New South Wales

Special Commission of Inquiry into LGBTIQ hate crimes

SUBMISSIONS OF COUNSEL ASSISTING

Investigative Practices Hearing

15 September 2023

PART A INTRODUCTION

1. These submissions are filed on behalf of Counsel Assisting the Special Commission of Inquiry into LGBTIQ hate crimes (**Inquiry**). They concern the Investigative Practices Hearing (**IPH**) which occurred from 4 to 7 July 2023 and on 15 August 2023.

2. Over the course of the Inquiry's work, a number of questions have arisen concerning the investigative practices of the NSW Police Force (**NSWPF**) over the period covered by the Terms of Reference, and in relation to the storage and retrieval of exhibits and documentary material (such as investigative files). The purpose of the IPH was to explore these questions.

3. The *first* topic considered in these submissions (in Part B) is homicide investigation, addressing both the period covered by the Terms of Reference and, where appropriate, the current NSWPF structure and procedures. This includes the investigation of homicides prior to the creation of a dedicated Homicide Squad; the creation and role of the Homicide Squad; the interaction between the Homicide Squad and other NSWPF teams; the education and training of homicide detectives, including in relation to the LGBTIQ community the forensic techniques available in homicide investigations; and, the relevance of conscious and unconscious bias in the process of homicide investigation.

4. The *second* topic explored in these submissions (in Part C) is that of unsolved homicides or "cold cases", including the establishment and operation of the Unsolved Homicide Team (**UHT**); the screening, triage and review process used by the UHT; and, the management of exhibits and documentary records. This section of the submissions covers the exhibit "lifecycle", and the archiving and retrieval of exhibits and investigative material.

5. The *third* topic considered in these submissions (in Part D) is document and exhibit management and investigative practices in the context of individual cases considered by the Inquiry, in addition to the processes of the UHT, and documents created by the UHT, in relation to these cases. Over the course of the Inquiry's work, the Inquiry identified a range of matters of concern in relation to individual matters considered by the Inquiry, and identified matters where it appeared that investigative material had been lost or destroyed.

6. As is explained in more detail at in Part A.1 below, Inquiry staff wrote to the NSWPF and annexed two schedules identifying, by reference to individual matters considered by the Inquiry, lost or destroyed exhibits and other matters of concern to the Inquiry. The Inquiry requested that the NSWPF address specified questions in relation to each case.

7. A number of statements were furnished by the NSWPF in response to those requests. Assistant Commissioner Rashelle Conroy (**AC Conroy**), Superintendent Roger Best (**Superintendent Best**), Detective Superintendent Daniel Doherty (**DS Doherty**) and Detective Inspector Nigel Warren (**DI Warren**) were also asked questions about these cases in the course of their oral evidence.

8. In addition, as explained in Pt A.1 below, the Inquiry had already received some evidence from the NSWPF in relation to the topics explored at the IPH.

A.1 Evidence obtained by the Inquiry in relation to the NSWPF's Investigative Practices

9. On 13 March 2023, the Inquiry wrote to the NSWPF requesting a statement or statements concerning the handling and storage of physical exhibits in homicide cases.[1] In response to this request, the NSWPF furnished a statement of Superintendent Best dated 24 April 2023 (**Best Statement**)[2] and a statement of AC Conroy dated 2 May 2023 (**First Conroy Statement**).[3]

10. On 13 March 2023, the Inquiry also wrote to the NSWPF requesting a statement or statements concerning topics in connection with the Homicide Squad.[4] In response to this request the NSWPF furnished a statement of DS Doherty dated 18 April 2023 (**Doherty Statement**).[5]

11. On 12 May 2023, the Inquiry wrote to the NSWPF requesting a further statement concerning exhibit management by reference to a number of the cases considered by the Inquiry and identified in a Schedule annexed to that letter (**Exhibits Statement**).[6] The Inquiry had previously received statements from the NSWPF concerning some of those cases.[7]

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[1] Exhibit 52, Tab 1, Letter from the Inquiry to the NSWPF re Request for statement concerning exhibit management, 13 March 2023 (NPL.9000.0002.0493).
[2] Exhibit 51, Tab 2, Statement of Superintendent Roger Best, 24 April 2023 (NPL.9000.0003.1533).
[3] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [52]-[54] (NPL.9000.0008.0905).
[4] Exhibit 51, Tab 1 Annexure 1, Letter from the Inquiry to the NSWPF re request for statement concerning the qualifications and training of NSWPF officers assigned to the Homicide Squad, 13 March 2023 (NPL.9000.0006.0038).
[5] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023 (NPL.9000.0006.0001).
[6] Exhibit 52, Tab 2, Letter from the Inquiry to the NSWPF re request for further statement, 12 May 2023 (SCOI.84216).
[7] Exhibit 16, Tab 31, Statement of Detective Sergeant Neil Sheldon – Cuthbert, 18 January 2023 (SCOI.82580); Exhibit 23, Tab 36A, Statement of Statement of Detective Sergeant Neil Sheldon – Wark, 19 January 2023 (SCOI.82332); Exhibit 28, Tab 169, Statement of Detective Sergeant Neil Sheldon – Bedser, 23 January 2023 (SCOI.82591); Exhibit 18, Tab 62, Statement of Detective Sergeant Neil Sheldon – Stockton, 17 April 2023 (NPL.9000.0005.0001); Exhibit 41, Tab 33, Statement of Detective Inspector Nigel Warren – Jones, 21 February 2023 (SCOI.83075); Exhibit 46, Tab 66, Statement of Detective Inspector Nigel Warren – Russell, 30 March 2023 (NPL.9000.0001.0001); Exhibit 46, Tab 67, Statement of Detective Inspector Nigel Warren – Russell, 5 May 2023 (NPL.9000.0001.0017).

12. On 26 May 2023, the Inquiry wrote to the NSWPF identifying two additional cases where exhibits had been lost or destroyed.[8] This letter contained an updated version of the Schedule identifying the cases where the Inquiry was aware of exhibits having been lost or destroyed (**Exhibits Schedule**). This letter also requested a statement (**Investigative Steps Statement**) addressing certain conduct of the NSWPF itemised in a second Schedule (**Investigative Steps Schedule**).

13. On 30 May 2023, the Inquiry wrote to the NSWPF requesting a statement or statements concerning the UHT (**UHT Statement**).[9]

14. In response to requests for the Exhibits Statement and the Investigative Steps Statement, the Inquiry received a statement of DI Warren dated 9 June 2023 (**Warren Statement**),[10] and a statement of AC Conroy dated 11 June 2023 (**Second Conroy Statement**).[11] In response to the request for the UHT Statement, the Inquiry received a statement of Detective Chief Inspector David Laidlaw (**DCI Laidlaw**) dated 13 June 2023 (**Laidlaw Statement**).[12]

15. The first tranche of the Investigative Practices Hearing took place on 4, 5, 6 and 7 July 2023. The Inquiry received oral evidence from each of the NSWPF witnesses. The second tranche of the Investigative Practices Hearing took place on 15 August 2023. The Inquiry received oral evidence from Sharon Neville of the Forensic and Analytical Science Service (**FASS**) and Dr Cheryl Allsop.

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[8] 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 (SCOI.84217).
[9] Exhibit 51, Tab 6, Annexure 1 to the Statement of Detective Chief Inspector David Laidlaw, 13 June 2023 (NPL.9000.0019.0001).
[10] Exhibit 51, Tab 5, Statement of Detective Inspector Nigel Warren, 9 June 2023 (NPL.9000.0018.0507).
[11] Exhibit 51, Tab 4, Second Statement of Assistant Commissioner Rashelle Conroy, 11 June 2023 (NPL.9000.0008.1049).
[12] Exhibit 51, Tab 6, Statement of Detective Chief Inspector David Laidlaw, 13 June 2023 (NPL.9000.0019.0001).

PART B HOMICIDE INVESTIGATION

B.1 The Homicide Squad and Homicide Detection

B.1.1 Homicide investigation and the management of unsolved homicides prior to the introduction of the Homicide Squad

B.1.1.1 Homicide investigation in the 1970s

16. Prior to approximately July 1972, the investigation of homicides was undertaken by specially selected groups of detectives, known as "General Duty Detectives", who worked in pairs under the supervision of the Superintendent in Charge of the Criminal Investigation Branch (**CIB**).[13] In around July 1972, these detectives were granted "squad status" and the "Special Crimes Squad" (**SCS**) (the precursor to the Homicide Squad) was established under the supervision of a Senior Detective Sergeant.[14] As at 1975, there were 33 detectives attached to the SCS.[15]

17. In around July 1976, the SCS was renamed the "Homicide Squad". From that time, the Homicide Squad was under the leadership of a Detective Inspector, assisted by a Senior Detective Sergeant and 23 Detective Constables. The Homicide Squad operated throughout NSW and investigated homicides; deaths of an unusual or suspicious nature; skeletal remains; and, the disappearances of persons under suspicious or unusual circumstances.[16]

B.1.1.2 The 1980s and the disbandment of the CIB

18. In around 1987, the CIB was disbanded. The specialised resources for investigating homicides in NSW were regionalised.[17] Until 1997, NSW had four "Homicide Units" which formed part of the four "Major Crime Squads", each of which was located within one of four regions: North (Chatswood and Newcastle), South (Strawberry Hills), South West (Flemington) and North West (Parramatta).[18]

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[13] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [20] (NPL.9000.0006.0001).
[14] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [21] (NPL.9000.0006.0001); Transcript of the Inquiry, 6 July 2023, T5041.26-36 (TRA.00074.00001).
[15] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [22] (NPL.9000.0006.0001).
[16] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [23] (NPL.9000.0006.0001); Transcript of the Inquiry, 6 July 2023, T5041.26-40 (TRA.00074.00001).
[17] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [25] (NPL.9000.0006.0001).
[18] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [26], [41] (NPL.9000.0006.0001); Transcript of the Inquiry, 6 July 2023, T5045.6-44 (TRA.00074.00001).

19. The regional Homicide Units worked independently of one another to investigate homicides within their regions.[19] Local detectives of each Patrol were responsible for notifying the relevant regional Homicide Unit of any potential homicide and seeking their assistance with the investigation.[20] At this time, the Patrol Commander had responsibility for all activities within their Patrol.[21]

B.1.1.3 The 1990s and centralisation

20. Following consideration of the report of the Working Party Reviewing the Effect of Regionalisation on the Investigation of Homicides (delivered in February 1990),[22] it was determined that it was more effective for specialised units (such as homicide units) to be centralised. Since 1997, there has been a centralised homicide unit within the NSWPF.[23]

21. Three historical versions of Standard Operating Procedures (**SOPs**) for the regional Major Crime Squads are in evidence.[24] In addition, DS Doherty refers in his statement to the "Major Crime Squad, Investigation Referral System" document, dated September 1994.[25] Prior to centralisation, it was a matter for each Patrol Commander to involve the relevant regional Major Crimes Squad by completing an investigation referral form.[26] DS Doherty also annexed to his statement a profile document concerning the Major Crime Squad, South Region.[27]

22. Centralisation was thought to be beneficial on the basis that it meant there would be "one point of contact, increase information sharing, communication; to have a specialist body that was answerable to certain crime types."[28]

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[19] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [27] (NPL.9000.0006.0001).
[20] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [28] (NPL.9000.0006.0001).
[21] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [29] (NPL.9000.0006.0001).
[22] Exhibit 51, Tab 1B, Report of the Working Party, February 1990 (NPL.0100.0003.0830).
[23] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [31] (NPL.9000.0006.0001).
[24] Exhibit 51, Tab 1C, North Region, Standard Operating Procedures ("SOPS"), June 1992 (NPL.0100.0003.0967); Exhibit 51, Tab 1E, Homicide Unit, Major Crime Squad North SOPS, Undated (NPL.0100.0003.0890); Exhibit 51, Tab 1G, Homicide Unit, Major Crime Squad South SOPS, January 1995 (NPL.0100.0003.961).
[25] Exhibit 51, Tab 1D, Major Crime Squad Investigation Referral System, 1994 (NPL.0100.0003.1130).
[26] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [43] (NPL.9000.0006.0001).
[27] Exhibit 51, Tab 1F, Homicide Unit, Major Crime Squad, South Region, Profile, October 1994 (NPL.0100.0003.1110).
[28] Transcript of the Inquiry, 6 July 2023, T5050.1-6 (TRA.00074.00001).

23. In around 1997, all major crime units within the NSWPF were re-centralised and "Crime Agencies" were formed. After this centralisation, the investigation of homicides was managed by the "Homicide and Serial Crime Agency".[29] In 2002, the State Crime Command (**SCC**) was established as a centralised body, and the Homicide Squad, as it now exists, was established.[30] The SCC has eleven squads which sit within it, and is one of the six commands which report to the Deputy Commissioner Investigations and Counter Terrorism.[31] In his statement, DS Doherty identified a number of benefits which he considers flowed from the centralisation of the Homicide Squad.[32] A copy of the SCC document "Investigation Support, Standard Operating Procedures" dated May 2003 is in evidence before the Inquiry.[33]

B.2 The formation of the Homicide Squad

24. DS Doherty explained in his statement:[34]

> Since 2002, the Homicide Squad has led and driven the NSWPF response to homicide and coronial investigations, at all levels. This is achieved through the development of tactical intelligence products, the provision of policy advice and advice as to best practice concerning the proper investigation of homicides to Police Area Commands **(PACs)** and police departments involved in such investigations. In addition, this is achieved through the provision of specialist investigative services on homicide investigations by providing experienced homicide detectives to lead, manage and consult on such investigations. The Homicide Squad, and its detectives, specialise in the investigation of murder, suspicious deaths, specific critical incidents and specific coronial investigations, as determined by the New South Wales State Coroner.

25. In his oral evidence, DS Doherty elaborated on the changes and improvements to the way in which suspicious deaths have been investigated since the formation of the Homicide Squad. He said that there were a number of advances: the transition from analogue to digital devices; enhancements to cameras and video recording; the availability of electronic information; the use of body-worn cameras; and developments in psychology, criminology and victimology.[35]

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[29] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [32] (NPL.9000.0006.0001).
[30] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [33] (NPL.9000.0006.0001).
[31] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [36] (NPL.9000.0006.0001).
[32] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [45] (NPL.9000.0006.0001).
[33] Exhibit 51, Tab 1H, Investigation Support SOPS, May 2003 (NPL.0100.0003.1038).
[34] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [34] (NPL.9000.0006.0001).
[35] Transcript of the Inquiry, 6 July 2023, T5042.1-37 (TRA.00074.00001).

26. In addition, DS Doherty identified the development of DNA as changing the way the NSWPF would investigate homicides (as well as other crimes). He said that the *Crimes (Forensic Procedures) Act 2000* (NSW) (**CFP Act**) had enhanced the ability of the NSWPF to gather DNA from suspects and volunteers, but also changed the way the NSWPF managed and stored exhibits.[36] The issue of advancements in DNA technology is dealt with in Part B.4.2 below.

B.2.1 Structure of the Homicide Squad

27. The Homicide Squad presently has a structure of 11 teams.[37] DS Doherty's experience is that entry to the Homicide Squad is competitive and "attracts applications from a range of experienced and dedicated detectives." DS Doherty said in his statement that homicide investigations require a "thorough, patient, and at times innovative approach."[38] Six of the 11 teams respond to recent homicides or missing persons reports. The other five operate as the UHT.[39]

28. According to the 2003 SOPs, it was mandatory for homicides (classified as a Level 1 offence) to be referred to the SCC as soon as they were detected.[40] In his oral evidence, in response to questions from Senior Counsel Assisting, DS Doherty said that this was, to his knowledge, the first time that notification became mandatory, but that this was a formalisation of the process that was generally followed and that "it was always a practice that homicide would always be notified." He confirmed that this notification had been "required" as a matter of proper police practice even before its formalisation.[41]

29. The role and responsibility of the SCC, including the Homicide Squad, was to provide specialist investigative support to the Local Area Command (**LAC**) in which the incident occurred. Discretion to direct the method of operation for serious major crimes, including homicides, rested with the Commander of the SCC.[42]

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[36] Transcript of the Inquiry, 6 July 2023, T5043.7-5044.2 (TRA.00074.00001).
[37] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [37] (NPL.9000.0006.0001).
[38] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [35] (NPL.9000.0006.0001).
[39] Transcript of the Inquiry, 6 July 2023, T5050.21-42 (TRA.00074.00001).
[40] Exhibit 51, Tab 1H, Investigation Support SOPS, May 2003, [5.7] (NPL.0100.0003.1038).
[41] Transcript of the Inquiry, 6 July 2023, T5051.38-T5052.44 (TRA.00074.00001).
[42] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [48] (NPL.9000.0006.0001).

B.2.2 Standard Operating Procedures of the Homicide Squad

30. The SOPs in place from May 2010 onwards are also in evidence before the Inquiry, as is the current version of the SOPs.[43] Since at least May 2010, a detective from the Homicide Squad will lead an investigation into a homicide or suspicious death for the first 72 hours of an investigation, unless and until the Homicide Squad determines otherwise.[44]

31. DS Doherty explained in his statement that "[t]his approach has been adopted to ensure that there is an experienced detective on homicide investigations that is responsible for making decisions concerning the future direction of the investigation and to ensure that best practice is being followed by the Investigation Team at the most critical point in the investigation."[45]

32. At the end of that 72 hour period (or at an earlier point, if the Homicide Squad determines that it should no longer lead the investigation), the Homicide Squad will, in consultation with the relevant Police Area Command (**PAC**)/Police Districts and Regions, determine which unit within the NSWPF should continue the investigation and, if that unit is not the Homicide Squad, whether a Homicide Squad Detective should be part of the investigative team.[46]

33. In the event that a homicide or suspicious death investigation is returned to the PAC in which it occurred, the Homicide Squad has authority (in consultation with the SCC) to take over leadership of the investigation or to assign a detective to the team conducting an investigation.[47] Officers of the NSWPF can also access the resources of the Homicide Squad while conducting investigations.[48]

34. In addition, if an investigation into a homicide or suspicious death is being conducted by an officer other than a Homicide Squad officer, that officer can liaise either formally or informally with the Homicide Squad. A formal request for assistance involves a request for a review of the investigation. Such a review is conducted by a panel of investigators from the Homicide Squad.[49]

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[43] Exhibit 51, Tab 1I, Leadership of Homicide and Suspicious Death Investigations, 1 May 2010 (NPL.0100.0003.0183); Exhibit 51, Tab 1J, Leadership of Homicide or Suspicious Death Investigations, 16 June 2022 (NPL.0100.0003.1163).
[44] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [51] (NPL.9000.0006.0001).
[45] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [51] (NPL.9000.0006.0001).
[46] Exhibit 51, Tab 1, Statement of Detective Superintendent Daniel Doherty, 18 April 2023, [55] (NPL.9000.0006.0001).
[47] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [57] (NPL.9000.0006.0001).
[48] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [60]-[62] (NPL.9000.0006.0001); Exhibit 51, Tab 1K, Homicide Squad Business Charter, Undated (NPL.0100.0003.1200).
[49] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [59] (NPL.9000.0006.0001).

35. As noted above at [2828], there is a mandatory requirement that any suspicious death be notified to the Homicide Squad. The Homicide Squad has investigative authority and control over an investigation for at least the initial 72 hours, but the investigative team would ordinarily comprise, in part, local officers and detectives from the PAC where the homicide occurred.[50] In his oral evidence, DS Doherty explained that there is a high level of collaboration and cooperation between officers at a PAC and the Homicide Squad in relation to suspicious deaths.[51]

B.2.3 Establishment of the UHT

36. DCI Laidlaw gave evidence that between 1985 and 1994, unsolved homicide investigations would remain with the Patrol in which the incident occurred until new information became available. There were occasions where matters were informally reviewed by new investigators on the basis that a new investigator might provide a different view or a new perspective (referred to as a "fresh eye approach"). However, there was no systematic procedure in place for the management or review of unsolved homicide cases.[52] It appears that, subject to what is said below, this continued until the establishment of the UHT in 2004.

37. Between 1997 and 2001, if an investigation into an unsolved homicide or suspicious death failed to identify a suspect – or if a suspect was identified but there was insufficient evidence to charge someone – the investigation would remain with the investigative team at the Patrol in which it occurred, unless the Major Crime Squad was leading the investigation, in which case it would remain with that Squad.[53]

38. DCI Laidlaw was not aware of any unsolved homicides or suspicious deaths which were reviewed in the 1997-2001 period. In his view, this was because the resources available at that time did not allow the Homicide Squad to undertake reviews or reinvestigations. He said that if matters were reviewed, it would have been an informal process undertaken by the Patrol or Command responsible for the original investigation.[54]

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[50] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [66] (NPL.9000.0006.0001).
[51] Transcript of the Inquiry, 6 July 2023, T5053.44-5054.43 (TRA.00074.00001).
[52] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [26]-[27] (NPL.9000.0019.0001).
[53] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [27] (NPL.9000.0019.0001).
[54] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [31] (NPL.9000.0019.0001).

39. DCI Laidlaw was not aware of any systematic process or procedure for the review of unsolved homicides before 2004.[55] He said that prior to 2004, a file would remain with the original team that had investigated the incident.[56] He was not aware of matters being reviewed or reinvestigated before 2004, but said that it is possible that this would not have come to his attention.[57]

40. The UHT was established as a team within the Homicide Squad in 2004.[58] DCI Laidlaw explained in his statement that it was established partly to address coronial recommendations.[59] It was initially referred to as the "Unsolved Homicide Unit".[60] When it was created in 2004 the UHT was only a "review mechanism" and there was no investigative arm.[61] DS Doherty gave evidence that "[s]ince its inception, the UHT remains a core component of the Homicide Squad."[62]

41. UHT detectives do not receive specific training beyond what is required in order to join the Homicide Squad.[63] DCI Laidlaw said in his oral evidence that he did not consider that there were particular skills which are recognised to be important for dealing with unsolved homicides that require special development.[64] He said that having an open mind is the first and foremost skill important for an UHT detective, and that "you have to be inquisitive, an inquisitive nature, and ask questions ... And you certainly have to have a passion for what you do, and commitment."[65] He confirmed that these are important skills for any homicide detective or any police officer. DCI Laidlaw did not identify any skills that he would recognise as particularly important specifically for the role of an unsolved homicide detective.[66]

B.2.4 Structure of the UHT

42. The UHT presently comprises 38 personnel organised into one "Review Team" (**Review Team**) and four "Investigation Teams" (**Investigation Team**).[67] There are two intelligence analysts attached to the UHT, and the teams are managed by three Investigation Coordinators accountable to the Commander of the Homicide Squad (presently DS Doherty).[68]

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[55] Transcript of the Inquiry, 6 July 2023, T5104.31-34 (TRA.00074.00001).
[56] Transcript of the Inquiry, 6 July 2023, T5104.44-5105.6 (TRA.00074.00001).
[57] Transcript of the Inquiry, 6 July 2023, T5105.8-14 (TRA.00074.00001).
[58] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023 [16] (NPL.9000.0019.0001); Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [70] (NPL.9000.0006.0001).
[59] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [26]-[27] (NPL.9000.0019.0001).
[60] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [70] (NPL.9000.0006.0001).
[61] Transcript of the Inquiry, 6 July 2023, T5104.14-20 (TRA.00074.00001).
[62] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [70] (NPL.9000.0006.0001).
[63] Transcript of the Inquiry, 6 July 2023, T5106.47-5107.3 (TRA.00074.00001).
[64] Transcript of the Inquiry, 6 July 2023, T5107.5-19 (TRA.00074.00001); 5107.36-5108.5 (TRA.00074.00001).
[65] Transcript of the Inquiry, 6 July 2023, T5107.23-30 (TRA.00074.00001).
[66] Transcript of the Inquiry, 6 July 2023, T5107.36-5108.5 (TRA.00074.00001).
[67] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 5 (NPL.0100.0003.0793).
[68] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [36]-[37] (NPL.9000.0019.0001).

43. The aim of the UHT is to monitor the status of, review, prioritise and reinvestigate historical unsolved homicides and suspicious missing persons cases (i.e., missing persons cases where homicide is presumed).[69] As noted above, at its inception the UHT did not have an investigative function or capacity. That capacity was introduced in around 2008.[70]

44. The UHT presently operates in accordance with SOPs published in 2022 and most recently reviewed in 2023 (**UHT SOPs**).[71] According to the UHT SOPs, a "cold case" is:[72]

> ...generally an unsolved homicide or suspicious missing person where an offender is undetected, typically for a period of some years. These cases can be inactive due to a lack of information to advance it to an active case. An unsolved case would normally remain open but in active for five years or more.
>
> One of the key factors in triggering an open inactive unsolved case to an open active case, is advances in forensic technology, witness coming forward, investigative opportunities develop with persons of interest.
>
> There is a great deal of sensitivity surrounding the activation of unsolved cases, particularly for the victim's family and friends but also within communities.

45. The UHT SOPs identify that "[o]ne of the most significant challenges for the UHT is determining which unsolved case is reviewed and determined a priority to reinvestigate amongst the hundreds of cases recorded."[73] The UHT SOPs explain that:[74]

> Each case is subject to a triage process which is incorporated in the overall review process. It is recognised that several critical aspects will impact on the ability to successfully investigate an unsolved case. It is for those reasons each case is prioritised against several considerations including Forensic Opportunities, Key Witness Availability, Suspect Availability, Investigative Opportunities, Locating Relevant Exhibits and Documentation and Community Impact.

46. In his oral evidence, DCI Laidlaw gave evidence that the practice in the UHT is, at least in some respects, not consistent with the 2022 SOPs; for example, UHT team members may contact witnesses during the review process, despite the 2022 SOPs providing that no witness is to be contacted as part of the review.[75]

47. The UHT is responsible for monitoring, reviewing and reinvestigating cases in circumstances where:

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[69] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [21] (NPL.9000.0019.0001).
[70] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [23] (NPL.9000.0019.0001).
[71] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 4 (NPL.0100.0003.0793); Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [86]-[88] (NPL.9000.0006.0001).
[72] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 4 (NPL.0100.0003.0793).
[73] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 4-5 (NPL.0100.0003.0793).
[74] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 4-5 (NPL.0100.0003.0793).
[75] Transcript of the Inquiry, 6 July 2023, T5155.39-5156.14 (TRA.00074.00001).

a. a case has been to an inquest and is referred by the Coroner to the UHT;

b. a case is one of selected historical homicides or suspicious missing cases where an investigation has led to an "open" finding;

c. a case has led to a charge of murder but the alleged offender was acquitted (other than on the basis of mental illness or self-defence; or

d. a direction has been made by the Commander of the Homicide Squad.[76]

48. The 2022 UHT SOPs state that the UHT is not responsible for the reinvestigation of cases that have not been the subject of an inquest or that are "current, incomplete or insufficient", although they may assist investigators in a consultative capacity.[77] Notwithstanding the SOPs, there are cases the Inquiry is aware of (such as that of James Meek, discussed in Part D below), where the matter appears to have come to the attention of the UHT notwithstanding the fact that no inquest was held. This may have occurred because there was a criminal trial.

49. The Inquiry is not presently in a position to understand how such cases came to the attention of the UHT, but in the event that there is no process for ensuring homicides that have not proceeded to an inquest are referred to the UHT, we submit that consideration should be given to a recommendation that an audit be undertaken to ensure that any matters in this category are drawn to the attention of the UHT (and, if appropriate, consideration be given to the appropriateness of an inquest in relation to them).

50. It is also submitted that it would be appropriate for steps to be taken to ensure that the practice of the UHT is consistent with the SOPs, or that the SOPs are amended to reflect the actual practice of the UHT.

[76] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 6 (NPL.0100.0003.0793).
[77] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 6 (NPL.0100.0003.0793).

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)

51. The Engagement and Hate Crime Unit (**EHCU**) is a unit within the Anti-Terrorism and Security Group (**ATIG**) and has 15 positions within its organisational structure.[78] The EHCU was established in December 2019 following the amalgamation of the Engagement and Intervention Unit (**EIU**) and the Bias Crimes Unit (**BCU**). The BCU was positioned within the EIU from November 2018, following a brief period when it was attached to the Fixated Persons Investigation Unit (**FPIU**).[79]

52. DS Doherty explained in his statement that the EHCU provides an intelligence function within the NSWPF (as opposed to an investigative function). EHCU officers are intelligence officers rather than detectives.[80] The Homicide Squad consults with the EHCU where the victimology of a case suggests that crime may have been motivated by hate, prejudice and bias.[81]

53. In his oral evidence, DS Doherty described the role of the EHCU as being: [82]

> ...assisting the field and specialist units with training and development around bias crime, in relation to prejudice or bias of persons that – due to a person's identity or their perceived difference, and they provide information that may assist in relation to a victim, a location of interest, for example, a group of people, that may assist an investigation. But they provide ongoing training through the State as well and in relation to bias crime...in relation to victims, how to treat the situation and the victim.

54. DS Doherty explained in response to questions from Senior Counsel Assisting that it will be up to a detective investigating a homicide to make a judgement to consult with the EHCU, and that the factors informing that decision would include the nature of the crime and the investigation, including whether a victim was a member of the LGBTIQ community.[83]

55. DS Doherty said that part of the training given to investigators is when to contact the EHCU. He was not able to assist the Commissioner in relation to how often the EHCU was consulted, but said it was "whenever we had... the circumstances arise" and that he could recall there were four matters since around 2020 when there had been a perception that bias crime might have been involved, and where he recalled the EHCU may have been consulted.[84]

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[78] Exhibit 6, Tab 3, Statement of Sergeant Ismail Kirgiz, 28 November 2022, [10] (SCOI.82035).
[79] Exhibit 6, Tab 3, Statement of Sergeant Ismail Kirgiz, 28 November 2022, [5] (SCOI.82035).
[80] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [92] (NPL.9000.0006.0001).
[81] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [92] (NPL.9000.0006.0001).
[82] Transcript of the Inquiry, 6 July 2023, T5068.14-25 (TRA.00074.00001).
[83] Transcript of the Inquiry, 6 July 2023, T5068.27-T5069.8 (TRA.00074.00001).
[84] Transcript of the Inquiry, 6 July 2023, T5069.40-5070.7 (TRA.00074.00001).

56. DS Doherty said in his statement that "[t]he EHCU is able to assist the Homicide Squad in the investigation by providing intelligence, for example, in relation to similar hate crimes which may have occurred in that area, information concerning the victim and why they may have been targeted or groups or persons of interest who may be linked to the incident or investigation."[85]

57. DS Doherty was asked by Senior Counsel Assisting how a detective joining the Homicide Squad would learn about the EHCU (noting that the induction package from 2020 does not refer to the EHCU). He said that they ought to be aware of it prior to joining the Homicide Squad, and that each team working on a matter would include experienced investigators who "have utilised all investigative practices and intelligence strategies." He said that a training day for supervisors scheduled for August of 2023 would include a presentation from the EHCU.[86]

58. Sergeant Ismail Kirgiz, who gave evidence to the Inquiry, assumed the role of Hate Crime Coordinator in the EHCU in August 2022. The equivalent of the Hate Crimes Coordinator in the BCU was the Bias Crimes Coordinator.[87]

59. In his statement, Sergeant Kirgiz explained that the primary role of the Hate Crime Coordinator is to "coordinate the operational and program-based response of the NSWPF to crime motivated by hate, by building the organisation's awareness, knowledge and operational capacity to respond effectively to all aspects of hate crime."[88]

60. In January 2020, the NSWPF moved from using the term "bias crime" to the term "hate crime" to provide greater clarity to frontline officers considering possible hate/bias motivations.[89]

61. Sergeant Kirgiz identified a range of tools used by the NSWPF to detect hate motivations. These include the mandatory use of "associated factors" in COPS reporting, which include the option of "hate crime related". This category has associated sub-categories, including LGBTIQA+. In addition, as set out above, officers have access to the Hate Crime Guidelines, a module available on the Police Education Training Environment (**PETE**); Hate Crime Awareness presentations to frontline police officers; and Hate Crime Awareness presentations to community groups.[90]

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[85] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [93] (NPL.9000.0006.0001).
[86] Transcript of the Inquiry, 6 July 2023, T5086.37-5087.6 (TRA.00074.00001).
[87] Exhibit 6, Tab 3, Statement of Sergeant Ismail Kirgiz, 28 November 2022, [8] (SCOI.82035).
[88] Exhibit 6, Tab 3, Statement of Sergeant Ismail Kirgiz, 28 November 2022, [6]-[7] (SCOI.82035).
[89] Exhibit 6, Tab 3, Statement of Sergeant Ismail Kirgiz, 28 November 2022, [12] (SCOI.82035).
[90] Exhibit 6, Tab 3, Statement of Sergeant Ismail Kirgiz, 28 November 2022, [14] (SCOI.82035).

62. The main protocol for interaction between the EHCU and other arms of the NSWPF, including the Homicide Squad and the UHT, is the Hate Incident Review Committee (**HIRC**). The HIRC was established in March 2021 and convenes fortnightly. It monitors all hate crime and hate incidents that have been assessed by the Hate Crime Team to require attention or follow-up.[91] The HIRC determines whether the EHCU will contact other investigators or PACs to "assist or encourage the progress of an investigation where it is considered necessary."[92]

63. Arms of the NSWPF are able to contact the EHCU if they wish to obtain advice on hate crime related matters.[93] The EHCU conducts hate crime awareness training at all LGBTIQ Liaison Officer (**GLLO**) training courses and liaises with GLLOs at relevant PACs if a hate crime incident is detected against a member or members of the LGBTIQ community.[94]

64. DCI Laidlaw was asked about the relationship between the UHT and the EHCU. Senior Counsel Assisting asked whether members of DCI Laidlaw's team dealt with the EHCU, and he said "[n]ot personally that I know of, no."[95] Senior Counsel Assisting asked whether it could be assumed, on the basis of that evidence, that any interaction between the EHCU and the UHT was "rare and not of a kind that would come to your attention as their supervisor." DCI Laidlaw then said he wouldn't say it was "rare" because "the [EHCU] is an intelligence-based unit, is my belief, is that our intel personnel that's attached to the [UHT] may engage with them to see whether there's information there that can assist our reviews."[96]

65. Senior Counsel Assisting then asked DCI Laidlaw whether he had misunderstood DCI Laidlaw's earlier evidence that in DCI Laidlaw's role as Investigation Coordinator, DCI Laidlaw was responsible for knowing the extent to which members of the Review Team engaged with the EHCU. DCI Laidlaw said that that evidence was correct, and that he could not say that people would come to him and say that they'd spoken to the EHCU.[97]

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[91] Exhibit 6, Tab 3, Statement of Sergeant Ismail Kirgiz, 28 November 2022, [16] (SCOI.82035).
[92] Exhibit 6, Tab 3, Statement of Sergeant Ismail Kirgiz, 28 November 2022, [17] (SCOI.82035).
[93] Exhibit 6, Tab 3, Statement of Sergeant Ismail Kirgiz, 28 November 2022, [19] (SCOI.82035).
[94] Exhibit 6, Tab 3, Statement of Sergeant Ismail Kirgiz, 28 November 2022, [20] (SCOI.82035).
[95] Transcript of the Inquiry, 7 July 2023, T5199.2-4 (TRA.00075.00001).
[96] Transcript of the Inquiry, 7 July 2023, T5199.17-31 (TRA.00075.00001).
[97] Transcript of the Inquiry, 7 July 2023, T5199.24-39 (TRA.00075.00001).

66. DCI Laidlaw had not himself ever spoken to his team about the availability of the EHCU as a resource, and had never been told about any occasion on which they had consulted with the EHCU.[98] He said he had never seen a document recording any communication between the EHCU and the UHT Review Team, although he said he would not necessarily expect this to be recorded on a triage document.[99]

B.3.1.1 Submissions concerning the role of the EHCU

67. The decision to contact the EHCU is one made by the investigating officer. It is, therefore, reliant on the investigating officer detecting signs that may indicate that a crime is a hate or bias crime.

68. As is set out at [156], in our submission there are real concerns in relation to the adequacy of the training provided to officers concerning the LGBTIQ community. It follows from that concern that officers may not be in a position to identify indicia of bias crime and to engage the EHCU. There does not appear to be any mechanism by which the EHCU, or any other person or team within the NSWPF, supervises or reviews the characterisation (or lack thereof) of matters as potential hate or bias crimes.

69. DCI Laidlaw gave evidence, as set out above, that he has not spoken to his team concerning the availability of the EHCU, and has never been told about any occasion where the UHT had consulted the EHCU, or seen any document recording engagement with the EHCU.

70. In our submission, the lack of meaningful engagement between the EHCU and the UHT is an unsatisfactory state of affairs. The role of the EHCU may be of particular significance in unsolved cases where ignorance or prejudice on the part of investigating officers may have led to hate crime factors being overlooked or ignored. The contribution of the EHCU may assist in discerning fruitful lines of Inquiry.

[98] Transcript of the Inquiry, 7 July 2023, T5199.41-47 (TRA.00075.00001).
[99] Transcript of the Inquiry, 7 July 2023, T5200.2-10 (TRA.00075.00001).

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

71. The role, function and structure of the Missing Persons Registry (**MPR**) has changed significantly over time.[100] DS Doherty explained in his statement that he understands that there have been significant improvements to the function and investigative capacity of the MPR following a number of internal reviews and coronial recommendations.[101]

72. The "Missing Friends Bureau" was established in 1930, and became the "Missing Persons Bureau" in around 1947, at which time it operated as a central recording agency for all missing persons including escaped psychiatric patients.[102] By 1974 a "Missing Persons Section" of the NSWPF was established and in around 1987 the "Missing Persons Section" was renamed the "Missing Persons Unit" (**MPU**).[103]

73. DS Doherty was not able to "uncover" any additional information about where the Missing Persons Unit sat within the operational structure of the NSWPF during the 1970s and 1980s, or its relationship with the Homicide Squad, but he observed that "internal police records suggest that a close liaison was maintained between the Missing Person Unit and the original Homicide Squad (under the CIB) in 1981."[104]

74. DS Doherty reviewed a number of documents concerning the SOPs from 2006 to 2013 in relation to missing persons in preparing his statement.[105] Those documents are in evidence before the Inquiry.[106] Missing persons cases were primarily investigated by the relevant Patrol or LAC (now PAC), and it was the responsibility of the Patrol or PAC to report the incident to the MPU.[107]

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[100] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [98] (NPL.9000.0006.0001).
[101] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [98] (NPL.9000.0006.0001).
[102] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [100]-[101] (NPL.9000.0006.0001).
[103] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [101] (NPL.9000.0006.0001).
[104] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [102] (NPL.9000.0006.0001). The document entitled "Crime Information and Intelligence System, Introduction of New Procedures respecting Missing Persons Unidentified Bodies and Unidentified Persons" referred to at [103] of Detective Superintendent Doherty's statement (Exhibit 51, Tab 1P, Crime Information and Intelligence System Procedures, 1985 (NPL.0100.0003.0001)) does not shed light on this matter. See also Transcript of the Inquiry, 6 July 2023, T5071.32-37 (TRA.00074.00001).
[105] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [105] (NPL.9000.0006.0001).
[106] Exhibit 51, Tab 1Q, Operational Information Agency, Missing Persons Unit, 16 July 2003 (NPL.0100.0003.0377); Exhibit 51, Tab 1R, Missing Persons, Policies and Procedures, 2007 (NPL.0125.0005.0001); Exhibit 51, Tab 1S, Missing Persons SOPS, 2013 (NPL.0100.0003.0218); Exhibit 51, Tab 1T, Missing Persons SOPS, June 2016 (NPL.0125.0005.0108).
[107] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [106] (NPL.9000.0006.0001).

75. The document entitled "Operational Information Agency, Missing Persons Unit" dated 16 July 2003 does not include any reference to the Homicide Squad.[108] By 2007, the equivalent policy document provided that if foul play was suspected in relation to a missing person, the duty officer and detectives should be briefed immediately so that a mandatory referral could be made to the Homicide Squad.[109] This instruction is repeated in the 2013 version of the document,[110] which also records that the MPU meets regularly with the Homicide Squad regarding suspicious cases.[111] At this time, it was the duty of the Crime Manager to manage suspicious missing persons cases and maintain liaison with the Homicide Squad.[112] The version of this document updated in 2016 records:[113]

> 3.1 State Crime Command Homicide Squad
>
> If foul play is suspected the Homicide Squad, State Crime Command is to be immediately notified. Consistent with the NSWPF Policy that during the first 72 hours of an investigation into a homicide or suspicious death the Homicide Squad should be the leading investigator unless and until the Homicide Squad decides otherwise, the on-call Homicide Squad Inspector will conduct an assessment and determine an appropriate response from the Homicide Squad.

76. In 2019, following a review of the MPU and a number of coronial recommendations, the NSWPF MPR was established "as an oversight unit for all NSW missing persons and unidentified bodies and human remains."[114] The SOPs concerning missing persons, unidentified bodies and human remains dated 2019, 2020, 2021 and 2022 are in evidence before the Inquiry.[115]

77. In his oral evidence, DS Doherty explained that until 2019 the PACs and the police districts would "own the investigation up to a certain point for a missing person" and that the MPU would provide guidance on how that would be managed through PACs or LACs. However, after 2019 the MPR evolved to have "complete oversight over missing persons".[116]

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[108] Exhibit 51, Tab 1Q, Operational Information Agency, Missing Persons Unit, 16 July 2003 (NPL.0100.0003.0377).
[109] Exhibit 51, Tab 1R, Missing Persons, Policies and Procedures, 2007, 7, 13, 24 (NPL.0125.0005.0001).
[110] Exhibit 51, Tab 1S, Missing Persons SOPS, 2013, 7, 8, 35 (NPL.0100.0003.0218).
[111] Exhibit 51, Tab 1S, Missing Persons SOPS, 2013, 4 (NPL.0100.0003.0218).
[112] Exhibit 51, Tab 1S, Missing Persons SOPS, 2013, 13 (NPL.0100.0003.0218).
[113] Exhibit 51, Tab 1T, Missing Persons SOPS, June 2016, 3 (NPL.0125.0005.0108).
[114] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [107] (NPL.9000.0006.0001).
[115] Exhibit 51, Tabs 1U-X, Missing Persons Unidentified Bodies and Human Remains SOPS dated 2019 (NPL.0100.0003.0494); 2020 (NPL.0125.0005.0033); 2021 (NPL.0100.0003.0262); and 2022 (NPL.0100.0003.0025).
[116] Transcript of the Inquiry, 6 July 2023, T5070.45-5071.9 (TRA.00074.00001).

78. At present, it is mandatory for there to be immediate notification to the on-call Homicide Inspector via the State Crime Coordinator where suspicious circumstances exist.[117] Missing persons, unidentified bodies and human remains investigations remain the responsibility of PACs/Police Districts unless investigative responsibility is accepted by the Homicide Squad.[118] The MPR provides assistance to an investigative team to coordinate the response on an investigation but does not assume responsibility for the investigation.[119]

79. DS Doherty said that the MPR works closely with the Homicide Squad, and that there is a lot of crossover and exchange of information between the two groups.[120] DS Doherty expressed the view that the MPR has "significantly improved" the response to an investigation of all missing persons.[121]

80. Matters involving long-term missing persons are reported to the Coroner within 12 months of the initial report being made.[122] At any subsequent inquest the Coroner may recommend a long-term missing persons case be referred to the UHT. If such a recommendation is made, management of the investigation will transfer to the Homicide Squad.[123] In his statement, DS Doherty said that the Homicide Squad has "a close relationship with the MPR," and that "[i]n recent years, the notification of suspicious missing persons matters to the Homicide Squad has greatly improved, enabling an earlier involvement and response if required".[124]

B.3.2.1 Submissions concerning the interaction between the Homicide Squad and MPR

81. In our submission, on DS Doherty's evidence, to the extent the cases before the Inquiry give rise to concerns about efficient communication and collaboration between the MPR and its predecessors and homicide investigators, it appears those concerns have been addressed through the present iteration of the MPR.

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[117] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [109] (NPL.9000.0006.0001); Exhibit 51, Tab 1X, Missing Persons Unidentified Bodies & Human Remains SOPS, 2022, 16 (NPL.0100.0003.0025).
[118] Exhibit 51, Tab 1X, Missing Persons Unidentified Bodies & Human Remains SOPS, 2022, 17 (NPL.0100.0003.0025).
[119] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [109] (NPL.9000.0006.0001).
[120] Transcript of the Inquiry, 6 July 2023, T5071.13-16 (TRA.00074.00001).
[121] Transcript of the Inquiry, 6 July 2023, T5075.7-11 (TRA.00074.00001).
[122] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [111] (NPL.9000.0006.0001).
[123] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [112] (NPL.9000.0006.0001).
[124] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [113] (NPL.9000.0006.0001).

B.3.3 Education and training of homicide detectives

B.3.3.1 Joining the Homicide Squad

82. In order to apply for the Homicide Squad, a person must have completed their detective training and achieved the designation of detective, and must possess "demonstrated experience in major crimes investigations."[125] DS Doherty said in his statement that "[a]s one of the most highly sought after squads in the NSWPF, the Homicide Squad receives a large number of expressions of interest from detectives within the NSWPF wishing to join the squad."[126] He said that many detectives possessed a broad range of qualifications and experience, including qualifications external to the NSWPF such as tertiary degrees and diplomas.[127]

83. In order to join the Homicide Squad, detectives submit an expression of interest which is then reviewed by the Homicide Squad Human Resources Panel (**Homicide Squad HR Panel**).[128] This is followed by an interview process. The Homicide Squad HR Panel then makes a recommendation to the Senior Management Team. If an officer is deemed suitable, they are accepted into the Homicide Squad subject to a psychological and professional standards risk assessment by the SCC and the successful completion of psychometric testing.[129]

84. DS Doherty said in his statement that he understood that between 1970 and 1996, it was always a requirement for officers investigating homicides to have achieved the designation of detective.[130] DS Doherty was asked by Senior Counsel Assisting about whether, in the 1990s, candidates were assessed by reference to the skills identified at [103] below, but he was unable to assist.[131]

B.3.3.2 Education and training

85. DS Doherty dealt with the training and education of homicide squad detectives in his statement. He annexed four documents to his statement which were utilised from the 1970s to the 1990s for the purposes of the NSW Police Homicide Detective Training Course:

    a. The first is entitled "Homicide". It appears to have been prepared in the 1970s. It concerns the distinction between lawful and unlawful homicides.[132]

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[125] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [115] (NPL.9000.0006.0001).
[126] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [116] (NPL.9000.0006.0001).
[127] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [116] (NPL.9000.0006.0001).
[128] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [118] (NPL.9000.0006.0001).
[129] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [120] (NPL.9000.0006.0001).
[130] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [122] (NPL.9000.0006.0001).
[131] Transcript of the Inquiry, 6 July 2023, T5049.25-29 (TRA.00074.00001).
[132] Exhibit 51, Tab 1Y, NSWPF Detectives Training Course, Undated, (NPL.0100.0003.0706).

b. The second is entitled "Homicide – Part I". It sets out the duties of both uniformed police and homicide detectives when called to the scene of a potential homicide.[133]

c. The third is entitled "Homicide – Part II" and sets out the duties of an Officer in Charge (**OIC**) at the scene, the body, and the investigation.[134]

d. The fourth is entitled "Homicide – Part III" and identifies further duties of an OIC, including in relation to exhibits. It identifies that not all investigations will require a specific OIC of exhibits, and that in smaller investigations this role can often be carried out by the OIC of running sheets.

86. These documents do not contain any reference to bias, hate crime, or engagement with the LGBTIQ community.

87. In 1996, the Homicide Investigators Course (**HIC**) was introduced as a consequence of recommendations from the then Standing Committee on Homicide.[135] In late 2005, the HIC was suspended while an application was made to obtain academic accreditation from Charles Sturt University and the NSWPF Academic Board. That process was finalised in mid-2008 and the HIC was re-introduced in December 2008.[136]

88. DS Doherty's evidence is that "the subject matter and focus of the Homicide Investigators Course has evolved over the years to address advancements in technology, improvements in police procedure and changes to the law."[137]

89. Although the completion of the course is not a prerequisite to joining the Homicide Squad, DS Doherty's experience is that most detectives who join the squad will have completed the course prior to joining.[138] At present the course runs over period of eight days with a final day of examinations.[139] Members of the Homicide Squad who have not completed the HIC prior to joining are required to complete it as soon as practicable after joining the Squad, and must have completed the course in order to become a supervisor and lead investigations.[140]

90. The HIC is open to all members of the NSWPF who fulfil the following requirements:[141]

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[133] Exhibit 51, Tab 1Y, NSWPF Detectives Training Course, Undated, (NPL.0100.0003.0706).
[134] Exhibit 51, Tab 1Y, NSWPF Detectives Training Course, Undated, (NPL.0100.0003.0706).
[135] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [124] (NPL.9000.0006.0001).
[136] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [125] (NPL.9000.0006.0001); Transcript of the Inquiry, 6 July 2023, T5083.34-39 (TRA.00074.00001).
[137] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [126] (NPL.9000.0006.0001).
[138] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [128] (NPL.9000.0006.0001).
[139] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [129] (NPL.9000.0006.0001).
[140] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [130] (NPL.9000.0006.0001).
[141] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [127] (NPL.9000.0006.0001).

a. The applicant must have completed the following courses;

   i. Investigators Course;

   ii. Advanced Diploma of Police Investigations; and

   iii. Detectives Designation Course (formerly the Detectives Education Program);

b. The applicant must have been placed into a designated detective position and occupy a permanent criminal investigator position within their Command; and

c. The applicant must have previously had substantial involvement in a homicide or suspicious death investigation.

91. DS Doherty was asked a number of questions by Senior Counsel Assisting about the content of the HIC. He said that there is no specific component of the course addressing bias crime, as there are other resources available to officers on that topic, but that the course deals with objectivity and open mindedness.[142] Similarly, there is no specific part of the course dealing with victims or witnesses from minority or marginalised communities, but DS Doherty said there were other optional training courses available dealing with that content.[143]

92. The 2022 HIC structure is in evidence before the Inquiry.[144] The key topics covered during the HIC are:

a. Crime scene management;

b. Canvassing and Searching;

c. Ballistics;

d. Initial Response & Homicide;

e. Establishing lines of inquiry and associated tasks;

f. Investigation planning/ management / leadership;

g. Utilising services provided by Forensic Services Group;

h. Forensic Pathology;

i. Role of the Homicide Investigator and Coronial Investigations;

j. Various types of Homicides;

[142] Transcript of the Inquiry, 6 July 2023, T5083.41-5084.18 (TRA.00074.00001).
[143] Transcript of the Inquiry, 6 July 2023, T5084.20-5084.45 (TRA.00074.00001).
[144] Exhibit 51, Tab 1Z, Homicide Investigators Course, 2022 (NPL.0100.0003.1161).

k. Unsolved Homicides;

l. Incident Room and Information Management;

m. Legislation relevant to homicide investigation; and

n. Legislation relevant to defence tactics in respect to homicide investigation.

93. In addition to the HIC, there are additional formal training courses available to members of the Homicide Squad.[145] DS Doherty also states that "as part of the application and interview process to join the Homicide Squad, all applicants are assessed to ensure they have suitable experience working on major crime investigations prior to joining the Homicide Squad."[146]

94. The Homicide Squad SCCC Induction Package dated March 2012 is in evidence before the Inquiry,[147] as is the Homicide Squad SCC Induction Package dated January 2020 (**2020 Induction Package**).[148] The 2020 Induction Package contains the following information concerning education and training:[149]

[145] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [127] (NPL.9000.0006.0001).
[146] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [127] (NPL.9000.0006.0001).
[147] Exhibit 51, Tab 1ZA, Homicide Squad Induction Package, 2012 (NPL.0100.0003.0151).
[148] Exhibit 51, Tab 1ZB, Homicide Squad Induction Package, 2020 (NPL.0100.0003.0184).
[149] Exhibit 51, Tab 1ZB, Homicide Squad Induction Package, 2020, 24 (NPL.0100.0003.0184).

95. DS Doherty gave evidence that there are mandatory courses that homicide detectives have to undertake each year, which are set by the Education and Training Command. Compliance is similarly monitored by the Education and Training Command.[150]

B.3.3.3 The value of tertiary qualifications

96. There is no requirement that members of the Homicide Squad have completed any form of tertiary education. However, many members of the Homicide Squad do have tertiary qualifications.[151]

97. AC Conroy was asked by Senior Counsel Assisting how the Bachelor of Policing had affected her approach to policing. She said that "[i]t assisted me with all avenues of policing in terms of investigative skill, community engagement, statement preparation, brief preparation...".[152]

98. Similarly, Superintendent Best was asked by Senior Counsel Assisting why he undertook the Bachelor of Policing. He said:[153]

> I saw that course and chose to do a course for personal development, and also with an understanding that it was going to be the future of policing and that those types of courses would be part of just general enrolment of becoming a police officer. So I saw that and to stay contemporary and then also for future promotion, that doing those sort of courses were requirements, essentially.

99. Senior Counsel Assisting asked DS Doherty what the value of detectives having tertiary degrees was. He said that it means that "they have more broad mindedness in terms of their abilities and what skill sets they have.... [a]nd I think it's good to have people with a tertiary background, as many as you can."[154]

B.3.3.4 Desirable qualities in a homicide investigator

100. In his oral evidence, and in response to questions from Senior Counsel Assisting, DI Warren agreed that professional curiosity is an important attribute for a homicide detective or other investigator, and that a detective should strive to avoid "blinkered" views" or "tunnel vision".[155] He said that an "open mind is the key thing there, and ensuring the way you interpret information, I think, is important as well."[156]

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[150] Transcript of the Inquiry, 6 July 2023, T5085.33-5086.2 (TRA.00074.00001).
[151] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [116] (NPL.9000.0006.0001).
[152] Transcript of the Inquiry, 4 July 2023, T4797.13-16 (TRA.00072.00001).
[153] Transcript of the Inquiry, 4 July 2023, T4869.13-20 (TRA.00072.00001).
[154] Transcript of the Inquiry, 6 July 2023, T5080.21-37 (TRA.00074.00001).
[155] Transcript of the Inquiry, 5 July 2023, T4951.26-30 (TRA.00073.00001).
[156] Transcript of the Inquiry, 5 July 2023, T4951.28-30 (TRA.00073.00001).

101. DI Warren was asked by Senior Counsel Assisting whether, in giving that evidence, he meant "that you might have tentative case theories but it is very important that case theories remain tentative", to which he agreed. He also agreed that this was because "you want to avoid making assumptions that are consistent with that case theory and perhaps overlooking signs that are inconsistent with that case theory."[157]

102. DI Warren agreed that if an investigator does not keep an open mind, they may overlook important lines of inquiry, and that this is also a reason why it is important to maintain objectivity and to avoid, as far as possible, rigid thinking.[158] He agreed that lateral thinking is valuable, and that there were good reasons not to be too prescriptive.[159] He agreed that there is a risk of confirmation bias, but said he did not know whether detectives were trained to be vigilant about the possibility of confirmation bias in the 1970s and 1980s.[160]

103. DS Doherty was taken by Senior Counsel Assisting to the Report of the Working Party Reviewing the Effect of Regionalisation on the Investigation of Homicides.[161] He was taken to a portion of the report that provided as follows:[162]

> The Working Party acknowledged the high level of expertise possessed by detectives performing duty in other fields. Nevertheless, it considers the investigation of homicide required both enhanced detective skills and, in addition, special expertise in other areas including:-
>
> * a penchant to detail:
> * the ability to assess the value of factors in isolation:
> * the ability to evaluate cumulatively:
> * the ability to conceptualise:
> * appreciation of forensic-medical matters particularly in relation to changes to the human body.
> * appreciation of social behaviour and, in particular, deviations from the accepted norm:
> * ability to plan, control and motivate lengthy complicated investigations:
> * extraordinary patience:
> * ability to prepare complicated reports and briefs:
> * an enhanced knowledge of the rules of evidence:

[157] Transcript of the Inquiry, 5 July 2023, T4951.38-42 (TRA.00073.00001).
[158] Transcript of the Inquiry, 5 July 2023, T4951.44-T4952.6 (TRA.00073.00001).
[159] Transcript of the Inquiry, 5 July 2023, T4952.8-16 (TRA.00073.00001).
[160] Transcript of the Inquiry, 5 July 2023, T4952.18-26 (TRA.00073.00001).
[161] Exhibit 51, Tab 1B, Report of the Working Party, February 1990 (NPL.0100.0003.0830).
[162] Exhibit 51, Tab 1B, Report of the Working Party, February 1990, 10-11 (NPL.0100.0003.0830).

* an ability to present evidence under the most stringent conditions.

Some of these skills spring from the individual personality and cannot be acquired by training. Many are sheer anathemas to detectives engaged in other fields of investigation.

104. DS Doherty confirmed that these qualities were recognised as important in the 1970s, 1980s and 1990s.[163] He said that the Homicide Squad has always been regarded highly and that it was often the case that those who finished in the top percentage of the Detectives Course would be recruited for the Homicide Squad. He said, "it was trying to get the right person for the job that's going to be very difficult to work in, it's very challenging working and they wanted to try to get a certain person and expertise."[164]

105. Later, in response to questions from Senior Counsel Assisting, DS Doherty agreed that accuracy and precision in record keeping, keeping an open mind and being vigilant to set aside personal beliefs or biases were important skills for detectives in the Homicide Squad, in addition to treating witnesses and persons of interest with respect, having professional curiosity, striving to avoid blinkered views or tunnel vision, and maintaining objectivity (including avoiding assumptions that might lead to important lines of inquiry being ignored).[165]

106. He agreed that it was important to avoid rigid thinking, and that investigators needed to be vigilant about confirmation bias or a tendency to fit facts to a case theory instead of recognising that evidence may point towards a different theory. He also agreed that it was important that investigators be vigilant in relation to conscious or unconscious bias against members of particular communities, because that may affect the quality of an investigation.[166] The question of conscious or subconscious bias is returned to in Pt B.3.3.8 below.

B.3.3.5 The value of cultural awareness

107. During the course of his oral evidence, DI Warren was asked a number of questions by Senior Counsel Assisting concerning the value of cultural awareness for homicide detectives. DI Warren agreed that knowledge about a community may assist investigators in making an informed judgement about fruitful lines of inquiry in investigations involving members of that community: an example of relevance to the Inquiry being recognising that an area might be a beat.[167]

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[163] Transcript of the Inquiry, 6 July 2023, T5046.16-41 (TRA.00074.00001).
[164] Transcript of the Inquiry, 6 July 2023, T5047.35-5048.1 (TRA.00074.00001).
[165] Transcript of the Inquiry, 6 July 2023, T5076.19-5077.6 (TRA.00074.00001).
[166] Transcript of the Inquiry, 6 July 2023, T5077.12-33 (TRA.00074.00001).
[167] Transcript of the Inquiry, 5 July 2023, T4953.13-24 (TRA.00073.00001).

108. In addition, DI Warren agreed that another reason that cultural awareness or open mindedness is important is that investigators with "broader horizons and more open minds will tend to be more professionally curious and perceive lines of inquiry that a narrow minded investigator might overlook."[168] DI Warren also agreed with the proposition that "a climate of trust and confidence between police and members of that community will tend to facilitate the flow of information towards the police from members of that community."[169] Similarly, he agreed that a climate of suspicion or distrust may hamper the flow of information.[170] DS Doherty agreed that cultural awareness is important for the same reasons.[171]

B.3.3.6 Education and training of investigators concerning conscious and subconscious bias, and the potential impact of bias on investigations

109. As set out above, DI Warren acknowledged in his evidence that during training as a detective "it was always instilled to keep that open mind and not to, I guess, lock in on a particular issue because that can cause you to, I guess, yes, as you are saying, a bias toward that particular view."[172] It is not controversial that, over the period of the Inquiry's Terms of Reference, homophobia existed within both the broader community and within the NSWPF.

110. The importance of maintaining open mindedness and the existence of homophobia within both society and the NSWPF raised two interconnected issues. The *first* is the impact that conscious or unconscious bias may have had on investigations. The *second* is to what extent training, education and supervision equipped officers to avoid conscious or unconscious bias.

111. Superintendent Best was asked by Senior Counsel Assisting whether he, and officers more generally, received training about conscious and unconscious bias. He said that they did.[173] He was also asked whether there was a risk of a Crime Scene Officer or an OIC, making a judgement (whether intentional or unintentional) based, in part, on a perception that a victim might be more sympathetic. Superintendent Best said:[174]

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[168] Transcript of the Inquiry, 5 July 2023, T4953.26-32 (TRA.00073.00001).
[169] Transcript of the Inquiry, 5 July 2023, T4952.45-4953.7 (TRA.00073.00001).
[170] Transcript of the Inquiry, 5 July 2023, T4953.9-11 (TRA.00073.00001).
[171] Transcript of the Inquiry, 6 July 2023, T5077.35-5078.4 (TRA.00074.00001).
[172] Transcript of the Inquiry, 5 July 2023, T4952.28-34 (TRA.00073.00001).
[173] Transcript of the Inquiry, 4 July 2023, T4884.28-41 (TRA.00072.00001).
[174] Transcript of the Inquiry, 4 July 2023, T4885.8-21 (TRA.00072.00001).

> No, I don't think that would happen. I don't think – our staff don't get exposed to the victims, you know? Our staff are – the way – the reason that they are able to survive in our world, in that world of crime scene, is that disconnect and they just come to it with a scientific mind and they approach it as a complex puzzle to make sense of. Not necessarily deliberately, but the very dynamics of a crime scene and the way that they are managed, they are excluded from that world of victims. They are certainly not interviewing victims, speaking to them. They do see that and I think we would have more issues of officers struggling with our environment and the trauma that they are exposed to if they were, additionally, exposed to the traumas of the victims.

112. Superintendent Best said he was unaware of whether there was an appreciation of a risk that officers would take greater care in relation to a sympathetic victim or, conversely, that they might take less care in relation to an unsympathetic victim.[175]

113. In re-examination by Mr Tedeschi KC, on behalf of the Commissioner of the NSWPF, Superintendent Best was asked what he would say to the proposition that in some individual officers there might be an impulse or tendency to work harder and be more thorough in relation to sympathetic victims. He said:[176]

> It's not something that I have experienced. In relation to my investigations, it's about achieving a positive outcome and that notion of making sure that the truth of the matter is exposed and known. But perhaps that notion of extra effort, some of the cases that I've been involved with certainly touch you on some level, but I don't know that that necessarily equates to an investigation that would be any different other than the way that it touches you as an investigator going through that. You are still doing the processes, you are still looking for those outcomes, and it's just that some cases perhaps have an effect on you more than others. I can't think of any time that I've investigated a crime and given it less because perhaps I didn't like the victim or some issue like that.

114. He said that he couldn't think of an example of this kind of behaviour in his investigator colleagues, though he acknowledged that his experience may not be indicative of the whole NSWPF.[177]

115. Senior Counsel Assisting also put to DI Warren the risk that some investigators – perhaps inadvertently – might work harder or be more thorough when dealing with someone they perceive to be a sympathetic victim. He agreed that this was a possibility.[178] He said he could not assist the Commissioner with whether officers in the 1970s and 1980s had been vigilant in relation to such matters, but that from the late 1990s onwards there had been greater consciousness of these issues and more supervision and oversight of investigations.[179]

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[175] Transcript of the Inquiry, 5 July 2023, T4926.10-19 (TRA.00073.00001).
[176] Transcript of the Inquiry, 5 July 2023, T4942.40-4943.8 (TRA.00073.00001).
[177] Transcript of the Inquiry, 5 July 2023, T4943.10-18 (TRA.00073.00001).
[178] Transcript of the Inquiry, 5 July 2023, T4953.34-40 (TRA.00073.00001).
[179] Transcript of the Inquiry, 5 July 2023, T4953.42-4954.11 (TRA.00073.00001).

116. Senior Counsel Assisting asked DS Doherty the same question. He said that:[180]

> Just from my own experience, you know, again, it's human nature when certain victims – and that's well known, if it is a young boy or girl gets murdered or – and there is a lot more media interest or public interest, there's always going to be a lot more reaction and sympathetic reaction, but in terms of an investigation, you have to remain completely mind of the fact you have to be objective.
>
> And I have seen that many a time. Not only with the LGBTIQ community where we've had many instances where we've dealt with victims who have been murdered from that community and resolved those matters, but also, conversely, where sympathy might be difficult to achieve from a community's perspective, for example, we've had victims from who are alleged paedophiles, alleged terrorists, alleged murderers, alleged major crime figures, and we still treat that person as a human being. We do our best to be empathetic with the family, we actually are empathetic with the family. We treat that and work tirelessly in those matters as in any other matter. So I think it is a point where whilst it is a challenge in certain areas not to be influenced by an outburst of emotion through some high-profile public issue, an investigator has to maintain objectivity, and I think, from those examples, we have to be objective in our approach.

