

The Special Commission of Inquiry
into LGBTIQ Hate Crimes

TENDER BUNDLE HEARING OF 6 AND 7 FEBRUARY 2023

**Concerning the deaths of John Hughes, Graham Paynter,
Russell Payne, William Dutfield, David Lloyd-Williams, Andrew Currie and
Brian Walker**

Submissions on behalf of the Commissioner of Police

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Introductory

1. These submissions are prepared on behalf of the Commissioner of Police by way of response to the submissions made by Counsel Assisting on 7 and 8 February 2023 in relation to the deaths of John Hughes, Graham Paynter, Russell Payne, William Dutfield, David Lloyd-Williams, Andrew Currie and Brian Walker.
2. These submissions are provided in advance of the Commissioner's submissions in respect of the Parrabell hearings. While they necessarily touch upon some of the general matters to which those hearings relate, they do not represent a comprehensive statement of the Commissioner's position on the general Parrabell issues, which will no doubt be informed by the submissions ultimately made by Counsel Assisting. In due course, these

submissions should be read with those made on behalf of the Commissioner of Police in connection with the Parrabell hearings.

3. Having said that, it is appropriate to make some general observations at the outset.
4. First, it is submitted that the Inquiry should bear firmly in mind the difficulties inherent in the categorisation of a death as a hate crime, particularly in the absence of direct evidence from an accused person as to their motivation. In most of the cases presently under consideration, the submissions of Counsel Assisting align broadly with the position reached by SF Parrabell. In any event, it is submitted that the fact that a different conclusion is reached in a particular case should not – without more – give rise to criticism of reviewing officers. Even setting aside the SF Parrabell process, there is a clear divergence in views between Counsel Assisting and other reviews that have concerned the same subject matter (specifically, ACON's In Pursuit of Truth and Justice review, and the foundational work conducted by Sue Thompson and Professor Stephen Tomsen – albeit with incomplete information). Having regard to absence of validated and reliable mechanisms for determining the existence of bias, and the inherently complex nature of violent offending and cases involving suicide or misadventure, these are matters about which reasonable minds can, and will, differ. These issues will be explored further in the context of the SF Parrabell hearings, but it should be noted at this stage that while further attempts to delimit bias indicators have been made in the academic world since SF Parrabell's report, there is still no widely accepted approach to the identification of a bias crime. Indeed, it appears that BCI indicators continue to be used in some contexts. All told, it does not appear that the approach adopted by Counsel Assisting is any more scientific than that employed by members of SF Parrabell. That should not, of course, be read as a criticism of Counsel Assisting. Rather, it is simply a reflection of the inherently challenging nature of the task, and the limitations on the Inquiry's capacity to conduct further investigations in the context of these deaths, all of which occurred decades ago.
5. Second, while it appears that there may have been shortcomings in some of the initial police investigations, it is important to recognise that these investigations occurred at a very different time, and that police practices have moved on very substantially in the intervening period. Importantly, for example, DNA analysis was not available to police at the time of each of these deaths (and, indeed, there have been many subsequent developments in DNA testing techniques and methodologies since it first became

available). Care should be taken to avoid criticising investigating police on the basis of a failure to adhere to modern investigative standards. Not only is there limited utility in criticising the approaches of long-retired police officers, it would be unfair to do so. The reason for this is twofold: police operating in the late 1980s cannot sensibly be held to modern day standards; and those officers have not been called to give evidence. Such evidence, might, for example, have shed light on why particular investigative steps were not thought necessary in the circumstances of a case, or indeed, reveal that particular steps were in fact taken, but have simply not been recorded in the documents available to the Inquiry some 35 years on.

6. Third, there appear to have been deficiencies in the archiving of information in relation to some of the cases. Where information has been lost, it is not clear when the loss occurred, or who was responsible. There have been enormous advances in computer systems, digitisation and, in turn, archiving of information in the intervening period.
7. Fourth, regard must be had to the nature of the task being undertaken by investigating police at the relevant time. Specifically, their central undertaking was the determination of the cause of a particular death (and, in some cases, who caused it). It would be inappropriate and unfair to criticise police for conducting that task in a way that does not align closely with the Inquiry's present undertaking (which is occurring in a very different social context, with a particular focus on the presence or otherwise of anti-LGBTIQ bias).
8. Fifth, none of the expert or other evidence relied on by the Inquiry in undertaking the present case studies has been tested by way of cross-examination or subjected to scrutiny by other experts. Particular care should be taken in relying on such untested evidence – some of which would not ordinarily be admissible in Court – as a foundation for criticism.
9. Sixth, the scope of the Parrabell task should be carefully considered in determining whether criticism should be directed to those conducting the review. Members of SF Parrabell were not charged with conducting a reinvestigation of cases, did not have powers to compel the production of documents, and did not have a budget that would have allowed for the retention of expert pathology, toxicology or psychiatric assistance.
10. Seventh, the individual officers who completed the BCIF forms as part of SF Parrabell have not been called to give evidence. Those officers have not, therefore, been afforded the opportunity to explain the observations they made in the forms, nor discussions that

occurred subsequent to the completion of the forms in formulating the position ultimately adopted in the Parrabell review.

11. Eighth, it is apparent that there are typographical errors in some of the documents placed before the Inquiry. In determining whether criticism should be levelled on that basis, it should be recalled that the relevant documents were prepared for internal consumption only. Additionally, the Inquiry should be mindful that police are not lawyers, whose central function often involves the production of documents, the contents of which will be subject to intense scrutiny by opponents in litigation. The standard applied in the assessment of the written work of police officers should not be unduly coloured by the expectations lawyers might apply to other lawyers in the context of litigation.
12. Some of these matters will no doubt be addressed further in the context of the Parrabell hearings. It is nevertheless appropriate that they be carefully considered in conducting an analysis of the individual cases such as those examined by the Inquiry in the hearings on 7 and 8 February 2023.

John Hughes

Circumstances of death

13. Mr Hughes was the victim of a brutal attack, dying of asphyxiation caused by strangulation with a ligature (CA, [4]-[7]). There is no real doubt as to the cause of his death.
14. There is nevertheless some complexity associated with the identification of the circumstances of his death.
15. Mr Ian Jones was charged with Mr Hughes' murder on 30 April 1990. He pleaded not guilty to the charge and was ultimately acquitted.
16. There is a range of compelling evidence to suggest that, in fact, Mr Jones was the perpetrator of the offence. Counsel assisting has provided a detailed summary of the circumstances relevant to Mr Hughes' death, together with an analysis of both the defence and prosecution cases: CA [54] – [116]. The Commissioner does not cavil with that analysis, which is succinctly put and reflective of the evidence. In particular, as identified by Counsel Assisting, the suggestion that Mr Hughes' passbook was planted in Mr Jones' jacket lining by police was entirely without foundation (see CA, [110] - [111]).

