

**2022 Special Commission of Inquiry
into LGBTIQ hate crimes**

Before: The Commissioner, the Honorable Justice John Sackar

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

On Wednesday, 2 November 2022 at 10.02am

(Day 3)

Counsel Assisting:

**Mr Peter Gray SC (Senior Counsel Assisting)
Ms Christine Melis (Counsel Assisting)
Mr Bill de Mars (Counsel Assisting)
Ms Kathleen Heath (Counsel Assisting)
Ms Gráinne Marsden (Counsel Assisting)
Ms Meg O'Brien (Counsel Assisting)
Ms Claire Palmer (Counsel Assisting)
Mr Enzo Camporeale (Director Legal)
Ms Kate Lockery (Principal Solicitor)**

1 THE COMMISSIONER: In a moment I will invite Mr Gray of
2 Senior Counsel to deliver an opening statement, but as this
3 is the first public hearing of this Special Commission of
4 Inquiry it's therefore appropriate that we acknowledge the
5 traditional custodians of the land on which we gather today
6 and we pay our respects to their elders past, present and
7 emerging and I extend that respect to any Aboriginal or
8 Torres Strait Islander peoples here today or watching
9 online.

10
11 Yes, Mr Gray.

12
13 MR GRAY: Commissioner, I have been appointed as Senior
14 Counsel assisting the Special Commission of Inquiry. Six
15 other barristers have been appointed as junior counsel
16 assisting. Ms Christine Melis on my right, Mr Bill
17 de Mars, Ms Claire Palmer, then Ms Meg O'Brien on my left,
18 Ms Kathleen Heath on the right, and Ms Grainne Marsden who
19 is not able to be here today. Mr Enzo Camporeale is the
20 instructing solicitor to the Special Commission leading a
21 team of solicitors, with Ms Kate Lockery, from the Crown
22 Solicitor's Office. They are behind me to my right.

23
24 As with any Special Commission of Inquiry, the Terms
25 of Reference provide the context and the essential
26 parameters within which this Special Commission will
27 undertake its work. I will come back to those Terms of
28 Reference in more detail shortly, but first I will say
29 this.

30
31 All of the deaths with which this Inquiry is
32 concerned, many of them lonely and terrifying, were of
33 people whose lives were tragically cut short. Many had
34 also suffered discrimination, or worse, while alive; some
35 of the deaths were obviously murders, others may well have
36 been. The response of the community, of society, of its
37 institutions to these deaths was, sadly, lacking. All of
38 these lives, of every one of these people, mattered. They
39 mattered to them, to their loved ones and, ultimately to
40 all of us. And their deaths matter. This Special
41 Commission, by shining a light on everything that is known
42 and can be found out about what happened, will aim to
43 provide some recognition of the truth.

44
45 The establishment of this Special Commission followed
46 a recommendation last year in the Final Report of the New
47 South Wales Legislative Council Standing Committee on

1 Social Issues, which I will call the Parliamentary
2 Committee. The Parliamentary Committee had carried out an
3 inquiry itself, over the course of some
4 two-and-a-half years between 2018 and 2021, into Gay and
5 Transgender hate crimes between 1970 and 2010.
6

7 In February 2019 the Parliamentary Committee published
8 an Interim Report and in May 2021 it published its final
9 report. One of the recommendations of that final report
10 was in these terms, and I quote:

11
12 *That the New South Wales Government*
13 *establish a judicial inquiry or other form*
14 *of expert review to enquire into unsolved*
15 *cases of suspected gay and transgender hate*
16 *crime deaths.*
17

18 The words "unsolved", "suspected" and deaths" are of
19 some significance as I will outline shortly.
20

21 In due course, on the 13th of April this year this
22 Special Commission was established by Letters Patent issued
23 in the name of the Governor of New South Wales pursuant to
24 the Special Commissions of Inquiry Act 1983. The Letters
25 Patent contained within them the Inquiry's Terms of
26 Reference.
27

28 So far as has been ascertained, this Special
29 Commission is the first of its kind anywhere in the world.
30

31 The inquiry carried out by the Parliamentary Committee
32 had followed on from the publication of two important
33 reports in 2018. Firstly, a report by ACON, formerly the
34 AIDS Council of New South Wales, entitled, "In Pursuit of
35 Truth and Justice" published in May 2018. I will refer to
36 that as "the ACON Report". And secondly, a report
37 concerning a New South Wales Police Strike Force called
38 Strike Force Parrabell published a month later in June
39 2018. I will refer to that as the "Parrabell Report".
40

41 Both of those reports in different ways had looked at
42 some 88 deaths in New South Wales between 1976 and 2000
43 where "gay hate" or "anti-gay bias" or "sexuality or gender
44 bias" had been relevant factors or might have been relevant
45 factors. Both reports were the result of years of work by
46 ACON and the Police respectively. Most of those 88 deaths
47 were regarded as "solved", for example, where the actual or

1 probable perpetrator or perpetrators had been identified
2 and/or had been charged and/or prosecuted and/or convicted.
3 Less than half of those 88 deaths were regarded as
4 "unsolved". However, the ACON Report on the one hand and
5 the Parrabell Report on the other, expressed different
6 views as to what that proportion of unsolved cases actually
7 was. ACON considered that about 30 of the 88 were
8 unsolved, while Parrabell regarded 23 as unsolved.

9
10 The two reports also arrived at very different
11 conclusions as to how many of the 88 cases were "gay hate"
12 related. The ACON Report treated all or most of the 88
13 cases as having had, or as being likely to have had, that
14 feature, whereas in the Parrabell Report less than
15 one-third of them were characterised in one or other of
16 those ways.

17
18 The Parliamentary Committee looked closely at both of
19 those two reports and also received written submissions and
20 oral evidence from those who had been responsible for, and
21 involved in, the work which had led to their compilation
22 and to their conclusions. The Committee also received
23 submissions and evidence from numerous other organisations
24 and individuals.

25
26 The work of ACON and Police, in embarking on these
27 tasks as they did, was in some ways the culmination of a
28 long-term building up of concern in many parts of the
29 community about the levels of violence, including
30 homicides, committed against LGBTIQ people especially in
31 the 1970s, 80s, and 90s.

32
33 The second half of the 20th Century was a period of
34 rapid social change on many fronts. In the particular
35 context with which this inquiry is concerned some of the
36 well-documented signposts were the following.

37
38 As late as 1958 the then NSW Police Commissioner,
39 Colin Delaney, described homosexuality as "the greatest
40 social menace" in Australia. A year earlier, in 1957, the
41 Wolfenden Report in the UK had recommended
42 decriminalisation of homosexual conduct between consenting
43 adult males in private. In 1967, 10 years after the
44 Wolfenden Report, such decriminalisation was implemented by
45 legislation, initially in England and Wales, and later in
46 all of the UK.

47

1 In 1969 the Stonewall riots in New York attracted
2 worldwide publicity and attention. In 1970 CAMP (Campaign
3 Against Moral Persecution) was formed in Australia. In
4 1975 homosexual conduct was decriminalised in South
5 Australia, the first Australian state to take that step.
6 In 1978 the first Mardi Gras was held in Sydney. In 1984
7 homosexual conduct was decriminalised in New South Wales.
8 And later still in Western Australia, 1989, Queensland
9 1991, and Tasmania 1997.

10
11 By 1984, the year of decriminalisation in this state,
12 HIV/AIDS had begun to have its devastating effects in
13 Australia and around the world. In 1987 the Grim Reaper
14 media campaign was given saturation coverage, and it was
15 not until 2014, eight years ago, that amendments to the
16 Crimes Act in this state effectively abolished a defence
17 known colloquially as the "gay panic defence" or
18 "homosexual advance defence" - whereby an accused might
19 assert that, although he had killed or injured a victim, he
20 had only done so because the victim had made a so-called
21 homosexual advance.

22
23 The Parliamentary Committee received submissions and
24 evidence from a number of participants in its inquiry to
25 the effect that, whereas the decriminalisation of
26 homosexual conduct in 1984 might have been expected to lead
27 to greater levels of acceptance for LGBTIQ people, the
28 combined effect of the AIDS epidemic and the Grim Reaper
29 campaign was to increase hostility and fear, directed
30 towards gay men, in particular, among many in the
31 community.

32
33 The ACON Report pointed to the particular frequency of
34 violent physical assaults on LGBTIQ people between the
35 mid-1980s and the early 1990s. Many of the 88 deaths
36 referred to in the ACON Report and the Parrabell Report,
37 indeed about half of that 88, occurred in that period of
38 less than 10 years.

39
40 During 2001 and 2002 a New South Wales Police Strike
41 Force called Strike Force Taradale conducted a substantial
42 investigation into the deaths of three men near Bondi which
43 had occurred in that concentrated period: one in 1985 and
44 two in 1989. That investigation led in turn to a lengthy
45 inquest in 2003 and 2004 before the then Deputy State
46 Coroner, Jacqueline Milledge. The Coroner's findings were
47 delivered in early 2005. They included findings that two

1 of those men, Ross Warren and John Russell, had been
2 victims of homicide perpetrated by a person or persons
3 unknown.

4
5 The Coroner also said that the evidence strongly
6 supported the probability that both men met their deaths at
7 the hands of what the Coroner called "gay hate assailants".
8 The Coroner concluded that it was not possible to make such
9 a finding in relation to the third man, Gilles Mattaini,
10 but said that there was a strong possibility that he died
11 in similar circumstances to the other two men. I will say
12 more about Strike Force Taradale and Coroner Milledge's
13 findings a little later.

14
15 Both Taradale and the Milledge inquest were the
16 subject of considerable publicity in the early 2000s, and
17 in the years that followed there was a succession of
18 newspaper articles, books and television programmes about
19 violence directed towards LGBTIQ people, including violence
20 causing deaths. Some of the most prominent of those
21 publications were in the years between 2013 and 2016.

22
23 One of the deaths which had increasing publicity was
24 that of Scott Johnson, whose body was found at the base of
25 a cliff at North Head near Manly in December 1988. The
26 original inquest in the Scott Johnson case in 1989 had
27 resulted in a finding of suicide. A second inquest in
28 2012, more than 20 years later, overturned that finding and
29 instead brought in an open finding as to how he had fallen.
30 The second Coroner drew attention in her findings to
31 comparisons which might be made to what was known about
32 North Head and the evidence of gay hate violence in the
33 Taradale-Bondi inquest.

34
35 During 2016 and in 2017 there was a third Johnson
36 inquest before the then State Coroner, Michael Barnes. In
37 late 2017 Coroner Barnes delivered his findings. He found
38 that Mr Johnson had fallen from the cliff top:

39
40 *As a result of actual or threatened*
41 *violence by unidentified persons who*
42 *attacked him because they perceived him to*
43 *be homosexual.*

44
45 In other words, in the view of Coroner Barnes, Scott
46 Johnson's death was caused by anti-gay violence, actual or
47 threatened.

1
2 The case of Scott Johnson is still before the criminal
3 courts. Indeed the Court of Criminal Appeal is presently
4 reserved on one aspect of the case, and so, it will not be
5 separately re-investigated in this Inquiry for reasons I
6 will mention. However, some of the background to the
7 Coroners' findings in the Scott Johnson case may be the
8 subject of evidence before this Special Commission.
9

10 Turning to the ACON Report of May 2018, it set out a
11 number of clear views and conclusions on the part of ACON
12 in connection with the 88 deaths, including the following,
13 and I will list these one to nine.
14

15 1. Killings occurred in three main spaces: the
16 majority in private homes, typically the home of the
17 victim, followed by deaths at beats and, thirdly, deaths at
18 other social locations such as near bars and clubs
19 frequented by gay men, for example, in Oxford Street and
20 Kings Cross.
21

22 2. "Beat" is a term used in Australia to describe a
23 place where men go to have consensual, non-commercial,
24 casual sex with other men.
25

26 3. Known beats included North Head, Marks Park near
27 Bondi, Rushcutters Bay and Alexandria Park.
28

29 4. Where a killing occurred in the victim's home the
30 victim was more likely to be known to the assailant, there
31 was likely to have been a single assailant, and the attacks
32 were often frenzied and vicious.
33

34 5. Where the killing took place at a beat, the
35 assailant or assailants typically had no relationship to or
36 knowledge of the victim.
37

38 6. Several cases involved men being found at the base
39 of cliffs located at known beats such as North Head and
40 Marks Park. These victims either slipped while trying to
41 escape or were pushed.
42

43 7. There was evidence of serial killings by gangs of
44 young men, as well as by lone assailants.
45

46 8. The 88 deaths investigated as part of the ACON
47 review were only a small sample of the violence experienced

1 by the LGBTIQ community between 1970 and 2000.

2
3 9. Approximately 30 of the 88 cases remained
4 unsolved.

5
6 Although the ACON Report itself did not contain the
7 names of most of the victims, various media articles and
8 books had by that time, May 2018, listed the names of some
9 or all of the 30 unsolved cases.

10
11 The Parrabell Report was released publicly by the New
12 South Wales Police one month later, in June 2018. Among
13 its features were the following: first, Strike Force
14 Parrabell reviewed 86 of the 88 deaths the subject of the
15 ACON Report. Of the other two, one was a case from
16 Tasmania while the second case was then under active
17 investigation.

