

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

**Before: The Commissioner,
The Honourable Justice John Sackar**

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

On Tuesday, 4 April 2023 at 10.05am

(Day 43)

Ms Meg O'Brien	(Counsel Assisting)
Ms Caitlin Healey-Nash	(Senior Solicitor)
Mr Rhys Carvosso	(Solicitor)

Also Present:

Mr Anders Mykkeltvedt and Mr Patrick Hodgetts for
NSW Police

Mr Hamish Bevan SC and Ms Laura Thomas for the Sheil family

1 THE COMMISSIONER: Yes.
2
3 MS O'BRIEN: Commissioner, I appear to assist you
4 instructed by Ms Healey-Nash and Mr Carvosso.
5
6 THE COMMISSIONER: Thank you.
7
8 MR MYKKELTVEDT: Commissioner, I appear for the
9 Commissioner of Police.
10
11 THE COMMISSIONER: Thank you very much, Mr Mykkeltvedt
12
13 MR BEVAN: Commissioner, with your leave, I appear with my
14 learned friend Ms Thomas for the Sheil family.
15
16 THE COMMISSIONER: Thank you. Leave is granted, Mr Bevan.
17 Yes?
18
19 MS O'BRIEN: Commissioner, these submissions concern the
20 death of Peter John Sheil. I have a bundle of documents to
21 hand up, and unless there are any objections, I will seek
22 to tender that bundle.
23
24 **EXHIBIT #20 BUNDLE OF DOCUMENTS TITLED "TENDER BUNDLE PETER**
25 **SHEIL"**
26
27 THE COMMISSIONER: All right. Thank you.
28
29 MS O'BRIEN: I also seek to tender, to separately tender,
30 a family statement that is prepared by the Sheil family.
31 I also hand up short minutes of order with respect to
32 non-publication orders in this matter, which I understand
33 are by consent.
34
35 **EXHIBIT #21 STATEMENT BY FAMILY OF PETER SHEIL**
36
37 THE COMMISSIONER: All right, thank you.
38
39 MR MYKKELTVEDT: Yes, that's so.
40
41 THE COMMISSIONER: Thank you, Mr Mykkeltvedt.
42
43 MS O'BRIEN: And I also hand up a copy of my written
44 submissions prepared in this matter.
45
46 THE COMMISSIONER: Thank you. I have made those orders.
47 Thank you very much. Yes.

1
2 MS O'BRIEN: Commissioner, at the outset of my
3 submissions, I wanted to note that although this Inquiry
4 summonsed all investigative material held by the New South
5 Wales Police Force in relation to Mr Sheil, no material was
6 produced, with the Inquiry being informed by the police
7 that they have been unable to locate any investigative
8 files relating to Mr Sheil's death.
9

10 I intend to make further submissions about that fact
11 in due course. However, at this stage I wanted to note
12 that this Inquiry's investigation into Mr Sheil's death is
13 based on the Coroner's court file only, which was requested
14 and received by this Inquiry. However, that file consisted
15 only of 18 pages of material. As will become apparent, the
16 absence of contemporaneous material has had a significant
17 impact on the ability of this Inquiry to investigate
18 Mr Sheil's death.
19

20 Unfortunately, Mr Sheil's parents are now deceased.
21 However, he is survived by his four siblings: Christopher,
22 Hugh, Robert and Margaret. I understand that they are
23 watching today's hearing and are represented by senior and
24 junior counsel.
25

26 The Sheil family has also provided the Inquiry with a
27 photograph of Peter that I'm hoping will be displayed on
28 the screen in court shortly. Mr Sheil was born in Sydney
29 on 7 February 1954. He died between 8.00 pm on 27 April
30 1983 and 10.00 am on 29 April 1983, at Gordons Bay, which
31 is referred to in some of the documentation as Thompsons
32 Bay, near Clovelly. He was 29 years old at the time of his
33 death.
34

35 Details about Mr Sheil's life have been provided to
36 this Inquiry by Mr Sheil's siblings by way of the family
37 statement that I tendered at the beginning of these
38 submissions. It is apparent from that statement that
39 Mr Sheil was known to enjoy music, reading, photography and
40 current affairs. He had a gregarious personality, was a
41 talented poet and was a much loved son, brother and friend,
42 and the impact of his death on his family was devastating.
43

44 Mr Sheil's adult life was afflicted by various
45 episodes of mental illness. In the three years prior to
46 his death, Mr Sheil was admitted over 12 times to the
47 Prince of Wales Hospital and the Prince Henry Hospital, as

1 it was then known, with depression and hypermania.
2 Mr Sheil was thought by one of his treating doctors to have
3 manic depressive illness or possibly schizo-affective
4 psychosis. He occasionally expressed suicidal ideation but
5 denied any suicidal intent. His conditions were being
6 treated by way of medication.

