The Special Commission of Inquiry
into LGBTIQ Hate Crimes

TENDER BUNDLE HEARING OF 18 AND 19 MAY 2023

Concerning the deaths of William Rooney, Richard Slater, Paul Rath and Simon Wark

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 in response to the submissions made by Counsel Assisting on 18 and 19 May 2023 in relation to the death of Richard Slater, William Rooney, Paul Rath and Simon Wark.

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.

William Rooney

Circumstances of death

3. The Commissioner of Police agrees with the overarching summary of the date, location, and circumstances of Mr Rooney's death set out at CA [2] – [7].

4. Mr Rooney died on 20 February 1986 as a result of injuries he suffered on 14 February 1986. It is not possible to determine whether he sustained his injuries as a result of an assault or an accidental fall (CA, [214]).

Adequacy of police investigations

5. Counsel Assisting raises concern in relation to the change in Detective Senior Constable Tate's view as to the extent to which Mr Rooney's death was suspicious. That change in view is said to have occurred "at some stage between 14 February 1986 and 5 February 1987" (CA, [38]).

6. The concerns raised by Counsel Assisting in this respect (CA [40] – [44]) make no reference to the fact that on 21 February 1986, Dr Vincent Verzosa's post-mortem report recorded that Mr Rooney's injuries were "probably due to a fall with [back] of head hitting a hard surface."[1]

7. In his statement, DSC Tate also records he came to the opinion Mr Rooney was under the influence of liquor and sustained his injuries as the result of falling following completion of a number of inquiries, having viewed the deceased and where he was found, and lengthy discussions with Detective Sergeant Passmore.[2]

8. D/Sgt Passmore's statement indicates that he "closely examined" the relevant area but "was unable to find anything which could assist with determining the cause of ROONEY's injuries".[3]

9. It appears that staff of the L & B Discounts store may have begun to wash away blood prior to D/Sgt Passmore's arrival. To the extent that police failed to prevent this occurring after they arrived on scene, it is undoubtedly a concerning feature of the original investigation.

10. D/Sgt Passmore also completed an examination of the injuries apparent on Mr Rooney's body with the assistance of Intensive Care Unit Staff on Wollongong Hospital. According to D/Sgt Passmore, Mr Rooney "appears to have only very slight superficial external injuries on his face and body which were not consistent with an assault victim".[4] Of note, D/Sgt Passmore attended the post-mortem examination conducted by Dr Verzosa, and it

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[1] Autopsy Report, SCOI.11268.00006.
[2] Statement of Tate, [9] (SCOI.11269.00018).
[3] Statement of Passmore, [3] (SCOI.11269.00016).
[4] Statement of Passmore, [3] (SCOI.11269.00016).

is quite likely that D/Sgt Passmore's views were influenced by those of Dr Verzosa, who very clearly considered Mr Rooney's death to be the result of an accident.[5]

11. In that respect, during the inquest, Dr Verzosa provided a detailed account of the observations he made during the autopsy.[6] In the course of that account, he stated "there was nothing disturbed on the surface of the skull"[7] before expressing his conclusions as follows:[8]

> *In my opinion I am of the strong belief that [Mr Rooney's injuries] would be caused by the head hitting a flat hard surface, with the back of the head hitting the flat hard surface, and the back of the elbow maybe also a part of the fall where reflex where the deceased might have tried to break his fall or reflex if elbow hit the ground first before the head.*

12. As to whether the injuries were consistent with being struck on the back of the head with an object of some kind, Dr Verzosa stated:[9]

> *In my experience battering of the head with hard instruments, whether wood or metal usually, maybe 99 percent of them the skin is split open together with the fracturing of the skull, and in most instances the surface of the skull following a blow from a very hard object would show by some destruction of the surface of the skull.*

13. Notwithstanding the significant reservations as to these opinions recently expressed by Dr Iles in her report prepared for the Inquiry, police cannot be criticised for affording weight to the clear views held by Dr Verzosa at the time of Mr Rooney's death. Of particular note, while Dr Iles was unable to exclude the possibility that Mr Rooney's head injury was inflicted by an object, her observations in that respect were informed by a study conducted almost 30 years after Mr Rooney's autopsy.[10] That study showed that "whilst lacerations were more common in homicidal head trauma with skull fracture, they were still absent in 23% of cases".[11]

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[5] Statement of Passmore, [7] (SCOI.11269.00016).
[6] Inquest Transcript, pp. 2 – 3 (SCOI.03683.00013).
[7] Ibid, p. 3.
[8] Ibid, p. 3.
[9] Ibid, p. 4.
[10] Dr Iles Report, p. 10 (SCOI.82574).
[11] Dr Iles Report, p. 10 (SCOI.82574).

14. Nevertheless, it is acknowledged that it is very unfortunate that the autopsy report does not include a comment in relation to the presence or absence of anogenital injuries and/or the conduct of anal or penile swabs.[12] The reasons such examinations were not conducted (or at least were not recorded) are not apparent on the material. Counsel Assisting's assertion (CA, [48]) that this may be attributable to a failure on police's part to provide relevant information to Dr Verzosa is speculative. The Inquiry does not appear to have explored the fact that no such examination was conducted with the officer-in-charge of the investigation.[13]

15. It appears that the investigation conducted in Mr Rooney's case was not as comprehensive as would have been expected today in the context of a *potential* homicide. Nevertheless, it is relevant to note that in October 1986 and May 1987, an inquest was held before Coroner Warwick Soden and that there is no indication in the Coroner's determination that the police investigation was regarded as in any way inadequate, having regard to the prevailing standards.

16. The basis of the hearsay statement regarding police attitudes attributed to Mr Davis (Mr Rooney's de facto partner) in Mr McNab's book (CA [45]) is not apparent and cannot sensibly be afforded any weight. In any event, this assertion has not been put to any of the relevant officers.

17. It is to Detective Inspector Ainsworth's credit that he later pursued the possibility that Mr Scerri was responsible for the death of Mr Rooney.

Strike Force Parrabell review

18. Counsel Assisting asserts that the disconnect between the conclusions in the BCIF categories (each of which was answered "No evidence of Bias Crime") and the overall categorisation, being "Insufficient information", suggests "some inconsistencies or confusion in the methodology of SF Parrabell officers" (CA, [55] – [56]). This observation fails to account for the fact that the overall conclusion of SF Parrabell in each case was not a product of some mathematical process involving the BCIF indicators, but rather

[12] Dr Iles Report, p. 9 (SCOI.82574).
[13] Detective Senior Constable Tate, for his part, states that he arrived at the scene after Mr Rooney had been removed, and states that if he had considered that Mr Rooney might have been sexually assaulted, he would have raised that with treating doctors, and that he would have expected Mr Rooney's treating doctors to let him know if, during their medical examination, anything led them to believe Mr Rooney might have been sexually assaulted: statement of John Robert Tate, [21] (SCOI.83107).

resulted from a consensus determination by the senior officers involved in the Parrabell review. The fact that the overall conclusion was not simply the result of blind deference to the notations made by the initial reviewing officer is evidence not of some failure in the Parrabell process, but rather of the way the consensus review by senior officers within SF Parrabell worked in practice.

19. Indeed, the criticisms in [64] and [65] of Counsel Assisting's submissions reflect a misapprehension of the way the SF Parrabell process worked. The conclusion and comment in the "Summary of Findings" section of the BCIF are reflective of the discussions and consensus reached by the senior members of the SF Parrabell team in relation to the appropriate categorisation of Mr Rooney's death. As is apparent from that consideration, the possible involvement of Mr Harrison or Mr Scerri (or some other person) in Mr Rooney's death led to an ultimate conclusion that Mr Rooney's case should be placed in the "insufficient information" category.

20. The conclusion aligns with the ultimate view of Counsel Assisting and was entirely appropriate for a number of reasons.

21. First, in light of the ambiguity in the evidence, it is not possible to be positively satisfied as to what caused Mr Rooney's death. He may have been assaulted with an object, but the medical evidence suggests that it is more likely that his injuries resulted from a fall. In that respect, while expressing significant reservations as to the sufficiency of post-mortem examination (perhaps in part on account of the relative lack of detail in the post-mortem report), Dr Iles indicates that she "favours" Dr Versoza's interpretation over that of Dr Ramsay,[14] who had given evidence that he found it "hard to believe" the injuries to Mr Rooney's skull were consistent with a fall from three metres on to a concrete floor.[15] While a finding that Mr Rooney's death resulted from a fall would not rule out the possibility of an assault, there is no presently available evidence that would allow a positive conclusion to be reached as to such a course of events.

