



Special Commission of Inquiry into LGBTIQ hate crimes

SUBMISSIONS OF COUNSEL ASSISTING

6 February 2023

IN THE MATTER OF ANDREW RONALD CURRIE

Introduction

1. These submissions are filed on behalf of Counsel Assisting the Special Commission of Inquiry into LGBTIQ hate crimes (**Inquiry**).

Summary of matter

Date and location of death

2. 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

3. Mr Currie was 29 years old and unfortunately had a longstanding addiction to prescription medications and other substances. 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 a friend on the evening of 12 December 1988. At around 7:15am the next morning his body was found lying face down inside the toilet block. This submission concludes that Mr Currie's death resulted from multi-drug toxicity which caused respiratory and central nervous system depression, leading to his death.

Findings of post-mortem examination

4. An autopsy was conducted on 17 December 1988 by Dr William Brighton. In his opinion¹ the direct cause of death was:

Poisoning by a combination of Pentobarbitone, Codeine, Methadone and Morphine.

¹ Post-mortem report of Dr William Brighton dated 13 February 1989 (SCOI.00016.00011).

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5. Dr Brighton noted that there was “*no significant injury on the body*”. 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. There were no internal injuries. Mr Currie’s body was noted to be in an unkempt state with much soiling to his feet. There was dark brown to dark green material around his nostrils that appeared to have been regurgitated.

Persons of interest

6. There are no individuals that the Inquiry regards as persons of interest. Mr Currie’s friend (**GB**) saw Mr Currie on the night of his death. Along with Mr Currie’s mother, he was also involved in finding Mr Currie’s body the following morning. There is no cogent evidence suggesting that this friend, or any other person, had any involvement in Mr Currie’s death.

Indicators of LGBTIQ status or bias

7. Mr Currie’s closest surviving relative, his brother, has no particular knowledge of Mr Currie’s sexuality and believed him to be heterosexual. 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. 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.
8. The particular area in question is not a location where, to the Inquiry’s knowledge, there are recorded instances of such attacks. However, as noted in the Strike Force Parrabell Bias Crimes Indicators Review Form (**BCIF**), records for the period prior to 1992 do not allow ready identification of criminal acts via the COPS system.² The possibility of such attacks cannot therefore be ruled out.
9. It was also a location at which Mr Currie and his friend and fellow drug user at the time, GB, would meet on occasion. This information appears in a police occurrence entry made at the time of the death.³ In the statement made by the officer in charge (**OIC**)⁴ he refers to the toilet areas around “District Park”⁵ being a regular meeting place for Mr Currie and GB to meet and use drugs.

² Strike Force Parrabell Bias Crimes Indicators Review Form – Andrew Currie (undated), p. 7 (SCOI.38973).

³ P109 Report of Occurrence dated 13 December 1988 (SCOI.00016.00020).

⁴ Statement of Constable Phillip Dean Greenhalgh dated 13 December 1988, at [5] (SCOI.00016.00007).

⁵ It is noted that District Park is the name given to the overall complex of sporting grounds in the relevant areas of the suburbs of North Manly and Manly Vale, of which Nolan Reserve, in North Manly, is one.

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10. The park and toilet block were on the walking route home from Mr Currie's last known location and the evidence generally is consistent with Mr Currie's death having resulted from an accidental drug overdose rather than having involved an act of violence.

Exhibits: availability and testing

11. A number of items were found in Mr Currie's possession at the time of his death and are noted later in the submission. They were returned to Mr Currie's mother at the time of his death. The records of the matter, including those held by the Department of Forensic Medicine do not suggest that there are any exhibits that are available for testing. The original forensic pathologist effectively concluded that the death occurred as a result of drug overdose. The findings of a forensic pathologist who has recently reviewed the matter are consistent with this and she is of the view that there are no further investigative steps that would be fruitful.