17. As noted by Counsel Assisting, Courts have at times been prepared to make findings by applying the civil standard of proof that a person who has been acquitted of a criminal offence did, in fact, commit that offence (CA, [77]).¹
18. There is nonetheless an important philosophical question as to the appropriateness of the Inquiry making a positive finding, in so public a forum, as to the guilt of a person who has been acquitted by a jury and, accordingly, maintains the benefit of the presumption of innocence. Mr Jones died in 2002, and so necessarily has not participated in the Inquiry. It is not clear whether the Inquiry has had any communications with his family members in respect of the findings proposed by Counsel Assisting. As explored further at [86] – [90] in the context of the Dutfield matter, the preservation of the reputation of a deceased person may, in certain instances, give rise to procedural fairness considerations vis-à-vis their family members,
19. Ultimately, it is a matter for the Inquiry whether to publish a positive finding that Mr Jones was responsible for the murder of Mr Hughes. The Commissioner of Police does not seek to advocate either in favour or against such a course; there are powerful considerations weighing in both directions.

Initial police investigations

20. Counsel Assisting raises a concern in relation to the management of exhibits at the crime scene CCA [20] – [21]).
21. It is accepted that relevant exhibits were not contemporaneously itemised and stored separately at the time of their seizure (CA, [20]). In that respect, the investigation failed to align with modern standards.
22. The Inquiry has not, however, called evidence (including from the officers involved in the original investigation) to consider the extent to which that practice aligned with the investigative standards of the day. As is the case in many organisations and institutions, police investigative practices have very substantially developed over the past 35 years. In particular, there have been very substantial developments in computer technology, which has greatly facilitated the recording, retention and archiving of information. Additionally, DNA testing technology was in its nascent stages in the late 1980s, and had not yet formed

¹ By reference to *Hytch v O’Connell* [2018] QSC 75 at [91], referring to *Helton v Allen* (1940) 63 CLR 691. See Also *Australian Communications and Media v Today FM* [2015] HCA 7 at [32]; *The Queen v Carroll* [2002] HCA 55 at [138].

a part of police investigative practice.² Accordingly, it is unsurprising that less attention was paid to the need for separate storage and documentation of exhibits than would be the case today.

23. As noted by Counsel Assisting, current police investigative practices involve the contemporaneous itemisation of all exhibits seized (CA, [21]). Such an approach may well have reduced the scope for the defence to contend that police planted a St George Building Society passbook in the lining of Mr Jones' jacket. In the absence of evidence as to a disconnect between the management of exhibits in this case, and what was regarded as proper police practice at the time, the Inquiry could not sensibly criticise the investigation on the basis that the management of exhibits did not align with what is regarded as best practice in 2023.
24. Such criticism would, in any event, be of no utility given the lapse of time and the evident changes to police practice in the intervening period.

Was the death LGBTIQ-hate motivated?

25. The evidence clearly discloses that Mr Hughes was gay and was known to be gay by his friends and acquaintances. It is further acknowledged that his sexuality was known to Mr Jones (see CA, [10]).
26. It is trite to say that the fact that a person is homosexual does not necessitate a conclusion that an offence committed against them was motivated by that fact.

Attitudes and motivations

27. There is clear evidence that robbery and/or revenge-related motivations were involved in the killing of Mr Hughes.
28. Nevertheless, there were some indications, after the killing, that suggested that Mr Jones harboured strongly homophobic attitudes. In particular, in a remark that appears to have been overlooked by the reviewing officer, Mr Jones is said to have said words to the following effect to Ms Dowsley³

² Our present understanding is that DNA evidence did not begin to be used as evidence in NSW Courts until approximately 1996.

³ Statement of Janice Dowsley dated 8 April 1992 at [7] (SCOI.10301.00015); Transcript of Proceedings 27 August 1992 (n 15) p. 10.

"Don't worry, he was a fucking faggot dog anyway and he deserved to die and he deserved everything that he got".

29. The fact that a person evinces anti-gay attitudes, even ones as abhorrent as those conveyed by these words, does not lead inexorably to a conclusion that any violent act they perpetrate against a gay person is motivated by that attitude.
30. The existence or lack thereof of alternative motives is an appropriate consideration in determining whether an offence is bias-related. For example, an attack on a gay service station attendant, that occurs in the context of a robbery, is less likely to be a bias crime than an attack on the same service station attendant, that is not accompanied by a robbery.
31. Equally, however, it is accepted that a particular act may be driven by multiple motivations. Accordingly, the mere fact that an offence was motivated by a desire to steal money, or to secure revenge, does not preclude a conclusion that anti-LGBTIQ bias also played a role.
32. Additionally, it is accepted that an attack on a victim who was deliberately selected because of a perception that their sexuality would make them less likely to report an offence or otherwise vulnerable, can properly be characterised as motivated by anti-LGBTIQ-bias (see CA, [32]).
33. There is, however, no clear evidence of such a thought pattern on Mr Jones' part. Counsel Assisting has "hypothesised" that the fact that Mr Jones considered that there would be "no big inquiry" over "another junkie dealer" suggests that "Mr Hughes' status as a gay person made Mr Jones perceive him as a target that would be less protected by police and the courts" (CA, [35]). This "hypothesis" is nothing more than that. Mr Jones considered that police would not inquire rigorously into the death of a drug addict who dealt drugs. It does not reflexively follow that he took the view that police would not inquire into the death of a gay person.

Level of violence

34. The officer/s who completed the BCIF form in relation to Mr Hughes' death undoubtedly recognised that the brutality of Mr Hughes' death was a matter to be considered in assessing it.
35. No evidence has been sought from the officer/s who completed the form. That being so, the Inquiry does not have evidence as to why particular decisions were made in the completion of the form.

36. The impact of a factor such as the level of violence must be viewed in context. Having regard to the apparent operation of personal animosity or a revenge-motivation on Mr Jones' mind, the degree of violence perpetrated on Mr Hughes may well have been regarded as a less significant indicator in this case than it would have been in others. In the absence of evidence from the relevant officer/s, however, the Inquiry could not draw a conclusion one way or the other in this respect (cf CA, [36] – [37]).

Evidence not available to Parrabell investigators

37. It should be noted that Counsel Assisting's submissions make reference to some evidence that was not, and could not have been, available to SF Parrabell investigators.
38. In particular, the Inquiry has obtained evidence from Dr Danny Sullivan, a forensic psychiatrist. Such a psychiatric review of the evidence fell outside the scope (and budget) of SF Parrabell. Having regard to the budgetary and time constraints confronting SF Parrabell, the absence of such evidence could not sensibly form a basis for criticism.
39. In any event, the evidence of Dr Sullivan contains a very clear element of speculation (in particular, as to what Dr Sullivan characterises as the "sexualised elements of the crime scene": CA, [120]), it is not clear how his opinions are based upon his expertise, and there is no prospect that such evidence would be admissible in proceedings against an accused person.
40. That being so, the two indicators set out at CA [121] could not, in isolation, have been sufficient to clearly earmark this case as a bias crime. In particular, Dr Sullivan's report fails to provide a satisfactory (and/or conventionally admissible) explanation as to how "the location and posing of the body on the bed may have suggested conscious or unconscious motivation of the offender to reflect Mr Hughes' sexuality, as they perceived it".