22. Second, a conclusion that Mr Rooney's death was caused by an assault would not, without more, allow a conclusion that his death was the product of anti-LGBTIQ bias. Even if it were established, for example, that Mr Rooney was a victim of Mr Scerri, that would not lead inexorably to a conclusion that Mr Rooney's homicide must have been motivated by

[14] Report of Dr Iles, received 31 January 2023, 11 (SCOI.82574).
[15] Inquest Transcript of 24 October 1986, 5 (SCOI.03683.00011).

anti-LGBTIQ bias. Mr Scerri was, himself, a gay man. His actions may have been driven not by an anti-LGBTIQ bias, but rather a form of sexual sadism or a more generalised desire for sexual gratification. That said, as noted by Counsel Assisting, there is some material to suggest that Mr Scerri may have committed offences against homosexuals as they were "easier targets"[16]. Accordingly, were Mr Scerri determined to be responsible for Mr Rooney's death, it is at least possible that anti-LGBTIQ bias was at play.

23. Third, there is no suggestion that Mr Davis was privy to any of the circumstances of Mr Rooney's death. In light of the fact that Mr Rooney had previously been attacked on account of his homosexuality[17], it was understandable that Mr Davis would have held the view that a similar attack had resulted in his death. The fact that he did so, however, is not evidence that Mr Rooney's death was a gay hate attack (cf CA, [27] – [28]).

24. Unfortunately, any conclusion as to the factors motivating Mr Rooney's assailant (if, indeed, he was assaulted) would be entirely speculative.

25. As a final note, in light of Counsel Assisting's consideration of potential investigative shortcomings in the context of criticisms of SF Parrabell, it is important to recall that it was not within the scope or resourcing of SF Parrabell to conduct a comprehensive analysis of the nature or quality of the initial investigations undertaken (cf CA, [61]).

Findings

26. As noted above, the Commissioner of Police agrees with Counsel Assisting's submissions in relation to the appropriate characterisation of Mr Rooney's manner and cause of death (CA, [214]).

27. In line with the findings of SF Parrabell, there is insufficient evidence to conclude that Mr Rooney's death was motivated by anti-LGBTIQ bias.

Richard Slater

Circumstances of death

28. Mr Richard Slater died at 5:07am on 22 December 1980 at Royal Newcastle Hospital.[18]

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[16] Letter from Dr Duflou to Detective Senior Constable S Bridge dated 23 October 2002 (SCOI.11269.00025).
[17] Inquest Transcript of 15 May 1989, 6 (SCOI.03683.00013).
[18] P79A Report of death to the Coroner, 13 May 1976, SCOI.82764.

29. Paragraphs [3]-[4] of Counsel Assisting's submissions provide an accurate summary of the circumstances in which Mr Slater was found on the afternoon of 19 December 1980 inside the men's toilet block in Birdwood Park in central Newcastle. Of particular relevance, while Mr Slater denied having been "bashed" or falling over, he had clearly recently suffered significant injuries, especially to his head,[19] and his money purse containing $30 was missing.[20]

30. Mr Slater was conveyed to Royal Newcastle Hospital and on examination, his injuries were found to include a frontal skull fracture with a small intra-cerebral haematoma in the left parietal lobe with contusion of the surrounding brain and some surrounding oedema, slight deformity of the left quadrigeminal plate cistern, and suspected contusion of the left temporal lobe. He also had a facial fracture and minor chest and bladder injuries.[21] The Resident Medical Officer attending to Mr Slater was of the opinion that his injuries were consistent with his having been "punched or kicked",[22] and it is submitted that it cannot be reasonably contended that Mr Slater suffered those injuries other than via an assault.

31. While on the morning of 20 December 1980 Mr Slater's condition was considered to be "satisfactory", at 12:30pm he went into acute pulmonary oedema. As he had a history of cardiac disease, it was considered he had had an acute myocardial infarction and he was transferred to Coronary Care. By 21 December 1980, Mr Slater had become drowsy and died during cardiac arrest on 22 December 1980.[23]

Cause of death

32. In the initial autopsy report of Dr Laszlo Banathy dated 22 December 1980, the direct cause of Mr Slater's death was listed as "traumatic brain damage", with an antecedent cause recorded as "myocardial infarction."[24]

33. In a revised autopsy report dated 28 January 1981, Dr Banathy added the following opinion:[25]

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[19] Statement of Detective Sergeant Robert Ross Clark, 24 May 1981 at [3], SCOI.10343.00022.
[20] Resume of Investigations, 21 June 1983 at [7]-[9], SCOI.1043.0004.
[21] Letter from Dr John Vincent Newton, 2 February 1981, SCOI.1043.00026.
[22] Statement of Dr Alfred Paul Bennett, 13 January 1981, SCOI.10343.00025.
[23] Letter from Dr John Vincent Newton, 2 February 1981, SCOI.1043.00026.
[24] Autopsy report prepared by Dr Laszlo Julius Joseph Banathy dated 22 December 1980, SCOI.82780.
[25] Revised autopsy report prepared by Dr Laszlo Julius Joseph Banathy dated 28 January 1981, SCOI.82771.

> *Traumatic brain damage was the main cause of death. However, the deceased had pre-existing myocardial infarctive changes. It is assumed that the shock caused by the trauma precipitated another infarctive change which contributed to the death.*

34. At an inquest held into Mr Slater's death in June 1981, Coroner Meehan referenced both the head injuries and the myocardial infarction, finding Mr Slater:[26]

> *…died from the effects of traumatic brain damage and myocardial infarction, following his admission to that hospital on the 19th day of December, 1980 after having been found in Birdwood Park, King Street, Newcastle on that date suffering from certain injuries, but as to the circumstances of his having received those injuries, the evidence adduced does not allow me to say.*

35. The neurosurgeon in charge of Mr Slater's care at Royal Newcastle Hospital offered the following opinion as to the respective roles of the head injuries and myocardial infarction in Mr Slater's death:[27]

> *From the neurological point of view the patient sustained a fairly severe head injury but his condition did not cause any undue concern and I would have expected him to have improved although he may have persisting neurological deficit. As I have stated above once he developed myocardial problems he was transferred to the care of Dr Noel Walker but I do believe that the cause of death was primarily that of a myocardial infarction and not a death directly attributable to his head injury.*
>
> *As a Neurosurgeon I am not really competent to comment on whether a head injury could precipitate a myocardial infarction and I would advise that a cardiological opinion be sought.*

36. In the course of its recent investigations, the Inquiry has sought and obtained expert opinions from both a cardiologist and a neurosurgeon as to the cause of Mr Slater's death. Cardiologist Associate Professor Mark Adams observes that in 1980, the pathophysiology of myocardial infarction, heart failure and other events were poorly understood, but since then a connection has been observed between brain injuries and acute cardiac events,

[26] Coronial findings, 18 June 1981, SCOI.82765.
[27] Report of Dr A.J. Bookallil, 3 December 1982, SCOI.10343.00009.

particularly in patients with underlying cardiac issues. He opines that plaque in Mr Slater's left main coronary artery likely became unstable around 20 December 1980, and:[28]

> *This temporal relationship supports the role of his assault in precipitating this and there are clear mechanisms as to why this might have occurred including the extensive bleeding activating his clotting system, the events causing physical stress and emotional stress leading to sympathetic activation as well as the observed role that significant head trauma can have on cardiac risk…*
>
> *I think that Mr Slater's mode of death was most likely the extensive myocardial infarction he suffered between 20 and 22 December 1980 as this led to cardiogenic shock that was irreversible, however as explained above I think that this event was precipitated by the assault and extensive injuries he sustained from the assault. I base this largely on the clinical course and the postmortem findings of extensive infarction involving almost the whole left ventricle.*

37. Neurosurgeon Professor Michael Besser AM agrees that Mr Slater's traumatic brain injuries likely precipitated the myocardial infarction:[29]

> *In my experience older patients over 65 years of age have a significant mortality with a traumatic brain injury to this extent. This is supported by the extensive local and international literature. The prognosis for a full recovery would be very poor and I disagree with Dr Bookallil's comments in this regard…*
>
> *The death of Mr Slater was most likely due to a forceful, multiple assault causing haemorrhagic contusions to his dominant hemisphere together with subarachnoid haemorrhage and a small subdural haematoma. At the age of 69 years this combination of pathologies carries a high mortality rate with a very poor outlook for functional recovery…*
>
> *The agonal event causing the immediate death of Mr Slater was heart failure due to a massive myocardial infarct. However I agree with the expert report of Professor Adams that the assault and subsequent severe traumatic brain injury precipitated his cardiac events.*

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[28] Expert report of Associate Professor Mark Adams, 1 December 2022, SCOI82758.
[29] Expert report of Professor Michael Besser AM, 7 March 2023, SCOI.82195.

