

The Special Commission of Inquiry
into LGBTIQ Hate Crimes

TENDER BUNDLE HEARINGS OF 22 AND 24 AUGUST 2023

Concerning the deaths of Crispin Dye and William Allen

Submissions on behalf of the Commissioner of Police

Introductory

1. These submissions are prepared on behalf of the Commissioner of Police in response to the submissions made by Counsel Assisting on 22 and 24 August 2023 in relation to the deaths of Crispin Dye and William Allen.
2. The Commissioner separately filed submissions on 28 June 2023 in respect of Public Hearing 2 issues (**Parrabell Submissions**). These submissions necessarily touch upon some of the general matters to which those hearings relate, but they do not represent a comprehensive statement of the Commissioner's position on the issues considered during those hearings.
3. The Commissioner also notes that separate submissions will be made by Counsel Assisting and by the Commissioner in due course in respect of the investigative practices hearings conducted by the Inquiry..
4. These submissions should be read together with the Parrabell Submissions, the submissions filed in the other "tender bundle" cases and, in turn, the submissions provided in respect of the investigative practices hearings.

Crispin Dye

Circumstances of death

5. In the early hours of Thursday, 23 December 1993, Mr Dye was found lying on the ground in Darlinghurst, near Taylor Square. When Mr Dye was found, he was in cardiac arrest, unconscious and not breathing. He was transported to St Vincent's Hospital.
6. Mr Dye had sustained extensive head and neck injuries during an assault which occurred in the early hours of that morning. Mr Dye died in hospital on 25 December 1993.

7. Mr Dye was a gay or bisexual man (CA, [17] and [297]). Police were aware of this fact from early on in the investigation.¹
8. On the evening of Tuesday, 22 December 1993, Mr Dye was drinking with friends at various bars and clubs in and around Oxford Street, Sydney. He was last seen (before being assaulted) at about 4.00am.² He was heavily intoxicated at the time.
9. Dr Liliana Schwartz conducted a post-mortem examination on Mr Dye's body on 27 December 1993. Dr Schwartz's report³ indicated that:
 - a Mr Dye sustained a range of injuries to his head and neck. These injuries included fractures and other minor injuries to his limbs including bruises, scratches and abrasions.
 - b At the time of his death, Mr Dye was suffering from acute bronchopneumonia and acute pancreatitis. Mr Dye's liver, spleen and heart had "septic features".
 - c Mr Dye's injuries were caused by a blunt instrument and that Mr Dye received at least three strikes to the face and left side of his head.
10. An inquest was conducted on 7 and 8 August 1995 before State Coroner Derek Hand. State Coroner Hand concluded that:⁴

on 25 December 1993 at the St George Hospital, Kogarah, Crispin Wilson Dye died of the effects of a head injury inflicted on 23 December 1993 in Campbell Street, Darlinghurst, by a person or persons unknown.
11. At the conclusion of the inquest, the Coroner and Mr Dye's mother commented on the thoroughness of the investigation. Ms Dye formally recorded her gratitude⁵ while the Coroner commended the NSWPF for the work involved in the initial investigation.⁶ No criticisms were made of the investigation at that time.

Adequacy of police investigations

12. The initial investigation was extensive. As noted above, the Coroner commended police in this regard.

¹ See for example Running sheet entry re information from Dorrington re movement of Dye prior to 23.12.93 dated 3 January 1994 (SCOI.10356.00215).

² Statement of Jeremy Barnabas Larkins dated 28 December 1993, [6], (SCOI.10347.00011).

³ Post-mortem report of Dr Liliana Schwartz, 27 April 1994 (SCOI.10178.00024)

⁴ Transcript of Coronial Inquest into the Death of Crispin Wilson Dye, 8 August 1995, 48 (SCOI.10179.00008).

⁵ Transcript of Coronial Inquest into the Death of Crispin Wilson Dye, 8 August 1995, 46, (SCOI.10179.00008).

⁶ Transcript of Coronial Inquest into the Death of Crispin Wilson Dye, 8 August 1995, 47, (SCOI.10179.00008).

13. The following is by no means an exhaustive summary of the investigative steps taken.
14. Canvassing and inquiries by police commenced shortly after Mr Dye was found. This included canvassing of potential witnesses, together with driving around the area with Scott Neilson, who observed three men apparently removing an item from Mr Dye's clothing on the ground, in an attempt to identify the offenders in the immediate aftermath.
15. Police also canvassed the general area, which consists mainly of business premises, and the drivers of buses operating from Randwick Port Botany and Waverley Depot.⁷
16. Task Force Barcoo was established on 29 December 1993 to investigate Mr Dye's death.
17. The inquiries made by Task Force Barcoo included ascertaining the movements of Mr Dye in the lead up to the assault. This included making inquiries of friends and family, together with staff from licenced premises that Mr Dye attended that evening. As part of those inquiries, details of other similar assaults were identified by investigating police. The circumstances of those assaults, and the potential for the assailants in those assaults to be linked to Mr Dye's assault were considered.
18. The investigating police also investigated various avenues regarding possible lost or stolen property of Mr Dye. This included conducting inquiries with ANZ bank, Ansett and Mr Dye's brother in connection with the possible stolen wallet of Mr Dye.⁸ The inquiries also included ascertaining whether Mr Dye may have had a diamond ring stolen from him, including by canvassing persons who saw Mr Dye on 22 December 1993.⁹
19. Further, the initial investigation involved obtaining and executing search warrants and the use of covert methods to obtain information and evidence about possible suspects. These steps are summarised in DS Knight's statements and report to the Coroner.
20. Notably, the police investigation into Mr Dye's murder was reopened in 1995 and again in 1999. This was as a result of fresh information coming to light on each occasion.
21. Counsel Assisting make some criticisms of police in the matter. These are addressed in turn below. However, there is no doubt that the investigation conducted by police was thorough. The criticisms made by Counsel Assisting largely stem from apparent oversights rather than a failure to conduct a thorough investigation.

