2022 Special Commission of Inquiry

into LGBTIQ hate crimes

Before: The Commissioner,
The Honourable Justice John Sackar

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

On Tuesday, 7 February 2023 at 10.00am

(Day 17)

Mr Peter Gray SC	(Senior Counsel Assisting)
Ms Kathleen Heath	(Counsel Assisting)
Mr Enzo Camporeale	(Director Legal)
Ms Kate Lockery	(Principal Solicitor)
Emily Burston	(Senior Solicitor)
Francesca Lilly	(Solicitor)

Also Present:

Mr Anders Mykkeltvedt (for NSW Police)

1 THE COMMISSIONER: Yes, Mr Gray?
2
3 MR GRAY: Commissioner, this is the opening for the
4 commencement of the third public hearing of the Special
5 Commission of Inquiry into LGBTIQ hate crimes. Seven
6 individual cases will be the subject of evidence tendered
7 before you this week.
8
9 May I address two matters before we move to the first
10 of those cases. First, an outline of the nature of today's
11 proceedings, an indication of the way in which Counsel
12 Assisting will proceed with the tender of evidence in these
13 cases and in numerous other cases which will follow in the
14 coming months; and, secondly, an update for you and for
15 those who may be following the work of the Inquiry as to
16 the public hearings held so far and as to some of the
17 matters about which I spoke in my opening address on
18 2 November last year concerning the nature and extent of
19 the work that the Special Commission has been doing, the
20 number of cases involved, and so on.
21
22 So, first, as to this public hearing, as I outlined in
23 my overall opening in November, the Terms of Reference
24 direct the Special Commission to inquire into LGBTIQ hate
25 crimes in two categories - Category A and Category B.
26 Category A is restricted to deaths which were considered by
27 the NSW Police Force in Strike Force Parrabell in
28 2016/2017. That strike force reviewed the historical
29 material available mainly from the original police and
30 coronial files in relation to some 88 deaths in a 24-year
31 period from 1976 to 2000.
32
33 The task given to the Special Commission by Category A
34 of the Terms of Reference is to inquire into those of the
35 88 deaths which "remain unsolved" as at the inception of
36 the Special Commission in April last year.
37
38 Strike Force Parrabell itself regarded some 24 of
39 those cases as unsolved. You, as Commissioner, will form
40 your own views on that question once all relevant material
41 has been assembled and considered.
42
43 Category B, as I explained in November, refers to
44 a much wider range of deaths which may need to be inquired
45 into. It directs the Special Commission to inquire into
46 all unsolved deaths in the 40-year period from 1970 to
47 2010, whether reviewed by Strike Force Parrabell or not,

1 which are suspected hate crime deaths where the victim was
2 a member of the LGBTIQ community.
3
4 As I also outlined in November, dealing with the scope
5 of the task bound up within Category B has involved an
6 enormous exercise on the part of the Special Commission
7 staff. Among other things, it has required close
8 examination of some 700 unsolved cases from that 40-year
9 period which are on a tracking file provided by the
10 Homicide Squad's Unsolved Homicide Team, and of a further
11 559 missing persons cases from that period.
12
13 Voluminous records and information from a wide range
14 of sources have been gathered, sifted and analysed,
15 enabling views to be formed as to which cases might fall
16 within Category B, and thereafter, the Special Commission
17 has embarked on the necessary and appropriate inquiries in
18 relation to those that do. I will say a little more about
19 that work when I come to the second of the two topics that
20 I am briefly speaking about today.
21
22 As to both categories, A and B, consideration has to
23 be given to the meaning of the word "unsolved". I referred
24 to this issue also in my November opening. It is another
25 issue on which you as Commissioner will form your own views
26 in due course.
27
28 In some of the cases which are or might be in either
29 Category A or Category B, the ways in which the Special
30 Commission is carrying out its inquiries include the
31 holding of public and/or private hearings at which
32 witnesses have given or will give oral evidence.
33
34 In other cases, for reasons which will be outlined in
35 submissions, hearings of that kind will not be held.
36 Rather, a comprehensive set of the evidentiary material
37 relevant to those cases will be assembled and tendered in
38 public proceedings of the Inquiry such as the one on which
39 we embark today, accompanied by written and oral
40 submissions by Counsel Assisting. That material will
41 include: documents relating to the circumstances of the
42 death itself; documents relating to previous investigations
43 of that death whether by the police or the coroner;
44 documents relating to the nature and extent of the
45 investigative and other steps which have been taken by this
46 Inquiry in relation to that death; and the results and
47 conclusions flowing from the completion of those steps; and

1 any statement which a family member may choose to make to
2 the Inquiry.
3
4 The submissions of Counsel Assisting will include
5 recommendations as to the finding or findings which you as
6 Commissioner should make as to the manner and cause of
7 death in each case.
8
9 This week, starting today, seven cases will be the
10 subject of the first of these public proceedings. They are
11 the deaths of John Hughes, Graham Paynter, Russell Payne,
12 William Dutfield, David Lloyd Williams, Andrew Currie and
13 Brian Walker.
14
15 Each of those seven cases was the subject of
16 consideration by Strike Force Parrabell. Three of them
17 were regarded as unsolved by Strike Force Parrabell, while
18 four of them were regarded by the strike force as solved.
19
20 These public proceedings this week will be conducted
21 over at least two days. They are open to the public and
22 are being live streamed via the Inquiry's website.
23
24 Secondly, I turn to the brief update that I mentioned,
25 first of all as to public hearings.
26
27 The Inquiry has held two public hearings so far. From
28 21 to 25 November 2022 the Inquiry conducted a public
29 hearing to receive evidence about the context in which
30 LGBTIQ hate crimes occurred between 1970 and 2010. The
31 Inquiry heard oral evidence from 10 witnesses in relation
32 to many aspects of LGBTIQ history and experience, both
33 during that period and in the many decades leading up to
34 that period. Some of the evidence related to public events
35 and developments, while the witnesses also gave deeply
36 personal evidence about their own experiences as members of
37 the LGBTIQ community, including their own experiences of
38 hate and hate crime.
39
40 From 5 to 13 December 2022, the Inquiry commenced
41 a second public hearing examining aspects of the approach
42 of the NSW Police to hate crimes, including strike forces
43 Parrabell, Neiwand and Macnamir and the history of the Bias
44 Crimes Unit within the NSW Police Force.
45
46 The Inquiry heard evidence from four police personnel:
47 Assistant Commissioner Anthony Crandell, who was the

1 commander of Strike Force Parrabell; Ms Shobha Sharma, who
2 was the manager of the Policy and Programs Team; Sergeant
3 Geoffrey Steer, the former Bias Crime Coordinator; and
4 Sergeant Ismail Kirgiz, the current Hate Crime Coordinator.
5
6 I anticipate that the Inquiry will resume the hearing
7 in relation to those issues on 15 February and that that
8 hearing will run for a further two to three weeks.
9
10 Next, as to Category A cases, two of the 24 cases
11 regarded by Strike Force Parrabell as unsolved are
12 presently before the courts. For the reasons explained
13 in November, the Inquiry will not be inquiring into those
14 two cases.
15
16 In all the other Parrabell cases which were regarded
17 by the strike force as unsolved, and also in a small number
18 of additional cases which the Inquiry has examined as
19 Parrabell cases which might also have been so regarded,
20 Counsel Assisting will tender the relevant material,
21 whether in documentary or oral form, and will make
22 submissions. The hearing commencing today in relation to
23 seven individual cases is an example of that approach.
24
25 Next as to Category B cases, as I outlined
26 in November, the Inquiry has been gathering and combing
27 through records relating to some 700 unsolved homicides and
28 some 559 cases of missing persons in the period from 1970
29 to 2010, identified from documents produced by the
30 NSW Police Unsolved Homicide Team and the Missing Persons
31 Unit respectively.
32
33 Additional cases were also identified by seeking and
34 obtaining information from numerous other sources to which
35 I referred in November, including the National Coronial
36 Information System, the Australian Institute of
37 Criminology, historical LGBTIQ media publications, and
38 submissions made to the parliamentary committee as well as
39 information from community groups, from the public, and
40 from the families and friends of people who have died.
41
42 As to the unsolved homicide cases, in November I set
43 out the provisional classifications which the Inquiry team
44 had made of the 700 or so cases identified from the
45 Unsolved Homicide Team's tracking file. Further work since
46 then has arrived at the following revised information.
47 First, a total of 51 cases have been provisionally assessed

1 as possibly falling within Category B. Twenty-seven of
2 those cases have already been identified by the Inquiry as
3 a potential case, those mainly being cases which had been
4 considered by Strike Force Parrabell. One of these cases
5 is the subject of current criminal proceedings and
6 accordingly the Special Commission will not be inquiring
7 into that case.
8
9 633 of the 700 or so in total have now been excluded
10 as being clearly outside the scope of the Inquiry - for
11 example, because the victim was a young child or the death
12 appeared to be a misadventure, such as a boat crash or
13 a plane crash.
14
15 In 15 cases, despite the issuing of summonses and
16 requests for information, the Inquiry has not yet received
17 any documents in relation to the death. The Inquiry is
18 continuing to pursue every available avenue in respect of
19 these 15 cases.
20
21 Next as to the Missing Persons Unit. For the 40-year
22 period between 1970 and 2010 there are 559 cases on the
23 Long-Term Missing Persons spreadsheet. In November I set
24 out the provisional classifications which the Inquiry team
25 had then made in respect of those 559 cases.
26
27 Further work since then has arrived at the following
28 revised assessments by the Inquiry team of those 559 cases
29 as at today. Nine cases are already under consideration by
30 the Inquiry, whether because they were among the Parrabell
31 cases or otherwise; 14 cases have been identified as
32 possibly falling within Category B; 503 cases either have
33 been excluded as being very unlikely to fall within
34 Category B or had already been considered in the review of
35 the unsolved homicide tracking file; and finally, in 33
36 cases, despite the issuing of summonses and requests for
37 information, the Inquiry has not received any documents in
38 relation to the death. Again, the Special Commission is
39 continuing to pursue every available avenue in respect of
40 these 33 cases.
41
42 Some remaining matters. In November I mentioned
43 a number of individuals who had had close involvement with
44 many of the issues with which the Inquiry is concerned and
45 who had given considerable assistance to its work. In that
46 regard, may I add the names of two others inadvertently
47 omitted from that list of names. Professor Stephen Tomsen

1 of Western Sydney University, one of the world's leading
2 researchers and authorities on gay hate crime, who has
3 assisted the Special Commission in a number of ways; and
4 journalist, Michael Burge, who has provided the Inquiry
5 with investigative files of his own and has also
6 facilitated contact by the Inquiry with relatives in a
7 number of cases.
8
9 I turn to a topic which I did address in November,
10 namely, information from the public and from families and
11 friends.
12
13 The Special Commission has attempted in many different
14 ways to contact family members, including by letters,
15 emails and text messages, to the extent that we have
16 current contact details. Some family members have
17 contacted us directly. Media releases and public notices
18 have also been utilised.
19
20 Identifying and tracing family members for many of the
21 cases being reviewed has been no simple task, and we are
22 well aware that we have not yet been able to reach everyone
23 who may wish to speak about the death or disappearance of
24 a loved one. If you are a family member or a friend of one
25 of the people whose unsolved death or disappearance is or
26 may be under review by the Special Commission and you have
27 not yet been contacted but would like to speak to us,
28 please do not hesitate to contact us. I will repeat at the
29 end of my remarks in a couple of minutes the ways in which
30 that may be done, as I did in November.
31
32 Next, a brief mention as to numbers of documents -
33 a brief update, I should say. I referred in November to
34 the very large volume of documents and records of various
35 kinds which the Inquiry had sought and/or obtained.
36 A brief update is as follows: to date, the Inquiry has
37 accumulated over 116,000 separate documents, many of them
38 very lengthy, some of them running to hundreds of pages
39 each.
40
41 The Special Commission has so far issued some 55
42 separate summonses to produce documents to the NSW Police
43 and has made 21 separate requests for material to the
44 Coroner's Court of New South Wales. The Inquiry has
45 received over 382 boxes of hard copy records as well as
46 a vast amount of digital material. That material includes
47 digital police briefs, criminal histories, intelligence

