The Special Commission of Inquiry
into LGBTIQ Hate Crimes

INVESTIGATIVE PRACTICES HEARING

Submissions on behalf of the Commissioner of Police

Contents

PART A: INTRODUCTION

1. These submissions are made on behalf of the Commissioner of Police in response to the submissions made by Counsel Assisting on 15 September 2023 concerning the Investigative Practices Hearing (**CA**).

2. Consistent with submissions made in connection with a variety of "documentary tender" hearings conducted by the Inquiry, the Commissioner of Police acknowledges that a significant number of the cases the subject of "documentary tender" hearings were affected by failures in the course of the original investigations.

3. Similarly, there have been significant failures in respect of the historical management of exhibits in a number of cases.

4. The specific investigative failures identified by Counsel Assisting and the issues that have arisen in relation to the management of exhibits and investigative records will be addressed further in Parts C and D of these submissions.

5. The deaths considered by the Inquiry during the Investigative Practices Hearing occurred between 1976 and 1997. There have been significant advances in the training of homicide investigators and fundamental shifts in forensic technology since that time. There have also been dramatic changes to the processes the NSW Police Force (**NSWPF**) employs in relation to the management of documentary records and exhibits in that period.

6. In particular, the management of documentary records relating to investigations is, as a result of the introduction of e@gle.i in 1999 and the various updates to that system rolled out since, now conducted electronically. Consequently, the documents produced in the course of an investigation are now stored in a permanent electronic record.

7. Similarly, the management of exhibits seized by the NSWPF is now centred around the Exhibits Forensic Information and Miscellaneous Property System (**EFIMS**), which was introduced in 2011. The introduction of the EFIMS system has greatly enhanced the capacity of the NSWPF to track the movement of exhibits (including their disposal) and to conduct routine audits to ensure that exhibits are not lost or disposed of inappropriately. Since the implementation of changes to the NSWPF's exhibit management procedures and the introduction of EFIMS in the

2000s and 2010s, the loss of exhibits seized by the NSWPF has become an exceedingly rare phenomenon.[1]

PART B: HOMICIDE INVESTIGATION

8. Homicide investigations are often complex and resource intensive. They routinely place extraordinarily onerous demands on officers involved in them.

9. The Homicide Squad is staffed by professional and dedicated officers, who regard the investigation of a person's death as a great responsibility.[2] Entry to the Homicide Squad is competitive and attracts applications from a range of experienced investigators throughout the State. As a result, the Homicide Squad is staffed by some of the most effective criminal investigators in NSW.[3]

B.1 – The Homicide Squad and homicide detection

10. The Commissioner of Police agrees with the overview provided by Counsel Assisting in relation to the Homicide Squad and homicide detection in Part B.1

B.2 – The formation of the Homicide Squad

11. In general terms, the Commissioner of Police also agrees with the summary of the structure and formation of the Homicide Squad and the Unsolved Homicide Team (**UHT**) provided at [24] – [48] of Counsel Assisting's submissions.

12. The recommendation proposed at CA [49] will be the subject of further consideration at Part E.

13. As concerns CA [50], Standard Operating Procedures (**SOPs**) such as the 2022 UHT SOPs are regularly reviewed to ensure consistency with proper practice. It is accepted that it is appropriate for consideration to be given to further reviewing those SOPs to ensure that they accurately reflect the full range of accepted practices within the UHT.

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[1] Transcript of the Inquiry, 4 July 2023, T4867.19-4868.4 (TRA.00072.00001).
[2] Exhibit 51, Tab 1, Statement of DSupt Daniel Doherty, 18 April 2023, [35] (NPL.9000.0006.0001).
[3] Exhibit 51, Tab 1, Statement of DSupt Daniel Doherty, 18 April 2023, [35] (NPL.9000.0006.0001).

B.3 – Interaction between the Homicide Squad and other agencies

B.3.1 Relationship between the Homicide Squad and the Engagement and Hate Crime Unit (and its predecessors)

14. While it may be accepted that the initial flagging of an incident as a potential hate crime falls to an investigating officer (CA, [67]), contact between the EHCU and investigating officers is not a one-way process.

15. There are approximately 35 to 50 incidents flagged as potential hate crimes for consideration by the EHCU each month.[4] As recorded in the Hate Crime Guidelines, the EHCU conducts an assessment of all such incidents.[5] Where an investigation into the matter remains underway, the case will be subject to consideration by the Hate Incident Review Committee (**HIRC**) within the EHCU.[6] The HIRC comprises the Commander, Anti-Terrorism & Intelligence Group, the EHCU manager, and the members of the Hate Crimes Team. It meets fortnightly to monitor all hate crimes and hate incidents.[7]

16. The process followed by HIRC in connection with a potential hate crime is described by Sgt Ismail Kirgiz as follows:

> *"The HIRC determines whether the EHCU contacts other investigators or PACs to assist or encourage the progress of an investigation where it is considered necessary. This typically occurs by the Hate Crime Coordinator calling or emailing the investigating officer to discuss the incident and offer assistance. The Hate Crime Coordinator will remain in regular phone or email contact with the officer until the matter is finalised. Deficiencies or delays in the investigation that are of greater concern are escalated to the investigating officer's PAC's Crime Coordinator (Detective Senior Sergeant rank) or Crime Manager (Detective Inspector rank). By way of example, if a delay in an investigation is found to be as a result of an officer being on a long leave of absence, the EHCU will request the relevant Crime Coordinator or Crime Manager to allocate the investigation to another officer to progress the matter in a timely manner."*[8]

[4] Transcript of the Inquiry, 12 December 2022, T1276.24 (TRA.00016.00001).
[5] Exhibit 6, Tab 195, [4.3.3], [4.4] (SCOI.77445).
[6] Transcript of the Inquiry, 12 December 2022, T1276.30-33 (TRA.00016.00001).
[7] Exhibit 6, Tab 3, [16]-[18] (SCOI.76961).
[8] Exhibit 6, Tab 3, [17] (SCOI.76961).

17. Accordingly, provided the relevant incident is flagged as a potential hate crime, it will come to the attention of the EHCU and the HIRC will monitor the investigation and offer assistance as appropriate.

18. As will be addressed below, the submissions at CA [156] do not reflect the extent of the training provided to officers concerning the LGBTIQ community. In particular, they do not have regard to the evidence provided to the Inquiry in two statements of AC Anthony Cooke dated 14 June 2023. Additionally, as set out in Sgt Kirgiz' evidence, various efforts have been made by the EHCU itself to raise awareness among members of the NSWPF regarding hate crimes.[9] The process of flagging an incident or offence as potentially hate-related in the COPS system is not an onerous one; all that is required is that an officer ticks a box to indicate "Hate Crime Related" in the "Associated Factors" pop up that confronts an officer in recording an incident. The officer is then required to tick one or more of the "Qualifying Factors" describing the type of hate, prejudice or bias.[10] Very clear guidance as to this process, with appropriate screenshots, is provided in the Hate Crime Guidelines.[11]

19. The LGBTIQA+ "Qualifying Factor" is defined in the Hate Crime Guidelines as follows:

> *"Any sexual orientation or gender identity, such as lesbian, gay, bisexual, transsexual, intersex, queer, transgender, non-binary and gender diverse people.*
>
> ***Sexual orientation** refers to who a person is sexually and/or romantically attracted to. Lesbian, gay and bi-sexual are examples of how people might self-identify their sexuality or sexual orientation.*
>
> ***Gender identity** refers to a person's internal and/or external experience of gender which may be the same or different from their sex at birth. Someone who is transgender or 'gender diverse' is anyone who feels their assigned gender does not completely or adequately reflect their internal gender (how they feel). Transgender people may or may not take steps to live as a different gender. A transgender person may express any sexuality."*

[9] Exhibit 6, Tab 3, [23]-[31] (SCOI.76961).
[10] Exhibit 6, Tab 195, [5.3] (SCOI.77445).
[11] Exhibit 6, Tab 195, [5.3] (SCOI.77445).

20. The Hate Crime Guidelines refer at length to the specific impacts of hate crimes and incidents, as well as the barriers that result in under-reporting of such events.[12] In this respect, the Hate Crime Guidelines draw attention to the fact that victims may report the incidents via community rather than police channels, and specifically draw attention to possible reporting to ACON and the Gender Centre.[13]

21. Importantly, the Hate Crime Guidelines repeatedly emphasise the need for open mindedness. The overview of the reporting procedure, for instance, commences with the following:

> *"Every officer must keep an open mind, acknowledging that any incident could have hate as a motivating factor".*[14]

22. The Hate Crime Guidelines have been disseminated to all officers in the NSWPF via an email message to all officers in the State, and then via the hate crime awareness package in the NSWPF's online education system.[15]

23. In the period since, the EHCU has undertaken significant number of face-to-face education sessions. The EHCU commenced that process by identifying the 10 Police Area Commands (**PACs**) that had the highest levels of hate crime and presenting to those commands.[16] The EHCU then proceeded to identify PACs that had significant populations of potentially vulnerable communities and presented at those locations. Having done so, the EHCU presented in certain regional centres and continues to roll out its education package throughout the State.[17]

24. As concerns the level of engagement between the EHCU and the UHT, it appears that there may well have been contact between the UHT and EHCU of which DCI Laidlaw was not aware. In that respect, he had the following exchange with Counsel Assisting:

> *Q. So if you know nothing about it, may we assume that there is no - any interaction is rare and not of a kind that would come to your attention as their supervisor?*
>
> *A. Well, I wouldn't say "rare". Because of - the Hate Crimes Unit is an intelligence-based unit, is my belief, is that our intel personnel that's attached to the Unsolved*

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[12] Exhibit 6, Tab 195, [4.5] (SCOI.77445).
[13] Exhibit 6, Tab 195, [4.5] (SCOI.77445).
[14] Exhibit 6, Tab 195, [5.1] (SCOI.77445).
[15] Transcript of the Inquiry, 13 December 2022, T1268.19-30.
[16] Transcript of the Inquiry, 13 December 2022, T1268.34-43.
[17] Transcript of the Inquiry, 13 December 2022, T1268.34-43.

Homicide may engage with them to see whether there's information there that can assist our reviews.[18]

25. It is unsurprising, given DCI Laidlaw's evidence as to his investigative commitments in recent years,[19] that he has not monitored the contact between UHT investigators and members of the EHCU.

26. It is, in any event, not clear how many of the cases subject to review by the UHT since the formation of the EHCU in 2019 are cases that might properly be regarded as hate crimes or potential hate crimes. Counsel Assisting has not identified any such cases where "ignorance or prejudice on the part of investigating officers may have led to hate crime factors being overlooked or ignored". That being so, a positive finding of the type advanced by Counsel Assisting at CA, [70] should not be made.

27. That said, the Commissioner of Police agrees that as a general proposition the EHCU may be in a position to discern fruitful lines of inquiry in unsolved homicides where there had initially been a failure to identify potential indicia of hate crimes; the EHCU's input should be sought in such cases.

B.3.2 Relationship between the Homicide Squad and the Missing Persons Registry

28. The establishment of the Missing Persons Registry (**MPR**) as the oversight body in relation to all missing persons cases in NSW has very significantly improved the response to, and investigation of, such cases.[20]

29. The Commissioner of Police agrees that the present iteration of the MPR constitutes an effective response to past issues in relation to communication and collaboration between homicide investigators and officers involved in the search for missing persons (CA, [81]).

B.3.3 Education and training of homicide detectives

30. The process associated with the selection and training of Homicide Squad members is accurately summarised at CA [82] – [95].

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[18] Transcript of the Inquiry, 7 July 2023, T5199.24-31 (TRA.00075.00001).
[19] Transcript of the Inquiry, 7 July 2023, T5252.43-5253.43 (TRA.00075.00001).
[20] Exhibit 51, Tab 1, Statement of DSupt Daniel Doherty, 18 April 2023, [113] (NPL.9000.0006.0001).

31. Similarly, as noted by Counsel Assisting at CA [96] – [99] many members of the Homicide Squad have tertiary qualifications, and such qualifications will often enhance the capacity of homicide detectives to perform their work.

32. The Commissioner of Police agrees with Counsel Assisting's analysis of the qualities that are desirable in the effective performance of the role of a homicide detective at CA [100] – [106]; as to the value of cultural awareness at CA, [107] – [108]; and as to the importance of awareness regarding conscious and unconscious bias at CA [109] – [120].

33. The Commissioner of Police also agrees that the Inquiry has before it a few instances where language varying from insensitive to patently unacceptable has been employed (CA, [121] – [122]).

B.3.3.1 The question of conscious and unconscious bias

34. It is accepted that it is possible that conscious or unconscious bias played a part in the investigation conducted in relation to some of the matters before the Inquiry. It is similarly accepted that this possibility should be publicly acknowledged (CA, [129]).

35. As was observed in the submissions filed on behalf of the Commissioner of Police in Public Hearing 2, the NSWPF is not merely a product of society, but plays an important culture-shaping role in it. That being so, the possible existence of bias within the NSWPF is to be abhorred and denounced, even where that bias may have reflected wider social norms of the time. As noted by Counsel Assisting (CA, [135]) a failure by an officer to discharge their duties impartially and with respect to all members of the community has the capacity to cause great harm.

36. The observations at [130] – [134] and [136] of Counsel Assisting's submissions, however, warrant further comment.

37. A finding that an investigator was motivated not to pursue a particular investigation because of bias would be a grave one. So far as the Commissioner of Police is aware, no such allegations have been raised with any individual officer involved in the investigation of the cases before the Inquiry. That being so, any finding of bias against an individual officer would constitute a very significant departure from the Inquiry's obligation to afford procedural fairness to persons with

an appropriate interest.[21] Even where officers are not specifically named, they will often be readily identifiable by reference to the matters under consideration.

38. Nevertheless, at CA [130], Counsel Assisting submits that it is open to observe not only that such bias is "possible" but that it is "likely" that officers investigating some of the cases considered by the Inquiry were affected by conscious or unconscious bias.

39. This is a very serious assertion. It is so even in circumstances where particular officers are not singled out. To conclude that it is "likely" that some such officers were affected by bias (as distinct from a reference to that "possibility") would be to cast a pall over the conduct of a large number of investigators whose actions have been the subject of consideration during the course of this Inquiry. The shadow cast by such a finding would extend to include a significant number of officers whose investigations were, by and large, appropriate and thorough. It would also extend to the NSWPF, which is – as an organisation – itself entitled to procedural and substantive fairness.

40. Counsel Assisting have identified a small number of comments that are potentially suggestive of homophobia or some form of bias at CA [121]. The conduct set out therein is concerning, and certainly raises the possibility of bias. Nevertheless, even in those cases, there is no evidence of a specific connection between a particular officer's bias and any investigative failing. That Counsel Assisting would urge a finding in line with CA [130] in the absence of any evidence of bias in the vast bulk of cases, and in the absence of *any* evidence of a connection between a particular officer's bias and an investigative failure, is surprising. A finding in line with such a submission would be devoid of anything approximating a sound foundation.

41. In particular, the finding propounded by Counsel Assisting is a serious finding of the type that attracts the operation of the principles elucidated in *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362 and countless cases that that have followed; it should not be arrived at lightly.[22] Given the absence of an appropriate evidentiary foundation, a conclusion that such bias is "likely" to have played a role in investigative failures and/or difficulties in exhibit management cannot properly be reached.

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[21] See Minister for Immigration and Border Protection v SZSSJ [2016] HCA 29 at [83]; Kioa v West (1985) 159 CLR 550 at [38], citing Kanda v Government of Malaya (1962) AC 322 at 337; Applicant VEAL of 2002 v Minister for Immigration and Multicultural and Indigenous Affairs [2005] HCA 72 at [15].

[22] See *Neat Holdings Pty Limited v Karajan Holdings Pty Limited and Ors* (1992) 67 ALJR 170 at [2] per Mason CJ, Brennan, Deane and Gaudron JJ.

B.3.4 The training received by NSWPF officers concerning hate crimes and the LGBTIQ community

42. As alluded to above, the submissions made by Counsel Assisting in relation to the training received by NSWPF officers concerning hate crimes and the LGBTIQ community do not have regard to the two statements of AC Anthony Cooke dated 14 June 2023 provided to the Inquiry on 14 June 2023. The Commissioner of Police requests that these statements be tendered in light of their central relevance to Counsel Assisting's submissions at [B.3.4] – [B.3.5].

43. The statements are as follows:

a) The statement of AC Cooke dated 14 June 2023 in relation to Recommendations 11 – 14 of the Taradale Inquest (**Taradale Statement**);[23] and

b) The statement of AC Cooke in relation to the Gay Lesbian Liaison Officer program (**GLLO program**), and LGBTIQ+ initiatives in place within the NSWPF (**GLLO statement**).[24]

44. That training includes, as detailed by AC Cooke at [76] – [77] of the GLLO Statement, the following:

> *"76. All NSWPF Academy students undertake mandatory LGBTIQ+ training as part of their induction to the force. The session takes several hours and consists of presentations to graduating classes from the Corporate Sponsor, a GLLO and a community member. On the most recent occasion, a member of the 78ers' (a participant in the events that took place in 1978) also presented to the class.*
>
> *77. Further, all NSWPF employees were required to complete a mandatory online LGBTIQ Awareness and Inclusion refresher module in mid-2020. A copy of the refresher training module is attached to this statement at NPL.0100.0001.0309. The refresher course was developed by the Corporate Sponsorship and policy support staff. It is available to all NSWPF employees to recomplete any time they wish to refresh their knowledge."*

[23] NPL.9000.0020.0025.
[24] NPL.9000.0020.0001.

B.3.5 Submissions concerning the education of homicide detectives in relation to the LGBTIQ Community

45. As is apparent from the contents of AC Cooke's statement considered at [44] above, it is incorrect to say that there is no mandatory education of NSWPF officers concerning the LGBTIQ community.

46. Any recommendation proposed in relation to mandatory education concerning the LGBTIQ community should have due regard to AC Cooke's evidence. The Commissioner of Police looks forward to considering any recommendations made by the Inquiry in relation to further education that can productively be provided to officers concerning the LGBTIQ community (see further, the submissions concerning Recommendation 2 in Part E) .

B.4 – Forensic Techniques available in homicide investigations

47. As outlined by Counsel Assisting at CA [163] – [177], the period falling within the Inquiry's terms of reference has seen a fundamental shift in the forensic analysis techniques available to the NSWPF as a consequence of the development of DNA testing and technology.

48. In a corresponding fashion, the relevant period has also seen very significant advances to the forensic evidence gathering capabilities of the NSWPF and, in particular, the Crime Scene Services Branch (**CSSB**) (as it now is). As noted by Counsel Assisting (CA, [187] – [189]), the level of training required of an officer engaged in the work of the CSSB has steadily increased over the years. Presently, all members of the CSSB are required to complete at least tertiary qualifications in science or forensic science.[25] Moreover, Forensic Investigators who join the CSSB also participate in a Forensic Investigator training program over a minimum of four years and complete (or undertake) training with the Australian Forensic Science Assessment Body (**AFSAB**). For certain serious offences, including homicides, an AFSAB-qualified officer is required to attend the scene.[26] AFSAB qualifications require yearly and five-yearly reviews to ensure appropriate continuing education.[27]

49. The work of the NSWPF is also supported by the Forensic and Analytical Science Service (**FASS**) (see CA [191] – [196]).

[25] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [41] (NPL9000.0003.1533).
[26] Transcript of the Inquiry, 4 July 2023, T4877.34-38 (TRA.00072.00001).
[27] Transcript of the Inquiry, 4 July 20231 T4878.2-11 (TRA.00072.00001}.

B.4.1 DNA Databases

50. As concerns the development of DNA database, it is appropriate to note that the *Crimes (Forensic Procedures) Act* (**CFP Act**) commenced on 1 January 2001 (cf CA, [226]).

51. As noted by Counsel Assisting, the DNA database was subject to significant limitations in the years following its commencement (CA, [226]). Prior to the introduction (and expansion) of DNA databases, the scope for successfully resolving an investigation using DNA evidence was heavily circumscribed.[28]

52. As identified by Counsel Assisting, the period from 2000 onwards has been characterised by very significant changes in the procedures followed by the NSWPF in relation to the testing of exhibits, and the technology that is available to conduct those tests (CA, [210] – [222]).

53. It was only following the introduction and development of DNA databases, which Ms Neville described as a "dramatic leap in capability" that changed the landscape,[29] that DNA profiling has become a commonly deployed investigative tool.

54. Notably, the evidence summarised by Counsel Assisting at CA [238] – [251] makes it clear that, to adopt Counsel Assisting's terms, "it is reasonable that officers may not have turned their minds to the potential evolution of DNA capabilities" (CA, [253]) as at the time of the deaths considered during the Investigative Practices Hearing.

55. Notwithstanding the fact that the availability of DNA testing and the implications thereof would not have been foreseeable to the relevant officers, it is accepted that, in a number of instances, there have been significant failures in relation to the retention of exhibits. There have similarly been failures in relation to the retention of records regarding the destruction of exhibits in a number of cases.

56. For reasons that will become apparent in Parts C and D, however, the matters raised at CA [255] – [257] should be addressed by reference to the circumstances of the individual cases. Whether the disposal of exhibits represented a breach of procedure at the relevant time varies from case to case. Likewise, the position as to whether the absence of records relating to the disposal of particular exhibits involved a breach of procedure cannot be determined at a general level.

[28] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [42] (SCOI.83528).
[29] Transcript of Inquiry, 15 August 2023, T5505.17-29 (TRA.00082.00001).

57. The Commissioner of Police acknowledges that, in a number of cases, the loss or destruction of exhibits or records has affected the Inquiry's ability to carry out its work. It is accepted that this is a serious concern.

PART C: COLD CASES AND UNSOLVED HOMICIDES

58. Unsolved homicide cases present a variety of challenges. In some instances, features of the case itself mean that there are very few investigative opportunities. Where, for example, no body is found, there will typically be no obvious crime scene and there may not be other clear lines of inquiry. In other instances, however, failings in the original investigation, or the subsequent management of exhibits, may have contributed to the fact a case was not solved at the outset, and has not been able to be solved since.

59. In this respect, unsolved homicides cannot be treated as a representative sample of police work; their unsolved status serves as a confounding variable. That is to say, given a case may have never been solved because of the loss of key material, or deficiencies in the original investigation, long-term unsolved cases are substantially more likely to be affected by such issues than cases that have resulted in a charge and conviction.

C.1 – Cold case investigations and "best practice"

C.1.1 Cold case investigations and 'best practice'

60. The Commissioner of Police agrees with the salient factors identified at CA [258]-[259] that may bear upon whether a cold case can or will be solved.

61. The Inquiry has had the benefit of expert evidence from Dr Cheryl Allsop, which provides a useful exploration of the challenges inherent in cold case investigations across different jurisdictions and a consideration of the way those challenges might best be addressed.

C.1.2 Availability of Exhibits and Exhibit Management

62. The loss of physical exhibits (or the inability to locate them) may undoubtedly have a substantial impact on both investigations and criminal trials.

63. The comments of Justice Buddin in *R v Smith (No 1)* [2011] NSWSC 725 cited at CA [266] were not addressed to the destruction of exhibits, but rather to failures in that case to promptly

investigate information received (at [64]). But there is no dispute that the loss of exhibits can, and in certain cases has, affected the course of criminal trials (CA [267]).

64. As set out at CA [268]-[273], the processes for collection and storage of exhibits for forensic testing have improved significantly over time. Well into the 1990s, there was not a widespread understanding of the potential advancements in DNA testing. This informed how exhibits were considered, collected and stored, as well as whether they were retained. Where exhibits have been retained, there are a range of factors which contribute to the value of, and degradation of, DNA on exhibits (CA [269]-[270]).

C.1.3 Record keeping practices

65. The Commissioner of Police agrees with the summary of evidence as to the impact of historical record keeping practices on cold case reviews and investigations.

66. In relation to the HOLMES system used in the UK (CA [280]-[282]), it is appropriate to note that the systems used by the NSWPF have similar capabilities. In particular, the e@gle.i investigation management system is used by the NSWPF for the investigation of major crime.[30] It was first introduced in 1999 and has been subject to various updates and enhancements in the period since.[31] Th e@gle.i system "is designed to centrally store all material relative to every major investigation, with monitoring and reporting capability to ensure thorough investigative oversight".[32] It enables police to record, review and categorise information, intelligence and evidence. It has an auditing function which provides a transparent record of the entirety of an investigation.[33] A detailed summary of the purpose and capabilities of e@gle.i is provided in the statement of Detective Inspector Ritchie Sim dated 19 May 2023.[34]

67. Additionally, the EFIMS system was introduced in 2011 for the electronic management of exhibits. This system is integrated with the Laboratory Information Management System at FASS as well as the COPS system within the NSWPF.[35]

[30] Statement of Detective Inspector Ritchie Sim, 19 May 2023, [28] (NPL.9000.0015.0001).
[31] Statement of Detective Inspector Ritchie Sim, 19 May 2023, [30], [31], [33] (NPL.9000.0015.0001).
[32] Exhibit 1, Tab 2 (Parrabell Report), 45 (SCOI.02632).
[33] Statement of Detective Inspector Ritchie Sim, 19 May 2023, [31] (NPL.9000.0015.0001).
[34] See statement of Detective Inspector Ritchie Sim, 19 May 2023, [33] – [50] (NPL.9000.0015.0001).
[35] Transcript of the Inquiry, 4 July 2023, T4824.19-31 (TRA.00072.00001).

