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 Wednesday, 8 February 2023 at 10.00am

(Day 18)

Ms Christine Melis	**(Counsel Assisting)**
Mr William de Mars	**(Counsel Assisting)**
Mr Enzo Camporeale	**(Director Legal)**
Ms Kate Lockery	**(Principal Solicitor)**
Ms Caitlin Healey-Nash	**(Senior Solicitor)**
Ms Elizabeth Blomfield	**(Senior Solicitor)**

Also Present:

Mr Anders Mykkeltvedt (for NSW Police)

THE COMMISSIONER: Before we start this morning, Mr Mykkeltvedt, a couple of things.

MR MYKKELTVEDT: Yes, your Honour.

THE COMMISSIONER: There was an outstanding series of objections taken by your client. I have ruled on them in effect in advance of yesterday and today, but I promised you some written reasons so I will give them to you now. So I will hand my judgment down and they will be available to you and those instructing you, and these are the reasons for my rejecting the ultimate redactions that weren't agreed.

MR MYKKELTVEDT: Thank you, your Honour.

THE COMMISSIONER: Thank you. I will also proceed upon the basis, unless you tell me otherwise, that when Counsel Assisting conclude their remarks, I will just take it as read that you will reserve your position in respect of each and every one of the cases that are ventilated.

MR MYKKELTVEDT: Yes. I will certainly let your Honour know if there is something I wish to be heard on.

THE COMMISSIONER: All right. And lastly, I should just make a short explanation for a couple of things that happened yesterday, not because we have had any inquiries about it but it occurred to me that I should say something about the redactions. Take a seat. I won't burden you to stand while I'm speaking, so please sit down.

MR MYKKELTVEDT: Yes, Commissioner.

THE COMMISSIONER: Yesterday in relation to the matters of Hughes, Paynter and Payne, I made a number of orders which were said to be pursuant to section 8 of the Special Commissions of Inquiry Act 1983, and I anticipate I will make other orders along similar lines today in relation to those cases which are ventilated.

I think I should just explain for those in the hearing room and for those watching online, in brief, the basis for those short minutes, and which has led to the certain redactions from the tender bundle.

Section 8 of the relevant Act provides me with power

to make orders making certain matters confidential if I think it's in the interests of justice that they remain confidential, and those minutes that I made yesterday had the effect, as I have said before, of taking out of the public domain certain details. Those details were taken out in order to necessarily protect either the identities of persons who are not concerned directly with what is going on here, perhaps in some cases the addresses or telephone numbers of people, in some instances the identity of minors or something to that effect.

Where possible, I will have as much information which is tendered before me or ventilated before me heard in public. However, from time to time, where I think it is necessary for certain redactions to occur, I will make orders accordingly. The materials, therefore, that will be published and available publicly will be those materials which I am of the view should be made publicly available.

Now, the redactions, in some instances, have been the subject of discussion between staff of the Inquiry and relevant persons, most relevantly the police, who have taken, in my view appropriately, some objections. However, there are some objections which have been taken which will be seen from my judgment delivered this morning I have not thought it necessary in all the circumstances for certain matters to remain confidential. Those issues will be dealt with on an ongoing basis from time to time, and perhaps I need say no more about it for the moment.

Yes, Mr de Mars.

MR de MARS: Commissioner, I appear today to assist you in relation to three Category A matters that are proceeding by way of documentary tender. They are the matters of William Dutfield, David Lloyd-Williams and Andrew Currie.

THE COMMISSIONER: Thank you.

MR de MARS: The first matter to proceed is that of William Dutfield. Could I firstly, Commissioner, tender a bundle of material. There are two volumes, in this matter. I understand those two volumes are already with you.

THE COMMISSIONER: Yes, they are.

MR de MARS: I think we are up to exhibit number 11.

EXHIBIT #11 ONE-VOLUME TENDER BUNDLE IN RELATION TO WILLIAM DUTFIELD

THE COMMISSIONER: Thank you. Perhaps if I can interrupt you again, and I apologise, Mr de Mars, what I should also say, Mr Mykkeltvedt, and it has been occurring on our website but it will be underlined today, is that some of the materials that I have deemed should be publicly ventilated may cause some stress or distress to those either members of families or even persons who were not connected to the deceased persons but who may wish to read the materials online, and so there will be, as you will have noticed this morning and ongoing, a warning to those persons who may be upset if they read some of the details relating to some of the homicides or the deaths of certain people.

I think that way, at least, we can ensure that if people do wish to access the material, they are warned in advance that it may be upsetting for some of them and, if needs be, there are services available, Lifeline and others, if they wish to make contact with those persons. I have taken that course and I can't imagine there will be any difficulty from your client's point of view.

MR MYKKELTVEDT: No, that's certainly so, Commissioner.

THE COMMISSIONER: Thank you. Yes, Mr de Mars.

MR de MARS: Commissioner, I also understand that you have before you a copy of a proposed order pursuant to section 8 of the Special Commissions of Inquiry Act, which, in keeping with the matters, Commissioner, you have just been addressing, deals with certain non-publication redactions.

THE COMMISSIONER: Thank you. I have looked at those minutes and I think in those circumstances the redactions which will be covered by those short minutes are appropriate and I make those orders. Thank you.

MR de MARS: Thank you. Thirdly, Commissioner, I understand you also should have a copy of the written submissions in this matter.

THE COMMISSIONER: Yes, I have, thank you.

MR de MARS: I adopt and rely upon those WRITTEN submissions, in addition to what I now say orally.

THE COMMISSIONER: Thank you.

MR de MARS: Commissioner, Mr Dutfield died on the evening of 19 November 1991 in the living room, in the apartment where he lived in the Sydney suburb of Mosman. He was 41 years old. It was plain from the outset that he had been the victim of a violent assault.

In a post-mortem report dated 1 April 1992, which appears at tab 4 of the bundle [SCOI.00027.00031_0001], Dr Duflou documented 16 lacerations to Mr Dutfield's head, as well as a number of abrasions and some minor bruising. He also documented abrasions, contusions and minor lacerations to his arms and some contusions to his right leg. Internal examination found extensive fracturing of the skull causing subdural and subarachnoid haemorrhages and extensive laceration of brain tissue.

In his report, Dr Duflou found the direct cause of death to be head injuries.

At an inquest that was held on 12 December 1994, Dr Duflou indicated in his evidence that the U shape of the head wounds was consistent with them having been caused by a large metal sticky tape dispenser located at the scene. He stated that the injuries were severe and had involved at least 12 blows to the head. The skull fracturing was extensive and Mr Dutfield would have died from half as many blows. He described Mr Dutfield as having defensive wounds on his arms, hands and wrists, and that he was likely facing his attacker at some stage. A bruise was identified on one of Mr Dutfield's knees.

It is also relevant to note, Commissioner, that Mr Dutfield's blood toxicology report indicated a very high level of alcohol. That report is at tab 2 [SCOI.00027.00032_0001], the relevant percentage being 0.242.

Mr Dutfield was known to be either gay or bisexual. He was of slight build, having previously worked as a jockey. His career came to an end after he suffered a number of falls. I will return in due course to further

background details concerning Mr Dutfield.

At the time of the original investigation from 1991 and for a number of years thereafter, police proceeded on the basis of a theory that Mr Dutfield had been the victim of a robbery committed by someone who was effectively preying upon him as a potentially vulnerable victim.

At paragraph 51 of the written submission, I set out details of an assault upon Mr Dutfield that had occurred just five weeks before his death and which was one of the reasons why police adopted this theory.

That assault occurred on 16 October 1991. The day after, on 17 October 1991, Mr Dutfield provided a statement to police about that matter. In it he described having six middies of beer at the Rex Hotel Bottoms Up bar with a male who he had met there. He invited the male back to his flat in Mosman. They had a scotch together and watched TV.

The male called Mr Dutfield a bastard and punched him to the face. The male then kicked Mr Dutfield to the face and body a number of times before searching his pockets and taking $900 from him. Mr Dutfield described the male as being about 23 years old and he gave a physical description of that person.

Commissioner, the original officer in charge of the investigation, a Detective Sergeant Peter O'Toole, gave evidence at the inquest in 1994. He expounded a theory that a male prostitute, as he described the person, and/or a drug addict, was preying on people such as Mr Dutfield, gaining entry to their residential premises under false pretences and then bashing and robbing them. This was partly based on, as I say, the break-in that had previously occurred.

The officer in charge considered that word would have gone around the Kings Cross area of Mr Dutfield's vulnerability as a target of robbery. He suggested that either a phone call was made by Mr Dutfield to someone or that he was visited without appointment by the assailant and that he either knew the person or Mr Dutfield was made known to them through associates from the Kings Cross area.

Police therefore appear to have concentrated their inquiries on what the OIC described, to use his language,

"on the male homosexual heroin addict type offenders in the prostitution area of Kings Cross". That's derived, your Honour, from tab 7 [SCOI.00027.00035_0001], which is the transcript of the inquest hearing.

By the time of the inquest, the police had been unable, however, to identify a clear suspect, leading to the coronial finding that the injuries causing Mr Dutfield's death had been inflicted by a person or persons unknown.

I might ask at this point, Commissioner, for tab 6 [SCOI.00027.00001_0001] to be brought up on screen. That's simply the original finding that was made by the Coroner of the time, Deputy State Coroner Abernethy, and as has been indicated, the finding at that stage, back in 1994, was one that indicated that the relevant injuries had been inflicted by a person or persons unknown.

Contrary to that police theory, the key person of interest in relation to the death is now someone else entirely, a man by the name of Mr Arthur Ashworth. Mr Ashworth was born on 16 June 1914 and was aged 77 at the time of Mr Dutfield's death. Although considerably older, he was a long-time friend and associate of Mr Dutfield.

At the time of the original investigation, the possibility of his involvement appears to have been dismissed on the basis of his age. Your Honour will see at tab 38 [SCOI.10068.00036_0001] of the material an investigation note evidencing discussion with the OIC in 2010 when the matter was reinvestigated, that is consistent approach taken by the OIC initially.

However, reconsideration of the evidence by the NSW Police Force upon reinvestigation by a strike force by the name of Strike Force Hamish, which commenced in late 2008, and this Inquiry's own consideration of the evidence, both strongly suggest that Mr Ashworth killed Mr Dutfield.

Tab 45 [SCOI.02712_0001], Commissioner, you have before you a record of the conclusions that were reached by Strike Force Hamish to that effect in 2013. I note at this point that Mr Ashworth is now himself deceased.

Commissioner, I move now to set out the various steps undertaken by the Inquiry in relation to this matter. The

Inquiry's consideration of the matter has involved firstly compelling the production of police investigative material, including that covering both the initial investigation of the matter from 1991 to 1994, and its subsequent reinvestigation from around 2008 until 2012 or 2013; secondly, obtaining Coroners Court files in relation to the inquest that was held in 1994; and, thirdly, reviewing and analysing all of this material and considering whether any further investigative or other avenues are warranted.

To give some more details to that work, Commissioner, this matter was one of those the subject of the Inquiry's first summons to police dated 22 May 2022 for all police investigative material relating to it. The follow-up summons was issued on 14 October 2022, as it was apparent that there was investigative material dating from late 2010 onwards that had not been produced in response to the initial summons. The later summons also sought the complete police fingerprint file to help clarify the basis for an assertion that Arthur Ashworth's fingerprint was found on the likely weapon used to kill Mr Dutfield.

In response to the later summons, additional material was produced to the Inquiry and clarification was provided regarding the location of relevant material within police archive boxes previously provided to the Inquiry.

A summons was also issued on 5 December 2022 to the Forensic and Analytical Science Service of New South Wales Health Pathology, known by the acronym FASS, for their file, so that all DNA and other forensic evidence relating to the death could be fully considered by this inquiry. Efforts were also made to contact surviving family members of Mr Dutfield, however, these have not resulted, to this, point, in any contact with a family member.

Commissioner, I now proceed to set out key matters arising from the Inquiry's consideration of the evidence and the conclusions that it is suggested can be drawn from the evidence. These are largely consistent with the consideration of the evidence and conclusions reached by Strike Force Hamish.

In relation to Mr Dutfield's background, as already observed, he was 41 years old when he died. He had four older brothers, one of whom died in 1989. He also had a twin brother by the name of John. He grew up in the

Sydney suburb of Dee Why on the Northern Beaches and attended Manly Boys High School leaving school at 15 to become an apprentice jockey. He worked for two different horse trainers until he was aged 27.

According to information provided to police by his brother Robert, he suffered injuries through a number of falls when riding which had affected his personality. He was said to have become depressed and he started to drink too much, and his relationship with other family members became strained.

He became friends with two older males, one of whom was Arthur Ashworth. After sharing a house initially with the other man for a period, Mr Dutfield met Mr Ashworth and he moved in with Mr Ashworth for about 10 years prior to his death.

At the time of his death, however, Mr Dutfield lived alone in a one-bedroom unit in Mosman that was owned by Mr Ashworth.

Mr Dutfield's brother Robert also told police that Mr Dutfield was lonely in the period leading up to his death. His only friends were these two older males. And he had mentioned that he wanted to meet other people. The day before his death, Mr Dutfield had met his twin brother at a cafe at Warringah Mall and appeared to be in good spirits.

I now turn, Commissioner, to provide some details of the account given by Mr Ashworth at the time of the death. It is important, in my submission, to understand what he initially told police in order to understand in part why he is now the key suspect.

Mr Ashworth was called to give evidence at the inquest held in 1994. Given the nature of the questions he was asked, he was clearly not considered to be a person of interest at that time. He adopted the statement he had made to police, qualifying it only by stating that Mr Dutfield had told him that he was bisexual rather than homosexual.

At this point, Commissioner, I will go to some of the detail of the statement, and it might be appropriate to have that put up on screen. It is at tab 16

[SCOI.00027.00044_0001]. If we stay at the front page for present purposes just to indicate that this is the statement, and as you will see, it bears the date 21 November 1991, being the day after the events which caused the death.

In the body of the statement, Mr Ashworth described drinking at the Rex Hotel in the 1970s after his retirement and meeting Mr Dutfield there when Mr Dutfield was working as a general hand at the hotel. He stated that he got to know Mr Dutfield well. Mr Dutfield would clean his unit for him once a week and confided in him that he was gay. Mr Ashworth described himself as becoming a father figure to Mr Dutfield.

As I have already indicated, Mr Dutfield subsequently boarded with Mr Ashworth for 10 years, first at Randwick and then at Cremorne. In June 1991, five months prior to Mr Dutfield's death, Mr Ashworth moved into a retirement village and so stopped living with Mr Dutfield in Cremorne. Mr Ashworth then bought a unit in Mosman that Mr Dutfield moved into - that is, the unit where he died - and Mr Ashworth thus became his landlord.

