Special Commission of Inquiry into LGBTIQ hate crimes

8 September 2023

Dr Victoria Kueppers
Forensic Pathologist
PathWest, Laboratory Medicine WA

By email:

Dear Dr Kueppers,

Special Commission of Inquiry into LGBTIQ hate crimes: Expert report on death of Scott Miller

As you are aware, I assist the Honourable Justice John Sackar in the Special Commission of Inquiry into LGBTIQ hate crimes ("the Inquiry"). Kathleen Heath, of counsel, and Kate Lockery, solicitor, are assisting his Honour in his consideration of the death of Scott Stuart Miller.

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:

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.

Mr Miller's death is one of the unsolved deaths which his Honour is inquiring into pursuant to item A of the Letters Patent.

Request for expert opinion

By this letter, you are briefed to prepare a written report in relation to Mr Miller's death to assist the Inquiry. It is requested that you provide your report by no later than **25 September 2023**.

In the event that you require further time to prepare your report, please advise Ms Lockery 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 Miller. 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 Miller (born 27 July 1975) was found deceased near Wharf 5, Hickson Road in Darling Harbour, Sydney on Monday, 3 March 1997. On the evening of Saturday, 1 March 1997, Mr Miller attended the Mardi Gras Parade on Oxford Street, Sydney, with three friends Shawn Kelly, Nathan White and Jason Elvy. It is noted that Mr Miller identified as heterosexual and had a long-term girlfriend.[1]

2. After the parade, the friends travelled to the Rocks. Mr Miller was expelled from one establishment due to his intoxication. At some time between 1.30am and 2.00am on the morning of Sunday, 2 March 1997, Mr Kelly saw Mr Miller walking across the road near the Orient Hotel. According to Mr Kelly, apart from being intoxicated, Mr Miller seemed himself. Mr Kelly told Mr Miller to meet the others in the Orient Hotel; however, when Mr Kelly returned, Mr Miller wasn't there, and no one had seen him.[2]

3. At around 2.10am, Mr Miller was possibly seen by local resident Jade Carter walking down Watson Road from Observatory Hill. If accurate, this is the last known sighting of Mr Miller alive (and 600m from where his body is ultimately found). Ms Carter described Mr Miller as being in no rush, looking neat and tidy, and not out of the ordinary.[3]

4. Mr Miller's body was found on the morning of Monday, 3 March 1997, by employees of Patrick the Australian Stevedore ("Patricks") in an area of Wharf 5 referred to as the "graveyard".[4] Mr Miller's body was at the bottom of a relatively small cliff, approximately 7 metres in height.[5] Photographs of the location of Mr Miller's body can be found at **Tab 8** of your briefing material.

5. The "graveyard" was an infrequently used part of the wharf which stored old, heavy machinery. It was fenced off with wire fencing with a gate that was accessible from within the wharf. However, public access to the wharf itself was blocked by a fence and required entry past a security checkpoint which was staffed at all times. Staff thought it was unlikely that somebody could get past the checkpoint without them knowing.[6]

[1] Statement of Plain Clothes Senior Constable Michael Lane, 1 May 1997 (Tab 12).
[2] Statement of Shawn Kelly, 4 March 1997 (Tab 16).
[3] Statement of Jane Carter, 6 March 1997 (Tab 17).
[4] Statements of Peter Cowan, Jim Gould and Vince Micallef dated 6 March 1997. These statements have not been provided but are available on request.
[5] Statement of Detective Senior Constable Lyle William Van Leeuwen, 14 June 1997 (Tab 13).
[6] Statements of Lance Neilson dated 28 October 1997, John Straube dated 14 March 1997, Warren White dated 6 October 1997, Stephen Williams dated 6 October 1997, Colin Plant dated 13 March 1997, and Archibald Price dated 14 March 1997. Statements not provided and available on request.