1 material, records from the Registry of Births, Deaths and
2 Marriages and Corrective Services records.
3
4 Lastly, I repeat another point that I made
5 in November, namely, a call to the public for information.
6 Investigations by the Special Commission are continuing
7 into many of these cases. That being so, may I repeat:
8 the Inquiry welcomes and positively requests any
9 information which anyone might have which may assist in the
10 task of unravelling what really happened in all these
11 cases. That applies, of course, to family and friends of
12 the people who have died. As I say, the Inquiry is
13 proactively endeavouring to make contact with families of
14 the people whose deaths the Special Commission is inquiring
15 into, and is at present in contact with 26 families or
16 other next of kin. However, the Inquiry welcomes contact
17 with other families as its work continues.
18
19 The Inquiry again also calls for information from
20 members of the public generally who might have seen or
21 heard something in years gone by that might be relevant.
22 Any recollections or pieces of information that you might
23 have, however major or minor you may think that information
24 is, could provide a vital link in understanding what
25 happened. And this applies with particular emphasis, as
26 I have said before, to anyone who was actually involved in
27 or saw events that resulted in the death or suspected death
28 of an LGBTIQ person a long time ago. If you have had
29 something weighing on your mind for years about these
30 things, now is your chance to do something about it. Now
31 is the time to break your silence. We need to hear from
32 you.
33
34 To date, 102 members of the public have come forward
35 to provide information to the Inquiry. All such
36 information has been and will be carefully considered by
37 the Inquiry.
38
39 The various ways of contacting the Inquiry are those
40 that I mentioned earlier, namely, by email, to the email
41 address, contact@specialcommission.nsw.gov.au; by post
42 addressed to LGBTIQ Hate Crimes Inquiry, GPO Box 5341,
43 Sydney, New South Wales, 2000; or by telephone by calling
44 (02) 92284855 and leaving a voice message. If you do
45 contact the Inquiry by any of these means, please provide
46 your telephone and/or email and/or other contact details to
47 the Inquiry so that the appropriate person can respond to

1 you.
2
3 Commissioner, if it is the convenient course, we will
4 now move to the evidence in the seven cases the subject of
5 this public hearing. My colleagues, Mr de Mars, Ms Melis
6 and Ms Heath of counsel will present that evidence to you
7 and will make submissions. Ms Heath will begin.
8
9 THE COMMISSIONER: Just before you do, Mr Mykkeltvedt, I'm
10 so sorry, I should have noted your appearance this morning
11 for the police. Thank you very much for being here.
12
13 MR MYKKELTVEDT: Thank you.
14
15 THE COMMISSIONER: Yes, Ms Heath.
16
17 MS HEATH: Thank you, Commissioner. Commissioner, this is
18 a hearing in relation to the death of Mr John Gordon
19 Hughes. Can I start firstly by handing up three volumes of
20 materials.
21
22 THE COMMISSIONER: I think I have them up here already, so
23 I will assume they are on my trolley.
24
25 MS HEATH: Thank you, and they can be handed to the
26 Commission.
27
28 THE COMMISSIONER: All right. Mr Mykkeltvedt, I'm going
29 to assume, unless you tell me otherwise, that you either
30 have the materials or you will get the materials.
31
32 MR MYKKELTVEDT: Yes, your Honour.
33
34 THE COMMISSIONER: Just keep me informed if there is any
35 issue that arises from your point of view.
36
37 MS HEATH: There are three volumes of material that
38 comprise the tender bundle relevant to the death of Mr John
39 Gordon Hughes. I tender those documents.
40
41 THE COMMISSIONER: I have lost track of the exhibits.
42 What exhibit number will that be?
43
44 MS HEATH: Exhibit 7.
45
46 **EXHIBIT #7 THREE-VOLUME BUNDLE IN RELATION TO THE DEATH OF**
47 **MR JOHN GORDON HUGHES**

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1
2 MS HEATH: Commissioner, the second document to hand up is
3 an order pursuant to section 8 of the Special Commission of
4 Inquiry Act. This relates to the non-publication of
5 certain material as well as pseudonym orders in respect of
6 some of the names contained within the material.
7
8 THE COMMISSIONER: Thank you. Yes, very well. Again,
9 Mr Mykkeltvedt, you have seen the short minutes?
10
11 MR MYKKELTVEDT: Yes, I have been provided those this
12 morning.
13
14 THE COMMISSIONER: Again, if there is any issue, just
15 please raise it.
16
17 MR MYKKELTVEDT: Yes, thank you.
18
19 THE COMMISSIONER: You want me to make these orders and
20 I will do so, thank you.
21
22 MS HEATH: Yes, thank you, Commissioner.
23
24 THE COMMISSIONER: In the matter of Hughes, which is
25 exhibit 7 before the Inquiry, there are agreed short
26 minutes of order dealing with a number of issues including
27 some redactions, pseudonyms and other matters. I will make
28 those orders and date them today and they will go with the
29 papers. Thank you.
30
31 MS HEATH: Thank you, Commissioner. Thirdly, I hand up
32 written submissions of Counsel Assisting. These are dated
33 6 February 2023.
34
35 THE COMMISSIONER: Thank you.
36
37 MS HEATH: I commence my submissions by saying that
38 I adopt and rely upon those written submissions.
39
40 THE COMMISSIONER: Thank you.
41
42 MS HEATH: Commissioner, I will briefly touch upon the
43 contents and preparation of the three-volume tender bundle
44 that is before you. In the course of inquiring into the
45 death of Mr Hughes, the Inquiry requested or summonsed and
46 received the investigation file from the NSW Police Force,
47 the coronial file from the New South Wales Coroner's Court,

1 the court file from the New South Wales Supreme Court, and
2 a prosecution file from the Office of the Director of
3 Public Prosecutions. My written submissions at
4 paragraph 41 and following set out in more detail the steps
5 that were taken to obtain this material.
6
7 This placed the Inquiry in a position where it had
8 a comprehensive collection of materials relating to
9 Mr Hughes's death, the subsequent investigation of it and
10 a trial for a person by the name of Mr Ian Jones, who was
11 charged with but ultimately acquitted of the murder of
12 Mr Hughes.
13
14 Tabs 1 to 89 in the tender bundle are a selection of
15 material taken from those summons documents relevant to the
16 manner and cause of Mr Hughes's death.
17
18 The Inquiry also summonsed and received records from
19 the NSW Police Force in relation to Strike Force
20 Parrabell's consideration of Mr Hughes's death.
21 Commissioner, you will see at tab 90 [SCOI.82199_0001] of
22 the tender bundle the Bias Crime Indicators Review Form
23 that was completed by officers of Strike Force Parrabell,
24 and I will come to that form in due course.
25
26 Your Honour, at tabs 91 [SCOI.82200_0001] and 92
27 [SCOI.82115_0001] there is a briefing letter to and
28 a report from forensic psychiatrist, Dr Danny Sullivan. An
29 expert opinion was obtained from Dr Sullivan in relation
30 to, among other things, whether there were any aspects of
31 the death of Mr Hughes or the crime scene that could
32 indicate that the homicide occurred in the context of
33 LGBTIQ hate, and again I will come to that in due course.
34
35 Finally, at tab 93 [SCOI.83249_0001] of the tender
36 bundle, you will see that the Inquiry ascertained, by way
37 of a summons to the Registrar of Births, Deaths and
38 Marriages, that Mr Locke, who was a key Crown witness, is
39 now deceased, and his death certificate is included in the
40 tender bundle.
41
42 My oral submissions will set out the key matters that
43 arise from the consideration of the totality of this
44 evidence. I'm going to two issues, first as to the manner
45 and cause of Mr Hughes's death; and, secondly, in relation
46 to whether Mr Hughes's death occurred in the context of
47 LGBTIQ bias.

1
2 Can I commence by providing some personal background
3 in relation to the deceased, Mr John Hughes. Mr Hughes was
4 45 years old at the time of his death. He was
5 affectionately known to his friends as "Skinny John", and
6 variously described in statements in the tender bundle as
7 quite passive, kind, soft hearted and generous to his
8 friends.
9
10 It's also relevant to note that Mr Hughes had
11 convictions for drug-related offences, and that it was well
12 known among his friends and acquaintances that Mr Hughes
13 was a low-level dealer in heroin and other drugs.
14
15 Mr Hughes was a gay man. The Inquiry will see from
16 various statements - I won't take you to these now but they
17 are set out in my written submissions at paragraph 5 - that
18 Mr Hughes's sexuality was well known amongst his friends
19 and his acquaintances.
20
21 His sexuality was also known to Mr Ian Jones. As
22 I will come to, and much of these submissions will be
23 dedicated to, Mr Jones is the key person of interest in
24 relation to the death of Mr Hughes. Mr Jones was charged
25 with the murder of Mr Hughes. There was a trial before
26 a jury in August of 1992 but Mr Jones was acquitted at
27 trial.
28
29 Notwithstanding that acquittal, my submission will be
30 that Mr Jones was likely responsible for Mr Hughes's death.
31
32 Mr Jones is now deceased.
33
34 Turning then to the circumstances of Mr Hughes's
35 death. Mr Hughes's body was found by his flatmate,
36 Mr Aaron Hill, at about 11am on Saturday, 6 May 1989. He
37 was last seen alive the day before - that is, the Friday,
38 5 May 1989.
39
40 After Mr Hill reported the discovery of the body to
41 police, police attended and they established a crime scene.
42 Their observations are variously described in the
43 statements of the attending police officer, but for
44 convenience, I would take the Commission to tab 24
45 [SCOI.10081.00011_0001] of the bundle at paragraph 5. This
46 will also be put up on the screen for the benefit of those
47 watching. This is the statement of the officer in charge