18
19 Second, the names of all 88 victims were included in
20 the Parrabell Report as published.

21
22 Third, the Strike Force was a purely paper review of
23 matters that all had already been investigated by the New
24 South Wales Police in the past. There was no
25 re-investigation of any of those cases. Rather, the
26 objective of the Strike Force was different: it was simply
27 to look at whatever material was available from previous
28 investigations, and in that way to form an opinion, at the
29 time of the Parrabell exercise, as to whether a "sexuality
30 or gender bias" or "anti-gay bias" or "gay hate" had been
31 involved in any of the deaths at the times they had
32 occurred many years earlier. All three of those
33 expressions that I just described in quotes were used in
34 various parts of the Report.

35
36 Fourth, the police officers who participated in Strike
37 Force Parrabell between 2016 and 2018 were of varying ranks
38 and experience. The task for those officers was to review
39 the historical material available in a particular case, and
40 then to fill out a form called a "Bias Crime Indicators
41 Form" by responding to 10 prompts or indicators set out in
42 the Form. The Form had been largely adapted from a
43 document originating in the United States.

44
45 Fifth, having filled out the 10 sections of the Form
46 in relation to a particular case, the Parrabell police
47 officers were then to complete the Form by assigning each

1 case to one out of four possible descriptions. The four
2 options to choose from were: (i) "Evidence of bias crime",
3 or (ii) "Suspected bias crime"; or (iii) "No evidence of
4 bias crime", or (iv) "Insufficient information to establish
5 a bias crime".
6

7 Sixthly, as part of the Parrabell Report, a team of
8 academics from Flinders University in Adelaide reviewed the
9 results of the Parrabell police officers. The academics
10 were provided with all the completed Bias Crime Indicators
11 Forms but none of the historical files or material on which
12 those completed Forms were based.
13

14 Seventh, the approach of the Flinders team is set out
15 in the longer second section of the Parrabell Report. The
16 Flinders academics adopted a completely different
17 methodology from that of the Police.
18

19 Eighth, they did not use or rely upon the 10 Bias
20 Crime Indicators as all, as set out on the Form used by the
21 police. They expressed some reservations about the
22 appropriateness of that Form. Instead, they devised a set
23 of concepts and definitions of their own.
24

25 Ninth, of the 86 cases, the Parrabell police officers
26 assigned eight to their first category, that is, as being
27 cases where there was "evidence of bias crime" and 19 to
28 their second category as being "suspected bias crimes".
29 They assigned the other 59 cases to either the third
30 category "no evidence of bias crime" - 34 cases; or the
31 fourth category "insufficient information to establish a
32 bias crime" - 25 cases.
33

34 Tenth, Strike Force Parrabell regarded only 23 of the
35 88 cases as unsolved.
36

37 Eleventh, of those 23 the Parrabell officers
38 considered that none of them came under the first option,
39 that is, "evidence of bias crime". Five were assigned to
40 the second category as "suspected bias crimes". The other
41 18 were either "no evidence of bias crime", four cases, or
42 "insufficient information to establish a bias crime" - 14
43 cases.
44

45 And twelfth, the Flinders academics, notwithstanding
46 their entirely different methodology, arrived at almost
47 identical numerical conclusions.

1
2 One of the subjects discussed in all of the four
3 reports that I have mentioned, that is, the ACON Report,
4 the Parrabell Report and the two Parliamentary reports
5 which followed, was the concerns that had been often
6 expressed about whether in the decades under review the
7 Police had investigated crimes against LGBTIQ people,
8 including possible homicides, adequately or fully.
9

10 The New South Wales Police have frankly and repeatedly
11 acknowledged in their own Parrabell Report itself and in
12 later submissions and evidence to the Parliamentary
13 Committee, and also in public statements going back much
14 earlier in time, both that such concerns existed and that,
15 at least to some extent, those concerns were justified.
16

17 Throughout the many days of the Taradale inquest in
18 2003 and 2004, relating to the three Bondi deaths from 1985
19 and 1989, the Commissioner of Police was represented by
20 counsel and solicitors. The closing submissions by counsel
21 for the Police Commissioner in December 2004 included the
22 following statements, and I quote:
23

24 *The climate which then existed [referring*
25 *to the 1980s] ... was a climate I think*
26 *that no-one in society could really be*
27 *proud of and that is the culture of gay*
28 *hate, a gay hate crime. The Police*
29 *Service, whatever defects it may have*
30 *suffered from during that period, was no*
31 *more than a reflection of it was exhibiting*
32 *the broader values and principles of the*
33 *then society.*
34

35 And a little later in his submissions counsel for the
36 Commissioner said:
37

38 *Prior to 1990 there was much hostility*
39 *between the gay and lesbian community and*
40 *the police, particularly taking into*
41 *account that homosexuality was only*
42 *decriminalised in 1984. This led to a*
43 *situation for a number of years when police*
44 *were viewed as the enemy of gay people.*
45

46 The findings of then Deputy State Coroner Milledge
47 were delivered a few months later, in March 2005. In the

1 course of those findings Coroner Milledge said, among other
2 things, the following:

3
4 *During the 1980s and 1990s police were*
5 *aware of a number of gangs of youths that*
6 *were systematically engaged in the assault*
7 *and robbery of gay men in Marks Park and*
8 *other areas.*

9
10 The Coroner said:

11
12 *The initial police investigation into the*
13 *death of Ross Warren in 1989 was "a grossly*
14 *inadequate and shameful investigation".*

15
16 A little later the Coroner said:

17
18 *A better investigation was undertaken for*
19 *Mr Russell but it too was far from*
20 *adequate.*

21
22 And the Coroner added:

23
24 *Marks Park was a known area for brutal*
25 *attacks on homosexual males.*

26
27 The Parrabell Report, 13 years later in June 2018,
28 also contained some very candid statements by the New South
29 Wales Police including the following: At page 14:

30
31 *The NSW Police Force is acutely aware of*
32 *and acknowledges without qualification both*
33 *its and society's acceptance of gay*
34 *bashings and shocking violence directed at*
35 *gay men and the LGBTIQ community between*
36 *1976 and 2000. It is clear beyond question*
37 *that levels of violence inflicted upon gay*
38 *men in particular were elevated, extreme*
39 *and often brutal.*

40
41 At page 15 of the Parrabell Report the Police made
42 this statement:

43
44 *The Gay and Lesbian Rights Lobby and later*
45 *the AIDS Council of NSW, now ACON, kept*
46 *records usually comprising self-reported*
47 *incidents of gay hate violence that on*

1 *several occasions amounted to more than 20*
2 *entries per day. Unfortunately, fear*
3 *associated with anti-gay attitudes of*
4 *officers within the NSW Police Force at the*
5 *time prevented these reports from being*
6 *formally recorded which in turn meant that*
7 *crimes were not investigated. This*
8 *inherent lack of consequences or*
9 *accountability meant that perpetrators were*
10 *given a kind of 'social licence' to*
11 *continue inflicting violence upon members*
12 *of the gay community.*

13
14 Then, at page 16 of the Report:

15
16 *The NSW Police Force must acknowledge, and*
17 *has to some extent acknowledged, its part*
18 *in marginalisation of the LGBTIQ community*
19 *during the 70s, 80s and 90s especially.*

20
21 In his oral evidence before the Parliamentary
22 Committee later that year on 9 November 2018, Assistant
23 Commissioner Tony Crandell, the Commander of Strike Force
24 Parrabell, reiterated each of those acknowledgments that I
25 have just read out.

26
27 Two years later, on 13 November 2020, Assistant
28 Commissioner Gelina Talbot, in the course of her evidence
29 before the Committee said this:

30
31 *We are, and should be, held to a higher*
32 *account given our role to protect and*
33 *serve. Everyone should be confident when*
34 *they report a matter to the police that it*
35 *will be recorded and investigated where*
36 *appropriate. I accept that we have not met*
37 *that standard at times in the past. I sit*
38 *here today acknowledging the victims of the*
39 *past and their families. I acknowledge the*
40 *past inadequacies of the New South Wales*
41 *Police Force in responding, recording and*
42 *investigating hate crimes against the*
43 *LGBTIQ community.*

44
45 In its Final Report published in May 2021 one of the
46 express public findings made by the Parliamentary Committee
47 was this:

1
2 *That historically the NSW Police Force*
3 *failed in its responsibilities to properly*
4 *investigate cases of historical gay and*
5 *transgender hate crime and this has*
6 *undermined the confidence of lesbian, gay,*
7 *bisexual, transgender, intersex and queer*
8 *communities in the NSW Police Force and the*
9 *criminal justice system more broadly.*

10
11 Before I turn to the specific language of the Terms of
12 Reference, I'll mention one other aspect of the historical
13 sequence of events which may be relevant to the work of
14 this Special Commission.

15
16 In early 2013, a Strike Force called Strike Force
17 Macnamir was established by the New South Wales Police to
18 re-investigate the death of Scott Johnson near Manly in
19 1988. That led in due course to the third Johnson inquest
20 in 2016 and 2017.

21
22 At about the same time, also in early 2013, Operation
23 Parrabell, which was the precursor to Strike Force
24 Parrabell, was established. In that year, 2013, the work
25 of Operation Parrabell was to assist Strike Force Macnamir
26 by carrying out a bias crime assessment in respect of the
27 North Head beat.

28
29 Two years later, in 2015, Operation Parrabell became
30 Strike Force Parrabell. The objective of Strike Force
31 Parrabell, as I have mentioned, was to consider whether
32 "sexuality or gender bias" or "anti-gay bias" or "gay hate"
33 was a factor in any of the 88 deaths in question.

34
35 Later in 2015 or early in 2016, while Strike Force
36 Parrabell and Strike Force Macnamir and the third Scott
37 Johnson coronial inquiry were all underway, another Strike
38 Force was established called Strike Force Neiwand. Strike
39 Force Neiwand was a re-investigation of the deaths of
40 Mr Warren, Mr Russell and Mr Mattaini, the three men whose
41 deaths near Bondi in the 1980s had been the subject of
42 Strike Force Taradale over the course of 2001 and 2002, of
43 the subsequent lengthy inquest during 2003 and 2004, and of
44 Coroner Milledge's findings in 2005. Coroner Milledge, it
45 will be recalled, had found that the deaths of Mr Warren
46 and Mr Russell were gay hate-related homicides and that
47 there was also a strong possibility that the death of

1 Mr Mattaini had occurred in similar circumstances.

2
3 In November 2017, as will also be recalled, Coroner
4 Barnes delivered his findings in the third Johnson Inquest.
5 The substance of his finding was that Mr Johnson's death in
6 1988 was also the result of anti-gay violence, actual or
7 threatened. About a month later, Strike Force Neiwand
8 concluded that the 2005 findings by Coroner Milledge about
9 the three Bondi deaths in the 1980s should, in effect, be
10 disregarded and that, while homicide could not be ruled
11 out, other causes of deaths were as likely or more likely
12 in all three of those cases.

13
14 A few months after that, in the Parrabell Report
15 of June 2018, Strike Force Parrabell assigned the cases of
16 Mr Warren and Mr Russell and also that of Mr Johnson to its
17 second category, that is, "suspected bias crime", and not
18 the first category being cases where there was "evidence of
19 bias crime". The case of Mr Mattaini was assigned to the
20 fourth category, "insufficient information".

21
22 Neither the existence nor the conclusions of Strike
23 Force Neiwand appear to have been referred to publicly by
24 the New South Wales Police, including in evidence or
25 submissions to the Parliamentary Committee.

26
27 I turn now to the Inquiry's Terms of Reference. The
28 Terms of Reference will be shown on the screen in a moment.
29 They authorise the Commissioner, as can be seen - and I'm
30 looking now at the paragraph below the word "Greeting" at
31 about the third-last line of that paragraph:

32
33 *The Commissioner is authorised to inquire*
34 *into and report and make recommendations to*
35 *Our Governor of the said State on:*

36
37 Two categories of death, Category A and B.

38
39 Category A is:

40
41 *The manner and cause of death in all cases*
42 *that remain unsolved from the 88 deaths or*
43 *suspected deaths of men potentially*
44 *motivated by gay hate bias that were*
45 *considered by Strike Force Parrabell.*

46
47 Category B is:

1
2 *The manner and cause of death in all*
3 *unsolved suspected hate crime deaths in New*
4 *South Wales that occurred between 1970 and*
5 *2010 where:*

6
7 *(i) the victim was a member of the lesbian,*
8 *gay, bisexual, transgender, intersex and*
9 *queer (LGBTIQ) community; and (ii) the*
10 *death was the subject of a previous*
11 *investigation by the NSW Police Force.*

12
13 Section C, if we scroll down just slightly further,
14 requires the Commissioner in conducting the Inquiry to have
15 regard to each of the four reports that I have talked
16 about, namely, the ACON Report of May 2018, the Parrabell
17 Report of June 2018, and the two reports of the
18 Parliamentary Committee itself, the Interim Report
19 of February 2019 and the Final Report of May 2021.

