The Special Commission of Inquiry
into LGBTIQ Hate Crimes

TENDER BUNDLE HEARING OF 29 AND 30 MARCH 2023

Concerning the deaths of Gerald Cuthbert, Samantha Raye, Mark Stewart and Carl Stockton

Submissions on behalf of the Commissioner of Police

Contents

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 29 and 30 March 2023 in relation to the deaths of Gerald Cuthbert, Samantha Raye, Mark Stewart and Carl Stockton.

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 and the other "tender bundle" cases.

Gerald Cuthbert

Circumstances of death

3. Mr Cuthbert was killed in a brutal manner; he was stabbed 62 times and his throat was cut. Perhaps surprisingly given the apparently frenzied nature of the attack, there were no defensive wounds.

4. The identity of Mr Cuthbert's killer has not been uncovered.

Initial police investigations

5. A post-mortem examination was conducted on Mr Cuthbert's body on 18 October 1981, about 12 to 18 hours after his death.

6. Police collected a number of exhibits for forensic testing. Those exhibits included a handkerchief, anal swabs and smears, a blood-stained sock, and two cigarette butts.

7. It appears that all of these items were appropriately tested, having regard to the methodologies available at the time; semen was detected on the anal swabs and the handkerchief, while saliva was found on the cigarette butts.

8. As noted by Counsel Assisting (CA, [16] – [17]) the results suggest that the saliva and semen located on the cigarette butts and handkerchiefs originated from a person other than Mr Cuthbert.

9. Attempts to have these exhibits re-tested have been thwarted by fact that it has not been possible to locate them. The loss of the exhibits (or at least those that were not consumed in the testing process) is regrettable.

10. It is appropriate to note that it is not clear in the material where or when in the process the exhibits were lost. Some of the exhibits or extracts therefrom may have been lost in connection with the testing process. That process was run by the Division of Analytical Laboratories (**DAL**), which is an entity independent of the NSW Police; it fell within the purview of what was then the Health Commission of NSW Health. A statement of Michele Franco, an employee of the Forensic and Analytical Science Service (**FASS**) (the successor to DAL) makes a number of relevant observations in that respect:

a) FASS has not retained any of the exhibits for this matter or sub-samples from the exhibits.

b) Reference samples received in the laboratory prior to 1986 were not stored.[1]

c) Extracts from the samples were entirely consumed in testing as at the relevant time.[2]

d) No submitted reference samples or sample extracts were retained in this matter.[3]

11. It appears that the cigarette butts would likely have been consumed or destroyed in the course of the original testing.[4] Ms Franco's statement does not expressly deal with whether the anal swabs would have been consumed in the same way the cigarette butts were, though the indication that extracts from samples were entirely consumed, together with the observation as to the likely destruction of the cigarette butts, at least raises this possibility.

12. Irrespective of how and by whom the exhibits were lost, it is clear that processes for managing exhibits (both within the NSW Police and in the other relevant agencies) have changed dramatically in the intervening 40 years.

13. Setting aside the loss of the exhibits – which is undoubtedly lamentable – there is nothing to suggest that the initial police investigation was deficient. As submitted by Counsel Assisting, the original police investigation into possible persons of interest was thorough (CA, [88]). There is no suggestion that the Coroner who reviewed Mr Cuthbert's death considered that any further or additional investigations were warranted.[5]

Was the death LGBTIQ-hate motivated?

Motivations regarding death

14. Strike Force Parrabell (and the academic reviewers) determined that the matter fell in the "insufficient information" category.[6] Counsel Assisting's view aligns with this conclusion (CA, [104]).

---

[1] Expert Certificate of Michele Franco, 3 March 2023, p. 2 (SCOI.82542).
[2] Ibid.
[3] Ibid.
[4] Expert Certificate of Michele Franco, 3 March 2023, p. 2 (SCOI.82542).
[5] See Form 2, Inquest before Coroner sitting alone, Tab 5, SCOI.00019.00003.
[6] Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries – Gerald Leslie Cuthbert, p. 3 (SCOI.76961.00014).

15. As identified by Counsel Assisting, Mr Cuthbert had previously been in a long-term committed relationship with a male partner.

16. In addition to the bare facts relating to Mr Cuthbert's sexuality, Counsel Assisting identifies three features of the case that are said to indicate a "real possibility" that Mr Cuthbert was killed in the context of LGBTIQ bias (CA, [13]). Those features are given as follows:

    a) the nature and extent of Mr Cuthbert's injuries significantly exceed what is necessary to kill a person, and are consistent with a frenzied or panicked attack;

    b) the evidence, including evidence suggesting receptive anal sexual intercourse with a male partner shortly before his death, suggests that Mr Cuthbert was likely killed by a person he took back to the apartment for the purpose of sex;

    c) the absence of evidence suggesting another motive for the crime (CA, [13]).

17. The Commissioner of Police agrees with the Counsel Assisting's submission that some form of LGBTIQ bias *may* have played a role in Mr Cuthbert's death.

18. In particular, the extreme violence involved in the attack suggests that the killer may have been driven by a deep-seated hatred or animosity. In turn, that hatred or animosity might have been propelled by intense homophobia. Unfortunately, however, in the absence of other indicators, such analysis is highly speculative.[7]

19. While it appears that robbery was not a likely motive for the killing, the extreme violence might be similarly consistent with a number of other possibilities (each of which is equally speculative). For example, and without being exhaustive:

    a) the killer could have been motivated by some kind of personal animosity towards Mr Cuthbert;

    b) the killer might have been suffering from a Schizophrenia Spectrum disorder associated with delusions and/or hallucinations that drove them to act as they did; and/or

[7] See, as to the speculative nature of such theorisations, the expert report of Dr Danny Sullivan, 24 October 2022 at [13], [15] (SCOI.82583).

c) the killer might have been driven by a Paraphilic Disorder, in particular Sexual Sadism Disorder or some form of other psychopathology that led them to derive pleasure from the extreme violence inflicted upon Mr Cuthbert.

20. Of course, the presence of one of those alternative motivations would not necessarily exclude the involvement of LGBTIQ bias; a person could, for instance, simultaneously be motivated by personal animosity and by homophobia.

21. Moving on from a consideration of the extreme level of violence, the second and third "indicators" of a possible LGBTIQ bias crime do not meaningfully advance the position.

