

**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)

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

3
4 MR MYKKELTVEDT: Yes, your Honour.

5
6 THE COMMISSIONER: There was an outstanding series of
7 objections taken by your client. I have ruled on them in
8 effect in advance of yesterday and today, but I promised
9 you some written reasons so I will give them to you now.
10 So I will hand my judgment down and they will be available
11 to you and those instructing you, and these are the reasons
12 for my rejecting the ultimate redactions that weren't
13 agreed.

14
15 MR MYKKELTVEDT: Thank you, your Honour.

16
17 THE COMMISSIONER: Thank you. I will also proceed upon
18 the basis, unless you tell me otherwise, that when Counsel
19 Assisting conclude their remarks, I will just take it as
20 read that you will reserve your position in respect of each
21 and every one of the cases that are ventilated.

22
23 MR MYKKELTVEDT: Yes. I will certainly let your Honour
24 know if there is something I wish to be heard on.

25
26 THE COMMISSIONER: All right. And lastly, I should just
27 make a short explanation for a couple of things that
28 happened yesterday, not because we have had any inquiries
29 about it but it occurred to me that I should say something
30 about the redactions. Take a seat. I won't burden you to
31 stand while I'm speaking, so please sit down.

32
33 MR MYKKELTVEDT: Yes, Commissioner.

34
35 THE COMMISSIONER: Yesterday in relation to the matters of
36 Hughes, Paynter and Payne, I made a number of orders which
37 were said to be pursuant to section 8 of the Special
38 Commissions of Inquiry Act 1983, and I anticipate I will
39 make other orders along similar lines today in relation to
40 those cases which are ventilated.

41
42 I think I should just explain for those in the hearing
43 room and for those watching online, in brief, the basis for
44 those short minutes, and which has led to the certain
45 redactions from the tender bundle.

46
47 Section 8 of the relevant Act provides me with power

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

11
12 Where possible, I will have as much information which
13 is tendered before me or ventilated before me heard in
14 public. However, from time to time, where I think it is
15 necessary for certain redactions to occur, I will make
16 orders accordingly. The materials, therefore, that will be
17 published and available publicly will be those materials
18 which I am of the view should be made publicly available.

19
20 Now, the redactions, in some instances, have been the
21 subject of discussion between staff of the Inquiry and
22 relevant persons, most relevantly the police, who have
23 taken, in my view appropriately, some objections. However,
24 there are some objections which have been taken which will
25 be seen from my judgment delivered this morning I have not
26 thought it necessary in all the circumstances for certain
27 matters to remain confidential. Those issues will be dealt
28 with on an ongoing basis from time to time, and perhaps
29 I need say no more about it for the moment.

30
31 Yes, Mr de Mars.

32
33 MR de MARS: Commissioner, I appear today to assist you in
34 relation to three Category A matters that are proceeding by
35 way of documentary tender. They are the matters of William
36 Dutfield, David Lloyd-Williams and Andrew Currie.

37
38 THE COMMISSIONER: Thank you.

39
40 MR de MARS: The first matter to proceed is that of
41 William Dutfield. Could I firstly, Commissioner, tender
42 a bundle of material. There are two volumes, in this
43 matter. I understand those two volumes are already with
44 you.

45
46 THE COMMISSIONER: Yes, they are.

47

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

2
3 **EXHIBIT #11 ONE-VOLUME TENDER BUNDLE IN RELATION TO**
4 **WILLIAM DUTFIELD**

5
6 THE COMMISSIONER: Thank you. Perhaps if I can interrupt
7 you again, and I apologise, Mr de Mars, what I should also
8 say, Mr Mykkeltvedt, and it has been occurring on our
9 website but it will be underlined today, is that some of
10 the materials that I have deemed should be publicly
11 ventilated may cause some stress or distress to those
12 either members of families or even persons who were not
13 connected to the deceased persons but who may wish to read
14 the materials online, and so there will be, as you will
15 have noticed this morning and ongoing, a warning to those
16 persons who may be upset if they read some of the details
17 relating to some of the homicides or the deaths of certain
18 people.

19
20 I think that way, at least, we can ensure that if
21 people do wish to access the material, they are warned in
22 advance that it may be upsetting for some of them and, if
23 needs be, there are services available, Lifeline and
24 others, if they wish to make contact with those persons.
25 I have taken that course and I can't imagine there will be
26 any difficulty from your client's point of view.

27
28 MR MYKKELTVEDT: No, that's certainly so, Commissioner.

29
30 THE COMMISSIONER: Thank you. Yes, Mr de Mars.

31
32 MR de MARS: Commissioner, I also understand that you have
33 before you a copy of a proposed order pursuant to section 8
34 of the Special Commissions of Inquiry Act, which, in
35 keeping with the matters, Commissioner, you have just been
36 addressing, deals with certain non-publication redactions.

37
38 THE COMMISSIONER: Thank you. I have looked at those
39 minutes and I think in those circumstances the redactions
40 which will be covered by those short minutes are
41 appropriate and I make those orders. Thank you.

42
43 MR de MARS: Thank you. Thirdly, Commissioner,
44 I understand you also should have a copy of the written
45 submissions in this matter.

46
47 THE COMMISSIONER: Yes, I have, thank you.

1
2 MR de MARS: I adopt and rely upon those WRITTEN
3 submissions, in addition to what I now say orally.
4

5 THE COMMISSIONER: Thank you.
6

7 MR de MARS: Commissioner, Mr Dutfield died on the evening
8 of 19 November 1991 in the living room, in the apartment
9 where he lived in the Sydney suburb of Mosman. He was 41
10 years old. It was plain from the outset that he had been
11 the victim of a violent assault.
12

13 In a post-mortem report dated 1 April 1992, which
14 appears at tab 4 of the bundle [SCOI.00027.00031_0001],
15 Dr Duflou documented 16 lacerations to Mr Dutfield's head,
16 as well as a number of abrasions and some minor bruising.
17 He also documented abrasions, contusions and minor
18 lacerations to his arms and some contusions to his right
19 leg. Internal examination found extensive fracturing of
20 the skull causing subdural and subarachnoid haemorrhages
21 and extensive laceration of brain tissue.
22

23 In his report, Dr Duflou found the direct cause of
24 death to be head injuries.
25

26 At an inquest that was held on 12 December 1994,
27 Dr Duflou indicated in his evidence that the U shape of the
28 head wounds was consistent with them having been caused by
29 a large metal sticky tape dispenser located at the scene.
30 He stated that the injuries were severe and had involved at
31 least 12 blows to the head. The skull fracturing was
32 extensive and Mr Dutfield would have died from half as many
33 blows. He described Mr Dutfield as having defensive wounds
34 on his arms, hands and wrists, and that he was likely
35 facing his attacker at some stage. A bruise was identified
36 on one of Mr Dutfield's knees.
37

38 It is also relevant to note, Commissioner, that
39 Mr Dutfield's blood toxicology report indicated a very high
40 level of alcohol. That report is at tab 2
41 [SCOI.00027.00032_0001], the relevant percentage being
42 0.242.
43

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

1 background details concerning Mr Dutfield.

2
3 At the time of the original investigation from 1991
4 and for a number of years thereafter, police proceeded on
5 the basis of a theory that Mr Dutfield had been the victim
6 of a robbery committed by someone who was effectively
7 preying upon him as a potentially vulnerable victim.

8
9 At paragraph 51 of the written submission, I set out
10 details of an assault upon Mr Dutfield that had occurred
11 just five weeks before his death and which was one of the
12 reasons why police adopted this theory.

13
14 That assault occurred on 16 October 1991. The day
15 after, on 17 October 1991, Mr Dutfield provided a statement
16 to police about that matter. In it he described having six
17 middies of beer at the Rex Hotel Bottoms Up bar with a male
18 who he had met there. He invited the male back to his flat
19 in Mosman. They had a scotch together and watched TV.

20
21 The male called Mr Dutfield a bastard and punched him
22 to the face. The male then kicked Mr Dutfield to the face
23 and body a number of times before searching his pockets and
24 taking \$900 from him. Mr Dutfield described the male as
25 being about 23 years old and he gave a physical description
26 of that person.

27
28 Commissioner, the original officer in charge of the
29 investigation, a Detective Sergeant Peter O'Toole, gave
30 evidence at the inquest in 1994. He expounded a theory
31 that a male prostitute, as he described the person, and/or
32 a drug addict, was preying on people such as Mr Dutfield,
33 gaining entry to their residential premises under false
34 pretences and then bashing and robbing them. This was
35 partly based on, as I say, the break-in that had previously
36 occurred.

37
38 The officer in charge considered that word would have
39 gone around the Kings Cross area of Mr Dutfield's
40 vulnerability as a target of robbery. He suggested that
41 either a phone call was made by Mr Dutfield to someone or
42 that he was visited without appointment by the assailant
43 and that he either knew the person or Mr Dutfield was made
44 known to them through associates from the Kings Cross area.

45
46 Police therefore appear to have concentrated their
47 inquiries on what the OIC described, to use his language,

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

5
6 By the time of the inquest, the police had been
7 unable, however, to identify a clear suspect, leading to
8 the coronial finding that the injuries causing
9 Mr Dutfield's death had been inflicted by a person or
10 persons unknown.

11
12 I might ask at this point, Commissioner, for tab 6
13 [SCOI.00027.00001_0001] to be brought up on screen. That's
14 simply the original finding that was made by the Coroner of
15 the time, Deputy State Coroner Abernethy, and as has been
16 indicated, the finding at that stage, back in 1994, was one
17 that indicated that the relevant injuries had been
18 inflicted by a person or persons unknown.

19
20 Contrary to that police theory, the key person of
21 interest in relation to the death is now someone else
22 entirely, a man by the name of Mr Arthur Ashworth.
23 Mr Ashworth was born on 16 June 1914 and was aged 77 at the
24 time of Mr Dutfield's death. Although considerably older,
25 he was a long-time friend and associate of Mr Dutfield.

26
27 At the time of the original investigation, the
28 possibility of his involvement appears to have been
29 dismissed on the basis of his age. Your Honour will see at
30 tab 38 [SCOI.10068.00036_0001] of the material an
31 investigation note evidencing discussion with the OIC in
32 2010 when the matter was reinvestigated, that is consistent
33 approach taken by the OIC initially.

34
35 However, reconsideration of the evidence by the
36 NSW Police Force upon reinvestigation by a strike force by
37 the name of Strike Force Hamish, which commenced in late
38 2008, and this Inquiry's own consideration of the evidence,
39 both strongly suggest that Mr Ashworth killed Mr Dutfield.

40
41 Tab 45 [SCOI.02712_0001], Commissioner, you have
42 before you a record of the conclusions that were reached by
43 Strike Force Hamish to that effect in 2013. I note at this
44 point that Mr Ashworth is now himself deceased.

45
46 Commissioner, I move now to set out the various steps
47 undertaken by the Inquiry in relation to this matter. The

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

10
11 To give some more details to that work, Commissioner,
12 this matter was one of those the subject of the Inquiry's
13 first summons to police dated 22 May 2022 for all police
14 investigative material relating to it. The follow-up
15 summons was issued on 14 October 2022, as it was apparent
16 that there was investigative material dating from late 2010
17 onwards that had not been produced in response to the
18 initial summons. The later summons also sought the
19 complete police fingerprint file to help clarify the basis
20 for an assertion that Arthur Ashworth's fingerprint was
21 found on the likely weapon used to kill Mr Dutfield.

22
23 In response to the later summons, additional material
24 was produced to the Inquiry and clarification was provided
25 regarding the location of relevant material within police
26 archive boxes previously provided to the Inquiry.

27
28 A summons was also issued on 5 December 2022 to the
29 Forensic and Analytical Science Service of New South Wales
30 Health Pathology, known by the acronym FASS, for their
31 file, so that all DNA and other forensic evidence relating
32 to the death could be fully considered by this inquiry.
33 Efforts were also made to contact surviving family members
34 of Mr Dutfield, however, these have not resulted, to this,
35 point, in any contact with a family member.

36
37 Commissioner, I now proceed to set out key matters
38 arising from the Inquiry's consideration of the evidence
39 and the conclusions that it is suggested can be drawn from
40 the evidence. These are largely consistent with the
41 consideration of the evidence and conclusions reached by
42 Strike Force Hamish.

43
44 In relation to Mr Dutfield's background, as already
45 observed, he was 41 years old when he died. He had four
46 older brothers, one of whom died in 1989. He also had
47 a twin brother by the name of John. He grew up in the

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

5
6 According to information provided to police by his
7 brother Robert, he suffered injuries through a number of
8 falls when riding which had affected his personality. He
9 was said to have become depressed and he started to drink
10 too much, and his relationship with other family members
11 became strained.

12
13 He became friends with two older males, one of whom
14 was Arthur Ashworth. After sharing a house initially with
15 the other man for a period, Mr Dutfield met Mr Ashworth and
16 he moved in with Mr Ashworth for about 10 years prior to
17 his death.

18
19 At the time of his death, however, Mr Dutfield lived
20 alone in a one-bedroom unit in Mosman that was owned by
21 Mr Ashworth.

22
23 Mr Dutfield's brother Robert also told police that
24 Mr Dutfield was lonely in the period leading up to his
25 death. His only friends were these two older males. And
26 he had mentioned that he wanted to meet other people. The
27 day before his death, Mr Dutfield had met his twin brother
28 at a cafe at Warringah Mall and appeared to be in good
29 spirits.

30
31 I now turn, Commissioner, to provide some details of
32 the account given by Mr Ashworth at the time of the death.
33 It is important, in my submission, to understand what he
34 initially told police in order to understand in part why he
35 is now the key suspect.

36
37 Mr Ashworth was called to give evidence at the inquest
38 held in 1994. Given the nature of the questions he was
39 asked, he was clearly not considered to be a person of
40 interest at that time. He adopted the statement he had
41 made to police, qualifying it only by stating that
42 Mr Dutfield had told him that he was bisexual rather than
43 homosexual.

