

**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 Friday, 16 June 2023 at 10.00am  
(Day 61)**

**Re: death of Scott Miller**

<b>Ms Kathleen Heath</b>	<b>(Counsel Assisting)</b>
<b>Ms Kate Lockery</b>	<b>(Principal Solicitor)</b>
<b>Ms Penelope Smith</b>	<b>(Solicitor)</b>

**Also Present:**

**Mr Daniel Tynan for the Miller family**

**Mr Mathew Short with Mr Aurhett Barrie for NSW Police**

1 THE COMMISSIONER: Yes?  
2  
3 MS HEATH: Commissioner, I appear as Counsel Assisting.  
4  
5 THE COMMISSIONER: Thank you.  
6  
7 MR SHORT: Commissioner, Short, S-H-O-R-T, for the  
8 Commissioner of Police.  
9  
10 THE COMMISSIONER: Thank you, Mr Short.  
11  
12 MR TYNAN: Commissioner, Tynan, T-Y-N-A-N. I seek leave  
13 to appear on behalf of the Miller family.  
14  
15 THE COMMISSIONER: Certainly. Leave is granted, Mr Tynan,  
16 thank you.  
17  
18 MR TYNAN: Thank you.  
19  
20 THE COMMISSIONER: Yes?  
21  
22 MS HEATH: Commissioner, this is a hearing in relation to  
23 the death of Scott Stuart Miller.  
24  
25 Before you, there should be two volumes of material  
26 and copies of those materials are being handed to Madam  
27 Associate.  
28  
29 Commissioner, I tender those materials. I understand  
30 we are up to exhibit 32.  
31  
32 **EXHIBIT #32 TENDER BUNDLE IN RELATION TO DEATH OF**  
33 **SCOTT MILLER**  
34  
35 MS HEATH: Commissioner, what has also been provided to  
36 Madam Associate are short minutes in relation to orders  
37 that the parties seek be made pursuant to section 8 of the  
38 Special Commissions of Inquiry Act. These orders relate to  
39 various redactions sought to documents in the tender bundle  
40 and pseudonym orders for particular witnesses.  
41  
42 THE COMMISSIONER: They are by consent, are they,  
43 Mr Short?  
44  
45 MR SHORT: They are, Commissioner, yes.  
46  
47 THE COMMISSIONER: Thank you. I have made those orders.

1 Thank you.

2

3 MS HEATH: Finally, Commissioner, you should have before  
4 you a copy of my written submissions. These are dated  
5 15 June and I adopt and rely upon those.

6

7 THE COMMISSIONER: Thank you.

8

9 MS HEATH: Commissioner, the family have provided  
10 a photograph of Scott Miller and I ask that that now be put  
11 on the screen.

12

13 THE COMMISSIONER: Certainly.

14

15 MS HEATH: Mr Miller was a young man, only 21 years of age  
16 as at the date of his death. He was the son of Stuart and  
17 Christine Miller and he had two brothers, Mark and Shane.  
18 He grew up in Orange and was a popular young man and keen  
19 footballer. He had close relationships with his family and  
20 with his friends, and a serious girlfriend of some five  
21 years, Bridget.

22

23 I would like to start today by acknowledging both  
24 Shane, his brother, and Bridget, who are here in person, as  
25 well as Mr Miller's family, including his parents, his  
26 brother Mark, and his friends, who are watching on the live  
27 stream.

28

29 Commissioner, the Miller family has prepared a family  
30 statement that honours the life of Scott Miller. I first  
31 seek to tender a written copy of that statement.

32

33 THE COMMISSIONER: Thank you.

34

35 MS HEATH: That will be exhibit 33.

36

37 **EXHIBIT #33 FAMILY STATEMENT**

38

39 MS HEATH: And, Commissioner, I invite Mr Shane Miller to  
40 read that statement on behalf of the family.

41

42 THE COMMISSIONER: Mr Miller, please just come forward, if  
43 you wish.

44

45 Make yourself comfortable and when you're ready, you  
46 just do it as you wish.

47

1 MR MILLER: In 1997, Scott Miller had just completed an  
2 electrical apprenticeship and had moved to Sydney to begin  
3 further studies by studying a degree in sports science. He  
4 was excited about his future, had a large circle of  
5 lifelong friends and was in a serious, happy relationship  
6 with his girlfriend, Bridget. Scott was a devoted son to  
7 Christine and Stuart and a loving brother to Mark and  
8 Shane. He was a joker, kind, generous and the life of the  
9 party.

10  
11 On 2/3/97 a tragedy occurred when his body was found  
12 on the same day he was due to attend his first lecture at  
13 university. The potential lost and the happiness and  
14 experiences he would never get to share with his loved ones  
15 is impossible to describe and always in our thoughts.

16  
17 He is greatly missed by his family and friends who  
18 have continued to grieve and remember him over the last  
19 26 years. We have come to accept that we will never know  
20 exactly what happened to Scott on the night of his death  
21 and remember him for the fine, loving young man that he  
22 was.

23  
24 THE COMMISSIONER: Thank you very much.

25  
26 Yes, Ms Heath?

27  
28 MS HEATH: Commissioner, on behalf of the Inquiry,  
29 I extend my sincere condolences to all of Mr Miller's  
30 family and friends and thank Shane for sharing those words  
31 about Scott.

32  
33 Commissioner, I will now turn to outline the  
34 circumstances, as they are known, of Mr Miller's death.

35  
36 On the evening of Saturday, 1 March 1997, Mr Miller  
37 attended the Sydney Gay and Lesbian Mardi Gras Parade on  
38 Oxford Street with three friends.

39  
40 Now, I pause here to note that although Mr Miller  
41 attended the Mardi Gras, there is no evidence that  
42 Mr Miller was a member of the LGBTIQ community.

43  
44 After the parade, the friends travelled to The Rocks  
45 and continued drinking.

46  
47 Mr Miller was last seen by his friends at some time

1 between 1.30 and 2 o'clock on the morning of Sunday,  
2 2 March 1997, outside the Orient Hotel.

3  
4 Shortly after that time, at about 2.10, a local  
5 resident saw a man who is believed to be Mr Miller walking  
6 alone down Watson Road from Observatory Hill.

7  
8 On Monday, 3 March 1997, at 7.50am - so that is over  
9 24 hours later - Mr Miller was found deceased within the  
10 compound of Patricks the Australian Stevedores on Hickson  
11 Road in Darling Harbour.

12  
13 His body was lying on asphalt at the bottom of  
14 a cliff, in a fenced-off area within the compound that was  
15 used by Patricks to store machinery, and at the top of the  
16 cliff was a small park called Munn Reserve.

17  
18 Commissioner, I will ask that a photograph be put up  
19 on the screen. This is an aerial photograph of the  
20 location that Mr Miller's body was found, taken by police  
21 in 1997. You will see that there is a yellow arrow. That  
22 points to Munn Reserve, and Munn Reserve abuts a sandstone  
23 cliff.