117. DS Doherty was asked how one trains and educates detectives to ensure that they are able to maintain objectivity. DS Doherty said that "some of that's from just internally and through our own training, but also a lot of that objectivity and open mindedness and – in the way we deal with that is on the homicide course, but also in terms of general training … and it's about being objective and treating every person on their own merit."[181] He said that the quality of training in relation to these matters had improved over time.[182]

118. In relation to the UHT, Senior Counsel Assisting asked DCI Laidlaw whether it was important for people screening or reviewing cases to be vigilant about conscious or unconscious bias. He agreed that it was, and said that in terms of training there was the HATE Crimes Awareness Module on PETE and then a "customer service face-to-face which brings into account unconscious and conscious bias."[183] He agreed that conscious or unconscious bias can affect the way investigators approach cases, and there is a risk that someone with a conscious or unconscious bias might more readily conclude that a death is not suspicious, and that investigators might work faster where they think of a victim as sympathetic.[184]

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[180] Transcript of the Inquiry, 6 July 2023, T5078.25-5079.4 (TRA.00074.00001).
[181] Transcript of the Inquiry, 6 July 2023, T5079.8-15 (TRA.00074.00001).
[182] Transcript of the Inquiry, 6 July 2023, T5079.17-19 (TRA.00074.00001).
[183] Transcript of the Inquiry, 6 July 2023, T5133.9-16 (TRA.00074.00001).
[184] Transcript of the Inquiry, 6 July 2023, T5132.39-42 (TRA.00074.00001).

119. Senior Counsel Assisting asked DCI Laidlaw whether there was a system of management or oversight to combat the risk of conscious or unconscious bias. DCI Laidlaw said that there is "a review committee that reviews all of the reviewed material", and that quality assurance is undertaken by a senior investigator within the UHT. The quality assurance document and the triage document are placed before the UHT Review Committee. DCI Laidlaw said that the UHT Review Committee does not specifically look for conscious or unconscious bias, but that those on the committee are aware of it as experienced detectives and investigators.[185]

120. DCI Laidlaw was not able to assist in relation to the supervision or oversight that occurred before 2018.[186] He said that at present the Review Committee looks at a review after a review has been completed, and that a triage document is reviewed by DCI Laidlaw and the other investigation coordinators.[187]

B.3.3.7 Examples before the Inquiry in relation to historical and present failures in relation to cultural awareness and sensitivity

121. The Inquiry has received evidence of a number of specific instances in which, in our submission, the conduct of officers fell short of what is to be expected. Many of the instances of homophobia or insensitivity are historical. They include:

    a. the insensitive and prurient questioning of Mr Brooks in relation to the death of Kenneth Brennan;[188]

    b. the description of Walter Bedser as "a cat" and of another man questioned by police as a "dead set poofter";[189]

    c. disparaging comments made about Mr Meek to his daughters;[190]

    d. the reference by an officer in the investigation into Mr Meek's death to the "gay or paedophile movement";[191]

    e. references to Samantha Raye as "it" (e.g., "it was wearing a mans Lorus brand digital wrist watch";[192]

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[185] Transcript of the Inquiry, 6 July 2023, T5133.44-5134.27 (TRA.00074.00001).
[186] Transcript of the Inquiry, 6 July 2023, T5135.18-26 (TRA.00074.00001).
[187] Transcript of the Inquiry, 6 July 2023, T5136.24-39 (TRA.00074.00001).
[188] See Submissions of Counsel Assisting, 23 June 2023, [29] (SCOI.84129).
[189] See Submissions of Counsel Assisting, 23 May 2023, [13] (SCOI.83249).
[190] Exhibit 35, Tab 22B, Letter from Blessington Judd to Commissioner of Police, 29 August 1995, 2 (SCOI.02729.00026).
[191] Exhibit 35, Tab 53, Transcript of ERISP with NP220, 23 March 1995, Q171-A172 (SCOI.10012.00008).
[192] Submissions of Counsel Assisting, 24 March 2023, [118] (SCOI.45171); Exhibit 17, Tab 18, Statement of Constable Wilcher, 8 May 1989 [6] (SCOI.11038.00027); Exhibit 17, Tab 19, Statement of Constable Duncombe, 8 May 1989, [4] (SCOI.11038.00028).

f. continual references to Wendy Waine as "he" or to her former name, and the treatment of her name, Wendy Waine/Wayne, as a nickname or alias.[193]

122. Regrettably, however, not every instance of an absence of cultural awareness and sensitivity is historical. As is set out at Pt 29.1 below, the UHT Review Form completed in 2021 relation to Samantha Rose, a trans woman, contains language which DCI Laidlaw accepted was not acceptable.[194] The issue of appropriate education in relation to matters such as appropriate and inclusive language is returned to at Pt B.3.5 below.

B.3.3.8 The relevance of conscious or unconscious bias

123. The NSWPF has itself acknowledged that, historically, homophobic attitudes were present within the NSWPF. The relationship, historical and present, between the LGBTIQ community and the NSWPF is canvassed at [158]-[192] of the submissions of Counsel Assisting dated 7 June 2023 (**PH2 Submissions**). As noted above, this leads to the question of whether, and if so to what extent, conscious or unconscious bias may have affected decision making in relation to matters such as investigative steps, exhibit management, and record retention and destruction.

124. In the 1970s and 1980s the decision to retain exhibits in each particular case was a decision to be made by the OIC.[195] AC Conroy was asked whether she could assist the Inquiry with the extent to which those judgements could have been affected by conscious or unconscious bias. She said she could not assist with that, and could not comment on whether there was a risk that the judgements of an OIC would be infected by conscious or unconscious bias against a particular community.[196]

125. Senior Counsel Assisting asked AC Conroy whether, knowing what is now known about police attitudes and the attitudes of the wider community in the 1970s and 1980s towards LGBTIQ people, she was able to comment on whether the Commissioner could infer that there is a significant prospect that some OICs were affected by conscious or unconscious bias. She said she was not able to do so, and was likewise unable to comment in relation to the 1990s and the 2000s.[197]

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[193] Submissions of Counsel Assisting, 9 June 2023, [17] (SCOI.83653); Exhibit 30, Tab 67A, UHT Case Screening Form, February 2005 (SCOI.02706).
[194] Transcript of the Inquiry, 7 July 2023, T5236.10-31 (TRA.00075.00001).
[195] Transcript of the Inquiry, 4 July 2023, T4821.3-7 (TRA.00072.00001).
[196] Transcript of the Inquiry, 4 July 2023, T4821.12-23 (TRA.00072.00001).
[197] Transcript of the Inquiry, 4 July 2023, T4821.25-45 (TRA.00072.00001).

126. Senior Counsel Assisting asked AC Conroy, having taken her through a number of matters where exhibits had been lost or destroyed, whether there was any way of knowing whether the volume of missing exhibits was indicative of the volume of missing exhibits in cases of the same age generally, or whether there were a greater volume of lost exhibits where victims were suspected members of the LGBTIQ community. AC Conroy said that she did not know.[198] She said she could not comment on the possibility that there are more missing exhibits where victims are members of the LGBTIQ community, or on whether there was any way of assessing the extent to which bias may have affected exhibit retention practices.

B.3.3.9 Submissions concerning conscious and unconscious bias

127. As is dealt with in Part D, in a wide range of cases considered by the Inquiry, Counsel Assisting has made submissions concerning the loss or destruction of documentary or evidentiary material, and the failure by police to take particular investigative steps in those cases. In this section, we will deal *first* with investigative steps, and *second* with decisions made concerning exhibit or document management.

128. It may well be impossible for a conclusion to be reached that any specific investigative decision or omission was motivated by conscious or unconscious bias. However, given the evidence that conscious or unconscious bias was prevalent in the NSWPF in the 1970s and 1980s, and was not wholly eradicated in the 1990s or 2000s, the possibility that conscious or unconscious bias directed to members of the LGBTIQ community affected investigative decisions cannot be discounted. Especially in those cases where there are records indicative of bias by particular officers (such as the cases referred to at paragraph [121]), that possibility should be recognised to be a material one.

129. It is important that this possibility be acknowledged, even if firm conclusions cannot be reached in individual cases. As is set out in more detail in Part D below, DI Warren accepted that in a significant number of cases before the Inquiry the conduct of the investigating officers was not consistent with proper police practice.

[198] Transcript of the Inquiry, 4 July 2023, T4861.34-47 (TRA.00072.00001).

130. It is not possible to know, from the evidence before the Inquiry, why the conduct of those officers was not consistent with proper police practice, or whether this type of conduct was more common in cases where the victim was or was perceived to be a member of the LGBTIQ community. However, no finding need be made in relation to individual cases in order for the observation to be made that it is possible, and indeed likely, that officers investigating some of the cases considered by the Inquiry were affected by conscious or unconscious bias.

131. To turn to the *second* matter dealt with in this section, it is likewise not possible to know, from the evidence before the Inquiry, whether the problems with lost or destroyed exhibits and records affect a greater number of cases where the victims were members of the LGBTIQ community or were perceived to be members of the LGBTIQ community. The evidence before the Inquiry, and particularly the Lehmann Report (discussed in Pt C.7.1), supports the proposition that it is a common experience of the UHT to discover that exhibits or records are missing or have been destroyed.

132. Nevertheless, given the evidence that conscious or unconscious bias was prevalent in the NSWPF in the 1970s and 1980s, and was not wholly eradicated in the 1990s or 2000s, there is a real possibility that the decisions made by individual OICs in relation to cases concerning members or perceived members of the LGBTIQ community were affected by conscious or unconscious bias.

133. The extent of and the effect of such bias, and whether it could be said to have been systemic during the period considered by the Inquiry, is likely unknowable. However, the number of cases before the Inquiry affected by the loss or destruction of investigative material, and the impact this has had upon the work of the Inquiry, requires that this possibility be acknowledged, particularly having regard to what is known concerning the attitudes of the NSWPF (and aspects of the broader community) during periods covered by the Inquiry's Terms of Reference.

134. Finally, in our submission the existence of homophobia in broader society is insufficient to explain, and certainly insufficient to justify, the possible effect of homophobia on police investigations, and on exhibit and document management.

135. The duty of a police force to the community requires officers to set aside their personal beliefs or prejudices in order to discharge their obligations to the community they are sworn to serve. Although the police officers are entitled to respect for the role they play in protecting the community, the obligations assumed by officers are accompanied by privileges intended to assist them in carrying out their sworn duties. 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.

136. A core aspect of the duty of police officers to the community is to treat all victims of crime as equally deserving of justice, irrespective of their personal characteristics. Although the extent and impact of homophobia in relation to each individual death will never be known, the real possibility that homophobia affected the way investigations were managed is, in itself, a grave matter.

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

137. The matters considered above raise the question of what education and training is presently available to NSWPF officers concerning hate crime, conscious and unconscious bias and the LGBTIQ community. Although each of these topics is distinct, there are a number of overlaps and intersections.

138. It is uncontroversial that the detection and investigation of hate crimes is an important matter. Hate crime is abhorrent. Not only does hate crime have grievous and long lasting impacts on individuals, it terrorises – and is intended to terrorise – communities who are already frequently vulnerable or marginalised. It is crucial that NSWPF officers are alert to signs that a crime may be a hate crime.

139. The Inquiry received evidence that training in relation to hate crimes (including LGBTIQ hate crimes) is made available to all members of the NSWPF.[199] In his statement, DS Doherty said that this training comprised an online module called the "HATE Crime Awareness Course".[200] He said that this training was mandatory. However, in his oral evidence DS Doherty accepted that he had been wrong and that the online module was optional, although he recalled mandatory training in relation to bias and victim support.[201]

[199] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [136] (NPL.9000.0006.0001).
[200] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [137] (NPL.9000.0006.0001).
[201] Transcript of the Inquiry, 6 July 2023, T5087.22-5088.16 (TRA.00074.00001).

140. DI Warren explained in his evidence that the NSWPF utilises PETE to provide education in relation to a wide range of topics including LGBTIQ awareness.[202] He said that officers are subject to mandatory continuing training requirements, and also have access to optional education courses, ordinarily in the form of a PowerPoint or a video presentation, which may run for anything from ten minutes to an hour.[203]

141. DS Doherty said in his statement that the HATE Crime Awareness Course module is intended to give officers an overview and understanding of hate crimes, including the definition of hate crime, and to educate officers on hate crime legislation, how to report crimes which may have been motivated by hate or bias on the COPS system, how the NSWPF can support and assist victims of hate crimes, and to develop knowledge around hate crimes, including activities to "provide officers with the mindset and skills required to help prevent, disrupt and respond to hate crimes."[204]

142. In response to a question from the Commissioner, DS Doherty said that the online module would take under an hour.[205] Senior Counsel Assisting asked DS Doherty whether he had completed the module and, if so, when he had completed it. He said he had, although he could not recall with any precision when. He agreed that he had taken it less than four years ago but more than one year ago. He recalled it was scenario-based, but could not recall whether there were any questions at the end. He said that as it was an optional course, a supervisor would not be expected to make sure that officers had completed it.[206]

143. On 28 October 2019, Superintendent Best attended a day long, in-person LGBTIQ awareness course. He described the content as comprising:[207]

> ...awareness of the community and the challenges they faced, certainly in relation to historical aspects, and how people might feel towards police based upon what had happened in the past, and that notion of regardless of what you might feel personally, the fact that you're wearing a uniform might elicit responses that aren't directed to you as an individual but to you as a member of an organisation that has had a troubled or challenging past with that organisation – with that group of people.

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[202] Transcript of the Inquiry, 5 July 2023, T4954.28-45 (TRA.00073.00001).
[203] Transcript of the Inquiry, 5 July 2023, T4955.7-4956.15 (TRA.00073.00001).
[204] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [138] (NPL.9000.0006.0001).
[205] Transcript of the Inquiry, 6 July 2023, T5088.25-27 (TRA.00074.00001).
[206] Transcript of the Inquiry, 6 July 2023, T5089.25-39 (TRA.00074.00001).
[207] Transcript of the Inquiry, 4 July 2023, T4869.34-43 (TRA.00072.00001).

144. Senior Counsel Assisting asked Superintendent Best whether the course had influenced his policing practice, and he said "[p]ersonally for me as an individual, no, because I had that clarity already. So I had already come to that understanding through just my exposure to that community over time."[208] It is notable that Superintendent Best appeared to have a far clearer recollection of this course, and its content, than DS Doherty did of the online HATE Crime Awareness Course module.

145. In addition to the online module available on PETE, a component on bias, unconscious bias perception, and dealing with victims is included in the Mandatory Continuing Police Education in relation to victim support (which is made up of six online modules that all NSWPF officers are required to complete).[209] These modules, in addition to the HATE Crime Awareness Course, relate to bias crime in general, and have a greater focus on victim support than on investigating deaths.[210]

146. The training provided to homicide detectives, including as part of the HIC, is subject to regular review. The HIC is reviewed at least every three years by the Education Development Unit within the People & Capability Command. DS Doherty gives the example of the practical scenario-based training aspect of the course, which he says "has been recently updated to further emphasise the importance of keeping an open mind in the course of a homicide investigation."[211]

147. DS Doherty said in his statement that if lines of inquiry during an investigation suggest a death may have been motivated by hate, prejudice or bias towards the LGBTIQ community, then the Homicide Squad will engage with the EHCU as a "key intelligence tool."[212] He said:[213]

> The assessment of potential perpetrator-motivations is a core part of a homicide detective's role; experienced detectives – particularly those within the homicide squad – are well versed in seeking indicators of motivation, which may assist in determining who committed a particular crime and, in turn, determining the appropriate charge to lay. The possibility that anti-LGBTIQ+ bias may have played a role in serious crime (including homicides) has been the subject of increased focus and discussion within the Homicide Squad in recent years.

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[208] Transcript of the Inquiry, 4 July 2023, T4870.7-13 (TRA.00072.00001).
[209] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [139] (NPL.9000.0006.0001).
[210] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [140] (NPL.9000.0006.0001).
[211] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [146] (NPL.9000.0006.0001).
[212] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [141] (NPL.9000.0006.0001).
[213] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [142] (NPL.9000.0006.0001).

148. Sergeant Kirgiz gave evidence to the Inquiry on 13 December 2022. He said that frontline police officers have access to the Hate Crime Guidelines dated April 2022 (should they require them), which were disseminated through a state-wide Nemesis message (Nemesis is an internal messaging service used by the NSWPF which goes to every sworn and unsworn officer in the State).[214]

149. Sergeant Kirgiz gave evidence that the Guidelines are actively promoted to frontline officers, disseminated as part of the online HATE Crime Awareness Course discussed above, and were also presented by the EHCU as part of a roll out to ten PACs with the most instances of hate crime. The specific roll out to those ten PACs involved a presentation that goes from 40 minutes to one hour with frontline officers and supervisors.[215] His evidence was that apart from his three-week induction period in the EHCU, he had not previously had any training with respect to hate crime.[216]

150. Sergeant Kirgiz explained that the EHCU provides training to officers concerning identifying and recording bias crimes. It delivers both internal and external training packages. The training packages were modelled around the recommendations of Strike Force Parrabell, and informed by a research study commissioned by Assistant Commissioner Anthony Crandell (**AC Crandell**) in accordance with the recommendations of Strike Force Parrabell.[217]

151. The EHCU also undertook a body of research that included online meetings with other police forces and a review of documents from police forces and prosecuting bodies in the United Kingdom (**UK**) and the United States of America (**USA**).[218] This research led to the development of the Hate Crime Guidelines, and online HATE Crime Awareness Course.[219]

152. The EHCU also delivers presentations during mandatory training days.[220] In addition, it sends out state-wide Nemesis messages concerning any changes to WebCOPS that are hate crime related, or any new laws or procedures.[221]

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[214] Transcript of the Inquiry, 13 December 2022, T1268.20-30 (TRA.00016.00001).
[215] Transcript of the Inquiry, 13 December 2022, T1268.36-43, 1277.6-33 (TRA.00016.00001).
[216] Transcript of the Inquiry, 13 December 2022, T1253.31-43 (TRA.00016.00001).
[217] Exhibit 6, Tab 3, Statement of Sergeant Ismail Kirgiz, 28 November 2022, [25] (SCOI.82035).
[218] Exhibit 6, Tab 3, Statement of Sergeant Ismail Kirgiz, 28 November 2022, [27] (SCOI.82035).
[219] Exhibit 6, Tab 3, Statement of Sergeant Ismail Kirgiz, 28 November 2022, [28] (SCOI.82035).
[220] Exhibit 6, Tab 3, Statement of Sergeant Ismail Kirgiz, 28 November 2022, [28] (SCOI.82035).
[221] Exhibit 6, Tab 3, Statement of Sergeant Ismail Kirgiz, 28 November 2022, [28] (SCOI.82035).

153. AC Crandell gave evidence to the Inquiry on 12 December 2022. He said that in 2018 he believed the NSWPF could improve the education component in relation to bias crimes, as was indicated in the recommendation of Strike Force Parrabell.[222] He expressed the view, that since the publication of the Strike Force Parrabell report, he has seen real changes in the greater commitment of education throughout NSWPF and "particularly criminal investigative training and general training of police offices through investigators courses that now contain bias crime components", and specifically, within the investigators course, the detectives training and the detectives designation course, there are now modules on bias crime.[223]

154. In addition to general training being boosted with bias crime components, AC Crandell also stated that there is a gay and lesbian liaison course, which already had a bias crime component and a forthcoming adult sexual assault investigation course which will incorporate a bias crimes component.[224] DS Doherty similarly referred to the Gay and Lesbian Liaison Officer Course in his oral evidence.[225]

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

155. At present, there is no mandatory education of NSWPF officers concerning the LGBTIQ community. The online awareness module focuses on hate crime, not the LGBTIQ community. It is notable that of all the NSWPF witnesses who gave evidence that they had received training concerning the LGBTIQ community, the witness who recalled the content of that training most clearly was Superintendent Best, who had attended an in-person module focussed on the LGBTIQ community.

156. In our submission, the present education provided to homicide detectives concerning the LGBTIQ community is insufficient. In making this submission, no criticism of the EHCU is intended. However, the work of the EHCU relies upon officers engaging voluntarily with material, the majority of which appears to be provided in an online format. It is the officers who may be most in need of this education and training who are unlikely to voluntarily undertake it.

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[222] Transcript of the Inquiry, 12 December 2022, T1066.45-1068.31 (TRA.00015.00001).
[223] Transcript of the Inquiry, 12 December 2022, T1067.34-1068.31, 1070.2-11 (TRA.00015.00001).
[224] Transcript of the Inquiry, 12 December 2022, T1067.44-1068.4 (TRA.00015.00001).
[225] Transcript of the Inquiry, 6 July 2023, T5090.8-24 (TRA.00074.00001).

157. The Inquiry has received a substantial volume of evidence concerning the historical attitude of the NSWPF, or some officers within the NSWPF, to members of the LGBTIQ community. This history necessarily affects interactions between the NSWPF and the LGBTIQ community, and is a matter of which officers should be aware. An absence of appreciation of this history may leave officers poorly equipped to deal respectfully and constructively with members of the LGBTIQ community.

158. In addition, as set out at [147] above, DS Doherty's evidence was that experienced detectives "are well versed in seeking indicators of motivation". We submit, however, that consistent with the evidence at [107]-[108] above, cultural awareness in relation to the LGBTIQ community may be of central importance to understanding the relevance of particular information, or to identifying what matters at a crime scene are of significance. If officers are not aware of, for example, locations and language of significance to the LGBTIQ community, then it is not clear how they are equipped to detect potential indicators of hate crime in that context.

159. In our submission, consideration should be given to a recommendation 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.

160. The problems with education of officers in relation to the LGBTIQ community may well extend to education concerning other marginalised communities, but that is not a matter within the scope of the Inquiry's Terms of Reference.

B.4 Forensic techniques available in homicide investigations

B.4.1 The forensic testing of exhibits

B.4.1.1 Introduction

161. Forensic testing is a broad term that encompasses many specialised scientific disciplines. It can involve medical, chemical, toxicological, or other expert examination or tests performed on physical evidence, including DNA testing and ballistics, to determine the association of evidence to a crime scene or other incident. Forensic testing has a long history and has evolved with developments in science and technology.

162. This section of Counsel Assisting's submissions addresses:

a. the developments in DNA technology and forensic science between 1970 and 2010, and (where applicable) as at the present day, including the relevance of those developments to the investigation of unsolved homicides or cold case investigations;

b. the procedures followed by the NSWPF in respect of arranging the forensic testing of exhibits in relation to the period from 1970 to 2010, and also in respect of the present day; and

c. the arrangements the NSWPF has in place with FASS for the testing of exhibits.

B.4.2 Evolution of DNA testing in NSW

163. One of the key developments in forensic science since 1970 has been the development of DNA testing and technology. It appears that the ability to test an item for DNA started to emerge in the 1980s. However, according to Ms Neville, prior to 1989 any item that needed to be tested for DNA was sent overseas.[226] Ms Neville confirmed in oral evidence that this did occur in practice, although she believed it only occurred rarely.[227]

164. FASS itself started to do DNA testing in around 1989/1990 using technique called Restriction Fragment Length Polymorphism (RFLP). According to Ms Neville, this technique "provided a capability for discrimination but was limited by requiring large sample sizes of good quality DNA"[228] (ideally a sample approximately as large as or larger than a 20c piece[229]) and it was rare and labour intensive.[230] It also relied on matching DNA to a specifically nominated person, as there was no DNA database to compare samples against until 2000.[231]

165. In around 1994 or 1995, a new testing method involving Polymerase Chain Reaction (**PCR**) was introduced at FASS.[232] Ms Neville described PCR as having many advantages over the RFLP method, including in relation to its ability to "amplify degraded DNA"[233] but noted that at least initially, it had a "low discriminating power between individuals".[234]

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[226] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [34] (SCOI.83528).
[227] Transcript of the Inquiry, 15 August 2023, T5503.6-8 (TRA.00082.00001).
[228] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [35] (SCOI.83528).
[229] Transcript of the Inquiry, 15 August 2023, T5502.38-40 (TRA.00082.00001)
[230] Transcript of the Inquiry, 15 August 2023, T5502.34-45 (TRA.00082.00001).
[231] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [35] (SCOI.83528).
[232] Transcript of the Inquiry, 15 August 2023, T5503.10-21 (TRA.00074.00001).
[233] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [36] (SCOI.83528).
[234] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [37] (SCOI.83528); See also Transcript of the Inquiry, 15 August 2023, T5503.10-21 (TRA.00082.00001).

166. To overcome these limitations, and in order to operate with DNA of a lesser quality and quantity, a different type of PCR testing was developed which involved the use of short tandem repeats (**STR**) "markers".[235] According to Ms Neville, this is now the "method of choice".[236] In the course of oral evidence, Ms Neville described the use of STR markers in the following way:[237]

> ... when we're looking at DNA, we're looking at a number of areas on the DNA. So... if I look at one marker, I'm looking at one area on the DNA which is different between different people. So, it might be like looking at one characteristic, to say you have brown eyes. I'm just looking at one area on the DNA to say what type the person has at that marker.
>
> If I look at two markers, I'm getting more information about the person. So, you have brown eyes and curly hair. So, each time I add a marker, I'm adding another characteristic to inform about that person's characteristics.
>
> ...
>
> If I was doing a statistical calculation to determine how many people in the population would have that particular combination, it will get rarer and rarer the more markers you add on.

167. In 1997, a "10-marker multiplex kit" called "Profiler" began to be used and in 1998, "Profiler Plus" began to be used (which targeted "9 markers and a sex marker").[238] Ms Neville described it as a "really good advancement for us" which began to be used on a "regular basis".[239] According to Ms Neville, the kit "significantly improved the discriminating power", and was sensitive and reliable.[240] Shortly thereafter, and since the early 2000s, FASS became able to recover skin cells referred to as 'trace' or 'touch ' DNA.[241]

168. According to Ms Neville, the "next big leap" in the ability to test for DNA occurred after 2012 when "PowerPlex 21" began to be used.[242] PowerPlex 21 gave FASS the ability to test for "20 highly variable markers as well as a sex marker".[243] According to Ms Neville, "the potential to discriminate between different individuals was enhanced greatly... we needed less DNA to develop a profile. It could also work with more degraded samples".[244]

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[235] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [38] (SCOI.83528); Transcript of the Inquiry, 15 August 2023, T5503.45-5504.1 (TRA.00082.00001).
[236] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [38] (SCOI.83528).
[237] Transcript of the Inquiry, 15 August 2023, T5504.9-27 (TRA.00082.00001).
[238] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [40]-[41] (SCOI.83528).
[239] Transcript of the Inquiry, 15 August 2023, T5504.3-5 (TRA.00082.00001).
[240] Transcript of the Inquiry, 15 August 2023, T5504.26-29 (TRA.00082.00001).
[241] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [29] (SCOI.83528).
[242] Transcript of the Inquiry, 15 August 2023, T5507.5-13 (TRA.00082.00001).
[243] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [49] (SCOI.83528).
[244] Transcript of the Inquiry, 15 August 2023, T5507.15-18 (TRA.00082.00001).

169. In 2013, new interpretation software called "STRmix" began to be used at FASS, which Ms Neville describes as "an expert system that applies a fully continuous approach to DNA profile interpretation and is particularly useful for mixtures of a more complex nature."[245] According to Ms Neville, the software "improved the capacity for some profiles which were previously unable to be interpreted to become useful for identification purposes,"[246] including DNA mixtures of up to five people.[247]

170. Although the STRmix software still requires the input of a biologist,[248] before the introduction of the STRmix software, FASS was limited to the manual interpretation of DNA profiles which Ms Neville described as "binary", and was limited to interpretations of mixed DNA profiles "of lower complexity (typically no more than 2 contributors), reasonable quantities of DNA and good quality DNA."[249] Ms Neville explains, however, that this manual "methodology continues to be applied by biologists for DNA data of a non-complex nature including single source profiles, and mixtures of lower complexity."[250]

171. According to Ms Neville, since the introduction of PowerPlex 21, the STRmix software, and other developments in technology around the same time (including the ability to conduct familial searching and the introduction of the "3500xl genetic analysers"), the capability of DNA testing at FASS improved exponentially.[251]

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[245] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [75] (SCOI.83528); Transcript of the Inquiry, 15 August 2023, T5512.17-23 (TRA.00082.00001).
[246] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [73] (SCOI.83528).
[247] Transcript of the Inquiry, 15 August 2023, T5512.18-19 (TRA.00082.00001).
[248] Transcript of the Inquiry, 15 August 2023, T5514.6-14 (TRA.00082.00001).
[249] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [74] (SCOI.83528); see also Transcript of the Inquiry, 15 August 2023, T5512.1-6 (TRA.00082.00001).
[250] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [74] (SCOI.83528).
[251] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [46]-[53] (SCOI.83528).

172. Since this time, further advances have been made in specialised DNA analysis, such as male specific "Y-STR" typing which targets DNA exclusively from male individuals and which can link males on the paternal line.[252] FASS can also now conduct mitochondrial DNA testing which can assist in analysing highly compromised samples (such as skeletal remains), which is of use in missing persons investigations. It can be used to match against relatives on the maternal line.[253] Most recently, since around 2021, FASS is able to analyse samples to predict ancestry and external physical characteristics using technology called Massively Parallel Sequencing. This technology can also increase the ability to discriminate between individuals,[254] and has increased the ability of FASS to identify unknown remains when "you've nowhere else to go".[255]

173. Finally, Ms Neville gave evidence that a number of advances have been made in the ability to identify contributors to a DNA profile. These advances include the way in which links are made (scene to scene matches and person to scene matches). They also include the ability to search for contributors to mixed profiles and conduct familial searches.[256] Ms Neville gave evidence, consistent with the evidence of Superintendent Best, that advances have been made in increasing the automation used in DNA processing which has, amongst other things, reduced the possibility of contamination which can occur with manual handling.[257]

174. Ms Neville says that currently, the "analytical system at FASS... has the capability to generate an uploadable autosomal DNA profile from as little as 10 cells, although the optimal target is approximately 120 cells."[258] Ms Neville described 120 cells as "a tiny amount", noting that "it's measured in picograms as opposed to grams".[259] (A picogram is one trillionth of a gram.) Ms Neville also gave evidence that the techniques available in the present day are "so sensitive... that even after the passage of decades, you still have that capability of perhaps getting a DNA profile".[260]

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[252] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [56]-[62] (SCOI.83528).
[253] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [63]-[64] (SCOI.83528).
[254] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [65]-[66] (SCOI.83528).
[255] Transcript of the Inquiry, 15 August 2023, T5517.18-44 (TRA.00082.00001).
[256] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [67]-[70] (SCOI.83528)
[257] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [54]-[55] (SCOI.83528)
[258] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [53] (SCOI.83528); Transcript of the Inquiry, 15 August 2023, T5509.2-8 (TRA.00082.00001).
[259] Transcript of the Inquiry, 15 August 2023, T5509.10-15 (TRA.00082.00001).
[260] Transcript of the Inquiry, 15 August 2023, T5528.22-25 (TRA.00082.00001).

175. Ms Neville gave evidence that these developments have improved DNA testing at each analytical step, being: extraction, quantification, amplification, and capillary electrophoresis.[261] Ms Neville gave evidence that by (emphasis in original) "enhancing the performance <u>at each step of the process</u>, more DNA profiles are recovered a suitable for upload to the DNA databases, which is a key tool to identify possible contributors to the samples."[262]

176. However, and despite the above, Ms Neville emphasised that an underlying limitation of DNA testing is the probabilistic nature of DNA profiling. Any profile 'match' will be reported with a statistical calculation, or the probability that the DNA came from the identified person.[263]

177. Ms Neville also explained that FASS was constrained by its resourcing. Ms Neville gave evidence that the complexity of the DNA testing undertaken may require more time from each biologist.[264] According to Ms Neville:[265]

> we're absolutely stretched at the current time to deal with our current operations in addition to major validation projects so that we can keep bringing the innovative methodologies online, which we must do to ensure the currency of what we're doing for the New South Wales community in terms of forensic investigations. So, we are under-resourced at the moment to meet the current requirements of what we need to do in forensic biology.

B.4.2.1 The history and structure of the CSSB

178. The responsibility for conducting and assisting with scene and laboratory examinations of exhibits to obtain forensic evidence lies with the Crime Scene Services Branch (**CSSB**).

179. The CSSB was set up in 1938 as the Scientific Investigation Bureau (**SIB**).[266] In the late 1940s it was amalgamated with the existing photographic, ballistics, and handwriting section of the NSWPF and continued to be known as the SIB under the CIB. Later, it became known as the Scientific Investigation Section (**SIS**), and in 1952 a decentralisation process commenced.[267]

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[261] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [46] (SCOI.83528)
[262] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [52] (SCOI.83528)
[263] Transcript of the Inquiry, 15 August 2023, T5528.47-5529.9 (TRA.00082.00001).
[264] Transcript of the Inquiry, 15 August 2023, T5530.30-39 (TRA.00082.00001).
[265] Transcript of the Inquiry, 15 August 2023, T5530.34-43 (TRA.00082.00001).
[266] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [21] (NPL.9000.0003.1533); Transcript of the Inquiry, 4 July 2023, T4870.20-33 (TRA.00072.00001).
[267] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [22] (NPL.9000.0003.1533); Transcript of the Inquiry, 4 July 2023, T4870.43-4871.15 (TRA.00072.00001).

180. In 1973 the SIS moved from CIB and was placed under the Scientific and Technical Services Command (**STSC**). The SIS subsequently returned to the CIB until 1987, and was then transferred to the State Operations Support Group and renamed the Physical Evidence Section (**PES**).[268] The SIS underwent a further name change following the Gibson Review in 1990[269] and became the Crime Scene Operations Branch (**CSOB**), before a name change to CSSB in the mid-2000s.

181. The Gibson Review was a review into police physical evidence support services that occurred in 1990 and was facilitated by the then Assistant Commissioner, Bruce Gibson (a former crime scene and ballistics practitioner) at the direction of the then Commissioner of Police, John Avery.[270] The Gibson Review set the direction of what ultimately became the CSSB.

182. Superintendent Best, a Superintendent in the CSSB since July 2021,[271] gave evidence that the substance and outcome of the Gibson Review was the "modernising" of the CSSB. The Gibson Review resulted in a range of recommendations, including in relation to additional training to ensure that first response officers were aware of what they needed to do to preserve evidence. Superintendent Best said that this recommendation "took hold". Other recommendations made by the Gibson Review related to the relationship between investigators and crime scene staff, including in relation to who should make decisions about things such as the submission of samples for testing.[272]

183. The command under which the CSSB sits changed in 1995 when the Forensic Services Group (FSG) was formed. In 2017, the FSG was renamed the Forensic Evidence and Technical Services Command (FETS), as it is known today.[273] Superintendent Best gave evidence that the various changes of name for both CSSB and FETS were administrative rather than changes to the functions of the service.[274]

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[268] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [22] (NPL.9000.0003.1533); Transcript of the Inquiry, 4 July 2023, T4871.17-23 (TRA.00072.00001).
[269] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [22] (NPL.9000.0003.1533).
[270] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [23] (NPL.9000.0003.1533).
[271] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [9] (NPL.9000.0003.1533).
[272] Transcript of the Inquiry, 4 July 2023, T4874.2-17 (TRA.00072.00001).
[273] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [25] (NPL.9000.0003.1533); Transcript of the Inquiry, 4 July 2023, T4874.41-4875.12 (TRA.00072.00001).
[274] Transcript of the Inquiry, 4 July 2023, T4871.25-40 (TRA.00072.00001).

184. As at the present day, the CSSB employs 420 staff and encompasses 18 laboratories (referred to as crime scene sections) located across NSW.[275] The CSSB consists of staff with a range of qualifications who attend crime scenes and conduct laboratory-based examinations to identify, record, and collect physical evidence using forensic science. There are seven geographic areas, referred to as "zones", responsible for the management of one or a number of crime scene sections under the overarching governance of the CSSB.[276]

185. The terms "crime scene units", "physical evidence sections" and "crime scene sections" all refer to the laboratories under the governance of the CSSB which have had various names over the years. These sections "are operational police response units generally housed at or near police stations where staff perform an assortment of forensic examinations."[277] The examinations performed at the sections include collecting exhibits with forensic value relevant to investigations, fingerprint recovery, shoe and tyre mark comparison, and blood stain pattern analysis.[278] There are also additional, specialised units within the CSSB.[279]

186. Superintendent Best has given evidence that there are now two "types" of NSWPF officers who provide a forensic response for the CSSB. The first type are officers that undertake forensic examinations. If these officers are sworn police officers, they are referred to as "Forensic Investigators". If these officers are civilians, they are referred to as "Crime Scene Officers". The second type of employee are called "Scenes of Crime Officers" (**SOCOs**). SOCOs are civilians who perform non-complex forensic examinations such as forensic photography and DNA swabbing,[280] and are often deployed for examinations of a lower complexity.[281]

187. The level of training required of an officer performing these roles has steadily increased over the years. Until the mid-1980s, 'crime scene investigators' were required to undertake the Detectives Course. This requirement was replaced with a 10-day Crime Scene Examiners course, an 18-day Police Drafting course, and on-the-job training.[282] The training required to become a forensic investigator or crime scene officer also changed following the Gibson Review, which recommended that officers undertake an Associate Diploma in Applied Science (Forensic Science). This recommendation was implemented in 1992-1993.[283]

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[275] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [10]-[12] (NPL.9000.0003.1533).
[276] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [28] (NPL.9000.0003.1533).
[277] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [29]-[30] (NPL.9000.0003.1533).
[278] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [32] (NPL.9000.0003.1533).
[279] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [33] (NPL.9000.0003.1533).
[280] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [38]-[40] (NPL.9000.0003.1533).
[281] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [94] (NPL.9000.0003.1533).
[282] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [35]-[36] (NPL.9000.0003.1533).
[283] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [35]-[37] (NPL.9000.0003.1533).

188. As at the present day, all civilian officers (Crime Scene Officers and SOCOs) must have undergraduate or postgraduate qualifications in science or forensic science. Forensic Investigators are required to hold an undergraduate policing qualification and must complete a postgraduate forensic science qualification.[284] Forensic Investigators who join the CSSB also participate in a Forensic Investigator training program over a minimum of four years, during which they are also required to complete external qualifications.[285]

189. Crime Scene Officers and Forensic Investigators will also have completed (or be currently undertaking) further training with the Australian Forensic Science Assessment Body (**AFSAB**). In certain specified instances, including homicides, serious sexual assaults and critical incidents, an AFSAB officer is required to attend.[286] Achieving the highest qualification with AFSAB would ordinarily take around five years. In addition, the AFSAB qualifications mandate yearly and five-yearly reviews to ensure continuing education.[287]

190. Other specialised forensic examinations fall within the scope of FASS.[288]

B.4.2.2 The history and structure of FASS

191. From 1969-2012, FASS was known as the Division of Analytical Laboratories (**DAL**), and prior to 1969 was known as the NSW Health Department Laboratory.[289] Between 1969 and 1986, forensic pathology and forensic biology was part of the Division of Forensic Medicine (**DoFM**), before becoming part of DAL in 1986.[290]

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[284] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [41] (NPL.9000.0003.1533).
[285] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [42] (NPL.9000.0003.1533).
[286] Transcript of the Inquiry, 4 July 2023, T4877.34-38 (TRA.00072.00001).
[287] Transcript of the Inquiry, 4 July 2023, T4878.2-11 (TRA.00072.00001).
[288] Transcript of the Inquiry, 4 July 2023, T4875.28-44 (TRA.00072.00001).
[289] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [7] (SCOI.83528).
[290] Transcript of the Inquiry, 15 August 2023, T5500.27-29 (TRA.00082.00001). For ease of reading and consistency, all references to DAL are to FASS or FBDNA.

192. FASS, in its current form, was established in December 2012[291] within NSW Health Pathology (**NSWHP**).[292] NSWHP is an administrative division of the Health Administration Corporation, which was established on 1 May 2012 under s 9 of the *Health Administration Act 1982* (NSW).[293] The NSWHP Instrument of Establishment dated 14 January 2013 makes NSWHP responsible for the management and coordination of FASS.[294] FASS was established as a unit to provide "integrated, sustainable, responsive, efficient, high quality forensic and analytical scientific services".[295]

193. According to Ms Neville, the Operations Director Criminalistics at FASS, FASS provides three "key services" being: Forensic Medicine; Criminalistics (which includes the Forensic Biology/DNA (**FBDNA**) Unit, the Illicit Drug Analysis Unit and the Chemical Criminalistics Unit); and Forensic & Environmental Toxicology.[296] FASS is also the "custodian" of the NSW DNA database and is responsible for uploading profiles to the NSW and National database, and reporting any DNA database links to NSWPF.[297]

194. The relationship between FASS and the NSWPF is facilitated by a Service Level Agreement (**SLA**). The current SLA commenced in 2017 and is currently under review.[298] The interaction between the Criminalistics division of FASS and the NSWPF also occurs pursuant to a formalised governance structure.[299]

195. FASS supports NSWPF investigations in various ways, including through the provision of services related to forensic biology and DNA. FASS and NSWPF will communicate, where required, about the exhibits or testing process.[300] FASS also conducts educational forums to ensure NSWPF members are aware of the testing and methods used by FASS, and so they are aware of the capabilities of FASS and can comprehend the results of the testing that it undertakes.[301]

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[291] Transcript of the Inquiry, 15 August 2023, T5500.7-9 (TRA.00082.00001).
[292] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [13] (SCOI.83528).
[293] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [13] (SCOI.83528).
[294] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [14] (SCOI.83528).
[295] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [14] (SCOI.83528).
[296] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [15] (SCOI.83528).
[297] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [19] (SCOI.83528).
[298] Transcript of the Inquiry, 15 August 2023, T5501.1-3. (TRA.00082.00001).
[299] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [25] (SCOI.83528).
[300] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [22]-[23] (SCOI.83528).
[301] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [24] (SCOI.83528).

196. In appropriate circumstances, NSWPF will submit an exhibit to FBDNA for testing, including in relation to the recovery and extraction of DNA for the purpose of generating a DNA profile.[302] Any DNA profile recovered can then be analysed and compared against reference samples and any profiles uploaded to the DNA database.[303] FASS biologists will also provide expert evidence in relation to DNA testing conducted for court proceedings.[304]

B.4.2.3 Forensic testing by CSSB and DAL/FASS in the 1970s to the 1990s

197. In the 1970s and 1980s, some forms of forensic testing were carried out by CSSB, and other forms of testing were carried out by the predecessors to FASS (for convenience, the balance of these submissions will refer to FASS and not to its predecessor entities which are identified above unless it is necessary to do so). The role of the CSSB (in its various forms) was to carry out some types of scientific analysis, including shoe and tyre impressions and blood stain analysis.[305] However, during this period, some types of forensic testing were only carried out by FASS.

198. Ms Neville gave evidence that prior to the introduction of DNA testing (which was formally introduced as a service provided by FASS in 1992),[306] FASS conducted testing such as tests to identify protein markers and ABO blood groupings,[307] and tests to detect biological materials such as semen, blood and saliva.[308] Ms Neville gave evidence that during this period, this testing was accurate where data was available, but that the availability of possible matches was scarce.[309] The evolution of DNA technology in particular is discussed below in Pt B.4.2.

199. The CSSB was responsible for the identification and collection of items, and then to transitioning those items to FASS. If that needed to occur, CSSB would generate a form and forward the item to the FASS laboratory.[310] All submissions for testing with FASS required the endorsement of the CSSB.[311]

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[302] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [16] (SCOI.83528).
[303] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [17] (SCOI.83528).
[304] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [21] (SCOI.83528).
[305] Transcript of the Inquiry, 4 July 2023, T4872.9-25 (TRA.00072.00001).
[306] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [72] (NPL.9000.0003.1533).
[307] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [18], [30], [31] (SCOI.83528).
[308] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [28] (SCOI.83528).
[309] Transcript of the Inquiry, 15 August 2023, T5502.2-27 (TRA.00082.00001).
[310] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [55] (NPL.9000.0003.1533).
[311] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [56] (NPL.9000.0003.1533).

200. In the 1970s and 1980s, the process for having an exhibit forensically tested depended on the type of exhibit. CSSB crime scene staff would attend a scene at the request of the OIC. When a forensic test could be undertaken, it was the responsibility of the OIC to make that request to the relevant area of CSSB. Decisions about the precise nature of the testing that was to be conducted were made by the CSSB in conjunction with the OIC, as were any decisions about what exhibits should be collected.[312] A decision to have an exhibit tested could be made at any point in the exhibit life cycle.[313]

201. The relationship between the OIC and a CSSB officer remained unchanged into the 1990s, although the Gibson Review (discussed above) impacted aspects of exhibit management, including the triaging of samples sent to FASS.[314] The Gibson Review recommended that the CSSB Crime Scene Officer should be the sole point of contact between the OIC and FASS when evidence had been collected by the CSSB Officer. This system was implemented following the Gibson Review.[315]

202. Decisions in relation to which exhibits required forensic examination were made by the Crime Scene Officer in conjunction with the OIC, and then decisions concerning the test procedures used were made by the FASS scientist.[316] An OIC could make a direct request to FASS in some circumstances.[317] The Commissioner's Notice setting out the process for submitting an exhibit to FASS is in evidence before the Inquiry, as is a 1999 Police Service Circular that amended the Notice, including by adding additional contamination protocols.[318]

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[312] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [54] (NPL.9000.0003.1533). Transcript of the Inquiry, 4 July 2023, T4879.5-15; 4879.41-4880.7 (TRA.00072.00001).
[313] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [57] (NPL.9000.0003.1533).
[314] Transcript of the Inquiry, 4 July 2023, T4880.13-27 (TRA.00072.00001).
[315] Transcript of the Inquiry, 5 July 2023, T4921.40-4922.20 (TRA.00073.00001).
[316] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [68] (NPL.9000.0003.1533).
[317] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [69] (NPL.9000.0003.1533).
[318] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [72] (NPL.9000.0003.1533).

203. In the 1970s and 1980s, officers who filled the role of "Exhibit Officers" were required to record the status and movement of items sent for forensic examination in their exhibit books.[319] Superintendent Best said in his statement that in his assessment, "on occasions during the 1970s and 1980s once an exhibit was transferred to either CSSB or FASS, there was a reduction in the effective recording of information about the status and location of that exhibit by Exhibit Officers and others."[320] In his oral evidence, Superintendent Best explained that he meant that the role of the Exhibit Officer was made more difficult by the fact that the Exhibit Officer was not able to physically sight the exhibits.[321] He went on to say:[322]

> So what I was pointing towards was how that system works well or did work well, even though it was an exhibit book, when we had an exhibit officer whose sole task was to maintain the continuity and the safety of those exhibits, versus when they physically left their presence, and then, because it wasn't there in front of them, the requirement for those monthly updates sort of could fall away.

204. At this time, transport of the item was completed by the OIC, a delegate of the OIC, or the Exhibit Officer, after completion of a form referred to as a "P.377".[323] Once testing was completed, the results would be provided to the station with carriage of the investigation and the OIC would arrange the exhibit's retrieval.[324] Superintendent Best said in his statement that:[325]

> From my review of the relevant records, there were times where an officer attending CSSB or FASS to deliver exhibits for testing may be asked to collect exhibits when testing was complete to return them to the relevant police station if the officer was from the same station (i.e., on occasions, exhibits would have been collected and transported as a result of logistical convenience rather than pre-arranged collection). There were also instances where an item would be destroyed and/or consumed during the analysis process and the exhibit entry would be reconciled with a copy of the analysis certificate. Such processes greatly reduced the effectiveness of the NSWPF exhibit management system to effectively track the exhibits that went to laboratories for analysis during this period. As I explain below, developments since this period have alleviated such difficulties.

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[319] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [62] (NPL.9000.0003.1533).
[320] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [62] (NPL.9000.0003.1533).
[321] Transcript of the Inquiry, 5 July 2023, T4924.5-14 (TRA.00073.00001).
[322] Transcript of the Inquiry, 5 July 2023, T4924.28-35 (TRA.00073.00001).
[323] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [63] (NPL.9000.0003.1533).
[324] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [64] (NPL.9000.0003.1533).
[325] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [65] (NPL.9000.0003.1533).

205. Superintendent Best, in his oral evidence, explained that he was not aware of a process or a system, other than case finalisation, that would trigger officers to turn their minds to exhibits that may have been with DAL.[326] Exhibit management procedures remained the same as those described above throughout the 1990s and the 2000s until the introduction of the NSWPF Exhibits Forensic Information and Miscellaneous Property System (**EFIMS**).[327] Computerised exhibit tracking was introduced in March 2011.[328] The management of exhibits and documentary records by the NSW Police Force from 1970 is discussed further below in Pts C.5 and C.6.

206. Superintendent Best gave evidence that it has not been, and is not, possible for CSSB to attend every incident. The CSSB is, and has been, subject to guidance concerning when it is necessary to notify or call out the CSSB.[329] Guidance was first developed in the 1990s by categorising investigations.[330]

207. Superintendent Best was asked by Senior Counsel Assisting about expectations around securing a crime scene. He agreed that the first few hours were crucial in any investigation, but said that once a scene had been secured there was nothing driving urgency in obtaining items for forensic analysis except the need to identify an offender to limit the risk of that offender being at large.[331]

208. Superintendent Best was asked whether he would expect a crime scene to be secured until the first report 24 hours later and said, "[n]ot necessarily, no." He explained, however, that it would be common for officers to be deployed to a crime scene, finish that crime scene and submit a situation report within a 12-hour shift.[332] He said a formal review would come as soon as possible, but definitely within the stipulated two week period.[333] He was not sure whether this sort of process was a formal one in the 1990s, though he said it did occur because had participated in them, and that it was an aspect of training in the homicide course that he had completed.[334]

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[326] Transcript of the Inquiry, 5 July 2023, T4927.16-19 (TRA.00073.00001).
[327] Transcript of the Inquiry, 5 July 2023, T4927.26-39 (TRA.00073.00001).
[328] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [66]-[67] (NPL.9000.0003.1533).
[329] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [76]-[77] (NPL.9000.0003.1533); Exhibit 51, Tab 2T, CSOB Notification and Call Out Guidelines, 1 June 2000 (NPL.9000.0003.1144); Exhibit 51, Tab 2U, CSOB Notification and Call Out Guidelines, 1 December 2005 (NPL.9000.0003.1147).
[330] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [90] (NPL.9000.0003.1533).
[331] Transcript of the Inquiry, 5 July 2023, T4931.2-21 (TRA.00073.00001).
[332] Transcript of the Inquiry, 5 July 2023, T4931.23-35 (TRA.00073.00001).
[333] Transcript of the Inquiry, 5 July 2023, T4931.37-42 (TRA.00073.00001).
[334] Transcript of the Inquiry, 5 July 2023, T4931.44-4932.10 (TRA.00073.00001).

209. Where CSSB officers did not attend a scene, the PES was responsible for providing advice to investigators concerning the handling and packaging of exhibits requiring forensic examination.[335] In 1998, in response to increasing requests for DNA recovery, 180 police positions were assigned to police stations across NSW to provide a forensic response to crimes. These positions were called Local Area Fingerprint Gatherers (**LAFGs**). There was significant recruitment to the CSSB in 2001.[336]

B.4.2.4 The 2000s to present

210. The period between 2000 and the present day has been characterised by a dramatic change in the procedures followed by the NSWPF in arranging for the testing of the exhibits, and the technology that is available to conduct those tests.

211. Superintendent Best explained that in terms of the procedures followed by the NSWPF in arranging for the testing of exhibits, the biggest change was the introduction of "automation" in 2011.[337]

212. Prior to 2011, and in the ordinary course, a biologist from FASS would decide what types of samples should be targeted and which areas should be swabbed or identified for a tape lift or other analysis, although crime scene officers would also have played a role in the collection of exhibits.[338]

213. After 2011, the decision-making process of what to target for forensic analysis was "handed over" to the Crime Scene Officers and automation meant those exhibits did not need to be handled by any person before they were tested.[339] According to Superintendent Best, automation resulted in greater efficiencies and reduced the possibility that exhibits would become contaminated.

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[335] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [79] (NPL.9000.0003.1533); Transcript of the Inquiry, 5 July 2023, T4933.2-15 (TRA.00073.00001).
[336] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [82] (NPL.9000.0003.1533).
[337] Transcript of the Inquiry, 5 July 2023, T4933.24-46 (TRA.00073.00001).
[338] Transcript of the Inquiry, 5 July 2023, T4935.5-15 (TRA.00073.00001).
[339] Transcript of the Inquiry, 5 July 2023, T4934.41-4935.3(TRA.00073.00001).

214. Superintendent Best also gave evidence that during this period, more decisions about forensic testing started to be made by the OIC, with little or no input from CSSB staff.[340] As at the present day, decisions concerning forensic testing lie with the OIC (in the case of a Strike Force or other major inquiry), or otherwise with an officer from CSSB. An analysis request can be sent through EFIMS directly to FASS or to a crime scene section depending on the nature of the testing required.[341] According to Superintendent Best, the "general practice" is for the OIC and CSSB to make joint decisions as to the forensic testing required in relation to any particular exhibit.[342]

215. As noted above, in the 1990s, guidance was given to investigating officers concerning when was necessary to notify or call out the CSSB.[343] However, in 2018 such guidance was removed, and 24-hour coverage by CSSB was implemented in Sydney metropolitan areas. Specialised regional guidance was also developed.[344] In major or complex investigations from around this time, a formal review process was undertaken to discuss case specifics and identify forensic opportunities.

216. The first aspect of this review process was the making of a report within 24 hours. This would then be followed by a review within two weeks of that initial report and ongoing monthly reviews.[345] The protocol governing the CSSB response is in evidence.[346] Almost all requests from an investigating officer will be met by the CSSB, deploying either a SOCO or a Forensic Investigator/Crimes Scene Officer. An AFSAB trained CSSB officer must be deployed to all homicides, critical incidents and counter-terrorism investigations.[347]

217. Generally, the CSSB officer will contact the OIC, assess the crime scene, and formulate a scene management plan in order to maximise the recovery of potential forensic evidence.[348] Given the expertise of investigative teams and the ability of OICs to refer exhibits to the CSSB and FASS, it is not necessary for the CSSB to attend a scene purely to obtain exhibits which will later be subject to forensic testing.[349] The CSSB has issued guidelines concerning relevant topics.[350]

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[340] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [70] (NPL.9000.0003.1533).
[341] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [83] (NPL.9000.0003.1533).
[342] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [85] (NPL.9000.0003.1533).
[343] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [76]-[77] (NPL.9000.0003.1533); Exhibit 51, Tab 2T, CSOB Notification and Call Out Guidelines, 1 June 2000 (NPL.9000.0003.1144); Exhibit 51, Tab 2U, CSOB Notification and Call Out Guidelines, 1 December 2005 (NPL.9000.0003.1147).
[344] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [91]-[92] (NPL.9000.0003.1533).
[345] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [78] (NPL.9000.0003.1533).
[346] Exhibit 51, Tab 2ZE, Crime Scene Manual – Initial Response and Scene Attendance, April 2023 (NPL.9000.0003.0021).
[347] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [94] (NPL.9000.0003.1533); Transcript of the Inquiry, 5 July 2023, T4934.45-4935.9 (TRA.00073.00001).
[348] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [93] (NPL.9000.0003.1533).
[349] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [96] (NPL.9000.0003.1533).
[350] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [97] (NPL.9000.0003.1533).

218. In major or complex investigations, a formal review process is undertaken to discuss forensic opportunities. In cases that are not major or complex, that discussion will take place between CSSB officers and the OIC, either at the scene or afterwards. There are limited times when no immediate forensic response is required.[351]

219. Superintendent Best also gave evidence that developments in technology over this period have allowed forensic investigators to take smaller subsamples from items of interest.[352] Most items submitted to FASS for testing are now subsamples. Most subsamples for FASS analysis are taken from the crime scene or exhibit and transported by courier to FASS while the original exhibit is retained at the relevant police station.[353] Once subsample results are provided, a CSSB representative will review the case and assess the value of further testing of the exhibit.[354] A priority system exists for forensic testing which is based upon risk management.[355]

220. Superintendent Best was asked by Senior Counsel Assisting about the prioritisation of testing and explained that it was a question of "risk and capacity". The greatest risk is where there is an offender who has not been identified and there is a risk that the offender may commit another crime before that identification occurs. This is the highest level of priority, described as "critical".[356] There are also "priority" cases, with prioritisation being determined by the seriousness of the offence or otherwise on a case-by-case basis.[357]

221. Superintendent Best gave evidence about the interaction between crime scene officers and forensic pathologists. He explained that crime scene officers will attend a post-mortem where there are suspicious circumstances, but that at present there was not a practice of forensic pathologists attending crime scenes.[358]

222. Superintendent Best gave evidence that the innovations at CSSB are continuing. Superintendent Best explained in his statement that:[359]

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[351] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [86]-[88] (NPL.9000.0003.1533).
[352] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [98]-[100] (NPL.9000.0003.1533).
[353] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [99] (NPL.9000.0003.1533).
[354] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [100] (NPL.9000.0003.1533).
[355] Exhibit 51, Tab 2, Statement of Superintendent Best, 24 April 2023, [100]-[103] (NPL.9000.0003.1533).
[356] Transcript of the Inquiry, 5 July 2023, T4936.8-11 (TRA.00073.00001).
[357] Transcript of the Inquiry, 5 July 2023, T4939.4-13 (TRA.00073.00001).
[358] Transcript of the Inquiry, 5 July 2023, T4936.42-4937.25 (TRA.00073.00001).
[359] Exhibit 51, Tab 2, Statement of Superintendent Roger Best, 24 April 2023, [126] (NPL.9000.0003.1533); Transcript of the Inquiry, 5 July 2023, T4939.45-4940.18 (TRA.00073.00001).

> ...the NSWPF is currently undertaking a procurement exercise to acquire an upgraded forensic case management system known as "Forensic Register". Forensic Register is a computer-based system which provides for evidence recording and collection, forensic examinations and reviews, digital image capture and retention, storage of digital files, diagrams, examination and analysis results into a single record which is available to NSWPF and FASS staff. The system is currently used in all comparable jurisdictions in Australia and has the potential to increase efficiencies both in the work of FASS itself (for example, by reducing the amount of manual recording and inputs into reports) and the communication between NSWPF and FASS. For example, currently CSSB staff are required to utilise three different systems to manage case notes, exhibit management and job requests. All these will now be conducted within the one system which will automatically workflow into FASS, who will also have complete vision over the case. It will also have powerful analytical tools which over time, will inform on the validity of certain high-volume tasks (such as, swabbing of certain areas on stolen motor vehicles or public place surfaces such as toilet door handles).
>
> The procurement process is ongoing; however, I am involved in this process and I have a high degree of confidence in its completion and implementation in the near future.

B.4.2.5 The Cold Case Justice program and projects to review historical cases

223. In relation to the review of cold cases generally (not just homicides), Ms Neville provided the example of the Cold Case Justice Program which was run by FASS from 2008 to 2012 in conjunction with the NSWPF, in which approximately 2,000 sexual assault cases and 80 unsolved homicides were reviewed, and samples were retested using new technology.[360] While that program ended, Ms Neville explained that cold cases continue to be reviewed by FASS (with cooperation from NSWPF), under the purview of a Cold Case Coordinator and the Forensic Evidence Advisory Committee.[361] Other programs include the Sexual Assault Investigation Kit Back-Capture (July 2022-December 2023),[362] and the Human Skeletal Remains Initiative (**HSRI**) (initiated in 2018), which has catalogued all unknown remains within NSW and uploaded them on the National database.[363]

224. When asked about the ability of FASS to undertake historical work, Ms Neville gave evidence that the capability is there, but it would require an assessment of what needed to be undertaken, and the resources required to do so.[364] When undertaking previous historical work, Ms Neville noted that specific resources were allocated in order to facilitate that work.[365]

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[360] Transcript of the Inquiry, 15 August 2023, T5519.42-T5520.7 (TRA.00082.00001).
[361] Transcript of the Inquiry, 15 August 2023, T5520.18-33 (TRA.00082.00001).
[362] Transcript of the Inquiry, 15 August 2023, T5520.35-T5521.7 (TRA.00082.00001).
[363] Transcript of the Inquiry, 15 August 2023, T5521.9-43 (TRA.00082.00001).
[364] Transcript of the Inquiry, 15 August 2023, T5530.45-5531.5 (TRA.00082.00001).
[365] Transcript of the Inquiry, 15 August 2023, T5531.1-5 (TRA.00082.00001).

225. Ms Neville gave evidence that if a historical project were to be undertaken, a systematic or tiered approach would be best. Given the effect of time on the quality of DNA, particularly where it has been stored in suboptimal conditions and/or was a small sample, such an approach would involve the examination of samples to determine how they have been stored, and analysis of the samples which have been best stored or protected would be the starting point for that body of work.[366] For example, Ms Neville gave evidence that with current technology, even after the "passage of decades", testing techniques are sensitive enough to be able to get a DNA profile, although it is possible the profile obtained is only a partial profile.[367]

B.4.3 DNA databases

B.4.3.1 Introduction of DNA databases

226. The NSW DNA database commenced in 2000 concurrently with the commencement of the CFP Act. The CFP Act, together with regulations made pursuant to it, regulate the access, use and management of the NSW DNA database. The Secretary of NSW Health is the person responsible for the care, control and management of the database, and it is managed by FASS in accordance with set procedures based on the legislation; all searching and matching against the database is performed only by authorised FASS staff.[368] The National Criminal Investigation DNA Database (**NCIDD**) was established in 2001 and is managed by the Australian Criminal Intelligence Commission (formerly CrimTrac).[369]

227. According to Ms Neville, in the absence of a DNA database, there was "no capability to search a crime scene profile against a database of individuals". DNA samples could only be compared based on a specific request and as against nominated individuals.[370]

228. Even after the introduction of the NSW DNA database and the CFP Act, the "database was limited by its size for quite some time",[371] because only samples taken after the commencement of the CFP Act could be entered in the database.[372] Furthermore, at first, the NSW DNA database only allowed for "direct searching of autosomal DNA".[373]

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[366] Transcript of the Inquiry, 15 August 2023, T5531.39-5532.2 (TRA.00082.00001).
[367] Transcript of the Inquiry, 15 August 2023, T5528.20-25 (TRA.00082.00001).
[368] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [43] (SCOI.83528).
[369] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [44] (SCOI.83528).
[370] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [42] (SCOI.83528).
[371] Transcript of the Inquiry, 15 August 2023, T5505.23-24 (TRA.00082.00001).
[372] Transcript of the Inquiry, 15 August 2023, T5532.11-17 (TRA.00082.00001).
[373] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [79] (SCOI.83528).

229. However, the ability to match DNA profiles as against the database has also improved over time. The ability to conduct person to scene matching was possible from 2007, while scene to scene matching was possible from 2014.[374] The introduction of the STRmix software in 2013, as discussed above, also "significantly increased the amount of usable DNA profiles able to be compared to potential contributors."[375] Since January 2021, the searching/matching capabilities as against mixed DNA profiles has increased with the ability to conduct a "one off 'point in time' search".[376]

230. According to Ms Neville, following the development of DNA databases, DNA profiling became a more routine investigative tool. FASS conducts DNA testing when the NSWPF submits exhibits for "examination and testing including the identification of biological substances, recovery and extraction of DNA, generation of DNA profiles, interpretation, and reporting of findings".[377]

231. The NSWPF also sends FASS reference samples from individuals for the purposes of "DNA analysis and comparison to crime profiles on the DNA database".[378] The database is live, and searching is continuous. Uploading and linking on the NSW DNA database occurs in real time.[379]

232. Ms Neville gave evidence about the different forms of database matching which the FASS can undertake: "there is the direct matching, just matching DNA profiles that are developed from a crime scene sample to persons, but there's also a whole range of other matching that we can do around familial matching."[380]

233. There is a dedicated "links team" within the FBDNA Case Management Unit that provides the NSWPF DNA Management Unit with intelligence links following direct matching of scene to scene and person to scene samples on the DNA databases.[381] Link information is provided to NSWPF via EFIMS, or as a report to the NSWPF DNA Management Unit.[382]

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[374] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [81] (SCOI.83528); confirmed in oral evidence, see Transcript of the Inquiry, 15 August 2023, T5518.6-20 (TRA.00082.00001).
[375] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [68] (SCOI.83528).
[376] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [86] (SCOI.83528).
[377] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [16] (SCOI.83528).
[378] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [17] (SCOI.83528).
[379] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [84] (SCOI.83528).
[380] Transcript of the Inquiry, 15 August 2023, T5507.19-22 (TRA.00082.00001).
[381] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [67] (SCOI.83528).
[382] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [19]-[20] (SCOI.83528).