44
45 At this point, Commissioner, I will go to some of the
46 detail of the statement, and it might be appropriate to
47 have that put up on screen. It is at tab 16

1 [SC0I.00027.00044_0001]. If we stay at the front page for
2 present purposes just to indicate that this is the
3 statement, and as you will see, it bears the date
4 21 November 1991, being the day after the events which
5 caused the death.
6

7 In the body of the statement, Mr Ashworth described
8 drinking at the Rex Hotel in the 1970s after his retirement
9 and meeting Mr Dutfield there when Mr Dutfield was working
10 as a general hand at the hotel. He stated that he got to
11 know Mr Dutfield well. Mr Dutfield would clean his unit
12 for him once a week and confided in him that he was gay.
13 Mr Ashworth described himself as becoming a father figure
14 to Mr Dutfield.
15

16 As I have already indicated, Mr Dutfield subsequently
17 boarded with Mr Ashworth for 10 years, first at Randwick
18 and then at Cremorne. In June 1991, five months prior to
19 Mr Dutfield's death, Mr Ashworth moved into a retirement
20 village and so stopped living with Mr Dutfield in Cremorne.
21 Mr Ashworth then bought a unit in Mosman that Mr Dutfield
22 moved into - that is, the unit where he died - and
23 Mr Ashworth thus became his landlord.
24

25 Mr Ashworth described his involvement with Mr Dutfield
26 on the day of his death as follows - it might be of some
27 assistance just to scroll down in the on-screen statement
28 initially, I think, to the second page, where we see
29 Mr Ashworth commenced to describe some of those events.
30

31 In the morning he says he went to Mr Dutfield's unit
32 and did some washing with him. At around 4.30pm,
33 Mr Dutfield showed up at Mr Ashworth's retirement village
34 apartment with two beers, most of which Mr Dutfield drank.
35 Mr Dutfield appeared to have been significantly affected by
36 alcohol and Mr Ashworth thought he was depressed and that
37 generally Mr Dutfield showed signs of manic depression.
38

39 At 5.30pm they both went to the Mosman unit. Both of
40 them drank two scotches. At 7pm, according to Mr Ashworth,
41 they went to the Mosquito Bar Restaurant together for
42 dinner. I note, Commissioner, that that establishment at
43 the time was about a 350 metre distance from the unit.
44

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

1 10 minutes to walk back to Mr Dutfield's unit. They had
2 a further scotch together and Mr Dutfield had two glasses
3 of wine. According to Mr Ashworth, after these drinks
4 Mr Dutfield was slightly high and drunk and wanted to go
5 out and drink at a bar. Mr Ashworth says that he cautioned
6 against it and left on his own, arriving back at his
7 retirement village at around 8.15pm.

8
9 According to Mr Ashworth, he observed Mr Dutfield to
10 have about 150 to 180 dollars in his wallet when they were
11 at the restaurant. This was potentially significant, as if
12 it was the case, it would appear to have been taken from
13 his wallet by the perpetrator.

14
15 That statement could come down at this point, and
16 I just draw to your attention, Commissioner, some of the
17 relevant evidence from neighbours, that evidence being of
18 particular importance to establishing the likely time of
19 the attack on Mr Dutfield.

20
21 Neighbours who lived directly below Mr Dutfield in the
22 apartment complex heard a number of thud sounds while
23 watching the first half of the program "LA Law" on TV,
24 which had aired between 9.30 and 10.30pm, thus placing the
25 likely time of the attack at between 9.30 and 10pm. They
26 also heard loud arguing occurring between two male voices,
27 one described as louder than the other, just prior to
28 hearing the initial thud.

29
30 Commissioner, a crime scene officer, Detective
31 Christopher Kolder, also gave evidence at the inquest.
32 I will go to some of the things Detective Kolder observed
33 at the time, because again, they become particularly
34 significant when looking at the later investigation of the
35 matter.

36
37 Detective Kolder's statement appears at tab 12
38 [SC0I.00027.00034_0001], and again it might be of some
39 assistance to put that on screen at present. I will ask
40 that it be left there for the present and will ask that it
41 be scrolled down a little later.

42
43 Detective Kolder attended the unit the following day,
44 on 20 November 1991, at 12 noon, after Mr Ashworth had
45 contacted police purporting to have found the body when
46 checking on Mr Dutfield. Detective Kolder gave evidence to
47 the following effect: a number of swabs of blood were

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

7
8 I pause at this point to note that that tissue was to
9 become subsequently a particularly important piece of
10 evidence. Detective Kolder also observed that the whole
11 unit had been fingerprinted with a negative result, and
12 that the offender appeared to have washed their hands in
13 both the kitchen and bathroom sinks. He said there were no
14 signs of struggle other than one drug having been
15 disturbed.

16
17 The bloodstain patterns at the scene suggested that
18 Mr Dutfield may have initially been attacked by being
19 struck by a heavy metal sticky tape dispenser whilst
20 seated. The tape dispenser was in the kitchen sink and an
21 attempt had been made to wash it, though blood remained on
22 it.

23
24 Detective Kolder also observed that the injury pattern
25 to Mr Dutfield's head was consistent with a tape dispenser
26 having been used to inflict all the blows. There were two
27 drinking glasses on a table in the lounge room near the
28 body that contained scotch, and a bottle of scotch in the
29 kitchen with a nip pourer ready. He observed that there
30 were no signs of a forced entry. The lack of fingerprints
31 on the glasses, ashtray, table and elsewhere suggested to
32 him that the perpetrator had gone to some trouble to wipe
33 things.

34
35 If we could just scroll down in the statement, I think
36 to page 8, thank you, and just down a little further.
37 Consistent with the evidence given at the inquest,
38 Commissioner, you will see that amongst other things, the
39 items that Detective Kolder indicates that he collected for
40 further examination included 2F, the tissue from the waste
41 bin in the kitchen, and also of note, and again I will
42 subsequently come to it, 2H, a black cardigan from the
43 lounge suite in the lounge room.

44
45 Commissioner, as you have already heard, despite
46 police following various leads based on the OIC's theory
47 that someone had committed the murder in the course of

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

5
6 The material obtained by this Inquiry discloses that
7 in 2005 the death was reviewed by the police Unsolved
8 Homicide Team. At paragraph 56 of the submission, I set
9 out the recommendations that were made following that
10 review on 2 May 2005. Critically, they included that there
11 should be further examination of the tissue with blood that
12 was retrieved from the kitchen waste bin, bearing in mind
13 that at the time of the original investigation, it had been
14 ascertained that the blood was not of the same blood group
15 as Mr Dutfield.

16
17 Further recommendation was that there should be
18 re-examination of the sticky tape dispenser, bearing in
19 mind that at the time of the original investigation,
20 partial fingerprints had been located.

21
22 It was further recommended that an elimination DNA
23 sample should be taken from Arthur Ashworth, noting that he
24 had provided elimination fingerprints but not DNA at the
25 time of the original investigation.

26
27 Regrettably, despite the recommendations made in 2005,
28 including that for obtaining a DNA sample from Mr Ashworth
29 and DAL testing of the tissue, it appears that neither had
30 been done by the time Mr Ashworth passed away in July 2006.

31
32 It was not until 8 February 2007 that a report was
33 received from DAL in relation to the tissue. That report
34 noted that a full DNA profile had been obtained from the
35 stained tissue that was recovered from the waste bin. In
36 view of this, and notwithstanding that by this stage
37 Mr Ashworth had died, it was noted in a March 2007 case
38 screening form, Commissioner, which was at tab 30A
39 [SC0I.10066.00036_0001], that obtaining a profile from
40 Mr Ashworth should be seen as a priority for elimination
41 purposes or otherwise. Due to his age, time may be
42 limited, and once he passes away, the opportunity may well
43 be lost. It seems, Commissioner, that the UHT did not seem
44 to appreciate that by this time, Mr Ashworth had in fact
45 already passed away.

46
47 Subsequently, Strike Force Hamish was formed

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

10
11 Much of the work of Strike Force Hamish focused on
12 re-examining evidence and re-interviewing witnesses in
13 connection with the possible involvement of Mr Ashworth in
14 the death and locating exhibits for further analysis.

15
16 Commissioner, the forensic evidence uncovered by
17 Strike Force Hamish strongly implicates Mr Ashworth.
18 I will come to that evidence shortly. However, there are
19 three other aspects of the evidence that it is submitted
20 are also highly incriminating in relation to Mr Ashworth,
21 that should have been apparent to investigators at a very
22 early stage. These relate, firstly, to the evidence of
23 timing of Mr Ashworth's movements on the evening of the
24 death; secondly, to evidence concerning Mr Ashworth's
25 movements on the day after the death; and, thirdly,
26 evidence in relation to clothing Mr Ashworth was wearing on
27 the evening of Mr Dutfield's death.

28
29 The issues as to the timing of Mr Ashworth's movements
30 on the day of the death are set out in the submission at
31 paragraphs 62 to 66. In essence, there is a significant
32 discrepancy between the evidence of Mr Ashworth on the one
33 hand and other objective evidence concerning when
34 Mr Ashworth and Mr Dutfield left the Mosquito Bar where
35 they had dinner. The difference in the evidence and its
36 significance suggests that Mr Ashworth's account is likely
37 to have been a self-serving fabrication.

38
39 Without traversing all of the detail that is in the
40 written submission, Mr Ashworth told police that he and
41 Mr Dutfield had left the Mosquito Bar Restaurant, where
42 they had had dinner, at 7.45pm. They then walked to
43 Mr Dutfield's flat, arriving just before 8pm. He stayed
44 with Mr Dutfield while he had a drink and Mr Dutfield had
45 two drinks, before he returned to The Garrison Retirement
46 Village, he said by 8.15pm.

47

1 By contrast, objective evidence from civilian
2 witnesses whose accounts corroborate each other indicates
3 that the pair did not leave the restaurant until around
4 8.45pm, thus returning, it would seem, to the flat shortly
5 before 9pm.
6

7 Given that Mr Ashworth, by his own account, remained
8 at the flat for some time while the pair drank, this timing
9 would appear to put Mr Ashworth squarely in the frame as
10 potentially present during the period from 9.30 to 10pm
11 when neighbours heard the sounds consistent with the fatal
12 assault.
13

14 The second area of evidence implicating Mr Ashworth,
15 as I have indicated, relates to his activities on the day
16 after the death. This is set out at paragraphs 67 to 69 of
17 the written submission.
18

19 On the morning after Mr Dutfield's death, Mr Ashworth
20 visited a friend in Woollahra in the Eastern Suburbs.
21 According to the account of the friend, they were due to go
22 to lunch together. However, rather than have lunch,
23 Mr Ashworth advised his friend that he had to go to
24 a teachers' reunion. They remained at the friend's house
25 for just half an hour, then got a train to Edgecliff
26 together, then parted ways at about 11am.
27

28 The friend spoke to Mr Ashworth on the phone later
29 that day, at which time Mr Ashworth told his friend about
30 Mr Dutfield's death. However, Mr Ashworth told his friend
31 that another person, and not he, had found Mr Ashworth's
32 body. I will return to the potential significance of that.
33

34 Thirdly, in relation to the question of Mr Ashworth's
35 clothing, on 21 November 1991 - that is, two days after the
36 death - Mr Ashworth told investigators that he had dropped
37 off a pair of blue trousers at a dry cleaner in Wynyard on
38 20 November. This information, including as to the colour
39 of the trousers, was later corroborated by police with the
40 dry cleaner. Your Honour will see the evidence of that at
41 tab 29j [SCOI.10067.00033_0001], a police running sheet.
42

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

1 it as grey and blue. The relevant civilian evidence is set
2 out and referenced at paragraph 74 of the submission.
3

4 The evidence, it is submitted, concerning
5 Mr Ashworth's clothing and his movements the following day
6 is cause for suspicion for a number of reasons. It seems
7 odd that Mr Ashworth would have arranged to visit his
8 friend in Woollahra in order to go to lunch, only to then
9 tell him that he had a teachers' reunion to go to, and then
10 not go to the reunion, it would seem, but instead return to
11 Mosman to check on Mr Dutfield.
12

13 The likelihood that Mr Ashworth later lied and told
14 his friend that another person and not himself had found
15 Mr Dutfield suggests that he was at a loss to explain to
16 his friend why he went and checked on Mr Dutfield rather
17 than going to the purported teachers' reunion.
18

19 Thirdly, Commissioner, Mr Ashworth appears to have
20 lied about the clothing he had worn when questioned by
21 police. The description of the clothes as seen by
22 witnesses does not match that given by Mr Ashworth.
23 Further, the colour of the trousers he took to the dry
24 cleaners the morning after the death does potentially match
25 the colour of the trousers he wore as seen by at least one
26 of those witnesses.
27

28 This evidence, it is submitted, is consistent with
29 Mr Ashworth, having killed Mr Dutfield, seeking to give the
30 appearance of normality the following morning by keeping
31 his commitment to visit his friend, while also returning to
32 the crime scene perhaps potentially to deal with
33 incriminating aspects of it, while also arranging to have
34 the trousers that he wore at the time of the death dry
35 cleaned at Wynyard.
36

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

1 not aware of it at the time.

2
3 In his statement made on 20 November 1991, Mr Ashworth
4 had stated that the tape dispenser was originally his, and
5 that he had left it in the flat when he had moved to the
6 retirement village, possibly providing an innocent
7 explanation for the presence of the fingerprint.

8
9 Analysis of the documentary evidence relating to the
10 fingerprint in question does indeed indicate that
11 a fingerprint was identified as on the tape dispenser, as
12 belonging to Mr Ashworth. The particular evidence is in an
13 email from the officer Craig Borton of the Major Crime
14 Section, Fingerprint Ops, dated 11 May to Detective Stephen
15 Hungerford, the officer in charge of the Strike Force
16 Hamish investigation.

17
18 Mr Borton states as follows:

19
20 *I have again compared [the relevant case*
21 *related] (prints on tape dispenser) against*
22 *fingerprints of Arthur Ashworth. Graph W1*
23 *is identified as the right ring finger of*
24 *Ashworth. I am unable to identify the*
25 *remaining graph W2 as Ashworth. Was*
26 *possibly incorrectly written off as Fully*
27 *Eliminated in 1991.*

28
29 The observations of officer Borton as to the relevant print
30 having been potentially incorrectly eliminated in 1991
31 appear to be consistent with photos of the relevant
32 fingerprints from the original investigative material.
33 Notations made on the back of the photos indicate that the
34 print or prints had either been fully or partly eliminated
35 at the time. Other notations and records are consistent
36 with Arthur Ashworth having been incorrectly fully
37 eliminated as a source of the prints at the time of the
38 original investigation. The references for those
39 observations, Commissioner, are provided in footnotes to
40 the submission in paragraph 79.