22. The evidence of receptive anal intercourse, together with the absence of any sign of forced entry to the apartment, gives rise to a strong possibility that Mr Cuthbert had sex with his killer shortly prior to his death. In this respect, Dr Sullivan refers to a possibility that "the unknown protagonist was conflicted about their sexual orientation".[8] Dr Sullivan acknowledges that this hypothetical is "speculative"; it appears to be premised on nothing beyond the fact of recent sexual intercourse and the extent of violence.[9]

23. It is appropriate to note that there is no prospect that such speculation would be admitted in evidence in criminal proceedings. In any event, while the fact of sexual intercourse between Mr Cuthbert and his killer gives rise to a notional possibility of violence driven by sexuality-related inner conflict, the fact of intercourse would not exclude motivations associated with personal animosity, psychiatric problems, or sexual sadism. The evidence regarding sexual relations, for example, might be taken to support a hypothesis of sexual sadism insofar as it evidences a temporal connection between the violence and sexual conduct. Further or alternatively, the evidence of intercourse gives rise to the possibility of a personal connection between Mr Cuthbert and his killer.

24. Again, these possibilities are premised on a substantial degree of speculation. Having regard to the paucity of evidence regarding motivation, it is not possible to advance one possibility in preference to another. Accordingly, the conclusion that there is insufficient information to determine whether or not bias was present was (and remains) appropriate.

[8] Ibid, [13].
[9] Ibid.

Use of the Bias Crimes Indicator Form

25. Counsel Assisting suggests that the use of the indicator in the BCIF labelled "Victim was engaged in activities promoting his/her group" was unclear. As noted by Counsel Assisting, the response in the BCIF commences with the observation: "There is no evidence to suggest that CUTHBERT was engaged in activities promoting homosexuality at the time of his death" (CA, [30]). Unless a strained construction is applied to broaden the ordinary meaning of the term "promote", neither the prompt nor the aforementioned conclusion of the reviewer in respect of the prompt are unclear. Consistent with the reviewer's observation, the evidence does not suggest that Mr Cuthbert was engaging in activities promoting homosexuality when he died.

Findings and recommendations

26. Counsel Assisting refers to the possibility that the Inquiry might, in due course, consider "global recommendations in relation to the retention, preservation and storage of exhibits" (CA, [106]).

27. The exhibit management systems of police and other agencies who are charged with the management of exhibits (e.g. FASS, the Coroners Court, Forensic Medicine) have been subject to substantial changes over time.

28. This Inquiry has not been charged with the conduct of a comprehensive review of the various agencies' systems in relation to the management of exhibits and the way those systems interact. With the exception of the NSW Police, none of the relevant agencies has appeared before the Inquiry.

29. In those circumstances, and in the absence of further detail, the Commissioner of Police reserves her position in respect of any such potential recommendations.

Samantha Raye

Circumstances of death

30. Samantha Raye's body was found in a cave below Hornby Lighthouse, South Head, at around 9.30am on 20 March 1989.

31. Counsel Assisting's submissions provide a detailed and accurate summary of the evidence as to the circumstances surrounding Ms Raye's death. The Commissioner of Police agrees with Counsel Assisting's observation that the question of whether Ms Raye's death was

the result of suicide "cannot be definitively proved or disproved" (CA, [126]); the available medical evidence creates a degree of ambiguity as to the cause of Ms Raye's death.

32. That, however, is not the end of the matter. Having regard to the evidence as a whole, and in particular the very strong circumstantial indications in support of a finding of suicide, it would be comfortably open to the Inquiry to conclude, *on the balance of probabilities*, that Ms Raye administered insulin with a view to causing her own death. In that respect:

a) Ms Raye was subject to an array of abuse and discrimination across her life. That abuse and discrimination understandably took an enormous toll on her psychological wellbeing.

b) Consistent with this, Ms Raye had a history of severe depression and suicidal ideation. That history extended to possible suicide attempts.[10] The evidence of her treating doctors is consistent with suicide:

(i) Dr Helen Borman, a psychiatrist who was treating Ms Raye for severe depression[11], noted that in the weeks prior to her death, Ms Raye spoke openly of suicide, saying "I'll have to suicide if things don't get better".[12] Ms Raye refused medication for depression. Ultimately, Dr Borman opined "I have no doubt that Samantha RAYE would have taken her own life. She spoke of Suicide to me often and was in the correct frame of mind to take her own life".[13]

(ii) Dr Peter Steinheuer, a general practitioner who saw Ms Raye approximately once a week in the lead up to her death, noted that she "was capable of taking her own life but I would have expected her to give some fore warning as to her intentions. She was the type of personality who would dramatize her suicide by leaving notes or suicide letters".[14]

(iii) Dr Edward Grieve, another general practitioner who treated Ms Raye about two or three times a month from June 1986 onwards, noted that Ms Raye was "very unstable psychologically" and indicated that he had "no doubt that

[10] See statement of Dr Edward Grieve, dated 3 May 1989, [3] (SCOI.11038.00025); Statement of Wayne Hurrell, [7].
[11] Statement of Dr Helen Borman, dated 12 April 1989, [4], (SCOI.11038.00034)
[12] Ibid, [7].
[13] Ibid, [9].
[14] Statement of Dr Peter Joseph Steinheuer, dated 14 April 1989, [9] (SCOI.11038.00035)

Samantha RAYE would take her own life" though, consistent with Dr Steinheuer's view, speculated that "she would make a show of the event".[15]

c) Ms Raye was subject to a number of significant stressors in the period leading up to her death, and there is evidence to suggest that her mental health suffered accordingly:

(i) She was the victim of aggressive and antisocial behaviour in the flats where she lived. In that respect, Dr Borman wrote to the Housing Commission to indicate "if she is not offered some accommodation in the very near future she is in more danger of committing suicide, or becoming the victim of violence."[16] She had not obtained such accommodation as at the time of her death.

(ii) She had multiple medical complications arising from the surgery she underwent in 1988.