Mr Ashworth described his involvement with Mr Dutfield on the day of his death as follows - it might be of some assistance just to scroll down in the on-screen statement initially, I think, to the second page, where we see Mr Ashworth commenced to describe some of those events.

In the morning he says he went to Mr Dutfield's unit and did some washing with him. At around 4.30pm, Mr Dutfield showed up at Mr Ashworth's retirement village apartment with two beers, most of which Mr Dutfield drank. Mr Dutfield appeared to have been significantly affected by alcohol and Mr Ashworth thought he was depressed and that generally Mr Dutfield showed signs of manic depression.

At 5.30pm they both went to the Mosman unit. Both of them drank two scotches. At 7pm, according to Mr Ashworth, they went to the Mosquito Bar Restaurant together for dinner. I note, Commissioner, that that establishment at the time was about a 350 metre distance from the unit.

They drank a bottle of wine with dinner and left, according to Mr Ashworth, at about 7.45pm. That timing assumed some significance, as I will come to. It took them

10 minutes to walk back to Mr Dutfield's unit. They had a further scotch together and Mr Dutfield had two glasses of wine. According to Mr Ashworth, after these drinks Mr Dutfield was slightly high and drunk and wanted to go out and drink at a bar. Mr Ashworth says that he cautioned against it and left on his own, arriving back at his retirement village at around 8.15pm.

According to Mr Ashworth, he observed Mr Dutfield to have about 150 to 180 dollars in his wallet when they were at the restaurant. This was potentially significant, as if it was the case, it would appear to have been taken from his wallet by the perpetrator.

That statement could come down at this point, and I just draw to your attention, Commissioner, some of the relevant evidence from neighbours, that evidence being of particular importance to establishing the likely time of the attack on Mr Dutfield.

Neighbours who lived directly below Mr Dutfield in the apartment complex heard a number of thud sounds while watching the first half of the program "LA Law" on TV, which had aired between 9.30 and 10.30pm, thus placing the likely time of the attack at between 9.30 and 10pm. They also heard loud arguing occurring between two male voices, one described as louder than the other, just prior to hearing the initial thud.

Commissioner, a crime scene officer, Detective Christopher Kolder, also gave evidence at the inquest. I will go to some of the things Detective Kolder observed at the time, because again, they become particularly significant when looking at the later investigation of the matter.

Detective Kolder's statement appears at tab 12 [SCOI.00027.00034_0001], and again it might be of some assistance to put that on screen at present. I will ask that it be left there for the present and will ask that it be scrolled down a little later.

Detective Kolder attended the unit the following day, on 20 November 1991, at 12 noon, after Mr Ashworth had contacted police purporting to have found the body when checking on Mr Dutfield. Detective Kolder gave evidence to the following effect: a number of swabs of blood were

taken from the scene, including of tissues in the kitchen waste bin. The latter indicated the presence of a small amount of blood of a different blood type to Mr Dutfield. This was being kept, he said, in a frozen state, in the hope that in future it could be DNA tested against other samples.

I pause at this point to note that that tissue was to become subsequently a particularly important piece of evidence. Detective Kolder also observed that the whole unit had been fingerprinted with a negative result, and that the offender appeared to have washed their hands in both the kitchen and bathroom sinks. He said there were no signs of struggle other than one drug having been disturbed.

The bloodstain patterns at the scene suggested that Mr Dutfield may have initially been attacked by being struck by a heavy metal sticky tape dispenser whilst seated. The tape dispenser was in the kitchen sink and an attempt had been made to wash it, though blood remained on it.

Detective Kolder also observed that the injury pattern to Mr Dutfield's head was consistent with a tape dispenser having been used to inflict all the blows. There were two drinking glasses on a table in the lounge room near the body that contained scotch, and a bottle of scotch in the kitchen with a nip pourer ready. He observed that there were no signs of a forced entry. The lack of fingerprints on the glasses, ashtray, table and elsewhere suggested to him that the perpetrator had gone to some trouble to wipe things.

If we could just scroll down in the statement, I think to page 8, thank you, and just down a little further. Consistent with the evidence given at the inquest, Commissioner, you will see that amongst other things, the items that Detective Kolder indicates that he collected for further examination included 2F, the tissue from the waste bin in the kitchen, and also of note, and again I will subsequently come to it, 2H, a black cardigan from the lounge suite in the lounge room.

Commissioner, as you have already heard, despite police following various leads based on the OIC's theory that someone had committed the murder in the course of

a robbery, potentially with prior knowledge of Mr Dutfield's vulnerability, by the time of the 1994 inquest, no clear suspect had been identified. That statement can come down now.

The material obtained by this Inquiry discloses that in 2005 the death was reviewed by the police Unsolved Homicide Team. At paragraph 56 of the submission, I set out the recommendations that were made following that review on 2 May 2005. Critically, they included that there should be further examination of the tissue with blood that was retrieved from the kitchen waste bin, bearing in mind that at the time of the original investigation, it had been ascertained that the blood was not of the same blood group as Mr Dutfield.

Further recommendation was that there should be re-examination of the sticky tape dispenser, bearing in mind that at the time of the original investigation, partial fingerprints had been located.

It was further recommended that an elimination DNA sample should be taken from Arthur Ashworth, noting that he had provided elimination fingerprints but not DNA at the time of the original investigation.

Regrettably, despite the recommendations made in 2005, including that for obtaining a DNA sample from Mr Ashworth and DAL testing of the tissue, it appears that neither had been done by the time Mr Ashworth passed away in July 2006.

It was not until 8 February 2007 that a report was received from DAL in relation to the tissue. That report noted that a full DNA profile had been obtained from the stained tissue that was recovered from the waste bin. In view of this, and notwithstanding that by this stage Mr Ashworth had died, it was noted in a March 2007 case screening form, Commissioner, which was at tab 30A [SCOI.10066.00036_0001], that obtaining a profile from Mr Ashworth should be seen as a priority for elimination purposes or otherwise. Due to his age, time may be limited, and once he passes away, the opportunity may well be lost. It seems, Commissioner, that the UHT did not seem to appreciate that by this time, Mr Ashworth had in fact already passed away.

Subsequently, Strike Force Hamish was formed

in September 2008, with Terms of Reference to further investigate the circumstances surrounding the murder of William James Dutfield at Mosman on 19 November 1991. A Detective Senior Constable Hungerford was allocated as the officer in charge. After reviewing the brief, issues that were recognised included following up outstanding exhibit inquiries and following up outstanding inquiries with Arthur Ashworth, who it was observed appeared never to have been considered a suspect.

Much of the work of Strike Force Hamish focused on re-examining evidence and re-interviewing witnesses in connection with the possible involvement of Mr Ashworth in the death and locating exhibits for further analysis.

Commissioner, the forensic evidence uncovered by Strike Force Hamish strongly implicates Mr Ashworth. I will come to that evidence shortly. However, there are three other aspects of the evidence that it is submitted are also highly incriminating in relation to Mr Ashworth, that should have been apparent to investigators at a very early stage. These relate, firstly, to the evidence of timing of Mr Ashworth's movements on the evening of the death; secondly, to evidence concerning Mr Ashworth's movements on the day after the death; and, thirdly, evidence in relation to clothing Mr Ashworth was wearing on the evening of Mr Dutfield's death.

The issues as to the timing of Mr Ashworth's movements on the day of the death are set out in the submission at paragraphs 62 to 66. In essence, there is a significant discrepancy between the evidence of Mr Ashworth on the one hand and other objective evidence concerning when Mr Ashworth and Mr Dutfield left the Mosquito Bar where they had dinner. The difference in the evidence and its significance suggests that Mr Ashworth's account is likely to have been a self-serving fabrication.

Without traversing all of the detail that is in the written submission, Mr Ashworth told police that he and Mr Dutfield had left the Mosquito Bar Restaurant, where they had had dinner, at 7.45pm. They then walked to Mr Dutfield's flat, arriving just before 8pm. He stayed with Mr Dutfield while he had a drink and Mr Dutfield had two drinks, before he returned to The Garrison Retirement Village, he said by 8.15pm.

By contrast, objective evidence from civilian witnesses whose accounts corroborate each other indicates that the pair did not leave the restaurant until around 8.45pm, thus returning, it would seem, to the flat shortly before 9pm.

Given that Mr Ashworth, by his own account, remained at the flat for some time while the pair drank, this timing would appear to put Mr Ashworth squarely in the frame as potentially present during the period from 9.30 to 10pm when neighbours heard the sounds consistent with the fatal assault.

The second area of evidence implicating Mr Ashworth, as I have indicated, relates to his activities on the day after the death. This is set out at paragraphs 67 to 69 of the written submission.

On the morning after Mr Dutfield's death, Mr Ashworth visited a friend in Woollahra in the Eastern Suburbs. According to the account of the friend, they were due to go to lunch together. However, rather than have lunch, Mr Ashworth advised his friend that he had to go to a teachers' reunion. They remained at the friend's house for just half an hour, then got a train to Edgecliff together, then parted ways at about 11am.

The friend spoke to Mr Ashworth on the phone later that day, at which time Mr Ashworth told his friend about Mr Dutfield's death. However, Mr Ashworth told his friend that another person, and not he, had found Mr Ashworth's body. I will return to the potential significance of that.

Thirdly, in relation to the question of Mr Ashworth's clothing, on 21 November 1991 - that is, two days after the death - Mr Ashworth told investigators that he had dropped off a pair of blue trousers at a dry cleaner in Wynyard on 20 November. This information, including as to the colour of the trousers, was later corroborated by police with the dry cleaner. Your Honour will see the evidence of that at tab 29j [SCOI.10067.00033_0001], a police running sheet.

At the same time, Mr Ashworth told police that he was not wearing these blue pants on the evening of the death but was wearing a brown outfit. Mr Ashworth's account of the colour of his clothing is at odds with descriptions of civilian witnesses who saw him on the evening and described

it as grey and blue. The relevant civilian evidence is set out and referenced at paragraph 74 of the submission.

The evidence, it is submitted, concerning Mr Ashworth's clothing and his movements the following day is cause for suspicion for a number of reasons. It seems odd that Mr Ashworth would have arranged to visit his friend in Woollahra in order to go to lunch, only to then tell him that he had a teachers' reunion to go to, and then not go to the reunion, it would seem, but instead return to Mosman to check on Mr Dutfield.

The likelihood that Mr Ashworth later lied and told his friend that another person and not himself had found Mr Dutfield suggests that he was at a loss to explain to his friend why he went and checked on Mr Dutfield rather than going to the purported teachers' reunion.

Thirdly, Commissioner, Mr Ashworth appears to have lied about the clothing he had worn when questioned by police. The description of the clothes as seen by witnesses does not match that given by Mr Ashworth. Further, the colour of the trousers he took to the dry cleaners the morning after the death does potentially match the colour of the trousers he wore as seen by at least one of those witnesses.

This evidence, it is submitted, is consistent with Mr Ashworth, having killed Mr Dutfield, seeking to give the appearance of normality the following morning by keeping his commitment to visit his friend, while also returning to the crime scene perhaps potentially to deal with incriminating aspects of it, while also arranging to have the trousers that he wore at the time of the death dry cleaned at Wynyard.

I now turn in some more detail, Commissioner, to the forensic evidence which implicates Mr Ashworth. That comprises both evidence of a fingerprint and DNA evidence. It is dealt with at paragraph 77 and following of the written submission. According to Strike Force Hamish investigators, the original investigation received fingerprint results identifying a fingerprint on the murder weapon, the tape dispenser, as belonging to Mr Ashworth. This was not a matter that was in the material presented to the Coroner, and when interviewed by Strike Force Hamish investigators in 2010, the original OIC said that he was

not aware of it at the time.

In his statement made on 20 November 1991, Mr Ashworth had stated that the tape dispenser was originally his, and that he had left it in the flat when he had moved to the retirement village, possibly providing an innocent explanation for the presence of the fingerprint.

Analysis of the documentary evidence relating to the fingerprint in question does indeed indicate that a fingerprint was identified as on the tape dispenser, as belonging to Mr Ashworth. The particular evidence is in an email from the officer Craig Borton of the Major Crime Section, Fingerprint Ops, dated 11 May to Detective Stephen Hungerford, the officer in charge of the Strike Force Hamish investigation.

Mr Borton states as follows:

I have again compared [the relevant case related] (prints on tape dispenser) against fingerprints of Arthur Ashworth. Graph W1 is identified as the right ring finger of Ashworth. I am unable to identify the remaining graph W2 as Ashworth. Was possibly incorrectly written off as Fully Eliminated in 1991.

The observations of officer Borton as to the relevant print having been potentially incorrectly eliminated in 1991 appear to be consistent with photos of the relevant fingerprints from the original investigative material. Notations made on the back of the photos indicate that the print or prints had either been fully or partly eliminated at the time. Other notations and records are consistent with Arthur Ashworth having been incorrectly fully eliminated as a source of the prints at the time of the original investigation. The references for those observations, Commissioner, are provided in footnotes to the submission in paragraph 79.

It is suggested that the appropriate conclusion is that at the time of the original investigation, the print was either not identified as belonging to Arthur Ashworth or, if it was, this information appears not to have been passed on to or acted upon by the original investigators. What is clear is that upon re-examination in 2010, officer

Borton identified one of the prints as belonging to Mr Ashworth.

In relation to the DNA evidence, as mentioned earlier, evidence collected at the scene in 1991 included a bloody tissue located in the kitchen waste paper basket, and also a cardigan on the lounge in the lounge area. Evidently, the perpetrator had gone to the kitchen after killing Mr Dutfield, as the tape dispenser was found in the sink, the kitchen sink. The bloodied tissue had been tested at the time and, as already referred to. Found to be of a different blood type to that of Mr Dutfield.

As also noted earlier, on 2 May 2005, a review of the matter by the Unsolved Homicide Team resulted in recommendations for further examination of the tissue and some other items and the taking of an elimination DNA sample from Arthur Ashworth. Plainly, these actions could have been taken somewhat earlier than 2005, given the timing of the introduction of DNA testing methodologies in New South Wales. However, the initial, and it is submitted inappropriate, dismissal of Mr Ashworth as a potential suspect was presumably at least partly a reason for an elimination sample not having been taken from Mr Ashworth at an earlier time.

When the tissue was resubmitted to DAL for DNA testing in 2005, resulting in confirmation that the blood was not from Mr Dutfield, a match was also found with blood on the cardigan that had been left on the lounge suite at the crime scene - that is, the profiles on the tissue and the cardigan were consistent.