7
8 At the time of his death, Mr Sheil had been living in
9 rehabilitation accommodation known as the Clovelly Flats at
10 Park Street in Clovelly and he had been living there since
11 22 March 1983, or for just over a month. He had been
12 referred to that accommodation by a social worker at the
13 Prince of Wales Hospital. The supervisor in charge of the
14 Clovelly Flats, Ms Patricia Campbell, considered that
15 Mr Sheil's condition had been improving since he began
16 living there.

17
18 There is no evidence to suggest that Mr Sheil was a
19 member of the LGBTIQ community, and during his lifetime he
20 had a number of girlfriends. However, his brother
21 Christopher has stated through the media that although
22 Mr Sheil didn't identify as gay, he may have been mistaken
23 as gay. Furthermore, there is evidence before this Inquiry
24 that the coastal path between Coogee and Clovelly beaches
25 around where Mr Sheil was found operated as a beat at the
26 time of Mr Sheil's death, as did the nearby Giles Baths.
27 The significance of those facts will be discussed in due
28 course.

29
30 The next matters I wish to address are the
31 circumstances of Mr Sheil's death and its immediate
32 aftermath. At 8.30 am on Wednesday, 27 April 1983,
33 Mr Sheil left his residence to go shopping in the Randwick
34 and Bondi Junction areas. Ms Campbell, the supervisor of
35 the Clovelly Flats, drove him to the corner of Clovelly
36 Road and Keith Street, where she saw Mr Sheil board a bus
37 to go to Randwick. Her recollection was that he was going
38 to enquire about his pension cheque and to attend the
39 Prince of Wales Hospital to see his doctor.

40
41 At around 8.00 pm that evening, Mr Sheil telephoned
42 his mother from the Coogee Bay Hotel to inform her that he
43 was about to walk home, where he had a 9.00 pm curfew.
44 This was the last known communication between Mr Sheil and
45 another person. According to family members, he was in
46 good spirits at this time and he gave no indication on the
47 telephone call that he was suicidal.

1
2 If I could bring up on the screen Attachment "A" to
3 the written submissions prepared, Commissioner, this
4 attachment is a map extracted from Google Maps. Mr Sheil
5 appears to have chosen to walk home via the coastal track
6 between Coogee and Clovelly. Based on Google Maps
7 estimates, it would have taken him about 20 minutes from
8 the Coogee Bay Hotel to reach the location where his body
9 was found, which is circled in red on that map, and that
10 map depicts the likely or most obvious walking route
11 between his home and the Coogee Bay Hotel.
12

13 At around 10.00 am on 29 April, Mr Sheil's body was
14 found on the rocks below the coastal track by
15 Mr Donald Ross, a Clovelly resident who was walking around
16 the rocks at the time. Mr Ross gave a statement to the
17 police which was available to the Inquiry through the
18 coronial file. That statement, Commissioner, is at tab 7
19 of the tender bundle and I am hoping it can be brought up
20 on screen now.
21

22 It is a short statement of some three paragraphs long.
23 According to Mr Ross, Mr Sheil was lying on his back
24 between some rocks about 150 metres from the Clovelly Beach
25 carpark. He was clothed in a blue short-sleeved shirt
26 which was open at the front and blue corduroy trousers.
27 Mr Ross also observed that Mr Sheil was wearing turquoise
28 underwear, which is described in other documents before the
29 Inquiry as a swimming costume, and that Mr Sheil's belt and
30 fly were undone and his trousers and underwear were around
31 his hips and below the line of his pubic hair. He was
32 wearing brown slip-on shoes and white socks. Mr Ross went
33 home and called the police and then returned to the scene.
34