68. The rollout of the cloud-based Integrated Policing Operations System (iPOS) in 2024 will further improve and integrate these electronic systems.[36]

C.1.4 Scientific and technological advancements

69. The evidence of Dr Allsop about the significance of advances in DNA technology (CA [283]-[288]) is complemented by the evidence of Dr Neville about the implementation of those technologies in NSW. The NSW DNA Database commenced in 2000, and the National Criminal Investigation DNA Database (**NCIDD**) was established in 2001.[37] Familial searching against the NSW DNA Database began in 2013, and was introduced on the NCIDD in 2018.[38]

70. The issues with the reliance on science in cold cases outlined by Dr Allsop, with a focus on the UK (CA [289] – [294]), provide important context, because they reflect that the difficulties encountered in the cases before the Inquiry are not unique to NSW. Those general issues include:

a) Where a crime took place before the advent of DNA testing, there is a risk of contamination because biological materials were not collected in the way they are now;[39]

b) Over time samples can become degraded such that a DNA profile cannot be obtained from them;[40]

c) "In the past, it was not uncommon for items to be returned to families, suspects, or victims if investigators did not think they were needed for a prosecution".[41] This continued into the 1990s in the UK, reflecting that there was not yet an awareness of the possibilities of future DNA technology;[42] and

d) "in many instances documentation and exhibits are missing, having been misfiled, destroyed or lost and exhibits returned".[43]

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[36] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [142]-[143] (NPL.9000.0008.0905).
[37] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [43]-[44] (SCOI.83S28).
[38] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [70] (SCOI.83S28).
[39] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023 [25] (SCOI.84938).
[40] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023 [25] (SCOI.84938).
[41] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023 [26] (SCOI.84938).
[42] Transcript of the Inquiry, 15 August 2023, T5540.28-34 (TRA.00082.00001).
[43] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023 [31] (SCOI.84938); Transcript of the Inquiry, 15 August 2023, T5543.3-42 (TRA.00082.00001).

C.1.5 Reviewing cold cases

71. The Commissioner of Police agrees with the summary of Dr Allsop's evidence at CA [295]-[307] concerning approaches to reviewing cold cases and the experience in the UK.

C.2 – The history of the UHT and its current operation

72. The initial review process carried out by the UHT between 2004 and 2008 involved searches and inquiries to identify unsolved homicide or suspicious death investigations. The searches and inquiries undertaken included with the Regional Major Crime Squads, on COPS, with the State Coroner's Office and with the NSW State Archives.[44] Again, the enormity of the task faced by the UHT at this time should not be overlooked.

73. As set out at CA [310]-[312], [315], the NSWPF has been unable to provide lists of the cases identified as warranting consideration for reinvestigation, and of the 9 cases that were re-opened for investigation. It is accepted that the lack of information now available about these aspects of the initial review is regrettable. Additional information may, of course, have been able to be obtained from the officers who were involved in that initial review. The Inquiry has not sought evidence from such persons.

C.2.1 The UHT Tracking File

74. As noted at CA [319], the UHT Tracking File is a record management system, not an investigation management system. It is "used to identify the status of each matter".[45] In the course of the triage process, the Review Team identifies available documentation, exhibits or evidence and inputs that data into the e@gle.i system.[46]

C.2.2 The Review and Investigation Teams

75. The structure of and role of the UHT Review Team, and of recruitment to the UHT, is accurately described at CA [330]-[333].

[44] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [58] (NPL.9000.0019.0001).
[45] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [72] (NPL.9000.0019.0001).
[46] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [76] (NPL.9000.0019.0001).

C.3 – The triage and review process

76. Counsel Assisting submit at CA [334] that there was a "disjunct" between the theoretical operation of the UHT set out in DCI Laidlaw's statement, and the practical operation of the UHT, as emerged during his oral evidence. It is accepted that there are various respects in which the UHT has not achieved in practice the operation envisaged in its procedures, addressed further below at Part D. But the framing of the submission might be taken to suggest that DCI Laidlaw was not entirely forthcoming in his statement; no such suggestion should be allowed to arise, as it is in no way borne out. DCI Laidlaw's statement was responsive to the request for statement dated 30 May 2023, which relevantly said, "with reference to the current and previous versions of the UHT Standard Operating Procedures, please outline the nature of the triage and review process undertaken by the UHT".[47] It is unsurprising, then, that DCI Laidlaw's statement focused on the SOPs and general processes. In his oral evidence, he was questioned about further practical challenges faced by the UHT over the years, where he gave candid evidence on those matters to the extent of his knowledge.

77. Counsel Assisting point to the lack of reference in DCI Laidlaw's statement to the fact that no reviews occurred between 2013 and 2017 due to a lack of resources (CA [335]). Counsel Assisting acknowledge that DCI Laidlaw "was not in a leadership role in the UHT during 2013-2017". More accurately, it should be noted that DCI Laidlaw was not within the UHT in any capacity, prior to joining the UHT in 2017.[48]

78. It must be observed that there were very significant impositions on the resources of the UHT in that period, including – without limitation – in connection with the investigation of Scott Johnson's death and the investigation of the Family Court bombings.[49] More generally, it is regularly necessary for resources within the UHT to be redirected to assist with current investigations by the Homicide Squad[50] and to assist the with the investigation of critical incidents, including during the investigation forming part of the relevant Coronial Inquest. The latter process can take many months and include the taking of hundreds of statements, such that the entirety of the relevant officers' time is directed to work associated with the Inquest.[51]

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[47] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, Annexure 1 - Request for statement dated 30 May 2023, [3] (NPL.9000.0019.0001).
[48] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [16] (NPL.9000.0019.0001).
[49] See Transcript of the Inquiry, 26 September 2023, T6011.41-6012.21 (TRA.00091.00001).
[50] Transcript of the Inquiry, 26 September 2023, T6114.10-14 (TRA.00091.00001).
[51] Transcript of the Inquiry, 26 September 2023, T6114.18-47 (TRA.00091.00001); Exhibit 6, Tab 513, Statement of Detective Chief Inspector John Lehmann, [18] (SCOI.85495).

79. Resources within the Homicide Squad, and in the NSWPF generally, are finite. It is neither surprising, nor inappropriate, that active investigations in relation to recent deaths will, on occasion, take priority over the review and/or reinvestigation of historical deaths. There are a number of sound reasons for this.

80. At the outset, the investigation of recent deaths may have important and immediate consequences for public safety. While the perpetrator of a killing has not been identified, there is an increased risk that person will engage in further violence of some kind. There is perhaps no clearer illustration of this than the manifold demands associated with the investigation of murders associated with organised crime, which have routinely impacted significantly upon the resources available for the work of the UHT.[52]

81. Additionally, evidence in relation to a homicide is most likely to be available in the hours, days and perhaps weeks immediately following the death. It is important that substantial resources are allocated in that period, to best ensure that all available evidence is gathered.

82. If a potential perpetrator is not identified in the early stages, it is substantially more likely that a case will remain unsolved. During periods of substantially increased workload, it is entirely appropriate for officers of the UHT – who are skilled homicide investigators – to be significantly involved in efforts to ensure that a case does not, as a result of an inability to identify and charge a suspect or suspects in the early stages, later fall within the scope of the UHT's work.

83. It is also appropriate to note that neither the UHT nor the Homicide Squad is able to effectively control the timing or extent of demands upon officers' time in connection with the conduct of Court Proceedings or Coronial Inquests. Trials in relation to homicide offences are often long and complex, and involve substantial demands on officers' time. They are regularly vacated and rescheduled, often at the last minute. Similarly, Coronial Inquests in respect of critical incidents routinely involve lengthy hearings, and invariably include a variety of requisitions from Coroners and those assisting them.[53] In such circumstances, Homicide Squad members are – entirely appropriately – bound to accommodate the timetabling requirements of the Court.

C.3.1 The screening process prior to 2018

84. The screening process prior to 2018 is accurately set out at CA [337]-[343].

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[52] Exhibit 6, Tab 513, Statement of Detective Chief Inspector Lehmann, [19] (SCOI.85495).
[53] See , Exhibit 6, Tab 513, Statement of Detective Chief Inspector Lehmann, [18] for an illustration of the impact of such requirements.

C.3.2 Current Review Process

85. The four stages of the current review process, in place since 2018, are accurately described at CA [344]-[363]. A significant change implemented in 2018 was to split the previous screening process into two stages: a triage process managed by the UHT Review Team, and a review, allocated to an investigator in one of the Investigation Teams.[54]

86. At CA [348]-[349], Counsel Assisting address DCI Laidlaw's evidence that there were 19 triage documents awaiting his assessment for the last 12 months. DCI Laidlaw gave evidence that he had prioritised other matters, including because there are not presently enough investigators to then conduct the reviews.[55] Previously in his evidence, DCI Laidlaw had explained that "we're moving a backlog of triage forms into the review area and they're unable to be reviewed because we can't resource them adequately".[56] A lack of capacity for a review to progress even after DCI Laidlaw's assessment of the triage does go some way to explaining his prioritisation of other matters. But it is not suggested that it provides justification for the triages not being progressed in a timely manner.

C.3.3 SOPs concerning the backlog presently experience by the UHT

87. In 2018, in an attempt to address the backlog in reviews, a process was implemented to assign reviews to investigators outside the UHT.[57] This gave rise to its own difficulties in oversight and a large number of reviews were not completed. The Triage and Review Backlog SOPS dated January 2022 outlined these challenges and implemented processes to address the outstanding reviews, arranging for their return to the UHT with all relevant material and information and prioritising them on return.[58] It is reflective of the efforts by the UHT to systematically manage a very large volume of reviews that has exceeded the capacity of investigators to undertake them.

C.3.4 How long it takes for cases to be screened or triaged by the UHT

88. On the UHT Tracking File for the period 1970-2010, as at 6 June 2022, 572 cases had been triaged. 125 cases had not been triaged.[59]

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[54] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [83] (NPL.9000.0019.0001).
[55] Transcript of the Inquiry, 7 July 2023, T5190.38-47 (TRA.00075,00001).
[56] Transcript of the Inquiry, 6 July 2023, T5126.2-14 (TRA.00075,00001).
[57] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [114] (NPL.9000.0019.0001); Exhibit 53, Tab 55, Triage and Backlog SOPS, January 2022, 5 (NPL.0205,0001.0917).
[58] Exhibit 53, Tab 55, Triage and Backlog SOPS, January 2022, 6-8 (NPL.0205,0001.0917).
[59] Transcript of the Inquiry, 6 July 2023, T5124.37-47 (TRA.00075,00001).

89. The Commissioner of Police acknowledges that it is a demonstrable failure of the triage process that a triage of all cases on the UHT Tracking File has not yet been completed, within the five years since the triage process was implemented in 2018 (CA [368]). The balance between the level of detail necessary, and the speed with which it is possible to get through a high volume of cases, is not right. The problems with the efficiency of the triage process should have been identified and addressed sooner.

90. At CA [369] Counsel Assisting write that "the Inquiry has not received evidence of a person in a position of responsibility asking themselves that question prior to this Inquiry". The adoption of a two-stage process in 2018 reflected consideration of the question of how to efficiently triage matters. In terms of the period since 2018, after DCI Laidlaw agreed with Senior Counsel Assisting that the balance in the triage process was not right, he was not asked whether that is a question he had previously asked himself.[60] The evidence indicates an ongoing attempt to systematically deal with a very large number of cases in a setting of limited resources and substantial demands on the time of UHT officers in connection with active investigations as discussed above at [76] – [83].

C.3.4.1 The initial case review in 2004-2008

91. The process conducted from 2004 to 2008 did not achieve a review of all cases: 329 of the 400 cases were reviewed (CA [372]). A number of cases considered by the Inquiry were not reviewed in that time. The Commissioner of Police agrees that the evidence indicates the initial review was not comprehensive. It appears to represent a significant missed opportunity (CA [373]), however, any such criticism must pay appropriate regard to the extraordinarily difficult task being undertaken by the relevant officers, the relative novelty of that task, and the absence of evidence from the relevant officers as to, among other things, the no doubt significant resources constraints they were subject to.

C.3.4.2 The period between 2009 and 2017

92. The issues paper and memorandum referred to at CA [374] – [376] identify the significant problems with the backlog of cases and ongoing capacity issues at the Homicide Squad in this period.

[60] Transcript of the Inquiry, 6 July 2023, T5126.35-45 (TRA.00075,00001).

C.3.4.3 The period between 2018 to present

93. The processes and procedures of the UHT, and DCI Laidlaw's supervision of the UHT, are addressed at Part D.31.

C.4 – Management of exhibits and documentary records

94. There is no dispute that there have been significant difficulties in relation to the NSWPF's management of exhibits and documents relating to unsolved historical homicides. It is similarly acknowledged that this is an issue that the UHT has been grappling with for some time.

95. The Inquiry has not called any of the officers involved in the initial review of unsolved homicides conducted in the early years of the unsolved homicide capability within the NSWPF to give evidence. In those circumstances, the Inquiry has little insight into the extraordinary challenges those officers were called upon to address. Prior to the formation of the UHT, there was no comprehensive accounting of unsolved homicides and long-term missing persons in NSW. The officers involved in that process were, in essence, confronted with a blank slate. Their task was not simply to review neatly compiled bundles of material regarding a ready-made subset of cases. They had to create the subset, compile the bundles, and begin the unquestionably challenging review process.

96. There is no evidence as to the resources available to those officers nor as to the constraints and pressures they no doubt confronted in undertaking that exercise.

97. It is also important to recall that a dedicated unsolved homicide capability was, as at 2004, a relatively novel concept.[61] Before the extraordinary developments in forensic science in the 1990s and 2000s, there was comparatively very little prospect of resolving unsolved homicide cases. It is unsurprising that relatively little attention had, to that point, been directed to developing a dedicated unsolved homicide unit within the NSWPF (or in other police forces internationally).

98. When the UHT was established (albeit only with a review capacity), DNA testing had been readily available for approximately 6 years.[62] The *Crimes (Forensic Procedures) Act 2000* (**CFP Act**) did not commence until 1 January 2001; the capacity to compel the provision of DNA samples

[61] See generally, Exhibit 51, Tab 16, Cheryl Allsop, 'Cold Case Homicide Reviews' in Fiona Brookman, Edward R. Maguire, and Mike Maguire (eds), *The Handbook of Homicide* (John Wiley & Sons, 2017), 568 – 569 (SC01.84206).
[62] Transcript of the Inquiry, 4 July 2023, T4816.42-44 (TRA.00072.00001); see also Transcript of the Inquiry, 4 July 2023, T4866.28-38 (TRA.00072.00001).

for testing was a relatively novel phenomenon and the sample database for DNA comparison purposes was in a comparatively nascent state.[63]

C.4.1 The process of identifying and retrieving documentary and exhibit material held by the NSWPF

C.4.1.1 How the NSWPF would identify and locate exhibits (CA, [402] – [404])

99. As noted by AC Conroy, as a result of the introduction of EFIMS in 2011[64], the NSWPF now has a capacity to "electronically manage all aspects of the exhibit life cycle".[65]

100. The introduction of EFIMS represented a fundamental shift in the exhibit management capabilities of the NSWPF. It has made it very substantially less likely that exhibits will be lost or destroyed or otherwise disposed of without a record of that disposal or destruction being made and retained.[66]

101. The steps summarised by Counsel Assisting at [403] – [404] accurately reflect the approach that might be taken to identify, to the greatest extent possible, the potentially relevant records in respect of a given case.

C.4.1.2 The role of the NSWPF Corporate Records, Record and Information Management Unit (CA [405] – [415])

102. As noted by Counsel Assisting, the NSWPF Corporate Records, Records and Information Management Unit (**Corporate Records**) plays a central role in the management of records within the NSWPF.

103. There is, unfortunately, the potential for human error in the archiving process. In particular, in some cases individual officers appear to have failed to archive records, or to correctly archive those records (for example, by providing the correct details in relation to a given file to Corporate Records).[67] The issue, as DI Warren clarified, lies in the process by which historical cases were archived, rather than in some deficiency in the systems of Corporate Records itself.[68]

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[63] Transcript of the Inquiry, 6 July 2023, T5094.26-5095.2 (TRA.00074.00001).
[64] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [127] (NPL.9000.0008.0905).
[65] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [128] (NPL.9000.0008.0905).
[66] Transcript of the Inquiry, 4 July 2023, T4827.18-21; T4867.43-4868.3 (TRA.00072.00001).
[67] Transcript of the Inquiry, 5 July 2023, T4959.34-45 (TRA.00073.00001); Transcript of the Inquiry, 5 July 2023, T5009.21-47 (TRA.00073.00001).
[68] Transcript of the Inquiry, 5 July 2023, T5009.46-T5010.33 (TRA.00073.00001).

104. It is accepted, in line with the evidence given by DI Warren, that there appear to have been deficiencies in the system applied to the archiving of files in the 1980s and 1990s and that it is likely that such deficiencies existed in the 1970s.[69]

C.4.1.3 Standard Operating Procedures and protocols of the Corporate Records Unit (CA [416] – [426])

105. The Commissioner of Police agrees with Counsel Assisting's overview of the SOPs concerning the processes applicable to Corporate Records.

106. Some further detail on functional retention and disposal authorities (CA [423]-[425]) is of assistance, as it informs the issues that follow about the loss or destruction of documentary records, and an absence of records of such destruction. It is addressed further at section C.8 in relation to the operation of the *State Records Act 1998* (NSW) (**State Records Act**).

107. A retention and disposal authority is an instrument approved by the State Archives and Records Authority of New South Wales under s 21(2)(c) of the State Records Act specifying the period after which categories of records may be disposed of, and which records are required as State archives.[70]

108. There are currently two functional authorities for the NSWPF. Functional Retention and Disposal Authority DA 221 governs the disposal of investigation case records.[71] It provides that records relating to the investigation of unlawful killing are required as State archives.[72]

109. Functional Retention and Disposal Authority DA 220 covers operational policing.[73] Relevantly for present purposes, it provides:

a) Occurrence Pads (in paper format which were created up until around 1994) are required as State archives;[74]

b) Duty books and notebooks are to be retained for a minimum of 30 years, then destroyed;[75]

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[69] Transcript of the Inquiry, 5 July 2023, T4961.12-29 (TRA.00073.00001).
[70] Exhibit 51, Tab 5E, Functional Retention and Disposal Authority: DA221 (NPL.9000.0018.0469); Exhibit 53, Tab 41, Records Disposal Procedures Manual, November 2008, 10 (NPL.0204.0002.0103).
[71] Exhibit 51, Tab 5E, Functional Retention and Disposal Authority: DA221 (NPL.9000.0018.0469).
[72] Exhibit 51, Tab 5E, Functional Retention and Disposal Authority: DA221, 7 (NPL.9000.0018.0469).
[73] Exhibit 51, Tab 3Q, Functional Retention and Disposal Authority: DA220, (NPL.9000.0008.0837).
[74] Exhibit 51, Tab 3Q, Functional Retention and Disposal Authority: DA220, 11 (NPL.9000.0008.0837).
[75] Exhibit 51, Tab 3Q, Functional Retention and Disposal Authority: DA220, 11 (NPL.9000.0008.0837).

c) Records relating to the registration of all exhibits are to be retained for a minimum of 20 years after action completed, then destroyed;[76]

d) Records relating to the disposal of exhibits are to be retained for a minimum of 10 years after action completed, then destroyed.[77]

110. As explained in more detail at section C.8 below, there is no information before the Inquiry about any authorities given under the *Archives Act 1960* (NSW) (**Archives Act**) prior to the commencement of the State Records Act in 1999.

111. The lengthy period covered by the Inquiry accordingly presents difficulties in ascertaining whether certain records, including records of disposal of exhibits, that do not now exist, were required by procedure to be retained.

C.4.1.4 Submissions concerning records management

112. As noted by Counsel Assisting, the cases subject to consideration by the Inquiry typically pre-date the document management SOPs that have been able to be produced (CA, [427]). The available evidence generally does not allow the Inquiry to reach a conclusion as to when or how particular records were lost or disposed of (or, indeed, whether they were disposed of or lost).

113. It is unfortunately correct that, in relation to historical deaths – which occurred prior to the introduction of electronic records management – there was a greatly increased scope for human error or failures of diligence (CA, [428]). The Commissioner of Police accepts that the apparent frequency of such human error and/or failures to diligently archive material correctly is regrettable (CA, [429]).

114. It is trite to say that any system (in any organisation) will be reliant on individual personnel to at least some extent. Very substantial efforts, however, have been made by the NSWPF to refine its exhibit and record management procedures. As a consequence, and in line with Counsel Assisting's submission (CA, [430]), the problems relating to the retention and location of documents and exhibits encountered during the course of the Inquiry are very substantially less likely to reoccur in the future.

[76] Exhibit 51, Tab 3Q, Functional Retention and Disposal Authority: DA220, 13 (NPL.9000.0008.0837).
[77] Exhibit 51, Tab 3Q, Functional Retention and Disposal Authority: DA220, 14 (NPL.9000.0008.0837).

115. The impact of these improvements is apparent from AC Conroy's evidence that, of 514,000 items stored, only 11 miscellaneous items of property and seven exhibits had been lost[78], equating to approximately 1 in 28,555 (or a rate of approximately 0.0035%).

C.5 – Historical practices in relation to exhibit management

C.5.1 The 1970s to the 1990s (CA [432] – [447]

116. Historically, the exhibit management processes within the NSWPF were not digitised. As noted by Counsel Assisting, responsibility for exhibit management was vested in particular officer/s at each station and the movements of exhibits were required to be recorded, by hand, in an exhibit book (CA, [433] – [435]).

117. In the 1970s to 1990s, police were operating in a dramatically different landscape vis-à-vis forensic testing, in particular as concerns DNA. Exhibits were simply collected and placed in unlabelled brown paper bags.[79]

118. Police were also operating in a vastly different information technology landscape at the time. In a clear illustration of that different position noted by Counsel Assisting, it was not until the late 1990s that exhibit bags were printed with a pre-formatted label.[80]

119. Police procedures required the exhibit books be kept up to date, and that all movements of exhibits (including their disposal or return to owners) be appropriately recorded in a timely fashion.[81] Nevertheless, the entirely manual process that existed in in the 1970s to the 1990s necessarily introduced a substantially greater of risk of human error or laxity than exists today.

120. Police made efforts to address these risks, including via the conduct of regular audits of exhibits.[82] In the pre-digital exhibit management landscape, that audit process required the officer in charge of the relevant police station to go through each page of the exhibit book and cross-reference the exhibits listed there to the items held in the relevant exhibit office.[83] Such a process was significantly more onerous and more susceptible to human error than the current process, which involves the use of barcodes and scanners.[84]

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[78] Transcript of the Inquiry, 4 July 2023, T4867.19-4868.4 (TRA.00072.00001).
[79] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [52], (NPL.9000.0008.0905).
[80] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [52]-[54] (NPL.9000.0008.0905); Transcript of the Inquiry, 4 July 2023, T4804.6-45, T4805.29-35 (TRA.00072.00001).
[81] See Transcript of the Inquiry, 4 July 2023, T4811.35-42 (TRA.00072.00001).
[82] Transcript of the Inquiry, 4 July 2023, T4812.1-6 (TRA.00072.00001).
[83] See Transcript of the Inquiry, 4 July 2023, T4805.46-4806.12 (TRA.00072.00001).
[84] Transcript of the Inquiry, 4 July 2023, T4814.44-4815.2 (TRA.00072.00001).

121. Instruction 33.01 in the *1989 – 1990 Police Rules and Instructions*, is illustrative of the very different approach to exhibits the widespread availability of DNA testing has engendered. As noted by Counsel Assisting (CA, [443]), those instructions provided, *inter alia*:

> *"While patrol commanders are accountable for the security, retention and disposal of exhibits, police generally have an obligation to assist them to carry out this function.*
>
> *Exhibits are not to be retained longer than absolutely necessary and patrol commanders will keep this firmly in mind. Exhibits will be photographed, fingerprinted or analysed as required, and returned to the owner or disposed of.*
>
> *The prosecution may satisfy its onus of presenting evidence to court by tendering photographs of such property, attested by the photographer and its existence corroborated by sworn testimony.*
>
> *The actual property seized need not be tendered to the court as an exhibit unless there is some feature which makes its production imperative, for example:*
>
> - *Murder weapons.*
> - *Implements used in armed hold-ups or serious assaults.*
> - *Documents, defective motor vehicle parts, money or other article with unique or distinctive characteristics.*
>
> *On occasions something seized as an exhibit may prove not to have any evidentiary value. In such circumstances there is no need to tender the item in court and it should be returned to the lawful owner.*
>
> *Where doubt exists the patrol commander or officer in charge of the case should consult the local police prosecutor or Commander, Regional Legal Services."*

122. This instruction reflects that the need to retain exhibits was considered to be comparatively limited. That fact is unsurprising given fact that, in the absence of bloodstains or fingerprints many (or even most) exhibits would have been regarded as having no real forensic utility. Once such exhibits had been photographed and tested for blood or fingerprints, there would – in the eyes of police operating in the late 1980s or early 1990s – have been no need for the exhibit to be further retained unless there was some particular feature of the exhibit that meant that the physical characteristics of an item (for example, a knife used in a murder) might itself have some forensic purpose.