⁷ Statement of DS Knight dated 27 September 1994, [40] and [41], (SCOI.10179.00008).

⁸ Summary prepared by DS Knight for coronial inquest dated 12 October 1994, at [8.23] to [8.27] and [8.30] to [8.31] (SCOI.10179.00011).

⁹ Summary prepared by DS Knight for coronial inquest dated 12 October 1994, at [8.28] to [8.29] (SCOI.10179.00011).

22. There is nothing to suggest that any failures in the investigation were attributable to any LGBTIQ bias on the part of investigating officers.

Exhibits

23. Counsel Assisting make criticisms of the initial investigation's approach to exhibits in the following three respects: (a) not all relevant exhibits were tested for fingerprints or sent to DAL for forensic analysis; (b) the scrutiny of exhibits from the crime scene was deficient; and (c) the recording and management of exhibits located is cause for concern.
24. Each of these criticisms are considered in turn below. The initial investigation occurred over 30 years ago. The Inquiry has received evidence and submissions (in the context of other deaths into which the Inquiry has inquired) about the prevailing forensic technology, including knowledge of that technology.
25. Indeed, in the context of Robert Malcolm's death into which the Inquiry has inquired, Counsel Assisting tendered a report of Michelle Franco, who is a forensic biologist who holds the position of Group Manager, Evidence Recovery Unit at the NSW Health Pathology Forensic & Analytical Science Service (**FASS**). Ms Franco's evidence is that "DNA testing was only in its infancy in 1992 and the enormous advances in DNA technology was not envisioned in that year."¹⁰ This statement appears to relate to persons involved in that field generally, not a specific comment on the original investigators.
26. Great care should be taken not to engage in criticism that reflects what is now known about DNA technology and the advances therein, rather than by reference to what little was likely to have been known to NSWPF investigators at the time of Mr Dye's death and at various points in the investigation in the decade or so following.

Failure to arrange DNA testing

27. Counsel Assisting state that the only item sent to DAL was Mr Dye's blood sample (CA, [46]). Counsel Assisting submit that the failure of the NSWPF to arrange for the testing of Mr Dye's clothing at the time of the original investigation or at any time thereafter is of particular concern. This criticism is plainly unwarranted in respect of the original investigation, having regard to the available evidence for at least two reasons.
28. First, in the context of Mr Dye's case specifically, Ms Franco stated as follows:

While DNA testing could have been carried out in 1994 when PCR typing began,

¹⁰ Statement of Michele Franco, FASS, dated 13 June 2023 at [17] (SCOI.83957).

the system used was inferior to current DNA typing methods. For example, DNA typing at the time was affected by inhibitors that may be extracted from a sample such as that from the blue dye of the jeans. In 1994 to 1995, there also needed to be suspects available for any meaningful comparisons to be made. If the testing had commenced in 1994 the limited information gained could only be compared to a suspect directly connected and typed in the same DNA typing system of that time. DNA typing results obtained in 1994 could not be uploaded onto a database, unless re-examined in DNA typing systems used later. Also, the biological sex of the DNA contributor could not be determined in 1994.

29. Second, as noted above, the observations Ms Franco made in her expert report in the context of Mr Malcolm's death are relevant in this context. As noted above, in the context of Mr Malcolm's death, Ms Franco observed that DNA testing was only in its infancy in 1992 and the enormous advances in DNA technology that have occurred since were not envisioned in that year.¹¹ There is nothing to suggest the position would have been different in 1993 and 1994.
30. Further, the Inquiry has received evidence in the context of the investigative practices hearings about when certain forensic science methods became available to NSWPF officers investigating crimes. Whilst the DNA testing technology may theoretically have been available at some point, Counsel Assisting's submissions do not consider the practical availability of the relevant forensic technologies to investigators at the time.
31. In addition, as observed by Ms Franco, the contemporaneous records indicate that Mr Dye's jeans were soiled or were 'faeces-stained'. Ms Franco points out that the jeans had extensive brown staining around the buttock area and therefore it was difficult to differentiate any blood-like staining from the brown staining due to the age of the exhibit. Ms Franco noted that over time the blood changes and becomes brown. It is not clear on the available evidence:
 - a First, whether the staining was of such a nature at the time of the jeans being obtained by police as to mask any potential blood on the jeans.
 - b Second, if the blood was not masked by faeces staining, when the blood would have become sufficiently brown to be masked by the other staining relative to the various

¹¹ Statement of Michele Franco, FASS, dated 13 June 2023 at [17] (SCOI.83957).

stages of the reopening of the investigation and the UHT review and triage.