20
21 Scrolling down again slightly further, Sections D, E
22 and F of the Terms of Reference set out other directions
23 binding on the Commissioner, some of which I will mention
24 briefly in a moment.

25
26 Importantly, the last paragraph of the Terms of
27 Reference, if we scroll down slightly further again,
28 stipulates a set date by which the report of the Inquiry
29 must be completed and delivered. That date is 30 June
30 2023.

31
32 It's clear from the Terms of Reference that this
33 Inquiry is not merely an exercise of reviewing past
34 investigations. Its task is to carry out its own inquiries
35 into, and to deliver its own report and recommendations on,
36 these two categories of unsolved deaths: Category A and
37 Category B. It is important therefore to emphasise that
38 the work of the Special Commission has been and will be
39 entirely independent. That requirement of independence is
40 inherent in both the Terms of Reference and the *Special*
41 *Commissions Act*. You as Commissioner are directed by the
42 Terms of Reference to inquire, yourself, into the nominated
43 subject matter. The words of that direction reflect the
44 words of section s.4(1) of the *Special Commissions Act*.
45 Accordingly, the Special Commission is conducting and will
46 conduct its own investigations.

47

1 The New South Wales Police have so far produced, to
2 the Special Commission, voluminous records relating to the
3 deaths the subject of the Inquiry. I will say more about
4 the extent of that documentation in a moment. And it is to
5 be expected that the Police will seek authorisation to
6 appear at some public hearings of the Inquiry. However,
7 the Inquiry itself is entirely independent of the Police.

8
9 If we could go back to the Terms of Reference briefly
10 on the screen, if that's possible. I will mention
11 Section E and Section F. Section E provides that the
12 Special Commission is required:

13
14 *To operate in a way that avoids prejudice*
15 *to criminal investigations, any current or*
16 *future criminal prosecutions, and any other*
17 *contemporaneous inquiries.*

18
19 Section F further provides:

20
21 *That the Commissioner is not required to*
22 *inquire into particular matters where*
23 *satisfied that the matter has been or will*
24 *be sufficiently and appropriately dealt*
25 *with by another inquiry or investigation or*
26 *a criminal or civil proceeding.*

27
28 With those matters in mind, the Special Commission has
29 taken considerable care to obtain from the New South Wales
30 Police, including the Unsolved Homicide Team, information
31 and details as to exactly how many cases, and which ones,
32 are the subject of any relevant inquiry or investigation or
33 prosecution or proceeding.

34
35 As one part of that checking process the Special
36 Commission held a private hearing in June 2022, during the
37 course of which a senior officer from the Unsolved Homicide
38 Team provided some information in relation to such matters.
39 The Police have subsequently provided the Special
40 Commission with the necessary information as to cases which
41 do come within the ambit of Section E and/or Section F of
42 the Terms of Reference. In most or all of those cases it
43 is likely that the Special Commission will, for that
44 reason, not inquire into those matters. I will say
45 something more about the work of the Unsolved Homicide Team
46 in a moment.

47

1 But I turn to Categories A and B, the specific words
2 chosen in the Letters Patent to describe the two categories
3 of deaths in the Terms of Reference, Category A and
4 Category B, pinpoint several significant features of this
5 Special Commission, including a number in particular to
6 which I now draw attention. I wonder if I could ask for
7 those terms, Category A and Category B, to be on the screen
8 again, if we just scroll up. Thank you.
9

10 First, the Special Commission is only to inquire into
11 and report on "deaths", not on crimes such as assaults and
12 bashings which did not result in death. That is consistent
13 with and follows the recommendation which was made by the
14 Parliamentary Committee. However, that does not by any
15 means have the effect that non-fatal attacks will
16 necessarily be excluded from the Inquiry's consideration.
17 Such attacks may well be relevant to investigations by the
18 Special Commission in relation to attacks which did result
19 in death.
20

21 Secondly, both Category A and Category B restrict the
22 ambit of the Special Commission to cases that are
23 "unsolved". It is for the Special Commission to make its
24 own determination in any given case as to whether that case
25 is "unsolved" or not. Whether a given case will be
26 regarded as "solved" or "unsolved" will depend on the
27 circumstances of that case. For example, the circumstances
28 in which the Special Commission will regard as case as
29 "solved" would be likely to include cases where one or more
30 persons have been charged and convicted in connection with
31 the death and all appeals have been finalised, or such a
32 person has been acquitted despite having been identified as
33 the perpetrator, on grounds such as self-defence.
34

35 Conversely, a case might be likely to be regarded as
36 "unsolved" where, for example, no person of interest could
37 be identified, or one or more persons of interest were
38 identified but no arrest has been made, or an arrest was
39 made but the prosecution was no-billed, or the charges were
40 dismissed at committal hearing, or the accused person or
41 persons were acquitted at trial for reasons other than
42 self-defence, or a conviction was overturned by a higher
43 court.
44

45 Thirdly, the name of this Special Commission includes
46 the expression "LGBTIQ hate crimes". That acronym, LGBTIQ,
47 comes directly from the Terms of Reference which use that

1 specific acronym to refer to certain specific words, which
2 we can see on the screen as part of Category B, namely:

3
4 *Lesbian, gay, bisexual, transgender,*
5 *intersex and queer.*
6

7 The Special Commission is aware that other words and
8 other acronyms are sometimes used in various contexts.
9 However, because those specific words and that specific
10 acronym are used in the Terms of Reference the Special
11 Commission for its purposes will adopt them.
12

13 Fourthly, as we see in both Category A and Category B,
14 it is the manner and cause of the deaths to which this
15 Inquiry is directed. That language, referring to the
16 "manner and cause" of deaths, is also found in s.81 of the
17 *Coroners Act* in this state in referring to one of the tasks
18 typically embarked upon by a Coroner. However, this is not
19 a coronial inquiry. There are several fundamental
20 differences between the functions carried out by a Coroner
21 and those of this Special Commission.
22

23 The first fundamental difference is that for this
24 Inquiry the concept of "manner and cause" is specifically
25 shaped by the Terms of Reference in particular ways which
26 are not present in the *Coroners Act*. The Terms of
27 Reference tie this Inquiry to the concepts of "gay hate
28 bias", the words used in Category A; and "hate crime
29 deaths" of LGBTIQ people, which are the words used in
30 Category B. I will come to that terminology and those
31 concepts in more detail in a moment.
32

33 Analysis of whether such a connection as "gay hate
34 bias" or "hate crime" was involved in relation to each of
35 these deaths is thus central to the particular "manner and
36 cause" task given to the Special Commission by the language
37 of the Terms of Reference.
38

39 A second fundamental difference is that, whereas a
40 Coroner is not bound by any strict time limit in
41 undertaking whatever investigations and inquiries may be
42 considered necessary in relation to a particular death,
43 this Special Commission is bound by such a time limit.
44 That time limit, bearing in mind that the Special
45 Commission must inquire into many deaths rather than one
46 single death, is a tight one, namely, the 30th of June
47 next year.

1
2 A third fundamental difference is that, conversely,
3 the Special Commission has coercive powers which are more
4 extensive than those of a Coroner.
5

6 Fifthly, coming back to the features of the language
7 of the Terms of Reference, as to the word "suspected" in
8 Category B, the provisional view of the Special Commission
9 is that what is required is that such a suspicion be
10 objectively able to be held today having regard to all the
11 material now available. It is not necessary that the
12 suspicion, that is, that a death was a LGBTIQ hate crime
13 death, was in fact entertained - whether by the police or
14 otherwise - at the time of the death or at the time of its
15 investigation.
16

17 Sixthly, Category A refers to 88 deaths of "men" that
18 were "considered by Strike Force Parrabell". In fact, some
19 of the deaths considered by Strike Force Parrabell were of
20 persons who were transgender, intersex and/or identified as
21 women. In Category B the reference is to the deaths of
22 people described as "victims". The Special Commission
23 regards Category A as having a similar intent. It does not
24 propose to interpret the word "men" in Category A in any
25 exclusionary way.
26

27 Seventhly, Category B uses the expression "member of
28 the LGBTIQ community". There may or may not be an accepted
29 or consensus view as to whether a single or discrete
30 community described in those words can or should be
31 delineated. There also may or may not be consensus as to
32 how such a delineation should be arrived at, or as to what
33 factors might need to be present to establish, as a matter
34 of objective fact, that a particular person was or was not
35 a member of that community. It may be that there are many
36 distinct groups or communities within such a general
37 overall expression. Even if there were such a consensus
38 view in some cases it may be difficult, whether for lack of
39 sufficient evidence or otherwise, to reach such an
40 objective determination.
41

42 These kinds of questions, among others, relate to
43 areas of cultural and sociological discourse which are
44 beyond the scope of this Special Commission. For example,
45 a person's sexual identity may not necessarily correlate
46 with the actual sexual practices of that person.
47 Transgender and gender diverse people might have any

1 sexuality. Some people may be unsure of their own
2 sexuality. Others may be in no doubt but may choose to
3 conceal it from some or all other people.
4

5 These and many other aspects of the discourse
6 surrounding matters of sexuality and gender are
7 multi-faceted, sensitive and nuanced. Analysis of and
8 conclusions about such matters do not form part of the
9 present Inquiry. For the purposes of this Special
10 Commission it is anticipated that a victim, to use the
11 language of Category B, may be considered to come within
12 the meaning of the expression "member of the LGBTIQ
13 community" where: (a) the victim self-identified as being
14 lesbian, gay, bisexual, transgender, intersex and/or queer;
15 or (b) there is reason to believe or suspect that the
16 victim was lesbian, gay, bisexual, transgender, intersex
17 and/or queer; or (c) there is reason to suspect that a
18 person or persons involved in the death of the victim
19 believed or assumed that the victim was or may be lesbian,
20 gay, bisexual, transgender, intersex and/or queer.
21

22 Eighthly, Category A refers to deaths that were
23 "potentially motivated by gay hate bias", while Category B
24 refers to "suspected hate crime deaths ... where ... the
25 victim was ... a member of the [LGBTIQ] community". Those
26 two different verbal formulations will be treated by the
27 Special Commission as referring to what is substantially
28 the same concept or criterion. Counsel assisting will
29 generally adopt the language of "LGBTIQ hate crime death"
30 as reflecting this one criterion.
31

32 For the purposes of the Special Commission, therefore,
33 a death is likely to be regarded as a suspected LGBTIQ hate
34 crime death and thus, if it is unsolved, prima facie within
35 one or both of Categories A or B in circumstances where
36 there is, objectively, reason to suspect both that the
37 death was a homicide and that the sexuality or gender
38 identity, actual or assumed, of the deceased person as
39 lesbian or gay or bisexual or transgender or queer or a
40 person's intersex status was a factor in the commission of
41 the crime.
42

43 Accordingly, for example, deaths associated with
44 attacks on people who may not themselves be or identify as
45 LGBTIQ but who are wrongly perceived by their assailants in
46 such a way would come within the meaning of "LGBTIQ hate
47 crime deaths".

1
2 This approach, it may be noted, is consistent with the
3 provisions of s.21A of the Crimes (Sentencing Procedure)
4 Act 1999 (NSW) in this state. That section sets out
5 matters which are to be treated as aggravating factors for
6 the purpose of determining the appropriate sentence for an
7 offence. One of those aggravating factors at
8 subsection (h) of s.21A is that:

9
10 *The offence was motivated by hatred for or*
11 *prejudice against a group of people [and I*
12 *stress] to which the offender believed the*
13 *victim belonged such as people of a*
14 *particular ... sexual orientation.*

15
16 I turn now, if it's convenient, to the nature and
17 scale of the task confronting this Special Commission. The
18 scale of the task emerges from an understanding of what is
19 included within the Terms of Reference that I have been
20 going through.

21
22 Category A cases, as I have said, are cases which were
23 considered by Strike Force Parrabell and which remain
24 "unsolved". As I have mentioned, the ACON Report regarded
25 about 30 of those cases as unsolved, whereas the Parrabell
26 Report treated 23 of them as unsolved. The general
27 approach of the Special Commission to the interpretation of
28 the word "unsolved" has been referred to earlier.

29
30 In addition, it is likely that a small number of cases
31 will not be inquired into by the Special Commission having
32 regard to the provisions of the Sections E and F of the
33 Terms of Reference that I looked at a few minutes ago
34 because of the need to ensure that other ongoing
35 investigations or proceedings are not prejudiced, or
36 because such other investigations are regarded as
37 "sufficient and appropriate".

38
39 At this stage of its work the Special Commission has
40 the provisional view that, for the purposes of this
41 Inquiry, some 20 to 25 of the Parrabell cases are likely to
42 be considered as both "unsolved", thus coming within
43 Category A of the Terms of Reference, and also as not
44 affected by the constraints of Sections E and F as to other
45 investigations.

