

**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 Thursday, 18 May 2023 at 10.07am**

**(Day 54)**

**Re Rooney:**

**Ms Meg O'Brien (Counsel Assisting)**

**Ms Elizabeth Blomfield (Senior Solicitor)**

**Re Wark:**

**Mr William De Mars (Counsel Assisting)**

**Mr Enzo Camporeale (Director Legal)**

**Ms Caitlin Healey-Nash (Senior Solicitor)**

**Also Present:**

**Mr Anders Mykkeldvedt with Mr Patrick Hodgetts for  
NSW Police**

**Ms Angela Pearman for Ms Rebecca Wark**

1 THE COMMISSIONER: Yes.

2

3 MS O'BRIEN: Commissioner, I appear to assist you,  
4 instructed by Ms Blomfield.

5

6 THE COMMISSIONER: Thank you.

7

8 MS O'BRIEN: Commissioner, these submissions concern the  
9 death of William Antony Rooney, known as Bill Rooney.

10

11 I have a number of documents to hand up: a tender  
12 bundle; a copy of written submissions by Counsel Assisting;  
13 and some short minutes of order with respect to  
14 non-publication orders, which I understand are by consent.

15

16 THE COMMISSIONER: Thank you.

17

18 MR MYKKELTVEDT: Yes, Commissioner, Mykkeltvedt for the  
19 Commissioner of Police. Those orders are by consent.

20

21 THE COMMISSIONER: Thank you, Mr Mykkeltvedt.

22

23 Thank you. I will make those orders. Yes.

24

25 MS O'BRIEN: Commissioner, Mr Rooney was a Scottish man  
26 originally from Glasgow who, at the time of his death at  
27 35 years of age, had been living in Australia for 18 years.  
28 He was an openly gay man who was living with his partner,  
29 Mr Wayne Davis, in Wollongong. The two men had met each  
30 other in 1982 at the Mardi Gras in Sydney.

31

32 According to Mr Davis, Mr Rooney was an easygoing,  
33 affable and highly intelligent man, who was also a party  
34 animal who liked to drink alcohol.

35

36 At around 8.40am on Friday, 14 February 1986,  
37 Mr Rooney was found on the ground between a toilet block  
38 and a concrete retaining wall at the rear of retail  
39 premises in Crown Lane, Wollongong. The gap between the  
40 wall and the toilet block was about half a metre.

41

42 Commissioner, in annexure A to Counsel Assisting's  
43 written submissions is an aerial view of part of the  
44 Central Wollongong area as at 1986 to 1987. That aerial  
45 view is on the screen now.

46

47 The area where Mr Rooney was found is marked by a red

1 arrow on that aerial view.

2

3

We can see that in annexure A the area where Mr Rooney was found is near a nightclub that was then known as Annabel's, and later known as Pip's.

6

7

At the top of the retaining wall, which is about three metres high, was a small car parking area, which you can see, which is the light grey area just under the red arrow on that annexure.

10

11

12

When he was found, Mr Rooney was alive but suffering from serious head injuries and was in a semiconscious condition. He was transported by ambulance to Wollongong Hospital, but he died from his injuries six days later, on 20 February 1986.

17

18

The following is what the Inquiry is able to establish about the events leading up to Mr Rooney's death. At around 5.45 on Thursday, 13 February 1986, Mr Rooney telephoned his partner, Mr Davis, and asked him whether he wanted to go for a few beers. Mr Davis agreed and collected Mr Rooney from their home.

24

25

They then went to the Tattersalls Hotel in Wollongong, arriving at around 6.15pm and drinking beers there until between around 9pm to 10pm. Mr Davis then left and went to a friend's place.

29

30

Before Mr Davis left the Tattersalls Hotel, Mr Rooney told Mr Davis that he planned to go to Annabel's Disco, which, as I have stated earlier, soon became Pip's International.

34

35

When the two parted, Mr Davis observed Mr Rooney to be in extremely good spirits and not overly affected by alcohol.

38

39

Mr Rooney's movements between around 10pm on 13 February, when he parted from Mr Davis, and 8.40am on 14 February, when he was found in Crown Lane, are not entirely clear. It appears that Mr Rooney did attend Annabel's Disco at some point in the early hours of 14 February, but he was also seen at the Grand Hotel not far away in Keira Street, Wollongong.

44

45

46

47

The subsequent police investigation into Mr Rooney's

1 death also identified and took statements from various men  
2 who had seen a man staggering down Crown Lane in a westerly  
3 direction before that man went to lie down on the grass  
4 area on the footpath on the northern side of Crown Lane  
5 where he was sleeping for at least one and a half hours.  
6 According to these men, the man that they saw did not  
7 appear to be injured.

8  
9 At around 8.53am on 14 February, paramedics were  
10 called to attend to a person who was said to have fallen  
11 off a roof at the rear of the retail store in Crown Lane.

12  
13 On arrival at the scene shortly afterwards, the  
14 paramedics observed Mr Rooney lying at the base of some  
15 steps. Mr Rooney was suffering significant injuries, was  
16 disoriented and difficult to treat. The paramedics could  
17 not locate any identification on him.

18  
19 One of the paramedics gave a statement to the police  
20 in which he stated that, from his observation, he had  
21 formed the opinion that Mr Rooney had fallen from the wall  
22 above and landed on his head.

23  
24 At around 9am on 14 February 1986, Constable Michael  
25 Tranby and Constable Revitt, from the NSW Police Force,  
26 attended the scene. When they arrived, Mr Rooney was  
27 already being treated by the paramedics. Constable Tranby  
28 observed that Mr Rooney was wearing only one shoe and one  
29 sock.

30  
31 Video footage taken at the scene by a cameraman from  
32 WIN Television shows that when he was found, Mr Rooney's  
33 pants and underwear were lowered to his pubic hair line and  
34 his fly was unzipped. The footage shows that while  
35 paramedics attempt to treat Mr Rooney, Mr Rooney resists  
36 these attempts to help him and tries to pull up his pants  
37 by lifting his hips.

38  
39 In the book "Getting Away With Murder", author  
40 Duncan McNab wrote that:

41  
42 *To one detective this was either an*  
43 *instinctive reaction or the act of a man*  
44 *trying to prevent the recurrence of an*  
45 *attack.*

46  
47 At 9.30am, DSC John Tate, from the NSW Police Force,

1 arrived at the scene. By this time, Mr Rooney had been  
2 conveyed to Wollongong Hospital. DSC Tate attended the  
3 scene with Detectives Stanley and Fitzgerald.  
4

5 At around 11.05am, Detective Sergeant Stephen Passmore  
6 attended the scene in his capacity as a member of the  
7 Scientific Investigation Section. DS Passmore tested  
8 certain areas of the scene for blood. However, he observed  
9 that the staff from the retail premises had taken it upon  
10 themselves to hose down the scene, which meant that most of  
11 the blood and physical evidence had gone.  
12

13 DS Passmore took photographs of the scene but  
14 ultimately said he did not find anything that could assist  
15 in determining the cause of Mr Rooney's injuries.  
16

17 That afternoon, DS Passmore and DSC Tate both attended  
18 the intensive care unit at Wollongong Hospital where they  
19 observed Mr Rooney. DS Passmore also took some photographs  
20 of Mr Rooney's injuries.  
21

22 At 2.50pm after attending both the scene on Crown Lane  
23 and the hospital, DSC Tate noted:  
24

25 *... there is no clear indication as to how*  
26 *this male person received these injuries.*  
27

28 At about 7.40pm, Mr Davis, Mr Rooney's partner, attended  
29 the Wollongong Police Station and informed the police that  
30 he was Mr Rooney's partner. A statement was obtained from  
31 him and his alibi was checked the following day.  
32

33 Some years later, in September 1993, in a public  
34 appeal to help solve the case, Mr Davis told journalist  
35 Brett Martin from the Illawarra Mercury about the  
36 experience of going to police. He told Mr Martin that the  
37 police were "initially very keen to pin it on" him and  
38 that, I quote again:  
39

40 *The police weren't interested, it was just*  
41 *another poofter.*  
42

43 The following day, Saturday, 15 February 1986, Mr Davis  
44 informed police that Mr Rooney had, and I quote:  
45

46 *... previously spoken to a person by the*  
47 *name of "Radar", who he alleges is*

1           a well-known Poofter basher.

2  
3           "Radar" was an alias then used by a person named  
4           Leslie Harrison.

5  
6           On 17 February 1986, police spoke to Mr Harrison,  
7           who denied any involvement in the incident. Mr Harrison  
8           said that, at the time, he was with his girlfriend,  
9           Joanne Garbutt, for the entire night.

10  
11           Over this time, Mr Rooney remained in hospital  
12           unconscious and on a ventilator. On 19 February 1986,  
13           Mr Rooney's condition began to deteriorate and the  
14           following day, 20 February 1986, he was formally evaluated  
15           as brain dead. His ventilator support was then terminated  
16           and he died at 2.35pm.