32. These factors must be borne in mind when considering any criticism made by Counsel Assisting on this front.
33. In any event, it appears that none of these matters have been explored with investigating officers.

Failure in respect of fingerprinting

34. Counsel Assisting submit at CA, [48] that it is not clear if the wallet itself (in which the Health Care card and Frequent Flyer card were located) was fingerprinted. In respect of the two wallets received by the police in connection with this investigation, DS Knight's summary for the Coroner relevantly records that "fingerprint examination of the items recovered were of a negative result"¹² and an examination was by the Central Fingerprint Bureau for latent fingerprints in respect of "the property referred to"¹³ in the context of the respective wallets.
35. Whilst the records available are not conclusive, it appears likely that the reference to 'the property' and 'the items' in the context of the wallets and their contents being described suggests that, on balance, the wallets themselves would have also been the subject of fingerprint testing. In any event, it is not clear to the Commissioner of Police whether the Inquiry has raised either of these concerns with any of the officers involved in the initial investigation.
36. Counsel Assisting also criticise police for returning Mr Dye's keys to Mr Dye's brother in circumstances where there is no record, on the material now available 30 years later, as to whether the keys were subjected to fingerprint analysis (CA, [49]). It is not clear to the Commissioner of Police whether the Inquiry has raised either of these concerns with any of the officers involved in the initial investigation.

Scrutiny of exhibits located at the scene

37. The Inquiry located two pieces of paper which were folded inside the top left-hand pocket of Mr Dye's shirt:¹⁴
 - a One contained a handwritten name and phone number on it.
 - b The other contained a brown mark on it.

¹² Summary prepared by DS Knight for coronial inquest dated 12 October 1994, at [8.32] (SCOI.10179.00011).

¹³ Summary prepared by DS Knight for coronial inquest dated 12 October 1994, at [8.40] (SCOI.10179.00011).

¹⁴ Statement of Michele Franco, 15 June 2023, 5 (SCOI.84016).

38. Based on the material presently available, it appears likely that these items were not located during the initial search.
39. That said, DS Knight found "several pieces of paper" in Mr Dye's pockets "containing telephone numbers and a Metway Bank business card".¹⁵ Counsel Assisting conclude that those pieces of paper seem to be different pieces of paper to those found by the Inquiry. However, it does not appear that the Inquiry has raised this question with the officers involved in the initial search.
40. Counsel Assisting suggest that the apparent failure to locate these pieces of paper is extraordinary in circumstances where there have been further police investigations of the case in the years following 1996 and 1999, and the UHT has reconsidered the case in 2005 and 2019.
41. The UHT reviews of the case were paper reviews. There is nothing to suggest they involved a search through the physical exhibits. In this respect, the criticism in respect of the failure to locate the pieces of paper should not extend to the UHT review in 2005 and triage in 2019, having regard to the nature of the review and triage processes involved. This is addressed in further detail below.
42. It is not clear, based on the material available to NSWPF, whether the Inquiry has approached any of the officers involved in the initial investigation, including in particular the officers who provided statements regarding the searches they made of Mr Dye's clothing at the time, to ascertain the circumstances in which the searches were conducted. The Commissioner of Police agrees that it is regrettable that the items do not appear to have been located.
43. Counsel Assisting suggest that subsequent investigations and reviews should have resulted in the items being located. However, as Counsel Assisting point out, the statements from officers involved in the original investigation were to the effect that the clothing had been searched and certain items had been located (CA, [121] and [122]). On the face of the material available to subsequent investigators, there was nothing to suggest that there was a particular need to further search the clothing.¹⁶

¹⁵ Police notebook of Detective Sergeant Knight, 10 January 1994, (SCOI.84797).

¹⁶ See for example Statement of DS Knight dated 27 September 1994, [9], (SCOI.10179.00008); Statement of Detective Senior Constable Lyle William Van Leeuwen dated 15 November 1994, 4, (SCOI.11036.00085).

Failure to retain exhibits

44. Counsel Assisting point out that the NSWPF did not catalogue some items as exhibits, such as Mr Dye's keys, the multiple papers found on Mr Dye's person, or either of the two wallets eventually received by police (CA, [58]).
45. Counsel Assisting state that the Inquiry has been hampered in efforts to carry out forensic testing of certain exhibits that were retained in this case, as well as of the two pieces of paper located by the Inquiry, due to the passage of time, nearly 30 years, since Mr Dye's death due to degradation over that time.
46. In making this criticism, Counsel Assisting acknowledge that during the same passage of time, the advancement of technology in the recovery of DNA profiles from exhibits has occurred. Counsel Assisting concede that it is "not possible to say with certainty that the results of testing conducted by this Inquiry are more limited than they might have been had such testing occurred earlier, especially in relation to the blood on Mr Dye's jeans". No analysis has been conducted by Counsel Assisting regarding the timeframe of the degradation of the exhibits and items over time relative to the advances in forensic science technologies.
47. In this respect, it is not clear, on the material available to the Commissioner of Police, whether the blood stain located by FASS on Mr Dye's jeans was in a form which was (or should have been) able to be identified by forensic investigators at the time of the initial investigation. Similarly, it is not clear whether this was also so during the points at which the investigation into Mr Dye's death was reopened during the 1990s. Finally, it is not clear whether the relevant technology was available in 2005 when the initial UHT review was conducted. Indeed, Ms Franco stated the following on this point:¹⁷

DNA testing could commence in 2005 but the DNA typing system used at the time was greatly affected by inhibitors that could be present in the blue dye of the denim jeans. If a profile was able to be obtained, it could be entered onto the DNA database and searched for a link to a person or crime scene.

