New South Wales

Special Commission of Inquiry into LGBTIQ hate crimes

# SUBMISSIONS OF COUNSEL ASSISTING

6 February 2023

## IN THE MATTER OF GRAHAM WILLIAM PAYNTER

### 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. 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.[1] The time of death was estimated to be approximately midnight on 12/13 October 1989.

*Circumstances of death*

3. Mr Paynter had last been seen alive at the Tathra Hotel shortly after 11:20pm on 12 October 1989.[2] 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 a caravan park at Andy Poole Drive in the lower (sea-level) section. Upon discovery of Mr Paynter's body at the base of the cliff the following day, police were called and recorded their observations of the scene.[3]

4. Mr Paynter's body was lying on its right side at the bottom of the cliff. 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

[1] P109 Report of Occurrence dated 13 October 1989 (SCOI.10935.00021).
[2] Statement of John David Roberts dated 12 January 1990 at [6] (SCOI.10935.00015); Statement of Michael Wilhelm Ochs dated 20 January 1990 at [12] (SCOI.10935.00016).
[3] Statement of Constable Michael John Callister dated 23 January 1990 at [5] (SCOI.10935.00022); Crime Scene Photographs, 13 October 1989 (SCOI.10935.00041).

jeans was done up, but his fly was down. 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.[4]

5. Photographs were taken of the deceased's body in situ.[5]

6. The cliff area above the location of the body had a pedestrian walkway 10 metres from the edge of the cliff. There was no fencing or signage near the cliff edge.[6] About 60m south 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 the beach and Andy Poole Drive.[7]

7. The top of the cliff was partially covered with vegetation, which may have obscured a person's view of the steepness of the decline.

8. On 16 October 1989, a canvass was conducted of the residents of Cliff Place, Tathra.[8] 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.[9]

9. 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 Mr Russell Longmore had attended the Tathra Hotel. The owner of the hotel, Mr John Roberts, observed that both men were intoxicated.[10]

    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.[11]

    c. At 7:30pm, Mr Paynter came to the attention of police for stealing a bottle of rum from a Bega Liquor Store. Constable Ian Castle described that Mr Paynter was "unsteady on his feet,

[4] Statement of Michael Wilhelm Ochs (n 2) at [6].
[5] Crime Scene Photographs (n 3).
[6] Statement of Ian John Castle dated 3 November 1989 at [8] (SCOI.10935.00017).
[7] Statement of Michael Wilhelm Ochs (n 2) at [10].
[8] Ibid at [11].
[9] Ibid.
[10] Statement of John David Roberts (n 2) at [3].
[11] Ibid at [4].

had difficulty speaking, had a flushed face and smelt strongly of intoxicating liquor." Mr Paynter was arrested and charged with larceny, but released on bail that same night.[12]

d. At 10:45pm, Mr Paynter and Mr Longmore returned to the Tathra Hotel. They were described as "loud" and "well intoxicated".[13]

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.

Mr Roberts noticed that Mr Paynter was "walking unsteadily".[14]

10. The investigating officer, Constable Ian Castle, 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.[15]

*Findings of post-mortem examination*

11. A post-mortem examination was conducted by Dr Mark Oakley on 15 October 1989.[16] Dr Oakley observed the following injuries:

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, 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;

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);

[12] Statement of Ian John Castle (n 6) at [3]-[4].
[13] Statement of John David Roberts (n 2) at [5].
[14] Ibid at [6].
[15] Statement of Ian John Castle (n 6) at [9].
[16] Medical Report of Dr Mark Oakley, 15 October 1989 (SCOI.10935.00008).

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);

k. One litre haemoperitoneum (i.e. internal bleeding in the space between organs and inner lining of abdominal wall).