17  
18           A post-mortem examination was conducted on Mr Rooney  
19           on 21 February 1986 by Dr Vincent Versoza. In his report  
20           completed that same day Dr Versoza concluded that the  
21           direct cause of Mr Rooney's death was, and I quote,  
22           a "massive (subdural) cerebral haemorrhage and intracardiac  
23           thrombus" as a result of torn meningeal vessels and skull  
24           fractures.

25  
26           In his report, Dr Versoza concludes that these  
27           injuries were most probably due to a fall, with the back of  
28           the head hitting a hard surface.

29  
30           Dr Versoza also reported that Mr Rooney had bruises on  
31           his limbs and chest and there was an abrasion to his right  
32           knee. Other observations of Dr Versoza are summarised in  
33           paragraphs 6 and 7 of the written submissions of Counsel  
34           Assisting.

35  
36           An inquest into Mr Rooney's death was held on  
37           24 October 1986 and 15 May 1987, before Coroner Warwick  
38           Soden.

39  
40           At the inquest, Dr Versoza gave evidence consistent  
41           with his post-mortem report - namely, that he considered  
42           that the injuries to Mr Rooney's head had been caused by  
43           his head hitting a hard, flat surface, rather than being  
44           struck with an object to the back of the head since, in his  
45           experience, being struck with an object would usually  
46           result in the skin being split open, which was not the case  
47           with Mr Rooney.

1  
2           However, Dr Mason Ramsay, who was the director of  
3 intensive care at the Illawarra Health Service, and who  
4 treated Mr Rooney at Wollongong Hospital, gave evidence  
5 that he did not consider that Mr Rooney's injuries were  
6 consistent with a fall from three metres on to a concrete  
7 floor.

8  
9           On 15 May 1987, Coroner Soden found that Mr Rooney  
10 died of head injuries, but delivered an open finding in  
11 relation to whether those injuries were sustained as  
12 a result of an accident or otherwise.

13  
14           Commissioner, I have just outlined to the Inquiry the  
15 key facts relevant to the initial investigation into  
16 Mr Rooney's death. However, events subsequent to this  
17 investigation are also highly relevant to this Inquiry's  
18 consideration of this particular case

19  
20           Between March 1986 and September 1989, 12 male victims  
21 were physically and/or sexually assaulted. The attacks  
22 occurred in circumstances that bear many similarities. All  
23 but two of these attacks occurred in Wollongong. Many of  
24 them involved a similar pattern in that the victims usually  
25 experienced an assault to the head, in several cases using  
26 a rock, before the victim was sexually assaulted. Many of  
27 the victims suffered serious head injuries. Most of the  
28 victims were intoxicated and most were gay.

29  
30           On 26 September 1989, Mark Anthony Scerri was charged  
31 with 29 offences in relation to these 12 victims. Charges  
32 in respect of nine victims were the subject of four  
33 separate trials in 1991 and 1992. Charges in respect of  
34 three victims did not proceed to trial.

35  
36           In Counsel Assisting's written submissions, there is  
37 annexed an annexure B which contains a table summarising  
38 the circumstances relating to these assaults and/or sexual  
39 assaults on the 12 victims, one of whom was the victim of  
40 three separate attacks, and the outcomes of the charges  
41 and/or trial in each case. In summary, however, Mr Scerri  
42 was acquitted in relation to the attacks on six victims and  
43 convicted of offences in relation to three victims. He was  
44 sentenced to a total effective sentence of 16 years  
45 imprisonment.

46  
47           Two further matters about these cases are particularly

1 notable. One of the victims, with the pseudonym "I194",  
2 was attacked in September 1989 on the other side of the  
3 same laneway, Crown Lane, where Mr Rooney had been found on  
4 14 February 1986. Mr Scerri was convicted in relation to  
5 this attack.  
6

7 Another one of the victims, with the pseudonym "I186",  
8 said that in the course of the attack on him, which  
9 occurred on 18 December 1986, his attacker said to him,  
10 "I'll kill you like I killed the poofter in the laneway."  
11 Mr Scerri was acquitted in relation to that attack.  
12

13 Further detail about these 12 offences is contained in  
14 annexure B, as I have noted, and in Counsel Assisting's  
15 written submissions at paragraphs 172 to 183. However,  
16 Commissioner, it was in the course of investigating the  
17 attacks against those 12 victims that police officer,  
18 Detective Inspector David Ainsworth, formed the view that  
19 Mr Rooney was likely to have been the victim of the same  
20 attacker.  
21

22 DI Ainsworth had previously attended the scene at  
23 Crown Lane on the day after Mr Rooney was found and formed  
24 the view that it was unlikely that Mr Rooney had fallen.  
25 However, and by around the end of 1989, Mr Scerri had  
26 emerged as a key person of interest in the death of  
27 Mr Rooney.  
28

29 In 1991, and again in 1993, DI Ainsworth referred  
30 Mr Rooney's case to the ODPP to consider laying charges  
31 against Mr Scerri for the death of Mr Rooney. DI Ainsworth  
32 expressed his view that there was no doubt in his mind that  
33 Mr Scerri was responsible for assaulting and murdering  
34 Mr Rooney.  
35

36 On 24 March 1993, following Mr Scerri's conviction in  
37 1992 and sentencing in 1993, police sent a brief to the  
38 then Deputy Senior Crown Prosecutor, Mr Tedeschi QC, for  
39 advice on whether Mr Scerri could be charged with the  
40 murder of Mr Rooney. However, on 28 June 1993, the  
41 New South Wales DPP advised that, in the opinion of  
42 Mr Tedeschi QC, there was insufficient evidence to do so.  
43 One reason for that opinion was the absence of evidence  
44 that Mr Rooney had been sexually assaulted.  
45

46 In November 2001, Mr Scerri was released on parole.  
47 In May 2002, Mr Scerri reoffended by attacking another

1 victim, a 26-year-old male, in Wollongong. Upon being  
2 sentenced, Judge Phelan stated that the attack was, and  
3 I quote, "remarkably similar" to the three offences of  
4 which Mr Scerri had been convicted in 1992.

5  
6 In 2003 he was convicted, having pled guilty, and  
7 again imprisoned. Further detail about that offence is  
8 contained at paragraphs 190 to 194 of Counsel Assisting's  
9 written submissions.

10  
11 By 2002, Mr Scerri was still a key suspect in the  
12 death of Mr Rooney. On 17 October 2002, the day after  
13 Mr Scerri's arrest, DS Bridge made inquiries about whether  
14 Mr Rooney's body could be exhumed and examined for semen.  
15 DS Bridge was subsequently informed that the likelihood of  
16 retrieving DNA from an assailant was extremely low, given  
17 the passage of time. In any event, Commissioner, the  
18 Inquiry has ascertained that Mr Rooney's remains have been  
19 cremated.

20  
21 On 10 February 2011, Mr Scerri was again released on  
22 parole, and on 9 September 2011 was placed on an extended  
23 supervision order for a period of three years.

24  
25 Commissioner, Mr Scerri continues to be the primary  
26 person of interest in this case.

27  
28 Commissioner, I would now like to take the opportunity  
29 to address you on the police investigation of this case and  
30 specifically on some key opportunities that were missed by  
31 the NSW Police Force.

32  
33 First, and based on the contemporaneous documents  
34 produced to this Inquiry by the police, Mr Rooney's death  
35 was initially considered to be either suspicious or having  
36 occurred in circumstances that were unknown. However, at  
37 the inquest into Mr Rooney's death, the police favoured the  
38 conclusion that Mr Rooney sustained his injuries as the  
39 result of an accidental fall. This evolution in thinking  
40 is discussed in detail at paragraphs 38 [sic] to 35 of  
41 Counsel Assisting's written submissions.

42  
43 However, in reaching the conclusion that Mr Rooney  
44 died as a result of an accidental fall, little, if any,  
45 attention or weight appears to have been given to evidence  
46 that tended to point to an explanation other than  
47 misadventure, including that Mr Rooney was not carrying ID;

1 that his pants and underwear were lowered; that he was  
2 missing a shoe and a sock; and that he appeared to have  
3 fingernail marks on his neck that were likely not his; and  
4 that he was known to regularly drink a lot and hold his  
5 liquor well.  
6

7 Secondly, NSW Police failed to secure the area where  
8 Mr Rooney's body was found. After having first attended  
9 the scene at 9am, by at least 11.05am, before the police  
10 Scientific Investigation Section had arrived, the lessee of  
11 the retail premises adjoining the scene had already taken  
12 it upon himself to clean the area by hosing it down.  
13 Naturally, this limited the ability of investigators to  
14 properly assess the area and recover any exhibits of any  
15 forensic value.  
16

17 Thirdly, no sexual assault examination was conducted,  
18 and after Mr Rooney died, there appears to have been no  
19 examination of the anus or genitals during the post-mortem.  
20

21 It may be that the original investigators did not  
22 provide Dr Versoza with any reason to conduct an anogenital  
23 exam, such as specifying the circumstances in which  
24 Mr Rooney's body was found, including that his jeans and  
25 underwear were lowered.  
26