41
42 It is suggested that the appropriate conclusion is
43 that at the time of the original investigation, the print
44 was either not identified as belonging to Arthur Ashworth
45 or, if it was, this information appears not to have been
46 passed on to or acted upon by the original investigators.
47 What is clear is that upon re-examination in 2010, officer

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

3
4 In relation to the DNA evidence, as mentioned earlier,
5 evidence collected at the scene in 1991 included a bloody
6 tissue located in the kitchen waste paper basket, and also
7 a cardigan on the lounge in the lounge area. Evidently,
8 the perpetrator had gone to the kitchen after killing
9 Mr Dutfield, as the tape dispenser was found in the sink,
10 the kitchen sink. The bloodied tissue had been tested at
11 the time and, as already referred to. Found to be of
12 a different blood type to that of Mr Dutfield.

13
14 As also noted earlier, on 2 May 2005, a review of the
15 matter by the Unsolved Homicide Team resulted in
16 recommendations for further examination of the tissue and
17 some other items and the taking of an elimination DNA
18 sample from Arthur Ashworth. Plainly, these actions could
19 have been taken somewhat earlier than 2005, given the
20 timing of the introduction of DNA testing methodologies in
21 New South Wales. However, the initial, and it is submitted
22 inappropriate, dismissal of Mr Ashworth as a potential
23 suspect was presumably at least partly a reason for an
24 elimination sample not having been taken from Mr Ashworth
25 at an earlier time.

26
27 When the tissue was resubmitted to DAL for DNA testing
28 in 2005, resulting in confirmation that the blood was not
29 from Mr Dutfield, a match was also found with blood on the
30 cardigan that had been left on the lounge suite at the
31 crime scene - that is, the profiles on the tissue and the
32 cardigan were consistent.

33
34 It is, regrettable, to say the least, that a DNA
35 sample from Mr Ashworth had not already been obtained as
36 of May 2005, nor was one taken from him in the 13 months
37 following the recommendation that such a sample be taken
38 and during which Mr Ashworth remained alive. If this had
39 occurred, the DNA match between the blood on the tissue,
40 the cardigan and Mr Ashworth could have resulted in the
41 initiation of a prosecution against him while he remained
42 alive, including attempts to confront him in interview as
43 the key suspect.

44
45 In fact, it was not until September 2008, more than
46 two years after Mr Ashworth's death, that Strike Force
47 Hamish was formed with these specific Terms of Reference

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

14
15 The totality of the available forensic evidence,
16 therefore, strongly supports the view that Mr Ashworth was
17 responsible for the attack. The fingerprint matching his
18 has been identified on the murder weapon and a DNA match to
19 his blood was made with a bloody tissue in the kitchen
20 where it appears the assailant had attempted to clean
21 things up after Mr Dutfield was killed. Blood matching his
22 DNA was also located on the cardigan on the lounge nearby
23 Mr Dutfield's body.

24
25 It's noted that the tape dispenser, as can be seen in
26 photographs within the tender bundle, is metal and has
27 a serrated part for the cutting of tape. It could readily
28 have caused a cut or abrasion to a person wielding it as
29 a weapon.

30
31 Commissioner, it's also relevant to consider the
32 question of a possible motive for Mr Ashworth to have
33 committed the crime. While it would not have been
34 essential to prove a case against him, consideration of
35 motive is, for obvious reasons, relevant to considering
36 whether any LGBTIQ bias may have been involved.

37
38 In relation to the question of motive, it's noted that
39 Mr Ashworth, Mr Dutfield and a third older male I have
40 referred to as their mutual friend appeared to have led
41 a quite insular existence spending much of their time in
42 each other's company. While various accounts made it clear
43 that Mr Dutfield was gay or bisexual, it does not appear
44 that Mr Ashworth openly identified as gay. Objectively the
45 nature of his relationship with Mr Dutfield suggests that
46 he may well have been. Further, both family members and
47 friends of Mr Ashworth have told Strike Force Hamish

1 investigators that they thought Mr Ashworth was gay.
2

3 It's also clear that Mr Dutfield had a significant
4 alcohol problem. On 14 November 1991, just five days prior
5 to his death, he had been referred by his GP to his local
6 community health centre for assistance with his alcohol use
7 and management of anxiety. One month prior to this,
8 in October 1991, someone who it appears must have been Mr
9 Ashworth, had contacted a counsellor at the same centre.
10 The statement of the counsellor appears at tab 24
11 [SC0I.00027.00050_0001] of the tender bundle.
12

13 The counsellor recalls the person, who it appears must
14 have been Mr Ashworth, telling her the following: that he
15 had a friend, who she thought the caller said was living
16 with him at the time, and who was driving the caller, in
17 their words, "crazy due to his drinking". He was drinking
18 and causing problems in the flat. The caller said that the
19 person was on an invalid pension, a fact consistent with
20 Mr Dutfield's known status, and that he was also causing
21 problems with another friend. The caller thought that his
22 friend would not attend alcohol counselling and that he
23 thought he needed psychiatric help. The counsellor tried
24 to encourage the caller to arrange to bring the person in
25 to see her.
26

27 Subsequently, the local community health centre
28 completed a mental health service intake form after
29 a referral was made by Mr Dutfield's GP listing contact
30 details of Arthur Ashworth, the referral being for alcohol
31 and psych problems.
32

33 The information in that form appears to make it quite
34 clear that Mr Ashworth appears to have been the person who
35 raised the issues with the counsellor.
36

37 On the evening of his death, it seems clear that
38 Mr Dutfield was heavily intoxicated. The Mosquito Bar
39 proprietor stated that when entering the restaurant
40 Mr Dutfield was quite drunk and was slurring his words. He
41 evidently had quite a bit more to drink after this, both at
42 the restaurant and back at his unit.
43

44 The close mutual friend of Mr Dutfield and
45 Mr Ashworth, in his statement at tab 17
46 [SC0I.00027.00045_0001] noted as follows in relation to
47 Mr Dutfield. He said he would be very moody, and when he

1 was drinking you had to watch what you said so that it
2 would not offend him, because he would get upset and very
3 angry. He was very sensitive when he had been drinking.
4 When spoken to by Strike Force Hamish investigators on
5 4 November 2010, the same friend made the following
6 observations, that Mr Dutfield did not see himself as an
7 equal intellectually to either himself or Mr Ashworth, as
8 he was dyslexic, and as a result of this, when intoxicated,
9 he would put Mr Ashworth and himself down verbally and was
10 quite abusive. He said that he never saw Mr Dutfield use
11 violence and observed that he was very short, physically
12 weak and said that he would be incapable of fighting.
13

14 The friend observed that Mr Ashworth was physically
15 stronger than Mr Dutfield, though he had never seen
16 Mr Ashworth fight with anyone.
17

18 While evidence concerning the nature of the
19 interaction between Mr Dutfield and Mr Ashworth on the
20 evening of Mr Dutfield's death is necessarily limited, the
21 fact that Mr Ashworth had previously expressed great
22 frustration with Mr Dutfield's conduct when intoxicated and
23 the close and possibly intimate nature of the relationship
24 between them, the fact they had both been drinking and
25 Mr Dutfield's high level of intoxication at the time
26 suggests a context in which emotions may have run high
27 between the two men at the time the offending occurred, and
28 that this set a context in which the offending occurred.
29

30 Before coming to suggested conclusions, Commissioner
31 that, might be reached in the matter, it is relevant to
32 make some observations about the way in which this matter
33 was treated by Strike Force Parrabell.
34

35 The content of the Bias Crimes Indicators Form that
36 was completed in the course of the work of Strike Force
37 Parrabell in 2016 to 2017 is, I think it must be said,
38 highly surprising, because despite having been completed
39 a number of years after Strike Force Hamish, it appears to
40 take no account of the key conclusion reached by police in
41 the reinvestigation of the matter by Strike Force Hamish,
42 namely, that the likely assailant was Arthur Ashworth and
43 not someone connected with a robbery that had taken place
44 five weeks prior to Mr Dutfield's death.
45

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

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

7
8 At this point, your Honour, it might be appropriate to
9 show on screen tab 79, [NPL.0115.0002.2149] which is the
10 relevant Bias Crimes Indicators Form. Whilst I certainly
11 won't traverse all of the form, to give you an example of
12 the type of comment that one sees repeatedly in that form,
13 perhaps we could go to page 13 of that form. You will see
14 there is a section 8, "Location of Incident".

15
16 If we scroll down to the bottom of that form, in
17 relation to the question of location, you will see the
18 bottom box, and it is reproduced in the submission at
19 paragraph 21, what is said in relation to Detective
20 Sergeant O'Toole, the officer in charge of the
21 investigation - namely, that the officer in charge of the
22 investigation believed that an unidentified male had met -
23 that Dutfield had met at the Rex Hotel on the night of the
24 robbery a month earlier or an associate was the person who
25 killed Dutfield.

26
27 If we go down to the top of the next page, consistent
28 with the rest of the content of this form, it seems the
29 author of the form effectively was adopting the same case
30 theory in relation to what had happened concerning the
31 matter.

32
33 Can I draw, Commissioner, your attention to the
34 reference to significant investigation having been
35 conducted, focusing on male prostitutes from the
36 Kings Cross area, but this failing to identify any of the
37 offenders, and the reference to the Rex Hotel rather than
38 Dutfield's home address being relevant to the
39 investigation, stating that it is not bias related as it is
40 most likely that the offenders in this murder were also
41 homosexual. Implicit in that, your Honour, is an
42 acceptance of the original case theory and, as I say, it's
43 repeated in other portions of that form.

44
45 One observation that I would make, Commissioner, is
46 that although adopting this by then outdated case theory,
47 the conclusions expressed in the form, nevertheless based

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

17
18 The indicators in relation to individual criteria
19 considered in the form all lead to one of two conclusions
20 being expressed in it: that the matter was either not bias
21 crime; or that there was insufficient information to make
22 a determination as to whether or not it was. The summary
23 of findings notes the relevant indicator as "Insufficient
24 Information", and the comment in the summary of findings
25 again fails to mention the findings of Strike Force Hamish
26 but instead repeats the views expressed by the original OIC
27 and the Coroner in the early 1990s. It concludes as
28 follows:

29
30 *It appears unlikely that sexuality or other*
31 *bias was involved in the death of William*
32 *Dutfield and it is most likely that the*
33 *motive for assaulting Dutfield was robbery*
34 *related however this cannot be confirmed.*
35

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

38
39 In relation to the Strike Force Parrabell case summary
40 for this matter, the content of the case summary is set out
41 at paragraph 25 of the submission - and I won't go to it in
42 detail - but by contrast with the Bias Crimes Indicators
43 Form, the case summary does contain an acknowledgment of
44 the strong evidence against Arthur Ashworth that was
45 highlighted upon reinvestigation of the matter after 2008.
46 It is nevertheless expressed in confusing terms, in that
47 the circumstances of death as they are described suggest

1 that the matter was in effect a robbery gone wrong, which
2 is not consistent with the conclusion that Mr Ashworth was
3 the perpetrator.
4

5 Inaccuracies in the summary narrative also suggest
6 that the evidence was not closely examined. Reference is
7 made to DNA matches with the murder weapon and blood found
8 in the unit, when the relevant forensic match with the
9 murder weapon was a fingerprint, not DNA. The statement
10 that the offender broke out of the rear of the residence
11 after stealing a small sum of cash rests on an acceptance
12 of the clearly now impugned account of Arthur Ashworth, and
13 is not consistent with the findings of Strike Force Hamish.
14

15 Commissioner, the quality of analysis disclosed by the
16 Bias Crimes Indicators Form, it is submitted, is
17 disturbing, particularly as it overlooks the entirety of
18 the work of Strike Force Hamish. Further, the inaccuracies
19 and inconsistencies in the case summary give rise to
20 similar concerns about the quality of the analysis more
21 generally conducted in relation to this matter by Strike
22 Force Parrabell, it is submitted.
23

24 Coming back, then, to concluding observations,
25 Commissioner, for reasons similar to those I have taken you
26 to, Strike Force Hamish investigators reached the
27 conclusion that Mr Ashworth was the offender responsible
28 for Mr Dutfield's murder, and that had he been alive, there
29 would have been sufficient evidence to arrest him. They
30 were of the view that there were no outstanding
31 investigative opportunities.
32

33 By contrast to the assessment of the officer in charge
34 of Mr Ashworth's physical capabilities, the assessment of
35 the mutual friend that I have referred to clearly suggests
36 that despite the age difference, Mr Ashworth was physically
37 stronger than Mr Dutfield. It is therefore surprising that
38 Mr Ashworth was not more seriously considered as a suspect
39 at the outset, and that obvious problems with his account
40 and his conduct the day after the murder were not observed
41 and interrogated at the time of the original investigation.
42 It appears highly likely he was the offender, to the extent
43 that further investigation does not appear to be warranted.
44

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

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

14
15 In relation to submissions on the manner and cause of
16 death, Commissioner, were Arthur Ashworth still alive
17 today, there would clearly be a basis to proceed to
18 prosecute him for the unlawful killing of Mr Dutfield. The
19 submission now being made would be for this Inquiry to
20 refer the matter to the ODPP, the Office of the Director of
21 Public Prosecutions, with a view to that office initiating
22 such a prosecution under its guidelines.

23
24 In view of Mr Ashworth's death, it's not now possible
25 for him to answer such an allegation. The question
26 remains, in my submission, for this Inquiry as to whether,
27 notwithstanding Mr Ashworth's death and the impossibility
28 of him answering such an allegation, the Inquiry can
29 proceed to make a positive finding that he was responsible
30 for the death.

31
32 At paragraphs 100 to 105 of the submission I set out
33 relatively briefly some of the legal considerations that it
34 is submitted are involved in considering whether such
35 a positive conclusion can be reached, namely, that
36 a particular individual who is deceased is responsible for
37 causing a death.