38. The law of causation does not require the acts of a person to be the only or most important cause;[30] rather, to establish criminal liability for a particular consequence, such as death, the Crown must be able to establish that the act or acts were a "substantial" or "significant" cause.[31]

39. Taking into account the expert opinions of Associate Professor Adams and Professor Besser, which set out the significant development in the understanding of the relationship between trauma-induced brain injuries and myocardial infarction since 1980 and the relevant literature, the Commissioner of Police agrees with Counsel Assisting (CA, [124]) that the person responsible for Mr Slater's injuries should also be considered, at law, to have caused Mr Slater's death, in that the brain injuries sustained via the assault may properly be said to be a substantial or significant cause of death.

40. Accordingly, the Commissioner of Police does not dispute the appropriateness of Counsel Assisting's proposed finding as to the manner and cause of Mr Slater's death (CA, 125). This finding more accurately reflects the causal nexus between the assault of and brain injuries sustained by Mr Slater and his ultimate death identified by Associate Professor Adams and Professor Besser, and is consistent with the findings at autopsy.

Adequacy of police investigations

Documentary records

41. Counsel Assisting asserts that it is difficult to assess the adequacy of the initial police investigation "not least because it seems that at least some of the records relating to that investigation are missing from the material produced to the Inquiry", and that the material produced relates primarily to the additional investigative steps taken in 1982 following the implication of Mr Jeff Miller in Mr Slater's assault by his associate I219 (CA, [36]).

42. It is an unfortunate reality that documentary records from approximately 40 years ago may be lost or no longer available. However, Counsel Assisting's criticisms of NSWPF's production must be considered in context.

43. Over 100 pages of the material tendered by Counsel Assisting in the Inquiry's documentary hearing in relation to this matter appears to have been produced by NSWPF. Indeed, despite the issuing of several summonses by the Commissioner of the Inquiry, the only

[30] *R v An; R v LM* [2022] NSWSC 776 at [87], citing *Swan v The Queen* [2020] HCA 11; 269 CLR 663 at [27].
[31] *Royall v The Queen* (1991) 172 CLR 378 at [18] per Deane and Dawson JJ.

other entity able to produce records relating to Mr Slater's death was the Newcastle Local Court, which produced 14 pages from the Coroner's file.[32] This was the case notwithstanding Mr Miller having been charged with Mr Slater's murder on 1 September 1982, the matter proceeding to a committal hearing at Newcastle Court of Petty Sessions in November 1982 where Mr Miller was committed to stand trial in the Supreme Court, and a successful application by the defence for a "No Bill" in March 1983 (CA, [33]-[35]).

44. The material produced by NSWPF and tendered by Counsel Assisting is extensive, comprising eight police statements, four statements from medical officers and an expert medical report, 14 statements or records of interview with persons of interest or witnesses, and crime scene photographs, together with a number of other documents summarising the investigations undertaken. In those circumstances, and bearing in mind the inability of other agencies to produce *any* relevant records, the criticism by Counsel Assisting that some documents appear to be missing from NSWPF's production rings somewhat hollow.

45. Further, that a number of documents produced by NSWPF and tendered by Counsel Assisting relate to investigations undertaken after evidence was given by a witness implicating Mr Miller in August 1982 is unsurprising, noting the preparation of more extensive written records necessary for the subsequent prosecution of Mr Miller, and indeed Counsel Assisting's own view that it appears "highly likely that Mr Miller was responsible for the assault on Mr [Slater]" (CA, [123]). In any event, it appears that approximately half of the documents tendered by Counsel Assisting that appear to have been produced by NSWPF relate to investigations that occurred *prior* to August 1982.

Exhibits not retained

46. The Commissioner of Police agrees with the submission of Counsel Assisting that it is highly regrettable that the exhibits in connection with the Slater matter, in particular Mr Slater's shirt and trousers on which semen had been detected, were not retained (CA, [29]).

47. Again, however, this must be viewed in context. All forensic testing that could be conducted on the clothing at that time was undertaken, and the quantity of semen present was found to be insufficient to allow for grouping testing.[33] The advancements in forensic testing capabilities and identification by DNA in the more than 40 years since Mr Slater's death

[32] Statement of Emily Burston, 18 May 2023 at [4], SCOI.45198; Counsel Assisting's submissions at [51].
[33] Report of forensic examination by Sandra Anne Gorringe, 16 February 1981, SCOI.10343.00031.

could simply not be known in the early 1980s. Even had such exhibits been retained, whether they would be suitable for testing, the results of such testing and the inferences able to be drawn from those results about the circumstances of Mr Slater's death are matters of speculation (cf CA, [29]-[30]).

Interviewing of members of the LGBTIQ community

48. Counsel Assisting next asserts that the police investigation may have been informed or affected by negative stereotyping, referencing an early police summary which notes that despite the assault taking place in a public toilet "frequented by homosexuals", Mr Slater enjoyed a good reputation and there was no suggestion he was an associate of a "criminal element"[34] (CA, [38]). While such an inference is undoubtedly offensive and inappropriate by today's standards, it is unfortunately reflective of the legal position at the time of Mr Slater's death: homosexuality remained a criminal offence in New South Wales until 1984.

49. That police are said to have interviewed "numerous homosexuals, transvestites and other persons" (CA, [38]) is also unsurprising given the Birdwood public toilets' well-known status as a beat. Interviews with members of the LGBTIQ community were therefore essential, both because persons using the toilets as a beat were among those likely to have witnessed the assault of Mr Slater or other assaults in that area, and to allow police to investigate the possible motivation (including gay hate bias) for the attack.

No Bill

50. Counsel Assisting also submits that the (CA, [39]):

> *…investigation was able to obtain convincing evidence incriminating Mr Miller, but ultimately fell short. Without knowing the complete case advanced at the committal, and the reasons why the prosecution was withdrawn, it is not possible to accurately assess to what extent that outcome was avoidable or whether it arose as a result of a shortcoming in the investigation.*

51. In the absence of any evidence in support of the proposition that the prosecution of Mr Miller did not proceed because of a shortcoming in the police investigation, any such inference is unfair and without foundation.

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[34] Summary of events leading to death of Richard Slater, 22 December 1980, SCOI.10343.00055.

52. This is particularly so in circumstances where, as acknowledged by Counsel Assisting (CA, [107]-[112]), it appears the ability to prove the necessary causal link between Mr Slater's injuries and his death from myocardial infarction may have been in question (especially in light of the report of Dr Bookallil), there were inconsistencies in the evidence of some eyewitnesses, and the key witness implicating Mr Miller, I219, had an extensive criminal history.

53. Further, as conceded by Counsel Assisting (CA, [37]), rather than any evidence suggesting the police investigation was in some way inadequate, the information available such as via media reports from that period, suggests the police investigation was even more extensive than is evident on the face of the documentary records available. In particular, police are reported as having interviewed as many as 60 people in connection with Mr Slater's death,[35] Mr Slater's family members were spoken to,[36] and a $50,000 reward (being a very substantial sum in 1980) for information was offered.[37]

54. A finding that the prosecution of Mr Miller was "No Billed" because of any "shortcoming" in the police investigation is not open to the Inquiry on the evidence.

Possible gay hate crime?

Relevant factors

55. There is no evidence to suggest Mr Slater was a member of the LGBTIQ community. Conversely, there is evidence to suggest he had used the Birdwood public toilets previously to relieve himself, noting he suffered from a prostate condition, rather than as a beat.[38] However, as correctly noted by Counsel Assisting (CA, [17]), Mr Slater's sexuality or reason for attending the toilet block is not determinative of whether his death should be classified as a gay hate homicide. Rather, it is the motivation of his attacker that is critical to such an assessment.