123. In that respect, Counsel Assisting referred to AC Conroy's evidence:

> *'*[T]*he considerations relating to the assessment of forensic value at the time were different. When making the decision to dispose of exhibits, I understand that the process at the time was generally to consider future evidentiary or forensic value, but, because DNA testing was not available, this did not generally factor into decision making. As a result, it is possible the exhibits which would be retained now (taking into account forensic potential) would not have been retained in the past. Similarly, there is now a much greater understanding that crimes that may not presently be able to be solved using current forensic and technological capabilities may be able to be progressed in the future due to subsequent advances in these areas. Decisions regarding the retention and disposal of exhibits are now therefore made bearing such factors in mind."*[85]

124. AC Conroy's oral evidence that it would be "preferable to keep exhibits for serious indictable offences for production at court"[86] needs to be understood in light of her qualification that the need for exhibits to be retained depended on the "evidentiary value" of the exhibit.[87] As is apparent from the above extract of the *1989 to 1990 Police Rules and Instructions,* many exhibits do not themselves have "evidentiary value"; with the exception of objects such as a weapons used in offences, or other material with "unique or distinctive" characteristics, many items likely to be seized in connection with an investigation are not themselves likely to be of "evidentiary value".

125. While it is accepted that, as noted by Counsel Assisting (CA, [446]) proper police practice required a consideration of the future forensic value of an exhibit, care needs to be taken not to import modern understandings into an assessment of what that consideration properly entailed. Until the mid or late 1990s, when the utility of DNA testing began to become apparent, a consideration of the future forensic value of an exhibit (that had been unsuccessfully tested for fingerprints or blood) would, in the eyes of a reasonably prudent officer, have been limited to the question of whether the relevant item needed to be tendered in a future trial of the proceedings.

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[85] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [113] (NPL.9000.0008.0905).
[86] Transcript of the Inquiry, 4 July 2023, T4818.14-16 (TRA.00072.00001).
[87] Transcript of the Inquiry, 4 July 2023, T4818.20 (TRA.00072.00001).

126. In 2002, after the commencement of the CFP Act, as the full scope and impact of a DNA database and the power to compel testing became apparent, the then Commissioner of Police imposed a moratorium on the disposal of exhibits that might be the subject of DNA testing.[88]

127. While great care needs to be taken not to unfairly judge decisions around the disposal of exhibits by reference to modern understandings, it is certainly true that the disposal (including by return to its owner) or destruction of an exhibit should, according to proper police practice, have been recorded in the relevant exhibit book.[89] The retention of exhibit books is addressed at C.6.3 below.

128. As concerns records management, it appears that, in the 1980s and 1990s the approach to the sending of documents into storage or to the GRR may not have been the subject of uniformly adhered to policy (CA [447]).

129. Section C.8 below sets out the position under the Archives Act (prior to 1999), where records could be destroyed after notification to the Archives Authority, or pursuant to an authorisation from the Archives Authority.

C.5.2 The 2000s and the introduction of the Command Management Framework

130. As noted by Counsel Assisting, police responsibilities and accountabilities in relation to exhibit management are now outlined in the Exhibit Procedures Manual.[90]

131. The Exhibit Procedures Manual sets up a variety of checks and balances to ensure that exhibit movements are appropriately tracked and that exhibits are not lost. Those checks and balances include a robust audit process; there is an annual 100% audit of all exhibits and monthly "dip samples" are conducted.[91]

132. In 2003, the Exhibits Guideline within the Police Handbook was reviewed and provision made for the moratorium on the disposal of exhibits mentioned above[92] within the Exhibits Guideline, which provided that all exhibits associated with the prosecution of serious indictable matters and sexual assaults were not to be destroyed or disposed of during the moratorium.[93]

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[88] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [114] (NPL.9000.0008.0905).
[89] Transcript of the Inquiry, 4 July 2023, T4819.47-4820.7 (TRA.00072.00001).
[90] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [85] (NPL.9000.0008.0905).
[91] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [86]-[87] (NPL.9000.0008.0905).
[92] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [114] (NPL.9000.0008.0905),
[93] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [115] (NPL.9000.0008.0905);
Exhibit 51, Tab 3S, Police Notice - Retention and Disposal of Exhibits, 22 September 2003 (NPL.9000.0002.4086).

133. In 2007, the moratorium was amended to better align with the scope of the CFP Act.[94] This had the effect that a more limited set of exhibits were required to be retained.[95] As noted by Counsel Assisting, the moratorium was subject to additional amendments in 2012.[96]

134. There were also a number of changes implemented in 2005 in association with developments in forensic testing. From that point on, the work of collecting exhibits containing biological material was performed by personnel from the Crime Scene Services Branch (CA, [454]). There were also changes implemented in relation to the storage of exhibits generally, and in particular in relation to the storage of samples of biological material.[97]

C.6 – Current policies and procedures concerning exhibit management

135. In 2012, the NSWPF introduced the Exhibit Procedures Manual, following an audit by the NSW Auditor General in 2011-2012 relating principally to drug exhibits (CA, [458]). The Exhibit Procedures Manual was also informed by coronial recommendations and the outcomes of criminal proceedings.[98]

136. At CA [455] – [460], Counsel Assisting accurately summarises some key aspects of the presently applicable exhibit management procedures. Of key import, exhibits are required to be entered into the EFIMS system subsequent to collection. All movements of the exhibit are then to be recorded in EFIMS.

C.6.1 Identifying and obtaining exhibits at a crime scene (CA, [461] – [462]

137. As acknowledged by Counsel Assisting, it is not always necessary to collect and retain the physical exhibit itself; in the absence of a need for analysis or testing, it may be sufficient to photograph the relevant item.[99]

138. Exhibits that are collected are to be entered into EFIMS at the first available opportunity.[100]

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[94] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [116] (NPL.9000.0008.0905);
Exhibit 51, Tab 3T, Police Notice -Change to Existing Exhibit Moratorium, 21 August 2007 (NPL.9000.0002.4085).
[95] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [116] (NPL9000.0008.0905).
[96] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [117] (NPL.9000.0008.0905);
Exhibit 51, Tab 3U, Commissioner's Policy Notice, Maintenance of Exhibits by NSWPF, Undated (NPL.9000.0002.4084).
[97] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [90] (NPL.9000.0008.0905).
[98] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [30]-[31] (NPL.9000.0008.0905).
[99] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [39] (NPL.9000.0008.0905).
[100] Transcript of the Inquiry, 4 July 2023, T4801.41-46 (TRA.00072.00001).

C.6.2 Storing Exhibits (CA, [463] – [467])

139. Counsel Assisting accurately summarises the processes for the storage of exhibits at CA [463] – [467].

140. As noted by Counsel Assisting, a four-day long Exhibit Managers course was developed in 2014.

141. Importantly, where exhibits remain in the custody of an Exhibit Officer, they will be subject to regular EFIMS audits and alerts will be generated in cases of anomalies or disruption in the chain of custody pertaining to an exhibit.[101] As a result of the introduction of EFIMS, the process of auditing exhibits has been streamlined, and can be conducted electronically.[102]

142. Since 2011, the NSWPF has been able to have recourse to the MEPC for the long-term storage of exhibits that are associated with serious indictable offences with a maximum sentence of 15 years or more (i.e. including murder).[103]

C.6.3 Exhibit Books (CA, [468] – [469])

143. The Commissioner of Police does not take issue with Counsel Assisting's summary of the position in relation to Exhibit Books.

144. It is appropriate to emphasise that the requirement to retain exhibit books is not unlimited; it extends to 20 years.[104] The exhibit books pertaining to almost all of the cases considered by the Inquiry are more than 20 years old. It should also be remembered that exhibit books were not specific to a particular investigation, but recorded the exhibits retained by a given police station.[105]

145. Section C.8 below sets out the position under the Archives Act (prior to 1999), where records could be destroyed after notification to the Archives Authority, or pursuant to an authorisation from the Archives Authority.

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[101] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [87] – [89] (NPL.9000.0008.0905).
[102] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [89] (NPL.9000.0008.0905).
[103] See Transcript of the Inquiry, 4 July 2023, T4809.14-31 (TRA.00072.00001).
[104] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [75] (NPL.9000.0008.0905); Exhibit 51, Tab 3Q, Functional Retention and Disposal Authority DA220, 15 July 2021 (NPL.9000.0008.0837); Transcript of the Inquiry, 4 July 2023, T4810.1-8 (TRA.00072.00001).
[105] See Exhibit 51, Tab 2D, Instruction No. 24 - Exhibits, 1962, [1] (NPL.9000.0003.1471).

C.6.4 The handling of exhibits (CA, [470])

146. Police processes in relation to the handling of exhibits have, once again, been significantly enhanced as a result of the introduction of EFIMS. In every instance where an exhibit is accessed or removed from an exhibit room, an appropriate record is required to be made on EFIMS.[106]

C.6.5 The destruction of exhibits (CA, [471])

147. The need to retain an exhibit is dependent on the nature of the exhibit and the nature of the matter to which it relates. The critical factor is evidentiary value: the retention of an exhibit that is unlikely to have evidentiary value is obviously less important. The current NSWPF Handbook provides that is "normally desirable to retain exhibits for production at court" in the case of serious offences, but this is not absolute and again turns on the evidentiary value of the exhibit.[107]

C.6.6 The Introduction of EFIMS (CA, [472] – [479])

148. The Commissioner of Police agrees with the summary of the rationale for, and implementation of, EFIMS provided by Counsel Assisting. As noted by AC Conroy, and extracted at CA [479], the following changes to the management of exhibits implemented by the NSWPF have greatly reduced the risk of exhibit loss:

a) mandatory centralised recording of every movement of an exhibit means that it is much less likely that exhibits will be lost because of a failure to record a movement or a movement to the correct place;

b) the digitisation of the system has eliminated the risk associated with the potential loss or disposal of exhibit books;

c) electronic recording has streamlined the process of auditing and improved its accuracy;

d) clear guidance has been developed and provided in relation to the collection and preservation of exhibits which maintains the integrity of exhibits for forensic testing (both in connection with presently available techniques and allowing for the potential development of technologies and testing capabilities);

[106] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [93]-[95] (NPL.9000.0008.0905).
[107] Exhibit 51, Tab 3F, NSWPF Handbook, 4 November 2022 (NPL.9000.0002.0128); Transcript of the Inquiry, 4 July 2023, T4819.8-20 (TRA.00072.00001).

e) improvements have been made to the guidance provided in relation to the disposal of exhibits and the authorisation required for same; and

f) additional audit and accountability measures have been introduced.[108]

149. As acknowledged by Counsel Assisting (CA, [478]), the NSWPF is in the process of rolling out an updated system to replace EFIMS.[109] That system is expected to be in place by 30 June 2024[110] and will further enhance the NSWPF's approach to exhibit management. The system will form part of a wider rollout of the cloud-based integrated Policing Operations System (**iPOS**) that is to replace COPS and other frontline policing systems.[111] It will have a number of important benefits, including:

a) enhanced in-field recording and transfer of exhibits via a mobile application;

b) including of dashboards providing status updates and improving search functionality;

c) the ability to send notifications to officers prompting action in respect of exhibits;

d) the inclusion of exhibit disposal and authorisation workflows, to allow these processes to be more effectively tracked; and

e) enhanced auditing, reporting and statistical functionality.

150. As a consequence of the roll-out of this new system, the potential for issues in relation to the loss or premature disposal of exhibits will be further reduced (noting again that, following the implementation of EFIMS and other developments in the 2000s and 2010s, the loss of exhibits is extremely rare).[112]

C.6.7 Treatment of exhibits at FASS (CA, [480] – [488])

151. The Commissioner of Police agrees with the summary of the evidence in relation to the treatment of exhibits by FASS at CA [480] – [488].

152. The Commissioner of Police notes, as identified by Ms Neville, that there have been instances – on limited occasions – where FASS has lost exhibits or misplaced samples.[113] However, in

[108] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [157]-[158] (NPL.9000.0008.0905).
[109] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [142]-[144] (NPL.9000.0008.0905).
[110] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [144] (NPL.9000.0008.0905).
[111] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [142] (NPL.9000.0008.0905).
[112] Transcript of the Inquiry, 4 July 2023, T4867.19-4868.4 (TRA.00072.00001).
[113] Transcript of the Inquiry, 15 August 2023, T5525.33-5526.4 (TRA.00082.00001).

any system where very substantial quantities of material are processed scientifically, there is a potential for human error of that type to emerge.

153. FASS has taken appropriate steps to reduce that risk as much as is reasonably possible, having regard to the nature of the task being undertaken by FASS, and the resources available to it.

C.6.8 Submissions concerning exhibit management

154. As a global proposition, and as conceded in submissions made in various of the tender bundle cases, it is accepted that in a number of cases there have been failures in the management of exhibits.

155. The position in relation to exhibit management in individual cases is considered further in Part D below.

156. Counsel Assisting has submitted that the evidence "suggests that these deficiencies were systemic or widespread within the NSWPF before the introduction of EFIMS" (CA, [489]). If the cases subject to consideration by this Inquiry are regarded as a representative sample of all cases considered by the NSWPF, that submission may well be appropriately founded. However, as alluded to above at [58] – [59], the cases subject to consideration by the Inquiry cannot sensibly be regarded as a representative sample. In some instances, a case was not solved because of a failure in investigative process. And cases that are initially unsolved may remain that way, at least in part, because of a failure in exhibit management. That being so, a failure in investigative practice or exhibit management is, by definition, more likely to be observed in unsolved cases than in cases that are solved.[114]

157. Indeed, the submission at CA [489], appears to conflict with the Counsel Assisting's own submission on this point at CA [906]. There, Counsel Assisting acknowledges that reviewing unsolved cases may produce a disproportionate number of cases in which the investigation fell short of proper police practices.

158. It is correct that in a few cases, the Commissioner of Police has made submissions to the effect that there is limited utility in making findings that align with some of the criticisms advanced by Counsel Assisting (CA, [490]). However, to indicate that there is limited utility in certain criticisms is not to say that the criticism should not be recorded. In many cases, little in practical terms is likely to be gained by criticising a practice that is long defunct or an officer who has been retired

[114] Transcript of the Inquiry, 26 September 2023, T6101.19-6102.25 (TRA.00091.00001).

for 20 years or more. Nevertheless, it is acknowledged that the simple fact of taking stock, and recording a past failure can give significant comfort to members of the community (in particular, family members of the deceased, and members of the LGBTIQ community).

159. There is, of course, an important caveat that must be applied to that acknowledgment. That is, prior to criticisms of the relevant kind being made, appropriate steps should be taken to afford procedural fairness to the person or persons subject to the criticism. In many instances, as recorded in submissions made in individual tender bundle cases,[115] and in correspondence with the Inquiry, that has – at least to the knowledge of the Commissioner of Police – simply not occurred.

160. The assessment of the exhibit management practices engaged in at CA [492] – [493] rests heavily on speculation, in circumstances where it is typically not known why an exhibit is no longer retained; in particular, there is ordinarily no evidence of when, how or why an exhibit ceased to be in the possession of the NSWPF. Of course, in cases where an exhibit was disposed of or returned to its owner, a record of that event should have been made. However, the fact that such a record is no longer available does not necessarily indicate that there has been some failure in the exhibit management process; given the lapse of time, the destruction of the relevant record may well have accorded with proper procedure (see Parts C.6.3 and C.8).

161. A further factor is that the disposal of exhibits may be authorised by the Coroner. In cases where a determination was made that a death was not suspicious, it would be more likely that there would be an approval to dispose of the exhibits.[116] As noted above, under DA 220 the retention period for records of the disposal of exhibits is 10 years.

162. As appears to be accepted by Counsel Assisting at [493], there is no evidence that would allow a conclusion to be reached that the problems with exhibit and record management are more prevalent in cases where victims were, or may have been perceived to be, members of the

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[115] See written submissions of Commissioner of Police (Cuthbert, Raye, Stewart, Stockton), 12 April 2023, [55]; written submissions of Commissioner of Police (Cawsey, Jones, Baumann), 10 July 2023, [56], [90], [95]; written submissions of Commissioner of Police (Rooney, Slater, Rath, Wark), 1 June 2023, [16], [18], [32], [65]; written submissions of Commissioner of Police (Bedser), 7 June 2023, [25]; written submissions of Commissioner of Police (Hughes, Paynter, Payne, Dutfield, Lloyd-Williams, Currie, Walker), 21 February 2023, [10], [66], [67], [107], [110]; written submissions of Commissioner of Police (Sheil), 18 April, [9], [16]; written submissions of Commissioner of Police (Waine), 23 June 2023, [15], [27]-[28], [41], [55]; written submissions of Commissioner of Police (Dye, Allen), 22 August 2023, [35]-[36], [39], [42], [54], [94]-[95]; written submissions of Commissioner of Police (Mattaini, Warren, Russell), 13 July 2023, [16], [20], [44], [49]-[50]; written submissions of Commissioner of Police (Brennan, Meek), 7 July 2023 [95], [128], [132]; written submissions of Commissioner of Police (Miller), 30 June 2023, [21], [46]; written submissions of Commissioner of Police (Rose), 16 June 2023, [19].

[116] Transcript of the Inquiry, 4 July 2023, T4864.40-4865.8 (TRA.00072.00001).

LGBTIQ community. Indeed, in many of the cases subject to consideration by the Inquiry, police were not aware of the sexuality of the deceased person or understood them to be heterosexual.

163. The precise meaning of Counsel Assisting's observation that the exhibit management issues "is not something that can be explained by isolated instances of human error, or an understandable failure to appreciate how technology may work" is not clear. Having regard to the context, this sentence may be interpreted as suggesting that some kind of systematic bias may have played a part. That would be a grave implication, and one that should not be accepted in circumstances where, as acknowledged by Counsel Assisting, it is unsupported by evidence.

164. The very likely reality is that cases of premature disposal or loss of exhibits were, in fact, cases of human error. In some instances, the loss likely resulted from a simple failure of diligence. In other cases, it is possible that there was a failure of foresight in relation to potential advances in technology (though such a conclusion should be approached carefully given the very great potential for it to be infected with unfair hindsight bias). The fact that there appear to have been such human errors in multiple cases may (subject to what is said above regarding the unrepresentative nature of the sample the Inquiry is concerned with) suggest deficiencies in the system or training provided to officers at the relevant time.

165. It is accepted that the absence of exhibits and records – whatever the reason for their absence – has had a significant impact on the work of the Inquiry in relation to some cases (CA, [494]). The absence of exhibits, for example, necessarily prevents them being subject to further forensic examination and, in turn, may reduce the likelihood that the relevant case will be solved.

166. As identified by Counsel Assisting, the issues in relation to exhibit management that have arisen in a number of cases subject to consideration by the Inquiry have been addressed (CA, [495]). The available evidence indicates that the loss of exhibits is now something that occurs very rarely indeed.

167. It is accepted that a more systematic approach to the management of historical exhibits could have been implemented subsequent to the formation of the UHT.

168. As for the early stages of the UHT – in particular the reviews conducted between 2004 and 2008 – it is appropriate (in line with observations made above) to acknowledge the scale of the task undertaken by those officers; they were called upon to establish an entirely new capability within the NSWPF, starting with the identification of which cases should be the subject of consideration for potential reinvestigation.

169. Again, the Inquiry has not sought evidence from any of the officers involved in the establishment of the UHT. That being so, the Inquiry does not have evidence in relation to the processes they followed; the reasons they approached their task in the way they did; what they did or did not do in relation to the identification of historical materials or exhibits; and any resourcing constraints they faced. The Inquiry is not, therefore, in a position to properly analyse the extent to which there were, or were not, "significant missed opportunities to improve the management of historical exhibits…during the initial review conducted by the UHT between 2004 and 2008" (CA, [495]).

170. DCI Lehmann gave evidence that around the time of his report of 5 August 2016 (**Lehmann Report**), active steps including archive searches and requests to various PACs, began.[117] Mr Lehmann, unfortunately, retired from the NSWPF for health reasons shortly thereafter. It appears that, subsequent to his departure, the project may not have been followed through in a systematic fashion to ensure it was completed.

171. Counsel Assisting's targeted criticism of DI Warren and AC Conroy at CA, [496] is unfair. DI Warren did not return to the Homicide Squad until 2020, having spent the previous 14 years working in the Sex Crimes Squad.[118] There is no evidence that he was a recipient of, or otherwise had his attention drawn, to the Lehmann Report, which was prepared some 4 years earlier.

172. Similarly, AC Conroy commenced in her position in April 2022.[119] She has myriad responsibilities in that role, including responsibility for more than 1000 staff[120], and could not reasonably be expected to have become familiar with difficulties confronting the UHT in connection with its work, expressed in an issues paper produced almost six years before her tenure commenced.

C.7 – Knowledge within the NSWPF concerning the difficulties locating and retrieving exhibits and documentary material

173. As noted at [169] above, the Inquiry has not obtained evidence from the officers involved in the review of unsolved homicide cases commencing in 2004 (i.e. almost 20 years ago).

174. The Inquiry has not explored with those officers the extent to which issues in relation to records or exhibits were examined, or reasonably able to be examined, having regard to the resources available at the time. Similarly, the Inquiry has not explored with those officers the extent to which

[117] Transcript of the Inquiry, 26 September 2023, T6102.41-6103.12 (TRA.00091.00001).
[118] Transcript of the Inquiry, 5 July 2023, T4945.10-16 (TRA.00073.00001).
[119] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [18] (NPL.9000.0008.0905).
[120] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [19]-[23] (NPL.9000.0008.0905).

problems with records were, in fact, identified or what those officers did in response to the issues they identified.

175. It is submitted that the Inquiry should, in those circumstances, avoid speculation as to what those officers did, or did not do (cf CA, [501]).

176. Nevertheless, it is accepted that there have been opportunities missed in respect of the conduct of a thorough audit of the records and exhibits relating to the cases falling within the purview of the UHT.

177. Those opportunities have, of course, been missed in circumstances where the UHT has been confronted with an extraordinary caseload, particularly relative to the limited resources available, and its members have directed extraordinary efforts to the resolution of a significant number of homicide cases in the relevant period.

C.7.1 The Lehmann Report – [503] – [514]

178. As noted by Counsel Assisting, the Lehmann Report addressed a range of problems confronting the UHT in relation to the availability and storage of exhibits.

179. DCI Lehmann made the following observation concerning the source of the problems:

> *"The problems outlined stemming from yesteryear have been alleviated by improvements in exhibit handling and record management, particularly through the advent of the EFIMS system. In addition a Commissioners Instruction now exists that all exhibits relating to homicide cases are to be retained indefinitely. It is the legacies of the poor exhibit and record management practices of the past, compounded by the passage of time that causes significant problems for the UHT today."*[121]

180. DCI Lehmann then set out a reconciliation plan for the location of exhibits, their entry into EFIMS and storage at the MEPC.

181. By the time DCI Lehmann left the UHT in October 2016, physical searches for exhibits led by the review team within the UHT had commenced.[122] UHT personnel had also contacted every Local Area Command in NSW to request a search for any potential exhibits relating to unsolved

[121] Exhibit 51, Tab 6F, Report of Detective Chief inspector John Lehmann, 5 August 2016, 3 (NPL.0100.0018.0001).
[122] Transcript of the Inquiry, 26 September 2023, T6015.20-22 (TRA.00091.00001).

homicides within their commands.[123] Some of those commands had provided responses by the time of DCI Lehmann's departure, though most of those responses indicated that the relevant Local Area Command had not located any property or documents.[124]

C.7.1.1 Evidence of the NSWPF witnesses concerning the Lehmann Report

182. Subsequent to the time of the Lehmann Report, and the associated direction to Commands to arrange their transfer, exhibits relating to unsolved homicides are stored in the MEPC.[125]

183. It appears that while progress was made such that by 2017, the UHT had received responses to approximately 80% of their requests to Local Area Commands[126], the reconciliation plan proposed by DCI Lehmann was not satisfactorily completed until recently.

184. Nevertheless, attempts to secure all exhibits continued, at least in the context of the triage process. One aspect of that process is to assess whether the exhibits are correctly stored at the MEPC.[127] If the relevant exhibits are not so stored, the UHT will send a direct request to the relevant Command requiring the exhibits to be collected and transferred to the MPEC.[128]

C.7.1.2 Additional documentary material concerning the Lehmann Report

185. As noted by Counsel Assisting (CA, [530]), memoranda were circulated to Local Area Commands in 2016 and 2017 asking them to conduct an inventory of all unsolved homicide exhibits.

186. The terms of the memoranda noted that the relevant exhibits had predated the advent of EFIMS and were not contained on the system. They also identified the possibility for exhibits to be subject to further forensic examination and required scrutiny of exhibit books to be undertaken to account for the possibility that exhibits may have been transferred to other locations (such as to FASS for forensic analysis).[129]

187. Reminder requests were made in early 2017, and then follow up requests were sent later in 2017. By way of example, Counsel Assisting has tendered a report of Detective Chief Inspector

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[123] Transcript of the Inquiry, 26 September 2023, T6015.31-35 (TRA.00091.00001).
[124] Transcript of the Inquiry, 26 September 2023, T6015.40-43 (TRA.00091.00001).
[125] Exhibit 51, Tab 6, Statement of Detective Chief Inspector David Laidlaw, 13 June 2023, [108]-[109] (NPI.9000.0019.0001).
[126] Transcript of the Inquiry, 6 July 2023, T5147.47-5148.1 (TRA.00074.00001).
[127] Exhibit 51, Tab 6, Statement of Detective Chief Inspector David Laidlaw, 13 June 2023, [109]-[110] (NPL.9000,0019.0001).
[128] Exhibit 51, Tab 6, Statement of Detective Chief Inspector David Laidlaw, 13 June 2023, [110] (NPL.9000.0019.0001).
[129] Exhibit 53, Tab 49, NSWPF internal memorandum - *'Request inventory of all unsolved homicide exhibits on hand at Ashfield Local Area Command'*, 18 October 2016 (NPL.0205.0001.0184).