(iii) Those who knew Ms Raye suggest that she became more depressed and withdrawn in the period leading up to her death.[17]

d) Alarmingly, research indicates that 45.6% of trans women will attempt to die by suicide during their lifetime.[18] The fact that trans people attempt suicide at an extremely high rate does not allow for a conclusion to be reached one way or the other in Ms Raye's case, but it is noteworthy in a contextual sense insofar as it speaks to the impact discrimination and abuse may have on a trans person's wellbeing.

e) Police found a note in Ms Raye's apartment that read "At lighthouse, will be back????".[19] That note is ambiguous, and does not adhere to conventional expectations of what might be found in a 'suicide note'. Nevertheless, the question marks certainly suggest that at the time Ms Raye wrote the note she at least countenanced the possibility that she would not return.

f) There is no indication that Ms Raye was assaulted or that another person was present at the time of her death.

---

[15] statement of Dr Edward Grieve, dated 3 May 1989, [4] (SCOI.11038.00025).
[16] Letter of Dr Helen Borman, 1 February 1989, SCOI.11038.00012.
[17] Statement of Wayne Hurrell, [7]; Statement of Cliff Connors, [8]-[9].
[18] Statement of Dr Eloise Brook, [101b].
[19] Statement of Constable William Wilcher dated 8 May 1989, [8] (SCOI.11038.00027).

g) A syringe and needle were found near Ms Raye's body, along with an empty box for an insulin product and a bottle containing a white substance.[20] Fluid in the syringe was later found to contain insulin. The white substance in the bottle was also found to contain insulin.

h) Several syringes were later found in Ms Raye's house, one of which was identical to the syringe found near her body. No insulin was found in her home.

i) Dr Steinheuer stated that "[t]here is no evidence of Samantha being diabetic or requiring Insulin of any type. It is inconceivable that Samantha would not have at some stage informed us of her diabetes or required treatment".[21] In that respect, Dr Steinheuer noted that Ms Raye "was somewhat of a hypochondriac and would certainly raise a problem like Diabetes if she had it."[22] Samantha did inform Dr Grieve that she was an insulin dependent diabetic, though tests he performed and inquiries he made with other doctors did not suggest any such condition.[23] There was nothing on any of Ms Raye's other medical records to indicate she was diabetic or otherwise required insulin.[24]

j) Dr Iles' opines that the development of bronchopneumonia in an otherwise healthy person suggests "a period of central nervous system depression/obtundation prior to death".[25] She goes on to observe that this central nervous system depression "may be due to intoxication with central nervous system depressing agents, or in this instance, could theoretically be consequent to insulin induced hypoglycaemia. There is however no way of confirming this mechanism based on the investigations undertaken".[26]

k) The Report of Professor John Carter, Consultant Endocrinologist, observes that "[e]stimations of insulin concentrations in unpreserved blood obtained post-mortem are unreliable in the determination of the cause of death... It is consequently impossible to determine whether the recorded insulin level of 21 micro units per ml contributed to her death either alone, in conjunction with the lung infection or in

---

[20] Statement of Constable William John Wilcherm, [4].
[21] Statement of Dr Peter Joseph Steinheuer, dated 14 April 1989, [5] (SCOI.11038.00035)
[22] Ibid, [6].
[23] Statement of Dr Edward Grieve, dated 3 May 1989, [3] (SCOI.11038.00025).
[24] Statement of Constable Patrick Duncombe, [10].
[25] Report of Dr Iles, p. 8.
[26] Report of Dr Isle, pp. 8 – 9.

conjunction with the meningoencephalitis." Ultimately, having regard to all the features of the case, Dr Carter observed: "All of the clinical and toxicological features found at post-mortem with Ms Raye are consistent with death secondary to an injection of a large dose of insulin. However, there are no features that unequivocally indicate that the cause of death was related to an insulin injection."[27]

l) Dr Iles expresses agreement with Professor Carter's analysis. She notes that in circumstances where Ms Raye was not diabetic and had not been prescribed insulin, the presence of "exogenous" insulin in blood is a "strong indicator that this has contributed to death".[28] However, the available *pathological* evidence would not allow a determination – one way or the other – as to whether the insulin in Ms Raye's blood was naturally occurring or the result of an injection. Accordingly, Dr Iles states that "The inference that Ms Raye may have died as a consequence of acute bronchopneumonia following hypogycemia due to the injection of exogenous insulin, can only be made on circumstantial rather than pathological evidence. There is circumstantial evidence in the form of the presence of insulin in containers located adjacent to Ms Raye's body. The strength and weighting given to that evidence is for others to determine."[29]

m) The bronchopneumonia exhibited in Ms Raye does not appear to be explained by any mechanism other than respiratory depression secondary to the administration of the insulin. Dr Steinheuer noted that Ms Raye "was in good physical condition"[30] while Dr Grieve noted that she had "mild asthma".[31] While necessarily somewhat speculative, the Inquiry might consider that if Ms Raye developed a breathing-related difficulty that was not connected with a deliberate act on her part, it is likely that she would have sought to move from the position where she was found in an effort to secure assistance.

33. Ms Raye's body was found in the presence of a syringe and a bottle containing insulin and the pathological findings made subsequent to her death were *consistent* with death secondary to the injection of insulin. She suffered very significant stressors, was severely depressed, and had repeatedly expressed suicidal ideation in the period leading up to her

[27] Report of Professor John Carter, p. 3.
[28] Report of Dr Isles, p. 9.
[29] Report of Dr Isles, pp. 9 – 10.
[30] statement of Dr Peter Joseph Steinheuer, dated 14 April 1989, [6] (SCOI.11038.00035)
[31] Statement of Dr Edward Grieve, dated 3 May 1989, [3] (SCOI.11038.00025).

death. She left a note that, while ambiguous, implied that she may not return from her venture to the lighthouse.

34. All told, the possibility that Ms Raye deliberately administered insulin in in order to end her life provides a logical explanation for her death that is wholly consistent with the circumstantial and medical evidence. No other plausible explanation for her death arises on the material. In those circumstances, it would be entirely open to the Inquiry to find that Ms Raye's death was the result of suicide.

35. Consistent with this, it was reasonable for the Strike Force Parrabell reviewers to proceed on the basis that Ms Raye's death was likely the product of suicide.

Initial police investigations

36. Counsel Assisting notes that no record of a missing persons' report arising from the apparent attendance of Mr Hurrell and Ms Raye's social worker on 19 March 1989 has been retained (CA, [34]).

37. It is not possible to discern why this is. As noted by Counsel Assisting, NSW Police practices in relation to missing persons' reports have advanced very substantially in the 34 years since Ms Raye's death.