6. Mr Miller's body was found about 1.1m from the base of the cliff, nearly parallel to the cliff face and adjacent to a gutter at the base of the cliff.[7] He was face down, with his body laid out straight. His right arm was tucked up underneath his chest and his left arm was extended down the left side of his body, with his palm facing up. Mr Miller was fully clothed, with his clothes intact and his wallet in his back pocket. Blood was pooling under Mr Miller and extending out to the right side. There was also blood staining on the back of his t-shirt. Testing confirmed that this was Mr Miller's blood.[8]

7. Police examined Munns Reserve, the park directly above where Mr Miller was located in the machinery yard. The western side of the reserve was fenced with galvanised chain wire fencing, which was 1.9m off the ground and topped with barbed wire, which made the overall height of the fence 2.3m. A portion of the barbed wire on the top of the fence had come away from the support poles, near where a tree was leaning against the fence. There were no recent scuff marks on the chain wire fencing or on the galvanised tubular steel top rails or any holes in the chain wire fence. The leaf litter on the reserve side of the fence showed no obvious signs of being recently disturbed.

8. On the outside of the chain wire fence was a sandstone ledge, which was 1m wide and covered in ivy. The ledge was below the level of the ground in Munns Reserve. There was a lack of disturbance of the vegetation or ivy on this ledge.[9] There was also no evidence of vegetation having slipped towards the edge of the cliff, indentation marks, or broken stems, although a small amount of ivy was found at Mr Miller's feet.

<u>Post-mortem investigations</u>

9. Dr Johan Duflou, forensic pathologist, attended the scene and conducted the autopsy. A copy of his final autopsy report is at **Tab 1** of your briefing material. In summary, Dr Duflou found multiple injuries, including massive skull fracturing and contusions of the brain, laceration of the liver, avulsion of the right kidney, intra-abdominal haemorrhage, bilateral wrist fractures, pulmonary contusion and previous injury to sternum and left tibia. Based on body temperature and information that Mr Miller was last seen alive at 2.00am on 2 March 1997, Dr Duflou estimated the likely time of death to be between 2.00am and 8.00am on 2 March 1997.[10]

10. Anal and oral swabs and smears were negative for the presence of semen.[11] A toxicology report found that Mr Miller had a blood alcohol level of 0.220g/100mL, reflecting a night of heavy drinking (although the report does not make it clear whether the blood alcohol level had been adjusted to account for the length of time between obtaining the sample and Mr Miller's death).[12]

<u>Manner and cause of death</u>

11. Various contradictory opinions have been provided as to whether Mr Miller's death was a homicide or an accidental fall.

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[7] Transcript of Coronial Inquest, 7 October 1997 (Tab 6).
[8] Additional DAL Certificate, 19 May 1998 (Tab 5).
[9] Statement of Detective Senior Constable Van Leeuwen, 14 June 1997 (Tab 13).
[10] Final Autopsy Report, 5 June 1997 (Tab 1).
[11] DAL Certificate, 1 April 1997 (Tab 4).
[12] Toxicology Report, 27 March 1997 (Tab 2).

Initial investigation and inquest (1997)

12. In his autopsy report (Tab 1), Dr Duflou stated that the manner by which the injuries were sustained remains unclear, but posited three possible scenarios:

    a. Scenario 1: that the injuries were inflicted by one or more persons in a homicidal fashion. In this scenario, the head injury may represent impact with a heavy object swung against the forehead, and injury to the liver and kidney may similarly have been inflicted by one or more persons either kicking Mr Miller or hitting him with an object. The wrist injuries may be an indication of defensive injury;

    b. Scenario 2: that the injuries were sustained during a fall from a height. Dr Duflou states that the wrist injuries, and possibly the head and abdominal injuries, could have been sustained during a fall from a height, but that “both the head and abdominal injuries… are somewhat atypical for a fall from a height”; or

    c. Scenario 3: a combination of Scenarios 1 and 2. This combination is said to “explain all the injuries satisfactorily, and the sequence would most likely have been an assault followed by a fall from a height.” He hypothesises that Mr Miller could have been moved to the place he was found.