35 Constable William Strange of Randwick Police Station
36 attended the scene shortly thereafter, apparently alone.
37 Constable Strange prepared a two-page or
38 nine-paragraph statement that was also provided to this
39 Inquiry has part of the Coroners Court file, and that is at
40 tab 10 of the bundle that I handed up earlier. That
41 statement contains Constable Strange's observations of the
42 scene and contains the only details this inquiry has about
43 any investigation conducted by the New South Wales Police
44 Force into Mr Sheil's death.
45

46 At paragraph 2 of that statement, Constable Strange
47 observed that when he arrived at the scene, he saw that

1 Mr Sheil was lying in a prone position, notably different
2 to that which was observed by Mr Ross, between two large
3 rocks. He also states that around 6 metres from where
4 Mr Sheil's body was found, there were bloodstains on the
5 rocks and some loose change and that there was a trail of
6 blood from that location to Mr Sheil's body. According to
7 paragraph 3 of Constable Strange's statement, scientific
8 police attended sometime later and took photographs of
9 Mr Sheil's body and the scene. These photographs, which
10 apparently have not either been retained or located, have
11 not been made available to the Inquiry. In that paragraph,
12 Constable Strange also makes remarks about the state of
13 Mr Sheil's clothing.

14
15 According to paragraph 4 of the statement, there was a
16 rock outcrop about 20 metres above Mr Sheil's body which
17 had, and I quote:

18
19 *... a very mossy surface of a highly*
20 *slippery nature ...*

21
22 And what is described as:

23
24 *... a magazine of a sexual nature.*

25
26 Was apparently found just below this rock outcrop. What
27 Constable Strange meant by the words "of a sexual nature"
28 is not known. At paragraph 5, Constable Strange states
29 that on 29 April 1983 at around 2.00 pm, he visited
30 Clovelly Flats and informed Ms Campbell of Mr Sheil's
31 death. She accompanied him to Mr Sheil's room and found
32 phone numbers for members of his family. It is apparent
33 from other documents before the Inquiry that at around
34 1.50 pm on 30 April, Mr Sheil's father, Peter Barry Sheil,
35 attended the city morgue and identified Mr Sheil's body.

36
37 At paragraph 8, Constable Strange details the nature
38 of his investigation into Mr Sheil's death. He states that
39 in the week following the discovery of Mr Sheil's body, he:

40
41 *... made inquiries in the immediate area of*
42 *the death as to any person who may have*
43 *witnessed anything [but] to no avail ...*

44
45 He also conducted what he calls a "further investigation of
46 the surrounding area". The nature of those inquiries is
47 not elaborated on in Constable Strange's statement, and

1 based on the limited information available to this Inquiry,
2 there is no way of knowing what exactly those inquiries
3 entailed. Constable Strange then concluded his statement
4 at paragraph 9, and I'll quote directly from that
5 paragraph:
6

7 *From the investigation carried out and the*
8 *prevailing area in which the Deceased met*
9 *his demise I have formed the opinion that*
10 *the Deceased had ventured onto a rock ledge*
11 *about 20 metres above the shoreline rock*
12 *base of Thompsons Bay and then lost his*
13 *footing on the slippery undergrowth,*
14 *causing him to fall to the rocks below and*
15 *apparently striking his head. It then*
16 *appears that he dragged himself a distance*
17 *of about 6 metres and lay in a more*
18 *comfortable position between rocks. I am*
19 *also of the opinion that the reason that*
20 *the Deceased's clothing was in a state of*
21 *disarray was caused by the fact that he had*
22 *presumably been masturbating before his*
23 *fall.*
24

25 The conclusions reached by Constable Strange will be the
26 subject of further submissions, but I will note,
27 Commissioner, that to the extent that the contents of
28 Constable Strange's statements raise matters that this
29 Inquiry would have liked to consider further, I submit
30 that, first, in the absence of any investigative file and,
31 second, given that the Inquiry has established that
32 Constable Strange is now deceased, there is very limited
33 scope to explore those matters any further.
34

35 On 3 May 1983, Dr Colin Goldschmidt conducted an
36 autopsy. In the post-mortem report dated 3 June 1983,
37 Dr Goldschmidt documented various injuries, some of which
38 are set out in my written submissions at paragraph 6, but
39 those injuries included a fracture dislocation of the
40 cervical spine. The direct cause of death was recorded by
41 Dr Goldschmidt as being "multiple injuries".
42 Dr Goldschmidt estimated that death had occurred around
43 three to four days pre-autopsy or between 8.00 am on
44 29 April and 8.00 am on 30 April which was some time after
45 Mr Sheil left the Coogee Bay Hotel on the evening of
46 27 April.
47

1 The Coroner ultimately dispensed with an inquest into
2 Mr Sheil's death. In the summary sheet, dated 1 September
3 1983, the cause of death is recorded as "multiple injuries"
4 and the manner of death is recorded as "a fall". The time
5 of death was recorded as being between 8.00 pm on 27 April
6 1983 and 10.00 am on 29 April 1983.