27 In this respect, it is notable that the day after  
28 Mr Rooney was found, Mr Davis had informed the police that  
29 Mr Rooney had spoken to Mr Harrison, or Radar, a well-known  
30 pooker basher in the area, and the police had interviewed  
31 him. They were effectively on notice that Mr Rooney may  
32 have been targeted because he was gay, yet still no sexual  
33 assault examination took place.  
34

35 Fourthly, the shortcomings of the original  
36 investigation became apparent when, in 1991 and again in  
37 1993, the case was referred to the DPP in relation to  
38 whether there was enough evidence to charge Mr Scerri in  
39 connection with the death of Mr Rooney.  
40

41 The advice of Mr Tedeschi QC in 1993 demonstrates that  
42 the failure to examine Mr Rooney for signs of possible  
43 sexual assault has severely impeded the possibility of  
44 investigating and/or prosecuting Mr Scerri or, indeed,  
45 anyone else, in relation to Mr Rooney's death.  
46

47 Fifthly, and while Mr Harrison or Radar claimed to

1 have an alibi for the night of 13 and 14 February, namely,  
2 that he had been with his girlfriend Ms Garbutt the entire  
3 night, there is no indication in the material produced to  
4 the Inquiry by the police that they ever interviewed or  
5 sought to interview Ms Garbutt about those matters.  
6 However, by 17 February 1986, so far as can be ascertained  
7 on the material available to the Inquiry, police had ceased  
8 pursuing any inquiries in relation to the possible  
9 involvement of Mr Harrison in the death of Mr Rooney.

10  
11 Sixthly, and based on the records made available to  
12 the Inquiry by police, there were various other  
13 deficiencies with the investigation, including the failure  
14 to obtain statements from some of the officers who attended  
15 the scene; the failure to mention the fact that Mr Rooney's  
16 pants and underwear were lowered and his fly was unzipped  
17 in the statements made by the paramedics and police  
18 officers; the failure to obtain and finalise statements in  
19 a timely manner; and the failure to obtain signatures on  
20 particular statements.

21  
22 Commissioner, the next topic I wanted to address is  
23 the Strike Force Parrabell review of Mr Rooney's case. The  
24 Bias Crime Indicators Review Form or BCIF in relation to  
25 Mr Rooney is contained at tab 30 of the tender bundle. All  
26 10 Bias Crime Indicators in relation to Mr Rooney were  
27 answered, "No evidence of bias crime." However, the  
28 overall categorisation of the case in the summary of  
29 findings was "Insufficient information". The academic team  
30 also categorised the case as one where there was  
31 insufficient information.

32  
33 The possible involvement of Mr Harrison and/or  
34 Mr Scerri in Mr Rooney's death is mentioned in seven of the  
35 10 "General Comments" sections of the BCIF and also in the  
36 summary of findings.

37  
38 The uniform answer of "No evidence of bias crime" to  
39 all 10 indicators seems at odds with the comments.

40  
41 The "General Comments" section also repeatedly notes  
42 that Mr Scerri was known to have been involved in other  
43 assaults against and rapes of men in locations not far from  
44 the area where Mr Rooney was found and that he was known to  
45 hit his victims over the head with bricks or large rocks.  
46 The alleged involvement of Mr Harrison in similar conduct  
47 was also repeatedly noted.

1  
2 Yet the "General Comments" section in relation to  
3 indicator number 3, which, Commissioner, you will recall is  
4 "Drawings, markings, symbols, tattoos, graffiti", states,  
5 and I quote:

6  
7 *In photographs taken of the crime scene by*  
8 *Detective Sergeant Passmore there is*  
9 *photographic evidence showing what appears*  
10 *to be a concrete rock near where Rooney was*  
11 *located however this bears no weight on*  
12 *bias motivation.*

13  
14 The view that the presence of a concrete rock at the  
15 scene bears no weight on a bias motivation in light of what  
16 was then known or alleged and acknowledged by the BCIF to  
17 have been known about the modus operandi of both  
18 Mr Harrison and Mr Scerri is difficult to fathom. The  
19 presence of the rock would also appear to cast some doubt  
20 upon the unsigned statement of DS Passmore which is  
21 referred to elsewhere in the BCIF.

22  
23 DS Passmore took those photographs referred to in the  
24 BCIF on 14 February 1986. These photos show a concrete  
25 rock, and yet, according to his unsigned statement eight  
26 months later, he made a thorough search of the entire area  
27 and found nothing which he could associate with Rooney's  
28 injuries. The Strike Force Parrabell officers made no  
29 comment on or reference to this inconsistency.

30  
31 In the "General Comments" section in relation to  
32 indicator 5, which you may recall is "Previous existence of  
33 bias crime incidents", the Strike Force Parrabell officers  
34 state that there is no evidence to suggest Rooney was  
35 visiting a location where previous bias crime had been  
36 committed. However, as officers recognised later in the  
37 same section, there was evidence presented in regards to  
38 the suspect, Mr Scerri, being involved in assaulting,  
39 kidnapping and robbing both homosexual and heterosexual  
40 males in the area where Mr Rooney was found, albeit shortly  
41 after, rather than before Mr Rooney's death.

42  
43 In the summary of findings in the BCIF, it similarly  
44 highlights the possible involvement of Mr Harrison and/or  
45 Mr Scerri in the death of Mr Rooney. There is a notable  
46 focus in the BCIF on Mr Scerri and Mr Harrison as persons  
47 of interest in the death of Mr Rooney or on their known or

1 alleged methods and the presence of the rock. Yet, in  
2 relation to every single indicator, as I have previously  
3 stated, the Strike Force Parrabell officers answered, "No  
4 evidence of bias crime".

5  
6 The BCIF refers to Mr Scerri's other offences, both  
7 alleged and proven, and to the allegations made against  
8 Mr Harrison, but then seemingly discounts this evidence as  
9 having any bearing on the question of bias. The basis for  
10 such apparent discounting is unclear.

11  
12 Conversely, and as I have stated, it is also puzzling  
13 that despite answering "Yes" to "No evidence of bias crime"  
14 in relation to all 10 indicators, Mr Rooney's case is,  
15 nonetheless, given the overall designation of "Insufficient  
16 information".

17  
18 At the very least, Commissioner, we submit that  
19 questions arise in relation to the coherence and rigour of  
20 the methodology of Strike Force Parrabell where the overall  
21 categorisation of a case review bears absolutely no  
22 correlation to the components of that review.

23  
24 Finally, the case summary produced by Strike Force  
25 Parrabell in relation to Mr Rooney's case, which is found  
26 at tab 49 of exhibit 6, is notable because, in particular,  
27 the last sentence of the case summary reads:

28  
29 *It is likely the original Coronial finding*  
30 *regarding Mr Rooney's death being caused by*  
31 *a fall is incorrect.*

32  
33 That sentence follows a series of sentences referring to  
34 the similarities between Mr Rooney's case and those of the  
35 12 men assaulted or allegedly assaulted by Mr Scerri, and  
36 to the possibility that Mr Rooney was the first victim of  
37 Mr Scerri.

38  
39 Even though Strike Force Parrabell's summary of the  
40 coronial finding itself is incorrect, this sentence  
41 presumably indicates that Strike Force Parrabell officers  
42 considered that what was likely was that Mr Rooney's death  
43 had been caused by an assault rather than a fall.

44  
45 Overall, the treatment of this case by Strike Force  
46 Parrabell as evidenced by the BCIF and case summary appears  
47 to have been devoid of any analytical sophistication or

1 nuance. Whether this is a consequence of having limited  
2 time to complete the review because Strike Force Parrabell  
3 had originally recorded Mr Rooney's last name as "Rudney"  
4 and hence, for some time, could locate no material about  
5 the case, or whether this indicates a more systemic problem  
6 with the work of Strike Force Parrabell, or both, is  
7 unclear.

8  
9 Furthermore, the BCIF fails to address or even engage  
10 with the failures of the original investigation including  
11 how those failures continue to impede the ability of any  
12 reviewer, including this Inquiry, to establish the manner  
13 and cause of Mr Rooney's death.

14  
15 Commissioner, the next matter I wish to address is the  
16 steps taken by the Inquiry in relation to Mr Rooney's case  
17 and the outcomes of those steps.

18  
19 The steps that this Inquiry has taken to investigate  
20 this matter include: compelling the production of  
21 NSW Police Force holdings in relation to the investigation  
22 into Mr Rooney's death and in relation to other offences  
23 with which Mr Scerri was charged; next, obtaining Coroners  
24 Court files in relation to the inquest held in 1987;  
25 compelling production of material held by the ODPP,  
26 Corrective Services and the Supreme Court of New South  
27 Wales; attempting to contact family members; obtaining  
28 a report from Dr Linda Iles, a forensic pathologist;  
29 interviewing people with relevant knowledge of the case,  
30 which has ranged from speaking to police officers involved  
31 in the initial investigation through to speaking with  
32 employees of Wollongong City Council about the lighting in  
33 Crown Lane in 1986; and of course, the Inquiry's staff have  
34 reviewed and analysed this material and considered whether  
35 any further investigative or other avenues are warranted.

36  
37 These steps are explained in more detail at paragraphs  
38 80 to 101 of Counsel Assisting's written submissions.