Findings at inquest, including as to manner and cause of death

12. No coronial inquest was held. The coronial records indicate that an inquest was dispensed with immediately following receipt by the Coroner of the autopsy and toxicology reports in February 1989. While the reason for dispensing with an inquest is not recorded on the file, the decision to dispense with an inquest indicates that it did not appear to the Coroner that Mr Currie had *died or may have died as a result of homicide*.⁶

Features of /concerns with original police investigation

13. Although it is not suggested that the nature of the police and forensic investigation was such that it has given rise to an incorrect conclusion having been reached in relation to the cause or manner of Mr Currie's death, the following features of the investigation are noted:
- The conclusion that Mr Currie's death was the result of an accidental drug overdose was reached very swiftly;
 - No statements were taken from family members;
 - There is no evidence that alternative possible causes of death were entertained, nor that the possibility that the area where the body was found may have been used at times as a beat was something that police considered; and

⁶ 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.

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- There is no record of the actions taken by detectives and scientific officers who attended the scene, beyond the existence of photographs that were taken.
14. It is unfortunate that there is no distinct original police investigation file that has been located and produced.
 15. While it is not submitted that these matters give rise to a concern that an incorrect conclusion was reached by police in relation to the cause and manner of death, a more detailed initial investigation and the retention of relevant records would potentially assist in allaying any concerns that family members may hold in relation to the investigation of the matter and conclusions reached in relation to the cause and manner of the death.

Strike Force Parrabell

Use of the Bias Crimes Indicators Review Form (BCIF)⁷

16. Consistent with the nature of Strike Force Parrabell's consideration of matters generally, relevant assessments were made in the absence of contact with Mr Currie's family and any particular information concerning his sexuality.
17. The "General Comment" section at page 6 of the form refers to 15 colour photographs of Mr Currie and "the scene" having been viewed. This may be cause for concern about the accuracy of matters recorded in the form as there appear to be only seven such photos in existence.
18. In section 4 of the form, "Organised Hate Groups (OHG)", it is stated that there are no indications that an OHG was involved or active in the Manly area at the time of Currie's death. This Inquiry is aware, however, of evidence that on occasions, gay men 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.
19. Although known to NSW Police at the time of Strike Force Parrabell, this is not the subject of comment in the BCIF. It appears that such attacks did not come within what was contemplated by police as constituting an OHG. If they did not, it may suggest a deficiency in the methodology behind the BCIF.

⁷ Strike Force Parrabell Bias Crimes Indicators Review Form – Andrew Currie (n 2), p. 7.

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Results of Strike Force Parrabell

(a) The “General Comment” and “Summary of Findings” boxes at the end of the BCIF

20. The “General Comments” sections of the BCIF consistently convey the view that the circumstances surrounding the death were not considered suspicious and that the evidence suggests that Mr Currie died of accidental drug overdose.
21. The “Summary of Findings” highlights the following matters:
- Mr Currie’s persistent drug use activities, often undertaken with his friend;
 - that there is no information in relation to Mr Currie’s sexuality;
 - that there was no information to suggest that the location was a known beat, however that toilet blocks often were; and
 - that it was unlikely that Mr Currie was at the location in order to engage in homosexual activity.
22. The summary concludes 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.

(b) Case Summaries

23. The Strike Force Parrabell case summary (no. 37) for this matter reads as follows:⁸

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, ‘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.

⁸ Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Andrew Currie, p. 18 (SCOI.76961.00014).

⁹ See generally (n 5) in relation to District Park.

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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

24. The content of the case summary is in keeping with the comments made in the BCIF for Mr Currie's death.

(c) Academic review

25. The notation in relation to the "Academic Review" in the case summary states "No Bias".

Investigative and other steps undertaken by the Inquiry

26. The Inquiry's consideration of the matter has involved:
- a) compelling the production of police investigative material, in relation to the death;
 - b) compelling the production of the file held by the Department of Forensic Medicine in relation to the matter;
 - c) obtaining the Coroners Court file in relation to the matter;
 - d) considering other material held by the Inquiry of potential relevance to the matter, for example information relating to the Northern Beaches during the relevant period;
 - e) reviewing and analysing this material, and considering whether any further investigative or other avenues are warranted;
 - f) making contact with Mr Currie's family in relation to any relevant information they may have; and
 - g) obtaining expert reports from a toxicologist and a forensic pathologist.

Attempts to locate and contact family members

27. The Inquiry was able to locate Mr Currie's only sibling, his younger brother, who was living at the family home with his mother and brother at the time Mr Currie's death. Sadly Mr Currie's mother passed away some years ago. His brother has been very helpful to the Inquiry, by meeting with staff of the Commission and discussing his knowledge of his brother's circumstances around the time of his death.

