2022 Special Commission of Inquiry

into LGBTIQ hate crimes

Before: The Commissioner,
The Honourable Justice John Sackar

At Level 2, 121 Macquarie Street,
Sydney, New South Wales

On Thursday, 30 March 2023 at 10.05am

(Day 42)

Ms Christine Melis	**(Counsel Assisting)**
Mr William de Mars	**(Counsel Assisting)**
Ms Kate Lockery	**(Principal Solicitor)**
Ms Caitlin Healey-Nash	**(Senior Solicitor)**
Ms Francesca Lilly	**(Solicitor)**

Also Present:

Mr Anders Mykkeltvedt and Mr Patrick Hodgetts for NSW Police

1 THE COMMISSIONER: Yes.
2
3 MS MELIS: Commissioner, I appear to assist you,
4 instructed by Ms Lilly.
5
6 THE COMMISSIONER: Thank you.
7
8 MR MYKKELTVEDT: Yes, your Honour, I appear for the
9 Commissioner of Police.
10
11 THE COMMISSIONER: Thank you, Mr Mykkeltvedt. Yes,
12 Ms Melis.
13
14 MS MELIS: Commissioner, these submissions address the
15 death of Carl Gregory Stockton.
16
17 THE COMMISSIONER: Thank you.
18
19 MS MELIS: Commissioner, I have some material in this
20 matter that I seek to hand up.
21
22 THE COMMISSIONER: Yes, thank you.
23
24 MS MELIS: Commissioner, unless there is any objection,
25 I tender the bundle of material.
26
27 THE COMMISSIONER: Thank you.
28
29 MR MYKKELTVEDT: No objection.
30
31 **EXHIBIT #18 BUNDLE OF DOCUMENTS TITLED "TENDER BUNDLE CARL**
32 **STOCKTON"**
33
34 MS MELIS: I also hand up, Commissioner, short minutes of
35 order with respect to non-publication orders in this
36 matter, and my written submissions.
37
38 THE COMMISSIONER: Thank you.
39
40 MR MYKKELTVEDT: The non-publication orders are by consent
41 again, your Honour.
42
43 THE COMMISSIONER: Thank you, Mr Mykkeltvedt.
44
45 Yes, I have made those orders, thank you.
46
47 MS MELIS: Commissioner, as I have mentioned, these

1 submissions address the death of Carl Gregory Stockton.
2 Unfortunately, Mr Stockton's parents are deceased. The
3 Inquiry wrote to other family members, however, no
4 responses have been received.
5
6 The coronial file and NSW Police file into
7 Mr Stockton's death were received by the Inquiry and formed
8 the basis of its review into his death. Relevant medical
9 records were also summonsed.
10
11 We have a photo of Mr Stockton, Commissioner, if that
12 could please be put up on the screen.
13
14 THE COMMISSIONER: Thank you.
15
16 MS MELIS: This is Mr Stockton. His death is both sad and
17 tragic. On the afternoon and evening of 5 November 1996,
18 being Melbourne Cup Day, Mr Stockton was drinking at the
19 Bar Cleveland in Redfern. He was a regular patron there.
20 He left the bar at about 11.30pm in a state of
21 intoxication.
22
23 At about 1am on 6 November 1996, he was found lying on
24 the roadway in Cleveland Street near the intersection with
25 Bourke Street, very close to the Bar Cleveland. He had
26 suffered severe head injuries, which, on the evidence at
27 the time, were likely to have been the result either of
28 a fall or of being struck by a car or of an assault.
29
30 Five days later, on 11 November 1996, Mr Stockton died
31 from those injuries in hospital.
32
33 The Inquiry's investigations have confirmed that
34 Mr Stockton's injuries were more likely than not the result
35 of an assault on him, but there have never been any persons
36 of interest identified. I will come to the detail of that
37 shortly.
38
39 This is what we know about Mr Stockton. He was
40 52 years old at the time of his death and lived alone in
41 Surry Hills. He worked as a train driver and had
42 a particular interest in trains and motor vehicles. He
43 owned several cars and was a member of the Rolls-Royce
44 Owners' Club of Australia.
45
46 Mr Stockton was gay. He had confided to various close
47 friends that he was gay. One friend said that she was

1 aware that years ago, Mr Stockton used to cruise for sexual
2 partners, but that this was no longer his practice at the
3 time of his death. He was described by friends as
4 eccentric, gentle and thoughtful.
5
6 Strike Force Parrabell found that there was
7 insufficient information to conclude that Mr Stockton's
8 death was a bias crime, and it will be my ultimate
9 submission, Commissioner, that despite evidence that
10 Mr Stockton was likely the victim of assaults because he
11 was gay earlier in his life in the mid to late '80s, the
12 evidence does not provide an adequate basis for a finding
13 that his death was motivated by LGBTIQ bias.
14
15 Commissioner, before I take you through the events of
16 5 and 6 November 1996, we need to revisit some earlier
17 events that took place in Mr Stockton's life to give the
18 events of 5 and 6 November some context.
19
20 As alluded to, there is evidence which suggests that
21 Mr Stockton may have been the victim of one or more
22 assaults motivated by LGBTIQ hate in the mid to late 1980s,
23 a period in Sydney 's history marred by violence against
24 the LGBTIQ community.
25
26 Mr Stockton's friend Peter Moore recalls Mr Stockton
27 telling him about one of these assaults in about 1986. If
28 we could please bring up Mr Moore's statement, tab 25,
29 paragraph 4 [SCOI.00045.00106_0001]. He tells it this way:
30
31 *One night I saw that he had a few bruises*
32 *on the side of his head and I said, "What*
33 *happened to you?" And he said, "I am*
34 *a homosexual, it happens occasionally."*
35
36 Mr Moore recounts that homosexuality was looked upon in a
37 different light than it is today, meaning 1997, when his
38 statement was made.
39
40 Another of Mr Stockton's friends, Gavan McLennan, said
41 that he knew that Mr Stockton had been bashed twice before.
42 The first, he said, was a long time ago when Mr Stockton
43 was due to go on a trip to China. He had been bashed the
44 night before and could not go. The second assault was six
45 or seven years prior to Mr Stockton's death, putting this
46 incident at around 1989 or 1990. Mr McLennan recalls
47 getting a call from Mr Stockton, who said he had been

1 bashed in Sydney and fled to Port Macquarie, where he was
2 staying in a motel for about five nights. He later told
3 Mr McLennan that the assault happened after he got off
4 a bus and was walking through Moore Park, a known beat.
5
6 Mr McLennan recalls that when Mr Stockton came to stay
7 with him shortly afterwards, he had bruising on his face.
8 Mr McLennan's statement is at tab 22 of the tender bundle.
9
10 Mr Stockton's father, Esmond Stockton, also recalled
11 Mr Stockton being assaulted, possibly six or seven years
12 previously at his home, by two or three people. He
13 suffered a broken finger and was apprehensive of further
14 attack. His father mentioned that Mr Stockton was also
15 robbed some months prior to his death. A camera,
16 electronic gear and antique jewellery were taken.
17
18 Mr McLennan told police that Mr Stockton was
19 particular about the doors to his house being locked.
20
21 Geoffrey Raymond Tyson had known Mr Stockton since
22 1982 through a shared interest in motor vehicles. About
23 a month prior to his death, Mr Stockton mentioned to
24 Mr Tyson that "People around here don't like me", and spoke
25 about moving to another suburb. He did not specify who
26 these people may have been.
27
28 There is one further notable event that needs to be
29 mentioned, Commissioner. About a month prior to his death
30 on 5 October 1996, at around 11pm, Mr Stockton attended the
31 Shakespeare Hotel in Surry Hills on his way home from work.
32 At around 12.16am on 6 October, police were contacted
33 regarding a possible assault on an intoxicated person,
34 being Mr Stockton, near the hotel.
35
36 Police initially struggled to rouse Mr Stockton from
37 sleep outside the hotel and noted he smelt strongly of
38 alcohol but showed no visible injuries. He was escorted to
39 Missionbeat Campbell House, a proclaimed place where
40 intoxicated persons were provided with beds and care.
41
42 Whilst at Campbell House, Mr Stockton attempted to
43 leave his bed and get into the linen cupboard. In doing
44 so, he fell backwards and struck his head on the ground.
45 This fall rendered him unconscious for two to three
46 minutes.
47