39  
40 However, there are a number of these steps that  
41 I would like to specifically touch on this morning. First,  
42 and in relation to the Inquiry's attempts to obtain all  
43 NSW Police Force holdings in relation to this case via the  
44 first summons it ever issued on 2 June 2022, NSW Police  
45 produced only nine documents comprising some occurrence  
46 reports and two witness statements.

1           After the Inquiry requested that more searches be  
2 undertaken, the NSW Police informed the Inquiry  
3 in September 2022 that all the documents in its possession,  
4 being the nine documents in total, had been produced  
5 already.  
6

7           It was not until November 2022 that the NSW Police  
8 informed the Inquiry that it had located a hard copy file  
9 at Wollongong Police Station and provided these documents  
10 to the Inquiry. That file contained autopsy photos,  
11 additional statements and some correspondence not  
12 previously received by this Inquiry.  
13

14           Second, this Inquiry's attempts to contact Mr Rooney's  
15 family members has been unsuccessful. Unfortunately,  
16 Mr Davis, Mr Rooney's partner, is now deceased. The  
17 Inquiry has also attempted to contact Mr Rooney's aunt, but  
18 these attempts have been unsuccessful.  
19

20           Third, as I have stated, the Inquiry sought and  
21 obtained a report from Dr Linda Iles, the forensic  
22 pathologist and Head of Forensic Pathology Services at the  
23 Victorian Institute of Forensic Medicine. Dr Iles  
24 addressed a number of issues in her report, including the  
25 adequacy of the post-mortem investigations conducted with  
26 respect to Mr Rooney; the likely cause of Mr Rooney's  
27 injuries; the inconsistencies in the evidence given by  
28 Drs Versoza and Ramsay at the inquest; and whether she had  
29 any recommendations for further investigations and with  
30 respect to determining the manner and cause of Mr Rooney's  
31 death.  
32

33           The report of Dr Iles in relation to Mr Rooney's case  
34 was received by the Inquiry on 31 January 2023, and that  
35 report is found at tab 39 of the tender bundle. In her  
36 report, Dr Iles noted that autopsy practice has evolved  
37 considerably since Mr Rooney's death. However, she  
38 outlined some key deficiencies in the autopsy and medical  
39 examinations in relation to Mr Rooney. In particular, she  
40 noted the inadequate documentation of his injuries in the  
41 autopsy report, including in relation to any anogenital  
42 injuries, and the lack of any comprehensive forensic  
43 medical examination after he was admitted to hospital.  
44 This means, according to Dr Iles, that addressing the  
45 mechanism by which Mr Rooney sustained his injuries in 2023  
46 is difficult.  
47

1           As to the different views expressed by Dr Versoza and  
2 Dr Ramsay, Dr Iles noted that Dr Versoza appeared to  
3 consider injury sustained in a fall seemed to be the most  
4 likely mechanism of injury, whereas by contrast, Dr Ramsay  
5 appeared to suggest that it was highly unlikely that such  
6 injuries could be sustained in a fall as described.

7  
8           Dr Iles considered that Dr Versoza or Dr Ramsay had  
9 both expressed a level of certainty about the mechanism of  
10 injury beyond that which was supported by the contemporary  
11 evidence base. However, in Dr Iles's view, there were  
12 several factors that favoured Dr Versoza's interpretation  
13 of Mr Rooney's injuries, including the type of skull  
14 fracture sustained, the absence of extensive cutaneous  
15 injuries and the possibility that the linear abrasions were  
16 caused by contact with a protruding roof structure or  
17 nails.

18  
19           However, Dr Iles said that on the evidence available,  
20 she was unable to exclude either mechanism, either a fall  
21 or a blow to the head by a blunt instrument, as the manner  
22 of death.

23  
24           Dr Iles stated, and I quote:

25  
26           *... I am not convinced that the post-mortem*  
27 *examination conducted has been*  
28 *sufficient ... to allow any type of*  
29 *accurate event reconstruction. If*  
30 *Mr Rooney's injuries had been sustained in*  
31 *a fall, I cannot say how that fall may have*  
32 *come about (ie, an accidental fall, or*  
33 *whether Mr Rooney was pushed between the*  
34 *retaining wall and the toilet block roof).*  
35           *...*

36           *On the evidence available, I am unable*  
37 *to exclude either mechanism. Examination*  
38 *of the literature demonstrates that*  
39 *Mr Rooney's injuries, as much as they have*  
40 *been documented, could have been sustained*  
41 *as a result of a fall from around 3 metres*  
42 *in height with, primary impact to the head,*  
43 *or could have been sustained via homicidal*  
44 *means (ie, blunt trauma to the head by an*  
45 *implement). I agree with the original*  
46 *coroner's determination that the mechanism*  
47 *of Mr Rooney's injuries is undetermined.*

1  
2 Dr Iles concluded that Mr Rooney's cause of death  
3 could be reasonably described as blunt head injuries,  
4 however, on the evidence available, she was unable to  
5 determine the manner of his death.  
6

7 Fourth, Commissioner, the Inquiry has spoken to  
8 Mr McNab, DI Ainsworth, DSC Tate and Ms Garbutt. Both  
9 DSC Tate and Ms Garbutt have provided statements to the  
10 Inquiry, and these are contained in the tender bundle.  
11

12 The information and evidence provided by these  
13 individuals are discussed in greater detail in the written  
14 submissions of Counsel Assisting. However, it is notable  
15 that Ms Garbutt has no recollection of ever being spoken to  
16 by Wollongong police in connection with where Mr Harrison  
17 was on a particular night in February 1986, or that she  
18 ever stayed overnight with Mr Harrison in Coniston around  
19 this time; rather, her recollection was that in February  
20 1986 she was living in Coffs Harbour.  
21

22 Fifth, my instructing solicitor, Ms Blomfield, has  
23 made inquiries with Wollongong City Council and Endeavour  
24 Energy about the street lighting that would have been in  
25 place in Crown Lane in February 1986. Although these  
26 inquiries have not been conclusive, it seems likely that  
27 the lighting currently in place in Crown Lane was not  
28 installed until December 1986.  
29

30 Sixth, inquiries have been made in relation to persons  
31 of interest. The Inquiry has established that Mr Harrison  
32 is now deceased. Mr Scerri, however, remains alive and his  
33 whereabouts is known to the Inquiry.  
34

35 Until 2023, Mr Scerri had never been questioned in  
36 relation to the death of Mr Rooney. An attempt to  
37 interview him by the police in 1993 was fruitless because  
38 Mr Scerri, who was then in custody, refused to speak to the  
39 police. However, earlier this month, Mr Scerri was  
40 questioned in a private hearing of this Inquiry. That  
41 evidence will be the subject of a confidential part of the  
42 report of the Inquiry in due course.  
43

44 The next matter I wanted to address is whether it is  
45 possible for this Inquiry to draw any conclusions about  
46 whether Mr Rooney's death was a homicide and, if so,  
47 whether that homicide was motivated by LGBTIQ bias.

1  
2 As stated earlier in these submissions, Mr Rooney was  
3 an openly gay man. He was living with his partner,  
4 Mr Davis, at the time of his death. As to whether his  
5 death involved LGBTIQ bias, the relevant factors are as  
6 follows: first, in the three and a half years immediately  
7 after Mr Rooney's death, there were a series of attacks on  
8 12 men in and near Wollongong, as I have detailed to you  
9 Commissioner this morning. Most of those men were gay.

10  
11 The first of those attacks was on 9 March 1986, only a  
12 little more than three weeks after Mr Rooney suffered the  
13 injuries which caused his death. Many of these attacks  
14 involved a similar modus operandi in which victims suffered  
15 a blow or blows to the head or the threat of such  
16 a physical assault prior to being sexually assaulted.

17  
18 In the letter from DS Bridge to Dr Duflou concerning  
19 the possibility of exhuming Mr Rooney's remains, DS Bridge  
20 stated that Mr Scerri initially committed offences against  
21 homosexuals in 1986 as they were easier targets, but  
22 apparently reverted to targeting heterosexual males in fear  
23 of catching AIDS.

24  
25 Psychiatric evidence before the court upon sentencing  
26 Mr Scerri for the offences he committed in 2002 also  
27 reveals that Mr Scerri sought to humiliate his victims and  
28 that he wanted to make them suffer.

29  
30 Secondly, Mr Davis was of the view that Mr Rooney was  
31 the victim of a gay hate attack.

32  
33 Thirdly, according to Mr Davis, he and Mr Rooney had  
34 previously been attacked in Wollongong for being gay.

35  
36 Fourthly, the possibility that Mr Rooney was attacked  
37 on this occasion because of his sexuality arises from what  
38 is suspected or known either in 1986 or subsequently about  
39 the activities of Mr Harrison and Mr Scerri.