48. The Commissioner of Police agrees that it is unfortunate that items that raised the possibility of being a useful source of fingerprint or other evidence were not located and/or tested by earlier. However, Counsel Assisting's submission that "at the very least, useful DNA results

¹⁷ Expert report of Michelle Franco dated 15 June 2023, 7 (SCOI.84016).

could have been obtained in 2005 (at the time of the UHT review) and in 2019 (at the time of the UHT triage)” is speculative.

49. First, there is no evidence to suggest that useful DNA results, relative to the DNA results obtained by the Inquiry recently, would have been obtained.
50. Second, NP252 died in 2002. Unfortunately, the DNA results that Counsel Assisting envisage would, unfortunately and regrettably, not have yielded any results which would have been more useful in determining through objective evidence whether Mr NP252 was involved in Mr Dye’s death. That said, the Commissioner of Police acknowledges that, on balance, it is possible that attempts to obtain information from associates of Mr NP252 would have been more likely to succeed in 2005 than in present day, given the passage of time.
51. Any criticism needs to pay appropriate regard to Ms Franco’s evidence in this and previous hearings conducted by the Inquiry regarding the nature and availability of DNA technology at relevant times since the initial investigation.

Lines of inquiry not fully explored

52. Counsel Assisting assert that police appear to not have followed up at least two pieces of significant information (CA, [67]).
53. First, there is no record of police having spoken to Mr Paige on 24 December 1993, or to otherwise follow up on what he told them about his encounter with Mr Dye on or about the evening he was killed (being 22 December 1993). Counsel Assisting state that Mr Paige’s evidence “was squarely relevant to ascertaining Mr Dye’s movements in the period leading up to his death, as well as to his sexuality” (CA, [67]).
54. It is not clear on the material presently available whether or not those enquiries were made. It appears that the police officers involved in those aspects of the case have not been approached by the Inquiry regarding whether such steps were taken. As Counsel Assisting acknowledge, police did contact Mr Paige on Christmas Eve in 1993 (presumably in response to finding the Paige note) (CA, [129]).
55. Regardless, the Commissioner of Police notes that investigating police were aware of Mr Dye’s sexuality from early on in the investigation.¹⁸ It is not clear what Counsel Assisting suggest the evidence of Mr Paige would have substantively added in that respect.

¹⁸ See for example Running sheet entry re information from Dorrington re movement of Dye prior to 23.12.93 dated 3 January 1994 (SCOI.10356.00215)

56. Further, Mr Paige's evidence is to the effect that he believes he did not have an encounter with Mr Dye on the evening he was killed, but rather, this was a number of days before then (although it was *possible* it was the same evening).¹⁹ The fact that Mr Paige described Mr Dye as 'lucid' that evening,²⁰ whereas Mr Dye was heavily intoxicated on the evening of his assault, suggests that Mr Paige's encounter with Mr Dye was likely a prior evening.
57. Second, Counsel Assisting point out that there is no evidence that the police followed up on information received from Richard Leonard's father, Stephen Leonard, in March 1994, insofar as this information was relevant to Mr Dye's case (CA, [67]).
58. It is not clear on the material presently available whether or not those enquiries were made. It appears that the police officers involved in those aspects of the case have not been approached by the Inquiry regarding whether such steps were taken.
59. Regardless, it is notable that Richard Leonard conveyed similar comments to an inmate (known as AC) to those which he conveyed to his father.²¹ Police investigated those comments, including through the use of listening devices. However, inquiries ultimately indicated that the assault to which Richard Leonard was referring (which appears to be the same assault recounted by his father) was not the assault on Mr Dye.²² This included obtaining evidence from a person known as SM who apparently witnessed the assault in question by Richard Leonard. The relevant matters in this regard are summarised at CA, [255] to [278]. Further, it is notable that NSWPF obtained advice from the ODPP during the course of the then ongoing investigation into Richard Leonard's potential involvement in Mr Dye's death. The ultimate advice was that no charges should be laid against Richard Leonard in connection with Mr Dye's death.²³
60. Therefore, there does not appear to be a failure to 'connect the dots' between the evidence of Richard Leonard's father and the evidence of AC and SM, contrary to Counsel Assisting's suggestion (CA, [289]). Rather, the basis on which the latter evidence was discounted appears to be the same basis on which Richard Leonard's father's evidence did not give rise to a reasonable prospect of a conviction.

¹⁹ Statement of Alexander Paige, 11 August 2023, [8] (SCOI.84925).

²⁰ Statement of Alexander Paige, 11 August 2023, [9] (SCOI.84925).