1 On this occasion, he was taken by Missionbeat staff to
2 Sydney Hospital emergency department, where he said he had
3 no memory since attending the Shakespeare Hotel.
4
5 Following discharge on 6 October 1996, Mr Stockton
6 experienced significant shoulder pain and upon attending
7 St Vincent's Hospital on 8 October was found to have
8 a fractured clavicle, for which he subsequently wore
9 a sling.
10
11 A close friend of Mr Stockton recalled that he had
12 been evasive regarding how he had injured his clavicle. He
13 initially told the friend that he had tripped on the stairs
14 and fallen, and then said he would tell her later how it
15 happened.
16
17 This may indicate some level of embarrassment or shame
18 around how the injury was obtained, and may raise the
19 possibility of another assault, but there is no way of
20 knowing.
21
22 Mr Stockton would still be wearing the sling a month
23 later, on Melbourne Cup Day, and his fate that night would
24 take somewhat of a similar trajectory to the events a month
25 earlier.
26
27 Turning now to the events of 5 and 6 November 1996, on
28 5 November, Mr Stockton was drinking alone at a table at
29 the Bar Cleveland. It was typical for him to attend the
30 bar alone and play a card machine in the back bar. He
31 suffered from anxiety and depression and told his general
32 practitioner that he drank approximately four to six drinks
33 a day.
34
35 At approximately 2pm, Mr Stockton was observed by
36 a fellow patron, Nathan Starcic, to be slurring his speech
37 and showing bloodshot eyes, though he was responsive to
38 conversation. Mr Starcic formed the view that Mr Stockton
39 was intoxicated. His arm was in a sling.
40
41 While evidence as to Mr Stockton's activities
42 throughout the day is sparse, it is possible that he
43 remained at the same table and continued drinking
44 throughout the day and into the night as he was again seen
45 by Mr Starcic at approximately 11pm and still appeared
46 drunk. A number of bar staff were working at the
47 Bar Cleveland that evening, including Brent Tozer, the

1 manager, and Magda Kos, a bar attendant. Ms Kos recalls
2 Mr Stockton leaving around 11.30pm and being slightly
3 intoxicated.
4
5 Mr Stockton is believed to have then purchased
6 take-away drinks from the bottle shop, as was his habit.
7 The pub closed around midnight.
8
9 Brigette Paroissien and her boyfriend Robert Diliberto
10 lived in a house which backed on to Matterson Lane behind
11 the Bar Cleveland. At around 12.50am on 6 November 1996,
12 Ms Paroissien returned to her home. She entered via the
13 unlocked back gate and discovered Mr Stockton in her
14 garden.
15
16 Mr Stockton provided no explanation for his presence
17 and when Ms Paroissien attempted to help him up, he said,
18 "Nah, can't move". Ms Paroissien then woke up her
19 boyfriend, Mr Diliberto, who came to the garden to assist.
20 Both tried to speak to Mr Stockton but he didn't answer
21 them. They helped him through the back gate and into the
22 laneway before lowering him to the ground. Ms Paroissien
23 saw Mr Stockton get up and take a few steps before falling
24 into some garbage bins. She and her boyfriend then went
25 back inside.
26
27 At around 1.15am on 6 November 1996, Ms Kos was
28 cleaning up in the back bar of the Bar Cleveland when she
29 was approached by a man who said, "There's an old guy
30 that's collapsed outside. I think you should call
31 someone." She then spoke to Mr Tozer, who was in the front
32 bar.
33
34 Mr Tozer walked out on to Cleveland Street and saw
35 Mr Stockton lying on his back, across the inside lane of
36 Cleveland Street, at the corner of Bourke Street.
37 Together, Mr Tozer and Gavin James, a patron of the
38 Bar Cleveland, who had been inside helping staff, lifted
39 Mr Stockton under the arms and helped him walk to the steps
40 of the hotel. Mr Tozer asked Mr Stockton where he lived, to
41 which he replied, "I don't know."
42
43 Mr Andrew Phillips, a friend of Mr Starcic, recalled
44 seeing a group of three to four people standing in a circle
45 outside the pub at the corner of Cleveland and Bourke
46 Street shortly before Mr Stockton was brought into the pub.
47 These people have never been identified; nor were they the

1 subject of any investigation. I will say more about this
2 in due course.
3
4 Mr Tozer brought Mr Stockton into the hotel and sat
5 him on a chair. He called Missionbeat to attend.
6 Mr Stockton had a black right eye and a small cut
7 underneath his eye. He tried to speak but was incoherent.
8
9 If we could now please bring up Mr Starcic's statement
10 at tab 27, paragraph 15 [SCOI.00045.00071_0001].
11 Mr Starcic said this about Mr Stockton:
12
13 *The only thing that he was able to say was,*
14 *"I've had enough. I want someone to take*
15 *me around the back and kill me." He said*
16 *that about 10 or 15 times. We tried to*
17 *calm him down and got a bag of ice and*
18 *placed it on his right eye.*
19
20 Mr James also said he heard Mr Stockton say, "I want to
21 die" two or three times.
22
23 I pause here, Commissioner, to observe that
24 Ms Paroissien did not describe in her statement Mr Stockton
25 as having facial injuries when she found him in her
26 backyard. If this is accurate, it can be inferred that
27 Mr Stockton sustained his head injuries after she left her
28 backyard and before he was found collapsed.
29
30 At around 1.30am, Eric-Emmanuel Hooson and Marc Leslie
31 William Kay, welfare officers with Missionbeat, arrived and
32 assessed Mr Stockton. They asked him how he had obtained
33 his black eye, to which Mr Stockton responded, "I don't
34 know." He advised that he had been drinking all day.
35
36 Mr Stockton was then taken again to Campbell House
37 Surry Hills, where he was helped to change into pyjamas and
38 given a bed by staff. At approximately 11.30am on
39 6 November, it was observed that Mr Stockton had vomited,
40 for what was by then a second time. He was observed to be
41 very disoriented and in a lost state, when asked if he was
42 okay, he replied "Help me". A short while later, he was
43 conveyed to Sydney Hospital by Missionbeat staff.
44
45 At about 11.40am on 6 November, Mr Stockton was
46 admitted to the accident and emergency unit at Sydney
47 hospital and later transferred to St Vincent's Hospital for

1 neurosurgical management.
2
3 In addition to his black eye and the pre-existing
4 fractured right clavicle, a CT scan showed very significant
5 head injury, with one doctor expressing doubts as to
6 Mr Stockton's chances of survival.
7
8 Mr Stockton's brother-in-law, a Dr Bruce Doust, who at
9 the time was the director of radiology at St Vincent's
10 Hospital, opined that, Mr Stockton's was the most severe
11 brain injury he had ever seen and could only describe it as
12 "monstrous".
13
14 Two police officers, Constables Moss and Sparkes,
15 attended Mr Stockton at St Vincent's Hospital on 6 November
16 1996. The exchange is worth highlighting. It is at
17 tab 18, paragraph 8, on page 3 [SCOI.00045.00084_0001].
18 The exchange went like this:
19
20 *"I am Tony Moss from the Surry Hills*
21 *detectives, can you tell us how you*
22 *suffered your injuries?"*
23 *The deceased said, "No."*
24 *I said, "Can you tell me how you got your*
25 *black eye?"*
26 *The deceased said, "No."*
27 *I said, "Were you assaulted?"*
28 *The deceased said, "No."*
29
30 Constable Moss said in his statement that Mr Stockton
31 was vague when spoken to and did not appear to fully
32 understand questions asked of him at that time. On
33 11 November 1996, at 4.40pm, Mr Stockton died at
34 St Vincent's Hospital from his injuries.
35
36 Upon review of the materials in this case,
37 Commissioner, there were three aspects to Mr Stockton's
38 death that, on the evidence, had been left wanting.
39 Firstly, there was a divergence of opinion among the
40 medical professionals about how Mr Stockton came to sustain
41 his fatal head injuries. To that end, the manner in which
42 Mr Stockton sustained his severe head injuries remained
43 open at the inquest into his death.
44
45 Secondly, there was a suggestion that there had been
46 anti-gay taunts made to Mr Stockton at the Bar Cleveland,
47 where he had been drinking on 5 November 1996. There was