24  
25 The orange arrow points to the approximate location at  
26 the bottom of the cliff where Mr Miller's body was found.  
27 You will see that the body was in a trapezoidal area  
28 surrounded by a fence. That fence marks the bounds of the  
29 machinery yard to which I referred.

30  
31 Now, at the time that this photograph was taken, there  
32 were no machines in the yard, but you will see at tab 12 of  
33 the tender bundle a survey that was prepared by police  
34 showing the layout of the machinery as at the time that  
35 Mr Miller was found.

36  
37 The areas below, so at the bottom of the photograph  
38 and to the right of the photograph, that are adjacent to  
39 the machinery yard, they're all part of the Patricks  
40 compound. The two buildings that are indicated by the  
41 green arrow were occupied by two companies unrelated to  
42 Patricks.

43  
44 Commissioner, as you will see from this photograph,  
45 there was vegetation that ran along the cliff edge at  
46 Munn Reserve. The cliff edge itself was fenced off by  
47 a chain-wire fence, and, Commissioner, I will ask that

1 a photograph of that fence now be put on the screen so that  
2 is the fence at Munn Reserve.

3  
4 It is not particularly visible in this photo due to  
5 overexposure, but at the top of the fence there was barbed  
6 wire, although the evidence from crime scene examiners was  
7 that a portion of the barbed wire had come away from the  
8 support poles near where a Melaleuca tree was leaning  
9 against it.

10  
11 Commissioner, Mr Miller's body was lying face down and  
12 his body was laid straight out. There was a portion of ivy  
13 that was adjacent to his left leg. He was fully clothed,  
14 dressed in a pair of blue denim jeans, a white T-shirt over  
15 the top of another white T-shirt and a pair of brown shoes.  
16 His wallet, credit cards and cash were all found in his  
17 jeans pocket.

18  
19 The front of his white T-shirt was heavily stained  
20 with blood and there was also bloodstaining on the back and  
21 right sleeve, and testing would later confirm that this was  
22 Mr Miller's blood.

23  
24 There was a large pool of blood in the region of his  
25 face and upper torso and a stream of blood that had flown  
26 from his face.

27  
28 The remainder of the machinery yard was examined but  
29 no other blood particles were located.

30  
31 Commissioner, I will briefly touch upon access to the  
32 Patricks compound. I might ask that the very first  
33 photograph that I referred to be shown. On the very right  
34 edge of that photograph you will see - it's cut off, but  
35 there's a hut, which was a security checkpoint.

36  
37 The evidence established that the only way into or out  
38 of the Patricks compound was to go past that security  
39 checkpoint. There were always two security guards on each  
40 shift. At least one would always remain at the checkpoint  
41 while the other security guard would conduct mobile patrols  
42 of the compound.

43  
44 The evidence which I've set out more fulsomely in my  
45 written submissions, paragraph 97 to 100, suggested that it  
46 would be very difficult for anyone to come through the gate  
47 without security officers knowing. However, people that

1 were known to staff, including staff at the wharf or people  
2 with passes, such as crews of vessels docked at the wharf,  
3 were able to pass through.  
4

5 None of the security guards that were on shift at the  
6 relevant time, the period across which Mr Miller likely met  
7 his death, reported seeing anything suspicious.  
8

9 That photograph can now be taken off the screen.  
10

11 Commissioner, Mr Miller's case has been a particularly  
12 complex one, in part because there have been numerous  
13 conflicting opinions expressed as to the manner and cause  
14 of Mr Miller's death. Specifically, whether the injuries  
15 that he suffered were the result of a fall from a cliff or  
16 whether the result of an assault or whether there was some  
17 combination of these two scenarios.  
18

19 Commissioner, my intention in these oral submissions  
20 is to work through each of these opinions chronologically  
21 and in what is hopefully a logical fashion.  
22

23 In view of these conflicting opinions, the Inquiry  
24 considered that it was essential to engage fresh and  
25 independent experts to undertake a full review of both the  
26 medical and crime scene evidence.  
27

28 As I will come to, the Inquiry briefed Dr Linda Iles,  
29 a forensic pathologist, to provide an opinion as to  
30 Mr Miller's injuries, and the Inquiry also briefed Ms Jae  
31 Gerhard, a forensic scientist and blood pattern analyst  
32 from Independent Forensic Services, who reviewed the blood  
33 pattern evidence from the crime scene and crucially, for  
34 the first time, conducted an examination of Mr Miller's  
35 clothing.  
36

37 What I will be submitting to you at the conclusion of  
38 these submissions is that, now, having regard to all the  
39 evidence and particularly the expert opinions of Dr Iles  
40 and Ms Gerhard, it is more probable than not that Mr Miller  
41 met his death as a result of an accidental fall from the  
42 fence at Munn Reserve, rather than as a result of  
43 a homicide.  
44

45 So, Commissioner, I will commence by taking you to the  
46 first autopsy report that was prepared, and I ask that  
47 tab 2 be placed on the screen [SCOI.02737.00048\_0001].

1 Commissioner, you will see that this is the final autopsy  
2 report of Dr Duflou, dated 5 June 1997. Now, this autopsy  
3 report spends quite some time describing in detail the  
4 injuries that were observed to Mr Miller's body.

5  
6 When Dr Iles was later to review this autopsy report,  
7 she noted that it comprehensively documented Mr Miller's  
8 injuries and also considered the photo documentation to be  
9 of a high standard.

10  
11 I ask that we scroll now to page 9 of this report,  
12 where there is a pathology summary. It notes the following  
13 injuries: massive skull fracturing; contusions, which is  
14 bruising, to the brain; a laceration of the liver with  
15 a near complete tear of the right lobe; tearing of the  
16 right kidney; intra-abdominal haemorrhage, or bleeding;  
17 bilateral wrist fractures; and bruising to the heart. He  
18 also earlier in his report recorded abrasion injuries to  
19 the face and neck, predominantly in a vertical plane.

20  
21 Mr Miller was noted to have a high blood alcohol  
22 concentration, so 0.22, and I pause to note that that was  
23 consistent with observations by witnesses of his level of  
24 intoxication on the night.

25  
26 Commissioner, I ask that we now scroll to page 10 of  
27 that document. You will see that Dr Duflou here expresses  
28 that the manner by which Mr Miller's injuries were  
29 sustained "remain unclear".

30  
31 Dr Duflou posits three scenarios. The first scenario  
32 is that the injuries were inflicted by one or more persons  
33 in a homicidal fashion. So in this scenario, according to  
34 Dr Duflou, the head injury may represent impact with  
35 a heavy object swung against the forehead, such as a length  
36 of timber, and injuries to the liver and kidney may  
37 similarly have been inflicted by one or more persons either  
38 kicking Mr Miller or hitting him with an object. Dr Duflou  
39 considered that the wrist injuries may be defensive  
40 injuries.

41  
42 In scenario 2, Dr Duflou considered whether the  
43 injuries could have been sustained during a fall from  
44 a height. Dr Duflou stated that the wrist injuries and  
45 possibly the head and abdominal injuries could have been  
46 sustained during a fall from a height. However, he  
47 qualified this opinion by noting that both the head and



1 abdominal injuries are somewhat atypical for a fall from  
2 a height.