It is, regrettable, to say the least, that a DNA sample from Mr Ashworth had not already been obtained as of May 2005, nor was one taken from him in the 13 months following the recommendation that such a sample be taken and during which Mr Ashworth remained alive. If this had occurred, the DNA match between the blood on the tissue, the cardigan and Mr Ashworth could have resulted in the initiation of a prosecution against him while he remained alive, including attempts to confront him in interview as the key suspect.

In fact, it was not until September 2008, more than two years after Mr Ashworth's death, that Strike Force Hamish was formed with these specific Terms of Reference

I have referred to. It was four years after Mr Ashworth's death in June 2010 that a forensic review of the matter was conducted. Relevant events which then occurred included the following: a DNA swab was taken from a nephew of Mr Ashworth on 12 September 2010; the Y DNA profile obtained was consistent with that obtained from the bloodied tissue and the blood on the cardigan at the scene. On 18 November 2010, police took possession of a 2003 diary that had belonged to Mr Ashworth, from a family member, and on 15 December 2010, the police received advice from DAL that DNA samples taken from the personal diary of Mr Ashworth had the same profile as those from the bloodied tissue and, therefore, also the cardigan.

The totality of the available forensic evidence, therefore, strongly supports the view that Mr Ashworth was responsible for the attack. The fingerprint matching his has been identified on the murder weapon and a DNA match to his blood was made with a bloody tissue in the kitchen where it appears the assailant had attempted to clean things up after Mr Dutfield was killed. Blood matching his DNA was also located on the cardigan on the lounge nearby Mr Dutfield's body.

It's noted that the tape dispenser, as can be seen in photographs within the tender bundle, is metal and has a serrated part for the cutting of tape. It could readily have caused a cut or abrasion to a person wielding it as a weapon.

Commissioner, it's also relevant to consider the question of a possible motive for Mr Ashworth to have committed the crime. While it would not have been essential to prove a case against him, consideration of motive is, for obvious reasons, relevant to considering whether any LGBTIQ bias may have been involved.

In relation to the question of motive, it's noted that Mr Ashworth, Mr Dutfield and a third older male I have referred to as their mutual friend appeared to have led a quite insular existence spending much of their time in each other's company. While various accounts made it clear that Mr Dutfield was gay or bisexual, it does not appear that Mr Ashworth openly identified as gay. Objectively the nature of his relationship with Mr Dutfield suggests that he may well have been. Further, both family members and friends of Mr Ashworth have told Strike Force Hamish

investigators that they thought Mr Ashworth was gay.

It's also clear that Mr Dutfield had a significant alcohol problem. On 14 November 1991, just five days prior to his death, he had been referred by his GP to his local community health centre for assistance with his alcohol use and management of anxiety. One month prior to this, in October 1991, someone who it appears must have been Mr Ashworth, had contacted a counsellor at the same centre. The statement of the counsellor appears at tab 24 [SCOI.00027.00050_0001] of the tender bundle.

The counsellor recalls the person, who it appears must have been Mr Ashworth, telling her the following: that he had a friend, who she thought the caller said was living with him at the time, and who was driving the caller, in their words, "crazy due to his drinking". He was drinking and causing problems in the flat. The caller said that the person was on an invalid pension, a fact consistent with Mr Dutfield's known status, and that he was also causing problems with another friend. The caller thought that his friend would not attend alcohol counselling and that he thought he needed psychiatric help. The counsellor tried to encourage the caller to arrange to bring the person in to see her.

Subsequently, the local community health centre completed a mental health service intake form after a referral was made by Mr Dutfield's GP listing contact details of Arthur Ashworth, the referral being for alcohol and psych problems.

The information in that form appears to make it quite clear that Mr Ashworth appears to have been the person who raised the issues with the counsellor.

On the evening of his death, it seems clear that Mr Dutfield was heavily intoxicated. The Mosquito Bar proprietor stated that when entering the restaurant Mr Dutfield was quite drunk and was slurring his words. He evidently had quite a bit more to drink after this, both at the restaurant and back at his unit.

The close mutual friend of Mr Dutfield and Mr Ashworth, in his statement at tab 17 [SCOI.00027.00045_0001] noted as follows in relation to Mr Dutfield. He said he would be very moody, and when he

was drinking you had to watch what you said so that it would not offend him, because he would get upset and very angry. He was very sensitive when he had been drinking. When spoken to by Strike Force Hamish investigators on 4 November 2010, the same friend made the following observations, that Mr Dutfield did not see himself as an equal intellectually to either himself or Mr Ashworth, as he was dyslexic, and as a result of this, when intoxicated, he would put Mr Ashworth and himself down verbally and was quite abusive. He said that he never saw Mr Dutfield use violence and observed that he was very short, physically weak and said that he would be incapable of fighting.

The friend observed that Mr Ashworth was physically stronger than Mr Dutfield, though he had never seen Mr Ashworth fight with anyone.

While evidence concerning the nature of the interaction between Mr Dutfield and Mr Ashworth on the evening of Mr Dutfield's death is necessarily limited, the fact that Mr Ashworth had previously expressed great frustration with Mr Dutfield's conduct when intoxicated and the close and possibly intimate nature of the relationship between them, the fact they had both been drinking and Mr Dutfield's high level of intoxication at the time suggests a context in which emotions may have run high between the two men at the time the offending occurred, and that this set a context in which the offending occurred.

Before coming to suggested conclusions, Commissioner that, might be reached in the matter, it is relevant to make some observations about the way in which this matter was treated by Strike Force Parrabell.

The content of the Bias Crimes Indicators Form that was completed in the course of the work of Strike Force Parrabell in 2016 to 2017 is, I think it must be said, highly surprising, because despite having been completed a number of years after Strike Force Hamish, it appears to take no account of the key conclusion reached by police in the reinvestigation of the matter by Strike Force Hamish, namely, that the likely assailant was Arthur Ashworth and not someone connected with a robbery that had taken place five weeks prior to Mr Dutfield's death.

Instead, the information in the Bias Crimes Indicators Form repeats and appears to adopt the conclusions reached

by the original officer in charge and by the Coroner in the early 1990s, namely, that Mr Dutfield was most likely to have been the victim of the same perpetrator of that robbery or someone acting on a similar basis who had become aware of the earlier robbery and Mr Dutfield's potential vulnerability.

At this point, your Honour, it might be appropriate to show on screen tab 79, [NPL.0115.0002.2149] which is the relevant Bias Crimes Indicators Form. Whilst I certainly won't traverse all of the form, to give you an example of the type of comment that one sees repeatedly in that form, perhaps we could go to page 13 of that form. You will see there is a section 8, "Location of Incident".

If we scroll down to the bottom of that form, in relation to the question of location, you will see the bottom box, and it is reproduced in the submission at paragraph 21, what is said in relation to Detective Sergeant O'Toole, the officer in charge of the investigation - namely, that the officer in charge of the investigation believed that an unidentified male had met - that Dutfield had met at the Rex Hotel on the night of the robbery a month earlier or an associate was the person who killed Dutfield.

If we go down to the top of the next page, consistent with the rest of the content of this form, it seems the author of the form effectively was adopting the same case theory in relation to what had happened concerning the matter.

Can I draw, Commissioner, your attention to the reference to significant investigation having been conducted, focusing on male prostitutes from the Kings Cross area, but this failing to identify any of the offenders, and the reference to the Rex Hotel rather than Dutfield's home address being relevant to the investigation, stating that it is not bias related as it is most likely that the offenders in this murder were also homosexual. Implicit in that, your Honour, is an acceptance of the original case theory and, as I say, it's repeated in other portions of that form.

One observation that I would make, Commissioner, is that although adopting this by then outdated case theory, the conclusions expressed in the form, nevertheless based

on such a theory, discount the likelihood of Mr Dutfield's death having been motivated by gay-hate bias, as you will see in the portion I have just taken you to. It's submitted that had in fact Mr Dutfield been killed in such circumstances, noting that the submission here is that he was not, the assertion that such a death could not be considered to be gay-hate bias related is not justified. The fact that the perpetrator of violent crime against a member of the LGBTIQ community may themselves engage in homosexual sex or be associated with people who do or, for example, someone who works as a male sex worker, it is submitted that it ought not be taken to automatically exclude the possibility that a crime committed by such a person involves gay-hate bias. But that appears to have been the approach taken in the Bias Crimes Indicators Form. That form can come down now.

The indicators in relation to individual criteria considered in the form all lead to one of two conclusions being expressed in it: that the matter was either not bias crime; or that there was insufficient information to make a determination as to whether or not it was. The summary of findings notes the relevant indicator as "Insufficient Information", and the comment in the summary of findings again fails to mention the findings of Strike Force Hamish but instead repeats the views expressed by the original OIC and the Coroner in the early 1990s. It concludes as follows:

> *It appears unlikely that sexuality or other bias was involved in the death of William Dutfield and it is most likely that the motive for assaulting Dutfield was robbery related however this cannot be confirmed.*

As I have already stated, the motive of robbery asserted in the conclusion simply does not appear to be correct.

In relation to the Strike Force Parrabell case summary for this matter, the content of the case summary is set out at paragraph 25 of the submission - and I won't go to it in detail - but by contrast with the Bias Crimes Indicators Form, the case summary does contain an acknowledgment of the strong evidence against Arthur Ashworth that was highlighted upon reinvestigation of the matter after 2008. It is nevertheless expressed in confusing terms, in that the circumstances of death as they are described suggest

that the matter was in effect a robbery gone wrong, which is not consistent with the conclusion that Mr Ashworth was the perpetrator.

Inaccuracies in the summary narrative also suggest that the evidence was not closely examined. Reference is made to DNA matches with the murder weapon and blood found in the unit, when the relevant forensic match with the murder weapon was a fingerprint, not DNA. The statement that the offender broke out of the rear of the residence after stealing a small sum of cash rests on an acceptance of the clearly now impugned account of Arthur Ashworth, and is not consistent with the findings of Strike Force Hamish.

Commissioner, the quality of analysis disclosed by the Bias Crimes Indicators Form, it is submitted, is disturbing, particularly as it overlooks the entirety of the work of Strike Force Hamish. Further, the inaccuracies and inconsistencies in the case summary give rise to similar concerns about the quality of the analysis more generally conducted in relation to this matter by Strike Force Parrabell, it is submitted.

Coming back, then, to concluding observations, Commissioner, for reasons similar to those I have taken you to, Strike Force Hamish investigators reached the conclusion that Mr Ashworth was the offender responsible for Mr Dutfield's murder, and that had he been alive, there would have been sufficient evidence to arrest him. They were of the view that there were no outstanding investigative opportunities.

By contrast to the assessment of the officer in charge of Mr Ashworth's physical capabilities, the assessment of the mutual friend that I have referred to clearly suggests that despite the age difference, Mr Ashworth was physically stronger than Mr Dutfield. It is therefore surprising that Mr Ashworth was not more seriously considered as a suspect at the outset, and that obvious problems with his account and his conduct the day after the murder were not observed and interrogated at the time of the original investigation. It appears highly likely he was the offender, to the extent that further investigation does not appear to be warranted.

I come then to suggested conclusions as to the question of bias. If the original and flawed police view of the killing had been accurate, namely, that the crime

had been perpetrated by someone who was aware of Mr Dutfield's sexuality and potential vulnerability to robbery, the clear potential for it to be considered a crime involving LGBTIQ bias would be apparent. However, in view of the very high likelihood that Mr Ashworth was the perpetrator, it would appear unlikely that Mr Dutfield's death was a crime involving LGBTIQ bias. While the immediate circumstances leading to it will remain unknown, it appears to have occurred in the context of a close and long-established relationship between the two men, which had been known at times to involve episodes when frustration and anger would be expressed, often associated with Mr Dutfield's heavy use of alcohol.

In relation to submissions on the manner and cause of death, Commissioner, were Arthur Ashworth still alive today, there would clearly be a basis to proceed to prosecute him for the unlawful killing of Mr Dutfield. The submission now being made would be for this Inquiry to refer the matter to the ODPP, the Office of the Director of Public Prosecutions, with a view to that office initiating such a prosecution under its guidelines.

In view of Mr Ashworth's death, it's not now possible for him to answer such an allegation. The question remains, in my submission, for this Inquiry as to whether, notwithstanding Mr Ashworth's death and the impossibility of him answering such an allegation, the Inquiry can proceed to make a positive finding that he was responsible for the death.

At paragraphs 100 to 105 of the submission I set out relatively briefly some of the legal considerations that it is submitted are involved in considering whether such a positive conclusion can be reached, namely, that a particular individual who is deceased is responsible for causing a death.

Commissioner, you will no doubt be very mindful of the grave nature of the allegation in determining whether or not it is appropriate to make such a finding in the present matter. In my submission, the evidence that could have been adduced in a trial against Mr Ashworth is strong and compelling and is of such a nature that it would be admissible in criminal proceedings. It comprises both a considerable degree of direct evidence implicating Mr Ashworth, strong circumstantial evidence and statements

made and actions taken by him from which a consciousness of guilt can be inferred.

While it is not possible to conclude with certainty what the outcome of a criminal trial would have been, it is submitted that a finding by this Inquiry in the following terms is open and should be made: that on 19 November 1991, at his apartment in Mosman, New South Wales, William Dutfield died as a result of head injuries received after he was struck repeatedly in the head with a metal tape dispenser by Mr Arthur Ashworth. Accordingly, it is further submitted that the death of Mr Dutfield is not unsolved and therefore does not fall within Category A of the Inquiry's Terms of Reference.

Finally, Commissioner, given that the matter can be considered to have been solved in circumstances where the likely perpetrator is deceased, there are no recommendations that arise.

THE COMMISSIONER: All right. Thank you. I note your position, Mr Mykkeltvedt. I might take the break now, so I will take the morning break now and we will resume after that. Thank you. I will now adjourn.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes.

MR de MARS: Commissioner, the next matter the subject of documentary tender is the matter of David Lloyd-Williams.

THE COMMISSIONER: Yes, thank you.

MR de MARS: Can I firstly hand up and tender a one-volume bundle of material. I understand, Commissioner, you may already have a copy, but I will formally hand up that bundle. I understand that could become exhibit 12.

EXHIBIT #12 ONE-VOLUME TENDER BUNDLE IN RELATION TO DAVID LLOYD-WILLIAMS

MR de MARS: Commissioner, I understand you will already have a copy of proposed short minutes of order dealing with non-publication issues and the like, and I ask that those orders be made.

THE COMMISSIONER: Yes, I will make those. I have had a look at those, thank you. I have made those orders.