1 no evidence of any inquiries being made about this in the
2 original police investigation.
3
4 Thirdly, there was information received from the
5 public about a group of white males preying on patrons as
6 they left the Bar Cleveland. The documents do not show
7 police further investigating this aspect or seeking to
8 discover whether there was any correlation between this
9 information and the three or four people that Mr Phillips
10 had seen on the corner of Bourke and Cleveland Streets when
11 Mr Stockton was found collapsed. As mentioned, to date, no
12 persons of interest have ever been identified in
13 Mr Stockton's death.
14
15 I will now take each issue in turn and outline the
16 evidence and further steps taken by the Inquiry in respect
17 of each.
18
19 Turning to the first issue, the manner and cause of
20 Mr Stockton's death, on the morning of 12 November 1996,
21 a post-mortem examination was performed at Glebe morgue by
22 Dr Christopher Lawrence. The autopsy revealed massive head
23 injuries, with three apparent areas of impact to the head.
24 The main injury was to the rear of the head.
25
26 Bruising to the legs, chest and arms was also
27 observed. It was noted that some of Mr Stockton's injuries
28 appeared older, including historic rib fractures and, of
29 course, the fractured right clavicle.
30
31 The antemortem blood sampling taken at around 12pm on
32 6 November upon admission to Sydney Hospital revealed
33 a blood alcohol level of 0.014 grams per 100mm, and
34 Diazepam was also present.
35
36 In his autopsy report, Dr Lawrence considered that
37 Mr Stockton's injuries, in particular the three impact
38 sites, were inconsistent with a single fall, and described
39 them as "odd". He opined that the pattern of injuries
40 could represent an assault, though the severity of the
41 injuries left open the possibility of Mr Stockton's being
42 struck by a motor vehicle.
43
44 An inquest was held on 1 December 1998 before Senior
45 Deputy State Coroner John Abernethy. At the inquest,
46 Dr Lawrence gave evidence that it was, in his professional
47 opinion, unlikely that Mr Stockton's injuries were the

1 consequence of a motor vehicle collision, noting that such
2 injuries to the head from motor collisions typically cause
3 death instantaneously.
4
5 Overall, Dr Lawrence's evidence was that it was not
6 possible to determine whether Mr Stockton's injuries were
7 caused by an assault, a fall or multiple falls, or an
8 assault followed by a fall. However, he expressed
9 reluctance to classify Mr Stockton's death as an accident,
10 and noted that any falling injuries may have been sustained
11 following an assault.
12
13 A consultant neurosurgeon, Dr John Matheson, provided
14 an expert opinion to the Coroner. Dr Matheson also
15 regarded Mr Stockton's injuries as inconsistent with the
16 impact of a motor vehicle collision. He expressed the
17 positive view that Mr Stockton's injuries pointed clearly
18 to an assault, with repeated head injuries.
19
20 One of Mr Stockton's treating doctors at St Vincent's
21 Hospital, Dr Raj Wijetunga, formed a similar opinion,
22 namely, that Mr Stockton's intracerebral haemorrhages and
23 extensive skull fractures were as a result of blunt trauma
24 and severe force to the back of the head.
25
26 By contrast, Dr Anthony Moynham, at that time Director
27 of the NSW Police Clinical Forensic Medicine Unit, provided
28 a statement in which he expressed the opinion that
29 Mr Stockton's injuries could have been the result of a fall
30 or a glancing type of blow from a large object, such as
31 a motor vehicle.
32
33 The Coroner made his findings on 1 December 1998. If
34 those could please be brought up, they can be found at
35 tab 49 [SCOI.0045.00001_0001]. I specifically wish to take
36 you to page 13. The Senior Deputy Coroner said of
37 Mr Stockton's case that:
38
39 *It is one of those cases where sadly I have*
40 *to record an open finding as to the manner*
41 *in which Mr Stockton came by those*
42 *injuries. We know who he is and we know*
43 *when he sustained his injuries and when he*
44 *died and where he died. We know what he*
45 *died of but we do not know how he came by*
46 *the injuries that killed him.*
47

1 He ultimately found that Mr Stockton died on 11 November
2 1996 at Darlinghurst of craniocerebral injuries suffered on
3 or about November 1996 at Redfern. As to how such injuries
4 were sustained, the evidence adduced, he said, "does not
5 enable me to say".
6
7 Given diverging state of the evidence as to how the
8 injuries were sustained, the Inquiry briefed forensic
9 pathologist, Dr Linda Iles. Dr Iles was requested to
10 provide her expert opinion on the manner and cause of
11 Mr Stockton's death, including whether it was likely that
12 the death was the result of a fall or being struck by
13 a motor vehicle or by an assault. Dr Iles's report was
14 received on 10 March 2023 and is at tab 54 of the tender
15 bundle.
16
17 She described Mr Stockton's cause of death as "blunt
18 head injuries". She notes that the description is
19 approximately equivalent to the cause of death given by the
20 pathologist, Dr Lawrence - that is, craniocerebral
21 injuries.
22
23 In Dr Iles's opinion, the pattern of skull fractures
24 observed is due to very significant blunt force impact to
25 the back of Mr Stockton's head. Dr Iles considers that
26 Mr Stockton's head injuries clearly cannot be accounted for
27 by a simple fall. A fall from a significant height with
28 impact to the back of the head may be able to produce this
29 pattern of skull fractures but does not appear plausible,
30 she says, in the circumstances as described.
31
32 Dr Iles considers that Mr Stockton's lack of
33 post-cranial injuries makes it unlikely that this pattern
34 of skull fractures was caused by an impact from a motor
35 vehicle. However, she considers that Mr Stockton's pattern
36 of injuries could be accounted for by an assault, with
37 multiple forceful impacts to the head. She adds that an
38 accelerated fall on to the back of the head could also be
39 accommodated in this scenario.
40
41 It is submitted, Commissioner, that with the inclusion
42 of Dr Iles's opinion, the preponderance of the medical and
43 expert evidence supports a finding that Mr Stockton's head
44 injuries were caused by an assault rather than a fall or
45 being hit by a motor vehicle.
46
47 Moving now to the second unresolved issue identified

1 by the Inquiry - that is, the suggestion of homophobic
2 taunting towards Mr Stockton at the Bar Cleveland.
3
4 At the time of Mr Stockton's death in 1996, Ms Sue
5 Thompson was serving as the gay liaison coordinator for
6 NSW Police.
7
8 Many years later, in 2016, journalist Rick Feneley
9 published an expose titled, "The Gay Hate Decades", which
10 cited Ms Thompson as saying that Surry Hills police had
11 told her at the time of Mr Stockton's death in 1996 that
12 patrons at the bar had heard a lot of anti-gay taunts made
13 to Mr Stockton.
14
15 On the Inquiry's review, none of the police reports
16 or witness statements included any reference to such
17 anti-gay comments having been directed at Mr Stockton at
18 the Bar Cleveland. The Inquiry made contact with Ms Sue
19 Thompson. She said that her recollection was that at least
20 one police officer or detective had told her of the
21 anti-gay taunts, but she could not recall who that was.
22
23 Ms Thompson looked back over her old diaries, which
24 thankfully she had kept, and for the date Friday,
25 15 November 1996, she had noted, "Phone call with Detective
26 Neil Walker - gay murder". This was only four days after
27 the date of Mr Stockton's death and Detective Senior
28 Constable Neil Walker was the officer in charge of the
29 case.
30
31 Detective Walker's original statement to the Coroner
32 was detailed and contained no reference to any such
33 taunting. It is at tab 8 of the tender bundle.
34
35 A member of the Inquiry's investigations team made
36 contact with the former officer in charge. Mr Walker
37 advised that he, "did not receive any information, either
38 direct or anecdotal, that Mr Stockton's death was as the
39 result of a hate crime against him as a result of his
40 sexual orientation". Nor, he said, did he have any witness
41 or anecdotal evidence of any homophobic taunts towards
42 Mr Stockton.
43
44 Commissioner, this closed off this area of inquiry.
45
46 Mr Walker did say, however, that he was assigned the
47 investigation into Mr Stockton's death about 48 hours after

1 he was taken to St Vincent's Hospital, which he says
2 impacted both available physical and witness evidence. The
3 exchange can be found at tab 59 of the tender bundle, at
4 annexure A.
5
6 Moving now to the third issue, Commissioner, the
7 absence of any persons of interest in Mr Stockton's death.
8 As mentioned, no specific persons of interest have ever
9 been identified by police in Mr Stockton's death. This was
10 despite a public appeal for witnesses to come forward with
11 information on 13 November 1996, and information about
12 Mr Stockton's death being published on the internet on
13 20 May 1997, as well as a segment on Australia's Most
14 Wanted on 30 June 1997.
15
16 It is, however, worth observing that Eric-Emmanuel
17 Hooson, who you would recall was one of the welfare
18 officers from Missionbeat, that collected Mr Stockton from
19 the Bar Cleveland, recounted in his statement that he had
20 heard rumours from a co-worker that, on the street, people
21 believe that four Caucasian males who frequent the
22 Bar Cleveland had perpetrated a number of similar assaults
23 in the vicinity of Bourke and Cleveland Streets.
24
25 Police did not obtain a statement from the co-worker
26 in relation to this information, and according to the
27 Strike Force Parrabell Bias Crimes Indicators Form, we're
28 unable to identify any historical events in the vicinity of
29 Bourke and Cleveland Streets to support the claim.
30
31 Further, some five months later, on 27 April 1997,
32 information was received by police from a source identified
33 only as "the general public", that assaults were being
34 committed on persons who drink at the Cleveland Hotel by
35 a group of "young white males", who were preying on
36 drinkers as they left the hotel. The source believed that
37 the majority of the assaults were not being reported to
38 police.
39
40 It is submitted that the absence of documented reports
41 of other bashings in the area would not necessarily
42 indicate that such bashings had not occurred.
43
44 Evidence before this Inquiry in November last year has
45 shown that it was common for victims of LGBTIQ bias crimes
46 not to report to police in the 1980s and 1990s, having
47 regard to the context at the time of mistrust of and