Olen provided to the Inverell Crime Scene Section on 5 July 2017. That report included the following:

> *"…The Unsolved Homicide Team (UHT), State Crime Command is conducting a project to recover record and centralise all unsolved homicide case exhibits at the Metropolitan Exhibit and Property Centre (MEPC). It is envisaged that the centralisation of all exhibits will provide opportunities for further forensic analysis and minimise the risk of misplacement of the exhibits particularly in relation to long term unsolved homicide cases.*
>
> *To facilitate this process correspondence was sent to all Local Area Commands and Crime Scene Sections on 4 October 2016 requesting a full audit of all homicide related exhibits on hand that had not been converted to EFIMS.*
>
> *In early 2017 a reminder to complete this request was emailed to Local Area Commands and Crime Scene Sections by the Commander, Homicide Squad, Michael Willing APM.*
>
> *CURRENT POSITION*
>
> *At this time no response has been received from Inverell Crime Scene Section. It is requested that every effort is made to comply with this request to enable completion of this phase of the homicide exhibit recovery project."*[130]

C.7.1.3 Media Coverage of difficulties with exhibits

188. The media article referred to at CA [533] is one that DCI Olen appears to have been actively participating in, perhaps to bring attention to the issue disclosed therein.

189. It is accepted that, in line with Counsel Assisting's submissions (CA, [533]) the UHT was alive to issues in relation to the loss of exhibits as at the time of that article in October 2017.

190. The Commissioner of Police agrees that, in line with what is said about Recommendation 5 in Part E below, it would be advantageous for a special project to be conducted to audit all unsolved matters with a view to locating – to the extent possible – any records or exhibits that continue to be outstanding.

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[130] Exhibit 53, Tab 52, NSWPF internal memorandum - *'Request inventory of all unsolved homicide exhibits on hand at Inverell Crime Scene Section'*, 10 July 2017 (NPL.0205.0001.0096).

C.7.1.4 The final report of Strike Force Parrabell

191. Counsel Assisting sets out the first of Strike Force Parrabell's recommendations, which was in the following terms (emphasis added):

> *"Details of all cases required significant investigative effort by Strike Force Parrabell operatives. The system of archiving across NSW Government departments including the NSW Police Force has been historically deficient given the existence of paper based files consistent with general use during the period of review. The NSW Police Force must ensure that the system of electronic recording and storage of evidence consistent with use of the e@glei system remains in use with policy imperatives requiring storage of all investigative material in the same location, so that permanent records of investigations from commencement to judicial conclusion are maintained".*

192. The function of e@gle.i was described as follows in the SF Parrabell Report itself:

> *"Management of major investigations is electronic within a NSW Police Force system (e@glei) of unlimited capacity and restricted investigator access. The e@glei system is designed to centrally store all material relative to every major investigation, with monitoring and reporting capability to ensure thorough investigative oversight."*[131]

193. The terms of CA [537] suggest that Counsel Assisting may have misapprehended the terms of the above recommendation by SF Parrabell. That recommendation sought simply to emphasise the importance of centralised electronic recording systems in respect of investigations, and to ensure that such a system (i.e. e@gle.i or an equivalent replacement) remained in place in the future.

194. As a result of the continued use of e@gle.i, the material generated during any investigation will, in fact, be stored in a centralised location such that permanent records of the investigation are maintained. In short, the functions available via e@gle.i accord with the recommendation made by SF Parrabell.

[131] Exhibit 1, Tab 2 (Parrabell Report), 45 (SCOI.02632).

C.7.2 Submissions concerning the knowledge of the NSWPF as to the significant problems with lost documentary and exhibit material

195. As noted by Counsel Assisting, in 2016 the impact of the absence of exhibits and key records was highlighted by DCI Lehmann. A significant project was commenced to address these issues. That project continued into 2017.

196. As is apparent from the email extracted at CA [532], it required very substantial efforts to be made by at individual police stations. The task was by no means a straightforward one.

197. Unfortunately, it appears that the project could have been implemented in a more systematic way. DCI Lehmann's departure in the months subsequent to its commencement no doubt had an impact in that respect.

198. It is accepted that those involved in responding to the Inquiry's requests for materials did not appreciate, at the outset, that there continued to be significant problems in relation to the centralisation of investigative materials concerning a number of cases subject to the Inquiry's consideration. It is further accepted that the delayed location of materials in a number of the documentary tender cases has had an impact on the Inquiry's work, in particular as concerns the finalisation of the relevant tender bundle cases.

199. It is acknowledged that issues in relation to the location of material have delayed the Inquiry's work. Representatives of the Commissioner of Police informed the Inquiry no later than February 2023 that various Police Area Commands had been asked to complete searches for material that had not been transferred to the GRR. The precise nature and extent of the difficulties in respect of the storage of documentary records became apparent to those responding to the various summonses issued by the Inquiry on a progressive basis. As set out in the affidavit of Natalie Marsic dated 26 June 2023, significant steps have been taken, and substantial expenditure incurred, in an attempt to respond as comprehensively and efficiently to the various requests made by the Inquiry throughout its operation. Through those processes, an enormous quantity of material has been reviewed, assessed for relevance to various summonses, and produced to the Inquiry.

200. Contrary to CA [543], a second extension of the Inquiry's Terms of Reference would have been required in any event to address the procedural fairness issues arising as a result of the fact that various persons were subject to stringent criticism in Counsel Assisting's Public Hearing 2

submissions, in circumstances where they had not been afforded the opportunity to seek to be represented, or to provide submissions and/or evidence to the Inquiry.

201. In more general terms, and having regard to the submission made at CA, [539], it is appropriate to reiterate, as confirmed in evidence by DCI Lehmann[132], that unsolved homicide cases do not provide a representative sample; they are plainly more likely to suffer from issues such as the loss of exhibits. Such issues, of course, may have contributed to the fact that the relevant matter was not solved at the outset and/or to the fact that it has remained unsolved.

202. The Commissioner of Police's response to the recommendation alluded to at CA [541] is set out at Part E. The relevant recommendation (i.e. Recommendation 5) is supported.

C.8 – Application of the State Records Act

203. Counsel Assisting submit that the State Records Act should be construed such that exhibits are "state records". As a consequence, Counsel Assisting submit that the loss or destruction of exhibits may have contravened the State Records Act or its predecessor the Archives Act. Counsel Assisting further suggest that there has been a failure by the NSWPF to "endeavour to comply with" or "perhaps even consider or appreciate" obligations under the State Records Act and the Archives Act (CA [577]-[582]).

204. Those submissions should not be accepted. In summary, the position of the NSWPF, which is clear in the NSWPF policy documents before the Inquiry, is that physical exhibits are not "state records". That position finds support in a construction of the relevant provisions of the State Records Act which gives due regard to the statutory text, context and purpose. One consequence of Counsel Assisting's novel construction would be that the NSWPF is prevented from complying with Part 17 of the *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) (**LEPRA**) with respect to management of exhibits, and that breaches of s 21 of the State Records Act have occurred where officers have exercised those statutory functions. The broader practical consequences of Counsel Assisting's approach would be extraordinarily onerous (and may well have serious implications that extend to the activities of various other NSW Government agencies).

[132] Transcript of the Inquiry, 26 September 2023, T6101.47-6102.25 (TRA.00091.00001).

205. Before addressing the status of exhibits, which is the primary focus of Counsel Assisting's submissions, it is useful first to consider the application of the State Records Act and the Archives Act to documents relating to criminal investigations that are properly "state records".

C.8.1 Loss or destruction of state records

C.8.1.1 Position under the State Records Act (CA [556] – [559])

206. Documentary records created in the course of investigation of an offence are "state records". This includes investigation case files, notebooks and exhibits books. NSWPF procedures set out below acknowledge that such documents are state records and are covered by the provisions of the State Records Act.

207. Section 11(1) of the State Records Act provides that "each public office must ensure the safe custody and proper preservation of the State records it has control of". Certainly, the overlay of statutory obligations under the State Records Act serves to emphasise the importance of the preservation of such documents (CA [579]).

208. Section 21(1)(a) and (e) of the State Records Act makes it an offence for a person to, respectively, "abandon or dispose of a State record", or "neglect a State record in a way that causes or is likely to cause damage to the State record". There will be no contravention if any of the circumstances in s 21(2) apply, which relevantly include:

a) Anything done in accordance with normal administrative practice as provided for in s 22 (s 21(2)(a));

b) Anything authorised or required to be done under a provision of any other Act prescribed by the regulations as being an exception (s 21(2)(b); *State Records Regulations 1998* (NSW) (**State Records Regulations**) cl 5, Sch 1);

c) Anything done by or with the permission of the State Records Authority or in accordance with any practice or procedure approved by the Authority (s 21 (2)(c)); and

d) Anything done pursuant to an order or determination of a court or tribunal (s 21(2)(d)).

209. As set out above at section C.4.1.3, Functional Retention and Disposal Authority DA 221 provides that records relating to homicide investigations are required as State archives. Functional Retention and Disposal Authority DA 220 specifies retention periods of 20 years for records of registration of exhibits, and 10 years for records of disposal of exhibits.

210. Where records have been lost or destroyed outside of proper procedures, this may have involved contravention of s 21(2)(a) or (e) of the State Records Act. On the evidence before the Inquiry, it is not possible to determine whether any particular person has committed an offence under that section. Nonetheless, it is accepted that the possibility that such contraventions have occurred is a serious matter and the Commissioner of Police acknowledges that it underscores the gravity of the loss of records in those circumstances.

C.8.1.2 Position under the Archives Act (CA [548] – [555])

211. As Counsel Assisting note, it is not clear whether material was lost or destroyed prior to or after the commencement of the State Records Act in 1999 (CA [555]). It is likely that much of the relevant material was lost, destroyed or otherwise disposed of prior to the relevant date. Counsel Assisting submit that material lost or destroyed prior to the State Records Act's commencement may have constituted a breach of the Archives Act.

212. There is insufficient material before the Inquiry to reach a view on that matter in relation to documentary records. Section 14 of the Archives Act required a public office to notify the Archives Authority before the destruction or disposal of public records. Section 15 provided that:

> (1) Nothing in this Act shall preclude the person in charge of any public office from destroying or disposing of any public records in the custody, or under the control, of that public office if he has been so authorised by the Authority.
>
> (2) Any authority given by the Authority for the purposes of subsection one of this section may relate to particular public records or to public records of a class specified in the authority.
>
> (3) The Authority shall keep a written record of all authorities given by it for the purposes of subsection one of this section.

213. As is acknowledged by Counsel Assisting at CA [554], there is no evidence before the Inquiry indicating whether any such authority was in place during the period covered by the Inquiry's Terms of Reference. There is also no evidence of whether notifications were given under s 14 of the Archives Act in respect of any documents. Further, it cannot be assumed that any such notifications or authorities were required to be retained by the NSWPF until present, as this suffers from the same lack of evidence addressed to ss 14-15.

214. Section 15(3) required the Archives Authority to keep a written record of authorities given by it; such records have not been sought by the Inquiry. Given the absence of a proper factual foundation, the Inquiry should not venture into speculation as to whether the NSWPF historically failed to comply with the Archives Act.

C.8.2 Evidence from the NSWPF addressing the status of exhibits (CA [578])

215. Counsel Assisting write that "despite being invited to provide evidence to the Inquiry about the NSWPF's position as to the status of documents or exhibits under the State Records Act, the evidence provided by the NSWPF is silent as to the issue" (CA [578]). Counsel Assisting submit that "this raises a concern that the responsible persons within the NSWPF have not turned their minds to their obligations under the State Records Act – including after being expressly invited by this Inquiry to provide a statement or statements addressing the issue" (CA [579]). That suggestion should not be accepted. In particular, as explained further below, the evidence is not "silent" as to the NSWPF's understanding of the scope of obligations under the State Records Act, but rather contains longstanding policies that reflect a considered position regarding those obligations.

C.8.2.1 Evidence concerning the status of exhibits

216. The Inquiry has evidence of the historical and current procedures of the NSWPF relating to record management and exhibit management, which is summarised at sections C.4-C.6 of Counsel Assisting's submissions. Without repeating that material, the following aspects are noted as of particular relevance to the submissions made on the State Records Act.

217. *First,* the Inquiry has evidence of the particular framework for the management of exhibits, dating back to 1957.[133] Since at least 1977, the relevant procedures have reflected a policy that exhibits should only be retained where necessary to do so for the prosecution of charges.[134] Instruction 33.01 in the 1989-1990 Police Rules and Instructions provided that "Exhibits are not to be retained longer than absolutely necessary and patrol commanders will keep this firmly in mind. Exhibits will be photographed, fingerprinted or analysed as required, and returned to the owner or disposed of."[135] The current "Exhibits Procedures Manual" states the general principle, "Do not keep exhibits longer than necessary. Photograph, fingerprint or analyse as needed, and

[133] Exhibit 51, Tab 2C, NSW Police Rules & Instructions, 1957 (NPL.9000.0003.0563).
[134] Exhibit 51, Tab 2E, Instruction No 33 - Exhibits and Miscellaneous Property, 1977, [17]-[19] (NPL.9000.0003.0584); Exhibit 51, Tab 2J, Instruction No, 33 - Exhibits and Miscellaneous Property, 1982, [17]-[19] (NPL.9000.0002.0047).
[135] Exhibit 51, Tab 5C, Police Rules and Instructions, [33.01] (NPL.9000.0018.0061).

return to the owner or dispose."[136] This policy aligns with the framework in the LEPRA, addressed below.

218. *Second,* in 1998 the Archives Authority of NSW issued standards and policies, in preparation for the passage of the State Records Act.[137] At that time, the NSWPF identified areas where the existing records management program required revision to conform to those standards, including the need to adopt a policy on electronic recordkeeping.[138] It is apparent that exhibit management was not considered to fall within the scope of those standards. For the reasons advanced below, this interpretation was, and remains, correct. The Archives Authority of NSW "Standard on Full and Accurate Records" adopted the definitions used in the "Australian Standard AS 4390, Records Management, Part 1, General", relevantly including:

> Documents: "Structured units of recorded information, published or unpublished, in hard copy or electronic form, and managed as discrete units in information systems."
>
> Records: "Recorded information, in any form, including data in computer systems, created or received and maintained by an organisation or person in the transaction of business or the conduct of affairs and kept as evidence of such activity".[139]

219. *Third,* the Records Disposal Procedures Manual adopted in November 2008 (**Manual**) directly addresses the status of exhibits, providing that exhibits are not regarded as records. The Manual is addressed to complying with obligations under the State Record Act:[140]

> 1.1 About This Manual
>
> This procedures manual:
>
> explains how to use a Disposal Authority for the authorised, appropriate, and timely disposal of NSW Police Force records;
>
> complements other records management documents such as Disposal Authorities and the Keyword Thesaurus which comprise the NSW Police Force's Standard Operating Procedures for Records Management;

[136] Exhibit 51, Tab 3E, Exhibit Procedures Manual, August 2022 (NPL.9000.0002.0147).
[137] Exhibit 53, Tab 40 (NPL.0204.0002.0010 at 0016).
[138] Exhibit 53, Tab 40 (NPL.0204.0002.0010 at 0013).
[139] Exhibit 53, Tab 40 (NPL.0204.0002.0010 at 0051).
[140] Exhibit 53, Tab 41 (NPL.0204.0002.0103).

is based on current standards of best practice in records management and conforms to the State Records Act, 1998 and the standards and guidelines of the NSW State Records Authority.

220. Section 5.1 is headed "What Records Are Covered By Disposal Authorities?":[141]

> Records Disposal Authorities are applicable to all records, irrespective of format. Records may include:
>
> - Accountable forms
> - Diaries and notebooks
> - Registers
> - Files Documents
> - Microfilm and microfiche
> - Electronic records Information held in systems and databases
> - Photographs
> - Maps and plans
> - Videos
>
> ***Note***: Exhibits and other physical evidence are not regarded as records and should be managed separately. For further information concerning the management of exhibits, see the NSW Police Handbook: Exhibits. (emphasis added)

221. Section 3.3 likewise provides that the storage of "physical evidence and non-record items" is the responsibility of Business Units and Commands, and not of Corporate Archives.[142]

222. The Manual addresses the operation of Functional Retention and Disposal Authorities. Functional records are "records pertaining to the unique functions of the NSW Police Force".[143] Investigation records are addressed as follows:

> 6.1 Investigation records

[141] Exhibit 53, Tab 41, 10 (NPL.0204.0002.0103 at 0116).
[142] Exhibit 53, Tab 41, 6 (NPL.0204.0002.0103 at 0112).
[143] Exhibit 53, Tab 41, 21 (NPL.0204.0002.0103 at 0127).

> Investigation records refers to Criminal Investigation Case Files that are created or received during the course of a criminal investigation, including records relating to the initial response, preliminary investigations, further investigations and any other information or matters relating to the case. Investigation files are created by Police Force Commands such as Local Area Commands, Strike Forces and specialist commands.
>
> Investigation Case Files and related criminal records are disposed of in accordance with Functional Retention and Disposal Authority DA 221: Investigation Case Files.[144]

223. The Manual accordingly makes clear that exhibits are not regarded as falling within the scope of Functional Retention and Disposal Authority DA 221. DA 221 provides that records relating to homicide investigations are required as State archives.

224. *Fourth,* the "Records and Information Management Policy Statement" (27 August 2021) also directly addresses the NSWPF's obligations under the State Records Act:[145]

> The destruction of NSWPF records, whether in hard-copy or electronic format, is regulated by section 21 of the State Records Act 1998. Functional Disposal Authorities are approved by the NSW State Records Authority and specify set retention periods and disposal actions relating to records specific to NSWPF. NSWPF records must be sentenced in accordance with approved disposal authorities; advice and guidance on the use of the Disposal Authorities used within NSWPF can be found on the Records and Information Management intranet site.[146]

225. The documentary evidence provided by the NSWPF to the Inquiry is accordingly not "silent" as to the issue of the status of documents or exhibits under the State Records Act (cf CA [578]). So much is implicitly acknowledged by Counsel Assisting at the outset of section C.6, where it is noted that "NSWPF internal documents make it apparent that the NSWPF does not regard exhibits as potentially being state records" (CA [545]). In those circumstances, the suggestion at CA [577] that there has been a "systemic failure … to even endeavour to comply" with obligations under the Archives Act and State Records Act must be rejected.

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[144] Exhibit 53, Tab 41, 21 (NPL.0204.0002.0103 at 0127); see also definition of "Investigation records" at 3 (NPL.0204.0002.0103 at 0109).
[145] Exhibit 53, Tab 44 (NPL.0204.0001.0012).
[146] Exhibit 53, Tab 44, 5 (NPL.0204.0001.0012 at 0016).

C.8.2.2 Invitation to address the issue

226. To the extent that the concern raised by Counsel Assisting is that the evidence provided by the NSWPF did not address Counsel Assisting's proposed construction of the State Records Act, that matter was not raised in advance of the Investigative Practices Hearing. It could not reasonably have been anticipated given the novel nature of the construction propounded by Counsel Assisting.

227. The issue about the application of the State Records Act was first raised in a letter from the Inquiry dated 26 May 2023. The letter updated a Request for Statement from the Inquiry dated 12 May 2023, which had requested that a statement address five questions in relation to each of the cases identified in the Exhibits Schedule. The relevant passage of the 26 May 2023 letter stated:

> Attached to this letter is an updated schedule identifying the cases where the Inquiry has summonsed exhibits and received a response that some or all of those exhibits have not been able to be located and/or have been destroyed ("Updated Exhibits Schedule"). I note that the additional cases appear at rows 3, 3A, 20 and 21 of Updated Exhibits Schedule.
>
> The Inquiry would be assisted if the requested statement regarding the loss and destruction of exhibits could address each of the cases in the Updated Exhibits Schedule. It would also be of assistance to the Inquiry if the requested statement addressed any relevant provisions under the State Records Act 1998 (NSW).[147]

228. The letter then set out a list of "matters to be addressed", which broadly directed attention to NSWPF policies and procedures, and proper police practice.[148] Those matters did not direct further attention to the State Records Act, nor otherwise further illuminate the issue contemplated as arising under it. It is not surprising that, where the longstanding understanding of the NSWPF has been that exhibits are not state records, no provisions of the State Records Act were identified as being of relevance. No further request was made to the NSWPF to address the matter after AC Conroy's statement was provided to the Inquiry.

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[147] Exhibit 52, Tab 3, Letter from the Inquiry to the NSWPF re further cases in which exhibits had been lost or destroyed, 26 May 2023, 1 (SCO1.84217).
[148] Exhibit 52, Tab 3, Letter from the Inquiry to the NSWPF re further cases in which exhibits had been lost or destroyed, 26 May 2023, 2 (SCO1.84217).

229. It was only in oral opening at the Investigative Practices Hearing that Senior Counsel Assisting first set out the anticipated submission that "exhibits, at least once they are tagged or placed in a bag or box and labelled, should be understood as being a source of information compiled by whatever means and would therefore be a record within the definition of the State Records Act".[149] AC Conroy was asked the following questions:

> MR EMMETT: Q. Can I say this, your statement doesn't refer to consideration of the State Records Act in relation to exhibits.
>
> A. Correct.
>
> Q. Is that a piece of legislation to which consideration is given when considering the destruction or the disposal of an exhibit?
>
> A. Not that I'm aware of, no.
>
> Q. I can't see any reference to it in the Exhibit Procedures Manual or the "Exhibits" chapter; is that right?
>
> A. Correct.
>
> Q. You don't know what I can see, sorry. You're not aware of any procedure, any part of the applicable Exhibits Procedure Manual or "Exhibits" chapter that deals with the State Records Act?
>
> A. Not that I'm aware of, yes.

230. The answers given by AC Conroy are consistent with the longstanding position of the NSWPF outlined at [219]-[223] above. Consideration is not given to the State Records Act when considering the disposal of an exhibit, because exhibits are not regarded as state records. As outlined below, that position is consistent with the relevant provisions of the State Records Act and the alternative construction proposed by Counsel Assisting should not be accepted.

231. In these circumstances, there is no reasonable basis for the criticism suggested by Counsel Assisting at CA [579] that "the responsible persons within the NSWPF have not turned their minds to their obligations under the State Records Act". Nor does the evidence establish a failure to "perhaps even consider or appreciate" the role of the State Records Act (CA [581]).

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[149] Transcript of the Inquiry, 4 July 2023, T4783.1-35 (TRA.00072.00001).

C.8.3 The meaning of state record (CA [560] – [576])

232. The NSWPF's position that exhibits are not state records is the preferable construction of the State Records Act, taking into account its text, context and purpose. That construction also avoids irreconcilable conflict between the State Records Act and LEPRA, and the extraordinary consequences, for various State government agencies and employees, that would be likely to flow from Counsel Assisting's preferred interpretation.

233. Counsel Assisting distinguishes between two categories of physical exhibits (at CA [563]):

a) Exhibits with a documentary character (such as written material, diaries, CDs, DVDs and fingerprints); and

b) Physical objects without this character (weapons, clothing, forensic material) (referred to below as "non-documentary physical exhibits").

234. This aligns with the definition of exhibits in the Police Handbook chapter on "Exhibits, Forensic Information and Miscellaneous Property System (EFIMS)", which provides that exhibits are "physical or documentary items seized and retained for evidentiary value", including those that require forensic analysis.[150]

235. For the reasons below, it is submitted that neither category falls within the definition of "state record".

C.8.3.1 Exhibits are not "state records"

236. "State record" is defined in s 3 of the State Records Act as follows:

> ***State record*** means a record made or received by a person, whether before or after the commencement of this section—
>
> (a) in the course of exercising official functions in a public office, or
>
> (b) for a purpose of a public office, or
>
> (c) for the use of a public office. (emphasis added)

[150] Exhibit 51, Tab 3F, NSWPF Handbook, Exhibits Chapter, updated 4 November 2022 (NPL. 9000.0002.0128).

237. "Record" is defined in s 3 to mean "any document or other source of information compiled, recorded or stored in written form or on film, or by electronic process, or in any other manner or by any other means".

238. Schedule 4 to the *Interpretation Act 1987* (NSW) (**Interpretation Act**) provides that:[151]

> ***document*** means any record of information, and includes—
>
> (a) anything on which there is writing, or
>
> (b) anything on which there are marks, figures, symbols or perforations having a meaning for persons qualified to interpret them, or
>
> (c) anything from which sounds, images or writings can be reproduced with or without the aid of anything else, or
>
> (d) a map, plan, drawing or photograph.

239. It is submitted that exhibits, whether documentary or non-documentary, do not fall within the definition of "state record" because they are not records "made or received" by a person in the NSWPF within the meaning of s 3. Rather, exhibits are items "seized" by the NSWPF, as reflected in Part 17 of LEPRA.

240. As a starting point, the ordinary meaning of "receive" is to "to admit or accept (a person or thing)".[152] The ordinary meaning relevant to its immediate context ("a record … received by a person") is: "to take into one's hands or one's possession (something offered or given by another); to take delivery of (something) from another, either for oneself or for a third party".[153] It involves an act by another person than the one who receives the thing. When an object is seized as an exhibit, it is not aptly described as being "received" by the person who has seized it. By contrast, for example, correspondence sent to a public office is clearly "received" by the office and would fall within the definition.

241. This construction also accords with the context and purpose of the provisions. The long title states that the Act is "to make provision for the creation, management and protection of the records of public offices of the State and to provide for public access to those records, to establish the State Archives and Records Authority; and for other purposes." The concern of the

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[151] The definition is found in sch 4, rather than s 21 (cf CA [562]), following passage of the *Statute Law (Miscellaneous Provisions) Act 2023* (NSW).
[152] Oxford English Dictionary (online), meaning I.
[153] Oxford English Dictionary (online), meaning III.9.a.