1 of the investigation, Detective Constable First Class
2 Michael Plotecki. His observations, which I will briefly
3 summarise, were that Mr Hughes's body was laying face down
4 across the bed, his feet were hanging over the side of the
5 bed, his hands were bound behind his back with white
6 electrical cord, as were his feet, bound just above the
7 ankles. A pink pillow slip covered the head of the
8 deceased. White electrical cord and a leather belt were
9 wrapped around his neck. A pair of kitchen tongs were
10 protruding from the back of the neck and appeared to have
11 been used to tighten the bindings that were around
12 Mr Hughes's neck. Pieces of broken pottery were scattered
13 on the bed around the head of the deceased and a light bulb
14 was next to his right arm. There were bloodstains on the
15 pillow slip and the bed below his head, and next to the
16 right side of the body there were a number of personal
17 papers. These were scattered around on the bed.
18
19 On the top of the papers was a kitchen knife with
20 a blade approximately 30cm long, with what appeared to be
21 blood on the blade, and a bloodstained T-shirt was found
22 behind the coffee table. I pause to note in relation to
23 those last two items - that is, the knife and the T-shirt -
24 the blood group testing, which was the testing that was
25 done at the relevant time, established that this blood
26 likely originated from Mr Hughes.
27
28 There were no signs of forced entry or interference
29 with the locks in the apartment. However, Mr Hughes's
30 wallet and credit card could not be located, nor could any
31 money be found around the flat.
32
33 A post-mortem examination was conducted by
34 Dr Schwartz. That is at tab 14 [SCOI.10081.0007_0001] of
35 the tender bundle. I will ask that that also be pulled up.
36 The conclusion is at page 3, and what the Commissioner
37 would observe is that the direct cause of death was
38 asphyxia due to strangulation with a ligature. That is
39 consistent, of course, with the observations of
40 investigating police that a belt and electrical cord had
41 been tightened around Mr Hughes's neck.
42
43 Blunt object injury to the head was another
44 significant condition contributing to the death.
45 Dr Schwartz observed bruises and deep lacerations to the
46 back of Mr Hughes's head, and the broken pottery scattered
47 around the head of the deceased may be capable of

1 explaining that blunt force injury to his head. That can
2 be taken down, thank you.
3
4 There was a police investigation into the death of
5 Mr Hughes. Your Honour, at tabs 1 to 12 of the tender
6 bundle - I don't ask your Honour to turn those up now -
7 that contains the resume of inquiries summarising the
8 actions taken by police. It ultimately resulted in Mr Ian
9 Jones being charged with the murder of Mr Hughes on
10 30 April 1990. As I have already stated, Mr Jones was
11 tried before a jury, that was in 1992, and ultimately
12 acquitted.
13
14 What I seek to do now in these submissions is turn to
15 an examination of the evidence that was adduced by the
16 Crown against Mr Jones, it being relevant to understanding
17 the manner and cause of Mr Hughes's death.
18
19 I make two preliminary observations before turning to
20 that. The first is that the evidence in the case is more
21 fulsomely set out in written submissions. These oral
22 submissions do not attempt to be comprehensive of all the
23 evidence, given that it was a long and complex trial. What
24 I hope to do in these submissions is to set out the four
25 primary strands of the case against Mr Jones, and
26 I indicate that I will turn to the topics of motive,
27 opportunity, the physical evidence linking Mr Jones to the
28 crime, and Mr Jones's admission, in that order.
29
30 The second comment I will make is that there are
31 points in the witness statements that I will take the
32 Commission to that there is crude and offensive language.
33 I don't seek to repeat that unnecessarily, but at times it
34 is essential to see and hear that language, particularly as
35 it may go, as I will come to submit in due course, to
36 establishing prejudice or bias on the part of Mr Jones.
37
38 So, turning then, first, to the question of motive.
39 The evidence established that Mr Jones had been temporarily
40 residing with Mr Hughes in his apartment, but that he had
41 relocated to Bathurst in mid-March 1989. So that is some
42 one to two months before Mr Hughes's murder.
43
44 After Mr Jones moved out of the apartment, there was
45 a dispute between Mr Hughes and Mr Jones arising because
46 Mr Hughes believed that Mr Jones had stolen some property
47 from him.

1
2 Now, the evidence as to this dispute came in part from
3 a man named Mr Mark Locke, in his statement to police that
4 he gave on 13 September 1989. Now, that statement is at
5 tab 42 [SCOI.10081.00024_0001] and I will ask that that be
6 put up on the screen.
7
8 Mr Locke, as will become apparent, was a key
9 prosecution witness. He was a friend of Mr Hughes and also
10 a client of Mr Hughes, in that he purchased heroin from
11 him.
12
13 At paragraph 16 of this statement, Mr Locke describes
14 a conversation that he had with Mr Hughes. Now in that
15 conversation - and it will be pulled up on the screen, but
16 to paraphrase - Mr Hughes complained to Mr Locke about
17 Mr Jones stealing his property and made statements first
18 threatening to have Mr Jones bashed, but then, secondly,
19 threatening to go to the cop shop, or the police, about the
20 stolen property.
21
22 At paragraph 18 - and this is the more critical
23 passage - Mr Locke describes a second conversation
24 occurring about a month later, and this is a conversation
25 between Mr Locke and Mr Jones, the accused. In this
26 conversation, Mr Locke told Mr Jones that Mr Hughes had
27 gone to the police about the stolen property. You will see
28 on the final line of that page:
29
30 *Well I'm pretty sure he went to the Police.*
31
32 Scrolling down on to page 6, you will see that
33 Mr Locke describes Mr Jones to become very mad, to the
34 point that he was spitting his words, and on line 5, the
35 Commission will observe the words attributed to Mr Jones:
36
37 *I was going to pay John a visit anyway and*
38 *give him a hiding for the things I've been*
39 *hearing. I've made up my mind now, I will*
40 *fix him properly.*
41
42 And it goes on to say:
43
44 *I'll kill the little cunt.*
45
46 Mr Jones then asked Mr Locke - and this is in the same
47 lengthy paragraph - if Mr Locke wanted to join him in, and

1 I quote, rorting Mr Hughes. In the context of
2 paragraph 18, it is apparent that Mr Jones is speaking of
3 stealing heroin from Mr Hughes, as he goes on to ask
4 Mr Locke to find out when Mr Hughes would be in receipt of
5 more heroin.
6
7 This concludes towards the end of paragraph 18 with
8 Mr Jones being alleged to have said:
9
10 *If anything happened to John, do you*
11 *honestly think there would be a big inquiry*
12 *over another junkie dealer?*
13
14 This was part of the evidence that the Crown relied upon,
15 and which the Commission is now able to consider, that
16 supports the proposition that Mr Jones was motivated
17 firstly to extract some revenge on Mr Hughes in relation to
18 the property dispute, but also to rob Mr Hughes of heroin.
19
20 Turning then to the question of opportunity - and the
21 Commission will recall that Mr Hughes was last seen alive
22 in the afternoon of Friday, 5 May and his body was found on
23 the morning, at 11am, on Saturday 6 May.
24
25 Ms Stanton was at the time of Mr Hughes's murder
26 Mr Jones's girlfriend. She was residing in Sydney, but on
27 Wednesday, 3 May - that is, the Wednesday before the
28 murder - she drove to Bathurst to visit Mr Jones where he
29 was then residing. On the Friday morning of her visit, so
30 5 May, Mr Jones appeared to Ms Stanton to be suffering from
31 heroin withdrawal symptoms. He called in sick to work.
32 Ms Stanton and Mr Jones ended up having a fight, the result
33 of which was that Mr Jones drove away in a green panel van.
34
35 The time at which he left was the subject of varying
36 evidence. Ms Stanton said it was approximately 10.30 in
37 the morning. Mr Jones would ultimately tell the court that
38 it was about 2.30 in the afternoon, and a flatmate,
39 Mr Lance Dodd, recalled the fight occurring at about
40 midday.
41
42 Ms Stanton did not see Mr Jones again from the time
43 that he left until the following day at about 11am on
44 Saturday, 6 May 1989.
45
46 Now, it's necessary here to turn to some of the
47 evidence as to the timing of Mr Hughes's death.

1 Ultimately, as I have submitted at paragraph 9 of my
2 written submissions, there was somewhat unsatisfactory
3 evidence given by the pathologist, Dr Schwartz, as to the
4 time of death. I have set this out, but to summarise, in
5 her evidence before the coronial inquest - and that was in
6 1990 - she placed time of death as occurring before 7.30pm
7 on 5 May. In her evidence at trial, she estimated that the
8 death occurred within a 27-hour period, between 11am on
9 5 May and 2pm on 6 May, and all of her evidence was
10 qualified, Commissioner, by the fact that the time of death
11 in this case could only be a rough estimate. That was
12 because the apartment where Mr Hughes's body was found had
13 a heater on, and that meant that limited inference could be
14 drawn from the body temperature that was taken as to the
15 time of death. So ultimately there is inconsistent
16 evidence as to the precise time of death, but in any event,
17 the window of opportunity where Mr Jones was away from
18 Ms Stanton and outside of Bathurst overlapped at least in
19 part with each of the various time ranges for death given
20 by Dr Schwartz, or estimated by Dr Schwartz.
21
22 Now, also important was that Ms Stanton gave evidence
23 that when she next saw Mr Jones, and that was on Saturday,
24 6 May, he was no longer suffering from heroin withdrawal
25 symptoms. Now, that gives rise, we submit, to the
26 inference that he obtained heroin in the period that he was
27 away from her, and that is consistent with the theory based
28 on Mr Locke's evidence that Mr Jones had intended to steal
29 heroin from Mr Hughes.
30
31 Mr Jones gave an unsworn statement at trial and in
32 that statement he claimed that he had gone to stay with
33 friends in Bathurst after the fight with Ms Stanton. There
34 was also alibi evidence called from other witnesses at
35 trial. I have summarised that in written submissions,
36 paragraphs 90 and 91. Relevantly, none of the alibi
37 evidence provided could exclude the possibility that
38 Mr Jones had travelled from Bathurst to Sydney on the
39 particular days in question.
40
41 Turning then to the third strand of the case, and this
42 is the physical evidence that links Mr Jones to the death
43 of Mr Hughes. It is respectfully submitted that this is
44 the most compelling strand of the case against Mr Jones and
45 ultimately, as the Commissioner would have appreciated from
46 my written submissions, what the greatest weight is put on
47 in now assessing the evidence.

1
2 When Ms Stanton was spoken to by police, she provided
3 them with several items of clothing that belonged to
4 Mr Jones. One such item was a jacket. The jacket was
5 delivered to the Physical Evidence Section of the
6 NSW Police Force and examined. Upon examination, it was
7 found that there was a tear to the inner lining of the
8 jacket. Inside the lining of the jacket was a St George
9 Building Society passbook that was in the name of
10 Mr Hughes.
11
12 Now, there are two indications as to when that
13 passbook must have come to be placed in the lining of the
14 jacket. The first is that the evidence was that the last
15 transaction in the passbook was on 21 April 1989. So that
16 is at least a month after Mr Jones moved out of Mr Hughes's
17 apartment. Mr Jones was interviewed twice by police in the
18 course of their investigations and on both occasions he
19 denied having seen Mr Hughes or having returned to
20 Mr Hughes's apartment since leaving for Bathurst in
21 mid-March.
22
23 Secondly, and more pertinently, Mr Gavin Scobie, who
24 is a friend of Mr Hughes, gave evidence that Mr Hughes had
25 shown him the passbook on the evening of 3 May 1989 at
26 Mr Hughes's apartment. Now, Mr Scobie's statement is at
27 tab 59 [SCOI.10081.00044_0001]. I don't need to take the
28 Commission to it at this time, but I note that that was
29 unchallenged evidence at trial.
30
31 Mr Scobie left Mr Hughes's apartment at about 1.15am
32 on Thursday, 4 May, so that is between one and two days
33 before Mr Hughes was killed. So Mr Jones must have come
34 into the possession of the passbook at some time after that
35 date.
36
37 Mr Jones's second interview with police was on
38 30 April 1990, and that was after the police had discovered
39 the passbook in the lining of the jacket. Mr Jones
40 initially denied ever seeing any of Mr Hughes's bankbooks.
41 When he was shown the passbook, he denied ever having seen
42 it before. However, importantly, he did accept that the
43 jacket was his, and he made the comment that "I often put
44 things in that jacket in the lining." When asked how the
45 passbook could have come to be in the jacket, he replied
46 "I must have picked it up at Hughes's place."
47