Appropriate conclusion regarding anti-LGBTIQ bias

41. Nevertheless, in all the circumstances, and having particular regard to Mr Jones' statements following Mr Hughes' death, it is accepted that the evidence suggests that anti-LGBTIQ bias *may* have played a role in the death of Mr Hughes. It is therefore accepted that the appropriate categorisation, in view of the evidence of Mr Jones' further statements, would have been that of a "*suspected bias crime*".
42. The evidence would not have allowed a conclusion to the criminal standard that the offence was motivated by gay-hate. Accordingly, in the absence of further evidence, it is very

unlikely that a Court would, following a guilty verdict, have been able to take a bias-motivation into account against Mr Jones on sentence. The relevant Parrabell investigators, however, ought to have identified the homophobic statements alleged to have been made by Mr Jones and, in turn, factored them into their analysis.

Findings and recommendations

43. The Commissioner of Police accepts the accuracy of the observations as to the manner and cause of Mr Hughes' death at CA [124].
44. As noted above, the question of whether the public interest favours the naming of an alleged perpetrator, in circumstances where that person has been acquitted and ostensibly maintains the benefit of the presumption of innocence, is ultimately a matter for the Inquiry.

Graham Paynter

Circumstances of death

45. As noted by Counsel Assisting (CA, [2]), the body of Graham Paynter was found at the bottom of a cliff at Shelley Beach, Tathra in the evening of 13 October 1989.
46. Counsel Assisting's submissions provide an accurate summary of the circumstances of Mr Paynter's death (CA, [3] – [15], [68] – [73]). Of particular relevance, no persons of interest were identified, a range of evidence spoke to Mr Paynter's extreme intoxication on the night of his death, his death occurred at about midnight, and there was no fencing at the top of the relevant cliff.

Initial police investigations

47. It is suggested by Counsel Assisting that "limited investigative steps were taken by police" (CA, [57]). That appears, on the face of the available documents, to be true. But that does not necessitate a conclusion that the investigation was deficient, having regard to the apparent circumstances of Mr Paynter's death, and accepted police practice of the time.
48. Additionally, those involved in the investigation have not given evidence in the context of this Inquiry. The absence of such evidence means, for example, that the Inquiry is not able to evaluate the possibility that further investigative steps (for example, an informal canvas of potential witnesses) were conducted.

Anti-LGBTIQ bias

49. As noted by Counsel Assisting (CA, [16]), there is nothing to indicate that Mr Paynter was a member of the LGBTIQ community.
50. Counsel Assisting nevertheless observes that two aspects of the case could be construed as potential indicators of a bias crime (CA, [17], [31] – [34]):
- a) First, the fact that the body was found at the base of a cliff formation in circumstances where some cliff locations (in other cities) have served as outdoor beats and some deaths in another location (i.e. Bondi) were caused, or possibly caused, by violence at clifftop locations.
 - b) Second, Mr Paynter's clothing was partly displaced. It is said that "this could indicate a sexual element to a death that could be indicative of LGBTIQ bias".
51. Care should be taken not to overstate the reliability of the first of these factors as an indicator of LGBTIQ bias. The Inquiry has not, to this point, received evidence as to the frequency of falls from clifftops or related places as a cause of death. Great care needs to be taken in reasoning that a particular death may have been caused by violence because of the prevalence of violence in a particular location. It is doubtful that that such analysis could ever be conducted in a reliable (or admissible) manner. If such analysis were to be attempted, it would need to be premised on robust comparative statistical information. An example of such information (albeit at level of generality that is unlikely to be useful in the present context) is provided by Australian Bureau of Statistics analysis from the year 2010, which suggests that almost 1800 persons fell to their death (either deliberately or accidentally) in that year.⁴ As a further example, in 2011 it was reported that approximately 50 people per year commit suicide by jumping from the clifftops at the Gap at Watson's bay in NSW.⁵ A conclusion that a person whose body was found at the bottom of the cliffs at the Gap could not sensibly be founded on information as to the frequency of violent deaths at that location, unless the analysis also considered the frequency of suicide and/or accidental falls.

⁴ <https://www.abs.gov.au/ausstats/abs@.nsf/Products/94BBA3060FC0657BCA2579C6001B676E>

⁵ <https://www.smh.com.au/national/nsw/new-fence-at-the-gap-just-not-high-enough-20110625-1gklq.html>

52. In any event, there is no suggestion that anti-LGBTIQ violence had occurred at the relevant Tathra clifftops, nor is there evidence that would enable the Inquiry to be positively satisfied that those clifftops served as a beat.
53. Similarly, the mere fact of clothing displacement, without more, should not be regarded as a reliable indicator of bias crime; any such conclusion needs to be prefaced by a careful consideration of the surrounding circumstances, and the relative likelihood that the displacement was attributable to a deliberate bias-related act by a perpetrator as distinct from, for instance, some act on the part of an intoxicated person prior to a fall, or the impact of the fall itself on the clothes in question.
54. Indeed, such a careful consideration is contained in Counsel Assisting's submissions (CA [63] - [64], [76]).
55. In view of that analysis, and the assessment that the area from which Mr Paynter fell was not likely a beat, Counsel Assisting submits that it is unlikely that Mr Paynter's death was a homicide or the result of an LGBTIQ hate crime (CA, [83]). It is respectfully submitted that Counsel Assisting's conclusion in that respect is correct.
56. It is acknowledged that SF Parrabell conducted its exercise as concerns Mr Paynter's death by reference to a limited range of material. The Parrabell review process could no doubt have been conducted in greater detail had police secured access to the Coronial file.
57. A review of that file, however, would not likely have meaningfully altered the resultant analysis; if anything, the additional information would likely have resulted in a conclusion that the case properly fell into the "no evidence of bias" category (i.e. the position adopted by Counsel Assisting), rather than the "insufficient information" category.⁶
58. It is noted that this categorisation stands against any suggestion that police were seeking to downplay the number of cases within the Parrabell sample that involved LGBTIQ-bias; if such an approach had been adopted, the case could readily have been characterised as one that did not involve any evidence of a bias crime.
59. It is accepted that the analysis in the BCIF appears somewhat superficial. That analysis, however, needs to be evaluated in light of the limited information available to the reviewing

⁶ See Tab 22, Paynter Bundle, SCOI.74992_0013.

officer, and the nature of the case being evaluated. There was nothing in the available material that gave rise to a real prospect that Mr Paynter's death was a possible bias crime. The Parrabell review process was an onerous, resource-intensive task, and it stands to reason that the attention of officers might have been concentrated more heavily on cases where there was likely to be a real question as to whether or not the death was bias-motivated.

60. Elsewhere, (CA, [30]) Counsel Assisting criticises the Parrabell review officers on the basis that in three separate locations in the BCIF the name "Sheil" appears in lieu of that of Mr Paynter. This error is regrettable. Nevertheless, it should be recalled that the BCIF forms were not intended to be read by anyone outside the Parrabell process, and that the police who completed them are not journalists, lawyers or other persons who habitually prepare documents for public consumption. It is therefore unsurprising that the relevant form has not been proofread with the rigor that might attend some other categories of document. Care should be taken not to level criticism of a severity that does not reflect the nature of the error, or the consequences flowing therefrom.

