



NSW POLICE FORCE

P190B

STATEMENT OF POLICE

In the matter of: Special Commission of Inquiry into LGBTIQ Hate Crimes
Place: Sydney, New South Wales, Australia
Date: 20 September 2023

Name: Alicia TAYLOR Tel. No: [REDACTED]
Rank: Detective Sergeant
Station/Unit: Child Abuse Squad, State Crime Command

STATES:

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give in court as a witness. The statement is true to the best of my knowledge and belief, and I make it knowing that, if it is tendered in evidence, I will be liable to prosecution if I have wilfully stated in it anything which I know to be false, or do not believe to be true.
2. I am 49 years of age.
3. In this statement, where I refer to documents I also include their document ID number for identification purposes, in the form **SCOI.XXXXXX_XXXX** and **NPL.XXXX.XXXX.XXXX**.
4. I make this statement in respect of letters I received from the Special Commission of Inquiry into LGBTIQ hate crimes (**Inquiry**) dated 22 August 2023 (**22 August Letter**) and 11 September 2023 (**11 September Letter**). The 11 September Letter enclosed a summons to attend the Inquiry on 25 September 2023.
5. The 22 August Letter noted that the second public hearing of the Inquiry (**Public Hearing 2**) is examining the ways in which the New South Wales Police Force (**NSWPF**) has approached issues relating to "bias crime" and "hate crime" from 1970 to present, including the investigations conducted by Strike Forces Parrabell, Macnamir and

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Ian McCarthy
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Neiwand. The 22 August Letter further noted that sections of the submissions of Counsel Assisting the Inquiry concern my involvement in the matters currently being examined by the Inquiry in Public Hearing 2.

6. The 22 August Letter identified sections of the submissions of Counsel Assisting the Inquiry (**CA submissions**) and the Commissioner of NSW Police (**CoP submissions**) that had been identified as relevant to me and invited me to provide this statement to the Inquiry.
7. Unless otherwise stated, I make this statement based on:
- (a) my review of relevant records held by the NSWPF;
 - (b) information known to me;
 - (c) information provided to me at my request by appropriate members of the NSWPF;
and
 - (d) my experience as a detective.

Structure of this statement

8. The structure of my statement is as follows:
- (a) **Section A:** provides background on my role and policing experience;
 - (b) **Section B:** sets out my qualifications and training;
 - (c) **Section C:** describes my experience and involvement with the Unsolved Homicide Review Team;
 - (d) **Section D:** comments on my review of the deaths of Ross Warren, John Russell and Gilles Mattaini post Operation Taradale; and
 - (e) **Section E:** discusses my review of the death of Scott Johnson and my subsequent involvement in Strike Force Macnamir.

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SECTION A: MY ROLE AND POLICING EXPERIENCE

9. I am currently a Detective Sergeant in the Child Abuse Squad, State Crime Command. I have held this position since 15 March 2020. The Child Abuse Squad investigates matters of serious child abuse including sexual offences, physical assaults and matters of severe neglect involving children. As part of this role, I supervise staff, manage investigations and work with partner agencies including NSW Health and the Department of Communities and Justice to facilitate a police response to reports of immediate risk of harm to children.
10. Prior to this, I was a Sergeant in the PoliceLink Child Wellbeing Unit from 2 June 2013 to 14 March 2020. I was also previously a Detective Senior Constable in the Homicide Squad from 21 October 2007 to 1 June 2013. While in the Homicide Squad, I worked in the Investigative teams, the Coronial Investigation Team and the Unsolved Homicide Review Team (UHRT) between 2010 and 1 June 2013, during which I held both full time and part time roles at different times. My duties and responsibilities during my time in the UHRT included reviewing unsolved homicide cases that had been allocated to me by a Detective Sergeant and completing a "Review of an Unsolved Homicide Case Screening Form". In early 2013, I was tasked as an investigator attached to Strike Force Macnamir (SF Macnamir) until 1 June 2013 when I transferred out of the Homicide Squad.
11. I have been a sworn officer of the NSWPF since attesting from the Police Academy on 14 February 1997.
12. As I set out later in this statement, I became involved in SF Macnamir shortly after I conducted a review into the death of Scott Johnson.
13. In 2012, I completed a review into the deaths of Ross Warren, John Russell and Gilles Mattaini, who were the subject of Operation Taradale. I spent approximately six to 12 months on that review. During the entirety of my time in the UHRT, including while I was working on my review into these three deaths, I was employed on a part time basis and

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was working two days per week. I did not have any involvement in Operation Taradale itself.