46
47 I will say something about some of the particular

1 Category A cases by name a little later.
2

3 Category B of the Terms of Reference, however, is cast
4 in very wide language. It requires the Special Commission
5 to inquire into all unsolved deaths in New South Wales in
6 the 40 years between 1970 and 2010 where: (a) the victim
7 was a member of the LGBTIQ community; and (b) the death was
8 a "suspected hate crime death"; and (c) the death was the
9 subject of a previous investigation by the New South Wales
10 Police.
11

12 That language obviously includes, firstly, many of the
13 cases in Category A. But it also has required the Special
14 Commission to endeavour to identify any and all other
15 deaths in the 40-year period starting from 1970 which might
16 fall within those three parameters. That has proved to be,
17 perhaps not surprisingly, a very substantial task. The
18 Inquiry has set about that task in numerous ways, many of
19 which are still ongoing.
20

21 The most significant of the avenues which the Special
22 Commission has explored and continues to explore are the
23 following: first, a close examination of the cases from
24 that 40-year period which are part of the remit of the
25 Unsolved Homicide Team within the New South Wales Police.
26

27 Secondly, a similar close examination of the many
28 other cases which are on the files of the Missing Persons
29 Unit within the New South Wales Police.
30

31 Thirdly, by seeking and obtaining information from the
32 National Coronial Information System and the Australian
33 Institute of Criminology.
34

35 Fourthly, by researching and analysing information
36 contained in historical LGBTIQ media publications,
37 including among others, the Sydney Star Observer, Campaign
38 Australia and other publications held by the State Library
39 of New South Wales and the Australian Queer Archives based
40 in Victoria.
41

42 Fifthly, by giving careful consideration to the
43 various submissions made to the Parliamentary Committee.
44

45 Sixthly, by seeking and receiving information from
46 community groups such as ACON and the Gender Centre.
47

1 Seventhly, by seeking information from the public and
2 from the families and friends of people who have died. I
3 will say something about each of these aspects of the
4 Inquiry's work to date.

5
6 First of all, as to the Unsolved Homicide Team. As I
7 mentioned earlier, the Special Commission held a private
8 hearing in early June 2022 in which a senior officer from
9 the Unsolved Homicide Team gave evidence and provided some
10 documents. That was a private hearing in accordance with
11 s.7(2) of the *Special Commissions of Inquiry Act*.

12
13 The present understanding of the Special Commission
14 substantially derived from that evidence and those
15 documents, is that the Unsolved Homicide Team was formed in
16 2004. It monitors, reviews, and in appropriate cases
17 re-investigates historical unsolved homicides. Prior to
18 2004 files connected to unsolved homicides would ordinarily
19 remain with the original investigator at the police station
20 where that original investigator was based or be sent to
21 the Coroners Court for inquest.

22
23 When it was first formed the Unsolved Homicide Team
24 was a review unit only and was not provided with any
25 re-investigation capacity. In the years since 2004 the
26 scope of the Team's work has expanded and it now does
27 include reinvestigations. Organisationally, the Unsolved
28 Homicide Team is within the Homicide Squad in State Crime
29 Command.

30
31 The Unsolved Homicide Team generally adopts a
32 three-stage process in relation to the cases which come to
33 it: first, a triage is undertaken to assess whether a full
34 review is warranted. If it is, an investigator reviews the
35 available material, including exhibits, and conducts other
36 inquiries such as whether suspects and/or witnesses are
37 still alive and available for questioning. Finally, a
38 decision is made as to whether to re-open a full
39 re-investigation of the death.

40
41 Later in June 2022 the Inquiry was provided by the New
42 South Wales Police with a Excel spreadsheet comprising what
43 is known as the Unsolved Homicide Team's "Tracking File".
44 The information on this spreadsheet includes the current
45 investigative status of all unsolved homicides in New South
46 Wales. According to the Tracking File, the overall number
47 of unsolved homicides in the 40-year period the subject of

1 Category B, that is, between 1970 and 2010, is in excess of
2 700. The Tracking File itself, with few exceptions, does
3 not contain any indication as to whether a particular
4 matter is or might be a hate-related homicide; nor is the
5 sexuality or gender identity of the victim of a homicide
6 apparent from the Tracking File.

7
8 Accordingly, it has been necessary for the Special
9 Commission to seek, obtain and analyse the underlying
10 material relating to each of those approximately 700 cases
11 in order to form a view as to which, if any, of those cases
12 might fall within Category B of the Terms of Reference.

13
14 As an initial step, the Inquiry team first conducted
15 preliminary word searches of the Tracking File using broad
16 search terms covering sexual and gender identities: words
17 like gay, lesbian, transgender, queer; locations, words
18 such as beat, Marks Park, Darlinghurst; and types of crime
19 such as gay bashing, and even pejorative and discriminatory
20 terms, which I will not repeat, but which unfortunately are
21 used in some of the materials describing these homicides.

22
23 From these preliminary searches several cases were
24 immediately identified for further consideration. The
25 Inquiry team went on to conduct online searches for any
26 publicly available information about those cases and also
27 sought and obtained all available files from the Coroners
28 Court of New South Wales and from the Police.

29
30 The Inquiry then sought and obtained from the Police
31 all case summaries and review documents prepared by the
32 Unsolved Homicide Team for each of the 700 or so homicides
33 in question. That material when provided comprised more
34 than 1,000 separate documents in total. The Inquiry team
35 then undertook a review of that material. They made a
36 provisional classification, whereby each of the 700 or so
37 cases was tentatively placed in one of five possible
38 categories.

39
40 The first category was cases which had already been
41 identified by the Inquiry as a potential case, those mainly
42 being cases which had been considered by Strike Force
43 Parrabell. 27 cases were identified as falling within that
44 category.

45
46 The second category was further cases which also
47 seemed very likely to fall within Category B. 11 such

1 cases were identified at that stage. One of those was the
2 subject of current criminal proceedings, and accordingly,
3 it is not expected that the Special Commission will be
4 inquiring into that case, so 10 cases remained in that
5 category.
6

7 The third was cases which appeared to be clearly
8 outside the scope of the Inquiry, for example, because the
9 victim was a young child or the death appeared to be a
10 misadventure, such as a boat crash or a plane crash. Some
11 535 cases were in that category.
12

13 A fourth category was cases which might potentially
14 fall within the Terms of Reference but which required
15 further consideration. There were 23 cases of that kind.
16

17 And the final category was for cases where there was
18 insufficient information to make a proper assessment.
19 There were 105 cases in that category.
20

21 In relation to the 23 cases which required further
22 consideration, that further consideration then followed;
23 the outcome of which was that only eight of those 23 cases
24 were ultimately considered as potentially falling within
25 Category B, again, subject to further review as and when
26 more information became available.
27

28 For all the cases identified as possibly falling
29 within Category B as a result of this process the Special
30 Commission sought and obtained the available files from the
31 NSW Police, the Coroners Court of New South Wales and the
32 Office of the Director of Public Prosecutions.
33

34 For the 105 cases in respect of which insufficient
35 information was initially available a number of separate
36 steps had to be successively taken. First, the team
37 conducted online searches for any publicly available
38 information about these homicides. From that review they
39 identified one case that was likely to fall within the
40 Terms of Reference. The Inquiry then obtained all relevant
41 documents from both the New South Wales Police and the
42 Coroners Court in relation to that case. They were able to
43 exclude 74 of those 105 cases as being clearly outside the
44 Terms of Reference, and they identified 30 cases for which
45 more information still was required.
46

47 Secondly, in relation to those remaining 30 cases two

1 further inquiries were made. Where the Tracking File
2 indicated that a person or persons had been charged with a
3 criminal offence arising from the homicide, copies of the
4 police facts for the charge were obtained. Where there had
5 not been charges laid, relevant material was requested from
6 the Coroners Court, including any findings and/or any
7 reasons for dispensing with an inquest and/or copies of any
8 report to the Coroner of the death or suspected death. The
9 Special Commission is continuing to pursue every available
10 avenue in respect of these 30 cases.
11

12 I have spoken so far about the Unsolved Homicide Team
13 and its Tracking File which produced a list of possible
14 cases in excess of 700. The second avenue that I mentioned
15 was the Missing Persons Unit. The Inquiry has also sought
16 to identify any long-term missing persons whose suspected
17 deaths may fall within Category B. Central to this part of
18 the analysis has been the contents of an Excel spreadsheet
19 provided to the Inquiry in July 2022 by the Missing Persons
20 Unit within the New South Wales Police.
21

22 That spreadsheet, known as the "Long-term Missing
23 Persons Spreadsheet" covers all long-term missing persons
24 cases in New South Wales. For the 40-year period between
25 1970 and 2010 there are 559 such cases. However, the
26 information in the spreadsheet comprises only the name of
27 the missing person, the date of the disappearance, and the
28 event or case reference. Once again, the spreadsheet
29 contains no indication as to whether a particular matter is
30 a hate-related homicide or as to the sexuality or gender
31 identity of the victim.
32

33 The Inquiry team has accordingly reviewed each of the
34 559 cases. Of those 559, nine cases were already under
35 consideration by the Inquiry, whether because they were
36 among the 88 Parrabell cases or otherwise; six cases were
37 identified as being likely to fall within Category B; 267
38 cases either were excluded as being very unlikely to fall
39 within Category B, for example, where a person disappeared
40 following a rock fishing accident or the abduction of a
41 young child; or had already been considered in the review
42 of the Unsolved Homicide Tracking File. As to the
43 remaining 277 cases, there was insufficient information
44 available to make a determination.
45

46 For the six missing persons cases considered likely to
47 fall within the scope of the Inquiry, a summons was issued

1 to the Police for all relevant files. For the 277 cases
2 with insufficient information, a summons was issued to the
3 Police for the missing persons reports. The available
4 documents in respect of 274 of those 277 cases were in due
5 course produced. Those documents, for those 274 cases,
6 amounted to almost 3,500 pages.

7
8 In respect of the 274 cases for which documents were
9 available the Inquiry team reviewed those documents.
10 Again, a number of cases were able to be excluded
11 immediately, such as young children, people lost at sea and
12 the like. The outcome of this review of these 274 cases
13 was: five of the 274 were identified as possibly falling
14 within Category B. A summons was issued to the NSW Police
15 for its investigation files in respect of those five cases.
16 229 of the 274 cases were able to be excluded. 40 cases
17 had insufficient information to make a determination. With
18 respect to the 40 cases with insufficient information, as
19 well as the three cases for which the Police were unable to
20 provide records, copies of any missing person reports were
21 requested from the Coroners Court.

22
23 The third avenue which has been explored, as I
24 mentioned, is the resources of the National Coronial
25 Information System and the Australian Institute of
26 Criminology. The National Coronial Information System is a
27 research database of information on deaths reported to a
28 Coroner throughout Australia and New Zealand covering the
29 period from 2000 to the present.

30
31 In July 2022 the Special Commission wrote to the NCIS
32 requesting that searches be undertaken of their extensive
33 digital records of New South Wales coronial findings.
34 Ultimately, the NCIS was able to identify five additional
35 deaths for further consideration. However, following
36 further searches undertaken by the Special Commission,
37 including of relevant media articles and court judgments,
38 it became apparent that none of those cases came within
39 Category B.

40
41 The Australian Institute of Criminology based in
42 Canberra conducts the National Homicide Monitoring Program.
43 The Special Commission has also written to the Institute
44 requesting that searches be undertaken of its holdings to
45 identify any other deaths which may fall within Category B
46 and which may not otherwise have come to the attention of
47 the Inquiry.

1
2 A fourth avenue was to review historical LGBTIQ media
3 publications. From the outset of the Inquiry in May
4 this year, the Inquiry team has undertaken a review of
5 historical LGBTIQ-related material held in various
6 libraries and other repositories. That review is ongoing.
7 One of the most important of these resources is the
8 archives of the State Library of New South Wales which
9 includes manuscripts, personal papers, newspapers,
10 magazines, photographs and graphics.
11

12 Another useful resource has been Campaign Australia
13 magazine which was published between 1975 and 2000.
14 Through text searches of the issues available online the
15 Special Commission obtained contemporaneous news articles
16 about a number of deaths within Category A of the Terms of
17 Reference and also identified a number of potential cases
18 for consideration under Category B.
19

20 The Australian Queer Archives, based in Victoria,
21 includes collections of approximately 150 LGBTIQ
22 periodicals which were current during the period 1970 to
23 2010, and which have been digitised and made available
24 through various libraries, including the State Library of
25 New South Wales. The Inquiry team has made extensive use
26 of this resource for contemporaneous news articles about
27 individual cases as well as historical beat locations and
28 other relevant material otherwise difficult to locate.
29

30 One notable periodical which has not been digitised is
31 the *Sydney Star Observer*. Issues are held in hard copy at
32 both the State Library of New South Wales and the
33 Australian Queer Archives. In September 2022 one of the
34 counsel assisting the Inquiry attended the Australian Queer
35 Archives in Victoria and, with the assistance of an
36 archivist, reviewed relevant issues of the *Sydney Star*
37 *Observer* between 1979 and 1997.
38

39 The fifth avenue was the submissions to the
40 Parliamentary Committee. The Special Commission has
41 carefully reviewed all of the submissions made to the
42 Parliamentary Inquiry in 2018, 2019 and 2020 as well as the
43 oral testimony of witnesses before the Committee. That
44 review identified an additional two cases potentially
45 falling within Category B of the Terms of Reference, over
46 and above what had already been identified, and the
47 relevant files were obtained from the NSW Police and the

1 Coroners Court.

2
3 The sixth avenue, a very important one, is information
4 from community groups. The Special Commission recognises
5 that many of the deaths and disappearances it is examining,
6 and the climate within which they took place, have had a
7 heavy impact, not only on the friends and families of those
8 who are gone, but on the LGBTIQ world as a whole. It is
9 important that as many LGBTIQ people and groups as possible
10 are aware of the Inquiry and feel comfortable coming
11 forward with information.

