorised the Bedser case as "Insufficient Information", and since the Case Summary for Mr Bedser makes no mention of a paedophile/revenge hypothesis, I accept the submission of Counsel Assisting that it may be inferred that Mr Bedser's case was not one of the six.

[450] Exhibit 28, Tab 164, Strike Force Parrabell Bias Crimes Indicators Review Form – Walter Bedser, 28 February 2017 (SCOI.49560).

[451] Exhibit 28, Tab 164, Strike Force Parrabell Bias Crimes Indicators Review Form – Walter Bedser, 28 February 2017, 21 (SCOI.10064.00002).

[452] Submissions of NSWPF, 7 June 2023, [31]–[32] (SCOI.83644).

[453] Exhibit 1, Tab 2, NSW Police Force, *Strike Force Parrabell Final Report* (Report, June 2018) 37 (SCOI.02632).

[454] Exhibit 1, Tab 2, NSW Police Force, *Strike Force Parrabell Final Report* (Report, June 2018) 37 (SCOI.02632).

5.599. The Case Summary in relation to Mr Bedser reads as follows:[455]

> ***Identity:*** *Walter John Bedser was 47 years old at the time of his death.*
>
> ***Personal History:*** *Mr Bedser operated an antique shop in a Parramatta arcade.*
>
> ***Location of Body/Circumstances of Death:*** *Mr Bedser was stabbed numerous times inside his antique shop before running to and collapsing in a nearby grocery store. He was conveyed to hospital where he later died of his injuries. Police interviewed many witnesses who describe seeing a man leave the antique shop moments after the stabbing of Mr Bedser, yelling 'get an ambulance'. The man was possibly accompanied by a young woman. A man with the same description as the person seen running from the antique shop had purchased the murder weapon (a sheath knife) from a Toyworld store located in the same arcade as Mr Bedser's antique shop shortly before the murder. No clear motive has been established for the murder of Mr Bedser. No suspects have been identified.*
>
> ***Sexual Orientation:*** *Mr Bedser's sexual orientation could not be confirmed however he was described by people who knew him as same sex attracted or bisexual.*
>
> ***Coroner/Court Findings:*** *Mr Bedser's murder remains unsolved.*

Academic review

5.600. The academic review categorised Mr Bedser's case as "Insufficient Information".[456]

5.601. The academic reviewers distinguished between cases where there was evidence of "anti-gay bias" (said to be 17) and cases of "anti-paedophile animus" (said to be 12).[457] They devoted several pages to a discussion of why such a distinction was considered appropriate.[458]

5.602. Professors Asquith and Lovegrove, in their respective expert reports, expressed a number of reservations about the academic review team's approach in this regard.[459] However, in any event, the academic reviewers, like the Strike Force Parrabell officers, actually categorised Mr Bedser's case as "Insufficient Information" — and thus not, it would seem, as either "Anti-gay Bias" or "Anti-paedophile Animus".

[455] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Walter Bedser, Undated 2 (SCOI.76961.00014).

[456] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Walter Bedser, Undated 2 (SCOI.76961.00014).

[457] Exhibit 1, Tab 2, NSW Police Force, *Strike Force Parrabell Final Report* (Report, June 2018), 92 (SCOI.02632).

[458] Exhibit 1, Tab 2, NSW Police Force, *Strike Force Parrabell Final Report* (Report, June 2018), 51, 84–86,101–104 (SCOI.02632).

[459] Exhibit 6, Tab 255, Expert Report of Professor Nicole Asquith, 20 December 2022, [193]–[195], [207]–[209] (SCOI.82386.00001); Exhibit 6, Tab 256, Expert Report of Professor Austin Lovegrove, 22 December 2022, [124] (SCOI.82366.00001).

5.603. Although the academic reviewers wrote in their report that there were 12 cases categorised by them as "anti-paedophile animus", in fact the actual number of cases categorised by them in that way seems to be 19, as indicated in the Case Summaries.[460] The explanation for this inconsistency is not known.

5.604. The approach of the academic reviewers to matters relating to paedophilia was the subject of submissions in respect of Public Hearing 2 and is dealt with in **Chapter 13.**

Review by the Inquiry

5.605. The Inquiry took the following steps in the course of examining the matter.

Summonses

Summonses to NSWPF

5.606. A summons was issued to the NSWPF on 18 May 2022 for all documents relating to investigations by the NSWPF of the death of Mr Bedser, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Bedser. Some documents were produced on 8 June 2022.

5.607. On 2 September 2022, a summons was issued to the NSWPF seeking, relevantly, criminal antecedents for Mr Smith (NSWPF14). Relevant records were produced by the NSWPF on 12 September 2022.

5.608. On 7 October 2022, a summons was issued to CSNSW seeking custodial records in relation to Mr Smith (CSNSW2). Relevant records were produced by CSNSW on 23 and 24 October 2022.

5.609. There was nothing contained in these records to indicate that any further consideration of Mr Smith by the Inquiry was necessary.

5.610. Summons NSWPF14 also sought criminal antecedents in relation to various other persons. On 15 May 2023, a further summons was issued seeking criminal antecedents in relation to various further persons (NSWPF105), which were produced on 19 May 2023. The material obtained as a result of those summonses also did not lead to or assist with any line of inquiry.

5.611. On 21 December 2022, the Inquiry issued a further summons to the NSWPF seeking production of the crime scene exhibits in relation to Mr Bedser's death (the knife, blood samples taken from the body of Mr Bedser, swabs of blood taken from the crime scene, and the clothing of Mr Bedser removed from his body at the mortuary) (NSWPF49). The response from NSWPF is further discussed below.

[460] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries, Undated cases numbered 5, 6, 8, 12, 13, 17, 23, 24, 41, 47, 59, 61, 62, 64, 72, 78, 81, 83 and 84 (SCOI.76961.00014).

Summons to Local Court

5.612. On 4 April 2023, a summons was issued to the Local Court (Parramatta Registry) for records relating to the legal proceedings commenced by Mr Bedser against the family of NP58 in 1980 (LCP1). On 17 April 2023, the Local Court of NSW advised that it was unable to identify any of the documents sought.

Interagency cooperation

5.613. On 11 May 2022, the Inquiry issued a written request to the Coroners Court to obtain the coronial file in relation to the death of Mr Bedser. The Coroners Court answered the request on 26 May 2022.

Family members

5.614. Through interagency cooperation, the Inquiry has identified one living family member of Mr Bedser. The Inquiry made attempts to contact that person, but no response has been received.

Searches for exhibits

5.615. On 23 January 2023, the NSWPF responded to NSWPF49 by way of a statement from Detective Sergeant Neil Sheldon, who stated that the exhibits have not been located despite what he describes as "an exhaustive search" by police.[461]

5.616. According to Detective Sergeant Sheldon's statement, the position appears to be that the exhibits, including the knife, were lost (or destroyed) at some time on or after 24 December 1980. Exactly when they were lost, and how that was allowed to happen, is not known and, it seems, cannot now be ascertained. I further consider the topic of exhibit management in **Chapter 8**.

Further forensic examinations

Review of fingerprint evidence

5.617. The Inquiry undertook a review of the available fingerprint evidence, including that associated with the 2008 UHT review.

5.618. It is not possible, from the records still available, to determine where the remaining unidentified fingerprints were located in the antique shop. Ultimately, given that difficulty and also the expectation that items in an antique shop would be frequently handled by customers, and noting further that the assailant had (apparently) left no fingerprints on the knife itself, the Inquiry considered there was no utility in attempting to pursue further fingerprint examinations in this matter.

5.619. By letter dated 8 May 2023, the Inquiry wrote to the NSWPF seeking a statement from a relevant officer as to whether the knife had been fingerprinted as stated by Detective Sergeant Hamilton in the course of the inquest.

[461] Exhibit 28, Tab 169, Statement of Detective Sergeant Neil Sheldon, 23 January 2023, [10] (SCOI.82591).

5.620. On 17 May 2023, the NSWPF produced a statement of Detective Inspector Nigel Warren outlining further searches taken by the NSWPF to identify a record of that fingerprinting, which were ultimately unsuccessful.[462]

Professional opinions

5.621. The Inquiry requested an expert report by Dr Danny Sullivan, consultant forensic psychiatrist, in relation to, relevantly, whether there were any aspects of the death and/or crime scene that may indicate that the homicide occurred in the context of "LGBTIQ hate/prejudice/bias".

5.622. In his report dated 24 October 2022, Dr Sullivan expressed the view that "there are no features of the crime scene suggesting hate crime."[463] However, he also acknowledged that the available evidence leaves open the possibility of an argument between Mr Bedser and his assailant over sexual relationships, including that the assailant may have been a male relative of one of the young persons with whom Mr Bedser had sexual interactions (although other possibilities are also available, including arguments over money).[464]

5.623. Dr Sullivan considered that "the purchase of a knife beforehand suggests that the protagonist had intended to kill Mr Bedser specifically".[465]

Witness statements

5.624. On 9 May 2023, the Inquiry sent email correspondence to a person likely to be Mr Bedser's solicitor, Bruce Macdonald, seeking to confirm that fact and obtain any further records regarding Mr Bedser which may be in his possession. On 9 June 2023, Mr Macdonald made telephone contact with the Inquiry. On 5 July 2023, Mr Macdonald provided a statement to the Inquiry.[466]

5.625. On 26 May 2023, Raymond Hadley contacted the Inquiry by email following the public hearing held on 24 May 2023, in the course of which Mr Hadley's statement to the original investigation had been referred to. On 30 June 2023, a conference was held between Mr Hadley and Counsel Assisting to discuss his recollections of Mr Bedser's death and the police investigation at that time. On 13 July 2023, Mr Hadley provided a statement to the Inquiry.[467]

[462] Exhibit 28, Tab 170, Statement of Detective Inspector Nigel Warren, 17 May 2023 (NPL.9000.0001.0023).

[463] Exhibit 28, Tab 166, Expert report of Dr Danny Sullivan, 24 October 2022, [26] (SCOI.82111).

[464] Exhibit 28, Tab 166, Expert report of Dr Danny Sullivan, 24 October 2022, [27] (SCOI.82111).

[465] Exhibit 28, Tab 166, Expert report of Dr Danny Sullivan, 24 October 2022, [27] (SCOI.82111).

[466] Exhibit 28, Tab 176, Statement of Emily Burston, 21 August 2023, [4] (SCOI.85172); Exhibit 28, Tab 172, Statement of Bruce Macdonald, 5 July 2023 (SCOI.85168).

[467] Exhibit 28, Tab 176, Statement of Emily Burston, 21 August 2023, [5] (SCOI.85172); Exhibit 28, Tab 173, Statement of Raymond Morris Hadley, 13 July 2023 (SCOI.85170).

5.626. On 11 July 2023, the Inquiry made telephone contact with Amani Youssef for the purpose of discussing her interview with police in the course of the original investigation, and in particular whether she had provided a (now lost) written statement to the original investigation, as suggested by a police occurrence entry available to the Inquiry. Following that telephone contact, on 16 August 2023, Ms Youssef provided a statement to the Inquiry.[468]

Other

Attempts to locate witnesses and persons of interest

5.627. Through summonses issued to BDM and various other forms of interagency co-operation, the Inquiry made extensive efforts to ascertain whether significant witnesses are still alive and, if so, whether they can be located.

5.628. Unsurprisingly, since it is now more than 42 years since Mr Bedser's death, many of those witnesses are deceased or unable to be located.

5.629. In particular, the Inquiry attempted to make telephone contact with the witness referred to by the pseudonym I41 and Debbie Faye Smith (whose recollections are discussed below).

5.630. Both I41 and Ms Smith were successfully contacted but declined to engage with the Inquiry.[469]

Development of crime scene and other photographs

5.631. Amongst the material produced to the Inquiry by the NSWPF in answer to Summons NSWPF1 were undeveloped photographic negatives in several envelopes.

5.632. Two of those envelopes were marked and contained photographs taken by police in the course of the original investigation, including of the crime scene and police surveillance at Mr Bedser's funeral. A third envelope was an unmarked Kodak prints envelope, containing a large number of loose snippets of photographic film. There is no information in the material produced to the Inquiry by the NSWPF as to the source or sources of those negatives.

5.633. The Inquiry took steps to develop all of those photographs. The photographs from the labelled envelopes were crime scene and post-mortem photographs, and photographs taken at Mr Bedser's funeral. They included a photograph of the murder weapon *in situ*.[470]

[468] Exhibit 28, Tab 174, Statement of Amani Ezzat Youssef, 10 August 2023 (SCOI.85169).

[469] Exhibit 28, Tab 175, Statement of Tiffany Sutherland, 21 August 2023 (SCOI.85171).

[470] Exhibit 28, Tab 10, Crime Scene and Post-mortem Photographs, undated (SCOI.82618).

5.634. The photographs from the unmarked envelope are very different. They include, relevantly, photographs of boys, some in sexually suggestive positions, and photographs of what appear to be family events involving various boys, including photographs which appear to have been taken overseas, probably in Greece. Whether these photos had been in the possession of Mr Bedser, or whether, for example, they were obtained by police for some investigative purpose, is unknown.

Property searches

5.635. The Inquiry took steps to seek to ascertain the property holdings of the family of NP58 as at 1980. The search revealed several other people who may have been linked to the family of NP58.

5.636. In the course of these inquiries, it became apparent that there were two sets of families with the same surname living in the area at that time, both of whom were approached by police. The existence or extent of a relationship between these families could neither be confirmed or excluded by the Inquiry.[471]

5.637. One of the running sheets referred to police speaking with a man with the same surname as NP58 at an address in Parramatta about his son, who also shared a given name with NP58.[472] However, the date of birth of the son (referred to here by the pseudonym I267) was in 1946, whereas NP58 had a birth date in 1963.

5.638. The same running sheet referred to police speaking with the mother of NP58 (referred to by the pseudonym NP59) at a different Parramatta address about her son NP58.[473]

5.639. The property search revealed a number of properties being linked to family of NP58, but only one property could be definitively linked to the family in 1980.

Contact with OIC

5.640. On 24 August 2023, the Inquiry wrote to former police officers Graeme Trebley, John McGregor and Ivan Hamilton, all of whom had been referred to as the OIC of the initial investigation in various records before the Inquiry.[474] In that correspondence, those persons were given the opportunity to make submissions responding to the written submissions of Counsel Assisting and the NSWPF should they wish to do so.[475]

5.641. On 28 August 2023, Mr Trebley advised that neither he nor Mr McGregor had been the OIC in relation to Mr Bedser's death, and that the OIC had been (then) Detective Sergeant Hamilton.[476] He otherwise did not consider he was able to further assist the Inquiry and did not seek to make any submissions.[477] The Inquiry did not receive a response from Mr McGregor.

[471] Submission of Counsel Assisting, 23 May 2023 [88] (SCOI.83249).

[472] Exhibit 28, Tab 42, NSWPF Report of Occurrence, 'Report of interview with NP60', 2 December 1980 (SCOI.82126).

[473] Exhibit 28, Tab 42, NSWPF Report of Occurrence, 'Report of interview with NP60', 2 December 1980 (SCOI.82126).

[474] See, for example, Exhibit 28, Tab 160, Case Screening Form, 18 September 2008, 4 (SCOI.02913); cf Exhibit 28, Tab 8, Transcript of Coronial Inquest into the death of Walter Bedser, 11 July 1983 (SCOI.00008.00139).

[475] Exhibit 28, Tab 177, Statement of Emily Burston, 7 September 2023, [4] (SCOI.85172).

[476] Exhibit 28, Tab 177, Statement of Emily Burston, 7 September 2023, [4] (SCOI.85172).

[477] Exhibit 28, Tab 177, Statement of Emily Burston, 7 September 2023, [5] (SCOI.85172).

5.642. On 18 September 2023, the Inquiry wrote again to Mr Hamilton in relation to the death of Mr Bedser.[478] The Inquiry did not receive a response from Mr Hamilton. The Inquiry did not receive a response from Mr Hamilton.

Consideration of the evidence

Witness accounts on the day of the murder (2 December 1980)

5.643. The records available to the Inquiry indicate that some 22 witnesses were interviewed by police about what they heard and saw at various times on the day of Mr Bedser's murder.

5.644. For 18 of those persons, statements were prepared and signed. For one witness, Ms Youssef, a statement is recorded as having been taken, but has not been produced to the Inquiry, and may not exist (as discussed below).

5.645. For all 22 witnesses there are running sheet entries summarising what that person said to police. For three witnesses, including Ms Youssef, these entries are the only record of what they saw and heard.

5.646. At least 15 of those 22 witnesses are now deceased.

5.647. Twelve of the 22 witnesses were near the antique shop at 2:00pm and witnessed the immediate aftermath of the assault, while ten provided evidence relating to possible sighting of the suspect earlier that same day. None of the 22 witnesses were inside the shop when the murder took place.

5.648. The accounts of these various witnesses present around the time of the assault have some similarities, but many differences. Among the features of their various recollections were the following:

a. Six of them involve hearing sounds of a struggle or argument (crashing, grunts, screaming or other noises) in the vicinity of the antique store shortly before 2:00pm, with four expressly reporting the sound of crashing glass;

b. Six saw a man hurriedly leaving the shop and fleeing down the street, and three others, more distant, did not see the man exit the shop but saw someone who was probably the same individual as he ran from the vicinity;

c. Two referred to having seen a woman in the shop just prior to the incident or leaving the shop just afterwards (as discussed below);

d. Eight saw the badly wounded Mr Bedser stumble out and collapse in a nearby greengrocer shop on the opposite side of the arcade. Of those, five said he exited after the man, and one prior to the man. The other two saw Mr Bedser but did not see the man at all, and of those two, one saw a woman exit the shop after Mr Bedser;

[478] Exhibit 66, Tab 12, Letter to Ivan Hamilton, 18 September 2023 (SCOI.86272).

e. Five said that the fleeing man shouted for an ambulance to be called; while three said it was the wounded man—Mr Bedser—himself who did so, and one did not know who it was that shouted; and

f. One reported the fleeing man as calling out, as he fled, something to the effect that he had nothing to do with it.

5.649. An ambulance was called and took Mr Bedser to the casualty section of Parramatta Hospital, where he died shortly later at 2:15pm on that day (2 December 1980).

5.650. The police who attended the scene observed that two glass display cases behind the counter inside the shop had been smashed (possibly as a result of someone having fallen into them), and the cash register was overturned and bloodstained.[479]

5.651. A knife, stained with what was subsequently identified as Mr Bedser's blood, was found lying behind the counter.[480]

5.652. These observations, as to the display cases and the knife, are consistent with the crime scene photos that were developed by the Inquiry during its investigation into the matter.

5.653. Police believed the suspect would have had blood on his hands and clothes as he ran down Darcy Street and across Church Street and into the Churchyard in Parramatta, and at least one witness reported as much.[481]

Descriptions of the person seen fleeing the scene

5.654. Despite the fact that the escaping suspect was seen by numerous witnesses, he has never been identified.

5.655. As noted above, two of the witnesses said that there was a woman in the shop with Mr Bedser immediately before his death. Those accounts were provided by I41 and John Roland Peck.[482] None of the other witnesses referred to seeing a woman.

5.656. I41, a teenage school girl collecting for charity, said that she entered Mr Bedser's antique shop at around 2:00pm and spoke briefly with a man and a woman, both of whom were standing behind the counter. They declined to give to charity, and she left the shop. Moments later she heard the sound of glass breaking and someone screaming who sounded like a woman. Thereupon she turned around and saw the man she had seen in the shop (evidently Mr Bedser) come through the door bleeding and calling for an ambulance, before entering the nearby fruit shop. She saw the ambulance arrive and then went about her business.

[479] Exhibit 28, Tab 72, NSWPF Report of Occurrence, 'Report of attendance at scene', 8 December 1980 (SCOI.82204).

[480] Exhibit 28, Tab 12, NSWPF Specimen/Exhibit Examination Form, 8 December 1980 (SCOI.10284.00017); Exhibit 28, Tab 15, Report of Paul Arthur Connellan, 22 December 1980 (SCOI.10284.00013).

[481] Exhibit 28, Tab 152, Doug Button, 'The Strange, Violent Death of the Quiet Antique Dealer', undated (SCOI.10064.00005); Exhibit 28, Tab 35, Statement of Eddie Mikha, 2 December 1980 (SCOI.10058.00054).

[482] Exhibit 28, Tab 63, Statement of I41, 5 December 1980 (SCOI.82136); Exhibit 28, Tab 66, Statement of John Roland Peck,6 December 1980 (SCOI.10058.00077).

5.657. I41 described the woman as "about 50 years of age, about 5/6, fattish build, greying hair and curly".[483] She said she did not see any other person run out of the shop before the injured man came out, nor did she observe the woman leave.[484]

5.658. Mr Peck also said he had seen a woman at the scene, but his description of that woman differed in numerous ways from that given by I41.

5.659. Mr Peck said that he was near the "second hand shop" at around 1:40pm or 1:45pm when he heard the sound of breaking glass and something "like a murmur" from within the shop. Seconds later, as he was standing near the doorway, a man appeared at the doorway holding his side or his arm and covered in blood. The man was calling out "Help me, get a doctor, get ambulance, I'm done for".[485] Mr Peck looked away for a second "because of the shock", and when he looked back the man was in the nearby greengrocer shop on the floor.[486] He looked back at the shop and saw a woman come out. He thought she closed the door behind her.

5.660. Mr Peck described the woman as being "about mid-twenties, 5'6", not plump but slightly overweight, natural olive complexion, straight dark brown hair," and wearing a blue top.[487]

5.661. Mr Peck did not see any other person exit the shop before or after the injured man.[488]

5.662. None of the other witnesses referred to a woman. Most described an adult male somewhere in the vicinity of the shop or running from it. Most thought he was about 30 to 40 years of age.[489] Several witnesses recalled him wearing a jacket or cardigan.[490]

[483] Exhibit 28, Tab 63, Statement of I41, 5 December 1980, [6] (SCOI.82136).

[484] Exhibit 28, Tab 63, Statement of I41, 5 December 1980, [7] (SCOI.82136).

[485] Exhibit 28, Tab 66, Statement of John Roland Peck, 6 December 1980, [3] (SCOI.10058.00077).

[486] Exhibit 28, Tab 66, Statement of John Roland Peck, 6 December 1980, [3] (SCOI.10058.00077).

[487] Exhibit 28, Tab 66, Statement of John Roland Peck, 6 December 1980, [4] (SCOI.10058.00077).

[488] Exhibit 28, Tab 66, Statement of John Roland Peck, 6 December 1980, [7] (SCOI.10058.00077).

[489] Exhibit 28, Tab 29, Statement of Athole Janice Aldwinkle, 2 December 1980 (SCOI.10058.00003); Exhibit 28, Tab 30, Statement of Elizabeth Beck, 2 December 1980 (SCOI.10058.00010); Exhibit 28, Tab 35, Statement of Eddie Mikha, 2 December 1980 (SCOI.10058.00054); Exhibit 28, Tab 39, Statement of Clive Mervyn Watt, 2 December 1980(SCOI.10058.00116); Exhibit 28, Tab 40, NSWPF Report of Occurrence, 'Report of interview with Amani Youssef', 2 December 1980 (SCOI.45111); Exhibit 28, Tab 36, Statement of Gail Mary Marshall, 2 December 1980 (SCOI.10058.00060); Exhibit 28, Tab 43, Statement of Rofiena Mary Davis, 3 December 1980 (SCOI.10058.00027); Exhibit 28, Tab 47, Report of Interview, 'Interview with Jean Daniels', 3 December 1980 (SCOI.45113).

[490] Exhibit 28, Tab 30, Statement of Elizabeth Beck, 2 December 1980 (SCOI.10058.00010); Exhibit 28, Tab 39, Statement of Clive Mervyn Watt, 2 December 1980 (SCOI.10058.00116); Exhibit 28, Tab 47, Report of Interview, 'Interview with Jean Daniels', 3 December 1980 (SCOI.45113).

5.663. In particular, one witness, Ms Youssef, said she had looked in through a window of the shop and had seen two men fighting. One (whom she recognised as being the deceased, Mr Bedser) was behind the counter and the other man was on the customer's side of the counter.[491] She described the other man as "in his mid to late 30s, about 6' to 6'2" tall, strong to solid build, an Australian, clean shaven, wearing a light coloured safari suit top, possibly a light grey colour and possibly light coloured pants. He had a round face and his hair was parted on one side. Well dressed and neat looking."[492]

5.664. As noted above, while the occurrence entry refers to a statement having been taken from Ms Youssef, no such statement has been produced to the Inquiry.

5.665. It appears that the police regarded the account of Ms Youssef as decisive in concluding that the assailant was a man, and noted also that the sightings of a woman by I41 and Mr Peck were not inconsistent with that being so.[493]

5.666. On 2 December 1980, the day of the murder, police published a description of the suspect as "Australian, mid to late 30's early 40's, 5'10" tall, solid build, thick dark brown hair, wearing a safari style top, light colour possibly grey or fawn."[494]

5.667. This description was evidently a composite or synthesis of some of the varying accounts provided by witnesses on that day. A "Crime Information Report" added that his "racial appearance" was "European" and that he had an olive complexion.[495]

5.668. On 12 December 1980, an identikit image (referred to as a "penry" in some police documents) of the fleeing man was completed and released to the public. It appeared in news media on that and following days. It was pieced together from descriptions by three of the witnesses who saw the suspect running from the crime scene on 2 December 1980 and were collectively interviewed by police.[496]

5.669. Police subsequently reinterviewed numerous witnesses as to whether the identikit image was consistent with their recollections. Some but not all of the responses were to the effect that the likeness was at least similar to the man they had seen, with varying suggested corrections.[497]

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[491] Exhibit 28, Tab 40, NSWPF Report of Occurrence, 'Report of interview with Amani Youssef', 2 December 1980 (SCOI.45111); Exhibit 28, Tab 91, NSWPF Report of Occurrence, 'Report of interview with Amani Youssef', 13 December 1980 (SCOI.45138).

[492] Exhibit 28, Tab 40, NSWPF Report of Occurrence, 'Report of interview with Amani Youssef', 2 December 1980 (SCOI.45111).

[493] Exhibit 28, Tab 27, NSWPF, 'Description of man wanted for fatal stabbing', 2 December 1980 (SCOI.00008.00020).

[494] Exhibit 28, Tab 27, NSWPF, 'Description of man wanted for fatal stabbing', 2 December 1980 (SCOI.00008.00020).

[495] Exhibit 28, Tab 27, NSWPF Crime Information Report, 'Report regarding assault on Mr Bedser', 2 December 1980 (SCOI.00008.00021).

[496] Exhibit 28, Tab 18, NSWPF Report of Occurrence, 'Identikit photo of assailant', 12 December 1980 (SCOI.45110); Exhibit 28, Tab 155, News report, 'Plea for information on mystery killer', *Daily Telegraph*, 13 December 1980 (SCOI.10064.00003).

[497] See, for example, Exhibit 28, Tab 47, NSWPF Report of Occurrence, 'Report of interview with Jean Daniels re identikit photo', 11 December 1980 (SCOI.45127); Exhibit 28, Tab 40, NSWPF Report of Occurrence, 'Report of interview with Amani Youssef', 2 December 1980 (SCOI.45111); Exhibit 28, Tab 92, NSWPF Report of Occurrence, 'Report of interview with Wendy Calkin re identikit photo', 13 December 1980 (SCOI.45139); Exhibit 28, Tab 93, NSWPF Report of Occurrence, 'Report of interview with Ross Calkin re identikit photo', 13 December 1980 (SCOI.45141); Exhibit 28, Tab 96, NSWPF Report of Occurrence, 'Report of interview with Elsie Nealon re identikit photo', 14 December 1980 (SCOI.45144); Exhibit 28, Tab 109, NSWPF Report of Occurrence, 'Report of interview with Clive Watt re identikit photo', 18 December 1980 (SCOI.45151); Exhibit 28, Tab 116, NSWPF Report of Occurrence, 'Report of interview with Gail Marshall re identikit photo', 28 December 1980 (SCOI.45154); Exhibit 28, Tab 83, NSWPF Report of Occurrence, 'Report of interview with Charles Wheat re identikit photo', 11 December 1980 (SCOI.45131); Exhibit 28, Tab 56, NSWPF Report of Occurrence, 'Report of interview with Ruth Decker re identikit photo', 13 December 1980 (SCOI.45140); Exhibit 28, Tab 84, NSWPF Report of Occurrence, 'Report of interview with Gwen Noblett re identikit photo', 11 December 1980 (SCOI.45132).

Purchase of a knife earlier on 2 December 1980

5.670. Police also spoke to two witnesses about a man who had purchased a knife from a nearby store earlier that day.

5.671. Ms Smith, a shop assistant at the Arcade Sports Store in the same arcade as Mr Bedser's shop, approximately 50 feet away, recalled a man purchasing a sheath knife from her, in the toy section of the store, at "about 10am" that morning.[498] The price of the knife was $15.50 and it was a "Mundial Sheriff" knife.[499] It had a five or six inch blade, the handle was black in colour with silver rings around it, and it was contained in a light brown leather sheath.[500]

5.672. Ms Smith described the man as "about 35 [years] old, 5'5" to 6" tall, average build, I think his hair was brown".[501] She said he "did not have any accent, I would say that he was an Australian." [502] She said she could not recall what he was wearing, other than that he was "dressed in casual clothes".[503]

5.673. On 11 December 1980, nine days later, Ms Smith was shown the identikit image. However, according to a police occurrence entry on that day, "she stated that she could not remember what the man looked like who purchased the knife at the Arcade Sports Store [at] about 9.15am on the 2.12.80. She was of no assistance."[504]

5.674. The police reference to "9.15am" in that entry (compared to Ms Smith's statement which had actually put the time at "about 10am") may be derived from an account given by another witness, Emma Clarke.[505]

5.675. In her statement dated 14 December 1980, Mrs Clarke said that she was present in the Arcade Sports Store on 2 December when, at about 9:15am, a man had said to the sales girl that he wanted the "black handled knife in the window."[506] Mrs Clarke said that the girl produced such a knife from the display case and asked "is this the one?" and the man said "yes".[507] The girl put the knife back in its sheath, and Mrs Clarke then left the shop. She did not see him pay for the knife, but she saw him come out just afterwards.[508]

[498] Exhibit 28, Tab 38, Statement of Debbie Faye Smith, 2 December 1980, [10] (SCOI.10058.00103).

[499] Exhibit 28, Tab 38, Statement of Debbie Faye Smith, 2 December 1980, [2]–[3] (SCOI.10058.00103).

[500] Exhibit 28, Tab 38, Statement of Debbie Faye Smith, 2 December 1980 (SCOI.10058.00103).

[501] Exhibit 28, Tab 38, Statement of Debbie Faye Smith, 2 December 1980, [4] (SCOI.10058.00103).

[502] Exhibit 28, Tab 38, Statement of Debbie Faye Smith, 2 December 1980, [4] (SCOI.10058.00103).

[503] Exhibit 28, Tab 38, Statement of Debbie Faye Smith, 2 December 1980 (SCOI.10058.00103).

[504] Exhibit 28, Tab 80, NSWPF Report of Occurrence, 'Report of interview with Debbie Smith re identikit photo', 11 December 1980 (SCOI.45129).

[505] Exhibit 28, Tab 80, NSWPF Report of Occurrence, 'Report of interview with Debbie Smith re identikit photo', 11 December 1980 (SCOI.45129).

[506] Exhibit 28, Tab 98, Statement of Emma Ellen Clarke, 14 December 1980, [2] (SCOI.10058.00018).

[507] Exhibit 28, Tab 98, Statement of Emma Ellen Clarke, 14 December 1980, [2] (SCOI.10058.00018).

[508] Exhibit 28, Tab 98, Statement of Emma Ellen Clarke, 14 December 1980, [2] (SCOI.10058.00018).

5.676. Mrs Clarke described the man as "Australian, 35 to 40 old, 5/10 tall, solidly built around the chest, tanned complexion, dark brown hair, untidy appearance, … clean shaven".[509] She thought he was wearing light coloured or brown trousers, and a jacket which was a darker brown.[510] Ms Clarke was shown the identikit image on 11 December and said it was similar to the man she had seen, except that his hair was curly and untidy.[511]

5.677. The crime scene photos show the knife as found behind the counter, on the floor, blood splatter evident around it. The knife shown in those photos matches the description of the "Mundial Sheriff" knife sold earlier that morning to the man in the sports store, as was confirmed by police at the inquest. [512]

Other possible sightings of the suspect on 2 December 1980

5.678. At around 10:50am on 2 December 1980, Enid Wooltorton saw a man crossing the road towards the antique shop. She described him as 28 to 30 years old, 5'9" tall, slim or "athletic" build, dark brown hair, with a "normal" or "slightly suntanned" complexion and wearing a caramel or light tan coloured safari jacket, with pants of a different colour.[513]

5.679. At about 12:10pm, Ruth Decker collided her shopping trolley with a man walking quickly towards the antique shop. Her description of him included that he was about 35 years old, with an olive complexion (possibly Greek), with dark wavy hair and wearing a beige jacket "with a zipper done right up to the neck" and chocolate trousers.[514] He was still standing in the middle of the arcade near the antique shop when she returned ten minutes later.[515]

5.680. Sometime around 12:10pm or 12:30pm (on their slightly varying accounts), Ross and Wendy Calkin visited the store and saw a man in conversation with Mr Bedser. Their descriptions differed somewhat but both said that the man had an olive complexion and dark brown hair, was 45 to 50 years old, and wore a tan or light brown cardigan.[516]

[509] Exhibit 28, Tab 98, Statement of Emma Ellen Clarke, 14 December 1980, [3] (SCOI.10058.00018).

[510] Exhibit 28, Tab 98, Statement of Emma Ellen Clarke, 14 December 1980, [3] (SCOI.10058.00018).

[511] Exhibit 28, Tab 82, NSWPF Report of Occurrence, 'Report of interview with Emma Clarke re identikit photo', 11 December 1980 (SCOI.45133).

[512] Exhibit 28, Tab 8, Transcript of Coronial Inquest into the death of Walter Bedser, 11 July 1983 (SCOI.00008.00139).

[513] Exhibit 28, Tab 76, NSWPF Report of Occurrence, 'Report of interview with Enid Wooltorton', 10 December 1980 (SCOI.83196); Exhibit 28, Tab 117, NSWPF Report of Occurrence, 'Report of interview with Enid Wooltorton re identikit photo', 28 December 1980 (SCOI.83195).

[514] Exhibit 28, Tab 56, NSWPF Report of Occurrence, 'Report of interview with Ruth Decker', 4 December 1980 (SCOI.45118).

[515] Exhibit 28, Tab 56, NSWPF Report of Occurrence, 'Report of interview with Ruth Decker', 4 December 1980 (SCOI.45118).

[516] Exhibit 28, Tab 32, Statement of Ross Augustus Calkin, 2 December 1980 (SCOI.10058.00020); Exhibit 28, Tab 33, Statement of Wendy Calkin, 2 December 1980 (SCOI.10058.00024).

5.681. At about 12:30pm, according to Mr Hadley (an auctioneer who worked at 20 Hassel St, a short distance from the murder scene), a man came to his showrooms and asked for a price on an antique lounge suite. Mr Hadley mentioned a figure of $300 to $400. The man said he had already been offered $850 by an antique dealer in Parramatta. Mr Hadley said the man should accept that offer (which he thought was too high). The man left without saying another word. Mr Hadley assumed that the man was referring to Mr Bedser (who he regarded as the only antique dealer in Parramatta).[517]

5.682. Mr Hadley described the man as "about 6'-6'1" tall about 30-35 old, medium to solid build, about 14 stone, fair hair and complexion wearing a beige/fawn safari jacket and a pair of dark brown trousers".[518] When shown the identikit image, Mr Hadley stated that it was identical to the person that entered the premises (notwithstanding he had previously indicated the person had fair hair), except that the person's hair was curly.[519]

5.683. Between about 1:00pm and 2:00pm, Brant Browne, a proprietor of a coffee lounge within the arcade, saw a man whom he thought "appeared to be agitated" standing at the front of the alley way next to the antique shop.[520] When the man noticed he was being observed by Mr Browne, he walked off up Darcy Street where he disappeared into an unspecified building.[521]

5.684. Mr Browne described the man as wearing "brown coloured trousers, a light brown patterned shirt, with a similar coloured long sleeve jacket".[522] When shown the identikit image, he could not say whether it was similar to the man he had seen.[523]

5.685. At about 1:20pm, Charles Wheat noticed a man leaning on the "reinforcement wire" just past the antique shop, "between 36 and his early 40s", with an olive complexion and collar length wavy dark brown hair.[524] He was wearing medium brown trousers and a shirt of a similar colour.[525]

5.686. At 1:30pm, Elsie Nealon saw a man leaning against a wall in the alleyway near the antique shop, who stared at her with a vacant expression as she passed. She described him as having a tanned face, dark well-groomed hair brushed back and a mid-brown jacket.[526]

[517] Exhibit 28, Tab 34, NSWPF Report of Occurrence, 'Statement of Raymond Morris Hadley', 2 December 1980 (SCOI.10058.00050); Exhibit 28, Tab 55, NSWPF Report of Occurrence, 'Report of interview with Raymond Morris Hadley', 4 December 1980 (SCOI.45117).

[518] Exhibit 28, Tab 34, NSWPF Report of Occurrence, 'Statement of Raymond Morris Hadley', 2 December 1980 (SCOI.10058.00050); Exhibit 28, Tab 55, NSWPF Report of Occurrence, 'Report of interview with Raymond Morris Hadley', 4 December 1980 (SCOI.45117).

[519] Exhibit 28, Tab 34, NSWPF Report of Occurrence, 'Statement of Raymond Morris Hadley', 2 December 1980 (SCOI.10058.00050).

[520] Exhibit 28, Tab 31, Statement of Brant Warland Browne, 2 December 1980 (SCOI.10058.00013).

[521] Exhibit 28, Tab 31, Statement of Brant Warland Browne, 2 December 1980 (SCOI.10058.00013).

[522] Exhibit 28, Tab 31, Statement of Brant Warland Browne, 2 December 1980 (SCOI.10058.00013).

[523] Exhibit 28, Tab 79, NSWPF Report of Occurrence, 'Report of interview with Brant Browne re identikit photo', 11 December 1980 (SCOI.45128).

[524] Exhibit 28, Tab 49, Statement of Charles Evan Wheat, 3 December 1980 (SCOI.10058.00121).

[525] Exhibit 28, Tab 49, Statement of Charles Evan Wheat, 3 December 1980 (SCOI.10058.00121).

[526] Exhibit 28, Tab 65, Statement of Elsie Nealon, 6 December 1980 (SCOI.10058.00067).

5.687. As is apparent, the descriptions given by each of Mrs Clarke, Ms Wooltorton, Ms Decker, the Calkins, Mr Hadley, Mr Browne, Mr Wheat and Ms Nealon as to what the man they saw was wearing, were broadly similar. Six of the witnesses who described the man fleeing the shop after Mr Bedser had been stabbed, gave similar descriptions of the man's clothing as generally brown in colour,[527] although only three clearly identified a layered top, with significant variations in reported style.[528] However, whether some or all of these sightings were of the same man is impossible to say.

Motive, and possible case theories

5.688. If the man seen by any or all of Ms Smith, Mrs Clarke, Mr Hadley and Mr Browne (who may have been the same man) was the man who killed Mr Bedser, then the man's behaviour in the hours leading up to the murder suggests some degree of premeditation.

5.689. Further, if (as the evidence of Detective Sergeant Hamilton at the inquest would suggest must have happened) the killer removed their fingerprints from the knife handle after stabbing Mr Bedser, or wore gloves so as to leave no fingerprints, that would also suggest a degree of premeditation, as well as perhaps some degree of criminal experience.

5.690. The available evidence would suggest that the police considered three main possible case theories, none of which could be established. As was submitted by Counsel Assisting, the limited and incomplete evidence available to the Inquiry is also insufficient to enable a conclusion to be reached that any one of those three hypotheses is more likely than the other.[529]

5.691. The following paragraphs outline the evidence relating to those three case theories.

(1) Revenge attack by the family of a teenager with whom Mr Bedser had, or may have had, sexual interaction

5.692. There is abundant evidence that Mr Bedser had had sexual interactions with, or had propositioned, a number of teenage boys, some of whom had at one time or another been employed by Mr Bedser in his shop. Most of those boys appear to have been from European, and especially Greek, backgrounds.

5.693. One such boy was NP58. As at 2 December 1980, NP58 was aged 17. The associations and dealings involving Mr Bedser and NP58, and Mr Bedser and NP58's family, seem to have been both close and complex.

[527] Exhibit 28, Tab 29, Statement of Athole Janice Aldwinkle, 2 December 1980 (SCOI.10058.00003); Exhibit 28, Tab 30, Statement of Elizabeth Beck, 2 December 1980 (SCOI.10058.00010); Exhibit 28, Tab 35, Statement of Eddie Mikha, 2 December 1980 (SCOI.10058.00054); Exhibit 28, Tab 36, Statement of Gail Mary Marshall, 2 December 1980 (SCOI.10058.00060); Exhibit 28, Tab 43, Statement of Rofiena Mary Davis, 3 December 1980 (SCOI.10058.00027); Exhibit 28, Tab 47, NSWPF Report of Occurrence, 'Report of interview with Jean Daniels', 3 December 1980 (SCOI.45113).

[528] Exhibit 28, Tab 30, Statement of Elizabeth Beck,2 December 1980 (SCOI.10058.00010); Exhibit 28, Tab 39, Statement of Clive Mervyn Watt, 2 December 1980 (SCOI.10058.00116); Exhibit 28, Tab 47, NSWPF Report of Occurrence, 'Report of interview with Jean Daniels', 3 December 1980 (SCOI.45113).

[529] Submissions of Counsel Assisting, 23 May 2023 (SCOI.83249).

5.694. NP58 was first interviewed by police on 3 December 1980. He said that his association with Mr Bedser had commenced about "two years ago" (i.e., about December 1978 when NP58 was 15) and ended about "4 or 5 months ago" (i.e., about July-August 1980).[530]

5.695. NP58 said he initially started working for Mr Bedser, including doing deliveries for him. After about two or three months, they developed a relationship in which they would have oral sex in a room above the shop, for which Mr Bedser would pay NP58 $10. The fact that Mr Bedser was having a so-called "affair" with NP58 was known amongst several people in Mr Bedser's and NP58's orbit.[531]

5.696. NP58 said that the end came after he and Mr Bedser had an argument because Mr Bedser had refused to lend money to NP58 to buy a car, having previously promised to do so. NP58 claimed that that was the last time he saw Mr Bedser.[532] This aspect of the relationship is discussed further below, in relation to the second possible case theory.

5.697. Three other youths, all of whom were aged between 15 and 20 as at December 1980, also told police that Mr Bedser had had sexual interactions with them.[533]

5.698. A further five youths said that Mr Bedser had propositioned them but that they had rejected his advances, although police appear to have suspected at least two of them of lying (for unspecified reasons).[534]

5.699. The available evidence indicates that at least two, and perhaps more, of the parents of these boys had come to know or suspect something of the nature of their sons' relationships with Mr Bedser. That evidence is discussed below.

PARENTS OF NP58

5.700. In a taped conversation in about June 1980, NP58's mother, NP59, is recorded as saying to Mr Bedser that she had some letters that Mr Bedser had written to NP58 "when he was young", which amounted to "big proof against" Mr Bedser.[535]

5.701. If NP58's parents (NP59 and NP60) were aware of Mr Bedser's sexual activity with or interest in NP58 or other boys, there is no indication in the available evidence that they harboured animosity towards Mr Bedser in that regard.

[530] Exhibit 28, Tab 45, NSWPF Report of Occurrence, 'Report of interview with NP58', 3 December 1980 (SCOI.82144)).

[531] Exhibit 28, Tab 77, NSWPF Report of Occurrence, 'Report of interview with Gregory James Bolton', 11 December 1980 (SCOI.82138); Exhibit 28, Tab 61, NSWPF Report of Occurrence, 'Report of interview with I39', 5 December 1980 (SCOI.82133); Exhibit 28, Tab 54, Statement of I35, undated (SCOI.10058.00079).

[532] Exhibit 28, Tab 45, NSWPF Report of Occurrence, 'Report of interview with NP58', 3 December 1980 (SCOI.82144).

[533] Exhibit 28, Tab 89, NSWPF Report of Occurrence, 'Report of interview I47', 12 December 1980 (SCOI.82140.00001); Exhibit 28, Tab 54, Statement of I35, 4 December 1980 (SCOI.10058.00079); Exhibit 28, Tab 61, NSWPF Report of Occurrence, 'Report of interview with I39', 5 December 1980 (SCOI.82133).

[534] Exhibit 28, Tab 77, NSWPF Report of Occurrence, 'Report of interview with Gregory James Bolton', 11 December 1980 (SCOI.82138); Exhibit 28, Tab 123, NSWPF Report of Occurrence, 'Report of interview with I40', 24 January 1981 (SCOI.82143); Exhibit 28, Tab 124, NSWPF Report of Occurrence, 'Report of interview with I46' 24 January 1981 (SCOI.82134); Exhibit 28, Tab 121, NSWPF Report of Occurrence, 'Report of interview with I37', 14 January 1981 (SCOI.82122); Exhibit 28, Tab 119, NSWPF Report of Occurrence, 'Report of interview with I36', 9 January 1981 (SCOI.82216).

[535] Exhibit 28, Tab 130, NSWPF Report of Occurrence, 'Transcript of recorded conversation between Walter Bedser and NP59 and police summary', 11 June 1980, 3, 9 (SCOI.82120).

WITNESS I37

5.702. A 15 year old boy, referred to the by the pseudonym I37, told police that he had refused advances by Mr Bedser, but that his father had found out that Mr Bedser was gay and had an argument with Mr Bedser in which he told him to keep away from his son.[536]

5.703. Another witness, a friend of Mr Bedser referred to by the pseudonym I38, told police that, in 1979, Mr Bedser had been threatened by the father of a boy who worked for him, with the same given name as I37, over advances made by Mr Bedser towards his son.[537] It would seem likely that the boy referred to by I38 was I37.

OTHER PERSONS CONNECTED TO MR BEDSER

5.704. Margaret Horwood, who did some bookkeeping work for Mr Bedser, told police that "numerous young boys used to hang around the shop" and that one of them, "a young Greek boy", had told her that he could have $5 from the till which he said was authorised by Mr Bedser.[538] She said that the father of that boy once "came into the shop and spoke to [Mr Bedser] about his son".[539]

5.705. A youth referred to by the pseudonym I46 (born 1961) told police that he himself had rejected sexual advances by Mr Bedser. He also said that the father of one of his friends, had found out about the "relationship" between that friend (referred to as I44) and Mr Bedser, or possibly NP58 and Mr Bedser (the language is ambiguous).[540] There is no indication, in the material produced by the NSWPF to the Inquiry, that police interviewed I44 or his father.

5.706. As noted by Counsel Assisting, the hypothetical possibility therefore exists that one of the fathers of one of these youths, or another family member or associate, killed Mr Bedser in retribution for his actual or feared sexual interactions with that youth.

5.707. It is not clear to what extent police ultimately pursued this possible motive, principally because the material produced by the NSWPF to the Inquiry breaks off at January 1981.

[536] Exhibit 28, Tab 121, NSWPF Report of Occurrence, 'Report of interview with I37', 14 January 1981 (SCOI.82122).

[537] Exhibit 28, Tab 106, NSWPF Report of Occurrence, 'Report of Interview with I38', 18 December 1980, (SCOI.82131).

[538] Exhibit 28, Tab 97, NSWPF Report of Occurrence, 'Report of interview with Margaret Heather Horwood', 14 December 1980, 2 (SCOI.45145).

[539] Exhibit 28, Tab 97, NSWPF Report of Occurrence, 'Report of interview with Margaret Heather Horwood', 14 December 1980, 2 (SCOI.45145).

[540] Exhibit 28, Tab 124, NSWPF Report of Occurrence, 'Report of interview with I46', 24 January 1981 (SCOI.82134).

5.708. A variant on this possibility was provided by Charles Duffield, who told police that Mr Bedser was bisexual and had been having sex with a 16 year old girl, and had been "thrown out" of her father's delicatessen in the Harris Park area.[541] Police made numerous enquiries with local delicatessens without identifying anyone matching that description.[542] On the other hand, another witness told police that Mr Bedser had a dislike of women.[543]

5.709. As noted above, many of the people who might have had some recollection of any of these matters are deceased or cannot be located. More fundamentally, however, as submitted by Counsel Assisting, the loss of the murder weapon and the blood samples means that it is now impossible to tie any person, who might theoretically be the subject of any such recollection on the part of any such witness, to the killing of Mr Bedser.[544]

5.710. I accept the submission of Counsel Assisting that this first hypothesis cannot be established on the evidence available to the Inquiry.

(2) Attack instigated by the family of NP58 as a result of acrimony arising from financial dealings

5.711. The financial and other dealings between and among Mr Bedser, NP58 and his family were both numerous and of some complexity.

5.712. In about late 1978, NP58 started working for Mr Bedser, and a few months later began having oral sex with him, as noted above.

5.713. Mr Bedser frequently travelled with NP58 on work trips to the country,[545] and had given NP58 items including a digital watch and clock radio.[546] On the other hand, NP58 had stolen jewellery from Mr Bedser (possibly on multiple occasions) and had gone joyriding in his car.[547] Mr Bedser was aware of these incidents and had confronted NP58 over them.[548]

[541] Exhibit 28, Tab 44, NSWPF Report of Occurrence, 'Report of interview with Charles Joseph Duffield', 3 December 1980 (SCOI.821 28); Exhibit 28, Tab 57, NSWPF Report of Occurrence, 'Report of inquiries as a result of information provided by Charles Duffield', 4 December 1980, [1] (SCOI.45119).

[542] Exhibit 28, Tab 57, NSWPF Report of Occurrence, 'Report of inquiries as a result of information provided by Charles Duffield', 4 December 1980 (SCOI.45119); Exhibit 28, Tab 58, NSWPF Report of Occurrence, 'Report of inquiries as a result of information provided by Charles Duffield', 5 December 1980 (SCOI.45120); Exhibit 28, Tab 59, NSWPF Report of Occurrence, 'Report of inquiries as a result of information provided by Charles Duffield', 5 December 1980 (SCOI.45121); Exhibit 28, Tab 60, NSWPF Report of Occurrence, 'Report of inquiries as a result of information provided by Charles Duffield', 5 December 1980 (SCOI.45122); Exhibit 28, Tab 99, NSWPF Report of Occurrence, 'Report of interview with NP59 and NP60', 16 December 1980 (SCOI.82139); Exhibit 28, Tab 126, NSWPF Report of Occurrence, 'Report of inquiries re I202' , 25 January 1981 (SCOI.82135).

[543] Exhibit 28, Tab 106, NSWPF Report of Occurrence, 'Report of Interview with I38', 18 December 1980, (SCOI.82131).

[544] Submissions of Counsel Assisting, 23 May 2023 [144] (SCOI.83249).

[545] Exhibit 28, Tab 46, NSWPF Report of Occurrence, 'Report of interview with I47', 3 December 1980 (SCOI.82127); Exhibit 28, Tab 68, NSWPF Report of Occurrence, 'Report of interview with NP58', 8 December 1980 (SCOI.82217).

[546] Exhibit 28, Tab 45, NSWPF Report of Occurrence, 'Report of interview with NP58', 3 December 1980 (SCOI.82144).

[547] Exhibit 28, Tab,61, NSWPF Report of Occurrence, 'Report of interview with I39', 5 December 1980 (SCOI.82133); Exhibit 28, Tab 121, NSWPF Report of Occurrence, 'Report of interview with I37', 14 January 1981 (SCOI.82122); Exhibit 28, Tab 68, NSWPF Report of Occurrence, 'Report of interview with NP58', 8 December 1980 (SCOI.82217); Exhibit 28, Tab 123, NSWPF Report of Occurrence, 'Report of interview with I40', 24 January 1981 (SCOI.82143).

[548] Exhibit 28, Tab 121, NSWPF Report of Occurrence, 'Report of interview with I37', 14 January 1981 (SCOI.82122).

5.714. In 1979 Mr Bedser's mother won $60,000 in a lottery and gave $20,000 to each of Mr Bedser and his sister.[549] Mr Bedser must have told NP58 and/or his family, as other documents make it clear that at least NP58 and NP59 were aware he had "won" the lottery.[550]

5.715. At some stage Mr Bedser gave NP58 a gift of $500.[551]

5.716. On 9 March 1980, Mr Bedser lent NP58, or the family, $2,900 to assist him/them to purchase a car (a 1973 Ford Escort).[552] On 20 March 1980, motor vehicle insurance in the amount of $2,999 was taken out on the car by NP58's parents.[553] Of that $2,900, all but $220 had been repaid by about June 1980.[554]

5.717. At some point Mr Bedser also lent $300 to NP59 to assist her in relation to her sick father in Greece.[555]

5.718. On 3 June 1980, Mr Bedser wrote a letter to NP59 demanding that the $220 and the $300 be repaid. [556]

5.719. On 11 June 1980, Mr Bedser secretly taped a conversation that he had with NP59 in his shop.[557] The next day, 12 June 1980, Mr Bedser wrote to his solicitor, enclosing the tape.[558]

5.720. After Mr Bedser's death, the solicitor provided the tape to police. The police had it transcribed.[559] The transcript is barely comprehensible, but it is clear that the conversation was heated and emotional. Among many other subjects discussed:

a. Each party accused the other of broken promises and/or letting the other down;

b. NP59 said she was aware that NP58 "loved" Mr Bedser and kept secrets for him. At one stage she described Mr Bedser as a "second father" to her son;[560]

[549] Exhibit 28, Tab 74, NSWPF Report of Occurrence, 'Report of interview with Edna Bedser', 9 December 1980 (SCOI.45126).

[550] Exhibit 28, Tab 130, NSWPF Report of Occurrence, 'Transcript of recorded conversation between Walter Bedser and NP59 and police summary', 11 June 1980, 9 (SCOI.82120).

[551] Exhibit 28, Tab 128, Letter from Walter Bedser to NP60, 3 June 1980 (SCOI.10061.00009); Exhibit 28, Tab 130, NSWPF Report of Occurrence, 'Transcript of recorded conversation between Walter Bedser and NP59 and police summary', 11 June 1980, 6 (SCOI.82120).

[552] Exhibit 28, Tab 128, Letter from Walter Bedser to NP60, 3 June 1980 (SCOI.10061.00009); Exhibit 28, Tab 127, Note prepared by Walter Bedser recording money owed by NP60 and NP59, undated (SCOI.10061.00008); Exhibit 28, Tab 141, Statutory Declaration of NP58, 30 October 1980 (SCOI.83091); Exhibit 28, Tab 45, NSWPF Report of Occurrence, 'Report of interview with NP58', 3 December 1980 (SCOI.82144).

[553] Exhibit 28, Tab 102, Statement of Douglas George Samuels, 17 December 1980, [2] (SCOI.82125); Exhibit 28, Tab 136, Car Insurance Proposal Form, 20 March 1980 (SCOI.83103).

[554] Exhibit 28, Tab 131, NSWPF Report of Occurrence, 'Report of interview with Bruce Macdonald', 19 December 1980 (SCOI.82123); Exhibit 28, Tab 128, Letter from Walter Bedser to NP60, 3 June 1980 (SCOI.10061.00009).

[555] Exhibit 28, Tab 131, NSWPF Report of Occurrence, 'Report of interview with Bruce Macdonald', 19 December 1980 (SCOI.82123); Exhibit 28, Tab 127, Note prepared by Walter Bedser recording money owed by NP60 and NP59, undated (SCOI.10061.00008); Exhibit 28, Tab 67, NSWPF Report of Occurrence, 'Report of interview with NP59', 7 December 1980 (SCOI.82142).

[556] Exhibit 28, Tab 128, Letter from Walter Bedser to NP60, 3 June 1980 (SCOI.10061.00009).

[557] Exhibit 28, Tab 129, Letter from Walter Bedser to Bruce Macdonald, undated (SCOI.10059.00007); Exhibit 28, Tab 131, NSWPF Report of Occurrence, 'Report of interview with Bruce Macdonald', 19 December 1980 (SCOI.82123).

[558] Exhibit 28, Tab 129, Letter from Walter Bedser to Bruce Macdonald, undated (SCOI.10059.00007); Exhibit 28, Tab 131, NSWPF Report of Occurrence, 'Report of interview with Bruce Macdonald', 19 December 1980 (SCOI.82123).

[559] Exhibit 28, Tab 131, NSWPF Report of Occurrence, 'Report of interview with Bruce Macdonald', 19 December 1980 (SCOI.82123); Exhibit 28, Tab 130, NSWPF Report of Occurrence, 'Transcript of recorded conversation between Walter Bedser and NP59 and police summary', 11 June 1980 (SCOI.82120).

[560] Exhibit 28, Tab 130, NSWPF Report of Occurrence, 'Transcript of recorded conversation between Walter Bedser and NP59 and police summary', 11 June 1980, 9 (SCOI.82120).

c. NP59 said that she "loved" Mr Bedser, "like a son", and would "never forget" him;[561]

d. NP59 accused Mr Bedser of seeking to be repaid relatively small sums of money despite being a "millionaire" after winning the lottery;[562]

e. Mr Bedser accused NP58 of repeatedly seeking money from him, and accused NP59 of coming to him for money when NP60 had $35,000;[563] and

f. Mr Bedser appears to speak to a "Zena" or "Zina" at the conclusion of the transcript. Police inquiries were unable to conclusively identify that person. It appears some enquiries were made regarding a 17 year-old girl recalled by Ms Driscoll (Mr Bedser's sister) who worked at a clothing shop in Mount Druitt. However, there are no records to confirm whether police followed through with an expressed intention to speak with her, nor any evidence directly connecting her to Mr Bedser beyond Ms Driscoll's familiarity with her, for reasons which are not expressed.[564]

5.721. Soon afterwards Mr Bedser asked the solicitor (Mr Macdonald) to write a letter of demand about the $220 and the $300, which Mr Macdonald did.[565]

5.722. On 24 July 1980, having had no response to the letter of demand, Mr Macdonald issued two small debt summonses, which were served on 25 July 1980.[566]

5.723. However, on that same day (25 July 1980), Mr Bedser contacted Mr Macdonald and told him that he had come to an arrangement with the family and asked Mr Macdonald to take no further action and to send him a bill, which Mr Macdonald did.[567]

5.724. In about July 1980 ("four or five months ago" according to NP58 on 3 December 1980), Mr Bedser offered to lend NP58 another $1,000 towards the purchase of another car (a Gemini).[568] However, again according to NP58, Mr Bedser then resiled from that offer, as a result of which they had an argument and NP58 told Mr Bedser to "piss off".[569] NP58 told police that was the last time he saw Mr Bedser.[570]

[561] Exhibit 28, Tab 130, NSWPF Report of Occurrence, 'Transcript of recorded conversation between Walter Bedser and NP59 and police summary', 11 June 1980, 8, 9 (SCOI.82120).

[562] Exhibit 28, Tab 130, NSWPF Report of Occurrence, 'Transcript of recorded conversation between Walter Bedser and NP59 and police summary', 11 June 1980 (SCOI.82120).

[563] Exhibit 28, Tab 130, NSWPF Report of Occurrence, 'Transcript of recorded conversation between Walter Bedser and NP59' and police summary', 11 June 1980 (SCOI.82120).

[564] Exhibit 28, Tab 132, NSWPF Report of Occurrence, 'Report of inquiries re identity of "Zina"', 29 December 1980 (SCOI.45159); Exhibit 28, Tab 133, NSWPF Report of Occurrence, 'Report of inquiries re identity of "Zina"', 30 December 1980 (SCOI.83246); Exhibit 28, Tab 134, NSWPF Report of Occurrence, 'Report of inquiries re identity of "Zina"', 31 December 1980 (SCOI.83244).

[565] Exhibit 28, Tab 131, NSWPF Report of Occurrence, 'Report of interview with Bruce Macdonald', 19 December 1980 (SCOI.82123).

[566] Exhibit 28, Tab 131, NSWPF Report of Occurrence, 'Report of interview with Bruce Macdonald', 19 December 1980 (SCOI.82123).

[567] Exhibit 28, Tab 131, NSWPF Report of Occurrence, 'Report of interview with Bruce Macdonald', 19 December 1980 (SCOI.82123).

[568] Exhibit 28, Tab 45, NSWPF Report of Occurrence, 'Report of Interview with NP58', 3 December 1980, 1, (SCOI.82144).

[569] Exhibit 28, Tab 45, NSWPF Report of Occurrence, 'Report of Interview with NP58', 3 December 1980, 1, (SCOI.82144).

[570] Exhibit 28, Tab 45, NSWPF Report of Occurrence, 'Report of interview with NP58', 3 December 1980 (SCOI.82144); Exhibit 28, Tab 68, NSWPF Report of Occurrence, 'Report of interview with NP58', 8 December 1980, 3 (SCOI.82217).

5.725. On 27 September 1980, the Ford Escort (which had been purchased in March 1980) was allegedly stolen, and was found burnt out. On 2 October 1980, NP58's parents made a claim on the insurer, NRMA.[571]

5.726. On 3 October 1980, an anonymous caller alleged to NRMA that NP58 had paid a person to burn the car for him. The caller stated that he had lent money to the family of NP58 to purchase the car, but that some of that loan had not been repaid. The caller made several subsequent calls to NRMA to check on the progress of the matter.[572]

5.727. NP58 was interviewed by NRMA on 30 October 1980. He told NRMA that Mr Bedser had lent money for the car, but that all but $200 had been repaid. NP58 said that his father had told him that he would have to pay the final $200 himself, and that an argument had ensued between him and Mr Bedser because the repayment was late (although it was ultimately made). He denied any wrongdoing in relation to the car.[573] NP58 signed a statutory declaration setting out his account of the theft on the same day.[574]

5.728. NRMA subsequently formed the view that the anonymous caller was Mr Bedser and interviewed him on 21 November 1980. Mr Bedser denied having made the calls.[575]

5.729. Mr Bedser told NRMA that all the money lent for the vehicle had been paid back to him. He showed the investigator a copy of a receipt for $100 dated 23 September 1980 made out to the family name of NP58, and said this was the final payment for all outstanding monies for the loan on the car.[576]

5.730. On 25 November 1980, NRMA interviewed NP58's friend (referred to by the pseudonym I42), who supported NP58's account of the theft and produced a statutory declaration to that effect.[577]

5.731. The insurance claim had not been finalised as at 2 December 1980, the date of Mr Bedser's death.

5.732. On 26 December 1980, police interviewed I42, who now admitted that the claim was false, that he had lied to the NRMA, and that NP58 had told him he had arranged for another friend to steal the car so that he could make a false claim and buy a different car. I42 also said he had overheard NP58 stating, shortly after Mr Bedser's murder, that he was happy Mr Bedser was dead but that it was a "slack" way for him to die.[578]

[571] Exhibit 28, Tab 102, Statement of Douglas George Samuels, 17 December 1980, [6] (SCOI.82125); Exhibit 28, Tab 138, NRMA Motor Vehicle Claim Form, 2 October 1980 (SCOI.83098); Exhibit 28, Tab 137, NRMA Stolen Vehicle Report, 2 October 1980 (SCOI.83104).

[572] Exhibit 28, Tab 102, Statement of Douglas George Samuels, 17 December 1980, [3]–[5] (SCOI.82125); Exhibit 28, Tab 139, NRMA File Note re conversation with anonymous informant, 3 October 1980 (SCOI.83099).

[573] Exhibit 28, Tab 104, Statement of Maria Carmen Ariti, 17 December 1980 (SCOI.82121).

[574] Exhibit 28, Tab 141, Statutory Declaration of NP58, 30 October 1980 (SCOI.83091).

[575] Exhibit 28, Tab 105, Statement of Ross William Thompson, 17 December 1980 (SCOI.82129); Exhibit 28, Tab 142, NRMA file note re interview with John Bedser, 21 November 1980 (SCOI.83097).

[576] Exhibit 28, Tab 105, Statement of Ross William Thompson, 17 December 1980 (SCOI.82129); Exhibit 28, Tab 142, NRMA file note re interview with John Bedser, 21 November 1980 (SCOI.83097).

[577] Exhibit 28, Tab 143, Statutory Declaration of I42, 25 November 1980 (SCOI.83089).

[578] Exhibit 28, Tab 113, NSWPF Report of Occurrence, 'Report of interview with I42', 26 December 1980, 2 (SCOI.75565).

5.733. Whether police interviewed NP58 or his parents thereafter about these matters is unknown, on the material available to the Inquiry.

5.734. Some other witnesses were aware, at least in a general way, of tensions between Mr Bedser and the family of NP58. One of these was Gregory Bolton, an antique dealer in Parramatta and associate of Mr Bedser, who told police that Mr Bedser had told him of "an alleged threat" made to him by NP59, apparently relating to the $300 owed by her to Mr Bedser.[579] It was Mr Bolton who suggested Mr Bedser record his conversations with her.[580] Another was Beverley Carn, a long-time associate of Mr Bedser, who was aware of his plans to tape a "Greek woman" who was refusing to repay him money and had abused his mother.[581]

5.735. On 19 December 1980, Mr Macdonald spoke to police and provided them with the taped conversation between Mr Bedser and NP59. There is no indication, in the material produced to the Inquiry by the NSWPF, that police spoke to NP59 or NP60 after that point. As noted earlier, the material produced to police does not extend past January 1981.

5.736. I46, a friend of both NP58 and Mr Bedser, spoke to NP58 after finding out about the murder. He said that NP58 had had "a lot of problems with his parents" because of his association with Mr Bedser, and that his parents had often used the words "what are we going to do with this bloke" when referring to Mr Bedser.[582] To what extent that information was pursued by police with either NP58 or his parents is not known.

5.737. NP58 supplied fingerprints for elimination, with no match, and he also did not match the description of the man fleeing from the crime scene. Although it is not apparent from the material before the Inquiry that police expressly ruled out his father NP60, it would seem that he was regarded as unlikely to be involved due to suffering from back injuries for which he was receiving worker's compensation.[583]

5.738. The review undertaken by the Senior Detectives Course participants in 2005 noted that there was no evidence that NP60 had been spoken to by police about the money apparently owed by NP59 to Mr Bedser, and that the initial investigation had failed to conclusively eliminate him by way of alibi.[584] NP60 died in 2016.

5.739. The extent to which police checked whether other members or associates of the family of NP58 resembled the identikit image is not known.

[579] Exhibit 28, Tab 77, NSWPF Report of Occurrence, 'Report of interview with Gregory James Bolton', 11 December 1980, 1 (SCOI.82138).

[580] Exhibit 28, Tab 77, NSWPF Report of Occurrence, 'Report of interview with Gregory James Bolton', 11 December 1980 (SCOI.82138).

[581] Exhibit 28, Tab 88, NSWPF Report of Occurrence, 'Report of interview with Beverly Carn', 12 December 1980 (SCOI.45137).

[582] Exhibit 28, Tab 124, NSWPF Report of Occurrence, 'Report of interview with I46', 24 January 1981, 2 (SCOI.82134).

[583] Exhibit 28, Tab 45, NSWPF Report of Occurrence, 'Report of interview with NP58', 3 December 1980 (SCOI.82144).

[584] Exhibit 28, Tab 159, NSWPF, Senior Detectives Course review material, 10 May 2005, 15 (SCOI.02915).

5.740. As was submitted by Counsel Assisting, it is clear from the foregoing that there had been considerable animosity during the course of 1980 between Mr Bedser and the family of NP58 in relation to the loans and other financial and legal dealings described above.[585] Whether that animosity still prevailed as at 2 December 1980 is less clear. NP58 bore no resemblance to the man the subject of the witness descriptions and the identikit image.

5.741. As set out above, the Inquiry has endeavoured to establish the extent of the property holdings of the family of NP58 in 1980. Whilst it has not been possible to confirm the exact holdings of the family, there are a number of properties linked to the family name with at least one property definitively owned in 1980.

5.742. In those circumstances, the likelihood that the family of NP58 would have been involved in the murder of a man over $220 or $520 seems remote. I agree with Counsel Assisting that resentment over Mr Bedser apparently having alerted NRMA to a false insurance claim may perhaps be different, but that the evidence available to the Inquiry does not enable anything more than speculation on that point.

5.743. The existence of a motive for killing Mr Bedser, stemming from any or all the financial and other dealings referred to above, is theoretically possible. However, I accept the submission of Counsel Assisting that on the available evidence it is unlikely that such a motive in fact lay behind the murder of Mr Bedser. Certainly, no such motive can be established on the material before the Inquiry.

(3) Robbery or dispute

5.744. In the immediate aftermath of the attack on Mr Bedser, on 2 December 1980, his sister Shirley Driscoll attended the shop and indicated to police that nothing in the shop appeared to have been stolen.[586]

5.745. However, at the inquest in July 1983, some two and a half years later, Ms Driscoll raised concerns that twenty to thirty thousand dollars worth of French watches, which had been advertised by Mr Bedser the day after his death, had not been located, nor any money indicating their sale. The OIC, Detective Sergeant Hamilton, acknowledged that police could not rule out the possibility that they had been stolen, although stated it was also possible they had simply been sold beforehand. Police had made enquiries with pawnbrokers and elsewhere, to no avail.[587]

[585] Submissions of Counsel Assisting, 23 May 2023, [179] (SCOI.83249).

[586] Exhibit 28, Tab 26, NSWPF Report of Occurrence, 'Police attendance at the crime scene', 2 December 1980 (SCOI.00008.00019).

[587] Exhibit 28, Tab 8, Transcript of Coronial Inquest into the death of Walter Bedser, 11 July 1983, 4-5 (SCOI.00008.00139).

5.746. The Inquiry conducted an extensive media search to find the advertisement relating to the French watches that Ms Driscoll mentioned at the Inquest. The relevant advertisement was found in the *Parramatta Advertiser* dated 3 December 1980.[588] The advertisement described a number of antiques, amongst them a "gold fob chain and pocket watches".[589] Whether these are the watches Mrs Driscoll was referring to is unknown. In the absence of any records regarding Mr Bedser's stock and transactions, there is little the Inquiry can do to pursue further the possibility that Mr Bedser was the victim of a robbery.

5.747. Two witnesses reported observing separate confrontations between Mr Bedser and male customers in his store at different times on the day before his death, but neither man matched the description of the man who fled the scene, and the disputes did not appear to rise to the level of violence.[590]

5.748. While the man seen by Mr Hadley on the day of Mr Bedser's death was inquiring as to the sale price of an antique lounge suite, there is nothing which connects that matter to Mr Bedser's death or even a dispute. Indeed, that evidence suggests that Mr Bedser had made an overly generous offer for the item.[591]

5.749. It is possible, on the evidence available, that Mr Bedser was the subject of a robbery or attempted robbery that did not proceed as planned, perhaps due to Mr Bedser displaying unexpected resistance, or the scuffle drawing unwanted attention by the breaking of a glass cabinet. In such hypothetical circumstances, the attacker may have fled before taking anything of value. However, there is no positive evidence to support that theory.

5.750. By contrast, the prior purchase of the knife that day, its abandonment at the scene, and the absence of any fingerprints would more strongly suggest the purchaser intended to use it to kill Mr Bedser while leaving minimal traceable evidence, as opposed to an opportunistic robbery gone awry.

5.751. I accept the submission of Counsel Assisting that the available evidence is insufficient to permit a conclusion one way or the other as to whether this third hypothesis lay behind the murder of Mr Bedser.

Police investigation

Loss or destruction of exhibits

5.752. The murder weapon and other crime scene exhibits have been lost. It is therefore now not possible to subject them to more modern forensic analysis.

[588] Exhibit 28, Tab 151, Advertisement for Parramatta Antiques, *Parramatta Advertiser*, 3 December 1980 (SCOI.83194).

[589] Exhibit 28, Tab 151, Advertisement for Parramatta Antiques, *Parramatta Advertiser*, 3 December 1980 (SCOI.83194).

[590] Exhibit 28, Tab 111, Statement of John Richard Dempster, 23 December 1980 (SCOI.82141); Exhibit 28, Tab 112, NSWPF Report of Occurrence, 'Report of identikit photo prepared from description provided by John Richard Dempster', 24 December 1980 (SCOI.10059.00012); Exhibit 28, Tab 41, NSWPF Report of Occurrence, 'Report of interview with Simon Dikranian', 2 December 1980 (SCOI.45112); Exhibit 28, Tab 110, NSWPF Report of Occurrence, 'Report of interview with Simon Dikranian re identikit photo', 20 December 1980 (SCOI.45152).

[591] Exhibit 28, Tab 34, NSWPF Report of Occurrence, 'Statement of Raymond Morris Hadley', 2 December 1980 (SCOI.10058.00050); Exhibit 28, Tab 55, NSWPF Report of Occurrence, 'Report of interview with Raymond Morris Hadley', 4 December 1980 (SCOI.45117).

5.753. It goes without saying that, as was submitted by Counsel Assisting, the NSWPF should have taken steps to ensure that the knife and other exhibits were retained and preserved, including for future reinvestigations or forensic testing.

5.754. If the knife was in fact tested for fingerprints, and none were found, its loss may (in that one respect) be less critical. However, whether such testing had actually occurred is not entirely clear, as outlined above.

5.755. Regardless of whether such testing was carried out or not, the loss of the murder weapon in an unsolved homicide is, as Counsel Assisting submitted, "plainly deplorable." The NSWPF accepted that the loss of the murder weapon and various exhibits is "entirely unacceptable".[592] Regrettably, this is not the only matter reviewed by the Inquiry where a murder weapon has been lost.

5.756. The NSWPF drew attention to the fact that the evidence of Detective Sergeant Sheldon was not that all the exhibits were lost, and that it is possible that some were destroyed — for example, that the blood samples and swabs may have been destroyed after testing for blood grouping, "noting that the potential for future DNA testing could not have been sensibly contemplated at that time."[593] The question of whether DNA testing could have been sensibly contemplated at the relevant time is a matter that was examined during the Investigative Practices Hearing, and is dealt with elsewhere in this Report.

5.757. The NSWPF submitted that on the evidence available, "it appears than an attempt was made to take fingerprints from the knife but that no fingerprints were found."[594]

5.758. During the Investigative Practices Hearing, Assistant Commissioner Rashelle Conroy acknowledged that that it is very unlikely that there was a proper basis for destroying or losing the knife seized. She accepted that fingerprint technology was readily available in 1980, and that there have been difficulties in ascertaining whether or not fingerprints were ever taken from the handle of the knife.[595]

5.759. In written submissions filed by the NSWPF in respect of the Investigative Practices Hearing, the NSWPF contended that the evidence before the Inquiry indicates that an attempt to take fingerprints from the knife was made but no fingerprints were found. However, the NSWPF acknowledged that it is not possible to conclusively confirm whether fingerprint testing of the knife occurred.[596]

[592] Submissions of NSWPF, 7 June 2023, [10] (SCOI.83644); Submissions of NSWPF, 10 October 2023 [329] (SCOI.86127)

[593] Submissions of NSWPF, 7 June 2023, [11] (SCOI.83644).

[594] Submissions of NSWPF, 7 June 2023, [13] (SCOI.83644).

[595] Transcript of the Inquiry, 4 July 2023, T4841.1–4842.1 (TRA.00072.00001); Submissions of Counsel Assisting, 15 September 2023, [661] (SCOI.85649).

[596] Submissions of NSWPF, 10 October 2023, [330] (SCOI.86127).

5.760. Further, during the Investigative Practices Hearing, Detective Chief Inspector Laidlaw conceded that the failure to enter homicide exhibits into Station Exhibit Books as they were recovered from crime scenes, as mentioned in the 2008 Bedser Case Screening Form,[597] was a well-known problem within the UHT.[598]

5.761. I accept that it *appears* that this was the case. However, I am unwilling to assume that such testing occurred in the absence of more comprehensive documentation. I accept the submission of Counsel Assisting that it is not possible to draw a positive conclusion about whether fingerprints were taken from the knife and analysis carried out.

Missing material

5.762. As submitted by Counsel Assisting, a considerable amount of material, at least some of which must have formed part of police records at an earlier time, has not been produced to the Inquiry by the NSWPF. In particular, the running sheets and occurrence entries produced to the Inquiry terminate in January 1981, only a month after Mr Bedser was murdered.

5.763. It is clear from other material that various avenues of investigation were still being actively explored at that time. In August 1981, the OIC stated that the investigation had not been completed,[599] and as noted above, the inquest did not take place until another two years after that, in July 1983. What enquiries were pursued, or sought to be pursued, and what was accomplished or not accomplished, between January 1981 and mid-1983, is unknown.

5.764. In addition, the coronial file includes only a one page document provided by Detective Sergeant John McGregor, a detective of the Homicide Squad, setting out the basic facts of Mr Bedser's death.[600] It appears that only one volume of running sheets was tendered at the inquest, even though two further volumes of material have been produced to the Inquiry by the NSWPF (consisting of both running sheets and witness statements).[601]

5.765. A notable example of the present-day absence of important records is an occurrence entry which records that a statement was taken from Ms Youssef.[602] Ms Youssef's account, as noted in the occurrence entry, was clearly of some potential importance in terms of identifying the assailant. However, no such statement appears in the material produced by the NSWPF to the Inquiry.

5.766. The Inquiry contacted Ms Youssef. She does not recall ever providing a written statement to the police.[603] It would therefore appear the occurrence entry may be incorrect in that regard.

[597] Exhibit 28, Tab 160, Case Screening Form, 18 September 2008, 5 (SCOI.02913).

[598] Transcript of the Inquiry, 7 July 2023, T5223.7–17 (TRA.00075.00001).

[599] Exhibit 28, Tab 161, Senior Detectives Course review material, 4 August 2011, 5 (SCOI.02914).

[600] Exhibit 28, Tab 6, Statement of Detective Sergeant John McGregor, undated (SCOI.00008.00008).

[601] Exhibit 28, Tab 8, Transcript of Coronial Inquest into the death of Walter Bedser, 11 July 1983, 4 (SCOI.00008.00139); Exhibit 28, Tab 7, Exhibit List, 11 July 1983 (SCOI.82206).

[602] Exhibit 28, Tab 40, NSWPF Report of Occurrence, 'Report of interview with Amani Youssef', 2 December 1980 (SCOI.45111).

[603] Exhibit 28, Tab 174, Statement of Amani Youssef, 10 August 2023 (SCOI.85169).

5.767. The approach of the NSWPF to the absence of relevant records in this case is encapsulated in the following submission:[604]

> *It is not disputed that the material now available approximately 43 years after Mr Bedser's death is incomplete in some respects. However, there is no evidential basis on which it can be submitted that either this is in some way reflective of the quality of the investigation conducted, or alternatively, that an inference should be drawn that certain steps were never taken by investigators. To the contrary, the evidence before the Inquiry emphasises the extensive, comprehensive nature of the investigation…*

5.768. There are a number of observations which might be made about that submission.

5.769. First, to suggest that the material is "incomplete in some respects" is a considerable understatement. The NSWPF produced no running sheets or occurrence entries, at all, later than January 1981. And statements of important witnesses such as Ms Youssef, although said to have been taken, were not produced.

5.770. Secondly, either certain steps were not taken, or they were taken but not recorded, or they were taken and recorded but the records have since been lost. Each of those possibilities is unsatisfactory, but the Inquiry is left with no way of knowing which it is.

5.771. Thirdly, Counsel Assisting made no submission to the effect that the absence of material should found a conclusion concerning the overall quality of the investigation.

5.772. Fourthly, however, given the striking gaps in production by the NSWPF, nor can I assume (much less be satisfied) that the investigation was "comprehensive".

5.773. The NSWPF attached significance to some remarks by the Coroner, that it had been a "very thorough investigation by the police department". It was submitted that "those observations provide a powerful indication that the investigation met the standards expected of comparable investigations in the early 1980s".[605]

5.774. I do not accept that submission. Based on what the Coroners Court provided the Inquiry, Coroner Glass did not have the whole file. In any event, as I have observed in relation to other cases, the presence or absence of comment (favourable or unfavourable) by a Coroner in the course of an inquest, about the merits of a police investigation, is not probative of its adequacy. Although plenty of records remain, they are manifestly not comprehensive. Whether that is a failure of the original investigation or of subsequent record-keeping I simply cannot tell. I further address this submission at **Chapter 8.**

[604] Submissions of NSWPF, 7 June 2023, [28] (SCOI.83644).

[605] Submissions of NSWPF, 7 June 2023, [13] (SCOI.83644) citing Exhibit 28, Tab 8, Transcript of Coronial Inquest into the death of Walter Bedser, 11 July 1983, 5, 10 (SCOI.00008.00139).

5.775. A striking example is in the statement provided to this Inquiry by Mr Macdonald. The evidence of Mr Macdonald is that the officers who interviewed him in 1980 indicated that their intention was to use the information he had provided them (being the recorded conversation between Mr Bedser and NP59) to make a further approach to the family of a Greek boy who had become "sick" of speaking with police (presumably referring to NP58 and his family).[606]

5.776. There is no record of any such step, in fact, being taken by police subsequent to the receipt of that tape. That is surprising given its contents. It was not referred to at the inquest, so it is possible that police somehow subsequently satisfied themselves it was not relevant to Mr Bedser's death. But if so, the basis for such a conclusion is now impossible to assess.

5.777. The tenor of the NSWPF's submissions on this issue is troubling. It seems to me to betray an unacceptably cavalier approach to what is obviously, for all unsolved homicides (not only those which may involve LGBTIQ bias), an utterly essential matter, namely the scrupulously careful retention of records and exhibits relating to such cases. Such an approach is particularly jarring in the light of the insistence on the part of numerous UHT officers who gave evidence to the Inquiry, that unsolved homicides are "never closed".[607] If the relevant records and/or exhibits are lost, as in the case of Mr Bedser, such a contention amounts to little more than window dressing. I deal further with exhibit management in **Chapter 8**.

No statement by the OIC

5.778. While police appear to have carried out quite extensive enquiries in relation to numerous aspects of their investigation into Mr Bedser's murder, at least up to January 1981, whether a comprehensive statement by the OIC, summarising and outlining the entirety of the investigation, ever existed is not clear. Certainly, none has been produced to the Inquiry.

5.779. In the absence of such a statement, and given that other investigative material has been lost, the Inquiry has been left to surmise the direction and extent of the investigation, up to the date of the July 1983 inquest, from such surviving materials (up to January 1981) as running sheets, occurrence pad entries and witness statements.

5.780. The NSWPF submitted that the transcript of the proceedings before Coroner Glass indicates that Detective Sergeant Hamilton, the OIC, did prepare a statement. The NSWPF submitted that:[608]

> *That the records now retained by the Coroner's Court and NSWPF do not contain a copy of this statement is unfortunate, but not entirely surprising given the passage of approximately 40 years since the inquest. The fact a statement is not now able to be located does not mean that one*

[606] Exhibit 28, Tab 131, NSWPF Report of Occurrence, 'Report of interview with Bruce Macdonald', 19 December 1980, [5] (SCOI.82123).

[607] See, for example, evidence of John Lehmann, Transcript of the Inquiry, 26 September 2023, T6057.29 (TRA.00091.00001); evidence of Detective Sergeant Penelope Brown, Transcript of the Inquiry, 3 October 2023, T6479.32.33 (TRA.00095.00001).

[608] Submissions of NSWPF, 7 June 2023, [14]–[15] (SCOI.83644).

> *was not made. Such a finding (and the associated negative implication as to the adequacy of the initial investigation) cannot be made.*

5.781. I agree that I cannot form a view about the adequacy of the OIC's statement because it has not been located. However, this in itself is a significant shortcoming on the part of the NSWPF, and not merely "unfortunate".[609] Mr Bedser's case was a homicide, and unsolved. Irrespective of the passage of time, it is to be expected that the records in relation to it — and particularly a record as significant as the OIC's statement — would be retained and accessible.

5.782. I observe that a statement of Detective Sergeant McGregor was tendered at the inquest, which is available to the Inquiry. That statement is a single page and undated. It appears to have been created for the purpose of the inquest, as it purports to both tender and admit material which (the transcript records) was separately tendered by the officer assisting the Coroner (Sergeant G Pye) and Detective Sergeant Hamilton.[610] As to the facts of the matter, it does no more than indicate the basic facts of Mr Bedser's death and that:[611]

> *At this time, ongoing inquiries are still being made into this matter, numerous persons have been spoken to, and as of this date, there are no suspects.*

5.783. As the statement is undated, it is impossible to know at what stage of the investigation it was created, although evidently it was anticipated it would be tendered at the inquest. If Detective Sergeant Hamilton was to provide, or did provide a separate OIC statement, it is unclear why the statement of Detective Sergeant McGregor was created at all, or why it was tendered.

Development of photographic negatives

5.784. As noted above, the Inquiry discovered and developed various photographic negatives in the files provided to it by the NSWPF, including crime scene photographs.

5.785. Whether police developed any of the negatives in the course of their investigations is unknown.[612] Counsel Assisting submitted that if that step was taken, the absence of any record of its being taken, and the absence of any such developed photos in the material produced to the Inquiry by the NSWPF, would indicate another inadequacy in the original investigation.[613]

[609] Submissions of NSWPF, 7 June 2023, [17] (SCOI.83644).

[610] Exhibit 28, Tab 8, Transcript of Coronial Inquest into the death of Walter Bedser, 11 July 1983 (SCOI.00008.00139); Exhibit 28, Tab 7, Exhibit List, 11 July 1983 (SCOI.82206).

[611] Exhibit 28, Tab 6, Statement of Detective Sergeant John McGregor, undated, 2 (SCOI.00008.00008).

[612] Submissions of Counsel Assisting, 23 May 2023, [71] (SCOI. 83249.0013).

[613] Submissions of Counsel Assisting, 23 May 2023, [71] (SCOI. 83249.0013).

5.786. The NSWPF submitted that Counsel Assisting had thereby "urged" a "finding" which was "speculative",[614] and that "[t]here is simply no evidence before the Inquiry first, as to the precise origin of the negatives, and in particular whether they have been in the possession of Mr Bedser, and secondly, whether the negatives had been developed."[615]

5.787. This submission by the NSWPF is misconceived. Counsel Assisting did not "urge" any "finding" on this point. Rather, Counsel Assisting drew attention to the fact that, in this additional respect, the state of the NSWPF records as produced did not enable the Inquiry to ascertain with any clarity what actually happened.

5.788. The responsibility for that absence of evidence, in my view, lies squarely with the NSWPF.

Failure to speak to witnesses

5.789. So far as can be ascertained from the material available, some witnesses were either not spoken to at all, or not pursued, in circumstances where there would appear to have been an obvious line of inquiry.

5.790. In particular, there is no indication in the material produced by the NSWPF that police ever spoke with the father of NP58 (referred to by the pseudonym NP60). The 2005 UHT review would suggest not, when it states that NP60 "appears to have never been spoken to despite his wife owing the deceased money unbeknownst to [NP60]."[616] That 2005 review goes on to state that NP60 does not appear to have been effectively eliminated by obtaining an alibi, although the review notes that "ID doesn't match suspect". It is not clear what is meant by this.

5.791. Overall, as Counsel Assisting submitted, and as explained above, it is not possible to say with certainty whether police did or did not take all appropriate steps with respect to witnesses, or that all steps were appropriately recorded, because the Inquiry has not been provided with all the police records of their investigation.

Homophobic language

5.792. As Counsel Assisting observed, and as the NSWPF acknowledged, the use of homophobic language in some of the contemporaneous police documents is striking. For example, an early investigation summary refers to Mr Bedser having been spoken to three years earlier in 1977 in a park at Parramatta, in the company of a man described by the investigating officers as "a dead set poofter". [617]

5.793. The NSWPF accepted that the language is "inappropriate and offensive".[618] However, the NSWPF submitted that:[619]

[614] Submissions of NSWPF, 7 June 2023, [25] (SCOI.83644).

[615] Submissions of NSWPF, 7 June 2023, [25] (SCOI.83644).

[616] Exhibit 28, Tab 159, NSWPF, Senior Detectives Course review material, 10 May 2005 (SCOI.02915).

[617] Exhibit 28, Tab 19, Summary of investigation by Detective Sergeant John McGregor and Detective Graeme Trebley, undated (SCOI.00008.00018); Submissions of Counsel Assisting, 15 September 2023, [121] (SCOI.85649).

[618] Submissions of NSWPF, 7 June 2023, [20] (SCOI.83644).

[619] Submissions of NSWPF, 7 June 2023, [20] (SCOI.83644).

> *…there is no evidence that the investigation of Mr Bedser's murder was anything other than extensive and thorough; that it, whatever individual officers' views were as to homosexuality at this time, there is no evidence to suggest that this affected the adequacy of the police investigation in any way.*

5.794. It would be surprising if there were positive evidence, recorded in the investigative documentation, that homophobic attitudes of police officers had affected the quality of the investigation. I could not draw such an inference, and I do not, but that is not the end of the matter. The impact of homophobic views on investigations was explored with a number of witnesses during the Investigative Practices Hearing, and is dealt with in **Chapter 8**.

5.795. Counsel Assisting noted that the whereabouts and alibi of this man from 1977 were pursued by police on the day of Mr Bedser's 1980 murder, notwithstanding that there was no suggestion of any connection with Mr Bedser other than that he had been with Mr Bedser in a park some three years earlier. The man was interviewed but had an alibi.[620]

5.796. The NSWPF submitted that the fact that inquiries were made in relation to this person was "unsurprising" in circumstances where this man and Mr Bedser had been spoken to by the police in 1977 for loitering in a park that was "a well known place for homosexuals to meet", at a time when sexual relations between two men were a criminal offence.[621] The NSWPF submitted that it was "not inappropriate for police attempting to identify the offender and motive for a murder to consider the possible involvement of a previous associate of the deceased who had prior contact with police."[622]

5.797. It is, of course, not inappropriate for police to pursue all available lines of inquiry. However, the alacrity with which the NSWPF pursued this line of inquiry is noteworthy. The extent of the "prior contact with police" is, on the material before the Inquiry, a single occasion when this man and Mr Bedser had been together in the park (with no recorded suggestion of any animosity or ill-will between them), three years prior to Mr Bedser's death.

5.798. That investigation summary, having referred to Mr Bedser (in connection with the 1977 incident) as having "homosexual tendencies", concluded as follows: "… as previously stated he [Mr Bedser] is a cat".[623] The term "cat" is "an old-school slang term for a homosexual", referring to "tomcats sneaking out for sex".[624]

[620] Exhibit 28, Tab 20, Investigation Synopsis (80/171), 2 December 1980 (SCOI.75586); Exhibit 28, Tab 19, Summary of investigation by Detective Sergeant John McGregor and Detective Graeme Trebley, undated (SCOI.00008.00018).

[621] Submissions of NSWPF, 7 June 2023, [21] (SCOI.83644) citing Exhibit 28, Tab 164, Strike Force Parrabell Bias Crime Indicators Review Form – Walter Bedser, 28 February 2017, 5 (SCOI.49560).

[622] Submissions of NSWPF, 7 June 2023, [22] (SCOI.83644).

[623] Exhibit 28, Tab 19, Summary of investigation by Detective Sergeant John McGregor and Detective Graeme Trebley', undated (SCOI.00008.00018).

[624] Exhibit 2, Tab 5, Statement of Barry Charles,14 November 2022, [6] (SCOI.77304).

5.799. As Counsel Assisting submitted, the use of such language in a police record of a murder investigation does not reflect well on the prevailing police views, seemingly unremarkable views within the organisation at the time, concerning men who were members of LGBTIQ community.[625]

Manner and cause of death

5.800. The 1983 coronial finding as to Mr Bedser's death remains appropriate, as both Counsel Assisting and the NSWPF submitted.[626]

5.801. That is, Mr Bedser died as a result of knife wounds inflicted on 2 December 1980 at his antique shop in Darcy St, Parramatta, by an unidentified person.

Bias

5.802. As Counsel Assisting submitted, whether Mr Bedser's death was motivated in whole or in part by LGBTIQ bias turns largely on two factors, namely:

a. Whether the motive for his murder was related to his sexual interactions with one or more teenage boys; and

b. Whether such a motive can be said to be correlated with LGBTIQ bias in these specific factual circumstances.

5.803. For the reasons outlined above, the motive behind Mr Bedser's stabbing cannot be determined on the available evidence.

5.804. I agree with Counsel Assisting that, if the person who bought the knife in the sports shop—quite possibly the same person seen by various people in the vicinity of the arcade on the day of Mr Bedser's murder—was indeed the killer, some premeditation seems to have been involved. Further, if the knife was wiped clean of fingerprints or if gloves were worn, that may suggest that the killing was the work of someone with some criminal experience. However, for the reasons outlined above, none of those various possibilities can be established.

5.805. I also agree with Counsel Assisting that, if the murder of Mr Bedser was motivated by knowledge of his sexual interactions with one or more teenage boys, that would raise for consideration the question whether that motivation, in the mind of the killer in question, was derived from animosity towards paedophiles or from animosity towards men who have sex with other men, bearing in mind also, in that regard, that some people (including some offenders) erroneously conflate membership of the LGBTIQ community and paedophilia. I also address this erroneous conflation in greater detail at **Chapter 13.**

5.806. The NSWPF made no submissions to the contrary of these submissions of Counsel Assisting.

[625] Submissions of Counsel Assisting, 23 May 2023, [47] (SCOI.83249).

[626] Submissions of NSWPF, 7 June 2023, [36]–[37] (SCOI.83644).

5.807. Counsel Assisting submitted (and the NSWPF accepted) that, on the available evidence, it is not possible to ascertain who killed Mr Bedser, and so the question of whether or not LGBTIQ bias was a factor in Mr Bedser's death cannot be answered.

5.808. While I accept that it is not possible to ascertain who killed Mr Bedser, it does not follow that there is no objective reason to at least suspect that LGBTIQ bias played a role. That Mr Bedser was killed for reasons relating to his interactions with boys at his store remains a leading case theory. It would be inappropriate to treat this matter in the same category as one for which there is no suggestion that LGBTIQ bias comes into the equation.

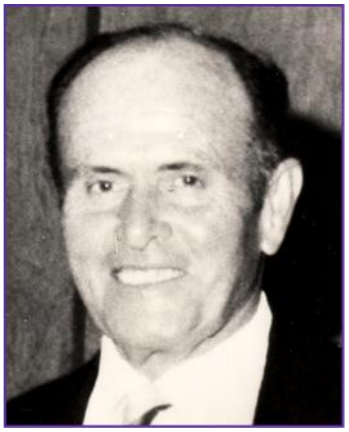
Conclusions and Recommendations

5.809. I find that Mr Bedser died as a result of knife wounds inflicted on 2 December 1980 at his antique shop in Darcy Street, Parramatta, by an unidentified person.

5.810. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in Mr Bedser's death.

5.811. I do not propose to make any recommendations arising from the Inquiry's consideration of Mr Bedser's death.

IN THE MATTER OF RICHARD SLATER



Factual background

Date and location of death

5.812. Richard Slater died on 22 December 1980 at Royal Newcastle Hospital. This followed an assault that had occurred on 19 December 1980 at the men's toilet block in Birdwood Park in Central Newcastle.

Circumstances of death

5.813. Mr Slater was 69 years old at the time of his death.

5.814. Sometime after 12:30pm on Friday 19 December 1980, while visiting the CBD of Newcastle to run some errands, Mr Slater entered the toilet block in Birdwood Park. He was found at around 1:00pm by a man who had entered to use the men's toilets. Mr Slater was lying on the ground with his left leg lying in the urinal trough. He was observed to have blood on his face, and was moaning and making gurgling sounds. His trousers and underpants were down just below his buttocks. An ambulance was called at 1:04pm. Mr Slater was able to provide his name to ambulance officers and, on being asked what happened, denied being bashed or falling, although he appeared to at least one of the ambulance officers to be confused in his responses.[627]

5.815. Although his car keys and some lottery tickets that he had purchased that day remained on him, his purse containing about $30 was missing.[628]

[627] Exhibit 24, Tab 24, Statement of Bruce James Varley, 31 December 1980, [7] (SCOI.10343.00018); Exhibit 24, Tab 25, Statement of Neville Alfred Barrett, 1 January 1981, [6]–[7] (SCOI.10343.00019); Exhibit 24, Tab 16, Statement of Detective Sergeant Robert Ross Clark, 24 May 1981, [3] (SCOI.10343.00022).

[628] Exhibit 24, Tab 14, Resume of investigations, 21 June 1983, [7], [9] (SCOI.10343.00004); Exhibit 24, Tab 16, Statement of Detective Sergeant Robert Ross Clark, 24 May 1981, [5] (SCOI.10343.00022).

5.816. Mr Slater was admitted to Royal Newcastle Hospital at about 1:35pm in a stable condition. His injuries (including multiple lumps on his skull, swelling under his eyes and to his left ear and multiple contusions to his face) were consistent with being punched and/or kicked.[629] Police attempted to interview Mr Slater but were unable to obtain any coherent information regarding what had occurred.[630]

5.817. Mr Slater's granddaughter recalls her mother (Mr Slater's daughter) describing that her father was beaten so badly that he was entirely non-verbal.[631] Professor Michael Besser, consultant neurosurgeon, who has reviewed relevant material for the Inquiry, describes the traumatic brain injury suffered by Mr Slater as "very significant". [632]

5.818. At 12:30pm on 20 December 1980, Mr Slater developed acute pulmonary oedema, consistent with myocardial infarction and his past history of cardiac disease. Treating doctors were able to stabilise him. However, on 22 December 1980, his condition rapidly deteriorated, and he died after a cardiac arrest at 5:07pm. [633]

Previous investigations

Original police investigation

5.819. The original police investigation was conducted by Detective Sergeant Robert Clark.[634] By 1982, Detective Senior Constable Grahame Inkster had taken over as the OIC.[635]

Findings of post-mortem examination

5.820. A post-mortem examination was performed on 22 December 1980 by Dr Lazlo Julius Banathy. The cause of death was identified as a traumatic brain injury, with an antecedent cause of myocardial infarction.[636]

[629] Exhibit 24, Tab 26, Statement of Dr Alfred Paul Bennett, 13 January 1981 (SCOI.10343.00025).

[630] Exhibit 24, Tab 16, Statement of Detective Sergeant Robert Ross Clark, 24 May 1981, [6]–[7] (SCOI.10343.00022).

[631] Exhibit 24, Tab 61, Email to Inquiry from Yvonne, 18 July 2022 (SCOI.45199).

[632] Exhibit 24, Tab 70, Expert report of Professor Michael Besser AM, 16 March 2023, [5] (SCOI.82914).

[633] Exhibit 24, Tab 27, Letter from Dr John Vincent Newton, 2 February 1981 (SCOI.10343.00026); Exhibit 24, Tab 12, Letter containing report of A. J. Bookallil, 3 December 1982 (SCOI.10343.00009); Exhibit 24, Tab 15, NSWPF, 'Summary of Richard Slater Murder', undated (SCOI.10343.00010).

[634] Exhibit 24, Tab 16, Statement of Detective Sergeant Robert Ross Clark, 24 May 1981 (SCOI.10343.00022).

[635] Exhibit 24, Tab 17, Statement of Detective Senior Constable Grahame Robert Inkster, 28 October 1982 (SCOI.82763).

[636] Exhibit 24, Tab 3, Post-mortem report of Dr Laszlo Julius Joseph Banathy, 22 December 1980 (SCOI.82780).

5.821. A histopathology report dated 2 December 1980 identified brain injury including a subarachnoid haemorrhage and cerebral oedema.[637] In a revised post-mortem report dated 28 January 1981, Dr Banathy expressed the view that traumatic brain injury was the main cause of death, but noted pre-dated myocardial infarctive changes and stated that "[i]t is assumed that the shock caused by the trauma precipitated another infarctive change which contributed to the death."[638] In effect, he was indicating that Mr Slater had a heart condition that pre-existed the head injuries that he had received. Against that background, the shock caused to Mr Slater by the head injuries had led to a further heart attack, which contributed to his death, with the head injuries being the main cause of death.

5.822. Although it is not reflected in either report, Dr Banathy apparently expressed the view to investigating police that Mr Slater's injuries were consistent with having been punched in the head, possibly four times, resulting in extensive bruising and fractures to the face bones, and a laceration of the left ear. He also expressed the view that Mr Slater's chest had been stomped on, causing bruising to the chest and a ruptured spleen.[639]

Exhibits

5.823. Shortly after the assault on Mr Slater, the following exhibits were collected for testing:[640]

a. A sample of blood taken from Mr Slater;

b. Clothing (shirt, underpants, trousers) taken from Mr Slater;

c. Two blood swabs taken from the toilet block; and

d. Two anal smears from Mr Slater.

5.824. Testing undertaken in 1981, using then available technology, identified Mr Slater as having the blood type Hp 2-2, PGM 2 (subtype 2+).[641] The blood on Mr Slater's trousers and underpants was consistent with his blood type. Blood testing on his shirt was unsuccessful. Semen was detected on Mr Slater's shirt and trousers but in insufficient quantities for grouping testing. Consequently, whether the semen was that of Mr Slater or someone else could not be established at the time of the original investigation. No semen was detected on his underpants.[642]

[637] Exhibit 24, Tab 4, Histopathology report of Dr Laszlo Julius Joseph Banathy, 22 December 1980 (SCOI.82759).

[638] Exhibit 24, Tab 5. Revised post-mortem report of Dr Laszlo Joseph Banathy, 28 January 1981, 2 (SCOI.82771).

[639] Exhibit 24, Tab 9, NSWPF Report of Occurrence, 'Summary of events leading up to the assault and subsequent death of Richard Slater', 22 December 1980, 2 (SCOI.10343.00055).

[640] Exhibit 24, Tab 20, Statement of Constable Gary John Clausen, 1 June 1981, [6]–[7] (SCOI.10343.00024); Exhibit 24, Tab 6, Forensic Biology report by Sandra Anne Gorringe, 16 February 1981 (SCOI.10343.00031).

[641] Exhibit 24, Tab 6, Forensic Biology report by Sandra Anne Gorringe, 16 February 1981, 2 (SCOI.10343.00031).

[642] Exhibit 24, Tab 6, Forensic Biology report by Sandra Anne Gorringe, 16 February 1981, 2(SCOI.10343.00031).

Persons of interest

5.825. There is very limited documentation before the Inquiry as to the scope or nature of the investigation of Mr Slater's death prior to 1982. There is some indication that a large part of the initial investigative efforts was directed to interviewing "numerous homosexuals, transvestites and other persons", seemingly because the toilet block was known to be a "renowned meeting place for the homosexual element of this area at all hours during the day or night".[643] A news article from early January 1981 claims that police had at that stage interviewed more than 60 people, including in relation to another assault which apparently proved unrelated.[644]

5.826. After apparently interviewing a large number of people over the months following the death of Mr Slater, at first no clear persons of interest emerged, although in due course the focus of police suspicion appears to have been on Jeffrey Miller and some individuals associated with him.

5.827. On 23 December 1980, Mr Miller and some of his associates provided statements to police. The effect of the statements was to suggest that at some time between 11:00am and 12:30pm on 19 December 1980, their group, including Mr Miller, I216 and I217, walked past the toilet block. I216 entered the toilet and noticed a man, possibly matching the description of Mr Slater, standing next to him at a urinal. Meanwhile the other members of his group were calling out in homophobic language, suggesting that he (I216) was intending to use the toilet as a beat. [645]

5.828. On 27 August 1982, more than a year after the inquest was held, another associate of Mr Miller, I219, provided information to the police implicating Mr Miller.[646] Police then reinterviewed Mr Miller's associates I217 and I216 who had been with Mr Miller on the day of Mr Slater's death.[647] The information they provided on this later occasion also implicated Mr Miller.

5.829. On 1 September 1982, Mr Miller, who by this stage was in custody for another matter, was taken by police to the toilet block where he made an implied admission to entering the toilet and assaulting Mr Slater.[648] However, he later sought to retract his admission by stating that he had entered the toilet with the intention of approaching someone to have sex, but had exited without approaching anyone.[649]

[643] Exhibit 24, Tab 14, NSWPF Resume of Investigations, 'Murder of Richard Slater', 21 June 1983, [11]–[12] (SCOI.10343.00004).

[644] Exhibit 24, Tab 48, 'Bashing mystery: 60 interviewed by police', *The Sun* 5 January 1981 (SCOI.82778).

[645] Exhibit 24, Tab 28, Statement of Jeffrey Miller, 23 December 1980, [2] (SCOI.10343.00048); Exhibit 24, Tab 30, Statement of I217, 23 December 1980, [3], [6] (SCOI.10343.00042); Exhibit 24, Tab 29, Statement of I216, 23 December 1980, [4] (SCOI.10343.00045).

[646] Exhibit 24, Tab 31, NSWPF Record of Interview, 'Interview with I219', 27 August 1982 (SCOI.10343.00044).

[647] Exhibit 24, Tab 34, NSWPF Record of Interview, 'Interview with I216', 1 September 1982 (SCOI.10343.00046); Exhibit 24, Tab 32, NSWPF Record of Interview, 'Interview with I217', 31 August 1982 (SCOI.10343.00043).

[648] Exhibit 24, Tab 17, Statement of Detective Senior Constable Grahame Robert Inkster, 28 October 1982 (SCOI.82763).

[649] Exhibit 24, Tab 33, NSWPF Record of Interview, 'Interview with Jeffrey Miller', 1 September 1982 (SCOI.10343.00049).

Findings at inquest

5.830. At an inquest lasting fifty minutes held on 18 June 1981 at Newcastle, Coroner Meehan found that on 22 December 1980 at Royal Newcastle Hospital, Mr Slater:[650]

> *…died from the effects of traumatic brain damage and myocardial infarction; following his admission to that hospital on [19 December 1980] after having been found in Birdwood Park, King St, Newcastle on that date suffering from certain injuries, but as to his circumstances of his having received those injuries, the evidence adduced does not enable me to say.*

Criminal proceedings

5.831. On 1 September 1982, as a result of the statements made by his associates and his own admission, Mr Miller was charged with the murder of Mr Slater. He pleaded not guilty, and a committal hearing was held on (at least) 24 November and 10 December 1982 at the Newcastle Court of Petty Sessions, as a result of which he was committed to stand trial in the Supreme Court.[651]

5.832. However, on 18 March 1983, prior to the commencement of any trial, following an application for a "No Bill" made by his legal representative, the prosecution filed a "No Bill" and the matter proceeded no further.[652]

5.833. Despite extensive attempts by the Inquiry to locate records of the committal proceedings and correspondence and documentation relating to the "No Bill", this material appears to have been lost. The rationale for the filing of the "No Bill" is therefore not clear. It may be that some of the civilian evidence given at the committal proceedings did not come up to proof. Alternatively, or in addition, it appears that the defence may have raised an issue concerning causation of the death (in view of Mr Slater's underlying heart condition), and that this may have played a role in the reasoning behind discontinuing the proceedings.

[650] Exhibit 24, Tab 7, Findings of R Meehan, Inquest into the death of Richard Slater, 18 June 1981 (SCOI.82765).

[651] Exhibit 24, Tab 14, NSWPF Resume of Investigations, 'Murder of Richard Slater', 21 June 1983, [11]–[12] (SCOI.10343.00004); Exhibit 24, Tab 55, 'Murder hearing told of death wish', *Newcastle Herald*, 25 November 1982 (SCOI.82767).

[652] Exhibit 24, Tab 14, NSWPF Resume of Investigations, 'Murder of Richard Slater', 21 June 1983, [11]–[12] (SCOI.10343.00004); Exhibit 24, Tab 57, 'Murder charge dropped'" unknown publication, 1983 (SCOI.82760).

Subsequent police investigation

5.834. Mr Slater's death has never been the subject of a review by the UHT.

5.835. However, in 2013 Detective Chief Inspector John Lehmann of the UHT conducted an "assessment" of 30 unsolved deaths on a list prepared by Sue Thompson, including that of Mr Slater, for the limited purpose of "determining" whether a "bias motivation" was involved in those deaths. With respect to Mr Slater, the assessment was that "this case remains as an unsolved homicide involving probable 'gay hate' motivation."[653] In reaching that conclusion, Detective Chief Inspector Lehman observed that the location of the assault was a known beat, that Mr Slater had denied being bashed to first responders, and that semen had been identified on his clothing.[654]

5.836. It appears that media around Strike Force Parrabell in 2017 (see further below), caused Mr Slater's family to contact the NSWPF regarding the status of the investigation of Mr Slater's death. On 12 December 2017, an investigator's note records that the family was advised:[655]

> *…as a result of the confirmation of the suspect's death, and due to there being no information available to indicate the involvement of any other POI/suspects, the availability of only limited records/case files and apparently no physical/forensic evidence being retained the investigation is to be suspended.*

Strike Force Parrabell

Bias Crimes Indicators Form

5.837. A BCIF was completed in this case by Strike Force Parrabell.

5.838. It is positively asserted in response to all ten of the individual indicators in the BCIF that there is "No Evidence of Bias Crime".[656] This is in stark contrast to the 2013 assessment by Detective Chief Inspector Lehmann, which the Strike Force Parrabell officers had, and to which the BCIF makes reference. The form contains no indication of the reasons for such an emphatic rejection of Detective Chief Inspector Lehmann's view.

[653] Exhibit 6, Tab 47, Issue Paper from Detective Chief Inspector John Lehmann re *Assessment of 30 potential 'gay hate' unsolved homicides by the Unsolved Homicide Team (UHT) to determine if any bias motivation existed*, 25 September 2013, 2-3 (SCOI.74906).

[654] Exhibit 6, Tab 47, Issue Paper from Detective Chief Inspector John Lehmann re *Assessment of 30 potential 'gay hate' unsolved homicides by the Unsolved Homicide Team (UHT) to determine if any bias motivation existed*, 25 September 2013, 2-3 (SCOI.74906).

[655] Exhibit 24, Tab 73, NSWPF Investigator's Note, 'Advice to NOK: Yvonne – Richard Slater murder 19/12/80', 12 December 2017 (SCOI.84831).

[656] Exhibit 24, Tab 60, Strike Force Parrabell, Bias Crimes Indicators Review Form – Richard Slater, 28 February 2017 (SCOI.32129).

5.839. The observations made in relation to several of the individual indicators do not seem to justify the definitive assertion that there is no evidence of the death being a bias crime. For example, in relation to Indicator 6, "Victim/Witness Perception", it is stated that "[t]he actual witnesses don't express a direct opinion that this particular incident was motivated by bias but they indicate that MILLER was previously actively targeting homosexual males as robbery victims and was known to attend public toilets to commit these crimes."[657] This observation, although not inaccurate, does not appear to justify the definite conclusion that there is no evidence of bias crime.

Case Summary

5.840. Strike Force Parrabell categorised the case as "no evidence of bias crime", and further as "unsolved".

5.841. The Strike Force Parrabell Case Summary reads as follows:[658]

> ***Identity:*** *Richard Slater was 69 years old at the time of his death.*
>
> ***Personal History:*** *Mr Slater had no close associates apart from immediate family and neighbours. Mr Slater suffered from a medical condition that caused him to urinate frequently and is believed to be the reason for his use of public toilets.*
>
> ***Location of Body/Circumstances of Death:*** *Mr Slater was found semi-conscious on the floor of a men's public toilet in Birdwood Park, Newcastle on 19 December 1980 suffering severe head and bodily injuries. There was no evidence to suggest that Mr Slater attended the toilet block other than to urinate, when it is likely that he was struck from behind with a blunt object. The location was known as a gay beat. Mr Slater died of his injuries in hospital 3 days later. His money clip containing $30 cash was missing. No suspects were identified until 18 months later with the nomination of Jeffrey Miller, 22 years old, as a suspect. Witnesses alleged that Miller was actively targeting gay men in public toilets as robbery victims. Miller was gay and alleged to have attended toilet blocks to engage in sex with other men before robbing them.*
>
> ***Sexual Orientation:*** *Mr Slater's sexual orientation could not be confirmed however he was described as a 'family man'.*
>
> ***Coroner/Court Findings:*** *Police charged Miller with the murder of Mr Slater which proceeded through committal hearing but was 'No Billed' before trial in 1983. There was no documentation outlining specific reasons for the matter being 'No Billed', however but it is believed that a lack of direct evidence, coupled with unreliable witness accounts contributed to the matter not proceeding. Miller remains the only suspect for this murder.*

[657] Exhibit 24, Tab 60, Strike Force Parrabell, Bias Crimes Indicators Review Form – Richard Slater, 28 February 2017, 11 (SCOI.32129).

[658] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Richard Slater, Undated 2 (SCOI.76961.00014).

SF Parrabell concluded there was no evidence of a bias crime

5.842. As with the BCIF, and regardless of any conclusion that may be drawn in relation to Mr Slater's reason for being present at the toilet block, it does not appear that the definitive conclusion stated in the last line of the case summary was justified, particularly where the case summary itself refers to evidence that Mr Miller was "actively targeting gay men in public toilets as robbery victims".[659]

5.843. The NSWPF submission defended the view reached by Strike Force Parrabell, asserting in effect that a "finding of insufficient or no evidence of gay hate crime could be justified, particularly in the absence of certainty as to the identity of the perpetrator".[660] The NSWPF also sought to justify the finding on the basis that an unknown perpetrator may have opportunistically beaten Mr Slater in the course of a robbery, in circumstances "entirely unrelated to the fact the toilet block was a beat".[661]

5.844. I find it remarkable that the NSWPF seeks to justify the conclusion reached by Strike Force Parrabell. Their own submission is not to this effect (see below). Even if one were to discount the evidence relating to Mr Miller, while the hypothetical scenario raised by the NSWPF is a possibility, the beat location and nature of the crime are, at the very least, evidence that Mr Slater's death may have occurred at the hands of someone who had presumed that Mr Slater was a beat user.

5.845. I also observe that the views on motivation expressed by Strike Force Parrabell and that reached by the NSWPF in its submissions run counter to the assessment made by Detective Chief Inspector Lehmann of the UHT in 2013 that the death had involved "probable hate motivation". I regard the conclusion by Strike Force Parrabell that there was no evidence of a bias crime as unsupported by the available evidence then and now.

Academic review

5.846. The academic reviewers, according to the case summary, categorised the case as: "Gay Bias Related (Anti-Paedophile)".[662] The "anti-paedophile" reference appears to have no basis in any evidence relating to the matter,[663] and when one of the academics was specifically asked about the basis for the conclusion in evidence before the Inquiry, he was unable to offer any reason for it.[664] On the evidence before me, there was no basis whatsoever for the "anti-paedophile" reference in the case summary.

[659] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Richard Slater, Undated 2 (SCOI.76961.00014).

[660] Submissions of NSWPF, 1 June 2023, [72] (SCOI.83645).

[661] Submissions of NSWPF, 1 June 2023, [72] (SCOI.83645).

[662] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Richard Slater Undated 2 (SCOI.76961.00014).

[663] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Richard Slater, Undated 2 (SCOI.76961.00014).

[664] Transcript of Inquiry, 2 March 2023, T2712.17–2715.21 (TRA.00031.00001).

Review by the Inquiry

5.847. The Inquiry took the following steps in the course of examining the matter.

Summonses

Summonses to the NSWPF

5.848. A summons was issued to the NSWPF on 18 May 2022 for all documents relating to investigations by the NSWPF of the death of Mr Slater, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Slater. In response, the NSWPF produced an investigative file principally comprising police and civilian witness statements, as well as typed records of interview with Mr Miller and his associates that were conducted in August and September 1982.

5.849. A further summons was issued on 11 October 2022 for crime scene photos that were referred to in material relating to the review of Mr Slater's death undertaken by Strike Force Parrabell (NSWPF28).

5.850. At the same time, in correspondence relating to the summons, the Inquiry asked the NSWPF to conduct further searches to ensure that all investigative material related to Mr Slater's death had been produced. This request arose as a result of a concern that the investigative material produced pursuant to Summons NSWPF1 had referred to various investigative steps and running sheets that did not form part of the material produced in response to that summons, as further discussed below.

5.851. The NSWPF subsequently advised the Inquiry that some further archived material had been located.[665] This included a number of photographs including the requested crime scene photographs. However, there was little additional material of substance. It remains the case that a significant amount of material from the original investigation, including running sheets and investigative notes, has not been produced by the NSWPF. It would therefore appear that it has been lost.

5.852. In a summons dated 5 December 2022, the Inquiry sought production of the exhibits associated with the original investigation including blood swabs from the crime scene, and Mr Slater's clothing and blood sample (NSWPF39). The NSWPF was unable to locate them and concluded that they no longer exist.[666] On 19 January 2023, the NSWPF produced a statement of Detective Sergeant Neil Sheldon setting out the searches it had undertaken for those exhibits.[667]

[665] Exhibit 24, Tab 72, Statement of Emily Burston, 18 May 2023, [7] (SCOI.45198).

[666] Exhibit 24, Tab 72, Statement of Emily Burston, 18 May 2023, [8] (SCOI.45198).

[667] Exhibit 24, Tab 68, Statement of Detective Sergeant Neil Sheldon, 18 January 2023 (SCOI.82916).

5.853. On 9 December 2022, by further summons, the Inquiry also sought copies of any criminal records and other background material held in relation to Mr Miller and some of his associates (NSWPF44). In response, the NSWPF provided a considerable amount of material largely concerning details of offending involving Mr Miller.

5.854. On 25 June 2023, the NSWPF advised the Inquiry that it had identified additional material relevant to Mr Slater's death responsive to Summons NSWPF1. That material amounted to a further 57 pages, including correspondence between the NSWPF and Mr Slater's family in 2017.[668]

Summonses to other bodies

5.855. On 7 December 2022, the Inquiry issued a summons to the Hunter New England LHD for records relating to Mr Slater (HNELHD02). The Inquiry was advised that the Hunter New England LHD was unable to locate any records relating to Mr Slater.[669]

5.856. On 21 June 2022, in an effort to obtain records of the criminal proceedings that had been brought against Mr Miller, the Inquiry issued a summons to the ODPP (ODPP1). The ODPP advised that any relevant record would have predated the ODPP and at that time would have been held by the "Clerk of the Peace".[670] As a result, on 10 August 2022 the Inquiry issued a summons to DCJ, seeking the relevant prosecution file maintained by the then Office of the Clerk of the Peace (DCJ1). By email response dated 6 September 2022, DCJ advised that relevant records could not be located. DCJ subsequently undertook further searches based on additional information provided by the Inquiry. On 11 November 2022, DCJ advised that none of Courts and Tribunal Services, the Supreme Court or any other relevant sections within DCJ were able to locate any relevant material.[671]

5.857. On 26 June 2023, following the receipt of additional material from the NSWPF pursuant to Summons NSWPF1, the Inquiry requested by email that DCJ undertake further searches for a record of the Attorney General's decision to "No Bill" the matter pursuant to Summons DCJ1, noting that the criminal records provided to the Inquiry in relation to Mr Miller appeared to identify a specific date and reference number for a relevant report. On 27 June 2023, however, DCJ advised by email that it remained unable to identify any relevant record in its holdings.[672]

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[668] Exhibit 24, Tab 76, Statement of Emily Burston, 21 July 2023, [4] (SCOI.84830).

[669] Exhibit 24, Tab 72, Statement of Emily Burston, 18 May 2023, [18] (SCOI.45198).

[670] At the time of the prosecution of Mr Miller in 1982-1983, the full title was Solicitor for Public Prosecutions and Clerk of the Peace. The office of Clerk of the Peace was of some antiquity; by 1982 in NSW it included instructing the Attorneys to the Crown in criminal prosecutions for indictable matters, handling appeals in Crown matters, and a registrar function as keeper of certain Court records: *Concise Guide to the State Archives of New South Wales* (3rd ed); see also *Registrar, Court of Appeal v Ritter (No 2)* (unreported, Court of Appeal 21 March 1986) per McHugh JA; *Watson v Attorney-General for New South Wales* (1987) 8 NSWLR 685 at 700-701 per Priestley JA, Street CJ and Hope JA agreeing. The office was abolished by s. 17 of the *Criminal Procedure Act 1986* (NSW), which provision conferred the registry functions of that office on the registrars and officers of the Supreme Court and District Court as appropriate. On the same day (23 December 1986), the *Director of Public Prosecutions Act 1986* (NSW) was assented to, creating the office of Director of Public Prosecutions.

[671] Exhibit 24, Tab 72, Statement of Emily Burston, 18 May 2023, [14]–[17] (SCOI.45198).

[672] Exhibit 24, Tab 76, Statement of Emily Burston, 21 July 2023, [6] (SCOI.84830).

Interagency cooperation

5.858. The Inquiry requested and received a copy of the Coroners Court file from the Newcastle Local Court. This comprised 14 pages of documents including a record of the formal findings, the initial Report of Death to Coroner, and a short record of the opinion of the forensic pathologist and an exhibit list. It did not include copies of exhibits tendered at the inquest, or of statements taken by police and included in the coronial brief of evidence.

5.859. Inquiries were made with BDM in relation to various witnesses. Unfortunately, a number of those witnesses are now deceased.

5.860. Mr Miller died in 1986.

5.861. I219 died in 1983. As well as being the witness who first implicated Mr Miller, I219 potentially may have been a helpful source of information concerning Mr Miller's past involvement in robberies at toilet blocks on other occasions.

5.862. I218, one of Mr Miller's three companions at around the time Mr Slater was assaulted, is also now deceased as at 2021.[673]

Family members

5.863. Mr Slater's wife (Gwen) and only child (Julie) have passed away. The Inquiry did have the benefit of contact with one of Mr Slater's four grandchildren, Yvonne. Yvonne was 11 years old when Mr Slater passed away. She has provided the Inquiry with helpful information concerning her grandfather, her family's recollections in relation to the circumstances of his death, as well as copies of some newspaper articles from the early 1980s relating to his death.

Searches for exhibits

5.864. As noted previously, on 5 December 2022 the Inquiry issued a summons to the NSWPF seeking details of the location of the original exhibits (NSWPF39). By letter dated 15 December 2022, the NSWPF advised that, despite undertaking various searches, they had been unable to locate the exhibits. They concluded that all avenues to locate the exhibits had been exhausted and that, as they were not logged on EFIMS, it would appear that they no longer exist.

5.865. Had the exhibits been retained, DNA testing of them would presumably now have been possible, with the possibility that such testing may have provided significant evidence concerning the identity of the attacker and whether any sexual activity had taken place involving Mr Slater and/or his attacker. It is highly regrettable that the exhibits are not now available.

[673] Exhibit 24, Tab 72, Statement of Emily Burston, 18 May 2023, [13] (SCOI.45198).

5.866. The presence of semen suggests that some recent sexual activity is likely to have occurred. It is noted, however, that the insufficiency of the sample to enable a grouping type to be determined suggests that the quantity of semen was small. The fact that only a small amount of semen was detected may weigh against the likelihood that any such sexual activity had occurred at the time Mr Slater was assaulted, as opposed to some earlier occasion. However, had Mr Slater's clothing been retained as an exhibit, the significant advances in the sensitivity of forensic testing capabilities that have been made since 1980 may have enabled identification of the person whose semen was on the clothing, and in particular whether it belonged to a potential suspect.

5.867. As it stands, in the absence of retention of the clothes and the capacity to conduct further testing, it is not possible to reach any clear conclusion in relation to the significance of the presence of the semen.

Professional opinions

Opinion obtained from Cardiologist

5.868. By letter dated 21 December 2022, an opinion was sought from Associate Professor Mark Adams, Head of the Department of Cardiology at the Royal Prince Alfred Hospital.[674] He was asked to address matters including the extent to which Mr Slater's death was attributable to a myocardial infarction and/or the injuries occasioned by the assault on 19 December 1980, or any other cause. His report, dated 13 January 2023, is considered below.

Opinion obtained from Neurosurgeon

5.869. As noted above, by letter dated 7 March 2023 the Inquiry also sought the opinion of Professor Michael Besser, consultant neurosurgeon, concerning the effect of Mr Slater's head injuries on his comprehension, relevant to comments Mr Slater is said to have made to those assisting him at the scene shortly after the assault.[675] In his report dated 16 March 2023, Professor Besser also made some helpful observations more generally concerning Mr Slater's injuries (see below).

[674] Exhibit 24, Tab 66, Letter of instruction from the Inquiry to Associate Professor Mark Adams, 21 December 2022 (SCOI.82578); Exhibit 24, Tab 67, Expert report of Associate Professor Mark Adams, 13 January 2023 (SCOI.82770).

[675] Exhibit 24, Tab 69, Letter of instruction from the Inquiry to Professor Michael Besser AM, 7 March 2023 (SCOI.82915); Exhibit 24, Tab 70, Expert report of Professor Michael Besser AM, 16 March 2023 (SCOI.82914).

Opinion obtained from Urologist

5.870. Subsequent to the public hearing, the Inquiry sought and received an opinion from Professor Anthony Costello, Emeritus Professor of Urology (Honorary), Royal Melbourne Hospital, as to the evidence of Mr Slater's grandson that Mr Slater suffered from a prostate condition. Professor Costello was briefed with a range of material relevant to that issue. Professor Costello provided his opinion by report dated 23 June 2023.[676] Assuming the accuracy of the account given by Mr Slater's grandson, Professor Costello observed that more likely than not Mr Slater had "untreated benign prostatic hyperplasia or hypertrophy" (these terms being used interchangeably). He considers that Mr Slater "more likely than not had symptoms of frequency and hesitancy"; and that "[d]elay in initiation of urination in these circumstances can take up to several minutes or even longer."[677]

Witness statements

5.871. The Inquiry made contact with two key surviving witnesses, I217 (now aged 70) and I216 (now aged 62), who were present with Mr Miller for a time on the day of the assault. Ultimately, for reasons elaborated upon below, it would appear that the information in the records of interview of both of these witnesses, conducted in 1982, are the more reliable sources of information from these witnesses.

Attempts to contact former legal representatives of Jeffrey Miller

5.872. In a further attempt to gain information concerning the circumstances in which the charges against Mr Miller were no-billed, the Inquiry attempted to make email contact with a barrister who it seems may have appeared for Mr Miller. To date, no response to this inquiry has been received.

5.873. Mr Miller's solicitor at the time is understood to be deceased, and the relevant firm has now gone through various changes and no longer exists under its original name. The Inquiry made contact with a firm of solicitors in Newcastle which may have inherited and retained some of the files of the firm which had acted for Mr Miller. The Inquiry was advised that that firm does not hold any relevant records.

Contact with OIC

5.874. On 24 August 2023 and 18 September 2023, the Inquiry wrote to former OIC, Robert Clark enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Slater.[678] Mr Clark advised that he did not wish to participate in the Inquiry.

5.875. Through interagency cooperation, the Inquiry also confirmed that Detective Senior Constable Inkster is now deceased.

[676] Exhibit 24, Tab 75, Expert report of Professor Anthony Costello, 21 July 2023 (SCOI.84786).

[677] Exhibit 24, Tab 75, Expert report of Professor Anthony Costello, 21 July 2023, 3 (SCOI.84786).

[678] Exhibit 24, Tab 77, Letter from Enzo Camporeale to Robert Ross Clark, 24 August 2023 (SC01.85873); Exhibit 24, Tab 78, Letter from Enzo Camporeale to Robert Ross Clark, 18 September 2023 (SC01.85874); Exhibit 24 Tab 79, Statement of Emily Burston, 9 October 2023, [4]-[7] (SCOI.86050).

Contact with next of kin of Jeffrey Miller

5.876. In light of the evidence before the Inquiry as to the potential involvement of Mr Miller in Mr Slater's death, and the possibility that Counsel Assisting may make submissions to that effect, the Inquiry wrote to Mr Miller's next of kin. By that letter dated 5 May 2023, the Inquiry advised of the date of the public hearing and provided a timeframe for Mr Miller's next of kin to contact the Inquiry to provide information and/or make submissions. The Inquiry did not receive a response.[679]

Consideration of the evidence

Civilian witness accounts relevant to role of Jeffrey Miller

5.877. The statements that police took in the days following Mr Slater's death, referred to above, included those of four people, including Mr Miller, who indicated that they had been present together while shopping in the area, and that they had also passed by the toilet block in question.

5.878. However, it was not until 27 August 1982 that a young person, I219, who was then aged 17, supplied information to the police implicating Mr Miller.[680] In particular I219 told police that on the afternoon of the day that Mr Slater was assaulted, Mr Miller had been at his house and had threatened I219, saying "you don't want to open your mouth or you will end up like the guy in the toilet".[681]

5.879. The NSWPF then reinterviewed the three people who had previously indicated that they had been present with Mr Miller earlier in the day. While their accounts upon being reinterviewed did not suggest that they had witnessed Mr Miller assaulting Mr Slater, the accounts taken together provided strong circumstantial evidence that Mr Miller had done so.

Evaluation of the accounts given by I216

5.880. I216 was aged 19 at the time of Mr Slater's death. The accounts he has given which are still available consist of a statement made on 23 December 1980,[682] a typed and signed record of interview with police dated 1 September 1982,[683] and more recently a statement he has provided to this Inquiry.[684] He also gave evidence at the committal proceedings in November 1982, but the record of those proceedings has been lost. There is a brief reference to his evidence in a Newcastle Herald newspaper report dated 25 November 1982 (see further below).[685]

[679] Exhibit 68, Tab 28, Letter from the Inquiry, 5 May 2023 (SCOI.86643).

[680] Exhibit 24, Tab 31, NSWPF Record of Interview, 'Interview with I219', 27 August 1982 (SCOI.10343.00044).

[681] Exhibit 24, Tab 31, NSWPF Record of interview, 'Interview with I219', 27 August 1982, Q6 (SCOI.10343.00044).

[682] Exhibit 24, Tab 29, Statement of I216, 23 December 1980 (SCOI.10343.00045).

[683] Exhibit 24, Tab 34, NSWPF Record of Interview, 'Interview with I216', 1 September 1982 (SCOI.10343.00046).

[684] Exhibit 24, Tab 71, Statement of I216, 15 May 2023 (SCOI.45197).

[685] Exhibit 24, Tab 55, 'Murder hearing told of sex wish', *The Newcastle Herald*, 25 November 1982 (SCOI.82767).

5.881. Without traversing the full detail of I216's accounts, it would appear that the most reliable account provided by him is the record of interview dated 1 September 1982.[686] In that account, I216 indicates that he had known Mr Miller for about two years.[687] He described walking into the toilet in Birdwood Park on 19 December 1980 to use the urinal, and that when he was at the urinal, a man entered and stood at the urinal on his right. He stated that the man "pulled out his penis and stood there as if urinating".[688]

5.882. In his earlier statement of 23 December 1980, I216 had said that the man "pulled out his dick and pretended to have a piss."[689] In the recent account provided in a statement to this Inquiry, I216 stated that he observed the man to be holding his penis, which was partially, though not fully erect, while "staring" at I216 and that for this reason, he took the man to be present in the toilets with a sexual purpose.[690] In that account, I216 states that there is "no doubt" in his mind that the man he saw was there to trying to "hook up".[691]

5.883. In his 1982 record of interview, I216 said that, after he exited the toilet, I218 was making sexual references to the toilet being a beat, in response to which he (I216) made a reference to there being "only one old bloke in there".[692] He said that Mr Miller then said something that gave him the impression that he (Miller) was then going to enter the toilet for "sexual reasons".[693]

5.884. In his recent statement to the Inquiry, I216 cast doubt on the likelihood that Mr Miller had assaulted anyone upon entering the toilet block, because he did not consider there would have been time, because he did not hear anything, and because of Mr Miller's unruffled demeanour.[694] Against this, however, is the fact that in his 1982 record of interview he had indicated that Mr Miller had been in the toilet block for "two to three minutes".[695] According to the Newcastle Herald, he gave similar evidence at the committal hearing.[696]

5.885. In both his December 1980 statement and his 1982 record of interview, I216 described the man in the toilet as about 5 foot 6, middle aged, of medium build and perhaps wearing grey trousers.[697] He also thought him to be "a bit thin on top."[698] As noted above, in his 1982 record of interview he said that he described the man to his associates as an "old bloke".[699]

[686] Exhibit 24, Tab 34, NSWPF Record of Interview, 'Interview with I216', 1 September 1982, (SCOI.10343.00046).

[687] Exhibit 24, Tab 34, NSWPF Record of Interview, 'Interview with I216', 1 September 1982, Q30 (SCOI.10343.00046).

[688] Exhibit 24, Tab 34, NSWPF Record of Interview, 'Interview with I216', 1 September 1982, Q13 (SCOI.10343.00046).

[689] Exhibit 24, Tab 29, Statement of I216, 23 December 1980, [4] (SCOI.10343.00045).

[690] Exhibit 24, Tab 71, Statement of I216, 15 May 2023, [6] (SCOI.45197).

[691] Exhibit 24, Tab 71, Statement of I216, 15 May 2023, [18] (SCOI.45197).

[692] Exhibit 24, Tab 34, NSWPF Record of Interview, 'Interview with I216', 1 September 1982, Q13 (SCOI.10343.00046).

[693] Exhibit 24, Tab 34, NSWPF Record of interview, 'Interview with I216', 1 September 1982, Q14 (SCOI.10343.00046).

[694] Exhibit 24, Tab 71, Statement of I216, 15 May 2023 (SCOI.45197).

[695] Exhibit 24, Tab 34, NSWPF Record of Interview, 'Interview with I216', 1 September 1982, Q24 (SCOI.10343.00046).

[696] Exhibit 24, Tab 55, 'Murder hearing told of sex wish', *Newcastle Herald*, 25 November 1982 (SCOI.82767).

[697] Exhibit 24, Tab 34, NSWPF Record of Interview, 'Interview with I216', 1 September 1982, Q13 (SCOI.10343.00046).

[698] Exhibit 24, Tab 34, NSWPF Record of Interview, 'Interview with I216', 1 September 1982, Q13 (SCOI.10343.00046).

[699] Exhibit 24, Tab 34, NSWPF Record of Interview, 'Interview with I216', 1 September 1982, Q14 (SCOI.10343.00046).

5.886. The Newcastle Herald article of 25 November 1982 reported on I216's committal evidence, saying that I216 was shown photographs of Mr Slater and replied that "the man he had seen in the lavatory could very easily be the man depicted in the photographs but he could not be sure."[700] The article indicated that the evidence I216 gave at the committal was consistent with his record of interview as in cross examination by Mr Miller's legal representative he had "denied that he had invented things in his second statement to police".[701]

5.887. Given the detail provided in his much earlier accounts, I place little weight on the opinion now expressed by I216, more than 40 years later, that he does not think Mr Miller assaulted Mr Slater as he does not think he would have had the time or opportunity. In saying this, I am not suggesting that I thought I216 was dishonest. It may well be that that view is the product of "wishful thinking" on I216's part, now many years after the event, rather than obfuscation. Whether or not that is the case, that suggestion does not sit comfortably with the detail provided by I216 in his 1982 record of interview, less than two years after the attack on Mr Slater.

Evaluation of the accounts given by I217

5.888. I217 was 28 years of age at the time of Mr Slater's death. The accounts she is known to have given consist of a statement made on 23 December 1980, and a typed and signed record of interview with police dated 31 August 1982. Additionally, Inquiry officers made contact with I217 by phone in April 2023.[702]

5.889. I217 indicated in that phone contact that her memory of the events surrounding Mr Slater's death, and of his prosecution, is poor. It appears likely that I217 would have given evidence at the committal proceedings in late 1982. The Newcastle Herald article refers to a question posed to I216 by Mr Miller's counsel, in which I216's account is contrasted with that of I217, thereby lending support to the likelihood that I217 gave evidence.[703] However, as noted earlier there is no record of those proceedings.

5.890. I217 has suggested to the Inquiry that she cannot vouch for the accuracy of her 1982 record of interview and has indicated (consistent with her record of interview) that she is dyslexic and would not have been able to read her record of interview. However, for reasons I now outline, it would appear that her record of interview is likely to represent the most reliable version of events from her perspective, even if she cannot now vouch for it.

[700] Exhibit 24, Tab 55, 'Murder hearing told of sex wish', *Newcastle Herald*, 25 November 1982 (SCOI.82767).

[701] Exhibit 24, Tab 55, 'Murder hearing told of sex wish', *Newcastle Herald*, 25 November 1982 (SCOI.82767).

[702] Exhibit 24, Tab 72, Statement of Emily Burston, 18 May 2023, [27]–[32] (SCOI.45198).

[703] Exhibit 24, Tab 55, 'Murder hearing told of sex wish', *Newcastle Herald*, 25 November 1982 (SCOI.82767).

5.891. Her 1982 record of interview includes an assertion by I217 that she cannot read. It then records that as a consequence, a detective read the typed record out loud to her, which contains her acknowledgment that the typed record of interview accurately records what she told the police, with the exception of one matter that she corrected.[704] The record of interview notes her agreement to signing each page of the record of interview. Each page of the record of interview bears her signature.

5.892. In her 1982 record of interview, I217 stated that at the time of making her initial statement in 1980 (in which she had not implicated Mr Miller), she had in fact suspected that Mr Miller was involved in the assault, but that he had threatened her not to say anything to the police.[705] She stated that she also knew him to be a violent and dangerous person and that she was frightened to tell the truth.[706]

5.893. In the 1982 record of interview, I217 indicated that she was present when I216 went into the toilet block. When he came out, I216 was talking to Mr Miller and told him that there was a bloke in the toilets, as a result of which Mr Miller said "I am going to crack it with the bloke in the toilet", which she said was a "term used by homosexuals that means to have sex with another bloke".[707] I217 went on to say that she then knew that Mr Miller was going to either "crack" it with the man, or that he was going to "roll him and take his wallet".[708] She then left, indicating that she did not "want any part of it".[709] She stated that her reference to "rolling" the man meant:[710]

> *[T]hat Jeff would have assaulted him and pushed him over and taken his wallet and money. Jeff is always doing that when he goes around to the toilets.*

5.894. She stated that soon thereafter Mr Miller rejoined her, and that she later accompanied him to his mother's house in Carrington, where Mr Miller changed his clothes, having told her that they were dirty.[711] Later in the afternoon she described accompanying Mr Miller when he went and spoke with I219. She stated that Mr Miller spoke to I219 because I219 "knew too much about Jeff rolling and bashing homosexuals and I have seen Jeff belt other blokes up for dobbing him in."[712]

[704] Exhibit 24, Tab 32, NSWPF Record of Interview, 'Interview with I217', 31 August 1982, Q8 (SCOI.10343.00043).

[705] Exhibit 24, Tab 32, NSWPF Record of Interview, 'Interview with I217', 31 August 1982, Q9, Q46 (SCOI.10343.00043).

[706] Exhibit 24, Tab 32, NSWPF Record of Interview, 'Interview with I217', 31 August 1982, Q9 (SCOI.10343.00043).

[707] Exhibit 24, Tab 32, NSWPF Record of Interview, 'Interview with I217', 31 August 1982, Q18-Q19 (SCOI.10343.00043).

[708] Exhibit 24, Tab 32, NSWPF Record of Interview, 'Interview with I217', 31 August 1982, Q20 (SCOI.10343.00043).

[709] Exhibit 24, Tab 32, NSWPF Record of Interview, 'Interview with I217', 31 August 1982, Q20 (SCOI.10343.00043).

[710] Exhibit 24, Tab 32, NSWPF Record of Interview, 'Interview with I217', 31 August 1982, Q21 (SCOI.10343.00043).

[711] Exhibit 24, Tab 32, NSWPF Record of Interview, 'Interview with I217', 31 August 1982, Q27 (SCOI.10343.00043).

[712] Exhibit 24, Tab 32, NSWPF Record of Interview, 'Interview with I217', 31 August 1982, Q36 (SCOI.10343.00043).

5.895. In the phone contact that the Inquiry staff had with I217,[713] she denied knowledge that Mr Miller had committed acts of violence. However, in her 1982 record of interview she gave an account of witnessing Mr Miller assaulting a gay man by the name of "Andrew" at Piper's Nightclub in Newcastle, and that "Andrew" worked at Newcastle courthouse and had "dobbed [Mr Miller] in to the Police".[714] She describes seeing Mr Miller bash this person and kick him, as a result of which he was taken to hospital.[715]

5.896. The veracity of this detail of I217's record of interview, and thereby of her record of interview more generally, is supported by the fact that the Inquiry has obtained a NSWPF record that is consistent with Mr Miller having committed such an assault. The record indicates that a victim, known by the pseudonym I220 before this Inquiry, "was assaulted by being punched and kicked by a well known homosexual in the person of the offender", naming Mr Miller as the offender.[716] The NSPWF record somewhat gratuitously added "[t]he complainant in this matter is effeminate." I return to this record below in the context of negative stereotyping. The Inquiry has made unsuccessful attempts to locate and interview the victim of that assault.[717]

Account given by I218

5.897. I218 was 20 years of age at the time of Mr Slater's death. It appears that she was spoken to by police shortly after Mr Slater's death, on 22 December 1980, although there was no statement taken from her at that time. A record of interview was later conducted with her on 3 September 1982.[718] I218 is now deceased.[719] It is evident from her statement that I218 was a member of the LGBTIQ community.

5.898. In her 1982 record of interview, I218 states that she was present with Mr Miller, I216 and I217 on the day Mr Slater was assaulted.[720] She described seeing I216 enter the toilet block in Birdwood Park and said that she then yelled something out to him, though she could not recall what this was.[721] After I216 exited the toilet, she thought he said something to Mr Miller, and at that point she and I217 walked off towards the markets. As they were walking, I216 and Mr Miller came running up to I217 and her.

5.899. I218's account is relatively general and contains limited detail, though in general terms it is consistent with the records of interview of I216 and I217, as to the timing of the group being at or near the toilet block, and as to the actions of I216 and Mr Miller at the toilet block (although she appears to have left before Mr Miller entered). She also corroborates I217's account that Mr Miller went to see I219 later that afternoon, and that there was some form of altercation between them.

[713] Exhibit 24, Tab 72, Statement of Emily Burston, 18 May 2023, [29] (SCOI.45198).

[714] Exhibit 24, Tab 32, NSWPF Record of Interview, 'Interview with I217', 31 August 1982, Q37 (SCOI.10343.00043)

[715] Exhibit 24, Tab 32, NSWPF Record of Interview, 'Interview with I217', 31 August 1982, Q38 (SCOI.10343.00043)

[716] Exhibit 24, Tab 42, NSWPF Crime Information Report, 28 November 1980 (NPL.0121.0001.0416).

[717] Exhibit 24, Tab 72, Statement of Emily Burston, 18 May 2023, [35] (SCOI.45198).

[718] Exhibit 24, Tab 35, NSWPF Record of Interview, 'Interview with I218', 3 September 1982 (SCOI.10343.00047).

[719] Exhibit 24, Tab 72, Statement of Emily Burston,18 May 2023, [13] (SCOI.45198).

[720] Exhibit 24, Tab 35, NSWPF Record of Interview, 'Interview with I218', 3 September 1982 (SCOI.10343.00047)

[721] Exhibit 24, Tab 35, NSWPF Record of Interview, 'Interview with I218', 3 September 1982, Q11 (SCOI.10343.00047).

Account given by I219

5.900. On 27 August 1982, I219 provided information to the police implicating Mr Miller. This was in the form of a record of interview.[722] I219 was 17 years old at the time he was interviewed.

5.901. In the 1982 record of interview, I219 described Mr Miller as an "ex acquaintance" whom he had known for two years and who at that time (August 1982) was in custody.[723] He stated that Mr Miller was responsible for the assault on Mr Slater, and that he knew this because of what Mr Miller had told him on the afternoon of the day that the assault had occurred, or possibly the next day.[724] The relevant admission was that Mr Miller came to his house and said "you don't want to open your mouth or you will end up like the guy in the toilet".[725]

5.902. When asked what he took Mr Miller to mean by this, his response was:

> *I suppose because I knew a lot about him, that he was rolling and bashing up people in the toilets around Hamilton, Burwood and Centennial Parks. He was also taking their wallets. I didn't know at the time what he meant when he said "like the guy in the toilet", I heard about it either the next day or a few days after that a man had died.*

5.903. I219 was further asked how he knew that Mr Miller was responsible for "assaulting and rolling people in the toilets at Newcastle".[726] The typed record of interview records his response as follows:[727]

> *I have him (sic) brag about it and I have also seen him bash other people, once in the toilets at Hamilton where this old drunk guy, about 60 was in the toilet and Geoff walked in and knocked him to the ground, kicked him into the trough and then took his wallet. I saw this myself but I took no part in it. He took about $16.00 or $17.00 from his wallet. Then there was another time at Pipers Night Club he saw a person that had dobbed him in to the Police about something. He told him to go down the stairs and when he was about half way down he kicked him then kicked him all the way down the stairs and then layed (sic) into him when he got to the bottom. This guy was covered in blood and had serious injuries. I can't remember the name of the guy that he bashed but they took him to Hospital half dead and it was reported to the Newcastle Police Station. I know Miller to be very violent and that on a number of thime (sic) he has threatened to do away with me if I open my mouth and tell anybody what he has done.*

[722] Exhibit 24, Tab 31, NSWPF Record of Interview, 'Interview with I219', 27 August 1982 (SCOI.10343.00044).

[723] Exhibit 24, Tab 31, NSWPF Record of Interview, 'Interview with I219', Q4 (SCOI.10343.00044).

[724] Exhibit 24, Tab 31, NSWPF Record of Interview, 'Interview with I219', 27 August 1982, Q5 (SCOI.10343.00044).

[725] Exhibit 24, Tab 31, NSWPF Record of Interview, 'Interview with I219', Q6 (SCOI.10343.00044).

[726] Exhibit 24, Tab 31, NSWPF Record of Interview, 'Interview with I219', 27 August 1982, Q9 (SCOI.10343.00044).

[727] Exhibit 24, Tab 31, NSWPF Record of Interview, 'Interview with I219', 27 August 1982, Q9 (SCOI.10343.00044).

5.904. I219 evidently gave evidence at the committal hearing in November 1982. A Newcastle Herald report refers to his evidence, while also stating that I219 was by then serving a seven year sentence for 132 offences committed while he was a juvenile, with a two year non-parole period.[728] The Inquiry sought details in relation to I219 with a view to speaking with him. However, it was established that he passed away in late 1983, aged 19, while in custody at Berrima Training Centre.

5.905. Although they are untested (from the Inquiry's point of view, in the absence of the committal record), I219's statements to police clearly provide support for the proposition that Mr Miller assaulted Mr Slater.

Apparent admission made by Mr Miller to Police

5.906. On 1 September 1982, police approached Mr Miller with the inculpatory accounts that had been provided to them by I217, I219 and I216.[729] At the time, Mr Miller was in custody on other matters.

5.907. In response, Mr Miller initially made statements that appeared to concede his involvement in the matter. He showed police to the toilet block where the incident occurred. According to the investigating officer, Detective Senior Constable Inkster, upon being told that I217 had signed a statement in writing, Mr Miller said "I knew I couldn't trust that bitch" and complained that I217 "couldn't keep her mouth shut".[730] He conceded that he had in fact entered the toilet block and asked as follows:[731]

> *What would happen if I say that old bloke had a go at me first.*

5.908. However, when formally interviewed the same day, while admitting to entering the toilet block (when he said he was looking to offer sex for money) sometime after 11:00am on 19 December 2022, he claimed that he had done so to "big note" himself with his companions and that he "lost courage" after checking the first cubicle (for reasons he declined to explain), then left without seeing anyone or taking any action.[732] He denied involvement in any other bashings or robberies.[733]

5.909. This questioning of Mr Miller in 1982 took place prior to the development of current practices and requirements mandating the electronic recording of such interviews of suspects. Nevertheless, assuming the typed record of the initial responses made by Mr Miller is reliable, it clearly provides significant evidence, by way of admission, implicating Mr Miller in the assault on Mr Slater.

[728] Exhibit 24, Tab 56, "Man for trial over park lavatory death", *Newcastle Herald*, 11 December 1982 (SCOI.82769).

[729] Exhibit 24, Tab 17, Statement of Detective Senior Constable Grahame Robert Inkster, 28 October 1982 (SCOI.10343.00032).

[730] Exhibit 24, Tab 17, Statement of Detective Senior Constable Grahame Robert Inkster, 28 October 1982, [7] (SCOI.10343.00032).

[731] Exhibit 24, Tab 17, Statement of Detective Senior Constable Grahame Robert Inkster, 28 October 1982, [11] (SCOI.10343.00032).

[732] Exhibit 24, Tab 33, NSWPF Record of Interview, 'Interview with Jeffrey Miller', 1 September 1982, Q14, Q15 (SCOI.10343.00049).

[733] Exhibit 24, Tab 33, NSWPF Record of Interview, 'Interview with Jeffrey Miller', 1 September 1982, Q13-Q23, Q28 (SCOI.10343.00049).

Police investigation

Loss of records

5.910. It is difficult to assess the adequacy of the police investigation as it seems that the records provided to the Inquiry in relation to the investigation are incomplete. Consistent with this, in 2017 one of the reasons given by a NSWPF officer for suspending any further investigation of the matter was the availability of only limited "case files". The material that has been provided focusses largely on later investigative steps taken in 1982 following the nomination of Mr Miller as a person of interest.

5.911. The NSWPF submitted that it is the "unfortunate reality" that records from approximately 40 years ago may be lost or no longer available.[734] Despite that, the NSWPF submitted that the records that were produced to the Inquiry were extensive, with over 100 pages of the material tendered by Counsel Assisting having been produced by the NSWPF. In comparison, it submitted, summonses made by the Inquiry to other entities were generally unfruitful, with only the Newcastle Local Court being able to produce 14 pages of records.[735] The NSWPF submitted that, in that context, the criticism of Counsel Assisting "rings somewhat hollow".[736]

5.912. I do not accept those submissions of the NSWPF. The difficulties arising from the loss of records by the NSWPF are not ameliorated by virtue of the fact that records may also have been lost by other entities. The issue faced by the Inquiry is that, regardless of what could be produced and by whom, records which may have assisted the Inquiry to understand the course of the initial investigation of the NSWPF have been lost, the investigation into Mr Miller and the reasons for the failure of his prosecution are not available, and the possibility of the Inquiry reaching conclusive findings regarding Mr Slater's death may have been adversely affected.

5.913. The NSWPF was the primary body responsible for maintaining records and exhibits, or at minimum tracking their whereabouts. It is not a redeeming feature of police record management that other entities also may have fallen short in maintaining relevant records, nor that by comparative page count they have produced more documents than another agency.

5.914. The NSWPF also submitted that it is unsurprising that better records exist in relation to the period after Mr Miller was identified as a suspect as they were presumably prepared in relation to the prosecution, and that in any case "approximately half" of the documents tendered by Counsel Assisting relate to the period prior to 1982.[737]

[734] Submissions of NSWPF, 1 June 2023, [42] (SCOI.83645).

[735] Submissions of NSWPF, 1 June 2023, [43] (SCOI.83645).

[736] Submissions of NSWPF, 1 June 2023, [44] (SCOI.83645).

[737] Submissions of NSWPF, 1 June 2023, [45] (SCOI.83645).

5.915. That submission is unhelpful. Counsel Assisting were necessarily limited to the material before them in determining the documents to tender to the Inquiry. That there is a balanced spread of dates in the material in fact tendered says nothing about the gaps in that material, which are readily apparent from the submissions of Counsel Assisting. It is clear, for example, that the material produced to the Inquiry by the NSWPF does not contain records that relate to the interviews of anywhere near the 60 witnesses who it appears were interviewed during the early phase of the investigation.[738] It is impossible to know the extent to which the quality of the material available for tender, and the Inquiry's understanding of this case, might have improved had all the records been available in relation to the earlier stage of the investigation into Mr Slater's death. It may be those documents would not have been helpful. It may be they would have thrown helpful light on the nature of the inquiries the initial investigation made with the LGBTIQ community, discussed further below.

5.916. It is notable that the NSWPF continued to produce documents to the Inquiry following the public hearing and the making of submissions in this matter. Those documents do not further enlighten the Inquiry as to the scope of the initial investigation (instead addressing enquiries made in 2017). While the late production of that material did not ultimately substantially impact the Inquiry's review of this matter, I accept the submission of Counsel Assisting that the timely production of that material would have helped facilitate the Inquiry's contact with Mr Slater's granddaughter by providing details of her previous interactions with the NSWPF regarding the matter and her ongoing interest in it.

5.917. Further, that records continued to be produced more than a year after they were due for production under the relevant summons and more than eight months after the Inquiry specifically requested further searches be undertaken in this matter, does not allow me to have confidence that all records available to the NSWPF have in fact been produced to this Inquiry.

Loss of exhibits

5.918. The NSWPF accepted the submission by Counsel Assisting that the loss of exhibits, in particular of Mr Slater's shirt and pants on which semen was detected, was "highly regrettable".[739] However, the NSWPF also submitted that it was necessary to contextualise the failure to retain the items. It submitted that forensic testing capabilities were insufficient to allow for satisfactory testing at the time of Mr Slater's death, and that the advancements in forensic testing that had occurred since the 1980s could not have been known at that time.

5.919. The NSWPF further submitted that, even if the exhibits had been retained and were subject to testing now, the results of any testing, if it could be done, are matters of speculation.[740]

[738] Exhibit 24, Tab 48, 'Bashing mystery: 60 interviewed by police', *The Sun*, 5 January 1981 (SCOI.82778); Exhibit 24, Tab 14, NSPWF Resume of Investigations, 'Murder of Richard Slater', 21 June 1983, [11]–[12] (SCOI.10343.00004).

[739] Submissions of NSWPF, 1 June 2023, [46] (SCOI.83645).

[740] Submissions of NSWPF, 1 June 2023, [47] (SCOI.83645).

5.920. During the course of oral evidence in the Investigative Practices Hearing, Assistant Commissioner Conroy accepted that in light of the exhibit book not being properly maintained in the matter, and in the absence of any other exhibit records, it is now not possible to understand what happened to the exhibits.[741] Assistant Commissioner Conroy told the Inquiry that, had the exhibit book been properly maintained, it may have recorded what happened to the exhibits, including whether they were consumed entirely during forensic testing. Assistant Commissioner Conroy gave evidence that there was no procedure in place at that time that would have justified the destruction of any record detailing what happened to the exhibits, including whether they were consumed during forensic testing, or whether they were destroyed for some other reason.[742]

5.921. In written submissions filed in respect of the Investigative Practices Hearing, the NSWPF accepted that there should be a record of what happened to the exhibits. However, the NSWPF also contended that Assistant Commissioner Conroy's evidence must be viewed in light of her understanding that exhibit books must be retained for 20 years, and that the destruction of exhibits was a matter outside of her responsibilities. The NSWPF ultimately submitted that it was not possible to conclude with certainty that the lack of records pertaining to the fate of the exhibits indicated a failure to comply with police procedure at the relevant time.[743]

5.922. The policies and practices of the NSWPF with respect to exhibit management in this period, and the failings thereof, are dealt with comprehensively at **Chapter 8** of this Report.

5.923. Although the outcome of any hypothetical testing of exhibits is speculative, that does not mean it can be inferred that nothing of value has been lost. The Inquiry and any other future investigation have been denied the opportunity to conduct testing of the exhibits which may have yielded critical evidence. The fact of "no physical/forensic evidence being retained" was one of the reasons given by a NSWPF officer in 2017 for the suspension of any further investigation. As noted in **Chapter 8**, although the advent of DNA technology may not have been foreseeable at the time of Mr Slater's death, retention of physical exhibits was known to be important in criminal investigations, especially for known homicides, so that they were available at prosecution and to permit any further forensic testing that may become available or relevant.

[741] Transcript of the Inquiry, 4 July 2023, T4849.27-43 (TRA.00072.00001); 4550.12-15 (TRA.00072.00001).

[742] Transcript of the Inquiry, 4 July 2023, T4849.35-4850.10 (TRA.00072.00001); 5450.17-20 (TRA.00072.00001).

[743] Submissions of NSWPF, 10 October 2023, [340] (SCOI.86127).

5.924. I also observe that this is not a case where exhibits can be said to have been disposed of according to a policy which did not anticipate technological advances. There is no known explanation for their loss. There is no record confirming their movements, destruction, or action taken in respect to them following 19 February 1981, less than two months after Mr Slater's death and significantly prior to the investigation of Mr Miller commencing in late August 1982. It is possible the exhibits were not destroyed until a much later date, or remain undiscovered somewhere in NSWPF custody. That investigating officers may not have anticipated future forensic opportunities does not account for what appear to be, at the very least, significant shortfalls in record-keeping relating to the exhibits.

Negative stereotyping

5.925. Counsel Assisting in effect submitted that the material reflects there having been an undue and negative focus in the investigation on a presumptive connection between the LGBTIQ community in Newcastle, criminality and drug usage.

5.926. As noted above, there is some material which suggests initial investigative efforts were directed to interviewing "numerous homosexuals, transvestites and other persons" because the toilet block was well known as a "renowned meeting place for the homosexual element of this area at all hours during the day or night".[744] Counsel Assisting pointed to an early police summary dated 22 December 1980 that appears to negatively contrast the fact that the assault took place in a public toilet "frequented by homosexuals", with the fact that Mr Slater enjoyed a good reputation and that there was no suggestion he was an associate of a "criminal element" or that he "associated with this class of individual."[745]

5.927. Similarly, in a criminal antecedent report prepared by Detective Senior Constable Inkster regarding Mr Miller, he writes:[746]

> *The accused person is known to me to be an associate of the criminal and homosexual element both in the Newcastle and Sydney areas. …*
>
> *…[he] has for several years been residing in temporary accommodation with other persons of his own character and all of whom are well known to police for their criminal, homosexual and drug activities…*
>
> *… he has informed that because of his involvement with the homosexual and transvestite types in this area he has become involved in drugs…*

5.928. The NSWPF submitted that an inference that homosexuality is associated with criminality is offensive by modern standards, but reflected the legal position at the time, as homosexuality remained a criminal offence in NSW until 1984.[747]

[744] Exhibit 24, Tab 14, NSWPF Resume of Investigations, 'Murder of Richard Slater', 21 June 1983, [11]–[12] (SCOI.10343.00004).

[745] Exhibit 24, Tab 9, NSWPF Report of Occurrence, 'Summary of events leading up to the assault and subsequent death of Richard Slater', 22 December 1980, 2 (SCOI.10343.00055).

[746] Exhibit 24, Tab 13, NSWPF Criminal Antecedent Report, 'Jeffrey Miller', 13 December 1982 (SCOI.10343.00007).

[747] Submissions of NSWPF, 1 June 2023, [48] (SCOI.83645).

5.929. Not only did it reflect the legal position, as the Inquiry heard during the Context Hearing, it frequently manifested itself in entrenched negative attitudes towards members of the LGBTIQ community more generally, including by some members of the NSWPF. While it may be anticipated that documents dating from before 1984 would treat sexual activity between men as a criminal offence, it is another matter to broadly describe the LGBTIQ community as associated with a "criminal element" in contrast to persons of "good reputation", and to infer a necessary or likely link between membership of the LGBTIQ community on the one hand and drug and criminal activities on the other.[748] I would add that the gratuitous comment in the NSWPF record about the victim I220 being "effeminate", referred to above suggests a similar or related form of negative stereotyping.

5.930. The NSWPF also submitted that, given the well-known status of the toilet block as a beat, it was essential that the original investigation interview members of the LGBTIQ community because that was the most likely source of witnesses to the assault, and because it allowed police to "investigate the possible motivation (including gay hate bias) for the attack".[749]

5.931. The fact that members of the LGBTIQ community were the subject of interview is not the point of the critique of Counsel Assisting. That there was reason for members of the LGBTIQ community (among others) to be interviewed is obvious. The concern is that, well-justified or not, those interviews may have been affected by negative stereotyping. Unfortunately, the absence of records does not permit the quality and nature of any interviews that were conducted with members of the LGBTIQ community (beyond Mr Miller's few associates) to be assessed.

5.932. The inference drawn by Counsel Assisting as to negative stereotyping is necessarily a weak one, given the limited material available. That is, again, an unfortunate consequence of the absence of records addressing that period of the investigation. However, to the limited extent that the available documents demonstrate that investigating officers may have conflated membership in the LGBTIQ community with criminality generally in conducting those inquiries, I accept the submission of Counsel Assisting that negative stereotyping may have influenced the investigation.

"No bill" decision

5.933. The submissions of the NSWPF address a comment made in the written submissions of Counsel Assisting as follows:[750]

> *Without knowing the complete case advanced at the committal, and the reasons why the prosecution was withdrawn, it is not possible to accurately assess to what extent that outcome was avoidable or whether it arose as a result of a shortcoming in the investigation.*

[748] Exhibit 24, Tab 13, NSWPF Criminal Antecedent Report, 'Jeffrey Miller', 13 December 1982, [5] (SCOI.10343.00007).

[749] Submissions of NSWPF, 1 June 2023, [49] (SCOI.83645).

[750] Submissions of Counsel Assisting, 18 May 2023, [39] (SCOI.83238).

5.934. The NSWPF submits that, in the absence of any evidence as to the reasons for the "No Bill" decision, an inference that it arose as a result of a shortcoming of the original investigation is unfair. The NSWPF points to the evidence of a possible issue with causation (discussed above), inconsistencies in the evidence of some eyewitnesses and the criminal history of a key witness (I219) who implicates Mr Miller. The NSWPF also submit that media from the period indicates that the police investigation was in fact more extensive than is evident on the face of the documentary records. [751]

5.935. The positions of Counsel Assisting and the NSWPF do not appear to be at odds. I accept that I cannot draw an inference as to the reasons for the "No Bill" decision in the absence of any evidence as to the reasons for that decision and a significant absence of evidence in relation to the investigation of Mr Slater's death. Nor, however, can I exclude the real possibility that there were shortcomings in the investigation (which may have been influenced by negative stereotyping) which contributed to the outcome.

Manner and cause of death

5.936. Counsel Assisting submitted that the evidence that the Inquiry has assembled, considered in its entirety, is strongly supportive of the view that Mr Miller was responsible for the assault upon Mr Slater. However, notwithstanding the considerable force of that evidence, Counsel Assisting identified a number of reasons why the Inquiry would hesitate to reach a positive conclusion.

5.937. As Mr Miller is deceased, it will never be possible to test the evidence implicating him in criminal proceedings. In the context of such proceedings, the relevant standard to be applied is proof beyond reasonable doubt. A particular concern, therefore, is that the record of the committal proceedings does not appear to exist. A record of the evidence of key witnesses, as tested at the time in those proceedings, would be critical to a full and fair assessment of the reliability of the accounts given by them.

5.938. While Mr Miller's apparent admissions are very significant, it must be noted that they are in typed form and were made prior to the later standard practice of making electronic recordings of such admissions. He appears to have disavowed them in subsequent statements made to the police.

5.939. In summary, while there is substantial evidence that Mr Miller was responsible for the assault upon Mr Slater, in view of the grave nature of the allegation, the inability of Mr Miller, now deceased, to put a contrary view, and the fact that the prosecuting authority as of 1983 took the view that there were deficiencies in the case such as to warrant the discontinuance of the prosecution, Counsel Assisting submitted that I should hesitate before making a formal finding declaring this to have been the case.

[751] Submissions of NSWPF, 1 June 2023, [53] (SCOI.83645)

5.940. The submissions of the NSWPF ultimately agree with the those of Counsel Assisting that, while there was "considerable force" in the evidence implicating Mr Miller, I should make no positive finding as to the identity of the individual responsible.[752]

5.941. I accept these submissions. In the absence of clear evidence as to the reason for the "No Bill" decision, I cannot fairly evaluate the evidence implicating Mr Miller and any potential weaknesses relating to it. The loss of records in this matter, by various government entities, is therefore particularly frustrating. In addition, as I have said at **Chapter 1**, I do not propose to make findings in this report that a specified person committed a specified offence.

5.942. In the course of its submission concerning the identity of the perpetrator, the NSWPF is critical of Counsel Assisting for not calling the witnesses I216 and I217 to give "viva voce evidence", and implies that this is an unsatisfactory basis on which to draw conclusions concerning the relative veracity of their accounts over time.[753]

5.943. The manner in which the Inquiry obtains and presents evidence obtained in the course of its inquiries and the reasons for doing so are necessarily influenced by a wide range of factors. Not the least of those is the need to minimise potential trauma to witnesses (reflected in Paragraph D of the Inquiry's Terms of Reference). The NSWPF submission also appears to overlook completely Counsel Assisting's submission regarding inconsistencies in the recent account of I217 in particular with other objective evidence (Mr Miller's past history of violence, including violence that on one occasion appears to have been directed towards a gay man), as providing a basis to evaluate the reliability of her current account without calling into question her honesty. Nor does the NSWPF attempt to engage with Counsel Assisting's submissions that set out the reasons why the more recent accounts of those witnesses appear to be unreliable. I reject the criticisms made by the NSWPF concerning the manner in which the later accounts of these witnesses have been adduced.

5.944. I further note that Counsel for the NSWPF failed to object to or otherwise raise any concerns relating to the form of the evidence of these witnesses following service of that evidence or at the public hearing. Nor did Counsel for the NSWPF make an application to call those witnesses in accordance with paragraph 20 of Practice Guideline 1 of the Inquiry. It is not helpful for the NSWPF to criticise the approach taken by Counsel Assisting only after declining to take any action to remedy the alleged deficiency at an appropriate stage of the matter.

[752] Submissions of NSWPF, 1 June 2023, [65]–[66], [76] (SCOI.83645).

[753] Submissions of NSWPF, 1 June 2023, [63] (SCOI.83645).

5.945. On the question of causation, Counsel Assisting submitted that evidence assembled by the Inquiry suggests there is no bar to finding that the person responsible for assaulting Mr Slater was also responsible for causing his death. The report of Dr Bookalil, as at the time of the "No Bill", may have left a question mark hanging over this question. However, it was submitted that the expert opinions of Professor Adams and Professor Besser are such as to establish that the person responsible for the assault should also be considered, at law, to have caused Mr Slater's death.

5.946. Counsel Assisting submitted that it would be appropriate therefore for a finding of cause and manner of death to differ slightly from that reached by the Coroner, so that it adequately reflects the causal nexus with the assault as established by the evidence of those two experts. The NSWPF agreed with that submission, and I accept it.

Bias

5.947. On the assumption that Mr Miller was Mr Slater's attacker, assessment of his motivation and the possibility of LGBTIQ bias is not straightforward. Mr Miller himself appears on the evidence to have engaged in sexual activity with men at times. It is not clear whether he identified as a member of the LGBTIQ community.

5.948. Statements given by both I217 and I219 suggest that Mr Miller had committed assaults on men at beats. In particular, I217 stated that she was aware that Mr Miller regularly "rolled" men for their wallets in public toilets, and that on the occasion Mr Slater was assaulted she understood that Mr Miller was entering the toilet with the intention of either having sex with him or "rolling" him.[754] I217 also asserted that Mr Miller threatened I219 because I219 "knew too much about Jeff rolling and bashing homosexuals".[755]

5.949. Although I219 was not explicit that Mr Miller would target gay men in particular, he stated that he knew that Mr Miller was "rolling and bashing people up in the toilets around Hamilton, Burwood and Centennial Parks".[756] He stated that he had heard him brag about doing so and that he had once witnessed Mr Miller assaulting and robbing an "old drunk guy" in a toilet at Hamilton.[757]

[754] Exhibit 24, Tab 32, NSWPF Record of Interview, 'Interview with I217', 31 August 1982, Q20 (SCOI.10343.00043).

[755] Exhibit 24, Tab 35, NSWPF Record of Interview, 'Interview with I218', 3 September 1982, Q36 (SCOI.10343.00047).

[756] Exhibit 24, Tab 31, NSWPF Record of Interview, 'Interview with I219', 27 August 1982, Q7 (SCOI.10343.00044).

[757] Exhibit 24, Tab 31, NSWPF Record of Interview, 'Interview with I219', 27 August 1982, Q36-Q37 (SCOI.10343.00044).

5.950. Both I219 and I217 also refer to an incident when Mr Miller bashed a man at Piper's Nightclub. I217 refers to the victim being gay and says that he was bashed because he had "dobbed Jeff in to the police".[758] This assault described corresponds with a police report of an assault allegedly committed by Mr Miller upon a man at Piper's Nightclub on 16 November 1980,[759] one month before the assault on Mr Slater. In the police report Mr Miller is described as a "well known homosexual", the complainant is described as "effeminate", and the nightclub is described as "a well-known hangout for homosexuals".[760]

5.951. Accordingly, if the Inquiry were satisfied that Mr Miller was the perpetrator, there is evidence that he had a practice of targeting beat users as targets for robbery. Counsel Assisting submitted that Mr Miller did make a practice of targeting men who were beat users, or who were presumed to be beat users, this is likely to have been for the reason that they were seen as "easy targets" of robbery who might be unlikely to report being attacked, or whose reports might not be the subject of vigorous police investigation.

5.952. Counsel Assisting submitted that, as noted in **Chapter 1,** for the purpose of assessing whether the assault a person was wholly or partially motivated by LGBTIQ bias, it is not necessary to make any finding or come to any conclusion about a person's sexuality. There is no evidence before the Inquiry to suggest that Mr Slater was previously known or targeted on any basis other than his presence or conduct in the toilet block that day.

5.953. I216 did not definitively identify the man in the toilet block as Mr Slater, but the weight of the evidence indicates that it was, noting the evidence of both I216 and Mr Miller than Mr Miller entered the toilet block shortly after I216 left it.

5.954. Counsel Assisting submitted that I216's opinion on the implications to be drawn from the man's conduct must be treated with caution. While those accounts by I216 would suggest the man was acting unusually, this interaction between the man and I216 occurred within a very limited timeframe. The implications to be drawn from that conduct, even if accurately described, might be considered highly subjective, especially given I216's prior knowledge (which may well not have been shared by Mr Slater) that the area was a beat. More importantly, I216's description would provide support for a conclusion that the man was acting in such a way that may have been interpreted by a person entering the toilet block as a sexual advance, and thus cause that person to identify him as member of the LGBTIQ community.

5.955. Further, Counsel Assisting submitted the record of interview accounts of both I216 and I217 tend to suggest that Mr Miller entered the toilet block on the understanding (whether correct or not) that the occupant was present in the toilet as a beat user.

[758] Exhibit 24, Tab 32, NSWPF Record of Interview, 'Interview with I217', 31 August 1982, Q37 (SCOI.10343.00043).

[759] Exhibit 24, Tab 42, NSWPF Crime Information Report, 28 November 1980 (NPL.0121.0001.0416).

[760] Exhibit 24, Tab 42, NSWPF Crime Information Report, 28 November 1980 (NPL.0121.0001.0416).

5.956. In those circumstances, Counsel Assisting submitted it is open to infer that Mr Miller entered the toilet with the intention of robbery, including the potential use of violence upon the vulnerable occupant, who, as a beat user, was considered to be an "easy target" of robbery. Counsel Assisting submitted that LGBTIQ bias may exist in such a case, when an offender "discriminatorily selects" a victim due to that victim's membership in the LGBTIQ community, actual or presumed, even if animus towards the victim as an actual or perceived member of the LGBTIQ community did not motivate the crime.

5.957. The NSWPF submitted that, in the absence of a positive conclusion as to the identity of the perpetrator, it is not possible to determine with certainty whether the assault on Mr Slater was motivated by LGBTIQ bias.[761] The NSWPF submitted that it remains possible that, for example, Mr Slater was assaulted in an opportunistic robbery entirely unrelated to the status of the toilet block as a beat. Accordingly, it is said that I could find no more than that it was "possible" the attack of Mr Slater was motivated by "gay hate".[762]

5.958. On the assumption that Mr Miller was in fact the perpetrator, the NSWPF submitted that, in circumstances where Mr Miller was himself a member of the LGBTIQ community and had no demonstrated animosity towards it, a distinction should be drawn between the selection of beat users as "easy targets" and "hate".[763]

5.959. I accept Counsel Assisting's view that if Mr Slater's death occurred at the hands of Mr Miller, it is likely to have involved the targeting, or "discriminatory selection" of someone presumed to be a beat user (whether or not this was a correct assumption) on the basis that he was therefore seen as a vulnerable target of robbery. Such a case (regardless of whether the perpetrator, additionally, had or exhibited an anti-LGBTIQ animus) is one in which LGBTIQ bias is present.

5.960. If Mr Miller was not involved in Mr Slater's death, there is nevertheless significant evidence suggesting the presence of LGBTIQ bias in the assault, being the location, the fact that Mr Slater denied being assaulted, and the presence of semen.

Conclusions and Recommendations

5.961. I find that Mr Slater died on 22 December 1980 at Royal Newcastle Hospital as a result of myocardial infarction which was precipitated by severe traumatic brain injury received as a result of being assaulted on 19 December 1980 at Birdwood Park in Newcastle.

5.962. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in Mr Slater's death.

[761] Submissions of NSWPF, 1 June 2023, [67] (SCOI.83645).

[762] Submissions of NSWPF, 1 June 2023, [69] (SCOI.83645).

[763] Submissions of NSWPF, 1 June 2023, [68] (SCOI.83645).

5.963. Accordingly, I make the following recommendation:

Recommendation 1

I recommend that the Commissioner of the NSWPF or a serving police officer make an application for a fresh inquest, in relation to the death of Mr Slater, having regard to the evidence considered by the Inquiry and the findings and conclusions I have made in relation to manner and cause of death.

IN THE MATTER OF GERALD CUTHBERT

Factual background

Date and location of death

5.964. Gerald Cuthbert died on 18 October 1981, in an apartment in the suburb of Paddington in Sydney. His death was estimated to have occurred between 2:15am and 8:15am.[764]

Circumstances of death

5.965. Mr Cuthbert was 27 years old at the time of his death. He was of Fijian descent, and had family in both Australia and New Zealand. Mr Cuthbert was a practising Christian, and was struggling with his concern that homosexuality was not compatible with his faith. He had therefore decided, a little over a year before his death, to make a "complete break from homosexuality", though he had various relationships with men throughout his life, including some after this decision.[765]

5.966. Mr Cuthbert's body was found at 6:15pm on Sunday, 18 October 1981, by I212 (a pseudonym) and Simon Cant, the residents of the Paddington apartment in which he died, shortly after arriving home.[766] I212 had previously been in a relationship with Mr Cuthbert, and had shared the Paddington apartment with Mr Cuthbert at that earlier time. Mr Cuthbert ended the relationship in about June-July 1990 because of his concern that it was incompatible with his Christian faith. I212 was also a practising Christian. They had maintained a friendship following their separation, and Mr Cuthbert continued to visit and use the apartment.[767]

[764] Exhibit 16, Tab 2, Post-mortem Report of William Harold Brighton, 14 December 1981 (SCOI.10027.00004).

[765] Exhibit 16, Tab 9, NSWPF Record of Interview, 'Interview with I212', 18 October 1981, Q18 (SCOI.10024.00006).

[766] Exhibit 16, Tab 9, NSWPF Record of Interview, 'Interview with I212', 18 October 1981, Q24 (SCOI.10024.00006); Exhibit 16, Tab 11, NSWPF Record of Interview, 'Interview with Simon Richard Cant', 18 October 1981, Q15 (SCOI.10027.00009); Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 1-3 (SCOI.82540).

[767] Exhibit 16, Tab 9, NSWPF Record of Interview, 'Interview with I212', 18 October 1981 (SCOI.10024.00006).

5.967. Mr Cuthbert was found lying naked and prone in a pool of blood on a bed. There were over 60 stab wounds to his body and his throat was cut. The bed covers were pulled back but covering his feet, and there was no evidence that they had been greatly disturbed.[768] The room did not appear to have been ransacked, and Mr Cuthbert's watch was on the bedside table.[769] There were no signs of forced entry to the flat.[770]

5.968. Clothes were found on the floor next to the bed, including a long sleeve white shirt with faint stripes, a pair of khaki-coloured jeans, and a damp blue denim jacket.[771]

5.969. No murder weapon was located in the apartment, the apartment block or in the surrounding area.[772] No knives were noted to be missing from the apartment, suggesting that the perpetrator carried the knife to the apartment.[773]

5.970. The identity of the person who killed Mr Cuthbert remains unknown.

Previous investigations

Post-mortem examination

5.971. A post-mortem examination was conducted on 18 October 1981 by Dr William Brighton. Dr Brighton identified a total of 62 stab wounds: 48 wounds in Mr Cuthbert's back, six wounds on the left side of the chest and eight wounds on the left side of the neck and the left shoulder. The stab wounds had penetrated Mr Cuthbert's lungs, heart, diaphragm, liver and spleen. The wounds were apparently inflicted by a knife with one sharp edge, and the maximum width of the wounds at the skin surface was 2cm. Mr Cuthbert's throat had been cut, and there were no defensive wounds.[774]

5.972. In his report, dated 14 December 1981, Dr Brighton expressed that the direct cause of death was "cut throat and multiple incised penetrating wounds of the chest."[775]

5.973. Mr Cuthbert's blood was tested and was negative for drugs and alcohol.[776]

Original police investigation

5.974. The original police investigation was conducted by Detective Sergeant Michael Arthur Hagan and Detective Senior Constable Mervyn James Hunter from the NSWPF Homicide Squad.[777]

[768] Exhibit 16, Tab 7, Statement of Detective Sergeant Roger William Johnson, undated (SCOI.10026.00002).

[769] Exhibit 16, Tab 7, Statement of Detective Sergeant Roger William Johnson, undated (SCOI.10026.00002).

[770] Exhibit 16, Tab 21, Statement of Detective Senior Constable Mervyn James Hunter, 4 July 1984, [3] (SCOI.10027.00002).

[771] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 12 (SCOI.82540).

[772] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 11 (SCOI.82540).

[773] Exhibit 16, Tab 37, NSWPF Report of Occurrence bundle, 18 October 1981, 2-3 (SCOI.84936).

[774] Exhibit 16, Tab 2, Post-mortem Report of William Harold Brighton, 14 December 1981, 2 (SCOI.10027.00004).

[775] Exhibit 16, Tab 2, Post-mortem Report of William Harold Brighton, 14 December 1981, 1 (SCOI.10027.00004).

[776] Exhibit 16, Tab 3, Toxicology Report of Allen Ernest Hodda, 6 November 1981 (SCOI.10027.00015).

[777] Exhibit 16, Tab 21, Statement of Detective Senior Constable Mervyn James Hunter, 4 July 1984, [3] (SCOI.10027.00002).

5.975. The original police investigation into possible persons of interest was thorough. It involved, amongst other things, forensic testing of exhibits (to the extent available in 1981); attempting to locate and interview all persons associated with Mr Cuthbert or named in paperwork at Mr Cuthbert's residence; canvassing clubs and pubs in the vicinity of the apartment or that he was known to frequent; canvassing residents of neighbouring rooms to Mr Cuthbert's accommodation at the YMCA; contacting gay media outlets to seek information from the broader gay community; interviewing persons who attended St Vincent's Hospital presenting with lacerations; obtaining a record of all vehicles in the area at the time; and investigating the maker of the socks found in the apartment.[778]

5.976. The scenario advanced by police was that Mr Cuthbert met someone after leaving the YMCA and took that person back to his apartment, where he was murdered after engaging in sexual intercourse.[779] Media articles at the time indicated that police suspected that Mr Cuthbert had returned to the apartment with the killer between 1:00am–2:00am.[780]

5.977. In the course of their enquiries, police considered numerous possible persons of interest in relation to Mr Cuthbert's death. One hypothesis considered was that Mr Cuthbert was killed by a US naval officer from one of four US naval ships in port in Sydney at the time of his death.[781] However, police ultimately were unable to obtain any evidence which connected any person with the death of Mr Cuthbert.

Forensic testing

5.978. Investigating police collected a number of exhibits from the crime scene and submitted them for forensic testing, including:

a. A handkerchief (on which blood was detected);

b. Anal swabs and smears from Mr Cuthbert (on which semen was detected);

c. A blood-stained sock; and

d. Two cigarette butts (on which saliva was detected).[782]

5.979. Semen was present on the anal swabs and smears. The concentration of semen on the anal swabs was insufficient for conclusive grouping results. This meant that the blood group of the depositor was not able to be determined. The semen stains on the handkerchief were consistent with not having originated from Mr Cuthbert.[783]

[778] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates (SCOI.82540).

[779] Exhibit 16, Tab 24, NSWPF Incident Report, 5 November 1981 (SCOI.10031.00004).

[780] Exhibit 16, Tab 28, 'Blood-stained socks vital murder clue', *The Sun* (Sydney, 25 November 1981) (SCOI.10031.00007).

[781] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 25 (SCOI.82540).

[782] Exhibit 16, Tab 4, Forensic Biology Report of Annette Louise Henry, 23 February 1982, 2 (SCOI.10027.00005).

[783] Exhibit 16, Tab 4, Forensic Biology Report of Annette Louise Henry, 23 February 1982, 2 (SCOI.10027.00005).

5.980. Human blood was detected on the handkerchief and the sock. There was insufficient blood present on the handkerchief for grouping results. Grouping tests revealed that the blood on the sock was consistent with having originated from Mr Cuthbert, although a significant percentage of the population would share the same blood grouping as Mr Cuthbert.[784]

5.981. A substantial amount of saliva was present on the two cigarette butts, but no blood group substances were detected. These results indicated that the cigarette butts were smoked by a non-secretor. Mr Cuthbert was determined to be a secretor and, therefore, unlikely to have been the contributor of the saliva on the cigarette butts.[785]

Fingerprint analysis

5.982. A number of identifiable fingerprints were obtained from the crime scene on 18 October 1981, including on the exit door, the vanity mirror in the bathroom, a coffee jar, a hand cream tube and a coffee table.[786] On or around 21 October 1981, a fingerprint was obtained from an exhibit located at the scene, described as an "OHMS Official envelope with various addresses."[787] Police believed that money had been stolen from this envelope by the offender.[788]

5.983. The original fingerprint examination in 1981 involved the manual comparison of the fingerprints in the apartment to suspects or elimination fingerprint records obtained by police. The fingerprints on the hand cream tube were matched to Mr Cuthbert.[789] The remaining fingerprints were compared against the fingerprints of people known to have been in the flat (including I212, Mr Cant and their friends from the Bondi Fellowship), with a negative result.[790]

5.984. In 1990, 2005 and 2022, Police conducted automated comparisons of the unidentified fingerprints with fingerprint records on the National Automated Fingerprint Identification System (**NAFIS**) database. Notwithstanding the fact the 2022 review utilised improved digital photographs and comparison software, each of these reviews failed to identify any of the unknown fingerprints.[791]

5.985. In 2007, the unidentified fingerprints were sent, via Interpol, to the FBI for searching against their database. However, Police were informed that the latent fingerprints were too damaged for examination.

[784] Exhibit 16, Tab 4, Forensic Biology Report of Annette Louise Henry, 23 February 1982, 2 (SCOI.10027.00005); Exhibit 16, Tab 35, Expert Certificate of Michele Franco, 3 March 2023 (SCOI.82542).

[785] Exhibit 16, Tab 4, Forensic Biology Report of Annette Louise Henry, 23 February 1982, 2 (SCOI.10027.00005).

[786] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, 8 (SCOI.82540).

[787] Exhibit 16, Tab 33F, NSWPF Expert Certificate, 'Statement of Senior Crime Scene Officer Kate REID', 21 March 2023 (NPL.0100.0001.0040). The Expert Certificate describes the fingerprint as having been obtained on 20 October 1981. However, police running sheets indicate that the exhibit was provided to them on 21 October 1981.

[788] Exhibit 16, Tab 38, NSWPF Report of Occurrence, 'Further Information from I212', 23 October 1981 (SCOI.84937).

[789] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 9 (SCOI.82540).

[790] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 6-7 (SCOI.82540).

[791] Exhibit 16, Tab 33B, NSWPF Summary of Fingerprint Evidence, 6 March 2023 (NPL.0100.0001.0003); Exhibit 16, Tab 33F, NSWPF Expert Certificate, 'Statement of Senior Crime Scene Officer Kate REID', 21 March 2023 (NPL.0100.0001.0040).

Findings at inquest

5.986. An inquest was held at Glebe Coroners Court on 26 July 1984 before Coroner Sleeman.

5.987. The formal finding made by Coroner Sleeman was that, on 18 October 1981, Mr Cuthbert:[792]

> *died from the effect of a cut throat and multiple incised penetrating wounds of the chest sustained then and there are inflicted by a person or persons unknown.*

Criminal proceedings

5.988. No criminal proceedings have ever been instituted against any person in relation to Mr Cuthbert's death.

Strike Force Parrabell

Bias Crimes Indicators Form

5.989. A BCIF was completed by Strike Force Parrabell. It categorised the case overall as "Insufficient information".[793]

5.990. Of the ten indicators considered, five were categorised as "Insufficient Information", three were categorised as "No Evidence of Bias Crime" and two were categorised as "Suspected Bias Crime".[794]

5.991. One of the three indicators to which the response was "No Evidence of Bias Crime" was the first indicator, "Differences", where the prompt 'Victim was engaged in activities promoting his/her group' elicited the response "There is no evidence to suggest that CUTHBERT was engaged in activities promoting homosexuality at the time of his death".[795]

5.992. It is true that there is no evidence that Mr Cuthbert was involved in activism amongst, or on behalf of, the LGBTIQ community. However, what the BCIF meant by "promoting" is unclear. On one view, as a man openly engaging in romantic and sexual relationships with other men, Mr Cuthbert arguably was "promoting" his "group".

5.993. As I have noted elsewhere in this Report, much of the language of the BCIF lacks clarity and/or is ill-suited to the task at hand, and as a result many of the responses are often of little, if any, assistance.

[792] Exhibit 16, Tab 5, Findings of Margaret Mary Sleeman, Inquest into the death of Gerald Cuthbert, 26 July 1984 (SCOI.00019.00003).

[793] Exhibit 16, Tab 25, Strike Force Parrabell, Bias Crimes Indicators Review Form – Gerald Cuthbert, Undated 18 (SCOI.32127).

[794] Exhibit 16, Tab 25, Strike Force Parrabell, Bias Crimes Indicators Review Form – Gerald Cuthbert, Undated 18 (SCOI.32127).

[795] Exhibit 16, Tab 25, Strike Force Parrabell, Bias Crimes Indicators Review Form - Gerald Cuthbert, Undated 18 (SCOI.32127).

5.994. Two of the ten indicators were answered as 'Suspected Bias Crime', namely: 'Lack of Motive' and 'Level of Violence'. The responses to those indicators noted, respectively, the absence of an economic or robbery motive, and the excessive violence, but did not offer any reasoning as to why those factors indicate a "suspected bias crime" (as in my view they do, as referred to below).

5.995. The answer "Insufficient Information", in respect of five indicators, was perhaps inevitable in a case such as this one — i.e., where the identity of the perpetrator is unknown. The utility of such indicators in any such case is likely to be negligible.

5.996. The 'Summary of Findings' section is essentially an amalgam of extracts from earlier parts of the document, which themselves frequently repeat the same text. It nominates 'Insufficient Information' as the overall outcome. Whether that is because five of the ten indicators were answered in that way, or for some other reason, is not apparent.

Case Summary

5.997. The Strike Force Parrabell Case Summary for this matter (case summary 7) reads as follows:[796]

> ***Identity**: Gerard Leslie Cuthbert was 37 years old at the time of his death.*
>
> ***Personal History**: Mr Cuthbert was in a gay relationship for approximately 5 years. During that time Mr Cuthbert lived with his partner in a unit at Stephen Street, Paddington. During the year prior to his death Mr Cuthbert ended the relationship and moved into another residence however only months prior to his death Mr Cuthbert returned to live at the same address with his ex-partner in a 'friend's [sic] only relationship'.*
>
> ***Location of Body/Circumstances of Death**: Mr Cuthbert was murdered inside his ex-partner's unit. Prior to being murdered, Mr Cuthbert was last seen leaving the YMCA on the evening before his body was located by his flatmates, some 12 to 18 hours post mortem. Police interviewed all flatmates, each of whom had keys to the residence, as there were no signs of forced entry. Both surviving occupants of the unit were eliminated as suspects early in the investigation. A suggestion that some money had been stolen was not confirmed. Police identified several suspects however each was eliminated for different reasons. No signs of forced entry with all key holders accounted for left a strong presumption that Mr Cuthbert willingly allowed his attacker/s entry to the unit before he was killed.*
>
> ***Sexual Orientation**: Mr Cuthbert identified as gay in the five years prior to his death when he was in a gay relationship, although not at the*

[796] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Gerald Cuthbert, Undated 3 (SCOI.76961.00014).

time of his death. He was reportedly conflicted between being same sex attracted and adherence to religious faith.

***Coroner/Court Findings**: The post mortem cause of death was 'multiple incised penetrating wounds of the chest' with 'a total of 62 stab wounds.' No persons have been charged and the case remains unsolved. The motive for Mr Cuthbert's murder has also been unable to be determined.*

SF Parrabell concluded there was insufficient information to establish a bias crime

5.998. The content of this case summary is consistent with the comments made in the BCIF.

Academic Review

5.999. The academic reviewers also categorised this case as "Insufficient information".[797] The reasoning of the academic reviewers in this particular case is unknown.

Review by the Inquiry

5.1000. The Inquiry took the following steps in the course of examining the matter.

Summonses

5.1001. A summons was issued to the NSWPF on 18 May 2022 for, all documents relating to investigations by the NSWPF of the death of Mr Cuthbert, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Cuthbert. Material in relation to Mr Cuthbert was produced to the Inquiry on 8 June 2022.[798]

5.1002. On 23 August 2022, the Inquiry issued a summons to BDM for death certificates of the following persons (BDM2):

a. I212;

b. I213 (a pseudonym);

c. I214 (a pseudonym);

d. I215 (a pseudonym);

e. Mr Bennett;

f. Mr Cant;

g. Gavin Cuthbert;

[797] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Gerald Cuthbert, 3 (SCOI.76961.00014).

[798] Exhibit 16, Tab 36, Statement of Francesca Lilly, 24 March 2023, [6] (SCOI.82543).

h. Patrick McGeady;

i. Gerard Petre;

j. Bevan Tynan; and

k. Warwick Whitford.

5.1003. On 25 August 2022, BDM produced a death certificate for I214 along with information in relation to the death certificate searches for the remaining persons listed in the summons.[799]

5.1004. On 19 May 2023, following the hearing and tender of material in this matter, the Inquiry progressed further investigative steps by a summons to the NSW Port Authority, seeking information as to what ships were in port at the time of Mr Cuthbert's death (NSWPA1). This was aimed at pursuing a hypothesis raised by the original investigating officers that Mr Cuthbert may have been killed by a visiting sailor. On 23 May 2023, the NSW Port Authority advised that they did not hold any of the documents requested and proposed that the Inquiry contact Transport for NSW.

5.1005. On 19 June 2023, the Inquiry issued a summons to Transport for NSW seeking information as to what ships were in port at the time of Mr Cuthbert's death (TFN2). On 21 June 2023, Transport for NSW advised that they did not hold the records sought.

Interagency cooperation

5.1006. On 11 May 2022, the Inquiry issued a written request to the Coroners Court to obtain the coronial file in relation to the death of Mr Cuthbert. The Coroners Court answered the request and provided the coronial file on 26 May 2022.[800]

Family members

5.1007. The Inquiry liaised with external agencies to attempt to make contact with Mr Cuthbert's brothers, Trevor Cuthbert and Gavin Cuthbert. On 7 October 2022, it was ascertained that Gavin Cuthbert was deceased, and the Inquiry was advised that Trevor Cuthbert could not be located.

5.1008. A summons was issued to BDM on 17 March 2023 seeking a death certificate for Patrick McGeady, Mr Cuthbert's uncle (BDM17). On 21 March 2023, BDM advised that no trace could be found of Mr McGeady and that Queensland BDM may hold such records. A summons was issued to QBDM on 21 March 2023 (QBDM3), and a death certificate for Mr McGeady was received by the Inquiry on 30 March 2023.[801] He had died on 9 January 1999.

[799] Exhibit 16, Tab 36, Statement of Francesca Lilly, 24 March 2023, [23]–[24] (SCOI.82543).

[800] Exhibit 16, Tab 36, Statement of Francesca Lilly, 24 March 2023, [4]–[5] (SCOI.82543).

[801] Exhibit 16, Tab 40, Death Certificate of Patrick McGeady, 29 March 2023 (SCOI.84048).

Searches for exhibits

5.1009. On 23 September 2022, a letter of request was sent to the NSWPF in relation to the identifying and locating forensic exhibits and fingerprint records, with a deadline of 30 September 2022. On 26 September 2022, the NSWPF advised that no digital records had been found and sought an extension to 7 October 2022 in order to consult with entities external to the UHT for the purposes of seeking physical records. On 28 September 2022, the Inquiry advised the NSWPF that the request for an extension was granted. On 6 October 2022, the Inquiry was advised that the searches undertaken by the NSWPF had failed to locate the requested exhibits. A microfiche FASS file was located but was unfortunately unreadable.[802]

5.1010. On 25 November 2022, the Inquiry sent a further letter to the NSWPF, seeking that the NSWPF redouble their efforts to locate the specified exhibits. On 1 December 2022, the NSWPF advised the Inquiry that further searches had been conducted but had again been unsuccessful.[803]

5.1011. On 23 December 2022, the Inquiry wrote to the NSWPF and requested that a statement be provided by an appropriate officer detailing the searches conducted for the lost exhibits. On 18 January 2023, a statement was provided by Detective Sergeant Neil Sheldon detailing the searches undertaken by the NSWPF. This included: searches on the NSWPF exhibit management system called EFIMS; a review of all NSWPF investigative holdings; a search for and review of relevant exhibit books; searches of the long-term exhibit repository, the MEPC and enquiries with FASS, FETS and DOFM. No documents or exhibits were located.

5.1012. In his 18 January 2023 statement, Detective Sergeant Sheldon advised that the fingerprint file had been located. On 28 February 2023, the Inquiry wrote to the NSWPF and requested that further examinations be undertaken. The Inquiry pointed out that the UHT Review Case Screening Form in relation to Mr Cuthbert's death dated 11 October 2005 had noted that a review of the fingerprint file would be undertaken as part of the UHT's review. The Inquiry sought clarification as to whether this foreshadowed review had occurred.[804]

5.1013. In response to that request, and following correspondence between the Inquiry and the NSWPF, the following documents were provided on 23 March 2023 by the NSWPF in relation to fingerprint examinations in relation to Mr Cuthbert's death:

a. A document entitled "Summary of Fingerprint Evidence" dated 6 March 2023, prepared by Detective Leading Senior Constable Di Donato;[805]

b. An Expert Certificate dated 21 March 2023 prepared by Kate Reid, Senior Crime Scene Officer, Fingerprint Expert;[806]

[802] Exhibit 16, Tab 36, Statement of Francesca Lilly, 24 March 2023, [9]–[11] (SCOI.82543).

[803] Exhibit 16, Tab 36, Statement of Francesca Lilly, 24 March 2023, [13] (SCOI.82543).

[804] Exhibit 16, Tab 36, Statement of Francesca Lilly, 24 March 2023, [17] (SCOI.82543); Exhibit 16, Tab 31, Statement of Detective Sergeant Neil Sheldon, 18 January 2023 (SCOI.82580); Exhibit 16, Tab 33A, Letter from Enzo Camporeale to Patrick Hodgetts, 28 February 2023 (SCOI.45168).

[805] Exhibit 16, Tab 33B, NSWPF Summary of Fingerprint Evidence, 6 March 2023 (NPL.0100.0001.0003)

[806] Exhibit 16, Tab 33F, NSWPF Expert Certificate, 'Statement of Senior Crime Scene Officer Kate REID', 21 March 2023 (NPL.0100.0001.0040).

c. A major crimes report from 2005 indicating that there were no results arising from the 2005 review;[807] and

d. A bundle of documents from 2007 in relation to a request to the FBI via Interpol for comparison of the fingerprints in the United States.[808]

Further forensic examinations

5.1014. There have been significant advances in forensic testing technology since 1982 when the exhibits in Mr Cuthbert's case were first tested, among the most significant of which is the ability to extract and analyse DNA profile from organic material. Accordingly, the Inquiry made substantial efforts to have exhibits re-tested. However, as referred to above, retesting has not been possible because of the fact that many of the exhibits in Mr Cuthbert's case have been lost.

5.1015. On 1 November 2022, the Inquiry met with staff of FASS and made enquiries as to whether further testing could now be done on certain exhibits, specifically the sock and handkerchief, if they could be located. FASS confirmed that further testing could be conducted.

5.1016. Given the inability of the NSWPF to locate the exhibits in this matter, the Inquiry requested that FASS prepare a formal statement setting out the opportunities for forensic testing which might have been available if all of the exhibits were able to be located, and the nature of any information that may have been obtained from such testing to assist in the investigation into Mr Cuthbert's death.

5.1017. On 3 March 2023, Michele Franco, Group Manager, Evidence Recovery Unit at FASS, provided such a statement in the form of an Expert Certificate pursuant to s. 177 of the *Evidence Act*.[809]

5.1018. While noting that DNA does degrade over time, Ms Franco stated that semen and blood samples (as found on the sock, handkerchief, and anal swabs and smears) are "high yield DNA sources" that are typically targeted for testing in reviews of historic crimes.[810] Ms Franco stated that sperm, in particular, has relatively strong cellular walls, increasing the likelihood of long-term preservation.[811] The semen recovered on the anal swabs and smears were, therefore, likely to be of high forensic value in Mr Cuthbert's case.

5.1019. Ms Franco stated that testing for trace DNA (generally from skin cells) on the handkerchief would also be possible, although as a low yield DNA source it would not have been the first targeting option. Further, it is likely that the cigarette butts were "consumed" or destroyed in the original testing, and consequently no further testing opportunities exist in relation to those items.

[807] Exhibit 16, Tab 33D, NSWPF Major Crimes Running Sheet, 26 October 2005, 1 (NPL.0100.0001.0036).

[808] Exhibit 16, Tab 33E, Letter from Detective Sergeant Karen Fishburn to Interpol, 20 March 2007 (NPL.0100.0001.0038).

[809] Exhibit 16, Tab 35, Expert Certificate of Michele Franco, 3 March 2023, 2 (SCOI.82542).

[810] Exhibit 16, Tab 35, Expert Certificate of Michele Franco, 3 March 2023, 2 (SCOI.82542).

[811] Exhibit 16, Tab 35, Expert Certificate of Michele Franco, 3 March 2023, 2 (SCOI.82542).

5.1020. Ms Franco advised the Inquiry that if the exhibits were obtained, the following testing could have been performed:[812]

a. Autosomal testing: a DNA typing kit that tests 21 areas of DNA that vary widely between individuals in the population;

b. Y-STR testing: DNA testing on the Y-chromosome only; and

c. Mitochondrial testing: DNA testing on compromised samples where autosomal testing is unsuccessful.

5.1021. Ms Franco further advised that if a DNA profile had been recovered by using any of these testing options, it could have been directly compared to known reference samples or uploaded onto a searchable DNA database.[813] In the case of Mr Cuthbert, where there are no known persons of interest, matching a DNA profile on such a database could have had obvious potential importance.

Fingerprint analysis

5.1022. On 28 February 2023, the Inquiry requested that further comparative examination be undertaken of the unidentified fingerprints obtained from the crime scene, including on the exit door, the vanity mirror in the bathroom, a coffee jar, a hand cream tube and a coffee table. Analysis was conducted, both manually and against suspect and elimination fingerprint profiles on the NAFIS database. The following results were obtained:[814]

a. The fingerprints on the hand cream, the coffee table and the bathroom vanity mirror were matched to I212 or Mr Cuthbert;

b. The fingerprint on the coffee jar was unsuitable for any comparison due to lack of comparable detail; and

c. The fingerprint on the exit door and the fingerprint on the envelope were not identified, either when manually compared to elimination or suspect fingerprint records, or when searched on NAFIS.

5.1023. The identification of I212's fingerprints on locations within his own apartment is unsurprising and of no forensic value to the investigation of Mr Cuthbert's death.

[812] Exhibit 16, Tab 35, Expert Certificate of Michele Anne Franco, 3 March 2023, 2 (SCOI.82542).

[813] Exhibit 16, Tab 35, Expert Certificate of Michele Anne Franco, 3 March 2023, 2-3 (SCOI.82542.).

[814] Exhibit 16, Tab 33B, NSWPF Summary of Fingerprint Evidence, 6 March 2023 (NPL.0100.0001.0003); Exhibit 16, Tab 33F, NSWPF Expert Certificate, 'Statement of Senior Crime Scene Officer Kate REID', 21 March 2023 (NPL.0100.0001.0040); Exhibit 16, Tab 21, Statement of Detective Senior Constable Mervyn James Hunter, 4 July 1984, [3], [17] (SCOI.10027.00002); Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 6-10 (SCOI.82540).

5.1024. Given the improvements in fingerprint comparison capabilities, the Inquiry liaised with the FBI and requested on 24 July 2023 that the NSWPF make a formal request for the fingerprints at the exit door and on the envelope to be further analysed by the FBI. The NSWPF confirmed it would make those arrangements on 26 July 2023, but advised that such requests were ordinarily made through Interpol and that it may take several months to receive a response. On 8 August 2023, the NSWPF confirmed that it had made a request to the FBI for the fingerprints to be re-assessed.[815]

5.1025. On 11 August 2023, the NSWPF advised the Inquiry that the FBI had deemed the provided fingerprints suitable for comparison, but that no identifications had been made on their automated fingerprint database. The NSWPF confirmed that the FBI had added the fingerprints to their Unsolved Latent File and shared them with other US government agencies. The FBI also requested that the Naval Criminal Investigative Service (**NCIS**) search their fingerprint database with the fingerprints provided.

5.1026. On 23 October 2023, in response to the Inquiry's request for an update on the status of searches being undertaken by the NCIS, the NSWPF confirmed that the NCIS was still processing the Inquiry's request in its fingerprint database, and that no timeframe had been provided as to when the request would be finalised. The NSWPF advised the Inquiry that the FBI would advise the UHT when further information was known.[816] No further information regarding these searches has been received by the Inquiry as at the finalisation of this Report.

Professional opinions

5.1027. The Inquiry requested an expert report from a forensic psychiatrist, Dr Danny Sullivan, on 30 September 2022, and this was duly provided on 24 October 2022.[817] In his report, Dr Sullivan considered whether any aspects of the manner of death and/or crime scene may indicate that the homicide occurred in the context of LGBTIQ bias. Dr Sullivan considered that "the nature and extent of the injuries significantly exceed what is necessary to kill a person, and are consistent with an attack occurring in a frenzy, panic or overkill."[818] Dr Sullivan also noted the evidence suggesting "recent receptive anal sexual intercourse with a male partner".[819]

[815] Exhibit 16, Tab 44, Letter from Katherine Garaty to Enzo Camporeale, 8 August 2023 (SCOI.84928).

[816] Exhibit 16, Tab 48, Letter from Katherine Garaty to Enzo Camporeale, 23 October 2023 (SCOI.86363).

[817] Exhibit 16, Tab 29, Expert Report of Dr Danny Sullivan, 24 October 2022 (SCOI.82583).

[818] Exhibit 16, Tab 29, Expert Report of Dr Danny Sullivan, 24 October 2022, [12] (SCOI.82583).

[819] Exhibit 16, Tab 29, Expert Report of Dr Danny Sullivan, 24 October 2022, [12] (SCOI.82583).

5.1028. Dr Sullivan considered that a possible motivation of the attack was anger or distress if the unknown perpetrator was conflicted about their sexual orientation.[820] Dr Sullivan also noted that Mr Cuthbert's conflict about his sexuality and Christian faith may have been relevant to the offence.[821] However, Dr Sullivan acknowledged that both these possible motivating factors are "speculative", in circumstances where the offender is unknown.[822] Dr Sullivan considered that no other motive was apparent on the material.[823]

Contact with OIC

5.1029. On 30 August 2023 and 18 September 2023, the Inquiry wrote to Michael Arthur Hagan enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Cuthbert.[824] The Inquiry did not receive a response from Mr Hagan.

Consideration of the evidence

Mr Cuthbert's personal circumstances

5.1030. Mr Cuthbert was a member of an extended Fijian family. He had family members in both New Zealand and Australia with whom he kept in regular contact.

5.1031. Mr Cuthbert had previously been in a committed relationship with a male, I212, for approximately 5 years with whom he resided. However, in June 1980 Mr Cuthbert started to question his relationship with I212, and "wanted to know what the bible said about having homosexual relationships".[825] He ultimately decided that he wanted to make a "complete break from homosexuality", and on 4 July 1980, he moved out of I212's apartment and went to reside in a share house with five other Christian males in Pennant Hills.[826] Mr Cuthbert stayed in contact with I212, but they were not close over this period.

5.1032. In about January or February of 1981, Mr Cuthbert disclosed to I212 that he was having "problems with his homosexuality again", and ultimately left his residence in Pennant Hills and moved into the YMCA.[827] I212 invited Mr Cuthbert to stay with him, and informed Mr Cuthbert that he had become a Christian himself and "knew that those things [i.e., homosexuality] were wrong".[828]

[820] Exhibit 16, Tab 29, Expert Report of Dr Danny Sullivan, 24 October 2022, [13] (SCOI.82583).
[821] Exhibit 16, Tab 29, Expert Report of Dr Danny Sullivan, 24 October 2022, [15] (SCOI.82583).
[822] Exhibit 16, Tab 29, Expert Report of Dr Danny Sullivan, 24 October 2022, [13],[15] (SCOI.82583).
[823] Exhibit 16, Tab 29, Expert Report of Dr Danny Sullivan, 24 October 2022, [14] (SCOI.82583).
[824] Exhibit 66, Tabs 25-26, Letters to Michael Arthur Hagan, 30 August 2023 and 18 September 2023 (SCOI.86289; SCOI.86290).
[825] Exhibit 16, Tab 9, NSWPF Record of Interview, 'Interview of I212', 18 October 1981, Q18 (SCOI.10024.00006).
[826] Exhibit 16, Tab 9, NSWPF Record of Interview, 'Interview of I212', 18 October 1981, Q18 (SCOI.10024.00006).
[827] Exhibit 16, Tab 9, NSWPF Record of Interview, 'Interview of I212', 18 October 1981, Q20 (SCOI.10024.00006).
[828] Exhibit 16, Tab 9, NSWPF Record of Interview, 'Interview of I212', 18 October 1981, Q20 (SCOI.10024.00006).

5.1033. The two men restored a "friendship relationship", and Mr Cuthbert would come to I212's apartment for meals and showers, occasionally staying overnight.[829] For the three or four months prior to his death, Mr Cuthbert was coming over to the apartment every night, and was given a key to the apartment.[830]

5.1034. In about October 1981, Mr Cant became a flatmate of I212's. The two men had met through Christian activities. He denied being gay, or in a relationship with I212, or knowing Mr Cuthbert well.[831]

Mr Cuthbert's relationships prior to his death

5.1035. It is apparent that Mr Cuthbert had developed a sexual relationship with at least two men since separating from I212:

a. First, a man who Mr Cuthbert met at the Exchange Hotel in late September 1981 and had sex with twice before his death;[832] and

b. Secondly, a man who Mr Cuthbert met in the men's toilet at Town Hall Station on 14 July 1981 and had sex with twice before his death (as well as "playing around" on other occasions). On 7 August 1981, this man picked Mr Cuthbert up from I212's flat and was invited in by Mr Cuthbert (who was alone) for a coffee before they left, but they apparently did not have sex there.[833]

5.1036. Mr Cuthbert was also seen in the company of another unknown man when he visited a friend two weeks prior to his death, although whether that was a third person is difficult to determine from the description given.[834]

5.1037. Mr Cuthbert confided to a Deacon of his church that he had recently met two American men, perhaps sailors, with whom he had an excellent relationship and whom he had taken around Sydney.[835] The possibility of some relationship with an American soldier is supported by evidence from a doorman of the Midnight Shift bar, a Mr Peter Bennett, who claimed that in the early hours of the day on which he later died, Mr Cuthbert had enquired as to whether there were American sailors in the bar and left when he was advised that there were not.[836]

[829] Exhibit 16, Tab 9, NSWPF Record of Interview, 'Interview of I212', 18 October 1981, Q20 (SCOI.10024.00006).

[830] Exhibit 16, Tab 9, NSWPF Record of Interview, 'Interview of I212', 18 October 1981, Q20 (SCOI.10024.00006).

[831] Exhibit 16, Tab 11, NSWPF Record of Interview, 'Interview of Simon Richard Cant', 18 October 1981, Q5-Q9, Q15 (SCOI.10027.00009).

[832] Exhibit 16, Tab 12, NSWPF Record of Interview, 'Interview of 1213', 19 October 1981, Q6-Q8 (SCOI.10026.00004).

[833] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 20 (SCOI.82540).

[834] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 5 (SCOI.82540).

[835] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 19 (SCOI.82540).

[836] Exhibit 16, Tab 20, Statement of Peter Bennett, 23 October 1981, [2]–[3] (SCOI.10026.00008).

5.1038. There was also evidence from a Minister with the Assemblies of God Church in Hornsby that about a month before his death, Mr Cuthbert had disclosed to 1212 that he had recently renewed and then terminated a relationship, with the suggestion an argument had occurred over the breakup.[837] There is no further information as to the identity of the person in question, and police recorded that the Minister could not assist further.[838]

Events leading up to Mr Cuthbert's death

5.1039. I212 last saw Mr Cuthbert alive on the Thursday evening prior to his death (i.e., 15 October 1981).[839] In the months preceding his death, Mr Cuthbert disclosed that he was struggling with his sexuality.[840]

5.1040. On the weekend of Mr Cuthbert's death, I212 and Mr Cant had travelled with the "Bondi Fellowship" to see a Christian concert in Nowra, leaving Saturday morning 17 October 1981, staying in a caravan park in Bomaderry and returning in the evening of Sunday, 18 October 1981.

5.1041. At around lunchtime on Saturday, 17 October 1981, Mr Cuthbert went to the house of his uncle, Mr McGeady. Also present at the address were his brother, Trevor Cuthbert, and friend Anthony Farrell.[841] Later that same afternoon, Mr Cuthbert apparently went to the house of his brother, Gavin Cuthbert, and argued with him over money that was owed to I212.[842]

5.1042. He was next seen that day (Saturday, 17 October 1981) by the supervisor at the YMCA, Mr Petre, at approximately 5:30pm. Mr Cuthbert came down to reception and told Mr Petre that he was going with his brother and uncle to see a movie. However, at about 7:00pm or 7:15pm, he came back in, "obviously annoyed" because his brother and uncle did not arrive.[843] This is consistent with information from Mr McGeady, and Trevor Cuthbert.[844] Mr Petre thought that Mr Cuthbert had been waiting outside the YMCA during this period. Mr Cuthbert then said he was "going for a drink" and left.[845]

[837] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 4 (SCOI.82540).

[838] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 4 (SCOI.82540).

[839] Exhibit 16, Tab 9, NSWPF Record of Interview, 'Interview ofI212', 18 October 1981, Q21-Q23 (SCOI.10024.00006).

[840] Exhibit 16, Tab 9, NSWPF Record of Interview, 'Interview of I212', 18 October 1981, Q20 (SCOI.10024.00006).

[841] Exhibit 16, Tab 13, NSWPF Record of Interview, 'Interview with Patrick Henry Wentworth McGeady', 19 October 1981 (SCOI.10027.00010); Exhibit 16, Tab 15, Statement of Trevor Cuthbert, 19 October 1981 (SCOI.10027.00011); Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 16 (SCOI.82540).

[842] Exhibit 16, Tab 14, NSWPF Record of Interview, 'Interview of Gavin David Cuthbert', 19 October 1981 (SCOI.10027.00012).

[843] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 14-15 (SCOI.82540).

[844] Exhibit 16, Tab 13, NSWPF Record of Interview, 'Interview with Patrick Henry Wentworth McGeady', 19 October 1981 (SCOI.10027.00010); Exhibit 16, Tab 14, Statement of Trevor George Cuthbert, 19 October 1989 (SCOI.10027.00011).

[845] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 14 (SCOI.82540).

5.1043. However, he came back to the YMCA soon afterwards, at around 7:45-8:00pm. He went to his room to change, before returning to the reception area and again leaving the YMCA.[846] As he left, he told Mr Petre that if anyone asked for him to tell them that he was going to "his flat".[847] This is presumed to be the flat of I212, as there is no evidence that Mr Cuthbert had another residence.

5.1044. Mr Cuthbert was said by Mr Petre to be wearing denim jeans and a jacket, colour unspecified, when he left the YMCA. This is the last confirmed sighting of Mr Cuthbert.[848]

5.1045. Numerous other witnesses, who did not know Mr Cuthbert but said they recognised him from photographs or otherwise, claimed to have seen him at various venues up to 1:30am the next morning, either alone or in the company of a group, although their varying descriptions of his clothing, and incompatibilities of timing, suggest some or all may be cases of mistaken identity.[849] These possible sightings include:

a. Warrick Whitford, a barman at the "Spanners" Bar at the Exchange Hotel in Oxford Street Darlinghurst, served a man he later identified as Mr Cuthbert from a photograph shown to him on 21 October 1981. Mr Whitford said that Mr Cuthbert was at the bar for at least two hours, and left about 11:30pm. He was with three other men, who between them consumed at least seven to eight schooners of beer. They appeared to be in good spirits. At some point during the evening a fifth man spoke with Mr Cuthbert and asked Mr Whitford for pen and a paper, with which (Mr Whitford assumed) they exchanged numbers. Mr Whitford recalls they left by "going up to the 'Ragtime Follies' Bar" (also in the Exchange Hotel), and that Mr Cuthbert had at one point asked Mr Whitford if he was going to 'Patches' that night.[850]

b. Mr Whitford describes the person he saw (as seen, and as depicted in a photograph of Mr Cuthbert) as being "Lebanese" in appearance and having a Lebanese accent. He also reports him to be wearing a red shirt with a wide collar, unbuttoned halfway down his torso, and possibly tight blue jeans. This does not match either Mr Petre's description of Mr Cuthbert's clothing on that night, or the clothing found next to Mr Cuthbert's body.

c. Lance Broome, a security guard at the Hilton Hotel in George Street in the city, recalls seeing Mr Cuthbert alone at Julianna's Bar at various points in the night, from 9:00pm to 12:30am. He remembered the person was wearing a light coloured suit and overcoat with gold chains around his neck.[851] However, no other staff at the Hilton (at which Mr Cuthbert was a regular) recall seeing him that night, and this description of his clothing is also different both from

[846] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 14-15 (SCOI.82540). (NB. There are slight differences in the times given by Mr Petre each time police spoke to him.)

[847] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 14 (SCOI.82540).

[848] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 14 (SCOI.82540).

[849] Exhibit 16, Tab 18, Statement of Warwick David Whitford, 21 October 1981 (SCOI.10026.00009); Exhibit 16, Tab 20, Statement of Peter Bennett, 23 October 1981, [2]–[3] (SCOI.10026.00008); Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 14-15 (SCOI.82540).

[850] Exhibit 16, Tab 18, Statement of Warwick David Whitford, 21 October 1981 (SCOI.10026.00009).

[851] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 17-18 (SCOI.82540).

Mr Petre's description of what he was wearing when he left the YMCA and from the clothing found next to the body of Mr Cuthbert.

d. Mr Tynan, on leaving the Albury Hotel in Oxford Street Darlinghurst at around 10:00pm, claimed to have seen Mr Cuthbert walking down towards Paddington in the direction of the apartment, in the spitting rain, and in the company of an unknown man.[852] Mr Tynan did not know Mr Cuthbert personally but had previously seen Mr Cuthbert at venues.

e. Mr Tynan described the man with Mr Cuthbert as approximately 5'11", of medium build, with black curly hair and wearing a white shirt and jeans. This is consistent with some of the clothing (white shirt and jeans) found next to Mr Cuthbert when his body was found. Mr Tynan could not recall what Mr Cuthbert was wearing.

f. Mr Bennett, a doorman of the Midnight Shift hotel at 85 Oxford Street Darlinghurst, said that at about 1:30am, he was asked by a man with short dark hair and a distinct accent, whether there were any "American sailors" at the bar that night. Mr Bennett believed the man "was an Islander but he wasn't of dark complexion" — a description possibly applicable to Mr Cuthbert. He was wearing a dark coloured jacket that could have been denim that was "thoroughly saturated." His hair was also wet. Mr Bennett told him that there were not any American sailors at the bar, and suggested going to the Cross, after which the man left. He said he later recognised the man as Mr Cuthbert from pictures in the newspaper after his murder.[853]

g. Mr Bennett's description of the man wearing a "dark" jacket, possibly denim, which was wet, may be consistent with the "damp" blue denim jacket which was among the clothing found next to Mr Cuthbert's body. Mr Petre's description of what he was wearing when he left the YMCA also included a denim jacket.

5.1046. The variety of possible sightings that night, some of them seemingly irreconcilable as to clothing or timing or both, makes it difficult to determine Mr Cuthbert's actual movements that night. The post-mortem analysis suggests he had not been drinking alcohol.[854]

Observations of the crime scene

5.1047. On the evening of Sunday, 18 October 1981, I212, Mr Cant, and three other members of the Bondi Fellowship returned to the apartment at about 6:15pm. They discovered Mr Cuthbert's body shortly after arriving there, and contacted the police.[855]

[852] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 21 (SCOI.82540).

[853] Exhibit 16, Tab 20, Statement of Peter Bennett, 23 October 1981, [2]–[3] (SCOI.10026.00008).

[854] Exhibit 16, Tab 3, Toxicology Report of Allen Ernest Hodda, 6 November 1981 (SCOI.10027.00015).

[855] Exhibit 16, Tab 9, NSWPF Record of Interview, 'Interview of I212', 18 October 1981, Q24 (SCOI.10024.00006); Exhibit 16, Tab 11, NSWPF Record of Interview, 'Interview of Simon Richard Cant', 18 October 1981, Q15 (SCOI.10027.00009); Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 1-3 (SCOI.82540).

5.1048. The police made a note describing the clothes found on the floor next to the bed on which the body was found. It included one long sleeve white shirt with faint stripes, one pair of khaki-coloured jeans, and one damp blue denim jacket.[856]

5.1049. No murder weapon was located in Mr Cuthbert's flat, or in the apartment block or in the immediately surrounding area.[857] Further, no knives were noted to be missing from the flat, indicating that the killer may have carried the knife to the scene of the crime. From this it may be inferred either that the killer carried a knife as a matter of course, or that there was some element of premeditation in killing Mr Cuthbert.

5.1050. Fingerprints were found in various parts of the crime scene, including on the exit door, the vanity mirror in the bathroom, a coffee jar, a hand cream tube and a coffee table. As set out above, the fingerprints on the hand cream tube, vanity mirror and coffee table were matched to either Mr Cuthbert or I212, while the fingerprints on the coffee jar and exit door remain unidentified.[858]

5.1051. Noting I212 resided at the apartment where Mr Cuthbert's body was discovered, the identification of I212's fingerprints on locations within his own unit is unsurprising.

5.1052. Only I212, Mr Cant and Mr Cuthbert had keys to the flat.[859] Mr Cant reported being surprised that Mr Cuthbert was found in the flat, saying that he occasionally attended, but normally only to meet or wait for I212. Mr Cant thought that the towels in the loungeroom and the blood in the bathroom indicated he had made himself sufficiently at home to have a shower, and that that was unusual.[860]

5.1053. This does not accord with I212's evidence that Mr Cuthbert was a frequent visitor, with a key and permission to make use of the apartment for showering and cooking.[861] However, Mr Cant had only very recently become I212's flatmate, and it may be that he had not yet seen or become familiar with Mr Cuthbert and I212's relationship, or the habits of Mr Cuthbert. Mr Cant recalled observing two towels, while police recorded finding only one. It is unclear which of those accounts is accurate.

[856] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 12 (SCOI.82540).

[857] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 11 (SCOI.82540).

[858] Exhibit 16, Tab 33F, NSWPF Expert Certificate, 'Statement of Senior Crime Scene Officer Kate REID', 21 March 2023 (NPL.0100.0001.0040); Exhibit 16, Tab 21, Statement of Detective Senior Constable Mervyn James Hunter, 4 July 1984, [3], [17] (SCOI.10027.00002).

[859] Exhibit 16, Tab 11, NSWPF Record of Interview, 'Interview of Simon Richard Cant', 18 October 1981, Q19 (SCOI.10027.00009).

[860] Exhibit 16, Tab 11, NSWPF Record of Interview, 'Interview of Simon Richard Cant', 18 October 1981, Q34-Q35 (SCOI.10027.00009).

[861] Exhibit 16, Tab 9, NSWPF Record of Interview, 'Interview of I212', 18 October 1981, Q20 (SCOI.10024.00006); Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 21 (SCOI.82540).

5.1054. On 21 October 1981, I212 reported that he had discovered $48 missing from a blue government departmental envelope which related to his work. The envelope had been in I212's black case which was found on the bed with Mr Cuthbert's body. Whether this money was stolen by Mr Cuthbert's killer is unknown.[862] Even if the offender did steal the money, robbery does not appear to have been a motive for the offence, since the apartment was not looted or ransacked, and valuables such as Mr Cuthbert's watch remained on the bedside table.[863]

Persons of interest

5.1055. Police considered the possibility that Mr Cuthbert was killed by a person with whom he had previously been sexually involved, including I213 and I214.[864] However, both men had alibis for the evening, albeit not ironclad, and there is no evidence linking them to Mr Cuthbert's death. I213 voluntarily provided his fingerprints, which did not match any found at the crime scene.

5.1056. Police also considered the possibility that Mr Cuthbert was killed by an American sailor with whom he may have formed a relationship. One media article reported that a movie called "Cruising", depicting the murders of gay men by a psychotic killer, was shown aboard a naval ship on the night of Mr Cuthbert's murder; [865] however, that information is not confirmed in the police files. Police made inquiries with the Naval Police. They were advised that four American naval vessels, carrying thousands of American sailors, had departed Sydney on 21 October 1989, but that no record was kept of sailors taking shore leave.[866] Police made no enquiries as to the type of combat knife that was regularly used by sailors, nor whether they were permitted to carry knives on onshore leave. No further investigation was undertaken in relation to the American naval personnel.

5.1057. The additional steps undertaken by the Inquiry in relation to this line of enquiry are set out above. No further investigative leads have been able to be developed.

5.1058. The possibility that Mr Cuthbert was killed by one of the persons close to him remains remote. While it was technically possible for I212 or Mr Cant to have returned on the night of 17-18 October 1989, they would have had to make a three-hour train trip each way, and to have left and returned without detection. It is not submitted that either man should be regarded as a person of interest.

5.1059. Various other possible persons of interest were considered and investigated by police. These people were largely targeted on the basis of their involvement in similar crimes, or their reputation for robbing and assaulting gay men (sometimes under the guise of attending their residence as a sex worker). Ultimately, however, there was nothing linking any person to Mr Cuthbert's murder.[867]

[862] Exhibit 16, Tab 38, NSWPF Report of Occurrence, 'Further Information from I212', 23 October 1981 (SCOI.84937).

[863] Exhibit 16, Tab 36, Statement of Francesca Lilly, 24 March 2023, [29] (SCOI.82543).

[864] Exhibit 16, Tab 12, NSWPF Record of Interview, 'Interview of 1213', 19 October 1981, Q6-Q8 (SCOI.10026.00004); Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 13, 23-24 (SCOI.82540).

[865] Exhibit 16, Tab 28A, 'Brutal knife attacks shock community', *Campaign Australia* (Sydney, November 1981) 5 (SCOI.02178).

[866] Exhibit 16. Tab 21, Statement of Detective Senior Constable Mervyn James Hunter, 4 July 1984, [14] (SCOI.10027.00002); Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates, 25 (SCOI.82540).

[867] Exhibit 16, Tab 22, NSWPF Report of Occurrence bundle, various dates (SCOI.82540).

5.1060. Mr Cuthbert's case was widely reported, as was the killing of Peter Parkes, another gay man stabbed in his home in the eastern suburbs (only two — three days after Mr Cuthbert, on 20 October 1981).[868] Some three weeks later, a third gay man, Constantine Giannaris, was also killed in his Eastern Suburbs residence, on approximately 16 November 1981.[869]

5.1061. Two young male sex workers, Michael Caldwell (aged 19) and a 16 year old minor, were convicted of the murders of Mr Giannaris and Mr Parkes and received life sentences.[870] However, there are notable differences between the killing of Mr Cuthbert and those of Mr Parkes and Mr Giannaris, including:

a. Mr Parkes and Mr Giannaris were bound before they were killed, whereas Mr Cuthbert was not;

b. A significant motive in the murders of Mr Parkes and Mr Giannaris was robbery, with money, jewellery and cars being stolen and then used or pawned by Mr Caldwell and the minor. By contrast, little or no property appears to have been stolen at the time of Mr Cuthbert's death, which does not appear to have been motivated by robbery.

5.1062. There is no available evidence to link Mr Caldwell and the minor to the killing of Mr Cuthbert.

5.1063. The identity of the person who killed Mr Cuthbert remains unknown, and at this time there are no suspects or clear persons of interest.

Police investigation

5.1064. The primary concern identified by Counsel Assisting with the police investigation is in relation to the loss of critical exhibits. Counsel Assisting submitted that the proper retention, preservation and storage of exhibits relevant to an unsolved homicide is critical to facilitating the reinvestigation of cold cases. Retention is especially critical in relation to physical exhibits that could be the subject of further forensic examination in accordance with technological advances.

5.1065. In Mr Cuthbert's case, the systems for retaining and storing exhibits failed. Critical exhibits, including a blood and semen-stained handkerchief, and anal swabs and smears on which semen was detected, have been lost. These exhibits may well have held the key to identifying Mr Cuthbert's killer, and their loss could be the cause of Mr Cuthbert's murder remaining unsolved.

5.1066. The NSWPF acknowledged that the loss of exhibits was "undoubtedly lamentable", but asserted that "it is clear that processes for managing exhibits (both within the NSW Police and in the other relevant agencies) have changed dramatically in the intervening 40 years".[871]

[868] See, eg, Exhibit 16, Tab 28A, 'Brutal knife attacks shock community', *Campaign Australia* (Sydney, November 1981) 5 (SCOI.02178); Exhibit 16, Tab 27, Doug Button, 'Smoking clue in 'gay blade' killing', *The Sun* (Sydney, 12 November 1989) (SCOI.10031.00013).

[869] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Gerald Cuthbert and Peter Parkes, Undated 3–4 (SCOI.76961.00014).

[870] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Gerald Cuthbert, Undated 3 (SCOI.76961.00014).

[871] Submissions of NSWPF, 12 April 2023, [12], [13] (SCOI.45187)

5.1067. The available material fails to identify, when, how or why the relevant exhibits came to be unavailable. The evidence before the Inquiry about the NSWPF exhibit management instructions at the time of the investigation into Mr Cuthbert's death indicates that an exhibit was permitted to be destroyed once it had been analysed.[872] The NSWPF otherwise submitted that the exhibits may have been consumed in the original testing carried out by FASS.[873]

5.1068. In the context of the Investigative Practices Hearing, Counsel Assisting submitted that not all of the exhibits were likely to have been entirely consumed during the testing process.[874] This was accepted by Assistant Commissioner Conroy, in the course of her oral evidence.[875] Assistance Commissioner Conroy was unable to account for what may have happened to the exhibits.[876]

5.1069. The NSWPF conceded that, regardless of how or why the exhibits may have been destroyed, a record should have been made.[877] Assistant Commissioner Conroy confirmed that this indicated a failure in police procedures, even by the standards of the time.[878]

5.1070. In my view, the loss of critical exhibits is unacceptable by both contemporary and historic policing standards. If some, or all of the exhibits, were properly destroyed in accordance with the NSWPF exhibit management instructions, there ought to have been a clear record and/or justification for doing so, particularly in circumstances where the case clearly remained unsolved, and no persons of interest could be identified at that time.

5.1071. If these critical exhibits had been retained, or further information about them captured in NSWPF records, they could have been the subject of further forensic examination in accordance with technological advances.

Manner and cause of death

5.1072. I agree with Counsel Assisting that the original finding at the coronial inquest remains appropriate, namely Mr Cuthbert died on 18 October 1981 in Paddington "from the effect of a cut throat and multiple incised penetrating wounds of the chest sustained then and there and inflicted by a person or persons unknown."[879]

5.1073. The NSWPF made no submission to the contrary.

[872] NSWPF IPH subs [348]; Transcript of Inquiry, 4 July 2023, T4838.22-27 (TRA.00072.00001); Exhibit 51, Tab 2E, Instruction No. 33 – Exhibits and Miscellaneous Property, 1977 (NPL.9000.0003.0576).

[873] Submissions of NSWPF, 12 April 2023, [10], [11] (SCOI.45187).

[874] Submissions of Counsel Assisting – Investigative Practices Hearing, 15 September 2023, [696] (SCOI.85649).

[875] Transcript of the Inquiry, 4 July 2023, T4836.23-36 (TRA.00072.00001).

[876] Exhibit 51, Tab 4, Second Statement of Assistant Commissioner Rashelle Conroy, 11 June 2023, [36] (NPL.9000.0008.1049).

[877] Submissions of NSWPF – Investigative Practices Hearing, 10 October 2023, [348], (SCOI.86127)

[878] Transcript of the Inquiry, 4 July 2023, T4837.24 (TRA.00072.00001).

[879] Submissions of Counsel Assisting, 28 March 2023, [25], (SCOI. 45170.0001) citing Form 2 — Inquest Before Coroner Sitting Alone, 26 July 1984 (SCOI.00019.00003).

Bias

5.1074. There are obvious difficulties in assessing possible motives or biases of Mr Cuthbert's killer when that person's identity is unknown.

5.1075. However, as Counsel Assisting noted, the following factors indicate the possibility, if not likelihood, that Mr Cuthbert was killed in the context of LGBTIQ bias:

a. The nature and extent of Mr Cuthbert's injuries significantly exceed what is necessary to kill a person, and are consistent with a frenzied or panicked attack;

b. The evidence, including evidence suggesting receptive anal sexual intercourse with a male partner shortly before his death, suggests that Mr Cuthbert was likely killed by a person he took back to the apartment for the purpose of sex; and

c. The absence of evidence suggesting another motive for the crime.

5.1076. Counsel Assisting was careful to submit, nevertheless, that the evidence was not sufficient to ground a positive finding that Mr Cuthbert's death was one in which LGBTIQ bias was a factor.

5.1077. The NSWPF agreed that some form of LGBTIQ bias *may* have played a role in Mr Cuthbert's death, while submitting that the paucity of evidence regarding motivation means that it is not possible to advance one possibility in preference to another.[880]

5.1078. I agree that the evidence does not permit a positive conclusion that the death of Mr Cuthbert was motivated by LGBTIQ bias.

5.1079. However, as I have explained at **Chapter 1**, I have reached my conclusions on the question of whether a death is a "suspected LGBTIQ hate crime death", in relation to each of the deaths under consideration, not by reference to either the civil or the criminal standard of proof but by applying a different test, namely whether there is, objectively, reason to suspect both that the death was a homicide and that the sexuality or gender identity, actual or assumed, was a factor in the commission of the crime.

5.1080. In my view, by reference to that criterion, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in the death of Mr Cuthbert.

5.1081. In reaching this conclusion, I have considered the nature and extent of the injuries sustained by Mr Cuthbert, which Dr Sullivan described as being consistent with a "frenzy, panic or overkill" and which significantly exceeded what was necessary to kill a person.

[880] Submissions of NSWPF, 12 April 2023, [24] (SCOI.45187)

5.1082. I have also taken into account the evidence that Mr Cuthbert was a gay man and had engaged in receptive anal sexual intercourse with a male partner shortly before his death. It is likely that this sexual partner, who has not been identified, is the person responsible for Mr Cuthbert's death, noting the position and state of undress in which Mr Cuthbert's body was discovered.

5.1083. Finally, I agree with Dr Sullivan that the evidence before this Inquiry does not suggest any other cogent motive for the attack on Mr Cuthbert.

5.1084. In this regard, Dr Sullivan speculated that the person who killed Mr Cuthbert may have been angry or distressed with respect to their own sexual orientation, motivating them to attack Mr Cuthbert following their sexual encounter. Dr Sullivan also posited that Mr Cuthbert's own conflict about his sexuality and Christian faith may have been relevant to the offence.

5.1085. Whilst I consider Dr Sullivan's views as to possible motives for the murder of Mr Cuthbert relevant, I accept the submissions of Counsel Assisting and the NSWPF that the evidence does not enable me to make a positive finding in relation to the motivation for the attack on Mr Cuthbert, including whether LGBTIQ bias was, in fact, a substantive motivation.

5.1086. Notwithstanding this, I am satisfied that, considered together, the above circumstances relating to Mr Cuthbert's death are sufficient to, objectively, ground a suspicion that LGBTIQ bias was a factor in the death of Mr Cuthbert.

Conclusions and Recommendations

5.1087. I find that on 18 October 1981 Mr Cuthbert died in an apartment in Paddington, NSW as a result of a cut to his throat and multiple incised penetrating wounds of the chest sustained then and there and inflicted by a person or persons unknown.

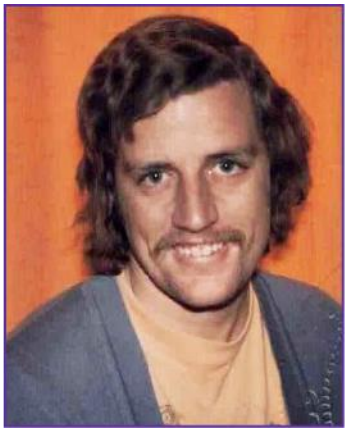
5.1088. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in Mr Cuthbert's death.

5.1089. I make the following recommendation:

Recommendation 3

I recommend that the NSWPF consider a reinvestigation into the death of Mr Cuthbert upon receipt of a response from the Federal Bureau of Investigation of the United States of America as to the results of any NCIS search.

IN THE MATTER OF PETER JOHN SHEIL



Factual background

Date and location of death

5.1090. Peter John Sheil died between 8:00pm on 27 April 1983 and 10:00am on 29 April 1983 at Gordons Bay, Clovelly.[881] Whether the evidence before this Inquiry allows me to make a narrower finding in relation to the time of Mr Sheil's death is discussed further below.

Circumstances of death

5.1091. Mr Sheil was 29 years old at the time of his death.[882]

5.1092. Mr Sheil had a history of mental illness and had been a patient at both the Prince of Wales Hospital (**POWH**) and Prince Henry Hospital (**PHH**) in Sydney in the years leading up to his death. He was thought to have "manic depressive illness or possibly schizoaffective psychosis".[883] Mr Sheil occasionally expressed "fleeting" suicidal ideation but denied having any serious intent.[884]

5.1093. At the time of his death, Mr Sheil had been living at the "Clovelly Flats" in Park Street, Clovelly. Mr Sheil had commenced living at the Clovelly Flats on 22 March 1983, after having been referred to the rehabilitation unit at The After Care Association of New South Wales (**Association**) by a social worker at the POWH Psychiatric Unit.[885] Patricia Campbell, who worked for the Association as the Supervisor in Charge of the Clovelly Flats, said that, at the time of his death, Mr Sheil's condition was being treated with medication and she considered that he had been responding to care and counselling and that his condition had been improving.[886]

[881] Exhibit 20, Tab 1, P79A Report of Death to Coroner, 2 May 1983, 1 (SCOI.11037.00003).

[882] Exhibit 20, Tab 5, Death Certificate of Peter Sheil, 14 September 1983 (SCOI.74053).

[883] Exhibit 20, Tab 9, Letter from Dr Christopher Rikard-Bell to the Coroner, 2 June 1983 (SCOI.11037.00007).

[884] Exhibit 20, Tab 9, Letter from Dr Christopher Rikard-Bell to the Coroner, 2 June 1983 (SCOI.11037.00007).

[885] Exhibit 20, Tab 8, Statement of Patricia Marlene Campbell, 31 May 1983, [2] (SCOI.11037.00009).

[886] Exhibit 20, Tab 8, Statement of Patricia Marlene Campbell, 31 May 1983, [1], [3] (SCOI.11037.00009).

5.1094. At around 8:00pm on 27 April 1983, Mr Sheil telephoned his mother from the Coogee Bay Hotel to inform her that he was about to walk home via the coastal track between Coogee and Clovelly.[887] According to the Report of Death to Coroner, Mr Sheil "did not appear depressed or in any way disressed [sic]" during this telephone call.[888] Indeed, Mr Sheil's brother, Hugh, in 2013 told Rick Feneley of the *Sydney Morning Herald* that Mr Sheil on the night of his death seemed to be "in good spirits".[889]

5.1095. Mr Sheil's body was found approximately 36 hours later, at around 10:00am on 29 April 1983, by Donald Ross, a Clovelly resident who was walking around the rocks at Gordons Bay.[890]

5.1096. According to Mr Ross, when he found Mr Sheil, he was "lying on his back between some rocks about 150 metres from the Clovelly Beach car park".[891] Mr Sheil was wearing a blue short-sleeved shirt that was open at the front, corduroy pants with his belt and fly undone, turquoise underpants, brown slip on shoes and white socks.[892] Mr Sheil's pants and underpants were around his hips and below the line of his pubic hair.[893] After finding Mr Sheil, Mr Ross went home to telephone the police before returning to the scene to await their arrival.[894]

5.1097. At around 11:00am on Friday, 29 April 1983, police attended the scene, with Scientific Squad Police attending later that same day to take photographs.[895] These photographs have not been produced to the Inquiry and, along with the entire NSWPF investigative file, appear to have been lost.

5.1098. After a relatively short investigation, police concluded that Mr Sheil had:[896]

> *ventured onto a rock ledge… and then lost his footing on the slippery undergrowth, causing him to fall to the rocks below and apparently striking his head.*

5.1099. Police also concluded that Mr Sheil had landed about three to six metres from where he was found and that he had "dragged himself a distance of about 6 metres and lay in a more comfortable position between rocks".[897]

[887] Exhibit 6, Tab 210, Rick Feneley, 'Up to 80 men murdered, 30 cases unsolved', *Sydney Morning Herald* (Sydney, 27 July 2013) 29 (SCOI.77369); Exhibit 20, Tab 21, Rick Feneley, 'He wasn't gay, but could Peter have been a gay-hate victim?', *SBS* (online, 27 September 2016) 3 <https://www.sbs.com.au/news/article/he-wasnt-gay-but-could-peter-have-been-a-gay-hate-victim/t2e3sm0rl> (SCOI.02439); Exhibit 20, Tab 1, P79A Report of Death to Coroner, 2 May 1983, 1 (SCOI.11037.00003).

[888] Exhibit 20, Tab 1, P79A Report of Death to Coroner, 2 May 1983, 1 (SCOI.11037.00003).

[889] Exhibit 6, Tab 210, Rick Feneley, 'Up to 80 men murdered, 30 cases unsolved', *Sydney Morning Herald* (Sydney, 27 July 2013) 29 (SCOI.77369).

[890] Exhibit 20, Tab 7, Statement of Donald McDonald Ross, 31 May 1983, [1] (SCOI.11037.00008).

[891] Exhibit 20, Tab 7, Statement of Donald McDonald Ross, 31 May 1983, [1] (SCOI.11037.00008).

[892] Exhibit 20, Tab 7, Statement of Donald McDonald Ross, 31 May 1983, [2] (SCOI.11037.00008).

[893] Exhibit 20, Tab 7, Statement of Donald McDonald Ross, 31 May 1983, [2] (SCOI.11037.00008).

[894] Exhibit 20, Tab 7, Statement of Donald McDonald Ross, 31 May 1983, [3] (SCOI.11037.00008).

[895] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [1]–[3] (SCOI.11037.00011).

[896] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [9] (SCOI.11037.00011).

[897] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [9] (SCOI.11037.00011); Exhibit 20, Tab 1, P79A Report of Death to Coroner, 2 May 1983, 1 (SCOI.11037.00003).

Previous investigations

Original police investigation

5.1100. The investigation into Mr Sheil's death was conducted by Randwick Police. Constable William Strange was the OIC of the investigation.

5.1101. Constable Strange first attended the scene with another officer, Constable Karskens, at about 11:00am on Friday, 29 April 1983, following the report of the incident by Mr Ross. After speaking to Mr Ross, Constable Strange and Mr Ross went to the location where Mr Ross found Mr Sheil's body.[898]

5.1102. Constable Strange described Mr Sheil as lying "between two large rocks" about five metres from the water's edge and 150 metres from the car park at Clovelly Beach.[899] However, Constable Strange described Mr Sheil as lying in a "prone position", which conflicts with Mr Ross's evidence unless Constable Strange was using "prone" in the looser, less precise sense of meaning "lying flat".[900]

5.1103. According to Constable Strange, an "investigation of the imediate [sic] area revealed" that about six metres from where Mr Sheil's body was found were "blood stains on the rocks and an amount of loose change", and there was a trail of blood stains from that location to Mr Sheil's body.[901] Constable Strange observed that Mr Sheil was:[902]

> *dressed in a blue short sleeve shirtwhich [sic] was opened, he was wearing blue corduory [sic] slacks and the fly on these was open and the pants were around the Deceased's hips, it was also noticed that the belt of the trousers was undone, he was also wearing a pair of turquoise underpants which were also down below the line of his pubic hair.*

5.1104. Constable Strange found a NSW Permanent Pass Book in Mr Sheil's shirt pocket that contained Mr Sheil's name and the address of the Clovelly Flats.[903] Mr Sheil also had $10 in notes on his person.[904]

5.1105. At some unspecified time that day (Constable Strange described the time as "[s]ome time later"), Scientific Squad Police attended the scene and took photographs of Mr Sheil and the scene.[905]

[898] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [1]–[2] (SCOI.11037.00011).
[899] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [2] (SCOI.11037.00011).
[900] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [2] (SCOI.11037.00011).
[901] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [2] (SCOI.11037.00011).
[902] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [3] (SCOI.11037.00011).
[903] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [4] (SCOI.11037.00011).
[904] Exhibit 20, Tab 1, P79A Report of Death to Coroner, 2 May 1983, 1 (SCOI.11037.00003).
[905] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [3] (SCOI.11037.00011).

5.1106. According to Constable Strange, an "inspection of the area above the rocks revealed" that there was a rock outcrop about 20 metres above Mr Sheil's body, which bore a "very mossy surface of a highly slippery nature".[906] A "magazine of a sexual nature" was found just below this rock outcrop.[907]

5.1107. At around 2:00pm that same day, Constable Strange visited the Clovelly Flats and informed Ms Campbell of Mr Sheil's death. Ms Campbell then accompanied Constable Strange to Mr Sheil's room and found phone numbers for Mr Sheil's parents.[908] Whilst at the Clovelly Flats, Constable Strange said he "ascertained that Peter Sheil was receiving psychiatric treatment and was an outpatient of the Prince of Wales Hospital Psychiatric Unit".[909]

5.1108. At some stage (Constable Strange again described the time as "[s]ome time later"), Constable Strange spoke with Mr Sheil's father, Peter Barry Sheil, about his son's death.[910] At around 1:50pm on 30 April 1983, Mr Sheil's father attended the City Morgue with Constable Strange and identified Mr Sheil's body.[911]

5.1109. According to Constable Strange, in the week following the discovery of Mr Sheil's body he "made enquiries in the imediate [sic] area of the death" as to anyone who might have witnessed anything "to no avail".[912] He also said that he conducted a "further investigation of the surrounding area".[913]

5.1110. Constable Strange ultimately reached the following conclusion about the manner of Mr Sheil's death:[914]

> *From the investigation carried out and the prevailing area in which the Deceased met his demise I have formed the opinion that the Deceased had ventured onto a rock ledge about 20 metres above the shoreline rock base of Thompsons Bay and then lost his footing on the slippery undergrowth, causing him to fall to the rocks below and apparently striking his head. It then appears that he dragged himself a distance of about 6 metres and lay in a more comfortable position between rocks. I am also of the opinion that the reason that the Deceased's clothing was in a state of disarray was caused by the fact that he had presumably been masterbating [sic] before his fall.*

[906] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [4] (SCOI.11037.00011).

[907] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [4] (SCOI.11037.00011).

[908] Exhibit 20, Tab 8, Statement of Patricia Marlene Campbell, 31 May 1983, [5] (SCOI.11037.00009); Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [5] (SCOI.11037.00011).

[909] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [5] (SCOI.11037.00011).

[910] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [6] (SCOI.11037.00011).

[911] Exhibit 20, Tab 6, Statement of Peter Barry Sheil, 30 April 1983, 1 (SCOI.11037.00010); Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [7] (SCOI.11037.00011).

[912] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [8] (SCOI.11037.00011).

[913] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [8] (SCOI.11037.00011).

[914] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [9] (SCOI.11037.00011).

5.1111. As noted above, any photographs of the scene or the magazine referred to by Constable Strange, that were taken by the Scientific Squad Police, have not been preserved. The only available description of the scene and the magazine is what is provided by Constable Strange. What precisely he meant by a magazine "of a sexual nature" is therefore not known. Likewise, the nature of the inquiries made by Constable Strange and the further investigation he undertook in the week following Mr Sheil's death is not readily apparent from the evidence before this Inquiry. Given that Constable Strange is deceased, these matters cannot now be explored further.

Post-mortem examination

5.1112. Dr Colin Goldschmidt conducted a post-mortem examination at 8:00am on 3 May 1983.[915]

5.1113. In the post-mortem report dated 3 June 1983, Dr Goldschmidt recorded the findings of his examination including that:

a. There was a 1.5cm laceration to the occipital region to the right of centre on Mr Sheil's scalp;

b. There were abrasions on both shoulders, the left buttock and the left hand;

c. There was bruising on both knees; and

d. There was a fracture dislocation of the cervical spine "between the 1st and 2nd cervical vertebrae" (with a notation that the "head moved freely on the cervical vertebral column"), and there were fractures to two ribs and the pelvis in two places.[916]

5.1114. Dr Goldschmidt estimated that Mr Sheil's death had occurred around three to four days prior to the post-mortem examination (i.e., between 8:00am on 29 April and 8:00am on 30 April 1983). The direct cause of death was recorded as being "multiple injuries".[917]

5.1115. In the toxicology report prepared by Dr Michael Leow, a small amount of alcohol was recorded as being in Mr Sheil's blood at the time of his death (0.018g per 100ml). Dr Leow also recorded that Mr Sheil's urine sample tested positive to cannabinoids, although he noted that this result "should be interpreted with caution due to the possibility of cross-reactivity with similar compounds".[918]

[915] Exhibit 20, Tab 3, Post-mortem Report of Dr Colin Goldschmidt, 3 June 1983, 1 (SCOI.11037.00004).

[916] Exhibit 20, Tab 3, Post-mortem Report of Dr Colin Goldschmidt, 3 June 1983, 1 (SCOI.11037.00004).

[917] Exhibit 20, Tab 3, Post-mortem Report of Dr Colin Goldschmidt, 3 June 1983, 1 (SCOI.11037.00004).

[918] Exhibit 20, Tab 2, Toxicology Report of Dr Michael Leow, 25 May 1983 (SCOI.11037.00005).

Exhibits

5.1116. There is no record of any exhibits being retained in the immediate aftermath of Mr Sheil's death. The clothing Mr Sheil was wearing at the time of his death was destroyed with the authorisation of Mr Sheil's father, and his personal property was returned to his father.[919]

Persons of interest

5.1117. No persons of interest in relation to Mr Sheil's death were identified at the time, nor subsequently.

Findings at inquest

5.1118. The Coroners Court file produced in relation to Mr Sheil revealed that an inquest was dispensed with on 1 September 1983. The Coroners Court "summary sheet" recorded that Mr Sheil's death occurred at the "bottom of a cliff at Thompsons Bay", the cause of death was "multiple injuries", and the manner of death was a "fall".[920] The time of death was recorded as being between 8:00pm on 27 April 1983 and 10:00am on 29 April 1983.

Strike Force Parrabell

Bias Crimes Indicators Form

5.1119. A BCIF was completed by Strike Force Parrabell in this case.[921] However, Strike Force Parrabell relied entirely on two media articles written by journalist Rick Feneley about Mr Sheil's death to complete the BCIF. This may have been because, as noted above, the NSWPF was unable to locate their investigative file in relation to Mr Sheil's case or obtain access to the Coroners Court file.

5.1120. The first of the media articles relied upon by Strike Force Parrabell was entitled 'Up to 80 men murdered, 30 cases unsolved' and was published by the *Sydney Morning Herald* on 27 July 2013.[922] The second article was entitled 'He wasn't gay, but could Peter have been a gay hate victim?' and was published online by SBS on 27 September 2016.[923]

[919] Exhibit 20, Tab 6, Statement of Peter Barry Sheil, 30 April 1983, 1 (SCOI.11037.00010); Exhibit 20, Tab 1, P79A Report of Death to Coroner, 2 May 1983, 1 (SCOI.11037.00003).

[920] Exhibit 20, Tab 4, Coroners Court Summary Sheet, 1 September 1983 (SCOI.11037.00002).

[921] Exhibit 20, Tab 16, Strike Force Parrabell, Bias Crimes Indicators Review Form – Peter Sheil, undated (SCOI.02996).

[922] Exhibit 6, Tab 210, Rick Feneley, 'Up to 80 men murdered, 30 cases unsolved', *Sydney Morning Herald* (Sydney, 27 July 2013) 29 (SCOI.77369).

[923] Exhibit 20, Tab 21, Rick Feneley, 'He wasn't gay, but could Peter have been a gay hate victim?', *SBS* (online, 27 September 2016) <https://www.sbs.com.au/news/article/he-wasnt-gay-but-could-peter-have-been-a-gay-hate-victim/t2e3sm0rl> (SCOI.02439).

5.1121. Given the absence of source material, it is perhaps not surprising that the BCIF completed in relation to this case contains analysis that could be generously described as superficial. The BCIF repeats the same handful of observations about Mr Sheil's death made by his brother, Christopher Sheil, to Mr Feneley, and the responses to each indicator are generalised and unoriginal. Furthermore, the BCIF did not address or analyse any of the matters that were readily apparent from the coronial file including the results of the original police investigation and the fact that Mr Sheil's trousers and underwear were around his hips and below the line of his pubic hair (in the latter regard, the BCIF noted only that the "fly of his trousers was undone").[924]

5.1122. Inevitably, in the circumstances, the Strike Force Parrabell officer/s who completed the BCIF in relation to this case concluded that in relation to all ten BCIF indicators, that there was "Insufficient Information" to make a determination in regard to bias motivation.[925]

Case Summary

5.1123. The Inquiry has been provided with a Case Summary summarising the final results of Strike Force Parrabell with respect to this matter.

5.1124. Strike Force Parrabell categorised the case as "Insufficient Information" to make a determination about bias motivation.[926]

5.1125. The matter was further categorised as "Unsolved".[927]

5.1126. The Case Summary read as follows:[928]

> ***Identity:*** *Peter Sheil was 29 years old at the time of his death.*
>
> ***Personal History****: In a recent media interview Mr Sheil's brother indicated that Mr Sheil was suffering from mental illness, stating: "He (Peter) wrote extraordinary poetry. It was a way to attract the girls. Peter wasn't gay, but he was mentally ill and he could be very gregarious and reckless. It's plausible that he was mistaken for being gay while walking through a gay beat – that he was attacked for that reason." Mr Sheil's mother insisted that he was not depressed prior to his death.*
>
> ***Location of Body/Circumstances of Death****: Mr Sheil's body was located with multiple injuries and without trousers at the base of a cliff known as Thompson's Bay, north of Coogee. Strike Force Parrabell did not locate any NSWPF holdings relating to the death of Mr Sheil. Information reviewed was from open media sources only. According to the limited information reviewed, on the night of his death Mr Sheil telephoned his mother saying he would walk home from the Coogee Bay Hotel via the*

[924] Exhibit 20, Tab 16, Strike Force Parrabell, Bias Crimes Indicators Review Form – Peter Sheil, Undated 1 (SCOI.02996).

[925] Exhibit 20, Tab 16, Strike Force Parrabell, Bias Crimes Indicators Review Form – Peter Sheil, Undated 3–6, 8–12, 14 (SCOI.02996).

[926] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Peter Sheil, Undated 5 (SCOI.76961.00014).

[927] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Peter Sheil, Undated 5 (SCOI.76961.00014).

[928] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Peter Sheil, Undated 5 (SCOI.76961.00014).

> *sea-cliffs path. At the time, the ocean path passed through a known gay beat area.*
>
> ***Sexual Orientation/Psychological Health**: Mr Sheil was described by his family as heterosexual, suffering mental illness.*
>
> ***Coroner/Court Findings**: There was no evidence of other persons involvement in Mr Sheil's death. From the limited information reviewed the circumstances surrounding Mr Sheil's death could not be established.*
>
> ***SF Parrabell concluded there was insufficient information to establish a bias crime***

5.1127. Various inaccuracies in this Case Summary are concerning and speak to a lack of attention to detail. The summary erroneously stated that Mr Sheil was found "without trousers".[929] In fact, as noted above, Mr Sheil's trousers were still on, but the fly was open, and the trousers were lowered to the level of his hips. The fact that his fly was open appeared in the 2016 Article on which the Strike Force Parrabell officers apparently relied, and indeed was noted in some of the responses to the ten indicators contained in the BCIF.[930] However, the Case Summary sets out an inaccurate account, derived, it would seem, from the 2013 Article (which does contain the phrase "without trousers").

5.1128. The Case Summary also stated that the Coroner concluded that: "there was no evidence of other persons [sic] involvement in Mr Sheil's death. From the limited information reviewed the circumstances surrounding Mr Sheil's death could not be established."[931] This is not accurate, in that an inquest was dispensed with and no such findings were ever made.

Academic review

5.1129. The academic review categorised the case as "Insufficient Information".[932] The reasoning of the academic reviewers is unknown, however the outcome likely reflects that the only source material used by Strike Force Parrabell was two media articles.

Review by the Inquiry

5.1130. The Inquiry took the following steps in the course of examining the death of Mr Sheil.

[929] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Peter Sheil, Undated 5 (SCOI.76961.00014).

[930] See, eg, Exhibit 20, Tab 16, Strike Force Parrabell, Bias Crimes Indicators Review Form – Peter Sheil, Undated 1, 11 (SCOI.02996).

[931] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Peter Sheil, Undated 5 (SCOI.76961.00014).

[932] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Peter Sheil, Undated 5 (SCOI.76961.00014).

Summonses

BDM

5.1131. On 16 September 2022, a summons to BDM was issued for the birth and death certificates for Mr Sheil (BDM3). On 20 September 2022, both certificates were produced.

5.1132. On 1 August 2023, the Inquiry issued a further summons to BDM for any death certificate and/or search of the death result for Ms Campbell (BDM53). On 2 August 2023, BDM produced a death certificate for Ms Campbell which indicated that she died in 2021.[933]

DOFM

5.1133. On 14 November 2022, a summons to DOFM was issued for all material held in relation to Mr Sheil, including photographs, CT images and/or notes relevant to his post-mortem examination on 3 May 1983 (DOFM3).[934]

5.1134. On 23 November 2022, one file was produced containing the Report of Death to Coroner, and the post-mortem and toxicology reports.[935]

NSWPF

5.1135. On 18 May 2022, a summons to the NSWPF was issued for, relevantly, all documents relating to investigations by the NSWPF into the death of Mr Sheil, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Sheil. No material was produced in response to that summons in relation to Mr Sheil.

5.1136. On 12 September 2022, the Inquiry wrote to the NSWPF noting that in the NSWPF documents contained in the Coroners Court file, Mr Sheil's last name is spelled incorrectly at various times, including, for example, "Shiel", "Sheils", "Shiels" and "Shell", and requesting that NSWPF conduct further searches for any investigation file under those names. On 13 September 2022, the NWPF advised that there were no records held in respect of any of the four spelling variations identified.[936]

South Eastern Sydney LHD

5.1137. On 12 April 2023, the Inquiry issued a summons to the SESLHD requesting all records held by them regarding Mr Sheil, including records held by the POWH and PHH (SESLHD2). On 19 April 2023, the SESLHD produced a five-page Chest Clinic file in relation to Mr Sheil. There were no results produced in response to the summons relating to Mr Sheil's psychiatric treatment.[937]

[933] Exhibit 20, Tab 24, Supplementary Statement of Caitlin Healey-Nash, 12 September 2023, [10] (SCOI.85435).

[934] Exhibit 20, Tab 18A, Summons to NSW Health Pathology – Forensic Medicine (DOFM3), 14 November 2022 (SCOI.82801).

[935] Exhibit 20, Tab 23, Statement of Caitlin Healey-Nash, 3 April 2023, [6] (SCOI.45175).

[936] Exhibit 20, Tab 17, Emails between Caitlin Healey-Nash and Patrick Hodgetts, 12–13 September 2022 (SCOI.82802).

[937] Exhibit 20, Tab 24, Supplementary Statement of Caitlin Healey-Nash, 12 September 2023, [5]–[7] (SCOI.85435).

5.1138. On 6 July 2023, the Inquiry requested that the SESLHD conduct additional searches for the various misspellings of Mr Sheil's last name that were identified in the NSWPF documents. On 31 July 2023, the SESLHD informed the Inquiry that a match for the name "Peter Sheil" had been identified, but with a different date of birth. The SESLHD advised the Inquiry that although it was apparent this patient had likely been admitted as a psychiatric patient, the relevant records had been destroyed in 2011.[938]

Interagency cooperation

5.1139. On 11 May 2022, the Inquiry requested the Coroners Court file for Mr Sheil. On 26 August 2022, this file was received. It consisted of 18 pages of material relating to the Coroners Court's consideration of the matter in 1983.

Family members

5.1140. Both of Mr Sheil's parents have passed away. Mr Sheil is survived by his four siblings, Christopher, Hugh, Robert and Margaret, with whom the Inquiry was able to make contact.

5.1141. Mr Sheil's siblings provided Inquiry staff with their recollections of the aftermath of Mr Sheil's death, including the nature and extent of the police investigation. Christopher and Robert confirmed that their recollections of their family's interactions with police in the days following Mr Sheil's death, as referred to in the 2013 Article and the 2016 Article, were accurate.

5.1142. Mr Sheil's siblings also provided the Inquiry with a family statement that gave the Inquiry information about Mr Sheil's life and the impact of Mr Sheil's death upon their family.[939] I am grateful to Mr Sheil's siblings for sharing their memories of Mr Sheil and for their reflections upon the impact that his death had on their family.

5.1143. Mr Sheil's siblings also made submissions to the Inquiry, which are discussed and addressed below.

Professional opinions

5.1144. On 13 March 2023, the Inquiry wrote to forensic pathologist Dr Linda Iles seeking an expert opinion on certain matters relating to Mr Sheil's death.[940]

5.1145. On 24 March 2023, Dr Iles provided her expert opinion to the Inquiry.[941]

[938] Exhibit 20, Tab 24, Supplementary Statement of Caitlin Healey-Nash, 12 September 2023, [8]–[9] (SCOI.85435).

[939] Exhibit 21, Family Statement provided by Peter Sheil's siblings, undated (SCOI.45181).

[940] Exhibit 20, Tab 22A, Letter of Instruction from Caitlin Healey-Nash to Dr Linda Iles, 14 March 2023, 4-6 (SCOI.45161).

[941] Exhibit 20, Tab 22, Expert Report of Dr Linda Iles, 24 March 2023 (SCOI.45162).

5.1146. First, and in relation to the question of whether there were any additional areas of medical investigation or expert opinion that would assist the Inquiry in determining the manner and cause of Mr Sheil's death, Dr Iles' view was that there were no such avenues of medical investigation "[i]n the absence of any further details or photographs relevant to the scene or the autopsy examination".[942]

5.1147. Secondly, and in relation to the question of the adequacy of the post-mortem investigations, Dr Iles' opinion was that although autopsy practice had evolved considerably since Mr Sheil's death, there were numerous omissions from the post-mortem report (for example, there was no documentation of the presence or absence of scalp bruising/facial injuries and there was apparently no examination of the cervical spinal cord).[943]

5.1148. Dr Iles further noted that in relation to the recorded time of death ("three to four days prior to the autopsy") she believed it was "unlikely that the autopsy pathologist intended his estimate of time of death to be viewed with any type of precision, and this estimate should be disregarded".[944]

5.1149. Ultimately, Dr Iles' opinion was that the post-mortem report was "sufficient to determine cause of death, however, it was inadequate to help address the question of 'how death occurred'".[945]

5.1150. Elsewhere in her report, Dr Iles observed how the absence of information affected her ability to provide any opinion in relation to the manner of Mr Sheil's death. In particular, Dr Iles noted that information about the specific elements of the C1 and C2 fractures sustained by Mr Sheil would have helped inform her conclusion about the likely mechanism of injury, and that given observations about Mr Sheil's state of undress, there should have been "a more thorough post-mortem examination and trace evidence sampling".[946]

5.1151. Thirdly, and in relation to the question of the medical cause of Mr Sheil's death, Dr Iles considered that the only documented injury capable of causing death was the upper cervical spinal cord injury; this conclusion differs from the cause of death recorded in the post-mortem report (i.e. "multiple injuries").[947] Dr Iles considered that a "reasonable cause of death" would be "[c]ervical spine injuries sustained in a fall".[948]

[942] Exhibit 20, Tab 22, Expert Report of Dr Linda Iles, 24 March 2023, 5 (SCOI.45162).

[943] Exhibit 20, Tab 22, Expert Report of Dr Linda Iles, 24 March 2023, 5–6 (SCOI.45162).

[944] Exhibit 20, Tab 22, Expert Report of Dr Linda Iles, 24 March 2023, 6 (SCOI.45162).

[945] Exhibit 20, Tab 22, Expert Report of Dr Linda Iles, 24 March 2023, 6 (SCOI.45162).

[946] Exhibit 20, Tab 22, Expert Report of Dr Linda Iles, 24 March 2023, 7, 9 (SCOI.45162).

[947] Exhibit 20, Tab 22, Expert Report of Dr Linda Iles, 24 March 2023, 7–8 (SCOI.45162).

[948] Exhibit 20, Tab 22, Expert Report of Dr Linda Iles, 24 March 2023, 8 (SCOI.45162).

5.1152. Dr Iles considered that it may have been possible for Mr Sheil to move voluntarily following his fall if the injuries he sustained to his spinal cord were non-fatal, but that any voluntary movement may have resulted in "completed cord injury/transection".[949] However, in Dr Iles' view, it was more likely that Mr Sheil "tumbled into" his final position, rather than having moved into it voluntarily, and that his death was "rapid in onset following impact".[950]

5.1153. Fourthly, Dr Iles considered that none of the findings in the toxicological analysis would have been a contributing factor in Mr Sheil's death.[951]

5.1154. Fifthly, and in relation to the manner of Mr Sheil's death, Dr Iles considered that suicide was "unlikely to be the manner for Mr Shiel's [sic] death" but there was otherwise no information in the post-mortem report "to indicate whether Mr Sheil's death was the result of misadventure, accident or foul play".[952] Dr Iles added that there was a "significant lack of detail with regards to both positive and negative autopsy findings to inform questions around how Mr Shiel's [sic] death occurred".[953]

Other

Bureau of Meteorology

5.1155. On 19 September 2022, the Inquiry requested information from the BOM to ascertain the weather conditions in the Clovelly area between 22 and 29 April 1983.

5.1156. On 20 October 2022, an officer of the BOM provided weather, synoptic and rainfall observations for the Clovelly area. The data indicated that it rained two to three days prior to 27 April 1983 and earlier that day.[954] At the time that Mr Sheil is thought to have been walking home, the temperature was 17 degrees celsius with low wind and good visibility, but high cloud cover.[955] Humidity was high and there may have been a very light shower at around 9:00pm.[956]

5.1157. On 28 October 2022, the Inquiry accessed further data from Geoscience Australia which established that sunset on 27 April 1983 occurred at 5:20pm.[957]

[949] Exhibit 20, Tab 22, Expert Report of Dr Linda Iles, 24 March 2023, 7 (SCOI.45162).

[950] Exhibit 20, Tab 22, Expert Report of Dr Linda Iles, 24 March 2023, 7, 9 (SCOI.45162).

[951] Exhibit 20, Tab 22, Expert Report of Dr Linda Iles, 24 March 2023, 8 (SCOI.45162).

[952] Exhibit 20, Tab 22, Expert Report of Dr Linda Iles, 24 March 2023, 9 (SCOI.45162).

[953] Exhibit 20, Tab 22, Expert Report of Dr Linda Iles, 24 March 2023, 9 (SCOI.45162).

[954] Exhibit 20, Tab 19, Bureau of Meteorology Data Document CAS-37787-S5G0Y9-11, 20 October 2022, 17 (SCOI.74834).

[955] Exhibit 20, Tab 19, Bureau of Meteorology Data Document CAS-37787-S5G0Y9-11, 20 October 2022, 7, 13 (SCOI.74834).

[956] Exhibit 20, Tab 19, Bureau of Meteorology Data Document CAS-37787-S5G0Y9-11, 20 October 2022, 13 (SCOI.74834).

[957] Exhibit 20, Tab 20, Geoscience Australia, 'Sunrise, Sunset and Twilight Times – Clovelly, 27 April 1983', (Webpage, 28 October 2022) <https://geodesyapps.ga.gov.au/sunrise> (SCOI.82804).

Media articles

5.1158. The Inquiry had regard to the 2013 Article and the 2016 Article which contained statements from Mr Sheil's brothers, Christopher and Hugh, about Mr Sheil's personality, last known movements and the initial police investigation.[958]

5.1159. In the 2013 Article, it states that:[959]

> *In April 1983, Sheil's body was found with "multiple injuries" – but without trousers – at the base of a small cliff at Gordons Bay, then commonly known as Thompsons Bay, north of Coogee. Sheil, 29, was not gay. He was schizophrenic and was on medication, but on the night of his death he was in good spirits, says brother Hugh. Peter had called his mother from the Coogee Bay Hotel at about 8.30pm to say he was heading home to a halfway house in Clovelly. He chose the coastal walk. It passed known gay beats.*
>
> *Sheil's mother was a devout Catholic. She could not countenance the possibility of suicide and the policeman who handled the case was helpful, perhaps too helpful. Christopher Sheil, then 27, witnessed the "inquiry" into his brother's death – a discussion between his father and the policeman. "It took all of about a minute. They got to the part on the form where you fill out cause of death. I can't remember whether it was Dad or the cop who suggested misadventure. I said, 'We don't know whether he jumped, fell or was pushed.' Dad said, 'Ah, we're not gunna go into any of that.'"*
>
> *Their parents are now dead. Christopher, 58, says, "Peter definitely wasn't gay. I wouldn't be embarrassed at all if he was. It's just not accurate. However, his behaviour could be reckless and it is quite possible he was mistaken for being gay, and attacked for that reason. It might also have been suicide, although if you look at the point where he died, it's not a likely choice. It's only a couple of storeys high. There were plenty of higher cliffs along the way."*

5.1160. The 2016 Article contains similar sentiments, including the following:[960]

> *Peter was not gay. He wrote his "wonderful" poetry partly to impress the girls, his bother [sic] Christopher Sheil recalls.*
>
> …
>
> *Their mother, deceased, had been determined that Peter was not depressed or suicidal on that April night when he called her about 8pm to say he*

[958] Exhibit 6, Tab 210, Rick Feneley, 'Up to 80 men murdered, 30 cases unsolved', *Sydney Morning Herald* (Sydney, 27 July 2013) 29 (SCOI.77369); Exhibit 20, Tab 21, Rick Feneley, 'He wasn't gay, but could Peter have been a gay hate victim?', *SBS* (online, 27 September 2016) <https://www.sbs.com.au/news/article/he-wasnt-gay-but-could-peter-have-been-a-gay-hate-victim/t2e3sm0rl> (SCOI.02439).

[959] Exhibit 6, Tab 210, Rick Feneley, 'Up to 80 men murdered, 30 cases unsolved', *Sydney Morning Herald* (Sydney, 27 July 2013) 29 (SCOI.77369).

[960] Exhibit 20, Tab 21, Rick Feneley, 'He wasn't gay, but could Peter have been a gay hate victim?', *SBS* (online, 27 September 2016) 2-5 <https://www.sbs.com.au/news/article/he-wasnt-gay-but-could-peter-have-been-a-gay-hate-victim/t2e3sm0rl> (SCOI.02439).

was about to walk back to the Clovelly hostel where he was living. He was anxious about meeting the hostel's 9pm curfew, but not "down".

…

Back at Gordons Bay, Christopher tells SBS: "It's plausible that he was mistaken for being gay while walking through a gay beat – that he was attacked for that reason."

…

Peter could be "gregarious" and "reckless", Christopher says.

Inquiries with witnesses

5.1161. The Inquiry made endeavours to contact the witness who discovered Mr Sheil's body, Donald Ross, but was unable to locate him.

5.1162. The Inquiry established that Constable Strange (OIC) and Ms Campbell (Supervisor at the Clovelly Flats) are deceased.

5.1163. The Inquiry was able to contact Dr Christopher Rikard-Bell, a Psychiatric Registrar at POWH at the time of Mr Sheil's death and Mr Sheil's treating doctor. However, Dr Rikard-Bell had no recollection of treating Mr Sheil and had no notes in relation to Mr Sheil or his treatment.[961]

Consideration of the evidence

Mr Sheil's background

5.1164. Mr Sheil was born on 7 February 1954 and was 29 years old when he died.[962] Mr Sheil was living in Clovelly at the time of his death.

5.1165. Mr Sheil was an active, intelligent, and gregarious man with a range of hobbies and interests. He was a gifted poet, who at the age of 16 won first prize in a district competition at the Festival of Australian Poetry.[963] Mr Sheil also studied and worked intermittently, when he was able to do so.[964]

5.1166. There is no evidence to suggest that Mr Sheil was a member of the LGBTIQ community.[965]

[961] Exhibit 20, Tab 24, Supplementary Statement of Caitlin Healey-Nash, 12 September 2023, [11]–[13] (SCOI.85435).

[962] Exhibit 20, Tab 5, Death Certificate of Peter Sheil, 14 September 1983 (SCOI.74053).

[963] Exhibit 20, Tab 21, Rick Feneley, 'He wasn't gay, but could Peter have been a gay hate victim?', *SBS* (online, 27 September 2016) 1-2 <https://www.sbs.com.au/news/article/he-wasnt-gay-but-could-peter-have-been-a-gay-hate-victim/t2e3sm0rl> (SCOI.02439).

[964] The P79A Report of Death to Coroner records Mr Sheil as a pensioner: Exhibit 20, Tab 1, P79A Report of Death to Coroner, 2 May 1983, 1 (SCOI.11037.00003). Ms Campbell also suggests that the last time she saw Mr Sheil he was going to Randwick "to enquire about his pension cheque": Exhibit 20, Tab 8, Statement of Patricia Marlene Campbell, 31 May 1983, [3] (SCOI.11037.00009). However, the occupation recorded on Mr Sheil's death certificate is "Taxi Driver": Exhibit 20, Tab 5, Death Certificate of Peter Sheil, 14 September 1983 (SCOI.74053).

[965] See Exhibit 20, Tab 21, Rick Feneley, 'He wasn't gay, but could Peter have been a gay hate victim?', *SBS* (online, 27 September 2016) 5 <https://www.sbs.com.au/news/article/he-wasnt-gay-but-could-peter-have-been-a-gay-hate-victim/t2e3sm0rl> (SCOI.02439). See also Exhibit 6, Tab 210, Rick Feneley, 'Up to 80 men murdered, 30 cases unsolved', *Sydney Morning Herald* (Sydney, 27 July 2013) 29 (SCOI.10445.00019).

Mental health

5.1167. According to a letter dated 2 June 1983 from Dr Rikard-Bell to the Coroner, Mr Sheil was a "well known" patient to both POWH and PHH, having been admitted to hospital more than 12 times over the three years prior to his death "with both depression and hypermania".[966]

5.1168. Mr Sheil was "thought to have manic depressive illness or possibly schizoaffective psychosis".[967] He was being treated with "Lithium carbonate 400 mg. b.d [by day], Modecate 12.5 mg. IMI fortnightly, and Amitriptyline 75 mg. nocte [at night]".[968] In his letter, Dr Rikard-Bell also stated:[969]

> *Even at his best, Peter had severe lack of motivation, anergia and complained that he couldn't do much. He occasionally had fleeting suicidal [ideation] but he denied any serious intent.*

5.1169. The other contemporaneous evidence that is available to the Inquiry is broadly consistent with the diagnosis proffered by Dr Rikard-Bell. The Report of Death to Coroner records that Mr Sheil was a "manic depressant" and an outpatient at "P.O.W. Hospital".[970] Ms Campbell also describes Mr Sheil as suffering from "Schizo Affective Disorder".[971]

5.1170. However, and as noted above, Ms Campbell considered that Mr Sheil's condition had been improving since he began his stay at the Clovelly Flats.[972] Further, as outlined below, the available evidence also suggests that on the evening of 27 April 1983, Mr Sheil was "in good spirits" and did not appear to be depressed or distressed.

Movements prior to death

5.1171. At 8:30am on Wednesday, 27 April 1983, Mr Sheil left his residence at the Clovelly Flats with Ms Campbell to go shopping and run errands in the Randwick and Bondi Junction areas.[973] Ms Campbell drove him by car to the corner of Clovelly Road and Keith Street, where she saw Mr Sheil board a bus to go to Randwick. Ms Campbell's recollection was that Mr Sheil was going to "enquire about his pension cheque, and also to attend the Prince of Wales Hospital to see his doctor".[974]

[966] Exhibit 20, Tab 9, Letter from Dr Christopher Rikard-Bell to the Coroner, 2 June 1983 (SCOI.11037.00007).

[967] Exhibit 20, Tab 9, Letter from Dr Christopher Rikard-Bell to the Coroner, 2 June 1983 (SCOI.11037.00007).

[968] Exhibit 20, Tab 9, Letter from Dr Christopher Rikard-Bell to the Coroner, 2 June 1983 (SCOI.11037.00007).

[969] Exhibit 20, Tab 9, Letter from Dr Christopher Rikard-Bell to the Coroner, 2 June 1983 (SCOI.11037.00007).

[970] Exhibit 20, Tab 1, P79A Report of Death to Coroner, 2 May 1983, 1 (SCOI.11037.00003).

[971] Exhibit 20, Tab 8, Statement of Patricia Marlene Campbell, 31 May 1983, [3] (SCOI.11037.00009).

[972] Exhibit 20, Tab 8, Statement of Patricia Marlene Campbell, 31 May 1983, [3] (SCOI.11037.00009).

[973] Exhibit 20, Tab 1, P79A Report of Death to Coroner, 2 May 1983, 1 (SCOI.11037.00003); Exhibit 20, Tab 8, Statement of Patricia Marlene Campbell, 31 May 1983, [4] (SCOI.11037.00009).

[974] Exhibit 20, Tab 8, Statement of Patricia Marlene Campbell, 31 May 1983, [4] (SCOI.11037.00009).

5.1172. At around 8:00pm on 27 April 1983, Mr Sheil telephoned his mother from the Coogee Bay Hotel to inform her that he was about to return home to the Clovelly Flats, where he had a 9:00pm curfew.[975] This was the last known communication between Mr Sheil and another person. According to his family, Mr Sheil was in "good spirits" at this time,[976] and gave no indication on the telephone call to his mother that he was suicidal.[977]

5.1173. Mr Sheil appears to have chosen to walk home via the coastal track between Coogee and Clovelly.[978] Based on an estimate taken from Google Maps, it would have taken Mr Sheil around 20 minutes to walk from the Coogee Bay Hotel to reach the location where his body was found. A map depicting Mr Sheil's likely walking route between the Coogee Bay Hotel and his residence, and the approximate location of his body, is depicted as 'Map 1' in the written submissions of Counsel Assisting.

5.1174. The Inquiry's consideration of the evidence in relation to the circumstances of Mr Sheil's death is otherwise dealt with below.

Location of death

5.1175. There was evidence before the Inquiry that the coastal path between Coogee and Clovelly beaches around where Mr Sheil was found operated as a beat in the 1960s to 1980s. Giles Baths, at the northern end of Coogee Beach near the beginning of that path, was also a beat.[979] The significance of the location is discussed further below.

Police investigation

Counsel Assisting submissions

5.1176. Counsel Assisting submitted that several aspects of the original NSWPF investigation were inadequate. The Sheil family submitted that they generally agreed with the submissions made by Counsel Assisting in this respect, but to the extent that the Sheil family made submissions in relation to specific matters concerning the NSWPF investigation in addition to the submissions made by Counsel Assisting, they are dealt with in this section below.

[975] Exhibit 6, Tab 210, Rick Feneley, 'Up to 80 men murdered, 30 cases unsolved', *Sydney Morning Herald* (Sydney, 27 July 2013) 29 (SCOI.77369); Exhibit 20, Tab 21, Rick Feneley, 'He wasn't gay, but could Peter have been a gay-hate victim?', *SBS* (online, 27 September 2016) 3 <https://www.sbs.com.au/news/article/he-wasnt-gay-but-could-peter-have-been-a-gay-hate-victim/t2e3sm0rl> (SCOI.02439); Exhibit 20, Tab 1, P79A Report of Death to Coroner, 2 May 1983, 1 (SCOI.11037.00003).

[976] Exhibit 6, Tab 210, Rick Feneley, 'Up to 80 men murdered, 30 cases unsolved', *Sydney Morning Herald* (Sydney, 27 July 2013) 29 (SCOI.77369).

[977] Exhibit 20, Tab 21, Rick Feneley, 'He wasn't gay, but could Peter have been a gay hate victim?', *SBS* (online, 27 September 2016) 3 <https://www.sbs.com.au/news/article/he-wasnt-gay-but-could-peter-have-been-a-gay-hate-victim/t2e3sm0rl> (SCOI.02439).

[978] Exhibit 20, Tab 21, Rick Feneley, 'He wasn't gay, but could Peter have been a gay hate victim?', *SBS* (online, 27 September 2016) 4 <https://www.sbs.com.au/news/article/he-wasnt-gay-but-could-peter-have-been-a-gay-hate-victim/t2e3sm0rl> (SCOI.02439).

[979] Exhibit 20, Tab 23, Statement of Caitlin Healey-Nash, 3 April 2023, [4] (SCOI.45175). See also Exhibit 2, Tab 1, Statement of Garry Wotherspoon, 14 November 2022, [38]–[39] (SCOI.77300); Exhibit 3, Garry Wotherspoon, *Gay Sydney: A History* (NewSouth Publishing, 2016) 50 (SCOI.03677); Transcript of the Inquiry, 21 November 2022, T233.7–10. Cf Exhibit 2, Tab 5, Statement of Barry Charles, 14 November 2022, [159] (SCOI.77304), where Mr Charles states that he does not remember there being a beat on the north side of Coogee, towards Gordon Bay.

5.1177. First, Counsel Assisting submitted that the original police investigation into Mr Sheil's death was inadequate because it appeared to have concluded within a week, and that the NSWPF quickly formed the view that Mr Sheil had died as a result of an accident (i.e., that Mr Sheil had accidentally fallen off the rock outcrop and had been masturbating shortly before he fell).

5.1178. Counsel Assisting also submitted that the investigation was lacklustre, and Mr Sheil's father and the OIC "agreed" that the cause of death was "misadventure" with limited attempts to find out what actually happened to Mr Sheil.

5.1179. Counsel Assisting submitted that attempts or inquiries should have been made to take statements from Mr Sheil's friends or family members, including, in particular, Mr Sheil's mother, who received a call from him on the evening of 27 April and may have been the last person to speak to him.

5.1180. The Sheil family also submitted that the "original police investigation was limited, to the point of inadequacy".[980] The Sheil family stated:[981]

> *While a circumscribed investigation may perhaps have reflected the stoic preference expressed by Peter's father, the actual reasons for the adoption of such an approach cannot now be explored as Constable Strange is deceased. It is sufficient for present purposes to observe, first, that another family member, Christopher, expressed a contrary view at the time and statements were not otherwise obtained from the family, and, secondly and in any event, that the course of independent objective inquiry in cases such as this may not be curtailed by subjective wishes.*

5.1181. Counsel Assisting did not expressly deal with this submission, but I accept the proposition that the NSWPF should not be curtailed in any investigation by the subjective wishes of family members, particularly in the aftermath of a tragic loss. In relation to the question of the time taken to investigate the death of Mr Sheil, and the attitude of the OIC generally, the NSWPF made several submissions which, for the most part, I find unpersuasive for the reasons set out below.

5.1182. The NSWPF submitted that there is an inconsistency in Counsel Assisting submitting that the investigation concluded within a week and the submission (see below) that some key witnesses (Mr Ross and Ms Campbell) did not provide statements until more than a month after the investigation. I consider that this is unpersuasive in circumstances where the length of the investigation was addressed in the OIC's statement prepared in 1983, and the delay in obtaining the statements is otherwise unexplained. Further, and in any event, the NSWPF have not produced any material to suggest the investigation into Mr Sheil's death was thorough, or even adequate.

[980] Submissions of the Sheil Family, 18 April 2023, [6] (SCOI.45193).

[981] Submissions of the Sheil Family, 18 April 2023, [6] (SCOI.45193) (footnotes omitted).

5.1183. The NSWPF also submitted that "the fact that an investigation concluded relatively quickly cannot, without more, be regarded as a foundation for finding that it was deficient".[982] As a general proposition, it can be accepted that a quick investigation is not necessarily deficient. However, and in the present case, the evidence (or lack thereof) suggests that the NSWPF investigation was deficient in more than a single respect.

5.1184. The NSWPF also submitted that to the extent that Counsel Assisting relied upon statements made by Mr Sheil's brother in various media articles about his perceptions of the adequacy of the police investigations, these statements should be given little weight as "untested second-hand hearsay observations".[983] Further, the NSWPF submitted that "a person" (presumably Constable Strange) should "not have their professional or personal conduct impugned on the basis of evidence in that form" and that such a limitation is "implicit" in ss. 9(3) and (4) of the *SCOI Act*.[984] Even if I were to accept these submissions, I would reach the same conclusions in relation to the investigation.

5.1185. The Sheil family contended that accepting that submission would result in the failure to consider useful and probative evidence from a family member of Mr Sheil who was present when the relevant events took place, and that the NSWPF have not specifically identified the way they could or would be able to "test" this evidence, and as such, amounts to a "hollow" submission.[985] I agree with the submissions made by the Sheil family. In the absence of any evidence to the contrary, the impressions of an eyewitness family member about the adequacy of the NSWPF investigation is probative and forms part of the overall circumstances in which I have drawn my conclusions about the inadequacy of the NSWPF investigation into Mr Sheil's death.

5.1186. The NSWPF submitted that it does not follow from the fact Mr Sheil's mother did not provide a formal statement to police that there was no attempt to obtain information from her. I accept that in the absence of evidence about an investigation (evidence that the NSWPF was responsible for preserving) it cannot be said definitively that no attempt was made to take a statement. However, it appears to me, based on the evidence that is available to the Inquiry including the evidence from the Sheil family, that the NSWPF neither took such a statement from Mr Sheil's mother, nor attempted to obtain information from her. The submission of the NSWPF also ignores the fact that the absence of records itself is a serious inadequacy.

5.1187. Secondly, Counsel Assisting submitted that, in the original investigation, the NSWPF did not appear to have given any weight, or perhaps any consideration, to other pieces of information which pointed *away* from misadventure as being the manner of death. Counsel Assisting also notes that there was no evidence before the Inquiry actually linking the "magazine of a sexual nature" with Mr Sheil.

[982] Submissions of NSWPF, 18 April 2023, [7] (SCOI.45192).

[983] Submissions of NSWPF, 18 April 2023, [10] (SCOI.45192).

[984] Submissions of NSWPF, 8 May 2023, [10] (SCOI. 83083).

[985] Submissions of the Sheil Family, 28 April 2023, [8] (SCOI.47468).

5.1188. The NSWPF submitted that the statement prepared by the OIC "is not as detailed as would be expected in modern times" and that "[i]n the absence of evidence from the relevant officer it cannot, for example, be assumed that his statement provides a comprehensive accounting of all of the investigative steps he undertook".[986]

5.1189. The difficulty with the NSWPF position is that any evidence in relation to what the NSWPF actually did as part of their investigation would have been on the investigative file, which has been lost. The evidence that has been produced, from the Coroners Court file, does not support the conclusion that even if there was a "comprehensive accounting"[987] of all relevant steps, that the investigation would have been considered adequate by the standard of the day or otherwise. Furthermore, and once again, the absence of records in relation to the case is itself a serious inadequacy.

5.1190. During the Investigative Practices Hearing, Detective Inspector Warren told the Inquiry that if there was evidence available in 1983 that the area where Mr Sheil died was a beat, an investigating officer should have taken that into account as part of the investigation.[988] If the OIC had knowledge that the area was a beat, Detective Inspector Warren considered that this was something that should have been brought to the attention of the Coroner. Detective Inspector Warren would also expect the investigating officer to have an up to date knowledge of what was happening in the area.[989]

5.1191. Detective Inspector Warren acknowledged that the magazine of a "sexual nature" was relevant to the investigation. Detective Inspector Warren was not sure why investigating police mentioned the magazine but failed to collect it.[990]

5.1192. In written submissions filed in respect of the Investigative Practices Hearing, the NSWPF submitted that there is no evidence that the OIC in Mr Sheil's case had knowledge that the area was a beat, such that this should have been brought to the attention of the Coroner.[991]

5.1193. Thirdly, Counsel Assisting submitted that there was an unexplained delay in obtaining statements from key witnesses, including a delay of just over one month in respect of Mr Ross (who found Mr Sheil's body) and Ms Campbell (who was the supervisor in charge of the property where Mr Sheil was residing).

[986] Submissions of NSWPF, 18 April 2023, [9] (SCOI.45192).

[987] Submissions of NSWPF, 18 April 2023, [9] (SCOI.45192).

[988] Transcript of the Inquiry, 5 July 2023, T4979.41–4980.8 (TRA.00073.00001).

[989] Transcript of the Inquiry, 5 July 2023, T 4980.10–12, 4980.37–46 (TRA.00073.00001).

[990] Transcript of the Inquiry, 5 July 2023, T4979.11–15, 4980.14–35 (TRA.00073.00001).

[991] Submissions of NSWPF, 10 October 2023, [354] (SCOI.86127).

5.1194. As noted above, the NSWPF addressed the issue of delay through the rubric of it being inconsistent with the criticism that the NSWPF investigation concluded within the week. The delay in finalising the statements is otherwise not addressed beyond a suggestion by the NSWPF in written submissions following the Investigative Practices Hearing that the delay in obtaining the statements cannot be conclusively determined to be in breach of police practice given the reasons for that delay are unknown. However, as noted above, evidence as to the length of the investigation is expressly stated to have occurred in the "following week"[992] after Mr Sheil was found and no explanation for the delay in obtaining the statements has been provided. The absence of an such an explanation is itself problematic and, in my view, it is the absence of such an explanation which means that such a criticism can be validly made. Further, in the Investigative Practices Hearing, Detective Inspector Warren conceded that even the passage of one month creates a risk of degraded memory, and this was appreciated at the time of Mr Sheil's death.[993]

5.1195. Fourthly, Counsel Assisting submitted that no investigative files or other documents can be located by the NSWPF in relation to Mr Sheil's death. Accordingly, among other things, there is no clear evidence as to the exact location of Mr Sheil's body. The failure of the police to preserve and locate such files and documents is particularly unfortunate in circumstances where, according to the OIC's statement given during the coronial investigation, Scientific Squad Police attended the scene of Mr Sheil's death and took photographs of his body and the surrounding area.[994] Such photographs are not available to the Inquiry.

5.1196. This submission was not addressed by the NSWPF in their written submissions.

5.1197. The Sheil family submitted that "the subsequent record-keeping by police was inexplicably deficient resulting in the loss of significant contemporaneous evidence, most notably forensic or scene photographs and other exhibits".[995]

5.1198. In the Investigative Practices Hearing, Assistant Commissioner Conroy told the Inquiry that she could not say whether the investigative file should have been retained given she "[had not] seen the investigative file and … [had not] received any documentation in relation to that matter".[996] Assistant Commissioner Conroy conceded that the effect of this evidence was that if an investigative file was missing, she would never be able to give an answer to the question of whether proper police practices had been adhered to in relation to the retention of that file.[997] Assistant Commissioner Conroy was unable to comment as to whether the absence of the police file was itself indicative of a failure in proper police practices.[998]

[992] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [8] (SCOI.11037.00011).

[993] Transcript of the Inquiry, 5 July 2023, T4980.47–4981.22 (TRA.00073.00001).

[994] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, 23 August 1983, [3] (SCOI.11037.00011).

[995] Submissions of the Sheil Family, 18 April 2023, [7] (SCOI.45193).

[996] Transcript of the Inquiry, 4 July 2023, T4846.15–16 (TRA.00072.00001).

[997] Transcript of the Inquiry, 4 July 2023, T4846.20–24 (TRA.00072.00001).

[998] Transcript of the Inquiry, 4 July 2023, T4846.33–36 (TRA.00072.00001).

5.1199. During the same hearing, Detective Inspector Warren gave evidence that records of the police investigation should have been retained, and that proper police practice would be to retain those records regardless of whether the Coroner had formed the view that the death was non-suspicious.[999]

5.1200. In written submissions filed in the context of the Investigative Practices Hearing, the NSWPF noted that, whilst the records retention schedule in place at the time of Mr Sheil's death is not before the Inquiry, the present scheme only requires police to retain records concerning reports of deceased persons, including death by suicide, for five years. The NSWPF submitted that, given Mr Sheil's death was not considered suspicious by investigating police or the Coroner, this may explain why the records are no longer held.[1000]

5.1201. This may be the case. However, as noted above, the NSWPF did not furnish the Inquiry with the relevant records retention schedule in place, and consequently at present this is a matter of speculation. In addition, Detective Inspector Warren's evidence was that the records should have been retained. The failure to preserve or adequately store the investigative file in relation to this case is a failure on behalf of the NSWPF, and one which has impeded the ability of this Inquiry to perform its functions, including to provide clearer answers to the questions surrounding the manner and cause of Mr Sheil's death.

5.1202. Fifthly, Counsel Assisting submitted that no exhibits appear to have been retained by the NSWPF. Investigating police appear to have disposed of Mr Sheil's clothing at a very early stage of the investigation — notably, prior to the post-mortem examination taking place.[1001] There is no record of precisely where the "magazine of a sexual nature" was located, its condition or contents. What else, if anything, was observed or examined from the scene cannot now be known.

5.1203. During the Investigative Practices Hearing, Assistant Commissioner Conroy gave evidence that she had no way of knowing whether there may be exhibits in relation to Mr Sheil's death somewhere among police records.[1002] These failures to retain exhibits and documents prevent the Inquiry from conducting an examination of any such exhibits using technology currently available.

5.1204. Once again, I consider that the failure to retain any exhibits in this case is another inexplicable failure on behalf of the NSWPF and one which has jeopardised the ability of this Inquiry to perform its functions.

[999] Transcript of the Inquiry, 5 July 2023, T4947.5–4948.39 (TRA.00073.00001).

[1000] Submissions of NSWPF, 10 October 2023, [351] (SCOI.86127).

[1001] Exhibit 20, Tab 1, P79A Report of Death to Coroner, 2 May 1983, 1 (SCOI.11037.00003).

[1002] Transcript of the Inquiry, 4 July 2023, T4847.38–42 (TRA.00072.00001).

NSWPF submissions

5.1205. The NSWPF has made the submission that, generally speaking, in levelling criticisms at the original police investigation, Counsel Assisting did "not afford sufficient weight to a number of matters of fundamental importance".[1003] These matters were identified as:[1004]

a. First, the fact that the Coroner dispensed with an inquest without directing that further investigations be undertaken should be considered "a clear indication that the police investigation was regarded as sufficient";

b. Secondly, the fact that Mr Sheil's death and the associated investigation occurred 40 years ago and the "adequacy of investigation into his death and the management of related exhibits should not be assessed by reference to modern investigative standards"; and

c. Thirdly, the Inquiry has not received evidence from the investigating officers or their contemporaries and in those circumstances the Inquiry could "not fairly conclude that the investigation was inadequate".

5.1206. In relation to the first issue, and in reply to the NSWPF submission on this issue, the Sheil family submitted that the fact that an inquest has been dispensed with (on the material then available to the Coroner) is a reflection of the exercise of the power set out in ss. 14(2) and 22 of the *Coroners Act*, but that it is no substantive answer to the sufficiency of the investigation given the evidence as a whole and, in particular, given Dr Iles' opinion as to the adequacy of the post-mortem investigations.

5.1207. In reply to this submission by the Sheil family, the NSWPF submitted that ss. 14 and 22 of the *Coroners Act* are "not merely window dressing",[1005] and that the "combined effect of these provisions", in circumstances where an inquest has been dispensed with, make it clear that the Coroner must have reached the conclusion that the manner and cause of Mr Sheil's death were "sufficiently disclosed" through "the investigation".[1006] Therefore, according to the NSWPF, the decision to dispense with an inquest is a "clear indication" that the Coroner "regarded the investigation as adequate, having regard to then-accepted standards".[1007]

5.1208. In my view, the conclusion that in Mr Sheil's case the Coroner considered the NSWPF investigation as adequate (either as a necessary consequence of the operation of the *Coroners Act* or otherwise) is not open on the evidence. The NSWPF submissions fail to account for the information provided to the Coroner, and the possibility of human error. Further, and in any event, it is apparent from the evidence before this Inquiry that the manner and cause of death as proffered by the OIC, and as accepted by the Coroner, were proffered despite little or no investigation of alternatives.

[1003] Submissions of NSWPF, 18 April 2023, [5] (SCOI.45192).

[1004] Submissions of NSWPF, 18 April 2023, [5] (SCOI.45192).

[1005] Submissions of NSWPF, 8 May 2023, [6] (SCOI.83083).

[1006] Submissions of NSWPF, 8 May 2023, [8] (SCOI.83083).

[1007] Submissions of NSWPF, 8 May 2023, [8] (SCOI.83083).

5.1209. In relation to the second issue, the NSWPF submitted that although it can be accepted that the investigation into Mr Sheil's death does not meet modern standards, its adequacy should be assessed against "reasonably prudent investigative practice in 1983".[1008]

5.1210. In reply to the NSWPF submission on this second issue, the Sheil family submitted that it is not necessary for this Inquiry to consider what relevant standard applies, but rather, to consider the adequacy of the police investigation based on all of the evidence before it. This is not solely a question of timing, but a question of "the combined effect of what was done and not done, then and subsequently".[1009]

5.1211. After receiving the Sheil family's submissions, the NSWPF provided the Inquiry with further submissions on this issue. The NSWPF submitted that, given Constable Strange was not available, and given the investigation took place "well before the introduction of electronic case management tools, and in circumstances where expectations as to the recording of investigative steps in statement form were plainly very different", it is by no means clear that such an assessment of the adequacy of the investigation on "all of the available evidence" can "accurately, fairly, or usefully be conducted".[1010]

5.1212. Although I accept some relevance must be attributed to the fact that the investigation into Mr Sheil's death occurred in 1983 and the applicable standards were not those of the modern day, I agree with the submissions of the Sheil family. When all of the evidence is examined, and even on the assumption that the OIC undertook further steps that are not accounted for in the evidence, it does not explain the absence of any evidence of such steps, such that a proper record could be kept about those steps. Furthermore, Detective Inspector Warren conceded that the investigation into Mr Sheil's death was inadequate by the standard of the day, at least in relation to record-keeping and retention, the awareness and consideration of the fact that the area around where Mr Sheil was found operated as a beat, and the delay in obtaining statements from witnesses.[1011]

5.1213. In relation to the third issue concerning the fairness of making findings about the adequacy of the NSWPF investigation without receiving evidence from the investigating officers or their contemporaries, I accept the submission of the Sheil family that the absence of such evidence does not prevent the Inquiry from reaching a conclusion about the adequacy or otherwise of the initial investigation.[1012]

[1008] Submissions of NSWPF, 8 May 2023, [9] (SCOI.83083).

[1009] Submissions of the Sheil Family, 28 April 2023, [6] (SCOI.45193).

[1010] Submissions of NSWPF, 8 May 2023, [5] (SCOI.83083).

[1011] See Transcript of the Inquiry, 5 July 2023, T4947.20–4948.40, T4978.36–4981.24 (TRA.00073.00001).

[1012] Cf Submissions of NSWPF, 18 April 2023, [5](c) (SCOI.45192).

5.1214. As to procedural fairness, the doctrine is essentially a practical one: see, for example, *Re Minister for Immigration and Multicultural and Indigenous Affairs; Ex parte Lam* (2003) 214 CLR 1 at 14 [37]; *Condon v Pompano Pty Ltd* (2013) 252 CLR 38 at 99 [156]. The doctrine does not require that the Inquiry contact, or obtain evidence from, the OIC of every case, or from relevant officers who were contemporaries of any OIC that is now deceased. Furthermore, and in the circumstances, it is not readily apparent how the interests of the deceased OIC in this case would be adversely affected. My observations concerning the police investigation relate to what emerges from the available objective evidence. As explained in **Chapter 1** and the introduction to this Chapter, they are not made, nor should they be understood, as a personal criticism of the OIC.

5.1215. In my view, contemporaneous documents are likely to constitute the best available evidence in cases from so long ago.[1013] In other words, even if the OIC of the original investigation in this case was alive and was able to give evidence, it is possible that he would have no independent recollection of the death or investigation in question, or that his memory has been significantly impaired by the passage of time. Such a course would appear to have limited utility.

Sheil family submissions

5.1216. The Sheil Family made the following submissions about the adequacy of the police investigation to the death of Mr Sheil:[1014]

a. First, the statement of Mr Ross was not signed by him, despite the fact that it bore Constable Strange's signature, and that no explanation was provided for this.

b. Secondly, there was a lengthy delay between Constable Strange's initial report to the Coroner on 2 May 1983 and the finalisation of his statement on 23 August 1983.

c. Thirdly, and relatedly, there were inconsistencies in the documents that did exist, including:

   i. Constable Strange's report to the Coroner refers to Mr Sheil "going shopping in the Randwick and Bondi Junction areas",[1015] which is not supported by any identified source and does not reflect what Ms Campbell said, namely, that Mr Sheil was going "to Randwick to enquire about his pension cheque, and also to attend the [POWH] to see his doctor"[1016]

   ii. There was no evidence of Mr Sheil's doctor being approached to see if that might give further insight into Mr Sheil's state of mind that day; and

   iii. There was a discrepancy between Mr Ross' description of Mr Sheil "lying on his back" and Constable Strange's statement that the body was in a "prone position". I observe that this might be explained by a loose or

[1013] See for example *R v Warwick* (No 93) [2020] NSWSC 926 at [62]-[63], per Justice Garling

[1014] Submissions of the Sheil Family, 18 April 2023, [8(a)–(d)] (SCOI.45193).

[1015] Exhibit 20, Tab 1, P79A Report of Death to Coroner, 2 May 1983, 1 (SCOI.11037.00003).

[1016] Exhibit 20, Tab 8, Statement of Patricia Marlene Campbell, 31 May 1983, [4] (SCOI.11037.00009).

imprecise use of the word "prone" by Constable Strange. There is force in the Sheil family submission that Mr Ross' description of the state of Mr Sheil's clothing could not have been given if the body was face-down.

d. Fourthly, the report of Dr Iles suggested that it was likely that Mr Sheil was found in his final position and that death would have been "rapid" following impact, casting doubt on the police conjecture about the spot on the cliff from where he fell, which is where the magazine was supposed to have been found, and the supposed subsequent movement.

5.1217. As to the first matter, this is another respect in which the documentary record may be regarded as insufficient. The second reinforces the submissions I have summarised above about the delay in preparing statements. As to the third and fourth, these matters support the submissions of Counsel Assisting as to the inadequacy of the investigation.

5.1218. I set out my findings and make further observations about the police investigation below.

Strike Force Parrabell

5.1219. It was submitted by Counsel Assisting that given the paucity of material available to Strike Force Parrabell in relation to Mr Sheil's case, for the Strike Force to even purport to conduct a review of his case was verging on pointless. It appears that the BCIF resorted to the same handful of observations about Mr Sheil's death, drawn from statements made by his brother Christopher to the media.

5.1220. According to the NSWPF, the conclusion that there was insufficient information to allow a determination as to whether Mr Sheil's death was the product of LGBTIQ bias was "appropriate", particularly given that Counsel Assisting submitted that the same conclusion should be reached by the Inquiry.[1017] In these circumstances, the NSWPF submitted that it is "difficult to comprehend" the criticisms made by Counsel Assisting.[1018] Mr Sheil's case was not, according to the NSWPF, a "good candidate" for reinvestigation given "the paucity of information and the fact that the death was probably not a homicide".[1019] Conversely, if the NSWPF had ignored the case as part of Strike Force Parrabell, it would have been "criticised for failing to consider the matter".[1020]

5.1221. The NSWPF also submitted that, in conducting Strike Force Parrabell, the NSWPF attempted to obtain the relevant information from the Coroners Court and from government archives but to no avail, with the implication it should not be criticised for basing its analysis on two media articles.

5.1222. The Sheil family have submitted that it is "most regrettable that the paucity of material in Peter's case was not brought to light and made transparent in the review under Strike Force Parrabell".[1021]

[1017] Submissions of NSWPF, 18 April 2023, [23] (SCOI.45192).

[1018] Submissions of NSWPF, 18 April 2023, [27] (SCOI.45192).

[1019] Submissions of NSWPF, 18 April 2023, [28] (SCOI.45192).

[1020] Submissions of NSWPF, 18 April 2023, [28] (SCOI.45192).

[1021] Submissions of the Sheil Family, 18 April 2023, [10] (SCOI.45193).

5.1223. I do not find Strike Force Parrabell's treatment of Mr Sheil's matter satisfactory and accept Counsel Assisting's submission that given the paucity of material available to Strike Force Parrabell, to purport to conduct a review of this case based on documentary "holdings" was pointless. The suggestion that the classification was appropriate because Counsel Assisting submitted the Inquiry should, effectively, reach the same conclusion is to miss the point entirely. It would have been preferable for Strike Force Parrabell frankly to acknowledge that, given the failure of the NSWPF to locate or retain any records at all, a review of the matter could not sensibly be conducted.

Manner and cause of death

Cause of death

5.1224. In light of the evidence of Dr Iles that the only injury capable of causing death was the upper cervical spinal cord injury, Counsel Assisting submitted that the evidence supported a finding that Mr Sheil died as a result of cervical spine injuries sustained in a fall.

5.1225. The NSWPF and the Sheil family accepted the formulation proposed by Counsel Assisting as to the cause of Mr Sheil's death.

Time of death

5.1226. Counsel Assisting also submitted, in light of Dr Iles' evidence and the known facts around Mr Sheil's last movements, that Mr Sheil died between 8:00pm on 27 April 1983 and 10:00am on 29 April 1983.

5.1227. According to the NSWPF, it is open to the Inquiry:[1022]

> *to find that Mr Sheil more likely than not died in a narrower time window following 8pm on 27 April 1983 than is proposed in Counsel Assisting's submissions (i.e. the 38 hour period between 8pm on 27 April 1983 when Mr Sheil last spoke with another person and the time at which his body was located).*

5.1228. However, the NSWPF conceded that the available evidence would not allow the time of death to be identified with any real precision.

5.1229. The Sheil family also submitted that it would be preferable for me to find that the time of Mr Sheil's death was after 8:30pm and on the evening of 27 April 1983. The Sheil family submit that while the broader finding accords with Dr Iles' opinion, that view is based on the non-existence of post-mortem data alone, and the Inquiry is not so confined. The Sheil family submitted that a narrower finding is consistent with both the timing of Mr Sheil's last-known movements and his failure to return home that evening prior to his 9:00pm curfew.

[1022] Submissions of NSWPF, 18 April 2023, [29] (SCOI.45192).

5.1230. In relation to the time of Mr Sheil's death, I agree with the NSWPF and the Sheil family that a narrow finding is more appropriate. The preponderance of evidence supports this finding.

Manner of death

5.1231. Counsel Assisting submitted that there is insufficient evidence to make a finding as to the manner of Mr Sheil's death, that is, whether Mr Sheil's fall was accidental or otherwise.

5.1232. The NSWPF and the Sheil family accepted that the formulation proposed by Counsel Assisting regarding the manner of Mr Sheil's death and the consequent recommendation proposed are open and appropriate in the circumstances.

5.1233. Nevertheless, all parties made additional submissions regarding the likelihood of the different hypotheses available as to manner of death, and I will consider these submissions below.

Misadventure

5.1234. Counsel Assisting submitted that the OIC's conclusion that Mr Sheil stepped off the coastal track to masturbate was open to considerable doubt for at least three reasons:

a. First, the fact that it was dark when Mr Sheil was walking home which meant that it is difficult to imagine that Mr Sheil could have been able to see a magazine without a light source (and there was no evidence of such a light source);

b. Secondly, the improbability of a man close to home and subject to a curfew would deviate from the coastal track in the dark to masturbate; and

c. Thirdly, there were other possible reasons for the state of Mr Sheil's trousers, including that he had stopped to urinate, and/or that his clothing had been moved in the course of his fall, and/or that an assailant had been involved.

5.1235. The Sheil family agreed with Counsel Assisting's submissions and also raised two further points. First, the use of the passive voice in describing the "magazine" in Constable Strange's statement obscured both who is said to have found the magazine and where and when (noting that the magazine is not mentioned in the available evidence before this statement is signed some four months later); and secondly, that the fact Mr Sheil's shirt was open at the front is consistent with it having been opened for comfort during a 20-minute walk on a night with high humidity (as pointed out above).

5.1236. The NSWPF accepted that the opinion expressed by the OIC that Mr Sheil was masturbating immediately prior to his death "appears to have been relatively speculative".[1023]

[1023] Submissions of NSWPF, 18 April 2023, [16] (SCOI.45192).

Suicide

5.1237. The NSWPF submitted that the Inquiry should consider the "possibility" that Mr Sheil died by way of suicide, and that homicide was "probably the least likely of the possible causes of Mr Sheil's death".[1024] In support of this proposition, the NSWPF noted that:

a. Mr Sheil "appears to have been suffering from a very significant mental illness, and his behaviour might not have accorded with conventional expectations";[1025]

b. The alleged "likelihood of his behaviour departing from conventional expectations" may have "included a decision to deliberately walk along the rocks at the edge of the cliff above where his body was found";[1026]

c. Mr Sheil's mental illness was one of the "possible" explanations for the "apparent disturbance to Mr Sheil's clothing" and that "Mr Sheil's psychological state was such that he was not concerned with the dishevelled state of his clothing (if, indeed, the state of his clothing following his fall reflected the position it was in before he fell)";[1027] and

d. Mr Sheil's mental illness, "together with the other circumstances surrounding his death, raises the possibility that he jumped deliberately from the cliffs (either in an attempt to die by suicide, or for some other reason associated with a psychotic episode)" and that "if Mr Sheil's state of mind was such that he was driven to suicide, he may well not have carefully considered the heights of different clifftops".[1028]

5.1238. In circumstances where the NSWPF agrees with the proposed formulation of Mr Sheil's manner and cause of death save for the proposed time of death (discussed below), it is baffling why NSWPF made these submissions in relation to the likelihood of suicide. I agree with the submissions of the Sheil family that the approach of the NSWPF in this respect is "perplexing" and it is understandable that for the Sheil family, it is "a point of no small dismay".[1029]

5.1239. In reply to the submissions of the NSWPF, the Sheil family submitted as follows:[1030]

> *From the fact of the description of Peter's mental illness, treatment and medication in the letter from the Prince of Wales hospital to the coroner, the [NSWPF] moves to conjecture as to possible divergence from "conventional expectations" (whatever they may be), disparaging remarks about Peter's self-awareness ("was not concerned with the dishevelled state of his clothing") and speculation as to his state of mind ("jumped deliberately … in an attempt to die by suicide, or for some other reason*

[1024] Submissions of NSWPF, 18 April 2023, [22] (SCOI.45192).

[1025] Submissions of NSWPF, 18 April 2023, [17] (SCOI.45192).

[1026] Submissions of NSWPF, 18 April 2023, [19] (SCOI.45192).

[1027] Submissions of NSWPF, 18 April 2023, [20] (SCOI.45192).

[1028] Submissions of NSWPF, 18 April 2023, [21] (SCOI.45192).

[1029] Submissions of the Sheil Family, 28 April 2023, [9] (SCOI.47468).

[1030] Submissions of the Sheil Family, 28 April 2023, [12] (SCOI.47468).

> *associated with a psychotic episode"). With respect, the [NSWPF's] submissions risk perpetuating regrettably popular misconceptions about mental illness generally, including that it is a continuous and permanent condition, makes people unpredictable and limits their ability to function normally in society. In Peter's particular case, the letter does not bear the weight the [NSWPF] seeks to give it. The preponderance of the evidence does not support the remarks.*

5.1240. In addition, the Sheil family submitted there is evidence to suggest that suicide was not a likely manner of death in that Mr Sheil was undergoing treatment, his condition was improving, and that he was in good spirits immediately prior to his death. Furthermore, this position was supported by the opinion of Dr Iles who concluded that that "[n]on-pathology related evidence appears to suggest suicide is unlikely to be the manner for Mr Shiel's [sic] death (no reported change in mood around the time of his death; body found in a location with a shorter fall than in immediate surrounding areas)".[1031]

5.1241. The Sheil family also submitted that the fact Mr Sheil had several episodes of mental illness with hospitalisation over a three-year period does not, of itself, make suicide more likely on the evening in question, particularly in light of other evidence indicating it was less likely. The Sheil family also submitted that the NSWPF would have no understanding of Mr Sheil's personality and the ways in which Mr Sheil's illness would manifest itself and, in the absence of such evidence, the NSWPF submission is only speculative.

5.1242. Finally, the Sheil family submitted that the NSWPF submissions about Mr Sheil being "not concerned with the dishevelled state of his clothing" are unfounded and illogical. They are said to be unfounded because the Sheil family's statement included reference to the fact that Mr Sheil was "always fashionably dressed, and usually very fit", and illogical because the state of Mr Sheil's dress cannot be connected to his mental illness, let alone the relative likelihood of suicide.[1032]

5.1243. In reply to the Sheil family's submissions, the NSWPF stated that they agree "that care should be taken not to unduly perpetuate stereotypes associated with mental illness"[1033] but then proceeded to double down on the submission that a person with Mr Sheil's diagnosis "may be more likely to behave in unconventional ways than a person who was not suffering from such an illness" and be more likely to die by suicide.[1034] The NSWPF provided statistics, gleaned from a range of sources and not tendered into evidence in this matter, in support of this position. However, the NSWPF then stated that they make no "positive assertion" that Mr Sheil died by way of suicide.[1035]

[1031] Exhibit 20, Tab 22, Expert Report of Dr Linda Iles, 24 March 2023, 9 (SCOI.45162).

[1032] Submissions of the Sheil Family, 28 April 2023, [16] (SCOI.47468).

[1033] Submissions of NSWPF, 8 May 2023, [16] (SCOI.83083).

[1034] Submissions of NSWPF, 8 May 2023, [17] (SCOI.83083).

[1035] Submissions of NSWPF, 8 May 2023, [19] (SCOI.83083).

5.1244. In circumstances where the NSWPF submissions in respect of this issue appeared to make no direct criticism of how Counsel Assisting dealt with the issue of Mr Sheil's mental health, the point of such submissions remains elusive. I have concluded that such submissions were gratuitous and unnecessary. I agree with the submissions of the Sheil family that the submissions made by the NSWPF risked perpetuating misconceptions about mental illness generally, including that it is a continuous and permanent condition, inevitably makes people unpredictable and limits their ability to function normally in society. I am surprised and disappointed to have seen such submissions from the NSWPF.

Homicide

5.1245. According to the NSWPF, the evidence suggestive that Mr Sheil died by homicide has to be weighed against other factors, such as, "the treacherous ground above where his body was found; the evidence as to Mr Sheil's severe mental illness; the timing and location of Mr Sheil's death relative to other possible 'gay-hate' homicides; and the infrequency of homicide generally" meaning that "homicide is probably the least likely of the possible causes of Mr Sheil's death".[1036]

Lack of investigative records

5.1246. I note that Counsel Assisting submitted that more precise findings with regards to the manner and cause of Mr Sheil's death may have been possible had NSWPF been able to locate the records of the investigation, which were said to have occurred by Constable Strange in the week following the finding of Mr Sheil's body. For example, the exact location of Mr Sheil's body is unable to be ascertained, making the failure of the police to preserve and locate investigative files or other documents (including photographs said to have been taken of Mr Sheil's body by the Scientific Squad Police) particularly unfortunate.

5.1247. I agree with Counsel Assisting that the failure to locate and/or preserve the investigative file in relation to Mr Sheil's death is unfortunate. It is also unacceptable and consistent with systemic problems with the preservations of material more generally which has hampered the work of this Inquiry.

Bias

5.1248. There is no evidence to suggest that Mr Sheil was a member of the LGBTIQ community. There is a possibility that he was perceived to be a beat user.

5.1249. Counsel Assisting submitted there were some elements of Mr Sheil's case that give rise to the possibility that Mr Sheil died by homicide, and that such homicide was motivated by LGBTIQ bias. In circumstances where Mr Sheil was walking through or near a beat shortly before his death, it is possible that he was mistaken for a beat user and attacked by persons unknown for that reason. However, as submitted by Counsel Assisting, "there is no direct evidence to substantiate that hypothesis".[1037]

[1036] Submissions of NSWPF, 18 April 2023, [22] (SCOI.45192).

[1037] Submissions of Counsel Assisting, 4 April 2023, [80] (SCOI.45180).

5.1250. Although the NSWPF conceded that the evidence suggested that the coastal path between Coogee and Clovelly operated as a beat at the relevant time:[1038]

> *there is nothing to indicate what proportion of the persons walking the path used it to seek sexual or romantic connection. No doubt the path was, as it is today, popular with residents moving from place to place in the eastern beaches, and with persons simply seeking to walk in a picturesque coastal locale.*

5.1251. The characterisation of the coastal path by the NSWPF in this manner does not appear to consider or appreciate the fact that Mr Sheil was walking that path after 8:00pm, close to three hours after sunset. It is highly improbable that the path was significantly populated by casual walkers with a benign interest in the natural scenery at that time. That is not to say that it is possible to quantify the amount of people using the path for different purposes (as submitted by the NSWPF) but the fact that the coastal path between Coogee beach and Clovelly beach, around where Mr Sheil was found, operated as a beat in the 1960s-1980s, and Giles Baths, at the northern end of Coogee Beach near the beginning of that path, was also a beat, is relevant to the circumstances of Mr Sheil's death.

5.1252. I accept that as Mr Sheil's last known movements involved walking home via a coastal track that included and/or passed by a beat, it is possible that he was presumed to be a beat user and attacked for that reason (although I note that there is no direct evidence on this point). This is not the equivalent of a "positive conclusion" Mr Sheil's death was occasioned by homicide.

5.1253. The NSWPF submitted that the "status" of the possibility that Mr Sheil's death was a homicide:[1039]

> *should not be unduly elevated by speculation driven almost entirely by the fact that Mr Sheil was present in a location that at times served as a beat. This is all the more so when the relevant location was a popular coastal walking track (given that it is likely that only a small proportion of the persons walking the path were doing so for the purposes of finding sexual partners).*

5.1254. To the extent that the NSWPF sought to characterise the submissions of Counsel Assisting as "unduly elevating" the hypothesis that Mr Sheil died by homicide, I do not accept it as accurate or fair. Counsel Assisting noted the factors making it less likely that Mr Sheil's death was a homicide (i.e., that Mr Sheil's death occurred some years before, and some kilometres away from, the homicides and suspected homicides, motivated by LGBTIQ bias, at Marks Park and Bondi). As noted above, Counsel Assisting also submitted there was "no direct evidence" substantiating the hypothesis that Mr Sheil died by homicide.

[1038] Submissions of NSWPF, 18 April 2023, [13] (SCOI.45192).

[1039] Submissions of NSWPF, 18 April 2023, [14] (SCOI.45192).

5.1255. However, it would be remiss not to consider the fact that Mr Sheil was found with his shirt, belt and fly undone, and with his pants around his hips. As submitted by Counsel Assisting, this is consistent with the possibility he was engaging in sexual activity before he died. However, I also accept there are also several other possible explanations for the state of Mr Sheil's clothes, including that he was urinating, or that his pants came down during his fall or when he moved upon impact on the rocks below. Unfortunately, and given the evidence available to this Inquiry, these are not matters I am able to resolve.

5.1256. Ultimately, Counsel Assisting submitted that the evidence does not allow me to reach any positive conclusion about the events leading up to Mr Sheil's death, including whether it involved any other person and whether (if so) it was motivated by LGBTIQ bias. I note that the NSWPF also agrees with that conclusion. I accept that submission. However, as I explained in **Chapter 1**, it is not necessary for me to make positive findings of this kind in order to be satisfied that there is reason to suspect that LGBTIQ bias may have played a role in a person's death.

Observations

Location of death

5.1257. I observe that there is no evidence before the Inquiry as to the precise location of Mr Sheil's body. It is particularly unfortunate that the photographs taken by the NSWPF who attended the scene of Mr Sheil's death are not available to the Inquiry. In the absence of such photographs and other evidence, I accept the position of Mr Sheil's body is on the rocks below the coastal track at the northern side of Gordons Bay near Clovelly.

5.1258. I note, for the avoidance of doubt, that Mr Sheil died at Gordons Bay, although in some of the relevant documents it is referred to as Thompsons Bay. These are distinct, albeit adjacent, locations.

Police investigation

5.1259. An assessment of the features and quality of the NSWPF investigation should account for the fact that the investigation occurred forty years ago, and in the intervening period, there has been a substantial shift in relation to the standard of police investigations.

5.1260. In line with the submissions of Counsel Assisting, I afford little weight to the suggestion that Mr Sheil's death was as a result of stepping off the coastal track to masturbate. This appears to be based purely off the discovery of a "magazine of a sexual nature". No further detail regarding the contents, location or condition of this magazine have been provided to the Inquiry. Further, it is implausible that Mr Sheil would step off the path to masturbate, in conditions where it would have been dark, he had no light source, he was close to home, and he was subject to a curfew.

5.1261. Additionally, I agree with the submissions of Counsel Assisting, that some investigative steps should have been taken, including exploring lines of inquiry for Mr Sheil's death other than misadventure, taking statements from his friends and family, not delaying in obtaining statements from key witnesses, and carefully preserving investigative files and other documents.

Conclusions and findings

5.1262. I note and accept the evidence of the Inquiry's expert pathologist Dr Iles as to the cause of Mr Sheil's death. Dr Iles was of the opinion that the only injury capable of causing death is the upper cervical spinal cord injury, and the remainder of the injuries recorded in the post-mortem report were of a sublethal nature.

5.1263. I accept the finding as to manner and cause of death proposed by Counsel Assisting, and note the NSWPF's agreement with this finding. Accordingly, I find that:

> *Mr Sheil died between 27 April 1983 and 29 April 1983 as a result of cervical spine injuries sustained in a fall. There is insufficient evidence to enable a finding to be made as to whether the fall was accidental or otherwise.*

5.1264. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in Mr Sheil's death.

5.1265. I make the following recommendation proposed by Counsel Assisting and welcomed by the Sheil family:

Recommendation 2

I recommend that BDM correct the Register of Births, Deaths and Marriages pursuant to s 45(1)(b) of the *Births,* Deaths *and Marriages Registration Act 1995,* such that Mr Sheil's cause of death is recorded as: "cervical spine injuries sustained in a fall".

IN THE MATTER OF WENDY WAINE

Factual background

Date and location of death

5.1266. Wendy Waine was found deceased at about midday on Tuesday, 30 April 1985, in her unit on Darlinghurst Road in Darlinghurst, Sydney.

5.1267. Ms Waine is likely to have met her death the previous day, Monday, 29 April 1985. The time of her death is uncertain. However, the available evidence suggests that she died at some time in the 18 hours or so between approximately 3:15am and 9:00pm on that day.

Circumstances of death

5.1268. Ms Waine was shot at close range in her own apartment. Her body was found lying face down and naked on the floor at the side of the bed.[1040]

5.1269. There was one shot to the back of her neck and one to her upper back. There was also a bullet wound to her left hand, which was probably caused by a third bullet (as opposed to being a secondary re-entry wound caused by one of the original shots).[1041] In addition to the gunshot wounds, Ms Waine had bruising to the back of her head consistent with blunt force trauma.[1042]

5.1270. The distinctive muzzle imprint around the wounds to the back and neck are typical of those caused by an automatic pistol, held in close contact with the skin at the time of discharge. The wounds are larger than what would be expected to be caused by a .22 to .32 inch calibre firearm.[1043]

[1040] Exhibit 30, Tab 49, Statement of Constable Raymond Constable, 4 May 1986, 1 (SCOI.00014.00017).

[1041] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022 (SCOI.82960); Exhibit 30, Tab 49, Statement of Constable Raymond Constable, 4 May 1986, 2 (SCOI.00014.00017).

[1042] Exhibit 30, Tab 3, Post-mortem report of Dr Thomas Oettle, 15 October 1985, 2 (SCOI.00014.00022).

[1043] Exhibit 30, Tab 81, Expert report of Frank Lawton, 26 May 2023, 2 (SCOI.47477).

5.1271. No bullets or spent cartridges were located upon a search,[1044] suggesting that the offender or offenders were sufficiently sophisticated to remove ballistic evidence from the scene.[1045]

5.1272. The precise circumstances of Ms Waine's death, including who discharged the firearm, are otherwise unknown.

Previous investigations

Post-mortem examination

5.1273. A post-mortem examination was performed on 30 April 1985 by Dr Thomas Oettle. His final report is dated 15 October 1985.[1046]

5.1274. Dr Oettle recorded the following bullet wounds:

a. A bullet entry wound in the back of the neck, from which a track ran through the second cervical vertebra, across the mouth and through the left side of the mandible where an exit wound was present (**gunshot A**);

b. A bullet entry wound in the upper back at the base of the neck, from which a track ran slightly to the right of the first thoracic vertebra, the oesophagus and the right side of the trachea, where an exit wound was present (**gunshot B**); and

c. An entry and exit wound on the left hand (**gunshot C**).[1047]

5.1275. Dr Oettle provided no opinion as to whether gunshot C was caused by a third bullet, or, alternatively, was a secondary injury caused by the re-entry of a bullet from one of the first two wounds. However, Dr Linda Iles favours the explanation of this wound being caused by a third bullet.[1048]

5.1276. Dr Oettle further described a rectangular bruise on the scalp, 45mm x 18mm, as well as bruising on the periosteum (outer covering) of the skull and a subarachnoid haemorrhage about the right temporal lobe.[1049]

5.1277. A parchment abrasion was noted to be present under the right-hand side of the chin. An area of blue bruising was present on the upper right arm, on the margin of which was an abrasion consistent with a fingernail mark. There was minor bruising on the left iliac crest (i.e., top of the left hip).[1050]

5.1278. Dr Oettle recorded the cause of death as "bullet wounds of the neck and thorax."[1051]

[1044] Exhibit 30, Tab 49, Statement of Constable Raymond Constable, 4 May 1986, 2 (SCOI.00014.00017).
[1045] Exhibit 30, Tab 81, Expert report of Frank Lawton, 26 May 2023, 3 (SCOI.47477).
[1046] Exhibit 30, Tab 3, Post-mortem report of Dr Thomas Oettle, 15 October 1985 (SCOI.00014.00022).
[1047] Exhibit 30, Tab 3, Post-mortem report of Dr Thomas Oettle, 15 October 1985, 1-2 (SCOI.00014.00022).
[1048] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 7-8 (SCOI.82960).
[1049] Exhibit 30, Tab 3, Post-mortem report of Dr Thomas Oettle, 15 October 1985, 2 (SCOI.00014.00022).
[1050] Exhibit 30, Tab 3, Post-mortem report of Dr Thomas Oettle, 15 October 1985, 2 (SCOI.00014.00022).
[1051] Exhibit 30, Tab 3, Post-mortem report of Dr Thomas Oettle, 15 October 1985, 1 (SCOI.00014.00022).

Original police investigation

5.1279. The original police investigation commenced in 1985 and considered a number of lines of inquiry, each pointing to a different person or persons who may have been involved in Ms Waine's death. The investigation did not result in any charges. The evidence obtained in the course of the police investigation, and concerns about its adequacy, are considered below.

Exhibits

5.1280. During the course of the investigation, police collected the following exhibits:

a. An anal swab from Ms Waine taken by Dr Oettle at the post-mortem examination;

b. Hair taken from the left hand of Ms Waine; and

c. Six cigarette butts taken from an ashtray in the loungeroom at Ms Waine's unit.[1052]

5.1281. The anal swab and cigarette butts were examined in 1985. Semen was not detected on the anal swab. Saliva was detected on one of the cigarette butts and showed the presence of a group A blood substance. This was consistent with having come from Ms Waine, who was a group A secretor, but not determinative of that fact. The hair from Ms Waine's left hand was never examined.[1053]

Findings at inquest

5.1282. On 18 September 1986, some 16 months after Ms Waine's death, an inquest was held at the Coroners Court at Glebe. On that date, State Coroner Glass found that Ms Waine "died of the effects of bullet wounds of the neck and thorax inflicted there and then by a person unknown".[1054]

Criminal proceedings

5.1283. No person has been charged with any offence in relation to Ms Waine's death.

Subsequent police investigation

UHT Case Screening Forms

5.1284. The Inquiry has been provided with three UHT "case screening forms" in relation to Ms Waine's death.

5.1285. The first case screening form is dated 13 October 2004 and is signed by eight people as "reviewers". The rank and location of each reviewing officer is not stated. The space for a "co-ordinator's certification" is blank.[1055]

[1052] Exhibit 30, Tab 49, Statement of Constable Raymond Constable, 4 May 1986, 3 (SCOI.00014.00017); Exhibit 30, Tab 4, Forensic Biology Report of Rudolf Weigner, 22 May 1985, [2] (SCOI.00014.00020).

[1053] Exhibit 30, Tab 4, Forensic Biology Report of Rudolf Weigner, 22 May 1985, [3] (SCOI.00014.00020).

[1054] Exhibit 30, Tab 5, Findings of SC Glass, Inquest into the death of Wendy Waine , 18 September 1986 (SCOI.00014.00001).

[1055] Exhibit 30, Tab 102, NSWPF Case Screening Form, 'Review of an Unsolved Homicide Case Screening Form', 13 October 2004 (NPL.9000.0012.0063).

5.1286. It would appear that this document was the product of a student syndicate at a training course. Under the heading "Location of Brief of Evidence", it is stated, "[t]his review was conducted by participants of Homicide Course No 18 at the Goulburn Police Academy in October 2004".[1056]

5.1287. The second case screening form includes a "reviewer's certification" in the name of Detective Senior Constable McDonald of the UHT, dated 31 January 2005, and a "co-ordinator's certification" in the name of Detective Inspector R.A. Jarrett, dated February 2005. However, the space provided for each signature is blank.[1057]

5.1288. It would appear that this second document is also related to the October 2004 training course, since under the heading "Location of Brief of Evidence" in that document, the following very similar words appear, "[t]his review was conducted by members of Syndicate #3 of Homicide Course No. 18 that was held at the Goulburn Police Academy in October 2004".[1058]

5.1289. The cover page of the second case screening form as produced to the Inquiry, is a one-page document which was one of a set of 88 such UHT documents provided to the Inquiry in June 2022. Those 88 documents each consisted of the relevant Strike Force Parrabell case summary, together with a UHT notation as to the "status" of each case. In the case of Wendy Waine, this UHT cover page document stated that:

a. "[T]he matter was reviewed in 2008 by the UHT and again in 2012 by the Senior Detectives Course", and

b. "On tracking file – review conducted 2005".

5.1290. The "review" said to have been "conducted [in] 2005" appears to be a reference to the second case screening form, which in fact related to a training course exercise in October 2004.

5.1291. On 25 June 2023, following the hearing and tender of the tender bundle in this matter on 9 June 2023, the NSWPF produced additional UHT material in relation to the matter of Ms Waine.

5.1292. Amongst that bundle were the following documents:

a. An undated and unsigned UHT case screening form, that was different in content to the two case screening forms that the NSWPF had previously produced (**third case screening form**).[1059] It does not expressly indicate that it was completed by a syndicate of students in the Homicide Course;

b. An undated, unsigned two-page document headed "State Crime Command Investigation Plan" (**Investigation Plan**);[1060] and

[1056] Exhibit 30, Tab 102, NSWPF Case Screening Form, 'Review of an Unsolved Homicide Case Screening Form', 13 October 2004 (NPL.9000.0012.0063).

[1057] Exhibit 30, Tab 67A, NSWPF Case Screening Form, 'UHT Case Screening Review Form', February 2005, 12 (SCOI.02706).

[1058] Exhibit 30, Tab 67A, NSWPF Case Screening Form, 'UHT Case Screening Review Form', February 2005, 2 (SCOI.02706).

[1059] Exhibit 30, Tab 103, NSWPF Case Screening Form, 'Review of an Unsolved Homicide Case Screening Form', undated (SCOI.84808).

[1060] NSWPF State Crime Command Investigation Plan, undated (SCOI.84806).

c. An undated, unsigned document, headed "Senior Detectives Course – Unsolved Homicide Assessment" (**Homicide Assessment**).[1061] This document comprises five questions and their corresponding answers concerning the original investigation and possible future investigative steps. The answers would appear to be those provided by a student syndicate. The spaces for assessment of those answers, by the "Unsolved Homicide Assessment Panel", as well as for the names of such assessors, are blank. The document contains an assertion, on the first page, that "the Unsolved Homicide Unit … rely upon the recommendations of syndicates".[1062]

5.1293. One possibility may be that the third case screening form relates to the "review" which (according to the cover page document noted at [5.1289] above) is said to have taken place in 2008. Another possibility may be that the third document relates to the "Senior Detectives Course" which, according to the cover page of the second case screening form, took place in 2012. However, no documents establishing or clarifying either of those possibilities have been produced, presumably (given the succession of summonses which have been issued seeking documents relating to Ms Waine's case) because such documents do not exist. Nor has the Inquiry been provided with any documents indicating when the Investigation Plan was created, or what followed after its creation.

5.1294. The similarities in the content of the three additional documents are striking. The language in each of them is in some respects identical.[1063] This may give rise to an inference that they had a common author. If so, an alternative possibility may be that all three of the additional documents were prepared in connection with, or shortly after, a review of Ms Waine's case by a syndicate of students in a "Senior Detectives Course", possibly in 2012.

5.1295. However, the paucity of the material produced by the NSWPF as to the UHT's activities in relation to Ms Waine's case is such that I cannot be sure what those UHT activities have actually been. The two case screening documents previously produced, bearing dates in October 2004 and January/February 2005 respectively, both appear to relate to a training course exercise in October 2004. The Homicide Assessment also relates to a training course exercise, perhaps in 2012. On the evidence available to the Inquiry, there is no indication that an actual "review" of Ms Waine's case, by the UHT itself, has ever taken place, and if so when and with what outcome.

5.1296. The UHT does not appear to have any clear record as to whether and when any review of Ms Waine's case, by the UHT itself, has been conducted, or by whom. No records have been produced indicating whether the recommendations made by two separate training course syndicates, one in October 2004 and another at the time relevant to the Homicide Assessment, were considered, accepted, rejected, implemented or otherwise.

[1061] NSWPF Unsolved Homicide Assessment, 'Senior Detectives Course – Unsolved Homicide Assessment', undated (SCOI.84807).

[1062] Exhibit 30, Tab 105, NSWPF Unsolved Homicide Assessment, 'Senior Detectives Course – Unsolved Homicide Assessment', undated (SCOI.84807).

[1063] See, for example, the text under the heading "synopsis" in third case screening form and Homicide Assessment(SCOI.84808, p. 8-9 and SCOI.84807, p 2), and under the heading "situation" in the Investigation Plan (SCOI.84806).

The nature of a UHT review

5.1297. The Inquiry sought clarification of the nature and status of a "review" completed by participants in a Homicide Course, and the significance of the document being "certified."[1064] On 9 May 2023, the Inquiry was advised by the NSWPF that "the significance and/or meaning of the term 'certified' in relation to the review document cannot be accurately explained."[1065]

5.1298. The Inquiry was informed that unsolved homicide cases were, from time to time, given to syndicates of students at such a Homicide Course as part of "desktop exercises" conducted during the course. The exercise was completed by a group of four or five participants, who were usually from various investigative backgrounds, locations, and experience levels.[1066]

5.1299. Each Case Screening Form (the same type of form was used both in the Course and by the UHT) has two signature blocks at the bottom of the document to "certify" the review: one for completion by the student "reviewer" and the second for completion by the "co-ordinator". The Inquiry has been informed that the "reviewer" was to undertake a thorough review of the matter by accessing all available documents and exhibits, whereas the "co-ordinator" conducted a high-level review of the matter to ensure reviews were being undertaken appropriately.[1067]

5.1300. The Inquiry sought further clarification of what function, if any, any such Homicide Course "review" performed in the context of the UHT's operations.[1068] The response provided by the NSWPF did not elucidate whether it was intended that any of the recommendations generated by such a "review" be given further consideration by the UHT.[1069]

5.1301. These responses provide me with no basis for an understanding of the status of the Homicide Course "reviews" in relation to Ms Waine's case, nor of how the outcomes of those "reviews" were treated thereafter.

Recommendations of the UHT case screening forms

5.1302. In the case of Ms Waine, each of the first and second case screening forms contained extensive recommendations as to possible further investigative steps, including submitting exhibits for forensic analysis (noting that the status of those exhibits was listed as "to be clarified"), interviewing persons of interest and checking their alibis, and reinterviewing a number of witnesses spoken to by investigating police.

[1064] Exhibit 30, Tab 78, Letter from Solicitor Assisting the Inquiry to Office of the General Counsel, NSW Police Force, 1 May 2023 (SCOI.82995).

[1065] Exhibit 30, Tab 79, Letter from Office of the General Counsel, NSW Police Force, to Solicitor Assisting the Inquiry, 9 May 2023, 2 (SCOI.47476).

[1066] Exhibit 30, Tab 79B, Letter from Office of the General Counsel, NSW Police Force, to Solicitor Assisting the Inquiry, 26 May 2023, 2-3 (SCOI.83325).

[1067] Exhibit 30, Tab 79B, Letter from Office of the General Counsel, NSW Police Force, to Solicitor Assisting the Inquiry, 26 May 2023, 2 (SCOI.83325).

[1068] Exhibit 30, Tab 79A, Letter from Solicitor Assisting the Inquiry to Office of the General Counsel, NSW Police Force, 17 May 2023, 2 (SCOI.83324).

[1069] Exhibit 30, Tab 79B, Letter from Office of the General Counsel, NSW Police Force, to Solicitor Assisting the Inquiry, 26 May 2023, 2-3 (SCOI.83325).

5.1303. The third case screening form states that the "most pertinent" line of enquiry is to reexamine the exhibits that were seized from the crime scene, namely, the anal swab, hair and cigarette butts.[1070] However, in that same form, the column intended to indicate the location of each of these exhibits is left blank.[1071] One of the answers recorded in the Homicide Assessment acknowledges that, as at the time of that assessment, the "…records maintained are made (sic) it difficult to determine what has occurred with each exhibits such as where they were located and what examination has taken place".[1072]

5.1304. Similarly, in the first case screening form, it was stated that "There are no details of current exhibit location", and that "Advice is that no items were retained after 1986. Inquiries need to be made … re location of all exhibits".[1073] In the second case screening form, it was stated that the location of exhibits was "to be established".[1074] Annexure A to that document, dealing with exhibits, does not mention the anal swab at all, but notes that the whereabouts of the hair and the cigarette butts were "to be clarified".[1075]

5.1305. The present whereabouts of all three of these exhibits are unknown. Taken together, the five UHT documents produced to the Inquiry suggest that this has been the position since 1986. There is no evidence that any re-examination of the exhibits seized from the crime scene was ever conducted.

5.1306. The second case screening form completed by Detective Senior Constable McDonald includes a reference to the "fired bullets" having been examined and retained by the Ballistics Unit.[1076] I understand this reference to be in error, as the evidence establishes that no bullets were lodged in Ms Waine's body, or located by police at the scene.

5.1307. For completeness, the Inquiry drew this contradiction to the attention of the NSWPF and asked for the basis or source of the information contained in the UHT document.[1077] The Inquiry was advised that it remains unclear how the conclusion that fired bullets were examined and retained by the Ballistics Unit was reached. The NSWPF confirmed that there is no mention in the Ballistics Case File of projectiles or fired cartridge casings being located or examined.[1078]

5.1308. There is no evidence that the recommendations proposed in any of the case screening forms were considered or implemented by the UHT.

[1070] Exhibit 30, Tab 103, NSWPF Case Screening Form, 'Review of an Unsolved Homicide Case Screening Form', Undated 9 (SCOI.84808).

[1071] Exhibit 30, Tab 103, NSWPF Case Screening Form, 'Review of an Unsolved Homicide Case Screening Form', Undated 5 (SCOI.84808).

[1072] Exhibit 30, Tab 105, NSWPF Unsolved Homicide Assessment, 'Senior Detectives Course – Unsolved Homicide Assessment', Undated 7 (SCOI.84807).

[1073] Exhibit 30, Tab 102, NSWPF Case Screening Form, 'Review of an Unsolved Homicide Case Screening Form', 13 October 2004, 4, 61 (NPL.9000.0012.0063).

[1074] Exhibit 30, Tab 67A, NSWPF Case Screening Form, 'UHT Case Screening Review Form', February 2005, 2 (SCOI.02706).

[1075] Exhibit 30, Tab 67A, NSWPF Case Screening Form, 'UHT Case Screening Review Form', February 2005, 10 (SCOI.02706).

[1076] Exhibit 30, Tab 67A, NSWPF Case Screening Form, 'UHT Case Screening Review Form', February 2005, 10 (SCOI.02706).

[1077] Exhibit 30, Tab 78, Letter from Solicitor Assisting the Inquiry to Office of the General Counsel, NSW Police Force, 1 May 2023, 2 (SCOI.82995).

[1078] Exhibit 30, Tab 79, Letter from Office of the General Counsel, NSW Police Force, to Solicitor Assisting the Inquiry, 9 May 2023 (SCOI.47476).

5.1309. There has been no actual review or reinvestigation of Ms Waine's death by the UHT itself.

Strike Force Parrabell

Bias Crimes Indicators Form

5.1310. A BCIF was completed by Strike Force Parrabell. Of the ten indicators in the BCIF:

a. Five were answered "Suspected Bias Crime", namely "Comments, Written Statements, Gestures", "Organised Hate Groups (OHG)", "Previous existence of Bias Crime Incidents", "Motives of Offenders", and "Location of Incident";

b. Four were answered "Insufficient Information", namely "Differences", "Drawings, Markings, Symbols, Tattoos, Graffiti", "Lack of Motive", "Level of Violence"; and

c. One was answered "No Evidence of Bias Crime", namely "Victim/Witness Perception."

5.1311. The comments as to the indicators "Comments, Written Statements, Gestures" and "Organised Hate Groups (OHG)" make reference to the phone calls from an anonymous caller claiming responsibility for the murder of Ms Waine on behalf of the "Coven of Mercy for Fate". However, it is also noted that the unknown caller was never identified and "was more than likely a hoax caller."[1079]

5.1312. Counsel Assisting submitted, and I agree, that the answer of "Suspected Bias Crime", to the indicator "Motives of Offenders", seems somewhat confused. The response to the prompt, "The victim was perceived to be breaking from traditional conventions or working non-traditional employment", was that Ms Waine was "breaking from traditional conventions and was working in non-traditional employment". However, the indicator concerns the motive of the offender or offenders. The mere repetition of part of the wording of the prompt, without reference to the perception of any offenders, is of no relevance. Any such perception, on the part of any such offender/s, was unknown.[1080]

5.1313. The NSWPF "acknowledged" this criticism, and "agreed" that this indicator would more appropriately have been marked "Insufficient Information". [1081]

[1079] Exhibit 30, Tab 68, Strike Force Parrabell, Bias Crimes Indicators Review Form – Wendy Waine, Undated 4 (SCOI.74969).

[1080] Exhibit 30, Tab 68, Strike Force Parrabell, Bias Crimes Indicators Review Form – Wendy Waine, Undated 11-12 (SCOI.74969).

[1081] Submissions of NSWPF, 23 June 2023, [91] (SCOI.84379).

5.1314. Counsel Assisting also noted that, whereas the indicator "Victim/Witness Perception" was answered "No evidence of bias crime", the actual response to the only prompt applicable to that indicator (as to the perception of witnesses "that the incident was motivated by bias") recorded statements by friends or acquaintances to the effect that they did not know who would want to hurt Ms Waine and were not aware of any threats against her, or enemies she may have had. Such statements, to the extent that they were relevant to the prompt or the indicator, would seem (if anything) to suggest a lack of any other motive than bias or hate for Ms Waine's killing.[1082]

5.1315. The NSWPF, in submissions, "accepted" that this indicator could appropriately have been marked "Insufficient Information". [1083]

5.1316. Although five of the ten indicators were answered "Suspected Bias Crime", the "Summary of Findings" ultimately categorised the case overall as "Insufficient Information." No criterion or basis for this overall position is disclosed. The "Summary of Findings" otherwise appears to be no more than a repetition of some of the earlier content entered in relation to each indicator.

Case Summary

5.1317. The Strike Force Parrabell case summary (no. 16) for this matter reads as follows:[1084]

> ***Identity**: Wayne Brennan (Aka Wendy Wain)[sic] was 36 years old at the time of her death.*
>
> ***Personal History**: Ms Brennan was well known as a 'drag queen' who worked as a manager and performer at gay cabaret restaurant 'Pete's Beat' in Oxford Street, Darlinghurst. Ms Brennan would routinely sit at the front of her unit block on Darlinghurst Road to solicit men as they walked past, and if successful, take them into her residential unit for sex.*
>
> ***Location of Body/Circumstances of Death**: Ms Brennan's body was located naked, lying face down on the floor of her residential unit at Darlinghurst Road, Darlinghurst. The pathologist report indicated Ms Brennan had been initially knocked unconscious by a blow to the back of her head before being shot twice to the back and head with a large (possibly .45 calibre) firearm. The person/s that murdered Ms Brennan intended to kill her. All traces of evidence were removed from the crime scene. Police interviewed many people during this investigation, however no clear motive or suspects were identified and no person has been charged with this murder which remains unsolved.*
>
> ***Sexual Orientation**: Ms Brennan identified as a transgender female.*

[1082] Exhibit 30, Tab 68, Strike Force Parrabell, Bias Crimes Indicators Review Form – Wendy Waine, Undated 10 (SCOI.74969).

[1083] Submissions of NSWPF, 23 June 2023, [93] (SCOI.84379).

[1084] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Wendy Waine, Undated 8 (SCOI.76961.00014).

SF Parrabell concluded there was insufficient information to establish a bias crime

5.1318. A person's gender identity is not a "sexual orientation." The Case Summary is consistent with the comments in the BCIF, although does not refer to the telephone calls from the Coven of the Mercy for Fate which formed the basis for two of the indicators being answered "Suspected Bias Crime".