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Summonses issued to NSWPF and follow up action taken

28. The matter was one of those the subject of the Inquiry's first summons to NSW Police Force (**NSWPF**) dated 22 May 2022, for all police investigative material relating to it (NSWPF1).
29. No police investigative file for Mr Currie's death was produced to the Inquiry in response to this summons.
30. However, on 12 August 2022, the NSWPF produced to the Inquiry its Strike Force Parrabell E@glei 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), as part of its response to summons NSWPF12.
31. A further summons (NSWPF20)¹⁰ was issued on 26 September 2022, seeking 15 colour scene photos purportedly taken on the day Mr Currie's body was found. This came about because the Strike Force Parrabell BCIF and an Investigator's Note¹¹ that had been produced to the Inquiry both made reference to "15 colour crime scene photographs of Mr Currie's body which were viewed by SF Parrabell investigators." These were said to have been provided to Strike Force Parrabell investigators by the original OIC of the matter.¹² It was a surprise to the Inquiry to hear that there were 15 crime scene photos, as only seven such photos had been produced to it.
32. 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.¹³
33. In order to understand why there had been no production of material in relation to Mr Currie's death in response to summons NSWPF1, yet there had been material later produced in connection with the NSWPF E@glei brief and a subsequent summons, and to seek further clarification concerning the number of crime scene photos, on 10 October 2022 the Inquiry wrote to the legal representative of the NSWPF, asking for a letter or statement addressing the following four matters:¹⁴

1. *Please outline what searches were performed to locate any documents relating to investigations by NSWPF of Mr Currie's death and the results of those searches.*

¹⁰ Summons to Produce to NSW Police Force (NSWPF20) dated 26 September 2022 (SCOI.82191).

¹¹ Investigator's Note of Constable Borg dated 13 October 2016, p. 6 (SCOI.82194).

¹² Letter from Solicitor Assisting the Inquiry to Office of the General Counsel, NSW Police Force, re Summons to produce documents dated 26 September 2022 (SCOI.82187).

¹³ Email from the Office of the General Counsel, NSW Police Force, to Solicitor Assisting the Inquiry re Summonses to produce dated 6 October 2022 (SCOI.82192).

¹⁴ Letter from Solicitor Assisting the Inquiry to Office of the General Counsel, NSW Police Force, re Request for further information dated 10 October 2022 (SCOI.82186).

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2. *Please outline the reason or reasons why no hard copy and/or original investigative files regarding Mr Currie's death were produced by NSWPF.*
3. *Are the documents produced as part of the Strike Force Parrabell E@glei brief the totality of NSWPF's holdings regarding Mr Currie's death?*
4. *Please explain the basis for the conclusion that only seven photographs were provided to Strike Force Parrabell investigators, despite the reference to 15 photographs in the Review Form and Investigator's Note.*

34. In response, on 24 October 2022, the Inquiry received an email from the NSWPF legal representative which advised as follows in relation to these four matters:¹⁵

1. Please outline what searches were performed to locate any documents relating to investigations by NSWPF of Mr Currie's death and the results of those searches:

In order to identify any material relating to the death of Mr Currie, the following searches have been undertaken:

- *A request to Corporate Records and State Archives to search for any records associated with the name "Andrew Currie";*
- *Searches of all NSWPF electronic databases for any material associated with the name "Andrew Currie". Those databases include E@glei, COPS, pre-COPS data, and using KODA (being the "overarching" NSWPF search engine). The only material identified was that contained under the Strike Force Parrabell E@glei file, which has been provided to the Inquiry;*
- *A request was recently made the Northern Beaches Police Area Command (being the Police Area Command that included North Manly, being the location where Mr Currie's body was found) for a search to be undertaken for any hard copy material held "locally" in relation to the death of Mr Currie. That search has been completed and did not identify any material in relation to the matter.*

2. Please outline the reason or reasons why no hard copy and/or original investigative files regarding Mr Currie's death were produced by NSWPF.

As noted above, it appears that Mr Currie's death was not originally treated as a homicide by NSWPF. Therefore, it is not unexpected that there appears to have been limited investigative material created or which can be identified.