14. I had no involvement in Strike Forces Parrabell or Neiwand.

SECTION B: QUALIFICATIONS AND TRAINING

15. I hold a Bachelors of Policing Investigations and Postgraduate Certificate in Business Management.

SECTION C: UNSOLVED HOMICIDE REVIEW TEAM: MY EXPERIENCE AND INVOLVEMENT

General functions of the UHRT

16. I was in the UHRT from the second half of 2010 to 2013, during which time I and other investigators in the team undertook in-depth reviews of unsolved suspected homicide cases. These reviews were also referred to as 'case screening'. The purpose of these reviews was to determine if there was any further opportunity or basis for reinvestigating a given case. The reviews were not investigations in and of themselves.
17. The UHRT was referred cases from other units or areas within the NSWPF that were historically unsolved or had been referred to the Unsolved Homicide Team as a result of a recommendation from the Coroner's Court. Once a case was referred to the Unsolved Homicide Team, depending on factors of urgency and case priority, the case would ultimately be allocated to an investigator in the UHRT for them to conduct the case screening process. Assessments of case priority and decisions of case allocation were made by Detective Sergeants and other senior officers in the Unsolved Homicide Team; I did not have any role in those assessments and decisions.
18. During my time in the UHRT, my role almost exclusively entailed undertaking case reviews. On two occasions I performed other investigative duties, one of which was during the time I was allocated to SF Macnamir in 2013 when I performed duties as tasked by the officer in charge.

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The UHRT review processes

19. The cases I reviewed when I was in the UHRT were delegated to me by my supervisors which, for the majority of my time in the UHRT, were Detective Sergeant Penelope Brown (**DS Brown**) and Detective Sergeant Connie Tse (**DS Tse**). The cases I reviewed over time would generally have had no new leads or fresh evidence for an extended period of time.
20. My experience during that time was that, at any given time, an investigator would usually be assigned to somewhere between one and five unsolved cases requiring review. There was an element of balance required due to the competing demands on your time, whereby you were required to thoroughly review each individual case you were responsible for at the same time as progressing all reviews you had been allocated.
21. In my experience, the case review process was a process that allowed the relevant investigator to make inquiries in locating records, or information available to consider and formulate recommendations. Investigators were able to discuss and seek guidance from supervisors and 'bounce' ideas off colleagues, but it was ultimately the investigator's responsibility to undertake tasks forming part of the review.
22. A review usually involved accessing and sighting relevant resources and materials (including COPS, holdings, archives and electronic records of exhibits) that the reviewer could identify and locate pertaining to the particular case, and forming an opinion on whether there were new potential lines of inquiry to be considered and pursued, or any other basis for further reinvestigation of the case.
23. The case review process was, in the first instance, guided by the steps that needed to be taken to address all matters required to complete the case screening form. The case screening form set out a number of steps that a reviewer would need to take, and categories of records and materials or databases that a reviewer would need to conduct searches of or for. The form prompted reviewers to insert details that reflected the steps taken and records or materials located. Where records or materials could not be located, this too would need to be recorded in the form. While the case screening form was a

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starting point for case reviews, in my opinion (which informed my practice when conducting reviews), it was important that a reviewer also used their own experience and critical thinking to determine the other steps that should be taken as part of a particular review. In my experience, this included considering and reviewing historical and current media reports as well as Crime Stoppers reports. When completing case reviews, and determining the appropriate steps to take, I drew from my experience as an investigator (including in previous reviews I had undertaken) as well as learnings from other investigators in the review team.

24. The general approach I took when making recommendations at the conclusion of a review was to keep an open mind when considering whether potential avenues for reinvestigation existed, which included considering factors such as advancements in DNA technology capabilities, use of covert strategies, registered sources, and the potential use of rewards for information that could be used in conjunction with other strategies to generate information. In my view, keeping an open mind meant that all available options for reinvestigation needed to be identified and assessed. It was important to consider investigative opportunities that had not been taken in previous investigations, but also steps that were taken and could be repeated with some benefit, for instance where advancements in technology or testing capabilities were relevant. The resourcing considerations associated with a reinvestigation were then left to the senior members of the Unsolved Homicide Team; in my experience, these decisions were never made by the investigator conducting the review.
25. The length of a review or case screening varied depending on the nature of the case, and the materials and information available with respect to a case.

SECTION D: POST OPERATION TARADALE: REVIEW OF THE DEATHS OF WARREN, RUSSELL AND MATTAINI

26. I conducted a review of the deaths of Ross Warren, John Russell and Gilles Mattaini, being the three individuals the subject of Operation Taradale. I cannot recall exactly when I was allocated this review, although from reading the CA submissions and CoP submissions I can see I completed the review around 26 November 2012.

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27. As part of the review, in accordance with the process I describe in paragraphs 19 to 25 above, I looked through police holdings that were listed in the case screening form as well as COPS events to establish what the NSWPF held with respect to these three cases. From memory, I looked at records, post-mortem reports, and information from old inquests and investigations. In the case of the post-mortem reports, I wrote down my observations. I also recall briefly speaking to Detective Sergeant Page (**DS Page**) to make inquiries about any further material that may be available or information he could provide to assist the review process. I do not recall the details of that conversation. DS Page had by that time left the NSWPF and, from memory, was working for Big W in loss prevention.
28. I also went through and itemised each exhibit and what was found in the original forensic reviews. That led me to making direct contact with the relevant crime scene officer. It became clear to me at that time that there were a number of exhibits missing. I made attempts to find the missing exhibits, but I was unable to.
29. Once I completed the process outlined above, I made recommendations as the final step of my review. I do not now have an independent recollection of what recommendations I made. At the completion of my review, I provided my documentation to my supervisor/s. This included the case screening form I prepared dated 25 October 2012. A copy of that case screening form is at **NPL.0113.0001.0001**.
30. I did not have any oversight of the process that followed after my review concluded. I cannot confirm what decisions, if any, were made during the assessment process that follows a review.