234. Ms Neville gave evidence that the NSWPF also has the capability to "request DNA profiles from FBDNA to search on Interpol databases or provide to another country to search on a specific database. This is generally requested through the NSWPF DNA Management Unit and facilitated through the Australian Federal Police."[383]

B.4.3.2 Familial searching

235. The ability to conduct familial searching against the NSW DNA database began in 2013, while familial searching on the national level became possible in 2018.[384] Ms Neville described the familial searching process as the process of "looking for profiles of people, individuals, on the database that... [are] sharing a lot with that crime scene sample... not a direct match, but they're sharing quite a lot."[385] Familial searching will often be conducted in the absence of a direct match.

236. If a familial search is made, the relevant database will generate candidates "who seem to share quite a bit [of DNA]" automatically, and then FASS looks "at that list and we use some of our additional capabilities to see whether they could be a relative or not".[386] Reports are also provided to the NSWPF "who may pursue investigation of the potential biological relative in their enquiries."[387]

237. The ability to conduct familial searches was enhanced by the use of Y-STR testing which has allowed FBDNA to link individuals and males on the same paternal line.[388] Ms Neville describes this as a "highly valuable tool". Ms Neville gave evidence that if the database is searched and a result is returned whereby "that Y profile is the same as the Y profile from the crime scene sample, well, now you've got a direct match that says these could be paternally related individuals".[389] The complement, mitochondrial DNA sequencing, has provided for the direct matching of people on the same maternal line.[390]

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[383] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [83] (SCOI.83528); confirmed in oral evidence at Transcript of the Inquiry, 15 August 2023, T5518.38-40 (TRA.00082.00001).
[384] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [70] (SCOI.83528); Transcript of the Inquiry, 15 August 2023, T5517.10-16; T5518.31-34 (TRA.00082.00001).
[385] Transcript of the Inquiry, 15 August 2023, T5517.10-16; T5507.42-45 (TRA.00082.00001).
[386] Transcript of the Inquiry, 15 August 2023, T5507.47-T5508.1-4 (TRA.00082.00001).
[387] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [78] (SCOI.83528).
[388] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [57] (SCOI.83528).
[389] Transcript of the Inquiry, 15 August 2023, T5508.12-29 (TRA.00082.00001).
[390] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [64] (SCOI.83528).

B.4.4 Evidence from NSWPF witnesses concerning the evolution of DNA testing

238. According to AC Conroy, DNA was "the most substantial forensic testing capability" developed over the course of the 1990s and the 2000s.[391] AC Conroy agreed that the careful gathering, labelling and retaining of exhibits is a "critical matter for investigations", and that it becomes even more important in relation to unsolved cases with the passage of time.[392] In response to questions from Senior Counsel Assisting, AC Conroy gave the following evidence concerning the availability of DNA and awareness of the possibility of DNA testing within the NSWPF:[393]

> Q. But before the moratorium [in 2002, see [451] below], when biological material was taken into custody, if dealing with an unsolved homicide, would there ever be a good reason to make a conscious decision to destroy that biological material?
>
> A. Well, prior to DNA evidence, DNA technology becoming available, then I imagine that the investigator wouldn't put their mind to that. So in the '70s and the '80s when DNA was not available, when an exhibit was collected that had biological evidence in it, the only value to that would have been for semen detection or for blood grouping, and that was being done at the Forensic Analytical Science Service, and then once that testing and that report had been returned to the NSW Police Force, then realistically there was no other evidentiary value to that exhibit.
>
> Q. What about at least in the '90s, when DNA testing was understood to be a reality, by then would there be a good reason for it?
>
> A. It migrated very slowly into the NSW Police Force investigative cycle, so DNA first became available to us in 1992 but it was – it didn't change our processes, it was just a capability or a test that FASS could do at that time should the unique circumstances enable that test to be done. It really wasn't until 1998 and the development of Profiler Plus that we had an ability and a validated process to use DNA more routinely in investigations.
>
> Q. If the question I'm about to ask is outside your knowledge, say so, but it would seem – it must have been obvious to Homicide detectives by at least the early '90s that DNA technology was on the scene and likely to advance?
>
> A. I can't put myself in the minds of the investigators. It was very early in the evolution of DNA in the 1990s. As I said, '98 was really when we saw the biggest change in DNA with the Profiler Plus system being able to identify biological evidence.

[391] Transcript of the Inquiry, 4 July 2023, T4805.23-27. (TRA.00072.00001).
[392] Transcript of the Inquiry, 4 July 2023, T4813.35-44 (TRA.00072.00001).
[393] Transcript of the Inquiry, 4 July 2023, T4816.19-4517.7 (TRA.00072.00001)

239. AC Conroy agreed with the proposition, put by Senior Counsel Assisting, that by 1989 there were NSW cases where DNA testing took place through the sending of samples overseas.[394] By 1992, DNA testing was available to the NSWPF, though in a "limited capacity".[395] At this time, AC Conroy explained that:[396]

> It was still in its infancy of being implemented as a law enforcement purpose and so we needed a large amount of, like, gross biological material, so blood, saliva or semen, so – and we didn't have the typing kits that we have available today and we didn't have a national DNA database. So there was a limited capacity about when we would use it and from '92 to '98 it was still a last-resort examination done at a special request. It wasn't a routine examination that we did for every exhibit. So we would still do blood grouping as a matter of course and then DNA could be potentially applied to an individual case.

240. AC Conroy was asked by Senior Counsel Assisting whether she could assist the Commissioner with the proposition that police officers in the NSWPF should have known that forensic science had developed significantly over the course of the 20th century and that these advances were likely to continue. She was not able to do so.[397] She agreed that there were cases from the 1970s and 1980s where exhibits were retained and formed the basis for reinvestigation and breakthroughs in the case.[398]

241. Superintendent Best agreed that DNA was "on the cards" by 1990.[399] He explained that in the 1990s DNA was:[400]

> ...limited in its application for investigations because it was requiring such large quantities of gross biological material, typically blood, and scenes where you had blood at a scene, you were invariably looking at a victim's blood, so the ability to match via DNA that blood to the victim, it's helpful at some level but not ground-breaking in relation to investigations. It was really when that trace DNA came in that we found some really ground-breaking abilities within that to solve crime.

242. The first experience that Superintendent Best had with DNA testing as an officer was in 1998.[401] In 1999 swabs were introduced for collecting samples for DNA testing. Prior to this time, the collection process had remained the same as officers would already take samples for blood grouping.[402]

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[394] Transcript of the Inquiry, 4 July 2023, T4817.24-27 (TRA.00072.00001).
[395] Transcript of the Inquiry, 4 July 2023, T4817.38-41 (TRA.00072.00001).
[396] Transcript of the Inquiry, 4 July 2023, T4866.28-38 (TRA.00072.00001).
[397] Transcript of the Inquiry, 4 July 2023, T4820.24-30 (TRA.00072.00001).
[398] Transcript of the Inquiry, 4 July 2023, T4820.43-8421.1 (TRA.00072.00001).
[399] Transcript of the Inquiry, 5 July 2023, T4918.15-16 (TRA.00073.00001).
[400] Transcript of the Inquiry, 5 July 2023, T4918.21-31 (TRA.00073.00001).
[401] Transcript of the Inquiry, 5 July 2023, T4928.36-41 (TRA.00073.00001).
[402] Transcript of the Inquiry, 5 July 2023, T4928.31-44 (TRA.00073.00001).

243. Superintendent Best was asked by Senior Counsel Assisting whether officers in the 1970s and 1980s should have been alive to the significant developments in technology and the prospective developments in technology. He said that his view is that they wouldn't have been, because the outcomes sought by officers from the CSSB were predominantly in relation to fingerprinting.[403] Senior Counsel Assisting took Superintendent Best to aspects of the Gibson Review that touched upon developments in different types of forensic technology.[404] He said that he was unable to give a definitive answer about the extent to which officers in the 1970s and 1980s were aware of developments in forensic science, although common sense told him that people would have recognised that it was important to keep abreast of developments in this field.[405]

244. Superintendent Best said that he was hesitant to make a "broad comment" about the 1970s and 1980s because he was trying to "think of what would be fair for them and then in doing so, what point of reference would they have to look at and go "Okay, this is an amazing advancement".[406]

245. DS Doherty gave evidence about the changes that the availability of DNA testing made to the way exhibits were stored and managed in response to questions from Senior Counsel Assisting. He said:[407]

> Well, it's a point now where going back in many decades ago, you know, there was points where, I suppose, the – having an exhibit that may be fingerprinted and blood tested, there was no foresight in relation to what would have happened down the track in relation to the advances in DNA technology. So whilst an item may have been photographed and swabbed or fingerprinted, it should have been retained but I suppose back in the day they weren't looking at what could have happened in the future where DNA and forensic process enhancement came along and would have given us the ability then to test for DNA.

[403] Transcript of the Inquiry, 5 July 2023, T4913.8-37 (TRA.00073.00001).
[404] Transcript of the Inquiry, 5 July 2023, T4914.17-4918.8 (TRA.00073.00001).
[405] Transcript of the Inquiry, 5 July 2023, T4916.43-4917.26 (TRA.00073.00001).
[406] Transcript of the Inquiry, 5 July 2023, T4919.2-10 (TRA.00073.00001).
[407] Transcript of the Inquiry, 6 July 2023, T5043.16-26 (TRA.00074.00001).

246. Senior Counsel Assisting asked DS Doherty whether he included the 1990s in the period during which he said there was no foresight in relation to DNA. He said that "for all serious crime, exhibit management was important and those items should have been retained. It's a point where the advances in DNA, for my memory and recollection, was more in the UK and was coming through from the mid '90s to the late '90s, not so much the early '90s."[408] He said that while people may have known about DNA in the early 90s, it "wasn't really available for us in the early '90s."[409]

247. In re-examination by Mr Tedeschi KC, DS Doherty was asked about the period when DNA testing first became available and used in NSW. He gave evidence that there was a two-part process, whereby both testing and a database to compare results to was important. He said that a database did not develop until the late 1990s to the early 2000s.[410]

248. In further examination by Senior Counsel Assisting, DS Doherty accepted that the first benefit of DNA in forensic analysis was matching it with known samples.[411] It was put to him by Senior Counsel Assisting that before the database had been developed, and while samples were gradually accumulating, it was clear that the database would grow over time and more DNA samples would be acquired.[412] He said that he could not assist the Commissioner with whether or not it was obvious in the early 1990s that the database would grow over time.[413]

249. Senior Counsel Assisting asked DCI Laidlaw whether he agreed that physical exhibits are "critically important" to unsolved homicides, to which he replied "[o]f course they are, yes." He agreed that the loss, contamination and deterioration of physical exhibits is a major obstacle to the success of any investigation, and that it has been known for many more than two decades how transformative scientific advances can be to forensic science.[414]

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[408] Transcript of the Inquiry, 6 July 2023, T5043.28-44 (TRA.00074.00001).
[409] Transcript of the Inquiry, 6 July 2023, T5044.23-41 (TRA.00074.00001).
[410] Transcript of the Inquiry, 6 July 2023, T5094.18-41 (TRA.00074.00001).
[411] Transcript of the Inquiry, 6 July 2023, T5098.10-15 (TRA.00074.00001).
[412] Transcript of the Inquiry, 6 July 2023, T5098.45-5099.8 (TRA.00074.00001).
[413] Transcript of the Inquiry, 6 July 2023, T5099.27-32 (TRA.00074.00001).
[414] Transcript of the Inquiry, 6 July 2023, T5151.16-39 (TRA.00074.00001).

250. DCI Laidlaw agreed that, based on his experience in the NSWPF in the 1970s and 1980s, investigators and forensic investigators were aware of the transformative power of scientific advancement. However, he said that "it was mainly fingerprints. There was no concept of transference of DNA."[415] He accepted, however, that there was a concept of transference, that is of a perpetrator leaving signs that could be picked up by physical evidence. He agreed that it was appreciated that technology had advanced and was likely to continue to advance to improve the things that could be picked up. DCI Laidlaw confirmed that this was well known in the 1970s, and that this was a good reason to keep physical exhibits.[416]

251. DI Warren was also questioned about the use of DNA technology by the NSWPF in the early 1990s.[417] DI Warren indicated that by November 1991, DNA technology was understood as a viable technology, however it was not available in police investigations until the mid to late 1990s.[418] DI Warren stated that the use of DNA technology was not something he was actively considering in the early 1990s, however also noted that he was not active in criminal investigations at that point in time.[419]

B.4.5 Submissions concerning the evolution of DNA technology

252. An important question that arises in the context of the evidence concerning the evolution of DNA technology is at what point it could reasonably be expected that knowledge about DNA technology should have informed police policy in relation to matters such as the retention of exhibits.

253. It is important not to allow hindsight to affect consideration of what could reasonably be expected of NSWPF officers in relation to the evolving capabilities of DNA. Dr Allsop's evidence, referred to at [259] below, was that there was likely not a widespread understanding of the potential advancements in DNA texting in the 1990s. Ms Neville's evidence was that FASS started DNA testing in 1989/1990, but that it was "rare and labour intensive" at this time, and that PCR became available in 1994/1995 (see [164]-[165] above). For that reason, it is reasonable that officers may not have turned their mind to the potential evolution of DNA capabilities.

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[415] Transcript of the Inquiry, 6 July 2023, T5151.33-39 (TRA.00074.00001).
[416] Transcript of the Inquiry, 6 July 2023, T5151.33-5152.14 (TRA.00074.00001).
[417] Transcript of the Inquiry, 5 July 2023, T4999 (TRA.00073.00001).
[418] Transcript of the Inquiry, 5 July 2023, T4999.6-9 (TRA.00073.00001).
[419] Transcript of the Inquiry, 5 July 2023, T4999.15-27 (TRA.00073.00001).

254. However, it might also be said that the evolution in science and its relevance to criminal investigation over the 20th century should have indicated that the retention of exhibits and samples in *unsolved* cases was particularly important. Even if a particular technology did not exist at a particular time, it was foreseeable that technology and scientific advancements would allow more information to be extracted in the future. The extent to which criticism could be made on this basis would depend upon the nature of the material that was not collected, stored or retained.

255. In many cases, it is not clear from the evidence before the Inquiry whether a conscious decision was made to destroy exhibits that have been unable to be produced to the Inquiry. This is, in our submission, extremely troubling.

256. If records of the destruction of particular exhibits had been made and retained, the Inquiry would be in a position to understand whether there was a rational basis for disposing of the exhibits (subject to what is said in Part C.8.2). For example, exhibits may have been disposed of in accordance with police procedures in place at a time when the significance of that material could not have been appreciated.

257. However, in many instances the material from the NSWPF has not allowed the Inquiry to understand what occurred in relation to particular exhibits. This means either that exhibits were either simply lost, or that they were destroyed but no proper records were kept. Neither of these alternatives is acceptable. The destruction or loss of exhibit material, and the failure by the NSWPF to produce records explaining what occurred in relation to this material, has affected the ability of the Inquiry to carry out its work. It is to be deplored.

PART C COLD CASES AND UNSOLVED HOMICIDES

C.1 Cold case reviews and best practice in cold case reviews

C.1.1 Cold case investigations and 'best practice'

258. This section of these submissions provides an account of some of the factors that can impede the investigation (or-reinvestigation, or review) of "cold case" homicides, and which bear upon whether a cold case can or will be solved. These include:

    a. First, the availability of physical exhibits and the way in which those exhibits have been stored.

    b. Second, the record-keeping practices of the relevant police force.

    c. Third, scientific and technical developments, including the ability to create DNA profiles.

    d. Fourth, the frequency and manner in which cold cases are reviewed by investigators.

259. The above factors are not necessarily definitive or determinative of whether a cold case will be solved. For example, it is possible that through the passage of time and shifts in personal allegiances additional evidence may become available, such as additional eyewitness evidence and/or evidence of admissions. However, the factors outlined above and addressed in more detail below are particularly salient in the context of this Inquiry given the extent to which they pervade the cases being examined by it.

260. This section concludes by identifying what is known about, or considered to be, best practice in how to approach cold case homicides.

261. This section refers to the academic literature addressing the topic of the effective investigation of cold cases, and the evidence provided to the Inquiry by Dr Cheryl Allsop, a Senior Lecturer in Criminology at the University of South Wales and researcher in major crime investigations. Dr Allsop prepared an expert report of the Inquiry dated 9 August 2023 (**Allsop Report**).[420] Dr Allsop was also called by the Inquiry to give oral evidence in relation to cold case investigations. Dr Allsop was not cross-examined by Counsel for the NSWPF, and, given her expertise, it is submitted her evidence should be accepted in its entirety.

262. This section also relies upon some of the evidence of Ms Neville, which is also identified and discussed above in Pt B.4.

[420] Exhibit 51, Tab 18A, Expert Report of Dr Cheryl Allsop, 9 August 2023 (SCOI.84938).

C.1.2 Availability of Exhibits and Exhibit Management

263. The loss of physical exhibits (or the inability to find or locate them) is a "major obstacle" to the success of cold case investigations.[421] In the past, it was "not uncommon" for police to return items to suspects, victims, and relatives if they did not believe items needed to be retained for any prosecution.[422] Additionally, in circumstances where items or exhibits were retained, they may have been misfiled, lost, or destroyed and therefore unable to be tested.[423] Furthermore, and as discussed in more detail below, even where exhibits were retained, police may not be able to locate them in the present day because of the record-keeping practices used at the time by the relevant police force or officer.[424]

264. Another problem that frequently arises in the investigation of cold cases is the integrity and ability to show the 'chain of custody' of physical exhibits.[425] Evidence handling practices have changed significantly over time.[426] Historically, detectives would not wear protective clothing and gloves, as they routinely do now. As stated in the Allsop Report:

> ... where forensic evidence is relied upon it is necessary to be able to show the chain of continuity of the exhibit from collection at the crime scene through to court. This means locating the officers involved in the original investigation so that they can explain what they did with the exhibit, or if they cannot remember what they did, what they would normally do in the circumstances.

265. A number of cases have recognised the impact that loss of physical exhibits may have on both investigations and subsequent criminal trials.

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[421] 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) 573 (SCOI.84206); Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 141 (SCOI.84208).
[422] 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) 573; Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 141 (SCOI.84208); Exhibit 51, Tab 18A Expert Report of Dr Allsop, 9 August 2023, [26] (SCOI.84938); Transcript of the Inquiry, 15 August 2023, T5540.41-45 (TRA.00082.00001); Transcript of the Inquiry, 15 August 2023, T5542.19-24 (TRA.00082.00001); Transcript of the Inquiry, 15 August 2023, T5543.3-17 (TRA.00082.00001).
[423] Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 141 (SCOI.84208); affirmed in oral evidence at Transcript of the Inquiry, 15 August 2023, T5543.7-42 (TRA.00082.00001); Transcript of the Inquiry, 15 August 2023, T5547.12-29 (TRA.00082.00001).
[424] Transcript of the Inquiry, 15 August 2023, T5542.19-24 (TRA.00082.00001); Transcript of the Inquiry, 15 August 2023, T5543.3-17 (TRA.00082.00001).
[425] Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 141 (SCOI.84208).
[426] Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 141 (SCOI.84208).

266. In *R v Smith (No 1)* [2011] NSWSC 725, Buddin J collated a number of authorities on the impact that the loss of physical exhibits may have on the conduct of an investigation and a subsequent criminal trial. His Honour's remarks were made in the context of considering the defendant's application for a permanent stay on the basis that police had lost or destroyed a number of exhibits, including records of interview, various photographic arrays shown to eye-witnesses, and a pair of blood-stained Nike running shoes. Buddin J described this situation and the overall inadequacies in the police investigation as "quite bewildering" at [64].

267. Justice Buddin did not grant a permanent stay, but observed at [96] that "the various matters which have been relied upon as being likely to give rise to prejudice are capable of being revisited during the course of the trial should the occasion arise." Similar observations have been made in other cases, where it has been held that the circumstances are not sufficiently exceptional to warrant a permanent stay, but where judicial comments make it clear that the loss of exhibits will likely affect the course of the trial: *R v Helmling* (NSWCCA, unreported, 11 November 1993) at pp 3-4; *R v Hatfield* [1999] NSWCCA 340; *Gilham v The Queen* (2007) 73 NSWLR 308; *R v Edwards* (2009) 83 ALJR 717; *Dawson v R* [2021] NSWCCA 117 at [95], [218].

268. In the past, items were also often retained in an 'exhibits bag' without being covered or sealed protectively.[427] As noted in the Allsop Report, "all exhibits should be correctly collected, retained, and stored to avoid cross contamination of exhibits". The failure to wear protective clothing or to properly store the exhibit increases the chance that exhibits are contaminated.[428]

269. Ms Neville gave evidence that how exhibits were collated and stored can affect the 'amenability' of any exhibits to forensic testing, particularly over time. Ms Neville said there are a range of variables around how a sample is collected and stored which contribute to the degradation of DNA on exhibits.[429] Some of these include the number of people who have handled the sample; whether the sample has been exposed to heat, UV or moisture; and the use of chemicals, for example cleaning products, on the exhibit.[430] According to Ms Neville, "the samples that have been retained within the stored forensic biology facility are the most amenable to applying the new technologies, because they have been stored in optimised conditions and protected from any inadvertent contamination".[431]

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[427] Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 142 (SCOI.84208).
[428] Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 141 (SCOI.84208).
[429] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [107b] (SCOI.83528).
[430] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [107b] (SCOI.83528).
[431] Transcript of the Inquiry, 15 August 2023, T5519.25-37 (TRA.00082.00001).

270. The availability and contamination of physical evidence will, obviously enough, have an impact upon the value of DNA obtained from a physical exhibit. The 'context' in which a DNA sample is found is, therefore, an important consideration in interpreting any test results. The utility of DNA evidence should also be assessed by a concurrent consideration of all the other forms of evidence available in the case.[432]

271. Given that many of the relevant scientific and technological advances in this area have been relatively recent, it is perhaps unsurprising that many investigators considered and collected exhibits in what became cold cases based on what analysis could be done at the time (see Pt B.4.4).[433]

272. When asked about the practice of officers in the 1990s, Dr Allsop considered that there likely was not a widespread understanding of the potential advancements in DNA testing which informed handling and retention of exhibits and samples.[434]

273. Finally, exhibits, particularly those consisting of DNA evidence, are also vulnerable to deterioration over time. The methods previously used to test forensic samples may have utilised much of that sample, so that there is little left to analyse today.[435]

C.1.3 Record keeping practices

274. The ability to solve a cold case may be affected by whether all the documentation from the original investigation and any subsequent reviews of that case have been correctly retained and filed, and whether investigators can easily locate any exhibits.

275. A cold case review will often begin by locating and collating all relevant documentation and exhibits. If these records are missing, or have been misfiled, destroyed or lost, it can hinder the progression of a cold case review. Dr Allsop summed up the inherent difficulties for cold case investigations with poor record keeping practices as follows:[436]

> if you haven't got the paperwork, if you haven't got the documentation, if you haven't got it in an organised manner such that you can see what is available, what exhibits you have got, what suspects you might need to eliminate, what witnesses you might need to speak to, it then makes it difficult to go back and review those cases, it makes it difficult to cross-reference any links with those cases.[437]

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[432] Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 142 (SCOI.84208).
[433] Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 55 (SCOI.84208).
[434] Transcript of the Inquiry, 15 August 2023, T5540.28-T5541.10 (TRA.00082.00001).
[435] Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 55 (SCOI.84208).
[436] Transcript of the Inquiry, 15 August 2023, T5545.39-46; reiterated at T5547.43-T5548.3 (TRA.00082.00001).
[437] Transcript of the Inquiry, 15 August 2023, T5545.39-46; reiterated at T5547.43-T5548.3 (TRA.00082.00001).

276. In the course of her research, Dr Allsop has encountered many instances where investigative paperwork has been misfiled, lost, moved away from the force area where the homicide occurred, or even discovered in the homes of former detectives.[438] In the absence of a complete set of documentation, the concept of "back engineering" will be one of the first steps in revisiting a crime. This refers to:[439]

> ... the process of rebuilding case files from scratch, gathering the paperwork and exhibits still available, and obtaining information and knowledge from the original investigating officers, drawing on their 'corporate memory'.

277. Dr Allsop emphasised the need for adequate record-keeping, not just for the purposes of investigation, but in order to present the material at trial to discharge the burden of proof.[440]

278. Dr Allsop also gave evidence that ensuring that all the relevant records are readily accessible leads to more efficient and effective reviews of cold cases. Likewise, Dr Allsop gave evidence that "[e]nsuring there are also closing reports for each cold case reviewed will help any future investigators understand the status of the investigation at that time and any outstanding opportunities that could be pursued". [441]

279. Dr Allsop worked with a police force which, in about 2010, recognised the concerns with storage of unsolved homicide material and made a concerted effort to collate, organise and review this paperwork. While Dr Allsop considered this to be good practice, she observed that it appears reliant on the initiative of that particular segment of the relevant police force, rather than a systematic approach to record keeping.[442] Amending historical deficiencies is undoubtedly going to be a resource intensive task.

280. Dr Allsop provided evidence to the Inquiry about the operation of the Home Office Large Major Enquiry System (**HOLMES**) which is currently used in the UK as an information management system for homicide investigations and serious complex cases.[443] The HOLMES system was introduced in about 1986, following the Byford Review of 1981, which identified missed opportunities to identify the offender in a series of linked murders in Bradford, UK, as a result of the record-keeping practices used in the investigation.[444]

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[438] Transcript of the Inquiry, 15 August 2023, T5543.7-42; T5547.12-21 (TRA.00082.00001).
[439] Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 115 (SCOI.84208).
[440] Transcript of the Inquiry, 15 August 2023, T5550.40-5551.4 (TRA.00082.00001).
[441] Exhibit 51, Tab 18A, Expert Report of Dr Cheryl Allsop, 9 August 2023 [32] (SCOI.84938).
[442] Transcript of the Inquiry, 15 August 2023, T5543.1-33 (TRA.00082.00001).
[443] Transcript of the Inquiry, 15 August 2023, T5534.20-42 (TRA.00082.00001).
[444] Transcript of the Inquiry, 15 August 2023, T5534.34-5535.12 (TRA.00082.00001).

281. According to Dr Allsop, HOLMES is "used in the UK to manage the high volume of information generated in large scale investigations".[445] The HOLMES system enables the "comprehensive storage and retrieval of information collected during a major crime investigation"[446] and, in its current form, allows several users to input, update and access information at the same time. The benefits of such a system are said to be cross force collaboration and data sharing, the ability to link incidents and conduct joint investigations, and to give the investigation's leader visibility in relation to how the investigation is progressing.[447] In oral evidence, Dr Allsop explained that HOLMES allows for analysis to be undertaken on the platform,[448] and it can "link and make connections" between the information stored on the system.[449]

282. Dr Allsop also provided information about the general operation and advantages of the HOLMES system, but could not be sure of its day-to-day use by the police force.[450] It is clear that the system has the capability to store all records regarding exhibits – including expert reports, testing results and the movement of exhibits – but that, to some extent, it still relies on members of the police inputting that data into the system.[451] If the system is used correctly, Dr Allsop confirmed that all data about exhibits and testing (what tests had been done and what tests had not been done) should be contained on the system.[452]

C.1.4 Scientific and technological advancements

283. Dr Allsop gave evidence that scientific and technological advances have been key to the successful resolution of cold cases. More specifically, Dr Allsop gave evidence that she considers DNA profiling using the Low Copy Number (**LCN**) technique (which was developed and continues to be used in the UK) as "pivotal" to cold case investigations,[453] and "fundamental" to renewing opportunities to identify and prosecute offenders.[454]

284. In many cold cases, these technologies were not available at the time of the original investigation. According to Dr Allsop and Sophie Pike in *Investigating homicide: back to the future*:[455]

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[445] Exhibit 51, Tab 18A, Expert Report of Dr Cheryl Allsop, 9 August 2023 [19] (SCOI.84938).
[446] Exhibit 51, Tab 18A, Expert Report of Dr Cheryl Allsop, 9 August 2023 [19] (SCOI.84938).
[447] Exhibit 51, Tab 18A, Expert Report of Dr Cheryl Allsop, 9 August 2023 [19] (SCOI.84938).
[448] Transcript of the Inquiry, 15 August 2023, T5536.8 (TRA.00082.00001).
[449] Transcript of the Inquiry, 15 August 2023, T5534.29-31 (TRA.00082.00001).
[450] Transcript of the Inquiry, 15 August 2023, T5536.27-43 (TRA.00082.00001).
[451] Transcript of the Inquiry, 15 August 2023, T5536.27-43 (TRA.00082.00001).
[452] Transcript of the Inquiry, 15 August 2023, T5536.37-43 (TRA.00082.00001).
[453] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023, [22] (SCOI. 84938); affirmed in oral evidence at Transcript of the Inquiry, 15 August 2023, T5537.24-30 (TRA.00082.00001).
[454] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023, [24] (SCOI. 84938).
[455] Exhibit 51, Tab 18, Cheryl Allsop and Sophie Pike, *'Investigating homicide: back to the future"* (2019) 5(3) Journal of Criminological Research, Policy and Practice 229, 230 (SCOI.84209).

> We have seen an exponential growth in the use of science and technology in investigations... progressive developments in scientific techniques and technologies, enabling DNA profiles to be established from ever-smaller amounts of biological material, has increased opportunities for offenders to be identified, linked to and eliminated from, crimes.

285. Likewise, Dr Allsop gave evidence there is now a greater chance of obtaining a DNA profile from a degraded sample.[456] Ms Neville also highlighted the opportunities that exist around DNA testing when she told the Inquiry that all modern techniques that are available can be applied to historical samples:

> So, there is a lot of opportunity for reviewing old cases and applying technology to achieve outcomes that wouldn't have been achieved at the time, and there has been a lot of work done in that space over the years.

286. Dr Allsop gave evidence that today, historical crimes are often prosecuted only with the assistance of forensic science.[457] Dr Allsop further observed that investigators are mindful of the need for "evidence" to successfully prosecute a cold case, and forensic science is perceived to provide that necessary evidence.[458] To reinvestigate a cold case murder is "difficult, resource intensive, and time-consuming, given the sheer volumes of data that would need to be reviewed".[459] Dr Allsop notes that in some instances, forensic science can help to identify a suspect which would then enable targeted investigations to be made.[460]

287. According to Dr Allsop, the development of DNA databases has also been significant. Dr Allsop gave evidence that the National DNA Database was introduced in the United Kingdom in 1995. Together with scientific and technological advancements, DNA databases have given investigators the opportunity to rework forensic samples from historical crime scenes and compare them with databased profiles.[461] In oral evidence, Dr Allsop summarised the significance of this development as follows:

> It allows you to link crimes. It allows you then to – if you've got potential suspects that were named in the original investigation, they can then be eliminated if it's not their DNA profile that was left at the crime scene. So, it gives you opportunities.

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[456] Transcript of the Inquiry, 15 August 2023, T5538.25-30 (TRA.00082.00001).
[457] Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 142 (SCOI.84208).
[458] Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 142 (SCOI.84208).
[459] Transcript of the Inquiry, 15 August 2023, T5545.20-22 (TRA.00082.00001).
[460] Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 142, 145 (SCOI.84208).
[461] Transcript of the Inquiry, 15 August 2023, T5537.45-T5538.5 (TRA.00082.00001). The National DNA Database in the UK was introduced in 1995.

288. The ability to make familial matches has also been significant in identifying offenders.[462] Dr Allsop noted that matching an unknown offender with an unknown relative "still requires a lot of detective work" but suggested that there has been some success in these cases in the UK.[463] Furthermore, in the USA, genealogy websites are "beginning to have an impact on cold cases", albeit less so in the UK, where Dr Allsop said the use of genealogy websites for cold case investigations raises human rights and privacy concerns.[464]

289. However, Dr Allsop gave evidence she considered that the reliance on science in cold case investigations is not "without issue".[465] In her oral evidence Dr Allsop also cautioned that DNA testing "is not the magic bullet you might think".[466]

290. *First*, and as noted above, Dr Allsop gave evidence that if the crime took place before the advent of DNA for forensic purposes became widely known, there is a risk of contamination to any samples collected.[467] However, Dr Allsop suggests that the advancement of testing means that even degraded, smaller or mixed samples *can* yield DNA profiles.[468]

291. *Second*, and as also noted above, science is only useful if it can be applied to a particular exhibit. The current reliance on scientific evidence means that the success of cold case reviews often depends on the availability of forensic opportunities to be pursued.[469] This, in turn, often hinges upon the availability of exhibits and other physical evidence, which are not always retained.[470]

292. *Third*, the focus on science can result in other opportunities for progressing a case being missed,[471] particularly when forensic opportunities are not immediately obvious. In such cases, opportunities that can be ascertained by what Dr Allsop (with Dr Pike) calls the "craft of investigative work"[472] can be overlooked or dismissed.

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[462] Transcript of the Inquiry, 15 August 2023, T5538.13-23 (TRA.00082.00001).
[463] Transcript of the Inquiry, 15 August 2023, T5538.13-23 (TRA.00082.00001).
[464] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023, [24] (SCOI. 84938); Transcript of the Inquiry, 15 August 2023, T5541.12-33 (TRA.00082.00001).
[465] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023, [25] (SCOI. 84938).
[466] Transcript of the Inquiry, 15 August 2023, T5542.25-26 (TRA.00082.00001).
[467] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023 [25 (SCOI.84938)] affirmed in oral evidence at Transcript of the Inquiry, 15 August 2023, T5541.38-T5542.17; T5542.2-17 (TRA.00082.00001).
[468] Transcript of the Inquiry, 15 August 2023, T5538.25-30 (TRA.00082.00001).
[469] Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 142, 54 (SCOI.84208).
[470] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023, [26] (SCOI.84938); Transcript of the Inquiry, 15 August 2023, T5542.19-25 (TRA.00082.00001).
[471] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023, [27] (SCOI. 84938)
[472] Exhibit 51, Tab 18, Cheryl Allsop and Sophie Pike, 'Investigating homicide: back to the future" (2019) 5(3) *Journal of Criminological Research, Policy and Practice 229, 237* (SCOI.84209).

293. These opportunities include witnesses who may have changed allegiances over time, or lines of enquiry which were not followed at the time of the original investigation.[473] Furthermore, investigators must have an understanding of the science and how to use it, because the "use of science in an investigation is only as good as the understanding officers have as to its use".[474] This requires investigators to keep up with the capabilities of science and technology, as well as how science and technology can be used in legal proceedings.

294. *Fourth*, utilising scientific tools and techniques can be costly, and the inability to show a chain of custody from collection to court can be a disincentive to apply resources to the testing of exhibits in cold cases if there will likely be legal issues in utilising the results of such testing.

C.1.5 Reviewing cold cases

295. The frequency and manner in which cold cases are reviewed by investigators can also affect whether a cold case can or will be solved. According to Dr Allsop, "there are no uniform or prescribed ways of approaching cold case reviews".[475]

C.1.5.1 Frequency of review

296. Dr Allsop gave evidence that since 1998, the then Association of Chief Police Officers (**ACPO**) (now the National Police Chiefs Council) in the UK have suggested that cold cases should be reviewed every two years, guidance which was re-affirmed in the 2000s.[476] Dr Allsop also gave evidence that regular reviews are important because of advances in scientific techniques and technologies "that may mean DNA profiles can be obtained from exhibits retained from the original investigation" and because "people do change allegiance and may be willing to come forward with information that they had not previously felt able to do".[477]

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[473] Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018), 145 (SCOI.84208); Transcript of the Inquiry, 15 August 2023, T5544.39 (TRA.00082.00001).
[474] Exhibit 51, Tab 17, Cheryl Allsop, *Cold Case Reviews: DNA, Detective Work and Unsolved Major Crimes* (Oxford University Press, 2018) 142, 55 (SCOI.84208).
[475] 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) 573, 568 (SCOI.84206).
[476] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023, [35] (SCOI. 84938); Transcript of the Inquiry, 15 August 2023, T5554.8-17 (TRA.00082.00001).
[477] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023 [35] (SCOI. 84938).

297. Dr Allsop expressed her opinion that the two-year guideline is good practice, but acknowledged that the ability to conduct reviews with that sort of frequency depends on adequate resourcing.[478] Dr Allsop also acknowledged that "you simply can't"[479] do a full review of everything every two years, and that a balance must be struck between the depth of review and the volume. The review actually undertaken might be limited in nature such as a "thematic review, an intelligence review, forensic review, exhibits review".[480]

298. However, Dr Allsop considers that conducting reviews with this sort of frequency allows an investigator to consider: [481]

> are there any new scientific techniques since last this was reviewed that might help in your case now? Is there any intelligence that you might have that might help you in your case now? And, of course, it helps you keep on top of your unsolved cases.

299. When asked about the difference between a two and a five year review cycle, Dr Allsop emphasised the importance of keeping up to date with scientific advancements, and preserving the ability to test exhibits.[482] If all scientific techniques are captured in the case, then Dr Allsop considered that five years was "fine".[483]

300. However, Dr Allsop considered that a focus on five years should not detract from other prompts that should instigate a review, for example, where an offender is otherwise identified who could assist the investigation, or the opportunity to initiate an anniversary appeal.[484] Although there are known problems with eyewitness testimony in investigations, Dr Allsop gave evidence that witnesses can and do remember information even despite the passage of time since the crime took place.[485] Anniversary appeals using the available media – usually on the date of the homicide or birthday of the victim can also be very useful to: [486]

> ...try and jog people's memories, to try and get either witnesses to come forward who might not necessarily have realised the significance of information that they held, who might have given information at the time and maybe have changed allegiance... [or] prompt a suspect to come forward.

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[478] Transcript of the Inquiry, 15 August 2023, T5554.19-23 (TRA.00082.00001).
[479] Transcript of the Inquiry, 15 August 2023, T5554.42-43 (TRA.00082.00001).
[480] Transcript of the Inquiry, 15 August 2023, T5555.12-16 (TRA.00082.00001).
[481] Transcript of the Inquiry, 15 August 2023, T5554.23-27 (TRA.00082.00001).
[482] Transcript of the Inquiry, 15 August 2023, T5555-T5556 (TRA.00082.00001).
[483] Transcript of the Inquiry, 15 August 2023, T5556.4-6 (TRA.00082.00001).
[484] Transcript of the Inquiry, 15 August 2023, T5556.19-26, 5557.9-32 (TRA.00082.00001).
[485] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023 [35] (SCOI.84208).
[486] Transcript of the Inquiry, 15 August 2023, T5557.14-22 (TRA.00082.00001).

C.1.5.2 Manner of review

301. In circumstances where a cold case review is taking place for the first time, Dr Allsop explains that the initial stage should focus on establishing the location of all relevant documents and exhibits so they can be collated for review.[487] Dr Allsop, in oral evidence, described this stage as "understanding your case",[488] particularly where the gaps might be.[489] According to Dr Allsop:[490]

> These documents and exhibits should then be thoroughly assessed to identify potential lines of enquiry and scope for progression of the cold case. Depending on the volume of cold cases a review team must manage, outstanding cold cases need be prioritised, weighing up factors such as the likely chances of success, the viability of forensic opportunities, whether there are suspects identified and considering the risk that the offender may offend again. A review should then focus on looking for forensic opportunities, witnesses, and potential suspects to be implicated or eliminated. A closing report should be prepared so that when the case is next reviewed investigators have the Senior Investigating Officer's views along with any outstanding lines of enquiry to pursue.

302. In oral evidence, Dr Allsop identified the "closing report" as an important document which she describes as a "point-in-time view of everything that has been done in that investigation and potential future opportunities",[491] which should have been prepared by the original investigator or the first cold case reviewer.[492] A review should be conducted in accordance with best practice so as to ensure any further review is efficient and effective.

303. Dr Allsop also identified that another difficulty in cold case reviews is that most investigation and review teams are periodically created and disbanded, and the process is required to start again each time.[493] According to Dr Allsop this involves investigators undertaking the following steps:[494]

> ... make sure all documentation and exhibits are corrected [sic] stored and maintained. Search forensic archives for any materials that may be retained there. Most important do not dispose of items and paperwork from any investigation. Keep abreast of scientific and technological advances and utilise media appeals to identify potential witnesses and people who may have changed allegiances since the original investigation ...

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[487] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023 [36] (SCOI.84208).
[488] Transcript of the Inquiry, 15 August 2023, T5558.25-27 (TRA.00082.00001).
[489] Transcript of the Inquiry, 15 August 2023, T5558.14-16 (TRA.00082.00001).
[490] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023 [36] (SCOI.84208).
[491] Transcript of the Inquiry, 15 August 2023, T5559.29-31 (TRA.00082.00001).
[492] Transcript of the Inquiry, 15 August 2023, T5559.11-31 (TRA.00082.00001).
[493] Transcript of the Inquiry, 15 August 2023, T5551.23-29 (TRA.00082.00001).
[494] Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023, [40] (SCOI.84208).

304. In oral evidence, Dr Allsop added that the relationship between investigators, prosecutors and forensic science providers was important in order for the investigator to understand both the forensic significance of the material in the case, and how it might play out at trial,[495] and so as not to miss an opportunity to advance a cold case investigation.[496] In a similar vein, Dr Allsop also suggests that drawing on scientific expertise outside of the usual or readily available forensic circle might assist in solving stubborn cold cases.[497]

305. There are dedicated review teams which exist in some regions of the UK, mostly for the purpose of reviews of ongoing investigations, designed to "check that investigations are running as they should do, that procedures are being followed, that standards are being conformed to, and to be a help to the senior investigating officer."[498] Dr Allsop suggests that these sorts of review teams could operate to review cold cases alongside live investigations, on an ongoing basis, rather than sporadically.[499]

306. Dr Allsop identified two national cold case operations specifically funded by the UK government, in the early 2000s (Operation Advance), and again in around 2007 (Operation Stealth).[500] Dr Allsop considered that the success of these national operations justified the expenditure required, as well as spurring action in some local forces in respect to cold cases.[501]

307. However, Dr Allsop emphasised the pivotal role that a dedicated cold case review team would play, in order to implement all of the best practice methods, particularly one that is led by a "tenacious" officer.[502] One of the key advantages of a dedicated team is the overarching view of all the unsolved cases, as opposed to the ebb and flow model of sporadic teams (as discussed above), which may not have this breadth of understanding or alertness.[503]

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[495] Transcript of the Inquiry, 15 August 2023, T5564.30-T5565.14 (TRA.00082.00001).
[496] Transcript of the Inquiry, 15 August 2023, T5561.2-T5561.17 (TRA.00082.00001); Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023, [38] (SCOI.84208).
[497] Transcript of the Inquiry, 15 August 2023, T5565.37-T5566.20 (TRA.00082.00001).
[498] Transcript of the Inquiry, 15 August 2023, T5551.36-40 (TRA.00082.00001).
[499] Transcript of the Inquiry, 15 August 2023, T5551.40-42 (TRA.00082.00001).
[500] Transcript of the Inquiry, 15 August 2023, T5552.23-T5553.20 (TRA.00082.00001). Although Dr Allsop could not specify when those operations might have ended.
[501] Transcript of the Inquiry, 15 August 2023, T5553.9-17 (TRA.00082.00001).
[502] Transcript of the Inquiry, 15 August 2023, T5561.40-T5562.8 (TRA.00082.00001); Exhibit 51, Tab 18A, Expert Report of Dr Allsop, 9 August 2023, [40] (SCOI.84208).
[503] Transcript of the Inquiry, 15 August 2023, T5561.41-47; T5562.20-40 (TRA.00082.00001).

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

308. The basic structure and function of the UHT is set out at Pts B.2.3 and B.2.4. The initial purpose of the UHT was to review unsolved homicides and suspicious deaths. The UHT Tracking File (see Pt C.2.1) was first created upon the establishment of the UHT in 2004.[504] The process of identifying and recording available exhibits for matters entered into the UHT Tracking File at its inception occurred during the initial review process between 2004 and 2008 (see [370]-[373]).[505]

309. The UHT conducted a review of unsolved homicide offences after its establishment in 2004 and identified 366 unsolved homicide offences from the period 1970 to 2000.[506] DS Doherty explained that as there was no information available to prioritise cases for review, the UHT performed a screening of all 366 cases starting with the most recent and working back in time.[507] The SOPs of the UHT dated 17 March 2006 are in evidence before the Inquiry (**2006 UHT SOPs**).[508]

310. DS Doherty's evidence was that, over the course of the review of the 366 cases, additional cases came to light.[509] Between 2004 and 2008, over 400 unsolved homicide cases from the period 1970 to 2000 were reviewed, and 201 of those were identified as warranting consideration for reinvestigation.[510] In response to questions from the Commissioner, DCI Laidlaw said that while there should be a list of the 201 cases initially identified as warranting consideration for reinvestigation, he was not sure where any such list was.[511]

311. Senior Counsel Assisting asked DCI Laidlaw whether he could explain what had occurred in relation to the other 199 cases (i.e. 400 minus 201) not identified as warranting consideration for reinvestigation. He said that he could not, and was not sure whether those cases would remain on the UHT Tracking File or not.[512] This apparent lack of corporate knowledge about aspects of this initial 2004-2008 review is regrettable.

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[504] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [57] (NPL.9000.0019.0001).
[505] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [103] (NPL.9000.0019.0001).
[506] Transcript of the Inquiry, 6 July 2023, T5109.25-27 (TRA.00074.00001).
[507] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [71]-[72] (NPL.9000.0006.0001); Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [58]-[62] (NPL.9000.0019.0001).
[508] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [57] (NPL.9000.0006.0001).
[509] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [75] (NPL.9000.0006.0001).
[510] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [76] (NPL.9000.0006.0001).
[511] Transcript of the Inquiry, 6 July 2023, T5110.38-T5111.39 (TRA.00074.00001).
[512] Transcript of the Inquiry, 6 July 2023, T51110.6-12 (TRA.00074.00001).

312. The Inquiry issued a Summons (Summons NSWPF146) seeking, relevantly, records comprising the source of DS Doherty's knowledge that 201 cases were identified as warranting reinvestigation, and any records identifying which matters comprised the 366 cases referred to by DS Doherty. No material was produced in response to this Summons.

313. The "initial screening and quality assurances processes" used by the UHT are set out in the 2006 UHT SOPs. Those processes involved reviewing each case for:[513]

314. DS Doherty said in his statement that:[514]

> Each of the above factors was scored and each case assigned a priority (high, low, medium, or nil). Cases assigned a 'nil' priority were identified for closure or suspension . Cases in that category would not be further reviewed unless additional information came to light. The remaining 201 cases were assigned a priority of high, medium or low depending on the score they received. Cases in each of these three categories were regarded as at least potentially warranting further investigation.
>
> Nine of those 201 cases were re-opened for investigation at the outset. Those cases were reopened because the information received by the UHT review team suggested they were likely to present the best opportunities for successful reinvestigation. It was decided that those cases should be prioritised accordingly and they were assigned to the PAC and Homicide Squad for investigation.
>
> However, at the time, there was not sufficient capacity within the Homicide Squad (or elsewhere with the NSWPF) to allocate the remaining 192 cases to a team or teams for reinvestigation. Accordingly, in around 2008, investigative teams were established within the UHT which expanded the remit of the UHT to not only review unsolved homicides or suspicious deaths, but to also conduct re-investigations into cases which were assessed as warranting a further investigation. The investigative capacity and number of units assigned to the UHT significantly increased at this time to the numbers it has today.

[513] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [76] (NPL.9000.0006.0001).
[514] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [77]-[79] (NPL.9000.0006.0001); Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [64] (NPL.9000.0019.0001).

315. DCI Laidlaw did not know how those initial nine cases were selected or whether there was a list of those nine cases in existence.[515] DCI Laidlaw said that during the 2004 to 2008 period "quality control was by the investigation coordinator at the time".[516]

316. In 2008, the investigative teams included a metropolitan unit as well as three smaller regional units, which were each comprised of four investigators. The regional units investigated unsolved homicide cases within those regional areas.[517] UHT SOPs from June 2009 are in evidence before the Inquiry.[518] In around 2012, the UHT's parameters were expanded to include pre-1970 and post-2001 homicide cases.[519]

317. In 2013, a review of the UHT was undertaken by senior management within the NSWPF. A recommendation was made to centralise the UHT to the metropolitan office of the UHT. The restructure was approved by Senior Executive in 2015, with the effect that there are now four investigative teams and one Review Team.[520]

C.2.1 The UHT Tracking File

318. The UHT maintains the UHT Tracking File. The UHT Tracking File is a spreadsheet which contains information concerning cases referred to the UHT. A version of the UHT Tracking File capturing all cases falling within the period from 1970-2010 was produced by the NSWPF to the Inquiry. Consequently, the Inquiry does not have before it the current or "live" version of the UHT Tracking File. Rather, it has before it an extract from the UHT Tracking File.

319. The UHT Tracking File was created in 2004 when the UHT was first established.[521] DCI Laidlaw described it as a record management system rather than an investigation management system.[522] In his statement, DCI Laidlaw said that since the inception of the UHT Tracking File there have been improvements in the amount of detail it captures in relation to each investigation.[523]

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[515] Transcript of the Inquiry, 6 July 2023, T5113.14-29 (TRA.00074.00001).
[516] Transcript of the Inquiry, 6 July 2023, T5111.2-9 (TRA.00074.00001).
[517] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [80] (NPL.9000.0006.0001).
[518] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [81] (NPL.9000.0006.0001).
[519] Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [83] (NPL.9000.0006.0001); Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [66] (NPL.9000.0019.0001).
[520] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [84]-[85] (NPL.9000.0019.0001).
[521] Transcript of the Inquiry, 6 July 2023, T5108.42 (TRA.00074.00001).
[522] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [72] (NPL.9000.0019.0001).
[523] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [73]-[74] (NPL.9000.0019.0001).

320. The UHT Tracking File is now primarily updated in the context of coronial recommendations, where the Coroner has made a recommendation that an investigation or a suspicious missing persons case be referred to the UHT for monitoring or further investigation. In addition, unsolved matters may be referred for consideration or review where those cases have been retained by police stations and are yet to go before the Coroner.[524] In this regard, as canvassed at [48] above, the 2022 SOPs provide that the UHT does not deal with matters where there has not been an inquest.

321. The UHT receives information daily from a range of sources. If information is considered to be significant, the Investigations Coordinator is advised, and the information is disseminated to the OIC of any existing investigation.[525] The information is then recorded in a "case management shell". Between 1970 and 2000, this shell was called "Strike Force Palace" (**SF Palace**). As of 2001, this shell has been referred to as "Strike Force Palace 2" (**SF Palace II**).[526]

322. SF Palace and SF Palace II do not involve reinvestigation of unsolved matters, rather they "allow the creation of the associated investigation files on e@gle.i to enable the electronic recording of any information pertaining to the investigation and any documentation associated with any triage or review."[527]

323. DCI Laidlaw explained in his statement that:[528]

> ...in the context of performing the triage process, the Review Team will identify any available documentation, exhibits or evidence in connection with an investigation and input that data into e@gle.i so it is available for the ultimate reviewer of the file. This is particularly necessary where documentation and exhibits pertaining to older investigations have not been captured or input into the current systems because those investigations pre-date the electronic investigation management systems used by the NSWPF, (formerly Taskforce Information Management System **(TIMS)** and now ***e@gle.i***).

[524] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [67]-[69] (NPL.9000.0019.0001).
[525] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 7 (NPL.0100.0003.0793).
[526] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 7 (NPL.0100.0003.0793).
[527] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [76] (NPL.9000.0019.0001).
[528] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [76] (NPL.9000.0019.0001).

324. The UHT's cases are categorised as one of "undetected" (where nobody has been detected and charged), "unresolved" (where a person has been charged and acquitted other than by reason of self-defence or mental illness, or where proceedings have not finalised and an arrest warrant for the alleged perpetrator exists), "undeterminable" (where a Coroner is unable to determine a person died of homicide and/or is unable to find that a missing person is deceased), and "solved" (where a person has been detected and charged and the prosecution has been successful).[529]

325. At present, there are 829 matters listed in the UHT Tracking File divided as follows:[530]

    a. 442 matters categorised as "undetected";

    b. 139 matters categorised as "undetermined";

    c. 132 matters categorised as "unresolved";

    d. 92 matters characterised as "solved"; and

    e. 24 matters categorised as "not homicide".

326. The "undetected" and "undetermined" categories were created in around 2018; matters now in these categories were previously categorised as "unsolved".[531] The categories in the file are not fixed and may change if further information or evidence comes to light.[532] DCI Laidlaw gave evidence that while the 2022 UHT SOP's refer to "undeterminable" rather than "undetermined" matters, his understanding is that these terms mean the same thing.[533]

327. Once a review is completed, if a matter is to be reinvestigated then management of the reinvestigation becomes the responsibility of the OIC. If reinvestigation is not possible, then the matter will remain with the UHT Review Team for monitoring.[534]

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[529] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 6 (NPL.0100.0003.0793). Detective Chief Inspector Laidlaw's oral evidence on this topic is at T5120.3-5123.36.
[530] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [77] (NPL.9000.0019.0001).
[531] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [78] (NPL.9000.0019.0001).
[532] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [79] (NPL.9000.0019.0001).
[533] Transcript of the Inquiry, 6 July 2023, T5123.6-28. (TRA.00074.00001).
[534] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [80] (NPL.9000.0019.0001).

328. All cases on the UHT Tracking File are monitored for further intelligence and information.[535] The two intelligence officers assigned to the UHT monitor intelligence reports received by the NSWPF and assess whether information received is relevant to a matter on the UHT Tracking file.[536] If relevant information is identified, then it is input into the UHT Tracking File and the intelligence officers contact the Investigation Coordinators and Team Leaders to discuss the potential impact of the information on current categorisation and/or priority assigned to a case.[537] Any DNA or fingerprint matches recorded by FASS or FETS will be notified to the UHT.[538]

329. In response to questions from Senior Counsel Assisting, DCI Laidlaw said it was not the case that there was a specific person responsible for administering the UHT Tracking File. He said that the only people who had access were the three Investigation Coordinators, the Team Leaders within the Review Team, and the two Detective Senior Constables, together with two intelligence staff.[539]

C.2.2 The Review and Investigation Teams

330. The Review Team comprises two Detective Sergeants and two Detective Senior Constable investigators. They are assisted by two Intelligence Analysts. The main roles of the Review Team are information management and maintaining the "triage" and "review" process.[540]

331. An investigator can apply to join the UHT without having previously served on the Homicide Squad. However, they must have successfully completed training to be designated as a detective within the NSWPF.[541] In his evidence, DCI Laidlaw sets out the training that a person would need to undergo in order to become a detective, and that is also a matter dealt with at [85]-[95].[542]

332. Once assigned to the UHT, a person is required to undertake the HIC, although DCI Laidlaw observed that in his experience most officers assigned to the Homicide Squad, and to the UHT, have already undertaken the HIC.[543] DCI Laidlaw gives the following evidence concerning additional training:[544]

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[535] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [140] (NPL.9000.0019.0001).
[536] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [141] (NPL.9000.0019.0001).
[537] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [142] (NPL.9000.0019.0001).
[538] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [43] (NPL.9000.0019.0001).
[539] Transcript of the Inquiry, 6 July 2023, T5120.34-46. (TRA.00074.00001).
[540] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 7 (NPL.0100.0003.0793).
[541] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [42] (NPL.9000.0019.0001).
[542] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [42]-[46] (NPL.9000.0019.0001).
[543] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [46] (NPL.9000.0019.0001).
[544] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [47] (NPL.9000.0019.0001).

> Based on my experience as an officer within the Homicide Squad, there is no specific training provided to investigators within the UHT, outside the training and major criminal investigations experience required of any officer to enable them to join the Homicide Squad. Based on my experience working as an officer within the Homicide Squad and the UHT, I believe that the experience and training required of all officers prior to joining the Homicide Squad makes them well equipped to perform the roles and responsibilities of an officer serving within the UHT.

333. DCI Laidlaw's evidence is that, like the Homicide Squad, the UHT is a highly sought after squad within the NSWPF.[545]

C.3 The triage and review process

334. The triage and review process utilised by the UHT was the subject of evidence from DCI Laidlaw both in his statement and orally. It became clear during his oral evidence that there was a disjunct between the theoretical operation of the UHT, as set out in his statement, and the practical operation of the UHT, as emerged during his evidence. That discrepancy is explored below.

335. For example, it became apparent from documents produced to the Inquiry following the first tranche of public hearings concerning investigative practices that no reviews occurred between 2013 and 2017 due to a lack of resources (see [376]). This is evidently a significant departure from the planned operation of the UHT. This is also not a matter that DCI Laidlaw referred to in his statement, although it must be acknowledged that he was not in a leadership role in the UHT during 2013-2017.

336. DCI Laidlaw gave evidence in relation to a number of the specific screening, review and triage forms before the Inquiry. His evidence, and consideration of those forms, is considered in Pt D below.

C.3.1 The screening process prior to 2018

337. DCI Laidlaw explained in his statement that prior to 2018, when the present triage process was introduced, cases were screened by a reviewing officer, and the reviewing officer would complete a case screening form. This would be subject to "quality assurance" by the UHT investigation coordinators.[546]

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[545] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [48] (NPL.9000.0019.0001).
[546] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [119] (NPL.9000.0019.0001).

338. Each case was given a priority rating of "nil", "low", "medium" or "high", and matters rated "low", "medium" or "high" were referred to Investigation Support within the SCC, which would allocate the matters for reinvestigation.[547] Cases rated "nil" priority would progress to an independent review panel where a case would either be returned for further review, closed or suspended.[548] The case screening process was not to involve investigation.[549]

339. The 2006 UHT SOPs explain that:[550]

> It is probable that a large number of cases requiring further investigation will be identified and that these cases will have varying likelihood of being solved. The prioritisation process is based on the premise that cases with the greatest likelihood of success receive the highest priority for resources. It is also concerned with identifying cases that should be suspended due to there being no realistic prospect of resolution.

340. In relation to the tracking of unsolved homicides, the 2006 UHT SOPs explain that:

> The Unsolved Homicide Unit has the responsibility of maintaining the list of unsolved homicides and tracking the status of each. At the time the Unsolved Homicide Unit commenced (1 March 2004) the list contained 366 unsolved homicides for the period 1970 to 2000. 12 of these cases were double homicides and two triple homicides, making a total of 350 unsolved cases. An additional 36 cases have been identified that may require inclusion in the unsolved homicide list.
>
> In addition to the 1970-2000 homicides there are still a number of high profile cases from the 1960's (such as the Bogle/Chandler and Wanda Beach murders). In some cases the offender is likely to still be alive. Cases for years after 2000 will be added to the unsolved homicide list on an annual basis (i.e. 2001 cases will be added to the unsolved homicide list in 2005 etc). Other cases will come into the list on an irregular basis, such as when a prosecution ends with an acquittal or a 'no bill' by the DPP or when an on-going investigation ends without the case being solved. All new cases entering the unsolved list will be subjected to case screening.
>
> The case screening process will form the basis of prioritising cases for investigation. Some cases will inevitably return to the unsolved homicide list after they have been further investigated. These cases will need to be reviewed via the case screening process on a regular basis. At present, it is suggested that each case returning to the unsolved homicide list be reviewed every three to five years.
>
> The Unsolved Homicide Review Unit will list all cases on a database/tracking system and collate the completed case screening forms.
>
> The Unsolved Homicide List will be continuously updated to indicate the status and priority of each case (e.g. undergoing case screening; currently being investigated; to be further screened in 2006 etc).

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[547] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [81] (NPL.9000.0019.0001).
[548] Exhibit 51, Tab 1L, UHT SOPS, 17 March 2006, 16-17 (NPL.0100.0003.0771).
[549] Exhibit 51, Tab 1N, UHT Metropolitan Country Regions SOPS, June 2009, 5 (NPL.0100.0003.0808); Exhibit 51, Tab 1L, UHT SOPS, 17 March 2006, 5, (NPL.0100.0003.0771).
[550] Exhibit 51, Tab 1L, UHT SOPS, 17 March 2006, 9 (NPL.0100.0003.0771).

341. The 2009 UHT SOPs essentially replicate the process set out in the 2006 UHT SOPs. DCI Laidlaw was unable to give evidence, beyond what was contained in the 2006 and 2009 UHT SOPs, about what triggered screening of a matter between 2009 and 2017 (the period 2004-2008 being taken up with the initial screening process after the creation of the UHT).[551]

342. Prior to 2016, any exhibits listed in the UHT Tracking File would be retained by the Command where the incident took place, stored in that Command's Exhibit Room, and managed in accordance with the usual processes for storage, management and auditing of exhibits.[552]

343. In around August 2016, as set out above, a project was commenced consistent with the recommendations in the Lehmann Report to locate and identify exhibits relating to unsolved homicide investigations, record them within EFIMS and e@gle.i and store them at the Metropolitan Exhibit and Property Centre (**MEPC**).[553]

C.3.2 Current Review Process

344. There are presently four stages of the current triage and review process. DCI Laidlaw explains:[554]

> I understand the triage process was implemented in response to a restructure of how reviews of unsolved homicides and suspicious missing persons cases were managed within the NSWPF. What was originally only a one stage review process was split into two stages. The first stage is a triaging process performed and managed by the UHT Review Team. The second stage is a review, which I explain in more detail below at paragraphs 111 to 128.
>
> Where a case has been referred to the UHT by the Coroner, that matter will not be triaged or reviewed by the UHT for five years in most cases, unless new evidence or information is uncovered which would justify an immediate triage process. The justification for this five-year period is that all available evidence would have been reviewed and considered by the Coroner at the time of the Inquest. The five-year period allows for the passage of time to take effect, which allows for new or fresh information to be identified or new evidence to be obtained through improved forensic technologies or investigative methodologies, which may be used to progress the investigation.

[551] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [92]-[93] (NPL.9000.0019.0001).
[552] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [105] (NPL.9000.0019.0001).
[553] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [106] (NPL.9000.0019.0001).
[554] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [83]-[84] (NPL.9000.0019.0001).

C.3.2.1 First stage: Triage

345. The first stage of the current triage and review process is a triage conducted by the UHT Review Team. The triage determines whether or not a matter should be progressed to review.[555] The triage involves review of an unsolved homicide using a standard review form.[556] [redacted]

[redacted]

346. DCI Laidlaw described the triage as "essentially an initial review of the file."[558] The template triage form is in evidence before the Inquiry.[559] A number of triage forms in individual matters are discussed in Pt D below. The process of identifying and collecting any available exhibits also occurs during the triage process, and "the Review Team will consider and assess the availability or viability of any exhibits (for instance, if the records demonstrate those exhibits may have been degraded or destroyed)."[560]

347. The triage process can take weeks or months to complete, dependent on factors such as the time taken to locate exhibits and the amount of information requiring input into electronic systems.[561] Once the triage form is complete it is provided to DCI Laidlaw for review.[562]

348. DCI Laidlaw disclosed in the course of his oral evidence that there are presently 19 triage documents which have been waiting for his review for the last 12 months. He gave evidence that he had not reviewed these triages because there were matters (other than any assistance provided in relation to the Inquiry) that had taken the majority of his time. At one point, DCI Laidlaw suggested that he had not prioritised looking at these matters because there are not presently people available who are of sufficient quality to conduct the reviews – "we need the right investigators to look at these reviews".[563] It is difficult to see how this could provide a justification for DCI Laidlaw to fail to perform his own function in relation to the triage documents.

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[555] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 8 (NPL.0100.0003.0793).
[556] Exhibit 51, Tab 6E, Template Triage Form, Undated (NPL.0100.0018.0008).
[557] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 8 (NPL.0100.0003.0793).
[558] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [86] (NPL.9000.0019.0001).
[559] Exhibit 51, Tab 6E, Template Triage Form, Undated (NPL.0100.0018.0008).
[560] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [87] (NPL.9000.0019.0001).
[561] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [88] (NPL.9000.0019.0001).
[562] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [89] (NPL.9000.0019.0001).
[563] Transcript of the Inquiry, 7 July 2023, T5189.45-5190.47 (TRA.00075.00001).

349. DCI Laidlaw gave evidence that his superiors were not aware, until he gave evidence before the Inquiry, that these 19 triage documents were awaiting his review, and that he had not sought additional resources to undertake this task.[564] However, he said he was aware that at some point prior to December 2019 a request was made for more personnel. He said, "because nothing eventuated, I didn't follow it up."[565]

350. In around 2018, cases from 2014 onwards were prioritised for triaging because it was thought that it was more likely that information and documentation would be recorded on e@gle.i and that the triage could therefore be completed more efficiently.[566]

351. There has, more recently, been a change from the practice implemented in 2018.[567] Prioritisation of matters for triage commences with officers in the UHT Review Team identifying matters categorised as "undetected". These cases are triaged before other cases because they are perceived to represent a more significant opportunity for reinvestigation.