56. In this regard, it is submitted that the following factors are or may be relevant:

    a) the Birdwood public toilets were a well-known beat;

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[35] "Bashing mystery: 60 interviewed by police", *The Sun,* 5 January 1981, SCOI.82779.
[36] Summary of events leading to death of Richard Slater, 22 December 1980, SCOI.10343.00055.
[37] Resume of investigations at [13], SCOI.10343.00004.
[38] Summary of events leading to death of Richard Slater, 22 December 1980, SCOI.10343.00055.

b) Mr Slater was found with his belt undone and his trousers and underpants part-way down with his genitals and buttocks exposed;[39]

c) semen was detected on Mr Slater's shirt and trousers;

d) Mr Slater denied being "bashed" or falling down when questioned by attending police and ambulance officers, but there is medical evidence suggesting his head injuries were likely to have caused confusion;[40]

e) Mr Slater's money purse containing $30 was missing and never found;

f) in relation to Mr Miller:

(i) Mr Miller appears to have been gay, or at least previously engaged in sexual activity with men;

(ii) Mr Miller had an extensive criminal history of theft,[41] and statements given by associates suggest he "rolled" men for their wallets in public toilets. I217 said that they had understood Mr Miller had entered the Birdwood public toilet to either have sex with Mr Slater or with the intention of "rolling" him;[42] and

(iii) Mr Miller made a partial admission to police, referencing an inability to trust an associate who had provided a statement to police and "couldn't keep her mouth shut", conceding he had entered the toilet block on the afternoon of 19 December 1980 and asking "what would happen if I say that old bloke had a go at me first",[43] which he later sought to disavow.

Identity of the perpetrator

57. However, to be able to reach any firm conclusion as to whether the assault of Mr Slater was motivated by gay hate, it is submitted that it is necessary to determine the identity of Mr Slater's attacker: this is not a matter in which a gay hate bias can be inferred by the surrounding circumstances.

58. Counsel Assisting's submissions set out an extensive summary of the various accounts given by persons of interest and witnesses, particularly in relation to the actions of Mr Miller

[39] Statement of Neville Alfred Barrett, 1 January 1981 at [8], SCOI.10343.00019.
[40] See for example, expert report of Professor Michael Besser AM, 7 March 2023, SCOI.82195.
[41] Criminal antecedent report for Jeffrey Miller, 13 December 1982, SCOI.10343.00007.
[42] Record of interview with I217, 31 August 1982, SCOI.10343.00043.
[43] Statement of Detective Senior Constable Grahame Robert Inkster, 28 October 1982, SCOI.10343.00032.

on and around 19 December 1980 (CA, [70]-[106]). These accounts are not reproduced here.

59. However, the Commissioner of Police observes the Inquiry recently obtained a statement from a I216 (another associate of Mr Miller),[44] and Inquiry officers spoke with I217 by phone.[45]

60. In a Record of Interview two years after Mr Slater's death, I216 said they were under the impression Mr Miller had entered the toilet block for "sexual reasons".[46] In their 2023 statement to the Inquiry, I216 stated they did not consider Mr Miller had assaulted Mr Slater for several reasons, including because they did not consider there was sufficient time for this to have occurred, because they did not hear anything, and because of Mr Miller's unruffled demeanour.[47]

61. Similarly, while in a 1982 Record of Interview with police I217 reported Mr Miller as having said "I'm going to crack it with the bloke in the toilet" which they said was a "term used by homosexuals that means to have sex with another bloke", and that they understood Mr Miller was either going to "crack" it with the man or "roll him and take his wallet",[48] in the 2023 phone conversation with Inquiry officers she is said to have denied any knowledge that Mr Miller had committed acts of violence and could not confirm the accuracy of her Record of Interview.[49]

62. In respect of the variations in the accounts given by both I216 and I217, Counsel Assisting submits their earlier accounts should be preferred (CA, [80], [89]).

63. The Commissioner of Police notes that Counsel Assisting the Inquiry has not sought to adduce viva voce evidence from these two key witnesses in the death of Mr Slater, and instead:

a) adduced the evidence of I216 in the form of a written statement. Neither the letter sent to I216 by solicitors assisting the Inquiry nor any record of the video conference

[44] Statement of I216, 15 May 2023, SCOI.45197.
[45] Statement of Emily Burston,18 May 2023 at [27]-[32], SCOI.45918.
[46] Record of interview with I216, 1 September 1982, SCOI.10343.00046.
[47] Statement of I216, 15 May 2023, SCOI.45197 at [11]-[16].
[48] Record of interview with I217, 31 August 1982, SCOI.10343.00043.
[49] Statement of Emily Burston,18 May 2023 at [29]-[30], SCOI.45918.

between Counsel and solicitors assisting the Inquiry and I216, said to have given rise to the statement, were tendered;[50]

b) adduced the evidence of I217 in the form of a hearsay summary of a phone conversation said to have taken place between her and solicitors and Counsel Assisting the Inquiry. This summary was provided in the form of a statement from a solicitor assisting the Inquiry; and

c) made submissions to the Commissioner of the Inquiry on the basis of this evidence as to the relative veracity of the accounts given by these witnesses.

64. In the Commissioner of Police's submission, such a process for obtaining and assessing the veracity of the evidence of witnesses to an alleged murder is unsatisfactory. It is highly unlikely that the evidence obtained would be admissible in the context of criminal proceedings. At the very least, the Commissioner of the Inquiry should have had the opportunity in the course of a hearing to ask those witnesses questions and make an assessment as to the reliability of their evidence.

65. Ultimately, Counsel Assisting submits that while there is considerable force in the evidence suggesting that Mr Miller was responsible for the assault of Mr Slater, in circumstances where Mr Miller is now deceased and cannot answer a case against him, and a 1982 prosecution did not proceed but no record of the reasons for that decision or the evidence given at the committal proceedings is available, the Inquiry would "hesitate to reach a positive conclusion naming Mr Miller as the individual responsible" (CA, [120]-[123]).

66. The Commissioner of Police submits that in those circumstances no positive finding should be made in respect of the responsibility or otherwise of Mr Miller for Mr Slater's death.

Assessment of presence of gay hate

67. In the absence of a positive conclusion as to the identity of the perpetrator, it is submitted that it is not possible to determine with certainty whether the assault on Mr Slater was motivated by gay hate.

68. Even if Mr Miller was responsible, his precise motivation remains unclear: he was gay himself and appeared to associate with other members of the LGBTIQ community, perhaps suggesting he did not hold any animosity towards members of that community;

[50] Statement of Emily Burston,18 May 2023 at [33]-[34], SCOI.45918.

witnesses suggested they understood him to have entered the toilet block with the intention of having sexual relations *or* stealing Mr Slater's wallet; and even if his motivation was primarily robbery (and a further leap in logic that he selected Mr Slater because he perceived him to be a beat user and an "easy target" is accepted), this may be suggestive of LGBTIQ bias in terms of selection of "targets", but it is not necessarily indicative of gay *hate*. This is considered further below in the context of SF Parrabell.

69. The Commissioner of Police submits that ultimately, the most that can be said is that it is possible that the attack on Mr Slater was motivated by gay hate bias.

Strike Force Parrabell review

70. Finally, Counsel Assisting is critical of the findings of Strike Force Parrabell in their assessment as to whether there was any evidence of gay hate bias in the Slater matter (CA, [42]-[47]). SF Parrabell ultimately concluded that there was no evidence of a bias crime.[51]

71. As is evident from the foregoing, assessing the motivation for the attack on Mr Slater in this matter is fraught.

72. While on one view, a finding of possible evidence of a gay hate crime could be made, that is not to say findings of insufficient evidence or no evidence of a gay hate crime could not be justified, particularly in the absence of certainty as to the identity of the perpetrator. There remain other potential motivations for the assault that find support in the evidence but are unrelated to gay hate. For example, an unknown perpetrator could have opportunistically beaten Mr Slater to rob him of his wallet in an incident entirely unrelated to the fact the toilet block also operated as a beat.

73. As concerns the academic reviewers' categorisation of the Slater case as "Gay Bias Related (Anti-Paedophile)", it is not contended by the NSWPF that there is any evidence suggesting Mr Slater was or was perceived to be a paedophile (CA, [48]-[49]).

Findings

74. As noted above, the Commissioner of Police does not dispute the appropriateness of the following finding proposed by Counsel Assisting as to the manner of cause of Mr Slater's death (CA, [125]):

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[51] Strike Force Parrabell Bias Crimes Indicators Review Form, 28 February 2017, SCOI.32129.

Richard Slater died on 22 December 1980 at Royal Newcastle Hospital as a result of myocardial infarction which was precipitated by severe traumatic brain injury received as a result of being assaulted on 19 December 1980 at Birdwood Park in Newcastle.