40  
41 Mr Rooney's case, so far as now can be ascertained on  
42 the available evidence, had some of the same features as  
43 those attacks that Mr Scerri was charged and/or convicted  
44 of, and which are set out in annexure B to Counsel  
45 Assisting's written submissions. However, whereas all of  
46 the other victims survived and were able to tell police  
47 that they had been assaulted, that is obviously not so in

1 relation to Mr Rooney.  
2

3 Whether, in his case, it was an assault or a fall  
4 which caused his injuries can only now be assessed by  
5 reference to objective evidence such as the nature and  
6 extent of his injuries. In addition, whereas the other  
7 victims were also sexually assaulted, there is no evidence  
8 as to whether or not that was so in the case of Mr Rooney,  
9 because no tests were carried out either on his admission  
10 to hospital or in the post-mortem examination in relation  
11 to that possibility.  
12

13 If it were to be assumed that Mr Rooney's death was  
14 a homicide and that homicide was committed by Mr Scerri,  
15 there would be ample grounds for a conclusion that  
16 Mr Rooney's death was a crime involving LGBTIQ bias.  
17 However, in this case, the available evidence does not  
18 allow either of those assumptions to be made.  
19

20 There exists a reasonable alternative hypothesis other  
21 than homicide, namely, that Mr Rooney sustained his  
22 injuries as a result of an accidental fall.  
23

24 No evidence was sought or obtained at the time as to  
25 whether Mr Rooney was sexually assaulted and it is now not  
26 possible to carry out any tests which would shed light on  
27 that issue.  
28

29 Commissioner, in my submission, the evidence before  
30 this Inquiry does not provide a sufficient basis to find  
31 that Mr Rooney's death was a homicide.  
32

33 In relation to the manner and cause of Mr Rooney's  
34 death, my submission is that the Inquiry should find as  
35 follows: Mr Rooney died on 20 February 1986 as a result of  
36 blunt head injuries sustained on 14 February 1986.  
37 However, the evidence available to the Inquiry is  
38 insufficient to establish whether these injuries were the  
39 result of an assault or an accidental fall.  
40

41 Commissioner, there are no recommendations  
42 specifically arising out of this matter, and that concludes  
43 my oral submissions.  
44

45 THE COMMISSIONER: Thank you.  
46

47 Mr Mykkeltvedt, you reserve your position, I presume?

1  
2 MR MYKKELTVEDT: Yes, that's so, Commissioner.

3  
4 THE COMMISSIONER: All right. Thank you.

5  
6 Before we proceed to the next matter, I will take  
7 a short break, thank you.

8  
9 **SHORT ADJOURNMENT**

10  
11 THE COMMISSIONER: Yes, Mr de Mars.

12  
13 MR de MARS: Commissioner, I appear as Counsel Assisting  
14 in this hearing by way of documentary tender in relation to  
15 the death of Simon Blair Wark.

16  
17 THE COMMISSIONER: All right.

18  
19 Yes, Ms Pearman, you seek leave to appear?

20  
21 MS PEARMAN: Yes, I do, thank you.

22  
23 THE COMMISSIONER: I grant you leave, thank you.

24  
25 Can I just say at the outset that, Ms Pearman, this  
26 morning and for the first time I think we have received  
27 a submission from your client. Understandably, we've only  
28 just seen it, but you can rest assured that whatever  
29 process you wish to undertake or your client wishes to  
30 undertake is fine by me. It will clearly be taken into  
31 account and be given careful consideration along with other  
32 materials that we will receive.

33  
34 MS PEARMAN: Thank you, Commissioner.

35  
36 THE COMMISSIONER: Thank you.

37  
38 Yes, Mr de Mars.

39  
40 MR de MARS: Thank you, Commissioner, can I firstly hand  
41 up a tender bundle of material prepared for this matter,  
42 comprising two volumes of material and 67 tabbed documents.

43  
44 THE COMMISSIONER: Thank you.

45  
46 MR de MARS: I'm not sure I have the current  
47 exhibit number in terms of what we are up to.

1  
2 THE COMMISSIONER: I'll just check for you.  
3  
4 MR de MARS: Twenty-two  
5  
6 THE COMMISSIONER: I have "exhibit 23" written on  
7 a post-it note, but I'm not quite sure.  
8  
9 MR de MARS: I've been corrected. You are right,  
10 Commissioner, 23.  
11  
12 **EXHIBIT #23 TENDER BUNDLE OF MATERIAL, COMPRISING TWO**  
13 **VOLUMES OF MATERIAL AND 67 TABBED DOCUMENTS**  
14  
15 MR de MARS: Next, could I hand up some proposed short  
16 minutes of order, which I understand you already have.  
17  
18 THE COMMISSIONER: Yes, I've got those.  
19  
20 MR de MARS: Commissioner, I ask that those orders be made  
21 under section 8 of the Special Commissions of Inquiry Act.  
22 As you'll see, they deal with certain discrete matters  
23 where non-publication orders, including pseudonym orders,  
24 are sought in relation to distinct material. I ask that  
25 those orders be made.  
26  
27 THE COMMISSIONER: All right.  
28  
29 Mr Mykkeltvedt, do you have any objection to them?  
30  
31 MR MYKKELTVEDT: I have no objection.  
32  
33 THE COMMISSIONER: Ms Pearman?  
34  
35 MS PEARMAN: We neither consent nor oppose, Commissioner.  
36  
37 THE COMMISSIONER: Thank you.  
38  
39 Consistently with the practice we have adopted and  
40 because I do think that the details which are recorded in  
41 the table of redactions are appropriately to be made,  
42 I will make those orders, thank you.  
43  
44 MR de MARS: Commissioner, I also - I think they've  
45 already been handed up - adopt the written submissions that  
46 I understand you have.  
47

1 THE COMMISSIONER: I have them, thank you.

2

3 MR de MARS: They have been prepared in this matter  
4 jointly by Senior Counsel Assisting this Commission and  
5 myself.

6

7 THE COMMISSIONER: Thank you.

8

9 MR de MARS: I now seek to supplement those submissions  
10 with an oral submission.

11

12 I note what is said in relation to the document that  
13 has come from the family this morning, Commissioner, and as  
14 presently advised, as I understand it, the intention is  
15 that Ms Rebecca Wark will speak to that document after  
16 I make my submissions.

17

18 THE COMMISSIONER: Certainly.

19

20 MR de MARS: Commissioner, Mr Wark was known to family and  
21 friends by his middle name, Blair. He died between 2pm on  
22 9 January 1990 and 9.30am on 10 January 1990. Mr Wark's  
23 body was found at 9.30am on 10 January in the northern area  
24 of Sydney Harbour, 200 to 300 metres off Dobroyd Point.

25

26 On 11 January, the following day, some personal items  
27 belonging to him were found near a cliff top at Gap Bluff  
28 in Watsons Bay.

29

30 Mr Wark was 28 years old when he died. He was, by all  
31 accounts, an intelligent, creative and kind young man with  
32 a likeable personality.

33

34 I understand that he grew up in his family home in  
35 Frenchs Forest in Sydney's northern suburbs before leaving  
36 for boarding school in his high school years. After he  
37 finished school he did a course at the City Art Institute  
38 in Paddington and after finishing that course, he also  
39 worked at the Institute, where he was employed in the  
40 print-making section at the time of his death.

41

42 Mr Wark was evidently close to his younger sister,  
43 Rebecca, who I think as you're aware, Commissioner, is  
44 present here in court today. He would see Rebecca at least  
45 monthly when visiting the family home.

46

47 His family knew that he was gay. They also understood

1 that he had a close relationship with an older man, who  
2 I will refer to as "KN", with whom he had lived on and off  
3 for eight years prior to moving into accommodation at the  
4 Pymont Arms Hotel in the months before his death. KN was  
5 a Catholic priest who had also taught at the City Art  
6 Institute. He was 57 years of age at the time of Mr Wark's  
7 death.

8  
9 KN is now deceased. Although in a statement he made  
10 at the time of Mr Wark's death he was ambiguous as to the  
11 nature of his relationship with Mr Wark, it seems likely  
12 that they had at times been in an intimate sexual  
13 relationship.

14  
15 In the days leading up to his death, Mr Wark had been  
16 acting in an unusual manner, characterised by some paranoia  
17 and what appear to have been unjustified fears that he was  
18 in some type of danger. He had not previously been  
19 diagnosed with any form of psychotic illness, but had  
20 sometimes experienced depression and had been prescribed  
21 anti-depressant medication.

22  
23 At the time, he was also endeavouring to move from his  
24 accommodation at the hotel in Pymont into rental  
25 accommodation at Potts Point with some friends, namely,  
26 a man who I will referred to as "MS" and the girlfriend of  
27 MS.

28  
29 MS was a friend of his from art school who had  
30 struggled over the years with the use of illicit drugs.

31  
32 Mr Wark's unusual behaviour had been exhibited over  
33 a period of days leading up to his death, including on two  
34 visits to his family home in Frenchs Forest. On one visit,  
35 his demeanour was of such concern that his parents called  
36 a local general practitioner who attended on a home visit.

37  
38 Mr Wark left the family home early on the morning of  
39 Tuesday, 9 December, and appears to have returned to his  
40 hotel accommodation in Pymont for a period of time. At  
41 around 11am on 9 December, a person matching Mr Wark's  
42 description left a bag with some items of clothing in it at  
43 the lost property counter at the David Jones store in the  
44 city.