12
13 With that in mind, the Special Commission has so far
14 engaged in various ways with a number of community groups
15 including ACON, the Gender Centre, and the Sex Workers
16 Outreach Project, or SWOP, with many more on our list. We
17 have sought their cooperation not only so as to spread word
18 of the Inquiry as widely as possible, but also to increase
19 our own awareness of social and cultural factors prevailing
20 both in the time period under review and at the present
21 time.

22
23 The Special Commission has also engaged in similar
24 ways with a number of individuals who have had close
25 involvement with some of the issues with which this Inquiry
26 is concerned including, among others, Sue Thompson, former
27 Gay and Lesbian Client Consultant with the NSW Police; Rick
28 Feneley, journalist; Duncan McNab, journalist, writer and
29 former police officer; Greg Callaghan, journalist and
30 author, and Magistrate Jacqueline Milledge.

31
32 Finally in this context the Special Commission has
33 attempted, of course, to contact family members by letters,
34 emails and text messages to the extent that we have current
35 contact details. Some family members have also contacted
36 us directly. Media releases and public notices have also
37 been utilised. However, identifying and tracing family
38 members for many of the cases being reviewed has been no
39 simple task, and we are well aware that we have not yet
40 been able to reach everyone who may wish to speak about the
41 death or disappearance of a loved one.

42
43 If you are a family member or a friend of one of the
44 people whose unsolved death or disappearance is or may be
45 under review by the Special Commission and you have not yet
46 been contacted but would like to speak to us, please do not
47 hesitate to contact us.

1
2 If possible, this next material might be brought up on
3 the screen, if that can be done.
4

5 There are three main ways in which you may contact the
6 Special Commission. The first is by email, and the email
7 address is contact@specialcommission.nsw.gov.au. Secondly
8 by post, and you address a letter to: LGBTIQ Hate Crimes
9 Inquiry, GPO Box 5341 Sydney, NSW 2000. And thirdly by
10 phone, by calling 02 9228 4855, and leaving a voice
11 message.
12

13 If you do contact the Inquiry by any of those means,
14 please provide your telephone and/or email or other contact
15 details to the Inquiry so that the appropriate person can
16 respond to you.
17

18 Category A relates to cases, as I've said, considered
19 by Strike Force Parrabell, namely, 86 deaths from a 24-year
20 period between 1976 and 2000. That is a considerably
21 shorter time period than the 40-year period in Category B
22 which covers 1970 to 2010. As I have been outlining,
23 identifying the cases which come within Category A is
24 comparatively straightforward. That is because the total
25 number of Parrabell cases is 86, and Category A requires
26 the Special Commission to inquire into those of the 86
27 which are "unsolved". Subject to any complexity which may
28 arise in a particular case in relation to that word
29 "unsolved", the identification of which cases come within
30 Category B can be, and is being, finalised without undue
31 difficulty.
32

33 However, as will be apparent from what I have been
34 saying about the scale of the task given to the Inquiry by
35 Category B, arriving at a definitive number of cases which
36 are captured by the words of Category B has been, and it
37 continues to be, a much more complicated, painstaking and
38 time-consuming undertaking. It is not yet clear which of
39 the many possible cases that have been found will
40 ultimately be considered by the Special Commission as
41 falling within Category B; that is, to be a death which was
42 previously investigated by the New South Wales Police,
43 which is unsolved and where the death was or may have
44 involved a hate crime. However, as at today, 2 November
45 2022, it seems likely that the number of cases which will
46 ultimately be considered to fall within those parameters,
47 and thus within Category B, will be in the range of 15 to

1 30.

2
3 I should add that in addition to lawyers, both
4 solicitors and counsel, the Special Commission also has a
5 range of other resources available to it. Without
6 attempting to be exhaustive, those resources include the
7 expertise and experience of its own team of criminal
8 investigators and specialist analysts led by the Director
9 of Investigations, as well as our Senior Media Adviser and
10 Associate Director - Projects.

11
12 The Special Commission has also sought, and has
13 obtained assistance and will continue to do so, from a wide
14 variety of expert consultants from various specialist
15 fields, including pathology, psychiatry, toxicology and
16 criminology.

17
18 Now, Commissioner, I see the time and I wonder whether
19 you have in mind taking a short adjournment?

20
21 THE COMMISSIONER: Yes, I did. I'll take the short break
22 now for perhaps 15 minutes. Thank you.

23
24 **SHORT ADJOURNMENT**

25
26 THE COMMISSIONER: Yes, Mr Gray.

27
28 MR GRAY: Commissioner, I will turn now to outline briefly
29 the processes which the Special Commission has adopted in
30 order to deal with the volume of material it has obtained
31 and is continuing to obtain.

32
33 As is apparent from what I was saying before the
34 break, as a result of seeking and obtaining the information
35 that we have, the Special Commission has received a very
36 large volume of documents and records of various kinds. To
37 date, the Inquiry has accumulated over 120,000 separate
38 documents, many of them very lengthy, some of them running
39 to hundreds of pages each. The vast majority of that
40 volume of material has already been reviewed and analysed
41 by the Inquiry's solicitor and counsel teams. Most of this
42 material has been obtained in answer to compulsory
43 summonses issued by the Special Commission, although large
44 quantities have also been provided in response to letters
45 and emails.

46
47 The two main sources of such documents have been the

1 New South Wales Police and the Coroners Court of New South
2 Wales. The Special Commission has so far issued some 32
3 separate summonses to the New South Wales Police and has
4 made 17 separate requests for material to the Coroners
5 Court. Documents and other materials have also been sought
6 from and provided by numerous bodies, both New South Wales
7 and elsewhere, including the Office of the Director of
8 Public Prosecutions, the Supreme Court, the District Court,
9 numerous local courts and over government agencies. They
10 have been sought and provided on a rolling basis as the
11 Special Commission learns of new cases or develops its
12 understanding of cases already under review. The nature of
13 those documents varies widely as I should indicate.
14

15 First of all, there is hard copy material. The
16 Inquiry has received over 370 boxes of hard copy records.
17 In many cases those records have been pulled directly from
18 the shelves of government archives and delivered to the
19 Special Commission's door. They have arrived in archive
20 boxes of various shapes and sizes, often with cryptic
21 identifying codes or handwritten descriptions. They
22 include statements, duty books, forensic and autopsy
23 reports, photographs, index cards, hand-drawn notes,
24 fingerprint records, correspondence, intelligence reports,
25 CDs, DVDs, audio and VHS cassettes.
26

27 They may contain files relating to one death or many.
28 Sometimes they relate to matters unrelated to the work of
29 the Special Commission which have been misfiled or
30 misplaced. Some deaths will have a dozen boxes of detailed
31 records associated with them, while others will have only a
32 single file or even just a sheaf of notes.
33

34 Depending on the age of a file, some records are so
35 worn and delicate that they must be handled with extreme
36 care. Others, including photographic negatives and audio
37 cassettes, are inherently fragile and require special
38 processing. Many records are obviously incomplete and
39 sometimes they remain so even after further and more
40 directed searches. Regrettably, it is not uncommon for
41 files to be, or to appear to be, missing or lost in whole
42 or in part. Where that is the case, the Special Commission
43 pursues further follow-up requests as far as it is possible
44 to do so. Sometimes that results in more documents being
45 located, but sometimes the trail runs cold.
46

47 Then there is digital material, of which the Inquiry

1 has obtained a vast amount, as well as these many and
2 varied physical records. The digital material includes
3 police briefs, criminal histories, intelligence material,
4 records from the Registry of Births, Deaths and Marriages,
5 and Corrective Services records from this State.
6

7 Also received in digital form have been various
8 reports, resources and other information provided by expert
9 consultants and by various stakeholders, including
10 community groups, academics and journalists.
11

12 In order for the Special Commission to track, preserve
13 and review all this material, both hard copy and digital,
14 it has engaged the services of iCourts, a legal services
15 provider with expertise in electronic evidence management.
16 The Inquiry has also established a digital database of all
17 source material received to date using the legal
18 document management platform, Relativity. All relevant
19 material received by the Inquiry is digitised, both to
20 facilitate its review and to preserve it for future
21 reference. Detailed protocols have been developed and
22 implemented in relation to the handling of both hard copy
23 and digital material.
24

25 Once the source material in its various forms has
26 reached the Relativity platform it undergoes a process of
27 review and analysis by the Inquiry team. Each case is
28 assigned to a particular solicitor and counsel. That
29 solicitor-counsel team conducts a detailed review of the
30 whole of the material received in relation to that death or
31 disappearance and produces a "case summary" outlining their
32 preliminary analysis of the case. That analysis includes,
33 among other things: an account of the known facts
34 surrounding the death or disappearance; details of the
35 initial police investigation and of any subsequent
36 investigation, for example by the Unsolved Homicide Team;
37 consideration of whether witnesses and persons of interest
38 are still alive and whether exhibits are still available;
39 and initial observations as to possible avenues of fresh
40 investigation.
41

42 Next, a separate and more focused document is also
43 prepared identifying specific factors for decision. The
44 Factors for Decision document includes recommendations as
45 to what, if any, new investigative steps or other steps
46 such as the obtaining of expert opinions, could or should
47 then be taken. Both of those documents are then considered

1 by Senior Counsel and the Director of Investigations at a
2 first case review meeting. At that meeting decisions are
3 made, including as to which, if any, of those
4 recommendations should be implemented.
5

6 Once any such steps have been implemented, a second
7 case review meeting is convened at which the Special
8 Commission decides how that particular case will be dealt
9 with thereafter, including in some cases whether further
10 investigation by way of public or private hearing should
11 occur.
12

13 A fundamental aspect of these case reviews, at the
14 first and/or second stage, is to consider and determine
15 whether, on the basis of all available material, the death
16 in question does or does not fall within Category A or
17 Category B, as the case may be, of the Terms of Reference.
18

19 The Special Commission has the power, and is entitled,
20 to acquire information and evidence by a wide variety of
21 means and, as is clear from what I have said so far, it has
22 been doing so since May this year. The holding of
23 hearings, either in public or private, is only one of those
24 means. When such hearings are held, they are part of the
25 investigative work of the Inquiry. They are not the same
26 as court proceedings, whether civil or criminal, where
27 usually there are two sides, each of which puts forward
28 evidence and arguments favourable to it.
29

30 Hearings as part of an inquiry such as this, by
31 contrast, are inquisitorial and investigative. The
32 Commissioner has a wide discretion, subject to the
33 requirements of procedural fairness, as to how such
34 hearings are conducted. In relation to some, although not
35 all, of the individual cases, it is anticipated that part
36 of the investigative work of the Special Commission will be
37 carried out by means of hearings either in public or in
38 private or both. Those hearings, for the most part, are
39 likely to take place early next year, although there will
40 be some public hearings this year which I will mention a
41 little later.
42

43 Applications for authorisation to appear at a public
44 hearing must be in writing in advance. All the details
45 relating to such applications are set out in a Practice
46 Guideline which is available on the website.
47

1 Against that background I now turn to say something
2 about some of the individual cases which are and will be
3 the subject of this Inquiry. I will not speak today about
4 any of the Category B cases. For numerous reasons that is
5 not appropriate. Some of those reasons I have outlined
6 already. Another reason is that, whereas the names of all
7 the cases in Category A have been in the public domain
8 for years, that is not so with respect to many of the
9 possible Category B cases. Nor will I speak today about
10 every single one of the Category A cases. For various
11 reasons, that is also not appropriate in every case.
12 Similarly, I will say more about some cases than others
13 because, for various reasons, that too is the appropriate
14 course.

15
16 It should not be thought that such choices reflect any
17 difference in the seriousness with which the Special
18 Commission is approaching every single one of these cases,
19 both Category A and Category B. To the contrary, the
20 Special Commission has been established to inquire into all
21 of the cases which fall within one or other of those two
22 categories, it has specific powers with which it is able to
23 pursue those inquiries, and it intends to use those powers
24 to the fullest extent possible and necessary in each and
25 every case.

26
27 I turn now to some of the people, some only of the
28 people, whose deaths fall within Category A; that is,
29 unsolved deaths occurring between 1976 and 2000 and
30 considered by Strike Force Parrabell. I will speak about
31 them today in the order in which their deaths occurred,
32 starting with the earliest in time in 1976 and finishing
33 with the latest in time in 1997.

34
35 Mark Stewart: Mark Stewart was 18 years old when he
36 died. Mark's name was originally Mark Spanswick which he
37 changed by Deed Poll to Mark Stewart a few months prior to
38 his death. At 10am on 11 May 1976 Mark's body was found by
39 a local fisherman at the base of the cliffs between Shelly
40 Beach and North Head, near Manly.