352. As a general rule, the oldest cases categorised as "undetected" are generally selected as a priority for triage.[568] DCI Laidlaw explains:[569]

> ... While it is still the case that more recent matters on the UHT Tracking File may present a greater opportunity for investigation (given the availability of records and witnesses), given the limited resources available within the UHT Review Team to conduct this triage process and the time each triage takes to complete, this change in process was seen as necessary by the UHT senior management team to ensure the oldest cases on the tracking file were triaged before, for example, witnesses passed away or investigative opportunities for some reason became unavailable due to the passage of time.
>
> That said, there are circumstances where new information or intelligence may come to light which warrants another case on the UHT Tracking File taking priority, as it represents a better opportunity for reinvestigation based on that new information. The process of prioritising another matter on the Tracking File to ensure it is triaged ahead of other cases in these circumstances is managed by me in consultation with the Review Team and the other Investigation Coordinators in the UHT. I would assess the new information or intelligence relevant to the matter and would allocate it to one of the Review Team members for triage.

[564] Transcript of the Inquiry, 7 July 2023, T5191.30-46 (TRA.00075.00001).
[565] Transcript of the Inquiry, 7 July 2023, T5192.4-5193.42 (TRA.00075.00001).
[566] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [95]-[96] (NPL.9000.0019.0001).
[567] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [99] (NPL.9000.0019.0001).
[568] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [98]-[99] (NPL.9000.0019.0001).
[569] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [99]-[100] (NPL.9000.0019.0001).

353. While the intention is that all cases in the UHT Tracking File will be triaged by the UHT Review Team, "the prioritisation and triaging of these cases is necessarily dependent on the resources available to the Review Team and the UHT more generally, and the availability of qualified officers to undertake those triages."[570] If the triage process identifies that there is no realistic prospect of further investigation progressing the matter, then a matter will not proceed to review. This type of case will remain on the UHT Tracking File for monitoring.[571]

C.3.2.2 Second Stage: Review

354. The review process is a "more detailed paper/desktop review of the investigation file", and does not involve any reinvestigation.[572] If a case is allocated for review, it is provided to an investigator in one of the Investigation Teams who will undertake a range of steps including retrieving the case file and existing briefs of evidence, obtaining court transcripts, identifying and locating existing exhibits, recovering COPS reports, and ascertaining all known suspects, persons of interest and witnesses.

355. The 2022 UHT SOPs state that an investigator is not to contact any suspects or witnesses, and is not to contact the next of kin or family of the deceased person, but will complete a pro forma case screening report.[573] However, in practice, contact with suspects and/or witnesses may occur with the consent of the reviewing officer's superior officer.[574]

356. As noted above, in 2018 the one-stage review process was split into the two-stage triage and review process now in place.[575] At that time, a decision was made by senior management within the NSWPF to assign reviews outside the UHT to other squads within the SCC, together with Detectives Offices within PACs and Patrols. By 2021, it was identified that a large number of these reviews had not been completed, and the UHT requested the return of all uncompleted reviews.[576]

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[570] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [101] (NPL.9000.0019.0001).
[571] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [90] (NPL.9000.0019.0001).
[572] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [111] (NPL.9000.0019.0001).
[573] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 8-9 (NPL.0100.0003.0793).
[574] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [118] (NPL.9000.0019.0001).
[575] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [112]-[113] (NPL.9000.0019.0001).
[576] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [114]-[116] (NPL.9000.0019.0001).

357. Once a matter is allocated for review following the triage process, the priority of matters listed for review will depend on the information available in connection with the investigation and which cases represent the best opportunity for reinvestigation. The process of prioritising and allocating cases for review involves consultation between DCI Laidlaw and the Investigation Coordinators. DCI Laidlaw said in his statement that at any given time each UHT investigator will be allocated one review to be conducted in conjunction with any reinvestigations they are conducting.[577]

C.3.2.3 Third Stage: Solvability Assessment

358. *Third*, following completion of the review report, the UHT management team consults with the reviewing officer and the UHT Review Team leader to complete a "solvability assessment" and to give a priority rating to cases for consideration for future re-investigation. This is done using a pro forma case solvability assessment form, which is a matrix document that uses scores based on the findings from the review report. An aggregate ratings score determines the priority to be given to the unsolved case compared to other unsolved cases.[578] If new information is received, the UHT management team will re-determine the solvability assessment and adjust the priority.[579]

359. The solvability assessment is not the only matter that is relevant to the determination of priority. [redacted] The time taken to complete a review will vary significantly depending on the size of the investigation and what is encompassed in the review of the matter.[581]

[577] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [128] (NPL.9000.0019.0001).
[578] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 8-9 (NPL.0100.0003.0793).
[579] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 9 (NPL.0100.0003.0793).
[580] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 10 (NPL.0100.0003.0793).
[581] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [122] (NPL.9000.0019.0001).

C.3.2.4 Fourth Stage: UHT Review Committee

360. *Fourth*, once the review report and the solvability assessment have been completed, the UHT Review Committee "will determine the quality assurance of the review and priority rating".[582] The UHT Review Committee then considers whether a case should be re-investigated, including by assigning a priority rating.[583] The ultimate decision concerning reinvestigation rests with the UHT Investigations Coordinators and needs to endorsed by the Commander of the Homicide Squad.[584] If a decision is made that a case should be reinvestigated, it is allocated to an Investigation Team.[585]

361. Cases where further investigative opportunities have been identified will be allocated to the UHT Investigation Teams for reinvestigation, with priority determined by the priority rating given by the UHT Review Committee.[586] Cases given a priority rating of zero will not be recommended for reinvestigation on the basis that there are no further investigative opportunities. Those cases remain on the UHT Tracking File for monitoring by the UHT Review Team, and will be reassessed if new information or evidence comes to light, or if new forensic technology comes into existence.[587]

362. If a case is opened for reinvestigation it is assigned to one of the UHT Investigation Teams, and the Team Leader will commence a SCC Strike Force for the investigation.[588] Ordinarily, the officer responsible for conducting the review will be appointed as the OIC of the reinvestigation. Investigative plans are developed in consultation with the Investigation Coordinator within the UHT, and others in the UHT Investigation or Review Teams.[589] The UHT has access to all the strategies, technologies and opportunities that are available to the Homicide Squad.[590]

363. The UHT Review Committee is generally convened every three to six months and will consider all completed review reports, which is ordinarily five to ten.[591]

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[582] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 11 (NPL.0100.0003.0793).
[583] Exhibit 51, Tab 6, Statement of Detective Chief Inspector David Laidlaw, 13 June 2023, [120]-[121] (NPL.9000.0019.0001).
[584] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 11 (NPL.0100.0003.0793).
[585] Exhibit 51, Tab 6A, produced at Exhibit 51, Tab 1M, UHT SOPS (Version 2.0), 2022, 11 (NPL.0100.0003.0793).
[586] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [122] (NPL.9000.0019.0001).
[587] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [124] (NPL.9000.0019.0001).
[588] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [129]-[130] (NPL.9000.0019.0001).
[589] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [129]-[134] (NPL.9000.0019.0001).
[590] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [137] (NPL.9000.0019.0001).
[591] Exhibit 51, Tab 6, Statement of Detective Chief Inspector Laidlaw, 13 June 2023, [125] (NPL.9000.0019.0001).

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

364. The time it takes, historically and presently, for the UHT to screen (prior to 2018) or triage and review (post 2018) unsolved homicide cases is one that is dealt with in Pt C.3.4.

365. In response to a summons issued after the first tranche of the Investigative Practices Hearing, the NSWPF produced a document entitled "Triage and Review Backlog SOPS" dated January 2022 (**Backlog SOPS**).[592] It is useful to set out some portions of that document in detail:

> 1.1 CURRENT PROCESS
>
> Since 2018 the dissemination of triages to PAC's has been coordinated under the control of Crime Operations, SCC. The PAC/PD were then required to complete a review and return the package to Crime Operations, SCC. A Summary of this operating procedure is as follows,
>
> 1. Unsolved Homicide Team prepare a triage of an unsolved case, which is then forwarded to Crime Operations, SCC.
>
> 2. Crime Operations, SCC then record and issue a SCC reference number to the triage.
>
> 3. The triage is then disseminated with a review package incorporating relevant documentation, to external and specialist commands to be assigned to an officer to prepare the review.
>
> 4. A review package is provided to the reviewing officer containing all the relevant material needed to complete the review.
>
> 5. All details regarding the dissemination of the triage are maintained by Crime Operations, SCC, including any correspondence with the PAC/PD and Specialist Commands.
>
> 6. The PAC/PD reviewing officer returns the review package to Crime Operations, SCC, where it is then provided to the Homicide Squad for quality control and assurance, along with prioritisation.
>
> 7. The review is then placed before a 'Review Committee' involving senior management of the Homicide Squad and Crime Operations, SCC. This process is to ratify and determine any reinvestigation of the reviewed unsolved homicides.
>
> 1.2 INHIBITING FACTORS
>
> In July 2021 UHT Investigation Coordinators identified that the above review process is problematic in the management of unsolved homicide reviews.
>
> The Homicide Squad, UHT currently does not have management and control of the dissemination of the original triage. This has impeded UHT's ability to accurately determine the status of a disseminated reviews whether completed or outstanding, or who the allocated officer is, their location, and at what stage the reviewing officer is up to with the review.

[592] Exhibit 53, Tab 55, Triage and Backlog SOPS, January 2022, 4, (NPL.0205.0001.0917).

The Commander of the Homicide Squad has the corporate responsibility of managing and prioritising unsolved homicides efficiently and with accurate information.

Since the commencement of this process in 2018, complications in management of the reviews have continued to arise. The review process is meant to enable the Homicide Squad to have consistency prioritising matters for reinvestigation. This is currently not the case with the dissemination of reviews to external and specialist commands.

A delay of more than two years to complete or start reviews is impacting the solvability of those cases. With the possibility of additional information being present, ongoing changes being made to investigation techniques, electronic capabilities, and forensic advancements, in particular DNA, cases are not being given the appropriate opportunities to be investigated and possibly solved.

As of November 2021, it was identified that 126 reviews remain outstanding. The below table is a breakdown of time frames in years that reviews have remained outstanding at external and specialist commands, awaiting return to the Homicide Squad.

Time outstanding	Qty	Percentage	
LESS THAN 1 YEAR =	11	8.73015873	AVERAGE YEARS OUTSTANDING = 2.17
1-2 YEARS =	38	30.15873016	
2 - 3 YEARS =	37	29.36507937	
OVER 3 YEARS =	29	23.01587302	
UNDATED	11	8.73015873	
Total outstanding	126		

This current process is creating a backlog and considerable uncertainty as to the progress of those reviews. The time that it is taking for the reviews to be completed is a significant corporate risk to the Homicide Squad

366. The Backlog SOPs identify the process to be implemented in relation to outstanding reviews, and conclude that "[o]nce the backlog of reviews is in a manageable state, this process will need to be further analysed to determine the ongoing management and process of unsolved homicide reviews." Follow up correspondence to audit the status of outstanding reviews was sent on 7 January 2022.[593] It is not clear what further steps, if any, have been taken about this recognised "significant corporate risk" since January 2022.

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

367. As noted above, prior to 2018, cases assigned to the UHT underwent a screening process. As of 2018, this was replaced by a triage and review process.

[593] Exhibit 53, Tab 56, NSWPF internal memorandum from DSI Dunstan – *"Request for status update on unsolved homicide reviews"*, 7 January 2022 (NPL.0205.0002.0003).

368. In our submission, any process that involves the triage of material seeks to work through a large number of cases as quickly and as efficiently as possible in order to allocate priority. A triage, by its nature, will not involve a comprehensive review of each individual case – that would defeat the purpose of a triage process. If the triage process cannot review all cases on the UHT Tracking File within the five years since 2018, that is a demonstrable failure of the triage process. It must have been obvious within 12 to 18 months of the adoption of the new process that the triage itself was not operating effectively.

369. DCI Laidlaw agreed with the proposition, put to him by Senior Counsel Assisting, that there is a balance to be struck between the level of detail necessary for triage and the speed with which it is necessary to get through cases in order to review a high volume of cases. He was asked whether he thought the balance was right at the moment and said "[p]ossibly no, no."[594] The Inquiry has not received evidence of a person in a position of responsibility asking themselves that question prior to this Inquiry.

C.3.4.1 The initial case review in 2004-2008

370. The first role of the UHT after its formation was to conduct an initial review of unsolved homicide cases. One matter that is dealt with in Part D.1 below is the fact that some of the cases considered by the Inquiry are not listed on the UHT Tracking File, despite the fact they are homicides or may have been homicides, and despite the fact they are unsolved.

371. In his oral evidence, DCI Laidlaw said that the cases that were the subject of this initial review should still be on the UHT Tracking File. He said that cases were not taken off the UHT Tracking File, but that he was not aware of any policy prohibiting anything being deleted from the UHT Tracking File. He did not know whether cases had been taken off the UHT Tracking File over the last 20 years, and accepted that this may have happened. He was not aware of any record of any cases that may have been taken off the UHT Tracking File.[595]

[594] Transcript of the Inquiry, 6 July 2023, T5126.14-42 (TRA.00074.00001).
[595] Transcript of the Inquiry, 6 July 2023, T5113.35-5114.26 (TRA.00074.00001).

372. DCI Laidlaw accepted in his oral evidence that the process conducted from 2004 to 2008 was not comprehensive and that only 329 of the 400 cases identified were reviewed in that time. He was unable to explain what had happened to the other 71 matters.[596] In addition, DCI Laidlaw agreed that a number of cases being considered by the Inquiry, and referred to at [590]-[599] below, should have been reviewed as part of this initial review and were not. As indicated above [311], there does not appear to be any complete record of what actually took place as part of this review in 2004 to 2008.

373. In our submission, the weight of the evidence indicates that this initial review was far from comprehensive or systematic. As articulated below, the unsatisfactory conduct of this initial review represents a significant missed opportunity and is likely to have contributed to many of the difficulties now faced by the UHT.

C.3.4.2 The period between 2009 and 2017

374. DCI Laidlaw gave evidence that 76 files were screened during the nine years between 2009 and 2017.[597] During this period, this indicates an average of fewer than nine cases screened each year. However, as noted at [376] below, there were no screenings conducted at all between 2013 and 2017.

375. The Inquiry has before it an "issues paper" entitled "Homicide Squad Review – Response to Homicide Squad Review on 29 March 2018. Ongoing capacity issues at the Homicide Squad." It contains the following relevant passages (emphasis added):

> Accumulation/Volume. The unsolved matters are accumulating faster than they can be solved. It is worth noting that there have been 3 Detective Chief Inspectors working within the Unsolved Unit who have reported off sick and never returned after working within the Unit. Recent auditing and reclassification of unsolved matters has determined the sheer volume of work that remains. **With current capacity limitation it will take over 900 years to clear the backlog even if no further matters are added to the list. Moreover, this does not include the large number of missing persons and unsolved homicides still held by PACs and PDs or the unidentified remains which taken together will triple the current investigations held at the squad.**
>
> These interrelated issues also have many command and corporate risks associated with them. Notwithstanding the changes already made to partially mitigate these risks (see current position) many remain both in terms of immediate and future risks.
>
> They include:

[596] Transcript of the Inquiry, 6 July 2023, T5129.2-22 (TRA.00074.00001).
[597] Transcript of the Inquiry, 6 July 2023, T5129.26 (TRA.00074.00001).

1. Perpetuating accumulation of unsolved matters. Given current solvability rates and current capacity levels, and even if there were no more murders committed in NSW, the squad would never be able to complete mattes [sic] currently held. Given that murders will continue to occur and given that they will occur at a greater rate than they are solved, the ongoing accumulation of cases will only increase.

2. Extending the duration of investigations. The greater the accumulation of investigations the less capacity to investigate, the greater time each investigation takes, the less capacity there is to absorb new workload. This generates a perpetual cycle that means things continuously get worse in terms of solvability even if the rate of homicide decreases. If this continues the NSWPF will be unable to resolve homicide matters unless an offender is arrested in the first 7-10 days. This means that the NSWPF will not meet its obligations to the community, primary or secondary victims.

376. In addition, a memorandum from Detective Superintendent Scott Cook, the then-Commander of the Homicide Squad records that:[598]

> Based on the current holdings and from the year 1972 onwards there are 763 unsolved homicide matters. If suspended (and rejected) matters are removed the total drops to 571. The number of these cases which have actually been reviewed is small, in fact, there have been no reviews conducted in relation to unsolved homicide matters since 2013. This has been due to significant staff shortages and the demand for resources required for current and new investigations, including critical incident investigations.

C.3.4.3 The period between 2018 to present

377. As set out above, the version of the UHT Tracking File before the Inquiry only pertains to homicides that occurred between 1970 and 2010. The Inquiry has before it a document entitled the UHT Tracking File Aide Memoire. The UHT Tracking File Aide Memoire was initially prepared by the staff of the Inquiry, and was subsequently updated and annotated by representatives of the NSWPF. Like the version of the UHT Tracking File before the Inquiry, the UHT Tracking File Aide Memoire relates to homicides that occurred between 1970 and 2010.[599]

378. As is explained in Pt C.3, the system used by the UHT changed significantly in 2018. However, in the five years since 2018 20% of cases have not been triaged.[600] In his oral evidence, and by reference to the UHT Tracking File Aide Memoire, DCI Laidlaw said that of the homicides allocated to the UHT where the death occurred between 1970 and 2010, 572 matters had been triaged and 125 had not.

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[598] Exhibit 53, Tab 54, NSWPF internal memorandum from DSI Scott Cook – "*Approval sought to commence new strategy to address backlog in unsolved homicide investigations*", 21 December 2017, 3 (NPL.0205.0001.0774).
[599] Exhibit 54, Aide Memoire, Undated (SCOI.84314).
[600] Transcript of the Inquiry, 6 July 2023, T5126.43-5127.4 (TRA.00074.00001).

379. Initially, the figure of un-triaged cases was thought to be 213, but that figure of 213 included some cases that had been solved and some that were not homicides.[601] DCI Laidlaw said he could not assist the Inquiry in relation to how long those 125 unsolved suspected homicide cases had been on the UHT Tracking File, but agreed that it would be at least seven years because the latest matter on the version of the UHT Tracking File produced to the Inquiry was from August 2016.[602]

380. In response to questions from Senior Counsel Assisting, DCI Laidlaw gave evidence that the UHT did not have enough people do to triages and reviews. He said, "we're moving a backlog of triage forms in the review area and they're unable to be reviewed because we can't resource them adequately."[603] The Commissioner asked whether more resources had been requested and DCI Laidlaw said they had not.[604]

381. DCI Laidlaw said in his oral evidence that no triages have been completed since the beginning of the Inquiry because the Review Team had been assisting DI Warren's team in collating data for the Commission.[605] As noted above, his evidence was that there were 19 triage forms which were awaiting his assessment for over 12 months. He was unable to say when he expected he would be able to review them.[606] Having regard to the evidence set out in Pt C.7 below, it is apparent that there have been significant difficulties with progressing UHT matters for some time, and certainly from well before the commencement of the Inquiry.

382. The Commissioner asked whether he had drawn this matter to the attention of the Commissioner of the NSWPF, and he said he had not.[607] When he was asked why he had not drawn this matter to the Commissioner of the NSWPF's attention he said[608]:

> If I can reiterate what I said before, we're going from a backlog of – we are we've still got triage forms that have been completed that we cannot even get out to review because there is so many of them. That's why, in 2008, the investigative arm of Unsolved became an investigative arm, because there was so much of a backlog of case screen/triage forms then, that they were just sort of sitting there. So that's why that – that concept – it's still there, it's – it's just another important aspect of policing in general, sir, is how I see it.

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[601] Transcript of the Inquiry, 6 July 2023, T5124.45-5125.18 (TRA.00074.00001).
[602] Transcript of the Inquiry, 6 July 2023, T5125.20-47 (TRA.00074.00001).
[603] Transcript of the Inquiry, 6 July 2023, T5126.11-14 (TRA.00074.00001).
[604] Transcript of the Inquiry, 6 July 2023, T5126.16-18 (TRA.00074.00001).
[605] Transcript of the Inquiry, 6 July 2023, T5127.6-12 (TRA.00074.00001).
[606] Transcript of the Inquiry, 6 July 2023, T5127.34-36 (TRA.00074.00001).
[607] Transcript of the Inquiry, 6 July 2023, T5127.38-43 (TRA.00074.00001).
[608] Transcript of the Inquiry, 6 July 2023, T5128.8-17 (TRA.00074.00001).

383. DCI Laidlaw agreed that there were 291 cases where a review had not been completed. He said that in fact there were 178 cases that had not been reviewed and 19 which were what he described as "ongoing investigations", although he went on to say that those 19 he referred to were the 19 on his desk (awaiting assessment as to whether they should be referred to review).[609] These figures only account for 197 cases. The reason for this discrepancy remains unexplained.

384. It was put to DCI Laidlaw by Senior Counsel Assisting that this did not seem like many to have been reviewed in nine years. DCI Laidlaw said "No it's possibly not, no", but explained that "an investigation can be one lever arch folder or it could be 200 lever arch folders" and "there's no set parameters around the time to do the review, because some are quite long and lengthy."[610] DCI Laidlaw said initially that the 76 matters being reviewed in this time was consistent with having the balance right between the volume of reviews and the time taken on each review.[611] Other information before the Inquiry, referred to at [381], suggests that the reason for the low number of matters screened between 2009 and 2017 was in part because *no* matters at all were screened from 2013-2017.

385. DCI Laidlaw was unable to assist with some aspects of the NSWPF annotations on the UHT Tracking File Aide Memoire, including the fact that the cases "under review" in the last 12 months have gone from 71 to 36, but only 5 cases were added to the "reviewed" number.[612] In addition, the number of cases "not reviewed" with no reason given has increased by 12. DCI Laidlaw explained that this may be because erroneous reasons have been removed but no new reason inserted in anticipation of all data being moved to the new database.[613]

386. DCI Laidlaw was asked questions by Senior Counsel Assisting about the 96 cases that have been reviewed more than once. A small number of those cases have been reviewed three or four times. He was asked how it was decided what cases would get a second review and said "[w]hat had occurred was the number of secondary reviews, it would have been upon review of the initial review, and with the elapse of time, to identify whether there were new investigative opportunities to further conduct a review and possibly look for an investigative strategy."

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[609] Transcript of the Inquiry, 6 July 2023, T5128.33-42 (TRA.00074.00001).
[610] Transcript of the Inquiry, 6 July 2023, T5129.28-37 (TRA.00074.00001).
[611] Transcript of the Inquiry, 6 July 2023, T5130.6-14 (TRA.00074.00001).
[612] Transcript of the Inquiry, 6 July 2023, T5130.26-42 (TRA.00074.00001).
[613] Transcript of the Inquiry, 6 July 2023, T5131.33-5132.32 (TRA.00074.00001).

387. Senior Counsel Assisting asked again how those 96 matters had been selected for a second (or subsequent) review. DCI Laidlaw said "[i]t would have been – I think it was in – 2018, we worked back from 2014 backwards, and then when we ran out of – I would say when we got to a certain scope, we then decided to do the further reviews on matters that had been reviewed." He was asked by Senior Counsel Assisting to clarify what he meant by "got to a certain scope", and said that "[w]e got down to about 2010 I think, from memory ... But then we had a look at matters that needed – that had been reviewed to see whether there was any forensic purpose to review those matters."[614]

388. DCI Laidlaw was asked a number of further questions by Senior Counsel Assisting about this process. In summary, his evidence was that in 2018 the UHT team focussed on working backwards through cases from 2010 to 2014. [615] He agreed that "quite possibly" during that period the UHT did not look at any cases from the period between 1970 and 2009.[616]

389. In relation to the 125 suspected homicide matters that have not been triaged, it was put to DCI Laidlaw by Senior Counsel Assisting that there was "no good reason for them not to have been triaged." He said, "We just haven't had the time to do them, yes."[617]

390. Senior Counsel Assisting returned to the 96 cases that had been selected for a second review. He clarified with DCI Laidlaw that, the process of looking at cases from between 2010 and 2014 having been completed, the UHT asked what cases which had already reviewed might be "ripe for a fresh review." DCI Laidlaw agreed that this was correct.[618] Senior Counsel Assisting asked how that analysis was conducted and DCI Laidlaw said:[619]

> Just by going through, seeing where the matter was, to identify first if it was undetected. If it was undetected, they took the priority of matters. So those matters were looked at in relation to whether there was anything from the initial review that we could establish, that there could be a possibility with – as I said, it could be changes in witnesses or the suspects, it could be forensic technology that could have been advanced. They're the ones that we looked at.

[614] Transcript of the Inquiry, 7 July 2023, T5194.46-5195.4 (TRA.00075.00001).
[615] Transcript of the Inquiry, 7 July 2023, T5194.46-5195.4 (TRA.00075.00001).
[616] Transcript of the Inquiry, 7 July 2023, T5194.46-5195.4 (TRA.00075.00001).
[617] Transcript of the Inquiry, 7 July 2023, T5195.38-46 (TRA.00075.00001).
[618] Transcript of the Inquiry, 7 July 2023, T5196.1-5 (TRA.00075.00001).
[619] Transcript of the Inquiry, 7 July 2023, T5196.8-16 (TRA.00075.00001).

391. After a sequence of questions from Senior Counsel Assisting, DCI Laidlaw clarified that UHT team members were given ten randomly selected screening documents (concerning cases that had been previously screened) and would then look at those documents to see what cases might be a good candidate for a second review.[620] It appeared from DCI Laidlaw's evidence that not all of the 400-odd initial screenings from 2004 to 2017 were looked at in this process, nor all those recorded as "undetected".[621] He said that matters with no exhibits were given a lower priority, and that determining whether or not exhibits were available was done by reference to the UHT Tracking File.[622]

392. DCI Laidlaw agreed with the proposition, put by Senior Counsel Assisting, that the Review Committee receives 5 to 10 reviews every 3 to 6 months, and that consequently it could take 22 years to review the 442 cases currently noted as being "undetected". He was asked again whether he thought the balance was right between the speed with which steps are being conducted and the enquiries that are being made and said "[i]n a perfect world, no."[623] He said that it would be "optimum" for cases to be reviewed every five years, but said that the UHT did not have the resources to review all cases every five years.[624]

393. Senior Counsel Assisting put to DCI Laidlaw that of the 125 matters that have not been triaged since 2018, and the 291 that have not been reviewed, these may include cases from the 1970s and 1980s and that, if there are exhibits in those matters, there is "every reason to think that there is more to be done in relation to them". DCI Laidlaw accepted that this was the case.[625] He later agreed that there could be dozens or hundreds of cases in which there are accessible exhibits and forensic opportunities available, but nobody has explored including because the cases have not been screened, triaged or reviewed.[626]

394. DCI Laidlaw then agreed with the proposition, put by Senior Counsel Assisting, that as at 2018 the UHT had been in place for 14 years; nearly 3 times the cycle of 5 years. In that time, a little over 400 cases have been reviewed out of approximately 700 or 800. DCI Laidlaw agreed that of those that cases haven't been reviewed, he did not know what matters may well "predate DNA and have exhibits ripe for examination for DNA."[627]

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[620] Transcript of the Inquiry, 7 July 2023, T5197.5-5198.47 (TRA.00075.00001).
[621] Transcript of the Inquiry, 7 July 2023, T5197.13-41 (TRA.00075.00001).
[622] Transcript of the Inquiry, 7 July 2023, T5197.32-5198.6 (TRA.00075.00001).
[623] Transcript of the Inquiry, 6 July 2023, T5138.14-17 (TRA.00074.00001).
[624] Transcript of the Inquiry, 6 July 2023, T5139.10-16 (TRA.00074.00001).
[625] Transcript of the Inquiry, 6 July 2023, T5149.41-44 (TRA.00074.00001).
[626] Transcript of the Inquiry, 7 July 2023, T5206.41-5207.5 (TRA.00075.00001).
[627] Transcript of the Inquiry, 6 July 2023, T5140.45-5141.1 (TRA.00074.00001).

395. The processes and procedures of the UHT, and DCI Laidlaw's supervision of the UHT, are the subject of submissions in Pt D.31 below.

C.4 Management of exhibits and documentary records

396. Before turning to the evidence given by the NSWPF witnesses about the storage, management and retrieval of documents and exhibits, it is useful to commence this section with a summary of the evidence given by the NSWPF witnesses about the process of identifying and retrieving material (see Part C.4.1).

397. The significance of this matter to the Inquiry is obvious. The work of the Inquiry was substantially reliant upon the NSWPF being in a position to produce all exhibit and investigative material in relation to each of the cases being considered by the Inquiry.

398. Over the course of the Inquiry, it became apparent that a substantial number of matters being considered by the Inquiry involved exhibits or records that were unable to be located, or had been damaged or otherwise destroyed. As is explained in Pt C.7 below, there was awareness within the NSWPF since at least December 2016 of ongoing difficulties with exhibits and other material in unsolved homicide cases having been lost, destroyed or contaminated.

399. In addition to its relevance to the work of the Inquiry, this evidence is significant to the consideration by the Inquiry of the work of the UHT. The difficulties experienced by the Inquiry raised the ancillary question of how the UHT was and is able to properly triage, review and investigate cases if it did and does experience the same problems in relation to lost or destroyed material.

400. As is developed further at [496]-[502] below, if the UHT had been thorough and systematic in its initial review of the 300-400 unsolved homicides in 2004-2008 then it should have been apparent at that time that these difficulties existed.

401. The failure to identify these issues and conduct a thorough audit in 2004-2008 (or in 2016) represents a significant oversight and a lost opportunity to ensure that future unsolved homicide reviews would be efficient and effective. It also has flow on effects: for example, if exhibit material is located and can be retested, then the passage of time increases the probability that persons of interest or witnesses may be deceased or unable to be located (as in the cases, for example, of Crispin Dye and Samantha Rose). Forensic opportunities that existed in 2004 may now have been lost.

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

402. AC Conroy was asked a number of questions by Senior Counsel Assisting concerning the process for identifying and locating exhibits in cold case investigations. She said that "EFIMS would be the first point but an officer could also look at exhibit books and other archives [sic] records."[628] EFIMS, according to AC Conroy, allows the NSWPF to "electronically manage all aspects of the exhibit life cycle".[629] In addition, EFIMS can generate reports such as chain of custody and audit reports (see [474]).[630]

403. AC Conroy identified that in the event an officer had a concern that an EFIMS record may not be complete, they may need to take the following steps:

a. look on COPS (the NSWPF's Computerised Operational Policing System) or the e@gle.i system;

b. physically search the PAC where the original investigation was conducted;

c. ask whether any exhibits were held by the FETS;

d. ask whether any exhibits were being held at the MEPC;

e. consult officers involved in the original investigation; and

f. consider whether any documentary exhibits may have been placed in the government repository at Kingswood.[631]

404. In an affidavit dated 26 June 2023, Natalie Marsic, the General Counsel of the NSWPF, set out the eight steps that were taken by the UHT in order to complete what she described as "comprehensive searches".[632] Although that evidence was given in the context of responding to summonses from the Inquiry, those steps appear equally relevant to the process of records being located for the NSWPF's internal purposes.

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[628] Transcript of the Inquiry, 4 July 2023, T4828.10-14 (TRA.00072.00001).
[629] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [128] (NPL.9000.0008.0905).
[630] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [129] (NPL.9000.0008.0905).
[631] Transcript of the Inquiry, 4 July 2023, T4528.5-34-4529.16 (TRA.00072.00001).
[632] Exhibit 58, Affidavit of Natalie Marsic, 26 June 2023, [46] (SCOI.84212).

C.4.1.2 The role of the NSWPF Corporate Records, Record and Information Management Unit

405. The NSWPF Corporate Records, Records and Information Management Unit (**Corporate Records**) is central to the process of the management of records within the NSWPF. DI Warren explained that Corporate Records fits in the NSWPF under Corporate Services and that officers in Corporate Records are responsible for the storage, retention and retrieval of archive material and other records or files within the NSWPF.[633]

406. DI Warren gave evidence that Corporate Records is controlled by the NSWPF whereas the Government Records Repository (**GRR**) maintains all government records across New South Wales and access to those records are on request from the government department.[634]

407. DI Warren was asked by Senior Counsel Assisting about the process the UHT uses to find all the documents in relation to a particular matter. He identified that the UHT would place a request with Corporate Records to search for records in relation to the matter being reviewed, and that Corporate Records would return a result identifying whether those records existed or where those records were. Ultimately, those records would be sent to the UHT.[635]

408. DI Warren explained that his understanding of the reliability of Corporate Records had evolved over the course of the Inquiry. His initial understanding, at the beginning of the Inquiry, was that Corporate Records could conduct a search using a victim's name which would identify all relevant records. However, he explained that over the course of the Inquiry it has been discovered that some records archived by officers had not been stored under the victim's name; rather, they might be under a particular number, location, or "in a box with multiple other matters that don't relate to that particular file."[636]

409. In response to questions from Mr Tedeschi KC, DI Warren explained that unreliability in the results delivered by Corporate Records comes about because individual officers may not have archived material through Corporate Records, as opposed to because of any unreliability in the internal records or processes of Corporate Records.[637]

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[633] Transcript of the Inquiry, 5 July 2023, T4957.39-4598.20 (TRA.00073.00001).
[634] Transcript of the Inquiry, 5 July 2023, T4958.32-4959.4 (TRA.00073.00001).
[635] Transcript of the Inquiry, 5 July 2023, T4957.33-4958.6 (TRA.00073.00001).
[636] Transcript of the Inquiry, 5 July 2023, T4959.34-45 (TRA.00073.00001).
[637] Transcript of the Inquiry, 5 July 2023, T5009.21-47 (TRA.00073.00001).

410. The Commissioner put to DI Warren the proposition that the records held by Corporate Records are not a complete record, and DI Warren agreed.[638] He also agreed that Corporate Records cannot be comprehensive because hardcopy records may exist elsewhere that have not been archived.[639] DI Warren said that from his experience there was no supervision of how an OIC compiled or archived material, and that he was not aware of any supervision in the 1970s.[640]

411. DI Warren agreed, in response to a question from Senior Counsel Assisting, that in order for the UHT to now be confident that it had all the records in relation to a particular matter they would need to 408access the multiple sources of documents that have been searched in order to provide material to the Inquiry.[641]

412. He was asked by the Commissioner whether his evidence meant that "in every case … before you can even start to review an unsolved homicide, you'd have to be sure, at least so far, all of those repositories that you have identified – you'd have to go through each and every one of those to make sure you haven't missed something, wouldn't you". DI Warren said "[y]es" but later said that the Inquiry was the first time that he had identified that multiple sources might need to be accessed for the purpose of putting together a file.[642]

413. DI Warren said that he had heard of officers occasionally retaining records themselves after leaving the NSWPF, and that this was, to his knowledge, inconsistent with police procedures. In addition, he agreed that if one wished to obtain all the relevant evidence in relation to a particular case, it may be necessary to consider what material had been taken home.[643] He went on to give the following evidence:[644]

> Q. if one wished to obtain all the evidence relevant to a particular case, you may need to ask yourself whether such records have been taken home?
>
> A. Yeah. Unsolved Homicide Team, when they receive the archived material, it becomes apparent that if there is something missing – so with unsolved matters there is normally a sequence or a category system, and if you find that there is particular number or something that's missing, then – or not in the archived material, then you have to start searching elsewhere.

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[638] Transcript of the Inquiry, 5 July 2023, T5010.4 (TRA.00073.00001).
[639] Transcript of the Inquiry, 5 July 2023, T5010.6-33 (TRA.00073.00001).
[640] Transcript of the Inquiry, 5 July 2023, T4961.12-29 (TRA.00073.00001).
[641] Transcript of the Inquiry, 5 July 2023, T5013.26-31 (TRA.00073.00001).
[642] Transcript of the Inquiry, 5 July 2023, T5012.28-39 (TRA.00073.00001).
[643] Transcript of the Inquiry, 5 July 2023, T4962.29-4963.13 (TRA.00073.00001).
[644] Transcript of the Inquiry, 5 July 2023, T4963.4-27 (TRA.00073.00001).

> Or same with if a document speaks to another document or a set of photos or something like that, and they are not contained within the archived material, then you have to go searching to see if you can locate them. So there might be cases where you do have the whole brief of evidence or the case files, and other times there might not be.
>
> Q. But if you don't have the whole record, there will often be indicators that you are missing something like numbered documents won't be sequential or there will be a reference to a document though ought to be in the file but is not there?
>
> A. That's right.

414. DI Warren said that notebooks or duty books seemed to have been stored independently to case files because duty books were used for many jobs rather than for one particular case file.[645] He said that you would ordinarily need to identify the officers and then "try and track down notebooks" by identifying the police station the officer was at and then identifying the process adopted for the archiving of notebooks or duty books by that police station.[646]

415. DI Warren said that, once again, the location of these records is something that would be searched through Corporate Records, but that locating them in this way depends on a record having made it to Corporate Records in the first place.[647] He said he was aware of instances where certain notebooks or duty books had not been able to be located, though he was unsure whether that may have been because they had been destroyed. He agreed that there would be a record if there were a discussion about destroying a particular document such as a notebook, though he was not sure where such a record should be kept.[648]

C.4.1.3 Standard Operating Procedures and protocols of the Corporate Records Unit

416. The Inquiry has before it a number of SOPs concerning the processes used by Corporate Records. The historical versions of these documents are primarily from the late 1990s and the early 2000s. An internal NSWPF memorandum dated 7 July 1998 records that there were standards in place for hardcopy records at that time.[649] A summons was issued to the NSWPF seeking relevant policies or standards, but no material was produced. It should be noted that the *State Records Act 1998* (NSW) (**State Records Act**) was introduced in 1998 and largely commenced in 1999. The impact of the State Records Act is considered further in Part C.8 below.

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[645] Transcript of the Inquiry, 5 July 2023, T4963.35-39 (TRA.00073.00001).
[646] Transcript of the Inquiry, 5 July 2023, T4963.43-4964.1 (TRA.00073.00001).
[647] Transcript of the Inquiry, 5 July 2023, T4964.12 (TRA.00073.00001).
[648] Transcript of the Inquiry, 5 July 2023, T4964.25-44 (TRA.00073.00001).
[649] Exhibit 53, Tab 40, NSWPF internal memorandum to Executive Director, Management Services re: "*Premier's Memorandum No. 98-16 'Records Management Standards and Policies"*, 7 July 1998, 2 (NPL.0204.0002.0010).

417. There is a document before the Inquiry from 2008 entitled "Records Disposal Procedures Manual".[650] The introduction to that document explains that "[t]he records of the NSW Police Force belong to the State of New South Wales. They contain the corporate memory of the organisation, explain how and why decisions are made, and provide accountability and evidence."[651] It continues "[e]ffective disposal of NSW Police Force records is the key to successful records management in the NSW Police Force…".[652] This document identifies that "Investigation files are created by Police Force Commands … Investigation Case Files and related records are disposed of in accordance with *Functional Retention and Disposal Authority (DA 221).*"[653]

418. Part 3 of this document identifies the division of roles and responsibilities between various entities. The State Records Authority was responsible for, relevantly, approving Records Retention and Disposal Authorities. Corporate Archives (now Corporate Records) was responsible for:

    a. "Records disposal and archival policies and procedures";

    b. "Overall management of disposal activity within the NSW Police Force";

    c. "Preparing Disposal Authorities for submissions to State Records"; and

    d. "Providing disposal reports to State Records and to NSW Police Force management."[654]

    e. Administrative units, LACs and specialist units were identified as being responsible for:[655]

    f. "Regular sentencing of records";

    g. "Ensuring records are sentenced, boxed and listed in accordance with this procedures manual";

    h. "Overseeing the confidential destruction of records authorised for destruction"; and

    i. "Storage of physical evidence and non-record items".

419. "Sentencing", in this context, means "the process of identifying and classifying records according to a Disposal Authority, recording those disposal decisions and actions, and assigning appropriate disposal actions to records (as identified in an approved Disposal Authority)."

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[650] Exhibit 53, Tab 41, NSWPF Records Disposal Procedures Manual, November 2008 (NPL.0204.0002.0103_E).
[651] Exhibit 53, Tab 41, NSWPF Records Disposal Procedures Manual, November 2008, 1 (NPL.0204.0002.0103_E).
[652] Exhibit 53, Tab 41, NSWPF Records Disposal Procedures Manual, November 2008, 1 (NPL.0204.0002.0103_E).
[653] Exhibit 53, Tab 41, NSWPF Records Disposal Procedures Manual, November 2008, 3 (NPL.0204.0002.0103_E)
[654] Exhibit 53, Tab 41, NSWPF Records Disposal Procedures Manual, November 2008, 6 (NPL.0204.0002.0103_E).
[655] Exhibit 53, Tab 41, NSWPF Records Disposal Procedures Manual, November 2008, 6 (NPL.0204.0002.0103_E)

420. This document notes that "Exhibits and other physical evidence are not regarded as records and should be managed separately", referring to the Police Handbook.[656] It identifies that NSW Police Functional Records Disposal Authorities cover operational records created during and after 1960.[657] As noted above, the relevant Disposal Authority concerning criminal investigation case records is DA 221.[658] A "Records Destruction Checklist" is included as part of this document, and notes that certificates of destruction must be received, relevant inventory forms completed and forwarded to the Records Centre, and the destruction documented and recorded on 'TRIM'.[659]

421. The Inquiry also has before it a "Records Management Policies & Guidelines" document dated June 2009. This document notes that "[a]ll records created by NSW Police Force personnel in the course of their duties are considered public records of the NSW Government. The NSW Police Force therefore has an obligation to the people of New South Wales to ensure that the principles of records management are adopted."[660]

422. The Inquiry has before it a "Records Disposal Procedures Manual" dated November 2009. This document identifies that "state archives" are "those records that have been selected for permanent preservation because of their legal, evidential or informational value. They are required to be transferred to the control of the NSW State Records Authority when they are no longer required by the NSW Police Force, and can then be made available to the public for historical research purposes."[661]

423. This document again identifies that Disposal Authority DA 221 governs the disposal of criminal investigation case records.[662] It also contains a Records Destruction Checklist which requires the documentation of records destruction.[663] TRIM Disposal Procedures dated November 2008 are also in evidence before the Inquiry.[664] They set out detailed requirements for the use of the TRIM system in records disposal.[665]

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[656] Exhibit 53, Tab 41, NSWPF Records Disposal Procedures Manual, November 2008, 10 (NPL.0204.0002.0103_E).
[657] Exhibit 53, Tab 41, NSWPF Records Disposal Procedures Manual, November 2008, 11 (NPL.0204.0002.0103_E).
[658] Exhibit 51, Tab 5E, NSWPF Records Retention Policy, 20 June 2017, 3 (NPL.9000.0018.0469).
[659] Exhibit 53, Tab 41, NSWPF Records Disposal Procedures Manual, November 2008, 62 (NPL.0204.0002.0103_E).
[660] Exhibit 53, Tab 43, NSWPF Records Management Policies & Guidelines, June 2009, 5 (NPL.0204.0002.0221).
[661] Exhibit 53, Tab 41, NSWPF Records Disposal Procedures Manual, November 2008, 13 (NPL.0204.0002.0103_E).
[662] Exhibit 53, Tab 41, NSWPF Records Disposal Procedures Manual, November 2008, 11 (NPL,0204.0002.0103_E).
[663] Exhibit 53, Tab 41, NSWPF Records Disposal Procedures Manual, November 2008, 62 (NPL,0204.0002.0103_E).
[664] Exhibit 53, Tab 42, NSWPF Accessing records held at NSW State Archives and Records Authority, October 2021, 2 (NPL.0204.0003.0185).
[665] Exhibit 51, Tab 5E, NSWPF Records Retention Policy, 20 June 2017, 3 (NPL.9000.0018.0469).

424. The present version of DA221 (approved 20 June 2017) contains the following explanation concerning records required as State archives:[666]

> Records which are to be retained as State archives are 'Required as State archives'. Records that are identified as being required as State archives should be stored in controlled environmental conditions and control of these records should be transferred to State Archives NSW when they are no longer in use for official purposes.
>
> The transfer of control of records as State archives may, or may not, involve a change in custodial arrangements. Records can continue to be managed by the public office under a distributed management agreement. Public offices are encouraged to make arrangements with State Archives NSW regarding the management of State archives.
>
> Transferring records identified as State archives when no longer in use for official purposes to State Archives NSW control should be a routine and systematic part of a public office's records management program. If the records are more than 25 years old and are still in use for official purposes, then a 'still in use determination' should be made.

425. Records relating to the investigation of "unlawful killing" and records relating to missing persons cases where the person is not located are required as State archives.[667]

426. The Inquiry has before it a "Records Information Management and Policy Statement" dated from 2021. This document identifies that "Records generated by NSWPF document and [sic] organisation's past activities and may be required for internal and external investigations, litigation, and public access reasons. It is therefore essential that records are properly created and can be retrieved when needed."[668] This document is a general statement of policy, and identifies the responsibilities of NSWPF officers in relation to records.[669] The Inquiry also has before it protocols relating to recalling documents from the GRR, accessing records held at the State Archives and Records Authority, and the process for transferring hardcopy records to storage.[670]

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[666] Exhibit 51, Tab 5E, NSWPF Records Retention Policy, 20 June 2017, 5 (NPL.9000.0018.0469).
[667] Exhibit 51, Tab 5E, NSWPF Records Retention Policy, 20 June 2017, 9 (NPL.9000.0018.0469).
[668] Exhibit 53, Tab 44, NSWPF Records and Information Management Policy Statement, 27 August 2021, 3 (NPL.0204.0001.0012).
[669] Exhibit 53, Tab 44, NSWPF Records and Information Management Policy Statement, 27 August 2021, 9-10 (NPL.0204.0001.0012).
[670] Exhibit 53, Tab 45, NSWPF Permanently recalling boxes from Government Records Repository, September 2021, 2 (NPL.0204.0003.0062); Exhibit 53, Tab 46, NSWPF Accessing records held at NSW State Archives and Records Authority, October 2021 (NPL.0204.0003.0185); Exhibit 53, Tab 47, NSWPF Recalling boxes from Government Records Repository, July 2022, 2 (NPL.0204.0003.0040); Exhibit 53, Tab 48, NSWPF Hardcopy records for transfer to storage received at NSW Police Headquarters, April 2023, 2 (NPL.0204.0003.0156).

C.4.1.4 Submissions concerning records management

427. The majority of the cases being considered by the Inquiry pre-date the SOPs and other protocols produced to the Inquiry by the NSWPF. In the majority of cases where records appear to have been lost, there is no evidence that would allow the Inquiry to identify with any specificity when this occurred.

428. In our submission, the difficulties experienced by the Inquiry are consistent with the evidence of the NSWPF witnesses that the question of whether material can easily be retrieved and located (prior to the introduction of electronic records management) was primarily reliant on the approach taken by the OIC or any other officer who took charge of records.

429. Although these failures in record keeping, or losses of records, may precede the introduction of SOPs, it is extremely regrettable that they are so prevalent. It should have been obvious as a matter of common sense to police officers during the whole period being considered by the Inquiry that it was important to preserve police records of investigations and to ensure they could be readily located.

430. The prevalence of these problems suggests a serious systemic failure in NSWPF record keeping practices throughout the period examined by the Inquiry. As set out at [479], AC Conroy gave evidence that record keeping practices (and exhibit management practices) have improved, particularly following digitisation. In our submission, the Inquiry can proceed on the basis that these problems are less likely to occur in the future although there is still some reliance on individual officers.

C.5 Historical practices in relation to exhibit management

431. AC Conroy explained in her statement that "[t]he exhibit management process within NSWPF can be best described as a lifecycle, comprising of a number of key stages."[671] Those key stages are identification, collection, recording, testing (if applicable), storage and destruction.[672] Those processes are presently contained in the Exhibit Procedures Manual and the Exhibits chapter of the Police Handbook, which is available on the NSWPF Intranet.[673] Present practices concerning exhibits are dealt with at Pt C.5 below.

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[671] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [25] (NPL.9000.0008.0905).
[672] Transcript of the Inquiry, 4 July 2023, T4800.4-4801.10 (TRA.00072.00001).
[673] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [25] (NPL.9000.0008.0905).

C.5.1 The 1970s to the 1990s

432. Between 1970 and 1990 the Police Rules and Instructions governed the management of exhibits, including the process for obtaining exhibits. The Police Rules and Instructions amended in 1991 are in evidence before the Inquiry, as are copies of Instruction 33, which pertains to exhibits, from 1982 and 1989.[674]

433. As at 1982, the safe custody of exhibits received at a police station was the responsibility of the Station Sergeant or Constable, if applicable, or the OIC of the Station.[675] The Instruction notes that "full particulars of property used by Police as exhibits should be recorded in an exhibit book". The entries in regard to each exhibit "should show at a glance the whole of the movements of the exhibit from the time of receipt to its ultimate disposal."[676]

434. In 1989, at Police Stations where permanent Station Sergeants or Constables performing the duties of a Station Sergeant were employed, the safe custody of exhibits at that Station was the responsibility of that person. In all other Stations, responsibility rested with the Patrol Commander.[677] Para 33.29 of the 1989 Instruction records:[678]

> EXHIBIT BOOK
>
> Full and detailed particulars of the property taken into possession by Police are to be recorded in the Exhibit Book. The entries in regard to each exhibit should show at a glance all the movements of the exhibit from the time of receipt to its ultimate disposal including the manner of disposal, the authorisation for such disposal, the Authorising Officer and where the exhibit is destroyed and signed by the Officer in whose presence the property was so destroyed.

435. Superintendent Best described exhibit books as "at the core of the exhibit management process during the 1970s and 1980s."[679] AC Conroy's evidence was that from the 1970s to the 1990s, the exhibit book should have recorded all movements of an exhibit, and that generally exhibits would remain in the custody of the senior arresting officer or an assigned officer (in the case of large investigations). The exhibit book was to record any receipts for the transfer, disposal or destruction of an exhibit.[680]

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[674] Exhibit 51, Tab 3H, Index to Police Rules and Instructions, Undated (NPL.9000.0002.3021); Exhibit 51, Tab 2J, Instruction No. 33 – Exhibits and Miscellaneous Property, 1982 (NPL.9000.0002.0038); Exhibit 51, Tab 2F, Instruction No. 33 – Exhibits and Miscellaneous Property, 1989 (NPL.9000.0002.0074).
[675] Exhibit 51, Tab 2J, Instruction No. 33 – Exhibits and Miscellaneous Property, 1982, 16(1) (NPL.9000.0002.0038).
[676] Exhibit 51, Tab 2J, Instruction No. 33 – Exhibits and Miscellaneous Property, 1982, 14 (NPL.9000.0002.0038).
[677] Exhibit 51, Tab 2F, Instruction No. 33 – Exhibits and Miscellaneous Property, 1989, 33-54 (NPL.9000.0002.0074).
[678] Exhibit 51, Tab 2F, Instruction No. 33 – Exhibits and Miscellaneous Property, 1989 (NPL.9000.0002.0074).
[679] Exhibit 51, Tab 2, Statement of Superintendent Roger Best, 24 April 2023, [60] (NPL.9000.0003.1533).
[680] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [96]-[97] (NPL.9000.0008.0905).

436. AC Conroy agreed in her oral evidence that in the 1970s and 1990s "the important document was the exhibit book", and that all movements of the exhibit should have been recorded in the exhibit book. She explained that during this period the OIC would enter exhibits into the exhibit book, but that custody of the exhibit book would stay with the Exhibit Officer.[681]

437. This is consistent with the "Homicide – Part III" document annexed to the statement of DS Doherty, which sets out the duties of the OIC of exhibits. Those duties included, at the completion of an inquiry or when an arrest has been made, indicating requirements concerning the storage of exhibits.[682] In addition, the OIC was to be responsible for the ultimate disposal of all exhibits and miscellaneous property at the conclusion of a trial and when approval had been obtained from both the OIC of the investigation and the Clerk of the Peace.[683] The document identifies that "[i]f no arrest is made, and the murder is not cleared up, the exhibits will be held indefinitely in the care and control of the O.I.C. exhibits until such time as he is otherwise directed by the O.I.C of the investigation."[684]

438. AC Conroy explained, in the First Conroy Statement and in her oral evidence, that generally prior to 1990 exhibits were collected in an unlabelled, brown paper bag (except for specific types of exhibits), and that the process for collecting an exhibit involved recording the exhibit in the exhibit book, adding a cross reference to the COPS event number, tagging the item, and securing the item in the exhibit room. Until the mid to late 1990s, the OIC of a case was responsible for obtaining exhibits. By the late 1990s, exhibit bags were printed with a pre-formatted label.[685]

439. From the 1970s to the 1990s, most exhibits were stored in the exhibit room either at the station that the OIC was attached to, or at the relevant NSWPF "charging" station.[686] At this time, there were "main" police stations, which were the charge stations where the Commander was located, and then stations referred to as "sub-stations" that had no charge facilities.[687] If there was no nearby charge station (e.g., if exhibits were collected in a regional or a remote area), secure transport would be arranged to a charge station. Exhibits were stored in the exhibit room in bags or boxes, grouped by crime scene where practical.[688]

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[681] Transcript of the Inquiry, 4 July 2023, T4815.25-27 (TRA.00072.00001).
[682] Exhibit 51, Tab 1Y, NSWPF Detectives Training Course, Undated, [34] (NPL.0100.0003.0706).
[683] Exhibit 51, Tab 1Y, NSWPF Detectives Training Course, Undated, [34] (NPL.0100.0003.0706).
[684] Exhibit 51, Tab 1Y, NSWPF Detectives Training Course, Undated, [34(f)] (NPL.0100.0003.0706).
[685] 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).
[686] Transcript of the Inquiry, 4 July 2023, T4811.8-12 (TRA.00072.00001).
[687] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [78]-[79] (NPL.9000.0008.0905).
[688] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [79] (NPL.9000.0008.0905).

440. Exhibit management was an entirely manual process, and AC Conroy observed in her statement that "[w]hen exhibits were moved from their nominated location, this was supposed to be recorded in the exhibit book, but given it was an entirely manual process, this was not always up to date."[689] In her oral evidence, AC Conroy acknowledged that applicable police procedures during this period, and proper police practice, required the exhibit book to be kept up to date.[690]

441. If an OIC moved from one station to another and transferred to another police district, the exhibits would ordinarily be reallocated to another officer.[691] Audits of exhibits were carried out every three months. If an exhibit was not located, the OIC would report that to their supervisor and a report would go to the Commander of the police station.[692] AC Conroy accepted that there should be an independent record of the fact that particular exhibits had not been located.[693] AC Conroy was not aware of any disciplinary, performance management or support consequences that might occur as a result of the loss of exhibits.[694]

442. In the 1990s, "Commissioner's Instructions" were introduced. A copy of the Commissioner's Instruction relating to exhibits is also in evidence before the Inquiry.[695]

443. Instruction 33.01 in the 1989-1990 Police Rules and Instructions records the general policy at this time in relation to exhibits:[696]

> 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.

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[689] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [81] (NPL.9000.0008.0905); Transcript of the Inquiry, 4 July 2023, T4811.27-42 (TRA.00072.00001).
[690] Transcript of the Inquiry, 4 July 2023, T4811.35-42 (TRA.00072.00001).
[691] Transcript of the Inquiry, 4 July 2023, T4811.14-17 (TRA.00072.00001).
[692] Transcript of the Inquiry, 4 July 2023, T4812.1-6 (TRA.00072.00001).
[693] Transcript of the Inquiry, 4 July 2023, T4812.8-10 (TRA.00072.00001).
[694] Transcript of the Inquiry, 4 July 2023, T4812.22-32 (TRA.00072.00001).
[695] Exhibit 51, Tab 2G, NSW Police Service – Commissioner's Instructions, 1991-1992 (NPL.9000.0003.0255).
[696] Exhibit 51, Tab 5C, Police Rules and Instructions, [33.01] (NPL.9000.0018.0061).

- 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.

444. Instruction 33 includes detailed rules for the recording, management, return and disposal of different types of exhibits. The previous iterations contain similar instructions. Instruction 33 also guided the disposal of exhibits, often referrable to the type of exhibit. There are broad similarities to the procedures for the disposal of exhibits during this period and current procedures.[697] However, AC Conroy explained:[698]

> [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.

445. In her oral evidence, in response to questions from Senior Counsel Assisting about [104] of the First Conroy Statement, that it was normally desirable to retain exhibits when dealing with serious offences, AC Conroy explained that while this wasn't explicitly in the instructions in the 1970s and following, "certainly it would be preferable to keep exhibits for serious indictable offences for production at court".[699] She agreed that proper police practice requires exhibits to be retained in relation to serious offences, depending on the evidentiary value of the exhibits.[700]

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[697] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [112] (NPL.9000.0008.0905).
[698] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [113] (NPL.9000.0008.0905).
[699] Transcript of the Inquiry, 4 July 2023, T4818.12-16 (TRA.00072.00001).
[700] Transcript of the Inquiry, 4 July 2023, T4818.18-20 (TRA.00072.00001).

446. In addition, AC Conroy agreed that in the 1970s and the period following, proper police practice required consideration or the future evidentiary of forensic value of an exhibit before it was destroyed.[701] She agreed that she would expect to see a record of the destruction of an exhibit, and that proper police practice required a record of a decision to destroy or dispose of an exhibit.[702]

447. In relation to records management, DI Warren explained that his experience was that in the 1980s and 1990s the OIC was required, once a matter was finalised, to compile the material and (place it in some sort of container that would then be stored at the police station until the OIC of the police station (effectively the Commander of the police station) determined what would happen to that material.[703] DI Warren was not aware of any policy prior to the early 2000s that indicated to OICs at what point documents in their investigative files should be put into the storage room of a police station or sent to Corporate Records or to the GRR, but accepted that if there was such a policy it appeared that it had not always been adhered to.[704]

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

448. In 2000, the NSWPF implemented the Command Management Framework (**CMF**), which is still used today. The CMF is "a risk-based accountability structure that was originally in place in a paper-based form and it identifies an area of risk within the police station or the police district command and it mandates certain inspections are done, dip samples are done and reporting is done to the commander in relation to a range of systems within that police station."[705]

449. The responsibilities and accountabilities in relation to exhibit management are outlined in the Exhibit Procedures Manual.[706] As noted by AC Conroy in her statement, the CMF requires certain tests and audits to be conducted on a regular basis in relation to exhibits, including an annual 100% audit of exhibits. In addition, monthly "dip samples" have been available from 2011 on the CMF.[707]

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[701] Transcript of the Inquiry, 4 July 2023, T4819.29-34 (TRA.00072.00001).
[702] Transcript of the Inquiry, 4 July 2023, T4819.47-4520.7 (TRA.00072.00001).
[703] Transcript of the Inquiry, 5 July 2023, T4956.1-20 (TRA.00073.00001).
[704] Transcript of the Inquiry, 5 July 2023, T4965.18-35 (TRA.00073.00001).
[705] Transcript of the Inquiry, 4 July 2023, T4812.40-46 (TRA.00072.00001).
[706] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [85] (NPL.9000.0008.0905).
[707] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [86]-[87] (NPL.9000.0008.0905).

450. Prior to the introduction of EFIMS, exhibit audits were conducted manually by officers checking each page of the exhibit books and sighting exhibits within the police station exhibit office.[708] AC Conroy's oral evidence was that the requirement of an annual "100 per cent audit" meant that "every single exhibit has been inspected and ratified against the exhibit book within that police station."[709]

451. In January 2002, the Commissioner of the NSWPF directed a moratorium on the disposal of exhibits which might be the subject of DNA testing.[710] AC Conroy explained in her oral evidence that in order to decide whether an exhibit had biological or forensic value officers would look at why it was collected, and then consider the ability to recover trace DNA, blood, semen or saliva from that exhibit.[711]

452. In 2003, the Exhibits Guideline in the Police Handbook was reviewed, with the result that all exhibits associated with the prosecution of serious indictable matters and all sexual assaults were to be retained by LACs and under no circumstances were these exhibits to be destroyed or disposed of during the period of the moratorium.[712] In 2007, the moratorium was amended to mirror the scope of the Crimes (Forensic Procedures) Act 2000 (NSW) (**CFP Act**), which had the effect that a more limited set of exhibits were to be retained.[713] There were some further amendments in 2012.[714]

453. In 2005, Commissioner's Instructions were replaced by the Police Handbook. Instruction 33 was incorporated into the Handbook as "Exhibits", with minor changes. A copy of the sections of the Police Handbook concerning exhibits as at 2005 are in evidence.[715] AC Conroy explains that prior to 2012, the OIC was in charge of the handling of exhibits, and that the movement of exhibits remained a manual process.[716]

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[708] Transcript of the Inquiry, 4 July 2023, T4805.45-4806.2 (TRA.00072.00001).
[709] Transcript of the Inquiry, 4 July 2023, T4813.8-10 (TRA.00072.00001).
[710] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [114] (NPL.9000.0008.0905).
[711] Transcript of the Inquiry, 4 July 2023, T4816.13-17 (TRA.00072.00001).
[712] 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).
[713] 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).
[714] 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).
[715] Exhibit 51, Tab 3M, NSWPF Handbook Extracts, February 2005 (NPL.9000.0002.4655).
[716] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [99]-[100] (NPL.9000.0008.0905).

454. AC Conroy said in her statement that the key changes to the process for obtaining exhibits implemented in 2005 centred on significant developments in forensic testing.[717] The job of collecting exhibits containing biological material fell to Crime Scene Services Branch (**CSSB**) staff (now known as Forensic Investigators), and the OIC would be responsible for the collection of physical items not requiring forensic testing. The exhibits would be taken to the OIC's police station.[718] The changes implemented in this time concerning storage of exhibits related to the separation of exhibit management from miscellaneous property, and the development of appropriate storage facilities for biological samples.[719]

C.6 Current policies and procedures concerning exhibit management

455. The current processes for storing exhibits are set out in the Exhibits chapter of the Police Handbook and in the Exhibit Procedures Manual. The Exhibits chapter of the Police Handbook provides general guidance in relation to the effective management of exhibits, and is read by officers in conjunction with specific instructions related to the use of EFIMS and the Exhibit Procedures Manual.[720]

456. In relation to accountability for exhibits, AC Conroy said in her oral evidence that:[721]

> Well, when an exhibit is collected, it's entered into EFIMS. Once it is entered into EFIMS it's stored in an exhibit room. Once it's under the exhibit room, in the exhibit room, the exhibit officer is responsible for that exhibit, however the OIC remains responsible for the lifecycle of that exhibit. And then the officer – the commander of that police station is - then takes whole responsibility for ensuring that auditing and storage, retention or disposal of that exhibit is in accordance with the Police Handbook or with the legislation around that exhibit.

457. AC Conroy gave evidence that all exhibits, including historical exhibits, should be entered in EFIMS at this point in time.[722]

458. The Exhibit Procedures Manual was first released in December 2012, and the version introduced at that time is in evidence before the Inquiry.[723] The Exhibit Procedures Manual was introduced following an audit by the NSW Auditor General in 2011-2012, referred to as the "Strategic Drug Exhibit Project", and AC Conroy understands that it also incorporated relevant coronial recommendations or significant trial outcomes.[724]

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[717] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [57] (NPL.9000.0008.0905).
[718] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [59]-[62] (NPL.9000.0008.0905).
[719] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [90] (NPL.9000.0008.0905).
[720] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [26]-[27] (NPL.9000.0008.0905).
[721] Transcript of the Inquiry, 4 July 2023, T4801.14-24 (TRA.00072.00001).
[722] Transcript of the Inquiry, 4 July 2023, T4801.28-29 (TRA.00072.00001).
[723] Exhibit 51, Tab 3B, Exhibits Procedures Manual (Version 1), December 2012 (NPL.0900.0002.1706).
[724] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [30]-[31].

459. The current version of the Exhibit Procedures Manual is also in evidence before the Inquiry, as is the Exhibits chapter of the Police Handbook.[725] At present, Police Area/District Commanders and equivalent Specialist Commanders are accountable for the overall effective management of exhibits, including transportation, retention, security, safe handling and disposal of exhibits, although all officers have a duty to assist in this regard. The responsibility for the decision to retain or dispose of an exhibit rests with the Commander or the OIC.[726] The Commander or equivalent is responsible for ensuring compliance with the CMF, including by ensuring that audits of exhibits are conducted.[727]

460. If an OIC ceases employment with the NSWPF, or is absent for more than three months, all pending investigations, including exhibit responsibilities, are allocated to another officer. If the OIC is absent for fewer than three months, the second OIC retains responsibility for exhibits for the duration of the OIC's absence.[728]

C.6.1 Identifying and obtaining exhibits at a crime scene

461. Power to obtain exhibits is conferred on the NSWPF by a range of legislative instruments. An officer will consider a number of factors before determining whether an item should become an exhibit.[729] In her oral evidence, AC Conroy agreed with the proposition that in identifying an exhibit the OIC of an investigation will consider both the evidentiary purpose of the exhibit and the available powers of seizure.[730]

462. Obtaining physical exhibits is not required in every case (for example, in the absence of a need for analysis or testing, or unique characteristics such as a label or marking, photographs may well be sufficient).[731] At the time of collection, an officer should photograph the exhibit and make a record, including a description, in their police notebook. The exhibit will remain in the custody of the officer until it is entered into EFIMS (see [472]-[479] below). The OIC is to enter an exhibit into EFIMS at the first available opportunity.[732]

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[725] Exhibit 51, Tab 3E, Exhibits Procedures Manual, August 2022 (NPL.9000.0002.0137); Exhibit 51, Tab 3F, NSWPF Handbook, Chapter (NPL.9000.0002.0128).
[726] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [34] (NPL.9000.0008.0905).
[727] Transcript of the Inquiry, 4 July 2023, T4801.41-4802.8 (TRA.00072.00001).
[728] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [35] (NPL.9000.0008.0905); Transcript of the Inquiry, 4 July 2023, T4802.17-29 (TRA.00072.00001).
[729] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [37]-[38] (NPL.9000.0008.0905).
[730] Transcript of the Inquiry, 4 July 2023, T4802.45-4803.4 (TRA.00072.00001).
[731] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [39] (NPL.9000.0008.0905).
[732] Transcript of the Inquiry, 4 July 2023, T4801.41-46 (TRA.00072.00001).