45  
46 Mr Wark appears to have been under an apprehension  
47 that he had an appointment with a psychologist that

1 afternoon. At around 2pm, he attended the psychologist's  
2 home address in Double Bay but was advised that the  
3 psychologist was not present.  
4

5 This was the last known sighting of Mr Wark prior to  
6 his body being found in the harbour at 9.30am the following  
7 morning.  
8

9 Commissioner, at this point, I think we are able to  
10 have put up on screen an attachment to the submission,  
11 which is a map, which might be of relevance to bring up  
12 now.  
13

14 Commissioner, the Inquiry's consideration of the  
15 matter has focused on determining whether or not Mr Wark's  
16 body entered the water from the location of The Gap where  
17 some of his personal property was found and, if so, the  
18 circumstances in which that occurred.  
19

20 The Inquiry has also remained open to considering  
21 whether there's any other possible location from which  
22 Mr Wark may have entered the harbour.  
23

24 Commissioner, marked on that map you will see with the  
25 letter "C" the approximate location, at Gap Bluff, where  
26 the items of personal property were found. The letter "B"  
27 represents the approximate location off Dobroyd Point where  
28 his body was located. "D" is a marker indicating the  
29 approximate location of Reef Beach, and down the bottom,  
30 location "A" is the location of the address of the  
31 psychologist where he was known to have been at  
32 approximately 2pm, just as a point of reference at the  
33 moment.  
34

35 If one assumes entry from Gap Bluff, then Mr Wark's  
36 body evidently must have drifted northwards and through the  
37 Sydney Harbour heads before being retrieved from the water  
38 off Dobroyd Head. Hence one of the matters the Inquiry has  
39 sought to address is the likelihood of a body drifting in  
40 this manner.  
41

42 That map could now come down.  
43

44 It's notable, Commissioner, that no coronial inquest  
45 was held in relation to Mr Wark's death. This was the case  
46 notwithstanding that Mr Wark's family members had raised  
47 a number of concerns with the Coroner in the weeks and

1 months following the death.

2  
3 Some of these concerns related to the extent of the  
4 police investigation that had occurred. It's evident from  
5 the Coroners Court records that an inquest was dispensed  
6 with because the view was taken at the time that the  
7 documentary record of the investigation was sufficient for  
8 a conclusion to be reached the death was clearly a suicide.

9  
10 It does seem clear that there was scope for the police  
11 investigation at the time to have been considerably more  
12 thorough than it was. Although the conclusion that Mr Wark  
13 took his own life is one that it is submitted this Inquiry  
14 should ultimately agree with, there were some unusual  
15 features surrounding Mr Wark's death that have  
16 understandably been a source of ongoing uncertainty for  
17 family members. Had they been addressed more thoroughly at  
18 an early stage, that uncertainty might have been avoided,  
19 and I will return to those matters later.

20  
21 One matter to note at this point concerning the police  
22 investigation is that an autopsy was commenced on the  
23 morning of 14 January 1990, over four days after Mr Wark's  
24 death. Initially the forensic pathologist, Dr Bradhurst,  
25 became concerned about what he thought may have been  
26 deep-seated bruising to Mr Wark's neck. As a result, the  
27 autopsy was paused and a detective from the Homicide Squad  
28 became involved in the investigation.

29  
30 As it turned out, upon the autopsy being completed,  
31 the bruising initially thought to be suspect was considered  
32 to be non-suspicious and in keeping with an injury caused  
33 by a fall from a height. I mention this because it  
34 explains why an officer from the Homicide Squad came to be  
35 involved in the matter at that point.

36  
37 Commissioner, I now turn to outline some of the  
38 investigative steps taken by the Inquiry. A range of steps  
39 have been taken to attempt to shed further light on the  
40 circumstances surrounding Mr Wark's death. The Inquiry  
41 compelled the production of the police file relating to the  
42 investigation of the matter back in 1990. In addition,  
43 a small number of documents were produced by NSW Police  
44 Force relating to consideration of the matter by Strike  
45 Force Parrabell in 2016.

46  
47 The Coroners Court file was obtained consisting of

1 108 pages of material from that court's consideration of  
2 the matter in 1990. The Inquiry also received under  
3 summons the contents of the file held by NSW Health  
4 Department of Forensic Medicine. That file contained some  
5 additional material to that held by the police, including  
6 a note of information received by the forensic pathologist  
7 from an officer with the Water Police who made some  
8 observations about the movement of bodies within Sydney  
9 Harbour which I'll come to later.

10  
11 The Inquiry was also able to confirm through the  
12 Registrar of Births, Deaths and Marriages, that KN, the  
13 priest with whom Mr Wark had had a long-term relationship,  
14 had died in 2006.

15  
16 The Inquiry also made use of other material held by  
17 it, such as information relating to violence at beats on  
18 the Northern Beaches during the relevant period.

19  
20 The Inquiry made contact with the psychologist whom  
21 Mr Wark had seen on two occasions in the months preceding  
22 his death and with one of the original investigating  
23 officers. The Inquiry also obtained by summons some  
24 documents from the Catholic Church relating to KN, although  
25 these steps did not lead to any further relevant  
26 substantive information being obtained.

27  
28 Commissioner, three expert reports have also been  
29 sought and obtained: a report of forensic pathologist  
30 Dr Linda Iles, the Head of Forensic Pathology Services at  
31 the Victorian Institute of Forensic Medicine, who reviewed  
32 the autopsy findings; a report of Dr Danny Sullivan,  
33 a forensic psychiatrist who reviewed materials related to  
34 the death and provided opinion in relation to Mr Wark's  
35 mental state and likely cause of death; and a report of  
36 Professor Robert Brander, a coastal geomorphologist, who  
37 provided a report in relation to the potential for  
38 Mr Wark's body to have drifted from The Gap to the location  
39 where it was found.

40  
41 The Inquiry also benefited from being able to meet  
42 with Rebecca Wark, Mr Wark's sister. Ms Wark, as I have  
43 already indicated, was close to her brother and was present  
44 at the family home when he was there 24 hours or less  
45 before his death. Ms Wark provided valuable information to  
46 police at the time of the original investigation, and in  
47 the weeks following her brother's death, she herself

1 located significant evidence that had not been followed up  
2 by the police.

3  
4 The Inquiry is grateful to Ms Wark for having shared  
5 her time and knowledge of the matter with Inquiry staff and  
6 notes the concern she has previously expressed about the  
7 quality of the police investigation into her brother's  
8 death.

9  
10 The Inquiry has remained mindful of those concerns in  
11 approaching its task of considering the evidence.

12  
13 Commissioner, I now turn to consideration of the  
14 evidence that has been available to the Inquiry. The  
15 written submission at pages 17 to 22 sets out at some  
16 length what that material tells us about Mr Wark's  
17 movements and conduct over the five days leading up to his  
18 death. This has been done to try and draw out some  
19 patterns of commonalities in what was observed by the  
20 different individuals who were interacting with him over  
21 that period.

22  
23 In considering this material, the Inquiry has been  
24 careful to consider the reliability of the accounts that  
25 were given by different individuals at the time. There is,  
26 of course, no reason to doubt the accuracy of accounts  
27 given by Mr Wark's family members. The signed statement  
28 made by KN at the time, in general terms, in relation to  
29 Mr Wark's movements and demeanour over his final days, also  
30 appears to be reliable, based its consistency with other  
31 material.

32  
33 Although a statement that police took from MS at the  
34 time is unsigned, its contents generally appear to be  
35 consistent with other known information, such as a rental  
36 tenancy application signed by Mr Wark and a letter that MS  
37 sent to Mr Wark in the days following his death, in the  
38 absence of knowledge that he had died.

39  
40 Without traversing all of the detail set out in the  
41 written submission, arising from those accounts, the  
42 following matters in particular are noted relevant to the  
43 days leading up to Mr Wark's death.