1 fractious relations with police amongst the LGBTIQ
2 community.
3
4 On the material available to the Inquiry, it is not
5 apparent that any investigation by NSW Police was conducted
6 into the young white males referred to in the contact from
7 a member of the public, nor the group of three or four
8 people observed by Mr Phillips when Mr Stockton was found
9 collapsed, and whether there was any correlation between
10 the two pieces of information.
11
12 Further investigation in this regard at the relevant
13 times that that information was received may have opened up
14 new lines of inquiry.
15
16 As mentioned, Commissioner, the Deputy State Coroner,
17 in making his findings, said he was sorry to have to record
18 an open finding as to the manner in which Mr Stockton came
19 by his fatal injuries. He went on to say more, and I wish
20 to quote that now. If we could please bring up tab 49
21 [SCOI.00045.00001_0001] again, at page 13. The Coroner
22 said this:
23
24 *If anyone comes forward the police will be*
25 *able to re-open the matter and they will*
26 *re-open the matter and that is not just*
27 *empty words, that does happen from time to*
28 *time, people walk into police stations and*
29 *say, "I have had this on my conscience for*
30 *a long time. I hit a bloke in a pub at*
31 *Redfern and I found out he died and I've*
32 *lived with it and I don't want to live with*
33 *it anymore."*
34
35 Of course, anyone listening today who may remember
36 something about Mr Stockton on 5 or 6 November 1996, or has
37 any information about how he came to sustain his fatal
38 injuries, can make contact with the Inquiry or with police.
39
40 Commissioner, as to the original police investigation,
41 I make the following pertinent observations. The homicide
42 investigation known as Strike Force Altea, commenced on
43 12 November 1996 following Mr Stockton's death, and
44 proceeded until the coronial findings were made on
45 1 December 1998.
46
47 Robbery was ruled out as a motive due to Mr Stockton's

1 retention of valuable items on his person, specifically,
2 his mobile phone and wallet. Although his keys were
3 missing, there was no evidence of intrusion at his home
4 address or theft of his motor vehicle, which was
5 a Rolls-Royce.
6
7 In the course of Strike Force Altea, police actioned
8 a number of investigative steps. These are all outlined at
9 paragraph 48 of my written submissions, and I will not
10 repeat them all here, other than to highlight the
11 following.
12
13 On 9 November 1996, police conducted a search of the
14 parkland in Moore Park, a known beat. No signs of an
15 assault or a struggle were observed. A number of pieces of
16 timber that were located in Matterson Lane on 12 November
17 1996 were examined and ruled out as being connected to
18 Mr Stockton's death. Fingerprint testing of Mr Stockton's
19 wallet and its contents, as well as wine and beer bottles
20 from his premises, was also conducted, without relevant
21 result.
22
23 An examination of the clothing Mr Stockton wore when
24 at the Bar Cleveland was undertaken on 13 November 1996.
25 The examination identified soils visibly similar to that
26 located on the laneway behind the Bar Cleveland. Whether
27 this clothing was retained at the time is unclear from the
28 materials so far provided to the Inquiry. The Inquiry has
29 made some further inquiries with NSW Police Force to
30 clarify the status of the exhibits obtained in relation to
31 Mr Stockton's death.
32
33 On 13 November 1996, a press release was made
34 requesting any witnesses come forward, and finally, details
35 of Mr Stockton's death were published online on 20 May
36 1997, and on the television program Australia's Most Wanted
37 on 30 June 1997.
38
39 Police followed up a resulting line of inquiry that
40 suggested Mr Stockton had once intervened in an assault by
41 the previous licensee of Bar Cleveland on an acquaintance.
42 That inquiry did not produce any result of significance.
43
44 I turn now, Commissioner, to my overall conclusions.
45 I say this with respect to conclusions as to bias: it is
46 uncontroversial that Mr Stockton was gay and that, in the
47 past, he had cruised for sexual partners. There is also

1 evidence of several assaults on Mr Stockton in the mid to
2 late 1980s, approximately eight to 10 years prior to his
3 death, including in Moore Park, a known beat. Comments
4 made by Mr Stockton to his friend Mr Moore in relation to
5 one of those assaults suggest that he believed he had been
6 assaulted at that time because he was gay.
7
8 The circumstances of Mr Stockton's collarbone injury
9 about a month prior to his death are unclear, but on the
10 available evidence, it seems likely that he was intoxicated
11 and fell after drinking at the Shakespeare Hotel.
12
13 At the time of the 1998 inquest, each of Dr Lawrence
14 and Dr Matheson had considered with greater or lesser
15 emphasis that Mr Stockton's injuries in November 1996 were
16 consistent with his having been assaulted. The expert
17 opinion of Dr Iles in 2023 substantially endorses those
18 earlier views.
19
20 However, the identity of the perpetrators of such an
21 assault remains unknown. Suggestions that a group of white
22 males were believed to have perpetrated a number of similar
23 assaults in the vicinity of Bourke and Cleveland Streets
24 did not lead to any more substantive evidence or
25 intelligence at the time, and the available material does
26 not permit those suggestions now to be pursued further by
27 this Inquiry.
28
29 The investigation by the Inquiry of the separate
30 suggestion of alleged gay taunts towards Mr Stockton on the
31 night he was drinking at the Bar Cleveland has not yielded
32 any information that might assist in investigating his
33 death. It is submitted that, on the available evidence, it
34 is not possible to say whether Mr Stockton's death was the
35 result of an LGBTIQ hate crime.
36
37 As to manner and cause of death, Commissioner, it is
38 submitted that the finding of the Coroner in this matter
39 not be disturbed and that an appropriate finding as to
40 manner and cause of death would be that Mr Stockton died on
41 11 November 1996 at Darlinghurst as a result of
42 craniocerebral injuries inflicted on or about 5 November
43 1996 at Redfern by a person or persons unknown.
44
45 Those are my submissions.
46
47 THE COMMISSIONER: Thank you.

1
2 MR MYKKELTVEDT: Nothing to say by way of oral submissions
3 at this time, Commissioner.
4
5 THE COMMISSIONER: All right. Thank you. Thank you,
6 Ms Melis.
7
8 I might take a short break now and we will resume with
9 Mr de Mars in a moment or two.
10
11 **SHORT ADJOURNMENT**
12
13 MR de MARS: Commissioner, I appear as Counsel Assisting.
14 This is a hearing in relation to the death of Mark Stewart.
15
16 THE COMMISSIONER: Thank you.
17
18 MR de MARS: Can I firstly hand up a tender bundle
19 of material prepared for this matter. It comprises of
20 43 separate tabbed items, and if that's received into
21 evidence, your Honour, I understand it will be
22 exhibit number 19.
23
24 **EXHIBIT #19 BUNDLE OF DOCUMENTS TITLED "TENDER BUNDLE MARK**
25 **STEWART"**
26
27 MR de MARS: I understand that short minutes of order are
28 now before you. They relate to certain redactions, and in
29 one instance there's a pseudonym that's proposed, and
30 I would ask that those orders be made under section 8 of
31 the governing legislation.
32
33 THE COMMISSIONER: Thank you.
34
35 MR MYKKELTVEDT: They are agreed.
36
37 THE COMMISSIONER: Thank you very much, Mr Mykkeltvedt.
38
39 MR de MARS: Thirdly, and again I understand this has
40 already been handed up, I refer to the written submission
41 that has been prepared and I adopt that written submission.
42
43 THE COMMISSIONER: Thank you very much.
44
45 MR de MARS: Commissioner, Mark Stewart died on 10 or
46 11 May 1976 at a headland near a place known as Fairy Bower
47 in the Sydney suburb of Manly. He was 18 years old when he