7
8 Commissioner, before I speak to the work conducted by
9 this Inquiry in relation to Mr Sheil's case, there are two
10 particular matters I would like to make submissions on.
11 The first of those matters is the quality of the police
12 investigation into Mr Sheil's death and the second is the
13 review of this case that was purported to be conducted by
14 Strike Force Parrabell. In relation to the first of these
15 matters, it is my submission that the conclusion of
16 Constable Strange that Mr Sheil stepped off the coastal
17 track to masturbate and then accidentally fell to his death
18 is doubtful for at least the following reasons.

19
20 First, the statement of Constable Strange indicates
21 that the investigation did not extend beyond about a week
22 after Mr Sheil's body was found on 29 April. As I have
23 submitted, precisely what the investigation entailed could
24 not be established by the Inquiry in any detail because of
25 the absence of any police record of what exactly they did
26 to investigate Mr Sheil's death. However, what the
27 documentation does establish is that the police were very
28 quick to form the view that the manner of Mr Sheil's death
29 was accidental.

30
31 Constable Strange, as I have noted earlier, expressed
32 the opinion that Mr Sheil had accidentally fallen off the
33 rock outcrop and had been masturbating before his fall.
34 This conclusion appears to have been based on the state of
35 Mr Sheil's clothing and what is called the "magazine of a
36 sexual nature" found at the scene. However, there was no
37 attempt to make inquiries of or to take statements from
38 friends or family members, including, in particular,
39 Mr Sheil's mother, who had received a call from Mr Sheil on
40 the evening of 27 April and may well have been the last
41 person to speak to him.

42
43 In an article written by Mr Rick Feneley, dated
44 26 September 2016 and titled, "He wasn't gay, but could
45 Peter have been a gay-hate victim?", and published by SBS
46 News, contained at tab 21 of the tender bundle, Mr Sheil's
47 brother, Christopher, who was 27 years old at the time of

1 Mr Sheil's death, recalls having witnessed an inquiry
2 conducted by his father and a police officer at the station
3 that day his body was found which lasted, and I quote from
4 that article, "all of about a minute."
5

6 According to another earlier article written by
7 Mr Rick Feneley in the Sydney Morning Herald on 27 July
8 2015 entitled, "Up to 80 men murdered, 30 cases unsolved,"
9 Mr Rick Feneley wrote to similar effect the following:

10
11 *Sheil's mother was a devout Catholic. She*
12 *could not countenance the possibility of*
13 *suicide and the policeman who handled the*
14 *case was helpful, perhaps too helpful.*
15 *Christopher Sheil, then 27, witnessed the*
16 *"inquiry" into his brother's death - a*
17 *discussion between his father and the*
18 *policeman. "It took all of about a minute.*
19 *They got to the part on the form where you*
20 *fill out cause of death. I can't remember*
21 *whether it was Dad or the cop who suggested*
22 *misadventure. I said, 'We don't know*
23 *whether he jumped, fell or was pushed.' Dad*
24 *said, 'Ah, we're not gunna go into any of*
25 *that.' "*

26
27 Secondly, Commissioner, the logic behind the
28 conclusions drawn by Constable Strange is not readily
29 apparent. In my submission, it is improbable that a man
30 who was close to home and subject to a curfew would deviate
31 from the coastal track in the dark at all, let alone to
32 masturbate. The improbability of this scenario is
33 compounded by the fact that sunset on 27 April occurred at
34 5.20 pm, meaning that it would have been dark when Mr Sheil
35 set out from the Coogee Bay Hotel. In those conditions, it
36 is difficult to imagine that Mr Sheil would have been able
37 to see a magazine without a light source. There is no
38 evidence of a light source found on Mr Sheil's person or
39 nearby, nor was there any evidence of lighting on the path
40 at that time.