C.6.2 Storing exhibits

463. The location and process for storage of exhibits varies depending on the type of exhibit. Police Area/District Commanders and equivalent Specialist Commanders are accountable for the safe handling and storage of exhibits.[733] Exhibits are stored for "as long as they are needed for investigative purposes or as evidence in a prosecution in accordance with LEPRA or other legislation, and the NSWPF policies and procedures set out in the Police Handbook and Exhibits Procedure Manual."[734] It is the OIC of an investigation who will determine how long an exhibit needs to be retained.[735]

464. Seized exhibits are ordinarily stored in either the police station closest to the location the exhibit was seized from, or the police station the OIC is attached to. An Exhibit Officer attached to the police station will manage the custody of the exhibit once it is in the exhibit room. The Exhibit Officer will liaise with the OIC until such time as the exhibit is either disposed of, returned to the owner, or destroyed.[736]

465. In 2014, an Exhibit Managers course was developed and is provided to officers undertaking Exhibit Officer functions.[737] The course takes four days, and is optional. AC Conroy was asked by Senior Counsel Assisting why the course was not mandatory for Exhibit Officers, but was not able to assist the Inquiry in relation to that matter.[738] AC Conroy was not aware of anyone monitoring whether or not Exhibit Officers had completed the course.[739]

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[733] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [65] (NPL.9000.0008.0905).
[734] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [66]-[67] (NPL.9000.0008.0905).
[735] Transcript of the Inquiry, 4 July 2023, T4806.28-33 (TRA.00072.00001).
[736] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [52]-[54] (NPL.9000.0008.0905).
[737] Exhibit 51, Tab 3N, Exhibit Managers Course Outline, September 2014 (NPL.9000.0008.0893); Exhibit 51, Tab 3O, Role Description, Team Leader – Exhibits, 18 October 2020 (NPL.9000.0008.0880).
[738] Transcript of the Inquiry, 4 July 2023, T4807.1-47 (TRA.00072.00001).
[739] Transcript of the Inquiry, 4 July 2023, T4807.7-9 (TRA.00072.00001).

466. Exhibits are stored in a range of different places. The MEPC warehouse has been available since 2011 for the storage of long term and bulky exhibits.[740] Some exhibits, including biological evidence and drug exhibits, require specialised storage.[741] While an exhibit remains in the custody of an Exhibit Officer, it will be subject to regular EFIMS audits, which will generate alerts if there is an anomaly or disruption in an exhibit's chain of custody.[742] Holding exhibits at the police station to which an OIC is attached is preferred because it allows the OIC to access the exhibit. Exhibits stored in police stations are subject to regular auditing and inspection for safe storage, and are held securely in exhibit storage rooms.[743]

467. However, some centralised storage facilities are available for exhibit storage.[744] Exhibits may be stored at the MEPC, but only if the exhibit is associated with a serious indictable offence with a potential sentence of more than 15 years. AC Conroy said in her oral evidence that exhibits associated with unsolved homicides could be kept at the MEPC for long term storage.[745] An exhibit must be entered into EFIMS in order to be accepted at the MEPC.[746]

C.6.3 Exhibit books

468. Physical exhibit books have now been replaced by the record keeping of exhibits via EFIMS, but may be used in limited cases, and exhibit books from prior to the introduction of EFIMS need to be stored.[747] Exhibit books are stored locally at Commands and Business Units for a minimum of two years or until they are no longer frequently accessed, in accordance with the Records and Information Policy Statement, "Policy Principle 2 – Storage and Transfer".[748] After this, they may be transferred for central storage to the GRR where they are retained for a period of at least 20 years in accordance with Functional Retention and Disposal Authority DA 220.[749]

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[740] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [135] (NPL.9000.0008.0905).
[741] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [73] (NPL.9000.0008.0905).
[742] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [76] (NPL.9000.0008.0905).
[743] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [147] (NPL.9000.0008.0905); Transcript of the Inquiry, 4 July 2023, T4809.9 (TRA.00072.00001).
[744] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [149]-[153] (NPL.9000.0008.0905).
[745] Transcript of the Inquiry, 4 July 2023, T4809.14-31 (TRA.00072.00001).
[746] Transcript of the Inquiry, 4 July 2023, T4828.36-46 (TRA.00072.00001).
[747] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [74] (NPL.9000.0008.0905).
[748] Exhibit 51, Tab 3P, Policy Principle 2 – Storage and Transfer, August 2022, 4 (NPL.9000.0008.0869); Transcript of the Inquiry, 4 July 2023, T4510.1-8 (TRA.00072.00001).
[749] 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).

469. AC Conroy gave oral evidence that there was no process by which physical exhibit books were recorded electronically.[750] She said the Corporate Owner of Records Management would be responsible for the destruction of any physical exhibit books after 20 years, in conjunction with the "destruction advice of the schedule that they have provided for those exhibit books or for those particular accountable books or documents."[751] She was not aware of a policy concerning the recording of when exhibit books or other documents were destroyed, but indicated that this would fall to the Corporate Owner of Records Management.[752]

C.6.4 The handling of exhibits

470. Since 2012, the Exhibit Procedures Manual has governed general procedures concerning the handling of exhibits.[753] AC Conroy said in her statement that the process of exhibit handling is complex because of the various circumstances that require handling of exhibits (e.g., transporting for forensic examination, producing during a suspect interview, producing at court). The process is therefore often case specific. However, in all cases where an exhibit has been accessed or removed from an exhibit room, a record of the movement is made on EFIMS, including the details of the officer removing the exhibit and the reason for the movement or access to the exhibit.[754]

C.6.5 The destruction of exhibits

471. Exhibit destruction at present is governed by relevant legislation, the Exhibit Procedures Manual, and the Exhibits chapter of the NSWPF Police Handbook. Whether and when an exhibit can be destroyed is dependent on the need for its retention for evidentiary purposes during an investigation or prosecution. When dealing with serious offences, it is normally desirable to retain exhibits. Generally, exhibit retention is considered on a case-by-case basis by the OIC.[755] If the OIC is of the opinion that an exhibit should be disposed of, the OIC will write to the PAC Commander or the Police District Commander to authorise the disposal of the exhibit.[756]

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[750] Transcript of the Inquiry, 4 July 2023, T4810.10-12 (TRA.00072.00001).
[751] Transcript of the Inquiry, 4 July 2023, T4810.14-19 (TRA.00072.00001).
[752] Transcript of the Inquiry, 4 July 2023, 4810.25-31 (TRA.00072.00001).
[753] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [92] (NPL.9000.0008.0905).
[754] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [93]-[95] (NPL.9000.0008.0905).
[755] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [103]-[105] (NPL.9000.0008.0905).
[756] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [106] (NPL.9000.0008.0905).

C.6.6 The introduction of EFIMS

472. As noted above, exhibits are now managed through EFIMS. EFIMS was implemented in March 2011 in order to "manage all aspects of the exhibit life cycle."[757] It was introduced, in part, out of the increasing demand for DNA services, and following a review by the Ombudsman in relation to DNA sampling and forensic procedure.[758]

473. It was put to AC Conroy by Senior Counsel Assisting that the extension of EFIMS from forensic exhibits to all exhibits was because it had been identified by the project team that "the paper-based exhibit management system was dysfunctional, inaccurate, labour intensive, constrained by red tape and embodied significant and substantial operational problems and risks".[759] AC Conroy agreed.[760]

474. Reports, including chain of custody reports and audit reports, can be generated through EFIMS.[761] On implementation, all NSWPF officers were given information about EFIMS, and training was implemented for new recruits.[762] In 2013, the NSW Auditor General observed that EFIMS represented a "significant improvement" to the system for recording and tracking drug exhibits.[763] AC Conroy said EFIMS has been improved since its introduction in 2012.[764]

475. Recording an exhibit in EFIMS involves an officer logging onto a computer connected to the NSWPF system, opening the EFIMS application, recording an exhibit entry (including mandatory fields) and saving the entry. A similar process applies for recording exhibit movements.[765]

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[757] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [127]-[129] (NPL.9000.0008.0905).
[758] Transcript of the Inquiry, 4 July 2023, T4822.2-9 (TRA.00072.00001).
[759] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [125] (NPL.9000.0008.0905); Exhibit 51, Tab 3X, Executive Summary and NSWPF Endorsement re FIMS, 11 June 2009, 3 (NPL.9000.0008.0063).
[760] Transcript of the Inquiry, 4 July 2023, T4822.42-47 (TRA.00072.00001).
[761] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [129] (NPL.9000.0008.0905).
[762] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [130] (NPL.9000.0008.0905).
[763] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [134] (NPL.9000.0008.0905).
[764] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [133] (NPL.9000.0008.0905).
[765] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [137]-[141] (NPL.9000.0008.0905).

476. AC Conroy gave evidence that when EFIMS was created, any exhibit that was a "live exhibit", in the sense of being within a police station, was entered onto EFIMS, but that historical exhibits were not entered onto EFIMS at that time.[766] Her evidence was that over a "significant period of time" every exhibit, including historical exhibits, was then entered onto EFIMS. Each police station was responsible for its exhibits and for transferring those exhibits from an exhibit book into EFIMS.[767] AC Conroy did not think that this process had included the digitisation of exhibit books.[768] The exhibit reconciliation process referred to by AC Conroy may be the process undertaken following the Lehmann Report, discussed at Part C.7.1.

477. The entry of exhibits into EFIMS is not supervised, but when an exhibit is moved there is a process where the movement of the exhibit needs to be "accepted" by another officer. Although EFIMS has a number of fixed forms and cells, there is no mechanism to detect other types of errors (e.g., a misdescription) in the way in which an exhibit has been recorded. However, this type of error may well be detected by the exhibit officer when they are handed the exhibit and compare the exhibit entry in EFIMS to the item description on the exhibit bag.[769]

478. AC Conroy noted in her statement that the Commissioner of the NSWPF has approved deployment of a new system that will allow for the decommissioning of EFIMS. This is part of a wider rollout of a cloud-based Integrated Policing Operations System (**iPOS**) to replace COPS and similar systems.[770]

479. In her statement, AC Conroy makes the following observations about the changes to exhibit management practices:[771]

[766] Transcript of the Inquiry, 4 July 2023, T4823 (TRA.00072.00001).
[767] Transcript of the Inquiry, 4 July 2023, T4823.25-42 (TRA.00072.00001).
[768] Transcript of the Inquiry, 4 July 2023, T4824.4-9 (TRA.00072.00001).
[769] Transcript of the Inquiry, 4 July 2023, T4824.37-4525.37 (TRA.00072.00001).
[770] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [142]-[144] (NPL.9000.0008.0905).
[771] Exhibit 51, Tab 3, Statement of Assistant Commissioner Rashelle Conroy, 2 May 2023, [157]-[158] (NPL.9000.0008.0905).

In my view, these extensive developments mean it is far less likely that exhibits will be lost, misplaced or stored inappropriately. While there have been many incremental changes to the procedures to manage exhibits over the last fifty years, of particular significance was the rollout of EFIMS in 2011, and the Exhibit Procedures Manual in 2012. I have already explained the development and nature of these initiatives at paragraphs [26] to [32] of my statement respectively. However, by way of brief summary, I consider that the procedures now in place by virtue of this combination of initiatives have significantly improved the tracking and preservation of exhibits, both for present and future use, for the following reasons: mandatory, centralised, electronic recording of every time an exhibit is accessed or transported from obtaining through to disposal means it is much more difficult for an exhibit to be lost through a failure to record a movement, a failure to record a movement in the correct place or a loss of the relevant physical documentation;

a. electronic recording also streamlines and improves the accuracy and efficacy of audits in identifying any discrepancies in the location of the exhibit, by pinpointing its last known location and the officer responsible;

b. the development of clear guidance regarding the collection and preservation of exhibits in a way which not only maintains their integrity for present forensic testing, but also for future development of new technologies and testing capabilities;

c. the development of clear guidance, including the authorisation required, for the disposal of exhibits, to ensure key evidence is not lost prematurely; and

d. the implementation of the CMF system described above at paragraphs and [83] – [89] introduced additional audit requirements and accountability measures.

As demonstrated by the continued updating of the exhibit management procedures and the software that supports them (including the rollout of a new system to replace EFIMS in 2024), review of the exhibits management process to ensure it is fit for purpose, up to date and takes advantage of all available technological and forensic advancements remains a key focus of NSWPF.

C.6.7 Treatment of exhibits at FASS

480. Ms Neville described the process in place at FASS for the storage and use of exhibits. Upon receipt of the exhibits, FBDNA will label exhibit bags or boxes and store them in secure locations (which includes cold storage if required), which Ms Neville described as "historical practice", which has now evolved to include barcode identifiers for exhibit bags.[772] Prior to the introduction of electronic casefiles to record stored locations, Ms Neville notes that individual biologists who conducted an examination of exhibits recorded the locations of stored samples.[773]

[772] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [90],[94]-[95] (SCOI.83528).
[773] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [100] (SCOI.83528).

481. Currently, all movements of the "exhibit from the Forensic Receipt Unit through to Evidence Recovery" is recorded in the Forensic Register Evidence Database (**FRED**).[774] Ms Neville believes that the FRED system has been operational since about 2012.[775]

482. Once received, exhibits "are examined in the FBDNA Evidence Recovery Unit (ERU), and appropriate samples are taken for testing either within the ERU and/or in the DNA laboratory."[776]

483. Ms Neville told the Inquiry that the FBNDA laboratory is subject to quality checks, proficiency testing programmes, compliance standards, training and competency assessments, and operating procedures to "ensure uniform and reliable testing and reporting and to detect and prevent errors."[777] The "FBDNA laboratory has been accredited by NATA (National Association of Testing Authorities, Australia) against ISO/IEC 17025 since 1999."[778]

484. Ms Neville also explained the ways in which the DNA testing methods used by FBDNA "undergo verification or validation prior to implementation,"[779] and the "significant training" that the forensic biologists at FBDNA undergo to carry out DNA testing.[780]

485. Once examination of exhibits by FBDNA is complete, exhibits not "consumed in analysis" are returned to the NSWPF by the FASS Forensic Receipt Unit (**FRU**), and the movement is recorded in EFIMS.[781] Prior to EFIMS, these movements were registered in an exhibit book.[782]

486. In addition, "processed substrates used to collect DNA from exhibits (e.g., swabs and tape lifts) and other substates such as swatches of material removed from an exhibit are discarded following extraction and DNA testing."[783]

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[774] Transcript of the Inquiry, 15 August 2023, T5523.10-31 (TRA.00082.00001).
[775] Transcript of the Inquiry, 15 August 2023, T5523.38-41 (TRA.00082.00001).
[776] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [96] (SCOI.83528).
[777] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [120] (SCOI.83528). See also Transcript of the Inquiry, 15 August 2023, T5510.8-47 (TRA.00082.00001).
[778] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [124] (SCOI.83528); affirmed in oral evidence at Transcript of the Inquiry, 15 August 2023, T5530.1-3 (TRA.00082.00001).
[779] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [108] (SCOI.83528); affirmed in oral evidence at Transcript of the Inquiry, 15 August 2023, T5529.15-31 (TRA.00082.00001).
[780] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [111] (SCOI.83528).
[781] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [88], [103], [104] (SCOI.83528); affirmed in oral evidence at Transcript of the Inquiry, 15 August 2023, T5524.21-25 (TRA.00082.00001).
[782] Transcript of the Inquiry, 15 August 2023, T5522.45-5524.6 (TRA.00082.00001).
[783] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [93] (SCOI.83528).

487. However, all DNA extracts or samples are retained by FBDNA indefinitely,[784] as with blood samples,[785] and, since 1986, samples removed from exhibits or DNA swabs have been retained by FASS in a storage freezer.[786] Unless a destruction order is received, "person reference samples are stored in a secure location at room temperature indefinitely" in line with the CFP Act requirements.[787] Since the introduction of EFIMS, the FBDNA team will provide information on EFIMS relating to stored untested swabs or exhibits, which were previously recorded only in FBDNA case files.[788]

488. Ms Neville told the Commissioner that she has experienced the loss of exhibits or misplaced samples in a "very, very small number of instances".[789] When this has occurred, Ms Neville said that a full investigation is carried out, which includes notifying the NSWPF and identifying "preventative maintenance controls to minimise any risk of a similar incident occurring".[790] However, Ms Neville stated that it is often not possible to find out what has happened or recoup the lost exhibit sample.[791]

C.6.8 Submissions concerning exhibit management

489. Part D below deals with exhibit management in specific cases before the Inquiry. In many of those cases, AC Conroy or DI Warren accepted that the management of exhibits in the relevant case did not accord with proper police practice. It is apparent that there were significant errors and oversights in the management of exhibits in relation to many of the cases before the Inquiry. The evidence summarised in this section of the submissions suggests that these deficiencies were systemic or widespread within the NSWPF before the introduction of EFIMS.

490. One submission that has been made in relation to a number of the cases dealt with in Part D below by the NSWPF is that there is limited utility in criticising the NSWPF in relation to historical failures in exhibit management.

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[784] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [92] (SCOI.83528); affirmed in oral evidence at Transcript of the Inquiry, 15 August 2023, T5522.27 and T5524.11-19 (TRA.00082.00001) as a practice which has continued from the start of DNA testing, unless NSWPF specifically request that the sample be returned.
[785] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [101] (SCOI.83528).
[786] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [91] (SCOI.83528); affirmed in oral evidence at Transcript of the Inquiry, 15 August 2023, T5522.34-43 (TRA.00082.00001).
[787] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [102] (SCOI.83528).
[788] Exhibit 51, Tab 14, Statement of Sharon Neville, 1 June 2023, [99] (SCOI.83528).
[789] Transcript of the Inquiry, 15 August 2023, T5525.33-5526.4 (TRA.00082.00001).
[790] Transcript of the Inquiry, 15 August 2023, T5525.42-T5526.4 (TRA.00082.00001).
[791] Transcript of the Inquiry, 15 August 2023, T5526.5-17 (TRA.00082.00001).

491. This submission should not be accepted. It is true that the evidence of the NSWPF witnesses explains changes that have been made that diminish the possibility that similar problems will occur in the future. However, a large number of the instances where exhibits or documents have been lost or destroyed are not instances where, for example, exhibits were destroyed in accordance with procedures which did not anticipate scientific developments, or where records were disposed of in accordance with relevant document retention and destruction authorities.

492. There is a distinction between a failure of foresight, which might explain policies or procedures which, with the benefit of hindsight, were insufficient, and the unexplained loss or destruction of documents and exhibits. Even in the former case, some criticism would be called if the NSWPF policies suggested a failure to anticipate future developments that should have been foreseen, for example, the possibility of advances in forensic science or, once DNA testing emerged, improvements in DNA technology. However, in many cases one or more of the NSWPF witnesses accepted that there was no explanation for why material had been lost or destroyed, or why there was no record of an authorised destruction. This could not be excused as a mere failure of foresight.

493. As is set out at [131] above, it is not possible for the Inquiry to know whether or not 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 LGBTIQ community. However, it is important that the public appreciate the extent to which this creates obstacles to the investigation of these presently unsolved homicides. The level of deviation from what might reasonably have been expected in relation to exhibits and records is not something that can be explained by isolated instances of human error, or an understandable failure to appreciate how technology might develop. Indeed, the extent of the problem is something that is described in internal NSWPF documents such as the Lehmann Report (described in more detail in Pt C.7.1 below).

494. The state of the exhibits and records held by the NSWPF has had a substantial impact on the ability of the Inquiry to perform its work in relation to some cases. It is not possible to conduct further forensic testing on exhibits that have been lost, or to explore avenues of investigation when entire investigative files cannot be located. This is a matter which should be acknowledged and recorded, particularly as in some cases it likely means that no perpetrator will ever be located.

495. The evidence before the Inquiry, especially AC Conroy's evidence as to present exhibit management practices, does not suggest that these systemic or widespread deficiencies have continued in relation to current investigations following the introduction of EFIMS. It is apparent that the introduction of the EFIMS system has significantly increased the ability for exhibits to be logged and tracked.

496. There were significant missed opportunities to improve the management of historical exhibits including, first, during the initial review conducted by the UHT between 2004 and 2008 and, second, following the Lehmann Report. It was remarkable how little some of the NSWPF witnesses appeared to know about the Lehmann Report and the widespread problems with historical exhibits. AC Conroy had not seen the report. DI Warren said that he did not know about these problems until they were encountered in the course of responding to the Inquiry.

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

497. As is set out at [370]-[373] above, the UHT was established and an initial review of unsolved homicide cases commenced in 2004. Dr Allsop's evidence concerning the matters that are important in reviewing cold cases is set out in Pt C.1 above. One of these matters is the availability of exhibits and investigative materials. This section considers knowledge within the NSWPF of the widespread problems with locating exhibits and investigative materials concerning unsolved homicides. This topic raises two key issues.

498. *First*, the question arises as to when the NSWPF could reasonably have been expected to take action such as an audit of exhibits and documentary material to seek to, as far as possible, remedy the problems being encountered in some matters considered by the UHT. *Second*, it raises the question of what, if anything, the NSWPF should have communicated to the Inquiry about this matter.

499. Given that the NSWPF dedicated resources to reviewing 300 to 400 cases in the period between 2004 and 2008, these widespread problems with records and exhibits should have been identified. That would also have presented an opportunity to conduct an audit and endeavour to establish what records and exhibits were available in relation to all unsolved homicides.

500. It is, frankly, implausible to think that these problems were not identified and discussed by the detectives who conducted the initial review process between 2004 and 2008. Some people within the NSWPF must have been aware of these problems at that time and, certainly by the time of the Lehmann Report (see Pt C.7.1), they were appreciated by at least some officers in very senior roles within the NSWPF.

501. If the UHT identified these problems in 2004 to 2008 and did not communicate them more widely at this time, that is to be deplored. If the UHT communicated these problems more widely, and the NSWPF did not take action, that is highly regrettable and reflects a major missed opportunity.

502. This initial review conducted by the UHT was commenced almost 20 years ago. Had efforts been made to conduct a thorough audit of records and exhibits at that time, material may have been located that has been lost or degraded in the period between 2004 and the present, or between 2004 and 2017 when the efforts described at [524]-[526] below were undertaken.

C.7.1 The Lehmann Report

503. The Inquiry has before it a report dated 5 August 2016 prepared by Detective Chief Inspector Lehmann of the UHT (**Lehmann Report**).[792]

504. The Lehmann Report identifies five problems faced by the UHT in relation to exhibits. Under the heading "Problem – 1" the Lehmann Report identifies that a significant component of the assessment and review process is searching for exhibits relating to a case. It states that "[t]he experience of the UHT is that [the assessment and review process] has been a frustrating and difficult task in many cases" because exhibits had been destroyed, lost or misplaced, and because exhibit records were destroyed, lost, inaccurate or incomplete.[793]

505. Under the heading "Problem – 2" the Lehmann Report identifies that exhibits which were located ("often through luck and at locations that are unexpected and not indicated through records") were unlabelled or improperly labelled, improperly secured, mixed with exhibits from other cases, or not readily identifiable as pertaining to a particular case.[794]

506. "Problem – 3" is described as being the fact that many of the "poorly secured exhibits" include the homicide victim's clothing and post-mortem and crime scene specimen swabs, raising a biohazard risk.[795]

507. "Problem – 4" is expressed as being that:[796]

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[792] Exhibit 51, Tab 6F, Report of Detective Chief Inspector Lehmann, 5 August 2016 (NPL.0100.0018.0001).
[793] Exhibit 51, Tab 6F, Report of Detective Chief Inspector John Lehmann, 5 August 2016 (NPL.0100.0018.0001).
[794] Exhibit 51, Tab 6F, Report of Detective Chief Inspector John Lehmann, 5 August 2016 (NPL.0100.0018.0001); Exhibit 51, Tab 5E, NSWPF Records Retention Policy (DA0221), 20 June 2017, 38 (NPL.9000.0018.0469).
[795] Exhibit 51, Tab 6F, Report of Detective Chief Inspector John Lehmann, 5 August 2016 (NPL.0100.0018.0001).
[796] Exhibit 51, Tab 6F, Report of Detective Chief Inspector John Lehmann, 5 August 2016 (NPL.0100.0018.0001).

> [a]t the conclusion of original investigations that remain unsolved, the UHT experience has found that many briefs of evidence, case file documents and physical evidence exhibits were not archived and stored in a proper manner. Many exhibits are improperly packaged and archived within case file boxes and in other cases, case file boxes including exhibits were not even recorded and archived, but left on shelves at various locations in police premises or in some cases, left in non police premises with no records to indicate their movement or whereabouts.

508. The Lehmann Report notes that when the NSWPF Records Repository at Stanmore closed, numerous exhibits were located amongst case file boxes having been improperly stored. It says that eight pallets of items being were transferred to the MEPC and were, at the time of the Lehmann Report, awaiting identification and recording. The Lehmann Report identifies that "[m]any of these items may relate to unsolved homicide cases and they will have to be examined by UHT investigators to determine this."[797]

509. In addition, the Lehmann Report identifies as "Problem – 5" that changes in organisational structure, police regions, districts and divisions, and the realignment of boundaries and formation of LACs have all had a "detrimental effect" in relation to locating historical exhibits. It records that historical exhibits may have been moved without the records reflecting those changes. The Lehmann Report states: [798]

> When the UHT reviewed 400 cases between 2004 and 2008, the reviewing officers relied on known exhibit records that existed indicating the last known location of the exhibit searched for. On occasions when making enquiries with the relevant staff in charge of exhibit management, UHT reviewing officers were informed that the exhibit was not at the location or could not be found. This essentially ended the search for that exhibit and was significant for the outcome of the case review and its determination for future re-investigation.
>
> Through experience gained since that time we now know that the exhibit may have existed but:
>
> a) The exhibit officer did not know that the item was at the location because there was no updated record that indicated so
>
> b) The exhibit had been moved to a new location however there was no updated exhibit movement record to indicate this.

510. The Lehmann Report goes on to comment:[799]

[797] Exhibit 51, Tab 6F, Report of Detective Chief Inspector John Lehmann, 5 August 2016, 3 (NPL.0100.0018.0001).
[798] Exhibit 51, Tab 6F, Report of Detective Chief Inspector John Lehmann, 5 August 2016 (NPL.0100.0018.0001).
[799] Exhibit 51, Tab 6F, Report of Detective Chief Inspector John Lehmann, 5 August 2016 (NPL.0100.0018.0001).

> 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.

511. In addition, it sets out the previous searches conducted by the UHT, and a proposed reconciliation plan in relation to the exhibits.[800] The front of the version of the Lehmann Report produced to the Inquiry has an annotation from Detective Superintendent Michael Willing (**DS Willing**), the then Commander of the Homicide Squad, dated 31 August 2016, reading "[f]or discussion asap with myself re moving forward."[801]

512. There is also an annotation at the end of the Lehmann Report from DS Willing dated 22 June 2016 identifying that the Lehmann Report had been forwarded for the information of the Director of the State Crime Directorate (**SCD**) and the Commander of the **SCC**. Both the Director of the SCD, Detective Chief Superintendent John Kerlatec (**DSC Kerlatec**), and the Commander of the SCC, have signed the Lehmann Report. DCS Kerlatec supported the proposed review of exhibits, and the Commander of the SCC (unnamed in the Report) recorded "Review Approved" and dated this note 1 December 2016.

513. The Lehmann Report identifies that in 2013 the UHT took a (limited) general search for exhibits at some locations and that "UHT officers were directed to a basement of a police centre storeroom and located a number of exhibit items relating to 22 unsolved homicide cases dating back to the 1970's that had been undiscovered."[802] Amongst those exhibits was physical evidence that became the "lynch pin" in charging Leonard John Warwick with the Jehovah's Witness Hall bombing in Casula in 1985 and associated crimes.[803]

514. The Warwick matter is, of course, outside the Inquiry's Terms of Reference. However, it is powerfully illustrative of a very serious sequence of crimes of major public concern, where the investigation was hindered for many years by the inability to locate crucial exhibits. As is set out in Part D below, there are a large number of matters in the Inquiry where exhibits cannot be accounted for. One of those exhibits may likewise have been a lynch pin in charging an offender.

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[800] Exhibit 51, Tab 6F, Report of Detective Chief Inspector John Lehmann, 5 August 2016 (NPL.0100.0018.0001).
[801] Exhibit 51, Tab 6F, Report of Detective Chief Inspector John Lehmann, 5 August 2016, 1 (NPL.0100.0018.0001).
[802] Exhibit 51, Tab 6F, Report of Detective Chief Inspector John Lehmann, 5 August 2016, 2-3 (NPL.0100.0018.0001).
[803] Exhibit 51, Tab 6F, Report of Detective Chief Inspector John Lehmann, 5 August 2016, 2-3 (NPL.0100.0018.0001).

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

515. AC Conroy was taken to the Lehmann Report by Senior Counsel Assisting. She said that she had seen the Lehmann Report while preparing for her evidence before the Inquiry, but not before that.[804]

516. AC Conroy agreed that the difficulties identified as Problem 2 in the Lehmann Report were consistent with her knowledge and experience as at 2016, and that, based on her review of the records in relation to unsolved homicides reviewed recently, this problem continues.[805] She likewise agreed that Problems 3 and 4 were and continue to be problems with historical exhibits.[806]

517. AC Conroy's evidence was that the situation described as Problem 5 was one that only came to her attention as a consequence of preparation for giving evidence before the Inquiry.[807] Her evidence was that she did not know whether the reconciliation plan described in the Lehmann Report had ever been implemented, but said it would not be fair to infer from her lack of knowledge that no plan of this kind had been carried out.[808]

518. DS Doherty was also taken to the Lehmann Report by Senior Counsel Assisting. He said he did not recall seeing the document before.[809] We note that the Lehmann Report was created before DS Doherty assumed his role as Commander of the Homicide Squad.

519. DS Doherty was asked by Senior Counsel Assisting whether, when he became Commander of the Homicide Squad, he was made aware of issues concerning the location, identification and reconciliation and identification of exhibits, and he said he had been made aware of those issues. He also agreed that each of the problems identified in the Lehmann Report were matters he was aware of in December 2019.[810]

520. DS Doherty said that these problems were raised in an ad hoc way by the UHT while cases were being reviewed. He was asked by Senior Counsel Assisting whether the problems existed in relation to a large number of unsolved homicides and said that he "wouldn't say a large number", although it "does come up in discussions". He said, "the issue's come up, it hasn't been an incredibly large number."[811]

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[804] Transcript of the Inquiry, 4 July 2023, T4858.8-17 (TRA.00072.00001).
[805] Transcript of the Inquiry, 4 July 2023, T4859.7-41 (TRA.00072.00001)
[806] Transcript of the Inquiry, 4 July 2023, T4859.43-4850.27 (TRA.00072.00001).
[807] Transcript of the Inquiry, 4 July 2023, T4860.29-47 (TRA.00072.00001).
[808] Transcript of the Inquiry, 4 July 2023, T4861.2-28 (TRA.00072.00001).
[809] Transcript of the Inquiry, 6 July 2023, T5055.22-34 (TRA.00074.00001).
[810] Transcript of the Inquiry, 6 July 2023, T5056.34-5057.16 (TRA.00074.00001).
[811] Transcript of the Inquiry, 6 July 2023, T5058.42-5060.22 (TRA.00074.00001).

521. DS Doherty was asked whether he was aware of the exhibit reconciliation plan proposed in the Lehmann Report, and he said that he was aware of a project by members of the UHT to centralise exhibits to the MEPC.[812] He said his understanding when he became Commander of the Homicide Squad was that this project was "getting to the end" but that "there were still issues around trying to locate exhibit items, documents."[813]

522. He was asked by the Commissioner whether "in some cases, notwithstanding the efforts that had been undertaken, you were or someone in the Unsolved Homicide Team was satisfied that you didn't have all the relevant holdings, paper and exhibits included?", and he agreed that this was the case.[814] He was not aware of any written document setting out that this project had come to an end, and accepted that such a report was likely to come to his attention if the project had been completed."[815]

523. It was put to DS Doherty by Senior Counsel Assisting that the centralisation of exhibits would not address all, or even most, of the problems identified in the Lehmann Report. He agreed that this was the case, and that Problems 1-5 were well known within the UHT and were brought to his attention when he assumed his position as Commander. He also accepted the proposition that these are still problems within the UHT, and the contention put to him by the Commissioner that there is "a significant...degree of uncertainty across the board in relation to the holdings of unsolved homicide cases."[816]

524. DCI Laidlaw was also taken to the Lehmann Report by Senior Counsel Assisting. DCI Laidlaw gave evidence that he was made aware of the Lehmann Report when he took over the UHT Review Team.[817] He accepted that as at August 2016, five problems had been identified in that report in relation to exhibits and documentary records including investigative files.[818] He said he was unable to assist the Inquiry with whether or not the reconciliation plan had been completed.[819]

[812] Transcript of the Inquiry, 6 July 2023, T5062.21-5063.18 (TRA.00074.00001).
[813] Transcript of the Inquiry, 6 July 2023, T5063.1-6 (TRA.00074.00001).
[814] Transcript of the Inquiry, 6 July 2023, T5064.13-22 (TRA.00074.00001).
[815] Transcript of the Inquiry, 6 July 2023, T5066.27-42 (TRA.00074.00001).
[816] Transcript of the Inquiry, 6 July 2023, T5067.31-35 (TRA.00074.00001).
[817] Transcript of the Inquiry, 6 July 2023, T5141.45-5142.8 (TRA.00074.00001).
[818] Transcript of the Inquiry, 6 July 2023, T5142.29-5143.10 (TRA.00074.00001).
[819] Transcript of the Inquiry, 6 July 2023, T5144.2 (TRA.00074.00001).

525. DCI Laidlaw gave evidence that he had not received written updates about the progress of the reconciliation project, and that there were outstanding requests to LACs in relation to exhibits. He said that he had not invoked his authority to require a response to these outstanding requests.[820] He said that the requests made in October 2016 had been followed up in 2017 and that they had received replies to around 80% of those requests.[821]

526. Senior Counsel Assisting asked whether someone was responsible for collating and reviewing the replies. DCI Laidlaw said that he supposed that responsibility now rested with him, but agreed that he had not conducted that exercise or taken any steps towards reviewing the responses received. He had not sought any additional resources for the purposes of conducting that exercise.[822] DCI Laidlaw was not aware of any similar project to reconcile documentary records.[823]

527. DCI Laidlaw was asked whether he was able to say whether a large number of unsolved homicides had exhibits missing. He said he could not give a number, but agreed that he could not exclude the possibility that it was a large number, and that he had "absolutely no idea as to the dimension of the likely problem or possible problem."[824] In relation to whether it was a "common issue", DCI Laidlaw repeated that he could not provide a number. He said that they did not find this problem with every case that was triaged, but that it affected some.[825]

528. DCI Laidlaw said in his statement that since the time of the Lehmann Report exhibits pertaining to unsolved homicides are now stored at the MEPC.[826] The Command responsible for the initial investigation arranges for the transfer of exhibits to the MEPC for any cases listed in the UHT Tracking File (see [318]-[329]), in accordance with a direction given to all Commands in 2016. During the triage process, the officer in the UHT Review Team will check to ensure exhibits are stored at the MEPC and, if they are not, will make a request to the relevant Command to have them transferred.[827]

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[820] Transcript of the Inquiry, 6 July 2023, T5145.9 (TRA.00074.00001).
[821] Transcript of the Inquiry, 6 July 2023, T5147.47-5148.1 (TRA.00074.00001).
[822] Transcript of the Inquiry, 6 July 2023, T5148.10-45 (TRA.00074.00001).
[823] Transcript of the Inquiry, 6 July 2023, T5145.40 (TRA.00074.00001).
[824] Transcript of the Inquiry, 7 July 2023, T5188.39-5189.11 (TRA.00075.00001).
[825] Transcript of the Inquiry, 7 July 2023, T5189.15-38 (TRA.00075.00001).
[826] Exhibit 51, Tab 6, Statement of Detective Chief Inspector David Laidlaw, 13 June 2023, [108] (NPL.9000.0019.0001).
[827] Exhibit 51, Tab 6, Statement of Detective Chief Inspector David Laidlaw, 13 June 2023, [109]-[110] (NPL.9000.0019.0001).

C.7.1.2 Additional documentary material concerning the Lehmann Report

529. The Inquiry issued a summons following the first tranche of the Investigative Practices Hearing seeking, relevantly, documents concerning the implementation of the recommendations of the Lehmann Report (summons NSWPF146).

530. It is clear that towards the end of 2016 and during 2017 memoranda were circulated to LACs requesting that they conduct an inventory of all unsolved homicide exhibits. Those memoranda, which are substantially in the same form, said:[828]

> BACKGROUND:
>
> The Unsolved Homicide Team (UHT), State Crime Command is embarking on a project to recover and centralise historical unsolved homicide case exhibits throughout New South Wales. There are approximately 650 unsolved homicide cases in NSW. Due to some poor exhibit management practices from years ago, the existence of many exhibits relating to those cases is not readily identifiable.
>
> A limited search for exhibits by the UHT in recent years has located exhibits at a number of locations, the existence and whereabouts of which were previously unknown. Many of the exhibits have since been subjected to new forensic analysis and yielded important evidence such as DNA, proving significant in the solvability potential of the cases they belong to. The exhibits in questions are those taken into police possession prior to the advent of EFIMS and have not been converted onto this system.
>
> CURRENT POSITION:
>
> The UHT are now requesting that an inventory be conducted of all exhibits on hand relating to all homicide cases (not converted to EFIMS). Searching should include all sub stations within the LAC and premises used for exhibit storage. Details are to be provided and the file returned to the UHT for information. This should include copies of exhibit book entries pertaining to exhibits on hand, including entries that indicate the transfer or destruction of items. 'Nil Return' files are to be returned to the UHT.
>
> If exhibits are located, the UHT should be contacted on eaglenet 28991 in order for arrangements to be made for the exhibits to be collected and transferred to the Metropolitan Exhibit and Property Centre, [REDACTED] by UHT personnel.
>
> The inventory should include scrutiny of exhibit books to ascertain the current or last location of exhibits in the event they have been transferred to other locations (eg. to FASS for scientific analysis). Once transferred to the MEPC, UHT personnel will maintain responsibility for each exhibit item to be entered onto EFIMS and kept for long term storage.

[828] 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).

531. The Inquiry has before it a number of responses from LACs. In cases where LACs had not responded, it appears that follow-up memoranda, signed by Detective Chief Inspector Christopher Olen (**DCI Olen**) of the UHT, were sent in July 2017.[829]

532. The documentary material before the Inquiry suggests that on occasion LACs had contacted the UHT to advise them that there were no relevant exhibits, but no records of this were made by the UHT.[830] No document compiling the responses of each LAC has been produced to the Inquiry, although such a document would have been within the terms of the summonses issued by the Inquiry. It is apparent that the task was not straightforward – for example, a response from the St George LAC records:[831]

> The Unsolved Homicide Exhibit report was allocated to me last year to address for St George LAC. As mentioned by Paul Simpkins, we have been in the process of addressing a room at Riverwood Police Station that basically was a dumping ground for a lot of the Commands old, old exhibits for a very long time. Until 12 months ago the exhibits were still being managed via the old Exhibit Books and basically forgotten about. To give you an idea we recently disposed of exhibits from an extortion in 1994 where the OIC was a Det Sen Con. No names but he recently became our Commissioner. Just an example of what we have been coming to terms with.
>
> As part of a greater exhibits project for the Command, I have had a part time officer at the location that has been back capturing and re-bagging the exhibits into the modern bags and placing as many details as she possibly can onto those bags - information she has to draw from COPS and in some instances she has to do iAsk's for the old CIR's. As of two weeks ago, all exhibits and that officer have been moved from Riverwood back up to Hurstville, however, it is a rather arduous process which the officer is doing a commendable job with. As it stood Sir, [REDACTED] would not accept the exhibits as they are as they are not on EFIMS and the bags have deteriorated over time, some you would pick up and the contents would spill onto the floor.
>
> Importantly to your Unsolved Homicide officers, there is definitely going to be items that relate to the file generated by D/C/Insp Lehmann.
>
> I do apologise Sir, I have always taken this request seriously, I was just holding off as long as I could so my response back to Detective Lehmann and his staff was as complete as it possibly could be. I did e-mail Detective Lehmann back in December (see below), committing to have something to him soon after that, but after meeting with the officer at Riverwood I realised it would be incomplete as her back capture was still underway and the spread sheet I referred to, although helpful, wouldn't assist Det Lehmann very much.

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[829] 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).

[830] Exhibit 53, Tab 53, NSWPF internal memorandum – '*Request for inventory of all unsolved homicide exhibits on hand at Penrith LAC, 19 July 2017, 2 (*NPL.0205.0001.0293); Exhibit 53, Tab 50, Email from Brett McFadden to Michael Willing re "*Unsolved Homicide Exhibits*", 7 April 2017 (NPL.0205.0005.0068).

[831] Exhibit 53, Tab 51, Email from Matthew Francis to Michael Willing re "*St George Exhibits*", 13 April 2017 (NPL.0205.0005.0056).

C.7.1.3 Media coverage of difficulties with exhibits

533. Senior Counsel Assisting took DCI Laidlaw to a *Daily Telegraph* article published on 8 October 2017 which referred to 50 unsolved homicides where evidence was missing or had been discarded.[832] DCI Laidlaw said he had not seen the article before, and was not sure if he was at the UHT at the time of its publication.[833] DCI Laidlaw accepted that the UHT was alive to the loss of exhibits described in the article as at October 2017, and that "it was known...that some of the exhibits were in the bowels of the police stations, attics of retired investigators, or hiding in plain sight, just incorrectly marked".[834]

534. DCI Laidlaw also accepted that it was known as at October 2017 that there were some unsolved homicides where it was discovered that exhibits had been destroyed 30 years ago and matters where exhibits were not returned from trials and inquests or after being sent to other agencies for testing. He said that he was aware when he joined the UHT that these matters were not only well known within the UHT but had been the subject of public comment. He said "that was the whole idea" behind the project to locate exhibits.[835]

535. The Commissioner asked DCI Laidlaw whether it had ever occurred to anyone in the NSWPF that a specially funded project urgently needed to take place to audit all unsolved matters to locate records and exhibits. DCI Laidlaw said he was unaware.[836]

C.7.1.4 The final report of Strike Force Parrabell

536. The Final Report of Strike Force Parrabell dated June 2018 contained a recommendation in the following terms (**Recommendation One**):[837]

> 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.

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[832] Transcript of the Inquiry, 6 July 2023, T5149.2-10 (TRA.00074.00001).
[833] Transcript of the Inquiry, 6 July 2023, T5149.12-19 (TRA.00074.00001).
[834] Transcript of the Inquiry, 6 July 2023, T5149.42-5150.18 (TRA.00074.00001).
[835] Transcript of the Inquiry, 6 July 2023, T5150.20-44 (TRA.00074.00001).
[836] Transcript of the Inquiry, 6 July 2023, T5150.46-5151.12 (TRA.00074.00001).
[837] Exhibit 1, Tab 2, NSW Police Force, *Strike Force Parrabell Final Report,* June 2018, 39 (SCOI.02632).

537. AC Conroy was asked by Senior Counsel Assisting whether she was familiar with the Final Report of Strike Force Parrabell, and said she was not.[838] She was asked whether steps had been taken with the result that all investigative material is stored in the same location, and said that she was not an e@gle.i user. She observed that exhibits are now on EFIMS, and that as of January 2017 all case records are digitised on the "RMS system".[839] AC Conroy was not in her present role at the time that the Final Report of Strike Force Parrabell was handed down.[840]

C.7.1.5 Submissions concerning the knowledge of the NSWPF as to the significant problems with lost documentary and exhibit material

538. In our submission, it is clear that while there must have been knowledge already in the UHT during 2004-2008 that there were significant problems with locating documentary and exhibit material because material had been lost, destroyed, or improperly archived, this matter was highlighted and affirmed at the highest level by 2016. As noted above in relation to records, it is likely that the majority of this loss and damage occurred prior to the introduction of EFIMS in 2012 and the present protocols for document management.

539. As is set out in Part D, in relation to a number of the cases before the Inquiry the NSWPF witnesses accepted that the loss or destruction of records and exhibits was, in their opinion, inconsistent with proper police practice both at the time and at present. That matter is considered in more detail below. In our submission, this evidence should be accepted – such failures in the management of records and exhibits falls far short of the standard the public would expect of a competent police force.

540. The material produced following the Lehmann Report makes it clear, in our submission, that steps were taken to implement the recommendations of the Lehmann Report in relation to auditing exhibits. Only a small number of those responses have been tendered. However, that material shows that some efforts were made to conduct an audit of exhibits following the Lehmann Report, and that the initial requests made of LACs were followed up, although not promptly. The correspondence also raises a concern that the UHT was seriously dilatory in recording information and responses, and following up non-responses, from LACs.

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[838] Transcript of the Inquiry, 4 July 2023, T4862.42-4863.7 (TRA.00072.00001).
[839] Transcript of the Inquiry, 4 July 2023, T4863.17-30 (TRA.00072.00001).
[840] Transcript of the Inquiry, 4 July 2023, T4863.40-47 (TRA.00072.00001).

541. In our submission, consideration should be given to undertaking a further and systematic audit of both exhibits and documentary records in unsolved homicides. Documentary records have never been subject to such an audit, and the evidence concerning the audit following the Lehmann Report raises a concern about how comprehensive and systematic this audit was in relation to exhibits. A process which relies heavily on LACs undertaking investigations and reporting back is likely to be vulnerable to errors or oversights.

542. It is regrettable that the extent of the difficulties with document and exhibit loss, destruction and mislabelling were not known to the Inquiry at the commencement of its work. The late production of material, and the fact that these issues were not appreciated throughout much of the Inquiry's work, has created substantial obstacles to the timely finalisation of many of the cases before the Inquiry.

543. The NSWPF has repeatedly stated that it supports the work of the Inquiry. The widespread and well known problems with historical exhibits and records is of obvious importance to the work of the Inquiry. Had the NSWPF been candid with the Inquiry at its commencement about these difficulties, steps could have been taken to manage them. This may even have obviated the need for a second extension of the Inquiry's Terms of Reference.

544. In fact, what occurred was that material in a number of matters was produced extremely late, on more than one occasion on the eve of a scheduled documentary tender. The Inquiry was put in a position where additional summonses were issued in order to seek to obtain material that appeared to exist, and should have been produced, but had not been produced. The fact that the Inquiry was not made aware of the problems with historical documents and exhibits meant that the Inquiry was not able to prepare for this eventuality, or discuss with the NSWPF the most effective way to progress the cases before the Inquiry.

C.8 Application of the State Records Act

545. A question arises concerning the application of the State Records Act to physical exhibits seized by the NSWPF (for example, murder weapons and forensic material). This is relevant to the loss of exhibits in a number of cases discussed in Part D below. As set out at [418.e] above, NSWPF internal documents make it apparent that the NSWPF does not regard exhibits as potentially being state records.

546. As a "public office" within the meaning of s 3 of the State Records Act, the NSWPF is required to comply with the obligations set out in the Act. This includes the obligation in s 21(1) not to abandon or dispose of a "state record".

547. Whether a particular physical exhibit is a "state record" will depend upon whether it can be described as a "document or other source of information". The significance of this question is that if physical exhibits are state records, the loss or destruction of those exhibits may have constituted a breach of the State Records Act.

C.8.1 The introduction of the State Archives Act

548. The State Records Act commenced on 1 January 1999. It replaced the now repealed *Archives Act 1960* (NSW) (**Archives Act**) and created the State Records Authority of NSW. The State Records Authority of NSW replaced the Archives Authority, which had previously been established under the Archives Act.

C.8.1.1 The position under the Archives Act

549. The Archives Act was principally concerned with delineating the powers and functions of the Archives Authority. The Archives Authority was responsible for the custody and control of the State Archives and the management of the Archives Office of New South Wales (s 13).

550. The Archives Act required a "public office" to notify the Archives Authority prior to the destruction or disposal of "public records" in the custody or under the control of that office pursuant to s 14. A "public office" was defined to include, relevantly, "any department, office, commission, board, corporation, agency, or instrument of any kind, performing any functions of any branch of the Government of NSW".

551. Under the Archives Act, a "public record" was defined to mean "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".

552. In our submission, documentary records such as exhibit books and duty books, and exhibits with a documentary character, would fall within the definition of "public record" under the Archives Act. Documents created in the course of an investigation are "documents … made in the course of … official duties." Similarly, exhibit material with a documentary character is "received … in the course of … official duties."

553. At [560]-[569] below, we make submissions about the application of the State Records Act to exhibits that would not ordinarily be described as "documents" or "records" (for example, a weapon or bloodstained clothing). There is ambiguity as to whether the Archives Act would have applied to physical exhibits of this kind (see the analysis concerning the word "document" at [564] below). However, tags or labels created and affixed to these objects, or to bags or containers they were placed in, would in our submission be public records.

554. Section 15(1) of the Archives Act provided that a person could destroy or dispose of public records if that destruction was authorised by the Archives Authority. There is no evidence before the Inquiry indicating whether, during the period covered by the Inquiry's Terms of Reference, such an authority was in place and applied to at least some documentary material.

555. In many cases, it is not clear whether material was lost or destroyed prior to or after the introduction of the regime under the State Records Act. For the reasons set out below, we submit that labelled exhibits in the custody of the NSWPF at the time the State Records Act came into force are public records. In the event that this material was lost or destroyed prior to the introduction of the Archives Act, this may have constituted a breach of the Archives Act.

C.8.1.2 The key provisions of the State Records Act

556. At present, under the State Records Act, the core obligations of a public office in relation to "state records" are contained in ss 11 and 21 of the Act. Sections 11 and 21 of the State Records Act are in the following terms:

> 11 Obligation to protect records
>
> (1) Each public office must ensure the safe custody and proper preservation of the State records that it has control of.
>
> (2) A public office must ensure that arrangements under which a State record that it has control of but that is in the possession or custody of some other person include arrangements for the safe keeping, proper preservation and due return of the record.
>
> (3) A public office must take all reasonable steps to recover a State record for which the public office is responsible and that the public office does not have control of, unless the record is under the control of the Authority or of some other person with lawful authority.
>
> 21 Protection measures
>
> (1) A person must not—
>
> (a) abandon or dispose of a State record, or
>
> (b) transfer or offer to transfer, or be a party to arrangements for the transfer of, the possession or ownership of a State record, or
>
> (c) take or send a State record out of New South Wales, or

(d) damage or alter a State record, or

(e) neglect a State record in a way that causes or is likely to cause damage to the State record.

Maximum penalty—100 penalty units.

(2) None of the following is a contravention of this section—

(a) anything done in accordance with normal administrative practice in a public office (as provided by section 22),

(b) anything that is authorised or required to be done by or under this Act, or by or under a provision of any other Act that is prescribed by the regulations as being an exception to this Part,

(c) anything done by or with the permission of the Authority or in accordance with any practice or procedure approved by the Authority either generally or in a particular case or class of cases (including any practice or procedure approved of under any standards and codes of best practice for records management formulated by the Authority),

(d) anything done pursuant to an order or determination of a court or tribunal,

(e) the disposal, in accordance with a resolution of a House of Parliament, of a State record for which the House is the responsible public office,

(f) anything done for the purpose of placing a record under the control of a public office,

(g) the transfer or disposal, in accordance with the Members of Parliament Staff Act 2013, of a record of information created or received by a political office holder (within the meaning of that Act) or the staff of such an office holder.

(3) The Authority must not do, or give permission or approval for or with respect to the doing of, anything referred to in subsection (1) except with the approval of the Board given either generally or in a particular case or class of cases.

(4) Anything done by a person (the employee) at the direction of some other person given in the course of the employee's employment is taken for the purposes of this section not to have been done by the employee and instead to have been done by that other person.

(5) It is a defence to a prosecution for an offence under this section for the defendant to establish that he or she did not know and had no reasonable cause to suspect that the record was a State record.

(6) This section prevails over a provision of any other Act enacted before the commencement of this section.

(7) An Act enacted after the commencement of this section is not to be interpreted as prevailing over or otherwise altering the effect or operation of this section except in so far as that Act provides expressly for that Act to have effect despite this section.

557. For present purposes, the following obligations under the State Records Act are of most relevance:

a. A public office must ensure the safe custody and proper preservation of the State records that it has control of (s 11(2) of the State Records Act);

b. A person must not abandon or dispose of a State record (s 21(1)(a) of the State Records Act); and

c. A person must not neglect a State record in a way that causes or is likely to cause damage to the State record (s 21(1)(e) of the State Records Act).

558. In addition to these specific obligations, relevantly, a public office is required by s. 12(1) to keep full and accurate records of the activities of that Office. Section 12(2) requires the public office to establish and maintain a records management program in conformity with the standards and codes of best practice that may be approved from time to time under s 13.

559. Clause 5 of the *State Records Regulations 2015 (NSW)* (**Regulations**) provides that anything that is authorised or required to be done by or under a provision of an Act specified in Schedule 1 of the Regulations is prescribed as an exception to Part 3 of the Act for the purposes of s 21(2)(b). In addition, the Inquiry has received evidence that, for example, there are existing arrangements between the State Records Authority and the NSWPF in relation to the retention and disposal of NSWPF documentary records.

C.8.2 Does the State Records Act apply to physical exhibits?

560. In order for ss 11 and 21 to apply to "physical exhibits" under the control of the NSWPF, those exhibits must fall within the meaning of "state records" under the State Records Act.

561. Section 3 of the State Records Act defines a "state record" 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.
>
> A record is defined 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." (Emphasis added)

562. Section 21 of the Interpretation *Act 1987* (NSW) (**Interpretation Act**) provides that in any act a "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.

563. "Physical exhibits" fall broadly, for the purposes of these submissions, into two categories. First, there are physical exhibits with a documentary character (such as written material, diaries, CDs, DVDs and fingerprints). Secondly, there are physical objects without this character (weapons, clothing, forensic material).

564. In *Council of the New South Wales Bar Association v Archer*[841] the Court considered the definition of "document" under s 21 of the Interpretation Act, in the context of contemplating the nature of contemporary electronic documents, such as computer files. Relevantly, Campbell JA stated:

> "[54] The etymological origin of 'document' is the Latin '*documentum*', meaning a lesson or an example. Thus, in the origin of the word itself, it is the information conveyed that is the dominant notion, not the physical form in which that information happens to be embodied. The origin is illustrated in the cognate word 'documentary' which is these days predominantly an audio visual means of conveying information.
>
> [55] Of course, words can sometimes stray from their linguistic roots, but in this case traces of the ancestry remain in the present day usage. The 'My Documents' entity that every use of Windows computing systems will be familiar with does not contain a single piece of paper. Further, the original use of the meaning of 'document' as something that conveys information has been recognised in the law. Thus there is authority, not dependent upon any extended definition of 'document', that a 'document' can be a photograph (Lyell v Kennedy (No 3) (1884) 27 Ch D 1 at 24, 31, 32), a tape recording (Grant *v Southwestern and Co Properties Ltd* [1975] Ch 185; *Cassidy v Engwirda Construction Company* [1967] QWN 16*; Australian National Airlines Commission v The Commonwealth* (1975) 132 CLR 582 at 594, disapproving *Beneficial Finance Corporation Co Ltd v Conway* [1970] VR 321; *Butera v Director of Public Prosecutions* (Vic) (1987) 164 CLR 180 at 193), a film or video (*Senior v Holdsworth; Ex parte Independent Television News Ltd* [1976] QB 23 at 36 and 41) or a computer file or database (*Electrolux Home Products Pty Ltd v Westside Direct Pty Ltd* [2003] FCA 1014)."

[841] (2008) 72 NSWLR 236; [2008] NSWCA 164.

565. In our submission, physical exhibits with a documentary character clearly fall within the meaning of "document". We note that this conclusion is consistent with cl 1.4 of the standard which the State Records Authority has issued pursuant to s 13(1) of the State Records Act in relation to the physical storage of State Records that are in a physical format (**the Standard**). Consequently, the loss, destruction or damage of documentary exhibits may comprise a breach of the State Records Act.

566. Similarly, while the position in relation to non-documentary physical exhibits is more complex, 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. In some circumstances, such an exhibit may be a "document" by reason of s 21(a), (b) or (c) of the Interpretation Act. However, a physical exhibit may also be a "other source of information" that must be "compiled, recorded or stored ... in any other manner or by any other means".

567. An ambiguity arises as to whether human agency, or some other active process, is required in order for something to have been "compiled, recorded, or stored" in the relevant sense. If that were the case, then some physical exhibits might not be state records, at least prior to the intervention of human agency (for example, intervention by "bagging and tagging" the item, or by placing it in a box with other items from the same crime scene).

568. On one view DNA could be viewed information which is "stored" in a blood sample. If an element of human agency or some other active process is not required, then it would fall within the meaning of a record by being a "source of information ... stored ... in any manner", even if it has not been collected, bagged, tagged or boxed by the NSWPF. However, 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".

569. The position changes once the exhibit has been taken into possession by NSWPF and marked (whether by tag, labelled bag or collection in a box). When that occurs, the tagged, bagged or boxed item is, in every ordinary sense of the words, a "source of information" that has been "compiled, recorded or stored" by the NSWPF. Indeed, the specific reason why the item is collected, marked and retained is because it is considered to be a source of information about the crime scene or incident being investigated. It is a "record" as defined.

C.8.3 The interaction between the State Records Act and other legislative schemes

570. If physical objects held by the NSWPF are "state records", a question arises about the interaction between the provisions of the State Records Act and other statutory schemes.

571. For example, Part 17 of the *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) (**LEPRA**) regulates the management and disposal of "property" in police custody. Property includes "every description of real and personal property; money, valuable securities, debts etc...".

572. Section 218 of that Part requires a police officer who seizes a thing to return the thing to the owner or person who had lawful possession of that thing if the officer is satisfied that its retention as evidence is not required. In the case of property connected with an offence, within 1 month after determination of proceedings for that offence, if the property has not been returned to a person under ss 218 or 219, the property may be disposed of in accordance with s 220(2). Section 220(2) authorises the sale of the property on behalf of the Commissioner.

573. Section 21(2)(b) of the State Records Act provides that s 21(1) will not be contravened by, relevantly, "anything that is authorised or required to be done by or under this Act, or by or under a provision of any other Act that is prescribed by the regulations as being an exception to this Part...".

574. Regulation 5 provides that for the purposes of section 21 (2) (b) of the Act, anything that is authorised or required to be done by or under a provision of an Act specified in Schedule 1 is prescribed as an exception to Part 3 of the Act. Schedule 1 specifically identifies certain provisions of the LEPRA, and of the *Police Act 1990* (NSW) (**Police Act**), but not the provisions of Pt 17 of the LEPRA.

575. None of the provisions under Part 17 of the Act are excluded from the operation of s 21 of the *State Records Act*. Therefore, if the meaning of "public record" encompasses physical property held by the NSWPF, it would be necessary to reconcile the obligations owed by police under Part 17 of the LEPRA and s 21 of the Act.

576. Section 21(7) of the State Records Act provides that "[a]n Act enacted after the commencement of this section is not to be interpreted as prevailing over or otherwise altering the effect or operation of this section except in so far as that Act provides expressly for that Act to have effect despite this section." On the face of the legislation, the obligations in s 21 of the State Records Act prevail, and the application of Part 17 of the LEPRA does not exclude the operation of s 21 of the State Records Act. It is possible that where items are actually dealt with under Part 17 of the LEPRA are dealt with "in accordance with normal administrative practice in a public office" as contemplated by ss 21(2)(a) and 22 of the State Records Act. It is not necessary for the Inquiry to decide that question – 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.

C.8.4 The consequences of the conclusion that exhibits may be State Records

577. Based on the analysis above, the evidence before the Inquiry suggests that there has been a failure to comply with the State Records Act in respect of at least some exhibits and documentary records. Indeed, 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, in relation to both exhibits and many kinds of documentary record which have been lost or destroyed.

578. In fairness, the apparent breaches of the Archives Act and the State Records Act may have proceeded from a view (a view we submit is erroneous) that the State Records Act does not apply to exhibits, or perhaps that the State Records Act is implicitly excluded when Part 17 of the LEPRA is engaged. However, 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.[842]

[842] 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 (SCOI.84217).

579. 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. Even if the widespread failure to comply with the Archives Act and State Records Act proceeded from an honest misunderstanding as to the operation of the law (a matter about which the evidence is silent), the additional overlay of statutory obligations under the Archives Act and later the State Records Act makes all the more serious the loss of documents and exhibits which are described elsewhere in these submissions.

580. A failure to comply with s 21(1) is an offence punishable by a maximum penalty of 100 penalty units. Proceedings for an offence against s 21(1) are to be taken before the Local Court (s 78(1)). Proceedings for such an offence must be commenced no later than three years from when the offence was alleged to have been committed (s 78(2)).

581. In respect of the matters considered by the Inquiry, s 78(2) has the effect that proceeding in respect of the loss or destruction of the relevant exhibits would be time-barred. In addition, in the majority of cases considered below it is not clear who was responsible for the loss or destruction of the relevant exhibit. Accordingly, it is not submitted that the widespread failure to comply with the State Records Act engages the Commissioner's duty in s 10(1) of the SCOI Act to report on evidence or sufficient evidence warranting the prosecution of a specified person for a specified offence. Nevertheless, the failure to comply with – and perhaps even consider or appreciate – the role of the State Records Act is a matter appropriate for comment by the Commissioner.

582. While we submit the preferable construction of the State Records Act is as set out above, consideration should be given to a recommendation that the State Records Act be amended to clarify the application of the Act to exhibits obtained by the NSWPF, or 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. 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. In any event, the present state of affairs is highly undesirable.

PART D INDIVIDUAL CASES UNDER REVIEW BY THE INQUIRY

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

583. The cases of Andrew Currie, Paul Rath, Russell Payne, Graham Paynter, Samantha Raye, Peter Sheil and Blair Wark are all before the Inquiry. Each of these cases is from the 1970s to the 1990s and each was the subject of a coronial dispensation or a finding of a non-suspicious death.

584. In some of these cases, including that of Mr Rath, the Inquiry has received evidence, including evidence that may have been available at the time of the original investigation, indicating reasons to regard those deaths as suspicious.[843]

585. Senior Counsel Assisting asked whether there was any scope for cases to come to the attention of the UHT. DCI Laidlaw said that there was not.[844]

586. It is regrettable that there is no formal process to bring matters of this kind to the attention of the UHT in the event that the NSWPF acquires information that suggests that they should be revisited. This may mean that solvable matters are not being referred to the UHT because it is not understood that they are homicides. Although it will never be possible to avoid some matters being overlooked because no such information comes to light, we submit that consideration should be given to a recommendation that a formal process be available in relation to matters of this kind.

587. In addition, in the cases of Mr Currie, Mr Payne, Graham Paynter, Ms Raye, Peter Sheil and Mr Wark, Counsel Assisting has made submissions raising suggested deficiencies in the initial police investigations, including the early exclusion of avenues of investigation.

588. In these matters, there were indicators of LGBTIQ bias that were never explored by the NSWPF. As these indicators were not explored by the NSWPF, they were never brought to the attention of the Coroner. It is very unfortunate that these indicators were not brought to the attention of the Coroner, and were likely to have causatively contributed to the Coroner dispensing with an inquest. Similarly, in the case of Mr Rath, the failure to consider these matters may well have contributed materially to the conclusion that the death was non-suspicious.

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[843] Transcript of the Inquiry, 7 July 2023, T5210.12-32 (TRA.00075.00001).
[844] Transcript of the Inquiry, 7 July 2023, T5210.12-5211.6 (TRA.00075.00001).

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

589. There are cases being considered by the Inquiry which are present on the UHT Tracking File and that were not reviewed in the initial review process between 2004 and 2008, or that have not been reviewed at all. The period between 2004 and 2008 is significant because the evidence of DCI Laidlaw and DS Doherty was that the UHT sought to review all (approximately) 400 cases on the list of unsolved cases during this period.[845]

590. As is set out at [310] and [312], the Inquiry has been told that there is no list of what cases comprised the initial list of unsolved cases to be reviewed by the UHT. However, there are cases which are on the UHT Tracking File, and which on any view should have been identified and reviewed in 2004-2008.