Academic Review

5.1319. The review by the Flinders University academic team also categorised this case as "insufficient information".

Review by the Inquiry

5.1320. The Inquiry took the following steps in the course of examining the matter.

Summonses

5.1321. A summons was issued to the NSWPF on 18 May 2022 for, all documents relating to investigations by the NSWPF of the death of Ms Waine, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Ms Waine. On 8 June 2022, a hard copy file in relation to Ms Waine's death was produced.

5.1322. On 29 September 2022, a further summons was issued requesting any personnel or Professional Standards records relating to "First Class Constable David Brown" (NSWPF23). On 11 and 19 October 2022, documents responsive to that summons were produced. The material produced is discussed further below.

5.1323. Extensive enquiries were made by the Inquiry, by way of summonses, to obtain information in relation to various witnesses or persons of interest. In total, over 20 summonses were issued in relation to these persons, to the NSWPF, BDM, the Department of Health, DCJ, Transport for NSW, MSS Security, and the police forces of each State and Territory in Australia. Requests for assistance were also made to DFAT, Services Australia, and FASS. Each of these summonses and requests, and their results, are set out in the statement of Mr Carvosso, solicitor at the Inquiry, dated 30 May 2023.[1085]

5.1324. On 18 April 2023, a summons was also issued to NSW Land Registry Services seeking to ascertain the registered proprietor of Ms Waine's Darlinghurst unit at the time of her death (LRS1).

Interagency cooperation

5.1325. On 11 May 2022, the Inquiry issued a written request to the Coroners Court for the coronial file in relation to Ms Waine's death. On 26 May 2022, that file was produced.

[1085] Exhibit 30, Tab 82, Statement of Rhys Carvosso, 30 May 2023 (SCOI.47479).

Family members

5.1326. On 17 April 2023, the Inquiry spoke with Ms Waine's sister Betty Ernst. Ms Ernst subsequently provided a statement to the Inquiry, dated 24 April 2023, recording her observations when attending Ms Waine's flat in the weeks after her death.[1086]

5.1327. On 11 May 2023, Ms Ernst provided the Inquiry with a further statement, reflecting on the life of Ms Waine and the impact her death had on her family.[1087]

Searches for exhibits

5.1328. On 24 August 2022, a summons to the NSWPF was issued requesting exhibit book references and EFIMS records in relation to four exhibits obtained in the course of the investigation of Ms Waine's death: strands of hair found in her left hand, six cigarette butts, bed linen, and fired bullets (NSWPF10).

5.1329. On 7 September 2022, being the return date of that summons, the NSWPF advised by email that two archive boxes previously delivered to the Inquiry on 2 June 2022 may contain material responsive to the summons. A search of those boxes revealed no responsive material. That email continued:[1088]

> *A further archive box was requested from archives on 1 September 2022 (as part of a broader request) which has not yet been received and which may also contain material responsive to this Summons. An estimate of the provision of this further archive box is being requested.*
>
> *I am instructed that apart from any relevant material that may be contained within those archive boxes, exhibit book references and EFIMS records for the exhibits listed in the Summons have been unable to be identified. This is apart from a single EFIMS record which appears to relate to a "sheet" that was located at the Ballistics Unit and was transferred to long-term exhibit storage in 2015. It is possible that that sheet relates to the "fired bullets" exhibit referred to in the Summons, however it is also possible that that exhibit was entered against the relevant event number in error. I am requesting that an attempt be made to clarify that.*

5.1330. On 14 September 2022, the NSWPF produced a photograph of a flannelette sheet, a J85-267 Ballistics Case File comprising two documents, J85-267 Ballistics Scene Photos, and three "floor plans". Referring to its outstanding searches, the covering email stated:[1089]

> *I am instructed that the outstanding box of archive material was couriered to the Inquiry on or about 1 August 2022, and is the same as that referred to above at Summons #7.*

[1086] Exhibit 30, Tab 34, Statement of Betty Ernst, 24 April 2023, [6]–[15] (SCOI.82945).

[1087] Exhibit 31, Family Statement – Wendy Waine (SCOI.83648).

[1088] Exhibit 30, Tab 70, Email from Office of the General Counsel, NSW Police Force, to Solicitor Assisting the Inquiry, 7 September 2022 (SCOI.82927).

[1089] Exhibit 30, Tab 71, Email from Office of the General Counsel, NSW Police Force, to Solicitor Assisting the Inquiry, 14 September 2022, 2 (SCOI.82937).

> *In relation to the "sheet" that was identified to have been held at the Ballistics Unit associated with the matter referred to in that Summons (and as referred to in my email of 7 September), it is apparent that that exhibit is a flannelette sheet. I attach a photograph of that exhibit. It is not clear to our instructing officers at this stage what the relationship of this exhibit is to the matter, if any. Our instructing officers are currently making attempts to clarify that.*

5.1331. It appears from crime scene photographs that the "sheet" referred to may be the flannelette sheet that covered Ms Waine's bed.[1090] The Inquiry also considered the utility of testing the flannelette sheet for gunshot residue or other evidentiary material. An independent ballistics expert briefed by the Inquiry, Mr Frank Lawton, advised that firearm debris could only assist in determining the type of ammunition used, not the type of firearm.[1091] He opined that there was little scope for further investigation or analysis that might identify the firearm used in the shooting.[1092] Having regard to this opinion, the Inquiry did not seek to have the sheet tested.

5.1332. On 6 March 2023, the Inquiry wrote to the NSWPF requesting a formal statement outlining the searches that had been carried out to locate material responsive to Summons NSWPF10. That statement was provided on 16 March 2023 by Detective Sergeant Neil Sheldon, who advised that:[1093]

a. Searches had been conducted on EFIMS;

b. Searches had been conducted of all NSWPF investigative holdings (WebCOPS, historical COPS data, pre-COPS data, e@gle.i and KODA);

c. Enquiries were made with the Kings Cross Police Area Command, which encompasses the Darlinghurst Police Station;

d. Enquiries were made with the NSWPF Records and Information Management Unit (Archives) for exhibit books located by Darlinghurst Police Station;

e. Searches were made of the exhibit books for the time period of April 1985 at Central Exhibits;

f. Enquiries were made with FETS; and

g. Enquiries were made with FASS.

5.1333. None of the above searches or enquiries located either the exhibit books or the exhibits.[1094]

[1090] Exhibit 30, Tab 51, Crime scene photographs (SCOI.82948).

[1091] Exhibit 30, Tab 81, Expert report of Frank Lawton, 26 May 2023, 4 (SCOI.47477).

[1092] Exhibit 30, Tab 81, Ballistics report of Frank Lawton, 26 May 2023, 5 (SCOI.47477).

[1093] Exhibit 30, Tab 75, Statement of Detective Sergeant Neil Sheldon, 16 March 2023, [9] (SCOI.82961).

[1094] Exhibit 30, Tab 75, Statement of Detective Sergeant Neil Sheldon, 16 March 2023, [8] (SCOI.82961).

5.1334. On 17 April 2023, a summons was issued to the NSWPF requesting the four exhibits the subject of Summons NSWPF10 (NSWPF86). By a letter of the same day, the Inquiry requested a formal statement as to the searches undertaken to locate those exhibits in the event that no exhibits were produced. That summons also requested, relevantly, the full fingerprint file in relation to Ms Waine's death. On 28 April 2023, the NSWPF advised by letter that there were no documents to produce in relation to either of the aforementioned categories, and that they relied on the statement of DS Sheldon dated 16 March 2023 as to the searches that have been conducted in relation to this matter.

Further forensic examinations

5.1335. The Inquiry sought and obtained a statement from Dr David Bruce, of FASS, as to the opportunities for forensic testing that would have been available had the exhibits (anal swab, hair samples and cigarette butts) been located.[1095]

5.1336. In relation to the anal swab, Dr Bruce noted that semen and spermatozoa were not detected in 1985. Chemical and microscopic examination of possible semen samples has not altered significantly to the present day, so it is unlikely this result would change with contemporary testing. In the absence of semen on the swab, Dr Bruce considered that DNA testing would be likely to only yield the DNA profile of the victim. Accordingly, the utility of re-testing the anal swabs would be limited.[1096]

5.1337. Of more significance, Dr Bruce considered that the hair sample from Ms Waine's left hand could have been subject to autosomal DNA profiling if there was cellular material on the root of the hair, as is typical of plucked hairs, or mitochondrial DNA sequencing if there was no such material, as is typical of shed hairs.[1097]

5.1338. Any autosomal, mitochondrial or Y-chromosome profile could have been compared to state, national or international databases, which could have yielded either direct matches to individuals and/or other crime scenes, or familial matches to possible relatives of an unknown individual.

5.1339. The hairs in Ms Waine's left hand are of particular forensic significance, as they may well have originated from a person involved in her homicide.

5.1340. In relation to the cigarette butts, Dr Bruce stated that these should contain saliva from the smoker, being a "high yield DNA source", which could have been DNA profiled using autosomal or Y-chromosome kits[1098], and, again, compared to state, national or international databases.

5.1341. The cigarette butts, while not necessarily left by any person involved in Ms Waine's death, could nonetheless have developed important investigative leads.

[1095] Exhibit 30, Tab 84, Expert certificate of David Bruce, 10 May 2023, [4] (SCOI.47480).

[1096] Exhibit 30, Tab 84, Expert certificate of David Bruce, 10 May 2023, [4] (SCOI.47480).

[1097] Exhibit 30, Tab 84, Expert certificate of David Bruce, 10 May 2023, [4] (SCOI.47480).

[1098] Exhibit 30, Tab 84, Expert certificate of David Bruce, 10 May 2023, [4] (SCOI.47480).

Professional opinions

5.1342. The Inquiry sought the opinion of Dr Linda Iles, forensic pathologist. The topics/questions she was asked to address included:

a. The adequacy of the post-mortem examinations conducted with respect to Ms Waine;

b. The time of Ms Waine's death; and

c. The location and nature of gunshot wounds found on Ms Waine's body.[1099]

5.1343. The Inquiry also sought the opinion of an independent ballistics consultant, Frank Lawton. The topics/questions he was asked to address included:

a. The likely calibre of the weapon used to shoot Ms Waine;

b. The number and trajectory of fired bullets;

c. The position of the shooter(s) and victim at the time of discharge; and

d. Whether any (and if so, what) testing was possible on the flannelette sheet produced by police.[1100]

Contact with OICs

5.1344. On 22 August 2023 and 25 September 2023, the Inquiry wrote to former Detective Senior Constable Di Francesco and former Detective Sergeant McCann enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Ms Waine. Former Detective Sergeant McCann advised that he did not wish to provide a response in relation to the death of Ms Waine.[1101] Further detail as to the contact between these officers and the Inquiry is outlined below.

Other

5.1345. The Inquiry carried out manual searches of relevant newspaper records, including the *Star Observer*, Queer Archives and daily newspapers (the *Sydney Morning Herald*, *Daily Telegraph*, *Daily Mirror* and *Sun* newspapers) to find any references to Ms Waine. Several relevant articles were identified.[1102]

[1099] Exhibit 30, Tab 80, Expert Report of Dr Linda Iles, (undated), 5-8, (SCOI.82960).

[1100] Exhibit 30, Tab 81, Ballistics report of Frank Lawton, 26 May 2023, 3-4 (SCOI.47477).

[1101] Exhibit 66, Tabs 81-82 and 84 to 85, Letters to Brian Di Francesco and Stephen McCann (SCOI.86339; SCOI.86340; SCOI.86342; SCOI.86343).

[1102] See Exhibit 30, Tabs 86-101.

Consideration of the evidence

Ms Waine's personal background

5.1346. Wendy Waine was a trans woman and a well-known entertainer in Kings Cross in the 1980s. She was reported to take great pride in being a member of the LGBTIQ community. Ms Waine received monthly hormone injections and was scheduled to have gender affirmation surgery. According to Ms Ernst, Ms Waine would sometimes present as male when working "odd jobs", but would present as female and go by "Wendy" when working in entertainment or socialising with friends.[1103]

5.1347. At the time of her death, Ms Waine was working at a cabaret bar named Pete's Beat on Oxford Street, not only performing, but also managing the talent and producing the many costumes for the casts of the shows that they hosted. Her drag performances were reported to draw large crowds, and she was known for her colourful, professional and dazzling shows.[1104] Ms Waine had also previously owned a plant shop with a friend, Ms Laurie Bradford, called "The Crown Plant Shop" on Crown Street, near Albion Street.[1105]

5.1348. Ms Waine was also a sex worker. In the months prior to her death, she had advertised her services in the *Wentworth Courier*,[1106] and would also work on Premier Lane[1107] and St Peters Lane[1108] (two connected laneways behind William Street in Darlinghurst) and outside her unit on Darlinghurst Road.[1109] Ms Waine used her residential unit for sex work.[1110] According to one witness, Ms Waine was "top-dog" or "very high up" on "the Street" as a sex worker.[1111]

5.1349. In early 1984, Ms Waine had been living at an address on Victoria Street, Potts Point. She later moved to an address on Liverpool Street, Darlinghurst, and moved again in about November 1984 to the Darlinghurst Road premises, where she would eventually be killed.[1112] She maintained the lease over the premises on Liverpool Street and sublet them to another sex worker, I247 (a pseudonym).[1113]

[1103] Exhibit 31, Family Statement – Wendy Waine, (undated), 1 (SCOI.83648).

[1104] Exhibit 30, Tab 99, Glenn Wells, 'Gay Murder Unsolved Two Years Later', *Darlinghurst Area Reporter Examiner* (Sydney, 14 May 1987); Exhibit 30, Tab 97, 'Wendy Waine', Obituaries, *Campaign Australia* (Sydney, June 1985).

[1105] Exhibit 30, Tab 29, Statement of I240, 3 May 1985, [8] (SCOI.10040.00083); Exhibit 30, Tab 30, Statement of Laurie Bradford, 7 May 1985, [3] (SCOI.00014.00019); Exhibit 30, Tab 62, Report of Occurrence, 'Shirley MacArthur Interviewed', 2 May 1985, 45 (SCOI.82924).

[1106] Exhibit 30, Tab 18, Statement of I238, 30 April 1985, [5] (SCOI.10040.00062); Exhibit 30, Tab 8, Statement of I242, 30 April 1985, [2] (SCOI.00014.00016).

[1107] Exhibit 30, Tab 16, Statement of I247, 30 April 1985, [2] (SCOI.10040.00047); Exhibit 30, Tab 21, Statement of Carmen Rupe, 30 April 1985, [4] (SCOI.10040.00034).

[1108] Exhibit 30, Tab 12, Statement of Patrick Crowe, 30 April 1985, [5] (SCOI.00014.00023).

[1109] Exhibit 30, Tab 31, Statement of Michael McCarthy, 7 May 1985, [3] (SCOI.00014.00009); Exhibit 30, Tab 62, Report of Occurrence, 'I228 interviewed', 9 May 1985, 82 (SCOI.82924).

[1110] Exhibit 30, Tab 16, Statement of I247, 30 April 1985, [2] (SCOI.10040.00047); Exhibit 30, Tab 29, Statement of I240, 3 May 1985, [5] (SCOI.10040.00083); Exhibit 30, Tab 62, Report of Occurrence, 'List of persons spoken to by vice squad police on 30.4.85', 30 April 1985, 28 (SCOI.82924) .

[1111] Exhibit 30, Tab 29, Statement of I240, 3 May 1985, [9] (SCOI.10040.00083).

[1112] Exhibit 30, Tab 16, Statement of I247, 30 April 1985, [1] (SCOI.10040.00047); Exhibit 30, Tab 26, Statement of I223, 1 May 1985, [6] (SCOI.00014.00012); Exhibit 30, Tab 28, Statement of I239, 3 May 1985, [4]–[5] (SCOI.10040.00081); Exhibit 30, Tab 62, Report of Occurrence, 'Interview with I236', 1 May 1985, 32 (SCOI.82924).

[1113] Exhibit 30, Tab 16, Statement of I247, 30 April 1985, [1] (SCOI.10040.00047).

5.1350. The premises on Darlinghurst Road had previously been leased, from the same owner, by NP181 (a pseudonym). NP181 used to "work out of" the unit with two other sex workers, and was eventually evicted for running the premises as a brothel.[1114] The landlord of the premises stated that "drag queens" had been living at his premises in the entire time that he owned it.[1115] One of Ms Waine's neighbours told police that he did not know how many people were living in the flat on Darlinghurst Road "because there [were] people coming and going all the time," including many trans people.[1116] There is some evidence that Ms Waine also allowed other sex workers to use her apartment for work.[1117]

5.1351. Ms Waine's criminal record comprised only three minor offences. The first two were for "offensive behaviour" and "offensive manner" in 1972, namely being a "male prostitute" and "offering French love dressed in womans [sic] clothing, male prostitute".[1118] These convictions were entered before the decriminalisation of sex work in NSW. The third charge was for larceny as a servant in 1983, relating to "four jackets".[1119] Beyond this limited and minor offending, there is no evidence that Ms Waine was involved in any criminal activities.

5.1352. Ms Waine was close to her family, including Ms Ernst and her children. Ms Waine's death had a devastating impact on her family, who have continued to mourn her loss, and struggle to understand why she was killed.[1120]

Discovery of Ms Waine's body

5.1353. Ms Waine's body was found by a friend, I230 (a pseudonym), at about midday on Tuesday, 30 April 1985. I230 worked at Pete's Beat.[1121]

5.1354. I230 had telephoned Ms Waine's number three times on the previous day, (Monday, 29 April 1985) with no answer.[1122] On the Tuesday, Mr Crowe, who managed the shows at Pete's Beat, called I230, also concerned that he had not heard from Ms Waine since Sunday.[1123] It was agreed that I230 would check to see if Ms Waine was home.[1124]

[1114] Exhibit 30, Tab 35, NSWPF Record of interview, 'Interview with NP181', 30 June 1986, 1 (SCOI.10040.00044); Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Landlord of premises interviewed', 30 April 1985, 25 (SCOI.82924).

[1115] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Landlord of premises interviewed', 30 April 1985, 25 (SCOI.82924).

[1116] Exhibit 30, Tab 27, Statement of Charles Saville, 2 May 1985, [3] (SCOI.10040.00073).

[1117] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'I232 Interviewed re Association with Deceased', 1 May 1985, 35 (SCOI.82924); Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'I228 interviewed', 9 May 1985, 82 (SCOI.82924).

[1118] Exhibit 30, Tab 67, NSWPF CNI Card of "Wayne Brennan", 'Criminal History of Wendy Waine' (SCOI.10039.00004).

[1119] Exhibit 30, Tab 67, NSWPF CNI Card of "Wayne Brennan", 'Criminal History of Wendy Waine' (SCOI.10039.00004).

[1120] Exhibit 31, Family Statement – Wendy Waine, Undated (SCOI.83648).

[1121] It is unknown whether I230 was transgender and identified as a woman. The name and pronouns are used consistently with contemporaneous police documents.

[1122] Exhibit 30, Tab 6, Statement of I230, 30 April 1985, [9] (SCOI.00014.00011).

[1123] Exhibit 30, Tab 6, Statement of I230, 30 April 1985 (SCOI.00014.00011).

[1124] Exhibit 30, Tab 6, Statement of I230, 30 April 1985, [10] (SCOI.00014.00011); Exhibit 30, Tab 12, Statement of Patrick Crowe, 30 April 1985, [8] (SCOI.00014.00023).

5.1355. At about midday on Tuesday, 30 April 1985, I230 went to Ms Waine's unit. When he arrived, he noticed that the front door was open about ten inches. He pressed the doorbell and called her name but received no response. After waiting some time, he went inside. The television and the electric heater were on. I230 discovered Ms Waine's body lying face down on the floor by the side of her bed. The bed was messed up and pillows were on the floor.[1125]

5.1356. I230 called Mr Crowe, who came to Ms Waine's flat with another employee at Pete's Beat, Mr Steven Crich.[1126] Police were called.

Crime scene examination

5.1357. When police arrived, the front door of the premises was open, and a set of keys was observed in the inside lock.[1127] Police would later receive information from a friend of Ms Waine's that it was her habit to place the key in her dead lock on the inside when she entered her flat.[1128] The television and electric heater remained on.[1129]

5.1358. On entering the bedroom, police observed a double bed in the centre of the room. The bedspread and blanket had been pulled down slightly in the centre of the bed, which was otherwise made. There was a blood-soaked pillow partially covered by the bedspread towards the centre of the bed, and blood spots on the lower part of the bedspread.[1130]

5.1359. When the bedspread was turned back, blood was observed on the top of the spread, and there was a hole through the spread in the vicinity of the blood.[1131]

5.1360. The right bedside table had blood smears on it, as did the wall to the left of the table. The body of Ms Waine was on the floor in front of the bedside table, lying face down, with her legs spread about a metre apart. Her left arm was outstretched above her head, while her right arm was under her right armpit. There was a pool of blood just above the left hand. A second pool of blood was to the right of that, connected to a blood smear leading to the location of Ms Waine's head. There was another pool of blood under Ms Waine's head.[1132]

[1125] Exhibit 30, Tab 6, Statement of I230, 30 April 1985, [11] (SCOI.00014.00011); Exhibit 30, Tab 12, Statement of Patrick Crowe, 30 April 1985, [9] (SCOI.00014.00023).

[1126] Exhibit 30, Tab 12, Statement of Patrick Crowe, 30 April 1985, [9] (SCOI.00014.00023); Exhibit 30, Tab 11, Statement of Steven Ross Crich, 30 April 1985, [3]–[4] (SCOI.10040.00026).

[1127] Exhibit 30, Tab 48, Statement of Senior Constable Stephen Coles, 30 April 1985, 1 (SCOI.00014.00013).

[1128] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'I238 Interviewed', 1 May 1985, 34 (SCOI.82924).

[1129] Exhibit 30, Tab 48, Statement of Senior Constable Stephen Coles, 30 April 1985, 1 (SCOI.00014.00013).

[1130] Exhibit 30, Tab 48, Statement of Senior Constable Stephen Coles, 30 April 1985, 1 (SCOI.00014.00013).

[1131] Exhibit 30, Tab 49, Statement of Constable Raymond Constable, 4 May 1986, 1 (SCOI.00014.00017).

[1132] Exhibit 30, Tab 48, Statement of Senior Constable Stephen Coles, 30 April 1985, 2 (SCOI.00014.00013).

5.1361. Later that same evening (30 April 1985), police returned to the unit to further search the premises for possible spent bullets or fired cartridge cases. A search, said to be "thorough", did not locate any fired cartridge cases or spent bullets.[1133] The search was said to have involved the removal of the carpet for possible damage to the floorboards by the projectiles; no damage to either the carpet or floorboards was noted in statements by the searching officers. No bullets were found lodged in Ms Waine's body, with each entry wound having a corresponding exit wound.

5.1362. Accordingly, it appears that at no time were any "fired bullets" found or collected as exhibits, despite assertions to the contrary in a later UHT review.

5.1363. Constable Raymond Constable, an officer attached to the Ballistics Unit, provided the following opinion:[1134]

> *From my examination of the bedroom I am of the opinion that the deceased was lying naked, face down on the bed and the first shot fired was either in the back or the neck, the bullet exiting the deceased and travelling through the bedspread stopping at the blanket. The deceased was then pushed off the left side of the bed onto the floor and the second shot discharged into the body. The offender then partially removed the bedspread to where the bullet had stopped at the blanket and removed it. The deceased was then dragged rearwards on the carpet and the bullet believed to be beneath [her] was recovered. A search was made of the room and the fired cartridge cases were found and all of these items removed from the scene by the offender, who then left the premises.*

5.1364. Police officers recorded no observations as to whether Ms Waine's flat appeared to have been searched or otherwise disturbed elsewhere. However, Ms Ernst told police that it appeared that Ms Waine's purse and other property was missing from her brown leather carry bag that was on the table in the living room, and that a diamond ring belonging to Ms Waine was missing. It is possible that these items were stolen by the offender or offenders.[1135]

5.1365. The Inquiry made contact with, and obtained a statement from, Ms Ernst. Ms Ernst recalled that, a few weeks after Ms Waine's death, police returned the apartment keys to her. She went to the apartment with her eldest son. On entering the bedroom where Ms Waine was killed, she did not observe blood on the floor or on the bed. The carpets did not appear to have been lifted, and she did not observe any bullet hole in the carpet.[1136]

5.1366. As is apparent, there may be an inconsistency on this point between the statement of the officers who conducted the search and the recollection of Ms Ernst. I do not consider it necessary to resolve this difference in making findings as to the manner and cause of Ms Waine's death.

[1133] Exhibit 30, Tab 49, Statement of Constable Raymond Constable, 4 May 1986, 2 (SCOI.00014.00017).

[1134] Exhibit 30, Tab 49, Statement of Constable Raymond Constable, 4 May 1986, 3 (SCOI.00014.00017).

[1135] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Information re Property Missing from the Flat Occupied by Brennan', 4 May 1985, 62 (SCOI.82924); Exhibit 30, Tab 34, Statement of Betty Ernst, 24 April 2023, [13]–[14] (SCOI.82945).

[1136] Exhibit 30, Tab 34, Statement of Betty Ernst, 24 April 2023, [8]–[9] (SCOI.82945).

Post-mortem examination, including review by Dr Iles

5.1367. The findings of the post-mortem examination are summarised above. Dr Oettle described three gunshot wounds as well as an injury to the back of Ms Waine's head, and recorded the cause of death as "bullet wounds of the neck and thorax."[1137]

5.1368. Dr Iles was briefed by the Inquiry to provide an independent review of the post-mortem report. While recognising the substantial changes to autopsy practice in the decades since Ms Waine's death, Dr Iles identified a number of deficiencies with the initial review.[1138]

5.1369. Dr Iles regarded the photo documentation of the gunshot wounds as "suboptimal", and the description of the gunshot wounds as "perfunctory".[1139] Of particular note, there were no detailed descriptions or measurements of the actual gunshot wounds contained within the report, nor was there a pathological determination of the range at which the shot was fired.[1140]

5.1370. In relation to the bruise on Ms Waine's head, Dr Iles noted that while the bruise on the under-surface of the scalp is documented, the hair from the scalp should have been removed to determine whether any patterned injury was evident on the skin of the scalp.[1141]

5.1371. In the statement of the OIC, Detective Sergeant McCann, it is noted that the force of the blow causing the injury to the back of Ms Waine's head "would have been sufficient to render the victim unconscious."[1142] This appears to be summarising an opinion apparently provided orally by Dr Oettle at the time of the post-mortem examination. That opinion does not appear in Dr Oettle's final report. Dr Iles' view was that the blow would not necessarily have rendered Ms Waine unconscious, although that possibility could not be excluded.[1143]

5.1372. Dr Iles also considered that specific documenting of the presence or absence of injury to the rectum and external genitalia would have been warranted, given the setting in which Ms Waine was found.[1144]

Opinions as to the gunshot wounds

5.1373. Dr Iles also provided her views in relation to the specific manner in which each of the gunshot injuries, described and defined above, may have been inflicted. Her opinions in those respects, as compared to the opinions of investigating police, are outlined below.

[1137] Exhibit 30, Tab 3, Post-mortem report of Dr Thomas Oettle, 15 October 1985, 1 (SCOI.00014.00022).

[1138] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 5-6 (SCOI.82960).

[1139] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 6, 8 (SCOI.82960).

[1140] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 6 (SCOI.82960).

[1141] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 6 (SCOI.82960).

[1142] Exhibit 30, Tab 47, Statement of Detective Sergeant Stephen Desmond McCann, 22 July 1986, [5] (SCOI.00014.00008).

[1143] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 9 (SCOI.82960).

[1144] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 6 (SCOI.82960).

Gunshots A and B

5.1374. The opinion of Constable Raymond Constable was that the wounds associated with gunshot A and gunshot B were "consistent with having been caused by the passage of a large calibre projectile with the muzzle of the weapon held in close contact with the skin at the time of discharge."[1145]

5.1375. Dr Iles' opinion is consistent with that of Constable Raymond Constable. Dr Iles described the entry wound associated with gunshot B as being "clearly a contact type wound", referring in particular to the "very distinct muzzle abrasion" evident in the photographs.[1146] The entry wound associated with gunshot A is less "well-demonstrated" in the photographs, but Dr Iles considered that there is "a suggestion of the outline of the recoil spring guard of a pistol" not dissimilar to that seen with gunshot B.[1147] Dr Iles also observed that less clarity as to a muzzle abrasion is reasonably expected given Ms Waine's scalp was covered by hair. [1148]

Gunshot C

5.1376. Neither Dr Oettle nor Constable Raymond Constable provided an opinion on the relationship between the wound to Ms Waine's left hand and the other two gunshot wounds.[1149] Detective Sergeant McCann's view was that the wound to the left hand was "consistent with it having been in line with the trajectory of either projectile [i.e. gunshot A or B]."[1150]

5.1377. However, Dr Iles favoured the view that the wound to the hand was caused by a third gunshot, rather than being a re-entry wound from a projectile related to gunshot A or B.[1151] Dr Iles noted the "apparent circular entry wound" with "notable blackening" around its margins, which she considered to be suggestive of "bullet wipe" (lubricant, gun barrel residue located on the outer surfaces of a bullet). Although Dr Iles noted that "drying artefact" around a penetrating wound can also give the appearance of blackening similar to bullet wipe, such that the possibility of gunshot C being a secondary entry wound cannot be excluded, she considered the wound to be "more suggestive" of a third gunshot entry wound.[1152]

5.1378. Given the absence of stippling or muzzle abrasion in the photograph, Dr Iles considered gunshot C to be a "distant" or "indeterminate pathological range" gunshot.[1153]

[1145] Exhibit 30, Tab 49, Statement of Constable Raymond Constable, 4 May 1986, 2 (SCOI.00014.00017).

[1146] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 8 (SCOI.82960).

[1147] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 8 (SCOI.82960).

[1148] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 8 (SCOI.82960).

[1149] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 7 (SCOI.82960).

[1150] Exhibit 30, Tab 47, Statement of Detective Sergeant Stephen Desmond McCann, 22 July 1986, [5] (SCOI.00014.00008).

[1151] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 8 (SCOI.82960).

[1152] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 7–8 (SCOI.82960).

[1153] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 7 (SCOI.82960).

The calibre, make and/or model of the firearm(s) used

5.1379. In a police running sheet dated 3 May 1985,[1154] authored by "Sandeman/ Constable" of the Ballistics Unit, an opinion was expressed that the wounds are consistent with having been caused "by large calibre projectiles possible .45 calibre."[1155] No basis was provided for this opinion, and its validity cannot be assessed in the absence of measurements taken of the gunshot wounds during the post-mortem examination. Dr Iles expressed no opinion as to the calibre of the firearm that inflicted the wounds.

5.1380. The Inquiry sought an opinion from Mr Lawton as to the calibre, make and/or model of the firearm used to shoot Ms Waine. In his report, dated 26 May 2023, Mr Lawton stated that the lack of firearm evidence (fired projectiles, fired cartridge cases and the firearm itself) precluded the identification of the type, make, model and calibre of the firearm used.[1156]

5.1381. He further observed that when a bullet hits and passes through the skin, it stretches and then contracts, making it difficult to estimate the size or calibre of a firearm from a gunshot wound.[1157]

5.1382. Nonetheless, he was of the opinion that the wounds in the photograph were "clearly" larger than those expected from a .22 to .32 inch, or similar, calibre firearm.[1158]

5.1383. A photograph taken at post-mortem shows a pair of hands holding a black pistol close to the entry wound of gunshot B.[1159] The shape of the muzzle appears to be consistent (at least approximately) with the muzzle abrasion on Ms Waine's back. There is no record as to the make or model of the firearm being held in the photograph.

5.1384. Mr Lawton reviewed the photograph taken at post-mortem. Mr Lawton identified the gun as an automatic pistol, similar in appearance to a Colt 1911, of which there are many copies, variants and manufacturers. He was unable to identify the precise gun shown. He further opined that the distinctive muzzle imprint around the wounds to the back and neck are typical of those caused by an automatic pistol.[1160]

5.1385. Mr Lawton considered there to be little scope for further analysis that might identify the firearm used.[1161]

[1154] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Murder of Wayne Brannan (sic) at Darlinghurst Road, Kings Cross', 3 May 1985, 56-57 (SCOI.82924).

[1155] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Murder of Wayne Brannan (sic) at Darlinghurst Road, Kings Cross', 3 May 1985, 57 (SCOI.82924).

[1156] Exhibit 30, Tab 81, Expert report of Frank Lawton, 26 May 2023, 2 (SCOI.47477).

[1157] Exhibit 30, Tab 81, Expert report of Frank Lawton, 26 May 2023, 3 (SCOI.47477).

[1158] Exhibit 30, Tab 81, Expert report of Frank Lawton, 26 May 2023, 3 (SCOI.47477).

[1159] Exhibit 30, Tab 52, Autopsy photographs, 6 (SCOI.82934).

[1160] Exhibit 30, Tab 81, Expert report of Frank Lawton, 26 May 2023, 1, 3-4 (SCOI.47477).

[1161] Exhibit 30, Tab 81, Expert report of Frank Lawton, 26 May 2023, 5 (SCOI.47477).

Medical evidence as to time of death

5.1386. In the original post-mortem report, Dr Oettle considered that the approximate time of death was about one day prior to the time and date on which the post-mortem examination had been performed (i.e., about 7:30pm on Monday, 29 April).[1162]

5.1387. By contrast, Dr Iles considered that there were no physical observations documented at the scene, or outlined in the post-mortem report, which provided any scientific support for a specific estimate of time of death. The post-mortem report does not record scene or core temperature observations, or the presence of rigor mortis or livor mortis. [1163] While early decompositional changes were noted in the liver, spleen and pancreas, the extent of decomposition depends not only on time since death, but other variables including ambient temperature, the presence or absence of clothing, cause of death, other underlying pathological conditions and entomological activity. Dr Iles concluded that there are "no medical observations recorded that usefully inform time of death estimation", and that estimates of time of death must instead be drawn from circumstantial information.[1164]

Movements prior to death

5.1388. Police conducted interviews with a large number of witnesses, including witnesses who were able to provide information as to the movements of Ms Waine in the days prior to her death.

5.1389. Ms Waine's movements are well accounted for on Sunday, 28 April 1985. In the early hours of that morning, at about 2:00am, Ms Waine finished work at Pete's Beat, and, when she left the club, said she was going "down to work."[1165] There is conflicting evidence as to whether she walked alone[1166] or was driven by a friend, Mr Nicholls;[1167] but in any event it is clear that she went to Premier Lane in Darlinghurst,[1168] where she worked as a sex worker.

5.1390. At about 1:00pm that same day, Sunday, 28 April, Ms Waine was seen by a friend, I224 (a pseudonym), walking in Liverpool Street, Darlinghurst, with an unknown man. I224 observed that they were arguing. She heard the man say, "Christ!" and wave his hands around in the air, but otherwise could not hear what they were saying.[1169] I224 described the unknown man as:[1170]

> *… about 37-38 old, about 5'10" tall, of average build with the start of a tummy, he had very dark collar length hair that was straight, but very messed up, very messy, like he had gel in it, but I don't think he did.*

[1162] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 6 (SCOI.82960); Exhibit 30, Tab 3, Post-mortem report of Dr Thomas Oettle, 30 April 1985, 1 (SCOI.00014.00022).

[1163] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 6 (SCOI.82960).

[1164] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 7 (SCOI.82960).

[1165] Exhibit 30, Tab 18, Statement of I238, 30 April 1985, [3] (SCOI.10040.00062).

[1166] Exhibit 30, Tab 18, Statement of I238, 30 April 1985, [3] (SCOI.10040.00062).

[1167] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Interview of Frederick George Nicholls, Associate of Deceased', 30 April 1985, 2 (SCOI.82924).

[1168] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Interview of I249 – Associate of Deceased', 30 April 1985, 1 (SCOI.82924).

[1169] Exhibit 30, Tab 13, Statement of I224, 30 April 1985, [4] (SCOI.10040.00055).

[1170] Exhibit 30, Tab 13, Statement of I224, 30 April 1985, [6] (SCOI.10040.00055).

> *He had an olive complexion and to me he looked like a Yugoslav or similar. He had a thick growth on his face. He had a blue denim jacket on and black trousers. He was wearing black running shoes with grey [stripes] on the side – they may have been dirty white. He had really noticeable eyebrows, very thick and bushy and they joined up in the middle and bit thinner that [sic] the rest. He had a very broad nose.*

5.1391. That evening, at about 5:00pm, Ms Waine met with her friend Mr Crowe and went for dinner with him and other friends on Oxford Street.[1171] At around 9:00 or 9:30pm, Ms Waine went to the apartment of I247, in Darlinghurst, to collect rent. She was dressed to go out.[1172]

5.1392. Ms Waine was seen at Premier Lane that night (Sunday, 28 April), and in the early hours of the following morning (Monday, 29 April), by other sex workers including I225 (a pseudonym) and I227 (a pseudonym).[1173]

5.1393. I225 worked at Premier Lane between 7:30pm on Sunday evening and 2:00am on Monday morning, and said that Ms Waine was at Premier Lane until at least the time when I225 went home. I225 described her as wearing a reddish brown and orange horizontally striped top, with a low neckline, and a very short white or cream skirt. She had a pink or cream jacket, a pair of cream shoes with a "mini-stiletto" type heel, and a black belt on her waistline.[1174] There is no record of whether such clothing was found in Ms Waine's apartment.

5.1394. At about 3:15am on Monday morning, 29 April, according to I227, Ms Waine was dropped at Premier Lane by a person known as "Bill".[1175] This might appear to be inconsistent with I225's evidence that Ms Waine was already at Premier Lane as at 2:00am. However, any such inconsistency may be explained by Ms Waine having left Premier Lane temporarily to see a client in a private location, possibly her apartment or in a car, before returning at a later time.

5.1395. Only moments after Ms Waine's arrival, I227 was approached by a male looking to purchase sexual services, but referred this man to Ms Waine when it became apparent that he was interested in a sex worker who had a room. According to I227, the man approached Ms Waine; they spoke for a few seconds, and then Ms Waine left Premier Lane with the man. As she was leaving, Ms Waine said, "I'll be back in half an hour girl at the latest."

5.1396. This was the last time that I227 saw Ms Waine, and is the last confirmed sighting of Ms Waine alive.[1176]

[1171] Exhibit 30, Tab 12, Statement of Patrick Crowe, 30 April 1985, [6] (SCOI.00014.00023); Exhibit 30, Tab 10, Statement of David Cook, 30 April 1985, [6] (SCOI.10040.00032).

[1172] Exhibit 30, Tab 16, Statement of I247, 30 April 1985, [3] (SCOI.10040.00047).

[1173] Exhibit 30, Tab 33, Statement of I225, 7 May 1985, [4] (SCOI.00014.00021); Exhibit 30, Tab 23, Statement of I227, 30 April 1985, [3] (SCOI.00014.00018).

[1174] Exhibit 30, Tab 33, Statement of I225, 7 May 1985, [4]–[5] (SCOI.00014.00021).

[1175] Exhibit 30, Tab 23, Statement of I227, 30 April 1985, [3] (SCOI.00014.00018).

[1176] Exhibit 30, Tab 23, Statement of I227, 30 April 1985, [3] (SCOI.00014.00018).

5.1397. I227 provided the following description of the male with whom Ms Waine left Premier Lane:[1177]

> *… about 22 to 26 years old, about 5'9" tall, medium build, medium complexion, dark collar length straight brown hair and he was wearing blue scraggy jeans and a black t-shirt which had a design on it… [H]e had a stud earring in his left ear which was silver… [He] had a tattoo on the back of his left hand which went down to his middle finger. I am not sure what the tattoo was but I thought it might have been a crucifix.*

5.1398. Some 12 hours later, between 3:45 and 4:00 pm on Monday afternoon, 29 April, a friend of Ms Waine's, I232 (a pseudonym), went to Ms Waine's unit on Darlinghurst Road. The front door was slightly open, and I232 knocked but received no answer.[1178] This information is recorded in a police occurrence pad, but no statement was taken.

5.1399. About five hours later still, at about 9:00pm on Monday evening, 29 April, another friend of Ms Waine's, I242 (a pseudonym), went past Ms Waine's unit. She also found the front door open an inch and the interior light on. She rang the doorbell and yelled out, but there was no answer. She looked in and saw that no one was in the living room.[1179]

5.1400. At about 11:00pm that night, I242 walked back past the flat, and noticed that the door was still open.[1180]

5.1401. As noted above, when Ms Waine's body was found at about midday the following day (Tuesday, 30 April), the door was ajar and the interior light was on. It seems likely, given the state of the door and the light as observed by I232 and I242, that the apartment had been left in this state from the time of her death. It is therefore possible that Ms Waine was already deceased at the time of those visits by I232 and I242, at 3:45pm and 9:00pm respectively on Monday, 29 April.

5.1402. However, in relation to the earlier visit at 3:45pm, consideration also needs to be given to a possible sighting of Ms Waine at 7:45pm, discussed below.

[1177] Exhibit 30, Tab 23, Statement of I227, 30 April 1985, [3] (SCOI.00014.00018).

[1178] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'I232 Interviewed re Association with Deceased', 1 May 1985, 35 (SCOI.82924).

[1179] Exhibit 30, Tab 8, Statement of I242, 30 April 1985, [3] (SCOI.00014.00016).

[1180] Exhibit 30, Tab 8, Statement of I242, 30 April 1985, [3] (SCOI.00014.00016).

Sighting of a woman outside Ms Waine's flat

5.1403. At approximately 7:45pm on Monday, 29 April 1985, two men, Mr Reid and Mr McCarthy, walked past Ms Waine's flat on Darlinghurst Road.[1181] Mr McCarthy saw a woman seated in front of the open door. Mr McCarthy believed her to be engaging in street based sex work and noted that there was a red light above the front door. He made a comment about her soliciting to Mr Reid, to the effect of, "Don't they ever give up, even in the rain." He described the woman as wearing a "black brief dress" and having "dark brown hair," but commented in his statement that he would not be able to recognise this person.[1182] Mr Reid confirmed that Mr McCarthy made that comment, but did not himself see the woman, as he was making a point of not looking, to avoid being propositioned.[1183]

5.1404. Investigating police treated this evidence as a conclusive sighting of Ms Waine. In his statement to the Coroner, Detective Sergeant McCann commented that the person described "fitted exactly the description of the deceased," and so surmised that Ms Waine probably died between 7:45pm and the time of I242's visit at 9:00pm. [1184]

5.1405. On this basis, Detective Sergeant McCann considered that "little value" could be given to the line of investigation regarding the man with whom Ms Waine had been seen leaving Premier Lane at about 3:15am that morning, or any other possible clients who may have engaged her in the early hours of that Monday morning.[1185]

5.1406. I agree with the submission of Counsel Assisting that the level of certainty expressed by Detective Sergeant McCann on this point seems unduly high, and that this 7:45pm sighting should not be treated as conclusive.

5.1407. The description provided by Mr McCarthy (which refers only to a "black brief dress" and "dark brown hair") is far from "fitting exactly" to Ms Waine. As to clothing, there is no record as to any clothing found at the crime scene that may have been worn by Ms Waine shortly prior to her death. As to her hair, photographs of Ms Waine show her with reddish brown hair in a distinctive curly bob style. Crime scene photographs show a dark coloured wig on the floor under the left knee of Ms Waine's body, but the exact colour or style of the wig cannot be ascertained.[1186]

5.1408. While the description given by Mr McCarthy does not exclude the possibility that it was Ms Waine whom he saw at 7:45pm on Monday evening, 29 April, it also is not a positive identification. This possible sighting, by Mr McCarthy, is insufficiently conclusive to rule out the possibility that Ms Waine was killed earlier than 7:45pm on Monday evening.

[1181] Exhibit 30, Tab 32, Statement of Anthony Reid, 7 May 1985, 1 (SCOI.00014.00010); Exhibit 30, Tab 31, Statement of Michael McCarthy, 7 May 1985, [3] (SCOI.00014.00009).

[1182] Exhibit 30, Tab 32, Statement of Anthony Reid, 7 May 1985, 2 (SCOI.00014.00010).

[1183] Exhibit 30, Tab 31, Statement of Michael McCarthy, 7 May 1985, [3] (SCOI.00014.00009).

[1184] Exhibit 30, Tab 47, Statement of Detective Sergeant Stephen Desmond McCann, 22 July 1986, [8]–[9] (SCOI.00014.00008).

[1185] Exhibit 30, Tab 47, Statement of Detective Sergeant Stephen Desmond McCann, 22 July 1986, [7]–[8] (SCOI.00014.00008).

[1186] Exhibit 30, Tab 51, Crime scene photographs (SCOI.82948).

5.1409. That would align with the evidence of I232, that Ms Waine's door was ajar, but no one was responding to the doorbell, at about 3:45pm on the Monday afternoon. That, in turn, would mean that it is possible that she was killed by a person who had engaged her at Premier Lane, including the male described by I227 as leaving Premier Lane with Ms Waine at about 3:15am on Monday morning, 29 April.

5.1410. In the opinion of Dr Iles, there are no medical observations that preclude the possibility that Ms Waine died prior to the alleged sighting at 7:45pm by Mr McCarthy.[1187]

5.1411. However, the possibility that Mr McCarthy did sight Ms Waine at about 7:45pm means that the time of her death may have been later than 7:45pm on Monday, 29 April, and that she may not have been deceased at the time of I232's visit to her apartment at 3:45pm on that day.

5.1412. Accordingly, on the available evidence, the appropriate conclusion is that Ms Waine's death occurred on Monday, 29 April 1985 at a time between approximately 3:15am (when she was last seen alive by I227) and 9:00pm (when I242 visited the Darlinghurst unit).

Lines of inquiry and persons of interest

5.1413. The police investigation identified a number of possible lines of inquiry in relation to how Ms Waine met her death. These included:

a. An association or relationship that Ms Waine had with a police officer known as "David";

b. An association or relationship that Ms Waine had with an MSS security guard, who was identified as possibly being NP179 (a pseudonym);

c. A theory that Ms Waine had been killed in relation to a dispute over a quantity of heroin that she had supposedly flushed down the toilet, based on statements allegedly made by NP176 (a pseudonym) to a man named Danny Shakespeare;

d. Claims made by an anonymous male that the "Coven of Mercy for Fate" was responsible for Ms Waine's killing; and

e. A fingerprint found on a phone in Ms Waine's apartment, identified as belonging to NP178 (a pseudonym).

5.1414. Each of these lines of inquiry is considered below.

Police officer "David"

5.1415. Numerous friends and associates of Ms Waine told police that she had been involved with a police officer, known to several of her friends as "David". Their various accounts have both similarities and differences, as indicated in the following paragraphs.

[1187] Exhibit 30, Tab 80, Expert report of Dr Linda Iles, 28 October 2022, 7 (SCOI.82960).

5.1416. **I223** (a pseudonym):[1188] I223 was a sex worker who would work at Premier Lane. She considered Ms Waine to be a close friend. I223 said that Ms Waine told her that she was "living in a relationship" with a police officer she called "David", that he worked at Darlinghurst Police Station, and that she ironed his shirts. I223 also said that Ms Waine told her that David was living partly with her and partly with his mother on Liverpool Street in Darlinghurst, and that David's mother did not approve of his relationship with Ms Waine because she was trans.[1189]

5.1417. I223 said that she first met David "about 6 months ago" (i.e., early November 1984), at Ms Waine's former unit in Victoria Street. He was wearing casual clothes. She described him as "a male, about 33 years of age, possibly of Greek or Italian origin, well built, dark short hair but not close cropped." She said David only stayed for a minute and then left.[1190]

5.1418. I223 said she saw David again once "about 2 months ago" (i.e., late February/early March 1985), this time at Ms Waine's apartment on Darlinghurst Road. On this occasion he was wearing white overalls.[1191]

5.1419. **Laurie Bradford**:[1192] Ms Bradford and Ms Waine were formerly business partners in a plant shop on Crown Street. When Ms Bradford knew Ms Waine, she was residing in "the Cross in a street behind the Crest Hotel."[1193] This may be a reference to her former apartment on Victoria Street, Darlinghurst.

5.1420. Ms Bradford said that Ms Waine told her that she was "going around" with a police officer called "David Brown or Brawn or something similar." Ms Waine had told her that he had "something wrong with his leg or arm." She had met David once when she went to Ms Waine's flat; he was sitting on the lounge in uniform. Ms Bradford also used to do Ms Waine's washing, and saw some police shirts with one stripe on them.[1194]

5.1421. Ms Bradford described David as "25 to 30 old, young looking face, slim build, (I only saw him sitting down) he wore Mens size shirts (I knew this because I ironed some)."[1195]

5.1422. **I233** (a pseudonym):[1196] I233 was a sex worker who had known Ms Waine for approximately five years, initially from their shared "beat" of Premier Lane.

[1188] Exhibit 30, Tab 26, Statement of I223, 1 May 1985 (SCOI.00014.00012).

[1189] Exhibit 30, Tab 26, Statement of I223, 1 May 1985, [7]–[8] (SCOI.00014.00012).

[1190] Exhibit 30, Tab 26, Statement of I223, 1 May 1985, [8] (SCOI.00014.00012).

[1191] Exhibit 30, Tab 26, Statement of I223, 1 May 1985, [9] (SCOI.00014.00012).

[1192] Exhibit 30, Tab 30, Statement of Laurie Bradford, 7 May 1985 (SCOI.00014.00019).

[1193] Exhibit 30, Tab 30, Statement of Laurie Bradford, 7 May 1985, [3] (SCOI.00014.00019).

[1194] Exhibit 30, Tab 30, Statement of Laurie Bradford, 7 May 1985, [4] (SCOI.00014.00019).

[1195] Exhibit 30, Tab 30, Statement of Laurie Bradford, 7 May 1985, [4] (SCOI.00014.00019).

[1196] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Interview with I233 re Alleged Policeman – Associate of Wayne Brennan', 10 May 1985, 85 (SCOI.82924).

5.1423. I233 recalled that in October or November 1984, she was at Ms Waine's apartment on Victoria Street when a man knocked on the door. Ms Waine said that this man was a "police officer who was hassling [her]." This police officer entered the apartment, and Ms Waine picked up the telephone "to call Internal Affairs." When she did this, the police officer hit her in the face, and then went into the kitchen where he broke a glass. Ms Waine had a conversation with the man and the situation settled itself.[1197]

5.1424. Ms Waine later told I233 that the police officer had lived with her for about a month and had taken money off her, and had also brought two friends to her home to have sex with her.

5.1425. I233 also said she saw the same person sitting in the passenger seat of a police truck, in uniform, patrolling Darlinghurst Road, Kings Cross.

5.1426. There is no record of any description of this person by I233 in the police note summarising the account she gave.

5.1427. As discussed below, I233 was later recorded by police as having recognised a photograph of a police officer in the Radar Technical Unit, Flemington, as being the person that she saw.[1198] The material produced to the Inquiry by the NSWPF includes no statement from I233, nor any such photograph, nor any documentation in relation to the photographs that she was apparently shown.

5.1428. **I237** (a pseudonym):[1199] I237 was a friend of Ms Waine's for approximately four years. I237 said that about "eight months ago" (i.e., September 1984), Ms Waine informed her that she was seeing a uniformed police officer from Darlinghurst Police Station. I237 said that Ms Waine told her of her relationship with the policeman on at least four or five occasions. However, she added that Ms Waine "carried on a bit" when bragging about who she was involved with. I237 could not recall Ms Waine mentioning the policeman's name.[1200] There is no statement from I237 in the material produced to the Inquiry by the NSWPF.

5.1429. **I231** (a pseudonym):[1201] I231 had known Ms Waine for about nine years, and used to live in Ms Waine's old premises in Liverpool Street. When asked by police about close associates of Ms Waine, I231 told police that Ms Waine had a "friend" who was a policeman called "George", although I231 never saw this person. There is no statement from I231 in the material produced to the Inquiry by the NSWPF.

[1197] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Interview with I233 re Alleged Policeman – Associate of Wayne Brennan', 10 May 1985, 85 (SCOI.82924).

[1198] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Interview with I233 re Alleged Policeman – Associate of Wayne Brennan', 10 May 1985, 85 (SCOI.82924).

[1199] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'I237 Interviewed', 6 May 1985, 74 (SCOI.82924).

[1200] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'I237 Interviewed', 6 May 1985, 74 (SCOI.82924).

[1201] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Interview of I231 re Brennan Murder', 6 May 1985, 75 (SCOI.82924).

5.1430. **I238** (a pseudonym):[1202] I238 had been a friend of Ms Waine's for about 20 years. She said that Ms Waine was "at one stage" going out with a uniformed police officer from Darlinghurst Police Station. I238 said that she saw him once only, when he arrived at Pete's Beat to collect Ms Waine. She described him as having "blonde hair and a moustache."[1203] There is no statement from I238 in the material produced to the Inquiry by the NSWPF.

5.1431. **I239** (a pseudonym):[1204] I239 was a casual waiter at Pete's Beat. I239 said that "about 10 months ago" (i.e. July 1984), Ms Waine had been at Pete's Beat when she received an upsetting phone call. Ms Waine said that she had a policeman as a boyfriend and that he had broken his arm. She said that this policeman stayed at her place on Victoria Street "off and on".[1205] I239 had also heard from Ms Waine that this policeman worked for the "Central Police Station."[1206]

5.1432. I239 was in a relationship with I223, and said that I223 had talked to him about Ms Waine's relationship with the police officer, specifically that she was seeing this policeman "pretty regular" and that his name was "David".[1207] Ms Waine had also, at a staff meeting in approximately September 1984, suggested that she could have criminal name checks done through this policeman, and had, in fact, found out that I239's brother was on a good behaviour bond.[1208]

5.1433. **I240** (a pseudonym):[1209] I240 was the brother of I239, and also knew Ms Waine through working at Pete's Beat. I240 had also heard that she was "seeing a copper friend", who was able to look into people's records. I240 believed this to be true as Ms Waine knew about his own juvenile record, and that he was on a good behaviour bond for arson.[1210]

5.1434. **Catherine Grimley**:[1211] Ms Grimley was a DJ at Pete's Beat. Ms Grimley told police that, in January 1985, she had been at the home of Ms Waine when Ms Waine received a phone call informing her that "David" had been injured at the Long Bay Gaol and that he was suffering from a broken arm and injuries to his ribs. Ms Waine had told Ms Grimley that she needed to arrange to have David's car moved from Long Bay Gaol. This car was said to "possibly" be a white Ford Fairmont that was owned jointly by "David" and Ms Waine.[1212] There is no statement from Ms Grimley in the material produced to the Inquiry by the NSWPF.

[1202] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'I238 Interviewed', 1 May 1985, 34 (SCOI.82924).

[1203] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'I238 Interviewed', 1 May 1985, 34 (SCOI.82924).

[1204] Exhibit 30, Tab 28, Statement of I239, 3 May 1985 (SCOI.10040.00081).

[1205] Exhibit 30, Tab 28, Statement of I239, 3 May 1985, [4] (SCOI.10040.00081).

[1206] Exhibit 30, Tab 28, Statement of I239, 3 May 1985, [7] (SCOI.10040.00081).

[1207] Exhibit 30, Tab 28, Statement of I239, 3 May 1985, [7] (SCOI.10040.00081).

[1208] Exhibit 30, Tab 28, Statement of I239, 3 May 1985, [9] (SCOI.10040.00081).

[1209] Exhibit 30, Tab 29, Statement of I240, 3 May 1985 (SCOI.10040.00083).

[1210] Exhibit 30, Tab 29, Statement of I240, 3 May 1985, [6] (SCOI.10040.00083).

[1211] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Information re Policeman "David"', 4 May 1985, 65 (SCOI.82924).

[1212] Exhibit 30, Tab 62, NSWPF Report of Occurrence, Information re Policeman "David"', 4 May 1985, 65 (SCOI.82924).

5.1435. **I234** (a pseudonym):[1213] A brief police note records that information was received from I234 that Ms Waine was "going out" with a police officer named "David Brown or Bowen."[1214] No further information is recorded. A statement was taken from I234 (under a different name); however, the statement made no mention of Ms Waine's relationship with a police officer.[1215]

5.1436. **I241** (a pseudonym):[1216] I241 had known Ms Waine for about nine months, having met her at Pete's Beat, but reported that they did not see "eye to eye." I241 stated that he was aware that Ms Waine was having a relationship with a policeman named "David", and that Ms Waine was "very protective" of him. If David was present when another friend visited her apartment, Ms Waine would not allow them to enter and would ask them to come back at another time.[1217] There is no statement from I241 in the material produced to the Inquiry by the NSWPF.

5.1437. **Robert William Lyon**:[1218] Mr Lyon was an inmate at the Metropolitan Remand Centre in Long Bay Gaol. He approached prison authorities stating he had information in relation to the murder of Ms Waine. Mr Lyon told police that he knew Ms Waine from working at Pete's Beat and had become good friends with her. On one occasion in November 1984, he said he was visiting Ms Waine at her flat on Victoria Street when a person came to the door and Ms Waine slammed the door on him. Ms Waine told Mr Lyon that the person's name was "David", and that he had been hassling her because Ms Waine kept on "knocking him back". Mr Lyon described David as being "in his early 30's, about 6' tall and clean shaven." He also reported that this person had a new sports car.[1219] There is no statement from Mr Lyon in the material produced to the Inquiry by the NSWPF.

5.1438. **I236** (a pseudonym):[1220] I236 was a friend and former flatmate of Ms Waine. I236 said she was aware that Ms Waine had at least two security guards as customers, and also one uniformed policeman and one detective who Ms Waine believed was in the drug squad. I236 was not able to provide further details about these persons.[1221] There is no statement from I236 in the material produced to the Inquiry by the NSWPF.

[1213] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Information re Police Officer David' , 5 May 1985, 67 (SCOI.82924).

[1214] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Information re Police Officer David', 5 May 1985, 67 (SCOI.82924).

[1215] Exhibit 30, Tab 24, Statement of I234, 30 April 1985 (SCOI.10040.00049).

[1216] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'I241 Interviewed re Murder of Wendy Wayne (sic)', 2 May 1985, 53 (SCOI.82924).

[1217] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'I241 Interviewed re Murder of Wendy Wayne (sic)', 2 May 1985, 53 (SCOI.82924).

[1218] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Interview of Robert William Lyon – Previous Associate of Deceased', 2 May 1985, 55 (SCOI.82924).

[1219] Exhibit 30, Tab 62, NSWPF Report of Occurrence, Interview of Robert William Lyon – Previous Associate of Deceased', 2 May 1985, 55 (SCOI.82924).

[1220] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Interview with I236 in Central Cells', 1 May 1985, 32 (SCOI.82924).

[1221] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Interview with I236 in Central Cells', 1 May 1985, 32 (SCOI.82924).

INQUIRIES BY INVESTIGATING POLICE INTO "DAVID BROWN" IN 1985-1986

5.1439. The accounts summarised above indicate that a large number of witnesses were aware of Ms Waine having a relationship with a person said to be a police officer. Some of those witnesses claimed to have seen this person, and several said that Ms Waine referred to him as "David". While there is some variance in the descriptions of this person, several witnesses said that he was attached to the Darlinghurst Police Station, and several estimated his age as being around 30. Mr Lyon and I233 referred to the police officer as "hassling" Ms Waine, and I233 recounted him being physically violent towards Ms Waine.

5.1440. Based on the material produced to the Inquiry by the NSWPF, the investigation into this "police officer" appears to me to have been incomplete.

5.1441. A police note dated 10 May 1985 recorded that I233 identified the photograph of a named police officer from the "Radar Technical Unit, Flemington" as being the person whom she had seen in company with Ms Waine, and that that officer had never been attached to Darlinghurst Police Station.[1222] As noted above, there is no statement from I233 in the material produced to the Inquiry by the NSWPF, nor any such photograph, nor any documentation in relation to the photographs that she was apparently shown.

5.1442. By contrast, when I223, who had seen "David" twice (as had I233), and provided a description of him, was also shown the photograph of the police officer nominated by I233, she said that this was definitely not the policeman "David" whom she had seen and with whom Ms Waine was "having an affair."[1223]

5.1443. In his statement to the Coroner, Detective Sergeant McCann referred to some of Ms Waine's associates having said that she was seeing a police officer named David, and to I223 and Ms Bradford having met David.[1224] (In fact, more than two witnesses claimed to have seen or met the policeman referred to, although not all of them said that they knew his name to be "David".)

5.1444. Detective Sergeant McCann said that, "in light of the fact that the killer had some awareness [of] ballistic evidentiary value, emphasis was placed on trying to identify this person."[1225] As to I233 having identified a constable from the photographs, Detective Sergeant McCann said:[1226]

> *That Constable was questioned and it [was] established that he has never been attached to Darlinghurst Police nor has he been in any Police truck in the area. Therefore it is felt that this line of enquiry has been exhausted.*

[1222] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Interview of I233 re Alleged Policeman – Associate of Wayne Brennan', 10 May 1985, 85 (SCOI.82924).

[1223] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Interview of I223 re Alleged Associate of Wayne Brennan named David', 10 May 1985, 84 (SCOI.82924).

[1224] Exhibit 30, Tab 47, Statement of Detective Sergeant Stephen Desmond McCann, 22 July 1986, [10] (SCOI.00014.00008).

[1225] Exhibit 30, Tab 47, Statement of Detective Sergeant Stephen Desmond McCann, 22 July 1986, [10] (SCOI.00014.00008).

[1226] Exhibit 30, Tab 47, Statement of Detective Sergeant Stephen Desmond McCann, 22 July 1986, [10] (SCOI.00014.00008).

5.1445. I accept the submission of Counsel Assisting, that to say that the line of enquiry concerning a policeman known as "David" had been "exhausted" may have overstated the position, for at least the following reasons:

a. First, it is possible that I233 identified the wrong person, particularly given that I223 thought that the person in the photograph was definitely not the person Ms Waine was in a relationship with;

b. Secondly, there were other witnesses who could have been asked whether they could identify the relevant person from photographs; however, there are no police notes or occurrence sheets to indicate that this occurred;

c. Thirdly, there were other details provided about the supposed police officer that could have provided a means of ascertaining his identity — for example, where he was residing, the apparent injuries he sustained, and the car he was said to have driven. There is no indication in the material produced to the Inquiry that such checks were made; and

d. Fourthly, several witnesses said that the police officer in question worked in the Darlinghurst area and/or was attached to the Darlinghurst Police Station. That would seem to indicate that the police officer from the Radar Technical Unit at Flemington was unlikely to have been that officer. Whether there were any Constables called "David", or otherwise meeting the description provided by witnesses, working in the Darlinghurst area does not seem to have been pursued.

5.1446. There is no evidence available to the Inquiry to link the police officer (if indeed the person in question was a police officer) with whom Ms Waine was in a relationship with her murder. However, further steps should have been taken to exhaust this line of enquiry.

THE INQUIRY'S INVESTIGATIONS INTO THE POLICE OFFICER KNOWN AS "DAVID"

5.1447. As noted above, the Inquiry received the personnel file for NP180(a pseudonym). The Service Register indicates that he was a "radar engineer" in 1985, and accordingly this is likely to be the same named police officer said to have been identified by I233 (and, according to the statement of Detective Sergeant McCann, questioned by police). There is no contemporaneous record in any of the material produced to the Inquiry by the NSWPF of NP180 being questioned.

5.1448. The records describe NP180 as being born in 1955 (and so, 29 or 30 at the time of Ms Waine's death), with fair hair, green eyes, weighing 78 kg and being 179 cm in height. I223 had described "David" as having "dark short hair" and as possibly having a Greek or Italian background, which tends to suggest that the person understood by I223 to be the police officer in a relationship with Ms Waine was not NP180.

5.1449. The Inquiry received information as to the name of another person (not NP180) who was suspected at the time of being the person, said to be a police officer, who witnesses identified as being in a relationship with Ms Waine. Various records were summoned in relation to this person, and in May 2023 he was questioned in a private hearing of the Inquiry.

5.1450. On the basis of the evidence obtained, this person is *not* considered to be the person who was in a relationship with Ms Waine, nor a person of interest in relation to Ms Waine's death. This evidence is addressed in **Chapter 17** of this report.

5.1451. It appears from a Police Armoury issue paper of 16 January 2023, produced to the Inquiry, that this person had been issued a .38 revolver when serving in the NSWPF in around 1985.[1227] Based on the expert evidence of Mr Lawton, Ms Waine was probably killed with an automatic pistol rather than a revolver.[1228]

The MSS Security Guard

5.1452. On 2 May 1985, William Elton, an associate of Ms Waine's, told police that Ms Waine was "keeping company" with an MSS Officer who drove a white Datsun 120 Y Sedan. Mr Elton also claimed to have overheard from other drag queens that this person would frequent the Premier Lane area, wearing his full uniform and in possession of a pistol.[1229]

5.1453. Also on 2 May 1985, Charles Saville, who resided in the same building as Ms Waine, told police that on the late morning of either Sunday, 28 April or Monday, 29 April 1985, between 10:00 am and 12:00 pm, he saw a man dressed in a blue "uniform type outfit" walk in the main doors of the building.[1230] Mr Saville said that this person was a security guard, and that he was "pretty sure" that the logo on his shoulder badge (which was light blue with red) was MSS Security. He described this man as:[1231]

> *30 to 35 old, 5'8 or 9" tall, well build [sic] by that solid and fit. [D]ark brown hair that was long at the sides and he was wearing a uniform type hat same as the Police and the colour matched his uniform. His skin was fair.*

5.1454. Mr Saville told police that he would recognise this person again.[1232]

5.1455. Whether Mr Saville saw this person on Sunday morning, 28 April or the Monday morning, 29 April is obviously important, but does not emerge clearly from his statement. In that statement, he described his movements on Sunday, 28 April, saying that he was "home through most of the day", other than leaving to attend the Hare Krishna Temple between 4:30pm and 8:00pm.[1233] This may perhaps suggest, although not necessarily, that his sighting of the security officer was more likely to have been on the Monday. A sighting of an MSS Security Officer entering Ms Waine's building on the Monday, 29 April would be of greater significance, since Ms Waine was not killed until sometime after about 3:15am on that day.

[1227] Exhibit 30, Tab 58, NSWPF Issue Paper, 'NSWPF Issue Paper by Chief Inspector R Steinborn (Police Armoury)', 16 January 2023 (NPL.0119.0002.0001).

[1228] Exhibit 30, Tab 81, Expert Report of Frank Lawton, 26 May 2023, 3 (SCOI.47477).

[1229] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Interview of William Elton re Wayne Murder', 2 May 1985, 49 (SCOI.82924).

[1230] Exhibit 30, Tab 27, Statement of Charles Saville, 2 May 1985, [8] (SCOI.10040.00073).

[1231] Exhibit 30, Tab 27, Statement of Charles Saville, 2 May 1985, [8] (SCOI.10040.00073).

[1232] Exhibit 30, Tab 27, Statement of Charles Saville, 2 May 1985, [8] (SCOI.10040.00073).

[1233] Exhibit 30, Tab 27, Statement of Charles Saville, 2 May 1985, [4] (SCOI.10040.00073).

5.1456. Police enquiries ultimately identified an MSS Security Officer by the name of NP179 (a pseudonym), who admitted to having a sexual relationship with Ms Waine.[1234] NP179 had dated, and would go on to date, other trans sex workers who lived in the Kings Cross and Darlinghurst areas.[1235]

5.1457. Mr Saville was never shown a photograph of NP179 to ascertain if he was the man he had seen entering Ms Waine's apartment block.

5.1458. Mr Saville is now deceased.[1236]

INTERVIEW WITH NP179 IN 1985

5.1459. On 2 May 1985, NP179 was interviewed by police and provided a signed statement.[1237]

5.1460. NP179 told police that he had been employed by MSS as a "static guard" for approximately eight months, and was engaged on duties in various locations throughout the metropolitan area. NP179 said he met Ms Waine at Pete's Beat about two years ago (i.e. in 1983), and had a relationship with her for only about two weeks after they first met, at which time she was living on Albion Street in Surry Hills. Since that time, he had seen Ms Waine "a couple of times" at Pete's Beat.[1238]

5.1461. However, Mr Elton's account to police (not the subject of a statement by him, but only of an entry in a run sheet), seems to have been that Ms Waine was "keeping company" with an MSS Security officer at the time of her death, in April 1985. If that is right, then either there was another MSS Security Officer (later than NP179) who was doing so, or NP179's account was not true.

5.1462. NP179 gave a detailed account of his movements between Friday, 26 April 1985 and Monday, 29 April 1985. Given that the time of Ms Waine's death must have been in or after the early hours of Monday morning, 29 April, it is his movements from late Sunday, 28 April 1985 to Monday, 29 April 1985 that are most relevant, and these are set out below:

a. NP179 lived with two people at an address in the suburb of "Karilla". There is no such suburb as "Karilla". The address may have been in Kareela, NSW;[1239]

b. NP179 claimed to have arrived home at about 6:00pm on Sunday, 28 April 1985, to have spoken to the two people with whom he resided, and then remained at home from that time on that evening;[1240]

[1234] Exhibit 30, Tab 41, Statement of NP179, 2 May 1985, [4] (SCOI.10035.00014).

[1235] Exhibit 30, Tab 25, Statement of I222, 30 April 1985, [2]–[3] (SCOI.10040.00053); Exhibit 30, Tab 50, Statement of Constable David William Gallagher, 7 March 1986 (SCOI.10040.00079).

[1236] Exhibit 30, Tab 82, Statement of Rhys Carvosso, 30 May 2023, [32] (SCOI.47479).

[1237] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Resume of statement obtained from NP179 re Murder of Wendy Wayne (sic)', 2 May 1985, 51 (SCOI.82924); Exhibit 30, Tab 41, Statement of NP179, 2 May 1985 (SCOI.10035.00014).

[1238] Exhibit 30, Tab 41, Statement of NP179, 2 May 1985, [3]–[5] (SCOI.10035.00014).

[1239] Exhibit 30, Tab 41, Statement of NP179, 2 May 1985, [2] (SCOI.10035.00014).

[1240] Exhibit 30, Tab 41, Statement of NP179, 2 May 1985, [8] (SCOI.10035.00014).

c. NP179 stated that he was woken by Michael at 6:00 am on Monday, 29 April 1985, and left for work at "Darlinghurst Social Security" on Oxford Street, Darlinghurst, at 7:30am;[1241]

d. He said that he took his lunch break at 12:30 pm, and also went to the bank to get money out, before returning to work at the Social Security Office, where he finished work at about 5:30pm;[1242] and

e. After that, NP179 said that he did martial arts training with Lawrence Lee at an address on Terry Street in Drummoyne. Training finished at 7:30pm, and he returned home to Kareela.[1243]

5.1463. NP179 stated that he received a pistol from MSS Security, which he had to sign for. The pistol was a Browning 32mm. He stated that he signed the pistol in at about 1:30am on Saturday, 27 April 1985 and did not sign the pistol back out until Tuesday, 30 April 1985, at about 5:30pm.[1244] Accordingly, on NP179's account, he did not have access to his MSS pistol over the window of time during which Ms Waine was killed. NP179 said that he did not have any private firearms and nor, to his knowledge, did the two people with whom he resided.

5.1464. As noted above, the material available to the Inquiry suggests that the firearm used to kill Ms Waine was of a larger calibre than .32.

5.1465. There is no indication in any of the material provided to the Inquiry by the NSWPF that any steps were taken to check the account given by NP179.

5.1466. In particular, police could and should have:

a. Identified, located and interviewed NP179's housemates in relation to his movements on the evening of Sunday, 28 April and the morning of Monday, 29 April;

b. Interviewed Lawrence Lee as to whether NP179 attended martial arts training on the evening of Monday, 29 April; and

c. Obtained employment rosters or other confirmation from MSS as to his work schedule.

5.1467. The Inquiry has attempted to pursue these matters, but the passage of time (now some 37 years) means that in some respects this is now not possible.

[1241] Exhibit 30, Tab 41, Statement of NP179, 2 May 1985, [10] (SCOI.10035.00014).

[1242] Exhibit 30, Tab 41, Statement of NP179, 2 May 1985, [10] (SCOI.10035.00014).

[1243] Exhibit 30, Tab 41, Statement of NP179, 2 May 1985, [10] (SCOI.10035.00014).

[1244] Exhibit 30, Tab 41, Statement of NP179, 2 May 1985, [11] (SCOI.10035.00014).

THE INQUIRY'S INVESTIGATIONS INTO NP179

5.1468. The Inquiry summoned material from the NSWPF for any firearms records for NP179. That material indicated that NP179 was issued with a one-year firearms license on 26 September 1989 (more than three years after Ms Waine's murder), and that no firearms offences are recorded against NP179.[1245] Despite not having a firearms license in 1985, NP179 may have had lawful access to a firearm licensed to MSS Security in his capacity as a "Licensed Private Inquiry Agent"[1246]: see *Firearms and Dangerous Weapons Act 1973*, s. 7 (as then in force).[1247]

5.1469. A summons was issued to MSS Security requesting any firearms and personnel records relating to NP179. However, such records were only held for seven years and are no longer available.[1248] The opportunity to test NP179's account against these objective records has been lost.

5.1470. Finally, summonses were issued to Transport for NSW requesting the vehicle registration history for NP179, and the DCJ requesting any employment records for NP179 at Long Bay Correctional Complex.[1249] Each was issued in order to explore the evidence given by Ms Grimley as to Ms Waine's partner 'David' having been injured in January 1985 at Long Bay and having owned a white Ford Fairmont, having regard to the possibility that witnesses may have confused a police officer and a security officer.

5.1471. The Inquiry received electronic records from Transport for NSW which did not pre-date 1990.[1250]

5.1472. The Inquiry received no documents from the DCJ in response to the summons, despite the Inquiry receiving confirmation that the records dated back to 1985.[1251] From this it may be inferred that NP179 was not employed at that facility at the relevant time.

5.1473. Although the Inquiry was able to ascertain the current whereabouts of NP179, other information acquired by the Inquiry was such that I determined it would be inappropriate to summons NP179 to give evidence before the Inquiry.[1252]

Interview with Danny Shakespeare

5.1474. On 5 January 1986, at the Maroubra Police Station, police from Darlinghurst Police Station (Detective Constable Short and Detective Constable Trench) interviewed a man named Danny Robert Shakespeare. A typed record of interview (**ROI**) was prepared, and it appears to have been signed by Mr Shakespeare (although not by the interviewing officer, Detective Constable Short). [1253]

[1245] Exhibit 30, Tab 82, Statement of Rhys Carvosso, 30 May 2023, [23] (SCOI.47479).

[1246] Exhibit 30, Tab 41, Statement of NP179, 2 May 1985, [11] (SCOI.10035.00014).

[1247] *Firearms and Dangerous Weapons Act 1973* (NSW) s 7.

[1248] Exhibit 30, Tab 82, Statement of Rhys Carvosso, 30 May 2023, [24] (SCOI.47479).

[1249] Exhibit 30, Tab 82, Statement of Rhys Carvosso, 30 May 2023, [25], [27] (SCOI.47479).

[1250] Exhibit 30, Tab 82, Statement of Rhys Carvosso, 30 May 2023, [25] (SCOI.47479).

[1251] Exhibit 30, Tab 82, Statement of Rhys Carvosso, 30 May 2023, [27] (SCOI.47479).

[1252] Exhibit 30, Tab 82, Statement of Rhys Carvosso, 30 May 2023, [20] (SCOI.47479).

[1253] Exhibit 30, Tab 45, NSWPF Record of interview, 'Interview with Danny Robert Shakespeare', 5 January 1986, 1 (SCOI.10034.00009).

5.1475. The running sheet in respect of that day, 5 January 1986, to which this ROI seems to have been attached, is headed "WENDY WAYNE [sic] @ BRENNAN MURDER INQUIRY". At the foot of the page of the running sheet appears a date five years later, 20 January 1991, against the name of Detective Senior Constable Di Francesco of Homicide South.[1254]

5.1476. Question 12 in the ROI was "Do you have any knowledge of who murdered Wendy WAYNE (sic)?" Mr Shakespeare's answer began as follows, "[y]es. I was living with [NP176] at Maroubra. I was questioned by Detectives over the murder of Wendy WAYNE (sic)."[1255] There is nothing in any of the material provided to the Inquiry by the NSWPF which indicates that Mr Shakespeare had been interviewed by police at any previous time in connection with the death of Ms Waine.

5.1477. In the ROI, Mr Shakespeare claimed to have known Ms Waine through a woman named NP176, with whom he said he was in a relationship with at the time of Ms Waine's death. Mr Shakespeare gave a detailed account of an alleged confession made by NP176, as to involvement in the murder of Ms Waine. The context and nature of that admission, according to Mr Shakespeare, was as follows:[1256]

a. Mr Shakespeare was living with NP176, and his mother, at his mother's address in Maroubra;

b. He knew where Ms Waine lived, in Darlinghurst. He had been there once but had not gone in;

c. He had been (as noted in the previous paragraph), "questioned by Detectives over the murder of Wendy WAYNE (sic)." He told NP176 that "I was worried that I could be charged with it";

d. NP176 replied "no you can't be". When Mr Shakespeare asked her why, she said, "Because I know who the person involved was," and told Mr Shakespeare that she could "prove that" to him;

e. At that point, NP176 went to the bathroom and had a shot of heroin, and Mr Shakespeare had a conversation with his mother; and

f. After Mr Shakespeare's mother had gone to bed, they continued their conversation about the murder. NP176 told Mr Shakespeare that she wanted to talk to somebody and that she trusted Mr Shakespeare. She told Mr Shakespeare to swear not to ever say anything about what she was about to tell him, because if he did they "would both be dead."

[1254] Exhibit 30, Tab 61, NSWPF Running Sheet, 'Wendy Wayne (sic) @ Brennan Murder Inquiry', created 5 January 1986, 3 (SCOI.82932).

[1255] Exhibit 30, Tab 45, NSWPF Record of interview, 'Interview with Danny Robert Shakespeare', 5 January 1986, 2 (SCOI.10034.00009).

[1256] Exhibit 30, Tab 45, NSWPF Record of interview, 'Interview with Danny Robert Shakespeare', 5 January 1986, 2 (SCOI.10034.00009).

5.1478. According to Mr Shakespeare, NP176 then proceeded to say the following things:[1257]

a. NP176 at first said that she and Ms Waine were selling heroin for "a person". (Mr Shakespeare said that he did not initially know who NP176 was talking about, but that he later understood from NP176 that it was Neddy Smith);

b. NP176 had been staying at Ms Waine's place when Mr Shakespeare first met NP176, which he estimated as "about 7 or 8 months ago". (That would indicate a period from early May to early June 1985, a period beginning slightly after Ms Waine was killed, and so must be inaccurate);

c. While staying at Ms Waine's place, NP176 had heroin that she and another sex worker named I236 were bagging to sell. When Ms Waine came home and saw what they were doing, an argument started, and NP176 said she would get rid of the drugs. NP176 went and made a phone call, and when she came back, both I236 and the drugs were gone;

d. The following day, I236 told her that Ms Waine had flushed the drugs, and that Ms Waine had demanded that I236 get out or she would call the police;

e. NP176 and I236 together then spoke to Ms Waine in a coffee shop, and Ms Waine confirmed that she had flushed the drugs;

f. NP176 told Ms Waine that she would have to "pay back the money", being five or six hundred dollars. Ms Waine replied that she wasn't going to pay NP176 back. She said that she knew who NP176 was selling drugs for, and that if NP176 did not leave her alone and stop "hassling" her, she would "drop them";

g. After that meeting, NP176 saw Ms Waine a number of times. Ms Waine still refused to "pay back the money". NP176 believed "she had no choice either Wendy copped it or she [NP176] copped it";

h. At some point after that, NP176 and two men, one named Ian and another man whose name Mr Shakespeare could not remember, had gone to Kings Cross, where NP176 and Ian waited across the road from Ms Waine's unit;

i. The other man drove to the lane and acted as a customer and picked up Ms Waine. He took her back to her apartment, where she did "the $100 and $200 jobs";

j. NP176 and Ian waited for 10 or 15 minutes, before entering the apartment with a key that NP176 had from when she was staying there. The unnamed man left;

k. NP176 started to argue with Ms Waine, who "had nothing on". NP176 pushed her to the ground, and Ian shot her "with a .22." (Mr Shakespeare added here, "I don't know if that is the right gun [NP176] doesn't know about guns");

l. NP176 grabbed a few of her belongings and left. The "other guy" (Ian) remained at the flat because "he was going to make sure that no one knew how or what she was shot with";

[1257] Exhibit 30, Tab 45, NSWPF Record of interview, 'Interview with Danny Robert Shakespeare', 5 January 1986, 2-4 (SCOI.10034.00009).

m. NP176 and Ian then met the unnamed man in his car outside the Gold Fish Bowl (a club in Kings Cross);

n. All three then drove to "the Art Museum", and NP176 got rid of the stuff that she had picked up at Ms Waine's flat. They also got rid of the gun "somewhere down there" (but NP176 did not tell Mr Shakespeare what they did with it); and

o. The murder was organised by Neddy Smith, and NP176 was paid in "smack" and her "debts were wiped out". Ms Waine was murdered because "she knew too much" about NP176's "association and activities and the people she was involved with".

5.1479. Ms Waine's reported reaction, on finding NP176 and I236 engaged in bagging heroin in her flat, would suggest that the initial claim recounted by Mr Shakespeare, that Ms Waine had been jointly involved with NP176 in selling drugs, was unreliable.

5.1480. Mr Shakespeare stated that he was prepared to attend court and give evidence in this matter. However, it appears that no statement was ever taken from Mr Shakespeare.

5.1481. Nor, so far as can be ascertained from the material produced to the Inquiry by the NSWPF, was any attempt ever made to locate and interview NP176 in relation to Mr Shakespeare's accusations.

INTERVIEW WITH NP181

5.1482. On 30 June 1986, nearly six months after the interview with Mr Shakespeare and more than a year after Ms Waine's death, investigating police (Detective Sergeant McCann and Detective Senior Constable Di Francesco) spoke to NP181. Again, a typed ROI was prepared, and it appears to have been signed by NP181 (although again not by the interviewing officer, who in this case was Detective Sergeant McCann).[1258]

5.1483. The running sheet in respect of that day, 30 June 1986, to which this ROI seems to have been attached, is also headed "WENDY WAYNE [sic] @ BRENNAN MURDER INQ". At the foot of the page of this running sheet again appears the much later date, 20 January 1991, against the name (again) of Detective Senior Constable Di Francesco of Homicide South.[1259]

5.1484. NP181's ROI is somewhat difficult to follow and at times ambiguous. However, NP181 does recount a conversation that she claims to have had with Mr Shakespeare about Ms Waine's murder. When this conversation is suggested to have taken place is not clear.[1260]

5.1485. According to NP181, Mr Shakespeare told her, among other things, that:[1261]

[1258] Exhibit 30, Tab 35, NSWPF Record of interview, 'Interview with NP181', 30 June 1986 (SCOI.10040.00044).

[1259] Exhibit 30, Tab 61, NSWPF Running Sheet, 'Wendy Wayne (sic) Brennan Murder Inq.', created on 30 June 1986, 7 (SCOI.82932).

[1260] Exhibit 30, Tab 35, NSWPF Record of interview, 'Interview with NP181', 30 June 1986, 1 (SCOI.10040.00044).

[1261] Exhibit 30, Tab 35, NSWPF Record of interview, 'Interview with NP181', 30 June 1986, 1 (SCOI.10040.00044).

a. He himself had been present at Ms Waine's flat on the night of Ms Waine's murder, at about 10:00pm. Also present, apart from himself, were Ms Waine, NP176, "some guy reportedly NP176's boyfriend" and a person called I231 who was "Wendy's best friend";

b. He "hadn't told the police everything because he didn't want his wife to know that he had been involved with these transexuals";

c. He had left NP176 at Ms Waine's place "because there was some argument over a quantity of heroin, reportedly about $15,000, street value worth", that Ms Waine had "flushed" down the toilet because she hadn't wanted heroin in her place; and

d. The heroin that NP176 had "came through" Neddy Smith, and Mr Shakespeare had "no doubt in his mind" that Ms Waine had been murdered over heroin.

5.1486. According to NP181, she expressed suspicion about the involvement of I231. She said that although I231 was Ms Waine's "best friend", she had not waited for the funeral but instead had just gone to New Zealand immediately after Ms Waine's death.[1262]

5.1487. However, more than a year earlier, on 6 May 1985, police had interviewed I231, a friend of Ms Waine's, who claimed that she had travelled to Christchurch, New Zealand, on 18 April 1985 — that is, some 11 days before Ms Waine's death.[1263]

5.1488. Through interagency cooperation, the Inquiry has confirmed that I231 did, in fact, depart Australia on 18 April 1985, on vessel TE44. On the assumption that I231 was the I231 in question, then the accusations about her both by Mr Shakespeare (to NP181), and by NP181 herself, would appear to be plainly wrong.

5.1489. NP181's whole account must be treated with great caution, including because it is second-hand hearsay and generally of an imprecise or speculative nature.

5.1490. There are also notable discrepancies between Mr Shakespeare's account in his own ROI and that attributed to him by NP181 in her ROI, including, for example:

a. Mr Shakespeare told police he had never been inside Ms Waine's flat, but supposedly told NP181 that he was in the flat on the very night that Ms Waine was murdered;

b. Mr Shakespeare's ROI makes no mention of any involvement of I231 in Ms Waine's death, but in the version he supposedly conveyed to NP181, I231 was also present in the flat on the night in question;

c. Mr Shakespeare's ROI makes no mention of anyone said to be NP176's boyfriend, while conversely NP181's ROI makes no mention of Mr Shakespeare saying anything about "Ian"; and

[1262] Exhibit 30, Tab 35, NSWPF Record of interview, 'Interview with NP181', 30 June 1986, 1, 3 (SCOI.10040.00044).

[1263] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Interview of I231 re Brennan Murder', 6 May 1985, 75 (SCOI.82824).

d. The reputed street value of the drug was "five or six hundred dollars" according to Mr Shakespeare's ROI, but "about $15,000" according to what Mr Shakespeare supposedly told NP181.

5.1491. The Inquiry has confirmed that NP181 is now deceased.[1264]

CREDIBILITY OF DANNY SHAKESPEARE

5.1492. Danny Shakespeare has a long public criminal history as a conman, police informer and liar. His criminal record dates back to 1979, and spans NSW, Victoria, South Australia and Queensland. His record includes offences of fraud, stealing, and robbery, as well as notably a charge of knowingly making a false accusation.[1265]

5.1493. Mr Shakespeare has been comprehensively and repeatedly discredited as a witness of truth. Two examples indicate the views of judicial officers about Mr Shakespeare's reliability:

a. Mr Shakespeare was the key prosecution witness in the case against Mr Garry Nye for the murder of Mr Roy Thurgar. Mr Nye was acquitted after trial in 1992, and sued the State of NSW for malicious prosecution, wrongful arrest and false imprisonment. Justice O'Keefe upheld Mr Nye's claims and awarded both aggravated and exemplary damages.[1266] In his Honour's judgment, O'Keefe J made a scathing assessment of Mr Shakespeare's credibility.[1267] His Honour described Mr Shakespeare as an "obvious liar",[1268] and found that Mr Shakespeare's account was "so shot-through with recantations, contradictions, discrepancies and like indications of the untrustworthiness as to be ludicrous".[1269] His Honour considered that "deliberate lies were apparent"[1270] and that Mr Shakespeare was "making a good deal of his story up as he went along."[1271] As Mr Shakespeare's evidence was essential to the prosecution case, his Honour concluded that there was no reasonable and probable cause for the institution of the criminal proceedings against Mr Nye; and

b. In 1996, Mr Shakespeare gave evidence before the Coroner that he had witnessed Detective Inspector John Davidson murder the notorious hitman Christopher Dale Flannery, also known as "Mr Rent-a-Kill".[1272] At that time, Mr Shakespeare was using the alias Danial Pagge.[1273] Mr Shakespeare's account was thoroughly discredited. In his findings as to the death of Mr Flannery, Coroner Glass commented that Mr Shakespeare "displayed an extraordinary ability to stand his ground, to persistently lie under oath with a straight face, and exhibit effrontery and boldness in the manner he gave his false evidence." His evidence was described as a "systematic and calculated attempt by him to

[1264] Exhibit 30, Tab 82, Statement of Rhys Carvosso, 30 May 2023, [19] (SCOI.47479).

[1265] See Exhibit 30, Tab 82, Statement of Rhys Carvosso, 30 May 2023, [12]–[18] (SCOI.47479).

[1266] *Nye v State of New South Wales & ors* [2003] NSWSC 1212

[1267] *Nye v State of New South Wales* & ors [2003] NSWSC 1212 at [47]–[94].

[1268] *Nye v State of New South Wales* & ors [2003] NSWSC 1212 at [93].

[1269] *Nye v State of New South Wales* & ors [2003] NSWSC 1212 at [88].

[1270] *Nye v State of New South Wales* & ors [2003] NSWSC 1212 at [59].

[1271] *Nye v State of New South Wales* & ors [2003] NSWSC 1212 at [80].

[1272] Findings of SC Glass, Inquest into the disappearance and suspected death of Christopher Dale Flannery, 5 June 1997.

[1273] Findings of SC Glass, Inquest into the disappearance and suspected death of Christopher Dale Flannery, 5 June 1997, 480.

> mislead police, coronial investigators, Counsel Assisting, the Court and even his own legal advisers on a grand scale."[1274] Mr Shakespeare would later plead guilty to a charge of making a knowingly false accusation against Mr Davidson.[1275] Coroner Glass referred the inquest papers to the ODPP, on the basis there was evidence to support a perjury charge against Mr Shakespeare.[1276]

5.1494. Some aspects of Mr Shakespeare's ROI are consistent with some of the objective circumstances known about Ms Waine's death, including: that Ms Waine was seen leaving Premier Lane with an unknown man; that Ms Waine was killed in her Darlinghurst apartment; that Ms Waine was naked when killed; that Ms Waine was killed by gunshot; and that the offender/s had removed ballistics evidence from the scene.

5.1495. However, a media review conducted by the Inquiry discloses that all of those details had been published in newspaper reports at the time of Ms Waine's death.[1277] Accordingly they cannot and do not indicate anything about the veracity of Mr Shakespeare's overall account.

SUBSEQUENT INVESTIGATIVE STEPS NOT TAKEN

5.1496. By 1986 (when Mr Shakespeare was interviewed in connection with the death of Ms Waine), Mr Shakespeare had been convicted of serious violent property offences, including robbery and demanding money with menace. However, he did not yet have any convictions for dishonesty offences. His first conviction for a dishonesty offence, dishonestly obtaining a benefit by deception, occurred in late 1987. It is therefore unknown whether investigating police would have been aware of his unreliability and untruthfulness.

5.1497. As noted above, the discrepancies between Mr Shakespeare's own ROI and what NP181 claimed that he had said to her are numerous and significant. Nevertheless, given that the central feature of Mr Shakespeare's two different versions was that NP176 had some involvement in the murder of Ms Waine and knew who the actual murderer was, the absence of any attempt to locate and interview NP176 is unexplained.

5.1498. The only material produced by the NSWPF to the Inquiry which refers to any interaction by police with NP176 is a Bureau of Crime Intelligence form called a "Criminal and General Information" (**CGI**) Form. It was dated 26 January 1986, and it recorded that at 12:20am, on Saturday, 25 January 1986, Detective Constable BJ Whittle spoke to NP176 on the street at Kings Cross Road, Kings Cross.

[1274] Findings of SC Glass, Inquest into the disappearance and suspected death of Christopher Dale Flannery, 5 June 1997, 482.

[1275] Findings of SC Glass, Inquest into the disappearance and suspected death of Christopher Dale Flannery, 5 June 1997, 484.

[1276] Findings of SC Glass, Inquest into the disappearance and suspected death of Christopher Dale Flannery, 5 June 1997, 485.

[1277] Exhibit 30, Tab 87, 'Drag queen's death riddle'. *The Daily Mirror,* 1 May 1985, 2 (SCOI.82939); Exhibit 30, Tab 86, Mark Forbes, 'Police hunt transvestite's killer'. *Sydney Morning Herald,* 1 May 1985 (SCOI.82923); Exhibit 30, Tab 88, Peter Holder and Steve Brian, 'Killer could strike again: Body in the pool of blood'. *The Sun*, 1 May 1985 (SCOI.82947); Exhibit 30, Tab 91, John Choueifate, 'I sent 'Wendy' his Killer! Police told of 'sick pervert'. *The Daily Mirror*, 3 May 1985 (SCOI.82966); Exhibit 30, Tab 89, Alan Hardie, 'Wendy killing shocks gays'. *The Daily Telegraph*, 1 May 1985 (SCOI.82963).

5.1499. The form, as completed by Detective Constable Whittle on 26 January 1986, made no mention of Ms Waine's murder. It included reference to an "alias/nickname" used by NP176. It referred to her "new address" in Petersham, and to things that she said, including who she was living with, that she had been released from prison three weeks ago, that she was not using heroin or working on the streets, and that she was receiving unemployment benefits.

5.1500. This CGI form, like the ROIs of both Mr Shakespeare (5 January 1986, three weeks earlier) and NP181 (30 June 1986, five months later), was also annexed to a police "running sheet", this one in respect of 26 January 1986. This running sheet was again headed "WENDY WAYNE [sic] @ BRENNAN MURDER INQ". Again, at the foot of the page of this running sheet appears the date, 20 January 1991, against the name of Detective Senior Constable Di Francesco of Homicide South.[1278]

5.1501. The running sheet in relation to the interaction with NP176 on 25 January 1986 contains the following under the heading "Narrative":

> *[NP176] was spoken to at Kings Cross on 26.1.86. At the time the interviewing officer did not realise that she/he was a suspect in the matter and only recorded the details as a matter of course.*

5.1502. Thus, according to this running sheet, NP176 was regarded as at 25/26 January 1986, by someone, as a "suspect in the matter". Whether that view was based on Mr Shakespeare's claims, or otherwise, is not apparent.

5.1503. However, regardless of the basis on which police held that view, there is nothing in any material produced to the Inquiry by the NSWPF which suggests that any other steps were ever taken to locate or interview that "suspect", NP176, in connection with the murder of Ms Waine.

5.1504. On 22 July 1986, Detective Sergeant McCann signed a statement for the Coroner, which was tendered at the inquest into Ms Waine's death on 18 September 1986.[1279] The statement made no mention of the claims made by Mr Shakespeare or NP181, or about any line of inquiry relating to Ms Waine being killed in relation to drug related matters. Detective Sergeant McCann said:[1280]

> *Extensive media coverage was given to the murder and consequently a number of lines of information were received. These enquiries have extended to other states of Australia, however, nothing of any constructive value has come to light. It is fair to say that at this stage, there is no singular concerted line of investigation.*

5.1505. Counsel Assisting submitted, and I agree, that the Coroner should have been made aware of the alleged confession by NP176 as to her involvement in the death of Ms Waine. At the very least, the Coroner may have taken steps to summons NP176 as a witness. Even if, as may be the case, police (not unreasonably) considered Mr Shakespeare's evidence to be of no "constructive value":

[1278] Exhibit 30, Tab 61, NSWPF Running Sheet, 'Wendy Wayne (sic) @ Brennan Murder Inq.', created on 26 January 1986, 4 (SCOI.82932).

[1279] Exhibit 30, Tab 47, Statement of Detective Sergeant Stephen Desmond McCann, 22 July 1986, (SCOI.00014.00008).

[1280] Exhibit 30, Tab 47, Statement of Detective Sergeant Stephen Desmond McCann, 22 July 1986, [11] (SCOI.00014.00008).

a. Mr Shakespeare's credibility was properly a matter to be considered by a Coroner; and

b. in any event, the real issue was what NP176 might say rather than what Mr Shakespeare might have said.

5.1506. The Inquiry has made extensive efforts to ascertain whether NP176 is still alive and if so her whereabouts.[1281] This included summonses to BDM as well as the corresponding agency in every other state and territory, the police forces of each state and territory, DCJ Housing and the Department of Health, as well as requests to Services Australia, the DFAT and FASS. Staff of the Inquiry also visited the last recorded address for NP176. These efforts have been unsuccessful. The last confirmed record of NP176 was for petty charges in Sydney in May 1986. Since then, there appears to be no record of her anywhere in Australia.

The Coven of Mercy for Fate

5.1507. On 1 May 1985, Alan Baskin, a journalist at 2UE radio station, received a call from an unknown male person, who told Mr Baskin that he was from the "Coven of Mercy for Fate." This person stated, "We got Wendy and hope to get all Sydney gays. This is a public announcement." The person was described as having a "youngish voice". [1282]

5.1508. On 2 May 1985, Terry Goulden from the Gay Counselling Service of NSW received a recorded telephone message of a male voice saying "We have got Wendy and you're going to pay. This is the Coven of Mercy for Fate."[1283]

5.1509. The material produced to the Inquiry by the NSWPF contains no indication that any steps were taken to request call records or to otherwise identify the caller or callers who made the phone calls received by Mr Baskin and Mr Goulden.

5.1510. The Inquiry's own investigations, including a media review, have not uncovered any information about any group or organisation called the "Coven of Mercy for Fate."

5.1511. There is no evidence to substantiate any link between Ms Waine's death and a hate group of this or any other name. It may be that the unknown caller/s was or were opportunistically taking advantage of Ms Waine's murder to sow fear amongst the LGBTIQ community.

[1281] Exhibit 30, Tab 82, Statement of Rhys Carvosso, 30 May 2023, [4]–[11] (SCOI.47479).

[1282] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Information received at radio station 2UE re Death of Wayne Brennan', 1 May 1985, 43 (SCOI.82924).

[1283] Exhibit 30, Tab 62, NSWPF Report of Occurrence, 'Information from Terry Goulden of Gay Counselling Service of N.S.W', 2 May 1985, 54 (SCOI.82924).

Fingerprint match in 1989

5.1512. In July 1989, more than four years after Ms Waine's death, a fingerprint that had been found on a telephone in Ms Waine's premises in 1985 was identified as belonging to a known person, NP178.[1284] This identification occurred shortly after NP178's prints were uploaded onto the police database in June 1989 when he was arrested for unrelated driving matters.[1285]

5.1513. On 10 January 1991, NP178 was interviewed by Detective Senior Constable Di Francesco. A typed record of the interview was made. In the interview, NP178 admitted to knowing Ms Waine through another "Kiwi" trans sex worker, and to engaging her services as a sex worker in 1984.[1286]

5.1514. NP178 initially denied ever going to Ms Waine's premises on Darlinghurst Road, Kings Cross. However, when confronted with the evidence that his fingerprint was located there, he told police that he had a friend who had lived at the premises prior to Ms Waine, named Carmen Rupe.[1287] Ms Rupe was also a trans sex worker, and had been spoken to by police early in their investigation, on 30 April 1985.[1288] The available evidence indicates that Ms Waine only moved into the apartment in November 1984, and that prior to that time the unit was already frequently being used for sex work.

5.1515. However, the police do not appear to have made any investigation into NP178's explanation for the presence of his fingerprint on the telephone. No enquiries were ever made with Ms Rupe, after police became aware of the fingerprint match, as to her association with NP178.

5.1516. The Inquiry has ascertained that Ms Rupe is now deceased, and the opportunity to corroborate or disprove NP178's explanation is lost.

5.1517. The material produced to the Inquiry by the NSWPF does not contain any statement from the crime scene officer who examined Ms Waine's unit for fingerprints in 1985. There is no description of where the telephone upon which NP178's fingerprints were found was located within the unit, nor as to where on the telephone the fingerprint was placed. There is also no information as to whether any other unidentified fingerprints were found in Ms Waine's apartment.

5.1518. In the absence of this information, it is impossible to assess the plausibility of NP178's fingerprint persisting on the telephone from November 1984, at the latest, until the date of Ms Waine's death. The Inquiry understands through interagency cooperation that NP178 is alive.

[1284] Exhibit 30, Tab 63, NSWPF Serious Crime Identification Report, 'Latent Fingerprint Unit, Serious Crime Identification Report', 27 October 1989 (SCOI.10228.00002).

[1285] See Exhibit 30, Tab 65, NSWPF Fingerprint Form, 'Fingerprint form for NP178', 18 June 1989, 2 (SCOI.82922).

[1286] Exhibit 30, Tab 36, NSWPF Record of interview, 'Interview with NP178', 10 January 1991, 2 (SCOI.10040.00045).

[1287] Exhibit 30, Tab 36, NSWPF Record of interview, 'Interview with NP178', 10 January 1991, 3-4 (SCOI.10040.00045).

[1288] Exhibit 30, Tab 21, Statement of Carmen Tione Rupe, 30 April 1985 (SCOI.10040.00034).

Police investigation

5.1519. As Counsel Assisting submitted, if the records produced to the Inquiry by the NSWPF, pursuant to summonses, are the totality of police records relating to the case, then there is ground for serious concern as to why various lines of inquiry were either not pursued at all, or not pursued to finality.[1289]

5.1520. Counsel Assisting acknowledged that, in respect of many cases being considered by the Inquiry, the Inquiry had been confronted with the reality that police records, or some parts thereof, could not now be located by the NSWPF. However, Counsel Assisting pointed out that in the case of Ms Waine, no such assertion was made by the NSWPF in response to any summons.

5.1521. I am entitled to proceed, and do proceed, as did Counsel Assisting, on the footing that all police records relating to the death of Ms Waine were located and produced.[1290]

5.1522. Bearing those matters in mind, and while recognising that numerous theories as to who may have been involved in Ms Waine's death were pursued, to greater or lesser extents, by investigating police. Counsel Assisting submitted that some lines of inquiry were not fully investigated, while in other respects there was insufficient material presently available from which to assess whether all appropriate steps were taken.[1291]

5.1523. In those respects, Counsel Assisting pointed out a number of specific deficiencies, which I address in turn below.

5.1524. It is necessary first, however, to deal globally with the submissions on behalf of the NSWPF as to whether the records in relation to Ms Waine's case were complete, and, if not, what are the consequences for this Inquiry.

5.1525. The NSWPF submitted that "38 years has passed since Ms Waine's death and, as a result, it would not be surprising (albeit unfortunate and regrettable) if certain records are no longer able to be located by an agency such as NSWPF."[1292] I have commented on the failures of the NSWPF record's management system at **Chapter 8**. If it is the case that records exist but can no longer be located, that itself represents a failure by police in respect of Ms Waine's case.

5.1526. The NSWPF went on to submit, positively, that "it appears that there are documents missing" and to submit further that "this suggests that the records may not provide a complete picture of the investigative steps taken by police."[1293] The NSWPF did not specify which documents or categories of document are said to be missing.

[1289] Written Submission of Counsel Assisting, 9 June 2023, [38] (SCOI.83653).

[1290] Written Submission of Counsel Assisting, 9 June 2023, [39] (SCOI.83653).

[1291] Written Submission of Counsel Assisting, 9 June 2023, [40] (SCOI.83653).

[1292] Submissions of the Commissioner of Police, 23 June 2023, [17] (SCOI.84379).

[1293] Submissions of the Commissioner of Police, 23 June 2023, [19] (SCOI.84379).

5.1527. However, on the basis that documents might have existed but be missing, the NSWPF submitted, in relation to a number of the deficiencies identified by Counsel Assisting, that the present evidence is insufficient to ascertain whether or not certain steps were taken.[1294]

5.1528. The Inquiry cannot be left to speculate on what additional material, if any, may once have been in the possession of the police. While I accept the possibility that some records were lost, and my findings must be read with that recognition in mind, I must and do proceed on the basis that the material produced to the Inquiry substantially represents the scope and extent of the police investigation.

5.1529. In Ms Waine's case, a large volume of statements and running sheets documenting the police investigation were created, stored and produced to the Inquiry. The Inquiry also received and reviewed the coronial file, which included a statement prepared by Detective Sergeant McCann purporting to summarise the key lines of the investigation.

5.1530. Having regard to the material that was produced, I share Counsel Assisting's concerns as to the lines of inquiry not fully investigated, as set out below, which Counsel Assisting fairly described as "striking and troubling".

Absence of evidence from Detective Sergeant McCann

5.1531. The NSWPF directed attention to the fact that Detective Sergeant McCann "does not appear to have given evidence" to the Inquiry, and "does not appear to have been notified or approached by the Inquiry in respect of the criticisms levelled against his investigation".[1295] The NSWPF also identified particular matters which were not "explored" with Detective Sergeant McCann. [1296]

5.1532. Arguments of a similar kind have been advanced in many of the NSWPF's submissions in relation to cases which proceeded to documentary tender. I have addressed these submissions in **Chapter 1** and in the introduction to this Chapter.

5.1533. I do not consider that I am under any inhibition, as to my consideration of the criticisms made by Counsel Assisting of the 1985-86 investigation, by reason of the absence of formal evidence from Detective Sergeant McCann. Those criticisms, as to steps not having been taken, are well open on the documentary material before me. They do not involve any suggestion as to the motives of individual officers or as to the probity of their conduct. Nor have Counsel Assisting proposed any findings of any such kind.

[1294] Submissions of the Commissioner of Police, 23 June 2023, [45] (SCOI.84379).

[1295] Submissions of the Commissioner of Police, 23 June 2023, [27] (SCOI.84379).

[1296] See for example Submissions of the Commissioner of Police, 23 June 2023, [28], [55], [60], [68], [73], [80], [83] (SCOI.84379).

5.1534. I also note for completeness that Inquiry staff did hold conferences with Detective Sergeant McCann and Detective Senior Constable Di Francesco on 8 May 2023 and 1 June 2023 respectively.[1297] Neither provided any information which assisted the Inquiry in its consideration of Ms Waine's death or shed light on the investigative steps taken or not taken in the original investigation.[1298] The NSWPF was informed of those conferences after the date of their written submissions.

Failure to obtain statements from witnesses

5.1535. Counsel Assisting noted that police did not obtain statements from a number of witnesses. Two witnesses in particular are identified, being I232, who may have been able to assist in determining the time of Ms Waine's death, and NP176, the witness who claimed to recognise, from photographs, a police officer with whom Ms Waine was thought to have been having a relationship.[1299]

5.1536. The NSWPF submitted that the circumstances underpinning the absence of the statements are not known, and suggested, as a possibility, that witnesses may have been unwilling to provide formal witness statements.[1300] However, while this hypothesis may be a plausible explanation, one would expect, if that were the case, that a comment to that effect would have been included in the running sheets, not least because such information would be critical to a prosecutor should the matter ever have resulted in criminal charges.

5.1537. The NSWPF further submitted that contemporaneous running sheets and notes were prepared which documented their interactions with witnesses.[1301] I do not accept that such running sheets will necessarily be an adequate substitute for a witness statements. These notes were generally brief summaries only, not adopted by the witnesses. In some cases, where the account of a witness is not considered to be material, such a note may be sufficient; however, in respect of material witnesses such records are inadequate.

5.1538. With those comments in mind, I turn to the two particular witnesses commented upon by Counsel Assisting.

5.1539. I have dealt with I232's evidence above. The NSWPF submitted that the evidence of I232 added nothing to the later evidence of I230, who "attended Ms Waine's unit later that day and discovered Ms Waine's body."

[1297] Exhibit 30, Tab 106, Supplementary Statement of Rhys Carvosso, 1 November 2023, [4], [11] (SCOI.86436).

[1298] Exhibit 30, Tab 106, Supplementary Statement of Rhys Carvosso, 1 November 2023, [5], [12] (SCOI.86436).

[1299] Written Submission of Counsel Assisting, 9 June 2023, [41] (SCOI.83653).

[1300] Submissions of the Commissioner of Police, 23 June 2023, [23] (SCOI.84379).

[1301] Submissions of the Commissioner of Police, 23 June 2023, [29] (SCOI.84379).

5.1540. This confuses the timeline. I230 found Ms Waine's body at about mid-day on Tuesday, 30 April 1985. I232 had gone to Ms Waine's apartment on the afternoon of the previous day, Monday, 29 April 1985, and had knocked but received no answer. I232's evidence, if accepted, could ground an inference that Ms Waine had been killed prior to 3:45 or 4:00 pm on 29 April 1985. This would contradict the apparent sighting of Ms Waine by Mr McCarthy at 7:45pm on that Monday evening, and give greater weight to the possibility that she was killed by somebody that she had met while working at Premier Lane. I232's evidence was of real importance in establishing the time and circumstances of Ms Waine's death.

5.1541. I have dealt with I233's evidence above. The NSWPF accepted that it would have been "prudent" for a formal statement to have been obtained, to "reflect" what (the NSWPF now suggest) investigating police "presumably" knew.[1302] However, the proper documenting of an identification process relating to a person of interest goes beyond prudence; it is critical. There is all the more reason to do this when the person of interest is or may be a police officer, especially where an apprehension may arise that police could have been motivated to protect a fellow officer.

5.1542. As to NP180, the NSWPF submitted that it was "very likely" that investigating police took steps such as reviewing NP180's employment records and roster, so as to result in him being discounted as a person of interest.[1303] There is no basis in the evidence for such a submission, and I do not share the confidence of the NSWPF, particularly given the failure to take other reasonable steps in relation to this line of enquiry, such as those set out above.

Loss of exhibits

5.1543. Counsel Assisting submitted (as is the fact) that the whereabouts of various exhibits was unknown, and made submissions as to the lost opportunities for developing investigative leads as a result of the loss of those exhibits.

5.1544. The NSWPF agreed that the loss of the hair samples is "highly regrettable", but submitted that it is not clear which agency was responsible for the retention of the hair sample at the point that it became lost, that the reasons for the loss have not been "explored" with investigating police, and that what might have been drawn from the testing of those samples in subsequent years (with the benefit of developments in technology) "are matters of speculation".[1304]

5.1545. In my view, even when an exhibit has been transferred to another agency for the purposes of testing, it is incumbent upon the NSWPF to keep records as to the movements of each exhibit.

5.1546. Nor is it to the point that the reasons for the loss of the exhibits have not been "explored" with investigating police. The recollection of an individual officer 38 years after the fact is no substitute for contemporaneous records. I have addressed the NSWPF's exhibit management at **Chapter 8**.

[1302] Submissions of NSWPF, 23 June 2023, [33]–[35] (SCOI.84379).

[1303] Submissions of NSWPF, 23 June 2023, [34] (SCOI.84379).

[1304] Submissions of NSWPF, 23 June 2023, [39]–[44] (SCOI.84379).

5.1547. Finally, while it is, of course, true that what might have been ascertained by later DNA testing of the hair samples cannot be known, it is disappointing that the NSWPF once again has chosen to take such a defensive approach to the loss of a potentially critical exhibit.

Weight given to the sighting by Mr McCarthy

5.1548. Counsel Assisting submitted, and I accept, that the apparent sighting of Ms Waine by Mr McCarthy is not conclusive.

5.1549. The NSWPF submitted that Counsel Assisting appeared to have "overstated" the impact that Mr McCarthy's apparent sighting of Ms Waine had on the remainder of the investigation, and that it would be "unfair" for Detective Sergeant McCann "to be criticised in the way suggested by Counsel Assisting".[1305] I reject those submissions. Counsel Assisting's submission simply went to what inferences should now be drawn as to the time of Ms Waine's death, and in my view involved no "overstatement" Further, those submissions did not "criticise" Detective Sergeant McCann, much less in any unfair way.

Failure to exhaust investigation as to Ms Waine's relationship with a police officer

5.1550. Counsel Assisting submitted that police did not thoroughly investigate the accounts of witnesses who referred to Ms Waine being in a relationship with a police officer, prior to declaring that line of enquiry to be "exhausted". This aspect of the evidence is dealt with above.

5.1551. The NSWPF pointed to the conflicting versions of the characteristics of the purported police officer with whom Ms Waine was in a relationship, as well as her tendency to embellish some details of her relationships, to support a submission that the veracity of the evidence regarding Ms Waine's possible relationship with a serving officer was unclear. [1306]

5.1552. Each of these matters was acknowledged in the submissions of Counsel Assisting. The NSWPF submissions, however, do not address the gravamen of those submissions, namely the obvious steps that could have been pursued by police, such as those set out above. There is no evidence that any such steps were taken, and I am left with the distinct impression that the investigation of this aspect of the case was lacklustre at best.

5.1553. The NSWPF also asserted that Counsel Assisting had discounted NP180 as having been the police officer in a relationship with Ms Waine on the basis on confidential evidence, and then submitted that this view is consistent with the conclusion of investigating police.[1307]

[1305] Submissions of NSWPF, 23 June 2023, [54] (SCOI.84379).

[1306] Submissions of NSWPF, 23 June 2023, [56]–[64] (SCOI.84379).

[1307] Submissions of NSWPF, 23 June 2023, [63]–[64] (SCOI.84379).

5.1554. However, this misunderstands the effect of Counsel Assisting's submissions as to that confidential evidence, which were directed not at NP180 but at a different person suspected to have been that officer. The fact remains that once NP180 had been discounted, investigating police appear not to have taken any further steps to identify the officer possibly involved.

5.1555. The NSWPF also submitted that, in the absence of evidence from the OIC (Detective Sergeant McCann), a finding could not "sensibly or fairly be reached" that police deliberately failed to consider the possible involvement of a police officer in a murder investigation. [1308] No such "finding" was suggested by Counsel Assisting.

Failure to exhaust investigations in respect of NP179

5.1556. Counsel Assisting criticised police for failing to check the alibi evidence relied upon by NP179, or obtain records in relation to whether he had signed in his MSS Security-issued pistol as claimed. Further, Counsel Assisting submitted that police did not check with Mr Saville, who saw an MSS Security Officer enter Ms Waine's building, whether the person he saw was NP179, and should have done so. This aspect of the evidence is dealt with above.

5.1557. Subject to their submissions set out above, the NSWPF accepted that, if these inquiries were not conducted, it would represent a "shortcoming" in the initial investigation. [1309]

5.1558. I accept the submissions of Counsel Assisting.

Failure to exhaust investigations in respect of NP178

5.1559. Counsel Assisting further submitted that police failed to investigate the explanation provided by NP178 for his fingerprint being found on a phone in Ms Waine's apartment. This aspect of the evidence is dealt with above.

5.1560. Subject to their submissions set out above, the NSWPF accepted that if no such attempts were made, this "may" represent a further "shortcoming" in the investigation of Ms Waine's death. [1310]

5.1561. I accept the submissions of Counsel Assisting.

Failure to investigate the Coven of Mercy for Fate

5.1562. Counsel Assisting identify as a deficiency that police did not obtain phone records or otherwise investigate the identity of the anonymous caller/s who claimed responsibility for Ms Waine's murder on behalf of the "Coven of Mercy for Fate".

[1308] Submissions of NSWPF, 23 June 2023, [60] (SCOI.84379).

[1309] Submissions of NSWPF, 23 June 2023, [68] (SCOI.84379).

[1310] Submissions of NSWPF, 23 June 2023, [73] (SCOI.84379).

5.1563. Subject to their submissions set out above, the NSWPF accepted that, if these steps were not taken, it was a "regrettable shortcoming or oversight" of the initial investigation. [1311]

5.1564. I accept the submissions of Counsel Assisting.

Failure to investigate an alleged confession by NP176

5.1565. Counsel Assisting criticised the NSWPF for the failure to investigate the alleged confession by NP176 to involvement in the murder of Ms Waine. Further, Counsel Assisting submitted that this information should have been, and was not, provided to the Coroner in connection with the inquest into Ms Waine's death. This aspect of the evidence is dealt with above.

5.1566. The NSWPF accepted that, if these inquiries were not conducted, then that would represent a "shortcoming" in the initial investigation. Further, the NSWPF accepted that this information should have been conveyed to the Coroner. [1312]

5.1567. I accept the submissions of Counsel Assisting. As I have said, I am deeply troubled by the apparent lack of investigation into direct evidence of a named person's involvement in the death of Ms Waine.

Manner and cause of death

5.1568. As Counsel Assisting submitted, the circumstances of Ms Waine's death leave no doubt that she was the victim of a homicide.

5.1569. Counsel Assisting further submitted, and I agree, that while there were a number of lines of inquiry in relation to Ms Waine's death, each of them pointing to a different person or persons who may have been involved in Ms Waine's death, there was insufficient available evidence to conclude that any one or more of those persons was in fact so involved.

5.1570. Accordingly, Counsel Assisting submitted that the original finding at the coronial inquest remains appropriate, namely that Ms Waine died on 29 April 1985 of the effects of bullet wounds of the neck and thorax inflicted there and then by a person unknown.

5.1571. The NSWPF supported these submissions of Counsel Assisting, which I accept.

Bias

5.1572. As submitted by Counsel Assisting, Ms Waine was a trans woman and a visible and prominent member of the LGBTIQ community, at a time of widespread contemporaneous hostility to members of that community including trans persons.

[1311] Submissions of NSWPF, 23 June 2023, [74] (SCOI.84379).

[1312] Submissions of NSWPF, 23 June 2023, [80]–[83] (SCOI.84379).

5.1573. Counsel Assisting submitted that these factors exposed her to the risk of being the target of LGBTIQ bias, so the possibility that her gender identity was a factor in her death cannot be excluded. I agree.

5.1574. However, as Counsel Assisting also noted, Ms Waine was killed by bullets fired from close range into the back of her neck and her upper back; a large calibre gun was used; and bullets and spent cartridges were apparently removed by the killer or killers. Those factors suggest the likelihood of a professional "hit" rather than an LGBTIQ hate crime. Counsel Assisting also directed attention to her work as a street-based sex worker, which exposed her to significant risks of violence generally.

5.1575. Counsel Assisting submitted, and I accept, that several other possibilities arise on the available evidence, including that Ms Waine's murder may have been:

a. Retaliation for her disposing of heroin that was being packaged for sale by others in her apartment; or

b. The result of violence against her by a person with whom she was in a relationship, possibly a police officer and/or a security guard (either of whom might have had access to firearms).

5.1576. Counsel Assisting submitted that while the identity of Ms Waine's killer or killers remains unknown, there is no sufficient basis for a conclusion as to whether or not her murder involved LGBTIQ bias.

5.1577. The NSWPF submitted that "the multitude of theories in relation to the motivation for killing Ms Waine makes it impossible to determine whether LGBTIQ bias was a factor in her death". [1313]

5.1578. I agree that, for the reasons I have mentioned, the evidence is not such as to permit me to reach a positive "conclusion", or "determination", either that LGBTIQ bias was a factor in Ms Waine's death, or that such bias was not a factor.

5.1579. However, as Counsel Assisting recognised (and the NSWPF did not submit to the contrary), that possibility cannot be excluded.

Conclusions and Recommendations

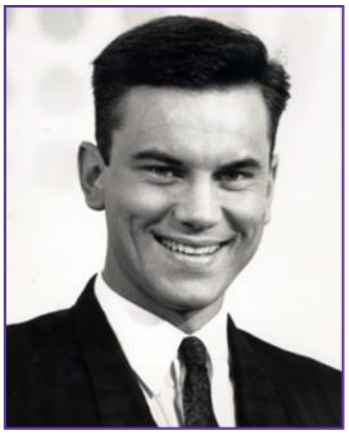
5.1580. I find that Wendy Waine died on 29 April 1985 of the effects of bullet wounds to the neck and thorax inflicted there and then by a person unknown.

5.1581. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in Ms Waine's death.

5.1582. I do not propose to make any recommendations arising from the Inquiry's consideration of Ms Waine's death.

[1313] Submissions of NSWPF, 23 June 2023, [96] (SCOI.84379).

IN THE MATTERS OF GILLES MATTAINI, ROSS WARREN AND JOHN RUSSELL



Introduction

5.1583. This section concerns the deaths of three gay men, all of which were the subject of findings in 2005 by Deputy State Coroner Milledge (**Coroner Milledge**), namely:

a. Gilles Mattaini, who went missing on 15 September 1985, as to whom the Coroner's finding was that he had died on or about that day;

b. Ross Warren, who went missing on 22 July 1989, as to whom the Coroner's finding was that he was a victim of homicide on or about that day; and

c. John Russell, who died late on 22 November or early on 23 November 1989, and who the Coroner found was a victim of homicide.

5.1584. These three deaths may or may not have been related to each other, in terms of whether particular assailants were involved in more than one of the deaths. However, they have many features in common, deriving in particular from the geographical area where many of the relevant events took place.

5.1585. Mr Russell's body was found at the base of the cliffs at Marks Park, between Bondi and Tamarama. Mr Warren's body has never been found, but his car and keys were found near those same cliffs a few months earlier. Mr Mattaini was last seen walking at Bondi four years before that.

5.1586. Marks Park, and the rocky areas below it, were well-known as a beat. They were also well-known, since at least the mid-late 1980s, as a place where beat users or those perceived to be beat users were targeted and assaulted. There is an abundance of evidence of assaults on gay men at or near the Marks Park beat in the 1980s and 1990s.[1314]

5.1587. Partly because of some of those common features, these three deaths have been jointly the subject of three major police and coronial procedures, namely:

a. Operation Taradale, a large-scale police investigation under the leadership of Detective Sergeant Stephen Page, between 2000 and 2003;

b. The ensuing coronial inquiry between 2003 and 2005 by Coroner Milledge, who considered, and made findings based on, the work of Operation Taradale (the **Milledge Inquest**); and

c. Strike Force Neiwand, a review of all three cases by the UHT, between October 2015 and January 2018.

[1314] Exhibit 6, Tab 155, Statement of Sergeant Adrian Macdonald Ingleby, 26 February 1990, [11]–[17] (SCOI.02744.00075); Exhibit 6, Tab 233, Statement of former Detective Sergeant Stephen McCann, 10 November 2022 (SCOI.77310); Exhibit 6, Tab 233A, Letter from Stephen McCann to the Commander, Modus Operandi Section, 10 August 1991 (SCOI.10342.00010); Exhibit 6, Tab 233B, Letter from Stephen McCann to Chief Superintendent Norm Maroney, 15 April 1991 (SCOI.10445.00128); Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen Page, 25 July 2002 (SCOI.02744.00023); Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005 (SCOI.02751.00021); Exhibit 6, Tab 173, Strike Force Neiwand, Summary of Investigation – John Russell, 8 January 2018, [46]–[65], [77]ff (SCOI.74882); Exhibit 6, Tab 174, Strike Force Neiwand, Summary of Investigation – Ross Warren, 8 January 2018, [62]–[112], [152]–[164] (SCOI.74883).

5.1588. Much of the work involved in those three exercises, and much of the evidence gathered and considered in the course of all three, were common to, or relevant to, the deaths of all three of these men. For that reason, in this chapter I will seek to consider that material in a way which, while avoiding repetition as far as possible, identifies aspects of the presently available evidence that are applicable to, or shed light upon, all three of these deaths.

5.1589. However, as the Inquiry has been careful to do throughout the course of its own work over the past 18 months, I will nevertheless seek to maintain a clear focus on each of these three men separately, as the distinct and distinctive individuals that each of them was, and on the particular features of what is now known about how each of them met his death.

Factual background

Date and location of death

Gilles Mattaini

5.1590. Mr Mattaini was last seen walking near Bondi Beach on 15 September 1985. His body has never been found. He was 26 years old when he disappeared.

Ross Warren

5.1591. Mr Warren was last seen driving east in Oxford Street Darlinghurst, in the early hours of 22 July 1989. His car and keys were found at Marks Park. His body has never been found. He was 25 years old.

John Russell

5.1592. Mr Russell was found dead at about 10:00am on Thursday, 23 November 1989, on the rocks at the bottom of the cliffs at Marks Park.[1315] He had multiple injuries including fractures to his skull.[1316] He was 31 years old when he died.

Circumstances of death

Gilles Mattaini

5.1593. Mr Mattaini was born in France on 25 October 1958. In about 1978 he met his partner, Jacques Musy, in France, and their relationship began. In 1983 they moved to Australia.

5.1594. As at September 1985 they lived together in an apartment in Ramsgate Avenue, Bondi Beach, near the intersection with Campbell Parade. Mr Mattaini worked at the Menzies Hotel in the city as a barman. Mr Musy also worked at the Menzies Hotel, as did a number of their friends including Marc Hubert and Vincent Ottaviani.

[1315] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 1 (SCOI.02751.00021).

[1316] Exhibit 6, Tab 173, Strike Force Neiwand, Summary of Investigation – John Russell, 8 January 2018, [139] (SCOI.74882).

5.1595. Mr Mattaini enjoyed walking around the beachside areas and paths near Bondi, including the scenic coastal path from Bondi to Bronte, that went around Marks Park.[1317] He would take headphones on his walks and listen to music. Mr Mattaini, according to Mr Musy and his friends, was a "shy" and "private" person and was not a user of the beat at Marks Park.[1318]

5.1596. As at September 1985 he had some concern about having overstayed his visa. However, Mr Musy and his friends thought that overall he was happy and in good spirits. He was looking forward to a visit from a friend from France, Antony Wyszynski, who would be staying with him, and was purchasing things for the apartment in anticipation of that visit.[1319]

5.1597. On 16 September 1985, while Mr Musy was in France on a holiday, Mr Mattaini failed to show up for his shift at the Hotel. There was naturally concern amongst his friends, who did what they could to try to find out what had happened to him. They had no success.[1320]

5.1598. Mr Musy, in France, was informed of Mr Mattaini's disappearance by one of those friends, Mr Ottaviani. Mr Musy was very distressed. He had the impression, which it seems was not correct, that Mr Ottaviani had reported the matter to the police. No record of any such report has ever been found, and there was no police investigation in 1985.[1321] Mr Ottaviani died in 1991.

5.1599. When Mr Musy returned from France, later in September 1985, he observed among other things that Mr Mattaini's keys and headphones, and a yellow spray jacket, were missing from the apartment.[1322]

5.1600. In his teens, in France, Mr Mattaini had made at least one and perhaps two suicide attempts. When he disappeared in Sydney in September 1985, his mother in France believed it was possible that her son had died by suicide.[1323] However, according to Mr Musy, since meeting him in 1978, Mr Mattaini had been very happy and had never subsequently expressed or shown any suicidal thoughts.[1324]

[1317] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 2 (SCOI.02751.00021).

[1318] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 2 (SCOI.02751.00021); Exhibit 6, Tab 172, Summary of Investigation – Gilles Mattaini, 27 December 2017, [43] (SCOI.76962.00007).

[1319] Exhibit 6, Tab 160, Statement of Detective Sergeant Stephen John Page, 28 August 2002, 3 (SCOI.02744.00024).

[1320] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 2–3 (SCOI.02751.00021).

[1321] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 2 (SCOI.02751.00021).

[1322] Exhibit 6, Tab 159, Statement of Jacques Paul Musy, 3 August 2002, [20]–[21] (SCOI.02744.00381).

[1323] Exhibit 44, Tab 4, Statement of Antony Jean Wyszynski, 3 August 2002, [15] (SCOI.02744.00382).

[1324] Exhibit 6, Tab 280, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 48.52–49.21 (SCOI.82371).

Ross Warren

5.1601. Mr Warren was a television presenter with WIN4 Television in Wollongong.

5.1602. On Friday evening 21 July 1989, after presenting the weather report at the end of the 6:00pm news, Mr Warren drove from Wollongong to Sydney. He was to stay with friends, Craig Ellis and Paul Saucis, at their home in Redfern for the weekend.

5.1603. Later in the evening, he drove to Oxford Street, where he met a co-worker, Phillip Rossini, at about 11:00pm. They drank at various bars on Oxford Street, parting ways at about 2:00am on Saturday morning 22 July 1989. Mr Rossini last saw Mr Warren driving east in Oxford Street, towards Paddington.[1325]

5.1604. On Sunday afternoon 23 July 1989, Mr Warren did not turn up for work at WIN4 Television. His friends Mr Ellis and Mr Saucis went to Paddington Police Station (**Paddington Police**) on the Sunday evening and reported him missing.

5.1605. Mr Ellis and Mr Saucis then searched for Mr Warren. They located his car in Kenneth Street, very close to Marks Park. They reported this to Paddington Police as well, the same night.[1326]

5.1606. The next morning, Monday, 24 July 1989, they went back to Marks Park again, and they found Mr Warren's keys in a rock "pocket" below the cliff-top, near the water's edge. Again, Mr Ellis and Mr Saucis reported this discovery to Paddington Police.

5.1607. On Wednesday, 26 July 1989, the *Daily Telegraph* reported that there were fears that Mr Warren had been murdered.[1327]

5.1608. However, on 28 July 1989 the OIC at Paddington Police, Detective Sergeant Kenneth Bowditch, wrote in the occurrence pad that "investigating police" had no such view, and were of the opinion that Mr Warren had "fallen into the ocean in some manner and it is anticipated that in the near future his body will surface and be recovered". The "investigation" seems to have effectively finished after four days.[1328]

5.1609. Mr Warren's body has never been found.[1329] His disappearance and suspected death were never reported to the Coroner.[1330]

[1325] Exhibit 45, Tab 6, NSWPF Report of Occurrence, 'Enquiries in relation to missing person Ross Bradley Warren', 28 July 1989, 2 (SCOI.02744.00031).

[1326]Exhibit 45, Tab 6, NSWPF Report of Occurrence, 'Enquiries in relation to missing person Ross Bradley Warren', 28 July 1989, 3 (SCOI.02744.00031).

[1327] Exhibit 2, Tab 61, Rod Mori, 'Murder Fears for TV Weatherman', *The Daily Telegraph* (Sydney, 26 July 1989) (SCOI.76851).

[1328] Exhibit 45, Tab 6, NSWPF Report of Occurrence, 'Enquiries in relation to missing person Ross Bradley Warren', 28 July 1989, 5 (SCOI.02744.00031); Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 2 (SCOI.02751.00021).

[1329] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 1–2 (SCOI.02751.00021).

[1330] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 2 (SCOI.02751.00021).

5.1610. Years later, between 1998 and 2000, Mr Warren's mother wrote to police numerous times seeking some finality in relation to her son's disappearance and presumed death.[1331] In 2000, her letters eventually came to the attention of Detective Sergeant Page, whose enquiries in relation to Mr Warren's case led to the formation of Operation Taradale in 2000 and to the resulting Milledge Inquest.[1332]

John Russell

5.1611. Mr Russell was a barman at the Bronte Bowling Club, and he lived with his brother, Peter Russell, in Bondi.

5.1612. At the time of his death, he had recently received an inheritance from his grandfather, and he was planning to leave Sydney and build a 'kit home' on his father's property at Wollombi. He also intended to use some of the funds to travel around Australia.[1333] He "was looking forward to the best time of his life", and "everything was looking up for him".[1334]

5.1613. On the evening of Wednesday, 22 November 1989, Mr Russell had farewell drinks with a friend at the Bondi Hotel. He had a similar evening planned for the following night, and then, on the Friday, his father, Ted Russell, was going to drive down from Wollombi to collect him. He left the Bondi Hotel at about 11:00pm.[1335]

5.1614. The position of Mr Russell's body when he was found on Thursday morning 23 November 1989 at the base of the Marks Park cliff was such that his head and upper body were facing towards the cliff face, while his feet were towards the ocean.

5.1615. Human hairs were observed on his left hand. Those hairs were "bagged" for analysis, but they were lost prior to the initial inquest into Mr Russell's death (which was conducted some seven months later on 2 July 1990). No forensic analysis was ever performed on those hairs.[1336]

5.1616. Police from Bondi Police Station investigated the scene. The OIC was a junior plain clothes constable.[1337] The OIC considered that Mr Russell's death was "accidental", and it was essentially not pursued as a homicide, although some police involved in the investigation suspected Mr Russell had been the victim of an assault.[1338]

[1331] See, eg, Exhibit 6, Tab 18–25.

[1332]

[1333] Exhibit 46, Tab 12, Statement of I403, 24 November 1989, [5] (SCOI.10566.00050); Exhibit 46, Tab 8, Statement of Constable Michael Antony Barrett, 1 December 1989, [16] (SCOI.02744.00073).

[1334] Exhibit 46, Tab 8, Statement of Constable Michael Antony Barrett, 1 December 1989, [16] (SCOI.02744.00073).

[1335] Exhibit 46, Tab 12, Statement of I403, 24 November 1989, [6] (SCOI.10566.00050); Exhibit 6, Tab 173, Strike Force Neiwand, Summary of Investigation – John Russell, 8 January 2018, 1 (SCOI.74882).

[1336] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 1 (SCOI.02751.00021).

[1337] Transcript of the Inquiry, 28 February 2023, T2347.32–40 (TRA.00029.00001).

[1338] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 1 (SCOI.02751.00021).

5.1617. That suspicion arose from a number of factors including: the location where Mr Russell's body was found, known at the time to be a beat; police awareness of assaults on men in the area of the beat; and the strands of hair found on Mr Russell's left hand.

Previous investigations

Post-mortem examination

5.1618. There was no post-mortem examination for either Mr Mattaini or Mr Warren, as their bodies were never found.

John Russell

5.1619. In the case of Mr Russell, a post-mortem examination was conducted on 29 November 1989, by Dr Sylvia Hollinger.

5.1620. Dr Hollinger noted bruising to both sides of Mr Russell's body, a number of lacerations on the left side of Mr Russell's body and fractures in both his arms.[1339] Internal examination found extensive fracturing of the skull to both the left and right sides and marked displacements of the fractures at the base of the skull.[1340]

5.1621. Dr Hollinger expressed the direct cause of death as "multiple injuries".[1341]

5.1622. In a toxicology report dated 5 January 1990, Keith Lewis of DAL found Mr Russell to have a blood alcohol level of 0.255g/100mL. Mr Russell was screened for cannabinoids, amphetamines, 'tricyclic antidepress', methadone, trichlorethanol, opiates, benzodiazepines, barbiturates and cocaine; none were detected.[1342]

Original police investigations

Gilles Mattaini

5.1623. There was no police investigation at the time of Mr Mattaini's disappearance.

Ross Warren

5.1624. In her findings in 2005, Coroner Milledge described the initial police investigation into the death of Mr Warren in 1989 as "a grossly inadequate and shameful investigation. Indeed, to characterise it as an 'investigation' is to give it a label it does not deserve."[1343]

[1339] Exhibit 46, Tab 2, Post-mortem report of Dr Sylvia Hollinger, 29 January 1990, 1 (SCOI.02752.00098).

[1340] Exhibit 46, Tab 2, Post-mortem report of Dr Sylvia Hollinger, 29 January 1990, 2 (SCOI.02752.00098).

[1341] Exhibit 46, Tab 2, Post-mortem report of Dr Sylvia Hollinger, 29 January 1990, 3 (SCOI.02752.00098).

[1342] Exhibit 46, Tab 3, Toxicology report of Keith William Lewis, 5 January 1990 (SCOI.02752.00102).

[1343] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 6 (SCOI.02751.00021).

5.1625. Coroner Milledge described as "appalling", and a state of affairs that "defies belief", the fact that Detective Sergeant Bowditch had effectively closed any further investigation within a week, and the failure of the NSWPF to produce either the brief of evidence said to have been submitted to the Coroner in 1990, or indeed any documents said to have been produced during the course of that investigation.[1344]

5.1626. Although Detective Sergeant Bowditch claimed to have carried out various steps as part of his "investigation", the evidence before Coroner Milledge strongly suggested that no such steps had actually been taken. Among other things, Detective Sergeant Bowditch claimed that:

a. He submitted a brief of evidence to the Coroner in 1990. However, no such brief was received by the Coroners Court.[1345]

b. Copies of all documents in relation to Mr Warren's disappearance would also have been sent to the Missing Persons Unit.[1346] However, no documents were received by the Missing Persons Unit.[1347]

c. Detective Sergeants Ryan, Glascock and Sharrock had assisted in the investigation into Mr Warren's disappearance.[1348] However, statements obtained by Operation Taradale from each of those officers indicated that in fact they had had no involvement.[1349]

d. The Air Wing and Water Police were involved.[1350] However, no record from either of those entities supported that claim.[1351]

e. He had met with, and taken formal statements, from Mr Saucis and Mr Ellis.[1352] No such statements were located, and Mr Saucis and Mr Ellis told Detective Sergeant Page that this did not occur.[1353]

f. He obtained Mr Warren's health and dental records, and recent photographs.[1354] However, no such documents were found by Operation Taradale.[1355]

[1344] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 5–6 (SCOI.02751.00021).

[1345] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 5 (SCOI.02751.00021); see also handwriting at bottom of Exhibit 45, Tab 28, Report of Detective Senior Constable G Sharrock, 14 June 2000 (SCOI.02744.00039).

[1346] Exhibit 45, Tab 33, Statement of Kenneth James Bowditch, 19 February 2001, [11] (SCOI.02744.00150).

[1347] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 5–6 (SCOI.02751.00021).

[1348] Exhibit 45, Tab 73, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 2 April 2003, 27 (SCOI.84103).

[1349] Exhibit 45, Tab 41, Statement of Detective Sergeant Adam Glascock, 1 August 2001, [5] (SCOI.02744.00148); Exhibit 45, Tab 40, Statement of Detective Sergeant Michael John Ryan, 26 July 2001, [5] (SCOI.02744.00147); Exhibit 45, Tab 44, Statement of Detective Senior Constable Gordon John Sharrock, 3 August 2001, [3] (SCOI.02744.00149).

[1350] Exhibit 45, Tab 33, Statement of Kenneth Jams Bowditch, 19 February 2001, [7] (SCOI.02744.00150).

[1351] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 5 (SCOI.02751.00021).

[1352] Exhibit 45, Tab 33, Statement of Kenneth James Bowditch, 19 February 2001, [4] (SCOI.02744.00150).

[1353] Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen John Page, 25 July 2002, [192] (SCOI.02744.00023).

[1354] Exhibit 45, Tab 33, Statement of Kenneth James Bowditch, 19 February 2001, [9] (SCOI.02744.00150).

[1355] Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen John Page, 25 July 2002, [193] (SCOI.02744.00023).

5.1627. On the evening of Sunday, 23 July 1989, at approximately 8:15pm, Mr Ellis and Mr Saucis attended Paddington Police to report Mr Warren missing. Their report was taken by Constable Robinson.[1356]

5.1628. Later that same evening (Sunday, 23 July 1989), they decided to search Marks Park.[1357] They thought Marks Park was a possible place that Mr Warren could have gone, in light of past conversations with Mr Warren when he told them he had gone to Marks Park sometimes to meet men for sex. Mr Ellis himself had met Mr Warren there in 1988.[1358]

5.1629. That Sunday evening, they found Mr Warren's car parked beside Marks Park, on the corner of Kenneth Street and Marks Lane. They also reported this to Paddington Police, later that night.[1359]

5.1630. On the next morning, (Monday, 24 July 1989) Mr Ellis and Mr Saucis returned to Marks Park. They did a door knock of houses in the area and spoke with residents but obtained no information.[1360] Mr Ellis then walked down an access route to the rock shelf below Marks Park, and saw on a rock ledge a set of keys he recognised as Mr Warren's. He said the keys appeared to have been placed on the ledge and were in a pocket which had been formed in the rock.[1361]

5.1631. On that day, (Monday, 24 July 1989) Mr Ellis and Mr Saucis reported to police that they had located the keys to Mr Warren's car.[1362]

5.1632. As a result of these various pieces of information, Constable Robinson made some enquiries into the whereabouts of Mr Warren. He contacted his place of work and his home address, both with a negative result.[1363] He also circulated Mr Warren as a missing person, with warnings that there were fears of his safety, and he "informed detectives of the situation."[1364]

5.1633. Constable Robinson said that the Paddington detectives subsequently "took charge of the matter".[1365]

[1356] Exhibit 45, Tab 13, Statement of Constable Daniel Robinson, 16 July 1991, [3] (SCOI.02744.00064); Exhibit 45, Tab 30, Statement of Sergeant Daniel Robinson, 24 July 2000, [3] (SCOI.02744.00137); NSWPF Crime Information Report, 'Missing person report – Warren', 23 July 1989 (SCOI.02744.00030).

[1357] Exhibit 45, Tab 53, Statement of Craig Ellis, 25 September 2000, [16]–[17] (SCOI.28744).

[1358] Exhibit 45, Tab 53, Statement of Craig Ellis, 25 September 2000, [17] (SCOI.28744).

[1359] Exhibit 45, Tab 53, Statement of Craig Ellis, 25 September 2000, [18] (SCOI.28744).

[1360] Exhibit 45, Tab 53, Statement of Craig Ellis, 25 September 2000, [23] (SCOI.28744).

[1361] Exhibit 45, Tab 53, Statement of Craig Ellis, 25 September 2000, [22]–[24] (SCOI.28744); Exhibit 45, Tab 6, NSWPF Report of Occurrence, 'Enquiries in relation to missing person Ross Bradley Warren', 28 July 1989, 1 (SCOI.02744.00031).

[1362] Exhibit 45, Tab 53, Statement of Craig Ellis, 25 September 2000, [23] (SCOI.28744); Exhibit 45, Tab 30, Statement of Sergeant Daniel Robinson, 24 July 2000, [6] (SCOI.02744.00137).

[1363] Exhibit 45, Tab 13, Statement of Constable Daniel Robinson, 16 July 1991, [4] (SCOI.02744.00064).

[1364] Exhibit 45, Tab 30, Statement of Sergeant Daniel Robinson, 24 July 2000, [5] (SCOI.02744.00137).

[1365] Exhibit 45, Tab 30, Statement of Sergeant Daniel Robinson, 24 July 2000, [7] (SCOI.02744.00137); Exhibit 45, Tab 3, NSWPF Report of Occurrence, 'Warren reported missing', 24 July 1989 (SCOI.02744.00151).

5.1634. On 24 July 1989, Constable Robinson went to the location with Mr Ellis. He searched Mr Warren's vehicle and found Mr Warren's wallet in the glove box. He said clothes were strewn about the vehicle and running shoes were on the floor in the rear as well as a small bag containing clothing. Inside the boot was another bag with clothing. Constable Robinson returned to Paddington police station and handed the personal effects of Mr Warren to detectives.[1366]

5.1635. No photographs of the crime scene or of Mr Warren's keys were taken.[1367]

5.1636. In an occurrence pad entry by Constable Robinson on 27 July 1989, he records, "Sgt CARL water police informed search of area where vehicle and keys located, to be conducted by launch until darkness."[1368]

5.1637. On 24 July 1989, Detective Senior Constable Evan Bouris from Bondi Police Station created a NSW Police Department Miscellaneous Property Receipt recording the items seized from the car of Mr Warren. How and why he came to do so, at Bondi, is not clear.

5.1638. In July 2001, Detective Sergeant Page spoke to Detective Senior Constable Bouris and took a statement from him. Detective Senior Constable Bouris attempted to obtain his notebook from 24 July 1989, but was advised that it had been destroyed. He did recall attending Kenneth St, Bondi where he saw a Nissan Pulsar, and speaking to some people at that location and being shown an area of bushes and rocks on the southern side of Kenneth St. He also recalled being shown a set of eight keys on a rock platform at the base of the cliff, and taking possession of the keys.[1369]

5.1639. One of the notable features of the events of 23 and 24 July, as summarised above, is that it was Mr Warren's friends, Mr Ellis and Mr Saucis, who took the initiative, rather than the police:

a. After first reporting to police that Mr Warren was missing, on the evening of Sunday, 23 July 1989, they conducted a search of Marks Park;

b. That Sunday evening, they found Mr Warren's car;

c. Again, they reported this to Paddington Police that night;

d. Again, it was Mr Ellis and Mr Saucis who returned to Marks Park on the morning of Monday, 24 July 1989;

e. They, not the police, did a door knock of houses in the area and spoke with residents; and

f. They found Mr Warren's keys, and reported that in turn to the police.

[1366] Exhibit 45, Tab 13, Statement of Constable Daniel Robinson, 16 July 1991, [6]–[9] (SCOI.02744.00064).

[1367] Exhibit 45, Tab 45, Statement of Senior Sergeant Daniel Robinson, 14 August 2001, [7]–[8] (SCOI.02744.00138).

[1368] Exhibit 45, Tab 3, NSWPF Report of Occurrence, 'Warren reported missing', 24 July 1989 (SCOI.02744.00151).

[1369] Exhibit 25, Tab 38, Statement of Detective Senior Constable Evan Bouris, 10 July 2001 (SCOI.02744.00068).

5.1640. There is no contemporaneous record of any steps whatsoever being taken by police after the occurrence pad entry of Detective Sergeant Bowditch on 28 July 1989.

5.1641. At the Milledge Inquest in 2003, Mr Bowditch gave evidence that Mr Warren's case actively continued and was not closed until 19 August 1989. However, he was unable to nominate any steps actually taken beyond 28 July 1989.[1370]

5.1642. Mr Warren was reported missing to Paddington Police. Had the matter been investigated by Bondi detectives, it is possible that when Mr Russell, another gay man, was found at the base of a cliff at Marks Park some four months later, a connection between the two events may have been made.[1371]

5.1643. Instead, the matter remained at Paddington Police with Detective Sergeant Bowditch, who within less than a week evidently ceased his limited investigations, and made the occurrence pad entry described above.[1372]

5.1644. It seems that the link between the two matters was not made until 1990-91, when Detective Sergeant McCann, the OIC of the investigations into the murders of Richard Johnson (at Alexandria in January 1990) and Krichikorn Rattanajurathaporn (near Marks Park in July 1990), documented a series of connections between and among other assaults on men, both in the Marks Park area and in other parts of Sydney. Among the incidents the subject of Detective Sergeant McCann's two reports (one in April 1991 and one in August 1991) were the disappearance of Mr Warren and the death of Mr Russell.[1373]

5.1645. The NSWPF accepted in submissions that "there appears to have been a total failure to respond appropriately to the disappearance of Mr Warren,"[1374] and that "[a]mong other things, the apparent failure to provide a brief to the Coroner was completely unsatisfactory". The NSWPF also submitted that "[t]he apparently false assertions of Detective Sergeant Bowditch in respect of various aspects of the investigation he purportedly conducted are extraordinary."[1375]

[1370] Exhibit 45, Tab 73, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 2 April 2003, 45–46 (SCOI.84103).

[1371] Exhibit 6, Tab 322, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 31 March 2023, 41–42 (SCOI.00173.00002).

[1372] Exhibit 45, Tab 6, NSWPF Report of Occurrence, 'Enquiries in relation to missing person Ross Bradley Warren', 28 July 1989, 1 (SCOI.02744.00031).

[1373] Exhibit 6, Tab 233, Statement of former Detective Sergeant Stephen McCann, 10 November 2022 (SCOI.77310); Exhibit 6, Tab 233A, Letter from Stephen McCann to the Commander, Modus Operandi Section, 10 August 1991 (SCOI.10342.00010); Exhibit 6, Tab 233B, Letter from Stephen McCann to Chief Superintendent Norm Maroney, 15 April 1991 (SCOI.10445.00128).

[1374] Submissions of NSWPF, 13 July 2023, [6] (SCOI.84454).

[1375] Submissions of NSWPF, 13 July 2023, [7] (SCOI.84454).

5.1646. The initial investigation of Mr Warren's death was inadequate. So far as criticism of individual officers is appropriate, such criticism is directed to Detective Sergeant Bowditch. The initial junior responding officer appears to have made some effort to respond appropriately before the matter fell to Detective Sergeant Bowditch to investigate the matter. Mr Bowditch declined the opportunity, afforded to him by the Inquiry, to make a statement or submission to the Inquiry about these matters.[1376]

John Russell

5.1647. Coroner Milledge's assessment in 2005 was that, although a "'better' investigation was undertaken for Mr Russell", "it too was far from adequate".[1377] Coroner Milledge observed that "[w]hilst it was known that Marks Park was an area where homosexual men were bashed and robbed, little investigation regarding this type of activity was undertaken into Mr Russell's death".[1378]

5.1648. Coroner Milledge described the loss of the hairs that had been found on Mr Russell's hand, and the absence of forensic testing, as "[d]isgraceful", and considered that no satisfactory explanation was given as to the loss of the exhibit.[1379]

5.1649. Coroner Milledge went on to say:[1380]

> *In both Mr Warren's disappearance and Mr Russell's death there were similarities that should have linked them in the early stages of the investigation and suggested to the police the possibility of foul play in both deaths.*
>
> *Both men were homosexual. The last place either man was prior to death was Marks Park. Mr Russell had coins scattered near his body, Mr Warren's keys were found on the rocks. These items were used by some men to attract attention in that area and may have been used for that purpose by the victims. Marks Park was a known area for brutal attacks on homosexual males. Yet investigating police believed Mr Warren and Mr Russell met their death by 'misadventure'.*
>
> *The earlier investigations into these men were inadequate and naïve.*

5.1650. The NSWPF submitted that (emphasis omitted):[1381]

> *While it certainly appears that the investigation was not as detailed or extended as one would have expected in case of a potential homicide, there is no indication that DSC Hand [the Coroner in the original inquest in*

[1376] Exhibit 6, Tab 477A, Letter to Kenneth Bowditch re Public Hearing 2, 22 August 2023 (SCOI.85474); Exhibit 66, Tab 90, Letter from the Inquiry to Nicholas Eddy, 25 August 2023 (SCOI.86349).

[1377] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 6 (SCOI.02751.00021).

[1378] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 6 (SCOI.02751.00021).

[1379] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 6 (SCOI.02751.00021).

[1380] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 8 (SCOI.02751.00021).

[1381] Submissions of NSWPF, 13 July 2023, [19] (SCOI.84454).

> *1989] regarded the investigation conducted by police as deficient (having regard to the standards of the time), or that his Honour considered that further inquiries could be usefully conducted that that time.*

5.1651. In the light of the evidence cited above, I regard that submission as misconceived. The deficiency of the investigation of Mr Russell's death cannot be excused by resort to the original Coroner's having apparently been unaware of its undoubted inadequacy, or to the "standards of the time".

EXHIBITS

5.1652. Exhibits noted at the scene on 23 November 1989 included:

a. The clothing worn by Mr Russell, notably jeans, sloppy joe and shoes.

b. Some hairs adhering to his left hand.

c. Some coins, a cigarette packet, a cigarette lighter and a Coca-Cola bottle.

5.1653. None of these exhibits were subjected to any fingerprinting or forensic testing during the course of the initial investigation.[1382] As to the cigarette packet and Coca-Cola bottle, Plain Clothes Constable Dunbar's evidence at the Milledge Inquest was that "quite possibly" retaining the exhibits was something that "simply did not occur to her".[1383]

The hairs on Mr Russell's hand

5.1654. Officers who attended the scene, including Sergeant Ingleby, noted there was some hair adhering to the left hand of the body behind the left index finger.[1384]

5.1655. At about 11:25am on 23 November 1989, Detective Sergeant Carl Cameron and Detective Senior Constable Manny Rivera from the NSWPF Crime Scene Unit arrived at the scene to conduct a forensic examination.[1385] They both also observed the hairs on Mr Russell's hand. Detective Cameron took photos of the scene, including of the hairs on the hand.[1386]

5.1656. Detective Sergeant Cameron and/or Detective Senior Constable Rivera collected the hairs. What was then done with them is less than clear on the available evidence. However, what is clear is that:

a. No forensic testing was carried out on the hairs; and

[1382] Exhibit 46, Tab 7, Statement of Constable Sally Jane Dunbar, 16 February 1990 (SCOI.10551.00031); Exhibit 46, Tab 36, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 2 April 2003, 24–25, 30–31 (SCOI.84026).

[1383] Exhibit 46, Tab 36, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 2 April 2003, 56–57 (SCOI.84026).

[1384] Exhibit 46, Tab 70, Statement of Adrian Macdonald Ingleby, 7 June 2023, [103] (SCOI.83543); Exhibit 46, Tab 10, Statement of Sergeant Adrian Macdonald Ingleby, 26 February 1990, [8] (SCOI.02744.00075).

[1385] Exhibit 46, Tab 21, Statement of Detective Senior Constable Manuel Antonio Rivera, 5 March 2002, [4] (SCOI.02744.00196).

[1386] Exhibit 46, Tab 22, Statement of Detective Carlton Graeme Cameron, 29 May 2002, [4]–[6] (SCOI.10388.00175); Exhibit 46, Tab 37, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 3 April 2003, 33 (SCOI.84025).

b. By the time of the inquest, some seven months later on 2 July 1990, the hairs had been lost.[1387]

5.1657. On 24 November 1989, Peter Russell went to the Glebe morgue to identify his brother's body. He saw the blood on John's clothes, and he saw "brownish, blonde hairs next to John's thumb." He said the hairs "were not John's; they were too long and the wrong colour."[1388]

5.1658. The NSWPF submitted that Peter Russell's evidence should be "approached cautiously", as he had not referred to those matters in earlier statements and "a very long period of time has elapsed".[1389] I do not find that submission persuasive. It may simply be, for example, that Peter Russell did not refer to this topic in earlier statements because no-one had previously asked him about it. No police officer at the time of the initial investigation made a record of a visual comparison of the hairs. Peter Russell has demonstrated and maintained, ever since 1989, a close and keen interest in the circumstances surrounding his brother's death. I accept his evidence.

5.1659. Sergeant Ingleby has no knowledge of how the hair/s were lost or destroyed.[1390]

5.1660. The February 1990 statement of the OIC, Plain Clothes Constable Dunbar, made no mention of the hairs on Mr Russell's hand. [1391]

5.1661. At the Milledge Inquest in 2003, Plain Clothes Constable Dunbar (by then Ms Johnston) gave evidence that she remembered the hairs being there but that she did not know what happened to them. She said she thought she would have been interested in the hairs, but that she would have let the onus be on the scientific section to do "whatever they do with it". She said she did nothing with the hairs "except to hand them over to scientific". She said she "took it for granted" that "they would be looking after that". When asked why she did not chase up, or follow up, the hairs, she said "I can't answer that".[1392]

5.1662. At the Milledge Inquest in 2003, a forensic pathologist, Dr Cala, gave evidence that whilst it was possible, he did not believe the hairs on Mr Russell's hand belonged to Mr Russell, and that it appeared to have been pulled, or "tugged out" from another person.[1393] Professor Duflou also thought that the hairs were more likely to be from a second person.[1394]

[1387] Exhibit 46, Tab 37, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 3 April 2003, 33–38,45–51 (SCOI.84025).

[1388] Exhibit 46, Tab 65, Statement of Peter Russell, 6 March 2023, [4] (SCOI.83423).

[1389] Submissions of NSWPF, 13 July 2023, [24] (SCOI.84454).

[1390] Exhibit 46, Tab 70, Statement of Adrian Macdonald Ingleby, 7 June 2023, [76] (SCOI.83543).

[1391] Exhibit 46, Tab 7, Statement of Constable Sally Jane Dunbar, 16 February 1990 (SCOI.10551.00031).

[1392] Exhibit 46, Tab 36, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 2 April 2003, 55–56, 62–63 (SCOI.84026).

[1393] Exhibit 45, Tab 73, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 2 April 2003, 10 (SCOI.84103); Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 6 (SCOI.02751.00021).

[1394] Exhibit 6, Tab 171, Expert report of Professor Johan Duflou, 16 August 2017, 8–9 (SCOI.10385.00060).

5.1663. The submissions of the NSWPF drew attention to the views of Elizabeth Brooks, a Senior Forensic Scientist with the Australian Federal Police (**AFP**). In May 2014 she had reviewed the available photographs and had expressed the opinion (based only on the photographs) that "these hairs are unremarkable in that they could have come from the deceased's own scalp."[1395]

5.1664. It is unclear who requested Ms Brooks to consider this question, nor why such a request was made in 2014.[1396]

5.1665. The NSWPF also sought to highlight the views of Adine Boheme, an AFP forensic biologist, as expressed to Strike Force Neiwand officers in 2016. Ms Boheme said that in homicides, if an offender's hair is left in the crime scene it would generally be a single strand of hair rather than a bundle, and she also said it was "highly probable", as Mr Russell had a 7.5cm laceration to the back of his head, that the hair from around the wound would be displaced.[1397]

5.1666. The suggestion by the NSWPF thus appeared to be that Mr Russell might have pulled out his own hair — presumably either just before, or during, or after, his fall. Such a speculative hypothesis perhaps cannot be completely ruled out, but I regard it as unlikely. Among other things, I note that two forensic pathologists also regarded it as unlikely, and that both those experts considered that Mr Russell was unlikely to have survived the impact with the rocks or to have moved thereafter (see further below).[1398]

5.1667. There are no recorded observations by any attending police officer at the crime scene as to a visual comparison between the hairs on Mr Russell's hand and Mr Russell's own hair.

5.1668. The loss of this critical exhibit meant the hairs were not tested at the time. Nor can the hairs ever be subjected to modern forensic testing. As Counsel Assisting submitted, they may well have held the key to identifying the perpetrator of an attack on Mr Russell.

5.1669. The NSWPF acknowledged that the loss of the hairs was "manifestly unacceptable."[1399] The NSWPF suggested that the officers at the time may not have conceived of the possibility that DNA testing might one day become available. However, the NSWPF did concede that the hairs could have been useful in other ways (for example, by way of a visual comparison with the hairs on Mr Russell's head, or the hair of a suspect identified through other means.[1400]

5.1670. Coroner Milledge described the loss of these "vital" hairs as "disgraceful". I agree.

[1395] Submissions of NSWPF, 28 June 2023, [421] (SCOI.84211).

[1396] Exhibit 6, Tab 173, Strike Force Neiwand, Summary of Investigation – John Russell, Undated [121] (SCOI.74882).

[1397] Submissions of NSWPF, 28 June 2023, [422] (SCOI.84211).

[1398] Exhibit 6, Tab 157, Expert report of Dr Allan Cala, 14 August 2001 (SCOI.10386.00142); Exhibit 6, Tab 327, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 2 March 2003, T17.26–50, T19.6–37 (SCOI.82588); Exhibit 6, Tab 171, Expert report of Professor Johan Duflou, 16 August 2017 (SCOI.10385.00060).

[1399] Submissions of NSWPF, 13 July 2023, [21] (SCOI.84454).

[1400] Submissions of NSWPF, 13 July 2023, [22] (SCOI.84454).

Mr Russell's clothing

5.1671. After Mr Russell's funeral (presumably in late November 1989), his father Ted Russell received a call from the Glebe Coroners Court asking him to pick up a box of John's possessions. Peter Russell picked up the box but did not look in it. He gave the box to his father. When his father opened the box, he picked up John's clothes and said; "I can smell the boy". John's shoes, socks, jeans and sloppy joe were in the box, all "as it had been taken off John", i.e. still with blood and salt water on it.[1401]

5.1672. Very soon afterwards, in December 1989, a mannequin wearing Mr Russell's clothing was displayed in Bondi as part of an appeal to the public for information.[1402]

5.1673. Peter Russell's recollection is that someone, presumably a police officer, had contacted his father and asked for clothes similar to what Mr Russell had been wearing on the night that he died. His father simply gave police back the whole box of John's clothes, just as Peter had collected them from the morgue.

5.1674. Police set up the mannequin in Bondi. Peter went to have a look at it, and he saw that the clothes were spotless and the shoes were clean. It was obvious to him that the clothes "had been through the wash", because when he had seen them on John's body at the morgue, they were covered in blood and salt water.[1403]

5.1675. When the clothes were later returned to his father a second time, Ted Russell said, "this has been washed".[1404]

5.1676. On 30 March 2023, a statement by Detective Inspector Nigel Warren set out a detailed account, based on records available to him in 2023, of the sequence of events in relation to the handling of Mr Russell's clothing.[1405] Among other things, Detective Inspector Warren's statement refers to the following:

a. On 1 December 1989, handwritten notes appear to state that Sergeant Ingleby attended 'CSU' at 3:15pm–3:30pm, to "browse clothing of deceased", also stating "cleaned" and "for fitting to display model".[1406] A further note appears to state, "clothing for (dummy dressed)";[1407]

b. On 9 December 1989, handwritten notes appear to state: "Rang Adrian I re above - dummy to be dressed I photo by Thurs 14112.";[1408]

c. On 10 December 1989, Detective Senior Constable Rivera took photographs of a mannequin wearing Mr Russell's clothing.[1409] (Plain Clothes Constable

[1401] Exhibit 46, Tab 65, Statement of Peter Russell, 6 March 2023, [10]–[11] (SCOI.83423).

[1402] Exhibit 46, Tab 66, Statement of Detective Inspector Nigel Warren, 30 March 2023, [12]–[40] (NPL.9000.0001.0001).

[1403] Exhibit 46, Tab 65, Statement of Peter Russell, 6 March 2023, [12] (SCOI.83423).

[1404] Exhibit 46, Tab 65 Statement of Peter Russell, 6 March 2023, [13] (SCOI.83423).

[1405] Exhibit 46, Tab 66, Statement of Detective Inspector Nigel Warren, 30 March 2023, [12]–[40] (NPL.9000.0001.0001).

[1406] Exhibit 46, Tab 66A, NSWPF File, 'Compilation of Crime scene notes', 26 (NPL.0100.0002.0017).

[1407] Exhibit 46, Tab 66A, NSWPF File, 'Compilation of Crime scene notes', 33 (NPL.0100.0002.0017).

[1408] Exhibit 46, Tab 66A, NSWPF File, 'Compilation of Crime scene notes', 22 (NPL.0100.0002.0017).

[1409] Exhibit 46, Tab 66G, Photograph taken by Detective Senior Constable Manuel Rivera, 10 December 1989 (NPL.0100.0002.0053).

Dunbar said that photographs of that mannequin were published in the newspaper in order to try to generate further lines of inquiry.[1410]); and

d. Mr Russell's clothes are likely to have been returned to his family after they had been removed from the mannequin.[1411]

5.1677. Detective Inspector Warren was unable to assist as to the precise means by which Mr Russell's clothing was "cleaned" prior to being placed on the mannequin.

5.1678. The "cleaning" of the clothing is likely to have had at least some adverse impact on the forensic testing subsequently undertaken in 2002, 2016 and 2023. Cleaning agents will typically dilute and/or remove staining and therefore make the DNA less concentrated. If the DNA is not totally removed by such cleaning, degradation of DNA is likely which means that some of the larger fragments of DNA will be lost.[1412] These matters are referred to further below.

PREMATURE CLOSING OF THE CASE

5.1679. On 21 December 1989, David McMahon was confronted and assaulted near Marks Park by a group of 10 to 12 young persons, at a point on the clifftop close to the point below which Mr Russell was found.[1413]

5.1680. On 3 January 1990, Sergeant Ingleby took a statement from Mr McMahon, and put the statement, once completed, in the "in tray" for the Bondi detectives with a note, as he considered it relevant to the investigation of Mr Russell.[1414]

5.1681. On 12 January 1990, an article headed "Mystery death of gay man near Bondi beat" was published in the *Sydney Star Observer*. The article stated that the investigating detectives believed the death "may have been a murder" but that there was no proof of foul play. Plain Clothes Constable Dunbar, the OIC, was reported as having said that the possibility of murder had not yet been eliminated. The article said that "the possibility that gay bashers had thrown [Mr Russell] over the cliff to his death remained, as did the possibility of an accident."[1415]

5.1682. On 16 February 1990, just a month after the article in the *Star Observer*, Plain Clothes Constable Dunbar signed her statement. Her opinion, in that statement, was that there was no evidence to suggest there were suspicious circumstances surrounding Mr Russell's death. Plain Clothes Constable Dunbar continued:[1416]

> *It is my opinion that the deceased fell from the cliff top to where he was located. Whether this can be attributed to the deceased's level of intoxication will be clear with the results of the forensic tests.*

[1410] Exhibit 46, Tab 36, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 2 April 2003, 54 (SCOI.84026).

[1411] Exhibit 46, Tab 66, Statement of Detective Inspector Nigel Warren, 30 March 2023, [18]–[19] (NPL.9000.0001.0001).

[1412] Exhibit 46, Tab 69, Statement of Michele Franco, 23 August 2023, [79] (SCOI.84089).

[1413] Exhibit 46, Tab 16, Statement of DM, 3 January 1990, [5] (SCOI.10386.00085).

[1414] Exhibit 46, Tab 70, Statement of Adrian Macdonald Ingleby, 7 June 2023, [58] (SCOI.83543).

[1415] Exhibit 46, Tab 72, 'Mystery death of gay man near Bondi beat', *Sydney Star Observer* (Sydney, 12 January 1990) (SCOI.02752.00109).

[1416] Exhibit 46, Tab 7, Statement of Constable Sally Jane Dunbar, 16 February 1990, [14]–[15] (SCOI.10551.00031).

5.1683. On the same day, Plain Clothes Constable Dunbar produced a document titled 'Information re death of John Alan Russell', indicating that she had "made a thorough perusal of all records held at Bondi Police Station" and that she had found only two reports (one relating to Mr McMahon) that may relate to a pattern involving assaults and the LGBTIQ community.

5.1684. However, Plain Clothes Constable Dunbar acknowledged that victims of these types of assaults were "reluctant to report the attacks due to their belief they may be ridiculed in the proceedings following the report", and that the low number of reported incidents "does not give a true indication".[1417]

5.1685. On 26 February 1990, Sergeant Ingleby signed his statement for the inquest into the death of Mr Russell. In his statement, he said that he was aware that crimes of violence on the "homosexual element" in the area were prevalent. He said he believed that "the level of unreported assaults and associated offences on the homosexual element in this area (and other areas) would be extremely high."[1418]

5.1686. Nevertheless, it would appear that after about February 1990 there were no further steps taken by police to investigate Mr Russell's death.

5.1687. The available evidence indicates that no canvassing of the local area was undertaken, other than the attempts by Sergeant Ingleby to locate a person called "Red", whom a local person (Rodney Stinson) had suggested may have known something about an altercation in the relevant area, possibly on the night of Mr Russell's death.[1419] Nor were any witness statements apparently taken after that of Mr McMahon on 3 January 1990.[1420]

5.1688. Mr Ingleby's view is that the Bondi detectives "were investigating Mr Russell's death as 'not suspicious' from day one". He said:[1421]

> *The focus of the investigation seems to have proceeded on the basis of 'accident' or 'misadventure', ignoring the potential new line of enquiry regarding the offenders who assaulted and robbed Mr McMahon.*

5.1689. The observations of Coroner Milledge, cited above, were amply justified. The original investigation in 1989-90 was barely an investigation of a possible homicide at all.

[1417] Exhibit 46, Tab 4, NSWPF Incident Report, 'Assault Incidences in the Bondi area with Attackers Believing their Victims to be Homosexuals', 21 December 1989 (SCOI.02752.00107).

[1418] Exhibit 46, Tab 10, Statement of Sergeant Adrian Macdonald Ingleby, 26 February 1990, [16]–[17] (SCOI.02744.00075).

[1419] Exhibit 46, Tab 10, Statement of Sergeant Adrian Macdonald Ingleby, 26 February 1990, [10]–[11] (SCOI.02744.00075); Exhibit 46, Tab 70, Statement of Adrian Macdonald Ingleby, 7 June 2023, [36]–[44] (SCOI.83543).

[1420] Exhibit 46, Tab 7, Statement of Constable Sally Jane Dunbar, 16 February 1990 (SCOI.10551.00031); Exhibit 46, Tab 8, Statement of Constable Michael Antony Barrett, 1 December 1989 (SCOI.02744.00073); Exhibit 46, Tab 36, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 2 April 2003 (SCOI.84026).

[1421] Exhibit 46, Tab 70, Statement of Adrian Macdonald Ingleby, 7 June 2023, [73]–[75] (SCOI.83543).

Persons of Interest

GILLES MATTAINI

5.1690. In the case of Mr Mattaini, there was no investigation of his 1985 disappearance until August 2002, when Mr Mattaini's case was added to Operation Taradale. There were no persons of interest.

ROSS WARREN

5.1691. As noted above, within days of Mr Warren's disappearance, Detective Sergeant Bowditch had recorded his view that he had fallen into the water at Marks Park by accident.

5.1692. No investigation as to the possibility of homicide took place. No persons of interest were identified.

JOHN RUSSELL

5.1693. The original OIC considered that Mr Russell died as a result of misadventure, possibly due to his level of intoxication.

5.1694. No persons of interest were identified.

Exhibits: Availability and testing

GILLES MATTAINI

5.1695. There were and are no exhibits available for testing.

ROSS WARREN

5.1696. Fingerprints were obtained from Mr Warren's vehicle in the initial investigation. They were tested in 1989. There were unidentified fingerprints on a cassette case and driver's licence found in the car.[1422]

5.1697. Fingerprint testing was not conducted on Mr Warren's keys. Detective Sergeant Bowditch stated that although he did not consult a fingerprint expert, in his experience, fingerprints did not hold onto metal when wet.[1423]

5.1698. In 1991, the fingerprints obtained from Mr Warren's vehicle were tested at the request of Detective Senior Constable Bignell of the Homicide Squad against a list of 'youth gang members', with no match.[1424]

5.1699. In 2001 and 2002 (during Operation Taradale), and in 2016 (during Strike Force Neiwand), various other fingerprinting tests were conducted. None yielded any information of investigative relevance.

[1422] Exhibit 6, Tab 174, Strike Force Neiwand, Summary of Investigation – Ross Warren, 8 January 2018, [171] (SCOI.74883).

[1423] Exhibit 45, Tab 73, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 2 April 2003, 43–44 (SCOI.84103).

[1424] Exhibit 6, Tab 174, Strike Force Neiwand, Summary of Investigation – Ross Warren, 8 January 2018, [78] (SCOI.74883).

5.1700. In 2016, several of the exhibits were tested for DNA by Strike Force Neiwand. All were unsuccessful, apart from a mixed DNA profile found on Mr Warren's drivers' licence, that produced a weak and/or complex result.[1425] The profile remains unidentified.

5.1701. On 1 November 2022, the Inquiry was advised by FASS that further forensic testing was unlikely to be successful.

JOHN RUSSELL

5.1702. As noted above, human hairs, which may have been from another person (such as a possible assailant), were observed on Mr Russell's left hand. Peter Russell, who saw the hairs next to his brother's thumb when he viewed his body at the morgue on 24 November 1989, said the hairs were not his brother's; they were too long and the wrong colour.[1426]

5.1703. As also noted above, those hairs were "bagged" for analysis, but by 2 July 1990 (the date of the initial inquest into Mr Russell's death) they had been lost. No forensic analysis was ever performed on those hairs.[1427]

5.1704. Mr Russell was found wearing a red sloppy joe, faded jeans,[1428] a pair of boxer shorts, a pair of white socks, a pair of black "gym boots" and with $4.60 in loose coins and a red credit card holder.[1429] Each of these items was photographed and collected.[1430]

5.1705. None of Mr Russell's clothing, including the jeans, sloppy joe and shoes, were the subject of any forensic testing at the time of the initial investigation in 1989-90. Nor were a cigarette packet, cigarette lighter or Coca-Cola bottle, all of which were found near Mr Russell's body. The whereabouts of these items appears now to be unknown.[1431]

5.1706. Mr Russell's jeans, sloppy joe and shoes were soon returned to the family, as outlined above. They were still "covered in blood and salt water", as they had been when Peter Russell saw them in the morgue.

5.1707. However, shortly afterwards, in December 1989, they were given back to police, for the purpose of being placed on a mannequin as part of an appeal to the public for information. When Peter Russell saw that mannequin, on display in Bondi, he noticed that that the clothes were "spotless", and the shoes were clean. It was obvious to him and to his father Ted that the clothes had been washed.[1432]

[1425] Exhibit 6, Tab 174, Strike Force Neiwand, Summary of Investigation – Ross Warren, 8 January 2018, [229] (SCOI.74883).

[1426] Exhibit 46, Tab 65, Statement of Peter Russell, 6 March 2023, [4] (SCOI.83423).

[1427] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 1 (SCOI.02751.00021).

[1428] The jeans are described as both blue and bone coloured in the material.

[1429] Exhibit 46, Tab 1, P79A Report of Death to Coroner, 24 November 1989 (SCOI.02744.00083).

[1430] Exhibit 46, Tab 22, Statement of Detective Carlton Graeme Cameron, 29 May 2002, [6] (SCOI.10388.00175).

[1431] Exhibit 46, Tab 71B, Letter from Katherine Garaty to Enzo Camporeale, 27 June 2023, 2 (SCOI.84159).

[1432] Exhibit 46, Tab 65, Statement of Peter Russell, 6 March 2023, [12], [13] (SCOI.83423).

5.1708. The jeans, sloppy joe and shoes have subsequently been tested by FASS (formerly DAL) on three separate occasions, namely: in about 2002 (Operation Taradale); in 2016 (Strike Force Neiwand); and in 2023 (at the request of the Inquiry). These various tests are referred to below.

Findings at initial inquest

Gilles Mattaini

5.1709. There was no inquest following Mr Mattaini's disappearance in September 1985.

Ross Warren

5.1710. There was no inquest following Mr Warren's disappearance in July 1989. The OIC, Detective Sergeant Bowditch, did not report the matter to the Coroner. [1433]

John Russell

5.1711. On 2 July 1990, an inquest was held at Glebe Coroners Court. No transcript of the proceeding is available, but the Master Tape History Sheet shows that Constable Barrett and Constable Dunbar, Sylvia Hollinger, Neville Smith, I403 and Rodney Stinson were called as witnesses.

5.1712. Whether any evidence was offered at the inquest in relation to the hairs adhering to John Russell's hand is unknown.[1434]

5.1713. The formal finding made by then Deputy State Coroner Hand was that:[1435]

> *the deceased on or about 22/11/1989 at Bondi Beach South in the State of New South Wales died of the effects of multiple injuries sustained then and there where he fell from a cliff to the rocks below, but whether he fell accidentally or otherwise the evidence does not enable me to say.*

Criminal proceedings

5.1714. No criminal proceedings have ever been brought against any person in respect of any of these three deaths.

2000-2005: Operation Taradale and the Milledge Inquest

1990-1991: Investigation by Detective Sergeant McCann

5.1715. Detective Sergeant McCann was the lead investigator into the murders of Mr Johnson in January 1990 (in Alexandria) and Kritchikorn Rattanajurathaporn in July 1990 (at Marks Park).

[1433] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 5 (SCOI.02751.00021).

[1434] Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen John Page, 25 July 2002, [322]–[323] (SCOI.02744.00023).

[1435] Exhibit 46, Tab 5, Findings of DSC Hand, Inquest into the death of John Russell, 2 July 1990 (SCOI.02752.00123).

5.1716. In April 1991, Detective Sergeant McCann compiled a summary of connections and links he had uncovered, both in relation to the deaths of Mr Johnson and Mr Rattanajurathaporn and also in relation to other attacks on gay men, some of them also resulting in deaths, in various parts of Sydney up to that time.[1436] These incidents included the deaths of William Allen (Alexandria) and Wayne Tonks (Artarmon).[1437] Relevantly for present purposes, they also included the disappearance of Mr Warren and the death of Mr Russell (both at Marks Park).

5.1717. On 15 April 1991, Detective Sergeant McCann sent his summary, in the form of a letter, to Chief Superintendent Norm Maroney, who was then the Director of Operations at State Command.[1438] Detective Sergeant McCann had in mind that State Command would sanction and resource a task force to investigate the incidents. However, he received no answer to the letter.[1439]

5.1718. On 10 August 1991, Detective Sergeant McCann sent a more detailed version of this summary, again in the form of a letter, to the Commander, Modus Operandi Section.[1440]

5.1719. Detective Sergeant McCann's understanding and expectation at the time was that the Modus Operandi Section would be able to locate and/or generate intelligence concerning the individuals and groups he had identified in his report and provide him with that intelligence. He considered that this may have enabled him to pursue further inquiries in relation to some of the unsolved deaths referred to in the report. Again, however, he received no response.[1441]

2000-2002: Operation Taradale

5.1720. In May 2000, Detective Sergeant Page, then the Investigations Manager at Rose Bay Local Area Command, received a file in relation to the disappearance of Mr Warren. Mr Warren's file contained a series of letters from his mother, Kay Warren, requesting that inquiries be made so that a death certificate could be issued in relation to her missing son. [1442]

5.1721. On becoming aware of Mrs Warren's requests, and of the belated and limited responses she had received, Detective Sergeant Page began to examine documents associated with the 1989 investigation, and requested resources to reinvestigate the matter.[1443]

[1436] Exhibit 6, Tab 233, Statement of former Detective Sergeant Stephen McCann, 10 November 2022, [11] (SCOI.77310).

[1437] Exhibit 6, Tab 233A, Letter from Stephen McCann to the Commander, Modus Operandi Section, 10 August 1991 (SCOI.10342.00010).

[1438] Exhibit 6, Tab 233B, Letter from Stephen McCann to Chief Superintendent Norm Maroney, 15 April 1991 (SCOI.10445.00128).

[1439] Exhibit 6, Tab 233, Statement of former Detective Sergeant Stephen McCann, 10 November 2022, [13]–[14] (SCOI.77310).

[1440] Exhibit 6, Tab 233A, Letter from Stephen McCann to the Commander, Modus Operandi Section, 10 August 1991 (SCOI.10342.00010).

[1441] Exhibit 6, Tab 233, Statement of former Detective Sergeant Stephen McCann, 10 November 2022, [17]–[18] (SCOI.77310).

[1442] Exhibit 6, Tab 314, NSWPF Investigator's Note, 'Annexure 2 to statement of Detective Sergeant Stephen Page', 19 August 2002 (SCOI.82476); Exhibit 6, Tab 314A, Letter from Kay Warren to NSWPF Missing Persons Unit, 15 July 1998 (SCOI.82478); Exhibit 6, Tab 314B, Letter form Kay Warren to NSWPF Missing Persons Unit, 5 September 1998 (SCOI.82475); Exhibit 6, Tab 314C, Letter from Kay Warren to NSW Missing Persons Unit, 1 December 1998 (SCOI.82473); Exhibit 6, Tab 314D, Letter from Kay Warren to NSW Missing Persons Unit, 26 May 1999 (SCOI.82479); Exhibit 6, Tab 314E, Letter from Kay Warren to the Crime Manager, Rose Bay Police, 7 December 1999 (SCOI.82477); Exhibit 6, Tab 314F, Letter from Kay Warren to the NSW Commissioner of Police, 26 April 2000 (SCOI.82474).

[1443] Exhibit 6, Tab 160, Statement of Detective Sergeant Stephen John Page, 28 August 2002, [3] (SCOI.02744.00024).

5.1722. Operation Taradale was subsequently established to investigate the disappearance and suspected death of Mr Warren in July 1989, the death of Mr Russell in November 1989, and the assault on David McMahon in December 1989 (which also occurred at Marks Park).

5.1723. In the course of his work in connection with this investigation, Detective Sergeant Page became aware of the two 1991 reports by Detective Sergeant McCann, and of the possible links between and among various gangs operating in the relevant period both in the Bondi-Tamarama area and elsewhere in Sydney.

5.1724. Apart from Detective Sergeant Page there were, at various stages of Operation Taradale, up to 12 police officers working on Operation Taradale.[1444] The scope of Operation Taradale, as Mr Page said, was "very substantial".[1445]

5.1725. Mr Page gave evidence that Operation Taradale adopted "a 'bottom-up' approach", meaning that "the team went in with an open mind in an attempt to gather and understand the information that was 'out there'".[1446] Operation Taradale "had no preconceptions" in relation to the likely manner and cause of death in relation to each case and "sought to explore all possible lines of inquiry in each case, including suicide, misadventure or foul play".[1447]

5.1726. Mr Page summarised some of the work of Operation Taradale as follows:[1448]

> *[A]s part of Taradale we did a search of all known or reported assaults perpetrated in the relevant local area, being all around Bondi and Tamarama (not just assaults that occurred in Marks Park) and interviewed many victims of possible gay hate violence. This strategy led to useful intelligence being provided by a number of victims of assaults. Taradale also sought to obtain intelligence in other ways including by issuing media releases, canvassing members of the community and through covert surveillance. This intelligence was turned into evidence where possible.*
>
> *As part of its investigation, Taradale sought to learn about and understand the personal background of each of Mr Russell, Mr Warren and Mr Mattaini, through locating and speaking to their relatives and associates, reviewing their financial and medical background and any criminal history, and generally seeking to gain an understanding of their lifestyle and relationships.*

5.1727. As I read the second of those paragraphs, it is describing in a summary way what is referred to elsewhere as "victimology".

5.1728. Among the many investigative techniques and steps pursued by Operation Taradale were: [1449]

[1444] Transcript of the Inquiry, 2 March 2023, T2347.15–2347.17 (TRA.00031.00001).

[1445] Exhibit 6, Tab 253, Statement of former Detective Sergeant Stephen John Page, 16 February 2023, [17] (SCOI.82472).

[1446] Exhibit 6, Tab 253, Statement of former Detective Sergeant Stephen John Page, 16 February 2023, [12] (SCOI.82472).

[1447] Exhibit 6, Tab 253, Statement of former Detective Sergeant Stephen John Page, 16 February 2023, [12] (SCOI.82472).

[1448] Exhibit 6, Tab 253, Statement of former Detective Sergeant Stephen John Page, 16 February 2023, [13]–[15] (SCOI.82472).

[1449] Exhibit 6, Tab 160, Statement of Detective Sergeant Stephen John Page, 28 August 2002 (SCOI.02744.00024).

- Electronic surveillance by means of telephone interceptions: over 17,000 telephone calls were intercepted and monitored.
- Electronic surveillance by means of listening devices,
- Interviewing and taking statements from numerous persons of interest.
- Arranging a re-enactment of Mr Russell's fall, by the use of a dummy, on 9 December 2001.
- Sending Mr Russell's clothes to DAL for forensic testing including for DNA.
- Obtaining expert evidence from, among others, Dr Cala (forensic pathologist), Dr Moynham (forensic pathologist) and Dr Brander (coastal geomorphologist).

5.1729. By late July 2002, Detective Sergeant Page had completed the brief of evidence for submission to the Coroner.

5.1730. That brief of evidence included a 287-page statement by Detective Sergeant Page dated 25 July 2002, in relation to the disappearance and suspected death of Mr Warren and the death of Mr Russell (**Russell/Warren Statement**). [1450]

5.1731. However, in August 2002, in the wake of publicity concerning Operation Taradale, Mr Wyszynski and Mr Musy reported the 1985 disappearance of Mr Mattaini to Detective Sergeant Page.[1451] Thereafter, Operation Taradale was expanded to include the disappearance of Mr Mattaini.

5.1732. Detective Sergeant Page promptly took various steps to obtain information about Mr Mattaini, including obtaining statements from both Mr Wyszynski and Mr Musy. [1452]

5.1733. In his oral evidence, Detective Sergeant Page explained how he created the Musy statement, in particular paragraphs 5 and 6 thereof on page 2 (which refer to previous suicide attempts by Mr Mattaini). He sat at his computer and typed what Mr Musy said on to the screen, with Mr Musy watching the screen as he did so. He asked Mr Musy "open-ended" questions about his recollections, and he typed what Mr Musy told him. Mr Musy did not say to him anything about suicide, or suicidal thoughts, in relation to Mr Mattaini, besides what appears in the statement. If Mr Musy had said anything else in relation to such topics, he would have included that in the statement. [1453]

5.1734. Mr Page was not challenged on this evidence, which I accept. I note that the oral evidence of Mr Page is also discussed in **Chapter 12.**

[1450] Exhibit 6, Tab 160, Statement of Detective Sergeant Stephen John Page, 28 August 2002 (SCOI.02744.00024).

[1451] Transcript of the Inquiry, 28 February 2023, T2341.25–2341.30 (TRA.00029.00001).

[1452] Exhibit 6, Tab 159, Statement of Jacques Paul Musy, 3 August 2002 (SCOI.02744.00381); Exhibit 44, Tab 4, Statement of Antony Jean Wyszynski, 3 August 2002 (SCOI.02744.00382).

[1453] Transcript of the Inquiry, 28 February 2023, T2343.17–2345.24 (TRA.00029.00001).

5.1735. On 28 August 2002, Detective Sergeant Page completed a second statement of his own, of seven pages, summarising the information he had received, and the steps he had been able to take (in a matter of weeks), in relation to the disappearance and suspected death of Mr Mattaini (**Mattaini Statement**).[1454]

5.1736. These two statements by Detective Sergeant Page annexed a total of 276 documents. The documentary material before Coroner Milledge consisted of six lever arch folders.[1455]

5.1737. Coroner Milledge described the Taradale investigation as having employed "sophisticated police techniques and methodology", and as "impeccable."[1456]

5.1738. The NSWPF, in its submissions in relation to Public Hearing 2, endorsed that language. As to Mr Warren and Mr Russell, the NSWPF added that the Taradale investigation was "exhaustive". As to Mr Mattaini, the NSWPF recognised that Detective Sergeant Page did what he could, having regard to the extremely limited avenues of investigation that were realistically open to him in connection with Mr Mattaini's disappearance.[1457]

5.1739. As will become apparent, those submissions of the NSWPF in 2023 are starkly different from the views expressed by Strike Force Neiwand in 2017-18.

5.1740. Unfortunately, although the investigation led by Detective Sergeant Page identified many persons of interest in respect of the 1989 deaths of Mr Warren and Mr Russell, mainly members or associates of gay hate-motivated groups, several of whom admitted involvement in assaults on gay men in the Bondi area, it did not uncover evidence sufficient to pinpoint any person or persons in connection with any of the three deaths.

Views advanced by Detective Sergeant Page and Operation Taradale

GILLES MATTAINI

5.1741. In the Mattaini statement, at [825], Detective Sergeant Page summed up his views, as at 28 August 2002, as follows (emphasis added):[1458]

> *In so far as early opinions in relation to the factors surrounding the suspected death of MATTAINI,* ***I do not believe that homicide can be excluded*** *taking into account the fact MATTAINI has gone missing with items he usually takes when going for a walk, and his walks take him past Marks Park at Tamarama which is known to be a violent area for gay victims.*
>
> ***I am aware that MATTAINI has previously tried to take his own life, however,*** *there is a significant passage of time since that era and whatever factors that did exist causing him to be suicidal there is*

[1454] Exhibit 6, Tab 160, Statement of Detective Sergeant Stephen John Page, 9 March 2005 (SCOI.02744.00024).

[1455] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 9 (SCOI.02751.00021).

[1456] Submissions of NSWPF, 28 June 2023, [247] (SCOI.84211).

[1457] Submissions of NSWPF, 28 June 2023, [251] (SCOI.84211).

[1458] Exhibit 6, Tab 160, Statement of Detective Sergeant Stephen John Page, 9 March 2005, [825] (SCOI.02744.00024).

> *no evidence to suggest that those factors still existed. Considering these suicide attempts occurred in his early teens,*[1459] *the causes may well have been confusion over sexuality and loss of liberty whilst performing national service.*

ROSS WARREN

5.1742. In the Russell/Warren statement, Detective Sergeant Page summarised his views as follows:[1460]

a. He noted that Mr Warren had not "let his financial affairs lapse", which people contemplating suicide sometimes do, and that he appeared to be in good spirits;

b. He believed that Mr Warren was deceased and that it was likely that his body entered the water surrounding Marks Park;

c. He believed it was likely that Mr Warren's keys had been placed where they were found, either by Mr Warren or by a finder;

d. He did not believe Mr Warren attended Marks Park to commit suicide, as he was a gay man attending a known beat at Marks Park and was likely to have been there for a clandestine sexual encounter;

e. Taking into account violence against gay men at Marks Park, he believed it was likely that Mr Warren met his death at Marks Park as a result of violence; and

f. Although available evidence showed the groups known as the Bondi Boys, the Tamarama Three and the Alexandria Eight were involved in violent offences towards the gay community in the vicinity of Marks Park, he was not able to offer an opinion as to who was responsible for Mr Warren's death.[1461]

5.1743. With respect to the adequacy of the initial police investigation, Detective Sergeant Page considered that it was flawed in the following respects:[1462]

a. The investigation was retained by a command not responsible for the incident scene;

b. The positioning of the subject vehicle and keys were not recorded by way of photograph;

c. There appeared to be no organised canvass conducted;

d. There was no brief of evidence submitted to the Missing Persons Unit or Coroners Court (as required by legislation) to assist any subsequent investigations;

[1459] The events in question seem to have occurred in Mr Mattaini's mid-late teens rather than "early teens": see Exhibit 6, Tab 159, Statement of Jacques Paul Musy, 3 August 2002, [5]–[6] (SCOI.02744.00381); Exhibit 6, Tab 170A, Statement of Jacques Paul Musy, 10 May 2017, 2 (SCOI.1097.00007).

[1460] Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen John Page, 25 July 2002, [791]–[795] (SCOI.02744.00023).

[1461] Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen John Page, 25 July 2002, [791]–[793] (SCOI.02744.00023).

[1462] Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen John Page, 25 July 2002, [796] (SCOI.02744.00023).

e. The diving unit was not utilised to conduct an underwater search in an effort to locate the body of Mr Warren;

f. Crime trends in relation to violence against members of the gay community were not monitored to establish whether it was likely that Mr Warren was the victim of foul play. It was illogical that the scenario of accidental death was considered likely in the very early stages of the investigation, with foul play almost eliminated; and

g. Other than the primary response controlled by Constable Robinson, the investigative follow up was negligible.

5.1744. I agree with Detective Sergeant Page that the initial police investigation was flawed in all those ways.

JOHN RUSSELL

5.1745. In the Russell/Warren statement, Detective Sergeant Page summarised his views as follows:[1463]

a. He did not believe Mr Russell attended Marks Park to commit suicide, as he was a gay man attending a known beat at Marks Park and was likely there for a sexual encounter;

b. Taking into account violence against gay men at Marks Park, he believed it was likely that Mr Russell met his death at Marks Park as a result of violence; and

c. Although available evidence showed the groups known as the Bondi Boys, the Tamarama Three and the Alexandria Eight were involved in violent offences towards the gay community in the vicinity of Marks Park, he was not able to offer an opinion as to who was responsible for Mr Russell's death.[1464]

5.1746. These views, as is apparent, mirrored his views in relation to Mr Warren, set out above.

5.1747. With respect to the adequacy of the initial police investigation, Detective Sergeant Page considered that it was flawed in the following respects:[1465]

a. There was no evidence of a canvas being conducted locally;

b. The likelihood of death by violent means was discounted at an early stage;

c. The investigation failed to take into account the unusual positioning of Mr Russell's body, which was not consistent with a forwards motion fall, the presence of hairs on Mr Russell's left hand, and the disturbance of vegetation on the cliff top above where Mr Russell's body was found; and

d. The hairs on Mr Russell's hand, which may have belonged to an offender, were misplaced, and were not submitted for forensic examination.

[1463] Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen Page, 25 July 2002, [793]–[795] (SCOI.02744.00023).

[1464] Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen Page, 25 July 2002, [791]–[793] (SCOI.02744.00023).

[1465] Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen Page, 25 July 2002, [797] (SCOI.02744.00023).

5.1748. Again, I agree with Detective Sergeant Page that the initial police investigation was flawed in all those ways.

2002–2005: The Milledge Inquest

5.1749. The hearings in the Milledge Inquest commenced on 31 March 2003. On that day, Counsel Assisting made an opening address, as did counsel for the NSWPF (who was represented by counsel and solicitors throughout the inquest).

5.1750. Thereafter, there were a further eight hearing days in 2003 (in April and September). Closing addresses by both counsel were delivered on 23 December 2004.

5.1751. As noted above, the brief of evidence, including the two statements by Detective Sergeant Page, comprised hundreds of documents as well as audio and video recordings, photographs and other exhibits.

5.1752. Among the many witnesses who gave oral evidence were:

a. Detective Sergeant Page;

b. Several survivors of violent attacks, including Mr McMahon;

c. Numerous persons of interest and associates of persons of interest;

d. Experts, including Dr Cala and Dr Brander;

e. As to Mr Mattaini: Mr Musy, Mr Wyszynski, Mr Hubert;

f. As to Mr Warren: Mr Ellis, former Detective Sergeant Bowditch; and

g. As to Mr Russell: Mr Peter Russell, former Plain Clothes Constable Dunbar, Sergeant Ingleby, former Detective Cameron.

Findings

5.1753. On 9 March 2005, Coroner Milledge delivered her findings as to manner and cause of death:[1466]

As to Gilles Mattaini

> *I find that Giles [sic] Jacques Mattaini died on or about the 15 September 1985 in Sydney. The cause and manner of his death remain undetermined as the evidence before me does not enable me to say.*

As to Ross Warren

> *I find that Ross Bradley Warren died in Sydney on or about 22 July 1989. Whilst the cause and manner of death are unknown, I am satisfied that the deceased was a victim of homicide perpetrated by person or persons unknown.*

[1466] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 14 (SCOI.02751.00021).

As to John Russell

> *I find that John Alan Russell died at Marks Park, North Bondi between the 22 or 23 November 1989. The cause of death is multiple injuries sustained when he was thrown from the cliff onto rocks, by a person or persons unknown.*

5.1754. Coroner Milledge also expressed clear views about certain other aspects of the evidence, including (emphasis added):

At page 3:[1467]

> *Mr Mattaini's father was not close to his son and his mother believed it was possible that her son had 'suicided'. <u>There is no evidence before me to support the finding of 'suicide'.</u>*

At page 14:[1468]

> *Many of the Marks Park victims that reported to police told of hearing their assailants threatening to throw them off the cliff face. There is no doubt that at the time of Mr Warren's and Mr Mattaini's disappearance and Mr Russell's death that this was a Modus Operandi of some gay hate assailants. <u>This strongly supports the probability that Mr Warren, Mr Mattaini and Mr Russell met their deaths this way</u>.*
>
> *To make a finding that each of these men were victims of homicide, I must be satisfied to the 'Briginshaw' standard of proof that one or more persons were responsible for their deaths. That standard of proof is slightly higher than the usual 'balance of probabilities'.*
>
> *I am comfortably satisfied that I can make the finding of 'foul play' in relation to Mr Warren and Mr Russell, but I cannot make a finding that Mr Mattaini met his death at the hands of another person or persons. The persons of interest that may have been responsible for the deaths of Mr Warren and Mr Russell would have been far too young at the time of Mr Mattaini's disappearance in August 1985.*
>
> *I can however bring in a finding of 'death' for Mr Mattaini, but where and how he died remains unknown although <u>there is a strong possibility that he died in similar circumstances to the other men.</u>*

[1467] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 3 (SCOI.02751.00021) (emphasis added).

[1468] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 14 (SCOI.02751.00021) (emphasis added).

The years from 2005-2015

5.1755. Despite the findings made by Coroner Milledge in March 2005, and despite the Coroner's view that the information gathered by Operation Taradale would provide an excellent source of evidence for future reinvestigation,[1469] police did not review or otherwise make any use of the findings of the Milledge Inquest for many years.

5.1756. The NSWPF submitted, in that regard, that there is no reason to think that an immediate reinvestigation would have borne additional fruit, and also that the UHT was only formed in 2004 and that it was not until 2008 that it was structured in a way that allowed it to conduct reinvestigations.[1470]

5.1757. I observe that in fact no reinvestigation of any of these three deaths occurred until Strike Force Neiwand in 2016-17.

5.1758. In October 2012, some four months after the second inquest into the death of Scott Johnson (in which Coroner Forbes made an open finding, in place of the original 1989 coronial finding of suicide, based in part upon the evidence and findings in the Milledge Inquest about the three Bondi cases), the deaths of Mr Warren, Mr Russell and Mr Mattaini were examined by Detective Senior Constable Alicia Taylor of the UHT.

5.1759. In the Case Screening Form prepared by Detective Senior Constable Taylor, dated 25 October 2012,[1471] Detective Senior Constable Taylor (relevantly):

a. Stated that, "The investigation into the death of Ross Warren, John Russell and Gilles Mattaini was meticulously undertaken by an experienced investigator, Detective Sergeant Page," and

b. Recommended that in relation to the murders of Mr Russell and Mr Warren, an opportunity existed, "due to" the passage of time, to engage the (known) persons of interest via an undercover operation.

5.1760. On 15 August 2013, the recommendations of Detective Senior Constable Taylor were reviewed and endorsed by Detective Chief Inspector John Lehmann.[1472]

5.1761. On 14 and 15 August 2013, however, Detective Chief Inspector Lehmann also completed Review Prioritisation Forms for each of the three cases. He assigned to them priority ratings of "low" (for Mr Mattaini and Mr Warren) and "medium" (for Mr Russell).[1473]

[1469] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 9 (SCOI.02751.00021).

[1470] Submissions of NSWPF, 28 June 2023, [253] (SCOI.84211).

[1471] Exhibit 6, Tab 162, Strike Force Neiwand, Review of an Unsolved Homicide Case Screening Form, 25 October 2012, 33 (NPL.0113.0001.0001).

[1472] Exhibit 6, Tab 162B, NSWPF Investigator's Note, 'Case review – Deaths of Russell, Warren and Mattaini', 15 August 2013, 1 (NPL.0135.0001.0001).

[1473] Exhibit 6, Tab 162C, NSWPF Review Prioritisation Form, 'Giles Mattaini (Missing Person)', 15 August 2013, 4 (NPL.0131.0001.2190); Exhibit 6, Tab 162D, NSWPF Review Prioritisation Form, 'John Russell 1989', 14 August 2013, 4 (NPL.0131.0001.2552_E); Exhibit 6, Tab 162E, NSWPF Review Prioritisation Form, 'Ross Warren 1989 (Missing Person)', 14 August 2013, 4 (NPL.0131.0001.2912).

5.1762. The recommendations made by Detective Senior Constable Taylor, endorsed by Detective Chief Inspector Lehmann, to engage the known persons of interest via an undercover operation, were never adopted or implemented. No reinvestigation of those known persons of interest was ever embarked upon.

5.1763. At about the same time, between July 2013 and September 2013, Detective Chief Inspector Lehmann and Detective Chief Inspector Young "conducted an assessment of the 30 'unsolved' cases listed by Ms Thompson ...".[1474] They presented their conclusions in an Issue Paper as follows: [1475]

> *Only 8 cases from 30 were probable or possible 'gay hate' motivated murders and these are on file at the Unsolved Homicide Team with consideration for future investigation.*
>
> 5.1764. *There is no doubt that anti gay hostility, particularly in the 1980's and 1990's resulted in a number of murders and serious crime of violence in NSW. In my opinion, the suggestion of 30 'gay hate' related unsolved murders is a gross exaggeration. Certainly there was no consultation with this command prior to the Sydney Morning / Sunday Herald articles which I suggest is poor, irresponsible journalism bordering on sensationalism.*[1476]

5.1765. The Lehmann/Young Issue Paper included the following conclusions as to the three Bondi deaths:[1477]

a. Mr Warren: "This case is probably a 'gay hate' motivated crime";

b. Mr Russell: "There are a number of suspects in a case that is probably 'gay hate' motivated"; and

c. Mr Mattaini: "It is believed that Mattaini is a possible victim of 'gay hate' motivated crime."

5.1766. In other words, notwithstanding their general view that the number of deaths referred to in the media was a "gross exaggeration", and that only eight of the 30 said to be "unsolved" were probable or even "possible" hate crimes, Detective Chief Inspector Lehmann and Detective Chief Inspector Young considered that three of those eight were these three deaths.

5.1767. Again, however, no reinvestigation of these three deaths was embarked upon.

[1474] Exhibit 6, Tab 47, NSWPF Issue Paper, 'Assessment of 30 potential "gay hate" unsolved homicides by the Unsolved Homicide Team (UHT) to determine if any bias motivation existed', 25 September 2013, 1 (SCOI.74906).

[1475] Exhibit 6, Tab 47, NSWPF Issue Paper, 'Assessment of 30 potential 'gay hate' unsolved homicides by the Unsolved Homicide Team (UHT) to determine if any bias motivation existed', 25 September 2013, 9 (SCOI.74906) (emphasis in original).

[1476] Exhibit 6, Tab 47, NSWPF Issue Paper, 'Assessment of 30 potential 'gay hate' unsolved homicides by the Unsolved Homicide Team (UHT) to determine if any bias motivation existed', 25 September 2013, 9 (SCOI.74906).

[1477] Exhibit 6, Tab 47, NSWPF Issue Paper, 'Assessment of 30 potential 'gay hate' unsolved homicides by the Unsolved Homicide Team (UHT) to determine if any bias motivation existed', 25 September 2013, 3, 5–6 (SCOI.74906).

5.1768. The NSWPF submitted that there is nothing to suggest that the Lehmann/Young review uncovered additional information that "might have elevated the priority of the Taradale cases as concerns a possible reinvestigation, identified possible avenues for reinvestigation, or enhanced the possibility that such a reinvestigation would be fruitful."[1478] While that is quite true, the review had made no attempt to uncover any such "additional information". Its aim was different, namely to respond to the media claims by looking at material already available.

5.1769. On 23 June 2015, the NSWPF announced rewards of $100,000 for information leading to the conviction of person/s who may be responsible for the disappearance and suspected deaths of Mr Warren, Mr Russell and Mr Mattaini. Mr Willing was quoted as saying that "the matters had been reviewed based on the Coroner's findings that they were suspicious in nature and possibly the result of gay hate-related crimes".[1479]

5.1770. No such "review" of the three Bondi deaths was actually underway at that time. Indeed, Mr Willing gave clear oral evidence that up to October 2015 there had never been any reinvestigation of these deaths.[1480] However, as the NSWPF submitted, the reference to review may have been to the work of Detective Senior Constable Taylor (in October 2012) and Detective Chief Inspector Lehmann (in August 2013) noted above, and/or to the 2013 Lehmann/Young Issue Paper.[1481]

5.1771. On 30 August 2015, Strike Force Parrabell was established.

5.1772. In October 2015, Strike Force Neiwand was established.[1482]

Strike Force Neiwand – Generally

5.1773. The establishment and conduct of Strike Force Neiwand are the subject of detailed consideration in **Chapter 12**, in the light of the evidence received in connection with Public Hearing 2. The following parts of this Chapter, dealing with Strike Force Neiwand, refer to only some of that evidence, and should be read together with Chapter 12.

Reasons/purpose – stated and actual

5.1774. The reasons why Strike Force Neiwand was established at all, why it was established at the time that it was, and its overall conduct, are addressed in **Chapter 12**.

5.1775. One conclusion which I have reached is that among the reasons for the establishment of Strike Force Neiwand were:

[1478] Submissions of NSWPF, 28 June 2023, [276] (SCOI.84211).

[1479] Exhibit 6, Tab 163, NSWPF Media Release, 'Deaths of Gilles Mattaini, Ross Warren and John Russell', 23 June 2015 (SCOI.76962.00014).

[1480] Transcript of the Inquiry, 21 February 2023, T1757.16–30 (TRA.00024.00001).

[1481] Submissions of NSWPF, 28 June 2023, [283] (SCOI.84211).

[1482] Exhibit 6, Tab 291, NSWPF Issue Paper, 'Request for creation of Terms of Reference and allocation of WBS number in relation to Strike Force Neiwand', 4 May 2016 (NPL.0115.0001.0009_E).

a. The extensive and sustained media interest (both past and anticipated) in matters involving suspected hate crime deaths including these three deaths;

b. Criticism of the police investigation of those deaths; and

c. The significance which had been attributed to the Operation Taradale investigation, and the Milledge findings, by Coroner Forbes in the second (2012) inquest into the death of Scott Johnson.

5.1776. Another conclusion is that what Strike Force Neiwand actually did, for most of 2016 and 2017, was to focus on analysing Operation Taradale, criticising it where possible, and ultimately contradicting the findings of Coroner Milledge.

5.1777. In that regard, I agree with Counsel Assisting that, on the evidence, it is difficult to resist the conclusion that the eventual implementation and outcomes of the strike force were consistent with what must have been (if not from the outset, then from an early stage) its objectives, albeit that those objectives do not appear to have been written down.

Conduct of Strike Force Neiwand - General

5.1778. My analysis of the work of the strike force, and of the submissions of Counsel Assisting and the NSWPF in relation thereto, is found in **Chapter 12**. The following paragraphs are included here merely to highlight some of what appears there.

The Strike Force Neiwand documentation

5.1779. The principal documents produced by Strike Force Neiwand were:

a. Nine Progress Reports, between July 2016 and November 2017.[1483]

b. Three Summaries, one for each of the three cases: the SFN Mattaini Summary,[1484] the SFN Warren Summary[1485] and the SFN Russell Summary[1486] (together, the **Neiwand Summaries**).

c. A Post Operational Assessment which referred to all three cases.[1487]

[1483] Exhibit 6, Tab 164A, Strike Force Neiwand, 'State Crime Command Led Strike Force Investigation Progress Report', 1 July 2016 (SCOI.82054); Exhibit 6, Tab 164B, Strike Force Neiwand, 'State Crime Command Led Strike Force Investigation Progress Report', 6 September 2016 (SCOI.82049); Exhibit 6, Tab 164C, Strike Force Neiwand, 'State Crime Command Led Strike Force Investigation Progress Report', 26 October 2016 (SCOI.82053); Exhibit 6, Tab 164D, Strike Force Neiwand, 'State Crime Command Led Strike Force Investigation Progress Report', 23 January 2017 (SCOI.82050); Exhibit 6, Tab 164E, Strike Force Neiwand, 'State Crime Command Led Strike Force Investigation Progress Report', 20 March 2017 (SCOI.82048); Exhibit 6, Tab 164F, Strike Force Neiwand, 'State Crime Command Led Strike Force Investigation Progress Report', 16 May 2017 (SCOI.82051); Exhibit 6, Tab 164G, Strike Force Neiwand, 'State Crime Command Led Strike Force Investigation Progress Report', 17 July 2017 (SCOI.82055); Exhibit 6, Tab 164H, Strike Force Neiwand, 'State Crime Command Led Strike Force Investigation Progress Report', 18 September 2017 (SCOI.82052); Exhibit 6, Tab 164I, Strike Force Neiwand, 'State Crime Command Led Strike Force Investigation Progress Report', 20 November 2017 (SCOI.82047).

[1484] Exhibit 6, Tab 172, Strike Force Neiwand, Summary of Investigation – Gilles Mattaini, 27 December 2017, [5] (SCOI.74881); Exhibit 6, Tab 172A, NSWPF Product Details Form, 'Summary of Investigation – Gilles Mattaini', 27 December 2017 (SCOI.76962.00004_0001).

[1485] Exhibit 6, Tab 174, Strike Force Neiwand, Summary of Investigation – Ross Warren, 8 January 2018, [78] (SCOI.74883); Exhibit 6, 174A, NSWPF Product Details Form, 'Summary of Investigation – Ross Warren', 8 January 2018 (SCOI.76962.00006_0001).

[1486] Exhibit 6, Tab 173, Strike Force Neiwand, Summary of Investigation – John Russell, 8 January 2018, [139] (SCOI.74882); Exhibit 6, Tab 173A, NSWPF Product Details Form, 'Summary of Investigation, John Russell' (SCOI.76962.00005_0001).

[1487] Exhibit 6, Tab 176, Strike Force Neiwand, Post Operational Assessment Review, 22 February 2018 (SCOI.76962.00007).

5.1780. Each of the Neiwand Summaries (as well as most of the Post Operational Assessment) seems to have been written by the OIC, former Detective Senior Constable Chebl (**Mr Chebl**), and reviewed and accepted by the Investigation Supervisor, Detective Sergeant Morgan. Both are responsible for their contents. Mr Chebl left the NSWPF some years ago, but Detective Sergeant Morgan gave both written and oral evidence about his role (and that of Mr Chebl) in Strike Force Neiwand.[1488]

5.1781. The Progress Reports, the Neiwand Summaries, and the Post Operational Assessment all make clear that Strike Force Neiwand made a deliberate choice not to pursue perosns of interest such as gang members, even though Operation Taradale had identified many such persons, and even though the original OIC, Detective Sergeant Brown, had listed 116 of them on a spreadsheet which she sent to Strike Force Neiwand personnel on 1 February 2016.[1489] Detective Sergeant Morgan agreed that Strike Force Neiwand made that "*deliberate decision*" relatively early in the course of the Strike Force, and instead focused on other approaches, such as victimology.[1490]

5.1782. The submissions on behalf of the NSWPF, in Public Hearing 2, accepted that the evidence suggests that what Strike Force Neiwand actually did:[1491]

> *…was to conduct a documentary review, together with some relatively limited further investigative work, principally directed to examining the possibility that each of the deaths were occasioned by suicide or accident or, in the case of Mr Warren, that he may have been the victim of an attack by someone he knew.*

The general attacks on Operation Taradale

5.1783. As both Mr Willing and Detective Sergeant Morgan acknowledged, the Neiwand Summaries and the Post Operational Assessment were replete with very serious criticisms of Operation Taradale and of then-Detective Sergeant Page.

5.1784. By their written submissions in Public Hearing 2, the NSWPF have now accepted that all of those criticisms were unjustified, and that in fact Operation Taradale was "a diligent and comprehensive investigation, that made use of sophisticated investigative techniques and was conducted in an open-minded manner."[1492]

5.1785. Some of the criticisms, all now (in 2023) withdrawn, related to particular aspects of each case. However, some of them were general in nature and common to all three Summaries.

[1488] Exhibit 6, Tab 320, Statement of Detective Sergeant Steven Morgan, 8 April 2015 (NPL.3000.0003.2171); Transcript of the Inquiry, 22 February 2023 (TRA.00025.00001); Transcript of the Inquiry, 23 February 2023 (TRA.00026.00001); Transcript of the Inquiry, 24 February 2023 (TRA.00027.00001); Transcript of the Inquiry, 27 February 2023 (TRA.00028.00001); Transcript of the Inquiry, 28 February 2023 (TRA.00029.00001).

[1489] Exhibit 6, Tab 306, Email from Detective Sergeant Penelope Brown to Strike Force Neiwand, 1 February 2016 (NPL.3000.0001.0026).

[1490] Transcript of the Inquiry, 23 February 2023, T1955.9–16 (TRA.00026.00001).

[1491] Submissions of NSWPF, 28 June 2023, [362] (SCOI.84211).

[1492] Submissions of NSWPF, 28 June 2023, [395], [398] (SCOI.84211).

5.1786. First, each Summary asserted that Operation Taradale had relied on "investigation confirmation bias", and that that had "limited the validity of the Coroner's findings." [1493]

5.1787. Secondly, both the Warren Summary and Russell Summary contained accusations to the effect that Operation Taradale had approached the investigation into these deaths with "tunnel vision", by focusing on members of youth gangs, and that no other hypotheses were "considered" or "explained".[1494]

5.1788. Thirdly, both the Warren Summary and Russell Summary also accused Operation Taradale of failing to conduct a thorough "victimology".[1495]

5.1789. Mr Page gave unchallenged evidence emphatically rejecting all of these attacks and criticisms.[1496] I accept his evidence.

5.1790. I repeat that all of these attacks and criticisms are not pressed in the NSWPF submissions.

The focus of Strike Force Neiwand was not on homicide

5.1791. The focus of Strike Force Neiwand was overwhelmingly, in all three cases, on factors pointing towards the possibility of either suicide (Mr Mattaini and Mr Warren) or misadventure (Mr Russell), or "domestic" (non-LGBTIQ bias) homicide (Mr Warren) and not on factors pointing towards the possibility of homicide (especially not LGBTIQ bias homicide).

5.1792. Strike Force Neiwand made virtually no attempt actually to investigate, as homicides, the deaths of any of these three men, notwithstanding that Coroner Milledge had expressly found the deaths of Mr Warren and Mr Russell to be homicides and had expressed the view that the death of Mr Mattaini was probably also a homicide.

5.1793. Instead it directed its considerable efforts and resources, over some two years, to attempting to build a case for contradicting and overturning those findings. It did so without informing either the Coroner's office, or Mr Page, or the families of the three deceased men about whom those public findings had been made, or the public generally.

A review only, not a reinvestigation at all

5.1794. The Terms of Reference for Strike Force Neiwand, and the Investigation Plan, describe it as a "reinvestigation" of the three deaths.

[1493] Exhibit 6, Tab 172, Strike Force Neiwand, Summary of Investigation – Gilles Mattaini, 27 December 2017, [59] (SCOI.74881); Exhibit 6, Tab 173, Strike Force Neiwand, Summary of Investigation – John Russell, 8 January 2018, [152] (SCOI.74882); Exhibit 6, Tab 174, Strike Force Neiwand, Summary of Investigation – Ross Warren, 8 January 2018, [268] (SCOI.74883).

[1494] Exhibit 6, Tab 173, Strike Force Neiwand, Summary of Investigation – John Russell, 8 January 2018, [107], [148] (SCOI.74882); Exhibit 6, Tab 174, Strike Force Neiwand, Summary of Investigation – Ross Warren, 8 January 2018, [79A] (SCOI.74883).

[1495] Exhibit 6, Tab 173, Strike Force Neiwand, Summary of Investigation – John Russell, 8 January 2018, [144] (SCOI.74882); Exhibit 6, Tab 174, Strike Force Neiwand, Summary of Investigation – Ross Warren, 8 January 2018, [79C] (SCOI.74883).

[1496] Exhibit 6, Tab 253, Statement of former Detective Sergeant Stephen Page, 16 February 2023 (SCOI.82472).

5.1795. In fact, with minor exceptions, it was not a "reinvestigation" at all. Rather, as now accepted in the submissions for the NSWPF in Public Hearing 2, it was essentially a review, on the papers, of the work of Operation Taradale.

Overturning the Milledge findings

5.1796. Coroner Milledge had returned findings of homicide for Mr Warren and Mr Russell, and an open finding for Mr Mattaini: see above.

5.1797. By contrast, Strike Force Neiwand reached the following conclusions (emphasis in original):

5.1798. In relation to Mr Warren:[1497]

> *WARREN'S disappearance – cause and manner of death remain* ***'undetermined'*** *despite the 2005 'homicide' findings of the Coroner, which list it as a homicide. It is recommended that this investigation be listed as inactive and only reactivated if new and compelling evidence becomes available…*

In relation to Mr Russell:[1498]

> *The manner of RUSSELL's death should be reclassified as* ***'undetermined'*** *despite the 2005 'homicide' findings of the Coroner. It is recommended that this investigation be listed as inactive and only reactivated if new and compelling evidence becomes available.*

In relation to Mr Mattaini:[1499]

> *it can be suggested that MATTAINI may well have taken his own life rather than met with foul play. … MATTAINI's disappearance – cause and manner of death remain* ***'undetermined'.*** *It is recommended that this investigation be listed as inactive and only reactivated if new and compelling evidence becomes available.*

5.1799. The word "despite", in the findings in relation to Mr Warren and Mr Russell, is particularly striking.

5.1800. As Detective Sergeant Morgan agreed, each of the three Neiwand Summaries arrived at conclusions which essentially contradicted both the findings of homicide as to Mr Russell's and Mr Warren's deaths, and the "expression of probability" in relation to the involvement of "gay hate assailants" in all three deaths.[1500]

5.1801. He also agreed that this contradiction of the coronial findings was made even though Strike Force Neiwand had, in fact, uncovered nothing of any consequence beyond what was before Coroner Milledge.[1501]

[1497] Exhibit 6, Tab 174, Strike Force Neiwand, Summary of Investigation – Ross Warren, 8 January 2018, [270] (SCOI.74883).

[1498] Exhibit 6, Tab 173, Strike Force Neiwand, Summary of Investigation – John Russell, 8 January 2018, [154] (SCOI.74882).

[1499] Exhibit 6, Tab 172, Strike Force Neiwand, Summary of Investigation – Gilles Mattaini, 27 December 2017, [61] (SCOI.74881).

[1500] Transcript of the Inquiry, 23 February 2023, T2031.32 (TRA.00026.00001).

[1501] Transcript of the Inquiry, 27 February 2023, T2269.31 (TRA.00028.00001).

5.1802. Accordingly, as Mr Willing agreed, for Strike Force Neiwand to purport to say that the cause and manner of death remain undetermined in the cases of Mr Warren and Mr Russell "despite" the homicide findings of the Coroner, was "completely without foundation".[1502] He agreed that it was "breathtaking", and said that he had never seen the like of it before.[1503]

Overall

5.1803. Overall, as outlined in **Chapter 12**, I have concluded that:

a. Strike Force Neiwand was mainly a review of, and an attack on, the work of Operation Taradale and Detective Sergeant Page;

b. The various attacks by Strike Force Neiwand on the methodology of Operation Taradale were unfounded, unjustified, and unsubstantiated;

c. In particular the accusations of investigation confirmation bias, of tunnel vision and of failing to use the techniques of victimology, were unfounded and wrong;

d. The investigations of the three deaths by Operation Taradale were appropriate and thorough;

e. Strike Force Neiwand had absolutely no basis for its purported conclusions that the 2005 findings of Coroner Milledge should be overturned; its activities had uncovered no new evidence which casts any doubt on those findings;

f. The failure by Strike Force Neiwand to afford any opportunity to Mr Page to answer the attacks made by it against him was unfair; and

g. The failure to inform the Coroner's Office, if those views were genuinely held, of the purported (albeit baseless) findings of Strike Force Neiwand, contradicting the express findings of a Coroner after a lengthy investigation and inquest, was indefensible.

Strike Force Neiwand: as to each of the three cases

5.1804. The many particular deficiencies of the three Neiwand Summaries are discussed in detail in **Chapter 12.** The following paragraphs summarise some of the more notable features of that analysis.

The Mattaini summary

5.1805. Strike Force Neiwand pursued no lines of inquiry other than suicide in relation to the death of Mr Mattaini. It made no attempt to investigate the possibility of homicide at all.

[1502] Transcript of the Inquiry, 21 February 2023, T1811.43 (TRA.00024.00001).

[1503] Transcript of the Inquiry, 21 February 2023, T1815.2–31 (TRA.00024.00001).

5.1806. Detective Sergeant Page took statements from Mr Musy and Mr Wyszynski in August 2002. They had been prompted, by media reports in July 2002 about Operation Taradale, to wonder whether Mr Mattaini's disappearance might also have been associated with homicide. Detective Sergeant Page also made a statement himself on 28 August 2002.

5.1807. The allegations made by Strike Force Neiwand in essence were these:

a. That Mr Mattaini had made "multiple" attempts at suicide.

b. That "throughout his relationship" with Mr Musy, Mr Mattaini spoke openly about dying, saying that he was comfortable with dying and that he preferred death to life, and said that if he did commit suicide he would do so in a way that no-one would find his body.

c. That Mr Musy told Detective Sergeant Page all these things in 2002 but Detective Sergeant Page failed to include them in Mr Musy's statement.

d. That it was Detective Sergeant Page who had persuaded Mr Musy that Mr Mattaini's disappearance was a homicide.

e. That as a consequence of Detective Sergeant Page withholding material information, Coroner Milledge did not consider the possibility of suicide in relation to Mr Mattaini.

5.1808. The evidence has established that all five of those allegations were completely wrong, as discussed in **Chapter 12**.

5.1809. In particular, as to (b) above, the sworn evidence of Mr Musy at the Milledge Inquest was that Mr Mattaini had not said such things "throughout his relationship" with Mr Musy; rather, to the contrary, although he had expressed such views in his youth, since meeting Mr Musy in 1978 had disavowed them, had reflected that he had been "stupid" to harbour such ideas, and was "very, very happy". [1504]

5.1810. If the authors of the Mattaini Summary had checked the transcript of the Milledge Inquest, in particular the evidence of Mr Musy and also the opening and closing addresses, they would have known that many of their allegations, including (b) above, were unsustainable.

5.1811. Either Detective Sergeant Morgan and Mr Chebl did not read the transcript of the Milledge Inquest, or they did read it but chose to omit any reference to it from the Mattaini Summary. Either alternative is indefensible.

5.1812. The accusations made in the Mattaini Summary, that Detective Sergeant Page deliberately withheld information from the Coroner, thereby causing her not to consider suicide as a possibility, were and are completely without foundation.

5.1813. The Mattaini Summary was also noticeably slanted towards suggesting the likelihood of suicide. For example:

[1504] Exhibit 6, Tab 280, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 48.53–49.21 (SCOI.82371).

a. It included Mr Wyszynski's hearsay impression (in his statement) that Mr Mattaini's keys were still in the apartment,[1505] but made no reference to Mr Wyszynski's acknowledging, at the Milledge Inquest, that he actually had no specific recollection of Mr Ottaviani saying anything to him about the keys;[1506]

b. Similarly, it referred to Mr Musy having noticed that Mr Mattaini's yellow spray jacket was missing,[1507] but conspicuously omitted the fact that Mr Musy also specifically said that Mr Mattaini's keys were also missing; and [1508]

c. It asserted that the issue relating to his visa expiring "appeared to weigh heavily on Mattaini's mind",[1509] whereas the express evidence of Mr Musy was that "it was not something which was really sort of weighing on him constantly not at all".[1510]

5.1814. As I explain in **Chapter 12**, I have formed the view that the Mattaini Summary, aimed as it plainly was at advancing only a suicide hypothesis, and at discrediting Mr Page, was at least incompetent, if not dishonest. I comprehensively reject it.

The Warren summary

5.1815. Operation Taradale had identified large numbers of persons of interest in respect of the deaths of Mr Warren and Mr Russell. Many of those persons were members or associates of various gangs which operated not only in the Bondi-Tamarama area but also in other parts of Sydney including Alexandria, Oxford Street and Kings Cross.

5.1816. However, as outlined above, Strike Force Neiwand made a deliberate decision not to pursue any of those persons of interest by any fresh investigative means. On the evidence available to the Inquiry, only one of them was spoken to by Strike Force Neiwand, but even then the subject of that conversation was not anything related to the deaths of Mr Warren or Mr Russell, but rather was about what that person might say, or have said, to the makers of the SBS/Blackfella Films programme *Deep Water: The Real Story* (***Deep Water***).[1511]

5.1817. Instead, Strike Force Neiwand:

a. Reviewed the work of Operation Taradale and made criticisms of it; and

b. Interviewed certain persons (most of whom had already previously been interviewed by Operation Taradale) in relation to the possibilities of either suicide or a "domestic" (non-LGBTIQ bias-related) homicide.

[1505] Exhibit 44, Tab 4, Statement of Antony Jean Wyszynski, 3 August 2002, [7] (SCOI.02744.00382).

[1506] Exhibit 44, Tab 14, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 61.34–44 (SCOI.84052).

[1507] Exhibit 6, Tab 173, Strike Force Neiwand, Summary of Investigation – John Russell, 9 January 2018, [24] (SCOI.74882).

[1508] Exhibit 6, Tab 159, Statement of Jacques Paul Musy, 3 August 2002, [20] (SCOI.02744.00381).

[1509] Exhibit 6, Tab 173, Strike Force Neiwand, Summary of Investigation – John Russell, 9 January 2018, [28] (SCOI.74882).

[1510] Exhibit 6, Tab 280, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 49.44–58 (SCOI.82371).

[1511] Transcript of the Inquiry, 27 February 2023, T2220.14–17 (TRA.00028.00001); Exhibit 6, Tab 168, NSWPF Investigator's Note, 'Contact with NP34', 30 March 2017 (SCOI.10389.00081); *Deep Water: The Real Story* (Blackfella Films/Sue Masters, 2016).

5.1818. As Detective Sergeant Morgan conceded, none of the lines of inquiry favoured by Strike Force Neiwand, as to either suicide or "domestic" homicide, actually "led anywhere in the end", and "the basic upshot" in relation to Mr Warren was that the work of Strike Force Neiwand "did not shed any further light on what had happened to Mr Warren, in the end".[1512]

5.1819. As a consequence, Strike Force Neiwand had no reasonable or proper basis for contradicting the findings of Coroner Milledge. [1513]

5.1820. I agree with Mr Page that the possibility pursued by Strike Force Neiwand, that Mr Warren's case was a "domestic" homicide (involving a former partner), is unlikely. Strike Force Neiwand did not point to any plausible motive, or opportunity, to substantiate such a theory. Operation Taradale had previously looked at Mr Warren's close associates including his friends and partners, and there was no indication of any conflict in his former relationships which might have impacted on his disappearance.[1514] Moreover, Mr Page knew of no other "domestic" homicides that happened to have occurred at beats.

5.1821. Strike Force Neiwand itself acknowledged that suicide was an "unlikely scenario" in Mr Warren's case, and that "his family and friends [said] that he wasn't suicidal or depressed" at the time.[1515] Yet nevertheless it doggedly advanced speculative theories as to factors that "may have led to him to taking his own life"—despite other evidence that also tends against the likelihood of suicide, including that Mr Warren locked his car, took his keys with him, and was a gay man attending a location that he knew was a beat.

5.1822. Again, if there was "tunnel vision" or "confirmation bias" at work anywhere (as Strike Force Neiwand suggested was the case in relation to Operation Taradale), it was in the approach of Strike Force Neiwand, not that of Operation Taradale.

The Russell summary

5.1823. In the case of Mr Russell, again Strike Force Neiwand made no attempt to investigate the possibility of homicide. Instead, its efforts were directed almost exclusively to advancing and bolstering a theory of misadventure — i.e. that Mr Russell had accidentally fallen to his death, possibly as a result of his level of intoxication. [1516]

5.1824. The three main components of Strike Force Neiwand's focus on the misadventure theory were:

a. Mr Russell's blood alcohol concentration, and the evidence of Dr Moynham;

b. Suggested differences of opinion between two forensic pathologists, Dr Cala and Dr Duflou; and

[1512] Transcript of the Inquiry, 27 February 2023, T2220.19–45 (TRA.00028.00001).

[1513] Transcript of the Inquiry, 27 February 2023, T2221.18–21 (TRA.00028.00001).

[1514] Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen John Page, 25 July 2002, [88]–[107] (SCOI.02744.00023).

[1515] Exhibit 6, Tab 174, Strike Force Neiwand, Summary of Investigation – Ross Warren, 8 January 2018, [263] (SCOI.74883).

[1516] Transcript of the Inquiry, 27 February 2023, T2236.33–43 (TRA.00028.00001).

c. The views of Sergeant Cameron, a crime scene officer, as to the disturbance of the bushes at the top of the cliff.

5.1825. As to Mr Russell's significant blood alcohol concentration, the evidence of Dr Moynham indicated quite clearly that that factor was capable of supporting not only the possibility of misadventure but also that of homicide.[1517]

5.1826. As to Dr Cala[1518] and Dr Duflou,[1519] both these experts (relevantly):

a. Considered the position of Mr Russell's body to be unusual for a fall, such that foul play (being thrown or pushed) was possible;

b. Thought that the hairs on Mr Russell's hand were more likely to be from a second person than to be Mr Russell's own hair; and

c. Considered that some of the bruising on Mr Russell's head could have come from an assault prior to death; while also acknowledging that misadventure could not be ruled out.

5.1827. As was submitted by Counsel Assisting, overall the two experts were largely in agreement, the few differences between their respective views were relatively slight, and Dr Duflou's findings did not (as was asserted by Detective Sergeant Morgan) "differ significantly" from those of Dr Cala.[1520]

5.1828. As to Sergeant Cameron, the suggestion sought to be derived from his evidence was that: [1521]

> *If we accept that evidence of the shrubbery on the cliff top being disturbed, then consideration needs to be given to the fact that RUSSELL had strands of grass near and underneath his body on the rock shelf. This would refute the theory of him being thrown over the edge of the cliff.*

5.1829. As Mr Page contended, this theory does not withstand scrutiny. It is at least equally possible, for example, that shrubbery could be disturbed during a struggle.[1522]

5.1830. As with each of the other two Neiwand Summaries, Strike Force Neiwand had no proper or reasonable basis for its purported conclusions that the 2005 findings of Coroner Milledge should be overturned.

[1517] Exhibit 46, Tab 28, Statement of Anthony Moynham, 20 July 2001 (SCOI.02744.00195).Done

[1518] Exhibit 6, Tab 157, Expert report of Dr Allan Cala, 14 August 2001 (SCOI.10386.00142); Exhibit 6, Tab 327, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 2 March 2003, 17.26–50, 19.6–37 (SCOI.82588).

[1519] Exhibit 6, Tab 171, Expert report of Professor Johan Duflou, 16 August 2017 (SCOI.10385.00060).

[1520] Exhibit 6, Tab 5, Statement of Detective Sergeant Steven Morgan, 31 October 2022, [65] (SCOI.76962).

[1521] Exhibit 6, Tab 173, Strike Force Neiwand, Summary of Investigation – John Russell, 9 January 2018, [150] (SCOI.74882).

[1522] Exhibit 6, Tab 253, Statement of former Detective Sergeant Stephen Page, 16 February 2023, [126] (SCOI.82472).

Strike Force Parrabell

Bias Crimes Indicators Form

Gilles Mattaini

5.1831. Of the ten indicators in the BCIF:[1523]

a. None were answered "Evidence of Bias Crime".

b. Five were answered "Suspected Bias Crime", namely: "Organised Hate Groups", "Previous existence of Bias Crime Incidents", "Victim/Witness Perception", "Motive of Offender/s" and "Location of Incident".

c. Four were answered "Insufficient Information", namely: "Differences", "Comments, Written Statements and Gestures", "Lack of Motive" and "Level of Violence".

d. One was answered "No Evidence of Bias Crime", namely: "Drawings, Markings, Symbols, Tattoos, Graffiti".

5.1832. In answering "No Evidence of Bias Crime" to the "Drawings, Markings, Symbols, Tattoos, Graffiti" indicator, the BCIF refers generally to some of the suspects identified by Operation Taradale as "likely responsible for the assaults and murders in the Bondi area". Yet similar references to such groups and individuals, provided in respect of the "Organised Hate Groups" indicator, led to the answer "Suspected Bias Crime". It is difficult to see how those two different responses could coherently be made.

5.1833. Most responses (although not all, as pointed out by the NSWPF in its submissions)[1524] proceed as though the work of Operation Taradale, in identifying persons of interest relevant to the two 1989 deaths, was also relevant to the 1985 death of Mr Mattaini. In most responses, although again not all, no appreciation or recognition is noted that that work, and those persons of interest, were not suggested by Operation Taradale to have related to Mr Mattaini's death.

5.1834. Strike Force Parrabell categorised Mr Mattaini's death overall as "Insufficient Information". In the light of five indicators having been answered "Suspected Bias Crime", and the considered remarks of Coroner Milledge in 2005, on one view the "Suspected Bias Crime" category may have been more appropriate.

Ross Warren

5.1835. Of the ten indicators in the in the BCIF:[1525]

a. One was answered "Evidence of Bias Crime", namely: "Location of Incident".

b. Seven were answered "Suspected Bias Crime", namely: "Differences", "Comments, Written Statements, Gestures", "Organised Hate Groups

[1523] Exhibit 44, Tab 34, Strike Force Parrabell, Bias Crimes Indicators Review Form – Gilles Mattaini, undated (SCOI.74972).

[1524] Submissions of NSWPF, 13 July 2023, [38] (SCOI.84454).

[1525] Exhibit 45, Tab 107, Strike Force Parrabell, Bias Crimes Indicators Review Form – Ross Warren, undated (SCOI.45406).

(OHG)", "Previous existence of Bias Crime Incidents", "Victim/Witness perception", "Motive of Offender/s" and "Level of "Violence".

c. One was answered "No Evidence of Bias Crime", namely: "Drawings, Markings, Symbols, Tattoos, Graffiti".

d. One was answered "Insufficient Information", namely: "Lack of Motive".

5.1836. As to "No Evidence of Bias Crime", a similar observation may be made as in the case of Mr Mattaini.

5.1837. For "Previous Existence of Bias Crime Incidents", the response is "Suspected Bias Crime", rather than "Evidence of Bias Crime". Yet the abundance of evidence accumulated by Operation Taradale and accepted by Coroner Milledge, as to the many violent attacks on gay men in the area, was well known to Strike Force Parrabell (and indeed some of it is referred to at some length elsewhere in the BCIF).

5.1838. Strike Force Parrabell categorised Mr Warren's death overall as "Suspected Bias Crime."

5.1839. By contrast, the academic review placed it in the "Insufficient Information" category.

John Russell

5.1840. Of the ten indicators in the BCIF:[1526]

a. One was answered "Evidence of Bias Crime", namely: "Location of Incident".

b. Six were answered "Suspected Bias Crime", namely: "Differences", "Comments, Written Statements, Gestures", "Organised Hate Groups (OHG)", "Previous existence of Bias Crime Incidents", and "Motive of Offender/s" and "Level of "Violence";

c. One was answered "No Evidence of Bias Crime", namely: "Drawings, Markings, Symbols, Tattoos, Graffiti";

d. One was answered "Insufficient Information", namely: "Lack of Motive"; and

e. One was answered both "Suspected Bias Crime" and "Insufficient Information", namely, "Victim/Witness Perception". It is not clear which answer was counted towards the overall Indicator.

5.1841. The indicator that was answered as "No Evidence of Bias Crime" was indicator 3, "Drawings, Markings, Symbols, Tattoos, Graffiti". The response noted that Mr Russell was found with several coins around his body, and referred to evidence which suggests that men who attended beat locations with the intention of engaging in sexual activity with other men would rattle keys or loose change in their pockets to indicate interest. Yet the indicator was marked "No Evidence of Bias Crime".

[1526] Exhibit 46, Tab 57, Strike Force Parrabell, Bias Crimes Indicators Review Form – John Russell, undated (SCOI.32191).

5.1842. Other anomalies include those referred to above with respect to Mr Warren.

5.1843. Strike Force Parrabell categorised Mr Russell's death overall as "Suspected Bias Crime."

5.1844. Again by contrast, the academic review placed it in the "Insufficient Information" category.

Case Summaries

Gilles Mattaini

5.1845. The Case Summary for this matter reads as follows:[1527]

> ***Identity:*** *Giles [sic] Mattaini was 27 years old at the time of his death.*
>
> ***Personal History:*** *In 1983 Mr Mattaini moved to Australia with his partner. At the time of his death Mr Mattaini had overstayed his visa which was causing him distress. Mr Mattaini was known to take long walks along the Marks Park walking track. Whilst the location was well known as a* 'gay beat', *Mr Mattaini did not frequent the area for this reason. A friend engaged in the original search for Mr Mattaini believed he had been reported missing to Police, however no such report could be found and no police investigation was undertaken at the time. It was not until 2002 that the death of Mr Mattaini was formally recorded as reported to Police following media attention surrounding Strike Force Taradale.*
>
> ***Location of Body/Circumstances of Death:*** *Mr Mattaini was last seen walking along the Marks Park walking track at Bondi on or about 15 September 1985. Strike Force Taradale identified a number of youth gangs involved in assault and robbery offences targeting gay men around Marks Park and Tamarama during 1989/1990. There was no direct evidence available to link the same group to the earlier death of Mr Mattaini. No suspects have been identified as involved in the death of Mr Mattaini. Mr Mattaini's body was never recovered.*
>
> ***Sexual Orientation:*** *Mr Mattaini identified as gay.*
>
> ***Coroner/Court Findings:*** *In 2005, the Deputy State Coroner declared Mr Mattaini formally deceased, but where and how he died remains unknown. The Deputy State Coroner stated,* "… there is a strong possibility that he died in similar circumstances to the other men (Warren and Russell). *The Deputy State Coroner determine,* 'Giles [sic] Jacques Mattaini died on or about 15 September 1985 in Sydney, the cause and manner of death are undetermined as the evidence before me does not enable me to say.' *The Deputy State Coroner also found that,* 'the persons of interest that may have been responsible for the deaths of Mr

[1527] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Gilles Mattaini, Undated 9 (SCOI.76961.00014).

> Warren and Mr Russell would have been far too young at the time of Mr Mattaini's disappearance in August 1985.'
>
> ***SF Parrabell concluded there was insufficient information to establish a bias crime***

5.1846. The assertion that Mr Mattaini was last seen "walking along the Marks Park walking track at Bondi" is a strange amalgam of the inaccurate (Marks Park walking track) and the accurate (Bondi).

Ross Warren

5.1847. The Case Summary for this matter reads as follows:[1528]

> ***Identity:*** *Ross WARREN was 25 years old at the time of his death.*
>
> ***Personal History:*** *Mr Warren was a popular newsreader working for NBN (sic).*
>
> ***Location of Body/Circumstances of Death:*** *Mr Warren was last seen driving along Oxford Street, Darlinghurst on 22 July 1989. He had been socialising with friends. The keys to his car were found 2 days later on a rock ledge below a cliff at Marks Park, Tamarama. His car was located nearby. His body has never been found. Mr Warren frequented gay beats, specifically Marks Park. In 2002, the disappearance of Mr Warren was reinvestigated by Strike Force Taradale which identified a number of youth gangs involved in assault and robbery offences targeting men perceived to be gay around Marks Park and Tamarama. Strike Force Taradale identified sexuality based animosity between suspects and gay men including homophobia, group initiation, proving masculinity, robbery, and a belief that gay men were soft targets who will not fight back or complain to authorities. Strike Force Taradale indicated possible links between other murders and violent assaults against gay men in this area and other gay beats. One identified link involved groups of youths targeting gay men at Bondi and Alexandria including the murder of William Allen* (Parrabell Case 30)*; the murder of Wayne Tonks* (Parrabell Case 41)*; the murder of Raymond Keam* (Parrabell Case 22)*; and the murder of John Russell* (Parrabell Case 36) *among other incidents of violence against gay men.*
>
> ***Sexual Orientation:*** *Mr Warren did not openly identify as gay however he was believed to be gay.*
>
> ***Coroner/Court Findings:*** *In 2005, the Deputy State Coroner found that Mr Warren died in Sydney on or about 22 July 1989. The Deputy State Coroner stated,* 'whilst the cause and manner of death are unknown, I am satisfied that the deceased was a victim of

[1528] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Ross Warren, Undated 17 (SCOI.76961.00014).

homicide perpetrated by person or persons unknown.' *The death of Mr Warren remains unsolved.*

SF Parrabell concluded there was evidence to suspect a bias crime

5.1848. The content of this case summary is for the most part consistent with the BCIF. However, the assertion that Mr Warren "did not openly identify as gay" is both factually wrong, and contrary to multiple passages in the BCIF.

John Russell

5.1849. The Case Summary for this matter reads as follows:[1529]

Identity: *John Alan Russell was 31 years old at the time of his death.*

Personal History: *Mr Russell lived with his brother at Bondi. He was employed in two jobs and had the support of his family. At the time of his death he was excited about plans to build a kit home on his father's farm at Wollombi, funded by an inheritance. He also intended to travel around Australia.*

Location of Body/Circumstances of Death: *Mr Russell's body was discovered lying on rocks at the base of a cliff below a popular Bondi to Tamarama walking path, known as Marks Park. The position of Mr Russell's body was unusual with his head facing the rocks and his feet towards the water. Marks Park was a well-known gay beat.*

Sexual Orientation: *Mr Russell identified as gay.*

Coroner/Court Findings: *The original Coroners finding stated that Mr Russell died from,* 'Effects of multiple injuries sustained then and there when he fell from a cliff to the rocks below, but whether he fell accidently or otherwise the evidence does not enable me to say'. *In 2002 the circumstances of Mr Russell's death were reinvestigated by Strike Force Taradale which indicated possible links between other murders and violent assaults against gay men in this area and other gay beats. One identified link involved groups of youths targeting gay men at Bondi and Alexandria including the murder of William Allen* (Parrabell Case 30)*; the murder of Wayne Tonks* (Parrabell Case 41)*; the murder of Raymond Keam* (Parrabell Case 22)*; and the disappearance (suspected murder) of Ross Warren* (Parrabell Case 34) *among other incidents of violence against gay men. In 2005 a second Coronial Inquest was held with the Deputy State Coroner finding that Mr Russell died at Marks Park, North Bondi between the 22 and 23 November 1989. The Deputy State Coroner stated,* 'the cause of death is multiple injuries sustained when he was thrown from the cliff

[1529] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – John Russell, Undated 18 (SCOI.76961.00014).

onto rocks, by a person or persons unknown.' *The death of Mr Russell remains unsolved.*

SF Parrabell concluded there was evidence to suspect a bias crime

Review by the Inquiry

5.1850. The Inquiry took the following steps in the course of examining these matters.

Gilles Mattaini

Family members

5.1851. On 31 October 2022, the Inquiry spoke with Mr Musy. He was unable to provide any information as to the full name or possible present whereabouts of the neighbour ("Terry") who last saw Mr Mattaini walking in Bondi.[1530]

5.1852. Mr Musy provided a statement as to his memories of Mr Mattaini and the impact of his death on him, which was received into evidence during the public hearing into Mr Mattaini's death.[1531] I thank Mr Musy for his assistance to the Inquiry.

Interagency cooperation

5.1853. On 11 May 2022, the Inquiry issued a written request to the Coroners Court for the coronial file in relation to the disappearance of Mr Mattaini. On 3 June 2022, the coronial file was produced to the Inquiry.

Summonses

5.1854. A summons was issued to the NSWPF on 18 May 2022 for all documents relating to investigations by the NSWPF of the death of Mr Mattaini, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Mattaini. Some documents were produced on 8 June 2022.

Professional opinions

PROFESSIONAL OPINION OBTAINED FROM FORENSIC PATHOLOGIST

5.1855. By letter dated 13 April 2023, an opinion was sought from Dr Iles, forensic pathologist, regarding the decomposition and behaviour of bodies in water. On 18 May 2023 Dr Iles produced her report to the Inquiry,[1532] which is considered below.

[1530] Exhibit 44, Tab 43, Statement of Emily Burston, 27 June 2023, [7] (SCOI.84055).

[1531] Exhibit 50, Statement of Jacques Musy, 19 June 2023 (SCOI.84155).

[1532] Exhibit 44, Tab 40, Expert report of Dr Linda Iles, 18 May 2023 (SCOI.83668).

PROFESSIONAL OPINION OBTAINED FROM COASTAL GEOMORPHOLOGIST

5.1856. On 25 January 2023, the Inquiry provided material relating to Mr Mattaini's disappearance to coastal geomorphologist Professor Robert Brander. By letter dated 3 April 2023, an opinion was formally sought from Professor Brander in relation to the probable movements of Mr Mattaini's body assuming he entered the water from the cliffs anywhere along the coast walk around Marks Park or between Bondi and Ben Buckler headland.

5.1857. On 9 May 2023, on the recommendation of Professor Brander, the Inquiry contacted Bruce Hopkins of Waverley Council Lifeguards. On 17 May 2023, Mr Hopkins advised the Inquiry that they did not hold any records of surf conditions from September 1985. He made some general comments regarding his experience of currents in the Bondi Bay area, which were provided to Professor Brander to consider.

5.1858. On 18 May 2023, the Inquiry forwarded the report of Dr Iles (referred to above) to Professor Brander.

5.1859. On 1 June 2023, Professor Brander provided the Inquiry with his report, considered below.[1533]

Witness statements

5.1860. On 30 November 2022 and 5 April 2023, the Inquiry interviewed Glen Lehman, the partner of Mr Ottaviani and a person within Mr Mattaini's social circle at the time of his disappearance. Mr Lehman provided a statement to the Inquiry dated 17 May 2023.[1534]

5.1861. On 20 April 2023, the Inquiry wrote to Marc Hubert at an Australian address provided to it via interagency co-operation, requesting that he make contact with the Inquiry to discuss his recollections of this matter. On 26 May 2023, the Inquiry was advised by a friend of Mr Hubert that he had been residing in France for ten years, but that she would pass on the relevant details of the Inquiry's request. As at the time of this Report, the Inquiry has not been able to speak with Mr Hubert.[1535]

Contact with OIC

5.1862. Stephen Page was called as a witness in the context of Public Hearing 2 and his evidence is dealt with elsewhere in this Report.[1536]

Enquiries with French consulate

5.1863. On 1 November 2022, the Inquiry made contact with the French Consulate General seeking any information it may hold regarding the disappearance of Mr Mattaini.

[1533] Exhibit 45, Tab 118, Expert report of Professor Robert Brander, 24 May 2023 (SCOI.83670).

[1534] Exhibit 44, Tab 43, Statement of Emily Burston, 27 June 2023, [11] (SCOI.84055).

[1535] Exhibit 44, Tab 43, Statement of Emily Burston, 27 June 2023, [12] (SCOI.84055).

[1536] See also Exhibit 6, Tab 253, Statement of former Detective Sergeant Steven Page, 16 February 2023 (SCOI.82472).

5.1864. On 21 and 22 November 2022, the French Consulate General provided information to the effect that a French resident in Australia recalled a French national in the gay community going missing at around the same period other gay men were vanishing in Bondi.

5.1865. On 6 December 2022, the Inquiry made contact with that witness. However, the information did not relate to Mr Mattaini.[1537]

Ross Warren

Family members

5.1866. On 30 September 2022, the Inquiry wrote to the siblings of Mr Warren. Mrs Warren, Mr Warren's mother, responded on behalf of the family indicating that they had no further information to provide.

Interagency cooperation

5.1867. On 11 May 2022, the Inquiry issued a written request to Coroners Court to obtain the coronial file in relation to the death of Mr Russell. On 2 June 2022, the coronial file was produced to the Inquiry.

5.1868. On 1 November 2022, the Inquiry held a conference with FASS regarding the possibility of further testing of exhibits, including Mr Warren's driver's licence and library card.

5.1869. FASS recommended against further DNA testing, as there have not been significant improvements in testing since 2016. Furthermore, FASS advised that attempting to match suspect DNA with the weak result obtained in 2016 was unlikely to be successful, due to the small and very degraded nature of the results.

5.1870. On 17 April 2023, the Inquiry requested assistance from NSWPF in conducting further fingerprint examinations.[1538] A statement dated 3 May 2023 was provided to the Inquiry by Detective (Tech) Acting Sergeant Joshua Thompson, a fingerprint expert.[1539]

5.1871. Fingerprint records were obtained from exhibits in Mr Warren's file from FETS.[1540] These were compared to Mr Warren's recorded fingerprints, obtained from the NAFIS.[1541]

5.1872. Detective Active Sergeant Thompson employed the Analysis, Comparison, Evaluation and Verification (ACE-V) methodology in analysing the fingerprint impressions,[1542] and reached the following conclusions:[1543]

a. The fingerprint located on the audio cassette case is inconclusive;

[1537] Exhibit 44, Tab 43, Statement of Emily Burston, 27 June 2023, [4]–[6] (SCOI.84055).

[1538] Exhibit 45, Tab 124, Letter from Enzo Camporeale to Patrick Hodgetts, 17 April 2023 (SCOI.83666).

[1539] Exhibit 45, Tab 116, Statement of Detective (Tech) Acting Sergeant Joshua Thompson, 3 May 2023 (SCOI.83663).

[1540] Exhibit 45, Tab 116, Statement of Detective (Tech) Acting Sergeant Joshua Thompson, 3 May 2023, [5], [7] (SCOI.83663).

[1541] Exhibit 45, Tab 116, Statement of Detective (Tech) Acting Sergeant Joshua Thompson, 3 May 2023, [6] (SCOI.83663).

[1542] Exhibit 45, Tab 116, Statement of Detective (Tech) Acting Sergeant Joshua Thompson, 3 May 2023, [8] (SCOI.83663).

[1543] Exhibit 45, Tab 116, Statement of Detective (Tech) Acting Sergeant Joshua Thompson, 3 May 2023, [10]–[11] (SCOI.83663).

b. The fingerprints located on the plastic bag have been identified as belonging to Mr Warren;

c. The fingerprint located on the rear of Mr Warren's drivers licence is identified as belonging to Mr Warren; and

d. The fingerprint located on the rear of the Radio Rentals receipt is inconclusive.

5.1873. An annexure to the statement of Detective Acting Sergeant Thompson titled "Scientific Principles" notes that a conclusion of 'inconclusive' indicates that there is insufficient information to identify or exclude the person as being the source of the fingerprint.[1544] As such, the NSWPF advised there is no need for further examination of the inconclusive fingerprints against other persons, as Mr Warren could not be eliminated as the source of the fingerprint.[1545]

Summonses

5.1874. A summons was issued to the NSWPF on 18 May 2022 for all documents relating to investigations by the NSWPF of the death of Mr Warren, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Warren. Some documents were produced on 8 June 2022

5.1875. On 8 June 2022, the Inquiry received a box from the NSWPF in relation to Operation Taradale and 12 boxes from the NSWPF in relation to Strike Force Neiwand.

5.1876. On 2 August 2022, the NSWPF produced their complete e@gle.i holdings in relation to Strike Force Parrabell, ostensibly in response to Summons NSWPF3. However, given that this material was not called for by Summons NSWPF3, the NSWPF may have intended to produce this material in response to Summons NSWPF1. These e@gle.i holdings reproduced various NSWPF documents in relation to Mr Warren.

5.1877. On 28 September 2022, the Inquiry issued Summons NSWPF21 for any Interactive Scene Recording and Presentation Systems (**ISRAPS**) created as part of Strike Force Neiwand in respect of the crime scene. On 6 October 2022, the NSWPF indicated no ISRAPS were ever created, as the crime scene had changed significantly since 1989.

5.1878. On 8 November 2022, the Inquiry issued Summons NSWPF34 for all NSWPF e@gle.i holdings in relation to Operation Taradale and Strike Force Neiwand. The NSWPF produced documents in three tranches. The e@gle.i briefs for both were received on 25 November 2022. Production was completed on 18 April 2023.

[1544] Exhibit 45, Tab 116, Statement of Detective (Tech) Acting Sergeant Joshua Thompson, 3 May 2023, 8 (SCOI.83663).

[1545] Exhibit 45, Tab 125, Letter from Patrick Hodgetts to Enzo Camporeale, 10 May 2023 (SCOI.83667).

Professional opinions

DR LINDA ILES

5.1879. The Inquiry briefed Dr Iles on 13 April 2023 to provide a report on the decomposition of bodies in water. On 18 May 2023, Dr Iles provided her expert report.[1546]

PROFESSOR ROBERT BRANDER

5.1880. The Inquiry briefed Professor Brander on 14 April 2023.[1547] Professor Brander's report is dated 24 May 2023.[1548]

Contact with OICs

5.1881. On 25 August 2023, the Inquiry wrote to Kenneth Bowditch through his legal representative enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Warren.[1549] Mr Bowditch, through his legal representative, advised that he does not wish to participate in the Inquiry by filing submissions in relation to the death of Mr Warren.

5.1882. On 22 August 2023 and 4 October 2023, the Inquiry wrote to Michael Chebl enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Warren.[1550] The Inquiry did not receive a response from Mr Chebl.

Other

5.1883. The Inquiry reviewed historical LGBTIQ media publications through the State Library of NSW and the Australian Queer Archives based in Victoria. In September 2022, one of the Counsel Assisting the Inquiry attended the Australian Queer Archives in Victoria and, with the assistance of an archivist, reviewed relevant issues of the *Sydney Star Observer* between 1979 and 1997, which has not been digitised.

5.1884. Historical publications in other newspapers were also identified through review of microfilm at the State Library of NSW from the Illawarra Mercury and other major newspapers.

John Russell

Family members

5.1885. On 30 September 2022, the Inquiry contacted Mr Russell's brother, Peter Russell and his partner, Donna Hannah. Both were in ongoing contact with the Inquiry thereafter. Both expressed a keen interest in the work of the Inquiry and attended almost every public hearing of the Inquiry.

[1546] Exhibit 44, Tab 40, Expert report of Dr Linda Iles, 18 May 2023 (SCOI.83668).

[1547] Exhibit 45, Tab 118A, Letter of instruction from Elizabeth Blomfield to Professor Robert Brander, 14 April 2023 (SCOI.83671).

[1548] Exhibit 45, Tab 118, Expert report of Professor Robert Brander, 24 May 2023 (SCOI.83670).

[1549] Exhibit 66, Tab 90, Letter to Nicholas Eddy, 25 August 2023 (SCOI.86349).

[1550] Exhibit 66, Tabs 91–92, Letters to Michael Chebl, 22 August 2023 and 4 October 2023 (SCOI.86350; SCOI.86351).

5.1886. Mr Russell's father, Ted Russell, passed away in September 2022.

5.1887. Both Peter Russell and Donna Hannah, along with Yvonne Hopkins (Mr Russell's cousin), provided statements as to their memories of John Russell and the impact of his death on them and others. Those statements were received into evidence during the public hearing into Mr Russell's death.[1551]

Interagency cooperation

5.1888. On 11 May 2022, the Inquiry issued a written request to the Coroners Court to obtain the coronial file in relation to the death of Mr Russell. On 2 June 2022, the coronial file was produced to the Inquiry.

5.1889. Over a number of months, the Inquiry utilised the services of FASS to have Mr Russell's clothing forensically tested. The results of that testing are contained in a statement by a FASS officer, Michele Franco, and are considered below.

Summonses

5.1890. The relevant summonses are those dealt with above in relation to Mr Warren.

5.1891. On 15 December 2022, the Inquiry wrote to the NSWPF requesting that Mr Russell's clothing be transported to FASS for forensic testing.

Witness statements

5.1892. On 6 March 2023, the Inquiry obtained a statement from Peter Russell.

5.1893. On 1 May 2023, members of the Inquiry met with former Detective Sergeant Adrian Ingleby and on 7 June 2023, Mr Ingleby provided a statement.

5.1894. On 13 March 2023, the Inquiry requested that the NSWPF provide a statement in relation to, *inter alia*, the cleaning of Mr Russell's clothing. On 3 April 2023, the NSW Police produced a statement of Detective Inspector Nigel Warren dated 30 March 2023, to which I have referred above.

5.1895. On 24 April 2023, the Inquiry requested a further statement from the NSWPF in relation to what was meant by the word "cleaned". On 5 May 2023, the NSWPF produced a supplementary statement indicating that there is no further information in the documentary records about what is meant by the word "cleaned", or by whom the clothing was cleaned, or what if any chemicals or other laundry products were utilised.

5.1896. On 5 May 2023, a staff member of the Inquiry spoke with former Plain Clothes Constable Dunbar, who was the original OIC in 1989–90. Ms Dunbar stated that she did not know anything about Mr Russell's clothing having been 'cleaned'.[1552]

5.1897. The Inquiry requested a statement from FASS addressing various matters including:

[1551] Exhibit 47, Statement of Peter Russell, 6 March 2023 (SCOI.83423); Exhibit 48, Statement of Donna Hannah, undated (SCOI.84157); Exhibit 49, Statement of Yvonne Hopkins, 9 November 2022 (SCOI.84154).

[1552] Exhibit 46, Tab 71, Statement of Elizabeth Blomfield, 27 June 2023, [5] (SCOI.83544).

a. The availability of DNA testing in 1989 and what, if any, tests could have been conducted on Mr Russell's clothing at that time;

b. What tests (if any) were conducted by FASS (formerly DAL) in relation to Mr Russell's clothing:

   i. In 1989–90 (at the time of the original investigation);

   ii. In about 2002 (at the time of Operation Taradale);

   iii. In about 2016 (at the time of Strike Force Neiwand); and

   iv. In 2023 (at the request of the Inquiry)

c. The results of those various tests;

d. The efficacy of DNA testing if the clothing had been cleaned prior to such testing; and

e. The likely persistence of any DNA recovered.

5.1898. The content of that statement is considered below.

Contact with OIC

5.1899. In addition to the conference with, and statement from, Adrian Ingleby, as discussed above, on 13 October 2023, the Inquiry wrote to Mr Ingleby enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Russell. Mr Ingleby advised the Inquiry that he did not wish to provide submissions.[1553]

5.1900. On 5 May 2023, the Inquiry spoke with Sally Johnston (née Dunbar) in relation to her involvement as the OIC of the investigation into Mr Russell's death.[1554] Subsequent attempts were made to contact Ms Johnston to ascertain whether she wished to provide a statement or submissions in the matter, all of which were unsuccessful.

Other

5.1901. The Inquiry reviewed historical LGBTIQ media publications: see above in relation to Mr Warren.

[1553] Exhibit 66, Tab 73, Letter from the Inquiry to Adrian Ingleby, 13 October 2023 (SCOI.86332).

[1554] Exhibit 46, Tab 71, Statement of Elizabeth Blomfield, 27 June 2023, [4]-[8] (SCOI.83544).

Consideration of the evidence

Gilles Mattaini

Mr Mattaini's background

5.1902. Mr Mattaini was 26 years old at the time of his disappearance on 15 September 1985, having been born on 25 October 1958. He was a French national, living in an apartment in Ramsgate Avenue Bondi, near the intersection with Campbell Parade, with his long-term partner Mr Musy.[1555]

5.1903. Mr Mattaini and Mr Musy met in Paris in about 1978. In 1983 they both moved to Sydney, Mr Musy doing so first, followed by Mr Mattaini.

5.1904. Mr Mattaini worked on a casual basis as a barman at the Menzies Hotel near Wynyard. He often took long walks from home wearing his headphones and listening to music, including the walk from Bondi to Mackenzie's Point.

5.1905. On 16 August 1985, Mr Musy travelled to France to see his family.[1556] He was still in France when Mr Mattaini went missing on 15 September 1985.

Mr Mattaini's state of mind

5.1906. While he was in France, Mr Musy had weekly telephone contact with Mr Mattaini. Mr Musy thought that although Mr Mattaini was missing him, he was laughing and very happy, buying things for the apartment and looking forward both to Mr Musy's return and to a forthcoming visit to Sydney by a friend, Anthony Wyszynski.[1557]

5.1907. Mr Mattaini's visa had expired, which was causing him some concern.

5.1908. Mr Hubert, his friend and supervisor at the Menzies Hotel, described Mr Mattaini as feeling "uncomfortable" about the visa situation and "trapped in that he could not leave Australia and come back." Mr Hubert also said that Mr Musy had told him that he and Mr Mattaini were "having problems with their relationship", which Mr Hubert said "may have related to the visa situation but I don't know."[1558]

5.1909. However, Mr Musy's evidence at the Milledge Inquest was significantly different.

[1555] Exhibit 6, Tab 172, Strike Force Neiwand, Summary of Investigation – Gilles Mattaini, 27 December 2017, [5] (SCOI.74881).

[1556] Exhibit 44, Tab 6, Statement of Heather Maria Thompson, 8 August 2002 (SCOI.02744.00386).

[1557] Exhibit 6, Tab 159, Statement of Jacques Paul Musy, 3 August 2002, [15]–[22] (SCOI.02744.00381); Exhibit 6, Tab 280, Transcript of Coronial Inquest into the death of John Russell and suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 51.9–39, 52.49–53.2 (SCOI.82371).

[1558] Exhibit 44, Tab 7, Statement of Marc Pierre Hubert, 14 August 2002, [12] (SCOI.02752.00191); see also Mr Hubert's oral evidence: Exhibit 44, Tab 12, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 41.45–42.8 (SCOI.84054).

5.1910. As to the visa issue, Mr Musy was prepared (when asked) to adopt Mr Hubert's terminology of Mr Mattaini feeling "uncomfortable" and "trapped".[1559] However, his own assessment, when asked how worried Mr Mattaini was about this, was that:[1560]

> *it was worrying him not to be in the law, like he was like illegal but I mean it was a thought but it was not something which was really sort of weighting [sic] on him constantly not at all.*

5.1911. As to their relationship, Mr Musy's evidence was eloquent. He agreed that he and Mr Mattaini were having some problems, in that their sexual relationship was not what it had once been. But he said that this:[1561]

> *was not something which was really a big issue because we were very very much in love, … so the sexual part was really not too much an issue at all because we had really an enormous bond and … this is what I missed the most after his disappearance that I had this absolutely amazing bond with that person and that would have helped through anything anyway and even if we were to stay together, without any sexual relationship, that would have been possible anyway.*

5.1912. In his teens, Mr Mattaini had attempted suicide at home by taking a number of tablets and cutting his wrists. This appears to have been prompted by his father's attitude towards his sexuality.[1562]

5.1913. In the late 1970s, aged about 20, he was conscripted into the French army. He was unhappy in the army. He made what was regarded as a second suicide attempt, by taking pills. This resulted in his being hospitalised and discharged from the military. Mr Musy thought that this second incident may have been actually a device to get out of the army.[1563]

5.1914. Mr Musy's sworn evidence to the Milledge Inquest was that during the whole of their relationship, between 1978 and 1985, Mr Mattaini had not given any indication that he was thinking about suicide or contemplating it in any respect. On the contrary, Mr Musy's evidence was:[1564]

[1559] Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 53.4–18 (SCOI.82371).

[1560] Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 49.44–58 (SCOI.82371).

[1561] Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 53.49–54.11 (SCOI.82371).

[1562] Exhibit 6, Tab 159, Statement of Jacques Paul Musy, 3 August 2002, [6] (SCOI.02744.00381); Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 48.42–51, 49.19–21 (SCOI.82371); Exhibit 6, Tab 167A, NSWPF Investigator's Note, 'Telephone call with Jacques Musy', 13 December 2016, 4 (SCOI.10389.00042).

[1563] Exhibit 6, Tab 159, Statement of Jacques Paul Musy, 3 August 2002, [5] (SCOI.02744.00381); Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 48.33–40, 49.19–21 (SCOI.82371).

[1564] Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 48.53–49.21 (SCOI.82371).

a. That "meeting me and being involved with me in a love relationship actually made him sort of forget about these thoughts or his problems he had in the past";

b. That whereas in the past he had "a kind of a frame of mind where he was somebody who was more attracted to death than life", meeting Mr Musy had "show[n] him life in a different way and he had a very fulfilling relationship with me";

c. That Mr Mattaini "was commenting often that he was really happy and how stupid he had been before to sort of want to die because there was much more to life than what he thought there was";

d. That "coming to Australia was a very sort of big part of this and he was extremely, very very happy to be in Australia and to find a new life living in Bondi by the seaside and all this was exhilarating for him"; and

e. That Mr Mattaini "was very very happy and he – it was just like a cure for him from his bad faults he had in the past".

5.1915. On a day shortly before Mr Mattaini's disappearance (possibly on 14 September 1985), Mr Mattaini asked Mr Hubert if he could finish his shift at the Menzies Hotel early. Mr Hubert said that, despite being a non-smoker, he uncharacteristically asked for a cigarette, and explained that he felt like one because he was feeling "very stressed".[1565]

Movements prior to disappearance

5.1916. A copy of a September 1985 calendar provided to police by Mr Musy is marked with the word 'OFF' on 15 September 1985. This is likely to be an indication that Mr Mattaini was not working on that day. The same calendar also had several future days, after 15 September, marked as days on which various anticipated events would occur.[1566]

5.1917. On or about 15 September 1985, Mr Mattaini had a telephone call with his friend Mr Wyszynski, whose visit to Sydney (from France) was approaching. In his statement, Mr Wyszynski said that Mr Mattaini "was very happy and he was looking forward to my visit". [1567] In his oral evidence, he described Mr Mattaini's state of mind at that time as "exhilarating" and said in that particular phone call he sounded "joyful".[1568]

5.1918. This seems to have been the last known contact by Mr Mattaini with anybody prior to his disappearance.

[1565] Exhibit 44, Tab 7, Statement of Marc Pierre Hubert, 14 August 2002, [13] (SCOI.02752.00191).

[1566] Exhibit 6, Tab 172, Strike Force Neiwand, Summary of Investigation – Gilles Mattaini, 27 December 2017, [14] (SCOI.74881).

[1567] Exhibit 44, Tab 4, Statement of Antony Jean Wyszynski, 3 August 2002, [6] (SCOI.02744.00382).

[1568] Exhibit 44, Tab 12, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 63.19–64.20 (SCOI.84052).

5.1919. There is evidence, in an Interpol communication in 2002, that Mr Wyszynski later told Mr Mattaini's mother that Mr Mattaini had told him (presumably in this phone call) that he was going swimming in the sea on the day of his disappearance.[1569] Mr Wyszynski himself did not refer to this either in his statement or in his oral evidence.

Location of last sighting, and "Terry"

5.1920. Mr Mattaini was last seen walking near the northern end of Bondi Beach on 15 September 1985 by a neighbour whom Mr Musy knew as "Terry", who described Mr Mattaini as looking "aloof".[1570] Mr Musy said he always remembered that word "aloof", and the date, because it was his birthday.[1571]

5.1921. Mr Musy's recollection was that he spoke to Terry on his return from France, and that Terry said he had seen Mr Mattaini walking, probably in the morning, near Terry's apartment, which was in Campbell Parade near Ramsgate Avenue, up the hill towards the Bondi Diggers.[1572]

5.1922. Strike Force Neiwand asserted, incorrectly, that Mr Mattaini was last seen "walking along a track around McKenzie's Point, Bondi."[1573] There is no basis in the evidence for that assertion.

5.1923. In his August 2002 statement, Mr Musy referred only to speaking to "a man who lived in a unit block nearby". In 2016, he described that man as living 50m or so from their home in Bondi, being "Australian", tall, lanky with dark hair and possibly gay, and said he might have worked at the Menzies Hotel.[1574]

5.1924. Mr Lehman did not recall anyone by the name of "Terry" who lived close by to Mr Musy and Mr Mattaini or who worked at the Menzies Hotel.

5.1925. The Inquiry has not been able to locate "Terry".

After 15 September 1985

5.1926. After Mr Mattaini did not turn up to his 3:00pm rostered shift at the Menzies Hotel on 16 September 1985, Mr Hubert became concerned and contacted Mr Ottaviani.[1575]

5.1927. On 16 or 17 September 1985, according to Mr Hubert, Mr Ottaviani visited Mr Mattaini's flat but there was no answer.[1576]

[1569] Exhibit 44, Tab 10, Memorandum from Interpol France to Interpol Canberra (English Version), 18 October 2002 (SCOI.02752.00189).

[1570] Exhibit 6, Tab 159, Statement of Jacques Paul Musy, 3 August 2002, [23] (SCOI.02744.00381); Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 54.13–55.20 (SCOI.82371). See also Exhibit 6, Tab 167A, NSWPF Investigator's Note, 'Telephone call with Jacques Musy', 13 December 2016, 4 (SCOI.10389.00042); Exhibit 44, Tab 43, Statement of Emily Burston, 27 June 2023, [7]–[8] (SCOI.84055).

[1571] Exhibit 6, Tab 159, Statement of Jacques Paul Musy, 3 August 2002, [23] (SCOI.02744.00381).

[1572] Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 55.1–15 (SCOI.82371).

[1573] Exhibit 6, Tab 172, Strike Force Neiwand, Summary of Investigation – Gilles Mattaini, 27 December 2017, [1] (SCOI.74881).

[1574] Exhibit 6, Tab 167A, NSWPF Investigator's Note, 'Telephone call with Jacques Musy', 13 December 2016 (SCOI.10389.00042)

[1575] Exhibit 44, Tab 7, Statement of Marc Pierre Hubert, 14 August 2002, [14]–[15] (SCOI.02752.00191).

[1576] Exhibit 44, Tab 7, Statement of Marc Pierre Hubert, 14 August 2002, [16] (SCOI.02752.00191).

5.1928. On or around 19 September 1985, Mr Ottaviani telephoned Mr Wyszynski and told him Mr Mattaini had not shown up for work for the last two or three days. Mr Wyszynski asked Mr Ottaviani to go to Mr Mattaini's place and check for him.

5.1929. According to Mr Wyszynski's statement, he received a further call from Mr Ottaviani informing him that he had checked Mr Mattaini's apartment and that it was intact with his passport and house keys present.[1577] How Mr Ottaviani could have gained entry to the apartment is unclear.

5.1930. When Mr Wyszynski gave oral evidence at the Milledge Inquest, he clarified that he had no specific recollection of Mr Ottaviani actually saying anything about the keys.[1578] When Mr Musy in due course returned, he saw that Mr Mattaini's keys were in fact missing. [1579]

5.1931. Mr Ottaviani commenced making enquiries with "the police and hospitals" as to Mr Mattaini's whereabouts.[1580] However, there is no police record of any report of Mr Mattaini being missing.[1581] Mr Ottaviani died in 1991.

5.1932. Mr Musy later had the impression that Mr Lehman had also searched for Mr Mattaini. However, Mr Lehman told the Inquiry that he did not do so. He said he would have been working during the day, whilst Mr Ottaviani and the other friends would have been working nights.[1582]

5.1933. On 24 September 1985, Mr Musy arrived back in Australia.[1583] He noticed that Mr Mattaini's Walkman, yellow spray jacket and keys were missing from the apartment. His wallet, passport, watch and credit cards were present.

5.1934. Mr Musy was under the impression that Mr Ottaviani and Mr Hubert had reported the disappearance to police whilst Mr Musy was still in France. Mr Musy himself was being treated with Valium for stress at Mr Mattaini's disappearance.[1584]

5.1935. Mr Mattaini's parents never officially reported their son missing to French police. They did make contact with the Australian Ambassador in Paris, who advised them to seek assistance from the International Red Cross.[1585]

5.1936. On 2 October 1985, Mr Wyszynski arrived in Australia.[1586] He assisted Mr Ottaviani in searching further for Mr Mattaini, but without success.[1587]

[1577] Exhibit 44, Tab 4, Statement of Antony Jean Wyszynski, 3 August 2002, [7] (SCOI.23971).

[1578] Exhibit 44, Tab 14, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 64.31–38 (SCOI.84052).

[1579] Exhibit 6, Tab 159, Statement of Jacques Paul Musy, 3 August 2002, [20] (SCOI.02744.00090); Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 52.23–47 (SCOI.82371).

[1580] Exhibit 44, Tab 7, Statement of Marc Pierre Hubert, 14 August 2002, [16] (SCOI.02752.00191).

[1581] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 3 (SCOI.02751.00021).

[1582] Exhibit 44, Tab 38, Statement of Glen Lehman, 17 May 2023, [17] (SCOI.83531).

[1583] Exhibit 44, Tab 6, Statement of Heather Maria Thompson, 8 August 2002 (SCOI.02744.00386).

[1584] Exhibit 6, Tab 167A, NSWPF Investigator's Note, 'Telephone call with Jacques Musy', 13 December 2016 (SCOI.10389.00042); Exhibit 44, Tab 7, Statement of Marc Pierre Hubert, 14 August 2002, [18] (SCOI.02752.00191).

[1585] Exhibit 6, Tab 172, Strike Force Neiwand, Summary of Investigation – Gilles Mattaini, 27 December 2017, [20] (SCOI.74881).

[1586] Exhibit 44, Tab 6, Statement of Heather Maria Thompson, 8 August 2002 (SCOI.02744.00386).

[1587] Exhibit 44, Tab 4, Statement of Antony Jean Wyszynski, 3 August 2002, [8] (SCOI.02744.00382).

5.1937. There was no contemporaneous police investigation into Mr Mattaini's death. It was first investigated as part of Operation Taradale. However, that investigation was relatively confined, due to the fact that Mr Musy and Mr Wyszynski only reported Mr Mattaini's disappearance to Detective Sergeant Page in August 2002, at a time when the brief of evidence (including Detective Sergeant Page's lengthy Russell/Warren statement, in relation to the 1989 deaths of Mr Warren and Mr Russell) had been completed.

What might have happened?

5.1938. According to an Interpol communication in October 2002, Mr Mattaini's mother recalled that Mr Wyszynski had told her that Mr Mattaini had told him that he was intending to go swimming in the sea "that day" (seemingly the day he disappeared, 15 September 1985).[1588]

5.1939. The same Interpol communication asserted that "we have learned that Mattaini … was an amateur scuba diver". The source of that assertion was not stated. However, Mr Musy advised Strike Force Neiwand that Mr Mattaini did not go scuba diving in the time Mr Musy knew him, was not an athlete and was too scared to go into the ocean.[1589]

5.1940. By contrast, Mr Lehman recalled Mr Mattaini as being a good swimmer, that he frequented the beach and that swimming was one of the social activities he took part in with his friends in Bondi.[1590]

5.1941. In relation to the possibility that the bodies of Mr Mattaini and/or Mr Warren had entered the water, the Inquiry obtained assistance from two expert reports, namely those of Dr Iles and Professor Brander.

Dr Linda Iles

5.1942. Dr Iles, was asked to provide a report on the following matters:

a. The rate of decomposition of a human body in seawater;

b. The average period between the initial submergence of a human body in seawater and its resurfacing (absent attack by a predator); and

c. The length of time before gasses are released.

5.1943. Her report was provided on 18 May 2023.[1591] The views expressed in the report are of potential applicability to the cases of both Mr Mattaini and Mr Warren.

[1588] Exhibit 44, Tab 10, Memorandum from Interpol France to Interpol Canberra (English Version), 18 October 2002 (SCOI.02752.00189).

[1589] Exhibit 44, Tab 10, Memorandum from Interpol France to Interpol Canberra (English Version), 18 October 2002 (SCOI.02752.00189); Exhibit 6, Tab 167A, NSWPF Investigator's Note, 'Telephone call with Jacques Musy', 13 December 2016 (SCOI.10389.00042).

[1590] Exhibit 44, Tab 38, Statement of Glen Lehman, 17 May 2023, [15]–[19] (SCOI.83531).

[1591] Exhibit 44, Tab 40, Expert report of Dr Linda Iles, 18 May 2023 (SCOI.83668).

5.1944. Dr Iles said that there is a generalised course of events that may occur after a deceased person is submerged in seawater, beginning from a stage of buoyancy that will decrease until the body sinks. The body may be moved about under the water, until such bloating occurs that the body once again becomes buoyant. As decomposition continues, the putrefactive gases that cause bloating are released from the body, and the body sinks again.[1592]

5.1945. Dr Iles stated that it is not possible to reliably estimate the rate of decomposition of human remains in seawater, given the complex interactions between significant amounts of variables. Although there is a "standard" process as above, there are a number of different events that may occur.[1593]

5.1946. For example, the initial buoyancy of a body depends on factors, including the individual's body composition, any trauma the person received prior to their death and subsequent immersion in sea water, any clothing worn, and the characteristics of the seawater they are in. In some situations, the body may never be buoyant at all, and in others, the body may not have sunk at any stage prior to discovery. [1594]

5.1947. Minimal formal studies of decomposition of bodies in seawater have been completed, due to the number of uncontrollable variables in both the individual and the environment. These variables make it extremely difficult to isolate each step of the decomposition cycle.[1595] Furthermore, where studies have been completed, the variables are specific to the local geographic area where the body was immersed, limiting the ability to apply results to other regions.[1596]

Professor Robert Brander

5.1948. Professor Brander's report is dated 1 June 2023.[1597]

5.1949. Professor Brander gave oral evidence at the Milledge Inquest, in relation to the death of Mr Warren, in April 2003.

5.1950. The Inquiry asked Professor Brander to provide a report in relation to what may have happened to Mr Mattaini's body, if it had entered the water:

a. At any point along the coastal walk around Marks Park (south from Bondi Beach); or

b. At any point along the walk from Bondi Beach to Ben Buckler Point (north from Bondi Beach).

[1592] Exhibit 44, Tab 40, Expert report of Dr Linda Iles, 18 May 2023, 2–3 (SCOI.83668).

[1593] Exhibit 44, Tab 40, Expert report of Dr Linda Iles, 18 May 2023, 2 (SCOI.83668).

[1594] Exhibit 44, Tab 40, Expert report of Dr Linda Iles, 18 May 2023, 3 (SCOI.83668).

[1595] Exhibit 44, Tab 40, Expert report of Dr Linda Iles, 18 May 2023, 3 (SCOI.83668).

[1596] Exhibit 44, Tab 40, Expert report of Dr Linda Iles, 18 May 2023, 4 (SCOI.83668).

[1597] Exhibit 44, Tab 42, Expert report of Professor Robert Brander, 1 June 2023 (SCOI.83670).

5.1951. While, in his opinion, it is unlikely that Mr Mattaini chose to go for a swim between 15–17 September 1985 due to the prevailing air and sea temperatures at that time,[1598] Professor Brander considered that conditions for swimming along the rocky coastline in the region of interest would have been challenging and hazardous due to the presence of larger and longer period waves than normal.[1599]

5.1952. If Mr Mattaini had chosen to go for a swim at Tamarama or Bondi Beach during the period in question, rip currents were likely to have been present outside of the patrolled flag locations, and conditions would have been challenging for swimming.[1600]

5.1953. Professor Brander considered that given wave conditions between 15–17 September, if Mr Mattaini's body had entered the water at any point along the coastal walk around Marks Park or between Bondi Beach and Ben Buckler Point, it would have remained in the vicinity, but may have travelled a short distance (30-40 metres) offshore. That would be the case regardless of whether Mr Mattaini was alive or dead on entering the water and regardless of whether his body was floating or submerged.[1601]

5.1954. Professor Brander's opinion is that if Mr Mattaini's body had been in the water anywhere along the coastline between Tamarama Beach and Ben Buckler Point (or even further in either direction), it would have travelled further distances offshore, possibly up to a kilometre, due to wave reflection and mega rip current activity during extremely large wave conditions that occurred from 19–21 September 1985.[1602]

5.1955. If Mr Mattaini's body had been floating during daylight hours between 15–19 September 1985, it would likely have been visible from elevated vantage points in the area.[1603]

5.1956. Professor Brander considered that, if Mr Mattaini had entered the water alive and uninjured during daylight hours in the period 15–19 September 1985, he would have remained close enough to have good prospects of attracting attention and aid from others in the area.[1604] However, if he entered the water during night hours, there was a strong possibility he would have drowned due to the combination of cooler temperatures, wave breaking and reflection, poor visibility (and concomitant difficulty signalling aid) and the possibility he was fully or partially clothed.[1605]

[1598] Exhibit 44, Tab 42, Expert report of Professor Robert Brander, 1 June 2023, [188] (SCOI.83670).

[1599] Exhibit 44, Tab 42, Expert report of Professor Robert Brander, 1 June 2023, [13]–[14] (SCOI.83670).

[1600] Exhibit 44, Tab 42, Expert report of Professor Robert Brander, 1 June 2023, [189] (SCOI.83670).

[1601] Exhibit 44, Tab 42, Expert report of Professor Robert Brander, 1 June 2023, [16]–[17], [190]–[191] (SCOI.83670).

[1602] Exhibit 44, Tab 42, Expert report of Professor Robert Brander, 1 June 2023, [21]–[22], [192] (SCOI.83670).

[1603] Exhibit 44, Tab 42, Expert report of Professor Robert Brander, 1 June 2023, [18] (SCOI.83670).

[1604] Exhibit 44, Tab 42, Expert report of Professor Robert Brander, 1 June 2023, [19] (SCOI.83670).

[1605] Exhibit 44, Tab 42, Expert report of Professor Robert Brander, 1 June 2023, [19]–[20], [184] (SCOI.83670).

5.1957. Dr Iles' report was provided to Professor Brander for his consideration. Professor Brander advised that, if Mr Mattaini's body had become submerged quickly after entering the water, it may have remained submerged for longer due to traditionally colder water temperatures in September in Sydney, and therefore may not have resurfaced prior to the extreme weather conditions which began on 19 September 1985.[1606]

Attempts to obtain DNA sample

5.1958. Unsuccessful attempts were made to obtain a DNA sample from Mr Mattaini's mother, Renee Mattaini, both in 2011 in relation to Operation Firenze[1607] and in 2016 by Strike Force Neiwand.[1608] Ms Mattaini passed away on 9 March 2017 and was cremated.[1609]

5.1959. It appears Ms Mattaini had a sister, Ms Liliane Michel, but Strike Force Neiwand did not seek to obtain a DNA sample from her.[1610]

5.1960. Any such DNA sample would in any event be of limited utility unless Mr Mattaini's body were found.

Ross Warren

Mr Warren's background

5.1961. Mr Warren was 25 years old at the time of his disappearance. He was living alone in an apartment in Wollongong,[1611] where he worked as a television presenter with WIN4 Television.[1612] He was known as an extremely friendly and good-natured person,[1613] with a wicked sense of humour,[1614] and was described as career driven.[1615]

Mr Warren's sexuality

5.1962. Mr Warren's parents and siblings,[1616] as well as his employer, [1617] were aware that he was gay. Mr Warren had many friends who were gay. At least some of those gay friends, including Mr Ellis, were aware that he sometimes used the Marks Park beat.[1618]

[1606] Exhibit 44, Tab 42, Expert report of Professor Robert Brander, 1 June 2023, [162], [164] (SCOI.83670).

[1607] Exhibit 44, Tab 21, Emails from Interpol Canberra to Kimelia Miller, 18 February 2011–18 May 2016 (SCOI.10391.00174).

[1608] Exhibit 44, Tab 22, Email from Acting Sergeant Kathleen Baird to John Oldfield, 7 August 2016 (SCOI.10391.00208).

[1609] Exhibit 44, Tab 27, NSWPF Investigator's Note, 'Renee Mattaini now deceased', 10 April 2017 (SCOI.10389.00106).

[1610] Exhibit 44, Tab 31, Email from Federal Agent Ashley Wygoda to Loisy Emmanuel, 19 December 2017 (SCOI.10463.00037).

[1611] Exhibit 6, Tab 325, Statement of Craig Ellis, 25 September 2000, [6] (SCOI.28744).

[1612] See, e.g., Exhibit 6, Tab 325, Statement of Craig Ellis, 25 September 2000, [8] (SCOI.28744); Exhibit 45, Tab 56, Statement of Kerry Kingston, 24 January 2001, [4] (SCOI.02744.00161).

[1613] Exhibit 6, Tab 325, Statement of Craig Ellis, 25 September 2000, [7] (SCOI.28744).

[1614] Exhibit 45, Tab 100, Statement of Kay Warren, 28 June 2017, [23] (SCOI.10385.00050).

[1615] See, e.g., Exhibit 45, Tab 63, Statement of NP250, 23 April 2002, [13] (SCOI.02744.00160); Exhibit 45, Tab 56, Statement of Kerry Kingston, 24 January 2001, [5] (SCOI.02744.00161).

[1616] Exhibit 45, Tab 100, Statement of Kay Warren, 28 June 2017 (SCOI.10385.00050).

[1617] Exhibit 45, Tab 56, Statement of Kerry Kingston, 24 January 2001, [5]–[6] (SCOI.02744.00161).

[1618] Exhibit 45, Tab 42, NSWPF Record of Interview, 'Video walkaround interview with Craig Ellis', 2 August 2001, 11 (SCOI.02744.00142); Exhibit 45, Tab 63, Statement of NP250, 23 April 2002, [5], [8] (SCOI.02744.00160).

5.1963. In 1985, Mr Warren had been arrested at a beat and convicted of gross indecency, for which he was placed on two years probation.[1619]

Mr Warren's movements on 21 July 1989

5.1964. On the evening of Friday 21 July 1989, Mr Warren left his workplace at WIN 4, Wollongong after reading the weather at the conclusion of the 6:00pm news. He drove to Sydney and arrived sometime between 8:00pm and 9:00pm at the Redfern home of his friend Mr Ellis, with whom he intended to stay whilst in Sydney, as he did approximately every second weekend.[1620]

5.1965. At about 10:30pm Mr Warren left Mr Ellis' home and drove to Oxford Street in Darlinghurst where he met with a WIN 4 colleague, Mr Rossini. Together they visited several bars and nightclubs along the Oxford Street strip, until around 2:00am on Saturday 22 July 1989.

5.1966. At that time Mr Rossini saw Mr Warren driving his vehicle on Oxford Street in an easterly direction towards Paddington. This was the last known sighting of Mr Warren. He was wearing black shoes, blue faded jeans, a white turtleneck shirt, and a black sports coat.[1621]

Mr Warren is reported missing

5.1967. On the morning of Saturday, 22 July 1989, Mr Ellis woke to discover that Mr Warren had not returned home.

5.1968. Thereafter Mr Ellis and Mr Saucis made the several successive searches, and reports to police, that I have described above.

Investigation in 1989

5.1969. The OIC at Paddington Police was Detective Sergeant Bowditch. I have expressed my views above, in relation to his so-called investigation, his occurrence pad entry dated 28 July 1989, and the damning evidence assembled by Detective Sergeant Page, and findings made by Coroner Milledge, in relation to that entry.

5.1970. None of the steps which Detective Sergeant Bowditch claims to have taken or organised, seems actually to have happened.

5.1971. In his statement provided to Operation Taradale, Detective Sergeant Bowditch said that there was nothing to suggest that Mr Warren's disappearance was the result of foul play. Although the area was a beat, he "stressed" there was nothing to suggest his disappearance was "gay related". He said the coastal walkway was frequently used by walkers and joggers of all ages at all hours of the day and night, and was slippery at the time.[1622]

[1619] Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen John Page, 25 July 2002, [273] (SCOI.02744.00023).

[1620] Exhibit 45, Tab 6, NSWPF Report of Occurrence, 'Enquiries in relation to missing person Ross Bradley Warren' 28 July 1989, 1–2 (SCOI.02744.00031).

[1621] Exhibit 45, Tab 17, Statement of Phillip Rossini, 26 July 1989 (SCOI.02744.00065).

[1622] Exhibit 45, Tab 33, Statement of Kenneth Bowditch, 19 February 2001, [10] (SCOI.02744.00150).

5.1972. Given the apparent failure of Detective Sergeant Bowditch to conduct any enquiries whatsoever as to the possibility either of foul play, or of a "gay related" factor, his views were and are of little weight.

1990–1996: Missing Persons

5.1973. Between 1990 and 1996, a number of reports from members of the public were received by the NSWPF. None yielded any useful information.

1991: Detective Sergeant McCann

5.1974. In 1990–91, as outlined above, Detective Sergeant McCann was investigating the murders of Mr Johnson (Alexandria, January 1990) and Mr Rattanajurathaporn (Marks Park, July 1990). In the course of doing so, he observed numerous links between those two deaths and their perpetrators, and other gangs and other deaths, including those of Mr Warren and Mr Russell.

5.1975. In April and August 1991, he produced his two reports documenting some of those links.[1623]

Marks Park, gangs and violence

5.1976. In her findings of 9 March 2005, Coroner Milledge said that Marks Park was "known as a nighttime beat and was very busy and popular".[1624] The Coroner went on:[1625]

> *The area is a popular walking track during the day and at night gay men will 'cruise' the coastal walkway rattling keys or coins as an indication of their availability for personal contact…. It was well known to everyone in the community that this was a gay beat, including the police.*

5.1977. The evidence before Coroner Milledge included evidence of the "gay hate" climate at the time. Gay men were more likely to be victims of violence than other men. Importantly, they were less likely to report crimes of violence against them, believing that police would not respond appropriately to their victimisation. This belief was reflected by the perpetrators, who saw homosexual men as easy targets, seeing the victims' "lifestyles" as a shield making them reluctant to report their attacks.[1626]

5.1978. Among the evidence before Coroner Milledge was the statement of Sergeant Ingleby, made in 1990 for the initial inquest into the death of Mr Russell. In that statement, Sergeant Ingleby's evidence included that:[1627]

[1623] Exhibit 6, Tab 233, Statement of former Detective Sergeant Stephen McCann, 10 November 2022 (SCOI.77310).

[1624] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 3 (SCOI.02751.00021).

[1625] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 3 (SCOI.02751.00021).

[1626] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 3–5 (SCOI.02751.00021).

[1627] Exhibit 6, Tab 155, Statement of Sergeant Adrian Macdonald Ingleby, 26 February 1990, [16]–[17] (SCOI.02744.00075) (emphasis in original).

> *From information received from [DM] and from my knowledge as a Police Officer I am aware that assaults and assault and robberies on homosexuals is a popular pastime with the juvenile and hoodlum element, unfortunately most of the victims, who are homosexual do not report the incidents to Police when they occur as they may not want publicity, or have a perception that Police are not interested, or if they are interested, that Police will not be able to detect and arrest offenders. I believe that the level of '<u>unreported</u>' assaults and associated offences on the homosexual element in this area, (and other areas) would be extremely high.*
>
> *… Some of the homosexuals who frequent the area sit near the edge of the cliff top; but it is not known if Mr Russell did so. It appears Mr Russell was in a normal state of mind which would rule out suicide. Crimes of violence on the homosexual element in the area is prevalent, as it is in many other areas of Sydney frequented by the homosexual community. I believe there would be a great number of '<u>unreported</u>' crimes of violence in this area.*

5.1979. The findings of the Streetwatch Report, published in 1990, were consistent with this evidence. Of those who were assaulted, in the six-month period from the start of November 1988 to the end of April 1989, 52% of survivors did not report the incident to police. Of this 52%, 17% believed that the report would not be taken seriously.[1628]

5.1980. Coroner Milledge heard that in 1989 and 1990 in NSW, 22% of "gay hate" homicides occurred at beats. Police were well aware of a number of gangs of youths that frequently engaged in the assault and robbery of gay men in Marks Park and other areas. The offenders were predominately white, Caucasian, single and unemployed. They often had a long history of violent attacks against gay men. Common motives for the attacks included prejudice and homophobia, group initiation, proving masculinity, proving that they were not gay, entertainment, robbery, and a belief that gay men were 'soft' targets and less 'legitimate'.[1629]

5.1981. In this time period, a number of gay men were attacked and killed in the inner city and eastern suburbs. They were all victims of "gay hate" violence. All assaults and killings were unprovoked and vicious.[1630] They occurred not only at beats, but also in the street and parks.[1631] Assaults at beats occurred most often between 3:00pm and 6:00pm, and 9:00pm and 3:00am.[1632]

[1628] Exhibit 2, Tab 22, Gary Cox, *The Streetwatch Report: A Study into Violence Against Lesbians and Gay Men*, (Project of the Gay and Lesbian Rights Lobby Incorporated, 1990) 6[1.27]–[1.30] (SCOI.76806).

[1629] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 4–5 (SCOI.02751.00021).

[1630] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 4 (SCOI.02751.00021).

[1631] Exhibit 2, Tab 22, Gary Cox, *The Streetwatch Report: A Study into Violence Against Lesbians and Gay Men*, (Project of the Gay and Lesbian Rights Lobby Incorporated, 1990) 15–22[4.2] (SCOI.76806).

[1632] Exhibit 2, Tab 22, Gary Cox, *The Streetwatch Report: A Study into Violence Against Lesbians and Gay Men*, (Project of the Gay and Lesbian Rights Lobby Incorporated, 1990) 21 (SCOI.76806).

5.1982. As Coroner Milledge observed in her findings in 2005, "it is fair to say that only a percentage of the brutality would have been reported to police at that time."[1633]

5.1983. However, some attacks on gay men or men who may have been assumed to be gay and/or beat users were reported to police. For the period between 1987 and 1990, they included at least the following:

a. Paul Wright: Marks Park, 26 October 1987;[1634]

b. I91: Bondi, 12 November 1989;[1635]

c. Alan Boxsell: Marks Park, 18 December 1989;[1636]

d. David McMahon: Marks Park, 21 December 1989;[1637]

e. I34: Marks Park, February 1990;[1638]

f. Krichikorn Rattanajurathaporn: Marks Park, July 1990.[1639]

5.1984. Some of the gangs, that were systemically engaged in the assault and robbery of men in Marks Park and other areas, had adopted names, such as 'PSK' which stood for 'Park Side Killers'. Coroner Milledge said, "[T]hese gangs of misfits saw homosexual men as easy targets. The victims' lifestyles often providing a shield for the perpetrators as they believed that their prey would be reluctant to come forward and report their attacks."[1640]

5.1985. Numerous persons of interest, several of them members of one or more of these gangs, gave evidence at the Milledge Inquest, including the killers of Mr Rattanajurathaporn, known as the "Tamarama Three". Many, but by no means all, denied any involvement in violence against gay men.

5.1986. As noted above, Operation Taradale deployed both telephone intercepts and listening devices to record conversations between and among persons of interest and their associates. Some 17,000 telephone conversations were intercepted and monitored. All of that evidence, assembled by Operation Taradale, was before the Coroner. (Detective Sergeant McCann had also utilised listening devices as early as July 1991 in the course of his investigations into the deaths of Mr Johnson and Mr Rattanajurathaporn.)

[1633] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 4 (SCOI.02751.00021). See also Exhibit 6, Tab 155, Statement of Sergeant Adrian Ingleby, 26 February 1990 (SCOI.02744.00075); Exhibit 6, Tab 233A, Letter from Stephen McCann to the Commander, Modus Operandi Section, 10 August 1991, [39] (SCOI.10342.00010).

[1634] Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen John Page, 25 July 2002, [446] (SCOI.02744.00023).

[1635] Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen John Page, 25 July 2022, [416] (SCOI.02744.00023).

[1636] Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen John Page, 25 July 2002, [400]–[401] (SCOI.02744.00023).

[1637] Exhibit 46, Tab 16, Statement of DM, 3 January 1990, [15] (SCOI.10386.00085).

[1638] Exhibit 45, Tab 57, Statement of I34, 10 April 2001, (SCOI.02744.00273).

[1639] Transcript of Proceedings, *R v MTD*; *R v Sean Patrick McAuliffe*; *R v David John McAuliffe*, Supreme Court of New South Wales, Wood J, 7 August 1992, 3 (SCOI.02462). See also Exhibit 6, Tab 233A, Letter from Stephen McCann to the Commander, Modus Operandi Section, 10 August 1991, [39]–[40] (SCOI.10342.00010).

[1640] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 14 (SCOI.02751.00021).

5.1987. The contents of some of the recorded conversations were such that it seemed they may have related to the disappearance of Mr Warren, but those possibilities were investigated and ultimately excluded by Detective Sergeant Page.

5.1988. As noted above, notwithstanding the volume of evidentiary material obtained and considered by Operation Taradale, Detective Sergeant Page was not able to uncover evidence sufficient to pinpoint any particular person or persons as having been involved in any of the three deaths.

5.1989. The Inquiry has had regard to all this material, including in the conduct of various private hearings. Those private hearings are considered in the confidential volume of the Inquiry's report.

5.1990. In her findings, Coroner Milledge extracted some examples of what was said by persons of interest, as captured on listening devices. Some of those are set out here, ugly as they are, as examples of the attitudes that were held by some in society toward gay men in the late 1980s and early 1990s:[1641]

> *I threw a fag off the cliff at Bondi … I've jumped on blokes head you wouldn't believe were always going out bashing fags…*
>
> *I had my new Boks from America on that day too, I had blood all over 'em … went up and I go Oooo … come up and grabbed a handful of hair and went, Dirty fuckin' maggot … He should have gone went off the cliff that night but he didn't …. we went down and put a cigarette butt out on his head.*

5.1991. When asked why he 'bashed fags', one assailant said:

> *Something to do mate. Mate I made fuckin one, one guy I bashed I got fuckin 1300 … he was doing a bank run, bank run, taking money to the bank. Stopped him, smashed him, fuckin jumped on his head, went out to his car, looked at his briefcase … do it for the fucking money mate. It's not fun … it's a sport in Redfern … Oh it's a fuckin hobby mate. What are you doin tonight boys? Oh, just going fag bashin …*

Report of Dr Iles

5.1992. As noted above in relation to Mr Mattaini, Dr Iles provided a report, dated 18 May 2023, in relation to the decomposition of bodies in water. [1642] The contents of that report are outlined above.

[1641] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 13 (SCOI.02751.00021).

[1642] Exhibit 44, Tab 40, Expert report of Dr Linda Iles, 18 May 2023 (SCOI.83668).

5.1993. The report of Dr Iles is generally consistent with the letter from Dr Cala provided to Operation Taradale on 19 September 2001 on the same topic. He considered a body immersed in a large body of water would initially sink and that it may, but not always, rise to the surface after a period. He also alluded to the many variables at play and indicated that there are instances of persons entering the ocean whose bodies are never recovered.[1643]

Report of Professor Brander

5.1994. In relation to Mr Warren, the Inquiry briefed Professor Brander on 14 April 2023.[1644] Professor Brander provided his report on 24 May 2023.[1645]

5.1995. Professor Brander had previously provided expert evidence in relation to the disappearance of Mr Warren in the course of earlier investigations, including during the Milledge Inquest.[1646]

5.1996. Professor Brander was briefed with his previous reports and evidence, as well as the following materials:

a. Weather, synoptic and rainfall observations for Tamarama for 1989.

b. Sea level observations (tidal information) at Fort Denison for 1989.

c. Sydney offshore wave data for 1989.

d. A topographic map of Marks Park.

e. A video walkthrough of Tamarama conducted on 2 August 2001.

5.1997. Professor Brander reviewed data on conditions between 22 and 29 July 1989, with a particular focus on the period between 2:00am and 9:00am on 22 July 1989.[1647]

5.1998. There was no significant wave activity between 22 and 24 July 1989, with low-energy wave energy conditions, and minimal rip current activity. Professor Brander observed that the dominant direction of water movement during this time was likely offshore into Mackenzies Bay.[1648]

5.1999. The period between 25 and 28 July 1989, however, was characterised by a significantly large wave event, which Professor Brander indicates would have been associated with extreme turbulence, wave reflection, wave topping and inundation of the area. There were likely mega rip currents in Mackenzies Bay and Tamarama Beach, with the dominant direction of water movement also offshore.[1649]

[1643] Exhibit 45, Tab 67, Letter from Dr Allan Cala to Detective Sergeant Stephen Page, 19 September 2001 (SCOI.02744.00185).

[1644] Exhibit 45, Tab 118A, Letter of instruction from Elizabeth Blomfield to Professor Robert Brander, 14 April 2023 (SCOI.83671).

[1645] Exhibit 45, Tab 118, Expert report of Professor Robert Brander, 24 May 2023 (SCOI.83670).

[1646] Exhibit 45, Tab 68, Statement of Professor Robert William Brander, 1 August 2001 (SCOI.02744.00184); Exhibit 45, Tab 69, Report of Professor Robert Brander, 5 April 2002 (SCOI.02744.00182); Exhibit 45, Tab 170, Statement of Professor Robert William Brander, 11 April 2002 (SCOI.02744.00183); Exhibit 45, Tab 74, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 3 April 2003 (SCOI.84105); Exhibit 45, Tab 105, Statement of Professor Robert William Brander, 31 January 2017 (SCOI.10390.00076).

[1647] Exhibit 45, Tab 118, Expert report of Professor Robert Brander, 24 May 2023, [34] (SCOI.83670).

[1648] Exhibit 45, Tab 118, Expert report of Professor Robert Brander, 24 May 2023, [15] (SCOI.83670).

[1649] Exhibit 45, Tab 118, Expert report of Professor Robert Brander, 24 May 2023, [16] (SCOI.83670).

5.2000. Professor Brander considered that if Mr Warren's body had entered the water during the period of 22–24 July 1989, it would have either slowly drifted offshore if it was floating on the surface; or remained offshore of the rock platforms if it was submerged.[1650] Professor Brander indicated that if Mr Warren's body was submerged, it is possible that it may have become caught or snagged by the irregular subaqueous rock topography in the region.[1651]

5.2001. Professor Brander further expressed the view that regardless of whether Mr Warren's body was floating, submerged, or otherwise lodged in the rock topography, the large wave event in the following days, during the period between 25–28 July 1989,[1652] would have transported his body hundreds of metres offshore. It would have then been subject to deeper ocean currents, and it would be unlikely that his body would have then been transported back towards the shoreline.[1653]

5.2002. Professor Brander considered that the large wave event is likely to be the primary reason why Mr Warren's body was never recovered.[1654]

John Russell

Mr Russell's background

5.2003. At the time of his death, Mr Russell was employed as a barman at Bronte Bowling Club and worked one day a week at a school in Double Bay. He lived with his brother, Peter Russell, in Bondi. They had lived together all their lives.[1655]

5.2004. I403 (a pseudonym), who had known Mr Russell for 13 years and described Mr Russell as his best friend, described Mr Russell as a happy go lucky person, and as a "social drinker".[1656] He said he did not touch drugs.[1657]

5.2005. Peter Russell knew his brother was gay but described him as not being "extremely active in this area."[1658] He was not aware of John being in a relationship at the time of his death.[1659]

5.2006. I403 did not think Mr Russell was into using beats.[1660] However, Peter Russell told Operation Taradale in 2001 that John had mentioned Marks Park on occasion and referred to it as "The Beat". Peter got the sense from those conversations that Mr Russell had been to Marks Park on a couple of occasions to meet other men, but that it wasn't a regular thing.[1661]

[1650] Exhibit 45, Tab 118, Expert report of Professor Robert Brander, 24 May 2023, [119] (SCOI.83670).
[1651] Exhibit 45, Tab 118, Expert report of Professor Robert Brander, 24 May 2023, [120] (SCOI.83670).
[1652] Exhibit 45, Tab 118, Expert report of Professor Robert Brander, 24 May 2023, [123] (SCOI.83670).
[1653] Exhibit 45, Tab 118, Expert report of Professor Robert Brander, 24 May 2023, [122] (SCOI.83670).
[1654] Exhibit 45, Tab 118, Expert report of Professor Robert Brander, 24 May 2023, [124] (SCOI.83670).
[1655] Exhibit 46, Tab 13, Statement of Peter Russell, 24 November 1989, [3] (SCOI.02744.00077).
[1656] Exhibit 46, Tab 8, Statement of Constable Michael Antony Barrett, 1 December 1989, [15] (SCOI.10386.00073).
[1657] Exhibit 46, Tab 12, Statement of I403, 24 November 1989, [12] (SCOI.10566.00050).
[1658] Exhibit 46, Tab 13, Statement of Peter Russell, 24 November 1989, [7] (SCOI.02744.00077).
[1659] Exhibit 46, Tab 13, Statement of Peter Russell, 24 November 1989, [7] (SCOI.02744.00077).
[1660] Exhibit 46, Tab 12, Statement of I403, 24 November 1989, [9] (SCOI.10566.00050).
[1661] Exhibit 46, Tab 13, Statement of Peter Russell, 15 June 2001, [18] (SCOI.02744.00191).

Mr Russell's movements on 22 November 1989

5.2007. On the evening of 22 November 1989, Mr Russell was at home with his brother Peter in Bondi. Peter Russell described him as being in good spirits.[1662]

5.2008. I403 met Mr Russell at Peter Russell's place at about 6:00pm,[1663] and together they went to the Bondi Hotel at about 7 or 7:15pm.

5.2009. They sat in the bar and spoke of Mr Russell's plans to build a house on Mr Russell's father's farm at Wollombi. Mr Russell's grandfather had just died, and he and Peter were to inherit $100,000 each. They spoke of what Mr Russell was going to do with the money and about how there were "happy times ahead."[1664]

5.2010. Mr Russell drank with I403 at the Bondi Hotel until about 11:00pm, when I403 left. I403 guessed that I403 would have had 12–15 drinks during his time at the Hotel.[1665]

5.2011. Mr Russell had been buying I403 drinks because it was the day before I403's pay day. I403 guessed that by the time he left the Hotel, Mr Russell would have had about $10 or $15 left.[1666]

5.2012. I403 was supposed to meet Mr Russell again on Thursday, 23 November 1989 for dinner with friends at the Legion Club in Charing Cross.[1667]

Position of John Russell's body

5.2013. In his report of 14 August 2001, Dr Cala said he considered the position of John Russell's body to be unusual for a case of jumping or falling from a height. He said, "the body is facing towards the base of the cliff, which is unusual given the small height of the cliff, implying if the deceased acted alone, he has been able to twist his body 180 degrees to rest in the position depicted." Dr Cala considered he would not have been able to move at all following his fall.[1668]

5.2014. Dr Duflou also considered that the position of the body was "somewhat unusual for an accidental or suicidal fall" and agreed that it was unlikely that Mr Russell would have moved after the fall. [1669]

Marks Park, gangs and violence

5.2015. My observations above in relation to the death of Mr Warren apply equally to the death of Mr Russell.

5.2016. As there outlined, Marks Park in 1989 was a well-known beat.

[1662] Exhibit 46, Tab 8, Statement of Constable Michael Antony Barrett, 1 December 1989, [15] (SCOI.10386.00073).

[1663] Exhibit 46, Tab 13, Statement of Peter Russell, 24 November, [6] (SCOI.02744.00077).

[1664] Exhibit 46, Tab 12, Statement of I403, 24 November 1989, [5] (SCOI.10566.00050).

[1665] Exhibit 46, Tab 12, Statement of I403, 24 November 1989, [6] (SCOI.10566.00050).

[1666] Exhibit 46, Tab 12, Statement of I403, 24 November 1989, [7] (SCOI.10566.00050).

[1667] Exhibit 46, Tab 12, Statement of I403, 24 November 1989, [10] (SCOI.10566.00050).

[1668] Exhibit 6, Tab 157, Expert report of Dr Allan Cala, 14 August 2001 (SCOI.10386.00142).

[1669] Exhibit 6, Tab 171, Expert report of Professor Johan Duflou, 16 August 2017, 6 (SCOI.10385.00060).

5.2017. During the original investigation, each of the investigating police noted that the southern end of Notts Avenue, Bondi was frequented by "homosexuals". Constable Barrett said that he was aware of this from working as a constable at the Bondi Police Patrol for the previous two and half years and described the beat as being from south of the Bondi baths through to Mackenzie's Bay. [1670]

Pathology evidence

5.2018. The evidence of Dr Cala and Dr Duflou has been considered above, in connection with Strike Force Neiwand.

5.2019. On 20 July 2001, as part of Operation Taradale, Associate Professor Anthony Moynham, the Director of Clinical Forensic Medicine Unit of the NSW Police, furnished a report in which he observed the following, in relation to Mr Russell's blood alcohol concentration of 0.255:[1671]

a. "If there was no putrefaction of the body then the blood alcohol concentration in the blood sample would be the blood alcohol concentration of the victim at the time of death. At a blood alcohol concentration of 0.255 grams of alcohol in 100 millilitres of blood, it would be expected that the victim would have been displaying signs of marked intoxication at the time of his death."

b. "He would have had impaired balance, impaired coordination and impaired spatial orientation. He would have had diminished vision and hearing as well as poor judgment of things such as speed and distance. He would probably have personality and mood changes as well. He would have a diminished capacity to protect himself from danger."

c. "If there had been putrefaction of the body at the time when the blood sample was taken it is not possible to comment on the blood alcohol concentration."

5.2020. On 26 May 2016, Associate Professor Moynham provided a further report to Strike Force Neiwand. In this report he said that his opinion had not altered since the statement prepared on 20 July 2001. However, he said that based on additional information available to him, putrefaction is less likely to have occurred.

5.2021. He made additional observations including the following:[1672]

a. "The post mortem blood alcohol concentration of 0.255 grams of alcohol in 100 millilitres of blood was most likely his blood alcohol concentration at the time of death."

b. "This level of intoxication would make a person more prone to trauma as a consequence of physical impairment. It would also make a person more vulnerable to predatory behaviour by other persons. His capacity to protect

[1670] Exhibit 46, Tab 8, Statement of Constable Michael Antony Barrett, 1 December 1989, [17] (SCOI.10386.00030); Exhibit 46, Tab 7, Statement of Constable Sally Jane Dunbar, 16 February 1990, [13] (SCOI.10551.00031); Exhibit 6, Tab 155, Statement of Sergeant Adrian Macdonald Ingleby, 26 February 1990, [11] (SCOI.02744.00075).

[1671] Exhibit 46, Tab 28, Statement of Dr Anthony Frederick Moynham, 20 July 2001, 4 (SCOI.02744.00195).

[1672] Exhibit 46, Tab 48, Report of Adjunct Associate Professor Anthony Moynham, 26 May 2016, 7, 9 (SCOI.10446.00199).

or defend himself would be impaired. It must be noted that he also had a relatively small body weight of 55 kilograms."

c. "It is not possible to determine if he was the victim of an accident or if he was the victim of foul play. Both are possible."

5.2022. As is apparent, Associate Professor Moynham's evidence made clear that Mr Russell's blood alcohol concentration was capable of supporting either the possibility of Mr Russell's having been a victim of "predatory behaviour", or the possibility of misadventure.

DNA testing

5.2023. No testing of Mr Russell's clothes was carried out in late 1989 or in 1990. As at that time, DNA testing was not readily available to police in NSW. While it was more advanced in other countries including the UK and USA by then, it was still in the early stages of use even there.[1673]

5.2024. However, by 2001–2 (Operation Taradale) and 2016 (Strike Force Neiwand), such testing was possible, and both Operation Taradale and Strike Force Neiwand did make arrangements for some DNA testing of Mr Russell's clothing (the sloppy joe, jeans and shoes).

5.2025. The Inquiry has also itself arranged for further such testing, in 2023.

5.2026. The results of each of those three testing procedures are outlined in a statement by Ms Franco of FASS dated 23 August 2023, [1674] and are summarised in the following paragraphs.

5.2027. Ultimately, despite comprehensive forensic testing in 2023 using modern technologies and standards, a DNA profile sufficient for comparison has unfortunately not been recovered from any of the items of clothing.

TESTING UNDERTAKEN IN 2001/02

5.2028. Mr Russell's shoes, jeans and sloppy joe were examined for the presence of blood. Some of the areas where blood was present were cut out and underwent DNA testing.[1675]

5.2029. For the jeans and the shoes, that testing was unsuccessful. The amount of DNA recovered was very low and did not generate a DNA profile.

5.2030. For the samples cut out of the sloppy joe, the presence of dye in the DNA extract meant that DNA profiles were not able to be generated.

5.2031. As no DNA results were obtained, a reference sample from Mr Russell's father or brother was not requested at this time.

[1673] Exhibit 46, Tab 84, Statement of Michele Franco, 23 August 2023, [11] (SCOI.84089).

[1674] Exhibit 46, Tab 84, Statement of Michele Franco, 23 August 2023 (SCOI.84089).

[1675] Exhibit 46, Tab 84, Statement of Michele Franco, 23 August 2023, [14]–[28] (SCOI.84089).

TESTING UNDERTAKEN IN 2016

5.2032. In 2016, Strike Force Neiwand submitted to FASS samples from the jeans and sloppy joe for DNA testing. The samples included 14 tape-lifts (in tubes) and a section of material cut from the front of the sloppy joe.

5.2033. Additional testing was also conducted on the DNA extracts from areas of clothing previously sampled in 2002.

5.2034. Testing of the tape-lift samples produced weak and complex DNA mixtures (that originated from more than one person).

5.2035. There were no distinct patterns to the DNA mixtures recovered from the tape-lifts submitted in 2016.

5.2036. The testing conducted on the 2002 samples that had been stored in the FASS freezer was either unsuccessful because no DNA was detected, or the DNA recovered was too weak. A very weak partial profile with indications that it was a mixture of more than one contributor was found on samples from the jeans and sloppy-joe.

5.2037. In November 2016, Strike Force Neiwand enquired of FASS if there was anything further that could be done with the mix of weak and complex results. Further profiling/interpretation was considered to be not warranted, due to the complexity and low levels of the mixed DNA profiles and the limitations of the software available to interpret the results for databasing purposes.

5.2038. Again, because there was not a substantial DNA profile available for comparison purposes, FASS did not request that a sample be obtained from a family member of Mr Russell for such comparison testing.

TESTING UNDERTAKEN IN 2022/23

5.2039. In 2022 the Inquiry facilitated the retrieval of a reference sample from Mr Russell's brother Peter and this was provided to FASS. The sample was used to infer a DNA profile for Mr Russell.

5.2040. In the course of 2022 and 2023, testing was undertaken by FASS over some of the 2002 samples and 2016 tape-lifts that were still stored by FASS. In addition, fresh cut-outs from the clothing were also subjected to testing.

5.2041. An area of the jeans, from the front left ankle, recovered a weak partial DNA profile with indications it was a mixture of more than one contributor.

5.2042. An area of the sloppy joe, on the right cuff, recovered a very weak partial profile with indications of more than one contributor.

5.2043. Due to the low levels and complexity of the mixtures, Ms Franco was unable to comment on the similarities or differences of the mixed profiles.

5.2044. It was observed that the jeans had been washed as the stains looked washed-out and diluted.

TRANSFER AND PERSISTENCE

5.2045. Ms Franco was asked to comment on how long before Mr Russell's death it is likely that any DNA recovered came in contact with the relevant item of clothing.

5.2046. Ms Franco said that the DNA recovered in the testing was either "trace DNA" (originating from loose skin cells and cellular debris) or DNA from a stronger biological source of DNA, such as blood.

5.2047. Ms Franco advised that determining the time of deposition of trace DNA is not possible for a number of reasons, including:

a. First, the chain of custody of the items was not maintained, as the items of clothing were returned to Mr Russell's family (in about early December 1989, as described above) before they were forensically examined. DNA from skin cells (trace DNA) could potentially be deposited onto any of the items, from anyone who inspected the clothing, before the clothing was again returned to police and eventually examined in the lab;

b. Secondly, it is possible that trace DNA, composing loose cells and cellular debris, which may have been present on the clothing, was removed upon washing; and

c. Thirdly, trace DNA can be contaminated from an external source, such as with an examiner or handler's own DNA.

5.2048. Ms Franco noted that testing for trace DNA was only implemented in NSW in around 2000. In 1989, there was no awareness regarding exhibit handling practices to minimise DNA contamination, and they were therefore not part of standard police procedures then.

5.2049. Ms Franco observed that if a blood stain is washed in cold water soon after its deposition on a fabric, all traces of blood are likely to be removed. If blood has had time to set it is difficult to remove the staining.

5.2050. In Ms Franco's view, it is impossible to determine when the blood stains were deposited on the clothing. The stains appeared to be washed out and old looking, but all that can be stated is that they were present on the garments some time before they were examined in 2001/2002.

Manner and cause of death

Gilles Mattaini

5.2051. Both the manner and the cause of Mr Mattaini's death remain unknown.

5.2052. Accordingly the open finding made by Coroner Milledge is still appropriate, namely that:

> 5.2053. *Gilles Jacques Mattaini died on or about 15 September 1985 in Sydney. The cause and manner of his death remain undetermined.*

As to misadventure

5.2054. As to the possibility of misadventure, whilst it cannot be discounted, it does not seem particularly likely. Mr Mattaini was, on the evidence, very familiar with the walking paths in the area. Professor Brander considers it is highly unlikely that Mr Mattaini chose to go for a swim given the prevailing air and sea temperatures. There is some conflicting evidence about Mr Mattaini's interest in swimming, and swimming ability; however, if he did go swimming on the day he disappeared, conditions for swimming would have been challenging and hazardous.

As to suicide

5.2055. The submissions for the NSWPF were at great pains to emphasise the contention that suicide was more likely than homicide (which possibility the NSWPF submissions otherwise did not address).[1676] Indeed, according to the NSWPF, that conclusion was "inescapable".[1677]

5.2056. The factors said to support that contention included:

a. Mr Mattaini's concern about his visa;

b. Problems in his relationship with Mr Musy;

c. What were said to have been two previous suicide attempts, the second of those (while he was conscripted to the army) having occurred after Mr Mattaini had met Mr Musy;

d. Statistics referred to in the NSWPF submissions, not in evidence before me at that time, said to show that suicide was a prevalent cause of death in the relevant age group at the time;[1678] and

e. Evidence that Mr Mattaini was not a user of the Marks Park beat and was unlikely to have been out walking late at night.

5.2057. As to the supposed "second suicide attempt", the NSWPF acknowledged that Mr Musy's evidence at the Milledge inquest was that it was probably a device to get out of the army, but then argued that if "the attempt" was not motivated by a genuine desire to end his life, it is "suggestive of" significant degree of recklessness and/or a preparedness on Mr Mattaini's part to impulsively put his life at risk. Either way, it was submitted that the "second suicide attempt" was of significant relevance to the assessment of the ultimate manner and cause of Mr Mattaini's death."[1679]

5.2058. In my view, as was submitted by Counsel Assisting, suicide—although it cannot be ruled out—is unlikely to have been the cause of Mr Mattaini's death. In reaching this conclusion, I have had regard to the principles set out in the introduction to this Chapter.

[1676] Submissions of NSWPF, 13 July 2023, [61]–[75], [88]–[99] (SCOI.84454).

[1677] Submissions of NSWPF, 13 July 2023, [99] (SCOI.84454).

[1678] Submissions of NSWPF, 13 July 2023, [86]–[89] (SCOI.84454).

[1679] Submissions of NSWPF, 13 July 2023, [63]–[65] (SCOI.84454).

5.2059. While he was worried about his visa status, that was not weighing significantly upon him. In fact, in September 1985 he was, as he had been for years, "very, very happy", in a "very fulfilling relationship", [1680] someone who was "really enjoying life fully", [1681] and "happy" that Mr Musy would soon be back from his holiday. [1682] As to the "problems" in their relationship, Mr Musy's evidence was that they were not remotely as important as the great love and bond they shared.

5.2060. As to the "second suicide attempt", on the whole of the evidence it seems to me that Mr Musy's assessment in his sworn evidence at the Milledge Inquest (that it was probably a device to get out of the army) is likely to have been correct. Mr Musy's consistent recollection was that after meeting him, in 1978, Mr Mattaini never had or showed any suicidal ideation, but rather was very happy and indeed regarded his earlier such thoughts, prior to meeting Mr Musy, as "stupid". That being so, and given the evidence that Mr Mattaini was very unhappy in the army (after meeting Mr Musy), in my view the likelihood that he took a step which he expected (correctly as it turned out) to enable him to escape the army and resume his new relationship is a realistic one.

5.2061. As to the statistics, no attempt has been made on the part of the NSWPF to submit any material supportive of the assertion that is made by Senior Counsel. It is certainly not a matter about which anyone could take judicial notice, nor is it a matter of notoriety.

5.2062. As to walking at night, in fact Mr Musy's evidence was that Mr Mattaini would go walking "in the daylight hours and early evening", both to the north (towards Ben Buckler) and to the south (around Marks Park). [1683] When asked at the Milledge inquest what time of day he would usually walk, Mr Musy said: [1684]

> *It could be any time depending on the shift. He could have been working in the morning, could have been working in the evening. … he could have been by himself in the evening and I would be working at the hotel so he would just go yes for a walk yeah.*

As to homicide

5.2063. Both misadventure and suicide being in my view unlikely, the possibility of homicide cannot be ruled out.

5.2064. However, not only can that possibility not be ruled out, there is an abundance of evidence which establishes that at least by later in the 1980s, and probably at least by 1985, violent attacks on gay men in the Bondi-Tamarama-Marks Park area were increasingly common.

[1680] Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 49.4–21 (SCOI.82371).

[1681] Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 50.5–11 (SCOI.82371).

[1682] Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 51.28–40 (SCOI.82371).

[1683] Exhibit 6, Tab 159, Statement of Jacques Paul Musy, 3 August 2002, [12]–[13] (SCOI.02744.00090).

[1684] Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 50.27–41, (SCOI.82371).

5.2065. There appear to have been no reported assaults or suspected LGBTIQ bias deaths in Bondi in 1985. However, within a few years, later in the 1980s, even Strike Force Neiwand recognised that there was under way a "spate" of attacks on gay men in the Bondi-Tamarama area.[1685]

5.2066. Consistent with that is the substantial weight of evidence which establishes that, at least by the late 1980s, many such assaults were occurring but not being reported: see for example the statements of Sergeant Ingleby in 1990,[1686] and Detective Sergeant McCann in 1991. [1687]

5.2067. Moreover, Mr Wyszynski gave evidence at the Milledge Inquest that after coming to Sydney in late September 1985 and helping in the search for Mr Mattaini, he stayed in Sydney for about a year. He said:[1688]

> *I stayed in Sydney for about a year. We could not find Gilles. I remember that Marks Park had a reputation for a cruising place for gay men. It also had a reputation for being dangerous, there were bashings and robbing of gay men at the park. This was happening in 1985, I know this because I was told this by men who had been bashed and robbed and were too scared to report it to police.*
>
> *I experienced myself between 1986 and 1989. I saw a group of men, there were more than four. They came out of two different cars and they chased a number a [sic] men who were in the park. I was in the park as well and I ran away. I didn't go there for a few months after that. I can't remember what these men looked like. It was dark and I blew a whistle that I had with me to scare them off. I did not report this to police.*

5.2068. Mr Mattaini was a gay man, shy and quiet, who on the evidence may well have been walking near Marks Park on the day he went missing. Whether that was in the daytime or at night is not known. The area was notorious for attacks on gay men. In my view the possibility that he was the victim of such an attack is itself "inescapable".

Ross Warren

5.2069. As with Mr Mattaini, both the manner and the cause of Mr Warren's death remain unknown.

5.2070. However, it was submitted by Counsel Assisting that the finding made by Coroner Milledge in 2005 is still appropriate, namely that:

> *Ross Bradley Warren died in Sydney on or about 22 July 1989. Whilst the cause and manner of death are unknown, I am satisfied that the*

[1685] Exhibit 6, Tab 173, Strike Force Neiwand, Summary of Investigation – John Russell, 8 January 2018, [46]ff (SCOI.74882); Exhibit 6, Tab 174, Strike Force Neiwand, Summary of Investigation – Ross Warren, 8 January 2018, [62]ff (SCOI.74883).

[1686] Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 51.28–40 (SCOI.82371).

[1687] Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 51.28–40 (SCOI.82371).

[1688] Exhibit 44, Tab 4, Statement of Antony Jean Wyszynski, 3 August 2002, [15] (SCOI.02744.00382).

deceased was a victim of homicide perpetrated by person or persons unknown.

5.2071. The NSWPF submitted that "no issue is taken" with Coroner Milledge's finding.[1689]

5.2072. For all the reasons outlined above, I agree that the finding made by Coroner Milledge remains appropriate.

5.2073. In short, in my view:

a. There is nothing in the evidence which would provide a reasonable basis for any suggestion that suicide might have been likely;

b. Nor in my view is misadventure likely. Mr Warren was familiar with the area. His keys had been "placed" in the rock "pocket" near the water's edge. That would, or at least might, tend to suggest that he had made his way to that position safely;

c. However, the third possibility, namely homicide, is supported by a great deal of evidence, as outlined above, including:

i. The location where Mr Warren's keys and car were found was a well-known beat;

ii. The high probability is that Mr Warren went to Marks Park in the early morning of 22 July 1989 to use the beat; and

iii. The abundance of evidence of LGBTIQ hate assaults in the Bondi-Tamarama area (and other parts of Sydney) in the late 1980s and early 1990s, including the death of John Russell in November 1989, the assaults on I91, Mr Boxsell and Mr McMahon in November and December 1989, and the murder of Mr Rattanajurathaporn in July 1990, all in or near Marks Park.

John Russell

Cause of death

5.2074. As to the cause of Mr Russell's death, it is uncontroversial that, as Coroner Milledge found, Mr Russell died from "multiple injuries".

Manner of death

5.2075. Nothing in the evidence or submissions suggested that suicide was at all likely.

5.2076. Having regard to all the evidence, including that of Dr Cala, Dr Duflou and Associate Professor Moynham, summarised and discussed above, misadventure and foul play were both possible.

[1689] Submissions of NSWPF, 13 July 2023, [107] (SCOI.84454).

5.2077. However, the finding made by Coroner Milledge in 2005 was expressly that Mr Russell's "multiple injuries" were sustained "when he was thrown from the cliff onto rocks by a person or persons unknown". Her Honour's finding was, in full:

> *John Alan Russell died at Marks Park near Bondi* [NB not 'North Bondi'] *between 22 and 23 November 1989. The cause of death is multiple injuries sustained when he was thrown from the cliff onto rocks by a person or persons unknown.*

5.2078. In the submissions on behalf of the NSWPF, two very different positions were advanced in relation to that aspect of Coroner Milledge's finding.[1690]

5.2079. It was submitted by the NSWPF that:

> *her Honour's conclusion that [Mr Russell] was 'thrown' from the cliff onto rocks was … speculative; even accepting her Honour's conclusion that another person was involved. The mechanism of the fall remains entirely unexplained.*

5.2080. However, the NSWPF later submitted that "the Commissioner of Police accepts that the finding made by Detective Senior Constable Milledge in 2005 remains appropriate," and that "it remains open to the Inquiry" so to conclude.

5.2081. I do not agree that the proposition that Mr Russell was "thrown" from the cliffs could fairly be described as "speculative" on the evidence available. As set out in Coroner Milledge's findings, that conclusion was supported by the evidence of Dr Cala.[1691] Further, if it is accepted, per the evidence of both Dr Cala and Dr Duflou,[1692] that the hair on Mr Russell's hand is very unlikely to be his own, it is a reasonable inference that Mr Russell died following an altercation. In those circumstances it is no great stretch to conclude that Mr Russell was "thrown" from the cliff, or at any rate was forced from the cliff in circumstances that warrant no practical distinction. I accordingly consider that finding was open to Coroner Milledge and, as acknowledged by the NSWPF, is open to this Inquiry. I see no compelling reason to vary it.

Bias

Gilles Mattaini

5.2082. Mr Mattaini was gay and living with his partner. He was known to walk around the Bondi-Tamarama-Marks Park area, which included the well-known Marks Park beat.

5.2083. Certainly by the late 1980s, and probably by at least 1985, the area was notorious for violent attacks on gay men.

[1690] Submissions of NSWPF, 13 July 2023, [46], [112] (SCOI.84454).

[1691] Exhibit 6, Tab 161, Findings and recommendations of Deputy State Coroner Milledge, Inquest into the death of John Alan Russell, Inquest into the suspected deaths of Ross Bradley Warren and Gilles Jacques Mattaini, 9 March 2005, 7 (SCOI.02751.00021).

[1692] Exhibit 6, Tab 157, Expert report of Dr Allan Cala, 14 August 2001, 3 (SCOI.10386.00142); Exhibit 6, Tab 171, Expert report of Professor Johan Duflou, 16 August 2017, 8–9 (SCOI.10385.00060).

5.2084. The evidence was that he did not use the beat himself. Moreover, the last known sighting of him, according to "Terry", was in the morning.[1693] However, he was known to go for walks in the area at any time of the day, including in the evening.

5.2085. It was submitted by Counsel Assisting that there is a distinct possibility that Mr Mattaini was murdered, and that (if so) LGBTIQ bias was likely to have been a factor in his death, while acknowledging that the available evidence does not permit a positive conclusion in either of those respects.[1694]

5.2086. The NSWPF submitted that it is unlikely (though not impossible) that Mr Mattaini's death was caused by LGBTIQ bias.[1695]

5.2087. In my view, for the reasons outlined above, while the evidence does not enable me to conclude positively that Mr Mattaini's death was a homicide, that possibility is a real one and can by no means be ruled out. That is to say, there is, objectively, reason to suspect that the death was a homicide.

5.2088. Since misadventure and suicide also cannot be conclusively ruled out, it is also not possible for me to reach a positive conclusion that LGBTIQ bias was a factor in Mr Mattaini's death.

5.2089. However, in my view, the presence of the factors identified above means that there is also, objectively, more than sufficient reason to suspect that LGBTIQ bias was a factor in the death of Mr Mattaini.

Ross Warren

5.2090. Counsel Assisting submitted that it was "highly probable" that Mr Warren met his death "at the hands of one or more gay hate assailants", and, further, that the evidence is "sufficient to establish that Mr Warren's death was a gay hate crime, that is, a death in which LGBTIQ bias was a factor".

5.2091. In making the submissions, Counsel Assisting drew attention in particular to the matters referred to above.

5.2092. The NSWPF did not directly respond to those submissions. However, as I have noted above, the NSWPF submitted that "no issue is taken" with Coroner Milledge's finding,[1696] and the NSWPF also submitted that Strike Force Parrabell's categorisation of Mr Warren's death as "suspected bias crime" was an appropriate one.[1697]

5.2093. That would appear to indicate, so far as I can deduce, substantial agreement with Counsel Assisting's overall submission on this point.

5.2094. My own view, based on all the evidence, is that the submission by Counsel Assisting is a powerful and justified one.

[1693] Exhibit 6, Tab 280, Transcript of the Coronial Inquest into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 1 April 2003, 54.13–55.20 (SCOI.82371).

[1694] Submissions of Counsel Assisting, 27 June 2023, [403] (SCOI.84160).

[1695] Submissions of NSWPF, 13 July 2023, [100] (SCOI.84454).

[1696] Submissions of NSWPF, 13 July 2023, [107] (SCOI.84454).

[1697] Submissions of NSWPF, 13 July 2023, [109] (SCOI.84454).

5.2095. However, as I have explained in **Chapter 1,** the question which I must answer is not whether the presence of LGBTIQ bias has actually been "established", as a fact. Rather, it is whether there is, objectively, reason to suspect both that the death was a homicide and that the membership of the LGBTIQ community (actual or assumed) of the deceased person, was a factor in the commission of the crime.

5.2096. I have provided my reasons above as to why there is, objectively, reason to suspect that the death was a homicide. The evidence is also amply sufficient for me to be satisfied that there is also, objectively, reason to suspect that LGBTIQ bias was a factor in the death of Mr Warren.

John Russell

5.2097. Counsel Assisting submitted that it is "highly probable" that Mr Russell met his death at the hands of one or more gay hate assailants, and that the evidence is "sufficient to establish" that Mr Russell's death was "a gay hate crime, that is, a death in which LGBTIQ bias was a factor".[1698]

5.2098. The NSWPF submitted that "the Commissioner of Police agrees that the Inquiry could properly conclude that Mr Russell's death was a gay hate crime."[1699]

5.2099. Among the matters that point to the likelihood that LGBTIQ bias was a factor in Mr Russell's death were:

a. The location where Mr Russell's body was found, being a well-known beat;

b. The probability that Mr Russell attended Marks Park to use the beat on the night that he was last seen;

c. The position in which Mr Russell's body was found, being unusual for an accidental fall;

d. The coins scattered around Mr Russell's body, possibly having been used by him to indicate a desire for contact at the beat;

e. The strands of hair found on Mr Russell's left index finger, likely to have been from another person;

f. The position of his sloppy joe, as remarked upon by both Dr Cala and Dr Duflou;

g. The assault on Mr McMahon only a month later, at the same location as where Mr Russell's body was found;

h. The abundance of evidence of LGBTIQ bias assaults in the Bondi-Tamarama area (and other parts of Sydney) in the late 1980s and early 1990s, including the disappearance of Ross Warren in July 1989, the assaults on I91, Mr Boxsell and Mr McMahon in November and December 1989, and the murder of Mr Rattanajurathaporn in July 1990, all in or near Marks Park.

[1698] Submissions of Counsel Assisting, 27 June 2023, [483], [485] (SCOI.84160).

[1699] Submissions of NSWPF, 13 July 2023, [113] (SCOI.84454).

5.2100. For the reasons outlined above, while it is not possible to conclude positively that Mr Russell's death was a homicide, that possibility in my view is more likely than the alternative namely misadventure. Certainly, in my view, there is, objectively, reason to suspect that the death was a homicide.

5.2101. Since misadventure cannot be conclusively ruled out, it is also not possible to reach a positive conclusion that LGBTIQ bias was a factor in Mr Russell's death.

5.2102. However, as I have explained in **Chapter 1**, the question which I must answer is whether there is objectively reason to suspect two things: first, that the death was a homicide (which in my view there is), and secondly, that LGBTIQ bias was a factor in the commission of the crime.

5.2103. In my view, the presence of the factors identified above means that there is also, objectively, reason to suspect that LGBTIQ bias was a factor in the death of Mr Russell.

Conclusions and Recommendations

5.2104. In respect of the death of Mr Mattaini:

a. I find that Gilles Jacques Mattaini died on or about 15 September 1985 in Sydney. The cause and manner of his death remain undetermined.

b. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect both that the death of Mr Mattaini was a homicide, and that LGBTIQ bias was a factor in the death.

5.2105. In respect of the death of Mr Warren:

a. I find that Ross Bradley Warren died in Sydney on or about 22 July 1989. Whilst the cause and manner of death are unknown, I am satisfied that the deceased was a victim of homicide perpetrated by person or persons unknown.

b. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in the death.

5.2106. In respect of the death of Mr Russell:

a. I find that John Alan Russell died at Marks Park near Bondi *[NB not 'North Bondi']* between 22 and 23 November 1989. The cause of death is multiple injuries sustained when he was thrown from the cliff onto rocks by a person or persons unknown.

b. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in the death.

IN THE MATTER OF WILLIAM (BILL) ANTONY ROONEY

Factual background

Date and location of death

5.2107. William Antony Rooney died at approximately 2:30pm on 20 February 1986 at Wollongong Hospital.[1700]

Circumstances of death

5.2108. At around 8:40am on Friday, 14 February 1986, Mr Rooney was found on the ground between a toilet block and a concrete retaining wall at the rear of retail premises named "L&B Discounts" in Crown Lane, Wollongong, near Annabel's Disco. At the top of the wall, which was about three metres high, was a small car parking area. The gap between the wall and the toilet block was about 0.5 metres.[1701]

5.2109. Mr Rooney was alive but suffering from serious head injuries and in a semi-conscious condition. He was transported by ambulance to Wollongong Hospital, but died from his injuries six days later on 20 February 1986. He was 35 years old.[1702]

Previous investigations

Original police investigation

5.2110. The original police investigation was overseen by Wollongong Police Station. Constable Michael Tranby was the OIC.

[1700] Exhibit 22, Tab 1, P79A Report to Death to Coroner, 20 February 1986 (SCOI.11269.00002).

[1701] Exhibit 22, Tab 14, Statement of Detective Sergeant Stephen George Passmore, 22 October 1986, [3] (SCOI.11269.00016).

[1702] Exhibit 22, Tab 3, Death Certificate of William Rooney, 20 February 1986 (SCOI.82611).

Findings of post-mortem examination

5.2111. A post-mortem examination was carried out by Dr Vincent Verzosa, forensic pathologist, at 10:15am on 21 February 1986 at Wollongong Hospital Mortuary, and a report was completed the same day.[1703] The handwritten post-mortem report included the following findings:[1704]

a. The death had taken place about 21 hours previously;

b. The direct cause of death was "massive (subdural) cerebral haemorrhage and intracardiac thrombus"; and

c. Antecedent causes of death were "torn meningeal vessels" and "basal skull fractures – most probably due to a fall with back of head hitting a hard surface".

5.2112. The report also included the following observations:[1705]

a. Mr Rooney's body had features consistent with his stated age, was fairly nourished, of medium build, about 5 feet 11 inches tall, and showing some bruises on the limbs and chest;

b. Mr Rooney had an oval abrasion/contusion about 3.5 inches long and 3 inches wide on his left upper limb, on the medial half of the elbow region. Mr Rooney's right knee showed a contusion/abrasion;

c. In relation to Mr Rooney's head region:

i. His scalp showed a diffuse haematoma across the lower half of the occipital area, horizontally extending from one side to the other side of the back of the head;

ii. His skull showed basal linear fractures on the posterior and middle cranial fossa. The posterior fossa showed a horizontal fracture running around the whole length of the lower portion of the occipital bone extending upwards to the floor of the temporal fossa on both sides. Another fracture on the posterior fossa was seen on the right half, running forwards near the middle of this area, reaching the lower margin of the foramen magnum. The horizontal fracture caused a tear of the branches of the middle meningeal arteries on both sides;

iii. His brain showed massive blood clot accumulation covering almost the entire surfaces of both cerebral hemispheres and cerebellar lobes. The bleeding was mainly subdural in character, coming from torn meningeal vessels; and

iv. His neck showed no fracture/dislocation or any apparent abnormality of other structures.

[1703] Exhibit 22, Tab 4, Post-mortem Report of Dr Vincent Verzosa, 21 February 1986 (SCOI.11269.00006).

[1704] Exhibit 22, Tab 4, Post-mortem Report of Dr Vincent Verzosa, 21 February 1986, 2 (SCOI.11269.00006); Dr Verzosa confirmed this opinion in his evidence at the inquest: Exhibit 22, Tab 8, Transcript of Coronial Inquest into the death of William Rooney, 15 May 1987, 4-5 (SCOI.03683.00013).

[1705] Exhibit 22, Tab 4, Post-mortem Report of Dr Vincent Verzosa, 21 February 1986 (SCOI.11269.00006).

Exhibits

5.2113. There is no record of any exhibits having been collected or retained in this case.

Persons of Interest

LESLIE JOHN HARRISON

5.2114. Between 15 and 17 February 1986, Leslie John Harrison, who was also known as "Radar", appears to have been a person of interest.

5.2115. However, by 17 February 1986, so far as can be ascertained on the material available to the Inquiry, police had ceased pursuing any enquiries in relation to the possible involvement of Mr Harrison in the death of Mr Rooney.

5.2116. Mr Harrison died in 2004.

MARK ANTHONY SCERRI

5.2117. By about late 1989, Mark Anthony Scerri had emerged as a key person of interest in relation to the death of Mr Rooney.

5.2118. On 26 September 1989, Mr Scerri was arrested and charged with a range of offences relating to a series of vicious assaults and sexual assaults inflicted on a total of 12 men, between March 1986 and September 1989, most of which occurred in and around the Wollongong area. Nine of the men identified Mr Scerri as the offender.

5.2119. Charges in respect of nine of the 12 men were the subject of four separate trials in 1991 and 1992.

5.2120. In one of those four trials, Mr Scerri was convicted of seven sexual offences relating to three of the men, all of whom had been attacked in 1989. Those charges, in respect of those three victims, were heard together in one trial, in the Supreme Court in November 1992.

5.2121. The attack on one of those three men, referred to as I194, occurred in September 1989 on the other side of the same laneway (Crown Lane) where Mr Rooney had been found several years earlier on 14 February 1986.[1706]

5.2122. On 19 February 1993, Mr Scerri was sentenced to 16 years' imprisonment in relation to the offences committed against those three men.[1707] He had been in custody since September 1989, and was to be eligible for parole no earlier than September 2001.

5.2123. In relation to the charges involving the other nine men, either Mr Scerri was acquitted of the relevant charges (six men) or they did not proceed to trial (three men).

[1706] *State of New South Wales v Scerri* [2011] NSWSC 683, [29].

[1707] *State of New South Wales v Scerri* [2011] NSWSC 683, [24].

5.2124. On 24 March 1993, police sent a brief to the then Deputy Senior Crown Prosecutor, Mark Tedeschi KC, for advice as to whether Mr Scerri could be charged with the murder of Mr Rooney.[1708] On 28 June 1993, the ODPP advised that in the opinion of Mr Tedeschi QC there was insufficient evidence to do so.

5.2125. The attack on another one of the men, referred to as I186, in relation to which Mr Scerri was acquitted, occurred in December 1986, only ten months after Mr Rooney's death in February 1986. I186 alleged that his attacker had said to him during the attack, "I'll kill you like I killed the poofter in the laneway."[1709]

5.2126. On 24 November 2001, Mr Scerri was released on parole.[1710]

5.2127. Less than six months later, on 12 May 2002, Mr Scerri attacked a 26 year old man, referred to in subsequent criminal proceedings as 'JS'. The circumstances of that attack had several features similar to the attacks the subject of the previous charges in the late 1980s.

5.2128. On 16 October 2002, Mr Scerri was arrested in connection with the attack on JS, and charged with, relevantly, one count of sexual intercourse without consent. In February 2003, Mr Scerri pleaded guilty.[1711]

5.2129. On 12 September 2003, Judge Phelan sentenced Mr Scerri to an effective term of eight years to commence on 12 September 2003, with a non-parole period of six years.[1712]

5.2130. Until 2023, Mr Scerri had never been questioned in relation to the death of Mr Rooney. An attempt to interview him in 1993, following the receipt of Mr Tedeschi KC's advice, was fruitless because Mr Scerri, then in custody, refused to speak to the police.[1713]

5.2131. In May 2023, Mr Scerri was questioned in a private hearing of the Inquiry. That evidence is the subject of a confidential part of this Report.

Findings at inquest

5.2132. The inquest was held on 24 October 1986 and 15 May 1987, before Coroner Warwick Soden.

[1708] Exhibit 22, Tab 35, Letter from Chief Superintendent P Cassidy to Mark Tedeschi QC, 24 March 1993 (SCOI.11269.00003); Exhibit 22, Tab 34, Letter from Inspector D Ainsworth to Craig Hyland, 17 March 1993 (SCOI.11076.00007).

[1709] Exhibit 22, Tab 26, Statement of I186, 14 October 1989, [7] (SCOI.11293.00035).

[1710] *State of New South Wales v Scerri* [2012] NSWSC 271, [6].

[1711] *State of New South Wales v Scerri* [2012] NSWSC 271, [7].

[1712] *State of New South Wales v Scerri* [2012] NSWSC 271, [7].

[1713] Exhibit 22, Tab 16, Statement of Detective Senior Constable Paul Anthony Davidson, 23 May 1993, [4] (SCOI.11076.00025).

5.2133. At the Inquest, Dr Mason Ramsay, the Director of Intensive Care at the Illawarra Health Service and Mr Rooney's treating doctor, gave evidence that Mr Rooney's head injuries and markings on the arms and chest were "probably due to a fall".[1714] When asked whether the injuries to Mr Rooney's skull were consistent with a fall from three metres onto a concrete floor, Dr Ramsay responded, "I find it hard to believe so".[1715] Dr Ramsay also said that the bruising to the front right of Mr Rooney's chest did not seem to "line up with" a fall from three metres.[1716]

5.2134. However, Dr Verzosa gave evidence, consistent with his post-mortem report, referred to above that he considered that the injuries to Mr Rooney's head had been caused by his head hitting a hard flat surface rather than being struck with an object to the back of the head, since in his experience that would usually result in the skin being split open, which was not the case with Mr Rooney.[1717]

5.2135. On 15 May 1987, Coroner Soden found:[1718]

> *that the deceased on 20th February, 1986 at Wollongong Hospital in the State of New South Wales died of the effects of head injuries sustained on 14.2.86 but whether such injuries were received accidentally or otherwise the evidence does not enable me to say.*

Criminal proceedings

5.2136. No criminal proceedings have ever been instituted against any person in relation to Mr Rooney's death.

Subsequent police consideration

Reviews by Detective Inspector Ainsworth

5.2137. On 3 July 1990, Detective Inspector Ainsworth (the OIC in relation to the prosecution of Mr Scerri for the 12 attacks that occurred between 9 March 1986 and 22 September 1989) viewed the video footage of Mr Rooney in Crown Lane, apparently taken by a cameraman from WIN Television.[1719]

5.2138. On 4 July 1990, Detective Inspector Ainsworth compiled a letter to the ODPP which outlined the available evidence in support of his view that Mr Rooney had been sexually assaulted and murdered by Mr Scerri. Detective Inspector Ainsworth's letter requested that a substantial reward be offered for information in relation to the death of Mr Rooney, and that the ODPP consider charging Mr Scerri for the murder of Mr Rooney.[1720]

[1714] Exhibit 22, Tab 7, Transcript of Coronial Inquest into the death of William Rooney, 24 October 1986, 5 (SCOI.03683.00011).

[1715] Exhibit 22, Tab 7, Transcript of Coronial Inquest into the death of William Rooney, 24 October 1986, 6 (SCOI.03683.00011).

[1716] Exhibit 22, Tab 7, Transcript of Coronial Inquest into the death of William Rooney, 24 October 1986, 7 (SCOI.03683.00011).

[1717] Exhibit 22, Tab 8, Transcript of Coronial Inquest into the death of William Rooney, 15 May 1987, 5 (SCOI.03683.00013).

[1718] Exhibit 22, Tab 9, Findings of Coroner Warwick Graeme Soden, Inquest into the death of William Rooney, 15 May 1987 (SCOI.11269.00008).

[1719] Exhibit 22, Tab 34, Letter from Inspector D Ainsworth to Craig Hyland, 17 March 1993, 11 (SCOI.11076.00007).

[1720] Exhibit 22, Tab 34A, Letter from Inspector D Ainsworth to Paul Conlon, 4 July 1990, [55] (SCOI.83191).

5.2139. On 28 March 1991, Detective Inspector Ainsworth referred the case of Mr Rooney to the ODPP, for consideration of an *ex officio* charge against Mr Scerri for the murder of Mr Rooney.[1721] It seems that Detective Inspector Ainsworth's 4 July 1990 letter was among the material considered by the ODPP at that time.