12. A blood sample taken from Mr Paynter returned a blood alcohol concentration of 0.290g per 100mL of blood.[17]

13. Dr Oakley opined that cause of death was internal bleeding and closed head injury, with possible alcohol intoxication listed as an antecedent cause.[18]

14. The time of death was estimated to be 58 hours prior to examination i.e. approximately 12:20am on 13 October 1989.[19]

*Persons of interest*

15. There were no persons of interest identified.

*Indicators of LGBTIQ status or bias*

16. The coronial file contains no material bearing upon whether Mr Paynter was or might have been a member of the LGBTIQ community. 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.[20]

17. Two factors might bear upon the possibility of Mr Paynter's death being the result of LGBTIQ bias, and are considered below:

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.[21]

[17] DAL Certificate, 23 October 1989 (SCOI.10935.00009).
[18] Medical Report of Dr Mark Oakley (n 16) p. 2.
[19] Ibid.
[20] Statement of Francesca Lilly dated 5 February 2023 at [15], [18]-[19] (SCOI.82356).
[21] See e.g. Exhibit 1, Tab 2, Strike Force Parrabell Report, p. 91 (SCOI.02632).

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 indicate a sexual element to a death that could be indicative of LGBTIQ bias.

18. However, for the reasons set out below at [75]-[85], it is submitted that it is unlikely that Mr Paynter's death was a homicide or the result of LGBTIQ bias.

*Exhibits: availability and testing*

19. There is no record of exhibits being gathered by police from the scene of Mr Paynter's death.

20. Tissue and blood samples were obtained from Mr Paynter at the time of the autopsy. The results of the testing of these exhibits are contained in an autopsy report and certificate from the Department of Health respectively.[22] The Inquiry did not consider that there was utility in requesting or retesting these samples.

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

21. On 27 July 1990, Coroner Ian Frank Grosse dispensed with an inquest. Consistent with the findings of Dr Oakley, cause of death was listed on Mr Paynter's death certificate as "internal bleeding and closed head injury."[23]

**Features of / concerns with original police investigation**

22. The expert report of Dr Linda Iles, as outlined below, expresses some concern with the quality of the post-mortem examination of Mr Paynter.

23. While Dr Iles considers that the post-mortem examination was "adequate to provide a cause of death", and acknowledges changes in autopsy practice in the decades since Mr Paynter's death, she identifies a number of limitations in the autopsy report.[24] In particular, she points 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.

24. Dr Iles considers 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

[22] Autopsy report of Dr Christopher Lawrence, 29 November 1989 (SCOI.10935.00023); Toxicology report, 23 October 1989 (SCOI.10935.00009).
[23] Notice of Dispensing with Inquest, 27 July 1990 (SCOI.10935.00030).
[24] Expert report of Dr Linda Iles (undated, provided on 11 November 2022), p. 5 (SCOI.82112).

protected areas" can assist in that regard. However, as she observes, in this case "the description of the external injuries is limited and not systematic, and thus is silent in regard to such injuries".[25]

25. Dr Iles further considers that a full toxicology screening would also have been advisable, to exclude the presence of drugs other than alcohol.[26]

26. In addition to these features of the post mortem, it is also of concern that the original police investigative file cannot be located.[27] In that regard, the coronial brief of evidence indicates that Mr Paynter's death was treated by police as being the result of an accidental fall, and that limited investigative steps were taken.

**Strike Force Parrabell**

*Use of the Bias Crimes Indicators Form*

27. The Strike Force Parrabell Report records that the files in Mr Paynter's case could not be located.[28] Footnote 23 records that these files "were either never returned to the archive or were returned and have subsequently been lost." An Investigators Note dated 13 October 2016 indicates that further investigations were made to locate the file in police holdings, which were unsuccessful. A media review was also conducted for relevant documents.

28. In the absence of the police file, the Strike Force Parrabell Report indicates that the Bias Crime Indicators Form (**BCIF**) was completed based on what was said about Mr Paynter's case in a review of a number of possible LGBTIQ hate crime deaths by Detective Chief Inspector John Lehmann of the Homicide Unit on 25 September 2013. DCI Lehmann's one paragraph summary of the death concluded as follows:

> *"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."*[29]

29. Regrettably, the Strike Force Parrabell officers ("the SFP officers") never took the step of obtaining the coronial file, and accordingly the views they expressed about bias in this case would appear to

[25] Expert report of Dr Linda Iles (n 24) p. 6.
[26] Ibid p. 5.
[27] Exhibit 1, Tab 2, Strike Force Parrabell Report, p. 70 (SCOI.02632).
[28] Ibid p. 70.
[29] Extract of Detective Chief Inspector Lehmann review of 30 unsolved homicides re Graham Paynter, 25 September 2013 (SCOI.82363).

have had a scant factual foundation. Much of the BCIF is no more than repetition of DCI Lehmann's conclusion.