44  
45 On Friday, 5 January - that is, four days before he  
46 was last seen - Mr Wark inspected a flat in Potts Point  
47 that he was interested in moving into with MS and the

1 girlfriend of MS. Consistent with this, he completed  
2 a joint tenancy application on that date. A deposit was  
3 paid but the up-front rental costs were yet to be paid.  
4

5 That afternoon, Mr Wark spoke to his father about  
6 borrowing \$500 for the bond payment for the flat. His  
7 father expressed concern about Mr Wark moving in with MS,  
8 who his father considered would be a bad influence upon  
9 him. Mr Wark subsequently told his father not to worry  
10 about lending him any money.  
11

12 According to KN, later, at around midnight in a phone  
13 call to him, Mr Wark was in a distressed state.  
14

15 On Saturday, 6 January, Mr Wark went to MS's flat on  
16 Crown Street, Surry Hills. Mr Wark told MS that he'd been  
17 unable to obtain the rental money and seemed very  
18 depressed.  
19

20 In his unsigned statement, MS says that they discussed  
21 the topic of suicide, including the suicide of a mutual  
22 friend who had jumped off a 40-storey building in  
23 Melbourne. According to that unsigned statement, Mr Wark  
24 was confused and gave the impression that he was drunk.  
25

26 The behaviour described by MS includes an odd remark  
27 being made by Mr Wark that the word "death" contained the  
28 word "eat", and that to eat is to die.  
29

30 As Mr Wark left the flat, they arranged to meet at  
31 MS's flat on Monday, 8 January. MS did not see Mr Wark  
32 again.  
33

34 Early on the Saturday evening, Mr Wark went to KN's  
35 home where he stayed overnight. According to KN, Mr Wark  
36 looked tired and was a little bit distraught.  
37

38 On Sunday, 7 January, Mr Wark phoned his parents and  
39 expressed some reservations about moving into the flat with  
40 MS. That evening, Mr Wark was again at KN's house. In his  
41 statement, KN said that Mr Wark was very upset and saying,  
42 "The triads are looking for me." He acted in a paranoid  
43 fashion by pulling the blinds down and described his  
44 potential new rental accommodation as "a shooting gallery".  
45

46 On Monday, 8 January, at around 12.30 in the  
47 afternoon, Mr Wark arrived at his parents' house in Frenchs

1 Forest. In a statement he made to police, Blair's father  
2 described Blair as shaking and distraught and that he  
3 appeared nervous and constantly on the move. Mr Wark again  
4 made reference to his new accommodation being "a shooting  
5 gallery". He suggested that the triads were after him and  
6 that he had been set up by MS and Michael Hutchence.

7  
8 His conduct appears to have been irrational. Notes  
9 made by his mother after the event record Blair as  
10 insisting that his father move away from a window as he was  
11 in danger, and that Mr Wark made a remark about there being  
12 subliminal transmissions being broadcast by a radio  
13 station.

14  
15 His parents were concerned enough to phone a GP who  
16 attended the family home. The GP was of the view that  
17 Mr Wark was showing signs of pre-psychosis.

18  
19 Later that day, Mr Wark's father dropped him back to  
20 the Pymont Arms Hotel where Mr Wark was staying, however,  
21 Mr Wark returned to the family home by taxi in the early  
22 hours of the morning. His sister Rebecca sat up talking to  
23 him and was later woken by him at 4am.

24 In a statement made in 1990, Ms Wark describes her  
25 brother again making references to a shooting gallery and  
26 the triads. He stated he thought he was going to be killed  
27 and that he wanted to return to the Pymont Arms Hotel  
28 where he would be higher up and could see people coming.

29  
30 Mr Wark ended up leaving on foot at around 6am on  
31 Tuesday, 9 January, followed by his father, who gave him  
32 a lift to a bus stop. This was the last time that his  
33 family saw him.

34  
35 Limited action seems to have been taken by police  
36 investigating the matter to determine Mr Wark's movements  
37 after he left the family home on 9 January.

38  
39 Rebecca Wark appears to have established, by contact  
40 with the caretaker of the Pymont Arms Hotel, that he  
41 returned to the hotel at some point during the morning.

42  
43 The last known sighting of Mr Wark was by a woman who  
44 was described as the landlady at the residential address of  
45 Mr Wark's psychologist, "NM", in New South Head Road in  
46 Double Bay.

47

1           It appears that whether correctly or not, Mr Wark was  
2 under the impression that he had an appointment to see NM  
3 at 1pm or 2pm that afternoon, and it was for this reason  
4 that he turned up at her address. There is evidence that  
5 he had left a phone message for NM the prior evening.  
6

7           Although no statement was taken from the landlady,  
8 there is a record made by police indicating that they spoke  
9 with her and she told them that Mr Wark had shown up at the  
10 Double Bay address at around 2pm. The information from the  
11 police says nothing about what may have been said to  
12 Mr Wark about NM's presence or availability, but evidently  
13 Mr Wark left, which would imply either that NM was not told  
14 of the visit or that she was not there.  
15

16           Most significantly, the landlady described Mr Wark at  
17 this point as being highly distressed and agitated.  
18

19           On the assumption that Mr Wark did end up at Gap Bluff  
20 later in the afternoon or evening, precisely what Mr Wark  
21 did after leaving Double Bay and how he got to Gap Bluff is  
22 not known. It is a distance of around seven kilometres on  
23 the road between the two locations.  
24

25           Commissioner, at around 9.20am the next morning,  
26 Wednesday, 10 January, a passenger on a Manly ferry spotted  
27 Mr Wark's body floating about 200 metres off Dobroyd Head.  
28

29           At 2.30pm the next day, 11 January, some items were  
30 found by a member of the public on a rock platform under  
31 a ledge at Gap Bluff. The man who found them described  
32 them as consisting of a white shirt with a small black  
33 pattern, neatly rolled up and tied with a black leather  
34 belt. Behind the shirt was a pair of metal-rimmed glasses,  
35 some receipts and a small tube of ointment. The property  
36 was described as being wet.  
37

38           Police were unable to attend the scene straightaway  
39 when the man reported the items to Vaucluse Police Station,  
40 and so he retrieved them and left them with an officer at  
41 that station. The items as recorded by police included  
42 a wallet, which contained Mr Wark's driver's licence and  
43 a small amount of cash.  
44

45           The property was subsequently returned to Mr Wark's  
46 family, as a result of which Rebecca Wark, via a docket  
47 from the David Jones department store, was able to, in

1 effect, do her own detective work to discover that a bag  
2 containing some of her brother's clothing and property had  
3 been left at the David Jones city department store by a man  
4 who appeared to match her brother's description under the  
5 name "Wark B", at around 11am on 9 January.  
6

7 It seems apparent from what Ms Wark was able to piece  
8 together at the time that her brother had purchased certain  
9 items of clothing that morning and at the same time had  
10 left a bag with some clothing that he had changed out of at  
11 the David Jones lost property counter.  
12

13 Commissioner, that completes what I intend saying in  
14 summary fashion about the movements and matters that might  
15 reflect on the behaviour of Mr Wark in the days leading up  
16 to his death.  
17

18 I now move to comment on what the expert opinion  
19 evidence gathered by the Inquiry tells us.  
20

21 Dr Iles reviewed the autopsy report and conclusions  
22 reached by the original forensic pathologist, Dr Bradhurst.  
23 She considered the documentation of injuries by  
24 Dr Bradhurst to have been quite comprehensive. She did not  
25 think that minor and superficial bruising documented by  
26 Dr Bradhurst was typical of injuries caused in an assault  
27 but, rather, that these could have been caused either in  
28 the course of impact or in the process of body retrieval.  
29

30 Dr Iles agreed with Dr Bradhurst's conclusion as to  
31 cause of death being multiple injuries sustained in a fall  
32 from a height, but she observed that a medical examination  
33 could provide little insight into how such a fall came  
34 about.  
35

36 In her opinion, the deep-seated bruising to the neck  
37 that initially caught Dr Bradhurst's attention was  
38 consistent with trauma to the spinal cord which is in turn  
39 consistent with having been caused in such a fall.  
40

41 Secondly, Commissioner, the Inquiry sought and  
42 obtained an opinion from Professor Brander as to the  
43 movement of Mr Wark's body in the water.  
44

45 This report was obtained because, on its face, the  
46 location of Mr Wark's body near Dobroyd Head within  
47 a period of no more than 18 hours from the earliest time

1 that Mr Wark feasibly might have fallen from somewhere in  
2 the vicinity of Gap Bluff, being approximately 2.30pm on  
3 9 January, is notable given the distance involved and the  
4 geography of the area.

5  
6 Professor Brander's report highlights the great  
7 difficulties involved in accurately predicting the likely  
8 movement of a body in the water in the relevant  
9 circumstances. In particular, he observed that, and  
10 I quote:

11  
12 *Complex and turbulent wave, tide and drift*  
13 *conditions combined with irregular*  
14 *topography makes it very difficult to*  
15 *determine the direction of travel of*  
16 *a human body entering the water at*  
17 *a coastal location such as the rocky*  
18 *coastline between Gap Bluff and South Head.*

19  
20 Professor Brander's ultimate opinion was that it was  
21 certainly possible that Mr Wark's body may have entered the  
22 water in the vicinity of Gap Bluff at any time during the  
23 period of interest but that this would have been more  
24 likely to have occurred between 9pm on 9 January and 4am on  
25 10 January.

26  
27 In reaching this view, Professor Brander was fortified  
28 by the terms of a handwritten memo that appears in the  
29 original forensic medicine file relating to Mr Wark.

30  
31 At this point, Commissioner, it might be useful to  
32 bring that document up on screen. It's tab 47.  
33 I understand that might be available.

34  
35 Commissioner, that handwritten memo appears to reflect  
36 a discussion that the forensic pathologist had with  
37 a police sergeant by the name of Sergeant Ashley, who would  
38 appear to have been from the Water Police, and it would  
39 appear to have been someone with experience in retrieving  
40 bodies from Sydney Harbour, in which the officer told  
41 Dr Bradhurst that the Dobroyd Head area was a common place  
42 for - you will see the quote in inverted commas, "Gap"  
43 bodies to be found, in circumstances where the tide was  
44 running in. Reference is made to that handwritten memo in  
45 Professor Brander's report.