1 Commissioner, considering this evidence together, it
2 is submitted that the inference to be drawn is that
3 Mr Jones placed the passbook into the lining of his own
4 jacket, in accordance with his practice, and that Mr Jones
5 did so at some time after it was seen by Gavin Scobie on
6 3 May 1989.
7
8 Now, the Commissioner will recall that Ms Stanton's
9 evidence puts Mr Jones in Bathurst at all times between 3
10 and 6 May, except for the period from between 10.30am or
11 possibly slightly later on Friday, 5 May, until about 11am
12 on Saturday, 6 May. So the period in which Mr Jones could
13 have taken Mr Hughes's passbook and placed it in his jacket
14 very much narrows to the window in which Mr Hughes was
15 killed.
16
17 Mr Jones's evidence that he picked up, or he must have
18 picked up, the passbook unwittingly from Mr Hughes's
19 apartment is unconvincing and cannot sit with his own
20 assertions that he had not returned to Mr Hughes's flat.
21
22 The defence at the trial of Mr Jones sought to deflect
23 the impact, the considerable impact, of the evidence about
24 the passbook by putting to Detective Constable First Class
25 Plotecki, the officer in charge, in cross-examination that
26 he had planted the passbook on Mr Jones, first by seizing
27 the passbook from the crime scene initially and then, at
28 a later time, by placing it in the lining of the jacket
29 provided to police by Ms Stanton.
30
31 Commissioner, these were very serious allegations
32 about police conduct, and they were put to DCI Plotecki and
33 strenuously denied.
34
35 I have extracted the portion of the transcript in
36 which there are denials at paragraph 93 of my written
37 submissions, and it is submitted that his denials, as well
38 as his explanation as to why there was an absence of any
39 reason for him to keep the passbook himself, if it had
40 actually been found at the crime scene, are objectively
41 persuasive.
42
43 In addition, weight can be put on Mr Jones's own
44 admission that he often placed items in the lining of that
45 jacket. There is an inherent improbability that police
46 would, by coincidence, choose to place the passbook in that
47 rather unusual location.

1
2 In short, it is submitted to this Commission that it's
3 highly improbable that the passbook was planted by police
4 in Mr Jones's jacket lining.
5
6 Having said that, I will note, and this is in my
7 written submissions at both paragraphs 20 and 94, that
8 there is some criticism that can be made against police in
9 this case, in that there was an unsatisfactory management
10 and documentation of the exhibits obtained from the crime
11 scene. So the evidence established at trial that rather
12 than cataloguing each and every exhibit that was seized,
13 police planted all - placed all items into one brown paper
14 bag, and it was that loose management and documentation of
15 the exhibits that opened the door to the defence being able
16 to explore the possibility that the passbook was planted,
17 and it is understood that police practice, now certainly,
18 is to separately itemise exhibits seized from a crime
19 scene.
20
21 The fourth strand of the case that I now turn to is
22 the admissions that were said to have been made by Mr Jones
23 and heard by at least two people - that is again Mr Locke
24 and also a woman named Ms Janice Dowsley. These admissions
25 were said to have come on a night out at a club in
26 Darlinghurst and then later, Kings Cross.
27
28 The statement of Mr Locke dated 28 May 1990 is at
29 tab 58 [SCOI.10081.00025_0001]. Commissioner, I don't
30 intend to take you to it, but I note that it is at
31 paragraph 10 that there is the critical portion, where
32 Mr Jones is reported to have said to Mr Locke:
33
34 *You know, not too many people know I killed*
35 *that [expletive].*
36
37 And Mr Locke understood that in the context of their
38 conversation to be a reference to Mr Hughes.
39
40 The second admission comes in the statement of
41 Ms Janice Dowsley. Her statement is dated 8 April 1992.
42 It is at tab 64 [SCOI.10401.00015_0001], and I might ask
43 that that statement be put up on the screen.
44
45 If we go to paragraph 7 of that statement, Ms Dowsley
46 is describing a conversation that was had after leaving the
47 Taxi Club in Darlinghurst, and effectively she describes

Transcript produced by Epiq

1 Mr Jones saying that "only Lockie" - that is, Mark Locke -
2 "knows about this". She then gives evidence, and this is
3 at the end of paragraph 7, that Mr Jones said:
4
5 *It's all right, don't worry about it. The*
6 *guy was a fucking faggot dog. He deserved*
7 *everything he got.*
8
9 Continuing on to paragraph 8, Mr Jones is reported to have
10 said:
11
12 *If I could kill the dog again I would, he*
13 *deserved it.*
14
15 And then he continued to yell out something about a
16 "faggot".
17
18 There are two admissions, two witnesses who gave
19 evidence of an admission by Mr Jones on that night. It
20 must be said that the credibility and reliability of
21 Mr Locke was the subject of significant and effective
22 attack at trial. I have set this out in some detail in my
23 written submissions between paragraphs 95 and 102. If
24 I could encapsulate it briefly, the evidence established
25 that Mr Locke had attended upon the chambers of Mr Jones's
26 barrister, along with Mr Jones, and had attempted to
27 retract his statement as to the oral confession made by
28 Mr Jones. What he told the lawyers was that he had been
29 stood over by police to implicate Mr Jones in the murder.
30
31 At trial, Mr Locke maintained that he had heard
32 Mr Jones's confession and explained the visit to the
33 lawyers by saying that he was fearful of Mr Jones and had
34 been pressured by Mr Jones into retracting his statement.
35 But certainly there were doubts raised as to the
36 credibility and reliability of Mr Locke at trial.
37
38 As always, however, evidence cannot be considered in
39 isolation, and what is submitted in my written submission
40 is that when evaluated in light of the hypothesis and the
41 submission that Mr Jones did in fact steal the passbook and
42 hide it in his jacket lining, once that is taken as the
43 first proposition, then the evidence of Mr Locke and
44 Ms Dowsley as to the statements made by Mr Jones gain
45 greater credence.
46
47 Your Honour, the ultimate submission that is made by

1 reference to all of the evidence, including some that
2 I haven't detailed now in oral submissions, is that the
3 objective evidence of the passbook that was found in
4 Mr Jones's jacket lining is compelling. When that is
5 considered alongside the evidence of motive, of opportunity
6 and of Mr Jones's admissions, it is submitted that there is
7 a strong probability that Mr Jones was responsible for the
8 death of Mr Hughes.
9
10 If I could refer the Commission to paragraph 124 of my
11 written submissions, therein is contained a submission that
12 the following finding is open and should be made - that is,
13 that on 5 or 6 May at his apartment in Potts Point,
14 New South Wales, John Hughes died as a result of
15 asphyxiation caused by strangulation with a ligature.
16 While it is not possible to arrive at a definitive
17 conclusion, and notwithstanding his acquittal at trial, the
18 available evidence points to the strong probability that
19 the ligature was applied by Mr Ian Jones.
20
21 Commissioner, the consequence of that finding would be
22 that this is not an unsolved case and accordingly does not
23 fall within Category A of the Terms of Reference.
24
25 So those are my submissions, in brief, as to the
26 manner and cause of death.
27
28 What I now wish to turn to, Commissioner, is the
29 question of whether Mr Hughes's death occurred in the
30 context of LGBTIQ bias. I might start with the approach of
31 Strike Force Parrabell officers when they considered this
32 case. If we could turn up tab 90 [SCOI.82199_0001], which
33 is the Bias Crimes Indicators Review Form for Mr Hughes,
34 the contents of this form - and I will take the Commission
35 to particular portions in just a moment - make it clear
36 that the Strike Force Parrabell officers considered that
37 notwithstanding Mr Jones was found not guilty, it was
38 highly likely that Mr Jones was responsible for murdering
39 Mr Hughes. So to this extent, the approach of Strike Force
40 Parrabell is consistent with the submissions I made moments
41 earlier.
42
43 The Strike Force Parrabell officers ultimately
44 concluded that there was insufficient information to
45 establish a bias crime. The review by the Flinders
46 academics concurred with that conclusion.
47

1 There are three points that I wish to make about the
2 manner in which the Bias Crime Indicators Form was used in
3 relation to the death of Mr Hughes.
4
5 First, if I could ask that we move on this to page 5.
6 You will see that this is, if we scroll down, indicator 2,
7 "Comments, Written Statements, Gestures".
8
9 Next to the prompt that is now showing - the top
10 prompt on the screen that is now showing - "Bias related
11 comments, written statements or gestures were made by the
12 person of interest", there is a comment that the only bias
13 related comments detected were found in the record of
14 interview of Mr Jones on 30 April 1990, during which he
15 cited his reason for leaving the flat of Mr Hughes as being
16 that he was fed up with the place, it was full of drugs and
17 poofters.
18
19 I didn't take the Commission earlier to that evidence
20 but that appears in his record of interview.
21
22 If we now scroll down to page 6, and, sorry, scroll
23 slightly further to the heading "General Comment" that sits
24 under indicator 2, you will see that sentence that the
25 "only bias related comments" and so forth is repeated under
26 that heading.
27
28 If I scroll up slightly, you will see that the
29 indicator has been answered "Yes" to the indicator of, "No
30 Evidence of Bias Crime".
31
32 Commissioner, plainly, in this analysis, the Strike
33 Force Parrabell officers overlooked the comments that were
34 attributed to Mr Jones by Ms Dowsley and to which I took
35 this Commission only moments ago. And to repeat, those
36 comments were, "Don't worry, he was a fucking faggot dog,
37 he deserved to die." And it was followed by further
38 derogatory language used by Mr Jones in discussing what we
39 say is the death of Mr Hughes.
40
41 That is a statement that is a far more compelling
42 indication of anti-LGBTIQ bias on the part of Mr Jones.
43
44 The second point that I wish to make with respect to
45 the use of the Bias Crimes Indicators Forms, starts on
46 page 15, if it could be scrolled down to that point. Now,
47 this is the indicator number 9, "Lack of Motive". There is

1 only one prompt that exists for this motive, and that is
2 that "No clear economic or other motive for the incident
3 exists".
4
5 Now, if we scroll down to page 16, again, it will be
6 noted that the indicator is answered that there is no
7 evidence of bias crime, and there is a long narrative in
8 both the "Comments" sections next to the prompts, as well
9 as the general comments that, in effect, extracts and
10 summarises the evidence that Mr Jones may have wanted to
11 rob Mr Hughes or extract revenge from him as a result of
12 the property dispute.
13
14 If I then ask that page 19 is turned to, and that is
15 the very final paragraph that I would direct your attention
16 to, so if we scroll down, this is the summary of findings.
17 It contains the overall comments of Strike Force Parrabell
18 officers. The final paragraph reads as follows:
19
20 *Dealing drugs whilst generally profitable*
21 *is a high risk occupation ...*
22
23 and then the next sentence:
24
25 *Whilst Police at the time acknowledged that*
26 *the murder of Hughes could have been bias*
27 *related, it is much more likely that*
28 *robbery was the clear motive for the*
29 *murder.*
30
31 And then the final sentence:
32
33 *Although found not guilty, it is highly*
34 *likely that Jones was responsible for the*
35 *murder of Hughes and was motivated by money*
36 *and revenge, rather than any personal bias*
37 *towards Hughes.*
38
39 Implicit in these comments, and possibly also in the
40 inclusion of indicator 9 in the Bias Crimes Indicator
41 Forms, appears to be an assumption that the presence of
42 a motive such a robbery or profit tells against the
43 simultaneous existence of LGBTIQ bias.
44
45 Commissioner, it is respectfully submitted that that
46 is an assumption that is too narrow and that discounts the
47 experiences of victims who are targeted because of their