The searches for any hard copy material associated with the death of Mr Currie have not identified any such material. The whereabouts of the hard copies of the electronic versions of the documents supplied in electronic form (as contained in the Strike Force Parrabell E@glei file) are not currently known. I am instructed that, as a matter of course, Strike Force Parrabell returned any hard copy documents obtained to the location from which they were obtained, including external sources. For example, any hard copy documents obtained from the Coroner's Court were returned to the Coroner's Court and any material retrieved from State Archives by Strike Force Parrabell was returned to State Archives at the conclusion of Strike Force Parrabell.

¹⁵ Email correspondence between Office of the General Counsel, NSW Police Force, and Solicitor Assisting the Inquiry re Summonses to Produce dated 24 October 2022-19 December 2022 (SCOI.82312).

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3. Are the documents produced as part of the Strike Force Parrabell E@glei brief the totality of NSWPF's holdings regarding Mr Currie's death?

The documents produced to date in relation to Mr Currie's death, which are those that are contained as part of the SF Parrabell E@glei brief, are the totality of NSWPF holdings that can be identified in relation to that death.

4. Please explain the basis for the conclusion that only seven photographs were provided to Strike Force Parrabell investigators, despite the reference to 15 photographs in the Review Form and Investigator's Note.

Contained in the Strike Force Parrabell E@glei brief are 7 colour photographs. The investigator's note associated with those photographs in the E@glei brief refers to 7 crime scene photographs only. The Investigator's note prepared by Christopher Borg as part of Strike Force Parrabell refers to 15 photographs being awaited from the original OIC, Constable Greenhalgh, however it is apparent that those photographs had not yet been received at the time that note was drafted. We indicated in our email of 6 October that it is apparent that only 7 photographs had in fact been received by the Strike Force Parrabell investigators, because only 7 are located in the E@glei brief and it would be expected that all photographs supplied would be uploaded to E@glei.

[REDACTED] In relation to our enquiry, Christopher Borg has informed us, [REDACTED], that he is unable to recall the specific details of the matter, however he would expect that he would have uploaded on to E@glei all photographs received in relation to the matter.

On that basis it is apparent that only 7 photographs were in fact received by Strike force Parrabell investigators.

We have also made contact with Sergeant Phillip Greenhalgh, who was the original OIC of the Andrew Currie matter. Sergeant Greenhalgh is currently on extended leave. He has, however, informed me that he will review his records to determine whether he can offer any assistance, and will get back to me as soon as possible. I had anticipated completing that enquiry today. We are actively following up in that regard and I anticipate being in a position to advise tomorrow.

35. On 16 December 2022, having not received the anticipated advice concerning Sergeant Greenhalgh's review of his records, the Inquiry sent an email enquiry to the NSWPF legal representative. On 19 December 2022 a response was received in the following terms:

I am informed that Sergeant Greenhalgh instructed our office in late October that he had undertaken a search of his records, however was unable to locate any record that indicated how many photographs he had in his possession or provided to SF Parrabell investigators. At that time, Sergeant Greenhalgh was intending to have his station conduct a search in an attempt to identify how many photographs were on file and he provided to SF Parrabell investigators. Sergeant Greenhalgh has today informed our office that that search has now occurred, and that his station has contacted him to indicate that no record to that effect was located.

Sergeant Greenhalgh has instructed us that he would have provided all photographs in his possession relevant to the matter to SF Parrabell investigators.

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36. These matters have been set out in some detail in order to demonstrate that the Inquiry has endeavoured to ensure that all information relating to the past investigation of the matter has been produced to it.
37. The end result is that the investigative material in existence appears to be largely confined to that which was in the coronial brief of evidence provided by police to the Coroners Court back in 1989. Further, the reason for references having been made to 15 scene photos, rather than the seven which have been produced, remains unclear. The legal representative for the NSWPF states that only seven such photos were received by Strike Force Parrabell, which would appear to suggest that the reason for reference to 15 photos in the Strike Force Parrabell BCIF and Investigator's Note is simply that these documents are both erroneous.
38. One might expect that there would have been additional notes and potentially other investigative material produced during the initial police investigation. For example, Detectives from Manly Police Station attended the scene, as did police scientific officers in order to take photos,¹⁶ yet no statements or notes from any of these officers have been produced. As noted above, unfortunately, the advice received from the NSWPF is that it is not known where the original hard copy of the police investigative file is.