Act is with the activities of public offices being fully and accurately recorded and preserved: see ss 11-12. Evidence seized and retained in connection with the investigation and prosecution of crime does not squarely fall within this scope. Exhibits have a distinct nature and purpose. Classifying exhibits as state records would prevent the NSWPF from using those exhibits, for example where the sample would be consumed in forensic testing, or from returning property not required for evidentiary purposes. It would also have the result that vast quantities of evidence of the commissions of criminal offences would be required to be retained, including potentially as State archives. That material would encompass, for example, child pornography material,[154] and (if Counsel Assisting are correct that non-documentary physical exhibits are records), weapons, prohibited drugs, or bloodstained clothing. Parliament should not readily be taken to have intended such an application.

242. By contrast, an exhibit book is a record that is "made" and falls within the definition. Likewise, a photograph of an exhibit is a record "made", as is a record of an exhibit taken in a notebook.[155] As extracted at [220] above, NSWPF procedures recognise such documents to be records. Likewise, the data in EFIMS constitutes state records.

C.8.3.2 Non-documentary physical exhibits are not "records"

243. There is an additional reason why non-documentary physical exhibits will not satisfy the definition. Non-documentary physical exhibits are not "records" because they are neither documents nor an "other source of information compiled, recorded or stored" (cf CA [566]-[569]). That is, a weapon, bloodstain, piece of clothing or other non-documentary object seized by police during an investigation is not a "record".

244. Counsel Assisting submit that "the better view is that a non-documentary physical exhibit is a state record, at least once it has been collected and marked/bagged/boxed by the NSWPF": CA [566]. This submission should not be accepted. Its premise is that the act of "storing" changes the nature of the item, which is not supported by the statutory text.

245. The phrase requiring interpretation is what constitutes an "other source of information compiled, recorded or stored in written form or on film, or by electronic process, or in any other manner or by any other means" for the purposes of s 3 of the State Record Act. Read in full, the phrase

[154] Child pornography material that is an exhibit in the prosecution of an offence of procuring a child for pornography would be required to be retained for 99 years, being transferred to the State archives when it is no longer in use for official purposes; see Exhibit 51, Tab 5E, Functional Retention and Disposal Authority: DA221, pp 4, 10 (NPL.9000.0018.0469).
[155] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [43] (NPL.9000.0008.0905).

should be understood to describe the nature of the item that is a record, not what is done with an item. To be a "record", a thing must be in itself a "source of information compiled, recorded or stored" in written or other form. It is the compilation, recording or storage of information within an item that makes it a record. For example, a written note will be a source of information "recorded"; a computer database will be a source of information "compiled"; and a CD will be a source of information "stored". The phrase "compiled, recorded or stored" does not describe what is done with an item. The act of storing an object does not convert that object from non-record to record. A record is defined by its intrinsic informational content.

246. That an object has evidentiary significance to an investigating officer does not qualify it as a "source of information" in the relevant sense (cf CA 569]). If that were the case, any physical object is a potential record, and its status is in the eye of the beholder (or the storer). The relevant question is not whether an object has some meaning or significance in a particular context. Rather, what makes an object a record is that it objectively contains information. An item of clothing seized at a crime scene – known by the investigating officer to have evidentiary significance – does not by reason of that knowledge become a record.

247. The construction that a "record" within the meaning of the State Records Act intrinsically contains information is reflected in the standards of the State Records Authority NSW. Section 13(1) of the State Records Act enables the Authority to "approve standards and codes of best practice for records management by public offices." The "Standard on the physical storage of State records" outlines the scope of the standard at section 1.4:

> This standard covers records in the control of the public office which have a physical format. It covers:
>
> - paper files and documents
> - volumes and registers
> - maps, plans, charts and drawings
> - photographic media including photographic prints and negatives, film, microforms, and x-rays
> - magnetic media such as digital tape, video and audio cassettes,
> - optical media such as CDs and DVDs, and
> - digital records stored on tapes, disks, or portable hard drives.

248. The standard contemplates that the above list comprises the types of records which have a physical format. It is clear that, for example, weapons or bloodstained clothing are not comprehended to be types of records.

249. This understanding is consistent with how the similar definition of "record" in the *Government Information (Public Access) Act 2009* (NSW)[156] has been interpreted. The NSW Civil and Administrative Tribunal considered that a request for physical items including forensic evidence (bloodstained clothing, wall swabs and glass pieces) did not fall within the meaning of "record", but a "schedule of analysis results and records" for the specified items did.[157]

250. Counsel Assisting posit at [568] that DNA could be viewed as information "stored" in a blood sample, but note that "it might be regarded as a stretch of the statutory language to hold that information in such a bloodstain has been 'compiled, recorded or stored'". Such an interpretation indeed stretches the statutory language, and also does not give due regard to the statutory context and purpose. The State Records Act is concerned with preserving records of the activities of public offices. It is difficult to see how an interpretation of "record" that encompasses a bloodstain coheres with the statutory purpose.

251. That position does not change if the bloodstain is tagged, bagged or boxed (cf CA [569]). The status of the tag or label is distinct. It is accepted that a tag or label may constitute a "record" "made" by the person. The disposal of tags or labels is a matter of normal administrative practice, in the sense addressed at Part C.8.3.4 below. But the addition of a tag does not convert the physical object it is attached to into a record.

252. To look to another setting, and as an illustration of the extraordinary consequences that would flow if Counsel Assisting's preferred construction were adopted, a blood or faecal sample collected at a public hospital is not a public record. Nor is a tissue sample taken as part of a biopsy. The labelling of the relevant sample does not convert it into a public record. The relevant public records are the records kept by the hospital of the taking of, and results of testing, the sample in question.[158]

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[156] Sch 4 cl 10 defines "record" as "any document or other source of information compiled, recorded or stored in written form or by electronic process, or in any other manner or by any other means".
[157] *Turner v Commissioner of Police, NSW Police Force* [2017] NSWCATAD 183, [38] (Principal Member L Pearson).
[158] See State Archives and Records Authority of New South Wales, General Retention and Disposal Authority GDA17 (2019) (covering the retention and disposal of patient records within the NSW public health system).

C.8.3.3 Interaction with other legislative schemes

253. Counsel Assisting note the potential for conflict between the State Records Act, if it is construed to encompass exhibits, and Part 17 of LEPRA (CA [570]-[576]). Section 218 of LEPRA requires an officer who seizes a thing to return that thing to the owner or person who had lawful possession, if the officer is satisfied that its retention as evidence is not required. There is further provision in Part 17 for what may or must be done with property in certain circumstances. Counsel Assisting's interpretation of the State Records Act would prevent police officers from complying with these statutory duties. The result would be that, if a police officer returns an exhibit to its owner as mandated by s 218 of LEPRA, the police officer will have committed an offence under s 21(1) of the State Records Act. (That is unless it is accepted that the "normal administrative practice", dealt with at Part C.3.8.4 below, applies in all such cases).

254. Counsel Assisting identify that schedule 1 to the State Records Regulations prescribe certain sections of LEPRA as exceptions to Part 3 of the Act, and that Part 17 of LEPRA is not amongst the sections prescribed. It is notable that the prescribed sections of LEPRA all deal with records made by the NSWPF: copies of data downloaded from computers (s 75B), fingerprints or palmprints taken (ss 137A, 137C, 138A) or photographs taken by police (s 137C). The fact that Part 17 is not prescribed would seem to reflect that the application of the State Records Act to exhibits has not been comprehended, reflecting the improbability of Counsel Assisting's construction that would have exhibits be records.

255. There are similar difficulties of conflicting statutory regimes in relation to drug exhibits. Section Division 3 of Part 3A of the *Drug Misuse and Trafficking Act 1985* (NSW) provides power to order the destruction of prohibited drugs or prohibited plants seized by the NSWPF. On Counsel Assisting's construction, the destruction of drugs pursuant to such an order would involve the commission of an offence under s 21(1) of the State Records Act. Again, schedule 1 to the State Records Regulations does not prescribe the provisions of the *Drug Misuse and Trafficking Act 1985* (NSW) as an exception.

C.8.3.4 Normal administrative practice

256. Counsel Assisting suggest that, where items are dealt with under Part 17 of the LEPRA, it is possible that this would fall within the exception of being "anything done in accordance with normal administrative practice in a public office" under ss 21(2)(a) and 22 of the State Records

Act (CA [576]). That proposition should be accepted, in the event that (contrary to the foregoing submissions) the Inquiry considers that exhibits are "state records".

257. Section 22(1) of the State Records Act provides that "[s]omething is considered to be done in accordance with normal administrative practice in a public office if it is done in accordance with the normal practices and procedures for the exercise of functions in the public office". An act will not be considered to be done in accordance with normal administrative practice if the practice or procedure has been declared by regulations to be unacceptable, or the Authority has notified the public office it is unacceptable: s 22(2)(c)-(d).

258. Schedule 2 to the State Records Regulations contain guidelines on what constitutes normal administrative practice, made pursuant to s 22(3) of the State Records Act. Section 22(3) provides that the guidelines do not limit what constitutes normal administrative practice. The guidelines address the disposal of various types of documents including drafts, working papers and records, duplicates and messages.

259. The relevant procedures on exhibit management form part of the "normal practices and procedures for the exercise of functions" in the NSWPF for the purposes of s 22(1). Those practices and procedures have not been disapproved by the NSW State Records Authority. It follows that, when exhibits are disposed of in accordance with those procedures, that disposal does not contravene s 21(1).

260. Reliance on the normal administrative practice exception has not been the understanding of the operation of the State Records Act held by the NSWPF.[159] As outlined above, the NSWPF has understood exhibits not to be state records. That construction is a much more straightforward understanding of the State Records Act and its interaction with other legislation governing police practices (and the practices of other government agencies). Nonetheless, the normal administrative practice exception is an available alternative basis upon which the disposal of exhibits is authorised.

261. After noting the potential relevance of the normal administrative practice exception, Counsel Assisting say it is not necessary to decide the question, because "it seems clear that the substantial majority of the documents and exhibits which have been lost, damaged or destroyed in matters before this Inquiry were not dealt with in accordance with proper police procedures at the time" (CA [576]). That global submissions should not be accepted. In the case of exhibits,

[159] See the section on normal administrative practice at Exhibit 53, Tab 41, Records Disposal Procedures Manual, November 2008 (NPL.0204.0002.0169).

the relevant historical policies did *not* generally mandate their retention. If the Inquiry proposes to reach conclusions about whether the disposal of exhibits contravened the State Records Act, and accepts that exhibits are "state records" as defined, it accordingly *is* necessary to consider the normal administrative practice exception. However, the Inquiry should accept the foregoing submissions that exhibits are not state records, in which event the normal administrative practice question does not arise.

C.8.4 Application of the Archives Act to exhibits

262. The Archives Act did not apply to exhibits for the same reasons outlined at Part C.8.3.1 above. "Public record" was defined in s 2 as "papers, documents, records, registers, books, maps, plans, drawings, photographs, cinematograph films and sound recordings, of any kind, made or received in the course of his official duties by any person employed in a public office and includes copies of public records as hereinbefore defined". Exhibits were not relevantly "made or received' by police officers.

263. Further, in relation to non-documentary physical exhibits, it is particularly clear that the definition of "state record" could not be satisfied (cf CA [553]). Such items are not "documents", nor any other of the listed types of record.

264. Counsel Assisting submit that "tags or labels created and affixed to these objects, or to bags or containers they were placed in" would be public records (CA [553]). That can be accepted. But it does not follow that those tags or labels were required to be retained.

265. The requirement of s 14 of the Archives Act was that a public office notify the Archives Authority prior to the destruction or disposal of public records. The Archives Act did not place positive obligations on public offices for the protection or management of public records akin to those under the State Records Act. As addressed at [212] – [214] above, there is no evidence before the Inquiry as to any notifications by the NSWPF to the Archives Authority for the destruction of records, nor of authorisations granted by the Authority under s 15 of the Archives Act. It would not readily be expected that tags and labels would be records of a kind that the Authority required retention of, noting that the information of substance was recorded in exhibit books. There is insufficient basis for the Inquiry to find that the destruction or disposal of any exhibits (or the tags associated with them) may have constituted a breach of the Archives Act.

C.9 – Recommendation

266. The recommendation proposed by Counsel Assisting is that the State Records Act be amended to clarify the application of the Act to exhibits obtained by the NSWPF (CA [935]). Counsel Assisting recognise at CA [582] that "the question of whether such items *should* constitute State Records invokes a number of policy considerations, and would undoubtedly require consideration of obligations under other legislative regimes". That is, Counsel Assisting do not suggest that exhibits *should* be treated as state records. As outlined above, there would be very substantial difficulties with that suggestion, both in practical terms for the functions of the NSWPF and in the resultant conflict with the tailored legislative frameworks which apply to exhibits.

267. The Commissioner of Police does not consider that any amendment to the State Records Act is required, because properly construed, the Act does not apply to exhibits. If, notwithstanding the foregoing submissions, the Inquiry considers that there is ambiguity that the State Records Act may apply to exhibits, then the Commissioner of Police does not oppose a recommendation that the position should be clarified.

268. There is a further alternative suggestion at CA [582] that "some other step be taken to ensure all persons involved understand the scope and nature of the obligations of members of the NSWPF under the State Records Act". As addressed at Part C.8.2 above, the current procedures and practices of the NSWPF appropriately reflect and implement the NSWPF's obligations under the State Records Act.

269. The findings or comments proposed by Counsel Assisting about potential breach of the State Records Act or Archives Act in relation to exhibits are not warranted. The Inquiry should not accept Counsel Assisting's submission that "the evidence indicates a systemic failure on the part of the NSWPF to comply, or even endeavour to comply, with obligations under the Archives Act and the State Records Act" (CA [577]).

270. This is not to downplay the seriousness of the loss or destruction of exhibits outside of proper procedures. Rather, that seriousness is to be assessed by reference to the departure from proper police practice and procedures at the relevant time, and the practical consequences that flowed. The relevant frame is not the Archives Act or the State Records Act.

PART D: INDIVIDUAL CASES UNDER REVIEW BY THE INQUIRY

271. In a number of individual cases addressed in Part D, Counsel Assisting has previously submitted that the case does not fall within Paragraph A of the Inquiry's Terms of Reference. In those cases, the manner and cause of death of the individual does not "remain unsolved", and/or was not a gay hate crime.

272. It follows that those cases likewise do not fall within Paragraph B of the Terms of Reference, on the basis that the case is not an "unsolved suspected hate crime death". Further, in some cases, there is no evidence to indicate that the victim was a member of the LGBTIQ community.

273. Paragraphs A and B of the Terms of Reference delimit the parameters of the Inquiry's task. The Inquiry's authorisation to report and make recommendations is on the subject of the "manner and cause" of deaths in Paragraphs A and B.

274. The investigative steps undertaken in a particular case may properly be the subject of inquiry where they are relevant to determining whether the case falls within Paragraphs A or B. Those steps may also be relevantly considered by the Inquiry where deficient investigative practices impede the Inquiry's ability to determine that question. However, once the Inquiry has inquired sufficiently to form the view that a case does *not* fall within Paragraphs A or B, it is beyond the scope of the Terms of Reference to conduct a wide-ranging examination of any and all alleged shortcomings into the police investigations of those deaths. Such findings would go beyond the Terms of Reference into a general consideration of police approaches to investigating suspected homicides.

275. Findings about the specific deficiencies in the investigations, or investigative steps that should have been taken in cases not falling within Paragraph A or B, are also not capable of assisting the Inquiry in its task of determining the manner and cause of death in Paragraph A and B cases. The deficiencies are specific to investigative steps in a particular case.

276. Accordingly, the Commissioner of Police submits that, in cases falling outside of Paragraphs A and B, findings about the conduct of the particular investigation are not supported by the Inquiry's Terms of Reference. The relevant individual cases are identified below.

D.1 – The Cases of Andrew Currie, Paul Rath, Russell Payne, Graham Paynter, Samantha Raye, Peter Sheil and Blair Wark

277. At Part D.1, Counsel Assisting considers seven cases that were the subject of a Coronial determination to dispense with an inquest, or a finding that the relevant death was not suspicious.

278. Of these cases, five are not contained on the UHT's tracking file: Andrew Currie, Paul Rath, Russell Payne, Samantha Raye and Blair Wark.[160]

279. At the outset, it is appropriate to note that in four of these cases (namely Andrew Currie, Russell Payne, Samantha Raye and Blair Wark), Counsel Assisting has submitted that the death was not suspicious, and that it does not fall within paragraph A of the Terms of Reference.[161]

280. As concerns the case of Graham Paynter, Counsel Assisting has submitted (correctly in the Commissioner of Police's view) that he died "as a result of multiple injuries sustained in an accidental fall from a height in the setting of alcohol intoxication."[162] Accordingly, Mr Paynter's case similarly does not fall within paragraph A of the Terms of Reference.

281. The remaining cases are those of Peter Sheil and Paul Rath. Both are cases that Counsel Assisting submits should be the subject of an open finding. The Commissioner of Police has expressed agreement with that position.[163] That is not, however, to say that that the Coronial determinations in those cases were inappropriate or not open to be reached; in both cases, homicide is significantly less likely to have been the cause of death than suicide or accident.[164]

282. The particular concerns raised by Counsel Assisting in relation to the investigations of each of the matters is addressed in the documentary tender submissions, and considered further below. As a general proposition, the criticism advanced at CA, [588] appears to result, at least in part, from the scrutiny of the relevant cases by reference to modern understandings and expectations regarding the possible role of LGBTIQ bias in homicide cases.

283. It is not correct to say that there is no scope for deaths previously regarded as non-suspicious to come to the attention of the UHT where new information emerges (cf CA, [585]). The evidence

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[160] Transcript of the Inquiry, 7 July 2023, T5210.17 (TRA.00075.00001).
[161] CA Currie Submissions, [87]-[88]; CA Payne Submissions, [63]-[64]; CA Raye Submissions, [140]-[143]; CA Wark Submissions, [135]-[136].
[162] CA Submissions, [84].
[163] Written submissions of the Commissioner of Police (Rooney, Slater, Rath, Wark), 1 June 2023, [52]; Written submissions on of the Commissioner of Police (Sheil), 18 April 2023, [30].
[164] Written submissions of the Commissioner of Police (Rooney, Slater, Rath, Wark), 1 June 2023, [50(a)]; Written submissions on of the Commissioner of Police (Sheil), 18 April 2023, [22].

of DCI Laidlaw relied upon by Counsel Assisting at CA, [585] was not given at large. Rather, DCI Laidlaw's evidence was that the cases of Andrew Currie, Paul Rath, Russell Payne, Samantha Raye and Blair Wark would not have come to the attention of the UHT in the absence of the present Commission of Inquiry.[165] That evidence should not be controversial; in the absence of the investigative efforts conducted by the Inquiry, no new information in relation to those cases is likely to have emerged.

284. Detective Chief Inspector Laidlaw, in his capacity as coronial liaison, has requested that the Registrar of the Coroners Court engage in a review of coronial findings to identify any cases that have been identified by a Coroner as potentially suspicious but not specifically referred to the UHT.[166]

285. In any event, it is accepted that it would be appropriate for a process for the communication of new information regarding deaths previously regarded as non-suspicious to the UHT to be formalised in policy (see the submissions regarding Recommendation 4 below).

D.2 – Cases considered by the Inquiry which have not been triaged or reviewed

286. As set out at Part C.3.4.1 above, in the initial review process conducted between 2004 and 2008, not all cases were reviewed. Of the 400 cases identified at that time, 329 were reviewed. It is acknowledged that there are a number of cases before the Inquiry that were not reviewed in the initial review process between 2004 and 2008, and some cases that have still not been reviewed.

287. The cases that have not been reviewed are those of Robert Malcolm, James Meek, William Rooney, Richard Slater and Brian Walker (CA, [591] – [599]). As noted in Part C.6.8, the Inquiry has not sought evidence from any of the persons involved in the 2004-2008 review process. That being so, there is no evidence as to why any of these matters were not reviewed during 2004-2008. Nevertheless, subject to the observations at Part C.6.8 regarding the difficulties that no doubt confronted the officers engaged in the initial review of unsolved homicides cases, it is accepted that a comprehensive and systematic review of those cases would have extended to include each of these cases.

[165] See Transcript of the Inquiry, 7 July 2023, T5210.14-17 (TRA.00075.00001) read with T5210.4-6.
[166] Transcript of the Inquiry, 7 July 2023, T5211.12-24 (TRA.00075.00001).

D.3 – The cases the subject of Strike Force Neiwand

288. The investigations in relation to the matters of John Russell, Ross Warren and Gilles Mattaini have been the subject of detailed submissions both in the context of Public Hearing 2[167] (**PH2 Submissions**) and in response to the submissions made by Counsel Assisting in connection with the Tender Bundle hearings of 28 and 29 June 2023 (**CoP Neiwand Submissions**).[168]

289. The Commissioner of Police repeats and relies upon those submissions.

290. The submission of Counsel Assisting regarding SF Neiwand referred to at CA [601] is addressed in the PH2 Submissions (relevant submissions including those at, *inter alia*, at [296] – [301], [328] – [331] and [361] – [367]). For the reasons expressed in the PH2 Submissions, a variety of the central assertions made by Counsel Assisting as concerns SF Neiwand were:

a) made in circumstances where procedural fairness had not been afforded to various key persons; and

b) in any event, wholly devoid of a proper factual foundation.

291. It is accepted that the classification of the matters of Ross Warren and John Russell as "undetermined" would have resulted in a decrease in the priority afforded to those cases (CA, [605]).

292. However, for the reasons addressed at length in the PH2 Submissions (which have been buttressed by evidence given during the resumption of Public Hearing 2 between 21 September and 6 October) the submissions advanced by Counsel Assisting in relation to the conduct and motivation of SF Neiwand are, in many respects, completely untenable. The Commissioner of Police is yet to make submissions on the additional evidence called. The observation of Counsel Assisting at CA, [606] regarding the "seriousness" of the relevant conduct should be considered in that light.

D.4 – General issues arising in relation to screening or triage forms (CA [607]-[609])

293. In a number of matters before the Inquiry, there are screening, triage or review forms identifying lines of inquiry, which were not then implemented or were not implemented for many years (CA, [607]). This is reflective of the capacity issues outlined in Part C.3, where after the completion of

[167] Submissions on behalf of the Commissioner of Police, 28 June 2023.
[168] Written submissions of the Commissioner of Police (Russell, Warren, Mattaini), 13 July 2023.

screening or triage, the number of cases with lines of inquiry identified far outstripped the investigative capacity to reinvestigate.

294. When considering the forms, the nature of these documents should be kept in mind – they are internal working documents and not formal reports. As identified by Counsel Assisting at [368], a triage process must necessarily find a balance between detail and the speed with which it is possible to get through a large number of cases. Nonetheless, it is acknowledged that there are a number of review forms before the Inquiry that are clearly incomplete (CA, [609]).

295. DCI Laidlaw indicated that the UHT would assess and act on any lines of inquiry identified by the Inquiry, and to do so as soon as possible (CA, [608]).

D.5 – Mark Stewart

296. The Commissioner of Police continues to rely on the submissions filed on 12 April 2023 at [44] – [72] addressing the investigation into Mr Stewart's death.

297. As noted at [49] of those submissions, it is accepted that the social context and policing practices of the 1970s do not appear to have been conducive to recognising the possibility that a death in the circumstances may have been a homicide where LGBTIQ bias was a factor (CA, [613]). However, in this case there is no evidence that Mr Stewart identified as gay, bisexual and/or queer. The focus of the investigations on possible suicide or accidental death was reasonable, where the possibility of Mr Stewart's death being a homicide finds little support in the evidence.[169]

D.5.1 Loss or destruction of exhibits – CA, [614]-[617]

298. No exhibits or records of the exhibits in connection with Mr Stewart's matter could be located by the NSWPF. This included the handwritten note, wristwatch, cigarette lighter and steel comb.

299. It is accepted that there ought to have been a record if the exhibits were destroyed, disposed of or returned to the family (CA, [617]). Noting that Mr Stewart's death occurred in 1976, it is not clear for what period such records, if they made, were required by procedure to be retained (see Part C.8.1.2). It is therefore not possible to discern if there has, in fact, been a breach of the applicable procedure. Of course, if the relevant records were disposed of in breach of procedure, that would be regrettable.

[169] Written submissions of the Commissioner of Police (Cuthbert, Raye, Stewart, Stockton), 12 April 2023, [48]-[56], [65]-[71].

300. Further, it should be noted that the possible breach of recordkeeping procedure is a distinct matter from whether it would reasonably be expected that the exhibits would have been retained (cf CA, [616]-[617]). The 1962 Instruction required the retention of exhibits until it was established that "all possible Court action has been finalised".[170] Both the Coroner and the Special Crime Squad found no evidence to suggest foul play. The case was not understood to be a murder which was not "cleared up" such that the exhibits would be held indefinitely until otherwise directed by the OIC.[171] Accordingly, it would be surprising if the exhibits had been retained for 47 years in those circumstances.

D.5.2 Matter of concern to the Inquiry – CA, [618]-[622]

301. There is no record of any photographs or other documentation recording the exact location or position of Mr Stewart's body or his possessions. It is not clear whether photographs were not taken, or are no longer retained. If photographs were not taken, it is accepted that this fell short of the accepted investigative standards in the 1970s (CA, [620]).