²¹ See for example statement of [269, 24 January 1996 (SCOI.10179.00005); NSWPF Transcript of Tape, 'Dye Murder', 7 March 1996, 8 (SCOI.10178.00040).

²² NSWPF Transcript of Interview, 'Interview with NP129', 15 April 1996, 9, 19-21 (SCOI.10179.00024).

²³ Table of Documents from ODPP, 16 June 2023 (SCOI.84018).

UHT review and triage

61. The UHT considered Mr Dye's case in 2005 (a review) and again in 2019 (a triage). Neither a review nor a triage process involves substantive investigative steps being taken.
62. The review conducted by UHT in 2005 was thorough. It resulted in various recommendations being made by DSC Natalie Barr.²⁴ It is not clear based on the material before the Inquiry what steps were subsequently taken within NSWPF in respect of the recommendations.
63. The Commissioner of Police agrees that the various recommendations made within the 2005 UHT were appropriate. At first blush, it is regrettable that, based on the records available, the further steps such as having the exhibits examined by FASS appear to have not been pursued. Of course, this says nothing about the resource constraints that are likely to have impeded the conduct of investigative steps in response to such reviews.
64. Again, Mr NP252 died about three years before the 2005 UHT review. As a result, presuming the DNA technology was sufficiently advanced as at 2005 to enable Mr NP252 DNA to be identified, analysed and matched to the DNA profile from the break and enter scene (which is not able to be established on the available evidence), further investigations would likely have been inhibited by Mr NP252 death.
65. The 2019 UHT triage conducted by DSC Leza Pessotto recommended that the matter should proceed to review. The form states that:²⁵

A review may confirm or eliminate the current identified persons of interest. It may also identify new lines of enquiries.

There appears to be an opportunity for a forensic review to be conducted as it appears that the deceased's blood is the only thing sent to DAL for testing.

Confirm in relation to the fingerprints identified and what they were identified on. Enquiries should be conducted on similar offences within the area and see if there are any potential links.

66. It is not clear based on the material before the Inquiry what steps were subsequently taken within NSWPF in respect of the recommendation that the triage proceed to a review.

²⁴ NSWPF Review of an Unsolved Homicide Case Screening Form, 'Crispin Wilson Dye', 25 May 2005, 6 (SCOI.03268).

²⁵ NSWPF Review of an Unsolved Homicide Case Screening Form, 'Crispin Wilson Dye', 25 May 2005, 17 (SCOI.03268); NSWPF Annexure A Triage Form Review of Unsolved Homicide, 'Crispin Wilson Dye', 16 November 2019, 17 (SCOI.03267).

Strike Force Parrabell review

67. Following its consideration of this matter, SF Parrabell concluded that there was 'Insufficient Information' as to the presence of a bias motivation. Counsel Assisting reach the same conclusion (CA, [301]), as did the academic review team.
68. Counsel Assisting submit at CA, [77] that an interchange between Sergeant Steer and the SF Parrabell officers regarding the appropriate characterisation seems to indicate that SF Parrabell categorised the case as "Insufficient Information" because of the possibility Mr Dye was the victim of a robbery. This is not correct. The points raised by Sergeant Steer formed part of the reasoning, as recorded in the following summary (emphasis added):

Sgt Steer suggested 'Suspected Bias Crime' because of level of violence suggestive of a motivation more than economic (robbery), the area as well known to be a gay location, gay men possibly targeted because they were perceived to be vulnerable, not fight back etc. Strikeforce maintained that multiple offenders in a robbery could account for the outcomes and determined 'Insufficient Information'. Sgt Steer clarified that motivation need only be partially bias and targeting group due to a perceived vulnerability can be bias motivation, however was happy to leave the determination as 'Insufficient Information'. What is not known is how the victim was dressed and whether he appeared 'gay'.²⁶

69. Counsel Assisting also submit that Sergeant Steer's "clarification" about "partial" motivations does not appear to have been engaged with by the SF Parrabell officers. This submission ignores the fact that Sergeant Steer was 'happy to leave the determination as Insufficient Information', per SF Parrabell's characterisation, even though Sergeant Steer came to a different conclusion. This demonstrates two things:
- a First, ascribing bias motivations is by no means a straightforward task; it is one in relation to which reasonable minds can – and do – differ. Otherwise, Sergeant Steer would not have conveyed his comfort in respect of the SF Parrabell officers' differing characterisation; and
 - b Second, SF Parrabell did consider whether partial motivations were at play but discounted the possibility on the basis that there was no (apparent) evidence as to whether Mr Dye would have appeared to a stranger to have been a member of the

²⁶ Exhibit 6, Tab 83, NSWPF, SF Parrabell/Bias Crimes Unit meeting minutes, 19 January 2017, 2 (SCOI.74429).

LGBTIQ community. Counsel Assisting point out that there was indeed evidence of Mr Dye's clothing. However, that evidence does not suggest that Mr Dye's appearance (or behaviour at the time) was indicative to a stranger that he was a gay or bisexual man. SF Parrabell's comment remains correct.