5.2140. However, on 26 April 1991, the ODPP declined to lay an *ex officio* charge for the murder of Mr Rooney, stating:[1722]

> *this being a murder charge, it is not in my view a matter where an ex officio indictment would be filed without the accused having the benefit of committal proceedings. I therefore recommend that the trial proceed in respect of the sexual assaults and depending upon the outcome thereof and the strength of the "similar fact" evidence, consideration should then be given by the police as to whether, taking into account the alleged admission, there is sufficient evidence to warrant charging the accused for the murder.*

5.2141. As noted above, on 24 March 1993, police wrote to Mr Tedeschi QC, requesting advice as to whether Mr Scerri could be charged with the murder of Mr Rooney.[1723]

5.2142. Annexed to this letter was a brief which had been prepared by Detective Inspector Ainsworth. That brief included a letter to the ODPP dated 17 March 1993, which was substantially in the same terms as Detective Inspector Ainsworth's 4 July 1990 letter.[1724]

5.2143. As also noted above, on 28 June 1993, the ODPP advised that it was the opinion of Mr Tedeschi QC that there was insufficient evidence to charge Mr Scerri for Mr Rooney's death.[1725] One reason for that opinion was the absence of evidence that Mr Rooney had been sexually assaulted.

2002: suggestion of exhumation

5.2144. On 17 October 2002, the day after Mr Scerri's arrest, Detective Senior Constable Bridge, from the Investigations Office in Wollongong, wrote to Dr Johan Duflou of DOFM, requesting:[1726]

> *an opinion from a Pathologist whether the body of William ROONEY would be suitable after exhumation to be examined for possible collection of semen samples from the rectum and throat areas of ROONEY's remains.*

5.2145. In that same letter, Detective Senior Constable Bridge told Dr Duflou that Mr Scerri "initially committed offences against homosexuals in 1986 as they were easier targets but apparently reverted to targeting hetrosexual (sic) males in fear of catching AIDS".[1727]

[1721] Exhibit 22, Tab 32, Letter from Sally Dowling SC to Kate Lockery, 3 April 2023, 3 (SCOI.82610).

[1722] Exhibit 22, Tab 32, Letter from Sally Dowling SC to Kate Lockery, 3 April 2023, 3 (SCOI.82610).

[1723] Exhibit 22, Tab 35, Letter from Chief Superintendent P Cassidy to Mark Tedeschi QC, 24 March 1993 (SCOI.11269.00003).

[1724] Exhibit 22, Tab 34, Letter from Inspector D Ainsworth to Craig Hyland, 17 March 1993 (SCOI.11076.00007).

[1725] Exhibit 22, Tab 32, Letter from Sally Dowling SC to Kate Lockery, 3 April 2023, 3 (SCOI.82610).

[1726] Exhibit 22, Tab 28, Letter from Detective Senior Constable Steve Bridge to Dr Johan Duflou, 17 October 2002 (SCOI.11269.00024).

[1727] Exhibit 22, Tab 28, Letter from Detective Senior Constable Steve Bridge to Dr Johan Duflou, 17 October 2002 (SCOI.11269.00024).

5.2146. On 23 October 2002, Dr Duflou replied that "decomposition does dramatically affect the ability to retrieve such trace evidence" and that it is "highly unlikely that any usable DNA will be available at this very late stage". Dr Duflou concluded that "there is an extremely low chance of retrieving DNA from an assailant in this case".[1728]

5.2147. Given that Detective Senior Constable Bridge wrote to Dr Duflou the day after Mr Scerri was arrested in connection with the attack on JS, it seems likely that it was Mr Scerri's reoffending which reignited interest in the case of Mr Rooney. However, this appears to have been the only new step taken at the time.

5.2148. The Inquiry has ascertained that in fact Mr Rooney's remains were cremated. "Exhumation" accordingly was not possible in any event.[1729]

UHT Review

5.2149. Mr Rooney's death has not been the subject of any review by the UHT.

Strike Force Parrabell

Bias Crimes Indicators Form

5.2150. All ten indicators in the BCIF were answered "No Evidence of Bias Crime". Yet the overall categorisation of the case in the "Summary of Findings" section was "Insufficient Information". Counsel Assisting submitted that this in itself would appear to suggest some inconsistencies or confusion in the methodology of Strike Force Parrabell. At the very least, it was submitted, a question arises about the coherence and rigour of the methodology of the strike force when the overall categorisation of a case review bears no correlation to the components of that review. Further discussion on this point can be point in **Chapter 13**.

5.2151. In seven of the ten "General Comment" sections, and also in the "Summary of Findings", the possible involvement of Mr Harrison and/or Mr Scerri in Mr Rooney's death, as possible bias crime attackers, was mentioned.[1730] The uniform answer of "No Evidence of Bias Crime", to all ten indicators, seems at odds with those comments.

5.2152. The "General Comment" sections repeatedly noted that Mr Scerri was known to have been involved in other assaults against, and rapes of, men in locations not far from the area where Mr Rooney was found, and was known to hit his victims over the head with bricks or large rocks. The alleged involvement of Mr Harrison in similar conduct was also repeatedly noted.

5.2153. Yet the "General Comment" section in relation to indicator 3, "Drawings, Markings, Symbols, Tattoos, Graffiti", stated as follows (emphasis added):[1731]

[1728] Exhibit 22, Tab 29, Letter from Dr Johan Duflou to Detective Senior Constable Steve Bridge, 23 October 2002 (SCOI.11269.00025).

[1729] Exhibit 22, Tab 3, Death Certificate of William Rooney, 20 February 1986 (SCOI.82611).

[1730] Exhibit 22, Tab 30, Strike Force Parrabell, Bias Crimes Indicators Review Form – William Rooney, undated (SCOI.03077).

[1731] Exhibit 22, Tab 30, Strike Force Parrabell, Bias Crimes Indicators Review Form – William Rooney, Undated 7-8 (SCOI.03077) (emphasis added).

> *In Photographs taken of the crime scene by Detective Sergeant PASSMORE there is photographic evidence showing what appears to be a concrete rock near where ROONEY was located however this bears no weight on a bias motivation.*

5.2154. As Counsel Assisting submitted, the view that the presence of a concrete rock at the scene "bears no weight" on a bias motivation, in light of what was by then known or alleged (and acknowledged in the BCIF) about the *modus operandi* of both Mr Harrison and Mr Scerri, is difficult to fathom.

5.2155. The presence of the rock would also appear to cast some doubt upon the (unsigned) statement of Detective Sergeant Passmore, referred to elsewhere in the BCIF. Detective Sergeant Passmore took the photographs which show the rock on 14 February 1986, and yet, according to his unsigned statement eight months later, he "made a thorough search of the entire area and found nothing which [he] could associate with ROONEY'S injuries".[1732] The Strike Force Parrabell officers made no comment on, or reference to, this apparent inconsistency.

5.2156. In the General Comment section in relation to indicator 5, "Previous existence of Bias Crime Incidents", the Strike Force Parrabell officers stated that "[t]here is no evidence to suggest ROONEY was visiting a location where previous bias crime had been committed".[1733] However, as noted elsewhere in the BCIF, the Strike Force Parrabell officers recognised there was "evidence presented in regards to the suspect SCERRI being involved in assaulting, kidnapping and robbing both homosexual and heterosexual males within the area where ROONEY was located" (albeit shortly after, rather than before, Mr Rooney's death).[1734] It would appear that this evidence was given little or no weight by the Strike Force Parrabell officers.

5.2157. The "Summary of Findings" in the BCIF highlights the following matters:[1735]

a. Mr Harrison was arrested and interviewed during the investigation into Mr Rooney's death;

b. Mr Scerri was later suspected of the murder of Mr Rooney and advice was sought in relation to charging him with that offence;

c. Mr Scerri was known, and Mr Harrison was alleged, to have been responsible for rapes and bashings of men in the area, and to hit their victims over the head with bricks;

d. Mr Scerri was involved in "assaulting, kidnapping and robbing both homosexual and heterosexual males" in or near Wollongong between March 1986 and September 1989, including close to the area where Mr Rooney had been found in February 1986;

[1732] Exhibit 22, Tab 14, Statement of Detective Sergeant Stephen George Passmore, 22 October 1986, [3] (SCOI.11269.00016).

[1733] Exhibit 22, Tab 30, Strike Force Parrabell, Bias Crimes Indicators Review Form – William Rooney, Undated 9 (SCOI.03077).

[1734] Exhibit 22, Tab 30, Strike Force Parrabell, Bias Crimes Indicators Review Form – William Rooney, Undated 10 (SCOI.03077).

[1735] Exhibit 22, Tab 30, Strike Force Parrabell, Bias Crimes Indicators Review Form – William Rooney, Undated 19–20 (SCOI.03077).

e. In photographs of the crime scene taken by Detective Sergeant Passmore, what appears to be a concrete rock is visible near where Mr Rooney was located;

f. In the original investigation, it was thought Mr Rooney fell to his death, the paramedic was of the opinion Mr Rooney had fallen, there was no evidence of any "weapons of opportunity", and the coroner delivered an open finding; and

g. Detective Inspector Ainsworth held the view that the death of Mr Rooney was never properly investigated by the NSWPF and that Mr Scerri was responsible for it.

5.2158. Thus, there was a notable focus in the BCIF on Mr Scerri and Mr Harrison as persons of interest in the death of Mr Rooney, on their known or alleged methods, and on the presence of the rock. Yet in relation to every single indicator, the Strike Force Parrabell officers answered "No Evidence of Bias Crime". The BCIF referred to Mr Scerri's other offences (both alleged and proven), and to the allegations against Mr Harrison, but then seemingly discounted this evidence as having any bearing on the question of bias. The basis for such apparent discounting is unclear.

5.2159. The NSWPF submitted that "the overall conclusion of SF Parrabell in each case was not a product of some mathematical process involving the BCIF indicators" but was a product of "a consensus determination by the senior officers involved".[1736] It was submitted that the BCIF indicators were filled out by "the initial reviewing officer" whereas the "Summary of Findings" section was "reflective of the discussions and consensus reached by the senior members of the SF Parrabell team".[1737]

5.2160. These submissions by the NSWPF are rejected for the following reasons:

a. First, such submissions fail altogether to grapple with how any such "consensus", by the three-member review committee finalising the whole BCIF (not just the "Summary of Findings"), could simultaneously reach two different outcomes; and

b. Secondly, as the evidence of Detective Senior Constable Bignell in Public Hearing 2 revealed, it was actually Detective Senior Constable Bignell, alone, who filled in the entirety of the BCIF in every case, both the responses to the ten indicators and the "Summary of Findings", and only a handful of "pretty minor" changes were made to any of the 80-plus BCIFs by the review committee (of which he was one of the three members).[1738]

[1736] Submissions of NSWPF, 1 June 2023, [18] (SCOI.83645).

[1737] Submissions of NSWPF, 1 June 2023, [19] (SCOI.83645).

[1738] Transcript of the Inquiry, 21 September 2023, T5789.7-5820.47 (TRA.00089.00001).

5.2161. The NSWPF also submitted that the overall categorisation of "Insufficient Information" was "accurate". That was said to be so because it is not possible to be satisfied about what caused Mr Rooney's death, and because even if Mr Rooney died as a result of an assault, that would not "inexorably lead to a conclusion" that his death was "occasioned by anti-LGBTIQ bias". It was submitted that such a conclusion would be "entirely speculative".[1739]

5.2162. To praise the "accuracy" of the "conclusion" (i.e. "Insufficient Information") seems to me to betray a failure to appreciate the nature of the problem under consideration.

5.2163. These submissions by the NSWPF highlight some of the shortcomings inherent in the BCIF methodology generally (discussed at greater length elsewhere in this Report), including the high standard of proof ("beyond reasonable doubt") required for a finding of "Evidence of Bias Crime", and the essentially subjective or "intuitive" nature of the exercise.

5.2164. Moreover, there is, in my view, (as was submitted by Counsel Assisting) a logical disconnect between:

a. The repeated acknowledgement in the BCIF of factors relevant to LGBTIQ bias;

b. The uniform response of "No Evidence of Bias Crime" to all ten indicators; and

c. An overall categorisation of "Insufficient Information".

5.2165. As Counsel Assisting submitted, this BCIF (like many others) is replete with repetition from one indicator to the next, and reflects a treatment of the case that appears to be devoid of any analytical sophistication or nuance. Counsel Assisting observed that it is unclear whether this is a consequence of having limited time to complete the review (it appears Strike Force Parrabell had originally recorded Mr Rooney's last name as "Rudney" and hence for some time could locate no material about the case),[1740] or whether this indicates a more systemic problem with the work of Strike Force Parrabell, or both. I further consider the BCIF in **Chapter 13.**

5.2166. Counsel Assisting also noted, correctly, that the BCIF fails to address, or even engage with, the failures of the original investigation, including how those failures continue to impede the ability of any reviewer (including Strike Force Parrabell) to establish the manner and cause of Mr Rooney's death.

5.2167. The NSWPF did not engage with these submissions in any substantive way, other than to say that it was "not within the scope or resourcing of SF Parrabell to conduct a comprehensive analysis of the nature or quality of the initial investigations".[1741]

[1739] Submissions of NSWPF, 1 June 2023, [22]–[24] (SCOI.83645).

[1740] Exhibit 22, Tab 45, Rick Feneley and Patrick Abboud, 'Police admit blunders in gay-hate murder hunt', *SBS News* (online, 4 October 2016) (SCOI.82587).

[1741] Submissions of NSWPF, 1 June 2023, [25] (SCOI.83645).

Case Summary

5.2168. The Case Summary for this matter reads as follows:[1742]

> ***Identity:*** *William Antony Rooney was 35 years old at the time of his death.*
>
> ***Personal History:*** *Mr Rooney's partner was the last person to see him alive.*
>
> ***Location of Body/Circumstances of Death:*** *Mr Rooney was discovered in a semi-conscious state on the morning of 14 February 1986 behind the L&S [sic] Discount store in Crown Lane, Wollongong. Mr Rooney was hospitalised suffering head injuries however died 6 days later due to a large skull fracture. The original police investigation concluded that Mr Rooney may have fallen. In 2002 a further police investigation was conducted with a suspect identified for assaulting and possibly sexually assaulting Mr Rooney. After Mr Rooney's death, 12 other men became victims of the same suspect in similar circumstances with all violently assaulted with a rock and then raped. The suspect identified as gay and was described as an extremely violent individual. The second investigation into Mr Rooney's death suggested that he should be considered the suspect's first victim in what was proven to be a lengthy period of violence and rapes of gay men.*
>
> ***Sexual Orientation:*** *Mr Rooney identified as gay.*
>
> ***Coroner/Court Findings:*** *In 1990 Police charged the suspect with 29 serious and violent offences against 12 other male victims including attempted murder, sexual assault, kidnapping, and assault occasioning grievous bodily harm. The later police Investigation created a brief of evidence for the suspect's prosecution over Mr Rooney's death which was forwarded to the DPP for prosecution. Upon review, the DPP determined there was insufficient evidence for charges to be laid relating to Mr Rooney's death. It is likely the original Coronial finding regarding Mr Rooney's death being caused by a fall is incorrect.*

5.2169. Counsel Assisting drew attention to a number of troubling aspects of this Summary, none of which was addressed in the submissions on behalf of the NSWPF.

[1742] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – William Rooney, Undated 10 (SCOI.76961.00014).

5.2170. First, on the evidence available to the Inquiry, there was no "further police investigation" in 2002. In 1991 and 1993, the case of Mr Rooney was referred by Detective Inspector Ainsworth to the ODPP (in the light of the 1989 charges against Mr Scerri) but, as noted above, neither of those referrals led to any further "investigation"; while in 2002 (probably in the light of Mr Scerri's reoffending and further prosecution in 2002), there was an approach by Detective Senior Constable Bridge to Dr Duflou about the possibility of exhuming Mr Rooney's remains, but nothing came of that either.

5.2171. Secondly, Mr Scerri was charged with the offences against the 12 other men in September 1989, not in 1990.

5.2172. Thirdly, and more significantly, the last sentence of the Case Summary reads, "[i]t is likely the original Coronial finding regarding Mr Rooney's death being caused by a fall is incorrect."[1743]

5.2173. That sentence follows a series of sentences referring to the similarities between Mr Scerri's case and those of the other 12 men assaulted or allegedly assaulted by him, and to the view of the "second investigation" that Mr Rooney was the first victim of Mr Scerri. This reference to the "second investigation" may perhaps be a reference to the report of Detective Inspector Ainsworth to the ODPP in 1993.

5.2174. That last sentence in the Case Summary presumably indicates that the Strike Force Parrabell considered that what was "likely" to be "correct" was that Mr Rooney's death had been caused by an assault rather than by a fall. In context, it seems also to indicate that the view of the Strike Force Parrabell was that it was Mr Scerri who had assaulted Mr Rooney.

5.2175. Yet the same Strike Force Parrabell officers had given the case the overall categorisation of "Insufficient Information", and had answered all ten indicators in the BCIF as "No Evidence of Bias Crime".

5.2176. How three such very different assessments could all be made simultaneously is not explained, perhaps because it is inexplicable. I accept the submission of Counsel Assisting that again, it indicates some considerable confusion and imprecision in the methodology of Strike Force Parrabell. Further discussion on this point is found at **Chapter 13**.

Academic review

5.2177. The review by the Flinders academic team categorised the case of Mr Rooney as "Insufficient Information".[1744]

5.2178. As Counsel Assisting submitted, the academic team, like the Strike Force Parrabell officers, do not address the reality that in some cases, of which this is one, the absence of information is attributable to a significant extent to the failures of the police to investigate an incident adequately at the time it occurred.

[1743] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – William Rooney, Undated 10 (SCOI.76961.00014).

[1744] Exhibit 6, Tab 115A, Flinders University Academic Review Team, 'Excel Spreadsheet titled 'Copy of Parrabell 17", (Excel spreadsheet, undated) (SCOI.74573).

Review by the Inquiry

5.2179. The Inquiry took a number of steps in the course of examining the matter.

Summonses

Attempts to obtain complete NSWPF holdings

5.2180. A summons was issued to the NSWPF on 18 May 2022 for, all documents relating to investigations by the NSWPF of the death of Mr Rooney, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Rooney.

5.2181. On 2 June 2022, the NSWPF produced only nine documents in relation to Mr Rooney's case, comprising some occurrence reports and two witness statements.

5.2182. On 25 July 2022, the Inquiry requested that the NSWPF conduct further searches for material in relation to Mr Rooney.[1745]

5.2183. On 2 August 2022, the NSWPF produced their complete e@gle.i holdings in relation to Strike Force Parrabell, ostensibly in response to Summons NSWPF3.

5.2184. Summons NSWPF3, dated 21 July 2022, had sought the production of various documents relating to investigations into the deaths of persons listed in that summons. Mr Rooney's death was not one of those listed. It may be, therefore, that the NSWPF was intending to produce this material in response to Summons NSWPF1.

5.2185. In any event, the material ultimately produced by the NSWPF included a document that referred to a "hard copy video" of Mr Rooney "being removed by ambulance officers from the sight [sic] of the incident" in Crown Lane (a copy of that video itself was not produced).[1746]

5.2186. On 9 August 2022, the NSWPF provided the Inquiry with, relevantly, a spreadsheet setting out further searches undertaken by NSWPF Corporate Records in relation to Mr Rooney. The spreadsheet indicated that the NSWPF files in relation to Mr Rooney were, at that point in time, on loan to the Unsolved Homicide Team.

5.2187. On 17 August 2022, the Inquiry requested those files.[1747] On 6 September 2022, the NSWPF informed the Inquiry that all NSWPF files in relation to Mr Rooney had already been provided to the Inquiry on 2 June 2022 (when only nine documents had been produced).[1748]

[1745] Exhibit 22, Tab 36, Emails from Kate Lockery to Patrick Hodgetts, 25 July 2022, 5-6 (SCOI.82564).

[1746] Exhibit 22, Tab 31A, Strike Force Parrabell, 'Case 20 – Video of ROONEY in Crown Lane', undated (SCOI.45252).

[1747] Exhibit 22, Tab 36, Email from Kate Lockery to Patrick Hodgetts, 17 August 2022, 4-5 (SCOI.82564).

[1748] Exhibit 22, Tab 36, Email from Patrick Hodgetts to Kate Lockery, 6 September 2022, 2-3 (SCOI.82564).

5.2188. On 13 September 2022, and following the production of material by the ODPP to the Inquiry on 8 and 9 September 2022 (see below), the Inquiry wrote to the NSWPF outlining the reasons why the Inquiry considered that further material likely existed (or should have existed) in relation to the case of Mr Rooney. In that correspondence, the Inquiry sought, relevantly, the video footage of Mr Rooney in Crown Lane.[1749]

5.2189. On 15 September 2022, the NSWPF replied by saying they had no record of the existence of further material but were able to provide, and did provide, the video footage of Mr Rooney in Crown Lane.[1750]

5.2190. On 12 October 2022, the Inquiry issued a letter to the NSWPF requesting that further enquiries be made, and in particular, with Detective Inspector Ainsworth and DS Bridge.[1751]

5.2191. On 1 November 2022, the NSWPF indicated that a hard copy file had been found at Wollongong Police Station. That file was then provided to the Inquiry. The file contained post-mortem photos, two additional statements and some correspondence not previously provided to the Inquiry.[1752]

5.2192. On 21 March 2023, the Inquiry issued Summons NSWPF73 to obtain material in relation to the 1986 offences with which Mr Scerri was charged. On 11 April 2023, the NSWPF produced this material to the Inquiry.

Other summonses issued

5.2193. On 23 August 2022, the Inquiry issued Summons ODPP2 to the ODPP to obtain, relevantly, material in relation to the potential prosecution of Mr Scerri for the death of Mr Rooney. On 8 and 9 September 2022, the ODPP produced this material. The material produced by the ODPP included the correspondence from 1993 (referred to above) between police, the ODPP and Mr Tedeschi QC, which contained reference to the video footage.

5.2194. The Inquiry also issued summonses to CSNSW and to the Supreme Court in relation to Mr Scerri. CSNSW produced material on 23 February 2023. The Supreme Court produced material on 15 February 2023 and 29 March 2023.

5.2195. On 14 March 2023, the Inquiry issued Summons ODPP4 to the ODPP, to obtain material in relation to two of the matters in respect of which Mr Scerri was charged on 29 September 1989. The ODPP produced this material on 30 March 2023 and 3 April 2023.

Interagency cooperation

5.2196. Upon request, the Coroners Court provided a copy of the coronial file in relation to Mr Rooney's death.

[1749] Exhibit 22, Tab 36, Email from Elizabeth Blomfield to Patrick Hodgetts, 13 September 2022, 1-2 (SCOI.82564).

[1750] Exhibit 22, Tab 36, Email from Patrick Hodgetts to Elizabeth Blomfield, 15 September 2022, 1 (SCOI.82564).

[1751] Exhibit 22, Tab 37A, Letter from Enzo Camporeale to Patrick Hodgetts, 12 October 2022 (SCOI.82569).

[1752] Exhibit 22, Tab 37, Emails from Patrick Hodgetts to Elizabeth Blomfield, 1 November 2022, 2-3 (SCOI.82569).

5.2197. The Inquiry also liaised with BDM and other agencies to confirm the status and location of various witnesses.

Family members

5.2198. Mr Rooney's de facto partner, Mr Davis, is now deceased.

5.2199. The Inquiry attempted to contact Mr Rooney's aunt, Irene Eipeldauer, but these attempts were unsuccessful.

Searches for exhibits

5.2200. As noted, there is no record of any exhibits having been collected or retained in this case.

5.2201. On 9 March 2023, the Inquiry requested that the NSWPF undertake enquiries to identify and locate any exhibits in this matter. The NSWPF undertook the following searches, none of which identified any exhibits, or records of exhibits, associated with this matter:

a. EFIMS;

b. MEPC;

c. Wollongong Police District;

d. FASS;

e. NSWPF Corporate Records; and

f. Wollongong CSU and Lake Illawarra CSU.

5.2202. There is accordingly no present-day capacity to carry out DNA or other testing of any relevant items or materials such as clothing.

Professional opinions

5.2203. The Inquiry sought and obtained a report from Dr Linda Iles. Dr Iles was asked to address the following issues:[1753]

a. The adequacy of the post-mortem investigations conducted with respect to Mr Rooney;

b. The nature of Mr Rooney's injuries, including:

i. Whether Mr Rooney's injuries were consistent with an accidental fall from three metres;

ii. Whether Mr Rooney's injuries were consistent with having been pushed off a three-metre platform (i.e. whether there was there a degree of force involved in a fall);

[1753] Exhibit 22, Tab 38, Letter of Instruction from Elizabeth Blomfield to Dr Linda Iles, 15 December 2022, 3 (SCOI.82596).

iii. Whether Mr Rooney's injuries were consistent with having been hit by an object;

iv. Whether she agreed with the opinion of Dr Verzosa that "battering of the head with hard instruments, whether wood or metal" usually splits open the skin and factures the skull;

c. To the extent of any inconsistency, whether the conclusions of Dr Verzosa or Dr Ramsay should be preferred and why;

d. Whether she had any recommendations for further investigations with respect to determining the manner and cause of Mr Rooney's death; and

e. Any other matters she considered relevant to the manner and cause of Mr Rooney's death.

5.2204. The opinion of Dr Iles is discussed below.

5.2205. The Inquiry also sought and obtained a report from Professor David Ranson. In his report, Professor Ranson addressed, amongst other things, pathology practice and procedure in NSW at the time of Mr Rooney's death and the post-mortem report prepared by Dr Verzosa.

Witness statements

5.2206. The Inquiry obtained a statement of former Detective Senior Constable John Tate dated 12 May 2023.

5.2207. The Inquiry obtained a statement of Joanne Garbutt dated 22 May 2023.

Contact with OIC

5.2208. On 24 August 2023 and 19 September 2023, the Inquiry wrote to former Constable Tranby enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Rooney. The Inquiry did not receive a response from former Constable Tranby.[1754]

Other

5.2209. On 13 December 2022, the Inquiry spoke with Duncan McNab in light of his discussion of Mr Rooney's death in Chapter 19 of his book, *Getting Away with Murder*, which was published in 2017.[1755] Mr McNab informed the Inquiry that this chapter of his book was based in part upon a contemporaneous note he made whilst interviewing Mr Davis, who is now deceased.

5.2210. The Inquiry also spoke with former Detective Inspector Ainsworth about his work in connection with the investigation of this case. Detective Inspector Ainsworth's recollection, as conveyed to the Inquiry, is discussed below.[1756]

[1754] Exhibit 66, Tabs 65A-66, Lettets to Michael Tranby, 24 August 2023 and 19 September 2023 (SCOI.86385; SCOI.86325).

[1755] Duncan McNab, 'Down in the 'Gong', *Getting Away with Murder* (Penguin Random House Australia, 2017) 189 (SCOI.03679).

[1756] Exhibit 22, Tab 40, Statement of Elizabeth Blomfield, 16 May 2023, [7]–[17] (SCOI.82575).

Consideration of the evidence

Thursday evening 13 February 1986

5.2211. At around 5:45pm on Thursday, 13 February 1986, Mr Rooney telephoned Mr Davis and asked him whether he wanted to go for a few beers. Mr Davis agreed and collected Mr Rooney from their home at Gwynneville. They then went to the Tattersalls Hotel in Wollongong, arriving at around 6:15pm and drinking schooners there until between around 9:00pm to 10:00pm. Mr Davis estimated that they would have had around six to eight schooners of beer during this time.[1757] Mr Davis then left and went to a friend's place in Keiraville.

5.2212. Before Mr Davis left the Tattersalls Hotel, Mr Rooney told Mr Davis that he planned to go to Annabel's Disco (Annabel's Disco, in Crown Lane, became known as Pips International shortly afterwards).[1758] When the two parted, Mr Davis observed Mr Rooney to be in extremely good spirits and not overly affected by liquor. Mr Davis noted that Mr Rooney could drink "quite a bit" and could "hold his liquor well".[1759]

5.2213. Mr Rooney's movements between around 10:00pm on Thursday, 13 February 1986 (when he parted from Mr Davis) and 8:40am on Friday, 14 February 1986 (when he was found in Crown Lane) are not entirely clear. It appears that Mr Rooney did attend Annabel's Disco at some point (probably after 12:00am),[1760] but he was also seen at the Grand Hotel, not far away in Keira Street, at some stage too.[1761]

Friday 14 February 1986 (morning)

5.2214. At around 8:40am on 14 February 1986, the manager of L&B Discounts store on Crown Street, Harvey Finch, walked to the rear of the store to open the gate and noticed a man lying on the ground between the toilet block and the wall. Mr Finch observed that the man was injured and called the ambulance.[1762]

5.2215. At around 8:53am on 14 February 1986, paramedics Terence Morrow and Annette Lavender were called to attend to a person who had reportedly "fallen off a roof" at the rear of a retail store in Crown Lane.[1763] On arrival at the scene shortly afterwards, they observed Mr Rooney lying at the base of some steps.[1764]

[1757] Duncan McNab, *Getting Away with Murder* (Penguin Random House Australia, 2017) 190 (SCOI.03679); Exhibit 22, Tab 11, NSWPF Report of Occurrence, 'Rooney Inquiry', 14 February 1986, 3 (SCOI.10338.00005).

[1758] Exhibit 22, Tab 11, NSWPF Report of Occurrence, 'Rooney Inquiry', 14 February 1986, 3 (SCOI.10338.00005).

[1759] Exhibit 22, Tab 30, Strike Force Parrabell, Bias Crimes Indicators Review Form – William Rooney, Undated 2 (SCOI.03077).

[1760] Exhibit 22, Tab 15, Statement of Detective Senior Constable John Robert Tate, 5 January 1987, [7] (SCOI.11269.00018).

[1761] Exhibit 22, Tab 18, Statement of Steven Brett Snedden, 22 February 1986, [2] (SCOI.11269.00011); Exhibit 22, Tab 15, Statement of Detective Senior Constable John Robert Tate, 5 January 1987, [7] (SCOI.11269.00018).

[1762] Exhibit 22, Tab 22, Statement of Harvey Finch, 24 October 1986, 1 (SCOI.11269.00015).

[1763] Exhibit 22, Tab 23, Statement of Terrence William Morrow, 25 February 1986 (SCOI.11269.00017).

[1764] Exhibit 22, Tab 24, Statement of Annette Robyn Lavender, 28 February 1986 (SCOI.03683.00006).

5.2216. Mr Morrow observed Mr Rooney to be "restless and disorientated and responding only to stimuli".[1765] He observed a large pool of blood around Mr Rooney's head, that his left ear canal was obstructed with congealed blood, and that blood was also oozing from Mr Rooney's nose. Mr Morrow observed an abrasion to Mr Rooney's left inner arm and bruising to the chest. He added that Mr Rooney was very irritable, which made treatment difficult. In addition, Ms Lavender observed an abrasion to the right lateral back area of the arm, that he had "no identity", and that Mr Rooney's "right leg was wedged under the down pipe of the toilet".[1766]

5.2217. From their observations, Mr Morrow and Ms Lavender both considered that Mr Rooney was suffering from a fractured skull.[1767]

5.2218. Mr Morrow's (unsigned) statement dated 25 February 1986 concluded, "[f]rom my observations and opinion I feel the patient had fallen from the wall above landing on his head on the concrete".[1768]

5.2219. At around 9:00am on 14 February 1986, Constable Tranby and Constable Revitt attended the scene in Crown Lane. The paramedics were there, attending to Mr Rooney. Upon arriving at the scene, Constable Tranby observed Mr Rooney "lying on the ground between a brick wall and a toilet block at the base of a set of steps", being treated by paramedics.[1769]

5.2220. According to Constable Tranby, Mr Rooney was wearing blue jeans and a blue t-shirt, and one shoe and sock. He appeared to be unconscious. His clothes were covered in blood, and there was also a large amount of dried blood on the ground near and around the upper part of Mr Rooney's body, as well as around and inside his left ear. His right leg was wedged under the down pipe of the toilet.[1770]

5.2221. Mr Rooney's pants and underwear were lowered to the start of his pubic hair, and his fly was unzipped, when he was found.[1771] Those facts, obviously noteworthy, are not mentioned in any of the statements of Mr Morrow (25 February 1986, unsigned), or Ms Lavender (28 February 1986), or Constable Tranby (19 March 1986), or in any police occurrence pad entries in February 1986, or in the much later statements of Detective Senior Constable Tate and Detective Sergeant Passmore.

5.2222. However, the state of Mr Rooney's pants and underwear is apparent from video footage showing Mr Rooney on the ground where he was found, while being attended to by the paramedics in the presence of police. The footage also shows Mr Rooney attempting to pull up his pants by lifting his hips.[1772]

[1765] Exhibit 22, Tab 23, Statement of Terrence William Morrow, 25 February 1986 (SCOI.11269.00017).

[1766] Exhibit 22, Tab 24, Statement of Annette Robyn Lavender, 28 February 1986 (SCOI.03683.00006).

[1767] Exhibit 22, Tab 23, Statement of Terrence William Morrow, 25 February 1986 (SCOI.11269.00017); Exhibit 22, Tab 24, Statement of Annette Robyn Lavender, 28 February 1986 (SCOI.03683.00006).

[1768] Exhibit 22, Tab 23, Statement of Terrence William Morrow, 25 February 1986 (SCOI.11269.00017).

[1769] Exhibit 22, Tab 13, Statement of Constable Michael Troy Tranby, 19 March 1986 (SCOI.03683.00004).

[1770] Exhibit 22, Tab 13, Statement of Constable Michael Troy Tranby, 19 March 1986 (SCOI.03683.00004).

[1771] Exhibit 22, Tab 50, 'Video of William Rooney in Laneway' (WIN Television, 14 February 1986) (SCOI.82576).

[1772] Exhibit 22, Tab 50, 'Video of William Rooney in Laneway' (WIN Television, 14 February 1986) (SCOI.82576).

5.2223. This footage, apparently taken by a "cameraman from WIN Television",[1773] was referred to in the complete e@gle.i holdings of Strike Force Parrabell, produced to the Inquiry on 2 August 2022 (said to be pursuant to Summons NSWPF3). It is also referred to and included in the brief assembled by Detective Inspector Ainsworth in March 1993, which formed part of the material produced to the Inquiry by the ODPP in September 2022.

5.2224. In Mr McNab's account of this case:[1774]

> *One of the ambulance officers who'd been at the scene recalled that [Mr Rooney's] fly had been open and when he tried to zip him to afford him some dignity, the severely injured man resisted. To one detective this was either an instinctive reaction or the act of a man trying to prevent the recurrence of an attack.*

5.2225. Such a reaction on the part of Mr Rooney appears to be visible in the footage.

5.2226. By 9:30am, when Detective Senior Constable Tate arrived at the scene,[1775] Mr Rooney was no longer there, having been conveyed to Wollongong Hospital. According to his statement, Detective Senior Constable Tate went to the scene with Detectives Stanley and Fitzgerald. No statement by either of those officers has been produced to the Inquiry. I assume that none exists.

5.2227. At least by 11:05am, before the Scientific Investigation Section had arrived, the lessee of the retail premises adjoining the scene had already taken it upon himself to clean the area by hosing it down.[1776]

5.2228. At around 11:05am on 14 February 1986, Detective Sergeant Passmore attended the crime scene in his capacity as a member of the Scientific Investigation Section and conducted an examination of the scene, at least insofar as he was able to do so given that the area had been hosed down.[1777]

5.2229. An unsigned statement by Detective Sergeant Passmore, about his involvement in the investigation between 14 and 21 February, is dated 22 October 1986, some eight months after Mr Rooney's death. No occurrence entries have been produced to the Inquiry which record or refer to the activities of Detective Sergeant Passmore in February 1986 in relation to Mr Rooney.

5.2230. The statement of Detective Senior Constable Tate was not made until even later, on 5 January 1987.[1778]

5.2231. According to his unsigned statement of October 1986, on 14 February 1986 Detective Sergeant Passmore took ten photographs of the scene (numbered one to ten).

[1773] Exhibit 22, Tab 34, Letter from Inspector D Ainsworth to Craig Hyland, 17 March 1993, 11 (SCOI.11076.00007).

[1774] Duncan McNab, *Getting Away with Murder* (Penguin Random House Australia, 2017) 193 (SCOI.03679).

[1775] Exhibit 22, Tab 15, Statement of Detective Senior Constable John Robert Tate, 5 January 1987, [3] (SCOI.11269.00018).

[1776] Exhibit 22, Tab 14, Statement of Detective Sergeant Stephen George Passmore, 22 October 1986, [3] (SCOI.11269.00016).

[1777] Exhibit 22, Tab 14, Statement of Detective Sergeant Stephen George Passmore, 22 October 1986, [3] (SCOI.11269.00016).

[1778] Exhibit 22, Tab 15, Statement of Detective Senior Constable John Robert Tate, 5 January 1987 (SCOI.11269.00018).

5.2232. The NSWPF produced to the Inquiry, pursuant to Summons NSWPF3, a total of twenty photographs of the crime scene, described as having been "taken by DS Passmore on 14 February 1986". Those twenty photographs are not numbered or otherwise identified. Presumably they include the ten photographs of the scene, numbered one to ten, as referred to in the unsigned statement, although that is not entirely clear.

5.2233. The unsigned statement of Detective Sergeant Passmore includes a short description of each of the ten photographs taken at the crime scene, but makes no mention of a rock.[1779] However, among the twenty photographs produced to the Inquiry, there are three which do show a concrete rock near where Mr Rooney was found, as referred to by the Strike Force Parrabell officers in the BCIF, noted above. This is at odds with the assertion in Detective Sergeant Passmore's statement that although he "closely examined" and "made a thorough search of the entire area", he was "unable to find anything which could assist with determining the cause of ROONEY's injuries" or "which [he] could associate with" those injuries.[1780]

Friday 14 February 1986 (afternoon)

5.2234. Later on the same day, 14 February 1986, Detective Sergeant Passmore and Detective Senior Constable Tate both attended the Intensive Care Unit of Wollongong Hospital. Whether they did so together or separately is not clear from their respective statements.

5.2235. According to his unsigned statement, while Detective Sergeant Passmore was at the hospital on 14 February 1986, he took 11 photographs of Mr Rooney's injuries, numbered 11 to 21. Then on 21 February 1986, the day after Mr Rooney's death, he took a further four photographs (numbered 22 to 25) of the "remaining injuries", noting that some had "almost healed".[1781]

5.2236. The NSWPF produced 22 photographs of Mr Rooney's injuries to the Inquiry, none of them numbered. Whether those 22 photographs include the 15 taken by Detective Sergeant Passmore, said to have been numbered 11–25, is not clear.

5.2237. Detective Senior Constable Tate also made some observations of Mr Rooney at the hospital on 14 February 1986, which are somewhat less detailed than those of Detective Sergeant Passmore set out above.[1782]

5.2238. At 2:50pm on 14 February 1986, after attending both the Crown Lane scene and the hospital, Detective Senior Constable Tate made a note in his occurrence pad, "[a]t this stage there is no clear indication as to how this male person received the injuries".[1783]

[1779] Exhibit 22, Tab 14, Statement of Detective Sergeant Stephen George Passmore, 22 October 1986, [4] (SCOI.11269.00016).

[1780] Exhibit 22, Tab 14, Statement of Detective Sergeant Stephen George Passmore, 22 October 1986, [3] (SCOI.11269.00016).

[1781] Exhibit 22, Tab 14, Statement of Detective Sergeant Stephen George Passmore, 22 October 1986, [5]–[8] (SCOI.11269.00016).

[1782] Exhibit 22, Tab 15, Statement of Detective Senior Constable John Robert Tate, 5 January 1987, [4] (SCOI.11269.00018).

[1783] Exhibit 22, Tab 11, NSWPF Report of Occurrence, 'Male Person Aged Approx. 25 Years Found in Semi-Conscious State off Crown Lane, Wollongong', 14 February 1986, 1 (SCOI.10338.00005).

5.2239. At about 7:40pm on 14 February 1986, Wayne Davis attended the Wollongong Police Station, and informed the police that he was Mr Rooney's partner. The note in the occurrence pad records that Mr Rooney and Mr Davis were "practising Homosexuals".[1784] A statement was obtained from Mr Davis that same day.[1785]

5.2240. On 15 February 1986, the NSWPF confirmed the alibi of Mr Davis.[1786]

5.2241. In his book *Getting Away with Murder,* Mr McNab wrote that when Mr Davis attended the Wollongong Police Station on 14 February 1986, Mr Davis:[1787]

> *was seated in a small room with detectives crowded around him. Their initial questions tried to identify Bill's wife or girlfriend, but when Wayne explained that Bill was gay and he was his partner, the crowd thinned quickly, and he gave a signed statement to detectives. At that early point it was likely he was a suspect – a reasonable assumption based on statistics and experience. However, he was eliminated rapidly after explaining his movements of the night of the thirteenth, and they were quickly verified.*

5.2242. The NSWPF submitted that the above constitutes a hearsay statement, the basis of which "is not apparent and cannot sensibly be afforded any weight", and which has not been put to any of the relevant officers.[1788] However, I readily infer that the basis of the statement was Mr McNab's interview with Mr Davis. It provides the Inquiry with the perspective of Mr Rooney's partner, Mr Davis, about the treatment of Mr Rooney's death by the police.

Early involvement of Detective Inspector Ainsworth

5.2243. On the morning of 14 February 1986, Detective Inspector Ainsworth heard a callout on the police radio for police assistance in Crown Lane, Wollongong where an incident had occurred.

5.2244. The following day, 15 February 1986, Detective Inspector Ainsworth obtained approval to review the occurrence pad entries and to attend the scene in Crown Lane to make his own observations. After doing so, Detective Inspector Ainsworth formed the view that it was most unlikely that Mr Rooney had fallen, because of the location where Mr Rooney was found and how intoxicated Mr Rooney was at the time. Detective Inspector Ainsworth suspected that Mr Rooney had been taken to the spot where he was found and dropped on his head.[1789]

5.2245. Detective Inspector Ainsworth was not formally assigned to the case of Mr Rooney. However, he did participate in the interviewing of some witnesses, and he also continued to work on the case in his own time.

[1784] Exhibit 22, Tab 11, NSWPF Report of Occurrence, 'Rooney Inquiry', 14 February 1986, 3 (SCOI.10338.00005). See also Exhibit 22, Tab 15, Statement of Detective Senior Constable John Robert Tate, 5 January 1987, [6] (SCOI.11269.00018).

[1785] Exhibit 22, Tab 15, Statement of Detective Senior Constable John Robert Tate, 5 January 1987, [6] (SCOI.11269.00018).

[1786] Exhibit 22, Tab 10, NSWPF Report of Occurrence, 'Rooney Inquiry', 15 February 1986, 6 (SCOI.10338.00009)

[1787] Duncan McNab, *Getting Away with Murder* (Penguin Random House Australia, 2017) 190 (SCOI.03679).

[1788] Submissions of NSWPF, 1 June 2023, [16] (SCOI.83645).

[1789] Exhibit 22, Tab 40, Statement of Elizabeth Blomfield, 16 May 2023, [12] (SCOI.82575).

5.2246. Detective Inspector Ainsworth was assigned, however, to the investigation of most of the subsequent 12 attacks in respect of which Mr Scerri was eventually charged. The first of these attacks, as noted above, occurred on 9 March 1986 (three weeks after Mr Rooney suffered his injuries) and the last occurred on 22 September 1989. During the course of his investigation of those subsequent 12 cases, Detective Inspector Ainsworth formed the view that Mr Rooney was likely to have been a victim of the same attacker.[1790]

15–20 February 1986: other enquiries made by police

Mr Harrison

5.2247. On Saturday, 15 February 1986, Mr Davis, informed Detective Senior Constable Tate that Mr Rooney had "previously spoken to a person by the name of 'RADAR' who he alleges is a well known Poofter basher."[1791]

5.2248. On the evening of Monday, 17 February 1986, Mr Harrison was detained and brought to Wollongong Police Station, where he was asked about his movements on 13 and 14 February 1986, the night on which Mr Rooney sustained his injuries.[1792]

5.2249. Mr Harrison claimed that he had been with his girlfriend, Joanne Garbutt, for the entire night of 13 February 1986. He said they were at the Coniston Hotel until closing time, and that he then went home with her to his residence (**the address**) where he said he lived with Tony Stagni. He said that he did not know Mr Rooney and had never hassled him.[1793]

5.2250. Mr Harrison claimed that scratches on his right hand, which were observed by the police during the interview on 17 February 1986, had been incurred during a fight he had had the day before, on 16 February 1986, with a man named "Steve Farrawell".[1794] There is no indication in the material produced to the Inquiry by the NSWPF that police followed up on that claim.

5.2251. Later on 17 February 1986, at about 11:00pm, police spoke with Ms Garbutt's mother, who said that Ms Garbutt had been staying with a person called "Radar" at the address.[1795]

5.2252. However, there is no indication in the material produced to the Inquiry by the NSWPF that police ever interviewed Ms Garbutt herself.

[1790] Exhibit 22, Tab 40, Statement of Elizabeth Blomfield, 16 May 2023, [17] (SCOI.82575).

[1791] Exhibit 22, Tab 10, NSWPF Report of Occurrence, 'Rooney Inquiry', 15 February 1986, 6 (SCOI.10338.00009).

[1792] Exhibit 22, Tab 11, NSWPF Report of Occurrence, 'Interview with Leslie John Harrison re Rooney Inquiry', 18 February 1986, 4 (SCOI.10338.00005).

[1793] Exhibit 22, Tab 11, NSWPF Report of Occurrence, 'Interview with Leslie John Harrison re Rooney Inquiry', 18 February 1986, 4 (SCOI.10338.00005).

[1794] Exhibit 22, Tab 11, NSWPF Report of Occurrence, 'Interview with Leslie John Harrison re Rooney Inquiry', 14 February 1986, 4 (SCOI.10338.00005).

[1795] Exhibit 22, Tab 10, NSWPF Report of Occurrence, 'Rooney Inquiry', 18 January 1986, 1 (SCOI.10338.00009).

5.2253. At about 11:30pm on that same night, 17 February 1986, police spoke to Mr Stagni at the address. He said that Ms Garbutt had been "stating [sic]" at those premises with Mr Harrison but had left on Sunday, 16 February 1986, after an argument with Mr Harrison.[1796]

5.2254. For her part, to the contrary, Ms Garbutt gave evidence to the Inquiry that in February 1986, she was living in Coffs Harbour. She said that she had first met Mr Harrison in about 1979, but had then moved up north. She said she came back to Wollongong in about early 1987 where she re-connected with Mr Harrison and became pregnant with his child, who was born in October 1987. She had no recollection of ever staying overnight with Mr Harrison at the address, nor did she recall anyone by the name of "Steve Farrawell".[1797] She did have a recollection of a man by the name of "Tony Stagni", known as "Pegleg", but she did not remember anything about him other than his nickname.[1798]

5.2255. Ms Garbutt also gave evidence that she does not recall ever being spoken to by Wollongong Police in connection with where Mr Harrison was on a particular night in February 1986, nor of an occasion in February 1986 when Mr Harrison was interviewed by police about where he had been on a particular night in that month.[1799]

5.2256. In my view, Ms Garbutt's recollection of events in 1986 and 1987 may not be entirely reliable. Her evidence was given in 2023, a significant time after the events in question. It is in various respects in conflict with contemporaneous accounts provided to the police by Mr Harrison, Mr Stagni and Ms Garbutt's mother. I have therefore afforded little weight to Ms Garbutt's evidence. The failure of the NSWPF to interview Ms Garbutt in 1986 means that Mr Harrison's alibi cannot now be properly tested.

5.2257. On the material produced to the Inquiry by the NSWPF, Mr Harrison was not the subject of any further inquiries or investigation, in relation to the possibility that he was involved in the death of Mr Rooney, at any time after 17 February 1986.

5.2258. As noted above, Mr Harrison died in 2004.

Eye witnesses

5.2259. On 20 February 1986, Andrew James Sherring told Detective Inspector Ainsworth that he had seen a male person staggering down Crown Lane in a westerly direction at about 11:00pm on Thursday, 13 February 1986. Mr Sherring said the man then went to lie down on the grass area of the footpath on the northern side of Crown Lane and slept there for about 1.5 hours, after which time Mr Sherring left the area. The person was described as wearing blue jeans and a blue denim jacket and did not appear to be injured.[1800] Mr Rooney was wearing clothes matching that description when he was found.

[1796] Exhibit 22, Tab 10, NSWPF Report of Occurrence, 'Rooney Inquiry', 18 January 1986, 4 (SCOI.10338.00009).

[1797] Exhibit 22, Tab 42, Statement of Joanne Garbutt, 22 May 2023, [22] (SCOI.83108).

[1798] Exhibit 22, Tab 42, Statement of Joanne Garbutt, 22 May 2023, [24] (SCOI.83108).

[1799] Exhibit 22, Tab 42, Statement of Joanne Garbutt, 22 May 2023, [18], [20] (SCOI.83108).

[1800] Exhibit 22, Tab 10, NSWPF Report of Occurrence, 'Rooney Death', 20 February 1986, 42 (SCOI.10338.00009).

5.2260. Geoffrey Gilroy and Anthony Galvin told Detective Inspector Ainsworth that they had also seen a man lying on the grass area just off the footpath, at about 12:30am on Friday, 14 February.[1801]

5.2261. However, a friend of Mr Rooney, Steven Snedden, told police that he had seen him at the Grand Hotel from about 9:30pm to closing time, between 12:00am and 12:30am, describing him as "pretty full ... still walking around but full" and saying that he knew Mr Rooney was a "heavy drinker".[1802]

5.2262. In relation to his drinking habits, Mr Snedden said:[1803]

> *I have seen him getting pissed, and I have seen him get to the stage that he is passed being pissed, but he dosen't [sic] fall over and things like that he normally stays on his feet.*

14–20 February 1986: Mr Rooney's hospitalisation and death

5.2263. At around 10:00am on 14 February 1986, Mr Rooney was brought to Wollongong Hospital, where he was initially treated by Dr Furber before being treated by Dr Ramsay, who was the Director of Intensive Care for the Illawarra Area Health Service. Dr Ramsay was advised that Mr Rooney had been found by ambulance officers at the bottom of a series of steps. He observed Mr Rooney to be hypothermic and unconscious. Mr Rooney was also "making some inappropriate noises and flexing to painful stimuli".[1804]

5.2264. Investigations carried out by police on 14 and 15 February 1986 confirmed that Mr Rooney was "fairly intoxicated".[1805]

5.2265. Dr Ramsay was shown x-rays of Mr Rooney's skull, which showed fractures in the occipital bone extending into the base of the skull. He also observed blood coming from Mr Rooney's left ear. A CAT Scan was taken, which showed multiple fractures, including through the left petrous temporal bone, at the right occipital region, in the left parietal region and in the right posterior parietal region. There was also extensive subarachnoid haemorrhage, deviation of mid-line structure to the left, and cerebral contusion in both frontal lobes and multiple small areas of haemorrhages.[1806]

5.2266. Mr Rooney was maintained on a ventilator and lightly sedated for the next four days, and his intracranial pressures were "basically stable".[1807]

[1801] Exhibit 22, Tab 19, Statement of Geoffrey Gilroy, 22 February 1986, [2] (SCOI.11269.00013); Exhibit 22, Tab 21, Statement of Anthony Galvin, 22 February 1986, [2] (SCOI.03683.00009).

[1802] Exhibit 22, Tab 18, Statement of Steven Brett Snedden, 22 February 1986, [4], [6] (SCOI.11269.00011).

[1803] Exhibit 22, Tab 18, Statement of Steven Brett Snedden, 22 February 1986, [4] (SCOI.11269.00011).

[1804] Exhibit 22, Tab 6, Report of Dr M Ramsay, 26 February 1986 (SCOI.11269.00007).

[1805] Exhibit 22, Tab 34, Letter from D Ainsworth to C Hyland, 17 May 1993, 1 (SCOI.11076.00007); Exhibit 22, Tab 34A Letter from D Ainsworth to P Conlon, 4 July 1990, 1 (SCOI.83191).

[1806] Exhibit 22, Tab 6, Report of Dr M Ramsay, 26 February 1986 (SCOI.11269.00007).

[1807] Exhibit 22, Tab 6, Report of Dr M Ramsay, 26 February 1986, 2 (SCOI.11269.00007).

5.2267. However, between 7:00am and 8:00am on 19 February 1986, Mr Rooney's responses decreased. Mr Rooney's condition further deteriorated between 7:00am and 8:30am the following morning and he was formally evaluated as brain dead between 1:00pm and 2:30pm on 20 February 1986. His ventilator support was then terminated, and Mr Rooney died at 2:35pm.[1808] Mr Davis formally identified Mr Rooney to police at 3:15pm.

The initial police investigation

5.2268. Several aspects of the original investigation were the subject of submissions and are of concern. The following criticisms are made a systematic level, and are not directed towards any individual officer.

5.2269. First, the documents produced to the Inquiry by the NSWPF appear to indicate that at some stage between 14 February 1986 and 5 January 1987, the police view as to the cause of Mr Rooney's death changed, from an initial openness to the possibility of foul play to a later position of dismissing that possibility.

5.2270. On 14 February 1986 (the day Mr Rooney was found and taken to hospital), Detective Senior Constable Tate made an occurrence pad entry that stated, "[a]t this stage there is no clear indication as to how this male person received the injuries as mentioned above".[1809]

5.2271. On 20 February 1986 (the date of Mr Rooney's death), as noted above, Constable Tranby noted in the Report of Death to Coroner that "SUSPICIOUS CIRCUMSTANCES ARE RELATED TO THIS DECEASED".[1810]

5.2272. On 26 February 1986, in his Report of Death of a Patient to Coroner of that date, the Casualty Registrar at Wollongong Hospital wrote (emphasis added): "Circumstances of accident or assault unknown".[1811]

5.2273. However, on 5 January 1987, nearly a year later, Detective Senior Constable Tate expressed the opinion, in his statement for the Coroner, that Mr Rooney fell whilst being intoxicated.[1812] According to his statement, this opinion was influenced by "lengthy discussions" with Detective Sergeant Passmore of the Scientific Investigation Section.[1813]

5.2274. Detective Sergeant Passmore, for his part, in an unsigned statement dated 22 October 1986, was said to have noted, on observing Mr Rooney in hospital eight months earlier on 14 February, that he "appeared to have only very slight superficial external injuries on his face and body which were not consistent with an assault victim" (emphasis added).[1814]

[1808] Exhibit 22, Tab 6, Report of Dr M Ramsay, 26 February 1986 (SCOI.11269.00007).

[1809] Exhibit 22, Tab 11, NSWPF Report of Occurrence, 'Male Person Aged Approx. 25 Years Found in Semi-Conscious State off Crown Lane, Wollongong', 14 February 1986, 1 (SCOI.10338.00005).

[1810] Exhibit 22, Tab 1, P79A Report of Death to Coroner, 20 February 1986 (SCOI.11269.00002).

[1811] Exhibit 22, Tab 2, Report of Death of a Patient to Coroner, 20 February 1986 (SCOI.03683.00007).

[1812] Exhibit 22, Tab 15, Statement of Detective Senior Constable John Robert Tate, 5 January 1987, [9] (SCOI.11269.00018).

[1813] Exhibit 22, Tab 15, Statement of Detective Senior Constable John Robert Tate, 5 January 1987, [9] (SCOI.11269.00018).

[1814] Exhibit 22, Tab 14, Statement of Detective Sergeant Stephen George Passmore, 22 October 1986, [5] (SCOI.11269.00016).

5.2275. However, later in the same paragraph of that unsigned statement, Detective Sergeant Passmore also noted that:[1815]

> *Close examination of his neck showed three very faint marks which were slightly curved. These could possibly be consistent with marks caused by fingernails. All ROONEY's nails were bitten down.*

5.2276. The conclusion drawn by Detective Sergeant Passmore, that Mr Rooney's injuries were "not consistent" with that of an assault victim, seems to overlook his own observation of the fingernail marks on Mr Rooney's neck (which Detective Sergeant Passmore evidently considered unlikely to have been made by Mr Rooney).

5.2277. Former Detective Senior Constable Tate told the Inquiry that he does not recall any discussions with Detective Sergeant Passmore about this case, but that given Detective Sergeant Passmore's expertise, he would have deferred to his views on the question of manner and cause of death. However, Mr Tate said that his best present recollection is that he thought from the outset of his investigation that it was likely that Mr Rooney had fallen while intoxicated.

5.2278. Detective Sergeant Passmore is deceased and the Inquiry cannot therefore test any of these matters with him.

5.2279. As Counsel Assisting submitted, the views of Detective Sergeant Passmore and Detective Senior Constable Tate, as expressed in October 1986 and January 1987 respectively, appear to give little if any attention or weight to evidence, available in 1986, that tended to point to an explanation other than an accidental fall. Such evidence included: that Mr Rooney was not carrying ID;[1816] that his pants and underwear were lowered;[1817] that he was missing a shoe and a sock;[1818] that he appeared to have fingernail marks on his neck;[1819] and that he was known to "hold his liquor" well.[1820]

5.2280. In the Investigative Practices Hearing, the NSWPF accepted in submissions that there are limited records explaining the basis for the change in police view between 14 February 1986 and 5 January 1987.[1821]

[1815] Exhibit 22, Tab 14, Statement of Detective Sergeant Stephen George Passmore, 22 October 1986, [5] (SCOI.11269.00016).

[1816] Mr Rooney was only found with a Medicare card and $5 in cash: Exhibit 22, Tab 1, P79A Report of Death to Coroner, 20 February 1986 (SCOI.11269.00002); See also Exhibit 22, Tab 41, Statement of John Robert Tate, 12 May 2023, [8] (SCOI.83107).

[1817] Exhibit 22, Tab 50, 'Video of Mr Rooney in Laneway' (WIN Television, 14 February 1986) (SCOI.82576).

[1818] Exhibit 22, Tab 13, Statement of Constable Michael Troy Tranby, 19 March 1986 (SCOI.03683.00004).

[1819] Exhibit 22, Tab 14, Statement of Detective Sergeant Stephen George Passmore, 22 October 1986, [5] (SCOI.11269.00016).

[1820] Exhibit 22, Tab 30, Strike Force Parrabell, Bias Crimes Indicators Review Form – William Rooney, undated (SCOI.03077); See also Exhibit 22, Tab 18, Statement of Steven Brett Snedden, 22 February 1986, [4] (SCOI.11269.00011).

[1821] Submissions of NSWPF, 10 October 2023, [374] (SCOI.86127).

5.2281. In its submissions in relation to the case of Mr Rooney, the NSWPF directed attention to the fact that on 21 February 1986, Dr Verzosa's post-mortem report recorded his conclusion that "Mr Rooney's injuries were 'probably due to a fall'".[1822] The NSWPF noted that Detective Sergeant Passmore was in attendance at the post-mortem examination, and submitted that "it is quite likely" the views of Detective Sergeant Passmore "were influenced by those of Dr Verzosa, who very clearly considered Mr Rooney's death to be the result of an accident".[1823]

5.2282. It may perhaps be the case that the views of Dr Verzosa played a part in the shaping of Detective Sergeant Passmore's own views. However, that speculative possibility does not go very far towards explaining why such different views were expressed in writing at different times. I note also that in the evidence he has provided the Inquiry in 2023, Detective Senior Constable Tate does not record or remember the content of his discussions with Detective Sergeant Passmore or rely on the post-mortem report as a reason for the change in his view (as recorded) some 11 months later.

5.2283. Secondly, the NSWPF failed to secure the area where Mr Rooney's body was found, as a result of which the lessee of the retail premises adjoining the scene took it upon himself to clean the area by hosing it down. As identified by Counsel Assisting, this naturally limited the ability of investigators to properly assess the area and recover evidence of forensic value.

5.2284. The NSWPF conceded that the failure of the police to prevent this from occurring is "undoubtedly a concerning feature of the original investigation"[1824] and a "matter of serious concern".[1825]

5.2285. During the Investigative Practices Hearing:

a. Superintendent Best conceded that the failure, by attending officers, to secure the scene of Mr Rooney's death and the subsequent destruction of evidence of potential forensic value was symptomatic of an issue with securing crime scenes that was subsequently addressed in the Gibson Report.[1826] However, Superintendent Best could not comment on "the sufficiency or otherwise" of the training of officers in relation to securing crimes scene prior to 1990.[1827]

b. Detective Inspector Warren said that, although recognised as an important matter in 1983,[1828] the securing of crime scenes around this time was a matter of discretion for the attending officers, which varied depending on the maturity, training, experience and supervision of the officer.[1829] Detective Inspector Warren appeared to suggest that the failure by attending officers to secure the scene of Mr Rooney's death was a result of a lack of supervision, noting that the supervisory protocol has "always" been in place, but became

[1822] Submissions of NSWPF, 1 June 2023, [5]–[6] (SCOI.83645).

[1823] Submissions of NSWPF, 1 June 2023, [10], [13] (SCOI.83645).

[1824] Submissions of NSWPF, 1 June 2023, [9] (SCOI.83645).

[1825] Submissions of NSWPF, 10 October 2023, [375] (SCOI.86127).

[1826] Transcript of the Inquiry, 4 July 2023, T4921.31-4922.3 (TRA.00072.00001).

[1827] Transcript of the Inquiry, 4 July 2023, T4922.5-11 (TRA.00072.00001).

[1828] Transcript of the Inquiry, 5 July 2023, T4984.17-17 (TRA.00073.00001).

[1829] Transcript of the Inquiry, 5 July 2023, T4984.15-4985.5 (TRA.00073.00001).

"more rigorous" in around 1994 with the onset of digital records within the NSWPF.[1830]

5.2286. Thirdly, and perhaps most critically, no sexual assault examination was conducted on Mr Rooney in hospital. Furthermore, after Mr Rooney died, there appears to have been no examination of the anus or genitals during the post-mortem. Counsel Assisting postulated that the original investigators may not have provided Mr Rooney's treating doctors or Dr Verzosa with any reason to conduct an anogenital exam, such as specifying the circumstances in which Mr Rooney's body was found (including that his jeans and underwear were lowered).[1831]

5.2287. During the Investigative Practices Hearing, Detective Inspector Warren could not offer any reason, consistent with proper police practice at the time, why police did not request a sexual assault examination.[1832]

5.2288. In its submissions specifically relating to this case of Mr Rooney, the NSWPF acknowledged that it is "very unfortunate" that the post-mortem report does not include a comment in relation to the presence or absence of anogenital injuries and/or the conduct of penile swabs",[1833] but submitted that the possibility that this occurred because of a failure by police to provide relevant information to Dr Verzosa was speculative.[1834]

5.2289. Former Detective Senior Constable Tate's recollection in this regard was as follows:[1835]

> *As far as I was aware, there were no signs that Mr Rooney had been sexually assaulted. I was not aware that Mr Rooney was found at the scene with his pants down or with a shoe and sock off. If I had considered that Mr Rooney might have been sexually assaulted, I would have raised this with his treating doctors at Hospital. Otherwise, I would have expected his treating doctors to let me know if, during their medical examination of him, anything led them to believe he had been sexually assaulted.*

5.2290. That evidence tends to indicate that nothing was said to Dr Verzosa about the possible need for an anogenital examination.

5.2291. In my view, the NSWPF must accept at least partial responsibility for the failure to conduct a sexual assault examination, and/or for the failure to alert the treating doctors and Dr Verzosa to the circumstances in which Mr Rooney was found, which should have led to such an examination taking place.

5.2292. Fourthly, as Counsel Assisting submitted, the significance of these failures became particularly apparent when, in 1991 and again in 1993, the case was referred to the ODPP by Detective Inspector Ainsworth.[1836]

[1830] Transcript of the Inquiry, 5 July 2023, T4895.7-19 (TRA.00073.00001).

[1831] Exhibit 22, Tab 41, Statement of John Robert Tate, 12 May 2023, [21] (SCOI.83107).

[1832] Transcript of the Inquiry, 5 July 2023, T4985.23-44 (TRA.00073.00001).

[1833] Submissions of NSWPF, 1 June 2023, [14] (SCOI.83645); Submissions of NSWPF, 10 October 2023, [376] (SCOI.86127).

[1834] Submissions of NSWPF, 10 October 2023, [376] (SCOI.86127).

[1835] Exhibit 22, Tab 41, Statement of John Robert Tate, 12 May 2023, [21] (SCOI.83107).

[1836] Exhibit 22, Tab 34, Letter from Inspector D Ainsworth to Craig Hyland, 17 March 1993, 2 (SCOI.11076.00007).

5.2293. The advice of Mr Tedeschi QC in 1993 (that there was insufficient evidence to charge Mr Scerri) was based in significant part on the absence of evidence as to whether or not Mr Rooney had been sexually assaulted, with the result, relevantly, that similar fact evidence as to the sexual assaults of other victims could not be relied upon by the prosecution.[1837]

5.2294. There is no doubt that, as Counsel Assisting submitted, the failure to examine Mr Rooney for signs of possible sexual assault has severely impeded the possibility of investigating and/or prosecuting Mr Scerri (or anyone else) in relation to Mr Rooney's death.

5.2295. The NSWPF accepted that it "appears" the investigation into Mr Rooney's death was "not as comprehensive as would have been expected today in the context of a potential homicide",[1838] but submitted that there is no indication in the coroner's determination that the police investigation was considered "in any way inadequate, having regard to the prevailing standards".[1839]

5.2296. I reject that submission for the same reasons expressed elsewhere in this Chapter. The absence of comment (favourable or unfavourable) by a Coroner in the course of an inquest, about the merits of a police investigation, is not probative of its adequacy.

5.2297. Moreover, in the course of the investigative practices hearing, the NSWPF did concede that the investigation into Mr Rooney's death was inadequate, and in several respects. In particular, the following concessions were made:

a. Assistant Commissioner Conroy agreed that Mr Rooney's death should have been treated as a suspicious death by the standards applicable in 1986 and exhibits should have been collected and recorded in an exhibit book that should have been retained;[1840] and

b. As noted above, Detective Inspector Warren agreed that, given the circumstances in which Mr Rooney was found, it could be expected that there would be a record about why his death was dismissed as non-suspicious; that the scene should have been secured; and that there was no reason, consistent with proper police practice understood at the time, why a sexual assault examination was not requested or conducted.[1841]

5.2298. Fifthly, while Mr Harrison claimed to have an alibi for the night of 13 and 14 February 1986, namely that he had been with his girlfriend Ms Garbutt, for the entire night of 13 and 14 February 1986, there is no indication that police ever interviewed Ms Garbutt about those matters.

[1837] Exhibit 22, Tab 32, Letter from Sally Dowling SC to Kate Lockery, 3 April 2023, 3 (SCOI.82610).

[1838] Submissions of NSWPF, 1 June 2023, [15] (SCOI.83645) (emphasis in original).

[1839] Submissions of NSWPF, 1 June 2023, [15] (SCOI.83645).

[1840] Transcript of the Inquiry, 4 July 2023, T4852.44-4853.45 (TRA.00072.00001).

[1841] Transcript of the Inquiry, 5 July 2023, T4981.25-4985.44 (TRA.00073.00001).

5.2299. In its submissions in relation to the Investigative Practices Hearing, the NSWPF pointed to an occurrence pad entry recording that on one occasion police attended premises in search of Ms Garbutt but to no avail.[1842] That appears to have been the extent of any efforts made by the NSWPF to interview, or seek to interview, Ms Garbutt.

5.2300. In my opinion, the failure to verify the reliability of Mr Harrison's alibi is not only unsatisfactory but inexplicable.

1986–1987: Coronial inquest

5.2301. At the inquest, held in July 1986 and February 1987, Dr Ramsay and Dr Verzosa gave evidence, as noted above.

5.2302. The formal finding of Coroner Soden is set out above.

After 1987: subsequent NSWPF consideration of the case

5.2303. Between March 1986 and September 1989, as noted earlier, 12 men were physically and/or sexually assaulted, in or near Wollongong, in circumstances having many similarities to each other.

5.2304. On 26 September 1989, Mr Scerri was charged with 29 offences in relation to these 12 men. Nine of the men identified Mr Scerri as their attacker, and similar fact evidence was sought to be used to support charges in relation to the other three men.

5.2305. Charges in respect of three of the men (referred to as I183, I188 and I190) did not proceed to trial. The ODPP issued a "no further proceedings" direction in each of these matters, for reasons which are not known to the Inquiry.

5.2306. Charges in respect of nine victims were the subject of four separate trials in 1991 and 1992:

a. In July 1991, there was a trial in relation to I193 alone, in the District Court. I193 was attacked in 1989 in Jindabyne. Mr Scerri was acquitted;

b. In October 1992, there was a trial in relation to I187, I186, I185 and I184, in the Supreme Court. Three of those victims were attacked in 1986 in McCabe Park in Wollongong, and one in 1987 elsewhere in Wollongong. Mr Scerri was acquitted;

c. In November 1992, there was a trial in relation to I189 alone, in the Supreme Court. I189 was attacked in 1987 in Nowra. Mr Scerri was acquitted; and

d. In November 1992, there was a trial in relation to I194, I192 and I191, in the Supreme Court. The attacks on all three of those men had taken place in 1989, all in Wollongong. On 18 November 1992, Mr Scerri was found guilty by a jury and convicted on all seven charges in relation to I194, I192 and I191.[1843]

[1842] Exhibit 22, Tab 10, NSWPF Report of Occurrence, 'Rooney Inquiry', 18 January 1986, 1-3 (SCOI.10338.00009).

[1843] *State of New South Wales v Scerri* [2012] NSWSC 271, [6].

5.2307. The attack on I194, in September 1989, being one of those in respect of which Mr Scerri was convicted, occurred on the other side of the same laneway (Crown Lane) where Mr Rooney had been found on 14 February 1986.

5.2308. One of the victims in respect of whom there was an acquittal, I186, gave evidence that during the attack on him (on 18 December 1986, only ten months after the death of Mr Rooney), the attacker held a rock in one hand above his head and threatened I186 with the rock while sexually assaulting him. According to I186, his assailant said, "I'll kill you like I did the other poofter in the laneway".[1844]

5.2309. On 19 February 1993, Justice James imposed an effective total sentence of 16 years' imprisonment, with a non-parole period of 12 years, in respect of the convictions relating to I194, I192 and I191.

5.2310. A convenient summary of what Mr Scerri did in those attacks is found in the judgment of Hoeben J in *State of New South Wales v Scerri* [2011] NSWSC 683:[1845]

> *[26] [I191], a 21 year old male, was one of the … victims. On 11 June 1989 he was walking home in Wollongong. The defendant grabbed the victim from behind and committed two offences of sexual intercourse without consent. The sexual assaults comprised oral sexual intercourse and penile anal sexual intercourse. The sexual assaults were accompanied by threats by the defendant to kill the victim and members of his family.*
>
> *[27] The defendant grabbed [I191] from behind and knocked him over a low boundary wall about a metre high running along the side of the street. The defendant then pushed [I191] across part of a vacant property into a shed. Inside the shed, the defendant took [I191]'s pants down and made him lie on his stomach. The defendant rolled [I191] onto his side and sucked his penis. The defendant then told [I191] to turn towards the wall of the shed and having made threats to kill him and members of his family, had full anal sexual intercourse with him. The defendant told [I191] to remain lying in the shed. Some hours passed before [I191] reported the offence to the police, because he was terrified that the defendant might kill him or members of his family. It was common ground that [I191] was physically very small and slender.*
>
> *[28] [I192], a 22 year old male, was another victim. On 25 June 1989 he was walking along the same street in Wollongong, having been out to a number of nightspots. The defendant tackled [I192] from behind and hit him three or four times on the back of his head with a rock. The defendant pushed [I192] in a westerly direction, past the shed in which he had assaulted [I191], and into a toilet block in a park. In a cubicle in the toilet block, the defendant told [I192] to take his pants down and he then took [I192]'s penis in his mouth. The defendant then told [I192] to get down on his knees and put his chest on the ground. The defendant then inserted his penis into [I192]'s anus and had anal sexual intercourse with him. [I192] bled profusely while he was in the*

[1844] Exhibit 22, Tab 26, Statement of I186, 14 October 1989, [4] (SCOI.11293.00035).

[1845] *State of New South Wales v Scerri* [2011] NSWSC 684, [26]–[29].

cubicle. When the defendant left, [I192] was able to get a lift from a passing motorist who took him to hospital.

[29] The third victim was a 29 year old male, [I194]. On the night of 21 September 1989 [I194] was one of a group of men celebrating the recent birth of a child. He had consumed a very large amount of alcohol and early in the morning of 22 September 1989 left a nightclub in Wollongong grossly intoxicated. The defendant and [I194] left the nightclub together, but when they were next to a site on which a building had been demolished, the defendant punched him on the nose several times, breaking it. The defendant then hit [I194] on the side and back of his head several times with a rock. The defendant removed [I194]'s pants and while he was on his hands and knees, he inserted his penis into [I194]'s anus and had anal sexual intercourse with him. He said to [I194] "Shutup or I will keep bashing you". When the defendant left the area, [I194] was disoriented and wandered about until he was able to get to the Wollongong Police Station a few hundred metres away. He was wearing a Tshirt which was covered in blood and he was naked from the waist down. He spent a week as a patient in the Wollongong Hospital and 40 stitches were inserted in wounds in his head.

5.2311. The attacks on the other nine men, in relation to which Mr Scerri was acquitted, also had many similarities, including:[1846]

a. The nature of the physical and sexual assaults;

b. The injuries suffered by the victims;

c. The manner in which those injuries were inflicted;

d. The geographical location in which many of the attacks occurred; and

e. The fact that the victims were usually intoxicated.

5.2312. Mr Rooney's case, so far as can now be ascertained on the available evidence, had some of these features. However, whereas all the other victims survived and were able to tell police that they had been assaulted, that is obviously not so in the case of Mr Rooney.

5.2313. In Mr Rooney's case, whether it was an assault or a fall which caused his injuries can only be assessed by reference to objective evidence such as the nature and extent of his injuries.

5.2314. In addition, there is no evidence as to whether Mr Rooney was sexually assaulted (as was the case with the other victims), because no tests were carried out in relation to that possibility, either on his admission to hospital or during the post-mortem examination.

[1846] Exhibit 22, Tab 34, Letter from Inspector D Ainsworth to Craig Hyland, 17 March 1993, 9-10 (SCOI.11076.00007).

5.2315. As outlined above, the nature of the attacks on these 12 men led to Detective Inspector Ainsworth's forming the view that Mr Scerri might also have attacked Mr Rooney, and to his considerable efforts to pursue the possibility of charges being brought against Mr Scerri in relation to Mr Rooney's death.

Report of Dr Iles

5.2316. The Inquiry sought and obtained an opinion from Dr Iles, a forensic pathologist.[1847] The issues which Dr Iles was asked to address are set out above.

5.2317. In her report, Dr Iles noted that post-mortem practice has evolved considerably since Mr Rooney's death. However, she outlined some key deficiencies in the post-mortem and medical examinations, and stated that:[1848]

> *[d]ue to inadequate documentation of injuries in the autopsy report, and the lack of a comprehensive forensic medical examination after Mr Rooney was admitted to hospital, addressing the mechanism by which Mr Rooney's sustained his injuries is difficult.*

5.2318. Some of the deficiencies in the post-mortem examination identified by Dr Iles were:[1849]

a. The incomplete documentation of cutaneous injuries;

b. The inadequate examination of the scalp;

c. No indication that an examination to detect the presence or absence of facial injuries, including about the oral mucosa, had been performed;

d. The lack of comment about the presence or absence of anogenital injuries;

e. The absence of any validity to the assessment of the age of the bruises on Mr Rooney's chest;

f. The erroneous attribution and description of injuries, including injuries said to contribute to the cause of death; and

g. Various issues with the post-mortem photographs including discrepancies between the photographs and the descriptions of the injuries in the post-mortem report.

5.2319. As to the different views expressed by Dr Versoza and Dr Ramsay, Dr Iles noted that Dr Versoza appeared to consider injuries sustained in a fall to be the "most likely" mechanism of injury, whereas by contrast Dr Ramsay appeared to suggest that it was "highly unlikely" that such injuries could be sustained in a fall as described.

[1847] Exhibit 22, Tab 39, Expert Report of Dr Linda Iles, undated (provided 31 January 2023) (SCOI.82574).

[1848] Exhibit 22, Tab 39, Expert Report of Dr Linda Iles, undated (provided 31 January 2023), 10 (SCOI.82574).

[1849] Exhibit 22, Tab 39, Expert Report of Dr Linda Iles, undated (provided 31 January 2023), 8-9 (SCOI.82574).

5.2320. Dr Iles considered that Dr Versoza and Dr Ramsay had both expressed "a level of certainty about the mechanism of Mr Rooney's injuries beyond that which [was] supported by the contemporary evidence base".[1850]

5.2321. Dr Iles considered that the following factors favoured Dr Versoza's interpretation:[1851]

a. The type of base of skull fractures observed and described are well recognised to occur from an inverted fall of less than three metres with primary impact around the top of the head;

b. Mr Rooney does not demonstrate extensive cutaneous injuries to either the front or back of his body that may be seen as a result of an assault where multiples impacts are sustained; and

c. The linear abrasions in front of the left elbow (antecubital fossa) demonstrates directionality; it is possible that they may have occurred via contact with a protruding roof structure or wall nails in the scenario described.

5.2322. However, Dr Iles said that on the evidence available, she was unable to exclude either mechanism (i.e., a fall, or a blow to the head by a blunt instrument). Her report went on:[1852]

> *However, I am not convinced that the post mortem examination conducted has been sufficient to exclude multiple scalp impacts, or subtle cutaneous or bony injuries, to allow any type of accurate event reconstruction. If Mr Rooney's injuries had been sustained in a fall, I cannot say how that fall may have come about (i.e., an accidental fall, or whether Mr Rooney was pushed between the retaining wall and toilet block roof). It is also noted that Mr Rooney has a [relative] paucity of documented post cranial injuries given the relatively small space for him to fall into (gap approximately 50cm) given his height (5 foot 11 inches/180cm) in a headfirst fashion. The small abrasion on his neck is non-specific, but this could represent a fingernail abrasion. There is no indication as to when this may have been sustained.*
>
> *On the evidence available, I am unable to exclude either mechanism. Examination of the literature demonstrates that Mr Rooney's injuries, as much as they have been documented, could have been sustained as a result of a fall from around 3 meters in height, with primary impact to the head, or could have been sustained via homicidal means (i.e. blunt trauma to the head by an implement). I agree with the original coroner's determination that the mechanism of Mr Rooney's injuries is undetermined.*

[1850] Exhibit 22, Tab 39, Expert Report of Dr Linda Iles, undated (provided 31 January 2023), 11 (SCOI.82574).

[1851] Exhibit 22, Tab 39, Expert Report of Dr Linda Iles, undated (provided 31 January 2023), 11 (SCOI.82574).

[1852] Exhibit 22, Tab 39, Expert Report of Dr Linda Iles, undated (provided 31 January 2023), 11-12 (SCOI.82574).

5.2323. Dr Iles concluded that Mr Rooney's *cause* of death could reasonably be described as "blunt head injuries".[1853] However, on the evidence available, she was unable to determine the *manner* of his death.[1854]

Report of Professor Ranson

5.2324. The Inquiry sought and obtained an opinion from Professor Ranson, a forensic pathologist.

5.2325. In his report, Professor Ranson observed the purpose of a post-mortem examination as part of a medico-legal death investigation is often not limited to a determination of cause of death.[1855] Professor Ranson stated that there are many purposes of a post-mortem examination. One such purpose is to record any findings as to fact in such detail so as to ensure that the post-mortem report is "technically, medically and scientifically reviewable".[1856]

5.2326. Professor Ranson considered Dr Verzosa's post-mortem report to be inadequate for various reasons, including the absence of relevant detail and analysis. These inadequacies impeded the ability of Professor Ranson to review Dr Verzosa's findings. However, Professor Ranson noted that, in his opinion, the injuries received by Mr Rooney "would have been modified/changed as a result of the body's normal healing processes by the time he died and the autopsy findings described in the report need to be read with this in mind".[1857]

5.2327. However, Professor Ranson concluded that many of the inadequacies in the post-mortem report were a product of the time at which it was prepared, and that these inadequacies were unlikely to be found in any such report prepared today.

5.2328. Professor Ranson also concluded that in the circumstances, forensic swabs should have been collected because "if in doubt it is always important in any forensic examination to speculatively collect potentially forensically significant samples even if the information yield is likely to be low or non-existent and this is even more relevant when the case may involve an unknown alleged perpetrator".[1858] Professor Ranson observed that any discussions between police investigators and Dr Verzosa as to the type of investigation and scope may well have influenced the procedures performed during the post-mortem examination.[1859] This is because understanding a person's medical history and/or background is an essential part of planning what medical examinations are to be undertaken.[1860]

[1853] Exhibit 22, Tab 39, Expert Report of Dr Linda Iles, undated (provided 31 January 2023), 12 (SCOI.82574).
[1854] Exhibit 22, Tab 39, Expert Report of Dr Linda Iles, undated (provided 31 January 2023), 12 (SCOI.82574).
[1855] Exhibit 22, Tab 53, Expert Report of Professor David Ranson, 2 August 2023 (provided 23 October 2023), 17 (SCOI.86368).
[1856] Exhibit 22, Tab 53, Expert Report of Professor David Ranson, 2 August 2023 (provided 23 October 2023), 17 (SCOI.86368).
[1857] Exhibit 22, Tab 53, Expert Report of Professor David Ranson, 2 August 2023 (provided 23 October 2023), 17 (SCOI.86368).
[1858] Exhibit 22, Tab 53, Expert Report of Professor David Ranson, 2 August 2023 (provided 23 October 2023), 19 (SCOI.86368).
[1859] Exhibit 22, Tab 53, Expert Report of Professor David Ranson, 2 August 2023 (provided 23 October 2023), 19 (SCOI.86368).
[1860] Exhibit 22, Tab 53, Expert Report of Professor David Ranson, 2 August 2023 (provided 23 October 2023), 19 (SCOI.86368).

Manner and cause of death

Cause of death

5.2329. As to the cause of Mr Rooney's death, Counsel Assisting submitted that I should adopt Dr Iles' opinion that an appropriate description would be "blunt head injuries".[1861] The NSWPF supported this formulation,[1862] and I adopt it.

Manner of death

5.2330. As to the manner of Mr Rooney's death, I agree with Counsel Assisting that the evidence available to the Inquiry is insufficient to permit a positive finding of either accident or foul play. Nor, however, does the evidence enable either of those possibilities to be ruled out.

5.2331. Consequently, as proposed by Counsel Assisting (with whose submission in this regard the NSWPF agreed), I find that Mr Rooney died on 20 February 1986 as a result of blunt head injuries sustained on 14 February 1986, noting, however, that the evidence available to the Inquiry is insufficient to establish whether these injuries were the result of an assault or an accidental fall.

5.2332. I add the following observations in relation to each of the two possibilities.

The possibility of accident

5.2333. The medical evidence (both at the time, and as distilled and elaborated in Dr Iles' 2023 report) is such that an accidental fall cannot be ruled out.

5.2334. At the inquest in October 1986, Dr Ramsay clearly doubted that Mr Rooney's injuries had been caused by a three-metre fall.

5.2335. Detective Inspector Ainsworth's commendably thorough examination of the available evidence led him to the considered view that a fall was unlikely, and to the suspicion that Mr Rooney had been first assaulted and then dropped on his head.[1863]

5.2336. On the other hand, Dr Iles provides some qualified support for the views of Dr Verzosa, as expressed both in his post-mortem report and at the 1986 inquest, namely that Mr Rooney's head injuries had probably been caused by hitting a hard flat surface rather than by being struck with an object.

5.2337. Investigations carried out by police on 14 and 15 February 1986 confirmed that Mr Rooney was "fairly intoxicated".[1864]

5.2338. In those circumstances, the possibility of misadventure cannot be ruled out.

[1861] Submissions of Counsel Assisting, 16 May 2023, [214] (SCOI.83199).

[1862] Submissions of NSWPF, 1 June 2023 [3]–[4] (SCOI.83645).

[1863] Exhibit 22, Tab 34, Letter from D Ainsworth to C Hyland, 17 May 1993, 1 (SCOI.11076.00007); Exhibit 22, Tab 34A Letter from D Ainsworth to P Conlon, 4 July 1990, 1 (SCOI.83191).

[1864] Exhibit 22, Tab 34, Letter from D Ainsworth to C Hyland, 17 May 1993, 1 (SCOI.11076.00007); Exhibit 22, Tab 34A Letter from D Ainsworth to P Conlon, 4 July 1990, 1 (SCOI.83191).

The possibility of foul play

5.2339. The evidence is also such as to accommodate the possibility that Mr Rooney was assaulted.

5.2340. First, the expert evidence of Dr Iles, in reviewing both the available medical records and the views of Dr Verzosa and Dr Ramsay, elegantly makes that clear.

5.2341. Secondly, as Counsel Assisting observed, a number of aspects of the evidence point towards the possibility that Mr Rooney was the victim of foul play, including:

a. That Mr Rooney was not carrying ID;[1865]

b. That his pants and underwear were lowered;[1866]

c. That he was missing a shoe and a sock;[1867]

d. That he appeared to have fingernail marks (not his own) on his neck;[1868] and

e. That he was known to "hold his liquor" well.[1869]

5.2342. In addition, of course, the relevant evidence includes the assaults on 12 other men, in locations most of which were fairly close by, some of them proven to have been perpetrated by Mr Scerri. The first of those occurred only three weeks after Mr Rooney suffered his injuries.

5.2343. The NSWPF acknowledged in its submissions that an assault cannot be ruled out as a possibility, even if it were to be found that the death did result from a fall, but submitted that the evidence did not "allow a positive conclusion to be reached as to such a course of events".[1870]

5.2344. I agree that each of the factors noted by Counsel Assisting is consistent with the possibility of foul play. However, as Counsel Assisting submitted, none of them — either separately or in combination — provides sufficient basis for a positive finding to that effect.

Bias

5.2345. Mr Rooney was an out gay man. He was living with his partner, Mr Davis, at the time of his death.

[1865] Mr Rooney was only found with a Medicare card and $5 in cash: Exhibit 22, Tab 1, P79A Report of Death to Coroner, 20 February 1986 (SCOI.11269.00002); See also Exhibit 22, Tab 41, Statement of John Robert Tate, 12 May 2023, [8] (SCOI.83107).

[1866] Exhibit 22, Tab 50, 'Video of Mr Rooney in Laneway' (WIN Television, 14 February 1986) (SCOI.82576).

[1867] Exhibit 22, Tab 13, Statement of Constable Michael Troy Tranby, 19 March 1986 (SCOI.03683.00004).

[1868] Exhibit 22, Tab 14, Statement of Detective Sergeant Stephen George Passmore, 22 October 1986, [5] (SCOI.11269.00016).

[1869] Exhibit 22, Tab 30, Strike Force Parrabell, Bias Crimes Indicators Review Form – William Rooney, undated (SCOI.03077); See also Exhibit 22, Tab 18, Statement of Steven Brett Snedden, 22 February 1986, [4] (SCOI.11269.00011).

[1870] Submissions of NSWPF, 1 June 2023 [21] (SCOI.83645).

5.2346. In the three and a half years which commenced immediately after Mr Rooney's death, there was a series of attacks on 12 men in and near Wollongong. Most of those men were gay. The first of these attacks was on 9 March 1986,[1871] only a little more than three weeks after Mr Rooney suffered the injuries which caused his death. Many of these attacks (including the three in relation to which Mr Scerri was convicted) involved a similar *modus operandi*, in which victims suffered a blow or blows to the head (or the threat of such a physical assault) prior to being sexually assaulted.

5.2347. Counsel Assisting submitted that if it were to be assumed that Mr Rooney's death was a homicide, and that it was committed by Mr Scerri, there would be ample grounds for a conclusion that Mr Rooney's death was a crime in which LGBTIQ bias was or may have been a factor.[1872]

5.2348. However, as Counsel Assisting acknowledged, the available evidence does not allow either of these assumptions to be positively established. There exists a reasonable alternative hypothesis other than homicide, namely that Mr Rooney sustained his injuries as a result of an accidental fall.[1873]

5.2349. The NSWPF added, of its submissions, that "a conclusion that Mr Rooney's death was caused by an assault would not, without more, allow a conclusion that his death was the product of LGBTIQ bias."[1874] I agree.

5.2350. The NSWPF also contended that, even if it were established that not only was the death was a homicide, but also that the perpetrator was Mr Scerri, that "would not lead inexorably" to a conclusion that Mr Rooney's homicide "must have been" motivated by LGBTIQ bias. The NSWPF submitted that Mr Scerri's actions (on that hypothesis) may have been driven, not by LGBTIQ bias, "but rather [by] a form of sexual sadism or a more generalised desire for sexual gratification".[1875]

5.2351. Those submissions by the NSWPF, focusing on "inexorably" and "must have been", are not to the point. The question for me is not whether LGBTIQ bias "must have been" involved, but whether there are, objectively, reasonable grounds for a suspicion that it was.

5.2352. Critically, no attempt was made at the time to ascertain whether Mr Rooney was sexually assaulted, and it is now not possible to carry out any tests which would shed light on that issue. Accordingly, it can never be known whether the circumstances of Mr Rooney's death included sexual assault (as occurred in many of the other 12 assaults of which Mr Scerri was accused and/or convicted).

5.2353. For the reasons outlined above, while it is not possible to conclude positively that Mr Rooney's death was a homicide, that possibility can by no means be ruled out. That is to say, there is objectively reason to suspect that Mr Rooney's death was a homicide.

[1871] Exhibit 22, Tab 34, Letter from Inspector D Ainsworth to Craig Hyland, 17 March 1993, 2 (SCOI.11076.00007).

[1872] Submissions of Counsel Assisting, 16 May 2023, [212] (SCOI.83199).

[1873] Submissions of Counsel Assisting, 16 May 2023, [213] (SCOI.83199).

[1874] Submissions of NSWPF, 1 June 2023 [22] (SCOI.83645).

[1875] Submissions of NSWPF, 1 June 2023 [22] (SCOI.83645).

5.2354. Since misadventure also cannot be ruled out, it is also not possible to reach a positive conclusion that LGBTIQ bias was a factor in Mr Rooney's death.

5.2355. However, as I have explained in **Chapter 1**, the question which I must answer is simply whether there is, objectively, reason to suspect that the death was a homicide (which in my view there is) but that membership of the LGBTIQ community (actual or assumed) of the deceased person, was a factor in the commission of the crime.

5.2356. In my view, the presence of the factors identified in [5.2339]–[5.2344] and [5.2345]–[5.2346] above means that there is also, objectively, reason to suspect that LGBTIQ bias was a factor in the death of Mr Rooney.

Conclusions and Recommendations

5.2357. I find that Mr Rooney died on 20 February 1986 as a result of blunt head injuries sustained on 14 February 1986. However, the evidence available to the Inquiry is insufficient to establish whether these injuries were the result of an assault or an accidental fall. I note that this finding is consistent with the previous coronial findings.

5.2358. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in the death of Mr Rooney.

5.2359. I do not propose to make any recommendations arising from the Inquiry's consideration of Mr Rooney's death.

IN THE MATTER OF ANDREW CURRIE

Factual background

Date and location of death

5.2360. Andrew Currie died between 11:00pm on 12 December 1988 and 7:15am on 13 December 1988 at a toilet block in Nolan Reserve in the suburb of North Manly in Sydney.

Circumstances of death

5.2361. Mr Currie was 29 years old when he died. He had a longstanding addiction to prescription medications and other substances, including Nembudeine.

5.2362. During the course of the day leading up to his death, it is apparent that he had taken excessive quantities of a restricted prescription medication. He appears to have collapsed while visiting the public toilet in a park that was on his walking route home after visiting his friend GB (a pseudonym) on the evening of 12 December 1988.

5.2363. At around 7:15am the next morning, GB found Mr Currie's body lying face down inside the toilet block. The state in which Mr Currie's body was found is described below.

Previous investigations

Original police investigation

5.2364. The original police investigation into Mr Currie's death was overseen by Manly Police. Constable Phillip Greenhalgh was the OIC of the investigation.[1876]

5.2365. Officers attended the toilet block after GB reported the death at Manly Police Station at 7:55am on 13 December 1988.[1877] Constable Greenhalgh attended the location with GB. At this stage Mr Currie's body was face up (having earlier been turned over by GB).[1878] He was described as wearing blue jeans, a brown woollen jumper, a yellow t-shirt that was torn around the neck area, and black thongs.[1879]

5.2366. Constable Greenhalgh described Mr Currie's face being covered in what appeared to be bile or body fluids, that he had a few grazes to his face and that his teeth appeared to be "dislodged". There was a "very shallow film of water" near him.[1880] He stated that ambulance officers arrived and said that Mr Currie had been deceased for a long period during the night.[1881]

[1876] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988 (SCOI.00016.00007).

[1877] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988, [2] (SCOI.00016.00007).

[1878] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988, [2] (SCOI.00016.00007).

[1879] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988, [2] (SCOI.00016.00007).

[1880] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988, [2] (SCOI.00016.00007).

[1881] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988, [3] (SCOI.00016.00007).

5.2367. According to Constable Greenhalgh, both detectives and scientific officers attended the scene.[1882] At least seven colour photos were taken of the scene, with Mr Currie's body *in situ*.[1883]

5.2368. Constable Greenhalgh's statement was unsigned and bears the date of 13 December 1988, the day that Mr Currie's body was found.[1884] In it, Constable Greenhalgh states that "no suspicious circumstances were apparent".[1885] He expresses his view of what occurred as follows:[1886]

> *It appears that from the time he was last seen at [GB's] residence he was going home, as the place where he was located was on (sic) route to home and the toilet areas around District Park was (sic) a regular meeting place for him and [GB] and to use drugs, and at this stage appears to be an overdose and due to incapacitation from the drugs fell to the ground and became unconscious. The small amount of water nearby would have been at a higher level during the evening and if the deceased fell down his facial area would have been in the water.*

5.2369. The Report of Death to Coroner, prepared and signed by Constable Greenhalgh on the same day, 13 December 1988, was in similar terms.[1887] It concluded that there were no suspicious circumstances, and that it appeared that Mr Currie:[1888]

> *had attended the location, which is on (sic) route from [GB's] residence to his own home, and overdosed and fallen down onto the concrete ground, face down, and became unconscious.*

Persons of interest

5.2370. No persons of interest in relation to the death were identified at the time of Mr Currie's death, or subsequently.

5.2371. The Inquiry has not identified any persons of interest. Mr Currie's friend, GB, saw Mr Currie on the night of his death, and along with Mr Currie's mother, he was involved in finding Mr Currie's body the following morning. However, there is no evidence suggesting that GB, or any other person, had any involvement in Mr Currie's death.

Post-mortem examination

5.2372. A post-mortem examination was conducted on 17 December 1988 by Dr William Brighton.[1889] In his opinion, the direct cause of Mr Currie's death was "[p]oisoning by a combination of Pentobarbitone, Codeine, Methadone and Morphine."[1890]

[1882] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988, [3] (SCOI.00016.00007).

[1883] Exhibit 13, Tab 9, Crime scene photographs, 13 December 1988 (SCOI.82213).

[1884] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988, 1 (SCOI.00016.00007).

[1885] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988, [3] (SCOI.00016.00007).

[1886] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988, [5] (SCOI.00016.00007).

[1887] Exhibit 13, Tab 1, Report of death to Coroner, 13 December 1988, 1 (SCOI.00016.00010).

[1888] Exhibit 13, Tab 1, P79A – Report of death to Coroner, 13 December 1988, 1 (SCOI.00016.00010).

[1889] Exhibit 13, Tab 5, Post-mortem report of Dr William Brighton, 13 February 1989 (SCOI.00016.00011).

[1890] Exhibit 13, Tab 5, Post-mortem report of Dr William Brighton, 13 February 1989, 1 (SCOI.00016.00011).

5.2373. Dr Brighton found "no significant injury on the body".[1891] He noted two areas of dry brown abrasion in the forehead and temple regions that were consistent with pressure at around the time of death and some slight reddening of skin over the nose and in the mid forehead region.[1892] There were no internal injuries.[1893]

5.2374. Mr Currie's body was noted to be in an unkempt state with much soiling to his feet.[1894] There was dark brown to dark green material around his nostrils that appeared to have been regurgitated.[1895]

5.2375. Toxicology testing found a combination of Pentobarbitone, Codeine, Methadone, Morphine and Paracetamol in Mr Currie's liver, stomach, blood and bile.[1896] No alcohol was detected.[1897]

Exhibits

5.2376. Property located on Mr Currie consisted of two handkerchiefs, a cigarette lighter, three keys on a keyring and a concession card in Mr Currie's name.[1898] Constable Greenhalgh stated that this property was later collected by Mr Currie's mother,[1899] there being no suggestion that it was the subject of any form of forensic testing.

5.2377. The records obtained by the Inquiry in this matter, including those held by DOFM indicate that no exhibits were retained, and were consequently not available for testing.

Findings at inquest

5.2378. No coronial inquest was held into Mr Currie's death. The coronial records indicated that an inquest was dispensed with immediately following receipt by the Coroner of the post-mortem and toxicology reports in February 1989.[1900] While the reason for dispensing with an inquest was not recorded on the file, the decision to do so indicates that it did not appear to the Coroner that Mr Currie had died, or may have died, as a result of homicide.[1901]

[1891] Exhibit 13, Tab 5, Post-mortem report of Dr William Brighton, 13 February 1989, 1 (SCOI.00016.00011).

[1892] Exhibit 13, Tab 5, Post-mortem report of Dr William Brighton, 13 February 1989, 1 (SCOI.00016.00011).

[1893] Exhibit 13, Tab 5, Post-mortem report of Dr William Brighton, 13 February 1989, 1 (SCOI.00016.00011).

[1894] Exhibit 13, Tab 5, Post-mortem report of Dr William Brighton, 13 February 1989, 1 (SCOI.00016.00011).

[1895] Exhibit 13, Tab 5, Post-mortem report of Dr William Brighton, 13 February 1989, 1 (SCOI.00016.00011).

[1896] Exhibit 13, Tab 4, Toxicology report, 2 February 1989, 1 (SCOI.00016.00012).

[1897] Exhibit 13, Tab 4, Toxicology report, 2 February 1989, 1 (SCOI.00016.00012).

[1898] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988, [3] (SCOI.00016.00007).

[1899] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988, [3] (SCOI.00016.00007).

[1900] Exhibit 13, Tab 6, Coroners Court summary sheet, 23 February 1989, 1 (SCOI.00016.00001).

[1901] As at February 1989, s. 14(5)(a) of the *Coroners Act 1980* (NSW) provided that an inquest could not be dispensed with in a case in which it appeared that the person died or might have died as a result of homicide (not including suicide). The current *Coroners Act 2009* (NSW) has a similar provision.

Strike Force Parrabell

Bias Crimes Indicators Form

5.2379. A BCIF was completed by Strike Force Parrabell.[1902] Nine of the ten indicators were answered "No Evidence of Bias Crime", and the Summary of Findings categorised the case in those terms overall. It was noted that the evidence suggested that Mr Currie died of accidental drug overdose.[1903]

5.2380. The ten "General Comment" sections of the BCIF repeatedly noted that the circumstances surrounding Mr Currie's death were not considered suspicious and that the evidence suggested that Mr Currie died of accidental drug overdose.[1904]

5.2381. The "Summary of Findings" highlighted the following matters:[1905]

a. Mr Currie's persistent drug use activities, often undertaken with GB;

b. That there is no information in relation to Mr Currie's sexuality;

c. That there was no information to suggest that the location was a known beat, however that toilet blocks often were; and

d. That it was unlikely that Mr Currie was at the location in order to engage in "homosexual activities".

5.2382. The summary concluded that, taking into consideration the state of Mr Currie's body, his ingestion of a large quantity of Nembudeine and examination of the scene, there was no evidence that any other person played a role in relation to his ingestion of drugs, leading to his death, nor that his death had been motivated by bias.[1906]

5.2383. As to indicator 4, "Organised Hate Groups (**OHG**)", it was stated that there are no indications that an OHG was involved or active in the Manly area at the time of Mr Currie's death.[1907] This Inquiry has evidence, however, that gay men and beat users (or people presumed to be gay and/or beat users) were the target of attacks by youths in certain parts of the Northern Beaches in the late 1980s, including the Manly area, often with the motive of robbery.[1908] Although these matters were known to the NSWPF at least by the time of Strike Force Parrabell, this is not the subject of comment in the BCIF. It would appear that such attacks did not come within what was contemplated by police as constituting an OHG. Indeed, the NSWPF submitted at [114] that "the relevant groups of youths could not sensibly be characterised as an "Organised Hate Group".

[1902] Exhibit 13, Tab 15, Strike Force Parrabell Bias Crimes Indicators Review Form – Andrew Currie, undated (SCOI.38973).

[1903] Exhibit 13, Tab 15, Strike Force Parrabell Bias Crimes Indicators Review Form – Andrew Currie, Undated 14 (SCOI.38973).

[1904] See e.g. Exhibit 13, Tab 15, Strike Force Parrabell Bias Crimes Indicators Review Form – Andrew Currie, Undated 4, 7–9, 11, 13 (SCOI.38973).

[1905] Exhibit 13, Tab 15, Strike Force Parrabell Bias Crimes Indicators Review Form – Andrew Currie, Undated 14 (SCOI.38973).

[1906] Exhibit 13, Tab 15, Strike Force Parrabell Bias Crimes Indicators Review Form – Andrew Currie, Undated 14 (SCOI.38973).

[1907] Exhibit 13, Tab 15, Strike Force Parrabell Bias Crimes Indicators Review Form – Andrew Currie, Undated 6–7 (SCOI.38973).

[1908] See, e.g., Exhibit 6, Tab 252F, Statement of Detective Chief Inspector Pamela Young, 13 July 2014, [1318]–[1322], [1338], [1405], [1431], [1583], [1606], [1758]–[1768], [1844]–[1868], [1869]–[1877] (SCOI.83088).

5.2384. In my view, the term OHG is lifted from an American context and presents no analogy to the Australian context.[1909] Rather, it represents yet another example of the inadequacy of the BCIF.

5.2385. In the "General Comment" section in relation to indicator 3 ("Drawings, Markers, Symbols, Tattoos, Graffiti"), reference is made to 15 colour photographs of Mr Currie and "the scene" having been viewed.[1910] A related Strike Force Parrabell Investigator's Note produced to the Inquiry included a similar reference. However, as noted below, it appears that only seven such photos were actually received by Strike Force Parrabell. If so, both the BCIF and the Investigator's Note are simply wrong.

5.2386. The NSWPF submitted at [109] that these references were indeed erroneous but that little should be made of what was an inadvertent typographical error in a document which was not intended for public consumption.

5.2387. It is, of course, understandable that occasional errors may appear in the records kept by a strike force such as this. However, in this instance both the relevant "Investigator", and the officer who completed the BCIF (eventually disclosed to be Detective Senior Constable Bignell), have stated that 15 photographs were "viewed" when evidently that is not so. Strike Force Parrabell had a minimal amount of material in relation to Mr Currie's death generally, and any crime scene photographs may have been of considerable probative value.

5.2388. In my view, this goes beyond a mere typographical error and is substantial. Indeed, there is simply no evidence to support the assertion that the error was merely typographical. Although the BCIFs were not produced for public consumption, they were the central records as to the methodology of Strike Force Parrabell, and they were the only NSWPF documents provided to the academic review team about each case.[1911] The need for accurate recording in the BCIFs was crucial.

Case Summary

5.2389. The Case Summary categorised the case as "solved", [1912] and also as "no evidence of bias crime".[1913]

5.2390. The Case Summary reads as follows:[1914]

> ***Identity**: Andrew Currie was 29 years old at the time of his death.*
>
> ***Location of Body/Circumstances of Death**: Mr Currie's body was located at a toilet block in District Park Ovals,9 Pittwater Road, North Manly. The post-mortem examination of Mr Currie's body found no significant injuries to indicate that he may have been assaulted. The Pathologist Toxicology Report stated the direct cause of death was,*

[1909] See Exhibit 6, Tab 255, Expert Report of Professor Nicole Asquith, 25 January 2023, [93] (SCOI.82368.00001).

[1910] Exhibit 13, Tab 15, Strike Force Parrabell Bias Crimes Indicators Review Form – Andrew Currie (undated), 6 (SCOI.38973).

[1911] Transcript of the Inquiry, 28 February 2023, T2379.33–43 (TRA.00029.00001).

[1912] Exhibit 6, Tab 49, Strike Force Parrabell case summaries – Andrew Currie, 18 (SCOI.76961.00014).

[1913] Exhibit 6, Tab 49, Strike Force Parrabell case summaries – Andrew Currie, 18 (SCOI.76961.00014).

[1914] Exhibit 6, Tab 49, Strike Force Parrabell case summaries – Andrew Currie, 18 (SCOI.76961.00014).

'Poisoning by a combination of Pentobarbitone, Codeine, Methadone and Morphine.' No suspects were identified as being involved in the death of Mr Currie with all the evidence indicating his death was caused by an overdose of drugs.

***Sexual Orientation**: Mr Currie's sexual orientation could not be confirmed.*

***Coroner/Court Findings**: The Report of Death to the Coroner stated, 'It appears the deceased had attended the location, which is on route from (GB's) residence to his own home, and overdosed and fallen down onto the concrete ground, face down and became unconscious.'*

SF Parrabell concluded there was no evidence of a bias crime

5.2391. The Case Summary is consistent with the contents of the BCIF.

Academic review

5.2392. The Academic Review categorised the case as "No Bias".[1915]

Review by the Inquiry

5.2393. The Inquiry took the following steps in the course of examining the matter.

Summonses

5.2394. A summons was issued to the NSWPF on 18 May 2022 for all documents relating to investigations by the NSWPF of the death of Mr Currie, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Currie.

5.2395. No police material in respect of Mr Currie's death was produced to the Inquiry in response to Summons NSWPF1.

5.2396. However, on 12 August 2022, the NSWPF produced to the Inquiry its Strike Force Parrabell e@gle.i brief. This included eight documents relating to Mr Currie's death. In addition, on 16 September 2022 the NSWPF produced a further document to the Inquiry (an Investigator's Note dated 13 October 2016),[1916] as part of its response to Summons NSWPF12.

[1915] Exhibit 6, Tab 49, Strike Force Parrabell case summaries – Andrew Currie, 18 (SCOI.76961.00014).

[1916] Exhibit 13, Tab 14, NSWPF Investigator's Note, 'Note of Constable Borg', 13 October 2016, 6 (SCOI.82194).

5.2397. A further summons was issued on 26 September 2022, seeking 15 colour scene photos (summons NSWPF20).[1917] As noted above, both the BCIF and an Investigator's Note dated 13 October 2016 made reference to "15 colour crime scene photographs of Mr Currie's body which were viewed by Strike Force Parrabell investigators."[1918] These were said to have been provided to Strike Force Parrabell investigators by the original OIC of the matter.[1919] Only seven such photos were produced to the Inquiry.

5.2398. By email dated 6 October 2022, a legal representative for the NSWPF advised that it appeared that there were only seven such photographs, despite the references to 15 photographs.[1920]

5.2399. On 10 October 2022, the Inquiry wrote to the NSWPF seeking a letter or statement explaining why the material produced in connection with the Strike Force Parrabell e@gle.i brief had not earlier been produced pursuant to Summons NSWPF1. The letter also sought clarification regarding a number of the crime scene photographs.[1921]

5.2400. In response, on 24 October 2022, an email from the NSWPF legal representative outlined searches that had been undertaken by the NSWPF, and advised that the police had been unsuccessful in locating any investigative material and that the whereabouts of any hardcopy investigative records was unknown.[1922]

5.2401. That email and a later email dated 19 December 2022 also outlined various steps that had been taken to ascertain whether any additional photos existed.[1923] No additional photos were located, and nor was there any record located by the original OIC that clarified how many photos there originally were.[1924]

5.2402. The end result is that the material available to the Inquiry was largely confined to that which was in the coronial brief of evidence provided by police to the Coroners Court back in 1989.

Interagency cooperation

5.2403. The Inquiry requested, and received, Mr Currie's coronial file in May 2022. The coronial file consisted of 34 pages of material, including witness statements, post-mortem and toxicology reports, police records relating to Mr Currie, and correspondence between the Coroners Court and Mr Currie's mother.

[1917] Exhibit 13, Tab 16A, Summons to Produce to NSWPF (NSWPF20), 26 September 2022 (SCOI.82191).

[1918] Exhibit 13, Tab 15, Strike Force Parrabell Bias Crimes Indicators Review Form – Andrew Currie, Undated 4, 7–9, 11, 13 (SCOI.38973); Exhibit 13, Tab 14, NSWPF Investigator's Note, 'Note of Constable Borg', 13 October 2016, 6 (SCOI.82194).

[1919] Exhibit 13, Tab 14, NSWPF Investigator's Note, 'Note of Constable Borg', 13 October 2016, 6 (SCOI.82194); Exhibit 13, Tab 16, Letter from Solicitor Assisting the Inquiry to Office of the General Counsel, NSW Police Force, 26 September 2022 (SCOI.82187).

[1920] Exhibit 13, Tab 17, Email from the Office of the General Counsel, NSW Police Force, to Solicitor Assisting the Inquiry, 6 October 2022, 1 (SCOI.82192).

[1921] Exhibit 13, Tab 18, Letter from Solicitor Assisting the Inquiry to Office of the General Counsel, NSW Police Force, 10 October 2022, 2 (SCOI.82186).

[1922] Exhibit 13, Tab 19, Email correspondence between Office of the General Counsel, NSW Police Force, and Solicitor Assisting the Inquiry, 24 October 2022-19 December 2022, 2–3 (SCOI.82312).

[1923] Exhibit 13, Tab 19, Email correspondence between Office of the General Counsel, NSW Police Force, and Solicitor Assisting the Inquiry, 24 October 2022-19 December 2022, 1 (SCOI.82312).

[1924] Exhibit 13, Tab 19, Email correspondence between Office of the General Counsel, NSW Police Force, and Solicitor Assisting the Inquiry, 24 October 2022-19 December 2022, 1 (SCOI.82312).

Family members

5.2404. The Inquiry was able to locate Mr Currie's only sibling, his older brother, who was living at the family home with his mother and brother at the time of Mr Currie's death. Sadly, Mr Currie's mother passed away some years ago. Mr Currie's brother provided helpful assistance to the Inquiry, by meeting with Inquiry staff and discussing his knowledge of his brother's circumstances around the time of his death.

Witness statements

5.2405. Subsequent to the public hearing in this matter, and having regard to the interest expressed by Mr Currie's family in relation to the conduct of GB prior to and after Mr Currie's death, the Inquiry located GB and obtained a statement from him.[1925] That statement is discussed below.

Contact with OIC

5.2406. On 24 August 2023 and 20 September 2023, the Inquiry wrote to former Constable Greenhalgh enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Currie.[1926] The Inquiry did not receive a response from former Constable Greenhalgh.

Searches for exhibits

5.2407. On 22 August 2022, the Inquiry issued a summons to DOFM in order to ascertain whether they held, separately to police, any photos or other records relating to the post-mortem examination performed on Mr Currie (BDM2).[1927] This was done in order to provide potential assistance to the expert forensic pathologist who was briefed by the Inquiry, as discussed below.

5.2408. In response, the Inquiry received 23 pages of material from DOFM. These consisted of the post-mortem and toxicology reports and other documentation related to the post-mortem examination,[1928] but did not shed any further light on the death beyond the contents of the post-mortem and toxicology reports. Nor did they include any photos.

Further forensic examinations

5.2409. The material before the Inquiry, including the records from DOFM, did not suggest that there were any exhibits in this matter available for testing.

5.2410. As noted above at [5.2376], the items found in Mr Currie's possession at the time he was discovered were returned to Mr Currie's mother.[1929]

[1925] Exhibit 13, Tab 29, Third statement of GB, 29 August 2023 (SCOI.85275).

[1926] Exhibit 66, Tab 22–23, Letters to Phillip Greenhalgh, 24 August 2023 and 20 September 2023 (SCOI.86286; SCOI.86287).

[1927] Exhibit 13, Tab 22, Letter from Solicitor Assisting the Inquiry to NSW Health Pathology, 22 August 2022 (SCOI.82201); Exhibit 13, Tab 22A, Summons to produce to Department of Forensic Medicine (DOFM1), 22 August 2022 (SCOI.82197).

[1928] See, e.g. Exhibit 13, Tab 23, HIV Antibody Screen, 15 December 1988 (SCOI.82196); Exhibit 13, Tab 24, Hepatitis B Antigen Screen, 16 December 1988 (SCOI.82193).

[1929] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988, [3] (SCOI.00016.00007).

Professional opinions

Dr Linda Iles

5.2411. The Inquiry sought and obtained a report from Dr Linda Iles. Dr Iles was asked to address the adequacy of the post-mortem investigations conducted in respect of Mr Currie, including as to:[1930]

a. Whether Mr Currie's teeth were "dislodged", as noted by the OIC;

b. Any significance in the disparity between the observation of the OIC and the post-mortem report regarding the state of Mr Currie's teeth;

c. Whether the water on the floor is likely to have played any role in the mechanism of death; and

d. Whether Mr Currie's injuries and bodily condition were consistent with misadventure, suicide, or foul play.

5.2412. Dr Iles was asked to comment on any potential significance of the observation made by the OIC that some of Mr Currie's teeth appeared to have been dislodged, bearing in mind that no relevant observation concerning the state of Mr Currie's teeth was made by Dr Brighton.[1931]

5.2413. Dr Iles noted that poor dentition was common among those with a history of illicit drug use and that the photos of Mr Currie's teeth show them to be yellowed, with some teeth absent.[1932] She stated:[1933]

> *[i]n the event of underlying dental and periodontal disease, dislodging of teeth either in the post-mortem period or consequent to a low energy impact from an agonal fall or collapse may be observed.*

5.2414. She also noted that there is no post-mortem documentation of other facial trauma. While observing that it is nowadays standard to comment on the state of dentition in post-mortem examination practice, she noted that the same may not have been the case in 1988.[1934]

5.2415. As to the cause of death, Dr Iles took a view that she described as "not significantly different to the opinions of Dr Brighton and Professor Jones", namely that it can be described as "Mixed drug toxicity (pentobarbitone, codeine, methadone)".[1935] She noted that in considering the likely cause of death for individuals (such as Mr Currie) whose blood contains central nervous system depressants, it is necessary to exclude other potential causes of death. She considered that although Dr Brighton's report is brief, it does reasonably exclude other causes of death.[1936]

[1930] Exhibit 13, Tab 25A, Letter of instruction to Dr Linda Iles, 19 December 2022, 4 (SCOI.82310).
[1931] Exhibit 13, Tab 25A, Letter of instruction to Dr Linda Iles, 19 December 2022, 4 (SCOI.82310).
[1932] Exhibit 13, Tab 25, Expert report of Dr Linda Iles, 24 January 2023, 5 (SCOI.82311).
[1933] Exhibit 13, Tab 25, Expert report of Dr Linda Iles, 24 January 2023, 5 (SCOI.82311).
[1934] Exhibit 13, Tab 25, Expert report of Dr Linda Iles, 24 January 2023, 5 (SCOI.82311).
[1935] Exhibit 13, Tab 25, Expert report of Dr Linda Iles, 24 January 2023, 6 (SCOI.82311).
[1936] Exhibit 13, Tab 25, Expert report of Dr Linda Iles, 24 January 2023, 6 (SCOI.82311).

5.2416. Dr Iles was of the view that the presence of the thin film of water on the floor was unlikely to have contributed significantly to the death. She expressed the view that the superficial or minor abrasions to Mr Currie's face and any dislodgment of his teeth can potentially be ascribed to perimortem phenomenon.[1937] Although it was not possible to exclude the possibility of blunt force trauma to the face, absent a thorough examination of relevant facial areas (and she could not say whether one had taken place), she was of the view that Mr Currie's death was most likely consistent with misadventure.[1938]

5.2417. Dr Iles described the drug Nembudeine (which on the evidence was a drug frequently used by Mr Currie) as an Australian preparation from Abbott Pharmaceuticals that she believed was no longer available.[1939] Its active ingredients included paracetamol (acetaminophen), codeine phosphate and pentobarbital sodium. The codeine, pentobarbitone, and morphine (as a metabolite of codeine) identified in Mr Currie's blood could all be "ascribed to ingestion of Nembudeine tablets".[1940] It could also explain the presence of paracetamol in Mr Currie's blood.[1941]

5.2418. Dr Iles did not believe, based on the material available to her, that any further investigation of the manner or cause of death would be of utility.[1942]

Professor Alison Jones

5.2419. The Inquiry also sought and obtained a report and a supplementary report from Professor Alison Jones, toxicologist and Acting Chief Medical Officer of the Department of Health, Western Australia.[1943] Professor Jones was asked for her opinion on a number of matters including the lethality of the concentrations of relevant substances detected in Mr Currie's blood and organs and the contribution made to his death by the ingestion of Nembudeine or any other substance.[1944]

5.2420. Professor Jones made the following observations:

a. Nembudeine ingestion could account for the presence of codeine, pentobarbitone and paracetamol in Mr Currie's toxicology results.[1945]

b. The morphine level in Mr Currie's blood was at a therapeutic level and was likely a contributing factor to the death. Morphine is a metabolite of codeine metabolism and was likely a by-product of Mr Currie's consumption of codeine.[1946]

c. Mr Currie's blood concentration of methadone was in the therapeutic range but below either the toxic or fatal ranges. Alone it would not be expected to

[1937] Exhibit 13, Tab 25, Expert report of Dr Linda Iles, 24 January 2023, 6–7 (SCOI.82311).
[1938] Exhibit 13, Tab 25, Expert report of Dr Linda Iles, 24 January 2023, 7 (SCOI.82311).
[1939] Exhibit 13, Tab 25, Expert report of Dr Linda Iles, 24 January 2023, 7 (SCOI.82311).
[1940] Exhibit 13, Tab 25, Expert report of Dr Linda Iles, 24 January 2023, 7 (SCOI.82311).
[1941] Exhibit 13, Tab 25, Expert report of Dr Linda Iles, 24 January 2023, 7 (SCOI.82311).
[1942] Exhibit 13, Tab 25, Expert report of Dr Linda Iles, 24 January 2023, 7 (SCOI.82311).
[1943] Exhibit 13, Tab 27, Supplementary expert report of Professor Alison Jones, 23 January 2023 (SCOI.82339).
[1944] Exhibit 13, Tab 26B, Letter of instruction to Professor Alison Jones, 26 September 2022, 4 (SCOI.82190).
[1945] Exhibit 13, Tab 27, Supplementary expert report of Professor Alison Jones, 23 January 2023, 1 (SCOI.82339).
[1946] Exhibit 13, Tab 26, Expert report of Professor Alison Jones, 22 October 2022, 6 (SCOI.82188).

result in clinical opioid toxicity effects (resulting in death predominantly due to respiratory depression), but would contribute to overall opioid toxicity when combined with other opioid drugs, e.g. codeine and morphine.[1947]

d. Pentobarbitone is a short-acting barbiturate used clinically as a sedating-hypnotic agent. The level of pentobarbitone in Mr Currie's post-mortem blood was in the toxic to lower end of the fatal ranges. The level of pentobarbitone in his liver was in the fatal range.[1948]

e. The level of codeine in Mr Currie's blood was in the toxic to fatal ranges. There was a therapeutic level of paracetamol in his blood.[1949]

5.2421. As noted above, Professor Jones stated that:[1950]

> *Pentobarbitone was found in toxic to lethal concentrations in Mr Currie's post-mortem blood and within the fatal range in his liver. Phenobarbitone would cause significant CNS [central nervous system] and respiratory depression. Alone it would be fatal, but when combined with the codeine (in toxic to fatal ranges), methadone (in the therapeutic range) and morphine (in the therapeutic range) would have added effects on the CNS and respiratory depression caused by all these opioid drugs.*

5.2422. Professor Jones concluded that:[1951]

> *Mr Currie most likely died as a consequence of codeine and pentobarbitone oral overdosage, on a background of methadone use. But for the presence of the codeine and pentobarbitone in overdose Mr Currie would have been expected to survive.*

Consideration of the evidence

Mr Currie's background

5.2423. Mr Currie was 29 years old when he died. He lived at home with his mother and older brother on Waine Street in Harbord (now known as the suburb of Freshwater).[1952]

5.2424. Mr Currie had a longstanding addiction to prescription medications and other substances, as a result of which he was known to Manly police. A facts sheet related to some minor offending with which Mr Currie was charged on 14 October 1988, two months prior to his death, described his interaction, while drug affected, with police after being found in possession of a bottle of a prescribed restricted drug.[1953]

[1947] Exhibit 13, Tab 26, Expert report of Professor Alison Jones, 22 October 2022, 9 (SCOI.82188).

[1948] Exhibit 13, Tab 26, Expert report of Professor Alison Jones, 22 October 2022, 11 (SCOI.82188).

[1949] Exhibit 13, Tab 26, Expert report of Professor Alison Jones, 22 October 2022, 12 (SCOI.82188).

[1950] Exhibit 13, Tab 26, Expert report of Professor Alison Jones, 22 October 2022, 13 (SCOI.82188).

[1951] Exhibit 13, Tab 26, Expert report of Professor Alison Jones, 22 October 2022, 14 (SCOI.82188).

[1952] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988, [2] (SCOI.00016.00007).

[1953] Exhibit 13, Tab 12, NSWPF Facts Sheet, 14 October 1988 (SCOI.00016.00022).

5.2425. In part the facts sheet read as follows:[1954]

> *The defendant is well known for this type of offence, and is a person who can often be found in the Manly and surrounding environs in an overdosed state by utilizing [sic] drugs of this type. The defendant comes from a good family and has a caring mother who, in the past, has expressed deep concern for the welfare of this defendant.*
>
> *The courts and Police in the Manly area have over the years attempted on numerous occasions to guide this defendant away from this type of offence but to this stage no success has been permanently experienced.*
>
> *Friends of this defendant have in fact died and this fact does not deter him from actions of this kind.*
>
> …
>
> *Other than placing this defendant before the Court, Police have exhausted all available means at their disposal by which the defendant may in time have a better future.*

5.2426. The statement of Constable Greenhalgh similarly described Mr Currie as "a weel (sic) known drug user" who had "come under police attention numerous times".[1955] He also stated that Mr Currie had been taken to hospital on several occasions for overdosing.[1956]

Friendship with GB

5.2427. Two statements were made by GB immediately following Mr Currie's death. One statement describes GB's involvement in finding Mr Currie's body (**first statement**),[1957] and the other deals with GB's interactions with Mr Currie on the evening preceding his death (**second statement**).[1958]

5.2428. A further statement, provided to the Inquiry in August 2023, outlined GB's present recollections of both of these matters (**third statement**).

5.2429. GB described Mr Currie as a good friend who he had known for 13 years. GB recalled that Mr Currie "was a funny character, and a good artist. … Andrew was a good bloke and helped me a lot."[1959]

[1954] Exhibit 13, Tab 12, NSWPF Facts Sheet, 14 October 1988, 1–2 (SCOI.00016.00022).

[1955] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988, [5] (SCOI.00016.00007).

[1956] Exhibit 13, Tab 8, Statement of Constable Phillip Dean Greenhalgh, 13 December 1988, [5] (SCOI.00016.00007).

[1957] Exhibit 13, Tab 20, First statement of GB, 13 December 1988 (SCOI.00016.00008).

[1958] Exhibit 13, Tab 21, Second statement of GB, 13 December 1988 (SCOI.00016.00009).

[1959] Exhibit 13, Tab 29, Third statement of GB, 29 August 2023, [7] (SCOI.85275).

5.2430. In his second statement, GB said that he had known Mr Currie to use various types of drugs from "grass" to the occasional use of heroin, but that it was mainly Nembudeine (which he referred to as "the N's") that he would use "quite frequently, every day or every second day", although he stated that Mr Currie had "cut back in the last few years".[1960]

5.2431. Consistent with this, a 1988 police facts sheet indicated that Mr Currie was charged with possession of Nembudeine (being a prescribed restricted substance) on 14 October 1988, two months prior to his death.[1961] The same facts sheet names GB as someone known to Mr Currie. It describes GB as a "like recidivist", stating that:[1962]

> *It is evident that once these two keep company both increase their ingestion of prescribed restricted and prohibited drugs.*

5.2432. GB's third statement confirmed the serious drug use problem that both he and Mr Currie faced around the time of Mr Currie's death, particularly in relation to illicitly obtained prescription medications.[1963] He stated that the toilet blocks in District Park were a location where he and Mr Currie would use drugs on occasion.[1964]

Last known movements

5.2433. GB told police that he last saw Mr Currie between 10:00pm and 11:00pm on 12 December 1988.

5.2434. He said that Mr Currie had come to GB's residence in Manly Vale at around 8:30pm that evening.[1965] GB's partner was home at the time.[1966] Mr Currie and GB spoke for a while and "had a cuppa".[1967]

5.2435. GB described Mr Currie as appearing to be "under the influence of a drug", and said that he was very slow and had slurred speech.[1968] Mr Currie told him that he had taken 25 Nembudeine tablets that morning and during the day. He told GB that he had no tablets left, however GB patted Mr Currie's pockets and heard a rattle, which suggested to GB that Mr Currie did have tablets on him. Mr Currie then told GB that he had three tablets on him, although GB thought that by the sound of the "rattle", he would have been in possession of a greater number of tablets.[1969]

[1960] Exhibit 13, Tab 21, Second statement of GB, 13 December 1988, [3] (SCOI.00016.00009).
[1961] Exhibit 13, Tab 12, NSWPF Facts Sheet, 14 October 1988, 1 (SCOI.00016.00022).
[1962] Exhibit 13, Tab 12, NSWPF Facts Sheet, 14 October 1988, 1 (SCOI.00016.00022).
[1963] Exhibit 13, Tab 29, Third statement of GB, 29 August 2023, [5]–[11] (SCOI.85275).
[1964] Exhibit 13, Tab 29, Third statement of GB, 29 August 2023, [11] (SCOI.85275).
[1965] Exhibit 13, Tab 21, Second statement of GB, 13 December 1988, [1] (SCOI.00016.00009).
[1966] Exhibit 13, Tab 29, Third statement of GB, 29 August 2023, [3] (SCOI.85275).
[1967] Exhibit 13, Tab 21, Second statement of GB, 13 December 1988, [1] (SCOI.00016.00009).
[1968] Exhibit 13, Tab 21, Second statement of GB, 13 December 1988, [1] (SCOI.00016.00009).
[1969] Exhibit 13, Tab 21, Second statement of GB, 13 December 1988, [1] (SCOI.00016.00009).

5.2436. GB further recounted that when Mr Currie was leaving (seemingly to go home), he asked GB to phone him (presumably meaning in the morning). However, GB told him that instead, Mr Currie should get his brother to wake him up. He suggested that Mr Currie come back to his place at 8:30am the following morning.[1970]

5.2437. GB recalled that Mr Currie was "still pretty wasted" when he left, and he thought that Mr Currie had his bottle of Nembudeine pills on him.[1971]

5.2438. GB recalled that, after Mr Currie left, he and his partner went to bed.[1972] The Inquiry attempted to contact GB's partner as to her recollection of that evening, but did not receive a response.[1973]

Discovery of body

5.2439. Early in the morning of 13 December 1988, Mr Currie's mother attended GB's residence. She was concerned because her son had not come home. From there they both travelled in Mr Currie's mother's car to look for Mr Currie at District Park.[1974]

5.2440. In his first statement, GB stated that at about 7:15am he was dropped off by Mr Currie's mother in Campbell Parade in Manly Vale, approximately 400 metres from where Mr Currie was found.[1975] He checked a toilet block next to a bowling club, then went to the toilet block in which he found Mr Currie.[1976] Thirty five years later, in his third statement, GB was not certain which of the toilet blocks in the park was the one where he found Mr Currie.[1977]

5.2441. When GB found Mr Currie, he was lying face down on the ground in the toilet block. There was a small amount of water on the ground. GB turned Mr Currie over and checked for a pulse. He described Mr Currie's skin as cold and clammy.[1978] When turning him over, he noticed what he thought was mud on Mr Currie's face.[1979]

5.2442. In his third statement, GB further recalled:

> *I panicked and thought he might still be breathing. I turned him over and put him in a seated position in front of me. I shook him to see if he was okay. I could see that he had smashed his nose, mouth and teeth. There was blood over his face, like he had gone down and hit the deck. He had swallowed his tongue and had green bile inside his mouth, so I started*

[1970] Exhibit 13, Tab 21, Second statement of GB, 13 December 1988, [2] (SCOI.00016.00009).
[1971] Exhibit 13, Tab 29, Third statement of GB, 29 August 2023, [16] (SCOI.85275).
[1972] Exhibit 13, Tab 29, Third statement of GB, 29 August 2023, [16] (SCOI.85275).
[1973] Exhibit 13, Tab 30, Supplementary statement of Caitlin Healey-Nash, 16 November 2023, [5]–[7] (SCOI.86618).
[1974] Exhibit 13, Tab 29, Third statement of GB, 29 August 2023, [17]–[19] (SCOI.85275).
[1975] Exhibit 13, Tab 20, First statement of GB, 13 December 1988, [1] (SCOI.00016.00008).
[1976] Exhibit 13, Tab 20, First statement of GB, 13 December 1988, [1] (SCOI.00016.00008).
[1977] Exhibit 13, Tab 29, Third statement of GB, 29 August 2023, [20] (SCOI.85275).
[1978] Exhibit 13, Tab 20, First statement of GB, 13 December 1988, [1] (SCOI.00016.00008).
[1979] Exhibit 13, Tab 20, First statement of GB, 13 December 1988, [3] (SCOI.00016.00008).

> *raking it out with my fingers. I wanted to give him mouth-to-mouth. But then I felt him, and he was all cold. I knew he was gone.*[1980]

5.2443. GB did not recall Mr Currie's t-shirt being ripped near the collar (as was evident in the crime scene photographs). However, he considered that, it if was, he would not have thought it important, as he and Mr Currie were "always catching our clothes on things".[1981]

5.2444. GB stated that he lay Mr Currie back down face up and waited in the toilets with him for a while. He could not recall checking Mr Currie's pockets, but considered it possible that if he had done so, and come across the Nembudeine tablet bottle, it was possible that he may have taken the bottle in order to protect Mr Currie.[1982]

5.2445. After taking some time to compose himself, GB walked out of the toilets and broke the news to Mrs Currie.[1983] GB and Mrs Currie then reported the death to Manly Police Station.[1984]

Indicators of LGBTIQ bias

5.2446. Mr Currie's closest surviving relative, his brother, has no particular knowledge of Mr Currie's sexuality. He believed him to be heterosexual.[1985] GB described Mr Currie as having no romantic inclination towards men or women.[1986]

5.2447. Mr Currie's body was found inside a public toilet in a park. Although there is no specific evidence of its use as a beat at the time, the location of the toilet is such that it may well have functioned as a beat from time to time.[1987] Indeed, GB had an understanding that many of the public toilet blocks around the Manly area were used by men for the purposes of having sex with other men, including the toilet blocks in District Park.[1988]

5.2448. More generally, at around this time in some areas of Manly there were known to be robberies that occurred at public toilets, sometimes involving gay men as victims.[1989] The particular area in question was not a location where, to the Inquiry's knowledge, there were recorded instances of such attacks. However, as was noted in the BCIF, records for the period prior to 1992 did not allow ready identification of criminal acts via the COPS system.[1990] The possibility of such attacks, at that time, cannot therefore be ruled out.

[1980] Exhibit 13, Tab 29, Third statement of GB, 29 August 2023, [22] (SCOI.85275).

[1981] Exhibit 13, Tab 29, Third statement of GB, 29 August 2023, [23] (SCOI.85275).

[1982] Exhibit 13, Tab 29, Third statement of GB, 29 August 2023, [24] (SCOI.85275).

[1983] Exhibit 13, Tab 29, Third statement of GB, 29 August 2023, [25] (SCOI.85275).

[1984] Exhibit 13, Tab 20, First statement of GB, 13 December 1988, [2] (SCOI.00016.00008).

[1985] Exhibit 13, Tab 28, Statement of Caitlin Healey-Nash, 2 February 2023, [7] (SCOI.82351).

[1986] Exhibit 13, Tab 29, Third statement of GB, 29 August 2023, [7] (SCOI.85275).

[1987] Exhibit 13, Tab 28, Statement of Caitlin Healey-Nash, 2 February 2023, [5] (SCOI.82351).

[1988] Exhibit 13, Tab 29, Third statement of GB, 29 August 2023, [12] (SCOI.85275).

[1989] See, e.g., Exhibit 6, Tab 252F, Statement of Detective Chief Inspector Pamela Young, 13 July 2014, [1318]–[1322], [1338], [1405], [1431], [1583], [1606], [1758]–[1768], [1844]–[1868], [1869]–[1877] (SCOI.83088).

[1990] Strike Force Parrabell Bias Crimes Indicators Review Form – Andrew Currie, Undated 7 (SCOI.38973).

Police investigation

5.2449. Counsel Assisting drew attention to several features of the police investigation. In addition, Mr Currie's case was the subject of further submissions from both Counsel Assisting and the NSWPF in the context of the Investigative Practices Hearing.

5.2450. First, the conclusion that Mr Currie's death was the result of an accidental drug overdose was reached very swiftly.

5.2451. In evidence given during the Investigative Practices Hearing, Detective Inspector Warren agreed that the conclusion that Mr Currie's death was an overdose was reached fairly promptly but that, nevertheless, he would expect an investigating officer to maintain an open mind as to other possible reasons for death.[1071] In Mr Currie's case, Detective Inspector Warren agreed that the circumstances of the death warranted its being treated as suspicious, a death the cause of which was not known, and potentially a homicide, according to the standards of 1988 and today.[1072]

5.2452. Secondly, no statements were taken from family members, such as Mr Currie's mother. The NSWPF submitted that the fact that the Coroner determined that an inquest was not necessary is a strong indication that the circumstances of the death appeared relatively clear cut, and that the officers involved may well have concluded that it was not necessary to subject the relevant family members to the potential trauma or discomfort of police interviews.[1991]

5.2453. In oral evidence at the Investigative Practices Hearing, Detective Inspector Warren said that he did not know whether the standard of the day would be to record a decision *not* to make enquiries with the family as "back then, it may have been more relaxed."[1992] The NSWPF submitted that in the absence of evidence from relevant officers, the reasons for not taking a statement from the family are unknown, and should not be the subject of criticism.[1993]

5.2454. This submission is somewhat unconvincing. The Coroner's decision necessarily rested on such material as was produced to the Coroners Court by police. The Coroner would have been better assisted had all available evidence been presented to the Coroners Court. Whether Mr Currie's mother would have found providing a statement helpful or otherwise, is not known.

5.2455. Thirdly, there was no evidence that alternative possible causes of death were entertained, nor that police gave any consideration to the possibility that the area where Mr Currie's body was found may have been a beat.

[1991] Submissions of NSWPF, 21 February 2023, [107] (SCOI.82560).

[1992] Transcript of Inquiry, 5 July 2023, T4987.11-27 (TRA.00073.00001).

[1993] Submissions of NSWPF, 10 October 2023, [381] (SCOI.86127); see also Submissions of NSWPF, 21 February 2023, [106]–[107] (SCOI.82560).

5.2456. The NSWPF accepted that there is evidence to support the general observation that attacks on gay men occurred in the Northern Beaches in the late 1980s. However, it was submitted that it was not reasonable to have expected attending police, faced in 1988 with what appeared to be a drug overdose, to have been alive to the possibility that the particular public toilet where Mr Currie's body was found may have been a beat.[1994] This submission was repeated in the context of the Investigative Practices Hearing, with the NSWPF submitting that "[t]he cause of death was clearly established and any initial basis for suspicion was allayed. Criticism of the police investigation is not warranted in Mr Currie's case."[1995] The NSWPF submitted that there is no basis in the evidence to find that the police should have known at the time that the toilet block was may have been used at the time as a beat.[1996]

5.2457. Detective Inspector Warren gave evidence at the Investigative Practices Hearing that in modern investigations, if a person was found in a toilet block, investigating police would give consideration to whether the area was a beat, by seeking intelligence about the area, and such intelligence may reveal whether the area was a beat. Detective Inspector Warren stated that he could not assist with what the situation would have been in the late 1980s.[1997]

5.2458. By 1988, both the use of areas such as toilet blocks in public parks as beats, and the fact that attacks on beat users, or those presumed to be beat users, occurred at such beats, were well known to police.[1998] In my view, police should have turned their minds to the *possibility* that a location such as the toilet block in District Park may have been a beat and that this may have been relevant to the circumstances of the death.

5.2459. Fourthly, there was no record of the actions taken by detectives and scientific officers who attended the scene, beyond the existence of seven photographs. Detectives from Manly Police Station did attend the scene, as did police scientific officers in order to take photos, yet no statements or notes from any of these officers have been produced. The NSWPF submitted, in the context of the Investigative Practices Hearing, that "[t]here is no basis to expect that any investigation file must have been retained for 24 years, where it was understood throughout that it concerned a death caused by an accidental drug overdose."[1999]

[1994] Submissions of NSWPF, 21 February 2023, [107] (SCOI.82560).

[1995] Submissions of NSWPF, 10 October 2023, [380] (SCOI.86127).

[1996] Submissions of NSWPF, 10 October 2023, [381] (SCOI.86127).

[1997] Transcript of the Inquiry, 5 July 2023, T4987.41–4988.7 (TRA.00073.00001).

[1998] See the evidence of Garry Wotherspoon (Exhibit 2, Tab 1, Statement of Garry Wotherspoon, 14 November 2022, [56]–[59] (SCOI.77300) and Transcript of the Inquiry, 21 November 2022, T196.3–21); Barry Charles (Exhibit 2, Tab 5, Statement of Barry Charles, 14 November 2022, [21]–[24] (SCOI.77304) and Transcript of the Inquiry, 22 November 2022, T283.33–46); Ulo Klemmer (Transcript of the Inquiry, 24 November 2022, T394.8–18); Brent Mackie (Transcript of the Inquiry, 22 November 2022, T270.16–37, 271.25–43); Les Peterkin (Exhibit, Tab 3, Statement of Les Peterkin, 14 November, [36]–[42] (SCOI.77302) and Transcript of the Inquiry, 22 November 2022, T313.24–314.17); and Gregory Callaghan (Exhibit 2, Tab 4, Statement of Gregory Callaghan, 17 November 2022, [22] (SCOI.77303)).

[1999] Submissions of NSWPF, 10 October 2023, [382] (SCOI.86127).

5.2460. As Counsel Assisting submitted, such statements should have been taken and should have been retained, and there is no evidence that this occurred or that the destruction of such documents was authorised. In addition, there should have been clearer documentation relating to the OIC's statement that some of Mr Currie's teeth appeared to have been dislodged, and this observation should have been brought to the attention of the forensic pathologist so that it could have been the subject of recorded examination and/or comment in the post-mortem report.

5.2461. Fifthly, it is unfortunate that no original police investigation file has been located or produced. The NSWPF informed the Inquiry that the whereabouts of any such material are unknown. As noted above, the NSWPF submitted that there is no basis to expect that an investigation file be retained for 24 years where it was understood that it concerned a death caused by an accidental drug overdose. That fact that we do not know what occurred to the file is the real concern – the absence of the material is unexplained.

5.2462. The NSWPF submitted that, in the absence of evidence from the officers who attended the scene, and in the absence of "a comprehensive understanding of police practices at the time", it would be inappropriate to direct criticism at those officers.[2000] Counsel Assisting's submissions were not directed towards any such criticism. My concern is with the systemic failures revealed in case studies such as this one. Whatever the "police practices at the time" were, the outcome today is that the original investigative materials cannot be found.

Manner and cause of death

5.2463. Counsel Assisting submitted that an appropriate description of the cause and manner of Mr Currie's death would be that it resulted from:[2001]

> *Multi-drug toxicity following his deliberate ingestion of Nembudeine tablets, causing respiratory and central nervous system depression, leading to his death, and in circumstances where he was known to have an addiction to restricted prescription medication.*

5.2464. I accept this formulation, which the NSWPF also adopted, as appropriate subject to one alteration.[2002] I think it is more appropriate to say "intentional ingestion of Nembudeine tablets".

5.2465. I also agree with Counsel Assisting that in view of the friendship between GB and Mr Currie and their well-known mutual drug use, there is no basis to suppose or infer anything suspicious about the fact that Mr Currie was at GB's flat from around 8:30pm until 10:00pm or 11:00pm, within hours of his death. Mr Currie's reported demeanour (slow slurred speech) and comments to GB (that he had taken 25 Nembudeine tablets) were consistent with him having been already heavily affected by drugs when he was at GB's flat.[2003]

[2000] Submissions of NSWPF, 21 February 2023, [107] (SCOI.82560).

[2001] Submissions of Counsel Assisting, 6 February 2023 [87] (SCOI.82379).

[2002] Submissions of NSWPF, 21 February 2023, [116] (SCOI.82560).

[2003] See Submissions of Counsel Assisting, 6 February 2023 [81] (SCOI.82379).

5.2466. GB's description of Mr Currie at that time was also entirely consistent with past police observations of Mr Currie, including his known propensity for use of Nembudeine, for overdosing on prescribed restricted substances, and for associating with GB in the context of his drug use.

5.2467. The location where Mr Currie's body was found was directly on the logical route that he would have taken in order to walk from GB's unit (in Manly Vale) to his mother's residence (in Harbord). The parkland and sporting fields comprising Nolan Reserve and Passmore Reserve provide a shortcut between the relevant parts of those suburbs.

5.2468. Additionally, the fact that GB accompanied Mr Currie's mother and went looking for him early the following morning (upon Mr Currie's mother realising he had not returned home) is unsurprising, given their close friendship, Mr Currie's known chronic drug use and his history of previous overdoses. Similarly, the fact that GB looked for Mr Currie in the two toilet blocks in the park areas would have been a logical step to take in the circumstances.

5.2469. For these reasons, as submitted by Counsel Assisting, I consider that GB's interaction with Mr Currie shortly before his death is not to be regarded as suspicious. The evidence from the scene of his death, and from the post-mortem and toxicology reports at the time, as well as the expert toxicology and forensic pathology reports obtained by the Inquiry, all support the probability that Mr Currie's death was the accidental outcome of his ingestion of drugs on 12 December 1988.

Bias

5.2470. On the evidence, there is objectively no reason to suspect that LGBTIQ bias was a factor in Mr Currie's death.

Conclusions and Recommendations

5.2471. In relation to the manner and cause of Mr Currie's death, I find that:

> *Mr Currie died between 11:00pm on 12 December 1988 and 7:15am on 13 December 1988 in Nolan Reserve, North Manly. Mr Currie's death resulted from multi-drug toxicity following his intentional ingestion of Nembudeine tablets, which caused respiratory and central nervous system depression, leading to his death. This occurred in circumstances where Mr Currie was known to have an addiction to restricted prescription medication.*

5.2472. In my view, on the evidence available to the Inquiry, there is objectively no reason to suspect that LGBTIQ bias was a factor in Mr Currie's death.

5.2473. I do not propose to make any recommendations arising from the Inquiry's consideration of Mr Currie's death.

IN THE MATTER OF WILLIAM ALLEN

Factual background

Date and location of death

5.2474. William Emmanuel Allen, also known as Bill, died on 29 December 1988 at his home in Alexandria, NSW. He died as a result of a head injury sustained on the evening of 28 December 1988 when he was attacked and beaten in Alexandria Park.[2004]

Circumstances of death

5.2475. Mr Allen was born on 14 August 1940 and was 48 years old when he died. He was a schoolteacher by profession before he medically retired due to high blood pressure and stress.[2005]

5.2476. On the evening of 28 December 1988 at around 10:00pm, Mr Allen was assaulted in the vicinity of Alexandria Park.[2006] At this time, Alexandria Park was a known beat, particularly the area around the toilet block.[2007]

5.2477. Following the assault, Mr Allen was able to signal to a passer-by driving along Park Road, Harry Berwick. Mr Allen had blood on his face.[2008] Mr Allen said he had been "bashed and kicked" and the offenders had taken his money and keys.[2009] Mr Allen's description of the assailants is further discussed in **Chapter 17**. Mr Berwick encouraged Mr Allen to report his assault to police, however Mr Allen said "[t]hat's what you expect when you do the beat." Mr Berwick gave Mr Allen a lift home.[2010]

[2004] Exhibit 61, Tab 6, Findings of State Coroner Waller, Inquest into the death of William Allen, 4 July 1989 (SCOI.00003.00001).

[2005] Exhibit 61, Tab 17, Statement of Joyce Elizabeth Allen, 30 December 1988, 1 (SCOI.10327.00007); Exhibit 61, Tab 18, Statement of Robert Joseph Dunn, 16 January 1989, 1 (SCOI.10329.00053).

[2006] Exhibit 61, Tab 10, Statement of Harry John Berwick, 11 January 1989, 1 (SCOI.10329.00052).

[2007] Exhibit 61, Tab 58, Strike Force Parrabell, Bias Crimes Indicators Review Form – William Allen, 28 February 2017, 4 (SCOI.45313); Exhibit 2, Tab 1, Statement of Garry Wotherspoon, 14 November 2022, [38] (SCOI.77300); Exhibit 2, Tab 5, Statement of Barry Charles, 14 November 2022, [129]–[144] (SCOI.77304).

[2008] Exhibit 61, Tab 10, Statement of Harry Berwick, 11 January 1989, 1 (SCOI.10329.00052).

[2009] Exhibit 61, Tab 10, Statement of Harry Berwick, 11 January 1989, 1 (SCOI.10329.00052).

[2010] Exhibit 61, Tab 10, Statement of Harry Berwick, 11 January 1989, 1 (SCOI.10329.00052).

5.2478. Mr Allen later returned to the scene of the assault in a car belonging Robert Dunn, a friend, to collect his own car at around 12:30am on 29 December 1988. Alexandria Park was about half a mile (about 800m) from where Mr Allen lived.[2011] He encountered Peter Martin, an Ordinance Inspector patrolling the area. Mr Martin was working with Wayne Murphy who was with him at the time. Mr Allen said that he had been bashed by "[t]wo or three kids" after dropping in to use the public toilets. He said he had been kicked when he was on the ground. When asked if the offenders got his money, Mr Allen said he had held onto that, whilst grabbing at his back pocket. Mr Martin also encouraged Mr Allen to report his assault to police. Mr Allen then drove home in his own car.[2012]

5.2479. Mr Allen was found deceased by his neighbours and a tradesman at around 12:15pm on 29 December 1988. They observed Mr Allen through the bathroom window. He was slumped over the bathtub with his arms and head in the bathtub, and the tap running. Mr Allen was dressed only in a singlet with no underpants or trousers, and was bleeding from the head.[2013] Police and ambulance were contacted, and Mr Allen was declared deceased at the scene.[2014]

5.2480. There is evidence that Mr Allen sexually abused boys, including at Penshurst Marist Brothers, where he previously taught science. There is also evidence that Mr Allen was involved in the production of child abuse material and in the production and supply of prohibited drugs.[2015]

5.2481. The person or persons responsible for the attack on Mr Allen have never been identified.

Previous investigations

Post-mortem investigation

5.2482. A post-mortem was performed by Dr Sylvia Hollinger on 30 December 1988.

[2011] Exhibit 61, Tab 7, Transcript of Coronial Inquest into the death of William Allen, 4 July 1989, 21–23 (SCOI.84271).

[2012] Exhibit 61, Tab 11, Statement of Peter Thomas Martin, 11 January 1989, 2 (SCOI.10329.00051).

[2013] Exhibit 61, Tab 13, Statement of Ronald Sigsworth, 3 January 1989, (SCOI.10327.00005); Exhibit 61, Tab 12, Statement of David James Oliver, 2 January 1989, (SCOI.10327.00008); Exhibit 61, Tab 21, Statement of Constable Paul Taylor, 22 January 1989, [4] (SCOI.10329.00054).

[2014] Exhibit 61, Tab 21, Statement of Constable Paul Taylor, 22 January 1989 (SCOI.10329.00054); Exhibit 61, Tab 19, Statement of Detective Sergeant Brian John Saunders, 28 February 1989 (SCOI.10329.00055); Exhibit 61, Tab 13, Statement of Ronald Sigsworth, 3 January 1989 (SCOI.10327.00005).

[2015] Exhibit 61, Tab 53, NSWPF Review of an Unsolved Homicide Case Screening Form – William Allen, 24 August 2021, 8–9 (SCOI.03130); Exhibit 61, Tab 56, Intelligence Report (I 2522378), 2 May 1991, 1 (SCOI.73835); Exhibit 61, Tab 57, Intelligence Report (I 11864177), 8 May 2001, 1 (SCOI.73829); Exhibit 61, Tab 58, Strike Force Parrabell, Bias Crimes Indicators Review Form – William Allen, 28 February 2017, 13 (SCOI.45313).

5.2483. The post-mortem report, dated 10 May 1989, recorded Mr Allen's direct cause of death as "head injury with brain damage, associated with alcohol ingestion".[2016] Samples of Mr Allen's blood were taken, and his blood alcohol content was found to be 0.181g per 100ml. A tablet removed from Mr Allen's stomach contained acetyl salicylic acid, more commonly known as aspirin.[2017] This is consistent with reports that Mr Allen was taking two aspirin tablets per day for pain in his legs.[2018]

5.2484. Mr Allen had numerous injuries consistent with an assault. These included:[2019]

a. Red and blue bruising on the dorsa of both hands and around both wrists;

b. A stellate laceration was present above the left eyebrow;

c. A markedly swollen and bruised left upper eyelid was present and less blue bruising was present of the right upper and lower eyelids;

d. A red abrasion was present on the nose and on the left-hand side of the nose;

e. The right cheek was swollen and an x-ray showed a fracture of the ramus of the mandible on the right side;

f. A thin laceration was present on the lower lip;

g. Two purple bruises were present above the left elbow;

h. A linear red abrasion was present on the back of the right arm;

i. A red abrasion was present on the left knee;

j. A swollen upper lip was present;

k. Blue bruising was present on the front of the left leg; and

l. A circular purple bruise was present on the right side of the chest and a linear transverse groove was present on the left side of the chest.

5.2485. An examination of Mr Allen's brain revealed swelling as well as subarachnoid haemorrhage and focal intracerebral haemorrhage.[2020]

5.2486. Mr Allen's injuries are further discussed in **Chapter 17**.

[2016] Exhibit 61, Tab 3, Post-mortem report of Dr Sylvia Hollinger, 10 May 1989, 2 (SCOI.10329.00067).

[2017] Exhibit 61, Tab 4, Toxicology Report, 28 April 1989 (SCOI.10329.00043).

[2018] Exhibit 61, Tab 18, Statement of Robert Joseph Dunn, 16 January 1989, 1 (SCOI.10329.00053).

[2019] Exhibit 61, Tab 3, Post-mortem report of Dr Sylvia Hollinger, 10 May 1989, 3 (SCOI.10329.00067).

[2020] Exhibit 61, Tab 3, Post-mortem report of Dr Sylvia Hollinger, 10 May 1989, 3 (SCOI.10329.00067).

5.2487. According to a statement by Constable Paul Taylor, it appears that when Dr Hollinger attended Mr Allen's home on 29 December 1988 and made her initial observations of him, she had considered that there was a possibility that he had been bashed at some stage and told Constable Taylor that there was a large swelling around the eyes and there was a possible fractured jaw.[2021] In discussions with the OIC, Detective Sergeant Brian Saunders, on 11 January 1989, Dr Hollinger indicated that Mr Allen did not die as a result of a heart attack but could have fallen.[2022] This was posited prior to police obtaining information about Mr Allen's attendance at Alexandria Park, and his assault there.

Original police investigation

5.2488. Following the discovery of Mr Allen's body, his neighbours called the police.[2023] Police attended Mr Allen's property and observed dried blood on the footpath leading from the front gate to the rear of the premises and drops of blood on the front veranda of a neighbouring house close to the side passage of Mr Allen's property. There was blood leading from the bathroom to the front bedroom, on the bathroom window frame and on the bedding. There were no signs of forced entry and no items appeared to have been stolen.[2024]

5.2489. Mr Allen was found kneeling beside the bathtub dressed only in a t-shirt with his arms and head hanging over into the bath, and blood coming from his head.[2025] A three centimetre laceration was observed above his left eye, and there was swelling to the same eye and to the lips and jaw.[2026]

5.2490. Detective Sergeant Carlton Cameron of the Crime Scene Unit expressed the view that, reconstructing the scene, Mr Allen was injured elsewhere and returned home. He climbed over the dividing wall or fence between numbers 19 and 21 and walked up the side passageway of his house, and entered the property via the bathroom window. He walked through the house and laid down in his bed, leaving bloodstains. He also smoked cigarettes and drank from a glass, based on bloodstained items in the kitchen sink. Sometime later, Mr Allen collapsed in the bathroom.[2027]

[2021] Exhibit 61, Tab 21, Statement of Constable Paul Taylor, 22 January 1989, [8] (SCOI.10329.00054).

[2022] Exhibit 61, Tab 20, Notes of Detective Sergeant Brian John Saunders re Autopsy, undated (SCOI.10327.00002).

[2023] Exhibit 61, Tab 13, Statement of Ronald Sigsworth, 3 January 1989 (SCOI.10327.00005).

[2024] Exhibit 61, Tab 21, Statement of Constable Paul Taylor, 22 January 1989, [5]–[7] (SCOI.10329.00054); Exhibit 61, Tab 19, Statement of Detective Sergeant Brian John Saunders, 28 February 1989, 1 (SCOI.10329.00055).

[2025] Exhibit 61, Tab 21, Statement of Constable Paul Taylor, 22 January 1989, [4] (SCOI.10329.00054).

[2026] Exhibit 61, Tab 19, Statement of Detective Sergeant Brian John Saunders, 28 February 1989, 1 (SCOI.10329.00055); Exhibit 61, Tab 22, Statement of Detective Sergeant Carlton Graeme Cameron, 4 July 1989, [6] (SCOI.10329.00083).

[2027] Exhibit 61, Tab 22, Statement of Detective Sergeant Carlton Graeme Cameron, 4 July 1989, [11] (SCOI.10329.00083).

5.2491. A number of videotapes were discovered during the search of Mr Allen's property, some of which contained child abuse material.[2028] These video tapes were not taken into evidence but were left at the property and later taken by a member of the public who knew Mr Allen. That person shared the tapes with another acquaintance of Mr Allen.[2029] The latter person gave a statement to the NSWPF in 1991 in which they said that, when they saw the content, they were revolted and wiped all the cassettes other than a cassette containing footage of Mr Allen and his friends on holiday.[2030] The admissibility of this statement is discussed separately below.

5.2492. Statements were obtained from Mr Allen's friends, family and neighbours, and other witnesses including Mr Martin.[2031] The passer-by, Mr Berwick, whom Mr Allen flagged down, came to the attention of police after Mr Allen's brother, Stuart Allen, heard from other friends in the area that Mr Berwick had driven past Mr Allen the night he was assaulted.[2032] A canvass was conducted of Buckland Street, Alexandria, however, no useful information was obtained. A number of youths "of the hoodlum element" who were known to frequent Alexandria Park were spoken to, but again no useful information was obtained.[2033] No specific record or canvass form recording the youths who were spoken to has been produced to the Inquiry.

5.2493. Mr Allen's brother, Stuart Allen, was contacted requesting a photograph of Mr Allen with a view to having it placed in the *Daily Mirror* newspaper together with a story surrounding his death. However, the request was denied. Stuart Allen said that the family did not wish any further publicity.[2034]

5.2494. In 1991, further investigative steps were undertaken by other police officers regarding Mr Allen's death. Colin Fisk and Mr Dunn (both of whom had been arrested by police for the sexual abuse of young boys by this time) provided police with information that Mr Allen was involved in the supply of illicit drugs, that he cultivated cannabis, and that he had a large amount of money on his premises prior to his death. As noted above, Mr Allen also had a number of video tapes containing child abuse material, variously made by and featuring Mr Allen and his associates.[2035] This information was not before the Coroner at the time of the inquest into Mr Allen's death.

[2028] Transcript of the Inquiry, 5 July 2023, T4988.38–41 (TRA.00073.00001).

[2029] Exhibit 61, Tab 49, Statement of I427, 19 August 1991, [4]–[5] (SCOI.10329.00034); Exhibit 61, Tab 53, NSWPF Review of an Unsolved Homicide Case Screening Form – William Allen, 24 August 2021, 11 (SCOI.03130).

[2030] Exhibit 61, Tab 49, Statement of I427, 19 August 1991, [5] (SCOI.10329.00034).

[2031] Exhibit 61, Tab 19, Statement of Detective Sergeant Brian John Saunders, 28 February 1989, 2 (SCOI.10329.00055).

[2032] Exhibit 61, Tab 7, Transcript of Coronial Inquest into the death of William Allen, 4 July 1989, 20–21 (SCOI.84271).

[2033] Exhibit 61, Tab 19, Statement of Detective Sergeant Brian John Saunders, 28 February 1989, 2 (SCOI.10329.00055).

[2034] Exhibit 61, Tab 19, Statement of Detective Sergeant Brian John Saunders, 28 February 1989, 2 (SCOI.10329.00055).

[2035] Exhibit 61, Tab 58, Strike Force Parrabell Bias Crimes Indicators Review Form – William Allen, 28 February 2017, 1, 3 (SCOI.45313).

Exhibits: Availability and testing

5.2495. An anal swab was taken during the post-mortem examination.[2036] It does not appear that this was ever tested. The Inquiry took steps to ascertain whether this was in fact the case and if so, whether FASS retains the swab for analysis now. The FASS was unable to locate any records relating to the death of Mr Allen.

5.2496. Fingerprints were lifted from items in Mr Allen's house, namely from two wine carafes and a jar of coffee. The identified fingerprints belonged to Mr Allen.[2037] The items were not collected by police as exhibits, as discussed below.[2038]

Persons of interest

5.2497. During the police investigation which occurred between 29 December 1988 and the coronial inquest into Mr Allen's death on 4 July 1989, it appears that no persons of interest were identified.

5.2498. On 13 May 1991, a 17 year old boy, NP141 (a pseudonym) attended Surry Hills Police Station and advised that he had been involved in the attack on Mr Allen. However, NP141 later admitted that he was being treated for depression and had recently attempted suicide, and made the confessions in an attempt to seek medical attention, feeling that being institutionalised was the only way for him to obtain such health care.[2039] NP141 had previously been involved in an assault on a gay man, I158 (a pseudonym), on 12 July 1988 in company of other boys.[2040] One of these boys was NP16 (a pseudonym), who was later found guilty, with a number of other boys, of the murder of Richard Johnson. NP141 appears to have been discounted as a genuine person of interest by police in the investigation of Mr Allen's death. However, there is limited material before the Inquiry as to the consideration by police of NP141's status as a person of interest.

5.2499. In February 1991, Mr Fisk provided information to police in which he nominated a boy named I356 (a pseudonym) as potentially being involved in the death of Mr Allen. Mr Fisk told police that I356 was a heroin addict and had a prior association with Mr Allen.[2041] "I356" does not appear to have been considered a person of interest in Mr Allen's death by police.

Findings at inquest

5.2500. A coronial inquest was held on 4 July 1989 before State Coroner Waller, with assistance from Sergeant Shields. Mr Allen's brother and sister were in attendance.[2042]

[2036] Exhibit 61, Tab 3, Post-mortem report of Dr Sylvia Hollinger, 10 May 1989, 4 (SCOI.10329.00067).

[2037] Exhibit 61, Tab 30, Fingerprints Running Sheet, 29 December 1988 (SCOI.10332.00007).

[2038] Exhibit 61, Tab 72, Letter from NSWPF to Enzo Camporeale, 13 June 2023 (SCOI.83985).

[2039] Exhibit 61, Tab 36, P109 Record of occurrence regarding interview of NP141, 13 May 1991 (SCOI.10331.00011).

[2040] Exhibit 61, Tab 36A, P83 Juvenile Report, 12 July 1988, 7 (SCOI.26326).

[2041] Exhibit 61, Tab 53, Unsolved Homicide Team Triage Form, 24 August 2021, 9 (SCOI.03130); Exhibit 61, Tab 55, Intelligence Report (I 1927659), 27 February 1991 (SCOI.73832).

[2042] Exhibit 61, Tab 9, Master Tape History for Inquest into the death of William Allen, 4 July 1989 (SCOI.00003.00004).

5.2501. State Coroner Waller found that Mr Allen "died of the effects of head injury sustained on the night of the 28th day of December, 1988 when he was beaten by persons unknown in Alexandria Park".[2043]

5.2502. The State Coroner's observations on the evidence are worth noting in full:[2044]

> *…the deceased was a 50-year-old man, apparently homosexual. He is shown to have gone to Alexandria Park, a place frequented by that sort of person, and was set upon there and bashed and beaten by unknown persons … There is no reason to doubt what he said. It is a risk of people, as the deceased himself admitted, when you are on the beat, you take the risk that people indulge in the sport of chasing and assaulting homosexuals, which is a disgraceful state of affairs, and, indeed, this is the second case I have had where a person has died as a result of being assaulted in the park by homosexuals [sic]. Of course, one could say, "Well, you shouldn't go to the park", but one can say, I think with perhaps more strength, that you shouldn't set about in numbers to assault people to such an extent that you kill them. It is a dreadful sort of business and I wish the people could be caught. It is made even worse by the fact that those violent persons revel and enjoy the situation that the victims do not like to report these crimes to police because of the ignominy that attaches to their roles as cruising homosexuals, but, nevertheless, it is a very sad case and I am sorry for the deceased and his family.*

Criminal proceedings

5.2503. No criminal proceedings occurred as a consequence of Mr Allen's death.

Subsequent police investigations

Information obtained following the arrest of Robert Dunn and others

5.2504. The Internal Police Security Branch (**IPSB**) conducted an investigation, following complaints made by Mr Dunn and Mr Fisk, into aspects of the original police investigation.[2045] At the time of the IPSB investigation, further information had come to light indicating that Mr Allen had allegedly perpetrated a number of child sex offences and produced and featured in child abuse material.[2046]

5.2505. The evidence of Mr Allen's suspected involvement in child sex offences was outlined and considered by the UHT in their triage of Mr Allen's death in 2021.[2047] In summary, the evidence suggested:

a. Suspected child sex offences perpetrated by Mr Allen on students when he was a teacher at Marist College in Penshurst;[2048]

[2043] Exhibit 61, Tab 6, Findings of State Coroner Waller, Inquest into the death of William Allen, 4 July 1989 (SCOI.00003.00001).

[2044] Exhibit 61, Tab 7, Transcript of Coronial Inquest into the death of William Allen, 4 July 1989, T26.10–32 (SCOI.84271).

[2045] Exhibit 61, Tab 80, Statement of Kathryn Lockery, 23 August 2023, [7] (SCOI.85150).

[2046] Exhibit 61, Tab 53, Unsolved Homicide Team Triage Form, 24 August 2021, 8–9 (SCOI.03130).

[2047] Exhibit 61, Tab 53, Unsolved Homicide Team Triage Form, 24 August 2021 (SCOI.03130).

[2048] Exhibit 61, Tab 57, Intelligence Report (I 11864177), 8 May 2001 (SCOI.73829); Exhibit 61, Tab 53, Unsolved Homicide Team Triage Form, 24 August 2021, 9 (SCOI.03130).

b. That Mr Allen allegedly made film recordings of sexual abuse of children by adults and himself appeared in such film recordings and had a collection of child abuse material;[2049]

c. That Mr Allen would "cruise Alexandria Park, near the school";[2050] and

d. That Mr Allen allegedly supplied illicit drugs, specifically marijuana and amphetamines.[2051]

5.2506. I accept Counsel Assisting's submission that it is important to treat this evidence with caution. It is neither necessary nor appropriate for the me to make findings of criminal guilt in relation to Mr Allen's suspected involvement in child sex offences. The focus of this Inquiry is on the manner and cause of Mr Allen's death. However, the Inquiry's Terms of Reference call for consideration of possible motives for Mr Allen's murder, and the evidence of Mr Allen's suspected involvement in child sex offences and the supply of illicit drugs may be relevant in this regard. That evidence is also relevant to the police investigation into Mr Allen's murder — including possible lines of inquiry which were not pursued and what information was available to the police at various points in time.

5.2507. In making submissions about this evidence, I note Counsel Assisting was mindful of the submission made elsewhere that it is flawed to dismiss LGBTIQ hate crimes by reference to the concept of "anti-paedophile animus",[2052] as discussed at **Chapter 13**. The perpetuation of any sort of perception that men who had sex with men were paedophiles, or more likely to be paedophiles, is offensive and has been responsible for substantial harm to the LGBTIQ community, as discussed at **Chapter 13.**

Investigation by Detective Sergeant McCann

5.2508. On 24 January 1990, the murder of Richard Johnson occurred at Alexandria Park, at the hands of a group of teenage boys who became known collectively as the "Alexandria Eight".[2053] Mr Johnson was lured to the park on the pretext of a "homosexual liaison"[2054] after one or more of the boys called his telephone number after acquiring it from inside the toilet block at Alexandria Park where it was written.[2055] Upon his arrival at the toilet block, he was set upon and beaten by the eight boys. He died at the scene.[2056]

[2049] Exhibit 61, Tab 55, Intelligence Report (I 1927659), 27 February 1991 (SCOI.73832); Exhibit 61, Tab 56, Intelligence Report (I 2522378), 2 May 1991 (SCOI.73835); Exhibit 61, Tab 53, Unsolved Homicide Team Triage Form, 24 August 2021, 8–9 (SCOI.03130).

[2050] Exhibit 61, Tab 55, Intelligence Report (I 1927659), 27 February 1991 (SCOI.73832); Exhibit 61, Tab 53, Unsolved Homicide Team Triage Form, 24 August 2021, 9 (SCOI.03130).

[2051] Exhibit 61, Tab 53, Unsolved Homicide Team Triage Form, 24 August 2021, 9 (SCOI.03130).

[2052] Submissions of Counsel Assisting the Inquiry, 7 June 2023, [1230]–[1256] (SCOI.84380).

[2053] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries, 20 (SCOI.76961.00014).

[2054] Exhibit 6, Tab 233A, Letter from Steve McCann to The Commander, Modus Operandi Section, 10 August 1991, [14] (SCOI.10342.00010).

[2055] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries, 20 (SCOI.76961.00014).

[2056] Exhibit 61, Tab 37, Remarks on Sentence, *R v NP141 & Ors*, Supreme Court of New South Wales, 1–2 (SCOI.02477).

5.2509. In 1991, former Detective Sergeant Steve McCann, the OIC of the investigation into the murder of Mr Johnson, conducted a further investigation into the death of Mr Allen. The investigation involved covert operations including the use of listening devices to lawfully record conversations with certain persons, including members of the Alexandria Eight, who by then were serving custodial sentences for their involvement in the death of Mr Johnson.[2057]

5.2510. In order to avoid prejudice to possible future investigations into the death of Mr Allen, the nature of the operations conducted, and the substance of the evidence obtained, is detailed within **Chapter 17**.

5.2511. A summary of the evidence obtained through the listening devices is set out in Detective Sergeant McCann's letter of 10 August 1991 to the Commander of the Modus Operandi Section. He said:[2058]

a. NP18 (a pseudonym), NP15 (a pseudonym) and NP42 (a pseudonym) did not implicate themselves on tape nor did NP19 (a pseudonym);

b. NP16 (a pseudonym) and NP19 make passing reference to the incident and indicate some knowledge of it implicating NP44 (a pseudonym), NP45 (a pseudonym) and NP42;

c. NP44 and NP45 had been interviewed by police and had denied their involvement; and

d. The information would be retained for future attention if any further corroboration was forthcoming.

5.2512. The evidence obtained from the listening devices did not lead to criminal charges being brought against anyone.

CrimeStoppers Report

5.2513. On 23 June 2015, an anonymous report was made to CrimeStoppers in relation to a number of LGBTIQ hate crimes. The information provided by the informant is contained in **Chapter 17**.

5.2514. As submitted by Counsel Assisting, it is concerning that the investigators did not obtain a formal statement from the informant, nor do they appear to have followed up on the information provided by interviewing the persons implicated. Whilst, as with the listening device material, there is scope for misinformation due to the desire of young inmates to appear tough and intimidating in the company of other offenders, the information provided by the above-mentioned informant may have proved of importance in uncovering the identity of the perpetrators of this case and a number of deaths suspected of being LGBTIQ hate crimes. The NSWPF did not dispute these concerns. It is an oversight in the investigation that is unexplained on the material available to the Inquiry.

[2057] Exhibit 6, Tab 230, Statement of Detective Sergeant Stephen Page, 25 July 2002, [128]–[165] (SCOI.02744.00023).

[2058] Exhibit 6, Tab 233A, Letter from Steve McCann to The Commander, Modus Operandi Section, 10 August 1991, [21]–[22] (SCOI.10342.00010).

UHT Review

5.2515. On 24 August 2021 Detective Senior Constable Kim Fidden completed a Triage Form for a review by the UHT. Detective Senior Constable Fidden assessed that the matter should proceed to review.[2059]

5.2516. The material before the Inquiry, including on the UHT Tracking File, revealed that no review ever occurred following the submission of Detective Senior Constable Fidden's Triage Form.[2060] It is not apparent on a review of the material why a review by the UHT has not occurred.

5.2517. This case was raised with Detective Chief Inspector Laidlaw in the Investigative Practices Hearing. Detective Chief Inspector Laidlaw was unable to offer any explanation as to why the case had not been triaged prior to 2021, or why it had not proceeded to review.[2061]

5.2518. The NSWPF submitted that it was "unfortunate" that the matter did not proceed to a further review by the UHT, but nevertheless were unable to provide any explanation as to why it did not proceed, nor any explanation as to what steps, if any, were taken within the NSWPF in response to the recommendation of Detective Senior Constable Fidden. The NSWPF further submit, that in the absence of any evidence to the contrary, such a review may not have been feasible due to significant resource constraints.[2062]

5.2519. That submission is unhelpful. The NSWPF was in a position to provide evidence in relation to the reason this matter had not proceeded to review. In the absence of evidence, the only finding I would make is that the failure to conduct a review is unexplained on the evidence. Moreover, the failure to conduct a review after 2021 provides no explanation for why the case had not been triaged, screened or otherwise reviewed during the many years prior to 2021.

5.2520. The Triage Form, in the section titled "Exhibits", records that no exhibits were collected but also says that an officer "mentions that somebody returned to the premises at a later stage and obtained the video's [sic] but nothing further".[2063] To the extent that this record suggests that the video cassettes were later collected by a police officer, the other evidence before the Inquiry makes it clear that this was not the case. The evidence obtained by the Inquiry, specifically the statement by an acquaintance of Mr Allen in 1991, clearly records that the cassettes were in fact collected by another person known to Mr Allen.

5.2521. As noted by Counsel Assisting, the tender of the 1991 statement at a public hearing raised the issue of the admissibility of the 1991 statement of I427 (a pseudonym). The *SCOI Act* only permits the evidence to be received in a public hearing if the Commissioner is of the opinion that it would be likely to be admissible in evidence in civil proceedings pursuant to s. 9(3) of the *SCOI Act*.[2064]

[2059] Exhibit 61, Tab 53, Unsolved Homicide Team Triage Form, 24 August 2021, 12 (SCOI.03130).

[2060] Transcript of the Inquiry, 6 July 2023, T5154.9–40 (TRA.00074.00001).

[2061] Transcript of the Inquiry, 6 July 2023, T5153.23–5155.29 (TRA.00074.00001).

[2062] Submissions of NSWPF, 5 September 2023, [103] (SCOI.85433).

[2063] Exhibit 61, Tab 53, Unsolved Homicide Team Triage Form, 24 August 2021, 11 (SCOI.03130).

[2064] *Special Commissions of Inquiry Act 1983* (NSW), s 9.

5.2522. The statement was prepared in the context of an investigation by the IPSB. At the time of the ISPB investigation, the *Police Regulation (Allegations of Misconduct) Act 1978* (***the 1978 Act***) dealt with investigations by the Internal Affairs Branch. Section 59 of *the 1978 Act* declared "a document brought into existence for the purposes of this Act" to be inadmissible in other proceedings (with certain exceptions).

5.2523. The *Police Services (Complaints, Discipline and Appeals) Amendment Act* 1993 (***the 1993 Amending Act***) introduced s 172A into the *Police Service Act 1990* (as the *Police Act* was then known) in the context of introducing Part 8A. However, *the 1993 Amending Act* also introduced Part 6 to Schedule 4 of the *Police Service Act*. Clause 25(2) in Part 6 of Schedule 4 states that Part 8A extends to conduct occurring after the commencement of the "former complaints Act", i.e., *the 1978 Act*. Clause 25(3) states that anything duly done before the commencement of Part 8A under a provision of the former complaints Act is (subject to the regulations) taken to have been duly done under the corresponding provision of Part 8A.

5.2524. Section 170 of the *Police Act* provides that a document brought into existence for the purposes of Part 8A is not admissible in evidence in any proceedings other than proceedings that concern the conduct of police officers and are dealt with by certain courts and tribunals. In considering the proper construction of "for the purposes of" in s. 170, I agree with the views of Counsel Assisting, that this should be construed as meaning at least a dominant purpose and arguably the sole purpose. It is to be expected that police will take statements from members of the public, in connection with a disciplinary inquiry, in circumstances where the statement was prepared for the dual purpose of the disciplinary inquiry and also future police investigations or operations. In that situation, it would be odd if s 170 prevented the police from using that statement in future court proceedings, merely because one of the purposes for which the statement was prepared was a disciplinary inquiry. This question was adverted to, but not decided, by Rothman J in *Clavel v Savage (No 3)* [2010] NSWSC 5 at [16].

5.2525. I accept the submission of Counsel Assisting that it can be inferred from the face of the document that the statement of I427 was prepared for a dual purpose, namely to set out evidence he would be prepared to give in court. I427 said as much in the first paragraph of the statement.

5.2526. I note that the maker of the statement is deceased. I further note, the Commissioner of the NSWPF was offered the opportunity to comment on the admissibility of the statement on two occasions and did not raise any objection or seek to be heard against the above analysis of Counsel Assisting. Whilst the NSWPF acknowledged that an internal investigation was conducted by the IPBS and material from that investigation was not tendered in the public hearing in light of the issues arising under s. 170 of the *Police Act*, the NSWPF did not make any further submissions with respect to admissibility.

5.2527. For these reasons, I am satisfied that the receipt of this evidence in a public hearing was permitted by s. 9(3) of the *SCOI Act*. Moreover, s. 9(3) does not place a restriction on my reporting function in ss. 4(1) and 10(1) of the *SCOI Act*. I am satisfied it is appropriate to include in this section of the report the material referred to herein, even if s. 170(1) has the effect that the material is inadmissible in civil proceedings other than proceedings of the kind described in s. 170(1)(a) or (b), as further discussed elsewhere in this Report.

Strike Force Parrabell

Bias Crimes Indicators Form

5.2528. A BCIF was completed in this case by Strike Force Parrabell. It concluded that Mr Allen's death was a "Suspected Bias Crime".[2065]

5.2529. Of the ten indicators considered in the BCIF, five were categorised as "Evidence of Bias Crime", two were categorised as "Suspected Bias Crime", two were categorised as "No Evidence of Bias Crime", and one was categorised as "Insufficient Information". The "Insufficient Information" categorisation was in response to the Indicator 9 (Lack of Motive), and noted that there were various potential motives, including revenge, robbery, and Mr Allen's supply and sale of cannabis and amyl nitrate.[2066]

5.2530. The BCIF indicates that Mr Allen was suspected to be a paedophile who grew and supplied cannabis, and that no persons of interest had been identified, beyond the description given by Mr Allen to the passer-by, Mr Berwick, following his assault. The BCIF notes that Mr Allen apparently believed his assault to be motivated by LGBTIQ bias, as indicated by his comment "That's what you expect when you do the beat".[2067]

Results of Strike Force Parrabell

5.2531. The "Summary of Findings" at the conclusion of the BCIF states that Mr Allen died as a consequence of head injuries sustained on the night of 28 December 1988. It detailed his history as a schoolteacher and the likelihood that he was a paedophile and engaged in the production of child abuse material. The summary notes that Alexandria Park is a "well known 'beat'" and that there are indications that an organised hate group was actively targeting beat users for assaults and robbery offences around the time of Mr Allen's death, including the death of Richard Johnson, the modus operandi of which "bears a resemblance" to the attack on Mr Allen.[2068]

[2065] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries, 15 (SCOI.76961.00014).

[2066] Exhibit 61, Tab 58, Strike Force Parrabell Bias Crimes Indicators Review Form – William Allen, 28 February 2017, 16–18 (SCOI.45313).

[2067] Exhibit 61, Tab 58, Strike Force Parrabell Bias Crimes Indicators Review Form – William Allen, 28 February 2017, 1, 11–12 (SCOI.45313).

[2068] Exhibit 61, Tab 58, Strike Force Parrabell Bias Crimes Indicators Review Form – William Allen, 28 February 2017, 20–21 (SCOI.45313).

Case Summary

5.2532. The Inquiry has been provided with a Case Summary summarising the final results of Strike Force Parrabell with respect to this matter.

5.2533. Strike Force Parrabell categorised the case as "Suspected Bias Crime".[2069]

5.2534. The matter was further categorised as "unsolved".[2070]

5.2535. The Strike Force Parrabell Case Summary identifies Mr Allen as a suspected paedophile who frequented the public toilets at Alexandria Park in search of "young male sexual partners". The Case Summary reads as follows:[2071]

> ***Identity**: William Allen was 50 years old at the time of his death.*
>
> ***Personal History**: Mr Allen was a retired school teacher and suspected paedophile. Evidence indicated that he was cultivating and dealing large amounts of cannabis which he would sell or give to young males for sex. Mr Allen was known to frequent the public toilets in Alexandria Park in search of young male sexual partners.*
>
> ***Location of Body/Circumstances of Death**: Mr Allen's body was found at his home address in Newton Street, Alexandria. Mr Allen suffered several injuries to his head when assaulted the previous evening in Alexandria Park. Mr Allen was driven home by a passing motorist who saw blood over his face and hands. Mr Allen stated that he had been bashed by 'a couple of … boys'. Mr Allen stated that he was bashed and kicked whilst on the ground, before being robbed of his money and keys. When told to report the matter to police, Mr Allen replied, 'That's what you expect when you do the beat.' Alexandria Park was a well-known gay beat. At the time police identified no clear suspects however circumstances surrounding the death of Mr Allen was noted to be similar to the later murder of Richard Johnson (Parrabell Case 40) in 1990. Both murders occurred at the same location in very similar circumstances. Police retrospectively investigated the 8 offenders from Mr Johnson's murder as fresh suspects for Mr Allen's murder however no evidence to implicate any of the 8 offenders was obtained.*
>
> ***Sexual Orientation**: Mr Allen identified as gay.*

[2069] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – William Allen, 15 (SCOI.76961.00014).

[2070] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – William Allen, 15 (SCOI.76961.00014).

[2071] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – William Allen, 15 (SCOI.76961.00014).

5.2536. Counsel Assisting submitted that there was more than sufficient evidence for Strike Force Parrabell to have characterised Mr Allen's death as "Evidence of Bias Crime",[2072] as opposed to giving it a weaker characterisation of "Suspected Evidence of Bias Crime" as it did, noting in particular Mr Allen's sexuality, the location of his assault at a beat, the evidence that Mr Allen used beats in the area, Mr Allen's contemporaneous report that he was assaulted for using the beat, and the similar *modus operandi* to other LGBTIQ hate crimes.

5.2537. The NSWPF did not disagree with Counsel Assisting's characterisation. However, the NSWPF submitted that the task of ascribing bias motivations is not a straightforward process, and one in which reasonable minds can differ.[2073] I accept this submission as far as it goes.

5.2538. The NSWPF also sought to justify the finding on the basis that two out of the three possible alternative motivations for Mr Allen's assault did not appear to arise from LGBTIQ bias.[2074] The NSWPF further submitted that no perpetrators were identified in relation to Mr Allen's death, and as such the actual intention remains unknown.[2075] On this basis, the NSWPF submit that the characterisation by Strike Force Parrabell was an available one.

5.2539. In all the circumstances, I accept the submission of Counsel Assisting that the evidence available to Strike Force Parrabell was sufficient to support the categorisation of Mr Allen's death as "Evidence of Bias Crime". In my view, this would have been the more accurate view to reach including on the basis of the evidence that was available at the time of Strike Force Parrabell.

Academic review

5.2540. The academic review categorised the case as "Gay Bias Related (Anti-Gay)".[2076]

Review by the Inquiry

5.2541. The Inquiry took the following steps in the course of examining the matter.

Summonses

5.2542. A summons was issued to the NSWPF on 18 May 2022 for, all documents relating to investigations by the NSWPF of the death of Mr Allen, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Allen. [2077]

[2072] Exhibit 1, Tab 2, NSW Police Force, *Strike Force Parrabell Final Report* (Report, June 2018) 68 (SCOI.02632); Submissions of Counsel Assisting, 23 August 2023, [77] (SCOI.85228).

[2073] Submissions of NSWPF, 5 September 2023, [107] (SCOI.85433).

[2074] Submissions of NSWPF, 5 September 2023, [107] (SCOI.85433).

[2075] Submissions of NSWPF, 5 September 2023, [107] (SCOI.85433).

[2076] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – William Allen, 15 (SCOI.76961.00014).

[2077] Exhibit 61, Tab 80, Statement of Kathryn Lockery, 23 August 2023, [6] (SCOI.85150).

5.2543. On 8 June 2022, a hard copy file was produced to the Inquiry.[2078] It appears the material produced did not include all the material set out in the summons, as further material responsive to Summons NSWPF1 has been subsequently produced in response to later summonses.

5.2544. On 28 July 2022, the Inquiry issued a further summons to the NSWPF for the criminal history, CNI profile and other related documents in relation to Mr Allen (NSWPF5).[2079] In August 2022, the NSWPF produced select material to the Inquiry, however the NSWPF were ultimately unable to locate any of the police notebooks or duty books sought pursuant to the summons.[2080] The NSWPF were also unable to locate the intelligence report referred to at item 3 of the schedule to the summons, or the records relating to the police interaction with I400 (a pseudonym) at item 4 of the schedule.[2081]

5.2545. On 5 June 2023, the Inquiry issued a further summons to the NSWPF, seeking the physical exhibits associated with the investigation into the death of William Allen, including wine carafes, a glass coffee jar, and hair and fingernail samples and an anal swab collected at post-mortem (NSWPF118).[2082] On 13 June 2023, the NSWPF wrote to the Inquiry to advise that none of the requested items could be located.[2083]

5.2546. On 20 July 2023, the Inquiry issued a summons to Telstra Limited for information as to Mr Allen's telephone number and records of public telephone boxes surrounding Alexandria Park as at the date of Mr Allen's death (TEL2).[2084] In a document dated 3 August 2023, Telstra advised that no records were held for Mr Allen or his address as at December 1988, and that no details for payphones were available for the relevant date.[2085]

5.2547. In addition to the above, the Inquiry also issued various summonses to the NSWPF, CSNSW, DCJ and other relevant entities in order to obtain intelligence records and background information regarding certain persons of interest. Relevant records were produced to the Inquiry.[2086]

Interagency cooperation

5.2548. On 11 May 2022, the Inquiry issued a written request to the Coroners Court to obtain the coronial file in relation to the death of Mr Allen.[2087] The coronial file was produced on 26 May 2022.[2088]

[2078] Exhibit 61, Tab 80, Statement of Kathryn Lockery, 23 August 2023, [6] (SCOI.85150).

[2079] Exhibit 61, Tab 64, Summons NSWPF5, 28 July 2022 (SCOI.83320).

[2080] Exhibit 61, Tab 80, Statement of Kathryn Lockery, 23 August 2023, [9] (SCOI.85150); Exhibit 61, Tab 65, Email from the NSWPF to the Inquiry re summons NSWPF5, 26 August 2022 (SCOI.83987).

[2081] Exhibit 61, Tab 69, Letter to Inquiry from NSWPF re summons NSWPF5, 29 June 2023 (SCOI.85147).

[2082] Exhibit 61, Tab 71, Summons NSWPF118, 5 June 2023 (SCOI.83986).

[2083] Exhibit 61, Tab 72, Letter to Inquiry from NSWPF re summons NSWPF118, 13 June 2023 (SCOI.83985).

[2084] Exhibit 61, Tab 73, Summons TEL2, 20 July 2023 (SCOI.85118).

[2085] Exhibit 61, Tab 74, Records produced by Telstra re summons TEL2, 3 August 2023 (SCOI.85117).

[2086] Exhibit 61, Tab 80, Statement of Kathryn Lockery, 23 August 2023, [12] (SCOI.85150).

[2087] Exhibit 61, Tab 80, Statement of Kathryn Lockery, 23 August 2023, [4]–[5] (SCOI.85150).

[2088] Exhibit 61, Tab 80, Statement of Kathryn Lockery, 23 August 2023, [4]–[5] (SCOI.85150).

5.2549. The Inquiry coordinated with BDM and other agencies to confirm the status and location of various witnesses.[2089]

Family members

5.2550. The Inquiry liaised with external agencies to seek the location of Mr Allen's brother and sister. The Inquiry attempted to contact both of Mr Allen's siblings by way of written correspondence, however no response was received from either of Mr Allen's siblings throughout the duration of the Inquiry.[2090]

5.2551. The Inquiry successfully contacted Mr Allen's cousin and informed him of the work of the Inquiry in relation to Mr Allen's death. He was unable to assist with making contact with Mr Allen's brother and did not otherwise wish to be involved.[2091]

Searches for exhibits

5.2552. On 2 June 2023, the Inquiry requested that FASS provide to the Inquiry:[2092]

a. Any P377 forms or other records of exhibits provided to FASS in relation to Mr Allen's death;

b. Any documents containing information in relation to whether hairs, fingernails or anal swabs were forensically examined, including any results; and

c. Any documents notifying whether FASS has retained any samples of the hairs, fingernails or anal swab collected at the time of Mr Allen's death.

5.2553. On 23 June 2023, FASS advised the Inquiry that checks were conducted of the Forensic Biology receipt books over the time period from December 1988 until the end of February 1989 and no records relating to the death of Mr Allen could be located.[2093] It is therefore not possible to know whether there was any forensic testing done on any exhibits at the time. Furthermore, the exhibits could not be located by the NSWPF, and as such could not be subjected to further testing.

[2089] Exhibit 61, Tab 80, Statement of Kathryn Lockery, 23 August 2023, [17]–[19]] (SCOI.85150).

[2090] Exhibit 61, Tab 80, Statement of Kathryn Lockery, 23 August 2023, [20]–[21] (SCOI.85150).

[2091] Exhibit 61, Tab 80, Statement of Kathryn Lockery, 23 August 2023, [22] (SCOI.85150).

[2092] Exhibit 61, Tab 77, Email from the Inquiry to FASS re William Allen, 2 June 2023 (SCOI.85154); Exhibit 61, Tab 80, Statement of Kathryn Lockery, 23 August 2023, [15] (SCOI.85150).

[2093] Exhibit 61, Tab 78, Email from FASS to the Inquiry re William Allen, 21 June 2023 (SCOI.85153).

Further forensic examinations

5.2554. On 7 June 2023, the Inquiry requested by letter that NSWPF provide a statement from an appropriate officer detailing the fingerprints collected from the scene of Mr Allen's death, the results of any analysis and whether any fingerprints remain unidentified.[2094] On 14 June 2023, the NSWPF provided to the Inquiry, an expert certificate by Karen Halbert, a Crime Scene Officer, Fingerprint Expert.[2095] In this statement, Ms Halbert confirmed that she had identified the fingerprints on the side of a green glass wine carafe as belonging to Mr Allen. One print, found on the side of a glass coffee jar in the kitchen, yielded an inconclusive result.[2096]

Witness statements

5.2555. On 26 June 2023, Inquiry staff held a conference with Mr Berwick, the passer-by whom Mr Allen flagged down following his assault.[2097] A statement was taken, that statement is dated 28 June 2023.[2098]

Persons of interest as at 2022-2023

5.2556. A series of private hearings and conferences were held in relation to Mr Allen's death with witnesses and persons of interest. The possible motivations for Mr Allen's death were canvassed at those hearings. That evidence obtained by the Inquiry in the course of the private hearings, is addressed in **Chapter 17**.

5.2557. It is appropriate to make some observations in the public section of my report about some of those persons of interest, although I make these comments without intending to identify any particular persons of interest. At the time when assaults on beat users or those presumed to be beat users were commonly occurring in Alexandria Park, a number of the persons of interest were young people who had been raised in circumstances of serious disadvantage. Some were exposed in their early lives to drugs, alcohol and violence. Some were homeless and others received little support or supervision from their families. Some experienced disadvantage or discrimination associated with other forms of diversity. Many had troubled relationships with the police themselves. None of this could be regarded as an excuse for engaging in violence targeting beat users, which must be denounced in strong terms. Nor should this exclude personal responsibility for such violence. However, these features of disadvantage are part of the context in which this violence arose and should not be ignored.

[2094] Exhibit 61, Tab 75, Email from the Inquiry to Katherine Garaty, 7 June 2023 (SCOI.83989).

[2095] Exhibit 61, Tab 76, Expert Certificate of Karen Halbert, Crime Scene Officer – Fingerprints, 15 June 2023 (NPL.0100.0020.0002).

[2096] Exhibit 61, Tab 76, Expert Certificate of Karen Halbert, Crime Scene Officer – Fingerprints, 15 June 2023, 3 (NPL.0100.0020.0002).

[2097] Exhibit 61, Tab 80, Statement of Kathryn Lockery, 23 August 2023, [23] (SCOI.85150).

[2098] Exhibit 61, Tab 79, Supplementary statement of Harry Berwick, 28 June 2023 (SCOI.84270).

Contact with OIC

5.2558. In light of the evidence before the Inquiry, and the possibility that Counsel Assisting might make submissions in relation to Detective Sergeant Saunders' role in the investigation of Mr Allen's death and material discussed in the IPSB investigation, the Inquiry wrote to former Detective Sergeant Saunders. By that letter dated 13 June 2023, the Inquiry advised of the date of the public hearing and noted that, having regard to Mr Saunders' interest, he may wish to be involved. The Inquiry was subsequently advised that Mr Saunders did not wish to seek leave to appear at the public hearing.[2099]

5.2559. On 22 September 2023, the Inquiry wrote to former Senior Constable Saunders enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Allen.[2100] The Inquiry received confirmation that Mr Saunders did not wish to participate in the Inquiry.

Consideration of the evidence

5.2560. This section of the submission sets out the key matters that arose in the course of the Inquiry's consideration of the evidence, and the conclusions that may be drawn in the light of that consideration.

Indicators of LGBTIQ bias

5.2561. The evidence indicates that Mr Allen was a member of the LGBTIQ community. Mr Allen's brother, Stuart Allen, told police that Mr Allen was gay.[2101] His sister, Joyce Allen, told police that Mr Allen did not discuss his personal life with her but that she believed he was bisexual.[2102]

5.2562. Mr Allen's neighbours and acquaintances observed that he regularly had male visitors to his house for barbecues and parties, and also had men visit his house after 10:00pm. Mr Allen's neighbours also noticed that he had a frequent visitor named "Robert".[2103] Robert Dunn was a close friend and former colleague of Mr Allen.[2104] Mr Dunn and Mr Allen "struck up a relationship" in 1979.[2105] They also lived together for a period.[2106]

[2099] Exhibit 66, Tab 1, Letter to Brian Saunders, 13 June 2023 (SCOI.86273).

[2100] Exhibit 66, Tab 2, Letter to Brian Saunders, 22 September 2023 (SCOI.86284).

[2101] Exhibit 61, Tab 33, P109 Report of Occurrence, 29 December 1989, 2 (SCOI.10329.00064).

[2102] Exhibit 61, Tab 17, Statement of Joyce Elizabeth Allen, 30 December 1988, 1 (SCOI.10327.00007).

[2103] Exhibit 61, Tab 13, Statement of Ronald Sigsworth, 3 January 1989, (SCOI.10327.00005); Exhibit 61, Tab 15, Statement of Eric Edward Jackson, 30 December 1988, (SCOI.10327.00006); Exhibit 61, Tab 14, Statement of Patricia Alice Wright, 30 December 1988, [4] (SCOI.10327.00004).

[2104] Exhibit 61, Tab 13, Statement of Ronald Sigsworth, 3 January 1989, (SCOI.10327.00005); Exhibit 61, Tab 15, Statement of Eric Edward Jackson, 30 December 1988, (SCOI.10327.00006); Exhibit 61, Tab 14, Statement of Patricia Alice Wright, 30 December 1988, [4] (SCOI.10327.00004); Exhibit 61, Tab 18, Statement of Robert Joseph Dunn, 16 January 1989, 1 (SCOI.10329.00053).

[2105] Exhibit 61, Tab 18, Statement of Robert Joseph Dunn, 16 January 1989, 1 (SCOI.10329.00053).

[2106] Exhibit 61, Tab 53, NSWPF Review of an Unsolved Homicide Case Screening Form – William Allen, 24 August 2021, 9 (SCOI.03130); Exhibit 61, Tab 56, Intelligence Report (I 2522378), 2 May 1991, 1 (SCOI.73835).

5.2563. As mentioned, Mr Dunn and Mr Allen "struck up a relationship" in 1979.[2107] They also lived together for a period.[2108] Mr Dunn told police he was aware that Mr Allen had an HIV test about 12 months before he died, which was negative.[2109] In his statement to police in 1989, Mr Dunn stated that Mr Allen was not interested in "casual sex" with men because of the risk of AIDS.[2110] When spoken to by police again in 1991, Mr Dunn stated that Mr Allen would frequent toilets in the Newtown area, but had ceased this practice as he considered it too dangerous.[2111]

5.2564. Apparatus for the production of amyl nitrate was located in Mr Allen's laundry/shed.[2112] This is consistent with information provided by Mr Dunn, who told police Mr Allen manufactured amyl nitrate which was "used by [Mr Allen] and given to his friends".[2113] Amyl nitrate is commonly, though not exclusively, used among men who have sex with men.

5.2565. As referred to above, at the time of Mr Allen's death, Alexandria Park was a known beat, particularly the area around the toilet block.[2114] It was also the location where Richard Johnson was murdered.[2115]

5.2566. On the night of his death, Mr Allen told the man who drove him home from the park after he was assaulted, Mr Berwick, "that's what you expect when you do the beat".[2116] That same night, Peter Martin, an Ordinance Inspector, told Mr Allen, "…there has been a number of homosexuals getting bashed here".[2117] Given the location, time of night and comments made by Mr Allen to Mr Berwick, it is likely that Mr Allen was present at Alexandria Park to use the beat.

5.2567. At the inquest into the death of Mr Allen on 4 July 1989, the State Coroner heard evidence that Alexandria Park was "a known area of resort by homosexuals." Detective Sergeant Saunders agreed that gay men were beaten up there from time to time and that, in fact, neighbours had told police during their canvass of the area that on several occasions people had asked to use their phone after being assaulted in those toilets, but "never - never ever to contact police." Detective Sergeant Saunders told the State Coroner he had contacted the "Police Gay Liaison Unit, who ran a number of articles in newspapers wishing for homosexuals who have been assaulted in parks to come forward, but they got a very poor response".[2118]

[2107] Exhibit 61, Tab 18, Statement of Robert Joseph Dunn, 16 January 1989, 1 (SCOI.10329.00053).

[2108] Exhibit 61, Tab 53, Unsolved Homicide Team Triage Form, 24 August 2021, 9 (SCOI.03130); Exhibit 61, Tab 56, NSWPF Intelligence Report – Robert Dunn, 2 May 1991, 1 (SCOI.73835).

[2109] Exhibit 61, Tab 18, Statement of Robert Joseph Dunn, 16 January 1989, 2 (SCOI.10329.00053).

[2110] Exhibit 61, Tab 18, Statement of Robert Joseph Dunn, 16 January 1989, 2 (SCOI.10329.00053).

[2111] Unsolved Homicide Team Triage Form, 24 August 2021, 9 (SCOI.03130); Intelligence Report (I 2522378), 2 May 1991, 1 (SCOI.73835).

[2112] Exhibit 61, Tab 58, Strike Force Parrabell, Bias Crimes Indicators Review Form – William Allen, 28 February 2017, 13 (SCOI.45313).

[2113] Exhibit 61, Tab 58, Strike Force Parrabell, Bias Crimes Indicators Review Form – William Allen, 28 February 2017, 13 (SCOI.45313).

[2114] Exhibit 61, Tab 58, Strike Force Parrabell, Bias Crimes Indicators Review Form – William Allen, 28 February 2017, 4 (SCOI.45313); Exhibit 2, Tab 1, Statement of Garry Wotherspoon, 14 November 2022, [38] (SCOI.77300); Exhibit 2, Tab 5, Statement of Barry Charles, 14 November 2022, [129]–[144] (SCOI.77304).

[2115] Exhibit 61, Tab 58, Strike Force Parrabell, Bias Crimes Indicators Review Form – William Allen, 28 February 2017, 10 (SCOI.45313).

[2116] Exhibit 61, Tab 10, Statement of Harry Berwick, 11 January 1989, 1 (SCOI.10329.00052).

[2117] Exhibit 61, Tab 11, Statement of Peter Thomas Martin, 11 January 1989, 2 (SCOI.10329.00051).

[2118] Exhibit 61, Tab 7, Transcript of Coronial Inquest into the death of William Allen, 4 July 1989, T21.8-22 (SCOI.84271).

5.2568. The Inquiry is aware, including from the evidence of activist Barry Charles, of other assaults on beat users or those presumed to be beat users at Alexandria Park.[2119] The Inquiry also received evidence in a public hearing of newspaper reports regarding the widespread nature of assaults on gay men. In an article published in the Sydney Morning Herald on 6 April 1991 titled, "In the Gay Killing Fields", author Martyn Goddard wrote:[2120]

> *Poofter-bashing exists throughout all levels of Australian society, but in some cases a lethal culture of this violence develops among teenage boys. It has been happening in Alexandria and Waterloo for years.*

5.2569. In April 1991, having led the investigations into the death of Richard Johnson and the death of Kritchikorn Rattanajurathaporn at Bondi in July 1990, both of whom were gay men, former Detective Sergeant Steven McCann compiled a summary of the links and connections he had discovered in relation to attacks on gay men, including attacks resulting in deaths, in Sydney.[2121] In August 1991, he compiled a more detailed account of the connections between these attacks. Detective Sergeant McCann included the circumstances of the death of Mr Allen, and the various persons of interest, in these letters.[2122] This reflected Detective Sergeant McCann's view that the death of Mr Allen may have been motivated by LGBTIQ bias.

Events of 27–29 December 1988

5.2570. On 27 December 1988, Mr Allen was visited by Mr Dunn. Mr Dunn recalled that Mr Allen complained of being dizzy, and his skin was yellow in tone. He suffered from a nosebleed but declined to call an ambulance.[2123]

5.2571. The next day, 28 December 1988, Mr Allen did not respond to knocks at his front door at 11:00am and later in the afternoon by David Oliver, a carpenter who had concluded renovations on Mr Allen's property and was seeking payment.[2124] Around 7:00pm, Mr Allen was observed on his front porch, appearing intoxicated but happy, and exchanged pleasantries with his neighbours, Edward Jackson and Patricia Wright.[2125]

5.2572. Mr Oliver returned at around 8:00pm, but there was no answer to his knock on Mr Allen's front door, though the hallway light was on, and his car was parked in front of the property. Mr Oliver called Mr Allen repeatedly until around 11:00pm that night, but received no response on the telephone.[2126]

[2119] Exhibit 2, Tab 5, Statement of Barry Charles, 14 November 2022, [129]–[144] (SCOI.77304).

[2120] Exhibit 2, Tab 51, Martyn Goddard, 'In the Gay Killing Fields', The Sydney Morning Herald (Sydney), 6 April 1991 (SCOI.76914).

[2121] Exhibit 6, Tab 233, Statement of Stephen McCann, 10 November 2022, [8], [11]–[12] (SCOI.77310); Exhibit 6, Tab 233B, Letter from Steve McCann to Chief Superintendent Norm Maroney, 15 April 1991 (SCOI.10445.00128).

[2122] Exhibit 6, Tab 233, Statement of Stephen McCann, 10 November 2022, [15] (SCOI.77310); Exhibit 6, Tab 233A, Letter from Steve McCann to The Commander, Modus Operandi Section, 10 August 1991 (SCOI.10342.00010).

[2123] Exhibit 61, Tab18, Statement of Robert Joseph Dunn, 16 January 1989, 2 (SCOI.10329.00053).

[2124] Exhibit 61, Tab 12, Statement of David James Oliver, 2 January 1989, 1 (SCOI.10327.00008).

[2125] Exhibit 61, Tab 15, Statement of Eric Edward Jackson, 30 December 1988 (SCOI.10327.00006); Exhibit 61, Tab 14, Statement of Patricia Alice Wright, 30 December 1988, [6] (SCOI.10327.00004).

[2126] Exhibit 61, Tab 12, Statement of David James Oliver, 2 January 1989, 1 (SCOI.10327.00008).

5.2573. At around 10:00pm, Mr Berwick was driving on Park Road which borders Alexandria Park, and observed Mr Allen standing in the road waving and signalling to Mr Berwick. Mr Berwick stopped his vehicle and Mr Allen came to the passenger side, and shouted "I've been bashed". Mr Allen's face and hands were covered in blood and his nose was bleeding. Mr Berwick smelled alcohol on Mr Allen's breath, but noted Mr Allen was lucid in his speech, and "did not appear to be outraged by the incident".[2127]

5.2574. Mr Allen asked for assistance and Mr Berwick agreed. Mr Allen told Mr Berwick that his assailants "bashed me and kicked me whilst I was on the ground, the bastards, and they took my money and keys". Mr Berwick repeatedly suggested that Mr Allen contact police, but Mr Allen replied, "[t]hat's what you expect when you do the beat". Mr Berwick understood this to be a reference to Mr Allen being a gay man, and an indication that he regularly attended Alexandria Park, which was "known to be frequented by homosexuals".[2128] Mr Berwick drove Mr Allen to his home and Mr Allen said, "I'll have to get a spare set of keys and go back to get my car". Mr Berwick then drove away.[2129]

5.2575. Mr Berwick had noted that there was a small light-coloured sedan car parked near the toilet block at Alexandria Park.[2130]

5.2576. In his recent statement provided to the Inquiry on 28 June 2023, Mr Berwick said that Mr Allen also told him that he had written his phone number on the toilet block wall. He said this as part of the conversation where he said, "that's what you get when you do the beat". Mr Berwick told the Inquiry that writing your phone number on the wall of the toilet block was a common practice by men living alone and wanting to meet men at the beat. Mr Berwick had the distinct impression that Mr Allen was at the beat by arrangement, rather than by chance.[2131]

5.2577. The other aspect of Mr Berwick's statement to the Inquiry that bears noting is that when Mr Allen said he had been bashed, Mr Berwick had the distinct impression that there were "three boys" involved in the assault.[2132]

5.2578. Later that night, at around 12:30am on 29 December 1988, Ordinance Inspectors Mr Martin and Mr Murphy observed a small silver car parked opposite the toilets at Alexandria Park. There was blood on the driver's door, a trail of blood leading to the toilets and a large amount of blood and a set of keys in the middle of the roadway.[2133]

[2127] Exhibit 61, Tab 10, Statement of Harry Berwick, 11 January 1989, 1 (SCOI.10329.00052).

[2128] Exhibit 61, Tab 10, Statement of Harry Berwick, 11 January 1989, 1 (SCOI.10329.00052).

[2129] Exhibit 61, Tab 10, Statement of Harry Berwick, 11 January 1989, 1 (SCOI.10329.00052).

[2130] Exhibit 61, Tab 10, Statement of Harry Berwick, 11 January 1989, 2 (SCOI.10329.00052).

[2131] Exhibit 61, Tab 79, Supplementary statement of Harry Berwick, 28 June 2023, [8] (SCOI.84270).

[2132] Exhibit 61, Tab 79, Supplementary statement of Harry Berwick, 28 June 2023, [7] (SCOI.84270).

[2133] Exhibit 61, Tab 11, Statement of Peter Thomas Martin, 11 January 1989, [3] (SCOI.10329.00051).

5.2579. A few minutes later, Mr Allen pulled up driving a white station wagon. He remained seated in the station wagon, and so Mr Martin approached. Mr Allen had blood around his mouth and a swollen lip, but did not, to Mr Martin's eye, appear to be seriously injured. He advised Mr Martin that it was his blood and keys on the road, and that "two or three kids have bashed me so I went and got a friends car" *[sic]*. Mr Martin recommended that Mr Allen report the assault to the police, and Mr Allen replied, "Yeah I will, I'd just dropped into these toilets for a squirt when the kids got me". Mr Allen indicated that he had been able to hold on to his money, but that his attackers "kicked me when I was on the ground". Mr Allen drove the silver car home, leaving Mr Dunn's car near the park.[2134]

5.2580. Later, at 7:45am and 12:10pm on 29 December 1988, Mr Oliver attended Mr Allen's home again, but received no answer at the door. On the second occasion, he spoke to Mr Allen's neighbour, Robert Gannon.[2135] Mr Gannon spoke to Mr Sigsworth, who entered Mr Allen's garden and observed the back door to be wide open. Mr Sigsworth called out and received no reply, but heard water running and looked through the bathroom window. Mr Sigsworth observed Mr Allen slumped over the side of the bathtub with the bath tap running, and blood at the bottom of the bath. Mr Sigsworth then went to his home and called the police.[2136]

Alexandria Park

5.2581. In addition to observations made above about Alexandria Park as a beat in the late 1980s, Mr Berwick, who lived nearby Alexandria Park in 1988, gave the Inquiry some pertinent details about how the beat operated.[2137] He says it was well known by people living in the area that the toilets at Alexandria Park were a beat. He describes the beat as being "very open". There were no paths to walk along like some other beats, or areas that were more private. If men wanted to have sex, they often sat in their car on Park Road and watched who arrived. If the person went into the toilet block and was there for a while, it suggested they were there to use the beat. If a man was attracted to the person who had entered the toilet block, they followed the person into the toilet block for sexual activity.[2138]

5.2582. Mr Berwick also recalled that the lighting around the toilet block and the park was poor. This was part of the reason why the beat was not busy at night. His impression was that the beat was used by local men, unlike the beats around the beaches which people travelled to visit. [2139]

[2134] Exhibit 61, Tab 11, Statement of Peter Thomas Martin, 11 January 1989, [4]–[5] (SCOI.10329.00051).

[2135] Exhibit 61, Tab 12, Statement of David James Oliver, 2 January 1989, 1–2 (SCOI.10327.00008).

[2136] Exhibit 61, Tab 13, Statement of Ronald Sigsworth, 3 January 1989 (SCOI.10327.00005).

[2137] Exhibit 61, Tab 79, Supplementary statement of Harry Berwick, 28 June 2023, [19] (SCOI.84270).

[2138] Exhibit 61, Tab 79, Supplementary statement of Harry Berwick, 28 June 2023, [15]–[16] (SCOI.84270).

[2139] Exhibit 61, Tab 79, Supplementary statement of Harry Berwick, 28 June 2023, [17]–[18] (SCOI.84270).

5.2583. At this time, that is, the late 1980s, Mr Berwick explained that assaults were happening all the time at different beats. The assaults were often not reported as beat users did not trust the police. According to Mr Berwick, the police believed that men who used the beat "deserved what they got". [2140]

5.2584. As submitted by Counsel Assisting, this is a good illustration of the way in which a lack of cultural awareness or cultural sensitivity can contribute to members of a community being less forthcoming with information relevant to the detection and prevention of crimes, as discussed further at **Chapter 8**.

Police investigation

5.2585. Counsel Assisting submitted that several aspects of the original NSWPF investigation were inadequate.

5.2586. First, police knew Alexandria Park was a beat. So much is clear from the coronial transcript[2141] and was not disputed by the NSWPF.[2142] There was a strong possibility that Mr Allen was bashed while attending the toilet block as a beat. The Inquiry has photographs that were taken of the inside of the toilet block by police on 3 February 1990, following the death of Richard Johnson. The walls contained numerous messages seeking or inviting sexual encounters with telephone numbers.[2143]

5.2587. Appreciating that those photographs were taken over a year after Mr Allen's death, I am satisfied that the photographs likely resemble the inside of the toilet block in December 1988. The photographs show messages on the walls with dates as early as 1988 being visible. This is also consistent with information from Mr Berwick who told the Inquiry in his most recent statement that writing your phone number on the wall of the toilet block was a common practice by men living alone and wanting to meet men at the beat.[2144] Mr Allen also told him that he had written his phone number on the toilet block wall. He said this as part of the conversation where he said, "that's what you get when you do the beat".[2145]

5.2588. The NSWPF submitted that the additional information provided by Mr Berwick to this Inquiry regarding Mr Allen's phone number being on the toilet block wall was not contained within his original statement to police in 1989, and as such, there is a real possibility that Mr Berwick's recollection is not accurate.[2146] Mr Berwick's recollection is consistent with the objective evidence of the photographs, which include visible messages dated in 1988. I regard Mr Berwick's recollection as reliable.

[2140] Exhibit 61, Tab 79, Supplementary statement of Harry Berwick, 28 June 2023, [20] (SCOI.84270).

[2141] Exhibit 61, Tab 7, Transcript of the inquest into the death of William Allen, 4 July 1989, T21.8-9 (SCOI.84271)

[2142] Submissions of NSWPF, 5 September 2023, [89] (SCOI.85433).

[2143] Exhibit 61, Tab 61, Photographs of the Alexandria Park Toilet Block (taken during investigation into the death of Richard Johnson), 3 February 1990 (SCOI.85149).

[2144] Exhibit 61, Tab 79, Supplementary statement of Harry Berwick, 28 June 2023, [8] (SCOI.84270).

[2145] Exhibit 61, Tab 79, Supplementary statement of Harry Berwick, 28 June 2023, [8] (SCOI.84270).

[2146] Submissions of NSWPF, 5 September 2023, [92] (SCOI.85433).

5.2589. I accept the submission of Counsel Assisting that it should have been obvious to anyone looking at the walls at the time that if Mr Allen had been attending the toilet block as a beat, then his number may be on that wall. This is regardless of the fact that Mr Berwick's original statement did not include information about Mr Allen's phone number possibly being on the wall. The toilet wall should have been reviewed for Mr Allen's phone number.

5.2590. Counsel Assisting further submitted that the failure to check if Mr Allen had placed his phone number in the toilet block was a significant oversight. In response, the NSWPF agreed that the toilet block should have been checked but submitted that a positive finding that this step was not taken cannot be made due to a lack of documentary evidence as to whether or not such enquiries were undertaken, and in the absence of the Special Commission making inquiries with the specific officers.

1.2. I disagree with this submission by the NSWPF. If indeed the toilet block was checked for Mr Allen's phone number and/or similar inquiries were made, I find it remarkable that there is no record of those investigative steps taken, nor the outcome. I observe that:

a. There is no evidence of it occurring or being considered despite there being records of other aspects of the investigation;

b. If it was not considered then that is a failure; and

c. If it was considered but not recorded, then that is itself a regrettable failure.

5.2591. The significance of this investigative oversight becomes starker when one has regard to the photographs that were taken by police of the inside walls of the toilet block after the death of Richard Johnson. It is now not possible to know whether Mr Allen's number was on the toilet wall and whether he received a call from a location proximate to Alexandria Park the night he was assaulted. The possibility that Mr Allen's phone number was on the toilet wall might have informed the direction of the police investigation, including conducting night patrols of the park and any nearby phone boxes for any potential persons of interest. An active investigation may have prevented the conduct in the future or reduced its prevalence earlier. The Coroner clearly wished something could be done.

5.2592. There is the possibility (which is, to a degree, speculative) that if police had pursued this line of investigation more actively in 1988, future assaults and even future homicides might have been avoided. It could have also informed future reviews and investigations into Mr Allen's death, particularly after Richard Johnson's murder. The information might have been used to better inform the strategy around the use of listening devices in 1991. It is a reasonable expectation that police should pursue all lines of inquiry with due diligence, and there is a real chance that a failure might have an adverse impact on the effectiveness and/or outcome of such an investigation.

5.2593. Secondly, Counsel Assisting submitted the child abuse material found at Mr Allen's home should have been seized by police. As noted above, investigations reveal that the video tapes were later taken by a member of the public.

5.2594. In my view, the failure to take the child abuse material into evidence represents a substantial neglect of Detective Sergeant Saunders' duties. If the videos recorded child abuse material as the contemporaneous records indicate, it would have been evident to even a layperson that the videos ought to have been provided to the relevant authorities to aid in the care of children and their protection from further abuse, as well as for the further investigation of the crimes they revealed. The tapes might also have shed light on the identities of victims of sexual abuse, noting sexual abuse may have been a potential motive for the assault on Mr Allen.

5.2595. During his evidence to this Inquiry, Detective Inspector Nigel Warren said that the video tapes would have been "an avenue…to identify persons that could lead to information…about perhaps something that happened before [Mr Allen] was at the toilet block."[2147] The identification of persons in the tapes could also give police "insight into persons that Mr Allen had connection with."[2148] Detective Inspector Warren was, however, unable to assist with whether the failure by police to seize the material was in accordance with proper police practice at the time,[2149] although told the Inquiry that today it would be expected that police would seize such material.[2150]

5.2596. The NSWPF agreed that the video tapes should have been seized. Further, the NSWPF noted, and did not disagree, with Counsel Assisting's submission that the failure by Detective Sergeant Brian Saunders to seize the video cassettes constituted a substantial neglect of duties.[2151]

5.2597. In fairness to the NSWPF, it should be recognised that the IPSB conducted an investigation, following complaints by Mr Dunn and Mr Fisk, into aspects of the original police investigation.[2152] I did not receive the brief of evidence that followed that IPSB investigation into evidence at a public hearing, given the combined effect of s. 9(3) of the *SCOI Act*, s. 170 of the *Police Act*, cl. 25(2) of Schedule 4 of the *Police Act* and s. 59 of the *1978 Act* as in force prior to 1990. However, I received the brief of evidence in private.

5.2598. As I explain above, s. 9(3) does not apply to my reporting function under ss. 4(1) and 10(1) of the *SCOI Act*. While it is not necessary to summarise that brief of evidence in any detail, I observe that the conclusion was that departmental charges of neglect of duty should be preferred against Detective Sergeant Saunders, including for failure to seize the video cassettes. Those charges were admitted and penalty was held in abeyance for 18 months with quarterly work performance reports. The documents produced to this Inquiry do not record whether any further penalty was imposed.

[2147] Transcript of the Inquiry, 5 July 2023, T4989.18–20 (TRA.00073.00001).

[2148] Transcript of the Inquiry, 5 July 2023, T4989.11–12 (TRA.00073.00001).

[2149] Transcript of the Inquiry, 5 July 2023, T4989.22–28 (TRA.00073.00001).

[2150] Transcript of the Inquiry, 5 July 2023, T4988.44–46 (TRA.00073.00001).

[2151] Submissions of NSWPF, 5 September 2023, [99]–[100] (SCOI.85433).

[2152] Exhibit 61, Tab 80, Statement of Kathryn Lockery, 23 August 2023, [7] (SCOI.85150).

5.2599. The NSWPF submitted that "[i]t is not clear based on the evidence tendered to the Inquiry whether the contents of the video tapes were known to the police."[2153] While this is true in relation to evidence received in a public hearing, the documents received in private make it clear, as the NSWPF knows, that the contents of the video tapes were known to police at the time of the original investigation. I am satisfied that it is appropriate to report on this as part of my function under ss. 4(1) and 10(1) of the *SCOI Act* and include it in a part of my report which I recommend be published.

5.2600. Thirdly, Crime Scene Officer, Karen Halbert has said in an expert certificate to the Inquiry dated 14 June 2023 that she had reviewed historical case information relating to the fingerprint examination of Mr Allen's home and a silver Holden Astra, by officers on 29 December 1988. A running sheet noted that Mr Allen was fully eliminated as the source of these fingerprints. However, there were no fingerprint determinations or results recorded as to which fingerprints were identified.[2154] I accept the submission of Counsel Assisting, with which the NSWPF did not disagree, that this was at the very least, poor record keeping by police.

Manner and cause of death

5.2601. Counsel Assisting submitted that the coronial finding as to the manner and cause of Mr Allen's death remains appropriate. Mr Allen died on 29 December 1988 "of the effects of head injuries sustained on the night of 28 December 1988 when he was beaten by persons unknown in Alexandria Park."[2155]

5.2602. The NSWPF agreed with the submissions of Counsel Assisting, that the coronial finding as to the manner and cause of Mr Allen's death remains appropriate.[2156]

Bias

5.2603. Counsel Assisting submitted that there is reason to suspect that Mr Allen met his death as a consequence of an assault motivated by LGBTIQ bias. One possible circumstance is that Mr Allen was assaulted by a group of people while he was attending the beat at the Alexandria Park toilet block. If so, there would be strong reason to suspect that the assault was motivated by LGBTIQ bias. The NSWPF agrees with this submission.[2157]

[2153] Submissions of NSWPF, 5 September 2023, [99] (SCOI.85433).

[2154] Exhibit 61, Tab 79, Expert Certificate of Karen Halbert, Crime Scene Officer – Fingerprints, 15 June 2023, [7]–[10] (NPL.0100.0020.0002).

[2155] Exhibit 61, Tab 6, Findings of State Coroner Waller, Inquest into the death of William Allen, 4 July 1989, 1 (SCOI.00003.00001).

[2156] Submissions of NSWPF, 5 September 2023, [110] (SCOI.85433).

[2157] Submissions of NSWPF, 5 September 2023, [109] (SCOI.85433).

5.2604. Another possibility is that Mr Allen met his death as a consequence of his suspected involvement in the sexual abuse of young boys and production of child abuse material. If this was the motivation, it would not exclude LGBTIQ bias, bearing in mind that some offenders, wrongly, conflate membership of parts of the LGBTIQ community, or men who have sex with men, with paedophilia. As noted above, this conflation is offensive and has caused substantial harm to the LGBTIQ community. Such a conflation, in the mind of an offender, will still be a crime involving "gay hate bias".[2158] The NSWPF accept this as an alternative possibility, and agree generally that any such conflation is offensive and has caused substantial harm to the LGBTIQ community and particularly gay men. However, the NSWPF submit that there is no evidence presently available to the NSWPF to suggest that there was in a fact the sort of conflation described above.[2159]

5.2605. Mr Allen's dealings in drugs apparently resulted in his possession of a large amount of cash, which was kept in his home.[2160] There was no evidence, however that anything was stolen from Mr Allen's home after the attack on him nor that this was the motivation for the assault on him. The NSWPF agree with the submissions of Counsel Assisting that this may have been a possible motivation for the assault of Mr Allen. However, the NSWPF submits that there was no evidence that anything was stolen from Mr Allen's home after the attack, nor that this was the motivation for the assault.[2161]

5.2606. It is possible that Mr Allen carried a quantity of cash on his person or in his car, and that he may have been assaulted and robbed as a result. However, there is conflicting evidence as to whether Mr Allen was robbed during his attack. Mr Allen advised Peter Martin that he had been able to keep hold of his money during his assault,[2162] however Mr Berwick recalled that Mr Allen advised that his assailants "took my money and keys".[2163] The suggestion that Mr Allen's keys were taken is inconsistent with Mr Martin having found them on the road. No objection was raised by the NSWPF with respect to this being a possible motivation for Mr Allen's death.

5.2607. The various motivations behind Mr Allen's fatal attack are addressed further in **Chapter 17**, so as to avoid any prejudice to possible future investigations.

[2158] See Submissions of Counsel Assisting – Public Hearing 2, 7 June 2023, [1249]–[1253] (SCOI.84380).

[2159] Submissions of NSWPF, 5 September 2023, [109b] (SCOI.85433).

[2160] Exhibit 61, Tab 58, Strike Force Parrabell Bias Crimes Indicators Review Form – William Allen, 28 February 2017, 13 (SCOI.45313).

[2161] Submissions of NSWPF, 5 September 2023, [109c] (SCOI.85433).

[2162] Exhibit 61, Tab 11, Statement of Peter Thomas Martin, 11 January 1989, [5] (SCOI.10329.00051).

[2163] Exhibit 61, Tab 10, Statement of Harry John Berwick, 11 January 1989, 1 (SCOI.10329.00052).

Conclusions and Recommendations

5.2608. I find that William Allen died on 29 December 1988 of the effects of head injuries sustained on the night of 28 December 1988 when he was beaten by persons unknown in Alexandria Park. I note that this finding is consistent with the earlier coronial finding.

5.2609. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in the death of Mr Allen.

5.2610. Further findings with respect to manner and cause and my recommendations arising from the Inquiry's consideration of Mr Allen's death are contained within **Chapter 17**.

IN THE MATTER OF RUSSELL PHILLIP PAYNE

Factual background

Date and location of death

5.2611. The body of Russell Phillip Payne (born Russel Phillip Adnum on 5 January 1956) was discovered in the kitchen of his rented residential unit on Henderson Street, Inverell on 2 February 1989.

5.2612. His time of death was estimated to be about three days before the post-mortem — that is, on or about 31 January 1989.[2164]

Circumstances of death

5.2613. Mr Payne was a 33 year old man who lived in a flat at a boarding house in Inverell owned by John Wills. Mr Wills considered him to be a quiet, well-mannered person.[2165]

5.2614. At about 6:15pm on Thursday, 2 February 1989, Mr Wills entered Mr Payne's flat. He did so because Mr Payne had, uncharacteristically, failed to pay his rent, and also because a friend had come to visit Mr Payne at 6:00pm but could not find him, and asked Mr Wills if he knew where he was. The front door was locked, and so Mr Wills entered through the open bedroom window.[2166]

5.2615. Mr Wills walked through the house into the kitchen and found the body of Mr Payne in the kitchen of the flat. He immediately left and rang the police. He left through the front door, which he noticed was "heavily locked" such that he had trouble unlocking it.[2167]

5.2616. Police arrived at about 7:15pm and found Mr Payne's body in the kitchen, dressed in a blue singlet and naked from the waist down.[2168]

5.2617. Detective Sergeant Patrick Moss observed that Mr Payne's body exhibited bruising on his right hip and penis, and there was blood smeared around Mr Payne's upper thighs and legs. There were also small drops of blood on the floor of the kitchen, near the doorway from the living room and into the bathroom. There were apparent blood stains on the bedding and a towel in the bedroom.[2169]

5.2618. Further, there was vomit in two containers on the floor next to the bed and on the carpet near the two containers. Containers of prescription drugs were beside the bed. The police report does not identify the drugs nor the medical conditions apparently treated.[2170]

[2164] Exhibit 10, Tab 3, Post-mortem report of Dr Alan Davison, 6 February 1989, 2 (SCOI.75544).

[2165] Exhibit 10, Tab 7, Statement of John Malcolm Wills, 2 February 1989 (SCOI.75547).

[2166] Exhibit 10, Tab 7, Statement of John Malcolm Wills, 2 February 1989 (SCOI.75547).

[2167] Exhibit 10, Tab 7, Statement of John Malcolm Wills, 2 February 1989 (SCOI.75547).

[2168] Exhibit 10, Tab 6, Statement of Detective Sergeant Patrick Moss, 3 March 1989, [3]–[4] (SCOI.75545).

[2169] Exhibit 10, Tab 6, Statement of Detective Sergeant Patrick Moss, 3 March 1989 (SCOI.75545).

[2170] Exhibit 10, Tab 6, Statement of Detective Sergeant Patrick Moss, 3 March 1989 (SCOI.75545).

5.2619. On the floor of the bathroom were a number of handkerchiefs and underpants, each of which was stained with apparent blood. There was also a stained sponge on the bathroom sink and the underside of the toilet lid was also stained. Inside the washing machine was a shirt with a small stain, apparently blood, and a stained handkerchief.[2171]

5.2620. There were no signs of a struggle or of ransacking of any rooms.[2172]

5.2621. In the bedroom was a sawn piece of timber (apparently a broom handle), the rounded end of which was stained with a dark coloured stain. There was a large number of "erotic photographs" at the flat.[2173] The police report does not describe or comment on the content of those photographs. They do not appear to have been retained as exhibits, and NSWPF did not produce the photographs in answer to summonses issued by the Inquiry.

Previous investigations

Original police investigation

Investigative steps taken by police

5.2622. Detective Sergeant Moss led the original police investigation into Mr Payne's death. No persons of interest were identified in the course of this investigation, and police formed the view that Mr Payne's death was a result of misadventure, specifically, the result of the self-insertion of a television antenna into the penile urethra.

Post-mortem investigation

5.2623. Pathologist Dr Alan Davidson conducted a post-mortem examination on the body at 3:30pm on 3 February 1989.[2174] His pertinent findings were as follows:

a. Rigor mortis was absent and early decomposition was present;

b. Bruising described around the right anterior iliac crest (5cm x 4cm) (the hip) with superficial blister formation and yellow discolouration;

c. Bruising of the right scrotum and under the surface of the penis;

d. Maggot infestation around the pubis and right eye;

e. Small area of bruising to the right occipitotemporal scalp associated with a hairline fracture in the midline extending into the right posterior cranial fossa, with no associated intracranial haemorrhage or brain injury;

f. Strap muscles of the neck free from bruising and laryngeal skeleton intact;

g. Blood-tinged fluid within the pleural cavities and pericardial sac;

[2171] Exhibit 10, Tab 6, Statement of Detective Sergeant Patrick Moss, 3 March 1989, [6] (SCOI.75545).

[2172] Exhibit 10, Tab 6, Statement of Detective Sergeant Patrick Moss, 3 March 1989, [5] (SCOI.75545).

[2173] Exhibit 10, Tab 6, Statement of Detective Sergeant Patrick Moss, 3 March 1989, [14] (SCOI.75545).

[2174] Exhibit 10, Tab 3, Post-mortem report of Dr Alan Davison, 6 February 1989, 2 (SCOI.75544).

h. Soft spleen;

i. Bruising of the soft tissues on both sides of the penis with bruising extending to involve the spermatic cord on the right;

j. A metal object with a spike at its base present in the penile urethra 1–2cm from its distal end. The urethra was discoloured and there was inflammation with purulent exudate;

k. No features to suggest obstructive uropathy (i.e., nothing to indicate that the urethral foreign body resulted in total obstruction of urine flow); and

l. Bruising of the muscle wall of the abdomen near the anterior iliac crest and bruising of the muscle around the right shoulder.

5.2624. The metal object with a spike at its base was removed from the urethra. On later inspection by police, this was revealed to be an antenna from a television set in Mr Payne's flat.[2175]

5.2625. Dr Davison also noted a smear of blood around the fingernails of the left hand and a dried discoloured stain from his right nose and right upper lip.[2176]

5.2626. Dr Davison estimated time of death to be about three days before the post-mortem (i.e. on or about 31 January 1989).[2177]

5.2627. Dr Davison examined a number of tissue samples taken from the deceased. He noted that examination of Mr Payne's organs showed inflammation that indicated "in no uncertain fashion the presence of a severe generalised infection". Dr Davison gave the following opinion as to cause of death:[2178]

> *[T]he cause of death was due to septicaemia as a result of an acute urethritis most probably caused by insertion of a foreign body into the penile urethra. The injuries to the pelvic and groin regions could have been caused by a fall some 24 to 36 hours prior to death while the fracture of the skull is consistent with a fall occurring immediately prior to death.*

Findings at inquest

5.2628. On 18 May 1989, the Coroners Court at Inverell Local Court dispensed with an inquest. Consistent with Dr Davison's report, Mr Payne's cause of death was listed as "septicaemia as a result of an acute urethritis most probably caused by insertion of foreign body into the penile urethra".[2179]

5.2629. It is apparent that Mr Payne's death was treated as being the result of misadventure, rather than suicide or foul play.[2180]

[2175] Exhibit 10, Tab 6, Statement of Detective Sergeant Patrick Moss, 3 March 1989, [13] (SCOI.75545).

[2176] Exhibit 10, Tab 3, Post-mortem report of Dr Alan Davison, 6 February 1989, 1 (SCOI.75544).

[2177] Exhibit 10, Tab 3, Post-mortem report of Dr Alan Davison, 6 February 1989, 1 (SCOI.75544).

[2178] Exhibit 10, Tab 3, Post-mortem report of Dr Alan Davison, 6 February 1989, 2 (SCOI.75544).

[2179] Exhibit 10, Tab 5, Notice of Dispensing with Inquest, 18 May 1989 (SCOI.82202).

[2180] Exhibit 10, Tab 5, Notice of Dispensing with Inquest, 18 May 1989 (SCOI.82202).

Strike Force Parrabell

Bias Crimes Indicators Form

5.2630. A BCIF was completed by Strike Force Parrabell. It categorised the case overall as "No evidence of bias crime".[2181]

5.2631. In response to the first indicator, "Differences", it was noted that "no information relating to the sexual orientation of PAYNE was located".[2182]

5.2632. The BCIF includes references to Mr Payne's "bizarre sexual practices" and to "erotic photographs" (as described in the statement of Detective Sergeant Moss in 1989) found in Mr Payne's flat. The BCIF did not indicate what was meant by those references.

5.2633. The ten "indicators" in the BCIF were all answered as either "No Evidence of Bias Crime" (seven indicators) or "Insufficient Information" (three indicators). The "Summary of Findings" settled overall on "No Evidence of Bias Crime".[2183]

5.2634. Throughout the BCIF, the responses to the various indicators consistently indicated that the circumstances surrounding Mr Payne's death were not suspicious and that the evidence suggested that Mr Payne died by misadventure, as the result of a self-inflicted wound.[2184]

5.2635. Both the "General Comment" and the "Summary of Findings" also note that Mr Payne's injuries appeared to be self-inflicted. The "Summary of Findings" adds that "there is no suggestion any persons were identified as being responsible of having any involvement in PAYNE'S death".[2185]

Case Summary

5.2636. Strike Force Parrabell categorised the case as "no evidence of bias crime".[2186] It further categorised the matter as solved.[2187]

5.2637. The Strike Force Parrabell Case Summary for Mr Payne's case read as follows:[2188]

> ***Identity**: Russell Payne was 33 years old at the time of his death.*
>
> ***Personal History**: Mr Payne was an Invalid Pensioner with his marital status listed as unknown.*

[2181] Exhibit 10, Tab 9, Strike Force Parrabell Bias Crimes Indicators Review Form, undated (SCOI.74987).
[2182] Exhibit 10, Tab 9, Strike Force Parrabell Bias Crimes Indicators Review Form, Undated 2 (SCOI.74987).
[2183] Exhibit 10, Tab 9, Strike Force Parrabell Bias Crimes Indicators Review Form, Undated 13 (SCOI.74987).
[2184] Exhibit 10, Tab 9, Strike Force Parrabell Bias Crimes Indicators Review Form, Undated 4, 5, 7, 10, 12, 13 (SCOI.74987).
[2185] Exhibit 10, Tab 9, Strike Force Parrabell, Bias Crimes Indicators Review Form, Undated 13 (SCOI.74987).
[2186] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Russell Payne, 15 (SCOI.76961.00014).
[2187] Exhibit 10, Tab 9, Strike Force Parrabell, Bias Crimes Indicators Review Form, undated (SCOI.74987).
[2188] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Russell Payne, 15 (SCOI.76961.00014).

> ***Location of Body/Circumstances of Death**: Mr Payne's body was located in his residential unit at Henderson Street, Inverell. The post mortem noted the following '... a metal piece, which upon closer examination appears to be the tip of the antenna from a television set at the flat ... was found inserted inside the urethra of the deceased, about 1cm from the tip'. 'Mr Payne's Death Certificate lists the cause of death as 'Septicaemia as a result of an acute urethritis most probably caused by insertion of a foreign body into the penile urethra.'*
>
> ***Sexual Orientation**: Mr Payne's sexual orientation could not be confirmed.*
>
> ***Coroner/Court Findings**: This cause of death together with other evidence located at the scene indicated that the injuries causing the death of Mr Payne were self-inflicted.*
>
> ***SF Parrabell concluded there was no evidence of a bias crime***

5.2638. The content of this Case Summary are broadly consistent with the comments made in the BCIF.

Academic review

5.2639. The academic review categorised the case of Mr Payne as "No Bias". The authors stated they were "greatly influenced" in their categorisation of "No Bias Cases" by coronial findings of misadventure.[2189] Under the heading 'No Bias Cases", the academic review noted:[2190]

> *In Payne (31), the victim appears to have been responsible for his own death by inserting a steel object into his urethra, resulting in fatal septicaemia.*

Review by the Inquiry

5.2640. The Inquiry took the following steps in the course of examining the matter.

Summonses

5.2641. A summons was issued to the NSWPF on 18 May 2022 for all documents relating to investigations by the NSWPF of the death of Mr Payne, including certain prescribed categories of information identified at (1)(a) to (j) of the summons. That summons also called for any other material held or created by the UHT in relation to the death of Mr Payne (NSWPF1). An electronic folder of material in relation to Mr Payne was produced on 12 August 2022.

[2189] Exhibit 1, Tab 2, NSW Police Force, *Strike Force Parrabell Final Report* (Report, June 2018) 99 (SCOI.02632).

[2190] Exhibit 1, Tab 2, NSW Police Force, *Strike Force Parrabell Final Report* (Report, June 2018) 99 (SCOI.02632).

5.2642. On 25 August 2022, the Inquiry issued a further summons to the NSWPF for all records in relation to, relevantly, Strike Force Parrabell (NSWPF12). This material was produced in tranches between 9 September 2022 and 18 November 2022. This material included the BCIF and certain Investigator's Notes in relation to Strike Force Parrabell's review of Mr Payne's death.[2191]

5.2643. On 30 September 2022, the Inquiry issued a summons to BDM for the death certificate of Mr Payne (BDM4).[2192] From the material produced in response to this summons, it was confirmed that Mr Payne's name at birth was Russel Phillip Adnum.[2193]

5.2644. On 7 October 2022, the Inquiry issued a summons to the Hunter New England LHD for all medical records in respect of Mr Payne (HNE01).[2194]

5.2645. On 13 October 2022, the Hunter New England LHD advised that no records had been located.[2195] By email dated 18 October 2022, it was further confirmed that they had searched using variations of the name Russell Phillip Payne and Russel Phillip Adnum.[2196]

Interagency cooperation

5.2646. On 15 June 2022, the Inquiry issued a written request to the Coroners Court to obtain the coronial file in relation to the death of Mr Payne. A further letter of request was issued to Inverell Local Court, where the coronial inquest had taken place, on 12 August 2022.

5.2647. The Coroners Court answered the request on 1 August 2022, and Inverell Local Court provided materials on 19 August 2022.[2197]

Family members

5.2648. On 4 August 2022, the Inquiry was contacted by Michael Burge, a freelance journalist, author, and artist who lives in the New England region of NSW. His work has covered issues of equality and LGBTIQ history, and he has reported on LGBTIQ hate crimes in regional NSW.

[2191] Exhibit 10, Tab 16, Statement of Francesca Lilly, 5 February 2023, [6]–[7] (SCOI.82353).

[2192] Exhibit 10, Tab 16, Statement of Francesca Lilly, 5 February 2023, [8]–[9] (SCOI.82353).

[2193] Exhibit 10, Tab 1, Death Certificate of Russell Phillip Payne, 13 October 2016 (SCOI.37332).

[2194] Exhibit 10, Tab 13, Summons to Hunter New England Local Health District (Summons HNE01), 7 October 2022 (SCOI.82170).

[2195] Exhibit 10, Tab 14, Letter from John Hunter Hospital to the Inquiry, 13 October 2022 (SCOI.82173).

[2196] Exhibit 10, Tab 16, Statement of Francesca Lilly, 5 February 2023, [12]–[13] (SCOI.82353).

[2197] Exhibit 10, Tab 16, Statement of Francesca Lilly, 5 February 2023, [4]–[5] (SCOI.82353).

5.2649. In around 2020, Mr Burge began investigating the death of Mr Payne, and he later published an article about the case.[2198] In the course of his investigations, he spoke to family members of Mr Payne, including sister Julie Kilgour, Julie's former husband Ray Kilgour, her daughter Lou Kilgour, and Julie's ex-partner Terry Forster. With the permission of those family members, Mr Burge provided their contact details, and the information he obtained, to the Inquiry.[2199]

5.2650. Mr Burge also provided a statement to the Inquiry, in which he records relevantly Mr Forster's account of Mr Payne coming out to him as gay within the year or so before his death.[2200]

5.2651. The Inquiry also spoke via telephone with Mr Forster on 27 and 30 January 2023. Mr Forster then provided a statement outlining how Mr Payne told him he was gay in about 1988–1989, as discussed below.

Searches for exhibits

5.2652. Detective Sergeant Moss recorded that a number of items were collected from the crime scene for forensic examination.[2201] However, the results of any such examination are unknown. No certificates of analysis are now on the coronial or police files as produced to the Inquiry. There is no record of the location of these exhibits on the coronial or police files, despite the Inquiry summoning all material held by both bodies.

5.2653. After receiving the report of Dr Linda Iles, forensic pathologist, referred to below, the Inquiry concluded that there was no utility in further requests for these exhibits.

5.2654. The "erotic photographs" referred to in the original police report do not appear to have been retained as exhibits.

5.2655. During the post-mortem examination, histology slides were prepared. The Inquiry requested these slides from DOFM, Newcastle Forensic Medicine and Inverell Hospital, but no records were identified.

Further forensic examinations

5.2656. Mr Payne's case did not indicate the need for any further forensic examination of exhibits. Given the absence of the exhibits, none was conducted.

Professional opinions

5.2657. The Inquiry sought an independent review of the post-mortem report prepared by Dr Davison, including as to the cause of Mr Payne's death and whether his injuries appeared to be self-inflicted or a result of foul play.

[2198] Michael Burge, 'What will the NSW inquiry into historical gay-hate crimes mean for the bush?', *Guardian Australia* (online, 14 November 2021) <https://www.theguardian.com/australia-news/2021/nov/14/what-will-the-nsw-inquiry-into-historical-gay-hate-crimes-mean-for-the-bush>.

[2199] Exhibit 10, Tab 15, Statement of Michael Burge, 31 January 2023, 1–2, [3]–[14] (SCOI.82352); Exhibit 10, Tab 16, Statement of Francesca Lilly, 5 February 2023, 2–4, [19]–[28] (SCOI.82353).

[2200] Exhibit 10, Tab 15, Statement of Michael Burge, 31 January 2023, 2, [9]–[10] (SCOI.82352).

[2201] Exhibit 10, Tab 6, Statement of Detective Sergeant Patrick Moss, 3 March 1989 (SCOI.75545).

5.2658. The Inquiry obtained an expert report from forensic pathologist Dr Iles on 11 November 2022.[2202]

5.2659. Dr Iles indicated she would be assisted by the histology slides. Enquiries were made with DOFM on 3 November 2022. On 7 November 2022, DOFM advised that that they held no records for Mr Payne. Enquiries were also made with Newcastle Forensic Medicine and Inverell Hospital (where the post-mortem was performed) on 8 November 2022, but no records were identified for Mr Payne.[2203]

Witness statements

5.2660. As noted above, the Inquiry obtained witness statements from Mr Burge and Mr Forster.

5.2661. This followed telephone contact with Mr Forster on 27 and 30 January 2023 and a teleconference with Mr Burge on 24 January 2023.[2204]

Contact with OIC

5.2662. On 30 August 2023 and 18 September 2023, the Inquiry wrote to Patrick Moss enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Payne. The Inquiry did not receive a response from Mr Moss.[2205]

Other

5.2663. The Inquiry conducted research and considered other material held or obtained by the Inquiry of potential relevance to the matter, including for example information concerning the sexual practice known as "sounding", which involves the insertion of an object (usually a thin sex toy) into the urethra.

Consideration of the evidence

Forensic analysis

5.2664. In her report, Dr Iles considered that the post-mortem of Dr Davison was reasonably comprehensive and conducted in "a thoughtful way, with a view to excluding major trauma contributing to or directly causing death".[2206] She considered the material was adequate to allow her to express a view as to cause of death.[2207]

[2202] Exhibit 10, Tab 11, Expert report of Dr Linda Iles, Undated provided on 11 November 2022 (SCOI.82113).

[2203] Exhibit 10, Tab 16, Statement of Francesca Lilly, 5 February 2023, [15]–[18] (SCOI.82353).

[2204] Exhibit 10, Tab 16, Statement of Francesca Lilly, 5 February 2023, 4, [29] (SCOI.82353).

[2205] Exhibit 66, Tabs 55-56, Letters to Patrick Moss, 30 August 2023 and 18 September 2023 (SCOI.86313; SCOI.86314).

[2206] Exhibit 10, Tab 11, Expert report of Dr Linda Iles, Undated provided on 11 November 2022, 5 (SCOI.82113).

[2207] Exhibit 10, Tab 11, Expert report of Dr Linda Iles, Undated provided on 11 November 2022, 5 (SCOI.82113).

5.2665. She adopted a view of the cause of death that is "not significantly different" to that of Dr Davison — namely, "death as a consequence of septicaemia secondary to Fournier's gangrene, precipitated by a urethral foreign body". Fournier's gangrene is a life-threatening, necrotising soft tissue infection of the perineum and surrounding tissues. Urethritis, the term used by Dr Davison, is a bacterial or viral infection in the urethra.

5.2666. Dr Iles noted that findings at the scene indicate Mr Payne had been unwell for a period preceding his death, consistent with systemic sepsis.[2208]

5.2667. Dr Iles referred to literature to support the propositions that insertion of foreign bodies into the urethra, although uncommon, was "well described in the setting of autoeroticism and masturbatory behaviour", and further that there were cases in the literature of Fournier's gangrene precipitated by self-inserted urethral foreign bodies.[2209]

5.2668. Dr Iles made the following comments in relation to the bruising or other injuries observable on Mr Payne's body:

a. In relation to the swelling and bruising to Mr Payne's genital region, it is highly likely that these are a manifestation of Fournier's gangrene;

b. The bruising described to Mr Payne's hip and pelvic region could be as a result of direct trauma (noting that Mr Payne is likely to have bruised easily in the setting of sepsis) or soft tissue infection and necrosis;

c. In relation to Mr Payne's skull fracture, it is not associated with intracranial injury, and is consistent with an agonal event (i.e., a fall backwards at the time of death) rather than being the primary cause for Mr Payne's death; and

d. The bruising to Mr Payne's right shoulder muscle would also be consistent with a fall backwards.[2210]

5.2669. Dr Iles was of the view that there were "no findings in the material … that necessitates the involvement of another person in Mr Payne's death". She expressed the view, on the available material, that "Mr Payne's death can be completely explained as a consequence of a natural disease process secondary to misadventure (i.e., a foreign body in the urethra)", and that there are "no features in the materials … to suggest either suicide or foul play". [2211]

Indicators of LGBTIQ bias

5.2670. At the time of the original police investigation, Mr Payne's landlord, Mr Wills, who had known Mr Payne for about 18 months at the time of his death, said Mr Payne had told him that he had once been married but was now divorced, and had a child living in Brisbane.

[2208] Exhibit 10, Tab 11, Expert report of Dr Linda Iles, Undated provided on 11 November 2022, 6 (SCOI.82113).

[2209] Exhibit 10, Tab 11, Expert report of Dr Linda Iles, Undated provided on 11 November 2022 (SCOI.82113).

[2210] Exhibit 10, Tab 11, Expert report of Dr Linda Iles, Undated provided on 11 November 2022, 5–6 (SCOI.82113).

[2211] Exhibit 10, Tab 11, Expert report of Dr Linda Iles, Undated provided on 11 November 2022, 7 (SCOI.82113).

5.2671. The police materials, as produced to the Inquiry, contain no material bearing upon whether Mr Payne was, or might have been, a member of the LGBTIQ community.

5.2672. However, the Inquiry now has some information relevant to Mr Payne's sexuality. Mr Forster, the ex-partner of Mr Payne's sister, used to visit Inverell every fortnight or so for a shopping trip in 1988–1989. He would see Mr Payne on those trips. On one of those trips, about a year before his death, Mr Payne came out as gay to Mr Forster.[2212] Mr Forster was not aware of any partner of Mr Payne's and Mr Payne did not discuss his sexual practices.[2213]

5.2673. Mr Payne's sister, Ms Kilgour, and her former partner Mr Kilgour, who also knew Mr Payne, were not aware that Mr Payne was gay. However, upon learning during a recent visit from journalist Michael Burge what Mr Payne had said to Mr Forster regarding his sexuality, the family expressed support and understanding of that possibility.[2214]

Police investigation

Communication with Mr Payne's family

5.2674. Mr and Ms Kilgour have expressed concern at the lack of communication between themselves and the investigating police. According to Mr Kilgour, he first learnt of Mr Payne's cause of death in 2022, more than 30 years after Mr Payne died, when journalist Mr Burge provided documents from the coronial file to him.

5.2675. The police file, as provided to the Inquiry, contains no record of any interactions between police and any of Mr Payne's family following his death. Counsel Assisting submitted that such engagement not only would have been courteous but would also have resulted in the obtaining of relevant information as to Mr Payne's circumstances.

5.2676. The NSWPF noted in their written submissions that these concerns were not explored with the original investigating police.[2215] My views as to such submissions, in the context of this Inquiry, are outlined at **Chapter 1** and in the introduction to this Chapter. For present purposes, I observe that any contact between investigating police and a family should be appropriately recorded. No such record exists here. My concerns as to the lack of contact with the family arise from both the absence of any documentary records supporting that such contact occurred, and the concerns raised by Mr and Ms Kilgour.

[2212] Exhibit 10, Tab 17, Statement of Terry Forster, 30 January 2023 (SCOI.82354).

[2213] Exhibit 10, Tab 17, Statement of Terry Forster, 30 January 2023, [4]–[10] (SCOI.82354).

[2214] Exhibit 10, Tab 15, Statement of Michael Burge, 31 January 2023, [11] (SCOI.82352).

[2215] Submissions of NSWPF, 21 February 2023, [66] (SCOI.82560).

5.2677. The NSWPF also submitted that the apparent lack of communication may have been an attempt to shield the family from the trauma or embarrassment that may have arisen in connection with information as to Mr Payne's death. This is possible, but speculative. The NSWPF conceded that such a desire might be regarded as "misplaced" in a modern context.[2216]

5.2678. On the information available to me, I consider it appropriate to observe that there ought to have been greater communication with the deceased's family. It is acknowledged that it is not always appropriate to keep the deceased's family, or members of the public, fully informed of the progress of an investigation while it is ongoing, for obvious reasons of confidentiality. However, the police should be able to devise a means by which family members are dealt with candidly and respectfully and informed of the progress of enquiries, even at a general level. The level of engagement with family may well need to be reassessed based on the views formed as to manner and cause of death. In this case, once a view was formed that Mr Payne's death was accidental and there was no person of interest, there was no justification for withholding information from his family.

Failure to secure relevant exhibits

5.2679. As noted above, Detective Sergeant Moss noted that a number of "erotic photographs" were found in the bedroom of Mr Payne's flat. As Counsel Assisting submitted, details should have been recorded as to the content of the "erotic photographs", and these items should have been secured as exhibits.

5.2680. The NSWPF stated in their submissions that the suggestion that police ought to have regarded the photographs as sufficiently pertinent to warrant their seizure is wholly speculative, noting the photographs may have been "entirely conventional erotic photographs". The NSWPF submitted that the task of police at the time was to identify what caused Mr Payne's death, not to exhaustively interrogate contextual factors that may have been relevant to the question of his sexuality.[2217]

5.2681. The failure to record the content of the "erotic photographs" or to take them into evidence was also the subject of submissions at the Investigative Practices Hearing. Counsel Assisting submitted that there would be force in the NSWPF's submissions if the OIC had not relied on and referred to the photographs in his reasoning. In addition, Counsel Assisting observed that the reference to "bizarre sexual practices" was concerning, as that language might be characterised as "prurient or contemptuous in relation to diverse sexual practices".[2218]

5.2682. The NSWPF responded to the submissions of Counsel Assisting by submitting that:[2219]

a. The mere fact that the OIC referred to the photographs did not indicate that they were a necessary component in his conclusion regarding the cause of Mr Payne's death;

[2216] Submissions of NSWPF, 21 February 2023, [66] (SCOI.82560).

[2217] Submissions of NSWPF, 21 February 2023, [67] (SCOI.82560).

[2218] Submission of Counsel Assisting the Inquiry, 15 September 2023, [686] (SCOI.85649).

[2219] Submissions of NSWPF, 21 February 2023, [67] (SCOI.82560).

b. There is no evidence as to where in the bedroom the photographs were located, and consequently nothing to suggest that they were located in a place that should have put police on notice as to a connection between the photographs and Mr Payne's death; and

c. It appears that it was not until the antennae piece was located during the post-mortem examination that the link between Mr Payne's sexual practices and his death became apparent, and thus it was unsurprising that the relevance of the photographs was not identified until the post-mortem examination, at which time police were able to confirm that there was nothing suspicious associated with the death and that, in turn, there was no need for further investigative steps to be taken.

5.2683. In addition, the NSWPF submitted that the word "bizarre" means "very strange and unusual", and that "[e]ven by modern standards, there is no doubt that the insertion of a television antenna into the urethra qualifies as a "very strange and unusual" sexual practice". Consequently, the NSWPF submit that while it is accepted that it would have been better for the word "bizarre" to be omitted, Counsel Assisting has been "unduly critical" of the OIC.

5.2684. Counsel Assisting filed submissions in reply in connection with the Investigative Practices Hearing on 19 October 2023.[2220]

5.2685. I reject the submissions of the NSWPF in relation to the failure by the OIC to describe the photographs in precise detail, or to take them into evidence. Detective Sergeant Moss' opinion that Mr Payne may have engaged in "bizarre" sexual practices was expressly based, at least in part, on the presence of the erotic photographs.[2221] That opinion in turn founded the conclusion that Mr Payne self-inserted a foreign object into his urethra. As such, even viewed through the lens of the original investigation, the photographs were relevant to the determination of Mr Payne's cause of death. Even if it is accepted that the relevance of the photographs became apparent only at the post-mortem, the fact they were relied upon as a step in the reasoning to cause of death required that they be at least described with specificity.

5.2686. I agree with Counsel Assisting that the photographs should have been secured as exhibits, or described with precision.

5.2687. In addition, I accept the submissions of Counsel Assisting in relation to the language used to describe Mr Payne's sexual practices. As the NSWPF accepted, it would have been preferrable for the word "bizarre" to be omitted. It is not necessary for me to make any further observations concerning Mr Payne's sexual practices, although I observe that I consider it is appropriate to be hesitant before ascribing labels such as "very strange" to any person's sexual practices. It may be that one of the reasons Mr Payne did not seek medical assistance was because he was embarrassed or concerned about a hostile or humiliating experience if he did so. It is important to avoid perpetuating the attitudes that may have led to this hesitancy.

[2220] Submissions of Counsel Assisting the Inquiry, 19 October 2023 (SCOI.86354).

[2221] Exhibit 10, Tab 6, Statement of Detective Sergeant Patrick Moss, 3 March 1989, 3, [14] (SCOI.75545).

Manner and cause of death

5.2688. As Counsel Assisting submitted, in all the circumstances, it is more probable than not that Mr Payne inserted the foreign body into his urethra, likely in the setting of autoeroticism.[2222]

5.2689. In that regard, I accept the expert opinion of Dr Iles, discussed above, which is essentially largely consistent with the original opinion of Dr Davison, noted above.

5.2690. As Counsel Assisting also submitted, a number of additional factors tend against a conclusion that another person was involved in, or responsible for, Mr Payne's death, and tend to suggest that Mr Payne himself inserted the foreign body into his urethra. Those factors include: there were no signs of struggle or ransacking in Mr Payne's unit; there was evidence that Mr Payne was unwell for some time before his death; and Mr Payne's unit was "heavily locked".

5.2691. I agree that it is very likely that Mr Payne died as a result of misadventure. There is no evidence of any third-party involvement and self-insertion of foreign objects into the urethra is a known sexual practice.

5.2692. I adopt the cause of death proposed by Dr Iles, namely death as a consequence of septicaemia secondary to Fournier's gangrene, precipitated by a urethral foreign body. This cause of death is not significantly different to that of the original pathologist, Dr Davidson, but reflects the presence of swelling and bruising in the genital region, as opposed to an infection isolated to the urethra.

Bias

5.2693. Notwithstanding the new information as to Mr Payne's sexuality, namely evidence that he was gay, I agree with Counsel Assisting that on the evidence available to the Inquiry, there is objectively no reason to suspect that LGBTIQ bias was a factor in Mr Payne's death.

[2222] Submissions of Counsel Assisting the Inquiry, 6 February 2023, [63] (SCOI.82372).

Conclusions and Recommendations

5.2694. I find that Russell Phillip Payne died at Henderson Street, Inverell between 31 January 1989 and 2 February 1989 as a consequence of septicaemia, precipitated by a urethral foreign body, which was self-inserted.

5.2695. In my view, on the evidence available to the Inquiry, there is objectively no reason to suspect that LGBTIQ bias was a factor in Mr Payne's death.

5.2696. I make the following recommendation:

Recommendation 2

I recommend that BDM correct the Register of Births, Deaths and Marriages pursuant to s 45(1)(b) of the *Births, Deaths and Marriages Registration Act 1995*, such that Mr Payne's cause of death is recorded as: "septicaemia secondary to Fournier's gangrene, precipitated by a urethral foreign body".

IN THE MATTER OF SAMANTHA RAYE

Factual background

Date and location of death

5.2697. Samantha Raye's body was found in a cave below Hornby Lighthouse, South Head in Sydney, at around 9:30am on 20 March 1989.[2223]

5.2698. The precise date of Ms Raye's death is unclear. Ms Raye had not been seen or heard from by her friends or doctors after 11 March 1989.[2224] A note indicating that she was going to "the lighthouse" was present at her flat (in Macleay Street, Potts Point) from at least 17 March 1989.[2225]

5.2699. The time of death was estimated at post-mortem to be two to three days prior to the post-mortem examination on 22 March 1989 — i.e., between approximately 7:00pm on 19 March 1989 and 7:00pm on 20 March 1989.[2226]

5.2700. Dr Linda Iles, a forensic pathologist, who was requested by the Inquiry to review the original post-mortem report, considered that estimate to be "not unreasonable", but noted that the post-mortem observations could not preclude Ms Raye's death being closer to the last time she was known to be alive.[2227]

Circumstances of death

5.2701. Ms Raye was a trans woman. She was also a person with intersex characteristics.

5.2702. As noted above, Ms Raye's body was found in a cave below Hornby Lighthouse, South Head. An empty bottle of insulin, a needle and a syringe were found next to her body, with a pack of Valium tablets found on her person.[2228]

[2223] Exhibit 17, Tab 9, Statement of Daniel Willis, 20 March 1989, [3] (SCOI.11038.00031).

[2224] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [8], [10] (SCOI.11038.00030).

[2225] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [9] (SCOI.11038.00030).

[2226] Exhibit 17, Tab 7, Post-mortem report of Dr Peter Bradhurst, 23 June 1989, 1 (SCOI.48922).

[2227] Exhibit 17, Tab 36, Expert report of Dr Linda Iles, 3 March 2023, 8 (SCOI.82545).

[2228] Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [4] (SCOI.11038.00027); Exhibit 17, Tab 19, Statement of Constable Patrick John Duncombe, 8 May 1989, [6] (SCOI.11038.00028).

5.2703. On or prior to 17 March 1989 (when Ms Raye's friend Wayne Hurrell saw the note in her apartment), Ms Raye had left a brief note on her mantelpiece which read, "At lighthouse. Will be back???", suggesting she went to the location of her death of her own accord.[2229]

5.2704. There were no significant injuries or signs of violence to Ms Raye's body that would suggest an assault or a homicide. No anogenital injury is described.[2230] On the evidence, Ms Raye's death was not the result of a homicide.

5.2705. The evidence available to the Inquiry, including the expert opinion of Dr Iles, supports a conclusion that Ms Raye died as a consequence of hypoglycaemic brain injury secondary to insulin toxicity, which followed the self-administration of insulin by Ms Raye.[2231]

Previous investigations

Post-mortem examination

5.2706. At 7:00pm on 22 March 1989, Dr Peter Bradhurst conducted the post-mortem on Ms Raye's body. His post-mortem report is dated 23 June 1989.[2232]

5.2707. In that report, Dr Bradhurst found no significant injuries or signs of violence.[2233] However, he noted that:

a. Sections of Ms Raye's lungs showed an acute bronchopneumonia affecting both lungs. The changes in the left lung were florid and appeared as a lobar pneumonia. In addition, the left lung had numerous gram positive cocci in pairs, short chains or clusters, which suggested streptococci;[2234] and

b. Microscopic examination of Ms Raye's brain revealed cell changes that were consistent with a viral infection of mild meningoencephalitis.[2235]

5.2708. Toxicology found insulin in Ms Raye's blood (21 micro units per mL) and glucose in her urine (0.90 millimole per litre). The plastic syringe and jar found near Ms Raye's body were both found to contain insulin.[2236]

5.2709. Dr Bradhurst recorded the direct cause of death as "acute bilateral bronchopneumonia and viral meningoencephalitis". Noted as an antecedent cause of death was "possible use of insulin".[2237]

[2229] Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [8] (SCOI.11038.00027). By contrast, in his statement to police, Mr Hurrell describes the note as being on a side table in Ms Raye's living room; see Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [9] (SCOI.11038.00030).

[2230] Exhibit 17, Tab 7, Post-mortem report of Dr Peter Bradhurst, 23 June 1989, 2 (SCOI.48922).

[2231] Exhibit 17, Tab 36, Expert report of Dr Linda Iles, 3 March 2023, 8 (SCOI.82545); Exhibit 17, Tab 43, Further supplementary expert report of Dr Linda Iles, 21 July 2023, Comment [3] (SCOI.84882).

[2232] Exhibit 17, Tab 7, Post-mortem report of Dr Peter Bradhurst, 23 June 1989, 1 (SCOI.48922).

[2233] Exhibit 17, Tab 7, Post-mortem report of Dr Peter Bradhurst, 23 June 1989, 2 (SCOI.48922).

[2234] Exhibit 17, Tab 7, Post-mortem report of Dr Peter Bradhurst, 23 June 1989, 4 (SCOI.48922).

[2235] Exhibit 17, Tab 5, Microscopic examination of brain, 12 May 1989 (SCOI.48922).

[2236] Exhibit 17, Tab 6, Toxicology report, 24 May 1989 (SCOI.11038.00010).

[2237] Exhibit 17, Tab 7, Post-mortem report of Dr Peter Bradhurst, 23 June 1989, 1 (SCOI. 48922).

5.2710. In respect of "[o]ther significant conditions contributing to the death but not relating to the disease or condition causing it", Dr Bradhurst entered the two words "[t]ransexual, [d]epression".[2238]

Original police investigation

5.2711. The original police investigation was led by Constable William Wilcher from the Bondi Police Station.

5.2712. At 10:25am on 20 March 1989, officers from the Bondi Police Station, including Constable Wilcher, attended Hornby Lighthouse and were shown to Ms Raye's body.

5.2713. In a job entry dated 10:50am, Constable Wilcher recorded the incident as "death suspicious."[2239]

5.2714. At 11:30am,[2240] officers from the crime scene unit attended and took photographs of Ms Raye and the surrounding area.[2241] Unlike Constable Wilcher, they recorded at 11:35am that there were "no suspicious circumstances".[2242] That variance is not subsequently explained or clarified in later NSWPF documents.

5.2715. Constable Wilcher expressed the following views as to cause and manner of death:[2243]

> *According to the medical evidence I have recorded, Samantha was mentally unstable, a person who constantly lived in a world of intrigue and scandal. Samantha RAYE was a loner, who would not fit into the bizarre world of the genuine transsexual or transvestite, and could not fit in with main stream society due to the way she was born. I have spoken to transvestite prostitutes at Darlinghurst, all of which knew Samantha RAYE by sight but all stated that she did not associate with the rest of the community. These Transvestites and transsexuals did not know of anyone named Syanti or Jaja or Swanny, so it would seem that the writing above the place where the body was found is unrelated.*
>
> *I cannot draw conclusion about how Samantha RAYE met her death, although suicide is the most likely verdict. The only thing out of character with Samantha RAYE committing suicide is that she did not leave a more descriptive suicide note or that she did not get the maximum effect from the event, as was consistent with her personality. I can find no motive for anyone wishing harm to Samantha RAYE.*

[2238] Exhibit 17, Tab 7, Post-mortem report of Dr Peter Bradhurst, 23 June 1989, 1 (SCOI. 48922).

[2239] Exhibit 17, Tab 17, NSWPF entry book extract, 20 March 1989 (SCOI.10333.00005).

[2240] This time is recorded as 11:30pm at [6] of the statement of Constable William John Wilcher, but this appears to be an error.

[2241] Exhibit 17, Tab 14, Crime Scene Photographs, 20 March 1989 (SCOI.11038.00039).

[2242] Exhibit 17, Tab 16, Scene attendance entry by Scientific Team, 20 March 1989 (SCOI.10333.00007).

[2243] Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [14] (SCOI.11038.00027).

5.2716. The use of the expression "genuine" "transsexual or transvestite" echoes the "gatekeeping" model used by the medical profession from the early 1950s, where psychiatrists determined whether someone was a "true transsexual" based on whether the person conformed to expected stereotypes for middle class, white, cis women, or looked sufficiently feminine. The views of a psychiatrist as to whether a person was a "true transsexual" or "genuine transexual" would determine who had access to hormones and/or gender affirmation surgery.[2244] For the reasons explored in the Context Hearing, these attitudes have done significant harm to the trans and gender diverse community.

5.2717. Similarly, the reference to "genuine transsexuals or transvestites" living in a "bizarre world", and the assumption that the reason why Ms Raye could not fit in with "mainstream" society was "the way she was born" (rather than, for example, discrimination and/or hostility towards persons with intersex characteristics or trans people), would now generally be regarded as reflecting views and attitudes of a different era.

Inquest dispensed with

5.2718. On 30 June 1989, Coroner Waller sitting in the Coroners Court at Glebe dispensed with an inquest into Ms Raye's death. The handwritten notation on the coroner's action cover sheet dated 30 June 1989 states:[2245]

> *? O/D insulin or death by natural cause. No one seeks inquest. No chance of finally establishing manner of death. IDW [I dispense with].*

5.2719. Ms Raye's death certificate is dated 19 April 1989. The entry in the field for 'Cause of death' reads:[2246]

> *Acute bilateral bronchopneumonia and viral meningoencephalitis.*
>
> *Possible use of insulin.*
>
> *Transexual depression.*

5.2720. The "[c]ause of death" field bears a handwritten notation, above the words "By whom certified", as follows: "[initials] 6.7.89".[2247] The handwritten initials are illegible, but do not correspond to those of Dr Bradhurst on the post-mortem report dated 23 June 1989.

5.2721. The term "transexual depression" is not found in Dr Bradhurst's post-mortem report. Nor did Dr Bradhurst include such a concept as a cause of death. Rather, Dr Bradhurst nominated two separate "conditions", namely "transexual," and "depression", as "[o]ther significant conditions contributing to the death but not relating to the disease or condition causing it."[2248] The presence of the term "transexual depression" in the death certificate is the subject of comment below.

[2244] Exhibit 2, Tab 10, Statement of Dr Eloise Brook, 15 November 2022, [20]–[21] (SCOI.77309).

[2245] Exhibit 17, Tab 31, Coroners Court (Police Prosecutors) – Action Cover Sheet, 18 April-30 June 1989 (SCOI.11038.00002).

[2246] Exhibit 17, Tab 8, Death certificate – Samantha Raye, 6 July 1989 (SCOI.73943).

[2247] Exhibit 17, Tab 8, Death certificate – Samantha Raye, 6 July 1989 (SCOI.73943).

[2248] Exhibit 17, Tab 7, Post-mortem report of Dr Peter Bradhurst, 23 June 1989, 1 (SCOI. 48922).

5.2722. Somewhat surprisingly, given the estimate at the post-mortem that the time of death was two to three days prior to the post-mortem examination on 22 March 1989, Ms Raye's date of death on her death certificate is listed as 12 March 1989.[2249] That date also appears on the coroner's action cover sheet:[2250]

Name of deceased:	*RAYE, Samantha*
Death	*21-3-89*
Identification	*Hurrell – Police – P.M.*
Manner	*Natural Causes*
Cause	*Acute Bilateral bronchopneumonia and viral meningoencephalitis*
Time & Date	*On or about 12-3-89*
Place	*South Head near Hornby Lighthouse*

5.2723. This is the only reference to a date of death of 12 March 1989 of which the Inquiry is aware, other than Ms Raye's death certificate.

Strike Force Parrabell

Bias Crimes Indicators Form

5.2724. In the BCIF, the Strike Force Parrabell officers answered "No Evidence of Bias Crime" to nine of the ten indicators.[2251]

5.2725. The exception is indicator 5 ("Previous existence of bias crime incidents"). For that indicator, the Strike Force Parrabell officers answered, "Insufficient Information", even though they acknowledged, under "Comment" in respect of that indicator, that Ms Raye had been "subjected to considerable harassment by a neighbour at the units where she lived and this was believed to be bias related".[2252] The same acknowledgement also appears both in the response to indicator 1 ("Differences") and in the concluding "Summary of Findings" box.[2253]

5.2726. The completed form includes numerous positive assertions that Ms Raye died by way of suicide,[2254] notwithstanding both the ambiguities in the medical evidence, and that the Coroner, when dispensing with an inquest, had indicated that whether death had been caused by natural means or suicide was uncertain, and that there was "no chance of finally establishing manner of death."[2255] It also does not engage with the conflicting evidence as to whether Ms Raye was diabetic.

[2249] Exhibit 17, Tab 8, Death certificate – Samantha Raye, 6 July 1989 (SCOI.73943).

[2250] Exhibit 17, Tab 31, Coroners Court (Police Prosecutors) – Action Cover Sheet, 18 April-30 June 1989 (SCOI.11038.00002).

[2251] Exhibit 17, Tab 20, Bias Crimes Indicators Review Form – Samantha Raye, 3 March 2017 (SCOI.32107).

[2252] Exhibit 17, Tab 20, Bias Crimes Indicators Review Form – Samantha Raye, 3 March 2017, 9-10 (SCOI.32107).

[2253] Exhibit 17, Tab 20, Bias Crimes Indicators Review Form – Samantha Raye, 3 March 2017, 4, 17 (SCOI.32107).

[2254] See, e.g., Exhibit 17, Tab 20, Bias Crimes Indicators Review Form – Samantha Raye, 3 March 2017, 2, 5, 10, 14, 17 (SCOI.32107).

[2255] Exhibit 17, Tab 31, Coroners Court (Police Prosecutors) – Action Cover Sheet, 18 April-30 June 1989 (SCOI.11038.00002).

5.2727. The "General Comment" section in respect of indicator 1 ("Differences"), asserts that a "handwritten suicide note" was located within Ms Raye's residence.[2256] As submitted by Counsel Assisting, the characterisation of the note in Ms Raye's flat as a "suicide note" is arguably open but by no means necessarily apt. Yet the note is said, in the BCIF, to have "confirmed the opinion of not only Police but all medical professionals involved in [her] treatment" that Ms Raye had died by way of suicide.[2257]

5.2728. As to the "considerable harassment" by a neighbour (including by urinating outside her front door and throwing acid through her window), which "was believed to be bias related",[2258] the BCIF asserts only that it "serves to demonstrate one of the factors which led [Ms Raye] to committing suicide and there is no suggestion that any other person or group was responsible for her death".[2259]

5.2729. The "Summary of Findings" repeats much of the content of earlier parts of the form. It concludes, "[a]s per the initial investigation, it has been shown that this case is clearly a suicide and is not a gay bias related homicide".[2260] The overall categorisation is "No Evidence of Bias Crime".

Case Summary

5.2730. The matter was categorised as "Solved".[2261]

5.2731. The Case Summary reads as follows:[2262]

> ***Identity:*** *Samantha Raye was 30 years old at the time of her death.*
>
> ***Personal History****: Ms Raye was named at birth, Frederick Roy Lethbridge. She was born with intersex characteristics. Ms Raye was raised as a boy by her parents in New Zealand before emigrating to Australia in the mid-1970s to begin a new life living as a female. In 1988, Ms Raye underwent surgery to transition from male to female. Ms Raye suffered from a number of medical conditions, including type one diabetes requiring daily insulin injections, and asthma which required Ventolin and an oxygen mask.*
>
> ***Location of Body/Circumstances of Death****: Ms Raye's body was located in a cave above the high-water mark at South Head, immediately below Hornby Lighthouse. An empty bottle of insulin was found next to her body as well as a book of handwritten love poems. South Head and the Hornby Lighthouse were significant to Ms Raye as she often attended the area to sit, reflect and write poetry. Ms Raye left a brief note which read, 'At lighthouse. Will be back?????' which was discovered by her friend at the Hornby Lighthouse. Ms Raye had previously informed*

[2256] Exhibit 17, Tab 20, Bias Crimes Indicators Review Form – Samantha Raye, 3 March 2017, 3, 5 (SCOI.32107).

[2257] Exhibit 17, Tab 20, Bias Crimes Indicators Review Form – Samantha Raye, 3 March 2017, 3, 5 (SCOI.32107).

[2258] Exhibit 17, Tab 20, Bias Crimes Indicators Review Form – Samantha Raye, 3 March 2017, 4, 5, 9, 10, 17 (SCOI.32107).

[2259] Exhibit 17, Tab 20, Bias Crimes Indicators Review Form – Samantha Raye, 3 March 2017, 4, 5, 9, 10, 17 (SCOI.32107).

[2260] Exhibit 17, Tab 20, Bias Crimes Indicators Review Form – Samantha Raye, 3 March 2017, 17 (SCOI.32107).

[2261] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Samantha Raye, 16 (SCOI.76961.00014).

[2262] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Samantha Raye, 16 (SCOI.76961.00014).

> *many people of her intention to commit suicide if her situation in life did not improve. All witnesses interviewed indicated that Ms Raye was capable of taking her own life, and that she was extremely fragile, both mentally and physically, immediately prior to her death.*
>
> ***Sexual Orientation/Psychological Health**: Ms Raye identified as heterosexual.*
>
> ***Coroner/Court Findings**: The post mortem did not reveal any signs of violence to Ms Raye's body. An Inquest was dispensed with by the Coroner, who found that Ms Raye most likely died of natural causes or suicide.*
>
> ***SF Parrabell concluded there was no evidence of a bias crime***

5.2732. The case summary differs starkly, in one crucial respect, from the BCIF. The case summary refers to Ms Raye suffering "type one diabetes requiring daily insulin injections",[2263] whereas the "Summary of Findings" in the BCIF states that despite having injected a dose of insulin intravenously shortly before her death, Ms Raye was "not a diabetic which would have led to an overdose and her subsequent death".[2264]

5.2733. The case summary asserts, quite incorrectly, that the Coroner "found that Ms Raye most likely died of natural causes or suicide." In fact, as noted above, the Coroner had indicated that whether death had been caused by natural means or suicide was uncertain, and that there was "no chance of finally establishing manner of death."[2265]

Academic review

5.2734. The academic review categorised the case as "No evidence as bias".[2266]

Review by the Inquiry

5.2735. The Inquiry took the following steps in the course of examining the matter.

Summonses and requests

5.2736. A summons was issued to the NSWPF on 18 May 2022 for all documents relating to investigations by the NSWPF of the death of Ms Raye, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Ms Raye. Hard copy material was produced on 6 August 2022.

[2263] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Samantha Raye, 16 (SCOI.76961.00014).

[2264] Exhibit 17, Tab 20, Bias Crimes Indicators Review Form – Samantha Raye, 3 March 2017, 16, 17 (SCOI.32107).

[2265] Exhibit 17, Tab 31, Coroners Court (Police Prosecutors) – Action Cover Sheet, 18 April-30 June 1989 (SCOI.11038.00002).

[2266] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Samantha Raye, 16 (SCOI.76961.00014).

5.2737. On 26 September 2022, a further summons was issued to NSWPF requesting a copy of the missing person report made at Kings Cross Police Station by Mr Hurrell and Ms Hedler on or around 19 March 1989 in relation to Ms Raye's disappearance (NSWPF19).[2267] On 7 October 2022, the NSWPF advised by email that neither the Missing Persons Registry nor State Archives holds any copy of that report.[2268]

5.2738. On 16 September 2022, a summons to the BDM was issued, requesting any birth, change of name or death certificate for Ms Raye (BDM3). A death certificate was produced on 21 September 2022, as well as a note certifying that no birth certificate had been located.

5.2739. The Inquiry requested that FASS produce documents or records indicating what testing was conducted on histological specimens collected at post-mortem as part of the "routine screening tests for poisons" referred to in the toxicology report of 24 May 1989.[2269] In response, FASS provided a letter from Michael Symonds, Director of FASS, summarising the relevant testing, and the case file relating to the toxicological testing.[2270] This material was provided to Dr Iles.[2271]

Interagency cooperation

5.2740. In August 2022 the Inquiry requested, and received, Ms Raye's coronial file, consisting of around 50 documents.

Family members and friends

5.2741. The Inquiry was able to locate and contact Ms Raye's friend and next of kin, Mr Hurrell. On 14 October 2022, Inquiry staff had a telephone conversation with Mr Hurrell and advised him of the work of the Inquiry.

Examination of histological specimens

5.2742. Contact was made with NSW Health, by way of a letter dated 24 February 2023, in order to ascertain whether DOFM held the blocks and slides of histological specimens retained from the original post-mortem performed on Ms Raye. That letter also enclosed a summons requesting the production of those slides on an urgent basis (DOFM4).[2272]

5.2743. On 27 February 2023, a DOFM representative responded by email to the effect that the Department's practice is not to provide original slides and blocks to third parties, but rather to obtain re-cuts of the blocks and provide those slides to the requesting third party.

[2267] Exhibit 17, Tab 21, Letter from Caitlin Healey-Nash to Patrick Hodgetts, 26 September 2022 (SCOI.82493); Exhibit 17, Tab 21A, Summons NSWPF (NSWPF19), 26 September 2022 (SCOI.82491).

[2268] Exhibit 17, Tab 22, Email from Patrick Hodgetts to Caitlin Healey-Nash, 7 October 2022 (SCOI.82495).

[2269] Exhibit 17, Tab 6, Toxicology report, 24 May 1989 (SCOI.11038.00010); Exhibit 17, Tab 41, Letter from Caitlin Healey-Nash to Michael Symonds , 23 June 2023 (SCOI. 84884).

[2270] Exhibit 17, Tab 40, Letter from Michael Symonds to Caitlin Healey-Nash, 30 June 2023 (SCOI.84884); Exhibit 17, Tab 41A, Case File (T9469), various dates (SCOI.84883).

[2271] Exhibit 17, Tab 44, Statement of Caitlin Healey-Nash, 28 July 2023, [8] (SCOI.84887).

[2272] Exhibit 17, Tab 33, Letter from Caitlin Healey-Nash to Dr Isabel Brouwer, 25 February 2023 (SCOI.82546); Exhibit 17, Tab 33A, Summons to NSW Health Pathology – Forensic Medicine (DOFM4), 24 February 2023 (SCOI.82548).

5.2744. At the request of the Inquiry, re-cuts of the blocks were prepared, and 35 slides were provided to Dr Iles on or around 19 April 2023.[2273] The slides included sections from the brain and central nervous system, the cardiovascular system, the respiratory system, the gastrointestinal tract, the genitourinary track, the haemopoietic and lymphoreticular system, and the endocrine system.[2274] Dr Iles' observations from her examination of these slides are discussed below.

Professional opinions

5.2745. The Inquiry sought and obtained a report dated 3 March 2023 from Dr Iles (**first report**), in which she addressed questions posed to her by a letter of instruction of 25 January 2023. Those questions concerned the adequacy of the post-mortem investigations conducted in relation to Ms Raye, and her views as to the estimated time, manner and medical cause of Ms Raye's death.[2275]

5.2746. Dr Iles' first report is considered below.

5.2747. The Inquiry also obtained supplementary reports from Dr Iles dated 23 June 2023 (**second report**)[2276] and 21 July 2023 (**third report**),[2277] following her examination of the histological slides and the material relating to the toxicological testing.

5.2748. Dr Iles' second and third reports are considered below.

5.2749. The Inquiry also sought and obtained a report dated 19 January 2023 from Professor John Carter, an endocrinologist, in which he addressed questions posed to him by a letter of instruction of 21 December 2022. Those questions concerned whether Ms Raye's blood sugar level was indicative of insulin use; and, whether the level of insulin recorded in Ms Raye's blood and/or urine contributed to her death, either alone or in conjunction with her severe lung infection and/or viral meningoencephalitis.[2278] Professor Carter's report is considered below.

Contact with OIC

5.2750. On 23 August 2023 and 20 September 2023, the Inquiry wrote to former Constable Wilcher enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Ms Raye. The Inquiry did not receive a response from former Constable Wilcher.[2279]

Other

5.2751. On 12 October 2022, Inquiry staff met with Dr Eloise Brook of The Gender Centre, who gave valuable advice as to how the Inquiry might consider approaching trans issues, such as are raised in this case.

[2273] Exhibit 17, Tab 44, Statement of Caitlin Healey-Nash, 28 July 2023, [4]–[6] (SCOI.84887).

[2274] Exhibit 17, Tab 42, Supplementary expert report of Dr Linda Iles, 23 June 2023, 2-3 (SCOI.84881).

[2275] Exhibit 17, Tab 36A, Letter of instruction from Caitlin Healey-Nash to Dr Linda Iles, 25 January 2023, 5-6 (SCOI.82539).

[2276] Exhibit 17, Tab 42, Supplementary expert report of Dr Linda Iles, 23 June 2023 (SCOI.84881).

[2277] Exhibit 17, Tab 43, Further supplementary expert report of Dr Linda Iles, 21 July 2023 (SCOI.84882).

[2278] Exhibit 17, Tab 35C, Letter of instruction from Caitlin Healey-Nash to Professor John Carter, 21 December 2022, 3-4 (SCOI.82492.00004).

[2279] Exhibit 66, Tabs 63 to 64, Letters from Inquiry to William Wilcher, 23 August 2023 and 20 September 2023 (SCOI.86322_E; SCOI.86323).

5.2752. Contact was also made with Morgan Carpenter of Intersex Human Rights Australia, who provided assistance in relation to intersex issues, including as to appropriate terminology and language.

Consideration of the evidence

Ms Raye's personal background

5.2753. Ms Raye was born on 22 January 1958 in New Zealand.[2280]

5.2754. As outlined above, Ms Raye was a person with intersex characteristics.[2281]

5.2755. Ms Raye was assigned male at birth and raised as a boy by her parents in New Zealand. It appears that Ms Raye had a traumatic childhood, some of which she had recounted to her psychiatrist.[2282] Her social worker, Ms Hedler, is quoted in a media article as saying that "her father wanted her to be a boy so much that he beat it into her."[2283]

5.2756. In the mid-1970s, Ms Raye emigrated to Australia. In around 1976, it appears that she was living in Sydney under a different name.[2284] At some point prior to or around 1980, she began to publicly identify as female, and to live as Samantha Raye.[2285] Ms Raye underwent gender affirming surgery in 1988.[2286]

5.2757. Ms Raye was a popular singer and dancer in the Kings Cross area in the early 1980s. Unfortunately, in 1984 at the age of 26, Ms Raye was attacked and assaulted, which brought an end to her career as an entertainer.[2287]

5.2758. At the time of her death, aged 31, Ms Raye was a pensioner.[2288] She lived in a social housing flat in Macleay Street, Potts Point.[2289] It appears that Ms Raye was close with Ms Hanna Hedler, who is referred to in the police brief as a "social worker",[2290] and a volunteer worker at the Wayside Chapel.[2291] Ms Hedler told reporters after Ms Raye's death that Ms Raye was "a talented artist and poet who wrote continually about her search for her real self".[2292]

[2280] Exhibit 17, Tab 11, Statutory Declaration of Samantha Raye, 16 February 1989 (SCOI.11038.00018).

[2281] Exhibit 17, Tab 28, Statement of Dr Peter Joseph Steinheuer, 14 April 1989, [8] (SCOI.11038.00035).

[2282] Exhibit 17, Tab 27, Statement of Dr Helen Borman, 12 April 1989, [8], (SCOI.11038.00034).

[2283] Exhibit 17, Tab 38, Brett McCarthy, 'Half man, half woman's tragedy', *Daily Mirror,* 9 May 1989, 1 (SCOI.11038.00019).

[2284] Exhibit 17, Tab 13, Statement of Cliff Connors, 12 April 1989, [3] (SCOI.11038.00033).

[2285] Exhibit 17, Tab 13, Statement of Cliff Connors, 12 April 1989, [4] (SCOI.11038.00033).

[2286] Exhibit 17, Tab 26, Letter from Dr Helen Borman to the Housing Commission, 1 February 1989 (SCOI.11038.00014). For further details, see Exhibit 17, Tab 7, Post-mortem report of Dr Peter Bradhurst, 23 June 1989, 2 (SCOI.11038.00006).

[2287] Exhibit 17, Tab 38, Brett McCarthy, 'Half man, half woman's tragedy', *Daily Mirror,* 9 May 1989 (SCOI.11038.00019).

[2288] Exhibit 17, Tab 24, Letter from Dr Ruth Berlin to the Department of Housing, 10 January 1989 (SCOI.11038.00012).

[2289] Exhibit 17, Tab 1, Report of Death to Coroner, 21 March 1989 (SCOI.11038.00004).

[2290] Police do not appear to have contacted Ms Helder. She is only referenced in Mr Hurrell's statement and in a media report from the time.

[2291] Exhibit 17, Tab 38, Brett McCarthy, 'Half man, half woman's tragedy', *Daily Mirror,* 9 May 1989 (SCOI.11038.00019).

[2292] Exhibit 17, Tab 38, Brett McCarthy, 'Half man, half woman's tragedy', *Daily Mirror,* 9 May 1989 (SCOI.11038.00019).

5.2759. According to her close friend Mr Hurrell, Ms Raye was estranged from her family. In February 1989, she designated Mr Hurrell as her next of kin.[2293] Constable Wilcher managed to contact Ms Raye's father in New Zealand after her death, and he advised that the family did not seek an inquest.[2294]

5.2760. Mr Hurrell also reported that Ms Raye did not have many friends. Other acquaintances described Ms Raye as "a quiet and withdrawn person, who was very insular" and "a loner".[2295]

5.2761. Ms Raye did have connections to some groups, and to places that she frequented. In the 1970s she met Cliff Connors through the Metropolitan Community Church, and in early 1987 she joined another church that Mr Connors had formed. Mr Connors said that in that time, he had quite a bit to do with Ms Raye and got to know her more personally and advised her often.[2296] However, by July 1988, Ms Raye was dropped as a member by the church, after she stopped attending and did not reply to attempts to communicate with her.[2297]

5.2762. Ms Raye would also spend time at PJ's coffee shop in Premier Lane, Darlinghurst, which was funded by the St John's Church and was a popular place within the LGBTIQ community. According to Bruce Day, who volunteered at PJ's, Ms Raye would talk to patrons from the church but did not seem to fit in with the trans people who attended PJ's on a regular basis.[2298]

5.2763. There is no conclusive evidence as to Ms Raye's sexuality, although the available material suggests that she was heterosexual. Ms Hedler told reporters of Ms Raye's wish to find a male companion, and police found letters from men responding to advertisements in Campaign magazine in Ms Raye's flat. Mr Hurrell told police that in the three years he knew Ms Raye, he never heard her talk of or refer to a sexual partner.[2299] Mr Hurrell and Ms Raye did not have a physical relationship, although, according to Mr Hurrell, this was something that Ms Raye hinted at wanting on a few occasions.[2300]

Medical history: treating practitioners

5.2764. Ms Raye had a complex medical history. Her treating practitioners included:

a. Dr Edward Grieve, GP, Woollahra. Dr Grieve started treating Ms Raye in 1986 and saw her two to three times per month for two years.[2301] Dr Grieve last saw Ms Raye on 26 October 1988.[2302] Dr Grieve provided a statement to police as part of the coronial investigation;

[2293] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [11] (SCOI.11038.00030).

[2294] Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [10] (SCOI.11038.00027).

[2295] Exhibit 17, Tab 13, Statement of Cliff Connors, 12 April 1989, [4] (SCOI.11038.00033); Exhibit 17, Tab 12, Statement of Bruce Day, 12 April 1989, [7] (SCOI.11038.00032).

[2296] Exhibit 17, Tab 13, Statement of Cliff Connors, 12 April 1989, [5] (SCOI.11038.00033).

[2297] Exhibit 17, Tab 13, Statement of Cliff Connors, 12 April 1989, [9] (SCOI.11038.00033).

[2298] Exhibit 17, Tab 12, Statement of Bruce Day, 12 April 1989, [5] (SCOI.11038.00032).

[2299] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [3] (SCOI.11038.00030).

[2300] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [12] (SCOI.11038.00030).

[2301] Exhibit 17, Tab 29, Statement of Dr Edward Grieve, 3 May 1989, [3] (SCOI.11038.00025).

[2302] Exhibit 17, Tab 29, Statement of Dr Edward Grieve, 3 May 1989, [3] (SCOI.11038.00025).

b. Dr Peter Steinheuer, GP, Potts Point. Dr Steinheuer started treating Ms Raye in May 1987. He saw Ms Raye fairly consistently between December 1988 and March 1989; initially once every fortnight, and then once a week just before her death.[2303] Dr Steinheuer provided a statement as part of the coronial investigation;

c. Dr Ruth Berlin, GP, Potts Point. Dr Berlin wrote to the Department of Housing on Ms Raye's behalf in January 1989.[2304] Dr Berlin and Dr Steinheuer were at the same medical practice and consulted each other about Ms Raye;[2305]

d. Dr Helen Borman, consultant psychiatrist, Edgecliff. Dr Borman started treating Ms Raye on 20 January 1989, on a referral of severe depression with suicidal thoughts.[2306] Dr Borman also provided a statement as part of the coronial investigation; and

e. Dr A.W Steinbeck, consultant physician and endocrinologist. Ms Raye had been seeing Dr Steinbeck for some months as at September 1985.[2307]

Medical history: Physical health

5.2765. There is a lack of clarity in relation to the nature and severity of Ms Raye's physical health problems, as a result of some disparities and divergences in the evidence.

5.2766. It is clear that Ms Raye suffered from asthma, which required Ventolin and an oxygen mask.[2308] Her GPs, Dr Grieve and Dr Steinheuer, both say that they treated Ms Raye for "mild" asthma.[2309] Other reports indicate that Ms Raye's asthma was actually "severe".[2310] According to Mr Hurrell, Ms Raye was not very fit and would be out of breath if she had to walk any great distance.[2311]

5.2767. There is conflicting evidence as to whether Ms Raye was a diabetic.

5.2768. Her friend Mr Hurrell said she was diabetic, as did the P79A form submitted to the Coroner following her death.[2312] Mr Hurrell stated that she "had to take insulin with a syringe and she used to inject the insulin into her behind".[2313] Indeed Mr Hurrell said that a previous suicide attempt by Ms Raye had been implemented in part by "not taking her insulin".[2314]

[2303] Exhibit 17, Tab 28, Statement of Dr Peter Joseph Steinheuer, 14 April 1989, [4] (SCOI.11038.00035).

[2304] Exhibit 17, Tab 24, Letter from Dr Ruth Berlin to the Department of Housing, 10 January 1989 (SCOI.11038.00012).

[2305] Exhibit 17, Tab 28, Statement of Dr Peter Joseph Steinheuer, 14 April 1989, [4] (SCOI.11038.00035).

[2306] Exhibit 17, Tab 27, Statement of Dr Helen Borman, 12 April 1989, [4] (SCOI.11038.00034).

[2307] Exhibit 17, Tab 23, Letter from Dr A.W Steinbeck to Janelle Ford, 20 September 1985 (SCOI.11038.00013).

[2308] Cf Dr Steinheuer who said that Ms Raye was prescribed Ventolin in the past and only used it occasionally: Exhibit 17, Tab 28, Statement of Dr Peter Joseph Steinheuer, 14 April 1989, [7] (SCOI.11038.00035).

[2309] Exhibit 17, Tab 29, Statement of Dr Edward Grieve, 3 May 1989, [3] (SCOI.11038.00025); Exhibit 17, Tab 28, Statement of Dr Peter Joseph Steinheuer, 14 April 1989, [7] (SCOI.11038.00035).

[2310] Exhibit 17, Tab 1, Report of Death to Coroner, 21 March 1989 (2289SCOI.11038.00004).

[2311] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [6] (SCOI.11038.00030).

[2312] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [6] (SCOI.11038.00030); Exhibit 17, Tab 1, Report of Death to Coroner, 21 March 1989 (2289SCOI.11038.00004).

[2313] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [6] (SCOI.11038.00030).

[2314] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [6] (SCOI.11038.00030).

5.2769. Further, Ms Raye told her GP, Dr Grieve, that she was an insulin-dependent diabetic, although her blood tests and enquiries made by Dr Grieve did not indicate that to be so.[2315]

5.2770. According to Dr Grieve, he conducted tests on Ms Raye which did not indicate any problems with blood sugar.[2316] Similarly, Dr Steinheuer told police that there was no evidence of Ms Raye being diabetic or requiring insulin of any type. He said it was inconceivable that Ms Raye would not have at any stage informed him of her diabetes or required treatment for it.[2317]

5.2771. In addition, enquiries were made with the chemists along Darlinghurst Road, Victoria Road and the area around Ms Raye's home address, none of whom remembered or had a record of supplying insulin, particularly Mixtard, to Ms Raye. All of the chemists, except two, knew Ms Raye from photographs shown to them.[2318]

5.2772. On the other hand, Ms Raye also told Dr Grieve that she was seeing two doctors (in the city) in relation to her diabetes.[2319] Those doctors do not appear to have been questioned by police.

Medical history: Gender affirming surgery and related healthcare

5.2773. Ms Raye was prescribed Primogyn and Estigyn (estrogen hormones) by her GPs.[2320]

5.2774. In October 1988, she underwent gender-affirmation surgery at a private hospital in Earlwood.[2321]

5.2775. Ms Raye was also under the care of Dr T Kennedy at the Gender Dysphoria Clinic, which was attached to the Department of Adult Psychiatry at Monash Medical Centre.[2322]

5.2776. A media article from the time of Ms Raye's death records that Ms Raye's social worker, Ms Hedler, told the reporter that Ms Raye's doctor would not perform the final part of her gender affirming surgery due to her poor living conditions.[2323]

[2315] Exhibit 17, Tab 29, Statement of Dr Edward Grieve, 3 May 1989, [3] (SCOI.11038.00025).

[2316] Exhibit 17, Tab 29, Statement of Dr Edward Grieve, 3 May 1989, [3] (SCOI.11038.00025). According to Dr Grieve, Ms Raye said she was seeing Drs Mason and Pannock from a practice in Centrepoint in the city. Dr Grieve made inquiries to speak with those doctors, with a negative result.

[2317] Exhibit 17, Tab 28, Statement of Dr Peter Joseph Steinheuer, 14 April 1989, [5] (SCOI.11038.00035).

[2318] Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [9] (SCOI.11038.00027).

[2319] Exhibit 17, Tab 29, Statement of Dr Edward Grieve, 3 May 1989, [3] (SCOI.11038.00025).

[2320] Exhibit 17, Tab 29, Statement of Dr Edward Grieve, 3 May 1989, [3] (SCOI.11038.00025); Exhibit 17, Tab 28, Statement of Dr Peter Joseph Steinheuer, 14 April 1989, [7] (SCOI.11038.00035).

[2321] Dr Borman refers to the surgery occurring in June 1988 – however, the evidence of Mr Hurrell and Mr Day (who knew Ms Raye at the time) was that the surgery was in October 1988.

[2322] Exhibit 17, Tab 23, Letter from Dr A.W Steinbeck to Janelle Ford, 20 September 1985 (SCOI.11038.00013); Exhibit 17, Tab 32, Letter from Dr T Kennedy to the Coroners Court, 18 July 1990 (SCOI.11038.00008).

[2323] Exhibit 17, Tab 38, Brett McCarthy, 'Half man, half woman's tragedy', *Daily Mirror,* 9 May 1989 (SCOI.11038.00019).

Medical history: Mental health

5.2777. Ms Raye had a history of anxiety neurosis, adjustment disorder and severe depression with suicidal thoughts,[2324] and at an unknown date between May 1987 and April 1989 had been prescribed Valium by Dr Steinheuer.[2325]

5.2778. There is some evidence (albeit inconclusive) of two suicide attempts in 1987 and 1988.

a. In October 1987, Ms Raye stabbed herself between the eyes with a letter opener. Mr Connors regarded this as a suicide attempt.[2326] The wound became infected and Ms Raye sought treatment from Dr Grieve. She initially stated that the wound was caused by an ingrown hair before disclosing her self-harm. Dr Grieve stated that the wound was consistent with a sharp object, but was not sure if Ms Raye suffered the wound as a result of a suicide attempt;[2327] and

b. Mr Hurrell referred to Ms Raye attempting suicide in June 1988 by not taking her insulin and taking another drug. He said that police from Kings Cross Police Station had to kick in Ms Raye's door and transport her to hospital.[2328] Enquiries made by Constable Wilcher found no records at St Vincent's Hospital, Sydney Hospital or Prince of Wales Hospital regarding any suicide attempt by Ms Raye, or any records at King's Cross Police Station regarding this incident.[2329] Mr Hurrell said that prior to this, Ms Raye had spoken to him about suicide, but did not speak of it again after June 1988.[2330]

5.2779. In the months prior to her death, Ms Raye's mental health deteriorated significantly. Her friends and acquaintances referred to her becoming more depressed and withdrawn.[2331] Mr Day said that Ms Raye was so depressed during this time that he thought she might be dying.[2332]

5.2780. At the time of her death, Ms Raye was under the specialist care of her psychiatrist, Dr Borman. Dr Borman considered that Ms Raye's depression was "largely reactive" to the following issues:[2333]

a. Multiple medical complications from her operation in 1988;

b. Anti-social behaviour directed at Ms Raye by her neighbours (see further below);

c. Ms Raye's unhappiness with where she was living. Dr Borman described Ms Raye's living situation (in the Housing Commission flat in Macleay Street,

[2324] Exhibit 17, Tab 28, Statement of Dr Peter Joseph Steinheuer, 14 April 1989, [5] (SCOI.11038.00035).

[2325] Exhibit 17, Tab 28, Statement of Dr Peter Joseph Steinheuer, 14 April 1989, [7] (SCOI.11038.00035).

[2326] Exhibit 17, Tab 13, Statement of Cliff Connors, 12 April 1989, [8] (SCOI.11038.00033).

[2327] Exhibit 17, Tab 29, Statement of Dr Edward Grieve, 3 May 1989, [3] (SCOI.11038.00025).

[2328] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [7] (SCOI.11038.00030).

[2329] Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [9] (SCOI.11038.00027).

[2330] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [7] (SCOI.11038.00030).

[2331] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [7] (SCOI.11038.00030); Exhibit 17, Tab 13, Statement of Cliff Connors, 12 April 1989, [8]–[9] (SCOI.11038.00033).

[2332] Exhibit 17, Tab 12, Statement of Bruce Day, 12 April 1989, [7] (SCOI.11038.00032).

[2333] Exhibit 17, Tab 27, Statement of Dr Helen Borman, 12 April 1989, [5], [(SCOI.11038.00034); Exhibit 17, Tab 26, Letter from Dr Helen Borman to the Housing Commission, 1 February 1989 (SCOI.11038.00014).

Potts Point) as "appalling". Ms Raye, who was a "clean living non-addict", was "surrounded by excessive hostility, alcoholism and drug addiction"; and

d. Ms Raye's feelings of rejection and discrimination by the Housing Commission, who had delayed providing her with new accommodation.

5.2781. According to Dr Borman, all these factors caused Ms Raye to lapse into severe depression. When Ms Raye went to therapy with Dr Borman, she wept openly and said, "I can't stand this much longer, I must get out of there".[2334] Dr Borman also states that in the weeks prior to her death, Ms Raye spoke of suicide and said, "I'll have to suicide if things don't get better".[2335] According to Dr Borman, Ms Raye refused any medication for her depression.[2336]

5.2782. All of Ms Raye's treating doctors were of the view that Ms Raye's mental health was such that death by suicide was a possibility.

a. Dr Borman said that she had no doubt that Ms Raye would have taken her own life. She spoke of suicide to her often and was in the frame of mind to take her own life;[2337]

b. Dr Grieve stated that Ms Raye was "very unstable psychologically" and he had "no doubt that [Raye] would take her own life, but she would make a show of the event";[2338] and

c. Dr Steinheuer said that he thought that Ms Raye was capable of taking her own life, but he would have expected her to give some forewarning as to her intentions. He considered that Ms Raye was the type of personality who would dramatise her suicide by leaving notes or suicide letters. He held no records indicating prior suicide attempts by Ms Raye.[2339]

5.2783. However, it does not appear that Ms Raye spoke to friends or acquaintances about suicide, particularly in the period before her death.[2340] According to Mr Hurrell, Ms Raye had spoken about suicide prior to what he described as her suicide attempt in June 1988, but not after that time.[2341]

[2334] Exhibit 17, Tab 27, Statement of Dr Helen Borman, 12 April 1989, [6] (SCOI.11038.00034).

[2335] Exhibit 17, Tab 27, Statement of Dr Helen Borman, 12 April 1989, [7] (SCOI.11038.00034).

[2336] Exhibit 17, Tab 27, Statement of Dr Helen Borman, 12 April 1989, [7] (SCOI.11038.00034).

[2337] Exhibit 17, Tab 27, Statement of Dr Helen Borman, 12 April 1989, [9] (SCOI.11038.00034).

[2338] Exhibit 17, Tab 29, Statement of Dr Edward Grieve, 3 May 1989, [4] (SCOI.11038.00025).

[2339] Exhibit 17, Tab 28, Statement of Dr Peter Joseph Steinheuer, 14 April 1989, [9] (SCOI.11038.00035).

[2340] Exhibit 17, Tab 12, Statement of Bruce Day, 12 April 1989, [7] (SCOI.11038.00032).

[2341] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [7] (SCOI.11038.00030).

5.2784. Several references are made to Ms Raye being a melodramatic and attention-seeking person. Dr Steinheuer described Ms Raye as a hypochondriac, while Dr Grieve said that she "would make up stories of intrigue and scandal, with her being the central figure".[2342] Mr Connors said that in around October/November 1987, Ms Raye claimed to be blind. But he and others had formed the opinion that she was not blind, and that it was one of her attempts to gain attention or get help.[2343] I have recorded these observations because they are relevant to evidence set out below, but I observe that these observations are necessarily impressionistic, and I have not attached substantial weight to them in considering the circumstances of Ms Raye's death.

Harassment at her residential flat

5.2785. One issue that emerges strongly from the available evidence is the physical and sexual harassment that Ms Raye is recorded as having faced at her home.

5.2786. In early 1989, each of Drs Borman, Steinheuer and Berlin wrote to the Housing Commission seeking urgent assistance with finding Ms Raye alternate accommodation.[2344] Ms Raye had been on the Housing Commission's priority list for two years, but had heard nothing. The comments of her treating doctors indicate a connection between this harassment and the severity of her depression.

5.2787. Dr Borman wrote that:[2345]

> *To enable her to start a normal life as a woman it is essential that she removes herself from her old environment. She is also extremely sensitive and has become the butt of aggressive behaviour in the flats where she lives. Such antisocial behaviour includes urinating outside her front door, and throwing acid through the window. Because of her, until recently, ambivalent sexual situation, she will not be accepted by any refuge, male or female. Her case has been on the priority list with the HC [Housing Commission] for two years but her plight has become desperate and if she is not offered some accommodation in the very near future she is in more danger of committing suicide, or becoming the victim of violence.*

5.2788. Dr Steinheuer stated that (emphasis in original):[2346]

> *In the last 6 months [Ms Raye] has been the victim of numerous psychological and physical assaults requiring treatment of this surgery. These assaults relate to her current terrible living situation and the public's perception of her as "abnormal" even though Samantha was <u>born</u> with the condition of hermaphroditism which presents as ambiguous gender characteristics. Both the assaults and long standing prejudice have made Samantha suicidal and depressed and I feel a continuation of her current living situation will increase the risk of her committing suicide.*

[2342] Exhibit 17, Tab 29, Statement of Dr Edward Grieve, 3 May 1989, [4] (SCOI.11038.00025).

[2343] Exhibit 17, Tab 13, Statement of Cliff Connors, 12 April 1989, [8] (SCOI.11038.00033).

[2344] Exhibit 17, Tab 26, Letter from Dr Helen Borman to the Housing Commission, 1 February 1989 (SCOI.11038.00014).

[2345] Exhibit 17, Tab 26, Letter from Dr Helen Borman to the Housing Commission, 1 February 1989 (SCOI.11038.00014).

[2346] Exhibit 17, Tab 26, Letter from Dr Helen Borman to the Housing Commission, 1 February 1989 (SCOI.11038.00014).

5.2789. Similarly, Dr Berlin explained that:[2347]

> *[Ms Raye] has suffered enormously from sexual harassment from her cohabitants and neighbours. She has been threatened and abused and I fully support her application for a home.*

5.2790. Mr Hurrell also noted that since December 1988, Ms Raye was having trouble with the resident of a neighbouring flat. This neighbour was generally harassing Ms Raye with threats of physical violence and bodily harm. Mr Hurrell heard of a case of him urinating against her front door.[2348] Mr Hurrell told police that the only person that he knew of that had anything against Ms Raye was her neighbour, but he did not witness any of the incidents which Ms Raye told him about.[2349]

5.2791. The only investigation made by police into these claims of harassment was "interviewing" the neighbour regarding the allegations. The neighbour apparently "denied everything put to him concerning Ms Raye".[2350] However, there is no record of this interview, or any statement from the neighbour, in the documents produced to the Inquiry by the NSWPF.

Last known movements

5.2792. Ms Raye was last seen alive by Mr Hurrell on 5 March 1989, when he visited her flat in Macleay Street. Ms Raye and Mr Hurrell sat and talked for about an hour. During this time, Ms Raye seemed to be in normal spirits.[2351]

5.2793. On 9 March 1989, Ms Raye had an appointment with her psychiatrist Dr Borman. Dr Borman says that, on this occasion, Ms Raye "seemed resigned to her situation".[2352]

5.2794. On 11 March 1989, Mr Hurrell spoke with Ms Raye for the last time, when she telephoned him from the Wayside Chapel at about 7:00pm. Hurrell said that the telephone conversation lasted for about 30-45 minutes, and that Ms Raye seemed to be upset but did not mention anything about suicide.[2353]

5.2795. According to Mr Hurrell, on 16 March 1989, Ms Raye did not attend an appointment with her psychiatrist.[2354] This is neither contradicted nor confirmed in Dr Borman's statement.

[2347] Exhibit 17, Tab 24, Letter from Dr Berlin to the Department of Housing, 10 January 1989 (SCOI.11038.00012).

[2348] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [7] (SCOI.11038.00030).

[2349] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [7] (SCOI.11038.00030).

[2350] Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [9] (SCOI.11038.00027).

[2351] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [8] (SCOI.11038.00030).

[2352] Exhibit 17, Tab 27, Statement of Dr Helen Borman, 12 April 1989, [6] (SCOI.11038.00034).

[2353] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [8] (SCOI.11038.00030).

[2354] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [10] (SCOI.11038.00030).

5.2796. Around midday on Friday, 17 March 1989, Mr Hurrell went to Ms Raye's flat. He let himself in with his key and found that she was not home. According to Mr Hurrell, this was unusual as Ms Raye was usually at home during the day and did not like going out much. Ms Raye also usually called Mr Hurrell on Thursday nights but had not done so the previous evening.[2355]

5.2797. While he was in Ms Raye's flat, Mr Hurrell noticed a note on the side table in the living room, with Ms Raye's handwriting, which read, "At lighthouse, will be back????". Mr Hurrell also noticed that "Hanna", Ms Raye's social worker, had written something under the note. Mr Hurrell left a note of his own under Ms Raye's note and left the unit.

5.2798. On 19 March 1989, Mr Hurrell returned to Ms Raye's unit, with Ms Hedler, and found it empty. They attended King's Cross Police Station and reported Ms Raye as a missing person.[2356]

5.2799. On 20 March 1989, Mr Hurrell decided to look for Ms Raye himself, and made enquiries with her doctor, psychiatrist and the Kings Cross branch of the St George Building society. None of those enquiries were fruitful. Mr Hurrell then went to the Lady Jane Beach at Watsons Bay, where Ms Raye sometimes went to swim. Mr Hurrell looked along the beach and in the bushes in search of Ms Raye, but then saw police vehicles at the lighthouse at South Head.[2357]

Discovery of Ms Raye's body

5.2800. At around 9:30am on 20 March 1989, Daniel Willis discovered Ms Raye's body in a rock cave underneath the Hornby Lighthouse at South Head.[2358] According to police, Ms Raye's body was located under a large overhang about two feet above the high tide mark.[2359] It was approximately 50 metres south of Hornby Lighthouse and 15 metres below the Lighthouse.[2360]

5.2801. Mr Willis stated that he saw Ms Raye's body as he was walking along the rocks. He walked closer to the body and saw that there was no movement. Ms Raye's left eye was open or partially open, and there was a dried stain of blood or mucus from running from her mouth to nose. Ms Raye's body was cold, and Mr Willis could not find a pulse. He returned to the top of the cliff and contacted a National Parks and Wildlife Officer who called Police.[2361]

[2355] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [9] (SCOI.11038.00030).

[2356] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [9] (SCOI.11038.00030).

[2357] Exhibit 17, Tab 10, Statement of Wayne Hurrell, 20 March 1989, [10] (SCOI.11038.00030).

[2358] Exhibit 17, Tab 9, Statement of Daniel Willis, 20 March 1989, [3] (SCOI.11038.00031).

[2359] Exhibit 17, Tab 19, Statement of Constable Patrick John Duncombe, 8 May 1989, [4] (SCOI.11038.00028).

[2360] Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [3] (SCOI.11038.00027).

[2361] Exhibit 17, Tab 19, Statement of Constable Patrick John Duncombe, 8 May 1989, [5] (SCOI.11038.00028); Exhibit 17, Tab 9, Statement of Daniel Willis, 20 March 1989, [5] (SCOI.11038.00031).

5.2802. Mr Willis then returned to the rocks where Ms Raye's body lay and sat about 20 yards away. He stated that while he was sitting there, no one else touched the body until police came, although an older man came and observed the body from about three metres away.[2362] The identity of this man is unknown, and his presence is not referred to or discussed anywhere else.

Police observations of the scene of death

5.2803. At 10:25am on 20 March 1989, officers from the Bondi Police Station, including Constable Wilcher, attended Hornby Lighthouse and were shown to Ms Raye's body. According to the officers' reports:[2363]

a. Ms Raye was lying on her back, with her right leg over her left leg. Her left fist was closed in the centre of her chest, and her right arm was along her side;

b. Ms Raye's head was turned to the right. Dried mucus was running from her open mouth and nose, and both her eyes were slightly open;

c. Ms Raye was dressed in brown pants with a black Spray jacket, with white shoes and a brown belt. She was wearing multiple pieces of jewellery;

d. A plastic bottle, similar to a film case, was found next to Ms Raye's body. It contained a white substance;

e. A large syringe and needle were found underneath a rock shelf around 1.5 metres from Ms Raye's head;

f. An empty syringe packet and an empty lance packet were found around 1.5 metres from Ms Raye's feet, lying in some water-filled rock pools;

g. An empty box of 'Mixtard' (a schedule 3 insulin) was found around five metres south of Ms Raye's body; and

h. The following messages were written on the rock face above Ms Raye's body in crayon or charcoal: "Syanti love Jaja" and "Swanny Forever". (Constable Wilcher later expressed the view that this writing seemed to be unrelated to Ms Raye's death.) [2364]

5.2804. At 11:30am,[2365] officers from the crime scene unit attended and took photographs of Ms Raye and the surrounding area.[2366]

5.2805. The crime scene unit officers also noted that a "condom" was located near Ms Raye,[2367] although this does not appear to be recorded anywhere else in the police material.

5.2806. Police then searched Ms Raye's body and found:[2368]

[2362] Exhibit 17, Tab 9, Statement of Daniel Willis, 20 March 1989, [6] (SCOI.11038.00031).

[2363] Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [4] (SCOI.11038.00027).

[2364] Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [14] (SCOI.11038.00027).

[2365] This time is recorded as 11:30pm at [6] of the statement of Constable William John Wilcher, but this appears to be an error.

[2366] Exhibit 17, Tab 14, Crime Scene Photographs, 20 March 1989 (SCOI.11038.00039).

[2367] Exhibit 17, Tab 16, Scene attendance entry by Scientific Team, 20 March 1989 (SCOI.10333.00007).

[2368] Exhibit 17, Tab 19, Statement of Constable Patrick John Duncombe, 8 May 1989, [6] (SCOI.11038.00028).

a. Ms Raye's black shirt (under her jacket) was unbuttoned, exposing her breasts;

b. Ms Raye's pants were undone, with the belt loosely threaded through the buckle and the fly half done up;

c. A small folding knife and a whistle in the right pocket of her jacket; and

d. A blister packet containing six 5mg Valium tablets, with two tablets missing.

5.2807. It does not appear that Ms Raye had any money or identification on her.[2369]

5.2808. At 12:25pm, Mr Hurrell (who had been out searching for Ms Raye) attended Lady Jane Beach, where Ms Raye went to swim. When he saw police vehicles, he approached and explained that he was looking for his missing friend. Mr Hurrell then identified the deceased person as Ms Raye.[2370]

Police investigation

5.2809. At around 1:00pm on the same day, 20 March 1989, police accompanied Mr Hurrell to Ms Raye's residence. Police searched the flat and took the following medications:[2371]

a. Serepax 30mg (a benzodiazepine used to treat anxiety);

b. Vibra-Tabs 50 (an antibiotic used to treat certain infections);

c. Primogyn (an estrogen hormone);

d. Tryptanol 25mg (a tricyclic antidepressant);

e. Panadeine forte (used to relieve severe pain);

f. Panamax 500mg (paracetamol for temporary relief of pain); and

g. Codalgin (used to relieve moderate to severe pain).

5.2810. Several syringes were also located in the unit, with one being identical to the syringe found near Ms Raye's body at Hornby lighthouse. No insulin was found in Ms Raye's flat.[2372]

5.2811. Police also found Ms Raye's note that read, "At lighthouse, will be back????". The note was left on the mantlepiece.[2373] No mention was made by police of the additional notes which had been left by Mr Hurrell and Ms Hedler.

5.2812. Several letters from men which had been written in response to advertisements in *Campaign* (a Sydney gay magazine) were also taken from Ms Raye's flat by police, as well as a book containing "sad poems" written by Ms Raye.[2374]

[2369] Exhibit 17, Tab 1, Report of Death to Coroner, 21 March 1989 (2289SCOI.11038.00004).

[2370] Exhibit 17, Tab 3, Identification statement of Wayne David Hurrell, 20 March 1989 (SCOI.11038.00029).

[2371] Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [8] (SCOI.11038.00027).

[2372] Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [8] (SCOI.11038.00027).

[2373] Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [8] (SCOI.11038.00027).

[2374] Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [8] (SCOI.11038.00027).

5.2813. Constable Wilcher contacted local hospitals to obtain medical records of Ms Raye. He found that Ms Raye had been treated five times in the prior two years in St Vincent's Hospital for minor injuries but had not been admitted. There was no record of her having received any treatment at Sydney Hospital. There was no mention on any of Ms Raye's medical records of her being diabetic or requiring insulin for other medical reasons.[2375]

5.2814. As part of the coronial investigation, police obtained witness statements from Mr Hurrell and two other associates of Ms Raye's, Bruce Day and Cliff Connors, as well as statements from three of Ms Raye's medical practitioners. Notably, no statement was taken from Ms Raye's social worker Ms Hedler.

5.2815. The police brief also contains copies of some media reporting at the time, including:

a. One article which includes several quotes from Ms Hedler, who is likely to be the "social worker" referenced by Mr Hurrell and a volunteer worker at the Wayside Chapel. Ms Hedler told the reporter that Ms Raye's doctor would not perform the final part of her gender affirming surgery due to her poor living conditions;[2376] and

b. A second article which refers to police finding a number of cigarette packets near Ms Raye's body. It also quotes a police spokesman who stated, "We believe the deceased was with someone shortly before the time of death".[2377] The basis of this comment remains unknown.

5.2816. Something of the societal attitudes of the time towards intersex and transgender people may be discerned from some of the reporting on Ms Raye's death. In one headline, for example, Ms Raye was described as "half man, half woman".[2378]

Discrimination and harassment of LGBTIQ people

5.2817. It is increasingly well understood that the stigmatisation of body diversity can lead to harmful practices in medical settings, including for example, interventions, by medication or otherwise, to make bodies appear and/or function in a manner more typically "male" or "female" (often when the person is too young to consent), prenatal genetic selection, and discrimination.[2379]

5.2818. People with intersex characteristics, such as Ms Raye, may identify as cisgender, transgender or non-binary. The innate sexual characteristics of a person such as Ms Raye should not be conflated with gender identity. Similarly, intersex characteristics are not associated with a person's sexuality.[2380]

[2375] Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [9] (SCOI.11038.00027).

[2376] Exhibit 17, Tab 38, Brett McCarthy, 'Half man, half woman's tragedy', *Daily Mirror,* 9 May 1989 (SCOI.11038.00019).

[2377] Exhibit 17, Tab 37, Mark Morri, 'Sad Love Poems on Cave Body', *Daily Mirror*, 21 March 1989 (SCOI.48947).

[2378] Exhibit 17, Tab 38, Brett McCarthy, 'Half man, half woman's tragedy', *Daily Mirror,* 9 May 1989 (SCOI.11038.00019). It may be, although this is perhaps ambiguous, that the 8 May 1989 statements of the attending police officers Constable Wilcher and Constable Duncombe also reflect such attitudes, in sometimes referring to the body of Ms Raye as "it": see Exhibit 17, Tab 18, Statement of Constable William Wilcher, 8 May 1989, [6] (SCOI.11038.00027); Exhibit 17, Tab 19, Statement of Constable Patrick John Duncombe, 8 May 1989, [4] (SCOI.11038.00028).

[2379] See Morgan Carpenter, "Discrimination" (n 15).

[2380] See 'Intersex', *Intersex Human Rights Australia* (Post, 1 June 2021) <https://ihra.org.au/19853/welcome/>.

5.2819. Ms Raye was also a trans woman, identifying as female despite being assigned as male at birth. The Inquiry has received evidence from Dr Brook about the mental health burden of discriminatory attitudes towards transgender and gender diverse people. Dr Brook stated:[2381]

> *Physical violence is not the only form of violence experienced by trans and gender diverse people. There is the violence of exclusion, the violence of having your reality questioned, the violence of having your identity disrespected, the violence of the people and institutions who want to "correct" you, the violence of systems that don't make see you or make space for you.*

5.2820. Dr Brook referred to a 2020 study by the Australian Research Centre in Sex, [2382] Health and Society (LaTrobe University),[2383] which found that across their lifetime, 45.6% of trans women, 52.9% of trans men and 40.2% of non-binary people will attempt to die by suicide, compared to 3.2% of the general population.

5.2821. Ms Raye's case is a sad example of the discrimination which may be faced by members of the LGBTIQ community. In the months prior to her death Ms Raye had been subjected to harassment, threats and aggression in the block of units where she lived, and she struggled to access social supports and services, inevitably due in part to societal discrimination against people with variations of sex characteristics. It seems clear that such discrimination deeply affected Ms Raye, and that her mental health deteriorated significantly in the months prior to her death.

5.2822. If Ms Raye's death was the result of suicide by an intentional insulin overdose, the evidence would indicate that the discrimination which she faced in the course of her lifetime, as an intersex person and/or as a trans person, was a significant factor in her forming such an intention.

5.2823. As noted above, Ms Raye's death certificate includes, seemingly as a third "cause of death", the term "transexual depression".[2384] Although the death certificate itself is dated 19 April 1989, the "certification" of "cause of death" appears to have been made on 6 July 1989 (after the date of Dr Bradhurst's post-mortem report dated 23 June 1989), by someone other than Dr Bradhurst.

5.2824. Whether the choice of the term "transexual depression", in the death certificate, flowed from a misreading or misunderstanding of Dr Bradhurst's actual (different) opinion as recorded in his post-mortem report, or was derived in some other way, is not known.

[2381] Exhibit 2, Tab 10, Statement of Dr Eloise Brook, 15 November 2022, [98] (SCOI.77309).

[2382] Exhibit 2, Tab 10, Statement of Dr Eloise Brook, 15 November 2022, [101(b)] (SCOI.77309).

[2383] Exhibit 2, Tab 14, Adam O Hill et al, 'Private Lives 3: The health and wellbeing of LGBTIQ people in Australia' (Report, ARCS HS Monograph Series No 122, Australian Research Centre in Sex, Health and Society, La Trobe University, August 2020), [101] (SCOI.77275).

[2384] Exhibit 17, Tab 8, Death certificate – Samantha Raye, 6 July 1989 (SCOI.73943).

5.2825. Although the word "transexual" was commonly used for many years, and although some trans people still use that terminology, the term "transgender" is now more widely regarded as appropriate.[2385]

5.2826. Moreover, the language in the death certificate seems to involve both an assumption that being "transexual" is a clinical issue, relevant (in itself) to cause of death, and an assumption that "transexual depression" is a specific type of "depression". Neither of those assumptions is tenable. In relation to the inclusion of "transexual depression" as a "cause of death" in the death certificate (but not in the post-mortem report), Dr Iles stated:[2386]

> *There is no biological or pathological evidence to justify the inclusion of "transexual" on Ms Raye's death certificate, i.e. there is no physiological link between Ms Raye's intersex biology, gender affirming surgery or hormonal therapy and her death. Likewise, depression cannot be assessed by a pathologist at autopsy. This is not a pathological finding that can be supported by physical evidence. Whilst a coroner might have a view as to the circumstances surrounding her death, this is not something that can be concluded by a pathologist. It is incorrect for a pathologist to include these elements on a medical certificate of cause of death.*

5.2827. As a separate matter, on the other hand, the harassment and discrimination evidently faced by Ms Raye, as both a person with intersex characteristics and a transgender woman, are plainly likely to have contributed to her poor mental health and depression.

Report of Professor Carter

5.2828. Professor Carter was briefed to provide an opinion as to whether insulin use could have contributed to Ms Raye's death. Professor Carter considered that while the clinical and toxicological features found at post-mortem are *consistent* with death due to an injection of a large dose of insulin, they do not unequivocally indicate that the cause of death was related to an insulin injection.[2387] Professor Carter outlined the limitations of attempting to ascertain if insulin overdose contributed to death, as follows:[2388]

a. There was no measurement of Ms Raye's blood glucose level and, in any event, there is a very poor correlation between post-mortem blood glucose levels and anti-mortem glucose levels. The breakdown of red blood cells following death releases glucose, such that even if a person died with very low blood glucose levels (hypoglycaemia), the post-mortem blood glucose levels could be normal or even high.

[2385] See Exhibit 2, Tab 12, Professor Noah Riseman, *New South Wales Trans History Report* (31 March 2022), 10 (SCOI.76805); see also Exhibit 17, Tab 39, TransHub, 'Trans-Affirming Language Guide', *Transhub* (online) <https://www.transhub.org.au/language> (SCOI.82538).

[2386] Exhibit 17, Tab 36, Expert report of Dr Linda Iles, 3 March 2023, 9 (SCOI.82545).

[2387] Exhibit 17, Tab 35, Expert report of Professor John Norman Carter, 21 January 2013, 3 (SCOI.82492.00001).

[2388] Exhibit 17, Tab 35, Expert report of Professor John Norman Carter, 21 January 2013, 2-3 (SCOI.82492.00001).

b. The finding of a urine glucose concentration of 0.9 mmol/L is not abnormal, and not of assistance in determining cause of death.

c. Estimates of insulin concentrations in unpreserved blood obtained post-mortem are unreliable in the determination of the cause of death, as insulin degrades in the body, and can also increase due to the diffusion of endogenous insulin from the pancreas. Ms Raye's insulin level at post-mortem was 21 micro units per mL. Such a level immediately prior to death would strongly suggest that insulin was *unrelated* to cause of death. However, it is possible that a much higher level had been injected and then progressively reduced to 21 micro units per mL over the days prior to a blood sample being taken. As such, it is impossible to determine whether Ms Raye's recorded insulin level at post-mortem, of 21 micro units per mL, contributed to her death.

Reports of Dr Iles

First Report

5.2829. Dr Iles was requested to review the original post-mortem report and provide an opinion as to the time and cause of Ms Raye's death. While noting the developments in post-mortem practice since the time of Ms Raye's death, Dr Iles noted the following (without criticism of the original pathologist):[2389]

a. Ms Raye was found in a state of partial undress. In these circumstances, Dr Iles considered a specific comment regarding the presence or absence of anogenital or breast injuries would have been prudent, as would the swabbing of her anogenital region for semen. It is unclear if the original pathologist was informed of the state of Ms Raye's dress;

b. Similarly, given Ms Raye was found in proximity to a syringe and Mixtard packet, Dr Iles considered a comment regarding the presence or absence of injection sites would have been desirable;

c. Dr Iles also noted that there was no comment regarding the presence or absence of petechial haemorrhages around the eyes and mouth, which is standard in contemporary practice when considering the possibility of neck compression. Likewise, there is no comment as to injury to the oral mucosa (i.e., the mucous membrane lining the inside of the mouth) or Ms Raye's dentition (i.e., teeth); and

d. While toxicological analysis of the blood, stomach contents and urine was undertaken, it is unclear whether substances other than alcohol and insulin were tested for, such that the contribution of other substances contributing to death cannot be excluded.

5.2830. Notwithstanding those limitations, Dr Iles considered that the post-mortem examination was sufficient to exclude significant injury contributing to Ms Raye's death.[2390]

[2389] Exhibit 17, Tab 36, Expert report of Dr Linda Iles, 3 March 2023, 6-7 (SCOI.82545).

[2390] Exhibit 17, Tab 36, Expert report of Dr Linda Iles, 3 March 2023, 6 (SCOI.82545).

5.2831. Dr Iles further commented on the limitations of determining insulin use prior to death from either assays of blood glucose or the insulin concentration in blood. Similarly to Professor Carter, Dr Iles noted that the fall in glucose after death, and the instability of insulin after death, make insulin readings of limited use, unless taken rapidly after death.[2391]

5.2832. Based on the material available to Dr Iles, she agreed with the opinion of Dr Bradhurst that it is likely that Ms Raye died as a consequence of bilateral bronchopneumonia.

5.2833. In Dr Iles' opinion, the development of bronchopneumonia in an otherwise healthy individual requires explanation and "suggests a period of central nervous system depression/obtundation prior to death".[2392] However, in her view the medical evidence was unable to confirm the mechanism of any central nervous system depression.[2393] She stated that "the precipitant of her lung infection is not clear and cannot be determined on the post-mortem or toxicological findings". [2394]

5.2834. Dr Iles considered that the post-mortem findings were "nonspecific", and while they allowed for the possibility that Ms Raye had self-injected insulin — inducing hypoglycaemia, a coma, and then death via acquired bronchopneumonia — such causation would be "implied purely on circumstantial evidence".[2395]

5.2835. Dr Iles also considered that the reported finding of mild meningoencephalitis was "difficult to reconcile" with the scenario of Ms Raye dying by self-injected insulin.[2396] She was unable, on the evidence then available, to assess the extent or likely contribution of mild meningoencephalitis to Ms Raye's death.[2397]

Second report

5.2836. In her second report, Dr Iles reviewed 35 slides cut from the histological specimens retained from the post-mortem of Ms Raye.

5.2837. Dr Iles observed "acute bronchitis and well-developed bronchopneumonia".[2398] The latter is consistent with the observations made at the time of the original post-mortem.[2399]

[2391] Exhibit 17, Tab 36, Expert report of Dr Linda Iles, 3 March 2023, 6 (SCOI.82545).
[2392] Exhibit 17, Tab 36, Expert report of Dr Linda Iles, 3 March 2023, 6 (SCOI.82545).
[2393] Exhibit 17, Tab 36, Expert report of Dr Linda Iles, 3 March 2023, 8-9 (SCOI.82545).
[2394] Exhibit 17, Tab 36, Expert report of Dr Linda Iles, 3 March 2023, 10 (SCOI.82545).
[2395] Exhibit 17, Tab 36, Expert report of Dr Linda Iles, 3 March 2023, 10 (SCOI.82545).
[2396] Exhibit 17, Tab 36, Expert report of Dr Linda Iles, 3 March 2023, 10 (SCOI.82545).
[2397] Exhibit 17, Tab 36, Expert report of Dr Linda Iles, 3 March 2023, 8-9 (SCOI.82545).
[2398] Exhibit 17, Tab 42, Supplementary expert report of Dr Linda Iles, 23 June 2023, 3, Comment [1] (SCOI.84881).
[2399] Exhibit 17, Tab 42, Supplementary expert report of Dr Linda Iles, 23 June 2023, 3, Comment [1] (SCOI.84881).

5.2838. On review of slides from Ms Raye's brain, Dr Iles observed the presence of "a lymphocytic infiltrate in the subarachnoid space", and "perivascular lymphocytosis", that "may indicate mild aseptic (viral) meningitis."[2400] However, in her view this was not associated with encephalitic change (i.e., inflammation of the brain) and may not have been symptomatic. In her view it is unlikely that this light chronic inflammation in the sub-arachnoid space was a primary operating factor in Ms Raye's death.[2401]

5.2839. Dr Iles observed evidence of "significant acute neuronal injury" within the hippocampus, and "patchy acute neuronal injury" in the section of the cortex that was sampled.[2402] Dr Iles considered that the combination of these findings suggest "a prolonged period of decreased consciousness prior to death, with features of early hypoxic ischaemic or metabolic neuronal injury."[2403] (A hypoxic ischaemic injury is caused by a lack of oxygen or blood to the brain; a metabolic injury occurs with the abnormal functioning of the metabolic system, including a deficiency of glucose caused by excess insulin.)

5.2840. In her first report, Dr Iles had expressed the opinion that the development of bronchopneumonia suggested a period of central nervous system depression prior to death. The opinions expressed in her second report point to the probability that Ms Raye suffered a prolonged period of decreased consciousness prior to death and also sustained a brain injury.

5.2841. Dr Iles considered that the non-specific findings at post-mortem could be accounted for by two possibilities:

a. "[I]nsulin toxicity precipitating hypoglycaemia and consequent hypoglycaemic brain injury"; or

b. "[I]ntoxication with a central nervous system depressing agent resulting in a prolonged period of decreased consciousness and hypotension prior to death".[2404]

5.2842. Dr Iles was unable to differentiate between these two possibilities based on the post-mortem findings alone.[2405] Only the first of these possibilities would be consistent with Ms Raye self-injecting insulin.

Third report

5.2843. Dr Iles' third report was written following review of the documentation provided by FASS as to toxicological testing of histological specimens obtained at post-mortem.

[2400] Exhibit 17, Tab 42, Supplementary expert report of Dr Linda Iles, 23 June 2023, 4, Comment [2] (SCOI.84881).
[2401] Exhibit 17, Tab 42, Supplementary expert report of Dr Linda Iles, 23 June 2023, 4, Comment [3] (SCOI.84881).
[2402] Exhibit 17, Tab 42, Supplementary expert report of Dr Linda Iles, 23 June 2023, 4, Comment [2] (SCOI.84881).
[2403] Exhibit 17, Tab 42, Supplementary expert report of Dr Linda Iles, 23 June 2023, 4, Comment [3] (SCOI.84881).
[2404] Exhibit 17, Tab 42, Supplementary expert report of Dr Linda Iles, 23 June 2023, 4, Comment [4] (SCOI.84881).
[2405] Exhibit 17, Tab 42, Supplementary expert report of Dr Linda Iles, 23 June 2023, 4, Comment [4] (SCOI.84881).

5.2844. Dr Iles observed that the toxicological testing excluded the presence of a number of important central nervous system depressants, including morphine, methadone, tricyclic antidepressants, and phenothiazines. "Insignificant traces" of benzodiazepines were noted in the liver.[2406]

5.2845. This testing tends to exclude, albeit not definitively, the second of the possibilities set out above.

5.2846. Dr Iles' conclusion was that:[2407]

> *on the balance of probabilities and given the information available …, the most likely precipitant of a period of decreased consciousness prior to Ms Raye's death is hypoglycaemia following the use of insulin in a non-diabetic person.*

5.2847. Accordingly, it was Dr Iles' opinion that:[2408]

> *notwithstanding some of the limited data available and the limitations of the toxicological studies performed, on the balance of probabilities it is most likely that Ms Raye… died as a consequence of hypoglycaemic brain injury secondary to insulin toxicity.*

Police investigation

5.2848. Counsel Assisting identified a number of concerns with the original police investigation into Ms Raye's death.

5.2849. First, there was little investigation into Ms Raye's movements prior to her death. There are almost eight days where Ms Raye is unaccounted for.

5.2850. In response, the NSWPF submitted that:[2409]

> *Investigating police appear to have conducted a detailed review of the scene and taken statements from a number of Ms Raye's friends, acquaintances and treating doctors. The State Coroner dispensed with an inquest, and there is nothing to suggest that his Honour regarded the police investigation to be in any way deficient.*

5.2851. However, during the Investigative Practices Hearing, Detective Inspector Warren acknowledged that police would be expected to conduct investigations into Ms Raye's movements for the eight or so days leading up to her death, as part of making enquiries to form a view about whether or not the death was suspicious. He agreed that he would expect a record to be made or retained of the initial report of 19 March 1989.[2410]

[2406] Exhibit 17, Tab 43, Further supplementary expert report of Dr Linda Iles, 21 July 2023, 2, Comment [1] (SCOI.84882).

[2407] Exhibit 17, Tab 43, Further supplementary expert report of Dr Linda Iles, 21 July 2023, 2, Comment [1] (SCOI.84882).

[2408] Exhibit 17, Tab 43, Further supplementary expert report of Dr Linda Iles, 21 July 2023, 3, Comment [3] (SCOI.84882).

[2409] Submissions of NSWPF, 12 April 2023, [39] (SCOI.45187).

[2410] Transcript of the Inquiry, 5 July 2023, T4990.34-43 (TRA.00073.00001).

5.2852. Moreover, I do not accept that the act of dispensing with an inquest should necessarily be treated as an endorsement of the original police investigation. As I have indicated elsewhere, in dealing with similar submissions made by the NSWPF in other cases, the absence of comment (favourable or unfavourable) by a Coroner in the course of an inquest, about the merits of a police investigation, is not probative of its adequacy.

5.2853. I accept the submissions of Counsel Assisting, particularly as regards the importance of careful documentation and retention of missing person reports.

5.2854. Secondly, Counsel Assisting submitted that although Ms Raye was reported as a missing person at Kings Cross Police Station on 19 March 1989, by Mr Hurrell and Ms Hedler,[2411] no record of this report appears to have been kept (or perhaps was ever made). A response to a summons issued by the Inquiry to the NSWPF revealed that neither the Missing Persons Registry nor State Archives holds any copy of that report.[2412]

5.2855. Counsel Assisting submitted that accurate and reliable recording of any missing person report is obviously essential, but would appear not to have occurred in this case. Counsel Assisting acknowledged, in this regard, the significant reforms to police practices in relation to missing persons in subsequent decades, particularly in response to coronial criticism of the previous Missing Persons Unit.[2413]

5.2856. In response, the NSWPF submitted only that it was not possible to discern why no missing person report was retained,[2414] and that "[i]t is unfortunate the report is not now available".[2415] The NSWPF suggested that it was "appropriate to note" that Ms Raye was almost certainly deceased at the time she was reported missing, and that her body was found the day after she was reported missing.[2416]

5.2857. During the Investigative Practices Hearing, Detective Inspector Warren agreed that a police information report detailing the missing person and the circumstances, should have been created in this matter as per the police practices of the day.[2417] On that point, the NSWPF subsequently noted that in this case the missing person report was made to Kings Cross Station in 1989, prior to the operation of the electronic system (i.e., a pre-COPS document). The record of that missing person report was identified in the COPS system, but steps taken to locate the report associated with the COPS record were "unfortunately unsuccessful".[2418]

[2411] See Exhibit 17, Tab 38, Brett McCarthy, 'Half man, half woman's tragedy', *Daily Mirror,* 9 May 1989 (SCOI.11038.00019).

[2412] Exhibit 17, Tab 22, Email from Patrick Hodgetts to Caitlin Healey-Nash, 7 October 2022 (SCOI.82495).

[2413] See Inquest into the suspected deaths of missing persons Ursula Barwick, Lionel Daveson, Gary Jones and Christof Meier (Findings of Deputy State Coroner Lee, Coroners Court of NSW, 2 November 2021), [21.1]–[21.12].

[2414] Submissions of NSWPF, 12 April 2023, [38] (SCOI.45187).

[2415] Submissions of NSWPF, 10 October 2023, [397] (SCOI.86127).

[2416] Submissions of NSWPF, 12 April 2023, [38] (SCOI.45187).

[2417] Transcript of the Inquiry, 5 July 2023, T4947.45–4948.37 (TRA.00073.00001).

[2418] Submissions of NSWPF, 10 October 2023, [394] (SCOI.86127).

5.2858. Thirdly, Counsel Assisting noted that police did not take a statement from the social worker Ms Hedler, notwithstanding that she appeared to have a close relationship with Ms Raye and that, since she was interviewed by journalists after Ms Raye's death, she was presumably available.[2419]

5.2859. In response, the NSWPF submitted only that "[t]he reason why a statement was not taken from Ms Raye's social worker is not apparent,"[2420] and speculated that the missing persons report may have illuminated these reasons.[2421]

Manner and cause of death

Date of death

5.2860. Counsel Assisting submitted that, consistent with the opinion of Dr Iles, the Inquiry should find that Ms Raye died at an unknown time and date between 12 and 20 March 1989.

5.2861. They submitted that the evidence indicates that the recording of the date "12 March 1989" in the Coroners Court Action Sheet, and subsequently on Ms Raye's death certificate, was not correct, and does not have any support either in the post-mortem report of Dr Bradhurst or in the investigations conducted by the NSWPF at the time.

5.2862. I accept the submission of Counsel Assisting. It is not possible, on the evidence available, to determine when Ms Raye died in the period between when she was last seen alive and when her body was located. I therefore find that Ms Raye died at an unknown time and date between 12 and 20 March 1989.

Cause of death

5.2863. Counsel Assisting submitted that, on the basis of the information available to the Inquiry, including in particular Dr Iles' reports, there was sufficient evidence to sustain findings that:

a. Ms Raye died as a consequence of hypoglycaemic brain injury secondary to insulin toxicity; and

b. Ms Raye self-administered insulin prior to her death.

5.2864. Counsel Assisting further submitted that conversely, in the light of Dr Iles' second report, there is insufficient evidence to establish that meningoencephalitis was a cause of Ms Raye's death. This represents a departure from the findings of Dr Bradhurst at post-mortem.

5.2865. I accept the submission of Counsel Assisting, to which the NSWPF did not demur. I find that Ms Raye died as a consequence of hypoglycaemic brain injury secondary to insulin toxicity, and that she self-administered insulin prior to her death. I do not find that meningoencephalitis also contributed to Ms Raye's death.

[2419] Exhibit 17, Tab 38, Brett McCarthy, 'Half man, half woman's tragedy', *Daily Mirror,* 9 May 1989 (SCOI.11038.00019).

[2420] Submissions of NSWPF, 10 October 2023, [397] (SCOI.86127).

[2421] Submissions of NSWPF, 10 October 2023, [397] (SCOI.86127).

Manner of death

5.2866. The evidence establishing the probability that Ms Raye self-administered insulin prior to her death is relevant to the question of Ms Raye's intention at the time of administering the insulin, including whether she intended to die by suicide.

5.2867. Counsel Assisting submitted, by reference to the three elements of suicide outlined in the introduction to this Chapter, that there was sufficient evidence to establish that Ms Raye acted voluntarily or deliberated, but not that, by administering insulin, she intended to end her own life, or had a conscious understanding at the time that the administration of the insulin would necessarily result in death.

5.2868. Counsel Assisting referred to Ms Raye's history of severe depression, suicidal ideation and possible suicide attempts, and the harassment she experienced at her residential flat. Counsel Assisting submitted, and I accept, that an intention to die by suicide is a realistic possibility in the context of such factors.

5.2869. However, Counsel Assisting submitted that a finding as to Ms Raye's intention is significantly complicated by the cause of her death, which can now be identified as the self-administration of insulin.

5.2870. Counsel Assisting noted the conflicting evidence as to whether Ms Raye was diabetic. Counsel Assisting submitted that that evidence suggested that Ms Raye may have used insulin for a prolonged period, perhaps believing herself to be diabetic, perhaps despite a lack of medical indication.

5.2871. Balancing these factors, and notwithstanding her poor mental health and evidence of her suicidal ideation, Counsel Assisting submitted that although suicide may have been the explanation for Ms Raye's death, other explanations cannot be ruled out. One such possibility is that Ms Raye administered insulin to herself on the day of her death, believing (perhaps wrongly) that it was medically indicated, and without a conscious understanding that doing so would result in her death.

5.2872. Counsel Assisting submitted that the note left on Ms Raye's mantelpiece, which read "At lighthouse, will be back????", does not assist in distinguishing between a scenario of suicide and one of misadventure. Counsel Assisting accepted that one possible interpretation of the note (as advanced by the NSWPF) was that Ms Raye had in mind that she would not return. However, Counsel Assisting submitted that the "????" could also have been simply an indication that she was not sure how long she would stay at the lighthouse.

5.2873. Accordingly, Counsel Assisting submitted that there is insufficient evidence to support a positive finding that Ms Raye self-administered insulin with the intention of causing her own death, and that no finding should be made as to Ms Raye's intention.

5.2874. The NSWPF, by contrast, devoted most of their submissions in this matter to emphasising the likelihood of suicide. The NSWPF submitted that on the evidence as a whole, it was "comfortably open" to the Inquiry to conclude that Ms Raye "administered insulin with a view to causing her own death", [2422] and that it was "entirely open" to "find" that Ms Raye's death was "the result of suicide".[2423]

5.2875. The NSWPF pointed to the following matters in support of this submission:[2424]

a. The abuse and discrimination to which Ms Raye was subjected;

b. Ms Raye's history of severe depression and suicidal ideation;

c. The several significant stressors for Ms Raye in the period leading up to her death;

d. Research which indicates high rates of suicide attempts by trans women;

e. The note left at Ms Raye's apartment (the NSWPF acknowledged that the note "is ambiguous, and does not adhere to conventional expectations of what might be found in a 'suicide note'", but submitted that the question marks "certainly suggest" that at the time Ms Raye wrote the note, "she at least countenanced the possibility that she would not return");

f. The lack of evidence that Ms Raye was assaulted or that another person was present at the time of her death;

g. The syringe, needle and empty box found near Ms Raye's body, which were found to contain insulin;

h. Several syringes found in Ms Raye's house;

i. The lack of medical evidence that Ms Raye was diabetic or otherwise required insulin; and

j. Dr Iles' opinion that the development of bronchopneumonia suggested a period of central nervous system depression/obtundation prior to death.

5.2876. The NSWPF submitted that the possibility that Ms Raye deliberately administered insulin in order to end her life "provides a logical explanation for her death that is wholly consistent with the circumstantial and medical evidence", and that no other plausible explanation for her death arises on the material. [2425]

5.2877. I am satisfied that there is no evidence of foul play in Ms Raye's death.

5.2878. However, I do not agree with the submission advanced by the NSWPF that "no other plausible explanation for her death arises on the material". For the reasons advanced by Counsel Assisting, that is not so. That Ms Raye self-administered insulin is now tolerably clear. But her reasons for doing so, and her intention in doing so, are not.

[2422] Submissions of NSWPF, 12 April 2023, [32] (SCOI.45187).

[2423] Submissions of NSWPF, 12 April 2023, [34] (SCOI.45187).

[2424] Submissions of NSWPF, 12 April 2023, [32] (SCOI.45187).

[2425] Submissions of NSWPF, 12 April 2023, [34] (SCOI.45187).

Bias

5.2879. Counsel Assisting submitted that while there was ample evidence that LGBTIQ bias had an adverse impact on Ms Raye's mental health, there is no basis for finding that her death was the result of a homicide, and accordingly no basis for finding that her death was an LGBTIQ hate crime.

5.2880. I accept this submission, which counsel for the NSWPF also adopted.

Conclusions and Recommendations

5.2881. I find that Ms Raye died at an unknown time between 12 and 20 March 1989 as a consequence of hypoglycaemic brain injury secondary to insulin toxicity, caused by Ms Raye self-administering insulin. As I have outlined above, there is insufficient evidence to enable me to make a finding as to Ms Raye's intention.

5.2882. In my view, on the evidence available to the Inquiry, there is objectively no reason to suspect that LGBTIQ bias was a factor in Ms Raye's death.

5.2883. I make the following recommendations:

Recommendation 2

I recommend that BDM correct the Register of Births, Deaths and Marriages pursuant to s 45(1)(b) of the *Births, Deaths and Marriages Registration Act 1995*, such that Ms Raye's:

a. Date of death is recorded as "unknown date between 12 and 20 March 1989";

b. Cause of death is recorded as "hypoglycaemic brain injury secondary to insulin toxicity, caused by the self-administration of insulin"; and

c. The phrase "transexual depression" be removed from the cause of death.

IN THE MATTER OF JOHN HUGHES

Factual background

Date and location of death

5.2884. John Gordon Hughes died on the evening of Friday, 5 May 1989 or the early hours of Saturday, 6 May 1989 in the apartment where he lived in Potts Point, Sydney.

Circumstances of death

5.2885. Mr Hughes was 45 years old at the time of his death. He was affectionately known to his friends by the nickname "Skinny John,"[2426] and described as a "kind" person who was generous to his friends.[2427] He was a gay man.

5.2886. Mr Hughes was found by a roommate, Aaron Hill, with his hands and feet bound with electrical cord and a pillow slip covering his head. There were bruises and lacerations to the back of the head, consistent with blows by a blunt object. A leather belt had been tightened around his neck, apparently using kitchen tongs, ultimately leading to death by asphyxiation due to strangulation with a ligature.[2428]

5.2887. Ian Jones was the primary person of interest in relation to the death of Mr Hughes. Mr Jones was charged with the murder of Mr Hughes, but acquitted after a trial by jury. The evidence in relation to Mr Jones, who is deceased, is discussed below.

[2426] Exhibit 7, Tab 42, Statement of Mark Phillip Locke, 13 September 1989, [5] (SCOI.10081.00024); Exhibit 7, Tab 75A, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 27 August 1992, 36 (SCOI.10400.00053); Exhibit 7, Tab 73, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 25 August 1992, 44 (SCOI.10400.00051).

[2427] Exhibit 7, Tab 73, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 27 August 1992, 38 (SCOI.10400.00053).

[2428] Exhibit 7, Tab 24, Statement of Detective Constable Michael Plotecki, 2 June 1990, [5] (SCOI.10081.00011).