3  
4 I pause to note that he does not at this point explain  
5 precisely why they are atypical but that will come later in  
6 the coronial evidence.

7  
8 Scenario 3 considered by Dr Duflou was a combination  
9 of scenarios 1 and 2. This combination was said by  
10 Dr Duflou to explain all the injuries satisfactorily and  
11 the sequence would most likely have been an assault  
12 followed by a fall from a height. He hypothesised, you  
13 will see, that Mr Miller could have been moved to the place  
14 he was found.

15  
16 In the final paragraph on that page, he notes that all  
17 possibilities described have inherent difficulties and it  
18 is unlikely that the autopsy alone will be able to offer  
19 any firm opinion as to the circumstances surrounding the  
20 death.

21  
22 So that was the first opinion given of Dr Duflou in  
23 his autopsy report.

24  
25 Commissioner, I now ask that tab 8 be put on the  
26 screen [SC0I.83347\_0001].

27  
28 This is a statement by Detective Senior Constable  
29 Van Leeuwen dated 14 June 1997. You will see that  
30 Detective Senior Constable Van Leeuwen was attached to the  
31 East Sydney Zone Crime Scene Unit.

32  
33 In this statement, Detective Van Leeuwen outlines the  
34 examinations that were made of the crime scene and  
35 ultimately concludes that the death of Mr Miller was  
36 suspicious. I'll ask that we scroll to the bottom of  
37 page 9 and starting at paragraph 14. This is where  
38 Detective Van Leeuwen expresses his opinion, and it is  
39 a list of factors that Detective Van Leeuwen says points to  
40 his opinion that the death is suspicious.

41  
42 The first factor he points to is the presence of  
43 bloodstains on the back of the deceased's white T-shirt  
44 that cannot be explained and are of a suspicious nature.

45  
46 Commissioner, this comment related to an observation  
47 made that although Mr Miller was lying face down, there was

1 blood observed to the back and right sleeve of his white  
2 T-shirt.

3  
4 Detective Van Leeuwen would go on to say at the  
5 coronial inquest that this bloodstaining was "the most  
6 crucial piece of forensic evidence", supporting his view  
7 that Mr Miller's death was a homicide. He considered that  
8 one scenario as to how the blood could have been positioned  
9 on his back in that way was that Mr Miller was assaulted in  
10 another place and then laid down in the back of a vehicle  
11 and had been bleeding on his back.

12  
13 Although Detective Van Leeuwen expressed this opinion,  
14 at no time was there a forensic examination of Mr Miller's  
15 clothing.

16  
17 Now, as I will come to, but to foreshadow where these  
18 submissions are going, Mr Miller's clothing, and in  
19 particular these stains, were examined by a blood pattern  
20 analyst engaged by the Inquiry, who was able to provide an  
21 explanation for the bloodstains that are consistent with  
22 being caused as a result of a fall.

23  
24 If we now scroll to factor 2, Detective Van Leeuwen  
25 notes the lack of separate individual blood spots  
26 throughout the machinery yard indicate that the deceased  
27 did not stagger around the machinery yard. I note that  
28 this observation is consistent with the medical evidence  
29 that the extent and severity of Mr Miller's injuries means  
30 that he would have been unable to move.

31  
32 I observe at this point, though, that this factor is  
33 equally consistent with Mr Miller having fallen from the  
34 top of the cliff.

35  
36 Factor number 3 was:

37  
38 *The deceased was located lying face down on*  
39 *the ground at the base of the cliff. If he*  
40 *had fallen or jumped from Munn Reserve*  
41 *I would have expected his position to have*  
42 *been more contorted than it was.*

43  
44 This observation, it will be submitted, was not  
45 supported by appropriate expertise. As I will come to,  
46 Dr Iles will make comment in her report as to what  
47 information can be gleaned from the positioning of the

1 body.

2

3

The next factor is:

4

5

*The deceased had a lack of external injuries usually seen in a person who has died as a result of a fall.*

6

7

8

9

10

11

12

13

14

Commissioner, what is submitted in relation to this factor is that it is most appropriately determined by a trained forensic pathologist, and so this opinion, as expressed in Detective Van Leeuwen's statement, will be again addressed in Dr Iles' report.

15

16

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I will return at the conclusion of my submissions to discuss what can be made of these observations.

33

34

35

36

37

38

39

40

41

So in paragraph 10, you'll see, what Detective Van Leeuwen is doing here is listing the exhibits that he received at the conclusion of the autopsy. Item number 10 is described as "A piece of gravel". Now, that piece of gravel is not further referred to in the material, it does not appear there was any forensic testing of it, and I will return in due course to that topic, but I just alert you to that in Detective Van Leeuwen's statement.

42

43

44

45

46

47

Commissioner, I next wish to take you to the opinion of Detective Senior Sergeant Cameron, who is also from the Crime Scene Unit, and I ask that tab 14 [SC0I.02737.00069\_0001] be placed on the screen. So this is his statement dated 3 October 1997.

1 Consistent with the observations of Detective Senior  
2 Constable Van Leeuwen, Detective Cameron observes there was  
3 no evidence of damage to the vegetation, as might be  
4 expected if someone had slipped, fallen or been pushed over  
5 the cliff edge.  
6

7 If we look at paragraph 5, notably, Detective Cameron  
8 considered that if someone had been lifted and pushed over  
9 the fence, as opposed to climbing the fence, he would have  
10 expected that there would be more damage to both the fence  
11 and the vegetation. That is an opinion that we submit  
12 accords with common sense, and I just note that at this  
13 time.  
14

15 The next opinion that is relevant is that of Senior  
16 Constable Lane. I ask that tab 5 [SCOI.02737.00051\_0001]  
17 be placed on the screen.  
18

19 Senior Constable Lane was the initial investigating  
20 officer and this is his statement to the Coroner dated  
21 1 May 1997. The majority of his statement deals with the  
22 police investigations that were undertaken, and I will  
23 return to the topic of the police investigation at the  
24 conclusion of my submissions. But at this time, I will ask  
25 that we go to paragraph 63, which is at the end of the  
26 statement.  
27

28 This is where Senior Constable Lane commences his  
29 opinion as to how Mr Miller may have met his death. Senior  
30 Constable Lane notes that there is no hard evidence to  
31 suggest that Mr Miller was either assaulted or robbed, and  
32 comments on the inability of Dr Duflou to distinguish  
33 between the injuries being caused by a blunt object or  
34 a fall. He also notes the absence of any physical evidence  
35 to determine whether Mr Miller was assaulted or whether he  
36 fell.  
37

38 Commencing at paragraph 64, he sets out his theory as  
39 to how Mr Miller died. If I could just summarise and  
40 paraphrase, his theory was that Mr Miller was attempting to  
41 go from The Rocks to the casino in Darling Harbour. In his  
42 state of intoxication he became lost or disoriented. From  
43 Munn Reserve, you are able to see Darling Harbour and the  
44 casino. So Senior Constable Lane suggested that Mr Miller  
45 may have attempted to take a shortcut down, via Munn  
46 Reserve, and his intoxication contributing to his poor  
47 judgment, he decided to scale the fence and from there

1 slipped and fell.