38. It is appropriate to note that Ms Raye was almost certainly deceased at the time she was reported missing[32], and that her body was found the day after she was reported missing.

39. Investigating police appear to have conducted a detailed review of the scene and taken statements from a number of Ms Raye's friends, acquaintances and treating doctors. The State Coroner dispensed with an inquest, and there is nothing to suggest that his Honour regarded the police investigation to be in any way deficient.[33]

Anti-LGBTIQ bias

40. SF Parrabell and the Academic Review both categorised this case as "No evidence of bias". Counsel Assisting's view accords with this conclusion (CA, [139]).

[32] See Report of Dr Isles, pp. 7 – 8; Autopsy Report, p. 1.
[33] Coroner's Court Summary Sheet, SOI.11038.00001.

41. Having regard to the likelihood that Ms Raye died by suicide, and the distressing prejudice she was subjected to, it might be said that anti-LGBTIQ bias was a powerful contributor to her death. Nevertheless, her death cannot be characterised as a hate crime.

Findings and recommendations

42. For the reasons expressed above, it would be open to the Inquiry to conclude that Ms Raye died after deliberately administering insulin in attempt to cause her own death.

43. The Commissioner of Police agrees that the phrase "transexual depression" should be removed from the entry in the Register of Births, Deaths and Marriages relating to Ms Raye's death.

Mark Stewart

Circumstances of death

44. Mr Mark Stewart was found dead at approximately 10am on 11 May 1976, aged 18 years. His body was located by a fisherman on rocks approximately six metres east of a cliff face in the vicinity of the Fairy Bower headland, near Manly.[34]

45. Paragraphs [4]-[7] of Counsel Assisting's submissions provide an accurate description of the findings at autopsy, which was conducted by Dr Thomas Oettle on 14 May 1976.[35] The direct cause of death was described in Dr Oettle's report as "multiple injuries", with an estimate that death had taken place three to four days previously.

46. Very little is known about the circumstances of Mr Stewart's death. By way of short summary, he had lived at a boarding house in Brisbane until shortly before his death,[36] he had checked into a Sydney hotel on 9 May 1976 for two nights,[37] he was last seen at that hotel at approximately 9:30pm on 9 May,[38] and he was found with a handwritten note which recorded "7.20 11.5.76" and had the name and telephone number of a hotel in one corner.[39]

---

[34] P79A Report of death to the Coroner, 13 May 1976, SCOI.82449.
[35] See also post mortem report of Dr Thomas Oettle, 3 June 1976, SCOI.02724.00009.
[36] Special Crime Squad synopsis extract, 21 May 1976, SCOI.47558.
[37] Statement of Patricia Cupitt, 7 July 1976, SCOI.02724.00013.
[38] Special Crime Squad synopsis extract, 24 May 1976, SCOI.47557.
[39] Statement of Senior Constable Keith Thoms, undated, SCOI.02724.00019.

47. At an inquest held at the Coroner's Court in Glebe in July 1976, Coroner Goldrick found Mr Stewart died on 11 May 1976:[40]

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

Initial police investigations

48. In written submissions, Counsel Assisting the Inquiry submits that "police investigation of the matter never appears to have seriously countenanced the possibility that the death may have been a homicide" (CA, [27]). In oral submissions made to the Commissioner of the Inquiry, Counsel Assisting went further, submitting that after the retrieval of the body and the search of the area in the vicinity of the cliff top, "the sole concern of the police investigation was evidently the identification of the body" (T3397:23-25). Counsel Assisting suggests that this is not a criticism of police involved in the investigation, but rather is likely to be a product of the social environment and policing practices of the era "not being conducive to considering and detecting whether a death in these circumstances may have been a gay hate homicide" (CA, [32]). In support, Counsel Assisting references evidence of policing practices in the 1980s and 1990s not adequately recognising gay-hate motivated homicides (CA, [20]-[23]).

49. That societal attitudes and policing practices in the 1970s were not conducive to recognising the possibility that crimes may have been motivated by LGBTIQ bias is not contested. However, a finding that the identification of the body was quickly the "sole" concern of the police investigation is not open on the evidence.

50. For example, a synopsis of the Special Squad dated 24 May 1976, after referencing Mr Stewart's name (as by that point he had been identified both by his passport photo and the hotel receptionist), included the observation:[41]

> *Death obviously caused by falling over cliff. No member of family yet located to establish whether possible suicide or drug involvement. His passport was issued at Fiji in 1970 and a telex was sent there on 21-5-76 to ascertain relatives but no*

[40] Inquest findings of City Coroner Goldrick, 17 July 1976, SCOI.02724.00001.
[41] Special Crime Squad synopsis extract, 24 May 1976, SCOI.47557.

reply as yet. As this stage reason for being at Fairy Bower not known, but there is no evidence to suggest foul play.

51. Further inquiries were made by police, resulting in the location of Mr Stewart's father. A statement was taken from him, with notes from the officer taking the statement recording the following:[42]

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

52. Such inquiries quite clearly extended beyond the identification of the body.

53. That the focus of investigations was on possible suicide or accidental death is also unsurprising: there was and remains no positive evidence of foul play, or indeed, evidence of anyone being present at or shortly before Mr Stewart's death. In those circumstances, it was reasonable for police to arrive at a hypothesis that Mr Stewart's death was either an accident or suicide.

54. It is also submitted that Police cannot reasonably be criticised for the fact that the clothing worn by Mr Stewart and the items found with his body, including the handwritten note, are now not available for forensic testing (CA, [15]-[17]) almost 47 years later. As has been repeatedly identified, police exhibit management practices have changed dramatically in that intervening period. Mr Stewart died roughly 10 years before DNA testing was used anywhere in the world, and almost 30 years prior to the formation of the Unsolved Homicide Team.

55. It is noted that those assisting the Inquiry sought further evidence from the officer in charge of the original investigation, Senior Constable Thoms, but concluded his statement is "ultimately of limited assistance" and the reliability of some of his recollections is "uncertain" (CA, [53]). Mr Thoms' age is not evident on the further statement, although it is recorded that he was an officer with NSWPF between 1962 and 1998.[43] It is similarly

[42] P109 Report of Occurrence entries, 28 May 1976, SCOI.82813.
[43] Further statement of Keith Thoms, 28 February 2023, SCOI.82809.

submitted that no criticism of Mr Thoms' conduct or recollections can be made, not least because he has not been called to give evidence, but also given his likely age and the length of time since those investigations took place.