41
42 There is a walking path which leads south from Shelly
43 Beach uphill and around to an area known as Blue Fish
44 Point. The path clings quite close to the cliff edge.
45 After a couple of hundred metres it arrives at a stone wall
46 which marks the boundary at one time of the North Head
47 Quarantine Station. The path continues through a gap in

1 the wall, continuing south towards the tip of North Head.
2 On both sides of the path there is bush and vegetation
3 which would provide seclusion for anyone who might wish it.
4

5 At least by the 1970s the area was a well-known beat,
6 and it is an area where several other deaths, which were or
7 might have been "gate hate"-related deaths, including that
8 of Scott Johnson, also occurred.
9

10 Mark Stewart was the second of three children. He
11 spent most of his childhood growing up in Fiji where his
12 father worked. At age 13 or 14 he left Fiji to attend
13 boarding school in New Zealand. He joined the New Zealand
14 Navy at the age of 16. However, he apparently went absent
15 without leave from the Navy in August 1974, just after his
16 17th birthday.
17

18 After leaving the Navy, Mark lived for a time in
19 Brisbane. On the evening of 9 May 1976, it seems that he
20 checked into the Hilton Hotel in George Street in Sydney.
21 The full extent of his movements between then and the
22 morning of 11 May, more than a day later, when his body was
23 found, is not yet known. A brief inquest was held
24 two months later, on 16 July 1976, and the Coroner found
25 that Mark had died of multiple injuries sustained as a
26 result of falling from the cliff top. The Coroner was
27 satisfied that there were no circumstances giving rise to
28 suspicion of foul play but said that he could not determine
29 whether the death was accidental or intentional.
30

31 In its paper-based review, Strike Force Parrabell
32 classified the case as one where there was "insufficient
33 information to establish a bias crime".
34

35 Paul Rath: Paul Rath was 27 years old when he died.
36 His body was found at 7.20am on Thursday, 16 June 1977,
37 near the base of a cliff not far from where Mark Stewart's
38 body had been found a year earlier. He had suffered
39 multiple injuries consistent with a fall from the cliff.
40

41 Paul was from a family of eight children and lived at
42 home in Manly with his parents and siblings. He was a
43 religious person who was involved with the local
44 Catholic Church and he worked as a volunteer catechist at
45 local public schools.
46

47 According to his father, Paul had suffered what his

1 father referred to as a "nervous breakdown" as a teenager.
2 He had later worked for three years at the local "House
3 with No Steps" but thereafter was on a pension and took
4 regular medication. His treating psychiatrist described
5 him as being well, in what turned out to be the
6 final months of his life, and as not giving any indication
7 of suicidal tendencies.

8
9 Paul seems to have been last seen alive, by one of his
10 brothers, at the family home at about 4.30pm on Wednesday,
11 15 June 1977. His brother thought that Paul seemed happy.
12 On Wednesday evenings, which this was, he often attended a
13 regular church gathering.

14
15 According to his father, Paul would often walk in the
16 Shelly Beach area and he would sit at the clifftop in
17 order to relax. His body was found at the bottom of one of
18 those cliffs.

19
20 The local Manly police quickly formed the view that
21 there was no foul play involved. A brief coronial inquest
22 was held in September 1977, three months after the death,
23 and the Coroner found that Paul had accidentally fallen.
24 However, it is anticipated that there will be evidence
25 before the Special Commission which may indicate possible
26 reasons to doubt the correctness of that finding. That
27 evidence will include Paul's body having been found in a
28 crouching position, neatly wedged in some rocks about
29 20 metres or so from the base of cliff, as well as evidence
30 as to the nature of some of his injuries.

31
32 As I mentioned a moment ago in relation to Mark
33 Stewart, the area near the top of these cliffs was a
34 well-known beat. There was evidence during the third Scott
35 Johnson inquest about groups or gangs of youths in the
36 Manly area who targeted gay men for assault and robbery, at
37 least in relation to a slightly later period in the 1980s.
38 Strike Force Parrabell assigned this case to the category
39 of "no evidence of bias crime".

40
41 Richard Slater: Richard Slater died on 22 December
42 1980 at Newcastle Hospital. He was 69 years old. He died
43 from the effect of significant head injuries inflicted on
44 him three days earlier, on 19 December 1980, at a toilet
45 block in Birdwood Park in central Newcastle. It is
46 possible that this is one of those cases where a person is
47 assaulted on the assumption that the person is gay even

1 though in fact that may not be so. The factual matrix in
2 relation to Mr Slater's case included the following:

3
4 Mr Slater was married and had a daughter and
5 grandchildren. He had lived in Newcastle for 25 years. He
6 had been employed throughout his adult life in a range of
7 jobs until he had retired at age 65. On the day he was
8 assaulted Mr Slater drove into town to do some shopping.
9 He was carrying a small money purse containing \$30. He
10 stopped to use the public toilet in Birdwood Park. It was
11 the middle of the day.

12
13 Among the evidence gathered by the police who
14 investigated his death was that he had a prostate condition
15 which meant that he needed to urinate relatively
16 frequently. While he was in the toilet block he was
17 assaulted. That toilet block, in fact, was known to be
18 used as a beat. Initially police were unable to identify a
19 perpetrator, but some two years later in 1982 an individual
20 was charged with Mr Slater's murder. However, this charge
21 was later the subject of a "no bill" and thus did not go to
22 trial.

23
24 The accused was a man whom his associates regarded as
25 someone known to engage in sex with men himself and also to
26 have assaulted gay men on other occasions, including at
27 toilet blocks, sometimes with the intention of robbing
28 them. Mr Slater's money purse containing the \$30 for his
29 shopping was stolen during the course of the assault.
30 Strike Force Parrabell assigned this case to the "no
31 evidence of bias crime" category.

32
33 Gerald Cuthbert: Gerald Cuthbert was murdered on 17
34 or 18 October 1981. He was 27 years old. He was a young
35 gay man whose sexuality caused him significant personal
36 conflict because of his adherence to the Christian faith.
37 He had been in a committed live-in relationship with a male
38 partner for some five years up to the year before his
39 death. However, he had ended that relationship in
40 about July 1980, it seems because he had felt that it was
41 incompatible with his Christian faith.

42
43 He and his ex-partner remained friends, and on the
44 weekend of his death Mr Cuthbert was staying in his
45 friend's apartment in Paddington, being the apartment they
46 had previously shared together for five years, while the
47 friend was away on this particular weekend.

1
2 Mr Cuthbert was found stabbed to death in that
3 apartment on Sunday, 18 October 1981. The last confirmed
4 sighting of him was on the previous evening, Saturday,
5 17 October. Mr Cuthbert's injuries were inflicted by what
6 looks to have been extreme and frenzied violence. He was
7 stabbed more than 60 times and his throat was slit. Strike
8 Force Parrabell assigned this case to the "insufficient
9 information to establish a bias crime" category.

10
11 Wendy Wain: Wendy Wain was a transgender woman who
12 was a well-known entertainer in Kings Cross in the 1980s.
13 At the time of her death she was working at a cabaret bar
14 called Pete's Beat on Oxford Street, both performing
15 herself and also managing the talent and producing the
16 costumes for the casts of the shows. Wendy Wain was killed
17 when she was shot at close range in her own apartment in
18 Kings Cross. Her body was found on Tuesday, 30 April 1985
19 by a close friend who had not heard from her for a few days
20 and came to check on her.

21
22 Wendy took great pride in being a member of the LGBTIQ
23 community. She was a popular person whose death caused
24 considerable fear and distress in that community. There
25 was a police investigation and an inquest. The Coroner
26 found that Wendy had died from bullet wounds inflicted by
27 an unknown person. Strike Force Parrabell assigned the
28 case to the "insufficient information to establish a bias
29 crime" category.

30
31 Gilles Mattaini: Mr Mattaini was a young gay man born
32 in France who lived with his partner, who was also French,
33 in Bondi, near the northern end of Bondi Beach.
34 Mr Mattaini worked at the Menzies Hotel in the city as a
35 barman. One of the leisure time activities that he enjoyed
36 was walking around the beachside areas and paths near
37 Bondi. Between Bondi Beach and Bronte Beach there was, and
38 is, a scenic coastal path very popular with walkers and
39 joggers. Bondi Beach itself has a wide walking promenade
40 along its whole length. The Bondi to Bronte path winds
41 around the water's edge, sometimes down almost at sea
42 level, and in other places quite high near the top of sheer
43 cliffs.

44
45 Near Tamarama Beach, which is midway between Bondi and
46 Bronte, the path has the ocean on one side and a park
47 called Marks Park on the other side. This whole area, the

1 Bondi-Tamarama-Marks Park area, is central to the facts
2 surrounding several of the cases the subject of Category A
3 of the Terms of Reference, possibly including that of
4 Mr Mattaini. Much of the area which includes the path, in
5 particular around Marks Park, was a well-known beat.
6 Mr Mattaini, according to his partner and friends, was a
7 shy and private person and was not a user of the Marks Park
8 beat.

9
10 In September 1985, Mr Mattaini's partner was
11 holidaying in France. Mr Mattaini was looking forward to
12 his return and also to the arrival of another friend from
13 France who would be staying with them in Bondi.

14
15 On 16 September 1985, Mr Mattaini failed to show up
16 for his shift at the Menzies Hotel. There was naturally
17 concern amongst his friends who did what they could to try
18 to find out what had happened to him but they had no
19 success.

20
21 Mr Mattaini's partner was in France at the time. He
22 was informed of Mr Mattaini's disappearance and was, of
23 course, very distressed by it. He had the impression,
24 which it seems was not correct, that one or other of
25 Mr Mattaini's friends had reported the matter to the
26 Police. No record of any such report has ever been found,
27 and there was no police investigation in 1985.

28
29 In 2001 and 2002, some 16 or 17 years later, the
30 disappearance of Mr Mattaini became part of the police
31 investigation called Strike Force Taradale. That
32 investigation led to the lengthy inquest, that I mentioned,
33 during the course of 2003 and 2004 before then Deputy State
34 Coroner Jacqueline Milledge.

35
36 I referred earlier to the Coroner's findings of March
37 2005. They were that Mr Mattaini was dead, that he had
38 died on or about 15 September 1985, that there was no
39 evidence to support a finding of suicide, and that while
40 she was not able to make a positive finding as to the cause
41 and manner of his death, there was "a strong possibility"
42 that he had died in similar circumstances to Mr Ross Warren
43 and Mr John Russell in 1989, to whose cases I will come
44 shortly.

45
46 By contrast, Strike Force Neiwand, nearly 13 years
47 later in December 2017, arrived at a very different view,

1 namely, that it was "highly probable" that Mr Mattaini
2 committed suicide. At about the same time, Strike Force
3 Parrabell, in the Parrabell Report published in June 2018,
4 assigned this case to the "insufficient information to
5 establish a bias crime" category.
6

7 William Rooney: William Antony Rooney, known as
8 "Bill", died on 20 February 1986. He was 35 years old and
9 originally from Scotland. He identified openly as a gay
10 man and lived with his partner, Wayne Davis.
11

12 On the night of Thursday, 13 February 1986, Mr Rooney
13 and Mr Davis went to Tattersalls Hotel in Wollongong where
14 they each drank a number of schooners of beer. They parted
15 company that night at about 10pm.
16

17 At around 8.40am the next morning, Friday, 14 February
18 1986, Mr Rooney was found in Crown Lane in Wollongong's
19 CBD. He was lying on the ground between a toilet block and
20 a wall with blood coming from his mouth and surrounding his
21 face and head. His injuries included a fractured skull.
22 Ambulance officers took Mr Rooney to Wollongong Hospital
23 where he died some days later.
24

25 There was an investigation by police. The police
26 considered that Mr Rooney's injuries may have been caused
27 by a fall. No swabs were taken from Mr Rooney's body.
28

29 The next year, 1987, saw a Coroner's finding that the
30 evidence did not enable him to say whether Mr Rooney's
31 injuries were received accidentally or otherwise.
32

33 Years later there were police investigations into a
34 series of assaults on other men in the Wollongong area. In
35 1989 there was an arrest of an individual who was then
36 charged with multiple offences against multiple victims,
37 including an attempted murder and sexual assault.
38 Mr Rooney was not one of the victims to whom any of the
39 charges related.
40

41 However, at least one of the assaults in question
42 occurred very close to where Mr Rooney's body had been
43 found. In 1993 the accused was convicted of various
44 offences and imprisoned. In 2001 he was released.
45 Within months he was charged with another violent assault.
46 He pleaded guilty and was imprisoned again.
47

1 In the light of what had become known about this
2 individual who had perpetrated these many assaults,
3 Mr Rooney's death was re-investigated. A brief was
4 forwarded to the DPP for consideration of charges against
5 the known perpetrator in connection with Mr Rooney's death.
6 However, the DPP determined that there was insufficient
7 evidence for charges to be laid. Strike Force Parrabell
8 assigned this case to the "insufficient evidence to
9 establish a bias crime" category.

