The Special Commission of Inquiry
into LGBTIQ Hate Crimes

TENDER BUNDLE HEARING OF 4 APRIL 2023

Concerning the death of Peter John Sheil

Reply submissions on behalf of the Commissioner of Police

Introductory

1. These submissions are prepared on behalf of the Commissioner of Police by way of reply to the submissions made by the family of Peter Sheil on 28 April 2023 (**FS**). They supplement the Commissioner's first submissions of 18 April 2023 (**PS**) and are filed in accordance with leave granted on 3 May 2023.

Police investigation

2. At PS [16], it is accepted that the opinion expressed by the Constable Strange "appears" to have been "relatively speculative". It is then noted that the basis of Constable Strange's opinion has not been explored with him. The caveats in that paragraph are important and should be borne firmly in mind when considering the position adopted at FS [3] – [4].

3. Constable Strange's conclusion may have been more firmly grounded in the factual material than is apparent on the basis of his statement alone; the photographs taken by the Scientific Squad are not available (which the Commissioner acknowledges is regrettable) and, given his death, Constable Strange is not available to further explain why he expressed the opinion set out in his statement.

4. In those circumstances, the criticisms levelled in Counsel Assisting's submissions, and those advanced on behalf of Mr Sheil's family, should be approached with caution.

5. At FS [6] it is said that the assessment of the adequacy of the initial police investigation is to be made on all on of the available evidence. At first blush, that observation appears wholly uncontroversial. It presupposes, however, that an examination of the adequacy of the investigation can accurately and fairly be conducted on the basis of the available material. Given the unavailability of Constable Strange, and the fact that this investigation

was conducted well before the introduction of electronic case management tools, and in circumstances where expectations as to the recording of investigative steps in statement form were plainly very different[1], it is by no means clear that such an exercise can accurately, fairly, or usefully be conducted:

a) first, the Inquiry could not easily be satisfied that the relevant criticisms are founded on a complete picture of the investigative steps actually undertaken, and the information available as a result of that investigation. The apparent loss or disposal of investigative materials may form a proper basis for criticism in relation to historical archiving practice, but it would not be appropriate for criticisms to be made on the basis of speculative inferences drawn by reference to "the lack of documents" (cf FS, [7]);

b) second, the unavailability of Constable Strange and the total absence of evidence from his contemporaries as to what was regarded as appropriate policing practice gives rise to a significant risk of unfairness. The fact that such persons may not readily be available is no answer to such unfairness (cf FS, [7]); and

c) third, there are questions as to what purpose such criticism would serve, in circumstances where Constable Strange is deceased and the relevant investigation was conducted 40 years ago, at a time when policing practice was guided by a very different set of procedures and norms, occurred in a very different social context, and did not have the benefit of modern investigative tools and information processing technologies.

6. Contrary to FS [5], ss. 14 and 22 of the *Coroners Act 1980* are not merely window dressing. Section 14 of the *Coroners Act 1980* provided, relevantly (emphasis added):

> (2) A coroner may dispense with the holding of an inquest concerning the death or suspected death of a person which, but for this subsection, he would be required under subsection (1) (a) or (b) (i) to hold if it appears to him—
>
> > (a) in the case of a suspected death of a person, that the person has died and, in the case of a suspected death or a death of a person, <u>that the</u>

[1] If available, Constable Strange's notebook, for example, may well have included additional detail (including, for instance, the names and contact details of the people with whom he spoke – cf FS, [6]).

> matters referred to in section 22 are sufficiently disclosed in relation to the person; or
>
> (b) that an inquest or other official inquiry concerning the death or suspected death has been or is to be held at a place outside this State.

7. Section 22 of the *Coroners Act 1980* then provided:

> (1) The coroner holding an inquest concerning the death or suspected death of a person shall, at its conclusion or termination, record in writing his findings or, if there is a jury, the jury's verdict, as to whether the person died and, if so—•
>
> (a) his identity;
>
> (b) the date and place of his death; and
>
> (c) except in the case of an inquest terminated under section 19 or 21, the manner and cause of his death.

8. The combined effect of these provisions is that the determination by the Coroner to dispense with an inquest was premised on a conclusion that the manner and cause of Mr Sheil's death were "sufficiently disclosed" via the investigation. In that sense, the decision to dispense with the Inquest without requiring further investigations to be conducted is a clear indication that the Coroner (who likely had access to all the investigative materials, including the crime scene photographs) regarded the investigation as adequate, having regard to then-accepted standards.