1 died.
2
3 Growing up, his name was Mark Spanswick. A year or so
4 before his death, he changed his name to Mark Stewart by
5 deed poll.
6
7 At around 10am on 11 May 1976, his body was discovered
8 lying on the rocks at the base of a cliff about 250 metres
9 south of what I will refer to as the Fairy Bower headland.
10 Prior to this, the last reported sighting of Mr Stewart was
11 at 9.30pm on 9 May 1976 at the Hilton Hotel on George
12 Street, in the Sydney central business district, where he
13 had booked a hotel room for two nights.
14
15 I pause at this point to make some observations about
16 the description of the area where the body was found and
17 the degree of certainty as to the precise location. For
18 this purpose, I would ask that the two maps that appear as
19 attachments to the written submissions be brought up on the
20 screen, please.
21
22 I might say, initially, Commissioner, the precise
23 location where Mr Stewart's body was found hasn't been
24 pinpointed beyond a description given by police at the time
25 that it was 250 metres south of the Fairy Bower headland,
26 or, alternatively, of Fairy Bower.
27
28 Commissioner, presently on screen is the first of two
29 maps, and you'll see on the first map the landmass known as
30 North Head filling most of the screen, and then you'll see,
31 towards the top of the map, how that geographical feature
32 then joins with the main commercial business district of
33 Manly.
34
35 Can I direct your attention in particular to the strip
36 of coast towards the top, just to the east of the reference
37 to "South Steyne", and the oceanfront beach area. You'll
38 see that that coastal strip comes around where you see the
39 words "Shelly Beach" in green, to the headland, just to the
40 right of those words "Shelly Beach".
41
42 That area of coast, Commissioner, is probably well
43 known by many as a fairly attractive coastal beach walk, if
44 I can describe it - sorry, coastal walk, if I can describe
45 it in that manner, and you will see that it takes one from
46 the surf beach at South Steyne across to Shelly Beach.
47

1 The bay area, so where there's a crook in that coastal
2 walk area, is known as Cabbage Tree Bay, and the land
3 adjacent to Cabbage Tree Bay has been known for a long time
4 as Fairy Bower.
5
6 That term, "Fairy Bower", has also come to be applied
7 at times to the area more generally, including to the
8 headland that rises above Shelly Beach. You can see that
9 area, Commissioner, circled in red on that map.
10
11 If we then move to the second map, which is a blown-up
12 portion in satellite form of the area we've just looked at,
13 you can see in satellite form the headland that was
14 circled. Can I make this observation: the terrain,
15 probably self-evidently, rises in height from the green
16 bushy area at the top as one proceeds south east to cliff
17 areas and rock platforms, as one passes the circled area of
18 Shelly Beach car park and then proceeds up to the area
19 that's labelled "Shelly Headland Upper Lookout".
20
21 Can I also just point out for future reference and
22 make the observation that one sees residential housing
23 along the strip as one approaches Shelly Beach on the
24 coastal walk, and one sees residential housing extending
25 along a street called Bower Street. You see the reference
26 to Bower Street Reserve. It ends up fairly close to the
27 headland area generally.
28
29 So given the shape of the relevant landmass and the
30 fact that it rises, the description given by police that
31 the body was found 250 metres south of Fairy Bower headland
32 leaves some imprecision as to the starting point for
33 measuring the 250 metres. Nevertheless, the description
34 seems to place it, or does place it, either within or very
35 close to an area now known to have been a beat from at
36 least the 1970s until the 1990s. The type of terrain
37 described by police at the cliff top is similar to that
38 known to have been used as part of the beat.
39
40 I would suggest, Commissioner, that the general
41 description in the police statements suggests that the area
42 from which Mr Stewart fell is likely to have been somewhere
43 in the vicinity of what's seen on the present map as what's
44 labelled as "Shelly Headland Upper Lookout", although it
45 may have been somewhat to the north or south of that
46 location.
47

1 The location in question is very close to the spot
2 from which a man in his 20s by the name of Paul Rath fell
3 to his death approximately 12 months later, this being
4 another death being considered by the Inquiry pursuant to
5 Part A of its Terms of Reference. Those maps could come
6 down from the screen, please.
7
8 Commissioner, I'll now take you to some of the
9 features of the matter that were observed as a result of
10 the police investigation at the time of Mr Stewart's death.
11
12 Mr Stewart's body was face-down at about 20 metres
13 from a cliff face. The cliff top was described as being
14 about 50 metres above. He was fully clothed. His shoes
15 were off but were in close proximity to his body. A piece
16 of banksia tree, similar to trees growing in the cliff top
17 above, was near the body, as was a men's Seiko wristwatch
18 which had stopped at 8.02 on Tuesday, the 11th.
19
20 Assuming the watch to have been accurate, it had
21 therefore stopped, it would seem, about two hours before
22 the body was found. While this suggests the possibility
23 that the death may have occurred at that time, it's also
24 possible, of course, that he died at some time earlier and
25 the watch stopped of its own accord at a later time.
26
27 His clothing included a denim jacket, light green
28 trousers, and what were described in newspaper reports as
29 distinctive green running shoes that had yellow stripes.
30
31 The only other items recorded as being found on
32 Mr Stewart were a cigarette lighter, a comb, around $15 in
33 cash and a piece of folded notepaper.
34
35 A search was conducted of the bush area in the
36 vicinity of the cliff top from which it was presumed
37 Mr Stewart fell. The search was described in a police
38 statement in the following terms:
39
40 *We then made an extensive search of the*
41 *headland near where it would appear the*
42 *deceased had fallen from. This area is*
43 *dense bushland with very rocky sections*
44 *jutting out of the bush, there are a number*
45 *of small trails leading from the roadway to*
46 *the edge of the cliff. A further search*
47 *was made of the edge of the cliff and this*

1 *area is also overgrown with dense bush and*
2 *it was noticed that there is no safety*
3 *fence or any other facility to prevent*
4 *persons from losing their footing and*
5 *falling to their deaths.*
6
7 The quote from the police statement continues:
8
9 *A thorough search of whole area by police*
10 *for any signs which explain how the*
11 *deceased came to fall to his death was made*
12 *and no sign of the persons (sic) prior*
13 *presence was found.*
14
15 A forensic pathologist, Dr Oettle, conducted
16 a post-mortem examination three days later on 14 May.
17 Dr Oettle recorded the direct cause of death as multiple
18 injuries, and estimated that death had taken place three to
19 four days previously - that is, 10 or 11 May. He listed
20 various bodily injuries that had been sustained by
21 Mr Stewart.
22
23 Toxicology testing was limited to testing for the
24 presence of alcohol, with none being found in Mr Stewart's
25 system.
26
27 Based on the police brief of evidence and Dr Oettle's
28 report, at a brief inquest held on 16 July 1976, the
29 Coroner found that Mr Stewart died of multiple injuries
30 sustained as a result of falling from the cliff top at the
31 Fairy Bower headland. He went on to say that he was
32 satisfied that there were, in his words:
33
34 *... no circumstances giving rise to*
35 *suspicion of foul play but that whether or*
36 *not the fall which caused the death was*
37 *accidental or was intended by the*
38 *[deceased] I am not able to determine on*
39 *the evidence, I will make an open finding*
40 *as to that.*
41
42 This Inquiry has obtained the opinion of an expert
43 forensic pathologist, Dr Linda Iles, the Head of Forensic
44 Pathology Services at the Victorian Institute of Forensic
45 Medicine, to review the autopsy report and address a number
46 of other matters, which are outlined at paragraph 52 of the
47 submission.

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1
2 Key aspects of Dr Iles's report are set out at
3 paragraph 89 and following of the submission. Dr Iles
4 agreed that Mr Stewart's cause of death was multiple
5 injuries, and considered that Mr Stewart's injuries were
6 consistent with a fall from a height of around 50 metres.
7
8 However, Dr Iles was unable to determine the manner of
9 Mr Stewart's death. She found that the documentation of
10 external injuries and marks in the autopsy report was
11 insufficient to address the presence or absence of subtle
12 injuries that might assist consideration of the possibility
13 of trauma being inflicted prior to the fall.
14
15 In particular, Dr Iles noted that the autopsy report
16 lacked a detailed description of external injuries,
17 provided no comment on the presence or absence of injury to
18 the aorta, larynx, ribs, sternal and lumbar areas, and gave
19 no description of the presence of anogenital injuries or
20 pathology.
21
22 Commissioner, after the retrieval of the body and the
23 search of the area in the vicinity of the cliff top, the
24 sole concern of the police investigation was evidently the
25 identification of the body.
26
27 At this point, I would ask for tab 23
28 [SCOI.82810_0001], please, to be brought up on screen. The
29 possibility of foul play being involved appears to have
30 been dismissed at a very early stage. This is apparent
31 from the Occurrence Pad entry made just five hours after
32 the body had been located.
33
34 Commissioner, you'll see in that entry firstly, one
35 sees the date and time, the typed entry appears to have
36 been made, at 3pm on the day the body was found. There are
37 certain entries made in handwriting, some of which it would
38 appear were made at a later time. But the typed entry on
39 the day includes the following references, that it was
40 apparent that the youth had either jumped or fallen from
41 the cliff top, and at the very bottom of the entry, it
42 states that there were no suspicious circumstances.
43
44 That entry could come down at this point.
45
46 Commissioner, the efforts of police to determine the
47 identity of the body led them on the evening of 13 May 1976