Findings and recommendations

61. It is submitted that the findings and recommendations proposed at [84] – [85] of Counsel Assisting's submissions are appropriate and should be adopted by the Inquiry.

Russell Payne

Circumstances of death

62. Mr Payne died on or about 31 January 1989. At the time of his death he was suffering from a severe infection, that appeared to have arisen following an injury he suffered when he inserted a foreign body into his urethra.
63. Counsel Assisting has provided a comprehensive and accurate summary of the circumstances surrounding Mr Payne's death, and of the medical evidence obtained by the Inquiry in connection with his case.
64. As noted by Counsel Assisting (CA, [59]), the available medical evidence concludes that "Mr Payne's death can be completely explained as a consequence of a natural disease

process secondary to misadventure (i.e., a foreign body in the urethra)"; there are "no features in the materials....to suggest either suicide or foul play".⁷

Initial police investigations

65. Counsel Assisting notes concerns expressed by Mr Payne's sister and her former partner as to a lack of communication, in particular, as to the cause of Mr Payne's death.
66. These concerns have not been put to those involved in the police investigation. It may be that any lack of communication was attributable to a desire to shield the family from the trauma or embarrassment that may have arisen in connection with that information. Such a desire might well be regarded as misplaced in a modern context. Social expectations in that respect, however, have significantly moved on in the intervening 35 years.
67. Criticism is also levelled at the original investigators on account of their failure to retain 'erotic photographs' present at the site (CA, [51] – [52]). No information as to the precise nature of those photographs is contained in the tender bundle. The statement of Sergeant Moss records only that those photographs were contained "in the bedroom" at the flat.⁸ It is not clear where in the bedroom those photographs were located. The photographs might, for example, have been entirely conventional erotic photographs stored in a drawer. Sergeant Moss has not been called to give evidence. Accordingly, the suggestion that, at the time of the investigation, police should have regarded the photographs as sufficiently pertinent to warrant their seizure is wholly speculative. Again, the task of police at the time was to identify what caused Mr Payne's death, not to exhaustively interrogate contextual factors that may have been relevant to the question of his sexuality.

Anti-LGBTIQ bias

68. The Inquiry has conducted some investigations into the sexuality of Mr Payne. Such investigations would have been beyond the scope of SF Parrabell. They have revealed, however, that Mr Payne may have been gay (CA, [38] – [39]).
69. Nevertheless, having regard to the circumstances that precipitated it, Mr Payne's death cannot be regarded as an LGBTIQ hate crime. SF Parrabell's conclusion⁹ that there was

⁷ Expert report of Dr Linda Iles, SCOI.82113, p. 7.

⁸ Payne Tender Bundle, Tab 6, SCOI75545_0003, [14].

⁹ Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Russell Payne, p. 15 (SCOI.76961.00014).

no evidence of a bias crime was appropriate. Counsel Assisting has arrived at the same view (CA, [62]).

Findings and recommendations

70. It is submitted that the findings and recommendations proposed by Counsel Assisting as to the manner and cause of Mr Payne's death (CA [63] – [65]) should be adopted by the Inquiry.

William Dutfield

Circumstances of death

71. William Dutfield died in his apartment in Mosman on the evening of 19 November 1991. At post-mortem, forensic pathologist Dr Duflou found the cause of death to be "head injuries",¹⁰ and at the inquest which followed, gave evidence that there were sixteen injuries to Mr Dutfield's scalp, several of which were each an "unusual U-shaped laceration".¹¹ Dr Duflou considered these lacerations to be consistent with having been caused by a single blunt object; specifically, they were consistent with having been inflicted by a metal sticky-tape dispenser found at the scene.
72. The key area of investigation following Mr Dutfield's death was the identity of his attacker, together with the motive for the attack.

Initial police investigations

73. As acknowledged by counsel assisting (CA, [17]), initial police investigations understandably focussed firstly on the fact Mr Dutfield had reported being the victim of a violent attack five weeks before his death, when he had been robbed at his unit.¹² The perpetrator of the crime had left behind a packet of cigarettes, but testing of the fingerprints on the cellophane packaging at the time did not return a positive result (either against elimination prints or wider searches).¹³

¹⁰ Autopsy report of Dr Johan Duflou, 1 April 1992 at p. 7 (SCOI.00027.00031).

¹¹ Transcript of Inquest Hearing, 12 December 1994, T18:16-49 (SCOI.00027.00025)

¹² Robbery with Striking (16-10-91) and Murder (19-11-91) of William Dutfield at [REDACTED] Spit Road, Mosman. Fingerprint

Case N-166513, 19 August 1998 (SCOI.10283.00073).

¹³ Robbery with Striking (16-10-91) and Murder (19-11-91) of William Dutfield at [REDACTED] Spit Road, Mosman. Fingerprint

Case N-166513, 19 August 1998 (SCOI.10283.00073).

74. It is accepted that early on in the investigation the Officer in Charge appears to have discounted the possibility that Mr Arthur Ashworth, a friend of Mr Dutfield's who had spent time with him on the evening of his death, had anything to do with the murder on account of Mr Ashworth's age (Mr Ashworth was 77 years old at the time of Mr Dutfield's death).¹⁴ Rather, the officer in charge considered the most likely suspect was a male sex-worker, or someone pretending to be a male sex-worker, in order to again rob Mr Dutfield. This theory was thought to be consistent with the fact that Mr Dutfield had "picked up" the perpetrator of the robbery while out five weeks earlier,¹⁵ and a report by Mr Ashworth that Mr Dutfield had approximately \$150 in his wallet the night of his death that could not be found.¹⁶ It is submitted that while Mr Ashworth should not have been excluded from suspicion at this stage, it was not unreasonable for the Officer in Charge's primary focus to be on the perpetrator of the earlier robbery (noting the prints on the cigarette packet had been found not to belong to Mr Ashworth).
75. At inquest in December 1994, the Coroner found that Mr Dutfield died of head injuries "inflicted on him by a person or persons unknown".¹⁷

Subsequent investigations

76. In 1998, subsequent investigations positively excluded the possibility that the perpetrator of the earlier robbery was the person responsible for the murder. The prints from the cigarette packet were run again (at that time it was thought the Dutfield murder was related to another matter), and returned a positive match for a [REDACTED] NP63.¹⁸ However, [REDACTED] NP63 was in custody at the time of Mr Dutfield's death.¹⁹
77. In 2005, the matter was reviewed by the Unsolved Homicide Team and a number of recommendations were made, including for the DNA testing of a blood-stained tissue found in the waste paper bin and cigarette butts from an ashtray, and obtaining a DNA sample from Mr Ashworth.²⁰ Despite receiving the exhibits on 24 March 2005, a report noting a full DNA profile had been obtained from the blood-stained tissue was not provided

¹⁴ Investigator's Note – Dennis O'Toole (OIC from 1991) dated 22 September 2010 (SCOI.10068.00036).