302. Counsel Assisting asserts that "the initial focus of police appeared to be on trying to identify the body, and little focus appears to have been directed to determining the circumstances of Mr Stewart's death" (CA, [618(b)]). An initial focus on identifying the body is unsurprising and does not appear to give basis for criticism. The second assertion, that little focus appeared to be directed to determining the circumstances of the death, is not borne out on the evidence. This was addressed in the submissions on behalf of the Commissioner of Police filed on 12 April 2023 at [49] – [56]. The investigations carried out into the circumstances of the death led police to a hypothesis of possible suicide or accidental death, with sound basis. Counsel Assisting note these submissions (CA, [619]) and do not identify any reason they should not be accepted.

303. At CA, [621], Counsel Assisting refer to the evidence given by DI Warren that he would expect investigating police to have taken steps to contact hotel staff to obtain information about Mr Stewart's movements after he checked in. It is not clear from the transcript whether the question asked of DI Warren, and his answer, related to steps to contact the Chevron Hotel or the Hilton Hotel.[172] Counsel Assisting's submissions of 24 March 2023 considered the potential confusion of the hotel name in detail, and submitted at [108] that "on balance it is more likely that the OIC wrongly recorded the name that appeared on the notepaper, and that the name on the notepaper

[170] Exhibit 51, Tab 2D, Instructions, 1962, [2] (NPL.9000.0003.1471).
[171] Exhibit 51, Tab 1Y, Homicide – Part III, [34(e)] (NPL.0100.0003.0706 at .0745).
[172] Transcript of the Inquiry, 5 July 2023, T4975.5-22 (TRA.00073.00001).

was in fact that of the Hilton Hotel". The Hilton Hotel was contacted by police on 11 May 1976, which Counsel Assisting considered to strengthen the inference that the name of the Hilton was on the notepaper. In view of the quick contact made by police with the Hilton Hotel, it is submitted that it is unlikely the police overlooked contacting the Chevron Hotel.

D.6 – Barry Jones

304. The police investigation into the death of Barry Jones was extensive.[173] The "limitations in the investigative material" referred to at CA, [624] relate to the form in which information was recorded – which (as acknowledged by Counsel Assisting) reflected the standards of the day[174] – and not to a failure take any particular investigative steps. The investigation is addressed in the submissions on behalf of the Commissioner of Police dated 10 July 2023 at [30] – [46], on which she continues to rely.

D.6.1 Loss or destruction of exhibits – CA, [625]-[629]

305. The Commissioner of Police agrees with Counsel Assisting's submissions at CA, [625]-[629] concerning the loss or destruction of exhibits. As accepted by AC Conroy, at least the murder weapon should have been retained, notwithstanding that the 1962 Instruction did not specifically require the retention of the exhibits.[175]

D.6.2 UHT screening, triage and review forms

306. As set out at CA, [630], the Case Screening Form in relation to Mr Jones is incomplete. However, the form is not the only record of the case being considered.

307. The submissions of Counsel Assisting dated 26 June 2023 set out that the incomplete form appears to date from sometime in or after 2012.[176] The UHT also considered the case in 2005 and 2010.[177] In August 2005, Inspector Jarrett of the UHT reviewed the brief and requested a review of the fingerprint evidence by the Major Crime Fingerprints Section.[178] This record

[173] Written submissions of Counsel Assisting (Jones), 26 June 2023, [56]; Written submissions of the Commissioner of Police, (Cawsey, Jones, Baumann) 10 July 2023, [31].
[174] Written submissions of Counsel Assisting (Jones), 26 June 2023, [55]-[56].
[175] Transcript of the Inquiry, 4 July 2023, T4851.4-11 (TRA.00072.00001).
[176] Written submissions of Counsel Assisting (Jones), 26 June 2023, [104]-[105].
[177] Written submissions of Counsel Assisting (Jones), 26 June 2023, [98]-[102].
[178] Written submissions of Counsel Assisting (Jones), 26 June 2023, [98]-[99]; Exhibit 41, Tab 15, Email from Rob Jarrett to Fiona West requesting fingerprint analysis, 31 August 2005 (SCOI.11028.00002); Exhibit 41, Tab 16, Email from Fiona West to Rob Jarrett providing results (SCOI.11028.0001).

indicates that there was, at least, some level of review of the matter between 2004 and 2008 (cf CA, [631]).

308. Nonetheless, the Commissioner of Police agrees that it is a matter of concern that the form is incomplete, and that the records of the steps undertaken by the UHT are otherwise very limited.

D.7 – Paul Rath

309. As set out in submissions filed on 18 May 2023[179] (**Rath Submissions**), the Commissioner of Police generally agrees with Counsel Assisting's characterisation of the circumstances and with the proposed formulation of Mr Rath's manner and cause of death.

310. More generally, the Commissioner of Police repeats and replies upon the Rath Submissions.

D.7.1 Loss or destruction of exhibits – CA, [635]-[638]

311. As noted by Counsel Assisting, four swabs from Mr Rath were taken by police investigators, who were plainly alive to the possibility that Mr Rath may have engaged in some form of sexual activity prior to his death.

312. A report of Robert John Goetz, forensic biologist, confirms testing of the swabs was conducted at the Division of Forensic Medicine (**DFM**).[180] No evidence of sexual assault or recent sexual activity was found.[181]

313. In connection with the present Inquiry, FASS has advised:

a) Laboratory records indicate the two swabs and two smears for this matter were received on 16 June 1977.

b) In 1977, the laboratory did not retain swabs and/or smears for long term storage.

c) There are no records retained relating to the disposal or dispatch of the swabs and/or smears.[182]

314. There is nothing to suggest that DFM returned the swabs to the NSWPF. They may have been disposed of by DFM or consumed during testing.

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[179] Rath Submissions, [1]–[2].
[180] Exhibit 26, Tab 2, Expert Report of Dr Robert John Goetz dated 21 June 1977 (SCOI.02734.00012).
[181] See Exhibit 26, Tab 34, Expert Report of Linda Elizabeth Iles dated 26 October 2022 (SCOI.82906 at .0008).
[182] Exhibit 26, Tab 19B, Letter from Office of the General Counsel, NSW Police Force, to Solicitor Assisting the Inquiry re: Biological articles for Paul Rath (SCOI.83235).

315. It appears that Counsel Assisting now accepts that that the evidence does not establish that the disposal or consumption of the swabs was inappropriate, having regard to the available testing procedures and potentially available forensic tools as at 1977 (CA, [637]).

316. The evidence does not establish what, if anything, DFM communicated to police about the retention, consumption, or destruction of the swabs.

317. It is accepted that it is unfortunate that neither DFM nor the NSWPF made (or, at least, retained) a record in relation to the consumption or disposal of the swabs.

318. That failure needs to be understood in light of the Coronial determination that Mr Rath's death was not suspicious.

319. Moreover, in line with Counsel Assisting's submissions (CA, [491], [495]), significant changes to police exhibit management practices since the time of Mr Rath's death mean that it is unlikely that a similar failure of record keeping would occur at present, even in deaths ultimately regarded as non-suspicious.

D.7.2 Matters of concern to the Inquiry – CA, [639]-[646]

320. In relation to the matters of concern to the Inquiry, the Commissioner of Police repeats and relies upon the matters at [3] – [11] of the Rath Submissions.

321. For the reasons set out in the Rath Submissions, it was not unreasonable for police and, in turn, the Coroner to arrive at a hypothesis that the death was likely not suspicious. As set out in the Rath Submissions (including, in particular, at [41] – [51]), the possibility that Mr Rath was the victim of a homicide cannot be conclusively ruled out, but there is no positive evidence to support it, and it is more likely than not that Mr Rath's death was not caused by another person.

322. Elsewhere, Counsel Assisting observe (CA, [588]) that in a number of cases the fact that "indicators of LGBTIQ bias…were never explored by the NSWPF" is "likely to have causatively contributed to the Coroner dispensing with an Inquest". Specifically as concerns Mr Rath's case, it is said that "the failure to consider these matters may well have contributed materially to the conclusion that the death was non-suspicious" (CA, [588]).

323. Counsel Assisting does not identify specifically which matters investigators failed to consider in the context of Mr Rath's death, why such a failure was inconsistent with proper investigative practice having regard to what was known about LGBTIQ bias crimes in 1977, or how additional information might have impacted upon the Coronial decision to dispense with an Inquest. Beyond

evidence that Mr Rath's death occurred near a location that served as a beat, it seems unlikely that a detailed consideration of indicators of LGBTIQ bias would have yielded further information to suggest bias may have played a part in Mr Rath's death. Again, according to Dr Linda Iles, the forensic pathologist engaged by the Inquiry, there was no evidence that Mr Rath had engaged in sexual activity around the time of his death.[183]

324. All told, the decision of the Coroner to dispense with an Inquest should be afforded significant weight; it serves as a powerful indicator that an independent observer, well versed in what was regarded as appropriate investigative practice as at 1977, reviewed all the available material (including material that may not be available presently), and determined that the investigation was adequate. Of further import, the Coroner's determination is substantially less likely to be infected by hindsight bias than any current assessment. It should not be discounted lightly.

D.8 – David Lloyd-Williams

325. As noted in submissions filed on behalf of the Commissioner of Police on 21 February 2023, and in line with the submissions advanced by Counsel Assisting, and the original Coronial finding[184], Mr Lloyd-Williams died as a result of suicide on 24 August 1978.

326. By the time of the SF Parrabell review, the investigative file in relation to Mr Lloyd-Williams' death, was no longer held by the NSWPF. There is no evidence as to when and/or how the investigative file relating to Mr Lloyd-Williams' death came to be disposed of (if, indeed, that is why it is no longer held).

327. In particular, there is no evidence before the Inquiry as to the authorities that were in place or notifications given for disposal of records under the Archives Act (see, in this respect, Part C.8.1.2). Having regard to the status of the matter as a non-suspicious death, it may well be that the disposal of the file, after a given period of retention, was authorised. If, of course, the relevant file was disposed of without authority or otherwise in contravention of the document management obligations of the NSWPF, that would be regrettable.

[183] Exhibit 26, Tab 34, Expert Report of Linda Elizabeth Iles dated 26 October 2022 (SCOI.82906 at .0008).
[184] Exhibit 12, Tab 5, Findings of City Coroner Leonard James Nash (SCOI.73571.00004).

D.9 – Walter Bedser

328. The police investigation into Mr Bedser's death is addressed at [9] – [28] of the submissions on behalf of the Commissioner of Police filed on 7 June 2023. The Commissioner of Police continues to rely on those submissions.

D.9.1 Loss or destruction of exhibits – CA, [656]-[661]

329. The Commissioner of Police agrees with Counsel Assisting's submissions at CA, [656] – [661] concerning the exhibits, including the murder weapon, that cannot be found. It is utterly unsatisfactory that the murder weapon was disposed of or lost. If the murder weapon was disposed of, that very likely involved a breach of policy at the relevant time.

330. At CA, [661], Counsel Assisting note AC Conroy's oral evidence that there have been difficulties ascertaining whether fingerprints were taken from the handle of the knife in the initial investigation. As outlined at [13] of the submissions on behalf of the Commissioner of Police filed on 7 June 2023, while it is not possible to conclusively confirm whether fingerprint testing of the knife occurred, the evidence before the Inquiry indicates that an attempt was made to take fingerprints from the knife but no fingerprints were found.

D.9.2 UHT screening, triage and review forms – CA, [662]-[672]

331. As set out at CA, [662], there are three Case Screening Forms before the Inquiry. Two were completed as part of Senior Detectives Review Courses (in 2005 and 2011). The content of each form is detailed and appears to be complete, with the exception of the fields for signature and date in the "Reviewer's Certification" and "Co-ordinator's Certification" at the end of each.

332. The 2005 Bedser Case Screening Form was accompanied by a covering letter from the Principal Tutor of the Senior Detectives Course dated 10 May 2006.[185] That letter makes clear that the case screening form was completed and was presented (cf CA, [664]). It is unsurprising that the form was unsigned, as it was prepared in the context of its completion in the Senior Detectives Course by a "syndicate" rather than an individual reviewer.[186]

333. It appears that, in the context of the Senior Detectives Course, the screening did not involve locating the exhibits. This is made apparent because locating exhibits is the step contemplated

[185] Exhibit 28, Tab 159, Senior Detectives Course review material-Walter Bedser, 10 May 2005, 20 (SCOI.02915).
[186] Exhibit 28, Tab 159, Senior Detectives Course review material-Walter Bedser, 10 May 2005, 20 (SCOI.02915).

by "Phase 1" of the Recommendation (cf CA, [668]).[187] It is further apparent because the form identifies that the exhibits are a "major restraint" arising from an investigation so long after the event – "can they be located or have they been destroyed?"[188].

334. By contrast, the 2008 Bedser Case Screening Form records that inquiries were made at that time about exhibits including the knife. The form records that the knife was not located by Parramatta exhibits at an audit in September 2007, and "It appears that it may have been destroyed".[189] The location of the exhibits is listed as "unknown/unable to be located", recording that the knife and blood swabs were "removed from DAL 24.12.1980".[190]

335. Although the form used is the same (CA, [668]), it can be inferred that the 2008 Bedser Case Screening Form was prepared by the UHT rather than the Senior Detective Course. This is because its contents record inquiries going beyond the apparent limitations of the Senior Detectives Course (noted at [333] above). It further records that "[t]he senior Detective course also reviewed this matter",[191] indicating that the author is not in such a course.

336. The 2008 Bedser Case Screening Form is detailed and it appears to be complete in its content. It is accepted that, without the certification of the reviewer or coordinator, whether the form was completed cannot be confirmed. This is unsatisfactory.

337. At CA, [670] – [672], Counsel Assisting set out questions asked of DCI Laidlaw concerning a line in the "Recommendation" section of the 2008 Bedser Case Screening Form, that "it is the reviewers opinion that a thorough investigation pursuing all lines of inquiry was conducted at the time".[192] That line must be read in context. The reviewer had also set out a number of lines of inquiry, including a review of the fingerprint file, and inquiries to locate certain persons. The reviewer acknowledged that "no exhibits available for retesting or further examination" and that it appeared documents were missing. As DCI Laidlaw accepted, in that context of the missing running sheets and inquest material it was not possible to know that a thorough investigation had been completed, and great care should be taken before making such a statement (CA, [671] – [672]). However, put in context where the reviewer had acknowledged the documentary

[187] Exhibit 28, Tab 159, Senior Detectives Course review material-Walter Bedser, 10 May 2005, 17 (SCOI.02915).
[188] Exhibit 28, Tab 159, Senior Detectives Course review material-Walter Bedser, 10 May 2005, 17 (SCOI.02915).
[189] Exhibit 281, Tab 160, Case Screening Form-Walter Bedser, 18 September 2008, 5 (SCOI.02913).
[190] Exhibit 281, Tab 160, Case Screening Form-Walter Bedser, 18 September 2008, 5 (SCOI.02913)
[191] Exhibit 281, Tab 160, Case Screening Form-Walter Bedser, 18 September 2008, 17 (SCOI.02913).
[192] Exhibit 281, Tab 160, Case Screening Form-Walter Bedser, 18 September 2008, 17 (SCOI.02913)

limitations and recommended further inquiries, there does not appear to be significant risk that the comment would affect the likelihood of further review in this case.

D.10 – Richard Slater

338. Mr Slater died on 22 December 1980. The police investigation into his death is addressed in the submissions on behalf of the Commissioner of Police dated 1 June 2023 at [41] – [54], on which she continues to rely.

339. At least some of the records relating to the initial investigation are missing from the material produced to the Inquiry (CA, [674]). As noted in previous submissions, this should be contextualised where other agencies (including courts) have been unable to produce any material in response to the summonses issued by the Commission (or in the case of the Newcastle Local Court, only 14 pages of material).[193] It serves to emphasise that more than 40 years has passed since the "No Bill" outcome to the prosecution of Mr Jeff Miller. Nevertheless, given Mr Slater's case was, and remains, an unsolved homicide it is accepted that the absence of certain records is unsatisfactory.

D.10.1 Loss or destruction of exhibits – CA, [675]-[680]

340. The Commissioner of Police accepts that there should be a record of what happened to the exhibits (CA, [679]). AC Conroy was asked whether she was "aware of any procedure that would have justified destroying any record that existed in the past of what happened to those exhibits", to which she answered no".[194] This must be understood in light of AC Conroy's earlier evidence of her understanding that exhibit books must be retained for 20 years, and that the destruction of exhibit books was a matter outside of her responsibilities.[195] The lack of record may indicate that there was a failure to comply with proper procedures or practice at the relevant time, but this cannot be said with certainty.

341. The use of the phrase "unfortunate reality" (CA, [680]) was not intended to obscure the responsibility of individual officers and/or the NSWPF to implement and adhere to recordkeeping procedures. The evidence before the Inquiry, including that of Dr Allsop outlined above at [70], does establish that the deficiencies in historical recordkeeping procedures are an intrinsic

[193] Written submissions of Counsel Assisting (Slater), 18 May 2023, [51], [58]-[59]; Written submissions of Commissioner of Police (Rooney, Slater, Rath, Wark), 1 June 2023, [41]-[44].
[194] Transcript of Inquiry, 4 July 2023, T4850.17-20 (TRA.00072,00001).
[195] Transcript of Inquiry, 4 July 2023, T4832.2-5, T.4833.1-9 (TRA.00072,00001).

challenge of cold case investigations. That is not to prevent past failures being acknowledged and attributed.

D.11 – Russell Payne

342. As noted by Counsel Assisting, Mr Payne died as a result of septicaemia that arose following an injury he suffered after inserting a foreign object into his urethra. As observed by Counsel Assisting, Mr Payne's death does not fall within the Inquiry's Terms of Reference.[196]

343. The Commissioner of Police's position in relation to Mr Payne's death is expressed in written submissions filed on 21 February 2023 (**Payne Submissions**).

D.11.1 Matters of concern to the Inquiry – CA, [682]-[686]

344. Counsel Assisting contends that the erotic photographs found in Mr Payne's bedroom should have been seized because they formed some part of the OIC's reasoning (CA, [685]) in relation to the death. In addition to the matters raised in the Payne Submissions, the following observations may be made by way of response:

a) the mere fact that the OIC referred to the photographs does not indicate that they were a necessary component of his conclusion regarding the cause of Mr Payne's death;

b) as noted in the Payne Submissions[197], there is no evidence as to where in the bedroom the photographs were located – there is nothing to suggest that they were located in a place that should have put police on notice as to a connection between the photographs and Mr Payne's death;

c) it appears that it was not until the antennae piece was located in Mr Payne's penis during the post-mortem examination that the link between Mr Payne's sexual practices and his death became apparent. It is unsurprising that the relevance (however peripheral) of the photographs to Mr Payne's death was not identified until the post-mortem examination, at which time police were able to confirm that there was nothing suspicious associated with the death and, in turn, that there was no need for further investigative steps to be undertaken.

[196] Written submissions of Counsel Assisting (Payne), 6 February 2023, [63]-[64].
[197] Written submissions of Commissioner of Police (Hughes, Paynter, Payne, Dutfield, Lloyd-Williams, Currie, Walker), 21 February 2023, [67].

345. As concerns the criticism in relation to the language employed by the OIC, it should be noted that the word "bizarre" is defined as "very strange and unusual".[198] Even by modern standards, there is no doubt that the insertion of a television antenna into the urethra qualifies as a "very strange and unusual" sexual practice. That being so, while it is accepted that it would have been better for the word "bizarre" to be omitted, Counsel Assisting's submission regarding the OIC's use of that word is unduly critical.

346. Further, and in any event, the Inquiry has not sought evidence from the OIC in relation to his decision-making about the seizure of exhibits or in relation to the language he employed in his statement. He does not appear to have been afforded the opportunity to respond to the criticisms advanced.[199]

D.12 – Gerald Leslie Cuthbert

347. The submissions on behalf of the Commissioner of Police filed on 12 April 2023 at [5] – [13] address the police investigation and loss of exhibits in relation to the death of Mr Cuthbert.

D.12.1 Loss or destruction of exhibits – CA [689]-[697]

348. The Commissioner of Police agrees with the summary of evidence and submissions at CA, [689] – [697]. For completeness, AC Conroy also gave oral evidence that it was not possible to conclude that, if the exhibits had been disposed of, this involved a breach of police procedure, because the 1976 Instruction permitted an exhibit to be destroyed after it had been analysed.[200] A record of any destruction of the exhibits should have been made (CA, [697]).

D.13 – Peter Sheil

349. Mr Sheil died between 27 April 1983 and 29 April 1983. The police investigation into his death is addressed in the submissions on behalf of the Commissioner of Police dated 18 April 2023 at [3] – [22] and in further submissions dated 8 May 2023. The Commissioner of Police continues to rely on those submissions.

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[198] *Cambridge Dictionary* (online at 9 October 2023) 'bizarre'.
[199] Minister for Immigration and Border Protection v SZSSJ [2016] HCA 29 at [82] – [83].
[200] Transcript of Inquiry, 4 July 2023, T4838.22-27 (TRA.00072.00001).

D.13.1 Loss or destruction of documents – CA, [701]-[708]

350. No investigative files or other documents can be located by the NSWPF (CA, [703]). It is unfortunate that those records, and in particular the photographs taken of the scene, are not now available to inform the work of the Inquiry.

351. It is relevant to note that Mr Sheil's death was understood to be accidental, and the Coroner dispensed with an inquest and recorded the manner of death as "fall".[201] While the records retention schedules in place at the time of Mr Sheil's death in 1983 are not before the Inquiry (see Part C.8.1.1), the present retention requirement for records relating to reports of deceased persons, including death by suicide, is 5 years.[202] This may assist to explain why the records are no longer held.

D.13.2 Matters of concern to the Inquiry – CA, [709]-[714]

352. As previously noted, the Commissioner of Police accepts that the opinion expressed by the OIC that Mr Sheil was masturbating before he fell appears to have been relatively speculative.[203] It is accepted that the magazine was treated as relevant to the investigation, and that there is no explanation for why it was not collected (CA, [714]).

353. The Commissioner of Police relies on submissions made previously as to the available basis for the conclusion reached that Mr Sheil's death was accidental.[204]

354. There is no evidence that the OIC had knowledge that the area was a beat such that this matter should have been brought to the attention of the Coroner (CA, [713]). The OIC in the matter has died.[205]

355. The fact that records have not been kept, including the photographs of the scene, may not have involved a failure to comply with proper procedures (CA, [709](b)], for the reasons at Part 8.1.1 above. Such records may have been initially retained, but destroyed at a later date in accordance with procedures in place at the time.

356. The Commissioner of Police acknowledges that the delay of one month in obtaining statements from a number of witnesses would create the risk of degraded memories (CA, [715]). It is possible

[201] Written submissions of Counsel Assisting (Sheil), 3 April 2023, [13].
[202] Exhibit 51, Tab 3Q, Functional Retention and Disposal Authority: DA220, p. 12 (NPL.9000.0008.0837).
[203] Written submissions of Commissioner of Police (Sheil), 18 April 2023, [16].
[204] Written submissions of Commissioner of Police (Sheil), 18 April 2023, [11]-[22]; Written Submissions of Commissioner of Police (Sheil), 8 May 2023, [12]-[19].
[205] Written submissions of Counsel Assisting (Sheil), 3 April 2023, [59].

that this involved a departure from proper police practices by the standards of the day. However, such a conclusion cannot be reached with certainty, when the reasons for that delay are not known.

D.14 – Peter Baumann

D.14.1 Matters of concern to the Inquiry – CA, [716]-[719]

357. The investigations into Mr Baumann's disappearance are addressed at [74] – [103] of the submissions on behalf of the Commissioner of Police filed on 10 July2023.

358. The Commissioner of Police agrees that, whether no investigative steps were taken in or around 1983 or there has been failure to keep records of such steps, neither of these possibilities is satisfactory (CA, [717] – [718]). However, it is important that the Inquiry acknowledge those possibilities, because there is a distinction between circumstances where a failure to take steps is established by evidence, and where it cannot be known whether the steps were taken or there is a failure of recordkeeping.

359. The lack of documentation regarding investigating steps taken in 1983 necessarily constrained the later investigation by the Missing Persons Unit. It is accepted that this constraint is attributable to the earlier actions of the NSWPF (CA, [719]).

D.14.2 UHT screening, triage and review forms – CA, [720]

360. The triage form in relation to Mr Baumann is not completed – most fields remain empty.[206] The reference to a post-mortem result is clearly in error. It is unsatisfactory that this is the only triage form in Mr Baumann's case.

D.15 – Wendy Waine

361. The police investigation into Ms Waine's death is addressed in submissions on behalf of the Commissioner of Police filed on 23 June 2023 at [14] – [86]. Those submissions responded in detail to the written submissions of Counsel Assisting dated 9 June 2023 which made criticisms of the investigation. No issue now appears to be taken with the adequacy of the investigative steps.

[206] Exhibit 42, Tab 83, Triage Form - Peter Baumann, Undated (SCOI.38971).

D.15.1 Loss or destruction of exhibits – CA, [722]-[732]

362. The exhibits collected by police were:

a) an anal swab taken at autopsy;

b) strands of hair found in Ms Waine's left hand;

c) six cigarette butts taken from an ashtray in the loungeroom of Ms Waine's unit.[207]

363. A flannelette sheet from the apartment was also retained. It was located in EFIMS to be held by the Forensic Ballistics Section and was provided to the Inquiry. The Inquiry considered the utility of testing the sheet for firearm debris or other evidentiary material, obtaining advice of an independent expert, Mr Frank Lawton, and did not seek to have the sheet tested.[208]

364. Semen was not detected on the anal swab. A statement from David Bruce of the FASS explained that examination of possible semen samples has not altered significantly to the present day, so the utility of its re-testing would be limited.[209]

365. The Commissioner of Police repeats her previous submissions concerning the cigarette butts and hair.[210] It is not clear which agency was responsible for these exhibits at the point they became lost. As is accepted at CA, [728], the evidence before the Inquiry establishes that in 1985, investigators would not have appreciated the potential scope of DNA testing.