Previous investigations

Post-mortem examination

5.2888. In a post-mortem report dated 23 June 1989, Dr Liliana Schwartz noted the following injuries upon her examination of Mr Hughes' body:[2429]

a. Ligature mark around the neck and abrasion to the left side of the neck;

b. Petechial haemorrhages on the face, nose, eyes and neck;

c. Bruises to the neck;

d. Multiple bruises to the back of the head, particularly on the left-hand side, including a large bruise measuring 5cm x 3.5cm to the back of the head (occipital region); and

e. Multiple lacerations to the back of the head, some superficial and others to the periosteum (i.e., the external membrane of the skull).

5.2889. Dr Schwartz found the cause of death to be asphyxia due to strangulation with a ligature, and noted blunt object injury to the head as another significant condition contributing to death.[2430]

5.2890. Mr Hughes' blood was negative for drugs and alcohol.

5.2891. Dr Schwartz noted the time of death to have been "3 to 4 days previously".[2431] Whether this meant three to four days prior to the date of an external examination on 9 May 1989 was not clear. If that is what was meant, then Dr Schwartz was placing the time of death as sometime on 5 or 6 May 1989.

5.2892. However, both at the coronial inquest in 1990 and at the trial in 1992, Dr Schwartz gave somewhat different, and to some extent inconsistent, evidence as to the time of death. At the inquest she agreed that the death must have been before 7:30pm on 5 May 1989. Subsequently, at the trial, her evidence was that the time of death was between nine and 36 hours before the time that she took his rectal temperature at 11:00pm on 6 May 1989 (i.e., a 27 hour period between 11:00am on 5 May and 2:00pm on 6 May 1989), describing this as a "rough estimate" because the body had been left in a room with a heater on.[2432]

Original police investigation

5.2893. The police considered, and excluded, a number of early suspects and leads in relation to the murder.

[2429] Exhibit 7, Tab 14, Post-Mortem Report of Dr Liliana Schwartz, 23 June 1989, 2-3 (SCOI.10081.00007).

[2430] Exhibit 7, Tab 14, Post-mortem Report of Dr Liliana Schwartz, 23 June 1989, 2-3 (SCOI.10081.00007).

[2431] Exhibit 7, Tab 14, Post-mortem Report of Dr Liliana Schwartz, 23 June 1989, 3 (SCOI.10081.00007).

[2432] Exhibit 7, Tab 14, Post-mortem report of Dr Liliana Schwarz, 23 June 1989 (SCOI.10081.00007); Exhibit 7, Tab 77, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 31 August 1992, 3-14 (SCOI.10400.00055).

5.2894. Initially, various information and tipoffs pointed to a man named Mark Locke being involved in the murder of Mr Hughes.[2433] Mr Locke was a sex worker and drug user in the Kings Cross area, who frequently bought drugs from Mr Hughes and had been reported to have stood over him and robbed him.[2434] Mr Locke admitted to having drug-related debts to Mr Hughes at the time of his death, owing about $1200.[2435] However, Mr Locke was excluded as a suspect after it was confirmed that he was in Queensland at the time of Mr Hughes' death.[2436]

5.2895. Police had been investigating Mr Jones as a potential suspect, but information provided by Mr Locke led to more police attention being placed on him. Mr Jones was ultimately charged and tried for the murder of Mr Hughes, and Mr Locke was a Crown witness in that trial.

Exhibits

5.2896. Exhibits were identified and tested by police during the initial investigation, and the results of that testing were tendered at the trial of Mr Jones. Relevant testing included:

a. Blood type testing on exhibits from the crime scene, including a bloody knife and t-shirt;[2437]

b. Development and analysis of fingerprints from the crime scene;[2438]

c. Development and analysis of fingerprints from a passbook belonging to Mr Hughes and found in the possession of Mr Jones;[2439] and

d. Examination for body fluids of a car previously owned by Mr Jones.[2440]

5.2897. It appears all relevant exhibits were located and tested. None of the testing returned results that were probative of the involvement of Mr Jones or any other person in the murder.

Findings at inquest

5.2898. On 18 July 1990, Deputy State Coroner Hand terminated the inquest into the death of Mr Hughes pursuant to s. 19 of the *Coroners Act 1980* (repealed), on the basis that Mr Jones had been charged with the murder of Mr Hughes.

[2433] Exhibit 7, Tab 3, NSWPF Resume of Inquiries – 'For the period ending 11 June 1989', 11 June 1989 (SCOI.10056.00057); Exhibit 7, Tab 7, NSWPF Resume of Inquiries – 'For the period ending 4 September 1989', 4 September 1989 (SCOI.10056.00060).

[2434] Exhibit 7, Tab 40, Statement of Gavin Scobie, 17 May 1989, [15] (SCOI.10081.00043); Exhibit 7, Tab 47, Statement of Ian Stuart Jones, 4 October 1989, [14] (SCOI.10081.00013).

[2435] Exhibit 7, Tab 42, Statement of Mark Phillip Locke, 13 September 1989, [5] (SCOI.10081.00024).

[2436] Exhibit 7, Tab 9, NSWPF Resume of Inquiries – 'For the period ending 15 September 1989', 12 September 1989 (SCOI.10056.00062); Exhibit 7, Tab 10, NSWPF Resume of Inquiries – 'For the period ending 1 October 1989', created 23 September 1989 (SCOI.10056.00064).

[2437] Exhibit 7, Tab 13, Statement of Virginia Friedman, 6 June 1989 (SCOI.10401.00073).

[2438] Exhibit 7, Tab 14, Statement of Detective Senior Constable Warren John English, 26 April 1991 (SCOI.10076.00027).

[2439] Exhibit 7. Tab 95, Statement of Constable Kevin Drevensek, 30 May 1990 (SCOI.10081.00068).

[2440] Exhibit 7. Tab 18, Statement of Detective Senior Constable David John Royds, 9 May 1990 (SCOI.10081.00066).

Criminal proceedings

5.2899. Mr Jones was charged with the murder of Mr Hughes on 1 May 1990.[2441] Mr Jones pleaded not guilty to the charge.[2442]

5.2900. A jury was empanelled on 17 August 1992,[2443] although subsequently discharged when it emerged that the defence counsel, Mr Greenwood QC, was at risk of becoming (and ultimately did become) a witness in the matter.[2444]

5.2901. A second jury was empanelled on 24 August 1992,[2445] and the trial ran until 1 September 1992, before Justice Mathews. Mr Jones was represented by Mr Finnane QC.

5.2902. On 3 September 1992, the jury returned a verdict of not guilty, and Mr Jones was discharged.[2446]

Strike Force Parrabell

Bias Crimes Indicators Form

5.2903. A BCIF was completed by Strike Force Parrabell. Of the ten indicators in the BCIF, seven were answered as "No Evidence of Bias Crime" and three were answered as "Insufficient Information". The Summary of Findings settled on "Insufficient Information".[2447]

5.2904. Three issues in particular are to be noted with respect to the "General Comment" and "Summary of Findings" boxes of the BCIF.

5.2905. First, in relation to indicator two, "Comments, Written Statements, Gestures", Strike Force Parrabell noted that the only bias-related comment detected was in the record of interview of Mr Jones on 30 April 1990, during which he cited his reason for leaving the flat of Mr Hughes as being that he was "fed up with the place, it was full of drugs and poofters."[2448] In relation to that indicator, Strike Force Parrabell nevertheless checked the box for "No Evidence of Bias Crime".[2449]

5.2906. It appears that Strike Force Parrabell also overlooked the comments attributed to Mr Jones by Janice Dowsley, namely words to the effect of "don't worry it… [t]he guy was a fucking faggot dog… he deserved everything that he got."[2450]

[2441] Exhibit 7, Tab 84, NSWPF Charge Sheet, 'Charge Sheet – Informant Copy', 1 May 1990, (SCOI.10081.00003).

[2442] Exhibit 7, Tab 69, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 1 (SCOI.10400.00049).

[2443] Exhibit 7, Tab 69, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 1 (SCOI.10400.00049).

[2444] Exhibit 7, Tab 70, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 1 (SCOI.10401.00007).

[2445] Exhibit 7, Tab 72, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 1 (SCOI.10400.00050).

[2446] Exhibit 7, Tab 94, Associate's Record of Proceedings, 3 September 1992 (SCOI.10400.00046).

[2447] Exhibit 7, Tab 90, Strike Force Parrabell, Bias Crimes Indicators Review Form – John Hughes, Undated 19 (SCOI.82199).

[2448] Exhibit 7, Tab 51, NSWPF Record of interview, 'Interview with Ian Stuart Jones', 30 April 1990, [A243] (SCOI.10081.00012).

[2449] Exhibit 7, Tab 90, Strike Force Parrabell, Bias Crimes Indicators Review Form – John Hughes, Undated 6 (SCOI.82199).

[2450] Exhibit 7, Tab 64, Statement of Janice Gaye Dowsley, 8 April 1992, [8] (SCOI.10401.00015).

5.2907. Secondly, in relation to indicator nine, "Lack of Motive", Strike Force Parrabell focused on facts suggesting that Mr Jones was likely motivated by a desire to steal property from Mr Hughes, or by animosity over the dispute over stolen property. In relation to that indicator, the chosen finding was "No Evidence of Bias Crime".[2451]

5.2908. The "Summary of Findings" concluded with the following passage:[2452]

> *Dealing drugs whilst generally profitable is a high risk occupation and is clearly why Police were of the belief that one of the motives for this murder was robbery. Whilst Police at the time acknowledged that the murder of HUGHES could have been bias related, it is much more likely that robbery was the clear motive for the murder. Although found not guilty, it is highly likely that JONES was responsible for the murder of HUGHES and was motivated by money and revenge, rather than any personal bias towards HUGHES.*

5.2909. Implicit in these comments, and possibly in the inclusion of indicator nine in the BCIF, appears to be an assumption that the presence of another motive (such as robbery or profit) tells against the simultaneous existence of LGBTIQ bias. That assumption was the subject of comment by Counsel Assisting, as considered below.

5.2910. Thirdly, in relation to indicator 10, "Level of Violence", Strike Force Parrabell recognised that the murder of Mr Hughes was "particularly brutal", and that "[w]hoever went into that unit meant to kill HUGHES and inflict an incredible amount of pain in doing so." Reference was also made to a media article which records that the original investigating police were "baffled why such a small-time drug dealer should have been killed so brutally." Nonetheless, in relation to indicator 10, Strike Force Parrabell checked the box for "Insufficient Information".[2453]

5.2911. In the "Summary of Findings", no mention is made of the brutal and graphic manner in which Mr Hughes was murdered, suggesting that limited, if any, weight was placed on it in forming a view as to whether this was a bias crime.

Case Summary

5.2912. The matter was categorised as "Solved (acquitted)" by Strike Force Parrabell. The Strike Force Parrabell case summary categorised the case as "Insufficient information to establish a bias crime".[2454]

5.2913. The Strike Force Parrabell case summary for this matter reads as follows:[2455]

> ***Identity:*** *John Hughes was 45 years old at the time of his death.*

[2451] Exhibit 7, Tab 90, Strike Force Parrabell, Bias Crimes Indicators Review Form – John Hughes, Undated 15-17 (SCOI.82199).

[2452] Exhibit 7, Tab 90, Strike Force Parrabell, Bias Crimes Indicators Review Form – John Hughes, Undated 19 (SCOI.82199).

[2453] Exhibit 7, Tab 90, Strike Force Parrabell, Bias Crimes Indicators Review Form – John Hughes, Undated 18-19 (SCOI.82199).

[2454] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – John Hughes, Undated 16 (SCOI.76961.00014).

[2455] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – John Hughes, Undated 16 (SCOI.76961.00014).

> ***Personal History:*** *Mr Hughes lived with a roommate in a residential unit at Greenknowe Avenue, Potts Point. At the time of his death Mr Hughes was on bail for serious drug supply matters and was believed to owe money related to drug debts. Police identified a suspect known to Mr Hughes for 10 years and described as his 'bodyguard'. The suspect identified as heterosexual. Up until 2 months prior to his death, Mr Hughes had been living with the suspect. Their relationship ended with the suspect leaving Mr Hughes' residence to live with a woman in Bathurst amid allegations that he had stolen a number of personal items, leaving a strong personal dislike between them. Both Mr Hughes and the suspect made threats against each other. The suspect was aware that Mr Hughes had $5000 in a bank account and when arrested by police had possession of Mr Hughes (sic) Westpac account passbook. The majority of witnesses interviewed were criminal associates, drug clients and personal friends of Mr Hughes.*
>
> ***Location of Body/Circumstances of Death:*** *Mr Hughes was located deceased lying face down across a bed in his residential unit at Greenknowe Street, Potts Point. He had been struck to the head several times with a lamp. His hands and feet had been tied and a pillow case was over his head. He also had an electrical cord around his neck.*
>
> ***Sexual Orientation:*** *Mr Hughes identified as gay.*
>
> ***Coroner/Court Findings:*** *Police charged the suspect with Mr Hughes' murder. Investigating Police believed that the motive for the murder was robbery and/or revenge. The suspect was acquitted of murder at trial for unknown reasons and died in 2002 from a drug overdose.*

5.2914. The case summary is consistent with the approach and comments in the BCIF.

Academic review

5.2915. The academic reviewers categorised this matter as "Insufficient information".[2456]

Review by the Inquiry

5.2916. The Inquiry took the following steps in the course of examining the matter.

Summonses

5.2917. A summons was issued to the NSWPF on 18 May 2022 for all documents relating to investigations by the NSWPF of the death of Mr Hughes, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Hughes. Several boxes of documents in relation to Mr Hughes were produced on 8 June 2022.

[2456] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – John Hughes, Undated 16 (SCOI.76961.00014).

5.2918. On 21 June 2022, the Inquiry issued a summons to the ODPP (ODPP1) to obtain all files in relation to the prosecution of Mr Jones. The ODPP answered Summons ODPP1 on 12 July 2022, and provided two boxes of material.

5.2919. A further summons to the NSWPF was issued on 25 August 2022 for all records in relation to Strike Force Parrabell, Strike Force Macnamir and Strike Force Neiwand (NSWPF12). This material was produced in tranches between 9 September 2022 and 18 November 2022. This material included the BCIF and relevant Investigator's Notes in relation to the review of Mr Hughes' death by Strike Force Parrabell.

5.2920. Information received from the UHT was that Mr Jones, the key person of interest, is deceased, dying as a result of a drug overdose in 2002. Such a statement is also found in the BCIF and Strike Force Parrabell case summary. The Inquiry sought to confirm the death of Mr Jones by seeking a death certificate from BDM as part of Summons BDM10; however, on 30 January 2023 BDM advised that no death certificate could be identified. Nevertheless, on the basis of the information provided by the Unsolved Homicide Team, the Inquiry has considered this case on the assumption that Mr Jones is deceased.

5.2921. On 23 August 2022, a summons was issued to BDM to ascertain the status of the following witnesses, with the following results received on 25 August 2022:

a. Mark Locke: deceased as at 25 April 2021 from a stab wound to the chest;[2457]

b. Janice Dowsley: no trace of registration of death;

c. I51: no trace of registration of death; and

d. Kerrie Stanton: no trace of registration of death.

5.2922. As both Mr Jones and Mr Locke (the key Crown witness) are deceased, Counsel Assisting considered that there would be limited forensic value in calling any other witnesses to give oral evidence before this Inquiry.

Interagency cooperation

5.2923. On 11 May 2022, the Inquiry issued a written request to the Coroners Court to obtain the coronial file in relation to the death of Mr Hughes. The Coroners Court answered the request on 26 May 2022.

5.2924. On 17 June 2022, the Inquiry issued a written request to the Supreme Court to obtain the court file in relation to the trial of Mr Jones. The Supreme Court answered the request on 29 June 2022 and provided one box of material. The material included the trial transcript, although it excluded the closing addresses of counsel and the Judge's summing up.

[2457] Exhibit 7, Tab 93, Death Certificate of Mark Phillip Locke, 30 January 2023 (SCOI.82349).

Family members

5.2925. The Inquiry was unable to locate any living family members of Mr Hughes to date. The initial police investigation established that he was an orphan.[2458]

5.2926. The Inquiry has also been unable to identify any living family members of Mr Jones.

Contact with OICs

5.2927. On 31 August 2023 and 18 September 2023, the Inquiry wrote to Michael Plotecki enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Hughes.[2459] On 21 September 2023, Mr Plotecki advised that he was not the OIC in the initial months of the investigation into Mr Hughes' death, and that Detective Senior Constable Neville John Scullion was the OIC at the time crime scene exhibits were collected. Mr Plotecki confirmed that he did not wish to make submissions in relation to the death of Mr Hughes.[2460]

5.2928. On 26 September 2023, the Inquiry wrote to Neville Scullion enclosing the written submissions made by both Counsel assisting and the NSWPF in relation to the death of Mr Hughes.[2461] On 29 September 2023, Mr Scullion advised that he did not wish to make submission in relation to the death of Mr Hughes.[2462]

Professional opinions

5.2929. The Inquiry obtained an expert report by Dr Danny Sullivan, consultant forensic psychiatrist, in relation to, relevantly, whether there were any aspects of the death and/or crime scene that may indicate that the homicide occurred in the context of LGBTIQ bias.[2463]

5.2930. In his report dated 24 October 2022, Dr Sullivan noted that the crime scene depicted "sexualised elements, including binding, strangulation, and hooding." In Dr Sullivan's opinion:[2464]

> *the location and posing of the body on the bed may have suggested conscious or unconscious motivation of the offender to reflect Mr Hughes' sexuality, as they perceived it.*

[2458] Exhibit 7, Tab 2, NSWPF Resume of Inquiries – 'For the period ending 4 June 1989', 4 June 1989, 2 (SCOI.10056.00056).

[2459] Exhibit 7, Tab 96, Letter from Solicitor Assisting the Inquiry to Michael Plotecki, 31 August 2023 (SCOI.86180); Exhibit 7, Tab 97, Letter from Solicitor Assisting the Inquiry to Michael Plotecki, 18 September 2023 (SCOI.86181).

[2460] Exhibit 7, Tab 99, Statement of Emily Burston, 16 October 2023, [6] (SCOI.86242).

[2461] Exhibit 7, Tab 98, Letter from Solicitor Assisting the Inquiry to Neville John Scullion, 26 September 2023 (SCOI.86182).

[2462] Exhibit 7, Tab 99, Statement of Emily Burston, 16 October 2023, [8] (SCOI.86242).

[2463] Exhibit 7, Tab 92, Expert Report of Dr Danny Sullivan, 24 October 2022 (SCOI.82115).

[2464] Exhibit 7, Tab 92, Expert Report of Dr Danny Sullivan, 24 October 2022, [19] (SCOI.82115).

Consideration of the evidence

Mr Hughes' background

5.2931. Mr Hughes lived in an apartment on Greenknowe Avenue, Potts Point. He often had people living or staying with him, including, at various points, Mr Hill, I51 (a pseudonym), Gregory West and Mr Jones.

5.2932. His sexuality was well known amongst his friends and acquaintances. Relevant evidence includes:

a. Gavin Scobie was a friend of Mr Hughes for over 15 years. He knew that Mr Hughes was gay;[2465] and

b. Mr Locke described Mr Hughes as an "active homosexual" who was in a sexual relationship with a 17 or 18 year old male who was a sex worker. He believed Mr Hughes to be "in love" with that person.[2466]

5.2933. Mr Hughes had convictions for drug-related offences, and at the time of his death was on trial for offences relating to the possession and supply of heroin.[2467] It was well-known amongst his friends and associates that Mr Hughes dealt in heroin and other drugs.[2468]

Discovery of Mr Hughes' body

5.2934. Mr Hughes was last seen alive by Detective Senior Constable Neville Scullion of the Kings Cross Police Station, at the Mirras Coffee Lounge in Kings Cross, at about 3:30pm on 5 May 1989. Mr Hughes was seated alone.[2469]

5.2935. During the course of the evening of 5 May 1989 and the morning of 6 May 1989, various friends of Mr Hughes went to his apartment, and either buzzed at the security door or knocked on his door. They received no answer.[2470]

5.2936. At some time after 11:00am on 6 May 1989, Mr Hill decided to climb into the apartment by the bathroom window. Mr Hill had been staying with Mr Hughes at the time but had forgotten his key and wanted to obtain his belongings. Upon entering the flat, Mr Hill discovered Mr Hughes' body. He reported his discovery to police, albeit using a false name, as he had outstanding warrants for his arrest at that time.[2471]

[2465] Exhibit 7, Tab 40, Statement of Gavin Scobie, 17 May 1989, [4] (SCOI.10081.00043).

[2466] Exhibit 7, Tab 42, Statement of Mark Phillip Locke, 13 September 1989, [9], [11] (SCOI.10081.00024).

[2467] Exhibit 7, Tab 16, Bail Report, 'John Gordon Hughes', 29 August 2013, 6 (SCOI.10053.00021).

[2468] Exhibit 7, Tab 42, Statement of Mark Phillip Locke, 13 September 1989, [5] (SCOI.10081.00024); Exhibit 7, Tab 40, Statement of Gavin Scobie, 17 May 1989, [5] (SCOI.10081.00043); Exhibit 7, Tab 35, Statement of Gregory West, 6 May 1989, [2] (SCOI.10082.00098); Exhibit 7, Tab 54, Statement of I51, 19 May 1990, [5] (SCOI.10081.00042).

[2469] Exhibit 7, Tab 27, Statement of Detective Senior Constable Neville John Scullion, 5 June 1990, [3] (SCOI.10081.00071); Exhibit 7, Tab 72, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 24 August 1992, 14 (SCOI.10400.00050).

[2470] Exhibit 7, Tab 37, Statement of Aaron Lee Hill, 6 May 1989, [4] (SCOI.10081.00021); Exhibit 7, Tab 40, Statement of Gavin Scobie, 17 May 1989, [9]–[10] (SCOI.10081.00043); Exhibit 7, Tab 36, Statement of Michelle Nicholas, 6 May 1989, [10]–[11] (SCOI.10082.00052); Exhibit 7, Tab 35, Statement of Gregory West, 6 May 1989, [10] (SCOI.10082.00098).

[2471] Exhibit 7, Tab 37, Statement of Aaron Lee Hill, 6 May 1989, [6]–[7] (SCOI.10081.00021); Exhibit 7, Tab 26, Statement of Constable Howard John Fox, 4 June 1990, [3]–[4] (SCOI.10081.00064).

5.2937. Police attended the scene and described the following:

a. The body was lying face down across the bed, with the feet of the body hanging over the side of the bed;

b. The hands were bound behind the back with white electrical cord, as were the feet, bound just above the ankles;

c. A pink pillow slip covered the head of the deceased;

d. White electrical cord and a leather belt were wrapped around the neck;

e. A pair of kitchen tongs was protruding from the back of the neck of the body, and appeared to have been used to tighten the bindings around the deceased's neck by having twisted them;

f. Pieces of broken pottery were scattered around on the bed, around the head of the deceased;

g. A light bulb was next to the deceased's right arm;

h. There were blood stains on the pillowslip and the bed, below the head of the deceased;

i. Next to the right side of the body were a number of personal papers, scattered around on the bed;

j. On top of the papers was a kitchen knife, with a blade approximately 30cm long, with blood on the blade; and

k. A bloodstained t-shirt was behind the coffee table.[2472]

5.2938. There were no signs of forced entry or of interference with the locks. However, Mr Hughes' wallet and credit card could not be located, nor could any money be found in the flat.[2473]

5.2939. Blood-typing analysis was conducted of swabs and exhibits taken from the scene. Relevantly, the blood on the knife and t-shirt found at the scene was consistent with having come from Mr Hughes. Approximately one in 1,700 people in the population would have the same blood type.[2474]

5.2940. Six cigarette butts taken from Mr Hughes' unit were also tested; however, there was no "ABO substance" found in the saliva of the cigarette butts, such that no typing analysis could be conducted.

[2472] Exhibit 7, Tab 24, Statement of Detective Constable Michael Charles Plotecki, 2 June 1990, [5] (SCOI.10081.00011); Exhibit 7, Tab 17, Statement of Detective Constable Samuel Khoudair, 1 March 1990, [4]–[5], [7] (SCOI.10081.00020).

[2473] Exhibit 7, Tab 24, Statement of Detective Constable Michael Charles Plotecki, 2 June 1990, [4], [6] (SCOI.10081.00011); Exhibit 7, Tab 17, Statement of Detective Constable Samuel Khoudair, 1 March 1990, [7] (SCOI.10081.00020).

[2474] Exhibit 7, Tab 76, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 28 August 1992, 6 (SCOI.10400.00054).

5.2941. Fingerprints and palm prints were developed from various locations in and around Mr Hughes' apartment.[2475] While some prints were matched to Mr Hill, this was not considered probative, given that he resided in the apartment and had on his account climbed into the apartment by the bathroom window. The fingerprints were also later compared to those of Mr Jones, with negative results.[2476]

The prosecution case against Mr Jones

5.2942. Mr Jones, on his own admission, lived with Mr Hughes in the early months of 1989.[2477] Mr Jones was aware that Mr Hughes was, in Mr Jones' words, an "active homosexual."[2478] It is also likely that Mr Jones had purchased heroin from Mr Hughes, and that he had been present in Mr Hughes' apartment at the time of other heroin sales.[2479]

5.2943. Mr Jones moved out of Mr Hughes' flat in mid-March 1989, travelling first to Lithgow and then settling in Bathurst.[2480] In an interview with police, Mr Jones stated his reason for leaving Mr Hughes' apartment was that he was "fed up with the place, it was full of drugs and poofters."[2481]

5.2944. According to Mr Locke, Mr Hughes believed that Mr Jones had stolen drugs, cash and electronical equipment from him when he moved out.[2482] Mr Hughes had told Mr Locke that he would "fix" Mr Jones and go to the police. Ronald Stanton, the father of Kerrie-Anne Stanton (partner of Mr Jones), gave evidence of receiving a phone call from a person named "John", looking for Mr Jones and claiming that Mr Jones had stolen from him,[2483] corroborating that some dispute existed between the men over stolen property.

5.2945. Mr Locke gave evidence that not long after Mr Jones moved out of Mr Hughes' apartment, Mr Jones and Mr Locke ran into each other and had a conversation about Mr Hughes. Mr Locke said that he told Mr Jones that Mr Hughes went to police about Mr Jones "knocking off his stuff'. This angered Mr Jones, to the point that he was described as "spitting his words".[2484]

5.2946. According to Mr Locke, Mr Jones said during that conversation, "I've made up my mind now, I'll fix him properly… I'll kill the little cunt."[2485]

[2475] Exhibit 7, Tab 33, Statement of Detective Senior Constable Warren John English, 26 April 1991 (SCOI.10076.00027).

[2476] Exhibit 7, Tab 33, Statement of Detective Senior Constable Warren John English, 26 April 1991, 2-3 (SCOI.10076.00027).

[2477] Exhibit 7, Tab 47, Statement of Ian Stuart Jones, 4 October 1989, [8] (SCOI.10081.00013).

[2478] Exhibit 7, Tab 47, Statement of Ian Stuart Jones, 4 October 1989, [5] (SCOI.10081.00013).

[2479] Exhibit 7, Tab 54, Statement of I51, 19 May 1990, [9] (SCOI.10081.00042); Exhibit 7, Tab 42, Statement of Mark Phillip Locke, 13 September 1989, [13] (SCOI.10081.00024).

[2480] Exhibit 7, Tab 47, Statement of Ian Stuart Jones, 4 October 1989, [15] (SCOI.10081.00013).

[2481] Exhibit 7, Tab 51, NSWPF Record of interview, 'Interview with Ian Stuart Jones', 30 April 1990, [A243] (SCOI.10081.00012).

[2482] Exhibit 7, Tab 42, Statement of Mark Phillip Locke, 13 September 1989, [16] (SCOI.10081.00024).

[2483] Exhibit 7, Tab 53, Statement of Ronald Stanton, 5 May 1990, [8] (SCOI.10091.00032).

[2484] Exhibit 7, Tab 42, Statement of Mark Phillip Locke, 13 September 1989, [18] (SCOI.10081.00024).

[2485] Exhibit 7, Tab 42, Statement of Mark Phillip Locke, 13 September 1989, [18] (SCOI.10081.00024).

5.2947. According to Mr Locke, Mr Jones then asked Mr Locke whether he wanted to "rort" Mr Hughes with him. Mr Jones allegedly said, "Look mate you can be in it or out of it, I'm only trying to do you a favour. If anything happened to John, do you honestly think there would be a big inquiry over another Junkie dealer." Mr Locke said that Mr Jones sought information about when Mr Hughes would pick up heroin, so that the heroin could be stolen soon after.[2486]

5.2948. Mr Jones gave a statement to police on 4 October 1989. In that statement, he claimed that since moving to Bathurst he had only returned to Sydney once, in mid-April 1989, for a court appearance at the Kogarah Local Court.[2487] He also claimed in that statement to have never seen Mr Hughes sell drugs, and that to his knowledge Mr Hughes never kept drugs in his flat. Mr Jones admitted to knowing that Hughes had $5,000 "snookered away" for solicitors' fees with either the National Australia Bank or the St George Building Society.[2488]

5.2949. In the course of making enquiries about Mr Jones, police spoke to his girlfriend, Ms Stanton. She told police that:

a. On 3 May 1989, she had hired a car and driven to Bathurst to visit Mr Jones. On her way she was breathalysed by police and found to be over the limit;

b. On 5 May 1989 (a Friday), Ms Stanton observed that Mr Jones was suffering from heroin withdrawal symptoms. Mr Jones called in sick to work;

c. At some time after that, Ms Stanton and Mr Jones had a fight, and as a result he stormed out and drove off in his.[2489] The time of his doing so was the subject of varying evidence. According to the unsworn statement of Mr Jones, it was after 2:30pm,[2490] whereas Ms Stanton suggested it was closer to 10:30am.[2491] Mr Jones' flatmate, Mr Lance Dodd, recalled the fight being at around midday;[2492] and

d. Despite making enquiries around Bathurst, Ms Stanton did not see Mr Jones again until about 11:00am on 6 May 1989 (Saturday). At this time, he was no longer suffering from withdrawal symptoms and so it appeared he had used heroin recently.[2493]

5.2950. Ms Stanton's version of events was, to some extent, supported by: Budget car rental forms, showing the dates on which she hired a car;[2494] police records of Ms Stanton being charged with a drink driving offence; and a time sheet from Mr Jones' employer showing that he was off sick on 5 May 1989.[2495]

[2486] Exhibit 7, Tab 42, Statement of Mark Phillip Locke, 13 September 1989, [18]–[18A] (SCOI.10081.00024).

[2487] Exhibit 7, Tab 47, Statement of Ian Stuart Jones, 4 October 1989, [16] (SCOI.10081.00013).

[2488] Exhibit 7, Tab 47, Statement of Ian Stuart Jones, 4 October 1989, [12] (SCOI.10081.00013).

[2489] Exhibit 7, Tab 45, Statement of Kerrie Stanton, 29 December 1989, [9] (SCOI.10081.00028).

[2490] Exhibit 7, Tab 47, Statement of Ian Stuart Jones, 4 October 1989 (SCOI.10081.00013).

[2491] Exhibit 7, Tab 45, Statement of Kerrie Stanton, 29 December 1989, [9] (SCOI.10081.00028).

[2492] Exhibit 7, Tab 48, Statement of Lance Dodd, 6 January 1990, [8] (SCOI.10081.00038).

[2493] Exhibit 7, Tab 45, Statement of Kerrie Stanton, 29 December 1989, [10] (SCOI.10081.00028).

[2494] Exhibit 7, Tab 80, Budget car rental form, 3 May 1989 (SCOI.10081.00015).

[2495] Exhibit 7, Tab 82, Mitchell Plant Hire Time Sheet, 10 May 1989 (SCOI.10081.00034).

5.2951. Mr Jones' flatmate in Bathurst, Mr Dodd, confirmed that Mr Jones left on 5 May 1989 after a fight with Ms Stanton, that his whereabouts were unknown until the morning of 6 May 1989, and that Ms Stanton had been looking for him.[2496]

5.2952. Ronald Flower, Mr Jones' landlord, gave evidence that Mr Jones had failed to attend Mr Flower's wedding held on 6 May 1989 (Saturday). When Mr Flower returned to Bathurst on 8 or 9 May 1989, he asked Mr Jones why he hadn't attended the wedding, and Mr Jones said that he had been in Sydney.[2497]

5.2953. Ms Stanton provided police with several items of clothing belonging to Mr Jones that she had kept after they had split up in or shortly after June 1989.[2498] These were collected by Detective Constable Michael Plotecki and conveyed to the Physical Evidence Section of the NSWPF.[2499]

5.2954. On examination of the jacket, it was found that there was a tear to the inner lining of the jacket. Inside the lining was a St George Building Society passbook belonging to Mr Hughes. The last transaction in the passbook was on 21 April 1989 — that is, at least a month after Mr Jones said he had last seen Mr Hughes.[2500]

5.2955. Mr Scobie gave evidence that Mr Hughes had shown him the passbook on 3 May 1989 at Mr Hughes' apartment, only days before the discovery of Mr Hughes' body. Mr Scobie was a co-accused with Mr Hughes in a trial for offences relating to the possession and supply of heroin. Mr Scobie knew that the money in the account connected to the passbook was going to be used to pay solicitors in that trial.[2501]

5.2956. The passbook was examined for fingerprints. The partial impressions that were obtained were not suitable for identification purposes.

5.2957. Police also examined the vehicle that Ms Stanton had seen Mr Jones drive away in, for the presence of body fluids, with negative results.[2502] However, it is noted that Mr Jones sold that vehicle on 26 May 1989. At the time of that sale, the interior of the vehicle had been scrubbed and there was new carpet in the vehicle.[2503] Mr Jones told police he had sold the vehicle because it had been "wrecked", but the purchaser said she bought it in "fair condition".[2504]

5.2958. On 30 April 1990, following discovery of the passbook, Mr Jones was reinterviewed.

[2496] Exhibit 7, Tab 48, Statement of Lance Dodd, 6 January 1990, [8]–[10] (SCOI.10081.00038).

[2497] Exhibit 7, Tab 49, Statement of Ronald Flower, 14 February 1989 (misdated, likely 1990) [5] (SCOI.10081.00036); Exhibit 7, Tab 50, Statement of Ronald Flower, 31 March 1990, [6] (SCOI.10081.00037).

[2498] Exhibit 7, Tab 52, Statement of Kerrie Stanton, 5 May 1990, [5] (SCOI.10081.00029).

[2499] Exhibit 7, Tab 24, Statement of Detective Constable Michael Charles Plotecki, 2 June 1990, [15] (SCOI.10081.00011).

[2500] Exhibit 7, Tab 17, Statement of Detective Constable Samuel Khoudair, 1 March 1990, [13] (SCOI.10081.00020).

[2501] Exhibit 7, Tab 59, Statement of Gavin Scobie, 1 June 1990, [6] (SCOI.10081.00044).

[2502] Exhibit 7, Tab 18, Statement of Senior Constable David John Royds, 9 May 1990 [3]–[4] (SCOI.10081.00066).

[2503] Exhibit 7, Tab 57, Statement of Sonia Elizabeth Adams, 26 May 1990, [7] (SCOI.10081.00041).

[2504] Exhibit 7, Tab 57, Statement of Sonia Elizabeth Adams, 26 May 1990, [7] (SCOI.10081.00041).

5.2959. Mr Jones initially denied ever seeing any of Mr Hughes' bankbooks, and on being shown the passbook claimed that he had never seen it before. However, he did accept ownership of the jacket in which it was found and said, "I often put things in that jacket in the lining."[2505] When asked how the passbook could have come to be in the jacket, he replied, "[b]y the sound of things I must have picket [sic] it up [at] Hughes' place."[2506] In this interview, Mr Jones also admitted returning to Sydney on two other occasions whilst living in Bathurst, but denied ever returning to Mr Hughes' apartment.[2507]

5.2960. Mr Jones was arrested after this interview.

5.2961. Subsequent to Mr Jones being arrested, Mr Locke made a second statement to police dated 28 May 1990. In that statement, Mr Locke said that he saw Mr Jones at the Taxi Club in Darlinghurst in about the middle of February 1990. Mr Locke, Mr Jones and two others ("Cheryl" and "Yankee John") left the club to "score" in Kings Cross.[2508] On the walk, Mr Jones was alleged to have said to Mr Locke, "[y]ou know, not to [sic] many people know I killed that cunt."[2509] This second statement of Mr Locke was the subject of some attention at the trial, as outlined below.

5.2962. Janice Dowsley, a sex worker with the working name "Cheryl", gave a similar account of a night out at the Taxi Club and then Kings Cross. Ms Dowsley reported Mr Jones as saying words to the effect that only "Whackie" and Mr Locke knew about "this", followed by him saying words similar to, "Don't worry, he was a fucking faggott dog anyway and he deserved to die and he deserved everything that he got."[2510]

The defence case

5.2963. In an unsworn statement at his trial, Mr Jones denied committing the offence. He stated that:[2511]

a. On 5 May 1989, he called his boss to ask for the day off because the weather was bad, and instead went for a drive with Ms Stanton to Orange;

b. After they returned home, sometime after 2:30pm, Mr Jones and Ms Stanton got into a fight, and so Mr Jones left and went to the house of Gillian Hibbard and Scott Mason, and also spoke to Margaret Higgins who had been at their house;

c. He stayed there overnight, and returned to his house on Saturday, 6 May 1989 in the afternoon;

[2505] Exhibit 7, Tab 51, NSWPF Record of Interview, 'Interview with Ian Stuart Jones', 30 April 1990, [A224] (SCOI.10081.00012).

[2506] Exhibit 7, Tab 51, NSWPF Record of Interview, 'Interview with Ian Stuart Jones', 30 April 1990, [A225] (SCOI.10081.00012).

[2507] Exhibit 7, Tab 51, NSWPF Record of Interview, 'Interview with Ian Stuart Jones', 30 April 1990, [A130], [A235] (SCOI.10081.00012).

[2508] Exhibit 7, Tab 58, Statement of Mark Philip Locke, 28 May 1990, [9] (SCOI.10081.00025).

[2509] Exhibit 7, Tab 58, Statement of Mark Philip Locke, 28 May 1990, [10] (SCOI.10081.00025).

[2510] Exhibit 7, Tab 64, Statement of Janice Gaye Dowsley, 8 April 1992, [4], [7] (SCOI.10301.00015); Exhibit 7, Tab 75A, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 27 August 1992, 10 (SCOI.10400.00053).

[2511] Exhibit 7, Tab 77, Transcript of proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 31 August 1992, 48-54 (SCOI.10400.00055). The right of an accused person to give unsworn evidence at trial, without being liable to cross-examination, was abolished in 1994: *Crimes Legislation (Unsworn Evidence) Amendment Act 1994*.

d. On Sunday, 7 May 1989, he took Ms Stanton to Ms Hibbard's house and introduced them; and

e. He had only returned to Sydney once since moving to Bathurst, in order to attend court (which contradicts what Mr Jones said in his interview on 30 April 1990, that he had returned to Sydney twice in that period).

5.2964. Mr Jones, by his lawyers, provided alibi notices nominating Ms Hibbard, Mr Mason and Ms Higgins as alibi witnesses. All three ultimately gave evidence at trial, called by the Crown.[2512]

a. Ms Hibbard gave evidence that Mr Jones had stayed at her house on one night in 1989, either the last weekend of April or the first weekend in May, but she could not remember which;[2513]

b. Ms Higgins thought there was no occasion where she saw Mr Jones at the house on a Friday, because she was at college all day on Fridays;[2514] and

c. Mr Mason said it was a possibility that Mr Jones stayed over one Friday, but that he had problems with his memory because he was drinking heavily at the time.[2515]

5.2965. Accordingly, the alibi evidence provided some support to Mr Jones' defence but did not exclude the possibility that Mr Jones travelled from Bathurst to Sydney and back some time on the particular days in question, namely 5 and/or 6 May 1989. Mr Jones' alibi was also inconsistent with the conversation recalled by Mr Flower as to his reason for missing the wedding on 6 May 1989.

5.2966. In addition to alibi evidence, there were two other key planks to the defence case.

5.2967. First, in answer to the evidence of the location of the passbook, it was put to the investigating officer, Detective Constable Michael Plotecki, that he collected the passbook from the crime scene, and then planted it in Mr Jones' jacket.[2516] This was denied by Detective Constable Plotecki, in the exchange with defence counsel extracted below:[2517]

> *Q. Well, Mr Plotecki, I would suggest that you took that bank book on the night of the raid, the attendance on the premises and kept it in your possession?*
>
> *A. No.*

[2512] Exhibit 7, Tab 77, Transcript of proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 31 August 1992 (SCOI.10400.00055).

[2513] Exhibit 7, Tab 77, Transcript of proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 31 August 1992, 19 (SCOI.10400.00055).

[2514] Exhibit 7, Tab 77, Transcript of proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 31 August 1992, 22 (SCOI.10400.00055).

[2515] Exhibit 7, Tab 77, Transcript of proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 31 August 1992, 23 (SCOI.10400.00055).

[2516] Exhibit 7, Tab 77, Transcript of proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 31 August 1992, 45-46 (SCOI.10400.00055).

[2517] Exhibit 7, Tab 77, Transcript of proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 31 August 1992, 45-46 (SCOI.10400.00055).

Q. You put it in the lining of the jacket?

A. No, that is not the case and you are well aware there are quite a number of good reasons why that couldn't be the case.

Q. Why do you say there are a number of good reasons, what are they?

A. You'd have to credit me with a lot of foresight to do that. As I said from the start, I wasn't initially in charge. Nor, had I anticipated being in charge of this matter. The first I knew of that bank book was when Mr Khoudair gave it to me.

Q. Was it something you had accidentally kept in your possession because of carelessness on the night?

A. No. It simply couldn't be possible. You couldn't seriously suggest I'd have two police from the mounted section whom I had never met before that night and two uniform police officers with me and that I kept it to myself.

Q. Why do you suggest you wouldn't keep it?

A. Why would I keep it in that scenario?

Q. If you, as a homicide officer, kept in during the conduct of the search, why would a mounted policeman from Redfern question what were you doing?

A. I'm sorry, I can't understand why I would keep it in the first place. I was only at the initial crime scene simply as a worker. I can't understand why I would keep it in the first place. You'd be attributing me with a considerable amount of foresight on the off chance that I'd secure the brief –

Q. What if you kept it by accident and then you saw an opportunity?

A. No. I'm sorry, it doesn't ring true. I mean, for a start, you'd have to seize the opportunity. I'd [sic] just couldn't see how you would do that.

5.2968. In the cross-examination of other police witnesses, the defence highlighted the poor documentation of exhibits seized from Mr Hughes' flat at the time of the initial crime scene examination.[2518] As set out below, it appears that police simply placed all items being seized into one brown paper bag and did not make a list of all items that were seized from the premises.[2519] This opened the door for the raising of doubt as to how the passbook came to be in Mr Jones' jacket.

[2518] Exhibit 7, Tab 72, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 24 August 1992, 31–34 (SCOI.10400.00050).

[2519] Exhibit 7, Tab 72, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 24 August 1992, 30, 33 (SCOI.10400.00050).

5.2969. Secondly, the defence led evidence to the effect that Mr Locke had spoken to Mr Jones' barrister and another lawyer and had attempted to "withdraw" his statement and "set the record straight", casting doubt on Mr Jones' alleged confession on the night that they visited the Taxi Club.[2520]

5.2970. Mr Greenwood QC had been Mr Jones' barrister until he had needed to recuse himself in circumstances where he became a witness in the case. He gave evidence that Mr Jones had unexpectedly arrived at his chambers on 7 June 1991 (**7 June meeting**), in company with Mr Locke and another man (Stephen Brazel), asking to speak to him. Mr Jones said that Mr Locke wanted to talk to him about his evidence and the statements he had given to the police.[2521]

5.2971. Mr Greenwood QC had asked for the assistance of an independent criminal solicitor, Gregory Gould, who had been in the chambers of one of Mr Greenwood QC's colleagues on unrelated business. Mr Gould joined Mr Greenwood QC and Mr Locke. An attempt was made to record the conversation, but due to technical issues only the last 10-15 minutes of the conversation were captured.[2522]

5.2972. Both lawyers gave evidence to the effect that Mr Locke had told them that his second statement of 28 May 1990, relating to Mr Jones' oral "confession",[2523] had been drafted by police, that it had only been read to him in detail after he signed it, and that he was then cajoled into sticking to that as the version of events. They testified that Mr Locke had further said that Detective Constable Plotecki had stood over him and threatened him that if he did not give evidence consistent with the statement, he would "go down" for the murder himself.[2524]

5.2973. Mr Locke and Mr Gould then left Mr Greenwood QC's chambers. Mr Locke agreed to accompany Mr Gould to his office in Bondi Junction for the purpose of making a statement. Mr Gould gave evidence that, while walking from Mr Greenwood QC's chambers to his car, Mr Locke had told him that he had seen the passbook, later found in Mr Jones' jacket, on a table in the room where he was being interviewed by Detective Constable Plotecki.[2525]

5.2974. Mr Gould recalled that Mr Locke was anxious about needing to make arrangements for his three year old son. Upon arriving at his office in Bondi Junction, Mr Gould briefly went into his office, leaving Mr Locke in the foyer. When Mr Gould returned to the foyer, Mr Locke had gone. Accordingly, no statement was taken from Mr Locke.[2526]

[2520] Exhibit 7, Tab 78, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 1 September 1992 (SCOI.10400.00056).

[2521] Exhibit 7, Tab 78, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 1 September 1992, 13-14 (SCOI.10400.00056).

[2522] Exhibit 7, Tab 78, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 1 September 1992, 15-16 (SCOI.10400.00056).

[2523] Exhibit 7, Tab 72, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 24 August 1992, 19 (SCOI.10400.00050).

[2524] Exhibit 7, Tab 78, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 1 September 1992, 36 (SCOI.10400.00056).

[2525] Exhibit 7, Tab 78, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 1 September 1992, 37 (SCOI.10400.00056).

[2526] Exhibit 7, Tab 78, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 1 September 1992, 26-27 (SCOI.10400.00056).

5.2975. Mr Locke was cross-examined about this 7 June meeting. He denied saying that Detective Constable Plotecki had threatened him with the words "If Jones doesn't go, you'll go."[2527] This was damaging to Mr Locke's credibility, as Mr Locke was recorded, on the tape recording of the meeting, saying those words.[2528] Mr Locke was also recorded on the tape as saying that there was no pressure being applied on him by Mr Jones.[2529]

5.2976. Mr Locke's evidence was that prior to the 7 June meeting, Mr Jones and another man had pressured and intimidated him into retracting his statement.[2530] He admitted telling Mr Greenwood QC and Mr Gould that he had come to change his statement of his own volition, not as the result of any pressure, but he said that that was a lie, told out of a fear.[2531] He said he would have told anything to Mr Greenwood QC or Mr Gould so that he could "get out" of the meeting and away from Mr Jones.[2532] Mr Locke said that he exaggerated his concerns about needing to make arrangements for his son, who was in fact the son of his then girlfriend, in order to leave prior to making a statement.[2533]

Verdict

5.2977. On 1 September 1992, the lawyers for the Crown and for Mr Jones addressed the jury. The addresses are referred to, but not transcribed, in the transcripts provided to the Inquiry.[2534]

5.2978. On 3 September 1992, her Justice Mathews concluded her summation to the jury.[2535] No transcription of that summation is available. On the same day, the jury returned a verdict of not guilty.[2536]

5.2979. There was no legal avenue for the Crown to appeal that acquittal.[2537]

[2527] Exhibit 7, Tab 74, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 26 August 1992, 19, 42, 66 (SCOI.10400.00052).

[2528] Exhibit 7, Tab 78, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 1 September 1992, 23, 26 (SCOI.10400.00056).

[2529] Exhibit 7, Tab 78, Transcript of Proceedings, *Regina v Ian Sturat Jones*, Supreme Court of New South Wales, Mathews J, 1 September 1992, 36 (SCOI.10400.00056).

[2530] See generally, Exhibit 7, Tab 74, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 26 August 1992, 59, 70, 72 (SCOI.10400.00052).

[2531] Exhibit 7, Tab 74, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 26 August 1992, 20-23 (SCOI.10400.00052).

[2532] Exhibit 7, Tab 74, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 26 August 1992, 20, 42, 62, 66-67, 72 (SCOI.10400.00052).

[2533] Exhibit 7, Tab 74, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 26 August 1992, 51, 65 (SCOI.10400.00052).

[2534] Exhibit 7, Tab 78, Transcript of Proceedings, *R v Jones*, Supreme Court of New South Wales, Mathews J, 1 September 1992, 43 (SCOI.10400.00052).

[2535] Exhibit 7, Tab 94, Associate's Record of Proceedings, 3 September 1992 (SCOI.10400.00046).

[2536] Exhibit 7, Tab 94, Associate's Record of Proceedings, 3 September 1992 (SCOI.10400.00046).

[2537] In NSW, a limited right of appeal against acquittals was introduced in 2006: *Crimes (Appeal and Review) Amendment (Double Jeopardy) Act 2006*. The Court of Criminal Appeal may order a retrial is there is "fresh and compelling evidence" against the acquitted person, or the acquittal is "tainted" by an administration of justice offence, and a retrial is in the public interest. Neither of those circumstances are applicable to the acquittal of Mr Jones.

Police investigation

5.2980. The principal concern with the original police investigation pertains to the unsatisfactory management and documentation of the exhibits obtained from the crime scene, which enabled the defence to advance the hypothesis that police had taken the passbook from the crime scene and planted it in the lining of Mr Jones' jacket. Rather than itemising each exhibit collected from the crime scene, police placed all items being seized into one brown paper bag.

5.2981. This was poor practice in relation to management of exhibits. Each and every item ought to have been catalogued and itemised separately. The Inquiry understands this to be standard police practice today. There is no scope to remedy this deficiency in the original investigation.

5.2982. With respect to the initial investigation, the NSWPF accepted that the relevant exhibits were not contemporaneously itemised and stored separately at the time of their seizure, but submitted that that should be regarded merely as a failure to align with "modern investigative standards". The NSWPF submitted that the Inquiry had no evidence as to whether what police did in this case conformed with investigative standards at the time, and that it was "unsurprising" that less attention was paid to separate storage and documentation of exhibits in a period where DNA testing technology was in its nascent stages and record-keeping did not have the benefit of modern developments in computer technology.[2538]

5.2983. The NSWPF submitted that, in the absence of evidence as to what was regarded as "proper police practice" at that time, the Inquiry "could not sensibly criticise" the investigation on the basis of its exhibit management, and that such criticism could have no utility due to changes in police practice in the intervening period.[2539]

5.2984. I do not accept these submissions.

5.2985. There can be no genuine suggestion that the problems with what was done in this case are only apparent with the benefit of hindsight. As observed by Counsel Assisting, the problems were more than obvious at the time, given the crucial role they played in Mr Jones' defence case. The failure of that prosecution could not have been the first occasion on which the NSWPF became aware that poor itemisation and tracking of exhibits might create critical opportunities for the defence at trial.

5.2986. I consider that the exhibit management procedures employed by the NSWPF with respect to the investigation of Mr Hughes' homicide were not adequate and damaged the prospects of that investigation securing a conviction of the perpetrator. I further consider the exhibit management practices of the NSWPF in **Chapter 8**.

[2538] Submissions of NSWPF, 21 February 2023, [5], [22] (SCOI.82560).

[2539] Submissions of NSWPF, 21 February 2023, [23]–[24] (SCOI.82560).

Manner and cause of death

5.2987. There is no question as to the physical manner and cause of Mr Hughes' death. The conclusions of Dr Schwartz in that respect are unchallenged; that is, Mr Hughes died as a result of asphyxia due to strangulation with a ligature, with blunt object injury to the head being a significant contributing factor.[2540]

5.2988. The controversy in this matter concerns the identity of the person who inflicted those injuries upon Mr Hughes.

5.2989. As Counsel Assisting observed, much of the evidence as to the circumstances of Mr Hughes' death, including the time of death and who was responsible for it, was tested extensively in the course of the 1992 criminal trial of Mr Jones which resulted in his acquittal.

5.2990. Counsel Assisting submitted that, despite the acquittal, there was a considerable body of objective evidence against Mr Jones.[2541]

5.2991. In particular, Counsel Assisting submitted that the following reasonable inferences could be drawn from the presence of the passbook in Mr Jones' jacket lining:[2542]

a. That Mr Jones placed the passbook into the lining of his own jacket, in accordance with his practice; and

b. That Mr Jones stole the passbook from Mr Hughes' flat at a date after 21 April 1989, being the date of the last transaction, and probably after 1:15am on 4 May 1989 (being the time and date when Mr Scobie said he left Mr Hughes' apartment on the occasion he saw the passbook, only days before the death of Mr Hughes).

5.2992. Counsel Assisting submitted that the evidence of Mr Jones that he "must have" picked up the passbook unwittingly was unconvincing, particularly in light of his assertions that he did not return to Mr Hughes' flat after moving out in mid-March 1989.[2543] I accept this submission. It is more likely that Mr Jones lied to police when he denied ever seeing or stealing Mr Hughes' passbook and denied returning to Mr Hughes' flat after mid-March 1989.

5.2993. Likewise, Counsel Assisting submitted that the denials by Detective Constable Plotecki of the serious allegations that he planted the passbook in Mr Jones' jacket after seizing it (some time earlier) from the crime scene were objectively persuasive. The allegations of misconduct were not supported by admissible evidence, and it was also objectively unlikely that Detective Constable Plotecki would have chosen by coincidence to place the passbook in such an unusual location (within the lining of the jacket), a location which (as it happened) Mr Jones admitted he "often" used.[2544]

[2540] Exhibit 7, Tab 14, Post-mortem Report of Dr Liliana Schwartz, 23 June 1989, 2-3 (SCOI.10081.00007).

[2541] Submissions of Counsel Assisting, 6 February 2023, [116] (SCOI.82374).

[2542] Submissions of Counsel Assisting, 6 February 2023, [106] (SCOI.82374).

[2543] Submissions of Counsel Assisting, 6 February 2023, [108] (SCOI.82374).

[2544] Submissions of Counsel Assisting, 6 February 2023 [110]–[111] (SCOI.82374).

5.2994. I agree that the suggestion that the passbook was planted by Detective Constable Plotecki in Mr Jones' jacket lining was highly improbable.

5.2995. Counsel Assisting acknowledged the unreliability of Mr Locke's evidence as to Mr Jones' apparent admission, and the potential motive for Mr Locke to lie. However, as Counsel Assisting observed, Mr Locke's evidence as to Mr Jones' motivation to rob Mr Hughes for drugs was supported by Ms Stanton's evidence as to the disappearance of Mr Jones' withdrawal symptoms between 5 and 6 May 1989.[2545]

5.2996. Further, as Counsel Assisting also submitted, the attacks at the trial on the credibility and reliability of Ms Dowsley's evidence as to the same admission, based as they principally were on stereotypes as to drug users being likely to be liars, were less persuasive.[2546]

5.2997. As observed by Counsel Assisting, the evidence of Mr Jones' movements after 3 May 1989 was consistent with his possible involvement in the homicide. Ms Stanton was with Mr Jones in Bathurst from the evening of 3 May 1989, where she arrived at approximately 11:00pm. She could not account for his whereabouts from the time of a fight sometime on 5 May 1989, until about 11:00am on 6 May 1989. That window of opportunity on 5/6 May (in which Mr Jones could have travelled to Sydney and taken the passbook from Mr Hughes' residence) overlapped with at least part of the various different ranges of time during which, on the (admittedly unsatisfactory) evidence of Dr Schwartz, Mr Hughes died in his apartment.[2547]

5.2998. Counsel Assisting ultimately submitted that, notwithstanding his acquittal at trial, there was a "strong probability" that Mr Jones was responsible for the death of Mr Hughes. There is considerable force in this submission, given the significant body of material which, objectively viewed, points to Mr Jones. I agree with that submission of Counsel Assisting.

5.2999. The NSWPF did not cavil with Counsel Assisting's analysis, and agreed that there was compelling evidence to suggest that Mr Jones was the perpetrator of the offence.[2548]

5.3000. Nevertheless, there is no doubt that there is a real question as to the appropriateness of the Inquiry making a positive finding as to the guilt of a person who has been acquitted by a jury in a public forum. Among other considerations, in some instances the preservation of the reputation of a deceased person may give rise to procedural fairness considerations vis-à-vis their family members.[2549]

[2545] Submissions of Counsel Assisting, 6 February 2023 [113]–[114] (SCOI.82374).

[2546] Submissions of Counsel Assisting, 6 February 2023, [115] (SCOI.82374).

[2547] Submissions of Counsel Assisting, 6 February 2023, [107] (SCOI.82374).

[2548] Submissions of NSWPF, 21 February 2023, [19] (SCOI.82560).

[2549] Submissions of NSWPF, 21 February 2023, [18] (SCOI.82560).

5.3001. The Inquiry has been unable to identify any family members of Mr Jones to make submissions on the possibility of such a finding being made. None have come forward since the public hearing into Mr Hughes' death and the submissions made by Counsel Assisting at that time as to the "strong probability" of Mr Jones' involvement.

5.3002. There is no doubt that there is a range of telling evidence implicating Mr Jones in the death of Mr Hughes, but according to the jury which acquitted Mr Jones such evidence fell short of the criminal standard of proof ("beyond reasonable doubt"). A jury in a criminal trial is not required to provide reasons for its decision; accordingly, there is no material by which the Inquiry is able to assess the specific basis on which the jury reached its decision according to that standard.

5.3003. As I have explained above at **Chapter 1**:

a. The standard of proof which I have generally adopted, where it is necessary to do so, is not the criminal standard but rather the civil standard ("on the balance of probabilities"); and further

b. When dealing with evidence as to the possible identity of a perpetrator, even where that person is deceased, I have determined that while I will express opinions about what the evidence indicates, I will refrain from making concluded findings as to whether a specified person committed a specified offence.

5.3004. I am satisfied that the evidence against Mr Jones, which was previously admitted in a criminal trial, would also have been admissible in civil proceedings, and accordingly that I may receive it in evidence pursuant to s. 9(3) of the *SCOI Act*.

5.3005. I agree with Counsel Assisting (to whose analysis the NSWPF did not demur) that there is on the evidence a "strong probability" that it was Mr Jones who applied the ligature which resulted in the death of Mr Hughes.

Bias

5.3006. Counsel Assisting referred to academic research which has challenged the assumption apparently underpinning the BCIF, that the presence of another motive (such as robbery or profit) tells against the simultaneous existence of LGBTIQ bias.[2550] I discuss this further in **Chapter 13**.

[2550] Submissions of Counsel Assisting, 6 February 2023, [30] (SCOI.82374).

5.3007. As Counsel Assisting pointed out, such an assumption is regarded as too narrow, and as discounting the experiences of victims who are targeted because of their actual or assumed LGBTIQ identity.[2551] That is because, as was observed, LGBTIQ bias may exist when an offender "discriminatorily selects"[2552] their victim due to their LGBTIQ status, even if animus towards the victim did not motivate the crime.

5.3008. For example, an offender may seek to rob a person, but strategically choose an LGBTIQ target not because of hatred but because they perceive such a person to be "easy prey". Put another way, "[b]igotry may serve as a factor in the selection of the particular victim rather than as the catalyst to the criminal act."[2553]

5.3009. The NSWPF accepted that a particular act may be driven by multiple motivations, and that attacks on victims who were deliberately selected because of a perception that their sexuality would make them less likely to report an offence or otherwise vulnerable can properly be characterised as motivated by LGBTIQ bias.[2554]

5.3010. As Counsel Assisting further submitted, regardless of whether the perpetrator was Mr Jones or another person, there was evidence that suggested that Mr Hughes' sexuality was a factor in the selection of him as a victim of the offence, even if robbery and/or revenge were also part of a mosaic of motives. This evidence includes:

a. The sexualised elements of the crime scene. In his report dated 24 October 2022, Dr Sullivan noted that the crime scene depicted "sexualised elements, including binding, strangulation, and hooding." In Dr Sullivan's opinion, "the location and posing of the body on the bed may have suggested conscious or unconscious motivation of the offender to reflect Mr Hughes' sexuality, as they perceived it"; and

b. The graphic manner in which Mr Hughes was killed, suggestive of a desire to inflict pain and humiliation on Mr Hughes beyond what would be necessary to rob him, or even to extract revenge on him over a property dispute.

5.3011. If Mr Jones was the perpetrator, then as Counsel Assisting also submitted, there was additional specific evidence of LGBTIQ bias on his part, namely:[2555]

a. The comments that Mr Jones made to Ms Dowsley, which imply that Mr Jones excused or justified his selection of a victim on the basis that Mr Hughes was gay; and

b. Previous comments that Mr Jones had made about being fed up with Mr Hughes' apartment because it was "full of… poofters", indicating a generally derogatory attitude towards gay men.

[2551] Exhibit 2, Tab 29, Jeff Gruenwald and Kristin Kelley, 'Exploring Anti-LGBT Homicide by Mode of Victim Selection' (2014) 41(9) *Criminal Justice and Behavior* 1130, 1132, 1146 (SCOI.76824); Submissions of Counsel Assisting, 6 February 2023, [31] (SCOI.82374).

[2552] Lawrence, F. M., *Punishing hate: Bias crimes under American law* (1999, Harvard University Press), cited in Exhibit 2, Tab 29, Jeff Gruenwald and Kristin Kelley, 'Exploring Anti-LGBT Homicide by Mode of Victim Selection' (2014) 41(9) *Criminal Justice and Behavior* 1130, 1134 (SCOI.76824); Submissions of Counsel Assisting, 6 February 2023, [32] (SCOI.82374).

[2553] Submissions of Counsel Assisting, 6 February 2023, [32]–[33] (SCOI.82374).

[2554] Submissions of NSWPF, 21 February 2023, [31] (SCOI.82560).

[2555] Submissions of Counsel Assisting, 6 February 2023, [122] (SCOI.82374).

5.3012. Having regard to all those factors, Counsel Assisting submitted that it was more probable than not that LGBTIQ bias was a factor in the murder of Mr Hughes.[2556]

5.3013. The NSWPF accepted that LGBTIQ bias may have played a role in the death of Mr Hughes.[2557]

5.3014. As I have explained above at **Chapter 1**, I have reached my conclusions on the question of whether a death is a "suspected LGBTIQ hate crime death", in relation to each of the deaths under consideration, not by reference to either the civil or the criminal standard of proof but by applying a different test, namely whether there is objectively reason to suspect both that the death was a homicide and that membership of the LGBTIQ community (actual or assumed) of the deceased person, was a factor in the commission of the crime.

5.3015. In this case, I acknowledge that there is evidence suggesting that Mr Jones was motivated, at least in part, by robbery. I also acknowledge that, to the extent the evidence demonstrates that Mr Jones may have expressed anti-LGBTIQ attitudes, it does not automatically follow that such attitudes played a role in the murder of Mr Hughes.

5.3016. However, noting the recollections of Mr Locke and Ms Dowsley with respect to Mr Jones' statements to them following Mr Hughes' death, it is significant that those expressions of LGBTIQ bias were made expressly in the context of discussing Mr Hughes' death and whether Mr Hughes "deserved" to die.

5.3017. I also accept that it may be inferred from Mr Jones' statements to Mr Locke, to the effect that there would be no "big inquiry" over "another Junkie dealer", that he was to some extent strategic, if indeed it was he who chose Mr Hughes as a victim, on the basis that he considered Mr Hughes' position in society making it easier to act with impunity. However, these remarks focus on his drug dealing rather than Mr Hughes' sexuality.

5.3018. These matters must be considered together with the unusual violence of Mr Hughes' death, well beyond what could be considered necessary for a robbery, and potentially expressing conscious or subconscious sexualised elements. In my view, those circumstances indicate that Mr Hughes' killer held a special dislike of him. That dislike is not adequately explained by the evidence as to Mr Jones' intention to rob Mr Hughes or even as to the grudge he may have held against Mr Hughes for pursuing a previous theft he may have committed.

5.3019. The possibility that robbery may have been an immediate motive in the attack on Mr Hughes does not exclude the additional possibility that LGBTIQ bias may have formed part of the mosaic of motives which lay behind both the selection of Mr Hughes as a victim and the brutality of the homicide. I accept the submission of Counsel Assisting in that respect.

[2556] Submissions of Counsel Assisting, 6 February 2023, [123] (SCOI.82374).

[2557] Submissions of NSWPF, 21 February 2023, [39], [41] (SCOI.82560).

Conclusions and Recommendations

5.3020. I find that Mr Hughes died as a result of asphyxiation caused by strangulation with a ligature. In my view, there is on the evidence a strong probability that it was Mr Jones who applied that ligature.

5.3021. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in the death of Mr Hughes.

5.3022. I do not propose to make any recommendations arising from the Inquiry's consideration of Mr Hughes' death.

IN THE MATTER OF GRAHAM WILLIAM PAYNTER

Factual background

Date and location of death

5.3023. The body of Graham Paynter was found by a passer-by at the bottom of a cliff, in an area known as Shelley Beach at Tathra on the NSW South Coast, at about 5:00pm on 13 October 1989.[2558]

5.3024. Mr Paynter's time of death was estimated to be approximately 12:00am on 12–13 October 1989.

Circumstances of death

5.3025. Mr Paynter was 36 years old at the time of his death. He was the only son of Gladys and Stanley Paynter, and had three sisters. He was also an uncle and great uncle. He was affectionately known to friends and family as "Possum" and had a reputation for being "a joker and a bit of a scally wag".[2559]

5.3026. At the time of his death, Mr Paynter had lost touch with some members of his family. He was living in a caravan in Tathra owned by his father. Mr Paynter had an alcohol addiction.[2560]

5.3027. Mr Paynter was last seen alive at the Tathra Hotel shortly after 11:20pm on 12 October 1989.[2561] There are two sections of the town of Tathra, one at the level of the beach and the other at the top of an uphill drive. The Tathra Hotel is in the upper section of the town, and Mr Paynter lived in the caravan park at Andy Poole Drive in the lower, sea-level section.

[2558] Exhibit 8, Tab 8, NSWPF Report of Occurrence, 'Deceased Person', 13 October 1989 (SCOI.10935.00021).

[2559] Exhibit 9, Family Statement provided by William Towler and Andrew Bird, 1 February 2023 (SCOI.82375).

[2560] Exhibit 8, Tab 26, Statement of William Towler, 3 February 2023, [5], [6], [10] (SCOI.82355).

[2561] Exhibit 8, Tab 11, Statement of John David Roberts, 12 January 1990, [6] (SCOI.10935.00015); Exhibit 8, Tab 9, Statement of Constable Michael Wilhelm Ochs, 20 January 1990, [12] (SCOI.10935.00016).

5.3028. The cliff area above the location where Mr Paynter's body was found had a pedestrian walkway ten metres from the edge of the cliff. There was no fencing or signage near the cliff edge.[2562] About 60 metres along the walkway beyond Cliff Place was a set of stairs that led down to the beach. The stairs were frequently used by persons wishing to gain access from Cliff Place to Andy Poole Drive and the beach.[2563]

5.3029. The top of the cliff was partially covered with vegetation, which may have obscured a person's view of the steepness of the decline.[2564]

5.3030. Mr Paynter's body was discovered at the bottom of the cliff. He was lying on his right side and there were abrasions on his body and some blood on his face. His skin was cold and limbs stiff. He was lying in a semi-foetal position, and his face was suffused with blood.[2565]His jumper was pulled up over his head, but his arms were still in the sleeves. Mr Paynter's jeans were pulled down around his lower legs, and his underpants were pulled down and sitting around his upper thighs. The top button of his jeans was done up, but his fly was down.

Previous investigations

Original police investigation

Investigative steps taken by police

5.3031. After Mr Paynter's body was discovered at the base of the cliff on 13 October 1989, police officers were called and recorded their observations of the scene.[2566] Photographs were taken of Mr Paynter's body *in situ*.[2567]

5.3032. On 16 October 1989, a canvass was conducted of the residents of Cliff Place, Tathra.[2568] No one could recall any event or noise out of the ordinary. The residents spoken to by police remarked that the noise of people passing was usual at that time of night, as patrons of the Tathra Hotel used that route to the beach and Andy Poole Drive.[2569]

5.3033. Investigating police obtained statements from witnesses that revealed Mr Paynter's movements prior to his death:

a. At about 12:00pm on 12 October 1989, Mr Paynter and Russell Longmore had attended the Tathra Hotel. The owner of the hotel, John Roberts, observed that both men were intoxicated;[2570]

[2562] Exhibit 8, Tab 10, Statement of Constable Ian John Castle, 3 November 1989, [8] (SCOI.10935.00017).

[2563] Exhibit 8, Tab 9, Statement of Constable Michael Wilhelm Ochs, 20 January 1990, [10] (SCOI.10935.00016).

[2564] Exhibit 8. Tab 13, Statement of Constable Michael Callister, Crime Scene Officer, 23 January 1990, [5] (SCOI.10935.00022).

[2565] Exhibit 8, Tab 9, Statement of Constable Michael Wilhelm Ochs, 20 January 1990, [6] (SCOI.10935.00016).

[2566] Exhibit 8, Tab 9, Statement of Constable Michael Wilhelm Ochs, 20 January 1990, [6], [10] (SCOI.10935.00016); Exhibit 8, Tab 13, Statement of Constable Michael John Callister, Crime Scene Officer, 23 January 1990, [5] (SCOI.10935.00022).

[2567] Exhibit 8, Tab 9, Statement of Constable Michael Wilhelm Ochs, 20 January 1990, [7] (SCOI.10935.00016); Exhibit 8, Tab 14, Crime Scene Photographs, 13 October 1989 (SCOI.10935.00041).

[2568] Exhibit 8, Tab 9, Statement of Constable Michael Wilhelm Ochs, 20 January 1990, [11] (SCOI.10935.00016).

[2569] Exhibit 8, Tab 9, Statement of Constable Michael Wilhelm Ochs, 20 January 1990 (SCOI.10935.00016).

[2570] Exhibit 8, Tab 11, Statement of John David Roberts, 12 January 1990, [3] (SCOI.10935.00015).

b. At about 4:15pm, Mr Roberts drove Mr Paynter and Mr Longmore from Tathra to the Bega Hotel. Bega is about 18 kilometres from Tathra. They told him they were going to continue drinking;[2571]

c. At 7:30pm, Mr Paynter came to the attention of police for stealing a bottle of rum from a Bega liquor store. The investigating officer, Constable Ian Castle, described that Mr Paynter was "unsteady on his feet, had difficulty speaking, had a flushed face and smelled strongly of intoxicating liquor". Mr Paynter was arrested and charged with larceny, but released on bail that same night;[2572]

d. At 10:45pm, Mr Paynter and Mr Longmore returned to the Tathra Hotel. They were described as "loud" and "well intoxicated";[2573]

e. At about 11:20pm, Mr Roberts noticed that Mr Paynter was now alone. Mr Paynter told him that his friend had gone home, but Mr Paynter stayed to finish both his own beer and the beer left by Mr Longmore. He remained at the bar until he was asked to leave at closing time;[2574] and

f. Mr Roberts noticed that Mr Paynter was "walking unsteadily".[2575]

5.3034. Constable Castle, OIC, formed the opinion that Mr Paynter accidentally fell to his death while in a very intoxicated state, perhaps after attempting to urinate over the side of the cliff.[2576]

5.3035. From the information available to the Inquiry, it appears that no persons of interest were identified in the original police investigation.

Post-mortem investigation

5.3036. A post-mortem examination was conducted by Dr Mark Oakley on 15 October 1989.[2577] Dr Oakley observed the following injuries:[2578]

a. Dried blood on the face, opined to have come from both nostrils;

b. Multiple lacerations around 3mm in size on the forehead;

c. Extensive abrasions: linear abrasions to the left and anterior aspects of the trunk, and parchment abrasions on the right upper arm, right lateral thorax, right lumbar back, left knee, anterior thigh and lateral pelvic areas;

d. Dirt and dried plant material on the face and feet;

e. Extensive contusion (i.e., bruising) to most of the scalp, most marked on the right side, but no injury to the skull;

[2571] Exhibit 8, Tab 11, Statement of John David Roberts, 12 January 1990, [4] (SCOI.10935.00015).

[2572] Exhibit 8, Tab 10, Statement of Constable Ian John Castle, 3 November 1989, [3]–[4] (SCOI.10935.00017).

[2573] Exhibit 8, Tab 11, Statement of John David Roberts, 12 January 1990, [5] (SCOI.10935.00015).

[2574] Exhibit 8, Tab 11, Statement of John David Roberts, 12 January 1990, [6] (SCOI.10935.00015).

[2575] Exhibit 8, Tab 11, Statement of John David Roberts, 12 January 1990, [6] (SCOI.10935.00015).

[2576] Exhibit 8, Tab 10, Statement of Constable Ian John Castle, 3 November 1989, [9] (SCOI.10935.00017).

[2577] Exhibit 8, Tab 3, Medical Report of Dr Mark Oakley, 15 October 1989, 2 (SCOI.10935.00008).

[2578] Exhibit 8, Tab 3, Medical Report of Dr Mark Oakley, 15 October 1989 (SCOI.10935.00008).

f. A minor left subdural and right subarachnoid haemorrhage, associated with contusion of the cerebellar hemisphere grey matter and cerebral white matter (i.e., bruising on the brain);

g. Extensive contusion of both the left and right lower lobes of the lungs, and a superficial laceration of the right lung;

h. Copious blood in the trachea;

i. Laceration of the liver;

j. A right haemothorax (i.e., blood between the chest wall and lungs); and

k. One litre haemoperitoneum (i.e., bleeding in the space between organs and inner lining of abdominal wall).

5.3037. A blood sample taken from Mr Paynter returned a blood alcohol concentration of 0.290g per 100ml of blood.[2579]

5.3038. Dr Oakley opined that cause of death was internal bleeding and closed head injury, with possible alcohol intoxication listed as an antecedent cause.[2580]

5.3039. The time of death was estimated to be 58 hours prior to examination i.e., approximately 12:20am on 13 October 1989.[2581]

Findings at inquest

5.3040. On 27 July 1990 at Bega Local Court, Coroner Grosse dispensed with an inquest. Consistent with the opinion of Dr Oakley, cause of death was listed on Mr Paynter's death certificate as "internal bleeding and closed head injury".[2582]

Strike Force Parrabell

Bias Crimes Indicators Form

5.3041. A BCIF was completed by Strike Force Parrabell. It categorised the case as "Insufficient information".[2583]

[2579] Exhibit 8, Tab 5, Toxicology Report, 23 October 1989 (SCOI.10935.00009).

[2580] Exhibit 8, Tab 3, Medical Report of Dr Mark Oakley, 15 October 1989, 2 (SCOI.10935.00008).

[2581] Exhibit 8, Tab 3, Medical Report of Dr Mark Oakley, 15 October 1989, 2 (SCOI.10935.00008).

[2582] Exhibit 8, Tab 7, Notice of Dispensing with Inquest, 27 July 1990 (SCOI.10935.00030).

[2583] Exhibit 8, Tab 22, Strike Force Parrabell, Bias Crimes Indicators Review Form – Graham Paynter, undated (SCOI.74992).

Material obtained by Strike Force Parrabell

5.3042. The Parrabell Report records that the police files in Mr Paynter's case could not be located and that they "were either never returned to the archive or were returned and have subsequently been lost." [2584] An Investigator's Note dated 13 October 2016 indicates that further investigations made to locate the file in police holdings were unsuccessful. A media review was also conducted for relevant documents.[2585]

5.3043. In the absence of the police file, the Parrabell Report indicates that the BCIF was completed based on what was said about Mr Paynter's case in an Issue Paper relating to some 30 deaths, said to be unsolved possible LGBTIQ hate crime homicides, signed by Detective Chief Inspector John Lehmann of the UHT on 25 September 2013.[2586] Detective Chief Inspector Lehmann's one paragraph summary of the death concluded as follows:[2587]

> *The details of this death are brief, recovered from police occurrence records. No other details appear available from the Coroner's office. The occurrence entry does not mention suspicious circumstances or any indication of foul play. There is no indication that the deceased was assaulted, murdered or the victim of "gay hate" related violence.*

5.3044. Strike Force Parrabell did not obtain the coronial file. As Counsel Assisting submitted, the BCIF comprises for the most part no more than repetition of Detective Chief Inspector Lehmann's 2013 assessment.[2588]

5.3045. The NSWPF accepted that Strike Force Parrabell conducted its review with reference to a limited range of material, but submitted that "if anything, the additional information would likely have resulted in a conclusion that the case properly fell into the "No Evidence of Bias" category rather than the "Insufficient Information" category".[2589]

5.3046. Nonetheless, the limited material upon which Strike Force Parrabell based its conclusion demonstrates a failure of process. It is *irrelevant* whether the additional information would have confirmed or contradicted the original categorisation of the case. The value of any findings reached by Strike Force Parrabell is plainly affected, and indeed diminished, by the failure to obtain all the material relevant to each death.

5.3047. The categorisation of "Insufficient Information" is a reflection only of the inability of the NSWPF to reach a conclusion as to LGBTIQ bias — an inability which, in this case, was substantially affected by the NSWPF's loss of the case file.

[2584] Exhibit 1, Tab 2, NSW Police Force, *Strike Force Parrabell Final Report* (Report, June 2018) 70, Footnote 23 (SCOI.02632).

[2585] Exhibit 8, Tab 23, NSWPF Investigator's Note, 'Strike Force Parrabell', 13 October 2016, 4–5 (SCOI.82207).

[2586] Exhibit 1, Tab 2, NSW Police Force, *Strike Force Parrabell Final Report* (Report, June 2018), 70 (SCOI.02632).

[2587] Exhibit 8, Tab 21A, Extract of Detective Chief Inspector Lehmann review of 30 unsolved homicides re Graham Paynter, 25 September 2013, 3 (SCOI.82363).

[2588] Submissions of Counsel Assisting the Inquiry, 6 February 2023, [29] (SCOI.82373).

[2589] Submissions of NSWPF, 21 February 2023, [57] (SCOI.82560).

Errors in the BCIF

5.3048. At pages 3, 4 and 9 of the BCIF, the Strike Force Parrabell officers appear to have copied and pasted from the form relating to another deceased person, Peter Sheil, and failed to amend the deceased's name.[2590]

5.3049. The NSWPF submitted that this error was "regrettable", but noted that the material was not intended for public consumption, that it was "unsurprising" that rigorous proofreading had not taken place, and that their officers did not have the same writing skills as other professions, such as journalists and lawyers.[2591]

5.3050. Whilst occasional errors can be expected in any area of work, the failure to name correctly the victim of a possible hate crime in the course of a well-publicised review said to have been aimed at demonstrating to the public the seriousness with which the NSWPF regarded such matters, does not inspire confidence in the care with which this review was undertaken.

Answers to the indicators in the BCIF

5.3051. All ten indicators considered in the BCIF were answered as "Insufficient Information".

5.3052. In respect of indicator 8, "Location of Incident", the BCIF records that there is "evidence suggesting this location was known as a beat location."[2592] However, this reference seems to relate to a quote from Ms Sue Thompson, in an Investigator's Note, that she would "not rule it out" as a gay hate crime given the possibility that the area was used as a beat, as were many similar cliff and beach locations.[2593] That remark hardly rises to the level of "evidence" that the area was "known as a beat location".

5.3053. Conversely, notwithstanding that Strike Force Parrabell took the view that there was "evidence" that the location was "known as a beat location", their response in respect of the "location" indicator was "Insufficient Information", rather than "Suspected Bias Crime".[2594]

5.3054. The BCIF contains no discussion of the significance of Mr Paynter having fallen from a cliff, or of his clothes being partially removed. Under the umbrella of indicator 4, "Organised Hate Groups (OHG)", the response to the prompt "MO [modus operandi] similar to known MO of an OHG" appears to bear little or no relation to that topic. It reads:[2595]

> *No suspicious circumstances or indicators of foul place [sic] are noted in respect to PAYNTER'S death. The exact cause of death has not been established, however from the available information, it would appear*

[2590] Exhibit 8, Tab 22, Strike Force Parrabell, Bias Crimes Indicators Review Form – Graham Paynter, Undated 3, 4, 9 (SCOI.74992).

[2591] Submissions of NSWPF, 21 February 2023, [60] (SCOI.82560).

[2592] Exhibit 8, Tab 22, Strike Force Parrabell, Bias Crimes Indicators Review Form – Graham Paynter, Undated 10 (SCOI.74992).

[2593] Exhibit 8, Tab 23, NSWPF Investigator's Note, 'Strike Force Parrabell', 13 October 2016, 4–5 (SCOI.82207).

[2594] Exhibit 8, Tab 22, Strike Force Parrabell, Bias Crimes Indicators Review Form – Graham Paynter, Undated 10 (SCOI.74992).

[2595] Exhibit 8, Tab 22, Strike Force Parrabell, Bias Crimes Indicators Review Form – Graham Paynter, Undated 6 (SCOI.74992).

> *PAYNTER fell from a 50 metre high cliff at the southern end of Tathra Beach.*

5.3055. At no point is consideration given to Mr Paynter's death in the context of other known or possible LGBTIQ hate crimes involving cliffs or the undressing of victims.

5.3056. The "General Comment" sections consistently include the response that there is no indication of foul play in Mr Paynter's death, and no persons of interest were identified. The "Summary of Findings" similarly conveys the view that Mr Paynter's death was as a result of misadventure.[2596]

5.3057. The treatment of the indicators by Strike Force Parrabell is superficial. Even making allowance for the lack of information gathered by Strike Force Parrabell, there was no engagement with the possible significance of the location of the death or the state of Mr Paynter's clothing. Instead, Strike Force Parrabell simply adopted the view of Detective Chief Inspector Lehman, that "there is no indication that the deceased was assaulted, murdered, or the victim of 'gay hate' related violence".

Case Summary

5.3058. The Strike Force Parrabell Case Summary for Mr Paynter's case reads as follows:[2597]

> ***Identity:*** *Graham Paynter was 36 years old at the time of his death.*
>
> ***Location of Body/Circumstances of Death:*** *Mr Paynter's body was found at the bottom of cliffs at Tathra Beach on the NSW South Coast. He was found with his jeans around his knees and his jumper over his head. Mr Paynter had been drinking heavily with a friend during the day prior to his body being discovered. He had been arrested by police at 7.45pm on the evening before his body was located for stealing a bottle of rum from a Bega liquor store. There was no evidence that Mr Paynter had been assaulted or murdered. There was no evidence to identify any suspect or suggest any other person's involvement in Mr Paynter's death. Details of Mr Paynter's death are scarce and very limited, having been recovered predominantly from historical police occurrence pad entries.*
>
> ***Sexual Orientation:*** *Mr Paynter's sexuality could not be determined.*
>
> ***Coroner/Court Findings:*** *Coronial details could not be obtained or located.*
>
> ***SF Parrabell concluded there was insufficient information to establish a bias crime***

5.3059. The content of this Case Summary is consistent with the contents of the BCIF.

[2596] Exhibit 8, Tab 22, Strike Force Parrabell, Bias Crimes Indicators Review Form – Graham Paynter, Undated 13 (SCOI.74992).

[2597] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Graham Paynter, Undated 17 (SCOI.76961.00014).

Academic review

5.3060. The Case Summary records that the academic review categorised this matter as "No Bias". However, the Flinders section of the Parrabell Report states that the case was classified by the academic review as "Insufficient Information".[2598]

Review by the Inquiry

5.3061. The Inquiry took the following steps in the course of examining the matter.

Summonses

5.3062. A summons to the NSWPF was issued on 18 May 2022 for all documents relating to investigations by the NSWPF of the death of Mr Paynter, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Paynter. On 21 July 2022, an electronic folder of material was produced, but it was in relation to a different Graham Paynter.

5.3063. The Inquiry advised the NSWPF of this error, and a file of five documents was subsequently produced by the NSWPF, said to be in response to Summons NSWPF3 (though this summons had not requested any material in relation to Mr Paynter).[2599] This contained a CNI report in relation to Mr Paynter, as well as four documents relevant to the Strike Force Parrabell review. However, the original investigative file was not received. This is consistent with the comments in the Strike Force Parrabell report as to the file being missing.

5.3064. A second summons to the NSWPF was issued on 25 August 2022 for all NSWPF records in relation to, relevantly, Strike Force Parrabell (NSWPF12). This material was produced in tranches between 9 September 2022 and 18 November 2022. This material included the BCIF and some Investigator's Notes in relation to the review of Mr Paynter's death by Strike Force Parrabell.

5.3065. On 28 October 2022, the Inquiry issued a summons to BDM for the death certificate of Mr Paynter (BDM5). A death certificate was provided by BDM on 31 October 2022. The death certificate also provided further information regarding Mr Paynter's parents.[2600]

Interagency cooperation

5.3066. On 11 May 2022, the Inquiry issued a written request to the Coroners Court to obtain the coronial file in relation to the death of Mr Paynter. The Inquiry was advised that files relating to Mr Paynter's death were held at Bega Local Court, and a request was issued to that Court on 12 August 2022.

[2598] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Graham Paynter, 17 (SCOI.76961.00014); Exhibit 1, Tab 2, NSW Police Force, *Strike Force Parrabell Final Report* (Report, June 2018), 70 (SCOI.02632).

[2599] Exhibit 8, Tab 27, Statement of Francesca Lilly, 5 February 2023, [5]–[6] (SCOI.82356).

[2600] Exhibit 8, Tab 1, Death Certificate of Graham William Paynter, 31 October 2022 (SCOI.82151).

5.3067. Bega Local Court answered the request by production of the file on 19 August 2022.

Family members

5.3068. The Inquiry issued summonses to BDM seeking death certificates for Mr Paynter's parents (BDM5). While death certificates were not held by BDM, the Inquiry was advised that both of Mr Paynter's parents were now deceased.

5.3069. On 4 August 2022, journalist Michael Burge contacted the Inquiry. Mr Burge is a freelance journalist, author and artist who lives in the New England region of NSW. His work has covered issues of equality and LGBTIQ history, and he has reported on LGBTIQ hate crimes in regional NSW.[2601]

5.3070. Mr Burge had recently investigated and reported on the death of Mr Paynter. In the course of his investigations, he spoke to family members of Mr Paynter. Mr Burge, with the permission of Mr Paynter's family, assisted the Inquiry in making contact with Mr Paynter's sister, niece and nephews, who have been in contact with the Inquiry since January 2023. Mr Paynter's family have spoken to staff of the Inquiry and discussed their knowledge of their brother and uncle.[2602]

5.3071. On 1 February 2023, William Towler and Andrew Bird, Mr Paynter's nephews, provided a joint statement to the Inquiry, with information about Mr Paynter and the impact of his death upon his family.[2603] The Inquiry is grateful to Mr Towler and Mr Bird for their assistance.

5.3072. On 3 February 2023, Mr Towler provided a statement to the Inquiry containing information as to Mr Paynter's background and circumstances at the time of his death.[2604]

Searches for exhibits

5.3073. There is no record of exhibits being gathered by police from the scene of Mr Paynter's death.

5.3074. Tissue and blood samples were obtained from Mr Paynter at the time of the post-mortem examination. The results of the testing of these exhibits are contained in an post-mortem report and certificate from the NSW Department of Health respectively.[2605] The Inquiry did not consider that there was utility in requesting or retesting these samples.

[2601] Michael Burge, 'What will the NSW inquiry into historical gay-hate crimes mean for the bush?', *Guardian Australia* (online, 14 November 2021) <https://www.theguardian.com/australia-news/2021/nov/14/what-will-the-nsw-inquiry-into-historical-gay-hate-crimes-mean-for-the-bush>.

[2602] Exhibit 8, Tab 27, Statement of Francesca Lilly, 5 February 2023, 3, [17]–[22] (SCOI.82356).

[2603] Exhibit 9, Family Statement provided by William Towler and Andrew Bird, 1 February 2023 (SCOI.82375).

[2604] Exhibit 8, Tab 26, Statement of William Towler, 3 February 2023 (SCOI.82355).

[2605] Exhibit 8, Tab 4, Post-mortem report of Dr Christopher Lawrence, 29 November 1989 (SCOI.10935.00023); Exhibit 8, Tab 5, Toxicology Report of Thanh Duong, 23 October 1989 (SCOI.10935.00009).

Contact with OIC

5.3075. On 30 August 2023 and 18 September 2023, the Inquiry wrote to Ian Castle enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Paynter. The Inquiry did not receive a response from Mr Castle.[2606]

Professional opinions

5.3076. The Inquiry sought an independent review of the post-mortem report prepared by Dr Oakley, including as to the cause of Mr Paynter's death and the inferences that could be drawn from the positioning of his clothes.

5.3077. In that regard, the Inquiry obtained an expert report forensic pathologist Dr Iles on 11 November 2022.[2607]

Consideration of the evidence

Forensic analysis

5.3078. Dr Iles reviewed the post-mortem report prepared by Dr Oakley and expressed some concern with the quality of the post-mortem examination of Mr Paynter.

5.3079. While Dr Iles considered that the post-mortem examination was "adequate to provide a cause of death", and acknowledges changes in post-mortem practice in the decades since Mr Paynter's death, she identifies a number of limitations in the post-mortem report.[2608] In particular, she pointed to the absence of any specific description of the presence or absence of anogenital injuries, even though the state of his clothing warranted such description.[2609]

5.3080. Dr Iles considered that differentiation between injuries caused by a fall from a height, and blunt force trauma sustained prior to a fall, is "usually very difficult", and that the "presence of subtle injuries in protected areas" can assist in that regard. However, as she observed, in this case, "the description of the external injuries is limited and not systematic, and thus is silent in regard to such injuries".[2610]

5.3081. Dr Iles further considered that a full toxicology screening would also have been advisable, to exclude the presence of drugs other than alcohol.[2611]

[2606] Exhibit 66, Tabs 58-60, Letters from the Inquiry to Ian Castle, 30 August 2023-6 October 2023 (SCOI.86316; SCOI.86317; SCOI.86319).

[2607] Exhibit 8, Tab 24, Report of Dr Linda Iles, undated (provided 11 November 2022) (SCOI.82112).

[2608] Exhibit 8, Tab 24, Report of Dr Linda Iles, undated (provided 11 November 2022), 4–5 (SCOI.82112).

[2609] Exhibit 8, Tab 24, Report of Dr Linda Iles, undated (provided 11 November 2022), 5 (SCOI.82112).

[2610] Exhibit 8, Tab 24, Report of Dr Linda Iles, undated (provided 11 November 2022), 6 (SCOI.82112).

[2611] Exhibit 8, Tab 24, Report of Dr Linda Iles, undated (provided 11 November 2022), 5 (SCOI.82112).

5.3082. Despite the limitations of the post-mortem examination, it is the opinion of Dr Iles that Mr Paynter's external injuries, the crime scene photographs and the description of the topography are "in keeping with a fall from a height with multiple secondary impact points and rolling/tumbling of the deceased's body following primary impact".[2612]

5.3083. However, the absence of any details of "subtle" injuries to protected areas in the initial post-mortem led Dr Iles to consider that there is nothing in the medical findings that could differentiate between an accidental fall, suicide, or a homicidal fall in which Mr Paynter was pushed.[2613]

5.3084. In relation to the positioning of Mr Paynter's clothes, Dr Iles notes that the numerous and multi-directional abrasions to Mr Paynter's body are "in keeping with multiple secondary impacts from tumbling following a primary impact", and that this mechanism allows for the possibility of Mr Paynter's clothing being disturbed from its original position.[2614]

5.3085. She considers it possible that his upper garment could have become snagged on branches or foliage. In relation to his pants, Mr Paynter's "body habitus", or physique, was of "truncal obesity with a small waist/hips", which would allow Mr Paynter's trousers and underpants to "passively end up below their normal position in the setting of tumbling following a high energy fall." Dr Iles considers that little can be inferred from his undone fly given his state of intoxication.[2615]

5.3086. Dr Iles considers that Mr Paynter's cause of death is accurately stated as:[2616]

> *Multiple injuries sustained in a fall from [a] height in the setting of alcohol intoxication.*

5.3087. In this phrase, fall from a height does not imply a specific mechanism of fall (i.e., accident, suicide, push). "Multiple injuries" incorporates the head, chest and abdominal injuries described above.[2617]

Indicators of LGBTIQ bias

5.3088. The coronial file contains no material bearing upon whether Mr Paynter might have been a member of the LGBTIQ community.

5.3089. The Inquiry has spoken to the family of Mr Paynter, none of whom knew or considered Mr Paynter to be a member of the LGBTIQ community, although they were open to the possibility.[2618]

5.3090. As Counsel Assisting submitted, two factors might bear upon the possibility of LGBTIQ bias being a factor in Mr Paynter's death:[2619]

[2612] Exhibit 8, Tab 24, Report of Dr Linda Iles, undated (provided 11 November 2022), 6 (SCOI.82112).
[2613] Exhibit 8, Tab 24, Report of Dr Linda Iles, undated (provided 11 November 2022), 6 (SCOI.82112).
[2614] Exhibit 8, Tab 24, Report of Dr Linda Iles, undated (provided 11 November 2022), 6 (SCOI.82112).
[2615] Exhibit 8, Tab 24, Report of Dr Linda Iles, undated (provided 11 November 2022), 6 (SCOI.82112).
[2616] Exhibit 8, Tab 24, Report of Dr Linda Iles, undated (provided 11 November 2022), 7 (SCOI.82112).
[2617] Exhibit 8, Tab 24, Report of Dr Linda Iles, undated (provided 11 November 2022), 7 (SCOI.82112).
[2618] Exhibit 8, Tab 27, Statement of Francesca Lilly, 5 February 2023, [15], [18]–[19] (SCOI.82356).
[2619] Submissions of Counsel Assisting the Inquiry, 6 February 2023, [76]–[77] (SCOI.82373).

a. First, his body was found at the base of a cliff formation. Evidence before this Inquiry indicates that some cliff locations have served as outdoor beats. Coronial findings have identified pushes from cliffs as the cause, or probable cause, of a number of LGBTIQ hate-related deaths near Bondi.[2620]

b. Secondly, Mr Paynter's clothing was partly displaced, and his body, when discovered, was in a state of partial undress. In some circumstances, this could be consistent with the use of a beat or other sexual activity.

5.3091. In relation to the positioning of Mr Paynter's clothing, I agree with Counsel Assisting that this would be relevant to possible bias only if it could be inferred that Mr Paynter was undressed before (or, by an offender, after) falling from the cliff. However, having regard relevantly to the opinion of Dr Iles set out above, there is no sufficient basis for drawing that inference. Rather, it is possible, and seems likely, that his clothing became disarranged during the fall, noting in particular the analysis of Dr Iles described above.[2621]

5.3092. In relation to the possibility that the cliff in Tathra was a beat, the Inquiry has received evidence in public hearings as to the presence of outdoor beats in regional areas. Garry Wotherspoon, a historian with a particular interest in the gay history of Sydney, said: [2622]

> *The locations of outdoor beats are chosen because they fulfil necessary criteria. First, they would have to be secluded in some way if sex was to occur there; so, parks, a public toilet, quiet walkways off the beaten track, would be likely spots. Secondly, there would be something that provided a legitimate reason why men could be there casually, or a place one could easily strike up a conversation with another person – for instance, a place where one could see a scenic view, or admire a piece of statuary, or ask for a light or for the time.*

5.3093. As to Tathra in particular, Mr Wotherspoon was not aware of the existence of a beat in the town.

5.3094. Les Peterkin, a gay man with experience of beats in regional and country areas, expressed the view that, in country towns, the public toilet in the local park is quite often a beat.[2623] He also described regional or country beats existing at "lookouts".[2624]

5.3095. Ulo Klemmer, who worked as a beat outreach worker, observed that beats were very often public toilets in parks, but could also be bushland and riverbank areas.[2625]

[2620] See e.g., Exhibit 1, Tab 2, NSW Police Force, *Strike Force Parrabell Final Report* (Report, June 2018), 91 (SCOI.02632).

[2621] The NSWPF submitted that the displacement of Mr Paynter's clothing, without further evidence, ought not be considered a reliable indicator of bias crime: see Submissions of NSWPF, 21 February 2023, [53] (SCOI.82560).

[2622] Exhibit 2, Tab 1, Statement of Garry Wotherspoon, 14 November 2022, [34] (SCOI.77300).

[2623] Exhibit 2, Tab 3, Statement of Les Angus Peterkin, 14 November 2022, [30] (SCOI.77302).

[2624] Exhibit 2, Tab 3, Statement of Les Angus Peterkin, 14 November 2022, [32] (SCOI.77302).

[2625] Exhibit 2, Tab 8, Statement of Ulo Klemmer, 11 November 2022, [15] (SCOI.77307).

5.3096. The Inquiry also has evidence relating to many examples of clifftop locations that have functioned as beats — two prominent examples are the cliffs around the Bondi headland, and those at North Head near Manly.

5.3097. The NSWPF submitted that caution ought to be exercised when considering the significance of Mr Paynter's fall from a cliff, noting the absence of evidence as to the frequency of falls from clifftops as a cause of death, and referring to statistics on the frequency of deaths resulting from falls from cliffs.[2626]

5.3098. In my view, as Counsel Assisting submitted, there are reasons to doubt that the location where Mr Paynter fell was a beat. There is evidence that Cliff Place and the pedestrian pathway were well-frequented by patrons leaving the Tathra Hotel and on their way down to the stairs to the beach.[2627] The pathway would not provide a secluded place for sexual activity. Indeed, to the contrary, it may be that it would have been considered a dangerous location, given what Mr Towler regarded as the "notoriety" of the Tathra Hotel for violence in that era.[2628] Other locations within Tathra, including various public toilets, are more likely candidates for a beat, if there was one in Tathra at that time.

Police investigation

5.3099. As Counsel Assisting submitted (and the NSWPF accepted), only limited investigative steps seem to have been taken by the original police officers. Mr Paynter's death was treated by police from the outset as being the result of an accidental fall. A thorough investigation would have involved, for example, obtaining more information as to Mr Paynter's personal circumstances, and obtaining a witness statement from Mr Longmore, with whom he had been drinking on the night in question.

5.3100. Having regard to the loss of the original police file, it is not possible to reach firm conclusions as to the adequacy of the original police investigation.

5.3101. However, the loss of the original police investigative file is itself of obvious concern. This is far from the only case among those considered by the Inquiry where the original police file has been lost or cannot be located. My views as to the adequacy of police document management is dealt with at **Chapter 8** of this Report.

Manner and cause of death

5.3102. The submissions of Counsel Assisting pointed to a number of factors relevant to the circumstances surrounding Mr Paynter's death:

a. First, it is reasonable to infer that, after leaving the Tathra Hotel on Bega Street in the upper section of the town, Mr Paynter walked downwards along Cliff Place and the pedestrian walkway, towards the stairs giving access to the

[2626] Submissions of NSWPF, 21 February 2023, [51] (SCOI.82560).

[2627] Exhibit 8, Tab 9, Statement of Constable Michael Wilhelm Ochs, 20 January 1990, [10] (SCOI.10935.00016).

[2628] Exhibit 8, Tab 26, Statement of William Towler, 3 February 2023, [11] (SCOI.82355).

beach below and to the caravan park where he lived on Andy Poole Drive, as this would represent his most direct route home;

b. Secondly, there are a number of factors that make an accidental fall plausible, including:

   i. Mr Paynter's extreme intoxication, with his blood alcohol concentration of 0.29% being almost six times the legal limit for driving. This is consistent with lay opinion of witnesses as to his level of intoxication, as well as observations of his drinking on the night;

   ii. The night-time darkness, with Mr Paynter last being seen alive shortly before midnight; and

   iii. The lack of fence or barrier in the area at the top of the cliff. The cliff top was fenced following, and in response to, Mr Paynter's death;[2629]

c. Thirdly, despite the post-mortem examination being silent as to any "subtle" injuries, there were no obvious injuries which Dr Iles considered could not be explained by a fall. That is, no medical evidence suggested that a violent assault occurred prior to his death;

d. Fourthly, a canvass of witnesses near the site of Mr Paynter's death revealed no information that may indicate foul play. Similarly, there is nothing suspicious in his movements on the night prior to his death, nor any indication of a fight between Mr Paynter and any other person who may have wished to cause him harm;

e. Fifthly, there is no material that would indicate the possibility of suicide, and Mr Paynter was generally observed to be in good spirits in the lead up to his death; and

f. Finally, there is no evidence that the cliff location above Mr Paynter's body was a beat, nor that assaults on beat users or others were occurring in that location.

5.3103. Although recognising that a push from the cliff, or suicide, cannot be definitively excluded given the limited evidence available, Counsel Assisting submitted that it is more likely than not that Mr Paynter accidentally fell to his death. The NSWPF concurred.[2630]

5.3104. I accept the submissions of Counsel Assisting. I note that Dr Iles was unable to determine whether Mr Paynter's fall was a consequence of misadventure, suicide or foul play. However, on the evidence available to me, misadventure is the most likely explanation for Mr Paynter's fall.

[2629] Exhibit 8, Tab 20, 'Tathra Cliff Top is to be Fenced Off', *Bega District News* (Bega, 27 July 1990) (SCOI.10935.00029).

[2630] Submissions of NSWPF, 21 February 2023, [61] (SCOI.82560).

Bias

5.3105. In light of the likelihood that Mr Paynter's death was the result of an accidental fall, and given the analysis summarised above in respect of location of the body and the positioning of his clothing, it is unlikely that Mr Paynter's death was a homicide.

5.3106. The review conducted by the Inquiry has found no evidence of third-party involvement, nor of LGBTIQ bias.

Conclusions and Recommendations

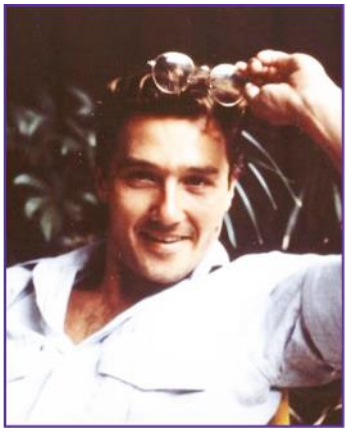
5.3107. I find that Mr Paynter died at Tathra on 13 October 1989, as a result of multiple injuries sustained in an accidental fall from a height in the setting of alcohol intoxication.

5.3108. In my view, on the evidence available to the Inquiry, there is objectively no reason to suspect that LGBTIQ bias was a factor in Mr Paynter's death.

Recommendation 2

I recommend that BDM correct the Register of Births, Deaths and Marriages pursuant to s 45(1)(b) of the *Births, Deaths and Marriages Registration Act 1995*, such that Mr Paynter cause of death is recorded as: "multiple injuries sustained in a fall from a height in the setting of alcohol intoxication".

IN THE MATTER OF SIMON BLAIR WARK



Factual background

Date and location of death

5.3109. Simon Blair Wark (known as "Blair") died between 2:00pm on 9 January 1990 and 9:30am on 10 January 1990. Mr Wark's body was found in the northern area of Sydney Harbour, 200 to 300 metres from Dobroyd Head. Personal items belonging to him were found near a cliff top at Gap Bluff in Watson's Bay, Sydney.

Circumstances of death

5.3110. Mr Wark was 28 years old when he died. He was by all accounts an intelligent, creative, likeable and kind young man. He was living in accommodation at the Pyrmont Arms Hotel, though was endeavouring to move into rental accommodation with some friends.

5.3111. In the days leading up to Mr Wark's death he had been acting in an unusual manner, characterised by psychomotor agitation and what appear to have been unjustified fears that he was in some type of danger. He had a history of depression and was taking anti-depressant medication, but on 8 January 1990 the Wark family's GP considered that he was displaying signs of "pre-psychosis".

5.3112. Mr Wark was gay, a fact which his family and friends knew.

5.3113. Mr Wark's unusual behaviour had been exhibited over a number of days leading up to his death, including on two visits to his family home in Frenchs Forest. On one of those visits, on 8 January 1990, his behaviour was of such concern that his parents called their family GP who attended on a home visit and made the observation noted above.

5.3114. Mr Wark left the family home early on the morning of Tuesday, 9 January 1990, and appears to have returned to his hotel accommodation in Pyrmont.

5.3115. At around 11:00am on that day, a person matching Mr Wark's description left a bag with some items of clothing in it at the "lost property" counter at the David Jones store in the Sydney CBD.

5.3116. Mr Wark appears to have been under the apprehension that he had an appointment with his psychologist I181 (a pseudonym) that afternoon. At around 2:00pm he attended I181's home address in Double Bay but was advised that I181 was not present. This was the last known sighting of Mr Wark.

5.3117. On the next day, Wednesday, 10 January 1990, at around 9:30am, Mr Wark's body was found floating face down in Sydney Harbour after being spotted by a passenger on a ferry travelling from Circular Quay to Manly. He was wearing blue jeans, black socks and black lace-up shoes. There was no record of clothing on his upper body.[2631]

5.3118. At 2:30pm the next day, 11 January 1990, Neil Champion (who was working at the Gap) found a pile of clothes (including a white shirt and a black leather belt) and personal property belonging to Mr Wark (including a wallet, credit cards and driver licence) on a rock platform under a ledge at a point at Gap Bluff in Watson's Bay. It appears probable that Mr Wark's body had entered the water from this location, or somewhere in its vicinity.

Previous investigations

Original police investigation

5.3119. The NSWPF investigation into Mr Wark's death was jointly undertaken by Sydney Water Police (with Constable Lisa Ford as the OIC) and the Homicide Squad office of the Regional Criminal Squad South (with Detective Constable Michael Plotecki as the OIC).

Retrieval of body

5.3120. At around 9:35am on 10 January 1990, Constable Ford and two other officers from Sydney Water Police arrived on scene at Sydney Harbour.[2632] There, they recovered Mr Wark's body and placed it onboard their vessel. They noted that the body had no sign of external injuries.[2633] Mr Wark's body was conveyed to Sydney Water Police Station and viewed by Senior Constable Egan-Lee from the Pillage Squad.[2634]

[2631] Exhibit 23, Tab 21, Statement of Constable Lisa Ford, 13 January 1990, 1 (SCOI.10022.00040); Exhibit 23, Tab 24, Statement of Constable John Cox, 11 January 1990, 1 (SCOI.00052.00019).

[2632] Exhibit 23, Tab 21, Statement of Constable Lisa Ford, 13 January 1990, 1 (SCOI.10022.00040); Exhibit 23, Tab 24, Statement of Constable John Cox, 11 January 1990, 1 (SCOI.00052.00019).

[2633] Exhibit 23, Tab 1, Report of Death to Coroner, 10 January 1990, 1 (SCOI.00052.00005).

[2634] Exhibit 23, Tab 1, Report of Death to Coroner, 10 January 1990, 1 (SCOI.00052.00005).

5.3121. The location in the water from which Mr Wark's body was retrieved by the NSWPF was not plotted on a map at the time. The best it can be pinpointed, from the description of the attending officers, is that the location was about 200 metres northeast of Dobroyd Head.[2635] The ferry master described seeing the body when his ferry was about 300 metres northeast of Dobroyd Head.[2636] No photographs were taken of the location where the body was found, nor were photos of the body taken after it was recovered. There is no statement from Senior Constable Egan-Lee in the materials provided to the Inquiry.

Discovery of property

5.3122. On the afternoon of 11 January 1990, Mr Champion found a pile of clothes and personal property under a ledge at Gap Bluff.[2637] He left the property at Gap Bluff and drove to Vaucluse Police Station to inform them of his discovery, but Police advised that they were unable to attend the scene right away.

5.3123. Mr Champion thereupon returned to the scene, collected the property, and placed it in a plastic bag.[2638] He then went back to Vaucluse Police Station, on the same day, and handed over the property to Constable Nichole Brown.[2639] The property, as described by Mr Champion, consisted of a white shirt with a small black pattern, neatly rolled up and tied with a black leather belt. Behind the shirt was a pair of metal rimmed glasses, some receipts and a small tube of ointment. All the property was wet.[2640]

5.3124. There were some discrepancies in the items of property as listed by Mr Champion and by Constable Brown.[2641] In particular, Constable Brown referred to a brown wallet, the contents of which included credit cards, Mr Wark's driver licence and $5. She also referred to a letter in the shirt pocket (not further described) and $15 loose in the plastic bag handed to her by Mr Champion. Constable Brown further noted that "[a]ll property was either wet or damp and contained sandstone sediment."[2642]

5.3125. The property was given over to Sydney Water Police, and subsequently returned to Mr Wark's family on or around 15 January 1990.[2643]

[2635] Exhibit 23, Tab 21, Statement of Constable Lisa Ford, 13 January 1990, 1 (SCOI.10022.00040); Exhibit 23, Tab 24, Statement of Constable John Cox, 11 January 1990, 1 (SCOI.00052.00019).

[2636] Exhibit 23, Tab 13, Statement of Stephen William Bird, 24 January 1990, 1 (SCOI.00052.00018).

[2637] Exhibit 23, Tab 12, Statement of Neil Andrew Champion, 14 January 1990, 1 (SCOI.00052.00021).

[2638] Exhibit 23, Tab 12, Statement of Neil Andrew Champion, 14 January 1990, 1-2 (SCOI.00052.00021).

[2639] Exhibit 23, Tab 12, Statement of Neil Champion, 14 January 1990, 1–2 (SCOI.00052.00021); Exhibit 23, Tab 25, Statement of Constable Nichole Brown, 14 January 1990, [5] (SCOI.00052.00020). The property recorded by Constable Brown was a white plastic bag containing a black and white shirt, set of keys, personal papers and receipts, a brown wallet and a man's belt which was apparently tied around the property when found.

[2640] Exhibit 23, Tab 12, Statement of Neil Champion, 14 January 1990 (SCOI.00052.00021).

[2641] The wire rimmed glasses and ointment are not noted by Constable Brown; whereas the wallet and keys are not noted by Mr Champion: see Exhibit 23, Tab 25, Statement of Constable Nichole Brown, 14 January 1990, [5] (SCOI.00052.00020); Exhibit 23, Tab 12, Statement of Neil Champion, 14 January 1990, 1 (SCOI.00052.00021).

[2642] Exhibit 23, Tab 25, Statement of Constable Nichole Brown, 14 January 1990, [6] (SCOI.00052.00020).

[2643] Exhibit 23, Tab 25, Statement of Constable Nichole Brown, 14 January 1990, [6] (SCOI.00052.00020).

Involvement of the Homicide Squad

5.3126. Detective Constable Plotecki of the Homicide Squad was first briefed in relation to Mr Wark's death on 14 January 1990, after the forensic pathologist noticed suspicious bruising on Mr Wark's neck. According to Detective Constable Plotecki, he was told the locations of Mr Wark's body and possessions, and that initial inquiries had led police to believe it was a possible suicide.[2644] Members of the Crime Scene Unit and Homicide Squad, including Detective Constable Plotecki, attended the resumed post-mortem at 5:30pm on 14 January 1990.[2645]

5.3127. According to Detective Constable Plotecki, on 15 January 1990 he made arrangements for the Police Crime Scene Unit and Constable Ford to photograph the scene at the Gap where the items of property had been found.[2646] However, Constable Ford's statements did not refer to such an attendance and there is no other record relating to it.

5.3128. The precise location where the property was found is therefore not clear. There are also no photographs of the items themselves, except the David Jones receipts and lost property receipt (which appear to have been photocopied at some point by Mr Wark's sister Rebecca Wark).[2647] Whether there was ever such an attendance by police at the Gap is discussed further below.

Concerns raised by the family

5.3129. As part of the investigation into Mr Wark's death, Constable Ford and Detective Constable Plotecki spoke to, and in certain instances took statements from, a number of witnesses. Those spoken to included family members, friends and other witnesses who saw Mr Wark in the days prior to his death, Mr Wark's treating doctors and psychiatrist, and witnesses involved in the discovery of Mr Wark's body and property. This included inquires by Detective Constable Plotecki regarding two key witnesses.

5.3130. In May 1990, Mr Wark's mother and sister wrote to the Coroner to express their concerns with the police investigation.[2648] The Coroner provided the family's letter to Constable Brown and Detective Constable Plotecki and requested that further investigations be conducted addressing the concerns raised. In June 1990, the OICs provided a report to the Coroner responding to the family's correspondence.[2649]

Police view as to manner and cause of death

5.3131. The view of Constable Ford and Detective Constable Plotecki as to the manner of Mr Wark's death was set out as follows in their report to the Coroner:[2650]

[2644] Exhibit 23, Tab 23, Statement of Detective Constable Michael Plotecki, 30 January 1990, [3] (SCOI.00052.00026).

[2645] Exhibit 23, Tab 23, Statement of Detective Constable Michael Plotecki, 30 January 1990, [4] (SCOI.00052.00026).

[2646] Exhibit 23, Tab 23, Statement of Detective Constable Michael Plotecki, 30 January 1990, [7] (SCOI.00052.00026).

[2647] Exhibit 23, Tab 53, David Jones receipt No. 2368, undated (SCOI.10022.00080); Exhibit 23, Tab 52, Scanned copy of David Jones receipts, undated (SCOI.10022.00079).

[2648] Exhibit 23, Tab 40, Letter from Enid Wark and Rebecca Wark to the Coroner, 4 May 1990 (SCOI.00052.00011).

[2649] Exhibit 23, Tab 41, Letter from Constable Lisa Ford and Detective Michael Plotecki to the Coroner, 19 June 1990 (SCOI.00052.00044).

[2650] Exhibit 23, Tab 41, Letter from Constable Lisa Ford and Detective Michael Plotecki to the Coroner, 19 June 1990, [18] (SCOI.00052.00044).

> *Despite strongly weighted evidence, which suggests suicide, Police have persevered with this inquiry, in an effort to satisfy the doubts of the family as to the circumstances surrounding the death.*

5.3132. In addition, in her statement, Constable Ford said that:[2651]

> *I feel that after extensive enquiries and statements that Simon Blair Wark took his own life by jumping from the Gap Bluff due to the completion of an eight year homosexual relationship and loneliness.*

Persons of interest and significant witnesses

5.3133. In my view, as will appear, the evidence is not such as to permit a conclusion to be reached that any known individual was involved in Mr Wark's death. However, two people who knew Mr Wark well had significant contact with him in the days leading up to his death.

5.3134. One of these men was I182 (a pseudonym) who was a Catholic priest and is now deceased.[2652] I182 was significantly older than Mr Wark. (In January 1990, I182 was 57 years old, while Mr Wark was aged 28.) They lived together over an eight-year period up until a few months prior to Mr Wark's death.[2653]

5.3135. It appears likely if not probable that Mr Wark and I182 were in a romantic and/or sexual relationship. A statement that I182 provided to the NSWPF is ambiguous about the nature of their relationship, but appears to suggest that it was not sexual. He describes it as "paternal/fraternal" and "homophiliac".[2654] He distinguished the latter term from homosexuality, and said that it involved there being a "strong attraction for a person of the same sex".[2655]

5.3136. The other man was I179 (a pseudonym), then a 30 year old man, whom Mr Wark had known for 11 years through a connection as students at the City Art Institute. In an unsigned statement, I179 provided police with a different account of the relationship between Mr Wark and I182. According to that unsigned statement, Mr Wark had a "long term affair" with I182, which had ended about six months before Mr Wark's death.[2656] According to I179, they broke up primarily because I182 would continually get drunk and "bash" Mr Wark. I179 claimed that Mr Wark would often come to his place with bruising to the face and would tell him of these bashings.[2657] I179 described Mr Wark as "heartbroken" over the breakup.[2658]

[2651] Exhibit 23, Tab 22, Statement of Constable Lisa Ford, 24 January 1990, 3 (SCOI.00052.00024).

[2652] Exhibit 23, Tab 14A, Death Certificate of I182, 5 July 2006, (SCOI.73940).

[2653] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [4]–[5] (SCOI.00052.00028).

[2654] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [5], [7] (SCOI.00052.00028).

[2655] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [7] (SCOI.00052.00028).

[2656] Exhibit 23, Tab 15, Statement of I179, 29 January 1990, [13] (SCOI.00052.00030).

[2657] Exhibit 23, Tab 15, Statement of I179, 29 January 1990, [13] (SCOI.00052.00030).

[2658] Exhibit 23, Tab 15, Statement of I179, 29 January 1990, [13] (SCOI.00052.00030); Exhibit 23, Tab 23, Statement of Detective Constable Michael Plotecki, 30 January 1990, [19] (SCOI.00052.00026).

5.3137. According to his unsigned statement, I179 himself had had close involvement with Mr Wark in the lead up to his death. I179 and his girlfriend, along with Mr Wark, had agreed to move into a shared flat together in Potts Point.[2659] Mr Wark was in the process of trying to obtain money for his share of the upfront rental costs, and the issue of moving into the flat featured prominently in his thoughts and the fears he expressed in the days before his death (see further in this regard below).

5.3138. On 17 January 1990 (a week after Mr Wark's death but apparently before I179 became aware of it), I179 sent a letter to Mr Wark to his address at the Pyrmont Arms Hotel.[2660] The letter is somewhat rambling and incoherent, consistent with references made in it by I179 to his drug use at the time. I179 was evidently asked about the letter at the time his unsigned statement was prepared.[2661] The contents of the letter suggest that I179 had heard Mr Wark discuss the topic of suicide on occasions, with specific reference to "jumping" as a means of suicide, as referred to in his unsigned statement.[2662] The letter also indicates that I179 was disappointed that Mr Wark had not turned up to the planned arrangement with the real estate agent and that consequently their plan to move had not gone ahead.

5.3139. Overall, I consider that the letter tends to support the reliability of I179's unsigned statement, the contents of which provide context to, and are consistent with, those aspects of the letter.

Post-mortem examination

5.3140. Mr Wark's body was first examined by forensic pathologist Dr Peter Bradhurst on the morning of 14 January 1990. However, the post-mortem was stopped after what might have been deep seated bruising was observed on Mr Wark's neck. The suspicion this aroused appears to have been cause for Dr Bradhurst to arrange for the Homicide Squad to be contacted.[2663]

5.3141. Dr Bradhurst resumed his examination at 5:30pm that day.[2664] Dr Bradhurst noted a small number of relatively minor external injuries, including bruising to the left side of the face and upper neck, and along the right side of the body. Dr Bradhurst found multiple severe internal injuries, including cracks, fractures and/or lacerations to the neck, spine, ribs, pelvis, liver and spleen, and haemorrhage to the heart, lungs, spine, thyroid, adrenals and one kidney.[2665]

[2659] Exhibit 23, Tab 15, Statement of I179, 29 January 1990, [6] (SCOI.00052.00030).

[2660] Exhibit 23, Tab 16, Letter from I179 to Simon Wark, 17 January 1990 (SCOI.82834).

[2661] Exhibit 23, Tab 15, Statement of I179, 29 January 1990, [15]–[16] (SCOI.00052.00030).

[2662] Exhibit 23, Tab 15, Statement of I179, 29 January 1990, [10], [16] (SCOI.00052.00030).

[2663] Exhibit 23, Tab 22, Statement of Constable Lisa Ford, 24 January 1990, 3 (SCOI.00052.00024); Exhibit 23, Tab 23, Statement of Detective Constable Michael Plotecki, 30 January 1990, [3] (SCOI.00052.00026).

[2664] Exhibit 23, Tab 7, Post-mortem report of Dr Peter Graham Bradhurst, 24 May 1990, 1–5 (SCOI.00052.00007). See also Exhibit 23, Tab 22, Second statement of Constable Lisa Ford, 24 January 1990, 3 (SCOI.00052.00024); Exhibit 23, Tab 23, Statement of Detective Constable Michael Plotecki, 30 January 1990, [3] (SCOI.00052.00026); Exhibit 23, Tab 26, Statement of Constable Kevin Stewardson, 27 March 1990, 1 (SCOI.00052.00037).

[2665] Exhibit 23, Tab 7, Post-mortem report of Dr Peter Graham Bradhurst, 24 May 1990, 1–5 (SCOI.00052.00007).

5.3142. Dr Bradhurst considered the direct cause of death to be "multiple injuries" and the date of death to have been "about 4½ to 4¾ days previously".[2666] Since the post-mortem commenced in the morning but appears not to have been completed until late in the afternoon on 14 January, this would accord with the death having occurred late on 9 January or in the early hours of 10 January 1990.

5.3143. Toxicology testing found tricyclic antidepressants in Mr Wark's blood, liver, stomach and bile, consistent with the low level of his prescribed anti-depressant medication. No blood alcohol was detected.[2667]

5.3144. Dr Bradhurst conducted a reexamination of the body on 17 January 1990. He considered the bruising to the neck and facial areas to be superficial, with no underlying subcutaneous tissue damage.[2668]

5.3145. According to the police officers who attended the post-mortem, Dr Bradhurst concluded that the injuries were consistent with having fallen from a great height and that there were no suspicious circumstances surrounding his death. He did not consider the bruising to the neck to be suspicious.[2669]

5.3146. In addition, a handwritten memorandum, bearing the initials of Dr Bradhurst, was produced to the Inquiry from the file held by DOFM. It was not among the material produced to the Inquiry by the NSWPF. The memorandum appears to be a record of Dr Bradhurst's contact with a "Sergeant Ashley" at Sydney Water Police on 16 January 1990. The memorandum reads as follows:[2670]

> *16/1 D/W Sgt ? Ashley OIC at time of shift.*
>
> *Dobroyd Head (Point) forms part of a triangle with Sth and Nth Heads forming entrance into Sydney Harbour.*
>
> *If tide is running in it is a common place for "Gap" bodies to be found. If found up to 10-12 hours following fall, bodies may appear fairly fresh and show little in way of immersion.*

Exhibits: Availability and testing

5.3147. During the post-mortem examination of Mr Wark, samples of scalp and pubic hair, nail clippings, and anal and perianal swabs and smears were taken. No record was produced to the Inquiry indicating that these samples were retained.

5.3148. When producing their file, DOFM advised the Inquiry that any biological samples would have been handed over to the NSWPF at the time of post-mortem and, thus, that any records relating to the testing of these samples would be held by the NSWPF.[2671]

[2666] Exhibit 23, Tab 7, Post-mortem report of Dr Peter Graham Bradhurst, 24 May 1990, 7 (SCOI.00052.00007).

[2667] Exhibit 23, Tab 6, Toxicology report, 1 May 1990 (SCOI.00052.00009).

[2668] Exhibit 23, Tab 7, Post-mortem Report of Dr Peter Graham Bradhurst, 24 May 1990, 5 (SCOI.00052.00007).

[2669] Exhibit 23, Tab 22, Statement of Constable Lisa Ford, 24 January 1990, 3 (SCOI.00052.00024); Exhibit 23, Tab 23, Statement of Detective Constable Michael Plotecki, 30 January 1990, [5] (SCOI.00052.00026).

[2670] Exhibit 23, Tab 47, Handwritten Memorandum referring to "Gap" bodies, 16 January 1990 (SCOI.74823.00019).

[2671] Exhibit 23, Tab 67, Statement of Caitlin Healey-Nash, 8 May 2023, [7] (SCOI.82558).

5.3149. These samples did not appear in the material produced by the NSWPF to the Inquiry. The NSWPF informed the Inquiry that, following extensive searches and enquiries within the NSWPF and with other agencies, they could not locate the samples or any documents relating to the samples.[2672]

5.3150. I note, as was submitted by Counsel Assisting, that the possibility that these samples would have retained any third party DNA may have been diminished by the extended period during which Mr Wark's body was immersed in water.

5.3151. Further, there is no record indicating what happened to the clothing which was on Mr Wark's body when it was found (jeans, socks and shoes). The clothing and other items located at the Gap (including shirt, belt and glasses) were returned to the family without being tested.[2673]

5.3152. However, the utility of any forensic testing now, were it possible, is speculative given that there is no evidence indicating that Mr Wark was the subject of an assault at the time of, or shortly prior to, his death.

Findings at inquest

5.3153. Deputy State Coroner Hand dispensed with a formal inquest on 30 July 1990.[2674] An entry on the coronial file dated 12 February 1990 reads as follows:[2675]

> *Brief and investigation complete seems certain suicide. Father fears suspicious circumstances. When [Post Mortem] arrives get [Constable] to check with father if attitude changed if not arrange for him to attend and read brief. … [Evidence] homosexual, drug / alcohol user, depression, broken relationship, talk of suicide, talk of 'triad' explained. I would recommend [Dispense].*

5.3154. A note made next to this recommendation states "Accepted" and is signed, evidently by the Coroner, and dated 30 July 1990.[2676] I accept the submission of Counsel Assisting that the relevant notations speak for themselves in relation to the view taken by the Coroner; namely, that the death was a suicide and that an inquest was unnecessary.

5.3155. Mr Wark's death certificate records the date of his death as 9 January 1990, the place of death as "Waters off Dobroyd Head, Sydney Harbour", and the cause of death as "Multiple Injuries."[2677]

[2672] Exhibit 23, Tab 36A, Statement of Detective Sergeant Neil Sheldon, 19 January 2023, [10] (SCOI.82332).

[2673] See Exhibit 23, Tab 11, Statement of Rebecca Sharon Wark, 18 March 1990, [13]–[14] (SCOI.00052.00035).

[2674] Exhibit 23, Tab 37, Coroners Court summary sheet, undated (SCOI.00052.00001).

[2675] Exhibit 23, Tab 38, Inquest running sheet, undated (SCOI.00052.00002).

[2676] Exhibit 23, Tab 38, Inquest running sheet, undated (SCOI.00052.00002).

[2677] Exhibit 23, Tab 8, Death Certificate of Simon Blair Wark, 13 August 1990 (SCOI.74040).

Strike Force Parrabell

5.3156. Unusually, there was some degree of engagement by the NSWPF officers working on Strike Force Parrabell with a family member of the deceased person, in this case Mr Wark's sister, Rebecca Wark. This came about because sometime prior to 17 June 2016, Ms Wark had seen a newspaper report in relation to the review that was to be conducted and made telephone contact with the NSWPF.[2678]

5.3157. Emails between Strike Force Parrabell officers indicated that Ms Wark advised the NSWPF of concerns that she had about the extent of the original investigation, the fact that there had been no coronial inquest, and that Mr Wark's death may have been too readily determined to be a suicide. Her primary concern was to see that the matter was "properly investigated".[2679]

5.3158. Strike Force Parrabell's contact with Ms Wark seems to have primarily involved police obtaining documentation about the original investigation from Ms Wark, as Strike Force Parrabell was initially unable to locate any of the investigative or coronial files.[2680]

5.3159. On 7 September 2016, an officer working on Strike Force Parrabell asked Ms Wark a number of questions which appear to have been aimed at eliciting information to help officers answer questions in the BCIF. This included questions such as whether or not Mr Wark had any particular bodily markings or tattoos, and whether the date of his death was of any particular significance.[2681]

Bias Crimes Indicators Form

5.3160. All ten indicators in the BCIF were answered "No evidence of bias crime", which is also the overall categorisation of the case in the "Summary of Findings" box. [2682]

5.3161. Counsel Assisting submitted that the BCIF does not provide a useful framework for considering whether or not Mr Wark's death may have been an LGBTIQ hate crime, given that it assumes the existence of a known person of interest.

5.3162. The NSWPF responded:[2683]

> *Counsel Assisting is perhaps correct to say that the BCIF is not well designed to consider whether or not Mr Wark's death may have been an LGBTIQ hate homicide (CA, [38]). But that is not because it "assumes the existence of a known person of interest" (a complaint which is relevant to only some of the indicators in any event). Rather, it is because Mr Wark's death was very clearly not a homicide, let alone a bias-motivated homicide. No doubt, SF Parrabell officers could have formed a conclusion in relation to Mr Wark's death without recourse to potential*

[2678] Exhibit 23, Tab 28, Email from Craig Middleton to Cameron Bignell, 17 June 2016, 1 (NPL.0115.0002.1440).

[2679] Exhibit 23, Tab 28, Email from Craig Middleton to Cameron Bignell, 17 June 2016, 1 (NPL.0115.0002.1440).

[2680] Exhibit 23, Tab 28, Email from Craig Middleton to Cameron Bignell, 17 June 2016, 1 (NPL.0115.0002.1440); Exhibit 23, Tab 30, Email from Cameron Bignell to Kathleen Collins, 22 July 2016, 1 (NPL.0115.0002.3353); Exhibit 23, Tab 31, Email from Cameron Bignell to Craig Middleton, 16 August 2016, 1 (NPL.0115.0002.3426).

[2681] Exhibit 23, Tab 33, NSWPF Investigator's Note, 'Information provided by Rebecca Wark', 9 September 2016, 1 (SCOI.32019).

[2682] Exhibit 23, Tab 34, Strike Force Parrabell, Bias Crimes Indicators Review Form – Simon Blair Wark, Undated 17 (SCOI.74996).

[2683] Submissions of NSWPF, 1 June 2023 [79] (SCOI.83645).

> *indicators of bias. That they are now criticised for adopting a diligent approach and nevertheless considering the possible application of potentially relevant factors is surprising.*

5.3163. I reject that submission. First, Counsel Assisting did not in the least "criticise [Strike Force Parrabell] for adopting a diligent approach". Secondly, and more fundamentally, the observation made by Counsel Assisting about the BCIF form itself is in my view a reasonable one. The assertion by the NSWPF, that Mr Wark's death was "very clearly not a homicide", even if that were considered to be so, has no bearing on the adequacy or suitability of the form.

5.3164. The NSWPF further submitted that "[d]espite reaching the same ultimate conclusion as SF Parrabell", Counsel Assisting made a number of criticisms of Strike Force Parrabell's review of Mr Wark's death and that a number of those criticisms were "wholly unwarranted".[2684]

5.3165. I reject that submission also, as outlined in the following paragraphs. The mere fact that Counsel Assisting reached, by quite different means and after far more detailed consideration, an ultimate conclusion which was similar to that of Strike Force Parrabell, has no bearing on the adequacy of the methodology adopted by Strike Force Parrabell.

Reliance on I181's view

5.3166. First, Counsel Assisting noted that the BCIF twice refers to "Wark's psychologist" (that is, I181) being of the opinion that "Mr Wark suicided himself as a result of depression and loneliness",[2685] in support of its categorisation of the case as "no evidence of a bias crime".[2686] Counsel Assisting submitted that the uncritical acceptance of I181's view demonstrated a limited level of analysis being applied to the evidence. Counsel Assisting noted that I181 was not a medical doctor (she was, rather, a clinical psychologist), had very limited contact with Mr Wark and was potentially a witness to events that immediately preceded his death. By contrast, the BCIF overlooked the assessment of the GP who saw Mr Wark on 8 January 1990, namely that Mr Wark was suffering from "pre-psychosis".[2687]

5.3167. In response, the NSWPF submitted that "Counsel Assisting appears to be labouring under a misapprehension of the training and function of clinical psychologists" and that "the diagnosis and treatment of mental health conditions such as depression is a central function of clinical psychologists such as [I181]".[2688] The NSWPF further submitted that while I181's contact with Mr Wark was somewhat limited, there was no reason to doubt the correctness of the conclusions she reached as to his mental health condition (which, it was asserted by the NSWPF, had been confirmed as likely to have been appropriate by Dr Danny Sullivan, a forensic psychiatrist engaged by the Inquiry).

[2684] Submissions of NSWPF, 1 June 2023 [77] (SCOI.83645).

[2685] Exhibit 23, Tab 32, Strike Force Parrabell, Bias Crimes Indicators Review Form - Simon Blair Wark, Undated 15 (SCOI.74996).

[2686] Submissions of Counsel Assisting, 22 May 2023 [39] (SCOI.83197).

[2687] Exhibit 23, Tab 23, Statement of Detective Constable Plotecki, 30 January 1990, [22] (SCOI.00052.00026).

[2688] Submissions of NSWPF, 1 June 2023 [80] (SCOI.83645).

5.3168. I accept the submissions of Counsel Assisting in relation to Strike Force Parrabell's reliance of I181's opinion in completing the BCIF. I agree that the BCIF was overly reliant on I181's opinion in its characterisation of the case. Moreover, Dr Sullivan did not "confirm as appropriate" the views of I181. To the contrary, he considered that Mr Wark's mental state was "consistent with a psychotic episode", and that, although there was a pre-existing history of depression, in Mr Wark's final days there were "no relevant signs or symptoms of persisting mood disorder".

5.3169. But in addition, the submission of the NSWPF rather misses the point. Counsel Assisting's point was not to attack I181's professional status or ability to proffer an opinion concerning a mental health diagnosis. Rather, it was to point out that the BCIF appeared to uncritically rely on I181's view that "Mr Wark suicided himself as a result of depression and loneliness",[2689] when the evidence overall actually suggested that the relevant precipitating mental state was his developing psychosis.

Inaccuracies in BCIF

5.3170. Secondly, Counsel Assisting submitted that the reliance on I181's opinion in the BCIF, in circumstances where Strike Force Parrabell's methodology did not involve the obtaining of independent expert opinion, resulted in the BCIF adopting evidence that is inaccurate. For instance, I181 referred to Mr Wark being on "strong doses" of anti-depressants.[2690] This is contrary to expert forensic psychiatric opinion obtained by the Inquiry that characterises Mr Wark's dose as "low but effective".[2691]

5.3171. In response, the NSWPF submitted that it was beyond the scope and resources of Strike Force Parrabell to seek independent expert opinion to assess the analysis of I181 and Dr Sleep (who referred Mr Wark to I181). However, this overlooks the terms of Dr Sleep's referral letter to I181, which was available to Strike Force Parrabell, which did not describe the prescription dosage as "strong".

5.3172. It is appreciated that recourse to expert evidence was beyond the scope of what Strike Force Parrabell chose to confine itself to, namely a paper review. However, this serves to highlight a broader problem with the methodology of Strike Force Parrabell: because it was only a paper review, any factual inaccuracies in those historical papers, which underpinned its own assessments and/or those of the original investigation, were unlikely to be picked up.

References to suicide

5.3173. Thirdly, the BCIF repeatedly referred to comments Mr Wark is said to have made, including comments about suicide. For example, the BCIF states that:[2692]

[2689] Exhibit 23, Tab 20, Letter from I181 to Coroner, 12 January 1990, 2 (SCOI.00052.00022).

[2690] Exhibit 23, Tab 32, Strike Force Parrabell, Bias Crimes Indicators Review Form – Simon Wark, Undated 1, 2, 4, 17 (SCOI.74996).

[2691] Exhibit 23, Tab 64, Report of Dr Danny Sullivan, 24 October 2022, [28] (SCOI.82114).

[2692] Exhibit 23, Tab 32, Strike Force Parrabell, Bias Crimes Indicators Review Form – Simon Wark, Undated 6 (SCOI.74996).

> *Comments and behaviour made by Wark in the days leading up to his death show Wark was in a state of depression. Wark often spoke with witnesses about his thoughts on suicide.*

5.3174. Counsel Assisting submitted that the implicit assumption regarding Mr Wark's "state of depression" (i.e. that his "depression" was associated with his "suicide") was not based on any expert evidence, and failed to consider or appreciate that his mental condition at the time immediately before his death was characterised more by symptoms of psychosis rather than depression (as observed by the family GP, Dr Marriott, on 8 January 1990 and outlined below).

5.3175. As Counsel Assisting submitted, the reference to Mr Wark "often" speaking to witnesses about his thoughts on suicide appeared to rest only on evidence that he had discussed such matters on some occasions with I182 and I179. However, to say that someone had discussed their thoughts on suicide at one time or another is a different matter to someone exhibiting suicidal ideation at or near the time of death. There was not, in the material considered by Strike Force Parrabell, any indication that Mr Wark was exhibiting suicidal ideation, as such, around the time of his death.

5.3176. The NSWPF did not make any submissions in response to these matters.

Reliance on evidence of I179

5.3177. Fourthly, Counsel Assisting submitted that the BCIF also placed heavy reliance on the account given by I179,[2693] and that (notwithstanding the observations made at above) the appropriateness of this may be questionable given that I179 was not prepared to sign his statement.

5.3178. In response, the NSWPF submitted that the "criticism of SF Parrabell's reliance on the unsigned statement of [I179] is unjustified".[2694] The NSWPF further submitted:[2695]

> *Constable Plotecki's statement explains that [I179] refused to complete his statement after becoming upset during the interview in response to a question as to whether he was, himself, gay and subsequently receiving legal advice from Redfern Legal. Such a turn of events is unsurprising in circumstances where [I179]'s statement was replete with admissions in relation to his own drug use. As is apparent from those admissions, the statement appears to have been made candidly. There is no reason, on the face of it, for SF Parrabell officers to regard the observations in [I179]'s statement regarding Mr Wark's suicidality as inherently unreliable, particularly in circumstances where they aligned with other evidence as to the circumstances surrounding Mr Wark's death.*

[2693] Exhibit 23, Tab 32, Strike Force Parrabell, Bias Crimes Indicators Review Form – Simon Wark, Undated 2, 11, 12, 13, 16, 17 (SCOI.74996).

[2694] Submissions of NSWPF, 1 June 2023 [82] (SCOI.83645).

[2695] Submissions of NSWPF, 1 June 2023 [82] (SCOI.83645).

5.3179. I agree that I179's statement appears to have been made candidly and does not seem "inherently unreliable". Nevertheless, I agree with the submission of Counsel Assisting that—in circumstances where Strike Force Parrabell was only conducting a paper review—I179's evidence should have been approached with more caution than appears to have been the case, given that he featured quite prominently in contact with Mr Wark over his final days and that his statement had not been signed.

Case Summary

5.3180. The Case Summary reads as follows:[2696]

> ***Identity:*** *Simon Blair Wark was 28 years old at the time of his death.*
>
> ***Personal History:*** *Mr Wark was employed as a Technical Officer with the City Art Institute. He was residing at The Pyrmont Arms Hotel, Pyrmont.*
>
> ***Location of Body/Circumstances of Death:*** *Mr Wark's body was located floating in Sydney Harbour near Dobroyd Head. The Post Mortem examination revealed that Mr Wark sustained multiple fractures to his spinal column, left rib cage and pelvis. Mr Wark's injuries were consistent with a fall from height. Property belonging to Mr Wark was located on the top of cliffs at The Gap, Watsons Bay. Evidence suggested that Mr Wark committed suicide. No suspects or other persons were identified as being involved in Mr Wark's death.*
>
> ***Sexual Orientation/Psychological Health:*** *Mr Wark identified as gay. A psychologist had diagnosed Mr Wark with depression for which he was prescribed strong antidepressant medication.*
>
> ***Coroner/Court Findings:*** *The Deputy State Coroner found no suspicious circumstances surrounding the death of Mr Wark and dispensed with a formal inquest.*
>
> ***SF Parrabell concluded there was no evidence of a bias crime***

5.3181. The content of the case summary is in keeping with the comments made in the BCIF in relation to Mr Wark's death.

Academic review

5.3182. The academic review categorised the case as "no bias".[2697]

Review by the Inquiry

5.3183. The Inquiry took the following steps in the course of examining the matter.

[2696] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Simon Blair Wark, 19 (SCOI.76961.00014).

[2697] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Simon Blair Wark, 19 (SCOI.76961.00014).

Summonses

NSWPF

5.3184. A summons was issued to the NSWPF on 18 May 2022 for all documents relating to investigations by the NSWPF of the death of Mr Wark, including certain prescribed categories of information identified at (1)(a) to (j) of the summons. That summons also called for any other material held or created by the UHT in relation to the death of Mr Wark (NSWPF1). In response to this summons, a hard copy file was produced relating to the investigation of the matter in 1990.

5.3185. In addition, a small number of documents in the form of emails and notes relating to Strike Force Parrabell's consideration of Mr Wark's death in 2016 were also produced to the Inquiry in response to a summons relating to Strike Force Parrabell (NSWPF12).

5.3186. A second summons to the NSWPF was issued on 20 December 2022 requesting all records and results relating to the biological samples taken at the post-mortem examination on 14 January 1990, namely of scalp and pubic hair, nail clippings from both hands, and anal and perineal swabs and smears (NSWPF47).[2698] On 20 January 2023, the NSWPF advised (by a statement of Detective Sergeant Neil Sheldon dated 19 January 2023) that it did not hold any material responsive to that summons.[2699]

DOFM

5.3187. A summons to DOFM was issued on 22 August 2022 for all records held in relation to Mr Wark, including photographs, CT images and/or notes relevant to his post-mortem on 14 January 1990 and reexamination on 17 January 1990 (DOFM1).[2700]

5.3188. On 11 October 2022, the DOFM file for Mr Wark was produced. This file included several new and relevant documents, including an interim post-mortem report, AIDS and Hepatitis B screening results, a memorandum by Dr Bradhurst of a discussion with a police officer concerning bodies found in the vicinity of Dobroyd Head, and diagrams of Mr Wark's external injuries.[2701]

5.3189. At the time of production, Forensic Medicine also advised that the test results for biological samples taken at post-mortem were handed over to the NSWPF, and that Forensic Medicine did not subsequently receive those results back and has no record of them.

[2698] Exhibit 23, Tab 35A, Summons to NSWPF (NSWPF47), 20 December 2022 (SCOI.82504).

[2699] Exhibit 23, Tab 36A, Statement of Detective Sergeant Neil Sheldon, 19 January 2023, [10] (SCOI.82332).

[2700] Exhibit 23, Tab 43A, Summons to the Department of Forensic Medicine (DOFM1), 22 August 2022, (SCOI.82197).

[2701] See Exhibit 23, Tab 45, AIDS/ Hep B Screening, 12 January 1990 (SCOI.74823.00012); Exhibit 23, Tab 46, Interim post-mortem report of Dr Peter Graham Bradhurst, 14 January 1990 (SCOI.74823.00022); Exhibit 23, Tab 47, Handwritten Memorandum referring to "Gap" bodies, 16 January 1990 (SCOI.74823.00019); Exhibit 23, Tab 48, Diagram of external injuries, 17 January 1990 (SCOI.74823.00021).

BDM

5.3190. A summons to BDM was issued on 23 August 2022 requesting Mr Wark's death certificate. On 26 August 2022, this death certificate was produced.[2702]

5.3191. A further summons to BDM was issued on 16 September 2022 requesting the death certificate for I182. This certificate was produced on 20 September 2022.[2703]

Catholic Dioceses

5.3192. Additionally, as a result of summonses issued on 29 and 31 March 2023, the Inquiry obtained material from the Catholic Archdiocese of Sydney and the Catholic Diocese of Armidale in relation to I182.[2704]

Woollahra Municipal Council and the National Parks and Wildlife Services

5.3193. Following the documentary tender hearing into Mr Wark's death, on 1 August 2023 summonses were issued to Woollahra Municipal Council and the National Parks and Wildlife Services (**NPWS**) for any records depicting the extent, nature and location of fencing installed along the cliff line at Gap Bluff as at January 1990 (WMC2 and NPWS1).[2705]

5.3194. It emerged, through correspondence with Woollahra Municipal Council and documents produced by the NPWS, that the relevant area of coastal walk and fencing at Gap Bluff is managed by the NPWS and not by the Council.[2706]

5.3195. The material provided to the Inquiry by the NPWS suggested that as of early 1990, tenders were being sought for the construction of a coastal pathway through the relevant area of Gap Bluff.[2707] The manner in which the pathway proposal was described suggested that safety fencing was to be installed as part of the process (implying that there was not pre-existing fencing).

5.3196. However, the associated diagrams appeared to indicate that at least in some parts of the area immediately north of Gap Bluff there was a degree of pre-existing fencing that was to be removed and replaced.[2708] There also appeared to have been fencing in the area to the south of Gap Bluff that was maintained by Woollahra Council. This fencing consisted of green "mesh" and appeared to be one metre or less in height.[2709]

[2702] Exhibit 23, Tab 8, Death Certificate of Simon Blair Wark, 13 August 1990 (SCOI.74040).

[2703] Exhibit 23, Tab 14A, Death Certificate of I182, 5 July 2006 (SCOI.73940).

[2704] Exhibit 23, Tab 67, Statement of Caitlin Healey-Nash, 8 May 2023, [9]–[12] (SCOI.82558).

[2705] Exhibit 23, Tab 70A, Summons to produce (summons NPWS1), 1 August 2023 (SCOI.85463); Exhibit 23, Tab 29, Supplementary Statement of Caitlin Healey-Nash, 15 October 2023 [5] (SCOI.86270).

[2706] Exhibit 23, Tab 29, Supplementary Statement of Caitlin Healey-Nash, 15 October 2023 [8] (SCOI.86270); Exhibit 23, Tab 71A, Gap Fence Timeline, Undated, 1 (SCOI.85295_E); Exhibit 23, Tab 71F, South Head Sydney Harbour National Park: Conservation Management Plan (extract), March 2010, 2 (SCOI.85299_E).

[2707] See Exhibit 23, Tab 71B, Gap Bluff Track Proposal, Undated (SCOI.85291); Exhibit 23, Tab 71D, Tender Document – Walking Track Construction, Gap Bluff – Part 1 (extract), 19 March 1990 (SCOI.85296_E).

[2708] Exhibit 23, Tab 71A, Gap Fence Timeline, Undated, 2 (SCOI.85295_E); Exhibit 23, Tab 71D, Tender Document – Walking Track Construction, Gap Bluff – Part 2, 19 March 1990, 4 (SCOI.85293).

[2709] Exhibit 23, Tab 71A, Gap Fence Timeline, Undated, 1 (SCOI.85295_E).

5.3197. The NSWPF did not make any further submissions in relation to the NPWS material, or the further statement from Mr Champion. The supplementary submissions made by Counsel Assisting and Ms Wark in relation to this material are discussed below.

Interagency cooperation

5.3198. The Inquiry requested and received the Coroners Court file for Mr Wark's death, which consisted of 108 pages of material relating to the Court's consideration of the matter in 1990.

Family members

5.3199. Inquiry staff were able to contact and meet with Mr Wark's sister, Rebecca Wark. Ms Wark was close to her brother and was present at the family home when he was there, the day before his death. She provided valuable information to police at the time of the original investigation, and in the weeks following her brother's death she herself located significant evidence that had not been followed up by police.

5.3200. Ms Wark was later represented at the Inquiry's public hearing into Mr Wark's death, and made oral and written submissions to the Inquiry.

Professional opinions

Report of Dr Linda Iles

5.3201. By letter dated 20 January 2023, an expert opinion was sought from forensic pathologist Dr Linda Iles.[2710] On 8 February 2023, Dr Iles provided a report to the Inquiry.[2711]

5.3202. Dr Iles was asked to review the post-mortem report and conclusions reached by Dr Bradhurst, and specifically, to comment on the bruising to Mr Wark's neck and face.[2712]

5.3203. Dr Iles considered the injury documentation and post-mortem examination of Dr Bradhurst to have been quite comprehensive. She noted that upon reexamination by Dr Bradhurst, certain minor cutaneous injuries or marks were identified, but that they are unlikely to be significant as they were not associated with any underlying bruising.[2713]

[2710] Exhibit 23, Tab 65A, Letter of instruction from Caitlin Healey-Nash to Dr Linda Iles, 20 January 2023, 5 (SCOI.82507).

[2711] Exhibit 23, Tab 65, Amended expert report of Dr Linda Iles, 1 May 2023 (SCOI.82509).

[2712] Exhibit 23, Tab 65A, Letter of Instruction from Caitlin Healey-Nash to Dr Linda Iles, 20 January 2023, 5 (SCOI.82507).

[2713] Exhibit 23, Tab 65, Amended expert report of Dr Linda Iles, 1 May 2023, 6 (SCOI.82509).

5.3204. Dr Iles considered that the minor and superficial bruising that was documented was not typical of injuries from a sustained assault and could have been caused in other ways, including from impact and during the process of retrieval of the body. The deep-seated bruising to the neck that initially caught Dr Bradhurst's attention was consistent with trauma to the spinal cord, consistent with Dr Bradhurst's ultimate conclusion.[2714]

5.3205. Dr Iles could not rule out the possibility that there could have been a contribution of drowning to the death, but considered that the injuries to Mr Wark's body were sufficient to have caused death.[2715]

5.3206. Dr Iles agreed with Dr Bradhurst's conclusion as to the cause of death being "multiple injuries sustained in a fall from a height."[2716] She further noted that Mr Wark's injuries were completely consistent with injuries sustained in such a fall, but observed that a medical examination could provide little insight into how such a fall came about.[2717]

Report of Dr Danny Sullivan

5.3207. As noted above, by letter dated 30 September 2022, an expert opinion was sought from Dr Sullivan.[2718]

5.3208. Dr Sullivan reviewed key documents from the investigatory material and set out parts of the evidence of potential relevance to his evaluation of Mr Wark's mental state in his report. He expressed the following view: [2719]

> *I consider that Mr Wark's presentation in the days before his death was consistent with psychosis. He displayed psychomotor agitation. He reported persecutory ideation, which appeared to be delusional, related to triads and two acquaintances. He was thought disordered, with loosening of associations. He was potentially hallucinating or alternatively experiencing auditory illusions while in a state of hypervigilance.*
>
> *It is also possible that Mr Wark was experiencing alcohol withdrawal, and that his agitation and psychotic symptoms occurred in the context of withdrawal from alcohol.*
>
> *There was a pre-existing history of depression, although the information conveyed in his final days does not confirm relevant signs or symptoms of persisting mood disorder, and he was taking a low but effective dose of a tricyclic antidepressant. Although there is mention of claustrophobia, this is not characterised.*

[2714] Exhibit 23, Tab 65, Amended expert report of Dr Linda Iles, 1 May 2023, 6–7 (SCOI.82509).

[2715] Exhibit 23, Tab 65, Amended expert report of Dr Linda Iles, 1 May 2023, 6 (SCOI.82509).

[2716] Exhibit 23, Tab 65, Amended expert report of Dr Linda Iles, 1 May 2023, 6 (SCOI.82509).

[2717] Exhibit 23, Tab 65, Amended expert report of Dr Linda Iles, 1 May 2023, 6–7 (SCOI.82509).

[2718] Exhibit 23, Tab 64A, Letter of instruction from Caitlin Healey-Nash to Dr Danny Sullivan, 30 September 2022, 6 (SCOI.82554).

[2719] Exhibit 23, Tab 64, Expert report of Dr Danny Sullivan, 24 October 2022, [26]–[28] (SCOI.82114).

5.3209. Dr Sullivan further noted in relation to the assessment of the GP who saw Mr Wark on 8 January 1990:[2720]

> *The description of Dr Marriott was based upon limited personal assessment, but in his observation, he noted pressure of speech, flight of ideas and concerns about psychosis ('pre-psychosis) or bipolar affective disorder ('manic depressant'). Based on a short, cross-sectional assessment, this would appear consistent with the information conveyed in the statements that Mr Wark displayed psychotic symptoms. A diagnosis of bipolar affective disorder (called 'manic-depression' in earlier days), requires the presence of mania or hypomania, and there is no evidence suggesting this.*

5.3210. As to a diagnosis, Dr Sullivan stated:[2721]

> *Mr Wark's mental state from 6 January 1990 until his death is consistent with a psychotic episode. The concern of family members and acquaintances suggests that this represented a clear deterioration from his usual presentation, and that he had not presented in such a way before. He would have met the criteria for a psychotic episode ('brief psychotic disorder' as set out in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)), with differential diagnoses, including alcohol-induced psychotic disorder, with onset during withdrawal, or cannabis-induced psychotic disorder, although the latter would be less likely in the absence of cannabis on toxicology.*

5.3211. Dr Sullivan expressed the following view in relation to whether or not Mr Wark's death may have occurred by way of suicide:[2722]

> *I consider Mr Wark's behaviour in the preceding days, and the circumstances of his death, are consistent with suicide. Suicide is strongly associated with alcohol dependence and withdrawal. He was in a state of significant anxiety and fear for delusional reasons. He was markedly restless. He was distressed and seeking help, including from his psychologist.*
>
> *His actions in buying new clothes, and leaving his clothes neatly folded with his possessions, are consistent with planning to kill himself. Finally, I note that Mr Wark's injuries were consistent with a fall or a leap from a significant height.*

5.3212. Dr Sullivan was also asked to comment on the likelihood of alternative causes of death, in relation to which he observed as follows:[2723]

> *I do not consider misadventure to have been likely given that he had changed his clothes and left them at the department store, folded up his other clothes, and left his wallet in place. Secondly, Mr Wark was exhibiting an abrupt*

[2720] Exhibit 23, Tab 64, Expert report of Dr Danny Sullivan, 24 October 2022, [35] (SCOI.82114).

[2721] Exhibit 23, Tab 64, Expert report of Dr Danny Sullivan, 24 October 2022, [37] (SCOI.82114).

[2722] Exhibit 23, Tab 64, Expert report of Dr Danny Sullivan, 24 October 2022, [38]–[39] (SCOI.82114).

[2723] Exhibit 23, Tab 64, Expert report of Dr Danny Sullivan, 24 October 2022, [41]–[44] (SCOI.82114).

> *change in mental state associated with anxiety and fear that he would be killed related to persecutory delusions. A person in a psychotic state is likely to exhibit significant disturbances of judgement, and their behaviour may not follow rational or predictable patterns when affected by delusions and distressed emotional state associated with this.*
>
> *It seems highly unlikely that another person was involved in throwing or pushing him from the cliff, noting that Mr Wark left his clothes neatly folded.*
>
> *The presence of cash and identity documents in the possessions found near Gap Bluff is not consistent with robbery. If he had have intended to go swimming, he would likely have purchased or brought bathers.*
>
> *There is no indication of the agency of another person involved in Mr Wark's death, on the available evidence.*[2724]

Report of Professor Robert Brander

5.3213. Finally, by letter dated 11 December 2022, an expert opinion was sought from coastal geomorphologist Professor Robert Brander, School of Biological, Earth and Environmental Sciences at the UNSW.[2725]

5.3214. Professor Brander was asked about the possibility of a body travelling either from Gap Bluff or Reef Beach to the location in Sydney Harbour where Mr Wark's body was found, at some point between 2:30pm on 9 January 1990 and 9:00am on 10 January 1990.

5.3215. Professor Brander's report highlighted the great difficulties involved in accurately predicting the likely movement of a body in the water in the relevant circumstances. In particular, he observed:[2726]

> *Complex and turbulent wave, tide and drift conditions combined with irregular topography makes it very difficult to determine the direction of travel of a human body entering the water at a coastal location such as the rocky coastline between Gap Bluff and South Head.*

5.3216. Professor Brander's opinion, subject to the various qualifications and assumptions that he identified, was that, if Mr Wark's body entered the water in the vicinity of Gap Bluff, which he regards as "certainly possible", this would most likely have occurred between 9:00pm on 9 January (the time of high tide) and 4:00am on 10 January.[2727] He considered that it was also possible that Mr Wark's body entered the water in the vicinity of Reef Beach, and if so, that the most likely time for that to have occurred was also between 9:00pm on 9 January and 4:00am on 10 January.[2728]

[2724] Exhibit 23, Tab 64, Expert report of Dr Danny Sullivan, 24 October 2022, [41]–[44] (SCOI.82114).

[2725] Exhibit 23, Tab 66C, Letter of instruction from Caitlin Healey-Nash to Professor Robert Brander, 11 December 2022, 6–7 (SCOI.82551).

[2726] Exhibit 23, Tab 66, Expert report of Professor Robert Brander, 23 March 2023, [109] (SCOI.82556).

[2727] Exhibit 23, Tab 66, Expert report of Professor Robert Brander, 23 March 2023, [14], [215] (SCOI.82556).

[2728] Exhibit 23, Tab 66, Expert report of Professor Robert Brander, 23 March 2023, [14]–[15], [213]–[215] (SCOI.82556).

5.3217. Professor Brander observed that, although the assumed wave direction at the time would not have generated a drift of water northwards from Gap Bluff towards the entrance to Sydney Harbour, it is possible that the complex interactions between wave breaking and the irregular coastline in the area could have generated a northward drift.[2729]

5.3218. Bearing in mind the qualification that Professor Brander had to make in view of the limitations of the data and the complexity of the interactions in such a rocky coastline environment, his ultimate opinion was that:[2730]

> *while it is possible that Mr Wark's body may have entered the water in the vicinity of Gap Bluff at any time during the period of interest, this would have been more likely to have occurred between 9:00pm on 9 January 1990 and 4:00am on 10 January 1990.*
>
> …
>
> *[b]ased on physical environmental conditions alone and the assumptions involved therein, it is easier to explain how Mr Wark's body entered the water near the vicinity of Reef Beach rather than Gap Bluff, although the latter is certainly possible, particularly given information provided in the memorandum I received on 3 March 2023 in relation to the movement of human bodies in the water near Gap Bluff to Dobroyd Head.*

5.3219. The "memorandum … received on 3 March" referred to the anecdotal evidence discussed above, to the effect that bodies had been known to move from the Gap to the Dobroyd Head area.[2731]

5.3220. Professor Brander's qualified opinion that entry into the water, if it had occurred at the Gap, was likely to have occurred after 9:00pm on 9 January (the time of the high tide), needs to be read in conjunction with the Professor's other observations, including that the relevant coastline conditions:[2732]

> *… make it difficult to conclude whether a human body on a rock platform, or in the water adjacent to a rock platform, would remain in those locations. A human body on a rock platform may be washed into the ocean by wave action or wedged between rocks by wave action. A human body in the water adjacent to a rock platform may remain in the water or may be washed back onto the rock platform. These are all potential scenarios as it is very difficult to determine or predict what would happen in such an energetic environment without direct observations of wave conditions.*

[2729] Exhibit 23, Tab 66, Expert report of Professor Robert Brander, 23 March 2023, [210] (SCOI.82556).

[2730] Exhibit 23, Tab 66, Expert report of Professor Robert Brander, 23 March 2023, [213] (SCOI.82556).

[2731] Exhibit 23, Tab 47, Handwritten memorandum referring to "Gap" bodies, 16 January 1990 (SCOI.74823.00019).

[2732] Exhibit 23, Tab 66, Expert report of Professor Robert Brander, 23 March 2023, [110] (SCOI.82556).

5.3221. Hence, the qualified opinion that, if Mr Wark fell at the Gap, it would be more likely that he entered the water between 9:00pm on 9 January and 4:00am on 10 January, needs to be understood in light of the fact that it cannot be known whether Mr Wark would have fallen directly into deeper water, or whether his body may have remained on a rock platform for a period before entering the open water.[2733]

Witness statements

5.3222. Neil Champion, the local worker who found Mr Wark's clothing at Gap Bluff, attended a teleconference with Inquiry staff and provided a statement dated 9 August 2023.[2734]

5.3223. While Mr Champion could not definitely recall where it was at the Gap that he found the clothing, he marked out on a map the location where he thought it may have been.[2735] He estimated the location was around the mark on the map or within 50 metres to the north-east of the mark.[2736]

5.3224. Mr Champion recalled that the clothes were within three metres of the cliff edge.[2737] He could not remember any fencing at the location where the clothes were. He thought that the pathway works that he was working on were an extension of the fence section; in that there was some low fencing (about one metre or less) in the area but that that fencing did not extend to the point where the clothes were.[2738]

5.3225. Mr Champion said that no police officer ever accompanied him to the location where he found the clothing or asked him to mark the location on a map.[2739]

5.3226. The Inquiry also made contact with I181.[2740] This did not lead to the Inquiry obtaining any additional relevant information.

Contact with OICs

5.3227. On 23 August 2023 and 20 September 2023, the Inquiry wrote to Michael Plotecki enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Wark. Mr Plotecki advised that he did not wish to participate in the Inquiry by filing submissions in relation to the death of Mr Wark.[2741]

[2733] Exhibit 23, Tab 66, Expert report of Professor Robert Brander, 23 March 2023, [155] (SCOI.82556).

[2734] Exhibit 23, Tab 68, Second statement of Neil Champion, 9 August 2023 (SCOI.85465).

[2735] See Exhibit 23, Tab 68, Annexure 2 to Second statement of Neil Champion, 9 August 2023 (SCOI.85465); Exhibit 23, Tab 68A, Colour versions of Annexures 1 and 2, 9 August 2023 (SCOI.85462).

[2736] Exhibit 23, Tab 68, Second statement of Neil Champion, 9 August 2023, [12] (SCOI.85465).

[2737] Exhibit 23, Tab 68, Second statement of Neil Champion, 9 August 2023, [13] (SCOI.85465).

[2738] Exhibit 23, Tab 68, Second statement of Neil Champion, 9 August 2023, [14] (SCOI.85465).

[2739] Exhibit 23, Tab 68, Second statement of Neil Champion, 9 August 2023, [15] (SCOI.85465).

[2740] Exhibit 23, Tab 67, Statement of Caitlin Healey-Nash, 8 May 2023, [13]–[16] (SCOI.82558).

[2741] Exhibit 23, Tab 67, Statement of Caitlin Healey-Nash, 8 May 2023, [13]–[16] (SCOI.82558); Exhibit 66, Tabs 41-42, Letters to Michael Plotecki, 23 August 2023 and 20 September 2023 (SCOI.86299; SCOI.86300).

5.3228. On 24 August 2023, 11 October 2023 and 16 November 2023, the Inquiry wrote to former Constable Lisa Ford enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Wark.[2742] The Inquiry did not receive a response.

Other

5.3229. On 7 November 2022, the Inquiry requested information about the weather and tidal conditions in the Sydney area in January 1990 from BOM. On 24 November 2022, an officer of the BOM provided the weather, synoptic and rainfall observations for the Watsons Bay area, as well as the sea level observations at Fort Denison for 1990.[2743]

5.3230. The Inquiry also requested and received various data from the Manly Hydraulics Laboratory including Sydney offshore wave data for January 1990.[2744] Other data in relation to the timing of sunrise, sunset and lunar phases was also obtained from relevant sources.[2745] This data, as well as the BOM data, was supplied to Professor Brander in connection with the report requested from him.

Consideration of the evidence

Blair Wark's background

5.3231. Mr Wark was born on 15 September 1961 and was 28 years old when he died in 1990.[2746] His parents have passed away and he is now survived by two of his four siblings, an older brother and his younger sister Rebecca Wark.

5.3232. The Wark family home was in Frenchs Forest in Sydney's northern suburbs. Mr Wark spent the final years of his high school education, from 1977, at a boarding school, and had not lived on a permanent basis at the family home since then.[2747]

5.3233. Mr Wark was intelligent and creative, and after school he did a course at the City Art Institute in Paddington. After finishing the course, he also worked at the Institute, and he was employed in the print-making section at the time of his death.[2748]

[2742] Exhibit 66, Tabs 88A, 89 and 89A, Letters to Lisa Feet/Keet, 24 August 2023, 11 October 2023, 16 November 2023 (SCOI.86667; SCOI.86348; SCOI.86673).

[2743] Exhibit 23, Tab 57, Sea Level Observations at Fort Denison for 1990 (Bureau of Meteorology Data Document CAS-40581-G1G8T9-1), 14 November 2022 (SCOI.82501); Exhibit 23, Tab 58, Weather, Synoptic and Rainfall Observations for Watsons Bay area for 1–24 January 1990 (Bureau of Meteorology Data Document CAS-42702-V4S0D9-4), 21 December 2022 (SCOI.82218).

[2744] Exhibit 23, Tab 62, Excel Spreadsheet of Sydney Offshore Wave Data for 1990, 9 November 2022 (SCOI.82508).

[2745] Exhibit 23, Tabs 59–60, Sunrise, Sunset and Twilight Times for the Gap on 9 and 10 January 1990 (SCOI.82505; SCOI.82500); Exhibit 23, Tab 63, Dates of Primary Phases of the Moon in 1990, undated (SCOI.82535).

[2746] Exhibit 23, Tab 8, Death Certificate of Simon Blair Wark, 13 August 1990 (SCOI.74040).

[2747] Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [4] (SCOI.00052.00035).

[2748] Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [4] (SCOI.00052.00035); Exhibit 23, Tab 10, Statement of Ian Wark, 27 January 1990, [5] (SCOI.00052.00027).

5.3234. Mr Wark was close to his younger sister Rebecca, who lived at the family home and whom he would see at least monthly.[2749] His family knew that he was gay.[2750] They also understood that he had a close friendship with I182,[2751] with whom he had lived on-and-off for eight years,[2752] prior to moving into accommodation at the Pyrmont Arms Hotel in the months before his death.[2753]

5.3235. In her oral submission to the Inquiry, Ms Wark described that Mr Wark:[2754]

> *took care of himself and respected his body. He swam regularly, he ate healthily, he walked a lot. He was handsome and strong.*
>
> *Blair was enviably artistic. He created beautiful paintings and leather work. He studied art, he created art, he taught art. He worked in an art school. He made regular forays to the Art Gallery of New South Wales with our mother, with whom he had a close relationship and whose companionship he sought for those excursions. His paintings hung in my parents' home and hang in my home - a daily reminder of an observant, curious, expressive, imaginative son and brother.*
>
> *Blair had an infectious chuckle that I still conjure in my head more than 30 years after I last heard it. When he laughed, his eyes crinkled, his cheeks inflated and no-one within earshot could resist being swept up in his joy.*
>
> *Blair had a love of finding words within five-letter words. His artistic signature was "earth" with a dotted line around the "art" within it, art being the centre of the earth. He had a rubber ink stamp made of it and it was on all of his prints and work. Another example of his love of words within words was "ear" within "heart" - listen to your heart.*

Movements prior to death

5.3236. Mr Wark's movements over the last few days of his life can be pieced together, to a considerable extent, through the various materials obtained by the Inquiry.

5.3237. In her oral submission to the Inquiry, Ms Wark emphasised that the behaviours that Mr Wark displayed in the days immediately before his death were dramatically out of character.

[2749] Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [12] (SCOI.00052.00035).

[2750] Exhibit 23, Tab 10, Statement of Ian Wark, 27 January 1990, [15] (SCOI.00052.00027); Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [12] (SCOI.00052.00035).

[2751] Exhibit 23, Tab 10, Statement of Ian Wark, 27 January 1990, [15] (SCOI.00052.00027).

[2752] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [5] (SCOI.00052.00018).

[2753] Exhibit 23, Tab 10, Statement of Ian Wark, 27 January 1990, [5] (SCOI.00052.00027); Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [4] (SCOI.00052.00035).

[2754] Transcript of the Inquiry, 18 May 2023, T3993.1-28 (TRA.00054.00001).

5-8 January 1990: Contact with I179 and I182

5.3238. On Friday, 5 January 1990, Mr Wark inspected a flat in Potts Point that he was seeking to move into with I179 and I180 (a pseudonym), who was the girlfriend of I179. Mr Wark and I180 completed a tenancy application. A deposit was paid, although Mr Wark was still to contribute a share of the upfront rental costs, which he indicated he would need to borrow from his father or from I182.[2755] According to I179, Mr Wark was intoxicated during the day.[2756]

5.3239. That afternoon Mr Wark spoke to his father about borrowing $500 for the bond. His father expressed concern about Mr Wark moving in with I179, who his father considered would be a bad influence upon Mr Wark.[2757] Mr Wark subsequently told his father not to worry about lending him any money.[2758] Later at around midnight, in a phone call to I182, Mr Wark was in a distressed state, and told I182 that he was coughing blood.[2759]

5.3240. On Saturday, 6 January 1990, Mr Wark went to I179's flat on Crown Street, Surry Hills. Mr Wark told I179 that he had been unable to obtain the rental money and seemed very depressed.[2760]

5.3241. In his unsigned statement, I179 said that they discussed the topic of suicide including the suicide of a mutual friend who had jumped off a 40-storey building in Melbourne. According to I179, Mr Wark was confused and very drunk.[2761] The behaviour described by I179 includes a remark being made by Mr Wark that the word "death" contained the word "eat", and that "to eat is to die".[2762] (While at first instance that remark might appear to be unusual, it seems likely to be an example of what Ms Wark referred to in her submission, as to her brother's love of finding words within five letter words.) As Mr Wark left the flat, he and I179 arranged to meet at I179's flat on Monday, 8 January. I179 did not see Mr Wark again.[2763]

5.3242. Early on the Saturday evening Mr Wark went to I182's home in Oatley, where he stayed overnight. According to I182, Mr Wark "looked tired and was a little bit distraught".[2764]

[2755] Exhibit 23, Tab 15, Statement of I179, 29 January 1990, [6]–[7] (SCOI.00052.00030).
[2756] Exhibit 23, Tab 15, Statement of I179, 29 January 1990, [8](SCOI.00052.00030).
[2757] Exhibit 23, Tab 10, Statement of Ian Wark, 27 January 1990, [6] (SCOI.00052.00027).
[2758] Exhibit 23, Tab 10, Statement of Ian Wark, 27 January 1990, [7] (SCOI.00052.00027).
[2759] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [8] (SCOI.00052.00018).
[2760] Exhibit 23, Tab 15, Statement of I179, 29 January 1990, [9] (SCOI.00052.00030).
[2761] Exhibit 23, Tab 15, Statement of I179, 29 January 1990, [12] (SCOI.00052.00030).
[2762] Exhibit 23, Tab 15, Statement of I179, 29 January 1990, [10]–[12] (SCOI.00052.00030).
[2763] Exhibit 23, Tab 15, Statement of I179, 29 January 1990, [12] (SCOI.00052.00030).
[2764] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [9] (SCOI.00052.00018).

5.3243. On the morning of Sunday, 7 January 1990, I182 was of the view that Mr Wark was going through alcohol withdrawal, and he gave him some port to drink. Mr Wark went into the city during the day.[2765] He also phoned his parents and expressed some reservations about moving into the flat with I179 and I180.[2766] He later returned to I182's house.[2767]

5.3244. That evening, according to I182, Mr Wark was very upset and was saying, "the Triads are looking for me."[2768] He acted in a paranoid fashion by pulling the blinds down and described his potential new rental accommodation as a "shooting gallery".[2769] I182 recalled that at some time over the weekend Mr Wark had asked for a loan of money to pay the balance of the rental bond for the Potts Point flat. I182 says that he declined, but that he did give Mr Wark some money in order to "pay his accounts" and as "pocket money".[2770]

5.3245. On Monday morning, 8 January 1990, Mr Wark woke up at 8:00am and, according to I182, he no longer seemed preoccupied with his fears from the previous evening. Mr Wark left I182's house at 8:30am, stating that he had an appointment in town.[2771]

5.3246. There is evidence suggesting that Mr Wark attended his work at the City Art Institute in Paddington that morning,[2772] and that he had a haircut at 11:30am.[2773] The hairdresser considered that Mr Wark seemed quiet and slightly depressed.[2774] According to I182, Mr Wark called him late in the morning and said, "it's all been worked out".[2775] I182 then asked if Mr Wark had obtained money for the rental bond, to which Mr Wark replied cryptically "that's not the point".[2776]

Monday, 8 January 1990: Mr Wark's behaviour while at his parents' house

5.3247. At 12:30pm on Monday, 8 January 1990, Mr Wark arrived at his parents' house in Frenchs Forest.[2777]

5.3248. In his initial statement to police made on 11 January 1990, Mr Wark's father Ian Wark said that his son arrived "in a very disturbed state."[2778] Ian Wark said that he "had never seen him like this before" and that Mr Wark "appeared to be hallucinating".[2779]

[2765] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [9] (SCOI.00052.00018).

[2766] Exhibit 23, Tab 54, Handwritten chronology of Enid Wark, Undated 1 (SCOI.82552); Exhibit 23, Tab 10, Statement of Ian Wark, 27 January 1990, [8] (SCOI.00052.00027).

[2767] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [9] (SCOI.00052.00018).

[2768] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [9] (SCOI.00052.00018).

[2769] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [9] (SCOI.00052.00018).

[2770] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [10] (SCOI.00052.00018).

[2771] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [10] (SCOI.00052.00018).

[2772] Exhibit 23, Tab 41, Letter from Constable Ford and Detective Plotecki to the Coroner, 19 June 1990, [15] (SCOI.00052.00044).

[2773] Exhibit 23, Tab 41, Letter from Constable Ford and Detective Plotecki to the Coroner, 19 June 1990, [9] (SCOI.00052.00044).

[2774] Exhibit 23, Tab 23, Statement of Detective Constable Plotecki, 30 January 1990, [24] (SCOI.00052.00026).

[2775] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [10] (SCOI.00052.00018).

[2776] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [10] (SCOI.00052.00018).

[2777] Exhibit 23, Tab 9, Statement of Ian Wark, 11 January 1990, 1 (SCOI.00052.00025).

[2778] Exhibit 23, Tab 9, Statement of Ian Wark, 11 January 1990 (SCOI.00052.00025).

[2779] Exhibit 23, Tab 9, Statement of Ian Wark, 11 January 1990, 1 (SCOI.00052.00025).

5.3249. In a later statement on 27 January 1990, Ian Wark said that the description of his son hallucinating did not accurately sum up his condition and he provided greater detail concerning his son's behaviour. He gave the following description which is set out in full due to its relevance to the assessment of Mr Wark's mental state:[2780]

> *Blair was shaking and distraught, he appeared nervous and was constantly on the move. I formed the opinion that he was in fear of his life based on my observations of his physical condition at this time and from subsequent conversation. When Blair arrived he had his swim gear with him and told us that he was on his way to North Sydney Pool when something had taken place. I asked Blair why he appeared so frightened. He said to my wife and I "I really thought it was a Real Estate Agents. I've been stupid. It was a 'Shooting Gallery'. I've been set up." I then said, "Where are you talking about?" He said, "Better you don't know Dad." I then asked him who was trying to get him. He said, "The Triads." We then talked some more and Blair mentioned two [names]. My wife Enid then said, "Who, [I179] and Michael Hutchence?" Blair then said "Don't even mention their names, don't even say them aloud."*

5.3250. In her notes made about Mr Wark's death, Mr Wark's mother Enid Wark said that on Mr Wark's arrival he insisted that his father move away from any window as he was "in danger". She also recounted that Mr Wark said something about there being subliminal transmissions being broadcast by a radio station.[2781]

5.3251. Mr Wark's parents were concerned enough about his condition that they called the family GP, Dr Marriott, who attended the house at 1:30pm.

5.3252. Dr Marriott observed Mr Wark's "pressure of speech" and thought he showed signs of "pre-psychosis".[2782] Mr Wark was not co-operative with Dr Marriott.[2783]

5.3253. After Dr Marriott left, Mr Wark expressed concern that his continued presence at the family home was leaving his family in danger. At Mr Wark's request his father drove him to the Pyrmont Arms Hotel and gave him twenty dollars. However, at 11:45pm, Mr Wark phoned home and stated that he wanted to return to the family home.[2784]

Tuesday, 9 January 1990: at the family home

5.3254. Mr Wark arrived back at the family home by taxi at 12:20am, early on Tuesday morning, 9 January 1990. At this stage, his sister Ms Wark was at home and he mainly interacted with her. Ms Wark gave Mr Wark money to pay for the taxi. She recalled his clothing as fly button jeans, a green coloured tropical shirt and thongs.[2785]

[2780] Exhibit 23, Tab 10, Statement of Ian Wark, 27 January 1990, [10] (SCOI.00052.00027).

[2781] Exhibit 23, Tab 54, Handwritten chronology of Enid Wark, Undated 2–3 (SCOI.82552).

[2782] Exhibit 23, Tab 23, Statement of Detective Constable Plotecki, 30 January 1990, [22] (SCOI.00052.00026).

[2783] Exhibit 23, Tab 10, Statement of Ian Wark, 27 January 1990, [11] (SCOI.00052.00027).

[2784] Exhibit 23, Tab 10, Statement of Ian Wark, 27 January 1990, [12] (SCOI.00052.00027).

[2785] Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [6] (SCOI.00052.00035).

5.3255. Mr Wark appeared exhausted, nervous, and was sweating and shaking. He told his sister that "the last three days have been outrageous".[2786] Ms Wark sat up talking with Mr Wark for a while and he repeated a concern that he had been "set up" by I179 and Michael Hutchence.[2787] Ms Wark did not get the impression that Mr Wark was affected by alcohol or drugs.[2788]

5.3256. Mr Wark then woke his sister up at 4:00am stating, "I am serious, they are going to kill me". He repeated the names I179 and Michael Hutchence, this time also adding the names "Mrs Woo and Nick Woo", and stating that the latter two were mixed up in "the Triads".[2789] He went on to again refer to the real estate agent as a "shooting gallery" and stated that he "was innocent".[2790]

5.3257. During their conversation, Mr Wark became concerned that there was somebody outside. He said he wanted to return to the Pyrmont Arms Hotel as he would be higher in the building and could see people coming. He was also concerned about getting to an appointment with his psychologist, I181, which he understood he had at 1:00pm that day. Ms Wark noticed when talking with Mr Wark that he seemed to have lost his sense of time and was "a day ahead of the actual date".[2791] At one point Ms Wark suggested that she take Mr Wark to the police, however he left the family home on foot at around 6:00am.[2792]

5.3258. Mr Wark's father Ian Wark recalled his son saying that his psychologist's appointment was at the MLC Centre at 1:00pm. Ian Wark followed Mr Wark up the road when he left on foot, and asked that he stay. Mr Wark declined to do so, although it appears that he accepted a lift to a bus stop.[2793] This was the last time that family members saw Mr Wark alive.

Tuesday, 9 January 1990: after leaving the family home

5.3259. Little if any action was initially taken by police investigating the matter to ascertain Mr Wark's movements after he left the family home in the early morning of 9 January 1990. However, Mr Wark's sister appears to have established, via contact with the caretaker of the Pyrmont Arms Hotel, that he returned to the Hotel at some point during the morning.[2794]

5.3260. After Mr Wark's death, police returned the items that had been found at the Gap to the family, rather than retaining them as exhibits or following up the potential significance of any of the papers which were among these.

[2786] Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [6] (SCOI.00052.00035).

[2787] Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [7] (SCOI.00052.00035).

[2788] Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [7] (SCOI.00052.00035).

[2789] Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [9]–[10] (SCOI.00052.00035).

[2790] Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [9]–[10] (SCOI.00052.00035).

[2791] Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [10] (SCOI.00052.00035).

[2792] Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [10] (SCOI.00052.00035).

[2793] Exhibit 23, Tab 54, Handwritten chronology of Enid Wark, Undated 8 (SCOI.82552); Exhibit 23, Tab 10, Statement of Ian Wark, 27 January 1990, [13] (SCOI.00052.00035).

[2794] Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [11] (SCOI.00052.00035).

5.3261. It was Ms Wark who was also responsible for discovering, via her own detective work, that one of the receipts amongst those papers related to items that had been left at the lost property section of the David Jones city store on the morning of Tuesday, 9 January 1990.[2795]

5.3262. Police thereafter took a statement, in May 1990, from the David Jones staff member involved. She recalled that at about 11:00am on Tuesday, 9 January a man came to the lost property counter.[2796] He gave her a light blue carry bag containing some clothing. She took the property and gave the man a docket,[2797] believing the property to have been something that the man had found. The man then explained to her that the bag was his and that he would pick it up later. As she had already filled out the docket, she did not quibble with this. She then opened the bag to see that it contained dirty clothing. When she did this, the man said, "it all belongs in the laundry".[2798] The man gave his name as "Wark B". Police subsequently showed the witness photos of Mr Wark. Without positively identifying him, she indicated that the person in the photo was of very similar appearance to the man, though looked slightly heavier.[2799]

5.3263. Ms Wark described the items in the bag at David Jones as consisting of some clean clothes, underwear, a shaving kit in a leather pouch, an alarm clock, a fob watch, a towel and a pair of wet jeans. She recognised most of the property as belonging to her brother.[2800]

5.3264. Also in the items found at the Gap were some other receipts, for purchases at David Jones that had been made on the morning of 9 January 1990.[2801] These appear to have been for a shirt, belt and handkerchief,[2802] consistent with items found at the Gap.[2803] The time of purchase can be made out on one of these receipts as 9:43am on 9 January and the three separate purchases cost around $120 in total, which was paid for in cash.

8 and 9 January 1990: Mr Wark's attempts to contact his psychologist

5.3265. Mr Wark's last known contact with anyone appears to have been at around 2:00pm on Tuesday, 9 January 1990 with Daphne McLaughlin, who is described as the landlady at the residential address of Mr Wark's psychologist I181 in Double Bay.[2804]

[2795] Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [13] (SCOI.00052.00035).

[2796] Exhibit 23, Tab 17, Statement of Xiaolin (Eileen) Dong, 5 May 1990, [5] (SCOI.00052.00036).

[2797] Exhibit 23, Tab 53, David Jones receipt No. 2368, Undated (SCOI.10022.00080).

[2798] Exhibit 23, Tab 17, Statement of Xiaolin (Eileen) Dong, 5 May 1990, [5] (SCOI.00052.00036).

[2799] Exhibit 23, Tab 17, Statement of Xiaolin (Eileen) Dong, 5 May 1990, [5]–[7] (SCOI.00052.00036).

[2800] Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [13] (SCOI.00052.00035).

[2801] Exhibit 23, Tab 52, Scanned copy of David Jones receipts, Undated (SCOI.10022.00079).

[2802] Exhibit 23, Tab 40, Letter from Enid Wark and Rebecca Wark to the Coroner, 4 May 1990, 2 (SCOI.00052.00011).

[2803] The items found at the Gap included a shirt and belt, though do not appear to have included a handkerchief: Exhibit 23, Tab 12, Statement of Neil Champion, 14 January 1990, 1 (SCOI.00052.00021); Exhibit 23, Tab 25, Statement of Constable Nichole Brown, 14 January 1990, [5] (SCOI.00052.00020).

[2804] Exhibit 23, Tab 41, Letter from Constable Ford and Detective Plotecki to the Coroner, 19 June 1990, [11] (SCOI.00052.00044).

5.3266. As outlined above, Mr Wark had told family members that he had an appointment with I181 at the MLC Centre (near Martin Place in Sydney) at 1:00pm on 9 January 1990.[2805]

5.3267. I181 provided police with a handwritten letter addressed to the Coroner dated 12 January 1990, on her letterhead (which carried an office address at the MLC Centre), on which she had also written her residential address in Double Bay. I181 stated in the letter that she had received a message on her "phone recorder" from Mr Wark on the afternoon of Monday, 8 January.[2806] She did not indicate what the content of that message was, and she said that she could not phone Mr Wark back as he did not have a phone.

5.3268. I181 stated that Mr Wark had attended her home address on Tuesday, 9 January without an appointment. I181 said that she was absent but that her landlady (Ms McLaughlin) opened the door for Mr Wark and told him that I181 was absent but would be back in the late afternoon.[2807] When I181 arrived back home at 5:00pm, she had a message on her phone recorder from Mr Wark's mother, who in a subsequent phone call with I181 expressed her concern about her son.[2808] I181 said that she then phoned the Pyrmont Arms Hotel and left a message for Mr Wark, but never heard back from him.[2809]

5.3269. Partly contrary to I181's account, a letter to the Coroner from Enid and Rebecca Wark in May 1990 suggested that I181 had told them that Mr Wark had turned up at her residential address for a 1:00pm appointment but that her landlady had inadvertently locked him out.[2810]

5.3270. In any event, it seems clear that Mr Wark did go to I181's address in Double Bay in the early afternoon of 9 January. Although no statement appears to have been taken from the landlady, Ms McLaughlin, the letter sent to the Coroner by the two OICs indicated that she had been contacted and had told police that Mr Wark had shown up at around 2:00pm. Ms McLaughlin said she had asked how Mr Wark had I181's residential address as I181 did not normally see patients at her home.[2811] The information from police says nothing about what may have been said to Mr Wark about I181's presence or availability, but evidently Mr Wark left, which would imply either that I181 was not told of the visit or that she was not there (as I181's account asserts).

5.3271. Most significantly, Ms McLaughlin described Mr Wark at this point as being "highly distressed and agitated".[2812]

[2805] Exhibit 23, Tab 10, Second statement of Ian Wark, 27 January 1990, [13]; Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [11] (SCOI.00052.00035).

[2806] Exhibit 23, Tab 20, Letter from I181 to Coroner, 12 January 1990, 2 (SCOI.00052.00022).

[2807] Exhibit 23, Tab 20, Letter from I181 to Coroner, 12 January 1990, 2 (SCOI.00052.00022).

[2808] Exhibit 23, Tab 20, Letter from I181 to Coroner, 12 January 1990, 2 (SCOI.00052.00022).

[2809] Exhibit 23, Tab 20, Letter from I181 to Coroner, 12 January 1990, 2 (SCOI.00052.00022).

[2810] Exhibit 23, Tab 40, Letter from Enid Wark and Rebecca Wark to the Coroner, 4 May 1990, 4 (SCOI.00052.00011).

[2811] Exhibit 23, Tab 41, Letter from Constable Ford and Detective Plotecki to the Coroner, 19 June 1990, [11] (SCOI.00052.00044).

[2812] Exhibit 23, Tab 41, Letter from Constable Ford and Detective Plotecki to the Coroner, 19 June 1990, [11] (SCOI.00052.00044).

5.3272. Mr Wark's attendance at I181's home address rather than at the MLC Centre should not necessarily be regarded as strange. In her letter to the Coroner, I181 said that the second and last occasion that she had seen Mr Wark was at her home address where she was conducting a group therapy session.[2813]

5.3273. What Mr Wark did after leaving I181's address in Double Bay in the early afternoon of Tuesday, 9 January is not known.

Mr Wark's mental state

5.3274. As Counsel Assisting submitted, the available evidence of Mr Wark's movements and behaviour over the four days leading up to his death provides considerable insight into his mental state in that period and his recurring pre-occupations and fears.

5.3275. Counsel Assisting submitted, and I accept, that it is very difficult to find a rational basis for those fears, although to a degree they appear to have related to Mr Wark's perception of events surrounding his planned move into the flat with I179 and I180, as both I179 and a real estate agency feature in them.

5.3276. Other aspects of Mr Wark's fears appear to be even less grounded in reality. These include his perception of there being subliminal messages from a radio station, his references to the Triads and unknown individuals named Nick and Mrs Woo, his repeated reference to the real estate agency as a "shooting gallery" and his inclusion of I179 and Michael Hutchence as persons somehow involved in these events.[2814]

5.3277. In their correspondence to the Coroner, after the family had raised the issue of there not being a statement from Mr Wark's more regular GP, the OICs indicated that contact had been made by phone with this doctor, Dr John Goldbaum. Dr Goldbaum indicated that he had been treating Mr Wark on a regular basis for depression since April 1988, and had last seen him on 12 December 1989 when he had prescribed his anti-depressant medication.[2815]

5.3278. As to the psychologist, I181, Mr Wark had been referred to her in November 1989 by another GP, Dr Jeff Sleep, who himself had had only limited involvement with Mr Wark.[2816] I181's handwritten letter to the Coroner was evidently prepared without her having any direct knowledge of Mr Wark's mental state in the days leading up to his death. It relied on one single clinical session that she had with Mr Wark two months earlier, along with a single group therapy session on 26 November 1989.[2817]

5.3279. In I181's letter to the Coroner, she expressed her view as follows:[2818]

[2813] Exhibit 23, Tab 20, Letter from I181 to the Coroner, 12 January 1990, 1–2 (SCOI.00052.00022).

[2814] It is noted that information from the family indicates that I180 had gone to school with Mr Wark's older brother, however there is no evidence to suggest that he had an ongoing association with Mr Wark: Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [9] (SCOI.00052.00035). I179 refers to Mr Wark as being obsessed with I180: Exhibit 23, Tab 15, Statement of I179, 29 January 1990, [14] (SCOI.00052.00030).

[2815] Exhibit 23, Tab 41, Letter from Constable Ford and Detective Plotecki to the Coroner, 19 June 1990, [12] (SCOI.00052.00044).

[2816] Exhibit 23, Tab 18, Referral letter from Dr Jeff Sleep to I181, 14 November 1989 (SCOI.00052.00023).

[2817] Exhibit 23, Tab 20, Letter from I181 to the Coroner, 12 January 1990, 1–2 (SCOI.00052.00022).

[2818] Exhibit 23, Tab 20, Letter from I181 to the Coroner, 12 January 1990, 1–2 (SCOI.00052.00022).

> *Mr Wark suffered from depression which was mainly due to the termination of 8 yr old homosexual relationship;*
>
> …
>
> *Dr Sleep informed me that Mr Blair Wark had a long history of depressive illness and was prescribed strong doses of antidepressants by other GP. Dr Sleep only saw Mr Wark twice;*
>
> …
>
> *In my opinion Mr Wark suicided himself as a result of depression and loneliness.*

5.3280. In fact, the referral letter from Dr Sleep to I181, while referring to his anti-depressant prescription, made no mention of it being "strong".[2819] By contrast, the expert forensic psychiatrist Dr Sullivan describes it as a "low but effective dosage".[2820]

5.3281. The police had available to them, from 31 January 1990, the diagnosis by Dr Marriott of "pre-psychosis", as at 8 January 1990 (probably the day before Mr Wark died), but do not appear to have taken it into account when providing their views to the Coroner as to the cause and manner of death.[2821]

5.3282. As Counsel Assisting submitted, while Mr Wark's treatment for depression over a period of nearly two years, by a GP (Dr Goldbaum), was clearly relevant information, it was not an adequate explanation for his mental state in the days immediately leading up to his death, or an adequate basis for a conclusion that he had died by way of suicide because of "depression and loneliness", as asserted by I181.

Evidence relevant to the inclusion of the matter in Strike Force Parrabell

5.3283. Features of Mr Wark's death that appear to have brought it to the attention of Sue Thompson and, later, Strike Force Parrabell are the fact that he was gay, and the proximity of where his body was found to Dobroyd Head and Reef Beach.[2822] This was an area then known as a beat, and where there were known instances of assaults targeting beat users in the late 1980s.[2823]

[2819] Exhibit 23, Tab 18, Referral letter from Dr Jeff Sleep to I181, 14 November 1989 (SCOI.00052.00023).

[2820] Exhibit 23, Tab 64, Expert report of Dr Danny Sullivan, 24 October 2022, [28] (SCOI.82114).

[2821] Exhibit 23, Tab 23, Statement of Detective Constable Plotecki, 30 January 1990, [22] (SCOI.00052.00026).

[2822] See Exhibit 6, Tab 47, NSWPF Issue Paper from Detective Chief Inspector John Lehmann, 25 September 2013, 6 (SCOI.74906); Exhibit 6, Tab 56B, Excel spreadsheet titled 'Possible Gay Hate Murders List' provided to Michael Willing by Sue Thompson, undated (SCOI.77315); Exhibit 6, Tab 223, Rick Feneley, 'The Gay-Hate Decades: 30 Unsolved Deaths', SBS (online), 3 October 2016, 34, <https://www.sbs.com.au/gayhatedecades/> (SCOI.82033).

[2823] See Exhibit 6, Tab 232, Findings of State Coroner Michael Barnes, Inquest into the death Scott Johnson, 30 November 2017, [160], [164], [170], [188]–[189] (SCOI.11064.00018).

5.3284. Moreover, Mr Wark's death occurred around a time when there were other known or suspected LGBTIQ bias deaths involving falls from cliffs in other Sydney coastal locations, and evidence generally before the Inquiry demonstrates that the late 1980s and early 1990s was a period when there were documented high levels of assaults of members of the LGBTIQ community in Sydney.[2824]

Police investigation

5.3285. Counsel Assisting submitted that Mr Wark's death had certain features that called for more thorough analysis than appears to have occurred at the time of the initial investigation. Some of those features understandably raised significant questions for family members. Some were the subject of correspondence to the Coroners Court in May and June 1990 by both Mr Wark's family and the OICs.[2825]

5.3286. In her oral submission to the Inquiry, Ms Wark stated:[2826]

> *I will always wonder what the police might have learned had they applied Blair's curious, imaginative approach to their investigations. What if they had asked, "Might we be missing something here?" But they didn't.*

5.3287. The NSWPF accepted that it is "undoubtedly true" that "certain additional investigative steps could have been conducted", and that the conduct of those steps "may have allayed some of the concerns or suspicions held by family members".[2827]

5.3288. However, the NSWPF further submitted:[2828]

> *That said, it is entirely appropriate for an investigation into a death bearing strong indications of suicide, to be more circumscribed than one where homicide is a real possibility.*
>
> *The investigations conducted by police included inquiries with Mr Wark's treating medical practitioners, his friends and family, a real estate agent and his former lover.*

[2824] See generally Exhibit 2, Tab 2, Statement of Brent Mackie,16 November 2022, [19] (SCOI.77301); Exhibit 2, Tab 4, Statement of Gregory Callaghan,17 November 2022, [10]–[30] (SCOI.77303).

[2825] See Exhibit 23, Tab 40, Letter from Enid Wark and Rebecca Wark to the Coroner, 4 May 1990 (SCOI.00052.00011); Exhibit 23, Tab 41, Letter from Constable Lisa Ford and Detective Michael Plotecki to the Coroner, 19 June 1990 (SCOI.00052.00044).

[2826] Transcript of the Inquiry, 18 May 20323, T3995.22-38 (TRA.00054.00001).

[2827] Submissions of NSWPF, 1 June 2023, [61] (SCOI.83645).

[2828] Submissions of NSWPF, 1 June 2023, [62]–[63] (SCOI.83645).

5.3289. While those observations may be accepted in general terms, every death falls to be considered on its individual circumstances. Suspicious, unexplained or unusual aspects of a death should be properly investigated whether or not the death has "strong indications" of suicide, homicide or misadventure. The NSWPF did make enquiries with the persons referred to in their submissions. However, it is the extent and quality of those enquiries—in a setting where there were plainly some unusual features—that understandably gave rise to the family's concerns, especially when it was left to the efforts of Ms Wark herself, rather than investigating police, to bring significant evidence to light.

5.3290. Counsel Assisting identified the following matters of concern with the police investigation. In the written submissions made on her behalf, Ms Wark agreed with the submissions made in these respects by Counsel Assisting.

Location of property

5.3291. Counsel Assisting submitted, first, that if police did attend the location where Mr Wark's property was found at Gap Bluff, this did not occur until several days after it was located.

5.3292. The NSWPF accepted, as was in my view inescapable, that police should have attended the location of Mr Wark's property at Gap Bluff earlier than they did.

5.3293. Secondly, whether police actually attended the location at all is by no means clear.

5.3294. As Counsel Assisting noted, there was no record indicating that police did in fact examine the location, either to determine whether there was any other physical evidence potentially relating to what may have happened to Mr Wark there, or to record the precise location.

5.3295. In his recent statement to the Inquiry, Mr Champion did not recall attending the location of the clothing with police or marking the location out on a map.

5.3296. The NSWPF agreed that no record of any such attendance, nor any photographs taken, are available "as at today's date (some 33 years after the relevant events)". However, the NSWPF submitted:[2829]

> *It does not appear that the Inquiry has made inquiries with either Constable Plotecki or Constable Ford to explore their recollections in this respect and no conclusion could be reached by the Inquiry as to what did, or did not, occur in the course of Constable Ford's visit to the scene.*

5.3297. I do not accept this submission.

[2829] Submissions of NSWPF, 1 June 2023, [65] (SCOI.83645).

5.3298. In the first place, prior to the documentary tender in this matter, Inquiry staff held a teleconference with the OIC, Mr Plotecki, who advised that he could not recall any information about Mr Wark's death beyond the contents of his statement.[2830] In addition, the Inquiry has subsequently made inquiries of Mr Plotecki, who advised that he did not wish to make any submissions in relation to the death of Mr Wark.[2831] The Inquiry has also made multiple attempts to contact Ms Ford, but was unable to successfully reach her. But secondly, I reject any suggestion that I cannot reach a conclusion as to whether there was a visit to the site by Constable Ford, or as to what did or did not occur in the course of any such visit if it occurred in the absence of speaking to Constable Ford.

5.3299. It is trite to say that detailed and accurate record-keeping is a critical feature of a police investigation. I should be able to rely on, and make findings based on, the documentary records provided to the Inquiry by the NSWPF. In the absence of any material even suggesting that such a scene visit actually occurred, I consider that it is open to me to conclude, at least, that *if* such a visit did occur it was limited in nature.

5.3300. Further, however, the evidence does not enable me to be satisfied that such a visit took place at all, given that it is not mentioned in any document other than the reference in Detective Constable Plotecki's statement to his making an arrangement for there to be such a visit in the future. Crucially, it is not mentioned in either of Constable Ford's two statements. Nor is there any mention of a scene visit in the coronial file.

5.3301. In my view, on the evidence, it is probable that no such visit occurred. If that is so, it is a damning indictment, not of Constable Ford, but of the police investigation of this case generally.

Location of body

5.3302. Thirdly, Counsel Assisting noted that there was no material, in the police brief to the Coroner, in relation to how the body of a person who jumps or falls from the vicinity of the Gap might end up near Dobroyd Head. By contrast, the Inquiry had located, in the Forensic Medicine file, a handwritten note (dating from January 1990) made by the forensic pathologist, Dr Bradhurst, indicating that he made contact with the Water Police Unit so as to satisfy himself that this was feasible.[2832]

5.3303. In response, the NSWPF referred to evidence now available, including the opinion of Professor Brander provided to the Inquiry, which supports the likelihood that Mr Wark's body could have drifted to such a position.

5.3304. However, the point of Counsel Assisting's submission was that there was no material in the police brief to the Coroner which sought to consider or explain the movement of Mr Wark's body from Gap Bluff to Dobroyd Head.

[2830] Exhibit 23, Tab 67, Statement of Caitlin Healey-Nash, 8 May 2023, [15]–[16] (SCOI.82558).

[2831] Exhibit 66, Tabs 41-42, Letters from Inquiry to Michael Plotecki, 23 August 2023 and 20 September 2023 (SCOI.86299; SCOI.86300).

[2832] Exhibit 23, Tab 47, Handwritten Memorandum referring to "Gap" bodies, 16 January 1990 (SCOI.74823.00019).

5.3305. As the note was located by the Inquiry in the DOFM file *only*, it is far from clear that it can be said (as the NSWPF submitted) that the police investigation "had resort to" the views of an officer with experience in tidal movements and wave conditions. There was nothing in the material before the Inquiry to indicate that the officers involved in the investigation of Mr Wark's death were aware of the existence of this note, or that they otherwise made enquiries or sought to obtain evidence as to tidal movements and wave conditions, or that, if they did, they passed on such information to the Wark family.

OIC's rapidly-formed views as to manner of death

5.3306. Fourthly, Counsel Assisting submitted that one of the investigating officers prematurely reached a firm conclusion as early as 12 or 13 January 1990 that Mr Wark's death was a deliberate act that was explained by the views of his psychologist I181.[2833] In her first statement, dated 13 January 1990, Constable Ford stated that "there are no suspicious circumstances",[2834] and as Counsel Assisting submitted, she appeared to rely heavily on the handwritten letter from I181 to the Coroner which expressed the opinion that Mr Wark "suicided himself" as a result of "depression and loneliness", such depression being said to be "mainly due to the termination of an 8 yr old homosexual relationship".[2835]

5.3307. Constable Ford's second statement, dated 24 January 1990 also appeared to rely on I181's letter, concluding as it did that Mr Wark "took his own life by jumping from the Gap Bluff due to the completion of an eight-year homosexual relationship and loneliness".[2836]

5.3308. In her oral submission, Ms Wark emphasised her view that:[2837]

> *the investigations undertaken by NSW Police in 1990 and again during Strike Force Parrabell appeared to our family to be cursory and their outcome a foregone conclusion – that is, Blair was a young gay man and therefore killed himself.*

5.3309. Ms Wark went on to stress, as well, that contrary to an "underlying implication" in some of the material that Mr Wark's depression was his "predominant, if not his singular, character trait, it was not". [2838] In this regard, she submitted:[2839]

> *I remain convinced, as did my parents until their aged deaths, that no matter how Blair died, the investigation by NSW Police Force had been narrow minded, with outcome bias. He was a gay and on anti-depressants, therefore, he jumped.*

[2833] Exhibit 23, Tab 2, Report of Death to Coroner (post-identification), 11 January 1990 (SCOI.00052.00004).

[2834] Exhibit 23, Tab 21, Statement of Constable Lisa Ford, 13 January 1990, 3 (SCOI.10022.00040).

[2835] Exhibit 23, Tab 20, Letter from I181 to the Coroner, 12 January 1990, 1 (SCOI.00052.00022).

[2836] Exhibit 23, Tab 22, Statement of Constable Lisa Ford, 24 January 1990, 3 (SCOI.00052.00024).

[2837] Transcript of the Inquiry, 18 May 2023, TR3992.1-8, (TRA.00054.00001).

[2838] Transcript of the Inquiry, 18 May 2023, TR3992.27–30 (TRA.00054.00001).

[2839] Transcript of the Inquiry, 18 May 2023, TR3995.33–38 (TRA.00054.00001).

5.3310. The NSWPF submitted that the "criticism" by Counsel Assisting was "unwarranted" and that "the conclusion that there were no suspicious circumstances surrounding the death (i.e. that Mr Wark had likely died by way of suicide) was premised not only on [I181]'s views, but a range of other inquiries".[2840] The NSWPF submitted that, at the time Constable Ford's statement of 13 January 1990 was prepared:

a. Mr Wark's body had been recovered from the water with no sign of apparent external injuries;

b. Constable Ford had obtained a statement from Mr Wark's father, who explained that he had been "very distraught over the last couple of days prior to his death" and "wasn't coping with life";[2841]

c. Constable Ford had contacted a doctor who had seen Mr Wark twice and noted that he had recently finished an eight-year relationship and was taking an anti-depressant;

d. Constable Ford had received consistent information from the psychologist I181, who also referred to his depression stemming from the end of an eight-year relationship; and

e. Mr Wark's property was found at the cliffs at the Gap, which had long been notorious as a place where a large number of people die after deliberately jumping from the cliffs.

5.3311. The NSWPF further submitted that Constable Ford's second statement of 27 January 1990 was prepared following confirmation from Dr Bradhurst that the injuries suffered by Mr Wark were consistent with a fall from a great height and that there were no suspicious indications arising from the post-mortem examination.

5.3312. There are two aspects to the submissions made by Counsel Assisting. The first is that, in my view, it is right to say that the conclusion reached by Constable Ford as of 13 January 1990, that there were "no suspicious circumstances", was premature. While the matters noted in the submission of the NSWPF may have occurred by 13 January 1990, they did not provide an adequate basis for such a conclusion to be reached at such an early juncture.

5.3313. I note that in fact the statement by Mr Wark's father did not describe his son as "not coping with life". Rather, this was a form of words used by Constable Ford in her statement.[2842] Ian Wark had described his son as "hallucinating", "nervous", "constantly on the move" and "frightened", which on any view is significantly different from "depression and loneliness".[2843]

[2840] Submissions of NSWPF, 1 June 2023, [67] (SCOI.83645)

[2841] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [9] (SCOI.00052.00018).

[2842] Exhibit 23, Tab 22, Statement of Constable Lisa Ford, 24 January 1990, [2] (SCOI.00052.00024)

[2843] Exhibit 23, Tab 9, Statement of Ian Wark, 11 January 1990, 1 (SCOI.00052.00025).

5.3314. Further, even if one were to accept that Constable Ford at some point attended the scene where the clothes had been located, this certainly had not occurred as of 13 January. To reach the conclusion that there were no suspicious circumstances, before police had so much as attended the location from which it was being assumed Mr Wark had deliberately taken his life, itself demonstrates that the conclusion was reached prematurely. Additionally, as I have remarked in other matters involving a fall from a clifftop, the fact that there may be no apparent injuries consistent with an assault is not a proper basis upon which it can be concluded that such a death is not suspicious.

5.3315. The second matter referred to by Counsel Assisting was Constable Ford's uncritical adoption, in both her statements, of I181's opinion that Mr Wark had taken his own life as a result of "depression and loneliness", such depression being said to be "due to the termination of an eight year homosexual relationship". I can well understand Ms Wark's concern that an assumption was made that because Mr Wark was a gay man and on anti-depressants, his death was a suicide. I agree that if such an assumption was made, it would clearly not be justified and could have unhelpfully served to substitute stereotypical assumptions for considered analysis of the evidence.

5.3316. I also accept Counsel Assisting's submission that I181 incorrectly described Mr Wark as taking "strong" doses of anti-depressants.

5.3317. Moreover, as submitted by Counsel Assisting, although the fact that Mr Wark had been treated for depression for some time was no doubt relevant information, it was not an adequate explanation for his mental state in the days leading up to his death. The "termination of the 8 yr old homosexual relationship" had occurred some months before Mr Wark's death (i.e. in the latter part of 1989), whereas Dr Goldbaum had been treating him for depression since April 1988 (well over 12 months earlier).

Evidence of I181

5.3318. Fifthly, Counsel Assisting submitted that as I181 had herself featured in events that occurred immediately prior to Mr Wark's death, at least as a matter of perception, reliance upon her opinion in relation to the cause of Mr Wark's death and his mental state was inadvisable. Counsel Assisting submitted that, rather than relying on her letter to the Coroner, police should have gone back to I181 and sought clarification from her in relation to contact from Mr Wark on 8 and 9 January and her understanding concerning his attendance at her home address on 9 January.

5.3319. In response, the NSWPF submitted that:

a. I181's evidence was consistent with other evidence obtained at the time;

b. "[W]ere the matter to have progressed further (either to inquest or to some form of criminal investigation) no doubt [I181]'s evidence would have been sought in more detail";[2844]

[2844] Submissions of NSWPF, 1 June 2023, [69] (SCOI.83645).

c. Counsel Assisting's suggestion that I181 "featured" in the events that occurred immediately before Mr Wark's death "imports a vaguely sinister tone that is unwarranted";[2845]

d. I181's evidence was clearly relevant to the investigation and "there is no reason her views as to Mr Wark's mental state should be discounted in the way suggested by Counsel Assisting";[2846]

e. Dr Sullivan had stated that the "impression of the psychologist related to depression and heavy alcohol use appears appropriate",[2847] and also that he considered Mr Wark's behaviour in the preceding days, and the circumstances of his death, to be "consistent with suicide".

5.3320. I do not find these submissions persuasive. In my view:

a. While it is true that I181's opinion was consistent with the limited information she had from Dr Sleep, and with Mr Wark's usual GP — in that Mr Wark had a history of depression, heavy alcohol use and had (some months previously) concluded a long-term relationship — it did not by any means capture the complete picture of Mr Wark's behaviour in the days and weeks prior to his death;

b. Mr Wark was displaying signs of psychosis;

c. While I181's evidence may have been "sought in more detail" had the matter gone to inquest, the reliability of and basis for her opinion was crucial and relevant at the time of the police investigation, including as to whether the matter went to inquest or not, and whether further police investigative steps should have been taken;

d. Counsel Assisting's submission did not import "a vaguely sinister tone"; and

e. Counsel Assisting's submission that I181's understanding of events occurring on 8 and 9 January 1990, and the extent of her appreciation of Mr Wark's mental state at that time, should have been examined, was entirely appropriate and I accept it.

Return of possessions to family

5.3321. Sixthly, Counsel Assisting submitted that police appear to have returned Mr Wark's possessions to his family without having photographed them or considered their investigative utility. It was left to Mr Wark's sister to investigate the significance of some dockets and receipts that were amongst the items left at the Gap, leading to the discovery of Mr Wark's property at the David Jones lost property counter.[2848]

[2845] Submissions of NSWPF, 1 June 2023, [69] (SCOI.83645).

[2846] Submissions of NSWPF, 1 June 2023, [69] (SCOI.83645).

[2847] Exhibit 23, Tab 64. Expert report of Dr Danny Sullivan, 24 October 2022, [36] (SCOI. 82114).

[2848] Exhibit 23, Tab 11, Statement of Rebecca Wark, 18 March 1990, [13]–[14] (SCOI.00052.00035).

5.3322. Counsel Assisting submitted that Mr Wark's clothing and other property should have been photographed and retained for potential forensic examination, and should also have been the subject of investigative follow-up by police.

5.3323. The submission by the NSWPF in response was:[2849]

> *had there been any real doubt as to the cause of Mr Wark's death, police would no doubt have further considered the investigative value of Mr Wark's clothing (see CA, [30](g)). The steps taken by Mr Wark's sister upon discovery of dockets and receipts among the items left at the Gap reflect very positively upon her, and the love she had for her brother. The information she uncovered, however, is not information that was required in order to sufficiently discern the manner and cause of Mr Wark's death.*

5.3324. A number of points must be made in relation to this submission:

a. At the time that Mr Wark's clothing was returned to his family, i.e., within days of his death, police ought not to have already formed the view (as the NSWPF submission presumes they had) that there was no "real doubt" as to the cause of Mr Wark's death. Even such limited investigative steps as were taken by police were far from completed at that stage, and a number of questions remained unanswered;

b. The NSWPF's praise for Ms Wark's work avoids the crucial point — Ms Wark should not have had to undertake these steps, because that was the responsibility of police. Family members should not be required to show their "love" for their deceased family members by doing the job of police;

c. The assertion that the information Ms Wark "uncovered" was not required "in order to sufficiently discern the manner and cause of Mr Wark's death" is untenable in my view. The information obtained by Ms Wark concerned Mr Wark's last movements and his behaviour in the hours before his death. That information was obviously relevant to a competent and thorough investigation of the circumstances surrounding his death (i.e. the manner of his death);

d. I find it extraordinary that it is apparently not now accepted by the NSWPF that a docket indicating that Mr Wark had left a bag of clothes at the David Jones store in the hours before his death was a matter which called for their own follow-up efforts;

e. I also note in particular Ms Wark's evidence to the Inquiry that the clothing found at the Gap was nothing like what Mr Wark would ever wear, and also that he always wore boots yet his body was found in lace-up shoes.[2850] Whatever the explanation may be for such discrepancies, they warranted at least some investigation by police;

f. Even if, in the end, the information had ultimately proven to be irrelevant to the manner and cause of death, that is a determination that can only be made

[2849] Submissions of NSWPF, 1 June 2023, [70] (SCOI.83645).

[2850] Transcript of the Inquiry, 18 May 2023, T3994.27–29 (TRA.00054.00001); Exhibit 23, Tab 21, Statement of Constable Lisa Ford, 13 January 1990, 1 (SCOI.10022.00040); Exhibit 23, Tab 24, Statement of Constable John Cox, 11 January 1990, 1 (SCOI.00052.00019).

once all available information has been gathered and assessed. At the time Ms Wark took these steps, the investigating police did not know whether the information was relevant or not; and

g. Even putting aside the potential relevance to manner and cause of death, the simple investigative step of checking the circumstances surrounding the deposit of the bag at the David Jones city store should have been undertaken by the police in the interests of providing relevant information, and thus some degree of reassurance, to family members. Not to have done so demonstrates, to my mind, an insensitivity towards the interests and concerns of family members left wondering about the circumstances of their loved one's death, and no doubt has contributed to the ongoing concerns that Ms Wark and her family have held over time in relation to the police investigation.

5.3325. I accept the submission by Counsel Assisting that the clothing and other property found at Gap Bluff should have been photographed and retained by the NSWPF, and that appropriate investigative steps should have been taken by police in relation to that clothing, to the documents found with it, and to the bag being left at David Jones.

Witness inquiries

5.3326. Seventhly, Counsel Assisting submitted that police did not take statements from a number of witnesses from whom it would have been advisable to do so. This included anyone at Mr Wark's workplace, and the last person known to have seen him alive, I181's landlady, who observed him to be "highly distressed and agitated",[2851] and some of the doctors involved in his care.

5.3327. In correspondence to the Coroner, sent in answer to queries raised by the family, the OICs indicated that they made phone contact with some of these people.[2852] Counsel Assisting submitted that the absence of such statements, however, affected the quality and detail of evidence available both for the Coroner's consideration and to help address the concerns of family members.

5.3328. The NSWPF accepted that "[i]deally, a statement would have been taken" from I181's landlady Mrs McLaughlin to "formally" record her account of seeing Mr Wark at I181's residence.[2853] However, the NSWPF further submitted that:[2854]

[2851] Exhibit 23, Tab 41, Letter from Constable Lisa Ford and Detective Michael Plotecki to the Coroner, 19 June 1990, [11] (SCOI.00052.00044).

[2852] Exhibit 23, Tab 41, Letter from Constable Lisa Ford and Detective Michael Plotecki to the Coroner, 19 June 1990, [11]–[13] (SCOI.00052.00044).

[2853] I note that the Submissions of NSWPF refer to Mrs McLaughlin as "Mr Wark's landlady", but consider that this is a typological mistake and that the NSWPF is referring to I181's landlady.

[2854] Submissions of NSWPF, 1 June 2023, [70] (SCOI.83645).

> *Having regard to the nature of the information obtained by police, and to the compelling evidence as to the cause of Mr Wark's death, the absence of such a statement is not a proper basis for criticism of investigating police. Had there been any real doubt as to the cause of Mr Wark's death, police would very likely have returned to formally record Mrs McLaughlin's account.*
>
> *As is explained in the correspondence from Constable Ford and Detective Constable Plotecki, "in any death inquiry, there will exist minor inconsistencies which are not able to be addressed".*

5.3329. Again, I do not accept these submissions. Among other things, I consider that:

a. The "nature of the information obtained by police" from Ms McLaughlin was highly concerning. When Ms McLaughlin spoke to Mr Wark, she said "he was highly distressed and agitated".[2855] In my view, "having regard" to this information should have prompted police to obtain a formal statement from her.

b. As of 12 January 1990, when I181 provided to police her letter to the Coroner, police were aware that I181's landlady was the last known person to have seen Mr Wark. While Mr Wark's injuries were in keeping with a fall from height, the precise location from where he entered the water, and t how he came to be at that location, were far from clear. Police also had evidence of irrational behaviour of Mr Wark in the days prior to his death which should have been a cause for further investigative work.

c. A statement from the last person to see a deceased person alive, within less than 24 hours of that person's death, is an investigative step that should be taken in every death being investigated by police for the Coroner.

d. The casual reference in the NSWPF submissions, to minor inconsistencies which are not able to be addressed", does not apply to the matters the subject of the submissions of Counsel Assisting and Ms Wark.

5.3330. Having regard to those matters, I do regard the absence of a statement from Mrs McLaughlin — as well as from those other persons referred to by Counsel Assisting — as "a proper basis for criticism of investigating police". As is evident in their letter to the Coroner, the family was very concerned that police had not spoken to a number of relevant witnesses. It was only when the Coroner asked the OICs to prepare a formal response to the family — in which the OICs outlined a number of witnesses they had spoken to — that these inquiries appear in the police or coronial record.

[2855] Submissions of NSWPF, 1 June 2023, [70] (SCOI.83645) citing Exhibit 23, Tab 41, Letter from Constable Lisa Ford and Detective Michael Plotecki to the Coroner, 19 June 1990 (SCOI.00052.00044).

5.3331. Counsel Assisting also submitted, and I agree, that questioning of significant witnesses (and statements from such witnesses) should have more thoroughly addressed certain matters. In the case of I182, for example, he did not appear to have been asked about suggestions of past violence in his relationship with Mr Wark. More detail should have been sought concerning any money he provided to Mr Wark, in view of family concerns as to where his money came from for the purchases he made on 9 January 1990.

Dispensing with an inquest

5.3332. Finally, Counsel Assisting submitted that it does not appear that the police pressed for the holding of an inquest, notwithstanding the family's concerns and that the witness I179 had not signed his statement.

5.3333. The response by the NSWPF stressed the issue of resources (references omitted):[2856]

> *Police resources are (and were) finite. While further inquiries may have been able to be conducted in relation to matters relating to Mr Wark's state of mind, such inquiries quite likely would not have resolved the family's residual doubts and, in any event, would not have advanced the position as concerns the manner and cause of Mr Wark's death.*
>
> *Similarly, coronial resources are finite. Where the manner and cause of death are appropriately disclosed on the available information, it is appropriate that an inquest be dispensed with. It is not the role of police to "press" for scarce coronial resources to be applied to such cases, in order to address inconsistencies that are unlikely to be of material significance to the determination of the manner and cause of a death.*

5.3334. As previously outlined, the assumptions too quickly made by police regarding Mr Wark's state of mind unduly emphasised his presumed "loneliness", "depression" and the "termination of a … homosexual relationship" rather than exploring and recognising the extent to which he was expressing fears about his safety and was in or approaching a state of psychosis.

5.3335. I do not accept that the concerns held by the family can be regarded as directed to mere "inconsistencies" which were not "material". The submission by the NSWPF that further enquiries "quite likely would not have resolved the family's doubts" is not only speculative but is indicative of a dismissive attitude towards those concerns even now.

5.3336. Whether or not the police should have pressed for the holding of an inquest, what can be said is that the coroner's decision in relation to whether to do so is heavily dependent on the quality of the police investigation, and it is most unfortunate that the investigation did not more thoroughly address the matters I have outlined above.

[2856] Submissions of NSWPF, 1 June 2023, [72] (SCOI.83645).

Manner and cause of death

Cause of death

5.3337. In line with the expert evidence of Dr Iles, and as submitted by Counsel Assisting, I find that Mr Wark's death resulted from "multiple injuries sustained in a fall from a height". This submission was supported by the NSWPF. I do not understand Ms Wark's submissions as propounding any different finding.

Location of death

5.3338. As Counsel Assisting noted, it might at first seem surprising that, if Mr Wark fell from somewhere near Gap Bluff at some time after about 2:30pm on 9 January, his body would be found near Dobroyd Head, within no more than about 18 hours, given the distance involved and the geography of the area.[2857] Professor Brander's opinions regarding this likelihood are set out at above.

5.3339. As Counsel Assisting further submitted, Professor Brander's opinion does not assist me in determining precisely when such a fall would have taken place. Rather, its value lies more in that it provides confirmation that it is quite possible that Mr Wark's body could have travelled from Gap Bluff to where it was found in the course of those (at most) 18 hours.

5.3340. As further submitted by Counsel Assisting, the strength of that possibility is fortified by the information in the memorandum prepared by Dr Bradhurst, which outlined that in January 1990 police officers with relevant experience also considered that Mr Wark's point of entry into the water could have been at the Gap.

5.3341. In addition, after obtaining the further statement from Mr Champion and material from the NPWS, Counsel Assisting submitted that Mr Champion's statement speaks for itself in relation to the likely location where the clothing was found.[2858] Counsel Assisting further submitted that the NPWS material tends to confirm Mr Champion's recollection that there was probably no fencing in place at the location as at January 1990, and that relevant fencing nearby was one metre or less in height.[2859]

5.3342. The NSWPF agreed that the likely point of entry of Mr Wark's body into the ocean was the Gap Bluff in Watson's Bay.

5.3343. Ms Wark took a different view. She stated in her oral submission, "[t]here was an assumption Blair was at the Gap. Is it possible that Blair was never at the Gap?"

[2857] See the map at Annexure A of the submissions of Counsel Assisting, 22 May 2023, 33 (SCOI.83197)

[2858] Supplementary submissions of Counsel Assisting, 18 October 2023, [7] (SCOI.86438).

[2859] Supplementary submissions of Counsel Assisting, 18 October 2023, [8] (SCOI.86438).

5.3344. Ms Wark also submitted in her supplementary submissions that the additional documents (namely, Mr Champion's further statement and the NPWS material) demonstrate the uncertainty of the precise location of the clothing found by Mr Champion and that, without a precise location for the clothing, the quality of the fencing at any "likely" location near Gap Bluff is simply irrelevant.[2860]

5.3345. Taking into account all the evidence, including the evidence of Mr Wark's last movements, his mental state at the time, the location of the clothing and other property at Gap Bluff, the handwritten memo of Dr Bradhurst, and the expert evidence of Dr Brander, I consider that Mr Wark's death occurred, on the balance of probabilities, as the result of a fall in the vicinity of the Gap at Watson's Bay.

5.3346. While the precise location of Mr Wark's clothing cannot be known, in light of the failure of investigating police to accurately record the location at the time, I accept Mr Champion's evidence that he found it at or close to the location he marked on the map for the Inquiry. I further find, having considered the evidence of Mr Champion and the material from NPWS, that there did not appear to be any high fencing at the location where Mr Wark's clothing was found. It is evident from the NPWS material that there was either no fencing or low fencing in this area.

Time of death

5.3347. Dr Bradhurst ultimately considered the direct cause of death to be "multiple injuries" and the date of death to have been "about 4½ to 4¾ days previously".[2861]

5.3348. Since the post-mortem commenced in the morning but appears not to have been completed until late in the afternoon on 14 January, that estimate is consistent with the period during which the evidence otherwise suggests Mr Wark's death must have occurred (namely, between around 2:30pm on 9 January and 9:30am on 10 January).

5.3349. I take into account the evidence from Professor Brander that (subject to the various qualifications and assumptions that he identified), if Mr Wark's body entered the water in the vicinity of Gap Bluff, this would most likely have occurred between 9:00pm on 9 January 1990 (the time of high tide) and 4:00am on 10 January 1990. As Professor Brander explained, allowance also needs to be made for the possibility that Mr Wark's body may have entered the water, or been on the rock platform at the base of the cliff, earlier than 9:00pm, before finally being washed into the ocean by wave action at high tide.

5.3350. I find that Mr Wark died between 2:30pm on 9 January and 9:30am on 10 January 1990.

[2860] Further submissions on behalf of Rebecca Wark, 1 November 2023, [4] (SCOI.86439).

[2861] Exhibit 23, Tab 7, Post-mortem report of Dr Peter Graham Bradhurst, 24 May 1990, 7 (SCOI.00052.00007).

Manner of death

5.3351. All parties made detailed submissions concerning the different hypotheses as to manner of death. I also received expert evidence relevant to the issue. I consider these submissions and evidence below.

Suicide

5.3352. Counsel Assisting submitted that the appropriate description of the cause and manner of Mr Wark's death would be that it resulted from "multiple injuries sustained in a fall from height after deliberately jumping from a cliff in the vicinity of the Gap at Watson's Bay. At the time of his death, Mr Wark was affected by a psychotic episode".[2862]

5.3353. In making this submission, Counsel Assisting noted:

a. The evidence of Mr Wark's mental state in the days preceding his death, which was consistent with psychosis;

b. Mr Wark's observed distress at about 2:00pm on 9 January 1990 while at I181's address in Double Bay; and

c. Dr Sullivan's opinions, as outlined above.

5.3354. Counsel Assisting submitted that, in light of this evidence, it appeared to be "highly probable" that Mr Wark took his own life while experiencing fears precipitated by the psychosis he was experiencing.

5.3355. The NSWPF submitted, as an unqualified assertion of fact, that "Mr Wark died as a result of a deliberate act during the course of a psychotic episode".[2863]

5.3356. However, counsel for Ms Wark submitted that there was insufficient evidence for a finding that Mr Wark's death was the result of suicide, and that the Wark family would be devastated if I made such a finding.[2864] This submission was reiterated in the supplementary submissions made by Ms Wark.[2865] In support of those submissions, counsel for Ms Wark identified the following factors:[2866]

a. The paucity of police investigations into Mr Wark's death at the time, and the subsequent inadequacies of the Strike Force Parrabell investigation;

b. The "remaining gaps in evidence in respect of the clothing and location at the Gap neither of which were photographed or investigated by police";

c. The "David Jones locker evidence" was never photographed or investigated;

d. The "all-too-willing assumptions" made by the initial police investigations, and then by Strike Force Parrabell, based on I181's letter to the Coroner; and

[2862] Submissions of Counsel Assisting, 22 May 2023, [135] (SCOI.83197).

[2863] Submissions of NSWPF, 1 June 2023, [59] (SCOI.83645).

[2864] Submissions on behalf of Rebecca Wark, 1 June 2023, [3] (SCOI.86415).

[2865] Further submissions on behalf of Rebecca Wark, 1 November 2023, [3], [11] (SCOI.86439).

[2866] Submissions on behalf of Rebecca Wark, 1 June 2023, [3] (SCOI.86415).

e. What was said to be the "heavy reliance by Counsel Assisting" on the statements of I182 and I179.

5.3357. Ms Wark submitted that due to the inadequacies of both the original police investigation and Strike Force Parrabell, there remains a reasonable doubt as to whether Mr Wark took his own life. She submitted that:[2867]

> *[t]he required standard of proof of a finding of suicide is simply not reached. The finding could only be reached relying on many doubtful assumptions, as regrettably, the Police left many obvious questions unanswered.*

5.3358. The submissions for Ms Wark made it clear that the Wark family does not agree with Dr Sullivan's views in relation to the possibility of suicide. Counsel for Ms Wark noted that Mr Wark's medication had worked successfully for him over many years and that Mr Wark's depression therefore was not his "predominant" or "singular character trait".[2868] Counsel also drew attention to Dr Sullivan's opinion that notwithstanding a history of depression, "…the information conveyed in his final days does not confirm relevant signs of symptoms of persisting mood disorder, and he was taking a low but effective dose of tricyclic antidepressant."[2869]

5.3359. In the introduction to this Chapter, I have considered the principles applicable to a finding of suicide.

5.3360. In the case of Mr Wark, by reference to the three elements comprising suicide, there is in my opinion insufficient evidence to establish that Mr Wark voluntarily or deliberately acted, where his intent was to end his own life, with a *conscious* understanding that jumping would necessarily result in death.

5.3361. In coronial proceedings a distinction is also often made between persons suffering from depression and those experiencing psychosis.[2870] Evidence that someone suffered from depression will not generally be seen as depriving that person of the ability to appreciate the consequences of their actions so as to preclude a finding of suicide, [2871] whereas "psychosis is generally deemed to preclude a finding of suicide, on the basis that the deceased's state of mind meant that they did not intend to kill themselves by their action even if death was the result."[2872]

5.3362. Ms Wark submitted that "a finding of suicide is unnecessary in this Inquiry and of no value to the historical record. Worse, it would support the Police's woefully inadequate investigations."[2873]

[2867] Submissions on behalf of Rebecca Wark, 1 June 2023, [5] (SCOI.86415).

[2868] Submissions on behalf of Rebecca Wark, 1 June 2023, [7] (SCOI.86415).

[2869] Submissions on behalf of Rebecca Wark, 1 June 2023, [7] (SCOI.86415) citing Exhibit 23, Tab 64, Expert Report of Dr Danny Sullivan, 24 October 2022, [28] (SCOI. 82114).

[2870] Stephanie Jowett, Belinda Carpenter and Gordon Tait, 'Determining a Suicide under Australian law', (2018) 41(2) *UNSW Law Journal,* 355.

[2871] Kevin M Waller, *Coronial Law and Practice in New South Wales* (Law Book, 2nd ed, 1982), 62.

[2872] Stephanie Jowett, Belinda Carpenter and Gordon Tait, 'Determining a Suicide under Australian law', (2018) 41(2) *UNSW Law Journal,* 355, 367.

[2873] Submissions on behalf of Rebecca Wark, 1 June 2023, [8] (SCOI.86415).

5.3363. Having considered all the evidence and submissions, I am satisfied both that Mr Wark died after falling from a cliff at Gap Bluff and that, at the time of his death, he was "affected by a psychotic episode".

5.3364. There is no direct evidence as to whether Mr Wark's fall was an intentional act on his part. Nor is there evidence which establishes that, if he did do so, he had either the intent to end his life or the understanding that such a result would follow. Moreover, while there is no evidence that the breakdown of his relationship with I182 some months earlier was present to his mind in the days immediately before his death, there is evidence which does establish that Mr Wark's fall occurred while he was in a psychotic state.

5.3365. In those circumstances I do not consider that a finding of suicide can be made.

Misadventure

5.3366. Dr Sullivan did not consider misadventure to have been likely. Relevant to his view in that regard was that Mr Wark (so Dr Sullivan inferred) had changed his clothes and left them at the department store, and that he had folded up his other clothes, and left his wallet in place (at the Gap). He also referred to Mr Wark's persecutory delusions and psychotic state.[2874]

5.3367. In her further submissions, Ms Wark submitted that, arguably, the apparent absence of a safety fence in the vicinity of the area marked by Mr Champion raises the possibility that Mr Wark's death was the result of an accident.[2875]

5.3368. While it is possible that Mr Wark slipped on the cliff edge at Gap Bluff and accidentally fell to his death, I also consider that this is unlikely, given that:

a. The weather on 9 January 1990 was fine, with no rain recorded after 9:00am on 9 January 1990 and before 9:30am on 10 January 1990;

b. Some of what seems to have been Mr Wark's clothing, along with other property of his including credit cards and driver licence, was located neatly folded and tucked under a rock at the cliff edge; and

c. Mr Wark's behaviour and mental state was consistent with psychosis and he appeared to be experiencing persecutory delusions.

5.3369. However, while misadventure may be unlikely, nor can it be definitively ruled out.

Foul play

5.3370. Counsel Assisting noted that Mr Wark's conduct at the family home on 8 and 9 January 1990 naturally would have come as a great shock to his family members, and that a question understandably arose in their minds as to whether something may have happened earlier on that day that precipitated a genuine fear in Mr Wark that may have been based in reality.

[2874] Exhibit 23, Tab 64, Report of Dr Danny Sullivan, 24 October 2022, [41] (SCOI.82114).

[2875] Further submissions on behalf of Rebecca Wark, 1 November 2023, [5] (SCOI.86439).

5.3371. As Counsel Assisting submitted, Mr Wark's mental state had shown clear signs of deterioration over a number of days prior to this. He had contacted I182 while in a distressed state on 5 January 1990.[2876] He was making odd comments to I179 on 6 January 1990 in relation to the words "eat" and "death" and again seemed distressed.[2877] On 7 January 1990, in I182's presence, he was acting in a paranoid fashion and demanding that the blinds be drawn, and was referring to the "Triads" and a "shooting gallery".[2878] On 8 January 1990, Dr Marriott considered that he showed signs of "pre-psychosis".

5.3372. As Counsel Assisting also submitted, Mr Wark's actions in purchasing new clothes and leaving a bag of clothes and other items at the David Jones store on the morning of 9 January are difficult to rationalise. The same can be said for the manner in which he left his clothes and other items at the Gap.

5.3373. However, as was also submitted, those actions do not indicate the likelihood of an act of foul play or the involvement of a second person in Mr Wark's death.

5.3374. Dr Sullivan's assessment was this:[2879]

> *Mr Wark was exhibiting an abrupt change in mental state associated with anxiety and fear that he would be killed related to persecutory delusions. A person in a psychotic state is likely to exhibit significant disturbances of judgement, and their behaviour may not follow rational or predictable patterns when affected by delusions and distressed emotional state associated with this.*

5.3375. The NSWPF submitted that there is "no cogent evidence" pointing to the involvement of any known individual in Mr Wark's death.

5.3376. Ms Wark's submissions — while not explicitly rising to a contention that foul play was the likely manner of death — noted the evidence that Mr Wark was scared for his own life and for his family's safety, and that he was dead less than 24 hours later.

5.3377. In her oral submission, Ms Wark raised concerns regarding I179 and I182, including the following matters:[2880]

a. The failure of investigating police to query the potential role of I179 in Mr Wark's death, given his reluctance to give a statement and his obvious anger with Mr Wark as expressed in the letter he wrote;

b. The weight that police put on I179's unsigned statement, particularly about Mr Wark's suicidal tendencies, when they had evidence that I179 was "an unreliable character, a heroin addict with form"; and

[2876] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [8] (SCOI.00052.00028).

[2877] Exhibit 23, Tab 15, Statement of I179, 29 January 1990, [9]–[12] (SCOI.00052.00030). I note however that I discount the relevance of this feature of Mr Wark's behaviour – see above.

[2878] Exhibit 23, Tab 14, Statement of I182, 27 January 1990, [9] (SCOI.00052.00028).

[2879] Exhibit 23, Tab 64, Expert report of Dr Danny Sullivan, 24 October 2022, [41] (SCOI.82114).

[2880] Transcript of the Inquiry, 18 May 2023, T3994.32-T3995.4 (TRA.00054.00001).

c. The failure of investigating police to query the circumstances around Mr Wark's long-term relationship with I182, including why I182 gave Mr Wark pocket money and money to pay his accounts.

5.3378. Further, in her supplementary submissions, Ms Wark submitted that the presence or absence of a fence does not rule out the possibility that an unknown party was involved in Mr Wark's fall, and that such a possibility was not investigated by the police, there having been no police inspection of the site.[2881]

5.3379. Ms Wark also stated that Mr Champion's impression of the neatness of the clothing raises a question as to whether the clothing may have been worn at all and, on one view, may support a theory that the clothing was not Mr Wark's and had been placed there by a third party to give the impression that Mr Wark had taken his own life at the Gap.[2882]

5.3380. I have given careful consideration to whether there is a possibility that any identifiable individual who had some interaction with Mr Wark in the days leading up to his death may have somehow been involved in it. That consideration has included some of the untested features of the evidence that might raise concerns if they are true.

5.3381. One such feature is the assertion, made by I179, that on past occasions I182 had been violent towards Mr Wark. This assertion cannot be tested given that I182 is deceased.

5.3382. However, even if that were true, I accept the submission of Counsel Assisting that there is no cogent evidence suggesting the involvement of I182 (or anyone else) in Mr Wark's death.

5.3383. I also do not consider there to be any real likelihood that I179 was involved in Mr Wark's death. Among other things, I note that I179 wrote his letter to Mr Wark at a time when Mr Wark was already dead, in terms inconsistent with any awareness on the part of I179 that that was so after Mr Wark's death in circumstances where he clearly had not become aware of the death. Mr Wark's references to Mr Hutchence (even if, as Ms Wark submitted, he had been a school friend of Mr Wark) and the Triads seem more likely to have been symptoms or instances of his psychosis, rather than a fear based in reality.

5.3384. As to the possibility that Mr Wark was assaulted near Dobroyd Head, I agree with Counsel Assisting that this is highly unlikely. For that scenario to apply, it would require either that Mr Wark went to the Gap, took off some of his clothes and left them there, and then took a trip to the Dobroyd Head area and was assaulted there, or that Mr Wark went to Dobroyd Head and was assaulted there, with such an assailant taking some items of his clothing and then travelling to the Gap and depositing them there. Neither of those alternatives is at all probable.

5.3385. Considered as a whole, the evidence in my view does not establish, or provide an objective basis for a reasonable suspicion, that Mr Wark's death was a homicide.

[2881] Further submissions on behalf of Rebecca Wark, 1 November 2023, [6] (SCOI.86439).

[2882] Further submissions on behalf of Rebecca Wark, 1 November 2023, [7] (SCOI.86439).

Conclusion as to manner of death

5.3386. For the reasons outlined above, in my view there is objectively no reason to suspect that Mr Wark's death was a homicide.

5.3387. However, in my view, neither suicide nor misadventure can be ruled out.

5.3388. Mr Wark had a long-term history of depression, but I am satisfied on the evidence that the dominant feature of his mental state in the days leading up to his death was not depression but psychosis. That being so, even if (as is possible) Mr Wark deliberately jumped from the cliff, it is at least possible if not probable that he did so while under the irrational influence of his psychosis. In such circumstances I consider that the evidence is not such as to support a conclusion that Mr Wark intended to end his life, or that he had the capacity to properly understand the probable consequences of his action.

5.3389. Accordingly, I have determined that the appropriate finding, in all the circumstances, is in the following terms:

> *Mr Wark died as a result of multiple injuries sustained in a fall from a height from a cliff in the vicinity of the Gap at Watson's Bay. At the time of his death, Mr Wark was affected by a psychotic episode.*

Bias

5.3390. As Counsel Assisting submitted, while the location of Mr Wark's body in Sydney Harbour was not far from Reef Beach and Dobroyd Head (two locations known to be beats at which men had been attacked), there is no evidence that Mr Wark frequented either Reef Beach or Dobroyd Head and (as noted above), it is very unlikely that he was assaulted there. Further, the evidence has established that it was feasible for Mr Wark's body to have travelled from the vicinity of Gap Bluff to the location in Sydney Harbour where it was found, within the relevant timeframe.

5.3391. As I have said, there is in my view objectively no reason to suspect that Mr Wark's death was a homicide, or that a second person was involved.

5.3392. In such circumstances, there is also, objectively, no reason to suspect that LGBTIQ bias was a factor in his death.

Conclusions and Recommendations

5.3393. As to manner and cause of death, I find that:

> *Mr Wark's death resulted from multiple injuries sustained in a fall from a height from a cliff in the vicinity of the Gap at Watson's Bay between 2:30pm on 9 January and 9:30am on 10 January 1990. At the time of his death, Mr Wark was affected by a psychotic episode.*

5.3394. In my view, on the evidence available to the Inquiry, there is objectively no reason to suspect that LGBTIQ bias was a factor in Mr Wark's death.

5.3395. I do not propose to make any recommendations arising from the Inquiry's consideration of Mr Wark's death.

IN THE MATTER OF WILLIAM DUTFIELD

Factual background

Date and location of death

5.3396. William Dutfield was found deceased in the lounge room of his apartment in Mosman, Sydney, on Wednesday 20 November 1991. It is likely that Mr Dutfield died on the evening of Tuesday 19 November 1991 as a result of multiple blunt force injuries to his head,[2883] having been struck by an assailant with a heavy metal "sticky-tape dispenser" that was located in his apartment.[2884]

5.3397. Mr Dutfield was 41 years old at the time of his death.[2885] He was known by his friends to be gay or bisexual (the conflicting evidence about Mr Dutfield's sexuality is discussed below).[2886]

Circumstances of death

5.3398. Evidence about Mr Dutfield's movements on 19 November 1991 is scarce, with information about his activities on that day primarily provided by his close friend, Arthur Ashworth, with whom he spent the majority of the day. As will become apparent, as a consequence of Mr Ashworth's possible involvement in Mr Dutfield's death, there is very little independent evidence concerning Mr Dutfield's movement on this day.

5.3399. Mr Ashworth's evidence was that he and Mr Dutfield had several drinks throughout the day, including two scotches each at Mr Dutfield's apartment at approximately 5:30pm.[2887]

5.3400. As described below, the times at which Mr Dutfield's and Mr Ashworth's subsequent movements occurred are the subject of conflicting evidence. However, it is at least clear that Mr Dutfield and Mr Ashworth went to the Mosquito Bar restaurant together at approximately 7:00pm on the evening of 19 November 1991, which is a 350 metre walk from Mr Dutfield's apartment.[2888]

[2883] Exhibit 11, Tab 4, Post-mortem Report of Dr Duflou, 1 April 1992 (SCOI.00027.0031); Exhibit 11, Tab 6, Findings of Deputy State Coroner Abernethy, Inquest into the death of William Dutfield, 12 December 1994 (SCOI.00027.00001).

[2884] Exhibit 11, Tab 7, Transcript of Coronial Inquest into the death of William Dutfield, 12 December 1994, T7 (SCOI.00027.00025).

[2885] Exhibit 11, Tab 9, Statement of Detective Senior Sergeant Dennis Peter O'Toole, 27 January 1994 (SCOI.00027.00036

[2886] Exhibit 11, Tab 9, Statement of Detective Senior Sergeant Dennis Peter O'Toole, 27 January 1994, [12] (SCOI.00027.00036); Exhibit 11, Tab 29A, NSWPF Running Sheet, '3/1/1', 12 August 1998 (SCOI.10067.00134); Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [4] (SCOI.00027.00044).

[2887] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [6]–[9] (SCOI.00027.00044).

[2888] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [7]–[9] (SCOI.00027.00044).

5.3401. Mr Dutfield and Mr Ashworth then returned to the apartment sometime between 7:45pm and 8:45pm.[2889] According to Mr Ashworth, he and Mr Dutfield had a further scotch in the apartment before Mr Ashworth left to his retirement home.[2890]

5.3402. Neighbours who lived directly below Mr Dutfield in the apartment complex heard loud arguing occurring between two male voices, one louder than the other, followed by a number of "thud" sounds while watching the first half of the program "LA Law" on TV, which had aired between 9:30pm and 10:30pm.[2891]

5.3403. Mr Ashworth called police at approximately 11:00am on Wednesday 20 November 1991 to say that he had found Mr Dutfield deceased in his apartment.[2892]

Criminal proceedings

5.3404. No criminal proceedings have ever been instituted against any person in relation to Mr Dutfield's death.

Person of interest

5.3405. The key person of interest in relation to the death is now Mr Ashworth, who died on 29 July 2006. Mr Ashworth was aged 76 at the time of Mr Dutfield's death in 1991.

5.3406. At the time of the original police investigation in 1991, the possibility of Mr Ashworth's involvement appears to have been dismissed on the basis of his age.[2893] I return to the early dismissal of the possibility of Mr Ashworth's involvement below.

5.3407. Counsel Assisting submitted that, in consideration of all the now-available evidence, there is a "very high likelihood" that Mr Ashworth killed Mr Dutfield.[2894] I return to this submission below.

Previous investigations

Original police investigation

5.3408. Police attended Mr Dutfield's apartment on Tuesday 20 November 1991 at approximately 12:00pm.[2895] When police arrived, Mr Dutfield's body was lying face down on a lounge chair, with "massive wounds" to the back of his head.[2896]

[2889] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [7]–[9] (SCOI.00027.00044); Exhibit 11, Tab 29E, NSWPF Running Sheet, 'Interview with I69 - Mosquito Bar patron', 26 November 1991 (SCOI.10067.00093).

[2890] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [10] (SCOI.00027.00044).

[2891] Exhibit 11, Tab 14, Statement of I58, 20 November 1991 (SCOI.00027.00042); Exhibit 11, Tab 16, Statement of I59, 20 November 1991 (SCOl.00027.00043); Exhibit 11, Tab 29A, NSWPF Running Sheet, '3/1/1', 12 August 1998 (SCOI.10067.00134).

[2892] Exhibit 11, Tab 9, Statement of Detective Senior Sergeant Dennis Peter O'Toole, 27 January 1994, [3] (SCOI.00027.00036).

[2893] Exhibit 11, Tab 38, NSWPF Investigator's Note, 'Dennis O'Toole', 22 September 2010 (SCOI.10068.00036).

[2894] Submissions of Counsel Assisting, 6 February 2023, [98] (SCOI.82376).

[2895] Exhibit 11, Tab 12, Statement of Constable Christopher Peter Kolder, 14 June 1993 (SCOI.00027.00034).

[2896] Exhibit 11, Tab 9, Statement of Detective Senior Sergeant Dennis Peter O'Toole, 27 January 1994, [3] (SCOI.00027.00036).

Investigative steps taken by police

5.3409. Senior Constable Christopher Kolder, a crime scene officer, examined the crime scene and made the following observations:[2897]

a. A number of swabs of blood were taken from the scene, including of tissues found in the kitchen waste bin;

b. The whole apartment had been fingerprinted;

c. Blood stain patterns were present in the apartment;

d. There were no signs of forced entry or a struggle, other than one rug having been disturbed;

e. The perpetrator appeared to have washed their hands in both the kitchen and bathroom sinks;

f. The tape dispenser was in the kitchen sink and it appeared that an attempt had been made to wash it, though blood remained on it;

g. There were two drinking glasses on a table in the lounge room near the body that contained scotch, and a bottle of scotch in the kitchen with a "nip pourer" was located nearby;

h. There was cardigan found on the arm of the lounge suite which had blood stains on it; and

i. A wallet was on the floor beside the deceased.

5.3410. The police investigation was then handed over to Detective Senior Sergeant Dennis O'Toole, who was the OIC on record.[2898]

5.3411. Investigating police spoke to residents of the apartment building, patrons of the restaurant attended by Mr Ashworth and Mr Dutfield, and sought information from taxi companies.[2899] The outcome of those enquiries is discussed further below.

5.3412. According to Detective Senior Sergeant O'Toole, Mr Ashworth and I54 (Mr Dutfield's long-time friend) were "extensively interviewed" by police, each of whom provided a statement to police.[2900] Police records of 26 November 1991, indicate that Mr Ashworth was to be further interviewed and that a further statement was to be obtained from him, but it appears that this never occurred.[2901]

5.3413. Mr Ashworth was excluded as a suspect by the original police investigation. Detective Senior Sergeant O'Toole later said that "he was never considered as a suspect due to his age and investigators believed [he] was physically incapable of committing a murder".[2902]

[2897] Exhibit 11, Tab 12, Statement of Constable Christopher Peter Kolder, 14 June 1993 (SCOI.00027.00034).

[2898] Exhibit 11, Tab 9, Statement of Detective Senior Sergeant Dennis Peter O'Toole, 27 January 1994 (SCOI.00027.00036).

[2899] Exhibit 11, Tab 9, Statement of Detective Senior Sergeant Dennis Peter O'Toole, 27 January 1994, [11] (SCOI.00027.00036).

[2900] Exhibit 11, Tab 9, Statement of Detective Senior Sergeant Dennis Peter O'Toole, 27 January 1994, [12] (SCOI.00027.00036).

[2901] Exhibit 11, Tab 29H, NSWPF Running Sheet, 'Interview of Arthur Ashworth on 21.11.91', 26 November 1991 (SCOI.10067.00076).

[2902] Exhibit 11, Tab 38, NSWPF Investigator's Note, 'Dennis O'Toole', 22 September 2010 (SCOI.10068.00036).

5.3414. A brief of evidence was provided to the Coroner's Court in early 1994. At that time, the police had been unable to identify a clear suspect.

Exhibits

5.3415. The NSWPF retained as exhibits many of the items taken from Mr Dutfield's apartment.

5.3416. At the time, the swabs of blood retrieved indicated the presence of a small amount of blood of a different blood type to Mr Dutfield. This was subsequently kept in a frozen state in the hope that in future it could be DNA tested against other samples.[2903]

5.3417. The fingerprinting of the apartment returned a negative result. At the Inquest, Senior Constable Kolder said that the lack of fingerprints (even belonging to Mr Dutfield) suggested that the apartment had been "wiped down" by the perpetrator.[2904]

5.3418. At the time of the original investigation, Mr Ashworth had provided "elimination prints" but not a DNA sample.[2905]

5.3419. The further forensic testing of the other exhibits is discussed below.

Findings of post-mortem examination

5.3420. An autopsy was performed by Dr Duflou on 20 November 1991. His Report of Death to the Coroner, dated 1 April 1992, documented multiple injuries to Mr Dutfield's body, including:[2906]

a. 16 lacerations on Mr Dutfield's head, as well as a number of abrasions and some minor bruising;

b. Abrasions, contusions and minor lacerations to the arms;

c. Some contusions to the right leg;

d. Extensive fracturing of the skull, causing subdural and subarachnoid haemorrhages; and

e. Extensive laceration of brain tissue.

5.3421. In his report, Dr Duflou considered the direct cause of Mr Dutfield's death to be "head injuries". Dr Duflou estimated the time of death to be about 11:00pm on 19 November 1991.[2907]

[2903] Exhibit 11, Tab 7, Transcript of Coronial Inquest into the death of William Dutfield, 12 December 1994, T5.54-60 (SCOI.00027.00025).

[2904] Exhibit 11, Tab 7, Transcript of Coronial Inquest into the death of William Dutfield, 12 December 1994, T8.1-9 (SCOI.00027.00025).

[2905] Exhibit 11, Tab 30, Review of an Unsolved Homicide Case Screening Form – William Dutfield, 2 May 2005, 16 (SCOI.10286.00008).

[2906] Exhibit 11, Tab 4, Post-mortem Report of Dr Johan Duflou, 1 April 1992 (SCOI.00027.00031).

[2907] Exhibit 11, Tab 4, Post-mortem Report of Dr Johan Duflou, 1 April 1992, 7 (SCOI.00027.00031).

5.3422. At the Inquest, Dr Duflou indicated that the U-shape of the head wounds was consistent with them having been caused by the sticky tape dispenser located at the scene. He stated that the injuries were severe and had involved at least 12 blows to the head. The skull fracturing was extensive, and Mr Dutfield would have died from half as many blows. He described Mr Dutfield's injuries to his arms, hands and wrists as defensive wounds, indicating that he was likely facing his attacker at some stage. A bruise was identified on one of his knees.[2908]

The police theory

5.3423. Detective Senior Sergeant O'Toole expounded a theory—about which he gave evidence at the Inquest—that Mr Dutfield's death was the result of a robbery. This appeared to be partly based upon an incident on 16 October 1991, some five weeks earlier, during which Mr Dutfield had been attacked and robbed by someone he had invited back to his apartment.

5.3424. On the night of 16 October 1991, Mr Dutfield had met a man, previously unknown to him, at the Rex Hotel "Bottoms Up" bar (a well-known gay venue in Kings Cross). Mr Dutfield invited the man back to his apartment in Mosman where they had a scotch together (noting the presence of the scotch glasses on the evening Mr Dutfield was killed). The man called Mr Dutfield a bastard and proceeded to punch and kick him to the face and body a number of times, before taking $900 from him.[2909] Fingerprints were found on a cigarette packet in Mr Dutfield's apartment, which were linked to N63 in 1998 (see further below).

5.3425. Detective Senior Sergeant O'Toole considered there to be similarities between Mr Dutfield's death and that of Wayne Tonks in Five Dock (who had been robbed, bashed, and killed in his residence, the weapon being a heavy ashtray).[2910] The police theory was that that "a person, or a number of persons, who are most probably male prostitutes, who are also most probably drug addicts from the Kings Cross area that prey upon these people", such as Mr Tonks and Mr Dutfield.[2911]

5.3426. The police, therefore, considered that the "most viable theory" in relation to Mr Dutfield's death was that after the October robbery of Mr Dutfield, "the buzz would've gone around that… this person is an easy touch and they may have had his phone number. Whether that further assault which turned into a murder was perpetrated by the original assault, or information might have been passed on by that person, we think that is most probably the most viable theory as to this murder."[2912]

[2908] Exhibit 11, Tab 4, Post-mortem Report of Dr Johan Duflou, 1 April 1992 (SCOI.00027.00031).

[2909] Exhibit 11, Tab 26, Statement of William Dutfield, 17 October 1991 (SCOI.00027.00038).

[2910] Exhibit 11, Tab 7, Transcript of Inquest into the death of William Dutfield, 12 December 1994, T12ff (SCOI.00027.00025).

[2911] Exhibit 11, Tab 7, Transcript of Inquest into the death of William Dutfield, 12 December 1994, T13.33-40 (SCOI.00027.00025).

[2912] Evidence of Detective Senior Sergeant O'Toole, Exhibit 11, Tab 7, Transcript of Inquest into the death of William Dutfield, 12 December 1994, T13.33-40 (SCOI.00027.00025).

5.3427. As a result, police concentrated their inquiries "on the male homosexual heroin addict type offenders in the prostitution area of Kings Cross" (to use the OIC's terminology).[2913] Detective Senior Sergeant O'Toole described attempts to "obtain information relating to the deceased's 'after dark' homosexual activities" from Mr Ashworth and I54, both of whom believed "he was engaged in this type of activity".[2914]

5.3428. I will return to this again when I consider the evidence below.

Findings at inquest

5.3429. An Inquest into Mr Dutfield's death was held on 12 December 1994 at Glebe Coroner's Court.

5.3430. Mr Ashworth gave evidence at the inquest held in 1994. He adopted the statement he had made to police on 20 November 1991 (the day after Mr Dutfield's death), qualifying it only by stating that Mr Dutfield had told him that he was bisexual rather than gay.[2915] Counsel Assisting submitted that given the nature of the questions Mr Ashworth was asked, he was clearly not considered to be a person of interest at the time.

5.3431. Following the evidence, the Coroner expressed the view that "Detective Senior Sergeant O'Toole's theory is a likely one".[2916] Counsel Assisting the Coroner submitted that he thought "the matter was investigated as thoroughly as it could."[2917]

5.3432. The formal finding made by then Deputy State Coroner Abernathy was that:[2918]

> *…the deceased on or about 19/11/1991… died of head injuries inflicted on him by a person or persons unknown.*

Subsequent police investigations

5.3433. In 1998, the investigation into Mr Dutfield's death was reopened. Police considered that the death may have been linked to the high-profile murder of Frank Arkell. However, investigators found the death to be unrelated to that matter.[2919]

[2913] Exhibit 11, Tab 7, Transcript of Inquest into the death of William Dutfield, 12 December 1994, 12ff (SCOI.00027.00025).

[2914] Exhibit 11, Tab 9, Statement of Detective Senior Sergeant Dennis Peter O'Toole, 27 January 1994, [12] (SCOI.00027.00036).

[2915] Exhibit 11, Tab 7, Transcript of Inquest into the death of William Dutfield, 12 December 1994, T25 (SCOI.00027.00025).

[2916] Exhibit 11, Tab 7, Transcript of Inquest into the death of William Dutfield, 12 December 1994, T33.14-15 (SCOI.00027.00025).

[2917] Exhibit 11, Tab 7, Transcript of Inquest into the death of William Dutfield, 12 December 1994, T32.13-15 (SCOI.00027.00025).

[2918] Exhibit 11, Tab 6, Findings of Deputy State Coroner Abernethy, Inquest into the death of William Dutfield, 12 December 1994 (SCOI.00027.00001).

[2919] Exhibit 11, Tab 31, Recommendation for Further Investigation–Historical Unsolved Homicide Case, 14 August 2007, 3 (SCOI.10286.00004).

5.3434. In August 1998, computer matching of fingerprint records identified a fingerprint found on a cigarette packet in Mr Dutfield's apartment belonged to NP63.[2920] NP63 was, therefore, considered to be a key suspect for the murder until he was positively excluded as a suspect when it was established that he had been in custody at the time of Mr Dutfield's death.[2921]

Unsolved Homicide Team review

5.3435. In 2005, Mr Dutfield's death was reviewed by the UHT. On 2 May 2005, a Case Screening Form was completed, recommending that the following action be taken:[2922]

a. Further examination of the tissue with blood from the kitchen waste bin, and cigarette butts, using contemporary techniques;

b. Reexamination of the sticky tape dispenser; and

c. Obtaining an elimination DNA sample from Mr Ashworth.

5.3436. At that time, it was noted that the exhibits were with FASS (then DAL) for re-testing. It appears that this report was not received until 2007. The sticky-tape dispenser was also being re-examined at Westmead Laboratories.

5.3437. Despite the fact that these recommendations were made in May 2005, it appears that no attempt had been made by the NSWPF to obtain a DNA sample from Mr Ashworth by the time he died in July 2006.

5.3438. On 8 February 2007 a report was received from FASS which noted that a full DNA profile had been obtained from the stained tissue that was recovered from the kitchen waste bin.[2923]

5.3439. In March 2007, in view of this (and notwithstanding that by this stage Mr Ashworth had died), an additional Case Screening Form recommended that:[2924]

> *Obtaining a profile from Ashworth should be seen as a priority … for elimination purposes or otherwise. Due to his age time may be limited and once he has passed away the opportunity may well be lost.*

Strike Force Hamish

5.3440. In September 2008 Strike Force Hamish was formed, with the following Terms of Reference: "[t]o further investigate the circumstances surrounding the murder of William James Dutfield at Mosman on 19/11/91."[2925]

[2920] Exhibit 11, Tab 53, Record of Fingerprint Identification – Fingerprint Case N-166513, 19 August 1998 (SCOI.10283.00073).

[2921] Exhibit 11, Tab 45, Strike Force Hamish Post-Operational Assessment, 2 October 2013, 5 (SCOI.02712).

[2922] Exhibit 11, Tab 30, Review of an Unsolved Homicide Case Screening Form – William Dutfield, 2 May 2005, 16 (SCOI.10286.00008).

[2923] Exhibit 11, Tab 30A, Additional Information Case Screening Form, 1 March 2007 (SCOI.10066.00036).

[2924] Exhibit 11, Tab 30A, Additional Information Case Screening Form, 1 March 2007 (SCOI.10066.00036).

[2925] Exhibit 11, Tab 45, Strike Force Hamish Post-Operational Assessment, 2 October 2013, 2 (SCOI.02712).

5.3441. Detective Senior Constable Hungerford was allocated as the officer in charge, and three priorities were identified as:[2926]

a. Outstanding follow up with possible suspect NP63;

b. Outstanding exhibit inquiries; and

c. Outstanding inquiries with Mr Ashworth.

5.3442. Much of the work of Strike Force Hamish, therefore, focussed on re-examining evidence and re-interviewing witnesses in connection with the possible involvement of Mr Ashworth. In June 2010, a forensic review of the matter was initiated, which involved locating all relevant existing crime scene exhibits which were then considered for relevant re-testing (or initial testing where none had yet occurred).

5.3443. In late 2010, following the forensic review, efforts were finally made to obtain a sample of Mr Ashworth's DNA. A sample was taken from a relative of Mr Ashworth's, as well as from a personal diary that had belonged to Mr Ashworth.

5.3444. In December 2010, FASS advised Strike Force Hamish investigators that the DNA samples taken from Mr Ashworth's personal diary matched those from the bloodied tissue and cardigan at the scene.[2927]

5.3445. In a discussion in 2010, Detective Senior Sergeant O'Toole told Strike Force Hamish investigators that Mr Ashworth "was never considered as a suspect due to his age and investigators believe [he] was physically incapable of committing the murder". Rather, he remained of the belief that the offender was a male sex worker, or someone posing as one. He was unaware that Mr Ashworth's fingerprint had been found on the murder weapon and could not say why no follow up statement was taken from him.[2928]

5.3446. As referred to above, NP63 was eliminated as a suspect by 2013, as it was ascertained that NP63 was in custody at the time of Mr Dutfield's death. Nevertheless, further testing by FASS had determined that blood on the tissue was not from Mr Dutfield nor from NP63.[2929]

5.3447. Strike Force Hamish investigators concluded that Mr Ashworth was the likely offender responsible for the murder of Mr Dutfield, and that, had he been alive, there would have been sufficient evidence to arrest him. They were of the view that there were no outstanding investigative opportunities.[2930]

[2926] Exhibit 11, Tab 45, Strike Force Hamish Post-Operational Assessment, 2 October 2013, 3–4 (SCOI.02712).

[2927] Exhibit 11, Tab 35, NSWPF Investigator's Note, 'I83 – DNA taken', 15 September 2010 (SCOI.10068.00058); Exhibit 11, Tab 43, Statement of I80, 18 November 2010 (SCOI.10065.00006); Exhibit 11, Tab 69, NSWPF Investigator's Note, 'DNA result advised by David Bruce', 15 November 2010 (SCOI.82158); Exhibit 11, Tab 71, Record of conversation between Forensic Biology and Detective Hungerford, 14 June 2012 (SCOI.82160).

[2928] Exhibit 11, Tab 38, NSWPF Investigator's Note, 'Dennis O'Toole', 22 September 2010 (SCOI.10068.00036).

[2929] Exhibit 11, Tab 45, Strike Force Hamish Post-Operational Assessment, 2 October 2013, 3 (SCOI.02712).

[2930] Exhibit 11, Tab 45, Strike Force Hamish Post-Operational Assessment, 2 October 2013, 10 (SCOI.02712).

Strike Force Parrabell

Bias Crimes Indicators Form

5.3448. A BCIF was completed in this case by Strike Force Parrabell.

5.3449. As Counsel Assisting observed, although the BCIF was completed several years after Strike Force Hamish, it makes no mention of the key conclusion reached by Strike Force Hamish, namely that the likely assailant was Mr Ashworth.[2931]

5.3450. Instead, the BCIF repeats, and appears to adopt the opinions expressed by the original OIC (and by the Coroner) which, after the conclusion of Strike Force Hamish, ought to have been considered a superseded case theory. [2932] Despite doing so, the BCIF nevertheless discounted the possibility of Mr Dutfield's death (assuming that it occurred in such circumstances) having been motivated by LGBTIQ bias (emphasis added):[2933]

> *The Rex Hotel rather than Dutfield's home address is relevant to the investigation but it is not bias related, as it is most likely that the offender/s in this murder were also homosexual.*

5.3451. I observe that the fact a perpetrator is or may be a member of the LGBTIQ community does not mean that person could not commit a crime motivated by LGBTIQ bias.

5.3452. Of the ten indicators in the BCIF, five were answered "No Evidence of Bias Crime", and five were answered "Insufficient Information". The Summary of Findings settled overall on "Insufficient Information", for reasons unstated. The "Comment" in the "Summary of Findings" is:[2934]

> *It appears unlikely that sexuality or other bias was involved in the death of William Dutfield and it is most likely that the motive for assaulting Dutfield was robbery related however this cannot be confirmed.*

5.3453. I accept the submission of Counsel Assisting characterising the quality of the work found in the BCIF as very poor. It takes no account of the conclusions of Strike Force Hamish, notwithstanding that the BCIF was completed a number of years after Strike Force Hamish concluded that it was highly likely that Mr Ashworth was the perpetrator or, at least, that NP63 had been excluded as a suspect. Conversely, as Counsel Assisting observed, if Mr Dutfield's death *had* occurred in the circumstances assumed in the BCIF, to dismiss the possibility of the presence of LGBTIQ bias was untenable.

[2931] Submissions of Counsel Assisting, 6 February 2023, [20] (SCOI.82376).

[2932] Exhibit 11, Tab 79, Strike Force Parrabell, Bias Crimes Indicators Review Form–William Dutfield, undated, 13-14, 19 (NPL.0115.0002.2149).

[2933] Exhibit 11, Tab 79, Strike Force Parrabell, Bias Crimes Indicators Review Form–William Dutfield, undated, 13-14 (NPL.0115.0002.2149).

[2934] Exhibit 11, Tab 79, Strike Force Parrabell, Bias Crimes Indicators Review Form–William Dutfield, undated, 19 (NPL.0115.0002.2149).

Case Summary

5.3454. The Strike Force Parrabell Case Summary for this matter (case summary number 50) reads as follows:[2935]

> ***Identity:*** *William James Dutfield was 41 years old at the time of his death.*
>
> ***Personal History:*** *Mr Dutfield was close friends with Arthur Ashworth, 76 years old.*
>
> ***Location of Body/Circumstances of Death:*** *On the night of his death Mr Dutfield and Ashworth had been to dinner at a nearby Mosman restaurant, before returning to Mr Dutfield's unit together. Ashworth indicated his absence about 9pm. Later that evening, a neighbour heard an argument from Mr Dutfield's unit followed by a loud noise. Mr Dutfield's body was located the next day by Ashworth who had returned to the residence. Ashworth was initially excluded as a suspect in relation to the murder given his age and frailty. Mr Dutfield suffered numerous head injuries having been violently assaulted with a cast iron sticky tape dispenser and a lamp having been attacked from behind whilst sitting in his lounge chair. An almost empty bottle of whiskey and two glasses were located on a coffee table. The offender broke out of the rear of the residence after stealing a small sum of cash. About one month prior to his murder, Mr Dutfield was the victim of a violent assault and robbery at his residence where he was punched and kicked about the head before $900 was stolen. No suspects were identified for this robbery.*
>
> ***Sexual Orientation:*** *Mr Dutfield identified as bisexual.*
>
> ***Coroner/Court Findings:*** *No suspects were identified for Mr Dutfield's murder until 1998 and then 2008 when police reinvestigated and re-affirmed Ashworth as a suspect. Ashworth's DNA was matched to the murder weapon and blood located within the unit. His original timeline of events was found to be incorrect and untruthful. Ashworth died in 2006. The Coroner stated that Dutfield, "... was bashed... that he invited someone home and there was in effect some sort of rip-off, probably for money."*
>
> ***SF Parrabell concluded there was insufficient information to establish a bias crime***

5.3455. In about January 2017, this matter was included in the "dip sample" by Sergeant Steer of the Bias Crimes Unit of the NSWPF, who also classified it as "Insufficient information".[2936]

[2935] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries–William Dutfield, 25 (SCOI.76961.00014).

[2936] Exhibit 6, Tab 84, Revised Strike Force Parrabell Review Table, undated (SCOI.74430).

5.3456. By contrast with the BCIF, the Case Summary does refer to the strong evidence against Mr Ashworth that was highlighted upon reinvestigation of the matter by Strike Force Hamish. However, the Case Summary is itself expressed in confused and confusing terms. For example:

a. That reference appears under "Coroner/Court findings", whereas in fact the DNA match only came to light many years after the inquest;

b. Under "Circumstances of Death", it still seems to be suggested that the death was motivated by robbery, reiterating the evidence of Mr Ashworth that "the offender broke out of the rear of the residence after stealing a small sum of cash", which was rejected by Strike Force Hamish; and,

c. The DNA matches are said to have involved the murder weapon and blood found in the apartment, whereas in fact the relevant forensic match with the murder weapon involved a fingerprint, not DNA.

5.3457. As Counsel Assisting submitted, the contents of the Case Summary, like those of the BCIF, indicate an entirely inadequate examination of the evidence available to Strike Force Parrabell.[2937]

5.3458. The NSWPF accepted that the Case Summary "may cause confusion" in that it refers to both the earlier theory in relation to the perpetrator of the initial robbery of Mr Dutfield, and the strong suspicions surrounding Mr Ashworth.[2938]

5.3459. The NSWPF went on to submit, nevertheless, that in the absence of a criminal proceeding against Mr Ashworth, a "cautious approach" to the categorisation of the death (as said to have been adopted by Strike Force Parrabell) was "appropriate".[2939]

5.3460. That submission is, in my view, unsustainable. It is clear that the BCIF and the Case Summary resort to a categorisation of "Insufficient Information", not as a result of "caution", but from confusion and carelessness.

Academic review

5.3461. The academic reviewers also classified the case as "Insufficient information".

Review by the Inquiry

5.3462. The Inquiry took the following steps in the course of examining the matter.

[2937] Submissions of Counsel Assisting, 6 February 2023 (SCOI.82376).

[2938] Submissions of NSWPF, 21 February 2023, [80] (SCOI.82560).

[2939] Submissions of NSWPF, 21 February 2023, [81] (SCOI.82560).

Summonses

5.3463. A summons was issued to the NSWPF on 18 May 2022 for all documents relating to investigations by the NSWPF of the death of Mr Dutfield, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Dutfield. Material in relation to Mr Dutfield was produced in response to Summons NSWPF1 on 8 June 2022.

5.3464. On 14 October 2022, a further summons was issued (NSWPF31), as it was apparent that there was investigative material dating from late 2010 onwards that had not been produced in response to NSWPF1. NSWPF31 also sought the complete police fingerprint file.[2940]

5.3465. In response to NSWPF31, additional material was produced to the Inquiry on 4 November 2022, and clarification was provided regarding the location of relevant material within police archive boxes previously provided to the Inquiry.

5.3466. On 5 December 2022, a summons was issued to FASS for their file so that all the DNA and other forensic evidence relating to the death of Mr Dutfield could be considered.[2941]

Interagency cooperation

5.3467. On 11 May 2022, the Inquiry wrote to the Coroners Court and requested a copy of the coronial file in relation to Mr Dutfield's death. This was provided on 26 May 2022.

Family members

5.3468. The Inquiry made efforts to contact surviving family members of Mr Dutfield, but these efforts were unsuccessful.

Contact with Mr Ashworth's family

5.3469. In light of the evidence before the Inquiry as to the potential involvement of Mr Ashworth in Mr Dutfield's death (which will be dealt with in more detail below), and the submissions of Counsel Assisting to that effect, the Inquiry wrote to Mr Ashworth's nephew on 3 May 2023. By that letter, the Inquiry enclosed the written submissions of Counsel Assisting and provided a timeframe for Mr Ashworth's family to contact the Inquiry to provide information and/or make submissions.[2942]

[2940] Exhibit 11, Tab 80, Letter from the Inquiry to the NSWPF enclosing Summons NSWPF31, 14 October 2022 (SCOI.82157).

[2941] Exhibit 11, Tab 81, Letter from the Inquiry to FASS enclosing Summons FASS2, 6 December 2022 (SCOI.82159).

[2942] Exhibit 68, Tab 5, Letter from E Camporeale to R Spence (nephew of Arthur Ashworth), 3 May 2023 (SCOI.86647).

5.3470. On 16 May 2023, the Inquiry received an email, which was sent jointly on behalf of two of Mr Ashworth's nephews and two nieces. In that email, Mr Ashworth's family stated that they found the submissions of Counsel Assisting difficult to accept because they presented a picture of their uncle that they "certainly did not know" and they set out a number of other observations concerning their uncle.[2943]

Contact with OIC

5.3471. On 18 September 2023, the Inquiry wrote to former OIC, Mr O'Toole, enclosing the written submissions made by Counsel Assisting and the NSWPF in relation to the death of Mr Dutfield.[2944]

5.3472. On 16 October 2023, the Inquiry received a submission from Mr O'Toole, who is no longer a serving member of the NSWPF.[2945] In his submission, Mr O'Toole expresses his continued belief that Mr Ashworth would not have been the perpetrator of the crime, and that it would have been committed by a person or persons unknown "who were attempting to rob him once again".

5.3473. I do not intend to summarise all of Mr O'Toole's observations, although I do note the following relevant beliefs or opinions he expresses:

a. Based on his experience dealing with suspects and offenders, he had a "sixth sense" as to whether a person he was interviewing would become "the main suspect, or even the offender", and that Mr Ashworth appeared to him to be a "person of truth";

b. He confirmed that he did not recall being informed by anyone that Mr Ashworth's fingerprints had been found on the murder weapon and repeats the observation (made in Counsel Assisting's submissions) that Mr Ashworth claimed the tape dispenser to have belonged to him, thereby providing a potential innocent explanation for the presence of his fingerprint on it;

c. He queries why Mr Ashworth would "need to murder [Mr Dutfield] in such a violent manner" and expresses the opinion that the frenzied nature of the attack is consistent with a different type of perpetrator; and,

d. He does not comment on the significance of discrepancies in the account given by Mr Ashworth, compared to those of a number of eyewitnesses, concerning the timing of his return with Mr Dutfield to the flat after having dinner, beyond observing that such "differing opinions" are "often the case when trying to tie people down to times".

[2943] Exhibit 68, Tab 5A, Email from family of Arthur Ashworth, 16 May 2023 (SCOI.86680).

[2944] Exhibit 66, Tab 28, Letter from the Inquiry to Mr Dennis O'Toole, 18 September 2023 (SCOI.86293).

[2945] Submissions of Mr Dennis O'Toole, 16 October 2023 (SCOI 86353).

5.3474. I have taken Mr O'Toole's submissions into account in my consideration of the matter. Respectfully, I do not find them persuasive. Notably, Mr O'Toole expresses no opinion concerning the DNA match subsequently made to Mr Ashworth's blood on items at the scene. While I recognise that Mr O'Toole would have had considerable experience as an investigator, I do not place any weight on an assertion that a rational assessment of the evidence can be made on the basis of the "sixth sense" he considers himself to have.

Consideration of the evidence

Mr Dutfield's personal background

5.3475. Known by family and friends as "Billy" or "Bill",[2946] Mr Dutfield was born on 21 May 1950, and grew up on the Northern Beaches of Sydney with four older brothers (one of whom died in 1989), including a twin brother. His father died in 1973. Mr Dutfield left school at the age of 15 and worked as a jockey until his late 20's.[2947]

5.3476. Mr Dutfield suffered a number of injuries from falls while a jockey, which his brother told police "appeared to affect his personality".[2948] As a result, Mr Dutfield was receiving an "invalid pension".[2949]

5.3477. According to his friend, I54 (who knew him for 20 years), Mr Dutfield had not held a permanent job in the nineteen years before his death.[2950] Requiring accommodation, Mr Dutfield was introduced to I54, and lived with him from 1971 for about five years. At that time, Mr Dutfield was approximately 21 years old, and I54 was 15 years older.

5.3478. During the 1970s, Mr Dutfield became friends with Mr Ashworth while working at the Rex Hotel in Kings Cross as a "bar useful".[2951] Mr Dutfield moved in with Mr Ashworth about ten years before Mr Dutfield's death.[2952] At the time of his death, Mr Dutfield was unemployed and lived alone in a one-bedroom apartment in Mosman owned by Mr Ashworth. Mr Ashworth lived nearby at a retirement village.[2953]

5.3479. His brother Robert told police that Mr Dutfield was lonely in the period leading up to his death. His only friends were I54 and Mr Ashworth and he had said that he wanted to meet other people.[2954]

[2946] Exhibit 11, Tab 17, Statement of I54, 20 November 1991, [2] (SCOI.00027.00045).

[2947] Exhibit 11, Tab 29c, NSWPF Running Sheet, 'Resume of Personal History of William Dutfield', undated (SCOI.10067.00134); Exhibit 11, Tab 9, Statement of Detective Senior Sergeant Dennis Peter O'Toole, 27 January 1994, [18] (SCOI.00027.00036).

[2948] Exhibit 11, Tab 29c, NSWPF Running Sheet, 'Resume of Personal History of William Dutfield', undated, 2 (SCOI.10067.00134).

[2949] Exhibit 11, Tab 26, Statement of William Dutfield, 17 October 1991 (SCOI.00027.00038).

[2950] Exhibit 11, Tab 17, Statement of I54, 20 November 1991, [3]-[4] (SCOI.00027.00045).

[2951] Exhibit 11, Tab 17, Statement of I54, 20 November 1991, [6] (SCOI.00027.00045); Exhibit 11, Tab 26, Statement of William Dutfield, 17 October 1991 (SCOI.00027.00038).

[2952] Exhibit 11, Tab 17, Statement of I54, 20 November 1991, [15] (SCOI.00027.00045).

[2953] Exhibit 11, Tab 17, Statement of I54, 20 November 1991, [15] (SCOI.00027.00045).

[2954] Exhibit 11, Tab 29c, NSWPF Running Sheet, 'Resume of Personal History of William Dutfield', undated (SCOI.10067.00134).

5.3480. There is also evidence that Mr Dutfield experienced poor mental health and may have developed a drinking problem. According to information provided to investigating police by his brother, Mr Dutfield's injuries from his time as a jockey affected his personality, and he often became depressed, started to drink heavily, and his relationship with other family members became strained.[2955]

5.3481. On two occasions, Mr Dutfield was referred to medical services. On 14 November 1991 (five days prior to his death), Mr Dutfield had been referred by his GP to his local community health centre for assistance with his alcohol use and management of anxiety.[2956]

5.3482. One month prior to this, in October 1991, someone (who appears to have been Mr Ashworth) had contacted a counsellor at the same centre. The counsellor recalls that the caller said:[2957]

a. He had a friend who (she recalls) was living with him at the time, and who was driving the caller "crazy" due to his drinking. He was drinking and causing problems in the flat;

b. The person was on an invalid pension, and that he was also causing problems with another friend; and

c. His friend would not attend alcohol counselling, and he (the caller) thought he (the friend) needed psychiatric help.

5.3483. The counsellor tried to encourage the caller to arrange to bring the person in to see her. Subsequently, the centre completed a mental health service intake form, after a referral was made by Mr Dutfield's GP, listing contact details of Mr Ashworth, the referral being for alcohol and "psych" problems.[2958]

5.3484. Mr Dutfield's friend I54 said that Mr Dutfield:[2959]

> *"would be very moody and when he was drinking you had to watch what you said, so that you would not offend him, because he would get upset and very angry. He was very sensitive when he had been drinking."*

5.3485. Mr Ashworth said that Mr Dutfield "drinks when he is depressed," and considered that Mr Dutfield "is a manic depressant, that is why he is on a pension."[2960]

[2955] Exhibit 11, Tab 29C, NSWPF Running Sheet, 'Resume of Personal History of William Dutfield', undated (SCOI.10067.00134).

[2956] Exhibit 11, Tab 24, Statement of I66 (Ridge Street Community Health Centre), 4 December 1991, (SCOI.00027.00050).

[2957] Exhibit 11, Tab 24, Statement of I66 (Ridge Street Community Health Centre), 4 December 1991, (SCOI.00027.00050).

[2958] Exhibit 11, Tab 24B, Intake data form (Ridge Street Community Health Centr), 4 December 1991, (SCOI.00027.00050).

[2959] Exhibit 11, Tab 17, Statement of I54 (friend), 20 November 1991, [15] (SCOI.00027.00045).

[2960] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [6] (SCOI.00027.00044).

Evidence regarding Mr Dutfield's sexuality

5.3486. The police investigators clearly held the view that Mr Dutfield was gay. Mr Ashworth said in his statement that Mr Dutfield confided in him that he was gay in the 1970s.[2961] At the Inquest, Mr Ashworth clarified that, when living together, Mr Dutfield told Mr Ashworth that he was bisexual.[2962]

5.3487. Detective Senior Constable O'Toole's evidence was that he made attempts to obtain "information relating to the deceased's 'after dark' homosexual activities" from Mr Ashworth and I54. Detective Senior O'Toole's statement recorded that they "stated that the deceased would not talk about any other sexual encounters he may have been involved in, however they both believe that he was engaged in this type of activity".[2963] An informant also indicated that Mr Dutfield was "known to frequent the Bottoms Up Bar, Kings Cross Rex Hotel, meet young homosexuals and later leave with them on an irregular basis".[2964] However Detective Senior Constable O'Toole also stated that no one at the Rex Hotel could identify Dutfield.

5.3488. Detective Senior Constable O'Toole considered that Mr Dutfield's attendance at a bar which was "frequented by homosexuals", and the evidence that he invited a man back to his apartment on the night of 16 October 2023 supported his conclusion that Mr Dutfield was gay.[2965]

Evidence regarding Mr Dutfield's relationship with Mr Ashworth

5.3489. As I have observed above, the key person of interest in this matter is Mr Ashworth. Mr Ashworth's evidence was that he met Mr Dutfield at the Rex Hotel in the 1970s, where Mr Dutfield was working at the hotel. By this time, Mr Ashworth was retired. Mr Ashworth and Mr Dutfield became close friends, and Mr Dutfield would, apparently, clean Mr Ashworth's unit weekly. Mr Ashworth described himself as becoming a "father figure" to Mr Dutfield.[2966]

5.3490. From about 1980, Mr Dutfield began living with Mr Ashworth, first at Potts Point, followed by Randwick and then at Cremorne. In June 1991, five months prior to Mr Dutfield's death, Mr Ashworth moved into a retirement village. Mr Dutfield moved into the apartment in Mosman, owned by Mr Ashworth.[2967]

5.3491. Their friend, I64 (who was 64 at the time of Mr Dutfield's death), described the relationship between Mr Ashworth and Mr Dutfield as "being a teacher, pupil type".[2968] I64 said that he had known Mr Dutfield for approximately 12 years, having met him through Mr Ashworth (who he knew for 25 years).

[2961] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [4] (SCOI.00027.00044).

[2962] Exhibit 11, Tab 7, Transcript of Inquest into the death of William Dutfield, 12 December 1994, T25.40-45 (SCOI.00027.00025).

[2963] Exhibit 11, Tab 9, Statement of Detective Senior Sergeant Dennis Peter O'Toole, 27 January 1994, [12] (SCOI.00027.00036); Exhibit 11, Tab 29A, NSWPF Running Sheet, '3/1/1', 12 August 1998 (SCOI.10067.00134).

[2964] Exhibit 11, Tab 9, Statement of Detective Senior Sergeant Dennis Peter O'Toole, 27 January 1994, [13] (SCOI.00027.00036).

[2965] Exhibit 11, Tab 9, Statement of Detective Senior Sergeant Dennis Peter O'Toole, 27 January 1994, [13] (SCOI.00027.00036).

[2966] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [4] (SCOI.00027.00044). Evidence later obtained from Mr Dutfield's brother suggests that Mr Dutfield was 23 when his father died.

[2967] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [5] (SCOI.00027.00044); Exhibit 11, Tab 29C, NSWPF Running Sheet, 'Resume of Personal History of William Dutfield', undated, 2 (SCOI.10067.00134).

[2968] Exhibit 11, Tab 22, Statement of I64 (friend), 25 November 1991, [3] (SC01.00027.00048).

5.3492. In their submission to the Inquiry, Mr Ashworth's family said, that while they "knew little of his private life", Mr Ashworth's relationship with Mr Dutfield was "understood by us as one centred on caring, kindness and mentorship of a younger man in need of support".[2969]

5.3493. The existence or extent of any sexual relationship between the two men, either in the past or around the time of the death, is not known. Mr Ashworth did not, at any stage during the police investigation, indicate that he was a member of the LGBTIQ community or otherwise had a sexual relationship with Mr Dutfield.

5.3494. Both family members and friends of Mr Ashworth, however, told Strike Force Hamish investigators that they thought that Mr Ashworth was "a [h]omosexual [m]ale".[2970] Of course, if Mr Ashworth was a member of the LGBTIQ community, that does not lead inexorably to any conclusion about his relationship with Mr Dutfield.

5.3495. When spoken to by Strike Force Hamish investigators on 4 November 2010, I54 made the following observations about Mr Dutfield and Mr Ashworth's relationship:[2971]

a. Mr Dutfield did not see himself as an equal intellectually to either I54 or Mr Ashworth because he was dyslexic. I54 considered that, as a result, Mr Dutfield would put Mr Ashworth and I54 down verbally and was quite abusive when intoxicated;

b. He never saw Mr Dutfield use violence. He was very short and physically weak and would be incapable of fighting; and

c. Mr Ashworth was physically stronger than Mr Dutfield, though he had never seen him fight with anyone.

5.3496. There is some evidence that Mr Dutfield would become argumentative in such circumstances and that Mr Ashworth would become frustrated with his conduct.[2972]

Mr Dutfield's movements before his death

5.3497. On Monday 18 November 1991, the day before his death, Mr Dutfield had met his twin brother, John, at a café at Warringah Mall and appeared to be in good spirits. He indicated to John that he was to see Mr Ashworth later that day.[2973] This was the last time Mr Dutfield's family were to see or hear from him.

[2969] Exhibit 68, Tab 5A, Email from family of Arthur Ashworth, 16 May 2023 (SCOI.86680).

[2970] Exhibit 11, Tab 36, NSWPF Investigator's Note, 'I83 – Information given', 20 September 2010 (SCOI.10068.00052); Exhibit 11, Tab 39, Investigator's Note, 'I79 spoken to', 22 September 2010 (SCOI.10068.00021); Exhibit 11, Tab 41, Investigator's Note, 'I55 spoken to', 3 November 2010 (SCOI.10068.00019).

[2971] Exhibit 11, Tab 42, NSWPF Investigator's Note, 'I54 spoken to', 4 November 2010 (SCOI.10068.00016).

[2972] Exhibit 11, Tab 42, NSWPF Investigator's Note, 'I54 spoken to', 4 November 2010 (SCOI.10068.00016).

[2973] Exhibit 11, Tab 29C, NSWPF Running Sheet, 'Resume of Personal History of William Dutfield', undated (SCOI.10067.00134).

5.3498. In respect of Mr Dutfield's movements on Tuesday 19 November 1991, there is a significant discrepancy between the evidence of Mr Ashworth on the one hand, and other eyewitness evidence. However, it is tolerably clear that, from at least 5:30pm on Tuesday, Mr Dutfield and Mr Ashworth were together.

Mr Ashworth's evidence

5.3499. According to Mr Ashworth, in the morning he went to Mr Dutfield's apartment and did some washing with him before returning to his retirement village.[2974]

5.3500. At about 4:30pm on the same day, Mr Dutfield visited Mr Ashworth's retirement village apartment with two beers, most of which Mr Dutfield proceeded to drink. Mr Ashworth thought that Mr Dutfield been already affected by alcohol "because he was a bit depressed".[2975]

5.3501. At 5:30pm they both went to Mr Dutfield's apartment where they each drank two scotches. At 7:00pm they went to the Mosquito Bar restaurant together where they drank a bottle of wine with dinner. When offering to pay for the meal, Mr Ashworth noted that Mr Dutfield had at least $150 in his wallet (which he did not use, as Mr Ashworth paid).[2976] The fact that no money was found in Mr Dutfield's wallet by police appeared to have caused the suspicion or assumption that he had been robbed.[2977]

5.3502. Mr Ashworth's recollection was that they left the restaurant at about 7:45pm and it took them ten minutes to walk back to Mr Dutfield's unit. They had a further scotch together and Mr Dutfield had two glasses of wine. Mr Ashworth recalled that the scotch bottle had a third remaining.[2978]

5.3503. According to Mr Ashworth, after these drinks Mr Dutfield was slightly drunk and wanted to go out and drink at a bar. Apparently, Mr Ashworth cautioned against it (citing the robbery incident) but Mr Dutfield said, "I might just go up the road, because I don't want to be by myself".[2979]

5.3504. According to Mr Ashworth, he then left Mr Dutfield's apartment on his own, arriving back at his retirement village at around 8:15pm where he "read for a while and went to sleep".[2980]

5.3505. When questioned by police, Mr Ashworth said that, on the Tuesday night, he had been wearing his "brown rig", which included brown pants, brown shoes, a beige shirt and light coloured jacket. He provided these items to the police.[2981]

[2974] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [6] (SCOI.00027.00044).

[2975] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [6] (SCOI.00027.00044).

[2976] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [8] (SCOI.00027.00044).

[2977] Exhibit 11, Tab 9, Statement of Detective Senior Sergeant Dennis Peter O'Toole, 27 January 1994, [12] (SCOI.00027.00036).

[2978] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [7]–[9] (SCOI.00027.00044).

[2979] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [10] (SCOI.00027.00044).

[2980] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [10] (SCOI.00027.00044).

[2981] Exhibit 11, Tab 29B, NSWPF Running Sheet 3/5/1, 'Clothing worn by Ashworth on the 19.11.91', 21 November 1991 (SCOI.10067.00122).

5.3506. Mr Ashworth assured the police that he was certain of his movements on the night of 19 November.[2982]

5.3507. Two days after Mr Dutfield's death, Mr Ashworth for the first time told police that he had seen a man in his 20s to 30s enter the lift as he departed the unit block on the evening of 19 November 1991.[2983] Counsel submitted that this was a "self-serving fiction" on the part of Mr Ashworth, being a "pertinent matter" which was not included in his statement, and not raised with the police until they questioned other inconsistencies in his account.[2984]

5.3508. The Coroner did not question the evidence provided by Mr Ashworth at the Inquest in 1994.[2985]

Independent evidence

5.3509. There are significant discrepancies between the evidence of Mr Ashworth and other eyewitness evidence.

5.3510. In respect of the time that Mr Dutfield and Mr Ashworth left the Mosquito Bar, the owner of the restaurant recalled that the pair left the restaurant somewhere between 8:25pm and 8:45pm.[2986] A customer, I69, told police that Mr Dutfield and Mr Ashworth were still there when she arrived at 8:40pm.[2987]

5.3511. This discrepancy of an hour is significant and raises doubt about the reliability of Mr Ashworth's account. Based upon the timing provided by eyewitnesses, Counsel Assisting submitted that Mr Dutfield and Mr Ashworth were more likely to have left the restaurant at 8:45pm, returning to the apartment closer to 9:00pm (after the time at which Mr Ashworth said that he had left).

5.3512. Counsel Assisting submitted that, if 9:00pm is taken to be the more accurate time for the return of the pair to Mr Dutfield's apartment, Mr Ashworth's evidence would place Mr Ashworth at Mr Dutfield's apartment at approximately 9:30pm – 10:00pm (the time that Mr Dutfield's neighbours heard the thudding). Mr Ashworth's evidence was that he only remained in Mr Dutfield's apartment for, at most, 20 minutes, was submitted by Counsel Assisting to be inconsistent with his account that they sat and talked (with Mr Dutfield having at least two drinks).

5.3513. In any case, Counsel Assisting submitted that, based on the above timing, it "is exceedingly unlikely that, after Mr Ashworth's departure, Mr Dutfield could have either gone out and returned with an assailant or could have arranged a liaison with an assailant".[2988]

[2982] Exhibit 11, Tab 29H, NSWPF Running Sheet, 'Interview of Arthur Ashworth on 21.11.91', 26 November 1991 (SCOI.10067.00076).

[2983] Exhibit 11, Tab 29H, NSWPF Running Sheet, 'Interview of Arthur Ashworth on 21.11.91', 26 November 1991 (SCOI.10067.00076).

[2984] Submissions of Counsel Assisting, 6 February 2023, [66] (SCOI.82376).

[2985] Exhibit 11, Tab 7, Transcript of Inquest into the death of William Dutfield, 12 December 1994 (SCOI.00027.00025).

[2986] Exhibit 11, Tab 18, Statement of I60 (witness), 21 November 1991 (SCOI.00027.00046).

[2987] Exhibit 11, Tab 29E, NSWPF Running Sheet, 'Interview with I69 - Mosquito Bar patron', 26 November 1991 (SCOI.10067.00093).

[2988] Submissions of Counsel Assisting, 6 February 2023, [65] (SCOI.82376).

5.3514. In respect of this possibility, police questioned a barman at the Rex Hotel who did not recognise a photo of Mr Dutfield shown to him, and stated that he was not in the bar on the night of 19 November 1991.[2989] According to investigating police, all enquiries to "to establish whether DUTFIELD was seen on the night of his murder after 9.00pm have proved negative."[2990]

5.3515. I accept Counsel Assisting's submissions in respect of the timing of Mr Ashworth's movements on the night of 19 November 1991. The NSWPF did not make any submissions in respect of these submissions.[2991] I do not consider it at all likely that Mr Dutfield left his apartment again on the Tuesday evening, and find it improbable that the timeframe allowed for an alternative assailant to enter Mr Dutfield's apartment.

5.3516. There is further conflicting evidence about the clothing of Mr Ashworth on the evening of 19 November 1991. Contrary to Mr Ashworth's description of his outfit as his "brown rig", the following evidence was provided to police:

a. I68, who had arrived at the Mosquito Bar at 8:20pm, recalled that Mr Ashworth was wearing a grey checked shirt, and said that he and Mr Dutfield were having a very involved conversation.[2992]

b. I69, who arrived at the Mosquito Bar at 8:40pm, also recalled that Mr Ashworth was wearing a grey checked shirt. She did not see when the pair left.[2993]

c. I58 described seeing Mr Dutfield and Mr Ashworth entering the apartment complex where Mr Dutfield lived at 5:30pm on 19 November (prior to going to dinner). He described Mr Ashworth as wearing a blue to grey coloured top with short sleeves and similar coloured pants.[2994]

5.3517. In respect of Mr Dutfield's level of intoxication, the evidence appears to be relatively consistent. The owner of the Mosquito Bar stated that when entering the restaurant Mr Dutfield was quite drunk and was slurring his words.[2995] I54 gave evidence that he had spoken to Mr Dutfield at about 6:30pm on 19 November 1991, and said that "I could tell that he was inebriated. He had enough to drink to make him bitter and sarcastic."[2996]

[2989] Exhibit 11, Tab 9, Statement of Detective Senior Sergeant Dennis Peter O'Toole, 27 January 1994, [13] (SCOI.00027.00036).

[2990] Exhibit 11, Tab 9, Statement of Detective Senior Sergeant Dennis Peter O'Toole, 27 January 1994, [16] (SCOI.00027.00036).

[2991] Submissions of NSWPF, 21 February 2023 (SCOI.82560).

[2992] Exhibit 11, Tab 29G, NSWPF Running Sheet, 'I68 spoken to re attendance at Mosquito Bar', 17 November 1991 (SCOI.10067.00088).

[2993] Exhibit 11, Tab 29E, NSWPF Running Sheet, 'Interview with I69 - Mosquito Bar patron', 26 November 1991 (SCOI.10067.00093).

[2994] Exhibit 11, Tab 14, Statement of I58, 20 November 1991 (SCOI.00027.00042).

[2995] Exhibit 11, Tab 18, Statement of I60, 21 November 1991, [5] (SCOI.00027.00046).

[2996] Exhibit 11, Tab 17, Statement of I54, 20 November 1991, [15] (SCOI.00027.00045).

Wednesday 20 November 1991

5.3518. On the morning of Wednesday 20 November 1991, Mr Ashworth said that he had visited I64 sometime after 8:00am.[2997] Mr Ashworth told police that he travelled to Woollahra via Wynyard, where he dropped off a pair of blue trousers at the dry cleaners.[2998]

5.3519. I64 confirmed that there was an arrangement for Mr Ashworth to visit him at his house in Woollahra at 10:00am on the morning of 20 November and that they were going to go to lunch together. According to I64, Mr Ashworth arrived early at 9:45am.[2999]

5.3520. I64 said that they did go into town together, but did not go to lunch as planned as Mr Ashworth said he had a teachers' reunion to go to. They remained at I64's house for half an hour, then got the train together from Edgecliff to Martin Place, before going their separate ways at about 11:00am. According to I64, Mr Ashworth was wearing brown pants and jacket and was carrying a briefcase that had a raincoat in it.[3000]

5.3521. Mr Ashworth stated he caught the train from Bondi Junction to Wynyard, where he attempted to call Mr Dutfield at a public phone at about 11:00am. Following this, Mr Ashworth caught a bus to Mr Dutfield's apartment. At the apartment, Mr Ashworth noted that the outside door was shut but (unusually) not locked, and that there was no answer when he rang the doorbell. Mr Ashworth then said that he opened the door to the apartment (with his own set of keys), and found Mr Dutfield's body in the lounge room.[3001]

5.3522. Mr Ashworth did not mention a teachers' reunion in his statement.

5.3523. I64 said he phoned Mr Ashworth at 6:30pm to ask how the reunion had gone. Mr Ashworth told him that Mr Dutfield had been murdered and "began to sob".[3002] From what Mr Ashworth had told him, I64 said he believed that I54 (another friend of Mr Ashworth's) had gone to Mr Dutfield's flat after I54 couldn't get hold of him on the phone, and that I54 had then discovered the body.[3003]

Police enquiries with dry cleaners

5.3524. Police records indicate that investigators attended a number of dry cleaning businesses on the morning of 21 November 1991 to make enquiries as to bloodstained clothing. This indicates that there was at least some attempt to check Mr Ashworth's evidence.

[2997] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [11] (SCOI.00027.00044).

[2998] Exhibit 11, Tab 29H, NSWPF Running Sheet, 'Interview of Arthur Ashworth on 21.11.91', 26 November 1991 (SCOI.10067.00076).

[2999] Exhibit 11, Tab 22, Statement of I64, 25 November 1991 (SCOI.00027.00048).

[3000] Exhibit 11, Tab 22, Statement of I64, 25 November 1991 (SCOI.00027.00048).

[3001] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [11]-[13] (SCOI.00027.00044).

[3002] Exhibit 11, Tab 22, Statement of I64, 25 November 1991, [7] (SCOI.00027.00048).

[3003] Exhibit 11, Tab 22, Statement of I64, 25 November 1991 (SCOI.00027.00048).

5.3525. One of the proprietors (Sheridan Gregory of Rosemont Dry Cleaners, located opposite where Mr Ashworth lived) stated that she had cleaned some bloodstained trousers on 20 November, which had stains to the pocket and cuff area. She could not provide any further details, including the name of the customer. Ms Gregory told police that it was not unusual to receive bloodstained clothing from residents of the nearby retirement village.

5.3526. On 22 November, police contacted Keith Halliday from Lawrence Dry Cleaners at Wynyard. Mr Halliday indicated that a pair of blue trousers had been taken to the business by Mr Ashworth for cleaning on 20 November 1991, and collected the next day 21 November. Mr Halliday could not assist in relation to whether or not the trousers were bloodstained.[3004]

Evidence regarding Mr Ashworth

5.3527. Regardless of the strength of the forensic evidence, considered below, I accept Counsel Assisting's submission that the evidence obtained during the course of the original investigation should have given rise to a strong suspicion that Mr Ashworth was involved in Mr Dutfield's death.

5.3528. In particular, the following inconsistencies and irregularities in Mr Ashworth's evidence should be remarked upon:

a. Mr Ashworth travelled to Woollahra for a lunch arrangement, but left prior to lunch to attend a teachers' reunion which he made no mention of in his evidence;

b. That Mr Ashworth took a pair of pants to Wynyard to be drycleaned on Wednesday (despite having many dry cleaners nearer to his residence), which matched the description of "blue to grey" that he was seen to be wearing on Tuesday night;

c. That Mr Ashworth told I64 that I54 had found Mr Dutfield's body, despite his later statement to police in which Mr Ashworth described finding the body.

5.3529. Counsel Assisting submitted that Mr Ashworth's actions were consistent with the possibility that, having killed Mr Dutfield on the Tuesday evening, Mr Ashworth sought to appear "normal" on Wednesday morning by keeping his commitment to visit I64, while arranging for his bloodstained trousers to be dry cleaned at Wynyard.

[3004] Exhibit 11, Tab 29J, NSWPF Running Sheet, 'Inquiries at Lawrence Dry Cleaners, Wynyard', 24 November 1991 (SCOI.10067.00033).

5.3530. Counsel Assisting acknowledged that the evidence concerning the nature of the interactions between Mr Dutfield and Mr Ashworth on the relevant evening is necessarily limited. Against the background of a close and possibly intimate relationship between Mr Dutfield and Mr Ashworth, Counsel Assisting considered it significant that Mr Ashworth had previously expressed great frustration with Mr Dutfield's conduct when intoxicated. However, on the Tuesday evening there is clear evidence that both men had been drinking, and that Mr Dutfield was highly intoxicated. Counsel Assisting submitted that it was possible that "emotions may have run high between the two of them".[3005]

5.3531. I accept, as far as the evidence allows, that there was some volatility in the relationship between Mr Ashworth and Mr Dutfield, and also that Mr Dutfield appeared to experience poor mental health. I also note that Mr Dutfield there were elements of dependency in the relationship Mr Dutfield had developed with Mr Ashworth over ten years (including the fact that Mr Dutfield lived in an apartment owned by Mr Ashworth), which suggests that a power imbalance existed between the two men, regardless of any romantic or sexual element which may have characterised the relationship.

5.3532. I turn now to consider the forensic evidence which, in Counsel Assisting's submission, strongly implicates Mr Ashworth.

Fingerprints on murder weapon

5.3533. During Strike Force Hamish, the NSWPF identified that a fingerprint located on the sticky-tape dispenser (being the murder weapon) belonged to Mr Ashworth. In an email of 11 May 2010 to Detective Stephen Hungerford, the OIC of Strike Force Hamish, Officer Craig Borton of "Major Crime Section Fingerprint Ops" stated as follows:[3006]

> *I have again compared Case N167016 (prints on Tape dispenser) against fingerprints of Arthur Ashworth. Graph W1 is identified as the right ring finger of Ashworth. I am unable to identify the remaining graph W2 as Ashworth. Was possibly incorrectly written off as Fully Eliminated in 1991. Graph W2 has now been scanned onto NAFIS with No Hit*

5.3534. The information available to Strike Force Hamish indicated that the "fingerprint was located and identified in the original investigation in 1991 and passed onto investigators however appears to have been overlooked as it is not mentioned in a running sheet, any statements or the [I]nquest."[3007]

[3005] Submissions of Counsel Assisting, 6 February 2023 [92] (SCOI.82376).

[3006] Exhibit 11, Tab 63, Emails between Stephen Hungerford and Craig Borton re Exhibits in Dutfield Murder, 11–14 May 2010 (SCOI.10283.00006).

[3007] Exhibit 11, Tab 45, Strike Force Hamish Post-Operational Assessment, 2 October 2013, 4 (SCOI.02712).

5.3535. The NSWPF records provided to the Inquiry from the original investigation indicate that the investigators *did* consider the fingerprint "Graph W1" against fingerprints supplied by Mr Ashworth, but that Mr Ashworth was incorrectly "fully eliminated" as a source of the prints.[3008]

5.3536. When interviewed by Strike Force Hamish investigators in 2010, Detective Senior Constable O'Toole said that he was not aware of this at the time.[3009] Mr O'Toole maintained that position in his submission to the Inquiry.[3010]

5.3537. Mr Ashworth, in his statement, provided an explanation for why his fingerprints may be on the tape dispenser. Mr Ashworth said:[3011]

> *When I retired from work about 16 years ago I took a large grey tape dispenser with me. This I left in the unit when I moved to the [retirement village] because I had no further use for it. This dispenser was kept on top of the fridge close to the wall on the right hand side.*

DNA evidence

5.3538. As mentioned above, a bloodied tissue located in the kitchen bin was retained for future DNA testing purposes (of which the police at the time were clearly aware).[3012] At the time of the original investigation, FASS (then DAL) was only able to determine that the blood type was different to that of Mr Dutfield.

5.3539. As discussed above, the 2005 UHT recommended further forensic testing of the retained exhibits, and for a DNA sample to be taken from Mr Ashworth (for elimination purposes).

5.3540. A DNA sample was not obtained from Mr Ashworth at the time. However, the tissue was resubmitted to FASS for DNA testing. The relevant profile obtained (from a person then described as unknown source "A") was also found to match the DNA profile of the blood found on the cardigan left at Mr Dutfield's apartment.[3013]

5.3541. As noted above, Mr Ashworth died in 2006.[3014]

[3008] Exhibit 11, Tab 50, NSWPF Fingerprint Full Elimination Jobs, 27 November 1991 (SCOI.10283.00024); Exhibit 11, Tab 51, NSWPF Record of Fingerprint Elimination, 'Fully Eliminated as Arthur William Ashworth', 2 December 1991 (SCOI.10283.00030); Exhibit 11, Tab 72, 'Part Elim – Ashworth 167016' – Photographs (SCOI.10283.00029)..

[3009] Exhibit 11, Tab 38, NSWPF Investigator's Note, 'Dennis O'Toole', 22 September 2010 (SCOI.10068.00036).

[3010] Submissions of Mr Dennis O'Toole, 16 October 2023 (SCOI 86353).

[3011] Exhibit 11, Tab 16, Statement of Arthur William Ashworth, 20 November 1991, [15] (SCOI.00027.00044).

[3012] Exhibit 11, Tab 7, Transcript of Coronial Inquest into the death of William Dutfield, 12 December 1994, T5.54-60 (SCOI.00027.00025).

[3013] Exhibit 11, Tab 33, Strike Force Hamish Investigation Plan, 27 April 2009, 2 (SCOI.10066.00002); Exhibit 11, Tab 73, Section 177 Certificate of Analysis, 1 February 2007 (SCOI.10065.00046).

[3014] Exhibit 11, Tab 8, Death Certificate of Arthur Ashworth, 26 May 2010 (SCOI.10068.00136)

5.3542. It was not until 2010, as part of Strike Force Hamish's forensic review, that the following forensic testing was carried out:

a. A DNA buccal swab was taken from a nephew of Mr Ashworth.[3015] The resulting Y DNA profile was consistent with that obtained from the bloodied tissue and blood on the cardigan at the scene; and

b. A diary, belonging to Mr Ashworth in 2003, was tested by FASS. The DNA samples taken from the diary had the same profile as those from the bloodied tissue (and therefore, also the cardigan).[3016]

5.3543. I accept Counsel Assisting submission that this forensic evidence strongly supports the view that Mr Ashworth was responsible for the attack. I consider it particularly persuasive that a DNA match was made with a bloodied tissue in the kitchen, where the evidence suggests that the assailant had attempted to take steps to clean up after killing Mr Dutfield.

Police investigations

5.3544. There are a number of aspects of the original and subsequent police investigations which have been the subject of submissions by Counsel Assisting and the NSWPF at the time of documentary tender, as well as in the context of the Investigative Practices Hearing.

Exclusion of Mr Ashworth as a suspect

5.3545. In my view, upon the evidence considered above, the early and erroneous dismissal of Mr Ashworth as a suspect was inexcusable. It is clear that there were numerous features of the evidence—including inconsistencies in the accounts given by Mr Ashworth in the days after the death—that, as Counsel Assisting submitted, should immediately have been "cause for a high level of suspicion" concerning Mr Ashworth's possible involvement in the death of Mr Dutfield.[3017]

5.3546. The NSWPF conceded in submissions that Mr Ashworth should not have been excluded from suspicion at the time of the original investigation. However, it was also submitted that it was "not unreasonable" for the original OIC to focus on the perpetrator of the earlier robbery.[3018] Those two submissions seem to me to be mutually inconsistent.

5.3547. In the context of the Investigative Practices Hearing, Counsel Assisting made further submissions about the early dismissal of Mr Ashworth as a suspect. Counsel Assisting submitted that the obvious inconsistencies in Mr Ashworth's evidence, apparent at the time of the original investigation, ought to have been tested with him at the time.[3019]

[3015] Exhibit 11, Tab 35, NSWPF Investigator's Note, 'I83 – DNA taken', 15 September 2010 (SCOI.10068.00058).

[3016] Exhibit 11, Tab 69, NSWPF Investigator's Note, 'DNA result advised by David Bruce', 15 November 2010 (SCOI.82158); Exhibit 11, Tab 71, Record of conversation between Forensic Biology and Detective Hungerford, 14 June 2012 (SCOI.82160).

[3017] Submissions of Counsel Assisting, 6 February 2023, [18] (SCOI.82376).

[3018] Submissions of NSWPF, 21 February 2023, [74] (SC01.82560).

[3019] Submissions of Counsel Assisting, 15 September 2023, [817] (SCOI.85649).

5.3548. Detective Inspector Warren, in oral evidence during the Investigative Practices Hearing, agreed that the absence of any fingerprints on the metal tape dispenser located in Mr Dutfield's kitchen sink should have indicated to investigators at the time that it had been wiped down.[3020] In relation to the early dismissal of Mr Ashworth as a suspect in the original investigation, Detective Inspector Warren agreed that it would have been inconsistent with proper police practice at the time to dismiss a person of interest on the basis of their age. Detective Inspector Warren indicated that proper police practice would have involved any dismissal of a person of interest to be based on exculpatory evidence or an alibi. The reasons for not pursuing a possible suspect should have been recorded.[3021]

Failure to reinvestigate prior to Mr Ashworth's death

5.3549. In my view, based on the evidence described above, the failure of the NSWPF to obtain a DNA sample from Mr Ashworth, prior to his death in 2006, precluded the opportunity to prosecute Mr Ashworth for the death of Mr Dutfield.

5.3550. This failure is particularly lamentable in light of the evidence that police were alive to the potential of DNA evidence at the time of the original investigation in 1991, and that DNA technology was being widely used by the NSWPF by 2006 (see **Chapter 8** for more information about the NSWPF use of DNA technology). At any time prior to 2005, the NSWPF should have sought to submit the exhibits for forensic testing and, crucially, obtain a DNA sample for Mr Ashworth. It is assumed, on the evidence, that the initial dismissal of Mr Ashworth as a potential suspect was a reason for an elimination sample not having been taken from Mr Ashworth at an earlier time.

5.3551. However, once the review was completed by the UHT in 2005, and the recommendation made for reinvestigation of Mr Dutfield's death,[3022] the inaction of the NSWPF became inexcusable.

5.3552. Despite the Case Screening Form explicitly recommending that a DNA sample be taken from Mr Ashworth, no attempt seems to have been made to do so until 2010.

5.3553. The NSWPF accepted that a DNA sample should have been obtained from Mr Ashworth at an earlier date, and that there were features of the case that should have resulted in it being prioritised for earlier reinvestigation than in fact occurred. It was observed that "unfortunately the NSWPF's approach to 'cold cases' was less systematic before the inauguration of the UHT" in 2004.[3023]

[3020] Transcript of the Inquiry, 5 July 2023, T4997.33-41 (TRA.00073.00001).

[3021] Transcript of the Inquiry, 5 July 2023, T4998.22-40 (TRA.00073.00001).

[3022] Exhibit 51, Tab 26, Review of an Unsolved Homicide Case Screening Form – William Dutfield, 2 May 2005, 16 (SCOI.10286.00008).

[3023] Submissions of NSWPF, 21 February 2023, [78] (SCOI.82560).

5.3554. Detective Chief Inspector Laidlaw also conceded that a recommendation made in 2005 to obtain DNA from a person of interest in the matter should have been actioned by an investigative team within a reasonable time after it was made.[3024] Detective Chief Inspector Laidlaw was initially unable to say what may constitute a "reasonable time". However, he later conceded that a reasonable time to act on the recommendation would have been within a matter of weeks or months.[3025]

5.3555. Detective Chief Inspector Laidlaw accepted that had the recommendation been properly considered in or around May 2005, it may have been possible to obtain the DNA sample prior to Mr Ashworth's death in 2006. Detective Chief Inspector Laidlaw was unable to proffer any explanation for the delay in obtaining the DNA sample and accepted that a two-year delay in acting on the recommendation was unreasonable.[3026]

5.3556. However, the NSWPF submitted that they continued to investigate the possibility of Mr Ashworth's involvement and, ultimately, were able to conclude that there was "sufficient evidence to arrest Mr Ashworth, had he been alive."[3027] While the efforts of the NSWPF, particularly Strike Force Hamish and the report from FASS in 2007, were able to lead to this conclusion, it appears that no officer from the NSWPF appreciated, at any material time, that Mr Ashworth was deceased.

5.3557. Detective Chief Inspector Laidlaw accepted that it appeared that the author of the Additional Case Screening Form dated 1 March 2007 did not appreciate that Mr Ashworth had died.[3028]

5.3558. The NSWPF agreed that a DNA sample should have been taken from Mr Ashworth at the earliest possible opportunity, and that the delay in actioning this step after it was recommended in 2005 had the result that the opportunity to do so was lost.[3029]

Manner and cause of death

5.3559. In my view, there can be no question as to the physical manner and cause of Mr Dutfield's death. Namely, that Mr Dutfield died after suffering multiple blunt force injuries to his head as a result of being struck by an assailant with a heavy metal tape dispenser that was located in his apartment.[3030] This finding is consistent with that of the Coroner in 1994.

[3024] Transcript of the Inquiry, 7 July 2023, T5223.33-T5226.6 (TRA.00075.00001).

[3025] Transcript of the Inquiry, 7 July 2023, T5227.36-50 (TRA.00075.00001).

[3026] Transcript of the Inquiry, 7 July 2023, T5227 (TRA.00075.00001).

[3027] Submissions of NSWPF, 10 October 2023, [410] (SCOI.86127).

[3028] Transcript of the Inquiry, 7 July 2023, T5227(TRA.00075.00001).

[3029] Submissions of NSWPF, 10 October 2023, [408] (SCOI.86127).

[3030] Exhibit 11, Tab 4, Post-mortem Report, 1 April 1992 (SCOI.00027.0031); Exhibit 11, Tab 6, Findings of Deputy State Coroner Abernethy, Inquest into the death of William Dutfield, 12 December 1994 (SCOI.00027.00001).

5.3560. However, where the Coroner concluded that Mr Dutfield's injuries were "inflicted on him by a person or persons unknown", Counsel Assisting submits that it is open to me to reach a positive finding that Mr Ashworth was responsible for the death of Mr Dutfield.[3031]

5.3561. The NSWPF acknowledged that there is strong evidence to suggest Mr Ashworth was responsible for Mr Dutfield's death. The same conclusion had been reached by Strike Force Hamish in 2013.

5.3562. As submitted by Counsel Assisting, if Mr Ashworth were still alive today, a report to the Governor under s. 10(1) of the *SCOI Act*—referring Mr Ashworth for prosecution—would have been appropriate. Counsel Assisting submitted, and I agree, that the evidence that could have been adduced in a trial against Mr Ashworth is strong and compelling, and of such a nature that it would be admissible in criminal proceedings.

5.3563. I am satisfied that the evidence against Mr Ashworth would also have been admissible in civil proceedings, and accordingly that I may receive it in evidence: see s. 9(3) of the *SCOI Act*.

5.3564. However, as both Counsel Assisting and the NSWPF observed, Mr Ashworth is now unable to answer, or defend, such an allegation. There has been, and can be, no trial in which the evidence against him might be tested. In those circumstances, there is a real question as to whether it would be appropriate for me to make a positive finding of Mr Ashworth's guilt. Among other considerations, in some instances the preservation of the reputation of a deceased person may give rise to procedural fairness considerations, including vis-à-vis their family members.[3032]

5.3565. I have taken the observations of Mr Ashworth's family members into account. However, on the available and contemporaneous evidence, I consider that these observations bear little weight.

5.3566. As I have explained more fully in **Chapter 1**, when dealing with evidence as to the possible identity of a perpetrator (regardless of whether that person is deceased), I have determined that while I will express opinions about what the evidence indicates, I will refrain from making concluded findings as to whether a specified person committed a specified offence.

5.3567. Accordingly, I record my view that there is, on the evidence available to me, that Mr Ashworth inflicted the injuries that killed Mr Dutfield.

Bias

5.3568. As Counsel Assisting submitted, if the original police theory had been accurate—namely that Mr Dutfield's death was perpetrated by someone who "preyed" upon Mr Dutfield because of his vulnerability and sexuality—the possibility that the crime involved LGBTIQ bias would be obvious.

[3031] Submissions of Counsel Assisting, 6 February 2023, [100] (SCOI.82376).

[3032] See *Annetts v McCann* (1990) 170 CLR 596 at [11], [16]

5.3569. However, Counsel Assisting submitted that in view of the strong probability that Mr Ashworth was the perpetrator, it would appear unlikely that Mr Dutfield's death was a crime involving LGBTIQ bias. The NSWPF substantially agreed with those submissions.

5.3570. I accept Counsel Assisting's submission that Mr Dutfield's death most probably occurred in the context of a close and long-established relationship between himself and Mr Ashworth, which had been known at times to be volatile, associated with Mr Dutfield's use of alcohol.

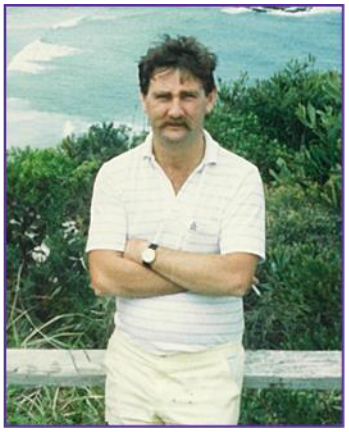
Findings and recommendations

5.3571. I find that on 19 November 1991 at his apartment in Mosman, NSW, William Dutfield died as a result of head injuries received after he was struck repeatedly in the head with a metal tape dispenser.

5.3572. In my view, on the evidence available to the Inquiry, there is objectively no reason to suspect that LGBTIQ bias was a factor in Mr Dutfield's death.

5.3573. I do not propose to make any recommendations arising from the Inquiry's consideration of Mr Dutfield's death.

IN THE MATTER OF ROBERT MALCOLM



Factual background

Date and location of death

5.3574. Robert Hart Malcolm died at Royal Prince Alfred Hospital on 29 January 1992 as a result of sequelae of head injuries.[3033]

5.3575. The injuries were sustained when Mr Malcolm was attacked by a person or persons unknown during the night of 10 or early hours of 11 January 1992 in Redfern.[3034]

Circumstances of death

5.3576. Mr Malcolm was 41 years old at the time of his death, and lived in Jannali with his parents, Robert McPherson Malcolm and Edith Malcolm.[3035] He worked in a clerical position in the staff pay section of the General Post Office in Martin Place, Sydney.[3036]

5.3577. On the afternoon and evening of 10 January 1992, Mr Malcolm was drinking at the Menzies Hotel with colleagues, and was last seen by friends at around 8:15pm.

5.3578. In the early hours of 11 January 1992, he was found unconscious in an abandoned and derelict house at 6 Holden Street, Redfern. He had suffered serious head injuries,[3037] which were likely the result of being assaulted with objects including a piece of timber and a broken brick.

5.3579. Almost three weeks later, on 29 January 1992, Mr Malcolm died from those injuries.[3038]

[3033] Exhibit 56, Tab 3, Post-mortem report of Dr Johan Duflou, 28 May 1992 (SCOI.10494.00017).

[3034] Exhibit 56, Tab 1, Report of death to Coroner, 29 January 1991 (SCOI.10494.00006).

[3035] Exhibit 56, Tab 34, Statement of Robert McPherson Malcolm, 13 January 1992, [4] (SCOI.10290.00018).

[3036] Exhibit 56, Tab 39, Statement of Gerald Stuart Birch, 31 January 1992, [2] (SCOI.10290.00036); Exhibit 56, Tab 35, Statement of Francis Thomas Loughland, 30 January 1992 (SCOI.47913); Exhibit 56, Tab 34, Statement of Robert McPherson Malcolm, 13 January 1992, [7] (SCOI.10290.00018).

[3037] Exhibit 56, Tab 3, Post-mortem report of Dr Johan Duflou, 28 May 1992 (SCOI.10494.00017).

[3038] Exhibit 56, Tab 1, Report of death to Coroner, 29 January 1991 (SCOI.10494.00006).

Previous investigations

Original police investigation

Investigative steps by police

5.3580. During the original police investigation, police formed the view that Mr Malcolm had been the victim of a robbery,[3039] and that Mr Malcolm had been struck about the face with a heavy weapon (such as a bat, brick or piece of wood) whilst lying on the ground.[3040]

5.3581. Police canvassed and took statements from a number of people in the Redfern community.[3041]

5.3582. One feature of the original police investigation is the poor relationship between the officers at Redfern Police Station and the Redfern community. Police worked with Aboriginal Liaison Officers David Bell and George Bracken throughout the initial investigation, who made inquiries and directed police to a number of the witnesses who later provided statements.

5.3583. On 28 January 1992, the police note that the community "expressed concern over the incident and a desire to catch the person responsible",[3042] however, an undated report by the Homicide Unit states that "investigating Police have met with a wall of silence and have received little or no assistance from the aboriginal community [sic]", and that a number of persons interviewed had given fictitious addresses, thereby posing issues for follow up or the taking of statements.[3043]

5.3584. In its submissions, the NSWPF agreed that it is "uncontroversial" that it and other police forces in Australia have had a "strained relationship with First Nations communities" and played a "significant part" in the discrimination suffered over a long period.[3044] The NSWPF submitted that the original investigating officers were alive to these issues and took steps to address them, including involving the Aboriginal Liaison Officers to Redfern Police Station.[3045]

5.3585. I accept the NSWPF submissions in this respect and acknowledge that the investigating officers at Redfern appear to have taken that step in an effort to address the issues present. The officers located at the Homicide Unit however, appear to unfairly characterise the situation by saying the community in Redfern offered "little or no assistance", when in fact many of the investigative steps taken were possible due to tips, assistance and the statements of Aboriginal witnesses.[3046]

5.3586. The NSWPF also submitted that the reluctance of members of the Redfern community to provide information to investigating police may also have been

[3039] Exhibit 56, Tab 1, Report of death to Coroner, 29 January 1991 (SCOI.10494.00006).

[3040] Exhibit 56, Tab 76, NSWPF Activity Sheet, 'Homicide Squad Activity Sheets', 16 February 1992 (SCOI.10290.00073).

[3041] Exhibit 56, Tab 80A, NSWPF Standard Canvass Forms bundle, 11 January 1992 (SCOI.84138).

[3042] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 24–25 (SCOI.83976).

[3043] Exhibit 56, Tab 78, NSWPF Situation Report, 'Situation Report -Homicide Unit', Undated 3 (NPL.0174.0001.0001.0005).

[3044] Submissions of NSWPF, 21 July 2023, [13] (SCOI.84843).

[3045] Submissions of NSWPF, 21 July 2023, [14] (SCOI.84843).

[3046] Exhibit 56, Tab 78, NSWPF Situation Report, 'Situation Report -Homicide Unit', Undated 3 (NPL.0174.0001.0001.0005).

caused because of a fear of retribution.[3047] In support of this submission, the NSWPF submissions note a threatening interaction between a person of interest (Richard Green) and a witness on 3 August 1992, and a statement by another person of interest (Anthony Hookey) that he "can't dob them in but my family will give them a bashing".[3048] I accept the NSWPF submission that such fears by community members may have played a role in the willingness of witnesses to speak with or assist police.

5.3587. Another feature of the police investigation was the involvement of media following Mr Malcolm's death, with a request made to Crime Stoppers on 7 February 1992, following which a Crime Stoppers release was made.[3049] The media were also invited to a conference on 10 February 1992, in which Mr Malcolm's father appealed to the public and a $1000 reward was offered.[3050]

Post-mortem investigation

5.3588. On 31 January 1992, a Post-mortem examination was performed by Dr Johan Duflou.[3051]

5.3589. The direct cause of death was "sequelae of a head injury".[3052] In addition to Mr Malcolm's external injuries, including a subconjunctival haemorrhage in his right eye and a number of scars and contusions, it was noted that there was also extensive bruising of the scalp, fractures to the skull and numerous injuries to the eyes, nose, mouth and teeth.[3053] In his report, Dr Duflou considered that Mr Malcolm's injuries were consistent with having been sustained in the second week of January 1992.[3054]

5.3590. Dr Duflou noted that the "rectum and anus were normal".[3055] The post-mortem report does not explicitly consider any indicators of sexual assault or evidence of sexual activity.[3056]

[3047] Submissions of NSWPF, 21 July 2023 (SCOI.84843).

[3048] Submissions of NSWPF, 21 July 2023, [15]–[17] (SCOI.84843).

[3049] Exhibit 56, Tab 84, Request to Crime Stoppers, 7 February 1992 (NPL.0174.0001.0001.0155); Exhibit 56, Tab 86, Crime Stoppers media release, undated (NPL.0174.0001.0001.0157).

[3050] Exhibit 56, Tab 85, Invitation to media conference, 10 February 1992 (NPL.0174.0001.0001.0156); see also Exhibit 56, Tab 87, NSWPF Media Unit Release, undated (NPL.0174.0001.0001.0158).

[3051] Exhibit 56, Tab 3, Post-mortem report of Dr Johan Duflou, 28 May 1992, (SCOI.10494.00017).

[3052] Exhibit 56, Tab 3, Post-mortem report of Dr Johan Duflou, 28 May 1992, 6 (SCOI.10494.00017).

[3053] Exhibit 56, Tab 3, Post-mortem report of Dr Johan Duflou, 28 May 1992, 1–3 (SCOI.10494.00017).

[3054] Exhibit 56, Tab 3, Post-mortem report of Dr Johan Duflou, 28 May 1992, 2 (SCOI.10494.00017).

[3055] Exhibit 56, Tab 3, Post-mortem report of Dr Johan Duflou, 28 May 1992, 4 (SCOI.10494.00017).

[3056] Exhibit 56, Tab 3, Post-mortem report of Dr Johan Duflou, 28 May 1992, 4 (SCOI.10494.00017).

Exhibits: Availability and testing

5.3591. On 11 January 1992 from around 5:15am, Constable Lyle Van Leeuwen attended 6 Holden Street to undertake a crime scene examination.[3057] Constable Van Leeuwen took 21 crime scene photographs, and collected a number of exhibits, including:

a. "Victorian Bitter" 375ml beer bottle, uncapped;[3058]

b. Pair of black male shoes;

c. Two blood-stained buttons;

d. Swab of blood from the veranda;

e. Broken brick with blood-staining;

f. Multiple pieces of blood-stained timber, from the courtyard;

g. "Telegraph Mirror" Newspaper dated 10 January 1992; and

h. "Toohey's Draught" 750ml beer bottle.[3059]

5.3592. Constable Van Leeuwen observed a number of items which were not collected as exhibits. On the verandah of 6 Holden Street, he photographed but did not collect a sock, empty bandage packets, a "Plastic bottle (Property of the Ambulance)" and strands of hair in a blood-stain.[3060] In the courtyard, a white blood-stained shirt, black plastic comb and further button were photographed but appear to have not been collected or entered as exhibits.[3061]

5.3593. Constable Van Leeuwen also prepared a sketch plan of the premises at 6 Holden Street.[3062]

5.3594. The police collected further exhibits from Mr Malcolm while at hospital, including:

a. Pair of grey trousers;

b. Belt;

c. Pair of underwear;

d. Torn, blood-stained singlet;[3063] and

e. Sexual Assault Investigation Kit (**SAIK** #5956).[3064]

[3057] Exhibit 56, Tab 19, Statement of Constable Lyle William Van Leeuwen, 19 April 1992, [1]–[2] (SCOI.10939.00063).

[3058] Detective Senior Constable Paul Thomas, who attended the crime scene at about 4:00am on 11 January 1992, observed that the open bottle of Victoria Bitter beer was 'still bubbling and did not appear to have gone flat' – see Exhibit 56, Tab 5, Statement of Detective Senior Constable Paul Andrew Thomas, 7 May 1992, [4] (SCOI.10939.00025).

[3059] Exhibit 56, Tab 19, Statement of Constable Lyle William Van Leeuwen, 19 April 1992, [4]–[6], [8]–[9] (SCOI.10939.00063).

[3060] Exhibit 56, Tab 19, Statement of Constable Lyle William Van Leeuwen, 19 April 1992, [5] (SCOI.10939.00063).

[3061] Exhibit 56, Tab 19, Statement of Constable Lyle William Van Leeuwen, 19 April 1992, [6] (SCOI.10939.00063).

[3062] Exhibit 56, Tab 19, Statement of Constable Lyle William Van Leeuwen, 19 April 1992, [8] (SCOI.10939.00063).

[3063] Exhibit 56, Tab 5, Statement of Detective Senior Constable Paul Andrew Thomas, 7 May 1992, [6] (SCOI.10939.00025).

[3064] Exhibit 56, Tab 4, Statement of Detective Constable Richard Yannakis, 6 May 1992, [6] (SCOI.10290.00012); Exhibit 56, Tab 27, NSWPF Sexual Assault Referral Unit Protocol, 11 January 1992, 3 (SCOI.83022).

5.3595. On 4 February 1992, Probationary Constable Belinda Hardy handed a red jumper in at the Crime Scene Unit. It appears that the red jumper at the Crime Scene Unit had been worn by Mr Hookey on the night of 10–11 January 1992,[3065] handed to Barbara Stacy (in a dirty condition) at around 8:00am on 11 January 1992,[3066] washed by Ms Stacy (intending to keep it for herself), and then handed in to police on 5 February 1992.[3067] It is also possible, from the records available, that the jumper could have been the maroon jumper that Mr Malcolm was seen to be wearing on the night.[3068] However, Constable Van Leeuwen noted that the Crime Scene Unit labelled the jumper "A Hookey", and that it was clean.[3069]

5.3596. On 28 January 1992, Rudolf Weigner was briefed with the following items for the purpose of forensic testing:

a. The SAIK;

b. Broken brick with blood-staining;

c. Broken pieces of timber with blood-staining; and

d. Swab of blood from the veranda.

5.3597. On 6 April 1992, Mr Weigner was provided with the red jumper on 5 February 1992, and the grey trousers and a portion of the white singlet.[3070]

5.3598. Mr Weigner identified human blood on each exhibit except for the SAIK and the red jumper.[3071] It appears that blood grouping analysis was conducted which indicates the blood detected comes from the same blood group.[3072]

5.3599. Ms Franco, forensic biologist, explained the results of Mr Weigner's report as follows:[3073]

a. Mr Malcolm's blood, which was taken post-transfusion, resulted in a mixture of blood types;

b. The human blood recovered from a piece of timber, swab of blood from the verandah, the stain on the grey trousers and the white singlet (items 4, 5, 7 and 8) was consistent with Mr Malcolm's blood types, which would occur in around one in ten people; and

c. The human blood recovered from the broken pieces of timber (item 3) was also consistent with Mr Malcolm's blood type within one blood typing system, which would occur in around one in four people.

[3065] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 31 (SCOI.83976); Exhibit 56, Tab 43, Statement of Joan Avril Honeysett, 14 January 1992, [10] (SCOI.10939.00034).

[3066] Exhibit 56, Tab 54, Statement of Barbara Dawn Stacy, 13 January 1992, [6]–[7] (SCOI.10939.00039).

[3067] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 33 (SCOI.83976).

[3068] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 14, 16 (SCOI.83976).

[3069] Exhibit 56, Tab 19, Statement of Constable Lyle William Van Leeuwen, 19 April 1992, [13] (SCOI.10939.00063).

[3070] Exhibit 56, Tab 24, Forensic Biology report of Rudolf Weigner, 30 May 1992, 1 (SCOI.10939.00091).

[3071] Exhibit 56, Tab 24, Forensic Biology report of Rudolf Weigner, 30 May 1992 (SCOI.10939.00091).

[3072] Exhibit 56, Tab 24, Forensic Biology report of Rudolf Weigner, 30 May 1992, 2 (SCOI.10939.00091).

[3073] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [13]–[15] (SCOI.83957).

5.3600. It does not appear that DNA testing was carried out during the initial police investigation on the blood as detected on the above exhibits. The possibilities for DNA testing at the time, and now, are discussed further below.

5.3601. In relation to the SAIK, Ms Franco states that spermatozoa were not detected on the rectal, perianal or perineum smears submitted in the SAIK, [3074] and as a result of that finding, the swabs were returned to police. Ms Franco notes that at that time, it was necessary to have semen or blood present on items to consider DNA testing and that it was routine practice to return swabs to police that were not suitable for testing.[3075]

5.3602. Fingerprints were recovered from the "Toohey's Draught" 750ml beer bottle, the "Victoria Bitter" 375ml beer bottle and the "Telegraph Mirror" newspaper. These fingerprints were submitted for analysis and cross-referenced against the fingerprints for the persons of interest and a number of the witnesses who were present at 6 Holden Street, but no matches were identified at the time of the initial police investigation.[3076]

5.3603. Mr Green also stated that after the police left 6 Holden Street, at around 1:00pm or 2:00pm, he saw a 3 feet long piece of wood as round as a baseball bat at 6 Holden Street with blood and hair all over it.[3077] I accept the NSWPF submission that Mr Green's evidence must be considered carefully in the absence of corroboration from other witnesses.[3078] Mr Green's evidence in this respect may not be accurate, and it is not corroborated by the statement of Constable Van Leeuwen. If Mr Green's evidence is accurate, then this piece of wood (which was possibly a weapon used in the assault on Mr Malcolm) was not collected.

Persons of interest

5.3604. The persons of interest identified and charged in relation to Mr Malcolm's death were:

a. Anthony Stanley Hookey, born in 1971 and currently living in NSW, known to some people as "Beaver";

b. Kirk Anthony Phillips, born in 1960 and died 14 February 2014; and

c. Richard John Green, born in 1963 and died 23 July 2021.

5.3605. On 11 January 1992, information was received by police, through the Aboriginal Liaison Officer to Redfern Police Station, David Bell, that:[3079]

> … *'BEAVER' HOOKEY was seen chasing a male Caucasian north in Eveleigh Street, about 2am on 11/1/92.*

[3074] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023 (SCOI.83957).

[3075] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [16] (SCOI.83957).

[3076] Exhibit 56, Tab 81, NSWPF Latent and Crime Scene Fingerprint Examination Form, 11 January 1992 (SCOI.10282.00002); Exhibit 56, Tab 83, Fingerprint chart for case 167888 (SCOI.10282.00018).

[3077] Exhibit 56, Tab 71, Second Statement of Richard Green, 4 March 1992, [7] (SCOI.10290.00023).

[3078] Submissions of NSWPF, 21 July 2023, [46] (SCOI.84843).

[3079] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates 3 (SCOI.83976).

5.3606. At around 12:30pm on 11 January 1992, Mr Hookey was located in Redfern and attended the police station. He later provided a statement on 13 January 1992 and participated in a recorded interview on 30 April 1992 (prior to being charged with murder that day).[3080]

5.3607. On 22 January 1992, it appears that an unidentified person provided further information to Mr Bell, that "Kirk PHILLIPS and Richard GREEN could be involved in the incident".[3081]

5.3608. Mr Phillips and Mr Green were part of the group that had found Mr Malcolm and provided statements on 11 January 1992. Following the above "tip", Mr Phillips participated in a recorded interview on 6 May 1992 (prior to being charged with murder that day) and Mr Green provided a further statement on 4 March 1992 (being later charged on 12 June 1992 with accessory after the fact to murder).[3082]

5.3609. Each of these persons of interest was discharged at the committal hearing on 3–4 August 1992.

Findings at inquest

5.3610. On 29 January 1992, Mr Malcolm's death was reported to the Coroner.[3083]

5.3611. On 1 June 1992, as a result of persons being charged with indictable offences, the inquest was terminated pursuant to s. 19(1) of the *Coroners Act 1980*.[3084]

5.3612. According to the file as produced by the Coroners Court to the Inquiry, it appears that no formal findings in relation to the identity and time and place of death were recorded.

Criminal proceedings

5.3613. On 30 April 1992, Mr Hookey was interviewed by police and subsequently charged with murder.[3085] When arrested, Mr Hookey asked Detective Sergeant Phillips "can't you make it manslaughter?",[3086] and further told Sergeant John Martlew the following:[3087]

> *I could get this down to Manslaughter, I saw it happen but I can't say… I can't dob them in but my family will give them a bashing… I was there, I walked away, when I came back they was bashing him with a bat or a brick or something, he was crying out and screaming I saw the blood then they ran away.*

[3080] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992 (SCOI.10290.00008); Exhibit 56, Tab 67, NSWPF Record of Interview, 'Interview with Anthony Stanley Hookey', 30 April 1992 (SCOI.10939.00019).

[3081] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates 25 (SCOI.83976).

[3082] Exhibit 56, Tab 69, NSWPF Record of Interview, 'Interview with Kirk Anthony Phillips', 6 May 1992 (SCOI.10290.00014); Exhibit 56, Tab 71, Second Statement of Richard John Green, 4 March 1992 (SCOI.10290.00023).

[3083] Exhibit 56, Tab 1, Report of death to Coroner, 29 January 1991 (SCOI.10494.00006).

[3084] Exhibit 56, Tab 88, Coroners Court Brief Running Sheet, 5 February 1992 – 1 June 1992 (SCOI.10494.00005); Exhibit 56, Tab 92, Letter from the Coroners Court to Robert Malcolm, 22 June 1992 (SCOI.10494.00016).

[3085] Exhibit 56, Tab 89, Bench Sheets for charges against Anthony Hookey, 1 May 1992 – 4 August 1992 (SCOI.11290.00016).

[3086] Exhibit 56, Tab 8, Statement of Detective Sergeant Gary Thomas Phillips, 5 May 1992, [11] (SCOI.83431).

[3087] Exhibit 56, Tab 10, Statement of Sergeant John Martlew, 1 May 1992, [8]–[9] (SCOI.10939.00021).

5.3614. On 6 May 1992, Mr Phillips was interviewed by police and charged with murder.[3088]

5.3615. On 12 June 1992, Mr Green was charged with accessory after the fact to murder.[3089] When he was charged, Mr Green responded, "[b]loody murder, it was an assault", and later remarked, "[i]f Kirk has done this to me, he's a fucking dog".[3090]

5.3616. On 3 August 1992, the matter was listed at the Coroners Court for committal hearing. Mark Kelly appeared on behalf of the ODPP as the committal solicitor.[3091]

5.3617. On 3 August 1992, a brief of evidence was tendered, and a number of witnesses were called to give evidence, including: Detective Constable Michael Starr; Detective Sergeant Gary Phillips; James Smith; Jenine Honeysett; Patricia (whose surname is the subject of a non-publication order); Barbara Stacy; Joan Honeysett; Margaret Vincent; Detective Constable Richard Yannakis; Detective Sergeant Brian Saunders; Sergeant Martlew, and Detective Michael Kane.[3092]

5.3618. The committal was adjourned to 4 August 1992 due to the non-appearance of Sharon Murphy, a key witness linking the defendants to Mr Malcolm's death.[3093] Ms Murphy was located by police on the evening of 3 August 1992.[3094]

5.3619. On 4 August 1992, Sharon Murphy gave evidence, after which the defendants were discharged.[3095]

Strike Force Parrabell

Bias Crimes Indicators Form

5.3620. A BCIF was completed in this case by Strike Force Parrabell. It concluded that it was "unlikely that sexuality or other bias was involved in the death".[3096]

5.3621. Of the ten indicators in the BCIF, seven were answered "No evidence that sexuality or other bias was involved in the death" and three were answered "Unlikely that sexuality or other bias was involved in the death".[3097]

[3088] Exhibit 56, Tab 90, Bench Sheets for charges against Kirk Phillips, 6 May 1992–4 August 1992 (SCOI.11290.00028); Exhibit 56, Tab 13, Statement of Constable Joshua Trevillion, 6 May 1992 (SCOI.83028).

[3089] Exhibit 56, Tab 79, NSWPF Crime Information Report, 12 June 1992 (SCOI.76957).

[3090] Exhibit 56, Tab 16, Second Statement of Detective Constable Michael Charles Starr, 12 June 1992, [5]–[6] (SCOI.10939.00093); Exhibit 56, Tab 18, Statement of Constable Scott Ronald Lejeune, 18 June 1992, [4]–[6] (SCOI.83033).

[3091] Exhibit 56, Tab 120, Statement of Mark Kelly, 5 June 2023 (SCOI.83437); Exhibit 56, Tab 93, ODPP Takeover Notice, 3 August 1992 (SCOI.11290.00040).

[3092] Exhibit 56, Tab 94, Master Tape History Sheet, 3 August 1992 (SCOI.11290.00072).

[3093] Exhibit 56, Tab 120, Statement of Mark Kelly, 5 June 2023 (SCOI.83437).

[3094] Exhibit 56, Tab 120, Statement of Mark Kelly, 5 June 2023 (SCOI.83437); Exhibit 56, Tab 46, Third Statement of Sharon Murphy, 3 August 1992, [5]–[8] (SCOI.10939.00083).

[3095] Exhibit 56, Tab 95, Master Tape History Sheet, 4 August 1992 (SCOI.11290.00077); Exhibit 56, Tab 96, Coroners Court Record, 4 August 1992 (SCOI.11290.00002).

[3096] Exhibit 56, Tab 97, Strike Force Parrabell, Bias Crimes Indicators Review Form – Robert Malcolm, 16 May 2016, 13 (SCOI.75127).

[3097] Exhibit 56, Tab 97, Strike Force Parrabell, Bias Crimes Indicators Review Form – Robert Malcolm, 16 May 2016 (SCOI.75127).

5.3622. In the "General Comment" section for Indicator 2 (Comments, written statements, gestures) and Indicator 6 (Victim/witness perception), the BCIF notes a derogatory comment by Mr Green about Mr Malcolm which may be linked with LGBTIQ bias, and that Mr Malcom's friends appeared uncertain about Mr Malcolm's sexuality with little evidence of past relationships.[3098]

5.3623. In the "General Comment" section for Indicators 5 and 8 (Previous existence of Bias Crime Incidents, and Location), it is noted that Mr Malcolm was not visiting a location where previous bias crimes are known to have been committed, and it is an area known for a high volume of street related crime, including robbery offences.[3099]

5.3624. In the "General Comment" section under Indicator 7 (Motive of Offender/s), it is noted that both Mr Hookey and Mr Phillips have criminal histories involving violent crimes and particularly robbery offences. [3100]

5.3625. The "Summary of Findings" repeats various components of the earlier sections of the BCIF, namely that Mr Malcolm was a heavy drinker, and was last seen heavily intoxicated and in the company of Mr Hookey, following which he was discovered in a battered and unconscious state in a derelict house at 6 Holden Street. Overall, the view expressed in the BCIF is that Mr Malcolm's death was part of a robbery in which Mr Hookey accompanied Mr Malcolm to an ATM, then lured him away where he bashed and robbed him in the company of Kirk Phillips, without consideration of his sexuality.[3101]

Case Summary

5.3626. Strike Force Parrabell categorised the case as "No Evidence of Bias Crime".[3102] The matter was categorised as "Solved".[3103]

5.3627. The Case Summary reads as follows:[3104]

> ***Identity**: Robert Hart Malcolm was 41 years old at the time of his death.*
>
> ***Personal History**: Mr Malcolm lived with his elderly parents in the Sutherland Shire. Mr Malcolm was described by his friends as a heavy drinker to the point of alcoholism.*
>
> ***Location of Body/Circumstances of Death**: Mr Malcolm was last seen eleven days prior to his death heavily intoxicated at a hotel in Redfern with Anthony Hookey, 20 years old; and Kirk Phillips, 31 years*

[3098] Exhibit 56, Tab 97, Strike Force Parrabell, Bias Crimes Indicators Review Form – Robert Malcolm, 16 May 2016, 4, 8 (SCOI.75127).

[3099] Exhibit 56, Tab 97, Strike Force Parrabell, Bias Crimes Indicators Review Form – Robert Malcolm, 16 May 2016, 7, 10, 13 (SCOI.75127).

[3100] Exhibit 56, Tab 97, Strike Force Parrabell, Bias Crimes Indicators Review Form – Robert Malcolm, 16 May 2016, 9 (SCOI.75127).

[3101] Exhibit 56, Tab 97, Strike Force Parrabell, Bias Crimes Indicators Review Form – Robert Malcolm, 16 May 2016 (SCOI.75127).

[3102] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Robert Malcolm, 25 (SCOI.76961.00014); see also Exhibit 56, Tab 97, Strike Force Parrabell, Bias Crimes Indicators Review Form – Robert Malcolm, 16 May 2016, 13 (SCOI.75127).

[3103] Exhibit 56, Tab 97, Strike Force Parrabell, Bias Crimes Indicators Review Form – Robert Malcolm, 16 May 2016, 1 (SCOI.75127).

[3104] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Robert Malcolm, 25 (SCOI.76961.00014).

old.[3105] *A short time later Mr Malcolm was located in a derelict house at Holden Street, Redfern. He was unconscious, suffering severe injuries consistent with being assaulted. His pants and underwear were around his ankles. A large amount of money had been stolen from him. Mr Malcolm died 10 days later in hospital. Mr Malcolm was found in an area well known for high volume crime including robbery offences. Police identified and interviewed both Hookey and Phillips, both of whom denied any knowledge of Mr Malcolm or his murder.*

***Sexual Orientation**: Mr Malcolm's sexuality could not be confirmed.*

***Coroner/Court Findings**: Police arrested and charged both Phillips and Hookey with Mr Malcolm's murder based upon circumstantial evidence, however both were found not guilty and discharged.*

SF Parrabell concluded there was no evidence of a bias crime

5.3628. The content of this case summary is generally consistent with the comments made in the BCIF.

Academic review

5.3629. The Academic Review categorised the case as "No Bias".[3106]

5.3630. The academic reviewers noted that classification under "No Bias" in any given case is where there is "no bias worth reflecting on".[3107]

Review by the Inquiry

5.3631. The Inquiry took the following steps in the course of examining the matter.

Summonses

5.3632. A summons was issued to the NSWPF on 18 May 2022 for all documents relating to investigations by the NSWPF of the death of Mr Malcolm, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). The summons also called for any other material held or created by the UHT in relation to the death of Mr Malcolm. The summons noted that such documents would include, relevantly, all running sheets, all intelligence and crime information reports, all police notebook and duty book entries, all photographs and all sketch plans.

[3105] I note that this description of events is not consistent with the evidence I have received. As set out in paragraphs [5.3700]–[5.3707], the evidence before this Inquiry is that Mr Malcolm was allegedly seen in the company of Mr Hookey on Eveleigh Street in Redfern, rather than at a hotel in Redfern. Further, no witnesses have indicated that Mr Phillips was seen in the company of Mr Malcolm prior to his death.

[3106] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Robert Malcolm, 25 (SCOI.76961.00014).

[3107] Exhibit 1, Tab 2 NSW Police Force, *Strike Force Parrabell Report Final Report*, (Report, June 2018), 99 (SCOI.02632).

5.3633. A hardcopy file was produced on 8 June 2022.[3108] The material produced did not include all responsive material, as further material responsive to Summons NSWPF1 was subsequently produced in response to later summonses.

5.3634. A summons to the ODPP was issued on 21 June 2022 for, relevantly, the materials held in relation to the prosecution of Mr Hookey and Mr Phillips for the death of Mr Malcolm (ODPP1). A file was produced on 12 July 2022.[3109]

5.3635. On 11 October 2022, the Inquiry issued a summons to the NSWPF, seeking further documents in relation to Mr Malcolm (NSWPF29). The documents specified in Summons NSWPF29 repeated a subset of the documents specified in NSWPF1, namely, crime scene photographs, sketch plans and police notebook and duty book entries. The notebook and duty book entries specifically requested were those of Detective Constable Yannakis and Detective Sergeant Phillips.[3110]

5.3636. On 24 October 2022, the NSWPF produced a number of documents responsive to Summons NSWPF29, including criminal history and intelligence reports, crime scene photographs and the duty book of Detective Constable Yannakis. However, the NSWPF was unable to locate sketch plans drawn by police for 6 Holden Street (Job No. 92-0081) and the duty book of Detective Sergeant Phillips.[3111]

5.3637. On 30 May 2023, the Inquiry issued a further summons to the NSWPF (NSWPF113). The documents specified in Summons NSWPF113 again repeated a subset of the material requested in Summons NSWPF1, in this instance, the running sheets for the investigation into Mr Malcolm's death, and the duty book entries of Plain Clothes Constable Shane Louise Bullock.[3112]

5.3638. On 5 June 2023, in response to Summons NSWPF113, the NSWPF produced over 1,500 pages of material, including a large volume of running sheets not previously provided to the Inquiry, which related to the initial police investigation into Mr Malcolm's assault and death.[3113] If this material, containing much of the core investigative police work in this matter, had been produced in response to Summons NSWPF1 in a timely manner, further lines of investigation may have been open to the Inquiry, such as following up with witnesses like NP243 (a pseudonym), NP244 (a pseudonym), or Wayne Hookey.