1 to the Hilton Hotel in George Street in Sydney's CBD. It
2 was discovered that Mr Stewart had booked in to the Hilton
3 Hotel at 9.30pm on Sunday, 9 May, for two nights.
4
5 A statement was obtained from the receptionist who
6 booked Mr Stewart in. I'm going to ask again for
7 a document to be brought up on screen, namely, tab 9
8 [SCOI.02724.00012_0001], which is the relevant statement
9 taken from the receptionist at the time.
10
11 The relevant things that I'd just point out to
12 your Honour at this point are that the author of that
13 statement, the receptionist who checked Mr Stewart in,
14 notes that no prior reservation had been made by
15 Mr Stewart. She gives a particular description of
16 Mr Stewart, that I just draw to your attention, because
17 really it's the last account anyone gives of contact with
18 Mr Stewart, in circumstances where, generally, there's very
19 limited information about him.
20
21 She describes him as slightly built, with fair
22 complexion and long, curly, unruly fair hair, which was
23 shoulder-length or thereabouts, and she says this:
24
25 *He had a very commanding manner and was*
26 *very self confident. He spoke with a well*
27 *educated voice and type of Public School*
28 *English.*
29
30 Commissioner, you'll see those words "Public School"
31 are capitalised, it would seem giving it a particular
32 meaning and not necessarily the meaning that one would
33 apply to those words presently in Australia. To put it
34 colloquially, it seems she was describing that he had
35 a fairly posh sort of English accent.
36
37 That document could come down at this point.
38
39 On 13 May, when police attended the Hilton Hotel in
40 the CBD, Mr Stewart's belongings remained in the hotel room
41 he'd booked in to. Police were able to positively identify
42 the body they had found two days earlier from the photo in
43 his passport that was found in his room. There were more
44 formal identification processes later undertaken with the
45 receptionist and also with Mr Stewart's father.
46
47 Commissioner, for three reasons, the assessment of the

1 manner and cause of Mr Stewart's death in this matter,
2 I suggest, is very challenging.
3
4 Firstly, it is submitted that from a very early stage,
5 whether appropriately or not, police approached the death
6 as one that did not involve foul play and hence the
7 investigation was very limited in its compass.
8 Investigative opportunities that may have been of
9 assistance if explored at the time of the death are now
10 impossible to pursue.
11
12 Secondly, for various reasons that I will come to,
13 very little is known about Mr Stewart's life circumstances
14 in the months leading up to his death, beyond the fact that
15 he had been living in rental accommodation in Brisbane.
16 This makes it particularly challenging to come to an
17 understanding about his mental state and intentions in
18 travelling to Sydney, and in particular in visiting Manly
19 and the Fairy Bower headland.
20
21 Thirdly, potential exhibits were either not retained
22 or have been lost. In particular, the piece of notepaper
23 that was located on his body could potentially have been
24 significant in helping to evaluate the likelihood that
25 Mr Stewart was a member of the LGBTIQ community.
26
27 Commissioner, I will now expand on each of those three
28 matters, starting with the limited approach of the police
29 investigation. The death occurred in 1976, now 47 years
30 ago. In the written submission at paragraphs 20 to 32
31 I make some observations concerning the historical context
32 in which the police investigation occurred. Without going
33 to the detail here, that context, it's submitted, was one
34 which does not appear to have been conducive to considering
35 and detecting whether a death in these circumstances may
36 have been a gay hate homicide.
37
38 Undoubtedly, assaults of gay men occurred in areas of
39 the Northern Beaches of Sydney during the 1970s. For
40 example, there is a documented instance of a gay hate
41 homicide in a suburb near Manly in late October 1975, less
42 than seven months prior to Mr Stewart's death. That matter
43 involved a number of young Navy recruits who were convicted
44 of the murder of a man at Curl Curl Beach, having met the
45 victim, a man by the name of Phillip Jones, and his friend
46 at a hotel in Manly Vale earlier in the evening.
47 Perceiving the men to be gay, the sailors lured them to the

1 beach and assaulted both of them, resulting in the death of
2 Mr Jones.
3
4 Further details of that matter can be found in
5 exhibits previously tendered in the Inquiry and referenced
6 in the written submission.
7
8 Commissioner, I mention that matter not to suggest any
9 association between that matter and Mr Stewart's death, but
10 rather to demonstrate that ideally, one might have hoped
11 that potential offending motivated by gay hatred would be
12 a consideration in the minds of police officers in that
13 era, particularly when investigating a death occurring in
14 proximity to a beat.
15
16 A key reason why his death was the subject of review
17 by Strike Force Parrabell was the proximity of the location
18 to a known beat, North Head. However, the extent of
19 understanding among local police of the existence of a beat
20 at North Head at the time is the subject of inconsistent
21 evidence.
22
23 The officer in charge in relation to Mr Stewart's
24 death has told the Inquiry that he had not been aware of
25 the existence of the beat in 1976, and it is not mentioned
26 in the documentary record of the investigation. However,
27 the officer in charge had not been stationed at Manly for
28 a lengthy period at the time of the death.
29
30 The Strike Force Parrabell review of the matter
31 acknowledged the beat's existence, which has been well
32 documented elsewhere both in evidence before the Inquiry
33 and in other proceedings.
34
35 Moreover, contemporaneous material suggests that at
36 least some Manly police officers must have been aware of it
37 by the mid 1970s. For example, The Manly Daily newspaper
38 article published on 27 May 1977, less than 12 months after
39 Mr Stewart's death, refers to a Starsky & Hutch beach
40 patrol policing crime in the beach areas of Manly and that
41 the patrol featured plain clothes officers who had, among
42 other things, busted homosexual activities at North Head.
43
44 It's evident that police investigating this matter
45 appear to have been oblivious to the possibilities both
46 that Mr Stewart may have been visiting the area in
47 connection with its known status as a beat and that someone

1 else may have been involved in the death.
2
3 Had there been an openness to the possibility that
4 Mr Stewart's death may have involved another party, there
5 may have been opportunities for police to immediately
6 canvass for information based on Mr Stewart's young age,
7 distinctive clothing, physical appearance and accent.
8
9 Such canvassing could have involved residents of
10 houses on the walk between Manly Beach and Shelly Beach and
11 those houses closest to the Fairy Bower headland at the end
12 of Bower Street, as well as Manly Ferry staff and ticket
13 sellers who were on duty, for example, early on 11 May.
14
15 Obvious questions may have included whether, if
16 noticed, Mr Stewart had been accompanied by anyone and
17 whether anyone was observed in his vicinity or otherwise
18 noticed to have been acting in a manner that aroused
19 suspicion.
20
21 Further, it's not clear whether any attempt was made
22 by police to speak with hotel staff, other than the
23 receptionist, with the aim of obtaining information about
24 anything that may have been known of Mr Stewart's movements
25 at any time after he checked in, including all day on
26 10 May and the morning of 11 May. If any attempt was made,
27 it doesn't appear to have been documented.
28
29 The second matter I alluded to that makes the
30 assessment of the cause and manner of Mr Stewart's death
31 challenging is the limited information that we have
32 concerning his background, particularly during the two
33 years prior to his death.
34
35 Information concerning Mr Stewart's background comes
36 largely from a statement made by his late father, Mr John
37 Spanswick, in 1976. The Inquiry has been able to confirm
38 and in some respects enhance that evidence by information
39 gained through recent contact that the Inquiry has had with
40 Mr Stewart's sister, who was two years younger than
41 Mr Stewart.
42
43 Mr Stewart was born in Papua New Guinea and was the
44 second of three children. The Spanswick family moved to
45 Fiji, when Mr Stewart was four or five years of age, in
46 connection with his father's work. While living in Fiji,
47 the family visited Manly on holiday on at least three