38
39 Commissioner, you will no doubt be very mindful of the
40 grave nature of the allegation in determining whether or
41 not it is appropriate to make such a finding in the present
42 matter. In my submission, the evidence that could have
43 been adduced in a trial against Mr Ashworth is strong and
44 compelling and is of such a nature that it would be
45 admissible in criminal proceedings. It comprises both
46 a considerable degree of direct evidence implicating
47 Mr Ashworth, strong circumstantial evidence and statements

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

3
4 While it is not possible to conclude with certainty
5 what the outcome of a criminal trial would have been, it is
6 submitted that a finding by this Inquiry in the following
7 terms is open and should be made: that on 19 November
8 1991, at his apartment in Mosman, New South Wales, William
9 Dutfield died as a result of head injuries received after
10 he was struck repeatedly in the head with a metal tape
11 dispenser by Mr Arthur Ashworth. Accordingly, it is
12 further submitted that the death of Mr Dutfield is not
13 unsolved and therefore does not fall within Category A of
14 the Inquiry's Terms of Reference.

15
16 Finally, Commissioner, given that the matter can be
17 considered to have been solved in circumstances where the
18 likely perpetrator is deceased, there are no
19 recommendations that arise.

20
21 THE COMMISSIONER: All right. Thank you. I note your
22 position, Mr Mykkeltvedt. I might take the break now, so
23 I will take the morning break now and we will resume after
24 that. Thank you. I will now adjourn.

25
26 **SHORT ADJOURNMENT**

27
28 THE COMMISSIONER: Yes.

29
30 MR de MARS: Commissioner, the next matter the subject of
31 documentary tender is the matter of David Lloyd-Williams.

32
33 THE COMMISSIONER: Yes, thank you.

34
35 MR de MARS: Can I firstly hand up and tender a one-volume
36 bundle of material. I understand, Commissioner, you may
37 already have a copy, but I will formally hand up that
38 bundle. I understand that could become exhibit 12.

39
40 **EXHIBIT #12 ONE-VOLUME TENDER BUNDLE IN RELATION TO DAVID**
41 **LLOYD-WILLIAMS**

42
43 MR de MARS: Commissioner, I understand you will already
44 have a copy of proposed short minutes of order dealing with
45 non-publication issues and the like, and I ask that those
46 orders be made.

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

3

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

7

8 THE COMMISSIONER: I have, thank you.

9

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

11

12 THE COMMISSIONER: Thank you.

13

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

23

24 THE COMMISSIONER: Thank you.

25

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

34

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

38

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

43

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

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

3
4 If we scroll down just a little, Commissioner, you
5 will see that the finding made, in terms of manner and
6 cause, was that Mr Lloyd-Williams died from multiple
7 injuries received when he cast himself from a cliff with
8 the intention of taking his own life whilst in a state of
9 mental depression.

10
11 Commissioner, the Inquiry's approach to the
12 investigation of this matter had an usual starting point.
13 This is because Strike Force Parrabell had been unable to
14 locate any records at all, including the coronial file.
15 Strike Force Parrabell had been proceeding on the basis of
16 information about the death received by former police Gay
17 Liaison Coordinator Ms Sue Thompson. That information
18 referred to a man whose body was found at a cliff in Manly
19 in 1979. The name given was David Lloyd Williams, not
20 hyphenated, in a manner that Lloyd may have been a middle
21 name.

22
23 The limited information in the spreadsheet also made
24 reference to the body being found naked and with clothes
25 folded.

26
27 I draw your attention, Commissioner, at this point, to
28 the Strike Force Parrabell case summary, which is produced
29 at paragraph 20 of the submission. The body of the Strike
30 Force Parrabell case summary, I think it is worth reading
31 it in full, reads as follows:

32
33 *Identity: the only information available*
34 *is within a spreadsheet prepared by*
35 *a former NSW Police employee indicating*
36 *that David Lloyd Williams was found naked*
37 *at the bottom of a cliff at Manly in 1979.*
38 *The person who provided the information was*
39 *only known as "Dave Davies", who could not*
40 *be located without further details.*
41 *Investigators were unable to locate any*
42 *records relating to this matter despite*
43 *extensive searches including all possible*
44 *dates of birth; dates of death; and/or*
45 *misspelling of names. Database searches*
46 *including: COPS; Ryerson Index; Media*
47 *Archives; Coroner; GRR; Police and State*

1 *Archives were also unsuccessful.*

2

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

7

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

12

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

18

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

26

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

35

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

1 who I will refer to later in the submission.

2
3 The description of the circumstances of death in the
4 certificate which appears at tab 6 of the brief,
5 [SC0I.74028_0001], made it apparent that this was of the
6 death the subject of the information that had been provided
7 to Ms Thompson and subsequently included in the Strike
8 Force Parrabell matters. That seems plain enough by virtue
9 of reference to the location of the death, the timing and
10 more generally the name.

11
12 Following receipt of the death certificate, the
13 Inquiry requested any coronial file related to the death.
14 The Coroners Court provided a file that consisted of 22
15 pages of material, including a number of witness
16 statements, post-mortem and toxicology reports and a very
17 brief record of the inquest proceedings that took place on
18 23 October 1978.

19
20 On 26 August 2022, the Inquiry issued a summons to
21 NSW Police that sought all documents relating to
22 investigations by them of the death of Mr Lloyd-Williams,
23 using the details of his name and dates of birth and death
24 as appeared in the death certificate - that is, of course,
25 with the hyphenated surname.

26
27 The legal representative for NSW Police replied by
28 email dated 9 September 2022 advising that the only
29 information or holdings of NSW Police in relation to the
30 matter were the Strike Force Parrabell case summary and the
31 Bias Crimes Indicators Form, and that any further
32 information or holdings could not be identified.

33
34 Commissioner, this is notwithstanding that the
35 coronial file produced to the Inquiry contains various
36 statements and documentation produced by NSW Police at the
37 time of Mr Lloyd-Williams' death. No explanation has been
38 provided to the Inquiry as to what may have happened to the
39 relevant NSW Police investigation file.

40
41 On 28 September 2022, the Inquiry issued a summons to
42 the New South Wales Health Pathology Department of Forensic
43 Medicine seeking all records held by the department
44 relevant to the autopsy of Mr Lloyd-Williams. On
45 11 October 2022 the department produced an electronic file.
46 This consisted of 12 pages of documents comprising copies
47 of the post-mortem report and report of death to the

1 Coroner, the blood alcohol test results and the formal
2 order for the autopsy. It did not provide any evidence of
3 substance not otherwise contained in the coronial file.
4

5 Through a statement in the Inquiry's holdings related
6 to another matter, the Inquiry was able to identify that
7 the Dave Davies referred to in Ms Thompson's spreadsheet as
8 the source of her information was likely to have been the
9 Honourable Justice David Davies, a justice of the Supreme
10 Court of New South Wales. Justice Davies was contacted and
11 was able to provide the details of another friend of
12 Mr Lloyd-Williams, Dr Neil McEwan, whom Justice Davies
13 thought may have been able to provide greater information
14 concerning Mr Lloyd-Williams.
15

16 A meeting was thereafter held with Dr McEwan, who
17 provided the Inquiry with some additional information
18 concerning Mr Lloyd-Williams.
19

20 The relevant information obtained from
21 Mr Lloyd-Williams' friends is commented on later in the
22 submission.
23

24 As I've already indicated, in the course of its work,
25 the Inquiry also made contact with Mr Lloyd-Williams'
26 sister, with whom he had contact around the time of his
27 death, and his daughter, who was an infant at that time.
28

29 By letter dated 19 December 2022, an expert opinion
30 was sought from forensic pathologist Dr Linda Iles, the
31 head of Forensic Pathology Services at the Victorian
32 Institute of Forensic Medicine.
33

34 Dr Iles was asked to address a number of matters.
35 These included the adequacy of the post-mortem
36 investigations conducted with respect to Mr Lloyd-Williams;
37 her view as to the medical cause of Mr Lloyd-Williams'
38 death, including any reasons why she might take a different
39 view to that formed originally by Dr Higgins; her view as
40 to whether Mr Lloyd-Williams' injuries were consistent with
41 misadventure, suicide or foul play; and any recommendations
42 for investigations with respect to determining the manner
43 or cause of Mr Lloyd-Williams' death.
44

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

1
2 The Inquiry also conducted searches in an effort to
3 determine whether there were any media articles relating to
4 the death of Mr Lloyd-Williams. Two articles were found in
5 The Manly Daily newspaper dated 25 and 26 August 1978.
6 Commissioner, they appear at tab 25 [SC0I.82319_0001] and
7 tab 26 [SC0I.82317_0001] of the bundle, exhibit 12.
8

9 I now go to key matters arising from the Inquiry's
10 consideration of the evidence that has been obtained.
11 Firstly, in relation to Mr Lloyd-Williams' background,
12 I start by observing that on the afternoon of his death,
13 Mr Lloyd-Williams' body was identified by a friend and work
14 colleague, a Mr Herbert Russell. That man provided
15 a statement that was tendered at the inquest. He explained
16 that he had worked with Mr Lloyd-Williams for five or six
17 years at the ABC, then known as the Australian Broadcasting
18 Commission, where Mr Russell was a concert manager. In the
19 "Report of Death to Coroner", Mr Lloyd-Williams was also
20 described as a manager with the ABC, and in the death
21 certificate I observe that he was described as a concert
22 manager.
23

24 According to his death certificate, Mr Lloyd-Williams
25 was born in Barnehurst in England and had been living in
26 Australia for seven years at the time of his death.
27 Information received from Mr Lloyd-Williams' friend
28 Dr McEwan is consistent with this. Dr McEwan had shared
29 a flat with Mr Lloyd-Williams prior to Mr Lloyd-Williams'
30 marriage. They had a mutual interest in music and
31 Dr McEwan had first met Mr Lloyd-Williams when
32 Mr Lloyd-Williams had auditioned for a church choir in
33 Mosman. Mr Lloyd-Williams' interest in music appears to be
34 consistent with the nature of his work at the ABC.
35

36 The evidence generally, Commissioner, does not suggest
37 that Mr Lloyd-Williams was a member of the LGBTIQ
38 community. Until a number of months prior to his death he
39 had been in a heterosexual marriage as a result of which he
40 had a young daughter, and his friend Dr McEwan did not
41 understand him to be gay.
42

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

1 tab 10 [SC0I.73571.00016_0001] of the bundle, exhibit 12.
2 Dr Hoult was treating Mr Lloyd-Williams at the time of his
3 death. The report clearly implies that Mr Lloyd-Williams
4 had spent time as an inpatient at North Ryde Psychiatric
5 Centre.
6

7 Dr Hoult was asked to see Mr Lloyd-Williams on
8 16 August 1978, eight days prior to his death, due to
9 reports from the centre's social worker that while at home,
10 Mr Lloyd-Williams had been staying in his room all day, not
11 answering the door and not attending work.
12

13 This is consistent with observations made in a
14 statement by Mr Lloyd-Williams' sister at tab 7,
15 [SC0I.73571.00011_0001] of exhibit 12. His sister states
16 that she had seen her brother two days prior to his death
17 when she had gone to his flat to make sure that he was
18 going to keep an appointment that he had with the welfare
19 officer at the ABC at 10.30am that day. She indicates that
20 he seemed to be in a very depressed state. She stayed with
21 him for some time before she had to leave. She made
22 contact with Mr Lloyd-Williams' mother-in-law to see if she
23 could come over and talk with him.
24

25 More generally, his sister observed that her brother
26 had always been in good health and spirits, but that this
27 had changed in April 1978. His wife left him at that time
28 and, according to his sister, he had seemed to go downhill
29 quickly, with fits of depression, and he seemed to get
30 worse over the last three weeks of his life.
31

32 In his statement, Mr Russell, the friend and work
33 colleague, said that six months prior to his death, he
34 noticed that Mr Lloyd-Williams was going through what he
35 describes as fits of depression caused by marital problems,
36 and that he had last seen Mr Lloyd-Williams three weeks
37 prior to his death at which time he did not seem to be
38 himself, as he was restless and agitated.
39

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

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

3
4 Over the two days and nights prior to his death, he
5 had been staying at the house of his parents-in-law but had
6 remained agitated.

7
8 At the appointment with Dr Hoult on 16 August at North
9 Ryde Psychiatric Centre, Mr Lloyd-Williams had told the
10 psychiatrist that he was feeling very depressed and that he
11 no longer felt he had anything to live for since his wife
12 had left him. He was having difficulty getting to sleep
13 and had lost his appetite. He told Dr Hoult that he had
14 recently seriously considered suicide, but that he was now
15 past this.

16
17 Dr Hoult was of the view that Mr Lloyd-Williams was
18 suffering a depressive neurosis as a result of his marriage
19 breakup. He prescribed an anti-depressant to last three
20 days and made a further appointment for two days time, on
21 18 August 1978, which Mr Lloyd-Williams did not keep.
22 Dr Hoult reported that his mother-in-law had then brought
23 Mr Lloyd-Williams to see him on 21 August 1978, five days
24 after the initial consultation and three days before his
25 death.

26
27 His mother-in-law reported being concerned that
28 Mr Lloyd-Williams was remaining in his room and not
29 adequately caring for himself. I reproduce the conclusion
30 of that report at paragraph 46 of the submission, the
31 report itself is at tab 10 [SC0I.73571.00016_0001]. The
32 report concludes as follows:

33
34 *It was agreed that he should not stay alone*
35 *and he consented to go and stay with his*
36 *mother-in-law ... I prescribed increased*
37 *quantities of Nortriptyline but requested*
38 *that [his mother-in-law] control the*
39 *medication and dispense each dose to*
40 *Mr Lloyd-Williams.*

41
42 The need for hospitalisation was considered but
43 Mr Lloyd-Williams was opposed to it and there were
44 insufficient grounds for compulsory admission. An
45 appointment was made to see Mr Lloyd-Williams on Friday,
46 25 August.