56. It is also relevant to note that there is no suggestion that the Coroner considered the investigation to be in any way deficient. Had Coroner Goldrick considered further investigations to be warranted, recommendations in that respect could have been made. The absence of recommendations or directions in relation to the conduct of further investigative steps gives rise to a clear inference that the investigation was regarded as at least adequate, having regard to police practice at the time.

Anti-LGBTIQ bias

57. There is no evidence that Mr Stewart identified as a member of the LGBTIQ community.

58. It is acknowledged that his body was located in or near a beat (CA, [84]-[85]) but there is no evidence to suggest this was in any way related to his death.

59. Counsel assisting posits "Mr Stewart's desertion from the New Zealand Navy at an early age and his apparent self-imposed estrangement from his family may also be consistent with him being a young man who was coming to terms with a non-heteronormative sexuality in a challenging environment in the 1970s" (CA, [13]).

60. While Counsel Assisting concedes such a conclusion involves "some speculation,"[44] the Commissioner of Police submits this is *entirely* speculative and cannot be given any weight. Self-evidently, there could be many reasons why an 18-year-old man is not in contact with his family, having recently deserted the navy without his father's permission.[45]

61. Counsel assisting also discusses at considerable length (CA, [10]-[12]; [34]-[37]; [94]-[108]) the possibility that the hotel listed on the handwritten note found with Mr Stewart's body was the Chevron Hotel in Pott's Point. This was considered to be of relevance as in the 1970s that hotel had a popular bar called the Quarterdeck Bar that was frequented by gay men (CA, [12]; [95]-[96]).

62. The Commissioner of Police submits this analysis does not in any way advance the position as to Mr Stewart's sexuality, or whether his death was motivated by gay hate bias.

---

[44] And in oral submissions "a high degree of speculation": T3403:28-31.
[45] See statement of John Spanswick, 28 May 1976, SCOI.02724.00015.

As conceded by Counsel Assisting ([108]), the evidence supports the conclusion that the officer in charge wrongly recorded the name of the hotel as the "Chevron Hotel", and that the name on the notepaper was in fact the Hilton Hotel in George Street where Mr Stewart had been staying, particularly noting that the Chevron Hotel had previously been known as the "Chevron Hilton" in the 1960s (CA, [99]). As is suggested by its association with the Hilton brand, the Chevron Hotel was a substantial operation; even if, contrary to the weight of the evidence, the note recorded its name, that could not sensibly lead to any reliable inferences about Mr Stewart's sexuality or, in turn, the circumstances surrounding his death.

63. In the absence of any evidence to establish that Mr Stewart's death was a homicide, a finding by Strikeforce Parrabell of "insufficient information to establish a bias crime" was entirely appropriate.

Findings and recommendations

64. Counsel Assisting considers three alternative explanations for Mr Stewart's death, submitting the possibility of suicide has little support in the evidence, but cannot be ruled out entirely (CA, [113]), the possibility of an accident remains open (CA, [114]), and then noting that Mr Stewart may have been the victim of foul play (CA, [117]).

65. It is unclear why Counsel Assisting so significantly discounts the possibility of suicide. It should be recalled in this respect that deaths by suicide are vastly more common than deaths by homicide. This probabilistic disparity is only heightened when one considers that the bulk of homicides occur in a residential setting.[46]

66. There is admittedly a paucity of evidence as to Mr Stewart's mental state, however, as noted by Counsel Assisting, there are at least some matters that might be consistent with suicide (CA, [111] – [112]). Indeed, it is clear is that the period prior to Mr Stewart's death was one of significant upheaval in his life: he deserted the New Zealand navy, moved to Brisbane where he lived in a boarding house, became estranged from his family, and changed his name. Moreover, it was at least highly unusual that Mr Stewart, an 18-year-

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

old who had resided in a boarding house for some months, reserved two nights at a luxury hotel immediately prior to his death.

67. The Commissioner of Police submits while the possibility of foul play cannot be entirely excluded, it finds little support in the evidence. For the reasons discussed above, there is no evidential basis to support a finding as to Mr Stewart's sexuality, and even if the notepaper found with his body did refer to the Chevron Hotel in Pott's Point, this does not advance the inquiry into either Mr Stewart's sexuality or the cause of his death. Both of these points are relied upon by Counsel Assisting as suggesting the possibility that Mr Stewart may have been the victim of foul play (CA, [117]), but in the Commissioner of Police's submission cannot be attributed any real weight.

68. Similarly, the mere fact that a death occurred in the vicinity of a beat cannot, without more, give rise to a realistic suggestion that Mr Stewart was the victim of a homicide. In particular, Fairly Bower is an attractive coastal location, and the vast majority of visitors to it were likely there for reasons other than the pursuit of sexual relations.

69. The absence of a wallet similarly does not provide meaningful support for a homicide finding. First, as noted by Counsel Assisting, it is not known whether Mr Stewart habitually carried a wallet. Second, if he committed suicide, he may have given his wallet away, or left it somewhere (other than his hotel room) prior to doing so. Third, Mr Stewart had a reasonable sum of money in his possession (relative to the average earnings of the time[47]), suggesting he was not likely the victim of a robbery. Fourth, there were no other indications consistent with robbery or attack of any kind.

70. In the latter respect, the hypothetical scenario of a push that was not associated with any other form of struggle proposed by Counsel Assisting (CA, [115]) is difficult to reconcile with ordinary human behaviour; it would have required Mr Stewart to be standing on or near the edge of the cliff and for someone to approach him unnoticed such that they were able to push him over the edge before he could offer any meaningful resistance.

71. Finally, "the absence of particularly compelling evidence in support of alternative hypothesis" (CA, [117]) cannot, without more, sensibly support a finding of possible foul

[47]https://www.ausstats.abs.gov.au/ausstats/free.nsf/0/B245ABB5FC28CEF1CA25750C00189F5B/$File/63020_DEC 1976.pdf

play. Again, this analysis fails to recognise the statistical reality that both suicide and accidental deaths are vastly more common than homicides.