5.3639. On 14 June 2023, the Inquiry issued a further summons to the NSWPF for photographs produced with the statement of Constable Van Leeuwen (NSWPF125). This summons again repeated the request made in NSWPF1 for all photographs relating to the investigation of the death of Mr Malcolm.[3114] On 20 June 2023, the Inquiry received a number of photographs in response to Summons NSWPF125.[3115]

[3108] Exhibit 56, Tab 123, Statement of Kathryn Lockery, 6 July 2023, [8]–[9] (SCOI.84074).
[3109] Exhibit 56, Tab 123, Statement of Kathryn Lockery, 6 July 2023, [20]–[21] (SCOI.84074).
[3110] Exhibit 56, Tab 104, Summons to NSWPF (NSWPF29), 11 October 2023 (SCOI.83432).
[3111] Exhibit 56, Tab 105, Email from NSWPF to the Inquiry, 24 October 2022 (SCOI.83961).
[3112] Exhibit 56, Tab 108, Summons to NSWPF (NSWPF113), 30 May 2023 (SCOI.83436).
[3113] Exhibit 56, Tab 109, Letter from NSWPF to the Inquiry, 5 June 2023 (SCOI.83977).
[3114] Exhibit 56, Tab 111, Summons to NSWPF (NSWPF125), 14 June 2023 (SCOI.83996).
[3115] Exhibit 56, Tab 123, Statement of Kathryn Lockery, 6 July 2023, [17] (SCOI.84074).

5.3640. On 21 June 2023, the Inquiry received a further 1,827 documents, which the NSWPF indicated were produced pursuant to Summons NSWPF1.[3116]

5.3641. Further summonses were issued in response to the fingerprint match discussed below:

a. On 6 June 2023, the Inquiry issued a summons to the CSNSW for copies of records held in relation to Percy Strong. On 9 June 2023, CSNSW advised that it was not possible to find Mr Strong on the CSNSW database, but that a hard copy file contained an index card for Mr Strong with his right thumbprint.[3117]

b. On 9 June 2023 the Inquiry issued a further summons to the NSWPF for the fingerprint file and records relating to the match (NSWPF121). Material was produced in response to that summons on 15 June 2023.[3118]

5.3642. On 13 July 2023, the Inquiry issued a summons to the Commonwealth Bank for any records held in relation to Mr Malcolm's bank accounts around the time of his death, including records of any ATM cash withdrawals (CBA2).[3119] On 14 July 2023, the Commonwealth Bank advised that it was unable to locate Mr Malcolm's accounts.[3120]

5.3643. In addition to the above, the Inquiry has issued various summonses to the NSWPF seeking criminal histories and intelligence records in relation to certain persons. These were produced to the Inquiry.[3121]

Interagency cooperation

5.3644. On 15 June 2022, the Inquiry issued a written request to Coroners Court to obtain the coronial file in relation to the death of Mr Malcolm. The coronial file was produced on 4 July 2022.[3122]

5.3645. On 9 March 2023, the Inquiry issued a further request to the Coroners Court for any records of the committal proceedings held at Glebe Coroners Court on 3–4 August 1992. The committal file was produced on 16 March 2023.[3123]

5.3646. On 15 June 2023, the Inquiry was advised by the Coroners Court that the transcript and sound recording for the committal hearing on 3–4 August 1992 were unable to be located.[3124]

5.3647. The Inquiry coordinated with BDM and other agencies to confirm the status and location of various witnesses.

[3116] Exhibit 56, Tab 113A, Letter from NSWPF to the Inquiry, 21 June 2023 (SCOI.84214).

[3117] Exhibit 56, Tab 112, Summons to the Commonwealth Bank (CSNSW20), 6 June 2023 (SCOI.83959); Exhibit 56, Tab 113, Index card for Percy Strong, undated (SCOI.83960).

[3118] Exhibit 56, Tab 110, Summons to NSWPF (NSWPF121), 9 June 2023 (SCOI.83997); Exhibit 56, Tab 123, Statement of Kathryn Lockery, 6 July 2023, [16] (SCOI.84074).

[3119] Exhibit 56, Tab 124, Summons to the Commonwealth Bank (CBA2), 13 July 2023 (SCOI.84788).

[3120] Exhibit 56, Tab 125, Email from the Commonwealth Bank to the Inquiry, 14 July 2023 (SCOI.84789).

[3121] Exhibit 56, Tab 123, Statement of Kathryn Lockery, 6 July 2023, [20] (SCOI.84074).

[3122] Exhibit 56, Tab 123, Statement of Kathryn Lockery, 6 July 2023, [4]–[5] (SCOI.84074).

[3123] Exhibit 56, Tab 123, Statement of Kathryn Lockery, 6 July 2023, [6] (SCOI.84074).

[3124] Exhibit 56, Tab 121, Letter from Coroners Court of NSWto the Inquiry , 15 June 2023 (SCOI.83994).

Family members

5.3648. The Inquiry obtained information that Mr Malcolm's parents, Robert McPherson Malcolm and Edith Malcolm, are both deceased.[3125]

5.3649. The Inquiry has had ongoing contact with Mr Malcolm's siblings, Graham Malcolm and Lynette Elias.[3126] They both attended the public hearing held by the Inquiry into Mr Malcolm's death on 7 July 2023.[3127]

5.3650. A statement was obtained from Ms Elias and is dated 21 June 2023.[3128] Ms Elias gives an account of Mr Malcolm's personal background and what she knew as to Mr Malcolm's sexuality. Ms Elias also recalls attending the committal hearing in 1992 with her parents. Ms Elias notes they were not given much warning about the court dates in 1992 and describes the process as being upsetting and confusing for her parents. The family were not given a copy of the brief of evidence until after the committal hearing and only after Ms Elias asked police for further information.[3129]

5.3651. Graham Malcolm and Ms Elias also provided the Inquiry with a statement on behalf of the Malcolm family,[3130] which Ms Elias read out at the public hearing.[3131]

Searches for exhibits

5.3652. On 9 May 2023, the Inquiry issued a further summons to the NSWPF, seeking 14 exhibits collected in the original police investigation (NSWPF102).[3132]

5.3653. On 18 May 2023, the NSWPF advised that 11 of the exhibits had been destroyed, and the three remaining exhibits had samples in cold storage with FASS.[3133] Recorded reasons for the destruction of the exhibits have not been provided.

Further forensic examinations

DNA Testing

5.3654. On 29 May 2023, Ms Franco, forensic biologist, confirmed that the three remaining crime scene samples in relation to this case (the others being destroyed, as discussed below) were held in cold storage at FASS, namely:

a. Swab of blood from the veranda;

b. Sample from the pair of grey trousers; and

c. Sample from the torn blood-stained singlet.[3134]

[3125] Exhibit 56, Tab 122, Statement of Lynette Elias, 21 June 2023 (SCOI.84073).

[3126] Exhibit 56, Tab 123, Statement of Kathryn Lockery, 6 July 2023, [39] (SCOI.84074).

[3127] Transcript of the Inquiry, 7 July 2023, T5164.10–T5164.13 (TRA.00075.00001).

[3128] Exhibit 56, Tab 122, Statement of Lynette Elias, 21 June 2023 (SCOI.84073).

[3129] Exhibit 56, Tab 122, Statement of Lynette Elias, 21 June 2023 (SCOI.84073).

[3130] Exhibit 57, Family Statement – Robert Malcolm (SCOI.84093).

[3131] Transcript of the Inquiry, 7 July 2023, T5164.22–T5165.22 (TRA.00075.00001).

[3132] Exhibit 56, Tab 106, Summons to NSWPF (NSWPF102), 9 May 2023 (SCOI.83308).

[3133] Exhibit 56, Tab 107, Letter from NSWPF to the Inquiry, 18 May 2023 (SCOI.83309).

[3134] Exhibit 56, Tab 118, Letter of instruction to FASS, 31 May 2023 (SCOI.83433).

5.3655. On 31 May 2023, the Inquiry requested that FASS conduct DNA testing of the remaining exhibit samples.[3135]

5.3656. On 13 June 2023, Ms Franco provided a statement regarding the exhibits and the outcome of the DNA analysis. Ms Franco stated that the DNA profile recovered from the three exhibit samples matched the profile for Mr Malcolm, and that Mr Malcolm's DNA profile did not appear to be affected by a blood transfusion.[3136] She explained that:[3137]

> … *it is greater than 100 billion times more likely to obtain this profile if it originates from Robert Malcolm, rather than if it originates from an unknown, unrelated individual in the Australian population*

5.3657. Ms Franco was also asked to provide a statement regarding the nature of the forensic analysis which could have been conducted in relation to the destroyed exhibits, had they been retained, that was either not available in 1992 or which was available but not carried out.[3138]

5.3658. Ms Franco noted that there have been enormous advances in DNA testing since 1992, and that for some exhibits with insufficient DNA for testing in 1992 (including the blood-stained brick), DNA testing in 2023 would be possible.[3139] Ms Franco also raised possibilities of testing the exhibits for skin cells (blood-stained brick and timber) and for saliva (the beer bottles). While Mr Malcolm's underwear was not tested by Mr Weigner, Ms Franco states that in 2023, such exhibits could be tested for blood, semen, saliva or hair.[3140]

5.3659. In relation to the red jumper, Ms Franco noted that as it had been washed and there was no indication of blood, there are no superior tests that could have been conducted in 2023 had the exhibit been retained.[3141]

5.3660. In relation to the SAIK, Ms Franco stated that, had the swabs been retained, DNA testing could now be conducted on the swabs using PCR technology.[3142] However, Ms Franco notes a number of challenges to recovering foreign DNA from the swabs, including the fact that Mr Malcolm's own DNA would have been present in large amounts, and the presence of any faecal matter on the swabs which would enhance the degradation of other DNA present.[3143]

[3135] Exhibit 56, Tab 118, Letter of instruction to FASS, 31 May 2023 (SCOI.83433).

[3136] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [7]–[9] (SCOI.83957).

[3137] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [7]–[9] (SCOI.83957).

[3138] Exhibit 56, Tab 118, Letter of instructions from the Inquiry to FASS, 31 May 2023, 3 (SCOI.83433).

[3139] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [17] (SCOI.83957).

[3140] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [17]–[33] (SCOI.83957).

[3141] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [27] (SCOI.83957).

[3142] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [31] (SCOI.83957).

[3143] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [31]–[32] (SCOI.83957).

5.3661. Ms Franco notes throughout her report that any testing in 2023 would be dependent on any degradation which occurred in the intervening years, and that the exhibits were collected from a crime scene which was partly exposed to the elements and various building materials, which may have compromised the recovery of any DNA.[3144]

Fingerprints

5.3662. On 26 May 2023, the Inquiry requested that FETS conduct a comparative examination of fingerprints found at the crime scene and to conduct further fingerprint examinations regarding the unidentified fingerprints found on the "Toohey's Draught" beer bottle at the crime scene, as compared to the NAFIS.[3145]

5.3663. A match with the prints on the beer bottle was made with a person named Percy Alexander Strong.[3146]

5.3664. As at 11 January 1992, Mr Strong lived at an address in Eveleigh Street and spoke to police during the initial canvass of the streets surrounding the crime scene. Police recorded in the Canvass Form that Mr Strong "didn't see or hear anything".[3147]

5.3665. Mr Strong does not appear to have been interviewed further, nor was he mentioned by other witnesses as a person connected to the investigation. Mr Strong's home was approximately 50 metres from the abandoned house at 6 Holden Street.[3148]

5.3666. Mr Strong died on 11 July 2021.[3149]

Professional opinions

5.3667. On 30 May 2023, the Inquiry briefed forensic psychiatrist Dr Sullivan to provide an expert report regarding the psychology of Mr Malcolm's killer, and whether Mr Malcom's death may have been motivated by LGBTIQ bias.[3150]

5.3668. On 7 June 2023, Dr Sullivan provided a report to the Inquiry. Dr Sullivan stated that a number of factors rendered Mr Malcolm vulnerable to attack, including his intoxication, possible display of money and being in an area in which he may have been at risk of being robbed.[3151]

[3144] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [34] (SCOI.83957).

[3145] Exhibit 56, Tab 116, Letter from the Inquiry to NSWPF, 26 May 2023 (SCOI.83434).

[3146] Exhibit 56, Tab 117, Statement of Paul Hubrechsen-Yung, 5 June 2023 (SCOI.83526); Exhibit 56, Tab 110B, NAFIS Fingerprint Job Card, 2 June 2023 (NPL.2031.0001.0024).

[3147] Exhibit 56, Tab 80A, NSWPF Standard Canvass Forms bundle, 11 January 1992, 5–6 (SCOI.84138).

[3148] Exhibit 56, Tab 80A, NSWPF Standard Canvass Forms bundle, 11 January 1992, 5–6 (SCOI.84138).

[3149] Exhibit 56, Tab 102A, Death certificate of Percival Alexander Strong, 11 July 2021 (SCOI.84205).

[3150] Exhibit 56, Tab 114, Letter of Instruction to Dr Danny Sullivan, 30 May 2023 (SCOI.83435).

[3151] Exhibit 56, Tab 115, Expert report of Dr Danny Sullivan, 7 June 2023, [37]–[46] (SCOI.83635).

5.3669. If Mr Hookey, Mr Phillips and Mr Green perpetrated the attack on Mr Malcolm, Dr Sullivan is of the view that robbery was the "driver of the assault", rather than a bias motivation, and that Mr Green's derogatory remark regarding Mr Malcolm may have been motivated by LGBTIQ bias, but also may have been a *post hoc* rationalisation to justify his assault or to depersonalise Mr Malcolm.[3152]

5.3670. Dr Sullivan further stated that Mr Malcolm being found with his pants and underwear down may be due to a number of possibilities: that he was urinating when attacked; that his clothes were removed after the attack; or that he was engaged in sexual activity at the time.[3153] It is possible that the removal of his clothes was intended to humiliate, but Dr Sullivan did not think this was obvious or clear.[3154]

5.3671. Lastly, Dr Sullivan opined that the result of the sexual assault samples may have been relevant. However, as noted above, these samples have now been destroyed.

Witness statements

5.3672. The Inquiry contacted Mr Kelly, the solicitor employed at the ODPP who appeared at the committal hearing on 3–4 August 1992. On 5 May 2023, members of the Inquiry conferenced with Mr Kelly in relation to his recollection of the committal hearing. Mr Kelly subsequently provided a statement dated 5 June 2023 regarding the committal proceedings.[3155]

Contact with OIC

5.3673. On 26 May 2023, the Inquiry held a conference with Richard Yannakis in relation to his recollection of the original police investigation, including in relation to any inquiries the police undertook to locate Dianne McGuinness. Mr Yannakis was unable to provide any information beyond what was contained in the police investigative file and did not recall whether contact was made with Ms McGuinness.[3156]

5.3674. On 18 September 2023 and 13 October 2023, the Inquiry wrote to Mr Yannakis enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Malcolm. The Inquiry did not receive a response from Mr Yannakis.[3157]

[3152] Exhibit 56, Tab 115, Expert report of Dr Danny Sullivan, 7 June 2023, [44] (SCOI.83635).

[3153] Exhibit 56, Tab 115, Expert report of Dr Danny Sullivan, 7 June 2023, [38] (SCOI.83635).

[3154] Exhibit 56, Tab 115, Expert report of Dr Danny Sullivan, 7 June 2023, [38]–[41] (SCOI.83635).

[3155] Exhibit 56, Tab 120, Statement of Mark Kelly, 5 June 2023 (SCOI.83437).

[3156] Exhibit 56, Tab 123, Statement of Kathryn Lockery, 6 July 2023, [37] (SCOI.84074).

[3157] Exhibit 66, Tabs 45-46, Letters from Inquiry to Richard Yannakis, 18 September 2023 and 13 October 2023 (SCOI.86303; SCOI.86304).

Contact with Persons of Interest

5.3675. In light of the evidence before the Inquiry as to the potential involvement of Anthony Hookey, Richard Green and Kirk Phillips in Mr Malcolm's death, and the possibility that Counsel Assisting may make submissions to that effect, the Inquiry wrote to Mr Hookey, Mr Phillip's next of kin and Mr Green's next of kin. By that correspondence, the Inquiry advised of the date of the public hearing and provided a timeframe to contact the Inquiry to provide information and/or make submissions.[3158]

Other

5.3676. The Inquiry took steps, including through inter-agency cooperation, to attempt to locate Ms McGuinness, with whom Mr Hookey said he spent time during the early morning of 11 January 1992. No person matching the details of Ms McGuinness was able to be located.[3159]

5.3677. Inquiries were also made in relation to Detective Sergeant Phillips, OIC, who was found to be deceased.[3160]

5.3678. The Inquiry also made a number of attempts to contact NP243, after running sheets recording his statements to investigating police were provided to the Inquiry on 5 June 2023. The person believed to be NP243 declined to assist the Inquiry.[3161]

5.3679. Steps have also been taken by the Inquiry to speak with witnesses, including in private hearings. Those steps are outlined in **Chapter 17** of this Report.

Consideration of the evidence

Indicators of LGBTIQ bias

5.3680. There is no direct information received by the Inquiry to suggest that Mr Malcolm was a member of the LGBTIQ community. At the time of his death, Mr Malcolm was single, and there is no information in relation to any previous romantic or sexual relationships.

5.3681. Mr Malcolm's siblings, Graham Malcolm and Lynette Elias, were not spoken to during the original police investigation. The Inquiry spoke with them both.[3162] Ms Elias subsequently provided a statement in which she said that whilst Mr Malcolm had a lot of interest from girls, she never knew him to have a girlfriend, and she does not know whether he was a member of the LGBTIQ community.[3163]

[3158] Exhibit 68, Tabs 13 to 18, Letters from Inquiry and related records, 15 June 2023-6 July 2023 (SCOI.86623; SCOI.86624; SCOI.86625; SCOI.86626; SCOI.86627; SCOI.86631).

[3159] Exhibit 56, Tab 123, Statement of Kathryn Lockery, 6 July 2023, [28]–[29] (SCOI.84074).

[3160] Exhibit 56, Tab 102, Death certificate for Gary Thomas Phillips, 10 December 2019 (SCOI.83551)

[3161] Exhibit 56, Tab 123, Statement of Kathryn Lockery, 6 July 2023, [38] (SCOI.84074).

[3162] Exhibit 56, Tab 123, Statement of Kathryn Lockery, 6 July 2023, [39] (SCOI.84074).

[3163] Exhibit 56, Tab 122, Statement of Lynette Elias, 21 June 2023 (SCOI.84073).

5.3682. Mr Malcolm's colleagues provided statements around their knowledge of Mr Malcolm's relationships. The statements, as set out below, indicate that investigating police must have been alive to the possibility that LGBTIQ bias may have been a factor in Mr Malcolm's death:

a. Richard Teaken stated "[d]uring the whole time that I knew Bob I never suspected him of being a homosexual. I never knew of any regular girlfriends although he had female acquaintances."[3164]

b. Peter Pickett stated "I did not know [Mr Malcolm] as a person who was inclined to pursue women", and that he instead gained pleasure from having a drink with friends.[3165]

c. Francis Loughland provided the opinion that if Mr Malcolm had been enticed anywhere it would have been for a drink, and that it would not have been for women, "as he was getting drunk and I wouldn't think women would have been on his mind".[3166]

d. Gerald Birch stated that Mr Malcolm did not seem concerned about "trying to pick up women" and would mainly sit with other men and drink.[3167] Mr Birch described one night about 18 months prior to Mr Malcolm's death where Mr Birch and Mr Malcolm went to the Mansions Hotel and then "caught a taxi back to Central with two Aboriginal women". They had a few beers with the women at the Subway Hotel and then left.[3168]

5.3683. Mr Malcolm was found with his underpants down around his knees and his trousers around his ankles. However, the post-mortem examination did not identify any factors or injuries indicative of sexual activity or assault. The Sexual Assault Referral Unit Protocol indicates that an examination was carried out from 8:35pm on 11 January 1992 (after Mr Malcolm had already been washed and bathed by nursing staff, and had a rectal probe for temperature monitoring inserted).[3169] The results of this examination included 'normal' results for Mr Malcom's genitals and noted that perianal and rectal swabs and smears had been collected.[3170] No records provided to the Inquiry include the results of these swabs, and the SAIK was then destroyed on 1 May 1996.[3171]

5.3684. When speaking to police on 9 June 1992, before being charged on 12 June 1992, Mr Green made a derogatory comment about Mr Malcolm, which may be linked with LGBTIQ bias.[3172]

[3164] Exhibit 56, Tab 38, Statement of Richard William Teaken, 31 January 1992, [11] (SCOI.47912).

[3165] Exhibit 56, Tab 40, Statement of Peter John Pickett, 31 January 1992, [7] (SCOI.83032).

[3166] Exhibit 56, Tab 35, Statement of Francis Thomas Loughland, 30 January 1992, [10] (SCOI.47913).

[3167] Exhibit 56, Tab 39, Statement of Gerald Stuart Birch, 31 January 1992, [2] (SCOI.10290.00036).

[3168] Exhibit 56, Tab 39, Statement of Gerald Stuart Birch, 31 January 1992, [2] (SCOI.10290.00036).

[3169] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [30] (SCOI.83957); Exhibit 56, Tab 27, Sexual Assault Referral Unit Protocol, 11 January 1992, 1 (SCOI.83022).

[3170] Exhibit 56, Tab 27, Sexual Assault Referral Unit Protocol, 11 January 1992, 4, 9 (SCOI.83022).

[3171] Exhibit 56, Tab 107, Letter from NSWPF to the Inquiry, 18 May 2023 (SCOI.83309).

[3172] Exhibit 56, Tab 14, First Statement of Detective Constable Michael Starr, 9 June 1992, [6], [9] (SCOI.10939.00092).

5.3685. On 30 January 1992, police executed a search warrant at an address in Eveleigh Street (which appears to back on to the "Factory" on Holden Street, where a number of the young persons who found Mr Malcolm on 11 January 1992 were staying on the night). The police running sheet for the search warrant indicates that a number of people were occupying the premises at this time, and then goes on to note that a young person named NP244 was residing at a different address in Eveleigh Street with "Jennie". Residing at this address was Patricia (whose middle name was "Jean" and whose surname is the subject of a non-publication order) and a person named "Darren", according to police canvass forms.[3173] NP244 was at that time on bail for robbery charges, some involving wounding.

5.3686. Relevantly, police note the following in relation to NP244's previous robbery offences:[3174]

> *[NP244] usually socialises with his victim's before attacking them. [NP244] usually meets his victims who are usually drinking. [NP244] is 19 years old but looks much younger, approximately 14 years old, and when drunk becomes aggressive if his victims mention how young he looks or makes comments such as calling him a 'boy' or 'child' and 'you should be drinking you're only a boy". [NP244] when drunk becomes extremely violent and will attack a group of four and still have the upper hand in the fight.*

5.3687. From the records available, it is not clear what connection the above search warrant and information has with Mr Malcolm's death. It may be possible that police were pursuing a line of inquiry that NP244 may have socialised with Mr Malcolm and had something to do with the assault on him. The records do not reveal any further steps taken on this line of inquiry, despite NP244 appearing to be a potential suspect.

5.3688. There are no other indicators of LGBTIQ bias, from the available documentation.

5.3689. Dr Sullivan considered the potential for LGBTIQ bias to have played a role in Mr Malcolm's death and his evidence is set out above.

Events preceding death

Mr Malcolm's drinking habits

5.3690. Mr Malcolm was a regular and heavy drinker.[3175] Martin Daly, bar attendant at the Menzies Hotel, knew Mr Malcolm to "drink to excess every time he entered either bar".[3176]

[3173] Exhibit 56, Tab 80A, NSWPF Standard Canvass Forms bundle, 11 January 1992, 7 (SCOI.84138).

[3174] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 29–30 (SCOI.83976).

[3175] Exhibit 56, Tab 34, Statement of Robert McPherson Malcolm, 13 January 1992, [10] (SCOI.10290.00018).

[3176] Exhibit 56, Tab 41, Statement of Martin Francis Daly, 31 January 1992, [4], [8] (SCOI.83037).

5.3691. His friends and colleagues described him as quiet, likeable and a happy-go-lucky person, but that he appeared to have a problem with drinking. Mr Teaken said that his nickname at work was "Alcy Malcy" and that "his attitude changed for the worse when he did drink".[3177] Mr Birch stated he would get "abusive but never aggressive".[3178] Mr Loughland stated that he would get "merry" and "a bit of an orator" when he drank.[3179]

5.3692. George O'Donnall stated that Mr Malcolm usually had a "big night" on Fridays and would still be at the Menzies Hotel in the city when Mr O'Donnall left at about 8:00pm.[3180]

5.3693. Two people who knew him said that, as a result of being robbed of his watch and wallet two to three years prior to his death, Mr Malcolm did not carry a wallet, usually just some cash and an ATM card.[3181] Mr Malcolm's father confirmed that missing from his son's property at home was his licence and Mastercard.[3182]

5.3694. Mr Teaken also stated to police that Mr Malcolm was "sympathetic and naïve with Aboriginal [people]" (I note that Mr Teaken's observations appear to be implicitly pejorative, but I record them as an aspect of Mr Teaken's evidence), and added that Mr Malcolm was "likely to go any where 'if offered a drink'".[3183] Mr Loughland stated that Mr Malcolm was "always on the side of the downtrodden" and was a "sociable sort of fellow if anyone offered him a drink or enticed him anywhere it would have been for this I think".[3184]

Mr Malcolm's movements during the day of 10 January 1992

5.3695. On 10 January 1992, Mr Malcolm left his home for work at around 6:50am. Between 1:00pm and 3:00pm, Mr Malcolm attended the King George Tavern with colleagues to celebrate a colleague, Bob Wright's, retirement.[3185] From 4:30pm to around 8:00pm, Mr Malcolm was drinking with friends at the Menzies Hotel.

5.3696. First, he went to the Terrace Bar in the Menzies Hotel with a group of colleagues at around 4:30pm. He was "moderately intoxicated" by the time Mr Loughland left at around 6:30pm. Mr Loughland asked Mr Malcolm if he was going home and he replied, "[n]o I am going to hang around for a while".[3186]

[3177] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates 20 (SCOI.83976); Exhibit 56, Tab 38, Statement of Richard William Teaken, 31 January 1992, [6]–[8] (SCOI.47912).

[3178] Exhibit 56, Tab 39, Statement of Gerald Stuart Birch, 31 January 1992, 2 (SCOI.10290.00036).

[3179] Exhibit 56, Tab 35, Statement of Francis Thomas Loughland, 30 January 1992, [9] (SCOI.47913).

[3180] Exhibit 56, Tab 37, Statement of George O'Donnall, 31 January 1992, [6] (SCOI.10939.00049).

[3181] Exhibit 56, Tab 39, Statement of Gerald Stuart Birch, 31 January 1992, 2 (SCOI.10290.00036); Exhibit 56, Tab 34, Statement of Robert McPherson Malcolm, 13 January 1992, [11] (SCOI.10290.00018); Exhibit 56, Tab 40, Statement of Peter John Pickett, 31 January 1992, [6] (SCOI.83032).

[3182] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 28 (SCOI.83976).

[3183] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 20 (SCOI.83976).

[3184] Exhibit 56, Tab 35, Statement of Francis Thomas Loughland, 30 January 1992, [10] (SCOI.47913).

[3185] Exhibit 56, Tab 35, Statement of Francis Thomas Loughland, 30 January 1992, [5]–[6] (SCOI.47913); Exhibit 56, Tab 38, Statement of Richard William Teaken, 31 January 1992, [9] (SCOI.47912).

[3186] Exhibit 56, Tab 35, Statement of Francis Thomas Loughland, 30 January 1992, [7] (SCOI.47913).

5.3697. There is indirect evidence that Mr Malcolm continued drinking at the Terrace Bar with another colleague, Ed Brown, until around 7:15pm.[3187] Sharon Stephens, bar attendant at the Terrace Bar, stated to police that Mr Malcolm left the Terrace Bar "really drunk" at around 8:00pm.[3188]

5.3698. Mr Malcolm then drank in the Punt and Pint Bar of the Menzies Hotel with John Baxter and George O'Donnall. Bar attendant Martin Daly stated that it would have been around 8:00pm–8:30pm that he served Mr Malcolm a drink at the Punt and Pint Bar.[3189] Mr Baxter stated that they started drinking at around 8:00pm and then he left at around 8:30pm (Mr O'Donnall approximating both times as 30 minutes earlier than Mr Baxter). At the time Mr O'Donnall left (8:15pm according to his statement, but possibly later if Mr Baxter's timings were accurate), Mr Malcolm was "pretty intoxicated", he was unsteady, his speech was slurred, and his eyes were glazy and blood shot.[3190]

5.3699. At one point Mr Malcolm asked Mr O'Donnall "Have you got $50 on you I can borrow?" and Mr O'Donnall responded "I could give you a hundred, Bob".[3191] However, Mr O'Donnall did not end up giving Mr Malcolm any money.[3192]

Possible sightings of Mr Malcolm during the night of 10 January 1992

5.3700. Between 8:30pm and 9:00pm, four witnesses say they saw Anthony Hookey walking down Eveleigh Street with a white man. Mr Hookey was known to all four witnesses, each of whom lived in or around the Redfern area. Mr Malcolm was unknown to each witness.

5.3701. Margaret Vincent saw Mr Hookey and a white man walking side by side on Eveleigh Street at around 8:45pm. The white man appeared to be drunk and was having trouble lighting his cigarette.[3193]

[3187] Exhibit 56, Tab 35, Statement of Francis Thomas Loughland, 30 January 1992, [7] (SCOI.47913).

[3188] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 21 (SCOI.83976).

[3189] Exhibit 56, Tab 90, NSWPF Running Sheets bundle, various dates, 18 (SCOI.83976).

[3190] Exhibit 56, Tab 37, Statement of George O'Donnall, 31 January 1992, [5] (SCOI.10939.00049); Exhibit 56, Tab 36, Statement of John Mitchell Baxter, 30 January 1992, [5] (SCOI.83021).

[3191] Exhibit 56, Tab 37, Statement of George O'Donnall, 31 January 1992, [5] (SCOI.10939.00049).

[3192] Exhibit 56, Tab 37, Statement of George O'Donnall, 31 January 1992, [5] (SCOI.10939.00049); Exhibit 56, Tab 36, Statement of John Mitchell Baxter, 30 January 1992, [5] (SCOI.83021).

[3193] Exhibit 56, Tab 42, Statement of Margaret Rose Vincent, 14 January 1992, [7] (SCOI.10939.00035).

5.3702. On 14 January 1992, Ms Vincent was interviewed by police and shown a group photo containing Mr Malcolm, in which she identified that one of the men "looked very much like the white fella I saw with Beaver".[3194] She described the man as white, 35–40 years old, chubby, brown hair and wearing light coloured clothes, maybe fawn pants.[3195] The pants do not quite match, but otherwise, this appears to be Mr Malcolm. When interviewed by police who were canvassing the streets surrounding 6 Holden Street on 11 January 1992, Ms Vincent noted that when she saw "the victim" at around 8:45pm, he may have had a jumper under his arms.[3196] This may have been Mr Malcolm's maroon jumper, or Mr Hookey's red jumper, later collected as an exhibit, as discussed above.

5.3703. Joan Honeysett saw Mr Hookey and a man walking down Eveleigh Street at about 9:00pm. She heard Mr Hookey say to the man, "come down here, Aunty Kay's down here".[3197] The man was "helpless drunk", unsteady on his feet and had his head down on his chest.[3198]

5.3704. On 14 January 1992, Ms Honeysett was interviewed by police and shown the same group photo. She stated that one of the men in it "had the same hair and same sort of build as the white fella I saw Beaver with".[3199] She describes the man as wearing a white or cream dress shirt and light-coloured suit trousers,[3200] which generally accords with what Mr Malcolm was wearing on 10 January 1992 but there is also nothing remarkable about that outfit.

5.3705. Merle Roberts saw Mr Hookey and a man walking down Eveleigh Street at around 9:00pm. The man appeared drunk and was staggering and walking behind Mr Hookey.[3201]

5.3706. On 12 January 1992, Ms Roberts was interviewed by police and was not shown any photo, but described the man she saw as being in his thirties, having a moustache and wearing a light-coloured shirt and dress trousers,[3202] which generally matches with a description of Mr Malcolm on the night.

[3194] Exhibit 56, Tab 42, Statement of Margaret Rose Vincent, 14 January 1992, [10] (SCOI.10939.00035).

[3195] Exhibit 56, Tab 42, Statement of Margaret Rose Vincent, 14 January 1992, [7] (SCOI.10939.00035).

[3196] Exhibit 56, Tab 80A, NSWPF Standard Canvass Forms bundle, 11 January 1992, 2 (SCOI.84138).

[3197] Exhibit 56, Tab 43, Statement of Joan Avril Honeysett, 14 January 1992, [5] (SCOI.10939.00034).

[3198] Exhibit 56, Tab 43, Statement of Joan Avril Honeysett, 14 January 1992, [5] (SCOI.10939.00034).

[3199] Exhibit 56, Tab 43, Statement of Joan Avril Honeysett, 14 January 1992, [8] (SCOI.10939.00034).

[3200] Exhibit 56, Tab 43, Statement of Joan Avril Honeysett, 14 January 1992, [10] (SCOI.10939.00034).

[3201] Exhibit 56, Tab 47, Statement of Merle Joyce Roberts, 12 January 1992, [4]–[6] (SCOI.10939.00036).

[3202] Exhibit 56, Tab 47, Statement of Merle Joyce Roberts, 12 January 1992, [4]–[6] (SCOI.10939.00036).

5.3707. Sharon Murphy saw Mr Hookey and a man walking down Eveleigh Street between 8:30pm and 9:30pm. She said they were both drunk and staggering, and carrying a carton of beer. Ms Murphy then called out to Mr Hookey for a dollar, and he told the other man to give her a dollar. Ms Murphy stated that the man then opened a black wallet and gave her a gold coin, and she saw that he had a lot of money in $100 and $20 notes and thought to herself "he's going to get bashed and they'll take the money off him".[3203] Mr Hookey and the man then turned left into Lawson Street.[3204]

5.3708. On 25 February 1992, Ms Murphy was interviewed by police and stated she saw Mr Malcolm lying in the abandoned house and spoke to I310 (a pseudonym) about it.[3205] She stated that she had seen the same man on the previous night, as described above. It is noted that Ms Murphy's identification may not be reliable, for the following reasons:

a. Mr Malcolm, by all accounts, did not carry a wallet;

b. Ms Murphy stated that he had blood on the left shoulder of his shirt when walking down the street on Friday night, which does not match with the accounts of the other three witnesses;[3206]

c. Ms Murphy's account of events differs between her first and second statement. In her first statement she states that she was walking back down the street between 9:30pm–10:00pm, and saw Mr Phillips and Mr Green standing outside the abandoned house but did not see Mr Hookey or Mr Malcolm.[3207] However, in her second statement, she states that her first statement was incorrect and that between 9:30pm–10:00pm she saw Mr Phillips and Mr Green walking up Eveleigh Street, and saw Mr Hookey and Mr Malcolm sitting and drinking with other people;[3208]

d. Ms Murphy identified Mr Malcolm as the man she later saw lying in 6 Holden Street.[3209] However, none of the other witnesses who found Mr Malcolm (including I310) refer to her presence that morning;

e. If Ms Murphy did see Mr Malcolm on the morning of 11 January 1992, his face would have been injured and covered in blood; and

f. The timing given by Ms Murphy would mean that Mr Malcolm was asking Mr O'Donnall to borrow money at 8:00pm–8:30pm but was then carrying a lot of cash at 8:30pm–9:00pm.

[3203] Exhibit 56, Tab 44, First Statement of Sharon Lee Murphy, 25 February 1992, [5] (SCOI.83025); see also Exhibit 56, Tab 45, Second Statement of Sharon Lee Murphy, 5 March 1992, [6] (SCOI.83038).

[3204] Exhibit 56, Tab 45, Second Statement of Sharon Lee Murphy, 5 March 1992, [6] (SCOI.83038).

[3205] Exhibit 56, Tab 44, First Statement of Sharon Lee Murphy, 25 February 1992, [3] (SCOI.83025).

[3206] Exhibit 56, Tab 45, Second Statement of Sharon Lee Murphy, 5 March 1992 (SCOI.83038).

[3207] Exhibit 56, Tab 44, First Statement of Sharon Lee Murphy, 25 February 1992, [6] (SCOI.83025).

[3208] Exhibit 56, Tab 45, Second Statement of Sharon Lee Murphy, 5 March 1992, [7] (SCOI.83038).

[3209] Exhibit 56, Tab 44, First Statement of Sharon Lee Murphy, 25 February 1992, [3] (SCOI.83025).

5.3709. It is possible that some of the issues set out above provided a basis for impeaching Ms Murphy's recollection at the committal hearing. According to Mr Kelly, Ms Murphy was the key witness who failed to give the Coroner the evidence to link the accused with Mr Malcom's death.[3210] Ms Vincent and Ms Joan Honeysett are also recorded to have given oral evidence at the committal hearing.[3211] It is possible that the Coroner did not find their evidence credible or reliable.

5.3710. There are limited sightings of Mr Malcolm from this point, with the exception of:

a. NP243, who spoke to police on 11 January 1992, stating that he was part of the group who found Mr Malcolm. NP243 said to police that he had seen Mr Malcolm in the Redfern area at approximately 11:30pm on 10 January 1992.[3212] NP243 did not provide a statement, and when followed up by police, did not reside at the address given.[3213] Investigations by the Inquiry indicate that the name provided by NP243 is an alias.[3214] As stated above, NP243 did not assist the Inquiry when contacted.

b. The anonymous source on 11 January 1992 (discussed above) stated that at around 2:00am, Mr Hookey was seen chasing a white male north in Eveleigh Street.

5.3711. Information was also received from Jan Flannigan, residing at a neighbouring house (approximately 250 metres from where Mr Malcolm was found), that at around 2:45am–3:00am on 11 January 1992, Ms Flannigan's husband was awakened by a cab sound and a male voice saying, "come on Bruce".[3215] However, no statement was taken from Ms Flannigan or her husband, and this may be unrelated to Mr Malcolm.

Discovery of Mr Malcolm and medical attention

Discovery of Mr Malcolm on 11 January 1992

5.3712. At about 2:00am on 11 January 1992, Mr Malcolm was found in a derelict house at 6 Holden Street, Redfern. He was found by young adults and children working or staying at the "Factory" on Holden Street, also known as the Aboriginal Christian Youth Organisation, which was a place where young people slept, ate and spent time, and where the Phillips family appeared to work.

[3210] Exhibit 56, Tab 120, Statement of Mark Kelly, 5 June 2023, [8]–[9], [11] (SCOI.83437).

[3211] Exhibit 56, Tab 94, Master Tape History Sheet, 3 August 1992, 3-4 (SCOI.11290.00072).

[3212] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 37 (SCOI.83976)

[3213] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 13 (SCOI.83976).

[3214] Exhibit 56, Tab 123, Statement of Kathryn Lockery, 6 July 2023, [38] (SCOI.84074).

[3215] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 12 (SCOI.83976).

5.3713. A group of 14–15 year old children including I308, I309 and I310 (pseudonyms) stated that they heard sounds from inside the abandoned house at 6 Holden Street at around 2:00am (1:00am according to I310), and then went to investigate. They saw Mr Malcolm through a hole in the wall, lying on his back and bleeding heavily from his face.[3216] NP243 also said that he was with this group.[3217] The younger children then fetched an older group which included Richard Green, Kirk Phillips and Max Bright.[3218]

5.3714. Kirk Phillips then went to Redfern Railway Station to call an ambulance,[3219] and Garry Phillips (caretaker) went back to the Factory to use the phone there to call an ambulance.[3220] At this time, Mr Green asked Jenine Honeysett, walking down Eveleigh Street, if he could use her grandmother's house phone to call an ambulance, but she told him to go to the train station.[3221]

5.3715. Sandra Matthew, living in one of the nearby houses, recalled hearing "arguing" and "chattering" in Caroline Lane at around 1:30am–2:00am on 11 January 1992.[3222] Ms Matthew said there was also music and this went on for a bit longer.[3223] It may be that the witnesses who discovered Mr Malcolm moved from 6 Holden Street to the nearby Caroline Lane.

5.3716. At some point between when the younger boys discovered Mr Malcolm and the arrival of the ambulance, it appears that Jason Phillips (younger brother of Kirk Phillips) went into the house. Jason stated that Mr Malcolm was choking on the blood coming out of his mouth and down his face, and so Jason turned Mr Malcolm on his side and propped him up with a stick to help him breathe.[3224] Garry Phillips, after using the telephone at the Factory to call the ambulance, returned to the house and saw that there was a stick leaning against the wall and Mr Malcolm's back was shifted to be leaning against it, and that Mr Malcolm was lying on his side.[3225] Richard Gilmore also gave a statement that he saw that Mr Malcolm was unconscious and propped up with a stick, so he then removed the stick and put Mr Malcolm on his side.[3226]

[3216] Exhibit 56, Tab 48, Statement of I308, 11 January 1992, [3] (SCOI.10939.00029); Exhibit 56, Tab 49, Statement of I309, 11 January 1992, [4]–[5] (SCOI.83040); Exhibit 56, Tab 50, Statement of I310, 11 January 1992, [4]–[6] (SCOI.10939.00030).

[3217] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 10 (SCOI.83976).

[3218] Exhibit 56, Tab 70, First Statement of Richard Green, 11 January 1992, [4]–[6](SCOI.10939.00032); Exhibit 56, Tab 71, Second Statement of Richard Green, 4 March 1992, [5] (SCOI.10290.00023); Exhibit 56, Tab 69, NSWPF Record of Interview, 'Interview with Kirk Anthony Phillips', 6 May 1992, [A67] (SCOI.10290.00014).

[3219] Exhibit 56, Tab 68, Statement of Kirk Anthony Phillips, 11 January 1992, [6] (SCOI.10939.00023); Exhibit 56, Tab 69, NSWPF Record of Interview, 'Interview with Kirk Anthony Phillips', 6 May 1992, [A47] (SCOI.10290.00014).

[3220] Exhibit 56, Tab 53, Statement of Garry Robert Phillips, 14 January 1992, [7] (SCOI.10290.00031).

[3221] Exhibit 56, Ta 61, Statement of Jenine Cecilia Honeysett, 6 March 1992, [7] (SCOI.83030); see also Exhibit 56, Tab 70, First Statement of Richard Green, 11 January 1992, [6] (SCOI.10939.00032).

[3222] Exhibit 56, Tab 80A, NSWPF Standard Canvass Forms bundle, various dates, 11 January 1992, 4 (SCOI.84138).

[3223] Exhibit 56, Tab 80A, NSWPF Standard Canvass Forms bundle, various dates, 11 January 1992, 4 (SCOI.84138).

[3224] Exhibit 56, Tab 51, Statement of Jason Bradley Phillips, 16 January 1992, [9] (SCOI.83036).

[3225] Exhibit 56, Tab 53, Statement of Garry Robert Phillips, 14 January 1992, [8] (SCOI.10290.00031).

[3226] Exhibit 56, Tab 52, Statement of Richard Ian Gilmore, 11 January 1992, [7] (SCOI.10939.00031).

5.3717. In his second statement to police, Mr Green stated that he was at the Factory when a young man came in and told them, "some blokes just been brought from Kings Cross, bashed and rolled".[3227] It is unclear how the young man had obtained that information, or, if this was invented by Mr Green, how he obtained that information, without some involvement in the assault.

5.3718. NP243, in his discussions with police, stated he had gone into the building to "meet some friends",[3228] and that "everyone knew he was in there but didn't know he's been extremely beaten".[3229]

5.3719. The statements of Mr Green and NP243 indicated that the abandoned house was possibly being used as a meeting place, which accords with the rubbish found including the beer bottles. Their statements further indicated that there was some awareness that Mr Malcolm had been "rolled" (robbed), although those who found him appeared shocked at the extent of his injuries.

Medical Treatment and Death

5.3720. At approximately 2:17am on 11 January 1992, paramedics arrived at 6 Holden Street.[3230] One of the paramedics, Mr Cribb, observed that Mr Malcolm's underpants were around his knees and his grey pants were folded in half and placed across his buttocks.[3231] It is unclear who folded Mr Malcom's pants, as the young people who discovered him only mention that his pants were down, not that they were folded.

5.3721. At this time, Mr Malcolm did not have any identification or valuables on him.[3232]

5.3722. Mr Malcolm was then conveyed by ambulance to Royal Prince Alfred Hospital and arrived at 2:37am.[3233]

5.3723. At approximately 2:45am, Mr Malcolm was examined by Dr Les Schmalzbach. At this point, Mr Malcolm had been intubated and was unconscious and hypotensive.[3234] The following injuries were clinically evident on examination:[3235]

a. Boggy swelling of the right side of the scalp, with possible underlying fracture;

b. Damage to the right eye which contained blood and had been partly pushed forward;

c. Fractures of the bones in the middle of the face, especially on the right;

d. A five centimetre deep laceration of the right cheek;

[3227] Exhibit 56, Tab 71, Second Statement of Richard John Green, 4 March 1992, [5] (SCOI.10290.00023).

[3228] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 9 (SCOI.83976).

[3229] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 10 (SCOI.83976).

[3230] Exhibit 56, Tab 26, Ambulance Service of New South Wales Treatment Report, 11 January 1992 (SCOI.83026).

[3231] Exhibit 56, Tab 25, Statement of Leon Joseph Cribb, 28 January 1992, [5]–[6] (SCOI.83031).

[3232] Exhibit 56, Tab 77, NSWPF Investigation Summary, undated (NPL.0174.0001.0001.0006).

[3233] Exhibit 56, Tab 25, Statement of Leon Joseph Cribb, 28 January 1992, [7] (SCOI.83031); Exhibit 56, Tab 26, Ambulance Service of New South Wales Treatment Report, 11 January 1992 (SCOI.83026).

[3234] Exhibit 56, Tab 29, Statement of Dr Les Schmalzbach, 11 May 1992, 1 (SCOI.10290.00059).

[3235] Exhibit 56, Tab 29, Statement of Dr Les Schmalzbach, 11 May 1992, 1 (SCOI.10290.00059); see also Exhibit 56, Tab 28, Statement of Dr Stephen John Halcrow, 4 May 1992 (SCOI.10290.00058).

e. Broken and/or missing front upper teeth; and

f. Bleeding from the nose and right ear, and possibly the left ear.

5.3724. Following extensive radiological investigations, the following injuries were also documented:[3236]

a. A small amount of diffuse blood throughout the brain (subarachnoid haemorrhage);

b. Complex fractures of the base of the skull, right facial bones and right orbit;

c. Probable division of the right optic nerve; and

d. Bilateral lung opacities consistent with aspiration of vomitus.

5.3725. On 13 January 1992, Mr Malcolm was identified.[3237]

5.3726. On 15 January 1992, Mr Malcolm had a tracheostomy, performed by Dr Michael Morgan.[3238]

5.3727. Mr Malcolm likely died between 6:30pm and 7:10pm on 29 January 1992.[3239] At 7:30pm on 29 January 1992, Mr Malcolm was pronounced deceased by Dr Anne Brady.[3240]

Persons of interest

Movements of Anthony Hookey on 10–11 January 1992

5.3728. In his statement to police on 13 January 1992, Mr Hookey provided an overview of his movements on 10–11 January 1992.[3241] Where Mr Hookey's account as to his movements are corroborated or contradicted by other witnesses, it is noted in a footnote.

5.3729. Redfern:

a. At around 6:30pm, he left Aunty Linda's house in Waterloo and walked to the Black Theatre in Redfern, where he spoke to Michelle Hookey. There was a group of ten people present.[3242]

b. At around 6:50pm, he left the Black Theatre to go to Eveleigh Street. He went through the street behind the TNT buildings, past Redfern Railway Station onto Lawson Street, and then turned right into Eveleigh Street, arriving at around 6:55pm.[3243] He then stopped and spoke to Tracy and Mary (whose

[3236] Exhibit 56, Tab 29, Statement of Dr Les Schmalzbach, 11 May 1992, 2 (SCOI.10290.00059).

[3237] Exhibit 56, Tab 34, Statement of Robert McPherson Malcolm, 13 January 1992, [7]–[9] (SCOI.10290.00018).

[3238] Exhibit 56, Tab 30, Statement of Dr Michael Morgan, 17 February 1992 (SCOI.10290.00056); Exhibit 56, Tab 29, Statement of Dr Les Schmalzbach, 11 May 1992, 2 (SCOI.10290.00059); Exhibit 56, Tab 3, Post-mortem report of Dr Johan Duflou, 28 May 1992, 1 (SCOI.10494.00017).

[3239] Exhibit 56, Tab 31, Statement of Claire Bronwen Aldis, 29 January 1992 (SCOI.83042), who observed him apparently alive at 6:30pm, but apparently deceased at 7:10pm.

[3240] Exhibit 56, Tab 32, Statement of Dr Anne Brady, 29 January 1992 (SCOI.83039).

[3241] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [1]–[9] (SCOI.10290.00008).

[3242] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [4] (SCOI.10290.00008).

[3243] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [4] (SCOI.10290.00008).

surnames are the subject of a non-publication order) for about half an hour.[3244]

c. In his later interview with police on 30 April 1992, Mr Hookey amended this element of the events.[3245] He stated that it was around 7:30pm–8:00pm when he walked up Lawson Street and turned onto Eveleigh Street. He also added that he asked a white man standing on the corner for a cigarette, and never saw the white man before or again.[3246] This may have been Mr Malcolm, but it is unlikely, as Mr Malcolm would have been at the Menzies Hotel at this time.

5.3730. Clifton Hotel, Redfern:

a. After speaking with Tracy and Mary, he walked to the Clifton Hotel on Regent Street and arrived at around 7:45pm. He ordered a beer and played pool with Barbara Stacy.[3247]

b. During the night, he also spoke to Michelle Hookey, Maria Hookey, Matt Perry, Debbie Murphy, Karen Lowe, I312 (a pseudonym) and Rebecca "Beccy" Smith. He also continued to drink beer.[3248]

c. At closing time (unspecified), he left the Clifton Hotel with his ex-girlfriend Dianne McGuinness and her cousin Tracy McGuinness, and they walked up Regent Street towards the Westpac Bank.[3249]

d. In his later interview with police on 30 April 1992, Mr Hookey mentioned only Dianne McGuinness and not Tracy McGuinness, as being present.[3250] According to the police running sheet, when Mr Hookey was spoken to by police on 11 January 1992, he did not mention Dianne McGuinness at all.[3251]

e. Mr Hookey then saw Karen Lowe, I312 and Beccy Smith outside the Westpac Bank and they took a taxi together to Kings Cross.[3252]

[3244] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [5] (SCOI.10290.00008).

[3245] Exhibit 56, Tab 67, NSWPF Record of Interview, 'Interview with Anthony Stanley Hookey', 30 April 1992, [A46]–[A47] (SCOI.10939.00019).

[3246] Exhibit 56, Tab 67, NSWPF Record of Interview, 'Interview with Anthony Stanley Hookey', 30 April 1992, [A46]–[A47] (SCOI.10939.00019).

[3247] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [5] (SCOI.10290.00008).

Consistent with Mr Hookey's evidence, Barbara Stacy and Matthew Perry recalled Mr Hookey playing pool, but they place the time as around 10:30pm–10:45pm, see Exhibit 56, Tab 54, Statement of Barbara Dawn Stacy, 13 January 1992, [5] (SCOI.10939.00039); Exhibit 56, Tab 59, Statement of Matthew Perry, 4 March 1992, [6] (SCOI.83035).

[3248] Inconsistent with Mr Hookey's evidence, Rene (whose surname is the subject of a non-publication order), I311, Jenine Honeysett, James Smith and Jason Phillips stated they were at the Clifton Hotel during the time period of 8:30pm to midnight but did not see Mr Hookey there, see Exhibit 56, Tab 55, Statement of Rene, 13 January 1992, [5] (SCOI.10939.00037); Exhibit 56, Tab 56, Statement of I311, 11 February 1992, [5] (SCOI.83041); Exhibit 56, Tab 61, Statement of Jenine Cecilia Honeysett, 6 March 1992, [6] (SCOI.83030); Exhibit 56, Tab 62, Statement of James Frederick Smith, 3 March 1992, 1 (SCOI.83029); Exhibit 56, Tab 51, Statement of Jason Bradley Phillips, 16 January 1992, [6] (SCOI.83036).

Consistent with Mr Hookey's evidence, Matthew Perry said he spoke to Mr Hookey in the Clifton Hotel at around 11:45pm, and Mr Hookey's uncle Wayne Hookey told police he saw his nephew at around 10:00pm in the Clifton Hotel, see Exhibit 56, Tab 59, Statement of Matthew Lawrence Perry, 4 March 1992, [6] (SCOI.83035); Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates 19 (SCOI.83976).

[3249] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [6] (SCOI.10290.00008).

[3250] Exhibit 56, Tab 67, NSWPF Record of Interview, 'Interview with Anthony Stanley Hookey', 30 April 1992 [A16] (SCOI.10939.00019).

[3251] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates 5–6 (SCOI.83976).

[3252] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [6] (SCOI.10290.00008).

f. When spoken to by police on 11 January 1992, Mr Hookey stated that in addition to the above women being in the taxi, Barbara Stacy was also present.[3253]

5.3731. Kings Cross:

a. After arriving in Kings Cross, he separated from the women and went to the Mansions Hotel.[3254]

b. He spoke to Michelle Hookey and her friend Victor for about 30 minutes but did not have a drink.[3255]

c. He then left the Mansions Hotel and told a friend (unnamed) who worked at the Mansions Hotel that he was going for a walk. He then walked down to the Crest Hotel and used the toilet there.[3256]

d. He then sat outside the closed entrance to Kings Cross Railway Station for about ten minutes before walking up and down the main street of Kings Cross.[3257]

e. In the early hours of 11 January 1992, he ran into Dianne McGuinness again and they walked around the streets until it started to become light.[3258]

5.3732. Subway Hotel, Central:

a. At dawn, he and Ms McGuinness took the train from Kings Cross to Central Station and went to the Subway Hotel.[3259]

b. When spoken to by police on 11 January 1992, Mr Hookey provided a different timeline of his movement from Kings Cross to Central. He stated that he stayed at the Mansions Hotel until around 3:30am and then went to

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Consistent with Mr Hookey's evidence, Rebecca (Beccy) Smith told police on 11 January 1992 that she took a cab from the Clifton Hotel at closing time, to the Mansions Hotel with a group of people including I312, Karen Holton/Lowe and 'Tony'. However, police noted that they felt her information was "suspect and not to be relied upon" (it is unclear for what reason). Police also noted that Karen Lowe/Holten was present but that she was drunk, see Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 7 (SCOI.83976).

[3253] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 5–6 (SCOI.83976).

Inconsistent with Mr Hookey's evidence, Ms Stacy stated that she only saw Mr Hookey when playing pool with him, and that she did not leave with him, see Exhibit 56, Tab 54, Statement of Barbara Dawn Stacy, 13 January 1992 [6] (SCOI.10939.00039).

Inconsistent with Mr Hookey's evidence, I312 stated she was only with her girlfriends during the night and "none of the fellas" came with them at any time, see Exhibit 56, Tab 57, Statement of I312, 11 January 1992, [7] (SCOI.83027).

[3254] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [7] (SCOI.10290.00008).

Inconsistent with Mr Hookey's evidence, Rene, Matthew Perry and Jenine Honeysett stated that they were at the Mansions Hotel at varying times between midnight and 5:00am, but did not see Mr Hookey there, see Exhibit 56, Tab 55, Statement of Rene, 13 January 1992, [6] (SCOI.10939.00037); Exhibit 56, Tab 59, Statement of Matthew Lawrence Perry, 4 March 1992, [7] (SCOI.83035); Exhibit 56, Tab 61, Statement of Jenine Cecilia Honeysett, 6 March 1992, [8] (SCOI.83030).

Consistent with Mr Hookey's evidence, James Smith stated that he saw Mr Hookey arrive at the Mansions Hotel at around 2:00am, see Exhibit 56, Tab 62, Statement of James Frederick Smith, 3 March 1992, 1 (SCOI.83029). However, as noted in Exhibit 56, Tab 120, Statement of Mark Kelly, 6 June 2023, [7] (SCOI.83437), Mr Smith appeared to waver in his memory of the date at committal.

[3255] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [7] (SCOI.10290.00008).

[3256] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [7] (SCOI.10290.00008).

[3257] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [7] (SCOI.10290.00008).

[3258] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [7] (SCOI.10290.00008); Exhibit 56, Tab 67, NSWPF Record of Interview, 'Interview with Anthony Stanley Hookey', 30 April 1992, [A16] (SCOI.10939.00019).

[3259] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [7]–[8] (SCOI.10290.00008).

Consistent with Mr Hookey's evidence, Barbara Stacy, Rene and James Smith reported seeing Mr Hookey at around 8:00am (5:00am for Mr Smith) at the Subway Hotel, see Exhibit 56, Tab 54, Statement of Barbara Dawn Stacy, 13 January 1992, [6] (SCOI.10939.00039); Exhibit 56, Tab 55, Statement of Rene, 13 January 1992, [7] (SCOI.10939.00037); Exhibit 56, Tab 62, Statement of James Frederick Smith, 3 March 1992, 2 (SCOI.83029).

the Subway Hotel, and there was no mention of walking around Kings Cross with Ms McGuinness.[3260]

c. At the Subway Hotel, he spoke to his aunt Dot Hookey, and a hotel employee.[3261] He also spoke to a man who he later saw again at Redfern Railway Station. Then he left the Subway Hotel (Ms McGuinness stayed) and caught a train from Central to Redfern.[3262]

d. In his later interview with police on 30 April 1992, Mr Hookey added that the unknown man bought him and his aunt a beer.[3263] He reported that he, his aunt and the unknown man then took a taxi from the Subway Hotel to Redfern, planning to go to the Boundary Pub, and that the unknown man paid for the taxi.[3264]

5.3733. Redfern:

a. When he arrived at Redfern Railway Station, the man who had spoken to him at the Subway Hotel also got off the train and spoke to him again in Lawson Street outside the station entrance. Mr Hookey then walked down Eveleigh Street and spoke to Karen Lowe's brother, Tommy. Tommy offered him a drink, but Mr Hookey did not have one. After leaving Tommy, Mr Hookey again saw the unknown man standing there.[3265]

b. He then walked up Redfern Street with the unknown man and Rene, who had been at Tommy's house or the house next door. Rene's surname is the subject of a non-publication order.

c. The unknown man was white and Mr Hookey did not know his name.[3266] In his later interview on 30 April 1992, he added that the man "seemed real friendly" and described the man as about 180 centimetres tall, wearing glasses, sort of grey hair, 35–38 years old, skinny, and was wearing brown trousers and a black t-shirt with something like "Harley Davidson" or a picture on the front.[3267] It is noted that this does not match the description of Mr Malcolm and that Mr Malcolm had already been found in 6 Holden Street by this time.

d. The unknown male stopped to use the Commonwealth Bank ATM on Redfern Street.[3268]

[3260] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 5–6 (SCOI.83976).

[3261] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [8] (SCOI.10290.00008); Exhibit 56, Tab 60, Statement of Bradford Keith Bloodworth, 8 February 1992, [6] (SCOI.83019).

[3262] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [8] (SCOI.10290.00008).

[3263] Exhibit 56, Tab 67, NSWPF Record of Interview, 'Interview with Anthony Stanley Hookey', 30 April 1992, [A16] (SCOI.10939.00019).

[3264] Exhibit 56, Tab 67, NSWPF Record of Interview, 'Interview with Anthony Stanley Hookey', 30 April 1992, [A23], [A26] (SCOI.10939.00019).

Consistent with Mr Hookey's evidence, Rene reported seeing, from out the front of Eveleigh Street, Mr Hookey get out of a taxi with "the lad" (having referred earlier to seeing Mr Hookey with a lad at the Subway Hotel), and then walk to the bank to get some money, see Statement of Rene, 13 January 1992, [8] (SCOI.10939.00037).

[3265] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [8] (SCOI.10290.00008).

[3266] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [9] (SCOI.10290.00008).

[3267] Exhibit 56, Tab 67, NSWPF Record of Interview, 'Interview with Anthony Stanley Hookey', 30 April 1992, [A18]–[A20] (SCOI.10939.00019).

[3268] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [9] (SCOI.10290.00008).

e. In his later interview with police on 30 April 1992, Mr Hookey reported that after the unknown man paid for the taxi from Kings Cross to Redfern, the unknown man tried to withdraw money from an ATM but could not, and that the bank was not open. He noted that the unknown male had about $20 or less on him at the time he paid the taxi fare.[3269]

f. Around the time that the unknown male was using the ATM, the police arrived and took Mr Hookey to Redfern Police Station.[3270]

g. In his later interview, he noted that the police took him, Rene and the unknown man to the police station, for questioning in relation to Mr Malcolm, and estimated that this was at about 10:00am–12:00pm on 11 January 1992.[3271]

h. A running sheet identifies that Mr Hookey was taken in for questioning at around 12:30pm, in the company of Rene and David William Whitlock.[3272] It is likely that it was Mr Whitlock, and not Mr Malcolm who was the unknown man referred to throughout Mr Hookey's description of events on 11 January 1992.

5.3734. As to Mr Hookey's clothing, he stated that between Friday (10 January 1992) and being picked up by police on Saturday (11 January 1992), he was wearing a short-sleeved black and white 'Sweathog' t-shirt, grey tracksuit pants, Lotto brand joggers, and white socks with green and blue stripes.[3273] This outfit was corroborated by Rene who reported seeing Mr Hookey at the Subway Hotel at around 8:00am on 11 January 1992, wearing a black shirt, tracksuit pants and joggers.[3274]

5.3735. However, in her statement, Barbara Stacy reported that she saw Mr Hookey at around 8:00am at the Subway Hotel, and that he gave her a nice red "dress jumper" that he had been wearing at the Clifton Hotel. She reported that it was dirty around the neck and had "fluff" on it, and that otherwise, Mr Hookey was wearing a black shirt and black shorts with Cronulla colours on the side.[3275] However, on 5 February 1992, after providing the jumper to police, Ms Stacy said that she did not know where Mr Hookey got the red jumper from and she wasn't sure if he had been wearing the red jumper the night before.[3276] Mr Hookey did not mention a red jumper.

5.3736. James Smith stated that Mr Hookey had come into some money as at 10–11 January 1992:

a. Mr Smith stated that Mr Hookey arrived at the Mansions Hotel shortly after 2:00am on 11 January 1992, and that he joined a group which came to include

[3269] Exhibit 56, Tab 67, NSWPF Record of Interview, 'Interview with Anthony Stanley Hookey', 30 April 1992, [A24], [A29] (SCOI.10939.00019).

[3270] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [9] (SCOI.10290.00008).

[3271] Exhibit 56, Tab 67, NSWPF Record of Interview, 'Interview with Anthony Stanley Hookey', 30 April 1992, [A30], [A43] (SCOI.10939.00019).

[3272] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 4 (SCOI.83976).

[3273] Exhibit 56, Tab 66, Statement of Anthony Stanley Hookey, 13 January 1992, [10] (SCOI.10290.00008).

[3274] Exhibit 56, Tab 55, Statement of Rene, 13 January 1992, [8] (SCOI.10939.00037).

[3275] Exhibit 56, Tab 54, Statement of Barbara Dawn Stacy, 13 January 1992, [7] (SCOI.10939.00039).

[3276] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 33 (SCOI.83976).

Mr Smith, Dot Hookey, Jenine Honeysett and Donna Morgan. Mr Smith reported that whilst they were sitting together, Mr Hookey "kept flashing all this money he had, mostly $20 notes". During this time, Mr Hookey paid for two or three rounds of drinks, including beer and spirits, for the five or six people in the group. Mr Hookey said to Mr Smith "I just rolled someone" or "I did a roll".[3277]

b. Mr Smith's recollection of events is not consistent with the account of his partner, Ms Honeysett, who stated she was with Mr Smith and her friend Donna Morgan at the Mansions Hotel that morning but did not recall seeing Mr Hookey.[3278]

c. Mr Hookey denied making the above statement to Mr Smith and denied giving him any money.[3279] He also denied buying beers for other people at the Mansions Hotel and said his aunt Michelle Hookey and her friend Victor bought him a beer.[3280]

d. Mr Smith stated that when he was at the Subway Hotel from around 5:00am, Mr Hookey again shouted drinks for the group there.[3281]

e. Mr Smith further stated that at around 9:45am, Mr Smith, Mr Hookey, Dot Hookey and a "white fellow" left the Subway Hotel and caught a cab to Eveleigh Street. Then whilst standing outside "Jean's" (Patricia Jean, whose surname is the subject of a non-publication order) house at an address in Eveleigh Street, Mr Smith asked Mr Hookey for some money and Mr Hookey said, "I'll give you 80 bucks and I'll shout you all day" and then gave Mr Smith $80 from out of his underwear. Mr Smith reported that he then gave $40 back to Mr Hookey to buy beer and then walked to Darby Ward's house at an address in Eveleigh Street and slept on the couch until around 3:00pm.[3282]

5.3737. Consistent with Mr Smith's statement, Patricia reported seeing Mr Hookey and Mr Smith get out of a taxi on Eveleigh Street at around 10:30am, have an argument and go into Darby Ward's house.[3283] Then at around 11:00am, Patricia reported seeing Mr Hookey and Mr Smith leave and walk down Eveleigh Street and stop at the empty house on the corner of Eveleigh and Holden Streets. She saw that Mr Hookey had a bundle of $20 notes in his left hand, possibly to the amount of a couple of hundred dollars. She then overheard the following conversation between Mr Hookey and Mr Smith:[3284]

AH: I'll give you $80 and I'll shout the grog for the rest of the day.

JS: What about the other money you've got in your underpants?

[3277] Exhibit 56, Tab 62, Statement of James Frederick Smith, 3 March 1992, 1–2 (SCOI.83029).

[3278] Exhibit 56, Tab 61, Statement of Jenine Cecilia Honeysett, 6 March 1992, [8] (SCOI.83030).

[3279] Exhibit 56, Tab 67, NSWPF Record of Interview, 'Interview with Anthony Stanley Hookey', 30 April 1992, [A15], [A17] (SCOI.10939.00019).

[3280] Exhibit 56, Tab 67, NSWPF Record of Interview, 'Interview with Anthony Stanley Hookey', 30 April 1992, [A54] (SCOI.10939.00019).

[3281] Exhibit 56, Tab 62, Statement of James Frederick Smith, 3 March 1992, 2 (SCOI.83029).

[3282] Exhibit 56, Tab 62, Statement of James Frederick Smith, 3 March 1992, 2 (SCOI.83029).

[3283] Exhibit 56, Tab 63, Statement of Patricia Jean, 25 February 1992, [4] (SCOI.83024).

[3284] Exhibit 56, Tab 63, Statement of Patricia Jean, 25 February 1992, [4] (SCOI.83024).

AH: I haven't got any money.

5.3738. Overall, it appears that Mr Hookey's accounts of his movements, first when speaking to police on 11 January 1992, then in his statement dated 13 January 1992 and later in his interview on 30 April 1992, are not entirely consistent with each other, with times being shifted and further people, including Dianne and Tracy McGuinness being added and removed from the narrative. Mr Hookey's account was at least partly corroborated by witness statements up to around midnight at the Clifton Hotel and then again from around 8:00am at the Subway Hotel. However, the hours between around midnight to around 8:00am, when Mr Hookey says he was in Kings Cross, are largely uncorroborated.

5.3739. Mr Hookey states he caught a taxi to Kings Cross with Karen Lowe/Holton, I312 and Beccy Smith, however I312 stated that during the night she was only with her girlfriends and "none of the fellas" came with them at any time.[3285] Mr Hookey further says he went to the Mansions Hotel in Kings Cross, but some of the people who were there (Rene, Matthew Perry, Jenine Honeysett) say they did not see him.[3286] The only person who puts him at the Mansions Hotel is James Smith, who says he saw Mr Hookey arrive at around 2:00am, and then display cash and brag about a roll.[3287] However, Mr Kelly, the committal solicitor, after reviewing his contemporaneous notes from the committal hearing on 3 August 1992, informed the Inquiry that his notes suggest that at the committal hearing Mr Smith was no longer sure about the day on which Mr Hookey said he had rolled someone.[3288]

5.3740. There are also a number of people mentioned by Mr Hookey (who may have been able to corroborate his movements during this period), who were not interviewed by police and did not give statements to police. Therefore, those elements of his account cannot be verified.

5.3741. In addition to the anonymous source, police also spoke to the occupants of an address in Lawson Street who were coming home from a night out at around 2:00am on 11 January 1992. They saw "a male of similar description" to the person of interest described to them by police (likely Mr Hookey), running west along Lawson Street from Regent Street, towards Redfern Railway Station. This person may have been Mr Hookey; however, it is noted that the location described would place the male as running towards the crime scene, rather than away from it, and the occupants stated to police that the male was wearing a light grey suit, which by all other accounts, is not what Mr Hookey was wearing.[3289]

[3285] Exhibit 56, Tab 57, Statement of I312, 11 January 1992, [7] (SCOI.83027).

[3286] Exhibit 56, Tab 55, Statement of Rene, 13 January 1992, [6] (SCOI.10939.00037); Exhibit 56, Tab 59, Statement of Matthew Lawrence Perry, 4 March 1992, [7] (SCOI.83035); Exhibit 56, Tab 61, Statement of Jenine Cecilia Honeysett, 6 March 1992, [8] (SCOI.83030).

[3287] Exhibit 56, Tab 62, Statement of James Frederick Smith, 3 March 1992, 1–2 (SCOI.83029).

[3288] Exhibit 56, Tab 120, Statement of Mark Kelly, 5 June 2023 [7] (SCOI.83437).

[3289] Exhibit 56, Tab 80A, NSWPF Standard Canvass Forms bundle, 11 January 1992, 9–10 (SCOI.84138).

5.3742. On 6 May 1992, Mr Phillips said the following to police, implicating Mr Hookey in Mr Malcolm's death:[3290]

> *Q93: Do you have any information whatsoever in relation to any person that made an assault on this gentleman on that night?*
>
> *A: No, to be honest you know, I'm being truthful, the only thing that I know, what I heard was – I heard something happened and Beaver had something to do with it. That's what I heard.*
>
> *Q94: Where did you get that information from?*
>
> *A: Just on the street.*

5.3743. Handwritten notes in the police file, likely written by the investigating officers during the early stages of the investigation, also recorded "Beaver won't go to gaol knows all about it [sic]" and that either I309 or I310 said to Mr Hookey's mother "that he knows all about it".[3291] This information did not appear in their written statements. It is not possible to tell from the handwritten notes how this information came to be obtained, nor its reliability. The handwritten notes were produced to the Inquiry as part of the 1,827 documents produced on 21 June 2023 (see above) and appeared amongst a miscellany of documents such as police facts, detective calendars and copies of statements.[3292] Accordingly, the provenance or reliability of these handwritten notes is unknown.

Movements of Kirk Phillips on 10–11 January 1992, and statements implicating him in the murder

5.3744. In his statement to police on 11 January 1992, Mr Phillips provided an account of the circumstances in which he and the other young people from the Factory found Mr Malcolm.[3293]

5.3745. On 6 May 1992, Mr Phillips gave a further interview providing the following account for his movements on the night of 10–11 January 1992:

a. From around 4:00pm or 5:00pm to around midnight, he was at the Clifton Hotel, playing snooker with a few people including Craig Goldie and 'Barbara'.[3294]

b. He left the Clifton Hotel at around midnight and stayed out the front for about 15 minutes.[3295]

[3290] Exhibit 56, Tab 69, NSWPF Record of Interview, 'Interview with Kirk Anthony Phillips', 6 May 1992, [Q93]–[Q94] (SCOI.10290.00014).

[3291] Exhibit 56, Tab 80B, Handwritten notes by police, Undated 1, 3 (SCOI.84150).

[3292] Exhibit 56, Tab 113A, Letter from NSWPF to the Inquiry, 21 June 2023 (SCOI.84214).

[3293] Exhibit 56, Tab 68, Statement of Kirk Anthony Phillips, 11 January 1992, [5] (SCOI.10939.00023).

[3294] Exhibit 56, Tab 69, NSWPF Record of Interview, 'Interview with Kirk Anthony Phillips', 6 May 1992, [A20]–[A29] (SCOI.10290.00014). Barbara Stacy does not mention seeing Mr Phillips when she was playing snooker (but nor does she say he was not there), see Exhibit 56, Tab 54, Statement of Barbara Dawn Stacy, 13 January 1992, [5] (SCOI.10939.00039).

[3295] Exhibit 56, Tab 69, NSWPF Record of Interview, 'Interview with Kirk Anthony Phillips', 6 May 1992, [A87] (SCOI.10290.00014).

c. He then went to a little park "up the top of" Eveleigh Street where the Housing Company is located and continued drinking there for approximately two hours with Craig, Craig's wife Thelma, and a couple of their friends.[3296]

d. At around 2:00am, he went "down" to the Factory on Holden Street and went inside to sleep, after which Mr Malcolm was discovered.

5.3746. Mr Phillips denied seeing Mr Hookey or Mr Green on the night of 10–11 January 1992.[3297] However, if Mr Phillips was playing snooker with Barbara Phillips, as was Mr Hookey, at the Clifton Hotel, it seems unlikely that they could avoid seeing each other there. Mr Phillips also denied speaking to any white person on the night.[3298]

5.3747. From the running sheets produced by police, it appears that a witness, Peter Carroll, approached police and stated that his brother John Carroll had some information about Mr Phillips being raised as a suspect in the attack on Mr Malcolm, and that the matter had been raised in "a meeting of the Aboriginal community in the Redfern area" at a date on or before 22 January 1992.[3299] However, when police spoke to John Carroll on 23 January 1992, he stated he "didn't really know anything" apart from details told to him by his brother Peter, including that the name "Phillips" had come up in conversation.[3300] No statement was taken from Peter or John Carroll, nor the other person named by Peter Carroll as being involved in the community meeting (Ruth Williams).

Movements of Richard Green on 10–11 January 1992

5.3748. Mr Green stated that he went to bed at 6:30pm on 10 January 1992 at the Factory and was asleep for seven and a half hours until he was woken up by some noise at about 1:50am, following which Mr Malcom's body was discovered.[3301]

5.3749. Mr Green said he had never seen Mr Malcolm before.[3302]

5.3750. When speaking with Detective Constable Starr on 9 June 1992, Mr Green gave two conflicting accounts regarding seeing Mr Phillips at the scene of Mr Malcolm's murder:[3303]

> *… I've had people put guns to my head 'cause I saw Kirk do it… Hang on, I couldn't see Kirk do it 'cause I wasn't there.*

[3296] Exhibit 56, Tab 69, NSWPF Record of Interview, 'Interview with Kirk Anthony Phillips', 6 May 1992, [A30]–[A35], [A80], [A121] (SCOI.10290.00014).

[3297] Exhibit 56, Tab 69, NSWPF Record of Interview, 'Interview with Kirk Anthony Phillips', 6 May 1992, [A53], [A55], [A99] (SCOI.10290.00014).

[3298] Exhibit 56, Tab 69, NSWPF Record of Interview, 'Interview with Kirk Anthony Phillips', 6 May 1992, [A53], [A55], [A99] (SCOI.10290.00014).

[3299] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates 22 (SCOI.83976).

[3300] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 23 (SCOI.83976).

[3301] Exhibit 56, Tab 71, Second Statement of Richard John Green, 4 March 1992, [5] (SCOI.10290.00023).

[3302] Exhibit 56, Tab 70, First Statement of Richard John Green, 11 January 1992, [8] (SCOI.10939.00032).

[3303] Exhibit 56, Tab 14, First Statement of Detective Constable Michael Starr, 9 June 1992, [6] (SCOI.10939.00092); Exhibit 56, Tab 15, Statement of Plain Clothes Constable Michael William Kane, 10 June 1992, 2 (SCOI.10939.00094).

Statements of Sharon Murphy implicating Kirk Phillips and Richard Green

5.3751. Sharon Murphy stated that she caught a train to her aunt's house in Eveleigh Street on 11 January 1992 and saw police standing on the corner of Eveleigh Street and Holden Street. She saw I310 and asked him what happened, and then walked down to the crime scene and saw "a man laying half in, and half out the door", who looked like he had "been bashed" with blood on his head, hair and clothes.[3304]

5.3752. Ms Murphy walked back to her aunt's house and saw Kirk Phillips and Richard Green standing there. She participated in the following conversation:[3305]

KP (to RG): *He should have been dead. We didn't do the job properly.*

SM: *What are you talking about?*

KP: *That man, Robert.*

KP: *Let's go before the coppers grab us.*

5.3753. When Ms Murphy was first interviewed on 14 February 1992, she said that Anne Hickey ("Shorty") was with her when hearing the above conversation, and the running sheet suggests she said it was a conversation she heard rather than one in which she participated.[3306]

5.3754. Mr Phillips denied seeing Mr Green in the street and having the above conversation.[3307]

5.3755. Later on the night of 11 January 1992 (the night after the assault), Ms Murphy went to Karen Roberts' house on Eveleigh Street. At around 8:30pm, Ms Murphy, Ms Roberts and Richard Green were sitting in the loungeroom. After Ms Roberts left the room, Mr Green turned to Ms Murphy and the following conversation occurred:[3308]

RG: *You're next.*

SM: *What do you mean?*

RG: *Like what happened to that man last night.*

5.3756. Following some further argument, Mr Green told Ms Murphy that "There's a man down there, there's a man there who's going to kill you, come for a walk".[3309]

[3304] Exhibit 56, Tab 44, First Statement of Sharon Murphy, 25 February 1992, [3] (SCOI.83025).

[3305] Exhibit 56, Tab 44, First Statement of Sharon Murphy, 25 February 1992, [4] (SCOI.83025).

[3306] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 36 (SCOI.83976).

[3307] Exhibit 56, Tab 69, NSWPF Record of Interview, 'Interview with Kirk Anthony Phillips', 6 May 1992, [A56], [A57] (SCOI.10290.00014).

[3308] Exhibit 56, Tab 44, First Statement of Sharon Murphy, 25 February 1992, [7] (SCOI.83025).

[3309] Exhibit 56, Tab 44, First Statement of Sharon Murphy, 25 February 1992, [7] (SCOI.83025).

5.3757. On 12 January 1992, Ms Murphy was standing in Eveleigh Street, across from Holden Street, and reported that Mr Phillips and Mr Green were outside the abandoned house. Ms Murphy heard Mr Phillips say to Mr Green "See we didn't do the job properly. He should have been dead".[3310] Ms Murphy reported then telling Patricia what she heard, but this conversation is not referenced in Patricia's statement.

5.3758. On 3 August 1992 at 6:00pm, after Ms Murphy failed to appear at the committal hearing, Ms Murphy saw Mr Green on Darlinghurst Road in King Cross. She stated that he spat at her and said "you fuckin' dog. You should have been at court. You give up".[3311] It is possible that Ms Murphy perceived this as a threat and when giving evidence on 4 August 1992, did not swear to the overheard statements set out above, out of fear of reprisals.

Other statements linking Kirk Phillips and Richard Green to the murder

5.3759. At around 11:00am on 11 January 1992, I376 (a pseudonym) was at the Black Theatre in Cope Street, drinking beer. I376 indicated that Mr Phillips and Mr Green said, "We did it, we killed him".[3312] I376 thought it was possible they were "big noting" themselves.[3313] Mr Phillips denied saying the above.[3314]

5.3760. In addition to hearing Mr Hookey admit to 'rolling' someone, Mr Smith further stated that he had spoken to Mr Green on a number of occasions since 11 January 1992 and Mr Green had been "carrying on real strange" and saying things like "they're going to get me" and "watch me back".[3315]

Police investigation

5.3761. A number of steps were not taken in the original police investigation, which ought to have been taken, or if taken, ought to have been appropriately recorded.

5.3762. After Mr Weigner identified human blood on a number of exhibits (discussed above) during the original police investigation, no steps were taken to arrange DNA testing to see if any blood from Mr Hookey, Mr Phillips or Mr Green was identified, even though there were some limited forms of DNA testing available at that time.

[3310] Exhibit 56, Tab 44, First Statement of Sharon Murphy, 25 February 1992, [9] (SCOI.83025).

[3311] Exhibit 56, Tab 46, Third Statement of Sharon Murphy, 3 August 1992, [4] (SCOI.10939.00083).

[3312] Exhibit 56, Tab 64, Statement of I376, 5 March 1992, [5] (SCOI.83020).

[3313] Exhibit 56, Tab 64, Statement of I376, 5 March 1992, [5]–[7] (SCOI.83020); Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates 11 (SCOI.83976).

[3314] Exhibit 56, Tab 69, NSWPF Record of Interview, 'Interview with Kirk Anthony Phillips', 6 May 1992, [A73] (SCOI.10290.00014).

[3315] Exhibit 56, Tab 62, Statement of James Frederick Smith, 3 March 1992, 2 (SCOI.83029).

5.3763. The NSWPF submitted that the above criticism, as set out in the submissions of Counsel Assisting,[3316] is unwarranted and that there is "no evidence" to establish that DNA testing could, in fact, have been available to the investigators.[3317] The NSWPF further submitted that in making the above criticism, Counsel Assisting did not identify the form of DNA testing which should have been undertaken.[3318]

5.3764. I accept that DNA testing was in its infancy in 1992, and there were a number of limitations to its use, as set out in Ms Franco's statement and in the NSWPF submissions.[3319]

5.3765. I note that blood grouping tests were available in 1992 but were applied only to ascertain whether Mr Malcolm's blood matched that at the crime scene,[3320] and not the blood of any persons of interest. With respect to the pieces of blood-stained timber, Ms Franco gave evidence that blood grouping tests would have been possible, even if they would not have been very discriminating between people in the population.[3321]

5.3766. DNA testing may have also revealed other suspects, such as Mr Strong, or NP242 (a pseudonym). The running sheets show that NP242 attended Redfern Police Station to report on bail at around 6:10am on 11 January 1992 with blood on his shirt which he said was ketchup.[3322] Further inquiries in relation to NP242, such as testing the blood on his shirt, were not taken. The NSWPF submitted that as NP242 was only reporting for a previous offence and not under arrest, it is not clear what power the police officers could have lawfully exercised to seize and test NP242's shirt.[3323] I acknowledge that NP242 was not under arrest at the time he was seen with "ketchup" on his shirt, but it is curious that this information was included in the running sheets in the investigative file. It indicates at the very least that police thought there may have been a connection to Mr Malcolm's death, but what further enquiries police made, or how NP242 was excluded in the police investigation, is unknown based on the records provided to the Inquiry.

5.3767. While fingerprint testing was conducted on the exhibits during the initial police investigation, no match was identified until the further testing requested by the Inquiry in 2023. If a match had been identified earlier and prior to the death of Mr Strong, a line of inquiry may have been open to police to interview Mr Strong about his knowledge of the abandoned house at 6 Holden Street and whether he had witnessed any assaults or robberies at that location.

5.3768. The NSWPF submitted that it appeared the Inquiry was able to match Mr Strong's fingerprints "as a result of" a summons issued by the Inquiry to the CSNSW.[3324]

[3316] See Submissions of Counsel Assisting , 6 July 2023, [101] (SCOI.84090).

[3317] Submissions of NSWPF, 21July 2023, [32] (SCOI.84843).

[3318] Submissions of NSWPF, 21 July 2023, [32] (SCOI.84843).

[3319] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [18]–[33] (SCOI.83957); Submissions of NSWPF, 21 July 2023, [33], [43] (SCOI.84843).

[3320] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [22] (SCOI.83957); see also Submissions of Counsel Assisting, 6 July 2023, [101] (SCOI.84090).

[3321] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [22] (SCOI.83957)

[3322] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 1 (SCOI.83976).

[3323] Submissions of NSWPF, 21 July 2023, [36] (SCOI.84843).

[3324] Submissions of NSWPF, 21 July 2023, [38] (SCOI.84843).

5.3769. As discussed above, the Inquiry issued Summons CSNSW20 on 6 June 2023, [3325] and received an index card for Mr Strong on 15 June 2023.[3326] The Inquiry took this step *as a result of* the match as set out in the statement of Senior Constable Paul Hubrechsen-Yung dated 5 June 2023.[3327] Senior Constable Hubrechsen-Yung stated that as part of the fingerprint review, searches were conducted on NAFIS on 31 May 2023, which returned record prints on 2 June 2023 bearing the name Percy Alexander Strong.[3328] From this information, it appears that Mr Strong's fingerprints were on the NAFIS before the Inquiry took any steps of summoning CSNSW. While I accept it is not clear when those fingerprints were obtained, it is not correct to suggest that the NSWPF could not have identified that match without the intervening action of the Inquiry in summoning CSNSW.

5.3770. Further, police did not retain the exhibits for later testing. Rather, 11 of the 14 exhibits were destroyed after examination or on 1 May 1992, including the SAIK.[3329] If police had taken the steps for the careful retention of these exhibits, further lines of investigation may have been open to the Inquiry.

5.3771. The NSWPF acknowledged that "it is undoubtedly unfortunate that the exhibits were not retained".[3330] However, on the basis of Ms Franco's above statement and particularly Ms Franco's evidence that "DNA testing was only in its infancy in 1992 and the enormous advances in DNA technology was not envisioned in that year",[3331] the NSWPF submitted that appropriate criticism should proceed by reference to what police investigators knew at the time of Mr Malcolm's death.[3332]

5.3772. Criticism by reference to the state of knowledge in 1992 may be appropriate in relation to any exhibits destroyed in 1992. The Inquiry has not received records indicating the year of destruction in relation to the three exhibits which were destroyed "after examination" (the two beer bottles and the newspaper).[3333] If those three exhibits were destroyed in 1992, then criticism may be advanced by reference to the state of knowledge in 1992. However, appropriate criticism of the destruction of the other eight exhibits, which occurred on 1 May 1996,[3334] should proceed by reference to what the police knew as at 1996.

[3325] Exhibit 56, Tab 112, Summons to CSNSW (CSNSW20), 6 June 2023 (SCOI.83959).

[3326] Exhibit 56, Tab 123, Statement of Kathryn Lockery, 6 July 2023, [16] (SCOI.84074).

[3327] Exhibit 56, Tab 117, Statement of Paul Huchrechsen-Yung, 5 June 2023 (SCOI.83526).

[3328] Exhibit 56, Tab 117, Statement of Paul Huchrechsen-Yung, 5 June 2023, [6] (SCOI.83526).

[3329] Exhibit 56, Tab 107, Letter from NSWPF to the Inquiry, 18 May 2023 (SCOI.83309).

[3330] Submissions of NSWPF, 21 July 2023, [41] (SCOI.84843).

[3331] Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [18]–[33] (SCOI.83957).

[3332] Submissions of NSWPF, 21 July 2023, [27]–[28], [42] (SCOI.84843); Exhibit 56, Tab 119, Statement of Michele Franco, 13 June 2023, [17] (SCOI.83957).

[3333] Exhibit 56, Tab 107, Letter from NSWPF to the Inquiry, 18 May 2023 (SCOI.83309).

[3334] Exhibit 56, Tab 107, Letter from NSWPF to the Inquiry, 18 May 2023 (SCOI.83309).

5.3773. Significant advances in forensic science and DNA testing occurred between Mr Malcolm's death in 1992 and the time of the exhibits being destroyed in 1996. In submissions filed in relation to the Investigative Practices Hearing, the NSWPF resisted a submission that it should have been obvious by 1996 that DNA technology was likely to continue to improve, on the basis of Dr Allsop's evidence that there was likely not a widespread understanding of the potential advancement of DNA technology in the 1990s.[3335] Dr Allsop's evidence that there was not a widespread understanding should be taken into account and it may be that many law enforcement officers were not aware or had not turned their minds to the possibility of such improvements. I am nevertheless satisfied that, had members of the NSWPF turned their minds to the question, it would have been reasonably clear that DNA technology had advanced and was likely to advance.

5.3774. The NSWPF accepted that it is regrettable that the exhibits were not retained, but contends criticism of the decision in 1996 is not warranted.[3336] I do not accept this. Even if DNA is put to one side, Mr Malcolm's case was a homicide in which it should have been clear that the physical exhibits might be important and ought to be retained.

5.3775. In addition to the exhibits which have been recorded as destroyed, it also appears that material from the original police investigation has been lost, such as the sketch plan prepared by Constable Van Leeuwen, and the duty book of Detective Sergeant Phillips.[3337] The NSWPF agreed that it is "regrettable" that these documents have been lost,[3338] and repeated this submission in the submissions filed in relation to the Investigative Practices Hearing.[3339] It is possible that Detective Sergeant Phillips' duty book, if available, may have provided further information on whether certain witnesses were located or contacted. As that information is not available to the Inquiry, the witnesses spoken to and investigations undertaken by Detective Sergeant Phillips are not clear.

5.3776. Further, some important exhibits appear to not have been collected in the first place, such as, first, the blood-stained shirt in the courtyard. It appears that only a singlet was collected from Mr Malcolm, while two witnesses gave evidence that he was wearing a light-coloured shirt, possibly with blue stripes.[3340] It does not appear that Mr Malcolm's shirt was ever collected as an exhibit, nor tested.

[3335] Submissions of NSWPF, 10 October 2023, [412] (SCOI.86127).

[3336] Submissions of NSWPF, 10 October 2023, [413] (SCOI.86127).

[3337] Exhibit 56, Tab 105, Email from NSWPF to the Inquiry, 24 October 2022 (SCOI.83961).

[3338] Submissions of NSWPF, 21 July 2023, [48] (SCOI.84843).

[3339] Submissions of NSWPF, 10 October 2023, [415] (SCOI.86127).

[3340] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 14–15, 17 (SCOI.83976); Exhibit 56, Tab 34, Statement of Robert McPherson Malcolm, 13 January 1992, [12] (SCOI.10290.00018); Exhibit 56, Tab 37, Statement of George O'Donnall, 31 January 1992, [7] (SCOI.10939.00049).

5.3777. The NSWPF agreed that it is regrettable that the blood-stained shirt was not seized, and that it appears this was an oversight in the initial investigation.[3341] The NSWPF raised the possibility that the shirt may have been cut off by attending ambulance officers to allow them to undertake immediate treatment on Mr Malcolm.[3342] I accept that this is possible, but it remains the case that the shirt was left at 6 Holden Street after the departure of the ambulance, and it may have contained valuable evidence which was missed. In the submissions filed in relation to the Investigative Practices Hearing, the NSWPF accepted that the shirt should have been collected, and that the failure to do so appears to have been an oversight in the initial investigation.[3343]

5.3778. A second exhibit which appears to not have been collected in the first place is the hair in the blood-stain on the verandah at 6 Holden Street, photographed by Constable Van Leeuwen.[3344]

5.3779. The NSWPF initially agreed that it would have been desirable for the hair to have been seized, but also submitted that DNA was a novel phenomenon as at 1992.[3345] In the submissions filed in relation to the Investigative Practices Hearing, the NSWPF agreed that the hair should have been collected and that this appears to have been an oversight in the initial investigation.[3346]

5.3780. I acknowledge the NSWPF submissions on this point. I am conscious of the impact of hindsight bias and I am cautious in not applying modern investigative standards to historical investigations. However, in 1992, when DNA testing was available to the NSWPF,[3347] it appears to me a remarkably short-sighted decision to notice and photograph a hair in a blood-stain, but not collect it with a view to exploring its forensic value. This is consistent with the submissions made by the NSWPF in the Investigative Practices Hearing, and these matters are discussed further in **Chapter 8**.

5.3781. Police also did not take the steps of contacting or obtaining statements from the following witnesses, whose evidence may have been important:

a. Tracy McGuinness, who was supposedly with Mr Hookey in the evening of 10–11 January 1992.

b. Dianne McGuinness, who was supposedly with Mr Hookey during the early hours of the morning on 11 January 1992. The NSWPF submitted that it is not clear from the material available whether the original police investigators were successful in identifying Dianne McGuinness or Tracy McGuinness.[3348] There is no evidence before the Inquiry of original police investigators making any attempt to identify these persons.

[3341] Submissions of NSWPF, 21 July 2023, [45] (SCOI.84843).

[3342] Submissions of NSWPF, 21 July 2023, [45] (SCOI.84843).

[3343] Submissions of NSWPF, 10 October 2023, [414] (SCOI.86127).

[3344] Exhibit 56, Tab 21, Crime Scene Photographs (Photographs 10–21), Photograph 16, 11 January 1992 (SCOI.83958).

[3345] Submissions of NSWPF, 21 July 2023, [47] (SCOI.84843).

[3346] Submissions of NSWPF, 10 October 2023, [414] (SCOI.86127).

[3347] Exhibit 51, Tab 2, Statement of Superintendent Roger Best, 24 April 2023, [72] (NPL.9000.0003.1533).

[3348] Submissions of NSWPF, 21 July 2023, [21] (SCOI.84843).

c. Sharon Stephens, bar attendant at the Terrace Bar at Menzies Hotel, who saw Mr Malcolm at around 8:00pm, and one of the last people to see him in the city. In response, the NSWPF submitted that the benefit of obtaining a formal statement from Ms Stephens is not clear, given her version is recorded in the running sheets.[3349] I note that the running sheets were not tendered in evidence at the committal hearing, and were not provided to the Inquiry until 5 June 2023 (see [5.3638]). A critical factor in ascertaining what occurred on 10–11 January 1992 is the timeline of Mr Malcom's movements, and particularly, whether it *could* have been Mr Malcolm who was seen with Mr Hookey in Redfern at around 8:30pm–9:00pm by Ms Vincent, Ms Honeysett, Ms Roberts and Ms Murphy. Ms Stephens was one of the last persons to see Mr Malcolm in the city, before these sightings in Redfern, and so her evidence should have been collected in a detailed and admissible form.

d. The employees of Mansions Hotel, one of whom Mr Hookey said he told he was going for a walk around Kings Cross in the early hours of 11 January 1992.

e. Dot Hookey, Mr Hookey's aunt, who was with him at the Subway Hotel.

f. David William Whitlock, who was with Mr Hookey at the time he was first questioned by police in the morning of 11 January 1992. The NSWPF acknowledged that unfortunately the material available does not record what Mr Whitlock said to police, and that any answers given by him should have been appropriately recorded.3350

g. NP244, who appears to have been considered by police as a potential suspect given his history of socialising and drinking with victims before robbing them and the evidence that Mr Malcolm was a heavy drinker.

h. NP243, who said to police that he had found the body and said he had also seen Mr Malcolm the previous night at 11:30pm. In response, the NSWPF submitted that it is not clear whether NP243 was prepared to provide a statement to police, and that his initial reluctance to provide names and the provision of a false address leads to an inference that NP243 was reluctant to provide his actual address.[3351]

i. Wayne Hookey, Mr Hookey's uncle, who attended Redfern Police Station on 13 January 1992 to tell police that Matt Perry saw Mr Hookey with a white man on 10 January 1992.[3352]

[3349] Submissions of NSWPF, 21 July 2023, [19(a)] (SCOI.84843).

[3350] Submissions of NSWPF, 21 July 2023, [19(c)] (SCOI.84843).

[3351] Submissions of NSWPF, 21 July 2023, [19(e)] (SCOI.84843).

[3352] Exhibit 56, Tab 80,NSWPF Running Sheets bundle, various dates, 19 (SCOI.83976). Wayne Hookey was not further interviewed, nor did he provide a statement, and Matthew Perry in his statement does not provide any information about seeing a white man when he saw Mr Hookey at the Clifton Hotel at around 11:15pm, see Exhibit 56, Tab 59, Statement of Matthew Lawrence Perry, 4 March 1992, [6] (SCOI.83035).

j. In response, the NSWPF submitted that it is possible Wayne Hookey was unwilling to provide a statement.[3353] I accept that this is possible, but also note there are no records of Wayne Hookey being asked to do so.

k. Michelle Hookey, Mr Hookey's aunt, and her friend Victor, who Mr Hookey said bought him a drink at the Mansions Hotel.

l. Donna Morgan, who James Smith said was part of the group who Mr Hookey bought drinks for at the Mansions Hotel.

m. Craig Goldie and his wife Thelma, who Kirk Phillips said he was with at the Clifton Hotel from 4:00pm–5:00pm up until midnight and then for a further two hours in a park.

n. Peter Carroll, and the people he nominated as having information regarding Kirk Phillips, namely John Carroll and Ruth Williams, at the meeting of the Aboriginal community where the matter appears to have been discussed. In response, the NSWPF submitted that it is not clear how extensive the searches for Ms Williams were, and that the Carroll brothers appeared to not know anything further about Mr Malcolm's death.[3354] In light of the statements made by Peter Carroll, and in circumstances where the investigating officers appeared to be alive to the importance of engaging with the local community (as discussed at [5.3582]–[5.3585]), it remains a matter of concern that further steps were not taken to investigate this source of community information.

o. Anne Hickey ("Shorty"), who Sharon Murphy said was present for one of the conversations with Kirk Phillips and Richard Green in which they admitted to being involved in the attack on Mr Malcolm.

5.3782. Efforts should have been made by police to contact all relevant witnesses, especially those mentioned in Mr Hookey's statement as people who could vouch for his whereabouts. Accepting that some witnesses may have given fictitious addresses, one would expect that the investigative file would contain records of attempts to contact them. These attempts are not evidenced in the material provided to the Inquiry.

5.3783. The NSWPF appeared to accept in the submissions filed in relation to the Investigative Practices Hearing that either steps were not taken to investigate the two McGuinness alibi witnesses, or alternatively if steps were taken they should have been documented and the record retained. The NSWPF accepted that this represents an oversight in either the investigation or in record keeping.[3355]

[3353] Submissions of NSWPF, 21 July 2023, [19(f)] (SCOI.84843).

[3354] Submissions of NSWPF, 21 July 2023, [19(g)] (SCOI.84843).

[3355] Submissions of NSWPF, 10 October 2023, [416]–[418] (SCOI.86127).

5.3784. The NSWPF noted that it is not clear whether witnesses would have been prepared to speak to police, or what assistance they would have provided.[3356] The NSWPF further submitted that any criticism of the steps taken or not taken needs to be considered in light of the reluctance of members of the local community to assist in the investigation, as discussed above.[3357]

5.3785. I accept that there is evidence that some witnesses appeared reluctant to speak with police. However, I do have concerns with an investigation into a man's death, where three persons have been charged, where relevant witnesses (including potentially significant alibi witnesses) have not been looked for, or not spoken to, or spoken to and their evidence not recorded in a detailed and admissible form.

5.3786. Lastly, the theory of investigating police was that Mr Malcolm was robbed by Mr Hookey as a result of displaying cash, being intoxicated and easily led. A key element of that theory was that Mr Malcolm had money with him. The evidence of Mr Malcolm's family and friends was that he did not carry a wallet as a precaution against robbery and carried only his licence and keycard with him. There is also the evidence that he asked to borrow $50 at around 7:30pm–8:30pm on 10 January 1992. If this is true, Mr Malcolm would have needed to make an ATM withdrawal at some time in the evening of 10–11 January 1992 in order to be the cash-laden victim that Sharon Murphy describes above.

5.3787. It does not appear that police took any steps to verify if there was a cash withdrawal from Mr Malcolm's account, despite having the details and ordering a freeze on the accounts on 13 January 1992, after speaking with Mr Malcom's father and identifying his missing valuables.[3358]

5.3788. As discussed above, the Inquiry issued a summons to the Commonwealth Bank for any records held of transactions made by Mr Malcolm, but the records were not able to be obtained.

Manner and cause of death

5.3789. Counsel Assisting submitted that it is clear that Mr Malcolm's death was a homicide, and his injuries were the result of a violent assault on a person made vulnerable by intoxication.[3359]

5.3790. Mr Malcolm was seen in the Menzies Bar up until around 8:30pm and then possibly recognised on Eveleigh Street at around 8:30pm–9:00pm. He was then discovered in the abandoned house at around 2:00am on 11 January 1992. Counsel Assisting submitted that Mr Malcolm is therefore likely to have been assaulted between 9:00pm on 10 January 1992 and 2:00am on 11 January 1992.[3360]

[3356] Submissions of NSWPF, 21 July 2023, [20] (SCOI.84843)

[3357] Submissions of NSWPF, 21 July 2023, [23]–[24] (SCOI.84843)

[3358] Exhibit 56, Tab 80, NSWPF Running Sheets bundle, various dates, 28 (SCOI.83976).

[3359] Submissions of Counsel Assisting, 6 July 2023, [182] (SCOI.84090).

[3360] Submissions of Counsel Assisting, 6 July 2023, [183] (SCOI.84090).

5.3791. Counsel Assisting submitted that the following evidence links the persons of interest to Mr Malcom's death:[3361]

a. Mr Malcolm *may* have been seen in the company of Anthony Hookey at around 8:30pm–9:00pm on 10 January 1992;

b. Mr Malcolm *may* have been chased by Mr Hookey down Eveleigh Street at around 2:00am on 11 January 1992;

c. According to James Smith, Mr Hookey came into money on the night of 10–11 January 1992 and told Mr Smith that he had "rolled" someone;

d. According to Sharon Murphy and I376, Kirk Phillips and Richard Green made various admissions and statements indicating guilt; and

e. When charged on 30 April 1992, and in what may have been an attempt to reduce a murder charge to one of manslaughter, Mr Hookey indicated to police that he had been present during the attack on Mr Malcolm.

5.3792. The evidence in its totality was insufficient to convince Magistrate Hand of a *prima facie* case at the committal hearing. It appears that James Smith wavered in his memory of the event during cross-examination on 3 August 1992,[3362] and that Ms Murphy's oral evidence at the committal hearing occurred immediately prior to Magistrate Hand finding that there was no case to answer.

5.3793. Counsel Assisting submitted that there is an inference that Ms Murphy's evidence failed to convince Magistrate Hand of a link between the persons of interest and the crime,[3363] noting the inconsistencies discussed above. The solicitor for the ODPP, Mr Kelly, remembered trying to elicit the evidence to connect the accused persons to the crime, without success. He recalled there being many objections during the evidence of this witness. He said it was possible that he tried to put the police statements made by the witness to her, which caused the objections.[3364]

5.3794. Ms Murphey's written statements appear to be in admissible form, and appear to have been tendered as part of the brief of evidence on 3 August 1992.[3365] However, the record indicates six objections, made by the legal representatives for Mr Hookey, Mr Phillips and Mr Green.[3366] The content of the objections is not known to the Inquiry. Further, it is possible that Ms Murphy was drug-affected at the time, noting Mr Kelly's recollection in his statement to the Inquiry that Ms Murphy, having failed to appear in Court on 3 August 1992, was located that evening and appeared drug affected.[3367] It is also possible that she failed to come up to proof due to fear after what may have been a threat, or perceived to be a threat, made to her by Mr Green at 6:00pm on 3 August 1992.

[3361] Submissions of Counsel Assisting, 6 July 2023, [184] (SCOI.84090).

[3362] Exhibit 56, Tab 120, Statement of Mark Kelly, 5 June 2023, [7] (SCOI.83437).

[3363] Submissions of Counsel Assisting, 6 July 2023, [185]–[186] (SCOI.84090).

[3364] Exhibit 56, Tab 120, Statement of Mark Kelly, 5 June 2023, [9] (SCOI.83437).

[3365] Exhibit 56, Tab 94, Master Tape History Sheet, 3 August 1992 (SCOI.11290.00072).

[3366] Exhibit 56, Tab 95, Master Tape History Sheet, 4 August 1992 (SCOI.11290.00077).

[3367] Exhibit 56, Tab 120, Statement of Mark Kelly, 5 June 2023, [8] (SCOI.83437).

5.3795. Counsel Assisting submitted that no stronger evidence linking the persons of interest to the crime has been uncovered by police since the committal hearing in 1992, nor in the course of the Inquiry. While the Inquiry is making findings to a different standard of proof, even on the balance of probabilities it was submitted by Counsel Assisting that the Inquiry would not make any positive findings as to the involvement of any of the persons of interest, on the available evidence.[3368]

5.3796. Separately, in the course of the Inquiry's investigations, a further person of at least some interest has been identified through the positive fingerprint match which places Mr Strong at the scene.[3369] Counsel Assisting submitted that there may have been other reasons for Mr Strong to attend 6 Holden Street, and the evidence available does not indicate when Mr Strong may have attended the scene.[3370] As Mr Strong is now deceased, it is not possible to pursue this line of inquiry further.

5.3797. Overall, Counsel Assisting submitted that an appropriate finding as to manner and cause of death would be that Mr Malcolm died on 29 January 1992 at Royal Prince Alfred Hospital, as a result of sequelae of head injuries inflicted during the night of 10 January or early hours of 11 January 1992 at 6 Holden Street, Redfern, by person or persons unknown.

5.3798. The NSWPF agreed with the submissions of Counsel Assisting as to manner and cause of death.[3371]

Bias

5.3799. Counsel Assisting submitted that on the available information, it is not possible to say whether Mr Malcolm was a member of the LGBTIQ community.[3372]

5.3800. If Mr Hookey, Mr Phillips and Mr Green were the persons responsible for Mr Malcom's death, then Counsel Assisting submitted that the likelihood is that the crime was motivated by financial gain through a robbery.[3373]

5.3801. While Mr Green's derogatory remark towards Mr Malcolm is relevant to a consideration of bias, it would not provide a sufficient basis on its own for suspecting that the crime (or the severity of the assault) was motivated by bias.

5.3802. There are several possible explanations for Mr Malcolm's pants being down, including that Mr Malcolm was urinating immediately before being assaulted, or engaging in sexual activity, or that the pants were pulled down in the course of the assault as an act intended to humiliate Mr Malcolm. These isolated pieces of evidence raise some limited grounds for suspicion that the crime may have been in part motivated by bias.

[3368] Submissions of Counsel Assisting, 6 July 2023, [187] (SCOI.84090).

[3369] Exhibit 56, Tab 117, Statement of Paul Hubrechsen-Yung, 5 June 2023 (SCOI.83526); Exhibit 56, Tab 110B, NAFIS Fingerprint Job Card, 2 June 2023 (NPL.2031.0001.0024).

[3370] Submissions of Counsel Assisting, 6 July 2023, [188] (SCOI.84090).

[3371] Submissions of NSWPF, 21 July 2023, [55] (SCOI.84843).

[3372] Submissions of Counsel Assisting, 6 July 2023, [189] (SCOI.84090).

[3373] Submissions of Counsel Assisting, 6 July 2023, [190] (SCOI.84090).

5.3803. The NSWPF agreed with the submissions of Counsel Assisting, consistent with the position expressed in Strike Force Parrabell, that there is no sufficient basis to conclude that Mr Malcolm's death was motivated by LGBTIQ bias.[3374]

5.3804. The NSWPF also agreed with the submissions of Counsel Assisting that *if* Mr Hookey, Mr Phillips and/or Mr Green were the perpetrators, the motive was likely financial gain.[3375]

Conclusions and Recommendations

5.3805. I find that:

> *Mr Malcolm died on 29 January 1992 at Royal Prince Alfred Hospital, as a result of sequelae of head injuries inflicted during the night of 10 January or early hours of 11 January 1992 at 6 Holden Street, Redfern, by person or persons unknown.*

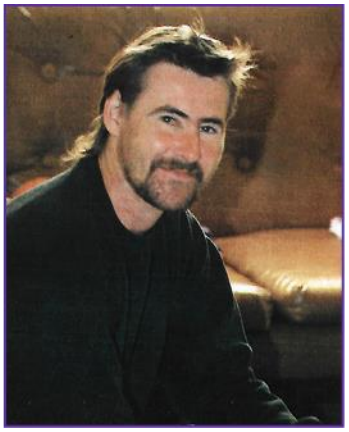
5.3806. In my view, on the evidence available to the Inquiry, including that considered in confidential **Chapter 17**, there is objectively reason to suspect that LGBTIQ bias was a factor in Mr Malcolm's death.

5.3807. I do not propose to make any specific recommendations arising from the Inquiry's consideration of Mr Malcolm's death. Global recommendations in relation to the retention, preservation and storage of exhibits are discussed in **Chapter 8**.

[3374] Submissions of NSWPF, 21 July 2023, [52] (SCOI.84843).

[3375] Submissions of NSWPF, 21 July 2023, [53] (SCOI.84843).

IN THE MATTER OF BRIAN WAYNE SCHMIDT WALKER



Factual background

Date and location of death

5.3808. Brian Wayne Schmidt Walker died in the early hours of 23 July 1992, at the residence of John Hokin in Burnett Street, Merrylands.

Circumstances of death

5.3809. Mr Walker was 30 years old when he died. At the time of his death, Mr Walker lived in Lockwood Street, Merrylands.[3376] Mr Walker had a friend, Kevin Leatham, who also lived in Burnett Street, Merrylands, and he visited Mr Leatham there on occasion.[3377] Mr Leatham, it appears, was also friends with Mr Hokin.

5.3810. According to Mr Hokin, he met Mr Walker for the first time only days before his death. Mr Hokin said that he had known Mr Walker for "one evening … 2 days ago, just from afternoon after work till late evening".[3378]

5.3811. Mr Hokin said that on 22 July 1992, at about 9:00pm, he was asleep in his house in Burnett Street when he was woken by Mr Walker. Mr Walker said he wanted to discuss some problems that Mr Leatham was having.[3379]

5.3812. Mr Hokin said that he and Mr Walker went to the backyard where they started drinking heavily. Mr Hokin claimed that at some point Mr Walker was "talking in a manner about sexual behaviour that I didn't prefer and he touched me a few times on the leg and on the shoulder and I tried to ignore that as … passively as I could because he had quite a bit to drink."[3380]

[3376] Exhibit 15, Tab 10, Statement of Constable Gary Fluke, 15 October 1992, [7] (SCOI.11163.00052).

[3377] Exhibit 15, Tab 14, Statement of Paul Mumbler, 23 July 1992, [5] and [8] (SCOI.11162.00040).

[3378] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A16] (SCOI.11163.00032).

[3379] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A15] (SCOI.11163.00032).

[3380] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A15] (SCOI.11163.00032).

5.3813. Mr Hokin said that he asked Mr Walker to leave "again and again", but Mr Walker "wasn't happy about that."[3381]

5.3814. Mr Hokin said that Mr Walker picked up a shovel and swung it at him. He said that in the course of the ensuing struggle he "dropped down underneath and I put both my arms around his chest and I hung on and hung on and hung on." The wrestle "went on and on and on for quite a long time because I … had become very worn out and I was trying to talk to him as to what's going on".[3382]

5.3815. Mr Hokin said they were wrestling for "at least an hour".[3383] He claimed that he held onto Mr Walker for as long as he did because he was frightened of him. He said, "I was too scared to get up and run because I was overcome about the strength of this person and I just felt that the moment I let go I would … be in trouble."[3384]

5.3816. Mr Hokin also claimed that during the struggle Mr Walker attacked him with a broken beer bottle. Craig and Julianne Donnelly were Mr Hokin's neighbours. Ms Donnelly said that at about 11:30pm she heard a bottle smash next door and a man yelling out, "[g]et off me you fucking cunt. Clear off. Get out of here." It sounded like someone was sitting on the man. She then heard Mr Hokin say, "[d]idn't I give you wine and cigars and you cut me to pieces".[3385]

5.3817. Mr Hokin subsequently called out to Mr Donnelly for help. According to Ms Donnelly's statement, at "about 1.15am [she] heard John screaming out 'Craig, help"'.[3386]

5.3818. Mr Hokin claimed that calling out seemed to make Mr Walker "more aggressive". He said that at that point Mr Walker used a square pole that held up an awning to get leverage. Mr Hokin started to worry because he was released from the "command position."[3387]

5.3819. Mr Hokin said that he held Mr Walker's head to his stomach and was "holding [his] body weight on [Mr Walker]" until Mr Walker stopping moving.[3388]

5.3820. Eventually, Mr Hokin stated that he "made a quick move to [Mr Walker's] hand" but felt no pulse and "both his legs just [fell]". Mr Hokin stated that, after checking Mr Walker's pulse, he got up and ran away from Mr Walker and made no attempts to revive him.[3389]

[3381] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A22] (SCOI.11163.00032).
[3382] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A15] (SCOI.11163.00032).
[3383] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A21] (SCOI.11163.00032).
[3384] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A15] (SCOI.11163.00032).
[3385] Exhibit 15, Tab 15, Statement of Julianne Donnelly, 24 July 1992, [6], (SCOI.11162.00082).
[3386] Exhibit 15, Tab 15, Statement of Julianne Donnelly, 24 July 1992, [8], (SCOI.11162.00082).
[3387] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A15] (SCOI.11163.00032).
[3388] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A39] (SCOI.11163.00032).
[3389] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A49]–[A50] (SCOI.11163.00032).

Previous investigations

Original police investigation

Presentation at Merrylands Police Station and interview

5.3821. Mr Hokin immediately ran and stopped a taxi and asked to be taken to Merrylands Police Station.[3390]

5.3822. Mr Hokin walked into the police station and said, "I've had a fight with my mate. I think I've killed him." Constable Aaron Nash stated that the front of Mr Hokin's shirt was open and he could see scratch marks on his body.[3391] His face was flushed, he was breathing heavily and he had grass clippings and dirt in his hair. He lifted up his jacket and another officer, Constable Pledge, saw a number of cuts and lacerations to his stomach and torso. Mr Hokin said, "[h]e's cut me up to buggery".[3392]

5.3823. Mr Hokin participated in a interview with police, which commenced at about 6:30am on 23 July 1992. During the interview, Mr Hokin asserted that he acted in self-defence to Mr Walker's actions of attacking him with a shovel and a piece of glass.[3393]

5.3824. Mr Hokin stated that during the altercation Mr Walker was cutting him with a "slicing" action "about the stomach and the back, lower left back" with a broken bottle.[3394]

5.3825. Mr Hokin stated he was heterosexual and frightened by gay men. When asked if he had sex with Mr Walker, Mr Hokin answered:[3395]

> *No way. That's what frightened me, because that frightens me …. when he started touching me, that's when I started getting worried and that's when I started watching him, just keeping an eye on him, looking this way and looking that way. They … petrify me, those people, frighten me.*

5.3826. Mr Hokin described Mr Walker as having had quite a bit to drink, about five large cups of wine.[3396] The certificate of analysis records Mr Walker's blood alcohol content as 0.216g per 100ml.[3397]

[3390] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A51] (SCOI.11163.00032).
[3391] Exhibit 15, Tab 9, Statement of Constable Aaron Nash, 15 October 1992, [4] (SCOI.11163.00038).
[3392] Exhibit 15, Tab 8, Statement of Constable Terry Pledge, 24 July 1992, [3]–[4] (SCOI.11163.00033).
[3393] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A48] (SCOI.11163.00032).
[3394] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A44] (SCOI.11163.00032).
[3395] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A58] (SCOI.11163.00032).
[3396] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A28] (SCOI.11163.00032).
[3397] Exhibit 15, Tab 3, DAL Certificate, 28 August 1992, [3] (SCOI.11163.00049).

5.3827. Mr Hokin said he had four or five cups of wine but was not affected.[3398] A blood sample was taken from Mr Hokin at Westmead Hospital on 23 July 1992.[3399] The sample was submitted to the Division of Analytical Laboratories, however it was clotted and therefore unsuitable for analysis.[3400]

5.3828. Mr Hokin said that if Mr Walker had made some sort of a sign to say "look, I've had it" or "I'm going home", Mr Hokin would have said "well, get up carefully" but that never happened. Mr Walker kept fighting.[3401]

5.3829. When asked what his intention was when holding Mr Walker, Mr Hokin said:[3402]

> *… to hold him down and call for help because I am petrified of what's going to happen to me because I'm on a bond. I must be of good behaviour … that's why I yelled … out to Craig as loud as I could.*

5.3830. Mr Hokin also told police:[3403]

> *If he hadn't have swung a shovel at me, I'd be home asleep... All I can say is that I've had those kind of people approach me many times in my life. I don't know why because I'm a ladies' man. I'm an entertainer. You can't be one of those and be an entertainer because the boss'll have you out.*

Attendance at scene and statements

5.3831. Shortly after Mr Hokin arrived at Merrylands Police Station in the early hours of 23 July 1992, Constable Pledge and Constable Nash attended Mr Walker's home in Merrylands and found his body. Mr Walker was lying on his back and his legs were around a pole supporting the roof of the verandah.[3404] There was a broken beer bottle about two metres from Mr Walker's head and near the bottle was a chair which had been knocked over. On the left-hand side of Mr Walker there was a spade on the ground.[3405]

5.3832. When Mr Walker was found, his "bib-and-brace" overalls were pulled down, and his jumper, shirt and singlet were pulled over his left arm and head exposing his chest.[3406] In his ERISP, Mr Hokin described to police how he believed Mr Walker's clothing became partially removed during the struggle.[3407]

5.3833. Police promptly obtained statements from Mr Hokin's neighbours, Mr and Ms Donnelly, on 24 July 1992.[3408]

[3398] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A23] (SCOI.11163.00032).

[3399] Exhibit 15, Tab 11, Statement of Detective Sergeant Hans Friedrich Rupp, 5 August 1992, [14] (SCOI.11163.00029).

[3400] Exhibit 15, Tab 22, DNA Certificate of David Kessly, Forensic Biologist, 14 January 1993, [2] (SCOI.11163.00042).

[3401] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A39] (SCOI.11163.00032).

[3402] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A65] (SCOI.11163.00032).

[3403] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A67] (SCOI.11163.00032).

[3404] Exhibit 15, Tab 8, Statement of Constable Terry Pledge, 24 July 1992, [6] (SCOI.11163.00033); Exhibit 15, Tab 9, Statement of Constable Aaron Nash, 15 October 1992, [5] (SCOI.11163.00038).

[3405] Exhibit 15, Tab 9, Statement of Constable Aaron Nash, 15 October 1992, [6] (SCOI.11163.00038).

[3406] Exhibit 15, Tab 18, Statement of Detective Senior Constable Mark Sweeney – Crime Scene Unit, 30 September 1992, [4] (SCOI.11163.00041).

[3407] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A56] (SCOI.11163.00032).

[3408] Exhibit 15, Tab 15, Statement of Julianne Donnelly, 24 July 1992, (SCOI.11162.00082). Exhibit 15, Tab 16, Statement of Craig Donnelly, 24 July 1992, (SCOI.11162.00023).

5.3834. Police also obtained a statement from the taxi driver who drove Mr Hokin to Merrylands Police Station, Ahmad Elsamad. Mr Elsamad confirmed Mr Hokin's account of the journey.[3409]

Persons of interest

5.3835. Mr Hokin was identified at the outset as the clear and only person of interest in relation to Mr Walker's death. He was subsequently charged with manslaughter at 7.03am on 23 July 1992 (following his participation in the ERISP).[3410]

5.3836. Mr Hokin was a first class metal machinist who had been on a disability pension for eight to nine months prior to the death of Mr Walker. He was divorced and living alone at the Burnett Street, Merrylands address. He was then aged 48. He had no real community ties and was experiencing financial difficulties.[3411]

5.3837. At the time of Mr Walker's death, Mr Hokin was subject to a four-year good behaviour bond in relation to an offence of malicious wounding in 1991. He was also subject to another bond for the offence of entering dwelling at night with intent to commit a felony, in 1990.[3412] In December 1991, following the charge of malicious wounding, he was admitted as an involuntary patient and assessed at the Cumberland Hospital by Dr R Joura.[3413]

5.3838. As to the offence of enter dwelling with intent to commit a felony, Mr Hokin's explanation was that he broke into his wife's residence in order to draw to the attention of the Court his perceived lack of access to his child.[3414]

5.3839. As to a further offence of hinder police (also on his criminal record), his explanation was that his son did not want to return to his mother and he attempted to stop his return.[3415]

5.3840. At Mr Hokin's committal hearing for the charge of manslaughter of Mr Walker, the pre-sentence reports in relation to each of those previous two matters were tendered.

5.3841. A report produced by Dr Joura in February 1992, following the malicious wounding charge, records that Mr Hokin told Dr Joura that he would commit the same offence again and again because "the perverts and deviant should be taught a lesson, the law is an ass and the world would definitely be a better place if everyone went and did the same as I did." Dr Joura concluded that Mr Hokin's actions and beliefs may well have been part of the psychotic condition that was evident on his admission after the malicious wounding charge. Dr Joura advised that Mr Hokin's "potential for violence not to be underestimated".[3416]

[3409] Exhibit 15, Tab 17, Statement of Ahmad Elsamad, 1 August 1992 (SCOI.11163.00038).

[3410] Exhibit 15, Tab 28, Charge Sheet for John Hokin, 23 July 1992 (SCOI.11163.00062).

[3411] Exhibit 15, Tab 27, Report of Dr Jenny Thompson in relation to John Hokin, 21 September 1992, 2 (SCOI.11163.00058).

[3412] Exhibit 15, Tab 27, Report of Dr Jenny Thompson in relation to John Hokin, 21 September 1992, 3 (SCOI.11163.00058); Exhibit 15, Tab 23, Criminal History of John Hokin, 25 May 1992 (SCOI.11162.00031).

[3413] Exhibit 15, Tab 26, Report of Dr R Joura, Cumberland Hospital in relation to John Hokin, 7 February 1992, 1 (SCOI.11163.00056).

[3414] Exhibit 15, Tab 26, Report of Dr R Joura, Cumberland Hospital in relation to John Hokin, 7 February 1992, 2 (SCOI.11163.00056).

[3415] Exhibit 15, Tab 24, Pre-sentence Report, 25 May 1992, 2 (SCOI.11163.00054).

[3416] Exhibit 15, Tab 26, Report of Dr R Joura, Cumberland Hospital in relation to John Hokin, 7 February 1992, 4 (SCOI.11163.00056).

5.3842. The report dated 25 May 1992 by Community Corrections Officer, David McLear, also in relation to the malicious wounding offence, disclosed that Mr Hokin suffered manic-depressive illness and attended Merrylands Area Health Centre regularly.[3417] He had first been admitted to Cumberland Hospital in 1967, when he was diagnosed with a schizophrenic illness.[3418]

5.3843. The May report outlines the facts of the malicious wounding offence, according to Mr Hokin. Mr Hokin says he was out for his usual Sunday morning walk. He saw the victim and thought he may be a devious person.[3419] He had previously told Dr Joura that he was suspicious of the victim "because of his duds – the way he wore his pants below his waist as deviates do."[3420] Mr Hokin walked behind the victim and quickened his pace. The victim walked faster and looked over his shoulder at him nervously. He caught up to the victim at the gate of the park. The victim allowed the gate to swing, and it hit Mr Hokin in the face. Mr Hokin questioned the victim repeatedly without adequate response. Mr Hokin claims the victim pushed him in the face. He said he punched the victim on the jaw, scuffled with him then kicked him. He said he then stood back shocked at what he had done. He returned home and had some beer to settle down.[3421]

5.3844. In the May report, Mr McLear concluded that it was difficult to assess whether Mr Hokin's prior convictions were a consequence of his mental illness or extremely poor judgement. It seems probable, he said, that without adequate monitoring of this man's mental condition by the health services, similar offences may occur.[3422]

5.3845. After Mr Hokin's arrest in connection with the death of Mr Walker, a psychiatric report was obtained from Dr Jennifer Thompson dated 21 September 1992. Dr Thompson documented a 45-year history of depression and opined that Mr Hokin:[3423]

> … *suffers a serious psychotic mental illness, characterised by hypomanic episodes, severe depressive episodes and paranoid, fixed delusions about homosexuals and perverts. He needs long term close supervision in the community.*

5.3846. Mr Hokin told Dr Thompson that, subsequent to his arrest for Mr Walker's death, he had initially been placed in a cell with a "real freak" and was then moved to a cell with a gay man. He said:[3424]

> *[W]hy go and put me in a cell with a homosexual … one of them has only to put hands on me and I'll murder him. God help them if they come near me.*

[3417] Exhibit 15, Tab 24, Pre-sentence Report, 25 May 1992, 1 (SCOI.11163.00054).

[3418] Exhibit 15, Tab 26, Report of Dr R Joura, Cumberland Hospital in relation to John Hokin, 7 February 1992, (SCOI.11163.00056).

[3419] Exhibit 15, Tab 24, Pre-sentence Report, 25 May 1992, (SCOI.11163.00054).

[3420] Exhibit 15, Tab 26, Report of Dr R Joura, Cumberland Hospital in relation to John Hokin, 7 February 1992, 2 (SCOI.11163.00056).

[3421] Exhibit 15, Tab 24, Pre-sentence Report, 25 May 1992, 2 (SCOI.11163.00054).

[3422] Exhibit 15, Tab 24, Pre-sentence Report, 25 May 1992, 2 (SCOI.11163.00054).

[3423] Exhibit 15, Tab 27, Report of Dr Jenny Thompson in relation to John Hokin, 21 September 1992, (SCOI.11163.00058).

[3424] Exhibit 15, Tab 27, Report of Dr Jenny Thompson in relation to John Hokin, 21 September 1992, 3-4 (SCOI.11163.00058).

5.3847. Dr Thompson concluded that, "unless closely supervised and reviewed, this man may quickly become psychotic again, and his delusions centre around 'perverts', [so] he may again attack people, as happened on other occasions."[3425]

5.3848. The evidence makes plain that Mr Hokin suffered from a serious psychotic mental illness. When experiencing a psychotic episode, he would become violent, paranoid and would have fixed delusions about "homosexuals".[3426] However, there is no evidence to suggest he was experiencing a psychotic episode at the time of Mr Walker's death.

Post-mortem investigation

5.3849. The forensic pathologist who conducted the post-mortem examination concluded that Mr Walker died as a result of an injury to the upper cervical (torn spinal ligament). The significant condition contributing to the death was "traumatic (crush) asphyxia and head injury."[3427]

5.3850. The post-mortem report noted that there was no evidence of injury to Mr Walker's penis or scrotum and no evidence of injury to the anal verge.[3428]

Findings at inquest

5.3851. No inquest was held in relation to Mr Walker's death.

Criminal proceedings

5.3852. On 1 October 1992, Mr Hokin was committed to trial at the Local Court at Parramatta. Bail was refused. His trial was set before the District Court at Parramatta on 15 February 1993.[3429]

5.3853. At that time, the so-called "homosexual advance defence" was still available in NSW.[3430]

5.3854. On 12 February 1993, the then Director of Public Prosecutions directed that the prosecution be discontinued on the basis that there was no reasonable prospect of conviction.

[3425] Exhibit 15, Tab 27, Report of Dr Jenny Thompson in relation to John Hokin, 21 September 1992, 5 (SCOI.11163.00058).

[3426] Exhibit 15, Tab 27, Report of Dr Jenny Thompson in relation to John Hokin, 21 September 1992, 1 (SCOI.11163.00058).

[3427] Exhibit 15, Tab 2, Post-Mortem Report of Dr Peter Ellis, 8 September 1992, 1 (SCOI.11163.00048).

[3428] Exhibit 15, Tab 2, Post-Mortem Report of Dr Peter Ellis, 8 September 1992, 5 (SCOI.11163.00048).

[3429] Exhibit 15, Tab 31, Letter from the Director of Public Prosecutions to the Inquiry, 24 January 2023 (SCOI.82335).

[3430] The so-called "homosexual advance defence" refers to an accused person alleging that they acted either in self-defence or under provocation in response to a homosexual advance made by the deceased person. In *Green v The Queen* (1997) 191 CLR 334, the majority of the High Court of Australia took the view that a reasonable jury would be entitled to consider that an ordinary person in the position of the accused could have formed an intention to kill or to inflict grievous bodily harm by a non-violent homosexual advance on the part of the deceased. In 2014, the Parliament of NSW passed the *Crimes Amendment (Provocation) Act 2014* which provided that a non-violent sexual advance did not constitute extreme provocation for the purpose of being a partial defence to murder: s. 23(3)(a). This signalled the end of the so-called "gay-panic" defence in NSW.

5.3855. On 24 January 2023, the current Director of Public Prosecutions wrote to the Inquiry in relation to this decision. She explained the decision to discontinue the prosecution of Mr Hokin as follows:[3431]

> *At the time, it was concluded that the Crown was unable to negative the accused's claim that he was acting in self-defence, in circumstances where his version of events was supported by the evidence of the forensic pathologist and another independent witness.*

Strike Force Parrabell

Bias Crimes Indicators Form

5.3856. A BCIF was completed by Strike Force Parrabell. It categorised the case overall as "no evidence of bias crime".[3432]

5.3857. The comments in the completed BCIF included that:[3433]

a. Mr Walker was "likely to be a homosexual male";

b. Mr Hokin was a heterosexual male;

c. Mr Walker had been making advances towards Mr Hokin on the night he died;

d. Mr Hokin was frightened of the advances made; and

e. There was no evidence suggesting animosity between the pair prior to Mr Walker's advances upon Mr Hokin.

5.3858. The comments in the BCIF also noted that Mr Hokin's neighbours did not report in their statements any statement or gesture they observed or perceived to be bias or express any view that they believed the murder to be motivated by any bias.[3434]

5.3859. However, it needs to be appreciated that the observations of the neighbours were limited. They were not present in Mr Hokin's backyard at any relevant point. At one stage during the evening, Mr Donnelly could hear two people singing. He recognised one of the voices as Mr Hokin. He looked out his bathroom window and saw Mr Hokin sitting in a chair in his backyard. He saw another man present but could not see that man's face as it was too dark. Mr Donnelly then returned to the living room and then went to bed at around 9:39pm.[3435]

5.3860. According to their statements, Mr and Ms Donnelly did not see either Mr Walker or Mr Hokin thereafter, and therefore could not have observed whether Mr Walker made the alleged gestures towards Mr Hokin (touching his leg etc) in the hours that followed. Their evidence about the subsequent physical altercation between the two men is limited to what they heard from inside their own home.

[3431] Exhibit 15, Tab 31, Letter from the Director of Public Prosecutions to the Inquiry, 24 January 2023 (SCOI.82335).

[3432] Exhibit 15, Tab 32, Strike Force Parrabell Bias Crimes Indicators Review Form – Brian Walker, 15 (SCOI.82185).

[3433] Exhibit 15, Tab 32, Strike Force Parrabell Bias Crimes Indicators Review Form – Brian Walker, 3 (SCOI.82185).

[3434] Exhibit 15, Tab 32, Strike Force Parrabell Bias Crimes Indicators Review Form – Brian Walker, 9 (SCOI.82185).

[3435] Exhibit 15, Tab 15, Statement of Julianne Donnelly, 24 July 1992, [6] (SCOI.11162.00082); Exhibit 15, Tab 16, Statement of Craig Donnelly, 24 July 1992, [6] (SCOI.11162.00023).

5.3861. Strike Force Parrabell noted that:[3436]

> *…even though the fight started as a result of an unwanted sexual advance from Mr Walker to Mr Hokin, the motive behind this death was self-defence, and this is backed by the coroner's report and from the DPP [Director of Public Prosecutions] withdrawing charges.*

Case Summary

5.3862. Strike Force Parrabell categorised the case "No Evidence of Bias Crime". The matter was further categorised as "solved" .[3437] That is plainly correct in the sense that Mr Hokin was identified as the perpetrator at the outset.

5.3863. The Case Summary for this matter reads as follows:[3438]

> ***Identity:*** *Brian Walker was 30 years old at the time of his death.*
>
> ***Location of Body/Circumstances of Death:*** *Mr Walker's body was located inside the residence of John Hokin, 48 years old, at Burnett Street, Merrylands. In the days prior to his death Mr Walker met Hokin whilst drinking together. Police interviewed Hokin who claimed he was woken by Mr Walker before they went to the back yard where they started drinking heavily. Hokin claimed that at some point Mr Walker started talking in a 'sexual manner' and began touching his leg. Hokin stated he was heterosexual and frightened by gay men. He stated that he rejected Mr Walker's advances and asked him to leave. Hokin stated that Mr Walker armed himself with a shovel and attacked him. Hokin avoided the shovel before taking Mr Walker in a wrestling hold at which time a lengthy struggle took place. During the struggle, Mr Walker broke a beer bottle and cut Hokin several times to his stomach and back. Hokin then choked Mr Walker until he died of upper cervical injury (torn/crush spinal ligament) and asphyxiation. After killing Mr Walker, Hokin immediately ran to Merrylands Police Station where he told Police that he did not let go of Mr Walker because he was frightened by him.*
>
> ***Sexual Orientation:*** *Mr Walker's sexual orientation could not be confirmed however he was believed to be gay.*
>
> ***Coroner/Court Findings:*** *Police charged Hokin with Mr Walker's manslaughter, however the Director of Public Prosecutions withdrew the charge prior to trial given the evidence of self-defence.*
>
> ***SF Parrabell concluded there was no evidence of a bias crime***

[3436] Exhibit 15, Tab 32, Strike Force Parrabell Bias Crimes Indicators Review Form – Brian Walker, 13 (SCOI.82185).

[3437] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Brian Walker (SCOI.76961.00014).

[3438] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Brian Walker, 27 (SCOI.76961.00014).

Academic review

5.3864. The academic review categorised this matter as "No Bias".[3439]

Review by the Inquiry

5.3865. The Inquiry took the following steps in the course of examining the matter.

Summonses

5.3866. A summons was issued to the NSWPF on 18 May 2022 for all documents relating to investigations by the NSWPF of the death of Mr Walker, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Walker. Material in relation to this matter was produced to the Inquiry on 8 June 2022.

5.3867. A further summons was issued on 25 August 2022 to the NSWPF for all police records in relation to Strike Force Parrabell, Strike Force Macnamir and Strike Force Neiwand (NSWPF12). This material was produced in tranches between 9 September 2022 and 18 November 2022. This material included the BCIF and certain Investigator's Notes in relation to the review of Mr Walker's death by Strike Force Parrabell.

5.3868. A summons to the ODPP was issued on 21 June 2022 for the prosecution file of Mr Hokin in respect of the manslaughter of Mr Walker (ODPP1).[3440] The prosecution file was produced on 12 July 2022.

Interagency cooperation

5.3869. Through inter-agency cooperation, the Inquiry was able to locate and write to Mr Walker's sister, Janice Walker.

5.3870. The Inquiry was also able to locate and contact Mr Hokin, who lives in an aged care facility. He was informed of the work of the Inquiry and its intention to hold a hearing in relation to Mr Walker's death. He was invited to attend the hearing if he wished. Mr Hokin declined to attend or otherwise participate in the Inquiry.[3441]

5.3871. The Inquiry also established that Mr Leatham died in August 2009.[3442]

Family members

5.3872. Ms Walker, Mr Walker's sister, made contact with the Inquiry on 26 October 2022. Ms Walker provided a witness statement to the Inquiry dated 3 February 2023, which included information about Mr Walker's early life and personal history.

[3439] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Brian Walker (SCOI.76961.00014).

[3440] Exhibit 15, Tab 34, Summons ODPP1, 21 June 2022 (SCOI.82118).

[3441] Exhibit 15, Tab 38, Email from Ms Chen to Special Commission of Inquiry, 3 February 2023 (SCOI.82357); Exhibit 68, Tab 30, Letter from Inquiry, 1 February 2023 (SCOI.86645).

[3442] Exhibit 15, Tab 36, Death Certificate for Kevin Leatham, 24 August 2009 (SCOI.82360).

5.3873. In her statement, Ms Walker indicated that she knew Mr Walker to have girlfriends. She described him as somewhat of a "wanderer" with no fixed address. She described him as befriending people easily, often doing odd jobs to help out others.[3443]

Contact with OIC

5.3874. On 5 and 28 September 2023, the Inquiry wrote to Hans Rupp enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Walker. The Inquiry did not receive a response from Mr Rupp.[3444]

Conclusion

5.3875. The further steps taken by the Inquiry did not materially add to or otherwise affect the information and evidence contained in the NSWPF and ODPP case files.

5.3876. As discussed below, I accept the version of events provided to police by Mr Hokin outlined above as a reasonably accurate summary of the events surrounding Mr Walker's death.

Police investigation

5.3877. As Counsel Assisting noted in submissions, the original police investigation did not obtain statements from Mr Walker's family or friends, including in particular Mr Leatham, who may have been able to shed some light on Mr Walker's sexuality. Nor was any investigation apparently made into Mr Hokin's account of how he came to know Mr Walker and how long they had known each other. Mr Leatham may have been able to provide information relevant to that issue.

5.3878. The NSWPF accepted in submissions that a statement should have been obtained from Mr Leatham and that "such evidence may have provided further background to the relationship between Mr Hokin and Mr Walker".[3445] However, the NSWPF submitted that it was "not unreasonable for the focus of police investigations, at least in the first instance, to be on a situation involving self-defence".[3446]

5.3879. The question of whether Mr Hokin acted in self-defence may well have been informed by evidence about the relationship between Mr Walker and Mr Hokin, and a statement from Mr Leatham ought to have been obtained. Moreover, it is apparent that the NSWPF did not immediately and uncritically accept Mr Hokin's claim of self-defence, given that he was charged with manslaughter and committed to trial.

[3443] Exhibit 15, Tab 35, Statement of Janice Walker, 3 February 2023 (SCOI.82361).

[3444] Exhibit 66, Tabs 86-87, Letters from Inquiry to Hans Rupp, 5 and 25 September 2023 (SCOI.86344; SCOI.86345).

[3445] Submissions of NSWPF, 21 February 2023, [120] (SCOI.82560).

[3446] Submissions of NSWPF, 21 February 2023, [120]–[121] (SCOI.82560).

5.3880. The lack of evidence from Mr Walker's friends and family also meant that there was no evidence of Mr Walker's sexuality, beyond Mr Hokin's claim that he made a sexual advance towards him.

Manner and cause of death

5.3881. As Counsel Assisting submitted, the appropriate finding is that Mr Walker died on 23 July 1992 after sustaining a torn spinal ligament as a result of the conduct of Mr Hokin during an altercation between the two men.[3447]

5.3882. As Counsel Assisting also submitted, the Inquiry has no basis to reach a different view from that of the ODPP in 1993, namely that self-defence could not be disproved.[3448]

5.3883. The NSWPF accepted each of those submissions.[3449]

5.3884. Counsel Assisting's submissions are in my view plainly correct. Mr Hokin went to the police of his own free will. His account of events during his interview was generally corroborated by other evidence, including the presence of a shovel at the scene, accounts given by Mr Hokin's next-door neighbours, the injuries to Mr Hokin and the report of both police and the forensic pathologist who noted on a scene examination that the "lower part of the body is astride an upright roof support."[3450] Mr Hokin also had numerous injuries to his torso.[3451]

5.3885. Accordingly, I find that Mr Walker died on 23 July 1992 after sustaining a torn spinal ligament as a result of the conduct of Mr Hokin during an altercation between the two men.

Bias

5.3886. There is limited evidence available to the Inquiry as to whether Mr Walker was a member of the LGBTIQ community. Mr Walker's sister told the Inquiry that she knew Mr Walker to have girlfriends.[3452] That, of course, does not indicate that Mr Walker was not a member of the LGBTIQ community.

5.3887. On Mr Hokin's account, Mr Walker made advances towards him, touching his leg and shoulder, and "talking in a manner about sexual behaviour".[3453] If the violence between Mr Hokin and Mr Walker had broken out as a consequence of Mr Walker's conduct, this would provide a basis for thinking that LGBTIQ bias was a factor in Mr Walker's death.

[3447] Submissions of Counsel Assisting, 6 February 2023, [70] (SCOI.82378).

[3448] Submissions of Counsel Assisting, 6 February 2023, [70] (SCOI.82378).

[3449] Submissions of NSWPF, 21 February 2023, [117] (SCOI.82560).

[3450] Exhibit 15, Tab 2, Post-Mortem Report of Dr Peter Ellis, 8 September 1992, 6 (SCOI.11163.00048).

[3451] Exhibit 15, Tab 8, Statement of Constable Terry Pledge, 24 July 1992, [6] (SCOI.11163.00033); Exhibit 15, Tab 20, Photographs of Injuries to John Hokin, 23 July 1992 (SCOI.82116).

[3452] Exhibit 15, Tab 35, Statement of Janice Walker, 3 February 2023 (SCOI.82361).

[3453] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A15] (SCOI.11163.00032).

5.3888. However, as Counsel Assisting submitted, according to Mr Hokin's interview with police, the physical fight between Mr Walker and Mr Hokin started when Mr Walker attacked Mr Hokin with a shovel. Even if there had been an earlier unwanted sexual advance from Mr Walker to Mr Hokin (as Mr Hokin asserted), Mr Hokin himself did not claim that he had fought Mr Walker for that reason. Rather, as noted above, Mr Hokin said that "if he hadn't have swung a shovel at me I'd be home asleep".[3454] Thus, Mr Hokin's claim of self-defence related to the physical violence comprised by Mr Walker's attacking him with a shovel, rather than to the asserted touching on the leg and shoulder.[3455]

5.3889. As Counsel Assisting also observed, there is no evidence to suggest that Mr Hokin was suffering a psychotic episode at the time, of the kind which had previously been characterised by paranoid, fixed delusions about "homosexuals" and "perverts".[3456]

5.3890. Accordingly, Counsel Assisting submitted that Mr Walker's death was unlikely to have been an LGBTIQ bias crime. The NSWPF did not disagree.

5.3891. I accept those submissions.

Conclusions and Recommendations

5.3892. I find that Mr Walker died on 23 July 1992 after sustaining a torn spinal ligament as a result of the conduct of John Hokin during an altercation between the two men.

5.3893. In my view, on the evidence available to the Inquiry, there is objectively no reason to suspect that LGBTIQ bias was a factor in Mr Walker's death.

5.3894. I do not propose to make any recommendations arising from the Inquiry's consideration of Mr Walker's death.

[3454] Exhibit 15, Tab 13, ERISP Transcript of John Hokin, 23 July 1992, [A67] (SCOI.11163.00032).

[3455] Submissions of Counsel Assisting, 6 February 2023, [67] (SCOI.82378).

[3456] Submissions of Counsel Assisting, 6 February 2023, [68] (SCOI.82378).

IN THE MATTER OF CRISPIN WILSON DYE

Factual background

Date and location of death

5.3895. Crispin Wilson Dye died at approximately 6:30pm on 25 December 1993 at St George Hospital, Kogarah.

Circumstances of death

5.3896. At about 4:30am on the morning of 23 December 1993, Mr Dye was seen lying on his stomach on the road "in the laneway at the back of Kinselas Nightclub" (i.e., Little Oxford Street, at the intersection with Campbell Street).[3457]

5.3897. About five minutes later, at around 4:35am, three men were seen standing around Mr Dye "picking [him] up" and "moving [him] around".[3458] Police and paramedics attended the scene.[3459] Police observed coins in the area where Mr Dye was found and it was subsequently discovered that his wallet was missing.[3460]

5.3898. When he was found, Mr Dye was alive but in cardiac arrest; he was blue, unconscious, was not breathing and had no cardiac output.[3461] He also had abrasions to his face, blood coming from his nose and a swollen left eye. Mr Dye was treated by paramedics at the scene,[3462] and was transported to St Vincent's Hospital at 5:07am.[3463]

[3457] Exhibit 59, Tab 26, Statement of Owen Read, 26 December 1993, [4]–[5] (SCOI.10274.00020).

[3458] Exhibit 59, Tab 25, Statement of Scott John Neilson, 23 December 1993, [3]–[5] (SCOI.10274.00039); Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [1.1]–[1.5] (SCOI.10179.00011).

[3459] Exhibit 59, Tab 20A, Statement of Constable Paul Andrew Johnstone, 29 August 1994, [4], [6]–[8] (SCOI.11036.00106); Exhibit 59, Tab 30, Statement of Darren Andrew Parker, 5 January 1994, [4]–[5] (SCOI.10274.00025).

[3460] Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [7.1] (SCOI.10179.00011); Exhibit 59, Tab 17, Statement of Detective Senior Constable Lyle William Van Leeuwen, 15 November 1994, 8 (SCOI.11036.00085).

[3461] Exhibit 59, Tab 30, Statement of Darren Andrew Parker, 5 January 1994, [5] (SCOI.10274.00025).

[3462] Exhibit 59, Tab 30, Statement of Darren Andrew Parker, 5 January 1994, [5] (SCOI.10274.00025).

[3463] Exhibit 59, Tab 57, NSWPF Running Sheet, 'Information from St Vincent's Hospital Regarding Admission of Crispin Dye on 23.12.1993', 3 January 1994 (SCOI.10356.00182); Exhibit 59, Tab 87, St Vincent's Hospital Progress Note, 'Accident and Emergency Centre – UNKNOWN, Harry', 23 December 1993 (SCOI.10363.00018).

5.3899. Upon arrival at St Vincent's Hospital, Mr Dye was observed to be suffering from a major head injury. At around 1:30pm on 23 December 1993, Mr Dye was transferred to St George Hospital.[3464] He died from his injuries two days later on 25 December 1993.[3465] He was 41 years old.[3466]

Previous investigations

Post-mortem examination

5.3900. A post-mortem examination was carried out by Dr Liliana Schwartz on 27 December 1993 and a report for the Coroner was prepared on 27 April 1994 (**27 April Report**).[3467] The following two reports were attached to the 27 April Report:

a. A macroscopic and microscopic description of Mr Dye's brain dated 12 April 1994 (**12 April Report**);[3468] and

b. A toxicology report.[3469]

5.3901. Some three years later, in July 1997, Dr Schwartz prepared a further report in response to specific questions from the NSWPF dated 9 July 1997 (**1997 Report**).[3470]

5.3902. The 27 April Report describes a range of injuries to Mr Dye's head and neck. These injuries included fractures (to the left zygoma, left mandibular condyle, both orbital plates, crysta galea and greater horn of the thyroid cartilage) and other minor injuries to his limbs including bruises, scratches and abrasions. At the time of his death, Mr Dye was also suffering from acute bronchopneumonia, and acute pancreatitis. Dr Schwartz also recorded that Mr Dye's liver, spleen and heart had "septic features".[3471]

5.3903. In the 12 April Report, Dr Schwartz noted that the examination of Mr Dye's brain had revealed that he had suffered a traumatic subarachnoid haemorrhage, diffuse hypoxic changes and brain swelling, including flattening of the gyri and bilateral mild uncal herniation with associated haemorrhage on the right uncus.[3472]

[3464] Exhibit 59, Tab 31, Statement of Dr Anthony Sherbon, 22 September 1994 (SCOI.10274.00029); Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [11] (SCOI.10274.00046).

[3465] Exhibit 59, Tab 18, Statement of Constable Mark Patrick Portlock, 9 September 1994 (SCOI.10274.00033); Exhibit 59, Tab 21, Statement of Brenton Wilson Dye, 8 August 1995, [7] (SCOI.10274.00035).

[3466] Exhibit 59, Tab 122, Death Certificate of Crispin Wilson Dye, 17 January 1994 (SCOI.83516).

[3467] Exhibit 59, Tab 3, Post-mortem report of Dr Liliana Schwartz, 27 April 1994 (SCOI.10178.00024).

[3468] Exhibit 59, Tab 4, Macroscopic Brain Description of Dr Liliana Schwartz, 12 April 1994 (SCOI.10178.00025).

[3469] Exhibit 59, Tab 5, NSW Health Division of Analytical Laboratories, 'DAL Certificate – Dye, Crispin', 28 February 1994 (SCOI.11036.00072).

[3470] Exhibit 59, Tab 12, Letter from Dr Liliana Schwartz to Detective Sergeant Popplewell, 9 July 1997 (SCOI.10178.00002).

[3471] Exhibit 59, Tab 3, Post-mortem report of Dr Liliana Schwartz, 27 April 1994, 7 (SCOI.10178.00024).

[3472] Exhibit 59, Tab 4, Macroscopic Brain Description of Dr Liliana Schwartz, 12 April 1994, 1 (SCOI.10178.00025).

5.3904. The toxicology report attached to the 27 April Report contained no results of any significance. Although Mr Dye's blood alcohol concentration was very high when he was first admitted to hospital (0.260g per 100mL),[3473] there was no alcohol remaining in Mr Dye's system on 29 December 1993 when the relevant tests were carried out.[3474]

5.3905. In the 27 April Report, Dr Schwartz concluded that the direct cause of Mr Dye's death was a "head injury".[3475]

5.3906. In the 1997 Report, Dr Schwartz categorised Mr Dye's head injuries into the following "groups", and further identified the likely cause of these injuries:[3476]

a. A bruise on the upper and lower eyelid of the left eye, a healing wound immediately to the left of the left eye and an abrasion on the bridge of the nose. These injuries were most likely caused by a direct impact to these areas. However, it may be possible that blood leakage from a fracture of the base of the skull contributed to the formation of the bruise on the upper eyelid of the left eye;

b. An abrasion on the area between the nose and the upper lip, bruising and abrasion of the lips, abrasion on the chin and a scratch on the left side of the jaw. These injuries were most likely caused by a direct impact to these areas; and

c. On the left side of the forehead, immediately above the left eyebrow, an area of abrasions. This was most likely due to direct impact.[3477]

5.3907. In the 27 April Report and the 1997 Report, Dr Schwartz concluded that Mr Dye's injuries were caused by a blunt instrument and that Mr Dye received at least three strikes to the face and left side of his head.[3478] Dr Schwartz also concluded that given Mr Dye had a square shaped abrasion above his left eyebrow and a blurred abrasion on his left temple, these injuries may have been caused "by a baton or by one of the edges of a cricket bat or other blunt object of similar characteristics".[3479]

5.3908. The 27 April Report also noted that Mr Dye had numerous minor injuries to his limbs.[3480] In the 1997 Report, Dr Schwartz provided her opinion in relation to the "possible" means by which these injuries could have been sustained. In this respect, Dr Schwartz noted:[3481]

a. An abrasion located on Mr Dye's left elbow may have been caused by a fall or by direct impact with a blunt object;

[3473] Exhibit 59, Tab 57, NSWPF Running Sheet, 'Information from St Vincent's Hospital Regarding Admission of Crispin Dye on 23.12.1993', 3 January 1994 (SCOI.10356.00182).

[3474] Exhibit 59, Tab 5, NSW Health Division of Analytical Laboratories, 'DAL Certificate – Dye, Crispin', 28 February 1994, 2 (SCOI.11036.00072).

[3475] Exhibit 59, Tab 3, Post-mortem report of Dr Liliana Schwartz, 27 April 1994, 8 (SCOI.10178.00024).

[3476] Exhibit 59, Tab 12, Letter from Dr Liliana Schwartz to Detective Sergeant Popplewell, 9 July 1997, 3 (SCOI.10178.00002).

[3477] Exhibit 59, Tab 12, Letter from Dr Liliana Schwartz to Detective Sergeant Popplewell, 7 July 1997, 2 (SCOI.10178.00002).

[3478] Exhibit 59, Tab 3, Post-mortem report of Dr Liliana Schwartz, 27 April 1994, 8 (SCOI.10178.00024); Exhibit 59, Tab 12, Letter from Dr Liliana Schwartz to Detective Sergeant Popplewell, 7 July 1997, 3 (SCOI.10178.00002).

[3479] Exhibit 59, Tab 12, Letter from Dr Liliana Schwartz to Detective Sergeant Popplewell, 7 July 1997, 2 (SCOI.10178.00002).

[3480] Exhibit 59, Tab 3, Post-mortem report of Dr Liliana Schwartz, 27 April 1994, 2–4 (SCOI.10178.00024).

[3481] Exhibit 59, Tab 12, Letter from Dr Liliana Schwartz to Detective Sergeant Popplewell, 7 July 1997, 3 (SCOI.10178.00002).

b. An area of bruising and abrasions located on the back and inner aspect of Mr Dye's left wrist, and an area of abrasions and discolouration of the skin located on the inner aspect of the left hand, had the characteristics of defensive wounds and were most likely caused by a direct impact with a blunt object; and

c. An abrasion located on the outer aspect of the right shin and areas of discolouration located on the left shin and foot may have been caused by a fall.

Original police investigation

5.3909. NSWPF officers attended the scene shortly after 4:35am on 23 December 1993. The surrounding area was patrolled in an attempt to locate the three men who had been seen "standing around" Mr Dye, but without success.

5.3910. At about 6:20am, an officer from the Crime Scene Unit examined the scene, took some photographs, and collected some exhibits and a swab of blood.

5.3911. Later that morning, the Crime Scene Unit also received Mr Dye's clothing.

5.3912. On 29 December 1993, Strike Force Barcoo was established to investigate Mr Dye's death.[3482] Although the police gathered a considerable amount of information and pursued various leads and persons of interest, the investigation did not result in the identification of the person or persons who had assaulted Mr Dye.

5.3913. Strike Force Barcoo was deactivated following the inquest into Mr Dye's death that was held on 7 and 8 August 1995.

5.3914. On 20 January 1999, Strike Force Barcoo was reactivated following an admission said to have been made by Richard Leonard (who, at the relevant time, was on remand in relation to two murders of which he was later convicted). However, information subsequently obtained by Strike Force Barcoo indicated that Mr Leonard was not actually Mr Dye's assailant, and no charges were laid.

Findings at inquest

5.3915. An inquest into Mr Dye's death was held on 7 and 8 August 1995 at the Coroners Court before State Coroner Hand. Sergeant Gibson assisted the State Coroner.

5.3916. A number of witnesses were called, including:[3483]

a. Detective Sergeant Geoffrey Knight (OIC);

b. Scott Neilson;

c. Jeremy Larkins;

d. Michael Travinski;

[3482] Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [8.1] (SCOI.10179.00011).

[3483] Exhibit 59, Tab 7, Transcript of Coronial Inquest into the Death of Crispin Wilson Dye, 7 August 1995 (SCOI.11036.00060); Exhibit 59, Tab 8, Transcript of Coronial Inquest into the Death of Crispin Wilson Dye, 8 August 1995 (SCOI.10179.00008).

e. Peter Snelling;

f. David Walker;

g. Brenton Dye;

h. NP128;

i. I324;

j. I323;

k. I325;

l. I326;

m. I321; and

n. I70.

5.3917. A central issue in the inquest was the possible involvement of NP128 in Mr Dye's death. However, while State Coroner Hand made adverse findings in relation to NP128's evidence and alibis, ultimately his Honour found there was insufficient evidence to tie him to Mr Dye's murder.

5.3918. On 8 August 1995, State Coroner Hand found:[3484]

> *That on 25 December 1993 at the St George Hospital, Kogarah, Crispin Wilson Dye died of the effects of a head injury inflicted on 23 December 1993 in Campbell Street, Darlinghurst, by a person or persons unknown.*

Criminal proceedings

5.3919. No person has ever been charged with any offence in relation to Mr Dye's death.

Unsolved Homicide Team

5.3920. The UHT considered Mr Dye's case in 2005 (a review) and again in 2019 (a triage).

5.3921. The UHT review in 2005, by Detective Senior Constable Natalie Barr, recommended the following steps be taken:

a. Locate the exhibits;

b. Conduct forensic testing (including trace DNA examination if possible) on suitable exhibits;

c. Confirm that any outstanding prints have been included on NAFIS, and establish the provenance of those fingerprints;

d. Consider re-issuing the reward;

e. Consider reinvestigating a person of interest, NP128 (who is discussed further below), including by using "the undercover technique";

[3484] Exhibit 59, Tab 8, Transcript of Coronial Inquest into the Death of Crispin Wilson Dye, 8 August 1995, 48 (SCOI.10179.00008).

f. In the event of a reinvestigation, conduct a detailed intelligence analysis of all suspects reported to the NSWPF, including by reference to F.A.C.E images created during the original police investigation; and

g. Establish a timeline or other sort of analysis of all the similar offences occurring in the Oxford Street area in the months leading up to Mr Dye's murder.[3485]

5.3922. However, none of these steps were taken by the NSWPF, except for re-issuing the reward in 2014.[3486]

5.3923. The NSWPF submitted that "it is not clear based upon the material before the Inquiry what steps were subsequently taken within the NSWPF in respect of the recommendations", and that "at first blush", it is "regrettable" that, based on the records available, the further steps such as having the exhibits examined by FASS "appear to have not been pursued".[3487]

5.3924. Those submissions are unfortunate. It is quite clear, on the documents produced by the NSWPF, that no such steps occurred. As in many other instances, the NSWPF has sought to suggest that, while it has no record whatsoever that indicates the slightest possibility that a certain step was taken, nonetheless it might have been taken — presumably on the footing that it might have been taken but not recorded, or recorded but the record lost. Again, I reject that submission.

5.3925. In 2019, the UHT conducted a triage of the case to consider whether a second review should be undertaken. In an unsigned Triage Form dated 16 November 2019, Detective Senior Constable Leza Pessotto noted that the matter "should proceed to review", that there "appears to be an opportunity for a forensic review to be conducted", that officers should "[c]onfirm in relation to the fingerprints identified and what they were identified on" and that "[e]nquiries should be conducted on similar offences within the area and see if there are any potential links."[3488]

5.3926. Once again, no such steps were taken. No review was actually conducted.

5.3927. The NSWPF submitted that "it is not clear based on the material before the Inquiry what steps were subsequently taken within NSWPF in respect of the recommendation that the triage proceed to a review".[3489] Again, as with the similar submission by the NSWPF in relation to the 2005 review, this submission is rejected. It is in my view entirely clear that no such review followed the 2019 triage. No such review, nor any document indicating the slightest possibility that such a review ensued, was produced in response to the Inquiry's summonses.

[3485] Exhibit 59, Tab 91, NSWPF Review of an Unsolved Homicide Case Screening Form - Crispin Wilson Dye, 25 May 2005, 17 (SCOI.03268).

[3486] Exhibit 59, Tab 56, Rick Feneley and Megan Levy, '$100,000 reward to find killers of AC/DC manager Crispin Dye', *Sydney Morning Herald* (Sydney, 13 August 2014) (SCOI.83514).

[3487] Submissions of NSWPF, 5 September 2023, [63] (SCOI.85433).

[3488] Exhibit 59, Tab 91, Review of an Unsolved Homicide Case Screening Form - Crispin Wilson Dye, 25 May 2005, 17 (SCOI.03268); Exhibit 59, Tab 92, UHT Triage Form Review of Unsolved Homicide, 'Crispin Wilson Dye', 16 November 2019, 11 (SCOI.03267).

[3489] Submissions of NSWPF, 5 September 2023, [66] (SCOI.85433).

Strike Force Parrabell

Bias Crimes Indicators Form

5.3928. A BCIF was completed by Strike Force Parrabell.[3490] In this BCIF:

a. Five of the ten indicators were answered "Insufficient Information" (namely Differences; Comments, Written Statements, Gestures; Drawings, Markings Symbols, Tattoos, Graffiti; Organised Hate Groups; and Level of Violence);

b. Four of the ten indicators were answered "Suspected Bias Crime" (namely Previous Existence of Bias Crime Incidents; Victim/Witness Perception; Motive of Offender/s; and Location of Incident); and

c. One indicator was answered "No Evidence of a Bias Crime" (namely Lack of Motive).

5.3929. The overall categorisation, in the "Summary of Findings", was "Insufficient Information". The basis for that categorisation appeared to be that, while Strike Force Parrabell "cannot totally rule out bias", there was "strong evidence" that the motive was robbery.

5.3930. Counsel Assisting submitted that the overall categorisation, and the responses to a number of the indicators and prompts, appeared to reflect an assumption or preconception on the part of the Strike Force Parrabell officers that where a robbery is involved, a binary choice is required as between robbery and bias: see for example the "General Comment" sections in relation to Indicator 6 (Victim/Witness Perception), Indicator 8 (Location of Incident) and Indicator 9 (Lack of Motive).

5.3931. In each of those parts of the BCIF, the Strike Force Parrabell officers acknowledged that bias might possibly have been present, but then opted for robbery as the likely motive. The approach that appeared to have been taken was that if robbery was the apparent motive, then bias was negated. In other words, the possibility of both motives co-existing did not appear to have been entertained.

5.3932. Yet for two of those three indicators (6 and 8, the "finding" chosen was "Suspected Bias Crime", while for indicator 9, the "finding" chosen was "No Evidence of Bias Crime". Counsel Assisting observed that it is difficult to identify a rational basis for those very different "findings".

5.3933. Counsel Assisting cited, as also tending to indicate that Strike Force Parrabell had taken such a binary approach, an exchange between Strike Force Parrabell officers and Sergeant Steer of the BCU at a meeting on 19 January 2017, when Sergeant Steer looked at 12 Strike Force Parrabell cases by way of a "dip sample" of the work of the strike force. One of those 12 was the case of Mr Dye.

[3490] Exhibit 59, Tab 90, Strike Force Parrabell Bias Crimes Indicators Review Form, undated (SCOI.45285).

5.3934. The minutes of the meeting included the following, in relation to the case of Mr Dye:[3491]

> *[Sergeant] Steer suggested 'Suspected Bias Crime' because of level of violence suggestive of a motivation more than economic (robbery), the area as well known to be a gay location, gay men possibly targeted because they were perceived to be vulnerable, not fight back etc. Strikeforce maintained that multiple offenders in a robbery could account for the outcomes and determined 'Insufficient Information'. [Sergeant] Steer clarified that motivation need only be partially bias and targeting group due to a perceived vulnerability can be bias motivation, however was happy to leave the determination as 'Insufficient Information'. What is not known is how the victim was dressed and whether he appeared 'gay'.*

5.3935. The minutes seem to indicate that Sergeant Steer was attempting to highlight to Strike Force Parrabell some of the factors pointing to the possibility of a bias attack, that the Strike Force Parrabell officers resisted by "maintaining" a robbery-hypothesis, and that Sergeant Steer then sought to explain that "motivation need only be partially bias".

5.3936. The NSWPF submitted that "the available evidence makes it clear" that Strike Force Parrabell "was alive to the possibility that multiple motivations may be at play in a given case, and that the presence of a robbery motivator does not exclude the prospect that LGBTIQ bias played a role in the relevant death", and that Strike Force Parrabell "did consider whether partial motivations were at play".[3492]

5.3937. These assertions by the NSWPF seem to be largely based on the minutes set out above — which to my mind suggest the very opposite.

5.3938. As Counsel Assisting also submitted, the last sentence of the minutes is not accurate, because of course how Mr Dye was dressed *was* in fact known. The clothing Mr Dye was wearing when he was assaulted was photographed and at least some of those items were retained as exhibits.

5.3939. Yet the NSWPF submitted that the Strike Force Parrabell comment in the last sentence "remains correct". That submission apparently related to the second part of the sentence ("and whether he appeared 'gay'").[3493]

5.3940. Plainly the last sentence was in fact inaccurate, at least in part. To resist that simple proposition in this somewhat pedantic way (and to base that resistance on the simplistic notion that people's sexuality is discernible from how they "appeared") seems to me to be an example of an overly defensive approach to this Inquiry by the NSWPF, of which there have been many, including in this particular case.

[3491] Exhibit 6, Tab 83, NSWPF, Strikeforce Parrabell/Bias Crimes Unit meeting minutes, 19 January 2017, 2 (SCOI.74429).

[3492] Submissions of NSWPF, 5 September 2023, [69], [71] (SCOI.85433).

[3493] Submissions of NSWPF, 5 September 2023, [69] (SCOI.85433).

5.3941. The more fundamental issue raised here by Counsel Assisting was that the interchange between Sergeant Steer and the Strike Force Parrabell officers, as minuted, seemed to indicate that the Strike Force categorised the case as "Insufficient Information" *because of* the possibility that Mr Dye was the victim of a robbery. Sergeant Steer's "clarification" about "partial" motivations (a concept explicitly adopted in the definitions of "bias" and "bias crime" which, according to the Parrabell Report, Strike Force Parrabell actually used)[3494] does not appear to have been engaged with.

5.3942. The NSWPF submitted that, to the contrary, this interchange indicated that the points raised by Sergeant Steer "formed part of the reasoning" of the Strike Force Parrabell officers, and that the case was categorised as "Insufficient Information" because there was no evidence as to whether Mr Dye would have "appeared to a stranger to have been a member of the LGBTIQ community".[3495]

5.3943. I do not accept these submissions by the NSWPF. Not only did the discussion with Sergeant Steer occur after Strike Force Parrabell had already reached and documented its conclusions, but according to the minutes, the strike force resisted the points made by Sergeant Steer about the possibility of a partial bias motivation. In my view the justification now suggested by the NSWPF for the rigidity of the strike force in that regard is quite unconvincing.

5.3944. I agree with Counsel Assisting that both the terms of the completed BCIF itself, and the minutes, do indicate the probability that the Strike Force Parrabell officers adopted a binary (robbery or bias) approach in this case.

Case Summary

5.3945. The Strike Force Parrabell Case Summary reads as follows:[3496]

> ***Identity**: Crispin Dye was 41 years old at the time of his death.*
>
> ***Personal History**: Mr Dye was a music publisher and musician who lived mostly in Cairns, Queensland.*
>
> ***Location of Body/Circumstances of Death**: Two days prior to his death police located Mr Dye with severe head injuries lying on the roadway of Campbell Street Darlinghurst. Mr Dye was taken to hospital however died of his injuries two days later on Christmas Day, 1993. On the night he was assaulted, Mr Dye had been drinking at various hotels in and around Oxford Street, Surry Hills until about 4am. He was last seen heavily intoxicated in Oxford Street. About 4.30am Mr Dye was assaulted by three men who were seen standing over him whilst he was lying on the roadway of Campbell Street. These men were seen removing something from Mr Dye's clothing before running away. Police later confirmed that Mr Dye's wallet and money were missing. At the time of Mr Dye's murder, the area was well known for street robberies and*

[3494] Exhibit 1, Tab 2, NSW Police Force, *Strike Force Parrabell Final Report* (Report, June 2018) 81 (SCOI.02632).

[3495] Submissions of NSWPF, 5 September 2023, [69] (SCOI.85433).

[3496] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Crispin Dye, Undated, 32 (SCOI.76961.00014).

> *assaults. The robbery of Mr Dye was very similar to an earlier robbery of another man in nearby Woolloomooloo which occurred one-hour prior. Police also identified other assaults and robberies which occurred in close proximity of time and space to the murder of Mr Dye. Intelligence suggested that a group of Islanders were actively targeting the area in pursuit of robbery targets. Over a 12-month investigation police identified numerous suspects who were either excluded or not proceeded against due to a lack of evidence. A suspect, Richard Leonard, was later convicted of two other murders (Including Case 67 - Dempsey). Leonard made admissions to killing Mr Dye, however he was excluded from involvement after an extensive reinvestigation.*
>
> ***Sexual Orientation**: Mr Dye most likely identified as bisexual, although his close friends believed him to be gay.*
>
> ***Coroner/Court Findings**: The murder of Mr Dye remains unsolved. Whilst it appears that robbery was a primary motivation for the murder of Mr Dye a bias motivation could not be eliminated.*
>
> ***SF Parrabell concluded there was insufficient information to establish a bias crime***

5.3946. Counsel Assisting drew attention to a number of aspects of the Case Summary.

5.3947. First, the Case Summary asserted as a fact that the three men observed "standing over" Mr Dye, and who removed something from his clothing before running away, were the people who assaulted him. Whether that is actually so, however, was and is not known. There is evidence (available to Strike Force Parrabell) that there was a period where Mr Dye was alone on the ground, after being assaulted, prior to the three men being seen standing around him.[3497]

5.3948. The NSWPF agreed that there is no direct evidence to confirm that the three men seen standing over Mr Dye were involved in the assault, but submitted that "on balance" it is "likely" that they were.

5.3949. Once again, the stance adopted by the NSWPF is a defensive one. The bald factual assertion in the Case Summary was simply wrong, and what the NSWPF now puts forward as "likely", in seeking to bolster the Case Summary, is merely speculative.

5.3950. Secondly, the Case Summary emphasises (under "Circumstances of Death") factors indicating robbery. There is no mention of the possibility of bias, except (inaccurately) under "Coroner/Court Findings".

5.3951. Thirdly, what appears against "Coroner/Court Findings" is inaccurate. The only "Court findings" were those of the Coroner. But Coroner Hand did not make either of the two findings suggested in the Case Summary — namely that "it appears that robbery was a primary motivation", and that "a bias motivation could not be eliminated".[3498]

[3497] Exhibit 59, Tab 26, Statement of Owen Read, 26 December 1993 (SCOI.10274.00020).

[3498] See Exhibit 59, Tab 7, Transcript of Coronial Inquest into the Death of Crispin Wilson Dye, 7 August 1995 (SCOI.11036.00060); Exhibit 59, Tab 8, Transcript of Coronial Inquest into the Death of Crispin Wilson Dye, 8 August 1995 (SCOI.10179.00008).

5.3952. The NSWPF, in submissions, contended that what appears in this part of the Case Summary was not actually put forward as a record of any "findings" by a Court or Coroner, but rather these "comments" merely "reflect the analysis of the author of the Case Summary". This submission is remarkable and I reject it. The Case Summary was plainly inaccurate in this respect, and the NSWPF should have acknowledged that.

Academic review

5.3953. The academic review categorised the case as "Insufficient Information".

Review by the Inquiry

5.3954. The Inquiry took the following steps in the course of examining the matter:

a. Compelling the production of NSWPF holdings relating to both the original investigation and any later reviews and reinvestigations;

b. Obtaining Coroners Court files in relation to the inquest into Mr Dye's death;

c. Reviewing and analysing this material and considering whether any further investigative or other avenues are warranted;

d. Interviewing and obtaining statements from persons with relevant knowledge;

e. Conducting private hearings;

f. Assessing the viability of forensic testing on the remaining exhibits, considering the most appropriate sequence of that testing, and prioritising the forensic tests to be conducted on them; and

g. Conducting testing of those exhibits, and of additional material located in the course of that analysis, and corresponding with the NSWPF about the same.

Summonses

5.3955. A summons was issued to the NSWPF on 18 May 2022 for all documents relating to investigations by the NSWPF of the death of Mr Dye, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Dye. On 8 June 2022, nine boxes of material in relation to Mr Dye were produced to the Inquiry.

5.3956. On 25 August 2022, a summons to the NSWPF was issued for all NSWPF records in relation to, relevantly, Strike Force Parrabell (NSWPF12). This material was produced in tranches between 9 September 2022 and 14 February 2023.

5.3957. On 19 June 2023 (the day before the documentary tender hearing in relation to Mr Dye was originally scheduled to take place), the NSWPF produced a further 261 pages of material in relation to Mr Dye, in response to Summons NSWPF1 (which had been issued more than 12 months earlier).[3499]

5.3958. At the time this additional material was produced, the NSWPF informed the Inquiry that the additional material would be "likely" to be documents that had already been produced to the Inquiry in hard copy.[3500] However, when this additional material was reviewed by Inquiry staff, it immediately became apparent that this material contained documents of considerable significance to the Inquiry's work which had not previously been produced. They included the witness statement of Janet O'Meara, which is referred to below.

5.3959. At the time this further material was produced, the NSWPF also advised the Inquiry that an additional hard copy of the coronial brief had been located and was in the process of being digitised.[3501] These documents were produced to the Inquiry on 21 June 2023. Again, these documents contained material not previously produced to the Inquiry, including investigative records which suggested that Mr Leonard had come to the attention of police investigating Mr Dye's death as early as 1 March 1994.

5.3960. Upon the production of the documents from the belatedly located hard copy of the coronial brief, on 21 June 2023 the NSWPF informed the Inquiry that its response to Summons NSWPF1 in relation to Mr Dye was complete.[3502]

Interagency cooperation

5.3961. On 11 May 2022, the Inquiry issued a written request to the Coroners Court to obtain the coronial file in relation to Mr Dye. On 25 August 2022, the Coroners Court provided this file to the Inquiry.

Private hearings

5.3962. The Inquiry conducted several private hearings in relation to the death of Mr Dye. The private hearings are discussed in the confidential volume of this Report.

Family members

5.3963. The Inquiry established that all Mr Dye's immediate family are deceased. His mother Jean died on 4 September 2018, his father Ian died on 21 October 1983 and his brother Brenton died on 13 October 2018.[3503]

5.3964. On 4 July 2023, Inquiry staff had a conference with Mr Dye's cousin Lisa Colnan and provided a summary of the Inquiry's work in relation to Mr Dye's death.

[3499] Exhibit 59, Tab 115H, Letter from Katherine Garaty to Enzo Camporeale, 19 June 2023 (SCOI.84798).

[3500] Exhibit 59, Tab 115H, Letter from Katherine Garaty to Enzo Camporeale, 19 June 2023 (SCOI.84798).

[3501] Exhibit 59, Tab 115H, Letter from Katherine Garaty to Enzo Camporeale, 19 June 2023 (SCOI.84798).

[3502] Exhibit 59, Tab 115I, Letter from Katherine Garaty to Enzo Camporeale, 21 June 2023 (SCOI.84109).

[3503] Exhibit 59, Tab 126, Death Certificate of Jean Mabel Dye, 4 September 2018 (SCOI.83553); Exhibit 59, Tab 127, Death Certificate of Ian Aubrey Wilson Dye, 7 November 1983 (SCOI.83467); Exhibit 59, Tab 123, Death Certificate of Brenton Wilson Dye, 13 October 2018 (SCOI.82857).

Matters relating to exhibits

Items labelled as exhibits

5.3965. The NSWPF records in relation to the investigation of Mr Dye's death indicate that the exhibits obtained by the NSWPF included the following items:[3504]

a. Blue denim jeans taken from Mr Dye;

b. Brown belt taken from Mr Dye;

c. Denim shirt taken from Mr Dye;

d. Maroon shoes taken from Mr Dye;

e. Maroon socks taken from Mr Dye;

f. White t-shirt taken from Mr Dye;

g. Blood samples taken from Mr Dye;

h. Health Care card and Frequent Flyer card belonging to Mr Dye; and

i. Items from a wallet, including Mr Dye's Metway bank card.

5.3966. During the course of the original investigation into Mr Dye's death, Detective Senior Constable Lyle Van Leeuwen from the Crime Scene Unit examined the items of clothing and observed that the jeans and shoes were soiled with faeces and the front of the t-shirt was blood stained. Detective Senior Constable Van Leeuwen was unable to locate any shoe prints or other trace evidence on the clothing.[3505]

5.3967. Detective Senior Constable Van Leeuwen sent a blood sample from Mr Dye for testing.

5.3968. The Health Care card and the Frequent Flyer card referred to above were contained in an envelope posted to Mr Dye's home address in Cairns by a member of staff of the Ansett Travel Office in Darlinghurst.[3506] Mr Dye's brother, Brenton Dye, collected that envelope from Mr Dye's Cairns home in January 1994.[3507]

5.3969. These items (the Health Care card and the Frequent Flyer card) were subsequently fingerprinted with a "negative result".[3508]

5.3970. The wallet referred to above, which contained various items including one of Mr Dye's Metway Bank cards, was handed in to the Inner City Legal Centre (**ICLC**) on 14 February 1994.

[3504] Exhibit 59, Tab 91, NSWPF, Review of an Unsolved Homicide Case Screening Form – Crispin Dye, 25 May 2005, 5 (SCOI.03268).

[3505] Exhibit 59, Tab 17, Statement of Detective Senior Constable Lyle William Van Leeuwen, 15 November 1994, 4 (SCOI.11036.00085).

[3506] Exhibit 59, Tab 70, NSWPF Running Sheet, 'Ansett Frequent Flyer Card and Health Benefits Card belonging to DYE handed to the Ansett Travel Office', 4 October 1994 (SCOI.10180.00014).

[3507] Exhibit 59, Tab 71, NSWPF Running Sheet, 'Ansett Frequent Flyer Card and Health Benefits Card Belonging to Deceased Received in Mail by Brother, Brenton Dye in Cairns', 4 October 1994 (SCOI.10180.00013).

[3508] Exhibit 59, Tab 63, NSWPF Running Sheet, 'Health Care Card and Ansett Frequent Flyer Card belonging to DYE collected from Fingerprint Unit', 16 February 1994 (SCOI.10180.00016); Exhibit 59, Tab 15, Statement of Detective Geoffrey Roy Knight, 27 September 1994, [59] (SCOI.10274.00046).

5.3971. This wallet contained a range of items, all (apart from the Metway Bank card) belonging to other people. Those items included an application for a loan in the name of I320, a credit card belonging to I320, and a Filipino passport in the name of NP221. NP221 said that the wallet had been I320's, who was his friend, and that I320 had gifted it to NP221.[3509] NP221 said that he had found Mr Dye's Metway Bank card. NP221's girlfriend, NP222, stated that she "recognised the wallet as belonging to [NP221], I have seen him with it ever since I have known him" (i.e. since December 1993).[3510]

5.3972. NP221 was later discounted as a person of interest in the investigation.[3511]

5.3973. These items were also fingerprinted with a "negative result".[3512] It is not clear whether the wallet itself was fingerprinted.

5.3974. On 15 June 2023, Detective Sergeant John Nance provided a statement to the Inquiry (**Nance Statement**).[3513] He stated that two other items, not identified above, had been identified as being "related to" Mr Dye's case on NSWPF systems. In what way they were said to be so "related" was not stated. These items were:

a. Images from fingerprint examination of "2 pages people mag"; and

b. Images from fingerprint examination of "5 letters and Envelopes".

5.3975. The Inquiry previously was not aware of these items and no explanation has been provided by the NSWPF about the nature of their connection to Mr Dye's case. The "people mag" item may refer to a copy of 'People' magazine identified in a 2019 UHT triage as having Richard Leonard's fingerprints on it.[3514] It is not clear what the "5 letters and Envelopes" are and how they relate to Mr Dye's death.

Items not labelled as exhibits

5.3976. Separately to any of the items listed above as exhibits, on some unknown date, a second (black) wallet was handed into Cairns Police Station. It was collected by Brenton Dye on 9 January 1994.[3515] This wallet contained Mr Dye's driver's licence, another Metway Bank card, and Mr Dye's Medicare card.[3516]

5.3977. Mr Dye had reported the loss of this Metway Bank card to the Metway Bank on 15 December 1993 after he arrived in Sydney.[3517]

[3509] Exhibit 59, Tab 38, NSWPF Record of Interview, 'Interview with NP221', 5 April 1994, [Q117]–[A118] (SCOI.10346.00025).

[3510] Exhibit 59, Tab 38A, Statement of NP222, 5 April 1994, [5], [10] (SCOI.10180.00078).

[3511] Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [8.52]–[8.53] (SCOI.10179.00011).

[3512] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [63] (SCOI.10274.00046).

[3513] Exhibit 59, Tab 125, Statement of Detective Sergeant John Nance, 12 June 2023 (NPL.0100.0019.0001).

[3514] Exhibit 59, Tab 92, UHT Triage Form Review of Unsolved Homicide, 'Crispin Wilson Dye', 16 November 2019, 10 (SCOI.03267).

[3515] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [56] (SCOI.10274.00046); Exhibit 59, Tab 61, NSWPF Running Sheet, 'Information from Brenton Dye Regarding Wallet of Deceased in Possession of Cairns Police', 10 January 1994 (SCOI.10180.00004).

[3516] See what appears to be photographs of these items here: Exhibit 59, Tab 62A, Photographs of wallet and other items, undated (SCOI.10349.00004).

[3517] Exhibit 59, Tab 47A, Statement of Jacqueline Dunn, 20 January 1994, [8] (SCOI.10274.00050).

5.3978. These items were never catalogued as exhibits. It would appear, from the evidence available to the Inquiry, that these items were never fingerprinted, perhaps on the assumption that Mr Dye had lost possession of these items in Cairns before flying to Sydney.

5.3979. It seems that the wallet that Mr Dye was actually carrying on the night that he was assaulted was never recovered.

5.3980. Brenton Dye believed that Mr Dye would have been carrying a black "Artex" wallet, because he had bought such a wallet for Mr Dye for Christmas in 1992.[3518] On 7 January 1994, Jean Dye, Mr Dye's mother, accompanied police to purchase a replica of this wallet.[3519]

5.3981. Among the material produced to this Inquiry by the NSWPF in response to Summons NSWPF1, was a black Artex wallet. The provenance of that wallet is unknown,[3520] although it may perhaps be the "replica" referred to in the previous paragraph.

UHT consideration of exhibits

5.3982. On 25 May 2005, some 11 years later, there was a UHT review of Mr Dye's case by Detective Senior Constable Natalie Barr. Detective Senior Constable Barr's review contained the following note (under the heading "comment") about the fingerprinting that had been done as part of the original investigation:[3521]

> *LEONARD identified on items … – NOT RELEVANT TO THE MURDER OF DYE.*
>
> *No prints located on Health Care card or Ansett Frequent Flyer card (printed by McCue)*
>
> *Items from the deceased's wallet and items belonging to [NP221] were printed. According to the negatives located by Fingerprint Major Crime, 4 graphs were searched with no hits and 6 graphs were not suitable for searching. Advice sought from them to establish whether the 4 graphs are now on NAFIS – TO BE UPDATED….*

[3518] Exhibit 59, Tab 61B, NSWPF Running Sheet, 'Description of Wallet Owned by Crispin Dye', 13 January 1994 (SCOI.10356.00161); Exhibit 59, Tab 61A, NSWPF Running Sheet – 'Wallet Similar to One Owned by Dye Obtained from Artex', 10 January 1994 (SCOI.10301.00061).

[3519] See what appears to be photographs of the replica wallet here: Exhibit 59, Tab 61C, Photographs of empty 'Artex' brand wallet, undated (SCOI.10301.00060); Exhibit 59, Tab 61A, NSWPF Running Sheet, 'Wallet Similar to One Owned by Dye Obtained from Artex', 10 January 1994 (SCOI.10301.00061).

[3520] Exhibit 59, Tab 121, Statement of Jacqueline Krynda, 18 June 2023, [24] (SCOI.83525); see Exhibit 59, Tab 61C, Photographs of empty 'Artex' brand wallet, undated (SCOI.10301.00060).

[3521] Exhibit 59, Tab 91, NSWPF Review of an Unsolved Homicide Case Screening Form - Crispin Wilson Dye, 25 May 2005, 6 (SCOI.03268).

5.3983. Which wallet is being referred to here as "the deceased's wallet" is unclear. It seems unlikely to be the wallet handed in to Cairns Police Station and collected by Brenton Dye (which contained Mr Dye's driver's licence, a Metway Bank card, and Mr Dye's Medicare card)[3522] since (as noted above) there is no indication that this item was ever catalogued as an exhibit and/or fingerprinted in the original investigation.

5.3984. It seems more likely to be the wallet handed in to the ICLC on 14 February 1994, as there is a record of items from that wallet being subject to forensic testing.[3523] However, given that this wallet seems to have belonged to NP221, [3524] it would be incorrect to call this wallet "the deceased's wallet". Nor are the available records clear on whether the wallet itself, as distinct from the items found with it, was fingerprinted.[3525]

5.3985. The note made by Detective Senior Constable Barr indicates that these items from the wallet (although apparently not including the wallet itself) were tested for fingerprints, but they were not sent to FASS (then DAL) for DNA or other forensic analysis. By early 1994 in NSW, the possible scope of forensic testing, including by reference to DNA, was increasing, although it was considerably more limited in its capacities than is the case in 2023.[3526]

5.3986. By the time of the 2005 UHT review, Mr Dye's Health Care card and Frequent Flyer card could not be located, nor could the items from "the deceased's wallet" (more likely to be NP221's wallet) and the items belonging to NP221.[3527] The completed review form states that "it appears that the deceased's blood is the only item which has ever been sent to DAL for examination".[3528]

The Inquiry's forensic examinations in 2023

5.3987. On 28 September 2022, the Inquiry wrote to the NSWPF requesting their assistance in identifying and locating the physical exhibits held by the NSWPF in relation to Mr Dye's case.[3529]

5.3988. On 30 September 2022, the NSWPF advised the Inquiry by email that some exhibits had been located.[3530]

[3522] Exhibit 59, Tab 61, NSWPF Running Sheet, 'Information from Brenton Dye Regarding Wallet of Deceased in Possession of Cairns Police', 10 January 1994 (SCOI.10180.00004).

[3523] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [63] (SCOI.10274.00046).

[3524] Exhibit 59, Tab 38, NSWPF Record of Interview, 'Interview with NP221', 5 April 1994, [Q117]–[A118] (SCOI.10346.00025).

[3525] See Exhibit 59, Tab 91, NSWPF Review of an Unsolved Homicide Case Screening Form - Crispin Wilson Dye, 25 May 2005, 6 (SCOI.03268); Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [62]–[63] (SCOI.10274.00046).

[3526] Exhibit 59, Tab 91, NSWPF Review of an Unsolved Homicide Case Screening Form - Crispin Wilson Dye, 25 May 2005, 6 (SCOI.03268); Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 7 (SCOI.84016). The DAL was the precursor to the Forensic and Analytical Science Service (FASS).

[3527] Exhibit 59, Tab 91, NSWPF Review of an Unsolved Homicide Case Screening Form - Crispin Wilson Dye, 25 May 2005, 5 (SCOI.03268).

[3528] Exhibit 59, Tab 91, NSWPF Review of an Unsolved Homicide Case Screening Form - Crispin Wilson Dye, 25 May 2005, 17 (SCOI.03268). DAL was the precursor to the Forensic and Analytical Science Service (FASS).

[3529] Exhibit 59, Tab 93, Email from Elizabeth Blomfield to Patrick Hodgetts, 28 September 2022 (SCOI.83495).

[3530] Exhibit 59, Tab 94, Email from Patrick Hodgetts to Elizabeth Blomfield, 30 September 2022 (SCOI.83471).

5.3989. On 7 October 2022, the NSWPF sent a further email that contained the following table which listed the exhibits that the police had managed to locate:[3531]

	Item	Exhibit Number	Location	Notes
1	*Jeans*	*X0000638075*	*MEPC*	*According to crime scene exhibit sheet, this exhibit also includes the belt*
2	*Socks*	*X0000638076*	*MEPC*	
3	*T-shirt*	*X0000638077*	*MEPC*	
4	*Shoes*	*X0000638078*	*MEPC*	
5	*Blue/denim shirt*	*X0000638079*	*MEPC*	
6	*Blood sample/blood swab*	*TBC*	*MEPC*	
7	*Head hair sample*	*X0000638080*	*MEPC*	
8	*Extendable baton*	*X0001547254*	*MEPC*	*This exhibit is linked to the event on EFIMS, however it is not clear how or if this exhibit is linked to the matter, or when it came in to possession of police*

5.3990. The NSWPF advised that the following exhibits could not be located, and that there were no further avenues of inquiry available to locate them:[3532]

a. The Health Care card and Frequent Flyer card belonging to Mr Dye; and

b. A credit card from a wallet and items belonging to NP221.

5.3991. The Inquiry made arrangements for the eight exhibits listed in the above table to be sent to FASS for testing.[3533] This was requested on 13 January 2023,[3534] and testing occurred in the following months.

5.3992. The results of that testing in 2023, at the behest of the Inquiry, resulted in two highly significant discoveries:

a. Two pieces of paper were found in the pocket of Mr Dye's shirt. Those papers had never previously been noticed, or subjected to any testing (including for fingerprints or DNA); and

[3531] Exhibit 59, Tab 95, Email from Patrick Hodgetts to Elizabeth Blomfield, 7 October 2022 (SCOI.83521).

[3532] Exhibit 59, Tab 95, Email from Patrick Hodgetts to Elizabeth Blomfield, 7 October 2022 (SCOI.83521).

[3533] Exhibit 59, Tab 121, Statement of Jacqueline Krynda, 18 June 2023, [10]–[11] (SCOI.83525).

[3534] Exhibit 59, Tab 97, Letter from Jacqueline Krynda to Clint Cochrane (FASS), 13 January 2023 (SCOI.83491).

b. Testing of samples of blood-stained cloth taken from Mr Dye's jeans resulted in a DNA match with an identified person.

5.3993. The results of the 2023 testing of those two papers from the shirt, and those samples from the jeans, are discussed in the following paragraphs.

2023 discovery of yellow post-it note and white card in Mr Dye's shirt pocket

5.3994. On 14 February 2023, FASS informed the Inquiry that FASS had found two pieces of paper in Mr Dye's shirt (exhibit number X0000638079), folded inside the top left front pocket (away from an area of the pocket that was stained).[3535]

5.3995. One was a yellow "post-it" style note that contained a handwritten name, apparently "Garry Hook", and phone number on it. The other was a thick white piece of paper with "Davidoff Cool Water" written on it, and which contained a brown mark that FASS thought might be a bloodstain.[3536] The white card was folded inside the yellow note.[3537]

5.3996. It is clear that the NSWPF had not previously been aware of the existence of these papers. Indeed, in April 2023 the NSWPF conceded that it was not previously aware of these items.[3538] During his oral evidence on 5 July 2023, Detective Inspector Warren agreed it was a significant oversight for investigators to have failed to search Mr Dye's clothes thoroughly in 1993 or 1994, including as judged by the standards of that time.[3539]

5.3997. Notwithstanding that evidence, and that concession, in its written submissions in relation to Mr Dye's case the NSWPF was only prepared to say that "it appears likely" that these items were not located during the initial search, and that it is "regrettable" that the items "do not appear" to have been located.[3540]

5.3998. I am bound to observe, once again, that such defensiveness, and unwillingness to make appropriate concessions, which have characterised much of the NSWPF's approach to this Inquiry generally, are both unfortunate and unhelpful.

5.3999. An immediate difficulty posed by the discovery of these items was to assess the viability, most appropriate sequence, and priority, of any forensic tests that could be conducted on them.

5.4000. FASS advised that they did not have the relevant skills to test these items for fingerprints, and also raised their concern that any fingerprint testing would negatively impact their ability to extract DNA from the cards.

[3535] Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 5 (SCOI.84016).

[3536] Exhibit 59, Tab 101, Email from Michele Franco to Jacqueline Krynda, 14 February 2023 (SCOI.83507).

[3537] Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 5 (SCOI.84016).

[3538] Exhibit 59, Tab 113, Letter from Katherine Garaty to Enzo Camporeale, 3 April 2023 (SCOI.83494); Exhibit 59, Tab 115G, Letter from Katherine Garaty to Enzo Camporeale, 5 June 2023 (SCOI.84023).

[3539] Transcript of the Inquiry, 5 July 2023, T5002.46–5003.5 (TRA.00073.00001).

[3540] Submissions of NSWPF, 5 September 2023, [38], [42] (SCOI.85433).

5.4001. On 10 March 2023, the Inquiry wrote to the NSWPF advising of the discovery of the two pieces of paper.[3541] Subsequent correspondence involving the Inquiry, the NSWPF and FASS eventually led to the following approach being adopted:

a. A small sample of the brown mark on the white card would be taken for the purposes of DNA testing before it was submitted for fingerprinting;[3542]

b. The rationale for this approach was that if any DNA profile so obtained was consistent with another DNA profile already recovered in the case, then it would not be crucial to extensively test the stain, and the card could then be subjected to fingerprint testing; and

c. Conversely, if a novel DNA profile was recovered, then priority may have to be given to investigating that DNA profile, even if that might mean that fingerprinting could not thereafter be carried out.[3543]

5.4002. On 31 May 2023, FASS informed the Inquiry that the profile that had been recovered from the brown mark on the white card was consistent with Mr Dye's profile.[3544] Consequently, the white card and the yellow post-it note were sent to the NSWPF for fingerprint testing.[3545]

5.4003. On 7 June 2023, the Inquiry received a statement from Detective Sergeant Nicole Smith, a fingerprint expert, which indicated that no fingerprints suitable for search or comparison were able to be developed from the white card or yellow post-it note.[3546]

5.4004. If the NSWPF had carefully examined Mr Dye's clothing at the time of the original investigation in 1993-1994, the white card would inevitably have been found, and at least fingerprint results, if not DNA results, may have been able to be obtained (then or subsequently). As noted above, Mr Dye had been observed on the ground at one stage surrounded by three people, who were apparently "picking [him] up", "moving [him] around" and "appeared to grab something" from him.[3547] It would seem likely that they were going through his pockets.

5.4005. However, as at today, it is not possible to ascertain whether the papers recently found in the shirt pocket with Mr Dye's blood bear any fingerprints or, if so, whose fingerprint it is.

[3541] Exhibit 59, Tab 104, Letter from Enzo Camporeale to Katherine Garaty, 10 March 2023 (SCOI.83489).

[3542] Exhibit 59, Tab 105, Email from Patrick Hodgetts to Jacqueline Krynda, 13 March 2023 (SCOI.83517); Exhibit 59, Tab 106, Letter from Enzo Camporeale to Patrick Hodgetts, 16 March 2023 (SCOI.83515); Exhibit 59, Tab 107, Email from Jacqueline Krynda to Michele Franco, 16 March 2023 (SCOI.83523); Exhibit 59, Tab 109, Email from Patrick Hodgetts to Jacqueline Krynda, 21 March 2023 (SCOI.83506); Exhibit 59, Tab 110, Email from Michele Franco to Jacqueline Krynda, 22 March 2023 (SCOI.83485); Exhibit 59, Tab 112, Letter from Jacqueline Krynda to Michele Franco, 3 April 2023 (SCOI.83484); Exhibit 59, Tab 113A, Email from Jacqueline Krynda to Patrick Hodgetts, 5 April 2023 (SCOI.84020); Exhibit 59, Tab 114, Letter from Michele Franco to Jacqueline Krynda, 12 April 2023 (SCOI.83490); Exhibit 59, Tab 115, Letter from Enzo Camporeale to Patrick Hodgetts, 19 April 2023 (SCOI.83492); Exhibit 59, Tab 115B, Email from Patrick Hodgetts to Jacqueline Krynda, 24 April 2023 (SCOI.84012); Exhibit 59, Tab 115C, Email from Michele Franco to Isabella Jiang, 1 May 2023 (SCOI.84017); Exhibit 59, Tab 115D, Email from Patrick Hodgetts to Jacqueline Krynda, 1 May 2023 (SCOI.84013).

[3543] Exhibit 59, Tab 114, Letter from Michele Franco to Jacqueline Krynda, 12 April 2023 (SCOI.83490).

[3544] Exhibit 59, Tab 121, Statement of Jacqueline Krynda, 18 June 2023, [15] (SCOI.83525); Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 5 (SCOI.84016).

[3545] Exhibit 59, Tab 121, Statement of Jacqueline Krynda, 18 June 2023, [15] (SCOI.83525).

[3546] Exhibit 59, Tab 124, Statement of Detective Sergeant Nicole Smith, 7 June 2023, [6] (NPL.0100.0016.0039).

[3547] Statement of Scott John Neilson, 23 December 1993, [4]–[5] (SCOI.10274.00039).

5.4006. The NSWPF submissions purported to respond to the submissions of Counsel Assisting in relation to various suggested failures to arrange for fingerprinting of certain exhibits. [3548] However, in those submissions, the NSWPF conspicuously failed to mention the most obvious such failure: the failure to locate and test these papers for fingerprints at the time. That missed opportunity is now perhaps incurable, as explained above. But the NSWPF, in its submissions, chose to say nothing about that.

5.4007. I agree with Counsel Assisting that it is plainly unsatisfactory that this evidence should have lain untouched for nearly thirty years without being found and/or subjected to testing.

5.4008. That is especially so when a UHT review as long ago as 2005 had recommended that the exhibits should be located, that checks should be made to ensure that relevant fingerprinting steps had been taken, and that the possibility of trace DNA testing on suitable exhibits should be explored. If those recommendations had been implemented, presumably the pieces of paper would have been discovered 18 years ago, and both they, and those exhibits which were still held, could have been tested at that time.

Other papers located with Mr Dye's clothing in 1993

5.4009. Following the discovery of the two pieces of paper in early 2023, the Inquiry conducted searches of:

a. The documents contained in the nine NSWPF boxes that had been produced in response to Summons NSWPF1; and

b. The Coroners Court file.

5.4010. In conducting these searches, the Inquiry's staff located a summary that was prepared for the Coroner dated 12 October 1994. The summary was prepared by Detective Sergeant Knight, and contained the following (emphasis added):[3549]

> *[Mr Dye] was diagnosed as suffering brain damage, and was placed on a resuscitator. Whilst there, photographs were taken by Police and his property was also taken possession of, which consisted of clothing and some papers containing phone numbers, however no form of identification was found, which gave rise to the suspicion at the time that he had been the subject of a robbery.*

[3548] Submissions of NSWPF, 5 September 2023, [34]–[36] (SCOI.85433).

[3549] Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [1.6] (SCOI.10179.00011).

5.4011. Detective Sergeant Knight also made a statement in 1994 to similar effect. In that statement, he said that that after visiting Mr Dye in hospital on 23 December 1993 and taking possession of Mr Dye's clothing:[3550]

> *Detective TAYLOR and I then returned to Surry Hills, where I made an examination of the clothing, in which were found several pieces of paper containing telephone numbers and a Metway Bank business card.*

5.4012. At that point in time, the only record of what was on these papers appeared to be a photocopy contained within the Coroners Court file, as Annexure E to the statement of Detective Sergeant Knight.[3551] That photocopy was of approximately five pieces of paper, each containing a name/s and phone numbers.[3552] They are not the pieces of paper located by the Inquiry.

5.4013. On 23 March 2023, the Inquiry wrote to the NSWPF asking for clarification about the papers referred to by Detective Sergeant Knight in the abovementioned documents, particularly whether they had been catalogued as exhibits and whether they had ever been subject to DNA and/or fingerprint testing.

5.4014. On 3 April 2023, the NSWPF indicated that it had searched several locations including Surry Hills Police Area Command, EFIMS, NSWPF investigative holdings, FETS, FASS, the Department of Forensic Medicine, NSWPF Archives and MEPC and the pieces of paper were not located.[3553] The NSWPF could not otherwise answer the questions posed by the Inquiry in its 23 March letter.

5.4015. When the NSWPF produced the "digitised" coronial brief on 21 June 2023, Inquiry staff identified what appeared to be colour scans of the same handwritten notes annexed to the statement of Detective Sergeant Knight.[3554] On 10 July 2023 the Inquiry wrote to the NSWPF to seek confirmation as to whether what had been scanned were the original notes, and if so, whether any measures had been taken to prevent contamination of the notes as such steps may have frustrated any utility in arranging fingerprint or DNA testing for those notes.[3555]

5.4016. On 13 July 2023 the NSWPF advised that the documents it had scanned were copies of the original documents.[3556] Accordingly, given that the original papers have apparently not been retained, and have certainly not been located and/or produced, the Inquiry has not been able to submit them for forensic testing.

[3550] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [9] (SCOI.10274.00046).

[3551] See Exhibit 59, Tab 11, Photocopy, undated (SCOI.11036.00110); Exhibit 59, Tab 10, Table of Contents, Inquest Touching the Death of Crispin Wilson DYE, Undated [16] (SCOI.11036.00087).

[3552] Exhibit 59, Tab 11, Photocopy, undated (SCOI.11036.00110).

[3553] Exhibit 59, Tab 113, Letter from Katherine Garaty to Enzo Camporeale, 3 April 2023 (SCOI.83494).

[3554] Exhibit 59, Tab 134, Scanned handwritten notes produced on 21 June 2023, undated (SCOI.84805).

[3555] Exhibit 59, Tab 115L, Letter from Enzo Camporeale to Katherine Garaty, 10 July 2023 (SCOI.84802).

[3556] Exhibit 59, Tab 115M, Letter from Katherine Garaty to Enzo Camporeale, 13 July 2023 (SCOI.84795).

5.4017. Notwithstanding the unambiguous nature of the evidence noted in the preceding paragraphs, the NSWPF submissions sought to leave open the possibility that the "papers" referred to by Detective Sergeant Knight in 1994 were the papers located this year by FASS.[3557] I am satisfied on all of the available evidence that they simply were not. The submission by the NSWPF in this regard is again unfortunate, and another example of the inappropriately defensive mindset I have previously mentioned.

5.4018. On 20 June 2023, the Inquiry became aware of a *further* note which had been found on Mr Dye's person but not retained or noted as an exhibit. That further piece of paper was a note written by a person named Alexander Paige. The contents of this note, and how it came to the Inquiry's attention, are discussed further below.

2023 testing of blood and trace DNA from Mr Dye's jeans

5.4019. On 16 February 2023, FASS advised the Inquiry that an area of the outside of the back right pocket of Mr Dye's jeans (exhibit number X0000638075) had blood on it which contained a mixture of DNA that originated from two individuals: Mr Dye and an unknown male. FASS advised the Inquiry that due to the degradation of the exhibit over time, DNA markers had only been partially recovered for the unknown profile.[3558]

5.4020. On 22 March 2023, FASS advised that it had made further progress in testing the blood stain from the back right pocket.[3559] In addition, trace DNA was also located on the jeans, via tape lift, on four inside surfaces, namely: the inside surface of the back right pocket, the inside surface of the outer layer of back right pocket, the inside surface of the back left pocket and the inside surface of the outer layer of front right pocket. This trace DNA originated from at least two individuals.

5.4021. On 19 April 2023, FASS advised the Inquiry that two more markers had been recovered from the unknown profile.[3560]

5.4022. On 13 May 2023, the Inquiry wrote to the Institute of Environmental Science and Research (**ESR**) in New Zealand requesting its assistance in testing the blood stain from the outside of the back right pocket of Mr Dye's jeans, as well as a reference sample from his shirt, with a view to ascertaining whether they were able to extract further markers using a "MiniFiler" kit which increases the ability to obtain DNA results from compromised samples.[3561]

5.4023. ESR later conducted these tests. However, on 2 June 2023, ESR confirmed that no further markers could be recovered from the jeans sample due to the degradation of the exhibit over time.[3562]

[3557] Submissions of NSWPF, 5 September 2023, [39] (SCOI.85433).

[3558] Exhibit 59, Tab 121, Statement of Jacqueline Krynda, 18 June 2023, [13] (SCOI.83525).

[3559] Exhibit 59, Tab 110, Email from Michele Franco to Jacqueline Krynda, 22 March 2023 (SCOI.83485).

[3560] Exhibit 59, Tab 121, Statement of Jacqueline Krynda, 18 June 2023, [14] (SCOI.83525).

[3561] Exhibit 59, Tab 115E, Email from Jacqueline Krynda to Sarah Cockerton, 13 May 2023 (SCOI.84011).

[3562] Exhibit 59, Tab 117, Statement of Jayshree Patel, 2 June 2023 (SCOI.83505).

5.4024. In the Franco Statement, the unknown profile from the bloodstain on the back of the jeans is referred to as "Unknown Male A".[3563] FASS uploaded the profile of Unknown Male A to the national database, but no matches were found.[3564] FASS further advised that NP128, NP127 and Mr Leonard could be excluded as contributors to the profile of Unknown Male A.[3565]

5.4025. In relation to the trace DNA found on the four inside pocket surfaces of the jeans, Mr Dye could not be excluded as the first contributor and Unknown Male A could not be excluded as the second contributor.[3566]

5.4026. The Inquiry requested that NSWPF liaise with FASS and the AFP to request the assistance of Interpol and make the appropriate requests to other international law enforcement agencies to identify any potential DNA matches with Unknown Male A.[3567]

5.4027. However, before that request could be actioned, on 19 June 2023 FASS advised the Inquiry that the DNA profile for Unknown Male A had been matched to another crime scene.[3568]

5.4028. The Inquiry then issued urgent summonses to the NSWPF (NSWPF132, NSWPF133 and NSWPF134) to obtain information in relation to the crime scene match.[3569]

5.4029. The documents produced in response to Summons NSWPF132 revealed that the relevant crime scene was 6 Cookson Place, Glenwood, where an offence of break and enter (steal) had allegedly been committed on 10 February 2002.[3570] The sole offender charged in relation to that offence was NP252.[3571]

5.4030. NP252 had been apprehended at the scene and two blood samples had been taken, one from a piece of broken glass at the rear of the premises and another from a VCR player which was stolen and subsequently recovered.[3572] NP252's DNA was taken via buccal swab with his consent,[3573] and a DAL analysis indicated that he was a match for one of the blood samples taken at the scene.[3574] NP252 was released on conditional bail and the matter was listed on 6 March 2002 at Blacktown Local Court for mention. However, before the charges could be finalised, NP252 died by way of suicide in late 2002.[3575]

[3563] Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 2–3 (SCOI.84016).

[3564] Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 3 (SCOI.84016).

[3565] Exhibit 59, Tab 110, Email from Michele Franco to Jacqueline Krynda, 22 March 2023 (SCOI.83485); see also Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023 (SCOI.84016).

[3566] Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 2 (SCOI.84016).

[3567] Exhibit 59, Tab 115A, Letter from Enzo Camporeale to Patrick Hodgetts, 29 April 2023 (SCOI.84027).

[3568] Exhibit 59, Tab 131, Supplementary Statement of Jacqueline Krynda, 7 August 2023, [8] (SCOI.84926).

[3569] As outlined in Exhibit 59, Tab 131, Supplementary Statement of Jacqueline Krynda, 7 August 2023, [9]–[10] (SCOI.84926).

[3570] Exhibit 59, Tab 141, Summary of DNA scene link, undated (NPL.0182.0001.0001).

[3571] Exhibit 59, Tab 138, NSWPF Facts Sheet, 12 February 2002 (NPL.0187.0001.0012).

[3572] Exhibit 59, Tab 138, NSWPF Facts Sheet, 12 February 2002 (NPL.0187.0001.0012); Exhibit 59, Tab 139, DAL Certificate of Robert Goetz, 10 October 2002, 4 (NPL.0187.0001.0015).

[3573] Exhibit 59, Tab 138, NSWPF Facts Sheet, 12 February 2002 (NPL.0187.0001.0012); Exhibit 59, Tab 139, DAL Certificate of Robert Goetz, 10 October 2002, 1 (NPL.0187.0001.0015).

[3574] Exhibit 59, Tab 139, DAL Certificate of Robert Goetz, 10 October 2002 (NPL.0187.0001.0015).

[3575] Exhibit 59, Tab 142, Death Certificate of NP252, 20 June 2023 (SCOI.84195).

5.4031. The Inquiry only has limited information about the charges brought against NP252, which remained unresolved at the time of his death.

a. In response to a summons requesting the relevant court file (BLC1), the Blacktown Local Court advised that all files for the year 2002 were destroyed at the government repository in error;[3576] and

b. In answer to a summons requesting relevantly the full brief of evidence for that charge, the NSWPF advised the Inquiry that "a number of archive boxes that may have contained responsive material were destroyed due to water damage" and only some material was produced.[3577]

5.4032. The Inquiry has not been able to arrange for the forensic testing of the buccal swab taken from NP252 directly against the Unknown Male A profile, because that swab was destroyed in accordance with the *Crimes (Forensic Procedures) Act 2000* (***CFP Act***).

5.4033. However, the Inquiry requested that FASS test the Unknown Male A profile against the blood swab obtained from the Glenwood crime scene. On 13 July 2023, FASS advised that a DNA match had been confirmed.[3578]

5.4034. The Inquiry also conducted an investigation into NP252's criminal antecedents and associates to identify others with whom he may have been involved.[3579] NP252's criminal history was substantial, but the following incidents are of particular relevance given their temporal proximity to the date of Mr Dye's death:

a. At 6:00pm on 30 December 1993, NP252 was arrested for his involvement in a group of unnamed persons fighting with "iron bars" in Mount Druitt,[3580] in relation to which he was charged with offensive conduct and offensive language; and

b. At 10:30pm on 4 January 1994, whilst in the company of five other unnamed men, NP252 assaulted a German tourist on William Street near Kings Cross. The assault occurred without any apparent provocation, and NP252 was arrested and charged with assault occasioning actual bodily harm.[3581]

5.4035. A summons issued to the NSWPF on 26 June 2023 requested the complete brief of evidence in relation to these charged offences (NSWPF137). However, the NSWPF advised that no records forming part of the brief of evidence had been located for either offence, noting that the briefs had "likely been destroyed" at the expiry of the relevant mandatory retention periods under the *State Records Act*.[3582]

[3576] Exhibit 59, Tab 143, Correspondence with Blacktown Local Court, 30 June 2023 (SCOI.84799).

[3577] Exhibit 59, Tab 115J, Letter from Katherine Garaty to Enzo Camporeale, 22 June 2023 (SCOI.84800); Exhibit 59, Tab 140, Riverstone Police Station request for approval for destruction, 4 November 2014 (NPL.0187.0001.0001).

[3578] Exhibit 59, Tab 132, Statement of Rhys Carvosso, 15 August 2023, [4] (SCOI.84927); Exhibit 59, Tab 133, Supplementary Statement of Michele Franco, 31 July 2023, [6]–[7] (SCOI.84910).

[3579] Exhibit 59, Tab 131, Supplementary Statement of Jacqueline Krynda, 7 August 2023 (SCOI.84926).

[3580] Exhibit 59, Tab 135, Crime Information Report, 30 December 1993 (NPL.0192.0001.0066).

[3581] Exhibit 59, Tab 136, Crime Information Report, 5 January 1994 (NPL.0186.0001.0077).

[3582] Exhibit 59, Tab 115K, Letter from Patrick Hodgetts to Enzo Camporeale, 30 June 2023 (SCOI.84803).

5.4036. In response to a summons issued to the ODPP on 26 June 2023 (ODPP6) in relation to the 4 January 1994 offence, the ODPP advised that it had no records.[3583]

5.4037. I agree with Counsel Assisting that the following conclusions can be drawn from the evidence about NP252:

a. NP252 was at 6 Cookson Place, Glenwood in 2002 when an offence took place, and his DNA was recovered from the scene in the form of blood samples;

b. NP252's DNA was located in a blood stain from the outside of the back right pocket of Mr Dye's jeans;

c. The existence of NP252's DNA within a blood stain on Mr Dye's jeans is consistent with his having made physical contact with Mr Dye on the night that he was assaulted; and

d. The possible presence of NP252's DNA in the four inside surfaces of Mr Dye's pockets indicates that NP252's hands were inside Mr Dye's pockets on the night he was assaulted.

5.4038. However, on the publicly available information, I accept that it is not possible to draw any conclusions about what (if any) role NP252 played in Mr Dye's death. In particular, it is not possible to determine whether he carried out or participated in any physical assault against Mr Dye. Whilst there was eyewitness evidence that three men were seen standing around Mr Dye, moving him around and then running away,[3584] there was no eyewitness evidence in relation to whether these same three men, or any of them, were involved in the assault of Mr Dye.

5.4039. As Counsel Assisting submitted, the Inquiry's 2023 identification of NP252 as a person of interest in relation to the death of Mr Dye in 1993 demonstrates the importance of ensuring the timely and/or repeated forensic testing of exhibits, even in cold cases.

5.4040. It is regrettable that, in Mr Dye's case, this step was not taken at any time after December 1993 until the Inquiry did so in 2023, by which time NP252's death, and the loss or destruction of relevant records, had made it significantly more difficult to pursue this vital information.

5.4041. The NSWPF submitted that since NP252 died prior to the 2005 UHT review, then even if testing had been carried out at the time of that 2005 review and had resulted in a DNA match with N252 (as has now been obtained in 2023), such results "would not have been more useful in determining through objective evidence whether N252 was involved in Mr Dye's death".[3585] I disagree: as the NSWPF conceded ("on balance"), "it is possible that attempts to obtain information from associates of NP252 would have been more likely to succeed in 2005 than in present day."[3586]

[3583] Exhibit 59, Tab 131, Supplementary Statement of Jacqueline Krynda, 7 August 2023, [12] (SCOI.84926).

[3584] Exhibit 59, Tab 25, Statement of Scott John Neilson, 23 December 1993, [1]–[17] (SCOI.10274.00039).

[3585] Submissions of NSWPF, 5 September 2023, [50] (SCOI.85433).

[3586] Submissions of NSWPF, 5 September 2023, [50] (SCOI.85433).

2023 discovery and testing of hairs

5.4042. The forensic testing carried out in 2023 at the request of the Inquiry also resulted in the discovery of multiple hairs: on Mr Dye's denim shirt, inside the pockets of his denim shirt, on his white t-shirt and on the yellow post-it note.

5.4043. These hairs were also tested, at the request of the Inquiry. DNA was unable to be extracted from most of them.[3587]

5.4044. However, one hair from the top left shoulder of Mr Dye's denim shirt provided a partial DNA profile. In a statement prepared for the Inquiry dated 15 June 2023 by Michele Franco, the Group Manager, Evidence Recovery Unit at FASS (**Franco Statement**), this profile is labelled "Unknown Male B".[3588] FASS uploaded the profile of Unknown Male B to the national database, but no matches were found.[3589]

5.4045. It has not been possible to obtain any further DNA markers from that exhibit because of the passage of time, even with current technologies.[3590] If this hair had been found and examined earlier, in a less aged and/or degraded state, more and/or better results may have been possible.

The extendable baton

5.4046. On 3 February 2023, the NSWPF informed the Inquiry that the extendable baton (exhibit number X0001547254) "was seized at some point during the course of the original investigation, possibly as a suspected murder weapon".[3591]

5.4047. The Inquiry sought further information about the extendable baton from the NSWPF,[3592] and the NSWPF subsequently conducted further searches for information about the baton.[3593] As a result of these searches, the NSWPF informed the Inquiry that:

a. There were no records indicating when or where the baton was "seized";

b. The baton was not referenced at the time the coronial brief was prepared, but was referenced in a letter from the NSWPF to Dr Schwartz dated 9 July 1997 which requested a comparison between the baton and the injuries sustained by Mr Dye;

c. Richard Leonard had spoken of using a baton to assault Mr Dye; and

d. The baton was recorded as being entered into the EFIMS system on 9 November 2012 and there were no records of it being subject to forensic testing.[3594]

[3587] Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 2–5 (SCOI.84016).

[3588] Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 4 (SCOI.84016).

[3589] Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 4 (SCOI.84016).

[3590] Exhibit 59, Tab 117, Statement of Jayshree Patel, 2 June 2023 (SCOI.83505); Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 4 (SCOI.84016).

[3591] Exhibit 59, Tab 100, Email from Katherine Garaty to Enzo Camporeale, 3 February 2023 (SCOI.83474).

[3592] Exhibit 59, Tab 102, Letter from Enzo Camporeale to Katherine Garaty, 14 February 2023 (SCOI.83470).

[3593] Exhibit 59, Tab 103, Email from Patrick Hodgetts to Enzo Camporeale, 22 February 2023 (SCOI.83493).

[3594] Exhibit 59, Tab 103, Email from Patrick Hodgetts to Enzo Camporeale, 22 February 2023 (SCOI.83493).

5.4048. Upon its own review of the NSWPF records produced, the Inquiry established that an extendable baton was purchased by the NSWPF, and provided to Dr Schwartz sometime between April 1996 and June 1997, to enable her to consider whether such a baton could have caused Mr Dye's injuries.[3595]

5.4049. In circumstances where other NSWPF records indicate that the blunt instrument that caused Mr Dye's death was "never located"[3596] the Inquiry considered it likely that the extendable baton described by the NSWPF as "exhibit number X0001547254" was the one later purchased by the NSWPF for the purpose of obtaining the views of Dr Schwartz.

5.4050. In March 2023, the NSWPF acknowledged that this was a reasonable inference.[3597]

5.4051. In his oral evidence on 5 July 2023, Detective Inspector Warren accepted it was not consistent with proper police practices at the time for the extendable baton to have been stored and classified as a potential murder weapon.[3598]

Fingerprints

5.4052. On 30 May 2023, the Inquiry wrote to the NSWPF asking whether the steps in relation to fingerprints identified in the 2005 UHT review and the 2019 UHT triage had been taken. Specifically, the Inquiry requested the NSWPF to:

a. Advise whether any outstanding fingerprints in relation to the death of Mr Dye have been included on NAFIS; and

b. Advise whether the NSWPF possessed any records about which specific exhibits the fingerprints were located on.[3599]

5.4053. In the Nance Statement, the NSWPF indicated that it had a fingerprint exhibit entry, "exhibit C161666" for "Crispin DYE's wallet and its contents".[3600] This is the same exhibit that is described in the 2005 UHT review as "[i]tems from deceased's wallet and items belonging to [NP221]".[3601]

5.4054. According to that exhibit entry, ten fingerprints were developed from these items, but the NSWPF has been unable to find any results from the developed fingerprints nor any photographic negatives of this examination.[3602]

[3595] Exhibit 59, Tab 75, NSWPF Memorandum, 'Memorandum of W. Popplewell: Request for Payment to be Met for the Purchase of a Telescopic Baton from Wellington Surplus Stores, Perth', 17 April 1997 (SCOI.10178.00033); Exhibit 59, Tab 12, Letter from Dr Liliana Schwartz to Detective Sergeant Popplewell, 7 July 1997, 2 (SCOI.10178.00002).

[3596] Exhibit 59, Tab 91, NSWPF Review of an Unsolved Homicide Case Screening Form - Crispin Wilson Dye, 25 May 2005, 4 (SCOI.03268); see also Exhibit 59, Tab 77, NSWPF 'To-do list', undated (SCOI.10303.00009).

[3597] Exhibit 59, Tab 104, Letter from Enzo Camporeale to Katherine Garaty, 10 March 2023 (SCOI.83489); Exhibit 59, Tab 105, Email from Patrick Hodgetts to Enzo Camporeale, 13 March 2023 (SCOI.83517); and Exhibit 59, Tab 108, Email from Patrick Hodgetts to Enzo Camporeale, 17 March 2023 (SCOI.83473).

[3598] Transcript of the Inquiry, 5 July 2023, T5003.7–33 (TRA.00073.00001).

[3599] Exhibit 59, Tab 115F, Letter from Enzo Camporeale to Patrick Hodgetts, 30 May 2023 (SCOI.84022).

[3600] Exhibit 59, Tab 125, Statement of Detective Sergeant John Nance, 12 June 2023, [6] (NPL.0100.0019.0001).

[3601] Exhibit 59, Tab 91, NSWPF Review of an Unsolved Homicide Case Screening Form - Crispin Wilson Dye, 25 May 2005 (SCOI.03268).

[3602] Exhibit 59, Tab 125, Statement of Detective Sergeant John Nance, 12 June 2023, [6] (NPL.0100.0019.0001).

5.4055. In any event, it seems likely that the wallet described in the Nance Statement as "Crispin DYE's wallet", was not Mr Dye's wallet at all. Rather, it was a wallet belonging to NP221, and the only item in it which had been Mr Dye's was the Metway card.

Witness statements

Richard Cobden SC

5.4056. On 13 December 2022, Inquiry staff held a conference with Richard Cobden SC. In a statement subsequently prepared for the Inquiry, Mr Cobden SC said that he was a close friend of Mr Dye during the period 1972-1977 and that:[3603]

> *[m]y recollection, assisted by the diary entries I made around this time, was that Crispin was openly gay in his social circle. He went regularly to exclusively gay venues. He may not have come out to his family, or in some of his working environments, but that was very common at the time.*

5.4057. Mr Cobden SC believed Mr Dye had been in the Oxford Street area to visit gay venues and had been targeted because of this.

Garry Hook and Steven Hodges

5.4058. On 15 February 2023, the Inquiry identified a "Garry Hook" who was recorded as living at an address in Earlwood which matched the phone number contained on the yellow post-it note.

5.4059. On 23 March 2023, Mr Hook and his partner, Steven Hodges, attended a conference with Inquiry staff.

5.4060. On 30 March 2023, Mr Hook provided a statement to the Inquiry.[3604] The statement included information about interactions with Mr Dye in December 1993, how Mr Hook's name and telephone number were on a post-it note in Mr Dye's pocket, Mr Dye's sexuality, and the venues Mr Dye frequented.

5.4061. Mr Hook said that neither he nor Mr Hodges had ever been contacted by the NSWPF in relation to the investigation into Mr Dye's death. He said "I had not seen and at no time was I made aware of the yellow post-it note with my name and number on it until 23 March 2023 when it was shown to me by Inquiry staff."[3605]

5.4062. Mr Hook said that he believed that Mr Dye was either gay or bisexual, but that Mr Dye was not out. He stated that while Mr Dye was gay, he did not necessarily frequent the "gay scene".[3606] He was aware that Mr Dye had told his mother he was gay in his trip to Sydney in December 1993, before he died.[3607]

[3603] Exhibit 59, Tab 120, Statement of Richard Cobden SC, 26 May 2023, [8] (SCOI.83496).

[3604] Exhibit 59, Tab 118, Statement of Garry Hook, 30 May 2023, (SCOI.83472).

[3605] Exhibit 59, Tab 118, Statement of Garry Hook, 30 May 2023, [18]–[19] (SCOI.83472).

[3606] Exhibit 59, Tab 118, Statement of Garry Hook, 30 May 2023, [17] (SCOI.83472).

[3607] Exhibit 59, Tab 118, Statement of Garry Hook, 30 May 2023, [16] (SCOI.83472).

Colin Copnell

5.4063. On 11 April 2023, the Inquiry conferred with Colin Copnell. On 19 May 2023, Mr Copnell provided a statement to the Inquiry.[3608]

5.4064. Mr Copnell had known Mr Dye since approximately 1973. He said that he knew Mr Dye had relationships with men but may have also had relationships with women. He also stated:[3609]

> *Crispin was not "obviously" gay and he kept his sexuality low-key. I remember that on one occasion I asked Crispin what it was like being gay in the music industry. He replied that 'they didn't know'. On another occasion, Crispin told me that he did not put his real name on his music, because he thought that if someone found out he was gay, they wouldn't buy his music. So as far as I was aware, Crispin was not out to the world at large.*

Colin Dorrington

5.4065. On 28 December 1993, Colin Dorrington, a friend of Mr Dye's, contacted police and said that Mr Dye had come to his work address ten days previously, when he arrived in Sydney from Cairns.[3610] Mr Dorrington said that Mr Dye told him that he had been to his mother's place and "informed her about his being homosexual", that his mother had not taken the news well, that Mr Dye had asked if he could stay at Mr Dorrington's home, and that "not long after this" Mr Dye and his mother spoke on the telephone and Mr Dye was invited back home.[3611]

5.4066. On 22 May 2023, Inquiry staff spoke with Mr Dorrington. Mr Dorrington confirmed that, in his view, Mr Dye was gay, that he was unaware of Mr Dye having any relationships with women,[3612] and that Mr Dye had come out to his mother on his trip to Sydney in December 1993. Mr Dorrington also confirmed various aspects of Mr Dye's movements in December 1993, as well as the account of relevant events that he had provided to NSWPF on 28 December 1993.[3613]

Contact with OICs

5.4067. On 25 September 2023 and 16 October 2023, the Inquiry wrote to former Detective Sergeant Knight, former Detective Sergeant Popplewell and Detective Senior Constable Waterman enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Dye.[3614]

5.4068. The Inquiry did not receive a response from former Detective Sergeant Popplewell and Detective Senior Constable Waterman.

[3608] Exhibit 59, Tab 119, Statement of Colin Copnell, 19 May 2023 (SCOI.83522).

[3609] Exhibit 59, Tab 119, Statement of Colin Copnell, 19 May 2023 (SCOI.83522).

[3610] Exhibit 59, Tab 58, NSWPF Running Sheet, 'Information from Dorrington Re Movements of Dye Prior to 23.12.93', 3 January 1994 (SCOI.10356.00215).

[3611] Exhibit 59, Tab 58, NSWPF Running Sheet, 'Information from Dorrington Re Movements of Dye Prior to 23.12.93', 3 January 1994 (SCOI.10356.00215).

[3612] Exhibit 59, Tab 121, Statement of Jacqueline Krynda, 18 June 2023, [21] (SCOI.83525).

[3613] Exhibit 59, Tab 121, Statement of Jacqueline Krynda, 18 June 2023, [21] (SCOI.83525).

[3614] Exhibit 66, Tabs 30, 32, 34, 36, 37, Letters to Geoffrey Knight, Wayne Popplewell and Andrew Waterman (SCOI.86188; SCOI.86295; SCOI.86189; SCOI.86191; SCOI.86187; SCOI.86190).

5.4069. The Inquiry received a short submission from Detective Sergeant Knight.[3615]

Contact with next of kin of NP252

5.4070. In light of the evidence before the Inquiry as to the potential involvement of NP252 in Mr Dye's death, and the possibility that Counsel Assisting may make submissions to that effect, the Inquiry wrote to NP252's siblings. By that correspondence, the Inquiry advised of the date of the public hearing and provided a timeframe for those persons to contact the Inquiry to provide information and/or make submissions. The Inquiry did not receive a response.[3616]

Other

5.4071. On 2 November 2022, Clem Van Der Weegen contacted the Inquiry. He had been the NSWPF coronial advocate in the second day of the coronial hearing into Mr Dye's death on 8 August 1995.

5.4072. On 8 November 2022, Inquiry staff spoke to Mr Van Der Weegen about the evidence given at the inquest by NP128.[3617] His account was consistent with the transcript of the inquest.

Profile of Little Oxford Street

5.4073. On 28 April 2023, the Inquiry issued a summons to the NSWPF (Summons NSWPF95) for information relating to "offences against the person" that had occurred in the Little Oxford Street area in Darlinghurst during the period from July 1993 to July 1994.

5.4074. On receipt of the material provided, Inquiry staff built a profile of recorded assaults in the area alongside other assaults recorded in NSWPF holdings.[3618]

Consideration of the evidence

13–22 December 1993

5.4075. On 13 December 1993, Mr Dye travelled to Sydney from his home in Cairns, to visit his mother and his friends for the holiday season.[3619]

5.4076. Mr Dye was a musician, the former manager of the Australian rock band AC/DC, and had also previously worked with The Easybeats and Rose Tattoo.[3620] Shortly before his death, Mr Dye had released his debut solo album, *A Heart Like Mine,* using the stage name "Cris Kemp".[3621]

[3615] Submission of former Detective Sergeant Geoffrey Knight, undated (SCOI.86192).

[3616] Exhibit 68, Tabs 6-9, Letters from the Inquiry, 21 August 2023 (SCOI.86648; SCOI.86649; SCOI.86650; SCOI.68851).

[3617] Exhibit 59, Tab 121, Statement of Jacqueline Krynda, 18 June 2023, [16]–[17] (SCOI.83525).

[3618] See Annexure A to Exhibit 59, Tab 121, Statement of Jacqueline Krynda, 18 June 2023 (SCOI.83525).

[3619] Exhibit 59, Tab 62, Police Notebook of Detective Sergeant Knight, 8 February 1994, 38 (SCOI.10166.00001); Exhibit 59, Tab 21, Statement of Brenton Wilson Dye, 8 August 1995, [4] (SCOI.10274.00035).

[3620] Exhibit 59, Tab 56, Rick Feneley and Megan Levy, '$100,000 reward to find killers of AC/DC manager Crispin Dye', *Sydney Morning Herald* (13 August 2014) (SCOI.83514).

[3621] Exhibit 59, Tab 52, Fred Pawle, 'Stars of Rock Mourn a Mate' *Daily Telegraph* (31 December 1993) (SCOI.10302.00015).

5.4077. On 22 December 1993, the day before Mr Dye was attacked, Mr Dye made a withdrawal of $20 at the Illawarra Mutual Building Society at Chatswood through an ATM, and another withdrawal on the same date of $50 at an Advance Bank ATM in Paddington.[3622] Little else is known about his movements over the course of the day on 22 December 1993. Mr Dye may have met Mr Hook and Mr Hodges for drinks at some time that afternoon.[3623] At around 5:00pm, he called Mr Dorrington to "try and arrange to go out for drinks but finally no arrangements were made".[3624]

5.4078. According to an article published in the *Sydney Morning Herald* on 28 December 1993, Mr Dye rang his mother at around 6:30pm on 22 December 1993 and informed her that "he was going to spend the night on the town with friends".[3625]

22–23 December 1993

5.4079. Between 6:00pm and 7:00pm on 22 December 1993, Mr Dye attended the Bellevue Hotel at 159 Hargrave Street, Paddington.[3626] There he met a friend and former employee, William MacAlister, and they had dinner and a few drinks.[3627]

5.4080. Before leaving the Bellevue Hotel, Mr Dye spoke with a waiter at the Bellevue Hotel, Michael Travinski about "meeting up…later on up at Oxford Street" because Mr Travinski and Peter Snelling, the Assistant Manager at the Bellevue Hotel and a friend of Mr Dye's, were going out after work.[3628]

5.4081. At around 8:10pm,[3629] William MacAlister and Mr Dye went to the Paddington Inn on Oxford Street, Paddington, where they met up with some acquaintances, "Jane Wilkinson", "Hamish" and William MacAlister's cousin, James MacAlister.[3630] William MacAlister also described a person called "Michael Shaw" as being in the company of Mr Dye that evening.[3631] At the Paddington Inn, William MacAlister and Mr Dye consumed a number of drinks. Mr Dye was observed to have coffee, two schooners of beer, a glass of champagne and a glass of water.[3632]

[3622] Exhibit 59, Tab 47A, Statement of Jacqueline Dunn, 20 January 1994, [6] (SCOI.10274.00050).

[3623] Exhibit 59, Tab 118, Statement of Garry Hook, 30 May 2023, [12] (SCOI.83472).

[3624] Exhibit 59, Tab 58, NSWPF Running Sheet, 'Information from Dorrington Re Movement of Dye Prior to 23.12.93', 3 January 1994 (SCOI.10356.00215).

[3625] Exhibit 59, Tab 51, Mark Riley, 'Thugs Beat Ex-AC/DC Manager to Death', *Sydney Morning Herald* (28 December 1993) (SCOI.10273.00027).

[3626] Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [6.1]–[6.10] (SCOI.10179.00011); Exhibit 59, Tab 24, Handwritten Statement of William James Richard McAlister, 24 December 1993 (SCOI.10274.00010).

[3627] Exhibit 59, Tab 24, Handwritten Statement of William James Richard McAlister, 24 December 1993 (SCOI.10274.00010).

[3628] Exhibit 59, Tab 23, Statement of Michael Richard Travinski, 30 December 1993, [5] (SCOI.10356.00201).

[3629] Exhibit 59, Tab 24, Handwritten Statement of William James Richard McAlister, 24 December 1993 (SCOI.10274.00010).

[3630] Exhibit 59, Tab 22, Statement of James Keith MacAlister, 23 December 1993, [4]–[5] (SCOI.10274.00045).

[3631] NSWPF Running Sheet, 'Information obtained from William MacAlister', 1 January 1994 (SCOI.10356.00218).

[3632] Exhibit 59, Tab 60, NSWPF Running Sheet, 'Movements of Crispin Wilson Dye for Evening of 22/12/1993 to 23/12/1993', 2 January 1994, 1 (SCOI.10356.00194).

5.4082. At around 10:00pm (though possibly as late as 10:30pm),[3633] Mr Dye left the Paddington Inn alone (the group of people he was with remaining behind) and went to Gilligan's, a bar above the Oxford Hotel which was on the north-western corner of Oxford and Bourke Streets, Darlinghurst. According to James MacAlister and a NSWPF running sheet, the group from the Paddington Inn (now accompanied by James MacAlister's girlfriend "Joe") also joined Mr Dye at Gilligan's at around 10:30pm.[3634]

5.4083. However, the evidence as to when Mr Dye left the Paddington Inn and when his friends joined him at Gilligan's is not altogether consistent. William McAlister said that Mr Dye left to go to Gilligan's bar "at about 10:00pm, maybe a bit later".[3635] He also said that he, James, Jane, and Hamish did not leave to go to Gilligan's Bar until "midnight".[3636]

5.4084. This discrepancy may be significant, depending on the view taken of the evidence of Mr Paige that he met Mr Dye at some time between 11:30pm and 12:30pm "a few days before Christmas" at the Bodyline Sauna on Taylor Street, Darlinghurst.[3637]

5.4085. One possibility is that that was the night of the attack, being the night of 22/23 December. However, Mr Paige's recollection was that Mr Dye was "quite lucid" during that encounter,[3638] which may not be consistent with the evidence as to Mr Dye having consumed several alcoholic drinks by the time he left the Paddington Inn. In addition, Mr Paige's recollection, on 24 December, was that he had met Mr Dye "a few days ago", which seems unlikely to have been in the early hours of the day before.

5.4086. Once at Gilligan's, the NSWPF running sheet records that Mr Dye was observed talking to an "effeminate male" at the bar, and later "another five males at the bar".[3639] He was seen consuming more beer and wine, as well as iced water between alcoholic drinks.[3640] He also went "downstairs alone to the Oxford Tavern, which [was] a known 'gay' bar".[3641]

[3633] Exhibit 59, Tab 22, Statement of James Keith MacAlister, 23 December 1993, [7] (SCOI.10274.00045).

[3634] Exhibit 59, Tab 22, Statement of James Keith MacAlister, 23 December 1993, [8] (SCOI.10274.00045); Exhibit 59, Tab 60, NSWPF Running Sheet, 'Movements of Crispin Wilson Dye for Evening of 22/12/1993 to 23/12/1993', 2 January 1994, 1 (SCOI.10356.00194).

[3635] Exhibit 59, Tab 24, Handwritten Statement of William James Richard McAlister, 24 December 1993, 2 (SCOI.10274.00010).

[3636] Exhibit 59, Tab 24, Handwritten Statement of William James Richard McAlister, 24 December 1993, 2 (SCOI.10274.00010).

[3637] Exhibit 59, Tab 129, Statement of Alexander Paige, 11 August 2023, [3] (SCOI.84925).

[3638] Exhibit 59, Tab 129, Statement of Alexander Paige, 11 August 2023, [9] (SCOI.84925).

[3639] Exhibit 59, Tab 60, NSWPF Running Sheet, 'Movements of Crispin Wilson Dye for Evening of 22/12/1993 to 23/12/1993', 2 January 1994, 1 (SCOI.10356.00194).

[3640] Exhibit 59, Tab 60, NSWPF Running Sheet, 'Movements of Crispin Wilson Dye for Evening of 22/12/1993 to 23/12/1993', 2 January 1994, 1 (SCOI.10356.00194).

[3641] Exhibit 59, Tab 60, NSWPF Running Sheet, 'Movements of Crispin Wilson Dye for Evening of 22/12/1993 to 23/12/1993', 2 January 1994, 1 (SCOI.10356.00194); Exhibit 59, Tab 24, Handwritten Statement of William James Richard McAlister, 24 December 1993, 2 (SCOI.10274.00010).

5.4087. At around 1:00am on 23 December 1993, William MacAlister, James MacAlister, Hamish, Jan Wilkinson, and possibly Joe, left Gilligan's to go to the Courthouse Hotel, at 189 Oxford Street, Darlinghurst, directly opposite Gilligan's on the south-western corner of the intersection.[3642] Mr Dye remained behind at the Oxford Hotel, where he was seen to have a black or brown leather wallet with money in it, Country Road glasses and various CDs.[3643]

5.4088. At around 2:30am, William MacAlister left the Courthouse Hotel and went home with Ms Wilkinson.[3644] At around 3:00am, James MacAlister also left the Courthouse Hotel, walking down Oxford Street to the Exchange Hotel, where his girlfriend was.[3645]

5.4089. At around 2:15am, Mr Snelling and Mr Travinski met Mr Dye outside the Oxford Hotel.[3646] Mr Travinski observed him at that time to be "extremely drunk, he was staggering" but in a "very happy, swaggery mood".[3647] Mr Snelling invited Mr Dye to join them at the Flinders Hotel, in Flinders Street, Darlinghurst, to play pool.

5.4090. Mr Dye, Mr Snelling and Mr Travinski then went to the Flinders Hotel together and consumed more beer and played some pool. Mr Dye was moving between the poolroom and the bar.[3648]

5.4091. At around 2:30am, James Hillman, a bartender at the Flinders Hotel, saw Mr Dye at the bar of the Flinders Hotel for around 10 to 15 minutes. Mr Hillman recalled that Mr Dye was well affected by alcohol, talking loudly and "shouting nonsense".[3649] He had the impression that Mr Dye was "looking for male company" in the hotel, although Mr Hillman did not see him speak to anyone in the bar.[3650]

5.4092. At around 2:45am, Mr Hillman saw Mr Dye leave the Flinders Hotel, turning left out the front door into Flinders Street.[3651] Mr Hillman observed that Mr Dye's friends left the Flinders Hotel about ten minutes after Mr Dye. At around 3:15am, Mr Hillman left the Flinders Hotel himself and went to a nearby café to get something to eat.

[3642] Exhibit 59, Tab 24, Handwritten Statement of William James Richard McAlister, 24 December 1993 (SCOI.10274.00010).

[3643] Exhibit 59, Tab 60, NSWPF Running Sheet, 'Movements of Crispin Wilson Dye for Evening of 22/12/1993 to 23/12/1993', 2 January 1994, 1 (SCOI.10356.00194).

[3644] Exhibit 59, Tab 24, Handwritten Statement of William James Richard McAlister, 24 December 1993, 2 (SCOI.10274.00010).

[3645] Exhibit 59, Tab 22, Statement of James Keith MacAlister, 23 December 1993, [12] (SCOI.10274.00045); Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [6.5] (SCOI.10179.00011).

[3646] Exhibit 59, Tab 28, Statement of Peter Edward Snelling, 29 December 1993, [6]–[7] (SCOI.10356.00199); Exhibit 59, Tab 60, NSWPF Running Sheet, 'Movements of Crispin Wilson Dye for Evening of 22/12/1993 to 23/12/1993', 2 January 1994, 1 (SCOI.10356.00194).

[3647] Exhibit 59, Tab 23, Statement of Michael Richard Travinski, 30 December 1993, [7] (SCOI.10274.00013).

[3648] Exhibit 59, Tab 23, Statement of Michael Richard Travinski, 30 December 1993, [7]–[8] (SCOI.10274.00013); Exhibit 59, Tab 28, Statement of Peter Edward Snelling, 29 December 1993, [9] (SCOI.10356.00199).

[3649] Exhibit 59, Tab 23, Statement of Michael Richard Travinski, 30 December 1993, [5]–[8](SCOI.10274.00013).

[3650] Exhibit 59, Tab 29, Statement of James Norman Hillman, 30 December 1993, [9] (SCOI.10301.00016).

[3651] Exhibit 59, Tab 29, Statement of James Norman Hillman, 30 December 1993, [8] (SCOI.10301.00016).

5.4093. At around 3:00am when Mr Snelling and Mr Travinski went to leave the Flinders Hotel, they could not find Mr Dye. Mr Snelling later told Detective Sergeant Knight that Mr Dye "was in and out of the back bar and apparently left at 3:00am" through the front entrance of the Flinders Hotel without saying goodbye.[3652] Mr Travinski and Mr Snelling did not see Mr Dye after around 3:00am.[3653] Mr Travinski described Mr Dye as being "extremely drunk, not at a collapsing stage just really wobbly".[3654]

5.4094. Mr Travinski and Mr Snelling then went to the Exchange Hotel.[3655] Mr Travinski remained at the Exchange Hotel between around 3:30am and 5:30am.[3656] Mr Snelling left at around 4:00am.[3657] At the inquest into Mr Dye's death, Mr Snelling explained that what he meant in his statement when he described Mr Dye as "street wise", was that "[h]e knew the area very well and we quite often drank late at night and we were always very aware of the dangers of that area late at night".[3658]

5.4095. At around 4:00am, Mr Dye attempted to purchase a drink at the Courthouse Hotel. Jeremy Larkins, the Assistant Manager, refused service to Mr Dye due to his level of intoxication, apparently having "wet his pants".[3659] At the inquest, he described Mr Dye's level of intoxication as "[c]omplete lack of motor co-ordination, very – I don't know the word to describe it, he wasn't very lucid and just his general motions and body language was that of someone who was intoxicated".[3660] According to Mr Larkins, when he refused service, Mr Dye did not become agitated but rather "took a deep breath and soughta [sic] worked out where he had to go and then staggered across the floor".[3661] Mr Dye then exited the hotel, turning left into Oxford Street.[3662]

5.4096. At around 4:00am, Mr Hillman recalled seeing Mr Dye on his own and "walking from the vicinity of the bus stop outside the court, across Oxford Street, towards the opposite corner, to 'Gilligan's Island' [a traffic island] or Café 191".[3663] Mr Hillman observed Mr Dye to be "walking normally, although … obviously intoxicated" and talking to himself.[3664]

[3652] Exhibit 59, Tab 56A, NSWPF Running Sheet, 'Information re Whereabouts of Deceased between 2am and 3am on 23.12.93', 1 January 1994 (SCOI.10356.00191).

[3653] Exhibit 59, Tab 23, Statement of Michael Richard Travinski, 30 December 1993, [9]–[11], [14] (SCOI.10274.00013); Exhibit 59, Tab 28, Statement of Peter Edward Snelling, 29 December 1993, [10]–[12] (SCOI.10274.00044).

[3654] Exhibit 59, Tab 23, Statement of Michael Richard Travinski, 30 December 1993, [14] (SCOI.10274.00013).

[3655] Exhibit 59, Tab 23, Statement of Michael Richard Travinski, 30 December 1993, [11] (SCOI.10274.00013).

[3656] Exhibit 59, Tab 23, Statement of Michael Richard Travinski, 30 December 1993, [12] (SCOI.10274.00013).

[3657] Exhibit 59, Tab 23, Statement of Michael Richard Travinski, 30 December 1993, [12] (SCOI.10274.00013).

[3658] Exhibit 59, Tab 8, Transcript of Coronial Inquest into the death of Crispin Wilson Dye, 8 August 1995, T5.40–47 (SCOI.10303.00139).

[3659] Exhibit 59, Tab 27, Statement of Jeremy Barnabas Larkins, 28 December 1993, [6]–[7] (SCOI.10347.00011).

[3660] Exhibit 59, Tab 8, Transcript of Coronial Inquest into the death of Crispin Wilson Dye, 8 August 1995, T3.10-16 (SCOI.10303.00139).

[3661] Exhibit 59, Tab 27, Statement of Jeremy Barnabas Larkins, 28 December 1993, [8] (SCOI.10347.00011).

[3662] Exhibit 59, Tab 27, Statement of Jeremy Barnabas Larkins, 28 December 1993, [9] (SCOI.10347.00011).

[3663] Exhibit 59, Tab 29, Statement of James Norman Hillman, 30 December 1993, [13] (SCOI.10301.00016).

[3664] Exhibit 59, Tab 29, Statement of James Norman Hillman, 30 December 1993, [13] (SCOI.10301.00016).

5.4097. At about 4:30am, Owen Read, a resident of Albion Street Lodge, Surry Hills, came upon Mr Dye lying on his stomach on the road "in the laneway at the back of Kinselas Nightclub" (i.e. Little Oxford Street, at the intersection with Campbell Street). He bent down and touched him and heard him grunt. He could not see his face or any blood. Mr Read then went to check on his friend "Arron" further up the laneway, but Arron was not there. Mr Read then walked back towards Mr Dye and spoke to the police, who had arrived at the scene by that time.[3665]

5.4098. In the meantime, at around 4:35am, Mr Neilson was driving to work and stopped at a traffic light at the intersection of Campbell Street and Bourke Street. He saw three men on the northern side of Campbell Street near the intersection with Little Oxford Street. He later described them as "Islanders". Mr Neilson said that these men "were standing around what appeared to be a large object which was laying on the ground and were picking it up slightly and moving it around". As Mr Neilson drove away from the lights, going west along Campbell Street, he saw the three men grab something from the object and then run west along Campbell Street on the northern footpath.[3666]

5.4099. As Mr Neilson continued to drive, he realised that the large object was a man lying face down in the street. Mr Neilson then attempted to look for a police station. He drove down Campbell Street and turned north into Crown Street and observed the three men run west into Goulburn Street. Mr Neilson then turned into Oxford Street and again observed the three men, this time walking in a westerly direction along the southern footpath of Oxford Street. He then continued past them and reported the incident at Surry Hills Police Station.[3667] NSWPF officers attended the scene along with paramedics soon thereafter.[3668]

5.4100. A map of the area (as at 1993) where Mr Dye was found and marked with Mr Dye's last known movements in the hours before he was attacked, appears at Annexure A to Counsel Assisting's written submissions.

23-25 December 1993: Mr Dye's medical treatment and death

5.4101. According to NSW Ambulance officer Darren Parker, Mr Dye was found:[3669]

> *…on the northern kerb of Campbell Street. His head was facing an easterly direction with his feet pointed towards a westerly direction. He was in the first lane on the street, perhaps about two feet from the kerb.*

[3665] Exhibit 59, Tab 26, Statement of Owen Read, 26 December 1993, [4]–[5] (SCOI.10274.00020).

[3666] Exhibit 59, Tab 25, Statement of Scott John Neilson, 23 December 1993, [3]–[5] (SCOI.10274.00039).

[3667] Exhibit 59, Tab 25, Statement of Scott John Neilson, 23 December 1993, [5]–[7] (SCOI.10274.00039).

[3668] Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [1.3]–[1.6] (SCOI.10179.00011).

[3669] Exhibit 59, Tab 30, Statement of Darren Andrew Parker, 5 January 1994, [5] (SCOI.10274.00025).

5.4102. Mr Parker observed that Mr Dye had abrasions to his face, blood coming from his nose and a swollen left eye. Mr Dye was in cardiac arrest; he was blue, unconscious, was not breathing and had no cardiac output.[3670] Mr Parker's partner then placed defibrillation pads on Mr Dye's chest, and Mr Parker commenced CPR.[3671] Mr Parker and his partner then began to "treat ventricular fibrillation".[3672] Shortly after 4:50am, Intensive Care Paramedics arrived at the scene and continued treatment.[3673]

5.4103. Mr Dye was transported to St Vincent's Hospital at 5:07am.[3674]

5.4104. Upon arrival at St Vincent's Hospital, Mr Dye was observed to have sustained a massive head injury, brain injury with petechial haemorrhages, facial fracture, cardiac arrest and had a blood alcohol concentration of 0.260g per 100mL.[3675] He required cardiac resuscitation, intubation and ventilation.[3676]

5.4105. At around 1:30pm on 23 December 1993, Mr Dye was transferred to St George Hospital where he received further treatment.[3677]

5.4106. However, his condition deteriorated between 23 and 25 December and life support was ceased on 25 December 1993.[3678] Life was pronounced extinct at 6:30pm on 25 December 1993.[3679]

1993–94: Original NSWPF investigation

Attendance at the crime scene

5.4107. According to the statement of Constable Keith Ridley, after Mr Neilson reported his observations of Mr Dye and the three men to the NSWPF (shortly after 4:35am), Constables Johnson and Luck attended the scene. At the same time, Constable Ridley and Constable Sparkes patrolled the surrounding area, with Mr Neilson, in an attempt to locate the three men whom Mr Neilson had seen. After doing so without success, Constables Ridley and Sparkes returned to Surry Hills Police Station and left Mr Neilson with another police officer, before returning to the crime scene.[3680]

[3670] Exhibit 59, Tab 30, Statement of Darren Andrew Parker, 5 January 1994, [5] (SCOI.10274.00025).

[3671] Exhibit 59, Tab 30, Statement of Darren Andrew Parker, 5 January 1994, [5] (SCOI.10274.00025).

[3672] Exhibit 59, Tab 30, Statement of Darren Andrew Parker, 5 January 1994, [6] (SCOI.10274.00025).

[3673] Exhibit 59, Tab 30, Statement of Darren Andrew Parker, 5 January 1994, [6] (SCOI.10274.00025).

[3674] Exhibit 59, Tab 57, NSWPF Running Sheet, 'Information from St Vincent's Hospital Regarding Admission of Crispin Dye on 23.12.1993', 3 January 1994 (SCOI.10356.00182); Exhibit 59, Tab 87, St Vincent's Hospital Progress Note, 'Accident and Emergency Centre – UNKNOWN, Harry', 23 December 1993 (SCOI.10363.00018).

[3675] Exhibit 59, Tab 31, Statement of Dr Anthony Sherbon, 22 September 1994 (SCOI.10274.00029).

[3676] Exhibit 59, Tab 31, Statement of Dr Anthony Sherbon, 22 September 1994 (SCOI.10274.00029).

[3677] Exhibit 59, Tab 31, Statement of Dr Anthony Sherbon, 22 September 1994 (SCOI.10274.00029); Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [11] (SCOI.10274.00046).

[3678] Exhibit 59, Tab 18, Statement of Constable Mark Patrick Portlock, 9 September 1994 (SCOI.10274.00033); Exhibit 59, Tab 21, Statement of Brenton Wilson Dye, 8 August 1995 (SCOI.10274.00035).

[3679] Exhibit 59, Tab 18, Statement of Constable Mark Patrick Portlock, 9 September 1994, [5] (SCOI.10274.00033).

[3680] Exhibit 59, Tab 19, Statement of Keith Robert Ridley, 12 September 1994, [3]–[5] (SCOI.10274.00023).

5.4108. At around 6:20am, Detective Senior Constable Van Leeuwen attended the crime scene in his capacity as an officer with the East Sydney Crime Scene Unit. Detective Senior Constable Van Leeuwen examined the roadway, took a number of photographs and collected some exhibits. He observed a pool of freshly congealed blood on the roadway and $3.30 in Australian coins near the pool of congealed blood. He collected a swab of blood from the roadway and handed the coins to Constable Johnson, who was present at the scene. At around 8:30am, Detective Senior Constable Van Leeuwen attended St Vincent's Hospital and took photographs of Mr Dye.[3681]

5.4109. At some point after 7:00am, Detective Sergeant Knight and Detective Paul Taylor also examined the crime scene.[3682]

5.4110. At around 9:30am at the Crime Scene Unit, according to Detective Senior Constable Van Leeuwen, he received a number of items of clothing from Detective Taylor of Surry Hills Police Station, including blue denim jeans and a brown belt, a denim shirt, a pair of maroon shoes, a pair of maroon socks and a white t-shirt.

5.4111. Detective Senior Constable Van Leeuwen examined the items of clothing and observed that the jeans and shoes were soiled with faeces and the front of the t-shirt was blood stained. He was unable to locate any shoe prints or other trace evidence on the clothing.[3683]

5.4112. However, according to Detective Sergeant Knight, the clothing was given to Detective Senior Constable Van Leeuwen by St Vincent's Hospital staff, after which he and Detective Taylor returned to Surry Hills to examine Mr Dye's clothing.[3684]

5.4113. On 27 December 1993, Detective Senior Constable Van Leeuwen attended the post-mortem examination and collected a blood sample from Dr Schwartz. Detective Senior Constable Van Leeuwen also received a blood sample of Mr Dye's from Detective McCarthy of Surry Hills Police station.[3685]

5.4114. At around 7:00pm on 27 December 1993, Brenton Dye attended Surry Hills Police Station and collected Mr Dye's keys.[3686]

5.4115. On 29 December 1993, Strike Force Barcoo was established to investigate Mr Dye's death.[3687]

[3681] Exhibit 59, Tab 17, Statement of Detective Senior Constable Lyle William Van Leeuwen, 15 November 1994 [2]–[4] (SCOI.11036.00085).

[3682] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [4] (SCOI.10274.00046).

[3683] Exhibit 59, Tab 17, Statement of Detective Senior Constable Lyle William Van Leeuwen, 15 November 1994, [5] (SCOI.11036.00085).

[3684] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [8]–[9] (SCOI.10274.00046).

[3685] Exhibit 59, Tab 17, Statement of Detective Senior Constable Lyle William Van Leeuwen, 15 November 1994, [6]–[7] (SCOI.11036.00085).

[3686] Exhibit 59, Tab 59, NSWPF Running Sheet, 'Brother of Deceased, Brenton Dye, Taking Possession of Property from Police at Surry Hills', 1 January 1994 (SCOI.10356.00173).

[3687] Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [8.1] (SCOI.10179.00011).

5.4116. That same day, Detective Senior Constable Van Leeuwen accompanied Detective Sergeant Knight to Little Oxford Street, Surry Hills and conducted a number of "presumptive tests" for blood on some stains on the pavement. Those tests gave a "negative indication".[3688]

Interviews with witnesses

5.4117. A number of witnesses told police about various unidentified males and possible suspects seen on the night of Mr Dye's death, as detailed below.

5.4118. At around 3:30am on the same morning that Mr Dye was attacked, 23 December 1993, I116 was attacked and robbed by five men in Brougham Street, near Cowper Wharf Road, in Woolloomooloo.[3689]

5.4119. Shortly before I116 was attacked, in the early morning of 23 December 1993, George Grace and Leah-Jane Cooper were sitting on the McElhone Stairs, which link Brougham Street (near Cowper Wharf Road) with Victoria Street Potts Point. Mr Grace and Ms Cooper saw a group of men walk past and were fearful they were going to be mugged.[3690]

5.4120. Mr Grace later compiled a F.A.C.E image of one of the men, whom he described as:[3691]

> *Islander appearance, 19 to 24 old, 180cm tall, medium muscular build, medium to dark complexion, collar length black hair in dreadlock curley style, wearing; a shirt with a collar, denim baggy jeans, a baseball cap with the peak facing the front with possibly with either a 'Chicago Bulls' or the 'New York Yankees' emblem on it*

5.4121. Mr Grace described a second man as being of Mediterranean appearance, 20 to 24 years old, and 180–185cm tall, with a thin to medium build, olive complexion and short black hair. The second man was wearing semi-baggy blue jeans and brown "dock" shoes. The remaining three men were of similar appearances.[3692]

5.4129. At around 2:30am on 23 December 1993, David Walker, the security guard at the Courthouse Hotel, observed three men walk around the Courthouse Hotel from Oxford Street into Bourke Street. He described all three men as being "17 [years] old, 5'7"-5'8" tall, maoris [sic] or half castes, wearing baggy jeans and baggy shirts, one wearing mustard coloured jeans and a red baseball style cap"[3693] and at about 3:30am he saw them again near the entrance to Kinselas nightclub. Mr Walker later compiled a F.A.C.E image of one of these men.[3694]

[3688] Exhibit 59, Tab 17, Statement of Detective Senior Constable Lyle William Van Leeuwen, 15 November 1994, [8] (SCOI.11036.00085).

[3689] Exhibit 59, Tab 34, Statement of I116, 27 December 1993 (SCOI.10300.00027); Exhibit 59, Tab 86, NSW Ambulance Treatment Report, 23 December 1993 (SCOI.10364.00017); Exhibit 59, Tab 32, Statement of George Norman Grace, 28 December 1993, [3]–[4] (SCOI.10346.00062).

[3690] Exhibit 59, Tab 32, Statement of George Norman Grace, 28 December 1993, [3]–[4] (SCOI.10346.00062).

[3691] Exhibit 59, Tab 32, Statement of George Norman Grace, 28 December 1993, [5] (SCOI.10346.00062).

[3692] Exhibit 59, Tab 32, Statement of George Norman Grace, 28 December 1993, [5]–[7] (SCOI.10346.00062); Exhibit 59, Tab 33, Statement of Leah-Jane Cooper, 28 December 1993 (SCOI.10346.00063).

[3693] Exhibit 59, Tab 60, NSWPF Running Sheet, 'Movements of Crispin Wilson Dye for Evening of 22/12/1993 to 23/12/1993', 2 January 1994, 1 (SCOI.10356.00194).

[3694] Exhibit 59, Tab 22A, Statement of David Anthony Walker, 23 December 1993, [9]–[11] (SCOI.10347.00012); Exhibit 59, Tab 22B, Statement of David Walker, 30 December 1993 (SCOI.10274.00018).

5.4130. Four days earlier, at around 11:00pm on 18 December 1993, Bradley Smith and Keith Laurie had been approached in Little Oxford Street by three men who asked Mr Smith for money and cigarettes. When he refused, the men became threatening, and Mr Smith and Mr Laurie walked away quickly.[3695] Mr Smith later created three F.A.C.E images of the males involved in the confrontation.[3696]

5.4131. On 2 January 1994, a newspaper article containing these images, and also the F.A.C.E image created by the security guard, Mr Walker, were published. Numerous calls were received from members of the public nominating various suspects.[3697]

Mr Dye's keys

5.4132. On 1 January 1994, Brenton Dye attended Surry Hills Police Station to collect Mr Dye's keys, which had been "found on his person upon admission to St. Vincent's Hospital on 23.12.93".[3698]

5.4133. There is no mention of the keys in the statements of investigating officers. Nor is there any indication in the material produced to the Inquiry by the NSWPF that the keys were tested for fingerprints before being returned to Brenton Dye.

5.4134. In his oral evidence during the Investigative Practices Hearing, Detective Inspector Nigel Warren of the Homicide Squad accepted that the failure to have Mr Dye's keys tested for fingerprints was a "significant oversight".[3699]

Two wallets and a package

5.4135. On 9 January 1994, Brenton Dye found a letter at Mr Dye's home in Cairns, indicating that Mr Dye's wallet had been located and was at Cairns Police Station.

5.4136. When the NSWPF made enquiries, they established that this wallet had been found in a street garbage bin in Cairns. A NSWPF running sheet indicated "it is apparent that the deceased had lost the wallet or it had been stolen, and had not recovered it prior to travelling to Sydney".[3700] This wallet contained a driver's licence, a Metway bank card, a Medicare card, business cards and papers. The person who handed in the wallet was never identified.

5.4137. As noted earlier, Brenton Dye believed that when Mr Dye travelled to Sydney in December 1993, he would have had with him a different wallet, namely one that he had given Mr Dye at Christmas 1992.[3701]

[3695] Exhibit 59, Tab 36, Statement of Bradley William Smith, 14 January 1994 (SCOI.10274.00042).

[3696] Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [8.20] (SCOI.10179.00011).

[3697] Exhibit 59, Tab 91, NSWPF Review of an Unsolved Homicide Case Screening Form - Crispin Wilson Dye, 25 May 2005, 10–11 (SCOI.03268).

[3698] Exhibit 59, Tab 59, NSWPF Running Sheet, 'Brother of Deceased, Brenton Dye, Taking Possession of Property from Police at Surry Hills', 1 January 1994 (SCOI.10356.00173).

[3699] Transcript of the Inquiry, 5 July 2023, T5002.20–27 (TRA.00073.00001).

[3700] Exhibit 59, Tab 61, NSWPF Running Sheet, 'Information from Brenton Dye Regarding Wallet of Deceased in Possession of Cairns Police', 10 January 1994 (SCOI.10180.00004).

[3701] Exhibit 59, Tab 61, NSWPF Running Sheet, 'Information from Brenton Dye Regarding Wallet of Deceased in Possession of Cairns Police', 10 January 1994 (SCOI.10180.00004).

5.4138. On 21 January 1994, Brenton Dye went to Mr Dye's home in Cairns again, and located a package in the mailbox which had been sent from Sydney. The package contained a number of cards, including Mr Dye's Frequent Flyer card.[3702]

5.4139. Enquiries revealed that those items had been handed in to offices of Ansett Australia, on the corner of Riley Street and Oxford Street, Surry Hills, on 23 December 1993, and the package had been posted back to Mr Dye's address in Cairns by a staff member of the Ansett Australia office.[3703] No records were kept by Ansett Australia, and none of the staff had a recollection of the property being handed in. Subsequent media appeals failed to provide further information.[3704]

5.4140. It seems that these items were fingerprinted, with a "negative result" as outlined above.

5.4141. On 14 February 1994, Richard Funston, a solicitor at the ICLC in Darlinghurst, was approached at his office by a man who refused to divulge his identity. The man produced a wallet which he said had been taken by him by mistake at a nearby McDonalds.[3705] In his statement, Mr Funston said the following conversation took place:[3706]

> *Unknown male: I don't want to take it down to the station because there is an outstanding traffic warrant for me.*
>
> *Mr Funston: Do you want to give me your personal details?*
>
> *Unknown male: No. Have you heard about the recent big Crispin DYE murder?*
>
> *Mr Funston: Rings a bit of a bell.*
>
> *Unknown male: Because one of the cards has his name on it.*

5.4142. This second wallet was found to contain Mr Dye's Metway Bank ATM card, along with other items not apparently connected with Mr Dye including a Filipino passport in NP221's name, ATM receipts for accounts with St George Bank and Sydney Credit Union, and an Australian Credit Union card in the name of FA.[3707]

5.4143. NSWPF ascertained that NP221 was an employee at McDonalds on Oxford Street and lived in Annandale with his girlfriend, NP222.[3708]

[3702] Exhibit 59, Tab 21, Statement of Brenton Wilson Dye, 8 August 1995, 9 (SCOI.10274.00035).

[3703] Exhibit 59, Tab 70, NSWPF Running Sheet, 'Ansett Frequent Flyer Card and Health Benefits Card Belonging to Dye Handed to the Ansett Travel Office, Oxford & Riley Sts, Darlinghurst', 4 October 1994 (SCOI.10180.00014).

[3704] Exhibit 59, Tab 21, Statement of Brenton Wilson Dye, 8 August 1995 (SCOI.10274.00035); Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [8.31] (SCOI.10179.00011).

[3705] Exhibit 59, Tab 47, Statement of Richard Funston, 15 February 1994 [4] (SCOI.10180.00018).

[3706] Exhibit 59, Tab 47, Statement of Richard Funston, 15 February 1994 [5] (SCOI.10180.00018).

[3707] Exhibit 59, Tab 38, NSWPF Record of Interview, 'Interview with NP221', 5 April 1994, 21 (SCOI.10346.00025).3

[3708] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [64] (SCOI.10274.00046).

5.4144. NP221 was interviewed and stated that prior to Christmas 1993 he had found Mr Dye's ATM card on the corner of Oxford Street and Riley Street, outside the Brighton Hotel. He admitted making no effort to return it to the owner.[3709]

5.4145. NP221 stated that the wallet had previously belonged to a friend of his, I320.[3710]

5.4146. On 5 April 1994, a lawfully obtained listening device was installed at NP221 and NP222's home. A search warrant was also executed at their address on the same day.[3711] Conversations recorded between NP221 and NP222 via the listening device failed to disclose any knowledge of Mr Dye's murder.[3712] Although NP221 did not have an alibi for the early hours of 23 December 1993, he was not investigated any further.[3713]

"Robbie"

5.4147. On 18 May 1994, the Drug Enforcement Agency advised Strike Force Barcoo that a registered informant allegedly had information about Mr Dye's murder. The informant was aware of a young man known as "Robbie", who said he was present near Campbell Street on 23 December 1993 and witnessed several young men assault Mr Dye.[3714]

5.4148. "Robbie" alleged that he knew the identity of at least two of the offenders but had no intention of assisting police.[3715] He told police he believed bikie gangs would be interested in the information due to Mr Dye's ties to AC/DC.[3716] An application was successfully made for a lawfully obtained listening device to be utilised.[3717] On 20 May 1994, in a lawfully recorded meeting, "Robbie" claimed the assault had been committed by a number of males and that he could find out the identity of the offenders from his associates.[3718] He made some allegations that the attack on Mr Dye was motivated by LGBTIQ bias.[3719] However, the NSWPF ultimately formed the view that "Robbie" did not actually possess information about the murder.[3720]

[3709] Exhibit 59, Tab 64, ERISP Synopsis Form, 'Interview with NP221', 5 April 1994, 3 (SCOI.10274.00056); Exhibit 59, Tab 38, NSWPF Record of Interview, 'Interview with NP221', 5 April 1994, 19-20, 51 (SCOI.10346.00025).

[3710] Exhibit 59, Tab 38, NSWPF Record of Interview, 'Interview with NP221', 5 April 1994, 14 (SCOI.10346.00025).

[3711] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [66]–[68] (SCOI.10274.00046).

[3712] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [72] (SCOI.10274.00046).

[3713] Exhibit 59, Tab 46, Statement of NP224, 7 April 1994, [8] (SCOI.10180.00081); Exhibit 59, Tab 38, NSWPF Record of Interview, 'Interview with NP221', 5 April 1994, 52, Q462-A464 (SCOI.10346.00025).

[3714] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [76] (SCOI.10274.00046).

[3715] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [77] (SCOI.10274.00046).

[3716] Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [10.3] (SCOI.10179.00011).

[3717] Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [10.2] (SCOI.10179.00011).

[3718] Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [10.4] (SCOI.10179.00011); Exhibit 59, Tab 66A, NSWPF Transcript of Listening Device Material, 'Operation Barcoo, Listening Device Material of Informant "Robbie"', 20 May 1994, 5 (SCOI.10180.00095).

[3719] Exhibit 59, Tab 66A, NSWPF Transcript of Listening Device Material, 'Operation Barcoo, Listening Device Material of Informant "Robbie"', 20 May 1994, 2 (SCOI.10180.00095).

[3720] Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [10.4] (SCOI.10179.00011).

NP128

5.4149. NP128 was nominated by several people as being similar to the F.A.C.E image created by Mr Grace, discussed above.[3721]

5.4150. On 14 June 1994, NP128 was arrested in Kempsey on unrelated matters, and interviewed. He denied any involvement in robbing I116 (in Brougham Street Woolloomooloo) but admitted to being in the vicinity around that time.[3722]

5.4151. In this initial interview he admitted to witnessing the assault on Mr Dye. He said he was present with a friend, I327, and "some Redfern fellas".[3723] He indicated that Mr Dye's assault had taken place in Little Oxford Street, without being first told this by police.[3724] During this interview, NP128 recounted an accurate timing of the incident and stated he was able to remember it because he had travelled from Sydney to Moree the day before Christmas.[3725]

5.4152. NP128 stated that he had been walking up Oxford Street and then back down Little Oxford Street when he saw a group of five youths punching a man. He and I327 then ran in separate directions. NP128 ran down Bourke Street to I327's house to smoke marijuana until dawn, when NP128 went home to Bondi.[3726]

5.4153. It appears that I327 was staying with family in Woolloomooloo at the time of Mr Dye's death.[3727] I327 died on 11 March 1994.[3728]

5.4154. On 15 June 1994 (the following day), Strike Force Barcoo detectives travelled to Kempsey and interviewed NP128. During this second interview, NP128 gave a different account. He said that he was not present in Sydney on 23 December 1993. He stated that he had travelled to Moree by train sometime between 5 and 20 December 1993, and arrived at the home of his aunt, I324.[3729]

5.4155. On 6 July 1994, however, when interviewed by Strike Force Barcoo officers again, NP128 gave a different account again. He maintained that he was not present in Sydney on 23 December 1993, and that what he had been talking about was a completely different incident.[3730] NP128 now said he had travelled from Sydney to Moree sometime in "mid-December" prior to 20 December 1993.[3731]

5.4156. In the course of June and July 1994, NP128's family and friends provided an assortment of suggested alibis, including the following:

[3721] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [84] (SCOI.10274.00046).

[3722] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [84] (SCOI.10274.00046).

[3723] Exhibit 59, Tab 20, Statement of Constable Brett Minmaw, 15 June 1994, [28] (SCOI.10348.00004).

[3724] Exhibit 59, Tab 67, NSWPF Record of Interview, 'Interview with NP128', 14 June 1994, Q30–A31 (SCOI.10348.00007); Exhibit 59, Tab 20, Statement of Constable Brett Minmaw, 15 June 1994, [30] (SCOI.10348.00004).

[3725] Exhibit 59, Tab 67, NSWPF Record of Interview, 'Interview with NP128', 14 June 1994, Q26–A30 (SCOI.10348.00007).

[3726] Exhibit 59, Tab 67, NSWPF Record of Interview, 'Interview with NP128', 14 June 1994, Q218-A220 (SCOI.10348.00007); Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [86]–[87] (SCOI.10274.00046).

[3727] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [87] (SCOI.10274.00046); Exhibit 59, Tab 67, NSWPF Record of Interview, 'Interview with NP128', 14 June 1994, Q31-A31, Q113-A115 (SCOI.10348.00007).

[3728] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [87] (SCOI.10274.00046).

[3729] Exhibit 59, Tab 68, NSWPF Record of Interview, 'Interview with NP128', 15 June 1994, Q23–A39 (SCOI.10346.00084).

[3730] Exhibit 59, Tab 69, NSWPF Record of Interview, 'Interview with NP128', 6 July 1994, Q19–A27 (SCOI.10346.00083).

[3731] Exhibit 59, Tab 69, NSWPF Record of Interview, 'Interview with NP128', 6 July 1994, Q61–A62 (SCOI.10346.00083).

a. On 15 June 1994, I324 told police that NP128 had arrived at her house sometime in early to mid-December 1993, and then on 5 July 1994 she provided an additional statement after having found a 1993 diary where she recorded NP128's arrival in Moree on 11 December 1993;[3732]

b. On 4 July 1994, NP128's grandfather I321 told police that on 15 December 1993 he withdrew $70 from an ATM to give to his grandson so he could purchase a train ticket to Moree and that he gave this money to NP128, plus an additional $10 for a taxi;[3733]

c. On 6 July 1994, NP128's mother I323 told police that her son arrived in Moree sometime before Christmas and caught a taxi to I324's home, before I324 drove NP128 to where I323 was living in Moree;[3734]

d. On 13 July 1994, I325 (brother of I324's de facto partner I326) claimed that he employed NP128 between 16 December 1993 and 7 January 1994 under a different name. He said that employment declaration forms and other records had been lost or stolen in about January 1994. Cheques in that different name had been cashed at the Moree Services Club, the Moree Hotel and at the ANZ Moree Branch. The signature on the back of one of these cheques appeared to be NP128's (the requirement that a person cashing a cheque sign the back of that cheque being "normal procedure" at one of these venues);[3735]

e. On 14 July 1994, I324's de facto partner, I326, stated that NP128 had been working for his brother I325 under a different name, and had worked with him in the five days prior to and including 24 December 1993, during which time I326 had driven NP128 to and from the cotton fields;[3736] and

f. On 8 September 1994, I70 stated he purchased a train ticket for NP128 under a different name 2-4 weeks before Christmas 1993, because NP128 said he was wanted by police and wanted to leave Sydney.[3737] Enquiries with Redfern Railway Station revealed records of the purchase of a train ticket on 3 December 1993 by someone with that name for $31.[3738]

5.4157. As is apparent, several of these "alibis" are inconsistent with each other.

5.4158. In August 1995, at the inquest into Mr Dye's death, NP128 gave evidence that the version of events he initially provided to police was false. He stated that he had supplied false information as a result of his fear of the interviewing police.[3739]

[3732] Exhibit 59, Tab 41, Statement of I324, 15 June 1994, [5] (SCOI.10348.00015); Exhibit 59, Tab 42, Statement of I324, 5 July 1994, [5] (SCOI.10348.00016).

[3733] Exhibit 59, Tab 40, Statement of I321, 4 July 1994, [14]–[16] (SCOI.10348.00018).

[3734] Exhibit 59, Tab 43, Statement of I323, 6 July 1994, [5]–[6] (SCOI.10348.00020).

[3735] Exhibit 59, Tab 44, Statement of I325, 13 July 1994, [7 –[17] (SCOI.10348.00023).

[3736] Exhibit 59, Tab 45, Statement of I326, 14 July 1994, [5]–[9] (SCOI.10348.00060).

[3737] Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest by Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [12.28]–[12.29] (SCOI.10179.00011).

[3738] Exhibit 59, Tab 49, Statement of David Austin McKeon, 27 July 1995, [8]–[9] (SCOI.10382.00034).

[3739] Exhibit 59, Tab 9, Transcript of Coronial Inquest into the death of Crispin Wilson Dye, 8 August 1994, T8.1-27 (SCOI.10179.00008).

5.4159. At the conclusion of the inquest, State Coroner Hand commented that NP128's alibis were "unbelievable", "had more holes in it than a sieve", and that he did not believe NP128's story but that there was insufficient evidence to tie him to the murder.[3740]

5.4160. In a submission to the Inquiry in October 2023, Detective Sergeant Knight stated that:[3741]

> *I do … remain committed to the belief, as I did at the time, that the young man referred to as [NP128] was responsible, either as the sole offender, as a participant with others, or at the very least a witness with specific knowledge of those responsible for the crime*

NP127

5.4161. On 14 May 1994, police received information that NP127 and NP227 may have knowledge about the attack on Mr Dye.[3742] Associates of NP127 claimed that he had told them he had been involved in assaulting and robbing gay men in the city[3743] and that two males, thought to be NP127 and NP227, had approached a police informant at "The Wall" on Darlinghurst Road, Kings Cross, to obtain some Rohipnol which they intended to use to drug gay men so they could be robbed whilst unconscious.[3744]

5.4162. NSWPF enquiries into NP127 and NP227 established that:[3745]

a. NP227 died of a drug overdose in June 1994; and

b. NP127 was also wanted for interview in relation to the murder of Stephen Seymour in Surry Hills on 16 April 1994.

5.4163. On 1 February 1995, Detective Sergeant Knight travelled to Perth, with police involved in the investigation into the murder of Mr Seymour, to interview NP127. However, after answering some initial questions relating to Mr Seymour, NP127 refused to speak to police any further. He was not asked any questions about the murder of Mr Dye.[3746]

5.4164. Detective Sergeant Knight ultimately concluded that while NP127 bore some physical similarities to the individuals described by witnesses in connection with the attack on Mr Dye, there was insufficient evidence to substantiate the possibility that NP127 and NP227 may have been involved in Mr Dye's murder.[3747]

[3740] Exhibit 59, Tab 8, Transcript of Coronial Inquest into the death of Crispin Wilson Dye, 8 August 1995, T45.45–46.4 (SCOI.10179.00008).

[3741] Submission of former Detective Sergeant Geoffrey Knight, undated (SCOI.86192).

[3742] Exhibit 59, Tab 16, Statement of Detective Sergeant Geoffrey Roy Knight, 26 July 1995, [3]–[5] (SCOI. 11036.00065).

[3743] See statement attributed to I117 at Exhibit 59, Tab 16, Statement of Detective Sergeant Geoffrey Roy Knight, 26 July 1995, [22] (SCOI. 11036.00065).

[3744] Exhibit 59, Tab 66, NSWPF Running Sheet, 'NP127 and NP227 Nominated as Suspects for the Murder of Dye by Informant', 19 May 1994 (SCOI.10180.00083).

[3745] Exhibit 59, Tab 16, Statement of Detective Sergeant Geoffrey Roy Knight, 26 July 1995, [8]–[9] (SCOI.10274.00007).

[3746] Exhibit 59, Tab 16, Statement of Detective Sergeant Geoffrey Roy Knight, 26 July 1995, [11],[31]–[48] (SCOI.10274.00007); see also Exhibit 59, Tab 48, Statement of Detective Sergeant Antonio Polito, 5 June 1995 (SCOI.10300.00107).

[3747] Exhibit 59, Tab 16, Statement of Detective Sergeant Geoffrey Roy Knight, 26 July 1995, [49] (SCOI.10274.00007).

5.4165. NP127 was not called to give evidence at the inquest into Mr Dye's death.

5.4166. As noted above, the hearing of the inquest into Mr Dye's death took place on 7 and 8 August 1995. Strike Force Barcoo was thereafter deactivated.

1996–2001: Further NSWPF investigations

5.4167. In January 1996, I269, an inmate at Long Bay Correctional Centre, contacted police indicating he had information regarding Mr Dye's death. In a statement dated 24 January 1996, I269 said that he had a conversation about the "murder" of Mr Dye with another inmate, Mr Leonard.[3748]

5.4168. At the time, Mr Leonard was on remand for the murders of Steven Dempsey on 4 August 1994 and Ezzedine Bahmad on 18 November 1994. He was later convicted of these murders. In sentencing Mr Leonard for Mr Dempsey's murder, Badgery-Parker J found Mr Leonard had been motivated by LGBTIQ bias.[3749]

5.4169. Between 4 and 8 March 1996, a lawfully obtained listening device was placed inside the cell shared by I269 and Mr Leonard. The device recorded a conversation of 5 March 1996 which included apparent admissions by Mr Leonard that he was responsible for Mr Dye's death. The recorded conversation occurred while Mr Leonard was using a Ouija board. Mr Leonard stated that he killed Mr Dye, and that NP129 was with him at the time. Mr Leonard described "cruisin'" for "whores" around the back of Kings Cross with NP129 while armed with a baton.[3750]

5.4170. Part of Mr Leonard's account was that he had walked up to a man and said, "I don't like faggots. I'm going to kill ya", before hitting the man as hard as he could on the back of the head with his baton.[3751]

5.4171. Mr Leonard said that a few days later, he heard that a man was killed on the same night and looked in the newspaper, television or "something" and became aware of Mr Dye's death. Mr Leonard said that he saw a photo of Mr Dye in a newspaper article and recognised him as the man he had assaulted.[3752]

5.4172. On 15 April 1996, NP129 participated in an electronically recorded interview with police.[3753] He stated that he was present when Mr Leonard assaulted a man in Sydney prior to Christmas 1993 and that Mr Leonard used a telescopic baton to strike the man around six times, after which the man lay bleeding on the ground.

[3748] Exhibit 59, Tab 50, Statement of I269, 24 January 1996 (SCOI.10179.00005).

[3749] Exhibit 59, Tab 88, *R v Leonard*, Remarks on Sentence of Badgery-Parker J, 10 November 1997, 26 (SCOI.02495). In particular, his Honour observed (at 26) that "I am satisfied that the circumstance that the prisoner found that his victim was a homosexual added to the pleasure that the prisoner has evidently derived from committing the offence". Mr Leonard was also described by a psychiatrist as suffering "… from a condition of ego-dystonic homosexuality which Dr. Westmore explained as meaning that he is homosexual in his sexual orientation, but having a great deal of difficulty in accepting and adjusting to that".

[3750] Exhibit 59, Tab 73, NSWPF Transcript of Tape, 'Dye Murder', 7 March 1996, 1 (SCOI.10178.00040).

[3751] Exhibit 59, Tab 73, NSWPF Transcript of Tape, 'Dye Murder', 7 March 1996, 8 (SCOI.10178.00040).

[3752] Exhibit 59, Tab 78, Summary of Investigation into the Murder of Crispin Wilson Dye prepared by Detective Senior Constable Andrew Waterman, 30 November 1999, [2.7] (SCOI.10302.00004).

[3753] Exhibit 59, Tab 65, NSWPF Transcript of Interview, 'Interview with NP129', 15 April 1996 (SCOI.10179.00024).

5.4173. However, NP129 said that this assault had taken place at about 2:00am or 3:00am, in Palmer Street, next to a lane running parallel with William Street. He then accompanied police to Palmer Street (in East Sydney) and indicated an area about 500 metres from the location where Mr Dye was found lying in Campbell Street at around 4:35am on 23 December 1993.[3754]

5.4174. NP129 was also shown a photograph of Mr Dye. he initially indicated he could have been the man Mr Leonard assaulted but later said that Mr Dye's photograph did not strike him as being the same person Mr Leonard assaulted.[3755] NP129 said that he thought Mr Leonard was glorifying himself and that the man he assaulted was not Mr Dye.[3756] NP129 described the victim as drunk or drugged and dishevelled, with short hair and wearing a white t-shirt and light-coloured shorts.[3757] That description does not match Mr Dye's appearance on the night in question.

5.4175. On legal advice, Mr Leonard refused to speak to police in relation to Mr Dye's death.[3758]

5.4176. As a result of Mr Leonard's recorded admissions, NSWPF officers sought clarification on a number of matters:

a. In July 1997, in her "1997 Report" referred to earlier, Dr Schwartz expressed the view that a baton of the kind she was asked to examine was capable of inflicting Mr Dye's injuries. However, she considered that the injuries on the back of Mr Dye's head were less than would be expected, if Mr Leonard's story were to be relied upon; [3759] and

b. In August 1997, Dr Warwick Stening, the consultant neurosurgeon who had treated Mr Dye, provided a written opinion in response to specific questions asked by the NSWPF. He confirmed that Mr Dye had a subarachnoid haemorrhage when entering St Vincent's Hospital on 23 December 1993, and that a CT scan the next day showed diffuse brain swelling indicating a diffuse hypoxic insult. He also offered the opinion that the original head injury might have rendered Mr Dye only temporarily unconscious, or might not have rendered him unconscious at all, with the consequence (if so) that it was possible that he could have moved under his own power for a distance of up to 500 metres, before another process caused the cardiac arrest which resulted in his brain damage.[3760]

[3754] Exhibit 59, Tab 78, Summary of Investigation into the Murder of Crispin Wilson Dye prepared by Detective Senior Constable Andrew Waterman, 30 November 1999, [2.8]–[2.14] (SCOI.10302.00004).

[3755] Exhibit 59, Tab 65, NSWPF Transcript of Interview, 'Interview with NP129', 15 April 1996, 21 (SCOI.10179.00024); Exhibit 59, Tab 78, Summary of Investigation into the Murder of Crispin Wilson Dye prepared by Detective Senior Constable Andrew Waterman, 30 November 1999, [2.15] (SCOI.10302.00004).

[3756] Exhibit 59, Tab 65, NSWPF Transcript of Interview, 'Interview with NP129', 15 April 1996, A238 (SCOI.10179.00024); Exhibit 59, Tab 78, Summary of Investigation into the Murder of Crispin Wilson Dye prepared by Detective Senior Constable Andrew Waterman, 30 November 1999, [2.16] (SCOI.10302.00004).

[3757] Exhibit 59, Tab 65, NSWPF Transcript of Interview, 'Interview with NP129', 15 April 1996, A40, Q57–A57 (SCOI.10179.00024).

[3758] Exhibit 59, Tab 79, Fax from Gary Stewart to Detective Sergeant Popplewell, 24 July 1997 (SCOI.10273.00009); Exhibit 59, Tab 83, Letter from Gary Stewart to Detective Senior Constable Waterman, 7 October 1999 (SCOI.10273.00034).

[3759] Exhibit 59, Tab 12, Letter from Dr Liliana Schwartz to Detective Sergeant Popplewell, 9 July 1997, 2 (SCOI.10178.00002).

[3760] Exhibit 59, Tab 14, Letter from Dr W.A Stening to Detective Sergeant Popplewell, 24 July 1997 (SCOI.10178.00009).

5.4177. However, there were no blood trails located to indicate that Mr Dye was assaulted anywhere other than where he was found.[3761] In my view, on the balance of probabilities, Mr Dye was assaulted where he was found.

5.4178. On 19 August 1998, advice was sought from the ODPP as to whether there were sufficient grounds for laying charges against Mr Leonard.[3762]

5.4179. On 14 December 1998, the ODPP informed the NSWPF that there was sufficient evidence for charges to be laid against Mr Leonard and NP129 in connection with Mr Dye's murder. Recommendations were made that Mr Leonard should be charged with murder and maliciously inflict grievous bodily harm, and NP129 with accessory after the fact to maliciously inflict grievous bodily harm and conceal serious indictable offence.[3763]

5.4180. On 21 January 1999, a further direction was made by the ODPP that the second charge against Mr Leonard should be maliciously inflict grievous bodily harm with intent.[3764]

5.4181. Meanwhile, on 20 January 1999, Strike Force Barcoo was formally reactivated (having been deactivated after the 1995 inquest into Mr Dye's death) to continue the investigation into Mr Dye's murder, under the command of Detective Senior Constable Andrew Waterman from the Homicide Squad, as directed by the ODPP.[3765]

5.4182. According to a summary by Detective Senior Constable Waterman in November 1999, as part of this "continue[d]" investigation "a review of the original investigation was undertaken".[3766] In the course of that review, an assault upon I115 was identified, in Darlinghurst during the early hours of 27 December 1993. The assault had been reported by I115's sister on 29 December 1993. [3767]

5.4183. On 12 January 1994, I115 had provided a statement to police, detailing the assault as follows:[3768]

a. On 26 December 1993, he was drinking beers with a friend in Oxford Street;

b. At around 2:00am on 27 December 1993, he and friends left the Oxford Hotel and went to the Flinders Hotel on Flinders Street, where he had one further beer before walking back to 5/199 William Street where he was staying;

[3761] Exhibit 59, Tab 17, Statement of Detective Senior Constable Lyle William Van Leeuwen, 15 November 1994 (SCOI.11036.00085), especially photographs at 7–11.

[3762] Exhibit 59, Tab 80, Letter from Detective Sergeant Popplewell to Solicitor for Public Prosecutions, 19 August 1998 (SCOI.10179.00016).

[3763] Exhibit 59, Tab 82, Table of Documents from the Office of the Director of Public Prosecutions, 16 June 2023 (SCOI.84018).

[3764] Exhibit 59, Tab 78, Summary of Investigation into the Murder of Crispin Wilson Dye prepared by Detective Senior Constable Andrew Waterman, 30 November 1999, [3.2] (SCOI.10302.00004).

[3765] Exhibit 59, Tab 78, Summary of Investigation into the Murder of Crispin Wilson Dye prepared by Detective Senior Constable Andrew Waterman, 30 November 1999, [3.3] (SCOI.10302.00004); Exhibit 59, Tab 84, NSWPF Submission to the Office of the Director of Public Prosecutions, 30 November 1999 (SCOI.10274.00003).

[3766] Exhibit 59, Tab 78, Summary of Investigation into the Murder of Crispin Wilson Dye prepared by Detective Senior Constable Andrew Waterman, 30 November 1999, [3.4] (SCOI.10302.00004).

[3767] Exhibit 59, Tab 78, Summary of Investigation into the Murder of Crispin Wilson Dye prepared by Detective Senior Constable Andrew Waterman, 30 November 1999, [3.3]–[3.4] (SCOI.10302.00004)

[3768] Exhibit 59, Tab 35, Statement of I115, 12 January 1994, [3]–[5] (SCOI.10273.00014).

c. As he approached St Peters Street, he was struck from behind on the back of his head and he fell to his hands and knees. As he turned his head, he was struck again to the upper side of his head; and

d. I115 believed he was knocked unconscious, and he woke up with a bad pain in his head, and blood on his head and t-shirt.

5.4184. I115 believed he was hit with a steel bar, wooden stick or similar. He said he saw the legs of a second person who was present but was unable to describe him. As a result of the assault, I115 received three cuts to his head which required a total of ten sutures.[3769]

5.4185. I115 was wearing a white cotton sleeveless t-shirt, black cotton shorts, long white socks pushed down, black leather lace up shoes and a black bum bag. Photographs were taken of I115 wearing clothing similar to what he was wearing on the night of the assault.[3770] These were then shown to NP129, who stated that the person Mr Leonard assaulted could have been I115.[3771]

5.4186. On 30 November 1999, this information was supplied to the ODPP.[3772]

5.4187. On 8 February 2001, the ODPP advised that no charges should be laid against Mr Leonard or NP129 in relation to Mr Dye's death.[3773]

5.4188. The investigation into the death of Mr Dye appears to have ceased upon receipt of that advice from the ODPP.

5.4189. Mr Leonard is presently incarcerated and serving two life sentences in relation to the murders of Mr Dempsey and Mr Bahmad.[3774] NP129's whereabouts are known to the Inquiry.

March 1994 interview of Stephen Leonard

5.4190. Among the materials produced by the NSWPF on 21 June 2023, said to be part of the digitised hard copy of the "coronial brief", was a handwritten police notebook.

5.4191. One entry in that notebook, dated 1 March 1994, refers to an interview at Dee Why Police Station on 1 March 1994 with Stephen Leonard, the father of Mr Leonard.[3775]

[3769] Exhibit 59, Tab 35, Statement of I115, 12 January 1994, [6]–[8] (SCOI.10273.00014).

[3770] Exhibit 59, Tab 39, Statement of I115, 27 April 1994, [11]–[12] (SCOI.10273.00015).

[3771] Exhibit 59, Tab 76, NSWPF Transcript of Interview, 'Interview with NP129', 28 July 1999, Q197–A201 (SCOI.10273.00016).

[3772] Exhibit 59, Tab 84, NSWPF Submission to the Office of the Director of Public Prosecutions, 30 November 1999 (SCOI.10274.00003).

[3773] Exhibit 59, Tab 82, Table of Documents from the Office of the Director of Public Prosecutions, 16 June 2023 (SCOI.84018).

[3774] Exhibit 59, Tab 91, NSWPF Review of an Unsolved Homicide Case Screening Form - Crispin Wilson Dye, 25 May 2005, 14 (SCOI.03268).

[3775] Exhibit 59, Tab 146, Police Notebook of Detective Sergeant Mulherin, 1 March 1994, 1 (SCOI.84796).

5.4192. The notebook entry recorded Stephen Leonard as having said, in that 1 March 1994 interview, that his son was "fascinated [by] violent videos" and had been a "difficult child"; that he was "paranoid" that his son might "end up in trouble"; and that his son had been "doing some research" into the murder of Mr Dye. It also records the name "[NP129]"; and the words "Richard copy of Observer Star… Son write reviews for some form of circulation".[3776]

5.4193. A later section of the same notebook appears to refer to conversations between Stephen Leonard and Fred Pratley, a local Baptist Minister, on "Monday 21st" (possibly 21 February or 21 March 1994, each of which was a Monday) and "Wed 23rd" (against which date it is recorded "father phone").[3777] The notes of these conversations referred to Mr Leonard being described as having a "regressive personality" (said to have been known for "3 ½ 4 years") and having a weapon called "Waddy". They also referred to a "6'2 skinhead person on George Street" who was hit three times and "thought dead"; and to an incident on Palmer Street where "use of drug caused him to kill person and got a rush out of it".[3778]

5.4194. An annotated copy of these 1 March 1994 notes was also annexed to a running sheet, which is signed by "GJ Mulherin, Chief of Detectives Rose Bay" and bears the date 12 April 1995 (but possibly created on 12 April 1994, given that the cover page describes it as a "faxed report dated 12/4/1994").[3779]

5.4195. The running sheet recorded that police attached to "[T]ask [F]orce 'Barcoo'" spoke with Stephen Leonard at Dee Why Police Station on 1 March 1994, and that Stephen Leonard had said that his son Richard:

a. Had told him that he had assaulted an unknown man one night in early December 1993 in Palmer Street, Darlinghurst whilst he was "stoned", and that the man subsequently died;[3780]

b. Had also told him that he attacked a "skin head" on George Street in the CBD in mid-November or early December 1993; and

c. "[P]ossessed a cosh style weapon at home he called 'waddy' (looks like a piece of water pipe with a telescopic action)".

5.4196. The running sheet did not mention Stephen Leonard having referred to his son "doing some research" into the murder of Mr Dye.

5.4197. There is no evidence that any formal statement was taken from Stephen Leonard by Strike Force Barcoo, or that Strike Force Barcoo ever followed up on Mr Leonard as a potential person of interest in connection with the death of Mr Dye upon receiving this information from Stephen Leonard in March 1994 (whereas police did so in January 1996 when they received information from I269 that Mr Leonard had admitted to being involved in Mr Dye's death).

[3776] Exhibit 59, Tab 146, Police Notebook of Detective Sergeant Mulherin, 1 March 1994, 1–5, 12 (SCOI.84796).

[3777] Exhibit 59, Tab 146, Police Notebook of Detective Sergeant Mulherin, 1 March 1994, 9–13 (SCOI. 84796).

[3778] Exhibit 59, Tab 146, Police Notebook of Detective Sergeant Mulherin, 1 March 1994, 10–11 (SCOI. 84796).

[3779] Exhibit 59, Tab 147, NSWPF Running Sheet, 12 April 1995 (SCOI.84804).

[3780] Exhibit 59, Tab 147, NSWPF Running Sheet, 12 April 1995 (SCOI.84804).

5.4198. When a reactivated Strike Force Barcoo made an attempt to interview Stephen Leonard again on 21 July 1999, Stephen Leonard stated that he no longer had a clear recollection of the conversations with his son about which he had told Detective Sergeant Mulherin in March 1994.[3781]

5.4199. In Detective Senior Constable Waterman's summary of the (reactivated) Strike Force Barcoo investigation dated 30 November 1999, the interview with Stephen Leonard on 1 March 1994 was not referred to.[3782] Indeed, the section of the summary titled "[I]nvestigation into Richard Leonard and [NP129]" commences in January 1996, in relation to the information from I269 referred to above.[3783]

5.4200. The omission of any reference to the 1 March 1994 interview with Stephen Leonard, in Detective Senior Constable Waterman's 30 November 1999 summary, would appear to suggest that the information provided to Detective Mulherin by Stephen Leonard on 1 March 1994 was never followed up. If not, that is obviously unfortunate. Whether or not that information was followed up at all, prior to Mr Leonard's murder of two men later in 1994, is not apparent, one way or the other, on the material available to the Inquiry.

5.4201. When Mr Leonard later became (again) a person of interest in the death of Mr Dye, following the receipt of information from I269 in January 1996, the information provided by Stephen Leonard in March 1994 does not appear to have been referred to or considered by the reactivated Strike Force Barcoo. The reason for this apparent failure to make this connection is unknown on the material available to the Inquiry.

5.4202. The NSWPF submitted that there was no such failure to make that connection, without (in any way that I can discern) explaining the basis for that assertion. [3784]

2022–2023: This Inquiry

2014 statement of Ms O'Meara

5.4203. On 19 June 2023, as noted above, the NSWPF produced 261 pages of further material in relation to Mr Dye. Among that material was a witness statement obtained by the NSWPF in September 2014 by Janet O'Meara,[3785] who was not mentioned in any documents previously produced to the Inquiry by the NSWPF.

[3781] Exhibit 59, Tab 148, Strike Force Barcoo Progress Report, 17 August 1999 (NPL.0131.0001.1583).

[3782] Exhibit 59, Tab 78, Summary of Investigation into the Murder of Crispin Wilson Dye prepared by Detective Senior Constable Andrew Waterman, 30 November 1999, [3.3] (SCOI.10302.00004).

[3783] Exhibit 59, Tab 148, Strike Force Barcoo Progress Report, 17 August 1999, [2] (NPL.0131.0001.1583).

[3784] Submissions of NSWPF, 5 September 2023, [57]–[60] (SCOI.85433).

[3785] Exhibit 59, Tab 144, Statement of Janet O'Meara, 11 September 2014 (NPL.0131.0001.1643).

5.4204. In her statement, Ms O'Meara said that in 1995 she lived with three women named Kerrie, NP253, and Sharon. She recalled that in around February or March 1995, she was in the dining room with Kerrie and NP253 when they began to discuss the murder of Mr Dye, at which point NP253 said, "I know who did that".[3786] She described NP253 as being in her late twenties or early thirties. Ms O'Meara's statement attached a colour Polaroid photograph of herself with NP253 and Sharon taken around that time.[3787]

5.4205. Nothing in the material produced to the Inquiry by the NSWPF indicates that this line of inquiry was ever pursued by the NSWPF, despite its obvious significance. The Inquiry has established that Ms O'Meara died on 20 November 2020.[3788] The person Ms O'Meara refers to as NP253 has since been identified by the Inquiry, and her whereabouts are known to the Inquiry.

5.4206. I agree with Counsel Assisting that it is of serious concern that a statement of such obvious significance to an investigation into Mr Dye's death not only was never followed up, but was not produced to the Inquiry until more than a year after it was first summoned. The NSWPF, in its submissions, chose not to address either of these concerns at all.

5.4207. The failure to follow up this information in 2014 and the effluxion of time since then, including the death of Ms O'Meara, has reduced the capacity of the Inquiry, or the NSWPF, to test this evidence.

5.4208. The failure to produce this material to the Inquiry in a timely fashion is unfortunately only one of many such shortcomings in the NSWPF's record-keeping practices which have come to light in the course of this Inquiry, both in relation to various individual cases and in the course of the Investigative Practices Hearing. Further detail in this regard is canvassed in **Chapter 8** of this Report.

2023 evidence of Alexander Paige

5.4209. On 20 June 2023, after the Inquiry's consideration of the death of Mr Dye received some publicity, Alexander Paige contacted the Inquiry. Subsequently, on 11 August 2023, he provided a statement to the Inquiry. [3789]

5.4210. Mr Paige said that "a few days" before Christmas in 1993 he attended the Bodyline Sauna on Taylor Street, Darlinghurst. At some time between 11:30pm and 12:30am, he met a man named "Cris".[3790] Cris said he lived outside of Cairns and was visiting Sydney for Christmas.

5.4211. Cris asked for Mr Paige's phone number, and as Mr Paige was staying with his parents over Christmas, Mr Paige provided him with a piece of paper with "Alex (parents)" written on it together with his parents' phone number.[3791]

[3786] Exhibit 59, Tab 144, Statement of Janet O'Meara, 11 September 2014, [7]–[8] (NPL.0131.0001.1643).

[3787] Exhibit 59, Tab 144, Statement of Janet O'Meara, 11 September 2014, [10], [12] (NPL.0131.0001.1643).

[3788] Exhibit 59, Tab 145, Death Certificate of Janet O'Meara, 3 July 2023 (SCOI.84295).

[3789] Exhibit 59, Tab 129, Statement of Alexander Paige, 11 August 2023 (SCOI.84925).

[3790] Exhibit 59, Tab 129, Statement of Alexander Paige, 11 August 2023, [3]–[4] (SCOI.84925).

[3791] Exhibit 59, Tab 129, Statement of Alexander Paige, 11 August 2023, [4] (SCOI.84925).

5.4212. Mr Paige said that on Christmas Eve, police telephoned his parents' phone number and left a number for him to ring. Mr Paige rang the number on that day.

5.4213. A police officer told him that the police were trying to locate the family of a man they believed to be Crispin Dye; and that Mr Dye had been found with a note that said "Alex (parents)" together with his parents' home number. Mr Paige explained that he had met Mr Dye when out drinking in Darlinghurst a few days earlier. That was Mr Paige's only contact with police in relation to Mr Dye's death.[3792]

5.4214. There is no original or copy of the note described by Mr Paige anywhere in the material produced by the NSWPF in relation to Mr Dye. Nor is there any police record of any conversation with Mr Paige.

5.4215. However, the notebook of Detective Sergeant Knight contains an entry dated 10 January 1994 which records:[3793]

> *Spa Bodyline Sauna – G'Sct Brisb Syd*
>
> *Written 'Alex' – [phone number redacted]*
>
> *(Parents)*
>
> *Piano? (Phil PAIGE)*

5.4216. This entry seems very likely to relate to the note described by Mr Paige. No other record relating to the note, or of the circumstances in which the note was found, or of what investigative steps (if any) were taken in relation to it, was produced by the NSWPF.

5.4217. Mr Paige's evidence reveals the existence (as now confirmed by Detective Sergeant Knight's notebook) of yet another note on Mr Dye's person which was not retained by the NSWPF. It was not fingerprinted at the time, and cannot now be subjected to fingerprinting or other forensic testing.

5.4218. Even if (as may be the case) the encounter between Mr Paige and Mr Dye at the Bodyline Sauna did not occur on the same night that Mr Dye was assaulted, this further failure of exhibit retention and management is obviously unsatisfactory.

Police investigation

5.4219. Various troubling aspects of the original investigation, and the submissions of Counsel Assisting and the NSWPF in relation thereto, have been addressed above.

5.4220. In addition, by way of overview and for completeness, I outline below a number of other matters which are also noteworthy and/or of concern.

[3792] Exhibit 59, Tab 129, Statement of Alexander Paige, 11 August 2023, [5]–[7] (SCOI.84925).

[3793] Exhibit 59, Tab 130, Police Notebook of Detective Sergeant Geoffrey Roy Knight, 10 January 1994 (SCOI.84797).

5.4221. First, very few of the available exhibits were tested for fingerprints or sent to FASS for forensic analysis. The only item sent to DAL was Mr Dye's blood sample. None of his clothing, or any of the other exhibits collected, was ever sent to DAL for any form of forensic analysis, either at the time of the initial investigation in 1993–94 or at any subsequent time.

5.4222. It is undoubtedly the case, as Counsel Assisting submitted, that the Inquiry has been hampered in its efforts to conduct forensic testing (notably of Mr Dye's clothes, and of the papers found in 2023 in his shirt pocket) because of the passage of time, nearly 30 years, since Mr Dye's death. These materials have degraded over that time.[3794]

5.4223. Counsel Assisting acknowledged, however, that the same passage of time has also seen the advancement of technology in the recovery of DNA profiles from exhibits. As a consequence, Counsel Assisting also acknowledged that it is not possible to say with certainty that the results of testing such as that arranged by this Inquiry in 2023 would have been better, or different, had such testing occurred earlier, especially in relation to the blood on Mr Dye's jeans.[3795]

5.4224. The NSWPF agreed with that acknowledgement, and added that no analysis has been undertaken "regarding the degradation of the exhibits and items over time relative to the advances in forensic science technologies". [3796]

5.4225. Nevertheless, as Counsel Assisting submitted, it is obviously unfortunate that items that could have been a useful source of fingerprint or other evidence were not located and/or tested by the NSWPF at any time since 1993. It is only this Inquiry, in 2023, which has done so. At the very least, it is possible (although I agree that one cannot say with certainty) that useful DNA results might have been obtained in 2005 (at the time of the UHT review) and/or in 2019 (at the time of the UHT triage), and/or at some point in the 14 years between those two dates.[3797]

5.4226. The NSWPF submitted, generally, that I should be cautious to criticise the NSWPF from the perspective of what is now known about DNA technology and the scientific advances therein, as opposed to "what little was likely to have been known to the investigators" at the time of Mr Dye's death and at various subsequent points in time.[3798]

5.4227. That submission is to some extent a legitimate one in relation to DNA technology, at least as at the time of the initial investigation in 1993-94, for the reasons referred to above.

5.4228. However:

a. It does not apply to the failure to submit relevant items for fingerprint testing; and

[3794] Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 2, 6 (SCOI.84016).

[3795] Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 2, 7-9 (SCOI.84016).

[3796] Submissions of NSWPF, 5 September 2023, [45]–[51] (SCOI.85433).

[3797] Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 7–9 (SCOI.84016).

[3798] Submissions of NSWPF, 5 September 2023, [24]–[31] (SCOI.85433).

b. As to DNA, it applies with less and less force with each succeeding year since 1993–94.

5.4229. In my view, as awareness increased of the developing capacity of DNA testing to yield valuable and reliable forensic results, the NSWPF — particularly a "cold case" unit such as the UHT from its establishment in 2004 onwards — should have proactively sought to ensure that exhibits such as blood-stained clothing were tested at regular intervals. No such system seems ever to have been in place. Indeed on the evidence before the Inquiry, no such system is in place even now.

5.4230. Specifically in relation to Mr Dye's jeans, the NSWPF submitted that it is not clear whether the faeces stain on Mr Dye's jeans was of such a nature as to "mask any potential blood on the jeans", nor whether (even if that were not so) the blood itself might have turned brown in colour and thus have been "masked" in that way. This rather bizarre submission appears to ignore the fact that the purpose of forensic testing typically includes the overcoming of just such possible difficulties so as to enable appropriate distinctions to be made.

5.4231. The NSWPF also submitted that "none of these matters have been explored with investigating officers".[3799]

5.4232. However:

a. It is not clear to me what such "exploration" might have achieved. There is no suggestion, for example, that any individual officer was at fault, or that DNA testing of relevant material was deliberately not sought in 1993-94. The problem is simply that, as a matter of historical fact, the testing was not carried out, either then or at any subsequent time, and that no system seems to have been in place to avoid such an outcome; and

b. As discussed, above, the Inquiry did contact the relevant officers (Detective Sergeant Geoffrey Knight, Detective Sergeant Wayne Popplewell and Detective Senior Constable Waterman), drew their attention to the submissions of Counsel Assisting and of the NSWPF in this matter, and offered them an opportunity to provide a statement or submissions to the Inquiry.[3800] The Inquiry received a short submission from Detective Sergeant Knight (which did not touch on these matters),[3801] but did not receive any response from Detective Sergeant Popplewell or Detective Senior Constable Waterman.[3802]

5.4233. Secondly, Counsel Assisting submitted that police appear not to have followed up at least two pieces of significant information received by them about Mr Dye's death, one in December 1993 and one in March 1994.

[3799] Submissions of NSWPF, 5 September 2023, [33] (SCOI.85433).

[3800] Exhibit 59, Tab 149, Letter from Solicitor Assisting the Inquiry to Geoffrey Knight, 25 September 2023 (SCOI.86188); Exhibit Tab 150, Letter from Solicitor Assisting the Inquiry to Wayne Popplewell, 25 September 2023 (SCOI.86189); Exhibit 59, Tab 151, Letter from Solicitor Assisting the Inquiry to Andrew Waterman, 25 September 2023 (SCOI.86187).

[3801] Submission of former Detective Sergeant Geoffrey Knight, undated (SCOI.86192).

[3802] Exhibit 59, Tab 153, Further letter from Solicitor Assisting the Inquiry to Wayne Popplewell, 16 October 2023 (SCOI.86191); Exhibit 59, Tab 153, Further letter from Solicitor Assisting the Inquiry to Andrew Waterman, 16 October 2023 (SCOI.86190).

5.4234. The first of those concerns Mr Paige. In addition to the failure to retain, or test for fingerprints, the note in Mr Paige's handwriting found in Mr Dye's clothing, police also failed to make any record of having spoken with Mr Paige on Christmas Eve 1993, or to take a statement from him, or otherwise to follow up on what he told them at that time about his encounter with Mr Dye at the Bodyline Sauna shortly before he was killed.

5.4235. The second was that there is no evidence that the police followed up on the information received from Mr Leonard's father, Stephen Leonard, in March 1994, at least insofar as this information was relevant to Mr Dye's case.

5.4236. Counsel Assisting submitted that those two examples appeared to indicate a somewhat desultory, or at least less than rigorous, approach to the initial investigation into Mr Dye's death.

5.4237. In response, the NSWPF again submitted (as to both these examples) that "it is not clear on the material presently available whether or not those enquiries were made", and that "it appears that the police officers involved in those aspects of the case have not been approached by the inquiry regarding whether such steps were taken". [3803]

5.4238. As with similar submissions elsewhere, my view is that where the police records do not contain any indication that steps were taken, in general it is reasonable to conclude that those steps were not taken. In addition, as to the officers in question, as noted above the Inquiry did in fact approach them, and no relevant response was received.

5.4239. As to Mr Paige, the NSWPF also submitted that Mr Paige probably encountered Mr Dye on a night prior to the night he was assaulted.[3804] The implication of the submission seemed to be that, if so, evidence from Mr Paige would have been of little relevance. I do not agree. For one thing, the specific date should have been clarified with Mr Paige, and in any event, evidence as to Mr Dye's movements even in the day or two before his death could have been of investigative significance and should at least have been properly recorded.

5.4240. As to Mr Leonard, the NSWPF also submitted that evidence to a similar effect as that provided by Stephen Leonard was ultimately obtained in 1996 via informants, witnesses, and through the use of listening devices, and the end result was that no charges were laid against Mr Leonard in connection with Mr Dye's death.[3805]

[3803] Submissions of NSWPF, 5 September 2023, [54], [58] (SCOI.85433).

[3804] Submission of NSWPF, 5 September 2023, [56] (SCOI.85433).

[3805] Submission of NSWPF, 5 September 2023, [59]–[60] (SCOI.85433).

5.4241. That submission misses the point. The information provided by Stephen Leonard in March 1994 was obviously of potential relevance to the 1993-94 police investigation into the death of Mr Dye, but was not followed up at the time, as it should have been. As it happens, by the time similar information came to light in 1996, and was followed up (leading to Mr Leonard's being discounted as a person of interest in the death of Mr Dye), Mr Leonard had killed two other men, later in 1994.[3806]

5.4242. Thirdly, the NSWPF submitted that the initial investigation into Mr Dye's death was "extensive",[3807] that State Coroner Hand had commended the NSWPF for its "thorough" work, that Mr Dye's mother had formally recorded her gratitude to the NSWPF, and that "[n]o criticisms were made of the investigation at that time". [3808]

5.4243. There are two points to be made here. The first is that, as I have remarked elsewhere in respect of similar submissions by the NSWPF, the presence or absence of comment about a police investigation by a Coroner in the course of an inquest or at its conclusion, is not probative of the quality of that investigation. A Coroner receives what is provided by the police in the brief. The Coroner does not receive, or know about, what is not provided.

5.4244. The second is that the deficiencies in this investigation, which Counsel Assisting have identified, do not relate to the extensiveness of what *was* done, but to the significance of what was *not* done.

5.4245. Finally, I observe that the late and unsystematic production of documents in this case, which has been a feature of the NSWPF's approach to this Inquiry more generally (as outlined in **Chapter 15**), had a significant effect on the progress of the Inquiry's investigation of Mr Dye's death. That effect was most drastic when, just one day before the documentary tender hearing was scheduled to occur, on 20 June 2023, the NSWPF produced substantial new materials relating to Mr Dye's death which revealed unexhausted lines of inquiry.

5.4246. The ensuing need to postpone the public presentation of Mr Dye's case, to review and analyse that material, and to pursue the necessary further investigative steps, required the allocation of further time and resources by the Inquiry. But it also meant that the friends and family of Mr Dye, who have been patiently awaiting answers for 30 years about the death of their loved one and were otherwise ready to attend the hearing, were told at the last minute that the hearing was not going ahead. The inevitable emotional impact on those family members and friends, which cannot be measured, was very unfortunate, and very much regretted by the Inquiry.

[3806] Exhibit 59, Tab 91, NSWPF Review of an Unsolved Homicide Case Screening Form - Crispin Wilson Dye, 25 May 2005, 14 (SCOI.03268).

[3807] Submissions of NSWPF, 5 September 2023, [12] (SCOI.85433).

[3808] Submissions of NSWPF, 5 September 2023, [11] (SCOI.85433).

Manner and cause of death

5.4247. Counsel Assisting submitted that the findings of State Coroner Hand in 1995 remain appropriate, namely:[3809]

> *[t]hat on 25 December 1993 at the St George Hospital, Kogarah, Crispin Wilson Dye died of the effects of a head injury inflicted on 23 December 1993 in Campbell Street, Darlinghurst, by a person or persons unknown.*

5.4248. The NSWPF supported that submission. [3810]

5.4249. In the circumstances outlined above, I agree that the original coronial finding remains appropriate. Although the DNA results which the inquiry has obtained in 2023 indicate the possibility that N252 was involved in Mr Dye's death, no positive conclusion can be reached in that regard.

Bias

5.4250. Counsel Assisting identified the following factors, among others, as relevant to the question whether Mr Dye's death involved LGBTIQ bias.

5.4251. First, the time and location of the attack, namely the early hours of the morning close to Oxford Street's gay pubs and nightclubs. Proximity to such known LGBTIQ locations is well recognised as a feature of many attacks on members of the LGBTIQ community in the 1970s, 1980s and 1990s.[3811] At the time of Mr Dye's murder the area surrounding Little Oxford Street was a hotspot for street robberies and assaults, including targeted robberies and assaults against members of the LGBTIQ community.[3812]

5.4252. Secondly, an eyewitness observed three men standing around a "large object laying on the ground" — later found to be Mr Dye.[3813] This may suggest that a gang was involved in the attack.

5.4253. Thirdly, in circumstances where Mr Dye was very intoxicated, the amount of force used to assault Mr Dye seems excessive if his assailant or assailants only intended to rob him. In the view of Professor Asquith, an extreme level of violence "is appropriate for assessing some hate crimes, especially those involving interpersonal violence".[3814] The tenth "bias crime indicator", developed by Sergeant Steer of the BCU and later incorporated by Strike Force Parrabell into its BCIF, recognised the significance of "level of violence" in assessing whether LGBTIQ bias may be a factor in a crime.

[3809] Exhibit 59, Tab 8, Transcript of Coronial Inquest into the death of Crispin Wilson Dye, 8 August 1995, T48.25-30 (SCOI.10179.00008).

[3810] Submissions of NSWPF, 5 September 2023, [80] (SCOI.85433).

[3811] Exhibit 1, Tab 1, ACON, In Pursuit of Truth and Justice: Documenting Gay and Transgender Prejudice Killings in NSW in the Late 20th Century (Report, May 2018) [4.3.3] (SCOI.03667); Exhibit 6, Tab 255, Expert Report of Professor Nicole Asquith, 25 January 2023, [109] (SCOI.82368.00001).

[3812] Exhibit 59, Tab 90, Strike Force Parrabell, Bias Crimes Indicators Review Form – Crispin Dye, 14 (SCOI.45285); See Annexure A to Exhibit 59, Tab 121, Statement of Jacqueline Krynda, 18 June 2023 (SCOI.83525).

[3813] Exhibit 59, Tab 25, Statement of Scott John Neilson, 23 December 1993, [4] (SCOI.10274.00039).

[3814] Exhibit 6, Tab 255, Expert Report of Professor Nicole Asquith, 25 January 2023, [100] (SCOI.82368.00001).

5.4254. Fourthly, Mr Dye's assailant/s may have had multiple or concurrent motivations.[3815] In Professor Asquith's view, most LGBTIQ bias crime is opportunistic, and many offenders who assault their victims will also take the opportunity to rob them.[3816] Others may deliberately target persons thought to be a member of the LGBTIQ community for robbery attacks, whether because they are perceived to be "easy" or "soft" targets or otherwise.

5.4255. Fifthly, there are indications that an 'Organised Hate Group' may have been active in Sydney at the time of Mr Dye's death. Strike Force Parrabell noted that the *modus operandi* in this case "of physically assaulting a male is similar to the M.O. of other known OHG'S".[3817] Some of the statements made by victims of robberies, in the area of Little Oxford Street around 1993 and 1994,[3818] refer to groups of men who were targeting gay men for robberies and assaults and using homophobic language in the course of these attacks.[3819]

5.4256. On the other hand, Counsel Assisting acknowledged that the area in question was also a hotspot for robberies generally. Mr Dye was intoxicated and staggering, and another possibility, which cannot be excluded, is that he was simply the victim of a robbery-based attack in which his membership of the LGBTIQ community was not a factor.

5.4257. Counsel Assisting submitted, however, that to make a binary distinction between a robbery and a bias crime is to fail to recognise the possibility that a crime may be *partially* motivated by bias, such as where members of the LGBTIQ community (or persons perceived as such) are selected as victims of robberies, whether because they are seen as "easy targets" or otherwise. The NSWPF agreed with this submission: "a robbery motivation would not exclude the possibility that LGBTIQ bias played a role". [3820]

5.4258. As I have said before, I agree that such a crime should be accepted as a bias crime, i.e., a crime in which LGBTIQ bias is a factor.

5.4259. Counsel Assisting submitted that as long as the identity of Mr Dye's assailant or assailants, and the motivations of such assailant or assailants, remain unknown, it is not possible to arrive at a "positive conclusion" that the attack on Mr Dye was motivated, either in whole or in part, by LGBTIQ bias.

5.4260. However, Counsel Assisting submitted that, having regard to the whole of the available evidence, "there is objectively reason to suspect that the attack was so motivated, either in whole or in part".

[3815] Exhibit 6, Tab 255, Expert Report of Professor Nicole Asquith, 25 January 2023, [94] (SCOI.82368.00001).

[3816] Exhibit 6, Tab 255, Expert Report of Professor Nicole Asquith, 25 January 2023, [96]–[97] (SCOI.82368.00001).

[3817] Exhibit 59, Tab 90, Strike Force Parrabell, Bias Crimes Indicators Review Form – Crispin Dye, 7 (SCOI.45285).

[3818] See a summary of these holdings contained in Annexure A of Exhibit 59, Tab 121, Statement of Jacqueline Krynda, 18 June 2023 (SCOI.83525).

[3819] See, for example, Exhibit 59, Tab 36, Statement of Bradley William Smith, 14 January 1994 (SCOI.10274.00042) and Exhibit 59, Tab 37, Statement of Leon Jurgen Oelofse, 29 December 1993 (SCOI.10382.00017).

[3820] Submissions of NSWPF, 5 September 2023, [79] (SCOI.85433).

5.4261. The NSWPF submitted that "[i]n order to be able to reach any firm conclusion as to whether any assault on Mr Dye was motivated by gay hate, it is necessary to determine the identity of the attacker/s". The NSWPF further submitted that "[t]his is not a matter where gay hate bias can be inferred from the surrounding circumstances.[3821]

5.4262. The NSWPF submitted that "there is no sufficient basis to conclude that Mr Dye's death was motivated by LGBTIQ bias".[3822]

5.4263. The OIC of the original investigation, former Detective Sergeant Knight, submitted that he "became aware from very early in the investigation that Mr Dye was either bi or homosexual", and that this was "considered from the outset as being a possible motive". However, he contended that "to this day" there was "no direct evidence that his sexuality had any relevance".[3823]

5.4264. Detective Sergeant Knight also expressed the following view: "Whilst of course being unable to be certain, I consider[s] that the motive for the crime was most likely robbery. I have no knowledge as to whether [Mr Dye's] behaviour at the time of the assault was such that the assailant(s) may have been aware of his sexuality, however there was no evidence to that effect and in my opinion I could not conclude then, or now that this attack might be considered what is now more commonly referred to as a 'gay hate crime'".[3824]

5.4265. In my view Counsel Assisting's submission should be accepted; there is objectively reason to suspect that the attack on Mr Dye was motivated by LGBTIQ bias, either in whole or in part.

5.4266. I accept that, as Counsel Assisting recognised, and as the NSWPF and Mr Knight emphasised, the evidence does not permit a positive conclusion or finding to that effect. None of the factors identified by Counsel Assisting is conclusive. They do not, either jointly or severally, establish as a fact the presence of LGBTIQ bias in connection with Mr Dye's death.

5.4267. However, the presence of those many factors identified by Counsel Assisting does mean that there is, objectively reason to suspect that LGBTIQ bias was a factor in the death of Mr Dye.

Conclusions and recommendations

5.4268. As to manner and cause of death, consistent with the earlier coronial finding, I find as follows:

> *On 25 December 1993 at the St George Hospital, Kogarah, Crispin Wilson Dye died of the effects of a head injury inflicted on 23 December 1993 in Campbell Street, Darlinghurst, by a person or persons unknown.*

[3821] Submissions of NSWPF, 5 September 2023, [77] (SCOI.85433).

[3822] Submissions of NSWPF, 5 September 2023, [78] (SCOI.85433).

[3823] Submission of former Detective Sergeant Geoffrey Knight, undated (SCOI.86192).

[3824] Submission of former Detective Sergeant Geoffrey Knight, undated (SCOI.86192).

5.4269. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in Mr Dye's death.

5.4270. I make the following recommendation:

Recommendation 4

I recommend that the NSWPF:

a. Regularly monitor all DNA databases available to them with a view to identifying a match to the profile of "Unknown Male B", whose DNA was located in 2023, at the direction of the Inquiry, from the hair found on Mr Dye's shirt; and

b. Ensure that the white card (located during the course of the Inquiry) is kept securely as an exhibit in the event that technological developments can assist in determining whether the bloodstained mark is a fingerprint.

IN THE MATTER OF JAMES MEEK

Factual background

Date and location of death

5.4271. James Meek (born 5 August 1943) died on Tuesday, 7 March 1995 in his apartment at the Northcott Flats on Belvoir Street, Surry Hills. He was 51 at the time of his death.

5.4272. Mr Meek's case is also dealt with in **Chapter 17** of this Report.

Circumstances of death

5.4273. Mr Meek was a gay man. His family and many of his neighbours in the Northcott Flats knew about his sexuality. He was active in organisations within the LGBTIQ community. He volunteered at the 1995 Mardi Gras shortly before his death.[3825]

5.4274. Mr Meek was diagnosed with HIV in 1986, some nine years before his death.[3826]

5.4275. Mr Meek spoke openly and in some detail about his sex life.[3827] Mr Meek's friends and neighbours knew that he would habitually bring men home to his unit for casual sex. He was also known to seek sexual relationships with younger men.[3828]

5.4276. The circumstances surrounding Mr Meek's death can only be fully understood if the evidence concerning his movements in the days before his death is set out in some detail. That evidence is set out below.

[3825] Exhibit 35, Tab 37, Statement of Carole King, 18 March 1995, [6] (SCOI.10002.00018).

[3826] Exhibit 35, Tab 23, Statement of Dr Alexander Beveridge, 27 March 1995, [5] (SCOI.10001.00166).

[3827] See, for example, Exhibit 35, Tab 26, Statement of Wayne Ruscoe, 14 March 1995, [8]–[14] (SCOI.10001.00143); Exhibit 35, Tab 24, Statement of Artur Bubis, 14 March 1995, [4]–[5], [12] (SCOI.83048); Exhibit 35, Tab 41, Statement of NP219,28 March 1995 [7] (SCOI.10002.00037).

[3828] See, variously, Exhibit 35, Tab 25, Statement of Eric Eadie, 21 March 1995, [3]–[5] (SCOI.10402.00072); Exhibit 35, Tab 56, Statement of Kevin Marsh, 30 April 1995, [5] (SCOI.10002.00044); Exhibit 35, Tab 54, Statement of Jason Radford, 23 March 1995, [9] (SCOI.10019.00011).

5.4277. The last occasions on which there is evidence of Mr Meek being alive were 10:30am on Tuesday, 7 March 1995, when he made a call to a radio show, and between 11:30am and midday on the same day, when he was seen walking his dogs by a neighbour, NP219.

5.4278. Mr Meek's body was found on Wednesday, 8 March 1995 after concerned neighbours contacted the NSWPF.

5.4279. There are suggestions in the evidence that Mr Meek would, on occasion, offer homeless young men accommodation in exchange for sex. There are also allegations that Mr Meek sought sexual relations with underage boys.[3829] For the reasons set out below, while care should be taken in relation to these allegations, this evidence is relevant to the circumstances of Mr Meek's death.

5.4280. I accept the submission of Counsel Assisting that it is important to take care not to countenance harmful stereotyping concerning gay men and paedophilia. The evidence concerning Mr Meek's interest in underage boys has not been tested, and is primarily hearsay.

5.4281. I also accept the submission of Counsel Assisting that it is not necessary for any finding to be made concerning Mr Meek's alleged sexual activity with underage boys. The proposition of relevance is that there is evidence that Mr Meek was believed by some people to be a paedophile. This, in turn, is relevant to the question of possible motivations for Mr Meek's murder.

5.4282. There are at least three plausible persons of interest in Mr Meek's death.

5.4283. Two (including Michael Heatley, who was charged with Mr Meek's murder) were young men at the time of Mr Meek's death, and there is evidence that both young men may have had sexual relationships with Mr Meek. Both men denied having a sexual relationship with Meek and there is some evidence to suggest that both may have held homophobic attitudes.

5.4284. The third potential person of interest is a woman who also lived in the Northcott Flats. She had a relationship of apparent animosity with Mr Meek and had acted violently towards him before, as is set out below.

5.4285. As explained below, it is also possible that the homicide was perpetrated by a fourth, unknown person.

5.4286. On 23 March 1995, the *Sydney Star Observer* and *Capital Q Weekly* reported that police were investigating the matter as a "gay hate" killing: "probably more so than not at this stage".[3830]

[3829] See, variously, Exhibit 35, Tab 25, Statement of Eric Eadie, 21 March 1995, [3]–[5] (SCOI.10402.00072); Exhibit 35, Tab 56, Statement of Kevin Marsh, 30 April 1995, [5] (SCOI.10002.00044); Exhibit 35, Tab 54, Statement of Jason Radford, 23 March 1995, [8]–[9] (SCOI.10019.00011).

[3830] Exhibit 35, Tab 64, Kristy Machon, 'Bashed to Death: Gay Hate Murder?', *Sydney Star Observer* (Sydney, 23 March 1995) (SCOI.84002); Exhibit 35, Tab 63, 'No concrete leads in Meek murder', *Capital Q Weekly* (Sydney, 23 March 1995) (SCOI.10013.00046).

5.4287. On 28 September 1995, Mr Heatley was charged with Mr Meek's murder.[3831] He was committed for trial, but a directed acquittal was ordered after the close of the prosecution case.[3832]

5.4288. The events of the morning of Tuesday, 7 March 1995 assumed a great deal of significance at the trial of Mr Heatley. In the course of the trial a number of witnesses who had provided written statements were cross-examined, and some concessions were made as to the accuracy of their accounts of the day. These concessions formed the basis of the directed acquittal.

Previous investigations

Original police investigation

Findings of post-mortem

5.4289. A post-mortem examination was conducted on 11 March 1995. Mr Meek's injuries included impacts to the head, a substantial blow to the left forehead and impact to left and right mandible, impact to the right chest and left flank, bruising to the back of his left hand and fourth knuckle of his left ring finger and bruising to the back of his head and injuries to his tongue. There were no skull fractures. However, there was subarachnoid and subdural haemorrhage.[3833]

5.4290. The cause of death was found to be blunt force head injuries, consistent with an assault.[3834] The forensic pathologist who conducted the post-mortem examination suggested that the injuries to Mr Meek's head could have been caused by stomping.[3835]

5.4291. The post-mortem examination noted bruising to Mr Meek's left hand. There was a 30 millimetre red bruise on the back of his hand. There was a purple bruise on his left ring finger.[3836] There was a compression mark below the bruise. The forensic pathologist who conducted the post-mortem examination suggested that the compression mark "could have been caused by the presence of a ring that has been removed".[3837]

Commencement of the criminal investigation

5.4292. As is set out below, a crime scene was established on 8 March 1995 but released later on the same day.

[3831] Exhibit 35, Tab 20, Statement of Detective Senior Constable Neil Walker, 20 September 1995 [22]–[23] (SCOI.83055)

[3832] Exhibit 35, Tab 59, *R v Heatley* (Unreported, Supreme Court of New South Wales, Ireland J, 4 December 1998) (SCOI.10402.00018).

[3833] Exhibit 35, Tab 4, Post-mortem Report of Dr Christopher Lawrence, 1 June 1995, 7 (SCOI.10004.00009).

[3834] Exhibit 35, Tab 4, Post-mortem Report of Dr Christopher Lawrence, 1 June 1995, 7 (SCOI.10004.00009).

[3835] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1998, T244.10-24 (SCOI.82969).

[3836] Exhibit 35, Tab 4, Post-mortem Report of Dr Christopher Lawrence, 1 June 1995, 4 (SCOI.10004.00009)

[3837] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1998, T245.31-32 (SCOI.82969).

5.4293. Mr Meek's daughter, Mercedes McMahon (who previously used the name Wendy Elizabeth Griffin), said that she was initially told by the NSWPF that Mr Meek had died of a heart attack.[3838] The criminal investigation into Mr Meek's death did not formally commence until 14 March 1995, following the post-mortem examination that took place on 11 March 1995.[3839]

Persons of interest

NP220

5.4294. NP220 was a 19 year old resident of Northcott Flats at the time of Mr Meek's death. Police interviewed various residents of the Northcott Flats after Mr Meek's death. Various residents reported seeing Mr Meek argue with NP220 in the week before Mr Meek's death.

5.4295. Kevin Marsh (another neighbour) reported seeing Mr Meek argue with a young man with blond hair on 1 March 1995, who was a resident of Northcott Flats. The description of the young man matched that of NP220. He reported the following conversation:[3840]

> [*NP220*]: *You fucked me and you owe me money, give it to me.*
>
> *Meek:* *Keep the change.*
>
> [*NP220*]: *It's not fucking enough, youre [sic] a fucking poofter and I want more.*

5.4296. Mr Marsh said that he was under the impression that NP220 was "Jim's latest fuck as it was common knowledge that whoever was seen with Jim on a regular basis was his boyfriend." He said, "I was also under the impression that this male had a key to Mr MEEKS [sic] apartment and had been told by other persons who lived in northcott that this was so".[3841]

5.4297. There is no other evidence to suggest that NP220 had a key to Mr Meek's apartment.

5.4298. It is possible, of course, that NP220's claim that Mr Meek "fucked" him was non-sexual in nature. For example, NP220 may have been suggesting that Mr Meek had crossed him or cheated him in some way.

5.4299. NP220 had purchased a car from Mr Meek in around November 1994 for $100. He had initially been going to pay $500 for the car, but the car was stolen from the Northcott Flats car park and "ruined".[3842] It is possible that the above altercation related to this transaction.

[3838] Exhibit 35, Tab 73, Statement of Mercedes McMahon, 19 June 2023, [7] (SCOI.84007).

[3839] Exhibit 35, Tab 18, Statement of Detective Sergeant Anthony Tanos, 20 September 1995, [3]–[5] (SCOI.10014.00003).

[3840] Exhibit 35, Tab 56, Statement of Kevin Marsh, 30 April 1995, [6] (SCOI.10002.00044).

[3841] Exhibit 35, Tab 56, Statement of Kevin Marsh, 30 April 1995, [8] (SCOI.10002.00044).

[3842] Exhibit 35, Tab 53, Record of interview, 'Interview with NP220', 23 March 1995, [A42-A56] (SCOI.10012.00008).

5.4300. William Robertson reported seeing Mr Meek argue with NP220 on 5 March 1995. He reported that NP220 yelled at Mr Meek, "[y]ou owe me that money".[3843]

5.4301. Jason Radford reported seeing Mr Meek and NP220 argue about a week and a half before Mr Meek's death. He told police that he had heard rumours that Mr Meek owed NP220 money, possibly for sexual favours. Mr Radford had previously been charged with bashing Mr Meek, with a trial listed in July 1994. Mr Radford claimed that NP220 had approached him in Ward Park a couple of days before his trial, "he told me to keep away from Jim or he'll punch me up".[3844]

5.4302. Michael Lawrence also reported that, "there were some young blokes who lived at Northcott flats who Jim saw sometimes but I don't think it was sexual. One of them was [NP220], about 19 or 20 old, over 6 foot, he has just bleached his hair from dark to blonde. He lived in [a block of the Northcott Flats]".[3845]

5.4303. The evidence of all four men suggested that Mr Meek and NP220 had some sort of relationship. Three of them suggested that the relationship may have been sexual. Two of them reported seeing NP220 argue with Mr Meek over money, and one of them reported rumours to the same effect.

5.4304. Police interviewed NP220 on 23 March 1995, after attending and searching his flat.[3846]

5.4305. NP220 said that Mr Meek was "a pretty nice guy" and that they were "pretty good friends".[3847] He said that he used to go to Mr Meek's flat sometimes and have coffee.[3848] He said that he had known Mr Meek for about two years and that he had been to Mr Meek's room twice.[3849] NP220 said that Mr Meek came to his home "plenty of times".[3850]

5.4306. NP220 denied having an argument with Mr Meek in the foyer of the Northcott Flats in the weeks prior to his death. He said that he had not spoken to Mr Meek for three weeks (which would, in fact, have been about a week before Mr Meek's death, given the date of the interview). He said that the conversation was about going to Mr Meek's flat to have a coffee.[3851]

5.4307. NP220 could not recall where he may have been on Monday, 6 March 1996 or Tuesday, 7 March 1995.[3852]

[3843] Exhibit 35, Tab 52, NWPF Running Sheet, 'Conversation with William Robertson', created 20 March 1995 (SCOI.10002.00039).

[3844] Exhibit 35, Tab 54, Statement of Jason Radford, 23 March 1995, [4]–[6] (SCOI.10019.00011).

[3845] Exhibit 35, Tab 36, Statement of Michael Lawrence, 11 March 1995, [28] (SCOI.10001.00140).

[3846] Exhibit 35, Tab 53, Record of interview, 'Interview with NP220, 23 March 1995 (SCOI.10012.00008).

[3847] Exhibit 35, Tab 53, Record of interview, 'Interview with NP220', 23 March 1995, [A18] (SCOI.10012.00008).

[3848] Exhibit 35, Tab 53, Record of interview, 'Interview with NP220', 23 March 1995, [A18] (SCOI.10012.00008).

[3849] Exhibit 35, Tab 53, Record of interview, 'Interview with NP220', 23 March 1995, [A21]–[A27] (SCOI.10012.00008).

[3850] Exhibit 35, Tab 53, Record of interview, 'Interview with NP220', 23 March 1995, [A80] (SCOI.10012.00008).

[3851] Exhibit 35, Tab 53, Record of interview, 'Interview with NP220', 23 March 1995, [Q39]–[A40] (SCOI.10012.00008).

[3852] Exhibit 35, Tab 53, Record of interview, 'Interview with NP220', 23 March 1995, [Q84]–[A86] (SCOI.10012.00008).

5.4308. NP220 denied ever having sexual relations with Mr Meek. He said that Mr Meek "tried to put an advance on me but I said no and he never tried ever again and that was when I first met him about 2 years ago".[3853] NP220 agreed that Mr Meek used to boast to him about his sexual activities. He said that this did not offend him "because [he] knew what sort of person he was".[3854]

5.4309. NP220 admitted that he was addicted to heroin. He said that he supported his habit by getting credit from his dealer and paying her back on his cheque day. He admitted that he had "hocked" property to fund his addiction, but denied that he had stolen property from his mother to do so.[3855]

5.4310. NP220 denied assaulting or killing Meek.[3856] Police appear to have accepted NP220's evidence as credible. Mr Marsh provided his evidence to police after NP220 was interviewed, but there is no evidence that they pursued this line of investigation further after speaking to NP220.

5.4311. The Inquiry conducted a private hearing with NP220.

MICHAEL HEATLEY

5.4312. Police searched Mr Meek's flat for fingerprints. By 11 May 1995, they had developed an identifiable fingerprint from a letter found on the table. The fingerprint belonged to Michael Heatley (then aged 18).[3857]

5.4313. Mr Heatley had an extensive criminal record. By 4 June 1995, police had located Mr Heatley in Devonport, Tasmania, where he was living with his sister and brother-in-law.[3858]

5.4314. The evidence in relation to Mr Heatley is discussed further below.

NP219

5.4315. NP219 was a resident of the Northcott Flats.[3859] She had a history of animosity with Mr Meek. Although they had been friends, the relationship deteriorated after Mr Meek failed to look after NP219's dog. NP219, enraged by Mr Meek's actions, held him off a balcony.[3860]

5.4316. NP219 later took the view that Mr Meek had killed her dog by running it over.[3861] There was evidence (discussed below) that NP219 disliked gay men.[3862] In addition, there was evidence that NP219 could become agitated and violent when under the influence of alcohol and drugs.[3863]

[3853] Exhibit 35, Tab 53, Record of interview, 'Interview with NP220', 23 March 1995, Q91]–[A91] (SCOI.10012.00008).
[3854] Exhibit 35, Tab 53, Record of interview, 'Interview with NP220', 23 March 1995, [Q117]–[A119] (SCOI.10012.00008).
[3855] Exhibit 35, Tab 53, Record of interview, 'Interview with NP220', 23 March 1995, [Q135]–[A147] (SCOI.10012.00008).
[3856] Exhibit 35, Tab 53, Record of interview, 'Interview with NP220', 23 March 1995, [Q179]–[A179] (SCOI.10012.00008).
[3857] Exhibit 35, Tab 11, NSWPF Situation Report, 'South Region – Situation Report', 11 May 1995 (SCOI.10005.00021).
[3858] Exhibit 35, Tab 13, NSWPF Situation Report, 'South Region – Situation Report', 4 June 1995 (SCOI.10005.00023).
[3859] Exhibit 35, Tab 41, Statement of NP219, 28 March 1995, [3] (SCOI.10002.00037)
[3860] Exhibit 35, Tab 41, Statement of NP219, 28 March 1995, [8] (SCOI.10002.00037).
[3861] Exhibit 35, Tab 41, Statement of NP219, 28 March 1995, [9] (SCOI.10002.00037).
[3862] Exhibit 35, Tab 53, Record of interview, 'Interview with NP220', 23 March 1995, [Q171]–[A173] (SCOI.10012.00008).
[3863] Exhibit 35, Tab 53, Record of interview, 'Interview with NP220', 23 March 1995, [Q121]–[A131] (SCOI.10012.00008).

5.4317. NP219 does not appear to have been seriously considered as a suspect. If her evidence is accepted, she was the last person known to have seen Mr Meek alive at around 11:30am on Tuesday, 7 March 1995, when she saw him walking his dogs.

5.4318. It may have been that the NSWPF did not pursue this avenue of investigation because NP219 told the NSWPF that she had an alibi: she had left Northcott Flats to meet a friend for lunch.[3864] Alternatively, it may have been because Mr Heatley emerged as more compelling suspect. NP219 is now deceased.[3865]

Findings at inquest

5.4319. It appears from coronial records obtained by the Inquiry that an inquest in Mr Meek's death was not held as his death was the subject of a murder investigation and ultimately a prosecution.[3866]

Criminal proceedings

5.4320. Police charged Mr Heatley with the murder of Mr Meek. A committal hearing was held on 4 to 8 March 1996 and 27 March 1996. Mr Heatley was ultimately committed to trial. The trial began on 16 November 1998.

5.4321. The case against Mr Heatley was entirely circumstantial. The essence of the case was as follows:[3867]

a. Mr Meek died between 11:15am and midday on 7 March 1995;

b. Mr Heatley, by his own admission, stole Mr Meek's ring;

c. A neighbour's evidence established that Mr Meek was wearing the ring at about 11:15am on 7 March 1995. A jury could conclude that Mr Heatley forcibly removed that ring and that he was responsible for the assault which killed Mr Meek;

d. The evidence of Mr Heatley, Roger Griffiths and Ian Puddicombe established that Mr Heatley attempted to sell the ring at the King's Loan Office at 1:15pm.

5.4322. The prosecution did not contend that Mr Heatley was motivated to kill Mr Meek by any LGBTIQ bias or by any motive relating to a sexual relationship or a sexual advance. The criminal proceedings are discussed in more detail below.

[3864] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley,* Supreme Court of New South Wales, Ireland J, 24 November 1998, T377 (SCOI.82969).

[3865] Exhibit 35, Tab 74, Open Statement of Tom Allchurch, 19 June 2023, [27] (SCOI.73527).

[3866] Exhibit 35, Tab 74, Open Statement of Tom Allchurch, 19 June 2023, [5] (SCOI.73527).

[3867] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1998 (SCOI.82969).

Strike Force Parrabell

Bias Crimes Indicators Form

5.4323. The BCIF records that Mr Meek died on 7 March 1995. It records his death as solved and names Michael Heatley as the offender.[3868]

5.4324. Counsel Assisting noted that the Strike Force Parrabell Case Summary recorded the matter as unsolved, which is in contrast to the BCIF. The NSWPF submitted:[3869]

> *Counsel Assisting state that the Strike Force Parrabell Case Summary for this matter describes this matter as unsolved, in contrast to the BCIF. This is not correct. The BCIF covering page lists the case as Unsolved which aligns with the Case Summary.*

5.4325. That is not correct. The version of the BCIF before the Inquiry, and included in Exhibit 35, clearly records the investigation status as "solved". As Counsel Assisting submitted, that is inconsistent with the Case Summary Form, which describes the matter as unsolved.

5.4326. The BCIF states that "[t]here is no information to suggest HEATLEY had any issue with MEEK'S sexuality."[3870] Counsel Assisting submitted that this is incorrect, and that Robert Woodward a neighbour stated that Mr Heatley held negative attitudes towards gay men.[3871] In addition, during his ERISP, Mr Heatley used a homophobic slur to describe Mr Meek and said that he "used to spin out on him having AIDS."[3872]

5.4327. The NSWPF makes submissions directed to Mr Woodward's evidence but does not address the statements made by Mr Heatley during his ERISP.[3873]

5.4328. I accept that, as the NSWPF submits, Mr Woodward's knowledge of Mr Heatley's views about the LGBTIQ community may have been limited. However, the statement in the BCIF is that there was no information to suggest that Mr Heatley had "any issue" with Mr Meek's sexuality. In my view, that statement is incorrect.

5.4329. Counsel Assisting was also critical of the statement in the BCIF that "HEATLEY is not known to have been involved in other bias related crimes or incidents that may have caused him to murder MEEK".[3874] Counsel Assisting drew attention to the fact that Mr Heatley subsequently committed another homicide (of Craig Behr) which is likely to have been a bias crime, and which had marked similarities to the death of Mr Meek.

[3868] Exhibit 35, Tab 60, Strike Force Parrabell, Bias Crime Indicators Review Form – James Meek, Undated 1 (NPL.0115.0002.1368).

[3869] Submissions of NSWPF, 7 July 2023, [140] (SCOI.84812).

[3870] Exhibit 35, Tab 60, Strike Force Parrabell, Bias Crime Indicators Review Form – James Meek, Undated 4 (NPL.0115.0002.1368).

[3871] Exhibit 35, Tab 49, Statement of Robert Woodward, 10 July 1995, [11] (SCOI.10005.00117).

[3872] Exhibit 35, Tab 47, NSWPF Record of Interview, 'Interview with Michael Heatley, 22 June 1995, [A77], [A85] (SCOI.10005.00047).

[3873] Submissions of NSWPF, 7 July 2023, [130]–[132] (SCOI.84812).

[3874] Exhibit 35, Tab 60, Strike Force Parrabell, Bias Crime Indicators Review Form – James Meek, Undated 8 (NPL.0115.0002.1378).

5.4330. Counsel Assisting submitted that the statement that Mr Heatley was "not known" to have been involved in other bias related crimes or incident could only be correct if Strike Force Parrabell chose not to conduct further searches concerning Mr Heatley's criminal history.[3875]

5.4331. The NSWPF noted in submissions that the scope of Strike Force Parrabell was confined to existing holdings. That is a matter dealt with elsewhere in this Report. In addition, the NSWPF submitted (presumably in the alternative) that Strike Force Parrabell should not be criticised for reaching a similar conclusion to that reached by Justice Whealy when sentencing Mr Heatley.

5.4332. The difficulty I have with accepting this submission is that there is no record that the death of Mr Behr was a matter known to the officer completing the BCIF. I accept that it may well have been open for a reviewer to conclude, having considered the information concerning Mr Behr's death, that it could not be affirmatively concluded that Mr Behr's death is a bias crime (and consequently that Mr Heatley was "not known" to have been involved in other bias crimes or incidents). However, there is no evidence before me that would allow me to conclude that this is in fact what occurred. On the NSWPF's own submissions, the reviewer would not have been expected to have undertaken any additional searches.

5.4333. Counsel Assisting was also critical of the statement in the BCIF that "[t]here is no evidence that suggests any previous existence or incidents of bias related crime having occurred towards MEEK".[3876] The incorrectness of this statement is accepted by the NSWPF.[3877]

5.4334. Mr Meek's daughter, Karen Franks, provided a statement to police in which she recounted other crimes of which Mr Meek had been a victim. In early 1994, Mr Meek was walking his dogs in the park and a young guy in the flat called him a "gay bastard and a poofter etc.". Mr Meek told Ms Franks that he was pushed to the ground, his glasses were broken, and the guy bashed him up.[3878] Mr Meek also described this incident to his doctor.[3879]

5.4335. Counsel Assisting also submitted that it appeared that Strike Force Parrabell uncritically accepted Mr Heatley's claims that there had been no sexual activity or sexual advance.[3880]

[3875] Submissions of Counsel Assisting, 22 June 2023, [84] (SCOI.84128).

[3876] Exhibit 35, Tab 60, Strike Force Parrabell Bias Crime Indicators Review Form – James Meek, Undated 8 (NPL.0115.0002.1378); Submissions of Counsel Assisting, 22 June 2023, [85] (SCOI.84128).

[3877] Submissions of NSWPF, 7 July 2023, [138]–[139] (SCOI.84812).

[3878] Exhibit 35, Tab 22, Statement of Karen Franks, 12 March 1995, [10] (SCOI.10001.00131).

[3879] Exhibit 35, Tab 23, Statement of Dr Alexander Beveridge, 27 March 1995, [6] (SCOI.10001.00166).

[3880] Exhibit 35, Tab 60, Strike Force Parrabell Bias Crime Indicators Review Form – James Meek, Undated 11-12 (NPL.0115.0002.1378).

