



## Special Commission of Inquiry into LGBTIQ hate crimes

7 March 2023

Professor Michael Besser  
 Clinical Professor Discipline of Surgery  
 2/155 Macquarie Street  
 Sydney NSW 2000

By email: [REDACTED]

Dear Professor Besser

### **Special Commission of Inquiry into LGBTIQ hate crimes: expert report in relation to the death of Richard Slater**

As you are aware, I assist the Honourable Justice John Sackar in the Special Commission of Inquiry into LGBTIQ hate crimes ("the Inquiry").

#### **The Inquiry**

By way of background, on 13 April 2022 the Governor of NSW, by Letters Patent, issued a commission to his Honour to inquire into and report on historical LGBTIQ hate crimes. Specifically, the Letters Patent require his Honour to inquire into and report to the Governor and Premier on the following matters by 30 June 2023:

- A. The manner and cause of death in all cases that remain unsolved from the 88 deaths or suspected deaths of men potentially motivated by gay hate bias that were considered by Strike Force Parrabell; and
- B. The manner and cause of death in all unsolved suspected hate crime deaths in New South Wales that occurred between 1970 and 2010 where:
  - i. The victim was a member of the lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) community; and
  - ii. The death was the subject of a previous investigation by the NSW Police Force.

#### **Request for expert opinion**

The Inquiry seeks your expert opinion on a specific question arising from its review of the death of Richard Slater. Mr Slater was 69 years old at the time of his death, and a pensioner. On 18 June 1981, Coroner Meehan found that Mr Slater died on 22 December 1980 from the effects of traumatic brain damage and subsequent myocardial infarction, following his hospitalisation due to assault on 19 December 1980.

## Special Commission of Inquiry into LGBTIQ hate crimes

---

By this letter, you are briefed to prepare a written report in relation to Mr Slater's death to assist the Inquiry. It is requested that you provide your report by no later than **17 March 2023**. In the event that you require further time to prepare your report, please advise Emily Burstun (details below) as soon as possible.

### Background

To assist you in the preparation of your report, you are provided with the following background information in relation to Mr Slater. This information is provided by way of summary only and should not be treated as a comprehensive record or a substitute for your own review of the materials.

1. Mr Slater (born 19 April 1911) died on 22 December 1980 at the Royal Newcastle Hospital. He had been assaulted on 19 December 1980 at the toilet block in Birdwood Park, and was subsequently found by Arthur Clements, a passer-by.
2. Mr Slater had an extensive medical history and had been suffering from a heart condition, angina, for fifteen years at the time of his death. He had previously had two hernia operations in the last eight years prior to his death, during which his heart had stopped on two occasions. A report from Newcastle Hospital obtained at the time of his death indicates that he suffered heart attacks twelve and five years prior. In addition, the report notes a diagnosis of hypotension over a ten year period.

### *Assault and discovery*

3. On 19 December 1980, between approximately 12:00pm and 12:20pm, Mr Slater attended Newcastle CBD with the intention of buying some groceries. It was apparently his weekly custom to purchase lottery tickets for himself and a neighbour, Michael McGlynn. To purchase the tickets, Mr Slater walked across Birdwood Park.
4. At around 1:00pm the same day, Arthur Clements entered the toilet block in Birdwood Park. He found Mr Slater lying on the ground, with his left leg in the urinal trough. Mr Slater had blood on the left side of his face, was moaning and making a "gurgling sound". His pants were below his buttocks.
5. On exiting the toilet block, Mr Clements met Kenneth Archer. Mr Archer entered the toilet block and saw Mr Slater with his head face down in the corner of the urinal. Mr Archer turned him over and attempted to speak with him, but Mr Slater did not respond.
6. Both men then left to a nearby store and asked an employee to call an ambulance at police. This call was logged at 1:04pm. Upon returning, Mr Slater was observed to be moaning and trying to pull his trousers up with one hand.
7. The attending ambulance officers observed Mr Slater in the same position with his feet in the urinal trough, as well as blood underneath his head and splattered on the walls of the toilet block. The officers noted that Mr Slater had his belt and fly undone, his pants were halfway down his buttocks and his genitals exposed.
8. Mr Slater was able to provide his name to ambulance officers. When asked what happened, denied being bashed or falling. He appeared to at least one of the ambulance officers to be confused in his responses. Bruce Varley, one of the ambulance officers, was of the view that given the swelling and congealed blood on Mr Slater, the wounds had been received a considerable time before the arrival of the ambulance.