72. Nevertheless, the Commissioner of Police agrees with the ultimate finding proposed by Counsel Assisting (CA, [122]), consistent with the classification of "insufficient information" by Strikeforce Parrabell, that:

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

Carl Stockton

Circumstances of death

73. Mr Carl Stockton died at St Vincent's Hospital, Sydney, on 11 November 1996, from severe head injuries.

74. Mr Stockton had been drinking at the Bar Cleveland in Darlinghurst throughout the afternoon and evening of 5 November 1996.[48] He left the bar at approximately 11:30pm, and was described as being slightly intoxicated.[49] At approximately 12:50am, Ms Bridgette Paroissien returned home to her house located behind the Bar Cleveland, and found Mr Stockton in her backyard.[50] Ms Paroissien spoke to Mr Stockton for about half an hour, before getting her boyfriend to assist in moving Mr Stockton out of the garden and into the street. Ms Paroissen reported that Mr Stockton "got up and then tripped about three steps and fell stomach first onto some garbage bins and then head first off then onto the ground."[51] She did not notice any injuries to his face.[52]

75. Magda Kos, a bar attendant at the Bar Cleveland was cleaning up in the back bar when a man approached her at about 1:45am saying, "There's an old guy that's collapsed outside, I think you should call someone."[53] Mr Stockton was found by the manager of Bar Cleveland, Brent Tozer, lying on his back on Cleveland Street, and was assisted by a passerby to lift Mr Stockton under the arms and help him walk into Bar Cleveland.[54] Mr Stockton was observed to have a black eye. Once in the bar, he was heard by one

---

[48] Statement of Nathan Starcic, 12 November 1996, SCOI.00045.00071.
[49] Statement of Magda Kos, 8 November 1996 at [8], SCOI.00045.00070.
[50] Statement of Bridgette Paroissen, 18 November 1996 at [3], SCOI.00045.00096].
[51] Statement of Bridgette Paroissen, 18 November 1996 at [10], SCOI.00045.00096.
[52] Statement of Bridgette Paroissen, 18 November 1996 at [12], SCOI.00045.00096.
[53] Statement of Magda Kos, 8 November 1996 at [5], SCOI.00045.00070.
[54] Statement of Brent Tozer, 9 November 1996 at [7]-[8], SCOI.00045.00069.

witness to say 10-15 times "I've had enough. I want someone to take me around the back and kill me"[55] and another to say "I want to die" two or three times.[56]

76. Welfare officers of the Mission Beat arrived shortly thereafter and took Mr Stockton to Campbell House, Surry Hills, where he was given a bed.[57] By 11:30am the next morning he had vomited twice and when asked if he was ok, replied "help me".[58] He was then taken to Sydney Hospital by Mission Beat staff, where he was treated for severe head injuries. Later that day he was transferred to St Vincent's Hospital, and on 7 November underwent surgery to attempt to relieve pressure in his brain. He died from his injuries at St Vincent's Hospital on 11 November 1996.[59]

77. An autopsy report of Dr Christopher Lawrence found Mr Stockton had died as a result of craniocerebral injuries.[60]

Initial police investigations

78. Counsel assisting emphasises police did not make inquiries about a "group of three to four people" observed by a witness, Andrew Phillips, to be standing outside Bar Cleveland at the time Mr Stockton was found on the road (CA, [14], [71], [91]).

79. Mr Phillips' recollection was as follows:[61]

> *Outside the pub I saw a group of three or four people. They were on the footpath on the corner of Cleveland and Bourke Street. I could see they were standing around in a circle. I then went back into the pub by the same door that I had come from.*
>
> *Once inside Gavin JAMES went outside. He went out by the door in the front bar, facing Cleveland Street. I saw him approach the group of people. Most of the people then left and I saw him talking to a guy. They were both sitting on the window ledge of the pub. They appeared to be talking. I think Brent the bar manager went outside and helped Gavin bring the guy in.*

---

[55] Statement of Nathan Starcic, 12 November 1996 at [15], SCOI.00045.00071.
[56] Statement of Gavin James, 11 November 1996 at [6], SCOI.00045.00072.
[57] Statement of Eric-Emmanuel Hooson, 5 November 1996, SCOI.00045.00074.
[58] Statement of Alan Clynch, 9 November 1996 at [6]-[8], SCOI.00045.00078.
[59] First P79A Report of death to the Coroner, 11 November 1996, SCOI.00045.00010.
[60] Autopsy report of Dr Christopher Lawrence, 14 February 1997, SCOI.00045.00055.
[61] Statement of Andrew Phillips, 12 November 1996 at [5]-[6], SCOI.00045.00073.

80. Gavin James recalled these events as follows:[62]

> *Then about 1.00am, Nathan and I were sitting down at one of the tables talking to Magda one of the staff, when I noticed people coming the door of the bar that leads from Cleveland Street near the corner of Bourke Street. I looked across and I saw two males coming into the bar. The I saw Brent the bar manager go over and talked to them. Then I think Nathan got up and went over to Brent and the two guys, who were standing just inside the door to my right as I looked at them. I saw one of the guys leave the same way he came in, it was then I noticed that he had a ponytail and that his hair might have been dark brown, I'm not sure.*
>
> *Then Nathan called me over to where he was with Brent and the other guy. As soon as got over to Nathan and Brent, I saw the guy had a black eye, I'm not sure which one it was, but it looked like it had just happened, it was a real purpley colour and could smell that he had been drinking.*

81. Finally, Nathan Starcic said:[63]

> *I'm not sure of the exact time but about 1am I saw two people standing in Cleveland Street outside the pub. They were on the sidewalk directly outside the pub. I saw there was a man with a ponytail holding the man with the sling in an upright position helping him towards the pub. That's when Brent went outside and helped the man with the ponytail bring the main in to the pub. They sat him down in a set and the man with the ponytail said, "I have to run." He then took off. I only really saw him from the back. He was Caucasian and between 20 and 25 years old. He was medium build and about five foot ten.*

82. The three accounts are therefore inconsistent in several key respects as to who was located where, and when. However, it appears clear that the Caucasian "man with a ponytail" was one of those men who had originally been outside the Bar Cleveland. The officer in charge confirmed in evidence before the coroner that the man with the pony tail had not been able to be identified, despite steps having been taken to feature Mr Stockton's case on Australia's Most Wanted programme with a view to obtain assistance in identifying Mr Stockton's last movements.[64] In these circumstances, it is submitted the

---

[62] Statement of Gavin James, 11 November 1996 at [5]-[6], SCOI.00045.00072.
[63] Statement of Nathan Starcic, 12 November 1996 at [14], SCOI.00045.00071.
[64] Transcript of Coronial Inquest, 1 December 1998 at T2:46-59 and 3:1, SCOI.00045.00001.

contention that police failed to investigate this aspect of the case is not made out on the evidence.