1 Commissioner, I now move to what the evidences tells
2 us, in my submission, about events on the day of the death.
3 As already noted and consistent with Dr Hoult's advice to
4 Mr Lloyd-Williams that he should stay with his
5 mother-in-law, Mr Lloyd-Williams stayed at the house of his
6 parents-in-law over the two days preceding his death.
7

8 In her statement, his mother-in-law said that she made
9 Mr Lloyd-Williams breakfast at about 8.30am on the morning
10 of his death. She stated that he seemed to be feeling
11 better and that he told her that he was going home to clean
12 up his flat and that he would phone her to arrange a time
13 to come over to her place to have lunch. She did not
14 subsequently hear from him and her statement recounts her
15 subsequent efforts to contact and locate Mr Lloyd-Williams
16 to no avail.
17

18 At 11.45am, a man by the name of Robert Steele was
19 standing at the edge of a cliff at North Head and observed
20 a body on the rocks below and waves crashing over the body.
21 It would appear that Mr Steele was on a work break at the
22 time as in his statement he describes then calling his base
23 over a two-way radio and asking for the police to be
24 informed. Mr Steele remained at the location in order to
25 show the police where the body was before returning to
26 work.
27

28 In an article that appeared in The Manly Daily the
29 following day, Mr Steele is quoted in similar terms to his
30 statement. He adds that he was looking for a fishing spot
31 when he observed the body.
32

33 The officer in charge of the investigation of the
34 death was Constable John Mortimer. In his statement, he
35 reported having attended the location at 3.30pm. By this
36 stage, other police were already in attendance and the body
37 of Mr Lloyd-Williams had been recovered by the Police
38 Rescue Squad and conveyed to Manly District Hospital.
39

40 Commissioner, the basis for the inclusion of the death
41 in the Strike Force Parrabell matters appears to have been
42 the suggestion that it occurred in an area that was or was
43 proximate to a known beat, and also the assertion that his
44 body was found naked and his clothes left folded.
45

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

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

8
9 There is also some evidence that attacks on men who
10 were using the area as a beat may have occurred during this
11 period.

12
13 North Head covers a large expanse and the area best
14 known as an area of beat activity is, however,
15 a considerable distance from the location where
16 Mr Lloyd-Williams was found.

17
18 At this point, Commissioner, I note there is a map
19 attached to the submission itself, and I understand it is
20 possible to have that put on screen, and I have asked for
21 that to be done.

22
23 Commissioner, the officer in charge described the
24 cliff location as at the south eastern point of North Head
25 and that the base of the cliff from which the body was
26 recovered was about 300 feet or roughly 90 metres below the
27 top. He described seeing a white Volkswagen station sedan
28 parked at the southern end of Scenic Drive. Whilst his
29 statement does not explicitly state that this was
30 identified as the car of Mr Lloyd-Williams, it appears to
31 imply this. Further, The Manly Daily article that I have
32 already referred to states that a car owned by a Mosman man
33 was found at the top of the cliff and that the keys were in
34 the ignition.

35
36 Although there is no diagram of the location in the
37 Coroners Court documentation, the description of the car
38 being at the southern end of Scenic Drive and the cliff
39 being at the south eastern point of North Head is
40 sufficient to establish in general terms the area of North
41 Head where the car and body were located. Consequently,
42 Commissioner, the map that you see now displayed on the
43 screen has been prepared on that basis. In addition to the
44 description of the south eastern point, that location would
45 seem to be consistent with the reference to the end of
46 Scenic Drive, that being proximate to the south eastern
47 point of North Head.

1
2 Commissioner, the evidence that I have referred to in
3 relation to at least what might be described as the
4 well-known beat area of North Head is an area that is
5 considerably to the north, and the evidence of the two
6 gentlemen that I have referred to describes access to that
7 location being gained by the car park above Shelly Beach.
8 I'm not sure how easy it is to see, but Shelly Beach is at
9 the northern extreme of that map and indeed there is
10 a reference to Shelly Beach car park. The evidence
11 otherwise of those men describes an area, it would seem,
12 that certainly goes no further south than, at the very
13 least, Bluefish Drive that one sees about a third of the
14 way down from the top of that map.

15
16 In relation to the suggestion that the body was naked
17 and the clothes left folded, the available material from
18 the coronial file is silent in relation to any clothing
19 worn by Mr Lloyd-Williams at the time of his death. There
20 is nothing in the coronial file that suggests that
21 Mr Lloyd-Williams' clothing was located at the top of the
22 cliff. Although the extent of investigative material is
23 limited, this may be because the circumstances of the death
24 were assumed at the time to be quite clear, namely, an
25 assumption of suicide, an assumption that ultimately, it is
26 suggested, was borne out once further evidence gathering
27 revealed the severity of Mr Lloyd-Williams' depression.

28
29 Despite the relatively limited nature of the material,
30 it would seem likely, in my submission, that had the body
31 of Mr Lloyd-Williams been naked and his clothing left
32 folded at the top of the cliff, this would have been
33 a distinctive and unusual feature that would have made its
34 way into the statement of the OIC and/or the report of the
35 death to the Coroner.

36
37 Commissioner, it remains relevant, then, to consider
38 the reliability of the information provided many years
39 later to Ms Thompson suggesting that the body was naked and
40 clothes were left at the top of the cliff. Relevant facts
41 are set out in a statement made by the Inquiry solicitor
42 with carriage of this matter, Caitlin Healey-Nash, which
43 appears at tab 24 of the brief, [SCOI.82364_0001].

44
45 As that statement sets out, Justice Davies had been
46 a mutual friend of both Mr Lloyd-Williams and Dr McEwan
47 based on the shared interest of the three men in church

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

8
9 Dr McEwan indicated, when meeting with Inquiry staff,
10 that although he had had an understanding for some time
11 that Mr Lloyd-Williams' clothes were found folded in a neat
12 pile, he did not know when or from whom he had heard this
13 account.

14
15 Further inquiries made by this Inquiry with
16 Ms Thompson indicate that her recollection is that the
17 matters attributed by her to Justice Davies had been passed
18 on to her by relatives of another man whose body had been
19 found at the base of a cliff at North Head. In the end, it
20 is submitted that it is not clear how it came to be that
21 Justice Davies and Dr McEwan had the understanding that
22 they did about these circumstances. It is possible that
23 whatever was said to them at some time and whatever they
24 subsequently said to others has become confused with the
25 reported circumstances of another death at North Head where
26 such circumstances - that is, a naked body and folded
27 clothes - did exist.

28
29 It is submitted that little weight can be afforded to
30 the hearsay suggestion first recorded, it seems, some 35
31 years after the death, that the body was naked and the
32 clothes folded, in view of the lack of clarity of the basis
33 for this suggestion and the likelihood that, if such were
34 the case, it would have been noted in the materials
35 provided by police to the Coroner or in the post-mortem
36 report.

37
38 Commissioner, I now move to the final significant
39 piece of evidence, the review by the forensic pathologist
40 Dr Iles, that has been obtained by the Inquiry.

41
42 Dr Iles was of the view that a reasonable statement of
43 the cause of Mr Lloyd-Williams' death is multiple injuries
44 sustained in a fall from height. She notes that this is
45 not materially different to that arrived at by Dr Higgins
46 back in 1978. Dr Iles opines in effect that the forensic
47 pathology alone cannot determine whether the death may have

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

7
8 The circumstances as described in the materials
9 available suggest that suicide was most likely. Dr Iles
10 was of the view that there were no further medical
11 investigations that would help to determine the manner of
12 Mr Lloyd-Williams' death.

13
14 Commissioner, before coming to some of the conclusions
15 that it is suggested you might reach in this matter, it is
16 pertinent to make the following observations about the
17 course of the investigation by police prior to the matter
18 being considered by the Inquiry. The first observation
19 I make is that the precise location from which
20 Mr Lloyd-Williams fell does not appear to have been well
21 documented, nor is there any evidence indicating that that
22 area was searched. If these matters were addressed at the
23 time, either no records were made of them or such records
24 no longer appear to exist.

25
26 Potentially significant matters, such as
27 Mr Lloyd-Williams' ownership of the motor vehicle located
28 near the cliff area from which he fell and the fact that
29 his keys remained in the ignition of the car, are derived
30 from a newspaper article found by the Inquiry and do not
31 appear in the police material. Nor are there photographs
32 of the area in that material. The only photograph of the
33 relevant area appears in the newspaper article and is of
34 limited assistance.

35
36 It is also submitted that the efforts of Strike Force
37 Parrabell to identify the circumstances of the death could
38 have been more thorough. While an officer working on the
39 strike force did make contact by email with Ms Thompson in
40 an attempt to find out more concerning the source of her
41 information - that's at tab 15 of exhibit 12,
42 [SCOI.82174_0001], it's submitted that more could have been
43 done in this respect and to ensure that alternative
44 rendering of the name David Lloyd-Williams were the subject
45 of searches.

46
47 As to the conclusions that it is suggested can be

1 drawn from the evidence, Commissioner, these are set out at
2 paragraph 64 and following. It is submitted that the
3 evidence clearly and consistently demonstrates that
4 Mr Lloyd-Williams was suffering from severe depression at
5 the time of his death. This is clear from all of the
6 witnesses who had contact with him in the weeks and days
7 prior, including his psychiatrist.
8

9 He had people around him, including his sister and
10 mother-in-law, who were clearly very caring and were
11 seeking to help Mr Lloyd-Williams, as his condition
12 appeared to worsen in the days leading up to his death.
13 The severity of his condition is reinforced by his
14 indication to his psychiatrist that he had been
15 contemplating suicide; his prior admission to an inpatient
16 facility; the psychiatrist's suggestion that he admit
17 himself as an inpatient; and the psychiatrist's requirement
18 that he stay with his mother-in-law and that he not be
19 permitted to administer his medication to himself.
20

21 The particular location at North Head that
22 Mr Lloyd-Williams drove to and the fact that he left his
23 keys in his car ignition, in my submission, also appear to
24 be consistent with an act of suicide.
25

26 Sadly, the evidence overwhelmingly, in my submission,
27 supports the proposition that on the morning of 24 August
28 1978, whilst suffering from deep depression,
29 Mr Lloyd-Williams travelled in his car from Mosman to North
30 Head at Manly where he deliberately ended his life by
31 jumping from a cliff at the south eastern end of North
32 Head.
33

34 In view of the conclusion reached as to the
35 circumstances of Mr Lloyd-Williams' death, it is submitted
36 that this is not a death that was motivated by LGBTIQ hate
37 bias.
38

39 In terms of a formal finding, it is suggested that an
40 appropriate finding would be that Mr Lloyd-Williams died on
41 24 August 1978 of multiple injuries after deliberately
42 jumping from a cliff at North Head in Manly. At the time
43 of his death, Mr Lloyd-Williams was suffering from severe
44 depression.
45

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

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

7
8 Finally, Commissioner, based on those submissions and
9 at this point, there is no suggestion that there are
10 recommendations. Thank you.

11
12 THE COMMISSIONER: Yes, thank you. Yes, Mr de Mars, if
13 you wish to move to the next matter, unless Mr Mykkeltvedt
14 has anything to say. I imagine you will reserve your
15 position.

16
17 THE COMMISSIONER: Thank you.

18
19 MR de MARS: Commissioner I am advised that because there
20 is a desire for some family members to be present, we may
21 need a very short break.

22
23 THE COMMISSIONER: Do you want me to adjourn until 2?

24
25 MR de MARS: I am in your hands, Commissioner, as to how
26 long. We don't necessarily need a long break.

27
28 THE COMMISSIONER: Oh, well, what about if I just go off
29 the Bench and you tell me when you are ready, and if that
30 happens to be a reasonable time before 2, we will start.
31 I will adjourn for a short time. Just keep me informed.
32 Thank you.

33
34 **SHORT ADJOURNMENT**

35
36 THE COMMISSIONER: Yes.

37
38 MR de MARS: Commissioner, the next matter is the matter
39 of Andrew Currie. Can I, firstly, hand up and tender
40 a bundle of material that has been prepared. The
41 appropriate number will be exhibit 13.

42
43 **EXHIBIT #13 ONE-VOLUME TENDER BUNDLE IN RELATION TO ANDREW**
44 **CURRIE**

45
46 MR de MARS: Additionally, Commissioner, in this matter -
47 I will come to this in a moment - some of Mr Currie's

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

4
5 THE COMMISSIONER: Thank you.

6
7 **EXHIBIT #14 FAMILY STATEMENT IN RELATION TO ANDREW CURRIE**

8
9 MR de MARS: Commissioner, in this matter again you should
10 have a copy of a proposed minute of order relating to any
11 relevant non-publication related matters, and I ask that
12 that order be made.

13
14 THE COMMISSIONER: Yes. I have had a look, thank you, and
15 I will make that order, thank you.

16
17 MR de MARS: Again you should have a copy of written
18 submissions that have been prepared and I adopt and rely
19 upon those submissions.

20
21 THE COMMISSIONER: Thank you.

22
23 MR de MARS: I have already mentioned that members of
24 Mr Currie's family are present. Without naming them all,
25 can I observe that that includes Andrew Currie's brother,
26 Graeme Currie. The Inquiry has been very appreciative of
27 the contact that they have had with the family and the
28 assistance they've been able to provide, and I pass on the
29 condolences of the Inquiry for their loss.

30
31 THE COMMISSIONER: Yes, thank you.

32
33 MR de MARS: Mr Currie died at some time between 11pm on
34 12 December 1988 and 7.15am on 13 December 1988 at a toilet
35 block in Nolan Reserve in the suburb of North Manly in
36 Sydney. Mr Currie was 29 years old and unfortunately had
37 a longstanding addiction to prescription medications and
38 other substances.

39
40 During the course of the day leading up to his death,
41 it is apparent that he had taken excessive quantities of
42 a restrictive prescription medication called Nembudeine.

43
44 His death was the subject of a police investigation at
45 the time. We know this based on the file that has been
46 produced to the Inquiry by the Coroners Court.

47

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

5
6 A few days after the death, on 17 December 1988, an
7 autopsy was conducted by Dr William Brighton. Dr Brighton
8 noted, and this appears at paragraph 4 of the written
9 submission, that there was no significant injury on the
10 body. He noted two areas of dry brown abrasion in the
11 forehead and temple regions that were consistent with
12 pressure at around the time of death, and some slight
13 reddening over the nose in the mid forehead region. There
14 were no internal injuries. Mr Currie's body was noted to
15 be in an unkempt state with much soiling to his feet.
16 There was dark brown to dark green material around his
17 nostrils that appeared to have been regurgitated.