Further searches for exhibits

39. By way of summons (DOFM1) and letter dated 22 August 2022 contact was also made with the Department of Forensic Medicine of NSW Health Pathology (DOFM)¹⁷ in order to ascertain whether they held, separately to police, any photos or other records relating to the autopsy performed on Mr Currie. This was done in order to provide potential assistance to the expert forensic pathologist who was briefed by the Inquiry to provide an opinion (see below).
40. In response, the Inquiry received 23 pages of notes from DOFM. These consisted of the autopsy and toxicology reports and other documentation related to the autopsy, but did not shed any further light on the death beyond the contents of the autopsy and toxicology reports. Nor did they include any photos.

¹⁶ Statement of Constable Phillip Dean Greenhalgh (n 4), at [3].

¹⁷ Letter from Solicitor Assisting the Inquiry to NSW Health Pathology – Forensic Medicine re Request for records dated 22 August 2022 (SCOI.82201).

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Professional opinions obtained

41. The Inquiry sought and obtained a report from Dr Linda Iles, forensic pathologist and Head of Forensic Pathology Services at the Victorian Institute of Forensic Medicine, in which she addressed the following questions that were posed to her:

1. *The adequacy of the post-mortem investigations conducted with respect to Mr Currie. Without limiting the matters which you may consider relevant to this question, please outline:*
 - a. *Your opinion, if you are able to give one, as to whether Mr Currie's teeth were 'dislodged', as noted by the officer in charge?*
 - b. *What if any significance you consider there may be to the any disparity between the observation of the officer in charge and the post-mortem report regarding the state of Mr Currie's teeth?*
2. *Your view as to the medical cause of Mr Currie's death (including any reasons for taking a different view to that formed by Dr Brighton and/or Professor Jones). Without limiting the matters which you may consider relevant to this question, please outline:*
 - a. *Whether you consider that the water on floor is likely to have played any role in the mechanism of death?*
3. *Your view as to whether Mr Currie's injuries and bodily condition were consistent with misadventure, suicide, or foul play.*
4. *Any recommendations for further investigations with respect to determining the manner and cause of Mr Currie's death.*
5. *Please provide any other comment, within the area of your expertise, regarding the likely cause of Mr Currie's death.*

42. Dr Iles's opinions are the subject of discussion later in the submission.

43. The Inquiry also sought and obtained a report from Professor Alison Jones, toxicologist and Acting Chief Medical Officer of the Department of Health, Western Australia, in which she addressed the following matters:

1. *Was the level of Pentobarbitone, Codeine, Methadone, Morphine and/or Paracetamol detected in Mr Currie's blood and organs likely to have been lethal, either alone or in combination with each other?*
2. *Which, if any, of the substances found in Mr Currie's toxicology results can be accounted for by the ingestion of Nembudeine prior to his death?*
3. *Which, if any, of the substances found in Mr Currie's toxicology results suggest separate ingestion of substances? Are you able to provide an opinion on the time period and/or manner of ingestion of these substances?*
4. *What is the significance, if any, of the chloride ion detected in Mr Currie's blood results?*

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5. *Please provide any other comment, within the area of your expertise, regarding the likely cause of Mr Currie's death.*

44. Professor Jones's opinions are also the subject of discussion later in the submission.

Steps which could / should have been taken, but which were not

45. Consistent with what has already been said, it would have been beneficial for statements to have been taken from attending detectives and scientific officers, and for such statements to have been retained.

46. Further, as discussed later in the submission, it would have been of assistance for there to have been clearer documentation relating to the OIC's statement that some of Mr Currie's teeth appeared to have been dislodged, and for this observation to have been brought to the attention of the forensic pathologist so that it could have been the subject of recorded examination or comment in the autopsy report.

47. Better procedures for the retention of the police investigative file and a greater degree of demonstrated engagement with the family at the time of death would also have been beneficial.

Results of investigative and other steps undertaken by the Inquiry

48. This part of the submission sets out key matters arising from the Inquiry's consideration of the evidence and the conclusions that it is suggested can be drawn from the evidence.

Andrew Currie's background

49. Mr Currie was 29 years old when he died, and lived at home with his mother and older brother at [REDACTED] Waine Street in Harbord (now known as the suburb of Freshwater).