1 actual or assumed LGBTIQ identity.
2
3 Now, on the evidence of this case, Mr Jones may well
4 have been - it is accepted that he may well have been
5 motivated by a desire to steal cash or heroin from
6 Mr Hughes, and that he may well have selected Mr Hughes on
7 the basis of his knowledge that both money and heroin would
8 be in his apartment. However, the comments that he made to
9 Ms Dowsley, to which I have taken the Commission, also
10 suggest that he was able to justify or excuse his selection
11 of Mr Hughes as a victim on the basis of his belief about
12 his sexuality and what that meant for whether he deserved
13 to live or die.
14
15 It would also be inferred from the comments allegedly
16 made to Mr Locke by Mr Jones to the effect that there would
17 be "no big inquiry over another junkie dealer", that
18 Mr Jones was to some extent strategic in picking Mr Hughes
19 as a victim on the basis that he considered that his
20 position in society made it easier for him to act with
21 impunity. It can be hypothesised that Mr Hughes's status
22 as a gay person made Mr Jones perceive him as a target that
23 would be less protected by the police and by the courts.
24
25 That's the second point I wish to make about the Bias
26 Crimes Indicators Form. The third point - and I will ask
27 that it be pulled up again - is on page 17, and it relates
28 to indicator 10, which is the "Level of Violence". If
29 I can ask that it be scrolled down slightly, there are
30 comments - and you will see it in response to the prompt -
31 that Mr Hughes's murder was a particularly brutal murder,
32 and the quote at the end of the "Comments" section in
33 relation to the first prompt, is:
34
35 *Whoever went into that unit meant to kill*
36 *Hughes and inflict an incredible amount of*
37 *pain in doing so.*
38
39 Now, notwithstanding that recognition of the brutal and
40 graphic manner of death in this case, the indicator that is
41 selected, if I scroll down, selects "Insufficient
42 Information" in relation to whether there was information
43 that allowed determination of a bias motivation.
44
45 If I again go to page 19, which is the "Summary of
46 Findings", this is a longer portion. What I note is an
47 absence in this portion of any mention of the manner in

1 which Mr Hughes was murdered. From this, as well as from
2 the indicator that was selected, it can only be inferred
3 that a very limited amount of weight was placed on the
4 manner of Mr Hughes's death in forming a view as to whether
5 this was a bias crime. However, it is submitted, and as
6 I will come to submit in due course, that the brutality of
7 Mr Hughes's death and the suffering inflicted upon
8 Mr Hughes is indicative of the fact that a robbery
9 motivation does not provide a sufficient or complete
10 explanation of the manner of death.
11
12 I turn then to the Inquiry's approach to assessing
13 whether the death occurred in the context of LGBTIQ bias.
14 As mentioned at the very beginning of my submissions,
15 Dr Danny Sullivan, a forensic psychiatrist, has provided
16 a report dated 24 October 2022 to the Inquiry. That's
17 included at tab 92 [SCOI.821115_0001]. It considered
18 possible motivations of a perpetrator, both on the
19 assumption that Mr Jones was the perpetrator, and another
20 unknown person was the perpetrator.
21
22 Now, in both cases, Dr Sullivan identified three
23 possible motives that he drew from the evidence. The first
24 being revenge - in the case of it being Mr Jones, that's
25 particularly related to the property dispute; the second,
26 being robbery of cash and drugs; and the third, relevantly,
27 is hatred of Mr Hughes at least in part based on his
28 homosexuality.
29
30 Now, regardless of whether it was Mr Jones or another
31 person who was the perpetrator, there is evidence that
32 selects that Mr Hughes's sexuality was a factor in the
33 selection of Mr Hughes as a victim of the offence, and that
34 is submitted even if robbery and/or revenge were also part
35 of the mosaic of motives.
36
37 First, Dr Sullivan identifies sexualised elements of
38 the crime scene. So in his report, he notes that the crime
39 scene depicts sexualised elements, including binding,
40 strangulation and hooding. In Dr Sullivan's opinion, the
41 location and posing of the body on the bed may have
42 suggested conscious or unconscious motivation of the
43 offender to reflect Mr Hughes's sexuality as they perceived
44 it.
45
46 Secondly, and I have already foreshadowed this point,
47 the graphic manner in which Mr Hughes was killed is

1 suggestive of a desire to inflict pain and humiliation on
2 Mr Hughes beyond what would be necessary to rob him or even
3 to extract revenge in relation to a property dispute.
4 Dr Sullivan has provided the opinion that the method of
5 death may be reflective of hate.
6
7 Now, if Mr Jones was the perpetrator, as it is
8 submitted that the Commission should find, then there is
9 further specific evidence of LGBTIQ bias on his part,
10 namely, first, the comments that were made that Strike
11 Force Parrabell officers identified, that Mr Jones was fed
12 up with Mr Hughes's apartment because it was "full of
13 poofters" - that is indicative of a generally derogatory
14 attitude towards gay men; and, more particularly, the
15 comments that Mr Jones made to Ms Dowsley, which I won't
16 repeat again, but which imply that Mr Jones excused or
17 justified his selection of Mr Hughes on the basis of him
18 being gay. We submit that is compelling evidence of LGBTIQ
19 bias.
20
21 So as, Commissioner, you will see in my written
22 submissions, having regard to all of these factors, and
23 notwithstanding that it is accepted that robbery of cash
24 and heroin likely motivated Mr Jones, I submit that it is
25 more probable than not that LGBTIQ bias was a factor in the
26 murder of Mr John Hughes.
27
28 Commissioner, in this case, there are no submissions
29 as to recommendations. Unless I can assist further, those
30 are my submissions in relation to the death of Mr Hughes.
31
32 THE COMMISSIONER: No, thank you.
33
34 Mr Mykkeltvedt, is there anything you wish to say at
35 the moment?
36
37 MR MYKKELTVEDT: No, not at this stage, your Honour.
38 There has been an indication that we will have an
39 opportunity to respond to the extent that it is necessary,
40 in writing.
41
42 THE COMMISSIONER: Yes. You can assume that, in each and
43 every case, reasonable opportunity will be provided. We
44 will keep in touch with you as to time frame, but certainly
45 that will be so.
46
47 MR MYKKELTVEDT: I'm grateful, your Honour.

1
2 THE COMMISSIONER: Thank you very much.
3
4 MS HEATH: Commissioner, I will next turn to the death of
5 Mr Graham Paynter.
6
7 THE COMMISSIONER: Yes.
8
9 MS HEATH: It may be convenient at this time to take a
10 short break to allow some rearrangement of the Bar table.
11
12 THE COMMISSIONER: Yes, I will, thank you.
13 Mr Mykkeltvedt, you are content if I take the break now?
14
15 MR MYKKELTVEDT: Yes.
16
17 THE COMMISSIONER: All right. I will take the morning
18 break now and I will resume in quarter of an hour.
19
20 **SHORT ADJOURNMENT**
21
22 THE COMMISSIONER: Yes.
23
24 MS HEATH: Thank you, Commissioner. The second hearing
25 this morning is a public hearing in relation to the death
26 of Mr Graham Paynter. Commissioner, I start by handing up
27 to your staff a one-volume bundle, the tender bundle in
28 relation to the death of Mr Graham William Paynter. It
29 contains 27 tabs.
30
31 THE COMMISSIONER: Thank you.
32
33 MS HEATH: I tender that, and I understand we're up to
34 exhibit 8.
35
36 **EXHIBIT #8 ONE-VOLUME BUNDLE IN RELATION TO THE DEATH OF**
37 **GRAHAM WILLIAM PAYNTER**
38
39 MS HEATH: Separately, Commissioner, I hand up a family
40 statement. This is prepared by Mr William Towler and his
41 brother, Andrew Bird. It was received by the Commission on
42 1 February 2023. I tender that and ask that it be marked
43 exhibit 9.
44
45 **EXHIBIT #9 STATEMENT PREPARED BY MR WILLIAM TOWLER AND**
46 **MR ANDREW BIRD**
47

1 MS HEATH: The third document I hand up is short minutes
2 of order in relation to an order pursuant to section 8 of
3 the Special Commissions of Inquiry Act. This relates to
4 various non-publication and pseudonym orders, and we seek
5 that those orders be made.
6
7 THE COMMISSIONER: Thank you. Yes, I will make those
8 orders, thank you.
9
10 MS HEATH: Thank you, Commissioner. Finally, I provide my
11 written submissions. These are dated 6 February 2023.
12
13 THE COMMISSIONER: Thank you.
14
15 MS HEATH: I commence my oral submissions by saying that
16 I adopt and rely upon those written submissions.
17
18 THE COMMISSIONER: Thank you very much.
19
20 MS HEATH: Commissioner, can I commence by acknowledging
21 that I understand that various members of Mr Paynter's
22 family may be listening to this hearing by way of the live
23 stream.
24
25 THE COMMISSIONER: All right.
26
27 MS HEATH: I would like to acknowledge them and express
28 the Inquiry's condolences to them.
29
30 Mr Paynter was the only son of Gladys and Stanley
31 Paynter, who are both now deceased. He was also a brother,
32 an uncle and a great uncle. He was affectionately known by
33 most people by the nickname "Possum". He is remembered as
34 a joker, as a bit of a scallywag, and as a person who
35 always enjoyed a laugh with his friends and family.
36
37 I will briefly, Commissioner, touch upon the contents
38 and preparation of the tender bundle that is exhibit 8.
39
40 In the course of inquiring into the death of
41 Mr Paynter, the Inquiry requested and received the coronial
42 file in relation to Mr Paynter's death from the Bega Local
43 Court. Documents at tabs 2 to 21 are extracted from that
44 material that was requested and provided.
45
46 The Inquiry also summonsed the original investigative
47 file from the NSW Police Force. That summons was

1 unfortunately less fruitful. At tab 27 of the tender
2 bundle [SCOI.82356_0001] is the statement of solicitor
3 Francesca Lilly, paragraphs 5 to 6, which set out our
4 efforts to obtain the original investigative file in
5 relation to Mr Paynter's death.
6
7 Commissioner, you will see at paragraph 6 that only
8 a very limited selection of documents were produced, and
9 certainly nothing that resembles the full investigative
10 file in relation to Mr Paynter's death.
11
12 This lack of production appears consistent with
13 comments that are contained in the Strike Force Parrabell
14 final report that reported the original investigative file
15 has been lost. As I have commented in my written
16 submissions, it is troubling that a police file in relation
17 to a death was not carefully and properly archived.
18
19 Nonetheless, the coronial file contains documents from
20 the police that evidence the nature of the police
21 investigations and allow submissions to be made.
22
23 Tabs 21A to 23 of the tender bundle contain material
24 that was summonsed from the NSW Police Force and is
25 relevant to Strike Force Parrabell's consideration of
26 Mr Paynter's death. I will come to that material in due
27 course.
28
29 Tabs 24 to 27 contain further material that the
30 Inquiry has obtained in the course of investigating
31 Mr Paynter's death. This includes at tabs 24
32 [SCOI.82112_0001] to 25 [SCOI.82164_0001] a report from
33 a forensic pathologist, Dr Linda Iles, and also a statement
34 from Mr William Towler, the nephew of Mr Paynter. That's
35 contained at tab 26 [SCOI.82355_0001]. I express my
36 gratitude to Mr Towler for providing that statement.
37
38 My oral submissions, as my written submissions have
39 already done, will set out key matters arising from
40 a consideration of this evidence.
41
42 Turning to the circumstances of Mr Paynter's death,
43 the body of Mr Graham Paynter was found by a passerby at
44 the bottom of a cliff in an area known as Shelley Beach in
45 Tathra on the New South Wales south coast. His body was
46 found as approximately 5pm on 13 October 1989. The time of
47 death was estimated to be approximately midnight the night