### *Deterioration*

9. Mr Slater was admitted to Royal Newcastle Hospital at about 1:32pm in a stable condition. He was initially attended to by Dr Alfred Bennett, who observed that his injuries were consistent with being punched or kicked. He was also attended to by a neurosurgeon, Dr A. J. Bookallil.

## Special Commission of Inquiry into LGBTIQ hate crimes

---

10. Police attended and attempted to interview Mr Slater but were unable to obtain any coherent information.
11. The Surgical Registrar reported that, at 12:30pm on 20 December 1980, Mr Slater developed acute pulmonary oedema, consistent with myocardial infarct and his past history of cardiac disease. Treating doctors were able to stabilise him. However, on 22 December 1980, Mr Slater's condition rapidly deteriorated, and he died after a cardiac arrest at 5:07pm.
12. A summary of Mr Slater's condition on admission, and subsequent deterioration and treatment is contained in a statement of Dr Bennett dated 13 January 1981; and a letter provided to investigating police by the Surgical Registrar, John Vincent Newton, on 2 February 1981. The Royal Newcastle Hospital no longer holds any medical records relating to Mr Slater, this admission, or his subsequent treatment.

### *Post-Mortem investigation*

13. An autopsy was performed on 22 December 1980. In a preliminary report dated the same day, the cause of death was identified as a traumatic brain injury, with an antecedent cause of myocardial infarction.
14. In a revised report dated 28 January 1981, the author, Dr Banathy, expressed the view that traumatic brain injury was the main cause of death, but noted the pre-existing myocardial infarctive changes and assumed that the shock of the trauma precipitated another infarctive change which contributed to Mr Slater's death.
15. Although it is not reflected in either report, Dr Banathy apparently expressed the view to investigating police that Mr Slater's injuries were consistent with having been punched in the head, possibly four times, resulting in extensive bruising and fractures to the face bones and laceration of the left ear, further resulting in brain damage. He also expressed the view that Mr Slater's chest had been stomped on causing bruising to the chest and a ruptured spleen.
16. In a report dated 3 December 1982, prepared for the purpose of related legal proceedings, Mr Slater's treating neurosurgeon, Dr Bookallil, opined that Mr Slater's cause of death was primarily myocardial infarction and not "directly" attributable to his head injury. Dr Bookallil noted that Mr Slater's head injury had not caused him undue concern, he would have expected Mr Slater to improve absent the development of a pulmonary oedema, which resulted in his transfer to the care of cardiologists. However, Dr Bookallil declined to speculate as to whether Mr Slater's myocardial infarction could have been precipitated by a head injury and recommended a cardiologist's opinion be sought.

### *Investigation by the Inquiry*

17. The Inquiry has obtained an expert report prepared by Associate Professor Mark Adams, a cardiologist, expressing the view that there was a causal connection between the injuries obtained by Mr Slater in the assault and the subsequent myocardial infarction causing his death.

## **Material with which you are briefed**

For the purpose of preparing your report, you are briefed with the materials in the **enclosed** index. The material contained in the index has been extracted from the NSWPF investigation file and the court file from the Coroners Court of NSW. In addition, an expert report has been obtained from A/Professor Mark Adams.

If there is any additional material that you consider would be of use to you in forming your opinion, please contact Emily Burston and this material will be provided to you (if available).

## Special Commission of Inquiry into LGBTIQ hate crimes

---

### Matters to be addressed in your report

I would be grateful if you could address the following matters in your report, having regard to the material with which you are briefed and to the extent that they are matters which fall within your expertise:

1. Your view as to the extent that Mr Slater's head injuries would have affected his comprehension and the coherency of his answers to attending ambulance and police officers.