2  
3 Commissioner, you will note at this time that that  
4 theory is not necessarily an implausible one but at this  
5 stage it involved a fair degree of speculation on the part  
6 of Senior Constable Lane.

7  
8 So, Commissioner, those were the statements that were  
9 prepared prior to the coronial inquest. The coronial  
10 inquest was then heard in October of 1997. Each of  
11 Dr Duflou, Detective Senior Constable Van Leeuwen,  
12 Detective Senior Sergeant Cameron and Senior Constable Lane  
13 gave evidence at the inquest, and a transcript of that  
14 inquest is at tab 42 [SC0I.02737.00041\_0001]. I might ask  
15 that that now be put on the screen

16  
17 I have already briefly referred to some of the  
18 comments made by Detective Van Leeuwen in his evidence to  
19 the coronial inquest. I wish to take you to evidence from  
20 Dr Duflou at the inquest. If we could start by going to  
21 page 6 and commencing at line 25, this is significant  
22 because Dr Duflou here expands upon the comment in his  
23 report that the injuries were considered atypical for  
24 a fall from a height.

25  
26 What Dr Duflou says is that the head injury was more  
27 consistent with a blow more in the middle, a transverse  
28 blow, as well as more a vertical blow to the neck itself.  
29 He then notes that the abdominal injuries are unusual in  
30 that there were no associated rib fractures or pelvic  
31 fractures, yet there were quite significant abdominal  
32 injuries. Dr Duflou comments that you would expect, if he  
33 fell on to a flat surface in any case, that to have  
34 abdominal injuries you'd have to have injuries on either  
35 side, and there were none.

36  
37 I highlight this point now because, as will become  
38 apparent, this is a point of distinction between the  
39 opinion of Dr Duflou and the opinion of Dr Iles.

40  
41 If we now go back to page 5, commencing at line 15,  
42 Dr Duflou was asked by Counsel Assisting about the three  
43 manners in which he believed Mr Miller may have died - so  
44 that is a reference to what I earlier took you to, which is  
45 the three scenarios in his report. In his report you will  
46 recall that he expressed no preference for any one of the  
47 three scenarios, saying that they all have inherent

1 difficulties.

2  
3 At line 28, Dr Duflou was asked whether there was any  
4 manner which is more likely that is consistent with the  
5 injuries. Dr Duflou commenced his answer by saying:

6  
7 *My understanding is that there is no*  
8 *evidence at all of the Deceased having been*  
9 *on top of the cliff face.*

10  
11 And the Coroner says to him, "That is correct." Dr Duflou  
12 continues:

13  
14 *If that's the case the Deceased could not*  
15 *have fallen from the cliff face or from the*  
16 *top of the cliff face and it sounds*  
17 *unlikely to me that he in fact started*  
18 *climbing the cliff face as an alternative.*  
19 *In that case the Deceased would more likely*  
20 *than not have been killed in a homicidal*  
21 *fashion.*

22  
23 So, Commissioner, it would appear that, in his oral  
24 evidence, in contrast to his report, Dr Duflou begins to  
25 lean more heavily in favour of a theory of an attack or an  
26 assault. But it should be noted that this opinion, it  
27 seems, took as a starting point that Mr Miller had not been  
28 at the top of the cliff - that is to say, that it was  
29 largely determined by non-medical evidence as opposed to  
30 medical evidence.

31  
32 Commissioner, the coronial findings are at tab 43  
33 [SCOI.02737.00032\_0001]. Senior Deputy State Coroner  
34 Abernethy presided over the coronial inquest and delivered  
35 his findings on the same day. I will ask that tab 43 be  
36 put on the screen.

37  
38 In paragraph 1, you will see that the Coroner  
39 identified the first issue to be determined was whether  
40 Mr Miller's death was a homicide. At paragraph 5, which  
41 we'll just scroll down to, the Coroner gives five reasons  
42 for rejecting the theory of Senior Constable Lane, which  
43 really just draws on factors that I've already taken the  
44 Commission to, that derive from the opinions of Dr Duflou  
45 and Detectives Van Leeuwen and Cameron. So, first, at the  
46 top of the cliff is a high wire fence; secondly, Mr Miller  
47 was very drunk with a blood alcohol level of 0.22; thirdly,

1 Crime Scene carefully examined the ledge above the cliff  
2 which was covered in ivy and they found no signs of  
3 disturbance to that ivy; fourthly, Mr Miller's body was  
4 laid out straight and was not cramped up, as often occurs  
5 in falls; and fifthly, Mr Miller's injuries in the main  
6 were more consistent with him being assaulted.

7  
8 At paragraph 6, he comments that while Dr Duflou  
9 believes his injuries may be consistent with a fall or  
10 push, he feels it is more likely that he was either  
11 assaulted near where he was found or taken there and  
12 dumped.

13  
14 The finding of the Coroner is at the bottom of page 2,  
15 and consistent with the evidence that the Coroner had  
16 before him at that time, his finding was that Mr Miller  
17 died of multiple injuries inflicted by a person or persons  
18 unknown, with the Coroner being unable to say who inflicted  
19 such injuries. So, in effect, the Coroner rejected the  
20 hypothesis that his injuries were the result of a fall,  
21 instead finding an assault.

22  
23 That is the position as at 1997 at the conclusion of  
24 the coronial inquest. That can now be taken from the  
25 screen.

26  
27 The next relevant investigation into Mr Miller's death  
28 came at the end of 1997 and continued into 1998. This was  
29 an investigation under the strike force name Strike Force  
30 Corone.

31  
32 So after the inquest, Coroner Abernethy referred the  
33 case back to the NSW Police Force by further investigation  
34 by specialist Homicide officers. Now, this was in part  
35 motivated by certain deficiencies in the original  
36 investigation, particularly some that were highlighted by  
37 Mr Miller's family. Commissioner, as I have already  
38 flagged, I will come back to deal with the sufficiency of  
39 the original police investigation as a separate topic in  
40 due course.

41  
42 The strike force was under the command of Detective  
43 Sergeant Desmond and it undertook a number of further  
44 investigations. I comment at this time that the Inquiry  
45 has only been provided with various documents that  
46 summarise the steps taken as a result of that  
47 reinvestigation and it appears that some of the

1 contemporaneous documents associated with this strike force  
2 are not available.

3  
4 What I will ask be put on the screen is the report at  
5 tab 49 [SCOI.10048.00002]. It is a report from Detective  
6 Sergeant Desmond seeking that a reward be posted for any  
7 information about the death of Mr Miller.

8  
9 Now, if I ask that we scroll firstly to page 6, under  
10 the heading "Present Status of Investigation", you'll see  
11 there that there is a list of the various investigations  
12 that were conducted at the time by Strike Force Corone.  
13 Amongst those investigations is the re-interviewing of  
14 security staff at Patricks.