591. The first of these is the case of Robert Malcolm. The circumstances of Mr Malcolm's death are set out at [828] below. Mr Malcolm was killed in 1992 and his death was obviously a homicide. DCI Laidlaw agreed that it would be very odd if that case were not on the list of the unsolved homicides from the start, and identified that it would be an "undetected" case.[846] DCI Laidlaw agreed that this matter would have been appropriate to be screened or reviewed in the 2004 to 2008 period, and that he was not aware of any reason why it wouldn't be screened or reviewed in that period.[847]

592. The second is the case of James Meek. The circumstances of Mr Meek's death are set out at [866] below. DCI Laidlaw identified that Mr Meek's death would have been classified as "unsolved" and would have received a lower priority on the UHT Tracking File until "such time as any information came forward or new evidence or even forensic techniques became available."[848]

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[845] Transcript of the Inquiry, 6 July 2023, T5109.29 - 47 (TRA.00074.00001); Exhibit 51, Tab 1, Statement of Detective Superintendent Doherty, 18 April 2023, [74]-[76] (NPL.9000.0006.0001).
[846] Transcript of the Inquiry, 6 July 2023, T5156.40-5157.37 (TRA.00074.00001).
[847] Transcript of the Inquiry, 6 July 2023, T5157.43-5158.3 (TRA.00074.00001).
[848] Transcript of the Inquiry, 6 July 2023, T5158.10-23 (TRA.00074.00001).

593. Senior Counsel Assisting asked whether any active step would be taken to obtain new evidence, and DCI Laidlaw said "Well, if there were exhibits involved in that matter, I would assume that they would then be identified [sic] that they could be – go before new forensic analysis."[849] Senior Counsel Assisting asked how that would occur if the matter was not the subject of screening or review. DCI Laidlaw said that it would "be a matter of going through these – some of these matters to identify if there are forensic possibilities."[850] DCI Laidlaw could not offer any explanation for why this matter would not have been reviewed during the 2004-2008 period.[851]

594. The third of these cases is that of William Rooney. The circumstances of Mr Rooney's death are set out at [740]. DCI Laidlaw agreed with the proposition put to him by Senior Counsel Assisting that Mr Rooney's death would have been classified as "undetermined" (on the current classification) because the Coroner returned an open finding in May 1987.[852] DCI Laidlaw agreed that this open finding was returned before the advent of DNA, and that this is a matter that may be "ripe for review."[853] DCI Laidlaw said that this matter should have been on the UHT Tracking File in 2004. He agreed that this matter should have been reviewed during the 2004-2008 period, and could not offer any reason why it was not.[854]

595. The fourth of these cases is that of Richard Slater. The circumstances of Mr Slater's death are set out at [673]. He died in 1980 as a consequence of what was obviously an assault. Once again, DCI Laidlaw agreed that the case should have been captured among the first 366 identified in 2004, and should have been reviewed during the initial five-year period. He said that if it had not been reviewed in that period then he did not have an explanation for that.[855]

596. Mr Slater's case is listed on the UHT Tracking File as "unresolved". Senior Counsel Assisting asked DCI Laidlaw whether it was correct for a matter to be recorded as "unresolved" when charges were brought but the matter was then no-billed. DCI Laidlaw said "I suppose that's a terminology used within our tracking – within that scope of what is unresolved. It could be – and I don't know the reasoning why the matter was no-billed, nor when the matters are withdrawn, whether there's just not enough evidence to convict the person who we say has committed the crime."[856]

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[849] Transcript of the Inquiry, 6 July 2023, T5158.27-29 (TRA.00074.00001).
[850] Transcript of the Inquiry, 6 July 2023, T5158.33-40 (TRA.00074.00001).
[851] Transcript of the Inquiry, 6 July 2023, T5159.22-24 (TRA.00074.00001).
[852] Transcript of the Inquiry, 6 July 2023, T5159.37-39 (TRA.00074.00001).
[853] Transcript of the Inquiry, 6 July 2023, T5159.46-47 (TRA.00074.00001).
[854] Transcript of the Inquiry, 6 July 2023, T5160.15-22(TRA.00074.00001).
[855] Transcript of the Inquiry, 7 July 2023, T5160 (TRA.00075.00001).
[856] Transcript of the Inquiry, 7 July 2023, T5201.25-38 (TRA.00075.00001).

597. Senior Counsel Assisting asked whether, if that were the case, a matter like this would be a good candidate for review by the Review Team to consider whether there was more evidence. DCI Laidlaw said "[t]o consider, but one would hope that all the evidence that was obtained would have been before the judicial process."[857]

598. DCI Laidlaw agreed with the proposition put by Senior Counsel Assisting that in a "broad-brush sense" unsolved homicides are matters where there may have been matters overlooked or particular investigative steps not taken, although he did not think that was the case on average.[858] He said that his team would have this possibility in mind when reviewing cases.[859] He also agreed that this is a reason that even in a matter no-billed in 1983 there may be material that the Review Team would pick up. He said "...there could be. It's not to say these matters won't get triaged and reviewed. They're just not given the priority because of that."[860] It is difficult to understand a rational basis for deprioritising all such cases, when the reason for no-bill or charges being withdrawn may readily be overtaken by later developments in technology.

599. The final case falling into this category is that of Brian Walker. Mr Walker's case is listed as "unresolved" on the UHT Tracking File. Mr Walker died on 23 July 1992. A person of interest was committed to trial, but the Office of the Director of Public Prosecutions (**ODPP**) directed that the prosecution be discontinued on the basis that there was no reasonable prospect of conviction.[861] DCI Laidlaw accepted that if the matter was obviously a homicide, it should have been on the UHT Tracking File from 2004.[862]

D.3 The cases the subject of Strike Force Neiwand

600. The Inquiry has before it a Case Screening Form in relation to the matters of John Russell, Ross Warren and Gilles Mattaini dated 14 August 2013.[863] As is explained in the PH2 Submissions, Strike Force Neiwand ran from October 2015 until late 2017, and considered the deaths of Mr Russell, Mr Warren and Mr Mattaini.[864]

601. We note the submission made at [163] of those submissions that Strike Force Neiwand, in its implementation and outcomes was "clearly aimed at discrediting both the work of Operation Taradale and Mr Page personally, and discrediting the findings of the Taradale Inquest as well."

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[857] Transcript of the Inquiry, 7 July 2023, T5201.32-38 (TRA.00075.00001).
[858] Transcript of the Inquiry, 7 July 2023, T5201.43-5202.22 (TRA.00075.00001).
[859] Transcript of the Inquiry, 7 July 2023, T5202.24-26 (TRA.00075.00001).
[860] Transcript of the Inquiry, 7 July 2023, T5202.43-45 (TRA.00075.00001).
[861] See Submissions of Counsel Assisting, 6 February 2023, [2], [39]-[41] (SCOI.82378).
[862] Transcript of the Inquiry, 7 July 2023, T5210.3-10 (TRA.00075.00001).
[863] Exhibit 6, Tab 162B, Review of an Unsolved Homicide Case Screening Form – John Russell, Ross Warren and Gilles Mattaini, 14 August 2013 (NPL.0135.0001.0001).
[864] Submissions of Counsel Assisting, 7 June 2023, [341], [504]-[505] (SCOI.84380).

602. Strike Force Neiwand made the following findings:

> In relation to Mr Warren:
>
> "WARREN'S disappearance – cause and manner of death remain **'undetermined'** despite the 2005 'homicide' findings of the Coroner, which list it as a homicide. It is recommended that this investigation be listed as inactive and only reactivated if new and compelling evidence becomes available..."[865]
>
> In relation to Mr Russell:
>
> "The manner of RUSSELL's death should be reclassified as **'undetermined'** despite the 2005 'homicide' findings of the Coroner. It is recommended that this investigation be listed as inactive and only reactivated if new and compelling evidence becomes available."[866]
>
> In relation to Mr Mattaini:
>
> "... it can be suggested that MATTAINI may well have taken his own life rather than met with foul play. ... MATTAINI's disappearance – cause and manner of death remain **'undetermined'.** It is recommended that this investigation be listed as inactive and only reactivated if new and compelling evidence becomes available."[867]

603. As set out at [326] above, the "undetected" and "undetermined" categories were created in around 2018. Previously, matters in these categories were categorised as "unsolved".[868] Ordinarily a case where a verdict of likely homicide was returned by the Coroner would be classified as "undetected", and cases classified in that way are prioritised for review ahead of cases with an "undetermined" classification.[869]

604. Senior Counsel Assisting asked DCI Laidlaw whether he was aware that although the Coroner returned a finding of likely homicide in relation to the deaths of Mr Warren and Mr Russell, those matters were reclassified as "undetermined" as a consequence of the recommendations of Strike Force Neiwand.

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[865] Exhibit 6, Tab 174, Summary of Investigation – Ross Warren, 8 January 2018, 62 (SCOI.74883).
[866] Exhibit 6, Tab 173, Summary of Investigation – John Russell, 8 January 2018, 42 (SCOI.74882).
[867] Exhibit 6, Tab 172, Summary of Investigation – Gilles Mattaini, 27 December 2017, 11 (SCOI.74881).
[868] Exhibit 51, Tab 6, Statement of Detective Chief Inspector David Laidlaw, 13 June 2023, [78] (NPL.9000.0019.0001).
[869] Transcript of the Inquiry, 6 July 2023, T5122.8-5124.19 (TRA.00074.00001).

605. DCI Laidlaw said that he was aware that this was one of the outcomes of Strike Force Neiwand.[870] Senior Counsel Assisting then asked DCI Laidlaw whether it was correct that his evidence was that the purpose of classifying matters was to determine priority. DCI Laidlaw agreed that this was the case.[871] DCI Laidlaw agreed that unless new information came to light, all matters classified as "undetected" would be reviewed before coming to the "undetermined" matters, and that the review of those "undetected matters" could "easily take more than 20 years".[872] DCI Laidlaw agreed that a consequence of the reclassification was that those two cases would be deprioritised, and that it could be the case that they would not be looked at for more than 20 years. He was not able to assist the Inquiry with the question of whether this consequence was likely to be known to those involved in Strike Force Neiwand.[873]

606. Submissions have been made to the Inquiry separately about inferences that are available as to the conduct and motivation of Strike Force Neiwand.[874] If those submissions are accepted, the consequence of the reclassification (i.e., deprioritisation so that the cases might not be looked at for 20 years or more) makes the conduct all the more serious.

D.4 General issues arising in relation to screening or triage forms

607. The Inquiry has before it screening, triage or review forms in a number of matters that identify lines of inquiry where those lines of inquiry were either not implemented or were not implemented for many years, even a decade or more. Senior Counsel Assisting asked DCI Laidlaw if this was a common occurrence and he said, "I can only say I hope not". Senior Counsel Assisting asked whether he knew one way or the other and he said he did not.[875]

608. Senior Counsel Assisting asked DCI Laidlaw how matters would be dealt with under the 2022 UHT SOPS if the Inquiry identifies further lines. DCI Laidlaw said "if new information is being gleaned as a result of this Commission, then we are able to assess it and then act upon that."[876] In relation to the question of how long it would take before the UHT looked at any given case, DCI Laidlaw said that he could only undertake that it would be done "as soon as possible." He said he was unable to assist the Commissioner any further in relation to that issue.[877]

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[870] Transcript of the Inquiry, 7 July 2023, T5207.13-5208.11 (TRA.00075.00001).
[871] Transcript of the Inquiry, 7 July 2023, T5208.13-22 (TRA.00075.00001).
[872] Transcript of the Inquiry, 7 July 2023, T5208.24-33 (TRA.00075.00001).
[873] Transcript of the Inquiry, 7 July 2023, T5208.44-5209.18 (TRA.00075.00001).
[874] Submissions of Counsel Assisting, 7 June 2023, Part D (SCOI.84380).
[875] Transcript of the Inquiry, 7 July 2023, T5242.40-5243.3 (TRA.00075.00001).
[876] Transcript of the Inquiry, 7 July 2023, T5243.17-20 (TRA.00075.00001).
[877] Transcript of the Inquiry, 7 July 2023, T5243.22-24; T5243.5-5244.29 (TRA.00075.00001).

609. Senior Counsel Assisting drew DCI Laidlaw's attention to forms where particular cells or particular parts of the form are incomplete or unpopulated. DCI Laidlaw agreed that the Inquiry should assume in relation to those forms that the form is incomplete and may never have been completed.[878] DCI Laidlaw said that matters identified by the Inquiry would be assessed by the UHT, including in relation to matters currently categorised as "undetermined" or "unresolved".[879]

D.5 Mark Stewart (died 10 or 11 May 1976)

610. Mark Stewart died on 10 or 11 May 1976 as a result of multiple injuries sustained in a fall from a height, the cause of which cannot be determined.[880]

611. Mr Stewart's body was found lying face down on rocks at the base of a cliff about 250 metres south of Fairy Bower headland in Manly. No alcohol was found in his blood.[881] He was last seen at 9:30pm on 9 May 1976 at the Hilton Hotel in Sydney, where he had booked a hotel room for two nights.

612. A handwritten note described in other material as containing the name and number of the Chevron Hotel in Sydney on one corner was found on Mr Stewart's body by the NSWPF. That piece was recorded as including the notation, "7:20, 11.5.76" (**the handwritten note**). The handwritten note was not retained and was not produced to the Inquiry, so its contents could not be verified. A men's Seiko wristwatch was found 21 feet east of Mr Stewart's body and had stopped at 8:02pm on 11 May 1976. His shoes were laced up and found in close proximity to his body. They were not on his feet.[882]

613. The police investigation into Mr Stewart's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 24 March 2023 at [20]-[32]. Counsel Assisting identifies a number of concerns with the original police investigation and notes at [32] that the social environment and policing practices of the era do not appear to have been conducive to considering and detecting whether a death in the circumstances may have been a homicide where LGBTIQ bias was a factor.

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[878] Transcript of the Inquiry, 7 July 2023, T5243.31-46 (TRA.00075.00001).
[879] Transcript of the Inquiry, 7 July 2023, T5244.42-46 (TRA.00075.00001).
[880] Submissions of Counsel Assisting the Inquiry, 24 March 2023, [121]; Exhibit 19, Tab 38, Expert report of Dr Linda Iles, 15 December 2022, 6 (SCOI.82457); Exhibit 19, Tab 5, Findings of City Coroner John Brian Goldrick, 16 July 1976 (SCOI.02724.00001).
[881] Exhibit 19, Tab 3, Toxicology report, 20 May 1976 (SCOI.02724.00010).
[882] Exhibit 19, Tab 12, Statement of Senior Constable Keith Douglas Thorns, Undated, 1 (SCOI.02724.00019); Exhibit 19, Tab 2, P79A Report of death to Coroner, 13 May 1976, 1 (SCOI.82449); Transcript of the Inquiry, 5 July 2023, T4973.23-4974.16 (TRA.00073.00001).

D.5.1 Loss or destruction of exhibits

614. On 29 September 2022, the Inquiry issued a summons to the NSWPF for the exhibit book entries for Mr Stewart's watch and the handwritten note, to ascertain whether the exhibits had been retained and their current locations (Summons NSWPF22).[883] The NSWPF replied by email dated 11 October 2022, advising the NSWPF had not located any documents responsive to the summons and that the May 1976 Manly Police Station Exhibit Book was unable to be located.[884]

615. On 3 March 2023, the Inquiry requested a formal statement from the NSWPF regarding the status of all physical exhibits identified in connection with Mr Stewart's matter, including the Seiko wristwatch, the handwritten note, a gold cigarette lighter and a steel comb found on or near Mr Stewart's body.[885] On 16 March 2023, the NSWPF provided a statement from Detective Sergeant Neil Sheldon (**DS Sheldon**), which outlined that, following extensive searches and enquiries within the NSWPF, no exhibits or records of the exhibits could be located.[886] DS Sheldon also considered that no further avenues of enquiry are available to locate the exhibits.[887]

616. In written submissions filed on behalf of the NSWPF on 12 April 2023, the NSWPF submitted that, "[p]olice cannot reasonably be criticised for the fact that the clothing worn by Mr Stewart and the items found with his body, including the handwritten note, are now not available for forensic testing almost 47 years later".[888]

617. During the course of her oral evidence, AC Conroy conceded that the exhibits identified above were "significant exhibits" and could not possibly have been consumed by forensic testing. AC Conroy accepted that if the exhibits were destroyed, disposed of or otherwise returned to somebody, there ought to have been a record to that effect. Despite making enquiries, AC Conroy could not point to such a record existing and conceded that the absence of documentation is indicative that "there's possibly been a breach of a police policy or procedure".[889] In these circumstances, it is our submission that criticism of the NSWPF is entirely reasonable.

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[883] Exhibit 19, Tab 20A, Summons to produce to NSWPF (Summons NSWPF22), 28 September 2022 (SCOI.82448).
[884] Exhibit 19, Tab 21, Email from NSWPF to the Inquiry re Summons NSWPF22, 11 October 2022 (SCOI.82446).
[885] Exhibit 19, Tab 23A, Letter from the Inquiry to NSWPF, re request for further information regarding exhibits, 3 March 2023 (SCOI.82813).
[886] Exhibit 19, Tab 23B, Statement of Detective Sergeant Neil Sheldon, 16 March 2023, [9] (SCOI.82812).
[887] Exhibit 19, Tab 23B, Statement of Detective Sergeant Neil Sheldon, 16 March 2023, [10] (SCOI.82812).
[888] Written submissions filed on behalf of the NSWPF, 12 April 2023, [54] (SCOI.45187).
[889] Transcript of the Inquiry, 4 July 2023, T4847.44-4848.19 (TRA.00072.00001).

D.5.2 Matters of concern to the Inquiry

618. As outlined in the written submissions of Counsel Assisting (at [24]-[26], [28], [30]), the following matters of concern arise in relation to the investigation of Mr Stewart's death:

a. There do not appear to be any photographs or other documents relating to the location or position of Mr Stewart's body or his possessions.

b. There did not appear to be any early canvassing for information about Mr Stewart's last movements. 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.

619. The NSWPF submitted that there were investigative steps taken by police that demonstrated that enquiries "quite clearly extended beyond the identification of the body." The submissions did not address the photographs.

620. DI Warren agreed that it is difficult to accurately identify the location of Mr Stewart's body absent any photographs or other documents relating to the location and position of his body or possessions. DI Warren told the Inquiry that there is no record of any such photographs or other documentation being taken, notwithstanding the fact that the requisite technology was available in 1976. DI Warren accepted that it was important in an investigation to have a photograph or other reliable record of the location of a body and personal effects. DI Warren also accepted that the importance of such steps was appreciated in the mid-1970s. He could not offer any reason why photographs were not taken.[890]

621. There is some ambiguity in the evidence as to whether Mr Stewart was in fact staying at the Chevron Hotel prior to his death. DI Warren acknowledged that the bar located within the hotel was a popular venue for gay men in 1976. He gave evidence that he would expect, and proper police procedures would require, investigating police in the mid-1970s to have taken steps to contact hotel staff to obtain information about Mr Stewart's movements at any time after he checked in. DI Warren accepted that these steps should have extended beyond taking a statement from the receptionist at the Hilton Hotel.[891]

[890] Transcript of the Inquiry, 5 July 2023, T4974.18-4975.47 (TRA.00073.00001).
[891] Transcript of the Inquiry, 5 July 2023, T4974.47-4975.22 (TRA.00073.00001).

622. In these circumstances, we submit that police can be reasonably criticised for the failure to take at least those steps set out at [620]. They fell short of the standard the public had a right to expect from the police force. The failure to retain the handwritten note means that it is not clear whether the steps referred to at [621] should have been taken, but the failure to retain the note in and of itself it a serious matter.

D.6 Barry Jones (died on 26 September 1976)

623. Barry Jones died on 26 September 1976 at the grandstand in Five Dock Park sometime after 10:00pm. He was aged 41 at the time. Mr Jones was stabbed at least 53 times in the chest and abdomen, and a distinctive knife was found sticking out of his chest.[892] Some of the wounds on Mr Jones' body had been inflicted after his death.[893] The Coroner returned a finding that Mr Jones had died from haemorrhage and respiratory failure due to multiple stab wounds to the chest and abdomen, inflicted by a person or persons unknown.[894]

624. The police investigation into Mr Jones' death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 26 June 2023 at [55] onwards. Counsel Assisting notes that limitations in the investigative material appear to reflect the standards of the day rather than any lack of investigative efforts ([56]). However, Counsel Assisting identifies the loss of all the exhibits (including the murder weapon) as a major problem from a contemporary perspective (see [57]).

D.6.1 Loss or destruction of exhibits

625. On 2 February 2023, the Inquiry issued a summons to the NSWPF for exhibits including a blood sample, anal and penile swabs and smears, the knife found protruding from Mr Jones' chest, fingernail cuttings, a Seiko wristwatch and chain and clothing belonging persons of interest, and a blood-stained phonebook from a nearby phonebooth (Summons NSWPF53).

626. On 21 February 2023, the NSWPF provided a statement from DI Warren, which outlined that, following extensive searches and enquiries within the NSWPF, no exhibits could be located.[895] DI Warren indicated in his statement that these searches and enquiries were "exhaustive" and there are no further avenues of enquiry available to locate the exhibits.[896]

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[892] Exhibit 41, Tab 2, Post-mortem Report of Dr William Brighton, 27 September 1976, 1-2 (SCOI.10495.00016); Submissions of Counsel Assisting the Inquiry, 26 June 2023, [11] (SCOI.84139).
[893] Submissions of Counsel Assisting the Inquiry, 26 June 2023, [13]-[15] (SCOI.84139).
[894] Submissions of Counsel Assisting the Inquiry, 26 June 2023, [54] (SCOI. 84139).
[895] Exhibit 41, Tab 33, Statement of Detective Inspector Nigel Warren, 21 February 2023 (SCOI.83075).
[896] Exhibit 41, Tab 33, Statement of Detective Inspector Nigel Warren, 21 February 2023, [8] (SCOI.83075).

627. In written submissions filed on behalf of the NSWPF on 10 July 2023, the NSWPF conceded at [37] and [38] that it was both "regrettable" and "unacceptable" that these exhibits were not retained and that there remains no record of what happened to them.[897] The NSWPF noted, however, that it was not clear on the available material when the exhibits were destroyed or lost, and which agency was responsible for the retention of the exhibits at the relevant time.[898] In this respect, the NSWPF further noted that at least some of the blood sample, swabs and smears, hair sample and fingernail cutting may have been consumed during forensic testing, and that FASS (and its predecessor organisations) did not begin storing samples until 1985.[899]

628. The NSWPF submitted that all forensic testing that could have been conducted on the exhibits at the time of the initial investigation was conducted and that advancements in forensic testing capabilities and DNA identification could not have been foreseen by investigating police in the 1970s (see evidence on this topic in Pt B.4.4).[900] The NSWPF also suggested that even if the exhibits were retained, whether they would be suitable for testing, the results of such testing and the inferences able to be drawn from such results are matters of speculation.[901]

629. During the course of her oral evidence, AC Conroy said that by the standards of the time, being the 1962 instruction relating to exhibits,[902] the retention of some of the exhibits identified at [625] was not explicitly mandated and any exhibit which had been analysed to the capability of the laboratory at the time could be disposed of in accordance with those 1962 instructions.[903] However, AC Conroy conceded that where the death of Mr Jones was clearly a homicide, the murder weapon should have "absolutely" been retained.[904] AC Conroy accepted that if the exhibits were destroyed, disposed of or otherwise returned to somebody, there ought to have been a record to that effect.[905]

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[897] Written submissions filed on behalf of NSWPF on 10 July 2023, [37]-[38] (SCOI.84381).
[898] Written submissions filed on behalf of NSWPF on 10 July 2023, [37] (SCOI.84381).
[899] Written submissions filed on behalf of NSWPF on 10 July 2023, [40] (SCOI.84381).
[900] Written submissions filed on behalf of NSWPF on 10 July 2023, [42] (SCOI.84381).
[901] Written submissions filed on behalf of NSWPF on 10 July 2023, [42] (SCOI.84381).
[902] Exhibit 51, Tab 2D, Instruction No. 24 – Exhibits, 1962 (NPL.9000.0003.1471).
[903] Transcript of the Inquiry, 4 July 2023, T4850.45-T4851.27 (TRA.00072.00001).
[904] Transcript of the Inquiry, 4 July 2023, T4850.27-28 (TRA.00072.00001); T4851.10-11 (TRA.00072.00001).
[905] Transcript of the Inquiry, 4 July 2023, T4850.37 (TRA.00072.00001).

D.6.2 UHT screening, triage and review forms

630. The Inquiry has before it a Case Screening Form in relation to Mr Jones.[906] Mr Jones died on 26 September 1976. The Case Screening Form produced to the Inquiry is unsigned, undated, and does not identify the officer who entered the information. There is a large amount of information in the document, but nothing in the recommendations. Senior Counsel Assisting asked DCI Laidlaw whether the Commissioner could draw any inference about whether the document was in fact completed and reviewed. DCI Laidlaw said that it appeared to him that it was not completed.[907]

631. Senior Counsel Assisting asked whether, if this document is the only record of a screening in relation to Mr Jones, the Commissioner should infer that there has never been a completed screening, review, or triage in relation to Mr Jones. DCI Laidlaw agreed that this was the case. DCI Laidlaw agreed that, according to proper police practices, this matter should have been reviewed between 2004 and 2008, assuming it was on the UHT Tracking File at that time.[908]

D.7 Paul Rath (died on 15 or 16 June 1977)

632. Paul Rath died on either 15 or 16 June 1977 as a result of spinal injuries sustained in a fall from a height at Fairy Bower headland in Manly.[909] Mr Rath had a schizophrenic disorder which was treated with medication and in the months leading up to his death he had been fairly well.[910]

633. The police investigation into Mr Rath's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 18 May 2023 at [31]-[50].

634. Counsel Assisting notes that Mr Rath's death occurred in the same era, at the same location, and in similar circumstances to that of Mr Stewart. At [33], Counsel Assisting submits that the environment in which policing was carried out in the 1970s and well into the 1980s, was not conducive to the detection or pursuit of the possibility of LGBTIQ bias. In written submissions filed on behalf of the NSWPF on 18 May 2023, the NSWPF accepted at [6] that "societal attitudes and policing practices in the 1970s were not conducive to recognising the possibility that crimes may have been motivated by LGBTIQ bias."

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[906] Exhibit 41, Tab 20, Review of an Unsolved Homicide Case Screening Form – Barry Jones, Undated (SCOI.62861).
[907] Transcript of the Inquiry, 7 July 2023, T5242.9-17 (TRA.00075.00001).
[908] Transcript of the Inquiry, 7 July 2023, T5241.37-5242.38 (TRA.00075.00001).
[909] Exhibit 26, Tab 1, P79A Report of Death to the Coroner, 17 June 1977, 1 (SCOI.82905).
[910] Exhibit 26, Tab 10, Statement of Dr O Reichard, 23 June 1977 (SCOI.02734.00018).

D.7.1 Loss or destruction of exhibits

635. On 18 May 2022, the Inquiry issued a summons to the NSWPF for, relevantly, all NSWPF investigative material, including any material held or created by the UHT, in relation to Mr Rath's death (Summons NSWPF1).[911]

636. The 79A Report of Death to the Coroner refers to a number of bodily swabs having been taken from Mr Rath by police on 16 June 1977, prior to an autopsy being performed.[912] A one-page forensic biology report dated 21 June 1977 records that four items were received from police on 16 June 1977 (one anal smear, one anal swab, one penile smear and one penile swab).[913] The two penile samples taken from Mr Rath returned a positive result for the presence of semen, but the anal samples did not. These samples have not been retained by either FASS or the NSWPF and, consequently, have not been produced to the Inquiry.[914]

637. In written submissions filed on behalf of the NSWPF on 18 May 2023, the NSWPF submitted at [23]-[26], that it would be "misplaced" for criticism to be directed at police for the disposal or consumption of exhibits. It was noted that the penile and anal samples were contemporaneously tested with nothing indicative of sexual assault found and that the earliest DNA testing processes did not emerge until the 1980s and were not available in Australia until sometime thereafter. Accordingly, NSWPF submitted, such changes in technology could not have been foreseen and it is unsurprising, in the circumstances, that the relevant exhibits were not retained. Whether or not the destruction of the samples was reasonable having regard to the procedures in place at that time, the destruction should have been properly documented.

638. During the course of oral evidence, DI Warren accepted that the penile swabs, which returned a positive result for the presence of semen, were not retained. DI Warren accepted that whilst the emission of semen is relatively common post-mortem, it is nevertheless a matter which ought to have prompted investigating officers to make enquiries. In that regard, DI Warren stated that the determination by police that Mr Rath's death was "non-suspicious" may have influenced subsequent investigative steps.[915] We note the submission at [588] above in relation to the way in which this matter was presented before the Coroner.

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[911] Exhibit 26, Tab 18A Summons to produce to NSWPF, 18 May 2022 (summons NSWPF1) (SCOI.82904).
[912] Exhibit 26, Tab 1, P97A Report of Death to the Coroner, 17 June 1977, 1 (SCOI.82905).
[913] Exhibit 26, Tab 2, Forensic Biologist report of Dr RJ Goetz, 21 June 1977, 1 (SCOI.02734.00012).
[914] Exhibit 26, Tab 19B, Letter from NSWPF to Inquiry re Biological articles for Paul Rath, 16 May 2023 (SCOI.83235); Exhibit 26, Tab 29B, Statement of Carrie Field, FASS, 10 May 2023 (SCOI.83234).
[915] Transcript of the Inquiry, 5 July 2023, T4976.8-25 (TRA.00073.00001).

D.7.2 Matters of concern to the Inquiry

639. As outlined in the written submissions of Counsel Assisting (at [37]-[39], [96]), the following matters of concern to the Inquiry arise in relation to the investigation of Mr Rath's death:

a. Mr Rath's stained clothing was destroyed after his death on the authority of his mother.[916]

b. There are no records of an attempt to search or inspect the area where Mr Rath's body was found, apart from a statement from the OIC that he "made an examination of the ledge from where the deceased apparently fell, however, [he] found no notes left by the deceased or signs of a struggle."[917]

c. There does not appear to have been any canvassing of local residents in Bower Street, Manly, nor were enquiries made with the church Mr Rath would have ordinarily attended at 7:30pm the evening before his body was discovered.[918]

d. Statements were not obtained from a broader number of family members and friends of Mr Rath concerning any understanding of his sexuality or a habit of visiting the Fairy Bower headland as a beat.

e. Failure by any NSWPF officer to contact Mr Rath's sister, Helen Colman, who spoke to her brother in the early evening of 15 June 1977.[919] Since approximately 2013, the NSWPF have been aware that Ms Colman may have had relevant information concerning events surrounding her brother's death.[920]

640. In written submissions filed on behalf of the NSWPF on 18 May 2023, the NSWPF submitted at [20]:

> There is no suggestion that the Coroner considered the investigation to be in any way deficient. Had the Coroner considered further investigations to be warranted, recommendations in that respect could have been made. The absence of recommendations or directions in relation to the conduct of further investigative steps gives rise to a clear inference that the investigation was regarded by the Coroner as at least adequate, having regard to accepted investigative practice at the time and the apparent circumstances of Mr Rath's death.

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916 Exhibit 26, Tab 1, P79A Report of Death to Coroner, 1 (SCOI.82905).
917 Exhibit 26, Tab 11, Statement of Constable Ross Parry, 10 August 1977, 1 (SCOI.02734.00009).
918 Exhibit 26, Tab 7, Statement of Elwyn Walter Rath, 10 August 1977, 1 (SCOI.02734.000016).
919 Exhibit 26, Tab 36, Statement of Helen Colman, 19 May 2023 (SCOI.82919).
920 Exhibit 6, Tab 56, Email correspondence between Craig Middleton and John Lehmann dated 16-17 June 2015 (SCOI.74113); Exhibit 6, Tab 56B, Excel spreadsheet titled 'Possible Gay Hate Murders List' provided to Michael Willing by Sue Thompson in about 2013 (SCOI.77315).

641. The NSWPF acknowledged, at [17] of their written submissions, that there is no evidence based on the material in the tender bundle which indicates that there was canvassing of local residents or with Mr Rath's church. Whilst noting that the information available to the Inquiry does not appear to include a comprehensive account of all investigative steps taken, the NSWPF accepts that it is "regrettable" if the steps identified above at [639.c] were not taken during the investigation.

642. As to the concern in [639.d], the NSWPF submitted at [31] that it seems unlikely that enquiries with Mr Rath's family as to the possibility he was "homosexual" would have yielded useful information concerning his sexuality.

643. As to the concern in [639.e], the NSWPF submitted at [13] that Mr Rath's sister was only 18 years of age at the time of his death and not forthcoming regarding about the information she had about Mr Rath's death during their initial investigation.

644. During the course of oral evidence and in relation to the concern in [639.a], DI Warren accepted that blood type analysis, specifically blood grouping, was an important forensic technique in the 1970s.[921] However, DI Warren could not say whether it was police practice to see whether all of the blood on relevant items was that of a deceased person. DI Warren acknowledged that where one was asking whether or not to dismiss a death as suspicious or potentially suspicious it would be a highly significant enquiry to make.[922]

645. As to the balance of the matters of concern, DI Warren indicated that all of the steps were available to investigating officers in the mid-1970s and would assist in forming a view about whether or not a death was suspicious. DI Warren said he would expect an investigating officer today to make those enquiries and could not offer any reason as to why that was not equally so in 1977.[923]

646. In our submission, the ready inference from DI Warren's evidence is that there were investigative steps and enquiries which were available at the time and which could and should have been taken.

[921] Transcript of the Inquiry, 5 July 2023, T4976.27-34 (TRA.00073.00001).
[922] Transcript of the Inquiry, 5 July 2023, T4977.31-45 (TRA.00073.00001).
[923] Transcript of the Inquiry, 5 July 2023, T4978.15-34 (TRA.00073.00001).

D.8 David Lloyd-Williams (died 24 August 1978)

647. David Lloyd-Williams died on 24 August 1978. Mr Lloyd-Williams died of multiple injuries after deliberately jumping from a cliff at North Head in Manly. A coronial finding to that effect was made on 23 October 1978.[924] The police investigation into Mr Lloyd-Williams' death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 6 February 2023 at [35]-[36].

D.8.1 Loss or destruction of exhibits

648. The Inquiry issued a summons to the NSWPF (Summons NSWPF13) that sought all documents relating to investigations of the death of Mr Lloyd-Williams, using the details of his name and dates of birth and death as they appeared in the death certificate.[925]

649. The legal representative for the NSWPF replied by email dated 9 September 2022, advising that the only information or holdings of the NSWPF in relation to the matter were the Strike Force Parrabell Case Summary and the Bias Crimes Indicator Review Form, and that any further information or holdings could not be identified.[926]

650. The entire investigation file in relation to Mr Lloyd-Williams' death, therefore, appears to have been lost. This is notwithstanding that the coronial file produced to the Inquiry contains various statements and documentation produced by the NSWPF at the time of Mr Lloyd-Williams' death.

651. In written submissions filed on behalf of the NSWPF on 21 February 2023, the NSWPF accepted that the loss of the investigation file in relation to Mr Lloyd-Williams' death was "regrettable".[927]

652. The NSWPF conceded that the absence of the file "likely serves to highlight" deficiencies in record keeping and archiving of such files at the time. The NSWPF further submitted, however, that there was "little to be gained now from criticising the record keeping practices of NSWPF 44 years ago or by comparing those practices to those employed more recently following the enormous advances in computer systems, digitisation and, in turn, archiving of information, in the intervening period."[928] Our submissions concerning submissions of this kind made by the NSWPF are set out at [490] above.

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[924] Exhibit 12, Tab 5, Findings of City Coroner Leonard James Nash, 23 October 1978 (SCOI.73571.00004).
[925] Exhibit 12, Tab 17A, Summons to produce to NSWPF (NSWPF13), 26 August 2022 (SCOI.82178).
[926] Exhibit 12, Tab 18, Email from NSWPF to the Inquiry re Summons NSWPF13, 9 September 2022 (SCOI.82176).
[927] Written submissions filed on behalf of NSWPF on 21 February 2023, [92] (SCOI.82560).
[928] Written submissions filed on behalf of NSWPF on 21 February 2023, [93] (SCOI.82560).

653. During the course of oral evidence, AC Conroy told the Inquiry that a coronial finding of suicide would have a bearing upon the appropriateness or otherwise of a decision to dispose of exhibits or investigative files. In particular, AC Conroy indicated that exhibits would be disposed of upon receipt of written instructions from the Coroner.[929]

654. DI Warren acknowledged that he would have expected documents to be created during the course of the police response into Mr Lloyd-Williams' death. Those records, according to practices of the day, would have been kept with the OIC at the police station where the incident occurred. DI Warren accepted that even if a coroner formed the view that it was more likely, on the balance of probabilities, that a death was non-suspicious, proper police practice would require those records to be retained.[930]

D.9 Walter John Bedser (died on 2 December 1980)

655. Walter John Bedser died on 2 December 1980. Mr Bedser died of hypovolaemic shock as a result of knife wounds inflicted by an unidentified person.[931] The police investigation into Mr Bedser's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 23 May 2023 at [34]-[47].

D.9.1 Loss or destruction of exhibits

656. On 21 December 2022, the Inquiry issued a summons to the NSWPF for the crime scene exhibits in relation to Mr Bedser's death: the knife, blood samples taken from the body of Mr Bedser, swabs of blood taken from the crime scene, and the clothing of Mr Bedser removed from his body at the mortuary (Summons NSWPF49).[932] On 23 January 2023, the NSWPF provided a statement from DS Sheldon, which outlined that, following searches and enquiries within the NSWPF, no exhibits could be located.[933]

657. DS Sheldon indicated in his statement that these searches and enquiries were "exhaustive" and there are no further avenues of enquiry available to locate the exhibits.[934]

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[929] Transcript of the Inquiry, 4 July 2023, T4865.26-46 (TRA.00072.00001).
[930] Transcript of the Inquiry, 5 July 2023, T4947.20-4948.39 (TRA.00073.00001).
[931] Submissions of Counsel Assisting the Inquiry, 23 May 2023, [2], [196] (SCOI.83249); Exhibit 28, Tab 3, Synopsis of clinical notes, 2 December 1980 (SCOI.00008.00012).
[932] Exhibit 28, Tab 168, Summons to produce to NSWPF (Summons NSWPF49), 21 December 2022 (SCOI.82592).
[933] Exhibit 28, Tab 169, Statement of Detective Sergeant Neil Sheldon, 23 January 2023 (SCOI.82591).
[934] Exhibit 28, Tab 169, Statement of Detective Sergeant Neil Sheldon, 23 January 2023, [10] (SCOI.82591).

658. In written submissions filed on behalf of the NSWPF on 7 June 2023, the NSWPF accepted at [10] that it cannot now be determined what happened to the exhibits identified above. The NSWPF agreed that "this is entirely unacceptable" and despite the 40 years since Mr Bedser's death, "noting the matter remains unresolved it is reasonable to expect that steps would have been taken to record the location of, or what ultimately transpired in relation to those exhibits, particularly the knife".[935]

659. The NSWPF further submitted at [11] that it is possible that at least some of the exhibits were destroyed, for example, following the testing of blood samples and swabs.

660. In the Second Conroy Statement, AC Conroy described this matter as one where the unavailability of certain exhibits was "almost certainly a breach of the relevant policy".[936] AC Conroy stated that key exhibits, including the murder weapon, have not been found and:[937]

> Given that case is (and was) an unsolved homicide the disposal of the murder weapon (if that occurred) would very likely have breached Instruction 33 (1977). The disposal of such an exhibit would also likely have breached Instruction 78 (1977) (78-9) if it did not occur in accordance with a direction from a Coroner. While the material available to me does not indicate whether or not such a direction was issued, it seems very unlikely that such a direction would have been given in this case. Whether the murder weapon in Mr Bedser's case was disposed of or lost, the fact that it is unavailable is obviously unsatisfactory.

661. During the course of her oral evidence, AC Conroy also acknowledged that it is very unlikely that there was a proper basis for destroying or losing the knife seized. She accepted that fingerprint technology was readily available in 1980, and that there have been difficulties in ascertaining whether or not fingerprints were ever taken from the handle of the knife.[938]

D.9.2 2023 UHT screening, triage and review forms

662. The Inquiry has before it a Case Screening Form dated 18 September 2008 in relation to the death of Mr Bedser, in addition to two Senior Detectives Course Review of an Unsolved Homicide Case Screening Forms dated 10 May 2005 and 4 August 2011.[939]

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[935] Written submissions filed on behalf of the NSWPF, 7 June 2023, [10] (SCOI.83644).
[936] Exhibit 51, Tab 4, Second Statement of Assistance Commissioner Rashelle Conroy, 11 June 2023, [43]-[44] (NPL.9000.0008.1049).
[937] Exhibit 51, Tab 4, Second Statement of Assistance Commissioner Rashelle Conroy, 11 June 2023, [44] (NPL.9000.0008.1049).
[938] Transcript of the Inquiry, 4 July 2023, T4841.1-4842.1 (TRA.00072.00001).
[939] Exhibit 28, Tab 159, Senior Detectives Course review material – Walter Bedser, 10 May 2005 (SCOI.02915); Exhibit 28, Tab 160, Case Screening Form – Walter Bedser, 18 September 2008 (SCOI.02913); Exhibit 28, Tab 161, Senior Detectives Course review material – Walter Bedser, 4 August 2011 (SCOI.02914).

663. DCI Laidlaw confirmed that the Case Screening Form dated 10 May 2005 is an example of one of the screening forms used during the period between 2004 and 2017.[940] The 2005 Screening Form was completed as part of the Detectives Education Course (**2005 Bedser Case Screening Form**). However, DCI Laidlaw said that the fact it had been used as part of the program did not indicate that it had been completed as a training exercise rather than a serious review. He said that reviews completed in this context are undertaken under management and "strict".[941]

664. The 2005 Bedser Case Screening Form is unsigned, undated and does not have a signature for the coordinator's certification. DCI Laidlaw gave evidence, in response to questions from Senior Counsel Assisting, that it appeared to him that the absence of a signature was an oversight.[942] Senior Counsel Assisting asked DCI Laidlaw whether there was any way of knowing whether an unsigned or undated form was in fact completed. DCI Laidlaw said he did not know. However, when Senior Counsel Assisting put to him that such forms may be incomplete forms, he said "I would say not, if they're on our system, they wouldn't be, which I assume is where you retrieved them from."[943]

665. DCI Laidlaw's reference to "where you retrieved them from" is somewhat odd given that the relevant documents were produced by the UHT, and presumably from the records of DCI Laidlaw's own team. DCI Laidlaw was far better placed than the Inquiry to understand from where the documents were retrieved.

666. The 2005 Bedser Screening Form recommends that while the case should not be reopened "as such", certain steps should be taken, after which "finalisation" could be reached.[944] DCI Laidlaw explained that "finalisation" refers to the decision as to whether or not the matter should be reinvestigated.[945] Senior Counsel Assisting asked DCI Laidlaw what he would expect to happen next in relation to the matter, and DCI Laidlaw said that he would expect that "phase 1" of the recommended steps would be taken. He agreed that if that had occurred, he would expect that a record of that step would be in the NSWPF records.[946]

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[940] Transcript of the Inquiry, 7 July 2023, T5212.34-36 (TRA.00075.00001).
[941] Transcript of the Inquiry, 7 July 2023, T5216.11-20 (TRA.00075.00001).
[942] Transcript of the Inquiry, 7 July 2023, T5212.38-5213.5 (TRA.00075.00001).
[943] Transcript of the Inquiry, 7 July 2023, T5213.11-21 (TRA.00075.00001).
[944] Exhibit 28, Tab 159, Senior Detectives Course review material – Walter Bedser, 10 May 2005, 17 (SCOI.02915).
[945] Transcript of the Inquiry, 7 July 2023, T5213.37-5214.5 (TRA.00075.00001).
[946] Transcript of the Inquiry, 7 July 2023, T5214.2-31 (TRA.00075.00001).

667. The 2005 Bedser Case Screening Form records, under the "Exhibits Located" heading a "knife" which is identified as "to DAL on 10/12/1980".[947] In fact, by 2005 the knife had been lost. Senior Counsel Assisting asked DCI Laidlaw if that was something that ought to have been identified in the 2005 Bedser Case Screening Form. DCI Laidlaw said that it was, but that the author may not have been aware of the loss of the knife.[948]

668. There is also a screening form completed in 2008 in relation to Mr Bedser (**2008 Bedser Case Screening Form**).[949] Once again, this screening form is not signed or dated. DCI Laidlaw said that the Commissioner could nonetheless draw an inference that the form was completed.[950] DCI Laidlaw was asked by Senior Counsel Assisting whether it was possible to tell from the face of the document whether it was a review by the UHT or by the Detectives Course, and DCI Laidlaw said it was not possible to tell.[951]

669. Senior Counsel Assisting took DCI Laidlaw to the recommendations made in the 2008 Bedser Case Screening Form.[952] He asked DCI Laidlaw when he would expect the actions recommended in the document to be taken, and DCI Laidlaw said "at a reasonable time shortly thereafter."[953] DCI Laidlaw said that they should have been undertaken by whoever had been assigned the matter, and that would have been someone outside the UHT as the UHT did not have an investigative function at that time.[954]

670. The 2008 Bedser Case Screening Form records that "[t]his appears to have been a thorough investigation pursuing all lines of inquiry".[955] Senior Counsel Assisting then drew DCI Laidlaw's attention to the observation, also contained in the 2008 Bedser Case Screening Form. that "[i]t is unclear whether all running sheets are truly available as they finish abruptly in January 1981".

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[947] Exhibit 28, Tab 159, Senior Detectives Course review material – Walter Bedser, 10 May 2005, 8 (SCOI.02915).
[948] Transcript of the Inquiry, 7 July 2023, T5214.44-5215.14 (TRA.00075.00001).
[949] Exhibit 28, Tab 160, Case Screening Form – Walter Bedser, 18 September 2008 (SCOI.02913).
[950] Transcript of the Inquiry. 7 July 2023, T5216.37-42 (TRA.00075.00001).
[951] Transcript of the Inquiry, 7 July 2023, T5218.1-5 (TRA.00075.00001).
[952] Transcript of the Inquiry, 7 July 2023, T5218.7-13 (TRA.00075.00001); Exhibit 28, Tab 160, Case Screening Form – Walter Bedser, 18 September 2008, 18 (SCOI.02913).
[953] Transcript of the Inquiry, 7 July 2023, T5218.15-22 (TRA.00075.00001).
[954] Transcript of the Inquiry, 7 July 2023, T5218.20-36 (TRA.00075.00001).
[955] Exhibit 28, Tab 160, Review of an Unsolved Homicide Case Screening Form – Walter Bedser, 18 September 2008, 17 (SCOI.02913).

671. DCI Laidlaw agreed that it should have been obvious to the reviewer that they did not have complete information. Senior Counsel Assisting directed DCI Laidlaw to the acknowledgement that no exhibits were available for retesting, and the comment that it appeared that "some paperwork may be missing and the inquest material cannot be located". Senior Counsel Assisting asked how a reviewer could form the view that a thorough investigation had been complete in those circumstances and DCI Laidlaw said "[t]hey can't".[956]

672. DCI Laidlaw agreed that language such as "[t]his appears to have been a thorough investigation pursuing all lines of inquiry" could affect the likelihood of a case being picked up and reviewed again in the future, and that this sort of statement may make a case less likely to be reviewed in the future. DCI Laidlaw agreed that it was incumbent on the person who prepared the document to take great care before making a statement like that, and that if there wasn't a basis for it, it shouldn't have been recorded in the document.[957]

D.10 Richard Slater (died on 22 December 1980)

673. Richard Slater died on 22 December 1980. Mr Slater died as a result of traumatic brain injury, with an antecedent cause of myocardial infarction.[958]

674. The police investigation into Mr Slater's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 18 May 2023 at [36]-[39]. Counsel Assisting notes, at [36], that the adequacy of the initial police investigation in 1982 is difficult to assess, because at least some of the records relating to the investigation are missing from the material produced to the Inquiry.

D.10.1 Loss or destruction of exhibits

675. On 5 December 2022, the Inquiry issued a summons to the NSWPF for the exhibits associated with the original investigation including blood swabs from the crime scene, and Mr Slater's clothing and blood sample (Summons NSWPF39).[959] The legal representative for the NSWPF replied by email dated 15 December 2022, advising that the exhibits were unable to be located and concluding that they no longer existed.[960]

[956] Transcript of the Inquiry, 7 July 2023, T5221.28-33 (TRA.00075.00001).
[957] Transcript of the Inquiry, 7 July 2023, T5222.12-28 (TRA.00075.00001).
[958] Exhibit 24, Tab 3, Post-mortem report of Dr Laszlo Banathy, 22 December 1980 (SCOI.082781).
[959] Exhibit 24, Tab 65, Summons to produce to NSWPF (summons NSWPF39), 5 December 2022 (SCOI.82775).
[960] Exhibit 24, Tab 72, Statement of Emily Burston, 18 May 2023, [8] (SCOI.45198).

676. On 23 January 2023, the Inquiry requested a formal statement from the NSWPF as to the searches undertaken in relation to Summons NSWPF39.[961] On 19 January 2023, the NSWPF provided a statement from DS Sheldon, which outlined that, following extensive searches and enquiries within the NSWPF, no exhibits could be located.[962] DS Sheldon indicated in his statement that these searches and enquiries were "exhaustive", and there were no further avenues of enquiry available to locate the exhibits.[963]

677. In written submissions filed on behalf of the NSWPF on 1 June 2023, the NSWPF submitted that it is an unfortunate reality that documentary records from 40 years ago may be lost or no longer available (at [42]), and that it is highly regrettable that the exhibits in connection with the matter, in particular Mr Slater's shirt and trousers on which semen had been detected, were not retained (at [46]). Submissions of this kind by the NSWPF are addressed at [907].

678. The NSWPF submitted at [47] that the loss of the exhibits must be viewed in context and that all forensic testing that could be conducted on the clothing at that time was undertaken. The NSWPF also advanced the submission that advancements in forensic testing since the time of Mr Slater's death could not be known in the early 1980s.

679. During the course of oral evidence, AC Conroy accepted that in light of the exhibit book not being properly maintained in the matter, and in the absence of any other exhibit records, it is now not possible to understand what happened to the exhibits. [964] AC Conroy told the Inquiry that had the exhibit book been properly maintained, it may have recorded what happened to the exhibits, including whether they were consumed entirely during forensic testing. AC Conroy gave evidence that there was no procedure in place at that time that would have justified the destruction of any record detailing what happened to the exhibits, including whether they were consumed during forensic testing, or whether they were destroyed for some other reason.[965]

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[961] Exhibit 24, Tab 72, Statement of Emily Burston, 18 May 2023, [9] (SCOI.45198).
[962] Exhibit 24, Tab 68, Statement of Detective Sergeant Neil Sheldon, 18 January 2023 (SCOI.82916).
[963] Exhibit 24, Tab 68, Statement of Detective Sergeant Neil Sheldon, 18 January 2023, [14] (SCOI.82916).
[964] Transcript of the Inquiry, 4 July 2023, T4849.27-43 (TRA.00072.00001); 4550.12-15 (TRA.00072.00001).
[965] Transcript of the Inquiry, 4 July 2023, T4849.35-4850.10 (TRA.00072.00001); 5450.17-20 (TRA.00072.00001).

680. Describing the loss or destruction of documentary records as an "unfortunate reality" disconnects that loss or destruction from human agency. It is indeed an unfortunate reality but, it is a reality that has occurred due to either a failure of the NSWPF to put in place appropriate policies and procedures, or a failure by individual officers to adhere to them. It is not unreasonable to expect that records and exhibits concerning an unsolved homicide would be preserved for a substantial period of time, and would be readily able to be located (or that their destruction would be probably recorded, and those records retained).

D.11 Russell Payne (died on 31 January 1989)

681. Russell Payne's body was found on 2 February 1989. It is estimated that Mr Payne died on or about 31 January 1989.[966] Mr Payne died of septicaemia, precipitated by a urethral foreign body, which was self inserted.[967] The police investigation into Mr Payne's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 6 February 2023 at [23]-[25].

D.11.1 Matters of concern to the Inquiry

682. As outlined in the written submissions of Counsel Assisting (at [17]-[20], [25], [51]) the NSWPF appear to have failed to secure (or to retain) "erotic photographs". The erotic photographs were relied upon by the OIC in reaching the conclusion that Mr Payne had engaged in "bizarre sexual practises."[968]

683. Details should have been recorded as to the content of these photographs, and these items should have been secured as exhibits. The OIC's statement does not raise the possibility of homicide, and attributes Mr Payne's death only to the self-insertion of the metal object into the urethra.[969] An inquest was subsequently dispensed with in Mr Payne's case.

684. In written submissions filed on behalf of the NSWPF on 21 February 2023, the NSWPF submitted the following in response to the Inquiry's concerns:[970]

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[966] Exhibit 10, Tab 3, Post-mortem report of Dr Alan Davison, 6 February 1989, 2 (SCOI.75544).
[967] Exhibit 10, Tab 3, Post-Mortem report of Dr Alan Davison, 6 February 1989, 2 (SCOI.75544); Exhibit 10, Tab 5, Notice of Dispensing with Inquest, 18 May 1989 (SCOI.82202); Exhibit 10, Tab 11, Expert report of Dr Linda Iles, Undated (provided on 11 November 2022), 7 (SCOI.82113).
[968] Exhibit 10, Tab 6, Statement of Detective Sergeant Patrick Moss, 3 March 1989, [14] (SCOI.75545).
[969] Exhibit 10, Tab 6, Statement of Detective Sergeant Patrick Moss, 3 March 1989, [13] (SCOI.75545).
[970] Written submissions filed on behalf of the NSWPF on 21 February, [67] (SCOI.82560).

> No information as to the precise nature of those photographs is contained in the tender bundle. The statement of Sergeant Moss records only that those photographs were contained 'in the bedroom' at the flat. It is not clear where in the bedroom those photographs were located. The photographs might, for example, have been entirely conventional erotic photographs stored in a drawer. Sergeant Moss has not been called to give evidence. Accordingly, the suggestion that, at the time of the investigation, police should have regarded the photographs as sufficiently pertinent to warrant their seizure is wholly speculative. Again, the task of police at the time was to identify what caused Mr Payne's death, not to exhaustively interrogate contextual factors that may have been relevant to the question of his sexuality.

685. In our submission, there would be force in the NSWPF's submissions on this issue if the OIC had not relied on and referred to the photographs in his reasoning. There is no doubt that Mr Payne's sexual practices were a relevant consideration in the investigation.

686. In addition, the reference to "bizarre sexual practises" is concerning. This language might be characterised as prurient or contemptuous in relation to diverse sexual practices. The word "bizarre" is both pejorative and imprecise.

D.12 Gerald Leslie Cuthbert (died on 18 October 1981)

687. Gerald Leslie Cuthbert died on 18 October 1981. Mr Cuthbert died from the effect of a cut throat and multiple incised penetrating wounds of the chest inflicted by a person or persons unknown.[971]

688. The police investigation into Mr Cuthbert's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 28 March 2023 at [27]-[28].

D.12.1 Loss or destruction of exhibits

689. The NSWPF collected a number of crucial exhibits in this matter, including a handkerchief stained with blood and semen, anal swabs and smears on which semen was detected, a blood-stained sock, and two cigarette butts on which saliva was detected. These exhibits were tested by the NSWPF as part of their original investigation into Mr Cuthbert's death.[972]

690. The Inquiry made substantial efforts to have these exhibits re-tested, including twice writing to the NSWPF asking for efforts to be made to locate the exhibits, in light of significant advances in forensic testing technology since 1982. However, the Inquiry's efforts were ultimately fruitless, as it appears that the exhibits in Mr Cuthbert's case have been lost.[973]

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[971] Exhibit 16, Tab 5, Coronial Findings, 26 July 1984 (SCOI.00019.00003).
[972] Exhibit 16, Tab 4, Statement re Forensic Analysis by Annette Louise Henry, 23 February 1982 (SCOI.10027.0005).
[973] Exhibit 16, Tab 36, Statement of Francesca Lilly, 24 March 2023, [9]-[13] (SCOI.82543).

691. A statement of DS Sheldon dated 18 January 2023 details the investigation into Mr Cuthbert's death. DS Sheldon's statement outlines the searches that were conducted by the NSWPF in response to various summonses issued by the Inquiry and two subsequent letters of request concerning the exhibits.[974]

692. DS Sheldon states that searches for the exhibits were conducted on EFIMS and all other investigative holdings held by the NSWPF, as well as with other agencies including FASS, FETS and the DoFM.[975] A review of exhibit book entries, from the exhibits books located, between October 1981 until the end of 1984 also produced no results.[976] In DS Sheldon's opinion, there are no further avenues of enquiry available to the NSWPF to locate the exhibits.[977]

693. In written submissions filed on behalf of the NSWPF on 12 April 2023 at [9]-[13], the NSWPF acknowledged that the loss of the exhibits in Mr Cuthbert's case was "regrettable" and "undoubtedly lamentable".

694. However, the NSWPF suggested at [10]-[11] that some of the exhibits or extracts taken from the exhibits may have been lost in connection with the testing process. The NSWPF referred to a statement of Ms Franco, who considered it likely that the cigarette butts seized by police would have been consumed or destroyed in testing.[978] Despite Ms Franco having made no reference to the anal swabs being destroyed, the NSWPF posited that the anal swabs may have been destroyed in a similar manner.

695. The Second Conroy Statement addresses the failure to retain the exhibits relating to Mr Cuthbert's death. In particular, AC Conroy states that she is unable to reach a confident conclusion as to whether or not the fact that the exhibits are no longer held by the NSWPF represents a failure to comply with the relevant policies or procedures of the time.[979] AC Conroy also states that some of the exhibits may have been consumed in the process of analytical testing conducted by FASS. In circumstances where the available material fails to identify when, how or why the relevant exhibits came to be unavailable, AC Conroy said that she was unable to definitively address what happened to the exhibits.[980]

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[974] Exhibit 16, Tab 31, Statement of Detective Sergeant Neil Sheldon, 18 January 2023 (SCOI.82580).
[975] Exhibit 16, Tab 31, Statement of Detective Sergeant Neil Sheldon, 18 January 2023, [8]-[9], [11]-[16] (SCOI.82580).
[976] Exhibit 16, Tab 31, Statement of Detective Sergeant Neil Sheldon, 18 January 2023, [10], [17] (SCOI.82580).
[977] Exhibit 16, Tab 31, Statement of Detective Sergeant Neil Sheldon, 18 January 2023, [23] (SCOI.82580).
[978] Exhibit 16, Tab 35, Expert Certificate of Michele Franco, 3 March 2023, 3 (SCOI.82542).
[979] Exhibit 51, Tab 4, Second Statement of Assistant Commissioner Rashelle Conroy, 11 June 2023, [35] (NPL.9000.0008.1049).
[980] Exhibit 51, Tab 4, Second Statement of Assistant Commissioner Rashelle Conroy, 11 June 2023, [36] (NPL.9000.0008.1049).

696. During the course of AC Conroy's oral evidence, a distinction was drawn Senior Counsel Assisting, and accepted by AC Conroy, between the nature of exhibits that were capable of being entirely consumed during the original FASS analytical testing, such as cigarette butts, and those exhibits that would likely not have been entirely consumed during the original FASS analytical testing, such as a handkerchief and a sock. AC Conroy accepted that it was not likely that the handkerchief or sock were consumed in testing. [981]

697. In circumstances where the handkerchief and sock cannot be located, AC Conroy conceded that it follows the exhibits have either been destroyed, or lost.[982] If the exhibits were destroyed, AC Conroy told the Inquiry that proper police practices required a record to be made of any decision to destroy exhibits. If the exhibits were moved to a location and subsequently lost, AC Conroy conceded that indicates a failure in police procedures.[983]

D.13 Peter Sheil (died between 27 and 29 April 1983)

698. Peter Sheil died between 27 April 1983 and 29 April 1983. Mr Sheil was found deceased on the rocks below the coastal track at the northern side of Gordons Bay. Mr Sheil died as a result of cervical spine injuries sustained in a fall. Mr Sheil was found in a short-sleeved shirt with his trousers, belt and fly undone.[984]

699. The OIC, who attended the scene alone, observed a magazine of a "sexual nature" just below a rock outcrop about 20 metres from Mr Sheil's body. The rock outcrop had a very mossy surface which was observed to be slippery in nature. In the week following the discovery of Mr Sheil's body, the OIC made enquires of the immediate area as to whether anyone had witnessed anything that may have assisted police. These enquiries were to no avail. The OIC concluded that Mr Sheil stepped off the coastal track to masturbate and then accidentally fell to his death.[985]

700. Counsel Assisting has previously submitted to the Inquiry that there is insufficient evidence to enable a finding to be made as to whether the fall was accidental or otherwise. The police investigation into Mr Sheil's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 4 April 2023 at [16]-[24] and [56]-[67].

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[981] Transcript of the Inquiry, 4 July 2023, T4836.23-36 (TRA.00072.00001).
[982] Transcript of the Inquiry, 4 July 2023, T4837.3-15 (TRA.00072.00001).
[983] Transcript of the Inquiry, 4 July 2023, T4837.24 (TRA.00072.00001).
[984] Submissions of Counsel Assisting the Inquiry, 4 April 2023, [11] (SCOI.45180); Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, [3] (SCOI.11037.00011).
[985] Submissions of Counsel Assisting the Inquiry, 4 April 2023, [56]-[63] (SCOI.45180); Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, [4], [8], [9] (SCOI.11037.00011).

D.13.1 Loss or destruction of exhibits

701. A summons to the NSWPF was issued on 18 May 2022 for, relevantly, all NSWPF investigative material, including any material held or created by the UHT, in relation to the death of Mr Sheil (Summons NSWPF1). No material has been produced by NSWPF in relation to Mr Sheil's matter.

702. On 12 September 2022, the Inquiry wrote to the NSWPF, noting that in documents contained in the Coroners Court file and other media sources, Mr Sheil's last name is at times spelled with different variations, including, for example, "Shiel", "Sheils", "Shiels" and "Shell", and requesting that the NSWPF conduct further searches for any investigative file under those names. On 13 September 2022, the legal representative for NSWPF advised that no records are held in respect of any of the four spelling variations identified.[986]

703. No investigative files or other documents can be located by the NSWPF in relation to Mr Sheil's death. Accordingly, among other things, there is no clear evidence as to the exact location that Mr Sheil's body was found. The failure of the police to preserve and locate such files and documents is particularly unfortunate in circumstances where, according to the OIC's statement given during the coronial investigation, Scientific Squad Police attended the scene of Mr Sheil's death and took photographs of his body and the surrounding area.[987] These photographs are not available to the Inquiry.

704. In written submissions filed on behalf of the NSWPF on 18 April 2023, the NSWPF submitted that, given the police investigation occurred 40 years ago, the management of exhibits related to Mr Sheil's death should "not be assessed by reference to modern investigative standards".[988]

705. During the course of her oral evidence, when asked by Senior Counsel Assisting whether the investigative file in Mr Sheil's case should have been retained, AC Conroy indicated that she was not able to answer the question because she "[had not] seen the investigative file and … [had not] received any documentation in relation to that matter".[989]

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[986] Exhibit 20, Tab 17, Email correspondence between the Inquiry and the NSWPF, re request for further searches re Peter Sheil, 12-13 September 2022 (SCOI.82802).
[987] Exhibit 20, Tab 10, Statement of Constable William Arthur Strange, [3] (SCOI.11037.00011).
[988] Written submissions filed on behalf of NSWPF on 18 April 2023, [5b] (SCOI.45193).
[989] Transcript of the Inquiry, 4 July 2023, T4846.15-16 (TRA.00072.00001).

706. AC Conroy conceded, under questioning by the Commissioner, that the effect of her evidence was that if an investigative file was missing, she would never be able to give an answer to the question of whether proper police practices had been adhered to in relation to the retention of that file.[990] AC Conroy was unable to comment as to whether the absence of the police file was itself indicative of a failure in proper police practices.[991] AC Conroy ultimately accepted that she had no way of knowing whether there may be exhibits in relation to Mr Sheil's death somewhere among police records.[992]

707. During the course of his oral evidence, DI Warren gave evidence that, based on his knowledge of police practices in existence at the time of Mr Sheil's death, a number of physical documents should have been created during the investigation and placed on the police file.[993] These would have included a P79A Report of Death to the Coroner, any relevant witness statements, records of scientific examinations, and police statements outlining the enquiries that were made during the investigation.[994]

708. According to DI Warren, these records would have been kept at the police station where the OIC was working.[995] Had police practices been followed, DI Warren said that the records "should have been kept" and that archiving would be "the appropriate situation for those records to be stored".[996] DI Warren accepted that proper police practices would "absolutely" require these records to be retained, even if a coroner formed the view that the death was not suspicious.[997]

D.13.2 Matters of concern to the Inquiry

709. As outlined in the written submissions of Counsel Assisting (at [16]-[23]), the following matters of concern to the Inquiry arise in relation to the investigation of Mr Sheil's death:

    a. It appears that Police quickly formed the view that Mr Sheil's death was accidental, and no attempts were made to make enquiries of or take statements from Mr Sheil's friends or family.

    b. Police failed to keep any records of the investigation, including photographs which were taken of the scene.