1 occasions for periods of six or seven weeks at a time.
2 Mr Stewart's sister has confirmed to Inquiry officers that
3 the family would visit Sydney for extended holidays from
4 Fiji. She stated that they would stay in both Manly and
5 Kings Cross during their holidays in Sydney.
6
7 Notably, both Mr Spanswick and Mr Stewart's sister
8 have observed that during these holidays, Mr Stewart would
9 enjoy walking in the Fairy Bower area, including around the
10 rocks.
11
12 Mr Stewart attended school in Fiji until he was 13 to
13 14 years old. He was then sent to a boarding school in
14 New Zealand. Following a recruitment visit to his school,
15 he joined the Royal New Zealand Navy as a cadet when he was
16 16 years old and was stationed at a training college in
17 Devonport.
18
19 During this time, Mr Stewart's parents received
20 regular correspondence from him. However, after some time,
21 Mr Stewart's letters indicated that he had become
22 disenchanted with Navy life and he sought permission from
23 his father to resign.
24
25 In August 1974, the Navy advised Mr Stewart's parents
26 that Mr Stewart had apparently deserted from the Navy and
27 was absent without leave.
28
29 Mr Stewart's parents emigrated from Fiji to
30 New Zealand in December 1974. They made extensive
31 inquiries to locate Mr Stewart but to no avail. However,
32 in mid 1975, Mr Stewart made contact with the family, and
33 came to New Zealand and stayed with his parents for a few
34 days.
35
36 Following this short stay, Mr Stewart's father drove
37 him to Christchurch where he caught a flight to Brisbane
38 for what Mr Stewart referred to as an appointment.
39
40 Mr Stewart's parents did not know what their son did
41 while in Australia or where he may have lived. He wrote to
42 his parents shortly after his arrival in Brisbane saying
43 that he had arrived safely, had a job and that everything
44 was okay. His parents didn't hear from him at any point
45 thereafter during the 11 months leading up to his death.
46
47 From an address Mr Stewart gave when booking in to the

1 Hilton Hotel, police were able to ascertain that Mr Stewart
2 lived at a boarding house in Brisbane from around Christmas
3 1975 until 6 May 1976, just a few days before he died.
4
5 As already noted, since leaving the Navy in 1974,
6 Mr Stewart had changed his name by deed poll from
7 Mark Spanswick to Mark Stewart. His parents were not aware
8 of the name change. They later assumed that Mr Stewart had
9 taken this action because of his desertion from the
10 New Zealand Navy.
11
12 At some point between 6 and 9 May 1976, evidently it
13 appears that Mr Stewart travelled from Brisbane to Sydney.
14 Where he stayed on 7 and 8 May and whether or not he was in
15 Sydney on those days is not known.
16
17 The absence of information from anyone who had contact
18 with Mr Stewart on a regular basis during his formative
19 years from ages 14 to 18 makes it very difficult to gain
20 insight into potentially significant matters concerning his
21 sexuality and mental state.
22
23 One possibility may be that Mr Stewart's desertion
24 from the New Zealand Navy at an early age and his apparent
25 self-imposed estrangement from his family is consistent
26 with him being a young man who was coming to terms with
27 a non-heteronormative sexuality in a challenging
28 environment in the 1970s. It is acknowledged, however,
29 that any such conclusion would involve a high degree of
30 speculation in the absence of any clear evidence concerning
31 his sexuality.
32
33 The third matter, I suggest, Commissioner,
34 contributing to the difficulty in evaluating the
35 circumstances of Mr Stewart's death, relates to the fact
36 that it's not known what has become of any exhibits and, in
37 particular, the piece of notepaper that was located on
38 Mr Stewart at the time of his death.
39
40 Before commenting on this matter further, it should be
41 observed that the Inquiry issued a number of summonses to
42 NSW Police in order to obtain any investigative material
43 held by them. Those efforts and related correspondence are
44 set out in the written submission at paragraphs 43 to 47.
45
46 Whilst some limited material in the form of entries
47 from Special Crime Squad synopsis books and very recently

1 some limited Occurrence Pad entries have been produced, no
2 investigative file for the matter has been produced by
3 NSW Police, and it appears to have been lost.
4
5 The Manly Police Station exhibit book for the relevant
6 period was unable to be located. As recently as two weeks
7 ago, NSW Police advised that following extensive searches
8 and inquiries, no exhibits or records of exhibits could be
9 located.
10
11 Most of the key material that the Inquiry has been
12 able to obtain has therefore come from the coronial file
13 that the Inquiry was able to obtain from the Coroners Court
14 and which includes copies of key statements obtained by the
15 police as part of the coronial brief of evidence.
16 Additional material obtained by the Inquiry includes
17 relevant newspaper articles at the time and documentation
18 from the file held by the Department of Forensic Medicine.
19
20 There is no evidence that there was ever any forensic
21 testing of Mr Stewart's clothing or of any of the items
22 located with or near his body. In view of the apparent
23 loss or failure to retain exhibits, no testing of them is
24 therefore possible. There's no evidence that any
25 photographs were taken of the items.
26
27 I now come in particular to the piece of notepaper
28 that was found on Mr Stewart. It might be helpful if we
29 could have tab 12 [SCOI.02724_00019_0001] brought up on
30 screen. Commissioner, that's the brief statement made by
31 the officer in charge of the investigation at the time of
32 or close to the time of Mr Stewart's death, although I note
33 that it is undated. It evidently formed part of the
34 coronial brief at the time.
35
36 Can I draw your attention to certain matters.
37 I referred earlier in the submission to the time on the
38 watch, the Seiko wristwatch, and one can see the manner in
39 which that was recorded by the officer in charge, just
40 before halfway down the statement, "8.02TUE11".
41
42 Additionally, then, Commissioner, there's a reference
43 towards the end of the statement that, on searching the
44 body, the only property found was a small piece of
45 notepaper with the telephone number of what's referred to
46 as the Chevron Hotel, Sydney, on it in one corner. And
47 written in biro was, one sees then the notation, "7.20

1 11.5.76".
2
3 Bearing in mind that Mr Stewart's body was found on
4 11 May 1976, that notation almost certainly appears to be
5 a reference to the time 7.20 on the date, 11 May 1976.
6
7 That statement could come down.
8
9 Commissioner, the Chevron Hotel was located in Macleay
10 Street in Potts Point. The downstairs bar at the Chevron
11 Hotel, known as the Quarterdeck, was a well known gay
12 venue.
13
14 The historian Garry Wotherspoon in his book "Gay
15 Sydney: A History", which is in evidence before the
16 Inquiry, states this:
17
18 *When the new Chevron Hotel in Macleay*
19 *Street opened in the early 1960s, its*
20 *downstairs bar, "The Quarter Deck", soon*
21 *became a favourite drinking place for [to*
22 *use his language] camps, not least because*
23 *of the large number of young sailors among*
24 *its patrons.*
25
26 In evidence to the Inquiry given in November last
27 year, Mr Wotherspoon stated, when referring to Kings Cross
28 venues generally:
29
30 *I think in the early 1960s, the Chevron*
31 *Hotel opened there and it had a Quarter*
32 *Deck Bar, another place you could go.*
33 *A lot of young sailors would go there for*
34 *a free drink, a bit of sex later, and then*
35 *a bashing,*
36
37 Mr Stewart's possession of the notepaper, which on one
38 view was from the Chevron Hotel, bearing a notation that
39 might be taken as a reference to a meeting time, coupled
40 with his presence in the vicinity of a beat, might be taken
41 as evidence that potentially points to him being gay.
42
43 However, it should be said that there is significant
44 reason to question whether the OIC accurately recorded the
45 name of the hotel that appears on the notepaper. This is
46 because there's other evidence from which it can be
47 inferred that it's likely that police contacted the Hilton

1 Hotel as a potential location where Mr Stewart may have
2 stayed for the reason that it was the phone number of the
3 Hilton Hotel that appeared on the notepaper and not that of
4 the Chevron Hotel.
5
6 On this analysis, the OIC incorrectly noted the name
7 of the hotel, as it appeared on the notepaper, in his
8 statement.
9
10 To complicate matters further, information supplied to
11 the media at the time appears to have left a journalist at
12 The Manly Daily newspaper under the impression that
13 Mr Stewart was staying at a hotel in Kings Cross at the
14 time of his death. The relevant newspaper article appears
15 in the tender bundle at tab 28.
16
17 There's evidence that police involved in the
18 investigation were conflating the two hotels. One officer
19 mistakenly refers to a security officer at the Hilton Hotel
20 as a security officer from the Chevron Hotel. In the
21 report of death to the Coroner document, the officer in
22 charge refers to the Chevron Hilton Hotel.
23
24 Commissioner, for a period of time in the 1960s, the
25 Chevron Hotel was known by the name the Chevron Hilton.
26 Relevant documents demonstrating this to be the case can be
27 found at tabs 40 to 42 of the tender bundle. This fact
28 might help explain how it came to be that the officers came
29 to confuse the two hotels, if that's what occurred.
30
31 Analysis of relevant evidence is set out in greater
32 detail in the written submission at paragraphs 95 to 108.
33 In summary, on balance, it's suggested that it's more
34 likely that the OIC wrongly recorded the name that appeared
35 on the notepaper, and that the name on the notepaper was in
36 fact that of the Hilton Hotel. However, there's
37 uncertainty about this and the distinct possibility remains
38 that it was notepaper from the Chevron Hotel. The
39 uncertainty around the issue serves to highlight that it's
40 highly regrettable that the notepaper was not retained or
41 photographed and that there are no records available that
42 enable it to now be located.
43
44 At this point, Commissioner, it's appropriate for me
45 to say something about the views reached in the course of
46 the review of the matter by Strike Force Parrabell.
47