15  
16 Now, at the bottom of page 6, there is  
17 a paragraph that commences:

18  
19 *After reviewing the evidence the writer the*  
20 *of the following opinion: ...*

21  
22 This is what Detective Sergeant Desmond states:

23  
24 *After reinterviewing security staff, it*  
25 *would appear no vehicle or pedestrian could*  
26 *have entered the terminal without being*  
27 *challenged.*

28  
29 He then says:

30  
31 *Taking into consideration the position of*  
32 *the body --*

33  
34 so that is lying at the bottom of the cliff --

35  
36 *no evidence of blood particles around the*  
37 *machinery yard, clothing intact and the*  
38 *aforsaid opinion --*

39  
40 so that's referring back to the opinion that it would be  
41 difficult to pass the security checkpoint, and he says that  
42 this:

43  
44 *... would indicate the deceased fell from*  
45 *the area of the cliff face.*

46  
47 He notes the lack of evidence of a struggle and that no



1 property was stolen from Mr Miller.  
2

3 At the top of page 7 he comments that the scenarios  
4 put forward by Dr Duflou give no clear indication of how  
5 the deceased died and he somewhat criticises here the  
6 opinion of Detective Van Leeuwen as to the injuries  
7 sustained by a fall as opinionated, stating that no two  
8 persons sustain identical injuries in a fall of this  
9 nature. I have already made some comment about this  
10 perhaps being straying beyond Detective Van Leeuwen's  
11 particular expertise.  
12

13 So certainly by 1998 it's apparent that there was  
14 a divide of opinions, within the NSW Police Force, at  
15 least, as to how Mr Miller met his death.  
16

17 A government reward was approved for any information  
18 relevant to Mr Miller's death but no information was  
19 forthcoming. Tab 49 can now be taken down.  
20

21 Commissioner, the next strike force that considered  
22 Mr Miller's death was in 1999 and it was named Strike Force  
23 Lincoln. Strike Force Lincoln was established to  
24 investigate the death of another man, so an unrelated  
25 death, who also died in 1997.  
26

27 The primary person of interest in relation to that  
28 person's death was a man who we have given a pseudonym, and  
29 I will refer to him as "NP130", and NP130 was ultimately  
30 charged and convicted in relation to an unrelated death.  
31

32 The reason that Mr Miller's death was considered by  
33 Strike Force Lincoln was because NP130's former girlfriend  
34 had given evidence about an incident that occurred in The  
35 Rocks and likely in Munn Reserve, in which NP130 began to  
36 push a male and later told his girlfriend that he had  
37 "shanked", which she understood to mean stabbed, the male,  
38 and "chucked him off a cliff."  
39

40 Now, Commissioner, this was investigated to see  
41 whether or not she could have, in fact, been describing an  
42 incident involving Mr Miller. For a number of reasons  
43 which I've set out more fulsomely at paragraph 128 of my  
44 submissions, the incident that she described did not match  
45 the objective circumstances known as to Mr Miller's death.  
46 I simply rely on my written submissions as to this point.  
47 Strike Force Lincoln did not otherwise consider the manner

1 of Mr Miller's death.

2  
3 That was in 1999. Now, at this point, the next time  
4 that Mr Miller's case is considered was by the Unsolved  
5 Homicide Team in 2004. I ask that tab 69  
6 [NPL.0100.0015.0001] be placed on the screen.

7  
8 Commissioner, this is a case screening form. It has  
9 been prepared by Detective Sergeant Barwick of the Unsolved  
10 Homicide Team. I will ask that we now scroll to page 9 of  
11 this document. So this is the conclusions or  
12 recommendations of Detective Sergeant Barwick. You will  
13 see that the recommendation here is for a forensic review  
14 of Mr Miller's death. What is anticipated is the Coroner  
15 may then issue a finding of "death by misadventure".

16  
17 Detective Sergeant Barwick, under the heading "Points  
18 of Issue" raises a number of factors which tend to support  
19 the view Mr Miller must have come over the cliff to his  
20 final resting spot. This includes various factors to which  
21 I've already taken this Commission and to which I'll later  
22 come.

23  
24 The point I wish to make at this time is that it  
25 appears that despite a forensic review having been  
26 recommended in 2004 there is no action that seems to have  
27 been taken in relation to that recommendation.

28  
29 The case screening form also noted that there had  
30 never been a forensic examination of Mr Miller's clothing  
31 and recommended such re-examination, or examination, and  
32 again, it does not appear that that step was taken.

33  
34 Then the final consideration given by the police was  
35 in the course of Strike Force Parrabell but, Commissioner,  
36 as you would be well aware, that did not involve  
37 a reinvestigation of the case but, rather, a review.

38  
39 Strike Force Parrabell concluded that there was no  
40 evidence of bias crime in Mr Miller's case, and I rely on  
41 my written submissions in relation to the analysis of the  
42 use of the Bias Crime Indicators Form by Strike Force  
43 Parrabell.

44  
45 That somewhat lengthy exposition sets out the previous  
46 opinions that had been expressed in relation to Mr Miller's  
47 death, and what I will now turn to is the steps that have

1           been taken by this Inquiry to clarify the circumstances.

2  
3           I start by talking and submitting in relation to the  
4 forensic report of Dr Linda Iles. After summoning and  
5 reviewing all of the material provided by the NSW Police  
6 Force and the Coroners Court, the first significant step  
7 taken by the Inquiry was to brief Dr Iles to review  
8 Mr Miller's case.

9  
10          Dr Iles, of course, relied upon the autopsy report of  
11 Dr Dufrou as well as photographs of both the crime scene  
12 and photographs taken at autopsy. As noted earlier,  
13 Dr Iles considered this documentation to be of a high  
14 standard and so sufficient for her to form a view as to how  
15 Mr Miller's injuries were sustained.

16  
17          Commissioner, it will be my submission that Dr Iles'  
18 report and her opinion is persuasive and cogent, and I will  
19 ultimately be submitting that her conclusions can be  
20 accepted by the Inquiry.

21  
22          I wish to start by setting out Dr Iles' comments in  
23 respect of the three significant injuries sustained by  
24 Mr Miller. First is Mr Miller's skull and brain injuries.  
25 Dr Iles considered that the injuries were consistent with  
26 a high magnitude force impact, such as a fall from  
27 a height. In her opinion, the pattern of craniofacial  
28 injuries sustained by Mr Miller can be observed in other  
29 high-energy scenarios, such as to pedestrians or cyclists  
30 in motor vehicle accidents, however, the absence of  
31 injuries to Mr Miller's torso and limbs and the  
32 circumstances in which he was found discount such  
33 scenarios.

34  
35          In addition, and importantly, Dr Iles observed that  
36 the injuries to Mr Miller's skull were all in a single  
37 plane and they had a vertically orientated abraded  
38 component to his neck and chin. So Dr Iles considered that  
39 to have such severe underlying craniofacial trauma but only  
40 a single plane of facial abrasion is not typical of an  
41 assault.

42  
43          Secondly, Dr Iles looked at Mr Miller's liver and  
44 right kidney injuries, which were accompanied by associated  
45 bleeding in his abdomen. You may recall that Dr Dufrou  
46 considered it "unusual" that there were severe internal  
47 injuries without associated fractures.