83. Counsel Assisting also criticises police for not obtaining a statement from a Mr Terry Hugo, who one of the Mission Beat workers claimed had said that "on the street people believe" that "four Caucasian males who frequent the Bar Cleveland" had perpetrated a number of similar assaults in the vicinity of Bourke and Cleveland Streets, or investigating further when a member of public later reported assaults were being committed on persons at the Cleveland Hotel by a group of "young white males" (CA, [12]-[13], [15]-[16], [70]-[71] and [91]).

84. It is accepted that on the available material, it does not appear that specific further investigations in relation to the rumours reported by the Mission Beat worker were undertaken, although the featuring of Mr Stockton's case on Australia's Most Wanted and the call for assistance from the public should not be overlooked. It is also noted despite an investigator for the Inquiry contacting the officer in charge, Mr Neil Walker, directly, Mr Walker was not asked about this report or whether any such specific investigations were undertaken.[65]

85. Overall, it is submitted that the police investigation into Mr Stockton's death was detailed and thorough, and included a significant number of investigatory steps by Strikeforce Altea as outlined by Counsel Assisting (CA, [48]). Such a sentiment was shared by Mr Stockton's father when giving evidence before the Coroner:[66]

> *We are also satisfied that the investigation by the agencies which society has put in place has been done thoroughly and competently… And I would like to pay a personal tribute to the competence and the commitment of the police force and particularly to Detective Senior Constable Neil Walker for whom I have a great respect, even an affection.*

86. And indeed, also by Senior Deputy State Coroner Abernethy:

> *It has been thoroughly investigated by Detective Constable Walker. All the people he could find who were around Mr Stockton on 5th and 6th have been interviewed. The man with the pony tail cannot be located. He has attempted through press*

[65] Statement of John Goobanko, 31 January 2023, SCOI.82816 and Annexure A to that statement.
[66] Transcript of Coronial Inquest, 1 December 1998 at T8:6-16, SCOI.00045.00001.

> *releases and Australia's Most Wanted to get people to come forward and no one has and we simply cannot ascertain how Mr Stockton came by his injuries. None of those people - no person has been able to tell the police how the injuries were sustained and sadly, although Mr Stockton lived for seven days, he couldn't or wouldn't and towards the latter stage certainly couldn't tell the police how he came by his injuries. Significantly he was unable to tell, or did not tell those at Mission Beat how he came by his injuries.*

Anti-LGBTIQ bias

87. The Commissioner of Police agrees with the submission of Counsel Assisting that the evidence does not provide an adequate basis for a finding that Mr Stockton's death was motivated by LGBTIQ bias (CA, [115], [121]-[122]).

88. While Mr Stockton identified as gay, and had been the victim of a number of previous assaults that he appeared to believe had been motivated by gay hate, there is little evidence as to how Mr Stockton obtained the head injuries which ultimately led to his death and, in particular, no evidence sufficient to establish he suffered those injuries in an attack motivated by gay hate. While a 2016 media article cited Ms Sue Thompson (at the time of Mr Stockton's death, the Gay Liaison Coordinator for NSW Police) as saying Surry Hills police had told her in 1996 that patrons at the bar had heard a lot of anti-gay taunts made to Mr Stockton,[67] on investigation by the Inquiry, Mr Walker confirmed he had never received any such information or reports.[68]

Findings and recommendations

89. Following the inquest in Mr Stockton's death, Senior Deputy State Coroner Abernethy made the following open finding:[69]

> *I find that Carl Gregory Stockton died on the eleventh day of November, 1996 at Darlinghurst of craniocerebral injuries suffered on or about the fifth day of November, 1996 at Redfern. As to how such injuries were sustained, the evidence adduced does not enable me to say.*

---

[67] Rick Feneley, 'The Gay Hate Decades' SBS (online) <https://www.sbs.com.au/gayhatedecades/>.
[68] Statement of John Goobanko, 31 January 2023, SCOI.82816 and Annexure A to that statement.
[69] Coronial Findings, 1 December 1998, SCOI.00045.00003.

90. The Coroner summarised the medical evidence in relation to the possible cause of Mr Stockton's head injuries, which led to his open finding, as follows:[70]

> *There has been reports by his neurosurgeon and a report was obtained from the Police Medical Officer, Dr Moynhan and of course a very thorough post-mortem examination was conducted by Dr Lawrence, staff pathologist at the New South Wales Institute of Forensic Medicine. Sadly it is inconclusive, three doctors have differing views and that is not unusual. I think Dr Moynhan feels it is most likely to be some sort of injury sustained in a car accident or when run over by a car, perhaps while lying on the road. Dr Matheson, the consultant neurosurgeon feels it is more likely to be an assault consisting of several blows to the head and he feels it is quite inconsistent with a motor vehicle trauma. Dr Lawrence who is a very experienced pathologist he is erring on the side of caution and frankly I do not blame him. He can only look at what he sees after the man has passed away and he notes the unusual nature of the craniocerebral injuries. There are a number of fractures to the skull and he basically gives three options, I think his most likely possibility is an assault perhaps coupled with injuries sustained as a result of the assault perhaps by hitting his head against something hard with the ground, cement, a wall, something like that and I think he favours that but he is not prepared to say that that is probably what happens, he says it is quite possibly what happened. He is not prepared to discount a car, a trauma with a motor vehicle in some way and there is a remote possibility he has fallen a number of times. I think that is unlikely, I think it is likely, it is either the car trauma which would have to be in the nature of a hit and run or more likely Mr Stockton was assaulted. The problem with that of course is that apart from his keys nothing was taken. His accommodation has never been interfered with and there are some puzzling aspects about it being an assault.*

91. Given the divergence of opinion in expert view, the Inquiry briefed Dr Linda Iles, forensic pathologist at the Victorian Institute of Forensic Medicine to prepare a report.[71] As to the possible cause of Mr Stockton's head injuries, Dr Iles opines:[72]

---

[70] Transcript of Coronial Inquest, 1 December 1998 at T12:49-59 and 13:1-22, SCOI.00045.00001.
[71] Expert Report of Dr Linda Iles, 10 March 2023, SCOI.82823.
[72] Expert Report of Dr Linda Iles, 10 March 2023 at p. 10, SCOI.82823.