70. Counsel Assisting also suggest that the exchange between Sergeant Steer and the SF Parrabell officers is also illustrative of "both the subjectivity involved in the SF Parrabell exercise, and the resulting fluidity in terms of whether a case was categorised as, for example, "Suspected Bias Crime" or "Insufficient Information"." (CA, [78]). It is not clear whether this is intended to be a criticism or a recognition of the fact that, as submitted above, and on numerous occasions previously, that reasonable minds may differ when it comes to assessing the possible presence of LGBTIQ bias.
71. Counsel Assisting suggest that the overall categorisation by SF Parrabell of 'Insufficient Information', and the responses to a number of the indicators and prompts, appear to reflect an assumption or preconception on the part of the SF Parrabell officers that where a robbery is involved, a binary choice is required as between robbery and bias (CA, [81]). This submission should be rejected, having regard to the extracted summary of the exchange between Sergeant Steer and the SF Parrabell officers at CA, [75] and the matters referred to in the paragraph immediately above. The available evidence makes it clear that SF Parrabell was alive to the possibility that multiple motivations may be at play in a given case, and that the presence of a robbery motivator does not exclude the prospect that LGBTIQ bias played a role in the relevant death.
72. Counsel Assisting raise three aspects of the SF Parrabell Case Summary in respect of Mr Dye.
73. First, Counsel Assisting point out at CA [86] that the Case Summary incorrectly assumes that the three men observed "standing over" Mr Dye, and who removed something from his clothing before running away, were the people who actually assaulted him. The Commissioner of Police agrees with Counsel Assisting's submission that there is no direct evidence to confirm that the three men observed to be standing over Mr Dye were involved in the assault. However, on balance, it is likely based on the timing and the fact that the alternative would require one individual or group to have assaulted Mr Dye and then, within a very short period of time, the group of three persons observed by Mr Neilsen to then come across Mr Dye in his injured state and, instead of rendering assistance, to opportunistically rob him. This is unlikely.

74. Second, Counsel Assisting suggest that the Case Summary emphasises factors indicating robbery (CA, [87]). Counsel assert that there is "no mention of the possibility of bias, except (inaccurately) under "Coroner/Court Findings"." It is not clear what Counsel Assisting suggest by the inaccuracy in this respect. If it relates to the third issue raised, this is addressed in the following paragraph. If it is addressed to the suggestion that either robbery was the primary motivation or that a bias motivation could not be ruled out, then this criticism should be rejected. The evidence indicates a clear robbery motivation and, as Counsel Assisting ultimately submit at CA, [301], an inconclusive (or at the very least, less certain) bias motivation.
75. Third, Counsel Assisting state that the information next to "Coroner/Court Findings" is inaccurate on the basis that the only "Court findings" were those of the Coroner. Counsel Assisting ignore the fact that this heading was from a template. The information contained in that section does not assert that there was any such court finding. Rather, insofar as it concerns a coroner or court finding, the Case Summary accurately states that the murder of Mr Dye remains unsolved.
76. The Case Summary does not, contrary to Counsel Assisting's submission, assert that Coroner Hand found that "it appears that robbery was a primary motivation" for the murder of Mr Dye. The author of the Case Summary does not assert that the Coroner found that "a bias motivation could not be eliminated". Rather, these comments reflect the analysis of the author of the Case Summary. The author does not state that the Coroner made any such findings.

Anti LGBTIQ bias

77. In order to be able to reach any firm conclusion as to whether the assault of Mr Dye was motivated by gay hate, it is necessary to determine the identity of the attacker/s. This is not a matter in which a gay hate bias can be inferred from any of the surrounding circumstances.
78. Consistent with the position expressed by SF Parrabell, the Commissioner of Police agrees with Counsel Assisting's submission that there is no sufficient basis to conclude that Mr Dye's death was motivated by LGBTIQ bias (CA, [301]).
79. Counsel Assisting's comments about the binary distinction between motivations (CA, [300]) are addressed above in the context of SF Parrabell. For completeness, the Commissioner of Police agrees with the general principle espoused by Counsel Assisting; a robbery motivation would not exclude the possibility that LGBTIQ bias played a role. The SF Parrabell

reviewers, however, did not approach their analysis in the manner suggested by Counsel Assisting.

Manner and cause of death

80. The Commissioner of Police supports the submissions made by Counsel Assisting as to the manner and cause of the death, namely that Mr Dye died on 25 December 1993 at St George Hospital as a result of effects of a head injury inflicted on 23 December 1993 in Campbell Street, Darlinghurst, by a person or persons unknown. (CA, [302]).

William Allen

Circumstances of death

81. Around midday on 29 December 1988, Mr Allen was found dead in his house. He was slumped over the bathtub with his arms and head in the bathtub with the tap running. He was dressed only in a singlet; he had no underpants or trousers. He was bleeding from the head.²⁷
82. Mr Allen had sustained injuries during an assault which likely occurred on the evening of 28 December 1988 at around 10:00pm in the vicinity of Alexandria Park.²⁸ Mr Allen informed Harry Berwick, who responded to Mr Allen's request for help in the aftermath of the assault, that it had been by " [REDACTED]".
83. Mr Allen was a gay man (CA, [3]). It is apparent that he had attended a beat at the toilet blocks in Alexandria Park.
84. Dr Sylvia Hollinger attended Mr Allen's home on 29 December 1988 and made her initial observations of him, she had considered that there was a possibility that he had been bashed at some stage.²⁹ A three centimetre laceration was observed above his left eye, and there was swelling to the same eye and to the lips and jaw.³⁰
85. In discussions with the officer in charge, Detective Sergeant Brian Saunders (**DS Saunders**), on 11 January 1989, Dr Hollinger indicated that Mr Allen did not die as a result of a heart

²⁷ Statement of Ronald Sigsworth, 3 January 1989, 1 (SCOI.10327.00005); Statement of NP86 ; 2 January 1989, 2 (SCOI.10327.00008).