1  
2 Dr Iles' opinion is that that pattern of injury is  
3 consistent with deceleration injuries consequent to a fall  
4 from a height. So that is, the primary point of impact was  
5 to Mr Miller's head and face, whereas the injuries to his  
6 internal abdominal organs were the result of deceleration.  
7 That explains the severe injuries without the associated  
8 fractures or other impact injuries. So Dr Iles considers  
9 that that is consistent with a fall rather than an assault.

10  
11 Thirdly, Dr Iles looks at Mr Miller's bilateral distal  
12 forearm fractures, so in simple terms, the fact that  
13 Mr Miller had fractures to both of his wrists. Dr Iles  
14 considers that those injuries are consistent with  
15 Mr Miller's arms being outstretched at the time of impact.

16  
17 Contrary to Dr Duflou's opinion, Dr Iles considered  
18 that these are not typical of defensive injuries, and the  
19 reason for that is that there is a lack of overlying  
20 bruising or haemorrhaging to the soft tissues that you  
21 would expect from defensive injuries.

22  
23 Commissioner, I will take you to the conclusions that  
24 Dr Iles reaches, and I ask that tab 72 [SCOI.82891\_0001] be  
25 placed on the screen. So this is the report of Dr Iles.  
26 If we go to page 10, that most conveniently summarises her  
27 opinions. Paragraph 1 on that page - if that could just be  
28 scrolled, thank you - is that:

29  
30 *Based on the medical findings, it is my*  
31 *view that Mr Miller's fatal injuries were*  
32 *sustained in a fall from a height with*  
33 *a primary impact point to the front of*  
34 *Mr Miller's face.*

35  
36 Now, she notes, appropriately, that she's unable to say how  
37 the fall occurred, and that she can't discriminate, from  
38 the medical evidence alone, between a fall and a push.

39  
40 At paragraph 2 she states:

41  
42 *It is my view that Mr Miller's injuries in*  
43 *toto are not typical of an assault.*

44  
45 She goes on in that paragraph to explain what I have  
46 already said.

47

1 At paragraph 3, she notes:

2

3 *A fall from a height of around 7 metres*  
4 *with a primary facial impact ... would be*  
5 *in keeping with the environment and the*  
6 *position in which Mr Miller was found.*

7

8 She considered that the medical findings were inconsistent  
9 with Mr Miller moving significantly from the point of  
10 impact.

11

12 She also noted that the injuries to Mr Miller's face  
13 would result in significant bleeding after death, and that  
14 is consistent with the pool of blood that was found in the  
15 location that his body was found in.

16

17 She also referred to circumstantial evidence about the  
18 lack of access to the wharf and the absence of blood  
19 particles in the machinery yard as support for the  
20 assertion that Mr Miller fell from the cliff above where he  
21 was found, but I should note that earlier in her report,  
22 she appropriately noted that these factors turn on  
23 non-medical evidence.

24

25 Dr Iles was asked in the letter of instruction about  
26 the position of Mr Miller's body, noting that Detective  
27 Van Leeuwen gave evidence that the position of the body was  
28 "less contorted" than would be expected following a fall.

29

30 Dr Iles' opinion was that the position of the body  
31 corresponded with Mr Miller's injuries, which indicated an  
32 anterior plane of impact. So that is, Mr Miller was found  
33 lying face down and the injuries were to the front of his  
34 body, so it's consistent in that regard. But she  
35 considered that the position of the body was not otherwise  
36 informative, and that's at the top of page 11, if we just  
37 scroll down to that.

38

39 Commissioner, I note page 11, paragraph 3. So this is  
40 in relation to the bloodstaining. What Dr Iles notes here  
41 is that the bloodstaining could be caused by the  
42 expiration, so the breathing out, of air and blood from  
43 Mr Miller's damaged nasopharynx into a pool of blood on the  
44 ground, but what she suggested was that an opinion be  
45 sought from others with appropriate expertise.

46

47 At paragraph 4, Dr Iles states that she cannot exclude

1 Mr Miller being assaulted prior to falling from a height or  
2 being pushed over, however, she did comment that Mr Miller  
3 had no injuries to indicate that that had occurred.  
4

5 In answer to question 7, and on page 11, you'll see  
6 that Dr Iles ultimately concluded that Mr Miller's cause of  
7 death may be expressed as:

8  
9 *Multiple injuries sustained in a fall from*  
10 *a height.*  
11

12 So you will see that Dr Iles' opinion is that the injuries  
13 are consistent with a fall and not consistent with an  
14 assault.  
15

16 Now, following the recommendation of Dr Iles to seek  
17 an opinion from a blood pattern expert, the Inquiry briefed  
18 Ms Jae Gerhard of Independent Forensic Services to conduct  
19 a review of the crime scene evidence. And, in addition to  
20 reviewing the material, the documentary material,  
21 Ms Gerhard and her colleague at Independent Forensic  
22 Services, Ms Roebuck, attended the Pemulwuy laboratory,  
23 which is operated by the NSW Police Force, in order to  
24 examine Mr Miller's clothing. They conducted a white-light  
25 and low-powered magnification examination of the clothing.  
26

27 Commissioner, I pause to clarify here that the report  
28 and the opinion is provided by Ms Gerhard but the  
29 examination of the clothing was jointly conducted by  
30 Ms Gerhard and Ms Roebuck, also of Independent Forensic  
31 Services, and that's consistent with best practice in  
32 forensic science.  
33

34 This is the first time that Mr Miller's clothing has  
35 been examined. I will briefly set out the pertinent  
36 findings of Ms Gerhard's report. In relation to  
37 Mr Miller's jeans, she noted that there were no bloodstains  
38 on Mr Miller's jeans, and that was despite both examination  
39 under magnification, as I previously noted, but also the  
40 chemical testing of apparent stains that were negative for  
41 blood.  
42

43 There was wear and tear on the jeans but none that  
44 indicated an action such as climbing over a barbed-wire  
45 fence.  
46

47 In relation to Mr Miller's shoes, again there was no

1 bloodstaining observed to his shoes.

2  
3 Coming to Mr Miller's T-shirts, as I mentioned  
4 earlier, Mr Miller was wearing two white T-shirts, one over  
5 the top of the other, and it is the top white T-shirt which  
6 has the most informative staining.

7  
8 That white T-shirt had extensive staining on the upper  
9 chest and neck region of the shirt, and that was confirmed  
10 to be blood, and that appeared to be what was described as  
11 "saturation staining" from blood soaking into and wicking  
12 through the fabric. So that heavy staining is, in the  
13 opinion of Ms Gerhard, consistent with Mr Miller having  
14 facial injuries and remaining prone, with little to no  
15 movement after the bleeding had begun.

16  
17 Now, within that larger saturation stain were smaller,  
18 darker spatter stains that were circular in shape. The  
19 significance of them being circular in shape is that it  
20 indicates they had no direction. Ms Gerhard considered  
21 that these spatters could have been the result of blood  
22 being expelled from Mr Miller's airways shortly after the  
23 fall, so that's consistent with what Dr Iles suggested, or  
24 liquid being distributed as a result of the impact of the  
25 fall.