SECTION E: STRIKE FORCE MACNAMIR: REVIEW OF THE DEATH OF SCOTT JOHNSON

31. I conducted a review of the death of Scott Johnson in around 2012. Prior to commencing my review, I had no substantial knowledge of the case or the previous investigations that had been undertaken. By the time I did begin my review, I recall Scott Johnson's death had already been the subject of coronial proceedings.

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32. During the review itself, I searched for and looked through briefs and holdings the NSWPF had. I sought access to all available material including general station pads, occurrence pad entries, charge books and intelligence report records from Manly Local Area Command for the period 1 December 1987 and 1 December 1989. I also recall going to the archiving facility in Kingswood with DS Brown and DS Tse during the review. This included reviewing the archived hard copy charge books from Manly Local Area Command on 20 September 2012 to understand how many events, incidents or suspected crimes occurred around the place in Manly where Scott Johnson's body was found. It was not common practice for reviewers (or their supervisors) to physically search old archive records. I remember we undertook this particular exercise because at that time questions arose regarding whether that specific place was a gay beat at around the time of Scott Johnson's death. I recall we were attempting to establish, based on the evidence available, whether there was a possibility that Scott Johnson's death was a result of a gay hate crime. We went beyond the usual review process requirements as we wanted to closely review and identify persons who fit a particular description, had a similar modus operandi or were in (or likely to have been in) the location where Scott Johnson was located in the hope of identifying potential perpetrators. We did not find that the events, incidents or suspected crimes that we were aware took place in or near North Head, Manly clearly suggested there was a pattern of anti-gay violence in that location from the charge records. This may have been because reporting levels were lower back then. The fact that we did not find a pattern of such events did not cause me to discount the possibility that Scott Johnson's death could have been the result of a violent attack.
33. I recall sighting documentary records, which included records pertaining to exhibits, I was able to locate that the NSWPF had in its possession and forming an opinion on whether further opportunities for investigation had arisen. I did not undertake physical inspections of exhibits, as this did not form part of the case review process. I recall viewing photographs of the physical exhibits in this particular case; however, I did not access or interfere with the physical exhibits themselves, in line with the usual case

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review process. I do not recall preparing any documentation aside from the case screening form.

34. During the course of my review, Detective Chief Inspector John Lehmann (as he then was) was who I reported to, and Mr Willing was the commander of the unit. I cannot speak to Mr Willing's involvement in the case of Scott Johnson because we never had any discussions about the case.
35. As with all other UHRT reviews I completed, I made recommendations at the conclusion of my review into the Scott Johnson case. I do not have an independent recollection of what those recommendations were, but for the purpose of determining prospects of future reinvestigation, I believe I would have considered factors such as the passage of time, potential new information that came to light since his death, considering new opportunities to conduct forensic examinations for any exhibits that were identified, and whether strategies around rewards for information had been or could contemporaneously be offered to promote information to open further lines of inquiry. I recall that once I had completed my review of the Scott Johnson case, I handed my completed form in hard copy to a supervisor. I do not recall receiving a case screening form back for review or amendment, or signing a finalised version of the case screening form.
36. I did not make any determinations on the solvability of the case. That was not the task of a reviewer. I was only tasked with making recommendations I saw as potential for opportunities for reinvestigation as part of my review. Those recommendations did not involve making assessments or comments on solvability. To the best of my recollection, the review process I undertook did not include consideration or selection of solvability ratings. I do not know who determined the zero solvability rating in the review of the Scott Johnson case. I do not know what factors are taken into account when determining a solvability rating. I am not aware of "solvability" being terminology that was used at the time I conducted this review, or during my time in the UHRT more generally.
37. After I completed my review, I became involved in SF Macnamir. My involvement in SF Macnamir ceased when I transferred out of the UHRT in June 2013.

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38. While I was involved in SF Macnamir, Detective Chief Inspector Pamela Young (as she then was) was the supervisor and DS Brown had carriage of that investigation. I assisted with completing ad hoc tasks, administrative tasks such as uploading products on e@gle.i, preparing witness statements and assisting DS Brown with conducting interviews with anyone identified as having potential relevance to the SF Macnamir investigation, as determined by the officer in charge.
39. During my time working on SF Macnamir, there was no agenda that a specific finding be made in the Scott Johnson case, nor an investigation objective to minimise the incidence of gay hate crime. To the best of my recollection, based on my observations at the time, the investigators I worked with on the Scott Johnson case kept an open mind as to the possible causes of Scott Johnson's death. I did not get the impression that the investigators I worked alongside had decided on or preferred a particular cause of death in this case.

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