MR de MARS: Thank you. Thirdly, Commissioner, I also understand that you will have before you a copy of written submissions that have been prepared.

THE COMMISSIONER: I have, thank you.

MR de MARS: I adopt and rely upon those submissions.

THE COMMISSIONER: Thank you.

MR de MARS: It is appropriate for me to observe at the outset that two of Mr Lloyd-Williams' family members, his daughter and sister, have had contact with the Inquiry, have been helpful to the Inquiry, and the Inquiry very much appreciates the contact that they have had with us and the assistance they have provided. I understand that there will be family members likely listening, watching online, and can I pass on the condolences of the Inquiry to them for their loss.

THE COMMISSIONER: Thank you.

MR de MARS: Commissioner, Mr Lloyd-Williams died on the morning of 24 August 1978 at North Head in the Sydney suburb of Manly. His body was found at the bottom of a cliff at the south-eastern point of North Head. His death was the subject of a limited police investigation at the time. We know this based on the file that has been produced to the Inquiry by the Coroners Court, which held a brief inquest on 23 October 1978.

Apart from material in the Coroner's file, no separate police investigation file has been located or produced to the Inquiry by NSW Police.

Two days after the death, Dr Grace Higgins conducted a post-mortem examination. She found multiple injuries to Mr Lloyd-Williams consistent with a fall from a significant height. A blood sample was taken with no alcohol found.

Could I ask to have put on screen now, tab 5, [SCOI.73571-00004_0001]. I mentioned, Commissioner, that a coronial inquest was held on 23 October 1978, and on screen, and also reproduced at paragraph 10 of the

submissions, is a record of the formal finding that was made at that time.

If we scroll down just a little, Commissioner, you will see that the finding made, in terms of manner and cause, was that Mr Lloyd-Williams died from multiple injuries received when he cast himself from a cliff with the intention of taking his own life whilst in a state of mental depression.

Commissioner, the Inquiry's approach to the investigation of this matter had an usual starting point. This is because Strike Force Parrabell had been unable to locate any records at all, including the coronial file. Strike Force Parrabell had been proceeding on the basis of information about the death received by former police Gay Liaison Coordinator Ms Sue Thompson. That information referred to a man whose body was found at a cliff in Manly in 1979. The name given was David Lloyd Williams, not hyphenated, in a manner that Lloyd may have been a middle name.

The limited information in the spreadsheet also made reference to the body being found naked and with clothes folded.

I draw your attention, Commissioner, at this point, to the Strike Force Parrabell case summary, which is produced at paragraph 20 of the submission. The body of the Strike Force Parrabell case summary, I think it is worth reading it in full, reads as follows:

> *Identity: the only information available is within a spreadsheet prepared by a former NSW Police employee indicating that David Lloyd Williams was found naked at the bottom of a cliff at Manly in 1979. The person who provided the information was only known as "Dave Davies", who could not be located without further details. Investigators were unable to locate any records relating to this matter despite extensive searches including all possible dates of birth; dates of death; and/or misspelling of names. Database searches including: COPS; Ryerson Index; Media Archives; Coroner; GRR; Police and State*

Archives were also unsuccessful.

Then, Commissioner, you will see in relation to sexual orientation/psychological health, Mr Williams' personal history, body location, sexual orientation, psychological health, coronial or court findings could not be confirmed.

And then there is a reference to the death of Mr Williams being noted in academic reports indicating that its occurrence had been in the same gay beat area as certain other matters looked at by Strike Force Parrabell.

The Strike Force Parrabell case summary, not unsurprisingly, concludes with the observation that the strike force did not review the matter as details of the death could not be confirmed. The death was categorised as unsolved and not reviewed.

The Bias Crimes Indicators Review Form was to similar effect. It concluded with the observation that searches were completed on any possible date of birth, possible misspelling of the name and date of death of Williams, and that, currently, no information has been located, and it suggested that the only other option for police would be to identify the person Dave Davies.

It appears that police searches of the Registry of Births, Deaths and Marriage, the Coroners Court and by other means, must have been limited to a search that used the surname Williams alone, as Mr Lloyd-Williams' surname. References to the name in the Parrabell material variously refer to David Williams and David Lloyd Williams, but in a manner that again has Lloyd as a middle name rather than a hyphenated surname.

Commissioner, I move to investigative steps that have been taken by this Inquiry. As a result of a summons issued by the Inquiry on 23 August 2022 to the New South Wales Registry of Births, Deaths and Marriages, two days later, on 25 August, that registry produced a death certificate for Mr Lloyd-Williams. The summons had asked for any relevant certificates, including death certificates, for Williams, David Lloyd, and also provided the name of his wife and the fact that he had been born in England. His wife's name and his place of birth were information that by this stage had been provided to the Inquiry by Dr Neil McEwan, a friend of Mr Lloyd-Williams

who I will refer to later in the submission.

The description of the circumstances of death in the certificate which appears at tab 6 of the brief, [SCOI.74028_0001], made it apparent that this was of the death the subject of the information that had been provided to Ms Thompson and subsequently included in the Strike Force Parrabell matters. That seems plain enough by virtue of reference to the location of the death, the timing and more generally the name.

Following receipt of the death certificate, the Inquiry requested any coronial file related to the death. The Coroners Court provided a file that consisted of 22 pages of material, including a number of witness statements, post-mortem and toxicology reports and a very brief record of the inquest proceedings that took place on 23 October 1978.

On 26 August 2022, the Inquiry issued a summons to NSW Police that sought all documents relating to investigations by them of the death of Mr Lloyd-Williams, using the details of his name and dates of birth and death as appeared in the death certificate - that is, of course, with the hyphenated surname.

The legal representative for NSW Police replied by email dated 9 September 2022 advising that the only information or holdings of NSW Police in relation to the matter were the Strike Force Parrabell case summary and the Bias Crimes Indicators Form, and that any further information or holdings could not be identified.

Commissioner, this is notwithstanding that the coronial file produced to the Inquiry contains various statements and documentation produced by NSW Police at the time of Mr Lloyd-Williams' death. No explanation has been provided to the Inquiry as to what may have happened to the relevant NSW Police investigation file.

On 28 September 2022, the Inquiry issued a summons to the New South Wales Health Pathology Department of Forensic Medicine seeking all records held by the department relevant to the autopsy of Mr Lloyd-Williams. On 11 October 2022 the department produced an electronic file. This consisted of 12 pages of documents comprising copies of the post-mortem report and report of death to the

Coroner, the blood alcohol test results and the formal order for the autopsy. It did not provide any evidence of substance not otherwise contained in the coronial file.

Through a statement in the Inquiry's holdings related to another matter, the Inquiry was able to identify that the Dave Davies referred to in Ms Thompson's spreadsheet as the source of her information was likely to have been the Honourable Justice David Davies, a justice of the Supreme Court of New South Wales. Justice Davies was contacted and was able to provide the details of another friend of Mr Lloyd-Williams, Dr Neil McEwan, whom Justice Davies thought may have been able to provide greater information concerning Mr Lloyd-Williams.

A meeting was thereafter held with Dr McEwan, who provided the Inquiry with some additional information concerning Mr Lloyd-Williams.

The relevant information obtained from Mr Lloyd-Williams' friends is commented on later in the submission.

As I've already indicated, in the course of its work, the Inquiry also made contact with Mr Lloyd-Williams' sister, with whom he had contact around the time of his death, and his daughter, who was an infant at that time.

By letter dated 19 December 2022, an expert opinion was sought from forensic pathologist Dr Linda Iles, the head of Forensic Pathology Services at the Victorian Institute of Forensic Medicine.

Dr Iles was asked to address a number of matters. These included the adequacy of the post-mortem investigations conducted with respect to Mr Lloyd-Williams; her view as to the medical cause of Mr Lloyd-Williams' death, including any reasons why she might take a different view to that formed originally by Dr Higgins; her view as to whether Mr Lloyd-Williams' injuries were consistent with misadventure, suicide or foul play; and any recommendations for investigations with respect to determining the manner or cause of Mr Lloyd-Williams' death.

On 11 January this year, Dr Iles provided a report to the Inquiry that addressed those matters, and which I will come to.

The Inquiry also conducted searches in an effort to determine whether there were any media articles relating to the death of Mr Lloyd-Williams. Two articles were found in The Manly Daily newspaper dated 25 and 26 August 1978. Commissioner, they appear at tab 25 [SCOI.82319_0001] and tab 26 [SCOI.82317_0001] of the bundle, exhibit 12.

I now go to key matters arising from the Inquiry's consideration of the evidence that has been obtained. Firstly, in relation to Mr Lloyd-Williams' background, I start by observing that on the afternoon of his death, Mr Lloyd-Williams' body was identified by a friend and work colleague, a Mr Herbert Russell. That man provided a statement that was tendered at the inquest. He explained that he had worked with Mr Lloyd-Williams for five or six years at the ABC, then known as the Australian Broadcasting Commission, where Mr Russell was a concert manager. In the "Report of Death to Coroner", Mr Lloyd-Williams was also described as a manager with the ABC, and in the death certificate I observe that he was described as a concert manager.

According to his death certificate, Mr Lloyd-Williams was born in Barnehurst in England and had been living in Australia for seven years at the time of his death. Information received from Mr Lloyd-Williams' friend Dr McEwan is consistent with this. Dr McEwan had shared a flat with Mr Lloyd-Williams prior to Mr Lloyd-Williams' marriage. They had a mutual interest in music and Dr McEwan had first met Mr Lloyd-Williams when Mr Lloyd-Williams had auditioned for a church choir in Mosman. Mr Lloyd-Williams' interest in music appears to be consistent with the nature of his work at the ABC.

The evidence generally, Commissioner, does not suggest that Mr Lloyd-Williams was a member of the LGBTIQ community. Until a number of months prior to his death he had been in a heterosexual marriage as a result of which he had a young daughter, and his friend Dr McEwan did not understand him to be gay.

I now, Commissioner, go to evidence in the coronial brief that has bearing in relation to Mr Lloyd-Williams' mental state in the period leading up to his death. The inquest exhibits included a brief report by a Dr JE Hoult, psychiatrist, dated 29 August 1978. That report is at

tab 10 [SCOI.73571.00016_0001] of the bundle, exhibit 12. Dr Hoult was treating Mr Lloyd-Williams at the time of his death. The report clearly implies that Mr Lloyd-Williams had spent time as an inpatient at North Ryde Psychiatric Centre.

Dr Hoult was asked to see Mr Lloyd-Williams on 16 August 1978, eight days prior to his death, due to reports from the centre's social worker that while at home, Mr Lloyd-Williams had been staying in his room all day, not answering the door and not attending work.

This is consistent with observations made in a statement by Mr Lloyd-Williams' sister at tab 7, [SCOI.73571.00011_0001] of exhibit 12. His sister states that she had seen her brother two days prior to his death when she had gone to his flat to make sure that he was going to keep an appointment that he had with the welfare officer at the ABC at 10.30am that day. She indicates that he seemed to be in a very depressed state. She stayed with him for some time before she had to leave. She made contact with Mr Lloyd-Williams' mother-in-law to see if she could come over and talk with him.

More generally, his sister observed that her brother had always been in good health and spirits, but that this had changed in April 1978. His wife left him at that time and, according to his sister, he had seemed to go downhill quickly, with fits of depression, and he seemed to get worse over the last three weeks of his life.

In his statement, Mr Russell, the friend and work colleague, said that six months prior to his death, he noticed that Mr Lloyd-Williams was going through what he describes as fits of depression caused by marital problems, and that he had last seen Mr Lloyd-Williams three weeks prior to his death at which time he did not seem to be himself, as he was restless and agitated.

Mr Lloyd-Williams' mother-in-law also provided a statement to the police. Consistent with the observations made by his sister, his mother-in-law describes Mr Lloyd-Williams as having been in good health and spirits up until April 1978, which coincided with his marriage breaking down. His mother-in-law states that he then started to have fits of depression. During this period, she would see Mr Lloyd-Williams every weekend and

over the two weeks prior to his death he had been visiting her place to have tea a couple of nights a week.

Over the two days and nights prior to his death, he had been staying at the house of his parents-in-law but had remained agitated.

At the appointment with Dr Hoult on 16 August at North Ryde Psychiatric Centre, Mr Lloyd-Williams had told the psychiatrist that he was feeling very depressed and that he no longer felt he had anything to live for since his wife had left him. He was having difficulty getting to sleep and had lost his appetite. He told Dr Hoult that he had recently seriously considered suicide, but that he was now past this.

Dr Hoult was of the view that Mr Lloyd-Williams was suffering a depressive neurosis as a result of his marriage breakup. He prescribed an anti-depressant to last three days and made a further appointment for two days time, on 18 August 1978, which Mr Lloyd-Williams did not keep. Dr Hoult reported that his mother-in-law had then brought Mr Lloyd-Williams to see him on 21 August 1978, five days after the initial consultation and three days before his death.

His mother-in-law reported being concerned that Mr Lloyd-Williams was remaining in his room and not adequately caring for himself. I reproduce the conclusion of that report at paragraph 46 of the submission, the report itself is at tab 10 [SCOI.73571.00016_0001]. The report concludes as follows:

> *It was agreed that he should not stay alone and he consented to go and stay with his mother-in-law ... I prescribed increased quantities of Nortriptyline but requested that [his mother-in-law] control the medication and dispense each dose to Mr Lloyd-Williams.*

The need for hospitalisation was considered but Mr Lloyd-Williams was opposed to it and there were insufficient grounds for compulsory admission. An appointment was made to see Mr Lloyd-Williams on Friday, 25 August.

Commissioner, I now move to what the evidences tells us, in my submission, about events on the day of the death. As already noted and consistent with Dr Hoult's advice to Mr Lloyd-Williams that he should stay with his mother-in-law, Mr Lloyd-Williams stayed at the house of his parents-in-law over the two days preceding his death.

In her statement, his mother-in-law said that she made Mr Lloyd-Williams breakfast at about 8.30am on the morning of his death. She stated that he seemed to be feeling better and that he told her that he was going home to clean up his flat and that he would phone her to arrange a time to come over to her place to have lunch. She did not subsequently hear from him and her statement recounts her subsequent efforts to contact and locate Mr Lloyd-Williams to no avail.

At 11.45am, a man by the name of Robert Steele was standing at the edge of a cliff at North Head and observed a body on the rocks below and waves crashing over the body. It would appear that Mr Steele was on a work break at the time as in his statement he describes then calling his base over a two-way radio and asking for the police to be informed. Mr Steele remained at the location in order to show the police where the body was before returning to work.