18
19 In Dr Brighton's opinion, the direct cause of death
20 was poisoning by a combination of pentobarbitone, codeine,
21 methadone and morphine.

22
23 Commissioner, no coronial inquest was held. The
24 coronial records indicate that an inquest was dispensed
25 with immediately following receipt by the Coroner of the
26 autopsy and toxicology reports in February 1989. While the
27 reason for dispensing with an inquest is not recorded on
28 the file, the decision to dispense with an inquest
29 indicates that it did not appear to the Coroner that
30 Mr Currie had died or may have died as a result of
31 homicide. That's consistent with the terms of the Coroners
32 Act then in existence and consistent with provisions that
33 currently exist.

34
35 His death certificate dated 5 January 1989, which
36 appears at tab 7 [SC0I.73948_0001] recorded the cause of
37 death as poisoning by combination of the four drugs
38 identified in the report of Dr Brighton.

39
40 Before turning to the Inquiry's consideration of the
41 matter, it is appropriate to make some observations about
42 the approach to the matter by Strike Force Parrabell and
43 any particular indicators of LGBTIQ status or bias.

44
45 Mr Currie's closest surviving relative, his brother
46 Graeme, has no particular knowledge of Mr Currie's
47 sexuality and believed him to be heterosexual. Mr Currie's

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

9
10 The particular area in question is not a location
11 where, to the Inquiry's knowledge, there are recorded
12 instances of such attacks. However, as noted in the Strike
13 Force Parrabell Bias Crimes Indicators Review Form for this
14 matter, records for the period prior to 1992 do not allow a
15 ready identification of criminal acts via the relevant
16 police data system, the COPS system. The possibility of
17 such attacks, therefore, cannot be ruled out.

18
19 It is relevant to observe that the location was also
20 one at which Mr Currie and his friend and fellow drug user
21 at the time, a man who I will refer to by the initials
22 "GB", would meet on occasion.

23
24 This information appears in a police occurrence entry
25 made at the time of the death. In the statement made by
26 the officer in charge, he refers to the toilet areas around
27 District Park, which encompassed Nolan Reserve, as being
28 a regular meeting place for Mr Currie and GB to meet and
29 use drugs. It's also noted that the park and toilet block
30 were on the walking route home from Mr Currie's last known
31 location.

32
33 Commissioner, consistent with the nature of Strike
34 Force Parrabell's consideration of matters generally,
35 relevant assessments were made by that strike force in the
36 absence of contact with Mr Currie's family and any
37 particular information concerning his sexuality.

38
39 The "General Comments" section at page 6 of the form
40 refers to 15 colour photographs of Mr Currie and of the
41 scene having been viewed. This may be cause for concern
42 about the accuracy of matters recorded in the form, as
43 there appear to be only seven such photographs in
44 existence. I will return to the question of the crime
45 scene photographs and the numbers of them later.

46
47 In section 4 of the form, headed "Organised Hate

1 Groups (OHG)", it is stated that there is no indications
2 that an OHG was involved or active in the Manly area at the
3 time of Mr Currie's death.
4

5 As I have already alluded to, however, on occasions,
6 it is known that gay men were the target of attacks by
7 youths in certain parts of the Northern Beaches in the late
8 1980s, including the Manly area, often with the motive of
9 robbery.
10

11 Although known to NSW Police at the time of Strike
12 Force Parrabell, the existence of such attacks is not the
13 subject of comment in the form. It may be that such
14 attacks did not come within what was contemplated by police
15 as constituting an OHG. If they did not, it may suggest
16 a deficiency in the methodology behind the Bias Crimes
17 Indicators Form.
18

19 The "Summary" section of that form concludes that,
20 taking into consideration the state of Mr Currie's body,
21 his ingestion of a large quantity of Nembudeine and the
22 examination of the scene, there was no evidence that any
23 other person played a role in relation to his ingestion of
24 drugs leading to his death nor that his death had been
25 motivated by bias.
26

27 Commissioner, to complete the picture, I note that the
28 Strike Force Parrabell case summary, number 37, for this
29 matter is set out at paragraph 23 of the written
30 submission. It is in similar terms to the conclusion that
31 was reached in the Bias Crimes Indicators Form and
32 concluded that there was no evidence of a bias crime.
33

34 The relevant notation in the academic review in the
35 case summary also states "No bias".
36

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

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

3
4 As I have indicated, the Inquiry was able to make
5 contact with Graeme Currie, Mr Currie's younger brother,
6 who was living at the family home, at the time of Andrew
7 Currie's death, and also with their mother. Sadly,
8 Mr Currie's mother passed away some years ago, but as
9 I have already referred to, Graeme Currie has been very
10 helpful to the Inquiry by meeting with us and discussing
11 any knowledge he has of the circumstances of his brother's
12 death.

13
14 To add some detail to the steps that have been taken
15 by the Inquiry, I note that the matter was the subject of
16 the Inquiry's first summons to police in May 2022 seeking
17 all relevant police investigative material. No
18 investigative file for Mr Currie's death was produced to
19 the Inquiry in response to this summons. However, on
20 12 August 2022, the NSW Police Force produced to the
21 Inquiry its Strike Force Parrabell e@gle.i brief. This
22 included eight documents relating to Mr Currie's death.

23
24 In addition, on 16 September 2022, NSW Police produced
25 a further document to the Inquiry, which was an
26 investigator's note dated 13 October 2016, as part of its
27 response to a further summons.

28
29 Another summons was issued on 26 September 2022
30 seeking 15 colour crime scene photos purportedly taken on
31 the day that Mr Currie's body was found. This came about
32 because the Strike Force Parrabell Bias Crimes Indicators
33 Form and relevant investigator's note that had been
34 produced to the Inquiry both made reference to 15 colour
35 crime scene photos of Mr Currie's body, which were said to
36 have been viewed by Strike Force Parrabell investigators.
37 These were said to have been provided to the strike force
38 by the original officer in charge of the matter.

39
40 It was a surprise to the Inquiry to hear that there
41 were 15 such photos, as only seven such photos had been
42 produced to it. By email dated 6 October 2022, the legal
43 representative for NSW Police advised that it appeared that
44 there were only seven such photographs, despite the
45 reference to 15 photos.

46
47 In order to understand why there had been no

1 production of the material in relation to Mr Currie's death
2 in response to the first summons, yet there had been
3 material later produced in connection with the NSW Police
4 Force e@gle.i brief and a subsequent summons, and to seek
5 further clarification concerning the number of crime scene
6 photos, on 10 October 2022, the Inquiry wrote to the legal
7 representative of the NSW Police asking for a letter or
8 statement addressing those matters.
9

10 The response from NSW Police is set out in detail at
11 paragraph 34 of the submission. In essence, it disclosed
12 that whilst searches had been undertaken, they had not
13 identified any hard copy material held by police associated
14 with the death of Mr Currie. The letter indicated that
15 further inquiries were being made to seek to resolve the
16 anomaly concerning the purported number of photos at the
17 crime scene, but that it appeared that only seven photos
18 had been received by Strike Force Parrabell, despite
19 documentation relating to the strike force indicating there
20 were 15 photos.
21

22 Having not received any further response from
23 NSW Police concerning the discrepancy, the Inquiry again
24 followed the matter up with NSW Police on 16 December 2022.
25 Detail in relation to that is contained in paragraph 35 of
26 the written submission. The Inquiry received a response
27 that, having followed the matter up with the original
28 officer in charge of the investigation, the officer was
29 unable to locate any record of how many crime scene photos
30 were taken and indicated that he would have provided all
31 photos in his possession to the strike force. These
32 matters have been set out in some detail in the written
33 submission in order to demonstrate that the Inquiry has
34 endeavoured to ensure that all information relating to the
35 past investigation of the matter has been produced to it.
36

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

1 documents are both erroneous.

2
3 One might expect there would have been additional
4 notes and potentially other investigative material produced
5 during the initial police investigation, for example,
6 detectives from Manly Police Station attended the scene, as
7 did police scientific officers in order to take photos, yet
8 no statements or notes, running sheets or occurrence pad
9 entries indicating the nature of work of these officers
10 have been produced.

11
12 Contact was also made with the Department of Forensic
13 Medicine of New South Wales Health Pathology in order to
14 ascertain whether they held, separately to police, any
15 photos or other records relating to the autopsy performed
16 on Mr Currie. This was done in order to provide potential
17 assistance to the expert forensic pathologist who was
18 briefed by the Inquiry to provide an opinion.

19
20 In response, the Inquiry received 23 pages of notes
21 from the Department of Forensic Medicine. These consisted
22 of the autopsy and toxicology reports and other
23 documentation related to the autopsy but did not shed any
24 further light on the death beyond the contents of the
25 autopsy and toxicology reports, nor did they include any
26 photos.

27
28 Finally, Commissioner, in relation to steps taken by
29 the Inquiry, at paragraphs 41 and 42 of the submission the
30 terms of the opinions sought from the two experts, the
31 toxicologist, Professor Alison Jones, and the forensic
32 pathologist, Dr Iles, are set out.

33
34 THE COMMISSIONER: Is that a convenient point?

35
36 MR de MARS: Yes, it is, thank you, Commissioner.

37
38 THE COMMISSIONER: All right. We will adjourn until
39 2 o'clock, thank you.

40
41 **LUNCHEON ADJOURNMENT**

42
43 THE COMMISSIONER: Yes.

44
45 MR de MARS: Commissioner, in relation to the present
46 matter, the matter of Andrew Currie, before the break I was
47 outlining steps that have been taken by the Inquiry in

1 order to consider this matter.

2
3 I now set out key matters arising from the Inquiry's
4 consideration of the evidence and the conclusions that it
5 is suggested can be drawn from it.

6
7 Firstly, some observations in relation to Andrew
8 Currie's background. Mr Currie was 29 years old when he
9 died and as I have already referred to, he lived at home
10 with his mother and younger brother. This was in Waine
11 Street in the suburb of Harbord, now known as the suburb of
12 Freshwater.

13
14 Unfortunately, he appears to have had a longstanding
15 and entrenched drug use problem, as a result of which he
16 was known to Manly police. A fact sheet related to some
17 minor offending with which Mr Currie was charged on
18 14 October 1988, two months prior to his death, describes
19 his interaction while drug affected with police after being
20 found in possession of a bottle of a prescribed restricted
21 drug. I wonder if tab 12 [SCOI.00016.00022_0001] could be
22 brought up on screen.

23
24 Commissioner, this is the relevant fact sheet. In
25 part, you will see that the fact sheet reads as follows -
26 and I'm looking here at the second full paragraph:

27
28 *The defendant is well known for this type*
29 *of offence, and, is a person who can often*
30 *be found in the Manly and surrounding*
31 *environs in an overdosed state by utilising*
32 *drugs of this type. The Defendant comes*
33 *from a good family background and has*
34 *a caring Mother, who, in the past has*
35 *expressed deep concern for the welfare of*
36 *this defendant.*

37
38 And then if we could just move down to the next page,
39 Commissioner, this is fully extracted at paragraph 50 of
40 the submission but you will see it goes on and explains, or
41 sets out:

42
43 *The Courts and the Police in the Manly*
44 *area, have, over the years attempted, on*
45 *numerous occasions, to guide this defendant*
46 *away from this type of offence ...*

1 There is also the observation:

2

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

6

7 And then the observation later on:

8

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

14

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

21

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

30

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

35

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

40

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

44

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

1 refers to as "grass" to the occasional use of heroin, but
2 that it was mainly Nembudeine, which he refers to as "the
3 N's", that he would use quite frequently every day or every
4 second day, although he stated that Mr Currie had, in his
5 words, "cut back in the last few years".
6

7 GB told police that he last saw Mr Currie between 10
8 and 11pm the previous night - that is, on 12 December 1988.
9 According to GB, Mr Currie had come to his place at around
10 8.30pm and they spoke for a while and had a cuppa. He
11 described Mr Currie as appearing to be under the influence
12 of a drug, that he was very slow and had slurred speech.
13 Mr Currie told him that he had taken 25 Nembudeine tablets
14 that morning and during the day. He told GB that he had no
15 tablets left, however, GB says that he patted Mr Currie's
16 pockets and heard a rattle, suggesting to GB that Mr Currie
17 had tablets on him.
18

19 Mr Currie then told GB that he had three tablets on
20 him, although GB thought that by the sound of the rattle he
21 would have been in possession of a greater number of
22 tablets. Mr Currie offered to show him, but GB says that
23 he told him not to worry.
24

25 GB further recounted that when Mr Currie was leaving,
26 evidently it must have appeared to GB to go home, he asked
27 GB to phone him, presumably meaning in the morning.
28 However, GB told him that rather than him phoning
29 Mr Currie, Mr Currie should get his brother to wake him up.
30 He suggested that Mr Currie come back to his place at 8.30
31 the following morning.
32

33 The police occurrence pad entry made by the officer in
34 charge, which is at tab 10 [SCOI.00016.00020_0001]
35 indicates that Mr Currie's mother became concerned that he
36 had not returned home, and it appears from what follows
37 that early the following morning she must have contacted GB
38 to enlist his help in locating Mr Currie.
39

40 Commissioner, there is a map attached to the written
41 submission, and at this point I would ask for that map to
42 be brought up on screen. I will come to that in a moment.
43

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

1 was found. He says he checked a toilet block next to
2 a bowling club, then went to the toilet block in which he
3 found Mr Currie.
4

5 Just to attempt to orientate those matters by way of
6 the map, Commissioner, we can see what is effectively
7 a creek or inlet, a water inlet, running through the middle
8 of the map, and it divides two green areas, Nolan Reserve
9 and Passmore Reserve. You will see just under Passmore
10 Reserve, Campbell Parade. That's the location where GB
11 indicated he was dropped off and then commenced to check
12 relevant toilet blocks, the first of which he said was near
13 a bowling club and the second of which was in Nolan
14 Reserve, where the body was found.
15

16 It is also relevant to point out by reference to the
17 map at this point the relevant locations of Mr Currie's
18 house on the one hand and GB's, bearing in mind the
19 evidence of GB that the evening before, Mr Currie was at
20 GB's house, and it would appear was then thereafter
21 en route home, and one can see by reference to the map how
22 relevant areas, including Nolan Reserve, do indeed appear
23 to fall within the walking route that might be taken
24 between those two locations.
25

26 When GB found Mr Currie, Mr Currie was face down in a
27 small amount of water on the ground. He turned Mr Currie
28 over and checked for a pulse. He describes Mr Currie's
29 skin as cold and clammy. When turning him over, he noticed
30 what he thought was mud on Mr Currie's face. He
31 subsequently returned to Mrs Currie in her car after taking
32 some time, it appears, to compose himself before breaking
33 the news to her. The matter was then reported by them to
34 Manly Police Station.
35

36 I turn then to forensic and crime scene evidence.
37 Police attended the toilet block after GB reported the
38 death to them at 7.55am on 13 December. The OIC attended
39 the location with GB. At this stage, Mr Currie's body was
40 face up, having earlier been turned over by GB. He's
41 described as wearing blue jeans, a brown woollen jumper,
42 a yellow T-shirt that was torn around the neck area, and
43 black thongs.
44

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

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

5
6 Property located on Mr Currie consisted of two
7 handkerchiefs, a cigarette lighter, three keys on a key
8 ring and a concession card in his name. The OIC states
9 that this property was later collected by Mr Currie's
10 mother, there being no suggestion that it was the subject
11 of any form of forensic testing.