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[990] Transcript of the Inquiry, 4 July 2023, T4846.20-24 (TRA.00072.00001).
[991] Transcript of the Inquiry, 4 July 2023, T4846.33-36 (TRA.00072.00001).
[992] Transcript of the Inquiry, 4 July 2023, T4847.38-42 (TRA.00072.00001).
[993] Transcript of the Inquiry, 5 July 2023, T4947.27-35 (TRA.00073.00001).
[994] Transcript of the Inquiry, 5 July 2023, T4948.1-10 (TRA.00073.00001).
[995] Transcript of the Inquiry, 5 July 2023, T4948.20-24 (TRA.00073.00001).
[996] Transcript of the Inquiry, 5 July 2023, T4948.28-33 (TRA.00073.00001).
[997] Transcript of the Inquiry, 5 July 2023, T4948.35-39 (TRA.00073.00001).

c. There was a delay in obtaining statements from witnesses, particularly Mr Ross (who found Mr Sheil's body) and Ms Campbell (the supervisor of the property where Mr Sheil was residing).

710. In written submissions filed on behalf of the NSWPF on 18 April 2023, the NSWPF submitted the following in response to Counsel Assisting's concerns, at [5]-[17]:[998]

a. The fact that the Coroner dispensed with the inquest, without directing that further investigations be undertaken, is a clear indication that the police investigation was regarded as sufficient (at [5b]).

b. That Counsel Assisting's criticism that the police investigation was too short is inconsistent with the concern expressed regarding key witness statements being obtained more than a month after the investigation. In respect of the investigation, the NSWPF submits that the investigation cannot be found to be deficient solely on the basis of its length. Regarding the statements, the NSWPF suggests that various practical factors may have influenced the delay in the taking of statements (at [7]).

c. That the conclusion that there was "no attempt" to gain information from Mr Sheil's mother, based on the lack of a formal statement, is incorrect having regard to the evidence that some information was obtained from Mr Sheil's family (at [8]).

d. While the NSWPF accepts that the "statement of the Officer-in-Charge is not as detailed as would be expected in modern times", it cannot be assumed that the "statement provides a comprehensive accounting of all of the investigative steps he undertook." The NSWPF attributes this to the expectations regarding statements which have "shifted substantially in the intervening 40 years" (at [9]).

[998] Written submissions filed on behalf of NSWPF on 18 April 2023, [5]-[17] (SCOI.45193).

711. In further written submissions filed on behalf of the NSWPF on 8 May 2023, in response to concerns expressed by the family of Mr Sheil,[999] the NSWPF submitted that the apparent loss or disposal of investigative materials may form a proper basis for criticism in relation to historical archiving practice, but it would not be appropriate for criticisms to be made on the basis of speculative inferences drawn by reference to "the lack of documents".[1000] It was also submitted that the unavailability of one police witness and the absence of evidence from his contemporaries as to what was regarded as appropriate policing practice gives rise to a significant risk of unfairness.[1001]

712. Relevantly, in the context of their reply submissions, the NSWPF note that Mr Sheil's death occurred "at a time when policing practice was guided by a very different set of procedures and norms, occurred in a very different social context, and did not have the benefit of modern investigative tools and information processing technologies".[1002] Submissions of this kind are addressed further at [490]-[491] above.

713. During the course of his oral evidence, DI Warren said that if there was evidence available in 1983 that the area where Mr Sheil died was a beat, he would consider that an investigating officer should have taken that into account.[1003] If the OIC had knowledge that the area was a beat, DI Warren considered that this was something that should have been brought to the attention of the Coroner.[1004] DI Warren would also expect the investigating officer to have an up to date knowledge of what was happening in the area.[1005]

714. Under questioning by the Commissioner, DI Warren acknowledged that the magazine of a "sexual nature" was relevant to the investigation.[1006] DI Warren was not sure why investigating police mentioned the magazine but failed to collect it.[1007]

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[999] Further submissions of the Sheil family in response to the written submissions filed on behalf of the NSWPF, 28 April 2023 (SCOI.47468).
[1000] Further written submissions filed on behalf of NSWPF on 8 May 2023, [5] (SCOI.83083).
[1001] Further written submissions filed on behalf of NSWPF on 8 May 2023, [3], [5b] (SCOI.83083).
[1002] Further written submissions filed on behalf of NSWPF on 8 May 2023, [5c] (SCOI.83083).
[1003] Transcript of the Inquiry, 5 July 2023, T4980.5-12 (TRA.00073.00001).
[1004] Transcript of the Inquiry, 5 July 2023, T4980.37-41 (TRA.00073.00001).
[1005] Transcript of the Inquiry, 5 July 2023, T4980.11-12 (TRA.00073.00001).
[1006] Transcript of the Inquiry, 5 July 2023, T4980.24-25 (TRA.00073.00001).
[1007] Transcript of the Inquiry, 5 July 2023, T4980.31-35 (TRA.00073.00001).

715. When questioned by Senior Counsel Assisting in relation to the delay by investigating police in obtaining statements from a number of witnesses, DI Warren acknowledged that the passage of one month would create the risk of degraded memories and that this was appreciated in 1983.[1008] It is submitted that the investigatory failures described above fell short of proper police practices, including judged according to the standard of their day.

D.14 Peter Baumann (died on or before 26 October 1983)

D.14.1 Matters of concern to the Inquiry

716. Mr Baumann's death is dealt with in the written submissions of Counsel Assisting dated 27 June 2023. Mr Baumann disappeared in 1983, and his body has never been found. Submissions concerning the steps which were not taken in relation to Mr Baumann's death are dealt with at [25]-[33] of the submissions of Counsel Assisting dated 27 June 2023. In summary, Counsel Assisting submits that a proper investigation should have been commenced in 1983, when Mr Baumann's disappearance was reported, and more comprehensive steps taken in 1992 or 1993 when an investigation was commenced.

717. In written submissions filed on behalf of the NSWPF on 10 July 2023, the NSWPF advanced the following submission in relation to the initial investigation:

> Counsel Assisting's criticisms of the initial investigation are premised on the assumption that no investigative steps were taken in or around 1983. As noted above, there is a significant degree of speculation involved in the assessment of whether no investigative steps were taken, as distinct from the possibility that steps were taken, but no records of those steps have been retained.

718. Neither of these possibilities are satisfactory. The fact that there is a degree of speculation involved in seeking to understand the initial investigation is attributable to the deficiencies in NSWPF record keeping practices. Having regard to the wholly deficient record keeping, there is reason to treat the submissions of the NSWPF as to what can be inferred from those records with caution (see, e.g., [86]).

719. The NSWPF submissions also address the subsequent investigation ([93]-[103]). The NSWPF submits that these criticisms must be understood in the context of the documents available to the MPU investigators ([97]). The absence of relevant documentation is, once again, attributable to the actions of the NSWPF.

[1008] Transcript of the Inquiry, 5 July 2023, T4981.1-23 (TRA.00073.00001).

D.14.2 UHT screening, triage and review forms

720. The Inquiry had before it a Triage Form in relation to Peter Baumann, a missing person.[1009] Once again, the Triage Form produced to the Inquiry was unsigned and undated. On this form, a large number of the fields were empty. However, there is a reference in the document to a post-mortem result.[1010] The evidence before the Inquiry indicates that Mr Baumann's body has never been recovered. DCI Laidlaw accepted that this was obviously an error.[1011] DCI Laidlaw said that it appeared to him that this triage form was not completed.[1012]

D.15 Wendy Waine (died on 29 April 1985)

721. Wendy Waine's body was found on 30 April 1985. The available evidence suggests that Ms Waine met her death between approximately 3:15am and 9:00pm on 29 April 1985.[1013] Ms Waine died as a result of the effects of bullet wounds to the neck and thorax inflicted by a person unknown.[1014] The police investigation into Ms Waine's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 9 June 2023 at [37]-[42].

D.15.1 Loss or destruction of exhibits

722. On 24 August 2022, the Inquiry issued a summons to the NSWPF for exhibit book references and EFIMS records in relation to four exhibits obtained in the course of the investigation of Ms Waine's death: strands of hair found in her left hand, six cigarette butts, bed linen, and fired bullets (Summons NSWPF10). The legal representative for the NSWPF replied by email dated 7 September 2022, advising that two archive boxes previously delivered to the Inquiry on 2 June 2022 may contain material responsive to the summons.[1015] A search of those boxes revealed no responsive material.[1016] The email continued:[1017]

> A further archive box was requested from archives on 1 September 2022 (as part of a broader request) which has not yet been received and which may also contain material responsive to this Summons. An estimate of the provision of this further archive box is being requested.

[1009] Exhibit 42, Tab 83, Triage Form – Peter Baumann, Undated (SCOI.38971).
[1010] Exhibit 42, Tab 83, Triage Form – Peter Baumann, Undated, 3 (SCOI.38971).
[1011] Transcript of the Inquiry, 7 July 2023, T5240.26-5241.15 (TRA.00075.00001).
[1012] Transcript of the Inquiry, 7 July 2023, T5241.23-25 (TRA.00075.00001).
[1013] Submissions of Counsel Assisting, 9 June 2023, [134]-[148] (SCOI.83653).
[1014] Exhibit 30, Tab 3, Post mortem report of Dr Thomas Oettle, 15 October 1985 (SCOI.00014.00022).
[1015] Exhibit 30, Tab 70, Email from NSWPF to the Inquiry, 7 September 2022 (SCOI.82927).
[1016] Submissions of Counsel Assisting, 9 June 2023, [71] (SCOI.83653).
[1017] Exhibit 30, Tab 70, Email from NSWPF to the Inquiry, 7 September 2022 (SCOI.82927).

> I am instructed that apart from any relevant material that may be contained within those archive boxes, exhibit book references and EFIMS records for the exhibits listed in the Summons have been unable to be identified. This is apart from a single EFIMS record which appears to relate to a "sheet" that was located at the Ballistics Unit and was transferred to long-term exhibit storage in 2015. It is possible that that sheet relates to the "fired bullets" exhibit referred to in the Summons, however it is also possible that that exhibit was entered against the relevant event number in error. I am requesting that an attempt be made to clarify that.

723. On 14 September 2022, the NSWPF produced a photograph of a flannelette sheet, a J85-267 Ballistics Case File comprising two documents, J85-267 Ballistics Scene Photos, and three "floor plans".[1018] Referring to its outstanding searches, the covering email stated:[1019]

> I am instructed that the outstanding box of archive material was couriered to the Inquiry on or about 1 August 2022, and is the same as that referred to above at Summons #7.
>
> In relation to the "sheet" that was identified to have been held at the Ballistics Unit associated with the matter referred to in that Summons (and as referred to in my email of 7 September), it is apparent that that exhibit is a flannelette sheet. I attach a photograph of that exhibit. It is not clear to our instructing officers at this stage what the relationship of this exhibit is to the matter, if any. Our instructing officers are currently making attempts to clarify that.

724. None of the above searches or enquiries located either the exhibit books or the exhibits. Among those exhibits, no longer available, were the "fired bullets".

725. On 17 April 2023, the Inquiry issued a summons to the NSWPF for, *inter alia*, the four exhibits the subject of summons NSWPF10 and the full fingerprint file in relation to Ms Waine's death (Summons NSWPF86).[1020] On 17 April 2023, the Inquiry also requested a formal statement from the NSWPF as to the searches undertaken to locate the four exhibits the subject of summons NSWPF10 in the event that no exhibits were produced. The legal representative for the NSWPF replied by letter dated 28 April 2023, advising that the NSWPF had not located any documents responsive to Summons NSWPF86.[1021] On 16 March 2023, the NSWPF provided a statement from DS Sheldon, which outlined that, following extensive searches and enquiries within the NSWPF, no exhibits could be located.[1022]

[1018] Exhibit 30, Tab 71, Email from NSWPF to the Inquiry, 14 September 2022 (SCOI.82937).
[1019] Exhibit 30, Tab 71, Email from NSWPF to the Inquiry, 14 September 2022 (SCOI.82937).
[1020] Exhibit 30, Tab 76A, Summons to produce to NSWPF (Summons NSWPF86), 17 April 2023 (SCOI.82930).
[1021] Exhibit 30, Tab 77, Letter from Office of the General Counsel, NSWPF, to Solicitor Assisting the Inquiry, 28 April 2023 (SCOI.82994).
[1022] Exhibit 30, Tab 75, Statement of Detective Sergeant Neil Sheldon, 16 March 2023 (SCOI.82961).

726. DS Sheldon indicated in his statement that these searches and enquiries were "exhaustive" and there are no further avenues of enquiry available to locate the exhibits.[1023]

727. In written submissions filed on behalf of the NSWPF on 23 June 2023, the NSWPF agreed with the submission of Counsel Assisting that the hairs located in Ms Waine's hand were of particular forensic significance.[1024] In light of this, the NSWPF conceded that it is "highly regrettable" that the hair samples cannot be located.[1025] However, the NSWPF submitted that it is not clear which agency was responsible for the retention of the hair sample at the point when it became lost.[1026]

728. Further, the NSWPF suggested that the loss of the hair samples needed to be viewed in the context of DNA testing not having been available as an investigative tool to the NSWPF at the time of Ms Waine's death.[1027] This submission is consistent with the evidence of Dr Allsop and Ms Neville that in 1985 investigators would not have appreciated the potential scope of DNA testing.

729. In relation to the cigarette butts, the NSWPF drew attention to the fact that these were tested by Dr Weigner. The NSWPF submitted that it was not clear whether these samples were destroyed by Dr Weigner, consumed during the testing process, or otherwise misplaced.[1028]

730. The NSWPF submitted that even if the exhibits had been retained, "whether they would be suitable for testing, the results of such testing and the inferences able to be drawn from those results about the circumstances of Ms Waine's death are matters of speculation".[1029]

731. During the course of oral evidence, AC Conroy accepted that in the absence of exhibit books or EFIMS records for the exhibits identified by the Inquiry in Summons NSWPF10 there was no way for her to know what had happened to these exhibits.[1030] AC Conroy confirmed that the inability of the NSWPF to locate these exhibits reflected a breach of police procedure.[1031]

[1023] Exhibit 30, Tab 75, Statement of Detective Sergeant Neil Sheldon, 16 March 2023, [13] (SCOI.82961).
[1024] Written submissions filed on behalf of the NSWPF on 23 June 2023, [39] (SCOI.84379).
[1025] Written submissions filed on behalf of the NSWPF on 23 June 2023, [39] (SCOI.84379).
[1026] Written submissions filed on behalf of the NSWPF on 23 June 2023, [39] (SCOI.84379).
[1027] Written submissions filed on behalf of the NSWPF on 23 June 2023, [43] (SCOI.84379).
[1028] Written submissions filed on behalf of the NSWPF on 23 June 2023, [41] (SCOI.84379).
[1029] Written submissions filed on behalf of the NSWPF on 23 June 2023, [44] (SCOI.84379).
[1030] Transcript of the Inquiry, 4 July 2023, T4848.34-38 (TRA.00072.00001).
[1031] Transcript of the Inquiry, 4 July 2023, T4848.40-44 (TRA.00072.00001).

732. In relation to the "fired bullets", AC Conroy conceded that had the exhibit books been properly maintained, the NSWPF would have been able to determine whether they were ever taken into police custody as exhibits.[1032] Assistant Commissioner Conroy reiterated that the failure to preserve these exhibit books represented a failure to comply with applicable police procedures in place at the time of the original investigation into Ms Waine's death.[1033]

D.15.2 UHT screening, triage and review form

733. The Inquiry has before it two documents in relation to the death of Ms Waine. The first is a Case Screening Form dated February 2005.[1034] The second is an undated Review Form.[1035]

734. The 2005 Screening Form is unsigned, but includes a name and a date for both the reviewer and the coordinator. DCI Laidlaw said that the Commissioner could infer that the Screening Form was reviewed by both the reviewer and the coordinator.[1036] In our submission, that inference is attended by some doubt.

735. Senior Counsel Assisting drew DCI Laidlaw's attention to a statement made in that document that "projectiles removed from victim's body at post-mortem are still on hand...".[1037] In fact, the evidence before the Inquiry is that there were no projectiles recovered at the post-mortem because there were entry and exit wounds, and the fired bullets, if they were ever taken into custody, could not be located.[1038]

736. On those assumptions, DCI Laidlaw accepted that this document appeared to be "just plain wrong". DCI Laidlaw was unable to assist the Commissioner with how often errors like that occurred. He said that he had not often had occasion to review screening forms of this kind and, consequently, was unable to assist the Commissioner with how prevalent errors like this may be.[1039]

[1032] Transcript of the Inquiry, 4 July 2023, T4849.14-16 (TRA.00072.00001).
[1033] Transcript of the Inquiry, 4 July 2023, T4849.18-20 (TRA.00072.00001).
[1034] Exhibit 53, Tab 37, Review of an Unsolved Homicide Case Screening Form – Wendy Waine, February 2005 (SCOI.02706).
[1035] Exhibit 53, Tab 37A, Review of an Unsolved Homicide Case Screening Form – Wendy Waine, Undated (NPL.0131.0017.0256_E).
[1036] Transcript of the Inquiry, 7 July 2023, T5237.34-5239.1 (TRA00075.00001).
[1037] Exhibit 53, Tab 37, Review of an Unsolved Homicide Case Screening Form – Wendy Waine, February 2005, 4 (SCOI.02706).
[1038] Submissions of Counsel Assisting, 9 June 2023, [52]-[53], [71], [74], [102 (SCOI.83653),
[1039] Transcript of the Inquiry, 7 July 2023, T5237.34-5239.1 (TRA00075.00001).

737. DCI Laidlaw agreed with the proposition, put to him by Senior Counsel Assisting, that this is an important detail, and that he would not expect a competent reviewer preparing a screening form to make this mistake.[1040] This was another matter where it was recommended that an investigation be reopened. DCI Laidlaw accepted that if this screening form had made it to someone outside the UHT, then that person should have commenced the reinvestigation within a reasonable time. DCI Laidlaw accepted that if there is no evidence of such a reinvestigation being commenced, that would be a failure to comply with proper police procedures at the time.[1041]

738. DCI Laidlaw was then taken to the Review Form completed in relation to Ms Waine. The document is not dated, but other information suggests that this document is from either 2008 or 2012.[1042] The fact that it is not possible to identify, on the face of the document, when it was completed, is unsatisfactory.

739. This document again recommends that the investigation into Ms Waine's death be reopened. The effect of this document is that by 2012 (or 2008) there had been two recommendations to reopen the investigation into Ms Waine's death. DCI Laidlaw said that he could not offer an explanation for why the investigation wasn't reopened. He said that the failure to reopen the investigation would constitute a failure to comply with proper police practice at the time.[1043]

D.16 William Rooney (died on 20 February 1986)

740. On 14 February 1986, Mr Rooney was found semi-conscious and suffering serious head injuries on the ground between a toilet block and concrete retaining wall in Wollongong. Mr Rooney later died on 20 February 1986 as a result of his injuries.[1044]

741. The police investigation into Mr Rooney's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 17 May 2023 at [37]-[53].

[1040] Transcript of the Inquiry, 7 July 2023, T5239.3-16 (TRA00075.00001).
[1041] Transcript of the Inquiry, 7 July 2023, T5239.22-32 (TRA00075.00001).
[1042] Exhibit 53, Tab 37, Review of an Unsolved Homicide Case Screening Form – Wendy Waine, February 2005, 4 (SCOI.02706).
[1043] Transcript of the Inquiry, 7 July 2023, T5239.37-5240.20 (TRA00075.00001).
[1044] Exhibit 22, Tab 1, P79A Report to Death to Coroner, 20 February 1986 (SCOI.11269.00002).

D.16.1 Loss or destruction of exhibits

742. A summons to the NSWPF was issued on 18 May 2022 for, relevantly, all NSWPF investigative material, including any material held or created by the UHT, in relation to the death of Mr Rooney (Summons NSWPF1). On 2 June 2022, the NSWPF produced only nine documents in relation to Mr Rooney's case, comprising some occurrence reports and two witness statements.[1045]

743. On 25 July 2022, the Inquiry requested that the NSWPF conduct further searches for material in relation to Mr Rooney.[1046]

744. On 2 August 2022, the NSWPF produced their complete e@gle.i holdings in relation to Strike Force Parrabell. The material produced included a document that referred to a "hard copy video" of Mr Rooney "being removed by ambulance officers from the sight [sic] of the incident".[1047] However, a copy of that video was not provided to the Inquiry.

745. On 9 August 2022, the NSWPF provided the Inquiry with, relevantly, a spreadsheet setting out further searches undertaken by Corporate Records in relation to Mr Rooney. The spreadsheet indicated that the NSWPF files in relation to Mr Rooney were, at that point in time, on loan to the UHT. On 17 August 2022, the Inquiry requested those files.[1048]

746. On 6 September 2022, the NSWPF indicated that all the NSWPF files in relation to Mr Rooney had already been provided to the Inquiry on 2 June 2022 (when only nine documents had been produced).[1049]

747. On 13 September 2022, the Inquiry again wrote to the NSWPF outlining the reasons why the Inquiry considered that further material likely existed (or should have existed) in relation to the case of Mr Rooney. In that letter, the Inquiry again sought, relevantly, the video footage of Mr Rooney in Crown Lane.[1050]

[1045] Written submissions of Counsel Assisting, 16 May 2023, [80] (SCOI.83199).
[1046] Exhibit 22, Tab 36, Emails to P Hodgetts re request for complete investigative file, 25 July 2022 – 15 September 2022, 5 (SCOI.82564).
[1047] Exhibit 22, Tab 31A, Extract from Strike Force Parrabell e@gle.i holdings, "Case 20 – Video of ROONEY in Crown Lane", Undated (SCOI.45252).
[1048] Exhibit 22, Tab 36, Emails to P Hodgetts re request for complete investigative file, 25 July 2022 – 15 September 2022 (SCOI.82564).
[1049] Exhibit 22, Tab 36, Emails to P Hodgetts re request for complete investigative file, 25 July 2022 – 15 September 2022, 2 (SCOI.82564).
[1050] Exhibit 22, Tab 36, Emails to P Hodgetts re request for complete investigative file, 25 July 2022 – 15 September 2022, 1-2 (SCOI.82564).

748. On 15 September 2022, the NSWPF replied by saying they had no record of the existence of further material but were able to provide, and did provide, the video footage of Mr Rooney in Crown Lane.[1051]

749. On 12 October 2022, the Inquiry issued a letter to the NSWPF requesting that further enquiries be made, and in particular, with Detective Inspector David Ainsworth and Detective Sergeant Stephen Bridge.[1052]

750. On 1 November 2022, the NSWPF indicated that a hard copy file had been found at Wollongong Police Station. That file was then provided to the Inquiry. The file contained autopsy photos, two additional statements, and some correspondence not previously received by the Inquiry.[1053]

751. By letter dated 9 March 2023, the Inquiry requested that the NSWPF undertake enquiries to identify and locate any exhibits in this matter. The NSWPF advised that it conducted searches on EFIMS, MEPC, FASS, Corporate Records, and with the Wollongong Police District and Wollongong and Lake Illawarra Crime Scene Units, but was unable to locate any of the exhibits collected in relation to Mr Rooney's death.[1054]

752. In written submissions filed on behalf of the NSWPF on 1 June 2023, the NSWPF did not seek to address the apparent loss of these exhibits by the NSWPF.[1055]

753. During the course of oral evidence, AC Conroy accepted that it was likely exhibits in the matter were taken into custody, and that there would have been an exhibit book recording details of the exhibits. AC Conroy was unable to advance any reason, consistent with police practice or proper police procedure, that would have allowed for the destruction of the exhibit book.[1056]

D.16.2 Matters of concern to the Inquiry

754. As outlined in the written submissions of Counsel Assisting (at [37]-[51]), the following matters of concern to the Inquiry arise in relation to the investigation of Mr Rooney's death:

[1051] Exhibit 22, Tab 36, Emails to P Hodgetts re request for complete investigative file, 25 July 2022 – 15 September 2022, 1 (SCOI.82564).
[1052] Exhibit 22, Tab 37, Email to P Hodgetts re request for further enquiries to be made, 12 October 2022 – 7 November 2022 (SCOI.82569; Exhibit 22, Tab 37A, Letter from E Blomfield re request for further enquiries to be made, 12 October 2022 (SCOI.82573).).
[1053] Exhibit 22, Tab 37, Email to P Hodgetts re request for further enquiries to be made, 12 October 2022 – 7 November 2022, 3 (SCOI.82569).
[1054] Written submissions of Counsel Assisting, 16 May 2023, [31] (SCOI.83199).
[1055] Written submissions filed on behalf of the NSWPF on 1 June 2023 (SCOI.83645).
[1056] Transcript of the Inquiry, 4 July 2023, T4853.29-45 (TRA.00072.00001).

a. At some stage between 14 February 1986 and 5 January 1987, the police view as to the cause of Mr Rooney's death appears to have undergone considerable change, from considering there to be suspicious circumstances to the view that Mr Rooney suffered an accidental fall. The basis for this change of view is unclear from the records produced to the Inquiry.

b. The NSWPF failed to secure the area where Mr Rooney was found on 14 February 1986. Mr Rooney was found at around 8:40am, police first attended at about 9:00am and the Scientific Investigation Section arrived at 11:05am. By 11:05am, the lessee of the adjoining retail premises had hosed the area down,[1057] limiting the subsequent ability of investigators to recover evidence of forensic value.

c. No sexual assault examination (such as with the use of a Sexual Assault Investigation Kit) was conducted on Mr Rooney while he was in hospital, and no examination of his anus or genitals was conducted during the post-mortem examination, despite Mr Rooney being found with his pants and underwear lowered and with fingernail marks on his neck.[1058]

d. There was a failure by the NSWPF to seek to check an alibi of a person of interest for the night of 13-14 February 1986.

755. In written submissions filed on behalf of the NSWPF on 1 June 2023, the NSWPF submitted at [5]-[14] the following in response to the Inquiry's concerns:

a. In relation to the change of view as to the extent to which Mr Rooney's death was suspicious, the NSWPF pointed to the post-mortem report of Dr Vincent Verzosa which records the injuries as probably occurring due to a fall,[1059] and also noted that Detective Senior Constable Tate recorded that his opinion came about as the result of completing a number of enquiries, having viewed the deceased and where he was found, and lengthy discussions with Detective Sergeant Stephen Passmore.[1060]

b. In relation to the failure to secure the scene and prevent nearby retail staff from washing away blood, the NSWPF accepted that it is "undoubtedly a concerning feature of the original investigation".

[1057] Exhibit 22, Tab 14, Statement of Detective Sergeant Stephen George Passmore, 22 October 1986, [3] (SCOI.11269.00016); Exhibit 22, Tab 13, Statement of Constable Michael Troy Tranby, 19 March 1986 (SCOI.03683.00004).
[1058] Exhibit 22, Tab 14, Statement of Detective Sergeant Stephen George Passmore, 22 October 1986, [5] (SCOI.11269.00016); Exhibit 22, Tab 50, Video of Mr Rooney in laneway, 14 February 1986 (SCO1.822576).
[1059] Exhibit 22, Tab 4, Autopsy Report, 21 February 1986 (SCOI.11269.00006).
[1060] Exhibit 22, Tab 15, Statement of Detective Senior Constable John Robert Tate, 5 January 1987, [9] (SCOI.11269.00018).

c. In relation to the absence of a sexual assault examination, the NSWPF submitted that it is "very unfortunate that the autopsy report does not include a comment in relation to the presence or absence of anogenital injuries and/or the conduct of anal or penile swabs".

d. The failure to check the alibi of a person of interest, as discussed in the written submissions of Counsel Assisting, is not addressed in the written submissions filed on behalf of the NSWPF.

756. In overall response to the criticisms levelled by Counsel Assisting surrounding the police investigation, the NSWPF further submitted at [15] that it is relevant to note that an inquest was held before Coroner Soden in October 1986 and May 1987,[1061] and there was "no indication" by the Coroner at that time that the "police investigation was regarded as in any way inadequate, having regard to the prevailing standards".

757. During the course of oral evidence, DI Warren accepted that, given the circumstances of Mr Rooney's death, it would be expected that careful records would be made of how the investigating officers reached conclusions, including the conclusion that the death was non-suspicious.[1062]

758. DI Warren also accepted that taking control of a crime scene is an important matter and was recognised to be so as at 1983. DI Warren could not provide a good reason to the Inquiry for the crime scene in this matter to have not been secured for the two hours prior to the arrival of the officers from the Scientific Investigation Section.[1063]

759. During the course of evidence, Superintendent Best stated that he was aware there were issues within the NSWPF regarding adequately securing crime scenes to preserve evidence, which was addressed by the Gibson Review. Superintendent Best was unable to comment on the adequacy of training prior to the Gibson Review and the training that was implemented throughout the 1990s.[1064]

760. During oral evidence, DI Warren accepted that there was no record of a sexual assault examination conducted on Mr Rooney, and was not able to offer any reason consistent with proper police practice at the time why that would not have been requested by police.[1065]

[1061] Exhibit 22, Tab 7, Inquest Transcript, 24 October 1986 (SCOI.03683.00011); Exhibit 22, Tab 8, Inquest Transcript, 15 May 1987 (SCOI.03683.00013).
[1062] Transcript of the Inquiry, 5 July 2023, T4983.32-33 (TRA.00073.00001).
[1063] Transcript of the Inquiry, 5 July 2023, T4984.15-24 (TRA.00073.00001).
[1064] Transcript of the Inquiry, 5 July 2023, T4921.44-4922.20 (TRA.00073.00001); Exhibit 51, Tab 2B, Gibson Review – Final Report, 20 November 1990 (NPL.9000.0003.0606).
[1065] Transcript of the Inquiry, 5 July 2023, T4985.44 (TRA.00073.00001).

D.17 Andrew Currie (died between 12 and 13 December 1988)

761. Andrew Currie died between 12 December 1988 and 13 December 1988 and his body was found at a toilet block in Nolan Reserve, North Manly. Mr Currie died of multi-drug toxicity which caused respiratory and central nervous system depression.[1066] The police investigation into Mr Currie's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 6 February 2023 at [13]-[15].

D.17.1 Matters of concern to the Inquiry

762. As outlined in the written submissions of Counsel Assisting, the following matters of concern to the Inquiry arise in relation to the investigation of Mr Currie's death:

a. No statements were taken from the family members of Mr Currie.

b. There is no record of the actions taken by detectives and scientific officers who attended the scene, beyond the existence of some photographs that were taken. No distinct original police investigation file has been located and produced.

c. There is no evidence that alternative possible causes of death were entertained, nor that the possibility that the Nolan Reserve toilet block may have been used at times as a beat was something that police considered. Counsel Assisting noted that more generally around this time, in some areas of Manly, there were known to be robberies that occurred at public toilets, sometimes involving gay men as victims.[1067]

763. On 10 October 2022, the Inquiry requested a letter or statement addressing, relevantly, the reason or reasons why no hard copy and/or original investigative files regarding Mr Currie's death were produced by the NSWPF.[1068] By email dated 24 October 2022, legal representatives for the NSWPF advised that, "it appears that Mr Currie's death was not originally treated as a homicide by NSWPF. Therefore, it is not unexpected that there appears to have been limited investigative material created or which can be identified".[1069]

[1066] Submissions of Counsel Assisting, 6 February 2023, [3] (SCOI.82379); Exhibit 13, Tab 5,Post-mortem report of Dr William Brighton, 13 February 1989 (SCOI.00016.00011).
[1067] Submissions of Counsel Assisting, 6 February 2023, [13], [34]-[35] (SCOI.82379).
[1068] Exhibit 13, Tab 18, Letter from Inquiry to NSWPF re request for further information, 10 October 2022 (SCOI.82186).
[1069] Exhibit 13, Tab 19, Email correspondence between Office of the General Counsel, PFNSW, and Solicitor Assisting the Inquiry re Summonses to Produce, 24 October 2022-19 December 2022 (SCOI.82312).

764. In written submissions filed on behalf of the NSWPF on 21 February 2023, the NSWPF submitted that the fact that the Coroner determined an inquest was not necessary strongly indicates that the circumstances of Mr Currie's death were relatively clear cut, noting also that Mr Currie was known to police as a person who overdosed regularly on drugs. The NSWPF submitted that in those circumstances, the investigating officers may have concluded it was unnecessary to take statements from his family members in order to minimise trauma or discomfort, and there is nothing to indicate that formal statements from the relevant officers should have been prepared.[1070]

765. In evidence, DI Warren agreed that the conclusion that Mr Currie's death was an overdose was reached fairly promptly but that, nevertheless, he would expect an investigating officer to maintain an open mind as to other possible reasons for death.[1071] In Mr Currie's case, DI Warren agreed that the circumstances of the death warranted its being treated as suspicious, a death the cause of which was not known, and potentially a homicide, according to the standards of 1988 and today.[1072]

766. DI Warren gave evidence that investigating police acting properly, according to the standards of the day, would obtain statements from families, as family members "would have [an] abundance of information about this particular person, his behaviour, and contribute to any issues that may arise that may not have been considered without speaking to them".[1073] DI Warren confirmed that when police question family members, they endeavour to do so in a way that is neither distressing nor traumatic.[1074] DI Warren gave evidence that he would expect to see a police record of police contact with family, but that he did not know if the standard of the day would require a police record of the decision *not* to make enquiries with family, as "[b]ack then, it may have been a bit more relaxed".[1075]

767. In response to Counsel Assisting's concern that investigating police did not entertain the possibility of the Nolan Reserve toilet block being used as a beat, the NSWPF submitted that there was no evidence the location was a beat, nor evidence that police were or should have been aware of that fact. The NSWPF submitted that it was "surprising" to suggest that police should have been alive to this possibility.[1076]

[1070] Written submissions filed on behalf of the NSWPF on 21 February 2023, [107], [110] (SCOI.82560).
[1071] Transcript of the Inquiry, 5 July 2023, T4986.14-25 (TRA.00073.00001).
[1072] Transcript of the Inquiry, 5 July 2023, T4986.27-37 (TRA.00073.00001).
[1073] Transcript of the Inquiry, 5 July 2023, T4986.39-4987.5 (TRA.00073.00001).
[1074] Transcript of the Inquiry, 5 July 2023, T4987.7-9 (TRA.00073.00001).
[1075] Transcript of the Inquiry, 5 July 2023, T4987.11-27 (TRA.00073.00001).
[1076] Written submissions filed on behalf of the NSWPF on 21 February 2023, [108] (SCOI.82560).

768. DI Warren gave evidence that in modern investigations, if a person was found in a toilet block, investigating police would give consideration to whether the area was a beat, by seeking intelligence about the area and such intelligence may reveal whether the area was a beat.[1077] DI Warren stated that he could not assist with what the situation would have been in the late 1980s.[1078]

D.18 William Allen (died between 28 and 29 December 1988)

769. William Allen died between 28 and 29 December 1988. Mr Allen died of the effects of a head injury sustained on 28 December 1988 when he was attacked and beaten in Alexandria Park.[1079] The police investigation into Mr Allen's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 23 August 2023 at [36]-[43].

D.18.1 Matters of concern to the Inquiry

770. As outlined in the written submissions of Counsel Assisting (at [44]-[50]),[1080] a number of matters of concern to the Inquiry arise in relation to the investigation of Mr Allen's death. In summary, they are:

a. Police did not check to see if Mr Allen had written his phone number on the walls of the Alexandria Park toilet block.

b. Police attended Mr Allen's house and viewed video tapes. Some of these tapes contained child abuse material involving young boys. These tapes were not taken into evidence.

c. On 29 December 1988, NSWPF officers conducted a fingerprint examination of Mr Allen's home and a silver Holden Astra. Apart from a running sheet which records that Mr Allen was fully eliminated as the source of the fingerprints, there were no further fingerprint determinations or results recorded as to which fingerprints were identified.

[1077] Transcript of the Inquiry, 5 July 2023, T4987.41-46 (TRA.00073.00001).
[1078] Transcript of the Inquiry, 5 July 2023, T4988.1-7 (TRA.00073.00001).
[1079] Exhibit 36, Tab 6, Findings of State Coroner Waller, Inquest into the death of William Allen, 4 July 1989 (SCOI.00003.00001).
[1080] Submissions of Counsel Assisting, 23 August 2023, [44]-[50] (SCOI.85228).

771. In written submissions filed on behalf of the NSWPF on 5 September 2023, the NSWPF submitted that it is not clear whether the walls of the Alexandria toilet block contained messages seeking or inviting sexual encounters at the time of Mr Allen's death.[1081] The NSWPF sought to call into question the evidence Mr Berwick provided to the Inquiry that Mr Allen told him that he wrote his phone number on the wall of the toilet block.[1082]

772. The NSWPF suggested that, given approximately 35 years had elapsed since this conversation occurred, Mr Berwick's recollection of it may not have been accurate and further noted that Mr Berwick did not provide this evidence to police at the time of the original investigation.[1083] However, the NSWPF did acknowledge that Mr Berwick's evidence "suggests but does not conclusively establish that the Alexandria Park toilet block had the telephone numbers at the relevant time".[1084]

773. Whilst the NSWPF acknowledged that the wall of the toilet block should have been reviewed to ascertain whether Mr Allen's phone number was on it, the NSWPF suggested that the material available to the Inquiry does not disclose whether or not such an examination occurred.[1085] In this respect, the NSWPF noted that the Inquiry had not made enquiries of the original investigating officers (other than Detective Sergeant Saunders) to ascertain what investigative steps were taken.[1086]

774. The NSWPF agreed with the submission of Counsel Assisting that the videotapes containing child abuse material located at Mr Allen's property should have been seized.[1087]

775. It is submitted that the matters identified by Counsel Assisting reflect a failure to comply with proper police practices, including judged by the standard of the day.

D.18.2 UHT screening, triage or review forms

776. A triage of Mr Allen's matter was completed and, in August 2021, the matter was recommended for review. There was no record of any review before the Inquiry. DCI Laidlaw was unable to assist in relation to whether a review had been commenced.[1088]

[1081] Written submissions filed on behalf of the NSWPF on 5 September 2023, [92] (SCOI.85429).
[1082] Exhibit 36, Tab 10, Statement of Harry Berwick, 11 January 1989 (SCOI.10329.00052).
[1083] Written submissions filed on behalf of the NSWPF on 5 September 2023, [92] (SCOI.85429).
[1084] Written submissions filed on behalf of the NSWPF on 5 September 2023, [92] (SCOI.85429).
[1085] Written submissions filed on behalf of the NSWPF on 5 September 2023, [93] (SCOI.85429).
[1086] Written submissions filed on behalf of the NSWPF on 5 September 2023, [95] (SCOI.85429).
[1087] Written submissions filed on behalf of the NSWPF on 5 September 2023, [99] (SCOI.85429).
[1088] Transcript of the Inquiry, 6 July 2023, T5153.23-5154.12 (TRA.00074.00001).

777. DCI Laidlaw agreed that it would be "very odd" if Mr Allen's case – which was obviously a homicide – was not on the UHT Tracking File from the commencement of the UHT Tracking File in 2004. He said "[i]t could have been missed."[1089] He agreed that Mr Allen's matter was "highly likely" to be one of the initial 366 cases identified in 2004, and accepted that in circumstances where the UHT Tracking File records no review prior to 2021, then it would be correct to assume that the matter was not reviewed between 2004 and 2020.[1090]

778. Senior Counsel Assisting asked DCI Laidlaw what the typical time between triage and review was. DCI Laidlaw said that "it's hard to say" and that "there is a bit of time variance".[1091]

D.19 Samantha Raye (died on or around 19-20 March 1989)

779. Samantha Raye's body was found on 20 March 1989. The precise date of Ms Raye's death is unclear. The time of death was estimated at autopsy to be two to three days prior to the post-mortem examination on 22 March 1989 — i.e., between approximately 7:00pm on 19 March 1989 and 7:00pm on 20 March 1989.

780. Dr Linda Iles, a forensic pathologist who was requested by the Inquiry to review the original autopsy report, considered that estimate to be "not unreasonable", but noted that the post-mortem observations could not preclude Ms Raye's death being closer to the last time she was known to be alive.[1092]

781. The police investigation into Ms Raye's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 24 March 2023 at [33]-[35].

D.19.1 Loss or destruction of exhibits

782. On 26 September 2022, the Inquiry issued a summons to the NSWPF for the missing persons report made by Wayne Hurrell and Hanna Hedler in relation to Ms Raye (Summons NSWPF19).[1093]

783. The legal representative for the NSWPF replied by email dated 7 October 2022, advising that neither the MPR nor State Archives holds any copy of the report.[1094] As such, the missing persons report could not be located.[1095]

[1089] Transcript of the Inquiry, 6 July 2023, T5154.17-20 (TRA.00074.00001).
[1090] Transcript of the Inquiry, 6 July 2023, T5154.9-44 (TRA.00074.00001).
[1091] Transcript of the Inquiry, 6 July 2023, T5154.46-T5155.16 (TRA.00074.00001).
[1092] Exhibit 17, Tab 36, Expert report of Dr Linda Iles, 3 March 2023, 8 (SCOI.82545).
[1093] Summons to produce to NSWPF, 26 September 2022 (Summons NSWPF19) (SCOI.82491).
[1094] Exhibit 17, Tab 22, Email from Office of the General Counsel, PFNSW, to Solicitor Assisting the Inquiry, 7 October 2022 (SCOI.82495).
[1095] Exhibit 17, Tab 22, Email from Office of the General Counsel, PFNSW, to Solicitor Assisting the Inquiry, 7 October 2022 (SCOI.82495).

784. In written submissions filed on behalf of the NSWPF on 12 April 2023, the NSWPF submitted that "It is not possible to discern why" the report was lost.[1096]

785. During the course of his oral evidence, DI Warren agreed that an electronic document, being the missing persons report, should have been created in this matter as per the police practices of the day.[1097]

D.19.2 Matters of concern to the Inquiry

786. As outlined in the written submissions of Counsel Assisting (at [33]-[35], [54], [133]), the following matters of concern to the Inquiry arise in relation to the investigation of Ms Raye's death:

a. Police did not take a statement from Hanna Hedler, Ms Raye's social worker who had reported her missing. Ms Hedler appeared to have a close relationship with Ms Raye and, since she was interviewed by journalists after Ms Raye's death, she was presumably available.[1098]

b. Police did not conduct investigations into Ms Raye's movements for the eight or so days leading to her death (meaning that it has been difficult to determine date of death).

c. No record was made or retained concerning the initial report to Kings Cross Police Station on 19 March 1989 that Ms Raye was missing.

787. In written submissions filed on behalf of the NSWPF on 12 April 2023, the NSWPF submitted the following in response to the Inquiry's concerns:

a. Regarding the taking of statements and conduct of investigations, "[i]nvestigating police appear to have conducted a detailed review of the scene and taken statements from a number of Ms Raye's friends, acquaintances and treating doctors. The State Coroner dispensed with an inquest, and there is nothing to suggest that his Honour regarded the police investigation to be in any way deficient"[1099]

b. Regarding the missing person's report, "[i]t is not possible to discern why this is. As noted by Counsel Assisting, NSW Police practices in relation to missing persons' reports have advanced very substantially in the 34 years since Ms Raye's death".[1100]

[1096] Written submissions filed on behalf of the NSWPF on 12 April 2023, [37] (SCOI.45187).
[1097] Transcript of the Inquiry, 5 July 2023, T4947.45-T4948.37 (TRA.00073.00001).
[1098] See Exhibit 17, Tab 38, Brett McCarthy, 'Half man, half woman's tragedy', *Daily Mirror,* 9 May 1989 (SCOI.48943).
[1099] Written submissions filed on behalf of the NSWPF on 12 April 2023, [39] (SCOI.45187).
[1100] Written submissions filed on behalf of the NSWPF on 12 April 2023, [37] (SCOI.45187).

788. In his oral evidence, DI Warren agreed that police would be expected to conduct investigations into Ms Raye's movements for the eight or so days leading up to her death, as part of making enquiries to form a view about whether or not the death was suspicious. He agreed that he would expect a record to be made or retained of the initial report of 19 March 1989.[1101]

789. DI Warren also acknowledged that based on the COPS file, the existence of a historical, pre-COPS document could be inferred, and further, that if record keeping were working as intended, that document would have been kept.[1102]

D.20 Ross Warren (disappeared on 22 July 1989)

790. Ross Warren was last seen at 2:00am on Saturday, 22 July 1989, driving his vehicle on Oxford Street in an easterly manner. His car was found on Kenneth Street on 23 July 1989. His keys were found in a nook below a cliff at Marks Park on 24 July 1989. Mr Warren was 25 years old.[1103]

791. The police investigation into Mr Warren's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 27 June 2023 at [73]-[82]. Mr Warren's matter proceeded to inquest before Deputy State Coroner Milledge, between 2003 and 2005 who said, relevantly:

    a. "During the 1980s and 1990s police were aware of a number of gangs of youths that were systematically engaged in the assault and robbery of gay men in Marks Park and other areas".[1104]

    b. The initial police investigation into the death of Mr Warren was "grossly inadequate and shameful."[1105]

    c. "Marks Park was a known area for brutal attacks on homosexual males".[1106]

792. The NSWPF accepted that, "on the available evidence, there appears to have been a total failure to respond appropriately to the disappearance of Mr Warren."[1107]

[1101] Transcript of the Inquiry, 5 July 2023, T4990.34-43 (TRA.00073.00001).
[1102] Transcript of the Inquiry, 5 July 2023, T4990.45-T4991.18 (TRA.00073.00001).
[1103] See Submissions of Counsel Assisting, 27 June 2023, [19]-[27] (SCOI.84160).
[1104] Exhibit 6, Tab 161, Findings of Senior Deputy State Coroner Jacqueline Milledge, Inquests into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 28 August 2002, 4 (SCOI.02751.00021).
[1105] Submissions of Counsel Assisting, 27 June 2023, [73] (SCOI.84160); Exhibit 6, Tab 161, Findings of Senior Deputy State Coroner Jacqueline Milledge, Inquests into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 28 August 2002, 6 (SCOI.02751.00021).
[1106] Exhibit 6, Tab 161, Findings of Senior Deputy State Coroner Jacqueline Milledge, Inquests into the death of John Russell and the suspected deaths of Ross Warren and Gilles Mattaini, 28 August 2002, 8 (SCOI.02751.00021).
[1107] Written submissions filed on behalf of the NSWPF on 13 July 2023, [6] (SCOI.84454).

D.21 John Russell (died on 23 November 1989)

793. Mr Russell's body was found on 23 November 1989. Mr Russell died of multiple injuries sustained when he was thrown from a cliff at Marks Park by a person or persons unknown. The police investigation into Mr Russell's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 27 June 2023 at [83]-[114].

D.21.1 Loss or destruction of exhibits

794. Two primary concerns arise in relation to the loss or destruction of exhibits in the case of Mr Russell, both of which are extensively dealt with in the written submissions of Counsel Assisting at [83]-[106]. They are as follows:

a. It appears that a clump of hair from the crime scene was collected, but then lost at some stage before the coronial inquest into Mr Russell's death. During the course of the coronial inquest, Deputy State Coroner Milledge described the loss of these "vital" hairs as "disgraceful".[1108]

b. The state of Mr Russell's clothing.

795. On 13 March 2023, the Inquiry sought an explanation from the NSWPF regarding the clothing Mr Russell was wearing when discovered. According to DI Warren, in his statement of 30 March 2023, the clothes were cleaned and placed on a mannequin before being returned to Mr Russell's family.[1109]

796. In written submissions filed on behalf of the NSWPF on 13 July 2023, the NSWPF acknowledged that the loss of the clump of hair was "manifestly unacceptable".[1110] The NSWPF conceded this is so irrespective of whether the investigating officers were aware that DNA testing may one day become available, given that the hairs could have been analysed in other ways (for example, by way of visual comparison with Mr Russell's hairs or the hairs of a suspect identified during the course of the investigation).[1111] The NSWPF did not seek to address the treatment of Mr Russell's clothing.

[1108] Exhibit 6, Tab 161, Findings of Senior Deputy State Coroner Jacqueline Milledge, 9 March 2005 (SCOI.02751.00021).
[1109] Exhibit 46, Tab 66, Statement of Detective Inspector Nigel Warren, 30 March 2023 (NPL.9000.0001.0001); Exhibit 46, Tab 67, Supplementary statement of Detective Inspector Nigel Warren, 5 May 2023 (NPL.9000.0001.0017).
[1110] Written submissions filed on behalf of the NSWPF on 13 July 2023, [21] (SCOI.84454).
[1111] Written submissions filed on behalf of the NSWPF on 13 July 2023, [22] (SCOI.84454).

797. During the course of oral evidence, AC Conroy accepted that it should have been plain to investigating officers that the clump of hair found on or in Mr Russell's hand had potential forensic significance. To this end, it should have been taken into custody and retained as an exhibit in accordance with standards of the day. AC Conroy also accepted the possibility that the clump of hair is located somewhere in police archives and is unable to be located due to improper or irregular labelling.[1112] That is an obviously unsatisfactory state of affairs.

D.22 Simon "Blair" Wark (died on 9-10 January 1990)

798. Simon Wark (known as Blair) died sometime between 2:00pm on 9 January 1990 and 9:30am on 10 January 1990. Mr Wark died as a result of multiple injuries sustained in a fall from a height in the vicinity of the Gap at Watson's Bay. He was discovered in the northern area of Sydney Harbour, 200-300 metres from Dobroyd Head. Mr Wark's personal items were found by a member of the public under a ledge at a cliff top at The Gap. In the days preceding Mr Wark's death, he had been acting in an unusual manner characterised by what appeared to be some paranoia or fears that he was in danger.[1113]

799. On the morning of 8 December 1990, Mr Wark left his family home and returned to hostel accommodation in Pyrmont. At around 11:00am, a person matching Mr Wark's description left a bag with some clothing in it at the lost property counter at David Jones in the Sydney CBD. At 2:00pm, Mr Wark attended the home of his psychologist in Double Bay because he believed he had an appointment, and was advised that his psychologist was not home.[1114]

800. Mr Wark's body was examined by a forensic pathologist who considered the direct cause of death was multiple injuries which had occurred four and a half to four and three-quarter days previously.[1115] Toxicology testing identified anti-depressants in Mr Wark's blood.[1116]

801. On 30 July 1990, Deputy State Coroner DW Hand dispensed with a formal inquest. It appears that this occurred on the basis that the Coroner formed the view that Mr Wark had died by way of suicide.[1117] The police investigation into Mr Wark's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 22 May 2023 at [28]-[30].

[1112] Transcript of the Inquiry, 4 July 2023 T4551-4552 (TRA.00072.00001).
[1113] Exhibit 23, Tab 14, Statement of KN, 27 January 1990 (SCOI.00052.00028); Transcript of the Inquiry, 5 July 2023, T4993-4994 (TRA.00073.00001).
[1114] Exhibit 23, Tab 41, Letter from Constable Ford and Detective Plotecki to the Coroner, 19 June 1990 (SCOI.00052.00044)..
[1115] Exhibit 23, Tab 7, Post-mortem report of Dr Peter Bradhurst, 24 May 1990 (SCOI.00052.00007).
[1116] Exhibit 23, Tab 6, Toxicology report, 1 May 1990 (SCOI.00052.00009).
[1117] Exhibit 23, Tab 38, Inquest running sheet, Undated (SCOI.00052.00002).

D.22.1 Loss or destruction of exhibits

802. On 20 December 2022, the Inquiry issued a summons to the NSWPF requiring the production of all records and results relating to biological samples taken from Mr Wark at the post-mortem examination performed on 14 January 1990 (Summons NSWPF47). These biological samples included, scalp and pubic hair, nail clippings from both hands, and anal and perineal swabs and smears.[1118]

803. On 20 January 2023, the NSWPF provided a statement from DS Sheldon, which outlined that, following extensive searches and enquiries within NSWPF, no exhibits could be located.[1119] DS Sheldon indicated in his statement that these searches and enquiries were "exhaustive" and there are no further avenues of enquiry available to locate the exhibits.

804. Upon producing material in response to Summons DOFM1, the DoFM advised that the testing results for any biological samples taken from Mr Wark during the post-mortem examination were handed over to the NSWPF.[1120]

805. In written submissions filed on behalf of the NSWPF on 1 June 2023, the NSWPF did not address the location of these exhibits.[1121]

806. During the course of oral evidence, AC Conroy conceded that the biological samples pertaining to Mr Wark should have been retained or, if they were used or disposed of, there should have been a record of this. In particular, AC Conroy accepted that if proper police practices had been complied with, there would have been a record to that effect.[1122]

807. AC Conroy also told the Inquiry that a coronial finding of suicide would have a bearing upon the appropriateness or otherwise of a decision to dispose of exhibits or investigative files. In particular, AC Conroy indicated that exhibits would be disposed of upon receipt of written instructions from the Coroner.[1123]

D.22.2 Matters of concern to the Inquiry

808. As outlined in the written submissions of Counsel Assisting (at [30]-[34]), the following matters of concern arise in relation to the investigation of Mr Wark's death:

[1118] Summons to Produce to NSWPF (NSWPF47), 20 December 2022 (SCOI.82504).
[1119] Exhibit 23, Tab 36A, Statement of Detective Sergeant Neil Sheldon, 19 January 2023, [10] (SCOI.82332).
[1120] Summons to produce to Department of Forensic Medicine (DOFM1), 22 August 2022 (SCOI.82536).
[1121] See Written submissions filed on behalf of the NSWPF on 1 June 2023 (SCOI.83645).
[1122] Transcript of the Inquiry, 4 July 2023, T4853.47-4854.6 (TRA.00072.00001).
[1123] Transcript of the Inquiry, 4 July 2023, T4865.26-40 (TRA.00072.00001).

a. If Police did attend the location where Mr Wark's property was found (which is not clear), it was not until several days after it was located.

b. Police appear to have returned Mr Wark's possessions to his family without photographing them or considering their investigative utility. It was then Mr Wark's sister who noticed a David Jones receipt, which led her to information about Mr Wark's last movements.

c. There does not appear to have been any real consideration as to how the body of a person who fell near the Gap might end up near Dobroyd Head.

809. In written submissions filed on behalf of the NSWPF on 1 June 2023, it was conceded that "it is undoubtedly true that certain additional investigative steps could have been conducted, and that the conduct of those steps may have allayed some of the concerns or suspicions held by family members."[1124] It was also accepted at [65] that the NSWPF should have attended the location of Mr Wark's property earlier than they did. The failure to do so was attributed to the fact that there had not been any real doubt as to the cause of Mr Wark's death. This in turn bore upon the perceived investigative value of Mr Wark's clothing.[1125]

810. As to [808.b] above, the NSWPF submitted that the steps taken by Mr Wark's sister reflect "very positively on her, and the love she had for her brother" but is not information that was required in order to sufficiently discern the manner and cause of Mr Wark's death.[1126]

811. The NSWPF further submitted that police resources are (and were) finite. In particular, it was submitted that "while further inquiries may have been able to be conducted in relation to matters relating to Mr Wark's state of mind, such enquiries quite likely would not have resolved the family's residual doubts and, in any event, would not have advanced the position as concerns the manner and cause of Mr Wark's death."[1127]

812. During the course of oral evidence, DI Warren indicated that he would expect the following to occur during the police investigation:[1128]

a. Investigators to attend and examine the location where Mr Wark's personal effects were found promptly upon receiving information to that effect;

[1124] Written submissions filed on behalf of the NSWPF on 1 June 2023, [61] (SCOI.83645).
[1125] Written submissions filed on behalf of the NSWPF on 1 June 2023, [71] (SCOI.83645).
[1126] Written submissions filed on behalf of the NSWPF on 1 June 2023, [71] (SCOI.83645).
[1127] Written submissions filed on behalf of the NSWPF on 1 June 2023, [72] (SCOI.83645).
[1128] Transcript of the Inquiry, 5 July 2023, T4994.11-4997.2 (TRA.00073.00001).

b. Those effects to be examined, photographed and for consideration to be given to their forensic utility;

c. Police to make a record of the personal effects, and visit the location where they were found to ensure there was a reliable record of both personal effects and their location;

d. Police to have observed the David Jones receipt, made enquiries into Mr Wark's last movements, and identified the lost property at David Jones;

e. Police to review and consider the forensic value of the property, including things like receipts, before returning them to the family;

f. Investigating officers to consider the significant distance between The Gap and Dobroyd Head where Mr Wark's body was located; and

g. Having regard to the injuries sustained by Mr Wark, investigating officers to treat Mr Wark's death as suspicious given that he had apparently been involved in a long-term relationship with another man and allegations that this former partner regularly assaulted him when intoxicated.

813. DI Warren further indicated that the above steps would be required in accordance with proper police practice in the 1990s.[1129] As to the treatment of Mr Wark's death as potentially suspicious, DI Warren accepted that would accord with today's standards having regard to the injuries. DI Warren also accepted that there is no record of whether the samples taken at post-mortem were retained or consumed or, if so, where.[1130]

D.23 William Dutfield (died on 19 November 1991)

814. William Dutfield died on 19 November 1991. Mr Dutfield died of multiple head injuries sustained after he was struck repeatedly in the head with a metal tape dispenser.[1131] The police investigation into Mr Dutfield's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 6 February 2023 at [17]-[19].

D.23.1 Matters of concern to the Inquiry

815. As outlined in the written submissions of Counsel Assisting (at [17]-[19], [37]-[38], [57]) two key matters of concern to the Inquiry arise in relation to the investigation of Mr Dutfield's death:

[1129] Transcript of the Inquiry, 5 July 2023, T4994.37-40, T4995.36-38, 4997.8-10 (TRA.00073.00001).
[1130] Transcript of the Inquiry, 5 July 2023, T4996.4-8 (TRA.00073.00001).
[1131] Submissions of Counsel Assisting, 6 February 2023, [3] (SCOI.82376).

816. *First,* the early dismissal of Arthur Ashworth as a suspect, despite inconsistencies in his evidence. The OIC of the investigation is recorded as stating that he did not seriously consider Mr Ashworth to be a suspect due to his age, Mr Ashworth being 76 at the time of Mr Dutfield's death.[1132] Despite Mr Ashworth's age at the relevant time, there were a number of pieces of evidence, along with inconsistencies in the account given by Mr Ashworth immediately after Mr Dutfield's death, that should have been cause for a high level of suspicion concerning his likely involvement in the death at the time it was originally investigated.[1133]

817. Counsel Assisting submitted that attempts should have been made to interview Mr Ashworth as a suspect and with a view to testing relevant inconsistencies with him, that the partial fingerprint match to the tape dispenser should have been accurately made and communicated to investigators, and that Mr Ashworth should have been treated as a person of interest at the inquest if he had not already been charged at that point.[1134]

818. The *second* matter of concern is the failure to take a DNA sample from Mr Ashworth before his death. Counsel Assisting submitted that priority should have been given to obtaining a DNA sample from Mr Ashworth for analysis and comparison with relevant forensic exhibits as soon as technical capacity allowed this to occur. This could and should have occurred by the late 1990s, several years before Mr Ashworth's death.[1135] In our submission, this omission is particularly troubling given that UHT reviews recommended that this step be taken (see [823]-[827] below).

819. In written submissions filed on behalf of the NSWPF on 21 February 2023, the NSWPF acknowledged that Mr Ashworth should not have been excluded as a suspect at such an early stage in the original investigation. Despite this, the NSWPF submitted that it was not unreasonable for the OIC's primary focus to have been on other potential suspects, given the OIC had developed a case theory that was consistent with Mr Dutfield having been murdered by the perpetrator of an earlier robbery, of which he had been the victim.[1136]

[1132] Exhibit 11, Tab 38, NSWPF Investigator's Note 'Dennis O'Toole (OIC from 1991)', 22 September 2010 (SCOI.10068.00036).
[1133] Submissions of Counsel Assisting, 6 February 2023, [17]-[18] (SCOI.82376).
[1134] Submissions of Counsel Assisting, 6 February 2023, [37] (SCOI.82376).
[1135] Submissions of Counsel Assisting, 6 February 2023, [38] (SCOI.82376).
[1136] Written submissions filed on behalf of the NSWPF on 21 February 2023, [74] (SCOI.82560).

820. The NSWPF also accepted that a DNA sample should have been obtained from Mr Ashworth "at an earlier date".[1137] However, the NSWPF made a number of observations in this regard at [78]. Several of these observations reiterate comments the NSWPF has earlier made in relation to the availability of DNA testing at the relevant time and the rate at which advancements in DNA technology occur.[1138] In addition, the NSWPF made the following further observations:

    a. The UHT did not have any capacity to conduct "reinvestigations" until 2008 and prior to the establishment of the UHT the NSWPF's approach to cold cases was "less systematic";

    b. The importance of obtaining a DNA sample from Mr Ashworth was not fully appreciated until Police received a report from DAL regarding the results of testing conducted on the cigarette butts and blood-stained tissues found at the scene. Whilst Police provided these items to DAL for analysis in 2005, the report was not received from DAL until 8 February 2007; and

    c. Any attempt to obtain a DNA sample from Mr Ashworth after the receipt of this report would have been fruitless given Mr Ashworth was already deceased.[1139]

821. During the course of oral evidence the Inquiry's concerns in relation to the investigation of Mr Dutfield's death were put to DI Warren.[1140] DI Warren agreed that the absence of any fingerprints on the metal tape dispenser located in Mr Dutfield's kitchen sink should have indicated to investigators at the time that it had been wiped down.[1141] The question of whether there was an absence of fingerprints is attended by some doubt: there is also evidence of a partial fingerprint match with Mr Ashworth which Counsel Assisting submits (at [37]) should have been accurately made and communicated to investigators (which should, in turn, have led to Mr Ashworth being treated as a person of interest).

[1137] Written submissions filed on behalf of the NSWPF on 21 February 2023, [78] (SCOI.82560).
[1138] Written submissions filed on behalf of the NSWPF on 21 February 2023, [78](a)-(b) (SCOI.82560).
[1139] Written submissions filed on behalf of the NSWPF on 21 February 2023, [78](c)-(e) (SCOI.82560).
[1140] Transcript of the Inquiry, 5 July 2023, T4997-4999 (TRA.00073.00001).
[1141] Transcript of the Inquiry, 5 July 2023, T4997.33-41 (TRA.00073.00001).

822. In relation to the early dismissal of Mr Ashworth as a suspect in the original investigation, DI Warren agreed that it would have been inconsistent with proper police practice at the time to dismiss a person of interest on the basis of their age.[1142] DI Warren indicated that proper police practice would have involved any dismissal of a person of interest to be based on exculpatory evidence or an alibi.[1143] The reasons for not pursuing a possible suspect should have been recorded.[1144]

D.23.2 UHT screening, triage and review forms

823. The Inquiry has before it a case screening form dated 2 May 2005 in relation to Mr Dutfield.[1145] The screening form recommends a reinvestigation, identifying a number of lines of inquiry.[1146] Senior Counsel Assisting asked DCI Laidlaw whether, if a recommendation like that is made, he would expect a re-investigation to be commenced in relation to Mr Dutfield. DCI Laidlaw said that he would expect a re-investigation to be commenced within a reasonable time after 2 May 2005.[1147] In circumstances where the UHT was focused on reviewing matters in 2005, the investigation should have been conducted by a separate investigative team.[1148]

824. A large focus of DCI Laidlaw's oral evidence concerning the death of Mr Dutfield related to the delay in actioning the 2005 recommendation to obtain DNA samples from Mr Ashworth.[1149] DCI Laidlaw conceded that a recommendation made in 2005 to obtain DNA from the person of interest in the matter should have been actioned by an investigative team within a reasonable time after it was made.[1150]

[1142] Transcript of the Inquiry, 5 July 2023, T4998.22-26 (TRA.00073.00001).
[1143] Transcript of the Inquiry, 5 July 2023, T4998.28-33 (TRA.00073.00001).
[1144] Transcript of the Inquiry, 5 July 2023, T4998.35-40 (TRA.00073.00001).
[1145] Exhibit 53, Tab 26, Review of an Unsolved Homicide Case Screening Form – William Dutfield, 2 May 2005 (SCOI.10286.00008).
[1146] Exhibit 51, Tab 26, Review of an Unsolved Homicide Case Screening Form – William Dutfield, 2 May 2005 (SCOI.10286.00008).
[1147] Transcript of the Inquiry, 7 July 2023, T5223.33-5224.6 (TRA.00075.00001).
[1148] Transcript of the Inquiry, 7 July 2023, T5224.11 (TRA.00075.00001).
[1149] Transcript of the Inquiry, 7 July 2023, T5223.337-T5226.43 (TRA.00075.00001).
[1150] Transcript of the Inquiry, 7 July 2023, T5223.33-T5226.6 (TRA.00075.00001).