41
42 Furthermore, as to the importance apparently ascribed
43 to the presence of the "magazine of a sexual nature" in the
44 general area where Mr Sheil was found, there does not
45 appear to have been any evidence actually linking the
46 magazine with Mr Sheil.
47

1 Thirdly, other possible reasons for the state of
2 Mr Sheil's clothing do not appear to have been considered,
3 including that he might have stopped to urinate and/or that
4 his clothing had been moved in the course of a fall, and/or
5 that an assailant might have been involved. The police do
6 not appear to have given any weight or perhaps any
7 consideration to other pieces of information that pointed
8 away from misadventure as being the manner of death.
9

10 As his last-known movements involved walking home via
11 a coastal track that included or passed a beat, it is
12 possible that he was presumed to be gay and attacked for
13 that reason. There is no evidence to suggest that
14 possibility was considered by the police.
15

16 Fourthly, there was an unexplained delay in obtaining
17 statements from key witnesses, including a delay of just
18 over one month in respect of Mr Ross and Ms Campbell.
19

20 Fifthly, as I have already stated, no investigative
21 files or other documents can be located by the New South
22 Wales Police Force in relation to Mr Sheil's death.
23 Accordingly, among other things, there is no clear evidence
24 as to the exact location of Mr Sheil's body. The failure
25 of the police to preserve and locate such files and
26 documents is particularly unfortunate in circumstances
27 where, according to Constable Strange, scientific police
28 attended the scene of Mr Sheil's death and took photographs
29 of his body and the surrounding area.
30

31 Sixthly, no exhibits appear to have been retained.
32 Investigating police appear to have disposed of Mr Sheil's
33 clothing at a very early stage of the investigation,
34 notably prior to the autopsy taking place. Mr Sheil's
35 personal property was returned to his father. There is
36 also no record of precisely where the magazine of a sexual
37 nature was located, its condition or its contents. What
38 else, if anything, was observed or examined from the scene
39 cannot now be known. These failures to retain exhibits and
40 documents prevents the Inquiry from conducting an
41 examination of such exhibits using technology currently
42 available.
43

44 The next topic I wanted to address is the Strike Force
45 Parrabell review of Mr Sheil's case. The Bias Crimes
46 Indicators Review Form completed in relation to Mr Sheil by
47 Strike Force Parrabell is contained at tab 16 of the tender

1 bundle. In completing this form in relation to Mr Sheil,
2 the Strike Force Parrabell investigators appear to have
3 relied entirely on the two articles written by Mr Feneley
4 in 2013 and 2016 about his death, which I have referred to
5 earlier in these submissions.
6

7 I don't intend to take you to it, Commissioner, but
8 the similarities between the form and the articles are
9 obvious. Indeed, extracts from these articles are either
10 quoted, repeated verbatim, or summarised. It seems that
11 the Strike Force Parrabell officers could not, or did not,
12 obtain access to the coronial file, and given that the New
13 South Wales Police Force had no documents of their own,
14 these two media articles were the only documentary
15 foundation for this review. As a consequence, the BCIRF
16 repeatedly resorts to the same handful of observations
17 about Mr Sheil's death, largely drawn from the statements
18 made by his brother, Christopher, to the media.
19

20 It is therefore not surprising that the BCIRF does not
21 provide original or even particularly specific or
22 insightful responses in relation to each indicator and does
23 not address or analyse any of the matters that are readily
24 apparent from the coronial file, including the results of
25 the original police investigation. Inevitably, in the
26 circumstances, the Strike Force Parrabell officers answered
27 all 10 BCIRF indicators on the case as a whole as having
28 insufficient information, in that there was insufficient
29 information to determine whether there was any bias
30 motivation involved in Mr Sheil's death. Unsurprisingly in
31 the circumstances, the academic review team concurred with
32 that result.
33

34 In my submission, Commissioner, and given the absence
35 of any materials other than the two articles written by
36 Mr Feneley, Strike Force Parrabell could only ever purport
37 to conduct a review in this case; it should have been
38 obvious to investigators that, in those circumstances,
39 trying to determine whether Mr Sheil's death involved
40 anti-gay bias was, to put it simply, verging on pointless,
41 and although the results of this review were ultimately
42 presented as thorough and authoritative, it should have
43 been patently obvious that such a review was not going to
44 yield any reliable result. In this sense, this particular
45 case is emblematic of some of the flaws of the Strike Force
46 Parrabell process.
47