13. During his evidence at the coronial hearing, Dr Duflou was asked which of the three scenarios was more likely. He gave the following evidence:

    > “My understanding is that there is no evidence at all of the Deceased having been on top of the cliff face… If that’s the case the Deceased could not have fallen from the cliff face or from the top of the cliff face and its sounds unlikely to me that he in fact started climbing the cliff face as an alternative. In that case the Deceased would more likely than not have been killed in a homicidal fashion… I suppose the only major reason why a fall from the cliff face was a possibility was the fact that he was found at the bottom of a cliff face. If he had been found anywhere else I would have been prepared to say that homicide was by far the most likely manner of death.”[13]

14. Dr Duflou further gave evidence that some of the injuries that Mr Miller received, particularly to the front of his neck and his wrists, could only be consistent with a fall if Mr Miller had moved at least a small amount following the fall.[14]

15. Detective Senior Constable Van Leeuwen, crime scene examiner, opined that the death of Mr Miller was “suspicious”. He provided the following opinions and/or observations from his examination of the crime scene:

    a. “The presence of blood stains on the back of the deceased’s white T shirt can not be explained and is of a suspicious nature.”

    b. “The lack of separate individual blood spots throughout the machinery yard indicate that the deceased did not stagger around the machinery yard.”

[13] Transcript of Coronial Inquest, 7 October 1997, 5 (Tab 6).
[14] Transcript of Coronial Inquest, 7 October 1997, 6 (Tab 6).

c. “The deceased was located lying face down on the ground at the base of the cliff. If he had fallen or jumped from Munns Reserve I would have expected his position to have been more contorted than it was.”

d. “The deceased had a lack of external injuries usually seen in a person who has died as a result of a fall. If he had fallen or jumped from Munns Reserve, he could have fallen a distance of between 7 and 11.1 metres.”

e. “There was a lack of trace evidence on the fencing at the western end of Munns Reserve indicating that the deceased had climbed the fence. It is not uncommon for clothing fibres or shoe imprints to be found on chain or barbed wire fencing or framework.”

f. “There was no disturbance to the vegetation or ivy on the outside of the fence at the western end of Munns Reserve.”

g. “There were no holes in the chain wire fence at the western end of Munns Reserve.”[15]

16. Detective Senior Constable Van Leeuwen considered that it was possible for a person to fall from the fence without touching the ivy, but for that to happen the body would have ended up further from the cliff than 1.1m.[16]

17. Detective Senior Sergeant Carlton Cameron, crime scene examiner, opined that he didn’t believe that Mr Miller “came through or over the fence” in Munns Reserve, and that Mr Miller’s injuries were not sustained by a fall.[17]

18. Plain Clothes Senior Constable Michael Lane, the original officer in charge of the investigation, formed the opinion that Mr Miller accidentally fell from the cliff.[18] His theory was that Mr Miller was attempting to go from The Rocks to the casino in Darling Harbour, where he liked to go after having been on a night out. On his way he may have become lost or disoriented and walked up Observatory Hill, where he was seen by the witness Jade Carter. He then walked the relatively short distance to Munns Reserve, from where you can see Darling Harbour and the casino. Once at the cliff, Mr Miller may have attempted to take a short cut down. He scaled the fence, which was made easier due to the barbed wire being down at one point of the fence. Once over the fence, Mr Miller may have either slipped and fell, or he may have realised there was no way down and fallen asleep and rolled off the cliff.[19]

19. As part of Plain Clothes Senior Constable Lane’s investigation, he noted that Mr Miller was found in an almost identical position to a deceased male who had fallen from scaffolding on the Opera House.[20]

20. On 7 October 1997, Coroner Abernethy returned a finding that Mr Miller died “of multiple injuries inflicted by a person or persons unknown.” The coroner found that a number of factors militated against PCSC Lane’s opinion that Mr Miller fell from the cliff. He considered that Dr Duflou gave “cogent reasons” for his view that it is more likely that Mr Miller was either assaulted near where he was found, or taken there and dumped.

[15] Statement of Detective Senior Constable Van Leeuwen, 14 June 1997, 9-10 (Tab 13).
[16] Statement of Detective Senior Constable Van Leeuwen, 14 June 1997, 9-10 (Tab 13).
[17] Transcript of Coronial Inquest, 7 October 1997, 10-11 (Tab 6).
[18] Statement of Plain Clothes Senior Constable Michael Lane, 1 May 1997 (Tab 12).
[19] Statement of Plain Clothes Senior Constable Michael Lane, 1 May 1997 (Tab 12).
[20] Police running sheet, 13 March 1997 (Tab 11).