²⁸ Statement of DS Saunders, 28 February 1989, 2 (SCOI.10329.00055).

²⁹ Statement of Constable Paul Taylor, 22 January 1989, [8]-[9] (SCOI.10329.00054).

³⁰ Statement of DS Saunders, 28 February 1989, 1 (SCOI.10329.00055); Statement of Detective Sergeant Carlton Graeme Cameron, 4 July 1989, [6] (SCOI.10329.00083).

attack but could have fallen. Police subsequently obtained information about Mr Allen's attendance at Alexandria Park, and his assault there.³¹

86. Dr Hollinger conducted a post-mortem examination on Mr Allen's body on 30 December 1988. Dr Hollinger's report recorded the direct cause of death as head injury with brain damage associated with alcohol ingestion.³² Mr Allen's injuries were consistent with him having been assaulted,³³ including having been [REDACTED]
[REDACTED]³⁴
87. A coronial inquest was held on 4 July 1989 before State Coroner Kevin Waller. State Coroner Waller found that Mr Allen died of the effects of head injury, sustained on the night of 28 December 1988 when he was beaten by persons unknown in Alexandria Park.³⁵ State Coroner Waller did not comment or find that the police investigation was deficient.

Adequacy of police investigations

88. Counsel Assisting make some criticisms of the original police investigative team in the matter. These are addressed in turn below.

Inquiries regarding Mr Allen's attendance at Alexandria Park toilets as a beat

89. Counsel Assisting state police knew Alexandria Park was a beat and suggest that there was a possibility that Mr Allen was bashed while attending the toilet block in its capacity as a beat (CA. [44]).
90. The Inquiry has photographs that were taken of the inside of the toilet block by police on 3 February 1990, following the death of Richard Johnson. The walls contained numerous messages seeking or inviting sexual encounters with telephone numbers. Counsel Assisting acknowledge that those photos were taken over a year after Mr Allen's death, but suggest they reflect the likely state of the inside of the toilet block as at the time of Mr Allen's death.
91. Counsel Assisting note that this is consistent with information from Mr Berwick who told the Inquiry in his most recent statement that writing your phone number on the wall of the toilet block was a common practice by men living alone and wanting to meet men at the beat.
92. In respect of the recent evidence of Mr Berwick, the Commissioner of Police notes that Mr

³¹ Notes of DS Saunders re Autopsy, undated, 1 (SCOI.10327.00002).

³² Post-mortem report of Dr Sylvia Hollinger, 10 May 1989, 2 (SCOI.10329.00067).

³³ Post-mortem report of Dr Sylvia Hollinger, 10 May 1989 (SCOI.10329.00067).

³⁴ [REDACTED]

³⁵ Findings of State Coroner Waller, Inquest into the death of William Allen, 4 July 1989, 1 (SCOI.00003.00001).

Berwick's evidence:

- a suggests, but does not conclusively establish that the Alexandria Park toilet block had the telephone numbers at the relevant time; and
 - b did not include, in his original statement, details that Mr Allen had told him that he had written his phone number on the wall of the toilet block. Without being critical of Mr Berwick, there is a real possibility that Mr Berwick's recollection of the conversation, which occurred approximately 35 years ago, is not an accurate recollection. In any event, it appears that the information was not provided to investigating police at the time.
93. Counsel Assisting submit at CA, [44] that that the wall at the Alexandria Park toilet block should have been reviewed to ascertain whether Mr Allen's phone number was on it. The Commissioner of Police agrees. The material presently available does not disclose whether or not investigating police did actually inspect the wall of the toilet block to determine whether Mr Allen's phone number was located on it.
 94. Counsel Assisting's positive assertion that no such inquiries were undertaken is not available based on the material available to the Commissioner of Police. Indeed, Counsel Assisting go a step further by suggesting that 'no officer thought to check'. Unless Counsel Assisting has enquired of the officers in question, that submission as to the subjective state of mind of the relevant officers is clearly unfounded.
 95. Further, putting to one side what the relevant officers did or did not think, it is not clear whether the Inquiry has made inquiries of the officers involved in the original police investigation (other than DS Saunders) to ascertain what investigative steps were taken. It is not clear from the evidence tendered by Counsel Assisting whether the contact made by the Inquiry to DS Saunders was in respect of seeking clarification of certain matters or in anticipation of submissions to the effect that adverse findings be made against him.
 96. Counsel Assisting further submit at CA, [45] that the failure to pursue this line of investigation "may reflect police indifference to homosexual men being assaulted in Alexandria Park". The investigative steps undertaken by police make it clear that there was no such indifference and, in any event, a finding to this effect could not properly be made in circumstances where it has not been explored with the relevant investigating officers.
 97. Counsel Assisting acknowledge that their submission that an active investigation may have prevented the conduct in future or reduced its prevalence earlier (CA, [45]) is speculative.