¹⁵ Robbery with Striking (16-10-91) and Murder (19-11-91) of William Dutfield at [REDACTED] Spit Road, Mosman. Fingerprint

Case N-166513, 19 August 1998 (SCOI.10283.00073).

¹⁶ Statement of Arthur Ashworth, 20 November 1991 at [8] (SCOI.00027.00044).

¹⁷ Coronial Findings of Deputy State Coroner Abernethy, 12 December 1994 (SCOI.00027.00001).

¹⁸ Robbery with Striking (16-10-91) and Murder (19-11-91) of William Dutfield at [REDACTED] Spit Road, Mosman. Fingerprint Case N-166513, 19 August 1998 (SCOI.10283.00073).

¹⁹ Strike Force Hamish Terms of Reference, 7 October 2008 at p. 5 (SCOI.10066.00019).

²⁰ Review of an Unsolved Homicide Case Screening Form, 2 May 2005 at p. 16 (SCOI.10286.0008).

by Division of Analytical Laboratories (“DAL”) until 8 February 2007,²¹ by which time Mr Ashworth had passed away.

78. Counsel assisting is critical of police for not obtaining a DNA sample from Mr Ashworth “as soon as technical capacity allowed this to occur” (CA, [38]) and for the delay in obtaining a sample from Mr Ashworth following the recommendations of the Unsolved Homicide Team in 2005 (CA, [56]-[57] and [84]-[85]). It is accepted that a DNA sample should have been obtained at an earlier date. However, the following observations should be made in this regard:

- a) DNA testing was unlikely to have been available to investigators for a number of years following Mr Dutfield's death.
- b) Significant developments in relation to forensic testing capabilities occur frequently. It is unrealistic to expect that all unsolved cases are able to be assessed and reinvestigated on an ongoing basis following each and every development of this type. It is, however, acknowledged that there were features of this case that should have resulted in it being prioritised for earlier reinvestigation.
- c) The Unsolved Homicide Team (**UHT**) was not established until 2004 and did not have a *reinvestigation* capability until 2008 (as distinct from a “review” capacity, which it possessed from the outset). Unfortunately, the NSWPF's approach to “cold cases” was less systematic before the inauguration of the UHT.
- d) In making their recommendations in 2005, the UHT reviewer noted that the cigarette butts and blood-stained tissues, were already “at DAL and Virginia FREEDMAN is in the process of examining them”. It is not known why a report from DAL was then not prepared and provided to police until 8 February 2007. DAL (as it then was) falls within the NSW Department of Health; it was independent of NSW Police. There is no evidence before the Inquiry as to the DAL's workload, resourcing or processes, including, for example, in relation to the priority that would have been afforded to unsolved homicide cases (as distinct from cases, for instance, involving an accused person on remand awaiting an upcoming trial).
- e) The importance of obtaining a DNA sample from Mr Ashworth for comparison was not fully known until the DAL report which confirmed a full DNA profile had been

²¹ Certificate of Analysis by Virginia Friedman, 1 February 2007 (SCOI.10065.00046).

able to be obtained. Even had a DNA sample from Mr Ashworth been sought immediately upon receipt of that report, it would have been too late; Mr Ashworth passed away in July 2006.

79. In July 2008 - shortly after the UHT was vested with a reinvestigation capability – a recommendation was made for the establishment of a strike force to conduct further investigations into the Dutfield matter, including the possibility of obtaining a DNA sample from material that had belonged to Mr Ashworth.²² Strike Force Hamish was formed, and conducted significant further investigations into the matter which cast strong suspicion on Mr Ashworth as being responsible for Mr Dutfield's murder, as set out in counsel assisting's submissions (CA, [77]-[80], [85], [87] and [91]). In the Post Operational Assessment for Strike Force Hamish, it was recorded that investigators had formed the view that there was "sufficient evidence to arrest this person [Mr Ashworth]" had he been alive.²³

Anti-LGBTIQ bias and Strike Force Parrabell

80. It is accepted that the BCIF for the Dutfield matter prepared in the course of SF Parrabell fails to record the key findings of SF Hamish,²⁴ and that the case summary may cause confusion in that it refers to both the earlier theory in relation to the perpetrator of the initial robbery of Mr Dutfield, and the strong suspicions surrounding Mr Ashworth (CA, [20] and [26]).²⁵
81. SF Parrabell concluded that the matter fell into the "insufficient information category". That conclusion was understandable in light of the little that is known about the circumstances surrounding the attack on Mr Dutfield and the contemporaneous factors that may have precipitated it. It was appropriate, in the absence of a criminal proceeding against Mr Ashworth, for a cautious approach to the categorisation of the death to be adopted by SF Parrabell. As noted by Counsel Assisting (CA, [97]), if the offence had been a robbery perpetrated by someone who perceived Mr Dutfield to be vulnerable, LGBTIQ bias might properly have been considered to play a role (depending, of course, on what was otherwise known about the circumstances of the robbery and the motivations of the offender).

²² Recommendation for further investigation: historical unsolved homicide case, 14 August 2007 (SCOI.10286.0004).

²³ Strike Force Hamish Post-Operational Assessment, 2 October 2013 at p. 10 (SCOI.02712).

²⁴ Strike Force Parrabell Bias Crimes Indicators Review Form – William Dutfield (undated), p. 19 (NPL.0115.0002.2149).

²⁵ Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – William Dutfield, p. 25 (SCOI.76961.00014).

82. If, however, the Inquiry concludes that Mr Ashworth was likely responsible for the death, it is probable that the offending was precipitated by personal grievances rather than LGBTIQ bias. With that in mind, the Commissioner of Police does not seek to contest the conclusion as to LGBTIQ bias urged by Counsel Assisting (at CA [98]).
83. Ultimately, this matter provides a further example of the SF Parrabell reviewers' cautious approach to ruling out LGBTIQ bias. While a finding that the death was not motivated by LGBTIQ bias was no doubt open to them, the SF Parrabell reviewers elected to place the matter in the "insufficient information" category.

Findings and recommendations

84. The Inquiry's investigation of the Dutfield matter comprised a review of all of the available material, including the detailed investigations conducted in the context of Strike Force Hamish. Noting the same conclusion was reached by investigators following that strike force, the Commissioner of Police does not disagree that there is strong evidence to suggest Mr Ashworth was responsible for Mr Dutfield's death.
85. However, it is worth observing that it appears in 2013 at the conclusion of SF Hamish that the Coroner concurred with the view that:²⁶

a further inquest would not be warranted as there must be sufficient clear and cogent evidence that Arthur ASHWORTH was the only person who could be responsible. Arthur ASHWORTH can not defend himself or answer any of the unanswered questions. Therefore the Coroner would be in the same position that he was in in 1994 and would have to hand down the same finding.