Reinvestigation (1997-1998)

21. Plain Clothes Senior Constable Lane's theory was given some support during the reinvestigation of Mr Miller's death by Detective Sergeant Desmond.[21] He noted the following factors which tended to support the theory that Mr Miller fell from the cliff above where his body was located:

    a. The evidence of security staff that no vehicle or pedestrian could have entered the wharf without being challenged;

    b. The lack of blood particles around the machinery yard.

    c. Mr Miller's clothing being intact.

Review by the Unsolved Homicide Team (2004)

22. A review of Mr Miller's death by the NSW Police Force Unsolved Homicide Team was conducted in 2004. For the purposes of your report, please assume the facts set out below in relation to that review.

23. The review concluded that Mr Miller "must have come over the cliff" to his final resting spot and supported a theory that Mr Miller died as a result of accident or misadventure. The review notes the following:

    a. Mr Miller's injuries which bled could only have occurred where he was found. No blood was located at the top of the cliff or the surrounding area. The blood was pooled and no splatter marks were located which would indicate the use of a weapon to inflict them.

    b. The reinvestigation determined that no pedestrian or vehicular access could have been gained to the Terminal, meaning that Mr Miller could not have been assaulted somewhere else and carried in.

    c. Crime scene photographs show green ivy and a tree branch next to Mr Miller.

    d. The position of the body is not unusual.

    e. The height of the fence makes it extremely unlikely that Mr Miller, who weighed 87 kg, was lifted over the fence by other persons.

    f. The distance from the top of the fence to the ledge is almost 4m. In the poor light and in a state of intoxication, Mr Miller may not have realised that the ledge was lower than the ground level of the park. The injuries to Mr Miller's stomach and organs may have been caused from landing on the ledge, or the edge of it, on his stomach.

    g. The injuries to Mr Miller's neck appear to be scratches/ grazes flowing in a vertical direction and would support the theory that the deceased slid over the ledge on his stomach before falling to the ground.

[21] Report of Detective Sergeant Desmond, "New information on Darling Harbour death", 3 January 1998 (Tab 15).

Review by Dr Linda Iles (2022)

24. On 23 November 2022, the Inquiry briefed Dr Linda Iles, forensic pathologist to review Mr Miller's case.[22] Dr Iles considered the autopsy report of Dr DuFlou to be comprehensive, and the photo-documentation of the injuries to be of a relativity high standard. The post-mortem investigations were sufficient for her to form a view as to how Mr Miller's injuries were sustained.[23]

25. Dr Iles opined that all of Mr Miller's physical injuries can be accounted for by a fall from a cliff face, with a primary impact point to the front of his face (i.e. a headfirst fall). In particular:

    a. Mr Miller's skull and brain injuries are consequent to severe blunt impact force to the front of his face and forehead. The injuries are located in a single plane, and have a vertically oriented abraded component most obvious on the neck and chin. Dr Iles considers these injuries to be "entirely in keeping" with a high magnitude force impact as may occur consequent to a fall from a height.[24] While Dr Iles notes that a similar pattern of cranio-facial injuries can be observed in other high-energy scenarios, such as to pedestrians or cyclists in motor vehicle accidents, the absence of injuries to the torso and lower limbs, and the circumstances in which he was found, discount such scenarios.[25]

    b. Mr Miller's liver and right kidney injuries, and associated bleeding in his abdomen, are in keeping with deceleration injuries that may be observed consequent to a fall from a height. The absence of associated fractures is accounted for by the primary impact being to Mr Miller's head and face, with the injuries to the abdominal organs being as a result of deceleration.[26]

    c. The bilateral distal forearm fractures are in keeping with Mr Miller's arms being outstretched at the time of impact. Abrasions about the left wrist and the back of the right wrist may represent stretch-type abrasions related to the underlying fractures.[27]

    d. The abrasions pictured to the back of Mr Miller's right hand and fingers may have been sustained during a fall, or could have been caused by foliage or barbed wire.[28]