There is simply no evidential basis for that submission.

Failure to seize video tapes containing CAM

98. Counsel Assisting point out that a number of videotapes were discovered during the search of Mr Allen's property. It appears that some of which contained child abuse material (**CAM**).
99. The Commissioner of Police agrees that the video tapes should have been seized. It is not clear based on the evidence tendered to the Inquiry whether the contents of the video tapes were known to police. However, as acknowledged by Counsel Assisting, NSWPF conducted an internal investigation into the original investigation (CA, [49]). The material from that investigation has not been tendered in this hearing because of the issue acknowledged by Counsel Assisting arising under s 170 of the *Police Act 1900* (NSW).
100. The Commissioner of Police notes Counsel Assisting's submission that the failure by DS Saunders to seize the video cassettes constituted a substantial neglect of duties. The Commissioner understands from the material tendered by Counsel Assisting that DS Saunders has been approached by the Inquiry to make submissions and that he has declined the opportunity to do so.³⁶
101. It is presumed that this particular issue was specifically drawn to DS Saunders' attention by the Inquiry. If not, it should be.

UHT triage

102. The UHT considered Mr Allen's case in 2021 in a triage of Mr Allen's death. The author recommended that the matter proceed to a review.
103. As noted above in the context of Mr Dye's case, the Commissioner of Police notes that issues of this nature are the subject of extant inquiries and will be the subject of submissions in the context of the investigative practices hearings. It is not clear based on the material before the Inquiry what steps were subsequently taken within NSWPF in respect of the recommendation that the triage proceed to a review. It is unfortunate that the matter did not proceed to a further review. The available material does not disclose that such a review would have been feasible having regard to the significant resource constraints at play.
104. Counsel Assisting's suggestion at CA, [63] that the triage review form contained a misleading statement to the effect that the video cassettes located at Mr Allen's house were later

³⁶ Statement of Kathryn Lockery, 23 August 2023, [25] (SCOl.85150).

collected by a police officer is rejected. The form states that 'somebody' returned. The form does not state that a *police officer* returned. Indeed, the author expressly states that exhibits were not seized.

Strike Force Parrabell review

105. Following its consideration of this matter, SF Parrabell considered that Mr Allen's death to have been a 'Suspected Bias Crime'.³⁷ The academic review team categorised Mr Allen's death as 'Gay Bias Related'.
106. Counsel Assisting submit at CA, [77] that there was more than sufficient evidence for SF Parrabell to have characterised Mr Allen's death as 'Evidence of bias crime', as opposed to the weaker characterisation of 'Suspected evidence of bias crime'.
107. The Commissioner of Police does not disagree with Counsel Assisting's characterisation. However, as submitted elsewhere, ascribing bias motivations is by no means a straightforward task; it is one in relation to which reasonable minds can – and do – differ. The SF Parrabell findings are not inconsistent with Counsel Assisting's propounded finding. Rather, Counsel Assisting take a more robust approach. Having regard to the possible alternative motivations for Mr Allen's assault, as noted by Counsel Assisting at CA, [111] to [114], two of the three possible alternative motivations would, on their face, appear to not arise from LGBTIQ bias. Notably, no perpetrators were identified for causing Mr Allen's death, which means that the actual intention is not known. On that basis, SF Parrabell's characterisation was an available one.

Anti LGBTIQ bias

108. The Commissioner of Police understands that Counsel Assisting intend to provide confidential submissions which address the possible motivations for the assault on Mr Allen. The Commissioner of Police proposes to respond, if necessary, to the further submissions in due course.
109. For present purposes, the Commissioner of Police agrees with Counsel Assisting's submissions in the open submissions to the effect that:
 - a One possible circumstance is that Mr Allen was assaulted by a group of people while he was attending Alexandria Park to use the toilet block as a beat. The Commissioner

³⁷ Exhibit 6, Tab 49, Strike Force Parrabell Case Summaries, 15 (SCOI.76961.00014).

of Police agrees that if that is so, there would be strong reason to suspect that the assault was motivated by LGBTIQ bias.

- b Another possibility is that Mr Allen's assault was because of his suspected or perceived involvement in abusing young boys. There is no evidence presently available to the Commissioner of Police to suggest that there was in fact a conflation of homosexuality and paedophilia (if this was the motivation). For completeness, the Commissioner of Police concurs generally that any such conflation is offensive and has caused substantial harm to the gay community.
- c Mr Allen's dealings in drugs apparently resulted in his possession of a large amount of cash, which was kept in his home. There was no evidence, however that anything was stolen from Mr Allen's home after the attack on him nor that this was the motivation for the assault on him.

Manner and cause of death

- 110. The Commissioner of Police supports the submissions made by Counsel Assisting that the coronial finding as to the manner and cause of Mr Allen's death remains appropriate, namely that he died on 29 December 1988 "of the effects of head injuries sustained on the night of 28 December 1988 when he was beaten by persons unknown in Alexandria Park" (CA, 108)].

per 
Mark Tedeschi KC
 Wardell Chambers

per 
Anders Mykkeltvedt
 Maurice Byers Chambers


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5 September 2023

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