1 before.
2
3 It's necessary to provide the Commission with some
4 background as to the layout of the town of Tathra. There
5 are two sections to the town of Tathra, one at the level of
6 the beach, and the other at the top of an uphill drive.
7 Mr Paynter lived in a caravan park at Andy Poole Drive in
8 the lower, sea-level section of Tathra. Mr Paynter had
9 last been seen alive drinking at the Tathra Hotel shortly
10 after 11.20pm, and the Tathra Hotel is at the top section
11 of the town.
12
13 The evidence establishes that when the Tathra Hotel
14 would close of a night, patrons seeking to go to the lower
15 part of the town would frequently walk down a street called
16 Cliff Place to a walkway that ran along the top of the
17 cliff. From that walkway, you could access a set of stairs
18 that led down to the beach. There was no signage or
19 fencing near the cliff edge at the time of Mr Paynter's
20 death. It was partially covered with vegetation, and it is
21 from this walkway that I have just described that
22 Mr Paynter fell.
23
24 I ask that tab 16 [SCOI.92214_0001] be put up. This
25 is page 5 of tab 16. I understand from the coronial file,
26 the comments made in it, that this is a photograph of the
27 cliff area above where Mr Paynter's body was located. As
28 you will observe, the cliff edge is not well marked, and
29 you can observe the vegetation in part obscures the edge of
30 the cliff.
31
32 When police attended the scene, they made a number of
33 observations of Mr Paynter's body and took a series of
34 photographs in situ. Of particular note was the
35 positioning of Mr Paynter's clothing. Mr Paynter's body
36 was partially undressed. His jumper was pulled up over his
37 head, but his arms were still in the sleeves. His jeans
38 were pulled down around his lower legs and his underpants
39 were pulled down and sitting around his upper thighs. The
40 top button of his jeans was done up but his fly was down.
41
42 There was a post-mortem examination conducted by
43 Dr Oakley. In my written submissions at paragraph 11,
44 I have set out the injuries that were documented and
45 observed by Dr Oakley. To summarise, there were
46 significant head, chest and abdominal injuries, consistent
47 with a fall from a height.

1
2 Mr Paynter's blood was also taken and sampled and his
3 blood alcohol concentration was found to be 0.29 grams per
4 100ml of blood.
5
6 Commissioner, I will return to this post-mortem report
7 in due course in the context of submitting in relation to
8 the review of this autopsy report that was conducted by
9 Dr Iles.
10
11 Investigating police obtained statements from
12 witnesses that revealed Mr Paynter's movements prior to his
13 death. I have set out at paragraph 9 of the written
14 submission what those statements contained, but I will
15 summarise them in this way: that Mr Paynter was observed
16 to have been drinking with a friend, Mr Russell Longmore,
17 from at least midday on 12 October 1989. He was drinking
18 first at the Tathra Hotel, then later at the Bega Hotel,
19 before finally returning again to the Tathra Hotel.
20
21 While in Bega, he was arrested for stealing a bottle
22 of rum from the Bega liquor store. He was processed,
23 charged with larceny, but released the same night.
24
25 Mr Paynter remained drinking on his own at the Tathra
26 Hotel until closing time, and this was after his friend,
27 Mr Russell Longmore, had left for the evening.
28
29 Various observations were made about his level of
30 intoxication throughout both the day and the night, but
31 relevantly, by the time that he left the Tathra Hotel, he
32 was observed to be loud, well intoxicated and walking
33 unsteadily, and all of these observations are consistent
34 with his recorded blood alcohol level of 0.29.
35
36 The investigating officer, Constable Ian Castle,
37 formed the opinion that Mr Paynter accidentally fell to his
38 death from the cliff while in a very intoxicated state,
39 perhaps after attempting to urinate over the side of the
40 cliff. Consistent with his death being accidental, an
41 inquest was dispensed with.
42
43 On the evidence available, noting that the original
44 police file is not in the possession of the Inquiry, it
45 appears that Mr Paynter's death was treated from the outset
46 like an accidental fall, with the result being that limited
47 investigative steps were taken by police. A thorough

1 police investigation, it is submitted, would have involved
2 obtaining more details and more information as to
3 Mr Paynter's personal circumstances, and obtaining
4 a witness statement from Mr Russell Longmore, with whom he
5 had been drinking on the night in question. Such steps may
6 have opened up further lines of inquiry.
7
8 Notwithstanding the treatment of Mr Paynter's death as
9 accidental, Inquiry staff have considered for ourselves the
10 possibility that the death was the result of an LGBTIQ hate
11 crime. Now, there is no material in the coronial file that
12 bears upon Mr Paynter's sexuality or gender identity one
13 way or the other.
14
15 The Inquiry has now spoken to and obtained evidence
16 from Mr Paynter's family. The conclusion of our inquiries
17 with Mr Paynter's family was that Mr Paynter was not known
18 or considered by his family to be a member of the LGBTIQ
19 community, although his family express that they were open
20 to the possibility and would have been very supportive of
21 him if that was the case.
22
23 Nonetheless, there were two factors in relation to
24 Mr Paynter's death that have been considered to be relevant
25 to assessing whether Mr Paynter's death was the result of
26 an LGBTIQ bias crime.
27
28 The first is that his body was found at the base of
29 a cliff formation. Evidence before this Inquiry indicates
30 that some cliff locations have been used and have served as
31 outdoor beats. Coronial findings have identified pushes
32 from cliffs as the cause or probable cause of a number of
33 LGBTIQ hate-related deaths near the Bondi area.
34
35 Secondly, Mr Paynter's clothing was partly displaced
36 and his body, when discovered, was in a state of partial
37 undress. In some circumstances, this could indicate
38 a sexual element to a death that could be indicative of
39 LGBTIQ bias.
40
41 I intend to come to analyse both of those
42 circumstances in some more detail. It is first of
43 assistance, however, to briefly canvass the approach that
44 Strike Force Parrabell took to Mr Paynter's death.
45
46 As I noted earlier, the Strike Force Parrabell final
47 report records that the files in Mr Paynter's case could

1 not be located. Footnote 23 of the report records that
2 these files were either never returned to the archive or
3 returned and have subsequently been lost. Regrettably,
4 Strike Force Parrabell officers did not take the step of
5 summonsing or obtaining the coronial file in relation to
6 Mr Paynter's death.
7
8 If I could ask tab 21A [SCOI.82363_0001] to be put up
9 on the screen, this is a document that was a review
10 conducted by Detective Chief Inspector John Lehmann. Now,
11 I understand that this document has previously been
12 tendered before the Commission, and that is in exhibit 6,
13 tab 47. I don't propose to touch at this point on the
14 context of the creation of this document. However, if we
15 scroll down on to page 3, the purpose of showing the
16 Commission this document is to note that the
17 paragraph summary on page 3 was the only material that
18 Strike Force Parrabell had when they were assessing whether
19 or not there was evidence of a gay hate crime.
20
21 If I then take the Commission to tab 22
22 [SCOI.74992_0001], and this is the Bias Crime Indicators
23 Form in relation to the death of Mr Paynter, at pages 3, 4
24 and 9 of this document - I don't need it to be scrolled to
25 at this time - it appears that the officers of Strike Force
26 Parrabell copied and pasted from the form relating to
27 another deceased person, Mr Sheil, and failed, in doing so,
28 to amend the deceased's name.
29
30 As I have noted in my written submissions, this is
31 concerning and perhaps indicative of a lack of care taken
32 with respect to very important subject matter.
33
34 Throughout this form, the analysis of whether
35 Mr Paynter's death was or could have been an LGBTIQ hate
36 crime was, it is respectfully submitted, superficial. Even
37 making allowance for the lack of information that was
38 before them, there was no engagement with the possible
39 significance of the location of the death or the state of
40 Mr Paynter's clothing and how that may relate to what is
41 known of other LGBTIQ hate crime deaths.
42
43 If I could have the form scrolled to page 5, and if I
44 could have it scrolled down, we're looking for indicator 4.
45 Indicator 4 is in relation to "Organised Hate Groups". If
46 I could now have it scrolled down to page 6, at the top of
47 page 6, you will see a prompt that says "MO", which we

1 understand to be "modus operandi", "is similar to a known
2 MO of an OHG" - that is, an organised hate group. The
3 comment that is there made is that no suspicious
4 circumstances or indications of foul play are noted in
5 respect of Mr Paynter's death and then it is commented that
6 it would appear that he has fallen from a cliff at the
7 southern end of Tathra Beach.
8
9 This is a prompt that may have led to some inquiry as
10 to both the similarity of Mr Paynter's death with other
11 deaths committed or suspected to have been committed by
12 organised hate crime groups, and also to note the state of
13 Mr Paynter's clothing. But ultimately, while those facts
14 were noted throughout the forms, they were not engaged
15 with.
16
17 Strike Force Parrabell ultimately concluded that there
18 was insufficient information to establish a bias crime, and
19 the academic review of Flinders University concurred in
20 this view.
21
22 That can now be removed from the screen.
23
24 So I turn then to some of the steps that have been
25 taken by the Inquiry to try to advance the position. As
26 noted earlier, the Inquiry obtained from Dr Iles an
27 independent review of the autopsy report prepared by
28 Dr Oakley. Among other things, Dr Iles was asked about the
29 cause of Mr Paynter's death and the inferences that could
30 be drawn from the positioning of his clothing.
31
32 The expert report of Dr Iles expresses some concern
33 with the quality of the post-mortem examination of
34 Mr Paynter. While Dr Iles considers that the post-mortem
35 examination was "adequate to provide a cause of death" and
36 acknowledges that there have been changes in autopsy
37 practice in the decades since Mr Paynter's death, she
38 identifies a number of limitations in the autopsy report.
39 First, Dr Iles points to the absence of any specific
40 description of the presence or absence of anogenital
41 injuries, even though the state of his clothing warranted
42 such description.
43
44 Secondly, Dr Iles comments that the description of the
45 external injuries is limited and not systematic.
46
47 Dr Iles considers that the differentiation between

1 injuries caused by falls from a height and blunt force
2 trauma sustained prior to a fall is usually very difficult,
3 and that the presence of subtle injuries in protected areas
4 can assist in making that differentiation. However, in
5 this case, in the opinion of Dr Iles, the report is silent
6 in regard to such subtle injuries.
7
8 It is the opinion of Dr Iles that Mr Paynter's
9 external injuries, the crime scene photographs and the
10 description of the topography are all consistent with
11 a fall from a height, with multiple secondary impact points
12 and rolling or tumbling of the deceased's body following
13 primary impact.
14
15 This fits with the topography of the cliff at the
16 bottom of which Mr Paynter was found. However,
17 particularly in light of the absence of any record as to
18 subtle injuries, Dr Iles considers that there is nothing in
19 the medical findings that could now differentiate between
20 an accidental fall, suicide, or a homicidal fall in which
21 Mr Paynter was pushed.
22
23 Regrettably, these are limitations with a post-mortem
24 examination that there is now no ability to rectify.
25
26 Given the limitations of the medical evidence in that
27 regard, it is necessary to turn to other features of the
28 case that may provide some indication as to the manner of
29 Mr Paynter's death.
30
31 First, it is reasonable to infer that after leaving
32 the Tathra Hotel in the upper section of the town,
33 Mr Paynter walked down along Cliff Place and the pedestrian
34 walkway towards the stairs giving access to the beach
35 below. This would represent the most direct route home for
36 him from the Tathra Hotel to the caravan park where he
37 lived on Andy Poole Drive.
38
39 Secondly, there are a number of factors that make an
40 accidental fall plausible. These include Mr Paynter's
41 extreme intoxication, with his blood alcohol concentration
42 of 0.29 being almost six times the legal limit of drinking,
43 and observations from witnesses that he was walking
44 unsteadily; secondly, the night-time darkness, with
45 Mr Paynter's estimated time of death being approximately
46 midnight; and, thirdly, the lack of a fence or barrier in
47 the area at the top of the cliff.