26. Dr Iles expressed the view that Mr Miller's injuries were, as a whole, not typical of an assault.[29]

27. In Dr Iles' view, the nature of Mr Miller's injuries precluded Mr Miller himself being able to move any significant distance from the site where his craniofacial injuries were sustained.[30] Dr Iles further considered that there is no scene or circumstantial evidence that would be compatible with Mr Miller's body being moved to the site it was located.[31] In particular, she noted that the injuries to Mr Miller's face

[22] Letter of Instruction to Dr Linda Iles, 23 November 2022 (Tab 19).
[23] Expert report of Dr Linda Iles, 14 December 2022, 7 (Tab 18).
[24] Expert report of Dr Linda Iles, 14 December 2022, 7 (Tab 18).
[25] Expert report of Dr Linda Iles, 14 December 2022, 8 (Tab 18).
[26] Expert report of Dr Linda Iles, 14 December 2022, 7-8 (Tab 18).
[27] Expert report of Dr Linda Iles, 14 December 2022, 10 (Tab 18).
[28] Expert report of Dr Linda Iles, 14 December 2022, 9 (Tab 18).
[29] Expert report of Dr Linda Iles, 14 December 2022, 10 (Tab 18).
[30] Expert report of Dr Linda Iles, 14 December 2022, 8 (Tab 18).
[31] Expert report of Dr Linda Iles, 14 December 2022, 8 (Tab 18).

would result in significant bleeding after death, which was in keeping with the pool of blood in which he was found.[32]

28. Dr Iles considered that the position of Mr Miller's body corresponded with his injuries, which indicated an anterior plane of impact. Contrary to the opinion of Detective Senior Constable Van Leeuwen, that the body was less contorted that would be expected following a fall, she considered the position of Mr Miller's body to be not otherwise informative.[33]

29. While Dr Iles reached the conclusion that Mr Miller died after falling from the cliff above where he was found, she was unable to say, based on the medical evidence, how Mr Miller's fall occurred – that is, she could not discriminate between Mr Miller falling from the cliff edge or being pushed over the cliff.[34] Nonetheless, she considered that Mr Miller did not have injuries to indicate that any assault occurred.[35]

Opinions of Jae Gerhard (2023)

30. Following the recommendation of Dr Iles to seek an opinion from a blood pattern expert,[36] the Inquiry briefed Ms Gerhard and Ms Roebuck of Independent Forensic Services.[37] Ms Gerhard's report sets out the examination and interpretation of each item of Mr Miller's clothing (Tab 20).

31. On the basis of her examinations, Ms Gerhard expressed the following conclusion:

> When considering the bloodstain patterns identified on all of the items of clothing examined, no bloodstains (such as spatter or drips) were observed to indicate that Mr Miller was assaulted (resulting in bleeding injuries) at the top or the bottom of the cliff.
>
> In my opinion, the bloodstaining patterns observed on the clothing and in the photographs are consistent with the position Mr Miller was found at the bottom of the cliff following a fall. Furthermore, there is no evidence of significant movement of Mr Miller once his bleeding facial injuries occurred.[38]

Testing of debris (2023)

32. In the course of the post-mortem examination, Dr Duflou located a piece of debris in Mr Miller's right hand.[39]

33. At the request of the Inquiry, Inspector Andrew Brady of the Forensic Evidence and Technical Services ("FETS") Command provided a statement dated 7 June 2023 addressing, *inter alia,* the nature of the debris.[40]

34. Subsequent testing of the debris by Professor Claude Roux, forensic scientist, supported the proposition that the debris came from a coated metallic object such as galvanized steel.[41]

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[32] Expert report of Dr Linda Iles, 14 December 2022, 10 (Tab 18).
[33] Expert report of Dr Linda Iles, 14 December 2022, 11 (Tab 18).
[34] Expert report of Dr Linda Iles, 14 December 2022, 10 (Tab 18).
[35] Expert report of Dr Linda Iles, 14 December 2022, 7 (Tab 18).
[36] Expert report of Dr Linda Iles, 14 December 2022, 11 (Tab 18).
[37] Letter of Instruction to Independent Forensic Services, 24 April 2023 (Tab 20).
[38] Expert report of Jae Gerhard, 24 April 2023, [15] (Tab 19).
[39] Statement of Inspector Andrew Brady, 7 June 2023, [21] (Tab 22).
[40] Statement of Inspector Andrew Brady, 7 June 2023 (Tab 22).
[41] Expert Report of Professor Claude Roux re debris, 25 August 2023, 3 (Tab 23).