30. At pages 3, 4 and 9 of the BCIF, the SFP officers appear to have copied and pasted from the form relating to another deceased person, Mr Sheil, and failed to amend the deceased's name.[30] Whilst occasional errors can be expected in any area of work, incorrectly naming the potential victim of a hate crime, in the course of a well-publicised review process 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.

31. 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, being "Organised Hate Groups (OHG)", the answer 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:

> *"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 PAYNTER fell from a 50 metre high cliff at the southern end of Tathra Beach."* [31]

32. 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.

33. In respect of the indicator "Location", the BCIF records that there is "evidence suggesting this location was known as a beat location." However, this reference seems to relate to a quote from Ms Sue Thompson in the 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 gay beat, as were many similar cliff and beach locations.[32] That remark hardly rises to the level of "evidence" suggesting that the area was "a known beat location".

34. Conversely, notwithstanding that the SFP officers 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."

[30] Strike Force Parrabell, Bias Crimes Indicators Review Form – Graham Paynter, pp. 3, 4, 9 (SCOI.74992).
[31] Ibid p. 6.
[32] Investigator's Note (SCOI.82207).

*Results of Strike Force Parrabell*

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

35. Nine of the ten indicators considered in the BCIF were answered in the form that there was "Insufficient Information" to make a determination as bias motivation. The exception was indicator 3, "Drawings, Markings, Symbols, Tattoos, Graffiti" where "No Evidence of Bias Crime" was selected.

36. 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.

37. The treatment of the indicators by the SFP officers is superficial. Even making allowance for the lack of information before them, there was no engagement with the possible significance of the location of the death or the state of Mr Paytner's clothing. Instead, the SFP officers simply adopted the view of DCI Lehman, that "there is no indication that the deceased was assaulted, murdered, or the victim of 'gay hate' related violence".

(b) Case summaries

38. The Strike Force Parrabell Case Summary for Mr Paynter's case read as follows:

> ***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.***[33]

[33] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Graham Paynter (undated), p. 17 (SCOI.76961.00014).

39. The content of this case summary is consistent with the comments made in the BCIF.

(c) Academic review

40. Mr Paynter's case was classified by the academic reviewers as having 'Insufficient Information' to determine whether the death was as the result of a bias crime.

41. The academic review noted that classification under 'Insufficient Information' "does not discount that gay bias *may* have been a factor" in the death,[34] but rather:

> *...Despite an exhaustive exploration of the archived material, 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. Part of the reason this was the case can be attributed to a relative paucity of information.*[35]

**Investigative and other steps undertaken by the Inquiry**

*Contact with family members of Mr Paynter*

42. The Inquiry issued summonses BDM4 and BDM5 to the Registry of Births Deaths and Marriages (**BDM**) seeking death certificates for Mr Paynter's parents. Certificates were not able to be obtained. However, the Inquiry was informed that both Mr Paynter's parents had passed away.

43. Journalist Michael Burge provided contact details to the Inquiry for 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.

44. On 1 February 2023, Mr William Towler and Mr Andrew Bird provided a statement to the Inquiry, with information about Mr Paynter as a person and the impact of his death upon his family. The Inquiry is grateful to Mr Towler and Mr Bird for their assistance.

45. On 3 February 2023, Mr Towler provided a statement to the Inquiry containing information as to Mr Paynter's background: see below at [59]-[60].