If there is any other matter arising from the circumstances of Mr Slater's death within your area of expertise on which you wish to express an opinion and which will be of assistance to his Honour, please do so.

I also request that you please attach a detailed curriculum vitae to your report.

### Expert Witness Code of Conduct

I **enclose** a copy of the Expert Code of Conduct with which expert witnesses in Supreme Court proceedings in NSW are typically required to comply. While the present inquiry is not a Court proceeding, I would be grateful if you would read the Code of Conduct and agree to be bound by it. I suggest the following form of words be included in the body of your report in due course:

"I, Professor Michael Besser, acknowledge that I have read the Expert Witness Code of Conduct in Schedule 7 to the Uniform Civil Procedure Rules 2005 (NSW) and agree to be bound by it."

### Terms of engagement

#### *Rates*

Per your email correspondence with Emily Burston dated 1 March 2023, I understand that your relevant rates are **\$250/hour**.

#### *Invoicing requirements*

It is essential to comply with the Australian Taxation Office requirements that any invoice issued be addressed to the business name: Department of Premier and Cabinet.

Prior to paying any invoice, the Department must register you as a consulting expert. In order to do, the Department will require the following documents:

- A completed confidentiality deed;
- A signed letter on company letterhead containing supplier name, address, ABN and bank details; and
- A bank statement or letter, no more than 6 months old, confirming your bank details (per the abovementioned letter).

A draft confidentiality deed is **enclosed**. I would be grateful if you could complete and return that document to me by email prior to commencing your review of the material in relation to this matter.

If an amount for GST is to be included in your fee, you will need to cite your ABN and either:

- Indicate that the fee is inclusive of GST; or
- Separately indicate the amount of GST charged.

## Special Commission of Inquiry into LGBTIQ hate crimes

---

Thank you for your consideration and assistance.

Please do not hesitate to contact Emily Burston, Senior Solicitor on [REDACTED] or Kate Lockery, Principal Solicitor on [REDACTED] if you have any queries in relation to this matter.

Yours faithfully,



Emily Burston  
Senior Solicitor  
**Solicitor Assisting the Inquiry**

Encl. (3)

## Special Commission of Inquiry into LGBTIQ hate crimes

### Index in the matter of Richard Slater

As at 7 March 2023

Tab	Description	Date	SCOI.No
1.	Report of death of a Patient to the Coroner	22 December 1980	SCOI.10343.00027
2.	Revised autopsy report prepared by Dr Laszlo Julius Joseph Banathy	28 January 1981	SCOI.10343.00029 and SCOI.10343.00030
3.	Histopathology report	22 December 1980	SCOI.73572.00012
4.	Report of Sandra Anne Gorringe	16 February 1981	SCOI.10343.00031
5.	Report of Dr A.J. Bookallil	3 December 1982	SCOI.10343.00009
<b>Medical Officer Statements</b>			
6.	Statement of Bruce James Varley	31 December 1980	SCOI.10343.00018
7.	Statement of Dr Alfred Paul Bennett	13 January 1981	SCOI.10343.00025
8.	Letter from Dr John Vincent Newton	2 February 1981	SCOI.10343.00026
<b>Police Statements and Material</b>			
9.	Statement of Detective Sergeant Ross Clark (original OIC)	24 May 1981	SCOI.10343.00022
10.	Statement of Sergeant Alfred James Power	1 November 1982	SCOI.10343.00020
11.	Statement of Sergeant Douglas Oliver Marsh	1 November 1982	SCOI.10343.00021
12.	Running sheet entry containing summary of events leading to death of Richard Slater	22 December 1980	SCOI.10343.00055
<b>Witness Statements</b>			
13.	Statement of Arthur Geoffrey Clements	22 December 1980	SCOI.10343.00022
14.	Statement of Kenneth Sydney Archer	7 January 1981	SCOI.10343.00014
<b>Report obtained by Inquiry</b>			
15.	Expert report of A/Prof Mark Adams (annexures omitted)	13 January 2023	N/A