86. There is a real question as to whether it would be appropriate for the Inquiry to publish a positive finding of Mr Ashworth's guilt; there has not been any criminal trial, any civil trial as to liability, or the hearing or testing of any evidence (as opposed to a documentary review). Mr Ashworth is not in a position to defend himself. As observed by Megarry J in *John v Rees*:²⁷

[a]s everybody who has anything to do with the law well knows, the path of the law is strewn with examples of open and shut cases which, somehow, were not; of

²⁶ Strike Force Hamish Post-Operational Assessment, 2 October 2013 at p. 10 (SCOI.02712).

²⁷ *John v Rees* [1970] Ch 345, 402, cited in *Re Refugee Tribunal; Ex parte Ala* (2000) 204 CLR 82 at [81] per Gaudron and Gummow J.

unanswerable charges which, in the event, were completely answered; of inexplicable conduct which was fully explained; of fixed and unalterable determinations that by discussion suffered a change.

87. Were Mr Ashworth alive, the making of such a finding would be in breach of the principles of natural justice in the absence of appropriate notice of the intended adverse findings and the provision of an appropriate opportunity to respond.²⁸ Personal reputation has been established as an interest which should not be damaged by an official finding after a statutory inquiry unless the person whose reputation is likely to be affected has had a full and fair opportunity to show why the finding should not be made.²⁹
88. The High Court has extended the application of this principle to the protection of the reputation of a deceased person in some circumstances.³⁰ For example, where the family of a deceased has been granted leave to appear at an inquest in which a coroner proposes to make a finding adverse to the deceased's reputation: the familial relationship suffices to establish the deceased's reputation as a relevant interest which should not be adversely affected without according natural justice to those who are seeking to safeguard that reputation.³¹
89. These considerations are complex. The Commissioner of Police has no knowledge of, for example, any discussions that may have occurred as between the Inquiry and Mr Ashworth's family to this point.
90. In those circumstances, the Commissioner of Police simply raises these matters for the Inquiry's consideration, and does not seek to be heard further as to whether the Inquiry should, or should not, publish a finding that Mr Ashworth was responsible for Mr Dutfield's death.

David Lloyd-Williams

Circumstances of death

91. David Lloyd-Williams died on the morning of 24 August 1978. His body was found at the bottom of a cliff at North Head, near Manly. In an inquest held in October 1978, the Coroner

²⁸ *The Honourable Thomas Peter Thomas Mahon v Air New Zealand* [1983] UKPC 29; accepted in *Applicant NAFF of 2002 v Minister for Immigration and Multicultural and Indigenous Affairs* [2004] HCA 62 at [64].

²⁹ *Annetts v McCann* (1990) 170 CLR 596 at [11] per Brennan J.

³⁰ *Ibid.*, [16].

³¹ *Ibid.*

found that Mr Lloyd-Williams “died from multiple injuries received when he cast himself from a cliff with the intention of taking his own life whilst in a state of mental depression.”³²

Initial police investigations

92. It is accepted that the investigation file containing the details of initial police investigations into Mr Lloyd-Williams’ death cannot be found and is likely lost.³³ This is regrettable.
93. While it is not possible to offer a definitive “explanation” (CA, [28]) as to what might have happened to the file, its absence likely serves to highlight deficiencies in record keeping and archiving of such files at the time. It must be borne squarely in mind that Mr Lloyd-Williams’ death occurred in 1978: there is little to be gained now from criticising the record keeping practices of NSWPF 44 years ago or by comparing those practices to those employed more recently following the enormous advances in computer systems, digitisation and, in turn, archiving of information, in the intervening period.
94. In the absence of the file, it is not possible to confirm whether any other inquiries not referenced in the Coroner’s Court holdings were undertaken (CA, [11]-[12], [35]).

Strike Force Parrabell

95. It is unsurprising that SF Parrabell was also unable to locate the original investigation file, which in all likelihood had already been lost at the time of review in 2016-2017.³⁴
96. Police’s request to the NSW Registry of Births, Deaths and Marriages (**RBDM**) during SF Parrabell was unsuccessful, while the Inquiry’s recent summons in respect of this matter produced a positive match and Mr Lloyd-Williams’ death certificate.³⁵ This is likely due to the additional information provided by the Inquiry to RBDM as to Mr Lloyd-Williams’ wife’s name and his place of birth.³⁶ This information was provided to the Inquiry by Dr Neil McEwan, who was referred to the Inquiry by The Honourable Justice David Davies, a Justice of the Supreme Court of New South Wales (CA, [23] and [30]). This information

³² Inquest before Coroner sitting alone, 23 October 1978 (SCOI.73571.0004).

³³ That the file is lost is even more likely when it is considered further searches were undertaken following the provision of further information by the Inquiry to the NSWPF as to Mr Lloyd-Williams’ surname and date of death and these further searches were also unsuccessful.

³⁴ Bias Crimes Indicators Review Form – David Williams dated 9 March 2017 (SCOI.82180).

³⁵ Death certificate of David Lloyd-Williams dated 9 November 1978 (SCOI.74028).

³⁶ While the summons to Births, Deaths and Marriages was not tendered, counsel assisting asserts this information was included in that summons at [23] of their submissions.

was not available to SF Parrabell. In any event, investigations such as interviews with friends or witnesses were clearly beyond its terms of reference.

97. The uncertainty as to Mr Lloyd-Williams' surname and date of death at the time of SF Parrabell would no doubt have impacted Police's ability to obtain the relevant files held by the Coroners Court.
98. In the absence of either the Police or Coroner's files, it is unsurprising that the matter was categorised as "insufficient information" and "unsolved" by Strike Force Parrabell.³⁷

Anti-LGBTIQ bias

99. The Inquiry has obtained a number of records relating to Mr Lloyd-Williams' death via summons, and has conducted further investigations such as interviews with friends and the commission of an expert report.
100. As noted above, SF Parrabell investigators did not have the ability to compel the production of such information. Nor did its terms of reference extend to the conduct of further investigative steps such as those undertaken by the Inquiry.
101. The Commissioner of Police has reviewed the material now available in the Lloyd-Williams matter and agrees with the conclusion of counsel assisting that, in light of the significant evidence of Mr Lloyd-Williams severely depressed state, particularly the evidence of his psychiatrist in the week preceding his death,³⁸ his death was a suicide. It was therefore not motivated by LGBTIQ hate bias.

Findings and recommendations

102. The Commissioner of Police agrees that the finding proposed by counsel assisting (CA, [70]) is appropriate:

that Mr Lloyd-Williams died on 24 August 1978 of multiple injuries after deliberately jumping from a cliff at North Head in Manly. At the time of his death, Mr Lloyd-Williams was suffering from severe depression.

³⁷ Bias Crimes Indicators Review Form – David Williams dated 9 March 2017 (SCOI.82180).

³⁸ Report of Dr J E Hault, 29 August 1978 (SCOI.73571.00016).