*Request for coronial file*

46. On 11 May 2022, the Inquiry issued a written request to the Registrar of the Coroners Court of NSW at Lidcombe to obtain the coronial file in relation to the death of Mr Paynter. The Inquiry was advised

[34] Exhibit 1, Tab 2, Strike Force Parrabell Report, p. 80 (SCOI.02632).
[35] Ibid p. 54.

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.

47. Bega Local Court answered the request by production of the file on 19 August 2022.

*Summons for police files and documents*

48. A summons to the NSW Police Force (**NSWPF**) was issued on 18 May 2022 for, *inter alia*, the investigative file in relation to the death of Mr Paynter (summons NSWPF1). An electronic folder of material in relation to a different Graham Paynter was produced on 21 July 2022.

49. The Inquiry advised NSWPF of this error, and a file of five documents was subsequently provided by NSWPF in response to summons NSWPF3 (though this summons had not requested any material in relation to Mr Paynter).[36] 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.

50. A second summons to the NSWPF was issued on 25 August 2022 for all NSWPF records in relation to, *inter alia,* Strike Force Parrabell (summons 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 Paynter's death by Strike Force Parrabell.

*Summons to Births, Deaths and Marriages*

51. On 28 October 2022, the Inquiry issued summons BDM5 to BDM for the death certificate of Mr Paynter. A death certificate was provided by BDM on 31 October 2022. The death certificate also provided further information regarding Mr Paynter's parents.[37]

*Professional opinions obtained*

52. The Inquiry sought an independent review of the autopsy report prepared by Dr Oakely, including as to the cause of Mr Paynter's death and the inferences that could be drawn from the positioning of his clothes.

53. In that regard, the Inquiry briefed forensic pathologist Dr Iles on 31 October 2022, and obtained an expert report by Dr Iles on 11 November 2022.[38] Her concerns with the original post-mortem

[36] Statement of Francesca Lilly (n 20) at [5]-[6].
[37] Copy of Death Certificate of Graham WIlliam Paynter dated 31 October 2022 (SCOI.82151).
[38] Expert report of Dr Iles (n 24).

examination is summarised above at [22]-[25]. Her opinion in relation to manner and cause of death is summarised below at [61]-[66].

*Other sources of information*

54. Mr Burge, referred to above, is a freelance journalist, author and artist who lives in the New England region of NSW. His work has covered issues of equality and LGBTIQA+ history, and he has reported on LGBTIQ hate crimes in regional NSW.[39]

55. Mr Burge has 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 family.

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

56. As set out above, the post-mortem examination should have been conducted with more careful regard to whether there were subtle injuries that could indicate the mechanism of Mr Paynter's fall. In addition, the post-mortem examination should have examined for, and/or recorded, the absence or presence of any anogenital injuries. The deficiencies in the post-mortem examination limit the ability of the Inquiry to test an alternative hypothesis that Mr Paynter was pushed from a cliff, or that there was a sexual element to the crime.

57. Because Mr Paynter's death was treated from the outset as an accidental fall, limited investigative steps were taken by police. A thorough investigation would have involved 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. This may have opened further lines of inquiry.

**Results of investigative and other steps undertaken by the Inquiry**

58. 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.

*Personal circumstances of Mr Paynter*

59. Mr Paynter was 36 years old at the time of his death. He was the only son of Gladys and Stanley Paynter, and had two full sisters and one half-sister, and was also an uncle and great uncle. He was

[39] 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>.

affectionately known to friends and family as "Possum" and had a reputation for being "a joker and a bit of a scally wag."[40]

60. 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 suffered from an alcohol addiction.[41]

*Opinion of Dr Iles as to cause of death*

61. Despite the limitations of the post-mortem examination as set out above, 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."

62. However, in light of the silence of the initial post-mortem examination on "subtle" injuries, Dr Iles considers 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.

63. 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.

64. 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.[42]

65. Dr Iles considers that Mr Paynter's cause of death is better stated as:

> "Multiple injuries sustained in a fall from [a] height in the setting of alcohol intoxication."

66. 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 at [11].

[40] Family statement provided by William Towler and Andrew Bird, received 1 February 2023.
[41] Statement of William Towler dated 3 February 2023 at [5] (SCOI.82355).
[42] Expert report of Dr Iles (n 24) p. 6.