35. Neither Dr Iles nor Dr Duflou would have been able to refer to the material from Inspector Brady or Professor Roux at the time of expressing their opinions as to the manner and cause of death.

Materials 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 court file from the Coroners Court of NSW and investigative file from NSW Police Force.

Please note that the briefing materials contain sensitive images. The relevant tabs of your briefing material have been marked in red. If there is any additional material that you consider would be of use to you in forming your opinion, please contact Ms Lockery and this material will be provided to you (if available).

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. Please conduct a peer review of the reports of Dr Iles and Dr Duflou, and the opinion of Dr Duflou provided orally at the inquest into Mr Miller's death.
2. Please comment on whether you agree or disagree with the opinions expressed by Dr Iles and Dr Duflou, and provide reasons for your agreement or disagreement.
3. To the extent that the opinions of Dr Iles and Dr Duflou differ, please identify which opinion you prefer and your reasons as to why.

The above questions are not intended to be exhaustive. Accordingly, if there is any matter arising from the circumstances of Mr Miller'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 Code of Conduct

I **enclose** a copy of the Expert Code of Conduct and ask that you read it carefully. In the report you should acknowledge that you have read the Code and agree to the bound by it. I suggest the following form of words be included in the body of your report:

> "I, Dr Victoria Kueppers, acknowledge for the purpose of Rule 31.23 of the Uniform Civil Procedure Rules 2005 that I have read the Expert Witness Code of Conduct in Schedule 7 to the said rules and agree to be bound by it."

Please do not hesitate to contact Kate Lockery on [redacted] or [redacted] if you have any queries in relation to this matter.

Thank you for your consideration and assistance.

Yours faithfully,

Kate Lockery
Principal Solicitor
Solicitor Assisting the Inquiry

DEATH OF SCOTT STUART MILLER
INDEX TO EXPERT BRIEF TO DR VICTORIA KUEPPERS

(as at 8 September 2023)

Tab	Document	Date	Reference No
Formal Documents			
1.	Final Autopsy Report of Dr Duflou	5 June 1997	SCOI.02737.00048
2.	Toxicology Report	27 March 1997	SCOI.02737.00019
3.	Neuropathology Report	1 April 1997	SCOI.02737.00049
4.	DAL Certificate	1 April 1997	SCOI.02737.00070
5.	Additional DAL Certificate	19 May 1998	SCOI.10048.00006
6.	Transcript of Coronial Inquest	7 October 1997	SCOI.02737.00041
7.	Coronial Findings	7 October 1997	SCOI.02737.00032
Photographs			
8.	Crime Scene Photographs (photographs 1 – 25) *[Sensitive material]*	3 March 1997	SCOI.83350
9.	Autopsy Photographs (photographs 26 – 49) *[Sensitive material]*	3 March 1997	SCOI.83349
10.	Panorama photograph of Munn Reserve (photograph 50)	6 March 1997	SCOI.83346
NSW Police Force statements and material			
11.	Police Running Sheet	13 March 1997	SCOI.02737.00106
12.	Statement of Plain Clothes Senior Constable Michael Lane	1 May 1997	SCOI.02737.00051
13.	Statement of Detective Senior Constable Lyle William Van Leeuwen *[Sensitive material]*	14 June 1997	SCOI.83347
14.	Statement of Detective Senior Sergeant Carlton Graeme Cameron	3 October 1997	SCOI.02737.00069
15.	Report of Detective Sergeant Desmond, "New information on Darling Harbour death"	3 January 1998	SCOI.10047.00034
Statements of witnesses			
16.	Statement of Shawn Kelly	4 March 1997	SCOI.10049.00031
17.	Statement of Jane Carter	6 March 1997	SCOI.10049.00039