Next, despite the post-mortem examination being silent as to subtle injuries, there were no obvious injuries which Dr Iles considered could not be explained by a fall. This makes it less likely, although it cannot be excluded definitively, that a violent assault occurred prior to his death.

Fourthly, a canvass of witnesses by police near the site of Mr Paynter's death revealed no information that may indicate foul play. Similarly, there is nothing suspicious in his movements on the night prior to his death, nor any indication of a fight between Mr Paynter and any other person who may have wished to cause him harm.

Fifthly, there is no material that would indicate the possibility of suicide, and Mr Paynter was generally observed to be in good spirits in the lead-up to his death.

There are, of course, the two additional factors which I earlier identified that bear upon the possibility that Mr Paynter's death was the result of an LGBTIQ hate crime.

First, consideration was given to whether the cliff-side location where Mr Paynter was found could have been a beat. Inquiries were made with both Garry Wotherspoon and Mr Paynter's nephew, Mr William Towler, who was at one time a resident of Tathra, as to whether they had knowledge of a beat in Tathra. No specific evidence to that effect could be obtained.

Nonetheless, the Inquiry has received evidence in the course of public hearings of various outdoor locations, including cliff sides, functioning as beats, not only in the Sydney city but also in regional areas of New South Wales. That evidence came, Commissioner, you may recall, from witnesses including Garry Wotherspoon, Les Peterkin and Ulo Klemmer, and I have summarised in my written submissions their evidence in relation to outdoor beats generally and also specifically outdoor beats in regional and rural locations.

Part of that evidence was that public toilets in parks would often function as beats in country or regional areas, and further, that one of the criteria for an outdoor beat was a degree of seclusion so that sexual activity could take place. Although this was given careful consideration,

1 there are reasons to doubt that the specific cliff-side
2 location from which Mr Paynter fell was a beat. Most
3 significantly, it does not fit with that essential
4 characteristic described by Mr Wotherspoon of providing
5 a secluded place for sexual activity. To the contrary, the
6 evidence was that it is well frequented by patrons leaving
7 the Tathra Hotel. Quite the opposite to it being secluded,
8 it may well be considered quite a dangerous location, given
9 evidence from Mr Towler - and this is at tab 26
10 [SCOI.82355_0001] of the tender bundle - as to the general
11 notoriety of the Tathra Hotel for violence in that era. If
12 there was a beat in Tathra, there are other locations
13 around Tathra, including at various public toilets, which
14 have been identified as more likely candidates for an
15 outdoor beat.
16
17 Secondly, in relation to the positioning of
18 Mr Paynter's clothing, Dr Iles was asked what could be
19 inferred from the positioning of his clothing. Dr Iles has
20 opined that a fall followed by a tumble allows for the
21 possibility of Mr Paynter's clothing having become
22 disturbed from its original position, so the mechanism of
23 the fall could provide the explanation for the positioning
24 of his clothing.
25
26 She notes in particular that Mr Paynter had truncal
27 obesity and narrow hips, making it possible or indeed
28 likely that his lower garments passively ended up below
29 their normal location in the setting of tumbling following
30 a high-energy fall.
31
32 Having received that opinion, it is submitted that the
33 positioning of his clothing cannot be probative of the
34 occurrence of a bias crime, being capable of explanation
35 simply by the mechanism of the fall.
36
37 In short, it is submitted that the likelihood is that
38 Mr Paynter's death was the result of an accidental fall,
39 rather than being the consequence of a homicide or the
40 result of an LGBTIQ hate crime.
41
42 It is submitted that this Inquiry should find that
43 Mr Paynter died on 13 October 1989 as a result of multiple
44 injuries sustained in an accidental fall from a height in
45 the setting of alcohol intoxication.
46
47 Commissioner, the final point to note - and this is at

1 paragraph 85 of my written submissions - is that there is
2 a recommendation in this case, a submission for
3 a recommendation in this case, and that is that
4 a recommendation should be made to the Registry of Births,
5 Deaths and Marriages to bring the cause of death in line
6 with the expression of the cause of death provided by
7 Dr Iles.
8
9 Commissioner, those are my submissions in relation to
10 this matter.
11
12 THE COMMISSIONER: Thank you.
13
14 MR MYKKELTVEDT: Similarly, your Honour, I don't wish to
15 be heard at this juncture.
16
17 THE COMMISSIONER: Yes, I understand. That's perfectly
18 fine, thank you.
19
20 MS HEATH: Commissioner, again there may need to be some
21 rearrangement of the Bar table. Would it be convenient to
22 take an early lunch break and return shortly after that?
23
24 THE COMMISSIONER: Does that inconvenience you?
25
26 MR MYKKELTVEDT: No, it doesn't.
27
28 THE COMMISSIONER: Yes, I will do that and I will return
29 at 2 o'clock. Thank you.
30
31 **LUNCHEON ADJOURNMENT**
32
33 MS HEATH: This is a public hearing into the death of
34 Mr Russell Phillip Payne. Can I start by handing up one
35 volume of material, being the tender bundle relevant to the
36 death of Mr Payne. There are 17 tabs in this tender
37 bundle. I tender it and I understand we're up to
38 exhibit 10.
39
40 **EXHIBIT #10 ONE-VOLUME BUNDLE IN RELATION TO THE DEATH OF**
41 **RUSSELL PHILLIP PAYNE**
42
43 MS HEATH: Secondly, I hand up some short minutes of order
44 pursuant to section 8 of the Special Commissions of Inquiry
45 Act that relate to various redactions to material. I seek
46 that those orders be made
47

1 THE COMMISSIONER: Yes, thank you. I will make those
2 orders, thank you.
3
4 MS HEATH: And finally, I hand up the written submissions
5 of Counsel Assisting dated 6 February 2023, and I adopt and
6 rely upon those written submissions.
7
8 THE COMMISSIONER: Thank you. I will receive those as
9 well, thank you.
10
11 MS HEATH: Thank you, Commissioner.
12
13 Commissioner, I understand that the family or some
14 family members of Mr Payne may be listening to this hearing
15 by way of the live stream. I would like to start by
16 expressing my condolences to them and thanking them for the
17 assistance that they have provided to the Inquiry.
18
19 I will touch briefly upon the contents and preparation
20 of the tender bundle. In the course of the inquiry into
21 the death of Mr Payne, the Inquiry received, first, the
22 investigation file from the NSW Police Force and, secondly,
23 the coronial file from the New South Wales Coroners Court.
24 Together, these files provided materials to the Inquiry
25 relevant to the manner and cause of Mr Payne's death and
26 the investigation of it. Material that has been extracted
27 from those summonsed documents can be found at tabs 2 to 8
28 of the tender bundle.
29
30 The Inquiry also summonsed and received records from
31 the NSW Police Force in relation to Strike Force
32 Parrabell's consideration of the death of Mr Payne. Those
33 documents are located at tabs 9 [SCOI.74987_0001] and 10
34 [SCOI.82203_0002].
35
36 At tabs 15 [SCOI.82352_0001] and 17 [SCOI.82354_0001]
37 Commissioner, you will see two statements that have been
38 obtained by the Inquiry. The first is a statement from
39 journalist Michael Burge, which relevantly sets out his
40 interactions with various members of Mr Payne's family.
41 The second is a statement from Mr Terry Forster. He is the
42 ex-brother-in-law of Mr Payne, and his statement I will
43 come to in due course.
44
45 I repeat the thanks given this morning by Senior
46 Counsel to Mr Burge for his assistance to this Inquiry and
47 also express my thanks to members of Mr Payne's family who

1 spoke with and assisted the Inquiry.
2
3 There are three additional steps that are reflected in
4 the index to the tender bundle. The first is that
5 a summons for Mr Payne's health records was issued to the
6 Hunter New England Local Health District. Unfortunately no
7 records could be obtained.
8
9 Secondly, Dr Iles, forensic pathologist, was briefed
10 to prepare an independent review of the autopsy report
11 prepared by Dr Davison. Her briefing letter and her report
12 are at tabs 11 [SCOI.82113_0001] and 12 [SCOI.82171_0001]
13 of the tender bundle.
14
15 Finally, on Dr Iles's suggestion, attempts were made
16 to obtain the histology slides created during the
17 post-mortem examination. However, again, those inquiries
18 were not fruitful. Tab 16 [SCOI.82353_0001] which is the
19 statement of solicitor Francesca Lilly, records the
20 attempts to locate those histology slides.
21
22 My oral submissions, like my written submissions, will
23 set out key matters arising from the consideration of that
24 evidence. I start by turning to and describing the
25 circumstances of Mr Payne's death.
26
27 Mr Payne was a 33-year-old man who lived in a flat at
28 a boarding house in Inverell owned by Mr John Wills.
29 Mr Wills considered him to be a quiet and well-mannered
30 person.
31
32 At about 6.15pm on Thursday, 2 February 1989, Mr Wills
33 entered Mr Payne's flat. He did so because Mr Payne,
34 uncharacteristically, had failed to pay his rent, and,
35 further, a friend of Mr Payne's was unable to locate him.
36 The front door was locked and so Mr Wills entered through
37 the open bedroom window.
38
39 Mr Wills walked through the house into the kitchen and
40 found the body of Mr Payne in the kitchen of the flat. He
41 immediately left and rang the police. Upon leaving through
42 the front door, he noticed that the front door was heavily
43 locked, such that he had trouble unlocking it.
44
45 Police arrived at approximately 7.15pm. Among them
46 was Detective Sergeant Patrick Moss, who was engaged in
47 physical evidence duties. He observed the following in