366. Counsel Assisting refer also to "fired bullets" (CA, [722], [732]). The reference to "fired bullets" arose in a case screening form and appears to be in error.[211] The records of the investigation make clear that no bullets or spent cartridges were located upon a "thorough" search of the crime scene.[212] The evidence does not support a real suggestion that "fired bullets" are amongst the exhibits no longer available.

367. It is accepted that the absence of exhibit books mean that it cannot be ascertained what happened to the strands of hair or cigarette butts (CA, [731]). It should be noted that the questions asked of AC Conroy (referred to at CA, [731] – [732]) about police procedures

[207] Written submissions of Counsel Assisting (Waine), 9 June 2023, [21].
[208] Written submissions of Counsel Assisting (Waine), 9 June 2023, [34].
[209] Written submissions of Counsel Assisting (Waine), 9 June 2023, [25].
[210] Written Submissions of Commissioner of Police (Waine), 23 June 2023, [36]-[44].
[211] Written submissions of Counsel Assisting (Waine), 9 June 2023, [52]-[53].
[212] Written submissions of Counsel Assisting (Waine), 9 June 2023, [6], [54]; Exhibit 30, Tab 49, Statement of Constable Raymond Constable, 4 May 1986 (SCOI.00014.00017).

mistakenly referred to Ms Waine's death occurring in 1995. Nonetheless, it is unacceptable that the exhibits cannot now be located and that it is not possible to say what happened to them.

D.15.2 UHT screening, triage and review forms – CA, [733]-[739]

368. As noted above, the 2005 Screening Form erroneously refers to fired bullets still being on hand, and that they were "removed from victim's body at post mortem" (CA, [735] – [737]). This is a significant error and how it arose is not apparent. The reviewer named on the form does not appear to have been contacted by the Inquiry or afforded an opportunity to explain how this error might have arisen.

369. As noted in Supplementary Submissions of Counsel Assisting on 4 August 2023, there is before the Inquiry a further Case Screening Form dated 13 October 2004 signed by eight people, completed by participants of Homicide Course No 18 at the Goulburn Police Academy (**2004 Screening Form**).[213] The 2005 Screening Form appears to have followed from the review completed at the training course.[214]

370. The Commissioner of Police agrees that it is unsatisfactory that it cannot be ascertained whether the undated Review Form was completed in 2008 or 2012 (CA, [738]). The overall state of the documents recording reviews of Ms Waine's case is unsatisfactory. There is no evidence that any reinvestigation was commenced in line with the recommendations in the forms (CA, [737], [739]).

D.16 – William Rooney

371. Mr Rooney died on 20 February 1986. The police investigation into his death is addressed in the submissions on behalf of the Commissioner of Police dated 1 June 2023 at [5] – [17].

D.16.1 Loss or destruction of exhibits – CA, [742]-[753]

372. The NSWPF has been unable to locate any exhibits collected in relation to Mr Rooney's death. As accepted by AC Conroy, it is likely that exhibits would have been collected as part of the initial investigation. The absence of exhibit books mean that it cannot be ascertained what happened to any exhibits which were collected (CA, [753]). It is not clear whether any relevant exhibit books

[213] Supplementary written submissions of Counsel Assisting (Waine), 4 August 2023, [2]-[3].
[214] Supplementary written submissions of Counsel Assisting (Waine), 4 August 2023, [4].

were required by procedure to be retained. It would have been preferable for any exhibit books to have been retained.

D.16.2 Matters of concern to the Inquiry – CA, [754]-[760]

373. Counsel Assisting raise four matters of concern.

374. The first concerns the change in police view between 14 February 1986 and 5 January 1987, from considering there to be suspicious circumstances to the view Mr Rooney suffered an accidental fall. There is some material in the records to explain this change in view.[215] The post-mortem report of Dr Vincent Verzosa on 21 February 1986 is significant, in that it recorded that Mr Rooney's injuries were "probably due to a fall with [back] of head hitting a hard surface." Overall, it is accepted that the records explaining the basis for the change in view are limited (CA, [754(a)], [757]).

375. The second matter is the failure to secure the scene and prevent nearby retail staff washing away blood. To the extent that police failed to prevent this occurring after they arrived on scene, this is undoubtedly a matter of serious concern.

376. In relation to the third matter, the absence of a sexual assault examination, and lack of an anogenital exam during the post-mortem, is very unfortunate (CA, [760]). Such an examination should have been requested. The Inquiry does not appear to have explored with the officer-in-charge of the investigation the fact that no such examination was conducted.

377. Fourth, Counsel Assisting state that there was a failure by the NSWPF to check an alibi of a person of interest (presumably John Harrison) for the night of Mr Rooney's death. The records indicate that investigating police made attempts to locate Joanne Garbett, who was the alibi provided by Mr Harrison.[216] It is not clear based on the material available whether those attempts were successful and, if so, whether Ms Garbett was willing to speak to police.

D.17 – Andrew Currie

378. The police investigation into Mr Currie's death is addressed in the submission on behalf of the Commissioner of Police filed on 21 February 2023 at [106] – [110].

[215] See Written submissions of Commissioner of Police (Rooney, Slater, Rath, Wark), 1 June 2023, [5]-[13].
[216] Exhibit 22, Tab 10, Occurrence pad entries, 18 January 1986 – 20 February 1986, (SCOI.10338.00009).

379. Mr Currie died as a result of an accidental drug overdose. This was the conclusion reached by police following his death. Counsel Assisting have submitted that the death of Mr Currie was not "unsolved" and so does not fall within Category A of the Terms of Reference.[217]

D.17.1 Matters of concern to the Inquiry – CA, [762]-[768]

380. Three matters are identified by Counsel Assisting as matters of concern relating to the investigation of Mr Currie's death.

381. The first is that no statements were taken from the family members of Mr Currie. In oral evidence, DI Warren did not know whether the standard of the day would be to record a decision *not* to make enquiries with family, as "back then, it may have been a bit more relaxed".[218] In the absence of evidence from the relevant officers (who have not been called or otherwise afforded an opportunity to respond), the reasons for not taking a statement from family are unknown, and should not be the subject of criticism.[219]

382. The second is that there is no record of the actions taken by officers who attended the scene, beyond photographs, and no distinct police investigation file has been located and produced. Mr Currie's death was at no time treated as a homicide by police, and the Coroner dispensed with an inquest.[220] There is no basis to expect that any investigation file must have been retained for 24 years, where it was understood throughout that it concerned a death caused by an accidental drug overdose.

383. The third is that there is no evidence of consideration of alternative possible causes of death, nor of the possibility that the toilet block may have been used at the time as a beat. There is no basis in the evidence to find that the police should have known the toilet block was used at times as a beat, nor that intelligence about the area should have been sought on that topic (CA, [767] – [768]). The cause of death was clearly established and any initial basis for suspicion was allayed. Criticism of the police investigation is not warranted in Mr Currie's case.

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[217] Supplementary written submissions of Counsel Assisting (Currie), 6 February 2023, [88].
[218] Transcript of Inquiry, 5 July 2023, T4987.11-27 (TRA.00073.00001).
[219] Written submissions of Commissioner of Police (Hughes, Paynter, Payne, Dutfield, Lloyd-Williams, Currie, Walker), 21 February 2023, [107], [110].
[220] Written submissions of Commissioner of Police (Hughes, Paynter, Payne, Dutfield, Lloyd-Williams, Currie, Walker), 21 February 2023, [104].

D.18 – William Allen

384. The police investigation into Mr Allen's death is addressed in submissions on behalf of the Commissioner of Police filed on 5 September 2023 at [88] – [104].

D.18.1 Matters of concern to the Inquiry – CA, [770]-[775]

385. Counsel Assisting submit that three matters of concern reflect a failure to comply with proper police practices, including judged by the standard of the day (CA, [770], [775]).

386. The first matter, that the police did not check if Mr Allen had written his phone number on the walls of the Alexandria Park toilet block, lacks sufficient basis in the evidence for the reasons set out by the Commissioner of Police previously.[221] Counsel Assisting summarise these submissions (CA, [771] – [773]), and do not give any reason why they should not be accepted.

387. The second matter is the failure to take video tapes containing child abuse material into evidence. The Commissioner of Police agrees this was a failure of proper police practice, including by standards at that time (CA, [775]).

388. The third matter relates to the fingerprint examination of Mr Allen's home [CA, [770(c)]. While the fingerprint examination also included a silver Holden Astra, no fingerprints were found in the Astra.[222] An expert report of fingerprint expert Karen Halbert dated 15 June 2023 provided to the Inquiry identified that the historical case information included a running sheet, but did not contain fingerprint determinations or results recorded as to which fingerprints were identified.[223] It is accepted that this likely reflects a failure to comply with proper record-keeping practices. However, it should be noted that the running sheet, the photographs of latent fingerprints and the fingerprint sets for Mr Allen were all retained, allowing further analysis in 2016 and by the Inquiry. Ms Halbert's analysis identified the fingerprints in Mr Allen's home as belonging to Mr Allen (with one fingerprint being an inconclusive match).[224]

389. As previously identified in the Commissioner of Police's submissions, it is not clear whether the Inquiry has brought the criticisms proposed by Counsel Assisting to DS Saunders' attention and provided an opportunity to respond to them.

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[221] Written submissions of Commissioner of Police (Dye, Allen), 5 September 2023, [89]-[97].
[222] Exhibit 36, Tab 30, Fingerprint Running Sheet, 29 December 1988 (SCOI.10332.00007).
[223] Exhibit 36, Tab 76, Expert Certificate of Karen Halbert, Crime Scene Officer – Fingerprints, 15 June 2023, [9] (NPL.0100.0020.0002).
[224] Exhibit 36, Tab 76, Expert Certificate of Karen Halbert, Crime Scene Officer – Fingerprints, 15 June 2023, [11] (NPL.0100.0020.0002).

D.18.2 UHT screening, triage or review forms – CA, [776]-[778]

390. There is no record of Mr Allen's case being reviewed between 2004 and 2020 (CA, [777]). A triage was completed on 24 August 2021, recommending that the matter should proceed to review. It is regrettable that, on the evidence before the Inquiry, a review has not yet been commenced.

D.19 – Samantha Raye

391. Ms Raye's body was found on 20 March 1989. The police investigation into her death is addressed in the submissions on behalf of the Commissioner of Police dated 12 April 2023 at [30] - [43].

392. The Coroner dispensed with an inquest into Ms Raye's death.[225] As outlined in previous submissions, while the question whether Ms Raye's death was a result of suicide cannot be definitively answered, there were very strong circumstantial indications in support of a finding of suicide.[226]

393. Counsel Assisting have previously submitted that Ms Raye's death was neither "unsolved" nor a death "motivated by gay hate bias" at the inception of the Inquiry, and that her death therefore does not fall within Paragraph A of the Inquiry's Terms of Reference.[227]

D.19.1 Loss or destruction of exhibits – CA, [782]-[785]

394. Counsel Assisting state at CA, [785] that during the course of his oral evidence, DI Warren agreed that an electronic document, being the missing persons report, should have been created according to the police practices of the day. To avoid confusion, it is noted that the missing person's report was made to Kings Cross Station in 1989, which was before the electronic system was operational (ie 'a pre-COPS document'[228]). There is a 'converted data' missing person report record identified in the COPS system, however, attempts to locate the microfilm ID record associated with that COPS record were unfortunately unsuccessful.[229]

[225] Written submissions of Counsel Assisting (Raye), 24 March 2023, [26].
[226] Written submissions of Commissioner of Police (Cuthbert, Raye, Stewart, Stockton), 12 April 2023, [30]-[34].
[227] Written submissions of Counsel Assisting (Raye), 24 March 2023, [143].
[228] Transcript of Inquiry, 5 July 2023, T4991.3-6 (TRA.00073.00001).
[229] Exhibit 17, Tab 22, Email from Patrick Hodgetts, 7 October 2022 (SCOI.82495).

395. The retention periods for missing persons reports as at 1985 are not clear on the evidence before the Inquiry. As noted previously by Counsel Assisting, there have been significant reforms to police practices in relation to missing persons in subsequent decades.[230]

D.19.2 Matters of concern to the Inquiry – CA, [786]-[789]

396. Counsel Assisting raise two additional matters of concern to the Inquiry. First, that police did not take a statement from Ms Raye's social worker who had reported her missing (CA, [786.a]). Second, Counsel Assisting state that police did not conduct investigations into Ms Raye's movements for the eight or so days leading to her death (CA, [786.b]).

397. As previously submitted, investigating police took statements from a number of Ms Raye's friends, acquaintances and treating doctors.[231] This appears to have included questioning around when each of those persons last had contact with Ms Raye. The reason why a statement was not taken from Ms Raye's social worker is not apparent. This may have been illuminated by the missing persons report (which may also have included inquiries about Ms Raye's movements before her death). It is unfortunate the report is not now available.

D.20 – Ross Warren

398. In line with submissions dated 13 July 2023 made in respect of the Tender Bundle hearings on 28 and 29 June 2023, the Commissioner of Police acknowledges that the initial investigation of Mr Warren's death was manifestly deficient.

D.21 – John Russell

399. The Commissioner of Police repeats her previous acknowledgement that the loss of the clump of hair found on Mr Russell's hand was plainly unacceptable.[232]

400. It is not clear when, where, or how those hairs went missing. Their disappearance was (and is) totally unsatisfactory.

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[230] Written submissions of Counsel Assisting (Raye), 24 March 2023, [34].
[231] Written submissions of Commissioner of Police (Cuthbert, Raye, Stewart, Stockton), 12 April 2023, [39].
[232] Written submissions of Commissioner of Police (Mattaini, Warren, Russell), 13 July 2023, [21].

D.22 – Simon "Blair" Wark

401. In line with the submissions made by Counsel Assisting in connection with the tender bundle hearing of Mr Wark's case, Mr Wark died by suicide in the context of a psychotic episode.[233] As a result, and as acknowledged by Counsel Assisting, the death of Mr Wark is not "unsolved" and does not fall within Paragraph A of the Inquiry's Terms of Reference.[234]

402. Contrary to the implication of CA, [802] – [806], there would be no basis to find that the NSWPF should have retained biological samples and/or other exhibits for some 33 years after a (well-founded) Coronial determination to dispense with the Inquest on the basis that Mr Wark died by suicide.[235] There is no evidence that would allow the Inquiry to determine precisely when the relevant exhibits were disposed of. In all likelihood, the relevant steps were undertaken in reasonably close proximity to the coronial determination that Mr Wark's death was a suicide. In the circumstances, there would be no basis to positively conclude that records in relation to those steps should continue to be held by the NSWPF in the present day.[236]

403. As concerns the matters addressed at CA, [808] – [813], the Commissioner of Police repeats and relies upon the submissions made in the course of the tender bundle hearing in connection with Mr Wark's death.[237] In particular, for the reasons expressed at [67] of those submissions (together with the matters raised at [68] – [73])[238], while certain investigative steps could have been conducted to allay the concerns or suspicions of Mr Wark's family[239], the assertion that investigating police "prematurely" concluded that there were no suspicious circumstances associated with the death should be rejected.

D.23 – William Dutfield

404. Mr Dutfield died on 19 November 1991. The police investigation into his death is addressed in the submissions on behalf of the Commissioner of Police dated 21 February 2023 at [71] – [90].

405. Counsel Assisting have previously submitted that the death of Mr Dutftield is not "unsolved", and accordingly, does not fall within category A of the Inquiry's Terms of Reference.[240]

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[233] Written submissions of Counsel Assisting (Wark), 22 May 2023, [133]-[135].
[234] Written submissions of Counsel Assisting (Wark), 22 May 2023, [136].
[235] Exhibit 23, Tab 38, Inquest running sheet, Undated (SCOI.00052.00002).
[236] See Part C.8.1.
[237] Written submissions of Commissioner of Police (Rooney, Slater, Rath, Wark), 1 June 2023, [56]-[84].
[238] Written submissions of Commissioner of Police (Rooney, Slater, Rath, Wark), 1 June 2023.
[239] Written submissions of Commissioner of Police (Rooney, Slater, Rath, Wark), 1 June 2023, [61].
[240] Written submissions of Counsel Assisting (Dutfield), 6 February 2023, [107].

D.23.1 Matters of concern to the Inquiry; UHT screening, triage and review forms

406. Counsel Assisting raise two matters of concern to the Inquiry in relation to this investigation: first, the early dismissal of Mr Arthur William Ashworth as a suspect and second, the failure to take a DNA sample from Mr Ashworth before his death. The second matter overlaps with the issues concerning the UHT forms.

407. In respect of the first concern, as acknowledged previously, Mr Ashworth should not have been excluded from suspicion at an early stage of the investigation.[241] However, it was not unreasonable for the OIC's primary focus to be on the perpetrator of the earlier robbery (noting the prints on the cigarette packet had been found not to belong to Mr Ashworth).

408. In respect of Counsel Assisting's second concern, the Commissioner of Police agrees that a DNA sample should have been taken from Mr Ashworth at the earliest possible opportunity. The delay in actioning this step after it was recommended in the 2005 case screening form had the result that the opportunity to do so was lost.

409. As set out in previous submissions,[242] in making their recommendations in 2005, the UHT reviewer noted that the cigarette butts and blood-stained tissues, were already "at DAL and Virginia FREEDMAN is in the process of examining them". It is not known why a report from DAL was then not prepared and provided to police until 8 February 2007. DAL (as it then was) falls within the NSW Department of Health; it was independent of NSW Police. There is no evidence before the Inquiry as to DAL's workload, resourcing or processes, including, for example, in relation to the priority that would have been afforded to unsolved homicide cases (as distinct from cases, for instance, involving an accused person on remand awaiting an upcoming trial). The full significance of obtaining a DNA sample from Mr Ashworth was not known until this report was provided in 2007, advising that a full DNA sample had been obtained from the tissue that was not Mr Dutfield's. This does not justify, however, the delay in taking the separate step of seeking the DNA sample.

410. The NSWPF continued to investigate the possibility of Mr Ashworth's involvement in Mr Dutfield's death following receipt of the information. Investigators concluded that there was sufficient evidence to arrest Mr Ashworth, had he been alive.

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[241] Written submissions of Commissioner of Police (Hughes, Paynter, Payne, Dutfield, Lloyd-Williams, Currie, Walker), 21 February 2023, [74].
[242] Written submissions of Commissioner of Police (Hughes, Paynter, Payne, Dutfield, Lloyd-Williams, Currie, Walker), 21 February 2023, [78(d)].

D.24 – Robert Malcolm

411. Mr Malcolm died on 29 January 1992. The police investigation into his death is addressed in the submissions on behalf of the Commissioner of Police dated 21 July 2023.

D.24.1 Loss or destruction of exhibits – CA [829]-[839]

412. Counsel Assisting submit that significant leaps in forensic science and DNA testing occurred between Mr Malcolm's death in 1992 and 1996, such that by the time of certain exhibits being destroyed in 1996 "it should have been obvious to the NSWPF that DNA testing technology was likely to continue to improve" (CA, [836]). This assertion is not supported by the evidence outlined at CA, [253], [259]. Dr Allsop's evidence was that there was likely not a widespread understanding of the potential advancements of DNA technology in the 1990s.

413. It is regrettable that the exhibits were not retained. However, criticism of the decision made by officers in 1996 is not warranted.

414. In relation to the two significant items at the crime scene that were not collected (CA, [837]), the Commissioner of Police agrees that they should have been and that this appears to have been an oversight in the initial investigation.

D.24.2 Loss or destruction of other investigative material – CA [840]-[842]

415. The NSWPF was unable to locate a crime scene sketch plan, police notebook and duty book. The Commissioner of Police repeats her acknowledgement that it is regrettable these documents cannot be located (CA, [842]).

D.24.3 Matters of concern to the Inquiry – CA [843]-[846]

416. The key matter of concern raised by Counsel Assisting concerns the apparent failure to test Anthony Hookey's alibi by speaking to Dianne McGuinness. The Commissioner of Police repeats the submissions at [21]-[24] of the submissions dated 21 July 2023.

417. It should be noted that the Inquiry's attempts to locate Dianne McGuinness (including through interagency cooperation, and extensive checks conducted across state and federal databases) were unsuccessful in identifying a person matching the details of Dianne McGuinness.[243]

[243] Exhibit 56, Tab 123, Statement of Kathryn Lockery dated 6 July 2023 at [28] to [29] (SCOI.84074).

418. It is not clear on the material whether the original investigators located or interviewed Dianne McGuinness or her cousin Tracy McGuinness. It is acknowledged that, if steps were taken to investigate the alibi, these steps should have been documented and retained. In either event, this represents an oversight either in the investigation or in recordkeeping (CA, [846]).

D.25 – Crispin Dye

419. Counsel Assisting's submissions regarding the matter of Crispin Dye consist largely of a summary of the submissions made by both Counsel Assisting and the Commissioner of Police in connection with the tender bundle hearing of Mr Dye's case. That being so, the Commissioner of Police repeats and relies upon the submissions previously made on 5 September 2023.

420. As concerns CA, [854], it should be noted that the Commissioner of Police has accepted that the failure to locate the relevant pieces of paper during the investigations of Mr Dye's death was regrettable.[244] All that is said regarding Counsel Assisting's criticism that the failure to locate the pieces of paper was "extraordinary" is that that criticism should not – contrary to the submissions of Counsel Assisting – extend to the paper review conducted in 2005 and the triage conducted in 2019, having regard to the nature of those processes.[245] In line with the observations of DI Warren referred to at CA, [858], it continues to be accepted that the failure to locate the pieces of paper constitutes a significant oversight.

421. Regarding the absence of any indication that Mr Dye's keys were subject to fingerprinting or other testing before being returned (CA, [857]), the Commissioner of Police repeats the observation that this criticism does not appear to have been raised with the relevant investigating officers[246], and otherwise accepts that any failure to conduct such an examination of the keys would appear to have constituted a significant oversight.

422. It is accepted that, in circumstances where Mr Dye's death was plainly a homicide, his healthcare card, frequent flyer cards and other items from his wallet should have been retained as exhibits (CA, [857]). Any movement, or disposal, of those exhibits should have been recorded in an exhibit book.

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[244] Written Submissions of the Commissioner of Police (Dye, Allen), 5 September 2023, [42].
[245] Written Submissions of the Commissioner of Police (Dye, Allen), 5 September 2023, [41].
[246] Written Submissions of the Commissioner of Police (Dye, Allen), 5 September 2023, [36].

D.25.1 UHT screening, triage and review forms – CA, [860]-[865]

423. The steps recommended in the Case Screening Form dated 25 May 2005 were not taken, with the exception of the offering of a reward many years later (CA, [861] – [863]). The triage form dated 16 November 2019 recommended the matter proceed to review, which has not yet occurred (CA, [865]). While resourcing constraints mean that it is not possible for all recommendations arising from UHT reviews to be followed, it is accepted that various of the recommendations made should have been followed at some stage between the 2005 review and the present day.

D.26 – James Meek

424. The police investigation into Mr Meek's death is addressed in submissions on behalf of the Commissioner of Police dated 7 July 2023 at [94] – [128].

425. Counsel Assisting's documentary tender submissions noted that "[t]he investigation by the NSWPF was thorough in several respects".[247] Further, "[t]he original investigation was open to the possibility that Mr Meek's death was a hate crime", and the NSWPF "actively pursued lines of investigation relating to this possibility".[248]

D.26.1 Loss or destruction of exhibits – CA [867]-[873]

426. Counsel Assisting set out at CA [867] – [872] that certain exhibits in the matter have been retained by FASS; a ring box containing a ring was returned to its owner; and the balance of the exhibits cannot be located. It is regrettable that those exhibits cannot be located. The exhibits should have been retained; if they had been, there would be opportunities for DNA testing on certain of those exhibits.[249]

D.26.2 Matters of concern to the Inquiry – CA [874]-[879]

427. The crime scene was released on 8 March 1995 and Mr Meek's daughters entered and cleaned the flat. As submitted previously, it appears this was because police were not treating the death as suspicious. The evidence suggests that investigating police were unaware of the extent of bruising present on Mr Meek's face.[250]

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[247] Written submissions of Counsel Assisting (Meek), 22 June 2023, [47].
[248] Written submissions of Counsel Assisting (Meek), 22 June 2023, [48].
[249] Written submissions of Counsel Assisting (Meek), 22 June 2023, [113]-[115].
[250] Written submissions of the Commissioner (Meek), 7 July 2023, [97]-[102].

428. As noted previously, it appears that the police officers involved in the initial investigation have not been approached by the Inquiry. They have therefore not been afforded the opportunity to respond to the criticisms advanced in relation to their work.[251]

429. The evidence of Superintendent Best set out at CA [877] outlined the considerations and challenges in making a decision on how long to keep a scene secured. Superintendent Best explained that death scenes are the "biggest call for service outside of volume crime";[252] on last year's figures there were 7,600 calls for service in relation to scenes of death, many of which are deaths by natural causes.[253]

430. It is regrettable that the matter was not treated as a potential homicide from the outset.[254] The Commissioner of Police acknowledges that the failure to take items at the scene in police custody, including the used condom, sachets of lubricant and handkerchief, before the release of the crime scene, appears to be a significant oversight (CA, [879]).

D.27 – Carl Stockton

431. The police investigation into Mr Stockton's death is addressed in submissions filed on behalf of the Commissioner of Police on 12 April 2023 at [78] – [86]. As set out at [85] – [86] of those submissions, the investigation was detailed and thorough.