5.4336. The NSWPF submitted that Counsel Assisting overstated Strike Force Parrabell's conclusion in making this submission, and said that the BCIF recorded Mr Heatley's denials of sexual activity in the context of a statement that no clear motive was established during the investigation. The NSWPF says that, consequently, the BCIF does not record that it accepted Mr Heatley's denials and says that this was not Strike Force Parrabell's role.[3881]

5.4337. As pointed out by Counsel Assisting, the BCIF does not refer to the evidence of Mr Kane (see below), who claimed that Mr Meek told him that he and Mr Heatley had had a sexual relationship. There were reasons to doubt the evidence of Mr Kane on this point, as set out below. However, Counsel Assisting submitted that the BCIF should have recorded this evidence.

5.4338. I accept that it was not the role of the reviewer to authoritatively adjudicate between competing evidence. However, the failure to record the evidence of Mr Kane in the BCIF was, implicitly, to reject its relevance. In circumstances where Mr Heatley was the primary person of interest, and where there was evidence from a witness that asserted that he had a sexual relationship with Mr Meek, I would expect this evidence to at least be adverted to in consideration of a potential motive.

Results of Strike Force Parrabell

5.4339. Strike Force Parrabell categorised the case as one where there was "no evidence of bias crime". [3882]

5.4340. The academic review team categorised it as "insufficient information" to make a determination as to whether Mr Meek's death was a bias crime.[3883]

5.4341. As noted above, the matter was categorised as "unsolved" in the Strike Force Parrabell Case Summary, in contrast to the BCIF.[3884] The final position of Strike Force Parrabell in relation to whether Mr Meek's death was solved is unclear. The submissions of the NSWPF suggested that it considered the final position of Strike Force Parrabell to be that the case was unsolved.

5.4342. The Case Summary reads as follows:[3885]

> ***Identity**: James (Jim) Meek was 47 years old at the time of his death.*
>
> ***Personal History**: Mr Meek lived in a residential unit at the Northcott Social Housing estate. He regularly visited different 'gay beat' locations. He had a reputation for meeting younger men in Ward Park, opposite his residential unit, some said 'street kids' and offering them a bed and food in exchange for sex.*
>
> ***Location of Body/Circumstances of Death**: Mr Meek's body was found inside his residential unit. He suffered severe head injuries as a*

[3881] Submissions of NSWPF, 7 July 2023, [139] (SCOI.84812).

[3882] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – James Meek, 33 (SCOI.76961.00014).

[3883] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – James Meek, 33 (SCOI.76961.00014).

[3884] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – James Meek, 33 (SCOI.76961.00014).

[3885] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – James Meek, 33 (SCOI.76961.00014).

> *result of blunt force trauma. It was determined that Mr Meek had been struck to the head by his killer using a ceramic bowl. Police identified an 18-year-old suspect, who had known Mr Meek for approximately 6 months after meeting him via his sister. The suspect resided in Tasmania before moving to Sydney where he stayed and slept at several relative's places and Mr Meek's residence. His sexuality could not be determined. Despite there being no witnesses to Mr Meek's death, investigators established that the suspect had slept on Mr Meek's couch two days prior to his death. The suspect admitted to staying at Mr Meek's residence 2 days prior and that he stole a ring from the premises upon leaving and pawned it later that same day. The suspect denied any involvement in Mr Meek's death. There was no sign of disturbance within or forced entry to Mr Meek's unit. It is likely Mr Meek knew his killer and allowed them entry.*
>
> ***Sexual Orientation**: Mr Meek identified as gay.*
>
> ***Coroner/Court Findings**: Police charged the suspect with Mr Meek's murder. At trial, he was found not guilty by judicial direction.*

5.4343. Counsel Assisting submitted that there were two inaccuracies in the Case Summary which do not appear in the BCIF.

5.4344. First, Mr Heatley did not stay at his flat "two days prior to his death", as the Case Summary claims. Mr Heatley stayed at Mr Meek's flat the night before his death and left the day of his death. Mr Meek's body was not found until the day after his death. The BCIF correctly recorded that Mr Meek died on 7 March 1995 and that Mr Heatley stayed at Mr Meek's flat "two days prior to him being discovered deceased" (which was not until 8 March 1995).[3886]

5.4345. The NSWPF accepts that this was an error, but notes that "the length of Mr Heatley's stay ultimately has no impact on the characterisation of whether Mr Meek's death was a bias crime, beyond the question of whether Mr Heatley was the perpetrator".[3887] Of course, the question of whether Mr Heatley was the perpetrator was extremely significant to the question of whether this was a bias crime. Although I accept this was not a significant error, I do not think it is immaterial.

5.4346. Secondly, Counsel Assisting submitted that it was not clear on what basis it is said that Mr Meek had been struck on the head using a ceramic bowl. The cause of Mr Meek's death was "blunt force trauma to the head by unknown means".[3888] The BCIF noted that there was a "confused abrasion show[ing] a pattern" which "may represent a shoe print". The BCIF also noted that no definitive murder weapon had been identified.[3889]

[3886] Exhibit 35, Tab 60, Strike Force Parrabell, Bias Crime Indicators Review Form – James Meek, Undated 10 (NPL.0115.0002.1378); Submissions of Counsel Assisting, 22 June 2023, [93] (SCOI.84128).

[3887] Submissions of NSWPF, 7 July 2023, [143] (SCOI.84812).

[3888] Exhibit 35, Tab 60, Strike Force Parrabell, Bias Crime Indicators Review Form – James Meek, Undated 7 (NPL.0115.0002.1378)

[3889] Exhibit 35, Tab 60, Strike Force Parrabell Bias Crime Indicators Review Form – James Meek, Undated 13 (NPL0115.0002.1380); Submissions of Counsel Assisting, 22 June 2023, [94] (SCOI.84128).

5.4347. Neither the post-mortem examination nor the prosecution concluded that Mr Meek's killer used a ceramic bowl. As noted above, the forensic pathologist gave evidence at the trial of Mr Heatley that Mr Meek's injuries were consistent with his killer stomping on his head.

5.4348. Counsel Assisting submitted that in these circumstances, while it may not have been possible to definitively exclude the ceramic bowl as the murder weapon, the evidence made it more probable that the blunt force injuries had been caused by Mr Meek being struck or kicked in the head.[3890]

5.4349. The NSWPF accepts that the Case Summary is incorrect in stating that it was determined that Mr Meek had been struck in the head by his killer using a ceramic bowl.[3891] The NSWPF submits, however, that the Case Summary was not used as a part of the review process, and that "while this error is unfortunate, it was ultimately immaterial."[3892]

5.4350. Immaterial or otherwise, I do not think it is unreasonable to expect that the Case Summary accurately record a detail as significant as the cause of Mr Meek's death. Counsel Assisting was correct to be critical of this aspect of the Case Summary.

5.4351. Finally, Counsel Assisting submitted that Strike Force Parrabell was incorrect to conclude that there was no evidence of bias crime. The evidence available to Strike Force Parrabell was sufficient, at the least, to support a conclusion of "suspected bias crime". That is particularly so given that the view appears to have been taken that Mr Heatley was responsible for Mr Meek's death, or at the very least that Mr Heatley was the most likely suspect.[3893]

5.4352. Counsel Assisting submitted that the evidence available to Strike Force Parrabell concerning Mr Meek's death, and Mr Heatley's potential involvement, was that:[3894]

a. Mr Meek was a gay man;

b. Mr Heatley had stayed at Mr Meek's flat the night before his death (not two days before his death);

c. Mr Heatley had expressed homophobic views;

d. There was a suggestion that Mr Meek and Mr Heatley had had a sexual relationship;

e. There was a used condom in Mr Meek's flat, suggesting that Mr Meek may have been killed by a sexual partner; and

f. Mr Heatley used to "spin out" about Mr Meek having HIV/AIDS.

[3890] Submissions of Counsel Assisting, 22 June 2023, [95] (SCOI.84128).

[3891] Submissions of NSWPF, 7 July 2023, [144] (SCOI.84812).

[3892] Submissions of NSWPF, 7 July 2023, [144] (SCOI.84812).

[3893] Submissions of Counsel Assisting, 22 June 2023, [96] (SCOI.84128).

[3894] Submissions of Counsel Assisting, 22 June 2023, [97] (SCOI.84128).

5.4353. In addition, Counsel Assisting submitted searches would have revealed that Mr Heatley had killed another man in similar circumstances, and that that homicide was likely to have been a bias crime.[3895]

5.4354. The NSWPF does not disagree with the submission by Counsel Assisting that the evidence available to the Inquiry supports a conclusion that Mr Meek's death is a "suspected bias crime".[3896] However, the NSWPF submitted that it must be borne in mind that Strike Force Parrabell was "only conducting a review of the records held…in relation to Mr Meek's death."[3897]

5.4355. Notwithstanding this caution, and even setting aside the evidence concerning the death of Mr Behr, I accept the submission of Counsel Assisting that the evidence available to Strike Force Parrabell was sufficient, at the least, to support the conclusion "suspected bias crime."

The Academic Review

5.4356. As noted above, the academic review concluded that there was "insufficient information" to make a determination. The academic team did not have access to the underlying case files and so would have been unaware of the evidence of Mr Kane and the evidence of Mr Heatley's attitude to Mr Meek having HIV.

5.4357. I accept the submission of Counsel Assisting that the academic team's conclusion is less open to criticism than the conclusion of Strike Force Parrabell, although it does speak to the limitations facing the academic team.

Review by the Inquiry

5.4358. The Inquiry took the following steps in the course of examining the death of Mr Meek.

Summonses

5.4359. A summons was issued to the NSWPF on 18 May 2022 for, all documents relating to investigations by the NSWPF of the death of Mr Meek, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Meek. Material in response that summons was produced on 8 June 2022.[3898]

5.4360. On 25 August 2022, a summons was issued to the NSWPF for records in relation to, relevantly, Strike Force Parrabell (NSWPF12). Material responsive to NSWPF12 was produced between 9 September 2022 and 18 November 2022.[3899]

[3895] Submissions of Counsel Assisting, 22 June 2023, [98] (SCOI.84128).

[3896] Submissions of NSWPF, 7 July 2023, [145] (SCOI.84812).

[3897] Submissions of NSWPF, 7 July 2023, [145] (SCOI.84812).

[3898] Exhibit 35, Tab 74, Open Statement of Tom Allchurch, 19 June 2023, [6] (SCOI.73527).

[3899] Exhibit 35, Tab 74, Open Statement of Tom Allchurch, 19 June 2023, [7] (SCOI.73527).

5.4361. On 2 September 2022, the Inquiry issued a summons to the NSWPF for the criminal history of Mr Heatley (NSWPF14).[3900] The NSWPF duly produced a criminal history as of 8 September 2022. That criminal history disclosed that Mr Heatley had been convicted of manslaughter in 2006.[3901]

5.4362. A search of the NSW Caselaw database for Mr Heatley revealed that he was sentenced for the manslaughter of Craig Behr by Justice Whealy in *R v Heatley* [2006] NSWSC 1199. Mr Heatley appealed against his sentence in *Heatley v R* [2008] NSWCCA 226.

5.4363. On 23 January 2023, the Inquiry issued a summons to the Supreme Court for the court file for the prosecution of Mr Heatley for the homicide of Mr Behr (SC02). Material responsive to SC02 was duly produced and reviewed by the Inquiry.[3902]

5.4364. On 23 January 2023, the Inquiry issued a summons to CSNSW for the custodial records of Mr Heatley and NP220 (CSNSW5).[3903] Material reseponsive to CSNSW5 was duly produced and reviewed by the Inquiry.

5.4365. As outlined below, the Inquiry issued a summons to the NSWPF seeking the production of documents recording calls made from Mr Meek's home phone. The NSWPF were not able to produce any material responsive to that summons.

5.4366. On 30 May 2023, the Inquiry issued a further summons to the NSWPF seeking some further documents in relation to Mr Heatley (NSWPF112). The NSWPF produced two documents in response to that summons.[3904]

5.4367. On 1 August 2023, the Inquiry sought production from the NSW Ombudsman of any material relating to a complaint made on behalf of Mr Meek's daughters concerning the investigation into the death of Mr Meek (OMB1). Material responsive to OMB1 was produced voluntarily on 11 August 2023.

5.4368. On 1 August 2023, the Inquiry issued a further summons to the NSWPF seeking the production of any document relating to the complaint made on behalf of Mr Meek's daughters (NSWPF159). Those materials were produced on 18 August 2023 and reviewed by the Inquiry.

Family members

5.4369. On 27 April 2023, the Inquiry wrote to Mr Meek's daughters, Karen Franks and Mercedes McMahon.[3905] On 4 May 2023, Ms McMahon contacted the Inquiry by telephone.[3906] Ms McMahon subsequently provided a statement to the Inquiry.[3907]

[3900] Exhibit 35, Tab 74, Open Statement of Tom Allchurch, 19 June 2023, [8] (SCOI.73527).
[3901] Exhibit 35, Tab 74, Open Statement of Tom Allchurch, 19 June 2023, [10] (SCOI.73527).
[3902] Exhibit 35, Tab 74, Open Statement of Tom Allchurch, 19 June 2023, [13]–[14] (SCOI.73527).
[3903] Exhibit 35, Tab 74, Open Statement of Tom Allchurch, 11 June 2023, [13]–[15] (SCOI.73527).
[3904] Exhibit 35, Tab 74, Open Statement of Tom Allchurch, 11 June 2023, [24]–[26] (SCOI.73527).
[3905] Exhibit 35, Tab 74, Open Statement of Tom Allchurch, 19 June 2023, [18] (SCOI.73527).
[3906] Exhibit 35, Tab 74, Open Statement of Tom Allchurch, 19 June 2023, [19] (SCOI.73527).
[3907] Exhibit 35, Tab 73, Statement of Mercedes McMahon, 19 June 2023 (SCOI.84007).

5.4370. On 5 June 2023, the Inquiry again wrote to Ms Franks. On 14 June 2023, Ms Franks advised the Inquiry that she did not wish to have any involvement with the work of the Inquiry.[3908]

Searches for exhibits

5.4371. On 3 May 2023, a summons was issued to the NSWPF requiring production of the following exhibits taken into evidence as part of the initial police investigation(NSWPF100):[3909]

a. A sample of blood from Mr Meek;

b. Fingernail scrapings from the right and left hand of Mr Meek;

c. Swab collected from the kitchen floor;

d. T-shirt;

e. Pair of shorts;

f. Pair of blue underpants;

g. Black wallet and contents;

h. Broken brown ceramic bowl;

i. Plastic water ampule; and

j. Newspaper.

5.4372. On 17 May 2023, the NSWPF wrote to the Inquiry indicating that none of the exhibits were able to be located.[3910] The searches undertaken by the NSWPF were set out in a statement of Detective Sergeant Andrew Hamill dated 26 May 2023.

5.4373. The sample of Mr Meek's blood was transported to FASS on 4 October 1995 and has been retained by FASS.[3911] A sample of Mr Meek's hair was destroyed on 23 December 1999 with the approval of Detective Sergeant Tanos.[3912] The t-shirt, pair of shorts, fingernail scrapings (right and left), oral and anal swabs and a pair of underpants were handed to Detective Sergeant Tanos on 20 November 1998.[3913] These exhibits were unable to be located.[3914] Similarly, the brown ceramic bowl, plastic ampule and several pieces of newspaper were returned to the Surry Hills Police Station on or around 23 March 1995. They were not located by Detective Sergeant Hamill's searches.[3915]

[3908] Exhibit 35, Tab 74, Open Statement of Tom Allchurch, 19 June 2023, [21]–[23] (SCOI.73527).

[3909] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [5]–[6] (NPL.9000.0012.0126).

[3910] Exhibit 35, Tab 74, Open Statement of Tom Allchurch, 19 June 2023, [15]–[16] (SCOI.73527).

[3911] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](c)(ii) (NPL.9000.0012.0126).

[3912] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](c)(iv) (NPL.9000.0012.0126).

[3913] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](c)(v) (NPL.9000.0012.0126).

[3914] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](d) (NPL.9000.0012.0126).

[3915] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](d) (NPL.9000.0012.0126).

5.4374. The searches conducted by Detective Sergeant Hamill located some additional exhibits which were not the subject of the summons. These were identified as a swab from the floor,[3916] yellow thongs, a sample of the hallway carpet, the floor mat and three separate bags of cigarette butts collected from ashtrays in the kitchen and dining room.[3917] The swab of the floor is still retained by FASS.[3918] The other exhibits were not located.[3919]

5.4375. In addition, a pair of glasses belong to Mr Meek were handed to Detective Sergeant Tanos on 20 November 1998. No further records in relation to these glasses could be located.[3920]

5.4376. A receipt from the Sydney Crime Scene records indicated that a black wallet containing various items was transported to the Surry Hills Police Station on 11 March 1995. Neither the wallet nor further records concerning the wallet could be located.[3921] Finally, a grey-coloured ring box containing a gold-coloured men's ring with a tiger's eye stone was recorded as being received by the Surry Hills Police Station on 2 October 1995 and returned to the owner on 10 March 1999.[3922]

Further forensic examinations

5.4377. On 19 May 2023, the Inquiry wrote to FASS and requested a statement addressing a number of topics concerning both the exhibits initially tested as part of the police investigation, and other exhibits which were collected but not tested.[3923] That statement was provided on 20 May 2023.

5.4378. FASS identified that both reference blood for Mr Meek and a swab of blood from the kitchen floor are stored at FASS, and that further testing could have been conducted on the swab from the kitchen floor.[3924] In addition, further DNA testing of extracts from the stored fingernails could be carried out to compare with reference samples of Mr Meek, Mr Heatley and NP220.[3925]

5.4379. If the clothing items were available, they could have been examined for the presence of biological material and, if those were located, DNA testing could have been carried out on any stains. In addition, DNA testing could have been carried out to seek to obtain foreign DNA deposited by contact with the clothing. Trace DNA and profiling could have been attempted on the wallet, brown ceramic bowl and ampule.[3926]

[3916] This appears to be an error in Detective Sergeant Hamill's statement, as a swab from the floor was the subject of the summons.
[3917] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](c)(viii) (NPL.9000.0012.0126).
[3918] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](c)(ix) (NPL.9000.0012.0126).
[3919] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](d) (NPL.9000.0012.0126).
[3920] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](c)(x) (NPL.9000.0012.0126).
[3921] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](c)(xi) (NPL.9000.0012.0126).
[3922] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](d)(vi) (NPL.9000.0012.0126).
[3923] Exhibit 35, Tab 70, Letter from Kate Lockery to Clint Cochrane, 19 May 2023 (SCOI.84005).
[3924] Exhibit 35, Tab 71, Statement of David Bruce, 30 May 2023, [1]–[2] (SCOI.84004).
[3925] Exhibit 35, Tab 71, Statement of David Bruce, 30 May 2023, [2] (SCOI.84004).
[3926] Exhibit 35, Tab 71, Statement of David Bruce, 30 May 2023, [2] (SCOI.84004).

5.4380. In relation to the condom observed in Mr Meek's bedroom, FASS identified that testing would not have been able to determine how recently the condom had been used, regardless of the presence or absence of semen.[3927] In addition:[3928]

> *DNA testing could have been carried out on subsamples taken from the interior and exterior of the condom, depending on the determination of the inside and outside of the condom as worn. The presence of semen, a high yield source of DNA, within the condom would have greatly assisted the recovery of DNA from the apparent wearer of the condom but could also contaminate the exterior of the condom during removal making the recovery of their sexual partner's DNA more problematic.*

Professional opinions

5.4381. The Inquiry obtained a statement from Dr Linda Iles concerning the compression marks observed by Dr Lawrence on the ring finger of Mr Meek's left hand. Dr Iles agreed that the compression marks could have been caused by the presence of a ring that had been removed. She said that the medical evidence was "insufficient to provide an indication of the probability that the injuries (i.e., the bruises) were caused by the forcible ring removal or by other means."[3929]

Evidence concerning the death of Craig Behr

5.4382. Mr Heatley committed an armed robbery on 15 March 2002. He was not located by police at the time and he disclosed the offence voluntarily in July 2003.[3930] While in custody, Mr Heatley bashed and killed Craig Behr, a fellow inmate on 27 March 2004. He pleaded guilty to manslaughter. The Crown accepted the plea, based on Mr Heatley's mental illness.[3931]

5.4383. Mr Heatley was asked how he had killed Mr Behr, to which he responded, "I kicked him to death".[3932] The post-mortem examination of Mr Behr found that he could have died from "a blow to the head or from asphyxiation caused by vomit in his airways".[3933]

5.4384. On 27 October 2006, while Mr Behr's mother read her Victim Impact Statement to the Court, Mr Heatley interrupted in a violent and aggressive manner. He asserted that Mr Behr had made a sexual advance towards him. On 30 October 2006, Mr Heatley apologised for his outburst.[3934]

5.4385. Justice Whealy did not ultimately accept that Mr Heatley was the subject of a sexual advance by Mr Behr.[3935]

[3927] Exhibit 35, Tab 71, Statement of David Bruce, 30 May 2023, [4] (SCOI.84004).

[3928] Exhibit 35, Tab 71, Statement of David Bruce, 30 May 2023, [4] (SCOI.84004).

[3929] Exhibit 35, Tab 76, Report of Dr Linda Iles, 21 July 2023, 4 (SCOI.84875).

[3930] Exhibit 35, Tab 65, *R v Heatley* [2006] NSWSC 1199, Supreme Court of New South Wales, Whealy J, [17] (SCOI.11283.00001).

[3931] Exhibit 35, Tab 65, *R v Heatley* [2006] NSWSC 1199, Supreme Court of New South Wales, Whealy J, [2] (SCOI.11283.00001).

[3932] Exhibit 35, Tab 65, *R v Heatley* [2006] NSWSC 1199, Supreme Court of New South Wales, Whealy J, [41] (SCOI.11283.00001).

[3933] Exhibit 35, Tab 65, *R v Heatley* [2006] NSWSC 1199, Supreme Court of New South Wales, Whealy J, [42] (SCOI.11283.00001).

[3934] Exhibit 35, Tab 65, *R v Heatley* [2006] NSWSC 1199, Supreme Court of New South Wales, Whealy J, [67] (SCOI.11283.00001).

[3935] Exhibit 35, Tab 65, *R v Heatley* [2006] NSWSC 1199, Supreme Court of New South Wales, Whealy J, [67] (SCOI.11283.00001).

Contact with OIC

5.4386. On 25 August 2023 and 18 September 2023, the Inquiry wrote to Mr Tanos, who was the OIC in the investigation into Mr Meek's death, enclosing the written submissions made by both Counsel Assisting and the NSWPF.[3936] On 20 September 2023, Mr Tanos provided a submission to the Inquiry.[3937] Although the document is styled as a submission, it is in effect a combination of a statement and a submission. The submissions of Mr Tanos are addressed in greater detail below.

5.4387. On 3 November 2023, the Inquiry wrote to Andrew McEncroe in relation to the Ombudsman's report discussed above. On 6 November 2023, the Inquiry wrote to Kaelene Richmonds, Saeran Adams and Suzana Apostolou in relation to the same.[3938] The Inquiry did not receive a response from Mr McEncroe, Ms Richmonds, Ms Adams or Mr Apostolou.

Contact with Mr Heatley

5.4388. In light of the evidence before the Inquiry as to the potential involvement of Mr Heatley in Mr Meek's death, and the possibility that Counsel Assisting may make submissions to that effect, the Inquiry wrote letters to the Mental Health Advocacy Service at Legal Aid, which were subsequently read to Mr Heatley, on 8 and 14 June 2023. The Inquiry also wrote to Mr Heatley's sister, Christine Heatley, on 15 June 2023 and the Clinical Director and Forensic Superintendent of the Forensic Hospital, where Mr Heatley is a patient.

5.4389. By those letters, the Inquiry advised of the date of the public hearing in relation to Mr Meek's death and provided a timeframe for Mr Heatley to contact the Inquiry to provide information and/or make submissions.[3939]

Consideration of the evidence

The events of 4 March 1995 to 7 March 1995

Saturday (4 March 1995) and Sunday (5 March 1995)

5.4390. On 4 to 5 March 1995, the 1995 Mardi Gras Parade was held. In the two weeks before Mardi Gras, Mr Meek helped Carole King prepare a float at her home. He volunteered at a stall at the Mardi Gras party at the showground. Ms King saw Mr Meek leave Mardi Gras at 4:00am on 5 March 1995.[3940]

[3936] Exhibit 35, Tab 77, Letter from the Inquiry to Anthony Tanos, 25 August 2023 (SCOI.85810); Exhibit 66, Tab 49, Letter from Inquiry to Anthony Tanos, 18 September 2023 (SCOI.86306).

[3937] Submissions of Mr Anthony Tanos, 12 September 2023 (SCOI.85778).

[3938] Exhibit 66, Tabs 50A, 50B, 50C, 50D, Letters to Andrew McEncroe, Kalene Richmonds, Saeran Adams, Suzana Apostolou, 3 November 2023 and 6 November 2023 (SCOI.86671; SCOI.86669; SCOI.86670; SCOI.86672).

[3939] Exhibit 68, Tabs 19-23, Letters from Inquiry, 8-22 June 2023 (SCOI.86632; SCOI.86634; SCOI.86635; SCOI.86636; SCOI.86637).

[3940] Exhibit 35, Tab 37, Statement of Carole King, 18 March 1995, [6]–[7] (SCOI.10002.00018).

Monday (6 March 1995)

5.4391. On Monday, 6 March 1995, Mr Meek met Ms King to help clean up the car that was used for the Mardi Gras float. He arrived between 12:30pm and 1:00pm and left about 3:00pm.[3941] Brian Kane gave evidence of some events that he said took place on Monday, 6 March 1995.[3942]

MR GARRATT VISITS MR MEEK

5.4392. In the evening of 6 March 1995, Robert Garratt, a security guard at the Northcott Flats, was doing his rounds. Mr Garratt had come to know Mr Meek over the previous ten months. He had developed a habit of rattling the handle of the security door to Mr Meek's flat to let him know that he was there when he did his rounds. Mr Meek would usually, but not always, invite him in for a cup of coffee and a talk.[3943]

5.4393. On this occasion, Mr Meek invited Mr Garratt into his flat and they had a cup of coffee and talked for a while. While Mr Garratt was at the flat, there was a young man with Mr Meek, who was about 18 years old. Mr Garratt had seen the young man there previously. He was smoking marijuana from a homemade bong.[3944]

5.4394. Mr Garratt described the young man as between five foot six inches and five foot seven inches tall, medium build with straight, unkept sandy brown hair, about collar length, and Australian in appearance.[3945] By the time of Mr Heatley's trial, it was uncontroversial that this young man was Mr Heatley.

5.4395. There was a movie on television while Mr Garratt was at Mr Meek's flat called "K2". Mr Garratt stayed at the flat until the end of the movie. He then left at about 10:35pm.[3946] This was the last time that Mr Garratt saw Mr Meek alive.

MR KANE'S EVIDENCE

5.4396. Police subsequently obtained a statement from Brian Kane, Mr Meek's friend and neighbour. He described an interaction with a young man who was staying with Mr Meek, which he thought occurred on Monday, 6 March 1995. For reasons explained below, there is reason to doubt that this occurred on Monday. It appears more likely that the interaction described by Mr Kane occurred on Tuesday morning.

[3941] Exhibit 35, Tab 37, Statement of Carole King, 18 March 1995, [8] (SCOI.10002.00018).

[3942] Exhibit 35, Tab 34, Statement of Brian Kane, 11 July 1995, [3]–[6] (SCOI.10001.00146).

[3943] Exhibit 35, Tab 30, Statement of Robert Garratt, 11 March 1995, [4]–[6] (SCOI.10002.00003); Exhibit 35, Tab 31, Second Statement of Robert Garratt, 5 April 1995, (SCOI.83053); Exhibit 35, Tab 32, Third Statement of Robert Garratt, 19 September 1995, (SCOI.10004.00048); Exhibit 35, Tab 58, Transcript of Proceedings, *R v Michael Alan Heatley*,, Supreme Court of New South Wales, Ireland J, 16 November 1996, T38.1-40 (SCOI.82969). The dates provided by Garratt in his first statement were incorrect. He amended those dates in his second statement, which is confirmed in the transcript of his evidence.

[3944] Exhibit 35, Tab 30, Statement of Robert Garratt, 11 March 1995, [7] (SCOI.10002.00003).

[3945] Exhibit 35, Tab 30, Statement of Robert Garratt, 11 March 1995, [7] (SCOI.10002.00003).

[3946] Exhibit 35, Tab 30, Statement of Robert Garratt, 11 March 1995, [7] (SCOI.10002.00003). In his initial statement to police, Mr Garratt stated that he went to Mr Meek's flat on Sunday, 5 March 1995 and watched a film called K9. However, he subsequently checked the television guide and saw that the movie was actually on Monday, 6 March 1995 and that it was called "K2" rather than "K9". He provided subsequent statements to the police to that effect: Exhibit 35, Tab 31, Second Statement of Robert Garratt, 5 April 1995 (SCOI.83053); Exhibit 35, Tab 32, Third Statement of Robert Garratt, 19 September 1995 (SCOI.10004.00048).

5.4397. Mr Kane said the young man came to Mr Kane's door at approximately 10:30am and asked, "[d]o you have any Tally Ho [cigarette] papers? Can I have two? Jim told me to ask you". Mr Kane gave the young man two cigarette papers. Mr Kane described seeing Mr Meek leaning out his flyscreen door, apparently waiting for the young man to return.[3947] He described this young man as "very good looking and in my own words gorgeous".[3948]

5.4398. Mr Kane claimed that this interaction occurred on Monday, 6 March 1995. Mr Kane said that he met Mr Meek between 1:00pm and 3:00pm that Monday and that they walked their dogs together. He said that he asked Mr Meek, "Where did you pick him up and is he any good?" Mr Kane said that Mr Meek told him that he found the man at a beat in a town somewhere in the Blue Mountains on Saturday afternoon. Mr Meek reportedly said, "[h]e is a very succulent number".[3949]

5.4399. Mr Kane understood this to mean "that Jim had sucked this guy off and the guy had blown in Jim's mouth quite a few times since Saturday afternoon … Jim did tell me that he sucked this guy off a number of times but I can't recall the actual words". Mr Meek also told Mr Kane that the man "was a good cuddler and a good tongue kisser".[3950]

5.4400. There is no other evidence that places Mr Heatley at Mr Meek's flat overnight on 5 March 1995 or on the morning of 6 March 1995. The evidence of Carole King suggests that Mr Meek was elsewhere between 1:00pm and 3:00pm on 6 March 1995, which casts doubt on the temporal aspect of Mr Kane's recollection.

5.4401. It is possible that the conversation Mr Kane recalled was about another man, who Mr Meek had "picked up" over the weekend and/or that the conversation had taken place on a different day and concerned either Mr Heatley or another man.

Tuesday morning (7 March 1995)

5.4402. Given the overlapping evidence, not all of which is definite or consistent as to the time of the morning, I address below relevant evidence of various witnesses as near to chronologically as the evidence allows.

THE PHONECALL WITH MR KANE

5.4403. At 6:30am on Tuesday, 7 March 1995, Mr Kane received a phone call from Mr Meek. Mr Meek asked if Mr Kane had any smokes. Mr Kane did not. Mr Meek said that he would "see what he could do" and they ended the conversation.[3951]

[3947] Exhibit 35, Tab 34, Second Statement of Brian Kane, 11 July 1995, [5] (SCOI.10001.00146).

[3948] Exhibit 35, Tab 34, Second Statement of Brian Kane, 11 July 1995, [10] (SCOI.10001.00146).

[3949] Exhibit 35, Tab 34, Second Statement of Brian Kane, 11 July 1995, [6] (SCOI.10001.00146).

[3950] Exhibit 35, Tab 34, Second Statement of Brian Kane, 11 July 1995, [6], [8] (SCOI.10001.00146).

[3951] Exhibit 35, Tab 33, Statement of Brian Kane, 11 March 1995, [6] (SCOI.10007.00054).

THE CIGARETTES

5.4404. Carmen Sanpedro ran a mixed business known as A-Z on Belvoir Street, Surry Hills. At about 6:30am on 7 March 1995, she was setting up the shop for the day with her husband. Mr Meek knocked on the door. He bought two packets of Horizons cigarettes on credit. Ms Sanpedro had known Mr Meek for three years. He usually bought one packet of Horizon cigarettes, not two.[3952]

5.4405. At 7:30am, Mr Meek went to Mr Kane's door and gave him a dozen Horizon brand cigarettes. Mr Kane recalled this detail as this was Mr Meek's brand of cigarettes, whereas Mr Kane usually smoked White Ox tobacco or Longbeach.[3953]

5.4406. Mr Kane described Mr Meek's clothing:[3954]

> *When I last saw Jim I recall he was wearing long pants, a collared t shirt and a jumper of some sort over that. I can't remember what he was wearing on his feet, but I remember during the last few weeks he has always been wearing rubber thongs when he has been walking the dogs in the park.*

THE EVIDENCE OF MR PLUMB AND MR SHARP

5.4407. Police obtained a statement from Kevin Plumb. Mr Plumb said that on 7 March 1995, his flatmate Peter Sharp walked their dog at about 7:30am and returned to the flat at about 7:45am. Mr Sharp told Mr Plumb that he saw Mr Meek walking his dogs.[3955]

5.4408. Police obtained a statement from Mr Sharp. Mr Sharp told police that the last time he saw Mr Meek was on "Tuesday the 6 March, 1995".[3956] 6 March 1995 was a Monday, not a Tuesday. Mr Sharp later addressed this issue in evidence, saying that he saw Mr Meek on Tuesday, 7 March 1995.[3957]

5.4409. Mr Sharp told police that he took his dog for a walk between 7:00am and 7:30am on that day. He saw Mr Meek also walking his dogs. Mr Meek was wearing "a pair of khaki coloured shorts and a 'Bonds penguin' style shorts [sic]. He had thongs on his feet".[3958] Mr Sharp later corrected the reference to 'Bonds penguin' style "shorts" to "shirt".[3959]

[3952] Exhibit 35, Tab 38, Statement of Carmen Sanpedro, 20 May 1995 [3]–[4] (SCOI.10002.00051).

[3953] Exhibit 35, Tab 33, Statement of Brian Kane, 11 March 1995, [6] (SCOI.10007.00054).

[3954] Exhibit 35, Tab 33, Statement of Brian Kane, 11 March 1995, [7] (SCOI.10007.00054).

[3955] Exhibit 35, Tab 43, Statement of Kevin Plumb, 14 September 1995, [4] (SCOI.83049).

[3956] Exhibit 35, Tab 44, Statement of Peter Sharp, 14 September 1995, [4] (SCOI.83045).

[3957] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T204 (SCOI.82969).

[3958] Exhibit 35, Tab 44, Statement of Peter Sharp, 14 September 1995, [4]–[5] (SCOI.83045).

[3959] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996 , T204.32(SCOI.82969).

5.4410. Mr Plumb took his dog for another walk at about 9:15am. He took the stairs because the lifts were out. He saw Mr Meek walking his dogs again. He returned to his flat at about 9:45am. He took the lift, which was working by this time. Mr Plumb said that the power was on by this time, and he described doing the laundry.[3960] Mr Plumb's evidence is impossible to reconcile with the evidence that the power was off at the Northcott Flats on Tuesday, 7 March 1995 between 9:00am and 11:05am.

THE EVIDENCE OF MR DONNELLAN OF SYDNEY ELECTRICITY

5.4411. Stephen Donnellan was a District Operator employed by Sydney Electricity. His work involved interrupting the power supply to premises to allow other people to work on equipment safely.

5.4412. On 7 March 1995, he completed an "Access Permit to Work" for the interruption of power to the Northcott Flats. He reviewed that document when consulted by the NSWPF and told the NSWPF that it reflected that the Sydney Electricity power to Northcott Flats was interrupted between 9:00am and 11:05am.[3961]

5.4413. As is explained below, in light of Mr Donnellan's evidence, Mr Plumb accepted at Mr Heatley's trial that he was mistaken in some aspects of his evidence, including the time of the second dog walk.

TELEPHONE CALLS TO AND FROM MR MEEK

5.4414. At about 9:15am to 9:30am Mr Garratt telephoned Mr Meek. There was no answer.[3962]

5.4415. On at least one occasion at around 10:30am, Mr Meek called the radio station 2WS FM 101.7 in the morning. The evidence indicated that Mr Meek was a regular caller to various radio stations.

5.4416. Peter Graham was a radio announcer at that station. He had come to know Mr Meek over the previous six months, as Mr Meek would call the station on a daily basis and would speak to Mr Graham, either on or off air. [3963] Mr Graham recalled receiving a telephone call from Mr Meek on Tuesday, 7 March 1995 at about 10:30am.[3964]

[3960] Exhibit 35, Tab 43, Statement of Kevin Plumb, 14 September 1995, [5]–[6] (SCOI.83049).

[3961] Exhibit 35, Tab 46, Statement of Stephen Donnellan, 21 September 1995, [3]–[6] (SCOI.83050).

[3962] Exhibit 35, Tab 30, Statement of Robert Garratt, 11 March 1995, [11] (SCOI.10002.00003). Mr Garratt clarified the date of this phone call in his subsequent statement.

[3963] Exhibit 35, Tab 39, Statement of Peter Graham, 23 March 1995, [6]–[7] (SCOI.83047).

[3964] Exhibit 35, Tab 39, Statement of Peter Graham, 23 March 1995, [11] (SCOI.83047). The evidence that Mr Meek called Mr Graham at 10:30am is consistent with the evidence that the power was out at the time. A landline phone such as Mr Meek's took its power from the local telephone exchange and could continue working while the power was out.

MR KANE'S OBSERVATIONS ON MONDAY MORNING

5.4417. Between 11:00am and midday, Mr Kane left his flat. He noticed that Mr Meek's flyscreen door was slightly open and that there was a rolled-up newspaper between the flyscreen door and the front door. He opened the flyscreen door and knocked on the front door. Mr Meek did not answer.[3965]

5.4418. As soon as Mr Kane knocked, Mr Meek's dogs started to bark. He waited a few minutes and knocked again. The dogs barked again. Mr Kane thought this was unusual because of the newspaper between the doors and because "the dogs wouldn't usually bark if he wasn't in the unit with them".[3966]

THE EVIDENCE OF MR PLUMB AND MR WATSON CONCERNING THE POST

5.4419. Mr Plumb said that at 11:00am, he went down in the lift with his dog because he wanted to talk to the postman, Stephen Watson, and to walk his dog again. He said that he spoke to Mr Watson for about ten minutes while Mr Watson was putting mail into people's letterboxes. He said that, while they were talking, Mr Meek walked over from the lift area. Mr Watson handed him two letters. Mr Meek then walked out through the single glass doors which lead from the B-block of Northcott Flats to the C-block.[3967]

5.4420. Mr Plumb recognised Mr Meek's ring and he said in his statement that he "definitely saw him wearing that ring on the ring finger of his right hand when he was given the mail by Stephen at 11am on Tuesday the 7th March, 1995".[3968] Mr Plumb said that Mr Meek was wearing "a light coloured 'T' shirt and darker coloured shorts, like stubbies, and thongs."[3969] Ms McMahon's evidence was that Mr Meek always wore the tiger's eye ring on the ring finger of his left hand, and that he did not take it off for any reason.[3970]

5.4421. Stephen Watson told police:[3971]

> *On Tuesday the 7 March 1995, I was speaking with a person by the name of Kevin PLUMB at the letter boxes in the foyer area of the Northcott Flats about 11:15am when James MEEK came over and started talking to us. He appeared in good spirits and talked briefly about the mail. I remember giving him one letter that was insufficiently addressed.*

5.4422. At Mr Heatley's trial, Mr Watson accepted that this may have occurred on Monday, 6 March 1995, rather than on Tuesday, 7 March 1995.[3972]

[3965] Exhibit 35, Tab 33, Statement of Brian Kane, 11 March 1995, [8] (SCOI.10007.00054).

[3966] Exhibit 35, Tab 33, Statement of Brian Kane, 11 March 1995, [8] (SCOI.10007.00054).

[3967] Exhibit 35, Tab 43, Statement of Kevin Plumb, 14 September 1995, [6] (SCOI.83049).

[3968] Exhibit 35, Tab 43, Statement of Kevin Plumb, 14 September 1995, [8] (SCOI.83049).

[3969] Exhibit 35, Tab 43, Statement of Kevin Plumb, 14 September 1995, [6] (SCOI.83049).

[3970] Exhibit 35, Tab 73, Statement of Mercedes McMahon, 19 June 2023, [9] (SCOI.84007).

[3971] Exhibit 35, Tab 42, Statement of Stephen Watson, 19 May 1995, [6] (SCOI.10013.00004).

[3972] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T125.52-126.34 (SCOI.82969).

5.4423. As discussed above, NP219 said she had seen Mr Meek walking his dogs between 11:30am and midday on Tuesday, 7 March 1995.[3973] NP219 said that she saw Mr Meek outside the window of her unit in the park.[3974] NP219 said that she remembered the time she saw Mr Meek because she had to meet someone at the taxi club at midday. That was a 30-minute walk from her unit, and she arrived there at 12:15pm.[3975]

Tuesday afternoon (7 March 1995)

MR KANE'S EVIDENCE OF TUESDAY AFTERNOON

5.4424. Between midday and 1:30pm on 7 March 1995, Mr Kane got a phone call from Gael McKay, who was a member of the Estates Advisory Board. She was concerned that Mr Meek had not come to the meeting of the Board that morning.[3976] Ms McKay had tried calling Mr Meek from just after 10:00am and had received no answer. She then rang Mr Kane. She asked Mr Kane to have Mr Meek contact her when he saw him. Mr Kane told Ms McKay that he would leave a note on Mr Meek's door. Ms McKay continued trying to ring Mr Meek throughout the day, "about every two hours".[3977]

5.4425. Mr Kane wrote a note on a blue piece of paper for Mr Meek to ring Ms McKay. He stuck it on the main door of Mr Meek's unit with sticky tape. He knocked again. Mr Meek did not answer. The dogs barked again.[3978] In a subsequent statement, Mr Kane provided the following further details of the note:[3979]

> *I took the note off the screen door on Wednesday afternoon whilst talking to Constable RICHMOND and offered it to her but she said they didn't require it. I took the note home and may still have it. On the note I wrote in the top right hand corner, '11am Tues, 7/3/95'. A little bit below and to the left of the page I wrote, Jim. The [sic] underneath that I wrote, 'Gail rang urgently needs to talk to you regarding EAB meeting today ring her on ... I then wrote my name, 'Brian', under which I drew a line and put two full stops after it, which is my normal way of signing informally.*

5.4426. Mr Kane did not explain why he wrote "11am" on the note if he was leaving a message from Ms McKay which he received after midday, but it may be this was a reference to the first time Mr Kane had knocked and not been answered.

[3973] Exhibit 35, Tab 41, Statement of NP219, 28 March 1995, [10] (SCOI.10002.00037).

[3974] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996 , T377.8 (SCOI.82969).

[3975] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996 , T377.19-58 (SCOI.82969).

[3976] Exhibit 35, Tab 33, Statement of Brian Kane, 11 March 1995, [9] (SCOI.10007.00055).

[3977] Exhibit 35, Tab 35, Statement of Gael McKay, 17 July 1995, [8]–[9] (SCOI.83043).

[3978] Exhibit 35, Tab 33 Statement of Brian Kane, 11 March 1995, [9] (SCOI.10007.00054).

[3979] Exhibit 35, Tab 34, Second Statement of Brian Kane, 11 July 1995, [13] (SCOI.10001.00146).

MR LAWRENCE KNOCKS ON THE DOOR

5.4427. Michael Lawrence was another friend of Mr Meek and a resident of Northcott Flats. He tried to call Mr Meek throughout the day on 7 March 1995 without success.[3980] In the early afternoon, he went to Mr Meek's flat. He saw that the security door was unlocked and that there was newspaper between the security door and the wooden door. He noticed the message from Mr Kane on the door. He opened the security door and knocked on the wooden door. There was no answer.[3981]

5.4428. Mr Kane heard Mr Lawrence knocking on Mr Meek's door and came out of his flat. They asked each other where Mr Meek was. They banged on Mr Meek's door and on the glass of the kitchen and bathroom windows. The only reaction was from the dogs, who barked.[3982]

MR GARRATT BECOMES CONCERNED

5.4429. That afternoon, Mr Garratt did his rounds as a security guard. At 5:15pm, he got to Mr Meek's flat. He noted that the security screen door was unlocked and open,[3983] and that there were newspapers stuck between the screen door and the main door. The main door was locked. Mr Garratt found this very unusual as Mr Meek was "very paranoid about locking the door, whether he was home or not".[3984]

5.4430. Mr Meek did not answer the door when Mr Garratt called out to him. Mr Garratt continued to check Mr Meek's flat during his patrol. Mr Garratt noted that Mr Meek's dogs were still in the flat and that his car was still parked in the carpark.[3985]

5.4431. At about 9:00pm, Mr Garratt was still concerned about Mr Meek. He went to Mr Meek's flat and put some tape on the door, which would fall out if anyone opened the door, to indicate whether anyone had been home. Mr Garratt told Mr Lawrence about the tape. [3986]

[3980] Exhibit 35, Tab 36, Statement of Michael Lawrence, 11 March 1995, [8] (SCOI.10001.00140).

[3981] Exhibit 35, Tab 36, Statement of Michael Lawrence, 11 March 1995, [10]–[12] (SCOI.10001.00140).

[3982] Exhibit 35, Tab 33, Statement of Brian Kane, 11 March 1995, [10] (SCOI.10004.00052); Exhibit 35, Tab 36, Statement of Michael Lawrence, 11 March 1995, [12] (SCOI.10001.00140).

[3983] The security door was opened by Michael Lawrence when trying to contact Mr Meek, although it was already unlocked at that point: see Exhibit 35, Tab 36, Statement of Michael Lawrence, 11 March 1995, [11] (SCOI.10001.00140).

[3984] Exhibit 35, Tab 30, Statement of Robert Garratt, 11 March 1995, [10] (SCOI.10002.00003).

[3985] Exhibit 35, Tab 30, Statement of Robert Garratt, 11 March 1995, [10] (SCOI.10002.00003).

[3986] Exhibit 35, Tab 30, Statement of Robert Garratt, 11 March 1995, [12] (SCOI.10002.00003); Exhibit 35, Tab 31, Second Statement of Robert Garratt, 5 April 1995, [5] (SCOI.83053); Exhibit 35, Tab 36, Statement of Michael Lawrence, 11 March 1995, [17] (SCOI.10001.00140).

Wednesday (8 March 1995)

A LOCKSMITH IS CALLED

5.4432. On the morning of 8 March 1995, Mr Lawrence told Mr Garratt that the tape was still there on Mr Meek's door. He said that he was going to see Bill Coffey, the manager of the buildings at Northcott Flats, about getting a locksmith to enter Mr Meek's flat.[3987]

5.4433. At about 3:00pm, Mr Lawrence called Surry Hills Police.[3988] At about 3:30pm, Constable Kaylene Richmond and Constable Saeran Humphreys attended Mr Meek's flat. They gained entry with the assistance of a locksmith. They found Mr Meek lying face down on the floor directly in front of the door in the entrance hall. Mr Coffey identified Mr Meek to police.[3989]

5.4434. There was a small amount of blood around Mr Meek's nose, which had dried. His face was a deep purple-grey colour and it appeared to be slightly bloated. Mr Meek was wearing a grey t-shirt, light blue shorts and rubber thongs.[3990] Mr Meek was holding a set of keys in his right hand. The house key was positioned between the index and middle finger of his right hand.[3991]

5.4435. Mr Meek's glasses were lying on the floor next to his head. A shoeprint was visible on the spectacles, indicating that they had been stepped on. Analysis of the shoeprint was insufficient to match it to a particular style of shoe.[3992]

5.4436. There was no sign of forced entry to Mr Meek's flat and there was no sign of a struggle. The flat was untidy, but it did not appear to have been ransacked or recently disturbed.[3993]

5.4437. Various people described Mr Meek as being security conscious.[3994] Mr Woodward, said that Mr Meek would lock the security door to his flat even if someone was in the flat with him, and that Mr Meek would keep a baseball bat behind the front door for security.[3995]

5.4438. Police identified that two items of property had been removed from Mr Meek's body: a Citizen band quartz watch with silver band which was engraved on the rear of the watch; and a men's gold-banded dress ring with a tiger's eye stone.[3996] Mr Meek was known to wear the tiger's eye ring on his ring finger.[3997]

[3987] Exhibit 35, Tab 30, Statement of Robert Garratt, 11 March 1995, [12]–[13] (SCOI.10002.00003).

[3988] Exhibit 35, Tab 36, Statement of Michael Lawrence, 11 March 1995, [21] (SCOI.10001.00140).

[3989] Exhibit 35, Tab 19, Statement of Constable Saeran Humphreys, [3]–[5] (SCOI.10001.00005).

[3990] Exhibit 35, Tab 19, Statement of Constable Saeran Humphreys, [4]–[7] (SCOI.10001.00005). See also Exhibit 35, Tab 5, Crime Scene Photographs, 8 March 1995, 8, 10-16 (SCOI.10402.00095).

[3991] Exhibit 35, Tab 17, Statement of Constable First Class Suzana Whybro, 2 April 1995, [9] (SCOI.10001.00091).

[3992] Exhibit 35, Tab 10, NSWPF Running Sheet, 'Taskforce Fireweed Inquiries Concerning Shoe Imprint', 26 April 1995 (SCOI.10001.00083).

[3993] Exhibit 35, Tab 17, Statement of Constable Suzana Whybro, 2 April 1995, [14] (SCOI.10001.00091).

[3994] Exhibit 35, Tab 26, Statement of Wayne Ruscoe, 14 March 1995, [14] (SCOI.10001.00143).

[3995] Exhibit 35, Tab 49, Statement of Robert Woodward, 10 July 1995, [5] (SCOI.10005.00117).

[3996] Exhibit 35, Tab 9, NSWPF Issue Paper, 'Memorandum re Murder of James Meek', 12 April 1995 (SCOI.10003.00237).

[3997] Exhibit 35, Tab 26, Statement of Wayne Ruscoe, 14 March 1995, [17] (SCOI.10001.00143).

5.4439. Police found a used condom on top of the chest of drawers in Mr Meek's bedroom, along with a number of homosexual pornographic magazines and a blue bum bag.[3998] The used condom was not taken into evidence.

Mr Heatley's account of events

5.4440. On 22 June 1995, police interviewed Michael Heatley in Tasmania, having identified him by way of a fingerprint as outlined above.

5.4441. Mr Heatley claimed that Mr Meek was "a friend and that was all" who he met through his sister in September 1994 or "maybe before then".[3999] Mr Heatley claimed that he would turn up to Meek's flat unannounced in order to get a sleeping tablet.[4000]

5.4442. Mr Heatley was aware that Mr Meek was gay. During the interview, Mr Heatley referred to Mr Meek as "a poofter". He denied having a sexual relationship with him and denied that Mr Meek had ever suggested having a sexual relationship.[4001]

5.4443. Mr Heatley knew that Mr Meek was HIV-positive:[4002]

> *Karen told me that he had AIDS and everything and I thought "Oh," and that didn't – ever since then I just didn't – I was just particular about what I ate and everything from there, if I ever ate anything, 'cause when he – and after that I didn't want him to cook me any meals or anything 'cause I just to [sic] used to spin out on him having AIDS.*

5.4444. Tasmanian Police interviewed Mr Heatley's sister, Karen Heatley. Ms Heatley claimed that "basically, no one's homophobic in our family".[4003] She also said: "when I found out he had AIDS, like, I told Christine and she didn't have any reaction and I told Michael and he didn't either".[4004]

5.4445. Ms Heatley had no recollection of Mr Meek "being touchy or anything like that" with Mr Heatley.[4005]

5.4446. Police asked Mr Heatley about the last time that he attended Mr Meek's flat. He did not recall the date or even the month. Mr Heatley said that he arrived between 5:30pm and 7:00pm. He asked if he could stay the night. He said that Mr Meek "ummed and aahed" and then said that he could stay "1 night and that's all".[4006]

[3998] Exhibit 35, Tab 17, Statement of Constable Suzana Whybro, 2 April 1995, [11] (SCOI.10001.00091).

[3999] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley', 22 June 1995, [Q65]–[A67] (SCOI.10005.00047).

[4000] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley', 2 June 1995 , [Q79]–[A82] (SCOI.10005.00047).

[4001] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley', 2 June 1995, [Q83]–[A87] (SCOI.10005.00047).

[4002] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley', 2 June 1995 , [A77] (SCOI.10005.00047).

[4003] Exhibit 35, Tab 48, NSWPF Record of interview, 'Interview with Karen Heatley', 22 June 1995, [A43] (SCOI.10012.00105).

[4004] Exhibit 35, Tab 48, NSWPF Record of interview, 'Interview with Karen Heatley', 22 June 1995, [A58] (SCOI.10012.00105).

[4005] Exhibit 35, Tab 48, NSWPF Record of interview, 'Interview with Karen Heatley', 22 June 1995, [A77] (SCOI.10012.00105).

[4006] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley', 2 June 1995, [A93] (SCOI.10005.00047).

5.4447. Mr Heatley described sitting up at the table with Meek and the security guard, "talking, just laughing and joking. I was smoking marijuana, Jim's marijuana, watched a few movies". He said that they watched movies until 11:00pm or midnight.[4007]

5.4448. Mr Heatley said that he slept on the couch and that Mr Meek slept in his bed. He said that Mr Meek woke him up at about 7:00am the next morning.

5.4449. Mr Heatley said that he and Mr Meek "played radio games…He rang 2WS to see if he could ring a – win a prize, 'cause he'd won prizes from them before, and he rang up 2WS".[4008]

5.4450. Mr Heatley also said that Mr Meek made and received phone calls while he was at the flat. He did not know who Mr Meek spoke to on the phone but he said, "only a few people rang him, though, I think".[4009]

5.4451. He said that he had a shower, cooked a few pieces of toast, had the toast, "had a few more bongs and then virtually left".[4010] Mr Heatley thought that Mr Meek bought the loaf of bread that he used to make toast that morning because the bread was new and the crust was right on the top.[4011]

5.4452. Mr Heatley said that before he left, he went next door and got a Tally-Ho and some tobacco from Meek's next-door neighbour, and that he rolled a joint.[4012] Mr Heatley claimed that he left the flat "before 9 o'clock".[4013]

5.4453. Mr Heatley admitted that he stole a ring from Meek. He claimed that he stole it from a cabinet drawer. He described the ring as "gold with a brown flecked stone in the top of it".[4014] Mr Heatley denied stealing anything else from the flat.[4015]

[4007] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley', 22 June 1995, [Q94]–[A98] (SCOI.10005.00047).
[4008] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley', 22 June 1995, [Q203]–[A204] (SCOI.10005.00047).
[4009] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley', 22 June 1995, [Q284]–[A286] (SCOI.10005.00047).
[4010] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley', 22 June 1995, [Q101]–[A104] (SCOI.10005.00047).
[4011] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley', 22 June 1995, [A282] (SCOI.10005.00047).
[4012] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley', 22 June 1995, [Q116]–[A117] (SCOI.10005.00047).
[4013] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley', 22 June 1995, [Q104]–[A105] (SCOI.10005.00047).
[4014] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley', 22 June 1995, [Q107]–[A114] (SCOI.10005.00047).
[4015] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley', 22 June 1995, [Q201]–[A202] (SCOI.10005.00047).

5.4454. Mr Heatley described leaving Mr Meek's flat as follows:[4016]

> *Jim said, "Unless you want the cherry pickers to come and pick you up, the fire engines to come and pick you up, you're gonna have to leave or whatever, because the lifts aren't going to be working." So anyway I said, "Okay, then" and, anyway, I rolled a joint and I tasted a little bit of his leaf from his … and then I left. I went down and he said, "Go down" – he said, "Use the stairwell," and so, anyway, I used the stairwell, walked along, used the lifts. The lifts weren't working, so I walked back along and walked back up the stairwell, knocked on his door and I told him that they weren't working and he said, "Sing out to 'em, then." I sang out to the fella down at the fire engine, told him that the lifts weren't working and he said, "No, that's all right." One of the fellas went in, then come out. So anyway, I said, "Okay, then," said goodbye to Jim, walked back down, walked along, pressed the button on the lift, it opened, went down…*

5.4455. A statement was subsequently obtained from a representative of the NSW Fire Brigade, who said that there was no record of a fire engine attending the Northcott Flats on that date.[4017]

5.4456. What did occur on 7 March 1995, as noted above, was that Sydney Electricity attended the Northcott Flats, in the course of which the power was cut off some time prior to 9:00am and was restored at around 11:05am.[4018] The contemporaneous documentary records confirmed this.[4019] This is consistent with Mr Heatley's evidence that Mr Meek told him that the lifts would not be working and with his evidence that the lifts did not work the first time he tried. On Mr Heatley's account, the lifts worked the second time he tried to use them, after he called down to the person at the ground floor (likely the electrician, not the fire brigade).

Mr Heatley's movements after he left Northcott Flats

5.4457. Mr Heatley said he took the ring to the "hockshop" in Merrylands to see if he could get some money for it.[4020] He went with his father's cousin, Roger Griffiths (who went by the alias Roger Cochrane).[4021] He said that he did not tell Mr Griffiths that he had stolen the ring. He said he received $40 for the ring. He said he pawned the ring the same day he stole it.[4022]

[4016] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley, 22 June 1995, [A123] (SCOI.10005.00047).

[4017] Exhibit 35, Tab 45, Statement of Ray Kelly, 4 August 1995, [4]–[5] (SCOI.83046).

[4018] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T71.41-75.11 (SCOI.82969).

[4019] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T71.41-75.11 (SCOI.82969).

[4020] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley , 22 June 1995, [Q126]–[A127] (SCOI.10005.00047).

[4021] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T331.44-50 (SCOI.82969)

[4022] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley , 22 June 1995, [Q133]–[A143] (SCOI.10005.00047).

5.4458. On 22 June 1995, police attended King's Loan Office, 142 Merrylands Road, Merrylands. They spoke to Ian Puddicombe, the owner of the pawnshop. They examined his purchase book and pawn receipts. They took possession of a ring matching the description of Mr Meek's ring, which had been sold by Roger Cochran at 1:30pm on 7 March 1995.[4023]

5.4459. Mr Puddicombe told police that Mr Heatley had first tried to sell the ring at 1:15pm, but that he had refused to buy it at that time because he thought Mr Heatley was underage and he did not have identification. He said that Mr Heatley returned to the store with Roger Cochran, at which point he bought the ring. [4024]

5.4460. Mr Griffiths provided a statement to police on 11 July 1995 which was broadly consistent with Mr Heatley's account. He said that on 7 March 1995, he walked to Merrylands with Mr Heatley from his house at Crosslands Street, Merrylands. He recalled that Mr Heatley told him he was broke and desperate and that he was going to sell his father's ring.[4025]

5.4461. Mr Griffiths went to the Billabong Hotel while Mr Heatley went to King's Loan Office. About ten minutes later, Mr Heatley came into the pub to ask if Mr Griffiths could vouch for him at King's Loan Office. Mr Griffiths went to King's Loan Office and spoke to the proprietor. Mr Heatley pawned the ring in Mr Griffiths' name.[4026] At the time he made his statement, Mr Griffiths was not sure whether Mr Heatley had stayed with him the night before.[4027]

5.4462. Mr Heatley had travelled to Merrylands by train. He told police later that he "got done for not having a ticket or the inspector at Granville got me at Granville for not having a ticket".[4028] Transit Police had no record of any infringement notice for Mr Heatley, nor of any infringement notice issued in Granville or Lidcombe on 7 March 1995.[4029] Nevertheless, there is no reason to doubt that Mr Heatley travelled by train.

5.4463. Mr Heatley said that he subsequently went to stay with his sister's boyfriend, Roger Bissett, who was staying with Mr Woodward. He said he stayed there for a couple of nights before Mr Woodward complained about the rent, at which point he went to stay with Mr Griffiths. After that, Mr Heatley lived "just on the street".[4030] Mr Woodward was a friend of Mr Meek's and also knew the Heatleys as a family. He confirmed that Mr Heatley stayed with him for two nights in the week after Mr Meek died.[4031]

[4023] Exhibit 35, Tab 15, NSWPF Situation Report, 'South Region – Situation Report' 12 July 1995, (SCOI.10005.00024).

[4024] Exhibit 35, Tab 51, Statement of Ian Puddicombe, 2 August 1995, [4]–[5] (SCOI.83054).

[4025] Exhibit 35, Tab 50, Statement of Roger Griffiths, 11 July 1995, [7] (SCOI.83051).

[4026] Exhibit 35, Tab 50, Statement of Roger Griffiths, 11 July 1995, [8] (SCOI.83051).

[4027] Exhibit 35, Tab 50, Statement of Roger Griffiths, 11 July 1995, [7] (SCOI.83051).

[4028] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley , 22 June 1995, [A289] (SCOI.10005.00047).

[4029] Exhibit 35, Tab 21, Statement of Michael Banning, 13 July 1995, [5]–[6] (SCOI.83052).

[4030] Exhibit 35, Tab 47, NSWPF Record of interview, 'Interview with Michael Heatley , 22 June 1995, [A145]–[A161] (SCOI.10005.00047).

[4031] Exhibit 35, Tab 49, Statement of Robert Woodward, 10 July 1995, [12] (SCOI.10005.00117).

5.4464. Mr Woodward told police, "[t]o my knowledge [Michael] knew Jim was gay, but when ever anyone mentioned gays or homosexuals, Michael would take offence and say things like 'I'm not a dirty poof'."[4032]

5.4465. Each of Mr Kane,[4033] Mr Plumb,[4034] Mr Garratt,[4035] Mr Puddicombe,[4036] and Mr Sharp[4037] subsequently identified Mr Heatley from a photobook shown to them by police.

5.4466. On 11 November 1998, police retraced Mr Heatley's steps based on the combined accounts of Mr Griffiths and Mr Heatley. They left Mr Meek's flat at 10:53am and walked to Central Station. They took a train to Merrylands. They walked from Merrylands Station to Mr Griffith's house. They then walked back to Merrylands Station. They then walked from Merrylands Station to the Billabong Hotel, which was roughly across the road from the King's Loan Office.[4038] Police measured the time it took to complete this journey with a stopwatch. The journey took "93 minutes and 20 seconds".[4039]

The basis of Mr Heatley's acquittal

5.4467. During the trial, the defence cross-examined Mr Plumb about his evidence that the power was off at 9:30am, but that it was back on by 9:45am on the day he saw Mr Meek in the foyer of the Northcott Flats. This was at odds with the evidence which established that the power was off between 9:00am and 11:05am on 7 March 1995. The defence put the following proposition to Mr Plumb:[4040]

> *…[I]f it is the case that there was a day in early March 1995 in which the Sydney Electricity power authority cut off the substation servicing part of the Northcott Flats…If there was a day when that happened, that the power was cut off from some time just before 9 o'clock to 11 o'clock continuously, no power at all between 9 o'clock and 11 o'clock because the substation is cut off, that is not the day you were talking about, is it?*

5.4468. Mr Plumb accepted that proposition and that it was not possible for the day he saw Mr Meek to be the same day that the power was cut. This cast doubt on his evidence about seeing Mr Meek alive on 7 March 1995.

[4032] Exhibit 35, Tab 49, Statement of Robert Woodward, 10 July 1995, [11] (SCOI.10005.00117).

[4033] Exhibit 35, Tab 18, Statement of Detective Sergeant Anthony Tanos, 20 September 1995, [19] (SCOI.10014.00003).

[4034] Exhibit 35, Tab 18, Statement of Detective Sergeant Anthony Tanos, 20 September 1995, [20] (SCOI.10001.00003).

[4035] Exhibit 35, Tab 18, Statement of Detective Sergeant Anthony Tanos, 20 September 1995, [21] (SCOI.10001.00003).

[4036] Exhibit 35, Tab 20, Statement of Detective Senior Constable Neil Walker, 20 September 1995, [18] (SCOI.83055).

[4037] Exhibit 35, Tab 20, Statement of Detective Senior Constable Neil Walker, 20 September 1995, [19] (SCOI.83055).

[4038] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T364.31-T365.30 (SCOI.82969).

[4039] Exhibit 35, Tab 58, Transcript of Proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T365.23-25 (SCOI.82969).

[4040] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T200.28-201.5 (SCOI.82969).

5.4469. The defence submitted that the conversation described by Mr Plumb "must have been the Monday".[4041] The defence also cross-examined Mr Plumb about his evidence that he saw Mr Meek wearing the ring. That cross-examination led the trial judge to conclude that it was "highly improbable that he would even be able to make the observation and especially if he wasn't specifically looking".[4042]

5.4470. The defence also cross-examined Mr Watson. Mr Watson accepted that it was possible that he had spoken to Mr Meek on Monday, 6 March 1995 rather than Tuesday, 7 March 1995.[4043]

5.4471. Mr Griffiths gave evidence at the trial that Mr Heatley had come to his home at Merrylands "no later than 11 o'clock" on 7 March 1995.[4044] Mr Griffiths was asked how he knew that Mr Heatley had come to his home that morning, when he had previously told police that he did not know if Mr Heatley had stayed over the night before:[4045]

> *Q. Do you know whether or not Michael, that is the accused, stayed at your place the night before?*
>
> *A. Well as I said to Detective Walker, I wasn't sure if he had stayed the night before or if he arrived that morning.*
>
> *Q. And you are still not sure, is that correct - you are still not sure?*
>
> *A. No, I believe that he did arrive that morning because, I mean this happened - three years ago - yes - but at the time when I spoke to Detective Walker, I wasn't sure but yes – he arrived that morning.*
>
> *Q. And how is it that you know he arrived that morning now as opposed to when you spoke to Detective Walker, in 1995?*
>
> *A. Because I have had time to think about it. At the time when Detective Walker spoke to me I really wasn't too concerned with it.*

5.4472. Mr Griffiths was asked what he did the morning after Mr Heatley arrived at his flat. He said:[4046]

> *Well I fed the cats, heated up water on the stove, ran a bath. I didn't have a hot water system - had a bath. I didn't drop everything the minute he came home. I got dressed, got the Cadillac and went to Merrylands.*

[4041] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T419.52 (SCOI.82969).

[4042] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T426.55-57 (SCOI.82969).

[4043] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T125.52-126.34 (SCOI.82969).

[4044] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T334.15-35 (SCOI.82969).

[4045] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T334.58-335.16 (SCOI.82969).

[4046] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T335.28-31 (SCOI.82969).

5.4473. He said that he and Mr Heatley walked to Merrylands.[4047]

5.4474. In light of the concessions which were made under cross-examination by Mr Plumb and Mr Watson, the defence applied for a directed acquittal. The trial judge accepted that the evidence was not sufficient for the jury to convict Mr Heatley and accordingly directed the jury to deliver an acquittal.[4048]

The available hypotheses

5.4475. Counsel Assisting submitted that four hypotheses that emerge from the evidence tendered publicly before the Inquiry:[4049]

a. First, Mr Heatley was responsible for the injuries that caused Mr Meek's death;

b. Secondly, NP220 was responsible for the injuries that caused Mr Meek's death;

c. Thirdly, NP219 was responsible for the injuries that caused Mr Meek's death; and

d. Fourthly, a person or persons unknown were responsible for the injuries that caused Mr Meek's death.

Police investigation

5.4476. Following the receipt of written submissions from both Counsel Assisting and the NSWPF, the Inquiry received evidence (set out in detail below) concerning a inquiry conducted by the Ombudsman into the NSWPF investigation of Mr Meek's death in 1996. The Ombudsman made findings about various deficiencies in that investigation.

5.4477. I considered whether, in light of the Ombudsman's Report, there was any need to consider the submissions of Counsel Assisting and the NSWPF concerning the investigation, or to make findings concerning the investigation, on the basis that the NSWPF investigation had already been sufficiently and appropriately dealt with by the Ombudsman.

5.4478. I determined it was appropriate for me to consider the relevant submissions and make findings in relation to the NSWPF investigation, noting that the evidence had already been tendered and submissions made, and that the matters addressed in submissions before me go beyond the matters in the Ombudsman's Report. My findings are consistent with those made in the Ombudsman's Report. I return to the Ombudsman's Report below.

[4047] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T335.33-37 (SCOI.82969).

[4048] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan Heatley*, Supreme Court of New South Wales, Ireland J, 16 November 1996, T428 (SCOI.82969).

[4049] Submissions of Counsel Assisting, 22 June 2023, [188] (SCOI.84128).

5.4479. I accept the submission of Counsel Assisting that the initial investigation by the NSWPF was thorough to some extent. The NSWPF spoke to many of Mr Meek's neighbours and associates. The investigation into Mr Meek's missing ring was particularly thorough, with the NSWPF contacting many pawnshops and ultimately located the pawnshop where Mr Heatley had sold the missing ring.

5.4480. The original investigation was open to the possibility that Mr Meek's death was a hate crime. The NSWPF actively pursued lines of investigation relating to this possibility. As noted above, the *Sydney Star Observer* and *Capital Q Weekly* reported that the NSWPF were investigating the matter as a "gay hate" killing "probably more so than not at this stage".[4050]

5.4481. The investigation ultimately identified Mr Heatley as a suspect and, consequently, charges were brought against Mr Heatley. There were, however, deficiencies in the initial investigation, which I explore below. I note that Mr Tanos submitted that the investigation into Mr Meek's death was "thorough and comprehensive".[4051] For the reasons I set out in the following passages, I do not accept that submission. While aspects of the police investigation were competently conducted, the Ombudsman's Report, in addition to those matters identified in the submissions of Counsel Assisting, demonstrate significant deficiencies in the investigation of Mr Meek's death.

The used condom in Mr Meek's bedroom and the release of the crime scene

5.4482. Constable Whybro, when she attended Mr Meek's apartment on the afternoon of 8 March 1995, observed a used condom in Mr Meek's bedroom. Police did not take that used condom into evidence. As a consequence, the used condom was never subjected to forensic testing and it is not available for forensic testing now.

5.4483. The evidence of Constable Humphreys is consistent with a crime scene being established on 8 March 1995, and then being released on the same day once the Crime Scene Unit left the premises.[4052]

5.4484. It appears that police at this time were not treating Mr Meek's death as suspicious, as reflected in the Report of Death to the Coroner of the same date and in Constable Whybro's observation that "[h]e did not appear to be the subject of recent trauma".[4053] This is consistent with the crime scene being released once the Crime Scene Unit left the premises.

5.4485. As set out above, Mr Meek's daughter Ms McMahon said that she was initially told by police that Mr Meek had died of a heart attack.[4054] The criminal investigation into Mr Meek's death did not formally commence until 14 March 1995, following the post-mortem examination that took place on 11 March 1995.[4055]

[4050] Exhibit 35, Tab 64, Kristy Machon, 'Bashed to Death: Gay Hate Murder?', *Sydney Star Observer* (Sydney, 23 March 1995) (SCOI.84002); Exhibit 35, Tab 63, 'No concrete leads in Meek murder', *Capital Q Weekly* (Sydney, 23 March 1995) (SCOI.10013.00046).

[4051] Submissions of Mr Anthony Tanos, 12 September 2023, [14] (SCOI.85778).

[4052] Exhibit 35, Tab 19, Statement of Constable Saeran Humphreys, 12 March 1994, [8]–[9] (SCOI.10001.00005).

[4053] Exhibit 35, Tab 1, NSWPF 'Report of Death to Coroner,' 8 March 1995 (SCOI.10001.00008); Exhibit 35, Tab 17, Statement of Constable Suzana Whybro, 2 April 1995, [14] (SCOI.10001.00091).

[4054] Exhibit 35, Tab 73, Statement of Mercedes McMahon, 19 June 2023, [7] (SCOI.84007).

[4055] Exhibit 35, Tab 18, Statement of Detective Sergeant Anthony Tanos, 20 September 1995, [3]–[5] (SCOI.10014.00003).

5.4486. By the time the criminal investigation commenced Mr Meek's daughters and their husbands had tidied Mr Meek's flat.[4056] Ms McMahon recalls picking up the condom and throwing it away, and said that because she had been told that Mr Meek had died of a heart attack, she "didn't think anything of it".[4057]

5.4487. Ms McMahon stated that she asked for a post-mortem to be conducted because she did not believe that Mr Meek's death had been caused by a heart attack.[4058] She appears to have formed this view after going to identify Mr Meek's body (see below). She described his face as being "bruised and bashed".[4059]

5.4488. On 29 August 1995, solicitors for Mr Meek's daughters wrote to the NSWPF raising concerns about the conduct of the investigation into Mr Meek's death. The letter noted the following concerns which suggest that police should not have formed the preliminary view that Mr Meek died from natural causes and should not have released the crime scene:[4060]

a. When Ms Griffin saw her father's body at the Glebe Morgue on 10 March 1995, she immediately perceived injuries which were extensive and which she believed were inconsistent with a heart attack;

b. The police officers who attended the scene considered that there were no suspicious circumstances despite the absence of personal belongings;

c. Ms Griffin and Ms Franks found blood under the front doormat when they attended Mr Meek's flat on 9 March 1995; and

d. The NSWPF considered that Mr Meek died as a result of a heart attack, but gave no indication to Ms Griffin and Ms Franks as to why they reached this conclusion. There was no history of heart disease in the family.

5.4489. I note the submissions of the NSWPF concerning the release of the crime scene.[4061] I accept that there is a possibility that the bruising later observed by Ms McMahon may have become visible at a later point in time, although that is not a matter about which I have received evidence in this case.

5.4490. However, irrespective of whether there were obvious injuries (and I observe that the crime scene photos do show blood on the back of Mr Meek's head), police did not have any information to suggest that Mr Meek had a history of heart failure, or of any other disease which would have explained his sudden collapse and death.[4062]

[4056] Exhibit 35, Tab 22, Statement of Karen Franks, 12 March 1995, [8] (SCOI.10001.00131); Exhibit 35, Tab 73, Statement of Mercedes McMahon, 19 June 2023, [7] (SCOI.84007).

[4057] Exhibit 35, Tab 73, Statement of Mercedes McMahon, 19 June 2023, [7] (SCOI.84007).

[4058] Exhibit 35, Tab 73, Statement of Mercedes McMahon, 19 June 2023, [8] (SCOI.84007).

[4059] Exhibit 35, Tab 73, Statement of Mercedes McMahon, 19 June 2023, [9] (SCOI.84007).

[4060] Exhibit 35, Tab 22B, Letter from Blessington Judd to NSWPF, 29 August 1995, 1-2 (SCOI.02729.00026).

[4061] Submissions of NSWPF, 7 July 2023, [97]–[102] (SCOI.84812).

[4062] Mr Meek had a background history of asthma and chronic obstructive airways disease, secondary to smoking (see Exhibit 35, Tab 23, Statement of Alexander Beveridge, [5] (SCOI.10001.00166)), but there is no suggestion the NSWPF were aware of this history at the time they located Mr Meek's body.

5.4491. Counsel Assisting submitted, and I accept, that it is not clear why the preliminary view that Mr Meek had died from natural causes led to police releasing the crime scene. Mr Meek was not an elderly man, and the photos of his body show residual blood on the back of his head, consistent with a blow.[4063]

5.4492. Although Mr Meek was HIV-positive, there was nothing to suggest that this had caused an unexpected collapse. Further, the position of Mr Meek's body did not suggest that he may have, for example, fallen and struck his head on an item of furniture.

5.4493. In my view, and consistent with the oral evidence given by Detective Inspector Warren and Superintendent Best at the Investigative Practices Hearing (set out below), the crime scene should not have been released when the cause of death was unknown and where there was a possibility of homicide. The premature release of the crime scene meant that the used condom was disposed of and could not be taken into evidence.

5.4494. The used condom was significant in two key respects.

5.4495. First, the condom suggested that Mr Meek had engaged in sexual activity prior to his death. It raised the possibility that Mr Meek had been killed by a sexual partner. The NSWPF were subsequently told that Mr Heatley may have had a sexual relationship with Mr Meek.

5.4496. Further, some witnesses had formed the view that NP220 had a sexual relationship with Mr Meek. Each of Mr Heatley and NP220 denied that he had a sexual relationship with Mr Meek. The existence of the condom was never put to NP220 or Mr Heatley, nor were they pressed by police on their assertions that they had not had a sexual relationship with Mr Meek.

5.4497. Secondly, forensic testing could have been performed on the condom.

5.4498. The results of forensic testing of the used condom could have affected the investigation as follows:

a. If Mr Heatley's DNA had been found on the used condom it would have cast significant doubt on his explanation of the morning's events. Having regard to the attitudes he had expressed in relation to Mr Meek's sexuality, and his denial of a sexual relationship with Mr Meek, it would have raised the possibility of a motive for killing Mr Meek other than robbery. This evidence would have materially affected the prosecution case;

b. If NP220's DNA had been found on the used condom, then police would have had reason to investigate him further; or

c. If a third person's DNA had been found on the used condom, then police would have had a further suspect to investigate.

[4063] Submissions of Counsel Assisting, 22 June 2023, [54] (SCOI.84128); Exhibit 35, Tab 5, Crime scene photographs [SENSITIVE], 8 March 1995, Photograph 12 (SCOI.10001.00008).

5.4499. I accept the submission of Counsel Assisting that failure to take the used condom into evidence foreclosed a significant avenue of investigation. It may have prevented the identification and successful prosecution of Mr Meek's killer. It was a significant oversight or error of judgment in the investigation.

5.4500. I acknowledge the submission put on behalf of the NSWPF that it is regrettable that the matter was not treated as a potential homicide at the earlier stages of the investigation, and the acknowledgement by the NSWPF that it would have been preferable for the used condom to be seized as a precaution.[4064]

5.4501. Mr Meek's case was also considered in the context of the Investigative Practices Hearing. In written submissions filed in the context of the Investigative Practices Hearing by Counsel Assisting the primary matter of concern in relation to Mr Meek's death is the release of the crime scene.[4065]

5.4502. In written submissions filed on behalf of the NSWPF in the context of the Investigative Practices Hearing, the NSWPF submitted that the crime scene was released on 8 March 1995, being the day Mr Meek's body was found, because police were not treating the death as suspicious.[4066]

5.4503. In circumstances where the evidence suggests investigating police were unaware of the extent of the bruising present on Mr Meek's face, the NSWPF submitted that this is the likely reason why Mr Meek's death was not treated as a potential homicide during the early stages of the investigation.[4067]

5.4504. The NSWPF acknowledged, once again, that it is regrettable Mr Meek's death was not treated as a potential homicide investigation at the earlier stages of the investigation, and acknowledged that it would have been preferable for the used condom to be seized as a precaution, regardless of whether the matter was being treated as a suspected homicide or not.[4068]

5.4505. In evidence given during the Investigative Practices Hearing, Superintendent Best confirmed that the decision to release a potential crime scene is informed by a number of considerations, such as whether exhibits of potential relevance have been identified and collected.[4069] Superintendent Best accepted that in circumstances where there is some evidence of trauma to the victim, then the crime scene should be secured.[4070] However, in matters where it may not be obvious whether the victim suffered trauma, the assessment of how long to keep the scene secured becomes more challenging and involves a consideration of resourcing, including the number of calls for service that NSWPF may receive at the time.[4071]

[4064] Submissions of NSWPF, 7 July 2023, [101]–[102] (SCOI.84812).

[4065] Submissions of Counsel Assisting, 15 September 2023, [874ff] (SCOI.85649).

[4066] Submissions of NSWPF, 7 July 2023, [97] (SCOI.85225).

[4067] Submissions of NSWPF, 7 July 2023, [101] (SCOI.85225).

[4068] Submissions of NSWPF, 7 July 2023, [101]–[102] (SCOI.85225).

[4069] Transcript of the Inquiry, 4 July 2023, T4881.6-22 (TRA.00072.00001).

[4070] Transcript of the Inquiry, 4 July 2023, T4881.34-4882.3 (TRA.00072.00001).

[4071] Transcript of the Inquiry, 4 July 2023, T4882.10-42, T4883.22-32 (TRA.00072.00001).

5.4506. During the course of her oral evidence during the Investigative Practices Hearing, Assistant Commissioner Conroy accepted that in circumstances where the cause of Mr Meek's death was unascertained, pending the results of a post-mortem examination, it would have been reasonable to expect police attending the crime scene to consider homicide as a possible cause of death.[4072]

5.4507. In his oral evidence during the Investigative Practices Hearing, Detective Inspector Warren accepted that it would be inconsistent with proper police practice at the time to make an assumption that his cause of death was a heart attack, resulting in the subsequent release of the crime scene.[4073] Detective Inspector Warren conceded that where the cause of death is unknown, police should proceed on the basis that the cause of death may be homicide,[4074] and items such as the used condom identified at the scene, should have been taken into police custody.[4075] The failure to do so was accepted by Detective Inspector Warren to be a significant oversight.[4076]

5.4508. I consider that, on the basis of this evidence, the release of the crime scene was a significant oversight. The access to the flat given to Mr Meek's daughters is also a matter addressed in the Ombudsman's Report.

Phone records

5.4509. The evidence establishes that Mr Meek made several phone calls on the morning of 7 March 1995, and that various people were attempting to call Mr Meek that morning. The timing of those phone calls assumes some significance in establishing when Mr Meek died.

5.4510. Of particular significance is the timing of Mr Meek's call or calls to the radio station. Mr Graham gave evidence that he spoke to Mr Meek at 10:30am, suggesting he was alive at the time. A copy of Mr Meek's call records could have confirmed whether that was the case and could have provided certainty as to the timing of that call.

5.4511. A copy of Mr Meek's call records could also have established whether he made other calls to the radio station that morning. That possibility was raised by the defence at the trial of Mr Heatley. If Mr Meek did make other calls to the radio station, that would be consistent with Mr Heatley's account that he left Mr Meek's flat before 9:00am, as discussed above.

5.4512. If Mr Meek did not make other calls to the radio station, that would tend to suggest that Mr Heatley was present when Mr Meek called Mr Graham at around 10:30am. That would undermine Mr Heatley's claim that he left the flat before 9:00am and it would tend to incriminate him by shrinking the window of time in which any other person could have killed Mr Meek.

[4072] Transcript of the Inquiry, 4 July 2023, T4855.39-44 (TRA.00072.00001).

[4073] Transcript of the Inquiry, 5 July 2023, T5005.5-19 (TRA.00073.00001).

[4074] Transcript of the Inquiry, 5 July 2023, T5005.21-26 (TRA.00073.00001).

[4075] Transcript of the Inquiry, 5 July 2023, T5005.28-46 (TRA.00073.00001).

[4076] Transcript of the Inquiry, 5 July 2023, T5005.46 (TRA.00073.00001).

5.4513. Police sought to obtain records showing the details of calls made by Mr Meek before his death. On 17 March 1995, police made a request to the Crime Data Centre for call charge records relating to Mr Meek's phone number. The Crime Data Centre provided information that there were no call charge records.[4077] On 8 July 1995, police requested that the Crime Data Centre provide "telephone patterns of calls made out of Meek's residence".[4078]

5.4514. The files provided to the Inquiry do not include any response from the Crime Data Centre to this request, or any other records of calls made by Mr Meek in March 1995.

5.4515. On 13 April 2023, the Inquiry issued a summons to the NSWPF for any documents provided by the Crime Data Centre in response to the request of 8 July 1995.[4079]

5.4516. On 18 April 2023, the NSWPF wrote to the Inquiry indicating that it did not hold any documents responsive to the summons. The NSWPF advised that if any documents did exist, they would be included in the documents already produced to the Inquiry. The NSWPF also advised that telecommunication companies retain data or material of this nature for a period of seven years only.[4080]

5.4517. The Inquiry has also received the Supreme Court file for the trial of Mr Heatley. Mr Meek's call records do not appear to have been in evidence at the trial. This might suggest that attempts to obtain them were unsuccessful.

5.4518. There were other steps that could have been taken to obtain Mr Meek's call records. The material before the Inquiry does include phone bills issued to Mr Meek for earlier months by Telecom Australia. Those phone bills included a record of calls made.

5.4519. An attempt could have been made to obtain Mr Meek's call records from Telecom Australia. No such attempt can be made now, given that telecommunication companies retain data of this nature for a period of seven years only. Likewise, an attempt could have been made to obtain phone records from 2WS FM 101.7.

5.4520. Counsel Assisting submitted that the officers investigating Mr Meek's death were aware of the potential utility of these records and that they sought to obtain them. If there were some difficulty obtaining these call records, this should have itself been recorded, given their potential significance to any prosecution or future investigation.[4081] The NSWPF agrees that it would have been prudent for any further steps taken by investigating police to obtain these records to have been included.[4082]

[4077] Exhibit 35, Tab 7, NSWPF Running Sheet, 'Return of Habitation Checks from Crime Data Centre', 20 March 1995 (SCOI.10002.00104).

[4078] Exhibit 35, Tab 14, NSWPF Running Sheet, 'Request re Patterns for Telephone Calls made by Meek', 8 July 1995 (SCOI.10011.00217).

[4079] Exhibit 35, Tab 68, Summons to NSW Police, (NSWPF85), 13 April 2023 (SCOI.82972).

[4080] Exhibit 35, Tab 69, Letter from NSW Police to Solicitor Assisting the Inquiry re Summons NSWPF85, 18 April 2023 (SCOI.45195).

[4081] Submissions of Counsel Assisting, 22 June 2023, [69] (SCOI.84128).

[4082] Submissions of NSWPF, 7 July 2023, [107] (SCOI.84812).

5.4521. Mr Tanos addressed the criticism advanced by Counsel Assisting regarding the failure to obtain these call records. Mr Tanos says that he recalls that the telephone provider advised that no calls were made from the service "for the period requested". He recalls that this "was very disappointing for the investigators". In addition, he observes that the Crime Data Centre would have provided the information by telephone rather than by documentary notification.[4083]

5.4522. If Mr Tanos' recollection is correct, it is regrettable that the fact there were no calls made from that service was not recorded (or that the record has since been lost). The question of whether Mr Meek had made a phone call on the morning that he died is of obvious significance, as it may have assisted in narrowing the window for his death, and/or in identifying a person who spoke to him shortly before his death. It should have been recorded and the record retained.

5.4523. I consider that failure to obtain these call records is unexplained on the material available to the Inquiry and appears to be a material oversight in the investigation.

The failure to investigate NP219 further

5.4524. The last evidence of Mr Meek being alive is NP219's evidence that she had seen Mr Meek walking his dogs between 11:30am and midday on Tuesday, 7 March 1995.[4084] NP219 said that she saw Mr Meek outside the window of her unit in the park.[4085]

5.4525. As is set out above, NP219 had a history of animosity and violence towards Mr Meek, and the NSWPF had evidence that she disliked gay men. NP220 told police that NP219 had told NP220 that she knew who had killed Mr Meek but did not "want to say anything because she doesn't want to get involved."[4086]

5.4526. I accept the submission of Counsel Assisting that it is appropriate to treat the evidence of NP219's dislike of gay men with caution. NP219 was a member of an LGBTIQ community and the evidence appears to be associated with a perception that the two different LGBTIQ communities "just do not get along" (as explained by NP220 when he summarised what he understood NP219's attitude to be).[4087]

5.4527. I accept the submission of Counsel Assisting, with which the NSWPF concurs[4088], that it would not be safe to conclude on this evidence alone that NP219 was homophobic.[4089]

5.4528. There is no evidence that police made enquiries concerning NP219's alibi. Although Mr Heatley emerged as a significant suspect, NP219 was a resident of the apartment building and had a known history of animosity with Mr Meek, including a previous occasion on which she had assaulted Mr Meek. NP219 was known to become violent when under the influence of alcohol and drugs.

[4083] Submissions of Mr Anthony Tanos, 12 September 2023, [9] (SCOI.85778).

[4084] Exhibit 35, Tab 41, Statement of NP219, 28 March 1995, [10] (SCOI.10002.00037).

[4085] Exhibit 35, Tab 58, Transcript of proceedings, *R v Michael Alan* Heatley, Supreme Court of New South Wales, Ireland J, 16 November 1996, T377.8 (SCOI.82969).

[4086] Exhibit 35, Tab 53, Transcript of ERISP with NP220, 23 March 1995, [Q176-A176] (SCOI.10012.00008).

[4087] Exhibit 35, Tab 53, NSWPF Record of interview, 'Interview with NP220', 23 March 1995, [Q172-A173] (SCOI.10012.00008).

[4088] Submissions of NSWPF, 7 July 2023, [109] (SCOI.84812).

[4089] Submissions of Counsel Assisting, 22 June 2023, [71] (SCOI.84128).

5.4529. The NSWPF notes in submissions that the basis on which NP219 was ruled out as a person of interest is not clear, and that it was not raised by either the prosecution or Mr Heatley's counsel at trial.[4090] The NSWPF's submissions observe that if NP219 did tell NP220 that she knew who had killed Mr Meek, she did not convey this information to police.[4091]

5.4530. As I understand it, an aspect of Counsel Assisting's submission was that police should have taken steps after NP220 conveyed this information to them to investigate NP219's alibi (and, in my view, to raise with her directly the statement conveyed to them by NP220).

5.4531. Mr Tanos address the criticism advanced by Counsel Assisting regarding the failure to verify the alibi of NP219. He observed that "during the course of a protracted investigation, not every inquiry or action may be recorded on the database". This may well be the case. However, given that NP219 was a person of interest in Mr Meek's death, I am of the view this is a matter that should have been recorded. If that record was made, it should have been retained.

5.4532. I accept the submission that the apparent failure to investigate NP219 alibi was an insufficiency in the original investigation.

Additional matters concerning exhibits

5.4533. Cigarette butts were collected from ashtrays in the kitchen and dining room, but were never subject to forensic testing, and were not able to be located in the searches undertaken by the NSWPF. The NSWPF accepted in submissions that the unavailability of the cigarette butts was unfortunate.[4092] Counsel Assisting also submitted that forensic testing of these cigarette butts should have been conducted.[4093]

5.4534. The photographs from the crime scene also show a large shifting spanner on top of the dresser. Counsel Assisting submitted that in circumstances where Mr Meek died of injuries inflicted by blunt force trauma, the spanner should also have been taken into evidence.[4094] The NSWPF accepted that the spanner should have been taken into evidence.[4095]

5.4535. I accept the submissions of Counsel Assisting on these matters.

[4090] Submissions of NSWPF, 7 July 2023, [112] (SCOI.84812).

[4091] Submissions of NSWPF, 7 July 2023, [110] (SCOI.84812).

[4092] Submissions of NSWPF, 7 July 2023, [114] (SCOI.84812).

[4093] Submissions of Counsel Assisting, 22 June 2023, [74] (SCOI.84128).

[4094] Submissions of Counsel Assisting, 22 June 2023, [74] (SCOI.84128).

[4095] Submissions of NSWPF, 7 July 2023, [115] (SCOI.84812).

5.4536. Finally, the crime scene photographs show two open sachets of lubricant and a crumpled handkerchief on the bedside table.[4096] Counsel Assisting submitted that given the other evidence that sexual activity occurred, it is possible that the handkerchief may have contained DNA evidence, particularly considering its location and proximity to sachets of lubricant.[4097] The NSWPF accepted in submissions that the failure to take the handkerchief into evidence, or the loss of the opportunity to do so, is regrettable.[4098]

5.4537. I accept the submission of Counsel Assisting that the handkerchief should also have been taken into evidence. If the handkerchief had been disposed of in the period between 8 and 11 March 1995, then the premature release of the crime scene, to which I have already referred, led to the loss of the opportunity to forensically test the handkerchief.

Complaint by Mr Meek's family

5.4538. In addition to their complaints about the preliminary conclusion that Mr Meek died as a result of a heart attack, Mr Meek's daughters raised complaints about the conduct of the police officers with whom they dealt. The letter from Blessington Judd recorded their concerns as follows:[4099]

> *Both daughters were extremely distressed by comments made to them by Constable Humphries [sic] of the Surry Hills Police Station at the time they were advised of their father's death by that Constable.*
>
> *In this regard both daughters had separate conversations with the Constable who made a similar disparaging remark to each of them about their father which was hurtful and uncalled for.*
>
> *Further, the Constable was unhelpful to the daughters when they enquired as to the whereabouts of their father's personal belongings. The Constable also made a cynical remark in this regard.*

5.4539. Both Counsel Assisting and the NSWPF agreed that it is uncontroversial that victims of crime and their family members should be treated with respect. It is extremely disappointing that Mr Meek's family felt that they were not treated with due respect, to such an extent that they retained solicitors to make a complaint.

5.4540. At the time that the initial written submissions of Counsel Assisting and the NSWPF were filed, it was not clear what was said to Mr Meek's daughters although, contrary to the submission made by the NSWPF, it was clear who was said to have made a comment to Mr Meek's daughters.[4100] It was always known on the material before me that Constable Humphreys was said to have made the statement.

[4096] Exhibit 35, Tab 5, Crime Scene Photographs, 8 March 1995, 28 (SCOI.10402.00095).

[4097] Submissions of Counsel Assisting, 22 June 2023, [75] (SCOI.84128).

[4098] Submissions of NSWPF, 7 July 2023, [116] (SCOI.84812).

[4099] Exhibit 35, Tab 22B, Letter from Blessington Judd to NSWPF, 29 August 1995, 2 (SCOI.02729.00026).

[4100] Submissions of NSWPF, 7 July 2023, [118] ((SCOI.84812).

5.4541. Counsel Assisting also submitted that there is evidence that at least one of the police officers involved in the investigation may have held homophobic views. Detective Constable Callanan, who interviewed NP220, referred to the "gay or paedophile movement."[4101]

5.4542. Counsel Assisting submitted that although Detective Constable Callanan may have been positing these two possibilities as discrete alternatives, the language is also consistent with him treating the two as equal in scope or overlapping to a significant degree.[4102]

5.4543. The NSWPF submits that in making this submission Counsel Assisting did not have sufficient regard to the context in which the statement was made. The NSWPF submits that the question was asked in a context where it was NP220 who was conflating hatred of paedophiles and hatred of gay people, and Detective Constable Callanan was asking was, in NP220's mind, was the relation between the two.[4103]

5.4544. I accept that this passage is ambiguous. However, I do not accept the submission of the NSWPF that it was NP220 who introduced conflation of "hatred of paedophiles" and "hatred of homosexuals".

5.4545. Initially, NP220 was asked, "[d]o you agree with me that – it's alleged that Jimmy may be well involved in the paedophile movement". NP220 responded, "[y]eah" and then elaborates on reasons why it might be thought that Mr Meek was a paedophile.[4104]

5.4546. It is then Detective Constable Callanan who introduces the question of NP219. He refers to NP220's earlier evidence and says, "[h]ates paedophiles and that…". NP220 corrects Detective Constable Callanan, saying "[h]ates gays, I said." It is then Detective Constable Callanan that says, "[c]an you clarify relations between transsexuals and the gay or paedophile movement".[4105]

5.4547. The NSWPF submits that the evidence referred to by Counsel Assisting is "manifestly insufficient" to ground a positive finding that Detective Constable Callanan held homophobic views.[4106]

[4101] Exhibit 35, Tab 53, NSWPF Record of interview, 'Interview with NP220', 23 March 1995, [Q171]–[A172] (SCOI.10012.00008).

[4102] Submissions of Counsel Assisting, 22 June 2023, [78] (SCOI.84128).

[4103] Submissions of NSWPF, 7 July 2023, [122], [124] (SCOI.84812).

[4104] Exhibit 35, Tab 53, NSWPF Record of interview, 'Interview with NP220', 23 March 1995, [Q169]–[A169] (SCOI.10012.00008).

[4105] Exhibit 35, Tab 53, NSWPF Record of interview, 'Interview with NP220', 23 March 1995, [Q170]–[A172] (SCOI.10012.00008).

[4106] Submissions of NSWPF, 7 July 2023, [127] (SCOI.84812).

5.4548. I do not understand Counsel Assisting to have been inviting me to make a positive finding of this kind. I make no finding that Detective Constable Callanan had homophobic views and recognise that, although the words recorded on the transcript construed objectively perpetuate the conflation between gay men and paedophiles, that may have been unintended by Detective Constable Callanan. However, having regard to the evidence that the Inquiry has received about the harm done to the LGBTIQ community by the assumption amongst parts of the broader community that men who were sexually interested in other men were paedophiles (or even that they were more likely to be paedophiles), I consider it was appropriate for Counsel Assisting to raise this matter.

NSW Ombudsman Report

5.4549. The complaint made by Mr Meek's daughters was the subject of an investigation by the Ombudsman. A report dated 31 October 1997 was prepared in relation to the complaint.

5.4550. An issue arose as to the admissibility of the material produced by the Ombudsman (including the Ombudsman's Report) and the NSWPF in relation to the complaint made by Mr Meek's daughters, pursuant to s. 170 of the *Police Act*. Counsel Assisting advanced submissions that the material produced was admissible, and the NSWPF advanced submissions in response contending that it was inadmissible and should not be received into evidence. It is not necessary for me to rule on this issue, because Counsel Assisting withdrew the tender of the material. Even if the Ombudsman's Report would be inadmissible at a public hearing by virtue of the combination of s 9(3) of the *SCOI Act* and s. 170 of the *Police Act*, I am satisfied that the content of that report (and other material produced by the Ombudsman) are matters with which I may nonetheless consider pursuant to s. 10(1) of the *SCOI Act*. I am not constrained to have regard only to admissible evidence or material tendered in public. This is consistent with the approach I have adopted in other matters considered by the Inquiry. The NSWPF has had an opportunity to make submissions about this approach to my reporting function and has not sought to challenge it.

5.4551. The Ombudsman's report explains the complaint and the investigation into the complaint in this way:

> *Mrs Karen Franks and Mrs Wendy Griffin (now Ms McMahon], through their solicitors Blessington Judd, made a complaint about the inadequacy of the initial police investigation. The Police Service conducted preliminary inquiries and then an investigation and found the complaint not sustained. The Office of the Ombudsman was unable to determine on the available evidence whether or not the complaint was sustained and decided to conduct its own investigation. Between 25 October and 12 November 1996 the Assistant Ombudsman conducted an inquiry exercising powers under section 19 of the Ombudsman Act. All future references in this report to evidence obtained relates to evidence provided during the inquiry.*

5.4552. The investigation carried out by the Ombudsman received evidence about these key matters:

a. Phone conversation with the family of Mr Meek: Ms Franks said that Constable Humphreys told her that Mr Meek had died of a heart attack. Constable Humphreys denied that she had told anybody that Mr Meek had died of a heart attack. She said she "told Mrs Franks that she didn't think there were any suspicious circumstances but someone from crime scene was going to attend." Constable Humphreys did not make notes in relation to her conversations with Mr Meek's family members.

b. Further contact with family members: Ms Franks said that she had a further conversation with Constable Humphreys and asked whether she could go to Mr Meek's unit to arrange for care of his dogs. She said that Constable Humphreys said that it was "O.K. to go to the unit". Constable Humphreys did not recall whether she sought information from Mr Meek's family members to assist the investigation, and said she did not recall Mr Meek's family members raising attending the unit with her.

c. Ms McMahon said she contacted the Surry Hills station and spoke to Constable Humphreys in relation to Mr Meek's personal belongings such as jewellery. She described Constable Humphreys as "defensive and unhelpful". Ms McMahon said she then rang the morgue and spoke to the grief counsellor. When it was apparent that the jewellery about which she was concerned was not at the morgue, she said she rang the station again and spoke to Sergeant Wallis, who she said was "much more sympathetic and professional in his attitude." After this conversation, Sergeant Wallis spoke with Detective Andrew McEncroe and arranged for detectives and crime scene police to attend the post-mortem examination.

d. The scope of the investigation: The Ombudsman's investigation canvassed a number of aspects of the police investigation, including:

   i. The failure by Constable Richmond to record in her notebook information given to her by Mr Kane about the "young male who had been visiting Mr Meek and who had approached Mr Kane on Monday asking for Tally Ho papers." Constable Richmond said she told Constable Humphreys this information and that Constable Humphreys had said not to record it. Constable Richmond said she was surprised by this instruction. Constable Humphreys said she had not received information that anyone had been staying with Mr Meek. Constable Richmond said that she had formed the view that Mr Meek had died of AIDS, and Mr Kane said he had told Constable Richmond that Mr Meek had AIDS.

   ii. The failure to ask Mr Coffey questions concerning Mr Meek's lifestyle and whether he may have been the subject of an assault. Mr Coffey gave evidence that Mr Meek had expressed concern about his personal safety.

   iii. Detective McEncroe's attendance at the scene and observations, including the decision to call crime scene police, and Detective McEncroe's failure to make any records in his notebook of his conversations, observations, or

decision to call crime scene police. Detective McEncroe gave evidence that he had not been told of any suspicions of paedophile activity.

iv. Detective Whybro's attendance at the scene, and her contemporaneous notes. Detective Whybro said that one of the officers at the scene had told her that Mr Meek "was 52 years old, possibly a homosexual and possibly a paedophile, had abdominal surgery in 1994 and was last seen alive by Mr Brian Kane." Detective Whybro gave evidence that it "would be a sensible practice for police to await either the issuing of a doctor's certificate or the result of an autopsy prior to allowing access to the premises."

v. The post-mortem examination, which concluded that Mr Meek had died of an injury caused by blunt force trauma.

5.4553. Assistant Ombudsman Kinmond made the following observations in his report:

a. First, he considered that although he was not in a position to determine precisely what was said, Constable Humphreys had acknowledged that she had a conversation with Mr and Ms Franks where she said that police did not think there were suspicious circumstances. The Ombudsman observed that Constable Humphreys failed to keep any records of her conversations, and that "[t]his reflects the general failure of police involved in this matter to keep adequate records." He also concluded that it was of concern that Constable Humphreys' conversations with family members did not result in her eliciting useful information."

b. Secondly, he did not consider that he had to determine conclusively what was said by Constable Richmond to Ms Franks about entering Mr Meek's apartment, because "it was unreasonable not to make it clear to the family members that unsupervised access to the premises should not occur due to the difficulties in this case of police making any firm judgement as to the cause of death and until the question of whether a doctor's certificate would be issued was resolved." He went on to observe that "I believe the question of access is an important issue and should be carefully considered in each situation. Clear guidelines relating to who should grant access and when it should be granted are necessary." Assistant Ombudsman Kinmond was also critical of the NSWPF for failing to put the family on notice of a significant amount of blood being present in the flat following the removal of the body.

c. Thirdly, Assistant Ombudsman Kinmond rejected the suggestion that Constable Humphreys would only have taken a decision to allow Mr Meek's family access to his flat after being informed that this was permissible by Detective McEncroe or Detective Whybro. He considered that there was not "satisfactory evidence" that Detective Whybro had been consulted, and recommended that the NSWPF give "further consideration to reviewing and improving or clarifying Police Service guidelines on preserving crime scenes and providing or refusing access to crime scenes by people other than police officers."

d. Fourthly, Assistant Ombudsman Kinmond expressed "real concerns" about the canvass of the area conducted by Constable Humphreys and Constable Richmond. He was particularly critical of Constable Richmond, and observed that the evidence indicated that the account given by Mr Kane in relation to the young man staying with Mr Meek was "deliberately omitted" from Constable Richmond's notes. He was further concerned that Constable Richmond had not immediately disclosed this information once she became aware that a murder investigation had been commenced. He said:

> *At best her actions on this issue indicate gross incompetence. I also have concerns over her integrity, in that I find it difficult to believe that any officer learning of a murder investigation in these circumstances would need to be prompted before remembering vital evidence. I cannot dispel the possibility that the constable has lied deliberately at my inquiry. I am concerned that her failure to promptly advise police investigating the murder of the vital evidence, may have been in order to cover her earlier failure to record this evidence.*

e. Assistant Ombudsman Kinmond did not consider the NSWPF's response to this issue had been sufficient, and considered that the NSWPF had sought to minimise the seriousness of Constable Richmond's conduct.

f. Fifthly, Assistant Ombudsman Kinmond considered that it was "unacceptable" that Detective McEncroe had failed to make any record of his observations and inquiries in his notebook or duty book. He contrasted those inquiries with those undertaken by Detective Whybro.

5.4554. Assistant Ombudsman Kinmond made the following observations at the conclusion of the Ombudsman's Report:

> *It is critically important that all police involved in investigating deaths are aware of their specific responsibilities. It is also important that the involvement of each police officer actually adds value to the investigation process. After considering all of the evidence in this matter, I am left with the conclusion that a number of police participated in and yet did not positively contribute to the investigation of Mr Meek's death.*
>
> *I am also concerned that the Police Service's own investigation of the complaint did not acknowledge the problems to which I have referred in this report. It is interesting to note that, in the covering Police Service letter provided to this Office (a copy of the relevant letter is attached), there is an incomplete sentence which indicates that, although the matter was "not sustained", the Police Service recognised that there were problems relating to inadequate performance by its officers in this matter. The public interest will be served when sentences acknowledging problems are not only commenced but completed. It is a pity that the Police Service did not see fit to do so.*

5.4555. Assistant Ombudsman Kinmond had circulated a statement of provisional findings and recommendations prior to the finalisation of the Ombudsman's Report. The NSWPF provided a response, and the adequacy of the steps taken by the NSWPF were assessed by the Ombudsman:

a. In relation to the recommendation that the NSWPF take appropriate managerial action in relation to the police officers who had engaged in unprofessional conduct in connection with the case, Assistant Ombudsman Kinmond was satisfied with the steps taken, save that he considered no managerial action should be taken in relation to Detective Whybro and that further consideration should be given to appropriate managerial action in relation to Constable Richmond given the concerns about "both [her] competence and integrity."

b. In relation to the recommendation that the NSWPF issue an apology to Ms Franks and Ms McMahon "apologising for both the unprofessional conduct in the initial handling of the investigation of Mr Meek's death and also its failure to recognise this lack of professionalism following its own investigation into the conduct of the officers concerned", Assistant Ombudsman Kinmond noted that he was "very disappointed" by the NSWPF's decision not to give an apology of this nature. He reiterated the recommendation that the NSWPF provide an apology of that kind.

c. In relation to the recommendation that the NSWPF "[r]eview police practices and procedure in relation to police inquiries into deaths," Assistant Ombudsman Kinmond noted that the NSWPF response had asserted that a review was not necessary because the "errors in this matter occurred through inexperience not through an inadequacy in the procedures themselves." He considered that this response had "not recognised and therefore failed to address the more general issues of possible deficient Police Service policies and procedures with respect to the proper co-ordination of inquiries into deaths including, in particular, those deaths which are or may be suspicious." He made the following recommendation:

> *In those circumstances, I recommend that the Police Service arrange for a copy of this report to be provided to the Commander of Crime Agencies with a request that the Commander conduct a comprehensive review of the nature and co-ordination of police inquiries into deaths, including a review of the issue of responsibility for permitting access to death/crime scenes. I also request that the Police Service provide this Office with a report on the outcome of that review, together with any Police Service response to recommendations for improvements to Police Service policies, guidelines and practices made by that review.*

Consideration of the Ombudsman's Report

5.4556. The evidence indicates that the Ombudsman conducted a thorough investigation. On the evidence before me, it appears that the recommendations made by the Ombudsman were carried into effect, with the exception of the recommendation that the NSWPF apologise to Mr Meek's daughters in relation to the deficiencies in the investigation.

5.4557. The failure of the NSWPF to apologise to Mr Meek's daughters in relation to the deficiencies in the investigation as a whole (as opposed to the alleged comment made by Constable Humphreys) is disappointing. Not only did the NSWPF doggedly refuse to accept that there had been any problems with the investigation, even when confronted with the stark reality of the deficiencies in the investigation embodied in the Ombudsman's Report, they refused to apologise to Mr Meek's daughters in relation to them. This failure is unjustifiable.

Manner and cause of death

5.4558. Counsel Assisting submitted that I should find that Mr Meek died in his home on Tuesday, 7 March 1995 between 11:30am and midday as a result of blunt force injuries to his head consistent with being bashed or kicked.[4107] The NSWPF concurred ([150]).[4108]

Bias

5.4559. Counsel Assisting addressed four different scenarios in addressing the question of bias.

5.4560. The NSWPF's submissions largely accord with those of Counsel Assisting, except that the NSWPF takes the view that "[t]he evidence regarding the extent to which bias may have played a part in any violence Mr Heatley directed towards Mr Meek is, as considered above, somewhat less clear than suggested by Counsel Assisting." However, the NSWPF accepted that if Mr Heatley was the perpetrator, bias *may* have played a role in Mr Meek's death.[4109]

5.4561. Counsel Assisting submitted that if Mr Meek was killed by someone other than Mr Heatley, there is no evidence concerning a likely motive for the perpetrator. It is possible that such a perpetrator may have been motivated by LGBTIQ bias, for example if it was someone who Mr Meek had invited to his apartment for the purposes of casual sex. However, Counsel Assisting was correct to submit that this is presently a matter of speculation.[4110]

5.4562. This is not to say that there was no evidence of bias crime in Mr Meek's case.

5.4563. I accept Counsel Assisting's submission that if Mr Meek was killed by Mr Heatley, there were indicators of possible LGBTIQ bias. Witnesses told police that they believed Mr Meek and Mr Heatley had been in a sexual relationship, and Mr Heatley was known to hold homophobic views.

5.4564. There was also evidence, in the form of the used condom, that sexual activity may have occurred between Mr Heatley and Mr Meek. In addition, Mr Heatley had said that he used to "spin out" in relation to Mr Meek being HIV positive.

[4107] Submissions of Counsel Assisting, 22 June 2023, [190] (SCOI.84128).

[4108] Submissions of NSWPF, 7 July 2023, [150] (SCOI.84812).

[4109] Submissions of NSWPF, 7 July 2023, [148] (SCOI.84812).

[4110] Submissions of Counsel Assisting, 22 June 2023, [191] (SCOI.84128).

5.4565. As was submitted by Counsel Assisting, in and of itself fear of contracting HIV does not indicate an LGBTIQ bias. However, the combination of circumstances in the present case suggests that if Mr Heatley was responsible to Mr Meek's death, then LGBTIQ bias may have been a factor in the commission of the offence.[4111]

5.4566. If Mr Meek was killed by NP219, there is some evidence to suggest she may have been motivated by an LGBTIQ bias (her dislike of gay men). However, I have previously indicated that I accept the submission of Counsel Assisting, with which the NSWPF agrees, that it would not be safe to make a finding on the basis of this evidence that NP219 was homophobic.

5.4567. The weight of the evidence suggests that the more likely cause of any violence by NP219 was her animosity towards Mr Meek because of her belief that Mr Meek was responsible for the death of her dog.

5.4568. I accept the submission of Counsel Assisting that if Mr Meek was killed by NP220, there is some evidence indicative of LGBTIQ bias. However, the weight of the evidence before me does not suggest that NP220 was involved in Mr Meek's death. I make further observations about alternative hypotheses in **Chapter 17**, including by reference to evidence received in private hearings. However, given that NP220 is alive, it is appropriate that I record in this Chapter, which I recommend be published, that the evidence before me did not establish, on the balance of probabilities or to any other standard, that NP220 was involved.

Conclusions and recommendations

5.4569. I find that Mr Meek died in his home on Tuesday, 7 March 1995 between 11:30am and midday as a result of blunt force injuries to his head consistent with being bashed or kicked. Mr Meek's death is also the subject of consideration in **Chapter 17**.

5.4570. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in the death of Mr Meek.

5.4571. I do not propose to make any public recommendations arising from the Inquiry's consideration of Mr Meek's death.

[4111] Submissions of Counsel Assisting, 22 June 2023, [194] (SCOI.84128).

IN THE MATTER OF KENNETH BRENNAN

Factual background

Date and location of death

5.4572. Kenneth Brennan died on 11 June 1995, in an apartment in Elizabeth Bay, Sydney. His death was estimated to have occurred between approximately 9:00pm and midnight. Mr Brennan was 53 years old at the time of his death.

Circumstances of death

5.4573. At around 5:20pm on Monday, 12 June 1995 (which was the Monday of the Queen's Birthday long weekend), Mr Brennan's body was discovered by his de facto partner NP215 (a pseudonym) in the apartment where the couple resided (**Elizabeth Bay apartment**).[4112] NP215 had been staying with a recent friend NP214 (a pseudonym) in Woollahra from 10 June 1995.

5.4574. Mr Brennan was lying naked on his left side in the loungeroom with a pillow placed under his head. His legs were slightly bent.[4113] Mr Brennan's head was positioned towards the kitchen and his left toes were touching the left side of the bedroom door jamb.[4114]

5.4575. Mr Brennan suffered multiple stab wounds to his torso, several defensive wounds to his left forearm and right hand, and what appeared to be a blunt force injury to his face and head.[4115]

[4112] Exhibit 37, Tab 161, Findings of SDSC John Abernethy, Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 1 (SCOI.00009.00063).

[4113] Exhibit 37, Tab 38, NSWPF Record of Interview, "Interview with NP215", 12 June 1995, 31-33 (SCOI.00009.00015); Exhibit 37, Tab 161, Findings of SDSC John Abernethy, 17 September 1996, 2 (SCOI.00009.00063); Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [9] (SCOI.00009.00008).

[4114] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [14] (SCOI.45105).

[4115] Exhibit 37, Tab 161, Findings of SDSC John Abernethy, Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 2 (SCOI.00009.00063); Exhibit 37, Tab 5, Post-mortem report of Dr Peter Bradhurst, 6 October 1995, 1 (SCOI.00009.00133).

5.4576. The double bed in the main bedroom was heavily bloodstained. There was blood throughout the apartment, including on a circular mirror, an orange towel (located 80cm south of the front door), a linen cupboard door, a full-length mirror, the security intercom, the telephone in the bedroom, a chair in the loungeroom, the kitchen bench, and various walls and floors.[4116]

5.4577. There was evidence to suggest Mr Brennan had engaged in sexual intercourse before his death and that his body had been sponged down.[4117] A dry, blood-stained cleaning sponge was located on Mr Brennan's right shoulder.[4118]

Previous investigations

Post-mortem examination

5.4578. A post-mortem examination was conducted on 13 June 1995 by Dr Peter Bradhurst.

5.4579. Dr Bradhurst identified a total of 15 stab wounds, mainly to the chest region. One lethal stab wound injured Mr Brennan's liver, diaphragm, lung, and the wall of the right atrium (heart).[4119] There were also stab wounds through Mr Brennan's right lateral and posterior parietal pericardium. The pericardial cavity contained a small volume of clotted blood. Dr Bradhurst identified injuries to Mr Brennan's thoracic vertebra and indicated that Mr Brennan had a collapsed lung. There was an intimal tear of the lower thoracic aorta and numerous smaller ladder intimal tears.[4120]

5.4580. Dr Bradhurst further identified defensive injuries on Mr Brennan's left forearm and right hand. There was no evidence of any injury to Mr Brennan's perineum, anus, rectum, scrotum, penis or testes. Bruising had developed on the right side of Mr Brennan's face and, together with the abrasions, gave rise to a patterned injury resembling a shoe print.[4121]

5.4581. Dr Bradhurst considered that the injuries (including the stab wounds, superficial cuts, and scratches) to Mr Brennan's body were consistent with having been caused by a knife, such as the blood-stained one shown to him during the examination (190mm in length, 25mm at its widest point).[4122]

5.4582. In his report, Dr Bradhurst found that the direct cause of death was stab wounds to the chest and that the death had taken place in the Elizabeth Bay apartment any time between 5:00pm to midnight on Sunday, 11 June 1995 (possibly a little earlier or later).[4123]

[4116] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [10]–[12] (SCOI.00009.00008); Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 21 (SCOI.00009.00059); Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [6]–[17]. (SCOI.45105).

[4117] Exhibit 37, Tab 161, Findings of SDSC John Abernethy, Inquest into the death of Kenneth Richard Brennan 17 September 1996, 2 (SCOI.00009.00063).

[4118] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [9] (SCOI.45105).

[4119] Exhibit 37, Tab 5, Post-mortem report of Dr Peter Bradhurst, 6 October 1995, 4 (SCOI.00009.00133).

[4120] Exhibit 37, Tab 5, Post-mortem report of Dr Peter Bradhurst, 6 October 1995, 8-10 (SCOI.00009.00133).

[4121] Exhibit 37, Tab 5, Post-mortem report of Dr Peter Bradhurst, 6 October 1995, 7-13 (SCOI.00009.00133).

[4122] Exhibit 37, Tab 5, Post-mortem report of Dr Peter Bradhurst, 6 October 1995, 9 (SCOI.00009.00133).

[4123] Exhibit 37, Tab 5, Post-mortem report of Dr Peter Bradhurst, 6 October 1995, 16 (SCOI.00009.00133).

Original police investigation

5.4583. The original police investigation was conducted by Detective Senior Constable Laura Thurtell from Kings Cross LAC with assistance from the Homicide Squad. Operation Monardia was conducted between 20 and 24 July 1995. Subsequently, on 15 October 1995, Strike Force Monardia was established to continue the investigation into the death of Mr Brennan.[4124]

5.4584. The original police investigation into possible persons of interest was thorough. It involved, among other things:

a. Setting up a Mobile Police Station outside the Darlinghurst District Court in Oxford Street, Darlinghurst;

b. A suspect press release and notification of several media outlets;[4125]

c. Forensic testing of several key exhibits;

d. Comparing fingerprints located at the Elizabeth Bay apartment to persons of interest;

e. Canvassing around Kingsteam Sauna in Darlinghurst and nearby areas, and interviewing neighbours who lived proximate to the Elizabeth Bay apartment;

f. Contacting St Vincent's Hospital and Sydney Hospital for information in relation to persons who had presented to the hospitals with abrasions and injuries to hands;[4126]

g. Interviewing various persons of interest nominated to or otherwise considered by police;

h. Obtaining DNA samples from various persons of interest;

i. Contacting Capital Q Weekly, which was a gay based newspaper publication, to obtain phone records regarding an advertisement by Mr Brennan;

j. Obtaining a Facial Image Portrait;[4127] and

k. Investigating the origins of the Yves Saint Laurent (**YSL**) underpants and "Roller" walking boots located at the Elizabeth Bay apartment.[4128]

[4124] Exhibit 37, Tab 118, Terms of Reference for Strike Force Monardia, 20 October 1997 (SCOI.10305.00061).

[4125] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [71] (SCOI.00009.00008).

[4126] Exhibit 37, Tab 93, St Vincent's Hospital Running Sheet – 'Check for Injury', 15 June 1995 (SCOI.10276.00088); Exhibit 37, Tab 94, Sydney Hospital Running Sheet – 'Records Checked', 15 June 1995 (SCOI.10276.00089).

[4127] Exhibit 37, Tab 113, Facial Image Portrait, 21 July 1995 (SCOI.00009.00126).

[4128] Exhibit 37, Tab 30, Statement of Vanessa Gale, 31 August 1995 (SCOI.10187.00056); Exhibit 37, Tab 31, Statement of Stuart Jennings, 1 September 1995, 1 (SCOI.10183.00053).

5.4585. The scenario advanced by police was that, after leaving the Kingsteam Sauna on the evening of 11 June 1995, Mr Brennan met a person (or persons) either: (i) at an unknown location; or (ii) by arrangement upon returning to the Elizabeth Bay apartment.[4129] Mr Brennan had sexual intercourse with such person or persons, and afterwards a struggle ensued in the bedroom and hallway.[4130] Mr Brennan was stabbed during the struggle, possibly in the bathroom and in other areas of the apartment, with a knife blade located at the Elizabeth Bay apartment.[4131] Investigating police were also of the opinion that Mr Brennan was hit in the face with a metal frypan and that his body had been sponged down.[4132]

5.4586. In the course of their enquiries, police considered numerous persons of interest in relation to Mr Brennan's death, but ultimately were unable to obtain any evidence which connected any of those persons to Mr Brennan's death. These persons of interest included persons with the following pseudonyms: NP182, NP183, NP184, NP185, NP186, NP187, NP188, NP189, NP190, NP191, NP192, NP193, NP194, NP195, NP196, NP197, NP198, NP199, NP200, NP202, NP203, NP204, NP205, NP206, NP208, NP211, NP212, NP214, NP215 and NP218.

Forensic testing

5.4587. Investigating police identified a significant number of exhibits from the crime scene. From these exhibits, those listed below were forensically tested and yielded the following results in 1995 and 1996:

a. A condom on the rim of the toilet bowl (**Condom 1**), which was found to contain a spermatozoon;[4133]

b. A pair of YSL underpants, which contained traces of DNA (on Area 2) that originated from more than one person (other than Mr Brennan, NP215, NP214 or NP189);[4134]

c. A distorted frypan, located in the bedroom, which was subject to DNA blood grouping tests;[4135]

d. A champagne flute with an unidentified fingerprint,[4136] which was not considered by police to belong to either NP215 or Mr Brennan;[4137]

[4129] Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 7 (SCOI.00009.00059).

[4130] Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 7, 21 (SCOI.00009.00059).

[4131] Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 7 (SCOI.00009.00059).

[4132] Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 7, 24 (SCOI.00009.00059).

[4133] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003).

[4134] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003).

[4135] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 3 (SCOI.10181.00003).

[4136] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [12] (SCOI.45105); Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 17 (SCOI.00009.00059).

[4137] Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 17 (SCOI.00009.00059).

e. Traces of DNA were detected on the inner front section of the YSL underpants and were noted to have originated from more than one person (other than Mr Brennan, NP215, NP214 or NP189);[4138]

f. Blood was detected on the distorted frypan and subject to blood grouping tests;[4139]

g. Semen was not detected on the oropharyngeal swab and smear or the rectal swab and smear obtained from Mr Brennan, or on a pair of white underpants located in the bedroom;[4140]

h. Semen was not detected on either of the two condoms located in the toilet bowl water (**Condoms 2 and 3**) and DNA testing of these condoms was unsuccessful;[4141]

i. Hair located in Mr Brennan's left hand and the bloodstain on the YSL underpants may have originated from Mr Brennan, but not NP215, NP214 or NP189;[4142]

j. A sample of drain water located in the "S" bend from the kitchen and bathroom sinks, which was found not to contain blood;[4143] and

k. Two 'Mates' condom wrappers. Evidence of the testing on these exhibits is unclear. The NSWPF records indicate these condom wrappers were subject to magna powder examination,[4144] and that this exhibit was fingerprinted.[4145] However, recent records confirm no fingerprints were developed.[4146]

5.4588. In the days following Mr Brennan's death, NP215 located the following foreign items in the Elizabeth Bay apartment, which were later seized by police:

a. A pair of underpants in the bedroom, which were not forensically tested in 1995;[4147]

b. A packet of Strepsils, which police tested using magna powder and ninhydrin. However, it appears that no fingerprints were developed;[4148] and

[4138] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003).

[4139] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 3 (SCOI.10181.00003).

[4140] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003).

[4141] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003).

[4142] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003).

[4143] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003); Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [27] (SCOI.45105).

[4144] Exhibit 37, Tab 123, Review of an Unsolved Homicide Case Screening Form, 6 August 2004, 5 (SCOI.44995).

[4145] Exhibit 37, Tab 122, Exhibit Management Spreadsheet, 5 November 2012, 6 (SCOI.10182.00001).

[4146] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [18] (SCOI.45105); Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [8] (NPL.0100.0017.0001).

[4147] Exhibit 37, Tab 86, Statement of Detective Senior Constable Brad Tayler, 29 January 1996, [16] (SCOI.00009.00005).

[4148] Exhibit 37, Tab 86, Statement of Detective Senior Constable Brad Tayler, 29 January 1996, [37] (SCOI.00009.00005); Exhibit 37, Tab 123, Review of an Unsolved Homicide Case Screening Form, 6 August 2004, 5 (SCOI.44995); Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [8] (NPL.0100.0017.0001).

c. A cardboard and plastic knife packaging (**knife packaging**),[4149] which police tested using ninhydrin. However, it appears that no fingerprints were developed.[4150]

5.4589. Additionally, police seized the following exhibits from the crime scene. As at 1996, these exhibits had not been forensically examined:

a. "Roller" brand walking boots;[4151]

b. A pair of white blood smeared sports socks;[4152]

c. Fingernail clippings from Mr Brennan;[4153]

d. The hair located in Mr Brennan's right hand;[4154]

e. A pair of underpants located in the bedroom;[4155]

f. A black leather studded strap found next to the bed (which NP215 identified during a police interview as Mr Brennan's cock ring);[4156]

g. A chrome metal ring found on the bed (referred to in some police records as a butt ring, but more likely another cock ring as described by NP215 in one of his statements);[4157]

h. A blood-stained pillow;[4158]

i. A glass of water;[4159]

j. A pair of blue jeans;[4160]

k. A piece of brown plastic;[4161]

l. A bent blood-stained knife blade of approximately 20.5cm to 25cm in length (missing the handle);[4162] and

m. A brown plastic knife handle located in the toilet bowl (**broken knife handle**).[4163] Police records indicate that at the time of the initial investigation,

[4149] Exhibit 37, Tab 43, Third statement of NP214, 16 June 1995, [4]–[5] (SCOI.10261.00079).

[4150] Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [8] (NPL.0100.0017.0001).

[4151] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [15] (SCOI.45105).

[4152] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [15] (SCOI.45105).

[4153] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003).

[4154] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003).

[4155] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [15] (SCOI.45105).

[4156] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [18] (SCOI.45105).

[4157] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [17] (SCOI.45105). I note Detective Senior Constable Van Leeuwen observed a tube of lubricant on the bed, however, it is unclear whether this item was seized.

[4158] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [17] (SCOI.45105).

[4159] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [18] (SCOI.45105).

[4160] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [19] (SCOI.45105).

[4161] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [20] (SCOI.45105).

[4162] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [20] (SCOI.45105).

[4163] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [22] (SCOI.45105).

DAL advised that the possibility of obtaining a DNA trace from the knife handle would be non-existent due to its immersion in water.[4164]

Fingerprints analysis

5.4590. Several identifiable fingerprints were obtained from the crime scene, including on the inside of the wardrobe door in the bedroom, the frypan, the mirror in the hall, the glass on the bedside table, the inside of the front door, the inside of the entrance door, and on the champagne flute.

5.4591. One of the fingerprints located on the inside of the wardrobe door in the bedroom was identified as belonging to NP215.[4165] The other remains unidentified. In 1995, the unidentified wardrobe fingerprint was manually compared to NP214 and NP189, without success.[4166] In 1996, this fingerprint was manually compared without success to NP190, NP217 (a pseudonym), NP240 (a pseudonym) and NP201 (a pseudonym). In 1999, this fingerprint was manually compared without success to NP216 (a pseudonym). In 1995, 1998 and 2012, police conducted an automated comparison of the unidentified fingerprints with fingerprint records on the NAFIS. These attempts failed to identify the unknown fingerprint.[4167]

5.4592. The fingerprint located on the exterior of the frypan, the kitchen knife blade and the broken knife handle were not suitable for any comparison on the NAFIS due to insufficient detail.

5.4593. The fingerprints located on the mirror and the glass on the bedside table were compared to Mr Brennan in 1995 with success.[4168]

5.4594. Three fingerprints located on the inside of the front door were compared to NP215 in 1995 with success.[4169]

5.4595. Two fingerprints and one palm print were located on the inside of the entrance door. In 1995, these prints were compared to NP215 with success.[4170]

5.4596. An unidentified fingerprint was detected on the champagne flute. Investigating police considered this fingerprint did not belong to Mr Brennan or NP215.[4171] It does not appear that NSWPF retained this exhibit or fingerprint.

5.4597. The following exhibits, seized from the crime scene, were subject to fingerprint testing but no fingerprints were developed:

a. The frypan;

[4164] Exhibit 37, Tab 123, Review of an Unsolved Homicide Case Screening Form, 6 August 2004, 10 (SCOI.44995).

[4165] Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [10] (NPL.0100.0017.0001).

[4166] Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [10] (NPL.0100.0017.0001).

[4167] Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [12] (NPL.0100.0017.0001).

[4168] Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [23] (NPL.0100.0017.0001).

[4169] Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [23] (NPL.0100.0017.0001).

[4170] Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [23] (NPL.0100.0017.0001).

[4171] Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 17 (SCOI.00009.00059).

b. The Strepsils packet (located at the crime scene by NP215).[4172] It does not appear that the NSWPF retained this exhibit;

c. The cardboard carving knife packet and plastic sheath (located at the crime scene by NP215).[4173] It does not appear that the NSWPF retained these exhibits; and

d. Two "Mates" condom wrappers.[4174] It does not appear that the NSWPF retained these exhibits.

Footprint/shoeprint analysis

5.4598. Several bloody footprints were located on the carpet inside the Elizabeth Bay apartment. Two of these footprints were located on the carpet near the bathroom doorway and the north-eastern wardrobe.[4175] One of these footprints appears to be made by a foot with a high arch, whereas the other was comparatively wide.[4176]

5.4599. Crime Scene Officers were of the view that these footprints originated from two different people.[4177] Investigating police attempted to repeat the method thought to have been used by the contributors to apply the footprints. From the results of these methods, and comparative analysis, police considered Mr Brennan to be the likely contributor of the high arched footprint.[4178] Police were unable to identify the contributor of the wider footprint.[4179]

5.4600. Police also located a blood-stained right shoe print on the linoleum floor of the kitchen.[4180] Police compared this shoeprint to identified persons, including Mr Brennan, NP215, NP214, NP190 and NP189, without success.[4181] Police initially considered that the "Roller" boots may have had a similar tread pattern to this shoe print, but excluded them on the basis of the wear characteristics.[4182] Police later confirmed that the shoeprint originated from a Windsor Smith boot.[4183]

[4172] Exhibit 37, Tab 86, Statement of Detective Senior Constable Brad Tayler, 29 January 1996, [37] (SCOI.00009.00005); Exhibit 37, Tab 123, Review of an Unsolved Homicide Case Screening Form, 6 August 2004, 5 (SCOI.44995); Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [8] (NPL.0100.0017.0001).

[4173] Exhibit 37, Tab 43, Third statement of NP214, 29 June 1995, [4]–[5] (SCOI.10261.00079); Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [8] (NPL.0100.0017.0001).

[4174] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [18] (SCOI.45105); Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [8] (NPL.0100.0017.0001).

[4175] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [20] (SCOI.45105); Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [12] (SCOI.00009.00008).

[4176] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [12] (SCOI.00009.00008).

[4177] Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 20 (SCOI.00009.00059).

[4178] Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 20 (SCOI.00009.00059).

[4179] Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 20 (SCOI.00009.00059).

[4180] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [11] (SCOI.45105).

[4181] Exhibit 37, Tab 123, Review of an Unsolved Homicide Case Screening Form, 6 August 2004, 9 (SCOI.44995); Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 20 (SCOI.00009.00059).

[4182] Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 20 (SCOI.00009.00059).

[4183] Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 20 (SCOI.00009.00059); Exhibit 37, Tab 31, Statement of Stuart Jennings, 1 September 1995, [4] (SCOI.10183.00053).

Findings at inquest

5.4601. An inquest was held at the Coroners Court on 17 September 1996 before Senior Deputy State Coroner Abernethy. The formal finding made by Senior Deputy State Coroner Abernethy was that Mr Brennan died on or about 11 June 1995 at the Elizabeth Bay apartment of "stab wounds to chest, inflicted then and there by persons unknown".[4184]

Criminal proceedings

5.4602. No criminal proceedings have ever been instituted against any person in relation to Mr Brennan's death.

Subsequent police investigation

5.4603. A reinvestigation of Mr Brennan's death was conducted by Strike Force Skarratt of the UHT from 23 March 2016 to 16 July 2019.[4185] This reinvestigation involved a comprehensive review of the matter, a reexamination of exhibits and consideration of potential new lines of inquiry.[4186]

5.4604. During the reinvestigation, investigating police examined paper in Mr Brennan's wallet and found three phone numbers on a piece of paper. Police identified the users of the numbers in 1995 as being NP210 (a pseudonym) (one number) and NP209 (a pseudonym) (two numbers).[4187]

5.4605. Police inquiries confirmed that NP210 was gay and that he died on 5 June 2011.[4188] Police subsequently requested a DNA sample from NP210's nephew, I294, for the purpose of conducting familial testing against the Unknown Male 'B' profile (discussed further below). I294, however, declined to provide a DNA sample.[4189]

5.4606. Investigating police located NP209 and obtained a DNA sample from him.[4190] Results from testing NP209's DNA later excluded him from being the contributor of the Unknown Male 'B' Profile.[4191]

5.4607. In March 2018, investigating police contacted NP214 who re-iterated that he was at home in Woollahra with NP215 on the weekend of Mr Brennan's death. NP214 again confirmed that NP215 could not have left his home without his knowledge and was confident that NP215 was with him the entire weekend.[4192]

[4184] Exhibit 37, Tab 161, Findings of SDSC John Abernethy, Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 3 (SCOI.00009.00063).

[4185] Exhibit 37, Tab 153, NSWPF Memorandum, 'Post Operational Assessment for Strike Force Skarratt', 1 August 2019, 12 (SCOI.82997).

[4186] Exhibit 37, Tab 153, NSWPF Memorandum, 'Post Operational Assessment for Strike Force Skarratt', 1 August 2019, 12 (SCOI.82997).

[4187] Exhibit 37, Tab 153, NSWPF Memorandum, 'Post Operational Assessment for Strike Force Skarratt', 1 August 2019, 2 (SCOI.82997).

[4188] Exhibit 37, Tab 142, NSWPF Investigator's Note, 'Meeting with Paul Ten-Bruggen-Cate', 19 January 2017, 2-3 (SCOI.45068); Exhibit 37, Tab 139, Death Certificate of NP210, 13 October 2016, 2 (SCOI.45061).

[4189] Exhibit 37, Tab 145, NSWPF Investigator's Note, 'Further contact with I294', 24 March 2017, 1 (SCOI.45076); Exhibit 37, Tab 153, NSWPF Memorandum, 'Post Operational Assessment for Strike Force Skarratt', 1 August 2019, 2 (SCOI.82997).

[4190] Exhibit 37, Tab 140, NSWPF Investigator's Note, 'Result of DNA sample from NP209', 11 January 2017, 1 (SCOI.45063); Exhibit 37, Tab 153, NSWPF Memorandum, 'Post Operational Assessment for Strike Force Skarratt', 1 August 2019, 2 (SCOI.82997).

[4191] Exhibit 37, Tab 140, NSWPF Investigator's Note, 'Result of DNA sample from NP209', 11 January 2017, 1 (SCOI.45063).

[4192] Exhibit 37, Tab 153, NSWPF Memorandum, 'Post Operational Assessment for Strike Force Skarratt', 1 August 2019, 2-3 (SCOI.82997).

Further forensic testing

5.4608. During the reinvestigation, investigating police obtained results from further DNA testing, which identified a mixed profile containing a partial unknown DNA profile on the following exhibits:

a. Condom 1; and

b. The inside front section of the YSL underpants.[4193]

5.4609. The Unknown Male 'B' profile was not suitable for familial searching, DNA phenotyping or Interpol searching, but was suitable for comparison with individual samples.[4194] Comparison analysis was subsequently conducted and eliminated Mr Brennan, NP215, NP214, NP189, NP190, NP204, NP188 and NP200 as the contributor to the Unknown Male 'B' profile.[4195] A partial profile of the Unknown Male 'B' profile was uploaded onto the National Criminal Investigation DNA database; however, it did not yield a match.[4196]

5.4610. The exhibits from the crime scene listed below were forensically tested and generated the following results:

a. Various blood swabs collected from the scene yielded a partial DNA profile that matched Mr Brennan;[4197]

b. A swab from the interior of the black leather studded cock ring yielded a DNA profile that matched Mr Brennan;

c. A tape lift administered to one side of the sponge yielded a partial DNA profile that matched Mr Brennan;[4198]

d. A trace swab from a broken knife handle yielded a mixed DNA profile that was weak/complex;[4199]

e. A tape lift administered to the tongue of the left "Roller" boot yielded a DNA profile that matched Mr Brennan. Other tape lifts administered to the "Roller"

[4193] Exhibit 37, Tab 153, NSWPF Memorandum, 'Post Operational Assessment for Strike Force Skarratt', 1 August 2019, 2, 12 (SCOI.82997); Exhibit 37, Tab 144, NSWPF Investigator's Note, 'Further contact with Virginia Friedman (FASS)', 10 March 2017, 1 (SCOI.45075); Exhibit 37, Tab 141, Forensic report re: DNA testing results (items entered on EFIMS), 13 January 2017, 4 (SCOI.45065).

[4194] Exhibit 37, Tab 151, NSWPF Investigator's Note, 'Email correspondence between I446 and Dr Bruce re possible DNA profile, 15 March 2019, 1 (SCOI.45094); Exhibit 37, Tab 154, NSWPF Investigator's Note, 'Familial DNA profiling unsuccessful', 4 September 2020, 1 (SCOI.45100); Exhibit 37, Tab 153, NSWPF Memorandum, 'Post Operational Assessment for Strike Force Skarratt', 1 August 2019, 2 (SCOI.82997).

[4195] Exhibit 37, Tab 147, NSWPF Investigator's Note, 'Clarification of forensic report of Dr Bruce', 18 April 2018, 1 (SCOI.45082); Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [38] (SCOI.00009.00008); Exhibit 37, Tab 55, Statement of I268, 16 April 1996 [4]–[5] (SCOI.10307.00238); Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003); Exhibit 37, Tab 163, Second report of Michele Franco, 16 August 1996, 2 (SCOI.10181.00004); Exhibit 37, Tab 164, Third report of Michele Franco, 10 September 1999, 2 (SCOI.10181.00005).

[4196] Exhibit 37, Tab 127, Email correspondence between Dr Bruce and I446, 14 April-1 June 2016, 2 (SCOI.45017); Exhibit 37, Tab 141, Forensic report re: DNA testing results (items entered on EFIMS), 13 January 2017, 4 (SCOI.45065).

[4197] Exhibit 37, Tab 129, NSWPF Investigator's Note, 'Results summary of exhibits re-examined by Detective Sergeant Schibeci', 3 June 2016, 2-3 (SCOI.45023).

[4198] Exhibit 37, Tab 129, NSWPF Investigator's Note, 'Results summary of exhibits re-examined by Detective Sergeant Schibeci', 3 June 2016, 2-3 (SCOI.45023).

[4199] Exhibit 37, Tab 129, NSWPF Investigator's Note, 'Results summary of exhibits re-examined by Detective Sergeant Schibeci', 3 June 2016, 2-3 (SCOI.45023).

boots confirmed the presence of a mixed DNA profile that was weak/complex;[4200]

f. The white underpants yielded DNA that matched Mr Brennan but also yielded evidence of a mixture containing profiles of at least three persons which were not suitable for interpretation;[4201]

g. Trace swabs from the broken knife handle yielded a mixed DNA profile that was weak/complex;[4202]

h. Tape lifts administered to one side of the interior/exterior of one sock yielded a mixed DNA profile that was weak/complex;[4203]

i. Tape lifts administered to one side of the orange towel yielded a mixed DNA profile that was weak/complex;[4204] and

j. Blood located on the fingernail clippings yielded a match to Mr Brennan.[4205]

5.4611. In 2016, FASS determined the partial bloody fingerprint located on the handle of the frypan seized from the crime scene was not sufficiently detailed for the purpose of carrying out a manual fingerprint comparison or NAFIS search. FASS also determined that the bloodstain was too weak to produce a DNA profile.[4206]

Further fingerprints analysis

5.4612. In 2016, the unidentified wardrobe fingerprints were manually compared without success to NP190, NP188, NP189, NP215, NP214 and NP200.[4207] In 2022, this fingerprint was compared to NP206 and NP207 (a pseudonym) without success.[4208]

5.4613. In 2022 and 2023, police conducted automated comparisons of the unidentified wardrobe fingerprint with fingerprint records on the NAFIS database. In June 2023, the unidentified wardrobe fingerprint was compared to the fingerprints of NP190, NP188, NP189, NP215, NP214, NP200 and NP206, NP217, NP240, NP216, NP201 and NP207 without success. To date these reviews have failed to identify the unknown fingerprint.[4209]

[4200] Exhibit 37, Tab 129, NSWPF Investigator's Note, 'Results summary of exhibits re-examined by Detective Sergeant Schibeci', 3 June 2016, 2-3 (SCOI.45023).

[4201] Exhibit 37, Tab 127, Email correspondence between Dr Bruce and I446, 14 April-1 June 2016, 2 (SCOI.45017).

[4202] Exhibit 37, Tab 141, Forensic report re: DNA testing results (items entered on EFIMS), 13 January 2017, 5 (SCOI.45065).

[4203] Exhibit 37, Tab 129, NSWPF Investigator's Note, 'Results summary of exhibits re-examined by Detective Sergeant Schibeci', 3 June 2016, 4-5 (SCOI.45023).

[4204] Exhibit 37, Tab 141, Forensic report re: DNA testing results (items entered on EFIMS), 13 January 2017, 7 (SCOI.45065).

[4205] Exhibit 37, Tab 130, NSWPF Investigator's Note, 'Exhibits examined by Dr Bruce', 7 June 2016, 2-3 (SCOI.45024).

[4206] Exhibit 37, Tab 132, NSWPF Investigator's Note, 'Exhibits examined by Crime Scene Officer Michael Whyte, 7 June 2016, 2 (SCOI.45027).

[4207] Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [17] (NPL.0100.0017.0001).

[4208] Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [16] (NPL.0100.0017.0001).

[4209] Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [16], [18] (NPL.0100.0017.0001).

5.4614. On 29 September 2022, the NSWPF informed the Inquiry that the UHT had confirmed that all forensic and investigative opportunities had been explored and were unable to be advanced further at that time.[4210]

Strike Force Parrabell

Bias Crimes Indicators Form

5.4615. The academic reviewers did not consider Mr Brennan's death because at the relevant time, Mr Brennan's death was classified as being under active investigation within the UHT.[4211] However, a case summary of the matter was prepared by officers of Strike Force Parrabell, who noted, "[t]he level of violence was extreme, however there was no other circumstantial indications of a bias motivated crime…The motive for Mr Brannan's [sic] murder has not been determined, leaving the case unsolved."[4212]

5.4616. Strike Force Parrabell arrived at the conclusion that there was "insufficient information" to categorise the case as a hate crime. [4213]

Review by the Inquiry

Summonses

NSWPF

5.4617. A summons was issued to the NSWPF on 18 May 2022 for, all documents relating to investigations by the NSWPF of the death of Mr Brennan, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Brennan. On 8 June 2022, the NSWPF produced material in response to this summons.[4214]

5.4618. On 11 October 2022, the Inquiry issued a summons to the NSWPF seeking production of all material held or created by the UHT in connection with the review of exhibits relating to Mr Brennan (NSWPF30). The NSWPF produced this material on 19 October 2022.

5.4619. On 8 December 2022, the Inquiry issued a summons to the NSWPF seeking production of all documents relating to Strike Force Skarratt (NSWPF41).

5.4620. On 19 December 2022, the NSWPF wrote to the Inquiry indicating that the entirety of the investigative material relating to Strike Force Skarratt was produced to the Inquiry on 18 August 2022.

[4210] Exhibit 37, Tab 157, Email from Patrick Hodgetts to Emily Burston, 29 September 2022 (SCOI.83001).

[4211] Exhibit 1, Tab 2, NSW Police Force, *Final Report of Strike Force Parrabell* (undated), 69 (SCOI.74801).

[4212] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries - Kenneth Brennan (undated), 34 (SCOI.76961.00014).

[4213] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Kenneth Brennan (undated), 34 (SCOI.76961.00014).

[4214] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [5] (SCOI.83469).

5.4621. On 22 December 2022, the Inquiry issued a letter to the NSWPF indicating that the Inquiry was unable to identify any record of receipt of the material relating to Strike Force Skarratt on 18 August 2022, and requesting an electronic copy of the full e@gle.i brief for Strike Force Skarratt as per Summons NSWPF41. On 23 January 2023, the NSWPF produced material in response to Summons NSWPF41. This material comprised the coronial file for Mr Brennan as well material related to Strike Force Skarratt.

5.4622. On 22 June 2023, the Inquiry received a further tranche of material produced by the NSWPF on 21 June 2023 (in response to Summons NSWPF1).

Registry of Births, Deaths and Marriages

5.4623. On 13 April 2023, the Inquiry issued a summons to the NSW BDM for, relevantly, death certificates for:[4215]

a. Mr Brennan;

b. Natalie Leonoff; and

c. Joan Henderson.

5.4624. On 17 April 2023, BDM produced death certificates for Mr Brennan and Mrs Leonoff.[4216]

5.4625. On 8 May 2023, the Inquiry issued a further summons to BDM for death certificates in relation to Mr Brennan's family and various persons of interest.

5.4626. On 10 May 2023, BDM produced death certificates for NP187, NP205, NP202 and NP191. BDM further confirmed there was evidence to suggest that NP198 and NP188 are deceased.[4217] BDM was unable to provide results in relation to the following persons of interest: NP189, NP190, NP204, NP199, NP203, NP200, NP182, NP218, NP212, NP208, NP206, NP183, NP194, NP211, NP185, NP184, NP196, NP186, NP195, NP192, NP193, NP197 and NP209.

Queensland Police Service

5.4627. On 31 May 2023, the Inquiry issued a summons to the Queensland Police Service (**QLDPS**) seeking its holdings in relation to NP189 (QLDPS8). On 2 June 2023, the QLDPS produced material in response to this summons.[4218]

[4215] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [6] (SCOI.83469).

[4216] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [6] (SCOI.83469).

[4217] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [17] (SCOI.83469).

[4218] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [18] (SCOI.83469).

Interagency cooperation

Coroners Court

5.4628. A written request was issued to the Coroners Court on 11 May 2022 to obtain the coronial file in relation to the death of Mr Brennan. On 26 May 2022, Mr Brennan's coronial file was provided to the Inquiry by the Coroners Court.[4219]

NSWPF

5.4629. On 30 August 2022, following a request from the Inquiry on 16 August 2022, the NSWPF provided the Inquiry with a copy of the Post Operational Assessment of Strike Force Skarratt.[4220]

5.4630. On 13 June 2023, following a request from the Inquiry on 31 May 2023, the NSWPF provided the Inquiry with an expert certificate from Senior Crime Scene Officer, Kate Reid, regarding the fingerprints located at the crime scene and testing conducted on those fingerprints.[4221]

Other cooperation

5.4631. Through interagency cooperation, the Inquiry sought to locate Mr Brennan's family members, relevant witnesses and persons of interest, including the following persons: Mrs Leonoff ; Ms Henderson; Christopher Crook; Christopher Thomas; NP182; NP183; NP184; NP185; NP186; NP189; NP190; NP192; NP193; NP194; NP195; NP196; NP197; NP199; NP200; NP203; NP204; NP206; NP208; NP209; NP211; NP212; NP214; NP215; and NP218.[4222]

Family members

5.4632. Mr Brennan was married to Rosemary Ferguson at the time of his death. They separated in 1989 but remained friends. The Inquiry has been in contact with Rosemary Ferguson through her sister-in-law, Jan Ferguson.[4223] Jan Ferguson has been the point of contact for Mr Brennan's wife since September 2022.

5.4633. The Inquiry conducted a conference with Jan Ferguson and her husband, Christopher Ferguson, on 14 October 2022. The Inquiry conducted a further conference with Jan and Christopher Ferguson and their children, Dylan and Jemma Ferguson, on 9 June 2023.[4224]

[4219] Exhibit 37, Tab 175, Statement of Hermione Nicholls, [4] (SCOI.83469).

[4220] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [36] (SCOI.83469).

[4221] Exhibit 37, Tab 180, Letter from Katherine Garaty to Enzo Camporeale, 13 June 2023 (SCOI.83975); Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023 (NPL.0100.0017.0001).

[4222] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [21]–[25] (SCOI.83469).

[4223] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [7] (SCOI.83469).

[4224] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [7] (SCOI.83469).

5.4634. The Inquiry understands that Mr Brennan's surviving family members are his sister, Ronda Saler, and his brother, Robert Brennan. The Inquiry was not able to identify contact details for Robert Brennan but was able to identify an address for Ms Saler through interagency cooperation. A letter was sent by the Inquiry to that address and no response was received.[4225]

5.4635. On 31 May 2023, the Inquiry issued a summons to the South Australian Police (**SAP**) to obtain contact details for Robert Brennan and Ms Saler (summons SAP3). On 2 June 2023, the SAP advised the Inquiry that the SAP could not identify any records in response.[4226]

5.4636. The Inquiry again conferenced with Jan Ferguson on 20 July 2023, following the public hearing in relation to Mr Brennan's death.

Searches for exhibits

5.4637. On 22 May 2023, the Inquiry issued a summons to the NSWPF seeking the location of physical exhibits (including a knife, tissue paper and a black leather suit bag) seized from the residence of I271 (a pseudonym) in early 1996 (NSWPF109).[4227]

5.4638. On 30 May 2023, the NSWPF produced material responsive to Summons NSWPF109.[4228] This response confirmed that the knife, tissue paper and a black leather suit bag were seized from the residence of I271, and that the knife was subject to super glue fuming testing in 1996.[4229] Testing yielded no results.[4230] Following testing, the NSWPF returned the black leather suit bag to I271 and disposed of the knife and tissue paper.[4231]

5.4639. On 30 May 2023, the Inquiry issued a summons to the NSWPF seeking the exhibit book references and EFIMS records for various exhibits obtained by the NSWPF from the crime scene (NSWPF114).[4232] On 7 June 2023, the NSWPF produced material responsive to that summons.[4233]

5.4640. On 22 June 2023, following the receipt of further material produced by the NSWPF on 21 June 2023 (NSWPF1), the Inquiry issued a summons to the NSWPF seeking any photographs, documents or records in relation to the property collected from the residence of NP215 on 16 July 2022, which was referred to in an Information Report contained in the further material (NSWPF138).[4234]

[4225] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [10] (SCOI.83469).

[4226] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [47] (SCOI.83469).

[4227] Exhibit 37, Tab 158A, Summons to produce to NSW Police Force (NSWPF109), 22 May 2023 (SCOI.83335).

[4228] Exhibit 37, Tab 159, NSWPF response to Summons NSWPF109, 30 May 2023 (SCOI.83344).

[4229] Exhibit 37, Tab 159A, Exhibit book (various) (NPL.0170.0001.0001); Exhibit 37, Tab 159B, Crime Scene Display, 7 March 1996, 2 (NPL.0170.0001.0004).

[4230] Exhibit 37, Tab 159B, Crime Scene Display, 7 March 1996, 2 (NPL.0170.0001.0004).

[4231] Exhibit 37, Tab 159, NSWPF response to Summons NSWPF109, 30 May 2023 (SCOI.83344).

[4232] Exhibit 37, Tab 176A, Summons to produce to NSWPF (NSWPF114), 30 May 2023 (SCOI.84085).

[4233] Exhibit 37, Tab 178, NSWPF response to Summons NSWPF114, 7 June 2023 (SCOI.83650).

[4234] Exhibit 37, Tab 195A, Summons to produce to NSW Police Force (NSWPF138), 22 June 2023, (SCOI.84225).

5.4641. On 23 June 2023, the NSWPF advised the Inquiry that searches had been conducted to locate the Miscellaneous Property Book (**MPB**) 134/C781446 and that no records had been found. It was noted that MPBs are destroyed after five years. The NSWPF further advised that enquires had been made at Ashfield Police Station and no records had been found.[4235] On 25 June 2023, the NSWPF produced six photographs of the material located at the residence of NP215, in response to Summons NSWPF138.[4236]

Further forensic examinations

5.4642. There have been advances in forensic testing technology since 2016 when the exhibits in Mr Brennan's case were last tested. Forensic technology now allows for further amplification of mixed DNA profiles (which were otherwise unsuitable for sequencing and phenotyping testing). Accordingly, the Inquiry requested relevant exhibits to be retested.

5.4643. On 3 May 2023, the Inquiry met with staff of FASS to discuss the possibility of advancing the partial Unknown Male 'B' profile located on the YSL underpants and Condom 1. FASS employees considered the following steps could be taken:

a. FASS could use updated "STRmix" software to attempt to identify further markers of the Unknown Male 'B' profile recovered from these exhibits; and

b. FASS could explore "Yfiler" PCR amplification, which would allow for the uploading of the Unknown Male 'B' profile on the national Y chromosome database with a view to identifying a relative (on the paternal line) of the profile contributor.

5.4644. Additionally, FASS indicated that DNA testing may also be possible on the bloodstained handle of the frypan.

5.4645. On 11 May 2023, the Inquiry requested that FASS conduct further forensic analysis with the view to advancing the identification of the Unknown Male 'B' profile and obtaining a DNA profile from the partial bloody fingerprint on the handle of the frypan.[4237]

5.4646. On 24 May 2023, the Inquiry further requested that FASS conduct further forensic analysis on the subsamples collected from the broken knife handle located at the crime scene.[4238]

5.4647. On 20 June 2023, FASS provided the Inquiry with the expert certificate of Dr David Bruce, which provides the following results from the further forensic analysis:[4239]

a. DNA testing was unsuccessful on:

[4235] Exhibit 37, Tab 196, Letter from Katherine Garaty to Enzo Camporeale, 25 June 2023 (SCOI.84224).

[4236] Exhibit 37, Tab 196A, Photographs of property (x6), 25 June 1995, 6 (NPL.0189.0001.0001).

[4237] Exhibit 37, Tab 172A, Letter of instruction from Hermione Nicholls to Dr David Bruce, 11 May 2023 (SCOI.83330).

[4238] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [55] (SCOI.83469).

[4239] Exhibit 37, Tab 172, Expert certificate of Dr David Bruce, 12 June 2023, [4] (SCOI.84091).

i. The partial bloody fingerprints located on the handle of the frypan;[4240]

ii. The curved exterior of the frypan; and

iii. The swabs A, B and C of the broken knife handle.

b. The DNA profile located on the frypan was too weak for meaningful comparison;

c. The partial DNA profile located on the base of the frypan was consistent with Mr Brennan;

d. A partial mixed DNA profile was located on the broken knife handle; the Unknown Male 'B' profile cannot be excluded as a contributor to this mixture; and

e. No close relatives (i.e., parents, children or siblings) matched the Unknown Male 'B' profile on FASS's familial database.

5.4648. On 24 August 2023, the Inquiry requested that FASS conduct further forensic analysis on Condoms 2 and 3, or swabs of those condoms, with a view to locating a DNA profile or profiles on those exhibits, and if successful, identifying the DNA profile or profiles on those exhibits.[4241]

5.4649. On 8 September 2023, Dr Bruce provided the Inquiry with an expert certificate which provides the following results:[4242]

a. A weak partial DNA profile originating from an unknown male (Unknown Male 'C' profile) was recovered from the outside surface of Condom 2. This profile could not have originated from NP215, NP214, NP204, NP200, NP190, NP189, NP188 or the Unknown Male 'B' profile;

b. Another DNA profile was recovered from the outside surface of Condom 3 was found to be too weak for comparison; and

c. A weak partial mixed DNA profile was recovered from the inside surface of Condom 3. Mr Brennan cannot be excluded as one of the contributors to this profile. The other contributor originated from an unknown male (**Unknown Male 'D' profile**). The Unknown Male 'D' profile could not have originated from NP215, NP214, NP204, NP200, NP190, NP189, NP188 or Unknown Males 'B' or 'C'.

[4240] No DNA profile was recovered from this sample.

[4241] Exhibit 37, Tab 199A, Letter of instruction from Hermione Nicholls to Clint Cochrane, 24 August 2023 (SCOI.86248).

[4242] Exhibit 37, Tab 199, Expert certificate of Dr David Bruce, 8 September 2023 (SCOI.86247).

Professional opinions

Dr Danny Sullivan

5.4650. The Inquiry obtained an expert report from Dr Danny Sullivan, consultant forensic psychiatrist on 24 October 2022.[4243] In his report, Dr Sullivan considered whether any aspects of the manner of death and/or crime scene may indicate that the homicide occurred in the context of LGBTIQ bias.

5.4651. Dr Sullivan did not consider there was any information from a psychiatric perspective relevant to the circumstances of death.[4244] Dr Sullivan observed that the possible motivations for the perpetrator of Mr Brennan's injuries included robbery, anger, or distress if the unknown person was conflicted about their sexuality. Dr Sullivan considered that the absence of a pre-arranged liaison and the use of a weapon or weapons obtained from the residence were indicative of the offending being opportunistic to some degree. Pathological interpretations of the injuries note a "struggle and significant number of injuries, suggesting marked anger, hatred or overkill".[4245]

5.4652. Dr Sullivan did not consider that there were any specific aspects of victimology relevant to Mr Brennan's death, nor any indication of any mental disorder or clinically significant substance abuse in Mr Brennan.[4246] Although there were reports of some relationship problems between Mr Brennan and NP215, Dr Sullivan noted that there was no evidence of overt acrimony or violence.[4247] He considered that there was no other information from a forensic psychiatric perspective of relevance to Mr Brennan's character or behaviour which could be assessed as an element in this offence.[4248]

5.4653. Dr Sullivan did not provide any suggestions as to recommendations for further investigations with respect to determining the manner and cause of Mr Brennan's death and did not have any further matters to raise with the Inquiry.[4249]

Dr Linda Iles

5.4654. The Inquiry also obtained an expert report from Dr Linda Iles, forensic pathologist, on 6 April 2023.[4250] Dr Iles considered the manner and cause of Mr Brennan's death.

[4243] Exhibit 37, Tab 170, Expert report of Dr Danny Sullivan, 24 October 2022, [1] (SCOI.83009).
[4244] Exhibit 37, Tab 170, Expert report of Dr Danny Sullivan, 24 October 2022, [24] (SCOI.83009).
[4245] Exhibit 37, Tab 170, Expert report of Dr Danny Sullivan, 24 October 2022, [26] (SCOI.83009).
[4246] Exhibit 37, Tab 170, Expert report of Dr Danny Sullivan, 24 October 2022, [27] (SCOI.83009).
[4247] Exhibit 37, Tab 170, Expert report of Dr Danny Sullivan, 24 October 2022, [28] (SCOI.83009).
[4248] Exhibit 37, Tab 170, Expert report of Dr Danny Sullivan, 24 October 2022, [30] (SCOI.83009).
[4249] Exhibit 37, Tab 170, Expert report of Dr Danny Sullivan, 24 October 2022, [31]–[32] (SCOI.83009).
[4250] Exhibit 37, Tab 171, Expert report of Dr Linda Iles, 6 April 2023, 2 (SCOI.83005).

5.4655. Dr Iles considered that Mr Brennan's death was caused by both sharp and blunt force injuries, quite possibly involving implements located at the scene (for example, a knife and a frypan) in addition to a possible stomping injury. Dr Iles did not consider that a blood pattern analysis expert would be able to further illuminate the cause of Mr Brennan's injuries for the Inquiry.[4251]

5.4656. Dr Iles considered that Dr Bradhurst's post-mortem examination was thorough and comprehensive, and agreed with the cause of death statement. Dr Iles noted that the quality and number of post-mortem photographs falls significantly short of contemporary standards (although they likely reflected the standard of practice in 1995). She indicated that the relatively small number of photographs provided limited her ability to review elements of the post-mortem examination.[4252]

5.4657. Dr Iles was unable to comment on whether: (i) the apparent head stomping injury matched the bloody boot print in linoleum at the scene; or (ii) the thoracic injury and aortic laddering were due to hyperextension injury. This was said to be due to the lack of photographic evidence from the post-mortem reexamination that took place on 16 June 1995.[4253]

5.4658. Dr Iles stated that the level of description for each stab wound, and the absence of individually photographed stab wounds, is not what would be expected in contemporary practice. However, Dr Iles indicated that this did not impact the conclusions reached regarding the nature of the injuries or cause of death. Dr Iles opined that, according to contemporary practice standards (and adopting conventional wound description practice), the total number of stab wounds is accurately described as 13 stab injuries (because some of the individual stab wounds described represent exit and re-entry wounds from the same knife track).[4254]

5.4659. The photo documentation was inadequate for Dr Iles to express an opinion as to how Mr Brennan acquired the blunt force injuries to his head. Noting that Mr Brennan only had minor scalp bruising and no intracranial injury, Dr Iles considered that the blunt force head injuries could have occurred at any time during the incident.[4255]

5.4660. Dr Iles did not consider it possible to determine the order of the stab wounds inflicted on Mr Brennan. However, the characteristics of the wounds support the possible case theory that Mr Brennan was moving about the apartment whilst the injuries were being inflicted or after the injuries had been sustained. Based on the post-mortem findings, Dr Iles considered Mr Brennan's injuries could have been inflicted by a single person.[4256]

[4251] Exhibit 37, Tab 171, Expert report of Dr Linda Iles, 6 April 2023, 5 (SCOI.83005).

[4252] Exhibit 37, Tab 171, Expert report of Dr Linda Iles, 6 April 2023, 5 (SCOI.83005).

[4253] Exhibit 37, Tab 171, Expert report of Dr Linda Iles, 6 April 2023, 6 (SCOI.83005).

[4254] Exhibit 37, Tab 171, Expert report of Dr Linda Iles, 6 April 2023, 6 (SCOI.83005).

[4255] Exhibit 37, Tab 171, Expert report of Dr Linda Iles, 6 April 2023, 6-7 (SCOI.83005).

[4256] Exhibit 37, Tab 171, Expert report of Dr Linda Iles, 6 April 2023, 7 (SCOI.83005).

Witness statements

5.4661. The Inquiry obtained a statement from each of Ms Henderson and Kieran Moran, who were both neighbours of Mr Brennan and NP215 at the time of Mr Brennan's death.[4257]

Contact with OICs

5.4662. On 24 August 2023 and 19 September 2023, the Inquiry wrote to I446 and Laura Thurtell enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Brennan. The Inquiry did not receive a response from either I446 or Ms Thurtell.[4258]

Contact with NP215

5.4663. In light of the evidence before the Inquiry as to the potential involvement of NP215 in Mr Brennan's death, and the possibility that Counsel Assisting may make submissions to that effect, the Inquiry wrote to NP215 on 14 and 16 June 2023. By those letters, the Inquiry advised NP215 of the date of the public hearing in relation to Mr Brennan's death and provided a timeframe for NP215 to contact the Inquiry to provide information and/or make submissions.[4259]

Consideration of the evidence

Mr Brennan's personal circumstances

5.4664. Mr Brennan was 53 years old at the time of his death. He was employed as a history teacher at the Open High School, Redfern, Sydney.[4260]

5.4665. After separating from Ms Ferguson in 1989, Mr Brennan commenced a relationship with NP215 in 1991.[4261] Sometime after the relationship commenced, Mr Brennan and NP215 relocated in Sydney.[4262]

5.4666. Upon their arrival in Sydney, Mr Brennan and NP215 resided with I282 for approximately six months.[4263] Mr Brennan and NP215 then resided together in the Elizabeth Bay apartment for approximately two years before Mr Brennan's death.[4264]

[4257] Exhibit 37, Tab 173, Statement of Joan Henderson, 11 May 2023 (SCOI.83222); Exhibit 37, Tab 174, Statement of Kieran Moran, 30 May 2023 (SCOI.83342).

[4258] Exhibit 66, Tabs 14-15, 17-18, Letters from Inquiry to I446 and Laura Thurtell, 24 August 2023 and 19 September 2023 (SCOI.86278; SCOI.86279; SCOI.86281; SCOI.86282).

[4259] Exhibit 68, Tabs 1-2, Letters from Inquiry to NP215, 14 and 16 June 2023 (SCOI.86619; SCOI.86633).

[4260] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [35] (SCOI.00009.00008)

[4261] Exhibit 37, Tab 40, Statement of NP215, 15 June 1995, [3] (SCOI.00009.00019).

[4262] Exhibit 37, Tab 38, NSWPF Record of Interview, 'Interview with NP215', 12 June 1995, 2 (SCOI.00009.00015).

[4263] Exhibit 37, Tab 38, NSWPF Record of Interview, 'Interview with NP215', 12 June 1995, 5 (SCOI.00009.00015).

[4264] Exhibit 37, Tab 38, NSWPF Record of Interview, 'Interview with NP215', 12 June 1995, 7 (SCOI.00009.00015).

5.4667. Throughout their relationship, Mr Brennan frequently and actively sought out other sexual partners.[4265] Mr Brennan was known to frequent the Pleasure Chest and Kingsteam Sauna for sexual encounters with men.[4266] Mr Brennan advertised for sexual encounters through the Capital Q Weekly. He was also a member of the Country Network, which was a program that provided intra and interstate accommodation and opportunities for sexual encounters with men.[4267]

5.4668. Mr Brennan and NP215's relationship reportedly deteriorated somewhat over the last six months of Mr Brennan's life.[4268] The cause of this deterioration was in part because NP215 wanted their relationship to be a monogamous one, whereas Mr Brennan wanted to have an open relationship.[4269]

Events prior to Mr Brennan's death

5.4669. During the days preceding his death, Mr Brennan had sexual encounters with the following people: NP196 (on 6 June 1995), NP189 (7 to 8 June 1995), NP214 (on 3 and 10 June 1995) and NP215 (on 3 and 10 June 1995). Mr Brennan also received 12 voice mailbox responses to an advertisement he had placed in Capital Q Weekly on 12 May 1995.[4270]

5.4670. On 7 or 8 June 1995, during the period NP189 stayed with Mr Brennan and NP215, NP215 provided NP189 with a spare set of keys, which NP189 says were cut for him.[4271] NP189 reportedly returned these keys to Mr Brennan on 8 June 1995.[4272]

5.4671. On 10 June 1995, Mr Brennan paid for his and NP215's rent. Later that evening, he travelled by taxi with NP215 to the apartment of NP214. NP214 lived in an apartment in Woollahra. Mr Brennan and NP215 had met NP214 around two weeks earlier, having been introduced by a mutual friend, NP199. At about 10:00pm on 10 June 1995, Mr Brennan left NP214's apartment, saying he was tired and that he intended to go home.[4273]

5.4672. NP215 reportedly remained at NP214's apartment until 12 June 1995.[4274]

[4265] Exhibit 37, Tab 38, NSWPF Record of Interview, 'Interview with NP215', 12 June 1995, 8, 9,41 (SCOI.00009.00015).

[4266] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [24] (SCOI.00009.00008).

[4267] Exhibit 37, Tab 46, Statement of NP189, 16 June 1995, [4]–[5] (SCOI.00009.00020); Exhibit 37, Tab 40, Statement of NP215, 15 June 1995, [16] (SCOI.00009.00019).

[4268] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [24] (SCOI.00009.00008).

[4269] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [37] (SCOI.00009.00008).

[4270] Exhibit 37, Tab 95, Running Sheet – Voice Box of Brennan Recreated Relative to Advertisement in Capital Q and Tele Pacific Communications, 16 June 1995 (SCOI.10321.00003).

[4271] Exhibit 37, Tab 46, Statement of NP189, 16 June 1995, [18] (SCOI.00009.00020).

[4272] Exhibit 37, Tab 46, Statement of NP189, 16 June 1995, [22] (SCOI.00009.00020).

[4273] Exhibit 37, Tab 38, NSWPF Record of Interview, 'Interview with NP215', 12 June 1995, 18-20 (SCOI.00009.00015); Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [28] (SCOI.00009.00008).

[4274] Exhibit 37, Tab 38, NSWPF Record of Interview, 'Interview with NP215', 12 June 1995, 19 (SCOI.00009.00015); Exhibit 37, Tab 41, First statement of NP214, 12 June 1995, [9] (SCOI.00009.00018); Exhibit 37, Tab 42, Second statement of NP214, 16 June 1995, [11] (SCOI.00009.00022).

5.4673. At 2:46pm on 11 June 1995, Mr Brennan was photographed at the National Australia Bank ATM on Darlinghurst Road withdrawing $150.[4275] At 5:15pm and again at 5:30pm that evening, Mr Brennan's sister, Ms Saler, spoke briefly to him on the telephone.[4276]

5.4674. At approximately 6:15pm, NP191 reportedly attempted to approach Mr Brennan at Kingsteam Sauna but Mr Brennan ignored him.[4277]

5.4675. At 6:30pm, NP190 reportedly spoke to Mr Brennan at Kingsteam Sauna.[4278] NP190 and Mr Brennan "commenced foreplay but did not continue further".[4279] NP190 indicated in his evidence that he had first met Mr Brennan in an adult bookshop on Pitt Street, approximately one year prior to Mr Brennan's death. On that occasion, NP190 and Mr Brennan had engaged in sexual intercourse in a room provided at the book shop.[4280] Mr Brennan had given his telephone number to NP190 at that time with a view to further sexual encounters.[4281] Over the next year, NP190 and Mr Brennan met for sexual encounters at both of their residences. On one occasion, NP215 joined them for a threesome.[4282]

5.4676. Sometime between 9:00pm and 10:00pm that evening, shop attendant Arturo Guijar observed Mr Brennan entering Oxford Street Cellars, Darlinghurst (located at 118 Oxford Street, Darlinghurst), in the company of a younger male, approximately 16 to 18 years of age with messy blond hair.[4283] Mr Guijar subsequently provided police with his observations of the younger male, and police arranged for a Facial Image Portrait to be drawn based on Mr Guijar's description.[4284]

5.4677. Mr Brennan's movements after 10:00pm are not known.

Evidence of Mr Brennan's neighbours

5.4678. Contemporaneous NSWPF records indicate that Ms Henderson, who resided in a nearby apartment block, heard screaming between 1:00am and 2:00am on 11 June 1995.[4285]

[4275] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [42] (SCOI.00009.00008); Exhibit 37, Tab 86, Statement of Detective Senior Constable Brad Tayler, 29 January 1996, [13] (SCOI.00009.00005).

[4276] Exhibit 37, Tab 9, Statement of Ronda Saler, 3 August 1995, [13] (SCOI.00009.00028).

[4277] Exhibit 37, Tab 60, Statement of NP191, 9 July 1995, [4]–[6] (SCOI.00009.00032).

[4278] Exhibit 37, Tab 47, Statement of NP190, 20 June 1995, [12]–[13] (SCOI.00009.00029).

[4279] Exhibit 37, Tab 47, Statement of NP190, 20 June 1995, [13] (SCOI.00009.00029).

[4280] Exhibit 37, Tab 47, Statement of NP190, 20 June 1995, [5] (SCOI.00009.00029).

[4281] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [46] (SCOI.00009.00008); Exhibit 37, Tab 47, Statement of NP190, 20 June 1995, [5] (SCOI.00009.00029).

[4282] Exhibit 37, Tab 47, Statement of NP190, 20 June 1995, [8] (SCOI.00009.00029).

[4283] Exhibit 37, Tab 26, Statement of Arturo Guijar, 25 July 1995, [6]–[7] (SCOI.00009.00045).

[4284] Exhibit 37, Tab 113, Facial Image Portrait (undated) (SCOI.00009.00126).

[4285] Exhibit 37, Tab 108, Witness Canvassing Handwritten Notes (undated) (SCOI.10316.00022).

5.4679. Pamela Boyer-Gooche, a neighbour who resided in Mr Brennan and NP215's apartment building stated that a man had greeted her in the foyer of the building at about 4:30pm on 11 June 1995. She believed this man to be Mr Brennan.[4286] Ms Boyer-Gooche reported that Mr Brennan was wearing a white shirt, black trousers and potentially a tie when she saw him.[4287]

5.4680. The NSWPF witness canvassing notes (undated) also indicate that a neighbour by the name of "C.D Crook" heard a male scream between 8:00am and 9:00am on 12 June 1995.[4288] The Inquiry was able to identify this neighbour as being Christopher Crook as set out above.

Observations of the crime scene

5.4681. At around 5:20pm on Monday, 12 June 1995, NP215 discovered Mr Brennan's body in the Elizabeth Bay apartment where they resided. Shortly after, NP215 ran to Kings Cross Police Station and reported Mr Brennan's death. Police subsequently attended the crime scene and their observations are recorded above.

5.4682. Police seized a significant number of exhibits from the crime scene as outlined above. It is understood that the bent blood-stained knife blade and the frypan may have been used as murder weapons. Both items were the property of Mr Brennan and NP215 and were ordinarily kept at the Elizabeth Bay apartment.

5.4683. Fingerprints were found in various locations at the Elizabeth Bay apartment as referred to above. One fingerprint was located on the inside of the wardrobe, two fingerprints and a palm print were located on the inside of the entrance door, and three fingerprints were located on the inside of the front door. All were successfully matched to NP215.[4289]

5.4684. Noting that NP215 resided at the Elizabeth Bay apartment where Mr Brennan's body was discovered, the identification of NP215's fingerprints and palm print is unsurprising.

5.4685. There were no signs of forced entry to the Elizabeth Bay apartment.[4290]

5.4686. The internal lock on the apartment door required a key to open it from the inside.[4291] There were four sets of keys to the Elizabeth Bay apartment. Ordinarily, NP215, Mr Brennan, and the real estate agent each had a set of keys. A spare set of keys was located in the apartment. All known sets of keys were accounted for in the apartment when Mr Brennan was discovered.[4292] However, there is the possibility that further keys were cut by NP215, as reported by NP189, or alternatively, that during the period NP189 had possession of such keys, he cut a further copy.

[4286] Exhibit 37, Tab 14, Statement of Pamela Boyer-Gooche, 18 June 1995, [4]–[6] (SCOI.10324.00038).

[4287] Exhibit 37, Tab 14, Statement of Pamela Boyer-Gooche, 18 June 1995, [5] (SCOI.10324.00038).

[4288] Exhibit 37, Tab 109, Witness Canvassing Form of occupants at Onslow Avenue, Elizabeth Bay (undated), 4 (SCOI.10316.00009).

[4289] Exhibit 37, Tab 180A, Expert certificate of Kate Reid, 9 June 2023, [9]–[10] (NPL.0100.0017.0001).

[4290] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [3] (SCOI.45105).

[4291] Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 46-47 (SCOI.00009.00059).

[4292] Exhibit 37, Tab 38, Transcript of interview of NP215, 12 June 1995, 42-43,50 (SCOI.00009.00015).

Persons of interest

5.4687. Investigating police made various inquiries in relation to a significant number of other persons of interest, including the following.

NP215

5.4688. NP215 was considered a person of interest because of his recent relationship difficulties with Mr Brennan and several inconsistencies in his evidence.

5.4689. Over the last six months of his life, Mr Brennan told friends that his relationship with NP215 was tumultuous and that he desired more independence from NP215.[4293] According to a mutual friend, Mr Brennan attempted to end the relationship with NP215 on multiple occasions, but NP215 refused.[4294] Additionally, in his statement dated 15 June 1995, NP215 states that he was very angry that Mr Brennan had engaged in sexual relationships with other men.[4295]

5.4690. NP215's evidence has been that on 10 June 1995, he and Mr Brennan attended NP214's apartment in Woollahra where they had dinner and then had sex. At about 10:00pm that evening, Mr Brennan stated that he was tired and decided to go home, while NP215 remained at NP214's apartment until the morning of 12 June 1995. NP215 reported that he telephoned Mr Brennan on 11 June 1995 and left a voicemail on the answering machine.[4296] NP214 corroborated this evidence.[4297]

5.4691. This alibi evidence is, however, at odds with the observations of one of NP214's neighbours, Mrs Leonoff. Mrs Leonoff reported to police that she observed NP215 outside NP214's apartment complex on 11 June 1995 on the following two occasions:[4298]

a. At about 3:00am, NP215 was standing outside Mrs Leonoff's apartment block. Mrs Leonoff had forgotten her security key to access the building and began to make noise to wake her son up so that he could let her inside. Mrs Leonoff reported that, at that point, NP215 became agitated and angry towards her.[4299] The reliability of her identification evidence is therefore unclear, particularly given the evidence that NP215 had stayed with NP214 for at least a few days after Mr Brennan's body was discovered, and the fact that Mrs Leonoff was not interviewed by police until the following Monday, 19 June 1995; and

b. At about 8:00pm, Mrs Leonoff observed NP215 in the company of a girl and an older man with grey hair. Mrs Leonoff said that the group was walking from the carpark towards the apartment building. Counsel Assisting

[4293] Exhibit 37, Tab 34, Further letter from Kenneth Brennan to John Sullivan (undated), 1,3 (SCOI.10278.00064); Exhibit 37, Tab 33, Letter to John Sullivan from Kenneth Brennan, 24 May 1995, 3 (SCOI.10278.00063); Exhibit 37, Tab 32, Statement of John Sullivan, 4 October 1995, [6] (SCOI.10278.00062); Exhibit 37, Tab 29, Statement of Graham Duckett, 3 August 1995, [13] (SCOI.00009.00052).

[4294] Exhibit 37, Tab 37, Statement of I271, 6 March 1996, [6] (SCOI.10324.00051).

[4295] Exhibit 37, Tab 40, Statement of NP215, 15 June 1995, [3]–[7] (SCOI.00009.00019).

[4296] Exhibit 37, Tab 40, Statement of NP215, 15 June 1995, [28] (SCOI.00009.00019); Exhibit 37, Tab 41, First statement of NP214, 12 June 1995, [8] (SCOI.00009.00018).

[4297] Exhibit 37, Tab 42, Second statement of NP214, 16 June 1995, [9] (SCOI.00009.00022).

[4298] Exhibit 37, Tab 97, Running Sheet – Information from Natalie Leonoff, 26 June 1995, 1 (SCOI.10276.00118).

[4299] Exhibit 37, Tab 97, Running Sheet – Information from Natalie Leonoff, 26 June 1995, 1 (SCOI.10276.00118).

submitted that it might be regarded as odd that NP215 was seen in the company of anyone other than NP214.

5.4692. Throughout the investigation into Mr Brennan's death, police observed other features of NP215's evidence that raised potential inconsistencies. These included:

a. Whether it was plausible or likely that NP215 had failed to notice Mr Brennan's body immediately upon entering the Elizabeth Bay apartment on the evening of 12 June 1995; [4300]

b. Whether it was plausible or likely that NP215 had been able to observe the answering machine after it had fallen off its podium in the main bedroom (even if in dim light);[4301]

c. The fact there appeared to be no messages recorded on the answering machine, although this would be consistent with Mr Brennan having deleted them;[4302]

d. That Mr Brennan's body appeared to have been partially sponged down after his death (which may be indicative of a level of remorse or compassion after the event causing death, but may equally be explicable as a stranger attempting to remove DNA);[4303]

e. That the apartment was secure with external and internal locks. Police recorded that all keys to the apartment were accounted for and that there were no signs of forced entry or use of the windows.[4304] Therefore, it would have been necessary for a stranger to open the apartment door from the inside, prop the door open, put the keys back in their place in the apartment and leave or alternatively have cut a key for themselves;[4305] and

f. That I271 and his mother located a knife with the blade wrapped in toilet paper hidden in a black leather suit bag months after NP215 resided with I271 after Mr Brennan's death.[4306]

5.4693. There is at least one possible scenario which would explain the evidence of Mr Brennan having at least one unknown male sexual partner in the apartment on 11 June 1995. Mr Brennan may have had sex with the unknown male sexual partner in the apartment, after which NP215 may have returned home, become jealous and killed Mr Brennan in anger. While this possible scenario is consistent with some of the evidence, it is inconsistent with NP214's alibi evidence.

[4300] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [29] (SCOI.00009.00008).

[4301] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [29] (SCOI.00009.00008); Exhibit 37, Tab 160, Transcript of Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 45 (SCOI.00009.00059).

[4302] Exhibit 37, Tab 160, Transcript of Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 50 (SCOI.00009.00059).

[4303] Exhibit 37, Tab 160, Transcript of Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 15 (SCOI.00009.00059).

[4304] Exhibit 37, Tab 86, Statement of Detective Senior Constable Brad Tayler, 29 January 1996, 2-4 (SCOI.00009.00005); Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [10] (SCOI.00009.00008).

[4305] Exhibit 37, Tab 160, Transcript of Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 51 (SCOI.00009.00059).

[4306] Exhibit 37, Tab 36, Statement of I281, 1 March 1996, [4]–[6] (SCOI.10261.00101); Exhibit 37, Tab 37, Statement of I271, 6 March 1996, [18]–[20] (SCOI.10324.00051).

5.4694. Furthermore, it might be regarded as inherently surprising that NP214 would lie for someone whom he had only known for about two weeks, especially in a context where that person might be responsible for a violent murder. It would be even more surprising to maintain the lie in 2018.

5.4695. NP215 was not excluded from the police investigation, despite the fact forensic results confirmed his DNA did not match the Unknown Male 'B' profile of the DNA located on the YSL underpants.[4307] This, and the forensic results confirming NP215's DNA did not match the Unknown Male 'C' and 'D' profiles located on Condoms 2 and 3, is consistent with the possible scenario described at [5.4693].

Other Persons of Interest

5.4696. NP214 was considered a person of interest because of his recent association with NP215 and Mr Brennan. NP214 stated that at the time of Mr Brennan's death, he was asleep at his apartment in Woollahra. NP214 was excluded from the police investigation because his DNA did not match the Unknown Male 'B' profile of the DNA located on the YSL underpants.[4308]

5.4697. NP188 was nominated after reportedly boasting about killing a man named "Kenneth".[4309] NP188 was excluded from the investigation after police confirmed that NP188 was in Byron Bay with NP207 from 10 to 12 June 1995,[4310] and because his DNA did not match the Unknown Male 'B' profile located on the YSL underpants. [4311] BDM confirmed that NP188 died on 3 August 2013.[4312]

[4307] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003); Exhibit 37, Tab 163, Second report of Michele Franco, 16 August 1996, 2 (SCOI.10181.00004).

[4308] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003); Exhibit 37, Tab 163, Second report of Michele Franco, 16 August 1996, 2 (SCOI.10181.00004).

[4309] Exhibit 37, Tab 51, Transcript of interview with I298, 11 November 1995, 14 (SCOI.10291.00065); Exhibit 37, Tab 123, Review of an Unsolved Homicide Case Screening Form, 6 August 2004, 8 (SCOI.44995); Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [91]–[92], [96]–[97] (SCOI.00009.00008).

[4310] Exhibit 37, Tab 53, Statement of Robert Ivey, 6 January 1996, [9] (SCOI.00009.00056); Exhibit 37, Tab 49, Statement of NP188, 23 October 1995, [6] (SCOI.10291.00093).

[4311] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003); Exhibit 37, Tab 163, Second report of Michele Franco, 16 August 1996, 2 (SCOI.10181.00004).

[4312] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [17] (SCOI.83469).

5.4698. NP189 was considered a person of interest because he had recently had sexual encounters with Mr Brennan via the Country Network.[4313] On 8 June 1995, NP189 stayed with Mr Brennan and NP215.[4314] NP189 said that NP215 had spare keys to the Elizabeth Bay apartment cut for NP189.[4315] I301, a friend of NP189, reported to police that while NP189 was staying at Elizabeth Bay apartment, he told I301 that he wanted to leave there because Mr Brennan would "continually pester him [NP189] for sex".[4316] I301 told NP189 that he could stay with him instead, and later that evening NP189 returned the spare keys to Mr Brennan.[4317] NP189 was excluded from the investigation after I282 confirmed that NP189 stayed with him on the evening of 11 June 1995,[4318] and after forensic results confirmed that his DNA did not match the Unknown Male 'B' profile located on the YSL underpants.[4319]

5.4699. NP190 was considered a person of interest because he was one of the last people to see Mr Brennan alive and because he had engaged in sexual activity with Mr Brennan on several occasions. Additionally, on 20 June 1995, when Detective Senior Constable Brad Tayler spoke to NP190, he noticed NP190 had injuries to his hands.[4320] Police took photographs of these injuries.[4321] However, from the evidence available to the Inquiry it does not appear that NP190 was questioned about these injuries, and the photographs have not been provided to the Inquiry. NP190 was excluded from the investigation after investigators compared his underwear and shoes to evidence located at the scene,[4322] and because his DNA did not match the Unknown Male 'B' profile located on the YSL underpants.[4323]

5.4700. NP204 was nominated as a person of interest because, in August 1995, he offended in a similar manner. NP204's de facto partner, I268, confirmed that NP204 was in Canberra at the relevant time.[4324] Additionally, NP204 was excluded from the investigation because his DNA did not match the Unknown Male 'B' profile.

[4313] Exhibit 37, Tab 123, Review of an Unsolved Homicide Case Screening Form, 6 August 2004, 9 (SCOI.44995).

[4314] Exhibit 37, Tab 40, Statement of NP215, 15 June 1995, [19] (SCOI.00009.00019).

[4315] Exhibit 37, Tab 40, Statement of NP215, 15 June 1995, [19] (SCOI.00009.00019).

[4316] Exhibit 37, Tab 11, Statement of I301, 15 June 1995, [14] (SCOI.10261.00004).

[4317] Exhibit 37, Tab 11, Statement of I301, 15 June 1995, [15] (SCOI.10261.00004); Exhibit 37, Tab 46, Statement of NP189, 16 June 1995, [21]–[22] (SCOI.00009.00020); Exhibit 37, Tab 40, Statement of NP215, 15 June 1995, [21] (SCOI.00009.00019).

[4318] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [38] (SCOI.00009.00008).

[4319] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003); Exhibit 37, Tab 163, Second report of Michele Franco, 16 August 1996, 2 (SCOI.10181.00004).

[4320] Exhibit 37, Tab 86, Statement of Detective Senior Constable Brad Tayler, 29 January 1996, [39] (SCOI.00009.00005).

[4321] Exhibit 37, Tab 86, Statement of Detective Senior Constable Brad Tayler, 29 January 1996, [39] (SCOI.00009.00005).

[4322] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [47]–[48] (SCOI.00009.00008).

[4323] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003); Exhibit 37, Tab 163, Second report of Michele Franco, 16 August 1996, 2 (SCOI.10181.00004).

[4324] Exhibit 37, Tab 86, Statement of Detective Senior Constable Brad Tayler, 29 January 1996, [70]–[73] (SCOI.00009.00005); Exhibit 37, Tab 55, Statement of I268, 16 April 1996, [4] (SCOI.10307.00238).

5.4701. NP200 was nominated as a person of interest by an individual who was assaulted by NP200, I302.[4325] NP200 was excluded from the investigation in 1999 after DNA testing confirmed that his DNA did not match the Unknown Male 'B' profile on the YSL underpants.[4326]

5.4702. NP199 was considered a person of interest because he was a sexual acquaintance of NP215 and Mr Brennan, and because he introduced NP214 to them.[4327] NP199 was unable to confirm his whereabouts on the evening of 11 June 1995.[4328] NP199 did not sign his statement to police, refused to supply police with samples of blood or hair, refused to supply police with footprints or fingerprints,[4329] and did not give evidence at the inquest into Mr Brennan's death (citing health concerns).[4330] From the police records, it does not appear that there was a proper basis for the investigating police to exclude NP199 from the investigation. NP199 was not investigated further during Strike Force Skarratt. The Inquiry has received information confirming that NP199 died on 9 April 2014.[4331]

5.4703. NP191 was considered a person of interest because he was reportedly one of the last people to see Mr Brennan alive. NP191 stated that on 11 June 1995, he left the Kingsteam Sauna at 11:00pm, had a meal at Hungry Jacks on Oxford Street and then caught a bus and arrived home at about 12:30am.[4332] NP191 reportedly remained at home until 8:00am on 12 June 1995, at which time he took his dog for a walk in Queens and Centennial Parks.[4333] From the police records, it does not appear that there was a proper basis for the investigating police to exclude NP191 from the investigation. NP191 was not further investigated during Strike Force Skarratt. BDM confirmed NP191 died on 17 November 2005.[4334]

5.4704. NP203 was nominated as a person of interest as a result of the Facial Image Portrait exercise, and because police intelligence indicated that NP203 was regularly seen in Darlinghurst in the early 1990s.[4335] Strike Force Monardia excluded NP203 from the investigation on account of a statement provided by his employer, I291, which confirmed that NP203 was in Victoria on Sunday, 13 June 1995.[4336] I291 was, however, unable to comment on NP203's whereabouts over the long weekend because no employees worked over the Queen's Birthday long weekend in 1995.

[4325] I note, the Inquiry is not aware of any other link between I302 and Mr Brennan.

[4326] Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003); Exhibit 37, Tab 164, Third report of Michele Franco, 10 September 1999, 2 (SCOI.10181.00005).

[4327] Exhibit 37, Tab 58, Statement of NP199, 24 August 1995, [7]–[11] (SCOI.10261.00034).

[4328] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [67] (SCOI.00009.00008).

[4329] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [67] (SCOI.00009.00008).

[4330] Exhibit 37, Tab 160, Transcript of Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 1, 9 (SCOI.00009.00059).

[4331] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [17] (SCOI.83469).

[4332] Exhibit 37, Tab 60, Statement of NP191, 9 July 1995, [7] (SCOI.00009.00032).

[4333] Exhibit 37, Tab 60, Statement of NP191, 9 July 1995, [7] (SCOI.00009.00032).

[4334] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [17] (SCOI.83469).

[4335] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [79] (SCOI.00009.00008).

[4336] Exhibit 37, Tab 62, Statement of I291, 28 November 1995, 1-2 (SCOI.10307.00222).

5.4705. NP198 was also nominated as a person of interest as a result of the Facial Image Portrait exercise and because police received information from a person, I299, that, about one month following Mr Brennan's death, I299 met NP198 at "The Wall" and took NP198 back to his home. I299 said NP198 stayed the night, and then when I299 left his room for a short time and, when he returned, NP198 was gone and a large kitchen knife was protruding from the wooden table in I299's kitchenette.[4337] NP198 was eliminated from the investigation on the basis that he was residing in Victoria at the relevant time and phone records confirmed he had not been in contact with Mr Brennan.[4338] BDM confirmed that NP198 died on 10 May 1996.[4339]

5.4706. NP202 was nominated as a person of interest by an informant known to the NSWPF. The informant reported that NP202 was allegedly molested by a teacher named 'Mr Brennan' and vowed revenge.[4340] NP202 was interviewed by police and, although he was unable to confirm his whereabouts on 11 June 1995, he stated that he was likely at home in the Blacktown area.[4341] NP202's former de facto partner, I288, confirmed that NP202 was residing with her in Blacktown from 5 June until 4 July 1995, however she was unable to recall his precise movements during this period.[4342] Further police inquiries confirmed NP202 was never a registered student of Mr Brennan.[4343] Police did not consider that NP202 was involved in Mr Brennan's death and he was excluded from the investigation.[4344] BDM confirmed that NP202 died on 14 May 2020.[4345]

5.4707. NP182 was nominated as a person of interest as a result of the Facial Image Portrait exercise.[4346] NP182 informed investigating police that on the afternoon and evening of 11 June 1995 he was at a house on the Central Coast of NSW with several friends, including I295.[4347] This evidence was corroborated by a statement from I295.[4348]

[4337] Exhibit 37, Tab 160, Transcript of Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 9 (SCOI.00009.00059).

[4338] Exhibit 37, Tab 123, Review of an Unsolved Homicide Case Screening Form, 6 August 2004, 10 (SCOI.44995); Exhibit 37, Tab 64, Statement of I289, 5 October 1995, [6] (SCOI.10278.00050); Exhibit 37, Tab 114, South Region – Situation Report: No. 9, 13 October 1995 (SCOI.10324.00041); Exhibit 37, Tab 160, Transcript of Inquest into the death of Kenneth Richard Brennan, 17 September 1995, 9-10 (SCOI.00009.00059); Exhibit 37, Tab 103, Running Sheet Telecom Australia Bill for mobile phone owned by NP198, 14 September 1995 (SCOI.10307.00167).

[4339] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [17] (SCOI.83469).

[4340] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [43]–[44] (SCOI.00009.00008); Exhibit 37, Tab 96, Running Sheet – Information from Detective Dennis Bray, 23 June 1995 (SCOI.10307.00055).

[4341] Exhibit 37, Tab 65, Statement of NP202, 27 December 1995, [6], [10] (SCOI.10307.00077); Exhibit 37, Tab 106, Running Sheet – Statement of NP202, 1 January 1996 (SCOI.10307.00076).

[4342] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [44] (SCOI.00009.00008).

[4343] Exhibit 37, Tab 99, Running Sheet – Request to I293, 26 July 1995 (SCOI.10307.00061).

[4344] Exhibit 37, Tab 106, Running Sheet – Statement of NP202, 1 January 1996 (SCOI.10307.00076).

[4345] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [17] (SCOI.83469).

[4346] Exhibit 37, Tab 105, Running Sheet – Statement of NP182, 26 December 1995 (SCOI.10307.00226).

[4347] Exhibit 37, Tab 67, Statement of NP182, 18 January 1996, [5]–[8] (SCOI.10183.00084).

[4348] Exhibit 27, Tab 68, Statement of I295, 19 January 1996, [4]–[8] (SCOI.10323.00016).

5.4708. NP218 was nominated as a person of interest by an informant.[4349] Police subsequently expressed doubt as to the reliability of the informant.[4350] NP218 informed investigating police that on the evening of 10 June 1995, he was assisting the AIDS Council of NSW (now known as ACON).[4351] This was corroborated by I296.[4352] It is not clear why investigating police questioned NP218 about the evening of 10 June 1995 (rather than the evening of 11 June 1995), given what was understood about Mr Brennan's time of death.

5.4709. NP205 was considered a person of interest because he was admitted to St Vincent's Hospital on 11 June 1995 for a head injury.[4353] Despite NP205 being unable to recall his whereabouts on 11 June 1995, he was excluded from the investigation because his movements were accounted for by a person who was in his company that day.[4354] BDM confirmed that NP205 died on 1 September 2018.[4355]

5.4710. NP212 was considered a person of interest because he was admitted to St Vincent's Hospital on 11 June 1995 for abrasions.[4356] NP212 was excluded from the investigation because his movements were also accounted for by a person who was in his company that day.[4357]

5.4711. NP208 was considered a person of interest because he was admitted to St Vincent's Hospital on 11 June 1995 for face abrasions.[4358] Investigating police were unable to locate NP208 because the address provided to St Vincent's Hospital was incorrect. The Police Intelligence System does not contain any information in relation to NP208.[4359]

5.4712. NP206 was admitted to Sydney Hospital on 12 June 1995 for an injury to his left hand.[4360] Initially, NP206 could not be located, but on 15 August 1996 NP206 was located in Leonora in Western Australia. NP206 was interviewed by the Western Australian Police Force regarding Mr Brennan's death and was subsequently excluded from the investigation.[4361] From the records produced by the NSWPF, it is not clear why NP206 was excluded.

5.4713. The following persons were considered persons of interest because they each responded to Mr Brennan's advertisement dated 12 May 1995 in the Capital Q Weekly:

[4349] Exhibit 37, Tab 116, Letter from I293 to NSW Police, 28 April 1997 (SCOI.10305.00044).

[4350] Exhibit 37, Tab 117, Issue Paper re: Letter received from I293, 16 May 1997 (SCOI.10305.00042).

[4351] Exhibit 37, Tab 69, Statement of NP218, 14 January 1998, [10] (SCOI.10305.00136).

[4352] Exhibit 37, Tab 70, Statement of I296, 6 February 1998, [7] (SCOI.10305.00139).

[4353] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [70] (SCOI.00009.00008); Exhibit 37, Tab 71, Statement of NP205, 19 January 1996, [7] (SCOI.10323.00015); Exhibit 37, Tab 94, Running Sheet – Sydney Hospital Records Checked, 15 June 1995 (SCOI.10276.00089).

[4354] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [70] (SCOI.00009.00008).

[4355] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [17] (SCOI.83469).

[4356] Exhibit 37, Tab 93, Running Sheet - St Vincent's Hospital, Check for Injury, 15 June 1995 (SCOI.10276.00088).

[4357] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [70] (SCOI.00009.00008).

[4358] Exhibit 37, Tab 93, Running Sheet – St Vincent's Hospital, Check for Injury, 15 June 1995 (SCOI.10276.00088).

[4359] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [70] (SCOI.00009.00008).

[4360] Exhibit 37, Tab 94, Running Sheet – Sydney Hospital Records Checked, 15 June 1995 (SCOI.10276.00089).

[4361] Exhibit 37, Tab 160, Transcript of Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 8 (SCOI.00009.00059).

a. NP183 reported that on 11 June 1995, he was at home with two friends watching a video hired from Video Ezy, Ingleburn. Investigating police excluded NP183 from the investigation after confirming with Video Ezy, Ingleburn that NP183 had hired two videos and returned one of them at midday on 12 June 1995;[4362]

b. NP184 was excluded from the investigation after stating that he was visiting a friend on 11 June 1995.[4363] BDM was unable to locate a registration of death for NP184 and the Inquiry was unable to locate him;[4364]

c. NP185 appears to have been excluded from the investigation on the basis that his mobile phone records confirmed he had not contacted Mr Brennan since 2 June 1995.[4365] Police records do not, however, indicate whether NP185 communicated with Mr Brennan closer to 11 June 1995 by some method other than his mobile phone;

d. NP186 reported that on Sunday, 12 June 1995, he attended the Clock Hotel in Newtown with Peter Tominson between 8:30pm and about 11:00pm,[4366] and then the Newtown Hotel from about 11:00pm to midnight.[4367] The reference to Sunday, 12 June 1995 appears to be an error because in 1995, 12 June fell on a Monday. From the records, it is not clear whether this is a reference to Sunday, 11 June 1995 or Monday, 12 June 1995. Counsel Assisting submitted that Sunday, 12 June 1995 may have been a reference to Sunday, 11 June 1995 (noting that date was the date of Mr Brennan's death). According to police, NP186's evidence was corroborated by Mr Tominson, but the Inquiry did not see this evidence.[4368] Police appear to have excluded NP186 from the investigation on the basis of this corroborating evidence. However, NSWPF records include a report made by a barman at the Newtown Hotel, Mr Thomas, who stated that on 11 June 1995, NP186 was either in the company of or had spoken to a man named 'Ken' at the Newtown Hotel from 8:00pm to 11:00pm that evening.[4369] BDM was unable to locate a registration of death for NP186. As noted above, no statement was obtained from Mr Thomas. The Inquiry has been informed that Mr Thomas died on 29 May 2020;[4370]

e. NP187 reported that he was at home with his ex-partner, I303, on the evening of 11 June 1995.[4371] Investigating police spoke to I303, however, he was unable to corroborate NP187's alibi.[4372] It is noted that NP187 had made plans

[4362] Exhibit 37, Tab 100, Running Sheet – Corroboration for NP183, 17 August 1995 (SCOI.10307.00046); Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [55] (SCOI.00009.00008).

[4363] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [56] (SCOI.00009.00008); Exhibit 37, Tab 104, Running Sheet – Statement of NP184, 8 December 1995 (SCOI.10275.00103).

[4364] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [20] (SCOI.83469).

[4365] Exhibit 37, Tab 74, Statement of NP185, 5 July 1995, [12] (SCOI.10275.00083).

[4366] Exhibit 37, Tab 78, Statement of NP186, 5 July 1995, [11] (SCOI.00009.00037).

[4367] Exhibit 37, Tab 78, Statement of NP186, 5 July 1995, [10] (SCOI.00009.00037).

[4368] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [54] (SCOI.00009.00008).

[4369] Exhibit 37, Tab 98, Running Sheet – Corroboration for NP186, 12 July 1995 (SCOI.10275.00077).

[4370] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [25]–[26] (SCOI.83469).

[4371] Exhibit 37, Tab 76, Statement of NP187, 19 June 1995, [15] (SCOI.10278.00037).

[4372] Exhibit 37, Tab 107, Running Sheet – Conversation with I303, 9 January 1996 (SCOI.10307.00007).

to meet Mr Brennan on 12 June 1995.[4373] BDM confirmed that NP187 died on 23 February 2004;[4374]

f. NP192 was excluded from the investigation after police confirmed that he was having dinner with two friends on 11 June 1995 from 7:00pm to 11:00pm.[4375] BDM was unable to locate a registration of death for NP192 and the Inquiry has been able to locate current contact details for him;[4376]

g. NP193 was unable to confirm his whereabouts on 11 June 1995;[4377]

h. NP194 was excluded from the investigation after police confirmed that he was working as a flight attendant and was not in Sydney at the relevant time;[4378]

i. NP195 informed police that on 11 June 1995 he attended work at Mascot airport with a colleague from 9:00pm on 11 June 1995 to 4:00am on 12 June 1995, at which point he went home and slept until 9:00am.[4379] NP195 informed police that he did not receive a response from either Mr Brennan or NP215 in relation to the advertisement.[4380] From the evidence available, it does not appear police conducted checks of NP195's phone records to confirm this;

j. NP196 reported that he was clubbing at The Den on Oxford Street from 9:00pm on 10 June to about 5:00am on 11 June 1995, and then walked home.[4381] NP196 said that he woke up on 11 June 1995 at about 10:00am and then was visited by a friend.[4382] His whereabouts on the evening of 11 June 1995 are not accounted for;

k. NP197 responded to Mr Brennan's advertisement and his name and number were located on a piece of paper on the dining table at the Elizabeth Bay apartment.[4383] NP197 informed investigating police that Mr Brennan may have had his number because NP197 was a real estate agent and Mr Brennan may have been interested in an apartment in Kings Cross.[4384] The Inquiry does not have any evidence that suggests NP197 was questioned in relation to that explanation.[4385] NP197 was subsequently excluded from the investigation

[4373] Exhibit 37, Tab 76, Statement of NP187, 19 June 1995, [10] (SCOI.10278.00037).

[4374] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, [17] (SCOI.83469).

[4375] Exhibit 37, Tab 86, Statement of Detective Senior Constable Brad Tayler, 29 January 1996, [61] (SCOI.00009.00005); Exhibit 37, Tab 80, Statement of NP192, 24 June 1995, [7]–[9] (SCOI.00009.00034).

[4376] Exhibit 37, Tab 175, Statement of Hermione Nicholls, 21 June 2023, 3 (SCOI.83469).

[4377] Exhibit 37, Tab 81, Statement of NP193, 10 July 1995, [10] (SCOI.00009.00035); Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [52] (SCOI.00009.00008).

[4378] Exhibit 37, Tab 73, Statement of NP194, 26 June 1995, [6] (SCOI.00009.00036); Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [53] (SCOI.00009.00008).

[4379] Exhibit 37, Tab 79, Statement of NP195, 6 July 1995, [7] (SCOI.00009.00039).

[4380] Exhibit 37, Tab 79 Statement of NP195, 6 July 1995, [5] (SCOI.00009.00039).

[4381] Exhibit 37, Tab 77, Statement of NP196, 16 June 1995, [16] (SCOI.00009.00040).

[4382] Exhibit 37, Tab 77, Statement of NP196, 16 June 1995, [17] (SCOI.00009.00040).

[4383] Exhibit 37, Tab 82, Statement of NP197, 22 June 1995, [4] (SCOI.00009.00041); Exhibit 37, Tab 86, Statement of Detective Senior Constable Brad Tayler, 29 January 1996, [25] (SCOI.00009.00005).

[4384] Exhibit 37, Tab 86, Statement of Detective Senior Constable Brad Tayler, 29 January 1996, [25] (SCOI.00009.00005).

[4385] Exhibit 37, Tab 86, Statement of Detective Senior Constable Brad Tayler, 29 January 1996, [25] (SCOI.00009.00005).

because he was visiting family and friends in the Hunter Valley over 11 and 12 June 1995;[4386] and

l. NP211 was excluded from the investigation after the Australian Customs Department confirmed that he was not in Australia on 11 or 12 June 1995.[4387]

Police investigation

5.4714. Counsel Assisting and NSWPF made the following submissions in relation to the police investigations into the death of Mr Brennan.

Canvassing

5.4715. Counsel Assisting submitted that it may have been desirable for the NSWPF to complete more canvassing at the Elizabeth Bay apartment and the surrounding apartment blocks to obtain additional observations from neighbours and possible witnesses.[4388]

5.4716. The NSWPF submitted that it is not clear what additional canvassing Counsel Assisting suggests would have been desirable, especially in the absence of evidence from the investigating officers.

5.4717. I accept that it may have been desirable for the NSWPF to complete more canvassing of the relevant locations, including NP214's apartment block and the apartment building in which Mr Brennan and NP215 resided. The material available confirms that many of Mr Brennan's neighbours were not home when the police attended the Elizabeth Bay apartment block on 12 and 13 June 1995. In light of this, it may have desirable for police to attend on a later date and obtain observations from those neighbours where possible. I note, however, that it is not evident that additional canvassing would have necessarily procured more information related to Mr Brennan's death.

5.4718. Counsel Assisting further submitted that investigative steps ought to have been taken to confirm that NP215 would not have been able to leave and return to NP214's apartment (as opposed to accepting NP214's word) at some point during the relevant period without alerting NP214. The NSWPF did not make any submissions in relation to this point. I accept the submission of Counsel Assisting.

[4386] Exhibit 37, Tab 82, Statement of NP197, 22 June 1995, [7]–[8] (SCOI.00009.00041).

[4387] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [60] (SCOI.00009.00008).

[4388] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [45] (SCOI.00009.00008).

Persons of interest excluded prematurely/lines of inquiry not fully explored

5.4719. Counsel Assisting submitted that a significant number of persons of interest were identified by Strike Force Monardia who were not excluded as suspects or were excluded only on a slender basis. Additional steps ought to have been taken to exclude persons of interest including NP203, NP191, NP218, NP199, NP182, NP208, NP183, NP187, NP196, NP186, NP195, and NP193. Neither Strike Force Monardia nor Strike Force Skarratt obtained covert DNA samples, or pursued the alibi evidence, from NP199, NP186, NP191, NP203, NP202, NP218, NP185, NP187, NP196 or NP193. That said, and in fairness to the NSWPF, Counsel Assisting acknowledged that the wide-ranging nature of this investigation (and the weak connection between the deceased and several of the suspects) raised the question of what steps ought to have been taken by police in circumstances where there are a great many possible leads and legitimate resourcing constraints which may prevent police from pursuing every lead.

5.4720. The NSWPF made the following submissions in relation to these persons of interest:

a. NP191: the NSWPF submitted that there is no evidence to suggest NP191 and Mr Brennan were known to each other and, regardless, Mr Brennan was seen alive after NP191 reportedly observed him at Kingsteam Sauna on 11 June 1995;

b. NP218: the NSWPF submitted that the Inquiry has not explored with investigating police as to why NP218 was questioned about his whereabouts on the evening of 10 June 1995 instead of 11 June 1995;

c. NP199: the NSWPF agreed with Counsel Assisting's submission that there did not appear to be a proper basis for investigating police to exclude NP199 from the investigation. The NSWPF agreed that from the evidence available it is not clear what precise basis was relied upon to rule NP199 out as a person of interest;

d. NP187: the NSWPF agreed, based on the evidence, that the precise basis as to why investigating police ruled NP187 out as a person of interest was unclear. The NSWPF submitted that NP187's relationship to Mr Brennan was limited. Further, the NSWPF submitted that the Inquiry did not explore this decision with the investigating police;

e. NP186: the NSWPF's submissions and my findings are detailed below; and

f. NP195: the NSWPF submitted that the fact investigating police did not conduct checks on the phone records of NP195 to confirm that he was not in contact with Mr Brennan prior to his death is of little importance in circumstances where NP195 had a valid alibi.

5.4721. I accept Counsel Assisting's submissions in relation to NP191. Without further evidence, I consider that it would have been preferable for investigating police to make further attempts to exclude NP191 from the investigation in light of the fact he was one of the last people to see Mr Brennan alive.

5.4722. I accept Counsel Assisting's submissions in relation to NP218, NP199 and NP187. As noted above, the NSWPF accepts the submissions of Counsel Assisting in relation to NP199 and NP187.

5.4723. I accept Counsel Assisting's submissions in relation to NP195. It cannot be said NP195 had a valid alibi on the basis of his own report to investigating police. In the circumstances, the NSWPF ought to have conducted further enquiries, including conducting a check of NP195's phone records.

5.4724. I note that the NSWPF did not make submissions in relation to NP203, NP182, NP208, NP183, NP196, NP193, NP202 or NP185. I accept the submissions of Counsel Assisting in relation to those persons of interest.

Failure to obtain statement from or call Natalie Leonoff

5.4725. Counsel Assisting submitted that police failed to obtain a statement from a potentially important witness, Mrs Leonoff, who reported to police on 26 June 1995 that she saw NP215 outside of NP214's apartment building in the early hours of 11 June 1995, contrary to NP215's alibi evidence. As explained above, the significance of this evidence is that, if reliable, it contradicted the evidence of NP215 and NP214 that NP215 did not leave NP214's apartment during the relevant period.

5.4726. In fairness, attempts were made by Probationary Constable Ross to speak with Mrs Leonoff between 20 and 26 June 1995,[4389] which were unsuccessful. The last record in the Running Sheet indicates that police were to call later in the afternoon of 26 June 1995. However, the Inquiry found no record of police attempting to contact Mrs Leonoff again. In the unsigned Recommendation for Further Investigation (**unsigned recommendation report**), the UHT recommended that police locate Mrs Leonoff and invite her to an interview.[4390] Strike Force Skarratt ought to have pursued this recommendation when it was established in 2016, and the reason for not doing so is unclear.

5.4727. The NSWPF submitted that by her conduct, Mrs Leonoff indicated to police in June 1995 that she refused to assist further. The NSWPF further submitted that the evidence does not allow a positive conclusion to be reached that Mrs Leonoff was, in or around 2007, willing to assist police. The NSWPF argued that it is not clear whether the reference to Mrs Leonoff being "available for further questions" in the unsigned recommendation report was a reference to her willingness to provide further information or an indication that further information from her may have assisted in the investigation of Mr Brennan's death.

[4389] Exhibit 37, Tab 123, Review of an Unsolved Homicide Case Screening Form, 6 August 2004, 12 (SCOI.44995); Exhibit 37, Tab 97, Running Sheet – Information from Natalie Leonoff, 26 June 1995, 1 (SCOI.10276.00118).

[4390] Exhibit 37, Tab 124, Recommendation for Further Investigation Report, 20 June 2007, 2 (SCOI.44995.00001).

5.4728. In my view, Mrs Leonoff's report to NSWPF on 19 June 1995 is evidence of an initial willingness to assist police, at least at the time she made that report. When police first attempted to follow up Mrs Leonoff on 20 June 1995, Mrs Leonoff said that she was busy on 20 June and 21 June 1995. Police contacted Mrs Leonoff on 21 June 1995 and made an appointment to meet at 11:00am on 22 June 1995. Shortly before that meeting, Mrs Leonoff communicated to police that she could not meet as her child was unwell.

5.4729. On 26 June 1995, the relevant officer made "at least 15" attempts to telephone Mrs Leonoff but found the phone to be engaged. Two officers attended her apartment on the same day. Mrs Leonoff's son spoke with police and said that Mrs Leonoff was in bed, but the officers should call later in the afternoon that day to arrange a time to speak with her. There is no evidence to suggest that police did contact Mrs Leonoff in the afternoon.

5.4730. Had further inquiries been made, police may have been able to ascertain whether Mrs Leonoff was still cooperative. The failure to make further inquiries in June 1995 (and later in 2016, especially in light of the 2007 recommendation to do so) cannot be said to be indicative of Mrs Leonoff's lack of cooperation. I do not accept the NSWPF's submission that Mrs Leonoff's conduct, on the evidence, indicated that she refused to assist further.

5.4731. Counsel Assisting also submitted that regardless of Mrs Leonoff's level of co-operation in relation to the initial investigation, it may have been appropriate for Senior Deputy State Coroner Abernethy to have summoned Mrs Leonoff to appear as a witness at the inquest to ensure all relevant information was considered.

5.4732. The NSWPF submitted that it is unlikely that summoning Mrs Leonoff to appear as a witness at the inquest would have made a real difference.

5.4733. I accept that Mrs Leonoff's evidence may have assisted Senior Deputy State Coroner Abernethy in his Honour's consideration of the matter at inquest. If Mrs Leonoff's evidence had been tested at the inquest, further conclusions may have been available about its reliability and value.

Failure to obtain statement from Joan Henderson and Christopher Crook

5.4734. Counsel Assisting submitted that statements ought to have been obtained from Ms Henderson and Mr Crook, who were neighbours of Mr Brennan and were documented in police notes as having heard screaming on 11 and 12 June 1995 respectively.

5.4735. The NSWPF submitted that it is not clear what benefit statements from these persons would have in circumstances where their observations appear to be of a low value and are documented in the police records, for example, running sheet notes.[4391]

[4391] Exhibit 37, Tab 109, Witness Canvassing Form of occupants at Onslow Avenue, Elizabeth Bay (undated), 4 (SCOI.10316.00009).

5.4736. I consider that investigating police ought to have obtained statements from Ms Henderson and Mr Crook. It is difficult to determine the value of such evidence today, after considerable delay. However, the fact that Ms Henderson, who resided in a nearby apartment block, heard screaming between 1:00am and 2:00am on 11 June 1995 is a relevant fact that ought to have been properly documented, particularly if it later became apparent that Ms Henderson had in fact heard screaming between 1:00am and 2:00am on 12 June 1995 rather than 11 June 1995.

Failure to obtain statement from Christopher Thomas

5.4737. Counsel Assisting also submitted that a statement ought to have been obtained from Mr Thomas, who was a barman present at the Newtown Hotel on 11 June 1995.

5.4738. The NSWPF submits that the reference to "Ken" in Running Sheet – Corroboration for NP186, 12 July 1995 is a typographical error, and that entry was intended to state NP186.[4392]

5.4739. I accept the submission of the NSWPF that the reference to "Ken" is likely a typographical error and that the writer in fact intended to refer to the name of NP186. Mr Thomas appears to have contacted police for the purpose of stating that he observed NP186 at the Newtown Hotel between 8:00pm and 11:00pm on the night of Sunday, 11 June 1995. That said, it would have been preferable for NSWPF to have obtained a statement from Mr Thomas to ensure all the details (including the name of the person referred to as "Ken") were recorded accurately and formally.

Failure to reinterview relevant persons of interest

5.4740. Counsel Assisting submitted, in relation to two persons of interest, that there may have been confusion regarding the specific time of Mr Brennan's death and the time in respect of which an alibi was relevant, particularly because it was a long weekend: see NP218 and NP186. In these circumstances, police ought to have reinterviewed witnesses to ensure that their evidence was clear and relevant to the accurate time and date of Mr Brennan's death.

5.4741. The NSWPF submitted that the Inquiry did not explore the discrepancies relating to NP218 with the investigating officers.

5.4742. However, I accept Counsel Assisting's submission that police ought to have re-interviewed these witnesses to ensure the evidence was accurate.

5.4743. The NSWPF acknowledged that it would have been preferrable for police to obtain separate evidence from Mr Tominson corroborating the evidence of NP186.

[4392] Exhibit 37, Tab 98, Running Sheet – Corroboration for NP186, 12 July 1995 (SCOI.10275.00077); Submissions of NSWPF, 7 July 2023, [37] (SCOI.84812).

Inconsistent reporting of fingerprint results

5.4744. Counsel Assisting submitted that police involved in the initial investigation ought to have ensured that the results obtained from analysis of the fingerprints located at the crime scene were reported consistently. The results of the fingerprints were reported differently on the following occasions:

a. During the inquest, Constable Thurtell gave evidence that only two fingerprints were taken from the Elizabeth Bay apartment, and that both were identified as belonging to NP215;[4393] and

b. Detective Senior Constable Tayler and the UHT Case Screening Form from 2004 state that all fingerprints (being those located on the mirror, glass, front door, wardrobe, entrance, two condoms, the packet of Strepsils and the knife packaging) matched Mr Brennan.[4394]

5.4745. The NSWPF did not make any submission in relation to this point.

5.4746. I accept the submissions of Counsel Assisting.

Failure to locate or investigate phone numbers on paper

5.4747. Counsel Assisting submitted that it appears in 1995, police did not locate, or did not pursue inquiries in relation to, a piece of paper in Mr Brennan's wallet that was later found by Strike Force Skarratt in 2016 to2019. That piece of paper had three phone numbers written down on it, which were subsequently traced to NP210 and NP209.[4395] Police in 1995 should have searched Mr Brennan's wallet and traced the three phone numbers before the reinvestigation from 2016 to 2019.

5.4748. The NSWPF submitted that it is not clear on the material available whether a thorough search of Mr Brennan's wallet was conducted during the initial investigation, and whether the piece of paper with the three phone numbers was located or investigated at the time. Additionally, the NSWPF submitted that the apparent failure of the initial investigation to take this step appears to have had no substantive impact on the investigation. The NSWPF further submitted that investigating police have not been approached by the Inquiry regarding this potential oversight in the initial investigation.

5.4749. On the basis of the material before the Inquiry, there does not appear to be any evidence to confirm whether investigating police located the piece of paper in Mr Brennan's wallet in 1995. There is also no evidence that suggests NSWPF made any enquiries in relation to the telephone numbers written on the piece of paper. The submission by the NSWPF that this may nevertheless have occurred is entirely speculative and I do not accept it.

[4393] Exhibit 37, Tab 83, Statement of Constable Laura Thurtell, 18 January 1996, [48] (SCOI.00009.00008).

[4394] Exhibit 37, Tab 123, Review of an Unsolved Homicide Case Screening Form, 6 August 2004, 4-5 (SCOI.44995).

[4395] Exhibit 37, Tab 136, NSWPF Investigator's Note, 'Phone number enquiries re: NP209 and NP210', 12 August 2016, 1 (SCOI.45046).

5.4750. I also do not accept the submission from the NSWPF that this apparent failure appears to have had no substantive impact on the investigation. The value of this evidence remains unknown. This is because police were not able to obtain DNA from NP210 (who died in June 2011) and his surviving family refused to provide a DNA sample for the purposes of familial testing.

Care, retention and testing of exhibits

5.4751. Counsel Assisting submitted that greater care ought to have been taken in relation to fingerprint evidence located on the frypan. It is reported that biologists who initially examined the frypan in 1995 *may* have inadvertently swabbed away part of the fingerprint on this exhibit, leaving the remainder heavily degraded.[4396] This is concerning because there is evidence to suggest that the frypan could have been used by the offender or offenders to hit Mr Brennan.[4397] The removal of evidence on a critical exhibit, such as this frypan, may have limited the quality of the investigation.

5.4752. The NSWPF submitted that the degradation of the fingerprint is regrettable. However, it is not clear whether the relevant "biologist" was an employee of the NSWPF or DAL.

5.4753. Counsel Assisting further submitted that police from the initial investigation did not retain, but ought to have retained, the following exhibits:[4398]

a. The champagne flute and/or a tapelift of the fingerprint located on it;[4399]

b. The condom wrapper (located on the bedside table);[4400]

c. The vial of amyl nitrate;[4401]

d. The tube of lubricant (located on the bed);[4402]

e. Two "Mates" condom wrappers;[4403]

f. The packet of Strepsils (located by NP215);[4404]

g. The knife packaging (located by NP215);[4405]

[4396] Exhibit 37, Tab 126, Email from Crime Scene Officer Michael Whyte to I446, 29 March 2016, 1-2 (SCOI.45006).

[4397] Exhibit 37, Tab 171, Expert report of Dr Linda Iles, 6 April 2023, 5 (SCOI.83005); Exhibit 37, Tab 160, Transcript of Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 7 (SCOI.00009.00059).

[4398] Exhibit 37, Tab 178C, List of exhibits and location (undated) (NPL.0176.0001.0026); Exhibit 37, Tab 178B, EFIMS – Exhibit Summary, 1 June 2023 (NPL.0176.0001.0018).

[4399] Exhibit 37, Tab 153, NSWPF Memorandum, 'Post Operational Assessment for Strike Force Skarratt', 1 August 2019, 12 (SCOI.82997). I note, however, that Detective Senior Constable Van Leeuwen stated during the inquest that this fingerprint is located on "the fingerprint computer should anyone come along at some stage": Exhibit 37, Tab 160, Transcript of Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 17 (SCOI.00009.00059); Exhibit 37, Tab 178C, List of exhibits and location (undated), 2 (NPL.0176.0001.0026); Exhibit 37, Tab 180A Expert certificate of Kate Reid, 9 June 2023 (NPL.0100.0017.0001).

[4400] I note, Detective Senior Constable Lyle Van Leeuwen stated there were two condom wrappers located at the crime scene: Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [18] (SCOI.45105); Exhibit 37, Tab 178C, List of exhibits and location (undated), 2 (NPL.0176.0001.0026).

[4401] Exhibit 37, Tab 178C, List of exhibits and location (undated), 3 (NPL.0176.0001.0026).

[4402] Exhibit 37, Tab 178C, List of exhibits and location (undated), 2 (NPL.0176.0001.0026).

[4403] Exhibit 37, Tab 178C, List of exhibits and location (undated), 3 (NPL.0176.0001.0026).

[4404] Exhibit 37, Tab 178C, List of exhibits and location (undated), 3 (NPL.0176.0001.0026).

[4405] Exhibit 37, Tab 178C, List of exhibits and location (undated), 4 (NPL.0176.0001.0026).

h. The sample of drain water from the kitchen sink 'S' bend;[4406] and

i. The sample of drain water from the bathroom sink 'S' bend.[4407]

5.4754. Additionally, Counsel Assisting submitted that police ought to have ensured that the exhibits referred above were forensically tested or fingerprinted as appropriate. Some of these exhibits, including the vial of amyl nitrate and the two "Mates" condom wrappers, appear to have been relevant to Mr Brennan's sexual activity before his death, and would, therefore, be considered important exhibits to have forensically tested.[4408]

5.4755. The NSWPF submitted that it is not clear whether the items above were initially seized and that this must be considered in context, noting that the *CFP Act* only introduced a regime for conducting forensic procedures on suspects for the purposes of DNA for testing on 1 January 2001.

5.4756. I accept Counsel Assisting's submissions on this point. From the Exhibit Management Spreadsheet and the Third Statement of NP214 it is clear that at least the two "Mates" condom wrappers, the packet of Strepsils, the knife packaging and the samples of drain water from the kitchen and bathroom sink 'S' bends were seized.[4409] This, in combination with a common-sense approach, would suggest that police would have been alive to the forensic value of retaining the exhibits referred to above, even if a regime for conducting forensic procedures had not yet been introduced. If these exhibits had been retained, they could have been the subject of future forensic examination in accordance with technological advances.

[4406] Exhibit 37, Tab 178C, List of exhibits and location (undated), 4 (NPL.0176.0001.0026).

[4407] Exhibit 37, Tab 178C, List of exhibits and location (undated), 5 (NPL.0176.0001.0026).

[4408] Exhibit 37, Tab 90, Statement of Detective Senior Constable Lyle Van Leeuwen, 13 August 1996, [18], [22] (SCOI.45105); Exhibit 37, Tab 162, First report of Michele Franco, 24 January 1996, 4 (SCOI.10181.00003).

[4409] Exhibit 37, Tab 122, Exhibit Management Spreadsheet, 5 November 2012 (SCOI.10182.00001); Exhibit 37, Tab 43, Third Statement of NP214, 29 June 1995 (SCOI.10261.00079); Exhibit 37, Tab 178C, List of exhibits and locations, undated (NPL.0176.0001.0026).

Inappropriate questioning of NP215

5.4757. Counsel Assisting submitted that the questioning of NP215 by police on 12 June 1995 was conducted in a manner that was insensitive.[4410] At the time, police were aware that NP215 had just lost his partner in a violent homicide and had also discovered Mr Brennan deceased in the apartment. Counsel Assisting submitted that police ought to have conducted their questioning of NP215 in a manner that was more respectful and sensitive, particularly when issues related to sex and sexuality were discussed.[4411] Related to this concern, NP215's statement dated 15 June 1995 contained significant detail about the sex lives and particular sexual activities engaged in between NP215 and Mr Brennan, or NP215, Mr Brennan and others (such as NP214).[4412] Even accepting that potential sexual partners were likely to be persons of interest in the investigation and it was appropriate to inquire into and record some aspects of their sexual activities, the questioning might reasonably be regarded as prurient or intrusive, and many of the details appear to have little or no potential relevance to the investigation.[4413]

5.4758. The NSWPF did not make submissions in relation to this point.

5.4759. I accept the submissions of Counsel Assisting on this point. In my view, the questioning in relation to NP215 and Mr Brennan's sex life was prurient and inappropriate. The statement of NP215 dated 15 June 1995 contained significant detail about the sexual activities engaged in by Mr Brennan and NP215 that was unnecessary and took the investigation into Mr Brennan's death no further.

Manner and cause of death

5.4760. In relation to manner and cause of death, Counsel Assisting submitted that the Inquiry should find that Mr Brennan died on 11 June 1995 between approximately 9:00pm and midnight (possibly a little earlier or later) as a result of around 13 stab wounds to his chest inflicted by a person or persons unknown.[4414] These findings are consistent with the original finding at the coronial inquest.

5.4761. The NSWPF supported the findings proposed by Counsel Assisting as to the manner and cause of Mr Brennan's death.

5.4762. While the possibility of NP215 being involved in Mr Brennan's death cannot be excluded, I do not think the evidence supports any conclusion being drawn, either to the civil or criminal standard or on any other basis, adverse to NP215.

[4410] Exhibit 37, Tab 38, NSWPF Record of Interview, 'Interview with NP215', 12 June 1995 (SCOI.00009.00015).

[4411] Exhibit 37, Tab 38, NSWPF Record of Interview, 'Interview with NP215', 12 June 1995, 14-15, 53-54 (SCOI.00009.00015).

[4412] Exhibit 37, Tab 40, Statement of NP215, 15 June 1995, [5]–[13] (SCOI.00009.00019).

[4413] Exhibit 37, Tab 40, Statement of NP215, 15 June 1995, [3]–[4] (SCOI.00009.00019).

[4414] Submissions of Counsel Assisting, 23 June 2023 (SCOI.84129); See also Supplementary Submissions of Counsel Assisting, 28 July 2023 (SCOI.84909) and Further Supplementary Submissions of Counsel Assisting, 20 October 2023 (SCOI.86358).

Bias

5.4763. Counsel Assisting submitted that there are difficulties in assessing the possible motives or biases of Mr Brennan's killer in the absence of knowing the person's identity.

5.4764. According to Counsel Assisting, the following factors may indicate that Mr Brennan was killed in the context of LGBTIQ bias:

a. The nature and extent of Mr Brennan's injuries, which exceeded what is necessary to kill a person and were arguably consistent with a frenzied attack (which included a possible stomping on the face/head);

b. The circumstances in which Mr Brennan's body was discovered, including the fact that a pillow had been positioned underneath his torso, and his body partially sponged down;[4415]

c. The presence of evidence indicating Mr Brennan had engaged in receptive anal sexual intercourse with a male partner shortly before his death, suggesting that Mr Brennan may have been killed by a person he took to the apartment for sex;

d. The lack of evidence indicating that any obvious items of value, such as Mr Brennan's wallet (containing credit cards), had been taken from the apartment;[4416] and

e. In the years preceding and following Mr Brennan's death, there were other attacks on gay men in the general vicinity of Elizabeth Bay. Some of these attacks involved a similar *modus operandi*, namely a victim would be assaulted (or threatened with assault), prior to and/or after sexual intercourse or being sexually assaulted.[4417]

5.4765. Counsel Assisting submitted that if Mr Brennan were killed by an unknown male whom he brought into his apartment for sex, there is a distinct possibility (arguably rising to the level of probability) that the crime was a hate crime. Obviously, it is not known whether Mr Brennan was in fact killed by such a person.

5.4766. Counsel Assisting further submitted that if NP215 was the perpetrator (and, on the evidence before the Inquiry, this possibility cannot be excluded), the motive was likely jealousy. The NSWPF agreed with this submission.

5.4767. The NSWPF submitted that the evidence that would support a conclusion that Mr Brennan's death was motivated by LGBTIQ bias is inconclusive. Accordingly, the NSWPF submitted that there was insufficient information to determine whether Mr Brennan's death was motivated by LGBTIQ bias.[4418]

[4415] Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 7 (SCOI.00009.00059).

[4416] It is possible some cash was taken from Mr Brennan's wallet. Mr Brennan made two withdrawals on 11 June 1995, including one at 9:46am ($50) and one at 2:41pm ($150). Mr Brennan's wallet was located in the Elizabeth Bay apartment but there was no cash in it: Exhibit 37, Tab 160, Transcript of Coronial Inquest into the death of Kenneth Richard Brennan, 17 September 1996, 22, 25 (SCOI.00009.00059).

[4417] See, for example, Exhibit 37, Tab 35, Statement of I280, 26 October 1995, [11]–[20] (SCOI.10323.00043).

[4418] Submissions of NSWPF, 7 July 2023, [82]-[85] (SCOI.84812).

5.4768. I have considered the submissions and proposed findings of Counsel Assisting and the NSWPF. Because the person or persons who killed Mr Brennan is/are unknown, evidence concerning the nature of any LGBTIQ bias is necessarily limited. I agree with the parties that there is insufficient evidence to draw conclusions about whether Mr Brennan's death was the consequence of a bias crime, save to observe that if Mr Brennan was killed by someone other than NP215, there are some grounds to suspect that LGBTIQ bias was present.

Conclusions and recommendations

5.4769. I find that Kenneth Brennan died on 11 June 1995 in an apartment in Elizabeth Bay, Sydney, as a result of a stab wounds to his chest inflicted by a person or persons unknown.

5.4770. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in Mr Brennan's death.

5.4771. I make the following recommendations for future investigations:

Recommendation 5

I recommend that FASS takes steps to:

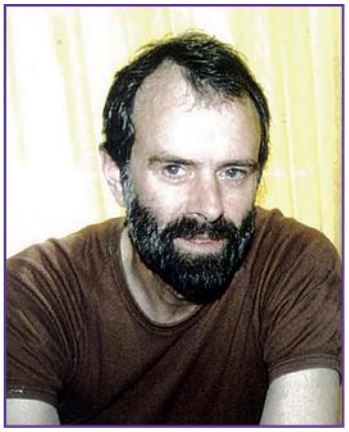
a. Enhance the "Unknown Male B", "Unknown Male C" and "Unknown Male D" profiles, should technological developments occur in the future that indicate a prospect of such enhancement; and

b. Run the "Unknown Male B", "Unknown Male C" and "Unknown Male D" profiles against state and national DNA databases on a regular basis, so that the NSWPF will be notified in the event that there is an individual or familial match with the profiles.

Recommendation 6

I recommend that the NSWPF take steps, including by DNA analysis, to eliminate suspects who may have been prematurely excluded from the investigation.

IN THE MATTER OF CARL GREGORY STOCKTON



Factual background

Date and location of death

5.4772. Carl Gregory Stockton died at St Vincent's Hospital, Sydney, on 11 November 1996, as a result of craniocerebral injuries sustained on 5 or 6 November 1996 in the vicinity of Bar Cleveland, Redfern.

Circumstances of death

5.4773. Mr Stockton was 52 years old at the time of his death, and lived alone in Surry Hills. He worked as a train driver, and had a particular interest in trains and motor vehicles. He owned several cars and was a member of the Rolls Royce Owners' Club of Australia.

5.4774. On the afternoon and evening of 5 November 1996, Mr Stockton was drinking at Bar Cleveland. He left the hotel at about 11:30pm, in a state of intoxication.

5.4775. At about 1:00am on 6 November 1996, Mr Stockton was found lying on the roadway in Cleveland Street near the intersection with Bourke Street. He had suffered severe head injuries, which on the evidence were likely to have been the result either of a fall, or of being struck by a car, or of an assault.

5.4776. Five days later, on 11 November 1996, Mr Stockton died from his injuries.

Previous investigations

Original police investigation

Investigative steps taken by police prior to Mr Stockton's death

5.4777. On 6 November 1996, following Mr Stockton's hospitalisation, Constable Anthony Moss and Constable Michael Sparkes attended Mr Stockton's home, which they found to be secure and with no persons present. They spoke with Mr Stockton's neighbour, who confirmed Mr Stockton lived alone at the premises, and stated he had no knowledge of Mr Stockton's injuries or condition.[4419]

5.4778. Robbery was ruled out as a motive in the assault on Mr Stockton due to his retention of valuable items on his person, specifically his mobile phone and wallet. Although his keys were missing, there was no evidence of intrusion at his home address or theft of his motor vehicle, which was a Rolls Royce.[4420]

5.4779. Constable Moss and Constable Sparkes then attended Campbell House (a Proclaimed Place where intoxicated persons were provided with beds and care), where they spoke with a Welfare Officer named "Manny", who provided information regarding Mr Stockton's movements from outside Bar Cleveland to Campbell House and subsequently to Sydney Hospital.[4421] The officers also accessed the records at Campbell House and noted that Mr Stockton had stayed there once before, on 5 October 1996.[4422]

5.4780. Constable Moss and Constable Sparkes attended Mr Stockton at St Vincent's Hospital (where Mr Stockton had been transferred from Sydney Hospital) on 6 November 1996. He was asked how he suffered his injuries; how he obtained his black eye; and whether he was assaulted. Mr Stockton replied "no" to all three questions. Constable Moss noted that Mr Stockton was vague when spoken to and did not appear fully to understand the questions asked of him at that time.[4423]

5.4781. Constable Moss and Constable Sparkes next spoke with staff at Bar Cleveland, and made a search of the area, but were unable to locate any physical evidence to explain Mr Stockton's injuries.[4424]

5.4782. On 8 November 1996, Constable Moss and Constable Sparkes attended the Neurological Ward at St Vincent's Hospital, where they took possession of Mr Stockton's personal property held by the hospital and secured it at Surry Hills Police Station.[4425]

[4419] Exhibit 18, Tab 18, Statement of Plain Clothes Senior Constable Anthony Moss, 26 March 1997, [4] (SCOI.00045.00084).

[4420] Exhibit 18, Tab 52, Strike Force Parrabell, Bias Crimes Indicators Review Form – Carl Stockton, Undated 14–15 (SCOI.32071).

[4421] Exhibit 18, Tab 18, Statement of Plain Clothes Senior Constable Anthony Moss, 26 March 1997, [5]—[6] (SCOI.00045.00084).

[4422] Exhibit 18, Tab 18, Statement of Plain Clothes Senior Constable Anthony Moss, 26 March 1997, [7] (SCOI.00045.00084).

[4423] Exhibit 18, Tab 18, Statement of Plain Clothes Senior Constable Anthony Moss, 26 March 1997, [8]—[9] (SCOI.00045.00084); Exhibit 18, Tab 15, First Statement of Plain Clothes Senior Constable Michael James Sparkes, 20 March 1997, [8]–[9] (SCOI.00045.00085).

[4424] Exhibit 18, Tab 18, Statement of Plain Clothes Senior Constable Anthony Moss, 26 March 1997, [10]–[11] (SCOI.00045.00084).

[4425] Exhibit 18, Tab 18, Statement of Plain Clothes Senior Constable Anthony Moss, 26 March 1997, [12] (SCOI.00045.00084).

5.4783. From 8 November 1996 to 12 November 1996, Constable Moss and Constable Sparkes proceeded to obtain statements from the bar manager of Bar Cleveland (Brent Tozer), and the Welfare Officers who had transported Mr Stockton between the Bar Cleveland, Campbell House and Sydney Hospital and provided care at Campbell House.[4426]

5.4784. On 9 November 1996, police conducted a search of the parkland in Moore Park, a known beat. No signs of an assault or a struggle were observed.[4427]

5.4785. On 11 November 1996, Constable Sparkes, together with Senior Constable Warren Stocks of the East Sydney Crime Scene Unit, attended Bar Cleveland and took photographs of the surrounding area, including Matterson Lane, which was behind the pub.[4428] Constable Sparkes then provided Mr Stockton's property (including clothing, a sling, coins and a wallet, as taken from St Vincent's Hospital) to the East Sydney Crime Scene Unit for examination.[4429]

5.4786. The standard canvass form for Bar Cleveland of this date recorded Mr Tozer, Magda Kos, a bar attendant, and Donna Strachan, another bar employee, as being present, and noted "occupants' attitude worthy of follow up".[4430] It is not clear from the evidence to whom specifically this comment referred, nor what was meant by "attitude". The evidence available to the Inquiry does not indicate what "follow up", if any, occurred as a consequence of this comment.

Investigative steps taken by police after Mr Stockton's death

5.4787. The original police homicide investigation, known as Strike Force Altea, commenced on 12 November 1996 following Mr Stockton's death, and proceeded until the coronial findings were made on 1 December 1998. The investigation was led by Detective Senior Constable Neil Walker.[4431]

5.4788. In the course of Strike Force Altea, police actioned a number of investigative steps, including the following:

a. Police examined the crime scene for evidence of an assault, struggle or motor vehicle accident, including testing timber found at the crime scene as to whether it was used in an assault;[4432]

b. Police canvassed Bar Cleveland and surrounding businesses and residences;[4433]

[4426] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [51], [54]–[55], [57] (SCOI.00045.00064); Exhibit 18, Tab 18, Statement of Plain Clothes Senior Constable Anthony Moss, 26 March 1997, [10]–[16] (SCOI.00045.00084).

[4427] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [56] (SCOI.00045.00064).

[4428] Exhibit 18, Tab 12, Statement of Senior Constable Warren Anthony Stocks, 4 March 1997, [5] (SCOI.00045.00087); Exhibit 18, Tab 15, First Statement of Plain Clothes Senior Constable Michael James Sparkes, 20 March 199, [21] (SCOI.00045.00085).

[4429] Exhibit 18, Tab 15, First Statement of Plain Clothes Senior Constable Michael James Sparkes, 20 March 1997, [22] (SCOI.00045.00085).

[4430] Exhibit 18, Tab 20A, Standard Canvass Form re Brent Tozer, Magda Kos and Donna Strachan, 11 November 1996 (SCOI.10265.00107).

[4431] Exhibit 18, Tab 49, Transcript of Coronial Inquest into the death of Carl Stockton, 1 December 1998 (SCOI.00045.00001).

[4432] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [72], [141] (SCOI.00045.00064).

[4433] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [73], [111], [115] (SCOI.00045.00064).

c. On 13 November 1996, police issued a media release requesting that any witnesses come forward;[4434]

d. On 13 and 19 November 1996, police searched Mr Stockton's home address to confirm whether any items had been stolen and to obtain personal documents for examination;[4435]

e. Police spoke with various friends and associates of Mr Stockton as to his background, personality and lifestyle, including prior assaults;[4436]

f. On 19 November 1996, police obtained a pre-operative blood sample of Mr Stockton for testing his pre-mortem blood alcohol level;[4437]

g. Police obtained records from Mr Stockton's treating practitioners, including his GP, Dr Heather McIntyre, and a neurologist to whom he had been referred following a recent injury in early October 1996, Dr Raymond Garrick;[4438]

h. Police arranged for fingerprint testing of Mr Stockton's wallet and its contents, as well as wine and beer bottles from his premises, without relevant result;[4439]

i. Police obtained information from relevant police officers as to locating Mr Stockton after the previous injury in early October 1996;[4440]

j. Police investigated a motor accident in which Mr Stockton and his godson, I197, had been involved in late October 1996, which apparently caused Mr Stockton to become agitated and to ask a friend, who was a "volunteer in policing",[4441] to look up the registration details of the offending vehicle;[4442]

k. Police engaged a consultant neurosurgeon, John Matheson, to comment on Mr Stockton's injuries and treatment, as well as obtaining the opinion of Dr Anthony Moynham of the Clinical Forensic Medical Unit;[4443]

l. Police made enquiries as to whether Mr Stockton had completed a will, as he had recently foreshadowed to friends and family. It was found that he had not;[4444] and

m. Police arranged for details of Mr Stockton's death to be published online on 20 May 1997, and on television on "Australia's Most Wanted" on 30 June

[4434] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [75] (SCOI.00045.00064).

[4435] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [76], [100] (SCOI.00045.00064).

[4436] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [82], [84], [107], [109], [123] (SCOI.00045.00064).

[4437] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [101] (SCOI.00045.00064).

[4438] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [83], [102] (SCOI.00045.00064).

[4439] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [104]–[106], [114] (SCOI.00045.00064).

[4440] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [110] (SCOI.00045.00064).

[4441] According to the NSWPF website accessed by those assisting me, the Volunteers in Policing program was introduced in 1995 to allow community members to assist police by performing functions that are not core police duties: https://www.police.nsw.gov.au/recruitment_links/volunteer_in_policing.

[4442] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [109], [112] (SCOI.00045.00064); Exhibit 18, Tab 24, Statement of I197, 12 March 1997, [5] (SCOI.00045.00105).

[4443] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [117]–[120] (SCOI.00045.00064).

[4444] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [124] (SCOI.00045.00064).

1997. They followed up a resulting line of inquiry that suggested Mr Stockton had once intervened in an assault by the previous licensee of Bar Cleveland on an acquaintance. That enquiry did not produce any result of significance.[4445]

Post-mortem investigation

5.4789. On the morning of 12 November 1996, a post-mortem examination was performed at Glebe Morgue by Dr Christopher Lawrence.[4446]

5.4790. The post-mortem examination revealed massive head injuries with three apparent areas of impact on the right temporal posterior parietal and left temporal regions. The main injury was to the rear of the head.[4447]

5.4791. Bruising to the legs, chest and arms was also observed. It was noted that some of Mr Stockton's injuries appeared older, including historic rib fractures and a fractured right clavicle.[4448]

5.4792. The ante-mortem blood sampling, taken at around 12:00pm on 6 November 1996 upon admission to Sydney Hospital, revealed a blood alcohol level of 0.014g/100ml, and diazepam was also present. Mr Stockton's blood alcohol level at 12:00pm on 6 November 1996 indicated that his blood alcohol level when he was admitted to Campbell House at 1:00am was within a range of 0.157g/100ml to 0.290g/100ml, most likely close to 0.234g/100ml.[4449] This high blood alcohol level is consistent with his presentation to witnesses on the night of 5 November 1996 and early hours of 6 November 1996, including slurred speech and loss of coordination.

5.4793. In his post-mortem report, Dr Lawrence considered that Mr Stockton's injuries, in particular the three impact sites, were inconsistent with a single fall, and described them as "odd". He opined that the pattern of injuries could represent an assault, though the severity of the injuries left open the possibility of Mr Stockton's being struck by a motor vehicle.[4450]

Persons of interest

5.4794. While there were no specific persons of interest identified, Eric-Emmanuel Hooson (from Mission Beat) recounted in his written statement that he had heard rumours from a co-worker, Terry Hugo, that people on the street believed that "four Caucasian males who frequent the Bar Cleveland" had perpetrated a number of similar assaults in the vicinity of Bourke and Cleveland Streets.[4451]

[4445] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [125]–[133] (SCOI.00045.00064).

[4446] Exhibit 18, Tab 4, Post-mortem Report of Dr Christopher Lawrence, 14 February 1997, 1 (SCOI.00045.00055).

[4447] Exhibit 18, Tab 49, Transcript of Coronial Inquest into the death of Carl Stockton, 1 December 1998, 11 (SCOI.00045.00001).

[4448] Exhibit 18, Tab 4, Post-mortem Report of Dr Christopher Lawrence, 14 February 1997, 4 (SCOI.00045.00055).

[4449] Exhibit 18, Tab 48, Statement of Dr Anthony Frederick Moynham (Director, Clinical Forensic Medicine Unit), 21 April 1997, 3 (SCOI.00045.00116).

[4450] Exhibit 18, Tab 4, Post-mortem Report of Dr Christopher Lawrence, 14 February 1997, 9 (SCOI.00045.00055).

[4451] Exhibit 18, Tab 34, Statement of Eric-Emmanuel Hooson, 5 November 1996, [8] (SCOI.00045.00074).

5.4795. Police did not obtain a statement from Mr Hugo in relation to this matter, and were unable to identify any historical events in the vicinity of Bourke and Cleveland Street to support Mr Hugo's claim.[4452]

5.4796. Similarly, as noted below, Andrew Phillips observed a group of three to four people standing outside Bar Cleveland at the time Mr Stockton was found on the roadway. These people have never been identified.

5.4797. Further, some five months later, on 27 April 1997, information was received by police, from a source identified only as the "general public", that assaults were being committed on persons who drink at the "Cleveland Inn Hotel" by a group of "young white males" who were preying on drinkers as they left the hotel. The source believed that the majority of the assaults were not being reported to police.[4453]

Exhibits: Availability and testing

MR STOCKTON'S CLOTHING

5.4798. An examination of the clothing Mr Stockton wore when at Bar Cleveland on 5 November 1996 was performed by Senior Constable Anthony Stocks on 13 November 1996. This examination identified soil visibly similar to that located in the laneway behind Bar Cleveland.[4454]

5.4799. Detective Sergeant Neil Sheldon, Team Leader in the UHT, provided a statement to the Inquiry on 17 April 2023 and confirmed that it is not clear whether any further testing or analysis was carried out on Mr Stockton's clothing.[4455] This document was tendered before me in chambers, and further submissions were made by Counsel Assisting on 22 June 2023. The NSWPF indicated on 27 June 2023 that no submissions would be made in relation to this document.

5.4800. Detective Sergeant Sheldon further stated that the clothing was returned to Surry Hills Police Station on 13 November 1996. Despite having pursued several lines of inquiry, it is unclear what happened to the clothing after this point.[4456]

MR STOCKTON'S PERSONAL EFFECTS

5.4801. Wine and beer bottles with fingerprints belonging to Mr Stockton were also recovered from Mr Stockton's property.[4457]

[4452] Exhibit 18, Tab 52, Strike Force Parrabell, Bias Crimes Indicators Review Form – Carl Stockton, 7–9 (SCOI.32071).

[4453] Exhibit 18, Tab 20, Intelligence Information System Information Report Summary, 27 April 1997, 1 (SCOI.10270.00007).

[4454] Exhibit 18, Tab 12, Statement of Senior Constable Warren Anthony Stocks, 4 March 1997, [5] (SCOI.00045.00087); Exhibit 18, Tab 62, Statement of Detective Sergeant Neil Sheldon, 17 April 2023 (NPL.9000.0005.0001); Exhibit 18, Tab 62D Stockton Crime Scene File, 2 (NPL.0100.0004.0005).

[4455] Exhibit 18, Tab 62, Statement of Detective Sergeant Neil Sheldon, 17 April 2023, [14] (NPL.9000.0005.0001).

[4456] Exhibit 18, Tab 62, Statement of Detective Sergeant Neil Sheldon, 17 April 2023, [15], [31] (NPL.9000.0005.0001); Exhibit 18, Tab 62D Stockton Crime Scene File, 2 (NPL.0100.0004.0005).

[4457] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [104]–[106] (SCOI.00045.00064).

5.4802. Detective Sergeant Sheldon said in his statement that 17 glass bottles were examined on 21 November 1996, that four fingerprints were identified on those bottles and that all fingerprints were identified as Mr Stockton's.[4458] It is unclear what happened to the glass bottles after they were examined.[4459]

5.4803. A wallet was collected from Mr Stockton at St Vincent's Hospital, which was also subject to fingerprint examination on 14 November 1996, with no identifiable fingerprints located.[4460]

5.4804. Records kept by the Fingerprint Unit indicate the wallet may have been returned to the Surry Hills Police Station on 10 December 1996, but where the wallet went after that, and its current location, is unclear.[4461]

TIMBER

5.4805. A number of pieces of timber that were located by police in Matterson Lane on 12 November 1996 were examined by Senior Constable Stocks and ruled out as being connected to Mr Stockton's death.[4462]

5.4806. It is unclear where the timber was stored before and after the above examination, and where it is located now.[4463]

Findings at inquest

5.4807. An inquest was held on 1 December 1998 before Senior Deputy State Coroner Abernethy.[4464]

5.4808. At the inquest, Dr Lawrence gave evidence that it was, in his professional opinion, unlikely that Mr Stockton's injuries were the consequence of a motor vehicle collision, noting that such injuries to the head from motor collisions typically cause death instantaneously. Dr Lawrence cited the pattern of Mr Stockton's injuries in support of this opinion.[4465] Dr Lawrence regarded some of Mr Stockton's injuries as "unusual" in the context of an assault, particularly the primary injury to the back of Mr Stockton's head, whereas the injury to the side of Mr Stockton's head was quite typical of an assault. The injury to the back of the skull was also inconsistent with a regular fall, although not, perhaps, a fall onto an irregular surface whilst under the influence of alcohol or otherwise incapacitated or disorientated.[4466]

[4458]Exhibit 18, Tab 62, Statement of Detective Sergeant Neil Sheldon, 17 April 2023, [20]–[21] (NPL.9000.0005.0001); Exhibit 18, Tab 62F, Stockton Fingerprint File 97–126 (NPL.0100.0004.0015).

[4459] Exhibit 18, Tab 62, Statement of Detective Sergeant Neil Sheldon, 17 April 2023, [22], [31] (NPL.9000.0005.0001).

[4460] Exhibit 18, Tab 62, Statement of Detective Sergeant Neil Sheldon, 17 April 2023, [23]–[26] (NPL.9000.0005.0001); Exhibit 18, Tab 62F, Stockton Fingerprint File 97–120 (NPL.0100.0004.0013) referring to Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [52], [143] (SCOI.00045.00064).

[4461]Exhibit 18, Tab 62, Statement of Detective Sergeant Neil Sheldon, 17 April 2023, [27], [31] (NPL.9000.0005.0001).

[4462] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [72] (SCOI.00045.00064).

[4463] Exhibit 18, Tab 62, Statement of Detective Sergeant Neil Sheldon, 17 April 2023, [30], [31] (NPL.9000.0005.0001).

[4464] Exhibit 18, Tab 49, Transcript of Coronial Inquest into the death of Carl Stockton, 1 December 1998 (SCOI.00045.00001).

[4465] Exhibit 18, Tab 49, Transcript of Coronial Inquest into the death of Carl Stockton, 1 December 1998, 9 (SCOI.00045.00001).

[4466] Exhibit 18, Tab 49, Transcript of Coronial Inquest into the death of Carl Stockton, 1 December 1998, 9, 11 (SCOI.00045.00001).

5.4809. Overall, Dr Lawrence's evidence was that it was not possible to determine whether Mr Stockton's injuries were caused by an assault, a fall or falls, or an assault followed by a fall. However, he expressed reluctance to classify Mr Stockton's death as an accident, and noted that any falling injuries may have been sustained following an assault.[4467]

5.4810. A consultant neurosurgeon, Dr John Matheson, provided an expert opinion. Dr Matheson also regarded Mr Stockton's injuries as inconsistent with the impact of a motor vehicle collision. He expressed the positive view that the injuries were likely to have been the result of an assault. He concluded:[4468]

> *In Mr Stockton's case it seems fairly clear that extensive fracturing of the skull involving all sides and the base could only have occurred from multiple repeated blows and is therefore inconsistent with impaction from a motor vehicle accident. One would expect that with impaction from a motor vehicle accident there would be more confined fractures and for the fractures to be associated with depression. One would also have expected a lack of a lucid interval. Mr Stockton's injuries therefore point clearly to an assault with repeated head injuries and are inconsistent with impaction from a motor vehicle accident.*

5.4811. Mr Stockton's radiologist brother-in-law, Dr Bruce Doust, also expressed, in a statement, the opinion that Mr Stockton's injuries could not have been obtained in the course of a motor vehicle collision, noting that the injuries were confined to the head, and that injuries to the rest of the body were absent. As such, Dr Doust opined that Mr Stockton's injuries were obtained by a blow or multiple blows to the head, though he noted he was not an expert in forensic medicine.[4469] However, Dr Doust's expertise was in radiology rather than forensic pathology, and he did not provide that statement as an expert witness.

5.4812. One of Mr Stockton's treating doctors at St Vincent's Hospital, Dr Raj Wijetunga, formed a similar opinion in a statement, namely that Mr Stockton's intracerebral haemorrhages and extensive skull fractures were as a result of blunt trauma with severe force to the back of the head.[4470]

5.4813. By contrast, Dr Anthony Moynham, Director of the NSW Police Clinical Forensic Medicine Unit, provided a statement in which he expressed the opinion that Mr Stockton's injuries could have been the result of a fall or a glancing type of blow from a large object, such as a motor vehicle.[4471]

[4467] Exhibit 18, Tab 49, Transcript of Coronial Inquest into the death of Carl Stockton, 1 December 1998, 11–12 (SCOI.00045.00001).

[4468] Exhibit 18, Tab 47, Letter from Dr JM Matheson to Detective Senior Constable Walker, 3 March 1997, 2 (SCOI.00045.00115).

[4469] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [38] (SCOI.00045.00064); Exhibit 18, Tab 39, Statement of Bruce David Doust, 11 November 1996, [13] (SCOI.00045.00080).

[4470] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [40] (SCOI.00045.00064); Exhibit 18, Tab 41, Statement of Dr L H Raj Wijetunga, 13 November 1996, [7] (SCOI.00045.00081).

[4471] Exhibit 18, Tab 48, Statement of Dr Anthony Frederick Moynham (Director, Clinical Forensic Medicine Unit), 21 April 1997, 4 (SCOI.00045.00116).

5.4814. The Coroner found that Mr Stockton died on 11 November 1996 at Darlinghurst of craniocerebral injuries suffered on or about 5 November 1996 at Redfern. The Coroner found, however, that the evidence adduced could not establish how those injuries were obtained.[4472]

Strike Force Parrabell

Bias Crimes Indicators Form

5.4815. A BCIF was completed in this case by Strike Force Parrabell.

5.4816. Of the ten indicators in the BCIF, five were answered "No evidence of Bias Crime" and five were answered "Insufficient Information". The overall categorisation, in the "Summary of Findings", was "Insufficient information".[4473]

5.4817. The ten "General Comment" sections of the BCIF reiterate, in largely identical terms, that Mr Stockton, though known by some friends to be gay, was not open about his sexuality to many people, and lived a fairly reclusive life at a house owned by his devout Christian family. That Mr Stockton was known to "never make enemies nor be aggressive in any situation" was made clear.[4474] It was also emphasised that there was very little evidence of how Mr Stockton had obtained his injuries, nor of any motive for an assault.[4475]

5.4818. For similar reasons, the BCIF concludes it was not known whether there were other persons involved, nor the sexuality of any such persons.

5.4819. In the "General Comment" section under both indicator 4 ("Organised Hate Groups (OHG)" and indicator 5 ("Previous existence of Bias Crime Incidents"), it is noted that Mr Hooson had said that a co-worker (Mr Hugo) had told him that "on the street people believe" that four Caucasian males who frequented Bar Cleveland were responsible for a number of similar bashings in the area, but that Police had been unable to identify any historical events around the location to support such claims.[4476]

5.4820. The absence of documented reports of other bashings in the area would not necessarily indicate that such bashings had not occurred. Evidence before the Inquiry has shown that it was common for victims of LGBTIQ bias crimes not to report incidents to police in the 1980s and 1990s, having regard to the context at that time of mistrust of, and fractious relations with, police amongst the LGBTIQ community.[4477]

5.4821. The "Summary of Findings" repeats various components of the earlier sections of the BCIF.

[4472] Exhibit 18, Tab 50, Findings of Senior Deputy State Coroner Abernethy, Inquest into the death of Carl Stockton, 1 December 1998 (SCOI.00045.00003).

[4473] Exhibit 18, Tab 52, Strike Force Parrabell, Bias Crimes Indicators Review Form – Carl Stockton, Undated 10–11 (SCOI.32071).

[4474] Exhibit 18, Tab 52, Strike Force Parrabell, Bias Crimes Indicators Review Form – Carl Stockton, Undated 5 (SCOI.32071).

[4475] Exhibit 18, Tab 52, Strike Force Parrabell, Bias Crimes Indicators Review Form – Carl Stockton, Undated 4, 10–14, 16 (SCOI.32071).

[4476] Exhibit 18, Tab 52, Strike Force Parrabell, Bias Crimes Indicators Review Form – Carl Stockton, Undated 8–9 (SCOI.32071).

[4477] Exhibit 2, Tab 1, Statement of Garry Wotherspoon, 14 November 2022, [51] (SCOI.77300); Exhibit 2, Tab 4: Statement of Barry Charles, 14 November 2022, [28]–[29] (SCOI.77304).

Case Summary

5.4822. Strike Force Parrabell categorised the case as "insufficient information to establish a bias crime".[4478] The matter was further categorised as "unsolved".

5.4823. The Strike Force Parrabell Case Summary for Mr Stockton's case read as follows:[4479]

> ***Identity:*** *Carl Stockton was 52 years old at the time of his death.*
>
> ***Personal History:*** *Mr Stockton lived alone in Surry Hills and worked as a train driver. He was not open about his sexuality. His family members were committed Christians. Mr Stockton often drank alone and socialised with very few people. He did not appear to have many friends or acquaintances. He lived alone and owned a Rolls Royce motor vehicle.*
>
> ***Location of Body/Circumstances of Death:*** *Mr Stockton died at St Vincent's Hospital, Darlinghurst 5 days after being transported from Campbell House (a proclaimed place) where he had been placed after a night drinking. Mr Stockton was seen drinking earlier in the evening at The Bar Cleveland before leaving. He was later found sitting on the roadway a short distance away and was taken back to the hotel. Due to his level of intoxication he was conveyed to a proclaimed place. In the morning Mr Stockton began vomiting and became disorientated. He was conveyed to St Vincent's Hospital where it was revealed that he had sustained 3 separate injuries to his head which caused his death. No suspects were identified. It was not known how he came to have received his injuries, with 3 doctors (neurosurgeon, pathologist and police medical officer) all having differing opinions.*
>
> ***Sexual Orientation:*** *Mr Stockton identified as gay.*
>
> ***Coroner/Court Findings:*** *The Coroner returned an open finding stating that Mr Stockton's injuries could have been caused by him being assaulted, falling, being hit by a motor vehicle, or any combination of all three. Police excluded a motive of robbery because although Mr Stockton's car keys could not be located, neither his house nor Rolls Royce car had been stolen or broken into.*
>
> ***SF Parrabell concluded there was insufficient information to establish a bias crime***

5.4824. The content of this case summary is generally consistent with the comments made in the BCIF.

[4478] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Carl Stockton (undated), 37 (SCOI.76961.00014).

[4479] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Carl Stockton (undated), 37 (SCOI.76961.00014).

Academic review

5.4825. The academic review categorised this matter as "Insufficient Information".[4480] The reasoning of the academic reviewers in this particular case is unknown.

Review by the Inquiry

5.4826. The Inquiry took the following steps in the course of examining the death of Mr Stockton.

Summonses

5.4827. A summons to the NSWPF was issued on 18 May 2022 for all documents relating to investigations by the NSWPF into the death of Mr Stockton, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF1). That summons also called for any other material held or created by the UHT in relation to the death of Mr Stockton. A hardcopy file was produced to the Inquiry on 8 June 2022.

5.4828. On 14 March 2023, the Inquiry issued Summonses SESLHD1 and SVH3 to South Eastern Sydney LHD and St Vincent's Hospital, respectively, seeking medical records in relation to Mr Stockton's care and treatment in October and November 1996.[4481] Sydney Hospital advised on 15 March 2023 that Mr Stockton's records had been destroyed.[4482] On 17 March 2023, St Vincent's Hospital advised that all images, including CT scans and x-rays, had been destroyed. However, it was able to supply various other records in relation to Mr Stockton, including imaging records.[4483]

5.4829. The Inquiry coordinated with BDM and other agencies to confirm the status and location of various witnesses.

Interagency cooperation

5.4830. On 11 May 2022, the Inquiry issued a written request to the Coroners Court to obtain the coronial file in relation to the death of Mr Stockton. The coronial file was produced on 26 May 2022.[4484]

Family members

5.4831. The Inquiry located and wrote to Mr Stockton's family members, including his sister and brother-in-law. To date, no responses have been received. Mr Stockton's parents are deceased.[4485]

[4480] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Carl Stockton (undated), 37 (SCOI.76961.00014).

[4481] Exhibit 18, Tab 57, Summons to South Eastern Sydney Local Health District (SESLHD1), 14 March 2023 (SCOI.82821); Exhibit 18, Tab 56, Summons to St Vincent's Hospital (SVH3), 14 March 2023 (SCOI.82824).

[4482] Exhibit 18, Tab 58, Letter from Sydney Hospital to the Inquiry, 15 March 2023 (SCOI.82815).

[4483] Exhibit 18, Tab 55, Email correspondence with Dr Linda Iles (with annexure), 22 March 2023 (SCOI.82817).

[4484] Exhibit 18, Tab 60, Statement of Francesca Lilly, 27 March 2023, [4]–[5] (SCOI.82818).

[4485] Exhibit 18, Tab 60, Statement of Francesca Lilly, 27 March 2023, [16] (SCOI.82818).

Further forensic examinations

5.4832. Noting the divergences of opinion among the medical experts commenting on Mr Stockton's injuries, the Inquiry briefed Dr Linda Iles, forensic pathologist. Dr Iles was requested to provide her expert opinion on, relevantly, the adequacy of the post-mortem investigations, and the manner and cause of Mr Stockton's death, including whether it was likely that the death was the result of a fall, or being struck by a motor vehicle, or an assault.[4486]

5.4833. The report of Dr Iles is undated, but was received by the Inquiry on 10 March 2023.[4487]

5.4834. Dr Iles described Mr Stockton's cause of death as "blunt head injuries". She notes that that description is "approximately equivalent" to the cause of death given by Dr Lawrence ("craniocerebral injuries"). In Dr Iles' opinion, the pattern of skull fractures observed is "due to very significant blunt force impact to the back of Mr Stockton's head".

5.4835. Dr Iles considered that Mr Stockton's head injuries "clearly cannot be accounted for by a simple fall. A fall from a significant height with impact to the back of the head may be able to produce this pattern of skull fractures but does not appear plausible in the circumstances as described."

5.4836. However, Dr Iles considers that Mr Stockton's pattern of injuries could be accounted for by an assault with multiple forceful impacts to the head. She adds that an "accelerated fall" on to the back of the head "could be accommodated in this scenario".

5.4837. Dr Iles considers that Mr Stockton's lack of post-cranial injuries makes it unlikely that his pattern of skull fractures was caused by an impact from a motor vehicle. She notes that the right rib and clavicular fractures (that Dr Moynham had relied upon in saying that the injuries may have been caused by a motor vehicle collision) were older injuries and "unhelpful in this regard". In Dr Iles' view, it is difficult to envisage a scenario where Mr Stockton could receive such severe craniocerebral trauma in a car accident without substantive injury anywhere else on his body.

5.4838. In Dr Iles' opinion, while the possibility that Mr Stockton's skull fractures were sustained by his head being "run over" cannot be excluded, such a scenario is significantly less likely than either an accelerated impact with the ground, or a substantive broad-based blow to the back of the head.

5.4839. Dr Iles considered that a review of medical records, including Mr Stockton's CT scan on admission to Sydney Hospital (films or report), and facial bone x-ray (films or report) may help delineate separate sites of impact and/or enable facial fractures to be excluded or included.

[4486] Exhibit 18, Tab 53, Letter of Instruction to Dr Linda Iles, 16 February 2023 (SCOI.82822).

[4487] Exhibit 18, Tab 54, Expert report of Dr Linda Iles, 10 March 2023 (SCOI.82823).

5.4840. As outlined above, such records are no longer available. However, St Vincent's Hospital did provide the Inquiry with various other records, including imaging reports. These were provided to Dr Iles on 22 March 2023. They did not cause Dr Iles to change her opinion as expressed in her expert report.[4488]

Contact with witnesses

Sue Thompson and Neil Walker (OIC)

5.4841. At the time of Mr Stockton's death, in 1996, Sue Thompson was serving as the Gay Liaison Coordinator for the NSWPF. In 2016, *The Gay Hate Decades* cited Ms Thompson as saying that Surry Hills police had told her, at the time of Mr Stockton's death in 1996, that patrons at the bar had heard a lot of anti-gay taunts made to Mr Stockton.[4489] None of the police reports or witness statements included any reference to such comments having been directed at Mr Stockton or any other person at Bar Cleveland.

5.4842. Accordingly, the Inquiry made further enquiries with Ms Thompson. She said that her recollection was that at least one police officer or detective had told her of the anti-gay taunts, but she could not recall who that was.

5.4843. Ms Thompson reviewed her diaries, and advised the Inquiry that for Friday, 15 November 1996 she had noted "phone call with Detective Walker – GAY MURDER". This was only four days after the date of Mr Stockton's death, and Detective Walker was the OIC of Strike Force Altea.[4490]

5.4844. On 16 November 2022, a staff member of the Inquiry made contact with the former OIC, Neil Walker. Detective Senior Constable Walker's original statement to the Coroner was detailed and contained no reference to any such taunting as described by Ms Thompson. On 30 November 2022, Mr Walker advised Mr Goobanko that he "did not receive any information, either direct or anecdotal, that Mr Stockton's death was as the result of a 'hate crime' against him as a result of his sexual orientation", nor did he have any witness or anecdotal evidence of any homophobic taunts towards Mr Stockton.[4491]

Contact with OIC

5.4845. Further to the contact outlined above, on 18 September 2023, the Inquiry wrote to Mr Walker enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Stockton. The Inquiry did not receive a response from Mr Walker.[4492]

[4488] Exhibit 18, Tab 55, Email correspondence with Dr Linda Iles (with annexure), 22 March 2023 (SCOI.82817).

[4489] Rick Feneley, 'The Gay Hate Decades' *SBS* (online) <https://www.sbs.com.au/gayhatedecades/>.

[4490] Exhibit 18, Tab 60, Statement of Francesca Lilly, 27 March 2023, [11]–[14] (SCOI.82818).

[4491] Exhibit 18, Tab 59, Statement of John Russell Goobanko, 31 January 2023, [4]–[7] (SCOI.82816).

[4492] Exhibit 66, Tab 79, Letter from Inquiry to Neil Walker, 18 September 2023 (SCOI.86337).

Terry Hugo

5.4846. On 19 July 2023, the Inquiry made telephone contact with Terry Hugo, Mr Stockton's co-worker. Mr Hugo advised that he was unable to recall Mr Hooson, or having a conversation with him regarding assaults in the area surrounding Bar Cleveland. Mr Hugo did not have any knowledge of assaults, including those motivated by LGBTIQ bias, occurring in this area. Mr Hugo was able to recall the name "Champagne Charlie" but could not recall anything further.[4493]

Attempted contacts

5.4847. On 19 July 2023, the Inquiry also attempted telephone contact with Mr Tozer, the bar manager. Mr Tozer did not answer or return the call, and was therefore not able to be questioned on his recollection of Mr Stockton's death and anti-LGBTIQ violence in and around Bar Cleveland.[4494]

5.4848. The Inquiry attempted to locate Magda Kos in order to make inquiries as to her recollections of Mr Stockton's death and any assaults or evidence of LGBTIQ bias at Bar Cleveland and in the surrounding areas. Unfortunately, Ms Kos was not able to be located.[4495]

Consideration of the evidence

Indicators of LGBTIQ bias

5.4849. Mr Stockton had confided to various close friends that he was gay, and his sexuality appears to have been more widely known despite Mr Stockton's generally private nature.[4496] Mr Stockton had come out to his close friend of 24 years, I208, who stated that she was aware of Mr Stockton's sexuality virtually from their first meeting, and advised that although he never had lived with a partner, she was aware that "years ago" he used to cruise for sexual partners. To I208's knowledge, this was no longer Mr Stockton's practice at the time of his death.[4497]

5.4850. There is some evidence which suggests that Mr Stockton may have been the victim of one or more assaults, potentially motivated by LGBTIQ bias, in the mid to late 1980s.

5.4851. Mr Stockton's friend Peter Moore recalled seeing bruises on one side of Mr Stockton's face in about 1986. In response to Mr Moore's enquiries, Mr Stockton replied with words to the effect of "I am a homosexual, it happens occasionally".[4498]

[4493] Exhibit 18, Tab 63, Statement of Darren Brown, 9 August 2023, [5] (SCOI.84929).

[4494] Exhibit 18, Tab 63, Statement of Darren Brown, 9 August 2023, [6] (SCOI.84929).

[4495] Exhibit 18, Tab 63, Statement of Darren Brown, 9 August 2023, [7] (SCOI.84929).

[4496] See e.g. Exhibit 18, Tab 25, Statement of Peter Moore, 7 July 1997, [4]–[5] (SCOI.00045.00106) regarding taunts about Mr Stockton's perceived sexuality.

[4497] Exhibit 18, Tab 23, Statement of I208, 15 November 1996, [6], [14] (SCOI.00045.00100).

[4498] Exhibit 18, Tab 25, Statement of Peter Moore, 7 July 1997, [4] (SCOI.00045.00106).

5.4852. Another of Mr Stockton's friends, Gavan McLennan, said that he knew that Mr Stockton had been bashed twice before. The first assault, he said, had occurred a long time ago when Mr Stockton was due to go on a trip to China. He had been bashed the night before and could not go. The second assault was six or seven years prior to Mr Stockton's death (i.e., around 1989 or 1990). Mr McLennan recalls getting a call from Mr Stockton who said he had been bashed in Sydney and fled to Port Macquarie where he was staying in a motel for about five nights. He told Mr McLennan that the assault happened after he got off a bus and was walking through Moore Park. Mr McLennan recalls that when Mr Stockton came to stay with him shortly afterwards, he had bruising on his face.[4499] The completed BCIF seems to suggest that this incident was the same incident as recounted by Mr Moore, although that is not clear. The years do not match, and Mr Moore had not mentioned that the incident had occurred in Moore Park. It is possible that the incidents are different, and Mr Stockton was assaulted on multiple occasions.

5.4853. Mr Stockton's father, Esmond Stockton, also recalled Mr Stockton being assaulted possibly six or seven years previously, in Mort Street, by two or three people. He suffered a broken finger and was apprehensive of further attack.[4500] Mr Stockton's father mentioned that Mr Stockton was also robbed on another occasion, and a camera, electronic gear and antique jewellery were taken.[4501]

5.4854. Geoffrey Tyson had known Mr Stockton since 1982 through a shared interest in motor vehicles. To his knowledge Mr Stockton had been assaulted three times: once in the city about ten years earlier (i.e., in approximately 1986), which was as a result of a traffic incident, and twice in Moore Park. Mr Tyson thought these incidents took place within two years of each other.[4502] Mr Tyson also mentioned the robbery referred to by Mr Stockton's father.[4503]

5.4855. I208's recollection was that Mr Stockton had been assaulted on two occasions in around 1988, in which his face and fingers were injured.[4504]

5.4856. It is not clear on the evidence available to the Inquiry whether some or all of these assaults may have occurred as a result of LGBTIQ bias. However, Mr Stockton's comment to Mr Moore suggests that at least Mr Stockton considered that was the basis for multiple assaults he had experienced.

[4499] Exhibit 18, Tab 22, Statement of Gavan McLennan, 26 November 1996, [9] (SCOI.00045.00101).

[4500] Exhibit 18, Tab 21, Statement of Esmond Henry Stockton, 13 November 1996, [9] (SCOI.00045.00098).

[4501] Exhibit 18, Tab 21, Statement of Esmond Henry Stockton, 13 November 1996, [10] (SCOI.00045.00098).

[4502] Exhibit 18, Tab 26A, Statement of Geoffrey Raymond Tyson, 14 November 1996, [9] (SCOI.00045.00099).

[4503] Exhibit 18, Tab 26A, Statement of Geoffrey Raymond Tyson, 14 November 1996, [10] (SCOI.00045.00099).

[4504] Exhibit 18, Tab 23, Statement of I208, 15 November 1996, [9] (SCOI.00045.00100).

Events of 5 to 6 October 1996

5.4857. On 5 October 1996, at around 11:00pm, Mr Stockton attended the Shakespeare Hotel in Surry Hills on his way home from work.[4505] At around 12:16am on 6 October 1996, police were contacted regarding a possible assault on an intoxicated person near the hotel.[4506] Police initially struggled to rouse Mr Stockton from sleep outside the hotel, and noted he smelled strongly of alcohol but showed no visible injuries.

5.4858. He was escorted to Campbell House.[4507] Whilst at Campbell House, Mr Stockton attempted to leave his bed and get into the linen cupboard. In doing so, he fell backwards and struck his head on the ground. This fall rendered Mr Stockton unconscious for two to three minutes.[4508]

5.4859. On 6 October 1996, he was taken by Mission Beat staff to Sydney Hospital Emergency Department, where he said he had no memory since attending the Shakespeare Hotel.[4509]

5.4860. Following his discharge on 6 October 1996, Mr Stockton experienced significant shoulder pain, and upon attending St Vincent's Hospital on 8 October 1996, was found to have a fractured clavicle, for which he subsequently wore a sling.[4510]

5.4861. On 11 October 1996, Mr Stockton attended his GP Dr Heather McIntyre, but appears to have demonstrated some reluctance to explain his injuries. He again saw Dr McIntyre on 17 October 1996, and on that occasion, Mr Stockton disclosed that he had been drinking heavily on the night of 6 October 1996, and was suffering from amnesia regarding that night, but was experiencing no other neurological symptoms. He had, however, initially vomited, and experienced severe headaches. Mr Stockton requested a referral to a neurologist, which was provided.[4511]

5.4862. On 22 October 1996, Mr Stockton was seen by neurologist Dr Raymond Garrick, who considered that though Mr Stockton had experienced a significant concussive injury, there was no cognitive deficit or cranial nerve abnormality. Mr Stockton's coordination was normal, headaches were gradually subsiding and blood pressure was 140/90. Dr Garrick deferred a CT scan, but suggested abstention from alcohol and time off work until Mr Stockton's headaches subsided.[4512]

[4505] Exhibit 18, Tab 44, Letter from Dr Raymond Garrick to Dr Heather McIntyre re neurological assessment of Mr Stockton, 22 October 1996 (SCOI.00045.00113).

[4506] Exhibit 18, Tab 20C, Computerised Incident Despatch System Archived Message Details, 6 October 1996 (SCOI.10264.00058).

[4507] Exhibit 18, Tab 10, Statement of Senior Constable Darren John Gregor, 26 November 1996, [3]–[7] (SCOI.00045.00107).

[4508] Exhibit 18, Tab 20B, NSWPF Running Sheet, 'Fax Received from Campbell House', 26 November 1996 (SCOI.10264.00059).

[4509] Exhibit 18, Tab 44, Letter from Dr Raymond Garrick to Dr Heather McIntyre re neurological assessment of Mr Stockton, 22 October 1996 (SCOI.00045.00113).

[4510] Exhibit 18, Tab 45, Medical Report of Dr Heather McIntyre, 13 November 1996, 2 (SCOI.00045.00114).

[4511] Exhibit 18, Tab 45, Medical Report of Dr Heather McIntyre, 13 November 1996, 2 (SCOI.00045.00114).

[4512] Exhibit 18, Tab 44, Letter from Dr Raymond Garrick to Dr Heather McIntyre re neurological assessment of Mr Stockton, 22 October 1996 (SCOI.00045.00113).

5.4863. On 24 October 1996 and again on 31 October 1996, Mr Stockton attended Dr McIntyre for check-ups. On both occasions, Dr McIntyre noted improvement to Mr Stockton's collarbone injury.[4513]

5.4864. Mr Stockton's friend Mr Tyson was not aware of the circumstances in which Mr Stockton injured his collarbone. Mr Stockton told him about the injury within some days of it occurring, but did not elaborate.[4514] Subsequent to his collarbone injury Mr Stockton mentioned to Mr Tyson that "people around here don't like me" and spoke about moving to another suburb. He did not specify who these people may have been.[4515]

5.4865. I208 also recalled that Mr Stockton had been evasive regarding how he had injured his collarbone, and after initially telling I208 that he had tripped on the stairs and fallen, had told I208 that "he would tell [her] later how it happened".[4516] This may indicate some level of embarrassment or shame around how the injury was obtained, and may raise the possibility of another assault.

Events of 5 to 6 November 1996

5.4866. On 5 November 1996 (Melbourne Cup Day), Mr Stockton was drinking alone at a table at Bar Cleveland, Redfern, where he was a regular patron. It was typical for Mr Stockton to attend the bar alone and play a card machine in the back bar.[4517] Mr Stockton suffered from anxiety and depression, and said he drank approximately 4-6 drinks a day.[4518]

5.4867. At approximately 2:00pm, Mr Stockton was observed by a fellow patron, Nathan Starcic, to be slurring his speech and showing bloodshot eyes, though he was responsive to conversation. Mr Starcic formed the view that Mr Stockton was intoxicated. His arm was still in a sling, following his injury on 6 October 1996.[4519]

5.4868. Sometime after 5:00pm, Mr Stockton he spoke to his godson via telephone, and seemed in good spirits. His godson formed the view that Mr Stockton was at a pub at the time they spoke due to the background noise and Mr Stockton's difficulty hearing the conversation. His godson also believed Mr Stockton was with a friend, as he heard him speak to someone, though it is not evident whether this was in fact a companion or a passer-by.[4520]

[4513] Exhibit 18, Tab 45, Medical Report of Dr Heather McIntyre, 13 November 1996 (SCOI.00045.00114).

[4514] Exhibit 18, Tab 26A, Statement of Geoffrey Raymond Tyson, 14 November 1996, [7] (SCOI.00045.00099).

[4515] Exhibit 18, Tab 26A, Statement of Geoffrey Raymond Tyson, 14 November 1996, [10] (SCOI.00045.00099).

[4516] Exhibit 18, Tab 23, Statement of I208, 15 November 1996, [8] (SCOI.00045.00100).

[4517] Exhibit 18, Tab 28, Statement of Brent Tozer, 9 November 1996, [4] (SCOI.00045.00069); Exhibit 18, Tab 29, Statement of Magda Kos, 8 November 1996, [8] (SCOI.00045.00070).

[4518] Exhibit 18, Tab 45, Medical Report of Dr Heather McIntyre, 13 November 1996, 1 (SCOI.00045.00114).

[4519] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [3] (SCOI.00045.00064); Exhibit 18, Tab 27, Statement of Nathan Starcic, 12 November 1996, [6]–[7] (SCOI.00045.00071).

[4520] Exhibit 18, Tab 24, Statement of I197, 12 March 1997, [7] (SCOI.00045.00105).

5.4869. While evidence as to Mr Stockton's activities throughout the day is sparse, it is possible that Mr Stockton remained at the same table and continued drinking throughout the day and into the night, as he was seen there again by Mr Starcic at approximately 11:00pm and still appeared drunk.[4521]

5.4870. A number of bar staff were working at Bar Cleveland that evening, including Mr Tozer, the manager, and Ms Kos, a bar attendant. Ms Kos noticed that Mr Stockton was drinking schooners of Reschs and stubbies of Coopers beer. She recalls him leaving around 11:30pm and being slightly intoxicated.[4522]

5.4871. Mr Stockton is believed to have then purchased "take-away" drinks from the bottle shop, as was his habit.[4523] The pub closed at around midnight.[4524]

5.4872. Bridgette Paroissien and her boyfriend, Robert Diliberto, resided in a house which backed on to the laneway, Matterson Lane, behind Bar Cleveland. At around 12:50am–1:00am on 6 November 1996, Ms Paroissien returned to her home. She entered via the unlocked back gate and discovered Mr Stockton in her garden.[4525] Ms Paroissien stated that she sat down with him for around half an hour, but Mr Stockton provided no explanation for his presence, and when Ms Paroissien attempted to help him up, he said "[n]ah, can't move".[4526]

5.4873. Ms Paroissien then woke up Mr Diliberto, who came to the garden to assist. Both Ms Paroissien and Mr Diliberto tried to speak to Mr Stockton, but he did not answer them. They helped him through the back gate and into the laneway before lowering him to the ground. Ms Paroissien saw Mr Stockton get up and take a few steps before falling into some garbage bins. Ms Paroissien and Mr Diliberto then went back inside.[4527]

5.4874. At around 1:15am on 6 November 1996, Ms Kos was cleaning up in the back bar of Bar Cleveland when she was approached by a man who said, "[t]here's an old guy that's collapsed outside, I think you should call someone". She then spoke to Mr Tozer, who was in the front bar.[4528]

5.4875. Ms Paroissien did not describe Mr Stockton as having facial injuries when in her backyard. If this is accurate, then Mr Stockton sustained his head injuries between about 1:00am and 1:15am on 6 November 1996.

[4521] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [5] (SCOI.00045.00064).

[4522] Exhibit 18, Tab 29, Statement of Magda Kos, 8 November 1996, [8] (SCOI.00045.00070).

[4523] Exhibit 18, Tab 29, Statement of Magda Kos, 8 November 1996, [8] (SCOI.00045.00070).

[4524] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [6] (SCOI.00045.00064).

[4525] Exhibit 18, Tab 32, Statement of Brigette Paroissen, 18 November 1996, [3] (SCOI.00045.00096).

[4526] Exhibit 18, Tab 32, Statement of Brigette Paroissen, 18 November 1996, [6]–[7] (SCOI.00045.00096).

[4527] Exhibit 18, Tab 32, Statement of Brigette Paroissen, 18 November 1996, [8]–[11] (SCOI.00045.00096); Exhibit 18, Tab 33, Statement of Robert Diliberto, 11 November 1996 (SCOI.00045.00095).

[4528] Exhibit 18, Tab 29, Statement of Magda Kos, 8 November 1996, [5] (SCOI.00045.00070); Exhibit 18, Tab 28, Statement of Brent Matthew Tozer, 9 November 1996, [6] (SCOI.00045.00069).

5.4876. Mr Tozer walked out onto Cleveland Street and saw Mr Stockton lying on his back across the inside lane of Cleveland Street, at the corner of Bourke Street.[4529] At the same time, an unknown passer-by (whose identity remains unknown) approached Mr Stockton. Mr Starcic recalled this man holding Mr Stockton in an upright position and helping him towards the pub. According to Mr Starcic, it was Mr Tozer and the passer-by who helped Mr Stockton into the pub and sat him down.[4530] The passer-by then said, "I have to run". The passer-by was described to investigating police as a white-presenting dark-haired man with a ponytail, approximately 25 years old.[4531]

5.4877. Andrew Phillips, a friend of Mr Starcic, gave a different account, stating that Mr Tozer and Gavin James, a patron of Bar Cleveland who had been inside helping staff clear up, helped Mr Stockton walk to the steps of the hotel. Mr Tozer asked Mr Stockton where he lived, to which Mr Stockton replied, "I don't know".[4532]

5.4878. Mr Phillips recalled seeing a group of three to four people standing in a circle outside the pub at the corner of Cleveland Street and Bourke Street shortly before Mr Stockton was brought into the pub.[4533] Whether these people were the "four Caucasian males", or "young white males" referred to above is unknown.

5.4879. Mr Tozer brought Mr Stockton into the hotel and sat him on a chair. He gave Mr Starcic and Mr James a wet cloth and some ice for Mr Stockton's injuries, and then went to contact Mission Beat. Mr Stockton had a black right eye and a small cut underneath his eye. Mr Stockton tried to speak but was incoherent. Mr Starcic heard him say repeatedly, "I've had enough. I want someone to take me around the back and kill me". Mr James heard Mr Stockton say "I want to die" two or three times. Bar staff, including Mr Tozer and Ms Kos, and patrons Mr Starcic and Mr James, attempted to calm Mr Stockton.[4534]

5.4880. At around 1:30am, Mr Hooson and Marc Kay, welfare officers with Mission Beat, arrived and assessed Mr Stockton. They noticed Mr Stockton's right arm was in a sling and he had a black eye. They assisted Mr Stockton outside to their van. They asked him how he had obtained his black eye, to which Mr Stockton responded, "I don't know". He advised that he had been drinking "all day". Mr Stockton was able to remember the date and where he lived. They then performed checks for further injuries to Mr Stockton's ribs, neck and legs. None were found. Mr Stockton did not respond to any of these checks.[4535]

[4529] Exhibit 18, Tab 28, Statement of Brent Matthew Tozer, 9 November 1996, [7] (SCOI.00045.00069).

[4530] Exhibit 18, Tab 27, Statement of Nathan Starcic, 12 November 1996, [14] (SCOI.00045.00071).

[4531] Exhibit 18, Tab 27, Statement of Nathan Starcic, 12 November 1996, [14] (SCOI.00045.00071).

[4532] Exhibit 18, Tab 31, Statement of Andrew Phillips, 12 November 1996, [5]–[6] (SCOI.00045.00073); Exhibit 18, Tab 28, Statement of Brent Matthew Tozer, 9 November 1996, [10] (SCOI.00045.00069).

[4533] Exhibit 18, Tab 31, Statement of Andrew Phillips, 12 November 1996, [5] (SCOI.00045.00073).

[4534] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [9] (SCOI.00045.00064); Exhibit 18, Tab 28, Statement of Brent Tozer, 9 November 1996, [10]–[12], [14] (SCOI.00045.00069); Exhibit 18, Tab 27, Statement of Nathan Starcic, 12 November 1996, [14]–[15] (SCOI.00045.00071); Exhibit 18, Tab 30, Statement of Gavin James, 11 November 1996, [5]–[6] (SCOI.00045.00072).

[4535] Exhibit 18, Tab 34, Statement of Eric-Emmanuel Hooson, 5 November 1996, [4]–[7] (SCOI.00045.00074); Exhibit 18, Tab 35, Statement of Marc Leslie William Kay, 8 November 1996, [5]–[15] (SCOI.00045.00075).

Events of 6 to 11 November 1996

5.4881. Mr Stockton was then taken again to Campbell House where he was helped to change into pyjamas and given a bed by staff. Welfare Officer Mark Lambrick made visual checks on Mr Stockton hourly: at 3:00am, 4:00am, 5:00am, 6:00am and 7:00am, during which Mr Stockton's breathing appeared normal and he did not change position. Mr Stockton did not leave his bed, and was not approached by anyone while he slept.[4536]

5.4882. At around 7:15am on 6 November 1996, staff were advised by another resident that Mr Stockton had vomited on his bed and the adjacent bed. There were no abnormalities observed in the vomitus, and when asked if he was okay, Mr Stockton replied "[y]es, just very tired".[4537]

5.4883. At 10:00am Mr Stockton was observed to be out of bed, and said, "I just want to get into bed". He was helped back into bed by staff. At approximately 11:30am it was observed that Mr Stockton had again vomited, this time on a different bed. He was observed to be "very disorientated and in a lost state". When asked if he was okay, Mr Stockton replied "[h]elp me". A short while later, Mr Stockton was conveyed to Sydney Hospital by Mission Beat staff.[4538]

5.4884. At about 11:40am on 6 November 1996, Mr Stockton was admitted to the Accident and Emergency Unit at Sydney Hospital, where he was examined and given a bed. In addition to his black eye, and the pre-existing fractured right clavicle, a cerebral CT scan showed Mr Stockton had suffered a comminuted skull fracture extending from the posterior parietal region to the vertex with some displacement. Further, there were some areas of intra-cerebral haematoma in the right temporal pole, both frontal poles, both posterior parietal regions and near the vertex on the right.[4539]

5.4885. Sydney Hospital staff performed hourly neurological observations, and treated Mr Stockton with prophylactic dosing of phenytoin and insertion of an in-dwelling catheter, before transferring him to St Vincent's Hospital, where he was admitted at around 4:50pm on 6 November 1996.[4540]

5.4886. Mr Stockton's brother-in-law, Dr Doust, was at that time Director of Radiology at St Vincent's Hospital. He advised that he and Mr Stockton did not have a close relationship but that he was aware that Mr Stockton had broken his clavicle around six weeks earlier. Mr Stockton apparently told Dr Doust that he could not recall how he had sustained those earlier injuries, but said that it had occurred whilst he was intoxicated.[4541]

[4536] Exhibit 18, Tab 38, Statement of Mark Desmond Lambrick, 11 November 1996, [10]–[12] (SCOI.00045.00076).

[4537] Exhibit 18, Tab 36, Statement of Meffan October Kaiwai, 9 November 1996, [5] (SCOI.00045.00077).

[4538] Exhibit 18, Tab 36, Statement of Meffan October Kaiwai, 9 November 1996, [6]–[8] (SCOI.00045.00077); Exhibit 18, Tab 37, Statement of Alan John Clynch, 9 November 1996, [7]–[9] (SCOI.00045.00078).

[4539] Exhibit 18, Tab 40, Statement of Dr Steven Dubenec, 12 November 1996, [6] (SCOI.00045.00079).

[4540] Exhibit 18, Tab 40, Statement of Dr Steven Dubenec, 12 November 1996, [6]–[7] (SCOI.00045.00079).

[4541] Exhibit 18, Tab 39, Statement of Dr Bruce David Doust, 1 November 1996, [6] (SCOI.00045.00080).

5.4887. Restraints were used on Mr Stockton's right hand at St Vincent's Hospital, a practice that is common when patients are confused and there is a potential for them to cause injury to themselves.[4542] Dr Doust observed that Mr Stockton was confused, and he had been sedated. Dr Doust and Dr Paul Preisz discussed Mr Stockton's CT scan, which showed a very significant injury, and Dr Preisz expressed doubts as to Mr Stockton's chances of survival. Dr Doust later opined that Mr Stockton's was "the most severe brain injury he had ever seen and [he] could only describe it as monstrous".[4543] Dr Doust, as a radiologist, did not give this opinion as an expert witness.

5.4888. On 7 November 1996, Mr Stockton received treatment under general anaesthesia, in the form of surgical procedures to the skull for the insertion of a right frontal external ventricular drain and right fronto-temporal craniotomy, right frontal and temporal partial lobectomy and insertion of an intracranial pressure monitor.[4544]

5.4889. On 11 November 1996 at 4:40pm, Mr Stockton died at St Vincent's Hospital.[4545]

Police investigation

5.4890. As noted above, there is a note in the standard canvass form relating to Bar Cleveland on 11 November 1996 which records, in relation to Mr Tozer, Ms Kos and Ms Strachan: "occupants' attitude worthy of follow up". The material available to the Inquiry does not indicate what "follow up", if any, occurred in respect of this comment.

5.4891. No statement was ever taken by the NSWPF from Mr Hugo in relation to his suggestion that "four Caucasian males who frequent the Bar Cleveland" were believed to have perpetrated a number of similar assaults in the vicinity of Bourke and Cleveland Streets.[4546] Mr Hugo's name was given to police by Mr Hooson of Mission Beat.

5.4892. In its submissions in respect of Mr Stockton's matter, the NSWPF acknowledged that, on the available material, it did not appear that specific further investigations were undertaken in relation to the reference to four Caucasian males, although the NSWPF drew attention to Mr Stockton's case being featured on Australia's Most Wanted. The NSWPF also noted that Mr Walker had not been asked about this matter when an investigator from this Inquiry spoke with him.

5.4893. As noted above, Mr Walker was provided with a copy of the submissions of Counsel Assisting and the NSWPF and has not sought to provide any further information to this Inquiry about the matter.

[4542] Exhibit 18, Tab 39, Statement of Dr Bruce David Doust, 1 November 1996, [9] (SCOI.00045.00080).

[4543] Exhibit 18, Tab 39, Statement of Dr Bruce David Doust, 1 November 1996, [10]–[12] (SCOI.00045.00080).

[4544] Exhibit 18, Tab 41, Statement of Dr L H Raj Wijetunga, 13 November 1995, [7] (SCOI.00045.00081).

[4545] Exhibit 18, Tab 8, Statement of Detective Senior Constable Neil Andrew Walker, 23 April 1998, [61] (SCOI.00045.00064).

[4546] Exhibit 18, Tab 52, Strike Force Parrabell, Bias Crimes Indicators Review Form – Carl Stockton, Undated 7–8 (SCOI.32071).

5.4894. On the material before me, there was limited investigation by the NSWPF into the "group of three to four people" observed by Mr Phillips, a patron of Bar Cleveland, when Mr Stockton was found. Similarly, it is not apparent that any investigation occurred into the "young white males" referred to in the contact from a member of the public months after Mr Stockton's death. I return to this matter below.

Management of Exhibits

5.4895. In evidence given during the Investigative Practices Hearing, Assistant Commissioner Conroy acknowledged that had police procedures been followed, the exhibits discussed above, would have been retained.[4547] Assistant Commissioner Conroy further conceded that the inability of the NSWPF to account for these exhibits is indicative of a failure to comply with applicable police practice.[4548]

5.4896. In written submissions filed in the respect of the Investigative Practices Hearing, the NSWPF accepted that the exhibits should have been retained and that it was "unsatisfactory" that no records can be located to account for what happened to them.[4549]

UHT screening, triage or review forms

5.4897. The Inquiry has before it a Triage Form in relation to Mr Stockton's death dated 6 November 2018 and an "Assessment of an Unsolved Homicide and Evidence Summary" dated 23 April 2019.[4550] In oral evidence given during the Investigative Practices Hearing, Detective Chief Inspector Laidlaw agreed that Mr Stockton's death should have been considered up as one of the original 366 cases examined by the UHT in 2004 and should have been reviewed in the initial five-year period.[4551]

5.4898. In fact, on the evidence before me, Mr Stockton's death was not reviewed until 2019.

5.4899. In written submissions filed in respect of the Investigative Practices Hearing, the NSWPF acknowledged that Mr Stockton's death should have been one of the original cases reviewed after the creation of the UHT.[4552]

[4547] Transcript of the Inquiry, 4 July 2023, T4855.10–12 (TRA.00072.00001).

[4548] Transcript of the Inquiry, 4 July 2023, T4855.14–17 (TRA.00072.00001).

[4549] Submissions of NSWPF, 10 October 2023, [434] (SCOI.86127).

[4550] Exhibit 53, Tab 35, Triage Review of an Unsolved Homicide – Carl Stockton, 6 November 2018 (SCOI.03389); Exhibit 53, Tab 35A, Assessment of an Unsolved Homicide and Evidence Summary – Carl Stockton, 23 April 2019 (SCOI.84312).

[4551] Transcript of the Inquiry, 6 July 2023, T5161.6-23 (TRA.00074.00001).

[4552] Submissions of NSWPF, 10 October 2023, [435] (SCOI.86127).

Manner and cause of death

5.4900. Counsel Assisting submitted that an appropriate finding as to manner and cause of death would be that Mr Stockton died on 11 November 1996 at Darlinghurst, as a result of craniocerebral injuries inflicted on 6 November 1996 at Redfern, by a person or persons unknown.

5.4901. The NSWPF agreed with Counsel Assisting that, having regard to the totality of the evidence now available, it appears unlikely that Mr Stockton's injuries were caused by a motor vehicle. The NSWPF further agreed that the finding that Mr Stockton died following an assault, proposed by Counsel Assisting, is open on the evidence as it now stands.

5.4902. However, the NSWPF submitted that there continues to be "significant uncertainty as to whether the cause of the injuries was, in fact, an assault, and, in turn, as to the circumstances surrounding any such assault". In support of that submission, the NSWPF made three further observations.

5.4903. First, that "little to no weight" ought to be given to the views of Dr Doust regarding the likely cause of death, as Dr Doust's expertise is in radiology and his familial relationship with Mr Stockton may compromise his objectivity. I accept his evidence should not be treated in the same way as the expert evidence. This is not a criticism of Dr Doust, who gave his evidence as a family member at the inquest and undoubtedly sought to do so to assist the Coroner. Nevertheless, as I note below, even putting aside the opinion of Dr Doust, the weight of the evidence favours a finding that Mr Stockton was assaulted.

5.4904. Secondly, referring to the evidence given by Dr Lawrence at inquest, that Dr Lawrence did not indicate that the cause of the head injuries was an assault.[4553] The submission does not take account of Dr Lawrence's post-mortem report in which he opined that the pattern of injuries *could* represent an assault. At inquest, he also did consider Mr Stockton's injuries in the context of an assault, even though he was ultimately unable to determine how Mr Stockton had come to sustain his injuries. In any event, the extent of the forensic evidence now allows me to find that the likely cause of the injuries was an assault.

5.4905. Thirdly, that there are discrepancies in the witness accounts as to the time Mr Stockton was brought into Bar Cleveland with a black eye, and consequently as to the likely time period within which Mr Stockton suffered his injuries.[4554] I do not consider that the time discrepancies have a bearing on my ultimate findings as to manner and cause of death.

[4553] See Exhibit 18, Tab 49, Transcript of Coronial Inquest into the death of Carl Stockton, 1 December 1998, 11 [48]–[56] (SCOI.00045.00001).

[4554] Submissions of NSWPF, 12 April 2023 [94(c)] (SCOI.45187) referring to Exhibit 18, Tab 29, Statement of Madga Kos, 8 November 1996, [5] (SCOI.00045.00070); Exhibit 18, Tab 34, Statement of Eric-Emmanuel Hooson, 5 November 1996, [4] (SCOI.00045.00074); Exhibit 18, Tab 54, Expert Report of Dr Linda Iles, 10 March 2023, 9–10 (SCOI.82823); Exhibit 18, Tab 32, Statement of Brigette Paroissen, 18 November 1996, [3]–[6] (SCOI.00045.00096).

5.4906. As a result of the above three reasons, the NSWPF submitted that "it is at least arguable that the open finding made by State Coroner Abernethy should not be disturbed". On all the evidence, and for the reasons I have outlined immediately above, I consider it appropriate to make a firmer finding in respect of Mr Stockton's death.

5.4907. The NSWPF also submitted that witness accounts are inconsistent in several key respects as to who was located where, and when, when Mr Stockton was found. The NSWPF submit that it appears clear that the Caucasian "man with a ponytail" was one of those men who had originally been outside Bar Cleveland. The OIC confirmed in evidence before the Coroner that the man with the ponytail had not been able to be identified, despite steps having been taken to feature Mr Stockton's case on the Australia's Most Wanted programme with a view to obtain assistance in identifying Mr Stockton's last movements. In these circumstances, it is submitted by the NSWPF that the contention that police failed to make inquiries about a "group of three to four people" observed by Mr Phillips to be standing outside Bar Cleveland at the time Mr Stockton was found, is not made out on the evidence.[4555]

5.4908. I acknowledge that some inquiries were made in respect of the "man with the ponytail", who was undoubtedly a potential witness. I do not accept those inquiries amounted to an adequate exploration of the possibility that Mr Stockton had been assaulted by a group of persons observed by one witness outside the hotel in circumstances where police had received information that four Caucasian males who frequented Bar Cleveland were believed to have perpetrated a number of similar assaults in the vicinity of Bourke Street and Cleveland Street and, separately, information that assaults were being committed on persons who drink at the "Cleveland Inn Hotel" by a group of "young white males" who were preying on drinkers as they left the hotel. This information warranted further investigation by police beyond what is evident on the material available to the Inquiry.

Bias

5.4909. Counsel Assisting submitted that it is uncontroversial that Mr Stockton was gay. There is some evidence that in the past he had "cruised" for sexual partners, but also that he had not done so in more recent times prior to his death.

5.4910. Counsel Assisting further submitted that there is also evidence of several assaults on Mr Stockton in the mid to late 1980s, approximately eight to ten years prior to his death, including in Moore Park, a known beat. Comments made by Mr Stockton to Mr Moore in relation to one of those assaults suggest that he believed that he had been assaulted at that time because he was gay, with the implication that he had suffered previous assaults for the same reason.

[4555] Submissions of NSWPF, 12 April 2023, [82] (SCOI.45187).

5.4911. The circumstances of Mr Stockton's collarbone injury about a month prior to his death are unclear, given Mr Stockton's stated amnesia regarding the event. However, on the available evidence, it cannot be excluded that he was intoxicated and fell after drinking at the Shakespeare Hotel.

5.4912. Counsel Assisting submitted that the preponderance of the medical and expert evidence supports a finding that Mr Stockton's head injuries were caused by an assault rather than a fall or being hit by a motor vehicle.

5.4913. At the time of the 1998 inquest, as noted above, each of Dr Lawrence and Dr Matheson had considered, with greater or lesser emphasis, that Mr Stockton's injuries in November 1996 were consistent with his having been assaulted. The expert opinion of Dr Iles, in 2023, substantially endorses those earlier views. Even putting aside the opinion of Dr Doust, on the basis that he was not a relevant expert, I agree that the weight of the evidence favours a finding that Mr Stockton was assaulted.

5.4914. Counsel Assisting submitted that the identity of the perpetrator/s of such an assault remain unknown. Hearsay suggestions that four caucasian males who frequented Bar Cleveland were believed to have perpetrated a number of similar assaults in the vicinity of Bourke and Cleveland Streets did not lead to any more substantive evidence or intelligence at the time. The available material does not permit those suggestions to be pursued further now.

5.4915. Counsel Assisting submitted that on the available evidence it is not possible to say whether Mr Stockton's death was the result of an LGBTIQ hate crime. The NSWPF also adopted that submission.

Conclusions and recommendations

5.4916. I find that Mr Stockton died on 11 November 1996 as a result of craniocerebral injuries inflicted on 6 November 1996 at Redfern, by a person or persons unknown.

5.4917. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in Mr Stockton's death.

5.4918. I make the following recommendation:

Recommendation 1

I recommend that the Commissioner of the NSWPF or a serving police officer make an application for a fresh inquest, in relation to the death of Mr Stockton, having regard to the evidence considered by the Inquiry and the findings and conclusions I have made in relation to manner and cause of death.

IN THE MATTER OF SCOTT STUART MILLER

Factual background

Date and location of death

5.4919. Scott Stuart Miller was found deceased within the compound of Patrick Corporation (**Patricks**), the stevedore business, near Wharf 4, Hickson Road in Darling Harbour, Sydney, on Monday, 3 March 1997. His body was lying on asphalt at the bottom of a cliff, in a fenced off area within the compound that was used by Patricks to store machinery. At the top of the cliff was a small park, Munn Reserve, with a chain link fence running along the cliff edge.

5.4920. It is likely that Mr Miller met his death in the early hours of Sunday, 2 March 1997. Dr Johan Duflou, forensic pathologist, estimated the likely time of death to be between 2:00am and 8:00am.[4556]

Circumstances of death

5.4921. On the evening of Saturday, 1 March 1997, Mr Miller attended the Sydney Gay and Lesbian Mardi Gras Parade (**Mardi Gras Parade**) on Oxford Street, Sydney, with three friends. After the parade, the friends travelled to The Rocks and continued drinking. Mr Miller was last seen by his friends sometime between 1:30am and 2:00am on the morning of Sunday, 2 March 1997, outside the Orient Hotel. Shortly after that time, at about 2:10am, a local resident saw a man believed to be Mr Miller walking alone down Watson Road from Observatory Hill.[4557]

5.4922. Various conflicting opinions were expressed during the initial police investigation as to whether Mr Miller's fatal injuries were incurred by falling from the cliff above where he was found, or by an assault, or by some combination of the two scenarios.

[4556] Exhibit 32, Tab 2, Post-mortem Report of Dr Johan Duflou, 5 June 1997, 2 (SCOI.02737.00048).

[4557] Exhibit 32, Tab 23, Statement of Jade Carter, 6 March 1997, [3]–[8] (SCOI.10049.00039).

5.4923. The forensic evidence obtained by the Inquiry, including reports of two forensic pathologists and a blood pattern analyst, supports a finding that Mr Miller's injuries were caused by a fall rather than an assault. Mr Miller's injuries, and the blood staining on his clothing, do not indicate that an assault occurred prior to his death.[4558]

5.4924. While the possibility of Mr Miller being lifted over the fence and pushed off the cliff cannot be excluded, the circumstantial evidence supports the conclusion that his fall was accidental.

Previous investigations

Original police investigation

Investigative steps taken by police

5.4925. After the discovery of Mr Miller's body, police were called and arrived by 8:10am on Monday, 3 March 1997.[4559]

5.4926. The original police investigation into Mr Miller's death was overseen by The Rocks Police. Plain Clothes Senior Constable Michael Lane was the OIC of the investigation.[4560]

5.4927. Police undertook an examination of the crime scene, as detailed below.

5.4928. Police took statements from the security officers at Patricks, who indicated that on the night of Saturday, 1 March 1997 until about 3:00am the following morning (Sunday, 2 March 1997), a New Zealand ship called "the Ranginui" was unloading containers and timber on Wharf 4.[4561] The extent of canvassing of information from crew members of the Ranginui is discussed below.

5.4929. The police conducted a canvass for witnesses in the two buildings next to the machinery yards, in the pubs and hotels in The Rocks and Millers Point, and in residences near Munn Reserve.[4562] A flyer with information about Mr Miller's death was handed out at all establishments in the area.[4563]

5.4930. Appeals were made to the media for information in relation to Mr Miller's death, and, on 11 March 1997, Mr Miller's case was featured on the television programme "Australia's Most Wanted".[4564]

[4558] Exhibit 32, Tab 72, Expert Report of Dr Linda Iles, 14 December 2022, 11 (SCOI.82891); Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [11.8], [15.1] (SCOI.83328); Exhibit 32, Tab 104, Expert Report of Dr Victoria Kueppers, 18 September 2023 (SCOI.85712).

[4559] Exhibit 32, Tab 7, Statement of Constable Sarah Anne Coates, 7 March 1997, [5] (SCOI.02737.00053); Exhibit 32, Tab 6, Statement of Senior Constable Brendan Crowe, 6 March 1997, [3]–[5] (SCOI.02737.00052).

[4560] Exhibit 32, Tab 5, Statement of Senior Constable Michael Lane, 1 May 1997 (SCOI.02737.00051).

[4561] Exhibit 32, Tab 36, Statement of Lance Neilson, 28 October 1997, [4] (SCOI.02737.00039).

[4562] Exhibit 32, Tab 19, Bundle of NSWPF Running Sheets, 4 March 1997–16 April 1997, 1–7, 9–11, 13 (SCOI.83327).

[4563] Exhibit 32, Tab 19, Bundle of NSWPF Running Sheets, 4 March 1997–16 April 1997, 13 (SCOI.83327).

[4564] Exhibit 32, Tab 5, Statement of Senior Constable Michael Lane, 1 May 1997, [40] (SCOI.02737.00051); Exhibit 32, Tab 17, NSWPF Media Release – 'Darling Harbour Death - Appeal for Information', 4 March 1997 (SCOI.02737.00076).

Post-mortem investigation

5.4931. An post-mortem examination was performed by Dr Duflou on 3 March 1997. His report detailed multiple injuries to Mr Miller's body, including:[4565]

a. Abrasion injuries to the face and neck, predominantly in a vertical plane;

b. Scattered abrasions and superficial lacerations to the hands;

c. Massive skull fracturing and contusion (bruising) of the brain;

d. Laceration of the liver, with a near complete tear of the right lobe;

e. Avulsion (tearing) of the right kidney from the right renal artery and vein;

f. Intra-abdominal haemorrhage;

g. Bilateral wrist fractures; and

h. Pulmonary contusion.

5.4932. Dr Duflou considered the direct cause of Mr Miller's death to be "multiple injuries."[4566]

5.4933. Anal and oral swabs and smears were negative for the presence of semen.[4567] A toxicology report found that Mr Miller had a high blood alcohol level of 0.220g/100mL, consistent with evidence of his state of intoxication on the night prior to his death.[4568]

5.4934. In his report, Dr Duflou stated that the manner in which the injuries were sustained was "unclear", and expressed no firm opinion as to the circumstances surrounding Mr Miller's death. He outlined that the injuries may have been inflicted by way of an assault, sustained during a fall from a height, or some combination of these two possibilities.[4569]

Exhibits

5.4935. The NSWPF retained as exhibits the clothing worn by Mr Miller at the time of his death, namely a brown belt, blue jeans, two white t-shirts, multicoloured socks and brown shoes. The Inquiry confirmed that these exhibits were in the custody of the NSWPF at the MEPC. [4570]

5.4936. Testing of Mr Miller's clothing is discussed below.

[4565] Exhibit 32, Tab 2, Post-mortem Report of Dr Johan Duflou, 5 June 1997 (SCOI.02737.00048).

[4566] Exhibit 32, Tab 2, Post-mortem Report of Dr Johan Duflou, 5 June 1997, 11 (SCOI.02737.00048).

[4567] Exhibit 32, Tab 15, Statement of Virginia Friedman, 1 April 1997 (SCOI.02737.00070).

[4568] Exhibit 32, Tab 3, Toxicology Report, 27 March 1997 (SCOI.02737.00019).

[4569] Exhibit 32, Tab 2, Post-mortem Report of Dr Johan Duflou, 5 June 1997, 10 (SCOI.02737.00048).

[4570] Exhibit 32, Tab 81, Statement of Kathryn Lockery, 14 June 2023, [10]–[11] (SCOI.83681).

5.4937. During the post-mortem examination, Dr Duflou retained debris taken from the right hand of Mr Miller (**debris**). In a 2004 screening of Mr Miller's case, this debris was noted to have been retained by the Crime Scene Unit (**CSU**) and held within the Sydney Police CSU Archive Room.[4571] It was not entered by the NSWPF into EFIMS as an exhibit or specimen until 2023, prompted only by enquiries made by the Inquiry.[4572]

5.4938. The Inquiry has subsequently had the debris forensically examined, as discussed below.

Findings at inquest

5.4939. On 7 October 1997, an inquest was held at the Coroners Court at Glebe. On that day, Senior Deputy State Coroner Abernethy returned the following finding:[4573]

> *That [Mr Miller] died on 2 March, 1997 at Sydney, of multiple injuries inflicted by a person or persons unknown. As to the person or persons who inflicted the injuries and the precise manner in which such injuries were inflicted, the evidence adduced does not enable me to say.*

Subsequent police investigation

Strike Force Corone

5.4940. After the inquest, Coroner Abernethy referred the case back to the NSWPF for further investigation by specialist homicide officers. Strike Force Corone was subsequently established under the command of Detective Sergeant Ken Desmond.[4574]

5.4941. The Inquiry was provided with a number of letters and memoranda which summarise this reinvestigation.[4575] Those documents do not appear to be a complete record of the investigation. It is accordingly difficult to comment on the thoroughness of the reinvestigation, or for the Inquiry to itself assess the significance of any new information that was obtained.

5.4942. In a 1998 letter to the Miller family, Detective Sergeant Desmond summarised that the following steps were taken (but that they revealed no "fresh or additional information"):

a. Reinterviewing of security staff at Patricks;

b. Reinterviewing and making inquiries with licensees and security staff at local hotels;

[4571] Exhibit 32, Tab 69, NSWPF Review of an Unsolved Homicide Case Screening Form – Scott Miller, 21 April 2004, 10 (NPL.0100.0015.0001).

[4572] Exhibit 32, Tab 79, Statement of Inspector Andrew Brady, 7 June 2023, [15]–[17] (NPL.9000.0017.0072).

[4573] Exhibit 32, Tab 43, Findings of Deputy State Coroner Abernethy, Inquest into the death of Scott Stuart Miller, 7 October 1997 (SCOI.02737.00032).

[4574] Exhibit 32, Tab 53, Letter from Commander Clive Small to Coroner Abernethy, 21 April 1998 (SCOI.02737.00033); Exhibit 32, Tab 45, NSWPF Strike Force Terms of Reference, 10 December 1997 (SCOI.10047.00038).

[4575] See, for example, Exhibit 32, Tabs 44–63.

c. Examination of medical records and log books on the vessel the Ranginui (to determine if any crew member returned from Mardi Gras with an indication of having been in a fight);

d. Inquiries with Combined Taxi Services;

e. Examination of police radio logs;

f. A media release in respect to information from a local resident about two men acting suspiciously;[4576] and

g. DNA testing of Mr Miller's t-shirt.[4577]

5.4943. Police also investigated an intelligence report that a young person was overheard bragging about assaulting a male person in The Rocks with a bottle, and throwing him over a cliff. The young person was excluded as a suspect on the basis that he was detained in a detention centre at the time of the incident.[4578]

5.4944. A government reward was approved and advertised for any information relevant to Mr Miller's death, but no information was forthcoming.[4579]

5.4945. By report dated 3 January 1998, Detective Sergeant Desmond provided his final observations and opinions,[4580] which tended to support the theory that Mr Miller fell to his death, as discussed below.

Strike Force Lincoln

5.4946. Strike Force Lincoln was established in 1999 to investigate the death of I304 (a pseudonym), who had also died in 1997.[4581] The primary person of interest in I304's death was NP130 (a pseudonym), who was ultimately charged and convicted in relation to I304's death.

5.4947. Strike Force Lincoln considered Mr Miller's death as a result of information provided by NP130's former girlfriend, I305 (a pseudonym), relating to an incident that occurred with NP130 in The Rocks in March 1997. I305 told police that she had left the Hero of Waterloo Hotel to go to a nearby park to vomit. The park identified by I305 was Munn Reserve. Whilst at the park, she spoke with a male fitting the description of Mr Miller for about five minutes. He appeared drunk and she offered to call him a cab, but he said he did not need one. NP130 then appeared and began pushing the male, telling him to stay away from I305. NP130 slapped I305 in the face and told her go around the corner and I305 walked away.[4582]

[4576] Exhibit 32, Tab 47, NSWPF Media Release – 'New Information on Darling Harbour Death', 3 January 1998 (SCOI.10047.00034).

[4577] Exhibit 32, Tab 50, Letter from Detective Sergeant Ken Desmond to Mr and Mrs Miller, 28 March 1998 (SCOI.02737.00034).

[4578] Exhibit 32, Tab 48, NSWPF Memorandum – 'Present status concerning the matter of Scott Stuart Miller', 8 January 1998 (SCOI.10047.00032).

[4579] Exhibit 32, Tab 57, NSWPF Memorandum – 'Present status concerning the matter of Scott Stuart Miller', 15 August 1998 (SCOI.10047.00010).

[4580] Exhibit 32, Tab 49, NSWPF Memorandum – 'Question of Government Reward being posted concerning the murder of Scott Stuart Miller at Darling Harbour on 2 March 1997', 27 March 1998 (SCOI.10048.00002).

[4581] Exhibit 32, Tab 69, NSWPF Review of an Unsolved Homicide Case Screening Form – Scott Miller, 24 April 2004, 8 (NPL.0100.0015.0001).

[4582] Exhibit 32, Tab 64, First Statement of I305, 11 April 1999 (SCOI.10047.00049); Exhibit 32, Tab 67, NSWPF Record of Interview – 'Interview with I305', 15 April 1999, 5–8 (SCOI.10047.00050).

5.4948. About 10 or 15 minutes later, NP130 returned and said that he had "shanked him and chucked him off a cliff" (referring to the male). I305 understood "shanked" to mean "stabbed". I305 did not believe him and assumed he had gotten into another fight. NP130 had a swollen fist.[4583]

5.4949. On the totality of the evidence, it is unlikely that I305 was describing an incident involving Mr Miller.

a. First, I305 did not recognise Mr Miller when shown photographs;[4584]

b. Secondly, I305 made no mention of the night being Mardi Gras;

c. Thirdly, the Palisade Hotel closed between 11:00pm and 12:00am on the night of Mr Miller's death,[4585] accordingly, any incident involving NP130 and a male must have occurred hours prior to the last reported sighting of Mr Miller by his friend (around 1:30am) and the last sighting of a person who seems likely to have been Mr Miller (around 2:10am);

d. Fourthly, there was no vomit found in the park by crime scene officers investigating Mr Miller's death, despite a thorough search of the park being conducted;[4586]

e. Fifthly, Mr Miller did not have any stab wounds; and

f. Finally, bearing in mind Mr Miller's solid build and the height of the fence at Munn Reserve, it is unlikely that he could have been lifted over the fence by NP130 alone while resisting. NP130 was only 158cm tall.[4587]

5.4950. Strike Force Lincoln did not otherwise reexamine the circumstances of Mr Miller's death.

Unsolved Homicide Team

5.4951. On 21 April 2004, Detective Sergeant Adam Barwick completed a Case Screening Form in relation to Mr Miller's death. While Detective Sergeant Barwick signed and dated the form as a reviewer, the space provided for the coordinator's certification was left blank.[4588]

[4583] Exhibit 32, Tab 64, First Statement of I305, 11 April 1999, [24] (SCOI.10047.00049); Exhibit 32, Tab 67, NSWPF Record of Interview – 'Interview with I305', 15 April 1999, 11 (SCOI.10047.00050).

[4584] Exhibit 32, Tab 65, Second Statement of I305, 11 April 1999 (SCOI.10047.00046).

[4585] Exhibit 32, Tab 19, Bundle of NSWPF Running Sheets, 4 March 1997–16 April 1997, 1 (SCOI.83327).

[4586] Exhibit 32, Tab 69, NSWPF Review of an Unsolved Homicide Case Screening Form – Scott Miller, 24 April 2004, 8 (NPL.0100.0015.0001); Exhibit 32, Tab 64, First Statement of I305, 11 April 1999, [12] (SCOI.10047.00049).

[4587] Exhibit 32, Tab 69, NSWPF Review of an Unsolved Homicide Case Screening Form – Scott Miller, 24 April 2004, 8 (NPL.0100.0015.0001).

[4588] Exhibit 32, Tab 69, NSWPF Review of an Unsolved Homicide Case Screening Form – Scott Miller, 11 (NPL.0100.0015.0001).

5.4952. In the context of the Investigative Practices Hearing, Detective Chief Inspector Laidlaw agreed that proper procedure required a coordinator's certification and was not aware why the signature was not affixed in this case. However, he also considered it "likely" that the coordinator had in fact certified the form, and that the omission of the coordinator's formal certification was an oversight.[4589] The NSWPF adopted this position in submissions, and I accept that this was likely the case.[4590]

5.4953. In the Case Screening Form dated 21 April 2004, Detective Sergeant Barwick noted that no examination had been made of Mr Miller's clothing.[4591] He recommended a "forensic review" of the case, commenting that:[4592]

> *A reexamination of the crime scene and the victim's injuries should be conducted to establish if the death was accidental. The Coroner may then issue a finding of 'death by misadventure.'*

5.4954. The evidence of whether a triage of Mr Miller's case occurred following the completion of the Case Screening Form is mixed. The UHT Tracking File records that a triage has been performed in relation to Mr Miller's case by an officer named "Pessotto", but no date is attached to that entry.[4593] No Triage Form has been provided to the Inquiry despite the issue of multiple summonses.[4594] Detective Chief Inspector Laidlaw was unable to assist the Inquiry in determining whether Mr Miller's case had in fact been triaged.[4595]

5.4955. Nearly six years after Detective Sergeant Barwick's Case Screening Form was completed, on 4 February 2010, Mrs Christine Miller (Mr Miller's mother) contacted the UHT and enquired about the status of the investigation into her son's death. Mrs Miller's inquiries were addressed by Detective Sergeant Robert Allison. In a note prepared by Detective Sergeant Allison dated 9 March 2010, he recorded a review of past contacts with the Miller family indicated that they had been informed that there was little hope of the matter being reinvestigated. Detective Sergeant Allison recorded in his note that the investigation had been "formally reviewed" by the "Review Team" of the UHT, and this "review" had recommended "a forensic examination of the deceased's clothing be undertaken in order to identify evidence of 'trace DNA' or signs of a struggle," but that recommendation remained outstanding.[4596]

[4589] Transcript of the Inquiry, 7 July 2023, T5231.6–37 (TRA.00075.00001), discussed in Submissions of Counsel Assisting, 15 September 2023, [892] (SCOI.85649).

[4590] Submissions of NSWPF, 10 October 2023, [439] (SCOI.86127).

[4591] Exhibit 32, Tab 69, NSWPF Review of an Unsolved Homicide Case Screening Form – Scott Miller, 21 April 2004, 9 (NPL.0100.0015.0001).

[4592] Exhibit 32, Tab 69, NSWPF Review of an Unsolved Homicide Case Screening Form – Scott Miller, 21 April 2004, 9 (NPL.0100.0015.0001).

[4593] Submissions of Counsel Assisting, 15 September 2023, [893] (SCOI.85649).

[4594] Exhibit 32, Tab 81, Statement of Kathryn Lockery, 14 June 2023, [7] (SCOI.83681).

[4595] Transcript of the Inquiry, 7 July 2023, T.5232.29–31 (TRA.00075.00001), discussed at Submissions of Counsel, 15 September 2023, [893] (SCOI.85649).

[4596] Exhibit 32, Tab 90, NSWPF Investigator's Note, 'Conference with Detective Senior Sergeant Steve Horn (CSU)', 9 March 2010 (NPL.0201.0001.0001).

5.4956. The "formal review" referred to by Detective Sergeant Allison in his note dated 9 March 2010 cannot be a reference to the 2004 Case Screening Form signed by Detective Sergeant Barwick. This is because:

a. Detective Sergeant Barwick had recommended an examination of Mr Miller's shoes and other clothing on the basis that it "may provide evidence of barbed wire punctures." He made no reference to trace DNA, or to testing to identify evidence of a struggle. Rather, his thesis in 2004 was that Mr Miller may have climbed over the fence, which was topped with barbed wire; and

b. The first paragraph of the 2004 Case Screening Form noted that it would be forwarded to the "Unsolved Homicide Review Team" following its completion. Other evidence before the Inquiry indicates that a recommendation by an individual reviewer is distinct from, and a precursor to, consideration of that recommendation by the "Review Team".[4597]

5.4957. Accordingly, some other document, containing the different recommendation referred to by Detective Sergeant Allison, must have existed in March 2010. The most likely inference is that the Unsolved Homicide Review Team, at some point after April 2004, reviewed Mr Miller's case and made the recommendation referred to by Detective Sergeant Allison.[4598]

5.4958. Detective Sergeant Allison put in train arrangements for the examination of the deceased's clothing,[4599] and on 10 March 2010 four items of Mr Miller's clothing were conveyed to FASS (then DAL).[4600] In the request form to FASS submitted by Detective Sergeant Allison in 2010, Detective Sergeant Allison stated that the objective of the further forensic testing was to identify any trace DNA on the items, as well as "signs of a struggle which may be evident from damage or stretch marks to any of the items".[4601]

5.4959. The results of the further testing by FASS were set out in a report dated 9 November 2012.[4602] In summary:

a. Blood was not detected on Mr Miller's blue Jag brand jeans.[4603] The notes prepared by FASS indicate that "several areas of r/b staining" were targeted for testing;[4604]

b. Four areas of the jeans pockets were tape-lifted, but DNA testing of those tape-lifts was unsuccessful;[4605] and

[4597] See for example Exhibit 6, Tabs 162B–E, Tabs 399 and 399A.

[4598] Exhibit 32, Tab 89, Letter from Katherine Garaty to Enzo Camporeale, 24 July 2023 (SCOI.85735).

[4599] Exhibit 32, Tab 90, NSWPF Investigator's Note, 'Conference with Detective Senior Sergeant Steve Horn (CSU)', 9 March 2010 (NPL.0201.0001.0001).

[4600] Exhibit 32, Tab 91, NSWPF Investigator's Note, 'Exhibits conveyed to DAL Lidcombe', 10 March 2010 (NPL.0201.0001.0002).

[4601] Exhibit 32, Tab 83, NSWPF Forensic Examination Request Form P377, 10 March 2010, 1 (SCOI.85742).

[4602] Exhibit 32, Tab 87, FASS Report to NSWPF, 9 November 2012 (SCOI.85741).

[4603] Exhibit 32, Tab 87, FASS Report to NSWPF, 9 November 2012 (SCOI.85741).

[4604] Exhibit 32, Tab 86, FASS General Worksheet, 8 March 2011, 1 (SCOI.85743); Exhibit 32, Tab 84, Photographs of the jeans, 10 February 2011 (SCOI.85972).

[4605] Exhibit 32, Tab 86, FASS General Worksheet, 8 March 2011 (SCOI.85743); Exhibit 32, Tab 87, FASS Report to NSWPF, 9 November 2012 (SCOI.85741); see also Exhibit 32, Tab 98, Supplementary Expert Report of Jae Gerhard, 21 August 2023, [10.2] (SCOI.85167).

c. Four stored extracts taken from the stains on Mr Miller's t-shirt were retested and returned results consistent with the blood originating from Mr Miller.[4606]

5.4960. The results of the forensic testing reported by FASS in 2012 did not advance the inquiry into the manner and cause of Mr Miller's death.

5.4961. The NSWPF advised the Inquiry that Mr Miller's case had not been considered by the Unsolved Homicide Review Committee for final determination as to whether there would be a reinvestigation.[4607]

Strike Force Parrabell

Bias Crimes Indicators Form

5.4962. A BCIF was completed in this case by Strike Force Parrabell. It concluded that there was "No Evidence of Bias Crime".[4608]

5.4963. In the BCIF, the Strike Force Parrabell officers answered "No Evidence of Bias Crime" to each of the ten indicators.

5.4964. The contents of the BCIF indicate that the officers completed the form on the basis that it was not possible to know who, if anybody, was responsible for Mr Miller's death. Accordingly, the "General Comment" sections are replete with references to various factors relevant to the determination of whether Mr Miller's death was the result of a hate crime being "unknown". For example:

a. In relation to indicator 1, "Differences", officers record: "No persons have been charged as a result of the death of Scott MILLER as such the sexual orientation of the offender/s is unknown. It is unclear if any persons did in fact play a role in the death of Mr Miller."

b. In relation to indicator 2, "Comments, Written Statements, Gestures", officers record that, as no persons have been identified as responsible for Mr Miller's death, it is "unknown if any bias related comments or gestures were made by anyone before, during or after the death."

c. In relation to indicator 3, "Drawings, Markings, Symbols, Tattoos, Graffiti", it is stated that it is "unknown if any persons was [sic] responsible for the death of MILLER and if so, if they had any bias related drawings, markings, symbols or graffiti on their bodies."

d. In relation to indicator 4, "Organised Hate Groups (OHG)", it is recorded that it is "unknown" if an organised hate group was responsible.

e. In relation to indicator 7, "Motive of Offender/s", it is noted that no motive was established during the investigation.

[4606] Exhibit 32, Tab 87, FASS Report to NSWPF, 9 November 2012 (SCOI.85741); see also Exhibit 32, Tab 98, Supplementary Expert Report of Jae Gerhard, 21 August 2023, [10.3] (SCOI.85167).

[4607] Exhibit 32, Tab 77, Letter from Katherine Garaty to Enzo Camporeale, 1 June 2023 (SCOI.83403).

[4608] Exhibit 32, Tab 70, Strike Force Parrabell, Bias Crimes Indicators Review Form – Scott Miller, Undated 15 (NPL.0129.0001.0169).

f. In relation to indicator 8, "Location of Incident", officers record that it is "unknown" if the location held any significance to any persons involved in the death of Mr Miller.

g. In relation to indicator 9, "Lack of Motive", it is recorded again that the investigation did not establish a motive for Mr Miller's death.

5.4965. The "Summary of Findings" repeats much of the content of earlier parts of the form, again emphasising that no persons were identified as responsible for the death of Mr Miller and that no motive could be established for his death.[4609]

5.4966. Given this uncertainty, it is surprising that the indicators were answered positively as "No Evidence of Bias Crime", when (according to the BCIF) that option is appropriate only if "the incident has been determined as… not being motivated by bias towards a protected group", as opposed to "Insufficient Information", which is appropriate where "insufficient information has been recorded to make [such] a determination".

5.4967. The reasoning process adopted by the officers, in choosing among the four "finding" options for each indicator, was the subject of evidence and submissions in relation to Public Hearing 2. I refer to my findings in **Chapter 13** in this regard.

Case Summary

5.4968. The Inquiry has been provided with a Case Summary summarising the final results of Strike Force Parrabell with respect to this matter.[4610]

5.4969. Strike Force Parrabell categorised the case as "No Evidence of Bias Crime".[4611]

5.4970. The matter was categorised as "Unsolved".[4612]

5.4971. The Case Summary reads as follows:[4613]

> ***Identity**: Scott Miller was 21 years old at the time of his death.*
>
> ***Personal History**: Mr Miller was about to start studying at university at the time of his death.*
>
> ***Location of Body/Circumstances of Death**: Mr Miller's body was located at the base of a 7-metre cliff at Wharf 5, Hickson Road, Darling Harbour. Mr Miller earlier attended the Sydney Gay and Lesbian Mardi Gras Parade with a group of friends earlier that evening. Mr Miller was last seen in the vicinity of the Orient Hotel, The Rocks. He was earlier asked to leave the Observer Hotel due to his level of intoxication. Police were unable to establish a motive for Mr Miller's death but did rule out misadventure due to factors including the positioning of his body; a high wire fence on the cliff above which would have inhibited Mr*

[4609] Exhibit 32, Tab 70, Strike Force Parrabell, Bias Crimes Indicators Review Form – Scott Miller, Undated 15 (NPL.0129.0001.0169).

[4610] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Scott Miller, Undated 35 (SCOI.76961.00014).

[4611] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Scott Miller, Undated 35 (SCOI.76961.00014).

[4612] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Scott Miller, Undated 35 (SCOI.76961.00014).

[4613] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Scott Miller, Undated 35 (SCOI.76961.00014).

> *Miller falling; and injuries to his body which were consistent with being assaulted. Two years later police identified two male suspects in light of comments they made to others about being involved in incidents of violence at The Rocks. Notwithstanding further investigation there was insufficient evidence to implicate either in Mr Miller's death.*
>
> ***Sexual Orientation**: Mr Miller identified as heterosexual.*
>
> ***Coroner/Court Findings**: The Coroner returned an open finding stating that Mr Miller died, 'at Sydney of multiple injuries inflicted by a person or persons unknown. As to the persons or persons who inflicted the injuries and the precise manner in which such injuries were inflicted, the evidence adduced does not enable me to say.'*
>
> ***SF Parrabell concluded there was no evidence of a bias crime***

5.4972. The case summary is inconsistent with the BCIF in a significant respect. The case summary states, in an unqualified manner, that although police could not establish motive, they "did rule out misadventure" as the cause of Mr Miller's death. However, in fact, there were conflicting opinions within the NSWPF as to whether his death was the result of a homicide or an accidental fall. As explained below, although the Coroner ruled out a fall and therefore ruled out misadventure on 7 October 1997, subsequent records from Strike Force Corone and from the UHT indicated that a fall (and therefore misadventure) remained a real possibility to the NSWPF. Consistent with this, the BCIF noted that there were thought to be "three probable scenarios", namely injuries inflicted by a homicidal attack, injuries inflicted by a fall, or a combination of the two.[4614]

Academic review

5.4973. The academic review categorised it as "insufficient information".[4615] The reasoning of the academic reviewers in this particular case is unknown.

Review by the Inquiry

5.4974. The Inquiry took the following steps in the course of examining the matter and preparing the matter for documentary tender on 15 June 2023:[4616]

a. Requesting the coronial file;

b. Summoning the police investigation file;

c. Locating and contacting family and friends of Mr Miller;

d. Seeking the expert opinion of a forensic pathologist, Dr Iles;

[4614] Exhibit 32, Tab 70, Strike Force Parrabell, Bias Crimes Indicators Review Form – Scott Miller, Undated 15 (NPL.0129.0001.0169).

[4615] Exhibit 6, Tab 49, Strike Force Parrabell, Case Summaries – Scott Miller, Undated 35 (SCOI.76961.00014).

[4616] Exhibit 32, Tab 81, Statement of Kathryn Lockery, 14 June 2023, [5], [7], [16], [18], [21]. [23] (SCOI.83681).

e. Seeking the expert opinion of blood pattern analysis experts, Ms Gerhard and Ms Roebuck at Independent Forensic Services;

f. Arranging for the examination of the debris by FETS officers; and

g. Enquiring as to the investigative file of a private investigator retained by the Miller family.

5.4975. On 16 June 2023, a public hearing was held in which a bundle of documentary material was tendered as Exhibit 32,[4617] alongside the written submissions of Counsel Assisting dated 15 June 2023.[4618] The NSWPF filed written submissions on 30 June 2023.[4619] The Miller family filed written submissions on 30 June 2023.[4620]

5.4976. The Inquiry subsequently undertook the following additional investigative steps:[4621]

a. Summoning material from FASS in relation to forensic testing in Mr Miller's matter;

b. Consequent upon (a), making enquiries as to further consideration of Mr Miller's case by the UHT between 2010 and 2012;

c. Obtaining from a third forensic pathologist, Dr Victoria Kueppers, a peer review of the opinions of Dr Duflou and Dr Iles;

d. Obtaining an expert opinion as to the ivy found next to Mr Miller's body from Peter Jobson, information botanist;

e. Obtaining a supplementary report from Ms Gerhard in relation to possible avenues for further forensic testing of Mr Miller's clothing;

f. Arranging for further DNA testing be carried out of Mr Miller's clothing;

g. Arranging for the examination of the debris by independent forensic scientist, Professor Claude Roux;

h. Arranging for DNA testing of the surface of the debris; and

i. Arranging for testing of a small fibre located on the surface of the debris.

5.4977. The results of these inquiries are set out below.

[4617] Transcript of the Inquiry, 16 June 2023, T4313.29–30 (TRA.00061.00001).

[4618] Submissions of Counsel Assisting, 15 June 2023 (SCOI.83998).

[4619] Submissions of NSWPF, 30 June 2023 (SCOI.84264).

[4620] Submissions of Miller Family, 30 June 2023 (SCOI.84265).

[4621] Exhibit 32, Tab 108, Statement of Penelope Smith, 5 October 2023 (SCOI.86023).

5.4978. On 16 October 2023, a supplementary bundle of documentary material was tendered as part of Exhibit 32, accompanied by the supplementary written submissions of Counsel Assisting dated 18 October 2023.[4622] The NSWPF filed supplementary written submissions on 24 October 2023.[4623] The Miller family filed supplementary written submissions on 31 October 2023.[4624]

Summonses

5.4979. A summons to the NSWPF was issued on 18 May 2022 for all documents relating to the investigation of the death of Mr Miller, including certain prescribed categories of information identified at (1)(a) to (j), and (2) of the summons (Summons NSWPF1). One specified category was material "held or created by the Unsolved Homicide Squad" in relation to Mr Miller's death.[4625]

5.4980. A bundle of documents said to answer Summons NSWPF1 was produced on 8 June 2022. Among the material produced by the NSWPF was an undated and unsigned Case Screening Form.[4626]

5.4981. On 24 May 2023, the Inquiry wrote to the NSWPF asking:[4627]

a. "Whether any other case screening form, triage document or review document has been prepared in association with Mr Miller's death"; and

b. "Whether Mr Miller's case has been considered by the Unsolved Homicide Review Committee for a final determination as to whether the matter will be reinvestigated."

5.4982. By a letter dated 1 June 2023, the NSWPF:[4628]

a. Provided the Inquiry with a copy of that Case Screening Form, as signed by Detective Sergeant Barwick on 21 April 2004;[4629]

b. Informed the Inquiry that that signed and dated copy had been located "in a homicide office storage room with hardcopy files" that was generally used for the temporary storage of files and only searched "out of an abundance of caution";[4630] and

[4622] Supplementary Submissions of Counsel Assisting, 18 October 2023 (SCOI.86272)

[4623] Supplementary Submissions of NSWPF, 24 October 2023 (SCOI.86370).

[4624] Supplementary submissions of Miller Family, 31 October 2023 (SCOI.86430).

[4625] Exhibit 32, Tab 81, Statement of Kathryn Lockery, 14 June 2023, [7] (SCOI.83681).

[4626] Exhibit 32, Tab 81, Statement of Kathryn Lockery, 14 June 2023, [7], [13] (SCOI.83681).

[4627] Exhibit 32, Tab 76, Letter from Enzo Camporeale to Patrick Hodgetts, 24 May 2023 (SCOI.83527).

[4628] Exhibit 32, Tab 77, Letter from Katherine Garaty to Enzo Camporeale, 1 June 2023 (SCOI.83403).

[4629] Exhibit 32, Tab 77, Letter from Katherine Garaty to Enzo Camporeale, 1 June 2023 (SCOI.83403); Exhibit 32, Tab 69, NSWPF Review of an Unsolved Homicide Case Screening Form – Scott Miller, 21 April 2004 (NPL.0100.0015.0001).

[4630] Exhibit 32, Tab 77, Letter from Katherine Garaty to Enzo Camporeale, 1 June 2023 (SCOI.83403).

c. Informed the Inquiry that the Case Screening Form prepared by Detective Sergeant Barwick in 2004 was the only case screening form, triage document or review document ever prepared in relation to Mr Miller's death, and that Mr Miller's matter had never been considered by the Unsolved Homicide Review Committee.[4631]

5.4983. On 7 June 2023, the NSWPF advised that a further archive box of material in respect of Mr Miller's death had been located and was being reviewed for responsiveness to the previous summons issued.[4632] A bundle of additional material was produced to the Inquiry on 9 June 2023.

5.4984. On 27 June 2023, the Inquiry issued a summons to FASS (FASS4) for all documents or other records held by FASS relating to the death of Mr Miller.[4633] This summons was issued with a view to pursuing further DNA testing.

5.4985. In response to that summons, FASS produced material which indicated that on 10 March 2010, Detective Sergeant Allison of the UHT had requested that FASS conduct testing on Mr Miller's clothing.[4634] The results of that testing by FASS are set out in a report dated 9 November 2012.[4635]

5.4986. No such testing by FASS, in or after 2010, had been referred to in any document received from the NSWPF.

5.4987. On 17 July 2023, the Inquiry issued a further summons to the NSWPF (NSWPF152) for material held by the UHT in relation to that testing, including, relevantly, any "document or summary recording the outcome of the above testing and any further investigations undertaken or recommended".[4636]

5.4988. On 24 July 2023, the NSWPF advised that *no* records were identified which recorded the outcome of the testing undertaken by FASS in Mr Miller's case between 2010 and 2012.[4637]

5.4989. Summons NSWPF152 also requested any correspondence, file note or other record of communications between the UHT and FASS.[4638] The NSWPF produced two documents in response, being two Investigator's Notes prepared by Detective Sergeant Allison dated 9 and 10 March 2010.[4639]

[4631] Exhibit 32, Tab 77, Letter from Katherine Garaty to Enzo Camporeale, 1 June 2023 (SCOI.83403).

[4632] Exhibit 32, Tab 78, Letter from Katherine Garaty to Enzo Camporeale, 7 June 2023 (SCOI.83643); see also Supplementary submissions of Miller Family, 31 October 2023, [5(c)] (SCOI.86430).

[4633] Exhibit 32, Tab 82, Summons to Produce to FASS (Summons FASS4), 27 June 2023 (SCOI.84762).

[4634] Exhibit 32, Tab 83, FASS Forensic Examination Request Form P377, 10 March 2010 (SCOI.85742).

[4635] Exhibit 32, Tab 87, FASS Report to NSWPF, 9 November 2012 (SCOI.85741).

[4636] Exhibit 32, Tab 88, Summons to Produce to NSWPF (Summons NSWPF152), 17 July 2023 (SCOI.85732); Exhibit 32, Tab 108, Statement of Penelope Smith, 5 October 2023, [8] (SCOI.86023).

[4637] Exhibit 32, Tab 89, Letter from Katherine Garaty to Enzo Camporeale, 24 July 2023 (SCOI.85735).

[4638] Exhibit 32, Tab 88, Summons to Produce to NSWPF (Summons NSWPF152), 17 July 2023 (SCOI.85732);

[4639] Exhibit 32, Tab 90, NSWPF Investigator's Note – 'Conference with Detective Senior Sergeant Steve Horn (CSU)', 9 March 2010 (NPL.0201.0001.0001).

Interagency cooperation

5.4990. On 11 May 2022, the Inquiry issued a written request to the Coroners Court to obtain the coronial file in relation to the death of Mr Miller. The coronial file was produced on 2 June 2022.[4640]

Family members

5.4991. The Inquiry located and wrote to Mr Miller's family members, including Mr Miller's parents Stuart and Christine Miller and Mr Miller's two brothers Shane and Mark Miller.[4641]

5.4992. On 18 October 2022, the Miller family, by letter to the Inquiry, outlined their concerns regarding the initial police investigation, noting that a review by a forensic pathologist may assist the Inquiry's investigations. The Inquiry has subsequently corresponded with Shane Miller to provide the Miller family with updates as to the work of the Inquiry and the professional opinions obtained.[4642]

5.4993. On 23 January 2023, the Inquiry also wrote to Mr Miller's girlfriend at the time of his death, Bridget Lott (previously Bridget McCleery). The Inquiry later conferred with Ms Lott, who provided a statement dated 6 June 2023.[4643]

5.4994. Shane Miller and Bridget Lott attended the documentary tender in person on 15 June 2023. The Miller family were represented by Daniel Tynan on a *pro bono* basis. Mr Tynan further assisted the Miller family in preparing their submissions dated 30 June 2023 and supplementary submissions dated 31 October 2023.[4644]

Contact with OICs

5.4995. On 5 September 2023 and 28 September 2023, the Inquiry wrote to Michael Lane and Kenneth Desmond enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Miller.[4645] The Inquiry did not receive a response from Mr Lane or Mr Desmond.

Searches for exhibits

5.4996. A summons was issued to the NSWPF on 13 April 2023 for the exhibits associated with the investigation into Mr Miller's death, specifically his clothing and items taken at post-mortem (NSWPF84), in order to facilitate the forensic examination of those items.[4646]

[4640] Exhibit 32, Tab 81, Statement of Kathryn Lockery, 14 June 2023, [5]–[6] (SCOI.83681).

[4641] Exhibit 32, Tab 81, Statement of Kathryn Lockery, 14 June 2023, [21] (SCOI.83681).

[4642] Exhibit 32, Tab 81, Statement of Kathryn Lockery, 14 June 2023, [22] (SCOI.83681).

[4643] Exhibit 32, Tab 80, Statement of Bridget Lott, 6 June 2023 (SCOI.83636).

[4644] Submissions of Miller Family, 30 June 2023 (SCOI.84265); Supplementary submissions of Miller Family, 31 October 2023 (SCOI.86430).

[4645] Exhibit 66, Tabs 52-53, Letters to Michael Lane, 5 September 2023 and 28 September 2023 (SCOI.86310; SCOI.86311); Exhibit 66, Tab 50E, Letter to Kenneth Desmond, 28 September 2023 (SCOI.86386).

[4646] Exhibit 32, Tab 81, Statement of Kathryn Lockery, 14 June 2023, [10] (SCOI.83681).

Professional opinions

Forensic pathology

5.4997. The Inquiry sought the opinion of Dr Iles, forensic pathologist, on:[4647]

a. The adequacy of the post-mortem investigations conducted with respect to Mr Miller;

b. The medical cause of Mr Miller's death;

c. Whether Mr Miller likely died at the location he was found;

d. Whether there were any abrasions, scratches or other injuries on Mr Miller's body which could be consistent with a person climbing a barbed wire fence or pushing through ivy; and

e. Whether Mr Miller's injury were consistent with misadventure or foul play.

5.4998. The findings of Dr Iles' report dated 14 December 2022 are addressed below.

5.4999. In written submissions filed on 30 June 2023, the Miller family raised concerns as to the inconsistency between the opinions of Dr Duflou and Dr Iles.[4648] As a result, the Inquiry briefed Dr Kueppers, an independent expert forensic pathologist from Western Australia, to conduct a peer review of the opinions of Dr Iles and Dr Duflou.

5.5000. Dr Kueppers was asked to comment on whether she agreed or disagreed with the opinions expressed by Dr Iles and Dr Duflou, and to provide reasons for her agreement or disagreement. To the extent that the opinions of Dr Iles and Dr Duflou differed, she was asked to identify which opinion she preferred and her reasons as to why.[4649]

5.5001. The findings of Dr Kueppers' report dated 18 September 2023 are addressed below.

Botany

5.5002. As discussed below, Mr Miller's body was discovered about 1.1 metres from the base of the cliff, with a portion of ivy located adjacent to his left leg.[4650] Munn Reserve, at the top of the cliff, was fenced with galvanised chain wire fencing and that beyond the fence was a sandstone ledge, covered with vines and vegetation.[4651]

[4647] Exhibit 32, Tab 73, Letter of Instruction to Dr Linda Iles, 23 November 2022 (SCOI.82890).

[4648] Submissions of Miller Family, 30 June 2023, [16]–[19] (SCOI.84265).