In an article that appeared in The Manly Daily the following day, Mr Steele is quoted in similar terms to his statement. He adds that he was looking for a fishing spot when he observed the body.

The officer in charge of the investigation of the death was Constable John Mortimer. In his statement, he reported having attended the location at 3.30pm. By this stage, other police were already in attendance and the body of Mr Lloyd-Williams had been recovered by the Police Rescue Squad and conveyed to Manly District Hospital.

Commissioner, the basis for the inclusion of the death in the Strike Force Parrabell matters appears to have been the suggestion that it occurred in an area that was or was proximate to a known beat, and also the assertion that his body was found naked and his clothes left folded.

The Inquiry has been careful to closely evaluate any evidence in relation to those matters. Firstly, in

relation to the location of the death, North Head is known to have had a well-used beat area, often visited by men to sun-bake or engage in sexual activity, and that it was used during the era in which the death occurred - that is, the late 1970s. The Inquiry already has before it in evidence tendered previously statements by, for example, Mr Ulo Klemmer and Mr Garry Wotherspoon that go to that point.

There is also some evidence that attacks on men who were using the area as a beat may have occurred during this period.

North Head covers a large expanse and the area best known as an area of beat activity is, however, a considerable distance from the location where Mr Lloyd-Williams was found.

At this point, Commissioner, I note there is a map attached to the submission itself, and I understand it is possible to have that put on screen, and I have asked for that to be done.

Commissioner, the officer in charge described the cliff location as at the south eastern point of North Head and that the base of the cliff from which the body was recovered was about 300 feet or roughly 90 metres below the top. He described seeing a white Volkswagen station sedan parked at the southern end of Scenic Drive. Whilst his statement does not explicitly state that this was identified as the car of Mr Lloyd-Williams, it appears to imply this. Further, The Manly Daily article that I have already referred to states that a car owned by a Mosman man was found at the top of the cliff and that the keys were in the ignition.

Although there is no diagram of the location in the Coroners Court documentation, the description of the car being at the southern end of Scenic Drive and the cliff being at the south eastern point of North Head is sufficient to establish in general terms the area of North Head where the car and body were located. Consequently, Commissioner, the map that you see now displayed on the screen has been prepared on that basis. In addition to the description of the south eastern point, that location would seem to be consistent with the reference to the end of Scenic Drive, that being proximate to the south eastern point of North Head.

Commissioner, the evidence that I have referred to in relation to at least what might be described as the well-known beat area of North Head is an area that is considerably to the north, and the evidence of the two gentlemen that I have referred to describes access to that location being gained by the car park above Shelly Beach. I'm not sure how easy it is to see, but Shelly Beach is at the northern extreme of that map and indeed there is a reference to Shelly Beach car park. The evidence otherwise of those men describes an area, it would seem, that certainly goes no further south than, at the very least, Bluefish Drive that one sees about a third of the way down from the top of that map.

In relation to the suggestion that the body was naked and the clothes left folded, the available material from the coronial file is silent in relation to any clothing worn by Mr Lloyd-Williams at the time of his death. There is nothing in the coronial file that suggests that Mr Lloyd-Williams' clothing was located at the top of the cliff. Although the extent of investigative material is limited, this may be because the circumstances of the death were assumed at the time to be quite clear, namely, an assumption of suicide, an assumption that ultimately, it is suggested, was borne out once further evidence gathering revealed the severity of Mr Lloyd-Williams' depression.

Despite the relatively limited nature of the material, it would seem likely, in my submission, that had the body of Mr Lloyd-Williams been naked and his clothing left folded at the top of the cliff, this would have been a distinctive and unusual feature that would have made its way into the statement of the OIC and/or the report of the death to the Coroner.

Commissioner, it remains relevant, then, to consider the reliability of the information provided many years later to Ms Thompson suggesting that the body was naked and clothes were left at the top of the cliff. Relevant facts are set out in a statement made by the Inquiry solicitor with carriage of this matter, Caitlin Healey-Nash, which appears at tab 24 of the brief, [SCOI.82364_0001].

As that statement sets out, Justice Davies had been a mutual friend of both Mr Lloyd-Williams and Dr McEwan based on the shared interest of the three men in church

music. Justice Davies' recollection, as conveyed to the Inquiry, is that he had heard a suggestion at some time that Mr Lloyd-Williams' clothes had been found folded at the top of the cliff above which the body was found. Although uncertain as to when and where he had heard this, Justice Davies thought that it may have been from Dr McEwan.

Dr McEwan indicated, when meeting with Inquiry staff, that although he had had an understanding for some time that Mr Lloyd-Williams' clothes were found folded in a neat pile, he did not know when or from whom he had heard this account.

Further inquiries made by this Inquiry with Ms Thompson indicate that her recollection is that the matters attributed by her to Justice Davies had been passed on to her by relatives of another man whose body had been found at the base of a cliff at North Head. In the end, it is submitted that it is not clear how it came to be that Justice Davies and Dr McEwan had the understanding that they did about these circumstances. It is possible that whatever was said to them at some time and whatever they subsequently said to others has become confused with the reported circumstances of another death at North Head where such circumstances - that is, a naked body and folded clothes - did exist.

It is submitted that little weight can be afforded to the hearsay suggestion first recorded, it seems, some 35 years after the death, that the body was naked and the clothes folded, in view of the lack of clarity of the basis for this suggestion and the likelihood that, if such were the case, it would have been noted in the materials provided by police to the Coroner or in the post-mortem report.

Commissioner, I now move to the final significant piece of evidence, the review by the forensic pathologist Dr Iles, that has been obtained by the Inquiry.

Dr Iles was of the view that a reasonable statement of the cause of Mr Lloyd-Williams' death is multiple injuries sustained in a fall from height. She notes that this is not materially different to that arrived at by Dr Higgins back in 1978. Dr Iles opines in effect that the forensic pathology alone cannot determine whether the death may have

involved foul play or misadventure as opposed to an act of suicide. This is because the available material is insufficient in determining the presence or absence of any subtle injury. As a result, Dr Iles concludes that circumstantial findings best inform the manner of Mr Lloyd-Williams' death.

The circumstances as described in the materials available suggest that suicide was most likely. Dr Iles was of the view that there were no further medical investigations that would help to determine the manner of Mr Lloyd-Williams' death.

Commissioner, before coming to some of the conclusions that it is suggested you might reach in this matter, it is pertinent to make the following observations about the course of the investigation by police prior to the matter being considered by the Inquiry. The first observation I make is that the precise location from which Mr Lloyd-Williams fell does not appear to have been well documented, nor is there any evidence indicating that that area was searched. If these matters were addressed at the time, either no records were made of them or such records no longer appear to exist.

Potentially significant matters, such as Mr Lloyd-Williams' ownership of the motor vehicle located near the cliff area from which he fell and the fact that his keys remained in the ignition of the car, are derived from a newspaper article found by the Inquiry and do not appear in the police material. Nor are there photographs of the area in that material. The only photograph of the relevant area appears in the newspaper article and is of limited assistance.

It is also submitted that the efforts of Strike Force Parrabell to identify the circumstances of the death could have been more thorough. While an officer working on the strike force did make contact by email with Ms Thompson in an attempt to find out more concerning the source of her information - that's at tab 15 of exhibit 12, [SCOI.82174_0001], it's submitted that more could have been done in this respect and to ensure that alternative rendering of the name David Lloyd-Williams were the subject of searches.

As to the conclusions that it is suggested can be

drawn from the evidence, Commissioner, these are set out at paragraph 64 and following. It is submitted that the evidence clearly and consistently demonstrates that Mr Lloyd-Williams was suffering from severe depression at the time of his death. This is clear from all of the witnesses who had contact with him in the weeks and days prior, including his psychiatrist.

He had people around him, including his sister and mother-in-law, who were clearly very caring and were seeking to help Mr Lloyd-Williams, as his condition appeared to worsen in the days leading up to his death. The severity of his condition is reinforced by his indication to his psychiatrist that he had been contemplating suicide; his prior admission to an inpatient facility; the psychiatrist's suggestion that he admit himself as an inpatient; and the psychiatrist's requirement that he stay with his mother-in-law and that he not be permitted to administer his medication to himself.

The particular location at North Head that Mr Lloyd-Williams drove to and the fact that he left his keys in his car ignition, in my submission, also appear to be consistent with an act of suicide.

Sadly, the evidence overwhelmingly, in my submission, supports the proposition that on the morning of 24 August 1978, whilst suffering from deep depression, Mr Lloyd-Williams travelled in his car from Mosman to North Head at Manly where he deliberately ended his life by jumping from a cliff at the south eastern end of North Head.

In view of the conclusion reached as to the circumstances of Mr Lloyd-Williams' death, it is submitted that this is not a death that was motivated by LGBTIQ hate bias.

In terms of a formal finding, it is suggested that an appropriate finding would be that Mr Lloyd-Williams died on 24 August 1978 of multiple injuries after deliberately jumping from a cliff at North Head in Manly. At the time of his death, Mr Lloyd-Williams was suffering from severe depression.

This submission is essentially consistent with the finding of the Coroner made on 23 October 1978. It is

submitted that the categorisation of the case as unsolved by Strike Force Parrabell based, as it appears to have been, on the failure by the strike force to locate any contemporaneous materials concerning the death, including the coronial file containing, among other things, the report of the psychiatrist, was erroneous.

Finally, Commissioner, based on those submissions and at this point, there is no suggestion that there are recommendations. Thank you.

THE COMMISSIONER: Yes, thank you. Yes, Mr de Mars, if you wish to move to the next matter, unless Mr Mykkeltvedt has anything to say. I imagine you will reserve your position.

THE COMMISSIONER: Thank you.

MR de MARS: Commissioner I am advised that because there is a desire for some family members to be present, we may need a very short break.

THE COMMISSIONER: Do you want me to adjourn until 2?

MR de MARS: I am in your hands, Commissioner, as to how long. We don't necessarily need a long break.

THE COMMISSIONER: Oh, well, what about if I just go off the Bench and you tell me when you are ready, and if that happens to be a reasonable time before 2, we will start. I will adjourn for a short time. Just keep me informed. Thank you.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes.

MR de MARS: Commissioner, the next matter is the matter of Andrew Currie. Can I, firstly, hand up and tender a bundle of material that has been prepared. The appropriate number will be exhibit 13.

EXHIBIT #13 ONE-VOLUME TENDER BUNDLE IN RELATION TO ANDREW CURRIE

MR de MARS: Additionally, Commissioner, in this matter - I will come to this in a moment - some of Mr Currie's

family are present and a family statement has been prepared, and I tender that family statement, if that could perhaps appropriately become exhibit 14.

THE COMMISSIONER: Thank you.

EXHIBIT #14 FAMILY STATEMENT IN RELATION TO ANDREW CURRIE

MR de MARS: Commissioner, in this matter again you should have a copy of a proposed minute of order relating to any relevant non-publication related matters, and I ask that that order be made.

THE COMMISSIONER: Yes. I have had a look, thank you, and I will make that order, thank you.

MR de MARS: Again you should have a copy of written submissions that have been prepared and I adopt and rely upon those submissions.

THE COMMISSIONER: Thank you.

MR de MARS: I have already mentioned that members of Mr Currie's family are present. Without naming them all, can I observe that that includes Andrew Currie's brother, Graeme Currie. The Inquiry has been very appreciative of the contact that they have had with the family and the assistance they've been able to provide, and I pass on the condolences of the Inquiry for their loss.

THE COMMISSIONER: Yes, thank you.

MR de MARS: Mr Currie died at some time between 11pm on 12 December 1988 and 7.15am on 13 December 1988 at a toilet block in Nolan Reserve in the suburb of North Manly in Sydney. Mr Currie was 29 years old and unfortunately had a longstanding addiction to prescription medications and other substances.

During the course of the day leading up to his death, it is apparent that he had taken excessive quantities of a restrictive prescription medication called Nembudeine.

His death was the subject of a police investigation at the time. We know this based on the file that has been produced to the Inquiry by the Coroners Court.

Apart from material in the Coroner's file, very limited material has been produced to the Inquiry by police and no distinct separate police investigation file has been located or produced.

A few days after the death, on 17 December 1988, an autopsy was conducted by Dr William Brighton. Dr Brighton noted, and this appears at paragraph 4 of the written submission, that there was no significant injury on the body. He noted two areas of dry brown abrasion in the forehead and temple regions that were consistent with pressure at around the time of death, and some slight reddening over the nose in the mid forehead region. There were no internal injuries. Mr Currie's body was noted to be in an unkempt state with much soiling to his feet. There was dark brown to dark green material around his nostrils that appeared to have been regurgitated.

In Dr Brighton's opinion, the direct cause of death was poisoning by a combination of pentobarbitone, codeine, methadone and morphine.

Commissioner, no coronial inquest was held. The coronial records indicate that an inquest was dispensed with immediately following receipt by the Coroner of the autopsy and toxicology reports in February 1989. While the reason for dispensing with an inquest is not recorded on the file, the decision to dispense with an inquest indicates that it did not appear to the Coroner that Mr Currie had died or may have died as a result of homicide. That's consistent with the terms of the Coroners Act then in existence and consistent with provisions that currently exist.

His death certificate dated 5 January 1989, which appears at tab 7 [SCOI.73948_0001] recorded the cause of death as poisoning by combination of the four drugs identified in the report of Dr Brighton.

Before turning to the Inquiry's consideration of the matter, it is appropriate to make some observations about the approach to the matter by Strike Force Parrabell and any particular indicators of LGBTIQ status or bias.

Mr Currie's closest surviving relative, his brother Graeme, has no particular knowledge of Mr Currie's sexuality and believed him to be heterosexual. Mr Currie's

body was found inside a public toilet in a park. Although there is no specific evidence of its use as a beat at the time that the Inquiry is aware of, the location of the toilet is such that it may well have functioned as a beat from time to time. More generally at around this time in some areas of Manly there were known to be robberies that occurred at public toilets, sometimes involving gay men as victims.

The particular area in question is not a location where, to the Inquiry's knowledge, there are recorded instances of such attacks. However, as noted in the Strike Force Parrabell Bias Crimes Indicators Review Form for this matter, records for the period prior to 1992 do not allow a ready identification of criminal acts via the relevant police data system, the COPS system. The possibility of such attacks, therefore, cannot be ruled out.

It is relevant to observe that the location was also one at which Mr Currie and his friend and fellow drug user at the time, a man who I will refer to by the initials "GB", would meet on occasion.

This information appears in a police occurrence entry made at the time of the death. In the statement made by the officer in charge, he refers to the toilet areas around District Park, which encompassed Nolan Reserve, as being a regular meeting place for Mr Currie and GB to meet and use drugs. It's also noted that the park and toilet block were on the walking route home from Mr Currie's last known location.