Andrew Currie

Circumstances of death

103. As submitted by Counsel Assisting (CA, [3]), sometime on 12 or 13 December 1988, Andrew Currie died of an apparent drug overdose, which caused respiratory and central nervous system depression and, in turn, his death. His body was found at a toilet block in Nolan Reserve in North Manly.
104. There are no persons of interest in connection with Mr Currie's death (CA, [6]). Consistent with this, the Coroner dispensed with an inquest into his death after receiving the autopsy and toxicology reports in February 1989 (CA, [12]).
105. Otherwise, Counsel Assisting provides a detailed and accurate summary of what was known about the circumstances concerning Mr Currie's death in 1988, and the expert evidence obtained more recently by the Inquiry.

Initial police investigations

106. Counsel Assisting expresses concerns about the speed at which a conclusion that Mr Currie's death was an accidental overdose was reached, the absence of statements from family members, and the fact that there is no evidence regarding the consideration of possible alternative causes of death or the fact that the relevant location may have been used at times as a beat (CA, [13]).
107. The officers who attended the scene have not been called to give evidence. This is, of course, unsurprising given that the death occurred 35 years ago. However, in the absence of such evidence, and a comprehensive understanding of police practices of the time, it would be inappropriate to direct criticism at them. The fact that the Coroner determined that an Inquest was not necessary is a strong indication that the circumstances of the death appeared relatively clear cut. In those circumstances, the officers involved may well have concluded that it was not necessary to subject the relevant family members to the potential trauma or discomfort of police interviews. Indeed, Mr Currie was known to police as a person who overdosed on drugs on a regular basis,³⁹ and the circumstances of his death were plainly consistent with the previous experience of police in that respect.

³⁹ See Fact Sheet dated 14 October 1988 (SCOI.00016.00022).

108. The suggestion that police should have been somehow alive to the *possibility* that the relevant toilet *may* have been a beat in the context of Mr Currie's death is surprising. There is no evidence that the location was, in fact, a beat – let alone evidence that police were, or should have been, aware of such a fact. Care should be taken to avoid viewing police actions in connection with an apparent drug overdose in 1988 through the lens of an Inquiry, conducted in 2023, specifically charged with addressing the question of whether particular deaths were LGBTIQ-bias related.
109. Similarly, there is a lengthy consideration in Counsel Assisting's submissions of an apparent discrepancy between a reference in an Investigator's Note to "15 colour crime scene photographs" and the seven photographs in fact produced (CA, [31] – [37]). The available information suggests that the reference to 15 photographs in the Investigator's Note (and, in turn, the BCIF) was erroneous (CA, [37]). While the Inquiry's endeavours to ensure the record is complete are commendable, the implicit criticism as to the documentary error is somewhat difficult to understand; typographical errors of that type occur every day in every organisation. That time and attention of those involved in the Inquiry was necessary to resolve the error was no doubt a source of some frustration, but it is submitted that the Inquiry should take care not to direct undue criticism on the basis of typographical errors. Again, the relevant documents were not intended for public consumption; no doubt the documents were not reviewed with the level of scrutiny that may have been applied had they been prepared with such a purpose in mind.
110. Additionally, concerns are expressed in relation to the absence of statements from some officers who attended the scene (CA, [38], [45]). Again, in the absence of evidence from *any* of the relevant officers, it would not be fair for criticism to be levelled on this basis. In any event, there is nothing to indicate – having regard to the circumstances of the case and the fact that an Inquest was dispensed with – that formal statements should have been prepared. There is little doubt additional statements would have been prepared had the matter proceeded either to an Inquest or criminal proceedings of some kind.

Anti-LGBTIQ bias

111. There is no information to suggest that Mr Currie was a member of the LGBTIQ community and there is no evidence that the public toilet in which Mr Currie's body was found functioned as a beat (CA, [7]).

112. SF Parrabell was a paper review. Even so, it was tremendously resource-intensive. Counsel Assisting appears to suggest (CA, [16]) that members of SF Parrabell should have approached members of Mr Currie's family, 30 years after the fact, to inquire into his sexuality. Having regard to the clear circumstances of his death, and the nature of the task being undertaken, that suggestion is, once again, surprising. Investigations of that type would no doubt have very substantially increased the time and resources required to complete the SF Parrabell exercise. Moreover, Counsel Assisting's submission overlooks the impact that such an approach might have had on the emotional well-being of the relevant family members.
113. Elsewhere, Counsel Assisting intimates that part of Section 4 of the BCIF was completed incorrectly because gay men were, on occasion, targeted for the purpose of robbery, by youths in certain parts of the Northern Beaches in the late 1980s (CA, [18]).
114. There is evidence to support the general observation that such attacks occurred. However, there is a difference between a conclusion that groups of youths sometimes targeted gay men for the purposes of robbery in the general area of the Northern Beaches or Manly, and one that "Organised Hate Groups" were operative in the area; the relevant groups of youths could not sensibly be characterised as an "Organised Hate Group". Similarly, there is no evidence that "Organised Hate Groups" were known to be active at the location where Mr Currie died; again, there is no evidence that the relevant public toilet functioned as a beat.
115. In any event, Counsel Assisting accepts SF Parrabell's conclusion that there was no evidence of a bias crime (CA, [86]).

Findings and recommendations

116. It is submitted that the Inquiry should accept Counsel Assisting's proposals as to the appropriate findings as to manner and cause of death (CA, [87] – [88]). Again, those proposals align with the conclusions reached by SF Parrabell.

Brian Walker

Circumstances of death

117. It is uncontroversial that Mr Brian Walker died on 23 July 1992 after sustaining an upper cervical injury (torn spinal ligament), with traumatic (crush) asphyxia and a head injury

contributing to his death.⁴⁰ Mr Walker's fatal injuries were caused during the course of an altercation with Mr John Hokin in the backyard of Mr Hokin's residence. Mr Hokin turned himself in to Police immediately following the incident, admitting "I put both my arms around his chest and I hung on and hung on and hung on... he lost a lot of strength rather quickly and it seemed that I asphyxiated him with my – with my chest."⁴¹

118. The only area of uncertainty as to the circumstances of Mr Walker's death was Mr Hokin's motive for his actions. In particular, Mr Hokin alleged that Mr Walker had started talking "about sexual behaviour that I didn't prefer and he touched me a few times on the leg and on the shoulder", that Mr Hokin had suggested he head home because he was quite drunk, and that Mr Walker then swung a shovel at Mr Hokin.⁴²

Initial police investigations

119. Counsel assisting submits that whether Mr Walker made a "homosexual advance" was not thoroughly investigated by Police because statements were not obtained from friends and family members who may have been able to shed light on Mr Walker's sexuality (CA, [49] and [63]).
120. It is accepted that a statement from Mr Kevin Leatham, a close friend of Mr Walker's and the person about whom Mr Hokin reported Mr Walker wanted to speak with him on the evening of his death,⁴³ should have been obtained during the course of the initial Police investigations. In particular, such evidence may have provided further background to the relationship between Mr Hokin and Mr Walker.
121. However, it is submitted that it was not unreasonable for the focus of Police investigations, at least in the first instance, to be on a situation involving possible self-defence for the following reasons:
- a) Mr Hokin himself contended his actions were directly as a result of Mr Walker swinging the shovel at him and not due to the earlier alleged sexual advance: "If he hadn't have swung a shovel at me I- I- I'd be home asleep."⁴⁴

⁴⁰ Post-Mortem Report of Dr Peter Ellis dated 8 September 1992, p. 1 (SCOI.11163.00048_0001).