50. Unfortunately he appears to have had a longstanding and entrenched drug use problem, as a result of which he was known to Manly police. A fact sheet related to some minor offending with which Mr Currie was charged on 14 October 1988, two months prior to his death, describes his interaction, while drug affected, with police after being found in possession with a bottle of a prescribed restricted drug. In part the fact sheet reads as follows:¹⁸

"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 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.

¹⁸ Fact Sheet dated 14 October 1988 (SCOI.00016.00022).

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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."

51. The statement of the OIC of the investigation into Mr Currie's death similarly describes Mr Currie as "a well known drug user" who had "come under police attention numerous times". He also states that Mr Currie had been taken to hospital on several occasions for overdosing.¹⁹

Civilian witness evidence

52. The civilian witness evidence consists of two brief statements made on 13 December 1988 by Mr Currie's friend (GB), immediately following the death. One statement deals with GB's interactions with Mr Currie on the evening preceding his death, and the other describes his involvement in finding Mr Currie's body the following morning.
53. GB describes Mr Currie as a good friend who he had known for 13 years. He says that during that time 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 refers 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".²⁰
54. Consistent with this, the police fact sheet²¹ already referred to indicates that Mr Currie was charged with possession of Nembudeine (being a prescribed restricted substance) on 14 October 1988, two months prior to his death. The same fact sheet names GB as someone known to Mr Currie. It describes GB as a "like recidivist", stating that:

It is evident that once these two keep company both increase their ingestion of prescribed restricted and prohibited drugs.

55. GB told police that he last saw Mr Currie between 10:00pm and 11:00pm the previous night (i.e. on 12 December 1988). Mr Currie had come to his place at around 8:30pm and they spoke for a while and "had a cuppa". He described Mr Currie as appearing to be "under the influence of a drug", that he was

¹⁹ Statement of Constable Phillip Dean Greenhalgh (n 4), at [5].

²⁰ Second statement of GB dated 13 December 1988, at [3] (SCOI.00016.00009).

²¹ Fact Sheet (n 18).

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very slow and had slurred speech. 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, suggesting to GB that Mr Currie had 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. Mr Currie offered to show him, but GB told him not to worry.

56. GB further recounted that when Mr Currie was leaving (evidently, it must have appeared to GB, to go home), he asked GB to phone him (presumably meaning in the morning). However, GB told him that rather than him phoning Mr Currie, Mr Currie should get his brother to wake him up. He suggested that Mr Currie come back to his place at 8:30 the following morning.
57. The police occurrence pad entry made by the OIC²² indicates that Mr Currie's mother became concerned that he had not returned home and it appears from what followed that early the following morning she must have contacted GB to enlist his help in locating Mr Currie.
58. In his statement describing the circumstances in which he found Mr Currie's body, GB states that at about 7:15am he was dropped off by Mrs Currie in Campbell Parade in Manly Vale, approximately 400 metres from where Mr Currie was found. He checked a toilet block next to a bowling club, then went to the toilet block in which he found Mr Currie. When he found Mr Currie, Mr Currie was face down in a small amount of water on the ground. He turned Mr Currie over and checked for a pulse. He describes Mr Currie's skin as cold and clammy. When turning him over, he noticed what he thought was mud on Mr Currie's face.
59. He subsequently returned to Mrs Currie in her car after taking some time to compose himself before breaking the news to her. The matter was then reported by them to Manly Police Station.

Forensic and crime scene evidence

60. Police attended the toilet block after GB reported the death to them at 7:55am on 13 December 1988. The OIC attended the location with GB. At this stage Mr Currie's body was face up (having earlier been turned over by GB). He is described as wearing blue jeans, a brown woollen jumper, a yellow t-shirt that was torn around the neck area and black thongs.
61. The OIC describes 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

²² P109 Report of Occurrence (n 3).

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film of water” near him. He states that ambulance officers arrived and said that Mr Currie had been deceased for a long period during the night. 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. The OIC states that this property was later collected by Mr Currie’s mother, there being no suggestion that it was the subject of any form of forensic testing.

62. As earlier indicated, the OIC states that both detectives and scientific officers attended the scene, and it is known that at least seven colour photos were taken of the scene, with Mr Currie’s body in situ.
63. The OIC’s statement is unsigned and bears the date of 13 December 1988, the day the body was found. In it he states that “no suspicious circumstances were apparent”. He expresses his view of what occurred as follows:²³

“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.”