Commissioner, consistent with the nature of Strike Force Parrabell's consideration of matters generally, relevant assessments were made by that strike force in the absence of contact with Mr Currie's family and any particular information concerning his sexuality.

The "General Comments" section at page 6 of the form refers to 15 colour photographs of Mr Currie and of the scene having been viewed. This may be cause for concern about the accuracy of matters recorded in the form, as there appear to be only seven such photographs in existence. I will return to the question of the crime scene photographs and the numbers of them later.

In section 4 of the form, headed "Organised Hate

Groups (OHG)", it is stated that there is no indications that an OHG was involved or active in the Manly area at the time of Mr Currie's death.

As I have already alluded to, however, on occasions, it is known that gay men were the target of attacks by youths in certain parts of the Northern Beaches in the late 1980s, including the Manly area, often with the motive of robbery.

Although known to NSW Police at the time of Strike Force Parrabell, the existence of such attacks is not the subject of comment in the form. It may be that such attacks did not come within what was contemplated by police as constituting an OHG. If they did not, it may suggest a deficiency in the methodology behind the Bias Crimes Indicators Form.

The "Summary" section of that form concludes that, taking into consideration the state of Mr Currie's body, his ingestion of a large quantity of Nembudeine and the examination of the scene, there was no evidence that any other person played a role in relation to his ingestion of drugs leading to his death nor that his death had been motivated by bias.

Commissioner, to complete the picture, I note that the Strike Force Parrabell case summary, number 37, for this matter is set out at paragraph 23 of the written submission. It is in similar terms to the conclusion that was reached in the Bias Crimes Indicators Form and concluded that there was no evidence of a bias crime.

The relevant notation in the academic review in the case summary also states "No bias".

Moving, then, to the Inquiry's consideration of the matter. The Inquiry's consideration has involved, firstly, compelling the production of police investigative material in relation to the death; compelling the production of the file held by the Department of Forensic Medicine in relation to the matter; obtaining the Coroners Court file; considering other material held by the Inquiry of potential relevance to the matter; reviewing and analysing this material and considering whether any further investigative or other avenues are warranted, and making contact with Mr Currie's family in relation to any relevant information

that they may have; and, finally, obtaining expert reports from both a toxicologist and a forensic pathologist.

As I have indicated, the Inquiry was able to make contact with Graeme Currie, Mr Currie's younger brother, who was living at the family home, at the time of Andrew Currie's death, and also with their mother. Sadly, Mr Currie's mother passed away some years ago, but as I have already referred to, Graeme Currie has been very helpful to the Inquiry by meeting with us and discussing any knowledge he has of the circumstances of his brother's death.

To add some detail to the steps that have been taken by the Inquiry, I note that the matter was the subject of the Inquiry's first summons to police in May 2022 seeking all relevant police investigative material. No investigative file for Mr Currie's death was produced to the Inquiry in response to this summons. However, on 12 August 2022, the NSW Police Force produced to the Inquiry its Strike Force Parrabell e@gle.i brief. This included eight documents relating to Mr Currie's death.

In addition, on 16 September 2022, NSW Police produced a further document to the Inquiry, which was an investigator's note dated 13 October 2016, as part of its response to a further summons.

Another summons was issued on 26 September 2022 seeking 15 colour crime scene photos purportedly taken on the day that Mr Currie's body was found. This came about because the Strike Force Parrabell Bias Crimes Indicators Form and relevant investigator's note that had been produced to the Inquiry both made reference to 15 colour crime scene photos of Mr Currie's body, which were said to have been viewed by Strike Force Parrabell investigators. These were said to have been provided to the strike force by the original officer in charge of the matter.

It was a surprise to the Inquiry to hear that there were 15 such photos, as only seven such photos had been produced to it. By email dated 6 October 2022, the legal representative for NSW Police advised that it appeared that there were only seven such photographs, despite the reference to 15 photos.

In order to understand why there had been no

production of the material in relation to Mr Currie's death in response to the first summons, yet there had been material later produced in connection with the NSW Police Force e@gle.i brief and a subsequent summons, and to seek further clarification concerning the number of crime scene photos, on 10 October 2022, the Inquiry wrote to the legal representative of the NSW Police asking for a letter or statement addressing those matters.

The response from NSW Police is set out in detail at paragraph 34 of the submission. In essence, it disclosed that whilst searches had been undertaken, they had not identified any hard copy material held by police associated with the death of Mr Currie. The letter indicated that further inquiries were being made to seek to resolve the anomaly concerning the purported number of photos at the crime scene, but that it appeared that only seven photos had been received by Strike Force Parrabell, despite documentation relating to the strike force indicating there were 15 photos.

Having not received any further response from NSW Police concerning the discrepancy, the Inquiry again followed the matter up with NSW Police on 16 December 2022. Detail in relation to that is contained in paragraph 35 of the written submission. The Inquiry received a response that, having followed the matter up with the original officer in charge of the investigation, the officer was unable to locate any record of how many crime scene photos were taken and indicated that he would have provided all photos in his possession to the strike force. These matters have been set out in some detail in the written submission in order to demonstrate that the Inquiry has endeavoured to ensure that all information relating to the past investigation of the matter has been produced to it.

The end result is that the investigative material in existence appears to be largely confined to that which was in the coronial brief of evidence provided by police to the Coroners Court back in 1989. Further, the reason for references having been made to 15 scene photos rather than seven which have been produced remains unclear. The legal representative for NSW Police states that only seven such photos were received by Strike Force Parrabell, which would appear to suggest that the reason for reference to 15 photos in the Bias Crimes Indicators Form and the investigator's note is simply that the references in these

documents are both erroneous.

One might expect there would have been additional notes and potentially other investigative material produced during the initial police investigation, for example, detectives from Manly Police Station attended the scene, as did police scientific officers in order to take photos, yet no statements or notes, running sheets or occurrence pad entries indicating the nature of work of these officers have been produced.

Contact was also made with the Department of Forensic Medicine of New South Wales Health Pathology in order to ascertain whether they held, separately to police, any photos or other records relating to the autopsy performed on Mr Currie. This was done in order to provide potential assistance to the expert forensic pathologist who was briefed by the Inquiry to provide an opinion.

In response, the Inquiry received 23 pages of notes from the Department of Forensic Medicine. These consisted of the autopsy and toxicology reports and other documentation related to the autopsy but did not shed any further light on the death beyond the contents of the autopsy and toxicology reports, nor did they include any photos.

Finally, Commissioner, in relation to steps taken by the Inquiry, at paragraphs 41 and 42 of the submission the terms of the opinions sought from the two experts, the toxicologist, Professor Alison Jones, and the forensic pathologist, Dr Iles, are set out.

THE COMMISSIONER: Is that a convenient point?

MR de MARS: Yes, it is, thank you, Commissioner.

THE COMMISSIONER: All right. We will adjourn until 2 o'clock, thank you.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes.

MR de MARS: Commissioner, in relation to the present matter, the matter of Andrew Currie, before the break I was outlining steps that have been taken by the Inquiry in

order to consider this matter.

I now set out key matters arising from the Inquiry's consideration of the evidence and the conclusions that it is suggested can be drawn from it.

Firstly, some observations in relation to Andrew Currie's background. Mr Currie was 29 years old when he died and as I have already referred to, he lived at home with his mother and younger brother. This was in Waine Street in the suburb of Harbord, now known as the suburb of Freshwater.

Unfortunately, he appears to have had a longstanding and entrenched drug use problem, as a result of which he was known to Manly police. A fact sheet related to some minor offending with which Mr Currie was charged on 14 October 1988, two months prior to his death, describes his interaction while drug affected with police after being found in possession of a bottle of a prescribed restricted drug. I wonder if tab 12 [SCOI.00016.00022_0001] could be brought up on screen.

Commissioner, this is the relevant fact sheet. In part, you will see that the fact sheet reads as follows - and I'm looking here at the second full paragraph:

> *The defendant is well known for this type of offence, and, is a person who can often be found in the Manly and surrounding environs in an overdosed state by utilising drugs of this type. The Defendant comes from a good family background and has a caring Mother, who, in the past has expressed deep concern for the welfare of this defendant.*

And then if we could just move down to the next page, Commissioner, this is fully extracted at paragraph 50 of the submission but you will see it goes on and explains, or sets out:

> *The Courts and the Police in the Manly area, have, over the years attempted, on numerous occasions, to guide this defendant away from this type of offence ...*

There is also the observation:

> *Friends of this defendant have in fact died and this fact does not deter him from actions of this kind.*

And then the observation later on:

> *Other than placing this defendant before the Court, Police have exhausted all available means at their disposal by which the defendant, may, in time, have a better future.*

Commissioner, the statement of the officer in charge of the investigation into Mr Currie's death similarly describes Mr Currie as, in his words, a "well-known drug user who had come under police attention numerous times". He also states that Mr Currie had been taken to hospital on several occasions for overdosing.

There is no evidence in the documentary material that touches on the question of Mr Currie's sexuality. As already observed, I note that Mr Currie's brother has told Inquiry officers that he had no particular knowledge of his brother's sexuality but that he believed him to be heterosexual. There is relevant evidence to that effect in the statement of the Inquiry solicitor Ms Healey-Nash at tab 28 [SCOI.83251_0001].

The civilian witness evidence in the matter consists of two brief statements made on 13 December 1988 by Mr Currie's friend, who I have already referred to as "GB". These were made immediately following the death.

One statement deals with GB's interactions with Mr Currie on the evening preceding his death, and the other describes his involvement on finding Mr Currie's body the following morning.

Commissioner, you will find those statements at tabs 20 [SCOI.00016.00008_0001] and 21 [SCOI.00016.00009_0001].

GB describes Mr Currie as a good friend who he had known for 13 years. He says that during that time he had known Mr Currie to use various types of drugs from what he

refers to as "grass" to the occasional use of heroin, but that it was mainly Nembudeine, which he refers to as "the N's", that he would use quite frequently every day or every second day, although he stated that Mr Currie had, in his words, "cut back in the last few years".

GB told police that he last saw Mr Currie between 10 and 11pm the previous night - that is, on 12 December 1988. According to GB, Mr Currie had come to his place at around 8.30pm and they spoke for a while and had a cuppa. He described Mr Currie as appearing to be under the influence of a drug, that he was very slow and had slurred speech. Mr Currie told him that he had taken 25 Nembudeine tablets that morning and during the day. He told GB that he had no tablets left, however, GB says that he patted Mr Currie's pockets and heard a rattle, suggesting to GB that Mr Currie had tablets on him.

Mr Currie then told GB that he had three tablets on him, although GB thought that by the sound of the rattle he would have been in possession of a greater number of tablets. Mr Currie offered to show him, but GB says that he told him not to worry.

GB further recounted that when Mr Currie was leaving, evidently it must have appeared to GB to go home, he asked GB to phone him, presumably meaning in the morning. However, GB told him that rather than him phoning Mr Currie, Mr Currie should get his brother to wake him up. He suggested that Mr Currie come back to his place at 8.30 the following morning.

The police occurrence pad entry made by the officer in charge, which is at tab 10 [SCOI.00016.00020_0001] indicates that Mr Currie's mother became concerned that he had not returned home, and it appears from what follows that early the following morning she must have contacted GB to enlist his help in locating Mr Currie.

Commissioner, there is a map attached to the written submission, and at this point I would ask for that map to be brought up on screen. I will come to that in a moment.

In his statement describing the circumstances in which he found Mr Currie's body, GB states that at about 7.15am he was dropped off by Mrs Currie in Campbell Parade in Manly Vale, approximately 400 metres from where Mr Currie

was found. He says he checked a toilet block next to a bowling club, then went to the toilet block in which he found Mr Currie.

Just to attempt to orientate those matters by way of the map, Commissioner, we can see what is effectively a creek or inlet, a water inlet, running through the middle of the map, and it divides two green areas, Nolan Reserve and Passmore Reserve. You will see just under Passmore Reserve, Campbell Parade. That's the location where GB indicated he was dropped off and then commenced to check relevant toilet blocks, the first of which he said was near a bowling club and the second of which was in Nolan Reserve, where the body was found.

It is also relevant to point out by reference to the map at this point the relevant locations of Mr Currie's house on the one hand and GB's, bearing in mind the evidence of GB that the evening before, Mr Currie was at GB's house, and it would appear was then thereafter en route home, and one can see by reference to the map how relevant areas, including Nolan Reserve, do indeed appear to fall within the walking route that might be taken between those two locations.

When GB found Mr Currie, Mr Currie was face down in a small amount of water on the ground. He turned Mr Currie over and checked for a pulse. He describes Mr Currie's skin as cold and clammy. When turning him over, he noticed what he thought was mud on Mr Currie's face. He subsequently returned to Mrs Currie in her car after taking some time, it appears, to compose himself before breaking the news to her. The matter was then reported by them to Manly Police Station.

I turn then to forensic and crime scene evidence. Police attended the toilet block after GB reported the death to them at 7.55am on 13 December. The OIC attended the location with GB. At this stage, Mr Currie's body was face up, having earlier been turned over by GB. He's described as wearing blue jeans, a brown woollen jumper, a yellow T-shirt that was torn around the neck area, and black thongs.

The OIC describes Mr Currie's face being covered in what appeared to be bile or body fluids, that he had a few grazes to his face and that his teeth appeared to be

dislodged. There was a very shallow film of water near him. He states that ambulance officers arrived and said that Mr Currie had been deceased for a long period during the night.

Property located on Mr Currie consisted of two handkerchiefs, a cigarette lighter, three keys on a key ring and a concession card in his name. The OIC states that this property was later collected by Mr Currie's mother, there being no suggestion that it was the subject of any form of forensic testing.

As earlier indicated, the OIC states that both detectives and scientific officers attended the scene, and it is known that at least seven colour photos, which I have already referred to, were taken at the scene, with Mr Currie's body in situ.

The OIC's statement was made on 13 December 1988, the day the body was found. In it, he states that in his view, no suspicious circumstances were apparent. He expresses his view of what occurred as follows, as set out in the body of paragraph 63 of the written submission:

> *It appears that from the time he was last seen at [GB's] residence, he was going home, as the place where he was located was on (sic) route to home and the toilet areas around District Park was (sic) a regular meeting place for him and [GB] and to use drugs, and at this stage appears to be an overdose and due to incapacitation from the drugs fell to the ground and became unconscious. The small amount of water nearby would have been at a higher level during the evening and if the deceased fell down his facial area would have been in the water.*

As I say, that was the assessment of the OIC in a statement made on the day the body was located.