[4649] Exhibit 32, Tab 105, Letter of Instruction to Dr Victoria Kueppers, 8 September 2023 (SCOI.85713).

[4650] See Exhibit 32, Tab 8, Statement of Detective Senior Constable Lyle Van Leeuwen, 14 June 1997, [6] (SCOI.83347); Exhibit 32, Tab 9, Crime Scene Photographs, 3 March 1997, photographs 3, 4, 5, and 6 (SCOI.83350); Exhibit 32, Tab 5, Statement of Senior Constable Michael Lane, 1 May 1997, [11] (SCOI.02737.00051).

[4651] See Exhibit 32, Tab 8, Statement of Detective Senior Constable Lyle Van Leeuwen, 14 June 1997, [6] (SCOI.83347); Exhibit 32, Tab 14, Statement of Detective Senior Sergeant Carlton Graeme Cameron, 3 October 1997, [4] (SCOI.02737.00069); Exhibit 32, Tab 9, Crime Scene Photographs, 3 March 1997, photographs 13–18 (SCOI.83350).

5.5003. The Inquiry engaged Peter Jobson, Information Botanist at the Australian Institute of Botanical Science, Royal Botanic Gardens and Domain Trust, to provide an expert opinion regarding the vegetation observed in the area where Mr Miller's body was found.[4652]

5.5004. Mr Jobson provided an expert report dated 5 October 2023, which is discussed below.

Further forensic examination on Mr Miller's clothing

Blood pattern analysis

5.5005. The Inquiry engaged Ms Gerhard and Ms Roebuck of Independent Forensic Services to conduct an examination in relation to Mr Miller's clothing, and to provide an expert opinion about conclusions that could be drawn from the bloodstain patterns on Mr Miller's clothing or observable in crime scene photographs.

5.5006. Ms Gerhard and Ms Roebuck are forensic scientists. Amongst other disciplines, Ms Gerhard is an expert in blood pattern analysis, a field that utilises the underpinning sciences of physics, mathematics and biology to provide opinions on the events or mechanisms responsible for blood stains.[4653]

5.5007. The questions and topics on which an opinion was sought included:[4654]

a. The cause/s (or possible cause/s) of blood patterns observed on Mr Miller's face and clothing;

b. Whether Mr Miller's body fell to the location where it was found, or whether it was moved to that location;

c. Whether there were any marks or damage to Mr Miller's clothing or shoes that could suggest he climbed over a fence while wearing them; and

d. Any conclusions that can be drawn as to the manner and cause of Mr Miller's death.

5.5008. Ms Gerhard and Ms Roebuck examined Mr Miller's clothing on 8 May 2023. Ms Gerhard furnished a report to the Inquiry dated 29 May 2023.[4655] Ms Gerhard's opinions are addressed below.

[4652] Exhibit 32, Tab 107, Letter of Instruction to Australian Institute of Botanical Science, 21 September 2023 (SCOI.85971).

[4653] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [8.3.1] (SCOI.83328).

[4654] Exhibit 32, Tab 75, Letter of Instruction to Independent Forensic Services, 24 April 2023 (SCOI.83326).

[4655] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023 (SCOI.83328).

Further testing of the blood staining on Mr Miller's shirt

5.5009. In written submissions dated 30 June 2023, the Miller family submitted that a more detailed examination of Mr Miller's clothing should be undertaken.[4656] In light of that submission, on 26 July 2023 the Inquiry requested a supplementary opinion from Ms Gerhard, in her capacity as both a forensic scientist and a blood pattern analyst, in relation to further avenues for forensic testing.[4657]

5.5010. Ms Gerhard furnished a supplementary report to the Inquiry dated 21 August 2023.[4658]

5.5011. Ms Gerhard confirmed that the overall bloodstain patterns on Mr Miller's shirt had the appearance of originating from the wearer of the shirt (i.e. Mr Miller). However, she observed that there were a number of small discrete stains that could "potentially" originate from someone else. Ms Gerhard identified four such discrete stains by marking photographs of the t-shirt.[4659]

5.5012. Following the receipt of Ms Gerhard's supplementary expert report, the Inquiry requested that FASS undertake further DNA testing of the discrete blood stains on Mr Miller's shirt identified by Ms Gerhard.[4660] The results of that further testing are set out in an expert certificate of Ms Friedman of FASS, discussed below.

Consideration of testing of the staining on Mr Miller's jeans

5.5013. Ms Gerhard also considered the forensic opportunities for testing the staining on Miller's jeans. Ms Gerhard noted that no blood was detected, but there was some "generalised staining" with a "dirty appearance" on the front and back of the jeans, and a "sticky type material" on the inside cuffs/seams of the jeans which also tested negative for blood.[4661] Ms Gerhard stated that it may be possible to do chemical analysis on the jeans to further identify the dirt type material and sticky residue, and recommended seeking the opinion of a forensic chemist as to what types of analysis could be performed and the likely probative value.[4662]

5.5014. In response to Ms Gerhard's recommendation, the Inquiry had a preliminary phone call with Professor Roux, in his capacity as a forensic scientist, regarding the testing possibilities for the staining on the jeans. The advice received from Professor Roux was that such testing would be complex and, in his opinion, unlikely to yield evidence that would assist in determining manner and cause of death.[4663]

[4656] Submissions of Miller Family, 30 June 2023, [12]–[14] (SCOI.84265).

[4657] Exhibit 32, Tab 100, Letter of Instruction to Jae Gerhard, 26 July 2023 (SCOI.85166).

[4658] Exhibit 32, Tab 98, Supplementary Expert Report of Jae Gerhard, 21 August 2023 (SCOI.85167).

[4659] Supplementary Expert Report of Jae Gerhard, 21 August 2023, [11.2], [12.2] (SCOI.85167); Exhibit 32, Tab 99, Appendix B to Supplementary Expert Report of Jae Gerhard, 21 August 2023 (SCOI.85165).

[4660] Exhibit 32, Tab 102, Letter of Instruction to FASS, 21 August 2023 (SCOI.85733).

[4661] Exhibit 32, Tab 98, Supplementary Expert Report of Jae Gerhard, 21 August 2023, [11.1.1]–[11.1.3] (SCOI.85167).

[4662] Exhibit 32, Tab 98, Supplementary Expert Report of Jae Gerhard, 21 August 2023, [11.1.4] (SCOI.85167).

[4663] Exhibit 32, Tab 108, Statement of Penelope Smith, 5 October 2023, [14] (SCOI.86023).

5.5015. After careful consideration, the Inquiry decided there was no utility in pursuing this testing. In the absence of any information as to how long Mr Miller had been wearing the jeans since they were last washed, or what substances he may have come into contact with during that period, the probative value of identifying the staining would be negligible.

Trace DNA testing inside Mr Miller's pockets

5.5016. In her supplementary report, Ms Gerhard noted that trace DNA testing had been conducted by FASS on the inside pockets of the jeans in 2012, without success (discussed above at [5.4959]). She explained that current DNA testing technology is more sensitive than the technology used in 2012, and that it would be possible to retest these DNA samples with current technology. She expressed the opinion that retesting of existing samples should be prioritised, rather than resampling the pockets, since cellular material would already have been removed from the inside of the pockets by the previous sampling.[4664]

5.5017. The Inquiry requested that FASS undertake further DNA testing of the swabs taken from the pockets of Mr Miller's jeans in 2012.[4665] The results of that retesting are set out in the expert certificate of Ms Friedman, and discussed below.

Further trace DNA testing

5.5018. Ms Gerhard considered that sampling and testing further areas of Mr Miller's clothing would be of "limited probative value".[4666]

5.5019. Ms Gerhard explained that trace DNA is DNA that cannot be attributed to a biological fluid, and also encompasses DNA that is deposited by handling or touching items, or that is shed into the environment.[4667]

5.5020. Ms Gerhard explained that trace DNA testing on Mr Miller's clothing would require speculative testing of areas of the clothing that may have been touched by another individual.[4668] Even if a DNA profile was obtained, it would not be possible to evaluate whether this DNA was deposited through some form of contact with Mr Miller, or via indirect DNA transfer through his social interactions.[4669]

5.5021. In relation to indirect transfer, Ms Gerhard noted that the sensitivity of modern DNA testing means that it cannot be assumed that trace DNA profiles are the result of recent direct contact.[4670] DNA can be transferred through activities like talking, sneezing, coughing, breathing or shedding skin cells in an environment, and can be transferred indirectly via another person or object. It is not possible to reliably determine the nature of the deposition.[4671]

[4664] Exhibit 32, Tab 98, Supplementary Expert Report of Jae Gerhard, 21 August 2023, [11.1.5.2] (SCOI.85167).
[4665] Exhibit 32, Tab 102, Letter of Instruction to FASS, 21 August 2023 (SCOI.85733).
[4666] Exhibit 32, Tab 98, Supplementary Expert Report of Jae Gerhard, 21 August 2023, [12.3] (SCOI.85167).
[4667] Exhibit 32, Tab 98, Supplementary Expert Report of Jae Gerhard, 21 August 2023, [11.1.5.1] (SCOI.85167).
[4668] Exhibit 32, Tab 98, Supplementary Expert Report of Jae Gerhard, 21 August 2023, [11.1.5.3], [12.3] (SCOI.85167).
[4669] Exhibit 32, Tab 98, Supplementary Expert Report of Jae Gerhard, 21 August 2023, [11.1.5.5], [12.3] (SCOI.85167).
[4670] Exhibit 32, Tab 98, Supplementary Expert Report of Jae Gerhard, 21 August 2023, [9.2.1] (SCOI.85167).
[4671] Exhibit 32, Tab 98, Supplementary Expert Report of Jae Gerhard, 21 August 2023, [9.2.2] (SCOI.85167).

5.5022. In Mr Miller's case, it is known that he was wearing his clothing from at least midday on Saturday, 1 March 1997, when he drove to the home of his friend Shawn Kelly. He then wore the same clothing while socialising with friends, attending the Mardi Gras Parade and attending the Observer Hotel in The Rocks. It is not known when he last washed his jeans or t-shirt. Accordingly, the presence of other DNA profiles may be expected, and is of no probative value to the Inquiry into the manner and cause of his death.

5.5023. Ms Gerhard finally noted that Mr Miller's clothing has been reexamined on multiple occasions, and there is a possibility that DNA (whether it be trace DNA or bloodstaining) could have been redistributed on other areas of the clothing.[4672] This factor again reduces the probative value of any result that may be achieved by testing for trace DNA.

5.5024. Guided by Ms Gerhard's opinions, no further steps were taken to sample Mr Miller's clothing to test for trace DNA.

Forensic examination of debris found in Mr Miller's hand

5.5025. As outlined above, during the post-mortem examination of Mr Miller's body, Dr Duflou retained debris taken from the right hand of Mr Miller. By letter dated 24 May 2023, the Inquiry requested a statement from a police officer as to the nature of the debris found in Mr Miller's right hand during the post-mortem examination, and any forensic testing that had been conducted on the debris.[4673]

5.5026. On 7 June 2023, the Inquiry received a letter from the NSWPF enclosing a statement of Inspector Andrew Brady of FETS dated 7 June 2023.[4674]

5.5027. According to that statement: the debris was located in the State Archives, but had not been booked into the EFIMS until 31 May 2023;[4675] there is no record of the debris being entered as an exhibit into the Physical Evidence Case Management System;[4676] and no previous forensic testing had been completed on the debris.[4677]

Inspection by the NSWPF

5.5028. At the request of the Inquiry,[4678] Inspector Brady visually examined the debris on 2 June 2023 and noted that it is a single piece of brown/orange (rust) debris, trapezoidal in shape (6 millimetres by 4 millimetres), with red staining on both sides which appeared to be blood.[4679]

5.5029. The debris also demonstrated magnetic properties.[4680]

[4672] Exhibit 32, Tab 98, Supplementary Expert Report of Jae Gerhard, 21 August 2023, [11.1.5.4] (SCOI.85167).

[4673] Exhibit 32, Tab 76, Letter from Enzo Camporeale to Patrick Hodgetts, 24 May 2023 (SCOI.83527).

[4674] Exhibit 32, Tab 79, Statement of Inspector Andrew Brady, 7 June 2022 (NPL.9000.0017.0072).

[4675] On 31 May 2023, the debris was booked into the EFIMS with reference X0000542512: Exhibit 32, Tab 79, Statement of Inspector Andrew Brady, 7 June 2022, [16]–[17] (NPL.9000.0017.0072).

[4676] Exhibit 32, Tab 79, Statement of Inspector Andrew Brady, 7 June 2022, [17]–[18], [24] (NPL.9000.0017.0072).

[4677] Exhibit 32, Tab 79, Statement of Inspector Andrew Brady, 7 June 2022, [35] (NPL.9000.0017.0072).

[4678] Exhibit 32, Tab 76, Letter from Enzo Camporeale to Patrick Hodgetts, 24 May 2023 (SCOI.83527).

[4679] Exhibit 32, Tab 79, Statement of Inspector Andrew Brady, 7 June 2022, [29]–[32] (NPL.9000.0017.0072).

[4680] Exhibit 32, Tab 79, Statement of Inspector Andrew Brady, 7 June 2022, [29]–[32] (NPL.9000.0017.0072).

5.5030. Inspector Brady provided the opinion that the debris appears to be neither gravel nor organic/plant material, but that it has some metallurgical properties.[4681] Inspector Brady stated that further analysis would be required to definitively conclude the nature of the debris.[4682]

5.5031. On 30 June 2023, following enquiries made by the Inquiry, the NSWPF indicated that there were no suitably qualified officers at the FETS Command to undertake the required further analysis of the debris.[4683]

Examination by Professor Claude Roux

5.5032. On 1 August 2023, the Inquiry requested that Professor Roux, forensic scientist and Director of the UTS Centre for Forensic Science, conduct a forensic examination of the debris.[4684]

5.5033. Professor Roux conducted an optical examination of the sample, with and without magnification. The optical examination revealed three visible layers, two described as "grey/brown, rusty", and one described as "white/light".[4685]

5.5034. The debris was then examined by two techniques:[4686]

a. "Fourier Transform Infrared Spectroscopy" (**FTIR**); and

b. "Laser Ablation-Inductively Coupled Plasma Mass Spectrometry" (**LA-ICP-MS**).

5.5035. Professor Roux provided an expert report dated 25 August 2023. The results of his examination are set out below.

DNA Testing of the surface of the debris

5.5036. Prior to the transportation of the debris from the custody of the NSWPF to the UTS Centre for Forensic Science, Sergeant Hayley Bennett of FETS collected a swab from each side of the debris, which were labelled "side A" and "side B".[4687]

5.5037. Virginia Friedman of FASS reported the following results from the testing of those swabs:[4688]

a. A partial profile the same as Mr Miller's was recovered from the side A swab; and

[4681] Exhibit 32, Tab 79, Statement of Inspector Andrew Brady, 7 June 2022, [34] (NPL.9000.0017.0072).

[4682] Exhibit 32, Tab 79, Statement of Inspector Andrew Brady re debris, 7 June 2023, [34] (NPL.9000.0017.0072).

[4683] Exhibit 32, Tab 92, Letter from Enzo Camporeale to Patrick Hodgetts, 30 June 2023 (SCOI.85739); Exhibit 32, Tab 93, Letter from Katherine Garaty to Enzo Camporeale, 3 July 2023 (SCOI.85740).

[4684] Exhibit 32, Tab 95, Letter of Instruction to Professor Claude Roux, 1 August 2023 (SCOI.85316).

[4685] Exhibit 32, Tab 94, Expert Report of Professor Claude Roux, 25 August 2023, 2 (SCOI.85317).

[4686] Exhibit 32, Tab 94, Expert Report of Professor Claude Roux, 25 August 2023, 2 (SCOI.85317).

[4687] Side "A" has EFIMS reference XF000536277 and Side "B" has EFIMS reference XF000536278.

Exhibit 32, Tab 96, Statement of Sergeant Hayley Bennett, 20 September 2023, [12] (NPL.9000.0036.0001); See also Exhibit 32, Tab 93, Letter from Katherine Garaty to Enzo Camporeale, 3 July 2023 (SCOI.85740); Exhibit 32, Tab 101, Expert Certificate of Virginia Friedman, 22 September 2023, 1 (SCOI.85779).

[4688] Exhibit 32, Tab 101, Expert Certificate of Virginia Friedman, 22 September 2023, 2 [R1], [R2] (SCOI.85779).

b. The profile recovered from side B was "not suitable for comparison due to the low level", which was explained to mean that DNA profiling was carried out, but "a very limited amount of DNA profile information was recovered, and as such, the result is not suitable for meaningful comparison".[4689]

5.5038. The results of the DNA testing of the swabs do not advance the inquiry into the manner and cause of Mr Miller's death.

Fibre attached to the debris

5.5039. On 31 July 2023, in the process of swabbing each side of the debris, Sergeant Bennett located a "very small fibre attached to the piece of debris which dislodged when turning the debris over".[4690] The fibre was approximately 1 millimetre in length.[4691]

5.5040. Inspector Brady provided a supplementary statement dated 28 September 2023 in which he stated that the fibre appeared to be attached to the debris at the time of his examination on 2 June 2023.[4692] In his view it was likely that the fibre became detached from the debris following his examination and the swabbing of the debris by Sergeant Bennett.[4693]

5.5041. On 6 September 2023, the Inquiry requested that FASS conduct a forensic analysis of the possible fibre to determine its nature and origin.[4694]

5.5042. The fibre was then tested by FASS, and Ms Friedman determined that the possible fibre was, in fact, two fibres. These fibres were not identified to be human or animal hair, and were not suitable for nuclear DNA testing.[4695] Accordingly, no information can be gleaned from the fibre located on the debris found in Mr Miller's hand.

5.5043. At the time of examining the fibre, Ms Friedman located a hair that appeared to be of animal origin on the outside of the container in which it had been placed.[4696] Since the fibre was located in 2023 and subsequently placed into the container, materials on the outside of that container were determined to be not relevant to Mr Miller's death.[4697]

[4689] Exhibit 32, Tab 101, Expert Certificate of Virginia Friedman, 22 September 2023, 3 [5.3] (SCOI.85779).

[4690] Exhibit 32, Tab 96, Statement of Sergeant Hayley Bennett, 20 September 2023, [13] (NPL.9000.0036.0001).

[4691] The fibre has EFIMS reference XF000536279.

Exhibit 32, Tab 96, Statement of Sergeant Hayley Bennett, 20 September 2023, [13] (NPL.9000.0036.0001).

[4692] Exhibit 32, Tab 97, Supplementary Statement of Inspector Andrew Brady, 28 September 2023, [14] (NPL.9000.0037.0001), annexing Exhibit 32, Tab 97D, High-resolution photograph of the debris, annexed and annotated, 15 September 2023 (NPL.0100.0026.0001).

[4693] Exhibit 32, Tab 97, Supplementary Statement of Inspector Andrew Brady, 28 September 2023, [16] (NPL.9000.0037.0001).

[4694] Exhibit 32, Tab 103, Letter of Instruction to FASS, 6 September 2023 (SCOI.85734).

[4695] Exhibit 32, Tab 101, Expert Certificate of Virginia Friedman, 22 September 2023, 2 [8a] and [8b] (SCOI.85779); Exhibit 32, Tab 108, Statement of Penelope Smith, 5 October 2023, [15]–[16] (SCOI.86023).

[4696] Exhibit 32, Tab 101, Expert Certificate of Virginia Friedman, 22 September 2023, 2 [8c] (SCOI.85779).

[4697] Supplementary Submissions of Counsel Assisting, 18 October 2023, [47] (SCOI.86272).

Other

5.5044. In 1998, after the inquest into Mr Miller's death, his parents Stuart and Christine Miller retained a private investigator from Bentley Hunt and Associates to investigate their son's death. The Inquiry made attempts to obtain any documents obtained or created by the private investigator. Investigations by the Inquiry revealed that Bentley Hunt and Associates is permanently closed, and the Inquiry has been advised by the Miller family that they do not have a copy of the private investigation file. Shane Miller advised that that no investigations appeared to have been conducted.[4698]

Consideration of the evidence

Mr Miller's personal background

5.5045. Miller was born on 27 July 1975 to parents Stuart Miller and Christine Miller. He was the second of three sons, with brothers Mark Miller and Shane Miller. Mr Miller grew up in Orange and had close relationships with his family and friends. He was a keen footballer. Following his schooling, he completed an electrical apprenticeship and had been accepted by the University of Western Sydney to study Sport Science. It was for that reason that he moved from Orange to Sydney. He moved on the Monday prior to his death.[4699]

5.5046. Although he grew up in Orange, Mr Miller had travelled to Sydney on a number of occasions, either travelling with his football team or to visit friends. He would usually stay with either Mr Kelly or Nathan White, both of whom he knew from Orange. The friends would often go to the pubs in North Sydney, The Rocks or Kings Cross, and Mr White considered that Mr Miller had a reasonably good knowledge of the Sydney area and how to get around. Mr Miller also enjoyed gambling, and it would not have been unusual for him to end a night by going to the Casino in Darling Harbour.[4700]

Indicators of LGBTIQ bias

5.5047. Mr Miller was heterosexual and had a steady girlfriend at the time of his death, Ms Bridget Lott.[4701] They had been together on and off for about five years.[4702] There is no suggestion in the evidence that Mr Miller was, or that he was perceived to be, a member of the LGBTIQ community.

[4698] Exhibit 32, Tab 81, Statement of Kathryn Lockery, 14 June 2023, [23]–[25] (SCOI.83681).

[4699] Exhibit 32, Tab 5, Statement of Senior Constable Michael Lane, 1 May 1997, [49] (SCOI.02737.00051).

[4700] Exhibit 32, Tab 22, Statement of Nathan White, 4 March 1997, [5]–[6](SCOI.10048.00019); Exhibit 32, Tab 20, Statement of Shawn William Kelly, 4 March 1997, [4] (SCOI.10049.00031); Exhibit 32, Tab 42, Transcript of Coronial Inquest into the death of Scott Miller, 7 October 1997, 13 (SCOI.02737.00041).

[4701] Exhibit 32, Tab 80, Statement of Bridget Lott, 6 June 2023, [3], [6] (SCOI.83636).

[4702] Exhibit 32, Tab 80, Statement of Bridget Lott, 6 June 2023, [3] (SCOI.83636).

Mr Miller's movements before death

5.5048. The weekend of Mr Miller's death was his first since moving to Sydney. According to Ms Lott, he was "a country boy excited to be out in Sydney and explore 'the Big Smoke'."[4703] In a letter he wrote to her on the Friday before his death, he said:[4704]

> *Tomorrow Shawny and me are meeting up, getting some lunch and a swim and joining up with Whitey to go out. We might even have a look at the Mardi Gras.*

5.5049. Consistent with this plan, at about midday on Saturday, 1 March 1997, Mr Miller drove to Mr Kelly's home in Maroubra. At about 5:00pm, Mr Miller and Mr Kelly drove together in Mr Kelly's car to Mr White's house in Willoughby.[4705] Another friend, Jason Elvy, joined them there, as well as two other young men.[4706] The friends shared a case of beer and a bottle of tequila.[4707] A few of them also smoked some marijuana. Mr Elvy thought that Mr Miller "possibly" had a cone of marijuana, but Mr White stated that Mr Miller did not normally smoke it and did not have any that night.[4708]

5.5050. Between around 9:30pm and 10:30pm, Mr Miller, Mr Kelly, Mr White and Mr Elvy travelled by taxi to Oxford Street, Darlinghurst, and watched the last hour of the Mardi Gras Parade. At about 11:30pm, after the parade concluded, they walked down Oxford Street, and then travelled by taxi to George Street in The Rocks. Mr Elvy and Mr Kelly went into the Orient Hotel, while Mr Miller and Mr White went to the Observer Hotel.[4709]

5.5051. The bartender at the Observer Hotel observed that Mr Miller and Mr White were "obviously intoxicated." She refused to serve them drinks.[4710] The bar manager believed Mr Miller was "extremely intoxicated" and described that "his eyes were red and watery and [he] had a vague look about him."[4711] The pair were asked to leave.[4712]

5.5052. Mr Miller and Mr White walked back to the Orient Hotel. On the way, Mr Miller started talking to two women. Mr White yelled out to Mr Miller that he would meet him in the Orient Hotel, and went ahead to meet Mr Kelly and Mr Elvy.[4713]

[4703] Exhibit 32, Tab 80, Statement of Bridget Lott, 6 June 2023, [5]–[6] (SCOI.83636).

[4704] Exhibit 32, Tab 80, Statement of Bridget Lott, 6 June 2023, [5] (SCOI.83636).

[4705] Exhibit 32, Tab 20, Statement of Shawn William Kelly, 4 March 1997, [6]–[7] (SCOI.10049.00031).

[4706] Exhibit 32, Tab 22, Statement of Nathan White, 4 March 1997, [10] (SCOI.10048.00019).

[4707] Exhibit 32, Tab 22, Statement of Nathan White, 4 March 1997, [10]–[11], [13] (SCOI.10048.00019).

[4708] Exhibit 32, Tab 21, Statement of Jason Elvy, 4 March 1997, [7] (SCOI.02737.00055); Exhibit 32, Tab 22, Statement of Nathan White, 4 March 1997 (SCOI.10048.00019).

[4709] Exhibit 32, Tab 22, Statement of Nathan White, 4 March 1997, [13]–[16] (SCOI.10048.00019); Exhibit 32, Tab 20, Statement of Shawn Kelly, 4 March 1997, [12]–[13] (SCOI.10049.00031); Exhibit 32, Tab 21, Statement of Jason Elvy, 4 March 1997, [8] (SCOI.02737.00055).

[4710] Exhibit 32, Tab 32, Statement of Chloe Green, 20 March 1997, [4] (SCOI.02737.00057).

[4711] Exhibit 32, Tab 24, Statement of Stephen Swart, 6 March 1997, [7] (SCOI.02737.00058).

[4712] Exhibit 32, Tab 33, Statement of Manni Solomona, 27 March 1997, [5]–[6] (SCOI.02737.00059).

[4713] Exhibit 32, Tab 22, Statement of Nathan White, 4 March 1997, [17]–[18] (SCOI.10048.00019).

5.5053. At about 1:30am, Mr Kelly left the Orient Hotel in order to meet his brother, who finished work at 2:00am. On his way, he saw Mr Miller walking outside the Orient Hotel. He said to Mr Miller, "The boys are in the Orient, go in there." Mr Miller replied, "Right Oh," and then Mr Kelly left to meet his brother.[4714]

5.5054. When Mr Kelly returned to the Orient Hotel about ten minutes later, Mr Miller was not there and no one had seen him.[4715]

5.5055. At about 2:10am (on the Sunday morning), a local resident named Jade Carter sighted a person, who seems likely to have been Mr Miller, walking down Watson Road from Observatory Hill about twenty paces behind her. She described this person as:[4716]

> *…a young man in his early 20s… He had a white TShirt [sic] which was tucked into his jeans, faded pale blue jeans that were a good fit, dark belt and dark shoes. He appeared to be well dressed… He didn't appear to have any injuries, his clothes were neat and tidy and he didn't look out of the ordinary.*

5.5056. The location where Ms Carter describes seeing this person is only about 600 metres from Munn Reserve.[4717]

The discovery of Mr Miller's body

5.5057. At 7:50am on Monday, 3 March 1997, Mr Miller's body was found by two employees of Patricks, lying face down in the machinery yard near Wharf 4. His pulse was checked, but his body was otherwise not moved.[4718]

5.5058. Mr Miller's body was found about 1.1 metres from the base of the cliff, nearly parallel to the cliff face and adjacent to a gutter at the base of the cliff.[4719] He was lying face down with his body laid out straight. His head was pointed towards the eastern side of the machinery yard and turned slightly to the right. His left arm was alongside his body and slightly bent at the elbow, while his right arm was under his body. A portion of ivy was adjacent to his left leg.[4720]

5.5059. Mr Miller was fully clothed, dressed in a pair of blue denim jeans, a white t-shirt over the top of another white t-shirt, a pair of brown shoes, a brown belt and a pair of multicoloured socks. The back and right sleeve of his white t-shirt was stained with blood; testing confirmed that this was Mr Miller's blood.[4721] There was a large pool of blood in the region of his face and upper torso, and a stream of diluted blood had flown from his face.

[4714] Exhibit 32, Tab 20, Statement of Shawn Kelly, 4 March 1997, [17]–[18] (SCOI.10049.00031).

[4715] Exhibit 32, Tab 22, Statement of Nathan White, 4 March 1997, [18] (SCOI.10048.00019); Exhibit 20, Tab 20, Statement of Shawn Kelly, 4 March 1997, [18] (SCOI.10049.00031).

[4716] Exhibit 32, Tab 23, Statement of Jade Carter, 6 March 1997, [4]–[5] (SCOI.10049.00039).

[4717] Exhibit 32, Tab 5, Statement of Senior Constable Michael Lane, 1 May 1997, [62] (SCOI.02737.00051).

[4718] Exhibit 32, Tab 25, Statement of Peter Cowan, 6 March 1997, [7] (SCOI.02737.00060); Exhibit 32, Tab 26, Statement of Jim Gould, 6 March 1997, [6]–[7] (SCOI.02737.00061); Exhibit 32, Tab 27, Statement of Vincent Micallef, 6 March 1997, [4] (SCOI.10048.00026).

[4719] Exhibit 32, Tab 42, Transcript of Coronial Inquest into the death of Scott Stuart Miller, 7 October 1997, 24 (SCOI.02737.00041).

[4720] Exhibit 32, Tab 8, Statement of Detective Senior Constable Lyle Van Leeuwen, 14 June 1997, [6] (SCOI.83347); Exhibit 32, Tab 9, Crime Scene Photographs, 3 March 1997 (SCOI.83350).

[4721] Exhibit 32, Tab 16, Second Statement of Virginia Friedman, 19 May 1998 (SCOI.10048.00006).

5.5060. Mr Miller's wallet was in his back pocket; no fingerprints were observed on examination.[4722] On a later date, police found two Commonwealth credit cards, a university card, a Medicare card and $25 in cash deep in his pockets.[4723] The presence of this property suggests that it is unlikely that Mr Miller was the victim of a robbery.

5.5061. One of the dock workers who found him, Peter Cowan, had also been working on the Sunday. He told police that most of the work on Sunday was on Wharf 8, and that no work was going on near Wharf 4. The machinery yard was only used periodically, about once a week.[4724] These circumstances may explain why Mr Miller's body was not discovered until the Monday morning, despite Dr Duflou estimating his time of death in the early hours of the Sunday morning.[4725]

5.5062. Police were called and arrived by 8:10am on Monday, 3 March 1997.[4726]

Crime scene examination

5.5063. The Patricks compound consisted of ten wharfs, covering approximately 1200–1500 metres along the waterfront, used for loading and unloading international shipping containers. The compound was bordered by a sandstone cliff, at the top of which was the suburb of Miller's Point.[4727]

5.5064. The machinery yard was an infrequently-used part of the wharf where old heavy mechanical machinery was stored. One side of the area abutted a sheer cliff face; the remaining three sides were fenced off with cyclone wire fencing. Entrance was via a gate on the southern end, which was typically left open.[4728] The eastern border of the machinery yard abutted buildings occupied by South Corp Wines and Polygram Music. The area was only accessible from within the Patricks compound; public access was blocked by the fence. An aerial photograph of the location of Mr Miller's body, taken in 1997 shortly after Mr Miller's death, is Annexure A to the submissions of Counsel Assisting dated 15 June 2023.[4729]

5.5065. Police inspected the machinery yard and mapped it using terrestrial photogrammetry technology.[4730] Other than the blood pooled under Mr Miller, there was no evidence of blood staining or droplets around the yard.[4731]

[4722] Exhibit 32, Tab 19, Bundle of NSWPF Running Sheets, 4 March 1997–16 April 1997, 12 (SCOI.83327).

[4723] Exhibit 32, Tab 19, Bundle of NSWPF Running Sheets, 4 March 1997–16 April 1997, 14–15 (SCOI.83327). Police only discovered this property after the clothing had been removed from the body at post-mortem and sent to the Crime Scene Office. The property was missed on an initial check of his pockets, likely due to Mr Miller's jeans having deep pockets.

[4724] Exhibit 32, Tab 25, Statement of Peter Cowan, 6 March 1997, [11] (SCOI.02737.00060).

[4725] Exhibit 32, Tab 2, Post-mortem Report of Dr Johan Duflou, 5 June 1997, 2, 9 (SCOI.02737.00048).

[4726] Exhibit 32, Tab 7, Statement of Constable Sarah Anne Coates, 7 March 1997, [5] (SCOI.02737.00053); Exhibit 32, Tab 6, Statement of Senior Constable Brendan Crowe, 6 March 1997, [5] (SCOI.02737.000052).

[4727] Exhibit 32, Tab 5, Statement of Senior Constable Michael Lane, 1 May 1997. [4] (SCOI.02737.00051)

[4728] Exhibit 32, Tab 31, Statement of John Straube, 14 March 1997 (SCOI.02737.00066).

[4729] Submissions of Counsel Assisting, 15 June 2023, 34 (SCOI.83998).

[4730] Exhibit 32, Tab 12, Terrestrial Photogrammetry Survey of 29-33 Hickson Road, Millers Point, 3 March 1997 (SCOI.83348).

[4731] Exhibit 32, Tab 8, Statement of Detective Senior Constable Lyle Van Leeuwen, 14 June 1997 (SCOI.83347).

5.5066. Munn Reserve was the top of the cliff bordering the machinery yard. Munn Reserve was on the southern side of Bettington Street in Millers Point, near the Palisade Hotel. The western edge of the reserve, which abutted the cliff, was fenced with galvanised chain wire fencing. The chain wire fencing was 1.9 metres off the ground and topped with barbed wire, such that the overall height of the fence was 2.3 metres. A portion of the barbed wire on the top of the fence had come away from the support poles, near where a Melaleuca tree was leaning against it.[4732]

5.5067. Police looked for, but did not observe, any recent scuff or indentation marks on the chain wire fencing or on the galvanised tubular steel top rails, or any holes in the chain wire fence. There were no threads of clothing or material caught on the barbed wire. The leaf litter on the reserve side of the fence showed no obvious signs of being recently disturbed.[4733]

5.5068. Beyond the chain wire fence was a sandstone ledge, approximately 1.8 metres below the ground level of the reserve. The ledge was approximately 1 metre wide and covered with ivy vines and small vegetation. From the ledge down to the machinery yard was a drop of 7 metres.[4734] The vegetation on the ledge did not appear to be disturbed, as police found no evidence of slippage, indentation marks or broken stems.[4735] However, as noted above, a small amount of ivy was found near Mr Miller's leg.

Access to the Patricks compound

5.5069. The Patricks compound was guarded by security officers employed by Patricks. At least two were rostered on each shift. To enter the wharf, it was necessary to go through a security checkpoint at the entrance gate. During each shift, one security guard would conduct mobile patrols by vehicle each hour while the other would stay at the security checkpoint.[4736] As the gate was manned at all times, it would be "very difficult" for someone to come through the gate without security officers knowing.[4737]

[4732] Exhibit 32, Tab 8, Statement of Detective Senior Constable Lyle Van Leeuwen, 14 June 1997, [6] (SCOI.83347).

[4733] Exhibit 32, Tab 8, Statement of Detective Senior Constable Lyle Van Leeuwen, 14 June 1997, [6] (SCOI.83347); Exhibit 32, Tab 14, Statement of Detective Senior Sergeant Carlton Cameron, 3 October 1997, [5] (SCOI.02737.00069).

[4734] Exhibit 32, Tab 8, Statement of Detective Senior Constable Lyle Van Leeuwen, 14 June 1997, [6] (SCOI.83347).

[4735] Exhibit 32, Tab 8, Statement of Detective Senior Constable Lyle Van Leeuwen, 14 June 1997, [6] (SCOI.83347); Exhibit 32, Tab 14, Statement of Detective Senior Sergeant Carlton Cameron, 3 October 1997, [5]–[6] (SCOI.02737.00069).

[4736] Exhibit 32, Tab 36, Statement of Lance Neilson, 28 October 1997, [5] (SCOI.02737.00039); Exhibit 32, Tab 31, Statement of John Straube, 14 March 1997 (SCOI.02737.00066); Exhibit 32, Tab 34, Statement of Warren White, 6 October 1997 (SCOI.02737.00038); Exhibit 32, Tab 35, Statement of Stephen Williams, 6 October 1997 (SCOI.02737.00040); Exhibit 32, Tab 29, Statement of Colin Plant, 13 March 1997 (SCOI.02737.00064); Exhibit 32, Tab 30, Statement of Archibald Price, 14 March 1997 (SCOI.02737.00065).

[4737] Exhibit 32, Tab 36, Statement of Lance Neilson, 28 October 1997, [5] (SCOI.02737.00039); Exhibit 32, Tab 34, Statement of Warren White, 6 October 1997 (SCOI.02737.00038); Exhibit 32, Tab 35, Statement of Stephen Williams, 6 October 1997 (SCOI.02737.00040).

5.5070. The security officers conducting mobile patrols would drive past the machinery yard but would not enter it.[4738] Until about 4:00am on Sunday, 2 March 1997, the area would have been lit by floodlights. After that time, the floodlights were switched off but pilot lights remained on. The security checkpoint was only about 100 metres away from the machinery yard.[4739]

5.5071. Police obtained a statement from each security officer who worked at Patricks from the night that Mr Miller was last seen alive to the morning that his body was found. No security officer reported seeing anything suspicious or unusual during their shifts, including in the machinery yard.[4740] The statements do not record whether any persons or vehicle were authorised to pass through the security gate during the window of time in which Mr Miller's death occurred. However, a police running sheet (undated) includes the following notation:[4741]

> *Persons allowed through gates – Shipping agents, Maritime staff, Customs/quarantine staff, staff of vessels. Most of the people allowed through gate are known to staff or show passes stating what vessels they are on.*

5.5072. The security officers told police that, on the night of Saturday, 1 March 1997 until about 3:00am the following (Sunday) morning, a New Zealand ship called the Ranginui was unloading containers and timber on Wharf 4.[4742]

Conflicting opinions as to the manner and cause of Mr Miller's death

5.5073. As noted above, conflicting opinions have been expressed as to the manner and cause of Mr Miller's death. The divergence of views has principally turned on whether the evidence supports Mr Miller's injuries being sustained after a fall from the cliff next to where his body was found, or alternatively is consistent with them being inflicted by a person or persons who assaulted Mr Miller. These various opinions are summarised below.

June/October 1997: Opinion of Dr Duflou

5.5074. In his post-mortem report dated 5 June 1997, Dr Duflou considered that the manner by which the injuries were sustained remains unclear, but posited three possible scenarios:[4743]

a. Scenario 1: That the injuries were inflicted by one or more persons in a homicidal fashion. In this scenario, the head injury may represent impact with a heavy object swung against the forehead (e.g. a length of timber), and injuries to the liver and kidney may similarly have been inflicted by one or more

[4738] Exhibit 32, Tab 36, Statement of Lance Neilson, 28 October 1997, [5]–[6] (SCOI.02737.00039); Exhibit 32, Tab 34, Statement of Warren White, 6 October 1997 (SCOI.02737.00038).

[4739] Exhibit 32, Tab 31, Statement of John Straube, 14 March 1997 (SCOI.02737.00066).

[4740] Exhibit 32, Tab 36, Statement of Lance Neilson, 28 October 1997, [5] (SCOI.02737.00039); Exhibit 32, Tab 31, Statement of John Straube, 14 March 1997 (SCOI.02737.00066); Exhibit 32, Tab 34, Statement of Warren White, 6 October 1997 (SCOI.02737.00038); Exhibit 32, Tab 35, Statement of Stephen Williams, 6 October 1997 (SCOI.02737.00040); Exhibit 32, Tab 29, Statement of Colin Plant, 13 March 1997 (SCOI.02737.00064); Exhibit 32, Tab 30, Statement of Archibald Price, 14 March 1997 (SCOI.02737.00065).

[4741] Exhibit 32, Tab 19, Bundle of NSWPF Running Sheets, 4 March 1997–16 April 1997, 3 (SCOI.83327).

[4742] Exhibit 32, Tab 36, Statement of Lance Neilson, 28 October 1997, [4] (SCOI.02737.00039).

[4743] Exhibit 32, Tab 2, Post-mortem Report of Dr Johan Duflou, 5 June 1997, 10 (SCOI.02737.00048).

persons either kicking Mr Miller or hitting him with an object. The wrist injuries may be defensive injuries.

b. Scenario 2: That the injuries were sustained during a fall from a height. Dr Duflou stated that the wrist injuries, and possibly the head and abdominal injuries, could have been sustained during a fall from a height. However, he qualified this opinion by noting that "both the head and abdominal injuries… are somewhat atypical for a fall from a height."

c. Scenario 3: A combination of Scenarios 1 and 2. This combination was said by Dr Duflou to "explain all the injuries satisfactorily, and the sequence would most likely have been an assault followed by a fall from a height." He hypothesised that Mr Miller could have been moved to the place he was found.

5.5075. Dr Duflou observed that each of the scenarios he posited had "inherent difficulties."[4744]

5.5076. At the coronial hearing in October 1997, Dr Duflou gave evidence that some of the injuries that Mr Miller received, particularly to the front of his neck and his wrists, could only be consistent with a fall if Mr Miller had moved at least a small amount following the fall.[4745] He expanded upon the comment in his report that the injuries were "atypical" for a fall from a height, stating:[4746]

> *The head injury itself was more consistent with a blow more in the middle, a transverse blow as well as more a vertical blow to the neck itself. The abdominal injuries are unusual in that there were no associated rib fractures or pelvic fractures, yet there were quite significant abdominal injuries. You'd expect if he fell onto a flat surface in any case that to have abdominal injuries you'd have to have injuries on either side and there was none.*

5.5077. He agreed that this lent support to the theory that Mr Miller was killed in a homicidal attack.[4747]

5.5078. Dr Duflou was asked which of the three scenarios was more likely. He gave the following evidence:[4748]

> *… My understanding is that there is no evidence at all of the Deceased having been on top of the cliff face.*
>
> *Coroner: That is correct.*
>
> *Witness: If that's the case the Deceased could not have fallen from the cliff face or from the top of the cliff face and it sounds unlikely to me that he in fact started climbing the cliff face as an alternative. In that case the Deceased would more likely than not have been killed in a homicidal fashion. The, I suppose the only major reason why a fall from the cliff face was a possibility was the fact that he was found at the bottom of a cliff*

[4744] Exhibit 32, Tab 2, Post-mortem Report of Dr Johan Duflou, 5 June 1997, 10 (SCOI.02737.00048).

[4745] Exhibit 32, Tab 42, Transcript of Coronial Inquest into the death of Scott Stuart Miller, 7 October 1997, 6 (SCOI.02737.00041).

[4746] Exhibit 32, Tab 42, Transcript of Coronial Inquest into the death of Scott Stuart Miller, 7 October 1997, 5 (SCOI.02737.00041).

[4747] Exhibit 32, Tab 42, Transcript of Coronial Inquest into the death of Scott Stuart Miller, 7 October 1997, 6 (SCOI.02737.00041).

[4748] Exhibit 32, Tab 42, Transcript of Coronial Inquest into the death of Scott Stuart Miller, 7 October 1997, 5 (SCOI.02737.00041).

face. If he had been found anywhere else I would have been prepared to say that homicide was by far the most likely manner of death.

June/October 1997: Opinion of Detective Senior Constable Van Leeuwen

5.5079. Detective Senior Constable Van Leeuwen, crime scene examiner, expressed the view that the death of Mr Miller was "suspicious". He provided the following opinions and/or observations from his examination of the crime scene:[4749]

a. "The presence of blood stains on the back of the deceased's white T shirt can not be explained and is of a suspicious nature."

b. "The lack of separate individual blood spots throughout the machinery yard indicate that the deceased did not stagger around the machinery yard."

c. "The deceased was located lying face down on the ground at the base of the cliff. If he had fallen or jumped from Munns Reserve I would have expected his position to have been more contorted than it was."

d. "The deceased had a lack of external injuries usually seen in a person who has died as a result of a fall. If he had fallen or jumped from Munns Reserve, he could have fallen a distance of between 7 and 11.1 metres."

e. "There was a lack of trace evidence on the fencing at the western end of Munns Reserve indicating that the deceased had climbed the fence. It is not uncommon for clothing fibres or shoe imprints to be found on chain or barbed wire fencing or framework."

f. "There was no disturbance to the vegetation or ivy on the outside of the fence at the western end of Munns Reserve."

g. "There were no holes in the chain wire fence at the western end of Munns Reserve."

5.5080. Detective Senior Constable Van Leeuwen gave evidence at the coronial hearing. In relation to the vegetation at the top of the cliff, he stated that the dead leaf matter on the reserve side of the fence would not be expected to "yield any evidence" as to whether there had been people through there; however, the ivy on the outside of the fence breaks easily and would tend to leave definite indentation marks if someone had walked, stumbled, fallen or rolled through it.[4750]

5.5081. Detective Senior Constable Van Leeuwen considered that it was possible for a person to fall from the fence without touching the ivy, but for that to happen the body would have ended up further from the cliff than 1.1 metres. He stated that this opinion was based on his expertise and "physics calculations."[4751] Detective Senior Constable Van Leeuwen's expertise for advancing such an opinion was not established.

[4749] Exhibit 32, Tab 8, Statement of Detective Senior Constable Lyle Van Leeuwen, 14 June 1997, 9–10 (SCOI.83347).

[4750] Exhibit 32, Tab 42, Transcript of Coronial Inquest into the death of Scott Stuart Miller, 7 October 1997, 8 (SCOI.02737.00041).

[4751] Exhibit 32, Tab 8, Statement of Detective Senior Constable Lyle Van Leeuwen, 14 June 1997, 8 (SCOI.83347).

5.5082. Detective Senior Constable Van Leeuwen described the blood stains on the back of Mr Miller's t-shirt as "the most crucial piece of forensic evidence" supporting his view that Mr Miller's death was a homicide, not a fall. He considered that one scenario, as to how the blood could have been positioned on his back in that way, was that Mr Miller was assaulted in another place and then laid down in the back of a vehicle, and had been bleeding on his back.[4752]

June/October 1997: Opinion of Detective Senior Sergeant Cameron

5.5083. Detective Senior Sergeant Carlton Cameron, a more senior crime scene examiner than Detective Senior Constable Van Leeuwen, provided the following opinions as to the manner in which Mr Miller sustained his injuries based on his observations of the crime scene:[4753]

a. In relation to the vegetation on the outside of the fence at Munn Reserve, "none of the vegetation had the appearance of having slipped southward towards the cliff edge as I would have expected had someone slipped, fallen or been pushed over the cliff edge."

b. If someone had been carried to and lifted up to the top of the fence, and pushed over the fence, he would have expected "more damage to the fence, the vegetation and for there to be physical evidence adhering to the barbed wire."

5.5084. In his evidence at the coronial hearing, Detective Senior Sergeant Cameron expressed the view that he did not believe that Mr Miller "came through or over the fence" in Munn Reserve, and that Mr Miller's injuries were not sustained by a fall.[4754]

1997: Opinion of Plain Clothes Senior Constable Michael Lane

5.5085. Contrary to those opinions of officers from the Crime Scene Unit, Plain Clothes Senior Constable Michael Lane, the original OIC of the investigation, formed the opinion that Mr Miller accidentally fell from the cliff.[4755]

5.5086. His theory was that Mr Miller was attempting to go from The Rocks to the casino in Darling Harbour, where he liked to go after a night out. On his way, he may have become lost or disoriented and walked up Observatory Hill, where he was seen by Ms Carter. He then walked the relatively short distance to Munn Reserve, from where you can see Darling Harbour and the casino. Once at the cliff, Mr Miller may have attempted to take a short-cut down. He scaled the fence, which was made easier due to the barbed wire being down at one point off the fence. Once over the fence, Mr Miller may have either slipped and fallen, or he may have realised there was no way down and fallen asleep and rolled off the cliff.[4756]

[4752] Exhibit 32, Tab 8, Statement of Detective Senior Constable Lyle Van Leeuwen, 14 June 1997, 9 (SCOI.83347).

[4753] Exhibit 32, Tab 14, Statement of Detective Senior Sergeant Carlton Cameron, 3 October 1997, [4]–[5] (SCOI.02737.00069).

[4754] Exhibit 32, Tab 42, Transcript of Coronial Inquest into the death of Scott Stuart Miller, 7 October 1997, 10–11 (SCOI.02737.00041).

[4755] Exhibit 32, Tab 5, Statement of Senior Constable Michael Lane, 1 May 1997, [70] (SCOI.02737.00051).

[4756] Exhibit 32, Tab 5, Statement of Senior Constable Michael Lane, 1 May 1997, [63]–[66], [70] (SCOI.02737.00051).

5.5087. As part of Plain Clothes Senior Constable Lane's investigation, he noted that Mr Miller was found in an almost identical position to a deceased male who had fallen from scaffolding on the Opera House,[4757] in effect contradicting the opinion of Detective Senior Constable Van Leeuwen that the position of the body was less contorted than would be expected following a fall.

October 1997: Coronial findings

5.5088. On 7 October 1997, Coroner Abernethy returned a finding that Mr Miller died "of multiple injuries inflicted by a person or persons unknown."[4758] The coroner found that a number of factors mitigated against Plain Clothes Senior Constable Lane's opinion that Mr Miller fell from the cliff, as follows:[4759]

> *First, at the top of the cliff is a high wire fence. Secondly, Scott was very drunk with a blood alcohol level of .22. Thirdly, crime scene carefully examined the ledge above the cliff which was covered in ivy. They found no signs of disturbance of that ivy. Fourthly, Scott's body was laid out straight and was not cramped up as often occurs in falls. Fifthly, Scott's injuries, in the main were more consistent with his being assaulted.*

5.5089. His Honour considered there were "cogent reasons" for Dr Duflou's opinion that it was "more likely that he was either assaulted near where he was found, or taken there and dumped."[4760] Coroner Abernethy's reasons involved a rejection of any hypothesis that Mr Miller came over the fence at Munn Reserve and fell to his death, either accidentally or after being pushed.[4761]

5.5090. Coroner Abernethy considered that his inquiry was hampered by the lack of evidence as to Mr Miller's movements after Ms Carter saw him. He speculated that he could have walked down onto the wharf from the area of the Palisade Hotel, or been picked up by unknown persons.[4762]

1997–1998: Strike Force Corone

5.5091. Following the open finding at inquest, Coroner Abernethy referred the case back to the NSWPF for further investigation.[4763]

[4757] Exhibit 32, Tab 19, Bundle of NSWPF Running Sheets, 4 March 1997–16 April 1997, 8 (SCOI.83327).

[4758] Exhibit 32, Tab 43, Findings of Deputy State Coroner Abernethy, Inquest into the death of Scott Stuart Miller, 7 October 1997, 2 (SCOI.02737.00032).

[4759] Exhibit 32, Tab 43, Findings of Deputy State Coroner Abernethy, Inquest into the death of Scott Stuart Miller, 7 October 1997, 1 (SCOI.02737.00032).

[4760] Exhibit 32, Tab 43, Findings of Deputy State Coroner Abernethy, Inquest into the death of Scott Stuart Miller, 7 October 1997 (SCOI.02737.00032).

[4761] Exhibit 32, Tab 43, Findings of Deputy State Coroner Abernethy, Inquest into the death of Scott Stuart Miller, 7 October 1997, 1 (SCOI.02737.00032).

[4762] Exhibit 32, Tab 43, Findings of Deputy State Coroner Abernethy, Inquest into the death of Scott Stuart Miller, 7 October 1997, 2 (SCOI.02737.00032).

[4763] Exhibit 32, Tab 43, Findings of Deputy State Coroner Abernethy, Inquest into the death of Scott Stuart Miller, 7 October 1997 (SCOI.02737.00032); Exhibit 32, Tab 46, Letter from Detective Sergeant Ken Desmond to Detective Chief Inspector Collins, 13 January 1998 (SCOI.10047.00035).

5.5092. By report dated 3 January 1998, Detective Sergeant Desmond offered the following observations/opinions, which tended to support the theory that Mr Miller fell from the cliff above where his body was located:[4764]

a. After reinterviewing security staff, it would appear no vehicle or pedestrian could have entered the terminal without being challenged;

b. The position of Mr Miller's body, the lack of blood particles around the machinery yard, Mr Miller's clothing being intact indicate that Mr Miller fell from the area of the cliff face;

c. The lack of evidence of a struggle, and the lack of property stolen from Mr Miller, "raises more questions than it answers"; and

d. Enquiries revealed "no two person's [sic] sustain identical injuries in a fall of this nature."

2004: Review by the UHT

5.5093. In his 2004 "screening" of Mr Miller's death, Detective Sergeant Barwick favoured the view that Mr Miller "must have come over the cliff" to his final resting spot.[4765] He canvassed the following "points of issue":

a. The victim's injuries that bled could only occur where he was found, and there were no splatter marks to indicate that a weapon was used to inflict the injuries;

b. No pedestrian or vehicular access could have been gained to the Patricks terminal;

c. Crime scene photographs showed ivy next to the deceased, and ivy is located on the cliff but not seen anywhere else along the base of the cliff;

d. The position of the body was not unusual; and

e. Given the height of the fence, which was topped with barbed wire, and the weight of the deceased, it was extremely unlikely that the deceased was lifted over the fence by other people.[4766]

5.5094. Detective Sergeant Barwick stated that in poor light and in a state of intoxication, Mr Miller may not have realised that the ledge was lower than the ground level of the park.

[4764] Exhibit 32, Tab 49, NSWPF Memorandum – 'Question of Government Reward being posted concerning the murder of Scott Stuart Miller at Darling Harbour on 2 March 1997', 27 March 1998 (SCOI.10048.00002).

[4765] Exhibit 32, Tab 69, NSWPF Review of an Unsolved Homicide Case Screening Form – Scott Miller, 21 April 2004, 9 (NPL.0100.0015.0001).

[4766] Exhibit 32, Tab 69, NSWPF Review of an Unsolved Homicide Case Screening Form – Scott Miller, 21 April 2004, 9 (NPL.0100.0015.0001).

5.5095. Detective Sergeant Barwick noted that no examination was made of the victim's clothing, and suggested that such an examination may provide evidence of barbed wire punctures. He further recommended a reexamination of the crime scene and Mr Miller's injuries to "establish if the death was accidental".[4767] Pending such a forensic review, he noted that the Coroner may change the finding to be "death by misadventure".[4768]

Investigations made by the Inquiry

Independent review by Dr Iles, forensic pathologist

5.5096. Noting the divergences of opinion on the manner and cause of Mr Miller's death, both at inquest and in subsequent investigations, the Inquiry briefed forensic pathologist Dr Iles to conduct a review of the post-mortem report.[4769]

5.5097. Dr Iles considered the post-mortem report of Dr Duflou to be comprehensive, and the photo-documentation of the injuries to be of a relatively high standard. The post-mortem investigations were sufficient for her to form a view as to how Mr Miller's injuries were sustained.[4770]

5.5098. Dr Iles opined that all of Mr Miller's physical injuries can be accounted for by a fall from a cliff face, with a primary impact point to the front of his face (i.e. a headfirst fall). In particular:

a. Mr Miller's skull and brain injuries are consequent to severe blunt impact force to the front of his face and forehead. The injuries are located in a single plane, and have a vertically oriented abraded component most obvious on the neck and chin. Dr Iles considered these injuries to be "entirely in keeping" with a high magnitude force impact such as may occur consequent to a fall from a height.[4771] While Dr Iles noted that a similar pattern of cranio-facial injuries can be observed in other high-energy scenarios, such as to pedestrians or cyclists in motor vehicle accidents, the absence of injuries to the torso and lower limbs, and the circumstances in which he was found, discount such scenarios;[4772]

b. Mr Miller's liver and right kidney injuries, and associated bleeding in his abdomen, are in keeping with deceleration injuries that may be observed consequent to a fall from a height. The absence of associated fractures (which Dr Duflou considered "unusual") is accounted for by the primary impact being to Mr Miller's head and face, with the injuries to the abdominal organs being as a result of deceleration;[4773]

[4767] Exhibit 32, Tab 69, NSWPF Review of an Unsolved Homicide Case Screening Form – Scott Miller, 21 April 2004, 9 (NPL.0100.0015.0001).

[4768] Exhibit 32, Tab 69, NSWPF Review of an Unsolved Homicide Case Screening Form – Scott Miller, 21 April 2004, 9 (NPL.0100.0015.0001).

[4769] Exhibit 32, Tab 73, Letter of Instruction to Dr Linda Iles, 23 November 2022 (SCOI.82890).

[4770] Exhibit 32, Tab 72, Expert Report of Dr Linda Iles, 14 December 2022, 7 (SCOI.82891).

[4771] Exhibit 32, Tab 72, Expert Report of Dr Linda Iles, 14 December 2022, 7 (SCOI.82891).

[4772] Exhibit 32, Tab 72, Expert Report of Dr Linda Iles, 14 December 2022, 8 (SCOI.82891).

[4773] Exhibit 32, Tab 72, Expert Report of Dr Linda Iles, 14 December 2022, 7–8 (SCOI.82891).

c. The bilateral distal forearm fractures are in keeping with Mr Miller's arms being outstretched at the time of impact. Abrasions about the left wrist and the back of the right wrist may represent stretch-type abrasions related to the underlying fractures;[4774] and

d. The abrasions pictured to the back of Mr Miller's right hand and fingers may have been sustained during a fall, or could have been caused by foliage or barbed wire.[4775]

5.5099. Dr Iles further expressed the view that Mr Miller's injuries were, as a whole, not typical of an assault. In particular, she considered that:[4776]

a. The presence of a single plane of facial abrasion in the setting of severe underlying craniofacial trauma is not typical of an assault; and

b. Bilateral distal forearm fractures, particularly in the absence of overlying bruising and lack of haemorrhage in the underlying soft tissues, are "not at all typical" of defensive injuries.

5.5100. In Dr Iles' view, the nature of Mr Miller's injuries precluded Mr Miller himself being able to move any significant distance from the site where his craniofacial injuries were sustained.[4777] Dr Iles further considered that there is no scene or circumstantial evidence that would be compatible with Mr Miller's body being moved to the site it was located.[4778] In particular, she noted that the injuries to Mr Miller's face would result in significant bleeding after death, which was in keeping with the pool of blood in which he was found.[4779]

5.5101. Dr Iles considered that the position of Mr Miller's body corresponded with his injuries, which indicated an anterior plane of impact (i.e. to the front of the body). However, contrary to the opinion of Detective Senior Constable Van Leeuwen that the body was less contorted than would be expected following a fall, she considered the position of Mr Miller's body to be not otherwise informative.[4780]

5.5102. While Dr Iles reached the conclusion that Mr Miller died after falling from the cliff above where he was found, she was unable to say, based on the medical evidence, how Mr Miller's fall occurred — that is, she could not discriminate between Mr Miller falling from the cliff edge or being pushed over the cliff.[4781] Nonetheless, she considered that Mr Miller did not have injuries to indicate that any assault occurred.[4782]

[4774] Exhibit 32, Tab 72, Expert Report of Dr Linda Iles, 14 December 2022, 10 (SCOI.82891).
[4775] Exhibit 32, Tab 72, Expert Report of Dr Linda Iles, 14 December 2022, 9 (SCOI.82891).
[4776] Exhibit 32, Tab 72, Expert Report of Dr Linda Iles, 14 December 2022, 10 (SCOI.82891).
[4777] Exhibit 32, Tab 72, Expert Report of Dr Linda Iles, 14 December 2022, 8 (SCOI.82891).
[4778] Exhibit 32, Tab 72, Expert Report of Dr Linda Iles, 14 December 2022, 8 (SCOI.82891).
[4779] Exhibit 32, Tab 72, Expert Report of Dr Linda Iles, 14 December 2022, 10 (SCOI.82891).
[4780] Exhibit 32, Tab 72, Expert Report of Dr Linda Iles, 14 December 2022, 11 (SCOI.82891).
[4781] Exhibit 32, Tab 72, Expert Report of Dr Linda Iles, 14 December 2022, 10 (SCOI.82891).
[4782] Exhibit 32, Tab 72, Expert Report of Dr Linda Iles, 14 December 2022, 7 (SCOI.82891).

5.5103. Dr Iles indicated that, in her view, the pattern of blood staining on the left shoulder and left upper arm region of Mr Miller's shirt may be accounted for by blood being absorbed into the shirt from the pooling below Mr Miller's body. Dr Iles also indicated that the blood staining on the top right back of Mr Miller's shirt and to the right side of his face and ear could possibly be accounted for by agonal expiration of air and blood.[4783] However, Dr Iles qualified that blood pattern analysis is not her area of expertise, and recommended an opinion be sought from a forensic biologist or blood pattern analysis expert.

5.5104. Dr Iles expressed the conclusion that the cause of Mr Miller's death may be expressed as "multiple injuries sustained in a fall from a height."

Review of clothing by Ms Gerhard and Ms Roebuck, Independent Forensic Services

5.5105. Following the recommendation of Dr Iles to seek an opinion from a blood pattern expert, the Inquiry briefed Ms Gerhard and Ms Roebuck of Independent Forensic Services. Ms Gerhard's report dated 29 May 2023 sets out the examination and interpretation of each item of clothing.[4784]

5.5106. On the basis of her examinations, Ms Gerhard expressed the following conclusion:[4785]

> *When considering the bloodstain patterns identified on all of the items of clothing examined, no bloodstains (such as spatter or drips) were observed to indicate that Mr Miller was assaulted (resulting in bleeding injuries) at the top or the bottom of the cliff.*
>
> *In my opinion, the bloodstaining patterns observed on the clothing and in the photographs are consistent with the position Mr Miller was found at the bottom of the cliff following a fall. Furthermore, there is no evidence of significant movement of Mr Miller once his bleeding facial injuries occurred.*

5.5107. The pertinent findings are described as follows.

BLUE JEANS WITH BROWN BELT

5.5108. There were no blood stains located on Mr Miller's jeans, despite examination under magnification and the testing of apparent stains for the presence of blood. There was "wear and tear" on the jeans, but none that indicated an action such as climbing over a barbed wire fence.[4786]

WHITE T-SHIRT (TOP)

5.5109. The white t-shirt worn by Mr Miller as a top layer had extensive staining over the upper chest and neck region of the shirt, confirmed as blood, that appeared to be saturation staining from blood soaking into and wicking through the fabric.[4787]

[4783] Exhibit 32, Tab 72, Expert Report of Dr Linda Iles, 14 December 2022, 11 (SCOI.82891).

[4784] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023 (SCOI.83328).

[4785] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [15] (SCOI.83328).

[4786] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [10] (SCOI.83328).

[4787] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [11.1]–[11.3] (SCOI.83328).

5.5110. Within the saturation stain were smaller, darker "spatter" stains that were circular in shape, indicating that they had no direction. Stains of this nature are created when a force in addition to gravity is applied to liquid blood. In this case, they could have been the result of:[4788]

a. Blood being expelled from an airway (expirated) shortly after a fall; or

b. Liquid blood being distributed as a result of an impact such as a fall.

5.5111. The heavy staining on the front of the shirt is consistent with Mr Miller having facial injuries and remaining prone, with little to no movement once the bleeding had started.[4789]

5.5112. The rear of the t-shirt had also had blood staining, predominantly on the right sleeve.[4790] Detective Senior Constable Van Leeuwen had considered this staining to be "suspicious" and the "most crucial piece of forensic evidence" supporting the theory that Mr Miller's death was a homicide: see above at [5.5082]).

5.5113. Some of the stains had been removed from the shirt for testing in 1998, which confirmed that the blood originated from Mr Miller. The removal of a small portion of the stains did not affect Ms Gerhard's ability to provide an opinion on the bloodstaining, as enough stains remained for the purpose of classification.[4791]

5.5114. Ms Gerhard categorised the bloodstaining on the back of the t-shirt as "non-descript", and opined that they could have resulted from blood being distributed as a result of the fall from the cliff and landing on the back of Mr Miller.[4792]

5.5115. Ms Gerhard concluded that the bloodstains on the back of the t-shirt were not indicative of an assault or of Mr Miller being upright with a bleeding injury. If there had been a single impact which created blood flow while an individual is upright, then drip type staining could have occurred. If there was an initial impact that opened a freely bleeding wound, then subsequent strikes could have distributed spatter-type stains. There was no evidence of either type of staining.[4793]

5.5116. There was an absence of drag or grab marks that would indicate that Mr Miller had been moved or dragged.[4794]

5.5117. There were no flow-type patterns that would indicate that Mr Miller was moved whilst freely bleeding.[4795]

5.5118. There was no damage observed on the shirt.[4796]

[4788] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [11.5] (SCOI.83328).
[4789] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [11.6] (SCOI.83328).
[4790] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [11.7] (SCOI.83328).
[4791] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [11.7] (SCOI.83328).
[4792] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [11.8] (SCOI.83328).
[4793] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [11.8]–[11.10] (SCOI.83328).
[4794] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [11.11] (SCOI.83328).
[4795] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [11.11] (SCOI.83328).
[4796] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [11.12] (SCOI.83328).

WHITE T-SHIRT (BOTTOM)

5.5119. The staining on this white t-shirt was consistent with it being worn underneath the other white t-shirt. There were no drip or spatter type stains observed on this t-shirt.[4797]

5.5120. While there were some areas of damage to the shirt, these appeared to be from wear and tear.[4798]

SHOES

5.5121. The shoes were examined under magnification. No blood staining was observed. The shoes were well-worn, but no damage was observed beyond general wear.[4799]

Further testing of clothing by FASS

5.5122. Ms Gerhard furnished a supplementary report to the Inquiry in which she considered possible avenues for forensic testing, as a result of which the Inquiry requested that FASS undertake further DNA testing of:[4800]

a. The discrete blood stains on Mr Miller's shirt identified by Ms Gerhard; and

b. The swabs from the pockets of Mr Miller's jeans.

5.5123. Ms Friedman of FASS produced an expert certificate dated 22 September 2023 outlining the results of the testing, described as follows.[4801]

TESTING OF BLOOD STAINS ON MR MILLER'S SHIRT

5.5124. Four further stains from Mr Miller's t-shirt were tested, with the following results:[4802]

a. A stain on the lower centre of the t-shirt's front (marked "5v") returned a partial, mixed DNA profile. Mr Miller was not excluded as a major contributor from this stain and the minor contributors were "too weak";

b. A stain on the mid centre of the t-shirt's front (marked "5vi") returned a partial profile which was the same as Mr Miller's;

c. A stain on the mid left of the t-shirt's back (marked "5vii") returned a partial profile which was the same as Mr Miller's; and

d. A stain on the back of the t-shirt's left sleeve (marked "5viii") returned a partial, mixed DNA profile. Mr Miller was not excluded as a major contributor from this stain and the minor contributors were "too weak".

5.5125. The results of the further testing on stains "5vi" and "5vii" indicate the likelihood of the blood having come from Mr Miller.

[4797] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [12.2]–[12.4] (SCOI.83328).

[4798] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [12.5] (SCOI.83328).

[4799] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [13] (SCOI.83328).

[4800] Exhibit 32, Tab 102, Letter of Instruction to FASS, 21 August 2023 (SCOI.85733).

[4801] Exhibit 32, Tab 101, Expert Certificate of Virginia Friedman, 22 September 2023 (SCOI.85779).

[4802] Exhibit 32, Tab 101, Expert Certificate of Virginia Friedman, 22 September 2023, 2 [5v], [5vi], [5vii], [5viii] (SCOI.85779).

5.5126. In relation to stains "5v" and "5viii", the description of Mr Miller as "not excluded" as the major contributor means that there are no differences between Mr Miller's DNA profile and the sample obtained from the stain.[4803] Accordingly, those results are also consistent with the blood originating from Mr Miller.

5.5127. The biological source of the profile of the minor or additional contributors to stains "5v" and "5viii" is unknown. Having regard to Ms Gerhard's comments as to the transfer and persistence of DNA, set out above, no conclusions can be drawn from the presence of a mixed DNA profile.

TESTING OF SAMPLES FROM THE POCKETS OF MR MILLER'S JEANS

5.5128. The Inquiry also requested that FASS retest the samples from the pockets of Mr Miller's jeans.[4804] These swabs had been tested without success in around 2012, after which FASS retained the DNA extracts collected from the swabs.[4805]

5.5129. The results of retesting the DNA extracts from the pockets of the jeans were as follows:[4806]

a. The DNA extracts from the front right pocket, front left pocket and back right pocket (marked "6bi", "6bii" and "6biii", respectively) returned mixed DNA profiles, which were "not suitable for comparison due to the low level"; and

b. A DNA profile was not recovered from the DNA extract from the back left pocket (marked "6biv").

5.5130. The low-level mixed DNA profiles taken from three of Mr Miller's pockets do not advance the inquiry with respect to the manner and cause of Mr Miller's death, having regard to the comments of Ms Gerhard in relation to the transfer and persistence of DNA (set out at [5.5019]-[5.5023]), and the many scenarios which may have occurred to result in trace DNA being located in the pockets.[4807]

The debris found in Mr Miller's hand

5.5131. As recorded above, Professor Roux examined and reported on the piece of debris that was reported to have been found in the hand of Mr Miller.

5.5132. The results of the examination were that the debris comprised 52% iron and 47% zinc, with the remaining 1% comprising small amounts of lead and chromium.[4808]

5.5133. Professor Roux expressed the opinion that the metal composition and multilayered morphology of the debris support the proposition that the sample comes from a "coated metallic object, possible galvanized steel".[4809]

[4803] Exhibit 32, Tab 101, Expert Certificate of Virginia Friedman, 22 September 2023, Appendix, [7.1] (SCOI.85779).

[4804] Exhibit 32, Tab 102, Letter of Instruction to FASS, 21 August 2023 (SCOI.85733).

[4805] Exhibit 32, Tab 101, Expert Certificate of Virginia Friedman, 22 September 2023, 2 [6bi], [6bii], [6biii], [6biv] (SCOI.85779).

[4806] Exhibit 32, Tab 101, Expert Certificate of Virginia Friedman, 22 September 2023, 2 [6bi], [6bii], [6biii], [6biv] (SCOI.85779).

[4807] Supplementary Submissions of Counsel Assisting, 18 October 2023, [68] (SCOI.86272).

[4808] Exhibit 32, Tab 94, Expert Report of Professor Claude Roux, 25 August 2023, 3 (SCOI.85317).

[4809] Exhibit 32, Tab 94, Expert Report of Professor Claude Roux, 25 August 2023, 3 (SCOI.85317).

5.5134. Professor Roux was not able to determine the likely provenance of the debris without access to comparison materials. However, his review of the brief, including photographs of the crime scene, indicated that the metallic fence, machinery and shipping containers in the vicinity of the crime scene should be considered as the possible provenance for the debris.[4810]

5.5135. Professor Roux also noted that, given Mr Miller was found in the machinery yard, and given the small size of the sample, the fact that the debris was found in Mr Miller's hand does not mean Mr Miller came into direct contact with the metallic object from which the debris came. It could be explained by contact between Mr Miller's hand and another surface on which the debris was present (such as the ground).[4811]

5.5136. Professor Roux's opinion is consistent with Mr Miller having climbed the fence at Munn Reserve and fallen to his death.[4812] In this scenario, the debris in Mr Miller's hand could be the result of direct contact with the fence at Munn Reserve. However, given the existence of alternative sources for the debris, and the availability of other explanations as to how metallic debris may have come to be on Mr Miller's hand, Professor Roux's opinion does not significantly advance the inquiry into the manner and cause of Mr Miller's death.

Expert opinion of Dr Victoria Kueppers, forensic pathologist

5.5137. Dr Kueppers was asked to conduct a peer review of the opinions of Dr Iles and Dr Duflou.[4813] The main issue identified by Dr Kueppers was "whether Mr Miller sustained his fatal injuries as a result of a fall from height versus homicidal action."[4814]

AS TO DR DUFLOU

5.5138. Dr Kueppers considered that the post-mortem report prepared by Dr Duflou was "reflective of a comprehensive approach" to Mr Miller's death and that the photographs were sufficient to assist in the formation of an opinion. She agreed with Dr Duflou that Mr Miller died from multiple injuries.[4815]

5.5139. Dr Kueppers observed that, in his post-mortem report, Dr Duflou considered a number of scenarios as to how the injuries occurred (including a fall from height, homicidal assault or combination of both) and did not favour any scenario over the other.[4816] By contrast, at the later inquest, Dr Duflou favoured the scenario that the injuries were due to assault, and opined that the injuries were overall not typical with a fall from height.[4817]

[4810] Exhibit 32, Tab 94, Expert Report of Professor Claude Roux, 25 August 2023, 3 (SCOI.85317).
[4811] Exhibit 32, Tab 94, Expert Report of Professor Claude Roux, 25 August 2023, 3 (SCOI.85317).
[4812] Submissions of Counsel Assisting, 15 June 2023, [171] (SCOI.83998).
[4813] Exhibit 32, Tab 105, Letter of Instruction to Dr Victoria Kueppers, 8 September 2023 (SCOI.85713).
[4814] Exhibit 32, Tab 104, Expert Report of Dr Victoria Kueppers, 18 September 2023, 3 (SCOI.85712).
[4815] Exhibit 32, Tab 104, Expert Report of Dr Victoria Kueppers, 18 September 2023, 4 (SCOI.85712).
[4816] Exhibit 32, Tab 104, Expert Report of Dr Victoria Kueppers, 18 September 2023, 4 (SCOI.85712).
[4817] Exhibit 32, Tab 104, Expert Report of Dr Victoria Kueppers, 18 September 2023, 4 (SCOI.85712).

5.5140. Dr Kueppers stated that she "mostly disagreed" with the verbal opinion of Dr Duflou expressed at inquest.[4818]

5.5141. In her opinion, Mr Miller's overall injuries, in conjunction with the circumstances surrounding the death, including the positioning of the body, are "entirely in keeping" with a fall from height. Dr Kueppers explained:[4819]

a. The blunt force injuries to Mr Miller's face and neck appear to have a vertical directionality, in areas appearing like "brush abrasions which are not infrequently seen with broad blunt impact with a degree of directional friction, i.e. impacting a rough surface such as asphalt";

b. The underlying skull and brain injuries are consistent with a frontal impact to the face, there being no obvious features of a localised assault and/or multiple impacts;

c. The internal injuries to Mr Miller's chest and abdomen are consistent with deceleration-type injuries, which may occur in a fall from height where the face is the primary impact site. In some cases of abdominal trauma, significant abdominal wall injuries or rib fractures may not be observed due to the pliable nature of the abdomen and ribcage, especially in a young person; and

d. Mr Miller's wrist injuries could have occurred due to the fall, and there is nothing specific to the wrist or hand injuries which would indicate defensive-type injuries.

5.5142. Dr Kueppers concluded that "the overall findings are in keeping with the death having occurred as a result of a fall from height. I cannot deduce how the fall may have occurred, i.e., as a result of an accident or a push".[4820]

5.5143. Dr Kueppers disagreed with Dr Duflou's conclusion that it is unlikely that Mr Miller climbed the fence given his blood alcohol level. In her view, while a blood alcohol content of 0.22% would render many individuals very intoxicated, the level of impairment depends on the individual and their tolerance to alcohol.[4821]

AS TO DR ILES

5.5144. Dr Kueppers expressed overall agreement with Dr Iles' interpretation of the findings and injuries.[4822] She agreed with Dr Iles that, "whilst other high energy blunt impact scenarios are possible (such as a pedestrian being hit by a moving vehicle), there are no truncal or lower limb injuries which suggest this". She further agreed that "no injuries suspicious of an assault or defensive action are clearly identifiable", although "an assault prior to the fall cannot be excluded".[4823]

[4818] Exhibit 32, Tab 104, Expert Report of Dr Victoria Kueppers, 18 September 2023, 4 (SCOI.85712).
[4819] Exhibit 32, Tab 104, Expert Report of Dr Victoria Kueppers, 18 September 2023, 5 (SCOI.85712).
[4820] Exhibit 32, Tab 104, Expert Report of Dr Victoria Kueppers, 18 September 2023, 5 (SCOI.85712).
[4821] Exhibit 32, Tab 104, Expert Report of Dr Victoria Kueppers, 18 September 2023, 5 (SCOI.85712).
[4822] Exhibit 32, Tab 104, Expert Report of Dr Victoria Kueppers, 18 September 2023, 4 (SCOI.85712).
[4823] Exhibit 32, Tab 104, Expert Report of Dr Victoria Kueppers, 18 September 2023, 6 (SCOI.85712).

5.5145. Based on all the information available to her, it appeared to Dr Kueppers that "there is a lack of evidence of homicidal assault", and that the injuries are "in keeping with a fall from height".[4824]

OTHER REPORTS

5.5146. Dr Kueppers was provided with, and commented on, the expert report of Ms Gerhard dated 29 May 2023 in relation to blood pattern analysis, the statement of Inspector Brady dated 7 June 2023 and the expert report of Professor Roux in relation to the debris.[4825] These reports were not available to either Dr Duflou or Dr Iles.

5.5147. Dr Kueppers considered that Ms Gerhard's report supported the scenario of a fall from height having resulted in Mr Miller's fatal injuries.

5.5148. She considered that while the findings of Inspector Brady and Professor Roux are not conclusive in relation to how Mr Miller's injuries occurred, "they could be consistent with Mr Miller falling off the cliff after having climbed the fence, the piece of metal representing direct transfer from the fence".[4826]

Further analysis of ivy at crime scene

5.5149. The Inquiry obtained an expert opinion from Mr Jobson, Information Botanist, in relation to the ivy found adjacent to the left leg of Mr Miller.

5.5150. Mr Jobson provided an expert report advising that the ivy growing in Munn Reserve and the ivy located next to Mr Miller were the same species, namely English ivy (*Hedera helix*), in contrast to the other types of ivy which grow in south-east Australia at the current time and also as at 1997.[4827]

5.5151. The fact that the ivy found adjacent to Mr Miller was the same species as that growing in Munn Reserve is consistent with, and provides some support for, the hypothesis that Mr Miller disturbed the ivy at the top of the cliff during a fall.[4828]

5.5152. Detective Senior Constable Van Leeuwen, in his oral evidence at the inquest, said that he "didn't place any weight on that ivy" in considering whether Mr Miller had fallen or been assaulted, on the basis that "it had been raining, it had been very windy and you will get naturally ivy just you know leaves and that moving around the area and there were only two leaves". Detective Senior Constable Van Leeuwen said that he would have expected a "significantly large number of leaves" had Mr Miller fallen through the ivy.[4829]

[4824] Exhibit 32, Tab 104, Expert Report of Dr Victoria Kueppers, 18 September 2023, 6 (SCOI.85712).

[4825] Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023 (SCOI.83328); Exhibit 32, Tab 79, Statement of Inspector Andrew Brady, 7 June 2023 (NPL.9000.0017.0072); Exhibit 32, Tab 94, Expert Report of Professor Claude Roux, 1 August 2023 (SCOI.85316).

[4826] Exhibit 32, 104, Expert Report of Dr Victoria Kueppers, 18 September 2023, 7 (SCOI.85712).

[4827] Exhibit 32, Tab 106, Expert Report of Peter Jobson, 5 October 2023, 2 (SCOI.86104).

[4828] Supplementary Submissions of Counsel Assisting, 18 October 2023, [87] (SCOI.86272).

[4829] Exhibit 32, Tab 42, Transcript of Coronial Inquest into the death of Scott Stuart Miller, 7 October 1997, 9 (SCOI.02737.00041).

5.5153. The Inquiry has no expert evidence in relation to how many ivy leaves would be expected to have been disturbed if Mr Miller had fallen from the cliff. However, it may be observed that Mr Miller's injuries were in a single plane with no obvious features of multiple impacts, which may suggest that he did not land heavily on the ledge covered with ivy during his fall. That may explain why more ivy was not found at the bottom of the cliff.

Police investigation

The original investigation

5.5154. Counsel Assisting submitted that the OIC, Plain Clothes Senior Constable Lane appears to have arrived quickly at the view that Mr Miller's death was accidental. In an undated letter from Mr Miller's parents to the Coroner, they wrote:[4830]

> *From my first contact with S/C Lane he has been adamant Scott's death was caused by a fall. S/C Lane also appears now unable to reconcile himself to the findings of the Senior Deputy Coroner.*

5.5155. This is consistent with Ms Lott's recollections of attending Rocks Police Station only one or two days after Mr Miller's death, and being told that he may have fallen over the cliff in search of the casino,[4831] although I accept that Ms Lott's evidence was only that police considered that he *might* have fallen.[4832]

5.5156. NSWPF submitted that there is no indication of what Plain Clothes Senior Constable Lane said to Mr Miller's parents.[4833] I accept that there are limited records of the exact matters discussed with the family. However, in circumstances where the possibility of homicide had been squarely raised, I consider that some aspects of the investigation into Mr Miller's death were not pursued as thoroughly or completely as they could or should have been if Mr Miller's death was treated as a possible homicide.

5.5157. Statements from all of the security guards across the relevant time window in which Mr Miller's death may have occurred were not taken until the inquest, at the prompting of Mr Miller's parents.[4834] As noted in the submissions for the Miller family, issues of degraded memory and recollection of events may arise when evidence is not obtained contemporaneously from witnesses.[4835]

5.5158. In addition, the canvassing of witnesses was not conducted thoroughly or carefully. This is particularly evident in relation to the canvassing of crew members onboard the vessel "Ranginui", a ship that was docked at Wharf 4 on the night of Mr Miller's death, close to the machinery yard where Mr Miller's body was found.

[4830] Exhibit 32, Tab 44, Letter from Stuart and Christine Miller to Deputy State Coroner Abernethy, undated (SCOI.02737.00036).

[4831] Exhibit 32, Tab 80, Statement of Bridget Lott, 6 June 2023, [10] (SCOI.83636).

[4832] Submissions of NSWPF, 30 June 2023, [24] (SCOI.84264).

[4833] Submissions of NSWPF, 30 June 2023, [23] (SCOI.84264).

[4834] Exhibit 32, Tab 34, Statement of Warren White, 9 October 1997 (SCOI.02737.00038); Exhibit 32, Tab 36, Statement of Lance Neilson, 28 October 1997 (SCOI.02737.00039).

[4835] Submissions of Miller Family, 30 June 2023, [6] (SCOI.84265).

5.5159. On 19 March 1997, when the Ranginui returned to Sydney,[4836] Plain Clothes Senior Constable Lane interviewed ten members of the crew. A running sheet, summarising those ten interviews, records the following:[4837]

a. Three of the crew members went to see the Mardi Gras Parade, walked back together and arrived back at the ship at around 11:30pm;

b. Two of the crew members were on board all night and did not leave the ship;

c. One crew member was on night watch shift until 12:00am;

d. One crew member was on the 12:00am to 4:00am night watch shift; and

e. Three crew members went to see the Mardi Gras Parade and "got separated during the night and consumed a large amount of alcohol". Each arrived back separately between 12:00am and 3:00am.

5.5160. The crew members spoken to were recorded as "not having seen anything suspicious".[4838]

5.5161. The running sheet does not indicate whether each crew member was spoken to separately or in the presence of others. There is a general lack of detail, particularly in relation to the three crew members who returned between 12:00am and 3:00am.

5.5162. As some of the only authorised entrants to the Patricks compound at the approximate time of Mr Miller's death, who would have been passing in close proximity to where his body was ultimately found, the crew members may have provided crucial evidence in relation to a homicide investigation.

5.5163. Counsel Assisting submitted that greater care should have been taken to capture their evidence as to their movements and observations on the night. This submission was developed further in submissions filed in relation to the Investigative Practices Hearing, where Counsel Assisting submitted that recording the view taken by crew members that they saw nothing suspicious is of no utility to officers coming to consider the case at a later time.[4839]

5.5164. The NSWPF submitted that the running sheet did include details beyond the fact that crew members "did not see anything suspicious", including evidence of their movements on the night.[4840] The NSWPF submitted that it is not clear what would have been gained from any further record of the crew members' evidence.[4841] The NSWPF acknowledged however the importance of police enquiries being "recorded with specificity".[4842]

[4836] Exhibit 32, Tab 18, NSWPF Situation Report, 7 March 1997 (SCOI.02737.00099).

[4837] Exhibit 32, Tab 19, Bundle of NSWPF Running Sheets, 4 March 1997–16 April 1997, 9 (SCOI.83327).

[4838] Exhibit 32, Tab 19, Bundle of NSWPF Running Sheets, 4 March 1997–16 April 1997, 9 (SCOI.83327).

[4839] Submissions of Counsel Assisting, 15 September 2023, [891] (SCOI.85649).

[4840] Submissions of NSWPF, 10 October 2023, [438] (SCOI.86127), referring to Exhibit 32, Tab 19, Bundle of NSWPF Running Sheets, 4 March 1997–16 April 1997, 9 (SCOI.83327).

[4841] Submissions of NSWPF, 30 June 2023, [51]–[52] (SCOI.84264).

[4842] Submissions of NSWPF, 10 October 2023, [438] (SCOI.86127).

5.5165. I accept the submissions of Counsel Assisting that much greater care should have been taken in capturing the evidence of the crew members of the Ranginui, and that the records were inadequate to be of utility to officers considering Mr Miller's case at a later point, particularly in light of one of the theories advanced by Dr Duflou that Mr Miller may have been moved to the location where he was found.

5.5166. The NSWPF further submitted that there is nothing to indicate that the crew members were interviewed in the presence of others, and that "[p]resumably, investigating police knew the pitfalls of conducting a group interview".[4843] The NSWPF acknowledged that if the crew members were interviewed collectively, then that would not have been an appropriate course.[4844]

5.5167. On the records available, it is impossible to know whether the presumption advanced by the NSWPF (i.e., that presumably investigative officers would not conduct a group interview) holds true in this instance. The available material does not indicate anything other than a group interview took place.

5.5168. I observe that the Coroner referred Mr Miller's death back to the NSWPF for further investigation by specialist homicide officers. The NSWPF submitted that the above referral does not appear to have been prompted by issues in respect of the thoroughness of the initial police investigation and that, rather, Coroner Abernethy appears to have placed a high degree of weight on the conflicting views surrounding Mr Miller's death.[4845]

5.5169. I do not accept that submission. In his coronial findings, Coroner Abernethy stated that it was "unfortunate that there was no further evidence" and that while a canvass was made of the staff at Patricks, investigators "must take that matter further and ensure that no person [on] duty that night saw Scott or anyone like him."[4846]

5.5170. In Coroner Abernethy's letter to the Commander of Crime Agencies on 11 November 1997, sent approximately a month after the conclusion of the inquest, Coroner Abernethy specifically referred to the concerns as to the investigation raised in a letter by Mrs Miller.[4847] Those concerns included:

a. That some statements had not been taken from relevant security officers at Patricks;

b. That staff at the Orient Hotel, "Jacksons on George" and the Fortune of War Hotel had not been canvassed;

c. The lack of detail in relation to the interview of the crew of the Ranginui; and

d. The lack of review of whether police had been called to any altercations at the time in question.[4848]

[4843] Submissions of NSWPF, 30 June 2023, [53] (SCOI.84264).

[4844] Submissions of NSWPF, 30 June 2023, [54] (SCOI.84264).

[4845] Submissions of NSWPF, 30 June 2023, [18] (SCOI.84264).

[4846] Exhibit 32, Tab 43, Findings of Deputy State Coroner Abernethy, Inquest into the death of Scott Stuart Miller, 7 October 1997, 2 (SCOI.02737.00032).

[4847] Exhibit 32, Tab 41, Letter from Deputy State Coroner Abernethy to NSWPF Commander, 11 November 1997 (SCOI.02737.00035).

[4848] Exhibit 32, Tab 44, Letter from Stuart and Christine Miller to Deputy State Coroner Abernethy, undated (SCOI.02737.00036).

5.5171. Coroner Abernethy asked that an officer be allocated to follow up Mrs Miller's concerns.[4849] Subsequently, the Terms of Reference of Strike Force Corone were issued, directing Detective Sergeant Desmond to conduct inquiries into Mr Miller's death, as directed by Coroner Abernethy, and "in particular" to address the issues raised in correspondence by Mrs Miller.

5.5172. While the conflicting views surrounding Mr Miller's death may have played a role in the referral by Coroner Abernethy for further investigation, the primary impetus appears to have been the inadequacies in the investigation as identified by Mrs Miller.

Exhibits

5.5173. As described above, an item of debris taken from the hand of Mr Miller at the post-mortem examination was located by the UHT in 2004. That debris was tested for the first time in 2023 by the Inquiry.

5.5174. Counsel Assisting submitted that collecting an exhibit but failing to record it, test it, or even consider its nature, was a significant oversight in the original investigation.[4850] The family of Mr Miller questioned how such an error could have been made regarding such critical evidence.[4851]

5.5175. The NSWPF acknowledged that no forensic testing or metallurgical examination had been previously completed on the debris, and that this appeared to be due to an oversight. It was acknowledged by the NSWPF that this was regrettable.[4852]

5.5176. I agree that the failure to properly store or test the debris was a failing in this investigation. That criticism is particularly pertinent in light of Professor Roux's opinion that it was not possible to determine the likely provenance of the debris without access to comparison materials. Had appropriate testing been conducted at the time, such comparison may have been possible. That forensic opportunity has long been lost given the passage of time and the substantial development of the Barangaroo precinct.

Reviews by the UHT

5.5177. As explained above, it seems likely that a review of Mr Miller's case of some kind occurred before March 2010, and some forensic testing of the clothing did occur between 2010 and 2012.[4853]

[4849] Exhibit 32, Tab 41, Letter from Deputy State Coroner Abernethy to NSWPF Commander, 11 November 1997 (SCOI.02737.00035).

[4850] Transcript of the Inquiry, 16 June 2023, T4338.27–30 (TRA.00061.00001).

[4851] Submissions of Miller Family, 30 June 2023, [9], [15] (SCOI.84265); Supplementary submissions of Miller Family, 31 October 2023, [5(b)] (SCOI.86430).

[4852] Submissions of NSWPF, 30 June 2023, [57] (SCOI.84264).

[4853] See Supplementary Submissions of Counsel Assisting, 18 October 2023, [9]–[20] (SCOI.86272).

5.5178. However, the NSWPF maintained in correspondence that no further review of Mr Miller's matter had occurred since April 2004,[4854] and that they were unable to find any documents in relation to such a review. The NSWPF were also unable to locate any records of its own of the results of the DNA testing reported by FASS as recently as 9 November 2012.[4855] I refer to the chronology set out above in relation to the Inquiry's efforts to obtain all material from the UHT relating to the consideration of Mr Miller's case.

5.5179. Counsel Assisting submitted that it was "remarkable and troubling" that the NSWPF were unable to locate these records.[4856]

5.5180. In response to this concern, the NSWPF submitted that the evidence tendered by the Inquiry does not disclose, one way or another, whether the final results of testing in 2012 were in fact provided to the NSWPF. However, the NSWPF correctly accepted that there is no evidence of the UHT Review Team following up the report,[4857] which I consider of itself to be a significant oversight. This submission also does not answer the concern as to why the UHT Review Team has been unable to locate its *own* records in relation to reviews of Mr Miller's case.

5.5181. In supplementary submissions dated 31 October 2023, the Miller family noted that they were *not* informed of the results of the further testing conducted in around 2012.[4858] This may indicate that the final results of the testing in 2012 were indeed not provided to the NSWPF. In the absence of detailed records held by the UHT, in relation to either receiving the final results or following up on the progress of testing, I am unable to reach a conclusion.

5.5182. Further, although some testing of Mr Miller's clothing did eventually occur, it would appear that this was only done after Mrs Miller's call prompted Detective Sergeant Allison to take steps to implement the recommendation which had evidently been made by the UHT Review Team. Counsel Assisting submitted that it should not be incumbent on the family of a deceased person to continue to call or enquire about their loved one's case in order for investigative steps to be taken.[4859] Supplementary submissions filed by the Miller family echoed this concern.[4860]

5.5183. In the absence of any evidence as to when the Review Team actually made that recommendation, I cannot make any finding as to how long that recommendation sat dormant and unactioned. However, what is known is that approximately six years passed between Detective Sergeant Barwick's initial recommendation (of April 2004) and the UHT arranging (in March 2010) for Mr Miller's clothing to be tested at all.

[4854] Exhibit 32, Tab 77, Letter from Katherine Garaty to Enzo Camporeale, 1 June 2023 (SCOI.83403).

[4855] Exhibit 32, Tab 87, FASS Report to NSWPF, 9 November 2012 (SCOI.85741).

[4856] Supplementary Submissions of Counsel Assisting, 18 October 2023, [22] (SCOI.86272); see also Supplementary Submissions of Counsel Assisting, 18 October 2023, [5(d)] (SCOI.86272).

[4857] Supplementary Submissions of NSWPF, 24 October 2023, [3] (SCOI.86370).

[4858] Supplementary submissions of Miller Family, 31 October 2023, [5(d)] (SCOI.86430).

[4859] Supplementary Submissions of Counsel Assisting, 18 October 2023, [23] (SCOI.86272).

[4860] Supplementary submissions of Miller Family, 31 October 2023, [5(a)] (SCOI.86430).

5.5184. Counsel Assisting submitted that arranging for testing to occur is not a resource intensive step, and the unexplained inactivity suggests a failure of the UHT's internal systems for monitoring and progressing the cases for which it has responsibility.

5.5185. The NSWPF, in reply, noted that the UHT did not have an investigative function between its inception in 2004 and 2008.[4861] The NSWPF accepted that the delay in the conduct of the further testing following the 2004 recommendation was regrettable, but must be viewed in light of the absence of a reinvestigation capacity, the enormity of the task and the competing demands on resources.[4862]

5.5186. The delay was unsatisfactory.

5.5187. The Miller family made the following submissions:[4863]

> *The Miller family consider that the submissions advanced by the police fail to adequately acknowledge the distress the police have added to the family's grief by prolonging the investigation and by failing to conduct the investigation in a competent and orderly manner….*
>
> *The Miller family submit that the police should acknowledge the flaws and shortcomings in their investigations into Scott's death.*

5.5188. In my view, the NSWPF *should* acknowledge the flaws and shortcomings in Mr Miller's case.

5.5189. The evidence indicates that the Miller family was not informed that testing had been requested and there is no evidence of any family member being informed of the results of testing. I accept the submissions of the Miller family that the NSWPF should be held to the "highest standards of conduct" in relation to relevantly, their communication with grieving families.[4864] I agree with this, although I am mindful that there are sometimes good reasons not to inform family members of specific investigative steps that are taken. Given the paucity of evidence (which is itself regrettable, as I have indicated) I cannot say confidently conclude that the Miller family should have been informed that testing had been requested. However, I am satisfied that, at some points, the NSWPF communications with the Miller family fell short of the standard the community expects.

Manner and cause of death

5.5190. Counsel Assisting the Inquiry submitted that, notwithstanding the original coronial finding that Mr Miller's injuries were inflicted by a person or persons unknown, the preponderance of the evidence, including expert opinions not available at the time of the inquest, supports a conclusion that Mr Miller's injuries were sustained by a fall from the cliff directly above where his body was found.[4865]

[4861] Supplementary Submissions of NSWPF, 24 October 2023, [5] (SCOI.86370).

[4862] Supplementary Submissions of NSWPF, 24 October 2023, [6] (SCOI.86370).

[4863] Supplementary submissions of Miller Family, 31 October 2023, [7]–[8] (SCOI.86430).

[4864] Supplementary submissions of Miller Family, 31 October 2023, [6], [8] (SCOI.86430).

[4865] Submissions of Counsel Assisting, 15 June 2023, [155] (SCOI.83998).

5.5191. Counsel Assisting submitted that the opinions of Dr Iles and Dr Kueppers were the most persuasive evidence supporting the hypothesis that Mr Miller fell to his death, and should be preferred to the opinion of Dr Duflou expressed verbally at inquest.[4866]

5.5192. In the submission of Counsel Assisting, Dr Iles' opinion, that each of Mr Miller's physical injuries can be accounted for by a fall from a cliff face with a primary impact point to the front of his face, should be preferred to Dr Duflou's evidence that the injuries were "atypical" for a fall from a height. Both Dr Iles and Dr Kueppers explained the mechanism for how each injury would be sustained, and answered Dr Duflou's concerns about the absence of rib or pelvic fractures despite the significant abdominal injuries.[4867]

5.5193. Counsel Assisting submitted that Dr Iles provided "cogent" reasons as to why Mr Miller's injuries were not typical of an assault, including the presence of a single plane of facial abrasion in the setting of severe underlying craniofacial trauma.[4868] Dr Kueppers agreed that there were no identifiable injuries suggestive of an assault or defensive action.

5.5194. Counsel Assisting also relied upon the bloodstain pattern analysis conducted by Ms Gerhard to support the proposition that Mr Miller died as a result of a fall. There was an absence of any bloodstaining (such as drip stains or directional spatter stains) that would have been consistent with Mr Miller being assaulted. To the contrary, the saturation bloodstaining was consistent with Mr Miller not moving after suffering bleeding facial injuries, with non-descript or non-directional spatter staining capable of explanation by the distribution of blood caused by the impact of the fall, or expiration of blood from an airway.[4869]

5.5195. Mr Miller's injuries precluded him moving any significant distance of his own motion, and there was no evidence to support his body being moved or dragged. Counsel Assisting submitted that this tells against one of Dr Duflou's hypotheses, which was reflected in the reasons of the Coroner, that Mr Miller's body could have been "dumped" in the location that it was found.[4870]

[4866] Supplementary Submissions of Counsel Assisting, 18 October 2023, [91] (SCOI.86272).

[4867] Submissions of Counsel Assisting, 15 June 2023, [155] (SCOI.83998); Supplementary Submissions of Counsel Assisting, 18 October 2023, [75] (SCOI.86272).

[4868] Submissions of Counsel Assisting, 15 June 2023, [157] (SCOI.83998).

[4869] Submissions of Counsel Assisting, 15 June 2023, [158] (SCOI.83998); Supplementary Submissions of Counsel Assisting, 18 October 2023, [91] (SCOI.86272).

[4870] Submissions of Counsel Assisting, 15 June 2023, [159] (SCOI.83998).

5.5196. That Mr Miller came to his resting place by falling from the cliff is also consistent, in the submission of Counsel Assisting, with the evidence that access to the wharf by members of the public was significantly limited.[4871] While Counsel Assisting acknowledge that the circumstantial evidence may leave open a possibility of Mr Miller's body being "placed" in the Patricks compound, it was submitted that this possibility was outweighed by the expert evidence indicating the probability that Mr Miller died as a result of injuries sustained from a fall and that his body did not move following his death.[4872]

5.5197. Counsel Assisting acknowledged that there was little evidence that establishes Mr Miller's presence at the top of the cliff. There was an absence of evidence of disturbance to the vegetation or ivy at the top of the cliff, an absence of trace evidence (such as clothing fibres or shoe imprints) on the barbed wire fence, and no tears or damage to Mr Miller's clothing.[4873]

5.5198. However, Counsel Assisting submitted that the presence of leaves from the same species of ivy found at his feet does tend to indicate his having been at the top of the cliff, and is at least consistent with him having disturbed that vegetation, whether as a result of a fall or otherwise.[4874]

5.5199. In any event, Counsel Assisting submitted that the absence of such evidence does not overcome the force of the forensic evidence as to Mr Miller's injuries and the bloodstain patterns. Counsel Assisting submitted that it was not inconceivable that Mr Miller would leave little trace of his presence at the top of the cliff, depending on how he came over the barbed wire fence, and whether Mr Miller fell from the fence without landing (or landing heavily) on the ivy on the cliff side of the fence.[4875]

5.5200. The forensic evidence cannot, of itself, determine whether Mr Miller came over the cliff as a result of an accidental fall or a push. However, Counsel Assisting submitted that it would seem implausible that Mr Miller, who was 180 cm tall and weighed 87 kilograms,[4876] could have been forced over the barbed wire fence by an unknown person and pushed off the cliff without sustaining any injuries consistent with an assault. [4877]

5.5201. In addition, the opinion of Detective Senior Sergeant Cameron was that if someone had been carried to and lifted or pushed over the fence, he would have expected greater damage to the fence and the vegetation, and for there to be more physical evidence adhering to the barbed wire fence. Counsel Assisting submitted that this accords with common sense. [4878]

[4871] Submissions of Counsel Assisting, 15 June 2023, [160] (SCOI.83998).

[4872] Supplementary Submissions of Counsel Assisting, 18 October 2023, [91] (SCOI.86272); Submissions of Miller Family, 30 June 2023, [20]–[23] (SCOI.84265).

[4873] Submissions of Counsel Assisting, 15 June 2023, [162] (SCOI.83998).

[4874] Supplementary Submissions of Counsel Assisting, 18 October 2023, [87] (SCOI.86272)

[4875] Submissions of Counsel Assisting, 15 June 2023, [163] (SCOI.83998).

[4876] Exhibit 32, Tab 2, Post-mortem Report of Dr Johan Duflou, 5 June 1997, 2 (SCOI.02737.00048).

[4877] Submissions of Counsel Assisting, 15 June 2023, [165] (SCOI.83998).

[4878] Submissions of Counsel Assisting, 15 June 2023, [166] (SCOI.83998).

5.5202. Accordingly, the limited evidence as to Mr Miller's having been at the top of the cliff may be seen as lending weight to the theory that Mr Miller climbed the fence himself, rather than being lifted over the fence and pushed.

5.5203. Having regard to all the evidence, and the expert opinions of Dr Iles, Dr Kueppers and Ms Gerhard, Counsel Assisting submitted that it is more probable than not that Mr Miller met his death after climbing the fence at Munn Reserve and accidentally falling to the wharf below.

5.5204. The reasons why Mr Miller might have climbed the fence at Munn Reserve are unknown and inevitably will remain so. Counsel Assisting submitted that the theory of Plain Clothes Senior Constable Lane, that he became lost on his way to the casino, was plausible but essentially speculative. Counsel Assisting suggested that Mr Miller's high blood alcohol level is likely to have contributed to some disorientation or poor judgment.[4879]

5.5205. In written submissions dated 30 June 2023, the NSWPF agreed with the submissions of Counsel Assisting and agreed that it was more probable that Mr Miller died after climbing the fence at Munn Reserve (rather than being forced over), and accidentally falling.[4880]

5.5206. In the written submissions of the Miller family following the documentary tender, it was submitted that a finding that Mr Miller died as a result of a fall would be "premature and unsafe",[4881] and that further investigative steps should be taken, including the testing of Mr Miller's clothing, the identification of the debris in Mr Miller's hand, and the obtaining of a third opinion from a forensic pathologist.[4882]

5.5207. As has been identified above, each of those investigative steps was given full consideration and, with the exception of chemical testing to ascertain the nature of the stains on Mr Miller's jeans, pursued. In relation to the stains on Mr Miller's jeans, as explained above, Ms Gerhard detected no blood, and the information available to the Inquiry indicated that further chemical testing lacks utility. As to other lines of inquiry, additional investigative steps were identified and undertaken by the Inquiry, including the briefing of an expert botanist, the DNA testing of the debris, and the testing of a fibre that was attached to the debris.

5.5208. In supplementary submissions dated 18 October 2023, Counsel Assisting maintained that the evidence supports a finding that Mr Miller died as a result of multiple injuries sustained in an accidental fall from a height. Particularly having regard to the additional investigative steps taken by the Inquiry following the documentary tender,[4883] Counsel Assisting submitted that such a finding, on the balance of probabilities, should not be regarded as premature.[4884]

[4879] Submissions of Counsel Assisting, 15 June 2023, [169] (SCOI.83998).

[4880] Submissions of NSWPF, 30 June 2023, [72]–[73] (SCOI.84264).

[4881] Submissions of Miller Family, 30 June 2023, [3], [24] (SCOI.84265).

[4882] See Submissions of Miller Family, 30 June 2023, [12]–[19] (SCOI.84265).

[4883] Supplementary Submissions of Counsel Assisting, 18 October 2023, [90] (SCOI.86272).

[4884] Supplementary Submissions of Counsel Assisting, 18 October 2023, [93] (SCOI.86272).

5.5209. In supplementary submissions dated 31 October 2023, Mr Miller's family submitted the following:[4885]

> *The Miller family feels that there are still some issues in conclusively ruling that Scott's death was a result of accidental causes and feel that they will never know with certainty exactly what happened on the night of his death.*

5.5210. I acknowledge that it will never be known with certainty the exact details of what happened on the night of Mr Miller's death, and that there are some details which are ultimately left to speculation.

5.5211. I accept however, the analysis and conclusions of Counsel Assisting as to the manner and cause of Mr Miller's death, to the standard of proof required as set out in **Chapter 1**. That Mr Miller fell to his final resting place, and was not moved, is the conclusion consistent with the expert opinions of Dr Iles and Dr Kueppers as to the nature of Mr Miller's injuries, and of Ms Gerhard in relation to the blood patterns on his clothing.

5.5212. Some support is also provided to this conclusion by the presence of the ivy leaf adjacent to Mr Miller's foot, which expert evidence supports being from the cliff top above his body.

5.5213. While the possibility that Mr Miller was lifted over the fence (or otherwise being the victim of homicide) cannot be altogether excluded, I accept that the probabilities support him having climbed the fence and fallen, for the reasons set out by Counsel Assisting.

Bias

5.5214. Counsel Assisting submitted that, on the basis of the conclusions that Mr Miller's death was as a result of an accidental fall and not a homicide, it was therefore not the result of LGBTIQ bias.[4886] The NSWPF joined in this submission.[4887]

5.5215. The Miller family did not specifically address bias in their submissions.[4888]

5.5216. In light of my conclusion that Mr Miller's death was accidental, I accept the submissions of Counsel Assisting.

Conclusions and recommendations

5.5217. I find that Mr Miller died in the early hours of Sunday, 2 March 1997, as a result of multiple injuries sustained in a fall from height. It is likely that the fall was accidental.

[4885] Supplementary submissions of Miller Family, 31 October 2023, [10] (SCOI.86430).

[4886] Submissions of Counsel Assisting, 15 June 2023, [170] (SCOI.83998).

[4887] Submissions of NSWPF, 30 June 2023, [71] (SCOI.84264).

[4888] Submissions of Miller Family, 30 June 2023 (SCOI.84265); Supplementary submissions of Miller Family, 31 October 2023, [5] (SCOI.86430).

5.5218. In my view, on the evidence available to the Inquiry, there is objectively no reason to suspect that LGBTIQ bias was a factor in Mr Miller's death.

5.5219. I make the following recommendations in relation to Mr Miller's death.

Recommendation 1

I recommend that the Commissioner of the NSWPF or a serving police officer make an application for a fresh inquest, in relation to the death of Mr Miller, having regard to the evidence considered by the Inquiry and the findings and conclusions I have made in relation to manner and cause of death.

IN THE MATTER OF SAMANTHA ROSE

Factual background

5.5220. Samantha Rose was a trans woman. It is clear from the evidence before the Inquiry that Ms Rose did not use the name Samantha in all contexts; at times, she used her former name, although she used Samantha in correspondence with friends and when she volunteered at radio stations 2RPH and 2SER. At the time of her death, she was undergoing hormone replacement therapy as part of the affirmation of her gender.

5.5221. As the evidence before the Inquiry demonstrates, there are many reasons why trans and gender diverse people may not be able to express their true gender in all aspects of their lives. For that reason, although Ms Rose was not able or did not choose to use the name Samantha in all contexts, I consider that the most appropriate and respectful approach is to proceed on the basis that Ms Rose was a woman who was not able to express that truth in all aspects of her life.

5.5222. At the time of her death, she was undergoing hormone replacement therapy as part of her affirmation of her gender.

Date and location of death

5.5223. Ms Rose was found deceased on 22 December 1997 at her home in the suburb of Kensington in Sydney. The Coroner found that Ms Rose died some time after 10:00am on 20 December 1997.[4889] She was 41 years old at the time of her death.

[4889] Exhibit 29, Tab 99F, Findings of Deputy State Coroner John Abernethy, Inquest into the death of Samantha Rose, 18 November 1999 (SCOI.83311). The Post-mortem Report of Dr Christopher Lawrence found that she died sometime between 10:00am on 20 December 1997 and 11:15am on 22 December 1997: see Exhibit 29, Tab 3, Post-mortem report of Dr Christopher Lawrence, 23 December 1997 (SCOI.00041.00016).

Circumstances of death

5.5224. Ms Rose was found deceased, lying on her back in the kitchen area of her apartment. Her arms were outstretched from her body and an unopened can of plums, one side of which was dented, was located between her legs. The injuries sustained by Ms Rose were severe and consistent with numerous heavy blows to the head with a blunt object. Maggots were observed around her nose and mouth.[4890]

5.5225. Ms Rose's apartment was in a state of disarray. Her furniture and personal items (including jewellery) were scattered throughout the unit. Two plastic breast implants were located, one in the loungeroom, and the other in the hallway. The television was lying face down in the loungeroom.

5.5226. Police officers gained entry to the unit through the kitchen window using a ladder. The front door was locked from the inside by way of two security locks and could not be opened without keys. The front screen door was unlocked. There was no evidence of forced entry.

Previous investigations

Post-mortem examination

5.5227. A post-mortem examination was conducted on 22 December 1997 by Dr Christopher Lawrence.[4891] Dr Lawrence identified significant injuries to the head including a subdural haematoma, an extradural haematoma, fractures on the left temple region, fractures in the occipital region and bruising on the back of the head. There were further impact sites on the cheeks and at least two to the back of Ms Rose's head. Dr Lawrence also reported bruising on various parts of Ms Rose's body including her arms, shoulder and sacrum. There was no indication of sexual trauma.[4892]

5.5228. Dr Lawrence concluded that "the pattern of injuries is strongly suggestive of an assault."[4893] The direct cause of death was recorded as "head injury".[4894]

5.5229. Ms Rose's blood was tested. No poisons or alcohol were detected.

Original police investigation

5.5230. The original police investigation into Ms Rose's death was overseen by Detective Sergeant Brian Matthes, until his resignation on 10 April 1998. Thereafter, Detective Senior Constable Michael Thornton assumed the role of OIC of the investigation into Ms Rose's death.[4895]

[4890] Exhibit 29, Tab 3, Post-mortem report of Dr Christopher Lawrence, 23 December 1997, 4 (SCOI.00041.00016).

[4891] Exhibit 29, Tab 3, Post-mortem report of Dr Christopher Lawrence, 23 December 1997 (SCOI.00041.00016).

[4892] Exhibit 29, Tab 3, Post-mortem report of Dr Christopher Lawrence, 23 December 1997, 2-3 (SCOI.00041.00016).

[4893] Exhibit 29, Tab 3, Post-mortem report of Dr Christopher Lawrence, 23 December 1997, 3 (SCOI.00041.00016).

[4894] Exhibit 29, Tab 3, Post-mortem report of Dr Christopher Lawrence, 23 December 1997, 2 (SCOI.00041.00016).

[4895] Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 23 October 1998, [3] (SCOI.00041.00005).

5.5231. At 11:00am on 22 December 1998, officers from Randwick Police Station attended Ms Rose's residence in response to concerns for her welfare raised by members of Ms Rose's family. At approximately 11:10am, Senior Constable Barry Thompson from the Police Rescue Squad obtained access to Ms Rose's unit via an open window. Upon entering the unit, Senior Constable Thompson observed Ms Rose's body lying in the kitchen.[4896]

5.5232. Subsequently, Crime Scene Officers, Detective Senior Constable Lyle Van Leeuwen and Detective Senior Constable Donald Nicol, attended Ms Rose's residence and conducted an examination of the scene.[4897]

5.5233. In his statement prepared for the coronial inquest, Detective Senior Constable Thornton outlined the steps taken by police to explore potential persons of interest and produced several statements which were obtained from friends and associates of Ms Rose. Police extensively canvassed houses in the area around Kensington and COPS inquiries were made of relevant incidents in Addison Street and its surrounds.[4898]

5.5234. Police also interviewed Ms Rose's co-workers at Radio 2RPH and Westpac. They generally described Ms Rose as a kind and well-liked person. None of Ms Rose's co-workers could identify anyone who would have wished to harm her.[4899]

5.5235. Inquiries were also made with various LGBTIQ establishments (described as "homosexual, trans-sexual and gender-based organisations" in the OIC's statement) to ascertain whether Ms Rose attended any of them and to get a better understanding of her lifestyle. These inquiries did not suggest Ms Rose had a connection with any of them.[4900]

5.5236. Information was obtained from the Camera Detection Unit that a relevant CCTV camera was not operating on the weekend of Ms Rose's death. Speed cameras from the vicinity returned nothing of interest.[4901]

5.5237. Detective Senior Constable Thornton explained that Mr Rose's death received "the usual media coverage at the beginning of the investigation, however this was toned down through the investigation at the request of the family of [Ms Rose]."[4902]

[4896] Exhibit 20, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 23 October 1998, [4]–[7] (SCOI.00041.00005).

[4897] Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 23 October 1998, [25], [32] (SCOI.00041.00005).

[4898] Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 23 October 1998, [296]–[299] (SCOI.00041.00005).

[4899] Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 23 October 1998, [61]–[73] (SCOI.00041.00005).

[4900] Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 23 October 1998, [292] (SCOI.00041.00005).

[4901] Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 23 October 1998, [293]–[294] (SCOI.00041.00005).

[4902] Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 23 October 1998, [295] (SCOI.00041.00005).

Persons of interest

5.5238. One key person of interest in relation to Ms Rose's death is Sandra Durward. Ms Durward died on 12 March 2006.[4903] She and Ms Rose met at some stage between 1986–1987, whilst volunteering at Radio Station 2RPH.[4904] They subsequently became friends and Ms Rose allowed Ms Durward to stay with her in her unit in Kensington from time to time. Ms Durward was aged 42 at the time of Ms Rose's death and worked as a sex worker at Final Touch Relaxation Centre and Bare Bunnies (massage parlours and/or sex-on-premises venues).[4905]

5.5239. Ms Durward had extant substance abuse issues and no stable accommodation. There is evidence of her drinking almost every day and some documented instances of aggression and violent outbursts in the lead up to Ms Rose's death.[4906] Her sister, Fiona Feary, said that Ms Durward had an alcohol and heroin addiction.[4907]

5.5240. At the coronial inquest into the death of Ms Rose, Ms Durward and David Thwaites (a friend of Mr Durward who provided an alibi for her movements on 20 December 1997), were called to give evidence. This is discussed further below. The Coroner all but excluded Ms Durward as the person responsible for Ms Rose's death stating:[4908]

> *[T]here is thus some suspicion about Ms Durward, largely because of some of the peculiar things she said to those around her after the death, but there is absolutely nothing to link her to the homicide of [Samantha] Rose, other than a vague suspicion.*

5.5241. The initial police investigation also considered other potential suspects, including Stephen Becker, a friend of Ms Rose, and Ian Rose, the brother of Ms Rose.

Exhibits: Availability and testing

5.5242. Upon the discovery of Ms Rose, police collected a number of exhibits from the crime scene. Those comprised the following items:[4909]

a. Can of plums;

b. Artificial breast implants;

c. Broken plate;

d. Clothing worn by Ms Rose, consisting of a white bra, orange mini-skirt, white t-shirt and white underpants; and

[4903] Exhibit 29, Tab 101, Death Certificate of Sandra Durward, 24 August 2022 (SCOI.73985); Exhibit 29, Tab 56, Transcript of recorded interview with Sandra Durward, 6 February 1997, 2 (SCOI.00041.00102).

[4904] Exhibit 29, Tab 54, Transcript of recorded interview with Sandra Durward, 26 December 1997, 3 (SCOI.00041.00101).

[4905] Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 3 October 1998, [110], [164]–[165] (SCOI.00041.00005).

[4906] Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 23 October 1998, [93], [106], [143] (SCOI.00041.00005).

[4907] Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 23 October 1998, [180] (SCOI.00041.00005).

[4908] Exhibit 29, Tab 99F, Findings of Deputy State Coroner John Abernethy, Inquest into the death of Samantha Rose, 18 November 1999, 6 (SCOI.83311).

[4909] Exhibit 29, Tab 99A, Review of Unsolved Homicide Case Screening Form, 6 May 2004, 19 (SCOI.03416).

e. Fingernails.

5.5243. I make mention of the exhibit referred to "[a]rtificial breast implants" when coming to consider the circumstances of Ms Rose's death. Although referred to as "implants", it would be more accurate to describe the exhibits as "inserts". The exhibits comprised padding (not dissimilar to the cup of a bra) which could be inserted into clothing or into a bra. However, in keeping with the language of this exhibit list, I will refer to those exhibits below as "artificial breast implants".

5.5244. Of the exhibits identified above, it appears that testing for the presence of blood was only conducted in respect of the can of plums and a broken plate found proximate to Ms Rose's body. Those tests returned a negative result for the presence of blood.[4910] It does not appear that any of the exhibits identified above were submitted for DNA testing. Rather, it appears that the label from the can of plums and swabs from the broken plate were retained for DNA analysis, "if required".[4911]

5.5245. In addition to those exhibits, a post-mortem blood sample was obtained from Ms Rose together with an oral and rectal swab/smear. A test of those items returned a positive result for blood on the oral and rectal swabs. Semen was not detected on the oral and rectal swabs and smears.[4912]

Findings at inquest

5.5246. An inquest was held at Glebe Coroners Court on 19 August 1999 before Deputy State Coroner Abernathy. The inquest was adjourned so that Mr Thwaites could be called in relation to Ms Durward's alibi and movements on 20 December 1997.[4913]

5.5247. On 18 November 1999, Deputy State Coroner Abernethy resumed the inquest and made the following finding in relation to Ms Rose:[4914]

> *Ms Rose died on 20 December 1997, at Kensington, of head injury inflicted then and there by a person or persons unknown.*

5.5248. No criminal proceedings were ever instituted against any person in relation to Ms Rose's death.

Subsequent police investigation

5.5249. Ms Rose's death has not been fully reinvestigated by police since the coronial inquest into her death concluded in 1999.

[4910] Exhibit 29, Tab 89, Further statement of Vivien Beilby, 3 February 1998, [3] (SCOI.10119.00025).

[4911] Exhibit 29, Tab 88, Expert statement of Vivien Beilby, 7 January 1998, 1 (SCOI.10119.00025); Exhibit 29, Tab 89, Further stat ement of Vivien Beilby, 3 February 1998, [3] (SCOI.10117.00003).

[4912] Exhibit 29, Tab 88, Expert statement of Vivien Beilby, 7 January 1998, 1 (SCOI.10119.00025).

[4913] Exhibit 29, Tab 99D, Transcript into the death of Samantha Rose, 19 August 1999, 78 (SCOI.8318).

[4914] Exhibit 29, Tab 99F, Findings of Deputy State Coroner Abernethy, Inquest into the death of Samantha Rose, 18 November 1999, 1 (SCOI.83311); Exhibit 29, Tab 100, 'Woman "must have killed", cross-dresser's inquest hears', *Daily Telegraph*, 20 August 1999 (SCOI.10122.00002).

5.5250. Ms Rose's death was the subject of reviews by the UHT in 2004 and 2021. It was also the subject of a Strike Force, which was established with a view to pursuing certain identified lines of inquiry arising out of the 2004 review. Further detail in this regard is canvassed below. Notably, recent UHT documents described Ms Rose in a manner that is accepted by the NSWPF to be disrespectful and unacceptable. That is addressed separately at **Chapter 8** of this Report.

5.5251. In 2004, an initial review of the investigation into the death of Ms Rose was conducted by the UHT and, on 6 May 2004, the following recommendations were made (**the First Review**):[4915]

a. Obtaining the Call Charge Records (**CCR**) and Reverse Call Charge Records (**RCCR**) for Ms Durward's mobile phone from 20–22 December 1997, being the weekend of Ms Rose's death;

b. Submitting exhibits held by the NSWPF to DAL for trace DNA examination to take place;

c. Enquiring with the Coroners Court, in particular Deputy State Coroner Abernathy, in relation to the evidence Ms Durward gave at the inquest into the death of Ms Rose, noting that the court file was unable to be located;

d. Approaching Ms Durward to obtain a DNA sample and conducting electronic surveillance on Ms Durward; and

e. Pursuing further lines of inquiry regarding Mr Thwaites, including re-interviewing him in relation to the alibi he provided for Ms Durward.

5.5252. On 20 May 2007, Detective Inspector Michael Ashwood recommended that the case of Ms Rose be allocated to the Eastern Beaches LAC for the purpose of further investigation. That further investigation comprised the pursuit of certain identified lines of inquiry with a view to resolving any "outstanding issues that may or may not lead to identifying or charging specific offenders". However, it was not intended that the case of Ms Rose be "fully reinvestigated".[4916]

5.5253. The following lines of inquiry were identified by Detective Inspector Ashwood in a Recommendation Report dated 28 March 2007, and largely mirror the recommendations recorded in the First Review:[4917]

a. Submitting exhibits held by the NSWPF to DAL for trace DNA examination to take place;

b. Conducting a review of all fingerprint evidence, including searches for palm prints on NAFIS II;

c. Obtaining the CCR and RCCRs for Ms Durward's mobile phone;

[4915] Exhibit 29, Tab 99A, Review of Unsolved Homicide Case Screening Form, 6 May 2004 (SCOI.03416); Exhibit 29, Tab 115, Case Screening Form, 22 June 2004, 18 (SCOI.84820).

[4916] Exhibit 29, Tab 113, Report recommending investigation, 20 May 2007 (SCOI.84816).

[4917] Exhibit 29, Tab 114, Recommendation for further investigation, 28 March 2007 (SCOI.84827); Exhibit 29, Tab 99A, Case Screening Form, 6 May 2004, 18 (SCOI.03416).

d. Enquiring with the Coroners Court, in particular Deputy State Coroner Abernathy, in relation to the evidence Ms Durward gave at the inquest into the death of Ms Rose, noting that the court file was unable to be located;

e. Conducting electronic surveillance on Ms Durward, including consideration of overt/covert collection strategies for DNA and fingerprints; and

f. Pursuing further lines of inquiry regarding Mr Thwaites, including reinterviewing him in relation to the alibi he provided for Ms Durward.

5.5254. Between 15–25 June 2007, Detective Inspector Ashwood's recommendation was endorsed by the Commander of the NSWPF Homicide Squad, Detective Superintendent Beresford, the Manager of Investigations Support within the State Crime Command, Detective Chief Inspector Del Monte, and other senior NSWPF officers, presumably within the Eastern Beaches LAC.[4918]

5.5255. Strike Force Cumbumarra was established, presumably after 25 June 2007, to reinvestigate the matter of Ms Rose "as per the review and subsequent recommendations" made by the UHT in March 2007. Detective Sergeant Anthony Shaw was appointed Commander with oversight from Detective Inspector Paul Pisanos.[4919]

5.5256. On the basis of material produced by the NSWPF, it appears that limited investigative steps were taken by Strike Force Cumbumarra throughout 2007. On 9 January 2008, Detective Sergeant Shaw reported that a number of general enquiries were conducted in an effort to locate Ms Durward. Those enquiries were unsuccessful and described as "ongoing". In response to the report, Detective Inspector Pisanos noted that he expected Detective Sergeant Shaw to "fully investigate this matter in a timely fashion and update E@gle.i".[4920]

5.5257. On 13 March 2008, Detective Sergeant Shaw reported that over 100 exhibits relating to Ms Rose's death were being considered by investigators. Investigators were also liaising with DAL for the purpose of determining the most appropriate exhibits to reexamine. The report also noted enquiries with the Coroners Court in relation to transcripts of Ms Durward's evidence and other enquiries regarding CCR and RCCRs for Ms Durward. In response to the report, Detective Sergeant Grant Elder, Investigation Manager at Eastern Beaches LAC, noted that "this investigation needs to be attended to prior to [Detective Sergeant Shaw's] proposed extended leave in 2008. There is little record of investigation performed this far". Detective Inspector Pisanos also noted that "action is required forthwith" and to "address the forensic side of things".[4921]

5.5258. On 4 February 2009, Detective Sergeant Shaw reported on the progress of the investigation and outlined the steps taken by Strike Force Cumbumarra. In response to that report, the following entries are recorded:[4922]

[4918] Exhibit 29, Tab 113, Report recommending investigation, 22 June 2007 (SCOI.84816).

[4919] Exhibit 29, Tab 116, Terms of Reference – Strike Force Cumbumarra, undated (SCOI.84821).

[4920] Exhibit 29, Tab 117, Report regarding dissemination of unsolved homicide case file, 14 January 2008 (SCOI.84823).

[4921] Exhibit 29, Tab 118, Report regarding dissemination of unsolved homicide case file, 25 March 2008, 2 (SCOI.84826); Exhibit 29, Tab 121, Exhibit book and related entries, various (SCOI.84822).

[4922] Exhibit 29, Tab 119, Report regarding dissemination of unsolved homicide case file, 12 February 2009, 2-3 (SCOI.84825).

a. Detective Sergeant Elder noted that it is "quite evident that [Detective Sergeant Shaw] has not conducted satisfactory and timely inquiries with this matter and further investigations need to occur forthwith";

b. The Crime Manager at Eastern Beaches LAC noted that "this matter has not progressed sufficiently from when it was received at the LAC. [Detective Sergeant Shaw] is to be monitored more closely to ensure the above enquiries are completed in a timely manner"; and

c. Detective Inspector Pisanos noted that the matter should be returned "with strict adherence to timeframes" with "monthly status reports required".

5.5259. On 12 February 2009, Detective Sergeant Shaw contacted the Eastern Beaches LAC. A related investigator's note records as follows:[4923]

> *[Detective Sergeant Shaw] stated he was given the investigation back in 2007 and by his own admission he has not conducted any inquiries into the matter. He informed me that the suspect in the matter Sandra DURWARD, died in 2006 and therefore his investigation was complete. He was informed that the necessary inquiries would still have to be undertaken regardless with the matter either put before the Coroner again if required, or a lengthy report completed and submitted to the Commander of Homicide outlining the inquiries and actions taken.*

5.5260. In 2021 the investigation into the death of Ms Rose was subject to a further review by the UHT (**the Second Review**). Recommendations made on 30 September 2021 included:[4924]

a. Submitting exhibits held by the NSWPF, in particular, the dented can of plums and the artificial breast implants located at the scene, and the t-shirt Ms Rose was wearing at the time of her death, for forensic analysis;

b. Pursuing further lines of inquiry regarding Mr Thwaites;

c. Consulting a pathologist regarding the injuries sustained by Ms Rose in order to ascertain the manner and cause of Ms Rose's death; and

d. Giving consideration to an offer of a reward for information, with a view to identifying a possible source or new lines of inquiry.

5.5261. It is unclear whether, and to what extent, any of the steps identified in the First Review, Strike Force Cumbumarra, and the Second Review were pursued. In particular, the exhibits held by the NSWPF do not appear to have been submitted for DNA trace examination to take place. There is no explanation in the material obtained by the Inquiry for the apparent failure to implement these recommendations.

[4923] Exhibit 29, Tab 120, Investigator's Note regarding enquiries, 16 February 2009, 1 (SCOI.84824).

[4924] Exhibit 29, Tab 99C, UHT review in relation to Samantha Rose, 30 September 2021, 62-64 (SCOI.02713).

5.5262. The Inquiry has taken steps consistent with some of the recommendations made in the First Review, Strike Force Cumbumarra, and the Second Review. These included submitting exhibits held by the NSWPF to FASS for forensic analysis and requesting FASS examine exhibits stored by them in this case, obtaining expert reports from Dr Linda Iles and Dr Danny Sullivan, and obtaining the Coroners Court file in relation to the inquest into the death of Ms Rose.

Strike Force Parrabell

Bias Crimes Indicators Form

5.5263. A BCIF was completed in this case by Strike Force Parrabell in 2017. It concluded that there was insufficient information to establish that Ms Rose's death was the result of a bias crime.

5.5264. Of the ten indicators used in the BCIF, eight are answered as "Insufficient Information" ("Comments, Written Statements, Gestures"; "Drawings, Markings, Symbols, Tattoos, Graffiti"; "Organised Hate Groups"; "Previous existence of Bias Crime Incidents"; "Victim/Witness Perception"; "Motive of Offender/s"; "Location of Incident"; and "Level of Violence"), and two ("Differences"; "Lack of Motive") as "Suspected Bias Crime".[4925]

5.5265. Under the first indicator, in response to the prompt "Historical animosity exists between the victim's group and the POI's group", the response set out in the BCIF begins as follows:[4926]

> *As no person/s was charged with the murder of ROSE it is unknown if any animosity existed between ROSE and the offender/s. It was suggested that ROSE's brother, Ian ROSE, could be a suspect with the understanding that he did not approve of his brothers [sic] cross dressing behaviour with historical animosity existing between the two because of this.*

5.5266. Counsel Assisting submitted that the meaning of the terms "historical animosity" and "victim's group" in the prompt is unclear. In particular, Counsel Assisting submitted that if it is intended to refer to a notion of historical animosity towards trans persons, there is no evidence to suggest that Ian Rose displayed any prior animosity towards Ms Rose on the basis that she was trans. Rather, the evidence suggests that among Ms Rose's family members, Mr Rose was generally accepting of Ms Rose's trans status.[4927] On that basis, both the prompt, and the content of what has been written in response to it, lack clarity.

[4925] Exhibit 29, Tab 99, Investigator's Note re Bias Crimes Indicator Review Form, 9 March 2017 (SCOI.45271).

[4926] Exhibit 29, Tab 99, Investigator's Note re Bias Crimes Indicator Review Form, 9 March 2017, 4 (SCOI.45271).

[4927] Submissions of Counsel Assisting, 2 June 2023, [37] (SCOI.83401).

5.5267. The NSWPF acknowledged in its submissions that the BCIF read in isolation does not set out sufficient particulars to allow a comprehensive understanding of the comment made regarding Mr Rose. The NSWPF also noted that the comment in respect of that indicator was evidently regarded as of no moment in the final conclusion reached. In particular, there is no real evidence that Mr Rose was in fact, involved in Ms Rose's death and Ms Durward was clearly the only current suspect.[4928]

5.5268. As to Counsel Assisting's submission that the prompt lacks clarity, the NSWPF submitted that the basis for this submission is unclear and the language in the prompt plainly refers to the possible existence of historical animosity between a group to which the victim belongs and a group of which the person of interest is a member.[4929]

5.5269. Assuming that there is clarity around what the prompt means, it is nevertheless evident that the response in the BCIF itself lacks clarity because it is silent as to any animosity between groups, and sits at odds with the underlying evidence in relation to Mr Rose's attitude.

Results of Strike Force Parrabell

5.5270. Strike Force Parrabell categorised the case as "insufficient information to establish a bias crime".

5.5271. The academic review categorised it as "insufficient information".

5.5272. The matter was categorised as "unsolved" by Strike Force Parrabell.

5.5273. As noted above, two of the ten indicators were answered as "Suspected Bias Crime", namely "Differences" and "Level of Violence". The "General Comment" section in respect of those two indicators summarises the applicable material in respect of each respectively, namely that Ms Rose was as a trans person; there were "no efforts to conceal [her] desire to dress as a woman"; it was unknown if animosity existed between Ms Rose and the offender/s; there was an absence of a firm motive; and there was a substantial degree of violence which did not appear premeditated. However, the summaries do not offer any reasoning as to why that material indicates a "suspected bias crime".[4930]

5.5274. The "Summary of Findings" section is derived from extracts from earlier parts of the document. It nominates "Insufficient' Information" as the overall outcome and is in the following terms:[4931]

> *The murder of ROSE remains unsolved. A number of suspects were identified but no charges were laid. As such, the offender's sexual orientation or identity is unknown. ROSE was described as 'asexual' having no sexual attraction to either females or males. ROSE lived [her] life as transgender, dressing in women's clothes from the age of 18. ROSE*

[4928] Submissions of NSWPF, 16 June 2023, [40] (SCOI.84153).

[4929] Submissions of NSWPF, 16 June 2023, [36]–[41] (SCOI.84153).

[4930] Exhibit 29, Tab 99, Investigator's Note re Bias Crimes Indicator Review Form, 9 March 2017 (SCOI.45271).

[4931] Exhibit 29, Tab 99, Investigator's Note re Bias Crimes Indicator Review Form, 9 March 2017, 16 (SCOI.45271).

had never had a sexual relationship with a male or female and from the early age of five or six had wanted to be female. No bias related drawings, markings, symbols or graffiti were depicted in photographs reviewed of ROSE or the scene. There was an apparent lack of evidence of any forced entry into ROSE'S unit suggesting that [she] knew the assailant. As there were no signs of break and enter, fraud or any other clear motivators, it cannot be ruled that sexuality or other bias may have been involved in the death of ROSE. ROSE suffered two fractures to his skull, accompanied by severe bruising. The head fractures were consistent with numerous heavy blows to the head with a blunt object ultimately proving fatal. There was no indication of sexual trauma. The level of violence displayed towards ROSE is substantial however there is no indication that the fatal assault on ROSE was [premeditated].

5.5275. The Case Summary for this matter reads as follows:[4932]

Identity: *[Samantha] Rose was 41 years old at the time of [her] death.*

Personal History: *[Ms] Rose was living [her] life as a transgender man. [She] dressed in female attire from 18 years of age. At the time of [her] death, [Ms] Rose was undergoing hormone therapy (Estrogens) to progress [her] transition to female and was suffering side effects from the treatment including nausea and headaches. [Ms] Rose worked as a computer analyst for Westpac Bank and often wore female clothing to work. [Ms] Rose also volunteered as a community radio presenter on radio stations 2RPH (Radio for the Print Handicapped) and 2SER. [Ms] Rose occasionally used an alias of 'Samantha' and disguised [her] voice to sound more feminine.*

Location of Body/Circumstances of Death: *[Ms] Rose's body was located inside [her] residential unit at Addison Street, Kensington. [Her] body suffered severe injuries including fractures of [her] skull and severe bruising. [Ms] Rose's injuries were consistent with numerous heavy blows to the head with a blunt object. There was no indication of sexual trauma.*

Sexual Orientation: *[Ms] Rose identified as asexual (without sexual feelings or association).*

Coroner/Court Findings: *Police identified a number of suspects, however no charges were laid, leaving the sexual identity of [Ms] Rose' attacker unknown. It was believed that [Ms] Rose had never had a sexual relationship. [Ms] Rose was very security conscious, however there was no evidence of forced entry to [her] unit suggesting [she] may have known [her] killer. [Ms] Rose was considered wealthy, owning several properties with a large amount of money in the bank. Police could not establish any clear motivation for [Ms] Rose's murder, whether linked to sexuality or other bias. The level of violence used to kill [Ms] Rose was substantial, however*

[4932] Exhibit 6, Tab 49, Strike Force Parrabell: Case Summaries, Undated 39 (SCOI.76961.00014).

> *there was no evidence to suggest premeditation. [Ms] Rose's murder remains unsolved.*
>
> ***SF Parrabell concluded there was insufficient information to establish a bias crime***

5.5276. The content of this case summary is consistent with the comments made in the BCIF.

5.5277. The Academic Review placed the case in the category of "Insufficient information". The reasoning of the academic reviewers in this particular case is unknown. Generally, as to their category of "Insufficient information", the academic team said that "it was ultimately impossible for the detectives to make definitive determinations about many of the deaths under review, and based on available information, the academic reviewers concur".[4933]

Review by the Inquiry

5.5278. The Inquiry took the following steps in the course of examining the matter.

Summonses

5.5279. A summons was issued to the NSWPF on 18 May 2022 for all documents relating to investigations by the NSWPF of the death of Ms Rose, including certain prescribed categories of information identified at (1)(a) to (j) of the summons. That summons also called for any other material held or created by the UHT in relation to the death of Ms Rose (NSWPF1). The NSWPF subsequently produced their holdings in relation to Ms Rose to the Inquiry in multiple tranches.

5.5280. On 23 August 2022, the Inquiry issued a summons to BDM for records of Ian Rose, Bertha Rose, Max Rose, David Thwaites, Clive Starling, Peter Thornton, and Sandra Durward (BDM2). On 25 August 2022, BDM produced the records to the Inquiry.

5.5281. On 2 September 2022, the Inquiry issued a summons to the NSWPF for, among other things, material relating to Mr Thwaites (NSWPF14). On 12 September 2022 the NSWPF produced Mr Thwaites' criminal history to the Inquiry.

5.5282. On 28 April 2023, the Inquiry issued a summons to the NSWPF for, among other things, material relating to Stephen Becker (NSWPF94). On 5 May 2023 the NSWPF produced Mr Becker's criminal history to the Inquiry.

5.5283. On 19 May 2023, the Inquiry issued a summons to the Northern Sydney LHD for medical recordings relating to Stephen Becker (NSLHD1). On 23 May 2023, the Northern Sydney LHD produced Mr Becker's records to the Inquiry.

[4933] Exhibit 1, Tab 2, Final Report of Strike Force Parrabell, June 2018, 54 (SCOI.02632).

Interagency cooperation

5.5284. On 23 August 2022, the Inquiry requested the coronial file in relation to Ms Rose's death. The Coroners Court advised that no records were held in relation to the inquest.

5.5285. On 26 April 2023, the Inquiry requested that a further search be conducted by the Coroners Court with a view to locating the coronial file. On 11 May 2023, the Coroners Court advised that upon conducting further searches the coronial file was located.

5.5286. On 12 May 2023, the coronial file was produced to the Inquiry.

Family members

5.5287. The Inquiry attempted to contact Ms Rose's brother, Ian Rose, and Ms Rose's mother, Bertha Rose, but these attempts were unsuccessful.

Further forensic examinations

5.5288. On 22 December 2022, a letter was sent to the FETS Command containing a request to conduct fingerprint and palm print examinations in relation to the death of Ms Rose.[4934] On 9 March 2023, the NSWPF produced a certificate regarding the fingerprint and palm print examinations.[4935]

5.5289. On 17 February 2023, a letter was sent to FASS requesting testing of specified exhibits held by the NSWPF from the initial investigation conducted in relation to Ms Rose's death. On 22 March 2023, a letter was sent to the NSWPF requesting that further exhibits held in relation to Ms Rose's death be transported to FASS for forensic testing.

5.5290. On 26 May 2023 and 29 June 2023 respectively, expert certificates setting out the analysis undertaken by FASS, and the results obtained in relation to the testing were received by the Inquiry. Further detail as to the results of that analysis appears below.

Results of further DNA analysis

5.5291. The Inquiry sought DNA analysis of some of the exhibits collected from the crime scene exhibits stored by FASS. On 26 May 2023, the Inquiry received a statement from Michele Franco setting out the results of the forensic analysis.[4936] Where a result is reported as "unsuccessful", it can indicate one of several outcomes, such as there was no DNA detected; or the amount of DNA recovered from the sample was below the laboratory threshold for routine further DNA testing. Ms Franco reported as follows:[4937]

[4934] Exhibit 29, Tab 107, Letter from the Inquiry to the NSW Police Force requesting fingerprint testing, 22 December 2022 (NPL.0100.0001.0006).

[4935] Exhibit 29, Tab 106, Expert Certificate of Karen Halbert, 8 March 2023 (NPL.0100.0001.0008).

[4936] Exhibit 29, Tab 109, Expert Certificate of Michele Anne Franco, 26 May 2023 (SCOI.83340).

[4937] Exhibit 29, Tab 109, Expert Certificate of Michele Anne Franco, 26 May 2023. [5] (SCOI.83340).

a. DNA testing on each of the five fingernails on the left and right hands was unsuccessful;

b. DNA testing of the can of plums identified a female profile that matched an elimination sample of a person on FASS' Quality Assurance Register. This means it matched a person from FASS who has come in contact with the exhibit. Otherwise, testing was unsuccessful or returned a low DNA profile that is not suitable for comparison;

c. The DNA recovered from one of the stored swabs of a broken plate recovered a mixture that originated from at least four individuals. Ms Rose could not be excluded as one of the major contributors. The DNA profiles of the individual contributors could not be determined due to the complexity of the mixture. DNA interpretation software was used to screen for possible contributors on the NSW DNA database. A person was identified as being a possible contributor, however it is believed that this is a result of a contamination event which occurred in the laboratory in 1998 before suitable contamination prevention measures were introduced to align with the increasing sensitivity of DNA testing. The evidence did not disclose the possible sources of the other apparent DNA contributors to this particular swab. Otherwise, DNA recovered from the other swabs taken from the broken plate had the same profile as Ms Rose;

d. DNA testing of the artificial breast implants identified a female profile that matched an elimination sample of a person on FASS' Quality Assurance Register. Otherwise, testing was unsuccessful on both artificial breast implants;

e. A positive screening test for blood was returned and two hair samples were retrieved from the white bra. Testing of the blood stain returned a partial DNA profile for Ms Rose. One hair sample has been identified as suitable for nuclear DNA testing and has been stored for testing, as required. Testing on the second hair sample was unsuccessful;

f. A positive screening test for blood was returned and a number of hair samples were retrieved from the orange mini-skirt. One hair sample returned a DNA profile for Ms Rose. Testing on the remaining hair samples was either unsuccessful or returned a low DNA profile that is not suitable for comparison;

g. A positive screening test for blood was returned and several hair samples were retrieved from the white t-shirt. Testing of two hair samples returned a DNA profile for Ms Rose. Three of the hair samples were identified as originating from an animal. Mitochondrial DNA testing may be able to determine the type of animal. Testing of the remaining hair samples was otherwise unsuccessful or returned a low DNA profile that is not suitable for comparison;

h. A clump of white tissues was located in the same exhibit bag as the white t-shirt. Yellow stains were observed on the tissues. Spermatozoa were not detected on the tissues; and

i. A positive screening test for blood was returned and several hair samples were retrieved from the white underpants. The hair samples are unsuitable for DNA testing.

5.5292. On 29 June 2023, an expert certificate setting out certain further analysis undertaken by FASS, and the results obtained in relation to the testing, was received by the Inquiry. Ms Franco reported that the hair located on Ms Rose's bra was unsuitable for DNA testing. As to the animal hair located on the outside of Ms Rose's t-shirt, mitochondrial testing revealed that the profile matched that of a guinea pig.[4938]

Professional opinions

Report of Dr Linda Iles

5.5293. As to the likely manner and cause of Ms Rose's death, the Inquiry sought the expert opinion of Dr Iles.[4939] The Inquiry received the report of Dr Iles on 28 May 2023.[4940]

5.5294. Dr Iles stated that Ms Rose's cause of death is best described as blunt head injuries. She observes blunt impacts to both sides of Ms Rose's head and face. On first principles, sustaining injuries to multiple different planes of the head is not indicative of a simple fall. Dr Iles considered that there is limited potential for a complex fall inside Ms Rose's home. She also precluded a complex fall related to stairs outside of Ms Rose's home.[4941]

5.5295. Dr Iles could not exclude that Ms Rose's head injuries were due to blows to the left and right side of the head with an object/weapon. However, it is possible that this spectrum of injuries may represent a significant crush type injury from a heavy object. The only object that Dr Iles could see in the photographs that might cause such an injury is the toppled over television.[4942]

5.5296. Dr Iles observed from the crime scene photos that the vents of the upturned television have a linearity similar, to an extent, to the linear patterning of intradermal bruising to the left side of Ms Rose's face. However, Dr Iles could not determine from the photographs the profile of this part of the television, nor could she accurately compare this to the injury on the left side of her face. She also could not exclude that this injury was caused by stomping on the face, but considered it is less likely. The Inquiry has reviewed all the material available to it and has been unable to find information relating to the make and model of the television. Unfortunately, the television was never treated as an exhibit by police and was never subjected to any forensic examination.[4943]

[4938] Exhibit 29, Tab 110, Expert Certificate of Michele Anne Franco, 29 June 2023, 2 (SCOI.84817).

[4939] Exhibit 29, Tab 104, Letter of Instruction to Dr Linda Iles, 26 April 2023 (SCOI.83314).

[4940] Exhibit 29, Tab 105, Expert Report of Dr Linda Iles, 28 May 2023 (SCOI.83339).

[4941] Exhibit 29, Tab 105, Expert Report of Dr Linda Iles, 28 May 2023, 8 (SCOI.83339).

[4942] Exhibit 29, Tab 105, Expert Report of Dr Linda Iles, 28 May 2023, 10 (SCOI.83339).

[4943] Exhibit 29, Tab 105, Expert Report of Dr Linda Iles, 28 May 2023, 9-10 (SCOI.83339).

5.5297. Dr Iles considered that the traumatic brainstem haemorrhage sustained by Ms Rose signifies significant primary traumatic brain injury and is highly suggestive of rapid unconsciousness following injury. Such an injury could occur via crush injury to the head from a heavy object. Fatal crushing head injuries from falling televisions are well recognised in children but are less common in adults. Dr Iles considers that the scattered objects and disturbed furniture raise the possibility of an altercation in Ms Rose's home. The television may have fallen on Ms Rose's head during the altercation. Whilst speculative, this scenario could account for the spectrum of pathological findings in the case. Significantly, Dr Iles could not readily construct a scenario that did not involve another individual in Ms Rose's death.[4944]

5.5298. Dr Iles noted that her review was limited in some respects. Some descriptive details are lacking, and the extent of photography limited her capacity for a thorough review. In particular, no scales of measurement were used in post-mortem photography. This is particularly pertinent to the injury to the left side of Ms Rose's face. There is injury to her left check and earlobe that has distinct rectangular linear components. Without a scale applied, it is difficult to compare this injury to potential objects that may have caused it. Dr Iles also noted that there were no photos of Ms Rose's hands nor any comment in the report regarding the presence or absence of offensive or defensive injuries.[4945]

Report of Dr Danny Sullivan

5.5299. As to a possible motive of Ms Rose's killer, the Inquiry sought the expert opinion of Dr Sullivan.[4946] The Inquiry received the report of Dr Sullivan dated 15 May 2023.[4947]

5.5300. Dr Sullivan considered whether any aspects of the manner of death and/or crime scene may indicate that the homicide occurred in the context of LGBTIQ hate or bias. He considered that there were "no aspects of the offence that suggest that the death was associated with Ms Rose's transgender identity" and that "no elements of the crime scene appear clearly associated with a hate crime". As to the presence of an unexplained or unidentified palm print on Ms Rose's breast implant, he opined that this does not clearly establish a sexual motive or interaction.[4948]

5.5301. As to the possible motivations of the perpetrator, Dr Sullivan noted that the can of plums between Ms Rose's legs may have had a symbolic sexual meaning to the killer but this cannot be confirmed and there was no indication of sexual interference. He does not consider that on the available evidence, sexuality or gender is a motive for the assault on Ms Rose.[4949]

[4944] Exhibit 29, Tab 105, Expert Report of Dr Linda Iles, 28 May 2023, 11 (SCOI.83339).

[4945] Exhibit 29, Tab 105, Expert Report of Dr Linda Iles, 28 May 2023, 7-10 (SCOI.83339).

[4946] Exhibit 29, Tab 102, Letter of Instruction to Dr Sullivan, 28 April 2023 (SCOI.83312).

[4947] Exhibit 29, Tab 103, Expert Report of Dr Sullivan, 15 May 2023 (SCOI.83317).

[4948] Exhibit 29, Tab 103, Expert Report of Dr Sullivan, 15 May 2023, [31] (SCOI.83317).

[4949] Exhibit 29, Tab 103, Expert Report of Dr Sullivan, 15 May 2023, [32] (SCOI.83317).

5.5302. Dr Sullivan's opinion highlights the inherent limitations of attempting to ascertain motive in circumstances where the offender is unknown.

Report of Professor Alison Jones

5.5303. There is evidence that Ms Durward was a consumer of methylated spirits. Accordingly, the Inquiry sought a report from Professor Alison Jones on the effects of methylated spirits consumption.[4950]

5.5304. Professor Jones reported that methylated spirits contain 70–99% ethanol, which is a known neurotoxin and central nervous system depressant. Professor Jones described the effects of consumption as follows:[4951]

a. Even at low to moderate blood ethanol levels, it has been observed to impair balance, visual focus, reaction times, executive judgment and to change a person's behaviour;

b. Substantial impairments across multiple measures of cognitive (e.g., information processing) and psychomotor functions (e.g., eye-brain-hand-foot coordination) that directly bear on the risk of all forms of injury; and

c. Acute effects of ethanol on the brain and central nervous system includes impairments of visuo-motor control, divided attention, focused attention, reaction time, response inhibition and working memory.

5.5305. Professor Jones also noted that alcohol-dependent people, who have built up a tolerance to alcohol, may use methylated spirits as their drink of choice due to the high alcohol content. Based on her experience, Professor Jones opines that patients who use methylated spirits are generally chronic alcohol-dependent people.[4952]

5.5306. As to the propensity for violence, Professor Jones opined that, although at times controversial, there is robust evidence supporting the conclusion that alcohol use by victims at the time of the offence increases the risk of interpersonal violence. In relation to Ms Durward in particular, Professor Jones observed that Ms Durward had a history of repeated violence and methylated spirits consumption.[4953]

5.5307. With respect to memory recall, Professor Jones reports that acute systemic exposure to ethanol and its metabolites through methylated spirits ingestion can result in behavioural and motor coordination changes and low blood alcohol concentration. In particular, consumption of ethanol is associated with an increased risk of injury, domestic violence and intentionally inflicted harm.[4954]

[4950] Exhibit 29, Tab 112, Letter of Instruction to Professor Alison Jones, 6 June 2023 (SCOI.84818).

[4951] Exhibit 29, Tab 111, Expert report of Professor Alison Jones, 13 July 2023, 2-3 (SCOI.84819).

[4952] Exhibit 29, Tab 111, Expert report of Professor Alison Jones, 13 July 2023, 5 (SCOI.84819).

[4953] Exhibit 29, Tab 111, Expert report of Professor Alison Jones, 13 July 2023, 4 (SCOI.84819).

[4954] Exhibit 29, Tab 111, Expert report of Professor Alison Jones, 13 July 2023, 6 (SCOI.84819).

Fingerprint analysis

5.5308. Fingerprints were found in various parts of the crime scene, including on the telephone handset, broom cupboard, archway leading to the dining room, bottle, appointment card, Christmas card, vehicle, and artificial breast implants.

5.5309. On 8 March 2023, at the request of the Inquiry, a comparative examination of the unidentified fingerprints was taken, both manually and against the National NAFIS database. The following results were obtained:[4955]

a. The fingerprints located on the telephone handset, broom cupboard, appointment card and archway were those of Ms Rose;

b. The fingerprints on the breast implant could not be identified, however Ms Durward's fingerprints were excluded;

c. The fingerprint located on the envelope of the Christmas card was Mr Becker's;

d. The fingerprints located on the surface of the bottle could not be identified, however, Mr Becker was excluded; and

e. The fingerprints located on the internal rear vision mirror of Ms Rose's vehicle could not be identified.

5.5310. The identification of Ms Rose's fingerprints on locations within her own unit is unsurprising. The balance of the findings are not of any significant forensic utility to the investigation of Ms Rose's death. Although there may be some relevance in Ms Durward's fingerprints being excluded from the breast implant, this does not exclude the possibility that the implant was displaced during the course of the assault on Ms Rose.

Contact with OICs

5.5311. On 24 August 2023 and 18 September 2023, the Inquiry wrote to Anthony Shaw enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Ms Rose.[4956] On 25 August 2023 and 18 September 2023, the Inquiry also wrote to Paul Thornton enclosing the same.[4957]

5.5312. The Inquiry did not receive a response from Mr Shaw. Mr Thornton advised that he did not wish to participate in the Inquiry by putting on submissions.

[4955] Exhibit 29, Tab 106, Expert Certificate of Karen Halbert, 8 March 2023, 3-8 (NPL.0100.0001.0008).

[4956] Exhibit 66, Tabs 68–69, Letter to Anthony Shaw, 24 August 2023 and 18 September 2023 (SCOI.86327; SCOI.86328).

[4957] Exhibit 66, Tabs 71–72, Letters to Paul Thornton, 25 August 2023 and 18 September 2023 (SCOI.86330; SCOI.86331).

Contact with next of kin of Sandra Durward

5.5313. In light of the evidence before the Inquiry as to the potential involvement of Ms Durward in Ms Rose's death, and the possibility that Counsel Assisting may make submissions to that effect, the Inquiry wrote to Ms Durward's sister on 26 May 2023. By that letter, the Inquiry advised of the date of the public hearing and provided a timeframe for Ms Durward's sister to contact the Inquiry to provide information and/or make submissions. The Inquiry did not receive a response.[4958]

Consideration of the evidence

Ms Rose's background

5.5314. Ms Rose was born on 29 April 1956 and was 41 years old when she died. She had one younger brother and was in regular contact with her parents. She worked at Westpac Bank in Sydney as a systems programmer and volunteered at radio stations 2RPH and 2SER as a presenter reading newspaper articles.[4959] In the context of her volunteer work at the radio stations, Ms Rose came to know Ms Durward and Mr Becker.[4960]

5.5315. At the age of around 12 years old, Ms Rose was prescribed a human growth hormone with a view to spurring her growth.[4961] This occurred in response to bullying at school due to her height. Ms Rose took human growth hormones for a period of two years, but she only grew to approximately five feet and one inch.[4962]

5.5316. On 7 October 1997, Ms Rose commenced hormonal treatment of Androcur and Progynova, prescribed by Dr Alfred Steinbeck, a medical practitioner and endocrinologist.[4963] Ms Rose had told Dr Steinbeck that she had never had a sexual relationship, and further that she was not attracted to men and was only attracted to women as friends.[4964]

5.5317. There is some evidence as to the attitude of Ms Rose's parents and brother to her transition.

[4958] Exhibit 68, Tab 28, Letter from the Inquiry, 26 May 2023 (SCOI.86642).

[4959] Exhibit 29, Tab 8, Statement of Bertha Ruth Rose, 9 January 1998, [4], [12], [34]–[35] (SCOI.00041.00030).

[4960] Exhibit 29, Tab 12, Transcript of recorded interview with Stephen Becker, 22 December 1997, 3 (SCOI.00041.00103); Exhibit 29, Tab 54, Transcript of recorded interview with Sandra Durward, 26 December 1997, 3 (SCOI.00041.00101).

[4961] Exhibit 29, Tab 8, Statement of Bertha Ruth Rose, 9 January 1998, [8] (SCOI.00041.00030).

[4962] Exhibit 29, Tab 8, Statement of Bertha Ruth Rose, 9 January 1998, [8] (SCOI.00041.00030); Exhibit 29, Tab 9, Statement of Max Rose, 9 January 1998, [8] (SCOI.00041.00032).

[4963] Exhibit 29, Tab 39, Statement of Dr Alfred Steinbeck, 21 January 1998, [10]–[11] (SCOI.00041.00083)

[4964] Exhibit 29, Tab 39, Statement of Dr Alfred Steinbeck, 21 January 1998, [8] (SCOI.00041.00083).

5.5318. Bertha Rose, the mother of Ms Rose, stated that at 21 years old, Ms Rose approached her and said that "[she] should have been a girl and that [she] would feel more comfortable as a girl."[4965] Max Rose, Ms Rose's father was also present, and they were both upset at Ms Rose's decision to transition. Bertha Rose states that she was "very upset", and they did not "discuss the subject very much".[4966] On one occasion, Bertha Rose became very upset when she saw Ms Rose wearing blue mascara and did not like Ms Rose wearing female clothing. She also told Ms Rose not to come back into her home wearing nail polish. Ms Rose returned the following week with nail polish on.[4967]

5.5319. Bertha Rose and Max Rose decided that they were "not going to be able to change" Ms Rose's mind and "did not pressure [her] anymore".[4968] It appears that Ian Rose was more accepting of Ms Rose's transition.[4969]

Events leading up to Ms Rose's death

5.5320. On 18 December 1997, Ms Rose was prescribed anti-nausea medication to treat a side effect of her hormonal treatment.[4970] That day, she contacted her friend Nicola Svenson and left a voice message on Ms Svenson's answering machine saying she had been "sick as a dog for the last few days".[4971]

5.5321. On 19 December 1997, Ms Rose was prescribed further anti-nausea medication.[4972] She did, however, attend Basil Real Estate in Kensington to wish her agent, Basil Michalopoulos a Merry Christmas and handed him a box of chocolates.[4973] She told Mr Michalopoulos that she was going away and would be back in January. Ms Rose had planned to take a trip to the Jenolan Caves with her friend Marcia Vagg.[4974]

5.5322. Ms Rose usually went to the chemist on Saturdays to receive her hormone treatment.[4975] According to Pamela Noble, a pharmacist who dispensed medication to Ms Rose on 6 and 13 December 1997, records indicate that Ms Rose did not attend the pharmacy on Saturday, 20 December 1997.[4976]

5.5323. On 20 December 1997, at 10:00am, Ms Rose spoke to Bertha Rose.[4977] Ms Rose indicated that she was feeling better but still tired.

[4965] Exhibit 29, Tab 8, Statement of Bertha Ruth Rose, 9 January 1998, [15] (SCOI.00041.00030).

[4966] Exhibit 29, Tab 8, Statement of Bertha Ruth Rose, 9 January 1998, [15] (SCOI.00041.00030).

[4967] Exhibit 29, Tab 8, Statement of Bertha Ruth Rose, 9 January 1998, [18] (SCOI.00041.00030).

[4968] Exhibit 29, Tab 9, Statement of Max Rose, 9 January 1998, [14] (SCOI.00041.00032).

[4969] Exhibit 29, Tab 8, Statement of Bertha Ruth Rose, 9 January 1998, [27] (SCOI.00041.00030); Exhibit 29, Tab 9, Statement of Max Rose, 9 January 1998, [15] (SCOI.00041.00032).

[4970] Exhibit 29, Tab 31, Statement of Dr Phillip Georgouras, 7 January 1998, [5] (SCOI.00041.00060).

[4971] Exhibit 29, Tab 24, Statement of Nicola Svenson, 23 December 1997, [10] (SCOI.00041.00046).

[4972] Exhibit 29, Tab 31, Statement of Dr Phillip Georgouras, 7 January 1998, [6] (SCOI.00041.00060).

[4973] Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 23 October 1998, [234] (SCOI.00041.00005).

[4974] Exhibit 29, Tab 26, Statement of Marcia Vagg, 31 December 1997, [15] (SCOI.00041.00049).

[4975] Exhibit 29, Tab 37, First statement of Pamela Noble, 21 January 1998, [9] (SCOI.00041.00081).

[4976] Exhibit 29, Tab 37, First statement of Pamela Noble, 21 January 1998, [10] (SCOI.00041.00081).

[4977] Exhibit 29, Tab 8, Statement of Bertha Ruth Rose, 9 January 1998, [39] (SCOI.00041.00030).

5.5324. At around 11:15am, Ms Rose spoke to Mr Becker.[4978] She told him she was unwell and too tired to talk. He told her that he would call her the following day and asked her to "please leave your answering machine on".[4979]

5.5325. Ms Rose was last seen alive between 1:00pm–2:00pm by Ai Lun Gu, who lived in the same unit block.[4980] Ms Rose last spoke to a friend, Louise Sadek, for over eight minutes via telephone at 2:48pm.[4981] Ms Rose stated that she was unwell and was watching television. Ms Rose's mother attempted to call Ms Rose multiple times, including at 3:00pm.[4982] The phone was engaged and remained so until her last attempt at about 9:00pm, and the following morning.[4983]

5.5326. At about 8:45pm, Mr Becker attended Ms Rose's unit to deliver a Christmas gift.[4984] He knocked on the door and rang the doorbell for a period of around five or ten minutes but could not raise Ms Rose. An attempt was also made to telephone Ms Rose with no success. Mr Becker observed that the lights were off and could not hear anything in Ms Rose's unit. He placed a Christmas greeting card and gift between the screen door and the front door of Ms Rose's unit, which was locked.[4985]

5.5327. On the morning of 21 December 1997, between 7:15am and 8:00am, Mr Becker made multiple attempts to contact Ms Rose by telephone.[4986] Her phone was off the hook. He made contact with the Prince of Wales Hospital to enquire as to whether Ms Rose had been admitted as a patient. He had fears that Ms Rose "may possibly have taken some drastic action".[4987]

5.5328. Sometime between 11:00am and 1:00pm on 21 December 1997, Takao Asano, a neighbour in the unit block, heard a plate breaking and assumed it came from Ms Rose's unit.[4988] A possibility remains that Mr Asano could have heard the plate break on 20 December 1997. On the totality of the evidence, it is unlikely that anyone attended Ms Rose's unit on 21 December 1997, and that by this point in time Ms Rose was already deceased.

[4978] Exhibit 29, Tab 12, Transcript of recorded interview with Stephen Becker, 22 December 1997, 6 (SCOI.00041.00103).

[4979] Exhibit 29, Tab 12, Transcript of recorded interview with Stephen Becker, 22 December 1997, 6 (SCOI.00041.00103).

[4980] Exhibit 29, Tab 19, Statement of Ai Lun Gu, 23 December 1997, [5] (SCOI.00041.00041).

[4981] Exhibit 29, Tab 16, Statement of Louise Sadek, 23 December 1997, [6] (SCOI.00041.00038); Exhibit 29, Tab 57, Phone calls surrounding the movements of Ms Durward, 20 December 1997 (SCOI.10123.00077).

[4982] Exhibit 29, Tab 8, Statement of Bertha Ruth Rose, 9 January 1998, [39]–[40] (SCOI.00041.00030).

[4983] Exhibit 29, Tab 8, Statement of Bertha Ruth Rose, 9 January 1998, [42] (SCOI.00041.00030).

[4984] Exhibit 29, Tab 12, Transcript of recorded interview with Stephen Becker, 22 December 1997, 7 (SCOI.00041.00103).

[4985] Exhibit 29, Tab 12, Transcript of recorded interview with Stephen Becker, 22 December 1997, 7 (SCOI.00041.00103).

[4986] Exhibit 29, Tab 12, Transcript of recorded interview with Stephen Becker, 22 December 1997, 8 (SCOI.00041.00103).

[4987] Exhibit 29, Tab 12, Transcript of recorded interview with Stephen Becker, 22 December 1997, 8 (SCOI.00041.00103).

[4988] Exhibit 29, Tab 14, Statement of Takao Asano, 22 December 1997, [6] (SCOI.00041.00011); Exhibit 29, Tab 95, Statement of Plain Clothes Senior Constable Andrew Bruce Pincham, 4 January 1998, [15] (SCOI.00041.00020).

5.5329. Somewhere between 2:00pm and 2:30pm on 21 December 1997, Ms Rose's mother and father went to Ms Rose's home. Bertha Rose noticed the Christmas parcel left between the door and the security door. She rang the doorbell several times and it stopped working. She and her husband banged the door loudly but could not raise Ms Rose. Bertha left a post-it note on the door asking Ms Rose to call her.[4989]

5.5330. On the morning of 22 December 1997, Mr Becker made contact with Bertha Rose and expressed his concerns for Ms Rose's welfare. Bertha Rose could not recall the exact conversation she had with Mr Becker, but recalled Mr Becker saying several kind things about Ms Rose. In her statement, Bertha Rose says "when he spoke about [Samantha] he spoke of [her] in the past tense. This really worried me because I was already concerned about [Samantha]. He really just rambled on and in the end I told him I had to go".[4990]

5.5331. Shortly after 9:20am, Ms Rose's mother and brother attended Randwick Police Station. They then went to the unit to meet police and Ms Rose's father to gain access.[4991]

5.5332. As noted above, there was no evidence of forced entry to Ms Rose's unit, suggesting she may have known her killer.[4992] A set of keys were located in the bedroom.[4993] Ms Rose's telephone was on the bench with the hand piece hanging to the floor.[4994] A television was lying face down in the loungeroom.[4995] The answering machine was upside down on the floor in the hallway.[4996] There was a pink coloured breast insert and photograph frame lying face down in the hallway.[4997] Another breast insert was on the loungeroom floor.[4998]

Crime scene investigators

5.5333. Crime Scene Officers, Detective Senior Constable Van Leeuwen and Detective Senior Constable Nicol, attended Ms Rose's residence upon the discovery of her body. Following their examination of the crime scene, they made a number of observations, including:[4999]

a. There were no signs of forced entry to the balcony doors;

b. The front door could only be closed and locked using a key;

[4989] Exhibit 29, Tab 8, Statement of Bertha Ruth Rose, 9 January 1998, [42] (SCOI.00041.00030).

[4990] Exhibit 29, Tab 8, Statement of Bertha Ruth Rose, 9 January 1998, [45]–[47] (SCOI.00041.00030).

[4991] Exhibit 29, Tab 8, Statement of Bertha Ruth Rose, 9 January 1998 (SCOI.00041.00030).

[4992] Exhibit 29, Tab 82, Statement of Detective Senior Constable Lyle William Van Leeuwen, 18 October 1998, [17] (SCOI.00041.00024).

[4993] Exhibit 29, Tab 82, Statement of Detective Senior Constable Lyle William Van Leeuwen, 18 October 1998, [13] (SCOI.00041.00024).

[4994] Exhibit 29, Tab 82, Statement of Detective Senior Constable Lyle William Van Leeuwen, 18 October 1998, [10] (SCOI.00041.00024).

[4995] Exhibit 29, Tab 82, Statement of Detective Senior Constable Lyle William Van Leeuwen, 18 October 1998, [11] (SCOI.00041.00024).

[4996] Exhibit 29, Tab 82, Statement of Detective Senior Constable Lyle William Van Leeuwen, 18 October 1998, [12] (SCOI.00041.00024).

[4997] Exhibit 29, Tab 82, Statement of Detective Senior Constable Lyle William Van Leeuwen, 18 October 1998, [12] (SCOI.00041.00024).

[4998] Exhibit 29, Tab 82, Statement of Detective Senior Constable Lyle William Van Leeuwen, 18 October 1998, [11] (SCOI.00041.00024).

[4999] Exhibit 29, Tab 82, Statement of Detective Senior Constable Lyle William Van Leeuwen, 18 October 1998, [10], [17] (SCOI.00041.00024).

c. The assault appeared to have commenced in the hallway near the bathroom door and continued into the loungeroom, where the ironing board had been knocked over and shorted out the electricity to the property;

d. The assault continued into the kitchen where Ms Rose was found;

e. The offender left the premises via the front door, closing and locking the door with a key upon leaving. The offender did not lock the security door, as a post-it note had been placed on the front door by Ms Rose's mother; and

f. To the right of Ms Rose's foot, small pieces of a broken plate were observed on the floor. The pieces were mustard in colour. A search of Ms Rose's fridge revealed two further pieces of a broken plate which were also mustard in colour.

5.5334. Detective Senior Constable Van Leeuwen concluded that the ironing board had fallen and dislodged the television that had been sitting on crates. The ironing board had a shirt hanging from the end. The iron was turned on and was face down on top of the extension lead. The iron had melted the insulation on the power cord and short circuited the power supply to the unit.[5000] This might suggest Ms Rose was ironing just prior to the assault.

5.5335. Detective Senior Constable Tim Mealing made a sketch plan of the crime scene.[5001]

Occupants of the Kensington residence

5.5336. At some stage before Ms Rose's death, Ms Durward stayed with her at the Kensington unit.[5002] At least at that time, Ms Durward had a set of keys to Ms Rose's unit.[5003]

5.5337. Between around October and December 1997, Ms Feary spoke with Ms Rose regularly in relation to Ms Durward.[5004]

5.5338. Ms Feary's understanding was that Ms Durward had left Ms Rose's unit on her own accord.[5005] However, Ms Rose provided a differing account to Marcia Vagg, a friend. Ms Vagg stated that Ms Rose called her and told her that a friend of hers was having very serious personal problems, was addicted to heroin and was an alcoholic. Ms Rose also told Ms Vagg that she had a conversation with the friend's sister, who told her she had thrown out the friend when she caught her stealing to buy heroin and alcohol. The friend's sister did not want Ms Rose to take her in because she feared what she might do. Ms Rose said she had let the friend stay with her before but had thrown her out after catching her drinking "turps" or methylated spirits, which had been mixed with cordial.[5006]

[5000] Exhibit 29, Tab 82, Statement of Detective Senior Constable Lyle William Van Leeuwen, 18 October 1998, [11] (SCOI.00041.00024).

[5001] Exhibit 29, Tab 85, Statement of Detective Senior Constable Tim Mealing, 21 September 1998 (SCOI.00041.00025).

[5002] Exhibit 29, Tab 54, Transcript of recorded interview with Sandra Durward, 26 December 1997, 9 (SCOI.00041.00101); Exhibit 29, Tab 62, Statement of Fiona Kathryn Feary, 9 January 1998, [12] (SCOI.00041.00071).

[5003] Exhibit 29, Tab 62, Statement of Fiona Kathryn Feary, 9 January 1998, [15] (SCOI.00041.00071).

[5004] Exhibit 29, Tab 62, Statement of Fiona Kathryn Feary, 9 January 1998, [12]–[13] (SCOI.00041.00071).

[5005] Exhibit 29, Tab 62, Statement of Fiona Kathryn Feary, 9 January 1998, [14] (SCOI.00041.00071).

[5006] Exhibit 29, Tab 26, Statement of Marcia Vagg, 31 December 1997, [19] (SCOI.00041.00049).

5.5339. Ms Vagg advised Ms Rose to not let the friend back in. Ms Rose was conflicted saying she was her friend, and it was a very hard thing to do. According to Ms Vagg, Ms Rose said that Ms Durward's sister described Ms Durward as an opportunist who was capable of anything.[5007]

5.5340. After Ms Durward left the unit, Ms Rose contacted Ms Feary regarding Ms Durward returning her unit keys.[5008] Ms Feary spoke with Ms Durward who told her she would organise to return them. She was of the belief that they had been returned but could not be sure.[5009]

5.5341. Ms Durward moved out and Ms Rose continued to live at the Kensington residence alone. Several witnesses stated that Ms Rose was very security conscious.[5010]

Police investigation into Ms Durward

5.5342. During the course of the police investigation into Ms Rose's death, several people provided information regarding Ms Durward. Megan Brownlow, a mutual friend of Ms Rose and Ms Durward, told police that Ms Rose had contacted her and warned her about Ms Durward's problems with alcohol and theft.[5011] Ms Brownlow was under the impression that Ms Rose was afraid of Ms Durward and noted that Ms Rose was much smaller than Ms Durward.[5012]

5.5343. Ms Durward's capacity for aggression was noted by various witnesses, including one instance where she admitted to kicking a friend's child.[5013] She was also described as being someone who could change their personality very quickly.[5014]

5.5344. At the time of Ms Rose's death, there is evidence of Ms Durward drinking almost every day.[5015] She drank "whatever was around".[5016] A flatmate said he had seen Ms Durward get up and have a drink to start off the day.[5017] There is also evidence of her having what she termed "acute" depression.[5018]

Inculpatory statements made by Ms Durward and related suspicious conduct following Ms Rose's death

5.5345. Following Ms Rose's death, Ms Durward made a number of apparent inculpatory statements to various persons.

[5007] Exhibit 29, Tab 26, Statement of Marcia Vagg, 31 December 1997, [19] (SCOI.00041.00049).

[5008] Exhibit 29, Tab 62, Statement of Fiona Kathryn Feary, 9 January 1998, [15] (SCOI.00041.00071).

[5009] Exhibit 29, Tab 62, Statement of Fiona Kathryn Feary, 9 January 1998, [16] (SCOI.00041.00071).

[5010] See, eg, Exhibit 29, Tab 62, Statement of Fiona Kathryn Feary, 9 January 1998, [15] (SCOI.00041.00071) and Exhibit 29, Tab 26, Statement of Marcia Vagg, 31 December 1997, [18] (SCOI.00041.00049).

[5011] Exhibit 29, Tab 18, Statement of Megan Patricia Brownlow, 24 December 1997, [6] (SCOI.00041.00040).

[5012] Exhibit 29, Tab 18, Statement of Megan Patricia Brownlow, 24 December 1997, [7] (SCOI.00041.00040).

[5013] Exhibit 29, Tab 69, Statement of Elizabeth Ruth King, 14 January 1998, [22] (SCOI.00041.00075).

[5014] Exhibit 29, Tab 69, Statement of Elizabeth Ruth King, 14 January 1998, [24] (SCOI.00041.00075).

[5015] Exhibit 29, Tab 70, Statement of Carl Ellwood, 26 December 1997, [7] (SCOI.00041.00047).

[5016] Exhibit 29, Tab 70, Statement of Carl Ellwood, 26 December 1997, [7] (SCOI.00041.00047).

[5017] Exhibit 29, Tab 70, Statement of Carl Ellwood, 26 December 1997, [7] (SCOI.00041.00047).

[5018] Exhibit 29, Tab 56, Transcript of recorded interview with Sandra Durward, 6 February 1997, 32 (SCOI.00041.00102).

5.5346. On 24 December 1997, Ms Durward told her colleague, Irene Burrows, that she thought she knew who killed Ms Rose and relevantly, that the door was locked and "there was no forced entry" into Ms Rose's unit. According to Ms Burrows, Ms Durward said that her stepson had keys to the unit.[5019]

5.5347. On 26 December 1997, Ms Durward participated in an interview with Detective Sergeant Matthes and Detective Senior Constable Thornton. In that interview, Ms Durward told police that, while she had been staying in Ms Rose's apartment while Ms Rose was travelling, an ex-partner, Paul Hilton, stayed with her with his then-girlfriend. Ms Durward said Mr Hilton's son, Joel Hilton, while visiting Paul Hilton in Ms Rose's apartment, had stolen CDs, some tools and electrical appliances. Ms Durward also said that Joel Hilton might have had a set of keys to Ms Rose's apartment made. When asked about her own movements on 20 December 1997, Ms Durward stated that she could not remember but would have been at work. Ms Durward then recalled that she had in fact worked that evening and made reference to a memorable client.[5020]

5.5348. That same day, a search of Ms Durward's room, at a house she was staying at in St Clair, was conducted with her permission. During the course of that search, an incomplete letter authored by Ms Durward was located. In that letter, Ms Durward wrote:[5021]

> *Geoff, I may as well come clean with you, I'm sick of dissimilating. You may prefer not to know any of this, but I'm way out there at the moment, whinged by horror not only at the fact that Dave [presumably, Samantha] has gone forever, but by the distinct possibility that I was responsible, however indirectly. I'll get to that later. In the meantime, I need to tell you about me.*

5.5349. On 27 December 1997, Ms Durward contacted Detective Sergeant Matthes and provided further information as to her movements on 20 December 1997. In particular, she stated that she had attended an AA meeting in Neutral Bay, and that Mr Thwaites, "Peter" and "Clive" were also in attendance and could provide an alibi for her.[5022] The alibi evidence assumed significance and is dealt with separately in these submissions below. This evidence as to Ms Durward's alibi prompted further police inquiries and led to a second police interview of Ms Durward on 6 February 1998 (discussed further below).

5.5350. That same day, Ms Durward told Louise Clifford words to the effect of "there was no sign of forced entry", "her fingerprints would be all over the place" and that she had "keys" to Ms Rose's unit.[5023] Whilst police were speaking to Ms Burrows, Ms Durward spoke to Ms Clifford and said:[5024]

[5019] Exhibit 29, Tab 73, Statement of Irene Patricia Burrows, 27 December 1997, [9] (SCOI.00041.00061).

[5020] Exhibit 29, Tab 54, Transcript of recorded interview with Sandra Durward, 26 December 1997, 21, 23-25 (SCOI.00041.00101).

[5021] Exhibit 29, Tab 60A, Handwritten letter from Sandra Durward to Geoff, 25 December 1997 (SCOI.83402).

[5022] Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 23 October 1998, [253] (SCOI.00041.00005).

[5023] Exhibit 29, Tab 72, Statement of Louise Margaret Clifford, 6 January 1998, [8] (SCOI.00041.00055).

[5024] Exhibit 29, Tab 72, Statement of Louise Margaret Clifford, 6 January 1998, [9] (SCOI.00041.00055).

> *At least [I now know] what day it happened on and they're not telling me anything about how it happened.*

5.5351. Ms Clifford did not know how Ms Durward came upon that information. Ms Durward gave evidence in this regard at the coronial inquest into Ms Rose's death (see below).[5025]

5.5352. On 31 December 1997, whilst working at Bare Bunnies, Ms Durward spoke to a colleague, Nazmeen Nisha Hudson. At around 9:00pm to 9:30pm, Ms Durward was asleep in the reception area and said, "I must have done it in my sleep."[5026] When asked what she had done, Ms Durward told Ms Hudson, "I must have killed this guy, didn't you see it on telly. The cross dresser. I couldn't have done it. He was my best friend."[5027] Ms Hudson told Ms Durward not to say these things if she did not kill Ms Rose as she "could be locked up".[5028] Ms Durward repeated the phrases, "I might have killed him in my sleep" and "no, it couldn't have been me. I must have been drinking".[5029]

5.5353. Ms Hudson recalled Ms Durward attempting to make a phone call a couple of times, stating that it was her "alibi".[5030] She also recalls Ms Durward speaking on the phone at a later stage and asking that person, "[have] any detectives come to check up?"[5031] Ms Hudson observed that Ms Durward had a black eye.[5032]

5.5354. On one occasion between 31 December 1997 and 1 January 1998, whilst working at Bare Bunnies, Ms Durward stated to her colleague Marisa Craker, "my life has been a real nightmare for the last few weeks" before falling asleep on a lounge located in the reception area.[5033] When she awoke, Ms Durward was asked to get up from the lounge. She stood up, placed both hands on the sides of her head and said, "I don't know what's wrong with me. Maybe it's not a nightmare. Maybe I did kill him."[5034] Ms Craker replied, "[y]ou're fucking kidding. You better get your shit together because if you did kill someone, this'll put you away for a long time."[5035]

[5025] Exhibit 29, Tab 72, Statement of Louise Margaret Clifford, 6 January 1998, [9]–[10] (SCOI.00041.00055).
[5026] Exhibit 29, Tab 78, Statement of Nazmeen Nisha Hudson, 10 January 1998, [3] (SCOI.00041.00068).
[5027] Exhibit 29, Tab 78, Statement of Nazmeen Nisha Hudson, 10 January 1998, [3] (SCOI.00041.00068).
[5028] Exhibit 29, Tab 78, Statement of Nazmeen Nisha Hudson, 10 January 1998, [3] (SCOI.00041.00068).
[5029] Exhibit 29, Tab 78, Statement of Nazmeen Nisha Hudson, 10 January 1998, [4] (SCOI.00041.00068).
[5030] Exhibit 29, Tab 78, Statement of Nazmeen Nisha Hudson, 10 January 1998, [5] (SCOI.00041.00068).
[5031] Exhibit 29, Tab 78, Statement of Nazmeen Nisha Hudson, 10 January 1998, [5] (SCOI.00041.00068).
[5032] Exhibit 29, Tab 79, Statement of Nisha Jasmine Hudson, 12 January 1998, [6] (SCOI.00041.00069).
[5033] Exhibit 29, Tab 75, Statement of Marisa Craker, 10 January 1998, [11] (SCOI.00041.00065).
[5034] Exhibit 29, Tab 75, Statement of Marisa Craker, 10 January 1998, [13] (SCOI.00041.00065).
[5035] Exhibit 29, Tab 75, Statement of Marisa Craker, 10 January 1998, [13] (SCOI.00041.00065).

5.5355. Ms Durward then indicated that she needed to make a phone call stating, "this is my alibi".[5036] She tried to make a call using a payphone but hung up and did not speak to anyone. When she returned to Bare Bunnies, Ms Durward sat down on the steps in front of the reception desk and said, "[m]aybe it's not a nightmare, maybe I did kill him in my sleep".[5037] She made reference to her stepson previously staying at Ms Rose's unit when she was overseas. She also made reference to her fingerprints being in the unit because she had stayed there before. Ms Craker did not think that Ms Durward was drunk or under the influence of any drugs.[5038] She observed that Ms Durward still had the black eye which she had seen two weeks prior.[5039]

5.5356. Ms Feary stated that Ms Durward told her that Ms Rose may have died as a result of the television falling from its stand.[5040] She noted that the stand was unstable. No persons other than investigating police and members of Ms Rose's family were aware that signs of a struggle were evident in the unit and that the television was lying screen down in the loungeroom. That information was also not released to the media.[5041]

5.5357. On 28 January 1998, Ms Durward was living with Ms Burrows. Ms Burrows states that on that day, Ms Durward was in a "very angry state", had urinated on the carpet, packed her bags and was leaving their home. She refused to return her set of keys to Ms Burrows, stating that she paid for them to be cut. Ms Burrows was "shocked" by Ms Durward's behaviour and her refusal to give back the keys. Ms Burrows observed that Ms Durward's eyes were "black and glazed" and that in that mood, she thought Ms Durward was "capable of murder".[5042]

5.5358. In her second police interview on 6 February 1998, Ms Durward offered the following explanations for her several statements at [5.5350]–[5.5355], namely that she may have killed Ms Rose and needed to make a phone call as it was her alibi:[5043]

> *Well this would have been about the time when I was feeling under so much pressure that I didn't know what I was saying, what I was doing. I certainly wouldn't have meant it. I don't know, I may have said it, but it, it, I mean that's along the lines of, I, I don't know, I don't, if I said it, it was, it was, it would have been in, out of fatigue and desperation and grief and I doubt whether I would have used those words because I'd become aware by that stage in the investigation that every single thing I say to every single person is being reported and, and, and, analysed…I've always had a sense of humour, it's not, it's gone, it's dead. I think you, you probably find I said to somebody at some stage some women have handbags referring to the sense that they might have a man with them on social occasions, a*

[5036] Exhibit 29, Tab 75, Statement of Marisa Craker, 10 January 1998, [13] (SCOI.00041.00065).

[5037] Exhibit 29, Tab 75, Statement of Marisa Craker, 10 January 1998, [14] (SCOI.00041.00065).

[5038] Exhibit 29, Tab 76, Second statement of Marisa Craker, 26 January 1998, [6] (SCOI.00041.00066).

[5039] Exhibit 29, Tab 75, Statement of Marisa Craker, 10 January 1998, [19] (SCOI.00041.00065).

[5040] Exhibit 29, Tab 63, Second statement of Fiona Kathryn Feary, 9 June 1999, [10] (SCOI.00041.00098).

[5041] Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Thornton, 23 October 1998, [275] (SCOI.00041.00005).

[5042] Exhibit 29, Tab 74, Second statement of Irene Patricia Burrows, 29 January 1998, [23]–[25] (SCOI.00041.00063). At [22] there appears to be an erroneous reference to this occurring on 28 January 1997, however the balance of the statement suggests it occurred on 28 January 1998.

[5043] Exhibit 29, Tab 56, Transcript of recorded interview with Sandra Durward, 6 February 1997, 41-45 (SCOI.00041.00102).

> *man with them with whom they have no relationship but who is referred to as a handbag and I said, Some women have handbags, I have an alibi, David. I would have referred to David.*

5.5359. As to whether she returned Ms Rose's house keys, Ms Durward said, "look, as far as I am aware yes, but you know, I was drunk through that time", "I would have got them back to [her] somehow, whether meeting [her] in town for lunch, which we did occasionally", "all I know is I don't have them in my possession" and "[she] was the security conscious one, [she] would have made sure [she] got them back".[5044] She described Ms Rose's spare set of house keys, which she utilised whilst living with her, as being on a ring that had "gremlins and at the bottom was a dolphin".[5045]

5.5360. In that second interview, Ms Durward told police the following: [5046]

a. Her last paid client at Final Touch was at 11:15pm on 20 December 1997;

b. After her shift at Final Touch, Ms Durward commenced work at Bare Bunnies. Her last recorded client was at 2:00am on 21 December 1997 but she may have stayed longer;

c. Ms Durward recalled completing her shift at Bare Bunnies at around 3:00am on 21 December 1997 and contacting Premier Cabs. She then caught a taxi to Dobell Circuit, St Clair, where she was staying with Deidre Miles;

d. Her first client on 22 December 1997 was at around 12:10pm;

e. Mr Becker informed her of Ms Rose's death on 23 December 1997;

f. She experienced mood swings and suffers from "acute depression" but noted that is an "inwardly directed thing";

g. She recalled making a written note on an envelope of what she did on 20 December 1997 and states "that was probably when I remembered, I connected the dots and realised that, that was the day, the Saturday that I had been to the AA meeting". Had she known she was going to be a suspect in the death of Ms Rose she would have "sat down with you at that point…I would have asked to sit down and work out with you at that point exactly what I'd been doing. I would have thought about it more deeply and I would have, but I just, I didn't know";

h. She bruised easily and her black eye was "occasioned in the course of the work that I was doing by the client's clumsiness, it didn't hurt at the time. I wasn't aware of it until I think it must have been the next morning when I happened to look in the mirror when I was on the phone and saw that I had a black eye". Ms Durward denied being assaulted by anyone; and

[5044] Exhibit 29, Tab 56, Transcript of recorded interview with Sandra Durward, 6 February 1997, 26-28 (SCOI.00041.00102).

[5045] Exhibit 29, Tab 56, Transcript of recorded interview with Sandra Durward, 6 February 1997, 25 (SCOI.00041.00102).

[5046] Exhibit 29, Tab 56, Transcript of recorded interview with Sandra Durward, 6 February 1997, 7-12, 23, 32, 34-35, 39-40, 53 (SCOI.00041.00102).

i. She attributed her sore leg to a "slight hip problem" which was caused when she was a child.

Evidence as to the relationship between Ms Durward and Mr Thwaites

5.5361. Ms Durward and Mr Thwaites both referred to their relationship as being platonic; however, other evidence suggests that their relationship was of a more romantic and/or sexual nature. In particular, Ms Durward indicated to a work colleague that she was in love with Mr Thwaites and spent significant amounts of time with him (including spending half a day with him in his bedroom).[5047]

5.5362. In her police interview on 6 February 1998, Ms Durward said that she and Mr Thwaites were "friends", having met in a detox unit at North Sydney Hospital.[5048] At first, she denied that they had a sexual relationship. When pressed, she said at first that it was "a desire on my part to have a sexual relationship with David, but David was not interested. We had just been friends and nothing else".[5049] She then admitted that there "have been a couple of occasions where there has been oral sex" but did not consider this to mean they had a sexual relationship.[5050]

5.5363. In that same police interview, Ms Durward acknowledged that she had previously stayed with Ms Rose but that Ms Rose did not want her to stay there any more.[5051]

5.5364. On 3 January 1998, Mr Thwaites participated in an interview with police and stated that he had met Ms Durward six months prior, at the Phoenix Rehabilitation Centre at Royal North Shore Hospital.[5052] They kept in regular contact after leaving the centre, and Ms Durward would often accompany him to AA meetings.

Evidence as to Ms Durward's alibi for the afternoon of 20 December 1997

ALCOHOLICS ANONYMOUS MEETING

5.5365. During the second police interview on 6 February 1998, Ms Durward said that, on 20 December 1997, she went to an AA meeting at Neutral Bay, after which she had coffee with three other people at Maisey's café, and then walked around with Mr Thwaites for an hour in Neutral Bay, before getting in a taxi at around 4:00pm to go to work.[5053] Ms Durward identified the three people with whom she had coffee at Maisey's café as Mr Thwaites, "Peter" (later identified as Peter Thornton) and "Clive" (later identified as Clive Starling).[5054]

[5047] Exhibit 29, Tab 74, Second statement of Irene Patricia Burrows, 29 January 1998, [17] (SCOI.00041.00061).

[5048] Exhibit 29, Tab 56, Transcript of recorded interview with Sandra Durward, 6 February 1997, 36, 54 (SCOI.00041.00102).

[5049] Exhibit 29, Tab 56, Transcript of recorded interview with Sandra Durward, 6 February 1997, 54 (SCOI.00041.00102).

[5050] Exhibit 29, Tab 56, Transcript of recorded interview with Sandra Durward, 6 February 1998, 56 (SCOI.00041.00102).

[5051] Exhibit 29, Tab 56, Transcript of recorded interview with Sandra Durward, 6 February 1998, 49-50. (SCOI.00041.00102).

[5052] Exhibit 29, Tab 65, Running sheet regarding interview with David John Thwaites, 3 January 1998, 1 (SCOI.00041.00096).

[5053] Exhibit 29, Tab 56, Transcript of recorded interview with Sandra Durward, 6 February 1998 (SCOI.00041.00102).

[5054] Exhibit 29, Tab 56, Transcript of recorded interview with Sandra Durward, 6 February 1998, 15-16 (SCOI.00041.00102).

5.5366. Consistent with this, Mr Thwaites stated that on the morning of 20 December 1997, Ms Durward contacted him at the halfway house where he was residing. He told her about an AA meeting that he was attending in Neutral Bay later that day. Ms Durward said that she would meet him there. [5055]

5.5367. Mr Thwaites did not see Ms Durward arrive at the meeting, but stated that he saw her at the end of the meeting "talking to a couple of people". He originally thought that she had arrived just before the end of the meeting, but she told him "she had been there a while".[5056] Subsequently, Mr Thwaites recalled Ms Durward arriving at around 1:15pm on 20 December 1997.[5057] He stated that after the meeting he and other attendees went to Maisey's café. At the inquest into Ms Rose's death, Mr Thwaites was called to give evidence. During the course of his oral evidence at the inquest, Mr Thwaites made the following statements as regards the AA meeting:[5058]

a. He left Neutral Bay and arrived at his NA meeting slightly after 4:30pm on 20 December 1997; and

b. He kept a daily journal as part of his recovery and made an entry in respect of 20 December 1997. Although that entry made no specific mention of the AA meeting in Neutral Bay, he could "positively say" the meeting occurred on that day. He referred to a "great talk with older members at a coffee shop" which he says occurred after the NA meeting that he attended after the AA meeting. He was "actually certain" and had "absolutely no doubt" that coffee happened on the same day as the AA meeting at Neutral Bay. It must be stressed that this diary entry makes no mention at all of Ms Durward and no mention of the two of them talking for about an hour after the AA meeting.

5.5368. Mr Starling stated that he also attended the AA meeting in Neutral Bay on 20 December 1997.[5059] He arrived at 1:15pm and observed Ms Durward in an "agitated" state, walking in and out of the meeting. Mr Starling spoke to Ms Durward at the end of the meeting, and they proceeded to Maisey's café.[5060]

5.5369. Mr Thornton also attended the AA meeting in Neutral Bay. He stated that the meeting was definitely on 20 December 1997 as he was quite upset about leaving a job the evening before. Mr Thornton recalled that the meeting concluded at around 1:30pm and he proceeded to Maisey's café at some stage thereafter.[5061]

[5055] Exhibit 29, Tab 64, Statement of David John Thwaites, 29 January 1998, [6] (SCOI.00041.00087).

[5056] Exhibit 29, Tab 64, Statement of David John Thwaites, 29 January 1998, [7] (SCOI.00041.00087).

[5057] Exhibit 29, Tab 65, Running sheet regarding interview with David John Thwaites, 3 January 1998, 1 (SCOI.00041.00096).

[5058] Exhibit 29, Tab 99E, Transcript of Coronial Inquest into the death of Samantha Rose, 18 November 1999, 3, 7-8, 12-13 (SCOI.83316).

[5059] Exhibit 29, Tab 71, Statement of Clive Ronald Starling, 19 February 1998, [5] (SCOI.00041.00089).

[5060] Exhibit 29, Tab 71, Statement of Clive Ronald Starling, 19 February 1998, [5] (SCOI.00041.00089).

[5061] Exhibit 29, Tab 66, Statement of Peter Leonard Thornton, 10 February 1998, [5], [17] (SCOI.00041.00097).

EVIDENCE AS TO MEETING AT MAISEY'S CAFÉ

5.5370. Ms Durward told police on 6 February 1998 that after speaking to a number of people at the AA meeting, she went to Maisey's café in Neutral Bay. She arrived by herself at first and was then joined "by Clive and then either Peter or David came in and then the other one came in". Whilst at the café, Ms Durward said she contacted Final Touch to enquire as to whether she was rostered on the next day, with a view to making plans to attend another meeting. At that time, the receptionist advised that a person (who we now know to be Ms Miles) had called her in hysterics because her daughter was missing. Ms Durward then got in touch with Ms Miles who indicated that her child had been found. Ms Durward had been staying with Ms Miles in St Clair at the time.[5062]

5.5371. Evidence of telephone calls to Final Touch confirm that Ms Miles called four times between 1:05pm and 2:03pm, and that a call was made from Maisey's café to Final Touch at 2:35pm.[5063]

5.5372. When interviewed by police on 3 January 1998, Mr Thwaites apparently stated that he and other meeting attendees went to Maisey's café on Military Road where they stayed until 4:00pm, after which Ms Durward caught a taxi to go to work. A record of the interview with Mr Thwaites on 3 January 1998 also noted the following:[5064]

> *He stated that the reason why Sandra had not told police about her going to the meeting was because she was embarrassed about it but he had attempted to tell her to be up front about it all. He admitted that Sandra had spoken to him about her alibi for being at the meeting but stated that the alibi was genuine. He could not account for her movements after 4.00pm that day.*

5.5373. In his signed statement dated 29 January 1998, Mr Thwaites said, contrastingly, that they left Maisey's café around ten minutes after Mr Starling left, which he estimated as being between 2:30pm and 3:00pm. Mr Thwaites said that he and Ms Durward walked a short distance before talking for about another hour.[5065]

5.5374. Mr Starling's evidence was that that Ms Durward "appeared very agitated and upset about something to the degree of being emotionally distressed. She tried to talk about her problems but just had difficulties about getting words out to tell me what was wrong."[5066] Mr Starling further stated:[5067]

> *She didn't exactly say what she was concerned about but at the time I was trying to listen to Sandra and David at the same time. At the time I was aware she was under a lot of stress with regards to her personal life and what was going down with her friend. I think she was also looking for somewhere to stay. I didn't know what she was trying to get at the time*

[5062] Exhibit 29, Tab 56, Transcript of recorded interview with Sandra Durward, 6 February 1997, 13-14, 16-17 (SCOI.00041.00102). Detective Sergeant Matthes notes on the transcript that the date was 6 February 1997. However, as this was prior to the death of Ms Rose, it can be inferred that the interview in fact occurred in 1998.

[5063] Exhibit 29, Tab 57, Phone calls surrounding the movements of Sandra Durward, 20 December 1997 (SCOI.10123.00077).

[5064] Exhibit 29, Tab 65, Running sheet regarding interview with David John Thwaites, 3 January 1998, 1-2 (SCOI.00041.00096).

[5065] Exhibit 29, Tab 64, Statement of David John Thwaites, 29 January 1998, [8]–[9] (SCOI.00041.00087).

[5066] Exhibit 29, Tab 71, Statement of Clive Ronald Starling, 19 February 1998, [6] (SCOI.00041.00089).

[5067] Exhibit 29, Tab 71, Statement of Clive Ronald Starling, 19 February 1998, [7]–[9] (SCOI.00041.00089).

> *but now I believe she was trying to get issues off her mind about the death of her friend.*
>
> *Sandra mentioned that she was looking for somewhere to live because she had to get out of the place where she was staying at. She didn't say why or where she intended to look. I got the impression that she needed to find somewhere to live fairly urgently. She had a bag and a diary with her that day. I saw her flicking through the diary. She said she had to make a couple of calls but I don't know who to. I didn't see her make any phone calls while I was there.*

5.5375. Mr Starling was of the view that Ms Durward's state of mind was such that she "may think she had some involvement in the death" of Ms Rose.[5068] In fairness, this appears likely to be retrospective speculation, noting that the evidence indicates Ms Rose was alive until at least 2:30pm on 20 December 1997. He noted that it is "not uncommon for alcoholics to have blackouts and not remember certain things".[5069] Ms Durward made no admission to Mr Starling and his view was based on her body language and emotional state.[5070]

5.5376. Mr Thornton states that Ms Durward appeared to be looking for accommodation and made a number of telephone calls. Mr Thornton said he thought he left the coffee shop at about 2:15pm or 2:30pm.[5071]

EVIDENCE AS TO MOVEMENTS OF MS DURWARD AND MR THWAITES AFTER MAISEY'S CAFÉ

5.5377. After being at Maisey's café, Ms Durward states that she and Mr Thwaites had "some time to kill" and so they "walked around the area". Mr Starling and Mr Thornton went their separate ways. Ms Durward could not recall how long she and Mr Thwaites walked around for but estimated that she and Mr Thwaites arrived at Military Road at around 4:00pm. She also estimated leaving Maisey's café at "probably about 2.15, 2.30pm", suggesting they walked together for over an hour and a half.

5.5378. When she reached Military Road, Ms Durward realised "it was going to be impossible" for her to get to work in an hour. She then caught a taxi and train to work at St Mary's. She estimated that she would have arrived at Final Touch at around 6:20pm.

5.5379. Mr Thwaites noted the following in his statement as to his and Ms Durward's movements after leaving Maisey's café:[5072]

a. After leaving Maisey's café, he and Ms Durward walked a short distance before talking "for about another hour" mainly "about her new job";

b. Ms Durward caught a taxi to work at St Mary's;

[5068] Exhibit 29, Tab 71, Statement of Clive Ronald Starling, 19 February 1998, [12] (SCOI.00041.00089).

[5069] Exhibit 29, Tab 71, Statement of Clive Ronald Starling, 19 February 1998, [12] (SCOI.00041.00089).

[5070] Exhibit 29, Tab 71, Statement of Clive Ronald Starling, 19 February 1998, [6]–[12] (SCOI.00041.00089).

[5071] Exhibit 29, Tab 66, Statement of Peter Leonard Thornton, 10 February 1998, [12]–[13] (SCOI.00041.00097).

[5072] Exhibit 29, Tab 64, Statement of David John Thwaites, 29 January 1998, [9]–[13] (SCOI.00041.00087).

c. Mr Thwaites proceeded to a second meeting, at Manly Hospital; and

d. Shortly after the meeting at Neutral Bay, Ms Durward contacted Mr Thwaites in relation to the "death of this person" and said that he could "be an alibi for her as we were at the same meeting on the weekend of [her] death".

5.5380. Mr Thwaites did not believe that Ms Durward had been drinking and observed that "she did not appear to be distressed about anything and from memory she was quite happy". She did not complain about "any illness or injury."[5073]

5.5381. At the inquest, Mr Thwaites gave evidence that he walked with Ms Durward and saw her get into a cab.[5074]

Analysis of timing and the possibility of Ms Durward going to Kensington

5.5382. The combined evidence of the telephone call logs and the recollections of Mr Starling and Mr Thornton confirms that Ms Durward attended the AA meeting and Maisey's café and was there until at least 2:35pm. The weight of evidence suggests that she left Maisey's café at or shortly after this time. After that, Ms Durward's alibi up to 4:00pm is supported only by her own evidence and Mr Thwaites' evidence. There are grounds to regard Mr Thwaites' evidence as unreliable. These include that:

a. Mr Thwaites had a close (and at least occasionally sexual) relationship with Ms Durward;

b. Mr Thwaites appears at first to have told police that they were at Maisey's café until around 4:00pm and then later made a statement that they left the café between 2:30pm and 3:00pm (the latter being more consistent with evidence from other witnesses, but calling for an explanation of what Mr Thwaites and Ms Durward did during the hour between 3:00pm and 4:00pm);

c. Mr Thwaites was willing to offer a somewhat implausible explanation for Ms Durward's failure to mention the Neutral Bay meeting in her first police interview. Mr Thwaites suggested she did not tell police about the AA meeting at first because she was embarrassed about it, which stands in contrast to Ms Durward's plain willingness to refer to herself as an alcoholic and ex-addict, and refer to having attended a different AA meeting in the past, in her first interview with the police on 26 December 1997;[5075] and

d. The fact that Mr Thwaites made no reference in his diary entry to having spent any time with Ms Durward on 20 December 1997. While that might not be surprising if he simply had a casual coffee with her and two other people at Maisey's, it might be regarded as somewhat more surprising if he then spent over an hour having a one-on-one conversation with her.

[5073] Exhibit 29, Tab 64, Statement of David John Thwaites, 29 January 1998, [13] (SCOI.00041.00087).

[5074] Exhibit 29, Tab 99E, Transcript of Coronial Inquest into the death of Samantha Rose, 18 November 1999, 13 (SCOI.83316).

[5075] Exhibit 29, Tab 54, Transcript of recorded interview with Sandra Durward, 26 December 1997, 4, 38 (SCOI.00041.00101).

5.5383. On the evidence, it is possible that Ms Durward left Maisey's café via taxi and proceeded to Ms Rose's unit in Kensington. Given the evidence of Mr Starling and Mr Thornton that Ms Durward appeared worried about accommodation, it would not be surprising if Ms Durward went there to ask Ms Rose for a place to stay.

5.5384. The evidence also suggests that Ms Durward arrived at work late on the afternoon/evening of 20 December 1997, and that there were several train services running to St Mary's, which offers further support for the theory that Ms Durward went to Kensington and from there to Final Touch. This scenario also fits with the hypothesis that Ms Rose was assaulted by a person known to her sometime between 2:48pm, when she last spoke with Ms Sadek and around 3:00pm, when her mother reports the phone being engaged after an attempt to call her.

Coronial proceedings before Deputy State Coroner Abernethy

5.5385. As noted above, Deputy State Coroner Abernethy held an inquest into the death of Ms Rose. At the inquest, Ms Durward, Mr Becker and Mr Thwaites were called to give evidence. Deputy State Coroner Abernethy ultimately found that Ms Rose's death was the result of an "unpremeditated killing" by someone who Ms Rose knew and let into the unit or who otherwise had a set of keys to her unit.[5076] This was consistent with the view expressed by Detective Senior Constable Thornton, namely that Ms Rose died as a result of head injuries caused by fatal blows by a person she knew and let into her unit.[5077]

5.5386. During the course of her oral evidence at the inquest, Ms Durward made the following statements: [5078]

a. She attributed the statements identified at [5.5354], to the effect that she may have killed Ms Rose, to her "sometimes somewhat macabre sense of humour";

b. As to the incomplete letter identified at [5.5348], she approached police voluntarily and the term "indirectly involved" relates to the possibility that her former partner had once stayed at Ms Rose's unit and may have been involved in her death. At the time of the inquest, she did not think her former partner was involved;

c. As to the interaction with Ms Burrows identified at [5.5346], she attributed that to her macabre sense of humour, "one of those stupid melodramatic, you know 'maybe I did do it' kind of things" and stated "believe me, if I could erase those words I would";

d. As to her comments to Ms Craker between 31 December 1997 and 1 January 1998, identified at [5.5355], she said that the use of the word alibi is "just inappropriate";

[5076] Exhibit 29, 99F, Findings of Deputy State Coroner Abernethy, Inquest into the death of Samantha Rose, 18 November 1999, 5 (SCOI.83311).

[5077] Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 23 October 1998, [320] (SCOI.00041.00005).

[5078] Exhibit 29, Tab 99D, Transcript of Coronial Inquest into the death of Samantha Rose, 19 August 1999, 16-21, 23, 25-27, 30-31, 43-44, 50 (SCOI.83318).

e. Her eye injury was caused by a client, who hit her in the eye socket with his knee cap;

f. She could not recall having any issues with her accommodation until after 25 December 1997;

g. As to the incident on 28 January 1998, regarding the episode of rage and retention of keys to Ms Burrows' residence (discussed above), she had no recollection but did recall disposing of the keys. She said she is not a violent person;

h. She apologised to her friend's child immediately after kicking her and felt that she "over-reacted a bit";

i. She attributed her comment to Ms Feary regarding the television, as outlined above at [5.5356] to "one of the police or someone" saying something to her about the television falling on Ms Rose's head and causing her death. She also said that the television stand was unstable and that she would not have said anything about the television falling "out of the blue." She denied being present or involved in Ms Rose's death;

j. Her understanding was that Ms Feary returned the keys to Ms Rose;

k. She attributed her comment to Ms Clifford, as outlined at [5.5350] regarding her fingerprints being all over the unit, to staying with Ms Rose previously;

l. She attributed her comment to Ms Clifford at [5.5350], about knowing what day Ms Rose was killed, to the fact that police were "so interested in my movements" on that day; and

m. She could not recall but did not deny making certain comments to Ms Hudson, as outlined at [5.5352]. She attributes those comments to being "under a fair amount of stress at the time".

5.5387. During the course of his oral evidence, at the inquest, Mr Thwaites made the following statements:[5079]

a. He described Ms Durward as "fairly gentle" but did not know what she was like under the influence; and

b. As to Ms Durward's comments that she may have killed Ms Rose, Mr Thwaites gave evidence of her "inappropriate sense of humour" and "black humour" but could not recall her saying anything to that effect. He noted that she was "quite stressed" by Ms Rose's death and the police investigation.

5.5388. Deputy State Coroner Abernethy concluded that "there is thus some suspicion about Ms Durward, largely because of some of the peculiar things she said to those around her after the death, but there is absolutely nothing to link her to the homicide of [Samantha] Rose, other than a quite vague suspicion."[5080]

[5079] Exhibit 29, 99E, Transcript of Coronial Inquest into the death of Samantha Rose, 18 November 1999, 13 (SCOI.83316).

[5080] Exhibit 29, 99F, Findings of Deputy State Coroner Abernethy, Inquest into the death of Samantha Rose, 6 November 1999, 5 (SCOI.83311).

5.5389. In forming that view, his Honour had regard to the lack of forensic evidence including fingerprints linking Ms Durward to the scene, the evidence of Ms Feary as to Ms Durward's capacity for violence noting that he had "little evidence to the contrary", and the lack of evidence that Ms Durward was near Ms Rose's apartment on 20 December 1997.

5.5390. Significantly, his Honour referred to Ms Durward's comments as to the state of Ms Rose's television as the "most damaging inference" connecting her to Ms Rose's death. In particular, he found:[5081]

> *Perhaps the most damaging inference can be drawn from her remarks to her sister that perhaps the television was knocked over and hit [her] on the head. She has little recognition of this or any of these conversations but suggests that it was just an explanation which came into her head. On the one hand, the television had been knocked over when police found the deceased, but as Durward says it may have been on a rickety stand - that is not really clear. On the other hand even if Durward is blaming it on the television as she in fact did kill the deceased, there is no forensic evidence that [she] fell or was thrown against it, perhaps hitting [her] head and knocking it over.*

5.5391. His Honour concluded that whilst there may be some suspicion surrounding Ms Durward, there was insufficient evidence, even viewing the Crown case in its most positive light, to satisfy a reasonable jury properly instructed of an indictable offence in connection with Ms Rose's death.[5082]

5.5392. Despite the position expressed by Deputy State Coroner Abernethy, in its totality, there is cogent circumstantial evidence that Ms Durward may have been involved in the death of Ms Rose. I will endeavour to draw this evidence together below but note in summary that my view is supported by the oral evidence of Ms Durward at the inquest, particularly her unpersuasive explanation for the apparent inculpatory statements identified above. Relevantly, his Honour noted that it was difficult to determine whether Ms Durward is "a witness of truth or a very clever liar".[5083]

Conclusions on the evidence regarding Ms Durward's possible involvement

5.5393. The lack of evidence of any forced entry suggests that Ms Rose knew her assailant.

5.5394. At the time of the murder, Ms Durward was seeking accommodation. Her evidence at the inquest that she was not looking for accommodation on 20 December 1997 but was looking for accommodation a few days later is open to doubt — the evidence indicates existing tension between Ms Durward and her then-host Ms Miles as early as 20 December 1997.

[5081] Exhibit 29, 99F, Findings of Deputy State Coroner Abernethy, Inquest into the death of Samantha Rose, 18 November 1999, 5-6 (SCOI.83311).

[5082] Exhibit 29, 99F, Findings of Deputy State Coroner Abernethy, Inquest into the death of Samantha Rose, 18 November 1999, 6 (SCOI.83311).

[5083] Exhibit 29, 99F, Findings of Deputy State Coroner Abernethy, Inquest into the death of Samantha Rose, 18 November 1999, 4 (SCOI.83311).

5.5395. It is possible Ms Durward went to Ms Rose's unit with the intention of seeking accommodation. Once there, Ms Rose may have told her she could not stay and/or told her that she had warned others not to take her in. At hearing this, Ms Durward may have flown into a rage, violently assaulting Ms Rose. This might explain the upheaval of the unit. Such behaviour is consistent with descriptions of her volatile personality given by various witnesses. The evidence of Mr Starling, who spoke to Ms Durward at the end of the AA meeting is also compelling in this regard. He indicated that Ms Durward "appeared very agitated and upset about something to the degree of being emotionally distressed."[5084] It is possible, although speculative, that in the course of this assault Ms Rose fell to the ground and the television was pushed or knocked onto her head, resulting in the injuries observed by Dr Iles.

5.5396. Ms Durward's initial approach to the police saying she thought her "stepson" Joel Hilton may have had something to do with Ms Rose's death might be regarded as somewhat suspicious. Police records indicate they interviewed Paul Hilton, Joel Hilton and Paul Hilton's then-girlfriend Susan North. The police investigation did not identify anything to connect Joel Hilton with the crime scene, nor has this Inquiry. This raises the possibility, albeit speculative, that Ms Durward may have thought she had to explain how someone might have keys to Ms Rose's apartment. A similar speculative possibility arises in relation to Ms Durward apparently volunteering reasons why her fingerprints could be expected to be at the apartment (although there is no evidence of Ms Durward's fingerprints actually being found there).[5085]

5.5397. It is possible that Ms Rose's assailant may not have appreciated that they had killed her. If the assailant was Ms Durward, this could be an explanation for Ms Durward's later comments that "maybe she had killed him". These comments are equally consistent with Ms Durward having "blacked out" following alcohol consumption, so that she came to think she may have been the assailant, conscious that she did not recall what she did that afternoon after coffee at Maisey's café. In other words, Ms Durward's inculpatory statements and her considerable efforts to ensure she had alibi evidence might indicate a consciousness of guilt but they might equally indicate someone who was afraid they *might* be guilty but did not remember one way or the other.

5.5398. It was never established whether the second set of apartment keys belonging to Ms Rose had been returned by Ms Durward; she may in fact have retained them in her possession.

5.5399. Assuming that the assault on Ms Rose occurred when her telephone became engaged at about 3:00pm on 20 December 1997, Ms Durward had an opportunity to attend Ms Rose's unit from the time she left the AA meeting at Neutral Bay to the time she attended work at St Mary's. The only alibi evidence to say she left Mosman at 4:00pm is Mr Thwaites. The reasons to doubt this alibi evidence are set out above.

[5084] Exhibit 29, Tab 71, Statement of Clive Ronald Starling, 19 February 1998, [6] (SCOI.00041.00089).

[5085] Exhibit 29, Tab 72, Statement of Louise Margaret Clifford, 6 January 1998, [8] (SCOI.00041.00055).

5.5400. Significantly, Ms Durward appeared to have special knowledge of the crime scene. According to Ms Burrows, Ms Durward appeared to believe as early as 24 December 1997 that there was no forced entry.[5086]Although, in her first interview with the police on 26 December 1997 she justified coming to the police on the basis that "the paper doesn't say anything about forced entry".[5087] More importantly, she volunteered information suggesting she knew of Ms Rose's television having fallen over, and referenced this being the cause of Ms Rose's death. This assumes even greater significance given the findings of Dr Iles regarding a potential crush injury and the possibility that this was caused by Ms Rose's television.

5.5401. The friendship between Ms Rose and Ms Durward had been known at times to involve conduct which led to Ms Rose holding concerns or fears regarding her safety. These concerns were often associated with Ms Durward's heavy use of alcohol. Indeed, Ms Durward's heavy use of alcohol may have been a factor in her not remembering whether she had something to do with Ms Rose's death, yet simultaneously thinking she may have. As Mr Starling told police, it is "not uncommon for alcoholics to have blackouts and not remember certain things".[5088] This scenario would be consistent with the sequence of events posited by Dr Iles and leading to Ms Rose's death as outlined above at [5.5297].

5.5402. Further, the evidence as to Ms Durward's dark or "macabre" sense of humour sits at odds with the way Ms Burrows, Ms Hudson and Ms Craker describe the apparent inculpatory comments made by Ms Durward and discussed above. It is possible that this evidence about a macabre sense of humour is an attempt to provide a false explanation for what are otherwise obviously inculpatory statements. However, if Ms Durward truly "blacked out" and did not remember her movements on the afternoon of 20 December 1997, then her subsequent explanations for these inculpatory statements, even if false, might not reflect a consciousness of guilt, but might rather reflect a person who has no memory of the relevant afternoon and therefore does not know whether she was guilty or not.

5.5403. Professor Jones' opinions in respect of the effects of consumption of methylated spirits furthers the hypothesis that Ms Durward, a consumer of methylated spirits, *may* have been experiencing changes in behaviour, impairment in judgement, cognitive impairment, increased violence and impairment to memory around the time of Ms Rose's fatal assault. This may explain, at least in part, some of the bizarre statements she made to friends and colleagues after Ms Rose's death.

[5086] Exhibit 29, Tab 73, First statement of Irene Patricia Burrows, 27 December 1997, [9] (SCOI.00041.00061).

[5087] Exhibit 29, Tab 54, Transcript of recorded interview with Sandra Durward, 26 December 1997, 25 (SCOI.00041.00101).

[5088] Exhibit 29, Tab 71, Statement of Clive Ronald Starling, 19 February 1998, [12] (SCOI.00041.00089).

5.5404. There are some features of this scenario which are nevertheless surprising. In particular, the absence of forensic evidence connecting Ms Durward to the crime scene is significant, even taking into account the gaps in fingerprinting and DNA tests described above. There is no reason to expect Ms Durward to have been a particularly sophisticated criminal. If Ms Durward was involved in Ms Rose's death it could not have been premeditated, and Ms Durward would presumably have been heavily under the influence of alcohol at the time. It would be surprising that no trace of her was found at Ms Rose's apartment.

5.5405. Without more to link Ms Durward to Ms Rose's death, the above scenario involves an unavoidable element of speculation.

Police investigation into Mr Becker

5.5406. On 22 December 1997, Mr Becker participated in a recorded interview with police. He described his relationship with Ms Rose as "purely semi-professional", through their contact at the radio station, a "professional association" and with "very limited social contact outside the radio".[5089] As to his attendance at Ms Rose's unit, Mr Becker told police:[5090]

> *[Samantha] actually came to my home for a barbecue, for the first and only time on, I think, the Sunday, the first Sunday in November. I'm certain as to the, this, this year, but I'm uncertain as to the exact date, but it was definitely on a Sunday, I know that, this year, 1997. So there was no, there was no social contact. I'd popped [by her] house, [by her] home unit once or twice, in fact [she'd] extended the invitation that I could pop by or give [her] a ring if I was in the area, because up until, up until six months ago I worked as a cab driver.*

5.5407. As to his movements on 20 December 1997, Mr Becker told police that he left Pennant Hills at around 5:00pm and proceeded to his friend Helene Topp's residence to deliver Christmas presents. He stayed at Ms Topp's between 6:15pm and 8:00pm before travelling to Ms Rose's unit to drop off her Christmas gift.[5091]

5.5408. Although Mr Becker stated that his relationship with Ms Rose was of a professional nature with limited social contact, his response to questions from police suggest that they may have had a closer relationship. During the course of his police interview, Mr Becker made reference to knowing that Ms Rose's parents had recently moved, indicated that Ms Rose was one of few people for whom he had purchased a Christmas gift, had attended Ms Rose's residence on several occasions and was aware that Ms Rose had ceased hormone treatment on medical advice.[5092]

[5089] Exhibit 29, Tab 12, Transcript of recorded interview with Stephen Becker, 22 December 1997, 6, 24 (SCOI.00041.00103).

[5090] Exhibit 29, Tab 12, Transcript of recorded interview with Stephen Becker, 22 December 1997, 6 (SCOI.00041.00103).

[5091] Exhibit 29, Tab 12, Transcript of recorded interview with Stephen Becker, 22 December 1997, 36 (SCOI.00041.00103); Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 23 October 1998, [118] (SCOI.00041.00005).

[5092] Exhibit 29, Tab 12, Transcript of recorded interview with Stephen Becker, 22 December 1997, 9, 26, 29-30, 39-40 (SCOI.00041.00103).

5.5409. At the time of his interview with police, Mr Becker also suffered from an injury to his eye which he indicated was occasioned by his dog. This was corroborated by medical records produced to the Inquiry by the Northern Sydney LHD from 17 October 1997 as well as earlier inquiries made by Detective Senior Constable Thornton with Mr Becker's partner and Ms Topp.[5093] There was evidence given from the bar table at the inquest that Detective Senior Constable Thornton had made inquiries of Hornsby Hospital and this confirmed Mr Becker's attendance there two months prior to Ms Rose's death with a complaint of a dog attack.[5094]

5.5410. At the inquest into Ms Rose's death, Mr Becker was called to give evidence. During the course of his oral evidence, Mr Becker made the following statements:[5095]

a. He was never a "close friend" of Ms Rose because they were not "friendly". Rather, "we met at the radio station and seldom outside there. If we did, it was for purposes related to radio work";

b. He had attended Ms Rose's unit on a "few occasions", "once or twice" but it was a radio-based visit;

c. Ms Rose told Mr Becker that Ms Durward was not the "warm-hearted person that he first met when she started at the radio station";

d. On 20 December 1997, he stayed at Ms Rose's unit for around 20 minutes trying to raise her by knocking on the door, ringing the doorbell, calling out her name and attempting to telephone her;

e. He was a "close associate" of Ms Rose and the "association really didn't go any further than the radio", he'd like to call Ms Rose a "friend, but it didn't extend to social occasions"; and

f. He bought Ms Rose "many presents in the context of the radio station".

5.5411. Although the Inquiry has considered the potential involvement of Mr Becker in Ms Rose's death, there is no evidence which would rise beyond mere suspicion. There is no motive evident on the materials before the Inquiry for Mr Becker wanting to harm Ms Rose.

Police investigation

5.5412. Counsel Assisting submitted that whilst the overall police investigation was adequate, the following matters of concern are noted:[5096]

a. There is no evidence to suggest the iron that was found at the crime scene was ever fingerprinted, swabbed or seized.[5097] The iron may have been used

[5093] Exhibit 29, Tab 13A, Extract of medical records produced by North Sydney Local Health District, 17 October 1997 (SCOI.83338); Exhibit 29, Tab 7, Statement of Detective Senior Constable Paul Michael Thornton, 23 October 1998, [118] (SCOI.00041.00005).

[5094] Exhibit 29, Tab 99D, Transcript of Coronial Inquest into the death of Samantha Rose, 19 August 1999, 77 (SCOI.83318).

[5095] Exhibit 29, Tab 99D, Transcript of Coronial Inquest into the death of Samantha Rose, 19 August 1999, 68, 70, 72, 76 (SCOI.833 18).

[5096] Submissions of Counsel Assisting, 2 June 2023, [24] (SCOI.83401).

[5097] Exhibit 29, Tab 99C, UHT review in relation to Samantha Rose, 30 September 2021, 54 (SCOI.02713).

as a weapon in the course of the assault on Ms Rose. The failure to at least seize it from the scene means it cannot now be subjected to forensic testing;

b. There is no evidence that the television, that had been sitting on crates in the loungeroom and that had fallen off those crates, was ever fingerprinted, swabbed or seized. The failure to at least seize the television from the scene means it cannot now be subjected to forensic testing.[5098] This assumes greater significance given the report of Dr Iles, that some of the head injuries appear consistent with Ms Rose's head being crushed by the television;

c. The omissions above suggest that there was limited attention given by police to the area of the loungeroom where the ironing board had fallen and dislodged the television that had been sitting on the crates. Indeed, the television, ironing board, iron and all the furniture within the loungeroom were omitted from the sketch plan prepared by the crime scene officer;[5099]

d. There was no DNA examination of any of the exhibits during the original police investigation; and

e. It appears that limited efforts were made by Detective Sergeant Shaw between 2007 and 2009 to action the items identified in the Recommendation Report dated 28 March 2007. It is also unclear, based on the material produced by the NSWPF to date, whether further steps were taken to action any of the inquiries after 2009. Given the recommendations contained in the 2021 UHT review, it appears that no, or limited, further enquiries were made by the NSWPF.

5.5413. The NSWPF addressed in written submissions Counsel Assisting's concerns in relation the iron and television observed at Ms Rose's residence as well as the DNA examination of exhibits.[5100] I will consider each of these submissions in turn.

5.5414. As to the iron, the NSWPF acknowledges that in the absence of evidence of the murder weapon, the use of the iron in connection with Ms Rose's fatal assault cannot be ruled out. However, the injuries sustained by Ms Rose, and the absence of burns, are inconsistent with an iron having been used in any significant way during the assault. That is because the evidence suggests that the iron was hot enough to melt an insulated power cord. Further, the NSWPF points to the fact that Dr Iles has provided a careful and thorough analysis of the pathological evidence and did not identify any injuries on Ms Rose consistent with the use of the iron as a weapon during the assault. On balance, the NSWPF submits that the iron was unlikely to have had any involvement in the death of Ms Rose but recognises that in an abundance of caution, it may have been appropriate for it to have been seized.[5101]

[5098] Exhibit 29, Tab 99C, UHT review in relation to Samantha Rose, 30 September 2021, 54 (SCOI.02713).

[5099] Exhibit 29, Tab 99C, UHT review in relation to Samantha Rose, 30 September 2021, 54 (SCOI.02713).

[5100] Submissions of NSWPF, 16 June 2023 (SCOI.84153).

[5101] Submissions of NSWPF, 16 June 2023, [20]–[23] (SCOI.84153).

5.5415. I accept the submissions of Counsel Assisting and the NSWPF that it would have been appropriate for the iron to have been seized. Given the uncertainty surrounding the mechanism by which Ms Rose sustained her injuries, the iron should properly have been seized with a view to ruling in or out its use in the assault.

5.5416. As to the television, the NSWPF submits that Counsel Assisting's criticism needs to be considered in light of the evidence available to the investigating police at the time. In particular, Ms Rose's body was not found in the vicinity of the television and the opinion proffered by Dr Lawrence was that Ms Rose's injuries were consistent with an assault.[5102]

5.5417. The NSWPF observed that Dr Iles' analysis does not take into consideration that (a) the dented can of plums was found in the direct vicinity of Ms Rose's body (though noting the apparent lack of physical evidence that the can was involved); and (b) the assailant could have taken the weapon with them when they left the unit. The NSWPF also notes that Dr Iles' analysis does not appear to have considered whether an item the likely weight of the television was able to inflict the relevant injuries to a person of Ms Rose's age and physical build.[5103]

5.5418. The NSWPF also pointed to the lack of evidence of any damage to the television (for example its screen) that would appear consistent with it having been used in some way to assault a person. Additionally, the television does not seem to have fallen from a significant height and there did not appear to have been any blood on the floor near the television. On balance, the NSWPF submits that it is relatively unlikely that the television had any involvement in the injuries sustained by Ms Rose. Rather, the most compelling aspect of the case insofar as the television is concerned was Ms Durward's apparent esoteric knowledge of the television having been found tipped over. The NSWPF agrees with the submission of Counsel Assisting to the effect that Ms Durward's knowledge of this fact is suggestive of her having been at Ms Rose's unit during or potentially after Ms Rose was assaulted.[5104]

5.5419. I accept that there is uncertainty surrounding whether or not the television was involved in the assault on Ms Rose or was otherwise the cause of her injuries. However, the television should have been fingerprinted, swabbed and/or seized by the NSWPF in order to preserve the forensic opportunities associated with the testing of that item. To this end, I share the concern expressed by Counsel Assisting that there was limited attention given by police to the area of the loungeroom where the ironing board had fallen and dislodged the television. This is significant given the opinions proffered by Dr Iles as to the possible source of Ms Rose's injuries. Dr Iles noted that there is nothing in the vicinity of Ms Rose's body to account for her primary traumatic brainstem haemorrhages, suggesting Ms Rose's body may have been moved.

[5102] Submissions of NSWPF, 16 June 2023, [24]–[33] (SCOI.84153).

[5103] Submissions of NSWPF, 16 June 2023, [31] (SCOI.84153).

[5104] Submissions of NSWPF, 16 June 2023, [33] (SCOI.84153).

5.5420. As to the apparent failure to conduct any DNA examination of the exhibits during the original police investigation, the NSWPF submitted that the reasons for this have not been explored with investigating police. Additionally, DNA testing was a relatively novel phenomenon as at December 1997 and at the time of Ms Rose's death, there was no mechanism by which Ms Durward's DNA or that of another suspect could be obtained via compulsion.[5105]

5.5421. In this regard, I consider that, given the NSWPF were at the very least aware of the emergence of DNA technology at the time of the original investigation, they should have been alive to the forensic potential of seizing and retaining exhibits for possible future DNA testing. The recommendation contained in the First Review, namely that the exhibits be submitted for DNA analysis clearly illustrates at least by 2004, the potential forensic value of DNA testing was recognised by the NSWPF. I also note the analysis and my conclusions at **Chapter 8** in relation to the global submission made by the NSWPF regarding the knowledge and availability of DNA testing.

Manner and cause of death

5.5422. Counsel Assisting submitted that I should make a finding as to manner and cause of death in the following terms:[5106]

> *Ms Rose died on 20 December 1997 at some time after 2:48pm, at Kensington, as a result of head injuries inflicted by a person or persons unknown.*

5.5423. The NSWPF supports the submission of Counsel Assisting as to manner and cause of death.[5107]

Bias

5.5424. I conclude that, if Ms Durward was involved in Ms Rose's death, then there is little or no reason to suspect that the death involved LGBTIQ bias. If Ms Rose was not involved, then LGBTIQ bias cannot be excluded, but no positive conclusion can be drawn that there is reason to suspect LGBTIQ bias.

5.5425. As I have said before, the absence of evidence on which I can draw a positive conclusion does not mean that there is no reason to suspect that LGBTIQ bias was a factor in Ms Rose's death. I consider that the circumstances of Ms Rose's death, including the positioning of her body, do give rise to a suspicion that LGBTIQ bias was a factor in Mr Rose's death.

[5105] Submissions of NSWPF, 16 June 2023, [35] (SCOI.84153).

[5106] Submissions of Counsel Assisting, 2 June 2023, [172] (SCOI.83401).

[5107] Submissions of NSWPF, 16 June 2023, [56]–[59] (SCOI.84153).

Conclusions and recommendations

5.5426. I find that Ms Rose died on 20 December 1997 at some time after 2:48pm, at Kensington, as a result of head injuries inflicted by a person or persons unknown.

5.5427. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in Ms Rose's death.

5.5428. I do not propose to make any public recommendations arising from the Inquiry's consideration of Ms Rose's death.

Chapter 6: Category B Deaths

Volume 2

CATEGORY B

Introduction

6.1. Category B of the Terms of Reference is expressed as follows:

> *B. The manner and cause of death in all unsolved suspected hate crime deaths in New South Wales that occurred between 1970 and 2010 where:*
>
> *i. the victim was a member of the lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) community; and*
>
> *ii. the death was the subject of a previous investigation by the NSW Police Force.*

6.2. Category B of the Terms of Reference is cast in very wide language. It requires me to inquire into all unsolved deaths in NSW, in the 40 years between 1970 and 2010, where:

a. The victim was a member of the LGBTIQ community;

b. The death was a "suspected hate crime death"; and

c. The death was the subject of a previous investigation by the NSWPF.

6.3. While my starting point for considering deaths that fall within Category A was necessarily limited to a subset of a finite number of deaths (the 88 cases considered by Strike Force Parrabell), Category B had no such limitation. Significantly, the 40-year period stipulated for Category B is a substantially longer time period than the 23 years in which the 88 deaths looked into by Strike Force Parrabell occurred.

6.4. Although the language of Category B literally includes deaths already covered by Category A, in practical terms it amounts to a "catch all" which covers all possible unsolved gay hate homicides in that 40-year period, including (in particular) any such cases which were not among the list of 88 (between 1976 and 1999). That proved to be a very substantial task attended by significant complexity.

6.5. The process for determining which deaths fell within Category B was therefore quite different to that which applied to Category A.

6.6. As explained in the Executive Summary, dealing with the scope of the task bound up within Category B proved to be an enormous exercise for the staff of the Inquiry, one which was complicated, painstaking and time-consuming. The Inquiry faced considerable difficulties in identifying deaths which fell within Category B. Many of those difficulties were logistical, as outlined below. However, some interpretation of the Terms of Reference was also required.

Matters of interpretation

6.7. In order to determine which deaths fell within Category B, I recognised the importance of grappling with the phrase "member of the LGBTIQ community".

6.8. I discuss how I have interpreted that expression in **Chapter 1**. By way of summary, for the purposes of this Inquiry, a "victim" (to use the language of Category B) is considered to come within the meaning of the expression "member of the LGBTIQ community" where:

a. They were out as member of the LGBTIQ community; or

b. There is reason to believe or suspect that the victim was a member of the LGBTIQ community; or

c. There is reason to suspect that a person or persons involved in the death of the victim believed or assumed that the victim was or may have been a member of the LGBTIQ community.

Identification of Category B deaths

6.9. With that framework in mind, in order to identify deaths which might fall within Category B, the Inquiry adopted the following approaches in particular:

a. Close examination of the UHT Tracking File, which lists more than 700 unsolved cases from the period 1970–2010;

b. Close examination of the MPU's Long Term Missing Persons Spreadsheet (**Long Term Missing Persons Spreadsheet**), which lists a further 559 Missing Persons cases from that 40-year period;

c. Seeking and obtaining information from the National Coronial Information System (**NCIS**) and the Australian Institute of Criminology (**AIC**);

d. Review of the NSWPF unsolved homicide rewards page;

e. Researching and analysing information contained in historical LGBTIQ media publications, including among others, the *Sydney Star Observer*, *Campaign Australia* and other publications held by the State Library of New South Wales and the Australian Queer Archives based in Victoria;

f. Giving careful consideration to the various submissions made to the Standing Committee;

g. Seeking and receiving information from community groups such as ACON and the Gender Centre; and

h. Seeking information from the public and from the families and friends of people whose deaths might possibly fall within the Category.

6.10. Each of these avenues is outlined in more depth below.

6.11. The Inquiry requested that the NSWPF identify, from its UHT Tracking File and Long Term Missing Persons Spreadsheet, those cases which were or might be LGBTIQ bias-related. Unfortunately, the NSWPF responded to the effect that it did not have either sufficient personnel, nor adequate electronic means, to do so. The Inquiry was therefore obliged to devise its own protocols, procedures and methods for scrutinising, analysing and researching the nearly 1300 cases on those two lists.

Examination of potential Category B cases by the Inquiry

UHT cases from 1970–2010

6.12. In June 2022, the NSWPF provided the Inquiry with an Excel spreadsheet comprising the UHT's Tracking File. The information on this spreadsheet includes the current investigative status of all unsolved homicides in NSW in the 40-year period the subject of Category B, which is in excess of 700.

6.13. The UHT Tracking File itself, with few exceptions, does not contain any indication as to whether a particular matter is or might be a bias-related homicide; nor is the sexuality or gender identity of the victim of a homicide apparent from the UHT Tracking File.

6.14. Accordingly, the Inquiry was obliged to, and did, seek, obtain and carefully analyse the underlying material relating to each of those approximately 700 cases, in order to form a view as to which, if any, might fall within Category B.

Preliminary search of the Tracking File

6.15. To begin this process, the Inquiry team first conducted word searches of the UHT Tracking File using broad search terms covering such themes as sexuality and gender identities, locations and types of crime.

6.16. From these preliminary searches, five cases were immediately identified for further consideration.[5108] The Inquiry team conducted online searches for any publicly available information (e.g., the NSWPF rewards pages and media articles) about the homicides and victims.

6.17. On 15 June 2022 and 7 July 2022, the Inquiry requested full files from the Coroners Court and the NSWPF, respectively, for each of these cases. Three of these five matters were ultimately found to fall within Category B.

Correspondence with the NSWPF

6.18. In a letter to the NSWPF of 10 June 2022, which I canvass in greater detail at **Chapter 15** this Report, the Inquiry requested the following:

a. Case summaries in respect of each of the 477 homicides identified as "undetected" by the UHT in its Tracking File. In a letter of 7 July 2022, the

[5108] These were the cases concerning Peter Baumann, Barry Jones, Stephen Seymour, Anthony Cawsey and Aaron Light.

Inquiry clarified that this was no longer pressed in relation to matters where a completed triage and/or review document had already been provided;

b. Case summaries in relation to each of the 65 homicides identified as "undeterminable" and where a review document had not yet been completed by the UHT; and

c. In relation to each of the deaths on the UHT Tracking File (excluding those for which a completed triage and/or review document had been provided), that the NSWPF identify whether the UHT considered the death to be likely or unlikely to fall within Category B, including the reasons for that view. The Inquiry requested that, in forming its view, the NSWPF undertake electronic searches of e@gle.i, COPS, and holdings for Strike Force Palace, using an enclosed schedule of search terms created by the Inquiry.

6.19. On 18 July 2022, the NSWPF informed the Inquiry that the preparation of the requested case summaries would be a significant undertaking, and that the UHT estimated that it would take several of its officers a number of months to properly review case material and prepare a case summary. The NSWPF asserted that it had not been possible to make provision for full-time designated police resources to respond to this request, and instead suggested that the preparation of case summaries be undertaken by the Inquiry. The NSWPF proposed to provide the Inquiry simply with its boxes of hardcopy files in respect of those matters that had not had a review completed (being 74 "undetected" cases and 13 "undeterminable" cases).

6.20. The NSWPF put forward two reasons for this response:

a. First, it was suggested that UHT personnel were engaged in other investigative activities outside the scope of cases before the Inquiry; and

b. Secondly, it was suggested that public confidence would be enhanced by an independent review by the Inquiry as to whether or not the police categorisation of the relevant death is an accurate one.

6.21. The NSWPF also informed the Inquiry that the electronic searches requested were not practicable due to limitations of the databases meaning that each individual file would have to be reviewed separately. The NSWPF proposed that the Inquiry, not the NSWPF, undertake that task, and that the NSWPF would provide the hardcopy files to the Inquiry to enable the Inquiry to do so. Again, it was said that this would avoid diverting resources away from the investigative activities of the UHT.

6.22. The Inquiry team subsequently took steps to devise its own protocols, procedures and methods for scrutinising, analysing and researching the cases on the UHT Tracking File.

Review of all UHT documents

6.23. On 10 June 2022, the Inquiry wrote to the NSWPF requesting, among other things, all review documents prepared by the UHT for each of the homicides identified as "undetected", "unresolved" or "undeterminable" (i.e., not solved). This request encompassed 708 cases.

6.24. In response, on 23 June 2022, the NSWPF provided the Inquiry with just over 1,000 documents. These were for the most part Triage Forms and Case Screening Forms. For many of the 708 cases, there were no such review documents.

6.25. The solicitors assisting the Inquiry undertook a preliminary review of each of the 708 cases to assess whether there was a possibility they could fall within Category B. At this initial stage, a deliberately inclusive approach was adopted. In making this assessment, the solicitors considered factors such as:

a. The victim's age, sexuality and gender identity;

b. The circumstances of the death (e.g., if it was a frenzied attack or a fall from a cliff); and

c. The location of the death (e.g., if it was at or near a known beat).

6.26. The solicitors would then assign the case to the following five categories:

(1) Cases which appeared to be clearly outside the scope of the Terms of Reference, for example, because the victim was a young child, the death related to organised crime, or the death appeared to be a misadventure, such as a boat, plane or vehicle crash. Some 535 cases fell in that category.

(2) Cases which had already been identified by the Inquiry as potentially falling within the Terms of Reference, those mainly being cases which had been considered by Strike Force Parrabell. Some 27 cases were identified as falling within this category.

(3) Cases which appeared *prima facie* to fall within Category B. Some 12 cases were identified at that stage, and requests were sent to the NSWPF, Coroners Court and the ODPP for the relevant cases files.

(4) Cases which might potentially fall within the Terms of Reference, but which required further discussion. There were 23 cases of that kind.

(5) Cases where there was insufficient information to make any proper assessment. There were 105 cases in that category.

6.27. The 23 cases in the fourth category were then subjected to greater scrutiny. These cases were presented and discussed at a group review of the counsel and solicitors assisting the Inquiry. As a result of this discussion, 14 cases were excluded. The remaining nine cases were considered to be potentially within the Terms of Reference, and requests were sent to the NSWPF, Coroners Court and the ODPP for the relevant case files.

6.28. For the 105 cases in the fifth category, in respect of which insufficient information was initially available, it was necessary to take a number of separate steps:

a. First, the Inquiry team conducted online searches for any publicly available information about these deaths. A number of cases were excluded on the basis of these searches. From this review the Inquiry team identified one case that was likely to fall within Category B, and requests were sent for the relevant case files.

b. Secondly, having excluded a number of cases on the basis of the online searches, 31 cases remained which still required further information in order for an assessment to be made. For those cases, inquiries were made with the NSWPF for a copy of police facts and/or to the Coroners Court for a copy of a Report of Death or Suspected Death, or a copy of the coronial findings or reasons for dispensing with an inquest.

c. Following receipt and consideration of this information, no further cases were considered to be within the Terms of Reference.

6.29. In total, 27 cases were identified through the UHT Tracking File as potentially falling within the Terms of Reference. Two cases were excluded at an early stage following review of the material produced:

a. The case concerning Bernd Lehmann was identified as involving ongoing criminal proceedings and so was not investigated by the Inquiry in light of Paragraph E of the Terms of Reference;

b. The case concerning Eric Kuhn was considered to be solved.

6.30. The remaining 25 cases proceeded to the case review process.

Information from the Missing Persons Unit

6.31. The Inquiry also sought to identify any long term missing persons whose suspected deaths may fall within Category B. Central to this part of the analysis was the content of an Excel spreadsheet provided to the Inquiry in July 2022 by the MPU.

6.32. The Long Term Missing Persons Spreadsheet covered all long term missing persons cases in NSW. For the 40-year period between 1970 and 2010 there are 559 such cases.

6.33. However, the information in the spreadsheet comprised only the name of the missing person, the date of the disappearance, and the event or case reference. As with the UHTs Tracking File, the MPU's spreadsheet contained no indication as to whether a particular matter was thought to be a potential hate-related homicide, nor as to the sexuality or gender identity of the victim.

6.34. The solicitors assisting the Inquiry undertook a review of each of the 559 cases to assess whether there was a possibility they could fall within Category B. Again, a conservative approach was taken to the exclusion of cases.

6.35. First, the Inquiry team conducted online searches of publicly available information about each of the missing persons and the circumstances of their disappearance, including but not limited to searches of the NCIS, the Australian Missing Persons Register, the National Missing Persons Coordination Centre (AFP), and media articles. Following these initial searches, the cases were given one of four classifications:

(1) Cases which appeared *prima facie* to fall within Category B. Seven such cases were identified at that stage.

(2) Cases which had already been identified by the Inquiry as potentially falling within the Terms of Reference (e.g., because they were on the UHT Tracking File). Nine cases were already under consideration by the Inquiry as at November 2022.

(3) Cases where there was insufficient information to make a determination. There were 277 cases in that category.

(4) Cases which were excluded as unlikely to fall within the Terms of Reference. Some 267 cases were identified as falling within this category, for example, where a person disappeared following a rock fishing accident or the abduction of a young child.

6.36. In relation to the seven cases in the first category, a summons was issued to the NSWPF for the complete investigative files for each case, including material from the MPR and the UHT. Following review of this material by the solicitor team, six of the seven cases moved to the case review process.

6.37. For the 277 cases in the third category, a series of steps were taken in order to obtain further information:

a. A summons was issued to the NSWPF for the COPS event entry or case report that had been referenced in the Long Term Missing Persons Spreadsheet for that person.

b. The NSWPF produced material for 274 cases, which amounted to approximately 3500 pages. This material was reviewed by the Inquiry team, with consideration given to a range of key words as occurred in the review of the UHT Tracking File above, as well as the circumstances and location in which the person went missing, and whether the missing person was a member of the LGBTIQ community.

c. From this review, eight cases were considered likely to fall within Category B. The Inquiry subsequently requested and reviewed files and records from the NSWPF and the Coroners Court or relevant Local Court in relation to these cases.

d. A number of cases were able to be excluded on the basis of the further material received, such as those involving young children or people lost at sea.

e. Some 43 cases remained which were still considered as having insufficient information (including the three cases for which the NSWPF did not produce any material). The Inquiry subsequently requested and reviewed files and records on these cases from the Coroners Court or relevant Local Court.[5109] A further summons was also issued for the complete NSWPF investigative files in relation to four of these cases. Despite the issuing of summonses and requests for information, the Inquiry has not received any documents in relation to several deaths. Following the review of the material available, none of these 43 cases proceeded to the case review process.

[5109] Specifically, the report of death or suspected death, and the findings or reasons for dispensing with an inquest.

6.38. A total of 14 cases from the Long Term Missing Persons Spreadsheet proceeded to the case review process.

National Coronial Information System (NCIS) and the Australian Institute of Criminology (AIC)

6.39. The NCIS is a research database of information concerning deaths reported to coroners throughout Australia and New Zealand covering the period from 2000 to the present.

6.40. In July 2022, the Inquiry wrote to the NCIS requesting that searches be undertaken of their extensive digital records of New South Wales coronial findings. Ultimately, the NCIS was able to identify five additional deaths for further consideration. However, following further searches undertaken by the Inquiry, including of relevant media articles and court judgments, it became apparent that none of those cases came within Category B.

6.41. The AIC conducts the National Homicide Monitoring Program. The Inquiry wrote to the AIC requesting that searches be undertaken of its holdings to identify any other deaths which may fall within Category B, and which may not otherwise have come to the attention of the Inquiry.

Review of the NSWPF Unsolved Homicide rewards page

6.42. From searches of the NSWPF rewards page, three cases were identified as potentially falling within Category B.

6.43. The Inquiry requested and received relevant records and files from the NSWPF and the Coroners Court for each of these cases. Following review of this material, each of the three cases proceeded to the case review process.

Historical LGBTIQ media publications

6.44. A further avenue of inquiry was a review of historical LGBTIQ media publications. From the outset of the Inquiry in May 2022, the Inquiry team undertook a review of historical LGBTIQ-related material held in various libraries and other repositories. One of the most important of these resources was the archives of the State Library of New South Wales which includes manuscripts, personal papers, newspapers, magazines, photographs and graphics.

6.45. Another useful resource was the *Campaign Australia* magazine which was published between 1975 and 2000. Through text searches of the issues available online, the Inquiry obtained contemporaneous news articles about a number of deaths within Category A and also identified a number of potential cases for consideration under Category B.

6.46. The Australian Queer Archives, based in Victoria, includes collections of approximately 150 LGBTIQ periodicals which were current during the period 1970 to 2010, and which have been digitised and made available through various libraries, including the State Library of New South Wales. The Inquiry team made extensive use of this resource for contemporaneous news articles about individual cases as well as historical beat locations and other relevant material otherwise difficult to locate.

6.47. One notable periodical which has not been digitised is the *Sydney Star Observer*. Issues are held in hard copy at both the State Library of New South Wales and the Australian Queer Archives. In September 2022 one of the Counsel Assisting the Inquiry attended the Australian Queer Archives in Victoria and, with the assistance of an archivist, reviewed relevant issues of the *Sydney Star Observer* between 1979 and 1997. Where this review identified relevant information, I have addressed that information below in my consideration of the individual deaths.

Submissions to the Parliamentary Committee

6.48. Another avenue of inquiry involved consideration of the submissions made to the Parliamentary Committee. The Inquiry carefully reviewed all of the submissions made to the Parliamentary Inquiry from 2018 to 2020, as well as the oral testimony of witnesses before the Committee. That review identified one additional case potentially falling within Category B.

6.49. The Inquiry obtained and reviewed the relevant files for this case from the Coroners Court and the NSWPF. Following that review, this case did not proceed to the case review process.

Information from community groups

6.50. A further avenue considered was information from community groups. The Inquiry recognised that many of the deaths and disappearances it examined, and the climate within which they took place, have had a major impact, not only on the friends and families of those who died, but on the LGBTIQ community as a whole. It was important to endeavour to ensure that as many LGBTIQ people and groups as possible were aware of the Inquiry and felt comfortable coming forward with information.

6.51. The Inquiry engaged in various ways with a number of community groups including but not limited to ACON, the Gender Centre, and the SWOP. The Inquiry team sought their cooperation both to spread word of the Inquiry as widely as possible, and also to assist the Inquiry and the community's awareness of social and cultural factors prevailing both in the time period under review and at the present time.

6.52. From information provided by the Gender Centre, three cases were identified as potentially falling part of Category B. The Inquiry obtained and reviewed the relevant files for these cases from the Coroners Court and the NSWPF. Following that review, none of these cases proceeded to the case review process.

Engagement with individuals

6.53. The Inquiry has also engaged in similar ways with a number of individuals who have had close involvement with some of the issues with which the Inquiry was concerned including, among others: Sue Thompson, former Gay and Lesbian Client Consultant with the NSWPF; Rick Feneley, journalist; Duncan McNab, journalist, writer and former police officer; Greg Callaghan, journalist and author; Magistrate Jacqueline Milledge; Professor Stephen Tomsen of Western Sydney University; and Michael Burge, journalist.

6.54. From information provided by Sue Thompson, two cases were identified as potentially falling part of Category B. The Inquiry obtained and reviewed the relevant files for these cases from the Coroners Court and the NSWPF. Following that review, neither of these cases proceeded to the case review process.

6.55. Finally, the Inquiry attempted to contact family members by letter, email and text message where current contact details were known. Some family members directly contacted the Inquiry. Media releases and public notices were also utilised. However, identifying and tracing family members for many of the cases being reviewed was by no means a simple task, and despite its best efforts the Inquiry cannot be certain to have reached everyone who may have wished to speak about the death or disappearance of a loved one.

6.56. From information provided by family and friends, two cases were identified as potentially falling part of Category B. The Inquiry requested and received relevant records and files from the NSWPF and the Coroners Court for each of these cases. Following review of this material, both cases proceeded to the case review process.

Coroners Court

6.57. In addition to the potential Category B cases identified through the methods discussed above, the Coroners Court also referred one case for consideration, which proceeded to the case review process.

Case review process

6.58. Overall, the Inquiry reviewed over 1,300 cases, and the following 46 deaths proceeded to the case review process, namely:

a. 25 cases from the UHT Tracking File;

b. 14 cases from the Long Term Missing Persons Spreadsheet;

c. 3 cases from searches of the NSWPF rewards page;

d. 2 cases from family/friends;

e. 1 case from submissions to the Parliamentary Inquiry; and

f. 1 case referred from the Coroners Court.

6.59. The case review process that was adopted in respect of these 46 deaths was consistent with the process adopted in respect of the Category A deaths. That process was outlined in greater detail in the introduction to **Chapter 5**. However, a general overview of that process as it applied to Category B deaths is outlined below.

6.60. Following the preparation of a Case Summary for each of the 46 cases, with a preliminary analysis of the death and a recommendation as to whether the matter appeared to fall within Category B, two cases were considered to fall outside the Terms of Reference.

6.61. For the remaining 44 cases, a "Factors for Decision" document was prepared identifying recommendations as to what investigative steps should be taken, and the available evidence as to indications of LGBTIQ bias.

6.62. The Case Summary and Factors for Decision were then discussed in a "First Case Review Meeting", where the following occurred:

a. Some 16 cases were determined to be clearly outside the Terms of Reference and excluded with no further steps taken.

b. The remaining 28 cases were regarded as needing further consideration. These cases were identified because there was some common factor which suggested or indicated that the death might have been motivated by LGBTIQ bias, for instance:

   i. The location of the homicide was that of the deaths of other LGBTIQ persons and/or was known or suspected to be a beat;

   ii. There was some evidence that the person was a member of the LGBTIQ community; and/or

   iii. There was some other evidence capable of suggesting indicators of LGBTIQ bias in the circumstances of the death (namely, location, nature of injuries, state of undress).

6.63. A decision was subsequently made as to which investigative steps or recommendations should be implemented in relation to each of these 28 cases. The Inquiry pursued a wide variety of investigative avenues as appropriate to each case, including issuing summonses to various agencies and organisations for additional records, contacting family and friends, conducting witness conferences, holding private hearings with witnesses, arranging for further forensic testing of physical exhibits (including DNA analysis and fingerprint testing), reviewing information provided by members of the public, media reviews, and obtaining advice and reports from a wide variety of expert consultants.

6.64. Following completion of the investigative steps decided at the First Case Review Meeting, the Inquiry determined that ten cases did not fall within the Terms of Reference.

6.65. In relation to the remaining 18 cases, a "Second Factors for Decision" document was prepared, providing a written update of the outcome of the steps taken to date and any recommendations as to further investigative steps. This document also presented updated views of those reviewing the death as to whether the case fell within Category B.

6.66. A Second Case Review Meeting was subsequently convened for the remaining 18 cases, to discuss the progress and recommendations made in relation to each case as recorded in a Second Case Review Outcomes document. The following decisions were made:

a. Some 14 cases were determined to fall outside the Terms of Reference.

b. Some 4 cases were identified as falling within Category B. These were the unsolved deaths of Peter Baumann, Anthony Cawsey, Ernest Head, and Barry Jones.

6.67. Whilst the process for identifying Category B deaths necessarily differed from the process I adopted in identifying Category A deaths, the review and documentary tender process remained the same. Public hearings by way of documentary tender were conducted in respect of each of the four deaths and the legal issues and common themes which I have identified in relation to Category A deaths were of relevance.

6.68. I ultimately formed the view in all four deaths I considered pursuant to Category B, that LGBTIQ bias was a factor.

Cases falling outside Category B

6.69. Given the volume of matters already before the Inquiry, it has been necessary to, in some instances, make the difficult determination that there is simply not enough positive evidence pointing to LGBTIQ bias being a factor in a death to warrant further investigation of that case theory. It is possible that of the over 1300 deaths the Inquiry reviewed, potential Category B matters were overlooked due to a variety of reasons, including the following:

a. The two lists produced by the NSWPF (the UHT Tracking File and the Long Term Missing Persons Spreadsheet) are themselves almost devoid of information as to whether the deaths and disappearances in question might have had any LGBTIQ-related aspect;

b. The efforts of the Inquiry to obtain the primary records relating to deaths and disappearances on those lists were only partly successful. Those efforts often met the problem which also recurred frequently in relation to deaths being considered by reference to Category A, namely that there were gaps in those records. In many cases those gaps were such as to have the effect that investigation and analysis were substantially thwarted;

c. Especially in cases dating from the earlier part of the 40-year period, even where primary records were available, they were often brief or rudimentary, containing little or nothing from which the possible presence of LGBTIQ bias might be discerned or inferred; and

d. The finite time and resources available to the Inquiry.

6.70. As has been detailed in this section, the Inquiry completed a significant amount of work to accurately identify the four cases which were determined to fall within Category B. In relation to the 24 cases which were more closely considered but were ultimately determined to fall outside Category B, there was either insufficient evidence to conclude that LGBTIQ bias played a role in the deaths, or there was sufficient evidence to show that LGBTIQ bias did *not* play a role in the death.

6.71. The conclusion that a case was outside the Inquiry's Terms of Reference should not be understood as a positive finding that such a case was *not* an LGBTIQ bias crime, nor as reflecting any conclusion about whether a person was or was not a member of the LGBTIQ community. It simply means that there was not sufficient evidence before the Inquiry to permit me to form the conclusion that a death *was* an LGBTIQ bias crime.

6.72. Although I determined that, ultimately, the majority of the cases which were initially identified as potential Category B cases did not fall within the Terms of Reference of the Inquiry, I consider it important to make some mention of the time and effort of the Inquiry staff in comprehensively reviewing and investigating the circumstances of these deaths. Although I could not ultimately report on the deaths of these persons, I acknowledge that their deaths are equally worthy of consideration, and that their loss is no less felt by those who loved them. As Senior Counsel Assisting poignantly said in his closing address:

> *…the work of the Special Commission has focused, as required by the Terms of Reference, on cases that were unsolved. Of course, it goes without saying that all the 88 Parrabell deaths, solved or not, as well as every other death that was or may have been LGBTIQ bias-related, are important for everyone following this Inquiry. In every case, families and loved ones, and the LGBTIQ community generally, have been left grieving and devastated.*

IN THE MATTER OF ERNEST HEAD

Factual background

Date and location of death

6.73. On 22 June 1976, Ernest Allan Head was found deceased in his apartment on Grosvenor Crescent, Summer Hill. He had last been seen at about 6:00pm on Thursday, 17 June 1976, and likely died that evening or early the following morning.[5110]

Circumstances of death

6.74. Mr Head was 44 years old at the time of his death. He was born in Malaysia and had emigrated to Australia in 1960.[5111] He was a gay man, and had previously been in a three year relationship and lived with I454 (a pseudonym), who remained one of his close friends.[5112]

6.75. Mr Head's body was found at around 11:55pm on Tuesday, 22 June 1976 by I454 and another friend, Sydney Moore, when they attended Mr Head's home to enquire after his welfare.[5113] His body was naked and lying face down in the kitchen covered in blood. He had been stabbed 35 times to the face, chest, abdomen, back, buttocks and limbs.[5114] The nature of Mr Head's injuries leaves no doubt that he was the victim of a homicide.

[5110] Exhibit 64, Tab 5, Findings of Coroner Nash, Inquest into the death of Ernest Head, 16 December 1977 (SCOI.11039.00008); Exhibit 64, Tab 2, Post-Mortem Report, 17 August 1976 (SCOI.85765); Exhibit 64, Tab 7, Statement of I454, 23 June 1976, [4] (SCOI.11039.00117); Exhibit 64, Tab 8, Statement of Sydney Moore, 23 June 1976 (SCOI.11039.00101).

[5111] Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, 4 July 1976, 37–38 (SCOI.85764); Exhibit 64, Tab 6, Statement of Arthur Head, 24 June 1976, 1 (SCOI.11039.00115).

[5112] Exhibit 64, Tab 6, Statement of Arthur Head, 24 June 1976, 1 (SCOI.11039.00115); Exhibit 64, Tab 7, Statement of I454, 23 June 1976, [1] (SCOI.11039.00117).

[5113] Exhibit 64, Tab 8, Statement of Sydney Moore, 23 June 1976, [7]–[8] (SCOI.11039.00101); Exhibit 64, Tab 7, Statement of I454, 23 June 1976, [7] (SCOI.11039.00117).

[5114] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [3], [14] (SCOI.11039.00099).

6.76. There were blood splashes, smears and drops in the kitchen, loungeroom, dining room, hallway, and main bedroom.[5115] All blood that was sampled was consistent with having originated from Mr Head.[5116]

6.77. There was no sign of forced entry into the flat.[5117] Various items of property were identified as having been stolen.[5118]

6.78. Occupants of a neighbouring unit heard an argument or disturbance involving Mr Head and at least one other man on the evening of 17 June 1976, but when they sought to check on Mr Head's welfare he assured them that he was "alright".[5119]

6.79. On the western wall of the kitchen, above Mr Head's body, were marks in blood resembling handprints, from which three palm prints potentially suitable for comparison were able to be determined.[5120] In 2023, after a fingerprint analysis (or, more accurately, a "palm print analysis"), was conducted on behalf of this Inquiry, one of those palm prints was identified as belonging to a man by the name of Engin Simsek.[5121]

6.80. The evidence indicates the involvement of Mr Simsek in the death of Mr Head. Mr Simsek had not previously been connected to Mr Head's death.

6.81. Mr Simsek departed from Australia on 13 August 1994.[5122] Mr Simsek died by way of suicide on 6 May 1999 in Türkiye.[5123]

Identification of this case by the Inquiry

6.82. On 6 June 2022, the Inquiry obtained a copy of the UHT Tracking File, as outlined in the introduction to this Chapter.

6.83. Mr Head was listed as a victim in that file. The brief description of the death of Mr Head included a comment indicating the possibility of "Sexual Preference prejudice" being associated with Mr Head's death. On this basis, the Inquiry identified the case as one that may fall within Category B.

6.84. The Inquiry obtained and analysed the underlying material relating to Mr Head's death in order to form a view as to whether the case in fact fell within Category B. The steps taken by the Inquiry are discussed below.

[5115] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976 (SCOI.11039.00099).

[5116] Exhibit 64, Tab 4, Expert Certificate of Paul Connellan, 17 September 1976, 4 (SCOI.11039.00036).

[5117] Exhibit 64, Tab 18, Statement of Detective Sergeant Albert McDonald, 14 November 1977, [2] (SCOI.11039.00021).

[5118] Exhibit 64, Tab 34, Special Circular No 76/22, 'Alleged Murder and Theft of Property', 1 July 1976 (SCOI.11039.00023); Exhibit 64, Tab 18, Statement of Detective Sergeant Albert McDonald, 14 November 1977, [8] (SCOI.11039.00021).

[5119] Exhibit 64, Tab 10, Statement of Donald Humphreys, 23 June 1976 (SCOI.11039.00105).

[5120] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976 (SCOI.11039.00099); Exhibit 64, Tab 57, First Expert Certificate of Kate Reid, Senior Crime Scene Officer — Fingerprint Expert, 30 May 2023, 2 (SCOI.85121).

[5121] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [33]–[34] (SCOI.85769).

[5122] Exhibit 64, Tab 74, Extract of Movement Records of Engin Simsek, Undated (SCOI.85766).

[5123] Exhibit 64, Tab 61A, Letter from Katherine Garaty to Enzo Camporeale, 6 October 2023 (SCOI.86038); Exhibit 64, Tab 75, Newspaper article re death of Engin Simsek and certified translation, 8 May 1999–28 August 2023 (SCOI.85752).

Previous investigations

Original police investigation

6.85. The original police investigation was conducted by officers from the Ashfield Police Station, with the assistance of the Special Crime Squad. The investigation was thorough. Police pursued multiple lines of inquiry and interviewed over a hundred people in relation to Mr Head's death.[5124] Their investigations included, among other things:[5125]

a. Canvassing the residents of Mr Head's building and neighbouring buildings;

b. Canvassing locations where Mr Head was seen or known to frequent, including bars, hotels, and local shops;

c. Canvassing known locations frequented by members of the LGBTIQ community (e.g., the Petersham beat);[5126]

d. Obtaining the names of any person treated for lacerations at local hospitals in the relevant period;

e. Making inquires with pawn shops for Mr Head's property;

f. Making inquiries with dry cleaners in relation to any bloodstained clothes that may have been received;

g. Interviewing almost all persons whose names or contact details were found in Mr Head's diary, wallet or calendar;

h. Interviewing a large number of Mr Head's known associates, including friends and work colleagues;

i. Requesting, through Interpol, for police in Penang to interview the family of Mr Head;

j. Publishing a pamphlet with Mr Head's photograph, and canvassing and distributing flyers in the local area;

k. Inquiring as to other patrons using the TAB at around the same time as Mr Head;

l. Inquiring with taxi operators to ascertain if there were any phone bookings at the relevant time;

m. Ascertaining if there were any links between Mr Head's death and the murders of other gay men in similar circumstances;

n. Canvassing local distributors of the types of cigarettes found in the ashtray at Mr Head's home; and

[5124] Exhibit 64, Tab 18, Statement of Detective Sergeant Albert McDonald, 14 November 1977 (SCOI.11039.00021).

[5125] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [10] (SCOI.85769).

[5126] Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, 9 July 1976, 24–25 (SCOI.85764).

o. Proclaiming a $10,000 reward for information.[5127]

6.86. Throughout this investigation, a large number of fingerprints and palm prints were obtained from the crime scene, by which suspects were eliminated.[5128]

6.87. Over 60 physical exhibits were seized by police in the course of the original investigation, 53 of which were submitted for forensic testing.[5129] The results of that forensic analysis is set out below.

6.88. Despite the scope of the original police investigation, no suspects or persons of interest emerged who were not ultimately excluded from the investigation.

Post-mortem investigation

6.89. A post-mortem examination was conducted by Dr Thomas Oettle at 9:30am on 23 June 1976.[5130] Dr Oettle estimated that death took place "about five days" prior to the post-mortem (approximately 18 June 1976), and the cause of death was stab wounds to the chest and abdomen.[5131]

6.90. Dr Oettle documented numerous stab wounds and lacerations, both superficial and substantive. He recorded that Mr Head's left lung had been punctured, and was partially collapsed and filled with blood. The pericardial sac was also filled with blood. The liver showed two stab wounds.[5132]

6.91. A blood sample was taken from Mr Head, which was found to have a blood alcohol content of 0.040g/100mL.[5133] It is unclear if that figure was adjusted to account for the decomposition of Mr Head's body.

6.92. Penile and anal swabs were taken for biological examination.[5134]

[5127] Exhibit 64, Tab 18, Statement of Detective Sergeant Albert McDonald, 14 November 1977, [9] (SCOI.11039.00021); Exhibit 64, Tab 33, Proclamation of $10,000 reward, 6 August 1977 (SCOI.11039.00027).

[5128] Exhibit 64, Tab 20, Statement of Sergeant Robert William Stone, 16 November 1977 (SCOI.11039.00111); Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, 4 July 1976, 17–18 (SCOI.85764).

[5129] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [7]–[33] (SCOI.11039.00099); Exhibit 64, Tab 4, Expert Certificate of Paul Connellan, 17 September 1976 (SCOI.11039.00036); Exhibit 64, Tab 49A, Extract of Receipt Book re Death of Ernest Head, Various (NPL.0145.0001.0007).

[5130] Exhibit 64, Tab 2, Post-Mortem Report, 17 August 1976 (SCOI.85765).

[5131] Exhibit 64, Tab 2, Post-Mortem Report, 17 August 1976, 1 (SCOI.85765).

[5132] Exhibit 64, Tab 2, Post-Mortem Report, 17 August 1976, 3 (SCOI.85765).

[5133] Exhibit 64, Tab 3, DAL certificate, 13 July 1976 (SCOI.11039.00034).

[5134] Exhibit 64, Tab 2, Post-Mortem Report, 17 August 1976, 3 (SCOI.85765).

6.93. Dr Oettle advised police that the murder weapon could be a very sharp knife, possibly a butcher's boning knife, approximately 18cm in length and 2cm wide at the base of the blade. This opinion was based on the length and width of one of Mr Head's wounds.[5135] This Inquiry has received evidence in another matter that the measurement of wounds cannot be used to reliably determine the size of a blade, as the human body is elastic and deformable, and the blade may not have entered the body cleanly or fully.[5136] It may be that the number or nature of the stab wounds in this case enabled Dr Oettle to estimate the approximate length and breadth, although the evidence does not shed further light on this.

Findings at inquest

6.94. An inquest was held into the death of Mr Head at Glebe Coroners Court. On 16 December 1977, Coroner Nash found that Mr Head had "died from stab wounds of the chest and abdomen wilfully inflicted by a person or persons unknown" at his home in Summer Hill on 17 June 1976.[5137]

Criminal proceedings

6.95. No criminal proceedings were ever instituted against any person in relation to Mr Head's death.

6.96. In light of Mr Simsek's death in Türkiye, no future criminal proceedings are anticipated in this matter.

Subsequent police investigation

6.97. The Inquiry has been provided with documents which indicate various actions or reviews taken in relation to Mr Head's case by the UHT.

6.98. On 15 March 2002, a request was made for further examination of the prints found in Mr Head's apartment, in the context Strike Force Palace (a strike force engaged in gathering information in relation to unsolved homicides from 1970 to 1999 (see **Chapter 8**).[5138] Unidentified fingerprints, including the palm print eventually matched to Mr Simsek, were searched on NAFIS and not identified.[5139]

6.99. On 9 August 2004, the fingerprint file was reviewed at the request of Detective Inspector Robert Jarrett of the UHT. A case summary indicated that the fingerprints located on the kitchen, bathroom and bedroom door jambs were eliminated to Mr Head, which in fact had been known from the time of the original investigation.[5140] It is unclear from the documents available to the Inquiry if the prints were searched on NAFIS at this time.

[5135] Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, 25 June 1976, 12 (SCOI.85764).

[5136] This was the subject of expert evidence at the inquest of Mr Anthony Cawsey, another death examined by this Inquiry: see Exhibit 39, Tab 5, Pathology Report of Dr Johan Duflou, 1 November 2017 (SCOI.10488.00020).

[5137] Exhibit 64, Tab 5, Findings of Coroner Nash, Inquest into the death of Ernest Head, 16 December 1977 (SCOI.11039.00008).

[5138] Exhibit 64, Tab 37, Request by Strike Force Palace for further examination of latent fingerprints, 15 March 2002 (SCOI.60864) .

[5139] Exhibit 64, Tab 59, Second Expert Certificate of Kate Reid, 20 June 2023, [10] (SCOI.85263).

[5140] Exhibit 64, Tab 20, Statement of Sergeant Robert William Stone, 16 November 1977 (SCOI.11039.00111); Exhibit 64, Tab 59, Second Expert Certificate of Kate Reid, 20 June 2023, [10] (SCOI.85263).

6.100. An Investigators Note dated 29 July 2005 records that, on 20 July 2005, Detective Inspector Michael Ashwood, during a review of Mr Head's case, came across a yellow envelope within an expanding file in one of the boxes related to Mr Head's murder. The writing on the envelope indicated that it contained four items; however, only three white envelopes were inside. Each white envelope recorded that it contained a cigarette butt. The exhibits were conveyed to Ashfield Police Station and logged as exhibits.[5141]

6.101. On 30 August 2005, a Case Screening Form was prepared by the UHT in relation to Mr Head's death.[5142] The signature block for the reviewer is unsigned, but the typed name of Detective Inspector Jarrett appears. The co-ordinator's certification is blank.[5143] In that Case Screening Form:

a. Consistent with the Investigators Note dated 29 July 2005, Detective Inspector Jarrett recorded that three labelled and sealed white envelopes were located in the hard copy brief, which indicated that they contained unfiltered cigarette butts.[5144] The Case Screening Form further states that these cigarette butts were submitted to DAL on 29 July 2005.[5145] This is consistent with a "Specimen/Exhibit Examination Form" signed by Detective Inspector Jarrett on 29 July 2005 and delivered to DAL on the same day.[5146]

b. Detective Inspector Jarrett recorded that the remainder of the exhibits were "not located".[5147]

c. Detective Inspector Jarrett recorded that a fingerprint review was conducted in 2005. Detective Inspector Jarrett states that "the offender has left behind a good quality palmprint, in blood", but that it was not matched to anyone on the NAFIS database.[5148]

d. Detective Inspector Jarrett concluded that "no further investigative inquiries can reasonably be made without the fingerprint or possible DNA evidence being linked to a particular person."[5149]

[5141] Exhibit 64, Tab 42, NSWPF Investigators Note, 'HEAD - exhibits located', 13 June 2007 (SCOI.60860).

[5142] Exhibit 64, Tab 44, Unsolved Homicide Team Review Form, 30 August 2005 (SCOI.02836).

[5143] Exhibit 64, Tab 44, Unsolved Homicide Team Review Form, 30 August 2005, 10 (SCOI.02836).

[5144] Exhibit 64, Tab 44, Unsolved Homicide Team Review Form, 30 August 2005, 10 (SCOI.02836).

[5145] Exhibit 64, Tab 44, Unsolved Homicide Team Review Form, 30 August 2005, 5 (SCOI.02836); see also Exhibit 64, Tab 42, NSWPF Investigators Note, 'HEAD - exhibits located', 13 June 2007 (SCOI.60860).

[5146] Exhibit 64, Tab 44, Unsolved Homicide Team Review Form, 30 August 2005, 5 (SCOI.02836).

[5147] Exhibit 64, Tab 44, Unsolved Homicide Team Review Form, 30 August 2005, 5 (SCOI.02836).

[5148] Exhibit 64, Tab 44, Unsolved Homicide Team Review Form, 30 August 2005, 6, 12 (SCOI.02836).

[5149] Exhibit 64, Tab 44, Unsolved Homicide Team Review Form, 30 August 2005, 12 (SCOI.02836); see also Exhibit 64, Tab 40, NSWPF Investigators Note, 'Fingerprint review – Ernest Alan Head', 30 August 2005 (SCOI.60861).

6.102. On 29 September 2005, following the completion of the Case Screening Form, Detective Inspector Jarrett submitted a report recommending that the unidentified palm print be sent to overseas jurisdictions for comparison. His report noted that it was "highly likely" that the palm print in blood was left by the person responsible for Mr Head's death. The jurisdictions identified for the fingerprints to be forwarded to were the United Kingdom, New Zealand, Malaysia, Singapore, Hong Kong and Taiwan.[5150] The Inquiry has been provided with documents indicating negative results for fingerprint comparisons conducted in Kuala Lumpur, New Zealand, Hong Kong and the United States.[5151] It is not apparent from the available documents whether the fingerprints were sent to the United Kingdom, Singapore or Taiwan in line with Detective Inspector Jarrett's recommendations.

6.103. The results of the forensic testing requested by Detective Inspector Jarrett in 2005 were recorded in a Database Report from DAL dated 20 January 2008. All testing was unsuccessful.[5152] The reason for the delay between the submission of the cigarette butts to DAL and the reporting of the results is unknown.

6.104. The Database Report also indicates that testing was conducted on a match, which it is inferred was located in one of the envelopes that contained a cigarette butt.[5153] There was no match listed amongst the list of items originally seized and submitted for forensic testing.[5154] The uncertain provenance of the match is discussed further below.

6.105. Mr Head's death was not reviewed by Strike Force Parrabell.

Review by the Inquiry

6.106. The Inquiry took the following steps in the course of examining the matter:

a. Attempting to locate and contact Mr Head's family members;[5155]

b. Requesting the coronial file;[5156]

c. Summoning the police investigative file;[5157]

d. Obtaining an expert report by Dr Danny Sullivan, forensic psychiatrist, regarding the possible motives of Mr Head's killer;[5158]

e. Summoning the NSW Supreme Court for information about Mr Head's estate;[5159]

[5150] Exhibit 64, Tab 38, Memorandum of Detective Inspector Robert Jarrett, 29 September 2005, 1 (SCOI.60863).

[5151] Exhibit 64, Tab 41, NSWPF Investigators Note, 'O/S Fingerprint Results re Murder of Ernest Allan HEAD', 14 March 2006 (SCOI.60862); Exhibit 64, Tab 43, FBI Laboratory Report, 18 July 2007 (SCOI.60866).

[5152] Exhibit 64, Tab 49C, DAL Database Report, 20 January 2008 (NPL.0145.0001.0006).

[5153] Exhibit 64, Tab 49C, DAL Database Report, 20 January 2008 (NPL.0145.0001.0006).

[5154] Exhibit 64, Tab 4, Expert Certificate of Paul Connellan, 17 September 1976 (SCOI.11039.00036).

[5155] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [11]–[15] (SCOI.85769).

[5156] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [4]–[5] (SCOI.85769).

[5157] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [6]–[9] (SCOI.85769).

[5158] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [24] (SCOI.85769).

[5159] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [14], [21] (SCOI.85769).

f. Requesting and summoning the available exhibits from the NSWPF, and obtaining a statement as to what searches had been undertaken with regard to the missing exhibits;[5160]

g. Causing the further testing of available exhibits by FASS, as well as inquiring into what testing would have been available if the missing exhibits had been able to be located;[5161]

h. Causing the reexamination of the unidentified fingerprints and palm prints;[5162] and

i. Making inquiries about Mr Simsek.[5163]

6.107. The Inquiry reviewed and analysed several thousand documents provided by the NSWPF, Coroners Court, and other material obtained by summons, and considered whether any further investigative steps or other avenues were warranted.

6.108. On 10 October 2023, a public hearing was held in which a bundle of documentary material was tendered as Exhibit 64,[5164] alongside the written submissions of Counsel Assisting dated 9 October 2023.[5165] The NSWPF filed written submissions on 24 October 2023.[5166] On 31 October 2023, a supplementary bundle of documentary material was tendered as part of Exhibit 64, accompanied by the supplementary written submissions of Counsel Assisting dated 31 October 2023.[5167]

Summonses

6.109. A summons was issued to the NSWPF on 21 July 2022 for all documents relating to the investigations by the NSWPF into the death of Mr Head, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF3). That summons also called for any other material held or created by the UHT in relation to the death of Mr Head. In response, a file in relation to Mr Head was provided to the Inquiry on 9 August 2022.[5168] Subsequent summonses were also issued seeking information in relation to key witnesses identified after a review of the original investigative file.[5169]

[5160] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [29]–[32] (SCOI.85769).

[5161] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [29]–[32] (SCOI.85769).

[5162] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [33]–[38] (SCOI.85769).

[5163] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [39]–[43] (SCOI.85769).

[5164] Transcript of the Inquiry, 10 October 2023, T6880.12–20 (TRA.00099.00001).

[5165] Submissions of Counsel Assisting, 9 October 2023 (SCOI.86054).

[5166] Submissions of NSWPF, 24 October 2023 (SCOI.86371).

[5167] Supplementary Submissions of Counsel Assisting, 31 October 2023 (SCOI.86429).

[5168] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [6]–[9] (SCOI.85769).

[5169] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [20], [39], [42] (SCOI.85769).

6.110. On 16 May 2023, the Inquiry issued a summons to the Supreme Court seeking the Letters of Administration and Grant of Probate to identify the beneficiaries of Mr Head's estate (SC05).[5170] On 22 May 2023, the Supreme Court produced the documents, which revealed that I454 was the beneficiary of Mr Head's estate.[5171]

Interagency cooperation

6.111. On 22 July 2022, the Inquiry issued a written request to the Coroners Court to obtain the coronial file in relation to the death of Mr Head.[5172] The Coroners Court answered the request and provided the coronial file on 26 August 2022.[5173]

6.112. Through interagency cooperation, the Inquiry also confirmed that Detective Sergeant Geoffrey William Fagan, the OIC of the original investigation, is now deceased.

Family members

6.113. The Inquiry issued summonses and utilised interagency cooperation in order to try to locate Mr Head's family. Arthur Head, the brother of Mr Head, was confirmed to be deceased. A number of other relatives were identified as residing overseas, and in the absence of dates of birth were unable to be traced by the Department of Foreign Affairs and Trading (**DFAT**).[5174]

6.114. Through summonses and interagency cooperation, a more distant relative of Mr Head was located in Western Australia. The Inquiry wrote to this person on 14 June 2023 and again on 26 September 2023. No response was received.[5175]

6.115. Unfortunately, attempts to locate or contact other family members of Mr Head were unsuccessful.

Searches for exhibits

6.116. On 14 March 2023, a summons was issued to the NSWPF in relation to the identification and location of forensic exhibits obtained in the investigation into Mr Head's death (NSWPF69).[5176] The Inquiry requested that, should the exhibits not be able to be located, a statement be provided from an appropriate officer detailing the searches conducted for the lost exhibits. On 29 March 2023, a statement was provided by Detective Inspector Nigel Warren detailing the searches undertaken by the NSWPF. This included: searches on EFIMS; a review of all NSWPF investigative holdings; a search for and review of relevant exhibit books; searches of the long-term exhibit repository (the MEPC); and enquiries with FASS, FETS and DOFM.[5177]

[5170] Exhibit 64, Tab 45, Summons to Supreme Court (SC05), 16 May 2023 (SCOI.85119).

[5171] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [21] (SCOI.85769); see also Exhibit 64, Tab 32, Bundle of Report of Occurrence records, various dates, 34 (SCOI.85764).

[5172] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [4] (SCOI.85769).

[5173] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [4]–[5] (SCOI.85769).

[5174] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [11]–[13] (SCOI.85769).

[5175] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [15] (SCOI.85769).

[5176] Exhibit 64, Tab 48, Summons to NSWPF (NSWPF69), 14 March 2023 (SCOI.85856).

[5177] Exhibit 64, Tab 49, Statement of Detective Inspector Nigel Warren, 29 March 2023 (NPL.0145.0001.0014).

6.117. The NSWPF advised that the only exhibits that were located were three cigarette butts.[5178] Accordingly, it would appear that the majority of the physical exhibits in Mr Head's case have been lost. As noted above, this was the situation that prevailed in 2005 at the time of the UHT review undertaken by Detective Inspector Jarrett. Despite the Inquiry causing the NSWPF to conduct further searches of their exhibit holdings, no further exhibits could be located.

6.118. On 12 May 2023, the Inquiry wrote to the NSWPF by letter requesting that the cigarette butts be transported to FASS for forensic analysis.[5179] The Inquiry also requested details of the location of the match which was apparently tested along with the three cigarette butts in 2008.[5180] On 17 May 2023, the NSWPF advised the Inquiry by email that it was not aware of the location of the match, and believed the match may be in an exhibit folder with the three cigarette butts.[5181] When further testing on the cigarette butts was carried out by FASS, the match was located.[5182]

Further forensic examinations

Request to FASS

6.119. On 30 March 2023, the Inquiry requested that FASS retrieve its case file in relation to Mr Head. On 3 May 2023, the Inquiry conferenced with FASS to discuss the possibility of further testing of the exhibits available, and what testing may have been able to be conducted had the original exhibits all been properly retained.[5183]

6.120. In relation to the available testing, Michele Franco and Dr David Bruce of FASS advised at this meeting that examinations to search for DNA could be carried out on the cigarette butts, however noted that the cigarette paper (which has contact with the mouth of the smoker and therefore is the best repository of saliva DNA) had disintegrated, reducing the prospects of obtaining a useful result.[5184]

6.121. On 12 May 2023, the Inquiry wrote to FASS to request that further testing be carried out on the cigarette butts.[5185] The results of that testing is discussed below.

[5178] Exhibit 64, Tab 49, Statement of Detective Inspector Nigel Warren, 29 March 2023, [9] (NPL.0145.0001.0014).

[5179] Exhibit 64, Tab 50, Letter from Enzo Camporeale to Patrick Hodgetts, 12 May 2023 (SCOI.85857).

[5180] Exhibit 64, Tab 50, Letter from Enzo Camporeale to Patrick Hodgetts, 12 May 2023 (SCOI.85857); Exhibit 64, Tab 49C, DAL Database Report, 20 January 2008 (NPL.0145.0001.0006).

[5181] Exhibit 64, Tab 51, Email from Patrick Hodgetts to Francesca Lilly, 17 May 2023 (SCOI.85858).

[5182] Exhibit 64, Tab 54, Statement of Dr David Bruce, 25 September 2023, 2 (SCOI.85768).

[5183] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [29] (SCOI.85769).

[5184] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [30] (SCOI.85769).

[5185] Exhibit 64, Tab 52, Letter from Francesca Lilly to Clint Cochrane, 12 May 2023 (SCOI.85122).

6.122. In the letter of 12 May 2023, the Inquiry also requested that all Specimen/Exhibit Examination (P377) forms and other similar documentation be provided to the Inquiry by 29 May 2023.[5186] Further, the Inquiry requested that an appropriate staff member of FASS provide a statement detailing what testing could have been performed had the exhibits not been lost, to be provided by 29 May 2023.[5187] Dr Bruce provided an expert certificate to this effect, dated 30 May 2023, and the requested documentation was provided to the Inquiry.[5188] The contents of Dr Bruce's expert certificate are discussed below.

Fingerprint analysis

6.123. On 24 April 2023, the Inquiry wrote to the NSWPF requesting further analysis be conducted on the palm print and fingerprints located at the scene of Mr Head's death.[5189] On 30 May 2023, the NSWPF provided to the Inquiry the First Expert Certificate of Kate Reid, Senior Crime Scene Officer and Fingerprint Expert.[5190] This certificate identified Mr Simsek as a match for a palm print in blood located above Mr Head's body on the kitchen wall.[5191]

6.124. On 14 June 2023, the Inquiry wrote to the NSWPF seeking clarifications regarding the past analysis that had been conducted on the finger and palm prints located at the crime scene, noting Mr Simsek's prints had been on file since 1980.[5192] On 20 June 2023, the Second Expert Certificate of Kate Reid was provided to the Inquiry, outlining the advances in fingerprint analysis technology which had enabled the match to be made.[5193]

6.125. On 13 September 2023, the Inquiry wrote again to the NSWPF seeking further information regarding the processes of fingerprint analysis, and capabilities for automatic testing once prints were uploaded to NAFIS.[5194] On 19 September 2023, the Inquiry received the Third Expert Certificate of Kate Reid.[5195]

[5186] Exhibit 64, Tab 52, Letter from Francesca Lilly to Clint Cochrane, 12 May 2023, 2 (SCOI.85122).

[5187] Exhibit 64, Tab 52, Letter from Francesca Lilly to Clint Cochrane, 12 May 2023 (SCOI.85122).

[5188] Exhibit 64, Tab 53, Expert Certificate of Dr David Bruce, 30 May 2023 (SCOI.85120); Exhibit 64, Tab 54, Statement of Dr David Bruce, 25 September 2023 (SCOI.85768).

[5189] Exhibit 64, Tab 56, Letter from Enzo Camporeale to Patrick Hodgetts, 24 April 2023 (SCOI.85259).

[5190] Exhibit 64, Tab 57, First Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 30 May 2023 (SCOI.85121).

[5191] Exhibit 64, Tab 57, First Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 30 May 2023 (SCOI.85121).

[5192] Exhibit 64, Tab 58, Letter from Enzo Camporeale to Patrick Hodgetts, 14 June 2023 (SCOI.85260).

[5193] Exhibit 64, Tab 59, Second Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 20 June 2023 (SCOI.85263).

[5194] Exhibit 64, Tab 62, Letter from Enzo Camporeale to Patrick Hodgetts, 13 September 2023 (SCOI.85750).

[5195] Exhibit 64, Tab 63, Third Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 19 September 2023 (NPL.9000.0034.0001).

6.126. On 11 October 2023, following the public hearing in relation to Mr Head's death on 10 October 2023, the Inquiry wrote again to the NSWPF seeking further information about the V11 matcher technology used in the identification of Mr Simsek as a match.[5196] On 16 October 2023, the NSWPF wrote to the Inquiry and advised that Ms Reid would need to request the information required from the ACIC,[5197] and on 18 October 2023, the Inquiry received the Fourth Expert Certificate of Kate Reid.[5198]

6.127. Ms Reid explained why the limits on earlier fingerprint matching technology meant that Mr Simsek was not identified during earlier reviews of the fingerprint file.[5199] Ms Reid's evidence is discussed below.

6.128. On 24 October 2023, the Inquiry met with ACIC regarding the functions and use of the V11 matcher technology.[5200] Relevant information received by the Inquiry in this conference is summarised below.

Professional opinions

6.129. On 24 April 2023, the Inquiry sought the expert opinion of forensic psychiatrist Dr Danny Sullivan as to the possible motive of Mr Head's killer.[5201] Dr Sullivan was asked to address topics including:[5202]

a. Whether there are any aspects of the manner of death (including the nature and extent of the injuries inflicted) and/or crime scene which may indicate that a homicide has occurred in the context of LGBTIQ hate/prejudice/bias;

b. The possible motivation/s of the unidentified perpetrator of Mr Head's injuries, to the extent that this can be discerned from the available evidence;

c. Aspects of victimology that may be relevant to Mr Head's death;

d. Any recommendations for further investigations with respect to determining the manner and cause of the person's death; and

e. Any other matters to raise within Dr Sullivan's expertise that may be of assistance to the Inquiry.

6.130. Dr Sullivan provided his report on 15 May 2023.[5203]

[5196] Exhibit 64, Tab 78, Letter from Enzo Camporeale to Patrick Hodgetts, 11 October 2023 (SCOI.86390).

[5197] Exhibit 64, Tab 79, Letter from Patrick Hodgetts to Enzo Camporeale, 16 October 2023 (SCOI.86392).

[5198] Exhibit 64, Tab 80, Fourth Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 18 October 2023 (NPL.9000.0039.0001).

[5199] Exhibit 64, Tab 80, Fourth Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 18 October 2023 (NPL.9000.0039.0001).

[5200] Exhibit 64, Tab 81, Statement of Penelope Smith, 31 October 2023, [8] (SCOI.86391).

[5201] Exhibit 64, Tab 47A, Letter of Instruction to Dr Danny Sullivan, 24 April 2023 (SCOI.86037).

[5202] Exhibit 64, Tab 47A, Letter of Instruction to Dr Danny Sullivan, 24 April 2023, 3 (SCOI.86037).

[5203] Exhibit 64, Tab 47, Expert Report of Dr Danny Sullivan, 15 May 2023 (SCOI.85123).

Person of interest

Inquiries into Engin Simsek and his family

6.131. On 1 June 2023, following the match of the palm print to Mr Simsek, the Inquiry issued Summons NSWPF116 seeking records in relation to Mr Simsek.[5204] Material was produced by the NSWPF in two tranches, the first on 5 June 2023 and the second on 6 June 2023. This material included a Bail Report and a CNI Profile for Mr Simsek.[5205]

6.132. The Inquiry issued Summons CSNSW19 to CSNSW on 1 June 2023 seeking various documents in relation to Mr Simsek.[5206] On 6 June 2023, CSNSW produced to the Inquiry an Inmate Profile Document and a Convictions, Appeals and Sentences Report in relation to Mr Simsek. On 8 June a further bundle of documents was provided including parole documentation. These documents identified Mr Simsek's sibling as residing at an address on Grosvenor Crescent, the same street on which Mr Head resided and died in 1976.[5207]

6.133. The Inquiry obtained a copy of Mr Simsek's arrival card dated 20 May 1972, on which he had recorded his intended address in Australia to be an address in Grosvenor Crescent.[5208] The street address was different to that of his sibling as at 1986.[5209]

6.134. On 27 July 2023, the Inquiry issued Summons RBB01 to the Rental Bonds Board of NSW seeking information as to the address recorded on Mr Simsek's arrival card.[5210] On 1 August 2023, the Rental Bonds Board advised the Inquiry that no records were held.[5211]

6.135. On 9 August 2023, through interagency cooperation, the Inquiry requested a Land Title Search be conducted in relation to this address.[5212] On 16 August 2023, the Inquiry was advised of the persons who owned the property, however these individuals were not found to have a connection to Mr Simsek.[5213]

6.136. The Inquiry, through summonses and interagency cooperation, attempted to locate any living relatives of Mr Simsek. Ultimately, one relative was located. That person was summoned to a private hearing of the Inquiry on 5 July 2023,[5214] and on 3 October 2023 provided a voluntary statement as to his knowledge of Mr Simsek.[5215]

[5204] Exhibit 64, Tab 64, Summons to NSWPF (NSWPF116), 1 June 2023 (SCOI.85749).

[5205] Exhibit 64, Tab 65, Bail Report of Engin Simsek, 2 June 2023, 1 (NPL.0175.0001.0001).

[5206] Exhibit 64, Tab 66, Summons to CSNSW (CSNSW19), 1 June 2023 (SCOI.85751).

[5207] Exhibit 64, Tab 70, Pre-Release Report, 29 May 1986, 4 (SCOI.12138.00053); Exhibit 64, Tab 71, Case History Data Sheet, 9 July 1986 (SCOI.12138.00004).

[5208] Exhibit 64, Tab 74A, Arrival card of Engin Simsek, 20 May 1972 (SCOI.85976); Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [41] (SCOI.85769).

[5209] Exhibit 64, Tab 67, Notes from Interviews with Engin Simsek, 19 March 1986–22 April 1986 (SCOI.12138.00059).

[5210] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [44] (SCOI.85769).

[5211] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [44] (SCOI.85769).

[5212] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [45] (SCOI.85769).

[5213] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [45] (SCOI.85769).

[5214] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [46] (SCOI.85769).

[5215] Exhibit 64, Tab 76, Statement of I450, 3 October 2023 (SCOI.85771).

6.137. Among other things, that relative informed the Inquiry that Mr Simsek had returned to Türkiye in the 1990s and had subsequently died in Türkiye.[5216] He also told the Inquiry that other family members of Mr Simsek's generation, who were likely to have more information about Mr Simsek, were now deceased.[5217]

Death certificate of Engin Simsek

6.138. On 30 June 2023, the Inquiry wrote to the Australian Embassy in Ankara seeking assistance in locating Mr Simsek.[5218] On 4 July 2023, the Embassy advised that it was not able to assist unless a formal request for mutual legal assistance was made via the Attorney-General's Department.[5219]

6.139. After being informed by Mr Simsek's relative on 5 July 2023 that Mr Simsek had died in Türkiye, the Inquiry took steps to confirm the accuracy of this information. Through interagency cooperation it was confirmed that Mr Simsek had departed Australia on 13 August 1994.[5220]

6.140. On 21 July 2023, the Inquiry requested the assistance of the media officer at the Australian Embassy in Ankara in obtaining a copy of a newspaper article regarding Mr Simsek's death. The Embassy advised on 21 July 2023 that searches had been conducted but no information was able to be located.[5221]

6.141. On 15 August 2023, the Inquiry wrote to the NSWPF requesting that it assist the Inquiry by making a request for assistance from the Turkish government, via Interpol, in obtaining a death certificate for Mr Simsek.[5222] The NSWPF confirmed that it was willing to assist, and that it had made the request via Interpol on 22 August 2023.[5223]

6.142. On 28 August 2023, the Inquiry obtained a copy of a Turkish language newspaper article regarding the death of Mr Simsek by suicide in 1999.[5224] A copy of the certified translation of this article is included in the tender bundle.[5225] Mr Simsek's relative confirmed that the person whose photograph was featured in the newspaper article was Mr Simsek.[5226]

6.143. The article was provided to NSWPF to assist with the searches being conducted via Interpol.[5227] On 6 October 2023, the NSWPF advised the Inquiry that Turkish authorities had confirmed, via Interpol, that Mr Simsek passed away on 6 May 1999.[5228]

[5216] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [46] (SCOI.85769).
[5217] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [46] (SCOI.85769).
[5218] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [48] (SCOI.85769).
[5219] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [48] (SCOI.85769).
[5220] Exhibit 64, Tab 74, Extract of Movement Records of Engin Simsek, Undated (SCOI.85766).
[5221] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [49] (SCOI.85769).
[5222] Exhibit 64, Tab 60, Letter from Enzo Camporeale to Patrick Hodgetts, 15 August 2023 (SCOI.85261).
[5223] Exhibit 64, Tab 61, Letter from Katherine Garaty to Enzo Camporeale, 22 August 2023 (SCOI.85262).
[5224] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [53] (SCOI.85769).
[5225] Exhibit 64, Tab 75, Newspaper article re death of Engin Simsek and certified translation, 8 May 1999–28 August 2023 (SCOI.85752).
[5226] Exhibit 64, Tab 76, Statement of I450, 3 October 2023, [15] (SCOI.85771).
[5227] Exhibit 64, Tab 77, Statement of Francesca Lilly, 10 October 2023, [54] (SCOI.85769).
[5228] Exhibit 64, Tab 61A, Letter from Katherine Garaty to Enzo Camporeale, 6 October 2023 (SCOI.86038).

Contact with Mr Simsek's next of kin

6.144. In light of the evidence before the Inquiry as to the potential involvement of Mr Simsek in Mr Head's death, and the possibility that Counsel Assisting may make submissions to that effect, the Inquiry wrote to Mr Simsek's next of kin (referred to by the pseudonym I450). I450 was the relative who had previously assisted the Inquiry with information about Mr Simsek, as discussed above. Following that letter, the Inquiry held a conference with I450 to discuss the forthcoming public hearing and the proposed submissions. I450 subsequently provided the Inquiry with a statement outlining his knowledge of Mr Simsek.[5229]

Contact with OIC

6.145. As discussed above, through interagency cooperation, the Inquiry determined that the OIC of the original police investigation is now deceased.

Consideration of the evidence

Mr Head's personal circumstances

6.146. Mr Head was born in Malaysia in 1932.[5230] Mr Head was described as a quiet, private and good-natured man, who lived alone and was employed as a clerk with the Corporate Affairs Commission.[5231] A colleague and friend said he was "soft hearted, kind, shy", and "took everything that was said to him seriously."[5232] He was a neat and tidy person, both in his personal appearance and in his home.[5233] He was well-dressed and groomed, with a friend describing him as "always immaculate, shirts pressed, not a hair out of place, always spick and span."[5234]

6.147. Mr Head was a gay man. He had previously been in a three-year relationship with I454, and they lived together.[5235] A diary was found in his flat containing contact details of a number of men with whom it appears Mr Head had had previous sexual contact.[5236] Mr Head had disclosed his sexuality to his brother, Arthur Head.[5237]

6.148. It appears that Mr Head was not out in all contexts, as may be unsurprising noting the prejudices against LGBTIQ people during Mr Head's lifetime. For example, Margaret McEvoy, a friend and colleague of Mr Head's, said that she was unaware of his sexuality.[5238]

[5229] Exhibit 64, Tab 76, Statement of I450, 3 October 2023 (SCOI.85771); Exhibit 68, Tabs 10 to 11, Letters from the Inquiry, 18 August 2023 and 11 September 2023 (SCOI.86620; SCOI.86621).

[5230] Exhibit 64, Tab 6, Statement of Arthur Head, 24 June 1976, 1 (SCOI.11039.00115).

[5231] Exhibit 64, Tab 6, Statement of Arthur Head, 24 June 1976, 1–2 (SCOI.11039.00115); Exhibit 64, Tab 7, Statement of I454, 23 June 1976, [3] (SCOI.11039.00117); Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 2–4 (SCOI.85764).

[5232] Exhibit 64, Tab 9, Statement of Margaret McEvoy, 23 June 1976, 1 (SCOI.11039.00038).

[5233] Exhibit 64, Tab 6, Statement of Arthur Head, 24 June 1976, 2 (SCOI.11039.00115); Exhibit 64, Tab 14, Statement of William Strachan, 24 June 1976, [9] (SCOI.10942.00069).

[5234] Exhibit 64, Tab 8, Statement of Sydney Moore, 23 June 1976, [13] (SCOI.11039.00101).

[5235] Exhibit 64, Tab 6, Statement of Arthur Head, 24 June 1976, 1 (SCOI.11039.00115); Exhibit 64, Tab 7, Statement of I454, 23 June 1976, [1] (SCOI.11039.00117).

[5236] Exhibit 64, Tab 18, Statement of Detective Sergeant Albert McDonald, 14 November 1977, [7] (SCOI.11039.00021).

[5237] Exhibit 64, Tab 6, Statement of Arthur Head, 24 June 1976, 1 (SCOI.11039.00115).

[5238] Exhibit 64, Tab 9, Statement of Margaret McEvoy, 23 June 1976, 1 (SCOI.11039.00038).

6.149. Mr Head's criminal history includes two charges of "offensive behaviour", said to be for masturbating in a toilet. This may indicate that Mr Head was a user of beats.[5239]

6.150. Mr Head had engaged in physical altercations with his brother and with a friend some years before his death. His brother said that he would become "a lot more sensitive and aggressive" after drinking, but nonetheless said that he never knew him to pick a fight.[5240] A colleague of Mr Head's similarly described that Mr Head could become aggressive while drinking.[5241]

6.151. Mr Head often gambled and was experiencing financial difficulties at the time of his death.[5242] However, there is no evidence to suggest Mr Head's death was connected to his financial situation.

Last known movements

6.152. Mr Head was last seen alive on 17 June 1976, when he attended the Bank Hotel, Newtown for a drink with I454 from 5:00pm. I454 departed at around 6:05pm, and Mr Head remained at the Hotel.[5243]

6.153. Mr Head is believed to have attended the Summer Hill TAB shortly after, as two TAB tickets dated 17 June 1976 were discovered at his flat, purchased at 1:57pm and 6:24pm.[5244] The TAB manager recognised Mr Head from a photograph as a person who had placed bets at that TAB on previous occasions. However, he had no recollection of Mr Head placing those bets on 17 June 1976. No other person present at the TAB at that time was able to recall seeing Mr Head at the relevant times. Despite this, the original investigation found there was no reason to believe any person other than Mr Head placed the bets.[5245]

Observations of neighbours

6.154. At around 7:00pm on 17 June 1976, two people in a neighbouring unit, Elaine Walsh and Donald Humphreys, overheard Mr Head calling out from his flat, saying words to the effect of "Help me" or "Somebody help me", as well as "Don't hurt me", or "Please don't hurt me." Ms Walsh described that there was "fear in his voice", and that he called for help about five times. Mr Humphries heard another male voice, and while he could not make out the conversation it appeared that there was an argument going on in the flat. Ms Walsh also heard "something being thrown around" prior to the calling out.[5246]

[5239] Exhibit 64, Tab 36, Table of Offences of Ernest Head, 17 April 1961–26 October 1964 (SCOI.10949.00025).

[5240] Exhibit 64, Tab 6, Statement of Arthur Head, 24 June 1976, 2 (SCOI.11039.00115).

[5241] Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 22 (SCOI.85764).

[5242] Exhibit 64, Tab 6, Statement of Arthur Head, 24 June 1976 (SCOI.11039.00115); Exhibit 64, Tab 8, Statement of Sydney Moore, 23 June 1976, [14] (SCOI.11039.00101).

[5243] Exhibit 64, Tab 7, Statement of I454, 23 June 1976, 2 [4] (SCOI.11039.00117).

[5244] Exhibit 64, Tab 18, Statement of Detective Sergeant Albert McDonald, 14 November 1977, [4]–[5] (SCOI.11039.00021).

[5245] Exhibit 64, Tab 18, Statement of Detective Sergeant Albert McDonald, 14 November 1977, [4]–[6] (SCOI.11039.00021).

[5246] Exhibit 64, Tab 10, Statement of Donald Humphreys, 23 June 1976, 1 (SCOI.11039.00105); Exhibit 64, Tab 12, Statement of Elaine Walsh, 23 June 1976, 1 (SCOI.11039.00107).

6.155. Mr Humphreys went onto the balcony and called out to Mr Head. He tapped on Mr Head's kitchen window and received no response. Mr Humphreys then went to the front door, and overheard some conversation between two men, one of the voices being that of Mr Head. The conversation was said to be in "quiet tones" that did not indicate that any argument was taking place. [5247]

6.156. Mr Humphreys knocked on the front door and said, "Are you alright Allan." (Allan was Mr Head's middle name.) Mr Head replied, "Who is it?" Mr Humphreys said, "It's Don from next door." Mr Head then said, "No everything's alright would you go away." Mr Humphreys returned to his own flat and heard nothing further.[5248]

6.157. As soon as he returned to his flat, Mr Humphreys twice rang the number of Mr Head's flat, and could hear ringing but the phone wasn't answered. Given that Mr Head had sounded "calm" in his conversation through the door, Mr Humphreys did not think that anything was wrong, but rather assumed that Mr Head was embarrassed.[5249]

6.158. Two women who were in the apartment directly below Mr Head's unit also heard this incident. Lillian Dreves heard "foot steps similar to a person running" followed by "a heavy scream" that "did not go on for very long at all."[5250] Galina Levendis, who was visiting Ms Dreves, described a "yell" that "sounded like help", followed by "a thump like a heavy object of some description hitting something" which seemed to be coming through the ceiling from the kitchen of the flat above. Ms Levendis described that the voice calling out for help and the thumping noises continued for about a minute, with the cries following the thumping sounds, and a few seconds of silence between each of the yells.[5251]

6.159. Both Ms Dreves and Ms Levendis reported hearing Mr Humphreys knocking on the door shortly after the yelling,[5252] making it likely that Mr Humphreys, Ms Dreves and Ms Levendis were all describing the same incident.

6.160. About one hour later, Mr Humphreys and Ms Walsh were sitting in their living room watching television and heard the front door of Mr Head's flat open. They heard a conversation which sounded like two men.[5253] Mr Humphreys thought that one of the voices belonged to Mr Head, and that the conversation was in a manner that "appeared to be normal." Mr Humphreys assumed that the other person had left the flat.[5254]

[5247] Exhibit 64, Tab 10, Statement of Donald Humphreys, 23 June 1976 (SCOI.11039.00105).

[5248] Exhibit 64, Tab 10, Statement of Donald Humphreys, 23 June 1976 (SCOI.11039.00105).

[5249] Exhibit 64, Tab 10, Statement of Donald Humphreys, 23 June 1976 (SCOI.11039.00105).

[5250] Exhibit 64, Tab 17, Statement of Lillian Dreves, Undated (SCOI.11039.00113).

[5251] Exhibit 64, Tab 15, Statement of Galina Levendis, 3 July 1976 (SCOI.10942.00053).

[5252] Exhibit 64, Tab 17, Statement of Lillian Dreves, Undated (SCOI.11039.00113); Exhibit 64, Tab 15, Statement of Galina Levendis, 3 July 1976 (SCOI.10942.00053).

[5253] Exhibit 64, Tab 10, Statement of Donald Humphreys, 23 June 1976, 2 (SCOI.11039.00105); Exhibit 64, Tab 12, Statement of Elaine Walsh, 23 June 1976, 1 (SCOI.11039.00107).

[5254] Exhibit 64, Tab 10, Statement of Donald Humphreys, 23 June 1976, 2 (SCOI.11039.00105).

6.161. At around the same time, Ms Dreves heard a "thump like somebody taking their boots off and dropping them" but was unable to be sure if this came from the unit above her or not.[5255]

6.162. Mr Humphreys told Jack McMahon, the secretary of the body corporate, about the argument that he heard, but the two men decided no action needed to be taken as Mr Head had said he was alright.[5256]

6.163. Later that night, at about 10:30pm, Ms Levendis heard noises coming from the bedroom in the unit directly above her. The noise was soft and unidentifiable, but gave her the impression that somebody was moving around in the bedroom. She did not hear any other sounds before falling asleep.[5257]

6.164. It appears likely that the altercation overheard by Mr Head's neighbours, during which Mr Head was heard to call for help and plead for an unknown person not to hurt him, was between Mr Head and a person or persons responsible for, or at least involved in, his death. Mr Head was never seen alive again, and the estimated of time of death made by Dr Oettle was consistent with him being killed on the night of 17 June 1976 (being five and a half days before the time of the post-mortem examination).[5258] It seems improbable that he was killed by a person unrelated to this interaction.

6.165. Mr Humphreys reported only hearing two male voices, both at the time that he first heard the argument and the time that he thought he heard the door open, and believed one of the voices to belong to Mr Head. This may suggest a lone assailant. On that hypothesis, Mr Humphreys must have been mistaken about hearing a person leaving. Alternately, if Mr Humphreys was correct in thinking that a person left when the door opened, this combined with the knowledge that there was at least one living person heard in the flat that night would suggest the possibility of there being two people in Mr Head's unit at the time of the altercation (in addition to Mr Head).

Concerns for welfare

6.166. On 19 June 1976, Mr Head was due to attend a party with Margaret McEvoy. She called him through the day and knocked on his front door in the afternoon, without response. Ms McEvoy left a note in the door jamb.[5259]

6.167. On 22 June 1976, Ms McEvoy heard that Mr Head had failed to turn up to his class at the Sydney Technical College. Ms McEvoy and her friend, Cheryn McCann, again went and knocked on Mr Head's unit, but no one answered. The note left in the doorjamb was in the same position. [5260]

[5255] Exhibit 64, Tab 17, Statement of Lillian Dreves, Undated (SCOI.11039.00113).

[5256] Exhibit 64, Tab 10, Statement of Donald Humphreys, 23 June 1976, 2 (SCOI.11039.00105); Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 19 (SCOI.85764).

[5257] Exhibit 64, Tab 15, Statement of Galina Levendis, 3 July 1976 (SCOI.10942.00053).

[5258] Exhibit 64, Tab 2, Post-Mortem Report, 17 August 1976 (SCOI.85765).

[5259] Exhibit 64, Tab 9, Statement of Margaret McEvoy, 23 June 1976 (SCOI.11039.00038); Exhibit 64, Tab 13, Statement of Cheryn McCann, 23 June 1976 (SCOI.10942.00064).

[5260] Exhibit 64, Tab 9, Statement of Margaret McEvoy, 23 June 1976 (SCOI.11039.00038); Exhibit 64, Tab 13, Statement of Cheryn McCann, 23 June 1976 (SCOI.10942.00064).

6.168. Ms McEvoy made contact with I454, who in turn contacted Mr Moore, who said he would check up on Mr Head.[5261]

6.169. At about 11:55pm that evening, I454 and Mr Moore called on Mr Head's flat. When no one answered the door, Mr Moore used keys to enter the flat.[5262]

6.170. Mr Moore discovered Mr Head's body lying naked and face down in the kitchen covered in blood. After telling I454 not to touch anything, the two men exited the flat. They immediately went to the flat of Mr Head's neighbours, Ms Walsh and Mr Humphreys. Mr Humphreys called the Ashfield Police Station.[5263]

The crime scene

6.171. Mr Head's flat was situated on the third floor of an apartment building in Summer Hill. It was a large block of units within walking distance of Summer Hill Railway Station.[5264]

6.172. There was only one access door which, when fully secured, required two keys to open. There was no sign of forced entry to the flat.[5265]

6.173. A crime scene investigation was undertaken by Senior Constable Munday of the Scientific Investigation Section on 23 June 1976 at 2:45am.[5266] A scale plan of the apartment was prepared,[5267] and crime scene photographs were taken.[5268] Other police were involved in seizing exhibits from the scene. Details of the officer's observations of the scene, and the exhibits seized, are set out below.

Kitchen

6.174. Mr Head's body was found in the kitchen, naked, lying on his front with his head turned to the right and his left cheek resting on the floor. The top of his head was up against the bottom of the refrigerator where a kick plate would normally fit. Mr Head's fingers were resting on the kick plate which was on the floor near the kitchen door.[5269]

[5261] Exhibit 64, Tab 9, Statement of Margaret McEvoy, 23 June 1976 (SCOI.11039.00038); Exhibit 64, Tab 13, Statement of I454, 23 June 1976 (SCOI.11039.00117).

[5262] Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records various dates, 2 (SCOI.85764); Exhibit 64, Tab 7, Statement of I454, 23 June 1976, [6]–[7] (SCOI.11039.00117); Exhibit 64, Tab 8, Statement of Sydney Moore, 23 June 1976, [8] (SCOI.11039.00101).

[5263] Exhibit 64, Tab 7, Statement of I454, 23 June 1976, [7] (SCOI.11039.00117); Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 2 (SCOI.85764); Exhibit 64, Tab 8, Statement of Sydney Moore, 23 June 1976, [8] (SCOI.11039.00101); Exhibit 64, Tab 10, Statement of Donald Humphreys, 23 June 1976, 3 (SCOI.11039.00105).

[5264] Exhibit 64, Tab 18, Statement of Detective Sergeant Albert McDonald, 14 November 1977 (SCOI.11039.00021).

[5265] Exhibit 64, Tab 18, Statement of Detective Sergeant Albert McDonald, 14 November 1977 (SCOI.11039.00021).

[5266] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976 (SCOI.11039.00099).

[5267] Exhibit 64, Tab 31, Scale plan of Ernest Head's apartment, undated (SCOI.11039.00096).

[5268] Exhibit 64, Tab 22, Statement of Senior Constable Munday, 26 September 1976 (SCOI.11039.00099); Exhibit 64, Tab 23, Crime scene photographs taken by Senior Constable Munday, 23 June 1976 (SCOI.85753), Exhibit 64, Tab 24, Photographs of garage, undated (SCOI.11039.00089); Exhibit 64, Tab 25, Photographs of tire tracks in garage, undated (SCOI.11039.00091); Exhibit 64, Tab 26, Photographs of tire tracks in garage, undated (SCOI.11039.00093); Exhibit 64, Tab 27, Crime scene photographs, undated (SCOI.85767); Exhibit 64, Tab 28, Crime scene and autopsy photographs, undated (SCOI.10948.00020); Exhibit 64, Tab 29, Autopsy photographs, undated (SCOI.11039.00087); Exhibit 64, Tab 30, Further crime scene and autopsy photographs, undated (SCOI.10948.00023).

[5269] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [3] (SCOI.11039.00099).

6.175. A pair of men's underpants were on the floor near the deceased's head. They were retained for further examination.[5270]

6.176. There were a large number of blood smears and splashes covering the kitchen floor around Mr Head's body, on Mr Head himself, and on the walls, refrigerator, stove, cupboards and the back of the kitchen door.[5271]

6.177. On the western wall of the kitchen above where the body was lying were blood marks, which bore the appearance of hand prints.[5272]

6.178. In the cutlery tray on the kitchen sink was a "Gerber Shorty" bread knife. On a shelf above the sink was a "Gerber French" brand knife in a wooden sheaf. Both these knives appeared to be clean. They were retained for further examination purposes.[5273]

Loungeroom

6.179. Further blood splashes were located on the carpet, closet door and room divider in the loungeroom.[5274]

6.180. A number of cigarette butts and partly used cigarettes were located on the floor and in an ashtray in the loungeroom.[5275] The cigarette butts were Benson and Hedges Super Virginia brand unfiltered cigarettes.[5276] Five cigarette butts or part-used cigarettes were seized as exhibits from the loungeroom: one said to be on the floor, the remaining found in the ashtray.[5277] Spent matches were found within the ashtray.[5278]

6.181. Mr Moore, who discovered Mr Head's body, noticed the cigarettes in the ashtray, and remarked that he did not believe that Mr Head smoked other than on occasions at a party.[5279]

[5270] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [3], [10] (SCOI.11039.00099).

[5271] Exhibit 64, Tab 22, Statement of Senior Constable Munday, 26 September 1976 (SCOI.11039.00099); Exhibit 64, Tab 23, Crime scene photographs taken by Senior Constable Munday, 23 June 1976 (SCOI.85753), Exhibit 64, Tab 24, Photographs of garage, undated (SCOI.11039.00089); Exhibit 64, Tab 25, Photographs of tire tracks in garage, undated (SCOI.11039.00091); Exhibit 64, Tab 26, Photographs of tire tracks in garage, undated (SCOI.11039.00093); Exhibit 64, Tab 27, Crime scene photographs, undated (SCOI. 85767); Exhibit 64, Tab 28, Crime scene and autopsy photographs, undated (SCOI.10948.00020); Exhibit 64, Tab 30, Further crime scene and autopsy photographs, undated (SCOI.10948.00023). Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [3] (SCOI.11039.00099).

[5272] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [3] (SCOI.11039.00099).

[5273] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [10] (SCOI.11039.00099).

[5274] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [7] (SCOI.11039.00099).

[5275] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [9] (SCOI.11039.00099).

[5276] Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 36, 39 (SCOI.85764); Exhibit 64, Tab 39, Specimen/Exhibit Examination Form, 27 July 2005 (NPL.0131.0001.1909); Exhibit 64, Tab 19, Examination of Partly-Smoked Cigarettes by Detective Sergeant McDonald, 17 August 1978 (SCOI.10960.00050).

[5277] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [30]–[31] (SCOI.11039.00099); Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 26 (SCOI.85764).

[5278] Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 26 (SCOI.85764).

[5279] Exhibit 64, Tab 8, Statement of Sydney Moore, 23 June 1976, [12] (SCOI.10942.00058).

6.182. A box of matches labelled "Mandarin Club" was seen lying on the room divider in the lounge area of the unit. The matches were observed to be longer than standard matches (the spent matches found in the ashtray being noted to be standard length). It appeared that the Mandarin Club box had "been used about 5 or 6 times and contained near a full box of unspent matches".[5280] There were five cigarettes believed to have been smoked at the scene. Later police enquiries ascertained that Benson and Hedges Super Virginia unfiltered cigarettes were available at the Mandarin Club, leading police to theorise that the offender had purchased cigarettes and matches at that location.[5281] However, inquiries made of patrons at the Mandarin Club did not yield any suspects.

Dining room

6.183. In the dining room was an HMV gramophone which had a "Decca" long playing record on the turntable. The record was still rotating when police attended the flat, and the stylus had worn a deep groove into the middle track of the record. Blood smears were located on the knobs of the radiogram.[5282]

Hallway

6.184. There was a trail of blood spots from the bedroom, down the hallway into the loungeroom and kitchen where a large amount of blood was in the near vicinity of the body.[5283]

6.185. Blood splashes were located on the hallway carpet and wall, the bathroom door, the door jamb and the door of the main bedroom.[5284]

Main bedroom

6.186. Blood splashes were located on the bed sheets and pillows of the double bed situated in the main bedroom. A number of hair fibres were removed from the bed for further comparisons. Blood smearing and blood splashes were also found on the eastern wall and blankets on the floor beside the bed in the main bedroom, and on the carpet underneath the blankets.[5285]

6.187. A partly used cigarette butt was located on the floor.[5286]

6.188. Two pairs of socks were found on the floor in the bedroom, one near the head of the bed, one in front of a chest of drawers and dressing table. In a bedside drawer, police found a handkerchief marked with a sticky white substance, believed to be semen.[5287]

[5280] Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 26 (SCOI.85764).

[5281] Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 27–28 (SCOI.85764).

[5282] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [9] (SCOI.11039.00099).

[5283] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [3], [7] (SCOI.11039.00099).

[5284] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [7] (SCOI.11039.00099).

[5285] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [7] (SCOI.11039.00099).

[5286] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [9] (SCOI.11039.00099).

[5287] Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 9 (SCOI.85764); Statement of Senior Constable Robert Munday, 26 September 1976, [15] (SCOI.11039.00099).

Bathroom

6.189. Examination of the bathroom revealed diluted blood smearing on the vanity unit, the power point above the vanity unit, and the light switch near the door. Several small blood splashes were also located on the walls inside the shower recess.[5288]

6.190. There was a pair of men's trousers hanging on the bathroom door on which blood smears were located.[5289]

6.191. Human vomit was in the toilet pan in the bathroom, no sample of which was retained.[5290]

6.192. In the bath was a wet navy-blue long-sleeved men's shirt and a green two-gallon plastic bucket containing water and items of men's clothing. A pair of damp, white men's buckle type shoes were resting against the hob of the shower recess.[5291] Mr Head's brother Arthur noted that it was Mr Head's custom to soak his clothes that were to be washed in a bucket in the bathroom, and police inquiries indicated that it was likely that the clothing in the bucket belonged to Mr Head.[5292]

6.193. A number of hair fibres were located and retained for further comparison, from the bath, shower, recess and vanity unit. Police also collected various washers and towels as exhibits.[5293]

Second bedroom

6.194. On 27 June 1976, Senior Constable Munday returned to the unit and collected a plastic bag with some blood spots on it found in the second bedroom.[5294] A cigarette butt found on the floor of the second bedroom was taken into evidence.[5295]

Garage

6.195. On 27 June 1976, Senior Constable Munday returned to the lockup garage on the ground floor of the block of units and photographed tyre tracks on the floor of the garage.[5296] Ms Walsh told police that Mr Head did not have a car.[5297]

[5288] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [8] (SCOI.11039.00099).

[5289] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [8] (SCOI.11039.00099).

[5290] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [8] (SCOI.11039.00099).

[5291] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [8] (SCOI.11039.00099).

[5292] Exhibit 64, Tab 6, Statement of Arthur Head, 24 June 1976, 2 (SCOI.11039.00115).

[5293] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [8] (SCOI.11039.00099); Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 16 (SCOI.85764).

[5294] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [16] (SCOI.11039.00099).

[5295] Exhibit 64, Tab 22, Statement of Senior Constable Robert Munday, 26 September 1976, [9] (SCOI.11039.00099).

[5296] Exhibit 64, Tab 24, Photograph of garage, undated (SCOI.11039.00089); Exhibit 64, Tab 25, Photograph of tire tracks in garage, undated (SCOI.11039.00091); Exhibit 64, Tab 26, Photograph of tire tracks in garage, undated (SCOI.11039.00093); Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 8 (SCOI.85764).

[5297] Exhibit 64, Tab 12, Statement of Elaine Walsh, 23 June 1976, 2 (SCOI.11039.00107).

Stolen property

6.196. Police identified that property had been stolen from the unit, including a watch, television, cassette recorder, transistor, gold dress ring, two pieces of jade, and a suitcase. A facsimile detailing the stolen property was circulated Australia wide but none of the property was located.[5298]

Exhibits

6.197. As described above, a number of exhibits were seized by police from the crime scene, including:[5299]

a. Blood scrapings;

b. Cigarette butts and matches;

c. Two knives;

d. A transistor stereo gramophone;

e. A handkerchief stained with a substance believed to be semen;

f. Clothing and bedding; and

g. Hair samples found in the main bedroom and bathroom of the crime scene.

6.198. In addition to the crime scene exhibits, samples were taken from Mr Head's body post-mortem, including penile and anal swabs and smears. Further, blood samples were taken from witnesses and persons of interest for comparison to the blood found at the crime scene.

Forensic testing: original investigation

6.199. A total of 53 items were submitted for forensic testing by DAL by the original police investigators.[5300]

6.200. Human blood was detected on the transistor stereo gramophone, the bedding from the main bedroom, a pair of men's trousers and a plastic bag from the second bedroom. The blood scrapings from the crime scene and Mr Head's body were also determined to comprise human blood.

6.201. All items where human blood was detected were subjected to blood grouping tests. All the blood samples were consistent with the blood having come from Mr Head. Mr Head's blood type (B, Hp 2-2, PGM 2-1) was only found in approximately 1% of the population.[5301]

6.202. The two knives from the scene were forensically examined, but blood was not detected.[5302]

[5298] Exhibit 64, Tab 18, Statement of Detective Sergeant Albert McDonald, 14 November 1977, [8] (SCOI.11039.00021); Exhibit 64, Tab 34, Special Circular No 76/22, "Alleged Murder and Theft of Property", 1 July 1976 (SCOI.11039.00023).

[5299] Exhibit 64, Tab 49, Statement of Detective Inspector Nigel Warren, 29 March 2023, Schedule 1 (NPL.0145.0001.0014).

[5300] Exhibit 64, Tab 4, Certificate of Paul Connellan, 17 September 1976 (SCOI.11039.00036).

[5301] Exhibit 64, Tab 4, Certificate of Paul Connellan, 17 September 1976, 4 (SCOI.11039.00036).

[5302] Exhibit 64, Tab 4, Certificate of Paul Connellan, 17 September 1976, 4 (SCOI.11039.00036).

6.203. Semen was found to be present on the penile and anal swabs taken from Mr Head post-mortem, although in quantities too low for grouping analysis.[5303]

6.204. The handkerchief found at the scene was found to be extensively stained with semen. It was found to have originated from a group O, PGM 2-1 individual (i.e. not Mr Head) and a B group individual (i.e. consistent with Mr Head).[5304]

6.205. Saliva was detected on four cigarette butts or part used cigarettes, and grouping tests revealed saliva originated from a group O individual.[5305] This is consistent with the cigarette butts having been smoked by the same person whose semen was found on the handkerchief, although not strongly probative of that fact given that the group O blood type occurs frequently in the population.

6.206. The hair samples found in the bedroom and bathroom were not forensically examined.[5306]

Manufacturer of the cigarette butts

6.207. In addition to the testing by DAL, police arranged for three non-filtered cigarette butts and one part used cigarette butt that were found in the ash tray in the loungeroom to be sent to W.D. & H.O. Wills (Australia) Ltd, the manufacturers of Benson and Hedges Super Virginia cigarettes in Australia, for examination.[5307] A report received from a Mr Bartholomew, on behalf of the "Manager, R&D Department, Amatil", identified the cigarettes as being consistent with having been manufactured in Australia, and reported that no Benson and Hedges Super Virginia cigarettes manufactured overseas had been imported into Australia for many years.[5308] Police made inquiries with shops where local Benson and Hedges Super Virginia cigarettes were sold, although these inquiries ultimately proved fruitless.

Discovery of a possible murder weapon in 1977

6.208. Nearly a year after Mr Head's death, on 27 May 1977, Mr Humphreys and Mr McMahon located a knife amongst cardboard rubbish that had accumulated in the area behind the units where Mr Head had resided. That knife was handed to police.[5309] There are no records as to whether that knife was retained as an exhibit or forensically tested, although statements were taken to document the provenance of the knife suggesting that the possible significance of the knife was recognised. The lack of records as to the whereabouts of that knife raises a concern about proper exhibit management.

[5303] Exhibit 64, Tab 4, Certificate of Paul Connellan, 17 September 1976, 4 (SCOI.11039.00036).

[5304] Exhibit 64, Tab 4, Certificate of Paul Connellan, 17 September 1976, 5 (SCOI.11039.00036).

[5305] Exhibit 64, Tab 4, Certificate of Paul Connellan, 17 September 1976, 5 (SCOI.11039.00036).

[5306] Exhibit 64, Tab 4, Certificate of Paul Connellan, 17 September 1976, 5 (SCOI.11039.00036).

[5307] Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 14–15 (SCOI.85764).

[5308] Exhibit 64, Tab 19, Examination of Partly-Smoked Cigarettes by Detective Sergeant McDonald, 17 August 1978 (SCOI.10960.00050); Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 36 (SCOI.85764).

[5309] Exhibit 64, Tab 16, Statement of John McMahon, 28 May 1977 (SCOI.10942.00060); Exhibit 64, Tab 11, Second Statement of Donald Humphreys, 27 May 1977 (SCOI.10942.00047).

Forensic testing: subsequent reviews by the UHT

6.209. As noted above, a 2005 review by the UHT located three cigarette butts and a match in sealed envelopes within the hard-copy brief. In 2008, DNA testing was conducted on the three cigarette butts, however they were found to be "unsuitable for DNA analysis".[5310] Testing on the match was recorded to be unsuccessful.[5311]

Forensic testing: review by the Inquiry

6.210. As noted above, only four physical exhibits collected by the original investigators remain:

a. One non-filtered cigarette butt said to be found on the floor near the front door in the loungeroom;

b. One part used non-filtered cigarette said to be found on the floor of the main bedroom;

c. One non-filtered cigarette butt said to be found on the floor of the second bedroom;[5312] and

d. One match.

6.211. It appears that all other exhibits have been lost.[5313]

6.212. At the request of the Inquiry, Dr Bruce of FASS conducted further testing on the cigarette butt remains. While the original testing attempted to identify the blood group of the person who deposited saliva on the cigarette butts, this testing attempted to recover DNA.[5314] On one of the cigarette butts, a weak partial DNA profile was obtained from an unknown individual (Individual "A"). The profile was not suitable for upload onto the DNA database, but may be suitable for comparison with a nominated individual.[5315]

6.213. As no reference DNA profile is held for Mr Head or Mr Simsek, it could not be determined whether Individual "A" may be either of those individuals.[5316]

6.214. As the profile was a weak partial DNA profile, it could only be of use for familial comparison with a parent or child, and, even then, could only be used to *exclude* a person as being Individual "A". A sibling relationship or more distant relatives (nephews, cousins, etc) would not be informative.[5317] The Inquiry was unable to locate any sufficiently close living relative or Mr Head or Mr Simsek who may have been able to provide a DNA sample for comparison to the DNA profile recovered on the cigarette butt.

[5310] Exhibit 64, Tab 49C, DAL Database Report, 20 January 2008 (NPL.0145.0001.0006).

[5311] Exhibit 64, Tab 49C, DAL Database Report, 20 January 2008 (NPL.0145.0001.0006).

[5312] Exhibit 64, Tab 49, Statement of Detective Inspector Nigel Warren, 29 March 2023, [9] (NPL.0145.0001.0014).

[5313] Exhibit 64, Tab 49, Statement of Detective Inspector Nigel Warren, 29 March 2023, [12] (NPL.0145.0001.0014).

[5314] Exhibit 64, Tab 55, Second Statement of Dr David Bruce, 27 September 2023, [4] (SCOI.85859).

[5315] Exhibit 64, Tab 54, Statement of Dr David Bruce, 25 September 2023, [4] (SCOI.85768).

[5316] Exhibit 64, Tab 55, Second Statement of Dr David Bruce, 27 September 2023, [5], [7] (SCOI.85859).

[5317] Exhibit 64, Tab 55, Second Statement of Dr David Bruce, 27 September 2023, [7] (SCOI.85859).

Fingerprint analysis: previous investigations

6.215. As noted above, handprints in blood were observed by Senior Constable Munday on his inspection of the unit on 23 June 1976. Sergeant Stone conducted the fingerprint examination of the unit, and identified that two of these were palm prints suitable for identification.[5318] Those palm prints were checked against approximately 200 elimination prints, but no matches were identified.[5319]

6.216. Fingerprints that were developed in the main bedroom doorway, the bathroom doorway and the kitchen doorway were all eliminated as belonging to the deceased.

6.217. The unidentified palm prints were reviewed on the following occasions:

a. On 16 April 2002, the case was reviewed at the request of Strike Force Palace. Unidentified prints were searched on NAFIS and not identified;

b. On 9 August 2004, the case was reviewed at the request of Detective Inspector Jarrett of the UHT. It is unclear if the prints were searched on NAFIS at this time;

c. On 17 August 2005, the case was again reviewed at the request of Detective Inspector Jarrett of the UHT. Unidentified prints were searched on NAFIS, with no matches identified;[5320]

d. In January 2006, police confirmed that both Kuala Lumpur and New Zealand had searched their databases with a negative result, while Hong Kong was unable to search palm prints on their system;[5321] and

e. In July 2007, the United States' FBI confirmed that an automated search was conducted with no identification made.[5322]

Fingerprint analysis: review by the Inquiry

6.218. On 24 April 2023, the Inquiry requested that bloody marks located above Mr Head's body in the kitchen be subjected to further analysis.[5323]

6.219. Ms Reid examined the photographs. Ms Reid identified three palm prints amongst the bloody marks, which she labelled graph B(1), B(2) and B(3) for ease of reference.

[5318] Exhibit 64, Tab 20, Statement of Sergeant Robert William Stone, 16 November 1977 (SCOI.11039.00111).

[5319] Exhibit 64, Tab 20, Statement of Sergeant Robert William Stone, 16 November 1977 (SCOI.11039.00111); Exhibit 64, Tab 40, NSWPF Investigators Note, 'Fingerprint review – Ernest Alan Head', 30 August 2005 (SCOI.60861).

[5320] This review also identified latent fingerprints on a motor vehicle. That was a stolen motor vehicle that the original investigating police had suspected may have been connected to Mr Head's death; however, it was eliminated from the inquiry when it was determined that the vehicle was not stolen until some 48 hours after the death of Mr Head: Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 14–15 (SCOI.85764). The fingerprint results from this examination are irrelevant to the death of Mr Head. See Exhibit 64, Tab 32, NSWPF Report of Occurrence, Bundle of Report of Occurrence records, various dates, 14–15 (SCOI.85764).

[5321] Exhibit 64, Tab 41, NSWPF Investigators Note, 'O/S Fingerprint Results re Murder of Ernest Allan HEAD', 14 March 2006 (SCOI.60862); Exhibit 64, Tab 40, NSWPF Investigators Note, 'Fingerprint review – Ernest Alan Head', 30 August 2005 (SCOI.60861).

[5322] Exhibit 64, Tab 43, FBI Laboratory Report, 18 July 2007 (SCOI.60866).

[5323] Exhibit 64, Tab 56, Letter from Enzo Camporeale to Patrick Hodgetts, 24 April 2023 (SCOI.85259).

6.220. Ms Reid has explained that at the time of Sergeant Stone's examination, the process of fingerprint analysis involved using a magnifying eyeglass to view the fingerprints. The digitisation of fingerprint images and the ability to import the image into Forensic Comparison Software has resulted in a greater discriminating power for low quality prints, and has provided the ability to zoom, rotate, and change the brightness, contrast and saturation for an image. Graph B(3) was a print noted to contain limited detail, but after digital enhancement Ms Reid determined the print to be suitable for comparison. This likely explains why she determined three palm prints to be suitable for comparison, in contrast to Sergeant Stone who only determined two as suitable.[5324]

6.221. Ms Reid conducted searches of the palm prints against the NAFIS database. As a result of that search, Ms Reid retrieved a set of record prints bearing the name Engin Simsek. Ms Reid carefully compared the fingerprints of Mr Simsek with the bloody palm prints at the scene, and reached a conclusion that print B(1) matched the right upper palm of Mr Simsek.[5325]

6.222. Palm prints B(2) and B(3) remained unidentified. However, Ms Reid noted that they were unable to be compared to the record prints of Mr Simsek due to the lack of comparable area in the record palm prints — Mr Simsek's record prints only capture the upper portion of the palm, whereas palm prints B(2) and B(3) capture the lower portion of the palms.[5326] This is because, at the time Mr Simsek's fingerprints were taken on 27 July 1980, standard practice was to take fingerprints, thumb prints and "the interdigital impressions, where only the upper segment of each palm is recorded".[5327] Accordingly, the fact that the palm prints remain unidentified does not necessarily indicate that the prints belonged to a person other than Mr Simsek.

Known information about Mr Simsek

6.223. Mr Simsek was born in Türkiye on 3 September 1943.

6.224. On 31 May 1972, Mr Simsek emigrated to Australia, where one of his siblings and their partner were residing. Mr Simsek's arrival card into Australia listed a unit on Grosvenor Crescent, Summer Hill as his intended address.

6.225. At various points between 1970 and 1992, Mr Simsek's relatives resided at two addresses on Grosvenor Crescent, Summer Hill, as well as other addresses in Sydney's Inner West.[5328] It cannot be determined where there were residing in 1976. Both addresses on Grosvenor Crescent were less than a two-minute walk away from Mr Head's apartment.

[5324] Exhibit 64, Tab 63, Third Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 19 September 2023 (NPL.9000.0034.0001).

[5325] Exhibit 64, Tab 57, First Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 30 May 2023, [9] (SCOI.85121).

[5326] Exhibit 64, Tab 57, First Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 30 May 2023, [9], [13] (SCOI.85121).

[5327] Exhibit 64, Tab 59, Second Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 20 June 2023, [11(I)] (SCOI.85263).

[5328] Exhibit 64, Tab 76, Statement of I450, 3 October 2023, [4]–[6] (SCOI.85771).

6.226. Mr Simsek was reported to have a close relationship with his sibling and their partner.[5329] While Mr Simsek resided at other addresses (mostly around the Inner West areas of Sydney, including Enmore and Newtown), he was reported to have resided with his sibling for at least some periods of time. While it is unknown where he was living in 1976, his connection with Grosvenor Crescent, Summer Hill suggests opportunity for Mr Simsek to have come into contact with Mr Head.

6.227. There are only scant records about Mr Simsek's life at around the time of Mr Head's death in 1976. In 1975, Mr Simsek had commenced a de facto relationship with a woman, and in approximately 1979 he had a daughter. Between 1976 and 1980, he was working at a factory in Enfield, a suburb approximately ten minutes from Summer Hill.[5330]

6.228. In August 1980, Mr Simsek was convicted of an offence of malicious injury, relating to an incident in July of that year in which Mr Simsek used a chair to smash a glass window and door, and juke box, at a shop in Enmore.[5331] Mr Simsek provided no explanation to police for his behaviour.

6.229. This was Mr Simsek's first offence in Australia, and he was fined $100 or ordered to serve 4 days of hard labour.[5332] Mr Simsek's fingerprints were taken at the Newtown Police Station in relation to this offence.[5333]

6.230. In September 1984, Mr Simsek was arrested in possession of a large quantity (234 grams) of heroin. A search of his residential premises revealed further quantities of heroin and marijuana. Mr Simsek was charged with offences of possessing and supplying a prohibited drug. In December 1985, he was convicted in respect of two counts of supplying a prohibited drug and sentenced to six years "hard labour", with a non-parole period of three years.[5334]

6.231. Mr Simsek was released to parole on 9 July 1986, with a proposal that he reside at his sibling's address on Grosvenor Crescent. This release date is earlier than the date indicated in Mr Simsek's bail report as the expiration of his non-parole period on 26 September 1987. The records available to the Inquiry do not explain the reason for his early release.

6.232. A report prepared immediately prior to his release described him as a "quiet and seemingly placid individual", noting it was "very difficult to assess [his] level of involvement in [the] distribution of heroin."[5335] Notes from an interview conducted with his sibling and their partner prior to Mr Simsek's release recorded that they characterised Mr Simsek as "a gentle and non-violent man whose involvement in the offences [they] still found hard to explain." They further described that Mr Simsek had "great difficulty in talking about his feelings".[5336]

[5329] Exhibit 64, Tab 70, Pre-Release Report, 29 May 1986, 2 (SCOI.12138.00053).

[5330] Exhibit 64, Tab 68, Pre-Release Interview Form, 22 April 1986, 2 (SCOI.12138.00060).

[5331] Exhibit 64, Tab 65, Bail Report of Engin Simsek, 2 June 2023, 1 (NPL.0175.0001.0001).

[5332] Exhibit 64, Tab 65, Bail Report of Engin Simsek, 2 June 2023, 1 (NPL.0175.0001.0001).

[5333] Exhibit 64, Tab 59, Second Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 20 June 2023, [8] (SCOI.85263).

[5334] Exhibit 64, Tab 65, Bail Report of Engin Simsek, 2 June 2023, 2 (NPL.0175.0001.0001).

[5335] Exhibit 64, Tab 72, Transfer of Case History, 14 July 1986 (SCOI.12138.00045).

[5336] Exhibit 64, Tab 69, Handwritten Note re Conversation with I451 and I452, 28 May 1986 (SCOI.12138.00055).

6.233. Mr Simsek was reported to be an alcoholic. His alcoholism ultimately caused him to become estranged from his family.[5337]

6.234. Mr Simsek's sexuality is unknown.[5338] The Inquiry has not found evidence of any prior relationship between Mr Simsek and Mr Head.

6.235. Mr Simsek departed from Australia on 13 August 1994.[5339] Mr Simsek died by way of suicide on 6 May 1999 in Türkiye.[5340]

Mr Simsek's involvement in Mr Head's death

6.236. The presence of Mr Simsek's palm print, in blood, on the kitchen wall above Mr Head's body, is significant evidence. It provides strong evidence that Mr Simsek was at least involved in the events surrounding Mr Head's death.

6.237. There can be no doubt that Mr Head was the victim of a violent and frenzied stabbing. Having regard to the position of the palm print, in close vicinity to Mr Head's naked body and surrounded by blood marks originating from Mr Head, the only reasonable inference is that the palm print was deposited at or shortly before or after the time of Mr Head's killing.

6.238. However, much remains unknown about the precise circumstances of Mr Head's death. Among other things, it is impossible to know whether Mr Head was killed by a lone assailant or by more than one person. It is also impossible to know whether Mr Head was killed at the time of the altercation heard by neighbours, or at some later time. For this reason, while the evidence is consistent with Mr Simsek being responsible in Mr Head's death, it cannot exclude other possibilities that arise on the evidence.

6.239. One other relevant circumstance over which uncertainty lingers is whether Mr Simsek or another person had engaged in sexual intercourse with Mr Head prior to his death.

6.240. The presence of semen on penile and anal swabs taken from Mr Head, the semen-stained handkerchief, and Mr Head's state of undress, are all indicators of Mr Head and another person having engaged in sexual activity shortly prior to his death.

6.241. The trail of blood spots from the bedroom, down the hallway, and into the kitchen where Mr Head's body was located, suggests an attack which commenced in the bedroom and proceeded through the unit and into the kitchen. This is consistent with Mr Head being attacked first in the bedroom, with the attack continuing into the kitchen where Mr Head's body was ultimately located.

[5337] Exhibit 64, Tab 76, Statement of I450, 3 October 2023, [9], [11] (SCOI.85771).

[5338] Exhibit 64, Tab 76, Statement of I450, 3 October 2023, [10] (SCOI.85771).

[5339] Exhibit 64, Tab 74, Extract of Movement Records of Engin Simsek, undated (SCOI.85766).

[5340] Exhibit 64, Tab 61A, Letter from Katherine Garaty to Enzo Camporeale, 6 October 2023 (SCOI.86038); Exhibit 64, Tab 75, Newspaper article re death of Engin Simsek and certified translation, 8 May 1999–28 August 2023 (SCOI.85752).

6.242. One possibility, therefore, is that the perpetrator had sexual intercourse with Mr Head in the bedroom before embarking on a frenzied and panicked attack on him. Forensic analysis of the exhibits, including the penile and anal swabs, would have been able to assist in confirming or excluding this theory; however, those exhibits have now been lost.

6.243. Ultimately, while the bloody palm print is *consistent* with Mr Simsek being responsible for Mr Head's death, the role Mr Simsek played in relation to Mr Head's death remains unknown. In view of Mr Simsek's death, it is not now possible for him to answer an allegation that he is responsible for, or was otherwise involved in, Mr Head's death.

Expert report of Dr Sullivan

6.244. Dr Sullivan is a consultant forensic psychiatrist, who provided a report to the Inquiry regarding Mr Head's death on 15 May 2023. Dr Sullivan's report was provided to the Inquiry prior to the identification of Mr Simsek as a person of interest and the likely assailant.

6.245. Dr Sullivan assessed whether any aspects of the manner of Mr Head's death and/or the crime scene may indicate that the death was a consequence of an LGBTIQ bias related attack. Dr Sullivan observed that the "nature and extent of injuries significantly exceed what is necessary to kill a person, and are consistent with an attack occurring in a frenzy, panic, or overkill".[5341]

6.246. Dr Sullivan noted that there was nothing sexualised or symbolic about the pattern of injuries. However, he considered there was evidence of recent, likely consensual, sexual activity with a male partner. He also considered that the conversation heard by witnesses in adjacent units, and the lack of signs of significant struggles, suggested that the offender was acquainted with Mr Head or had been invited into the property.[5342]

6.247. Dr Sullivan considered that robbery was one possible motive, although stated that it could not be determined whether this was a primary or secondary motivation. He considered there to be "insufficient information about the unidentified perpetrator, and no other features at the scene of Mr Head's death to make further inferences about hate crime motives".[5343]

6.248. As has been the case in other deaths considered by this Inquiry, Dr Sullivan's report is demonstrative of the inherent limitations of attempting to assess the motivations of an unknown offender.

[5341] Exhibit 64, Tab 47, Expert report of Dr Danny Sullivan, 15 May 2023, [15] (SCOI.85123).

[5342] Exhibit 64, Tab 47, Expert report of Dr Danny Sullivan, 15 May 2023, [16] (SCOI.85123).

[5343] Exhibit 64, Tab 47, Expert report of Dr Danny Sullivan, 15 May 2023, [17]–[18] (SCOI.85123).

6.249. Although Mr Simsek has been identified as a person likely involved in Mr Head's killing, he cannot now provide information as to the circumstances of the death or his motives. While some information has been obtained that allows for a limited profile of Mr Simsek to be created, there is no reliable information as to his sexuality, his biases, or his psychological or psychiatric health. The identification of Mr Simsek does not, of itself, permit assessment of his motivations to be advanced significantly.

Police investigation

Indicators of police bias

6.250. There are some indicators of negative police attitudes towards gay men in the original police investigation. In a letter to the Superintendent in Charge of the Criminal Investigation Branch, two detectives refer to Mr Head's likely sexual activity prior to his death as being consistent with "what we have been told about the nefarious activities of the deceased."[5344] Mr Head died prior to the decriminalisation of "homosexual acts" in NSW.

6.251. Despite that, I accept the submissions of Counsel Assisting that the original police investigation was extensive and thorough, such that there is no evidence that any bias impacted upon the quality or extent of the investigation.[5345]

Management of exhibits

6.252. The retention, preservation, storage and tracking of exhibits is a critical part of police work, and is essential in any reinvestigation of a cold case, particularly in light of advances in technology.

6.253. In this case, of the exhibits that were seized by the investigating police, only three cigarette butts and a match remain. The location of the remaining exhibits, including the knife discovered by Mr Humphreys and Mr McMahon, is unknown, despite the searches as detailed above.[5346] The cigarette butts were not, until 2005, properly logged or stored as exhibits.

6.254. The match which was located in 2005 appears to have been stored with the cigarette butts. As noted above, there was no match listed amongst the list of items originally seized and submitted for forensic testing.[5347] There were matches located at the crime scene, including unused matches in a box and spent matches in an ashtray. The provenance of the match which now remains as an exhibit cannot be determined with any certainty. This would have been of significant concern if the match had become relevant to the investigation.

[5344] Exhibit 64, Tab 35, Letter from Detective Sergeant Albert McDonald to Superintendent in Charge, Criminal Investigation Branch, 14 September 1977 (SCOI.60867).

[5345] See Submissions of Counsel Assisting, 9 October 2023, [16]–[19], [170] (SCOI.86054).

[5346] Exhibit 64, Tab 49, Statement of Detective Inspector Nigel Warren, 29 March 2023, [12] (NPL.0145.0001.0014).

[5347] Exhibit 64, Tab 4, Expert Certificate of Paul Connellan, 17 September 1976 (SCOI.11039.00036).

6.255. The NSWPF agrees with submission of Counsel Assisting in that it is regrettable that the exhibits are not now available.[5348] However, the NSWPF submitted that the evidence suggests that all available forensic testing at the time was undertaken (except for hair samples provided to FASS).[5349]

6.256. The NSWPF submitted that the evidence available does not indicate whether certain exhibits were wholly consumed as part of initial testing.[5350] The NSWPF submitted that the evidence of Dr Bruce indicated that grouping and other chemical testing required large samples, which may have led to the total consumption of the biological stains available on certain exhibits.[5351]

6.257. The NSWPF submitted that it is unclear what happened to the missing exhibits that were not consumed, but that the evidence before the Inquiry indicates that some exhibits may not have been returned to NSWPF and may have remained with FASS.[5352] This was submitted to have occurred with certain hair samples, with a view to their being examined at a later date "if deemed necessary". [5353]

6.258. Significantly, the NSWPF noted the oral evidence of Assistant Commissioner Rashelle Conroy, during the Investigative Practices Hearing, that the 1976 instruction permitted an exhibit to be destroyed after it had been analysed.[5354] It was accepted by the NSWPF in submissions that a record of the destruction of any exhibits should have been made, however given the length of time since the death, it was not possible to determine where the disposal of such a record, if it existed, would itself have breached proper police practice.[5355]

6.259. Without a record of destruction or the disposal of that record and the rationale for doing so, the loss or destruction of many documents and exhibits remains unexplained.[5356] The destruction of exhibits is discussed further in **Chapter 8**.

Lost forensic opportunities

6.260. The expert certificate of Dr Bruce sets out the contemporary testing that may have been able to be carried out on the items that were lost. Of particular relevance:[5357]

a. The semen detected on penile and anal swabs taken from Mr Head post-mortem, and on a handkerchief located at the scene, may have been suitable for DNA testing. Semen is a high yield DNA source. Tests of the semen on the handkerchief in 1976 indicated a mixture of blood groups, one consistent

[5348] Submissions of NSWPF, 24 October 2023, [16], [23] (SCOI.86371).

[5349] Submissions of NSWPF, 24 October 2023, [17] (SCOI.86371).

[5350] Submissions of NSWPF, 24 October 2023, [13], [17] (SCOI.86371).

[5351] Submissions of NSWPF, 24 October 2023, [13] (SCOI.86371) citing Exhibit 64, Tab 53, Expert Certificate of Dr David Bruce, 30 May 2023 (SCOI.85120).

[5352] Submissions of NSWPF, 24 October 2023, [14] (SCOI.86371).

[5353] Submissions of NSWPF, 24 October 2023, [15] (SCOI.86371) citing Exhibit 64, Tab 4, Expert Certificate of Paul Connellan, 17 September 1976, 5 (SCOI.11039.00036).

[5354] Submissions of NSWPF, 24 October 2023, [18] (SCOI.86371) citing Transcript of the Inquiry, 4 July 2023, T4838.22–27 (TRA.00072.00001).

[5355] Submissions of NSWPF, 24 October 2023, [19] (SCOI.86371).

[5356] Submissions of Counsel Assisting, 19 October 2023, [94] (SCOI.86354).

[5357] Exhibit 64, Tab 53, Expert Certificate of Dr David Bruce, 30 May 2023, [4] (SCOI.85120).

with Mr Head and the other with an unknown contributor. The identity of the unknown contributor may have been significant;

b. The saliva detected on several of the cigarette butts may have been suitable for DNA testing, although the potential target areas for DNA testing may have been consumed by the testing conducted in 1976;

c. Human blood was detected on multiple items (including a radio, knives, trousers, bedding and scraps from the crime scene). Blood typing conducted in 1976 was consistent with the blood having originated from Mr Head; however, in relation to some testing that was incomplete (due to an insufficient sample or unsuccessful testing), modern testing may have been able to yield a DNA profile; and

d. Hair samples recovered from the crime scene could have been microscopically examined and, if the hair was human, subject to either nuclear or mitochondrial DNA testing.