64. The formal report of the death by the OIC to the Coroner prepared and signed on the same day, 13 December 1988, is in similar terms. It concludes that there are no suspicious circumstances, and that it appears that Mr Currie “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”.²⁴
65. Subsequent to these initial conclusions reached by the OIC, the autopsy was conducted that has been earlier described. The findings of Dr Brighton who conducted the original autopsy, along with the toxicology results, appear to be consistent with the initial conclusions reached by the OIC. Nevertheless, the Inquiry has considered it important to subject certain matters arising from the police scene evidence, the autopsy report and toxicological results to further scrutiny, by means of expert forensic pathology and toxicology reports.

²³ Statement of Constable Phillip Dean Greenhalgh (n 4), at [5].

²⁴ P79A – Report of Death to Coroner dated 13 December 1988 (SCOI.000016.00010).

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Forensic pathology opinion of Dr Iles

66. The questions posed to Dr Iles have already been set out in this submission: see 41 above. Included in the materials provided to Dr Iles were the seven colour photos of the location with Mr Currie's body in situ. Key aspects of the opinion provided by Dr Iles are noted as follows.
67. 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. She opined 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. She states that "[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."²⁵ She also notes that there is no autopsy documentation of other facial trauma. While observing that it is nowadays standard to comment on the state of dentition in autopsy practice, she notes that the same may not have been the case in 1988.
68. As to the cause of death, she 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)*". She noted that in cases of the likely cause of death for individuals whose blood contains central nervous system (or CNS) depressants, it is necessary to exclude other potential causes of death. She notes that although Dr Brighton's report is brief, it does reasonably exclude other causes of death.
69. Dr Iles was of the view that the presence of the thin film of water on the floor was unlikely to have contributed particularly significantly to the death and 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. Although it is 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 is most likely consistent with misadventure.
70. She described the drug Nembudeine as an Australian preparation from Abbott Pharmaceuticals that she believes is no longer available. Its active ingredients included paracetamol (acetaminophen), codeine phosphate and pentobarbital sodium. The codeine, pentobarbitone, and morphine (as a

²⁵ Expert report of Dr Linda Iles dated 24 January 2023, p. 5 (SCOI.82311).

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metabolite of codeine) identified in Mr Currie's blood could all be ascribed to ingestion of Nembudeine tablets. It could also explain the presence of paracetamol.

71. Finally, 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.

Toxicology opinion of Professor Jones

72. The questions posed to Professor Jones have already been set out in this submission: see 43 above. Professor Jones provided a report to the Inquiry dated 22 October 2022, and, following the receipt of Dr Iles's report, a brief supplementary report dated 23 January 2023. Key aspects of the Professor's opinion are as follows.
73. Nembudeine ingestion could account for the presence of codeine, pentobarbitone and paracetamol in Mr Currie's toxicology results.
74. 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.
75. 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 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.
76. 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.
77. 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.
78. Professor Jones concluded that pentobarbitone was found in toxic to lethal concentrations in Mr Currie's post-mortem blood and within the fatal range in his liver. Pentobarbitone would cause significant CNS 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.

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79. Professor Jones concluded that 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.

Conclusion reached after evaluation of the evidence

80. Careful consideration has been given to whether there is any realistic possibility that the death involved a third party and whether any substantive reinvestigation would be fruitful, including, for example by revisiting individuals from whom statements were taken for any further information they may be able to provide. The conclusion has been reached that further investigation of the matter, including by way of taking further witness statements, is unlikely to be fruitful.
81. In view of the known friendship between GB and Mr Currie in the context of their mutual drug use, there does not appear to be anything suspicious about the fact that Mr Currie was at GB's flat from around 8:30pm until somewhere between 10:00pm and 11:00pm, shortly prior to his death. Mr Currie's reported demeanour (slow slurred speech) and comments to GB (that he had taken 25 Nembudeine tablets) are consistent with him having been heavily affected by drugs while he was at GB's flat.
82. GB's description of Mr Currie at this time is 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.
83. Further, the location where Mr Currie's body was found is 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 convenient shortcut between the relevant parts of those suburbs (see map at **Attachment A**).
84. Further, 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 appears to be a logical step to take in the circumstances.
85. For these reasons GB's involvement with Mr Currie around the time of his death is not considered to be suspicious. Evidence from the scene of his death, from the autopsy and toxicology reports at the time, as well as expert review of the toxicology and forensic pathology reports obtained by the Inquiry,

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support the view that Mr Currie's death was the accidental outcome of his ingestion of drugs on 12 December 1988.