⁴¹ ERISP Transcript of John Hokin dated 23 July 1992, at [A15] (SCOI.11163.00032).

⁴² ERISP Transcript of John Hokin dated 23 July 1992, at [A15] (SCOI.11163.00032).

⁴³ ERISP Transcript of John Hokin dated 23 July 1992, at [A15] (SCOI.11163.00032).

⁴⁴ ERISP Transcript of John Hokin dated 23 July 1992, at [A67] (SCOI.11163.00032).

- b) The physical evidence was consistent with a version of events in which Mr Hokin was acting in self-defence, including the location of a shovel near the body,⁴⁵ the presence of broken glass at the scene,⁴⁶ and cuts and lacerations to Mr Hokin's torso.⁴⁷
- c) There was considerable ambiguity in the evidence from the only independent witness (neighbour Julieann Donnelly) as to the conversation that took place between Mr Hokin and Mr Walker. On one view, her account was not necessarily supportive of the allegation of a sexual advance having been made by Mr Walker, and was consistent with other possibilities. Ms Donnelly's evidence that she heard someone yell "get off me you fucking cunt. Clear off. Get out of here" and that it sounded like someone was sitting on the person speaking, may have suggested that at that point Mr Hokin was the one being pinned down and asking Mr Walker to leave. As a matter of logic it makes more sense for Mr Hokin to have been telling Mr Walker to leave (and therefore being the one initially pinned down) than Mr Walker telling Mr Hokin to "get out of" his own residence.
122. Finally, it is observed that, at best, statements of family members and friends would have provided circumstantial evidence of limited relevance and weight: in the early 1990s many people identifying as members of the LGBTIQ community may not have been open about their sexuality with family and friends. Accordingly, evidence they provided as to Mr Walker's sexuality may not have been accurate. In any event, what was of significance was *Mr Hokin's* perception of Mr Walker and the motivation for his actions: accurately or not, it is not in dispute that Mr Hokin perceived Mr Walker to be gay. In those circumstances, evidence showing that Mr Walker was gay (in the event such evidence was obtained) may not have meaningfully assisted in determining the true motivation for Mr Hokin's actions.

Anti-LGBTIQ bias

123. Counsel assisting is also critical of SF Parrabell's observation in the BCIF for the Walker matter that Mr Hokin's neighbours did not report any statement or gesture they observed

⁴⁵ Statement of Constable Aaron Nash, 15 October 1992, at [6](SCOI.11163.00051); Statement of Detective Senior Constable Mark Sweeney, 30 September 1992, at [8](SCOI.11163.00041).

⁴⁶ Statement of Detective Senior Constable Mark Sweeney, 30 September 1992, at [7](SCOI.11163.00041).

⁴⁷ Statement of Constable Terry Pledge, 24 July 1992, at [4] (SCOI.11163.00033).

or perceived to be bias, or express any view that they believed the murder to be motivated by bias (CA, [53]).

124. It is accepted that the observations of Mr and Mrs Donnelly are limited. However, the finding urged by Counsel Assisting that Mr and Mrs Donnelly “could not have seen whether Mr Walker made the alleged gestures toward Mr Hokin (touching his leg etc)” and that “their observations of the altercation between the two men are limited to what they heard from inside their own home” is at odds with at least some of the evidence. In particular, it does not align with the evidence of Mr Craig Donnelly, who states that at one point he “opened the window about 10cm’s, I could see into John’s backyard and I could see him sitting on a chair.”⁴⁸
125. Counsel Assisting also references (CA, [47]) an academic article by Professor Stephen Tomsen, criminologist, entitled “Hatred, Murder and Male Honour: Anti-homosexual Homicides in New South Wales, 1980-2000” in apparent support of the proposition that the case was an example of the “male honour scenario” – that is, Mr Hokin’s reaction to an advance by Mr Walker was due to “Masculine heterosexual identity... built around ensuring the sanctity of the body, with rigid limits imposed on the circumstances and social admitted forms of male physical contact.”⁴⁹
126. It is submitted that no weight can be accorded to these views. Professor Tomsen’s article was not tendered and he has not provided evidence before the Inquiry, such that his opinion has not been tested. In any event, Professor Tomen’s view appears to be speculative at best; it is not clear how the opinion is founded on Professor Tomsen’s expertise in a way that would render it admissible in Court. Furthermore, the documents and information on which Professor Tomsen relied in order to form his opinion are not disclosed and it is therefore not possible to assess the factual basis on which he proceeded. In particular, it is unclear whether Professor Tomsen was aware of Mr Hokin’s psychiatric background, and whether this would have impacted his views on the applicability or otherwise of the “male honour scenario”.

⁴⁸ Statement of Craig Donnelly, 24 July 1992 at [5] (SCOI.11162.00023).

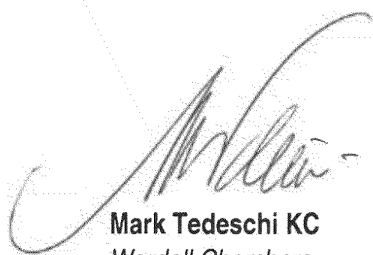
⁴⁹ “Hatred, Murder and Male Honour: Anti-homosexual Homicides in New South Wales, 1980-2000” by Professor Stephen Tomsen at pp. 77-78.

Findings and recommendations


127. Ultimately counsel assisting agrees with the conclusions of Strike Force Parrabell,⁵⁰ that Mr Walker's death is unlikely to have been the result of an LGBTIQ hate crime (CA, [69]).
128. This is consistent with the evidence obtained in the initial Police investigations, and the view of the Office of the Director of Public Prosecutions that the fact Mr Hokin was motivated by self-defence could not be disproved.⁵¹
129. As noted by counsel assisting (CA, [72]), the death of Mr Walker is not "unsolved" and does not fall within category A of the Inquiry's terms of reference.
130. It is submitted that the submissions of Counsel Assisting as to the manner and cause of Mr Walker's death and the question of LGBTIQ bias should be adopted by the Inquiry.

Conclusion


131. As is apparent from the foregoing, the Commissioner of Police accepts the submissions made by Counsel Assisting as to the manner and cause of each of the deaths and, in particular, the question of whether those deaths were motivated by anti-LGBTIQ bias.
132. Further submissions will be made as to the general issues pertaining to the activities of Strike Force Parrabell in due course.



Mark Tedeschi KC
Wardell Chambers



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Maurice Byers Chambers



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21 February 2023

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⁵⁰ Strike Force Parrabell Bias Crimes Indicators Review Form – Brian Walker (undated) at p. 15 – "No evidence of bias crime"(SCOI.82185).

⁵¹ Letter from Office of the Director of Public Prosecutions to the Inquiry dated 24 January 2023.