75. This finding more accurately reflects the causal nexus between the assault of and brain injuries sustained by Mr Slater and his ultimate death.

76. The Commissioner of Police submits that in circumstances where Mr Miller is now deceased and cannot answer a case against him, and a previous prosecution of Mr Miller for murder did not proceed but no record of the reasons for that decision or the evidence given at the committal proceedings is available, no positive finding should be made by the Inquiry as to whether he was responsible for Mr Slater's death.

77. Finally, the Commissioner of Police submits that in the absence of the confirmed identity of the perpetrator of Mr Slater's injuries, it is not possible to determine with any certainty whether the crime was motivated by gay hate.

Paul Rath

Circumstances of Death

1. The Commissioner of Police generally agrees with Counsel Assisting's characterisation of the circumstances surrounding Mr Rath's death (CA, [3] – [9]) and with the proposed formulation of Mr Rath's manner and cause of death (CA, [129], [131]).

2. The Commissioner of Police notes that the Inquiry has sought, but not yet obtained, an expert forensic scientist's report regarding possible staining to Mr Rath's clothing. The Commissioner of Police reserves her position in respect of any such evidence.

Police investigations

3. Counsel Assisting direct a number of criticisms at the police investigation. At the outset, it is important to note that Mr Rath's death was the subject of an inquest. The Coroner was positively satisfied that the death was accidental, and did not express any concerns with the police investigation, or require any further investigations to be conducted.[52]

[52] See Findings of Coroner Ray William Henry; see also, Transcript extract, undated (SCOI.02734.00007).

4. There is nothing to suggest that, having regard to what was accepted practice as at 1977, the Coroner regarded the investigation as deficient.

5. Counsel Assisting refers to the case of Mr Mark Stewart, where it is said that "police quickly concluded that there were no suspicious circumstances involved in the death" (CA, [31]) and suggest that a similar criticism might be made in the present case (CA, [41]). Counsel Assisting go on to allude to evidence in other matters being considered by the Inquiry which suggests that some police officers investigating deaths in the late 1980s and early 1990s at times gave little or no attention to the possibility that they may have been homicides motivated by gay hate, notwithstanding that, based on the objective circumstances, there was reason to suspect that they were, or may have been, homicides of that nature (CA, [32]).

6. In line with submissions previously made, the Commissioner acknowledges 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.[53]

7. However – and again in line with previous submissions – it would be unfair to subject an investigating officer to criticism on the basis that they did not consider the possibility of anti-LGBTIQ bias in the way that would be expected today, having regard to what is now known about the extent of anti-LGBTIQ violence.

8. Counsel Assisting suggests that as at the late 1980s and early 1990s "there was reason to suspect that there were, or may have been, [anti-LGBTIQ] homicides" (CA, [32]) and goes on to observe that if little attention was given to the possibility of homicides motivated by gay hate in the late 1980s and early 1990s, there is "even more reason to expect" that anti-LGBTIQ bias was not a focus of investigations in the 1970s (CA, [33]). Reference is then made to the 1975 murder of Philip Jones by a group of navy recruits 19 months prior to Mr Rath's death (CA, [34]).

9. It is of course likely that less was known about potential gay-hate homicides in 1977 than in the late 1980s and early 1990s. It is not entirely clear whether Counsel Assisting is suggesting that notwithstanding the very different circumstances surrounding the murder of Mr Jones (which involved a group assault after Mr Jones and a friend had been lured to Curl Curl beach by the recruits), this should have given rise to a consideration of possible

[53] This has previously been acknowledged: see submissions in relation to the death of Mark Stewart at [49].

gay-hate homicide in Mr Rath's case. If such a submission is being advanced, it should be rejected having regard to:

a) the vastly different set of circumstances surrounding Mr Jones' murder;

b) the absence of positive indications of assault on Mr Rath; and

c) the fact that Mr Jones' assailants were the subject of a successful prosecution.

10. In any event, the fact that anti-LGBTIQ bias was not independently explored during an investigation does not, without more, justify a conclusion that the possibility of foul play was 'readily dismissed' (cf, [41]).

11. This is all the more so in circumstances where, apart from the fact that Mr Rath was found deceased in a location that the investigating officer knew was "frequented by homosexuals", there was no evidence available to police that he was gay.[54] The location of Mr Rath's death was not disregarded as irrelevant by investigating police. Rather, having regard to both the location and the fact that Mr Rath's trousers were partly removed, it was determined that an anal swab should be taken.[55]

Investigations regarding the possibility of homicide

12. Counsel Assisting's submissions include a detailed consideration of the possibility that Mr Rath's death was a homicide. While it is accepted that such a possibility cannot be ruled out with certainty, the likelihood that Mr Rath's death was a homicide should not be overstated.

Possible involvement of AB

13. It should be noted at the outset that the information from Mr Rath's sister, Helen Colman (nee Rath), that she was the last known person who saw Mr Rath was not forthcoming during the initial investigation. Counsel Assisting note that Ms Colman's recollection of her brother's visit to her house was not recorded in any note or statement until this Inquiry spoke with her, more than 45 years after the event (CA, [7]). This appears to be because Ms Colman – who was then only 18 years of age – did not provide the information at the time of the initial investigation. Ms Colman attributes her decision not to provide this information to

[54] P79A, Report of Death to the Coroner, (SCOI.82905); cf the recent statement of Gregory Rath SCOI.82920, which indicates that Mr Rath may, in fact, have been gay (at [19] – [21]). It is unsurprising that this information would not have been disclosed to police, having regard to the prevailing societal attitudes to homosexuality (as evidenced by the prevailing criminalisation of homosexual sex).
[55] P79A, Report of Death to the Coroner, (SCOI.82905).

conversations she had both with her then partner (**AB**) (who was concerned an investigation "would affect him professionally as a teacher or throw a bad light on our relationship") and with her parents (who said there was "no need to stir anything else up").[56]

14. Counsel Assisting observe that no persons of interest were identified at the time of the initial investigation but that Ms Colman has expressed a concern that there may be some possibility that AB "could have been involved in some way in Mr Rath's death" (CA, [16]). This concern was not expressed to investigating police. Counsel Assisting submits that Ms Colman's suspicions do not provide a sufficient basis for a conclusion or finding that AB had any involvement in the circumstances of Mr Rath's death (CA, [118]). It may be that these submissions do not go far enough; Ms Colman's suspicions appear to be wholly speculative and should be approached with very great caution, particularly given AB is not represented before the Inquiry.[57]

Other matters relevant to possibility of homicide

15. That the focus of investigations was on possible suicide or accidental death is unsurprising; there was and remains no positive evidence of foul play. Indeed, there is no evidence of anyone being present at or shortly before Mr Rath's death. The only suggestion of Mr Rath intending to meet someone that night came to light more than three decades after his death. In all the circumstances, it was reasonable for police to arrive at a hypothesis that Mr Rath's death was most likely either an accident or suicide.

16. Counsel Assisting note that the officer in charge of the initial investigation stated in his statement for the coronial brief that he "made an examination of the ledge from where the deceased apparently fell, however, I found no notes left by the deceased or signs of a struggle". Counsel Assisting then observe that where a death resulting from a fall from a clifftop had involved foul play, one would not necessarily expect to find positive evidence indicating that a struggle had taken place (CA, [38]). That may be true, but it is arguably trite, and certainly not unreasonable, to conclude that the absence of any indication of a struggle is a matter relevant to an assessment of whether a struggle, in fact, took place.

17. Counsel Assisting also observe that there does not appear to have been any canvassing of local residents or with Mr Rath's church (CA, [39]). The Commissioner of Police acknowledges that there is no evidence based on the material in the tender bundle which

[56] See SCOI.82919, [31], [35].
[57] Having regard to Ms Colman's evidence as to the 15 year age gap between her and AB, it would appear that AB is – if still alive – likely to be approximately 80 years old.

indicates that these investigations were undertaken. If that is so, then it is regrettable that the investigation did not include such steps. However, it should be noted that the information available to the Inquiry does not appear to include a comprehensive account of all investigative steps undertaken.

18. There has been some contact between the officer in charge and the Inquiry, including a teleconference between the officer and those assisting. Understandably, the officer in charge had no independent recollection of Mr Rath's death or the investigation into it more than 45 years later.[58] It does not appear that the teleconference with the officer in charge included an exploration of his ordinary investigative practices, or that it was suggested to him that his investigation was in any way deficient.