10
11 William Allen: William Allen was a retired school
12 teacher who lived in Alexandria. He was 48 years old and
13 he was gay. On the night of 28 December 1988 he was
14 savagely beaten by persons unknown in Alexandria Park which
15 was a well-known beat. With the help of a passerby he
16 managed to make his way home but he was found dead there
17 the next day. The passerby had been driving in his car
18 when he saw Mr Allen near the toilet block in the park. He
19 stopped his car and Mr Allen came to the passenger's side
20 and shouted, "I've been bashed". Mr Allen's face and hands
21 were covered in blood and he was bleeding from the nose.
22 Mr Allen said that his assailants had bashed and kicked him
23 while he was on the ground and had taken had his money and
24 keys. The driver implored Mr Allen to call the police but
25 Mr Allen's response was, "That's what you expect when you
26 do the beat".

27
28 The finding by the Coroner, in July the following year
29 1989, was that Mr Allen had died of the effects of head
30 injury sustained when he was beaten by persons unknown in
31 Alexandria Park.

32
33 Six months later, in January 1990, just over a year
34 after Mr Allen's death, a gay man named Richard Johnson was
35 punched and kicked to death near that same toilet block in
36 Alexandria Park. Police charged eight teenagers, aged
37 between 16 and 18 at the time, with Mr Johnson's murder.
38 They became known as "The Alexandria Eight". Three were
39 convicted of murder and five of manslaughter.

40
41 The murder of Richard Johnson and the prosecution and
42 conviction of his killers led police to look again at the
43 killing of Mr Allen. Various member of the Alexandria
44 Eight admitted at various times to having been involved in
45 numerous bashings of gay men in both the Alexandria and the
46 Bondi areas. However, it was considered that there was
47 insufficient evidence to bring charges against any person

1 in relation to the death of Mr Allen. Strike Force
2 Parrabell assigned Mr Allen's death to its second category,
3 "suspected bias crime".
4

5 John Hughes: John Hughes openly identified as gay and
6 was known to his friends as "Skinny John". He lived in the
7 Kings Cross-Potts Point area. At the time of his death
8 in May 1989 he was aged about 45. Mr Hughes was murdered
9 in his own apartment in a particularly graphic manner. He
10 was found with his hands and feet bound with electrical
11 cord and a pillow slip covering his head. There were
12 bruises and lacerations to the back of the head consistent
13 with blows by a blunt object and a belt had been tightened
14 around his neck, ultimately leading to death by
15 asphyxiation. Police identified a suspect who was an
16 associate and sometime flatmate of Mr Hughes and charged
17 him with Mr Hughes's murder. One witness at the trial of
18 that accused claimed that the accused had referred to
19 Mr Hughes as "a faggot" who "deserved to die" and "deserved
20 everything he got". The accused was tried before a jury
21 but he was acquitted and he is now deceased himself.
22 Strike Force Parrabell formed the view that the case was
23 solved rather than unsolved, seemingly on the basis that
24 the accused, although acquitted, was probably the
25 perpetrator. Strike Force Parrabell otherwise assigned
26 this case to the "insufficient information to establish a
27 bias crime" category.
28

29 Ross Warren: Ross Warren was a television news reader
30 with Channel WIN4 in Wollongong. He was gay and his
31 friends were aware that he sometimes went to beats.
32 In July 1989, on a visit to Sydney, he went missing. He
33 was 25 years old. His car was found at Tamarama and his
34 keys were found not far away on rocks below the walking
35 path at Marks Park, an area which, as I have said, was a
36 beat. His body has never been found.
37

38 On the evening of Friday, 21 July 1989, after
39 presenting the weather report at the end of the 6 o'clock
40 news, Mr Warren drove from Wollongong to Sydney to a
41 friend's place. At about 10.30 that night he drove to
42 Oxford Street in Darlinghurst. He and a work colleague
43 visited several bars and nightclubs along the Oxford Street
44 strip before going their separate ways in the early hours
45 of Saturday morning, 22 July 1989. He was in good spirits,
46 but he was never seen again.
47

1 On Sunday, 23 July, Mr Warren did not turn up for work
2 at WIN Television. This was uncharacteristic for him. His
3 friends in Sydney went to Paddington Police Station on the
4 Sunday evening and reported him missing. Then those same
5 friends went looking for him themselves. They wondered if
6 he might have gone to Marks Park. On that same Sunday
7 evening they located his car in Kenneth Street, Tamarama,
8 very close to Marks Park. They reported that to Paddington
9 Police the same night.

10
11 The next morning, Monday, 24 July, Mr Warren's friends
12 went back to Marks Park again. This time they found his
13 keys on a rock ledge below the walking path. Again, they
14 reported this to Paddington Police. Two days later, on
15 Wednesday, 26 July, an article in the *Daily Telegraph*
16 reported that there were fears that Mr Warren had been
17 murdered. However, two days after that, on Friday,
18 28 July, the officer in charge of the investigation at
19 Paddington Police wrote in the Occurrence Pad that
20 investigating police had no such view and were of the
21 opinion that Mr Warren had "fallen into the ocean in some
22 manner and it is anticipated that in the near future his
23 body will surface and be recovered." There was no inquest.
24 The investigation seems to have effectively finished after
25 four days.

26
27 This original police investigation into Mr Warren's
28 disappearance was subsequently described by Coroner
29 Milledge in 2005, as I mentioned earlier, as "grossly
30 inadequate and shameful". The Coroner found, in 2005, that
31 Mr Warren was a victim of homicide, probably by gay hate
32 assailants. However, Strike Force Neiwand which
33 re-investigated the case in 2016 and 2017, reached a very
34 different conclusion. Neiwand's conclusion, as at January
35 2018, was that "despite the Coroner's finding of homicide"
36 in 2005, Mr Warren's death "could be one of several
37 possibilities" and should in fact be treated as
38 "undetermined".

39
40 At about the same time, Strike Force Parrabell, in the
41 Parrabell Report published in June 2018, assigned
42 Mr Warren's death to the second of its four possible
43 categories, namely, "suspected bias crime".
44

45 John Russell: John Russell was a barman at the Bronte
46 Bowling Club. He lived with his brother, Peter, at Bondi.
47 He identified openly as gay. As at November 1989, he was

1 excited about his plans to leave Sydney and build a 'kit
2 home' on his father's property at Wollombi near Cessnock
3 which would be funded by an inheritance from his
4 grandfather. He also intended to use some of that money to
5 travel around Australia.
6

7 On the evening of Wednesday, 22 November 1989,
8 Mr Russell went for some farewell drinks with a friend at
9 the Bondi Hotel. He had a similar evening planned for the
10 next night, Thursday, and then on the Friday his father Ted
11 was going to drive down from Wollombi to collect him. He
12 was 31 years old. But after leaving the Bondi Hotel at
13 about 11 o'clock on that Wednesday night he was never seen
14 alive again.
15

16 The next morning, Thursday, 23 November 1989, his body
17 was found lying on rocks below the Bondi to Bronte walking
18 path at Marks Park, a well-known beat, as I have mentioned.
19 He had multiple injuries including skull fractures. Police
20 from Bondi Police Station investigated. The officer in
21 charge was a junior plain clothes detective constable.
22

23 The position of Mr Russell's body was that his head
24 and upper body were facing towards the cliff face, while
25 his feet were towards the ocean. On one view that might
26 perhaps be thought to indicate that jumping or falling were
27 unlikely. On one of Mr Russell's hands were human hairs,
28 possibly from another person. A crime scene photograph
29 depicts these hairs and it seems that they were bagged for
30 analysis, but even before the initial inquest in 1990 they
31 had somehow been lost. They were never forensically
32 examined, and it is now impossible for such testing to be
33 carried out.
34

35 On 2 July 1990 a Coroner made an open finding as to
36 Mr Russell's death. The Coroner's words were:
37

38 *Whether he fell accidentally or otherwise,*
39 *the evidence does not enable me to say.*
40

41 Almost 15 years later, on 9 March 2005, following the
42 re-investigation by Strike Force Taradale and the resultant
43 second inquest, Coroner Milledge found as a fact that
44 Mr Russell's death was in fact a homicide which occurred
45 when he was thrown from the cliff onto rocks by a person or
46 persons unknown. The Coroner also found that the evidence
47 strongly supported the probability that those who had

1 caused him to meet his death in that way were, in her
2 words, "gay hate assailants".

3
4 Once again, however, Strike Force Neiwand many years
5 later reached a different conclusion from Coroner Milledge.
6 According to Strike Force Neiwand in January 2018, while
7 there was a "possibility" of Mr Russell's death being the
8 result of a homicide, there was "a lack of corroborating
9 evidence" for such a possibility, whereas there was
10 corroborating evidence which supported a finding of
11 misadventure, for example, that Mr Russell had simply
12 fallen.

13
14 At about the same time, in the Parrabell Report
15 published in June 2018, Strike Force Parrabell assigned
16 Mr Russell's death to its second category, namely,
17 "suspected bias crime".

18
19 Simon Blair Wark: On the morning of 10 January 1990,
20 the body of Simon Blair Wark, known as Blair, was found
21 floating about 200 metres off Dobroyd Point, not far from
22 Manly, clad in jeans, shoes and socks but no shirt. Blair
23 was known to be gay and an area near Reef Beach in the
24 vicinity of Dobroyd Point, was a known beat where assaults
25 had taken place prior to 1990. However, a shirt, belt,
26 wallet and other property associated with him were then
27 found the next day on a rock platform at the top of The Gap
28 near Watsons Bay on the south side of the Harbour. The
29 last known sighting of Blair had been at Double Bay on the
30 afternoon of 9 January, the day before his body was found
31 off Dobroyd Point.

32
33 Blair had a history of treatment for depression and,
34 although he was not regarded by family members as deeply
35 depressed or suicidal, he was exhibiting some concerning
36 behaviour in the lead-up to his death. An autopsy found
37 the cause of death to be multiple injuries consistent with
38 having fallen from a great height.

39
40 The police report to the Coroner, which was dated
41 10 January 1990, that is, the day the body was found,
42 indicated "no suspicious circumstances". Homicide
43 detectives subsequently formed the view that the death
44 appeared to be by suicide and the coronial file later
45 included a note to that effect. In July 1990, the Coroner
46 dispensed with an inquest on the basis that there were no
47 suspicious circumstances. Strike Force Parrabell

1 designated the case as "solved", evidently adopting the
2 view that it was suicide, and otherwise assigned it to the
3 category of "no evidence of bias crime".
4

5 Robert Malcolm: Robert Malcolm, known to his
6 workmates as "Bob", worked in a clerical position at the
7 GPO in Martin Place. He was a single man who lived with
8 his parents in suburban Sydney.
9

10 On Friday, 10 January 1992, Mr Malcolm went for a
11 drink after work with colleagues at the Menzies Hotel near
12 Wynyard. He was still there at about 8.15pm when all
13 others in the group had left. Not long after that, between
14 about 8.30 and 10pm, a person thought to be Mr Malcolm was
15 seen in Eveleigh Street, Redfern, with another man.
16

17 In the early hours of the next morning, Saturday,
18 11 January 1992, Mr Malcolm was found in a derelict house
19 in Eveleigh Street. He was lying on his back, bleeding
20 from the head and with his pants and underpants down near
21 his ankles. He was taken by ambulance to Royal Prince
22 Alfred Hospital where he died later that month on
23 29 January 1992. He was 41 years old.
24

25 The cause of death was the sequelae of head injuries.
26 Mr Malcolm's injuries were extremely severe, including
27 complex fractures to the base of the skull and the right
28 side of the face, damage to the right eye, deep lacerations
29 to the face, broken and missing teeth, and a fractured rib.
30

31 Two men, one of them now deceased, were charged with
32 Mr Malcolm's murder and a third, also now deceased, was
33 charged as accessory after the fact. All those charges were
34 dismissed following a committal hearing in 1992. Strike
35 Force Parrabell classified this case as "solved" rather
36 than "unsolved", and otherwise assigned it to the category
37 of "no evidence of bias crime".
38

39 Cyril Olsen: Cyril Olsen was a man who identified
40 openly as gay. He lived in Woollahra and was always
41 immaculately dressed. He was described by one witness as
42 being "like an English gentleman". He was reported to be a
43 heavy drinker and as being a regular at the back bar of the
44 Rex Hotel in Kings Cross, the "Bottoms Up Bar", which was
45 known as a gay bar.
46

47 On the evening of Friday, 21 August 1992, Mr Olsen was

1 seen drinking at various places, including in Kings Cross
2 and on Oxford Street in Darlinghurst. The next morning,
3 Saturday, 22 August 1992, at around 7am, a number of
4 witnesses saw Mr Olsen walking through Rushcutters Bay Park
5 near the Cruising Yacht Club. Rushcutters Bay Park extends
6 from the Harbour's edge on the north to New South Head Road
7 on the south, and from New Beach Road on the east to the
8 stormwater canal on the west. It is not far from Oxford
9 Street and Taylor Square, which can be reached on foot in
10 about 20 minutes. Rushcutters Bay Park was another
11 well-known beat.

12
13 The witnesses who saw Mr Olsen walking in the park at
14 about 7am described him as "obviously distressed" and
15 "dazed". He was wearing neither trousers nor shoes and
16 there was mud on his bare legs. There was a cut on his
17 head and blood on his face. Despite one witness offering
18 assistance, Mr Olsen insisted "I'm fine, I'm okay", but
19 only minutes later his body was found floating face down in
20 the water near the Cruising Yacht Club. His shoes and
21 trousers were later located in or near the stormwater canal
22 on the western side of the park. Mr Olsen was 63 years
23 old.