> *Given the number of impact points as outlined above, and the extent of skull fracturing, Mr Stockton's head injuries clearly cannot be accounted for by a simple fall. A fall from a significant height with impact to the back of the head may be able to produce this pattern of skull fractures but does not appear plausible in the circumstances as described.*
>
> *Mr Stockton's pattern of injuries could be accounted for by an assault with multiple forceful impacts to the head. An accelerated fall onto the back the head could be accommodated in this scenario.*
>
> *Whilst an impact from a motor vehicle would impart the energy requisite in Mr Stockton's pattern of skull fractures, his lack of post-cranial injuries makes this scenario unlikely. The right rib and clavicular fractures that Dr Anthony Moynham relied upon to inform his opinion that the deceased's injuries were caused by a motor vehicle collision are older injuries and are unhelpful in this regard. It is difficult to envisage a scenario where Mr Stockton could receive such severe craniocerebral trauma without substantive injury anywhere else on his body.*
>
> *Whilst it cannot be excluded that Mr Stockton's skull fractures have not been sustained by his head being run over, there are no cutaneous injuries to indicate that this has taken place. I find it difficult to accommodate the number of planes of injury into this scenario, unless some of these injuries were sustained in a separate incident. This scenario is significantly less likely, in my view, than an either an accelerated impact with the ground, or a substantive broad-based blow to the back of the head, it cannot be completely excluded.*

92. Counsel assisting asserts that the "preponderance of the medical and expert evidence" now supports a finding that Mr Stockton's head injuries were caused by an assault rather than a fall or being hit by a motor vehicle (CA, [119]).

93. The Commissioner of Police agrees that, having regard to the totality of the evidence now available, it appears unlikely that Mr Stockton's injuries were caused by a motor vehicle.[73] There continues, however, to be significant uncertainty as to whether the cause of the injuries was, in fact, an assault and, in turn, as to the circumstances surrounding any such assault.

[73] Expert Report of Dr Linda Iles, 10 March 2023 at p. 10, SCOI.82823.

94. Some further observations in this respect should be made:

a) little to no weight should be attributed to the views of Dr Doust as to the likely cause of death of Mr Stockton, noting his expertise is in radiology, not forensic pathology or neurology, and that his familial relationship with Mr Stockton may compromise his objectivity (see CA, [33] and [100] and c.f. CA, [118]);

b) despite being asked directly by the Coroner, Dr Lawrence did not favour the cause of the head injuries being an assault:[74]

> *Coroner: Q. The neurosurgeon Dr Matheson really feels that it points to an assault. I get the impression you favour that although you're not prepared to raise it to the level of probability, I'm not asking you to?*
>
> *A. Look we've got three options. I think that of the three options the car one is probably the least likely of the three options. What I cannot tell is whether we're dealing with several falls or an assault and several falls or a straight out assault.*

c) there are significant discrepancies in the witness accounts as to the time Mr Stockton was brought into the Bar Cleveland with a black eye,[75] and as a consequence, the likely time period within which Mr Stockton suffered his injuries. Dr Iles states: "Brigette Paroissien did not describe Mr Stockton as having facial injuries when in her back yard. If she is a reliable witness, then it appears that Mr Stockton sustained his injuries between 12:50am and 1am on November 6, as indicated by the bar manager who observed both a bruise and a cut about Mr Stockton's right eye."[76] However, even on Ms Paroissen's evidence alone this timeline cannot be accurate: she states she first saw Mr Stockton at about 12:50am and sat with him for about half an hour.[77] This is relevant as Dr Iles discounts a fall from a significant height as not appearing "plausible in the circumstances"[78] when it appears those circumstances relied upon may not be accurate.

---

[74] Transcript of Coronial Inquest, 1 December 1998 at T11:48-56, SCOI.00045.00001.
[75] For example, Ms Kos suggests it was about 1:45am when she was approached by a man telling her there was someone requiring assistance (statement of Magda Kos, 8 November 1996 at [5], SCOI.00045.00070), whereas Beat Mission workers suggest they had arrived to collect Mr Stockton from the Bar Cleveland by 1:30am (statement of Eric-Emmanuel Hooson, 5 November 1996 at [4], SCOI.00045.00074).
[76] Expert Report of Dr Linda Iles, 10 March 2023 at p. 9, SCOI.82823.
[77] Statement of Bridgette Paroissen, 18 November 1996 at [3]-[6], SCOI.00045.00096].
[78] Expert Report of Dr Linda Iles, 10 March 2023 at p. 10, SCOI.82823.

95. In those circumstances, it is at least arguable that the open finding made by State Coroner Abernethy should not be disturbed.

96. Nevertheless, the finding proposed by Counsel Assisting that Mr Stockton died following an assault is open on the evidence as it now stands (CA, [123]).

97. As noted above, the Commissioner of Police agrees that there is insufficient evidence for a finding that Mr Stockton's death was motivated by LGBTIQ bias, consistent with the findings of Strikeforce Parrabell.[79]

Conclusion

98. As is apparent from the foregoing, the Commissioner of Police supports the submissions made by Counsel Assisting as to the manner and cause of the deaths of Gerard Cuthbert and Mark Stewart.

99. For the reasons expressed above, there remains real doubt as to the mechanism by which Carl Stockton came to suffer his injuries, but the submission of Counsel Assisting is open on the evidence as it now stands.

100. Contrary to the submissions of Counsel Assisting, it would be open to find, on the balance of probabilities, that Samantha Raye died as a result of suicide.

101. In each of the cases considered on 29 and 30 March 2023, the conclusions advocated by Counsel Assisting as to whether each of those deaths were motivated by anti-LGBTIQ bias align with the findings of Strike Force Parrabell.

102. 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

Anders Mykkeltvedt
Maurice Byers Chambers

Amber Richards
Maurice Byers Chambers

12 April 2023

[79] Bias Crimes Indicators Review Form, undated, SCOI.32071.