19. In any event, based on the evidence which was available at the time of the initial investigation, it is unlikely that such inquiries would have revealed any information which would have meaningfully shed light on the circumstances surrounding Mr Rath's death.

20. Again, there is no suggestion that the Coroner considered the investigation to be in any way deficient. Had the Coroner 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 by the Coroner as at least adequate, having regard to accepted investigative practice at the time and the apparent circumstances of Mr Rath's death.

Availability of exhibits

21. Counsel Assisting notes that the clothing found on Mr Rath was destroyed on the authority of his mother. Counsel Assisting also notes that penile and anal swabs and smears were taken and tested as part of the initial police investigation but that these samples have not been retained (CA, [24] – [27]).

22. The samples were tested by the Division of Forensic Medicine and tested by a forensic biologist. It is not clear whether these samples were disposed of by the Division of Forensic Medicine or consumed during the testing process. In 1977, the relevant laboratory did not retain swabs or smears for long-term storage.[59]

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[58] Statement of Caitlin Healey-Nash, [14], SCOI.82921.
[59] Statement of Carole Field, [7] (SCOI.83234).

23. It is not clear whether Counsel Assisting is suggesting that police should be criticised for the fact that these exhibits have been disposed of (or consumed). Such criticism would be misplaced.

24. The penile and anal samples were contemporaneously tested with nothing indicative of sexual assault found.[60]

25. As acknowledged by Counsel Assisting, at the time of Mr Rath's death, there was no DNA testing capacity available to NSWPF (CA, [27]). Indeed, the earliest DNA testing processes did not emerge internationally until the 1980s and were not available in Australia for some time thereafter. Such changes in technology could not have been foreseen and it is unsurprising, in the circumstances, that the relevant exhibits were not retained.

26. This is all the more so in circumstances where Mr Rath's death was the subject of an inquest, and, in turn, a positive finding that Mr Rath died as a result of misadventure.

Investigations relevant to Mr Rath's sexuality

27. The Commissioner agrees with Counsel Assisting's assessment that, at the time of Mr Rath's death, the evidence that was gathered gave no indication of Mr Rath's sexuality (CA, [17]).

28. As noted above, the possibility that Mr Rath had engaged in some form of homosexual activity in the period surrounding his death appears to have led to the decision to take penile and anal swabs.

29. Counsel Assisting submit that the police investigation ought to have involved the taking of statements from a broader number of family members and friends of Mr Rath concerning any understanding they may have had of his sexuality and any habit he may have had of visiting the Fairy Bower headland as a beat (CA, [40]).

30. Counsel Assisting note that evidence obtained by the Inquiry from Gregory Rath indicates that Mr Rath had been involved in a homosexual relationship. It is not clear from the available material whether investigating police made specific inquiries of Gregory Rath (or anyone else) as to Mr Rath's sexual preferences during the initial investigation.

31. In any event, it is apparent that the inquiries made by investigating police indicated that Mr Rath was a devout Catholic. Mr Rath's family (in particular his parents) were also devout Catholics. Indeed, the evidence recently obtained by the Inquiry suggests that Mr Rath's parents' strongly wished that a finding of suicide be avoided (CA, [43]). In those

[60] See the observations of Expert report of Linda Elizabeth Iles dated 26 October 2022 at page 8 (SCOI .82906_0008).

circumstances, it seems unlikely that Inquiries with Mr Rath's family as to the possibility he was homosexual would have yielded useful information concerning his sexuality.

32. The Inquiry should take care not to unfairly evaluate the steps taken by the officer in charge (who is not separately represented in these proceedings, has not given evidence, and in any event, has no independent recollection of the relevant events), by reference to modern social norms and investigative standards.

33. Counsel Assisting submits in passing that there is evidence that the police conclusions regarding the likely mode of Mr Rath's death was influenced by a sensitivity of Mr Rath's parents to a conclusion not only in relation to suicide, but also as concerns homicide (CA, [42]). The basis of this submission is not explored further in Counsel Assisting's submissions and it is difficult to understand why it was made. The Inquiry should reject the grave assertion, made without any clear evidence, that investigating police unduly minimised the possibility that Mr Rath's death was a homicide in order to avoid causing offence to his parents' religious beliefs.

Anti-LGBTIQ bias

34. There is no contemporaneous evidence that Mr Rath identified as a member of the LGBTIQ community. It is acknowledged that his body was located at or near a beat. However, there is no evidence to suggest this was in any way related to his death.

35. 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 Rath's death was motivated by LGBTIQ bias (CA, [128]). Counsel Assisting's addendum that "it may have been" such a death (CA, [128]) should be approached cautiously.

36. As indicated above, while an open finding as to the cause of death is appropriate, the possibility that the death was a homicide should not be unduly elevated; in all probability, it was not.

37. SF Parrabell categorised this case as "no evidence as to bias". The academic reviewers placed Mr Rath's case in the "insufficient evidence" category. Counsel Assisting's view accords with the latter conclusion (CA, [139]).

38. Given the residual possibility, albeit unlikely, that Mr Rath's death was a homicide, it is accepted that it may have been appropriate to classify Mr Rath's death in the "insufficient evidence" category. This is a matter about which reasonable minds can differ, as is apparent

from a comparison between the conclusions reached by the SF Parrabell reviewers and the Academic Review Team.

39. Having regard to the available evidence, the relative unlikelihood of homicide, and the Coronial finding of accident, the conclusion reached by SF Parrabell that there was "no evidence of bias" is readily understandable. It should not be regarded as pointing "to the likelihood of system classificatory confusion on the part of the Strike Force Parrabell officers" (CA, [54]). Rather, it is reflective of the process whereby the final coding adopted was the result of discussions within the SF Parrabell team, leading to an overall determination being reached by consensus among the senior members of the team.

40. The scope of SF Parrabell did not extend beyond a review of existing holdings. Investigative steps undertaken by the Inquiry, such as the exploration of Mr Rath's sexuality with his family, obtaining of various expert reports, and a consideration of Ms Colman's suspicions about, for example, AB's possible involvement, all fall beyond the scope of the terms of reference and resourcing available to SF Parrabell.

Findings and recommendations

41. Counsel Assisting considers three alternative explanations for Mr Rath's death, namely suicide, accident, and homicide.

Suicide

42. Counsel Assisting concludes that "the possibility that Mr Rath deliberately took his own life cannot be ruled out" (CA, [122]).

43. The evidence would not allow a finding of suicide to be made on the balance of probabilities. Having regard to all the circumstances, however, it is submitted that there is a real possibility that Mr Rath died by suicide. In particular, the following matters at least *potentially* weigh in favour of a conclusion of suicide:

    a) Mr Rath's body was found at the base of a cliff at a location at which a significant number of persons have died by suicide.[61]

    b) Mr Rath suffered from schizophrenia, a condition associated with a very significantly elevated risk of suicide[62].

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[61] See BCIF (SCOI.32131_0010),

[62] See, for example, research indicating that between 5 and 13% of persons with schizophrenia die by suicide: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1845151/#:~:text=Suicide%20is%20a%20major%20cause,is%20the%20most%20accurate%20estimate;

c) As noted by Counsel Assisting (CA, [120]), Gregory Rath (who was only 14 at the time) has recently stated that he "felt like something was wrong" with his brother on the afternoon of 15 June (contrary to the account he gave in 1977 at the urging of his mother) and Ms Colman, thought he was in a contemplative mood about life generally on that same evening.

d) A note entitled "Children" signed by Mr Rath was found in his pocket which read:

i. "God loves little children. 'Children love God with your whole heart and whole soul. Let God's light shine upon you from day to day. Let your little hearts become a replica of His. Place your faith and love in his sacred heart. And he will find a special place in heaven where you will be with Him for eternity."

44. It is appropriate to note that the conclusion in the 1970s that a person had died by suicide no doubt carried greater social stigma than it does today. It was wholly understandable that Mr Rath's family wished to avoid a finding of suicide.

Accident

45. At the time of Mr Rath's death, at law there was a rebuttable presumption against a finding of suicide.[63] Having regard to that fact, and the attitude of Mr Rath's family, as informed by their religious beliefs, the Coroner's conclusion that his death was occasioned by accident is readily comprehensible.

46. However, as noted by Counsel Assisting, the possibility of an accident is not supported by any compelling evidence and the matters that favour a conclusion of accident are relatively speculative (CA, [123] – [124]).

47. Mr Rath's mental illness *may* also be relevant to the possibility that the died by way of an accident (see CA, [123]).[64]

48. The Commissioner of Police agrees with Counsel Assisting's ultimate conclusion that the possibility of accident cannot be ruled out.