1 Having dealt with those two matters, the next matter
2 I wish to address is the steps taken by the Inquiry in
3 relation to Mr Sheil's case and the outcome of those steps.
4

5 First, and as previously stated, a summons to the New
6 South Wales Police Force was issued on 18 May 2022 for all
7 New South Wales Police Force investigative material,
8 including any material held or created by the unsolved
9 homicide team, in relation to the death of Mr Sheil. No
10 material was produced. On 12 September 2022, the Inquiry
11 wrote to the Office of the General Counsel of the New South
12 Wales Police Force, noting that in the New South Wales
13 Police Force documents contained in the Coroners Court
14 file, Mr Sheil's last name is spelt at times with different
15 variations, and requesting the New South Wales Police Force
16 conduct further searches for any investigation file under
17 those names. On 16 September 2022, the legal
18 representative for New South Wales Police Force advised
19 that no records are held in respect of any of the four
20 spelling variations identified. The Inquiry has therefore
21 received no documents in relation to this case from the New
22 South Wales Police Force.
23

24 The Inquiry did, however, request and receive the
25 Coroners Court file in relation to Mr Sheil, which
26 consisted of 18 pages of material relating to the Coroners
27 Court consideration of the matter in 1983. As I noted at
28 the beginning of my submissions, these documents form the
29 basis of the Inquiry's review. The Inquiry also contacted
30 and spoke to Mr Sheil's four siblings and on 16 September
31 2022 a summons was issued to the New South Wales Registry
32 of Births, Deaths and Marriages and we obtained the birth
33 and death certificates for Mr Sheil.
34

35 On 19 September 2022, the Inquiry requested
36 information about the weather conditions in the Clovelly
37 area between 22 and 29 April. The purpose of this request
38 was to determine the weather conditions from around the
39 time of Mr Sheil's death. On 20 October 2022, an officer
40 of the Bureau provided the weather, synoptic and rainfall
41 observations for the Clovelly area. The data indicates
42 that it rained two to three days prior to 27 April and
43 earlier that day. There may also have been a very slight
44 shower at around 9.00 pm on 27 April.
45

46 On 28 October 2022, the Inquiry accessed sunrise,
47 sunset and twilight time for 27 April 1983 from Geoscience

1 Australia. The Inquiry also had regard to the two articles
2 written by Rick Feneley and to which I referred earlier in
3 these submissions.
4

5 The Inquiry made endeavours to contact the witness who
6 discovered Mr Sheil's body, Mr Ross, but was unable to
7 locate him.
8

9 On 14 November 2022, a summons was issued to New South
10 Wales Health Pathology for all material held in relation to
11 Mr Sheil, including any photographs, CT images or notes
12 relevant to his autopsy. By issuing this summons, the
13 Inquiry was hopeful we could obtain further additional
14 information that was not contained in the Coroners Court
15 file.
16

17 On 23 November 2022, one file was produced in relation
18 to this case, but that file did not contain any information
19 that was not already before the Inquiry.
20

21 Finally, by letter dated 13 March 2023, the Inquiry
22 sought a report from Dr Linda Iles, forensic pathologist
23 and head of forensic pathology services at The Victorian
24 Institute of Forensic Medicine. Dr Iles was asked to
25 address various questions which are set out in my written
26 submissions at paragraph 40.
27

28 In her report received on 24 March 2023, Dr Iles noted
29 a number of matters which I wish to bring to the Inquiry's
30 attention. First, and significantly to this Inquiry and
31 its Terms of Reference, Dr Iles's conclusion is that in the
32 absence of any further details, including photographs,
33 there is no other medical avenue that could shed any light
34 on the manner and cause of Mr Sheil's death.
35

36 Secondly, Dr Iles states that although autopsy has
37 progressed significantly since Mr Sheil's deaths, there
38 were a number of features and deficiencies of the autopsy
39 examination and report. According to Dr Iles, the
40 information provided by the autopsy report is sufficient to
41 determine the cause of death but is not sufficient to help
42 address the manner of Mr Sheil's death or how his death
43 occurred.
44

45 In terms of the cause of death, Dr Iles's opinion is
46 that the only documented injury capable of causing
47 Mr Sheil's death was the upper cervical spinal cord injury.