*Other features indicating manner of death*

67. The surrounding circumstances include the following relevant factors.

68. *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 beach below and to the caravan park where he lived on Andy Poole Drive, as this would represent his most direct route home.

69. *Secondly*, there are a number of factors that make an accidental fall plausible, including:

    a. Mr Paynter's extreme intoxication, with his blood alcohol concentration of 0.29% being almost six times the legal limit for drinking. This is consistent with lay opinion of witnesses as to his level of intoxication, as well as observations of his drinking on the night;

    b. The night-time darkness, with Mr Paynter last being seen alive at approximately midnight;

    c. 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.[43])

70. *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. This makes it less likely that a violent assault occurred prior to his death.

71. *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.

72. *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.

73. *Finally*, there is no evidence that the cliff location above Mr Paynter's body was a beat, nor that gay bashings were occurring in that location. (See below at [77]-[82].)

74. A push from the cliff, or suicide, cannot be definitively excluded given the state of the evidence. However, on the totality of the evidence, it is submitted that it is more likely than not that Mr Paynter accidentally fell to his death.

[43] 'Tathra Cliff Top is to be Fenced Off', 27 July 1990 (SCOI.10935.00029).

*Consideration of factors indicating LGBTIQ bias*

75. There was no information on the coronial file as to Mr Paynter's sexuality. The Inquiry's own investigations revealed that none of Mr Paynter's family knew him to be an LGBTIQ person, although were open to the possibility.

76. In relation to the positioning of Mr Paynter's clothing, this would be probative of 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 to the opinion of Dr Iles set out above, there is no proper basis for drawing that inference. Rather, it is possible, and seems likely, that his clothing became disarranged during the fall, noting in particular his truncal obesity and narrow hips making it possible that his lower garments could have "passively end[ed] up below their normal location in the setting of tumbling following a high energy fall".

77. 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:

> *"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."*[44]

As to Tathra in particular, Mr Wotherspoon was not aware of the existence of a beat in the town.[45]

78. 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.[46] He also described regional or country beats existing at "lookouts".[47]

79. 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.[48]

[44] Exhibit 2, Tab 1, Statement of Garry Wotherspoon dated 14 November 2022, at [34] (SCOI.77300).
[45] Mr Wotherspoon provided this information to the Inquiry in conference.
[46] Exhibit 2, Tab 3, Statement of Les Peterkin dated 14 November 2022 at [30] (SCOI.77302).
[47] Ibid at [32].
[48] Exhibit 2, Tab 8, Statement of Ulo Klemmer dated 11 November 2022 at [15] (SCOI.77307).

80. 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.

81. However, 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.[49] 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.[50] Other locations within Tathra (including various public toilets) are more likely candidates for a beat (if there was one in Tathra at that time).

82. Accordingly, neither the location of Mr Paynter's body nor the positioning of his clothing gives significant support to the hypothesis that Mr Paynter died as a result of an LGBTIQ hate crime.

**Conclusions as to bias**

83. In light of the likelihood that Mr Paynter's death was the result of an accidental fall, and given the analysis above in respect of location of the body and the positioning of his clothing, it is submitted that it is unlikely that Mr Paynter's death was a homicide or the result of an LGBTIQ hate crime.

**Submissions as to manner and cause of death**

84. It is submitted that the Inquiry should find that Mr Paynter died on 13 October 1989 as a result of multiple injuries sustained in an accidental fall from a height in the setting of alcohol intoxication.

**Submissions as to recommendations**

85. It is submitted that a recommendation should be made to the Registry of BDM to correct the Register of BDM pursuant to s 45(1)(b) of the *Births, Deaths and Marriages Registration Act 1995*, such that Mr Paynter's cause of death is recorded as: "multiple injuries sustained in a fall from a height in the setting of alcohol intoxication."

Kathleen Heath

Counsel Assisting

[49] Statement of Michael Wilhelm Ochs (n 2) at [10].

[50] See Statement of William Towler (n 41) at [11].