The formal report of death by the officer in charge to the Coroner prepared and signed on the same day, 13 December, is in similar terms. It concludes that there are no suspicious circumstances and that it appears that Mr Currie had attended the location which is en route from

GB's residence to his own home and overdosed and fallen down on to the concrete ground, face down, and became unconscious.

Subsequent to these initial conclusions reached by the officer in charge, the autopsy was conducted that was described earlier before the break. The findings of Dr Brighton, who conducted the original autopsy, along with the toxicology results, appear to be consistent with the initial conclusions reached by the officer in charge. Nevertheless, the Inquiry has considered it to be very important to subject certain matters arising from the police scene evidence, the autopsy report and toxicological results to further scrutiny by means of expert forensic and toxicology reports.

That brings me to those reports. Dr Iles, the forensic pathologist, who has provided a report to the Inquiry, was provided with materials that included the seven colour photos of the location where Mr Currie's body was located and also depict the body. They depict his mouth and facial area and indeed the state of his clothing, including his shirt, said by the officer in charge to have been ripped.

Dr Iles was asked to comment on any potential significance of the observation made by the officer in charge that some of Mr Currie's teeth appeared to have been dislodged, bearing in mind that no relevant observation concerning the state of Mr Currie's teeth had been made by Dr Brighton. She opined that poor dentition was common among those with a history of illicit drug use and that the photos of Mr Currie's teeth showed them to be yellowed with some teeth absent. She states that in the event of underlying dental and periodontal disease, dislodging of teeth, either in the post-mortem period or consequent to a low-energy impact from an agonal fall or collapse, may be observed. She also notes that there is no autopsy documentation of other facial trauma. While observing that it is nowadays standard to comment on the state of dentition in autopsy practice, she notes that the same may not have been the case in 1988.

As to the cause of death, Dr Iles took a view that she described as not significantly different to the opinions of Dr Brighton and Professor Jones, namely, that it can be described as mixed-drug toxicity (pentobarbitone, codeine,

methadone). She noted that in cases of the likely cause of death for individuals whose blood contains central nervous system (CNS) depressants, it is necessary to exclude other potential causes of death. She notes that although Dr Brighton's report is brief, it does reasonably exclude other causes of death.

Dr Iles was of the view that the presence of the thin film of water on the floor was unlikely to have contributed particularly significantly to the death, and she expressed the view that the superficial or minor abrasions to Mr Currie's face and any dislodgment of his teeth can potentially be ascribed to perimortem phenomena. Although it is not possible to exclude the possibility of blunt force trauma to the face absent a thorough examination of relevant facial areas, and she could not say whether one had taken place, she was of the view that Mr Currie's death is most likely consistent with misadventure.

She described the drug Nembudeine as an Australian preparation from Abbott Pharmaceuticals that she believes is no longer available. Its active ingredients included paracetamol, codeine phosphate and pentobarbitone sodium. The codeine, pentobarbitone and morphine, being a metabolite of codeine, that were identified in Mr Currie's blood, could all be ascribed to ingestion of Nembudeine tablets. Ingestion of those tablets could also explain the presence of the paracetamol.

Finally, Dr Iles did not believe, based on the material available to her, that any further investigation of the manner or cause of death would be of utility.

Professor Jones provided a report to the Inquiry dated 25 October 2022 and then, following the receipt of Dr Iles' report, a brief supplementary report dated 23 January 2023. Key aspects of the professor's opinion are as follows: Nembudeine ingestion could account for the presence of codeine, pentobarbitone and paracetamol in Mr Currie's toxicology results; the morphine level in Mr Currie's blood was at a therapeutic level and was likely a contributing factor to the death. Morphine, as already observed, is a metabolite of codeine metabolism and was likely to be a byproduct of Mr Currie's consumption of codeine.

Mr Currie's blood concentration of methadone was in the therapeutic range but below either toxic or fatal

ranges. Alone it would not be expected to result in clinical opioid toxicity effects (resulting in death predominantly due to respiratory depression), but would contribute to overall opioid toxicity when combined with other opioid drugs, for example, codeine and morphine.

Pentobarbitone is a short-acting barbiturate used clinically as a sedating hypnotic agent. The level of pentobarbitone in Mr Currie's post-mortem blood was in the toxic to lower end of the fatal ranges. The level of pentobarbitone in his liver was in the fatal range. The level of codeine in Mr Currie's blood was in the toxic to fatal ranges. There was a therapeutic level of paracetamol in his blood.

Professor Jones concluded that pentobarbitone was found in toxic to lethal concentrations in Mr Currie's post-mortem blood and within the fatal range in his liver. Pentobarbitone would cause significant central nervous system and respiratory depression. Alone, it would be fatal, but when combined with the codeine in toxic to fatal ranges, methadone in a therapeutic range and morphine in a therapeutic range, it would have added effects on the central nervous system and respiratory depression caused by all these opioid drugs.

She concluded that Mr Currie most likely died as a consequence of codeine and pentobarbitone oral overdosage on a background of methadone use.

Careful consideration has been given to whether there was any realistic possibility that the death involved a third party. In view of the known friendship between GB and Mr Currie in the context of their mutual drug use, in my submission, there does not appear to be anything suspicious about the fact that Mr Currie was at GB's flat from around 8.30pm until somewhere between 10pm and 11pm shortly prior to his death.

Mr Currie's reported demeanour, slow slurred speech and comments to GB that he had taken 25 Nembudeine tablets are consistent with him having been heavily affected by drugs while he was at GB's flat. GB's description of Mr Currie at this time is also entirely consistent with past police observations of Mr Currie, including his known propensity for use of Nembudeine, for overdosing on prescribed restricted substances and for associating with

GB in the context of his drug use.

Further, the location where Mr Currie's body was found is directly on the logical route he would have taken in order to walk from GB's unit in Manly Vale to his mother's residence in Harbord. The parkland and sporting fields comprising Nolan Reserve and Passmore Reserve provide a convenient shortcut between the relevant parts of those suburbs. Further, the fact that GB accompanied Mr Currie's mother and went looking for him early the following morning, upon Mr Currie's mother realising he had not returned home, is, it is submitted, unsurprising given their close friendship. Mr Currie's known chronic drug use and his history of previous drug overdoses, similarly, the fact that GB looked for Mr Currie in the two toilet blocks in the two park areas appears to be a logical step to take in the circumstances.

For these reasons, Commissioner, it's my submission that GB's involvement with Mr Currie around the time of his death is not considered to be suspicious. Evidence from the scene of his death, from the autopsy and toxicology reports at the time, as well as the expert review of the toxicology and forensic pathology reports obtained by the Inquiry from two renowned experts, supports the view that Mr Currie's death was the accidental outcome of his ingestion of drugs on 12 December 1988.

Before coming to the more formal aspects of the findings that are suggested, I want to return to make some comments for the benefit of Mr Currie's family, who are here.

I have already observed that the police investigative material in relation to this matter is somewhat limited in scope. It would certainly be understandable that some family members may be concerned at the limited nature of investigative material produced many years ago in a matter such as this.

At the time, the conclusion that Mr Currie's death was the result of an accidental drug overdose was reached very swiftly and it appears that no statements were taken from family members. While it is not submitted that these matters resulted in an incorrect conclusion being reached by police in relation to the cause and manner of death, a more detailed initial investigation and the retention of

relevant records would potentially assist in allaying any concerns that family members may hold as to the investigation of the matter and the conclusions reached in relation to the cause and manner of death.

In the case of Mr Currie's family, the Inquiry has appreciated having a dialogue with them about such concerns and the Inquiry, in my submission, should remain open to further discussion with the family in the event that there is anything that the Inquiry can do to help address those concerns.

Commissioner, to turn then to the formal conclusions made in the submission, given the conclusion reached in relation to the cause and manner of Mr Currie's death, it's not suggested that the death involved gay-hate bias, probably more properly put, LGBTIQ bias. It's submitted that an appropriate description of the cause and manner of Mr Currie's death would be that it resulted from multi-drug toxicity following his deliberate ingestion of Nembudeine tablets, causing respiratory and central nervous system depression, leading to his death, and in circumstances where he was known to have an addiction to restricted prescription medication.

Accordingly, Commissioner, it's further submitted that the death of Mr Currie was not unsolved and therefore does not fall within Category A of the Inquiry's Terms of Reference. At this stage, Commissioner, there are no suggested recommendations related to Mr Currie's death. Those are the submissions.

THE COMMISSIONER: All right. Thank you. I understand Ms Melis is going to conduct the next aspect of the matter, and she needs a few moments to get her papers in order, so I will just go off the Bench for a few minutes, thank you.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes, Ms Melis?

MS MELIS: Thank you, Commissioner. Commissioner, these submissions relate to the death of Brian Wayne Schmidt Walker. Commissioner, in making these submissions, I rely on a bundle of material, and I will have that handed up to you.

THE COMMISSIONER: Thank you.

MS MELIS: Commissioner, unless there is any objection, I tender that material.

THE COMMISSIONER: Thank you.

MS MELIS: I understand we might be up to exhibit number 15.

THE COMMISSIONER: Thank you.

EXHIBIT #15 ONE-VOLUME TENDER BUNDLE IN RELATION TO BRIAN WALKER

MS MELIS: As with other matters, Commissioner, I also seek orders pursuant to section 8 of the Act in respect of this matter, if I may also hand those up.

THE COMMISSIONER: Thank you. Yes, I think they are appropriate, thank you. I will make those orders.

MS MELIS: Finally, Commissioner, a copy of my written submissions, which have been served on my learned friend.

THE COMMISSIONER: Thank you. Yes, thank you.

MS MELIS: Commissioner, this is a case where police charged a man, a Mr John Hokin, with the manslaughter of Mr Walker. However, the Director of Public Prosecutions withdrew the charge prior to the trial of Mr Hokin in 1993 on the basis that there was no reasonable prospect of conviction. It is a case that Strike Force Parrabell has categorised as solved.

The Inquiry has undertaken its own assessment as to whether the death of Mr Walker should be regarded as one which remained unsolved as at April 2022 when the Inquiry was constituted and therefore whether it fell within Category A of the Inquiry's Terms of Reference. The Inquiry has also considered the circumstances of Mr Walker's death generally, including whether a gay-hate bias was involved.

To facilitate this review, the Inquiry summonsed the NSW Police Force investigative file in relation to the death of Mr Walker, as well as the records in respect of

Strike Force Parrabell's review of Mr Walker's death. This material included the Bias Crimes Indicators Form that has been referenced in other matters presented to you this week.

The Inquiry also received and reviewed the prosecution file in respect of the charge of manslaughter against Mr Hokin from the Office of the Director of Public Prosecutions. Through its investigation, the Inquiry has ascertained that Mr Hokin is alive, aged 78, and lives in an aged care facility. He informed the Inquiry that he did not wish to attend or otherwise participate in today's hearing.

Mr Walker was born on 17 April 1962. He died in the early hours of 23 July 1992 at the residence of Mr Hokin in Burnett Street, Merrylands. Mr Walker was 30 years old when he died.

I will come to the circumstances of Mr Walker's death in a moment, but first, some details about Mr Walker and who he was. Mr Walker was born to Yvonne Schmidt and Cedric Dacey. Both are now deceased. He was one of three siblings, he had an older sister, Janice Walker, and a younger brother, David Schmidt.

Ms Walker, Commissioner, is listening to today's proceeding on the live stream and I wish to acknowledge that. We give our condolences to Ms Walker and Mr Schmidt on the passing of their brother, and the Inquiry thanks Ms Walker for recently providing a statement and telling us some of the things she remembers of her brother. That statement is at tab 35 [SCOI.82361_0001] of the tender bundle.

Mr Walker went to Bexley Primary School and later Mount Druitt High School. He didn't finish school. He left home when he was around 16 or 17 years old. He did not have regular employment and he sometimes did odd jobs and liked to help people out.

Ms Walker remembers Mr Walker as a happy-go-lucky man who was very trusting of people. He was quick to befriend others and was very talented at drawing.

Mr Walker was a bit of a drifter. He did not have a fixed address and would stay with friends and move

between houses.

In terms of Mr Walker's sexuality, Ms Walker did not think he was interested in men because she had previously seen him with girlfriends. The evidence of Mr Walker's sexual identity is otherwise limited on the evidence. I will say more about this shortly.

I turn now to the circumstances of Mr Walker's death. Commissioner, it is important to observe at the outset that there is only one version of events as to what happened in the lead-up to Mr Walker's death, and that is the version of Mr Hokin as told by him to police. Having said that, the version can be tested in part against other evidence, including the post-mortem report, the state of the crime scene, statements of neighbours and injuries sustained by Mr Hokin that were consistent with altercation having occurred between him and Mr Walker.

Mr Hokin told police in his interview in the early hours of 23 July 1992 that he had only come to know Mr Walker two days prior to his death. They spent time together after work one afternoon until late evening.

In outlining what Mr Hokin told police, I will be quoting extensively from Mr Hokin's electronically recorded interview to police. The transcript can be found at tab 13 of the tender bundle, [SCOI.11163.00032 _0001].

Mr Hokin told police that on 22 July 1992 at about 9pm, he was asleep in his house in Burnett Street when he was woken by Mr Walker. Mr Walker said he wanted to discuss some problems their mutual friend Kevin Leatham was having. Kevin Leatham also lived in Burnett Street, Merrylands. A close friend of Mr Walker, Mr Paul Mumbler, said in a statement to police that it was nothing out of the ordinary for Mr Walker to go and stay at Mr Leatham's house. In fact, he told Mr Mumbler on 22 July 1992 that he was going to stay at Mr Leatham's house that very day.

Mr Hokin said he and Mr Walker went to the backyard where they started drinking heavily. Mr Hokin claimed that at some point Mr Walker was:

> *Talking in a manner about sexual behaviour that I didn't prefer and he touched me a few times on the leg and on the shoulder*

and I tried to ignore that as ... passively as I could because he had quite a bit to drink.

Mr Hokin stated that he repeatedly asked Mr Walker to leave, but Mr Walker wasn't happy about that.

Mr Hokin told police that Mr Walker picked up a shovel and swung it at him. He said that in the course of the ensuing struggle, he dropped down underneath and put both his arms around Mr Walker's chest and hung on. He said they were wrestling for at least an hour. During the struggle, according to Mr Hokin, Mr Walker also attacked him with a broken beer bottle. He was cut about the stomach and the back.