825. DCI Laidlaw was initially unable to tell the Inquiry what a reasonable amount of time would have been.[1151] However, DCI Laidlaw later conceded that a reasonable time to act on the recommendation would have been within a matter of weeks of months.[1152] DCI Laidlaw accepted that had the recommendation been properly considered in or around May 2005, it may have been possible to obtain the DNA sample prior to Mr Ashworth's death.[1153] DCI Laidlaw was unable to proffer any explanation for the delay in obtaining the DNA sample and accepted that a two year delay in acting on the recommendation was unreasonable.[1154]

826. DCI Laidlaw was asked by Senior Counsel Assisting to assume that by February 2007 the first step had been taken but that there was no evidence of the other steps identified as part of the re-investigation being taken. Senior Counsel Assisting then took DCI Laidlaw to an additional document titled "Additional Information Case Screening Form."[1155] Senior Counsel Assisting asked DCI Laidlaw what this type of form was, and he indicated that such a form is used when new information comes to the UHT.[1156]

827. This Additional Information Case Screening Form refers to a report being received from DAL and to a DNA profile being obtained from Mr Ashworth. The Additional Case Screening Form is dated 1 March 2007 and by the time of its completion the named person had died.[1157] DCI Laidlaw accepted that had the recommendation made in May 2005 been acted upon promptly it may have been possible to obtain that DNA sample from Mr Ashworth. DCI Laidlaw was not able to assist with an explanation for the delay that led to the inability to obtain the DNA sample. He said that it is not the sort of delay he would expect and is outside a reasonable time. He accepted that on any view those investigations ought to have taken place much closer to May 2005.[1158] DCI Laidlaw also accepted that it appeared that the author of the Additional Case Screening Form did not appreciate that Mr Ashworth had died.[1159]

[1151] Transcript of the Inquiry, 7 July 2023, T5224.15 (TRA.00075.00001).
[1152] Transcript of the Inquiry, 7 July 2023, T5227.36-38 (TRA.00075.00001).
[1153] Transcript of the Inquiry, 7 July 2023, T5227.23-47 (TRA.00075.00001).
[1154] Transcript of the Inquiry, 7 July 2023, T5227 (TRA.00075.00001).
[1155] Exhibit 51, Tab 27, Additional Case Screening Form – William Dutfield, 1 March 2007 (SCOI.10066.00036).
[1156] Transcript of the Inquiry, 7 July 2023, T5224.17-5225.14 (TRA.00075.00001).
[1157] Submissions of Counsel Assisting, 6 February 2023, [8] (SCOI.82376).
[1158] Transcript of the Inquiry, 7 July 2023, T5225.31-5226.43 (TRA.00075.00001); 5227.23-47 (TRA.00075.00001).
[1159] Transcript of the Inquiry, 7 July 2023, T5227.1-4 (TRA.00075.00001).

D.24 Robert Malcolm (died on 29 January 1992)

828. Robert Malcolm died on 29 January 1992. Mr Malcolm died of a sequelae of head injuries inflicted upon him by a person or persons unknown.[1160] The police investigation into Mr Malcolm's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 6 July 2023 at [101]-[109]. DCI Laidlaw was not aware of any good reason why Mr Malcolm's death would not have been screened or reviewed by the UHT.[1161]

D.24.1 Loss or destruction of exhibits

829. By summons dated 9 May 2023 (Summons NSWPF102), the Inquiry sought production of the following exhibits associated with the investigation into the death of Mr Malcolm:[1162]

a. Broken brick with bloodstaining;
b. Multiple pieces of blood-stained timber;
c. "Toohey's Draught" beer bottle;
d. "Victorian Bitter" beer bottle;
e. Swab of blood from the veranda;
f. "Telegraph Mirror" newspaper;
g. Pair of black male shoes;
h. Red jumper;
i. 2 buttons;
j. Sexual Assault Investigation Kit (**SAIK** #5956;)
k. Pair of grey trousers;
l. Belt;
m. Pair of underwear;
n. Blood-stained singlet (torn).

830. On 18 May 2023, that NSWPF advised that 11 of the exhibits had been destroyed, and the 3 remaining exhibits had samples in cold storage with FASS.[1163] It is not clear why the exhibits were destroyed, especially as no DNA testing had been carried out, nor were the results of the SAIK collected from Mr Malcolm recorded in any material provided to the Inquiry.

[1160] Exhibit 56, Tab 1, P79A Report of death to the Coroner (SCOI.10494.00006); Exhibit 56, Tab 3, Post-mortem report of Dr Johan Duflou, 28 May 1992 (SCOI.10494.00017).
[1161] Transcript of the Inquiry, 6 July 2023, T5157.43-5158.3 (TRA.00074.00001).
[1162] Exhibit 56, Tab 106, Summons to produce to NSWPF (Summons NSWPF102), 9 May 2023 (SCOI.83308).
[1163] Exhibit 56, Tab 107, Letter from Office of the General Counsel, NSWPF, to the Inquiry, 18 May 2023 (SCOI.83309).

831. On 13 June 2023, Ms Franco provided a statement addressing, in part, the nature of the forensic analysis which could now be conducted in relation to the destroyed exhibits had they been retained, that was either not available in 1992 or which was available but not carried out.[1164]

832. Ms Franco noted that there have been enormous advances in DNA testing since 1992, and that for some exhibits with insufficient DNA for testing in 1992 (including the blood-stained brick), DNA testing in 2023 would be possible. Ms Franco also raised possibilities of testing the exhibits for skin cells (blood-stained brick and timber) and for saliva (the beer bottles). While Mr Malcolm's underwear was not tested by Mr Weigner, Ms Franco states that in 2023, such exhibits could be tested for blood, semen, saliva or hair.[1165]

833. During the course of her oral evidence, AC Conroy accepted that the exhibits, having been taken into custody by police, should have been retained in custody, but was unable to assist the Commissioner with whether the destruction of the exhibits was consistent with proper police practices at the time.[1166]

834. In written submissions filed on behalf of the NSWPF on 21 July 2023, the NSWPF acknowledged that "it is undoubtedly unfortunate that the exhibits were not retained".[1167] However, on the basis of Ms Franco's above statement and particularly Ms Franco's evidence that "DNA testing was only in its infancy in 1992 and the enormous advances in DNA technology was not envisioned in that year",[1168] the NSWPF submitted that appropriate criticism should proceed by reference to what NSWPF investigators knew at the time of Mr Malcolm's death.[1169]

835. Criticism by reference to the state of knowledge in 1992 may be appropriate with regards to the three exhibits destroyed following forensic examination (the two beer bottles and the newspaper).[1170] However, appropriate criticism of the destruction of the other exhibits, which occurred on 1 May 1996, should proceed by reference to what the NSWPF knew as at 1996.

[1164] Exhibit 56, Tab 119, Statement of Michele Franco, FASS, 13 June 2023 (SCOI.83957); see also Exhibit 56, Tab 118, Letter of Instruction to FASS requesting testing and statement on exhibits, 31 May 2023 (SCOI.83433).
[1165] Exhibit 56, Tab 119, Statement of Michele Franco, FASS, 13 June 2023, [17]-[33] (SCOI.83957).
[1166] Transcript of the Inquiry, 4 July 2023, T4856.14-24 (TRA.00072.00001).
[1167] Written submissions filed on behalf of the NSWPF on 21 July 2023, [41] (SCOI.84843).
[1168] Exhibit 56, Tab 119, Statement of Michele Franco, FASS, 13 June 2023, [17] (SCOI.83957).
[1169] Written submissions filed on behalf of the NSWPF on 21 July 2023, [27]-[28], [42] (SCOI.84843); Exhibit 56, Tab 119, Statement of Michele Franco, FASS, 13 June 2023, [17] (SCOI.83957).
[1170] Exhibit 56, Tab 107, Letter from NSWPF to Inquiry re exhibits, 18 May 2023 (SCOI.83309).

836. Significant leaps in forensic science and DNA testing occurred between Mr Malcolm's death in 1992, and the time of the exhibits being destroyed in 1996, noting that DNA testing first became available to the NSWPF as a service offered by FASS in 1992. By the time the additional exhibits were destroyed on 1 May 1996, it should have been obvious to the NSWPF that DNA testing technology was likely to continue to improve.

837. In addition to the destroyed exhibits, there were also some significant items at the crime scene which appear to have not been collected in the first place.

838. First, a blood-stained shirt in the courtyard of the crime scene was photographed by the Crime Scene Officer, but not collected.[1171] Only a singlet was collected from Mr Malcolm, while two witnesses gave evidence he was wearing a light-coloured shirt, possibly with blue stripes.[1172] The NSWPF agreed that it is regrettable that the bloodstained shirt was not seized, and that it appears this was an oversight in the initial investigation.[1173]

839. Second, a hair in a bloodstain at the verandah of the crime scene was photographed by the Crime Scene Officer, but not collected. The NSWPF agreed that it would have been desirable for the hair to have been seized.[1174]

D.24.2 Loss or destruction of other investigative material

840. By summons dated 11 October 2022 (Summons NSWPF29), the Inquiry sought production of, relevantly, the crime scene sketch plan prepared by Detective Senior Constable Lyle Van Leeuwen (**DSC Van Leeuwen**) and the police notebook and duty book of Detective Sergeant Gary Phillips (**DS Phillips**).[1175]

841. On 24 October 2022, the NSWPF advised that it was unable to locate the sketch plan and DS Phillips' duty book.[1176]

[1171] Submissions of Counsel Assisting, 6 July 2023, [27], [106] (SCOI.84090); see also Exhibit 56, Tab 19, Statement of Constable Lyle William Van Leeuwen, 19 April 1992, [5]-[6] (SCOI.10939.00063); Exhibit 56, Tab 21, Crime Scene Photographs (Photographs 10-21), 11 January 1992, Photograph 18 (SCOI.83958).
[1172] Exhibit 56, Tab 80, Bundle of Selected Running Sheets, 14–15, 17 (SCOI.83976); Exhibit 56, Tab 34, Statement of Robert McPherson Malcolm, 13 January 1992, [12] (SCOI.10290.00018); Exhibit 56, Tab 37, Statement of George O'Donnall, 31 January 1992, [7] (SCOI.10939.00049).
[1173] Written submissions filed on behalf of the NSWPF on 21 July 2023, [45] (SCOI.84843).
[1174] Written submissions filed on behalf of the NSWPF on 21 July 2023, [47] (SCOI.84843).
[1175] Exhibit 56, Tab 104, Summons to produce to NSWPF, 11 October 2023 (summons NSWPF29) (SCOI.83432).
[1176] Exhibit 56, Tab 105, Email from NSWPF to Inquiry re NSWPF29, 24 October 2022 (SCOI.83961).

842. In written submissions filed on behalf of the NSWPF on 21 July 2023, the NSWPF agreed that it is "regrettable" that the above documents were lost.[1177] The NSWPF noted that these records predated its use of an electronic document management system, and submitted that it is "unlikely" that a similar issue would arise in modern-day investigations.[1178]

D.24.3 Matters of concern to the Inquiry

843. As outlined in the written submissions of Counsel Assisting, the key matter of concern arising in relation to Mr Malcolm's death is the apparent failure to test a lead suspect's alibi. Anthony Hookey was charged with the murder of Mr Malcolm. He provided an alibi of being in the company of Dianne McGuinness in Kings Cross during the early hours of 11 January 1992. When spoken to by police on 11 January 1992, Mr Hookey provides a different timeline of his movement from Kings Cross to Central. He states that he stayed at the Mansions Hotel until around 3:30am and then went to the Subway Hotel, Surry Hills, and there is no mention of wandering around Kings Cross with Dianne McGuinness.[1179] It is not until his statement on 13 January 1992 that Ms McGuinness is mentioned.[1180] There are no documented attempts by police to confirm or disprove this alibi.

844. In written submissions filed on behalf of the NSWPF on 21 February 2023, the NSWPF acknowledged that it is "not clear from the material presently available" whether Dianne McGuinness or her cousin Tracy McGuinness were located and interviewed by the original investigators.[1181]

845. During the course of his oral evidence, DI Warren told the Inquiry that there are no records of any attempts to prove or disprove Mr Hookey's alibi in the form of Dianne McGuinness. DI Warren accepted that where a principal suspect has given an alibi, an important step is to explore it.[1182]

[1177] Written submissions filed on behalf of the NSWPF on 21 July 2023, [48] (SCOI.84843).
[1178] Written submissions filed on behalf of the NSWPF on 21 July 2023, [48] (SCOI.84843).
[1179] Exhibit 56, Tab 80, Bundle of Selected Running Sheets, 5-6 (SCOI.83976).
[1180] Exhibit 56, Tab 66, Statement of Anthony Hookey, 13 January 1992 (SCOI.10290.0008).
[1181] Written submissions filed on behalf of the NSWPF on 21 July 2023, [21] (SCOI.84843).
[1182] Transcript of the Inquiry, 5 July 2023, T5000.32-38 (TRA.00073.00001).

846. DI Warren accepted that a significant oversight occurred either in a failure to explore Mr Hookey's alibi, a failure to record the steps taken in exploring the alibi, or an oversight in the record keeping if such a record was made but subsequently lost. DI Warren confirmed that such a failure was not consistent with proper police practice at the time.[1183] In written submissions filed on behalf of the NSWPF on 21 February 2023, the NSWPF acknowledged that it is "not clear from the material presently available" whether Dianne McGuinness or her cousin Tracy McGuinness were located and interviewed by the original investigators.

D.25 Crispin Dye (died on 25 December 1993)

847. Crispin Dye died on 25 December 1993. Mr Dye died of the effects of a head injury inflicted by a person or persons unknown.[1184] The police investigation into Mr Dye's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 22 August 2023 at [44]-[67].

D.25.1 Matters of concern to the Inquiry

848. As outlined in the written submissions of Counsel Assisting (at [44]-[67]), the following matters of concern to the Inquiry arise in relation to the investigation of Mr Dye's death:

a. An apparent failure to search the top left-hand pocket of a long-sleeved outer shirt worn by Mr Dye. That pocket contained a white card (with a blood stain) and a yellow post-it note which had a handwritten name and phone number on it.[1185] It is clear that these pieces of paper had never previously been noticed. They were found folded in the top left front pocket of the exhibit (the shirt) and never separately catalogued.[1186] The Inquiry has searched all the files provided by the NSWPF and the Coroners Court in relation to Mr Dye's death and these pieces of paper are never mentioned or referred to. The NSWPF has confirmed by correspondence to the Inquiry that it has no information about these papers.[1187] The previous failure to find these pieces of paper is, in the submission of Counsel Assisting, extraordinary given that:

[1183] Transcript of the Inquiry, 5 July 2023, T5000.40-5001.37 (TRA.00073.00001).
[1184] Exhibit 59, Tab 3, Post-mortem report of Dr Liliana Schwartz, 27 April 1994, 8 (SCOI.10178.00024); Exhibit 59, Tab 8, Transcript of Coronial Inquest into the Death of Crispin Wilson Dye, 8 August 1995, 48 (SCOI.10179.00008).
[1185] Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 5 (SCOI.84016).
[1186] Exhibit 59, Tab 116, Statement of Michele Franco, 15 June 2023, 5 (SCOI.84016).
[1187] Exhibit 59, Tab 113, Letter from Katherine Garaty to Enzo Camporeale, 3 April 2023 (SCOI.83494); Exhibit 59, Tab 115G, Letter from Katherine Garaty to Enzo Camporeale, 5 June 2023 (SCOI.84023).

i. By their own accounts, DSC Van Leeuwen examined Mr Dye's clothing on 23 December 1993, and Detective Taylor and Detective Sergeant Geoffrey Knight (**DS Knight**) also separately did so on the same day.[1188] Although DS Knight found "several pieces of paper" in Mr Dye's pockets "containing telephone numbers and a Metway Bank business card",[1189] those pieces of paper seem clearly to be different pieces of paper to those found by the Inquiry;[1190]

ii. In addition, there have also been two further police investigations of the case (in the years following 1996 and 1999), and the UHT has twice reconsidered the case (in 2005 and 2019).[1191]

b. The apparent failure to keep, test or label as exhibits multiple pieces of paper found on Mr Dye. The Inquiry's staff located a summary prepared for Coroner Hand on 12 October 1994 by DS Knight, and the statement of DS Knight, which noted that police took possession of Mr Dye's possessions, including papers containing phone numbers.[1192] The only record of what was on these papers appears to be a photocopy contained within the Coroners Court file, as Annexure E to the statement of DS Knight.[1193] This is a photocopy of approximately five pieces of paper, each containing a name/s and phone numbers.[1194] They are not the pieces of paper located by the Inquiry. The NSWPF were unable to determine the location of these papers, or whether they had ever been subject to DNA and/or fingerprint testing.[1195]

[1188] Exhibit 59, Tab 17, Statement of Detective Senior Constable Van Leeuwen, 15 November 1994, 4 (SCOI.11036.00085); Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [9] (SCOI.10274.00046).
[1189] Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [9] (SCOI.10274.00046).
[1190] See Exhibit 59, Tab 11, Photocopy, Undated (SCOI.11036.00110); Exhibit 59, Tab 10, Table of Contents, Coronial Inquest into the Death of Crispin Wilson Dye, Undated (SCOI.11036.00087).
[1191] See Submissions of Counsel Assisting, 22 August 2023, [54] (SCOI.85164).
[1192] Exhibit 59, Tab 6, Summary prepared for purposes of Coronial Inquest of Detective Sergeant Geoffrey Roy Knight, 12 October 1994, [1.6] (SCOI.10179.00011); Exhibit 59, Tab 15, Statement of Detective Sergeant Geoffrey Roy Knight, 27 September 1994, [9] (SCOI.10274.00046).
[1193] See Exhibit 59, Tab 11, Photocopy, Undated (SCOI.11036.00110); Exhibit 59, Tab 10, Table of Contents, Inquest Touching the Death of Crispin Wilson DYE, Undated (SCOI.11036.00087).
[1194] Exhibit 59, Tab 11, Photocopy, Undated (SCOI.11036.00110).
[1195] Exhibit 59, Tab 113, Letter from Katherine Garaty to Enzo Camporeale, 3 April 2023 (SCOI.83494).

c. The apparent failure to keep, test or label as an exhibit a further note authored by Alexander Paige around the time Mr Dye was attacked. Mr Paige told the Inquiry that he provided a note recording his parents' phone number to a man called "Cris", whom he met at the Bodyline Sauna on Taylor Street, Darlinghurst. Whilst there is no original or copy of the note referred to by Mr Paige anywhere in the material produced by the NSWPF in relation to Mr Dye, both the notebook of DS Knight and his statement make reference to the note, which makes it clear that it was among the notes found by investigating police.[1196]

d. The apparent failure to test or document the finding of Mr Dye's keys on his person. A NSWPF running sheet created on 1 January 1994 notes that, on that day, Brenton Dye attended Surry Hills Police Station to collect Mr Dye's keys, which were "found on his person upon admission to St. Vincent's Hospital on 23.12.93".[1197] There is no mention of the keys in the statements of investigating officers. The keys were evidently not tested for fingerprints before being returned to Brenton Dye.[1198]

e. Labelling an extendable baton as an exhibit when, in fact, it appears highly likely that this baton was purchased by the NSWPF in around 1997 in order to obtain a further opinion from Dr Liliana Schwartz, who carried out the post mortem examination. On 3 February 2023, the NSWPF informed the Inquiry that this baton "was seized at some point during the course of the original investigation, possibly as a suspected murder weapon."[1199] However, the Inquiry subsequently found a record of a baton, of the make in question, having been purchased by the NSWPF to allow Dr Schwartz to prepare the 1997 Report in relation to whether that type of baton could have caused Mr Dye's injuries.[1200] On 17 March 2023, after reviewing its own records, the NSWPF agreed it was likely that that the baton that had been labelled as an exhibit had actually been purchased by the NSWPF at a later time and had not been seized as a suspected murder weapon.[1201]

[1196] Submissions of Counsel Assisting, 22 August 2023, [55] (SCOI.85164).
[1197] Exhibit 59, Tab 59, NSWPF running sheet, 'Brother of Deceased, Brenton Dye, Taking Possession of Property from Police at Surry Hills', 1 January 1994 (SCOI.10356.00173).
[1198] Submissions of Counsel Assisting, 22 August 2023, [49]-[50] (SCOI.85164).
[1199] Exhibit 59, Tab 100, Email from Katherine Garaty to Enzo Camporeale, 3 February 2023 (SCOI.83474).
[1200] See Submissions of Counsel Assisting, 22 August 2023, [61] (SCOI.85164).
[1201] Exhibit 59, Tab 108, Email from Patrick Hodgetts to Enzo Camporeale, 17 March 2023 (SCOI.83473).

f. The apparent failure to test other exhibits in relation to the death of Mr Dye. The only item sent to DAL was Mr Dye's blood sample. None of his clothing, or the wallet later handed in to the Inner City Legal Centre, or the other items such as cards from the wallet, were ever sent for analysis. As to fingerprinting, the 2005 UHT review indicates that the healthcare card and Frequent Flyer card were "fingerprinted 27/01/1994 with a negative result", but that although "items from deceased's wallet and items belonging to MB" were "delivered to Fingerprints on 17/02/1994", no result was noted. All of those items are described, in the 2005 UHT review, as "NOT LOCATED". As noted above, it is not clear if the wallet itself was fingerprinted.[1202]

g. The apparent failure of the NSWPF to follow up on two significant pieces of information received by them about Mr Dye's death, in December 1993 and March 1994. First, Police failed to make any record of having spoken with Mr Paige on Christmas Eve 1993, or to take a statement from him, or otherwise to follow upon on what he told them at that time about his encounter with Mr Dye at the Bodyline Sauna. Second, there is no evidence that Police followed up on information received from the father of Richard Leonard, Stephen Leonard, in March 1994 who told police that his son had been doing "research" into Mr Dye's case and had admitted to assaulting two persons in Darlinghurst and the CBD between November and December 1993. It was only in 1996 that Richard Leonard was seriously treated as a person of interest in relation to Mr Dye's death.[1203]

849. In written submissions filed on behalf of the NSWPF on 9 September 2023, the NSWPF submitted that the investigation conducted by police was "thorough" and "extensive".[1204] The NSWPF further suggested that the criticisms made by Counsel Assisting largely stem from apparent oversights, as opposed to a failure by Police to conduct a proper investigation.[1205]

850. With respect to the failure to arrange DNA testing, the NSWPF submitted that Counsel Assisting's criticism of the NSWPF for failing to arrange for the testing of Mr Dye's clothing at the time of the original investigation was "plainly unwarranted" for two reasons.

[1202] Submissions of Counsel Assisting, 22 August 2023, [46] (SCOI.85164); Exhibit 59, Tab 91, NSWPF Review of an Unsolved Homicide Case Screening Form, 'Crispin Wilson Dye', 25 May 2005, 6 (SCOI.03268).
[1203] Submissions of Counsel Assisting, 22 August 2023, [67] and [280]ff (SCOI.85164)
[1204] Written submissions filed on behalf of the NSWPF on 9 September 2023, [12], [21] (SCOI.85429).
[1205] Written submissions filed on behalf of the NSWPF on 9 September 2023, [21] (SCOI.85429).

851. First, having regard to the evidence of Ms Franco concerning the capacity to perform DNA testing in Mr Dye's case, DNA testing of his clothing – whilst possible at the time of the original investigation, was "inferior to current DNA typing methods" and therefore, in the view of the NSWPF – would have been of limited utility.[1206]

852. Second, the NSWPF noted the observations of Ms Franco in her expert report prepared in the context of Mr Malcolm's death, that DNA testing was only in its infancy in 1992 and that the significant advancements in DNA technology that have occurred since then were not envisioned at the time.[1207] In this respect, the NSWPF also drew attention to evidence the Inquiry received during the IPH regarding the practical availability of forensic testing to investigators at the relevant time.[1208] Additionally, the NSWPF submitted that the blood staining on Mr Dye's jeans may have been obscured by faeces stains that were also present.[1209]

853. With respect to the absence of evidence that fingerprints were taken from the wallets seized by police in connection with Mr Dye or Mr Dye's keys, the NSWPF submitted that references in police records to "the property" and "the items" having been fingerprinted, suggests that, on balance, the wallets themselves were likely subject to fingerprint testing.[1210]

854. The NSWPF acknowledged that the two pieces of paper found in the top left-hand pocket of Mr Dye's shirt were likely not located by police during the initial search of Mr Dye's clothing. However, the NSWPF noted that DS Knight's observation that he found "several pieces of paper" in Mr Dye's pockets, which Counsel Assisting suggested were different pieces of paper to those found by the Inquiry, was not explored with the officers involved in the original search.[1211] The NSWPF rejected Counsel Assisting's submission that the failure to locate the two pieces of paper was "extraordinary". In this regard, the NSWPF noted that any such criticism could not properly be directed towards the UHT reviews as these were solely "paper reviews".[1212] Additionally, the NSWPF submitted that, given the statements from the officers involved in the original investigation were to the effect that the clothing had been searched and items located, there was nothing to suggest to subsequent investigators that there was a particular need to further search the clothing.[1213]

[1206] Written submissions filed on behalf of the NSWPF on 9 September 2023, [28] (SCOI.85429).
[1207] Written submissions filed on behalf of the NSWPF on 9 September 2023, [29] (SCOI.85429).
[1208] Written submissions filed on behalf of the NSWPF on 9 September 2023, [30] (SCOI.85429).
[1209] Written submissions filed on behalf of the NSWPF on 9 September 2023, [31] (SCOI.85429).
[1210] Written submissions filed on behalf of the NSWPF on 9 September 2023, [34] (SCOI.85429).
[1211] Written submissions filed on behalf of the NSWPF on 9 September 2023, [39] (SCOI.85429).
[1212] Written submissions filed on behalf of the NSWPF on 9 September 2023, [41] (SCOI.85429).
[1213] Written submissions filed on behalf of the NSWPF on 9 September 2023, [43] (SCOI.85429).

855. With regards to the first of the two lines of enquiry investigators failed to pursue, the NSWPF submitted that it was not clear on the material presently available whether further enquiries were in fact made with Mr Paige.[1214] The NSWPF further submitted that given police were aware of Mr Dye's sexuality from an early stage in the investigation, it is not clear how the evidence of Mr Paige would have added anything substantive in this respect.[1215]

856. With regards to the second of the two lines of enquiry investigators failed to pursue, the NSWPF similarly submitted that it was not clear on the material presently available whether further enquiries were made in relation to the information provided by Richard Leonard's father.[1216] The NSWPF further noted that later investigation of Richard Leonard's potential involvement in Mr Dye's death indicated that the assault which Richard Leonard was referring to in comments made to his father was not the assault on Mr Dye.[1217] There was therefore, in the NSWPF's submission, no failure to "connect the dots" between the evidence of Richard Leonard's father and similar information received from persons known as AC and SM which had the potential to implicate Richard Leonard in Mr Dye's death.[1218]

857. During the course of oral evidence, AC Conroy accepted that Mr Dye's death was plainly a homicide, and that his healthcare card, frequent flyer cards and other items from his wallet should have been retained as exhibits. In particular, those items ought to have been entered in an exhibit book. Had proper police procedures been followed at the relevant time, it would be possible to say today what happened to those exhibits.[1219]

858. DI Warren also conceded that the failure to test or fingerprint Mr Dye's keys before they were returned to his brother represented a significant oversight. As to the two pieces of paper located in February 2023, one of which included a blood stained fingerprint, DI Warren accepted that the failure to thoroughly search Mr Dye's clothes was a significant investigative oversight.[1220]

[1214] Written submissions filed on behalf of the NSWPF on 9 September 2023, [54] (SCOI.85429).
[1215] Written submissions filed on behalf of the NSWPF on 9 September 2023, [55] (SCOI.85429).
[1216] Written submissions filed on behalf of the NSWPF on 9 September 2023, [58] (SCOI.85429).
[1217] Written submissions filed on behalf of the NSWPF on 9 September 2023, [59] (SCOI.85429).
[1218] Written submissions filed on behalf of the NSWPF on 9 September 2023, [60] (SCOI.85429).
[1219] Transcript of the Inquiry, 4 July 2023, T4854.22-41 (TRA00072.00001).
[1220] Transcript of the Inquiry, 5 July 2023, T5002-3 (TRA00073.00001).

859. Senior Counsel Assisting took DCI Laidlaw to the evidence in relation to an extendable baton which was stored and classified as an exhibit in Mr Dye's case. That baton was recorded as being a possible suspected murder weapon but was in fact purchased at a time subsequent to Mr Dye's death "as a comparison". DI Warren accepted that it was not consistent with proper police practices at the time to store and classify the baton as a potential murder weapon.[1221]

D.25.2 UHT screening, triage and review forms

860. The Inquiry has before it a Case Screening Form dated 25 May 2005,[1222] and a Triage Form dated 16 November 2019 in relation to Mr Dye.[1223]

861. Senior Counsel Assisting raised with DCI Laidlaw the fact that the Case Screening Form has a reviewer's certification, including a name, but is unsigned, and that there is no signature, name or date in the space for the coordinator's certification. Senior Counsel Assisting asked what the Commissioner could infer as to whether the document was in fact completed, and whether it was reviewed by the coordinator. DCI Laidlaw said, "I can't say, because the mere fact it wasn't signed doesn't mean it wasn't done."[1224]

862. DCI Laidlaw agreed that the recommendations made in this document should have been undertaken within a reasonable time, and that doing so would have been in accordance with proper police procedures. Senior Counsel Assisting asked DCI Laidlaw to assume that none of the recommended steps were taken, with the exception of the offering of a reward which was reissued in 2014 about nine years after the completion of the document.[1225]

863. DCI Laidlaw said that the failure to take those steps was not consistent with proper police practice, and agreed that those actions should have been taken much earlier. Senior Counsel Assisting asked DCI Laidlaw whether there was any procedure by which anyone within the UHT or anywhere else followed up with whoever was responsible for implementing these recommendations in order to find out whether they were in fact implemented. DCI Laidlaw said, "that's unknown to me." He clarified that he was not a member of the UHT at the time and so he did not know their practices.[1226]

[1221] Transcript of the Inquiry, 5 July 2023, T5003.7-33 (TRA00073.00001).
[1222] Exhibit 53, Tab 29, Review of an Unsolved Homicide Case Screening Form – Crispin Dye, 25 May 2005 (SCOI.03268).
[1223] Exhibit 53, Tab 30, Triage Review of an Unsolved Homicide – Crispin Dye, 16 November 2019 (SCOI.03267).
[1224] Transcript of the Inquiry, 7 July 2023, T5228.6-30 (TRA00075.00001).
[1225] Transcript of the Inquiry, 7 July 2023, T5228.32-6 (TRA00075.00001).
[1226] Transcript of the Inquiry, 7 July 2023, T5229.1-16 (TRA00075.00001).

864. Senior Counsel Assisting then took DCI Laidlaw to the Triage Form dated 16 November 2019. DCI Laidlaw agreed that this was the form that has been in place since 2018. The Triage Form recommended that the matter proceed to review. No record of any review has been produced in response to the summonses issued by the Inquiry. DCI Laidlaw agreed that if the matter had proceeded to review, he would expect to see that reflected in the UHT Tracking File.[1227]

865. Senior Counsel Assisting asked whether the Commissioner should infer that, despite the recommendation that the matter should proceed to review, no step was taken in relation to this matter after 16 November 2019. DCI Laidlaw said that that could be the case. He agreed that it was surprising or troubling that no action has been taken in the years since November 2019. He agreed that this was not consistent with proper police practice, and was unable to offer any explanation for why there is no record of any step being taken.[1228]

D.26 James Meek (died 7 March 1995)

866. James Meek died on 7 March 1995. Mr Meek died as a result of blunt force injuries to his head consistent with being bashed or kicked. The police investigation into Mr Meek's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 22 June 2023 at [47]-[78].

D.26.1 Loss or destruction of exhibits

867. On 3 May 2023, a summons was issued to the NSWPF requiring production of the following exhibits taken into evidence as part of the initial police investigation:[1229]

a. A sample of blood from Mr Meek;
b. Fingernail scrapings from the right and left hand of Mr Meek;
c. Swab collected from the kitchen floor;
d. T-shirt;
e. Pair of shorts;
f. Pair of blue underpants;
g. Black wallet and contents;
h. Broken brown ceramic bowl;
i. Plastic water ampule;
j. Newspaper.

[1227] Transcript of the Inquiry, 7 July 2023, T5229.22-5230.21 (TRA00075.00001).
[1228] Transcript of the Inquiry, 7 July 2023, T5230.6-43 (TRA00075.00001).
[1229] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [5]-[6] (NPL.9000.0012.0126).

868. By letter dated 17 May 2023, the NSWPF informed the Inquiry that none of the exhibits were able to be located.[1230] The searches undertaken by the NSWPF in relation to these exhibits were set out in a statement of Detective Sergeant Andrew Hamill (**DS Hamill**) dated 26 May 2023.[1231]

869. The sample of Mr Meek's blood was transported to FASS on 4 October 1995 and has been retained by FASS.[1232] A sample of Mr Meek's hair was destroyed on 23 December 1999 with the approval of Detective Sergeant Anthony Tanos (**DS Tanos**).[1233] The t-shirt, pair of shorts, fingernail scrapings (right and left), oral and anal swabs and a pair of underpants were handed to DS Tanos on 20 November 1998.[1234] These exhibits were unable to be located.[1235] Similarly, the brown ceramic bowl, plastic ampule and several pieces of newspaper were returned to the Surry Hills Police Station on or around 23 March 1995. They were not located by DS Hamill's searches.[1236]

870. The searches conducted by DS Hamill located some additional exhibits which were not the subject of the summons. These were identified as a swab from the floor,[1237] yellow thongs, a sample of the hallway carpet, the floor mat and three separate bags of cigarette butts collected from ashtrays in the kitchen and dining room.[1238] The swab of the floor is still retained by FASS.[1239] The other exhibits were not located.[1240]

871. In addition, a pair of glasses belonging to Mr Meek were handed to DS Tanos on 20 November 1998. No further records in relation to these glasses could be located.[1241]

872. A receipt from the Sydney Crime Scene records indicated that a black wallet containing various items was transported to the Surry Hills Police Station on 11 March 1995. Neither the wallet nor further records concerning the wallet could be located.[1242] Finally, a grey-coloured ring box containing a gold-coloured men's ring with a tiger's eye stone was recorded as being received by the Surry Hills Police Station on 2 October 1995 and returned to the owner on 10 March 1999.[1243]

[1230] Exhibit 35, Tab 74, Statement of Tom Allchurch, 19 June 2023, [15]-[16] (SCOI.73527).
[1231] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10] (NPL.9000.0012.0126).
[1232] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](c)(ii) (NPL.9000.0012.0126).
[1233] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](c)(iv) (NPL.9000.0012.0126).
[1234] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](c)(v) (NPL.9000.0012.0126).
[1235] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](d) (NPL.9000.0012.0126).
[1236] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](d) (NPL.9000.0012.0126).
[1237] This appears to be an error in Detective Sergeant Hamill's statement, as a swab from the floor was the subject of the summons.
[1238] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](c)(viii) (NPL.9000.0012.0126).
[1239] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](c)(ix) (NPL.9000.0012.0126).
[1240] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](d) (NPL.9000.0012.0126).
[1241] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](c)(x) (NPL.9000.0012.0126).
[1242] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](c)(xi) (NPL.9000.0012.0126).
[1243] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [10](c)(vi) (NPL.9000.0012.0126).

873. DS Hamill states that searches were conducted on EFIMS and all other investigative holdings held by the NSWPF. Additional searches were conducted with FETS, Surry Hills Police Station and Corporate Records. DS Hamill considered these searches and enquiries to be "exhaustive". In DS Hamill's opinion, there are no further avenues of enquiry that are available to locate the exhibits sought by the Inquiry.[1244]

D.26.2 Matters of concern to the Inquiry

874. As outlined in the written submissions of Counsel Assisting the Inquiry (at [51]-[60]), the primary matter of concern in relation to Mr Meek's death is that the crime scene was released on 8 March 1995 and Mr Meek's daughters entered and cleaned the flat. This meant that by the time the criminal investigation commenced on 11 March 1995, some material – including a used condom observed in the bedroom and sachets of lubricant and a handkerchief visible in the photographs taken on 8 March 1995 – were not taken into evidence.

875. In written submissions filed on behalf of the NSWPF on 7 July 2023, the NSWPF submitted that the crime scene was released on 8 March 1995, being the day Mr Meek's body was found, because police were not treating the death as suspicious.[1245] In circumstances where the evidence suggests investigating police were unaware of the extent of the bruising present on Mr Meek's face, NSWPF submitted that this is the likely reason why Mr Meek's death was not treated as a potential homicide during the early stages of the investigation.[1246]

876. The NSWPF submitted that it is regrettable Mr Meek's death was not treated as a potential homicide investigation at the earlier stages of the investigation, and acknowledged that it would have been preferable for the used condom to be seized as a precaution, regardless of whether the matter was being treated as a suspected homicide or not.[1247]

[1244] Exhibit 35, Tab 72, Statement of Detective Sergeant Andrew Hamill, 26 May 2023, [11] (NPL.9000.0012.0126).
[1245] Written submissions filed on behalf of the NSWPF on of NSWPF7 July 2023, [97] (SCOI.85225).
[1246] Written submissions filed on behalf of the NSWPF on 7 July 2023, [101] (SCOI.85225).
[1247] Written submissions filed on behalf of the Submissions of NSWPF, 7 July 2023, [101]-[102] (SCOI.85225).

877. In the course of oral evidence, Superintendent Best confirmed that the decision to release a potential crime scene is informed by a number of considerations, such as whether exhibits of potential relevance have been identified and collected.[1248] Superintendent Best accepted that in circumstances where there is some evidence of trauma to the victim, then the crime scene should be secured.[1249] However, in matters where it may not be obvious whether the victim suffered trauma, the assessment of how long to keep the scene secured becomes more challenging and involves a consideration of resourcing, including the number of calls for service that NSWPF may receive at the time.[1250]

878. During the course of her oral evidence, AC Conroy accepted that in circumstances where the cause of Mr Meek's death was unascertained, pending the results of an autopsy, it would have been reasonable to expect police attending the crime scene to consider homicide as a possible cause of death.[1251]

879. During the course of his oral evidence, DI Warren accepted that it would be inconsistent with proper police practice at the time to make an assumption that his cause of death was a heart attack, resulting in the subsequent release of the crime scene.[1252] DI Warren conceded that where the cause of death is unknown, police should proceed on the basis that the cause of death may be homicide,[1253] and items such as the used condom identified at the scene, should have been taken into police custody.[1254] The failure to do so was accepted by DI Warren to be a significant oversight.[1255]

D.27 Carl Stockton (died on 11 November 1996)

880. Carl Stockton died on 11 November 1996. Mr Stockton died as a result of craniocerebral injuries inflicted on 6 November 1996 by a person or persons unknown. The police investigation into Mr Stockton's death is dealt with in the written submissions of Counsel Assisting the Inquiry filed on 27 March 2023 at [37]-[48].

[1248] Transcript of the Inquiry, 4 July 2023, T4881.6-22 (TRA00072.00001).
[1249] Transcript of the Inquiry, 4 July 2023, T4881.34-4882.3 (TRA00072.00001).
[1250] Transcript of the Inquiry, 4 July 2023, T4882.10-42 (TRA00072.00001); T4883.22-32 (TRA00072.00001).
[1251] Transcript of the Inquiry, 4 July 2023, T4855.39-44 (TRA00072.00001).
[1252] Transcript of the Inquiry, 5 July 2023, T5005.5-19 (TRA00073.00001).
[1253] Transcript of the Inquiry, 5 July 2023, T5005.21-26 (TRA00073.00001).
[1254] Transcript of the Inquiry, 5 July 2023, T5005.28-46 (TRA00073.00001).
[1255] Transcript of the Inquiry, 5 July 2023, T5005.46 (TRA00073.00001).

D.27.1 Loss or destruction of exhibits

881. By letter dated 27 March 2023, the Inquiry requested a statement from the NSWPF outlining the location and status of the following exhibits collected as part of the initial investigation into the death of Mr Stockton:

a. Mr Stockton's clothing;
b. 17 glass bottles located at Mr Stockton's address;
c. Mr Stockton's wallet; and
d. Timber seized from Matterson Lane.[1256]

882. In a statement dated 17 April 2023, DS Sheldon advised the Inquiry that these exhibits could not be located.[1257] DS Sheldon's statement also outlines the searches that were conducted by the NSWPF to locate these exhibits. DS Sheldon states that searches were conducted by the NSWPF on EFIMS and all other investigative holdings held by the NSWPF. Enquires and physical searches were also carried out at Surry Hills and King Cross Police Stations, being the stations with carriage of the original investigation. Additional enquires were made with FETS, Corporate Records, FASS, and the DoFM.

883. In DS Sheldon's opinion, these searches and enquiries were "exhaustive" and there are no further avenues of enquiry available to locate the exhibits.[1258]

884. 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.[1259] For completeness, I note that supplementary submissions of Counsel Assisting were served on the NSWPF on 22 June 2023 and 18 August 2023 respectively. The NSWPF did not seek to address their failure to locate these exhibits or otherwise seek to reply to those supplementary submissions.

885. During the course of oral evidence, AC Conroy acknowledged that had police procedures been followed, the exhibits identified by the Inquiry would have been retained.[1260] AC Conroy further conceded that the inability of the NSWPF to account for these exhibits is indicative of a failure to comply with applicable police policies.[1261]

[1256] Exhibit 18, Tab 61, Letter to Office of the General Counsel, NSWPF, 27 March 2023 (SCOI.84102).
[1257] Exhibit 18, Tab 62, Statement of Detective Sergeant Neil Sheldon, 17 April 2023 (NPL.9000.0005.0001).
[1258] Exhibit 18, Tab 61, Statement of Detective Sergeant Neil Sheldon, 17 April 2023, [32] (NPL.9000.0005.0001).
[1259] Written submissions filed on behalf of the NSWPF on 12 April 2023, [73]-[97] (SCOI.45187).
[1260] Transcript of the Inquiry, 4 July 2023, T4855.10-12 (TRA00072.00001).
[1261] Transcript of the Inquiry, 4 July 2023, T4855.14-17 (TRA00072.00001).

D.27.2 UHT screening, triage or review forms

886. The Inquiry has before it a Triage Form in relation to Mr Stockton's death dated 6 November 2018 and an "Assessment of an Unsolved Homicide and Evidence Summary" dated 23 April 2019.[1262] Once again, DCI Laidlaw agreed that Mr Stockton's death should have been picked up as one of the original 366 cases in 2004 and should have been reviewed in the initial five-year period.[1263] In fact, Mr Stockton's matter was not reviewed until 2019.

D.28 Scott Miller (died on 2 March 1997)

887. Scott Miller's body was found on 3 March 1997. It is likely that Mr Miller met his death in the early hours of Sunday, 2 March 1997, after attending Mardi Gras.[1264] Mr Miller died as a result of multiple injuries sustained in a fall from height.[1265] The police investigation into Mr Miller's death is dealt with in the submissions of Counsel Assisting the Inquiry filed on 15 June 2023 at [23]-[31].

888. As outlined in the written submissions of Counsel Assisting (at [4], [28]-[31]), the primary matter of concern in relation to Mr Miller's death was an 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 those who had left the ship and attended Mardi Gras.

889. In response to Counsel Assisting's submissions in relation to the general lack of detail recorded regarding the Ranginui interviews, the NSWPF submitted that Counsel Assisting failed to account for the fact that each crew member is recorded as having seen nothing suspicious. The NSWPF submitted that "it is not clear what would have been gained from any further record of their evidence" having regard to this ultimate conclusion.[1266]

890. In response to the ambiguity around the interviews being in the presence of the other witnesses, the NSWPF submitted that "[p]resumably, investigating police knew the pitfalls of conducting a group interview" and there is nothing to indicate the interviews were conducted collectively.[1267] The NSWPF acknowledged that if the witnesses were interviewed collectively, then that would not have been the appropriate course.[1268]

[1262] Exhibit 53, Tab 35, Triage Review of an Unsolved Homicide – Carl Stockton, 6 November 2018 (SCOI.03389); Exhibit 53, Tab 35A, Assessment of an Unsolved Homicide and Evidence Summary – Carl Stockton, 23 April 2019 (SCOI.84312).
[1263] Transcript of the Inquiry, 6 July 2023, T5161.6-23 (TRA00074.00001).
[1264] Exhibit 32, Tab 2, Autopsy report of Dr Duflou, 5 June 1997 (SCOI.02737.00048).
[1265] Exhibit 32, Tab 2, Autopsy report of Dr Duflou, 5 June 1997 (SCOI.02737.00048); Exhibit 32, Tab 72, Expert Report of Dr Linda Iles dated 14 December 2022, 10 (SCOI.82891); Exhibit 32, Tab 74, Expert Report of Jae Gerhard, 29 May 2023, [15.2] (SCOI.83328).
[1266] Written submissions filed on behalf of the NSWPF on 30 June 2023, [52] (SCOI.84264).
[1267] Written submissions filed on behalf of the NSWPF on 30 June 2023, [53] (SCOI.84264).
[1268] Written submissions filed on behalf of the NSWPF on 30 June 2023, [54] (SCOI.84264).

891. DI Warren was not taken to these investigative steps in the course of his oral evidence. Nonetheless, in our submission the written submissions of Counsel Assisting concerning the investigation should be accepted. The witnesses from the NSWPF emphasised the importance of open mindedness, and not foreclosing avenues of Inquiry. Recording the view taken by the crew members that they saw nothing suspicious is of no utility to officers coming to consider the case at a later point in time. It is not unreasonable to expect police enquiries to be recorded with specificity.

D.28.1 UHT screening, triage and review forms

892. The Inquiry has before it a Case Screening Form dated 21 April 2004 in relation to Mr Miller's death.[1269] The Case Screening Form has been signed and dated by a reviewer, but there is no coordinator's certification. DCI Laidlaw agreed that proper procedure required the coordinator's certification. He was not aware of any reason why the signature was not affixed. He was asked by Senior Counsel Assisting whether the coordinator may nevertheless have certified the Case Screening Form. He said that he thought, based on his knowledge of the reviewer, that this was likely to be the case, and that the omission of the coordinator's formal certification was an oversight.[1270]

893. The UHT Tracking File indicates that a triage has been performed in relation to Mr Miller's case although the UHT Tracking File does not indicate the date on which that occurred. No Triage Form has been produced to the inquiry in relation to Mr Miller. DCI Laidlaw agreed that if a triage had occurred, and the entry in the UHT Tracking File is correct, there ought to be a record of that triage. Senior Counsel Assisting asked DCI Laidlaw whether he was able to assist the Commissioner one way or another as to whether such a Triage Form exists. DCI Laidlaw said that he was not able to assist.[1271]

[1269] Exhibit 53, Tab 31, Review of an Unsolved Homicide Case Screening Form – Scott Miller, 21 April 2004 (NPL.0100.0015.0001).
[1270] Transcript of the Inquiry, 7 July 2023, T5231.6-37 (TRA00075.00001).
[1271] Transcript of the Inquiry, 7 July 2023, T5232.29-31 (TRA00075.00001).

D.29 Samantha Rose (died 20 December 1997)

D.29.1 UHT screening, triage and review forms

894. The Inquiry has before it three documents relating to the death of Ms Rose. The first is a Case Screening Form dated 6 May 2004.[1272] The second is a Triage Form dated 23 May 2019.[1273] The third is a Review Form dated 30 September 2021.[1274]

895. Ms Rose was a trans woman who was recorded in the 2004 Case Screening Form by reference to her former name.[1275] DCI Laidlaw was not familiar with the case of Ms Rose. This was, again, a matter where a number of recommendations were made, and one where there was a reviewer's certification with a name but no signature and a date. Once again, there was no certification name or date for the coordinator. Senior Counsel Assisting asked whether the Commissioner was able to draw any inference as to whether or not the coordinator actually reviewed this document. DCI Laidlaw said "no."[1276]

896. DCI Laidlaw accepted that if this document had been provided by the UHT to somebody else then those recommendations should have been implemented within a reasonable time. This was a matter where a person of interest died in 2006; that is, within two years of the screening taking place. DCI Laidlaw accepted that had the recommendations in the case screening form been taken earlier or implemented within a reasonable time, those steps would have been taken while that person of interest was still alive. He accepted that not doing so was a failure of police procedure.[1277]

897. Senior Counsel Assisting drew to DCI Laidlaw's attention the recording of Ms Rose under her former name, and the mislabelling of Ms Rose's gender in the 2004 Screening Form. He asked DCI Laidlaw whether, in 2004, officers received training or education in respectful ways to refer to members of the trans community. DCI Laidlaw said that he did not know. He said that he had never received such training and had not received any guidance in relation to that matter in a professional context. He said that he had undertaken a computer module available in relation to LGBTIQ awareness, but did not recall when he had undertaken that module.[1278]

[1272] Exhibit 53, Tab 32, Review of an Unsolved Homicide Case Screening Form – Samantha Rose, 6 May 2004 (SCOI.03416).
[1273] Exhibit 53, Tab 34, Triage Review of an Unsolved Homicide – Samantha Rose, 23 May 2019 (SCOI.03415).
[1274] Exhibit 53, Tab 33, Review of an Unsolved Homicide Case Screening Form – Samantha Rose, 30 September 2021 (SCOI.02713).
[1275] Transcript of the Inquiry, 7 July 2023, T5232.37-47 (TRA00075.00001).
[1276] Transcript of the Inquiry, 7 July 2023, T5233.2-28 (TRA00075.00001).
[1277] Transcript of the Inquiry, 7 July 2023, T5233.30-5234.10 (TRA00075.00001).
[1278] Transcript of the Inquiry, 7 July 2023, T5234.12-38 (TRA00075.00001).

898. The Triage Form in relation to Ms Rose is dated May 2019. Senior Counsel Assisting asked DCI Laidlaw whether, by 2019, it would be fair to assume that officers, including the officer named as having completed the Triage Form, had undergone training in relation to cultural awareness in respect of the LGBTIQ community. DCI Laidlaw said that this was possible. He said that such training would have included information about respectful ways to refer to people who were or might be members of the trans community. DCI Laidlaw said that he assumed that the recorded name given with the initial review was "utilised across the board", and went on to say "admittedly, there should have been an alias or another name, but it wasn't recorded that way."[1279]

899. A Review Form was completed in relation to Ms Rose in 2021. DCI Laidlaw accepted that this document was a lengthy evidence summary, and that it looked not altogether dissimilar to the degree of information one might see in an OIC's statement to a coronial inquest. Senior Counsel Assisting drew DCI Laidlaw's attention to a passage on the first page of the Review Form which states, "he was a cross-dresser, wore makeup and commenced treatment for a sex change."[1280]

900. Senior Counsel Assisting asked DCI Laidlaw whether he had learned from the training he had received that this would not be a respectful way to refer to a member of the trans community. DCI Laidlaw said that was correct. He also said that it would be fair to infer that the officer who completed the report had also received the training. DCI Laidlaw accepted that this language could not be explained by a desire to ensure consistency of names. DCI Laidlaw said that he could not offer any reason for this use of language.[1281]

901. In our submission, the use of this type of language raises real concerns about the efficacy of the training officers receive concerning members of the trans community. There are reasons that a person's legally assigned sex marker, or former name, may need to be referred to in police documents. There is, however, no justification for the use of phrases such as "cross dresser" when referring to a person who was or may have been a member of the trans community. DCI Laidlaw agreed that the language used in this form was not appropriate.

[1279] Transcript of the Inquiry, 7 July 2023, T5235.4-27 (TRA00075.00001).
[1280] Exhibit 53, Tab 33, Review of an Unsolved Homicide Case Screening Form – Samantha Rose, 30 September 2021, 1 (SCOI.02713).
[1281] Transcript of the Inquiry, 7 July 2023, T5236.1-46 (TRA00075.00001).

D.30 Submissions concerning the individual matters before the Inquiry

902. As is set out above, in a significant number of individual cases before the Inquiry, exhibits or documentary material cannot be accounted for, or have been destroyed. In several cases, the NSWPF took the position in submissions that, when assessed by reference to the standards of the time, there was no failure to comply with proper police practice. At least in relation to the matters summarised above, those submissions by the NSWPF cannot be sustained having regard to the evidence of the NSWPF's own officers. As indicated, they candidly conceded many occasions on which lost documents, lost exhibits or investigative deficiencies reflected a failure to comply with proper police practice, including judged by the standards of their day.

903. This is a matter for which the NSWPF properly can be the subject of criticism.

904. As is set out at [130] above, it is not possible to assess from the evidence before the Inquiry whether the deviations from proper police practice were more common in cases involving LGBTIQ victims.

905. These deviations from proper police practice occurred in a significant number of cases considered by the Inquiry. If such deviations were widespread across all homicide investigations between 1970 and 2010, that is a matter of serious concern. If such deviations are more prevalent in the cases considered by the Inquiry, that is extremely troubling. In any event, the possibility that failures to adhere to proper police practice were influenced by LGBTIQ bias, whether conscious or unconscious, cannot be discounted.

906. In fairness, it should be borne in mind that reviewing unsolved cases may produce a disproportionate number of cases in which the investigation fell short of proper police practices. It may be that if one only looks at unsolved crimes one tends to see a greater proportion of cases in which something may have miscarried in the investigation.[1282] Nevertheless, the prevalence of investigative failures and lost documents and exhibits in the matters examined by the Inquiry is remarkable. It demonstrates that, on many occasions, the discharge of police functions fell well short of the standard the public has a right to expect from a competent police force.

[1282] Transcript of the Inquiry, 7 July 2023, T5201.43-5202.22 (TRA.00075.00001).

907. In our submission, it is important to distinguish between steps where reasonable minds might differ concerning their necessity, or where reasoned judgements were discovered, in hindsight, to be erroneous, as compared to failures to adhere to proper police practice. It is in the public interest for failures to adhere to proper police practice to be acknowledged and recorded. While many deficiencies may be historical, it is important to identify and condemn those deficiencies to diminish the likelihood of them recurring, and to recognise the legitimacy of the sense of grievance held by many within the LGBTIQ community concerning the way in which potential LGBTIQ bias crimes were investigated.

908. It is disappointing that the position taken by the NSWPF, in the submissions filed in individual cases, frequently failed to accept that particular acts or omissions were inconsistent with proper police practice in circumstances where the NSWPF witnesses later conceded that this was the case. In addition, the NSWPF witnesses frequently made concessions in their oral evidence which went well beyond the evidence they gave in their statements, particularly in relation to matters where the evidence given in their statements was that they were not able to form a view about a particular matter. That was shown not to be the case when their evidence was tested during oral examination.

909. In our submission, it is apparent that the NSWPF was largely unwilling to make reasonable concessions or engage constructively with concerns raised in the submissions of Counsel Assisting until the contrary position was made untenable by reason of evidence given by senior NSWPF officers. AC Conroy, DI Warren, DS Doherty and DCI Laidlaw all conceded in their oral evidence that there were deficiencies in historical police practices, and with historical processes and systems. It is regrettable that this was not more readily acknowledged in the response made to the submissions of Counsel Assisting in relation to a number of individual matters.

D.31 Submissions concerning the UHT

910. There are a number of matters that must be borne in mind when consideration is given to the evidence concerning the UHT. These matters are of particular significance to the question, raised by the Terms of Reference, as to whether matters have already been sufficiently investigated.

911. The *first* of these matters is that the UHT is necessarily constrained by its resources. It is indisputable that there are many demands on the resources of the NSWPF. The question of the appropriate allocation of resources to the UHT is not one that falls within the purview of the Inquiry, and is necessarily a question that raises complex social and policy considerations.

912. It became clear throughout DCI Laidlaw's evidence that the UHT has experienced resourcing challenges in seeking to grapple with the large number of unsolved homicides within its ambit.

913. The Commissioner asked DCI Laidlaw during his evidence whether the NSWPF did not "rate unsolved homicide too highly in terms of priorities". DCI Laidlaw disagreed, saying "the whole idea of setting up the Unsolved Homicide Team was to look at those matters, therefore giving them the appropriate priority".[1283] That led to the following exchange between DCI Laidlaw and the Commissioner:[1284]

> Q. But it would seem to me, if I may say so, that one of the primary considerations with old cases or unsolved cases is to take an immediate stocktake or audit of what you've got?
>
> A. I agree, sir. I agree, sir.
>
> Q. Because if you start off from the proposition that the exhibits have been lost or if important witnesses are dead --
>
> A. Yes.
>
> Q. -- and there are forensic opportunities which haven't been exploited historically but might now be exploited, isn't it something which a special - some sort of special audit and funding or resource allocation urgently needs to occur, so that you can draw a line in the sand and at least come to your own views as to where best to allocate your resources in relation to the unsolved cases?
>
> A. I agree, sir.

914. In our submission, it should be accepted that the UHT has been affected by limitations in resourcing. However, in examination by Mr Mykkeltvedt, Counsel for the NSWPF, DCI Laidlaw confirmed that one third of detectives in the Homicide Squad comprise part of the UHT.[1285] In those circumstances, it may be doubted that the real problem is one of resourcing per se.

915. The evidence suggests a major failing in the efficiency with which the UHT deploys the resourcing it actually receives. Despite its resourcing, the evidence indicates that the UHT, in its function of reviewing unsolved homicide cases, has been beset by inactivity and delay and that this continues today. The evidence of DCI Laidlaw also made it plain that until recently there appears to have been very little method in the selection of cases for screening, triage or review. In circumstances where there may have been resourcing constraints, the question of efficiently (and transparently) allocating resources and prioritising cases is even more significant.

[1283] Transcript of the Inquiry, 7 July 2023, T5204.33-5205.2 (TRA00075.00001).
[1284] Transcript of the Inquiry, 7 July 2023, T5205.4-22 (TRA00075.00001).
[1285] Transcript of the Inquiry, 7 July 2023, T5245.32 (TRA.00075.00001).

916. The work of the UHT is now focussed on undetected cases.[1286] As is dealt with at [370]-[373] above, the apparent failure to conduct a thorough and systematic review of unsolved homicide cases between 2004 and 2008 represented a serious missed opportunity to commence an audit of exhibits and documentary material which:

    a. may have identified and organised key documentary and exhibit material; and

    b. may have led to the discovery of material that could be the subject of further scientific analysis.

917. In addition to a failure to be systematic, in our submission there has also been a clear failure to assess critically whether the balance between speed and thoroughness is complete in the triage process. It is extraordinary that, despite the UHT having been established for nearly 20 years, 20% of cases have never been screened, triaged or reviewed, including a number of cases within the Inquiry's Terms of Reference. It is unknown how many obvious investigative opportunities have never been taken up, and perhaps now cannot be taken up.

918. There are also unexplained periods of inactivity in screening cases: for example between 2013 and 2017. It was not clear from DCI Laidlaw's evidence that he was aware that no cases had been screened in this time, although it was a matter one would have expected him to refer to while he gave evidence about the rate at which matters were reviewed.

919. DCI Laidlaw gave evidence that there were 19 triage documents on his desk awaiting his review. His evidence was that he had not given them priority because there were not reviewers available. That may be the case. However, he also told the Inquiry that he had not told his superiors that there were 19 triaged cases which he had not been able to assess (due to other policing commitments).[1287] The fact that this matter had not come to the attention of DCI Laidlaw's superiors may also indicate a failure of supervision of DCI Laidlaw and the UHT by the Homicide Squad, and by superior officers of the NSWPF more broadly.

920. This was not the only matter where DCI Laidlaw gave evidence that a responsibility rested with him, but that he had not taken steps to pursue a matter, or to notify his superiors that he was not in position to take those steps. Having regard to the position held by DCI Laidlaw, this is extremely troubling. In our submission, the failure by DCI Laidlaw to review these matters, or to bring his inability to do so to the attention of his superiors, is a substantial failure.

[1286] Transcript of the Inquiry, 6 July 2023, T5123.28, 5124.15-19, (TRA.00074.00001); Transcript of the Inquiry, 7 July 2023, 5203.18-5204-7 (TRA.00075.00001).
[1287] Transcript of the Inquiry, 6 July 2023, T5127.21-5128.24 (TRA.00074.00001).

921. The *second* matter that must be considered is that the NSWPF represents itself to the community as having a competent and adequately resourced team to deal with unsolved homicides. It is common for the Coroner to refer matters to the UHT. It is to be assumed that, when doing so, the Coroner and relatives of a deceased person expect that there is a realistic prospect that the matter will be considered by the UHT within a reasonable time (and not a period of time that can be measured in centuries).

922. It is by no means clear that coroners appreciate that returning an open finding means a case will be classified as "undetermined" and will be de-prioritised. On the current system, such a case may not be considered, even for triage, until all the "undetected" cases have been triaged/reviewed, which may take over 20 years. This is particularly troubling in circumstances where the Coroner might refer a case to the UHT because it appears that avenues of investigation, for example by way of covert policing techniques, might be fruitful if pursued in a timely fashion.

923. Any system for reviewing unsolved homicides, as explained by Dr Allsop above, will need to balance the need for regular reviews with the volume of unsolved cases and the resources available. However, the Inquiry has before it examples of cases (such as Mr Dutfield's) where a significant delay in implementing a recommendation meant the loss of an opportunity to pursue a potentially fruitful line of Inquiry.

924. The *third* matter is that the work of the UHT is constrained by historical exhibit management and record keeping practices. Some of the cases being considered by the Inquiry are now almost 50 years old. It is unsurprising that practices around exhibit and document management have changed significantly in the intervening period. Similarly, failures to comply with historical protocols are not the fault of the UHT.

925. However, there are also many examples before the Inquiry of poor practices, including in relation to record-keeping within the UHT itself. Having regard to the stated purpose of the UHT, it is reasonable to expect that matters are progressed in a methodical and systematic way accepting that, at least at the triage stage, a triage is not a complete and comprehensive review, but rather a mechanisms for allocating priority. It might be expected that a triage document would omit some information, or might occasionally contain an error of misstatement.

926. The Inquiry has before it documents that are incomplete or unsigned, documents containing significant factual errors, documents containing objectionable language in relation to deceased persons, and occasions where a screening, triage or review is recorded on the UHT Tracking File but there is no evidence that one has actually taken place. In many instances, there were recommendations for investigation or review and no evidence of those steps being implemented, or even considered. These poor practices cannot be dismissed as historical: there are instances of them occurring in the last three years. Nor can they be described as the sort of errors that are inevitable as part of a triage process.

927. There is no evidence before the Inquiry that the failure to take investigative steps, or to follow recommendations, was the culmination of a considered decision-making process that determined, for example, that as a matter of resourcing a particular matter needed to be prioritised. If records of that nature existed, they would have fallen within the purview of summonses from the Inquiry. If these decisions were made and no record was kept, that is in itself a matter of concern.

928. These poor practices are of particular concern given Dr Allsop's evidence, set out at [263]-[282] above, that document management and record-keeping are important to cold case review, including record management of previous case reviews.

929. It must be recognised, especially in a triage process, that there is a balance or trade-off between speed or efficiency on the one hand and the care or level of detail on the other.[1288] However, the evidence before this Inquiry indicates not only that the UHT does not have the balance right, but that it is achieving neither objective – the triage and screening process appears to have been neither quick and efficient nor careful and thorough. This is unfortunate and requires attention at the appropriately senior level within the NSWPF.

930. We note also the submissions at [155]-[160] above, concerning cultural awareness and the importance of educating officers in relation to the LGBTIQ community. It is difficult to see how the LGBTIQ community could have confidence in the UHT when there is objectionable language within its internal documents, and where there appears to be no or minimal engagement with the EHCU. Given the apparent lack of literacy concerning the LGBTIQ community, there is a possibility that some matters might not be identified as hate crimes, despite the fact that this could open investigative opportunities.

[1288] See [297], [369], [384], and [392] above.

931. In our submission, consideration should be given to making a recommendation concerning the systematic review of all unsolved cases, and a review of the existing procedures and allocation of resources within the UHT. Such a review should adopt a procedure that creates some prospect of matters being reviewed regularly, even if that review is brief.

PART E RECOMMENDATIONS

932. In a number of places throughout these submissions we submit that consideration should be given to making recommendations concerning particular subject matter. Those recommendations are summarised in this section. The precise form of any recommendation will of course be a matter for the Commissioner based on all of the evidence and submissions received in the Inquiry.

933. *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).

934. *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.

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

936. *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.

937. *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.

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

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