Opinions obtained by the Inquiry			
18.	Expert Report of Dr Linda Iles, Forensic Pathologist	14 December 2022	SCOI.82891
19.	Letter of instruction to Dr Linda Iles	23 November 2022	SCOI.82890
20.	Expert Report of Jae Gerhard, Independent Forensic Services	29 May 2023	SCOI.83328
21.	Letter of instruction to Independent Forensic Services	24 April 2023	SCOI.83326
22.	Statement of Inspector Andrew Brady re debris found in Mr Miller's hand (annexures available on request)	7 June 2023	NPL.9000.0017.0072
23.	Expert Report of Professor Claude Roux re debris	25 August 2023	SCOI.85317

SCOI.85713_0013

NSW legislation

Uniform Civil Procedure Rules 2005

Current version for 1 July 2023 to date (accessed 1 August 2023 at 8:53)

Schedule 7

Schedule 7 Expert witness code of conduct

(Rule 31.23)

1 Application of code

This code of conduct applies to any expert witness engaged or appointed—

(a) to provide an expert's report for use as evidence in proceedings or proposed proceedings, or

(b) to give opinion evidence in proceedings or proposed proceedings.

2 General duties to the Court

An expert witness is not an advocate for a party and has a paramount duty, overriding any duty to the party to the proceedings or other person retaining the expert witness, to assist the court impartially on matters relevant to the area of expertise of the witness.

3 Content of report

Every report prepared by an expert witness for use in court must clearly state the opinion or opinions of the expert and must state, specify or provide—

(a) the name and address of the expert, and

(b) an acknowledgement that the expert has read this code and agrees to be bound by it, and

(c) the qualifications of the expert to prepare the report, and

(d) the assumptions and material facts on which each opinion expressed in the report is based (a letter of instructions may be annexed), and

(e) the reasons for and any literature or other materials utilised in support of each such opinion, and

(f) (if applicable) that a particular question, issue or matter falls outside the expert's field of expertise, and

(g) any examinations, tests or other investigations on which the expert has relied, identifying the person who carried them out and that person's qualifications, and

(h) the extent to which any opinion which the expert has expressed involves the acceptance of another person's opinion, the identification of that other person and the opinion expressed by that other person, and

(i) a declaration that the expert has made all the inquiries which the expert believes are desirable and appropriate (save for any matters identified explicitly in the report), and that no matters of significance which the expert regards as relevant have, to the knowledge of the expert, been withheld from the court, and

(j) any qualification of an opinion expressed in the report without which the report is or may be incomplete or inaccurate, and

SCOI.85713_0014

(k) whether any opinion expressed in the report is not a concluded opinion because of insufficient research or insufficient data or for any other reason, and

(l) where the report is lengthy or complex, a brief summary of the report at the beginning of the report.

4 Supplementary report following change of opinion

(1) Where an expert witness has provided to a party (or that party's legal representative) a report for use in court, and the expert thereafter changes his or her opinion on a material matter, the expert must forthwith provide to the party (or that party's legal representative) a supplementary report which must state, specify or provide the information referred to in clause 3(a), (d), (e), (g), (h), (i), (j), (k) and (l), and if applicable, clause 3(f).

(2) In any subsequent report (whether prepared in accordance with subclause (1) or not), the expert may refer to material contained in the earlier report without repeating it.

5 Duty to comply with the court's directions

If directed to do so by the court, an expert witness must—

(a) confer with any other expert witness, and

(b) provide the court with a joint report specifying (as the case requires) matters agreed and matters not agreed and the reasons for the experts not agreeing, and

(c) abide in a timely way by any direction of the court.

6 Conferences of experts

Each expert witness must—

(a) exercise his or her independent judgment in relation to every conference in which the expert participates pursuant to a direction of the court and in relation to each report thereafter provided, and must not act on any instruction or request to withhold or avoid agreement, and

(b) endeavour to reach agreement with the other expert witness (or witnesses) on any issue in dispute between them, or failing agreement, endeavour to identify and clarify the basis of disagreement on the issues which are in dispute.