24
25 The post-mortem examination identified the cause of
26 death as drowning, but also noted significant lacerations,
27 abrasions and bruising, including a deep laceration, to the
28 depth of the bone, on the top of his head. The officer in
29 charge of the police investigation expressed the opinion in
30 his statement for the Coroner that Mr Olsen had been the
31 victim of a gay bashing or robbery in Rushcutters Bay Park.

32
33 At an inquest in 1994 the formal finding by the
34 Coroner was death by drowning. Strike Force Parrabell
35 assigned this case to the category of "insufficient
36 information to establish a bias crime".

37
38 Crispin Dye: Crispin Dye died on Christmas Day 1993.
39 He was 41 years old. Mr Dye lived in Cairns but was in
40 Sydney visiting his mother for Christmas. He was the
41 former manager of the rock bands AC/DC and Rose Tattoo and
42 he was also a musician in his own right.

43
44 On the night of 22 December, and well into the
45 early hours of 23 December, Mr Dye was out drinking with
46 friends in and around Oxford Street, Darlinghurst. At
47 about 4am on the morning of 23 December, Mr Dye was

1 observed lying on his stomach on the road in the laneway at
2 the back of Kinselas nightclub. Police attended the scene
3 a short time later and arranged for Mr Dye, who was
4 unconscious, to be transferred to hospital. He died there
5 two days later. The post-mortem identified multiple
6 significant injuries, including fractures to the skull
7 caused by a blunt instrument.

8
9 An initial police investigation identified one
10 principal suspect and led to an inquest in 1994 and 1995.
11 There was insufficient evidence to tie that suspect to the
12 murder. The Coroner's finding in August 1995 was that
13 Mr Dye died of the effects of a head injury inflicted by a
14 person or persons unknown.

15
16 There was a second investigation, some years later in
17 1999, which also did not result in any charges being laid.
18 Some of Mr Dye's friends thought he was gay or bisexual but
19 whether that was in fact so seems to be unclear. The scene
20 of the attack was close to Oxford Street's LGBTIQ bars and
21 nightclubs, and one suggestion in the evidence gathered by
22 Police was that he may have been attacked by three men, and
23 thus that a gang may have been involved. However, the area
24 around Oxford Street was at the time also considered by
25 police to be a hotspot for street robberies generally.
26 Strike Force Parrabell assigned the case to the category of
27 "insufficient information to establish a bias crime".
28

29 Kenneth Brennan: Kenneth Brennan was a history
30 teacher with the Open High School in Sydney. Mr Brennan
31 was a gay man who shared an apartment in Elizabeth Bay with
32 his partner of five years. However, on the weekend of
33 10 June 1995 his partner had been staying at the home of a
34 mutual friend. Mr Brennan was sighted on the Sunday night
35 attending Kingsteam Sauna, a popular cruising venue for gay
36 men.
37

38 When Mr Brennan's partner returned home on Monday,
39 12 June 1995, he found Mr Brennan's naked body at the
40 entrance to the living room. He had been stabbed multiple
41 times with a knife which police located broken at the
42 scene. He was 53 years old. There was a police
43 investigation and an inquest, but the killer's identity
44 remained hidden. The Coroner found that Mr Brennan had
45 died of stab wounds to the chest inflicted by persons
46 unknown.
47

1 A subsequent second police investigation, some
2 20 years later in 2016-2017, also did not lead to any
3 charges. Strike Force Parrabell assigned this case to the
4 category of "insufficient information to establish a bias
5 crime".
6

7 Carl Stockton: Carl Stockton lived alone in Surry
8 Hills and he was a train driver, having previously worked
9 in the Taxation Department. He was a gay man, although it
10 seems he kept his sexuality mostly private. Mr Stockton
11 was a regular patron of the Bar Cleveland, a hotel on the
12 corner of Cleveland Street and Bourke Street in Redfern.
13 He usually attended alone and played a card machine in the
14 back bar. He was there drinking alone on Melbourne Cup Day
15 in 1996. In that year, that was 5 November.
16

17 Early the next morning, at about 1am on 6 November,
18 Mr Stockton was found, apparently intoxicated, sitting in
19 the backyard of a house that backed onto the laneway behind
20 the Bar Cleveland. The owners of the house helped him
21 through the back gate and into the laneway. But shortly
22 afterwards, at about 1.15am, Mr Stockton was seen lying on
23 his back on the inside traffic lane of Cleveland Street, at
24 the corner of Bourke Street outside the Bar Cleveland. A
25 passerby, with the help of a member of staff of the Bar
26 Cleveland, lifted Mr Stockton up and helped him walk to the
27 steps of the Hotel. He had a black eye and a cut to his
28 face. A call was made to the Sydney City Mission and at
29 about 1.30am welfare officers arrived and took Mr Stockton
30 to Campbell House, a proclaimed place where he would
31 receive care. However, by 11.30am that day there were
32 concerns about his wellbeing, he had been vomiting and was
33 disoriented. He was taken to hospital and he died there
34 five days later. He was 52.
35

36 An autopsy revealed massive head injuries, with three
37 separate areas of impact, as well as bruising on the legs,
38 chest and arms. There was an inquest. A pathologist
39 considered that it was unlikely Mr Stockton had been struck
40 by a motor vehicle given the pattern of multiple injuries.
41 A consultant neurosurgeon also considered a motor vehicle
42 accident unlikely and concluded that Mr Stockton's injuries
43 clearly pointed to an assault with repeated head injuries.
44 The Coroner returned an open finding. Strike Force
45 Parrabell assigned the case to the category of
46 "insufficient information to establish a bias crime".
47

1 Scott Miller: Scott Miller grew up in Orange. In
2 early 1997, aged 21, after completing an electrical
3 apprenticeship, he moved from Orange to Sydney to study
4 Sports Science at the University of Western Sydney. He was
5 a keen footballer with many friends. There appears to be
6 no suggestion that Mr Miller was gay.

7
8 On the Saturday evening, 1 March 1997, Mr Miller was
9 at the annual Sydney Mardi Gras parade with friends and he
10 later went on to drink with some of them at various pubs in
11 The Rocks.

12
13 On the Monday morning, 3 March, Mr Miller's body was
14 found in a wharf area adjacent to Darling Harbour, at the
15 bottom of a steep drop below a park near The Palisades
16 Hotel in Millers Point. How that happened has been the
17 subject of several police investigations. The
18 possibilities included that he fell, or was pushed, or was
19 killed elsewhere and his body placed where it was found.

20
21 In 1997 the finding of the Coroner was one of
22 homicide, namely, that Mr Miller died of multiple injuries
23 inflicted by a person or persons unknown. Strike Force
24 Parrabell assigned the case to the category of "no evidence
25 of bias crime".

26
27 Samantha Rose: Samantha Rose, who was given the name
28 "David" at birth, was a transgender woman who worked as a
29 computer analyst for Westpac Bank. So as far as the
30 Inquiry has been able to ascertain, she identified as
31 female. She often wore female clothing to work and had
32 confided in several friends regarding her gender identity.
33 She sometimes used the name "Samantha", including in
34 correspondence with friends and when she volunteered at
35 radio stations 2RPH and 2SER. On the radio she used a more
36 feminine voice. At the time of her death she was
37 undergoing hormone replacement therapy as part of her
38 affirmation of her gender. The Inquiry will refer to
39 Ms Rose consistently with her own preference.

40
41 On the morning of 22 December 1997 police found
42 Ms Rose deceased in her home at Kensington. She had been
43 last seen in the early afternoon of 20 December. The time
44 of her death seems likely to have been some time on 20 or
45 21 December. She was found lying on her back near the
46 kitchen table. She was wearing female clothing. A kitchen
47 chair was fallen over near her head and her unit was in a

1 state of disarray. She had suffered major injuries,
2 including fractures to her skull and severe bruising. Her
3 injuries were consistent with numerous heavy blows to the
4 head with a blunt object. There was no evidence of forced
5 entry to Ms Rose's unit, suggesting she may have known her
6 assailant.

7
8 At the inquest in 1999 the Coroner found that Ms Rose
9 had died due to head injuries inflicted by a person or
10 persons unknown. No charges were ever laid against any
11 person. One person of interest to investigating police has
12 subsequently died. Strike Force Parrabell assigned this
13 case, as it did 15 of the 23 cases it treated as unsolved,
14 to the category of "insufficient information to establish a
15 bias crime".

16
17 Now, Commissioner, I see the time

18
19 THE COMMISSIONER: I'll adjourn until 2 o'clock. Thank
20 you.

21
22 **LUNCHEON ADJOURNMENT**

23
24 MR GRAY: Commissioner, for the reasons I indicated
25 earlier today, it is not appropriate at this stage to
26 outline any of the possible Category B cases today in
27 opening in the way that I did this morning with some of the
28 Category A cases. However, the processes of review and
29 analysis of each of these cases are well under way, by the
30 same comprehensive methods that the Special Commission has
31 deployed with respect to the Category A cases.

32
33 All of the cases which are determined to fall within
34 Category B of the Terms of Reference will be the subject of
35 evidence and submissions in due course, just as will those
36 in Category A.

37
38 The Special Commission's website contains further
39 information about the work of the Commission. It is
40 updated regularly. Among the material to be found on the
41 website is the Practice Guideline which outlines, among
42 other things, the way in which interested parties should
43 contact the Special Commission if they wish to seek
44 authorisation to appear at any of the public hearings which
45 will be held. Applications for such authorisation should
46 be made in writing to the solicitor assisting the Special
47 Commission at the email address given on the website.

1
2 At this stage, it is anticipated that there will be
3 two sets of public hearings this year: one later this month
4 and one in December. The hearings this month will be
5 directed to the experience of LGBTIQ people who lived
6 through the period with which this Inquiry is particularly
7 concerned, namely, the 40 years between 1970 and 2010,
8 including their experience of the changing approaches of
9 the New South Wales Police.

10
11 The hearings in December will be directed mainly to
12 various aspects of Strike Force Parrabell, including the
13 methodologies used by the Parrabell police officers on the
14 one hand and, if time permits this year, the Flinders
15 University academic team on the other hand, and also to the
16 ways in which the New South Wales Police have approached
17 the recording, analysing and policing of "bias crime" or
18 "hate crime" over the years from 1970 to the present. It
19 will also involve some aspects, I expect, of Strike Force
20 Neiwand.

21
22 Next year, in 2023, it is anticipated that there will
23 be both public and private hearings directed to obtaining
24 further evidence in relation to many of the individual
25 cases the subject of Categories A and B of the Terms of
26 Reference. Information about upcoming public hearings will
27 be published on the website at the appropriate time.

28
29 Finally, I repeat, the Special Commission welcomes and
30 particularly positively requests any information which
31 anyone may have which might assist in the task of
32 unravelling what really happened in all these cases. That
33 applies to family members and friends of the people who
34 have died, and it applies to members of the public
35 generally, who might have seen or heard something in years
36 gone by that might be relevant. Any recollections or
37 pieces of information that you might have, however major or
38 minor, could provide a vital link in understanding what
39 happened. In some cases, it may ultimately lead to arrests
40 and prosecutions. And this applies with particular
41 emphasis to anyone who was actually involved in or saw
42 events that resulted in the death or suspected death of a
43 LGBTIQ person a long time ago.

44
45 If you have had something weighing on your mind
46 for years about these things, now is your chance to do
47 something to make amends. Now is the time to break your

1 silence. Justice in these cases has been long-delayed and
2 long-awaited. This may be the last chance for the truth
3 about some of these historical deaths to be exposed. We
4 need to hear from anyone who can help us do that.

5
6 I will repeat the various ways of contacting the
7 Inquiry that I mentioned earlier and those details are on
8 the screen.

9
10 By email, to contact@specialcommission.nsw.gov.au; by
11 post, addressed to LGBTIQ Hate Crimes Inquiry GPO Box 5341,
12 Sydney, NSW 2000, or by phone, by calling (02) 9228 4855
13 and leaving a voice message. If you do contact the Inquiry
14 by any of those means, please provide your telephone and/or
15 email or other contact details so that the appropriate
16 person can respond to you. Thank you.

17
18 THE COMMISSIONER: Thank you. What I'd like to do though
19 is adjourn for the moment to a particular date. I think,
20 given what you've outlined, the most appropriate date for
21 the moment would be Monday, 21 November.

22
23 MR GRAY: Yes, Commissioner, that is an appropriate date.

24
25 THE COMMISSIONER: All right. We'll work on that basis
26 for the moment and, as you've indicated, if there is any
27 change in that date, that will be notified in due course on
28 the website.

29
30 MR GRAY: Indeed.

31
32 THE COMMISSIONER: All right. Well, thank you. What I'll
33 do then for the moment is adjourn the hearing of the
34 Special Commission until Monday, 21 November this year.
35 Thank you.

36
37 **AT 2.09PM THE COMMISSION WAS ADJOURNED TO**
38 **MONDAY, 21 NOVEMBER 2022**
39

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