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[63] See *R v City of London Coroner, Ex parte Barber* [1975] 1 WLR 1310, 1313; *Mutual Life Insurance Co of New York v Moss* (1906) 4 CLR 311; *Spiratos v Australian United Steam Navigation Co Ltd* (1955, 93 CLR 317, 320 (Dixon CJ, Webb and Fullagar JJ).

[64] See Dr Sullivan's remarks regarding the likelihood his medication would have caused sedation and potentially slowed reactions at [23]. See also, 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.

Homicide

49. A number of observations regarding the possibility that Mr Rath was the victim of homicide are made above.

50. To those, some further observations, by way of response to Counsel Assisting's submissions, may be added:

    a) The absence of compelling evidence in support of alternative hypotheses is not, without more, a sound basis to advance homicide as a real possibility. As has been observed in submissions previously made to the Inquiry, such analysis fails to recognise the statistical reality that suicide and accidental deaths are vastly more common than homicides.

    b) The mere fact that a death occurred in the vicinity of a beat cannot, without more, give rise to a realistic suggestion that Mr Rath was a homicide victim. Indeed, other than Gregory Rath's evidence that Mr Rath had discussed sexual activities he had engaged in with a close friend, there is no evidence to suggest that Mr Rath may have been at the Fairy Bower headland to pursue romantic or sexual connection.

    c) As acknowledged by Counsel Assisting, Ms Colman's evidence that Mr Rath was due to meet someone on leaving her flat on 15 June needs to be considered with an appropriate degree of caution, having regard to the 45 years which passed between the occurrence of the event the subject of the evidence and the taking of the evidence. And, of course, the fact that Mr Rath stated he was planning to meet someone is scarcely sound evidence in support of homicide. Indeed, his refusal to indicate who he was meeting might be taken to suggest that he was not actually planning to meet anyone, but rather was lying about his plans. Such a lie might, in turn, be regarded as consistent with a plan to die by suicide.

    d) There are a range of explanations for the positioning of Mr Rath's trousers. Without more, the position of his trousers could not be regarded as a reliable indicator of possible foul play.

51. All told, homicide cannot be ruled out, but in the absence of *any* concrete evidence that would support such a finding, the possibility that Mr Rath died by way of homicide should not be unduly elevated.

Findings

52. Notwithstanding the submissions made above concerning the relative likelihood of suicide, accident, and homicide, the Commissioner of Police agrees with the ultimate formulation Counsel Assisting proposes in relation to both the cause of Mr Rath's death (CA, [129]) and as to the manner of it (CA, [132]).

Simon Wark

56. These submissions are prepared on behalf of the Commissioner of Police in response to the submissions made by Counsel Assisting on 18 May 2023[65] in relation to the death of Simon Wark.

Circumstances of death

57. The Commissioner generally agrees with Counsel Assisting's characterisation of the circumstances of Mr Wark's death (CA, [2] to [12]). The Commissioner also agrees with Counsel Assisting's ultimate submission as to the manner and cause of death (CA, [135]).

58. Mr Wark's body was located at about 9.30am on 10 January 1990 in the waters in the vicinity of Dobroyd Point. The body had been spotted in the water earlier that morning "somewhere north of Dobroyd Head".[66] The likely point of entry of Mr Wark's body into the ocean was the Gap Bluff in Watson's Bay.

59. Counsel Assisting state that there is no cogent evidence pointing to the involvement of any known individual in Mr Wark's death (CA, [13]). The Commissioner of Police agrees; Mr Wark died as a result of a deliberate act during the course of a psychotic episode (see CA, [135]).

Initial police investigations

60. Counsel Assisting assert that the initial investigation had "certain features that called for more thorough analysis than appears to have occurred" (CA, [28]).

61. It is undoubtedly true that certain additional investigative steps could have been conducted, and that the conduct of those steps may have allayed some of the concerns or suspicions held by family members.

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[65] As amended in Counsel Assisting's amended written submissions dated 22 May 2023.
[66] Statement of Stephen William Bird dated 24 January 1990 (SCOI.00052.00018_0001).

62. That said, it is entirely appropriate for an investigation into a death bearing strong indications of suicide, to be more circumscribed than one where homicide is a real possibility.

63. The investigations conducted by police included inquiries with Mr Wark's treating medical practitioners, his friends and family, a real estate agent and his former lover.

64. Counsel Assisting levels a number of particular criticisms at the police investigation (CA, [30]). A number of observations should be made in response to those criticisms.

65. Detective Senior Constable Michael Plotecki's statement indicates that on the morning of 15 January 1990 (i.e the morning following the conclusion of the post-mortem examination the evening before) he arranged for Constable Ford of the Water Police to photograph the scene at the Gap where Mr Wark's clothing had been located.[67] It is accepted that police should have attended the location of Mr Wark's property at the Gap Bluff earlier than they did (CA, ([30](a)). No record of that attendance (or the photographs taken) is available as at today's date (some 33 years after the relevant events). It does not appear that the Inquiry has made inquiries with either Constable Plotecki or Constable Ford to explore their recollections in this respect and no conclusion could be reached by the Inquiry as to what did, or did not, occur in the course of Constable Ford's visit to the scene (CA, [30](b)).

66. As concerns the absence of material in the police brief to the Coroner regarding the location of Mr Wark's body at Dobroyd Point:

    a) As noted by Counsel Assisting, there was a record held by Forensic Medicine which appears to have been created by the forensic pathologist, Dr Bradhurst. This records the author's contact with a "Sergeant Ashley" at Sydney Water Police on 16 January 1990. Sergeant Ashley (who was recorded as the "OIC at time of shift") appears to have informed Dr Bradhurst that "if tide is running in it [being Dobroyd Head] is a common place for "Gap" bodies to be found'.[68] Notably, Professor Brander states in his expert report prepared for the Inquiry that "It would be useful to consult with someone with experience in search and rescue in the region of the Gap Bluff as they may have an understanding of drift directions along

[67] Statement of Detective Constable Michael Charles Plotecki dated 30 January 1990 at [7] (SCO I. 00052. 00026_0003).
[68] SCOI.74823.00019.

that coastline under different wave conditions."[69] It is apparent that this was done during the initial investigation; that is to say, the investigation had resort to the views of an officer[70] with experience of precisely the type contemplated by Professor Brander.

b) The surrounding evidence (in particular the location of Mr Wark's belongings at the Gap) supported the conclusion that the Gap was the point at which Mr Wark's body entered the water. Counsel Assisting acknowledge (as discussed below) that the alternative hypothesis of Mr Wark's body entering the water in the vicinity of Dobroyd Head is extremely unlikely.

c) All of the studies upon which Professor Brander relies forming his opinion post-date the initial police investigation. It therefore seems unlikely this body of work would have been available as at the time of the initial investigation.

67. It is asserted that the conclusion that Constable Ford reached by 13 January 1990 that there were no suspicious circumstances associated with the death was "premature" ([CA, [30.d.]) and then that the subsequent conclusion that Mr Wark took his own life because of the end of his eight-year homosexual relationship and associated loneliness was "entirely reliant" on the views of Mr Wark's psychologist, NM (see CA, [30.e – f]). This criticism is unwarranted; the conclusion that there were no suspicious circumstances surrounding the death (i.e. that Mr Wark had likely died by suicide) was premised not only on NM's views, but a range of other inquiries. At the time her statement of 13 January 1990[71] was prepared:

a) Mr Wark's body had been recovered from the water with no sign of apparent external injuries;

b) Constable Ford had obtained a statement from Mr Wark's father, who explained that he had been "very distraught over the last couple of days prior to his death" and "wasn't coping with life";

c) Constable Ford had contacted a doctor who had seen Mr Wark twice and noted that he had recently finished an 8-year relationship and was taking an anti-depressant;

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[69] Brander Report at [44]. (SCOI.82556_0010).
[70] Constable Ford was herself a Water Police officer, who likely had experience that aligned with that of Sgt Ashley.
[71] See SCOI.10022.00040.

d) Constable Ford had received consistent information from the psychologist NM, who also referred to his depression stemming from the end of an 8-year relationship; and

e) Mr Wark's property was found at the cliffs at the Gap at about 5pm on Thursday, 11 January 1990. The Gap has long been notorious as a place where a large number of people die after deliberately jumping from the cliffs.