1 Unfortunately, the Bias Crimes Indicators Form appears
2 to repeat the error made by officers involved in the
3 original investigation by conflating the two hotels. The
4 form was completed, it seems, under the misapprehension
5 that the Hilton Hotel in the CBD and the Chevron Hotel in
6 Potts Point were one and the same. It appears to conflate
7 the two hotels on four separate occasions. In one
8 instance, it states the Chevron Hotel is in fact the Hilton
9 Hotel, the place that Stewart had stayed for two nights
10 before his death. In another instance it states, "Stewart
11 stayed at the Chevron Hotel (also known as the Hilton
12 Hotel) for two nights prior to his death".
13
14 One consequence of the incorrect assumption in the
15 form that the two hotels were one and the same is that
16 Strike Force Parrabell officers presumably did not turn
17 their minds to the possibility that Mr Stewart may have
18 attended the Chevron Hotel, the bar of which was known as
19 a popular venue for gay men, at some point proximate to the
20 time of his death.
21
22 The form also states as fact that Mr Stewart stayed at
23 the Hilton Hotel on the night of 10 May 1976. Although he
24 was booked to do so, there is no clear evidence that he was
25 seen at the hotel after checking in at 9.30pm on 9 May.
26
27 Unsurprisingly, given that the Bias Crimes Indicator
28 Form did not consider the possibility that Mr Stewart had
29 visited the Chevron Hotel, nor does the Strike Force
30 Parrabell case summary mention this possibility. Further,
31 although the form mentions the existence of the beat at
32 North Head, this is not mentioned in the case summary.
33 Both the Bias Crimes Indicator Form and the case summary
34 conclude that there is insufficient information to
35 establish a bias crime. The academic review similarly
36 categorises the case as "Insufficient Information".
37
38 So, Commissioner, bearing in mind the significant
39 challenges posed by the limited nature of the evidence as
40 I have outlined, I now wish to make some brief observations
41 about the alternative possibilities in relation to
42 Mr Stewart's death, they, broadly speaking, being suicide,
43 accident or foul play.
44
45 Firstly, in relation to suicide, Mr Stewart's father
46 told police that he could not offer any reason or
47 explanation as to why Mr Stewart would be at Fairy Bower,

1 and that he did not know of anything that would cause
2 Mr Stewart to take his own life. That opinion needs to be
3 understood in the context of the very limited contact
4 between Mr Stewart and his father in the 18 months prior to
5 his death.
6
7 Mr Stewart's sister was of the view that her brother's
8 past associations with the area were happy ones, in the
9 context of their childhood holidays.
10
11 Other evidence that ideally would assist in evaluating
12 the likelihood of suicide would include information
13 regarding Mr Stewart's life in Brisbane or elsewhere in the
14 months preceding his death. So, too, would evidence
15 concerning the motivations for his decision to desert the
16 New Zealand Navy and to change his name by deed poll.
17 However, other than the fact that he resided at a boarding
18 house for around five months leading up to his death, there
19 is no evidence about Mr Stewart's personal relationships,
20 health, employment or any personal difficulties in that
21 period which might assist in revealing his state of mind.
22
23 His two-day booking at the Hilton Hotel could perhaps
24 be consistent with his having intended to end his life on
25 10 or 11 May. The notepaper and notation could be viewed
26 as a record intentionally left by Mr Stewart to indicate
27 where he had been staying and the time at which he was
28 about to take his life. However, it might be thought
29 unlikely, given the bare nature of the notation and there
30 being no indication, for example, that a pen was located at
31 the scene.
32
33 Conversely, the existence of the note indicating
34 a potential arrangement or plan for the time of 7.20,
35 whether AM or PM, on 11 May, might be thought inconsistent
36 with any suicidal intention and consistent with a positive
37 plan to engage in some form of social liaison.
38
39 It is submitted that the possibility that Mr Stewart
40 may have intentionally taken his own life has little
41 support in the evidence but cannot be ruled out entirely.
42
43 In relation to the possibility of accident, it is
44 noted that the terrain in the vicinity of the cliff edge,
45 as described by an attending officer, suggests the
46 possibility that Mr Stewart could have fallen accidentally,
47 bearing in mind his father's account that he used to love

1 climbing around the rocks in the area on past family
2 holidays. It is submitted that the presence of the
3 broken-off banksia branch at the base of the cliff is more
4 consistent with either an accident or foul play, rather
5 than suicide, as its presence may indicate an attempt to
6 grasp at a branch in circumstances where the fall was not
7 an intentional act.
8
9 Thirdly, in relation to the possibility that foul play
10 may have been involved in the death, I note that no
11 evidence appears to have been found at the cliff top
12 indicative of a struggle or assault having taken place
13 there. It is suggested, however, that limited weight can
14 be given to the absence of such evidence in circumstances
15 where such a death can be effected by a push and where the
16 autopsy report may not have adequately documented any
17 external injury.
18
19 Although a sum of money, around $15, is noted to have
20 been found on Mr Stewart, the absence of any wallet having
21 been found on his person or in the vicinity at the time of
22 his death or in his hotel room is potentially consistent
23 with Mr Stewart having been the victim of a robbery,
24 bearing in mind, however, that it is not known whether it
25 was his practice to carry a wallet.
26
27 In summary, the features of this matter that together
28 might suggest at least the possibility that Mr Stewart may
29 have been a victim of foul play are as follows: firstly,
30 the absence of particularly compelling evidence in support
31 of alternative hypotheses; secondly, the fact that the
32 death occurred in the vicinity of a beat; thirdly, the
33 possibility that Mr Stewart may have attended the Chevron
34 Hotel, the bar of which was a well-known gay venue, and the
35 potential consistency of this with his visit to a known
36 beat location; fourthly, the hypothesis that Mr Stewart was
37 gay being potentially consistent with his self-imposed
38 estrangement from family and his departure from the
39 New Zealand Navy as action taken by him in coming to terms
40 with his sexuality in a challenging environment; fifthly,
41 the absence of a wallet in his hotel room or at the scene
42 at Fairy Bower; and, sixthly, the possibility that the
43 notation on the notepaper was a reference to an arrangement
44 to meet another person. If this were the case, bearing in
45 mind the time that was noted, it suggests that Mr Stewart
46 may have been with someone in the lead-up to his death.
47

1 Commissioner, I now come to conclusions as to the
2 issue of whether gay hate bias may have been involved in
3 the death. In light of the uncertain state of the evidence
4 as to the circumstances of Mr Stewart's death, it is
5 submitted that it is not possible to determine whether
6 Mr Stewart's death was a homicide and, therefore, it is not
7 possible to determine whether it was the result of an
8 LGBTIQ hate crime, although it is possible that it may have
9 been the result of such a crime.
10
11 Commissioner, in relation to the question of an
12 appropriate finding on manner and cause of death, it is
13 submitted that the evidence before the Inquiry does not
14 enable a formal finding to be made that would definitively
15 distinguish between the possibilities of suicide, accident
16 or foul play.
17
18 While the Coroner's principal finding that it is not
19 possible to determine the manner of death is supported, it
20 is submitted that his secondary finding, that foul play
21 could be ruled out, should not be adopted by the Inquiry.
22
23 Further, it is submitted that the Coroner's finding
24 that Mr Stewart died on 11 May 1976 too narrowly confines
25 the potential time of death in the absence of evidence as
26 to Mr Stewart's movements between 9.30pm on 9 May and the
27 discovery of his body at 10am on 11 May.
28
29 As to the cause of death, while the Coroner's finding
30 of multiple injuries is consistent both with Dr Oettle's
31 original post-mortem report and Dr Iles's review of the
32 forensic materials, Dr Iles's recommendation is that the
33 cause of death be more specifically described as multiple
34 injuries sustained in a fall from a height.
35
36 Accordingly, it is suggested that the Inquiry should
37 find that Mr Stewart died on 10 or 11 May 1976 as a result
38 of multiple injuries sustained in a fall from a height, the
39 cause of which cannot be determined.
40
41 Finally, Commissioner, there are no proposed
42 recommendations arising from that.
43
44 THE COMMISSIONER: Thank you, Mr de Mars.
45
46 Again, you will reserve your position, Mr Mykkeltvedt?
47

1 MR MYKKELTVEDT: That's so.
2
3 THE COMMISSIONER: Thank you very much. Thank you all.
4 I will now adjourn for the balance of the day. Thank you.
5
6 **AT 11.48AM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
7 **ACCORDINGLY**
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