12
13 As earlier indicated, the OIC states that both
14 detectives and scientific officers attended the scene, and
15 it is known that at least seven colour photos, which I have
16 already referred to, were taken at the scene, with
17 Mr Currie's body in situ.

18
19 The OIC's statement was made on 13 December 1988, the
20 day the body was found. In it, he states that in his view,
21 no suspicious circumstances were apparent. He expresses
22 his view of what occurred as follows, as set out in the
23 body of paragraph 63 of the written submission:

24
25 *It appears that from the time he was last*
26 *seen at [GB's] residence, he was going*
27 *home, as the place where he was located was*
28 *on (sic) route to home and the toilet areas*
29 *around District Park was (sic) a regular*
30 *meeting place for him and [GB] and to use*
31 *drugs, and at this stage appears to be an*
32 *overdose and due to incapacitation from the*
33 *drugs fell to the ground and became*
34 *unconscious. The small amount of water*
35 *nearby would have been at a higher level*
36 *during the evening and if the deceased fell*
37 *down his facial area would have been in the*
38 *water.*

39
40 As I say, that was the assessment of the OIC in a statement
41 made on the day the body was located.

42
43 The formal report of death by the officer in charge to
44 the Coroner prepared and signed on the same day,
45 13 December, is in similar terms. It concludes that there
46 are no suspicious circumstances and that it appears that
47 Mr Currie had attended the location which is en route from

1 GB's residence to his own home and overdosed and fallen
2 down on to the concrete ground, face down, and became
3 unconscious.
4

5 Subsequent to these initial conclusions reached by the
6 officer in charge, the autopsy was conducted that was
7 described earlier before the break. The findings of
8 Dr Brighton, who conducted the original autopsy, along with
9 the toxicology results, appear to be consistent with the
10 initial conclusions reached by the officer in charge.
11 Nevertheless, the Inquiry has considered it to be very
12 important to subject certain matters arising from the
13 police scene evidence, the autopsy report and toxicological
14 results to further scrutiny by means of expert forensic and
15 toxicology reports.
16

17 That brings me to those reports. Dr Iles, the
18 forensic pathologist, who has provided a report to the
19 Inquiry, was provided with materials that included the
20 seven colour photos of the location where Mr Currie's body
21 was located and also depict the body. They depict his
22 mouth and facial area and indeed the state of his clothing,
23 including his shirt, said by the officer in charge to have
24 been ripped.
25

26 Dr Iles was asked to comment on any potential
27 significance of the observation made by the officer in
28 charge that some of Mr Currie's teeth appeared to have been
29 dislodged, bearing in mind that no relevant observation
30 concerning the state of Mr Currie's teeth had been made by
31 Dr Brighton. She opined that poor dentition was common
32 among those with a history of illicit drug use and that the
33 photos of Mr Currie's teeth showed them to be yellowed with
34 some teeth absent. She states that in the event of
35 underlying dental and periodontal disease, dislodging of
36 teeth, either in the post-mortem period or consequent to
37 a low-energy impact from an agonal fall or collapse, may be
38 observed. She also notes that there is no autopsy
39 documentation of other facial trauma. While observing that
40 it is nowadays standard to comment on the state of
41 dentition in autopsy practice, she notes that the same may
42 not have been the case in 1988.
43

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

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

7
8 Dr Iles was of the view that the presence of the thin
9 film of water on the floor was unlikely to have contributed
10 particularly significantly to the death, and she expressed
11 the view that the superficial or minor abrasions to
12 Mr Currie's face and any dislodgment of his teeth can
13 potentially be ascribed to perimortem phenomena. Although
14 it is not possible to exclude the possibility of blunt
15 force trauma to the face absent a thorough examination of
16 relevant facial areas, and she could not say whether one
17 had taken place, she was of the view that Mr Currie's death
18 is most likely consistent with misadventure.

19
20 She described the drug Nembudeine as an Australian
21 preparation from Abbott Pharmaceuticals that she believes
22 is no longer available. Its active ingredients included
23 paracetamol, codeine phosphate and pentobarbitone sodium.
24 The codeine, pentobarbitone and morphine, being
25 a metabolite of codeine, that were identified in
26 Mr Currie's blood, could all be ascribed to ingestion of
27 Nembudeine tablets. Ingestion of those tablets could also
28 explain the presence of the paracetamol.

29
30 Finally, Dr Iles did not believe, based on the
31 material available to her, that any further investigation
32 of the manner or cause of death would be of utility.

33
34 Professor Jones provided a report to the Inquiry dated
35 25 October 2022 and then, following the receipt of Dr Iles'
36 report, a brief supplementary report dated 23 January 2023.
37 Key aspects of the professor's opinion are as follows:
38 Nembudeine ingestion could account for the presence of
39 codeine, pentobarbitone and paracetamol in Mr Currie's
40 toxicology results; the morphine level in Mr Currie's blood
41 was at a therapeutic level and was likely a contributing
42 factor to the death. Morphine, as already observed, is
43 a metabolite of codeine metabolism and was likely to be
44 a byproduct of Mr Currie's consumption of codeine.

45
46 Mr Currie's blood concentration of methadone was in
47 the therapeutic range but below either toxic or fatal

1 ranges. Alone it would not be expected to result in
2 clinical opioid toxicity effects (resulting in death
3 predominantly due to respiratory depression), but would
4 contribute to overall opioid toxicity when combined with
5 other opioid drugs, for example, codeine and morphine.
6

7 Pentobarbitone is a short-acting barbiturate used
8 clinically as a sedating hypnotic agent. The level of
9 pentobarbitone in Mr Currie's post-mortem blood was in the
10 toxic to lower end of the fatal ranges. The level of
11 pentobarbitone in his liver was in the fatal range. The
12 level of codeine in Mr Currie's blood was in the toxic to
13 fatal ranges. There was a therapeutic level of paracetamol
14 in his blood.
15

16 Professor Jones concluded that pentobarbitone was
17 found in toxic to lethal concentrations in Mr Currie's
18 post-mortem blood and within the fatal range in his liver.
19 Pentobarbitone would cause significant central nervous
20 system and respiratory depression. Alone, it would be
21 fatal, but when combined with the codeine in toxic to fatal
22 ranges, methadone in a therapeutic range and morphine in a
23 therapeutic range, it would have added effects on the
24 central nervous system and respiratory depression caused by
25 all these opioid drugs.
26

27 She concluded that Mr Currie most likely died as
28 a consequence of codeine and pentobarbitone oral overdose
29 on a background of methadone use.
30

31 Careful consideration has been given to whether there
32 was any realistic possibility that the death involved
33 a third party. In view of the known friendship between GB
34 and Mr Currie in the context of their mutual drug use, in
35 my submission, there does not appear to be anything
36 suspicious about the fact that Mr Currie was at GB's flat
37 from around 8.30pm until somewhere between 10pm and 11pm
38 shortly prior to his death.
39

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

1 GB in the context of his drug use.

2
3 Further, the location where Mr Currie's body was found
4 is directly on the logical route he would have taken in
5 order to walk from GB's unit in Manly Vale to his mother's
6 residence in Harbord. The parkland and sporting fields
7 comprising Nolan Reserve and Passmore Reserve provide
8 a convenient shortcut between the relevant parts of those
9 suburbs. Further, the fact that GB accompanied Mr Currie's
10 mother and went looking for him early the following
11 morning, upon Mr Currie's mother realising he had not
12 returned home, is, it is submitted, unsurprising given
13 their close friendship. Mr Currie's known chronic drug use
14 and his history of previous drug overdoses, similarly, the
15 fact that GB looked for Mr Currie in the two toilet blocks
16 in the two park areas appears to be a logical step to take
17 in the circumstances.

18
19 For these reasons, Commissioner, it's my submission
20 that GB's involvement with Mr Currie around the time of his
21 death is not considered to be suspicious. Evidence from
22 the scene of his death, from the autopsy and toxicology
23 reports at the time, as well as the expert review of the
24 toxicology and forensic pathology reports obtained by the
25 Inquiry from two renowned experts, supports the view that
26 Mr Currie's death was the accidental outcome of his
27 ingestion of drugs on 12 December 1988.

28
29 Before coming to the more formal aspects of the
30 findings that are suggested, I want to return to make some
31 comments for the benefit of Mr Currie's family, who are
32 here.

33
34 I have already observed that the police investigative
35 material in relation to this matter is somewhat limited in
36 scope. It would certainly be understandable that some
37 family members may be concerned at the limited nature of
38 investigative material produced many years ago in a matter
39 such as this.

40
41 At the time, the conclusion that Mr Currie's death was
42 the result of an accidental drug overdose was reached very
43 swiftly and it appears that no statements were taken from
44 family members. While it is not submitted that these
45 matters resulted in an incorrect conclusion being reached
46 by police in relation to the cause and manner of death,
47 a more detailed initial investigation and the retention of

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

5
6 In the case of Mr Currie's family, the Inquiry has
7 appreciated having a dialogue with them about such concerns
8 and the Inquiry, in my submission, should remain open to
9 further discussion with the family in the event that there
10 is anything that the Inquiry can do to help address those
11 concerns.

12
13 Commissioner, to turn then to the formal conclusions
14 made in the submission, given the conclusion reached in
15 relation to the cause and manner of Mr Currie's death, it's
16 not suggested that the death involved gay-hate bias,
17 probably more properly put, LGBTIQ bias. It's submitted
18 that an appropriate description of the cause and manner of
19 Mr Currie's death would be that it resulted from multi-drug
20 toxicity following his deliberate ingestion of Nembudeine
21 tablets, causing respiratory and central nervous system
22 depression, leading to his death, and in circumstances
23 where he was known to have an addiction to restricted
24 prescription medication.

25
26 Accordingly, Commissioner, it's further submitted that
27 the death of Mr Currie was not unsolved and therefore does
28 not fall within Category A of the Inquiry's Terms of
29 Reference. At this stage, Commissioner, there are no
30 suggested recommendations related to Mr Currie's death.
31 Those are the submissions.

32
33 THE COMMISSIONER: All right. Thank you. I understand
34 Ms Melis is going to conduct the next aspect of the matter,
35 and she needs a few moments to get her papers in order, so
36 I will just go off the Bench for a few minutes, thank you.

37
38 **SHORT ADJOURNMENT**

39
40 THE COMMISSIONER: Yes, Ms Melis?

41
42 MS MELIS: Thank you, Commissioner. Commissioner, these
43 submissions relate to the death of Brian Wayne Schmidt
44 Walker. Commissioner, in making these submissions, I rely
45 on a bundle of material, and I will have that handed up to
46 you.

1 THE COMMISSIONER: Thank you.

2

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

5

6 THE COMMISSIONER: Thank you.

7

8 MS MELIS: I understand we might be up to exhibit number
9 15.

10

11 THE COMMISSIONER: Thank you.

12

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

15

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

19

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

22

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

25

26 THE COMMISSIONER: Thank you. Yes, thank you.

27

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

35

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

44

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

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

5
6 The Inquiry also received and reviewed the prosecution
7 file in respect of the charge of manslaughter against
8 Mr Hokin from the Office of the Director of Public
9 Prosecutions. Through its investigation, the Inquiry has
10 ascertained that Mr Hokin is alive, aged 78, and lives in
11 an aged care facility. He informed the Inquiry that he did
12 not wish to attend or otherwise participate in today's
13 hearing.

14
15 Mr Walker was born on 17 April 1962. He died in the
16 early hours of 23 July 1992 at the residence of Mr Hokin in
17 Burnett Street, Merrylands. Mr Walker was 30 years old
18 when he died.

19
20 I will come to the circumstances of Mr Walker's death
21 in a moment, but first, some details about Mr Walker and
22 who he was. Mr Walker was born to Yvonne Schmidt and
23 Cedric Dacey. Both are now deceased. He was one of three
24 siblings, he had an older sister, Janice Walker, and a
25 younger brother, David Schmidt.

26
27 Ms Walker, Commissioner, is listening to today's
28 proceeding on the live stream and I wish to acknowledge
29 that. We give our condolences to Ms Walker and Mr Schmidt
30 on the passing of their brother, and the Inquiry thanks
31 Ms Walker for recently providing a statement and telling us
32 some of the things she remembers of her brother. That
33 statement is at tab 35 [SCOI.82361_0001] of the tender
34 bundle.

35
36 Mr Walker went to Bexley Primary School and later
37 Mount Druitt High School. He didn't finish school. He
38 left home when he was around 16 or 17 years old. He did
39 not have regular employment and he sometimes did odd jobs
40 and liked to help people out.

41
42 Ms Walker remembers Mr Walker as a happy-go-lucky man
43 who was very trusting of people. He was quick to befriend
44 others and was very talented at drawing.