Conclusions as to bias

86. Given the conclusion reached in relation to the cause and manner of Mr Currie's death, it is not suggested that the death involved gay hate bias.

Submissions as to manner and cause of death

87. It is submitted that an appropriate description of the cause and manner of Mr Currie's death would be that it resulted from:

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.

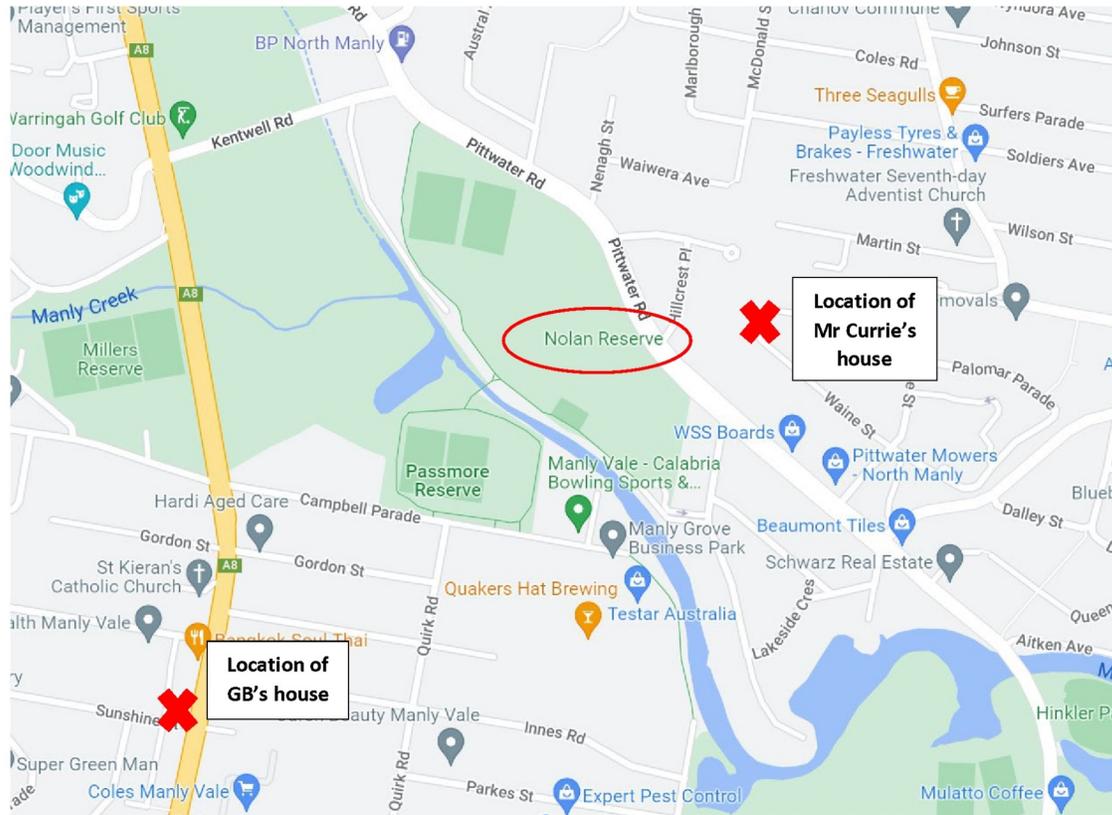
88. Accordingly it is further submitted that the death of Mr Currie was not "unsolved", and therefore does not fall within category A of the Inquiry's terms of reference.

Submissions as to recommendations

89. There are no suggested recommendations relating to any further investigative steps relating to Mr Currie's death.
90. This does not preclude the possibility that factual findings in relation to the matter may have some relevance to recommendations that might be suggested at a more general level, once the circumstances of all deaths have been considered by the Inquiry.

William de Mars
Counsel Assisting

Attachment A



Map showing distance between GB's house and Mr Currie's house, with Nolan Reserve.

Source: Google Maps