1 This conclusion differs from the cause of death recorded in
2 the autopsy and on the death certificate, which is
3 "multiple injuries." In relation to the question of
4 whether Mr Sheil was likely to be able to move after he
5 fell, Dr Iles considered that although this was possible,
6 given the nature of his injuries, it was more likely that
7 Mr Sheil tumbled into his final position rather than moving
8 into that position voluntarily, and that death would have
9 been rapid following impact.

10
11 Thirdly, in terms of the matters going to the manner
12 of death, Dr Iles observed the following. She observed
13 that additional information to that which was contained in
14 the autopsy report about the specific elements of the C1
15 and C2 fractures sustained by Mr Sheil would have helped
16 inform the analysis as to manner of death. She stated that
17 the estimate of time of death provided by Dr Goldschmidt
18 should be disregarded and was unlikely to have been
19 intended to be a precise estimate. She stated that
20 although the state of Mr Sheil's clothing when he was found
21 could partially be explained by ordinary human behaviour
22 such as urinating, it did not explain his open shirt, and
23 given the observations about Mr Sheil's state of undress,
24 there should have been a more thorough postmortem
25 examination and trace evidence sampling.

26
27 Finally, she considered that suicide was an unlikely
28 manner of death because there was no reported change in
29 Mr Sheil's mood around the time of his death and his body
30 was found in a location with a shorter fall than the
31 immediate surrounding areas. However, ultimately Dr Iles's
32 conclusion was that she was unable to indicate whether
33 Mr Sheil's death was a result of misadventure, accident or
34 foul play.

35
36 The final matter I wanted to address, Commissioner, is
37 whether it is possible for this Inquiry to draw any
38 conclusions about whether Mr Sheil's death was a homicide
39 and, if so, whether that homicide was motivated by LGBTIQ
40 bias.

41
42 In circumstances where Mr Sheil was walking through or
43 near a beach shortly before his death, it is possible that
44 Mr Sheil was mistaken for a gay man and attacked by persons
45 unknown for that reason. However, there is no direct
46 evidence to substantiate that hypothesis. Mr Sheil's death
47 occurred some years before the homicides and suspected

1 homicides motivated by LGBTIQ bias or suspected to be
2 motivated by LGBTIQ bias at Marks Park in Bondi, some of
3 which are also the subject of this Inquiry, and in
4 Gordons Bay, several kilometres from the Bondi and
5 Marks Park areas.

6
7 Furthermore, and although the fact that Mr Sheil was
8 found with his shirt, belt and fly undone and with his
9 pants around his hips is consistent with the possibility he
10 was engaging in sexual activity before he died, there are
11 also several other possible explanations for the state of
12 his clothes which I have flagged previously.

13
14 Ultimately, my submission, Commissioner, is that the
15 evidence available to this Inquiry does not allow any
16 positive conclusion to be reached about the events leading
17 up to Mr Sheil's death, including whether it involved any
18 other person and whether, if so, it was motivated by LGBTIQ
19 bias.

20
21 In relation to this Inquiry's ultimate finding on the
22 manner and cause of Mr Sheil's death, my submission is that
23 the Inquiry should find as follows:

24
25 That Mr Sheil died between 8.00 pm on 27 April 1983
26 and 10.00 am on 29 April 1983 as a result of cervical spine
27 injuries sustained in a fall. There is insufficient
28 evidence to enable a finding to be made as whether that
29 fall was accidental or otherwise.

30
31 Arising from my submission in relation to that
32 finding, Commissioner, I would also submit that a
33 recommendation be made to Births, Deaths and Marriages to
34 amend the death certificate to more accurately reflect the
35 cause of death. That concludes my oral submissions,
36 Commissioner.

37
38 THE COMMISSIONER: Thank you. Mr Mykkeltvedt?

39
40 MR MYKKELTVEDT: I don't wish to be heard orally.

41
42 THE COMMISSIONER: Mr Bevan?

43
44 MR BEVAN: I don't wish to be heard orally.

45
46 THE COMMISSIONER: All right. Thank you very much.
47 I will reserve my position on the findings that I will

1 ultimately make on this and I will now adjourn. Thank you,
2 both.

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**AT 10.48AM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED
ACCORDINGLY**

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