9. Depending on the contents of the investigative materials that are no longer available (in particular, the photographs), it is quite likely that a Coroner working today would have required further investigative steps to be conducted. It is accepted that a review of the available materials suggests that the investigation did not meet modern standards. However, when determining whether criticism is appropriate or fair, comparisons should be drawn not with modern standards, but rather with what would have been regarded as reasonably prudent investigative practice in 1983.

10. Finally, the umbrage taken to the observations (at PS [10]) that the Inquiry should be slow to found criticism on second-hand hearsay evidence is surprising (FS, [8]). It should not be controversial to say that a person should not have their professional or personal conduct impugned on the basis of evidence in that form. So much is implicit in the

limitations as to evidence contained in ss. 9(3) and (4) of the *Special Commissions of Inquiry Act 1983*.

Circumstances of death

11. The description (FS [9]) of the Commissioner's submissions as "perplexing" and "a point of no small dismay" is unwarranted.

12. An attempt is made by reference to the "tenor" of the Commissioner's submissions to impute to them a vaguely sinister tone (FS, [11]). That submission should not be entertained by the Inquiry. The "thrust" of the Commissioner's submissions is clear and should not be mischaracterised:

    a) the appropriate finding in relation to the manner of Mr Shiel's death is an open finding in line with Counsel Assisting's proposed formulation (PS, [30]), subject to possible amendment as concerns the likely time of death (PS, [29]);

    b) suicide is a possibility, as is a fall attributable to a deliberate act associated with an episode of psychosis or hypermania (PS, [21]);

    c) accident, on account of the treacherous ground and lack of protective barriers, is a reasonable possibility (PS, [22]);

    d) homicide cannot be ruled out, though in the absence of any positive indications in support of homicide, and having regard to the considerations summarised at PS [22], it is probably less likely than accident or suicide.

13. As to the specific objections to PS [12]-[22] at FS [10] – [16], some additional observations should be made.

14. There is no doubt that Mr Sheil was using the coastal walking track after dark (FS, 10). It was not suggested that the track would have been "populated by casual walkers with a benign interest in the natural scenery at that time" (cf, FS, [10]). That does not alter the observation at PS [13] that there is no evidence that would allow a conclusion to be reached as to what proportion of the path's users were seeking sexual or romantic connections. While there is no evidence as to the relative quantities of persons using the path for different purposes, it would be surprising if – as at approximately 8pm on the day in question – the number of persons using the path as a beat was not smaller than the number of people simply moving from place to place. Whatever the position in that respect,

the mere fact that a location at times served as a beat cannot, without more, provide a steady foundation for a positive conclusion that a death was occasioned by homicide.

15. There is very little evidence in relation to Mr Sheil's mental illness. What evidence there is, suggests that his illness was a very significant one, resulting in 12 admissions to a psychiatric hospital in a 3-year period.

16. The Commissioner of Police agrees that care should be taken not to unduly perpetuate stereotypes associated with mental illness. An assessment of the potential causes of Mr Sheil's death cannot, however, sensibly be undertaken without a consideration of the potential that his mental illness played a role in his death.

17. It is arguably trite (and scarcely inappropriate – cf FS, [12]) to note that a person who has suffered from a mental illness of sufficient gravity as to warrant their admission to hospital a dozen times in a relatively short period in connection with depression and hypermania *may* be more likely to behave in unconventional ways than a person who was not suffering from such an illness.

18. It is similarly trite to note that a mental illness (in particular, bipolar or a schizophrenia-spectrum illness) may be relevant to an assessment of the possibility that Mr Sheil died by way of suicide[2] or accident.[3]

19. For the avoidance of doubt, the Commissioner's observation that Mr Sheil's mental illness *may* have played a role in his death should not be read as a positive assertion that it did so.

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[2] See, for example, research indicating that between 5 and 13% of persons with schizophrenia die by suicide and up to 20% of people with bipolar die by suicide. By way of comparison, the suicide rate in 1983 was 11.9 per 100,000 in the general population:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1845151/#:~:text=Suicide%20is%20a%20major%20cause,is%20the%20most%20accurate%20estimate;

https://www.nature.com/articles/s41398-021-01500-w

https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-over-time

[3] See, for example, research suggesting that persons with schizophrenia are more likely to die by way of accident: https://pubmed.ncbi.nlm.nih.gov/29580741/#:~:text=Results%3A%20A%20total%20of%2012%2C425,compared%20to%20the%20background%20population.

Conclusion

20. As outlined above, the Commissioner agrees with Counsel Assisting's proposed formulation of the manner and cause of Mr Sheil's death, though supports the submissions advanced by Mr Sheil's family as to the likely time of his death.

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