26  
27 Ms Gerhard then commented upon the staining on the  
28 rear of the T-shirt that was predominantly on Mr Miller's  
29 right sleeve, which you will recall Detective Van Leeuwen  
30 had considered a crucial piece of forensic evidence  
31 consistent with a homicide.

32  
33 Ms Gerhard described these bloodstains as nondescript  
34 and, as with the other bloodstains that were seen on the  
35 front of Mr Miller's shirt, she considered that these could  
36 have resulted from blood being distributed as a result of  
37 the impact of the fall.

38  
39 What is important in regards to the bloodstains to  
40 Mr Miller's T-shirt, particularly to the right and back, is  
41 that they were not indicative of an assault or of Mr Miller  
42 being upright with a bleeding injury. So what Ms Gerhard  
43 explains is that if there had been a single impact that  
44 created blood flow while Mr Miller was upright, then you  
45 would expect drip-type staining, so staining that has  
46 a clear direction. If there were multiple strikes, then  
47 the strikes could distribute spatter-type stains, that

1 would be stains again that indicated direction as opposed  
2 to being circular. Ms Gerhard notes that there was no  
3 evidence of either type of that staining.  
4

5 She also notes that the blood patterns on Mr Miller's  
6 clothing did not indicate that he had been moved. There  
7 were no drag or grab marks on the shirt, and there were  
8 also no flow-type patterns that would indicate that  
9 Mr Miller was moved whilst freely bleeding.  
10

11 Her opinion in relation to the top white T-shirt was  
12 that the bloodstaining was consistent with either  
13 expiration of air or the impact of the fall.  
14

15 The bottom white T-shirt was consistent with it having  
16 been worn under the top white T-shirt, and it did not have  
17 any independent drip or spatter stains.  
18

19 Commissioner, I will ask that Ms Gerhard's opinion be  
20 put on the screen, and this is at tab 74 of your brief  
21 [SCOI.83328\_0001]. That's the expert report of Ms Gerhard,  
22 and if we go to page 13, paragraph 15.1, this is the  
23 conclusion that's reach by Ms Gerhard:  
24

25 *When considering the bloodstain patterns*  
26 *identified on all of the items of clothing*  
27 *examined, no bloodstains (such as spatter*  
28 *or drips) were observed to indicate that*  
29 *Mr Miller was assaulted (resulting in*  
30 *bleeding injuries) at the top or bottom of*  
31 *the cliff.*  
32

33 And she continues that:  
34

35 *In my opinion, the bloodstaining patterns*  
36 *observed on the clothing and in the*  
37 *photographs are consistent with the*  
38 *position Mr Miller was found at the bottom*  
39 *of the cliff following a fall.*  
40 *Furthermore, there is no evidence of*  
41 *significant movement of Mr Miller once his*  
42 *bleeding facial injuries occurred.*  
43

44 That can now be taken down.  
45

46 So, Commissioner, notwithstanding the original  
47 coronial finding, the preponderance of the evidence,



1 including those expert opinions that were not available at  
2 the time of the inquest, supports a conclusion, it is  
3 submitted, that Mr Miller's injuries were sustained by  
4 a fall from the cliff directly above where his body was  
5 found.

6  
7 It is submitted that Dr Iles' opinion that each of  
8 Mr Miller's physical injuries can be accounted for by  
9 a fall from a cliff face, with a primary impact point to  
10 the front of his face, should be preferred to that of  
11 Dr Duflou, in particular Dr Duflou's evidence that the  
12 injuries were atypical for a fall from a height.

13  
14 Dr Iles' evidence adequately explains the mechanism  
15 for how each injury would have been explained and, in  
16 particular, answers Dr Duflou's concerns about the absence  
17 of rib or pelvic fractures despite the significant  
18 abdominal injuries.

19  
20 Dr Iles also provides cogent reasons, it is submitted,  
21 as to why Mr Miller's injuries were not typical of an  
22 assault.

23  
24 The bloodstain pattern analysis conducted by  
25 Ms Gerhard supports Dr Iles' opinion and the proposition  
26 that Mr Miller died as a result of a fall. There was an  
27 absence of any bloodstaining, such as drip stains or  
28 directional spatter stains, that would have been consistent  
29 with Mr Miller being assaulted.

30  
31 Mr Miller's injuries precluded him moving any  
32 significant distance of his own motion, and there was no  
33 evidence to support his body being moved or dragged. To  
34 the contrary, he was found in the pool of blood that would  
35 have been caused by his facial injuries. This tells  
36 against one of Dr Duflou's hypotheses, which was reflected  
37 ultimately in the reasons of the Coroner, that Mr Miller's  
38 body could have been dumped in the location that it was  
39 found.

40  
41 That Mr Miller came to his final resting place by  
42 falling from the cliff is also consistent with the evidence  
43 that access to the wharf by members of the public was  
44 significantly limited.

45  
46 Now, Commissioner, it's acknowledged that there is  
47 little evidence that establishes Mr Miller's presence at

1 the top of the cliff. This includes that there is an  
2 absence of evidence of disturbance to the vegetation or the  
3 ivy at the top of the cliff; there's an absence of trace  
4 evidence on the barbed-wire fence, and there is a lack of  
5 tears or damages to Mr Miller's clothing.  
6

7 However, it is submitted that the absence of this  
8 evidence does not overcome the force of the forensic  
9 evidence as to Mr Miller's injuries and the bloodstain  
10 patterns. It is not inconceivable that Mr Miller would  
11 leave little trace of his presence at the top of the cliff  
12 depending upon how he came over the fence. In addition,  
13 the presence of the ivy that was found adjacent to his feet  
14 is at least consistent with him having disturbed that  
15 vegetation.  
16

17 Now, the forensic evidence cannot, of itself,  
18 determine whether Mr Miller came over the cliff as a result  
19 of an accidental fall or a push. However, we submit that  
20 it would seem implausible that Mr Miller, who was 180cm  
21 tall and weighed 87 kilograms, could have been forced over  
22 any barbed-wire fence by an unknown person and pushed off  
23 the cliff without sustaining any injuries consistent with  
24 an assault and without there being blood patterns  
25 consistent with an assault.  
26

27 You will recall the evidence of Detective Sergeant  
28 Cameron that if anyone had been carried to and lifted or  
29 pushed over the fence, he would have expected greater  
30 damage to the fence and the vegetation and for there to be  
31 more physical evidence adhering to the barbed-wire fence.  
32 Accordingly, if it is accepted that Mr Miller fell to his  
33 death, then the limited evidence as to Mr Miller having  
34 been at the top of the cliff, in fact, lends weight to the  
35 theory that he climbed the fence himself, rather than being  
36 lifted over the fence and pushed.  
37

38 Accordingly, having regard to the totality of the  
39 evidence now available, it is submitted that it is more  
40 probable than not that Mr Miller met his death after  
41 climbing the fence at Munn Reserve and accidentally falling  
42 to the wharf below. Commissioner, you will see this  
43 conclusion reflected in my written submissions at  
44 paragraph 171.  
45

46 The reasons why Mr Miller climbed the fence at  
47 Munn Reserve are unknown and inevitably will remain so.

1 As I noted earlier, the theory of Senior Constable Lane  
2 that he became lost on his way to the casino is one  
3 plausible theory but essentially speculative. Mr Miller's  
4 high blood alcohol level is likely to have contributed to  
5 some poor judgment.