D.27.1 Loss or destruction of exhibits – CA [881]-[885]

432. The statement of DS Sheldon dated 17 April 2023 outlines that the exhibits collected as part of the initial investigation cannot be located. DS Sheldon's statement also outlines the records of the analysis of the exhibits carried out during the initial investigation:

a) Mr Stockton's clothing was examined at East Sydney Crime Scene on 13 November 1996. The examination revealed soil on the clothing that was visibly similar to the soil at the laneway of the Bar Cleveland Hotel;[255]

[251] Written submissions of the Commissioner (Meek), 7 July 2023, [95].
[252] Transcript of the Inquiry, 4 July 2023, T4882.10-14 (TRA00072.00001).
[253] Transcript of the Inquiry, 4 July 2023, 4882.16-25 (TRA00072.00001).
[254] Written submissions of the Commissioner of Police (Meek), 7 July 2023, [101].
[255] Exhibit 18, Tab 62, Statement of Detective Sergeant Neil Sheldon, 17 April 2023, [13] (NPL9000.0005.0001).

b) The 17 glass bottles located at Mr Stockton's address were examined by the Fingerprint Section, and "all latent fingerprints" on the glass bottles were identified as Mr Stockton's;[256]

c) Mr Stockton's wallet (which was on his person) underwent fingerprint examination, and no identifiable fingerprints were located;[257]

d) The pieces of timber seized from Matterson Lane were subject to examination at East Sydney Crime Scene. The Senior Constable who performed the examination "formed the opinion that none of the articles were consistent with producing the injuries inflicted upon [the] deceased".[258]

433. Counsel Assisting write that "In written submissions filed on behalf of the NSWPF on 12 April 2023, the NSWPF did not seek to address their failure to locate these exhibits" (CA, [884]). Those written submissions were filed prior to DS Sheldon's statement. The brief supplementary submissions of Counsel Assisting dated 22 June 2023 (concerning exhibits and record keeping) and dated 18 August 2023 (concerning further inquiries made by the Investigations Team) did not seek a response from the Commissioner of Police.

434. The Commissioner of Police accepts that the exhibits should have been retained, where Mr Stockton's death was a suspected homicide that remained unsolved. It is likewise unsatisfactory that no records can be located to account for what has happened to the exhibits.

D.27.2 UHT screening, triage or review forms – CA, [886]

435. A triage was completed for Mr Stockton's case on 23 April 2019. It is acknowledged that Mr Stockton's death should have been among the original cases reviewed after the creation of the UHT, but it was not reviewed during that period.

D.28 – Scott Miller

436. The police investigation into Mr Miller's death is addressed in the submissions on behalf of the Commissioner of Police dated 30 June 2023.

437. Counsel Assisting raise the apparent failure to closely interview or take statements from the crew of the Ranginui, a ship close to the machinery yard where Mr Miller's body was found, particularly

[256] Exhibit 18, Tab 62, Statement of Detective Sergeant Neil Sheldon, 17 April 2023, [20] (NPL9000.0005.0001).
[257] Exhibit 18, Tab 62, Statement of Detective Sergeant Neil Sheldon, 17 April 2023, [23]-[26] (NPL9000.0005.0001).
[258] Exhibit 18, Tab 62, Statement of Detective Sergeant Neil Sheldon, 17 April 2023, [28]-[29] (NPL.9000.0005.0001).

those who had left the ship and attended Mardi Gras (CA, [888]). This matter is addressed at [49] – [55] of the submissions on behalf of the Commissioner of Police dated 30 June 2023. The available evidence suggests that the relevant crew members were interviewed (and there is nothing to suggest this was not done individually) and those crew members reported seeing nothing suspicious.

438. The Commissioner of Police acknowledges the importance of police enquiries being recorded with specificity (CA, [891]). It should be noted that the running sheet does include details beyond that the various crew members "did not see anything suspicious", including evidence of their movements on the night.[259] It is not the case that these records would be of no utility to officers considering the case at a later point (cf CA, [891]).

D.28.1 UHT screening, triage and review forms – CA [892]-[893]

439. A detailed review form was completed on 21 April 2004. The lack of the coordinator's formal certification appears to be an oversight (CA [892]).

440. There is no triage form to reflect that a triage has been complete for Mr Miller's matter thereafter (CA, [893]).

D.29 – Samantha Rose

D.29.1 UHT screening, triage and review forms – CA [894]-[901]

441. Ms Rose died on 20 December 1997. The police investigation into her death is addressed in the submissions on behalf of the Commissioner of Police dated 16 June 2023.

442. The Inquiry has before it a Case Screening Form dated 6 May 2004, a Triage Form dated 23 May 2019 and a Review Form dated 30 September 2021.

443. The Commissioner of Police agrees that it is unsatisfactory that it cannot be ascertained whether (and, if not, why) further steps were not taken after the case screening in 2004. As noted above, the Inquiry has received evidence regarding the extensive case load of unsolved cases which were the subject of UHT reviews during the period between 2004 and 2008[260]. That said, it is acknowledged that the failure to reinvestigate within a reasonable period of time meant that

[259] Exhibit 32, Tab 19, Bundle of running sheets dated 4 March 1997 to 16 April 1997, 9 (SCOI.83327).
[260] Exhibit 51, Tab 1, Statement of Detective Superintendent Daniel Doherty, 18 April 2023, [71] and [72] (NPL.9000.0006.0001).

opportunity to take steps in relation to a person of interest before they died was lost. This was a failure of proper police procedure.

444. The Commissioner of Police acknowledges that references to Ms Rose by her former name, the mislabelling of her gender and references to her as a 'cross-dresser' are disrespectful and unacceptable. It appears that some of the references to Ms Rose as a 'cross-dresser' were reflecting the language used in statements taken following Ms Rose's death.[261] Other references are not of that nature and are in no way appropriate. Where historical material referred to Ms Rose in ways that are offensive, such references should not be perpetuated in new records created unless there is a clear forensic purpose underpinning the use of the relevant language.

D.30 – Submissions concerning the individual matters before the Inquiry

445. The position expressed by the Commissioner of Police in respect of the individual tender bundle cases should not be over-simplified. Those submissions should be considered individually and in detail, not reduced to sweeping generalisations (cf CA, [902] and [908]). In submissions made in the context of the tender bundle hearings, the Commissioner of Police has routinely accepted various deficiencies that appear on the face of the available material.[262] In a number of instances, however, the Commissioner of Police has suggested that particular criticisms advanced by Counsel Assisting should not be accepted, or should be approached cautiously, in circumstances where, *inter alia* and by way of example:

a) the individual officer the subject of criticism has not been called to give evidence or otherwise afforded the opportunity to respond to the criticism levelled at them;

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[261] Exhibit 53, Tab 32, Review of an Unsolved Homicide Case Screening Form-Samantha Rose, 6 May 2004, 8, 11, 15 (SCOI.03416). See, for example, Exhibit 29, Tab 18, Statement of Megan Patricia Brownlow, 24 December 1997, [9] (SCOI.00041.00040); Statement of Gaynor Margaret Foster, 7 January 1998, [10] (SCOI.00041.00059); Statement of Alfred Steinbeck, 21 January 1998, [6] (SCOI.00041.00083); Statement of Detective Senior Constable of Police Paul Michael Thornton, 23 October 1998, [21], [28], [120], [125], [129], [141], [147], [177], [211] and [286] (SCOI.00041.00005); Statement of Nada Laura Borovnik, 9 January 1998, [4] (SCOI.10125.00058)

[262] See, for example: Written submissions of Commissioner of Police (Cuthbert, Raye, Stewart, Stockton), 12 April 2023, [9], [12]-[13], [37], [84]; Written submissions of Commissioner of Police (Cawsey, Jones, Baumann), 10 July 2023, [37]-[39], [42]-[43], [46], [51], [56], [74], [76]-[79], [83], [90], [92], [95]-[97], [101], [103]; Written submissions of Commissioner of Police (Rooney, Slater, Rath, Wark), 1 June 2023, p. 4 [14], p. 10 [42], p. 11 [46], p. 19 [6], p. 21 [17], p. 28 [61], p. 29 [65]; Written submissions of Commissioner of Police (Bedser), 7 June 2023, [10]; Written submissions of Commissioner of Police (Hughes, Paynter, Payne, Dutfield, Lloyd-Williams, Currie, Walker), 21 February 2023, [70], [74], [78], [80], [92], [116]; Written Submissions of Commissioner of Police (Sheil), 18 April, [16]; Written submissions of Commissioner of Police (Waine), 23 June 2023, [15], [17], [19]-[20], [28]-[29], [35], [39], [43]-[44], [73], [74], [80]; Written submissions of Commissioner of Police (Dye, Allen), 5 September 2023, [42], [63], [93], [103]; Written submissions of Commissioner of Police (Mattaini, Warren, Russell), 13 July 2023, [6], [7], [21], [22], [113]; Written submissions of Commissioner of Police (Brennan, Meek), 7 July 2023, [101], [102], [107], [114], [116], [144], [145]; Written submissions of Commissioner of Police (Miller), 30 June 2023, [48], [54], [57], [69], [71], [72], [73]; Written submissions of Commissioner of Police (Malcolm), 21 July 2023, [19(c)], [25], [41], [45], [47], [48].

b) the documentary record may not comprehensively reflect the investigative steps actually undertaken (whether because of a loss or disposal of material or by virtue of different historical standards regarding the detail required to be recorded in OIC statements and other investigative documents);

c) the criticism made by Counsel Assisting does not accurately reflect the evidence regarding aspects of the relevant investigation; and/or

d) the matter has been the subject of an independent review by a Coroner, either in the context of a decision to dispense with an Inquest, or in reaching findings following an Inquest, with no indication that the Coroner considered the relevant investigation to be deficient or that further investigative steps were warranted.

446. As addressed at Part B.3.3.9, while it is certainly possible that bias may have played a part in the investigative failings observed in some cases, there is (as acknowledged by Counsel Assisting) no evidence to support such a finding. Again, in many of the cases where criticisms have been made of the investigating officers, police were not aware of the sexuality of the deceased person, or understood them to be heterosexual.

447. As concerns the frequency of deviations from proper police practice, the Commissioner of Police repeats the observation made at [58]-[59]. Unsolved homicides simply cannot be treated as a representative sample of police work; the unsolved status of those cases serves as a confounding variable. Failures in exhibit management or investigative practice are, by definition, more likely to be observed in cases that are unsolved than cases that are solved.

448. The submissions at CA [908] and [909] do not fairly characterise the position advanced on behalf of the Commissioner of Police. As noted above, the Commissioner of Police has routinely made significant concessions in relation to apparent failures in investigative practice or exhibit management. It is scarcely unreasonable to make submissions that a given criticism should be approached cautiously given the failure to seek evidence from, or afford procedural fairness to, the person the subject of criticism. It is surprising that exception appears to have been taken to the making of such submissions.

449. Similarly, it is hardly unconstructive to identify matters apparently overlooked by submissions advancing certain criticisms, or to note the possibility that the documentary record might not comprehensively record every step taken by the relevant investigator. Again, the submissions

advanced in respect of each case by the Commissioner of Police should be considered individually, not reduced to generalisations.

D.31 – Submissions concerning the UHT

450. As identified by Counsel Assisting (CA, [911]), questions relating to the appropriate allocation of resources to the UHT fall outside the ambit of the Inquiry and raise complex social and policy considerations. Those considerations are necessarily informed by a range of competing and important imperatives.

451. While significant resources have been allocated to the UHT, as noted at [78] – [83] of Part C above, those resources are regularly diverted to work on pressing current investigations. There is, as expressed above, good reason for such diversion of resources.

452. In short, the UHT has very regularly been forced to make do with fewer officers in practice than it would appear to have available on paper.[263] Of course, even if the full complement of UHT officers was available to work on unsolved cases at all times, that does not say anything about whether the UHT has sufficient resources to allow it to complete its work as expeditiously as would, in a vacuum, be desirable. There is therefore no basis to conclude that the resources constraints facing the UHT are not significant (cf, CA, [914]).

453. As acknowledged at [89] above, there is reason to think that the UHT has at various times failed to efficiently progress its triage and review of unsolved homicides. However, Counsel Assisting's submission at CA, [915] that the UHT has been "beset by inactivity" cannot be sustained. Unsolved homicide investigations are typically onerous[264], and as observed at [78] – [83] above, members of the UHT are regularly diverted to other investigative roles. The officers of the UHT and the Homicide Squad generally undertake challenging, emotionally taxing work, in service of the victims' families and the broader community. They are subject to extraordinary personal and professional demands and routinely work very long hours. Their efforts should not be unduly denigrated.

454. Subject to the various observations made above and in Part C regarding the extraordinary challenges facing members of the UHT from its inception to the present day, it is accepted that there have been deficiencies in the system employed in the screening, triage and review of

[263] Exhibit 6, Tab 513, Statement of John Paul Lehmann, 29 August 2023, [17]-[19] (SCOI.85495); Transcript of Inquiry, 26 September 2023, T6010.9-6011.21.
[264] Exhibit 6, Tab 513, Statement of John Lehmann, 29 August 2023, [17]-[23] (SCOI.85495).

cases. In particular, it appears that, at various times, the correct balance has not been struck between speed and depth in the review process.

455. As noted at Part C.3 above, Counsel Assisting's observations regarding the lack of reference in DCI Laidlaw's statement to the fact that no reviews occurred between 2013 and 2017 does not account for the fact that DCI Laidlaw was not within the UHT in any capacity until 2017.[265] The very significant impositions on the resources of the UHT in that period are addressed at Part C.3. It is nevertheless accepted that, even in the face of extraordinary demands, resources should have been managed such that at least some review activity continued in the relevant period.

456. DCI Laidlaw has himself been subject to an extraordinary workload during the period in which he has not assessed the 19 triaged cases referred to at CA [519].[266] He nevertheless accepts responsibility for the failure to assess those completed triage forms. As noted at [86] above, DCI Laidlaw explained that the significant resourcing constraints faced by the UHT mean that "we're moving a backlog of triage forms into the review area and they're unable to be reviewed because we can't resource them adequately".[267] The lack of capacity for a review to be progressed after his completed assessment of the triage forms assists to explain DCI Laidlaw's prioritisation of other matters. DCI Laidlaw further acknowledges that he did not bring this particular difficulty to the attention of his superiors.[268] Counsel Assisting goes on to submit that the fact that this matter did not come to the attention of DCI Laidlaw's superiors may indicate a failure of supervision by the "by the Homicide Squad, and by superior officers of the NSWPF more broadly" (CA, [919]). That submission is wholly speculative and has not been explored with DCI Laidlaw's superiors.

457. As concerns the submissions made at CA [921] – [923], it is acknowledged that the classification as a matter as "undetermined" will result in it having a diminished priority. Ordinarily, there is a delay between the referral of a case from the Coroner to the UHT and the consideration of that case by the UHT. That is because, in the usual course, the Coronial process will involve the implementation of all available investigative strategies that are available at the relevant time.[269] Should additional information become available in the interim, that information is reviewed and officers consider whether to conduct a reinvestigation in response to it.[270]

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[265] Exhibit 51, Tab 6, Statement of Detective Chief Inspector David Laidlaw, 13 June 2023, [16] (NPL.9000.0019.0001).
[266] Transcript of Inquiry, 7 July 2023, T5252.43-5253.43 (TRA.00075.00001).
[267] Transcript of the Inquiry, 6 July 2023, T5126.2-14 (TRA.00075,00001).
[268] Transcript of Inquiry, 6 July 2023, T5127.43 (TRA.00074.00001).
[269] Transcript of Inquiry, 7 July 2023, T5247.40-46 (TRA.00075.00001).
[270] Transcript of Inquiry, 7 July 2023, T5247.46-5248.3 (TRA.00075.00001).

458. The Homicide Squad is presently in the process of developing a database designed to capture and monitor information in respect of all homicides, including those currently regarded as unsolved.[271] It is anticipated that the implementation of that system will improve the monitoring and prioritisation of unsolved homicides and aid in decision-making as concerns which matters ought to be subject to reinvestigation.[272]

459. As acknowledged at CA [924], the work of the UHT is constrained by historical exhibit management and record keeping practices. This is an inherent challenge faced in investigating cold cases across jurisdictions (see [70]). It is unsurprising that police practices were significantly different before developments in DNA technology were known or foreseen. That must be kept firmly in mind in considering whether there have been failures to comply with historical protocols (CA, [924]). Further, as Counsel Assisting note, those failures are not the fault of the UHT.

460. The Commissioner of Police acknowledges that there are examples before the Inquiry of poor record-keeping practices within the UHT itself (CA, [925]). The task of the UHT in dealing with a very large number of unsolved cases is one that necessarily requires a methodical and systematic approach. While the UHT has aimed to operate in such a way, it is accepted that this has not always occurred.

461. There are instances of recommendations for investigation or review where this is no evidence of those steps being implemented or further considered (CA, [926]). Decisions to prioritise resourcing a particular matter at a given time would not necessarily be reflected in the evidence before the Inquiry, noting the broader purview of the work undertaken by the UHT (cf CA, [927]). Unfortunately, reviews of cases may well result in recommendations for further investigation that are unable to be followed for want of resources. It is accepted that where this occurs, it would be appropriate for the relevant decision, and the reasons for it, to be recorded.

462. The features of document management and record-keeping identified by Dr Allsop (CA, [928]) have now been in place within the NSWPF for some considerable time. At the triage stage, available documentation and exhibits are identified and recorded in the e@gle.i system (see C.2.1 above; CA, [275] – [276]). All exhibits are now recorded in EFIMS. In terms of "closing reports for each cold case reviewed" to help future investigators understand the status of the case (CA, [278]), this is the function of the review form. Complete and accurate record

[271] Transcript of Inquiry, 7 July 2023, T5250.7-5252.19 (TRA.00075.00001).
[272] Transcript of Inquiry, 7 July 2023, T5251.12-19 (TRA.00075.00001).

management of previous case reviews is of significant importance to the efficient operation of the UHT.

463. As acknowledged at [89] above, the triage process in place since 2018 does not strike the necessary balance between detail and speed. It is accepted that it has failed to properly meet either objective (CA, [929]). The Commissioner of Police agrees that the triage process requires reconsideration to better emphasise the importance of expedition.

464. As addressed at [42]-[46], the submissions advanced at CA [155] – [160] fail to take into account the evidence provided to the Inquiry in the Statements of AC Cooke dated 14 June 2023. Otherwise, it is appropriate to record that the Commissioner of Police is cognisant that the use of inappropriate language can be extremely harmful in various ways. It is of the utmost importance that NSWPF officers communicate in respectful and inclusive ways.

465. The observation at CA [931] appears to correspond to Recommendations 5 and 6. Those recommendations are considered further below at Part E. Both Recommendations 5 and 6 are supported.

PART E: RECOMMENDATIONS

466. Various submissions of Counsel Assisting relevant to the proposed recommendations are addressed in Parts B, C and D above. The Commissioner of Police's position in respect of the recommendations proposed by Counsel Assisting is addressed at various parts of the above.

467. A short summary of the Commissioner of Police's position in respect of each of the recommendations appears below.

Recommendation 1 – Audit of inquests dispensed with

468. Proposed Recommendation 1 is in the following terms:

> *First, that an audit be undertaken to ensure that matters where an inquest was dispensed with, but where later information suggests they may have been a homicide, are drawn to the attention of the UHT (and, if appropriate, become the subject of an inquest).*

469. The precise scope of this recommendation is somewhat unclear. An enormous number of inquests are dispensed with every year. The NSWPF plays no part in many of those cases. There is no practical way for the NSWPF to conduct an audit of all Inquests that have been dispensed with to assess whether additional information may be available in relation to those

cases. Such a process would require the involvement of the Coroners Court and, potentially, various other agencies. It would be protracted and extremely resource intensive.

470. Similarly, a comprehensive 'audit' involving a review of all records held within the NSWPF regarding matters where an Inquest has been dispensed with would simply not be practicable; given the number of Inquests dispensed with, it would again require a review of many thousands of files.

471. As a practical solution, it may be possible to disseminate an express request to all PACs asking that officers convey information they are aware of that may be relevant to an assessment of whether a given case was, contrary to the determination to dispense with an Inquest, potentially a homicide. Such a process would likely go hand in hand with steps taken in the implementation of Recommendation 4 which, as set out below, is supported in principle.

Recommendation 2 – Mandatory education concerning the LGBTIQ community

472. Proposed Recommendation 2 reads as follows:

> *Second, that NSWPF officers participate in mandatory education concerning the LGBTIQ community. Any such program should be developed with input from LGBTIQ representatives and organisations, and consideration should be given to whether better outcomes could be achieved through an in-person format, and by having this education delivered by an LGBTIQ organisation external to the NSWPF.*

473. As addressed in Part B, the NSWPF provided mandatory LGBTIQ awareness and inclusion training during the 2020 training year, and mandatory training is provided to all students at the NSWPF Academy each year.[273]

474. Additionally, LGBTIQ community organisations (including Pride in Diversity and Twenty10) have worked closely with the NSWPF to deliver training during the GLLO course,[274] and also to provide feedback and guidance to support the continued development of that course.[275]

475. The Commissioner of Police agrees in principle that it is appropriate for additional mandatory LGBTIQ training to be provided to NSWPF personnel. Further, the Commissioner of Police is in

[273] Statement of AC Anthony Cooke regarding the GLLO program, 14 June 2023, [76]-[77] (NPL.9000.0020.0001).
[274] See Statement of AC Anthony Cooke regarding the GLLO program, 14 June 2023, [76]-[84] for detail regarding the training of GLLOs (NPL.9000.0020.0001).
[275] Statement of AC Anthony Cooke regarding Taradale recommendations, 14 June 2023, [34] (NPL.9000.0020.0025).

firm agreement that any such program should be developed with input from LGBTIQ representatives and organisations.

476. Matters such as the timing of training, the mode of delivery and the identity of presenters will need to be the subject of careful consideration, having regard to various practical considerations.

477. In particular, there are more than 21,000 NSWPF employees, dispersed across more than 400 locations throughout NSW. The involvement of LGBTIQ community organisations in relation to the delivery of training is appropriate and warmly welcomed (as it has been in the past). There may, of course, be significant practical hurdles to having such organisations themselves provide training to *all* members of the NSWPF. Those challenges may be heightened if the training is to be delivered in a face-to-face format, having regard to the number of NSWPF personnel and their distribution throughout NSW. Those practical matters would need to be explored in due course, with a view to ensuring the best outcomes from the training.

Recommendation 3 – State Records Act

478. Proposed Recommendation 3 states:

> *Third, that the State Records Act be amended to clarify the application of the Act to exhibits obtained by the NSWPF.*

479. For the reasons expressed in Part C.8, it is submitted that, properly construed, the State Records Act does not apply to exhibits. Accordingly, the Commissioner of Police does not consider that any amendment to the State Records Act is necessary.

480. At CA [582], Counsel Assisting recognise that "[t]he question of whether such items *should* constitute State Records invokes a number of policy considerations, and would undoubtedly require consideration of obligations under other legislative regimes."

481. For the avoidance of doubt, the Commissioner of Police considers that there are very strong policy considerations militating against the treatment of exhibits as State records. As considered at Part C.8, such an approach would potentially have significant impacts on a number of different legislative regimes (and potential impacts on agencies other than the NSWPF). It would also have enormous practical implications for the NSWPF and the GRR.

482. If, notwithstanding the submissions at Part C.8, the Inquiry considers that there is ambiguity in relation to the State Records Act's application to exhibits, the Commissioner of Police does not oppose a recommendation that the position should be clarified. Again, in the Commissioner of

Police's view, any such clarification should result in exhibits seized by police being expressly excluded from the operation of the State Records Act.

Recommendation 4 – Treatment of information received after an Inquest is dispensed with

483. Recommendation 4 is proposed by Counsel Assisting in the following terms:

> *Fourth, that a formal process be implemented to ensure that in circumstances where information is received by the NSWPF that indicates that a case the subject of a coronial dispensation or a finding of a non-suspicious death may, in fact, be a homicide, this information is brought to the attention of the UHT.*

484. This recommendation is supported in principle. The precise mechanics of the formal process will, of course, need to be the subject of further consideration in due course in an effort to best give effect to the intent of the recommendation.

Recommendation 5 – Audit of unsolved cases

485. Counsel Assisting's proposed Recommendation 5 is as follows:

> *Fifth, that a systematic review be conducted of all unsolved cases, including an audit of what exhibits have been retained and their location. Such a review should adopt a procedure that created creates some prospect of matters being reviewed regularly, even if that review is brief.*

486. This recommendation is supported.

487. A range of steps have already begun to be implemented in an attempt to address the issues underlying this recommendation. The Commissioner of Police would be pleased to provide further information in this respect if it is required by the Inquiry.

Recommendation 6 – Review of UHT procedures and resource allocation

488. Proposed Recommendation 6 is in the following terms:

> *Sixth, that a review be conducted of the existing procedures and allocation of resources within the UHT.*

489. This recommendation is supported. A process of external review led by a senior officer within the Professional Standards Command is currently underway in relation to the procedures and resource allocation within the UHT. The current terms of the Terms of Reference proposed for this review are as follows:

To conduct a review of the practices, procedures and resourcing of the Unsolved Homicide Team (UHT), including any issues with those practices, procedures and resourcing considered by the Special Commission of Inquiry into LGBTIQ hate crimes, with a view to determining the most appropriate and effective practices, procedures and resourcing to give effect to the Charter of the UHT and the management of the investigation of unsolved homicides within New South Wales.

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