Craig and Julianne Donnelly were Mr Hokin's neighbours. Mrs Donnelly says that at about 11.30pm she heard a bottle smash next door and some guy yelling out - this is a direct quote, Commissioner, and I apologise for any offence it may cause, some guy yelling out, "Get off me, you fucking cunt. Clear off. Get out of here". She said it sounded like someone was sitting on him. She then heard Mr Hokin say, "Didn't I give you wine and cigars and you cut me to pieces".

The reason Mr Hokin gave during his police interview for holding on to Mr Walker for as long as he did was because he was frightened of him. He said:

I was too scared to get up and run because I was overcome about the strength of this person and I just felt that the moment I let go I would ... be in trouble.

Mr Hokin subsequently called out to Craig Donnelly for help. Mrs Donnelly says that this was at about 1.15am when she heard Mr Hokin screaming out, "Craig, help." However, Mr Hokin told police that calling out seemed to make Mr Walker more aggressive. He said that at that point, Mr Walker used a square pole that held up an awning on his verandah, to get leverage. Mr Hokin started to worry because he was released from what he had described as the command position.

Mr Hokin said that he held Mr Walker's head to his stomach and was holding his body weight on Mr Walker until

Mr Walker stopped moving.

Mr Hokin made a quick move to Mr Walker's hand but felt no pulse and both his legs just fell. Mr Hokin got up and ran away. He made no attempt to revive Mr Walker. He immediately stopped a taxi and asked to be taken to Merrylands Police Station. This is confirmed by taxi driver Ahmed Elsamad, whose statement can be found at tab 17 of the tender bundle [SCOI.11163.00038_0001].

Mr Hokin walked into the police station at around 1.50am on 23 July 1992 and said, "I've had a fight with my mate. I think I've killed him." Constable Aaron Nash states that the front of Mr Hokin's shirt was open and he could see scratch marks on his body. His face was flushed, was breathing heavily and had grass clippings and dirt in his hair. He lifted up his jacket and another officer, Senior Constable Pledge, saw a number of cuts and lacerations to his stomach and torso. Mr Hokin said, "He cut me up to buggery."

Mr Hokin told police he was heterosexual and frightened by gay men. When asked if he had sex with Mr Walker, Mr Hokin answered:

> *No way. That's what frightened me ... when he started touching me, that's when I started getting worried and that's when I started watching him, just keeping an eye on him.*

Shortly after Mr Hokin arrived at Merrylands Police Station, Senior Constable Pledge and Constable Nash attended his home in Merrylands and found Mr Walker's body. Mr Walker was lying on his back and his legs were around a pole supporting the roof of the verandah. Police observed a broken beer bottle about two metres from Mr Walker's head and near the bottle was a chair which had been knocked over. On the left-hand side of Mr Walker, there was a spade on the ground.

Mr Hokin's [sic] bib and brace overalls were pulled down and his jumper, shirt and singlet were pulled over his left arm and head, exposing his chest. Mr Hokin described to police how he believed Mr Walker's clothing became partially removed during the struggle.

He also described Mr Walker as having had quite a bit to drink. He was drinking wine from a large cup and had about five of those. The certificate of analysis records Mr Walker's blood alcohol content as 0.216 grams per 100ml.

Mr Hokin said he had four or five cups of wine himself but was not affected. A blood sample was taken from Mr Hokin at Westmead Hospital on 23 July 1992. The sample was submitted for analysis, however it was clotted and therefore unsuitable for analysis.

Mr Hokin said to police that if Mr Walker had made some sort of sign to say, "Look, I've had it", or, "I'm going home", Mr Hokin would have said, "Well, get up carefully", but that never happened. Mr Walker kept fighting.

When asked what his intention was when holding Mr Walker, Mr Hokin said:

> *To hold him down and call for help because I am petrified of what's going to happen to me because I'm on a bond. I must be of good behaviour ... that's why I yelled ... out to Craig as loud as I could.*

Mr Hokin also told police:

> *If he hadn't have swung a shovel at me I'd be home asleep ... All I can say is that I've had those kind of people approach me many times in my life. I don't know why because I'm a ladies' man, I'm an entertainer. You can't be one of those and be an entertainer because the boss'll have you out.*

Mr Hokin was subsequently charged with manslaughter at 7.03am on the same morning, 23 July 1992, following his participation in the electronically recorded interview.

The forensic pathologist who conducted the autopsy concluded that Mr Walker died as a result of an injury to the upper cervical - that is, he suffered a torn spinal ligament. The significant condition contributing to the death was traumatic crush asphyxia and head injury.

I now turn to say something about Mr Hokin. Mr Hokin was a first class metal machinist who had been on an invalid pension for the past eight to nine months. He was divorced and living alone at the Burnett Street, Merrylands address. He was then aged 48. He had no real community ties. He had been unable to pay the electricity bill and it had been cut off, as had the water. He cooked in the backyard.

At the time of Mr Walker's death, Mr Hokin was subject to a four-year good behaviour bond in relation to an offence of malicious wounding in 1991 and also subject to another bond for two years for the offence of entering dwelling at night with intent to commit a felony in 1990.

In December 1991, following the charge of malicious wounding, he was admitted as an involuntary patient and assessed at the Cumberland Hospital by a Dr Joura. At Mr Hokin's committal for the charge of manslaughter of Mr Walker, the presentence reports in relation to each of those previous two criminal matters I have mentioned were tendered. I deal with those reports in detail in my written submissions at paragraphs 28 to 34.

In short, Mr Hokin had been diagnosed as suffering manic depressive psychosis and attended Merrylands area health centre every six weeks. He was on medication. He had first been admitted to Cumberland Hospital as long ago as 1967 when he was diagnosed as schizophrenic.

The facts of the malicious wounding offence are of interest insofar as they describe beliefs Mr Hokin held about gay men in the context of his psychotic mental illness. In summary, in respect of the malicious wounding offence, Mr Hokin says he was out for his usual Sunday morning walk, he saw the victim and thought he may be a devious person. He previously told Dr Joura of the Cumberland Hospital that he was suspicious of the victim "because of his duds, the way he wore his pants below his waist as deviates do". He walked behind the victim and caught up to him at the gate at the park. The victim allowed the gate to swing, which hit Mr Hokin in the face. Mr Hokin claims the victim pushed him in the face. He said he punched the victim on the jaw, scuffled with him and then kicked him, but said he then stood back, shocked at what he had done, he returned back home and had some beer to settle down.

Mr Hokin said that after his arrest he was placed in the exercise area at the Merrylands Police Station, a man approached him and gestured to him, which Hokin interpreted to mean the man may have wanted to have a sexual encounter with him. He then attempted to hit this man.

Mr Hokin told Dr Joura that he would commit the same offence again and again because the perverts and deviant should be taught a lesson:

> *The law is an ass and the world would be definitely be a better place if everyone went and did the same as I did.*

Dr Joura concluded that Mr Hokin's actions and beliefs may well have been part of a psychotic condition that was evident on his admission after the malicious wounding charge.

After Mr Hokin's arrest in connection with the death of Mr Walker, a psychiatric report was obtained from Dr Jennifer Thompson, dated 21 September 1992. Dr Thompson opined that Mr Hokin:

> *... suffers a serious psychotic mental illness characterised by hypomanic episodes, severe depressive episodes and paranoid, fixed delusions about homosexuals and perverts. He needs long-term close supervision in the community.*

She documented a 45-year history of depression.

Mr Hokin told Dr Thompson that subsequent to his arrest for Mr Walker's death, he had initially been placed in a cell with a real freak and was then moved to a cell with a homosexual. He said:

> *Why go and put me in a cell with a homosexual ... one of them has only to put his hands on me and I'll murder him. God help me if they come near me.*

Despite the evidence of Mr Hokin's mental illness, characterised by paranoid fixed delusions about homosexuals, there is no evidence to suggest that Mr Hokin

was experiencing a psychotic episode of that kind at the time of Mr Walker's death. He immediately went to the police of his own free will, self-aware of the possible consequence his actions could have on his status in the criminal justice system, particularly being on a four-year bond.

John Hokin was committed to trial on 1 October 1992 at the Local Court at Parramatta on the charge of manslaughter. Bail was refused. His trial was set before the District Court at Parramatta on 15 February 1993.

At that time, the so-called homosexual advance defence was still available in New South Wales, and something of this defence was mentioned before you, Commissioner, during our November hearings. In short, the homosexual advance defence refers to an accused person alleging that they acted either in self-defence or under provocation in response to a homosexual advance made by the deceased person.

In a High Court decision in 1997 of *Green v the Queen*, the majority of the High Court of Australia took the view that a reasonable jury would be entitled to consider that an ordinary person in the position of the accused could have formed an intention to kill or to inflict grievous bodily harm by a non-violent homosexual advance on the part of the deceased.

In 2014, the Parliament of New South Wales passed the Crimes Amendment (Provocation) Act 2014, which provided that a non-violent sexual advance did not constitute extreme provocation for the purpose of being a partial defence to murder. This signalled the end of the so-called gay panic defence in New South Wales.

However, and in any event, no trial of Mr Hokin took place. This is because on 12 February 1993, the Director of Public Prosecutions directed that the prosecution be discontinued on the basis that there was no reasonable prospect of conviction. At the time, it was concluded that the Crown was unable to negative Mr Hokin's claim that he was acting in self-defence, in circumstances when Mr Hokin's version of events was supported by the evidence of the forensic pathologist and another independent witness.

I move now, Commissioner, to mention any indicators of LGBTIQ bias in this case. On the evidence before the Inquiry, Mr Walker's sexual orientation cannot be confirmed. As mentioned, his sister, Ms Walker, had seen him with girlfriends.

There are, however, two indicators that he may have been gay. First, as I have already mentioned, he had a friend, Kevin Leatham, with whom he was understood to stay regularly through the day or the night. The nature of the relationship between Mr Walker and Mr Leatham is unknown. No statement was ever taken from Mr Leatham by police. This is unfortunate, because he may have been able to shed some light on Mr Walker's sexual orientation. Being a mutual friend of Mr Walker and Mr Hokin, and living on the same street as Mr Hokin, he may also have known something more about how Mr Walker came to know Mr Hokin, how long they had known one another and the nature of that relationship.

The Inquiry has established that Kevin Leatham died in August 2009. The death certificate, Commissioner, appears at tab 36 [SCOI.82360_0001] of the tender bundle,

The second indicator is that, on Mr Hokin's account, Mr Walker made advances towards him, touching his leg and shoulder and "talking in a manner about sexual behaviour".

A Bias Crimes Indicators Review Form was completed in this case by Strike Force Parrabell. It concluded that there was no evidence of bias crime. The academic review characterised it as "no bias".

The comments in the completed form included that Mr Walker was likely to be a homosexual male, that Mr Hokin was a heterosexual male, that Mr Walker had been making advances towards Mr Hokin on the night he died, that Mr Hokin was frightened of the advances made, and that there was no evidence suggesting animosity between the pair prior to Mr Walker's advances upon Mr Hokin.

The comments in the form also noted that Mr Hokin's neighbours did not report in their statements any statement or gesture they observed or perceived to be bias or express any view that they believed the murder to be motivated by any bias. However, it needs to be appreciated that the observations of the neighbours were limited. They were not

present in Mr Hokin's backyard at any relevant point. They did not see or could not have seen whether Walker made the alleged gestures towards Mr Hokin, for example, touching his leg. Their observations of the altercation between the two men are limited to what they heard from inside their home.

It is also worth mentioning that the form mentions the author having no details in relation to Mr Hokin's violent history, particularly in respect of the malicious wounding offence, nor his psychotic mental illness and episodes of paranoid fixed delusions about homosexuals. This is perhaps indicative of Strike Force Parrabell not having all relevant material tendered in the court proceedings when they came to review this matter.

The view expressed by the Parrabell officers in the completed form was that even though the fight started as a result of an unwanted sexual advance from Mr Walker to Mr Hokin, the motive behind this death was self-defence, and this is backed by the Coroner's report and from the DPP withdrawing charges. The matter, as I have mentioned, was characterised as solved by Strike Force Parrabell. That is plainly correct in the sense that the identity of the perpetrator, Mr Hokin, has been known from the outset.

Commissioner, on the totality of the evidence, I submit the following conclusions on the question of whether this case is an LGBTIQ hate crime. According to Mr Hokin's statement to police, the physical fight between Mr Walker and Mr Hokin started when Mr Walker attacked Mr Hokin with the shovel. Even if, as asserted by Mr Hokin, there had been an earlier unwanted sexual advance from Mr Walker to Mr Hokin, Mr Hokin himself did not claim that he had fought Mr Walker for that reason. Rather, the actual catalyst for his fighting with Mr Walker as he did was Mr Walker attacking him with a shovel and then with broken glass.

As already mentioned, Mr Hokin said that if Mr Walker hadn't have swung a shovel at him, he'd be home asleep. His claim of self-defence related to the physical violence comprised by Mr Walker's attacking him with a shovel, rather than to the asserted touching on the leg and shoulder.

This conclusion is further supported by the fact that

there is no evidence to suggest that Mr Hokin was suffering a psychotic episode at the time of the kind which had previously been characterised by paranoid fixed delusions about homosexuals and perverts. On the balance of probabilities, it is submitted that the death is unlikely to have been an LGBTIQ hate crime.

Finally, Commissioner, my submissions as to manner and cause of death in this case. Mr Hokin's account of events was generally corroborated by other evidence, including the presence of a shovel at the scene, accounts given by Mr Hokin's next-door neighbours, the injuries to Mr Hokin and the report of both police and the forensic pathologist on a scene examination. Mr Hokin also had numerous observable injuries to his torso. The crime scene photos and photographs of Mr Hokin's injuries have been reviewed by the Inquiry.

The Inquiry has no basis for reaching a different view from that of the Office of the Director of Public Prosecutions in 1993 - namely, that self-defence could not be disproved. It is submitted that the appropriate finding is that Mr Walker died after sustaining a torn spinal ligament as a result of the conduct of John Hokin during an altercation between the two men. Those facts have been plain and uncontentious since 1992. Accordingly, it is further submitted that the death of Mr Walker is not unsolved and therefore does not fall within Category A of the Inquiry's Terms of Reference. I otherwise submit no further recommendations in respect of this matter, Commissioner.

THE COMMISSIONER: All right, thank you. I will note your position is reserved again, Mr Mykkeltvedt.

MR MYKKELTVEDT: Thank you, Commissioner.

THE COMMISSIONER: I propose to adjourn until the next listed public hearing, which I think is already on the website or you have been notified of that event.

MR MYKKELTVEDT: Yes, that's so.

THE COMMISSIONER: All right. Thank you very much, everyone concerned. I will now adjourn, thank you.

AT 3.10PM THE COMMISSION WAS ADJOURNED ACCORDINGLY

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