1 Mr Payne's flat: the body of Mr Payne was in the kitchen.
2 He was dressed in a blue coloured singlet and naked from
3 the waist down. His body exhibited bruising on his right
4 hip and his penis. There was blood smeared around the
5 upper thighs and the legs of the deceased. There were
6 small drops of blood on the kitchen floor near the doorway
7 from the living room and into the bathroom. There were no
8 signs of a struggle or the ransacking of any rooms. There
9 were apparent bloodstains on the bedding and a towel in the
10 bedroom. There was vomit in two containers on the floor
11 adjacent to the bed, and on the carpet near the two
12 containers. Beside the bed were containers which held
13 prescription drugs for various medical conditions, and
14 I pause to note that the police report does not identify
15 what those drugs were, nor the medical conditions that were
16 apparently treated by them.
17
18 On the floor of the bathroom were a number of
19 handkerchiefs and underpants, each of which was stained
20 with apparent blood. There was also a stained sponge on
21 the bathroom sink and the underside of the toilet lid was
22 also stained.
23
24 Inside the washing machine was a shirt with a small
25 stain, apparently blood, and a stained handkerchief. In
26 the bedroom was a sawn piece of timber, apparently a broom
27 handle, the rounded end of which was stained with
28 a dark-coloured stain. There were a large number of erotic
29 photographs at the flat, and again, the police report does
30 not describe or comment upon the content of those
31 photographs. They do not appear to have been retained as
32 exhibits.
33
34 Commissioner, you will see at paragraphs 25 and 51 of
35 my written submissions that some criticism is made of this
36 failure to seize and record those exhibits, particularly
37 when they in part informed the opinion of the investigating
38 officer that the injuries were self-inflicted.
39
40 A post-mortem examination was conducted of the body at
41 3.30pm on 3 February 1989 by pathologist Dr Alan Davison.
42 I have set out in my written submissions at paragraph 8
43 a description of his findings, and I will repeat orally
44 only a summary of those findings - that is, in general
45 terms, there was bruising to Mr Payne's hip, pelvic region
46 and genital region; there was bruising to Mr Payne's right
47 shoulder; there was a hairline fracture to Mr Payne's

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1 skull, but notably there was no associated brain injury;
2 and, finally, a metal object with a spike at its base was
3 located in the penile urethra, 1 to 2cm from its distal
4 end. On later inspection by police, this was revealed to
5 be an antenna there a television set in Mr Payne's flat.
6 Dr Davison estimated the date of death to be three days
7 prior to autopsy - that is, on or around 31 January.
8
9 After examining tissue samples from the deceased,
10 Dr Davison expressed the view that Mr Payne was suffering
11 from a severe generalised infection. He expressed the
12 cause of death to be due to septicaemia as a result of
13 acute urethritis, most probably caused by insertion of
14 a foreign body into the penile urethra.
15
16 On 18 May 1989, an inquest was dispensed with and the
17 cause of death was recorded in a manner consistent with
18 Dr Davison's findings at autopsy.
19
20 The police file contains very little material bearing
21 upon whether Mr Payne was or might have been a member of
22 the LGBTIQ community. There is a comment from Mr Payne's
23 landlord, who had known Mr Payne for approximately 18
24 months, who reported that Mr Payne had told him he had once
25 been married but was now divorced and had a child in
26 Brisbane. This would seem to indicate that, at some point
27 in the past, Mr Payne had been in a heterosexual
28 relationship.
29
30 The Inquiry has now found some further information
31 relevant to Mr Payne's sexuality. The Inquiry was
32 initially provided this information by journalist
33 Mr Michael Burge, and it's now contained in a statement at
34 tab 17 [SCOI.82354_0001] from Mr Terry Forster.
35
36 Mr Forster is the ex-partner of Mr Payne's sister. He
37 describes that he used to visit Inverell every fortnight or
38 so for a shopping trip, and that during those trips he
39 would meet Mr Payne. On one of those trips, which is
40 estimated to be approximately a year prior to his death,
41 Mr Payne said to Mr Forster words to the effect of, "Did
42 you know I was gay?" And Mr Forster said, "I didn't."
43 Mr Forster was accepting of Mr Payne's sexuality and their
44 friendship continued as it had before. Relevantly,
45 Mr Payne did not discuss any of his sexual practices with
46 Mr Forster, including any interest in, for example,
47 sadomasochism.

1
2 At tab 15 [SCOI.82352_0001], which is a statement from
3 Mr Burge, he recounts his conversations that he has had
4 with Mr Payne's sister, Julie Kilgour, and her partner, Ray
5 Kilgour, about Mr Payne. You will see at paragraph 11 of
6 that statement that they did not know that Mr Payne was gay
7 until their recent conversations with Mr Burge and
8 Mr Forster. However, upon learning of his sexuality, they
9 expressed their support and understanding of that
10 possibility.
11
12 Mr Payne's family have expressed some concerns at the
13 lack of communication between themselves and investigating
14 police throughout the investigation of Mr Payne's death.
15 They had no knowledge of the cause of Mr Payne's death
16 until later approached by journalist Mr Burge.
17
18 Another point that has raised questions for Mr Payne's
19 family is that they recall being sent to collect Mr Payne's
20 belongings from an address on Warialda Road in Inverell,
21 not the Henderson Road location where Mr Payne's body was
22 found, and they understood him to be living at that former
23 address.
24
25 The police file that the Inquiry is in possession of
26 contains no indication or record of the nature or extent of
27 interactions between police and any family of Mr Payne
28 following his death. So the reasons for that discrepancy
29 remain unknown on the material before the Inquiry.
30
31 I say at this point, as I have said in my written
32 submissions, that better engagement with Mr Payne's family
33 would have not only been courteous but may also have
34 resulted in obtaining further relevant information as to
35 Mr Payne's personal circumstances.
36
37 Commissioner, I will turn to consider the approach of
38 Strike Force Parrabell to Mr Payne's death. Strike Force
39 Parrabell did not contact Mr Payne's family and was not,
40 therefore, aware of the information that is now in the
41 possession of the Inquiry as to Mr Payne's sexuality. This
42 was, of course, consistent with the general approach of the
43 strike force, which was a paper review of the historical
44 material only and did not involve approaching to or
45 speaking with any witnesses.
46
47 The Bias Crime Indicators Review Form is located at

1 tab 9 [SCOI.74987_0001] of the tender bundle. Strike Force
2 Parrabell concluded that there was no evidence of a bias
3 crime. Throughout the form "General Comment" sections,
4 which are under each indicator, consistently indicate that
5 the authors were not of the view that Mr Payne's death
6 ought to be considered a bias crime, and they considered
7 that the circumstances surrounding Mr Payne's death were
8 not suspicious, and that the evidence suggested that
9 Mr Payne died by misadventure as a result of
10 a self-inflicted wound. The review of Flinders University
11 concurred in that conclusion.
12
13 Commissioner, I will turn to the results of some of
14 the investigative steps undertaken by this Inquiry and,
15 most notably, that is the report that has been obtained of
16 Dr Iles. Dr Iles was asked to provide an independent
17 review of the autopsy report of Dr Davison, and also to
18 comment upon the manner and cause of Mr Payne's death.
19
20 In her report, Dr Iles considers that the autopsy of
21 Dr Davison was reasonably comprehensive and conducted in
22 a thoughtful way with a view to excluding major trauma
23 contributing to or directly causing death. Consistent with
24 that, she adopts a view of the cause of death that is "not
25 significantly different" to that of Dr Davison.
26
27 The cause of death that Dr Iles favours is death as a
28 consequence of septicaemia secondary to Fournier's gangrene
29 precipitated by a urethral foreign body. The difference
30 between the cause of death given by Dr Davison and given by
31 Dr Iles is this: Fournier's gangrene is a life-threatening
32 soft tissue infection of the perineum and surrounding
33 tissues; urethritis, the term which was used by Dr Davison,
34 is a bacterial or viral infection in the urethra, so the
35 location of the source of the infection is different.
36
37 Dr Iles noted that findings at the scene indicate that
38 Mr Payne had been unwell for a period of time prior to his
39 death, consistent with systemic sepsis.
40
41 Commissioner, you may recall, for example, that there
42 was vomit located around the scene, and some evidence of
43 attempts to clean by Mr Payne.
44
45 Dr Iles was specifically asked whether Mr Payne's
46 injuries were consistent with misadventure, suicide or foul
47 play. Her opinion is that there are no findings in the

1 material that necessitate the involvement of another person
2 in Mr Payne's death. She expresses the view that on the
3 available material, "Mr Payne's death can be completely
4 explained as a consequence of a natural disease process
5 secondary to misadventure", ie, a foreign body in the
6 urethra, and that there are no features in the material to
7 suggest either suicide or foul play.
8
9 In support of this opinion, Dr Iles refers to
10 literature to support the proposition that insertion of
11 foreign bodies into the urethra, although uncommon, is well
12 described in the setting of autoeroticism and masturbatory
13 behaviour, and, further, that there are cases in the
14 literature of Fournier's gangrene being precipitated by
15 self-inserted urethral foreign bodies.
16
17 Dr Iles makes the following comments in relation to
18 the bruising and other injuries that were observed on
19 Mr Payne's body. First, in relation to the swelling and
20 bruising to his genital region, it is highly likely that
21 that was a manifestation of Fournier's gangrene. Secondly,
22 the bruising described to Mr Payne 's hip and pelvic region
23 could be the result of either direct trauma, noting that
24 Mr Payne is likely to have bruised easily in the setting of
25 sepsis, or, alternatively, of soft tissue infection and
26 necrosis, that is, the death of those tissues. Thirdly, in
27 relation to Mr Payne's skull fracture, it's noted that it's
28 not associated with any intracranial injury. That being
29 the case, it's consistent with a fall backwards at the time
30 of death, rather than being the primary cause of Mr Payne's
31 death. Finally, the bruising to Mr Payne's right shoulder
32 would be also consistent with such a fall at time of death.
33
34 In light of Dr Iles's opinion, it is submitted that it
35 follows that the probability is that a foreign body was
36 self-inserted by Mr Payne, and it is submitted that this
37 Inquiry should accept the expert opinion of Dr Iles, which
38 is largely consistent with the original opinion of
39 Dr Davison.
40
41 In addition to the opinion of Dr Iles, other relevant
42 factors that support that conclusion are: first, that
43 there were no signs of struggle or ransacking in Mr Payne's
44 unit; secondly, the evidence that Mr Payne was unwell for
45 some time prior to his death; and, thirdly, that Mr Payne's
46 unit was heavily locked from the inside.
47

1 All of these factors tend against a conclusion that
2 another person was involved in or responsible for
3 Mr Payne's death and tend to suggest that Mr Payne
4 self-inserted the foreign body into his urethra.
5
6 Accordingly, notwithstanding the new information that
7 has been obtained by the Inquiry as to Mr Payne's
8 sexuality, it is submitted that Mr Payne's death was not
9 the result of an LGBTIQ hate crime. In view of the
10 totality of the circumstances, it's more probable than not
11 that the foreign body was self-inserted, likely in the
12 setting of autoeroticism.
13
14 Commissioner, you will see at written submissions
15 paragraph 63 the finding that it is submitted is open to
16 and should be made by the Commission. It is consistent
17 with the cause of death given by Dr Iles. Accordingly,
18 upon making that finding, this case would not fall within
19 Category A of the Inquiry's Terms of Reference, it not
20 being an unsolved case.
21
22 Finally, Commissioner, at paragraph 65 of the written
23 submissions, there is a submission in relation to
24 a recommendation. This is to be made to the Registrar of
25 Births, Deaths and Marriages, and that is to correct the
26 cause of death so as to bring it in line with the expert
27 opinion of Dr Iles.
28
29 Commissioner, those are my submissions in relation to
30 this matter.
31
32 THE COMMISSIONER: All right. Thank you. And you reserve
33 your position?
34
35 MR MYKKELTVEDT: Yes, your Honour.
36
37 THE COMMISSIONER: All right. Thank you. I think that
38 concludes the day's proceedings, doesn't it?
39
40 MS HEATH: That's correct, Commissioner.
41
42 THE COMMISSIONER: We will resume in the morning at 10 and
43 I will adjourn until then. Thank you very much.
44
45 **AT 2.21PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
46 **TO WEDNESDAY, 8 FEBRUARY 2023 AT 10AM**
47

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