6.261. Dr Bruce qualified that the potential recovery of DNA from items would depend upon the amount of sample available on the exhibit following the testing carried out in 1976 and the degradation of DNA over time, particularly if not stored optimally. Nonetheless, there may have been sufficient information for direct comparison to reference DNA profiles and for searching on DNA databases, and mitochondrial DNA sequencing could be used if the nuclear DNA component was too degraded for testing.

6.262. While the palm print was sufficient to identify a person of interest in relation to Mr Head's death, this does not detract from the observation that the loss of exhibits in Mr Head's case was unsatisfactory and has hampered the full reinvestigation of Mr Head's death.

6.263. DNA testing of exhibits may have assisted in confirming the identity of Mr Simsek. It also could have shed light on other aspects of the circumstances of Mr Head's death. For example, it would be highly probative to ascertain whether it was Mr Simsek or a third person who had sexual intercourse with Mr Head shortly prior to his death. It also could have shed light on whether Mr Simsek was likely in the unit with Mr Head alone or with another person who also may have been involved in the death.

6.264. While DNA testing was not foreseeable in 1976, physical evidence was nonetheless important for other kinds of forensic testing at that time. It should have been obvious by reference to the technology of the day, including blood typing, that *at least* the handkerchief should have been retained as evidence, if not also the knives, cigarettes and human hairs. If a person of interest had emerged, it may have been critically important to prove in later proceeding that the substance was indeed semen, and that the semen was group O, PGM 2-1, as the DAL testing had indicated.

6.265. The NSWPF submitted that DNA testing did not exist in 1976, could not have been foreseen and did not form part of routine police practices for more than 20 years thereafter.[5358] Although expressing some doubt as to whether forensic analysis could have "confirm[ed] or exclude[d]" the theory that the perpetrator had sexual intercourse with Mr Head before attacking him, the NSWPF accepted that "the theory arises as a possibility on the evidence, and the absence of the exhibits undoubtedly impedes an effective consideration of this theory".[5359]

6.266. With regard to the above, I conclude that the loss of exhibits was not consistent with proper police practice, including when judged by the standards of the day. Had Mr Simsek been alive or had another suspect been identified, the loss of the exhibits might have seriously impaired the prospects of a successful prosecution.

Delay in the identification of Mr Simsek

6.267. Mr Simsek's "record fingerprints" were taken at the Newtown Police Station on 27 July 1980.[5360] Despite being in the possession of police and examinations by the UHT in 2002, 2004 and 2005, his fingerprints were not matched to the palm print from the crime scene until 2023. The Inquiry sought to explore the reasons why the prints were not matched earlier than 2023.

6.268. Ms Reid has provided evidence regarding the process of comparing and matching latent fingerprints to record fingerprints. The latent print is the print found at a scene for which a match is sought. The record print is the print of a known person to which the latent print is compared.

6.269. Ms Reid stated that searching of palm prints (as opposed to fingerprints) was not possible until 2001. The early Automated Fingerprint System, which permitted computerised search from 1985 onwards, had no capability for searching latent palm print impressions. In 1999, Australia began to move towards using NAFIS. This process required the conversion of all hardcopy fingerprint records from binary to greyscale. This process was undertaken for Mr Simsek's records. In May 2001, for the first time, a "rudimentary" palm print matching system was in operation.[5361]

[5358] Submissions of NSWPF, 24 October 2023, [9], [20] (SCOI.86371).

[5359] Submissions of NSWPF, 24 October 2023, [21] (SCOI.86371).

[5360] Exhibit 64, Tab 59, Second Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 20 June 2023, [8] (SCOI.85263).

[5361] Exhibit 64, Tab 59, Second Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 20 June 2023, [11(III)] (SCOI.85263).

6.270. Despite palm print searching being available from 2001, Ms Reid explains that the ability of an automated fingerprint system to match a fingerprint is "highly reliant on the accuracy of its matching fingerprint algorithm".[5362] The process of fingerprint comparison involves fingerprints being digitised and subjected to a "minutiae extraction process", where features within the fingerprint are identified that permit comparison between fingerprints. This process depends upon the quality of the fingerprint image, and factors such as "displacement and rotation, distortion and pressure, or skin condition differences at the time of capture."[5363] These factors can result in "minutiae extraction errors" and the presence of "spurious minutiae".[5364]

6.271. Various upgrades to NAFIS between 2010 and 2013 improved the algorithm to provide greater accuracy in minutiae extraction. In particular, in February 2015, there was an upgrade to the "V11 matcher" which incorporated a new algorithm that provided "greater accuracy and matcher capabilities for future searches."[5365]

6.272. Mr Simsek's record fingerprints were converted from hardcopy to digital format in a process that commenced in early 2000. At that time, Ms Reid suggests that there were likely "spurious minutiae or missing minutiae in the palm print impressions" of Mr Simsek.[5366] The reviews conducted in 2002, 2004 and 2005 were limited by the quality of the original minutiae extraction process in 2000,[5367] and no matches were identified.

6.273. Ms Reid says the V11 matcher upgrade in 2015 is likely to have provided a "more accurate coding" of Mr Simsek's record prints.[5368] In short, Ms Reid states that when the palm print was re-searched in March 2023, NAFIS was "substantially more technically capable of identifying an accurate candidate for matching and less affected by the presence of spurious minutiae than previous iterations."[5369]

[5362] Exhibit 64, Tab 59, Second Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 20 June 2023, [11] (SCOI.85263).

[5363] Exhibit 64, Tab 59, Second Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 20 June 2023, [11] (SCOI.85263).

[5364] Exhibit 64, Tab 59, Second Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 20 June 2023, [11] (SCOI.85263).

[5365] Exhibit 64, Tab 59, Second Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 20 June 2023, [11] (SCOI.85263).

[5366] Exhibit 64, Tab 59, Second Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 20 June 2023, [12] (SCOI.85263).

[5367] Exhibit 64, Tab 59, Second Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 20 June 2023 (SCOI.85263); Exhibit 64, Tab 63, Third Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 19 September 2023, [11] (NPL.9000.0034.0001).

[5368] Exhibit 64, Tab 59 Second Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 20 June 2023 (SCOI.85263); Exhibit 64, Tab 63, Third Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 19 September 2023, [11] (NPL.9000.0034.0001).

[5369] Exhibit 64, Tab 59, Second Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 20 June 2023, [12] (SCOI.85263).

6.274. Ms Reid indicated that NAFIS is an ACIC system provided through the vendor IDEMIA (formerly known as Morpho). It was utilised in a Morpho Technology Benchmark in 2013 to compare the accuracy between the V10 and V11 algorithms.[5370] Subsequently, in November 2013, Morpho provided "Capacity Extension and Enhancement Proposal" to CrimTrac (prior to its 2016 merger with the ACC to form the ACIC).[5371]

6.275. Ms Reid advised that the V11 technology was deployed as a part of the "broader NAFIS Capacity Extension and Enhancement Project" delivered to all States and Territories in April 2015.[5372] Ms Reid further advised that there was no option for any State and Territory to "opt out" or retain previous versions of NAFIS.[5373] It therefore appears that the V11 matcher technology that enabled the identification of Mr Simsek's palm print in 2023 was not available to the NSWPF prior to when it was obtained in 2015.

6.276. In conference with the Inquiry, Jeremy Johnson and Andy Waugh of ACIC advised that the V11 matcher technology showed a significant increase in accuracy from the previous version in identifying latent palm prints, particularly for marginal prints where the reference print and/or the target print are of poor quality. The matcher technology returns a list of possible candidates for a match, and the newer technology means a genuine match is more likely to be close to the top of the list.[5374]

6.277. In short, it would appear that the failure to match the fingerprint records of Mr Simsek to the bloody palm print at the time of the reviews in 2002, 2004 and 2005 was, in part, a reflection of the limitations in fingerprint identification technology at the time, as well as being potentially influenced by a number of other factors. In addition to the update in technology, the likelihood of finding a palm print match is also dependent on the work of the fingerprint expert in reviewing the candidates returned by the matching technology, as well as on the quality of the coding of the latent palm print.

6.278. On the totality of the evidence, I consider that no criticism should be made of the NSWPF for failing to match the bloody palm print to Mr Simsek at the time of each of the earlier UHT reviews.

[5370] Exhibit 64, Tab 80, Fourth Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 18 October 2023, [9] (NPL.9000.0039.0001).

[5371] Exhibit 64, Tab 80, Fourth Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 18 October 2023, [9] (NPL.9000.0039.0001); Exhibit 64, Tab 81, Statement of Penelope Smith, 31 October 2023, [9] (SCOI.86391).

[5372] Exhibit 64, Tab 80, Fourth Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 18 October 2023, [10] (NPL.9000.0039.0001).

[5373] Exhibit 64, Tab 80, Fourth Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 18 October 2023, [11] (NPL.9000.0039.0001).

[5374] Exhibit 64, Tab 81, Statement of Penelope Smith, 31 October 2023, [10]–[11] (SCOI.86391).

Automatic searching and the need for regular reviews of latent prints

6.279. Although the V11 matcher technology was available from 2015, Ms Reid notes that NAFIS did not have the capability to *automatically* re-search latent or record prints already on the database. That is, the search of the latent fingerprint would need to be manually initiated by a fingerprint examiner.[5375] No such search was initiated in Mr Head's case between 2005 and 2023. The 2023 search was the first time the fingerprints had been searched using the V11 matcher technology.

6.280. Mr Head's case highlights the importance of frequent and regular reviews of unidentified latent fingerprints and palm prints held by the UHT, particularly following upgrades to fingerprint analysis technology. The continuing growth of the fingerprint and palm print database is another reason why cases should be reconsidered from time to time.

6.281. The Inquiry sought further information about the process of automated searching on the NAFIS database. Ms Reid provided the following evidence:[5376]

a. Any latent fingerprint obtained from a crime is encoded by the minutiae extraction process (automated or manual). If that latent fingerprint is not identified against the NAFIS database, it is registered on the Unsolved Latent database;

b. Record fingerprints are those captured by police employees. All record prints are subject to a quality assurance process. Most record prints are uploaded on the NAFIS database, but some are not (such as visa applicants or adoption applicants). However, all newly entered record prints are automatically searched against the Unsolved Latent database, in a process called the Tenprint to Unsolved Latent (**TP/UL**) search;

c. By contrast, there is no capacity for automatic or periodic searching of an unsolved latent print against the NAFIS database. These searches need to be initiated manually; and

d. If a latent print is identified by a NAFIS search and verified by a fingerprint expert, a notification of the result will be issued on EFIMS.

6.282. Because Mr Simsek's prints were a conversion set of prints, rather than a new record print, a TP/UL search was never initiated in relation to Mr Simsek's prints.

6.283. In respect of other cases considered by the Inquiry in which there remain unidentified prints, the latent prints have been searched against the current NAFIS database using the existing technology. They have also been registered indefinitely on the Unsolved Latent database, so that any new record prints captured by the NSWPF will be automatically compared to those prints and there should be an automatic notification of any future matches.[5377]

[5375] Exhibit 64, Tab 63, Third Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 19 September 2023, [16] (NPL.9000.0034.0001).

[5376] Exhibit 64, Tab 63, Third Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 19 September 2023, [13]–[17] (NPL.9000.0034.0001).

[5377] Exhibit 64, Tab 63, Third Expert Certificate of Kate Reid, Senior Crime Scene Officer – Fingerprint Expert, 19 September 2023 (NPL.9000.0034.0001).

6.284. However, as Mr Head's case reveals, a forensic opportunity may be lost if no search of a latent fingerprint is initiated against *existing* record prints following upgrades in technology. This case demonstrates the importance of ensuring the retesting of exhibits at appropriate times. The 2015 V11 upgrade ought to have prompted the UHT to resubmit any unidentified latent print for reexamination. Future upgrades to fingerprint comparison technology should similarly prompt a UHT review.

6.285. NSWPF submitted that the reexamination of any identified latent prints poses "significant practical impediments".[5378] NSWPF stated that the UHT team would have been required to work through the extant unsolved cases to identify cases that contained fingerprint evidence.[5379] Those identified would have needed to be provided to FETS, before a manual search is performed to establish which cases have unidentified latent prints. These prints would then need to be scanned into NAFIS to be searched against prints in that system.[5380]

6.286. In supplementary submissions, Counsel Assisting noted that further information received from both Ms Reid and from the ACIC indicates that there may be a balance to be struck between reconsidering cases periodically and resource management.[5381] Reconsidering palm prints and fingerprints requires the allocation of time by the reviewer, with the amount of time dependant in part on how many possible match candidates the reviewer determines to analyse in the list produced by the matcher technology.

6.287. By February 2015, being the time that the technology was available to match the palm print from the crime scene to Mr Simsek, Mr Simsek had been deceased for over 15 years. Accordingly, there is no basis to conclude that a further fingerprint review between 2015 and 2023 would have created the possibility of a criminal prosecution against Mr Simsek.

Manner and cause of death

6.288. Counsel Assisting submitted that I should make the following finding, consistent with Coroner Nash, regarding the manner and cause of death of Mr Head:[5382]

> *Ernest Head died on or about 17 June 1976 in Summer Hill from wilfully inflicted stab wounds of the chest and abdomen.*

6.289. The NSWPF supports a finding in these terms being made.[5383]

6.290. I accept that a finding in those terms is appropriate and should be made.

[5378] Submissions of NSWPF, 24 October 2023, [38] (SCOI.86371).

[5379] Submissions of NSWPF, 24 October 2023, [38] (SCOI.86371).

[5380] Submissions of NSWPF, 24 October 2023, [38] (SCOI.86371).

[5381] Supplementary Submissions of Counsel Assisting, 31 October 2023, [6] (SCOI.86429) citing Exhibit 64, Tab 81, Statement of Penelope Smith, 31 October 2023 (SCOI.86391).

[5382] Submissions of Counsel Assisting, 9 October 2023, [198] (SCOI.86054).

[5383] Submissions of NSWPF, 24 October 2023, [49] (SCOI.86371).

Bias

6.291. As set out above, the available evidence supports there being a temporal proximity between Mr Head engaging in sexual activity with a man, and the excessive, frenzied and/or panicked attack on him. This temporal proximity raises the possibility that the attack was committed in response to, or as a result of, the sexual activity which just took place. This being the case, there is a real possibility that Mr Head's death was motivated by LGBTIQ bias (including, for example, disgust or anger at having participated in sexual intercourse with a man).

6.292. The theft of property from Mr Head's unit does not exclude the possibility of LGBTIQ bias. It is impossible, as Dr Sullivan observed, to determine whether this was a primary or secondary motive. It is unlikely that theft could provide the only motive for Mr Head's death — noting that the injuries that were inflicted went significantly beyond what would be required to effect a robbery, and the apparent connection between the injuries and the sexual intercourse. A binary distinction should not be drawn between a robbery and a bias crime, as this would fail to recognise the possibility that LGBTIQ bias may still be a factor in a property offence.

6.293. The NSWPF agreed with the submission of Counsel Assisting that there is reason to suspect that Mr Head's death was motivated in whole or in part by LGBTIQ bias.[5384] The NSWPF further agreed that the potential presence of a robbery motivation would not exclude the possibility that LGBTIQ bias played a role in Mr Head's death.[5385]

6.294. Having regard to the whole of the available evidence, I conclude that there is objectively reason to suspect that the attack was motivated by LGBTIQ bias, either in whole or in part. However, without further information as to the attacker's motivations or biases, or the precise circumstances surrounding Mr Head's death, it is not possible to arrive at any more positive conclusion.

Conclusions and recommendations

6.295. I make the following finding in relation to the death of Mr Head:

> *Ernest Head died on or about 17 June 1976 in Summer Hill from wilfully inflicted stab wounds of the chest and abdomen.*

6.296. The person who inflicted the stab wounds is unknown. While evidence indicates that Mr Simsek was involved in Mr Head's death, I cannot make a positive finding regarding the role that he played.

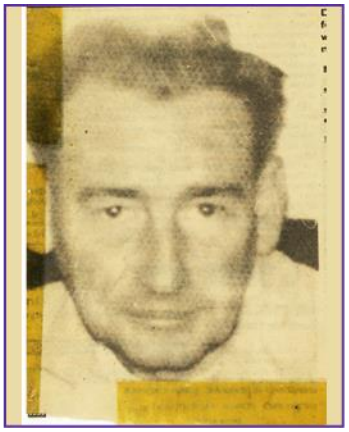
[5384] Submissions of NSWPF, 24 October 2023, [46] (SCOI.86371).

[5385] Submissions of NSWPF, 24 October 2023, [48] (SCOI.86371).

6.297. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in Mr Head's death.

6.298. I do not propose to make any specific recommendations arising from the Inquiry's consideration of Mr Head's death. Global recommendations in relation to the retention, preservation and storage of exhibits are discussed in **Chapter 8.**

IN THE MATTER OF BARRY JONES



Factual background

Date and location of death

6.299. Barry Jones died from multiple stab wounds on 26 September 1976 at the grandstand in Five Dock Park, Five Dock, sometime after 10:00pm. He was 41 years old at the time of his death.

Circumstances of death

6.300. Mr Jones lived at Walker Avenue, Haberfield with his cousin, Kenneth Grant, and Mr Grant's de facto partner, Carol Grant. He worked as a labourer for Drummoyne Municipal Council.[5386] He appears to have spent most of his time outside of work drinking and socialising at pubs and clubs in the Five Dock area, where he was well known by other locals.

6.301. On Sunday, 26 September 1976, Mr Jones left home at about 10:00am, having told Mr Grant that he was going to the local bowling club for a drink and suggested that Mr Grant join him. Mr Grant did not join Mr Jones there but did meet up with him later in the day.[5387]

6.302. Mr Jones arrived at the Five Dock Bowling Club (the **Bowling Club**) sometime before midday, where he drank with a local couple who he knew, Elizabeth ("Lil") Adair and Robert ("Bob") Adair. As a result of a past incident, Mr Jones was on a curfew at the Bowling Club and required to leave before 2:00pm.[5388] Mr Jones left the Bowling Club at around that time.[5389]

[5386] Exhibit 41, Tab 12, Statement of Kenneth Grant, 27 September 1976, 1 (SCOI.10495.00023).

[5387] Exhibit 41, Tab 12, Statement of Kenneth Grant, 27 September 1976, 2 (SCOI.10495.00023).

[5388] Exhibit 41, Tab 6, Statement of Detective Sergeant Donald McCusker, 6 December 1977, [7] (SCOI.10495.00015).

[5389] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 83-85, 141 (SCOI.83626).

6.303. After leaving the Bowling Club, Mr Jones went to the Western Suburbs Soccer Club (the **Soccer Club**). Between 3:00pm and 3:30pm, Mr Grant met Mr Jones in the foyer of the Soccer Club. They went to the lounge and sat with Jimmy Briggs, a friend of Mr Jones. Mr Grant stayed with them for about half an hour, before leaving at about 3:30pm.[5390]

6.304. There are very different accounts as to when Mr Jones left the Soccer Club that evening. These are considered below.

6.305. Whatever time he left the Soccer Club, Mr Jones ended up in the vicinity of the grandstand in Five Dock Park, most likely sometime between 10:00pm and midnight. The grandstand was (and is) in an open park and could be accessed by any person, day or night.

6.306. At around 7:15-7:20am the following morning (Monday, 27 September 1976), the body of Mr Jones was found at the top of the grandstand in Five Dock Park by Aldo Zajc, a gardener employed by Drummoyne Municipal Council. Mr Zajc reported the matter to Five Dock Police Station.[5391]

6.307. Mr Jones had been stabbed at least 53 times in the back, the underside of the left arm, the right side of his chest, and the stomach area. In addition, one wound in the left side of his chest measured 14cm by 10cm and had been caused by further repeated knife blows. Mr Jones also suffered cuts to his throat.[5392]

6.308. A knife was found sticking out of Mr Jones' chest, with the blade driven fully into his body. The knife was distinctive — it was a Black Eagle hunting knife with a 5 inch blade, and a 5 inch black handle made of buffalo horn. The handle was carved into the shape of a hoof.[5393]

6.309. Mr Jones was fully dressed when he was found. He was wearing black shoes, fawn socks, fawn trousers, a belt, white underpants, a yellow t-shirt, blue shirt, red jumper and a grey cardigan. He had a watch on his left wrist and had $2.26 in coins on his person.

Identification of this case by the Inquiry

6.310. On 6 June 2022, the Inquiry obtained a copy of the UHT Tracking File, as outlined in the introduction to **Chapter 5**.

6.311. Mr Jones was listed as a victim in that file. The file recorded that Mr Jones' death had associated factors of "Possible Homosexual Hate Crime" and "Homosexual Hate Crime Related". On that basis, the Inquiry identified Mr Jones' death as possibly falling within Category B of the Terms of Reference. The Inquiry proceeded to conduct its own review and investigations in relation to the death of Mr Jones.

[5390] Exhibit 41, Tab 12, Statement of Kenneth Grant, 27 September 1976, 2 (SCOI.10495.00023).

[5391] Exhibit 41, Tab 8, Statement of Aldo Zajc, 30 September 1976 (SCOI.10495.00020).

[5392] Exhibit 41, Tab 2, Post-mortem Report of Dr William Brighton, 27 September 1976, 1–2 (SCOI.10495.00016).

[5393] Exhibit 41, Tab 7, Memorandum from Detective Sergeant Donald McCusker, 'Inquiries as to knife', 24 September 1976, 1 (NPL.2015.0001.1065).

6.312. The evidence obtained by the Inquiry in relation to Mr Jones' sexuality is ambiguous.[5394]

6.313. In January 1977, police spoke to I375, a gay man who was said to be a member of the gay rights lobby group, CAMP. I375 told police that Five Dock Park had been "a regular meeting place for homosexuals, until about 18 months ago", but that it had ceased to be a "recognised meeting place" although "on occasion homosexuals are seen there".[5395] I375 expressed the view that Mr Jones may have been killed as a result of "friction between the 'gay' and 'square' faction of the area." It appears that Five Dock Park had been a beat and may still have been used as a beat at the time of Mr Jones' death.

6.314. Although the original investigators did not explicitly record a theory that the homicide had occurred at a beat and may have involved LGBTIQ bias, it seems evident that investigators were alive to the possibility that Mr Jones may have been a member of the LGBTIQ community and/or that his death may have occurred in circumstances that had been preceded by a sexual act. Investigators frequently asked witnesses about Mr Jones' sexuality. They received information about, and from, men whom they pointedly described as "homosexual".[5396]

6.315. That the original investigators seem to have entertained such a theory may also be related to their receipt of information that semen had been identified on a penile swab, on Mr Jones' underpants and on his trousers. However, caution is necessary in drawing any inference from this evidence in view of the potential for the semen to have been a post-mortem artefact. This is discussed in greater detail below.

6.316. Further, the gratuitous infliction of wounds well in excess of those necessary to bring about death is indicative of a frenzied attack and would be consistent with a hate-based motivation for killing Mr Jones.

Previous investigations

Post-mortem investigation

6.317. On Monday, 27 September 1976, Dr William Brighton examined Mr Jones' body *in situ*. He noted that rigor mortis was complete and post-mortem lividity was fixed.[5397] Later on the same day, Dr Brighton conducted a more detailed post-mortem examination at the mortuary. He concluded that Mr Jones died as a result of haemorrhage and respiratory failure, as a result of multiple stab wounds to the chest and abdomen.[5398]

[5394] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 6, 28, 58, 76–77, 95, 122, 132, 135 (SCOI.83626).

[5395] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 148 (SCOI.83626).

[5396] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 11 (SCOI.83626).

[5397] Exhibit 41, Tab 2, Post-mortem Report of Dr William Brighton, 27 September 1976, 2 (SCOI.10495.00016).

[5398] Exhibit 41, Tab 2, Post-mortem Report of Dr William Brighton, 27 September 1976, 1–2 (SCOI.10495.00016).

6.318. Dr Brighton noted that it was possible to see the interior of Mr Jones' chest through the large wound.[5399] The main cut to Mr Jones' throat was approximately 10cm in length but had not carried through into the larynx or trachea.[5400] There were no defensive cuts on Mr Jones' hands, although there was a single stab wound near the left wrist.[5401]

6.319. Dr Brighton concluded that several of Mr Jones' injuries had been inflicted after his death, including the massive wound to the left chest area, the slashing of the throat and the two wounds to the front thoracic area (including the wound in which the knife was found).[5402]

6.320. Mr Jones had a blood alcohol level of ".350".[5403]

Original police investigation

6.321. The OIC of the original police investigation was Detective Sergeant Donald McCusker. In his statement made in 1977 he noted that the investigation had involved speaking to over 400 persons including Mr Jones' drinking friends and patrons of the clubs and hotels he frequented. According to Detective Sergeant McCusker, among other things this established that Mr Jones had no known enemies, that he had never been seen to be engaged in fights or arguments, and that he had "no known female associates".[5404]

Crime scene and local area

6.322. There was a large amount of blood around Mr Jones' feet, and around his shoulders and chest. There was a continuous stream of blood running down the 16 steps of the grandstand. There were blood smears on the wall behind Mr Jones' right foot, at a height of 3'6".[5405]

6.323. There appeared to be bare footprints in the blood around Mr Jones' feet. Further such prints were located on the concrete path at the entrance to the grandstand. A partial impression of a shoeprint, most likely from a rubber thong, was also found in blood near the body.[5406]

6.324. On 28 September 1976, police identified graffiti at various locations in Five Dock Park, mostly written in chalk. This included the words "I KILLED THE JUY (sic) IN THE PARK" written in chalk on the path behind the Bowling Club.[5407]

6.325. Police extensively canvassed houses in the area around Five Dock Park.[5408]

[5399] Exhibit 41, Tab 2, Post-mortem Report of Dr William Brighton, 27 September 1976, 2 (SCOI.10495.00016).
[5400] Exhibit 41, Tab 2, Post-mortem Report of Dr William Brighton, 27 September 1976, 2 (SCOI.10495.00016).
[5401] Exhibit 41, Tab 2, Post-mortem Report of Dr William Brighton, 27 September 1976, 2 (SCOI.10495.00016).
[5402] Exhibit 41, Tab 2, Post-mortem Report of Dr William Brighton, 27 September 1976, 2 (SCOI.10495.00016).
[5403] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 11 (SCOI.83626).
[5404] Exhibit 41, Tab 6, Statement of Detective Sergeant Donald McCusker, 6 December 1977, [16] (SCOI.10495.00027).
[5405] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 6 (SCOI.83626).
[5406] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 7 (SCOI.83626).
[5407] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 9 (SCOI.83626).
[5408] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 29–53 (SCOI.83626).

6.326. At around 10:20pm on 26 September 1976, Peter Kohlenberg was at home at Park Road, Five Dock when he heard a scream. He got up and looked through his window. He saw a car about 50 yards further down the road towards the grandstand. He saw a female in the passenger seat and another person in the driver seat. He returned to bed. He saw persons coming and going from the vehicle. He saw a female enter the front passenger seat and close the door. He stated that the vehicle was parked in the vicinity of 41 Park Avenue.[5409]

6.327. Carmelia Calleja was also at home at Park Road. She recalled hearing a woman scream at about 10:15pm. She looked out the window and saw nothing.[5410]

Canvasses of pubs and clubs

6.328. Police conducted extensive canvassing of the pubs where Mr Jones drank. The evidence of the patrons provides a detailed, but somewhat conflicting picture of Mr Jones' movements prior to his death.

6.329. On the day before his death, Saturday, 25 September 1976, Mr Jones attended the Five Dock Hotel, where he drank with Jack Thornberry, Lorna Thornberry, Lil Adair, Lulu Booth and Betty Collins.[5411] It appears that he arrived at around 11:45am and left at closing time.[5412]

6.330. On Sunday, 26 September 1976, Mr Jones attended the Bowling Club, arriving before midday and leaving at around 2:00pm in accordance with his curfew. After leaving the Bowling Club, Mr Jones attended the Soccer Club, where he met Mr Grant. They were together at the Soccer Club until around 3:30pm.

6.331. Police running sheets record in detail the efforts of police in interviewing a very large number of patrons of the Soccer Club on the afternoon and evening of 26 September 1976. These include records relating to 13 individuals who asserted that they saw Mr Jones either in or outside the club at times ranging between 3:00pm and 10:15pm.[5413]

Canvasses of taxi services and evidence in relation to Mr Jones' departure from the Soccer Club

6.332. Police also interviewed various cab drivers who picked up jobs from the Soccer Club on the evening of 26 September 1976.

6.333. William Fuller, a cab driver with Cumberland Cabs, recalled picking up a couple from the Soccer Club at about 10:30pm on 26 September 1976. He recalled calling out to another male, who he thought was also waiting to be picked up. He said that he thought this man was Mr Jones, but this man waved his arms as if to indicate that he did not want to get into the cab. Mr Fuller remarked that the man

[5409] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 37, 42 (SCOI.83626).

[5410] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 37 (SCOI.83626).

[5411] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 92-93, 133, 140–144 (SCOI.83626).

[5412] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 94-95, 136–140 (SCOI.83626).

[5413] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 134 (SCOI.83626).

seemed "a bit full" and called over the radio that "the fare is an M6" (which was code for an unacceptable or drunk passenger).[5414]

6.334. Yuri Shewchyk was a radio operator at Cumberland Cabs. He worked the evening shift on 26 September 1976. He called a job over the radio at 10:11pm to pick up a booking in the name of "McColl" at the Soccer Club to take two passengers to Ashfield. At 10:14pm, he also called a job in the name of 'Adair' from the Soccer Club to Five Dock. According to Mr Shewchyk, Mr Fuller (driving car 303) acknowledged that he would do both jobs. Shortly after, Mr Fuller radioed back and said he could not locate Mr Adair. Mr Fuller said there was another fellow by the name of Jones who wanted to go to Haberfield but that he could not do the job because it was too wide a sweep from the route to Ashfield.[5415]

6.335. Police located Florence McColl and Fred Williams, a couple who had been the passengers in Mr Fuller's cab. They did not recall the name of the person who tried to share their cab that night. Mr Williams said that he and this other person had used the telephone to book their cabs. He recalled that this other person was smoking (Mr Jones did not smoke) and wearing a grey suit, collar and tie (Mr Jones was wearing different clothes).[5416]

6.336. Mr Shewchyk recalled that, after Mr Fuller dropped the "McColl" booking at Ashfield, at 10:22pm Mr Fuller acknowledged a job for "Jessing" at the Bowling Club for two passengers to Burwood. According to Mr Shewchyk, Mr Fuller went to that club and there were no passengers waiting, and so at 10:28pm, Mr Shewchyk asked Mr Fuller if he wanted to return to the Soccer Club for "Jones". He also gave Mr Fuller a job in the name of "Young" to go to Summer Hill. Mr Fuller returned to the Soccer Club and collected "Young". According to Mr Shewchyk, Mr Fuller told him that the passenger "Young" was unwilling to share the cab with "Jones" and that "Jones" was an "unacceptable passenger".[5417]

6.337. The inconsistencies between the accounts of Mr Fuller and the radio operator are to some extent explained by the account given by Robert Adair Sr., who said that he was the person who had booked the cab to share with McColl, and had been refused service, which was consistent with Mr Williams' description of the person and the records of Cumberland Cabs.[5418]

[5414] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 –27 May 1977, 97 (SCOI.83626).

[5415] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 99–100 (SCOI.83626).

[5416] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 98 (SCOI.83626).

[5417] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 99–100 (SCOI.83626).

[5418] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 98, 105 (SCOI.83626).

6.338. Trevor Calland was another cab driver at Cumberland Cabs. He recalled two jobs being called in on the radio on 26 September 1976 at about 10:30pm from the Soccer Club, one to Haberfield and one to the Petersham area. He heard one driver offer to take the Petersham area. The operator said that a "Mr Jones" had been waiting for a while and asked if that cab could take him as well and drop him at Haberfield. The driver said that would be okay. Mr Calland later heard the driver tell the operator that "Mr Jones" was "pretty full" and that the other party was not prepared to share the cab with him. Mr Calland said he recalled the incident because he had taken Mr Jones home a couple of times.[5419]

6.339. Marjorie Hayman attended the Soccer Club on 26 September 1976 from about 5:30pm to 10:30pm. She had known Mr Jones for the past two years. She told police she saw Mr Jones in the club on the Sunday night, but she could not recall which part of the club. She stated that when she left the club at about 10:30pm, she saw Mr Jones outside the club premises, and she saw him get into a taxi alone.[5420]

6.340. Conflicting with Ms Hayman's account and also some of the evidence from the taxi company witnesses was the account of Alan Grimes, who had become acquainted with Mr Jones as a drinking companion over six years at the Five Dock Hotel. On 26 September 1976, Mr Grimes left home at 10:16pm to drive his wife to work. Shortly after departing, he saw Mr Jones outside Soul Pattinsons Pharmacy in Great North Road, Five Dock. Mr Jones was attempting to hitchhike at that time. Mr Grimes did not see Mr Jones when he drove past that location again 20 minutes later.[5421]

6.341. At approximately 10:40pm a motorist, Lawrence McEnally, passed a man walking towards Haberfield, in Ramsay Road, Five Dock (near the Motor Vehicle Registry that then existed at 1 Ramsay Road). The man was hitchhiking and walking in the gutter, and Mr McEnally's description of the man broadly matched that of Mr Jones.[5422] The location of this sighting was en route towards Mr Jones' home from the location of the possible sighting by Mr Grimes of Mr Jones at 10:16pm in Great North Road.

Canvasses of co-workers

6.342. Police interviewed Mr Jones' co-workers at Drummoyne Municipal Council. None of Mr Jones' co-workers could identify anyone who would have wished him harm. He was often referred to with terms such as "harmless" and "inoffensive". He was also generally described as spending all his spare time outside of work drinking at different establishments and was said to suffer from alcoholism.[5423]

[5419] Exhibit 41, Tab 11, Statement of Trevor Calland, 11 October 1976 (SCOI.83625).

[5420] Exhibit 41, Tab 10, Statement of Marjorie Hayman, 2 October 1976 (SCOI.83624).

[5421] Exhibit 41, Tab 9, Statement of Alan Grimes, 27 September 1976 (SCOI.10495.00021).

[5422] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 86 (SCOI.83626).

[5423] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 17–28 (SCOI.83626).

6.343. One co-worker, Reginald Mullins, recalled Mr Jones recounting an incident where he was beaten by two youths in a laneway near his home. Mr Mullins considered him to be telling the truth. Mr Mullins thought that, after the incident, Mr Jones would not go into a park at night.[5424]

6.344. Another co-worker, Francis Rowland, was a personal friend of Mr Jones. In September 1975, Mr Rowland, Mr Jones and Jim Riley went on holiday to Surfers Paradise. Mr Rowland said that he and Mr Riley noted that Mr Jones was carrying a large Bowie knife. Mr Jones told them that "it's to protect myself". Mr Riley took the knife from Mr Jones and said he would give it back when they returned to Sydney. Mr Rowland stated that before they went to Surfers Paradise, Mr Jones had been in a fight somewhere in Haberfield. Mr Jones had bruises on his body and had told them that he had been attacked by two men on his way home one night.[5425] Mr Rowland was later shown the knife and said that it was not the same knife.[5426]

Other investigative steps

6.345. In his statement dated 6 December 1977, Detective Sergeant McCusker outlined the range of investigative steps that were taken by police. In addition to the broad canvas of hotels and clubs, those steps included:

a. Locating and interviewing all "local criminals";

b. Checking all hospitals to see if any persons had been treated on the night in question, and interviewing those persons;

c. Contacting all dry cleaners in the Metropolitan area. This yielded some bloodstained clothing (including, it seems the raincoat which was forensically examined – see below) but none of items were considered to be relevant to the investigation;

d. Locating and interviewing all attendees at Mr Jones' funeral;

e. Visiting local psychiatric hospitals;

f. Making appeals for information through the media; and

g. Offering a reward of $10,000.[5427]

6.346. On 30 September 1976, police made inquiries about the knife. They spoke to Bruce Angus and Douglas Angus, the managing directors of Sheldon and Hammond Pty Ltd (**Sheldon and Hammond**), which reportedly imported 90% of all sporting knives into Australia. They identified the knife as a "Black Eagle", made by J Nowill & Sons. On inspection of the knife, Bruce Angus stated that it had seen a lot of use and was between 15 and 25 years old.[5428]

[5424] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 28 (SCOI.83626).

[5425] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 63 (SCOI.83626).

[5426] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 68 (SCOI.83626).

[5427] Exhibit 41, Tab 6, Statement of Detective Sergeant Donald McCusker, 6 December 1977, [12]–[18] (SCOI.10495.00015). See also Exhibit 41, Tab 26, Reward for information, 10 October 1977 (NPL.2015.0001.1125).

[5428] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 91 (SCOI.83626).

6.347. On 7 October 1976, Mr Angus further stated his firm had imported the knife up until 1964 and at that time, it had been the sole importer from the knife manufacturers. Sheldon and Hammond stopped dealing with the manufacturers in 1972. He could not say if the knife was imported by any other firm since 1964.[5429]

6.348. Police received many reports of people who reportedly possessed knives similar to that used in the assault on Mr Jones. Investigation of those reports did not result in police identifying any persons of interest.

Exhibits: Availability and testing

6.349. In late 1976, various exhibits were provided to Robert Goetz, microbiologist, for forensic testing:

a. Blood sample, penile swab and smear, anal swab and smear, hair sample and fingernail cuttings from Mr Jones;

b. Knife located in Mr Jones' body;

c. Raincoat from Florida Dry Cleaning Co.;

d. Pair of white underpants and fawn trousers worn by Mr Jones;

e. Pair of white ladies' shoes belonging to Carol Grant;

f. White and red torch collected from Kenneth Grant's car;

g. Seiko watch and silver chain belonging to Kenneth Grant; and

h. Telephone book, from telephone box in Walker St, Haberfield.

6.350. Semen was located on the swab and smear taken from Mr Jones' penis. Semen stains were also found on the inside front of Mr Jones' underwear and trousers. Testing of the semen established the presence of Group O blood type, which was consistent with the semen being that of Mr Jones. Semen was not detected on the anal swab and smear.[5430]

6.351. Mr Goetz estimated that the semen would have been present within 15 hours before Mr Jones' death. He could not determine whether Mr Jones had ejaculated in his pants or outside his pants, with the stains caused when he replaced his penis inside his pants.[5431]

6.352. The Inquiry has received expert evidence relevant to these matters in other cases, such as the death of Paul Rath. In her report in relation to that death, Dr Linda Iles observed that the presence of semen on a penile swab should not necessarily be considered significant if the profile is consistent with that of the deceased, as its presence can be a post-mortem phenomenon.[5432]

[5429] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 91 (SCOI.83626).

[5430] Exhibit 41, Tab 3, Report of Robert Goetz, 5 November 1976, 2–3 (SCOI.10495.00028).

[5431] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 12-13 (SCOI.83626).

[5432] Exhibit 26, Tab 34, Expert Report of Dr Linda Iles, 26 October 2022, 8 (SCOI.82906).

6.353. Blood was found on a number of the items that were tested. In particular, the torch from Mr Grant's car tested positive to the presence of blood, though in insufficient quantity to enable a blood group to be identified. Blood located on the telephone book was of a different blood type to that of Mr Jones.[5433]

6.354. The knife found in Mr Jones' chest tested positive to blood with a blood grouping consistent with that of Mr Jones. There is no record that it was tested for fingerprints. That matter is discussed further below.

Person of interest: Kenneth Grant

6.355. Police investigated the possibility that Mr Jones had been killed by his cousin, Mr Grant.

6.356. Mr Jones owned the house in Haberfield where he lived with Mr and Ms Grant. In May 1976, 16 months before his death, he had changed his will to leave the house to Mr Grant, and also granted a power of attorney to Mr Grant. In July 1976, Mr Jones and Mr Grant took out a joint personal loan of $2,500 to repay a fine, or restitution order, related to an embezzlement charge against Mr Grant.[5434]

6.357. Ms Rowland, told police that Mr Jones had bought two watches for Ms Grant in the two months prior to his death. Mr Rowland also told police about comments reportedly made by Mr Jones which suggested he may have had sexual interactions with Ms Grant.[5435]

6.358. Mr Grant's financial dealings with Mr Jones, and Mr Rowland's claims, if true, provided plausible motives for Mr Grant to kill Mr Jones.

6.359. Mr Grant provided a statement to police. He claimed that after he left the Soccer Club at around 3:30pm, he drove to his mother's place. He stayed there with his mother, daughter and Ms Grant until he and Ms Grant left at about 4:30pm to 5:00pm. He and Carol drove home, read the papers, drank some coffee and decided to go out for dinner. After getting dinner, they drove home and arrived just before 9:00pm. They watched television and went to bed at about 11:00pm. Mr Grant did not get to sleep until about 12:30am to 1:00am. Mr Jones was not home when he went to sleep, to his knowledge.[5436] When Mr Grant woke up the next morning at 6:50am, Mr Jones was not in the house.[5437]

[5433] Exhibit 41, Tab 3, Report of Robert Goetz, 5 November 1976, 3 (SCOI.10495.00028).

[5434] Exhibit 41, Tab 6, Statement of Detective Sergeant Donald McCusker, 6 December 1977, [20]–[22] (SCOI.10495.00015).

[5435] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 66 (SCOI.83626).

[5436] Exhibit 41, Tab 12, Statement of Kenneth Grant, 27 September 1976, 2–3 (SCOI.10495.00023).

[5437] Exhibit 41, Tab 12, Statement of Kenneth Grant, 27 September 1976, 3 (SCOI.10495.00023).

6.360. Ms Grant confirmed Mr Grant's account of events when interviewed separately by police.[5438] She also confirmed that Mr Jones had bought her various presents over a period of 18 months: three watches, a zodiac pendant, a travelling watch radio, a pop-up toaster and a couple of pairs of shoes. She said that Mr Jones bought the presents cheaply and that he also bought Mr Grant presents such as cigarettes and lighters. Ms Grant claimed that Mr Jones did not give any reason for buying these presents.[5439]

6.361. Ms Grant told police that she and Mr Jones had never had sex and that Mr Jones had never made any sexual advances towards her.[5440]

6.362. Even if Mr Rowland accurately reported what Mr Jones told him, it does not follow that Mr Jones was truthfully suggesting he had had a sexual relationship with Ms Grant. That would appear to contradict the evidence that Mr Jones was not sexually interested in women and that he was uncomfortable about the topic of sex.

6.363. In the days following the homicide, the police seized a number of items of property from the property of Mr and Ms Grant for forensic testing. One of the items, a torch located in Mr Grant's car, tested positive to the presence of blood, though in insufficient quantity to determine the relevant blood group.[5441]

6.364. There was no other evidence to implicate Mr and Ms Grant in the death of Mr Jones. The frenzied nature of the attack does not appear to be consistent with a motive of greed related to inheritance of Mr Jones' house.

Person of interest: NP246

6.365. On 9 October 1976, police separately spoke to I378 (a pseudonym), and her sister I379 (a pseudonym) after receiving information that those individuals may have had knowledge of the persons responsible for the death of Mr Jones.

6.366. I379, aged 15, told police that a group of boys had been boasting that they knew who killed the man in the park. She identified one of those boys as NP246 (a pseudonym) also aged 15, of Minnesota Avenue, Five Dock. I379 did not know the other boys, but described them as "Sharpie" types who hung around the milk bar known as "Alberts" in Great North Road, Five Dock. I378 later confirmed her sister's story but was unable to provide further information.[5442]

6.367. On 11 October 1976, police interviewed NP246. He denied bragging about or knowing who committed the homicide. He claimed that he became aware of the death, when on the school bus, from another young person, I389 (a pseudonym). Police established that I389's house was one of those that had been canvassed by police at an early stage of the investigation, due to its proximity to the park.

[5438] Exhibit 41, Tab 13, Record of Interview with Carol Grant, 2 October 1976, Q3–A3, Q20–A29 (SCOI.83632).

[5439] Exhibit 41, Tab 13, Record of Interview with Carol Grant, 2 October 1976, Q35–A42 (SCOI.83632).

[5440] Exhibit 41, Tab 13, Record of Interview with Carol Grant, 2 October 1976, Q46–A49 (SCOI.83632).

[5441] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 60 (SCOI.83626); Exhibit 41, Tab 3, Report of Robert Goetz, 5 November 1976, 2–3 (SCOI.10495.00028)

[5442] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 123 (SCOI.83626).

6.368. Police questioned NP246 about his whereabouts on the day of Mr Jones' death. Whether NP246 was questioned in the presence of his parents is not clear. The relevant running sheet recorded NP246's version of events and then added that NP246's parents "were also interviewed."[5443]

6.369. NP246's parents said that he arrived home before 9:00pm that night (as NP246 himself also claimed). At the time, NP246 was under the supervision of the Child Welfare Department and was not permitted to be outside his home after 8:00pm.[5444]

6.370. The NSWPF submitted that:[5445]

> *It may be assumed that, even in 1976, investigating police were alive to the potential pitfalls of conducting an interview of a person in the presence of their alibi witnesses. It goes without saying that it would not have been appropriate for the witnesses to be interviewed collectively. There is not, however, any sound basis to positively conclude that such an approach was, in fact, adopted.*

6.371. I do not know, and do not need to determine, whether or not such an assumption is appropriate. The running sheet is ambiguous. I accept the submission of the NSWPF that I cannot positively conclude that NP246 was interviewed in the presence of his parents. However, even allowing for what may have been the different standards of the day, a more accurate and detailed record of the interviews should have been kept so that the circumstances in which they took place were apparent. Certainly, NP246 should have been interviewed separately from his parents.

6.372. NP246 described his movements as follows:[5446]

a. He was at the home of a friend, I390, a pseudonym, in First Avenue, Five Dock, until around 7:00pm. He went home for a few minutes;

b. He then went to the home of another friend, I382 (a pseudonym), in Curtin Avenue, Abbotsford, where he stayed until approximately 8:30pm;

c. He caught a bus to Five Dock and walked home, arriving between 8:45pm and 9:00pm; and

d. He watched television until about 10:30pm, went to bed and did not leave the house again that night.

6.373. I390 and his father subsequently confirmed that NP246 had been at their home on the day of the murder.[5447] I382 and his mother also confirmed that NP246 had been at their home on the day of the murder.[5448]

[5443] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 125 (SCOI.83626).

[5444] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 125 (SCOI.83626).

[5445] Submissions of NSWPF, 10 July 2023, [35] (SCOI.84381).

[5446] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 125 (SCOI.83626).

[5447] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 127 (SCOI.83626).

[5448] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 126 (SCOI.83626).

6.374. Subsequently, on 24 November 1976, police received information from a 14 year old boy that at around the time of the fatal assault, he had heard from a friend, I395 (a pseudonym), that NP246 had committed the assault. The police record made at the time indicated that NP246 would be further interviewed, although there is no record of such an interview taking place.[5449]

6.375. In 1998 police received a further report from a member of the public who had been told that NP246 was responsible for Mr Jones' death.

Person of interest: NP247

6.376. On 18 March 1977, police received information from a member of the public, Mr Albert Hatfield, about a possible suspect for Mr Jones' death. Mr Hatfield reportedly described the man as someone who suffered from schizophrenia and who was "mad keen" on knives, swords and similar weapons.[5450]

6.377. When interviewed on 20 May 1977, Mr Hatfield informed police that the person concerned was his nephew, NP247 (a pseudonym). NP247 lived alone at an address in Abbotsford. Mr Hatfield's mother had bequeathed the house to NP247 in her will.[5451]

6.378. Mr Hatfield advised that NP247 had "confessed" to Mr Hatfield's wife that he was a "homosexual", and that he had had a relationship with a man in Canada. Mr Hatfield described to police an occasion in August 1976 when NP247 had threatened one of his uncles with a sword while saying "I'll kill the bastard". Mr Hatfield asserted that NP247 bore hatred towards this uncle as a result of overhearing the uncle refer to NP247 as a "poofter".[5452]

6.379. Mr Hatfield advised that NP247 sometimes drank at the Five Dock Hotel and at the Soccer Club, and that NP247 knew Mr Jones.[5453] Mr Hatfield also said that he had only recently persuaded NP247 to wear something on his feet. Prior to this, he said that NP247 would wear nothing on his feet, but would now often wear thongs.[5454]

6.380. On 24 May 1977, police again interviewed Mr Hatfield, and subsequently his wife, Marjorie Hatfield. They were shown the knife, which they stated they did not recognise. Ms Hatfield confirmed her husband's account of NP247 describing a relationship he had had with a man in Canada.[5455]

[5449] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 146 (SCOI.83626).
[5450] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 149 (SCOI.83626).
[5451] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 150 (SCOI.83626).
[5452] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 150 (SCOI.83626).
[5453] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 151 (SCOI.83626).
[5454] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 151 (SCOI.83626).
[5455] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 152 (SCOI.83626).

6.381. On 24 May 1977, police interviewed Dr Greenway, Deputy Superintendent of Broughton Hall Psychiatric Centre, regarding NP247, then an out-patient. Dr Greenway described NP247 as "a paranoid schizophrenic who suffers dreams of voices and shadows appearing whilst in a depressed alcoholic state". Dr Greenway attributed NP247's illness to alcoholism and said he was capable of acting responsibly when not under the influence of alcohol.[5456]

6.382. On 25 May 1977, police interviewed NP247. NP247 stated that he probably would have been watching television on the night in question. He told police that he met Mr Jones in June 1976 at the Bald Faced Stag Hotel, Leichhardt and then again, three months prior to his death, at the Five Dock Hotel. They had talked about their drinking and losing weight.[5457] NP247 subsequently contacted police on 26 May 1977 to inform them that he had met Mr Jones at the Five Dock Hotel two weeks before his death, when NP247 had noticed two men aged around 35 years who were acting strangely. NP247 died in November 2001.[5458]

Findings at inquest

6.383. An inquest into Mr Jones' death was held on 26 January 1978.

6.384. Deputy State Coroner Parnell found that Mr Jones died on 26 September 1976 in the grandstand of Five Dock Park, Park Road, Five Dock "from haemorrhage and respiratory failure due to multiple stab wounds to the chest and abdomen inflicted by a person or persons unknown."[5459]

Criminal proceedings

6.385. No criminal proceedings were ever instituted against any person in relation to Mr Jones' death.

Subsequent police investigation

6.386. In August 2005, according to email correspondence before the Inquiry, Inspector Robert Jarrett of the UHT "reviewed the brief", which indicated to him that there were "no real suspects".[5460]

6.387. On 31 August 2005, Inspector Jarrett made a request of the Major Crime Fingerprints section, that the fingerprint evidence in the original brief be reviewed. His understanding was that this principally consisted of some prints located on two posts within the grandstand, and he noted that the utility of any positive match might be limited, as there was no indication in the brief that associated the prints with the offender (as opposed to them belonging to any person who may have attended the grandstand at some time prior to the murder).

[5456] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 153 (SCOI.83626).

[5457] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 154 (SCOI.83626).

[5458] Exhibit 41, Tab 37, Statement of Tom Allchurch, 26 June 2023, [29]–[31] (SCOI.83979).

[5459] Exhibit 41, Tab 1, Findings of Coroner Parnell, Inquest into the death of Barry Jones, 26 January 1978 (SCOI.10495.00002).

[5460] Exhibit 41, Tab 15, Email from Rob Jarrett to Fiona West, 31 August 2005 (SCOI.11028.00002).

6.388. The results of the analysis, provided by email on 23 September 2005, included two fingerprints from the grandstand identified as those of the deceased, and one additional fingerprint from the grandstand not identified. That print was not a match to NP246, nor could it be matched to any known individual via the NAFIS fingerprint database. [5461]

6.389. There is no indication in the material produced to the Inquiry that any further steps were taken by the UHT in 2005 after receipt of these fingerprint results.

6.390. A record created on 7 July 2010 by Detective Chief Inspector Dennis Bray indicates that, on that date, a review of the investigation of Mr Jones' death, conducted by Detective Sergeant Connie Tse, "was considered". This was presumably to have been a review by the UHT, as both of those officers are known by the Inquiry to have been deployed to that unit at around that time. It was concluded, according to Detective Chief Inspector Bray's note, that: "There are no further lines of investigation that can be undertaken to progress this investigation. The deceased had not married and has no surviving relatives."[5462] The material produced to the Inquiry contains no further details which would allow the substance of any such review, if it did take place, to be ascertained.

6.391. A further record created on 19 October 2012, states that the matter was to be assigned to the UHT for review and allocation.[5463]

6.392. The materials produced to the Inquiry by the NSWPF included an undated, unsigned, partially completed UHT Case Screening Form, presumably following the allocation of the matter in 2012. The partially completed form summarised some of the information available from the original case file. It did not refer to the information provided by Mr Syron. It did not contain any recommendations. [5464]

6.393. During the Investigative Practices Hearing, Detective Chief Inspector Laidlaw agreed with Senior Counsel Assisting that the Commissioner could infer from this that there has never been a completed screening, review or triage in relation to Mr Jones. Detective Chief Inspector Laidlaw's evidence was that, according to proper police practice, Mr Jones' case should have been reviewed by the UHT between 2004 and 2008, assuming it was on the UHT Tracking File at that time.[5465]

6.394. In written submissions filed in the Investigative Practices Hearing, the NSWPF agreed that it is a matter of concern that the form is incomplete and that there are limited records available to discern what steps the UHT has taken in this case. However, the NSWPF pointed to Inspector Jarrett's "review of the brief" and request for a review of the fingerprint evidence as indicative of there being, at least, some level of review of the matter between 2004 and 2008.[5466]

[5461] Exhibit 41, Tab 15, Email from Rob Jarrett to Fiona West, 31 August 2005 (SCOI.11028.00002); Exhibit 41, Tab 16, Email from Fiona West to Rob Jarrett, 23 September 2005 (SCOI.11028.00001); Exhibit 41, Tab 17, Major Crime Running Sheet – M/C76/45, 23 September 2005, 1–2 (SCOI.11027.00003).

[5462] Exhibit 41, Tab 18, NSWPF e@gle.i – Product Details IN2443, 7 July 2010 (SCOI.62865).

[5463] Exhibit 41, Tab 19, CNI Profile – Barry Jones, 1 August 2022, 2 (SCOI.62860).

[5464] Exhibit 41, Tab 20, Review of an unsolved homicide case screening form – Barry Jones, undated (SCOI.62861).

[5465] Transcript of the Inquiry, 7 July 2023, T5241.37–5242.38 (TRA.00075.00001).

[5466] Submissions of NSWPF, 10 October 2023, [307]–[308] (SCOI.86127).

2018: information provided by Allan Adair

6.395. In early 2018, Mr Allan Adair contacted the New Zealand emergency services number to provide information in relation to the death of Mr Jones.[5467] He subsequently provided a statement to New Zealand Police, signed on 4 February 2018, that gave the following account.[5468]

6.396. Allan Adair lived in Five Dock with his parents at the time of Mr Jones' death. He recalled attending the Five Dock Hotel at around 12:30pm-1:00pm on a Saturday before the death. He went with his father (Robert Adair Senior), his brother (Robert Adair Junior), and three of his father's friends: "John Wylie, a big guy called Paddy, and an English guy called Jimmy".[5469]

6.397. Mr Adair recalled hearing a loud noise, looking outside and seeing a light blue car stopped at the lights belching smoke, backfiring and stalling. The car was then driven around the corner and parked at the back of the pub.[5470]

6.398. Two men then walked into the pub: "one was short and squat with black hair, and the other was taller and skinnier with long blonde hair". They were younger than Mr Adair.[5471] Mr Adair recalled that he was 20 at the time but, in fact, he would have been 24.

6.399. According to Mr Adair the two men approached the table and spoke to Jimmy, saying "long time no see, what you been up to". Mr Adair did not know the men. He asked them where they came from and they said they were from Parramatta, and that they had driven there in the car that was backfiring.[5472]

6.400. The two men saw Mr Jones sitting underneath the windows at the far side of the bar. Mr Adair recalled: "They knew Barry because they kept saying, 'that bastard he's a queer, he's a poof.'" Mr Adair recalled that it was mostly the skinny blond man making these comments.[5473] Mr Adair appeared to indicate in the call he made to New Zealand Emergency Services his own understanding that Mr Jones was gay, stating "that man was a homosexual man but it didn't bother us …".[5474]

6.401. The blond man took a knife out of his jeans and showed it around. He discussed its merits with Mr Adair. Mr Adair said, "that's no good, it's not even sharp". The blond man said that it would be no good for slashing but would be really good for stabbing. Mr Adair said something like, "rubbish, put it away mate". Eventually the blond man put the knife away. Mr Adair described the knife as having "a handle shaped like a deer's hoof at the end".[5475]

[5467] Exhibit 41, Tab 21, Transcript of 111 Emergency Call, undated (SCOI.62863).

[5468] Exhibit 41, Tab 22, Statement of Allan Adair, 4 February 2018 (SCOI.62862).

[5469] Exhibit 41, Tab 22, Statement of Allan Adair, 4 February 2018, [6]–[14] (SCOI.62862).

[5470] Exhibit 41, Tab 22, Statement of Allan Adair, 4 February 2018, [15]–[16] (SCOI.62862).

[5471] Exhibit 41, Tab 22, Statement of Allan Adair, 4 February 2018, [17]–[18] (SCOI.62862).

[5472] Exhibit 41, Tab 22, Statement of Allan Adair, 4 February 2018, [19]–[22] (SCOI.62862).

[5473] Exhibit 41, Tab 22, Statement of Allan Adair, 4 February 2018, [23]–[25] (SCOI.62862).

[5474] Exhibit 41, Tab 21, Transcript of 111 Emergency Call, 7 (SCOI.62863).

[5475] Exhibit 41, Tab 22, Statement of Allan Adair, 4 February 2018, [26]–[30] (SCOI.62862).

6.402. The two men were with the group for "another hour or two", after which Allan Adair never saw them again.[5476]

6.403. Mr Adair stated that he had found out about the death of Mr Jones at the time it happened, when his father came home and told the family that "Barry from our local" had been found murdered. He recalled that at the time, in 1976, he had been interviewed by the police in relation to the murder.[5477]

6.404. Weeks or months later, Mr Adair recalled seeing a newspaper article about the death with an accompanying photograph of the knife that he had seen in the pub. Allan Adair asked his father if he remembered the incident with the knife, and reminded him that they had all handled the knife at the table in the pub. Robert Adair Sr said, "no, you didn't bloody see nothing, you didn't hear nothing". He told Allan not to let Jimmy hear him saying such things, that Jimmy used to be in the Special Air Service (**SAS**), that he was a hard man, that he had been charged with manslaughter and that he had got off the charge.[5478]

6.405. Mr Adair did not report the information at the time as a result of these comments made by his father to him.[5479]

6.406. In 2018, New Zealand Police forwarded Mr Adair's information to the NSWPF. Detective Sergeant Peter Costello obtained the relevant materials from archives and reviewed them. Detective Sergeant Costello correctly concluded that, despite extensive canvassing of patrons who were at the Five Dock Hotel on 25 September 1976, there was no mention of Allan Adair being present at the Hotel on that occasion, and that there was no mention of any person being in possession of a knife. Detective Sergeant Costello therefore reasoned that if Mr Adair did see Mr Jones at the Five Dock Hotel, it was two or more weeks before his death.[5480]

6.407. Detective Sergeant Costello sought to make contact with Mr Adair, and eventually spoke to him by telephone on 22 May 2018. Detective Sergeant Costello tested Mr Adair's account of events. Mr Adair accepted that aspects of his recollection must be muddled—he claimed that he had moved to New Zealand in June 1976, three months before the Mr Jones' death. However, on the whole, Detective Sergeant Costello concluded: "Adair was coherent, polite, rational and sounded sober. He came across as believable."[5481]

[5476] Exhibit 41, Tab 22, Statement of Allan Adair, 4 February 2018, [31] (SCOI.62862).

[5477] Exhibit 41, Tab 22, Statement of Allan Adair, 4 February 2018, [36]–[38] (SCOI.62862).

[5478] Exhibit 41, Tab 22, Statement of Allan Adair, 4 February 2018, [39]–[41] (SCOI.62862).

[5479] Exhibit 41, Tab 22, Statement of Allan Adair, 4 February 2018, [32]–[35] (SCOI.62862).

[5480] Exhibit 41, Tab 23, NSWPF Investigator's Note, 'Information of Allan Adair provided via New Zealand Police', 23 May 2018, 1–4 (NPL.0120.0001.0001).

[5481] Exhibit 41, Tab 23, NSWPF Investigator's Note, 'Information of Allan Adair provided via New Zealand Police', 23 May 2018, 4–5 (NPL.0120.0001.0001).

6.408. Mr Adair was not able to provide any more detailed description of the knife or the two men. He could not identify anyone who was alive and could corroborate his account, except his brother, Robert Adair Junior. Detective Sergeant Costello provided Mr Adair with his contact details and advised him to contact him or the UHT if he had any further information.[5482]

6.409. The materials produced to the Inquiry do not record any further action taken by the NSWPF following the information provided by Mr Adair.

6.410. The NSWPF submitted that this was a matter which the Inquiry could have, but has not, taken up with Detective Sergeant Costello. As discussed in **Chapter 8**, I am prepared in some circumstances to infer that investigative steps were not taken in circumstances where the NSWPF has not produced any records of those steps being taken.

Review by the Inquiry

6.411. The Inquiry took the following steps in the course of examining the matter.

Summonses

NSWPF

6.412. On 21 July 2022, the Inquiry issued a summons to the NSWPF (Summons NSWPF3), returnable on 5 August 2022, for all NSWPF and UHT documents in relation to various deaths, including that of Mr Jones.

6.413. On 12 August 2022, the NSWPF produced 53 documents in response to NSWPF3 that related to the death of Mr Jones.

6.414. On 20 December 2022, the Inquiry wrote to the NSWPF, noting that it appeared likely that there was further material that had not been produced.[5483]

6.415. On 13 January 2023, Detective Sergeant Neil Sheldon provided a statement to the Inquiry, outlining the searches undertaken by the NSWPF for documents relating to the death of Mr Jones. Detective Sergeant Sheldon's statement concluded that "I consider the above searches and enquiries to be an exhaustive search for the Documents and no further avenues of enquiry are available to locate the Documents. Therefore, I do not expect any further Documents to be provided to the Inquiry in relation to the death of Barry Richard JONES."[5484]

6.416. At that time, the NSWPF produced the Investigator's Note prepared by Detective Sergeant Costello in 2018. The Investigator's Note referred to a box of material which had not been produced to the Inquiry, reference number REPO/B/2003/17409.[5485]

[5482] Exhibit 41, Tab 23, NSWPF Investigator's Note, 'Information of Allan Adair provided via New Zealand Police', 23 May 2018, 5–6 (NPL.0120.0001.0001).

[5483] Exhibit 41, Tab 37, Statement of Tom Allchurch, 26 June 2023, [6]–[8] (SCOI.83979).

[5484] Exhibit 41, Tab 30, Statement of Detective Sergeant Neil Sheldon, 13 January 2023, [10] (SCOI.83072).

[5485] Exhibit 41, Tab 23, NSWPF Investigator's Note, 'Information of Allan Adair provided via New Zealand Police', 23 May 2018, 2 (NPL.0120.0001.0001).

6.417. On 21 February 2023, the Inquiry wrote to the NSWPF regarding the absence of that box of material.

6.418. On 22 February 2023, the NSWPF produced that box of material to the Inquiry, which contained the original investigative file for the death of Mr Jones.[5486] The original investigative file ran to over a thousand pages and was significantly more voluminous than the material that had previously been produced to the Inquiry.

6.419. The delay in producing this material appears to have been the result of a failure of document management by the NSWPF. The absence of the original investigative file from the limited material produced to the Inquiry in August 2022 hindered the Inquiry's review of this matter, and its ability to undertake investigative steps, until late February 2023.

Interagency cooperation

6.420. On 15 June 2022, the Inquiry requested the coronial file in relation to Mr Jones from the Coroners Court. On 4 July 2022, the Coroners Court provided the coronial file to the Inquiry.[5487]

6.421. Inquiries were also made with BDM which confirmed that former Detective Sergeant McCusker, OIC, is now deceased.

Records obtained in relation to NP246

6.422. On 9 December 2022, the Inquiry issued a summons to the NSWPF (NSWPF44) for the criminal history and holdings in relation to NP246. On 17 February 2023, the NSWPF produced eight documents relating to NP246.

6.423. Those documents recorded that, as of 10 June 1976, NP246 was 155-160cm tall, with a medium slim build and brown/blond hair.[5488]

6.424. These documents also recorded that NP246 had distinctive tattoos on his left inside forearm as of 10 June 1976. Those tattoos included a crescent and star, the letters "FDD" and a shark with a dagger through it.[5489]

6.425. On 13 February 2023, the Inquiry requested a copy of the coronial file relating to NP246. On 14 February 2023, the Coroners Court produced the coronial file to the Inquiry.

6.426. The coronial file revealed that NP246 died of an overdose of anti-psychotic medication at home on 21 December 1983.[5490] It also notes his height as 155cm.[5491]

[5486] Exhibit 41, Tab 37, Statement of Tom Allchurch, 26 June 2023, [11]–[12] (SCOI.83979).

[5487] Exhibit 41, Tab 37, Statement of Tom Allchurch, 26 June 2023, [4]–[5] (SCOI.83979).

[5488] Exhibit 41, Tab 34, NP246 – Criminal History, 10 June 1976 (NPL.0121.0002.0013).

[5489] Exhibit 41, Tab 34, NP246 – Criminal History, 10 June 1976 (NPL.0121.0002.0013).

[5490] Exhibit 41, Tab 35, NP246 – Coronial File, 23 December 1983 – 19 March 1984, 3, 8 (SCOI.83630).

[5491] Exhibit 41, Tab 35, NP246 – Coronial File, 23 December 1983 – 19 March 1984, 8 (SCOI.83630).

6.427. On 20 December 1983, the day before his death, NP246 had been released from Gladesville Psychiatric Hospital where he was treated for chronic schizophrenia. His symptoms included auditory hallucinations, experiencing electric shocks through his body, disorientation, gross thought disorder, bizarre behaviour and suicidal thoughts. He had been diagnosed with schizophrenia since at least 1981.[5492]

6.428. The coronial file suggests that NP246 had been expelled from Drummoyne Boys High School in his second year. If accurate, this would or might call into question NP246's claim that he heard about the death of Mr Jones from another young person while he was on the bus to school, given that NP246 was 15 years old at the time of Mr Jones' death. However, it is possible, for example, that the information in the coronial file is mistaken, or that NP246 was old for his year, or that NP246 had started attending another school, or that he would travel on the school bus despite having been expelled.

6.429. On 9 June 2023, the Inquiry issued a summons to Northern Sydney LHD (NSLHD3) for records relating to the treatment of NP246 prior to his death in 1983. On 15 June 2023, the Inquiry received a copy of records from Gladesville Psychiatric Hospital, which contain details of his treatment for schizophrenia over the period from 1981 to 1983.[5493]

Family members

6.430. Police concluded in 2010 that Mr Jones has no surviving family members.

Searches for exhibits

6.431. On 30 January 2023, the Inquiry held a conference with FASS. FASS advised that it would not hold any DNA extracts or samples, as FASS (and its predecessor organisations) did not begin storing samples until 1985. FASS also advised that it did not hold the forensic exhibits for the death of Mr Jones.[5494]

6.432. On 2 February 2023, the Inquiry issued a summons to the NSWPF (NSWPF53) for the forensic exhibits. On 21 February 2023, the NSWPF advised that they could not locate the exhibits. As noted above, Detective Inspector Nigel Warren provided a statement to the Inquiry outlining the searches that had been undertaken.[5495]

6.433. The loss of the exhibits is most unfortunate, particularly the loss of the knife. Given the significant advances in forensic technology that have occurred since 1976, if the exhibits were available, forensic testing of items including the knife, Mr Jones' clothing and the torch from Mr Grant's car would almost certainly be possible. That possibility is now foreclosed.

[5492] Exhibit 41, Tab 35, NP246 – Coronial File, 23 December 1983 – 19 March 1984, 5, 13 (SCOI.83630).

[5493] Exhibit 41, Tab 37, Statement of Tom Allchurch, 26 June 2023, [36]–[37] (SCOI.83979).

[5494] Exhibit 41, Tab 37, Statement of Tom Allchurch, 26 June 2023, [13]–[14] (SCOI.83979).

[5495] Exhibit 41, Tab 33, Statement of Detective Inspector Nigel Warren, 21 February 2023 (SCOI.83075).

6.434. The material produced to the Inquiry does not disclose whether, upon the receipt of information from Mr Syron in 1998, or during the course of the UHT's consideration of the case in 2005, 2010 and/or about 2012, consideration was given to locating exhibits for potential DNA testing (or fingerprinting, in the case of the knife). If this did not occur, it should have, and may have yielded valuable evidence.

6.435. The NSWPF submitted that it is not clear on the material available whether or not those enquiries were made, and that it appears that the relevant police officers have not been approached by the Inquiry regarding whether such steps were taken.[5496] The NSWPF advanced similar submissions in a number of other cases. I have addressed this submission generally in the introduction to this Chapter.

Contact with next of kin of NP246

6.436. In light of the evidence before the Inquiry as to the potential involvement of NP246 in Mr Jones' death, and the possibility that Counsel Assisting may make submissions to that effect, the Inquiry wrote to NP246's next of kin. The Inquiry did not receive a response.[5497]

Other

6.437. On 3 April 2023, the Inquiry spoke to Allan Adair by telephone. Allan Adair generally confirmed the account that he had provided to New Zealand Police and the NSWPF in 2018.[5498]

6.438. His account differed in one respect. In 2018, he told New Zealand Police that he had seen the knife in a newspaper sometime after the death of Mr Jones. In 2023, he told the Inquiry that he had attended the Royal Easter Show with his brother, and that he had seen the knife on display at a police tent.[5499]

6.439. Allan Adair provided some further information to the Inquiry in relation to the two young men who attended the Five Dock Hotel:[5500]

a. He thought that they were "pretty young" and would have been around 18 or 19 years old;

b. The shorter man looked Greek or Italian. He had curly hair and was wearing a black t-shirt, black shorts and black "jandals";

c. The taller man had blonde hair that was straight and scraggly. It looked like it hadn't been washed in weeks. He was wearing a light blue t-shirt and "jandals"; and

[5496] Submissions of NSWPF, 10 July 2023, [51] (SCOI.84381).

[5497] Exhibit 68, Tab 12, Letter from Inquiry, 22 June 2023 (SCOI.86622).

[5498] Exhibit 41, Tab 37, Statement of Tom Allchurch, 26 June 2023, [19] (SCOI.83979).

[5499] Exhibit 41, Tab 37, Statement of Tom Allchurch, 26 June 2023, [20] (SCOI.83979).

[5500] Exhibit 41, Tab 37, Statement of Tom Allchurch, 26 June 2023, [21] (SCOI.83979).

d. He did not see tattoos on either man. Allan Adair noted that he had tattoos himself and that both men were wearing t-shirts, so he thought he would have noticed any tattoos, including on their arms.

6.440. On 14 April 2023, the Inquiry spoke to Robert Adair Junior by telephone. He confirmed, in general terms, his brother's account of the events at the Five Dock Hotel.[5501] He did not provide any further information in relation to the two men beyond that provided by his brother.

6.441. The Inquiry located I392 and on 9 May 2023 a conference was held with him. I392 confirmed that he was the source of the information that evidently prompted Mr Syron to make his report to police in 1998. He indicated that he subsequently attended Burwood Police Station where he provided information to police about the "rumour" he had heard concerning the potential involvement of NP246 in Mr Jones' death.

6.442. He could not recall who had told him that NP246 was involved, and said that he was not aware of any further details concerning the possible involvement of NP246, merely that it had been asserted that NP246 was responsible. I392 had grown up in the Five Dock area and was a similar age to NP246. He recalled NP246 as someone who was frequently in trouble as a young person.[5502]

6.443. I392 provided the Inquiry with details of some of the associates of NP246 at around the time of Mr Jones' death.[5503] The Inquiry conducted investigations into these associates, but did not obtain any evidence positively linking them to the death of Mr Jones.[5504]

Consideration of the evidence

Mr Jones' movements after leaving the Soccer Club

6.444. The evidence in relation to Mr Jones' departure from the Soccer Club is outlined above.

6.445. Although the accounts of some witnesses suggest that Mr Jones might have left the Soccer Club as early as 7:00pm to 7:30pm,[5505] it is possible either that Mr Jones was at the Soccer Club and that they did not see him, or that he left and returned later in the evening. The preponderance of the evidence (including the accounts of David Cashman and "Mrs Mann") suggests that Mr Jones was at the club until at least 9:30pm and possibly later still.[5506]

[5501] Exhibit 41, Tab 37, Statement of Tom Allchurch, 26 June 2023, [22]–[23] (SCOI.83979).

[5502] Exhibit 41, Tab 37, Statement of Tom Allchurch, 26 June 2023, [40]–[46] (SCOI.83979).

[5503] Exhibit 41, Tab 37, Statement of Tom Allchurch, 26 June 2023, [47]–[49] (SCOI.83979).

[5504] Exhibit 41, Tab 38, Supplementary Statement of Tom Allchurch, 28 July 2023, [21]–[22] (SCOI.84886).

[5505] Exhibit 41, Tab 6, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 134 (SCOI.83626).

[5506] Exhibit 41, Tab 6, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 134 (SCOI.83626).

6.446. There is conflicting evidence in relation to whether or not Mr Jones was present outside the Soccer Club as late as 10:15pm to 10:30pm, seeking a taxi. On the account of Mr Grimes this was not possible. The potential reliability of Mr Grimes' account, of seeing Mr Jones hitchhiking on Great North Road at around 10.16pm, is supported by the fact that it was given to police less than 48 hours later, his familiarity with Mr Jones, his description of the clothing worn by the person he saw, the good reason he had for being aware of the precise time, and the consistency of Mr Jones' location and actions with his known practice (attempting to hitch a lift home from a location on his likely walking route).

6.447. However, there are a number of references in police running sheets to a man by the name of "Jones" being present outside the Soccer Club and seeking a taxi in the time period of 10:15pm to 10:30pm.

6.448. If these accounts are erroneous, a possible explanation may be that the two jobs that the taxi driver, Mr Fuller, picked up from the Soccer Club that evening after 10:00pm had become conflated in his memory by the time the police spoke with him several days later. He incorrectly described the intoxicated person he anticipated picking up along with the "McColl" booking as Mr Jones, when it was evidently Mr Adair Sr. The basis for the radio operator, Mr Schewchyk having an understanding that there was a "Mr Jones" who required a cab was Mr Fuller, who had told him this. There was no record that Mr Jones had himself requested such a booking directly with the operator.

6.449. It remains possible, therefore, that the impression that the radio operator and other drivers were under, that there was a prospective passenger in the name of "Jones" who was seeking a lift at around 10:15pm to 10:30pm, emanated from information incorrectly passed on by Mr Fuller, who had incorrectly assumed Mr Adair to be Mr Jones.

6.450. Such an explanation is not entirely satisfactory, however, as it appears that Mr Fuller referred to that passenger as someone who was seeking a lift to the suburb of Haberfield. This was the suburb where Mr Jones, rather than Mr Adair, lived. This might possibly be explained by Mr Fuller having known where Mr Jones lived and, incorrectly assuming the prospective passenger to be Mr Jones, thereby making the reference to Haberfield.

6.451. Regrettably, as was the position reached by the investigating police at the time, the situation remains that it is not possible to reconcile or prefer one or other of the conflicting accounts of Mr Grimes on the one hand, and the evidence suggesting the possibility that Mr Jones remained in the vicinity of the Soccer Club until sometime after 10:15pm.

6.452. It does seem clear, however, that Marjorie Hayman's account of seeing Mr Jones get into a cab at the Soccer Club was mistaken. There is no other evidence to suggest he did so, including in the extensive checks that were conducted with taxi companies.

6.453. If Mr Jones had taken a taxi, it is likely that he would have made it home. Mr Grant went to bed at 11:00pm and went to sleep at 12:30am-1:00am. To his knowledge, Mr Jones was not home at that time. It is highly unlikely that Mr Jones would have returned home (unnoticed by Mr Grant) and then left again. It seems likely then that Mr Jones left the Soccer Club on foot.

6.454. Just how Mr Jones came to be at Five Dock Park remains a mystery. It was not on the logical walking route to his home from the Soccer Club.

6.455. The logical walking route home would have taken Mr Jones in an easterly direction from the Soccer Club and reached Great North Road, where he may have been seen attempting to hitchhike by Mr Grimes. If Mr Grimes' sighting was of Mr Jones, it may also be the case that the person seen by Mr McEnally further south at around 10:40pm (in the direction of Walker Avenue) was Mr Jones. Had Mr Jones made it that far, it seems unlikely that he then would have made his way to Five Dock Park without the intervention of a third party.

6.456. Alternatively, from Great North Road, Mr Jones may have continued walking to Five Dock Park. It is also possible that he was successful in his attempts to hitchhike and that he was driven from Great North Road to Five Dock Park. There is no evidence to suggest that this occurred, but the possibility cannot be excluded.

6.457. On either account, the timing is such that it is unlikely that the scream heard by Mr Kohlenberg and Ms Calleja at approximately 10:15pm to 10:20pm related to the death of Mr Jones.

6.458. The extensive canvassing of local residents did not uncover evidence suggesting anyone heard or witnessed an event consistent with Mr Jones having been taken to the location forcibly.

6.459. While it is possible he could have been forcibly taken to the location by car, it would seem more likely that Mr Jones made his own way to the park on foot, either alone or (initially at least) in willing company with another person. He may have been trying to reach the Bowling Club, which was located in the north-east corner of the park. He may have been searching for a place to urinate. He may have been seeking a sexual encounter. None of these possibilities can be confirmed.

The accounts of Allan Adair and Robert Adair Junior

6.460. On balance, and allowing for some uncertainty as to just when the relevant event occurred and some of the surrounding circumstances, I accept that the account given to police by Allan Adair is likely to be reliable in its core features: namely that on a weekend not long before Mr Jones' death, Mr Adair encountered two young men at the Five Dock Hotel who were in possession of a knife with the same distinctive features as the weapon used to attack Mr Jones, and that they made disparaging remarks about Mr Jones and his presumed sexuality.

6.461. There is nothing to suggest that either of the Adair brothers had any reason to fabricate their accounts, particularly considering that Allan Adair contacted authorities in New Zealand unprompted and voluntarily. Detective Sergeant Costello formed the view that Allan Adair was credible. Both men came across as believable in their dealings with the Inquiry. Albeit at a level of generality, Robert Adair Junior corroborated his brother's account.

6.462. One curiosity about their account is the question of why it was not reported to the authorities at some earlier point in time. A possible explanation for this may lie in Allan Adair's account that his father had cautioned him against doing so on the basis that one of the other (older) men present at the pub on the relevant occasion would not take kindly to this occurring. It may be that Mr Adair felt more comfortable raising the matter in 2018, by which time his father and his father's associates had passed away.

6.463. On the basis that their accounts appear to be reliable in their core features, given the similarity between the knife described by Allan Adair and Robert Adair Junior and the distinctive knife, and the disparaging remarks made about Mr Jones, Counsel Assisting submitted that it is likely that one or both of the two young men who attended the Five Dock Hotel were involved in Mr Jones' murder.

6.464. Nothing in the original investigative materials suggested that either of the Adair brothers was present at the Five Dock Hotel on Saturday, 25 September 1976. Nor is there any evidence that the people who were present on that day recalled a knife being handed around.

6.465. Counsel Assisting submitted that it is likely that the occasion on which the two young men were seen by Allan Adair at the Five Dock Hotel was a week or more prior to Mr Jones' death, and that the attack may therefore have been premeditated over a period of some time. Detective Sergeant Costello reached a similar conclusion on the question of timing.

6.466. The NSWPF submitted: "[t]he evidence of Mr Adair does not appear to be sufficiently reliable to enable a positive conclusion that he observed Mr Jones at the Five Dock Hotel and/or that his observations were made on the day of Mr Jones' death."[5507]

6.467. I do not agree. Both Counsel Assisting and Detective Sergeant Costello appreciated (as the NSWPF submission appears not to do) that Allan Adair made his observations, not on the day of Mr Jones' death, but on a different occasion in the preceding weeks.

6.468. Detective Sergeant Costello, having had the benefit of speaking with Allan Adair, recorded his view that Allan Adair was "coherent, polite, rational and sounded sober. He came across as believable".[5508] Further, Robert Adair Junior generally corroborated his brother's recollection.

[5507] Submissions of NSWPF, 10 July 2023, [59] (SCOI.84381).

[5508] Exhibit 41, Tab 23, Investigator's Note – Information of Allan Adair provided via New Zealand Police, 23 May 2018, 4-5 (NPL.0120.0001.0001).

6.469. Allan Adair's account is compellingly specific in certain respects, including the distinctive nature of the knife, the fact that Mr Jones was known to frequent the Five Dock Hotel, and the alignment between the evidence of Mr Jones' sexuality and the use of slurs described by Allan Adair.

6.470. I accept the submissions of Counsel Assisting that:

a. It is likely that one or both of the two young men observed by Allan Adair at the Five Dock Hotel were subsequently involved in Mr Jones' death;

b. It is likely that the day on which those two young men were seen by Mr Adair at the Five Dock Hotel was a week or more prior to Mr Jones' death; and

c. The attack may therefore have been premeditated over a period of some time.

NP246

6.471. Several different sources suggested that NP246 may have been involved in the death of Mr Jones, as noted above. Ultimately, however, the material available to the Inquiry which implicates NP246 does not rise beyond the level of rumour.

6.472. One question that arises is the possibility that NP246 was one of the two young men seen by Allan Adair at the Five Dock Hotel. The following matters are noted:

a. NP246 (aged 15 at the time) was younger than the ages estimated by Allan Adair and Robert Adair Junior in relation to those two young men (18 or 19 years old);

b. NP246's physical description does not closely match the description of either of the two young men provided by Allan Adair. Although short, and of Greek descent, NP246 was not (in 1976) of stocky build and his hair colour appears to have been lighter than that of the shorter man remembered by Allan Adair; and

c. NP246 had distinctive tattoos on his forearm, but Allan Adair did not recall seeing any tattoos on either of the young men even though, on his account, they were both wearing t-shirts.

6.473. It is possible, although unlikely, that NP246 could have been the shorter of the two men remembered by the Adair brothers. Another possibility is that he could have had an association with the two men, although such a possibility is merely speculative.

Other possible suspects

6.474. Neither NP247 nor Kenneth Grant matches the descriptions of the two men provided by Allan Adair, both being considerably older.

6.475. Although a potential financial motive could be surmised in relation to Kenneth Grant, who stood to inherit Mr Jones' house, the gruesome nature of the death is not in keeping with such a motive.

6.476. NP247 does appear to be someone who should have been given closer consideration by investigating police at the time. As noted earlier, it is regrettable that a footprint analysis was not undertaken in order to rule out his possible involvement, and that he was not more extensively questioned. Nevertheless, particularly in view of the information subsequently received from the Adair brothers, it is not considered that NP247 should be regarded as a likely perpetrator.

Police investigation

Exhibits and forensic testing

6.477. The death of Mr Jones is one of the earliest deaths falling within the Inquiry's Terms of Reference. The records of the original investigation reflect that fact. Information is often recorded by running sheet rather than by a formal statement, and interviews are not electronically recorded nor, in most cases, are they transcribed verbatim. The original investigative material therefore has some obvious limitations.

6.478. This would appear to reflect the standards of the day in relation to the recording of the results of investigative steps, rather than a lack of effort on the part of investigating officers. Generally speaking, it would appear that the police investigation at the time was extensive. In his statement summarising investigative efforts as at December 1977, Detective Sergeant McCusker notes that 30 detectives were involved full-time on the investigation.[5509]

6.479. Nevertheless, as Counsel Assisting submitted, a major problem (not only from the perspective of 2023) is that at some point after November 1976 all of the exhibits—including the knife—were lost. None of the exhibits, including the knife, are available to the Inquiry. As one consequence, no modern-day forensic testing of any of those exhibits is possible.

6.480. The NSWPF submitted that it is "regrettable" that the exhibits that "may have been linked to Mr Jones' death" were not retained. It was also submitted that it is not clear on the material when the exhibits were destroyed or lost, nor which agency was responsible for "any such decision" (and for the ongoing retention of the exhibits to that time).[5510]

6.481. The NSWPF nevertheless agreed that it is "unacceptable" that key exhibits have not been retained, and "regrettable" that a record does not exist as to what happened to them.[5511]

6.482. The NSWPF acknowledged that the knife was a "central feature" of the inquiries made by investigating police and that, given the matter was an unsolved homicide, "steps should have been taken to record the location of, and what ultimately transpired in relation to, the exhibits (particularly the knife)".[5512]

[5509] Exhibit 41, Tab 6, Statement of Detective Sergeant Donald McCusker, 6 December 1977, [10] (SCOI.10495.00015).

[5510] Submissions of NSWPF, 10 July 2023, [37] (SCOI.84381).

[5511] Submissions of NSWPF, 10 July 2023, [38] (SCOI.84381).

[5512] Submissions of NSWPF, 10 July 2023, [39] (SCOI.84381).

6.483. In oral evidence given at the Investigative Practices Hearing, Assistant Commissioner Conroy stated that by the standards of the time, being the 1962 Instruction relating to exhibits,[5513] the retention of some of the exhibits identified above was not explicitly mandated and any exhibit which had been analysed to the capability of the laboratory at the time could be disposed of in accordance with the 1962 Instruction.[5514] However, Assistant Commissioner Conroy conceded that where the death of Mr Jones was clearly a homicide, the knife should have "absolutely" been retained.[5515] Assistant Commissioner Conroy accepted that if the exhibits were destroyed, disposed of or otherwise returned, there ought to have been a record to that effect.[5516]

6.484. In written submissions filed in the Investigative Practices Hearing, the NSWPF agreed with Counsel Assisting's submissions concerning the loss or destruction of evidence. The NSWPF similarly adopted Assistant Commissioner Conroy's evidence that, at a minimum, the knife should have been retained, notwithstanding the 1962 Instruction did not specifically require the retention of exhibits.[5517]

6.485. With regard to the forensic evidence, the NSWPF submitted that it was "likely" that at least some of the blood sample, swabs and smear, hair sample and fingernail cuttings would have been consumed during the process of forensic examination, and noted that FASS (and its predecessor organisations) did not begin storing some samples until 1985.[5518]

6.486. The NSWPF submitted that "it appears that" all forensic testing that could be conducted on the exhibits at the time of the initial investigation was undertaken,[5519] and that most of the items were ruled out as having any connection (based on the available technology) to Mr Jones' death. [5520]

6.487. The NSWPF submitted that advancements in forensic testing capabilities and identification by DNA, in the more than 40 years since Mr Jones' death, could not have been known in the 1970s. The NSWPF noted that the earliest DNA testing in a criminal context did not occur until 1986 in the UK (i.e. a decade after Mr Jones' death) and that DNA testing was not available as an investigative tool to the NSWPF for a number of years thereafter. It was submitted that even if such exhibits had been retained, whether they would be suitable for testing, the results of such testing and the inferences able to be drawn from those results about the circumstances of Mr Jones' death "are matters of speculation".[5521]

6.488. The NSWPF advanced similar submissions in a number of other cases, and they have been addressed separately in **Chapter 8** of this Report.

[5513] Exhibit 51, Tab 2D, Instruction No. 24 – Exhibits, 1962 (NPL.9000.0003.1471).

[5514] Transcript of the Inquiry, 4 July 2023, T4850.45-T4851.27 (TRA.00072.00001).

[5515] Transcript of the Inquiry, 4 July 2023, T4850.27-28 (TRA.00072.00001); T4851.10-11 (TRA.00072.00001).

[5516] Transcript of the Inquiry, 4 July 2023, T4850.37 (TRA.00072.00001).

[5517] Submissions of NSWPF, 10 October 2023, [305] (SCOI.86127).

[5518] Submissions of NSWPF, 10 July 2023, [40] (SCOI.84381).

[5519] Exhibit 41, Tab 3, Report of Robert Goetz, 5 November 1976 (SCOI.10495.00028).

[5520] Submissions of NSWPF, 10 July 2023, [41] (SCOI.84381).

[5521] Submissions of NSWPF, 10 July 2023, [42] (SCOI.84381).

6.489. The NSWPF noted that in two statements provided to the Inquiry, dated 2 May 2023 and 11 June 2023,[5522] Assistant Commissioner Conroy set out in detail developments in the NSWPF's exhibits management practice since the 1970s and 1980s, including in respect of the handling, recording and storage of exhibits. The NSWPF submitted that, for the reasons set out in those statements, it is "highly unlikely" that a similar issue would occur today.[5523]

6.490. A matter of great concern to me is that there is no record indicating that police ever sought to obtain fingerprints from the knife.

6.491. The NSWPF agreed that a failure to fingerprint the knife "would have been a very significant deficiency" in the investigation, but submitted that the Inquiry could not conclude that this is what occurred.[5524] The NSWPF submitted that the available material indicates that the knife, among various other exhibits, was provided to the Health Commission of New South Wales for forensic examination,[5525] and that Detective Sergeant McCusker's statement indicated that:[5526]

> *Detective R Johnston of the Scientific Section arrived and I was present when he took certain photographs and measurements and carried out other scientific duties. A statement has been supplied by that Detective fully setting out the inquiries he conducted.*

6.492. The NSWPF noted, next, that the tender bundle did not contain a statement from Detective Johnston, and submitted that it was "therefore not clear whether such a statement is presently available".[5527]

6.493. However, the reason why there was no statement from Detective Johnston in the tender bundle is that no such statement was produced to the Inquiry by the NSWPF.[5528]

6.494. The NSWPF also submitted that, given the thoroughness of the initial investigation and the fact that fingerprinting was conducted on Mr Jones, on the grandstand in which he was located and on beer bottles located in the vicinity of the grandstand, it is "more likely than not" that fingerprinting on the knife "would have been conducted" and that any prints located "would have been recorded" and pursued. [5529]

[5522] See Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023 (NPL.9000.0008.0905); Exhibit 51, Tab 4 Statement of Assistant Commissioner Rashelle Conroy, 11 June 2023 (NPL.9000.0008.1049).

[5523] Submissions of NSWPF, 10 July 2023, [43] (SCOI.84381).

[5524] Submissions of NSWPF, 10 July 2023, [46] (SCOI.84381).

[5525] Exhibit 41, Tab 3, Report of Robert Goetz, 5 November 1976, 2 (SCOI.10495.00028).

[5526] Exhibit 41, Tab 6, Statement of Detective Sergeant Donald McCusker, 6 December 1977, [3] (SCOI.10495.00027).

[5527] Submissions of NSWPF, 10 July 2023, [44]–[45] (SCOI.84381).

[5528] Exhibit 41, Tab 38, Supplementary Statement of Tom Allchurch, 28 July 2023, [5]–[6] (SCOI.84886).

[5529] Submissions of NSWPF, 10 July 2023, [45] (SCOI.84381).

6.495. The suggestion by the NSWPF that fingerprinting of the knife was "more likely than not" to have occurred is speculative. The absence of any record strongly suggests that no such fingerprinting took place, which certainly would be a "very significant deficiency" in the investigation. If fingerprinting of the knife did occur, but all records (if any) of that fingerprinting have been lost, then that is a serious deficiency in recordkeeping.

6.496. Whichever of those deficiencies is applicable, the outcome is—especially when the knife itself has been lost—that present-day investigations into the death of Mr Jones, including that of this Inquiry, are irremediably hampered.

Investigation of NP247

6.497. A number of factors suggest that NP247 should appropriately have been regarded as a person of interest, including:[5530]

a. A reported propensity to threaten violence and an interest in knives and swords;

b. Evidence that he had previously had sex with another man and that he experienced some conflict about his sexuality;

c. Evidence that he knew Mr Jones from local pubs and clubs;

d. His known practice of going about either barefoot or in thongs;

e. His history of experiencing psychotic episodes in the context of alcohol use; and

f. The potentially self-serving approach he made to police the day after being interviewed by them, when he indicated that he had remembered seeing Mr Jones two weeks prior to his death in circumstances where two other men were "acting strangely".

6.498. The record of the two occasions on which police interviewed NP247 consists of a one-page typed occurrence pad entry.[5531] That entry does not disclose whether NP247 had been asked about his sexuality, or his familiarity with Five Dock Park and its status as a beat. Nor does it indicate whether he was asked about the instances of threatening behaviour that his uncle had referred to, or his habit of walking barefoot. There is no record of any attempt to ascertain his shoe size or to obtain his footprints.

6.499. It appears that investigating police accepted NP247 as a credible witness and did not regard him as a serious suspect in Mr Jones' death. While such a decision may have been justified, the limited manner in which the police interviews were recorded and, in particular, the lack of any record that police investigated the possibility that his footprint or thong print had been left at the scene is cause for concern about the level of thoroughness with which police approached the possibility that NP247 may have been involved.

[5530] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 149–154 (SCOI.83626

[5531] Exhibit 41, Tab 5, Relevant Running Sheets, 27 September 1976 – 27 May 1977, 154 (SCOI.83626).

6.500. The NSWPF did not make any submissions in relation to the apparent failure to investigate NP247 more thoroughly.

6.501. NP247 is now deceased and any opportunity to pursue this possibility further has now been lost.

Investigation of NP246

6.502. NP246 was interviewed by police on 10 October 1976, after a report had been made of him boasting that he knew who had killed Mr Jones. Subsequently, on 24 November 1976, police received a report alleging that a young person named I395 had said that NP246 was responsible for the murder, and a note was made that NP246 was to be further interviewed. There is no record that such an interview took place. Nor is there any record indicating that police sought to interview I395 in order to obtain details of the source of his understanding.

6.503. More than twenty years later, in 1998, information suggesting knowledge of the involvement of NP246 in the murder again surfaced. That serves to highlight that it is unfortunate that, apparently, the matter was not followed up with I395 in 1976, and NP246 was not reinterviewed as had been planned.

6.504. After interviewing NP246 on 10 October 1976, police did take further steps to corroborate NP246's account of his whereabouts on the day of Mr Jones' death, by interviewing I390 and I382. However, the information they provided to police only accounted for NP246's whereabouts up until 8:30pm on the evening of 26 September 1976 (i.e., probably two hours or more prior to Mr Jones' death). The fact that NP246 had been at their homes earlier in the evening does not preclude him being involved in Mr Jones' death later that night. His family home was only a short walk from Five Dock Park.

6.505. The only support for NP246's claim that he was at home from approximately 8:45pm onwards came from his parents. The reliability of the alibi provided to police by NP246's parents would be easier to assess had the police records made clear who was present when NP246 was spoken to by police.

6.506. Putting aside the circumstances in which NP246 was interviewed, his parents had some reason to suggest that their son was home before 9:00pm that night, regardless of how certain they may have been of the matter, given that NP246 was under the supervision of the Child Welfare Department and was not supposed to be out at night after 8:00pm.

1998: further report relating to NP246

6.507. On 5 May 1998, Patrick Syron attended Five Dock Police Station. He said that he had been talking to an acquaintance, I392 (a pseudonym), at the Drummoyne RSL Club. I392 reportedly claimed that NP246 was responsible for the death of Mr Jones and that he had subsequently died as a result of jumping out of a hospital window.[5532]

[5532] Exhibit 41, Tab 14, COPS Event E499934, 8 May 1998, 1 (SCOI.11032.00002).

6.508. The materials produced to the Inquiry by the NSWPF do not record whether Mr Syron provided a formal statement to police. Nor do they record whether any attempt was made to locate and speak to I392, the source of Mr Syron's information. The related COPS Event is marked "No Further Investigation" as at 14 June 1999.[5533]

6.509. The Inquiry sought to give further consideration to the possible involvement of NP246. In the course of so doing, it was established that NP246 died in 1983.

6.510. The Inquiry also established that I392 was spoken to by police following the 1998 report made by Mr Syron. I392 advised the Inquiry that he attended Burwood Police Station to "provide further information and explain what he had heard", though he cannot now recall the details of what he then told police. Materials produced to the Inquiry by the NSWPF do not record what I392 told them at that time.

6.511. The NSWPF accepted that a record of the conversation or interview with I392 should have been made (or, if it was made, retained). [5534]

Manner and cause of death

6.512. Deputy State Coroner Parnell found that Mr Jones died on 26 September 1976 in the grandstand of Five Dock Park, Park Road, Five Dock "from haemorrhage and respiratory failure due to multiple stab wounds to the chest and abdomen inflicted by a person or persons unknown."[5535]

6.513. Counsel Assisting submitted that a finding in the same terms remains appropriate, and that the evidence does not permit the Inquiry to identify the person or persons who killed Mr Jones.

6.514. The NSWPF supported those submissions of Counsel Assisting, which I accept.

Bias

6.515. Counsel Assisting submitted that, notwithstanding that the perpetrator of Mr Jones' death cannot be identified, on the available evidence it is probable that Mr Jones' death was one in which LGBTIQ bias was a factor.

6.516. The NSWPF agreed that it is *possible* that Mr Jones' death was one in which LGBTIQ bias was a factor, however, submitted that Counsel Assisting's assessment that it is *probable* was "surprising", given the paucity of evidence relating to the identity of the offender/s or the motivations driving the murder of Mr Jones.[5536]

[5533] Exhibit 41, Tab 14, COPS Event E499934, 8 May 1998, 1 (SCOI.11032.00002).

[5534] Submissions of NSWPF, 10 July 2023, [49] (SCOI.84381).

[5535] Exhibit 41, Tab 1, Findings of Coroner Parnell, Inquest into the death of Barry Jones, 26 January 1978 (SCOI.10495.00002).

[5536] Submissions of NSWPF, 10 July 2023, [57]–[58] (SCOI.84381).

6.517. The NSWPF accepted that the fact that the Five Dock Park had been a beat or a "regular meeting place for homosexuals" is a "relevant consideration" in assessing the presence or absence of bias, as is the possibility that Mr Jones may have been gay, and that the "apparently frenzied" nature of the attack is "potentially consistent" with a homicide motivated by LGBTIQ bias. [5537]

6.518. However, the NSWPF submitted that in the absence of further evidence regarding the identity or motivations of Mr Jones' assailant/s, it is difficult to see how a "positive conclusion", on the balance of probabilities, can be arrived at in relation to the possibility that bias played a role in Mr Jones' death. [5538]

6.519. The views advanced by the NSWPF rest in part on discounting the reliability of Allan Adair's account. However, even if that account is put to one side, the other factors suggesting that Mr Jones' death may have been a bias crime (albeit not conclusively establishing such a fact) are considerable. Those factors include:

a. This case is among the most violent of the deaths considered by the Inquiry. The NSWPF's reference to the attack being "apparently frenzied" rather underplays the reality of at least 53 stab wounds, several of them inflicted after death, including the massive wound to the chest and the slashing of the throat, followed by the knife being driven fully into his body;

b. The fact that Five Dock Park was a beat; and

c. The presence of semen on Mr Jones' underpants and trousers.

6.520. In addition, however, I take a different view of the likely reliability of Mr Adair's account in its core features. Those features include his own understanding that Mr Jones was gay, and that the likely perpetrators were disparaging of him for that reason. Both those matters (along with the balance of his recollections) were volunteered by Mr Adair, and were put forward by him outside of and prior to the work of the Inquiry. His evidence (that the likely perpetrators were expressing hate towards Mr Jones based on his presumed sexuality) provides further strong support, in my view, for the possibility that LGBTIQ bias was a factor in the death of Mr Jones.

6.521. I have explained elsewhere that the question which I have set out to answer, in relation to bias, is whether there is objectively reason to suspect that LGBTIQ bias was a factor in the death. As the NSWPF properly concede, the presence of such a factor is at least "possible". Given the matters discussed above, in my view the answer to the question is plainly "yes".

Conclusions and recommendations

6.522. I adopt the finding of Deputy State Coroner Parnell who concluded that:[5539]

> *Mr Jones died on 26 September 1976 in the grandstand of Five Dock Park, Park Road, Five Dock from haemorrhage and respiratory failure*

[5537] Submissions of NSWPF, 10 July 2023, [57], [60] (SCOI.84381).

[5538] Submissions of NSWPF, 10 July 2023, [61] (SCOI.84381).

[5539] Exhibit 41, Tab 1, Findings of Coroner Parnell, Inquest into the death of Barry Jones, 26 January 1978 (SCOI.10495.00002).

due to multiple stab wounds to the chest and abdomen inflicted by a person or persons unknown.

6.523. The evidence available to the Inquiry does not permit the identification of the person or persons who attacked Mr Jones.

6.524. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in Mr Jones' death.

6.525. I do not propose to make any recommendations arising from the Inquiry's consideration of Mr Jones' death.

IN THE MATTER OF PETER KARL BAUMANN

Factual background

Date and location of disappearance

6.526. Peter Karl Baumann (born 20 April 1957) is recorded in a coronial finding as having died on or sometime after 26 October 1983.[5540] Mr Baumann was a German national who arrived in Sydney on 11 December 1981 on a temporary visa that was valid until 11 June 1982.[5541]

6.527. On 29 November 1983, a missing persons report was prepared by the NSWPF, recording a report by Mr Baumann's landlady, Ruth Binney.[5542] There is evidence that the NSWPF were notified of Mr Baumann's disappearance as early as 5 November 1983.[5543] Mr Baumann was 25 years old at the time of his disappearance. On 4 August 2009, Deputy State Coroner Milovanovich found that Mr Baumann was deceased, but was unable to determine a precise date, place, or manner and cause of his death.[5544]

6.528. Mr Baumann's body has never been found and as such a post-mortem examination has never been conducted.

[5540] Exhibit 42, Tab 1, Findings of DSC Milovanovich, Inquest into the death of Peter Baumann, 4 August 2009 (SCOI.10850.00002); Exhibit 42, Tab 84, Death Certificate – Peter Baumann, 22 December 2022 (SCOI.82230). Although that finding was consistent with material provided to the Coroner, there is some doubt about the date Mr Baumann was last seen.

[5541] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [3] (SCOI.11010.00007).

[5542] Exhibit 42, Tab 15, Statement of Ruth Binney, 16 November 1993 (SCOI.10850.00024); Exhibit 42, Tab 19, Report to Waverley Police Station made by Ruth Binney, 29 November 1982 (SCOI.10850.00106).

[5543] Exhibit 42, Tab 20, Letter from ABC Welfare Officer to Peter Baumann, including file note re contact from Ruth Binney and Sharmalie Seneviratne, 7 November 1983, (SCOI.10850.00046).

[5544] Exhibit 42, Tab 1, Findings of DSC Milovanovich, Inquest into the death of Peter Baumann, 4 August 2009 (SCOI.10850.00002).

Circumstances of disappearance

6.529. Mr Baumann's last known contact was either with his ex-partner, Sharmalie Seneviratne (now Sharmalie Kotoga) or with another partner, Allan Smyth.[5545] Given that the police investigative file uses the name "Seneviratne", Ms Kotoga will be referred to as Ms Seneviratne in this Report. No disrespect is intended.

6.530. According to Ms Seneviratne, she spoke with Mr Baumann by telephone at his home on "one Friday" evening. During that conversation, "the telephone went dead in his mid sentence".[5546] Ms Seneviratne tried to ring Mr Baumann back "a number of times but the line was dead".[5547] Ms Seneviratne was worried something had happened to Mr Baumann, so she drove to his home and went inside. She noted that Mr Baumann's house was "very untidy" and it "looked as though there had been a struggle in the room". She also noticed that a small cushion had been burnt in the shower recess.[5548]

6.531. Ms Seneviratne later telephoned Ms Binney who went to Mr Baumann's flat to find "the chair overturned and the door open… and his bed pillow was lying in the shower half burnt".[5549] Later, after reporting the incident to Waverley police, while looking through Mr Baumann's room, Ms Binney "saw that the word AIDS" had been written on a mirror".[5550] There is evidence to suggest that Ms Seneviratne saw (or knew about) the fact that "AIDS" was written on a mirror in the flat "with chalk or felt-tip pen" but also conflicting evidence suggesting that Ms Seneviratne did not know about this.[5551]

6.532. The date that Mr Baumann was "last seen" was recorded by the NSWPF to be on or around 26 October 1983.[5552] However, the evidence available about Mr Baumann's last known movements suggests that he was seen after that date. This evidence includes:

a. Mr Baumann was recorded as having "walked off duty at about 11:30am on Thursday 27th October" at his place of employment, the Australian Broadcasting Commission (**ABC**);[5553]

b. Ms Seneviratne provided a statement to the NSWPF in 1993 where, as noted above, she stated that the last time she spoke to Mr Baumann was a Friday, meaning that she likely spoke to him on 28 October 1983 (although it is possible that it was 21 October 1983, or conceivably 4 November 1983);[5554]

[5545] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [4]–[5] (SCOI.10850.00020).

[5546] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [5] (SCOI.10850.00020).

[5547] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [5] (SCOI.10850.00020).

[5548] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [6] (SCOI.10850.00020).

[5549] Exhibit 42, Tab 15, Statement of Ruth Binney, 16 November 1993, 1 (SCOI.10850.00024).

[5550] Exhibit 42, Tab 15, Statement of Ruth Binney, 16 November 1993, 2 (SCOI.10850.00024).

[5551] Exhibit 42, Tab 36, Letter from Missing Persons Unit to NSWPF Services Section enclosing file and requesting decision re follow-up action, 4 March 1994, 7 (SCOI.38945).

[5552] Exhibit 42, Tab 1, P79A Report of Death to Coroner, 25 June 2008, 1 (SCOI.10850.00012).

[5553] Exhibit 42, Tab 20, Letter from ABC Welfare Officer to Peter Baumann, including file note re contact with Ruth Binney and Sharmalie Seneviratne, 7 November 1983 (SCOI.10850.00046).

[5554] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [4]–[5] (SCOI.10850.00020).

c. A statement given by Mr Smyth in 1993, with whom Mr Baumann was in a relationship at the time of his disappearance, might be construed as indicating that Mr Baumann was seen as late as Sunday, 30 October 1983, or even the following Sunday, 6 November 1983;[5555] and

d. Some police documentation, including documentation prepared closer to the date of Mr Baumann's disappearance, which provides that he disappeared on 27 October 1983.[5556]

6.533. What is clear is that Mr Baumann has not been seen since late October or November 1983 and his remains have never been found.

Identification by the Inquiry

6.534. The Inquiry has determined that Mr Baumann's death falls within Category B of the Terms of Reference. That is, Mr Baumann's death is an unsolved suspected hate crime death in NSW that occurred between 1970 and 2010, where the victim was (or was perceived to be) a member of the LGBTIQ community and the death was the subject of a previous investigation by the NSWPF.

6.535. Further detail as to the process I adopted in identifying cases falling within Category B of the Terms of Reference is outlined at **Chapter 6** of this Report.

Indicators of LGBTIQ bias

6.536. At the time of his disappearance, Mr Baumann was in a relationship with another man, Mr Smyth.[5557] It appears that Mr Smyth was also in a long-term relationship with another man called Mervyn Oliver Keasberry (who went by "Oliver") at the same time, although that relationship may not have been sexual.[5558] Mr Smyth and Mr Keasberry lived together in Edgecliff, Sydney.[5559]

6.537. The circumstances of Mr Baumann's disappearance and the motivation for his suspected death are unclear. Given that Mr Baumann disappeared in suspicious circumstances and that Ms Binney saw the word "AIDS" written on a mirror in Mr Baumann's flat, there is a reasonable basis to suspect homicide with an LGBTIQ bias motive. Ms Seneviratne also told Mr Baumann's brother and sister that the word "AIDS" was written on a mirror in Mr Baumann's flat with "chalk or felt-tip pen".[5560] However, this fact is not contained in the statement she provided to police and conflicts with other (indirect, hearsay) evidence provided to the Inquiry.[5561] It may have been that Ms Seneviratne was passing on information she had learned from the NSWPF or Ms Binney.

[5555] Exhibit 42, Tab 11, Statement of Allan Smyth, 16 November 1993, 2 (SCOI.10850.00023).

[5556] Exhibit 42, Tab 83, UHT Triage Form – Review of an Unsolved Homicide, Undated 1 (SCOI.38971); Exhibit 42, Tab 22, Missing Person Form – Ante Mortem Record, undated (SCOI.10850.00032).

[5557] Exhibit 42, Tab 3, Statement of Detective Sergeant Darren Smith, 12 August 2008, [12] (SCOI.34345).

[5558] Exhibit 42, Tab 3, Statement of Detective Sergeant Darren Smith, 12 August 2008, [12] (SCOI.34345).

[5559] Exhibit 42, Tab 11, Statement of Allan Smyth. 16 November 1993, 1 (SCOI.10850.00023).

[5560] Exhibit 42, Tab 39, Interpol request to Missing Persons Unit re review of matter, 11 November 1999, 3 (SCOI.38957).

[5561] Cf Exhibit 42, Tab 36, Letter from Missing Persons Unit to NSWPF Services Section enclosing file and requesting decision re follow-up action, 4 March 1994, 7 (SCOI.38945).

6.538. I accept the observation made by Counsel Assisting that the evidence available to this Inquiry does not allow any positive conclusions to be drawn about whether Mr Baumann's death was an LGBTIQ bias crime. It is also important to bear in mind that bias on the basis of sexuality and on the basis of HIV/AIDS-status are distinct, although they may overlap, especially given social perceptions and attitudes at the time of Mr Baumann's disappearance.[5562]

Previous investigations

Original police investigation

1983-1991

6.539. As noted above, Mr Baumann's disappearance was reported to the NSWPF in 1983.[5563] Although there is evidence to indicate that the NSWPF attended the Cross Street premises and obtained some personal information about Mr Baumann, no contemporaneous record of any police investigation into Mr Baumann's disappearance at the time has been produced to the Inquiry.

6.540. Although there is evidence to suggest that "all the Occ Pads and T.P. Messages for 1983 were accidentally burnt",[5564] I accept that does not explain the absence of *any* records of any investigative steps. Furthermore, there is evidence before this Inquiry that this matter was "not investigated until 1993".[5565] It is not known why Mr Baumann's disappearance was not investigated at the time.

6.541. On 27 September 1989, Waverley Police Station conducted some routine checks for people listed as missing "within the Waverley patrol". These checks did not appear to include Mr Baumann.[5566]

1992-1994

6.542. From around 1992, the matter was investigated by Senior Constable William Gribble from the MPU. Senior Constable Emery also appears to have been involved in the investigation from around this time.[5567]

6.543. In 1992, the NSWPF conducted various checks to see whether Mr Baumann could be located, but with no relevant results.[5568]

[5562] Submissions of Counsel Assisting, 27 June 2023, [15] (SCOI.84145).

[5563] Exhibit 42, Tab 19, Report to Waverley Police Station made by Ruth Binney, 29 November 1982 (SCOI.10850.00106).

[5564] Exhibit 42, Tab 36, Letter from Missing Persons Unit to NSWPF Services Section enclosing file and requesting decision re follow-up action, 4 March 1994, 6 (SCOI.38945).

[5565] Exhibit 42, Tab 52, Request from Senior Constable John Gribble to be assigned case and response from Eastern Suburbs LAC, 13 February 2006 – 21 April 2006, 2 (SCOI.34229).

[5566] Exhibit 42, Tab 21, Report of Constable GR Aston re missing persons, including Peter Baumann, 27 September 1989 (SCOI.38969).

[5567] Exhibit 42, Tab 44, NSWPF Running Sheet, 'Enquiries made by Constable Emery', 5 August 1992 – 26 March 2002 (SCOI.34263).

[5568] Exhibit 42, Tab 4, Statement of Senior Constable Simon Field, 15 September 2008, [21] (SCOI.10850.00014); Exhibit 42, Tab 24, Inquiry – Chefpolice 1097/Baumann, 11 May 1992 (SCOI.10850.00043); Exhibit 42, Tab 25, Inquiry – Fedpol 174/Baumann/Missing Persons, 11 May 1992 (SCOI.10850.00042); Exhibit 42, Tab 26, Inquiry – Vedette 1007/Baumann/Missing Persons, 11 May 1992 (SCOI.10850.00041); Exhibit 42, Tab 27, Inquiry – SPHYNX 973/Baumann/Missing Persons, 12 May 1992 (SCOI.10850.00039); Exhibit 42, Tab 28, Inquiry – SPHYNX 982/Baumann, 14 May 1992 (SCOI.10850.00040).

6.544. On 27 August 1993, the NSWPF received information from Interpol in relation to Mr Baumann.

6.545. On 3 September 1993, the NSWPF submitted a request to the Bavarian State Police through Interpol requesting that Anne Baumann-Serr, Mr Baumann's sister, be interviewed to obtain particular information.[5569]

6.546. On 9 September 1993, Senior Constable Gribble submitted a report to the Department of Immigration in relation a Japanese national, "Hyuma Hoshi, who was identified as a possible witness to Mr Baumann's disappearance".

6.547. Ms Baumann-Serr further wrote to Senior Constable Gribble on 26 October 1993 referring to another telephone conversation the week prior. She expressed to Senior Constable Gribble that "you told some things that just seem very strange to me" and asked further questions of him, including the precise date of Mr Baumann's disappearance.[5570]

6.548. On 26 November 1993, the NSWPF wrote to the ABC to request their assistance in obtaining the employment records of Mr Baumann and the contact details of Mr "Govey" (presumably referring to "H.A.R Gover" who was the Acting Welfare Officer at the ABC at the time of Mr Baumann's disappearance).[5571]

6.549. In 1993, "a number of statements were obtained from next of kin and witnesses".[5572] These statements included:

a. A statement of Ms Seneviratne dated 26 August 1993;

b. A statement from Mr Smyth dated 16 November 1993;

c. A statement of Ms Binney dated 16 November 1993; and

d. A statement of Ms Foster dated 14 September 1994.

6.550. In 1994, Mr Baumann's matter was briefly transferred to Waverley Police Station before being almost immediately transferred back to the MPU.[5573]

6.551. According to the recollection of Mr Baumann's family, they were told, either in late 1993 or early 1994, that it would assist the NSWPF if a family member could meet with the NSWPF in Sydney.[5574]

6.552. On 26 May 1994, the NSWPF spoke with Mr Baumann's brother and sister (Franz Baumann and Ms Baumann-Serr) who had arrived in Australia from Germany the previous day. At this meeting the NSWPF "spoke… at length" and Mr Baumann's siblings were "informed of the possibilities concerning their missing brother".[5575]

[5569] Exhibit 42, Tab 47, Request to Interpol re further information from Anna Baumann, 3 September 2003 (SCOI.34289).

[5570] Exhibit 42, Tab 96, Letter from Ms Baumann-Serr to Missing Persons Unit, 26 October 1993, 2 (SCOI.38907).

[5571] Exhibit 42, Tab 34, Letter from Inspector Morton to V Rimoldi, 26 November 1993 (SCOI.38894); Exhibit 42, Tab 20, Letter from ABC Welfare officer to Peter Baumann, including file note re contact with Ruth Binney and Sharmalie Seneviratne, 17 November 1983 (SCOI.10850.00046).

[5572] Exhibit 42, Tab 4, Statement of Senior Constable Simon Field, 15 September 2008, [4] (SCOI.10850.00014).

[5573] Exhibit 42, Tab 38, Report of Senior Constable Emery, Missing Persons Unit, 17 June 1994 (SCOI.38939).

[5574] Exhibit 43, Statement of Mr Baumann's family, 25 June 2023 (SCOI.84143).

[5575] Exhibit 42, Tab 37, NSWPF Running Sheets, 'Inquiries re missing person Peter Baumann', 25 May 1994 – 1 June 1994, 2 (SCOI.34256).

6.553. On 30 May 1994, Mr Baumann's brother and sister met with Cherie Foster at the MPU. NSWPF records indicate that the "Baumanns appeared to be distressed as to the lack of Police action taken".[5576]

6.554. Counsel Assisting submits that there is evidence to suggest that by June 1994, there was tension between Senior Constable Gribble and Senior Constable Emery about the NSWPF response to Mr Baumann's disappearance.[5577] As noted above, Senior Constable Gribble appears to have been frustrated or angry that not enough was being done and that Mr Baumann's family had not been told earlier about the disappearance. Senior Constable Emery appears to have been opposed to investigating the matter further. Without full records, it is impossible to draw any definitive conclusions about what appears to be conflict within the NSWPF about this death.[5578]

1999-2002

6.555. On 11 November 1999, the NSWPF received a request from Mr Baumann's siblings, through Interpol, that further attempts be made to try and find him.[5579]

6.556. In 2001, certain routine checks were made to try to ascertain Mr Baumann's whereabouts.[5580] On 11 September 2001, a fax was sent by the MPU to Mr Baumann's family providing them with an update and informing them of a program whereby the MPU obtained DNA samples from the families of long-term missing persons.[5581] There was subsequent correspondence through Interpol about collecting a DNA sample from Mr Baumann's parents.[5582]

6.557. In 2002, Operation Utica was instituted with a view to investigating a number of missing persons matters within the Penrith LAC. Mr Baumann's matter seemingly fell within the purview of Operation Utica. Notwithstanding, it appears that no investigative steps were taken in furtherance of Mr Baumann's matter. Rather, an attempt was made to reassign the matter to the Eastern Suburbs LAC. Separate to Operation Utica, the MPU made checks with financial institutions in respect of Mr Baumann during this time.[5583]

2005-2009

6.558. On 9 November 2005, Detective Sergeant Darren Smith was appointed as the OIC.[5584] Detective Sergeant Smith undertook the following investigative steps:

[5576] Exhibit 42, Tab 37, NSWPF Running Sheets, 'Inquiries re missing person Peter Baumann', 25 May 1994 – 1 June 1994, 2 (SCOI.34256).

[5577] Exhibit 42, Tab 37, NSWPF Running Sheets, 'Inquiries re missing person Peter Baumann', 25 May 1994 – 1 June 1994, 3 (SCOI.34256).

[5578] Submissions of Counsel Assisting, 27 June 2023, [129] (SCOI.84145).

[5579] Exhibit 42, Tab 39, Interpol request to Missing Persons Unit re review of matter, 11 November 1999 (SCOI.38957).

[5580] Exhibit 42, Tab 40, Fax from NSWPF Information and Intelligence Centre to Interpol, 25 July 2001 (SCOI.38944).

[5581] Exhibit 42, Tab 41, Fax from Constable Karen Dawson to Interpol, 11 September 2001 (SCOI.34287).

[5582] Exhibit 42, Tab 42, Letter from Interpol Canberra to NSWPF, 19 October 2001, (SCOI.34261).

[5583] Exhibit 42, Tab 43, Results of inquiries with financial institutions re Peter Baumann, 26 March 2002 to 2 April 2002 (SCOI.34225).

[5584] Exhibit 42, Tab 3, Statement of Detective Sergeant Darren Smith, 12 August 2008 (SCOI.34345).

a. On 17 November 2005, Detective Sergeant Smith made enquiries with the Coroners Court to ascertain whether they held any records in relation to Mr Baumann. He was informed that they did not;[5585]

b. On 17 November 2005, Detective Sergeant Smith contacted the MPU to obtain the investigative file in relation to Mr Baumann and "all related paperwork". On 7 December 2005, Detective Sergeant Smith received the requested items and he recorded that they consisted of "the statements obtained by Police investigating BAUMANN'S disappearance and enquiries made by Police back in 1993, 10 years after he was reported missing";[5586]

c. On 5 April 2006, Detective Sergeant Smith sought to have Mr Baumann's case allocated to the "detective's office at Eastern Suburbs" for further investigation.[5587] On 7 March 2007, the case was allocated to Detective Sergeant Smith when he transferred to the Eastern Suburbs LAC;[5588]

d. In April 2007, Detective Sergeant Smith contacted and obtained statements from John Pauperis (Ms Foster's boyfriend at the time Mr Baumann disappeared), and Hamish Pears (Ms Seneviratne's cousin). Detective Sergeant Smith was unable to contact Ms Foster;[5589]

e. Also in April 2007, Detective Sergeant Smith contacted Mr Smyth and Mr Keasberry and recorded that Mr Smyth's "memory may be failing him" and that Mr Keasberry denied ever knowing Mr Baumann;[5590]

f. Also in April 2007, Detective Sergeant Smith contacted Ms Seneviratne who confirmed she had no further information beyond what she provided the NSWPF in 1993, save that she thought she had seen Mr Baumann in 1996 but she did not report this to the police.[5591] A further statement from Ms Seneviratne was subsequently obtained;

g. In May 2008, Detective Sergeant Smith requested information from Medicare, telecommunications companies, Centrelink, the NSW Electoral Commission and the Department of Immigration and Citizenship;[5592] and

h. Also in May 2008, Detective Sergeant Smith made enquiries within the NSWPF about whether any unidentified persons had been located that matched Mr Baumann's description. Detective Sergeant Smith also made enquiries about the location of two items of property (Mr Baumann's guitar and carving knife) that were apparently handed to Parramatta Police Station on 13 September 1993 by Senior Constable Gribble. No relevant results appear to have been obtained.[5593]

[5585] Exhibit 42, Tab 3, Statement of Detective Sergeant Darren Smith, 12 August 2008, [4] (SCOI.34345).

[5586] Exhibit 42, Tab 3, Statement of Detective Sergeant Darren Smith, 12 August 2008, [5]–[6] (SCOI.34345).

[5587] Exhibit 42, Tab 3, Statement of Detective Sergeant Darren Smith, 12 August 2008, [7] (SCOI.34345).

[5588] Exhibit 42, Tab 3, Statement of Detective Sergeant Darren Smith, 12 August 2008, [7] (SCOI.34345).

[5589] Exhibit 42, Tab 3, Statement of Detective Sergeant Darren Smith, 12 August 2008, [13] (SCOI.34345).

[5590] Exhibit 42, Tab 3, Statement of Detective Sergeant Darren Smith, 12 August 2008, [12] (SCOI.34345).

[5591] Exhibit 42, Tab 4, Statement of Senior Constable Simon Field, 15 September 2008, [5] (SCOI.10850.00014).

[5592] Exhibit 42, Tab 3, Statement of Detective Sergeant Darren Smith, 12 August 2008, [14]–[18] (SCOI.34345).

[5593] Exhibit 42, Tab 3, Statement of Detective Sergeant Darren Smith, 12 August 2008, [20]–[21] (SCOI.34345).

6.559. In 2006, the Eastern Suburbs LAC requested the assistance of the Homicide Squad. This request for assistance was denied pending any coronial findings being made as to the disappearance of Mr Baumann.[5594]

6.560. On 8 March 2007, Strike Force Blissett was formed to investigate the disappearance of Mr Baumann.[5595]

6.561. Between 26 May 2008 and 3 June 2008, the investigation into Mr Baumann's disappearance was transferred to Plain Clothes Senior Constable Simon Field.[5596] Plain Clothes Senior Constable Field "made a number of name checks utilising the Police and RTA systems" and "received information…. [t]hat a fresh search of the 'Unidentified Bodies' data base had failed to locate a match for BAUMANN".[5597]

6.562. On 25 April 2008, Plain Clothes Senior Constable Field completed the Report of Death to Coroner. Plain Clothes Senior Constable Field concluded that:

> *It is apparent that BAUMANN is missing believed deceased. BAUMANN has not left the country under his original passport and is believed to still be in the country. Through the various witness statements it may appear that BAUMANN has met with foul play with the varied and bizarre relationships he held whilst in Australia. Although it can not be discounted that BAUMANN, using an alias, has simply changed his name to avoid detection, so that he may remain within Australia illegally, as is stated by witnesses, that he had held grave fears of returning to Germany. Due to the length of time involved in this investigation, police have little evidence at this stage to assist in the disappearance of BAUMANN.*[5598]

2011 onwards

6.563. In 2011, 2014 and 2016-2017, several discrete investigations were made regarding Mr Baumann's dental records and potential links with an unidentified body in the Northern Territory. There also appears to have been some liaison between the MPU and the Eastern Suburbs LAC regarding outstanding requisitions to be progressed.

Persons of interest

6.564. In the years following Mr Baumann's disappearance (although not in its immediate aftermath), police spoke to a select number of witnesses which included friends, intimate partners, and acquaintances of Mr Baumann. No persons of interest were identified in relation to Mr Baumann's death.

[5594] Exhibit 42, Tab 56, Response from Detective Chief Superintendent Rock Del Monte re request for State Crime Command assistance, 12 April 2006 (SCOI.10850.00038).

[5595] Exhibit 42, Tab 79, Response of Detective Inspector Leggat to request by Senior Constable Gribble, 13 April 2017 (SCOI.11010.00003).

[5596] Exhibit 42, Tab 3, Statement of Detective Sergeant Darren Smith, 12 August 2008, [26] (SCOI.34345); Exhibit 42, Tab 4, Statement of Senior Constable Simon Field, 15 September 2008, [3] (SCOI.10850.00014).

[5597] Exhibit 42, Tab 4, Statement of Senior Constable Simon Field, 15 September 2008, [26]–[27] (SCOI.10850.00014).

[5598] Exhibit 42, Tab 4, Statement of Senior Constable Simon Field, 15 September 2008, [29] (SCOI.10850.00014).

Exhibits: availability and testing

6.565. Following Mr Baumann's disappearance, Ms Binney kept his guitar and a "long knife" found in Mr Baumann's jacket pocket.[5599] Police subsequently seized these items, but they were never the subject of any forensic examination.[5600] In 1994, these items were returned to Mr Baumann's family.[5601] This is likely why these items could not be located by Detective Sergeant Darren in 2008, as identified above.

Findings at inquest

6.566. On 4 August 2009, an inquest was conducted by Deputy State Coroner Milovanovich. That same day, his Honour made the following finding in relation to Mr Baumann:[5602]

> *I am satisfied that Peter Karl Baumann is deceased. I find that he died some time on or after the 26th October, 1983. As to the precise date of death, place of death or manner and cause of death from the available evidence I am unable to say.*

Criminal proceedings

6.567. No criminal proceedings were ever instituted against any person in relation to Mr Baumann's disappearance or death.

Subsequent police investigation

UHT reviews

6.568. The Inquiry has been provided with an undated Triage Form which purports to be a triage assessment of Mr Baumann's case by the UHT.[5603]

6.569. This form appears to be incomplete, and it has not been signed. To the extent that the form has been populated, it is curious that it states that a post-mortem examination was conducted by a "Dr Paul Botterill" and that the cause of death was determined to be "[h]omicidal violence of undetermined aetiology".[5604] In circumstances where Mr Baumann's remains have never been recovered (and therefore no post-mortem has been able to be performed) it can be assumed this entry erroneously relates to another case.

[5599] Exhibit 42, Tab 15, Statement of Ruth Binney, 16 November 1993, 1 (SCOI.10850.00024).

[5600] Exhibit 42, Tab 33, Miscellaneous Property Receipt A400194 – Gibson brand guitar and carving knife, 13 September 1993 (SCOI.34340).

[5601] Exhibit 42, Tab 37, NSWPF Running Sheet, 'Inquiries re missing person Peter Baumann', 26 May 1994 (SCOI.34256).

[5602] Exhibit 42, Tab 2, Findings of DSC Milovanovich, 4 August 2009 (SCOI.10850.00002).

[5603] Exhibit 42, Tab 83, UHT Triage Form – Review of an Unsolved Homicide, undated (SCOI.38971).

[5604] Exhibit 42, Tab 83, UHT Triage Form – Review of an Unsolved Homicide, Undated 3 (SCOI.38971).

6.570. During the course of the Investigative Practices Hearing, Detective Chief Inspector Laidlaw was questioned in relation to the Triage Form. He accepted that the post-mortem result was an error and indicated that it appeared to him the Triage Form was not completed.[5605] The NSWPF also accepted that it is "unsatisfactory" that this is the only Triage Form in relation to Mr Baumann's death.[5606]

6.571. On 13 April 2017, Detective Inspector Leggat from the UHT finalised an "Issue Paper" in response to a request from Senior Constable Gribble and dated 21 November 2016 to conduct a further investigation into the disappearance of Mr Baumann. Detective Inspector Leggat concluded that the UHT should not conduct an investigation into Mr Baumann's disappearance. Detective Inspector Leggat wrote that:[5607]

> *The matter has been adequately investigated by the Eastern Suburbs LAC and in the absence of fresh information a further investigation by the Unsolved Homicide Team is not warranted.*

6.572. Detective Inspector Leggat ultimately recommended that the investigation remain with Eastern Suburbs LAC to finalise the outstanding issues identified by Senior Constable Gribble in his correspondence to the UHT that had not already been performed by other police officers.[5608]

Review by the Inquiry

6.573. In the course of investigating Mr Baumann's case, the Inquiry took a number of investigative and other steps. These included requesting the coronial file and issuing a summons for the police investigative file.

6.574. The Inquiry reviewed and analysed a considerable volume of material provided by the NSWPF and the Coroners Court, and obtained by summons, and considered whether any further investigative steps or other avenues were warranted. These investigative steps included:

a. Issuing summonses to BDM and the equivalent agency in Western Australia to obtain information about key witnesses;

b. Issuing summonses to NSW Health and St Vincent's Hospital (**St Vincent's**) to obtain any medical records relating to Mr Baumann;

c. Requesting information from Services Australia in relation to Mr Baumann;

d. Contacting key witnesses;

[5605] Transcript of the Inquiry, 7 July 2023, T5240.26–5241.15, 5241.23–25 (TRA.00075.00001).

[5606] Submissions of NSWPF, 10 October 2023, [360] (SCOI.84381).

[5607] Exhibit 42, Tab 79, Response of Detective Inspector Leggat to request by Senior Constable Gribble, 13 April 2017, 3 (SCOI.11010.00003).

[5608] Exhibit 42, Tab 79, Response of Detective Inspector Leggat to request by Senior Constable Gribble, 13 April 2017, 3 (SCOI.11010.00003).

e. Contacting FASS as to requesting that the DNA profiles of Mr Baumann's relatives be run against all unidentified bodies in NSW; and

f. Contacting Mr Baumann's family.

Summonses

Summonses and requests issued to NSWPF

6.575. A summons to the NSWPF was issued on 21 July 2022 for all documents in relation to the investigations by the NSWPF into the death of Mr Baumann, and any other material held by the UHT in relation to Mr Baumann's death (NSWPF3). Material in relation to Mr Baumann was provided to the Inquiry in two tranches on 9 and 12 August 2022, respectively.[5609] A further tranche of material was provided to the Inquiry on 22 June 2023, which consisted of 401 pages of documents.

6.576. On 31 January 2023, the Inquiry wrote to the NSWPF seeking further information about documents which indicated that the Northern Territory Police Force (**NTPF**) notified the MPU of an unidentified body that the NTPF believed might have been Mr Baumann and sought to compare the DNA profile obtained from Mr Baumann's mother with the unidentified body.[5610]

6.577. On 6 and 21 March 2023, the NSWPF informed the Inquiry that the DNA comparison that was conducted does not support the conclusion that the unidentified remains were those of Mr Baumann.[5611]

6.578. On 5 June 2023, a summons to the NSWPF was issued seeking intelligence material in relation to various witnesses (NSWPF119). That material was produced on 8 June 2023.

6.579. On 31 August 2023, a summons to the NSWPF was issued seeking, relevantly, intelligence material in relation to various witnesses and additional files held by the NSWPF (NSWPF176). I note that several documents produced in response this summons were properly captured and ought to have been produced by the NSWPF in response to Summons NSWPF119. The consequences of such a failure to produce material responsive to a summons lawfully issued have been canvassed in **Chapter 15**.

Other summonses issued

6.580. On 21 December 2022, the Inquiry issued a summons to BDM for records of, relevantly, Mr Baumann (BDM8). On 22 December 2022, BDM produced these records to the Inquiry.[5612]

[5609] Exhibit 42, Tab 94, Statement of Aleksandra Jez, 26 June 2023, [6]–[7] (SCOI.84144).

[5610] Exhibit 42, Tab 89, Letter from Caitlin Healey-Nash to Aurhett Barrie, 31 January 2023 (SCOI.84117).

[5611] Exhibit 42, Tab 90, Correspondence between the Inquiry and NSWPF re Northern Territory remains, 6 March 2023 – 21 March 2023 (SCOI.84116).

[5612] Exhibit 42, Tab 94, Statement of Aleksandra Jez, 26 June 2023, [9] (SCOI.84144).

6.581. On 21 December 2022, the Inquiry issued a summons to NSW Health to obtain any medical records relating to Mr Baumann, including in relation to any HIV/AIDS diagnosis (NSWH1).[5613] On 11 January 2023, NSW Health advised that it held no records responsive to the summons. NSW Health further advised that HIV/AIDS became a "notifiable condition" in NSW in 1984 and suggested that the Inquiry approach St Vincent's in relation to any HIV/AIDS diagnoses made between 1982 and 26 October 1993.[5614]

6.582. On 10 March 2023, the Inquiry issued a summons to St Vincent's to obtain any medical records relating to Mr Baumann (SVH2).[5615] On 15 March 2023, St Vincent's advised that it held no records responsive to the summons and that it was unable to be of any further assistance.[5616]

6.583. On 10 March 2023 and 19 June 2023, further summonses were issued to the Western Australia BDM, for the records of various witnesses (WBDM4 and WBDM6). These records were produced on 16 March 2023 and 20 June 2023 respectively. Those records include a death certificate which records that Mr Smyth died on 6 October 2016, aged 96 years.[5617]

6.584. On 1 June 2023, a summons was issued to the Western Australia Police Force seeking records in relation to various witnesses (WAP3). Those records were produced in two tranches, on 7 June 2023 and 19 June 2023 respectively.

Interagency cooperation with the Inquiry

6.585. On 15 June 2022, the Inquiry issued a written request to the Coroners Court to obtain the coronial file in relation to the death of Mr Baumann. The Coroners Court provided the coronial file on 1 August 2022.[5618]

6.586. On 22 December 2022, a letter was sent to Services Australia regarding any Medicare and PBS records that were in existence in relation to Mr Baumann.[5619] On 17 January 2023, the Inquiry received a response from Services Australia confirming that there were no such records available.[5620]

Family members

6.587. On 19 June 2023, the Inquiry sent a letter to Ms Baumann-Serr, requesting any information she may hold in relation to Mr Baumann's death. On 22 June 2023, the Inquiry was contacted by Ms Baumann-Serr.[5621]

[5613] Summons to NSW Ministry of Health (NSWH1), 21 December 2022 (SCOI.82344).

[5614] Exhibit 42, Tab 87, Letter from Dr Richard Broome to Commissioner Sackar, 11 January 2023 (SCOI.84115).

[5615] Summons to produce to St Vincent's Hospital (SVH2), 10 March 2023 (SCOI.86387).

[5616] Exhibit 42, Tab 88, Letter from St Vincent's Hospital to Caitlin Healey-Nash, 15 March 2023 (SCOI.84121).

[5617] Exhibit 42, Tab 93, Death Certificate – Allan Smyth, 20 June 2023 (SCOI.84122).

[5618] Exhibit 42, Tab 94, Statement of Aleksandra Jez, 26 June 2023, [4]–[5] (SCOI.84144).

[5619] Exhibit 42, Tab 85, Letter from Caitlin Healey-Nash to Services Australia, 22 December 2022 (SCOI.84120).

[5620] Exhibit 42, Tab 86, Letter from Services Australia to the Inquiry, 17 January 2023 (SCOI.84119).

[5621] Exhibit 42, Tab 94, Statement of Aleksandra Jez, 26 June 2023, [12]–[13] (SCOI.84144).

6.588. On 25 June 2023, the Inquiry received a statement from Mr Baumann's family, co-written by his six brothers and sisters.[5622] In this statement, Mr Baumann's siblings stated that their contact with Mr Baumann was lost sometime in October 1983. They described their "continuous efforts" to locate Mr Baumann over the ten year period between 1983 and 1994.

6.589. On 14 September 2023, Ms Baumann-Serr provided documentation which detailed several inquiries made to Australian agencies between 1990 and 1994 to locate Mr Baumann.[5623] I return to this documentation below.

6.590. In a letter dated 22 August 1993, Ms Baumann-Serr contacted Senior Constable Gribble and Senior Constable Emery expressing her surprise "that not much has been done to find my brother in all these years he went missing", which she said she had only learned in a phone call that day.[5624] In that correspondence, Ms Baumann-Serr set out a number of queries in relation to Mr Baumann, and informed the officers that she had made several attempts to contact different agencies to obtain information about Mr Baumann, to no avail.[5625] Ms Baumann-Serr stated she was "sure something happened to my brother since I otherwise would not have to find him".[5626]

6.591. This account of the late notice provided to Mr Baumann's family is consistent with correspondence sent to the DOFM on 25 August 1993. In that correspondence, Ms Baumann-Serr indicated that she had learned a week earlier than her letter (i.e., around 18 August 1993) that Mr Baumann had been reported missing to the NSWPF in 1983.[5627]

6.592. Mr Baumann's family expressed that they were "exhausted and completely disenchanted" after their visit to Sydney and interactions with the NSWPF.

6.593. Mr Baumann's siblings told the Inquiry that in the years following 1994, they "repeatedly gave saliva samples to the local police for comparison".[5628]

Other sources of information

6.594. On 13 March 2023, a letter was sent to Ms Binney, inviting her to meet with the Inquiry to discuss the circumstances surrounding Mr Baumann's disappearance. On 14 April 2023, Ms Binney contacted the Inquiry, advising that she was not in a position to provide any further information relating to Mr Baumann's disappearance.[5629]

[5622] Exhibit 43, Statement of Mr Baumann's family, 25 June 2023 (SCOI.84143).

[5623] Exhibit 42, Tab 95, Letter from the Red Cross Tracing Agency to Mr Peter Baumann, 18 March 1992 (SCOI.34241); Exhibit 42, Tab 97, Various enquiries made by Ms Baumann-Serr re Peter Bauman, 1990-1994 (SCOI.86022).

[5624] Exhibit 42, Tab 96, Letter from Ms Baumann-Serr to Missing Persons Unit, 22 August 1993, 1 (SCOI.38907).

[5625] Exhibit 42, Tab 97, Various enquiries made by Ms Baumann-Serr re Peter Bauman, 1990-1994 (SCOI.86022).

[5626] Exhibit 42, Tab 96, Letter from Anne Baumann-Serr to Missing Persons Unit, 22 August 1993, 1 (SCOI.38907).

[5627] Exhibit 42, Tab 97, Various enquiries made by Anne Baumann-Serr re Peter Bauman, 1990-1994 (SCOI.86022).

[5628] Exhibit 43, Statement of Mr Baumann's family, 25 June 2023 (SCOI.84143).

[5629] Exhibit 42, Tab 94, Statement of Aleksandra Jez, 24 June 2023, [16] (SCOI.84144).

6.595. On 13 March 2023, a letter was sent a letter to Ms Seneviratne inviting her to meet with the Inquiry to discuss the circumstances surrounding Mr Baumann's disappearance. On 5 June 2023, Ms Seneviratne contacted the Inquiry, advising that she was not in a position to provide any further information relating to Mr Baumann's disappearance.[5630]

6.596. On 5 June 2023, a letter was sent to Ms Foster, inviting her to meet with the Inquiry to discuss the circumstances surrounding Mr Baumann's disappearance.[5631] The Inquiry did not receive a response from Ms Foster.

6.597. On 5 June 2023, the Inquiry wrote to FASS seeking confirmation that it held the DNA profiles for Mr Baumann's mother and father, and requesting that, if so, the DNA profiles of Mr Baumann's parents be run against all unidentified bodies in NSW.[5632] On 20 June 2023, Carole Field, Group Manager of the Database and Case Management Unit at FASS, provided the Inquiry with a statement detailing FASS' response to the Inquiry's queries.[5633] Ms Field stated that FASS did not hold a reference sample for either of Mr Baumann's parents but that the NSWPF had received a mitochondrial DNA report in relation to Mr Baumann's mother and her mitochondrial DNA profile could be used to search against all mitochondrial DNA profiles from unidentified human remains on the national DNA database. However, Ms Field stated that to date, no mitochondrial DNA match had been identified.

6.598. On 1 September 2023, the Inquiry wrote to the NSWPF seeking their assistance with obtaining DNA samples from Mr Baumann's siblings in Germany, and with arranging for autosomal and Y-chromosome testing of those samples.[5634]

6.599. On 6 September 2023, the NSWPF wrote to the Inquiry and advised that the NTPF obtained DNA samples from two of Mr Baumann's siblings in 2016. The NSWPF further advised that FASS may be able to liaise with the Northern Territory Forensic Services (**NTFS**) to arrange for the further testing to be conducted. The NSWPF sought the Inquiry's consent to contact the NTFS to arrange for the further testing to be conducted.[5635]

6.600. On 7 September 2023, the Inquiry wrote to the NSWPF advising that it consented to the NSWPF contacting the NTFS to arrange for the further testing to be conducted.[5636]

[5630] Exhibit 42, Tab 94, Statement of Aleksandra Jez, 24 June 2023, [17] (SCOI.84144).

[5631] Exhibit 42, Tab 94, Statement of Aleksandra Jez, 24 June 2023, [18] (SCOI.84144).

[5632] Exhibit 42, Tab 91, Letter from Aleksandra Jez to Clint Cochrane, 5 June 2023 (SCOI.84114).

[5633] Exhibit 42, Tab 92, Statement of Carole Field, 20 June 2023 (SCOI.84118).

[5634] Exhibit 42, Tab 99, Letter from the Inquiry to NSWPF re autosomal DNA testing, 1 September 1993 (SCOI.86018).

[5635] Exhibit 42, Tab 100, Letter from NSWPF to the Inquiry re DNA samples held by Northern Territory Police, 6 September 2023 (SCOI.86020).

[5636] Exhibit 42, Tab 101, Letter from the Inquiry to NSWPF re facilitation of DNA testing, 7 September 2023 (SCOI.86019).

6.601. On 11 September 2023, the NSWPF wrote to the Inquiry advising that the NTFS does not currently have capacity to upload volunteer and victim samples to a National Database. However, the NSWPF was in the process of arranging a "Thatcher Form" so that the samples from Mr Baumann's relatives could be sent for testing. It appears that this form is submitted to authorise the release of the DNA samples to the NSWPF, such that testing can be conducted outside of the NTFS.[5637]

6.602. On 1 November 2023, the NSWPF wrote again to the Inquiry advising that FASS has successfully profiled the DNA samples received from the NTFS, and they would be uploaded to the national database so as to allow for testing against unidentified human remains in the future.[5638]

6.603. As I indicated above, Ms Baumann-Serr provided the Inquiry with records of several inquiries made to Australian agencies between 1990 and 1994 to locate Mr Baumann. Ms Baumann-Serr corresponded with BDM in South Australia, Victoria, ACT, and the NT between 1990-1991; the Australian Red Cross Society in 1992; the Australian Performing Rights Association Ltd in 1992; the Department of Foreign Affairs in 1993; and, the Australian Consulate General in Los Angeles in 1993 and Bali in 1994. No record of Mr Baumann was returned from any of the agencies contacted by Ms Baumann-Serr.[5639] None of this correspondence led to Ms Baumann-Serr to being informed of the missing person report, nor does any of the correspondence suggest that she make inquiries of the NSWPF.

6.604. Counsel Assisting made reference to the "unfortunate" lack of interagency cooperation—both internationally and domestically—which meant that none of the extensive efforts by the family members of Mr Baumann since the disappearance of their brother in 1983 brought them into contact with the NSWPF.[5640]

6.605. In this regard, the NSWPF advised the Inquiry of the current procedures relating to enquiries made by persons residing overseas regarding their missing relatives. It appears that two policies have been implemented with a view to improving this process, including the 2022 NSWPF Standard Operating Procedures for Missing Persons, Unidentified Bodies and Human Remains,[5641] and the 2020 Australia New Zealand Policing Advisory Agency's Australia and New Zealand Policy for Missing Persons Investigations.[5642] The practical effect of these procedures and policy appears to be that family members of missing persons are contacted by the NSWPF following the receipt of a missing person's report.

[5637] Exhibit 42, Tab 102, Letter from NSWPF to the Inquiry re facilitation of DNA testing, 11 September 2023 (SCOI.86021).

[5638] Exhibit 42, Tab 104, Letter from NSWPF to the Inquiry re DNA testing update, 1 November 2023 (SCOI. 86665).

[5639] Exhibit 42, Tab 95, Letter from the Red Cross Tracing Agency to Mr Peter Baumann, 18 March 1992 (SCOI.34241); Exhibit 42, Tab 97, Various enquiries made by Ms Baumann-Serr re Peter Bauman, 1990-1994 (SCOI.86022).

[5640] Supplementary submissions of Counsel Assisting, 6 October 2023, [21] (SCOI.86039).

[5641] Exhibit 51, Tab 001X, NSWPF Standard Operating Procedure for Missing Persons, Unidentified Bodies and Human Remains, January 2002, (NPL.0100.0003.0025).

[5642] Exhibit 42, Tab 103, Letter from NSWPF to the Inquiry re supplementary Submissions of Counsel Assisting, 11 October 2023, 1–2 (SCOI.86135).

6.606. The NSWPF also advised the Inquiry that for relatives seeking to find a missing relative in Australia the following lines of inquiry are available and may be of assistance:[5643]

a. The relevant Australian Consulate;

b. Filing a missing persons report with a foreign local police station, which are disseminated by Interpol to the relevant Australian police jurisdiction;

c. The National Missing Person's Co-ordination Centre which provides information for next of kin regarding making a report, as well as maintaining a publicly-available registry of missing persons; and

d. The MPR, which coordinates the NSWPF response to missing persons investigations.

6.607. This suggests there has been some level of improvement in the ability for families located overseas to access information about missing family members. I therefore do not propose to make a targeted recommendation in this respect. However, I note that in the time made available to the Inquiry, I have not been able to examine in any detail how the abovementioned entities, particularly the National Missing Person's Co-ordination Centre, operate to assist the families of missing persons, I consider that generally speaking, ongoing consideration needs to be given to whether the processes and procedures can be improved in this respect.

Contact with OICs

6.608. On 24 August 2023 and 27 September 2023, the Inquiry wrote to the former OICs enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to Mr Baumann's death: Mr Emery; Mr Gribble; Mr Smith and Mr Field. On 18 September 2023, the Inquiry again wrote to Mr Field and did not receive a response. The Inquiry was advised by Mr Emery and Mr Smith that they did not wish to provide any submissions in relation to Mr Baumann's disappearance and suspected death.[5644]

6.609. On 27 September 2023, the Inquiry received written submissions from Mr Gribble in relation to the death of Mr Baumann. In his written submissions, Mr Gribble stated that he was involved in the investigation into Mr Baumann's disappearance for a period of around three months at the end of 1993 and maintained an interest in the case thereafter. The submissions of Mr Gribble are considered in greater detail below.

[5643] Exhibit 42, Tab 103, Letter from NSWPF to the Inquiry re supplementary Submissions of Counsel Assisting, 11 October 2023, 1–2 (SCOI.86135).

[5644] Exhibit 66, Tabs 3 to 5, 7-8 and 10, Letters to Jeffrey Emery, Simon Field, William Gribble and Darren Smith (SCOI.86294; SCOI.86298_E; SCOI.86307; SCOI.85904_E; SCOI.86336; SCOI.86274).

Other steps

6.610. On 20 June 2023 the Inquiry arranged for a search to be conducted on the NCIS for any further information related to Mr Baumann's disappearance. No relevant results were obtained.[5645]

6.611. The Inquiry also took certain steps by way of private hearing, which are addressed in **Chapter 17**.

Consideration of the evidence

Background and disappearance

Arrival in Australia

6.612. There is some evidence to suggest that Mr Baumann travelled to Australia for the purpose of pursuing a music career as a composer.[5646] After arriving in Australia, Mr Baumann may have worked as a musician at the Sydney Conservatorium of Music, although the NSWPF never confirmed this.[5647] At the time of his disappearance, Mr Baumann was employed by the ABC as an Assistant Sound Librarian. When he was initially employed by the ABC, Mr Baumann utilised the surname "Moltzen".[5648]

Living arrangements

6.613. Upon his arrival in Australia, it appears that Mr Baumann resided at a property in Bennett Street, Bondi, but there is no record of the NSWPF ever confirming this.[5649]

6.614. From around March to July 1982, NSWPF records indicate that Mr Baumann resided at Glebe Point Road, Glebe, with a person named Keith Smith.[5650] The nature of Mr Baumann's relationship with Mr Smith is not clear; there is no record of Mr Smith ever being spoken to by the NSWPF.

6.615. On or around late 1982 to early 1983, Mr Baumann moved to Cross Street, Waverley (now in Bronte) which was owned by Ms Binney.[5651] At the time of Mr Baumann's disappearance Ms Binney's name was Ruth Van Duyn (although she was still referred to by Mr Gover in his contemporaneous note as "Mrs Binney"). By the time she provided a statement to the NSWPF, her name was changed to Ruth Binney. Mr Baumann was living at this address until he disappeared in around October 1983.

[5645] Exhibit 42, Tab 94, Statement of Aleksandra Jez, 24 June 2023 (SCOI.84144).

[5646] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [2], [69] (SCOI.11010.00007); Exhibit 42, Tab 30, Missing Persons Unit Running Sheet, 21 October 1993, 3 (SCOI.38950); Exhibit 42, Tab 36B, Report of Senior Constable John Gribble re missing persons investigation, 3 December 1993, 3 (SCOI.38945).

[5647] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [12] (SCOI.11010.00007).

[5648] Exhibit 42, Tab 34, Letter from Inspector Morton to V Rimodli (ABC) re Peter Baumann, 26 November 1993, 2 (SCOI.38894).

[5649] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [4] (SCOI.11010.00007).

[5650] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [8] (SCOI.11010.00007).

[5651] Exhibit 42, Tab 15, Statement of Ruth Binney, 16 November 1993, 1 (SCOI.10850.00024).

6.616. Ms Binney would collect the rent from Mr Baumann on a fortnightly basis and, in accordance with a request from Mr Baumann, Ms Binney provided rent receipts in the name of "Peter K.J Ann".[5652]

6.617. The Cross Street premises was a house that had been converted into five flats. At the time of Mr Baumann's disappearance, only one other flat was occupied and the occupant was a Japanese cartoonist whose name was initially believed to be "Hyuma Hoshi" but was later revealed to be Hiroshi Hamasaki.[5653] There is no record of Mr Hamasaki ever being spoken to by the police.

Relationship with Ms Seneviratne

6.618. According to Ms Seneviratne's 1993 statement, Mr Baumann first approached her in around December 1981. Ms Seneviratne stated that she initially refused to go out with him, but in January 1982 they struck up a relationship. He told her that he was a musician at the Conservatorium of Music, and they met for lunch on most days outside the Conservatorium.[5654] Their relationship lasted until around July 1982 and she went to his flat at Bennett Street, Bondi, on a number of occasions during that period.[5655]

6.619. In her 1993 statement, Ms Seneviratne stated that Mr Baumann seemed generally stable but at times could be aggressive, very demanding and possessive of her. She was prevented from talking to friends or having a social life outside of their relationship.[5656] Around three months into their relationship, Ms Seneviratne stated that Mr Baumann asked her to marry him, that he had all of the relevant forms on hand, and that all she needed to do was "fill our [her] section". Ms Seneviratne said she rejected Mr Baumann's proposal on the basis that she was young and that she also harboured suspicions that he may be using the marriage to gain permanent residency. Mr Baumann was "very upset" with Ms Seneviratne's response and continued to ask her to marry him until she broke off the relationship in July 1982.[5657] They had limited contact after the breakup until just prior to Mr Baumann's disappearance in October 1983.

Relationship with Mr Smyth

6.620. Mr Smyth gave a statement to police on 16 November 1993. The copy of this statement that has been produced to the Inquiry is not signed, and refers to the fact that the signed copy is contained in the official notebook of Senior Constable Gribble. These notebooks were not produced to the Inquiry and are, presumably, missing. The failure by the NSWPF to retain these notebooks, so as to be in a position to produce them to the Inquiry, is another material deficiency in the NSWPF record-keeping.

[5652] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [9] (SCOI.11010.00007).

[5653] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [10] (SCOI.11010.00007).

[5654] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, 2 (SCOI.11010.00007).

[5655] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [3]–[4] (SCOI.10850.00020).

[5656] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [3] (SCOI.10850.00020).

[5657] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [4] (SCOI.10850.00020).

6.621. According to Mr Smyth, he was in a relationship with Mr Baumann that commenced in December 1981/January 1982. Mr Smyth met Mr Baumann in Centennial Park in the summer of 1981 when he was walking his dogs. They would meet two to three times a week either at Mr Baumann's home or Mr Smyth's home in Artlett Street, Edgecliff, and the relationship continued until Mr Baumann's disappearance.[5658] According to a NSWPF running sheet, Mr Smyth "used to regularly see" Mr Baumann and continually referred to him as "absolutely delightful".

6.622. Mr Smyth described Mr Baumann as having an obsession about not going back to Germany and wanting to avoid being conscripted. He described this as a "real fear". Mr Smyth recalls that one day Mr Baumann attended his home and told him that he had met "a prostitute" and offered her $20,000 to marry him. Mr Smyth alleges that at some stage after the marriage, Mr Baumann told him that some people, namely "the girl's protectors", had approached him and asked for a further $30,000. Mr Smyth got the impression that Mr Baumann was being blackmailed and that the threats being made were of a violent nature.[5659]

6.623. During this period, Mr Smyth was living with Mr Keasberry in Artlett Street, Edgecliff, and the two men had been living together since 1971.[5660]

Marriage to Ms Foster, permanent residency, and divorce

6.624. In or around March 1982, Mr Baumann met Ms Foster.

6.625. According to the Report of Death to Coroner, Ms Foster was a sex worker "who he met in Byron Bay, so that he could obtain permanent residency in Australia".[5661]

6.626. This conclusion appears to be supported by evidence that suggests that Mr Baumann wanted to remain in Australia and that he did not want to return to Germany. Mr Baumann was said to have expressed his desire to stay in Australia on a number of occasions, including that he was concerned about being conscripted in Germany.[5662] Whilst he was living at the Cross Street premises, Mr Baumann told Ms Binney that he was married but that he was in the process of arranging a divorce. Ms Binney told police that she thought the marriage had occurred so that Mr Baumann could stay in Australia.[5663] However, there is also evidence that Mr Baumann was exempt from conscription on medical grounds.[5664]

6.627. There is some evidence to suggest that Mr Baumann paid an amount to Ms Foster in exchange for her agreeing to marry him (but the evidence in relation to whether this involved a lump sum payment or regular payments over the course of the marriage is conflicting).

[5658] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, 3 (SCOI.11010.00007); Statement of Allan Smyth, 16 November 1993, 1 (SCOI.10850.00023).

[5659] Exhibit 42, Tab 11, Statement of Allan Smyth, 16 November 1993, 1 (SCOI.10850.00023).

[5660] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [55] (SCOI.11010.00007).

[5661] Exhibit 42, Tab 1, P79A Report of Death to Coroner, 25 June 2008 (SCOI.10850.00012).

[5662] Exhibit 42, Tab 11, Statement of Allan Smyth, 16 November 1993, 1 (SCOI.10850.00023).

[5663] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [11] (SCOI.11010.00007); Exhibit 42, Tab 15, Statement of Ruth Binney, 16 November 1993, 1 (SCOI.10850.00024).

[5664] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 21 November 2016, [68] (SCOI.11010.00007).

6.628. According to a statement given to the police on 11 April 2007 by John Pauperis, Ms Foster's boyfriend over the years from about 1980 to 1987, Ms Foster had told him she was a "prostitute", but she did not go into details. As far as he knew, she did not have a pimp. Mr Pauperis attended Mr Baumann's residence on one occasion and was not aware of any money being provided by Mr Baumann to Ms Foster.[5665]

6.629. Ms Foster set out in her 1993 statement a more detailed account of events. According to Ms Foster, she had met Mr Baumann in Byron Bay whilst Ms Foster was helping some friends at the Byron Bay Markets. Mr Baumann told Ms Foster that he was looking to marry an Australian so that he could stay in the country and that he would rather die than go back to Germany. Mr Baumann indicated that he was willing to marry Ms Foster in exchange for some money. She could not recall the exact amount but said that it was not a large sum of money. Ms Foster gave Mr Baumann her contact details.

6.630. Ms Foster was later contacted by Mr Baumann after she had returned to Sydney. He attended her residence in Balmain where she lived with Mr Pauperis, who was also present. They discussed Mr Baumann's suggested arrangement. Ms Foster told Mr Baumann that if she married him, she would not be able to claim any welfare benefits. He offered her $70 per week which was equivalent to those benefits.

6.631. On 12 June 1982, Mr Baumann married Ms Foster.[5666]

6.632. Ms Foster attributes her decision to marry Mr Baumann to her sympathetic nature. She states that she certainly did not agree to it for the money. Rather, "the money was a consequence of the circumstance".

6.633. According to Ms Foster, after the wedding, Mr Baumann stayed in touch with Ms Foster to provide her with the agreed $70 per week. In March 1983, Ms Foster moved to a new home, but Mr Baumann continued to provide her with the funds on a weekly basis. She observed that Mr Baumann had become extremely paranoid and had developed an aggressive attitude towards women. She stated that he had been slipping notes under her door and accusing her of conspiring to have him deported. She was of the view that the notes were very out of character.

6.634. According to Ms Foster, she and Mr Baumann filed for divorce in around June or July 1983. She last saw him at around that time after she asked him for their divorce certificate.[5667]

6.635. On 29 April 1983, Mr Baumann was granted permanent residency.[5668]

[5665] Exhibit 42, Tab 18, Statement of John Pauperis, 11 April 2007, [12] (SCOI.10850.00026).

[5666] Exhibit 42, Tab 17, Certificate of Marriage – Cherie Foster, 12 June 1982 (SCOI.38933).

[5667] Exhibit 42, Tab 1, P79A Report of Death to Coroner, 25 June 2008 (SCOI.10850.00012); Exhibit 42, Tab 16, Statement of Cherie Kim Foster, 14 September 1994, [12] (SCOI.10850.00025).

[5668] Exhibit 42, Tab 67, Review by Coronial Advocate Assisting – Sergeant G Robinson, 11 December 2008, 1 (SCOI.10850.00007).

October 1983

6.636. According to Ms Seneviratne's 1993 statement, Mr Baumann telephoned her "one Friday" at about 7:00pm. They spoke on the telephone for around 30 to 40 minutes. She was "very shocked" by the call but observed that he sounded "very relaxed". He told her about his job at the ABC and indicated that he wanted to meet up. They arranged to meet at the Compass Centre in Bankstown the next day. Ms Seneviratne stated that during her call with Mr Baumann she asked him where he was living, and he would not answer. She became suspicious because he called her out of the blue and would not disclose where he was residing.[5669]

6.637. Later that same evening, she looked up Mr Baumann's details. Ms Seneviratne found Mr Baumann's contact details in the phone book. He was listed under the name "'Peter K.J. Ann", a name he had written on an audio cassette he gave her. Ms Seneviratne telephoned that number and Mr Baumann answered. Mr Baumann wanted to know how she got his number and was "very angry and sounded almost scared". During the conversation, the telephone "went dead in his mid-sentence". Ms Seneviratne was unable to call Mr Baumann back despite a number of attempts to do so.[5670]

6.638. Ms Seneviratne was worried and at around 9:00pm to 9:30pm, she went to the Cross Street premises with her cousin, Mr Pears (although as explained below Mr Pears denied this). Ms Seneviratne said that when she arrived at the Cross Street premises, the door was open and the flat was very untidy. Clothes were scattered across the room, and there were full ashtrays and beer bottles lying around. She said it "looked as though there had been a struggle in the room" and that "a small cushion had been burnt in the shower recess".[5671]

6.639. According to Ms Seneviratne, she then left the Cross Street premises, but as she did so she spotted something sticking out of the letterbox. She "just grabbed it," observed that there was an address on the back of the letter, and then drove to that address. The address was in Artlett Street, Edgecliff, and is known now to be the home of Mr Smyth and Mr Keasberry. At about 10:30pm that evening, Ms Seneviratne drove to this address.[5672]

[5669] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [5] (SCOI.10850.00020).

[5670] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [5] (SCOI.10850.00020).

[5671] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [6] (SCOI.10850.00020).

[5672] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [6] (SCOI.10850.00020).

6.640. According to Ms Seneviratne, when she arrived at the Artlett Street residence, she rang a bell on the gate. A man walked through the front door towards the gate and asked if he could help. Ms Seneviratne described him as "caucasian, five feet eight inches tall, medium build, thirtyish, balding, dressed all in black" and said he spoke with a German accent. I observe that, at this time, Mr Smyth was 63 years old and Mr Keasberry was 32 years old, meaning that if Ms Seneviratne spoke to either of these two persons it was likely to have been Mr Keasberry.[5673] Ms Seneviratne told the man that she was looking for Mr Baumann and sought his assistance. The man asked how she got his address and she indicated that it was on the back of the letter which she had found in Mr Baumann's letter box. Ms Seneviratne stated that the man "then became nervous" and asked where the letter was. After Ms Seneviratne told him that the letter was in the letter box, the man said that Mr Baumann "should be at home". The man then told Ms Seneviratne that he had no idea where Mr Baumann was and that he "might take a jog down to Peter's place". Ms Seneviratne asked why the man would do that when she had just been there and he replied, "yes, I might still take [a] jog down there anyway".[5674]

6.641. Ms Seneviratne stated that she then drove home and read the letter she had taken. She did not keep it, but recalled it said something to the following effect:

> *Dear Peter,*
>
> *I have finally told Oliver about us. I have told him how much I love you and that I want to be with you. I have also told him that I want to sell the house but (word was unreadable) was giving him a hard time about selling the house.*

6.642. Ms Seneviratne could not remember the entire letter but recalled that it said, "how much he cares for Peter how much he wants to be with him". Ms Seneviratne stated that the letter was signed either "Dillian" or "William".[5675]

6.643. According to Ms Seneviratne, she returned to the Cross Street premises the next day (a Saturday) with her sister, Dilania Seneviratne. They arrived at around 9:00am-10:00am and she noticed that Mr Baumann's room was in the same condition as it had been the previous day. Ms Senevirante knocked on the door of Mr Baumann's neighbour and enquired as to his whereabouts. Mr Baumann's neighbour did not know where Mr Baumann was but heard him arguing with a girl on the phone and stated that Mr Baumann had "burnt a cushion".[5676]

6.644. Ms Seneviratne's recollection as set out above is not supported by the statement of Mr Pears dated 13 April 2007, or Dilania Seneviratne dated 14 June 2007.[5677] However, Dilania Seneviratne does remember "standing at the door" of a "very messy" room.

[5673] Exhibit 42, Tab 93, Death Certificate – Allan Smyth, 20 June 2023 (SCOI.84122). It should be observed that an Investigator's Note dated 8 March 2007 records Mr Smyth's birthday as 21 January 1934, but this note also misspells Mr Smyth's first name as "Allen" and does not disclose its source. Mr Smyth's death certificate is the more reliable record and should be preferred.

[5674] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [6] (SCOI.10850.00020).

[5675] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [6] (SCOI.10850.00020).

[5676] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [7] (SCOI.10850.00020).

[5677] Exhibit 42, Tab 8, Statement of Hamish Pears, 13 April 2007, (SCOI.10850.00028); Exhibit 42, Tab 9, Unsinged notebook statement of Dilani Seneviratne, 19 May 2008 (SCOI.34336).

6.645. According to Ms Seneviratne, after "a few weeks" she notified Mr Baumann's "landlady Ruth BAVAMDYUM" (presumably Ms Binney) by telephoning her at her home in Epping, Sydney. Ms Binney told her she had not seen Mr Baumann since he paid his rent money "about two weeks before he went missing". Ms Binney also told her that she had "reported the matter to Waverley or Bondi Police Stations". According to Ms Seneviratne, Ms Binney told her that the NSWPF had taken "his passport and wallet and personal papers". Other items belonging to Mr Baumann were placed in storage at her house in Epping.[5678]

6.646. According to an unsigned statement provided to the police by Ms Binney in 1993, Ms Binney, at some time in "October 1983", became aware that Mr Baumann was missing. She received a telephone call from Ms Seneviratne who informed her that she had been on the phone with Mr Baumann when the line went dead and that she had been to his flat and found "the chair overturned and the door open". Ms Binney stated she went over to the flat "the next day".[5679]

6.647. According to Ms Binney, upon looking through his room, she saw "the armchair turned over, his jacket was on the bed and it looked as though he was packing his clothes into plastic bags… and his bed pillow was lying in the shower half burnt". Ms Binney also noticed the word "AIDS" had been written on a mirror.[5680] As noted above, there is evidence to suggest that Ms Seneviratne may also have seen the word "AIDS" written on the mirror. After Ms Binney inspected Mr Baumann's flat, she stated that she "rang the Police at WAVERLEY and the uniformed Police arrived and they took a photograph from his identity card."[5681]

6.648. On 29 November 1983, the NSWPF prepared a missing person report in relation to Mr Baumann that records Ms Binney as the informant.[5682]

6.649. According to an unsigned statement of Mr Smyth in 1993, Mr Smyth last saw Mr Baumann "on a Sunday, it was in Summer in 1983" when he visited him at the Cross Street premises.[5683] Although the police appear to have deduced that this date was 23 October 1983, it is also possible that this date was 30 October 1983, for the reasons explained below. Mr Smyth stated that Mr Baumann was meant to see him the next day, which was a Monday, but that he did not show up.[5684] Depending on whether the Sunday was 23 October 1983 or 30 October 1983, Mr Smyth may have been the last person to see Mr Baumann before he disappeared.

[5678] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [8] (SCOI.10850.00020).

[5679] Exhibit 42, Tab 15, Statement of Ruth Binney, 16 November 1993, 1 (SCOI.10850.00024).

[5680] Exhibit 42, Tab 15, Statement of Ruth Binney, 16 November 1993, 2 (SCOI.10850.00024).

[5681] Exhibit 42, Tab 15, Statement of Ruth Binney, 16 November 1993, 1 (SCOI.10850.00024).

[5682] Exhibit 42, Tab 19, Report to Waverley Police Station made by Ruth Binney, 29 November 1982 (SCOI.10850.00106).

[5683] Exhibit 42, Tab 11, Statement of Allan Smyth, 16 November 1993, 2 (SCOI.10850.00023).

[5684] Exhibit 42, Tab 11, Statement of Allan Smyth, 16 November 1993, 2 (SCOI.10850.00023).

6.650. On the Tuesday or Wednesday after Mr Baumann failed to meet Mr Smyth, Mr Smyth stated that he became worried and attended the Cross Street premises. He observed that the front door of Mr Baumann's flat was open, his bed had not been made but that "his guitar and everything was intact". Mr Smyth asked a neighbour (an Australian man in his late 50s) for a key to Mr Baumann's flat so that he could lock it. The neighbour said he would lock it and Mr Smyth asked him to inform Mr Baumann that "Allan" had been around.[5685]

6.651. According to Mr Smyth, "later that week" he received a telephone call from "a man at the A.B.C. asking if I had seen Peter". Mr Smyth told them he "hadn't seen him since that last Sunday".

6.652. Mr Smyth said he "might have" gone back to Mr Baumann's flat the following Friday or on the weekend. Mr Smyth stated that over the next week, he started to worry because he "knew of the demand for money" and that the notion of "Cooper Pedy" was stuck in his mind. Mr Smyth was also unsure about why Mr Baumann left his expensive guitar behind.[5686]

6.653. Mr Smyth also stated that a "man and lady" attended his residence a "couple of weeks" after Mr Baumann's disappearance and that occurred at around 8:30pm. He stated that these two people asked about Mr Baumann's whereabouts and told him that they were worried. Mr Smyth described them as "both white and he was a bit overweight and the girl was medium build with fair [hair]". Mr Smyth says that he was suspicious because Mr Baumann never mentioned these friends but did not go to police as he had his "own problems at the time". He further stated that he did not make any enquiries about Mr Baumann until he was contacted by police.[5687] There is a chance that Mr Smyth is referring to the visit to the Artlett Street property by Ms Seneviratne and Mr Pears, but Mr Smyth's description of the woman that attended his property does not match the description of Ms Seneviratne provided by her cousin Mr Pears, who described her as having "dark skin, wavy long black hair, dark eyes, thin build".[5688]

6.654. At some stage during the course of the police investigation, the police seem to have concluded that the conversation between Ms Seneviratne and Mr Baumann occurred on or around 26 October 1983, and that Mr Baumann has not been seen or heard from since this time. However, Counsel Assisting has identified several issues arising out of the evidence described in the above paragraphs that are worth considering when trying to establish what happened prior to Mr Baumann's disappearance, and when it happened.

[5685] Exhibit 42, Tab 11, Statement of Allan Smyth, 16 November 1993, 2 (SCOI.10850.00023).

[5686] Exhibit 42, Tab 11, Statement of Allan Smyth, 16 November 1993, 2 (SCOI.10850.00023).

[5687] Exhibit 42, Tab 11, Statement of Allan Smyth, 16 November 1993, 2 (SCOI.10850.00023).

[5688] Exhibit 42, Tab 8, Statement of Hamish Pears, 13 April 2008, [7] (SCOI.34336).

6.655. First, if Mr Smyth's statement is accurate and he last saw Mr Baumann on a Sunday (and he was contacted by the ABC "later" the following week), it would appear likely that Mr Smyth saw Mr Baumann on Sunday, 30 October 1983, and that he was supposed to meet with Mr Baumann on Monday, 31 October 1983. The telephone call with the ABC would then have occurred sometime in early November.

6.656. In a file note prepared by Mr Gover dated 9 November 1983, Mr Gover refers to a call from "William" of "artell(?) St Edgecliff stating that he did not know the whereabouts of Peter". Mr Smyth could be the "William" who is recorded as contacting Mr Gover on Wednesday, 9 November 1983, which raises the possibility that Mr Smyth's meeting was as late as Sunday, 6 November 1983, although it is equally or perhaps more likely that Mr Smyth's recollection may have been imperfect, and his conversation with the person from ABC may not have been the week immediately after the Sunday.

6.657. Secondly, the above is consistent with the contemporaneous evidence that suggests Mr Gover sought to locate Mr Baumann on Thursday, 3 November 1983 and again on Friday, 4 November 1983.[5689]

6.658. Thirdly, the above is also consistent with some of the non-contemporaneous evidence contained in Mr Smyth's statement and Ms Seneviratne's statement. Mr Smyth states that the person from the ABC told him that Mr Baumann's job would be kept open for two weeks, and it is recorded that by 9 November 1983, Mr Gover was thinking the job would need to be terminated that day.[5690] Ms Seneviratne states that she spoke to Mr Baumann "one Friday" and contacted Ms Binney "a few weeks later". It is possible this date was Friday, 4 November 1983 and not Friday, 28 October 1983. Mr Gover prepared a file note that indicated that "Sharmalee" contacted him on 7 November 1983 (i.e., the following Monday) and was going to see him the following day.

6.659. However, there is still some conflict between Ms Seneviratne's evidence that she spoke to Mr Baumann "one Friday" and went to Mr Smyth's house that same day, and the visit that Mr Smyth recalls as occurring "around a couple of weeks later", after Mr Baumann disappeared. There are several possible explanations for this, including possible imprecision in memory and/or that Ms Seneviratne saw Mr Keasberry rather than Mr Smyth, and that the visit Mr Smyth recalls from a white woman with fair hair was not from Ms Seneviratne.

[5689] Exhibit 42, Tab 20, Letter from ABC Welfare Officer to Peter Baumann, including file note re contact from Ruth Binney and Sharmalie Seneviratne, 7 November 1983 (SCOI.10850.00046).

[5690] Exhibit 42, Tab 34, Letter from Inspector Morton to V Rimoldi (ABC), 26 November 1993, 3 (SCOI.38894).

6.660. Fourthly, as noted above, the relevant dates and days of the week may not be reliable given the passage of time before Ms Seneviratne and Mr Smyth prepared their first statement. Both statements appear to contain a certain level of telescoping and/or imprecision as to the relevant dates. Mr Gover's record appears to be contemporaneous and is the most reliable record as far as it goes. On the basis of the above matters, however, it is not clear how the NSWPF arrived at the conclusion that Mr Baumann disappeared on 26 October 1983 or why Deputy State Coroner Milovanovich was informed that Mr Baumann disappeared on or around this date.

Events after October 1983

6.661. According to Ms Seneviratne, just after speaking to the police in 1992 about Mr Baumann's disappearance, she made various enquiries and obtained the contact number for Mr Smyth. At that time, she telephoned him and asked if he knew where Mr Baumann was. Mr Smyth said, "[n]o sorry love I have'nt [sic] heard from him for years". Ms Seneviratne again telephoned that number and asked to speak to "Dillian". She states that the following conversation ensued:

> *Unknown male: "Speaking"*
>
> *Ms Seneviratne: "Do you have any idea as to where Peter is?"*
>
> *Unknown male: "No I don't know where he is, who's calling?"*
>
> *Ms Seneviratne: "I know what was written in the letter. I know that you were going to leave Oliver for Peter."*
>
> *Unknown male: [becomes upset] "I'm in the security business. I'll find out who you are."*

6.662. Ms Seneviratne then hung up and made no further enquiries after that incident.[5691] Ms Seneviratne's separate reference to speaking to Mr Smyth and then speaking to a person who answered to "Dillian" suggests she did not think they were the same voice.

6.663. The evidence available in 1993 indicated that, at that time, both Mr Smyth and Mr Keasberry had some connection with the security industry, in that Mr Keasberry held a security licence and Mr Smyth was the director of a security firm named Watchguard Pty Ltd.[5692]

[5691] Exhibit 42, Tab 5, Statement of Sharmelie Seneviratne, 26 August 1993, [11] (SCOI.10850.00020).

[5692] Exhibit 42, Tab 36B, Report of Senior Constable John Gribble re missing persons investigation, 3 December 1993, 8 (SCOI.38945).

6.664. There is other evidence that suggests that, prior to the preparation of his statement (which was dated 15 October 1993) Mr Smyth telephoned police. NSWPF records indicate that Mr Smyth told police that Mr Baumann was probably accidentally killed by unknown persons and that his body was "probably dumped in a bush". The records further indicate that Mr Smyth told police he "wished to speak privately of [the] matter in the future".[5693] There is nothing to suggest that police ever followed up Mr Smyth or acted on his desire to speak privately to them.

6.665. Furthermore, at some stage during the police investigation, Mr Smyth told police not to speak to Mr Keasberry as he was exclusively heterosexual, "highly moral" and had very little contact with Mr Baumann.[5694] The NSWPF records also contain the following handwritten note under information about Mr Keasberry:[5695]

> *Shares house with SMYTH and was sharing house at the time of relationship with BAUMANN financial arrangement (both equal partners in house at Edgecliff at time of disappearance.) SMYTH denies that OLIVER homosexual, describes him as very straight, conservative highly moral person ? does not want police to interview OLIVER.*

6.666. In the mid 1980s, the Artlett Street property was sold.[5696] There is no evidence to suggest that any person other than Mr Smyth or Mr Keasberry lived there at the time of Mr Baumann's disappearance, although this line of enquiry does not appear to have been exhausted by police. There is also evidence that Mr Smyth leased an adjacent property to the Artlett Street residence, which had an in-ground swimming pool, and that parties were held on this property from time to time.[5697] It appears that swimming pool was filled in prior to the sale of the property in the mid 1980s.

6.667. In 2007, the NSWPF took the following steps to further the investigation into Mr Baumann's disappearance:

a. Police established that Mr Smyth was still living with Mr Keasberry but they had relocated to Western Australia;[5698]

b. The NSWPF spoke to Mr Smyth who denied ever saying that Mr Baumann may have been accidentally killed and dumped in a bush;[5699]

c. The NSWPF obtained a second statement from Ms Seneviratne dated 27 April 2007. In that statement, Ms Seneviratne recalled an occasion in 1996 where a brown Valiant drove up and down her street. She watched the vehicle for a period and then saw a man standing under a tree across the road. She thought the man looked like Mr Baumann and had similar physical features. She saw

[5693] Exhibit 42, Tab 30, Missing Persons Unit Running Sheet, 15 October 1993, 3 (SCOI.38950).

[5694] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [55] (SCOI.11010.00007).

[5695] Exhibit 42, Tab 36B, Report of Senior Constable John Gribble re missing persons investigation, 3 December 1993, 8 (SCOI.38945).

[5696] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [77] (SCOI.11010.00007).

[5697] Exhibit 42, Tab 36, Letter from Missing Persons Unit to NSWPF Services Section enclosing file and requesting decision re follow-up action, 4 March 1994, 4 (SCOI.38945).

[5698] Exhibit 42, Tab 12, NSWPF Investigator's Note – Contact with Allan Smyth, 18 April 2007 (SCOI.34300).

[5699] Exhibit 42, Tab 13, NSWPF Investigator's Note – Contact with Allan Smyth, 24 April 2007 (SCOI.34303).

> the man approach her house and quickly closed the door before contacting her neighbour. The man walked back under the tree across the road.[5700]

6.668. Counsel Assisting submitted that the above evidence raises many questions that the NSWPF did not seek to explore. Furthermore, and to the extent that there are inconsistencies in the evidence, it appears that no steps were taken in 1993 to 1994 to reconcile such inconsistencies with each other or to determine whether the evidence provided by each of the witnesses was reliable or not. Some steps were taken in 2007 to ascertain the reliability of the evidence provided by witnesses in 1993 but these steps were incomplete and rendered more difficult due to the passage of time.

Hypotheses as to manner and cause of Mr Baumann's disappearance

6.669. As noted above, Counsel Assisting submit that there are a number of available hypotheses as to the manner and cause of Mr Baumann's disappearance and suspected death.

6.670. First, Mr Baumann may still be alive and living under an assumed identity. This hypothesis was considered likely by Senior Constable Emery in 1994,[5701] and possibly by Senior Constable Gribble.[5702] The fact that Mr Baumann used other identities or aliases including "Peter Moltzen" and "Peter Ann" may support this theory. Some more support for this hypothesis may be drawn from the fact that Mr Baumann was reluctant to return to Germany for compulsory military service. However, the evidence on this point is equivocal and he had already obtained permanent residency. I also observe that all proof of life checks returned unsuccessful results since the police began making them in 1992.

6.671. Mr Gribble made submissions regarding the likelihood that Mr Baumann engineered his own disappearance. He considered it notable that there was a lack of evidence linking Mr Baumann with a criminal fraternity which would be necessary to obtain fraudulent identification documents or exit Australia illegally and without detection. He further submitted that there was no evidence of animosity between Mr Baumann and his family which could explain why he would never make contact with his family.[5703]

6.672. Although it is highly doubtful that Mr Baumann is still alive, this hypothesis cannot be completely ruled out.

[5700] Exhibit 42, Tab 6, Statement of Sharmalie Seneviratne, 27 April 2007, [5] (SCOI.10850.00022).

[5701] Exhibit 42, Tab 38, Report of Senior Constable J P Emery, Missing Persons Unit, 17 June 1994 (SCOI.38939).

[5702] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [96] (SCOI.11010.00007).

[5703] Submissions of William John Gribble, 27 September 2023, 1–2 (SCOI.85910).

6.673. Secondly, Mr Baumann may have died by way of suicide. This hypothesis was also considered likely by Senior Constable Emery in 1994,[5704] although unlikely by Senior Constable Gribble.[5705] Although there are no medical records before the Inquiry concerning Mr Baumann's medical history, some witnesses have given evidence about Mr Baumann's depression and a marked decline in his mental health in around March 1982. During this period, he was said to have become increasingly paranoid and aggressive, which may have been due to Mr Baumann's belief that persons were conspiring to have him deported.[5706] There is also evidence that in the days or weeks preceding his disappearance, Mr Baumann was absent from work, apparently due to influenza and nausea. Furthermore, it is alleged that Mr Baumann stated words to the effect of, "I would rather die than return to Germany".[5707]

6.674. However, any evidence said to support the hypothesis that Mr Baumann died by way of suicide must be considered against other evidence, including that that Mr Baumann had successfully obtained permanent residency in April 1983 and secured ongoing employment as a Sound Library Assistant at the ABC.

6.675. Mr Gribble, in submissions to the Inquiry, maintained his belief that Mr Baumann did not commit suicide. Mr Gribble provided a number of reasons for this view, including that:[5708]

a. Mr Baumann never showed any signs of instability to his family who offered the view that he was the product of a stable and loving family environment and kept in regular contact with them;

b. Mr Baumann was in regular employment;

c. Mr Baumann appeared to have adequate accommodation;

d. Mr Baumann appeared to have "satisfactory relations" with Ms Seneviratne and Mr Smyth;

e. There was no suicide note; and

f. There was no evidence that he had sufficient knowledge of the area to carry out his own death in a location that would have enabled the successful concealment of his body for a period of nearly 40 years.

6.676. Thirdly, Mr Baumann's death may have been caused by associates of Ms Foster as explained below.

[5704] Exhibit 42, Tab 38, Report of Senior Constable J P Emery, Missing Persons Unit, 17 June 1994 (SCOI.38939).

[5705] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [94] (SCOI.11010.00007).

[5706] Exhibit 42, Tab 36B, Report of Senior Constable John Gribble re missing persons investigation, 3 December 1993, 5 (SCOI.38945).

[5707] Exhibit 42, Tab 16, Statement of Cherie Kim Foster, 14 September 1993, [3] (SCOI.10850.00025).

[5708] Submissions of William John Gribble, 27 September 2023, 1–2 (SCOI.85910).

6.677. Mr Smyth gave evidence that Mr Baumann paid Ms Foster in exchange for her getting married to him, and that she was a sex worker. According to Mr Smyth, Mr Baumann told him that persons described as Ms Foster's "protectors" had asked for "another $30,000". They told Mr Baumann that they knew where he lived, and Mr Smyth formed the impression that they were blackmailing Mr Baumann. Although Mr Smyth did not know the precise nature of the threats directed at Mr Baumann, he thought they were of a physical nature. In a subsequent statement to police, Mr Smyth stated that he believed Mr Baumann was killed after a "situation got out of hand" and that his body had been disposed of in the bush.

6.678. It does not appear this hypothesis was pursued by the NSWPF in any considered or systematic way. Whilst a statement was obtained from Ms Foster in 1993, it did not address the allegations identified above. Further, it appears that no efforts were made to identify Ms Foster's "protectors" or whether, in fact, any threats were made to Mr Baumann. To that end, Ms Foster denies that a lump sum was ever paid to her, and attributes the weekly payment to Mr Baumann covering her loss of the "dole" upon their marriage.

6.679. Fourthly, Mr Baumann may have died or been killed as a result of his relationship with Mr Smyth and/or Mr Smyth's partner, Mr Keasberry. There is no evidence before the Inquiry to indicate that this hypothesis was ever seriously contemplated by investigating police. There is no record of the NSWPF interviewing Mr Keasberry at any stage of their investigations, nor was this theory put to Mr Smyth or explored in any real way with any of the witnesses.

6.680. From around December 1981 to the time of his disappearance, Mr Smyth was in a relationship with Mr Baumann. However, the nature of the relationship between Mr Smyth and Mr Keasberry is less clear. Mr Smyth and Mr Keasberry resided together in Artlett Street, Edgecliff, and indeed, they continued to reside together for many years after this. However, there is conflicting evidence as to Mr Keasberry's level of involvement with (or knowledge of) Mr Baumann, at least around the time of his disappearance.

6.681. Ms Seneviratne's evidence that she found a letter in Mr Baumann's mailbox that was authored by someone called a "William" or "Dillian" who lived at the Artlett Street property was going to leave "Oliver" for Mr Baumann, may suggest Mr Smyth was in fact the "William" or "Dillian" who was in a relationship with Mr Keasberry. The contemporaneous file note by Mr Gover also records that he received a call from someone by the name of "William" who lived at the Artlett Street property (in his file note of this call Mr Gover put the name 'William' in inverted commas). That person told Mr Gover that they did not know the whereabouts of Mr Baumann.[5709] It is also possible that the name "Allan", when handwritten, could look like "William" or "Dillian", and when spoken, could sound like "William". In this respect, it is relevant that Mr Smyth recalls speaking to a man from the ABC about Mr Baumann's disappearance although his recollection was that a man from the ABC called him.[5710]

[5709] Exhibit 42, Tab 34, Letter from Inspector Morton to V Rimoldi, 26 November 1993, 3 (SCOI.38894).

[5710] Exhibit 42, Tab 11, Statement of Allan Smyth, 16 November 1993, 2 (SCOI.10850.00023)

6.682. It could also be considered suspicious that Mr Smyth did not want police to speak to Mr Keasberry about Mr Baumann's disappearance and the contents of the letter itself and the reference to difficulties in "selling the property" may align with Mr Smyth and Mr Keasberry jointly owning the Edgecliff property.

6.683. A curious feature of the eventual sale of the Artlett Street property was the existence of a plastic swimming pool which was built on land adjacent to the property that was leased by Mr Smyth. The pool was filled prior to the Artlett Street property being sold in December 1987.[5711]

6.684. Mr Baumann's family appear to have held the view that Mr Baumann's disappearance is linked to his "homosexual contacts" and their impression that Mr Keasberry was that he was very jealous that Mr Baumann "intruded into this community".[5712]

6.685. The evidence available to the Inquiry does not permit any positive conclusion about this theory.

6.686. Fifthly, the hypothesis that Mr Baumann was killed in an LGBTIQ bias motivated homicide.

Police investigation

Failure to conduct an adequate investigation in 1983

6.687. Counsel Assisting submitted that the most concerning aspect of the investigation into Mr Baumann's disappearance is the absence of any such investigation. As Counsel Assisting observed, there is no record of any investigation being conducted by the NSWPF into Mr Baumann's disappearance in 1983.[5713] Indeed, based on the material produced to the Inquiry, it appears that a period of nine years elapsed from when Mr Baumann was reported missing to the time that the NSWPF took any substantive investigative steps in relation to his disappearance.

6.688. The missing persons report by Ms Binney was apparently prepared on 29 November 1983. However, Counsel Assisting submitted that, based on a contemporaneous file note, the NSWPF were made aware of Mr Baumann's disappearance by 5 November 1983, when Mr Gover notified Waverley Police Station that Mr Baumann had not contacted the ABC since 27 October 1983, and that Mr Gover had been unable to find him.[5714] Counsel Assisting noted that Ms Binney's evidence is also consistent with her notifying the police much earlier in November than 29 November 1983.

[5711] Exhibit 42, Tab 30, Missing Persons Unit Running Sheet, 5 January 1993 – 29 November 1993, 2 (SCOI.38950).

[5712] Exhibit 42, Tab 39, Interpol request to Missing Persons Unit re review of matter, 11 November 1999, 2-3 (SCOI.38957).

[5713] Exhibit 42, Tab 1, P97A Report of Death to Coroner, 25 June 2008, 1 (SCOI.10850.00012).

[5714] Exhibit 42, Tab 20, Letter from ABC Welfare officer to Peter Baumann, including file note re contact with Ruth Binney and Sharmalie Seneviratne, 17 November 1983 (SCOI.10850).

6.689. Counsel Assisting drew attention to another NSWPF document prepared on 22 November 2016 which indicates that Mr Baumann was reported missing on 27 October 1983. Although this document was prepared in 2016, it was submitted by Counsel Assisting that the contemporaneous documentation should be preferred as the likely date or dates the NSWPF were notified about Mr Baumann's disappearance.[5715]

6.690. It was acknowledged by Counsel Assisting that at some stage following the receipt of the report of Mr Baumann's disappearance, officers from Waverley Police Station attended Mr Baumann's residence, apparently with Ms Binney. A note was made or a photograph taken of Mr Baumann's identity card or passport details (the evidence is not perfectly clear which), but, no other investigative steps appear to have been taken.[5716]

6.691. Counsel Assisting drew attention to Ms Binney's evidence in her 1993 statement that she kept Mr Baumann's clothes, personal possessions and papers at her house until 1992, when they were destroyed as they were rotting.[5717] According to Ms Seneviratne in her statement in 1993, Ms Binney said that police had taken his passport, wallet and personal papers.[5718] In Counsel Assisting's submission, given Ms Seneviratne's evidence is based upon second hand hearsay, in this respect, it is not reliable and Ms Binney's first hand account should be preferred.

6.692. The NSWPF acknowledged that there are limited contemporaneous records available regarding Mr Baumann's disappearance in 1983 and that this situation is "entirely unsatisfactory".[5719] The NSWPF also acknowledged that it is concerning *if* no investigation was conducted at the time.[5720]

6.693. To the extent that the NSWPF failed to make enquiries with Mr Baumann's associates, the NSWPF conceded that this would represent a "significant shortcoming" of the initial missing persons investigation in 1983.[5721]

6.694. Counsel Assisting submitted that the failure of the NSWPF to conduct a proper investigation in 1983 meant that Mr Baumann's family was "left in a state of doubt and anxiety" for approximately ten years, before the NSWPF contacted them in around August 1993 about Mr Baumann's disappearance.[5722]

[5715] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [44] (SCOI.11010.00007).

[5716] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [58] (SCOI.11010.00007).

[5717] Exhibit 42, Tab 15, Statement of Ruth Binney, 16 November 1993, 2 (SCOI.10850.00024).

[5718] Exhibit 42, Tab 5, Statement of Sharmalie Seneviratne, 26 August 1993, [8] (SCOI.10850.00020).

[5719] Submissions of NSWPF, 10 July 2023, [74], [77] (SCOI.84381).

[5720] Submissions of NSWPF, 10 July 2023, [74] (SCOI.84381).

[5721] Submissions of NSWPF, 10 July 2023, [83] (SCOI.84381).

[5722] Supplementary submissions of Counsel Assisting, 6 October 2023, [19] (SCOI.86039).

6.695. Counsel Assisting further submitted that it was "entirely unacceptable" that Mr Baumann's family was "effectively left to conduct the investigation themselves due to police inaction".[5723] The numerous inquiries that Ms Baumann-Serr made between at least 1990 and 1994, Counsel Assisting submitted, amounted to normal and routine aspects of police work, which should have been carried out following the filing of a missing persons report.[5724]

6.696. I accept the submission of Counsel Assisting that a proper investigation should have been commenced in 1983, when Mr Baumann's disappearance was reported. The investigation that was undertaken was deplorable. In this regard, I note that any proper investigation would have led the NSWPF to Mr Gover, Ms Binney, Ms Seneviratne and Mr Smyth at a far earlier juncture. As noted above, Mr Gover was in fact in touch with Ms Binney, Ms Seneviratne and Mr Smyth in November 1983. The evidence before the Inquiry indicates that none of these people were contacted until 1992/1993. A proper investigation would also have involved the NSWPF identifying and making contact with Mr Baumann's family at this time.

6.697. I also accept Counsel Assisting's submission that the failure to establish a crime scene and/or identify or retain any exhibits of forensic value, and the failure to identify and locate relevant witnesses, has limited the ability of subsequent investigators and other finders of fact to establish the manner and cause of Mr Baumann's death.

Grounds for suspicion warranting further inquiries

6.698. Counsel Assisting submitted that there were several grounds of suspicion which should have led police to conduct a thorough investigation.

6.699. If Ms Binney's recollection in 1993 is reliable, police attended the unit in 1983 where they should have observed "AIDS" written on a mirror. There were other grounds for suspicion as to Mr Baumann's absence, including the room being in disarray, a burnt pillow in the shower, and all Mr Baumann's personal effects apparently being left.

6.700. By 29 November 1983, it appears both Mr Gover and Ms Binney had notified police. Mr Gover had also received a telephone call from "Sharmalee" (presumably Ms Seneviratne) and "William" who lived at "Artell (?) St Edgecliff". Counsel Assisting contended that simple inquiries in November/December 1983 would likely have identified each of Ms Seneviratne, Mr Smyth and Mr Keasberry as persons who may have information about Mr Baumann's disappearance. At least by 1993, Ms Binney appears to have come to believe or suspect that Mr Baumann's disappearance was "a murder involving homosexuals", although it is unclear whether Ms Binney suspected this in 1983.

[5723] Supplementary submissions of Counsel Assisting, 6 October 2023, [18], [20] (SCOI.86039).

[5724] Supplementary submissions of Counsel Assisting, 6 October 2023, [20] (SCOI.86039).

6.701. Counsel Assisting submitted that the Inquiry cannot draw any affirmative conclusion as to whether the failure to investigate further was actuated by bias, but further submitted that it is a real possibility given (a) what was known or readily ascertainable to police, including "AIDS" written on the mirror, and (b) the widespread bias in the police force and the wider community at the time. Even if the failure to investigate was not motivated by bias, Counsel Assisting suggested that there was enough information available to indicate that Mr Baumann's disappearance was suspicious, calling for immediate investigation. The earliest written policy or procedure produced to the Inquiry by the NSWPF in relation to missing persons is dated 1985. Accordingly, it is not known whether the failure was a breach of any applicable policy or procedure. Counsel Assisting submitted that it would be open to the Inquiry to conclude, in the absence of other evidence, that the apparent failure to investigate was a material oversight or deficiency in the NSWPF response to Mr Baumann's disappearance.

6.702. In respect of the suspicious circumstances surrounding Mr Baumann's disappearance, the NSWPF sought to cast doubt on whether the word "AIDS" appeared on a mirror in Mr Baumann's flat. The NSWPF noted that Ms Binney's evidence was the only "first-hand" evidence to support this and suggested that there were some reasons to doubt the accuracy of her recollection, namely that:

a. There is no mention in the very limited contemporaneous material provided to the Inquiry which suggests that the NSWPF were informed that Mr was gay or that the word "AIDS" had been written on the mirror. This reasoning is circular. First, if police indifference was caused by any indication that Mr Baumann was gay and/or had HIV/AIDS, then it is unsurprising that there is no mention of it. Secondly, given there is no record of *any* investigative steps being taken in the aftermath of Mr Baumann's disappearance, including any NSWPF records about the condition of Mr Baumann's unit when it was inspected by police in around October/November 1983; and

b. That there was no mention in several statements provided by other witnesses during the investigation between 1992 and 1994 of the word AIDS appearing on a mirror in Mr Baumann's apartment. This is true but I also consider that Ms Binney as the landlady is the most likely person, of the witnesses from whom statements were taken, to have noticed it and remembered it, even given the passage of time between the relevant events the date at which Ms Binney provided a statement to the NSWPF.

Inadequate investigation in 1992-1994

6.703. As Counsel Assisting noted, it was not until between 1992 and 1994 that an investigation into Mr Baumann's disappearance was conducted by the MPU. This investigation appears to have been triggered by an inquiry made by Ms Seneviratne to the MPU. The NSWPF then undertook various investigative steps, but even these investigative steps were limited in scope.

6.704. Counsel Assisting ultimately submitted that the failure to properly investigate Mr Baumann's disappearance in 1983 created a situation where it was much more difficult, even by 1992, for subsequent investigators and other finders of fact to establish the manner and cause of Mr Baumann's death.

6.705. Mr Gribble submitted that the investigation by the NSWPF cannot be described as satisfactory.[5725]

6.706. The NSWPF agreed that the lack of available documentation regarding investigative steps taken in 1983 "significantly constrained" the MPU investigation.[5726] The NSWPF submitted that any criticism of the MPU Investigation needed to be viewed in this context. However, the NSWPF ultimately accepted Counsel Assisting's submission that the constraint was attributable to the earlier actions of the NSWPF.[5727]

6.707. As dealt with both above and below, Counsel Assisting identified a number of key steps that could or should have been taken in this case but were not.

6.708. Mr Gribble, too, submitted that there were a number of inquiries that could have been made by the NSWPF, in either 1983 or 1992-1994, that would have served to dispel several alternative hypotheses in relation to Mr Baumann's disappearance and assist any investigation to arrive at a more likely hypothesis, including:[5728]

a. Conducting an interview with Mr Smyth prior his death in 2016;

b. Making inquiries with, and/or interviewing Mr Keasberry;

c. Attempting to locate Mr Hamasaki (Mr Baumann's neighbour);

d. Inquiring with authorities regarding the vacant land adjacent to Mr Keasberry and Mr Smyth's property prior to the building of the house on that property; and

e. Liaising with German authorities or immigration services to determine whether Mr Baumann had ever returned to Germany under that name or an alias he had previously used.

6.709. It appears to me that many worthwhile steps could have been carried out in 1992-1994, notwithstanding the absence of available records from 1983. However, as they were not, those forensic opportunities have been lost.

[5725] Submissions of William John Gribble, 27 September 2023, 2 (SCOI.85910).

[5726] Submissions of NSWPF, 10 July 2023, [97] (SCOI.84381), and repeated in the Submissions of NSWPF (Investigative Practices Hearing), 10 October 2023, [359] (SCOI.86127).

[5727] Submissions of Counsel Assisting (Investigative Practices Hearing), 15 September 2023, [719] (SCOI.85649); Submissions of NSW PF (Investigative Practices Hearing), 10 October 2023, [359] (SCOI.86127).

[5728] Submissions of William John Gribble dated 27 September 2023, 1-2 (SCOI.85910).

6.710. In addition, Counsel Assisting noted that there is evidence to suggest that by June 1994 there was tension between Senior Constable Gribble and Senior Constable Emery about the NSWPF response to Mr Baumann's disappearance, including about the fact that it had apparently taken over ten years to notify Mr Baumann's family that he had been reported missing.[5729] Senior Constable Gribble appears to have been frustrated or angry and took the view that not enough was being done in relation to this particular case, with Senior Constable Emery informing him that "Waverly Dets were satisfied that all avenues of inquiry have been exhausted and Waverly Dets would not make any further inquiries".[5730] Elsewhere, at the same time, Senior Constable Emery noted that "every attempt to locate Peter Baumann" had been made.[5731] In this respect it is both notable and laudable that Senior Constable Gribble continued to agitate for this case to be reinvestigated as recently as 2016.[5732] Counsel Assisting submitted that the failure of the NSWPF to identify the fact that there were still several significant avenues of inquiry available to them, including as at 1994, was a material oversight or deficiency in the police investigation.

6.711. The NSWPF similarly agreed with Counsel Assisting's praise of Senior Constable Gribble's attempts to agitate for Mr Baumann's case to be reinvestigated. However, the NSWPF felt it necessary to record that the Inquiry had not sought to explore with Senior Constable Emery the basis for the beliefs he held regarding the adequacy of the police investigation.[5733] As noted above, former Senior Constable Emery was provided with the written submissions of Counsel Assisting and the NSWPF and advised that he did not wish to participate in the Inquiry.

Failure to make enquiries with Mr Baumann's family and associates

6.712. Counsel Assisting submitted that the NSWPF should have sought to speak with Mr Baumann's family and associates as soon as practicable after Mr Baumann disappeared. It is clear from the evidence provided by Mr Baumann's family and the available NSWPF records, that Mr Baumann's family and associates were not contacted by the NSWPF until at least 1993.

[5729] Exhibit 42, Tab 37, NSWPF Running Sheet, 25 May 1994 – 1 June 1994, 3 (SCOI.34256).

[5730] Exhibit 42, Tab 37, NSWPF Running Sheet, 26 May 1994 (SCOI.34256).

[5731] Exhibit 42, Tab 38, Report of Senior Constable J P Emery, Missing Persons Unit, 17 June 1994 (SCOI.38939).

[5732] Exhibit 42, Tab 78, Request by Senior Constable Gribble to be assigned, 22 November 2016, [44] (SCOI.11010.00007).

[5733] Submissions of NSWPF, 10 July 2023, [103] (SCOI.84381).

6.713. Counsel Assisting noted that there are some inconsistencies in the evidence provided by some of the witnesses, and the details around particular events are vague, if not dubious. It can be assumed that this is due, at least partly, to the passage of time. However, based on the documents produced to this Inquiry, the NSWPF did not take any steps to test the veracity of the accounts provided to them by various witnesses, even when they conflicted. There were also a number of investigative leads, generated by the information provided by these witnesses, that were also never tested in the investigatory steps taken in 1992-1994. The failure to take such steps was another missed opportunity. For example, Counsel Assisting drew attention to the fact that the NSWPF never made further enquiries about the "protectors" of Ms Foster who were allegedly threatening Mr Baumann, nor did the police seek to interview Mr Keasberry. Some of the inconsistencies and evidence raising lines of inquiry that were not pursued are canvassed further below.

6.714. No explanation has been provided about why the NSWPF failed to contact Mr Baumann's family or associates at an earlier stage. This failure appears particularly acute given that the presence of Mr Baumann's family members in Sydney was considered "of great help" in 1994.[5734]

6.715. The failure to locate and speak to Mr Baumann's family and associates as soon as possible after his disappearance has limited the ability of subsequent investigators and other finders of fact to establish the manner and cause of Mr Baumann's death. With the passage of time, the ability to identify and obtain evidence from any relevant witnesses has greatly diminished. In this case, it is understandable that the ability of the witnesses a decade later to identify the dates and/or times on which specific events took place has been compromised by the passage of time. Indeed, when the police contacted Mr Gover in 1994, he appeared to have no recollection of Mr Baumann's disappearance at all.[5735] Likewise, the failure to identify and retain exhibits means that it is not possible to utilise developments in forensic science to collect additional evidence that could assist with resolving the question of the manner and cause of Mr Baumann's death.

6.716. Regarding the failure of the NSWPF to both retain or conduct any forensic examination of Mr Baumann's guitar and knife in 1993 or 1994, the NSWPF submitted that it was not clear whether those items were subject to forensic testing. The NSWPF noted that this issue had not been explored with the OIC of the MPU Investigation or other police involved in that investigation. As to the Inquiry's contact with OICs, this is addressed above.

6.717. Additionally, the NSWPF made a number of further observations:

a. It is likely that any forensic value in the guitar and the knife would have diminished in the ten or so years before it was seized, especially noting that the items were transferred from Mr Baumann's apartment to Ms Binney's house. It is not clear whether the items would have been transported and stored in a manner which preserved any forensic value;

[5734] Exhibit 43, Statement of Mr Baumann's family, 25 June 2023 (SCOI.84143).

[5735] Exhibit 42, Tab 38, Report of Senior Constable J P Emery, Missing Persons Unit, 17 June 1994 (SCOI.38939).

b. There is no suggestion in the material that either the guitar or the knife contained any overt signs of involvement in Mr Baumann's disappearance (for example, the presence of bloodstains); and

c. The failure to retain these items must be considered in context. DNA testing was a relatively novel phenomenon as at 1993. Indeed, the *CFP Act*, which introduced a regime for conducting forensic procedures on suspects in order to gather DNA for testing did not commence until 1 January 2001. It is important to ensure that the assessment of the investigating police officer's actions is not infected by hindsight bias.

6.718. With respect to the MPU Investigation, the NSWPF noted that a statement was obtained from Ms Foster during that investigation. The NSWPF observed that her statement made no mention of her having "protectors" who were allegedly threatening Mr Baumann. The NSWPF further noted that Mr Pauperis was unaware of Ms Foster having any "protector".[5736]

Failure to ensure that the investigation was based on accurate information

6.719. To the extent that the NSWPF did investigate Mr Baumann's disappearance, Counsel Assisting submitted that it should have ensured that its understanding of events was as accurate as possible, particularly in relation to understanding the chronology around Mr Baumann's disappearance. In some of the NSWPF documentation, particularly those produced in more recent years, little regard appears to have been paid to contemporaneous documentation and there is a lack of precision in relation to the date that Mr Baumann was thought to have disappeared. Counsel Assisting submitted that investigations, particularly when a long period has elapsed between the relevant events and the investigation, need to be mindful of the unreliability of reconstructions based on a recollection many years later, and the primacy of whatever objective contemporaneous records can be obtained.[5737]

6.720. The NSWPF acknowledged that it was "uncontroversial" that investigators need to be mindful of the unreliability of reconstructions based on a recollection many years after the relevant event.[5738]

Manner and cause of death

6.721. Counsel Assisting submitted that I should make a finding that is consistent with the finding of Deputy State Coroner Milovanovich, save that the finding of the Inquiry should reflect the evidence about the likely date that Mr Baumann went missing, as explained above.

[5736] Submissions of NSWPF, 10 July 2023, [99] (SCOI.84381).

[5737] *R v Warwick (No. 93)* [2020] NSWSC 926.

[5738] Submissions of NSWPF, 10 July 2023, [92] (SCOI.84381).

6.722. The finding proposed by Counsel Assisting was in the following terms:

> *Peter Baumann is deceased. I find that he died some time on or after 27 October 1983. As to the precise date of death, place of death or manner and cause of death from the available evidence I am unable to say.*

6.723. The NSWPF supported the submissions of Counsel Assisting as to the manner and cause of Mr Baumann's death.[5739]

6.724. I accept the submissions of Counsel Assisting.

Bias

6.725. Counsel Assisting submitted that Inquiry's ability to assess whether any LGBTIQ bias was involved in Mr Baumann's death is compromised by the fact that it is not apparent that Mr Baumann died as a result of foul play, and if so, who was involved in his death and why.[5740]

6.726. Nonetheless, Counsel Assisting suggested that there is evidence that Mr Baumann may have been a victim of foul play. Indeed, at least since 1993, at all relevant times the NSWPF appeared to consider Mr Baumann's disappearance as suspicious. For example, for the purpose of the coronial proceedings, Plain Clothes Senior Constable Field furnished a statement in his capacity as OIC where he stated that "through the various witness statements it may appear that [Mr Baumann] was met with foul play" noting the "varied and bizarre relationships" he had whilst in Australia.

6.727. Counsel Assisting noted that there are a limited number of factors that suggest Mr Baumann's death may have occurred in circumstances of LGBTIQ bias, namely that Mr Baumann was a gay or bisexual man, that he disappeared in suspicious circumstances, and that the word "AIDS" was written on a mirror at the Cross Street premises.[5741] As observed above, Counsel Assisting acknowledged that it is important to note that bias in relation to HIV/AIDS-status does not necessarily indicate LGBTIQ bias, although there is significant potential for overlap, especially considering social attitudes to HIV/AIDS at the time.

6.728. Even if Mr Baumann was not the victim of a hate or bias crime, it is possible that the failure of the police to investigate the disappearance thoroughly in 1983 was influenced by bias. However, given the absence of adequate police records, Counsel Assisting suggested that no affirmative conclusion can be drawn in this regard.

6.729. The NSWPF agreed with Counsel Assisting's submission that there is insufficient evidence to make a positive finding that Mr Baumann's death involved LGBTIQ bias. The NSWPF acknowledged that LGBTIQ bias was widespread in society at the time of Mr Baumann's death, and for many years thereafter, and that this bias infected at least some police activity in that period.

[5739] Submissions of NSWPF, 10 July 2023 [108] (SCOI.84381).

[5740] Submissions of Counsel Assisting, 27 June 2023 (SCOI.84145).

[5741] Submissions of Counsel Assisting, 27 June 2023, [13]-[15] (SCOI.84145).

6.730. However, the NSWPF contended that Counsel Assisting's submission that it is possible that the failure of police to investigate Mr Baumann's disappearance was influenced by bias is "entirely speculative". The NSWPF noted that the Inquiry had not sought to explore this issue with the officers involved in the original investigation and further noted that it was unclear, on the material presently available, whether these officers were aware that Mr Baumann was, or might have been, gay.[5742]

6.731. Mr Gribble submitted that, in his opinion, Mr Baumann's death was unrelated to LGBTIQ bias. Mr Gribble submitted that there was no evidence that Mr Baumann frequented beats, or of his involvement in a relationship otherwise than with Mr Smyth.[5743]

Conclusions and recommendations

6.732. I find that Peter Karl Baumann is deceased and that he died some time on or after 27 October 1983. As to the precise date of death, place of death or manner and cause of death, from the available evidence, I am unable to say.

6.733. But for the date on or after which I find Mr Baumann died, this is consistent with the earlier coronial finding.

6.734. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in Mr Baumann's death.

6.735. I make the following recommendation:

Recommendation 2

I recommend that BDM correct the Register of Births, Deaths and Marriages pursuant to s 45(1)(b) of the *Births, Deaths and Marriages Registration Act 1995,* such that Mr Baumann's date of death is recorded as: "on or after 27 October 1983".

[5742] Submissions of NSWPF, 10 July 2023, [86], [105], [106] (SCOI.84381).

[5743] Submissions of William John Gribble, 27 September 2023, 1 (SCOI.85910).

IN THE MATTER OF ANTHONY CAWSEY

Factual background

Date and location of death

6.736. Anthony Cawsey died on the morning of Saturday, 26 September 2009. Mr Cawsey's body was discovered lying prone and outstretched on a path that ran along the southern bank of Busby's Pond in Centennial Park, Sydney.

6.737. Mr Cawsey had been on a phone call until 5:24am. He therefore met his death in the 32- minute window between the end of the phone call and the discovery of his body.

Circumstances of death

6.738. Mr Cawsey had walked from his apartment in Redfern to Centennial Park in the early hours of the Saturday morning. The available evidence suggests that it is likely that he went to Centennial Park for the purpose of engaging in sexual activity with a man.

6.739. Mr Cawsey suffered a single stab wound to the chest. When his body was found, his pants were pulled down to a position just above his knees.

6.740. The precise circumstances of Mr Cawsey's death, including the identity of the person who inflicted the stab wound, remain unknown. The key person of interest in the death of Mr Cawsey is Moses Kellie. The evidence in relation to Mr Kellie, who is deceased, is discussed below.

Identification by the Inquiry

6.741. As outlined in the introduction to this Chapter, the Inquiry obtained a copy of the UHT Tracking File on 6 June 2022. Mr Cawsey was listed as a victim in that file.

6.742. The Inquiry reviewed the media coverage of Mr Cawsey's death, and on the basis of that material identified the case as possibly falling within Category B of the Terms of Reference. The Inquiry proceeded to conduct its own review and investigations in relation to the death of Mr Cawsey, and identified various indicators of LGBTIQ bias.

6.743. Mr Cawsey was considered by many of his friends and family to be heterosexual, albeit very private about his love and sex life. A review of his phone use, SMS history and photographs revealed that Mr Cawsey also engaged in sexual activities with men.[5744] He was a frequent user of gay chat line telephone services such as Mediatel and Manhunt.[5745]

6.744. The evidence indicates that Mr Cawsey had gone to Centennial Park to seek out a sexual encounter with a man. He had left a recorded message on the gay chat line Mediatel where he stated that he wanted to engage in a sexual act with another man.[5746] Parts of Centennial Park are well-known and popular beats.[5747]

6.745. Immediately prior to his death, Mr Cawsey had connected with a man via the gay chat line and was engaging in phone sex.[5748] His body was found with his pants around his knees and his underwear and buttocks exposed.[5749]

6.746. All of these circumstances give rise to a reasonable suspicion that Mr Cawsey was the target of an attack on the basis of actual or assumed membership of the LGBTIQ community.

Previous investigations

Post-mortem examination

6.747. A post-mortem examination was performed by Dr Rebecca Irvine on 29 September 2009.[5750] Her report to the Coroner determined that Mr Cawsey died of haemopericardium, an accumulation of blood in the pericardial cavity, due to a single stab wound to the left chest. The knife punctured the right ventricle of the heart, and the injury would have been quickly disabling.[5751]

[5744] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [71] (SCOI.10464.00009).

[5745] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [76] (SCOI.10464.00009).

[5746] Exhibit 39, Tab 62, Transcript of Mediatel recording by Anthony Cawsey, 26 September 2009 at 4:45 (SCOI.10466.00005).

[5747] Exhibit 39, Tab 35, Statement of Colin Cheshire, 24 June 2015, [33]–[34] (SCOI.83386); Exhibit 39, Tab 36, Statement of Lee Doull, 4 November 2015, [8] (SCOI.10467.00125); Exhibit 39, Tab 37, Statement of David Nelson, 20 November 2015, [8] (SCOI.10467.00133); Exhibit 39, Tab 40, Statement of Juliet Johnson, 2 February 2016, [10] (SCOI.10467.00127).

[5748] Exhibit 39, Tab 27, Statement of I354, 28 September 2009, [11]–[12] (SCOI.83374).

[5749] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [23] (SCOI.10464.00009).

[5750] Exhibit 39, Tab 2, Post-mortem Report by Dr Rebecca Irvine, 14 December 2009 (SCOI.10464.00008).

[5751] Exhibit 39, Tab 2, Autopsy Report of Dr Rebecca Irvine, 14 December 2009 (SCOI.10464.00008).

6.748. The stab wound was approximately 2.7cm long and 10 cm deep and caused by a single-edged blade. There were two small abrasions at the end of the wound, which could indicate that the knife had been pushed deep enough that the handle was touching the skin.[5752] The measurement of the wound could not be used to reliably estimate the size of the blade, as the human body is elastic and deformable, and the blade may not have entered the body cleanly or fully.[5753]

6.749. In addition to the knife wound, Mr Cawsey had various small, superficial abrasions, including a 4 cm x 2 cm abrasion on the underside of his chin and a 3.2 cm x 0.6 cm abrasion on his right forearm.[5754]

6.750. Toxicology samples indicated a modest concentration of alcohol (0.005g/110mL) and the presence of cannabinoids (Delta-9-tetahydrocannabinol at 0.010 mg/L and Delta-9-THC Acid at 0.025 mg/L) and methamphetamine (0.2mg/L).[5755]

Forensic testing

6.751. Exhibits retained and collected in relation to the death of Mr Cawsey included:[5756]

a. Two cigarette butts and a cigarette lighter located near Mr Cawsey's body;

b. The clothing worn by Mr Cawsey, and the property found on his body (including a wallet and a phone);

c. Swabs taken from Mr Cawsey at post-mortem;

d. Various items of clothing, shoes and property belonging to Mr Kellie, and either worn by Mr Kellie when arrested by police or found at his various campsites around Centennial Park;

e. Knives that had been seized from Mr Kellie, or from locations in Centennial Park; and

f. Miscellaneous items collected from Centennial Park on the morning of Mr Cawsey's death.

6.752. Police also obtained a large number of reference DNA samples from people who knew or were connected to Mr Cawsey, and from Mr Kellie.[5757]

6.753. These exhibits were subject to various forensic examinations by FASS at the time of the original police investigation. There were two results of particular note: [5758]

[5752] Exhibit 39, Tab 2, Post-Mortem Report of Dr Rebecca Irvine, 14 December 2009, 3, 6 (SCOI.10464.00008); Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 24 February 2017, [31] (SCOI.10464.00009).

[5753] Exhibit 39, Tab 5, Pathology Report of Dr Johan Duflou, 1 November 2017, 7 (SCOI.10488.00020).

[5754] Exhibit 39, Tab 2, Post-Mortem Report of Dr Rebecca Irvine, 14 December 2009, 7 (SCOI.10464.00008).

[5755] Exhibit 39, Tab 3, Certificate of Analysis of Mark David, 21 October 2009 (SCOI.10465.00024).

[5756] Exhibit 39, Tab 4, Certificate of analysis of Lisa-Ann Wedervang, 18 April 2016 (SCOI.10465.00005); Exhibit 39, Tab 21, Statement of Crime Scene Officer Anna Wood, 27 July 2010 (SCOI.10464.00165); Exhibit 39, Tab 22, Statement of Crime Scene Officer Detective Sergeant Crimmins, 26 September 2009 (SCOI.83364).

[5757] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016 (SCOI.10464.00009).

[5758] Exhibit 39, Tab 4, Certificate of analysis of Lisa-Ann Wedervang, 18 April 2016 (SCOI.10465.00005).

a. On a section of a "rolly" cigarette, found near the body of the deceased, analysts recovered DNA that was a mixture that originated from two individuals, "unknown male 'A'" and "unknown male 'B'"; and

b. The black g-string worn by Mr Cawsey screened positive for blood and semen. Analysts recovered DNA that was a mixture that appears to originate from two individuals. Mr Cawsey and a second individual, "unknown male (individual 'C')", could not be excluded as contributors to this mixture.

6.754. These profiles were not matched to any person on the national DNA database, nor to any person in relation to whom police had obtained a reference sample, including Mr Kellie.

6.755. It is unknown whether these unidentified DNA profiles were deposited at the scene during the murder of Mr Cawsey.[5759] The cigarette butt may have been left by any member of the public who used Centennial Park. The DNA profile on the g-string may have been deposited during an earlier sexual encounter. Nonetheless, identification of any of the unknown profiles may have generated investigative leads.

Original police investigation

6.756. On 26 September 2009, Strike Force Annand was set up by the Homicide Squad to investigate Mr Cawsey's death. The investigation was led by then Detective Sergeant Leggat and Detective Senior Constable Frame. In November 2013, Detective Senior Constable Staples assumed carriage of the investigation, and remained the OIC at the time of the coronial hearing in 2017.[5760]

6.757. The statement of Detective Senior Constable Staples dated 24 February 2017 summarises the lines of inquiry that were followed during the course of the initial investigation and subsequently at the time of the coronial inquest, including:

a. Inquiries relating to Mr Cawsey's movements: A detailed timeline was established in relation to Mr Cawsey's movements in the days and hours leading up to his death. Mr Cawsey's mobile phone activity was scrutinised. The evidence suggested that Mr Cawsey's decision to go to Centennial Park was unplanned and that he did not have a pre-arranged meeting with any particular individual;[5761]

b. Inquiries related to Mr Cawsey's use of gay chat lines: Police considered that the absence of specific location details in Mr Cawsey's message left on the Mediatel message made it unlikely that he was killed by a person from that service. Nonetheless, to fully investigate this possibility, extensive enquiries were undertaken to identify men who were using either Manhunt or Mediatel around the time of the murder, and to obtain volunteer DNA samples from them and/or interview them as to their movements. This line of enquiry identified no persons of interest;[5762]

[5759] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 24 February 2017, [97] (SCOI.10464.00009).

[5760] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [11], [175] (SCOI.10464.00009).

[5761] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [91]–[94], [105] (SCOI.10464.00009).

[5762] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [110]–[119] (SCOI.10464.00009).

c. Inquiries relating to Mr Cawsey's background and associates: Police obtained statements from friends, family, co-workers and associates of Mr Cawsey. This included including drug related associates or other people who it was thought may have some animosity towards Mr Cawsey. These statements pertained to their relationship with Mr Cawsey, and their movements on 25 and 26 November 2009. In some cases, their movements were confirmed by review of call charge records and/or CCTV footage. These inquiries did not reveal any conflicts, debts, or other interpersonal issues which could have provided a motive to kill Mr Cawsey, nor did any persons of interest emerge;[5763] and

d. Forensic analysis: Police obtained a total of 76 volunteer DNA samples for comparison to the unknown DNA profiles obtained from exhibits at the crime scene, with no match identified.[5764]

6.758. Police also considered the possibility that Mr Cawsey was killed as a result of a bias crime. This line of enquiry is considered further below.

6.759. After pursuing multiple lines of inquiry, police formed the opinion that Mr Kellie had committed the murder of Mr Cawsey. It was the police case that Mr Cawsey was stabbed and killed by Mr Kellie during an interaction in which Mr Cawsey propositioned Mr Kellie for sex.[5765] The police case against Mr Kellie is considered in detail below.

Criminal prosecution

6.760. Mr Kellie was charged and arrested for the murder of Mr Cawsey on 6 October 2015.

6.761. On 7 September 2016, the ODPP withdrew the charge and Mr Kellie was discharged. The ODPP considered that there was no reasonable prospect of conviction.[5766]

Inquest

6.762. An inquest into Mr Cawsey's death was conducted on 11-13 December 2017 by Deputy State Coroner Russell. Although the charges against Mr Kellie had by this time been withdrawn, Mr Kellie remained the only person of interest.[5767]

[5763] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [9], [87], [99]–[109] (SCOI.10464.00009).

[5764] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [119] (SCOI.10464.00009).

[5765] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [145] (SCOI.10464.00009).

[5766] Exhibit 39, Tab 11, Letter from Deputy Director of Public Prosecutions Kara Shead to Detective Chief Inspector Jason Dickinson, 13 September 2016 (SCOI.83377).

[5767] Exhibit 39, Tab 7, Findings of inquest into the death of Anthony Cawsey, 13 December 2017, 1–2 (SCOI.10483.00005).

6.763. On 13 December 2017, Deputy State Coroner Russell suspended the inquest pursuant to s. 78(3)(b) of the *Coroners Act*, being of the opinion that there was evidence capable of satisfying a jury beyond reasonable doubt that Mr Kellie had committed an indictable offence and that there was a reasonable prospect that a jury would convict him of that offence.[5768]

6.764. On suspension of the inquest, Deputy State Coroner Russell made the following findings:[5769]

> *Anthony Cawsey died at Centennial Park, Sydney, New South Wales on 26 September 2009. The cause of his death was Haemopericardium as a result of a stab wound to his left chest.*

6.765. On 7 March 2018, her Honour referred the matter to the ODPP pursuant to s. 78(4) of the *Coroners Act*.[5770]

Subsequent consideration by the ODPP

6.766. The ODPP reconsidered the prosecution of Mr Kellie following the above referral in March 2018, but again declined to prosecute on the basis that, even with new evidence obtained during the inquest, there remained no reasonable prospect of conviction.[5771]

Unsolved Homicide Team

6.767. Mr Cawsey's death has not been reviewed by the UHT.

Strike Force Parrabell

6.768. Mr Cawsey's death in 2009 was not reviewed by Strike Force Parrabell, which only reviewed deaths between 1976 and 2000.

Review by the Inquiry

6.769. The Inquiry took the following steps in the course of examining the matter.

Summonses

6.770. A summons was issued to the NSWPF on 21 July 2022 for all documents relating to investigations by the NSWPF of the death of Mr Cawsey, including certain prescribed categories of information identified at (1)(a) to (j) of the summons (NSWPF3). That summons also called for any other material held or created by the UHT in relation to the death of Mr Cawsey. Documents in relation to Mr Cawsey were produced to the Inquiry on 9 August 2022.

[5768] Exhibit 39, Tab 6, Notice of Suspension of Inquest, 5 March 2018 (SCOI.10483.00069); Exhibit 39, Tab 8, Letter from Deputy State Coroner Magistrate Paula Russell to Mr Lloyd Babb SC, 7 March 2018 (SCOI.10483.00054).

[5769] Exhibit 39, Tab 7, Findings of inquest into the death of Anthony Cawsey, 13 December 2017, 3 (SCOI.10483.00005).

[5770] Exhibit 39, Tab 8, Letter from Deputy State Coroner Magistrate Paula Russell to Mr Lloyd Babb SC, 7 March 2018 (SCOI.10483.00054).

[5771] Exhibit 39, Tab 12, Letter from Deputy Director of Public Prosecutions Peter McGrath SC to Magistrate Paula Russell, 16 November 2018 (SCOI.10483.00062).

6.771. NSWPF subsequently advised the Inquiry that some further archived material had been located. This included a number of photographs of exhibits. There was little additional material of substance.

6.772. On 22 June 2022, the Inquiry issued a summons to the ODPP (ODPP1) requesting all material in relation to the prosecution of Mr Kellie. On 11 July 2022 the ODPP provided materials in relation to Mr Kellie.

Interagency cooperation

6.773. On 15 June 2022, the Inquiry issued a written request to the Coroners Court to obtain the coronial file in relation to the death of Mr Cawsey. The Coroners Court produced material to the Inquiry on 7 July 2022.

Family members

6.774. The Inquiry made contact with Mr Cawsey's sisters, Christine and Kerry Cawsey, who provided a family statement.[5772]

Further forensic examinations

6.775. On 30 January 2023, the Inquiry conducted a conference with FASS in relation to the potential for further forensic testing in Mr Cawsey's matter. Several exhibits were identified as having the potential for further forensic testing.

6.776. On 13 February 2023, the Inquiry sent a letter to FASS requesting all Forensic Examination Request (P377) forms held by FASS in relation to the exhibits in Mr Cawsey's matter. These were received by the Inquiry on 16 February 2023.

6.777. On 30 March 2023, the Inquiry wrote to FASS requesting that further forensic analysis be conducted on eight exhibits.

6.778. On 23 June 2023, 26 July and 4 October 2023 the Inquiry received expert certificates from Dr David Bruce, forensic biologist.[5773] The results of the further analysis conducted by FASS are set out below.

Professional opinions

6.779. By letter dated 21 December 2022, the Inquiry sought a report from Dr Kerri Eagle, forensic psychiatrist. Dr Eagle was asked to address topics including:[5774]

a. Whether there were any aspects of the manner of Mr Cawsey's death (including the nature and extent of the injuries inflicted) and/or the crime scene which may indicate that a homicide has occurred in the context of LGBTIQ bias;

[5772] Exhibit 40, Family Statement provided by Christine Cawsey AM and Kerry Cawsey, 23 June 2023 (SCOI.84135).

[5773] Exhibit 39, Tab 76, Expert Certificate of David Bruce regarding re-testing of exhibits, 23 June 2023 (SCOI.84130); Exhibit 39, Tab 87, Expert Certificate of David Bruce regarding re-testing of exhibits, 26 July 2023 (SCOI.84898); Exhibit 39, Tab 89, Expert Certificate of David Bruce regarding re-testing of exhibits, 4 October 2023 (SCOI.86013).

[5774] Exhibit 39, Tab 77, Letter from Solicitor Assisting the Inquiry to Dr Kerri Eagle, 21 December 2022, 5 (SCOI.83372).

b. Whether, on the assumption that Mr Kellie's admission pertained to the stabbing of Mr Cawsey, there was evidence of Mr Kellie being motivated by LGBTIQ bias; and

c. The conclusions reached in an email from psychologist Kimberly Ora to the NSWPF.

6.780. Dr Eagle considered that she did not have the particular expertise required to be able to provide an opinion in respect of the first of those topics.[5775]

6.781. Dr Eagle's report, dated 17 February 2023, is considered below.

Contact with OICs

6.782. On 25 August 2023, the Inquiry wrote to Ms Staples, OIC, enclosing a copy of both the written submissions filed on behalf of Counsel Assisting and the NSWPF in relation to the death of Mr Cawsey. By that letter, the Inquiry invited Ms Staples to provide written submissions in relation to Mr Cawsey's death, should she choose to do so.[5776]

6.783. On 14 September 2023, the Inquiry received written submissions from Ms Staples. Ms Staples submitted that, in her view, there is sufficient evidence to establish that Mr Kellie was responsible for the death of Mr Cawsey.[5777]

6.784. On 25 August 2023, the Inquiry also wrote to Stewart Leggat enclosing the written submissions made by both Counsel Assisting and the NSWPF in relation to the death of Mr Cawsey. On 21 August 2023, Mr Leggat's legal representatives advised that they acted for him. After no further correspondence was received, the Inquiry wrote to Mr Leggat's legal representatives on 20 September 2023 and advised that as no written submissions had been received, the Inquiry would proceed on the basis that Mr Leggat did not wish to make any written submissions in relation to the death of Mr Cawsey.[5778]

Contact with next of kin of Moses Kellie

6.785. In light of the evidence before the Inquiry as to the potential involvement of Mr Kellie in Mr Cawsey's death, and the possibility that Counsel Assisting may make submissions to that effect, the Inquiry wrote to Mr Kellie's sisters, including I357.[5779] The Inquiry did not receive a response.

[5775] Exhibit 39, Tab 78, Expert Report of Dr Kerri Eagle, 17 February 2023, [82.1.1] (SCOI.83375).

[5776] Exhibit 39, Tab 90, Letter from Solicitor Assisting the Inquiry to Melanie Staples, 25 August 2023 (SCOI.86015).

[5777] Submissions of Detective Senior Constable Melanie Staples, 14 September 2023, 1 (SCOI.86015).

[5778] Exhibit 66, Tab 20, Letter to Stewart Leggat, 25 August 2023 (SCOI.86285); Exhibit 66, Tab 20A, Letter from Wotton + Kearney, 31 August 2023 (SCOI.86674); Exhibit 66, Tab 20B, Letter to Wotton + Kearney, 20 September 2023 (SCOI.86668).

[5779] Exhibit 68, Tabs 3 to 4, Letters from Inquiry to next of kin, 8 and 14 June 2023 (SCOI.86644; SCOI.86646).

Consideration of the evidence

Personal circumstances of Mr Cawsey

6.786. Mr Cawsey was 37 years old at the time of his death. He was the youngest son of Esmond and Laurie Cawsey, each of whom is now deceased, and had three older sisters. He worked as a stage-hand for a company named Show Support, and was physically active and fit. He was variously described by friends and family as vibrant, charismatic and kind.[5780]

6.787. Mr Cawsey lived in Redfern with a flatmate. At the time of his death, he had been in a sexual relationship with a woman.[5781]

6.788. Mr Cawsey was a long-term user of prohibited drugs, including amphetamines, LSD, cocaine and cannabis. His drug use did not appear to prevent him from maintaining regular employment and functional relationships.[5782]

Movements prior to death

6.789. At 4:24am on 26 September 2009, Mr Cawsey left his apartment in Redfern and walked to Centennial Park.[5783] Mr Cawsey's communications suggest that this was an unplanned trip, and he did not have a pre-arranged meeting with any individual.[5784]

6.790. At 4:44am, while walking to Centennial Park, Mr Cawsey connected to a gay chat line, Mediatel Services.[5785]

6.791. Mediatel Services and Manhunt allow callers to dial in to an access number. They are prompted to record their name and a brief description of themselves, which can then be listened to by other users. They can then listen to the messages recorded by other users, and either record a message to send directly to another user, or request a live chat. Once connected, the two people may swap numbers and connect outside the system. Messages are deleted after 24 hours.[5786]

6.792. During a call, he recorded the following message:[5787]

> *Hi I'm a tall slim guy feeling really horny and kinky. I'm just in a park on the edge of the city in Sydney and um yeah I've just ah I've got a t-shirt that's cut just below my nipples, some girlie's panties and a pair of boots and I just left my pants and my shirt on the other side of the park and I'm walking through in the dark like a little sissy girl, I've got a really small*

[5780] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 24 February 2017, [42]–[46] (SCOI.10464.00009).

[5781] See Exhibit 39, Tab 30, Statement of I362, 9 October 2009, [3]–[5] (SCOI.10465.00040); Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [48] (SCOI.10464.00009).

[5782] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 24 February 2017, [61]–[63] (SCOI.10464.00009).

[5783] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Stables, 24 February 2017, 41 (SCOI.10464.00009).

[5784] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Stables, 24 February 2017, [105] (SCOI.10464.00009).

[5785] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Stables, 924 February 2017, 41 (SCOI.10464.00009).

[5786] Exhibit 39, Tab 34, Statement of Matthew Price, Mediatel, 14 May 2010, [4]–[5] (SCOI.10467.00054); Exhibit 39, Tab 38, Statement of Matthew Price, 30 November 2015 (SCOI.10467.00065); Exhibit 39, Tab 28, Statement of Mark Burrows, Manhunt, 30 September 2009, [4]–[5] (SCOI.10467.00067).

[5787] Exhibit 39, Tab 62, Transcript of Mediatel recording by Anthony Cawsey, 26 September 2009 at 4:45 (SCOI.10466.00005).

little skinny cock I like, I want a man that want to treat me like a little girl show me what man cocks they've got compared to mine.

6.793. Mr Cawsey did not reveal his specific location details.

6.794. Mr Cawsey was connected to the chat line until 5:01am. Assuming he walked the most direct route from his apartment to Centennial Park at a moderately brisk walking pace, Mr Cawsey would have arrived at the Snake Bank path (where his body would eventually be found) at 4:54am.[5788]

6.795. Between 5:12am and 5:24am, Mr Cawsey used his mobile to call the landline of a man by the name of I354 (a pseudonym). According to I354, they spoke to each other about sex while I354 masturbated. It is likely that Mr Cawsey also masturbated.[5789]

6.796. I354 was investigated by police, but excluded as a suspect given that he resided in Westmead and a CCTV review confirmed he did not leave his house.[5790]

6.797. At 5:56am, the body of Mr Cawsey was discovered by several park users who separately notified police.[5791] Accordingly, the evidence establishes that Mr Cawsey met his death in the 32 minute window between the end of his phone call at 5:24am and the discovery of his body at 5:56am.

Crime scene examination

6.798. Mr Cawsey's body was found on a path along Snake Bank on the southern side of Busby's Pond, Centennial Park. Police made the following observations upon their attendance:[5792]

a. Mr Cawsey was lying prone and outstretched, partially positioned on the track;

b. On his upper body, Mr Cawsey was dressed in a blue short sleeved shirt with a cut-off black top underneath. The black t-shirt was soaked through with blood;

c. On his lower body, Mr Cawsey was wearing navy blue tracksuit pants with parallel white stripes running down each leg, pink women's underpants and a black g-string. The tracksuit pants and the pink underpants were pulled down and positioned just above his knees. The g-string remained in place, covering his genitalia but leaving his buttocks exposed;

d. Mr Cawsey was also wearing a blue baseball cap and a pair of brown suede women's boots;

[5788] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 24 February 2017, 42–43 (SCOI.10464.00009).

[5789] Exhibit 39, Tab 27, Statement of I354, 28 September 2009, [11]–[14] (SCOI.83374).

[5790] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Stables, 24 February 2017, 43 (SCOI.10464.00009).

[5791] Exhibit 39, Tab 23, Statement of Rodney Long, 26 September 2009 (SCOI.10464.00014), Exhibit 39, Tab 24, Statement of Brylan Stewart, 26 September 2009 (SCOI.10464.00023), Exhibit 39, Tab 25, Statement of Keaton Stewart, 26 September 2009 (SCOI.10464.00018); Exhibit 39, Tab 26, Statement of Rita Uechtritz, 26 September 2009 (SCOI.10464.00027).

[5792] Exhibit 39, Tab 13, Statement of Melanie Staples, 9 December 2016, [22]–[25] (SCOI.10464.00009).

e. The upper body garments were lifted at the crime scene revealing a single stab wound to the left lower chest and two defects with cut edges in the lower left blue shirt; and

f. Mr Cawsey's wallet (with driver license), keys and mobile phone were all left on his person.

6.799. Police concluded that Mr Cawsey had been stabbed proximate to where his body was located, as there was no blood trail in the vicinity and blood pooling was confined to the body and area immediately surrounding it.[5793]

6.800. The property found on Mr Cawsey's body tends against a hypothesis that Mr Cawsey was the victim of a robbery offence.

6.801. Several items were found near Mr Cawsey's body, including: a "rollie" cigarette butt, a tailor-made cigarette and a red plastic disposable cigarette lighter.[5794]

6.802. Police searched Centennial Park. Detective Senior Constable Staples described this as a "systematic search", but the details of the search are not recorded in the material before the Inquiry. It may be inferred that it was more thorough in areas around where Mr Cawsey's body was found. The search does not appear to have located any of Mr Kellie's campsites. No other items were established by police to be associated with Mr Cawsey's death.[5795]

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6.803. As noted above, after pursuing multiple lines of inquiry, police formed the opinion that Mr Kellie had committed the murder of Mr Cawsey. It was the police case that Mr Cawsey was stabbed and killed by Mr Kellie during an interaction in which Mr Cawsey propositioned Mr Kellie for sex.[5796]

6.804. Mr Kellie was a Sierra Leone national who immigrated to Australia in 2006.[5797] Between April and November 2009, Mr Kellie was homeless and living in Centennial Park at three or four different campsites. Mr Kellie was charged and convicted of two other offences which occurred in the Centennial Park precinct shortly after the murder of Mr Cawsey.

6.805. Mr Kellie was spoken to by police on a number of occasions, about both Mr Cawsey's death and other incidents that occurred in a similar time period. By way of overview:

a. At about 5:15am on 3 October 2009, police were conducting a canvass of Centennial Park in connection with the investigation in Mr Cawsey's death. Mr Kellie was spoken to by Detective Sergeant Peter Bishop. Mr Kellie told

[5793] Exhibit 39, Tab 13, Statement of Melanie Staples, 9 December 2016, [24] (SCOI.10464.00009).

[5794] Exhibit 39, Tab 13, Statement of Melanie Staples, 9 December 2016, [26] (SCOI.10464.00009).

[5795] Exhibit 39, Tab 13, Statement of Melanie Staples, 9 December 2016, [27] (SCOI.10464.00009).

[5796] Exhibit 39, Tab 13, Statement of Melanie Staples, 9 December 2016, [145] (SCOI.10464.00009); Exhibit 39, Tab 10 Facts Sheet, 2 (SCOI.83380).

[5797] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [150] (SCOI.10464.00009).

police that he was sleeping in Centennial Park, and showed police two locations where he slept;[5798]

b. Later on 3 October 2009, Mr Kellie provided a three-page typed statement to police at the Maroubra Police Station. This version outlined where he resided in Centennial Park, his movements on 25 and 26 September 2009, and his knowledge of both violence and beat activity occurring in the park;[5799]

c. On 16 October 2009 at Waverley Police Station, Mr Kellie was interviewed by police in relation to an assault on I360 (a pseudonym). In this interview, he provided information about his practices in relation to using and carrying knives, and referred to being interviewed by police in relation to Mr Cawsey's death;[5800]

d. At about 12:32pm on 17 October 2009, police located Mr Kellie sitting in the entrance of a large concrete drain on the southern bank of Busby's Pond in Centennial Park. Detective Sergeant Bishop had a conversation with Mr Kellie, and Mr Kellie was subject to a search. Both the conversation and the search were recorded;[5801]

e. Also on 17 October 2009, Mr Kellie was interviewed by police at the Maroubra Police Station.[5802] This interview pertained to, among other things, his campsites within Centennial Park, his movements around the time of Mr Cawsey's death, and his knowledge of beat activity occurring in Centennial Park;

f. Also on 17 October 2009, Mr Kellie participated in a video-recorded walkthrough of Centennial Park, where he described his position and movements on the morning of Mr Cawsey's death;[5803]

g. On 17 January 2010, Mr Kellie was interviewed by police at the Eden Police Station in relation to the robbery of I359 (a pseudonym) on Lang Road, Centennial Park. During this interview, Mr Kellie made various admissions that police considered were consistent with Mr Cawsey's murder and inconsistent with the robbery of I359;[5804]

h. On 6 October 2015, upon being arrested in relation to the death of Mr Cawsey, Mr Kellie was interviewed at Wagga Wagga Police Station.[5805] Mr Kellie denied involvement in Mr Cawsey's death, and denied that he had been

[5798] Exhibit 39, Tab 19, Statement of Detective Sergeant Peter Bishop, 7 December 2009, [5]–[10] (SCOI.10468.00003); Exhibit 39, Tab 18, Statement of Detective Senior Constable Scott Johnson, 11 February 2010, [5] (SCOI.10471.00103).

[5799] Exhibit 39, Tab 42, Statement of Moses Kellie, 3 October 2009 (SCOI.10468.00063).

[5800] Exhibit 39, Tab 43A, NSWPF Record of Interview, 'Interview with Moses Kellie', 16 October 2009 (SCOI.10468.00068).

[5801] Exhibit 39, Tab 44, Transcript of questioning and search of Moses Kellie at Centennial Park, 17 October 2009 (SCOI.10468.00072); Exhibit 39, Tab 19, Statement of Detective Sergeant Peter Bishop, 7 December 2009, [13]–[28] (SCOI.10468.00003); Exhibit 39, Tab 18, Statement of Detective Senior Constable Scott Johnson, 11 February 2010, [6]–[14] (SCOI.10471.00103).

[5802] Exhibit 39, Tab 45A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 October 2009 (SCOI.10468.00076).

[5803] Exhibit 39, Tab 46, Transcript of video walkthrough, 17 October 2009 (SCOI.10468.00088); Exhibit 39, Tab 14, Statement of Detective Sergeant Fiona Frame, 1 April 2016, [21] (SCOI.10468.00023).

[5804] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010 (SCOI.10469.00004).

[5805] Exhibit 39, Tab 48A, NSWPF Record of Interview, 'Interview with Moses Kellie', 6 October 2015 (SCOI.10469.00008).

speaking about Mr Cawsey's murder when interviewed by police on 17 January 2010.[5806]

6.806. Despite Mr Kellie becoming a person of interest to police in 2009 only shortly after Mr Cawsey's death, police did not charge Mr Kellie until October 2015.

6.807. There was no forensic evidence linking Mr Kellie to the scene of the crime or to Mr Cawsey's body. Mr Kellie was not a match to any of the unknown DNA profiles recovered from the crime scene. Police seized a large number of exhibits from Mr Kellie and his campsites, including clothing, knives, backpacks and shoes. Analysis of all these items failed to establish a forensic link between Mr Kellie and Mr Cawsey. None of Mr Cawsey's property was ever found on Mr Kellie or at any of his campsites.[5807]

6.808. The evidence comprising the case against Mr Kellie is discussed below.

Sightings of Mr Kellie in proximity to the crime scene

6.809. Three witnesses — Mark Kay, Lachlan Youll and Harriet Pembroke — provided statements to police regarding a sighting a man who generally fit the description of Mr Kellie within the vicinity of the crime scene the day before the murder.[5808] Another witness, Jonathan Edgington, gave evidence of seeing a man broadly fitting the description of Mr Kellie shortly after the murder.[5809]

6.810. Mr Kay was walking his dog in Centennial Park from about 3:00pm on Friday, 25 September 2009. About halfway along the path that runs along the southern bank of Busby's Pond, he described seeing a man emerge from the bush adjacent to the path. The man caught and held Mr Kay's attention because he was wearing long black trousers and a hooded jacket despite it being a hot day. The man stared intensely at Mr Kay, in a manner that he perceived as aggressive. Mr Kay described the man in the following terms:[5810]

> *[H]e had dark brown complexion and appeared to have Indonesian or Malay facial features. By this I mean his eyes were more oval than slanted. He looked as though he would be around 30 years of age and appeared to be around the same height as me, which is around 6 ft 1" tall. He was an average build, not skinny and not stocky.*

6.811. As set out below, Mr Kellie had a campsite concealed by bushes along the southern bank of Busby's Pond, which supports the proposition that the man seen by Mr Kay was in fact Mr Kellie.

[5806] Exhibit 39, Tab 48A, NSWPF Record of Interview, 'Interview with Moses Kellie', 6 October 2015, Q324–A367, Q493-A495 (SCOI.10469.00008).

[5807] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [39], [169]–[171] (SCOI.10464.00009).

[5808] Exhibit 39, Tab 31, Statement of Mark Kay, 28 October 2009, [5]–[7] (SCOI.10467.00098); Exhibit 39, Tab 33, Statement of Lachlan Youll, 22 December 2009, [4] (SCOI.10467.00104); Exhibit 39, Tab 32, Statement of Harriet Pembroke, 17 December 2009, [5]–[6] (SCOI.10467.00108); Exhibit 39, Tab 10, Facts Sheet, p 4 (SCOI.83380).

[5809] Exhibit 39, Tab 29, Statement of Jonathan Edgington, 30 September 2009 (SCOI.10467.00101); Exhibit 39, Tab 10, Facts Sheet, 7 (SCOI.83380).

[5810] Exhibit 39, Tab 31, Statement of Mark Kay, 28 October 2009, [6] (SCOI.10467.00098).

6.812. Between 7:30pm and 8:30pm on the same day, Mr Youll and Ms Pembroke were jogging through Centennial Park, and saw a man wearing all dark clothing, with a hood over his head, next to the fence which surrounds McKay Oval, close to the start of the track that leads to Busby's Pond. Mr Youll described the man as being about 5 feet 11 inches and of a medium build, but did not see his face.[5811] Ms Pembroke described him as "about 5'9" tall, medium or athletic build". She also stated that it was too dark to see his face.[5812]

6.813. None of these sightings amount to a positive identification of Mr Kellie, notwithstanding that they may be said to be, in broad terms, consistent with being Mr Kellie.

6.814. Mr Edgington gave evidence of seeing a man walking on a bush track in an area on the south-western side of Centennial Park known as the "SW Paddock", at about 6:10am on Saturday, 26 September 2009 (that is, only about 14 minutes after the discovery of Mr Cawsey's body). Mr Edgington described the man as wearing a camouflage jacket in shades of dark green, with the hood pulled up over his head, and dark pants. He further stated:[5813]

> *I could see that he had brown skin and was of an Asian appearance, when I say Asian, more along the lines of an Indian background… His face was a round shape. There was nothing distinguishing about his face that I can recall I couldn't say if he had facial hair.*

6.815. Mr Edgington described the person to be "walking at a normal pace" and carrying a clear two litre water bottle with a large red or orange top.[5814]

6.816. Mr Kellie would later tell police that on the morning of Mr Cawsey's murder he went to fill up a one litre coke bottle of water and then returned to the SW Paddock, and that he was wearing a green shirt, lending some credence to this being a sighting of Mr Kellie.[5815]

6.817. The probative value of these alleged sightings is limited. Even assuming each to be Mr Kellie, it is known that Mr Kellie was homeless and living in Centennial Park at the time of Mr Cawsey's death, which provides an innocent explanation for him being sighted by multiple people in the area. None of the purported sightings tie Mr Kellie closely to the crime scene at the time of Mr Cawsey's death. The sightings by Mr Kay, Mr Youll and Ms Pembroke were the afternoon or evening before Mr Cawsey came to the park. Mr Edgington's sighting, which is the closest in time, places him an approximately ten minute walk from the crime scene.

[5811] Exhibit 39, Tab 33, Statement of Lachlan Youll, 22 December 2009, [4] (SCOI.10467.00104).

[5812] Statement of Harriet Pembroke, 17 December 2009, [6] (SCOI.10467.00108)

[5813] Exhibit 39, Tab 29, Statement of Jonathan Edgington, 30 September 2009, [8] (SCOI.10467.00101).

[5814] Exhibit 39, Tab 29, Statement of Jonathan Edgington, 30 September 2009, [8] (SCOI.10467.00101).

[5815] Exhibit 39, Tab 42, Statement of Moses Kellie, 3 October 2009, [9]–[10] (SCOI.10468.00063); Exhibit 39, Tab 45A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 October 2009, Q662-676, Q697 (SCOI.10468.00076).

Location of Mr Kellie's campsites

6.818. On 3 October 2009, Mr Kellie was spoken to by police in Centennial Park, and was asked to show police where within the park he had been living. Mr Kellie took police to two locations, the first being a sandstone pavilion situated off Park Drive, where he had slept the previous night because it had been raining, and the second being a location under a tree in SW Paddock (Campsite 1).[5816]

6.819. In his statement dated 3 October 2009, Mr Kellie stated, "I don't have any possessions to carry or to hide."[5817]

6.820. At a later date, on 17 October 2009, Mr Kellie was located by police at a drainpipe that opened into Busby Pond, that was concealed from view by foliage. In the drainpipe was a sleeping bag, a number of backpacks, food packaging and other items (Campsite 2). This site was approximately 75 metres east of where Mr Cawsey's body was located.[5818] Mr Kellie had not disclosed the location of this campsite when spoken to on 3 October 2009.

6.821. Mr Kellie stated that he used the drain campsite on and off, and did not stay there permanently because of the possibility of rain. He indicated that he had only left the drain campsite a few days before 26 September 2009.[5819]

6.822. On 9 November 2009, police conducted a search of the south-western corner of Centennial Park. A campsite was found in the bushes that separated the McKay and Mission playing fields (Campsite 3). The campsite contained a number of sketch pads with Mr Kellie's name written in them. Also located in the campsite were newspapers dated 19 and 20 September 2009.[5820]

Lies as consciousness of guilt

6.823. The police sought to rely on multiple "lies" in interviews given by Mr Kellie as evidence of his guilt.[5821] These arose from omissions or inconsistencies in his accounts to police, pertaining to the location of his campsites, when he had last been in the area around the crime scene, and his movements on the morning of Mr Cawsey's death.

6.824. Police alleged that Mr Kellie "made false statements to distance himself from the area where the victim's body was located" and that Mr Kellie "deliberately lied… because he knew that the truth would implicate him in the murder."[5822]

[5816] Exhibit 39, Tab 19, Statement of Detective Sergeant Peter Bishop, 7 December 2009, [4]–[8] (SCOI.10468.00003); Exhibit 39, Tab 18, Statement of Detective Senior Constable Scott Johnson, 11 February 2010, [4]–[6] (SCOI.10471.00103); Submissions of Counsel Assisting, 26 June 2023, Annexure A (SCOI.84134).

[5817] Exhibit 39, Tab 42, Statement of Moses Kellie, 3 October 2009, [6] (SCOI.10468.00063).

[5818] Exhibit 39, Tab 19, Statement of Detective Sergeant Peter Bishop, 7 December 2009, [14] (SCOI.10468.00003); Exhibit 39, Tab 18, Statement of Detective Senior Constable Scott Johnson, 11 February 2010, [7] (SCOI.10471.00103); Exhibit 39, Tab 10, Facts Sheet, 12 (SCOI.83380).

[5819] Exhibit 39, Tab 45A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 October 2009, 20, 41 (SCOI.10468.00076).

[5820] Exhibit 39, Tab 19, Statement of Detective Sergeant Peter Bishop, 7 December 2009, [39]–[40] (SCOI.10468.00003).

[5821] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [146] (SCOI.10464.00009).

[5822] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016 [146] (SCOI.10464.00009); Exhibit 39, Tab 10, Facts Sheet, 2 (SCOI.83380).

6.825. As a preliminary comment, relying on these errors as deliberate lies, and lies made on account of a consciousness of guilt, is fraught. Mr Kellie was a homeless and itinerant man with a borderline IQ level.[5823] While Mr Kellie's mental health presentation is complex, it is at least possible, if not likely, that he suffered from a psychotic illness. An imperfect recollection of where he was camping, his waking times, and his routes, when interviewed one week and three weeks after Mr Cawsey's death, may simply reflect that he had a disorganised mind, experienced some temporal disconnect associated with his living conditions, or was generally an unreliable historian.

6.826. These are all matters that bear upon his credit and reliability, and can be used when determining what weight to place on Mr Kellie's exculpatory statements.[5824] However, for these errors to be treated as proof of a guilty conscience and an implied admission, they would need to be deliberate falsehoods told by Mr Kellie due to a consciousness that "the truth would convict him".[5825] It is necessary to consider other reasonable explanations for any lie told by Mr Kellie.

6.827. The three lies relied upon by police are considered in turn.

"LIES" ABOUT THE LOCATION OF HIS CAMPSITE

6.828. The "lie" alleged against Mr Kellie was his omission to reveal the location of two campsites, Campsites 2 and 3, that were closer to the scene of the crime than the ones he took police to on 3 October 2009. The police case was put as follows:[5826]

> *It is significant that [Mr Kellie] has attempted to distance himself from the campsites close to Busby's Pond and therefore the crime scene where the victim's body was located. On 3 October 2009… [Mr Kellie] only disclosed the campsite which was the most remote campsite to where the murder occurred. [Mr Kellie] deliberately withheld information about the location and existence of the campsites close to Busby's Pond.*

6.829. It is necessary to bear in mind that Mr Kellie appeared to be transient and sleeping in multiple locations around the park, depending on conditions such as the weather. The term "campsite" may imply a degree of semi-permanency that these sites did not in fact possess.

6.830. Mr Kellie may have had other reasons for not disclosing all locations where he slept or stored property in the park: to preserve what limited privacy he had; and to prevent him being "moved on" from these places. Another explanation is that he was aware that a person had been killed and was fearful of being wrongfully accused.

[5823] Exhibit 39, Tab 67, Psychological Report of Dr John Jacmon, 8 November 2010 (SCOI.10488.00008); Exhibit 39, Tab 69, Psychiatric Report of Dr Thomas Oldtree Clark, 9 June 2011 (SCOI.10488.00009); Exhibit 39, Tab 70, Psychiatric Report of Dr Jonathan Adams, 15 June 2011 (SCOI.10486.00231).

[5824] *Zonneff v The Queen* (2000) 200 CLR 234.

[5825] *Edwards v The Queen* (1993) 178 CLR 193; *R v Lane* [2011] NSWCCA 157.

[5826] Exhibit 39, Tab 10, Facts Sheet, 15 (SCOI.83380).

6.831. It further might be regarded as surprising, if Mr Kellie was lying to deflect police by distancing himself from the crime scene, that he remained in the park following the murder (although it is of course possible that Mr Kellie only lied after it became obvious that he was under suspicion.)

"LIES" ABOUT WHEN HE WAS LAST IN THE AREA AROUND THE CRIME SCENE

6.832. When Mr Kellie was interviewed on 17 October 2009, he told police that the last time that he was in the area "where the police tape was" (i.e., around the crime scene) was one to two weeks before the murder.[5827] The police case was that the newspapers found in Campsites 2 and 3, dated 19-20 September 2009, indicated that he was in fact at those campsites at a date closer to Mr Cawsey's death.[5828]

6.833. Further, if Mr Kay's sighting is assumed to be of Mr Kellie, it would place Mr Kellie close to the crime scene only a day prior to the murder.

6.834. In relation to the comments made on 17 October 2009, Mr Kellie's estimate of one to two weeks was an approximation only. The dates on the newspaper were close to a week prior to Mr Cawsey's death, so it may be doubted whether Mr Kellie's description could be treated as deliberately misleading.

6.835. The sighting by Mr Kay may be more compelling evidence of a lie, but still must be treated with caution.

"LIES" ABOUT HIS MOVEMENTS ON THE MORNING OF MR CAWSEY'S DEATH

6.836. When Mr Kellie was first interviewed on 3 October 2009, he said that on Friday, 25 September 2009 he had stayed at a camp he had set up near Alison Road, Kensington, and slept under a tree on the park bench. He stated he woke up at 3:00am on Saturday, 26 September 2009, and had walked along Anzac Parade to a newsagency located at the intersection of Todman Avenue, before continuing to walk to the UNSW. He said that he reached UNSW as the sun was starting to rise, and so decided to return to the park, walking the same way he had come.[5829]

6.837. When interviewed on 17 October 2009, he said he woke up at 5:30am, and asserted that he knew this to be the exact time because he was wearing a watch.[5830] He again said that he walked to the newsagency, before walking to UNSW.[5831] He said he walked this route because people had left rubbish on the street before, including newspaper and electronics, saying he had found his radio this way on a previous occasion.[5832] He again said that when he arrived at UNSW, the "sun start to come up."[5833]

[5827] Exhibit 39, Tab 45A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 October 2009, Q755–758, Q 842–848 (SCOI.10468.00076).

[5828] Exhibit 39, Tab 10, Facts Sheet, 14 (SCOI.83380).

[5829] Exhibit 39, Tab 42, Statement of Moses Kellie, 3 October 2009, [9] (SCOI.10468.00063).

[5830] Exhibit 39, Tab 45A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 October 2009, Q530–564, Q624 –628 (SCOI.10468.00076).

[5831] Exhibit 39, Tab 45A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 October 2009, Q586–593 (SCOI.10468.00076)

[5832] Exhibit 39, Tab 45A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 October 2009, Q577–582 (SCOI.10468.00076).

[5833] Exhibit 39, Tab 45A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 October 2009, Q636–638 (SCOI.10468.00076).

6.838. The assertion that he woke at 5:30am was characterised by police as a "lie", and said to be an attempt by Mr Kellie "to absent himself from Centennial Park at the approximate time of the murder" once he was aware that he was under suspicion.[5834] However, on both versions, he claimed to have been at UNSW at sunrise, being the approximate time of Mr Cawsey's death.

6.839. At 7:37pm on 17 October 2009, Mr Kellie participated in a "video walk-through" of Centennial Park and its surrounds with police. From a police vehicle, Mr Kellie appeared to indicate that he walked down Doncaster Avenue to reach the newsagency, rather than Anzac Parade.[5835] The inconsistencies may be thought to reinforce the falsity of his account of being away from Centennial Park on the morning of the murder.

6.840. However, ascertaining the path being indicated by Mr Kellie is unclear due to the video being taken from a moving vehicle at night. Police requested that Mr Kellie return with them to walk the route during daylight. For unknown reasons, this never occurred.

6.841. Police obtained CCTV from two premises along Anzac Parade: the Doncaster Hotel; and the Mobile Service Station. While Mr Kellie was not identified on the CCTV, the angles of each camera and quality of the footage are such that Mr Kellie's account of walking to UNSW cannot be definitively excluded.

CONCLUSIONS AS TO LIES

6.842. The omissions or inconsistencies in Mr Kellie's accounts are capable of being construed as lies amounting to admissions, and can be considered as one element of the circumstantial case against Mr Kellie. However, the purported "lies" may not have been deliberately false, or alternatively may not have been told out of a consciousness of guilt.[5836]

6.843. While capable of comprising part of the circumstantial case against Mr Kellie, I exercise considerable care in determining what reliance can be placed on these "lies" in assessing Mr Kellie's involvement in Mr Cawsey's death.

Tendency and coincidence evidence

6.844. The police case against Mr Kellie relied upon evidence of other offences in or around Centennial Park that were said to have been committed by Mr Kellie. Mr Kellie was convicted of two offences, and was suspected to have been the offender in relation to a third incident. The police case was that these offences demonstrated a pattern of behaviour, or tendency, on the part of Mr Kellie that made it more likely that he committed the offence against Mr Cawsey. The police case was also that it would be improbably coincidental, having regard to the similarities between the offences, that a person other than Mr Kellie committed Mr Cawsey's murder.

6.845. The police case was put as follows:[5837]

[5834] Exhibit 39, Tab 10, Facts Sheet, 14 (SCOI.83380).

[5835] Exhibit 39, Tab 46, Transcript of video walk-through, 17 October 2009, 6–7 (SCOI.10468.00088).

[5836] *Edwards v The Queen* (1993) 178 CLR 193; *R v Lane* [2011] NSWCCA 157.

[5837] Exhibit 39, Tab 10, Facts Sheet, 2 (SCOI.83380).

> *The common features of these offences were: unprovoked violent attacks; no personal history with the victims; involving the use of knives or bladed weapons; inside or in the immediate vicinity of Centennial Park; during the evening or early morning; and all within a one month period between September and October 2009. It is the Prosecution case that these offences and the murder of [Mr Cawsey] reveal patterns of behaviour in relation to [Mr Kellie].*

6.846. Each offence relied upon as tendency or coincidence evidence is set out below.

ASSAULT OF I361 (A PSEUDONYM), 23 SEPTEMBER 2009

6.847. It was the police case that Mr Kellie was responsible for an assault on I361 on 23 September 2009.[5838] Mr Kellie was never charged in relation to this alleged conduct.

6.848. At about 4:10am on 23 September 2009, I361 was walking along the eastern side of Anzac Parade at Moore Park. He heard a man, alleged by police to be Mr Kellie, screaming at him from the other side of the road, saying words such as "[w]hy are you looking at me?" and "[y]ou look at me." I361 ignored the man.[5839]

6.849. The man then crossed the road and walked up behind I361. I361 turned to look at the man, but turned back and continued walking. I361 then felt something hit him twice to the back of the head. When he turned around, the man said "Why did you say what you said to me before down the street?" The man then lunged towards I361 and his bag. I361 dodged the man and ran onto Anzac Parade.[5840]

6.850. After he got away, I361 realised that he had a small cut to the back of his head. He hadn't seen anything in the hands of the man, such that it is unknown whether this incident involved "the use of knives or bladed weapons."

6.851. In his first statement, dated 23 September 2009 but unsigned, I361 described the offender as follows:[5841]

> *I would describe this male as African, in his early 20's, about 175 to 180 centimetres tall, of a medium build, with a shaved head, wearing a grey coloured jacket and long dark pants.*

6.852. In a later statement, made some seven years later on 30 May 2016, I361 added the following:[5842]

> *The man spoke in English with a dense accent. From his accent and his facial appearance I believed the man was from one of the former British colonies in west Africa such as Ghana or a nearby country. He was a dark skinned African. The man also had a very rounded face. When I say he had a shaved head, the man had black hair which was short as in shaved like a number 1 or number 2. I would say the man was of medium or*

[5838] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [147] (SCOI.10464.00009).

[5839] Exhibit 39, Tab 51, Statement of I361, 30 May 2016, [9] (SCOI.10470.00033).

[5840] Exhibit 39, Tab 51, Statement of I361, 30 May 2016, [11]–[12], [16] (SCOI.10470.00033).

[5841] Exhibit 39, Tab 50, Statement of I361, 23 September 2009, [4] (SCOI.10471.00029).

[5842] Exhibit 39, Tab 51, Statement of I361, 30 May 2016, [13] (SCOI.10470.00033).

> *average built. I am 183 tall (6 feet) and the man was definitely shorter than me, I'd say about 5 feet 9 to 5 feet 10 inches tall.*

6.853. I361 was not asked to participate in a photo identification procedure in relation to the offender.

6.854. I361's description is broadly consistent with Mr Kellie, who was of black African appearance, about 172 cm tall, of medium build, with a round face and short dark hair.[5843] However, the description falls well short of a positive identification of Mr Kellie.

ROBBERY WITH WOUNDING OF I359, 11 OCTOBER 2009

6.855. Mr Kellie pleaded guilty to an offence of robbery with wounding in relation to an incident involving I359. He was sentenced to 5 years imprisonment.[5844]

6.856. According to the agreed facts, at about 2:30am on 11 October 2009, I359 was walking on Lang Road in a poorly-lit residential area opposite Centennial Park. He was talking to his friend on the phone.[5845]

6.857. With no apparent provocation, Mr Kellie confronted I359 and began to yell something at him that I359 could not understand. He then waved a "silver-coloured object" in his left hand, believed by I359 to be a knife. Mr Kellie was wearing a dark coloured hooded jacket with a centre zip. The hood was up, disguising his features.[5846]

6.858. I359 stepped backwards and felt his back touch the fence to Centennial Park. I359 held his phone out towards Mr Kellie, and either handed it to Mr Kellie or dropped it. Either way, Mr Kellie ran off in possession of I359's phone.[5847]

6.859. The friend with whom I359 had been speaking to on the phone called I359's phone multiple times, and a male voice with a strong accent had answered.[5848]

6.860. When I359 arrived home, he realised that he had received a cut to his left upper arm that required suturing. He was uncertain how he received the injury.[5849] In an interview with police, Mr Kellie denied carrying a knife, or using any weapon to cause injuries to I359.[5850]

[5843] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [150] (SCOI.10464.00009).

[5844] Exhibit 39, Tab 49, Bail Report of Moses Kellie, 1 December 2016, 3 (SCOI.83357).

[5845] Exhibit 39, Tab 52, Statement of agreed facts, 7 October 2010, [2]–[3] (SCOI.83362).

[5846] Exhibit 39, Tab 52, Statement of agreed facts, 7 October 2010, [4], [7] (SCOI.83362).

[5847] Exhibit 39, Tab 52, Statement of agreed facts, 7 October 2010, [5] (SCOI.83362).

[5848] Exhibit 39, Tab 55, Statement of Hayley Reynolds, 11 October 2009, [12]–[14] (SCOI.83376).

[5849] Exhibit 59, Tab 52, Statement of agreed facts, 7 October 2010, [6] (SCOI.83362).

[5850] Exhibit 59, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q198–Q217 (SCOI.10469.00004).

ASSAULT OF I360, 16 OCTOBER 2009

6.861. Mr Kellie was convicted after a summary hearing of an assault occasioning actual bodily harm in relation to a woman, I360, on Lang Road near the Fox Studios Complex, and a related charge of possession of a knife in a public place. Mr Kellie was sentenced to 12 months imprisonment, with a non-parole period of 9 months.[5851]

6.862. The transcripts of the sentencing hearing, which would indicate factual findings made by the magistrate, are not available. The following facts are discerned from the statements provided by I360.

6.863. At approximately 8:30pm on 16 October 2009, I360 exited the Fox Studios Complex and was walking along footpath on Errol Flynn Boulevard. As she was walking, she noticed Mr Kellie sitting on a brick wall near the entrance to the complex, drinking from a bottle. He was wearing a hooded jacket with the hood off and had a dark coloured backpack next to him.[5852]

6.864. As I360 walked past Mr Kellie, he greeted her and she acknowledged him in reply. I360 continued to walk on, but began to suspect that Mr Kellie was following her. When she had walked about 300 m from where she first seen Mr Kellie, she turned and saw Mr Kellie about 15 metres behind her, with his hood drawn over his face.[5853]

6.865. I360 continued walking, but moments later heard Mr Kellie break into a run. Seconds later, Mr Kellie grabbed her by the arms and began to pull her out of the streetlight and towards the bushes in front of a house. Her bag was over her right shoulder.[5854] I360 managed to break free and get into a taxi, which took I360 to the police station. I360 provided a description of the offender.[5855]

6.866. At 8:45pm, police returned to the Fox Studio complex and located Mr Kellie. He was searched by police. In a garden bed behind Mr Kellie, police found a kitchen knife with a brown handle and a silver serrated blade, of which Mr Kellie ultimately admitted to ownership and possession.[5856]

AVAILABILITY OF COINCIDENCE AND TENDENCY REASONING

6.867. Section 9(3) of the *SCOI Act* provides that the Commissioner shall only receive as evidence matters which are, in the opinion of the Commissioner, likely to be admissible in evidence in civil proceedings. It through this lens that I now turn to consider the likely admissibility of the evidence as coincidence and tendency evidence in turn.

[5851] Exhibit 39, Tab 49, Bail Report of Moses Kellie, 1 December 2016, 1 (SCOI.83357).

[5852] Exhibit 39, Tab 57, Statement of I360, 16 October 2009, [3]–[4] (SCOI.83373); Exhibit 39, Tab 58, Statement of I360, 21 October 2009, [4]–[5] (SCOI.83368).

[5853] Exhibit 39, Tab 57, Statement of I360, 16 October 2009, [4]–[6] (SCOI.83373); Exhibit 39, Tab 58, Statement of I360, 21 October 2009 (SCOI.83368).

[5854] Exhibit 39, Tab 58, Statement of I360, 21 October 2009, [5]–[6] (SCOI.83368).

[5855] Exhibit 39, Tab 57, Statement of I360, 16 October 2009, [6]–[7] (SCOI.83373).

[5856] Exhibit 39, Tab 10, Facts Sheet, 11 (SCOI.83358).

6.868. Section 98 of the *Evidence Act* restricts the circumstances in which evidence that two or more events occurred can be used to prove that a person did a particular act (in the present case, that Mr Kellie stabbed Mr Cawsey), on the basis that, having regard to any similarities in both the events and the circumstances in which they occurred, it is improbable that the events occurred coincidentally.

6.869. Coincidence evidence may only be admitted if it is of "significant probative value", either by itself or having regard to other evidence adduced or to be adduced by the party seeking to adduce the evidence (s. 98(1)(b) of the *Evidence Act*). For evidence to have "significant probative value", it "should make more likely, to a significant extent, the facts that make up the elements of the offence charged".[5857] The evidence must be "important" or "of consequence" to the assessment of the probability of the existence of a fact in issue.[5858]

6.870. Dissimilarities between events will not necessarily displace the availability of coincidence reasoning. However, dissimilarities may undercut the improbability of something being a coincidence, and so detract from the strength of the inferential mode of reasoning permitted by s. 98 of the *Evidence Act*.[5859]

6.871. In the present case, the reasoning invited is that the similarities between the four offences (including Mr Cawsey's murder) would render it improbably coincidental for the murder of Mr Cawsey to have been committed by another person. The relevant similarities include that the offences were unprovoked, committed on persons unknown to Mr Kellie, in the hours of darkness, in the immediate vicinity of Centennial Park, between September and October 2009.

6.872. However, these identified similarities are generic to many assault and robbery offences. In my opinion, it would hardly be surprising, or improbably coincidental, that many robbery offences in the Centennial Park area would be unprovoked attacks on strangers in darkness.

6.873. Beyond those broad similarities, there is little commonality between each of the other offences and the circumstances (to the extent that they are known) of the death of Mr Cawsey, for the following reasons:

a. First, there is no reliable evidence that a knife was used in either the other offences. I359 describes a silver-coloured object, but cannot identify it as a knife, nor confirm how he received his injury. In his interview with police, Mr Kellie suggests that he only had a fork on him during the robbery.[5860] I361 did not see anything in the man's hands. There is no allegation of a knife being used in the assault of I360 (despite one being found in the garden bed);

b. Secondly, there is no evidence that Mr Cawsey had any property stolen from him, distinguishing the circumstances of his death from the circumstances of I359's robbery (and the assault of I361 if it is accepted that Mr Kellie lunged at his bag with the intention of stealing it); and

[5857] *Hughes v The Queen* (2017) 263 CLR 338, [40].

[5858] *Hughes v The Queen* (2017) 263 CLR 338, [81], [86], [215].

[5859] *Selby v The Queen* [2017] NSWCCA 40, [24].

[5860] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q200–201 (SCOI.10469.00004).

c. Finally, and most significantly, the sexual component to Mr Cawsey's death, inferred from the positioning of his clothing and his stated intentions for coming to Centennial Park, is suggestive that the killing of Mr Cawsey occurred in a significantly different context from the offending against I359, I360 or I361.

6.874. Given the generic nature of the identified similarities, and the significant dissimilarities, I consider that the evidence would not satisfy the threshold requirement of having significant probative value to be admitted as coincidence evidence.

6.875. Section 97 of the *Evidence Act* prevents evidence of the character, reputation or conduct of a person to prove that a person has a tendency to act in a particular way unless the evidence is of "significant probative value". The assessment of probative value requires consideration of two interrelated but separate matters: (1) the extent to which the evidence supports the asserted tendency; and (2) the extent to which the asserted tendency makes more likely the fact or facts sought to be proved by the evidence (here, that it was Mr Kellie, rather than another person, who stabbed Mr Cawsey).[5861]

6.876. The assault on I361 cannot safely be attributed to Mr Kellie, and accordingly is of limited value in supporting any tendency on the part of Mr Kellie.

6.877. The remaining two offences, of which Mr Kellie was convicted, support the existence of a tendency on the part of Mr Kellie to approach and assault people unknown to him, in an unprovoked manner, while they are alone, during the hours of darkness, in the vicinity of Centennial Park. However, there are no distinctive similarities between the offences, when regard is had to the manner of the assault, the identity of the victims, the use of a weapon, or motivation (insofar as it can be discerned from the facts, with only I359 having property stolen from him).

6.878. I consider that any tendency of Mr Kellie that can be supported by the evidence is only general in nature. While there is no rule that demands or requires close similarity between the conduct evidencing the tendency and the offence, the specificity of the tendency has a direct impact on the strength of the inference mode of reasoning.[5862] As a general proposition, a closer similarity will be required when tendency evidence is relied upon to prove the identity of an offender for a known offence, rather than where the fact in issue is the occurrence of the offence.[5863]

[5861] *Hughes v The Queen* (2017) 263 CLR 338, [41].

[5862] *TL v The Queen* (2022) 405 ALR 578, [29].

[5863] *Hughes v The Queen* (2017) 263 CLR 338, [39]; *TL v The King* (2022) 405 ALR 578, [30].

6.879. Here, tendency is not the only evidence as to identity, and the probative value of the evidence must be considered with regard to the other evidence against Mr Kellie, most significantly the "admissions" by Mr Kellie in the 17 January 2010 interview. However, those admissions would support a theory of the case that Mr Kellie became angered and violent after, on his perception, being repeatedly propositioned for sex. A tendency on the part of Mr Kellie to approach and attack people who are walking alone, without provocation, is not significantly probative of the case that was advanced by the prosecution case as to how Mr Cawsey met his death.

6.880. Accordingly, the tendency evidence does not make it significantly more likely that it was Mr Kellie who stabbed Mr Cawsey, and it is submitted that the evidence would not satisfy the threshold requirement of significant probative value to be admitted as tendency evidence.

6.881. In criminal proceedings, tendency or coincidence evidence relating to a defendant and adduced by the prosecution cannot be used against the defendant unless the probative value of the evidence outweighs the danger of unfair prejudice to the defendant.[5864]

6.882. That restriction does not apply in civil proceedings.[5865] Although the Court has a discretion to refuse to admit evidence if its probative value is substantially outweighed by the danger that the evidence may be unfairly prejudicial,[5866] the danger of improper use of the evidence is lessened in the absence of a jury.[5867] Accordingly, if, contrary to the submissions above, the evidence was determined to have significant probative value, s. 9(3) of the *SCOI Act* would not prevent its admission.

6.883. However, given my findings that the evidence does not have significant probative value as either tendency or coincidence evidence, the question of unfair prejudice does not arise. In summary, I have reached the conclusion that it is unlikely that the evidence would be admitted as tendency or coincidence evidence in civil proceedings.[5868]

Alleged admissions by Mr Kellie in his interview regarding the I359 robbery

6.884. On 17 January 2010, Mr Kellie was being interviewed in relation to the robbery with wounding against I359, described above.[5869]

[5864] *Evidence Act*, s. 101(2).

[5865] *Evidence Act,* s. 101(1).

[5866] *Evidence Act*, s. 135(a)).

[5867] *R v Droudis (No 13)* [2016] NSWSC 1350, [78]–[95].

[5868] I am able to, and do, receive the evidence for other purposes, including as evidence relevant to understanding the progression of Mr Cawsey's case through the criminal courts and coronial system. The use of the evidence for this purpose does not permit its use for a tendency or coincidence purpose: Evidence Act, s. 95(1).

[5869] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010 (SCOI.10469.00004).

6.885. During that interview, Mr Kellie described an incident that police considered was more consistent with the known circumstances of Mr Cawsey's death than the robbery on I359. The police sought to rely upon Mr Kellie's interview in relation to the robbery of I359 as "tantamount to an admission of being involved in a direct physical altercation" with Mr Cawsey.[5870]

6.886. The police characterised this interview as "significant evidence" implicating Mr Kellie in the murder of Mr Cawsey.[5871]

6.887. It is necessary to set out, in some detail, portions of the transcript of this interview.

6.888. The interviewing officer described to Mr Kellie the brief facts of I359's robbery, noting that it took place "on Lang Road, just short of Mitchell Street, Centennial Park".[5872] He asked him about his knowledge of that incident. Mr Kellie provided the following narrative:[5873]

Q128 […]

A Umm that, that particular morning, I was like coming from one of the restaurants, there's a café there, in the, in the Centennial Park.

Q129 Mmm Mmm.

A There's a café in the Centennial Park, the Centennial Park Café - - -

Q 131 […]

A […] as I come out of the gates, the guy, 'cause it's a popular spot like for gay people.

Q 132 All right

A Yeah people are approaching, they just keep come, coming after you, you know, he was standing there you know, he, he start talking about something, which I don't understand about, yeah. I tell him I'm not like interested in the guy.

[…]

Q134 So you thought he was gay?

A No, he approached me.

Q135 He approached you?

A Yeah

[5870] Exhibit 39, Tab 10, Facts Sheet, 2 (SCOI.83380).

[5871] Exhibit 39, Tab 10, Facts Sheet, 18 (SCOI.83380).

[5872] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q125 (SCOI.10469.00004).

[5873] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q128–137 (SCOI.10469.00004).

Q136 All right, can you say - - -

A 'Cause that's a popular spot where - - -

Q 137 Where gays meet?

A Yeah.

[…]

6.889. At this point, Mr Kellie marked the café that he was describing on a map with an asterisk.[5874]

6.890. The asterisk appears to mark the location of the restaurant and café near the corner of Parkes Drive and Grand Drive. On the map, there is a small gate into Centennial Park at the location marked "A". Although not marked, this map also includes the Robertson Road gate, located where Grand Drive comes to an apex in the bottom left quadrant of the map, as well as the tip of Busby's Pond along the bottom edge of the map.

6.891. After indicating the location of the café on the map, Mr Kellie continued:[5875]

Q151 […]

A Yeah, and there's a café around there, so I got the food, yeah and I was coming like out, with the bike, with my bike, I was…

Q152 Yeah.

A Then he, he was standing around there, not the first time I saw that guy before I've - - -

Q153 All right.

A - - - seen him like, yeah a few times - - -

6.892. The interviewing officer then showed Mr Kellie a photograph of I359 and asked if he recognised him. Mr Kellie stated, "[y]eah, I, I yeah do recognise him, yeah."[5876]

6.893. The interviewing officer next showed Mr Kellie a photograph of the wound on I359's arm, and asked him if he wanted to say anything about that. In response, Mr Kellie continued the narrative that he had commenced earlier (emphasis added):[5877]

Q162 […]

[5874] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q146–150 (SCOI.10469.00004).

[5875] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q151–153 (SCOI.10469.00004).

[5876] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q156 (SCOI.10469.00004).

[5877] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q156 (SCOI.10469.00004).

A *Well, well when I actually, actually say I'm not interested, like when he was talking then,* ***he start to pretend he was talking on the phone.***

Q163 *[…]*

A *Yeah, so he start to walk, he start, no make like, h****e's still forcing, still forcing*** *himself like,* ***I said, I'm not interested like in gay sex****, because that's where they thought anybody they see around that area…*

Q164 *Does he say anything to you?*

A *Yeah, he approach me… in the morning.*

Q 165 *Sorry?*

A *Like… two time, the first time I was entering to the Park, when I, when I met with him and he had like the, the sport area, down, but when I,* ***when I enter the park, I come up, he was still like behind me*** *- - -*

Q166 *Alright.*

A *- - - and he was talking.*

Q167 *So how long would he have been there?*

A ***That was the area I used to live. Around that area.***

Q168 *So.*

A *So he was, he had been there like an hour.*

Q169 *An hour?*

A *Yeah, 'cause I saw him first when I was come out****, when I was, when I was coming into the park.***

6.894. The interviewing officer attempted to clarify various aspects of this account. The interview continued (emphasis added):[5878]

Q175 *All right. Well what I don't understand about your, the description you've given me, is that you think he was pretending to be on the phone, do you?*

A *No, what, what I mean is that, he approached me first.*

Q176 *Right.*

[5878] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q175–200 (SCOI.10469.00004).

A *So when, when I give him like the, I say, I'm not interested in that kind of stuff.*

Q177 *Yeah.*

A *Yeah, when he first approached me then it was like he was talking, like somebody… after the… I just know… like.. that kind of stuff.*

Q178 *All right, all right.*

A *Somebody like, I don't know if the phone rang or he was pretending because it's like iPhone, maybe you know - - -*

Q 179 *Yeah*

A *- - - is like I I technology… stuff.*

Q180 *So the first time he approached you?*

A *Mmm.*

Q181 *Was about an hour before?*

A *Yeah.*

Q182 *OK.*

A ***Down by the sporting area**…*

Q183 *And did he ask you for some sort of sexual favour?*

A *Yeah, it's,* ***it's like a popular place****, it's like a popular spot.*

Q184 *I realise that, but - - -*

A *Yeah, that area*

Q185 *Can you remember what he specifically said to you, what did he ask for? Oral sex? Some other form of sex?*

A *Yeah… they approaching me, and they don't, they don't, they don't hide any stuff around that area.*

Q186 *All right.*

A *Yeah, just like… a lady on the street, you know.*

Q187 *All right, yeah. Did he offer you some money to do anything?*

A *Yeah. I said, I'm not interested,* ***he forced, he forced attempt****.*

Q188 *Did you complain about that to anyone, at any stage?*

A *No, it was like two of us… after.*

[…]

Q190 *Yeah.*

A *OK. After, I actually said, I'm not interest… Back off.*

Q191 *Right.*

A *Yeah because, because some people do, when you say you're not interested, they don't go away.*

Q192 *All right.*

A *But* ***he still keep coming****, like when I was,* ***when I enter I was in the park, he was like on the side of the park.***

[…]

Q198

A *No I, I did not stab him. When, when, when I, when I come outside [the gates]… I said what is your problem, we start arguing, we start to argue.*

Q199 *Right*

A *Yeah, when* ***we start to argue I said, If you don't, I said, If you don't, I said the F word. I said I, I will, I will, you know I will, I will stab you****… I was not carrying a knife - -*

Q200 *But did you stab him or not?*

A *- - - I was not carrying a knife, it was like a fork, this - - -*

6.895. The words "the gates" at Q198 is not in the transcript of the interview, but can be heard on the audio file.[5879]

6.896. The interviewing officer pressed Mr Kellie on how I359 may have sustained the wound that was shown to Mr Kellie in a photograph. Mr Kellie responded (emphasis added):[5880]

A *He dropped the phone, when the argument was going on, 'cause he was like talking to somebody, when the argument was going on, when I pushed him,* ***I pushed him like onto the park****, because the park has like a… sharp wires from the park.*

[5879] Exhibit 39, Tab 83, Video ERISP of Moses Kellie, 17 January 2010 (SCOI.84081).

[5880] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q209–221 (SCOI.10469.00004).

Q209 Right.

A Like if you know Centennial Park, you know there is a old - - -

Q210 Yeah I know the fence that, yeah, yeah.

A The fence is there, and that's a iron fence.

Q211 Yeah.

A So when the argument was going on, I pushed him the, the phone drop. I said, if you come down again I, I will do something to you and when he start to run he drop the phone, and I, I took the phone, yeah.

Q212 What did you intend to do with the phone?

A I was not even want the phone, first I, I try to, to, to… I said, come on take your phone, or something like that. Then he's started to run, start going up, then later the lady called me…

Q214 […]

A […] I push to the railing, to the wall, to the, how you call it, the fence.

[…]

Q221 […]

A […] I tell him, I say, I'm not interested, I say why you following… what's your problem something like that, we start arguing, when I pushed him onto the wall, onto the wall. Maybe that's how he got this injury."

6.897. After this account, the interviewing police asked Mr Kellie about the iPhone which they found in his campsite in a pipe next to Busby's Pond (Campsite 2). Mr Kellie claimed that he intended to return the phone, and denied putting his sim card into it.[5881]

6.898. The interviewing officer redirected the interview to the confrontation (emphasis added):[5882]

[…]

Q288 What, what did he confront you with that made you end up in a struggle with him?

A ***It was, it was the gay sex.***

[5881] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q242–270 (SCOI.10469.00004).

[5882] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q288–289 (SCOI.10469.00004).

Q289 Gay sex - - -

A Yeah, yeah.

6.899. In the exchange that follows, Mr Kellie is gesturing to locations featured on the same map referenced above (emphasis added):[5883]

Q290 […]

A At the first, it was like the first entrance to the gates that's where I met him like hour before.

Q291 At the gates?

A Yeah.

Q292 Here?

A Down, the first gate in Centennial Park, if you enter, this is the Lang Road, Centennial Park…

Q293 Yeah, the main gates, are up here are they?

A Yeah, ***this is the cricket ground around the main gate*** *is here, around here.*

Q294 Yeah

A This is the Grand Drive, so when you enter here, this would, I think it was around this, this Lang Road, around this area… this happened. When I enter I came to the café, he was still there, so I decided to, to, it's like… like when I come out of there, where I'm gunna go next, it's like, is, is there this… One, two, two, three times, not the first time I've seen him, seen him.

6.900. It is reasonably clear from the video recording that Mr Kellie gestured to the Robertson Road Gates as the "main gate".

6.901. The interviewing officer then asked Mr Kellie where he was "camping near this pipe". Mr Kellie stated that it was off the first map that he was shown, but identified it on a second map that showed a greater portion of Centennial Park.[5884] He did not purport to relate this location to any interaction with the victim.

6.902. The interviewing officer challenged Mr Kellie's version of events, by reference to the fact that I359 stated that Mr Kellie walked up behind him and brushed past him. Mr Kellie stated (emphasis added):[5885]

Q316 […]

[5883] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q290–294 (SCOI.10469.00004).

[5884] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q296–304 (SCOI.10469.00004).

[5885] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q316–329 (SCOI.10469.00004).

A *Nope. I, I, I didn't actually walk behind… **I was actually like on the gate**, because when I'm first met him, for 1 hour before, he was coming up. It it it doesn't take that long to 1 hour to reach to the other gate cos like short distance. So I enter the café and **come out of that gate**, I was going to [Woollahra]… so I was like standing at the **side of the fence**, put the bag there, then he come, he come again, come like, he was talking… he was talking to… on the phone, **but he was talking on the same topic, yeah about sex stuff**, on the same, like talking to a female person about going out something like that, having a great time… like yeah - - -*

[…]

Q318 *[…]*

A *He was like **pretending phone**, when he was talking with, then he past me.*

Q319 *Yeah.*

A *Then I say, I… I, this guy still keep coming you know, because like he was watching when I enter the café, I you know, still… there, he come out, I was, yeah he was like… **he would have reached the next gate**.*

[…]

Q321 *[…]*

A *One hour I met him at the, the gate - - -*

Q322 *No I understand the one hour before.*

A *Yeah.*

Q323 *But at the time you've had a bit of push and shove against the fence.*

A ***I was back at the other gate**.*

Q324 *At the other gate?*

A *It's Lang Road there, **that's other gate there, small gate**.*

[…]

Q328

A *He, like he was talking to her, but she was not talking… one like, like me to her, like I, I was standing there at the next gate.*

Q329 *All right.*

> *A* *At the other gate after I've come out of the café, its* ***like he was waiting on the other, he was waiting like the… you do not take that long like to walk that distance."***

6.903. Mr Kellie was asked about his comments of having seen the victim on previous occasions (see above at Q294) (emphasis added):[5886]

> *Q357* *All right, and you say you seen this bloke three or four times before, this same person, this fella?*
>
> *A* *Mmm.*
>
> *Q358* *Three or four times before, you've seen him before?*
>
> *A* *Yes, yes.*
>
> *Q359* *Had he approached you for sex on those occasions as well?*
>
> *A* *Yeah, yeah.*
>
> *Q360* *And what was your reaction to that?*
>
> *A* *I'm still not interested I didn't like force, I didn't, it did not anger me, because like people do it you know, but* ***when he start, keep coming, that's when I get angry over this…***

6.904. As may be apparent from the extracts above, Mr Kellie's account in the interview is confusing to follow and open to multiple interpretations. He often rambled and gave answers that were not responsive to questions asked. His English is heavily accented and his grammar is imperfect. This is an inherent limitation in relying upon the interview as an admission.

6.905. It is clear that, at least at some points during the course of the interview, Mr Kellie is describing an incident consistent with the assault on I359: he recognises the photograph of I359 (which does not bear any particular resemblance to the appearance of Mr Cawsey);[5887] he describes the victim as speaking on an iPhone (whereas Mr Cawsey had an old Nokia); he describes pushing the victim against the fence of Centennial Park; and he describes taking the victim's phone.

6.906. However, there are two indications that Mr Kellie may have been, at times, switching to a description of an interaction with Mr Cawsey, which he had conflated with the robbery of I359. These are:

a. The nature of the incident he described; and

b. The apparent location of the incident.

[5886] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q357–360 (SCOI.10469.00004).

[5887] See annexure to Exhibit 39, Tab 20, Statement of Detective Sergeant Mark Winterflood, 28 January 2010, 5–7 (SCOI.83385).

NATURE OF THE INCIDENT DESCRIBED BY MR KELLIE

6.907. Mr Kellie gave a version of events in which the victim repeatedly propositioned him for "gay sex", which was what angered Mr Kellie and led to an "argument".[5888]

6.908. There was no evidence that I359 was gay or that he was seeking to meet other men at Centennial Park.[5889] I359's evidence was that he was walking home along Lang Road towards Oxford Street while looking for a taxi.[5890] By contrast, Mr Cawsey was in Centennial Park with the expressed intention of seeking a sexual encounter (although it is speculative as to whether he in fact propositioned any person).

6.909. Similarly, Mr Kellie described the man as pretending to talk on the phone and talking about "sex stuff" on the phone.[5891] This is consistent with Mr Cawsey connecting to a gay chat line and engaging in phone sex with I354. This was a fact that was not publicly known.[5892]

6.910. Together, these are significant features that suggest Mr Kellie may have been, at least at times, describing an encounter with Mr Cawsey.

6.911. Against that, however, it is not implausible that Mr Kellie was recounting to police a distorted perception of his interaction with I359. I359 was speaking on the phone to a friend when Mr Kellie confronted him and began to yell incoherently. A report by Dr Clark prepared in connection with the criminal proceedings in relation to the robbery of I359 found that it was likely that Mr Kellie had a schizophrenic illness at the time of the robbery.[5893] Dr Clark stated:[5894]

> *[H]e was paranoid, feeling that people were after him and that he had experienced hallucinatory voices, with threatening intimidating sexual content.*
>
> *[…]*
>
> *He was paranoid and convinced that the victim was a sexual predator. This was unrealistic in context but these were his convictions at the time.*

6.912. It is significant that Mr Kellie maintained his version of the victim being a "sexual predator" in his interview with Dr Clark, over a year after the interview of January 2010 and in the context of preparing for the sentencing of the robbery on I359, where the offence that he had pleaded to would have been plain.

[5888] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q156–222 (SCOI.10469.00004).

[5889] See Exhibit 39, Tab 54, Statement of I359, 11 September 2010 (SCOI.10491.00011).

[5890] See Exhibit 39, Tab 54, Statement of I359, 11 September 2010, [8]–[9] (SCOI.10491.00011).

[5891] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q162, Q316–318 (SCOI.10469.00004).

[5892] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 24 February 2017, p 81 (SCOI.10464.00009).

[5893] Exhibit 39, Tab 68, Psychiatric report of Dr Thomas Clark, 12 April 2011 (SCOI.10488.00009).

[5894] Exhibit 39, Tab 68, Psychiatric report of Dr Thomas Clark, 12 April 2011, 4, 6 (SCOI.10488.00009).

6.913. Alternatively, if Mr Kellie was indeed confused and conflating events, a reasonable possibility exists that he was conflating the robbery of I359 with another occasion, or multiple other occasions, on which he was approached for sex in Centennial Park. There is some indication of this by Mr Kellie's description of having been approached for sex by the same victim up to three or four times before, and his knowledge of Centennial Park as a "popular" meeting place for men seeking sexual activity with men.[5895]

6.914. In evaluating whether Mr Kellie described a sexual advance by Mr Cawsey, it may be observed that Mr Kellie never describes the victim as having his pants or underpants removed. Given Mr Kellie's preoccupation with the sexual advances made by the victim, that would be an unusual detail for him to omit.

LOCATION OF THE INCIDENT DESCRIBED BY MR KELLIE

6.915. Mr Kellie described meeting the victim twice. From his account, it is reasonably clear that the first location that he met the victim was at the Robertson Road Gates.[5896] This would have been the gate used by Mr Cawsey if he was taking the most direct route from his Redfern apartment. I359 would have passed this gate as he walked on Lang Road towards Oxford Street and may have been seen by Mr Kellie, but I359 did not suggest in his account that he met or spoke to anyone in person prior to being robbed, nor is there any suggestion that I359 propositioned any person for sex.[5897]

6.916. On one interpretation of Mr Kellie's interview, one of the incidents in which he said he was propositioned for gay sex occurred "down by the sporting area" or around the area where Mr Kellie used to live.[5898] At least one of Mr Kellie's campsites was near Busby Ponds adjacent to where Mr Cawsey's body was found. I359, by contrast, was never within Centennial Park when he was robbed of his phone, and never near Busby Pond.

6.917. Another reading of the interview as a whole is that Mr Kellie described both meetings with the victim as occurring at two sets of gates into Centennial Park, the first being at the Robertson Road Gate (which is near the area Mr Kellie "used to live"), and the second at smaller gates further down Lang Road, close to where I359 was in fact robbed.

[5895] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q357–360, Q130–137 (SCOI.10469.00004).

[5896] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q290, Q293 (SCOI.10469.00004).

[5897] Exhibit 39, Tab 54, Statement of I359, 11 September 2010 (SCOI.10491.00011).

[5898] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q167, Q182 (SCOI.10469.00004).

6.918. Mr Kellie makes repeated reference to coming out of the gates to the park.[5899] While Mr Kellie entered the park, the man stayed "on the side of the park".[5900] Across a number of answers, Mr Kellie expressed concern that the man was taking too long to walk from the Robertson Road Gate to the smaller gates on Lang Road, which fuelled his paranoia that the man was "waiting" for him.[5901] On this interpretation, Mr Kellie could reasonably be describing I359's movements, notwithstanding that he has interpreted I359's innocuous path along Lang Road with paranoia.

6.919. In summary, there are aspects of Mr Kellie's interview that give rise to a real suspicion that he was conflating his interactions with Mr Cawsey and I359, such that the interview could be taken as an admission to meeting Mr Cawsey and becoming angered at him after being propositioned for sex. That was the interpretation favoured by the original investigating police as well as, later, the Coroner.[5902]

6.920. However, Mr Kellie's interview is open to a number of other, reasonable interpretations, including:

a. That he was describing a distorted perception of his interactions with I359;

b. That he was conflating the robbery of I359 with other occasions on which he had been propositioned by men within Centennial Park, a popular beat; or

c. That Mr Kellie was lying about being propositioned by I359 in order to try and mitigate his conduct in the robbery. In this regard, it is relevant that he lied at other points in the interview, including by saying that he was intending to return the phone to I359 and denying placing his own sim card in the phone.[5903]

6.921. Further, even if it is accepted that Mr Kellie was conflating encounters with I359 and Mr Cawsey, it would follow that Mr Kellie's memory was confused and distorted. The two events must have become enmeshed into one incident in his mind, such that he was switching between the two events throughout the interview. It would be necessary to not only identify which aspects of the interview related to Mr Cawsey as opposed to I359, but also treat those aspects of the interview as sufficiently reliable. The difficulties with this are self-evident.

6.922. Thus, while it is an arguable proposition that Mr Kellie was conflating the murder of Mr Cawsey and the robbery of I359 in the January 2010 interview, these statements do not provide a safe or reliable basis, at least on their own, for concluding that Mr Kellie was responsible for Mr Cawsey's death.

[5899] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q128–132, Q198, Q294, Q316, Q323–323 (SCOI.10469.00004).

[5900] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q192 (SCOI.10469.00004).

[5901] Exhibit 39, Tab 47A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 January 2010, Q294, Q316, Q319, Q329 (SCOI.10469.00004).

[5902] Exhibit 39, Tab 8, Letter from Deputy State Coroner Magistrate Paula Russell to Lloyd Babb SC, 7 March 2018, [29] (SCOI.10483.00054).

[5903] Exhibit 39, Tab 48A, NSWPF Record of Interview, 'Interview with Moses Kellie', Q 338–341 (SCOI.10469.00008).

Subsequent interview with Mr Kellie

6.923. When Mr Kellie was interviewed on 6 October 2015, he denied confusing the two incidents.[5904] Mr Kellie stated, "[w]ell, you don't, don't mix two things together. That's two, armed robbery and murder, that's two different thing… No, I didn't get them confused."[5905] He maintained that he had been propositioned for sex by I359 prior to committing an armed robbery on him. He provided the following version of events:[5906]

Q65 *[…]*

A *I mean the, the victim, because I got charged with armed robbery - - -*

Q66 *Yes*

A *I remember the, um, the police asked me, um, do you know this fella before. I said, Nah. I say, I'm, I'm, I first met him in the, in, in front of Centennial Park.*

Q67 *Yes.*

A *Um, he asked me for gay sex. Then he walk away. I walk into the park. And that's where I walked behind him and I rob him of his mobile phone.*

Q68 *OK.*

Yeah, that was the, the person for the armed robbery.

[…]

Q76 *[…]*

A *[…] I was sitting there. He came past talking on the phone. Then he, he talked to me but I can't remember what he actually said. Then he walked off. I said, What's, I said to myself, What's wrong with this, with this person, you know? Um, then I saw him again the second time. He was talking on the phone. Um, that's when I, that's, that's when I went and rob him. I went from the other side of the park, I come out of the other, on the other entrance, and robbed him, robbed him of his mobile phone.*

[…]

Q89 *[…]*

A *[…] So as he start walking up the street, then I went into the park, and when I come out from the other side, he was still talking*

[5904] Exhibit 39, Tab 48A, NSWPF Record of Interview, 'Interview with Moses Kellie', 6 October 2015 (SCOI.10469.00008).

[5905] Exhibit 39, Tab 48A, NSWPF Record of Interview, 'Interview with Moses Kellie', 6 October 2015, Q 338–341 (SCOI.10469.00008).

[5906] Exhibit 39, Tab 48A, NSWPF Record of Interview, 'Interview with Moses Kellie', 6 October 2015, Q65–89 (SCOI.10469.00008).

> *on the phone, on, on the other side of the fence. That's when I, that's when I walked outside and robbed him.*[5907]

6.924. On one view, this is consistent with the interpretation of his interview on 17 January 2010 that the second interaction was at the "smaller gates" on Lang Road, and furthers the difficulty of relying upon the earlier interview as an admission.

Alleged admission to Mr Kellie's sister, 1357

6.925. On 18 January 2016, I357 (a pseudonym), the eldest sister of Mr Kellie, provided a statement to police in which she recounted a conversation that she had with Mr Kellie in Goulburn Gaol. According to I357, she "directly" asked Mr Kellie "what he did and whether he did the killing."[5908] She stated:[5909]

> *[Mr Kellie] told me that it was his friends that did the killing but they ran away and [Mr Kellie] was the one that got caught. [Mr Kellie] said that he got caught with the man's phone. […] He denied killing and denied having the knives. He said his friends did the killing in a group and he was there.*

6.926. I357's statement does not specify when this alleged admission was made, nor what words were used by Mr Kellie. It is at odds with Mr Cawsey's phone being left in his shirt pocket.

6.927. In the letter from the Coroner referring the matter to the ODPP, the Coroner observed the following:[5910]

> [I357]'*s oral evidence at the inquest raised serious concerns regarding the reliability of the statement above. It was 6 years between the date of the conversation and her recording the contents of it in her statement. She was vague in evidence as to precisely what was said by Moses Kellie and was unable to recall clearly what words were used by Moses and what facts she had assumed or inferred. As such it is near impossible to discern whether in fact Moses said that his friends did the killing and whether in fact Moses said that he was present while they did the killing.*
>
> *Little or no weight could be given to the evidence based on the oral evidence of* [1357].

[5907] Exhibit 39, Tab 48A, ERISP Transcript of Moses Kellie, 6 October 2015 (SCOI.10469.00008).

[5908] Exhibit 39, Tab 39, Statement of I357, 18 January 2016, [20] (SCOI.10470.00019).

[5909] Exhibit 39, Tab 39, Statement of I357, 18 January 2016, [20] (SCOI.10470.00019).

[5910] See also Exhibit 39, Tab 8, Letter from Deputy State Coroner Magistrate Paula Russell to Mr Lloyd Babb SC, 7 March 2018, [47]–[48] (SCOI.10483.00054).

6.928. If it was accepted that Mr Kellie made the statement attributed to him by I357, it may amount to a direct admission to presence at the time of Mr Cawsey's death. However, the admission would be inconsistent with the purported admission in the 17 January 2010 interview and also the facts of Mr Cawsey's murder to the extent that they are known. Consistent with the Coroner's findings, I give limited weight to this admission.

September 2016: The "no bill" decision

6.929. On the basis of the above evidence, police considered that there was sufficient evidence to prosecute Mr Kellie for the offence of murder.[5911]

6.930. On 6 October 2015, Mr Kellie was brought to Wagga Wagga Police Station from Junee Correctional Centre, and arrested for the murder of Mr Cawsey.[5912]

6.931. On 7 September 2016, the ODPP made a direction that there be no further proceedings against Mr Kellie. The court was advised of the determination and Mr Kellie was discharged.[5913]

6.932. In a letter from Ms Kara Shead, Deputy Director of Public Prosecutions, to Detective Chief Inspector Dickinson of the NSWPF Homicide Squad dated 13 September 2016, the following reasons were provided for the determination that there be no further proceedings:[5914]

> *In determining there was no reasonable prospect of conviction, there were difficulties with the admissibility of the tendency and coincidence evidence, as well as the reliability of the "admissions", and the statements made by the accused alleged to be "lies as consciousness of guilt", given his history of mental illness.*

2017: The coronial inquest

6.933. A coronial inquest was conducted into the death of Mr Cawsey on 11-13 December 2017, by Deputy State Coroner Russell.

6.934. Her Honour formed the opinion that there was evidence capable of satisfying a jury beyond reasonable doubt that Mr Kellie had committed an indictable offence – in her opinion, the offence of manslaughter by dangerous and unlawful act.[5915]

6.935. There were some items of evidence adduced during the coronial hearing that were not available at the time of the 2015-2016 prosecution of Mr Kellie. The new evidence is considered and assessed below.

[5911] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [181] (SCOI.10464.00009).

[5912] Exhibit 39, Tab 13 Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [182] (SCOI.10464.00009).

[5913] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [184] (SCOI.10464.00009).

[5914] Exhibit 39, Tab 11, Letter from Deputy Director of Public Prosecutions Kara Shead to Detective Chief Inspector Jason Dickinson, 13 September 2016 (SCOI.83377).

[5915] Exhibit 39, Tab 8, Letter from Deputy State Coroner Magistrate Paula Russell to Mr Lloyd Babb SC, 7 March 2018, [2] (SCOI.10483.00054).

New evidence as to Mr Kellie's mental health

6.936. At the coronial hearing, the nature and extent of Mr Kellie's mental health diagnoses, particularly at the time of Mr Cawsey's death and the interviews of police, was probed. This line of enquiry explored whether Mr Kellie had a mental illness, and if so whether it affected his cognition, or his ability to answer questions responsively, truthfully, or reliably.

6.937. It is necessary to set out and comment upon each of the expert reports in relation to Mr Kellie.

PSYCHOLOGICAL ASSESSMENT REPORT OF DR JOHN JACMON, 8 NOVEMBER 2010:

6.938. Dr Jacmon, a psychologist, assessed Mr Kellie by way of testing and clinical interview.[5916] Dr Jacmon concluded that Mr Kellie's day-to-day functioning was impaired by PTSD, depression and anxiety at clinically significant levels.

6.939. Dr Jacmon further assessed Mr Kellie to be at a "borderline level of IQ", characterised by significantly below-average general intellectual functioning existing concurrently with related limitations in two or more adaptive skill areas. This was said to be the lowest level of intelligence at which an individual may function independently, i.e. without the need for carer assistance.

PSYCHIATRIC REPORT OF DR THOMAS CLARK, 12 APRIL 2011

6.940. Dr Thomas Clark, psychiatrist, prepared a report in connection with Mr Kellie's court proceedings in relation to the robbery of I359.[5917] Dr Clark was asked to comment on whether Mr Kellie was fit to plead, and whether the defence of insanity was open to him.

6.941. Dr Clark diagnosed Mr Kellie with a schizophrenic illness which "in all probability, was present at the time of his offence."[5918] Dr Clark noted that Mr Kellie showed the "typical social and personal deterioration of a schizophrenic illness, with loss of supports."[5919]

EVIDENCE RAISING DOUBTS ABOUT MR KELLIE'S SELF-REPORTED HISTORY

6.942. Subsequent to the provision of these reports, police obtained information which was said to give rise to "some concern… that [Mr Kellie] has created or exaggerated a mental health situation because he saw that as being advantageous to his court proceedings."[5920]

[5916] Exhibit 39, Tab 67, Psychological report of Dr John Jacmon, 8 November 2010 (SCOI.10488.00008).

[5917] Exhibit 39, Tab 68, Psychiatric Report of Dr Thomas Clark, 12 April 2011 (SCOI.10488.00009).

[5918] Exhibit 39, Tab 68, Psychiatric Report of Dr Thomas Clark, 12 April 2011, 4 (SCOI.10488.00009).

[5919] Exhibit 39, Tab 68, Psychiatric Report of Dr Thomas Clark, 12 April 2011, 4 (SCOI.10488.00009).

[5920] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [205] (SCOI.10464.00009).

6.943. Some of the "concerns" arose from an unreliable history provided by Mr Kellie. For example, Mr Kellie told Dr Jonathan Adams in 2011 that he had previously attended Blacktown Hospital for mental health services and was prescribed psychiatric medication.[5921] However, Blacktown Hospital had no record of having Mr Kellie as a mental health patient.[5922]

6.944. Other concerns arose from comments recorded in Mr Kellie's Justice Health file in which he appeared to acknowledge lying about his mental health. For example, in a note dated 3 November 2010, Dr Elliot is reported to have recorded that Mr Kellie "now denies hearing AH (auditory hallucinations) and appeared to indicate he said this only to convey his distress re court."[5923]

6.945. Nonetheless, police acknowledged some of the observations of Mr Kellie in September and October 2009 could be seen as indicators of mental health issues, including not dressing for the weather, shouting at people for no apparent reason, and muttering to himself.[5924] Indeed, I359's own account of the robbery, according to which Mr Kellie began yelling at him incoherently with no provocation, may be seen as indicative of some degree of poor mental health on the part of Mr Kellie. Similarly, on the police case, Mr Kellie was responsible for the assault of I361, which bore hallmarks of paranoid and irrational behaviour.

6.946. Moreover, the 17 January 2010 interview, in which Mr Kellie was conflating and switching between describing interactions with I359 and Mr Cawsey (or interactions with other men who propositioned him for sex), is itself an indication of seriously disordered thinking.

PSYCHIATRIC REPORT OF DR JONATHAN ADAMS, 15 JUNE 2011

6.947. Dr Jonathan Adams, psychiatrist, prepared a report in connection with Mr Kellie's sentencing proceedings in relation to the robbery of I359.[5925] The report was prepared following clinical interview and a review of Mr Kellie's health records since being in custody, as maintained by Justice Health.

6.948. This report was commissioned at the request of the sentencing Judge. The comment in the statement of Detective Senior Constable Staples that the report was "commissioned by Defence and is sympathetic to [Mr Kellie's] purposes" is inaccurate.[5926]

6.949. Dr Adams summarises the reports of signs and symptoms of psychotic symptoms contained in his mental health file. From that summary, it appears that while Mr Kellie was not initially treated by mental health services in custody, in July 2010 Mr Kellie began reporting auditory hallucinations and was placed on antipsychotic medication.[5927] In about November 2010, Mr Kellie was transferred to the Mental Health Accommodation Area within the custodial facility.

[5921] Exhibit 39, Tab 70, Psychiatric report of Dr Jonathan Adams, 15 June 2011, 3 (SCOI.10486.00231).

[5922] Exhibit 39, Tab 8, Referral from the Coroner to the ODPP, 7 March 2018, [36] (SCOI.10483.00054).

[5923] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [205] (SCOI.10464.00009).

[5924] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [196] (SCOI.10464.00009).

[5925] Exhibit 39, Tab 70, Psychiatric report of Dr Jonathan Adams, 15 June 2011 (SCOI.10486.00231).

[5926] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [204] (SCOI.10464.00009).

[5927] Exhibit 39, Tab 70, Psychiatric report of Dr Jonathan Adams, 15 June 2011, 7–9 (SCOI.10486.00231).

6.950. Dr Adams opined that Mr Kellie's account "was in keeping with symptoms of a psychotic disorder, with associated mood disturbance and post traumatic features."[5928] Dr Adams did not express an opinion of Mr Kellie's mental state at the time of the robbery of I359, noting that there was no available collateral information of his presentation prior to incarceration.

PSYCHIATRIC REPORTS OF DR DANNY SULLIVAN, 17 SEPTEMBER 2017 AND 8 DECEMBER 2017

6.951. Dr Danny Sullivan, psychiatrist, provided a report to the Coroner dated 17 September 2017 in relation to Mr Kellie's mental state at the time of police interviews (including, most significantly, the interviews of 17 October 2009 and 17 January 2010), and also during his time in custody. He provided a short supplementary report after reviewing Dr Adams' report of 4 December 2017, dated 8 December 2017.[5929]

6.952. In his report dated 17 September 2017, Dr Sullivan opined that in each police interview conducted with Mr Kellie, there was "no clear evidence of mental illness."[5930] He stated:[5931]

> *He appeared oriented and alert. His answers were cogent and appropriate. There was no indication that at the times of the interviews he was experiencing auditory hallucinations or other perceptual abnormalities. His statements and demeanour did not suggest that he was suspicious or held grandiose ideas. His cognitive abilities and intellect did not appear in any way compromised.*

6.953. In relation to whether Mr Kellie's behaviour in custody disclosed a mental illness, Dr Sullivan observed that the evidence of mental illness was largely supported by Mr Kellie's self-report rather than behavioural observations. Dr Sullivan referred to two occasions, recorded in Mr Kellie's mental health records, where he acknowledged being untruthful about his history because he considered this would help his court case.[5932]

6.954. Dr Sullivan did not assess Mr Kellie in person. On the basis of his review of the materials, Dr Sullivan expressed his view as follows:[5933]

> *[…] I cannot be confident that Mr Kellie does clearly suffer from a psychotic illness. The possibilities are that he has a genuine psychotic illness; or that he has feigned psychosis for various secondary gains, including sentencing advantages, benefits within the correctional system, and/or obtaining sedative medication…*
>
> *Given the uncertainty about whether Mr Kellie had any confirmed mental illness, and based upon observing the ERISP interviews, I cannot find*

[5928] Exhibit 39, Tab 70, Psychiatric report of Dr Jonathan Adams, 15 June 2011, 9 (SCOI.10486.00231).

[5929] Exhibit 39, Tab 71, Psychiatric report of Dr Danny Sullivan, 17 September 2017 (SCOI.10488.00012); Exhibit 39, Tab 73, Psychiatric report of Dr Danny Sullivan, 8 December 2017 (SCOI.10488.00016).

[5930] Exhibit 39, Tab 71, Psychiatric report of Dr Danny Sullivan, 17 September 2017, [60] (SCOI.10488.00012).

[5931] Exhibit 39, Tab 71, Psychiatric report of Dr Danny Sullivan, 17 September 2017, [60] (SCOI.10488.00012).

[5932] Exhibit 39, Tab 71, Psychiatric report of Dr Danny Sullivan, 17 September 2017, [62] (SCOI.10488.00012).

[5933] Exhibit 39, Tab 71, Psychiatric report of Dr Danny Sullivan, 17 September 2017, [64], [68] (SCOI.10488.00012).

> *evidence for any clear impediment to his cognitive abilities or his ability to answer questions responsively, truthfully, or reliably.*

PSYCHIATRIC REPORTS OF DR JONATHAN ADAMS, 4 AND 8 DECEMBER 2017

6.955. Dr Adams, who assessed Mr Kellie in 2011, provided a report to the Coroner dated 4 December 2017, in which he addressed the same topics as Dr Sullivan. He provided a supplementary report dated 8 December 2017 after being provided with and reviewing Dr Sullivan's report dated 17 September 2017.[5934]

6.956. Similarly to Dr Sullivan, Dr Adams noted the absence of any overt or manifest signs of mental illness during the 17 January 2010 interview. He was "not able to conclude that Mr [Kellie] was clearly suffering from symptoms of a mental illness at the time of these interviews."[5935]

6.957. However, Dr Adams added the following important qualification:[5936]

> *It is important to note, however, that these police interviews were not formal psychiatric evaluations. Although in my view it is reasonable to conclude that there was no clear evidence of Mr [Kellie] experiencing symptoms of a major mental illness during these interviews given his behaviour and responses, that is not to say that he was not experiencing underlying symptoms of mental illness.*

6.958. In relation to Mr Kellie's presentation in custody, Dr Adams commented that Mr Kellie had been assessed by several different mental health clinicians since his arrest in 2010, and had regularly been observed to be experiencing symptoms consistent with a psychotic illness.[5937]

6.959. Dr Adams referred to the areas of concern regarding the reliability and consistency of Mr Kellie's account. Dr Adams stated that, in the absence of a further evaluation of Mr Kellie in person in which to explore these issues, he had "no reason to alter" his diagnosis in 2011 of a psychotic disorder, in the absence of a further assessment of Mr Kellie in person.[5938]

ANALYSIS

6.960. While Mr Kellie's mental health presentation is complex and contested, at least two forensic psychiatrists who examined Mr Kellie in 2011 (Dr Clark and Dr Adams), concluded that he suffered from a psychotic illness. This is consistent with evidence that he was diagnosed with and treated for mental illness while in custody, notwithstanding some comments that he had exaggerated or lied about some symptoms. It is also congruent with his presentation while living in Centennial Park.

[5934] Exhibit 39, Tab 72, Psychiatric report of Dr Jonathan Adams, 4 December 2017 (SCOI.10488.00017); Exhibit 39, Tab 74, Psychiatric report of Dr Jonathan Adams, 8 December 2017 (SCOI.10488.00019).

[5935] Exhibit 39, Tab 72, Psychiatric report of Dr Jonathan Adams, 4 December 2017, 9 (SCOI.10488.00017).

[5936] Exhibit 39, Tab 72, Psychiatric report of Dr Jonathan Adams, 4 December 2017, 9 (SCOI.10488.00017).

[5937] Exhibit 39, Tab 72, Psychiatric report of Dr Jonathan Adams, 4 December 2017, 10 (SCOI.10488.00017).

[5938] Exhibit 39, Tab 72, Psychiatric report of Dr Jonathan Adams, 4 December 2017, 10 (SCOI.10488.00017).

6.961. In the opinion of Dr Adams, the lack of outward signs of psychosis during a police interview cannot exclude that Mr Kellie was experiencing symptoms of psychosis. Further, even assuming Mr Kellie was not affected by psychosis at the time of the 17 January 2010 interview, any psychotic illness may only manifest periodically. It cannot exclude Mr Kellie having been affected by psychosis at the time of the robbery of I359, and his paranoid interpretation of the events at the time colouring the account he provided to police.

6.962. Dr Sullivan's opinion, which casts the most doubt on Mr Kellie's diagnosis, puts it no higher than that he cannot be confident that Mr Kellie suffered from a psychotic illness, and that a *possibility* existed that he feigned psychosis. Dr Sullivan did not himself examine Mr Kellie, which Dr Adams considered to be a necessary step before commenting "conclusively as to the reliability of Mr Kellie's account."[5939]

6.963. In the expert report of Dr Kerri Eagle, forensic psychiatrist, dated 17 February 2023, obtained by the Inquiry, Dr Eagle comments that it is "not unusual" for individuals with mental illness to exaggerate or falsely deny symptoms of mental illness, for a variety of reasons, and that she would not be able to exclude a psychotic illness on that basis.[5940] Further, Dr Eagle refers to which was "more than just self report" to suggest Mr Kellie had a mental health condition, including a deterioration in function resulting in itinerancy.[5941]

6.964. Having regard to the whole of the psychiatric evidence as well as observations of Mr Kellie from 2009, it is likely that Mr Kellie was affected by mental illness at the time of the robbery of I359.

6.965. More significantly, even if one were to assume that Mr Kellie was not affected by psychotic illness at the time of the interviews or the robbery of I359, many of the issues identified above with relying upon the interview of 17 January 2010 as an admission to the murder of Mr Cawsey remain.

6.966. It remains the fact that Mr Kellie did not unambiguously describe an encounter with Mr Cawsey. Indeed, to accept the 17 January 2010 as a reliable admission with substantial probative weight would require the walking of a fine line between establishing that Mr Kellie's mental state was sufficiently impacted that he would confuse or conflate two separate events, but not so impacted that he could be confabulating or misperceiving some details.

6.967. The new psychiatric evidence obtained at the coronial inquest does not, in my opinion, substantially change the treatment that should be given to Mr Kellie's interview on 17 January 2010 as a purported admission.

[5939] Exhibit 39, Tab 72, Psychiatric report of Dr Jonathan Adams, 4 December 2017, 10 (SCOI.10488.00017).

[5940] Exhibit 39, Tab 78, Expert report of Dr Kerri Eagle, 17 February 2023, [79] (SCOI.83375).

[5941] Exhibit 39, Tab 78, Expert report of Dr Kerri Eagle, 17 February 2023, [82.2.1] (SCOI.83375).

Expert report of Dr Johan Duflou in relation to the knives possessed by Mr Kellie

6.968. In 2009, police seized six knives that were found in Mr Kellie's possession: one was seized at the time he was arrested for the assault on I360, the remaining five were seized from a backpack in his campsite. Each of these knives had previously been forensically tested for blood, with negative results.[5942]

6.969. On 1 November 2017, Dr Johan Duflou, forensic pathologist, provided an opinion to the Coroner as to whether any of the six knives found in Mr Kellie's possession were capable of causing the stab wound inflicted upon Mr Cawsey.[5943]

6.970. Dr Duflou set out clear limitations on the ability to infer the size or shape of a blade from the nature of the wound. Dr Duflou considered comments of the likelihood of a specific knife causing an observed injury to be "inherently unreliable", and that "often at best only various knives can be excluded."[5944] In relation to the limitations, Dr Duflou commented:[5945]

a. With extremely few exceptions, knives do not have unique characteristics which allow an examiner to determine that a specific knife caused an injury to the exclusion of all others;

b. Parts of the human body are elastic and deformable, with the effect of making a wound on the surface of the skin appear either smaller or larger than the width of the blade;

c. The depth of a wound is only an approximation, and the knife may have entered the body for a longer or shorter distance, depending on variables such as the position of the deceased and his internal organs at the time of the stabbing, the position of the organs when lying on the mortuary table, whether the deceased was exhaling or inhaling at the time of the stabbing, and any possible compression of the chest by the weapon;

d. An altercation is not a static event, such that the weapon may not have entered "cleanly"; and

e. A knife may be thrust into the body to the hilt, or may enter the body for only part of the blade length.

6.971. In relation to five of the six knives, Dr Duflou stated that while it was reasonably possible that they could have caused the injury, it was also entirely possible for another knife with similar dimensions to have caused the stab wound. He added that it was also reasonably possible for a knife which has "different appearances altogether" from the six that he examined to have been used to inflict the fatal stab wound.[5946]

6.972. This evidence is neutral as to Mr Kellie's possible involvement in the stabbing of Mr Kellie.

[5942] Exhibit 39, Tab 4, Certificate of analysis of Lisa-Ann Wedervang, 18 April 2016c, 2–4, 13–14, 16 (SCOI.10465.00005).

[5943] Exhibit 39, Tab 5, Pathology report of Dr Johan Duflou, 1 November 2017 (SCOI.10488.00020).

[5944] Exhibit 39, Tab 5, Pathology report of Dr Johan Duflou, 1 November 2017, [14] (SCOI.10488.00020).

[5945] Exhibit 39, Tab 5, Pathology report of Dr Johan Duflou, 1 November 2017, [14]–[16] (SCOI.10488.00020).

[5946] Exhibit 39, Tab 5, Pathology report of Dr Johan Duflou, 1 November 2017, [18] (SCOI.10488.00020).

2018: The ODPP declines to prosecute Mr Kellie following the coronial referral

6.973. On 16 November 2018, Mr Peter McGrath SC, Deputy Director of Public Prosecutions, advised Detective Senior Constable Staples that the ODPP would not be further prosecuting Mr Kellie in relation to the death of Mr Cawsey. Mr McGrath SC noted that, in light of the previous direction that there be no further proceedings on 6 September 2016, consideration was given to whether there was "significant new evidence to warrant the reversal of that direction."[5947] Mr McGrath continued:[5948]

> *The case against Mr Kellie is a circumstantial one. Upon an assessment of the new evidence arising since the discontinuance of the previous proceedings, this Office considers that there remains no reasonable prospect of conviction and that the new evidence does not overcome the previously identified difficulties in the prosecution of this matter. In particular, the newly obtained medical opinions as to Mr Kellie's mental health do not overcome difficulties with the reliability of 'admissions' and statements alleged to be 'lies as consciousness of guilt'.*

6.974. It may be observed that the reasons provided by Mr McGrath SC, while brief, are consistent with the analysis provided above as to the probative value of the new evidence.

LGBTIQ bias motivation on the part of Mr Kellie

6.975. Notwithstanding the above conclusion, on the basis that Mr Kellie is the only person of interest and that a Coroner considered that there was evidence capable of satisfying a jury beyond reasonable doubt that Mr Kellie had committed an indictable offence, an opinion was sought from Dr Eagle as to whether there was evidence that Mr Kellie was motivated by LGBTIQ bias, on the assumption that:[5949]

a. Mr Kellie's interview on 17 January 2010 related to interactions between Mr Kellie and Mr Cawsey, rather than I359; and

b. Mr Kellie stabbed Mr Cawsey.

6.976. Dr Eagle considered that there was insufficient information to reliably determine the motivation for Mr Kellie's behaviour.[5950]

6.977. In Dr Eagle's opinion, it is plausible that, if Mr Kellie had a chronic psychotic illness, symptoms of psychosis could have impaired his judgment and resulted in a misinterpretation of Mr Cawsey's behaviour, contributing to the violence. This would "complicate the interpretation of this offence as a hate crime."[5951]

[5947] Exhibit 39, Tab 12, Letter from Deputy Director of Public Prosecutions Peter McGrath SC to Magistrate Paula Russell, 16 November 2018 (SCOI.10483.00062).

[5948] Exhibit 39, Tab 12, Letter from Deputy Director of Public Prosecutions Peter McGrath SC to Magistrate Paula Russell, 16 November 2018 (SCOI.10483.00062).

[5949] Exhibit 39, Tab 77, Letter of Instruction to Dr Kerri Eagle, 21 December 2022, 4–5 (SCOI.83372).

[5950] Exhibit 39, Tab 78, Expert Report of Dr Kerri Eagle, 17 February 2023, [82.2.3]–[82.2.4] (SCOI.83375).

[5951] Exhibit 39, Tab 78, Expert Report of Dr Kerri Eagle, 17 February 2023, [82.2.1], [82.3.2] (SCOI.83375).

6.978. Possible motivations for Mr Kellie's response to Mr Cawsey's alleged advances include:[5952]

a. "[A] reactive albeit excessive response to a persecutory misinterpretation of Mr Cawsey's intentions",

b. "[P]oorly controlled anger at Mr Cawsey for propositioning him sexually but not necessarily motivated by hate (arising from problems with anger management rather than hatred towards a specific group due to prejudice)", or

c. "[A]nger motivated by hatred due to prejudice towards a specific group."

6.979. The third of these motivations would bring Mr Kellie's response to Mr Cawsey within the definition of an LGBTIQ bias crime, as adopted by this Inquiry.[5953] Mr Cawsey's sexuality, as perceived by Mr Kellie, would have been a factor in the commission of the stabbing.

6.980. However, in respect of the first two motivations, Mr Cawsey's sexuality *per se* would not have played a factor in the commission of the offence, as opposed to Mr Kellie's perception of, and/or reaction to, Mr Cawsey's "forced" sexual advances.

6.981. Accordingly, even on the assumption that Mr Kellie stabbed Mr Cawsey following an interaction that was described by him in his interview of 17 January 2010, it is not possible to conclusively determine that the killing of Mr Cawsey was motivated by LGBTIQ bias.

Possibility of an LGBTIQ bias attack by another person

6.982. Police investigating Mr Cawsey's death considered the possibility that Mr Cawsey was the subject of LGBTIQ motivated violence by a person other than Mr Kellie. Detective Senior Constable Staples provided the opinion that Mr Cawsey's death "was not a targeted 'gay-hate' attack", on the basis of the following factors:[5954]

a. First, "[T]he murder itself is not indicative of it being hate crime related". This assertion was principally based on an email received from forensic psychologist Ms Kimberley Ora (as discussed below); and

b. Secondly, the area of Snake Bank and Busby's Pond was not known as being a place for male sexual activity, which would make it unlikely that persons intent on committing violence against men would choose to focus on this area; and

c. Thirdly, there are no police or internet records indicating that LGBTIQ bias crimes were occurring in the Centennial Park area during 2009.

6.983. Each of these factors is considered below.

[5952] Exhibit 39, Tab 78, Expert Report of Dr Kerri Eagle, 17 February 2023, [82.2.3]–[82.2.4] (SCOI.83375)

[5953] Transcript of the Inquiry, 2 November 2022, T138.22–139.14 (TRA.00003.00001).

[5954] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [130] (SCOI.10464.00009).

6.984. In relation to the first factor, that the "murder itself is not indicative of it being hate crime related", police principally relied upon an email received from Ms Ora dated 17 February 2015, in which she stated, among other things, that:[5955]

> *primarily the absence of excessive violence against the victim in this case would be the main factor that does not support this as being a hate crime…*

6.985. It is necessary to appreciate that Ms Ora's email, which was tendered at the inquest into Mr Cawsey's death, was not an expert report. Ms Ora, appropriately, qualified her opinion as preliminary ("From what I have read so far…") and not based on a thorough review of the materials ("In the next few weeks I will review the case material more thoroughly…").[5956] Despite Ms Ora stating that she would "put some of these thoughts into a report for you", no report was ever prepared or tendered at the coronial inquest.[5957]

6.986. In any event, while it may be accepted that excessive violence can indicate an "emotion based motive" consistent with anger, rage and hate, it does not necessarily follow that its absence can serve as a basis to *exclude* a hate crime.

6.987. Dr Eagle, in commenting on Ms Ora's preliminary opinion as expressed in the email, considered that the absence of excessive violence does not contribute to the issue of whether this is or is not a hate crime.[5958] She explained:[5959]

> *Indicators, much like risk factors, are circumstances that have been associated in the literature with specific types of outcomes (such as offences). It would not be reliable, in my view, to extrapolate from an indicator derived from the literature, a conclusion as to a certain fact such as motivation.*

6.988. In relation to the second factor, police relied upon the evidence of park rangers and security guards to the effect that sexual activity within Centennial Park principally occurred in two areas: first, along Carrington Drive in the north of the park (principally used by gay men); and secondly, at Lachlan Swamp.[5960] These areas were indicated with the letter "B" in the map marked by park ranger Colin Cheshire on 24 June 2015.[5961]

6.989. This was corroborated by information on a website accessed by Detective Senior Constable Staples and quoted in her statement.[5962]

[5955] Exhibit 39, Tab 63, Email from Kimberly Ora to Detective Senior Constable Melanie Staples, 17 February 2015, 1 (SCOI.10472.00151).

[5956] Exhibit 39, Tab 63, Email from Kimberly Ora to Detective Senior Constable Melanie Staples, 17 February 2015 (SCOI.10472.00151).

[5957] Exhibit 39, Tab 63, Email from Kimberly Ora to Detective Senior Constable Melanie Staples, 17 February 2015, 2 (SCOI.10472.00151).

[5958] Exhibit 39, Tab 78, Expert report of Dr Kerri Eagle, 17 February 2023, [46]–[47] (SCOI.83375).

[5959] Exhibit 39, Tab 78, Expert report of Dr Kerri Eagle, 17 February 2023, [82.3.3] (SCOI.83375).

[5960] Exhibit 39, Tab 35, Statement of Colin Cheshire, 24 June 2015, [33]–[35] (SCOI.83386); Exhibit 39, Tab 36, Statement of Lee Doull, 4 November 2015, [8] (SCOI.10467.00125); Exhibit 39, Tab 37, Statement of David Nelson, 20 November 2015, [8] (SCOI.10467.00133); Exhibit 39, Tab 40, Statement of Juliet Johnson, 2 February 2016, [9]–[10], [13] (SCOI.10467.00127).

[5961] Exhibit 39, Tab 35A, Annexure to Statement of Colin Cheshire, 24 June 2015 (SCOI.83386).

[5962] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [123] (SCOI.10464.00009).

6.990. Accepting this information to be true reduces the likelihood of a planned LGBTIQ bias attack in the location of Busby's Pond. However, it does not exclude the possibility of an opportunistic attack on Mr Cawsey, or Mr Cawsey being followed from a known beat location to the location where he was ultimately killed.

6.991. In relation to the third factor, on 20 December 2016 a Request for Assistance was sent to the BCU seeking further information about whether there existed any evidence of LGBTIQ bias offending within the Centennial Park area between 1 January 2008 and 31 December 2010.

6.992. In response to the request, Acting Sergeant Corbett of the Bias Motivated Crimes Unit within Operational Programs prepared a document setting out each "sexual preference prejudice incident" for each month between January 2008 and May 2009. No incidents in the Centennial Park area were identified.[5963]

6.993. In an email to Detective Senior Constable Staples dated 9 December 2016, Sergeant Geoffrey Steer set out the following limitations of the data that could be provided:[5964]

a. First, in June 2009 the BCU was disbanded, and no bias crime capability existed within the NSWPF from then until September 2012. (This is a matter which has been the subject of evidence in public hearings of the Inquiry.) As a result, there was no available data from May 2009, and none in the months preceding Mr Cawsey's death; and

b. Secondly, in the opinion of Sergeant Steer, hate crimes were underreported by the community, and "police especially back then either didn't flag the associated factor to identify it or didn't identify the crime as a hate crime."

6.994. Bearing those limitations in mind, the data produced by the Bias Motivated Crimes Unit can at most be taken as qualified evidence for there being no readily identifiable cluster of "sexual preference prejudice incidents" occurring in Centennial Park.

6.995. Each of the above factors is relevant to an assessment of the probability of Mr Cawsey being the target of an LGBTIQ bias motivated attack. However, in the absence of a known person responsible for Mr Cawsey's death, they cannot exclude the possibility of the stabbing of Mr Cawsey being an LGBTIQ hate crime.

2023: Forensic testing by the Inquiry

6.996. The Inquiry arranged for the further forensic analysis in relation to a number of exhibits that were assessed to be of particular forensic significance. The results in relation to this analysis is as follows.

a. Section of "rollie" cigarette butt: As set out above, previous testing of a cigarette butt located next to Mr Cawsey's body revealed a mixed DNA profile that could have originated from unknown males A and B.

[5963] Exhibit 39, Tab 66, Bias Motivated Crimes Unit, Data on Gay Hate Offending 2008-2010, 22 December 2016 (SCOI.83355).

[5964] Exhibit 39, Tab 65, Email from Sergeant Steer to Detective Senior Constable Staples, 9 December 2016 (SCOI.83365).

b. Further testing conducted in 2023 utilised the latest "deconvolution" software to separate the profiles in the mixture by determining the probabilities of likely allele combinations from the contributors. Partial DNA profiles were obtained. Those profiles were uploaded not the NSW database on 14 February 2023, with no matches.[5965]

c. Black underpants: As set out above, previous testing of the black g-string worn by Mr Cawsey revealed that the DNA recovered was a mixture that originated from two individuals, Mr Cawsey and unknown male "C".

d. At the request of the Inquiry, the original profile obtained was "upgraded" using the latest DNA typing system used by FASS. The upgraded typing system, known as PowerPlex 21, increases the amount of loci on the chromosome tested from 10 to 21. This enhanced profile has been uploaded for searching on the NSW and National database, however remains unidentified.[5966]

e. Penile swab: A penile swab was taken from Mr Cawsey post-mortem. Previous testing revealed that a partial DNA profile recovered matched Mr Cawsey.[5967] Further testing by FASS in 2023 was unable to yield any further information, with again a weak partial DNA profile consistent with Mr Cawsey being obtained.[5968]

f. Black hood and black glove: On 17 October 2009, police seized several items of clothing from Mr Kellie's campsite on the shoreline of Busby's Pond (campsite 2). Among these were a black hood and a black glove. Previous testing had been negative to blood, and testing for trace DNA was not carried out.[5969] Mr Edgington described a man, believed to be Mr Kellie, wearing a hood on the morning of Mr Cawsey's murder, as discussed above.[5970]

g. Notwithstanding the absence of blood, the Inquiry considered that any trace DNA from Mr Cawsey would be of forensic significance as it could indicate an interaction between the two men.

h. A total of 43 tape lifts were taken from the inside and outside of the hood in order to exhaustively sample the item. DNA testing of these samples yielded the following results:[5971]

    i. Testing was "unsuccessful" on 26 swabs. That is, either a DNA profile was not obtained or the amount of DNA in the sample was below the threshold for detection;

[5965] Exhibit 39, Tab 76, Certificate of analysis of David Bruce, 23 June 2023, 1 (SCOI.84130).

[5966] Exhibit 39, Tab 76, Certificate of analysis of David Bruce, 23 June 2023, 1–2 (SCOI.84130); Exhibit 39, Tab 75, Letter from Solicitor Assisting the Inquiry to Forensic and Analytical Science Service, 30 March 2023 (SCOI.83356).

[5967] Exhibit 39, Tab 4, Certificate of analysis of Lisa-Ann Wedervang, 18 April 2016, item 16 (SCOI.10465.00005)

[5968] Exhibit 39, Tab 76, Certificate of analysis of David Bruce, 23 June 2023, 1 (SCOI.84130).

[5969] Exhibit 39, Tab 4, Certificate of analysis of Lisa-Ann Wedervang, 18 April 2016, items 46 and 47(SCOI.10465.00005)

[5970] See above at [6.814].

[5971] Exhibit 39, Tab 76, Certificate of analysis of David Bruce, 23 June 2023 (SCOI.84130).

ii. In relation to 13 swabs, DNA was recovered but was too weak for meaningful comparison with reference samples;

iii. In swabs recovered from one area of the hood, a partial unknown female DNA profile was returned (unknown female "E");

iv. In swabs recovered from another area on the hood, an unknown male DNA profile (unknown male "D") was returned. Mr Kellie and Mr Cawsey were excluded as contributors;

v. In swabs recovered from another area of the hood, a partial DNA profile was recovered. Mr Kellie was not excluded, although further work is required to confirm or verify that result.

i. A total of ten tape lifts were taken from the interior and exterior surfaces of the glove. DNA testing of each tape lift yielded partial profiles matching Mr Kellie.[5972]

j. Mr Kellie's DNA would be expected on both the hood and the glove, given that it was believed to belong to him. The results are otherwise of no forensic significance to the investigation of Mr Cawsey's death.

k. Left and right Puma shoes belonging to Mr Kellie: On 17 October 2009, police seized Puma-brad shoes worn by Mr Kellie, which he later admitted to wearing on the date of Mr Cawsey's murder.[5973] Previous testing of the left shoe had received a partial DNA profile; however, due to the low level of DNA, further interpretation was not carried out.[5974] DNA testing was unsuccessful in relation to the right shoe.

l. As with the hood and glove, the Inquiry considered that any trace DNA from Mr Cawsey would be of forensic significance. The Inquiry arranged for further forensic testing to be undertaken on Mr Kellie's shoes. Partial and mixed DNA profiles were recovered. The DNA profiles that were recovered from the testing either matched Mr Kellie or were unsuitable for comparison due to additional DNA contributors being too weak for interpretation. A DNA profile matching Mr Cawsey was not detected on any of the samples that were tested.[5975]

m. Wallet of Mr Cawsey: During the crime scene examination, a small wallet containing Mr Cawsey's driver's license was located in his trackpants. Previous testing had revealed trace DNA from at least one other individual, but at levels too low for further interpretation.[5976]

n. Although Detective Senior Constable Staples would ultimately conclude that there was no evidence of any property being stolen from Mr Cawsey,[5977]

[5972] Exhibit 39, Tab 76, Certificate of analysis of David Bruce, 23 June 2023, 2 (SCOI.84130).

[5973] Exhibit 39, Tab 45A, NSWPF Record of Interview, 'Interview with Moses Kellie', 17 October 2009, Q737–744 (SCOI.10468.00076).

[5974] Exhibit 39, Tab 4, Certificate of analysis of Lisa-Ann Wedervang, 18 April 2016, item 50 (SCOI.10465.00005)

[5975] Exhibit 39, Tab 76, Certificate of analysis of David Bruce, 23 June 2023, 2 (SCOI.84130); Exhibit 39, Tab 87, Certificate of Analysis of David Bruce, 26 July 2023 (SCOI.84898); Exhibit 39, Tab 89, Certificate of Analysis of David Bruce, 4 October 2023 (SCOI.86013).

[5976] Exhibit 39, Tab 4, Certificate of analysis of Lisa-Ann Wedervang, 18 April 2016, item 66 (SCOI.10465.00005)

[5977] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [132] (SCOI.10464.00009).

investigations had revealed that he had withdrawn $650 from his bank account on the Thursday prior to his death (i.e., 24 September 2009).[5978] The Inquiry considered than an investigative lead could arise from identifying the individual who deposited the trace DNA identified by earlier testing.

o. Consistent with the original testing, re-analysis of a swab from the wallet revealed a mixed DNA profile, with the major profile matching Mr Cawsey and the minor profile being too weak for interpretation.[5979]

6.997. In short, none of the forensic testing yielded new lines of inquiry nor advanced any theory as to who may have been responsible for the death of Mr Cawsey.

Police investigation

6.998. Counsel Assisting submitted that the original police investigation was extensive and thorough. Counsel Assisting's only comment about the police investigation was in relation to the timing of the arrest of Mr Kellie.

6.999. As set out above, despite police having obtained all relevant evidence against Mr Kellie by 2010, they failed to bring charges against him until October 2015. It appears that the decision to charge Mr Kellie was prompted by a review of the investigation materials pending his transfer from imprisonment to immigration detention at the expiration of his sentence for other matters, rather than any breakthrough in the case.[5980]

6.1000. As Counsel Assisting submitted, and I accept, delay in prosecution risks weakening the Crown case, and can also impact upon the ability of an accused person to fully test the evidence relied upon by the Crown: see *Longman v The Queen* (1989) 168 CLR 79. Witnesses may become unavailable, or their memory of events may fade. Documents, records or other exhibits may be lost. The reality of the impact of the passage of time on the evidence in a case is all too familiar to this Inquiry.

6.1001. The NSWPF submitted that the timing of Mr Kellie's arrest does not appear to have had any impact on the ODPP's decision not to prosecute him. I cannot make a positive finding that the delay had no impact upon that decision - the reasons of the ODPP for discontinuing the prosecution against Mr Kellie are privileged and confidential, with the exception of the short explanations quoted above in relation to which privilege was waived. However, I appreciate and accept the point that, in this case, there was no evidence that the delays in fact contributed to any prejudice to the prosecution case.

6.1002. In these circumstances, I make no adverse comments as to the police investigation, nor specific criticism of the delay. I consider it appropriate to make the general observation, consistent with the submission of Counsel Assisting, that delays in commencing prosecutions should, where possible, be avoided.

[5978] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, 23 (SCOI.10464.00009).

[5979] Exhibit 39, Tab 76, Certificate of analysis of David Bruce, 23 June 2023, 2 (SCOI.84130).

[5980] Exhibit 39, Tab 13, Statement of Detective Senior Constable Melanie Staples, 9 December 2016, [180]–[181] (SCOI.10464.00009).

Manner and cause of death

6.1003. Counsel Assisting submitted that while there was a plausible argument that Mr Kellie was responsible for the death of Mr Kellie, such that a Coroner was persuaded to refer the case to the ODPP, the evidence was inconclusive.

6.1004. Counsel Assisting identified the circumstantial case against Mr Kellie to include:

a. The close proximity of Mr Kellie's campsites to the crime scene;

b. The omissions or inconsistencies in Mr Kellie's accounts, which are capable of being construed as lies amounting to admissions;

c. The aspects of the interview with Mr Kellie on 17 January 2010 which gave rise to a real suspicion that he was conflating his interactions with Mr Cawsey and I359, such that the interview could be taken as an admission to meeting Mr Cawsey and becoming angered after being propositioned for sex; and

d. The purported admission to Mr Kellie's sister.

6.1005. However, Counsel Assisting noted the limitations or deficiencies of the evidence in the case against Mr Kellie, including:

a. The absence of forensic evidence connecting Mr Kellie to the crime scene or Mr Cawsey's body;

b. The limited probative value of sighting of Mr Kellie in proximity to the crime scene, given that he was known to be homeless and living in Centennial Park at the time;

c. The "fraught" nature of relying on inconsistencies or omissions in Mr Kellie's account to police as lies as consciousness of guilt;

d. The difficulties in relying upon Mr Kellie's interview with police on 17 January 2010 as an admission; and

e. The lack of reliability or specificity in respect of Mr Kellie's admission to his sister.

6.1006. Counsel Assisting further submitted that the evidence as to Mr Kellie's involvement in other offending in and around the Centennial Park area would not be admissible as tendency and coincidence evidence. I agree with this, for the reasons I have provided above. I do not have regard to this evidence in assessing whether Mr Kellie was involved in Mr Cawsey's death.

6.1007. The NSWPF agreed with the submissions of Counsel Assisting that the person who inflicted the stab wound is unknown.

6.1008. I accept Counsel Assisting's analysis of the evidence, which is reflected in my consideration of the evidence above. Having regard to the standard of proof identified in **Chapter 1**, although the evidence gives rise to a real suspicion against Mr Kellie, I do not regard the evidence as going further.

6.1009. Counsel Assisting submitted that a finding by the Inquiry in the following terms is open:[5981]

> *Anthony Cawsey died on 26 September 2009 at Centennial Park, Sydney, New South Wales. The cause of his death was Haemopericardium as a result of a stab wound to his left chest. The person who inflicted the stab wound is unknown.*

6.1010. The NSWPF supported a finding in these terms being made.

6.1011. I accept that a finding in those terms is appropriate and should be made.

Bias

6.1012. Counsel Assisting submitted that it was "difficult to ignore" the confluence of features of Mr Cawsey's death that make it likely that LGBTIQ bias played a role in his death. This includes:[5982]

a. His purpose for attending Centennial Park, namely, to engage in a sexual act with another man, as evidenced by the message left on the Mediatel service;

b. The fact that parts of Centennial Park are known beats;

c. The evidence that he engaged in mutual masturbation over the phone not long prior to his death; and

d. The positioning of his clothing when his body was located.

6.1013. Counsel Assisting submitted that while the circumstances of Mr Cawsey's death remain unknown, it can be inferred that Mr Cawsey was engaged in the planned sexual activity in the period preceding his death, and would have been seen to be doing so by any offender. Counsel Assisting submitted that this gives rise to a distinct possibility that Mr Cawsey was the target of an attack on the basis of the expression of his sexuality.

6.1014. Despite this realistic possibility, Counsel Assisting submitted that while the identity of Mr Cawsey's killer remains unknown, there is no sufficient basis for a definitive conclusion as to whether or not his murder involved LGBTIQ bias.

6.1015. The NSWPF agreed with these submissions. I accept Counsel Assisting's analysis.

6.1016. Counsel Assisting considered the question of bias on the hypothesis that Mr Kellie killed Mr Cawsey following an encounter in which Mr Cawsey was perceived to have propositioned him for sex.

6.1017. As Counsel Assisting submitted, this excessive hostility is open to being interpreted as anger motivated by prejudice against LGBTIQ people. However, interpretation of Mr Kellie's version of events is significantly complicated by his psychotic illness and traumatic experiences, and there is insufficient information to reliably determine the motivation for his behaviour.

[5981] Submissions of Counsel Assisting the Inquiry, 26 June 2023, [292] (SCOI.84134).

[5982] Submissions of Counsel Assisting the Inquiry, 26 June 2023, [288] (SCOI.84134).

6.1018. I further accept that, even if it was assumed that Mr Kellie killed Mr Cawsey after an encounter consistent with that contained in his interview with police on 17 January 2010, there would remain real doubt about whether the death was the result of LGBTIQ bias.

6.1019. However, the fact that I am unable to reach a conclusion about whether a death was motivated by LGBTIQ bias does not mean that there is no reason to suspect that LGBTIQ bias was a factor in a death.

Conclusions and Recommendations

6.1020. I find that Anthony Cawsey died on 26 September 2009 at Centennial Park, Sydney, NSW of haemopericardium as a result of a stab wound to his left chest. The person who inflicted the stab wound is unknown.

6.1021. In my view, on the evidence available to the Inquiry, there is objectively reason to suspect that LGBTIQ bias was a factor in Mr Cawsey's death.

6.1022. Consistent with the submissions of Counsel Assisting, and supported by the NSWPF, I make the following recommendations.

Recommendation 7

I recommend that FASS take steps to:

a. Further enhance the profiles of "Unknown Male A", "Unknown Male B" and "Unknown Male C", should technological developments occur in the future that indicate a prospect of such enhancement; and

b. Run the unidentified profiles against state and national DNA databases on a regular basis, so that the NSWPF will be notified in the event that there is an individual or familial match with any profile.