45
46 Mr Walker was a bit of a drifter. He did not have
47 a fixed address and would stay with friends and move

1 between houses.

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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

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

4
5 Mr Hokin stated that he repeatedly asked Mr Walker to
6 leave, but Mr Walker wasn't happy about that.

7
8 Mr Hokin told police that Mr Walker picked up a shovel
9 and swung it at him. He said that in the course of the
10 ensuing struggle, he dropped down underneath and put both
11 his arms around Mr Walker's chest and hung on. He said
12 they were wrestling for at least an hour. During the
13 struggle, according to Mr Hokin, Mr Walker also attacked
14 him with a broken beer bottle. He was cut about the
15 stomach and the back.

16
17 Craig and Julianne Donnelly were Mr Hokin's
18 neighbours. Mrs Donnelly says that at about 11.30pm she
19 heard a bottle smash next door and some guy yelling out -
20 this is a direct quote, Commissioner, and I apologise for
21 any offence it may cause, some guy yelling out, "Get off
22 me, you fucking cunt. Clear off. Get out of here". She
23 said it sounded like someone was sitting on him. She then
24 heard Mr Hokin say, "Didn't I give you wine and cigars and
25 you cut me to pieces".

26
27 The reason Mr Hokin gave during his police interview
28 for holding on to Mr Walker for as long as he did was
29 because he was frightened of him. He said:

30
31 *I was too scared to get up and run because*
32 *I was overcome about the strength of this*
33 *person and I just felt that the moment*
34 *I let go I would ... be in trouble.*

35
36 Mr Hokin subsequently called out to Craig Donnelly for
37 help. Mrs Donnelly says that this was at about 1.15am when
38 she heard Mr Hokin screaming out, "Craig, help." However,
39 Mr Hokin told police that calling out seemed to make
40 Mr Walker more aggressive. He said that at that point,
41 Mr Walker used a square pole that held up an awning on his
42 verandah, to get leverage. Mr Hokin started to worry
43 because he was released from what he had described as the
44 command position.

45
46 Mr Hokin said that he held Mr Walker's head to his
47 stomach and was holding his body weight on Mr Walker until

1 Mr Walker stopped moving.

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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.

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

5
6 Mr Hokin said he had four or five cups of wine himself
7 but was not affected. A blood sample was taken from
8 Mr Hokin at Westmead Hospital on 23 July 1992. The sample
9 was submitted for analysis, however it was clotted and
10 therefore unsuitable for analysis.

11
12 Mr Hokin said to police that if Mr Walker had made
13 some sort of sign to say, "Look, I've had it", or, "I'm
14 going home", Mr Hokin would have said, "Well, get up
15 carefully", but that never happened. Mr Walker kept
16 fighting.

17
18 When asked what his intention was when holding
19 Mr Walker, Mr Hokin said:

20
21 *To hold him down and call for help because*
22 *I am petrified of what's going to happen to*
23 *me because I'm on a bond. I must be of*
24 *good behaviour ... that's why I yelled ...*
25 *out to Craig as loud as I could.*

26
27 Mr Hokin also told police:

28
29 *If he hadn't have swung a shovel at me I'd*
30 *be home asleep ... All I can say is that*
31 *I've had those kind of people approach me*
32 *many times in my life. I don't know why*
33 *because I'm a ladies' man, I'm an*
34 *entertainer. You can't be one of those and*
35 *be an entertainer because the boss'll have*
36 *you out.*

37
38 Mr Hokin was subsequently charged with manslaughter at
39 7.03am on the same morning, 23 July 1992, following his
40 participation in the electronically recorded interview.

41
42 The forensic pathologist who conducted the autopsy
43 concluded that Mr Walker died as a result of an injury to
44 the upper cervical - that is, he suffered a torn spinal
45 ligament. The significant condition contributing to the
46 death was traumatic crush asphyxia and head injury.

47

1 I now turn to say something about Mr Hokin. Mr Hokin
2 was a first class metal machinist who had been on an
3 invalid pension for the past eight to nine months. He was
4 divorced and living alone at the Burnett Street, Merrylands
5 address. He was then aged 48. He had no real community
6 ties. He had been unable to pay the electricity bill and
7 it had been cut off, as had the water. He cooked in the
8 backyard.
9

10 At the time of Mr Walker's death, Mr Hokin was subject
11 to a four-year good behaviour bond in relation to an
12 offence of malicious wounding in 1991 and also subject to
13 another bond for two years for the offence of entering
14 dwelling at night with intent to commit a felony in 1990.
15

16 In December 1991, following the charge of malicious
17 wounding, he was admitted as an involuntary patient and
18 assessed at the Cumberland Hospital by a Dr Joura. At
19 Mr Hokin's committal for the charge of manslaughter of
20 Mr Walker, the presentence reports in relation to each of
21 those previous two criminal matters I have mentioned were
22 tendered. I deal with those reports in detail in my
23 written submissions at paragraphs 28 to 34.
24

25 In short, Mr Hokin had been diagnosed as suffering
26 manic depressive psychosis and attended Merrylands area
27 health centre every six weeks. He was on medication. He
28 had first been admitted to Cumberland Hospital as long ago
29 as 1967 when he was diagnosed as schizophrenic.
30

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

1
2 Mr Hokin said that after his arrest he was placed in
3 the exercise area at the Merrylands Police Station, a man
4 approached him and gestured to him, which Hokin interpreted
5 to mean the man may have wanted to have a sexual encounter
6 with him. He then attempted to hit this man.

7
8 Mr Hokin told Dr Joura that he would commit the same
9 offence again and again because the perverts and deviant
10 should be taught a lesson:

11
12 *The law is an ass and the world would be*
13 *definitely be a better place if everyone*
14 *went and did the same as I did.*

15
16 Dr Joura concluded that Mr Hokin's actions and beliefs may
17 well have been part of a psychotic condition that was
18 evident on his admission after the malicious wounding
19 charge.

20
21 After Mr Hokin's arrest in connection with the death
22 of Mr Walker, a psychiatric report was obtained from
23 Dr Jennifer Thompson, dated 21 September 1992. Dr Thompson
24 opined that Mr Hokin:

25
26 *... suffers a serious psychotic mental*
27 *illness characterised by hypomanic*
28 *episodes, severe depressive episodes and*
29 *paranoid, fixed delusions about homosexuals*
30 *and perverts. He needs long-term close*
31 *supervision in the community.*

32
33 She documented a 45-year history of depression.

34
35 Mr Hokin told Dr Thompson that subsequent to his
36 arrest for Mr Walker's death, he had initially been placed
37 in a cell with a real freak and was then moved to a cell
38 with a homosexual. He said:

39
40 *Why go and put me in a cell with*
41 *a homosexual ... one of them has only to*
42 *put his hands on me and I'll murder him.*
43 *God help me if they come near me.*

44
45 Despite the evidence of Mr Hokin's mental illness,
46 characterised by paranoid fixed delusions about
47 homosexuals, there is no evidence to suggest that Mr Hokin

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

7
8 John Hokin was committed to trial on 1 October 1992 at
9 the Local Court at Parramatta on the charge of
10 manslaughter. Bail was refused. His trial was set before
11 the District Court at Parramatta on 15 February 1993.

12
13 At that time, the so-called homosexual advance defence
14 was still available in New South Wales, and something of
15 this defence was mentioned before you, Commissioner, during
16 our November hearings. In short, the homosexual advance
17 defence refers to an accused person alleging that they
18 acted either in self-defence or under provocation in
19 response to a homosexual advance made by the deceased
20 person.

21
22 In a High Court decision in 1997 of *Green v the Queen*,
23 the majority of the High Court of Australia took the view
24 that a reasonable jury would be entitled to consider that
25 an ordinary person in the position of the accused could
26 have formed an intention to kill or to inflict grievous
27 bodily harm by a non-violent homosexual advance on the part
28 of the deceased.

29
30 In 2014, the Parliament of New South Wales passed the
31 Crimes Amendment (Provocation) Act 2014, which provided
32 that a non-violent sexual advance did not constitute
33 extreme provocation for the purpose of being a partial
34 defence to murder. This signalled the end of the so-called
35 gay panic defence in New South Wales.

36
37 However, and in any event, no trial of Mr Hokin took
38 place. This is because on 12 February 1993, the Director
39 of Public Prosecutions directed that the prosecution be
40 discontinued on the basis that there was no reasonable
41 prospect of conviction. At the time, it was concluded that
42 the Crown was unable to negative Mr Hokin's claim that he
43 was acting in self-defence, in circumstances when
44 Mr Hokin's version of events was supported by the evidence
45 of the forensic pathologist and another independent
46 witness.

1 I move now, Commissioner, to mention any indicators of
2 LGBTIQ bias in this case. On the evidence before the
3 Inquiry, Mr Walker's sexual orientation cannot be
4 confirmed. As mentioned, his sister, Ms Walker, had seen
5 him with girlfriends.
6

7 There are, however, two indicators that he may have
8 been gay. First, as I have already mentioned, he had
9 a friend, Kevin Leatham, with whom he was understood to
10 stay regularly through the day or the night. The nature of
11 the relationship between Mr Walker and Mr Leatham is
12 unknown. No statement was ever taken from Mr Leatham by
13 police. This is unfortunate, because he may have been able
14 to shed some light on Mr Walker's sexual orientation.
15 Being a mutual friend of Mr Walker and Mr Hokin, and living
16 on the same street as Mr Hokin, he may also have known
17 something more about how Mr Walker came to know Mr Hokin,
18 how long they had known one another and the nature of that
19 relationship.
20

21 The Inquiry has established that Kevin Leatham died
22 in August 2009. The death certificate, Commissioner,
23 appears at tab 36 [SCOI.82360_0001] of the tender bundle,
24

25 The second indicator is that, on Mr Hokin's account,
26 Mr Walker made advances towards him, touching his leg and
27 shoulder and "talking in a manner about sexual behaviour".
28

29 A Bias Crimes Indicators Review Form was completed in
30 this case by Strike Force Parrabell. It concluded that
31 there was no evidence of bias crime. The academic review
32 characterised it as "no bias".
33

34 The comments in the completed form included that
35 Mr Walker was likely to be a homosexual male, that Mr Hokin
36 was a heterosexual male, that Mr Walker had been making
37 advances towards Mr Hokin on the night he died, that
38 Mr Hokin was frightened of the advances made, and that
39 there was no evidence suggesting animosity between the pair
40 prior to Mr Walker's advances upon Mr Hokin.
41

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

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

7
8 It is also worth mentioning that the form mentions the
9 author having no details in relation to Mr Hokin's violent
10 history, particularly in respect of the malicious wounding
11 offence, nor his psychotic mental illness and episodes of
12 paranoid fixed delusions about homosexuals. This is
13 perhaps indicative of Strike Force Parrabell not having all
14 relevant material tendered in the court proceedings when
15 they came to review this matter.

16
17 The view expressed by the Parrabell officers in the
18 completed form was that even though the fight started as
19 a result of an unwanted sexual advance from Mr Walker to
20 Mr Hokin, the motive behind this death was self-defence,
21 and this is backed by the Coroner's report and from the DPP
22 withdrawing charges. The matter, as I have mentioned, was
23 characterised as solved by Strike Force Parrabell. That is
24 plainly correct in the sense that the identity of the
25 perpetrator, Mr Hokin, has been known from the outset.

26
27 Commissioner, on the totality of the evidence,
28 I submit the following conclusions on the question of
29 whether this case is an LGBTIQ hate crime. According to
30 Mr Hokin's statement to police, the physical fight between
31 Mr Walker and Mr Hokin started when Mr Walker attacked
32 Mr Hokin with the shovel. Even if, as asserted by
33 Mr Hokin, there had been an earlier unwanted sexual advance
34 from Mr Walker to Mr Hokin, Mr Hokin himself did not claim
35 that he had fought Mr Walker for that reason. Rather, the
36 actual catalyst for his fighting with Mr Walker as he did
37 was Mr Walker attacking him with a shovel and then with
38 broken glass.

39
40 As already mentioned, Mr Hokin said that if Mr Walker
41 hadn't have swung a shovel at him, he'd be home asleep.
42 His claim of self-defence related to the physical violence
43 comprised by Mr Walker's attacking him with a shovel,
44 rather than to the asserted touching on the leg and
45 shoulder.

46
47 This conclusion is further supported by the fact that

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

7
8 Finally, Commissioner, my submissions as to manner and
9 cause of death in this case. Mr Hokin's account of events
10 was generally corroborated by other evidence, including the
11 presence of a shovel at the scene, accounts given by
12 Mr Hokin's next-door neighbours, the injuries to Mr Hokin
13 and the report of both police and the forensic pathologist
14 on a scene examination. Mr Hokin also had numerous
15 observable injuries to his torso. The crime scene photos
16 and photographs of Mr Hokin's injuries have been reviewed
17 by the Inquiry.

18
19 The Inquiry has no basis for reaching a different view
20 from that of the Office of the Director of Public
21 Prosecutions in 1993 - namely, that self-defence could not
22 be disproved. It is submitted that the appropriate finding
23 is that Mr Walker died after sustaining a torn spinal
24 ligament as a result of the conduct of John Hokin during an
25 altercation between the two men. Those facts have been
26 plain and uncontentious since 1992. Accordingly, it is
27 further submitted that the death of Mr Walker is not
28 unsolved and therefore does not fall within Category A of
29 the Inquiry's Terms of Reference. I otherwise submit no
30 further recommendations in respect of this matter,
31 Commissioner.

32
33 THE COMMISSIONER: All right, thank you. I will note your
34 position is reserved again, Mr Mykkeltvedt.

35
36 MR MYKKELTVEDT: Thank you, Commissioner.

37
38 THE COMMISSIONER: I propose to adjourn until the next
39 listed public hearing, which I think is already on the
40 website or you have been notified of that event.

41
42 MR MYKKELTVEDT: Yes, that's so.

43
44 THE COMMISSIONER: All right. Thank you very much,
45 everyone concerned. I will now adjourn, thank you.

46
47 **AT 3.10PM THE COMMISSION WAS ADJOURNED ACCORDINGLY**

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