68. A subsequent statement, dated 24 January 1990[72], was then prepared by Constable Ford following confirmation from Dr Bradhurst that the injuries suffered by Mr Wark were consistent with a fall from a great height and that there were no suspicious indications arising from the autopsy examination.[73]

69. Some further observations should be made regarding Counsel assisting's criticisms of the approach made to NM's evidence:

a) First, Counsel Assisting point out that NM's evidence was in the form of a handwritten letter rather than a formal statement. NM's evidence was consistent with other evidence obtained at the time. The ultimate conclusion was that there was no foul play. Were the matter to have progressed further (either to inquest or to some form of criminal investigation) no doubt NM's account would have been sought in more detail.

b) Second, Counsel Assisting's suggestion that NM 'featured' in the events that occurred immediately before Mr Wark's death imports a vaguely sinister tone that is unwarranted. NM had engaged with Mr Wark as his treating clinical psychologist.[74] Clinical psychologists are trained to diagnose mental health conditions, including depression. NM's contact with Mr Wark occurred subsequent to a referral from Mr Wark's general practitioner, Dr Jeff Sleep. As noted above, Dr Sleep had provided police with information that corroborated NM's account of Mr Wark's mental state.[75] In the circumstances, NM's evidence was clearly relevant to the investigation and there is no reason her views as to Mr Wark's mental state should be discounted in the way suggested by Counsel Assisting. Notably,

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[72] SCOI.00052.00024.
[73] SCOI.00052.00007.
[74] See SCOI.00052.00022.
[75] Letter from Constable Lisa Ford and Detective Senior Constable Plotecki to the Coroner, in response to issues raised by the Wark family with the Coroner at [11] (SCOI. 00052.00044.0005).

> Dr Sullivan states that the 'impression of the psychologist related to depression and heavy alcohol use appears appropriate.[76] Dr Sullivan further states that he considers Mr Wark's behaviour in the preceding days, and the circumstances of his death, are consistent with suicide.[77]

70. A range of further aspects of the inquiries conducted by police are set out in a report provided to the Coroner on 19 June 1990.[78] As is noted by Counsel Assisting, one witness – Mr Wark's landlady, Mrs McLaughlin – indicated that when she spoke to Mr Wark in the afternoon of 9 January 1990 he was highly distressed and agitated.[79] Ideally, a statement would have been taken from Mrs McLaughlin to record this formally. Having regard to the nature of the information obtained by police, and to the compelling evidence as to the cause of Mr Wark's death, the absence of such a statement is not a proper basis for criticism of investigating police. Had there been any real doubt as to the cause of Mr Wark's death, police would very likely have returned to formally record Mrs McLaughlin's account. As is explained in the correspondence from Constable Ford and Detective Constable Plotecki, "in any death inquiry, there will exist minor inconsistencies which are not able to be addressed".

71. Similarly, had there been any real doubt as to the cause of Mr Wark's death, police would no doubt have further considered the investigative value of Mr Wark's clothing (see CA, [30](g)). The steps taken by Mr Wark's sister upon discovery of dockets and receipts among the items left at the Gap reflect very positively upon her, and the love she had for her brother. The information she uncovered, however, is not information that was required in order to sufficiently discern the manner and cause of Mr Wark's death.

72. Police resources are (and were) finite. While further inquiries may have been able to be conducted in relation to matters relating to Mr Wark's state of mind, such inquiries quite likely would not have resolved the family's residual doubts and, in any event, would not have advanced the position as concerns the manner and cause of Mr Wark's death.

73. Similarly, coronial resources are finite. Where the manner and cause of death are appropriately disclosed on the available information, it is appropriate that an inquest be

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[76] Sullivan Report at [36] (SCOI.82114_0005).
[77] Sullivan Report at [38] (SCOI.82114_0006).
[78] SCOI.00052.00044.
[79] SCOI.00052.00044, [11].

dispensed with.[80] It is not the role of police to "press" for scarce coronial resources to be applied to such cases, in order to address inconsistencies that are unlikely to be of material significance to the determination of the manner and cause of a death (cf, CA [30.i]).

Was the death LGBTIQ-hate related?

74. The Commissioner agrees with Counsel Assisting's assessment that Mr Wark's death did not involve gay hate bias (CA, [134]). This accords with the determination by Strike Force Parrabell (and the academic reviewers). It is also consistent with the initial investigation.

75. Counsel Assisting state that apart from the 'possibility' that Mr Wark's body could have entered the water from the Reef Beach or Dobroyd Head area (being an area known to have functioned as a beat at times and where there were known instances of assaults targeting gay men in the late 1980s) (CA, [19]),there is no cogent evidence to support the conclusion that Mr Wark's death was one motivated by gay hate bias.

76. In this regard, the Commissioner of Police adopts Counsel Assisting's analysis at CA [132] of the extreme unlikelihood that either:

a) Mr Wark went to the Gap, took off some of his clothes and left them there, then took a trip to the Dobroyd Head area where he happened to be assaulted; or

b) Mr Wark travelled to Dobroyd Head and, after being the victim of an assault there, his assailant retained some items of his clothing and travelled to the Gap to deposit the items.

77. Despite reaching the same ultimate conclusion as SF Parrabell, Counsel Assisting make a number of criticisms of SF Parrabell's review of Mr Wark's death. These largely overlap with the criticisms made of the initial police investigation (which are addressed above). For the reasons expressed above, a number of those criticisms are wholly unwarranted.

78. Some additional observations regarding Counsel Assisting's criticisms should be made.

79. First, Counsel Assisting is perhaps correct to say that the BCIF is not well designed to consider whether or not Mr Wark's death may have been an LGBTIQ hate homicide (CA, [38]). But that is not because it "assumes the existence of a known person of interest" (a complaint which is relevant to only some of the indicators in any event). Rather, it is because Mr Wark's death was very clearly not a homicide, let alone a bias-motivated

[80] See *Coroners Act 1980*, ss. 14(2), 22.

homicide. No doubt, SF Parrabell officers could have formed a conclusion in relation to Mr Wark's death without recourse to potential indicators of bias. That they are now criticised for adopting a diligent approach and nevertheless considering the possible application of potentially relevant factors is surprising.

80. Second, Counsel Assisting appears to be labouring under a misapprehension of the training and function of clinical psychologists (CA, [39] – [41]). As alluded to above, the diagnosis and treatment of mental health conditions such as depression is a central function of clinical psychologists such as NM. No doubt that is why Dr Sleep referred Mr Wark to NM. While NM's contact with Mr Wark was somewhat limited, there is no reason to doubt the correctness of the conclusions she reached as to his mental health condition (which have, in any event, been confirmed as likely to have been appropriate by Dr Danny Sullivan[81]).

81. Third, it was beyond the scope and resources of SF Parrabell to seek independent expert opinion to assess the analysis of NM and Dr Sleep (cf Counsel Assisting's criticism at [40]).

82. Fourth, the criticism of SF Parrabell's reliance on the unsigned statement of MS is unjustified. Constable Plotecki's statement explains that MS refused to complete his statement after becoming upset during the interview in response to a question as to whether he was, himself, gay and subsequently receiving legal advice from Redfern Legal. Such a turn of events is unsurprising in circumstances where MS's statement was replete with admissions in relation to his own drug use. As is apparent from those admissions, the statement appears to have been made candidly. There is no reason, on the face of it, for SF Parrabell officers to regard the observations in MS's statement regarding Mr Wark's suicidality as inherently unreliable, particularly in circumstances where they aligned with other evidence as to the circumstances surrounding Mr Wark's death.

Conclusion

83. The Commissioner of Police supports the submissions made by Counsel Assisting as to the manner and cause of the death of Mr Wark.

84. The conclusion advocated by Counsel Assisting as to whether Mr Wark's death was motivated by anti-LGBTIQ bias aligns with the findings of SF Parrabell.

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[81] SCOI.82114, [36].

Overall conclusion

85. The conclusions of Counsel Assisting regarding the possible presence of anti-LGBTIQ bias align with those of SF Parrabell in relation to the cases of Mr Rooney and Mr Wark.

86. Having regard to the circumstances of Mr Rath's death, and to the relative unlikelihood of homicide, SF Parrabell's conclusion that there was no evidence of bias was a reasonable one.

87. Similarly, to the extent Counsel Assisting's views in relation to Mr Slater's death depart from the conclusion of SF Parrabell, the difference in views is readily comprehensible given the residual uncertainty surrounding the perpetrator, and the motivations of that person.

88. Further submissions will be made as to the general issues pertaining to the activities of SF Parrabell in due course.

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