6  
7 Having reached this conclusion, it follows that  
8 I submit that Mr Miller's death was not a homicide or the  
9 result of LGBTIQ bias.

10  
11 Commissioner, there remain two topics that I wish to  
12 address. The first relates to the evidence that I took you  
13 to earlier in Detective Van Leeuwen's statement about  
14 a piece of what he described as "gravel" being collected  
15 from Mr Miller's hand at autopsy and provided to police.  
16 The Unsolved Homicide Team's case screening form also  
17 refers to this debris and said that it was located in a box  
18 in the archive room.

19  
20 The Inquiry made some efforts to find the location of  
21 this debris to find out what the nature of the debris was  
22 and to determine whether it had ever been tested. Now,  
23 a statement was obtained by Inspector Brady of the Forensic  
24 Evidence and Technical Service, and according to that  
25 statement, the debris was located in the State Archives,  
26 but it had never been booked or recorded as an exhibit and  
27 it had never been tested. It's submitted that collecting  
28 an exhibit but failing to record it, failing to test it or  
29 even consider its nature is a significant oversight in the  
30 original investigation.

31  
32 Commissioner, I might ask that tab 79I  
33 [NPL.9000.0017.0001] at page 5 be placed on the screen.  
34 This is a photograph of the debris that is in a jar. The  
35 jar is shown to have a sense of scale, and a closer image  
36 of the debris is at page 6.

37  
38 This debris was visually inspected by Inspector Brady.  
39 He described it as brown or orange in colour, having the  
40 appearance of rust. In his opinion, the debris appeared to  
41 be neither gravel nor organic or plant material. He also  
42 noted that the debris was magnetic, which suggests that it  
43 has metallurgic properties.

44  
45 Commissioner, the origin of the debris in Mr Miller's  
46 hand is at this time unknown and the Inquiry is in the  
47 process of briefing an appropriate expert to ascertain the

1 nature of the material, which could reveal whether it was  
2 consistent with it originating from the fence or the cliff  
3 above where Mr Miller was found.

4  
5 Supplementary submissions on this issue, as well as on  
6 any other investigations carried out by the Inquiry, may be  
7 provided in due course, and both parties will be provided  
8 and given the opportunity to respond.

9  
10 That image can now be taken down.

11  
12 Commissioner, I finally wish to make some comments  
13 about the original police investigation. Senior Constable  
14 Lane appears to have arrived quickly at the view that  
15 Mr Miller's death was accidental. In an undated letter  
16 from Mr Miller's parents to the Coroner, they wrote that:

17  
18 *From my first contact with Senior Constable*  
19 *Lane he has been adamant Scott's death was*  
20 *caused by a fall. Senior Constable Lane*  
21 *also appears now unable to reconcile*  
22 *himself to the findings of the Senior*  
23 *Deputy Coroner.*

24  
25 As I noted, this was part of the motivation for a separate  
26 strike force being established.

27  
28 Now, this observation is also confirmed by Ms Lott's  
29 recollections, that's Ms Bridget Lott, who was the partner  
30 of Mr Miller at the time, who recalls attending The Rocks  
31 police station only one or two days after Mr Miller's death  
32 and being told that he may have fallen over the cliff in  
33 search of the casino.

34  
35 Now with the benefit of new evidence, Senior Constable  
36 Lane's view appears to have been somewhat validated.  
37 However, it should be noted that at the time of his  
38 investigation, the evidence of crime scene examiners and  
39 a forensic pathologist was that homicide was at least  
40 a possibility and the investigation, it is submitted,  
41 accordingly needed to be conducted as a homicide  
42 investigation.

43  
44 In those circumstances, some aspects of the  
45 investigation into Mr Miller's death were not pursued as  
46 thoroughly or completely as they could have been. A number  
47 of relevant statements were not taken until the inquest and

1 at the prompting of Mr Miller's parents. For example,  
2 police had failed to take statements from all of the  
3 security guards across the window of time in which  
4 Mr Miller's death may have occurred.

5  
6 As I have noted, Strike Force Corone would ultimately  
7 go on to take many other investigative steps some of which,  
8 it is submitted, should have been carried out at first  
9 instance.

10  
11 In addition, the canvassing of witnesses was not  
12 conducted thoroughly or carefully. Now, this is  
13 particularly evident in relation to the canvassing of crew  
14 members on board the vessel Ranginui, which was a ship that  
15 was docked at Wharf 4 on the night of Mr Miller's death.  
16 Now, Wharf 4 was the closest wharf to the machinery yard  
17 where Mr Miller's body was found.

18  
19 So on 19 March 1997, when crew members of the Ranginui  
20 had departed from Sydney but then returned, police did  
21 interview 10 members of the crew. A running sheet  
22 summarises those 10 interviews and it records that six crew  
23 members went to see the Mardi Gras, three returned together  
24 at 11.30pm, while the other three became separated while  
25 drinking during the night and arrived back separately  
26 between 12am and 3am.

27  
28 The running sheet also indicates that two crew members  
29 were on the night watch shift. All crew members spoken to  
30 were recorded as not having seen anything suspicious.  
31 However, the running sheet does not indicate whether each  
32 crew member was spoken to separately or in the presence of  
33 others, and there is, it is submitted, a general lack of  
34 detail, particularly in relation to the three crew members  
35 who returned between 12 and 3am.

36  
37 As some of the only authorised entrants to the  
38 Patricks compound at the approximate time of Mr Miller's  
39 death, who would have been passing in close proximity to  
40 the place where his body was ultimately found, the crew  
41 members may have provided crucial evidence in relation to  
42 a homicide investigation. So it is submitted that greater  
43 care should have been taken to capture their evidence as to  
44 their movements and observations on the night.

45  
46 So, Commissioner, I otherwise rely on my written  
47 submissions in relation to the police investigation.

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THE COMMISSIONER: Thank you.

Is there anything you wish to say at the moment,  
Mr Short?

MR SHORT: No, your Honour. The Commissioner of Police  
seeks to reserve her position.

THE COMMISSIONER: All right.

Do you wish to say anything at the moment?

MR TYNAN: No, Commissioner. The family is giving  
consideration as to whether to submit written submissions  
in due course.

THE COMMISSIONER: Thank you. Can I just direct my  
remarks to Bridget and Shane and to other members of the  
family who are watching. I, too, on behalf of my staff and  
myself, convey my sincere condolences to you all. This has  
been a very tough time for each and every one of you and  
I appreciate your attendance here today.

I will continue to give consideration to the matters  
that are put before me and, of course, in due course,  
I will hear from the police, and then I will give my report  
in due course, but thank you very much. I will now  
adjourn.

**AT 11.11AM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED  
ACCORDINGLY**

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