46  
47 That can come down.

1 Commissioner, a further observation made by Dr Brander  
2 appears to add to the difficulty in predicting a particular  
3 time that Mr Wark may have fallen from The Gap - namely,  
4 that, depending on the particular location and conditions,  
5 it's difficult to say for how long a body may have remained  
6 in the area of a rock platform before then being washed  
7 into the ocean. This fact appears to introduce a further  
8 level of uncertainty in relation to determining the precise  
9 time at which a body had fallen from that location and  
10 would have ended up off Dobroyd Point.

11  
12 It's noted that Professor Brander was also asked about  
13 the possibility that Mr Wark may have entered the water  
14 from Dobroyd Point or Reef Beach and concluded that this  
15 was also a possibility and potentially a more likely one  
16 were all things equal.

17  
18 It is noted, however, that there's simply no evidence  
19 that would suggest that Mr Wark had been at Dobroyd Head  
20 and that the greater significance of Professor Brander's  
21 opinion lies in his view that, purely based on the relevant  
22 environmental factors, it was certainly possible that  
23 Mr Wark had entered the water from The Gap in circumstances  
24 where there's otherwise substantial evidence to suggest  
25 that this was the entry point.

26  
27 The third expert report obtained was that of forensic  
28 psychiatrist, Dr Danny Sullivan. Dr Sullivan reviewed the  
29 material relating to Mr Wark's death and was of the opinion  
30 that, and I quote:

31  
32 *... Mr Wark's presentation in the days*  
33 *before his death was consistent with*  
34 *psychosis. He displayed psychomotor*  
35 *agitation. He reported persecutory*  
36 *ideation, which appeared to be delusional,*  
37 *related to triads and two acquaintances.*  
38 *He was thought disordered with loosening of*  
39 *associations. He was potentially*  
40 *hallucinating or alternatively experiencing*  
41 *auditory illusions while in a state of*  
42 *hypervigilance.*

43  
44 While Dr Sullivan noted that there was a pre-existing  
45 history of depression, he did not think that there was  
46 an indication of a persisting mood disorder and he noted  
47 that Mr Wark's anti-depressant medication appeared to be at

1 a low but effective dose.

2  
3 Dr Sullivan concluded that Mr Wark's mental state from  
4 6 January 1990 until his death was consistent with  
5 a psychotic episode and that the concern of family members  
6 and acquaintances suggested that this represented a clear  
7 deterioration from his usual presentation and that he had  
8 not presented in such a way before.

9  
10 It is submitted that Dr Sullivan's report is helpful  
11 in the context of considering the potential competing  
12 scenarios relating to the manner of Mr Wark's death.

13  
14 Commissioner, given Dr Sullivan's view, it's worth  
15 reflecting on the view of Mr Wark's mental state as it was  
16 considered at the time of the original police  
17 investigation.

18  
19 The police investigation of the matter relied on some  
20 very limited information from a medical practitioner and  
21 psychologist who had seen Mr Wark in the past, rather than  
22 seeking any opinion as to Mr Wark's mental state as  
23 evidenced by his conduct in the days leading up to his  
24 death. This appears to have formed the basis for the  
25 initial officer in charge, Constable Ford from the Water  
26 Police, to conclude in her statement to the Coroner that  
27 Mr Wark took his own life by jumping from the Gap Bluff,  
28 and I quote:

29  
30 *... due to the completion of an eight year*  
31 *homosexual relationship and loneliness.*

32  
33 That conclusion appears to have been drawn directly from  
34 the views expressed by the psychologist NM in the brief  
35 letter that she provided to the police.

36  
37 NM's letter was evidently prepared without her having  
38 any understanding of Mr Wark's mental state in the days  
39 leading up to his death. It relied on one single clinical  
40 session that she had had with Mr Wark two months earlier,  
41 in addition to which he had participated in a single group  
42 therapy session conducted by NM. It's submitted that it  
43 clearly did not provide an adequate explanation for  
44 Mr Wark's death.

45  
46 Further, as expressed in the officer's statement, with  
47 no basis, it appears to suggest that Mr Wark's sexuality

1 was somehow relevant to him intentionally having taken his  
2 own life. There doesn't otherwise appear to be any basis  
3 for that suggestion.  
4

5 Those observations lead me to make some brief comments  
6 about the treatment of this matter by Strike Force  
7 Parrabell. Those reviewing the matter for Strike Force  
8 Parrabell also appear to rely on the views expressed by NM  
9 in support of its characterisation of the case as one where  
10 there is no evidence of bias crime. The Bias Crimes  
11 Indicator Form twice refers to NM's opinion, to use the  
12 language employed in the form, that Mr Wark suicided  
13 himself as a result of depression and loneliness. It's  
14 submitted that the uncritical acceptance of NM's view  
15 demonstrates a limited level of analysis being applied to  
16 the evidence.  
17

18 The form also uncritically repeats NM's assertion that  
19 Mr Wark was on strong doses of anti-depressants. This does  
20 not accord with expert forensic psychiatric opinion  
21 obtained by the Inquiry that characterises Mr Wark's dose  
22 as low but effective.  
23

24 Commissioner, more generally in relation to the police  
25 investigation of the matter, although the ultimate  
26 submission which is being made in this matter is that  
27 Mr Wark's death was not one that involved foul play, it had  
28 certain features that it's submitted call for more thorough  
29 analysis than appears to have occurred at the time of the  
30 initial investigation. Had there been a more thorough  
31 approach, ongoing concerns of Mr Wark's family in relation  
32 to the death, it is submitted, are likely to have been  
33 allayed.  
34

35 In particular, the following matters are noted:  
36 firstly, it remains unclear whether police ever attended  
37 the location where Mr Wark's property was found at Gap  
38 Bluff. If this did occur, it was not until several days  
39 after the property was located.  
40

41 Secondly, there's also no record indicating that  
42 police examined that location to determine whether there  
43 was any other physical evidence potentially relating to  
44 what may have happened to Mr Wark there or to record the  
45 precise location.  
46

47 Thirdly, there's no material in the police brief to

1 the Coroner that seeks to consider or explain how the body  
2 of a person who jumps or falls from the vicinity of The Gap  
3 might end up near Dobroyd Head.  
4

5 Fourthly, the psychologist NM herself featured in  
6 events that occurred immediately prior to Mr Wark's death,  
7 and at least as a matter of perception, reliance upon her  
8 opinion in relation to the cause of Mr Wark's death and his  
9 mental state might be thought inadvisable.  
10

11 Fifthly, police appear to have returned Mr Wark's  
12 possessions to his family without having photographed them  
13 or considered their investigative utility. As a result, as  
14 I've outlined, it was Mr Wark's sister who investigated the  
15 significance of some dockets and receipts that were amongst  
16 the items left at The Gap, leading to the discovery of  
17 Mr Wark's property at the David Jones lost property  
18 counter.  
19

20 And lastly, there were certain potentially significant  
21 witnesses with whom police spoke but from whom it appears  
22 no statement was taken. This included anyone at Mr Wark's  
23 workplace and the last person to have seen him alive, NM's  
24 landlady, who observed him to be highly distressed and  
25 agitated. It is suggested that the inclusion of such  
26 material in the coronial brief of evidence would have been  
27 advisable and may have gone some way to addressing the  
28 family's concerns.  
29

30 Commissioner, in considering whether there is any  
31 possibility that Mr Wark's death could have involved an act  
32 of foul play, the Inquiry has endeavoured to keep an open  
33 mind to any possibility that the fears Mr Wark was  
34 expressing to his family early in the morning of 8 and  
35 9 January could have been based in reality.  
36

37 In considering such a possibility, it's noted that  
38 Mr Wark's mental state had shown clear signs of  
39 deterioration over a number of days prior to his death. He  
40 had contacted KN in a distressed state on 5 January. He  
41 was making odd comments to MS on 6 January and again seemed  
42 distressed. On 7 January, in KN's presence, he was acting  
43 in a paranoid fashion and demanding that the blinds be  
44 drawn and he was also referring to the triads and  
45 a shooting gallery  
46

47 Further, Mr Wark's actions in purchasing new clothes

1 and leaving a bag of clothes and other items at David  
2 Jones' store on the morning of 9 January are difficult to  
3 rationalise as a matter of logic. The same can be said for  
4 the manner in which his clothes and other items were left  
5 at The Gap.  
6

7 It is suggested that those actions are best understood  
8 as explained by Dr Sullivan who says as follows in his  
9 report:

10  
11 *... Mr Wark was exhibiting an abrupt change*  
12 *in mental state associated with anxiety and*  
13 *fear that he would be killed relating to*  
14 *persecutory delusions. A person in a*  
15 *psychotic state is likely to*  
16 *exhibit significant disturbances of*  
17 *judgement, and their behaviour may not*  
18 *follow rational or predictable patterns*  
19 *when affected by delusions and distressed*  
20 *emotional state associated with this.*  
21

22 Consideration of the possibility of foul play being  
23 involved in Mr Wark's death has also taken account of the  
24 proximity of his body, when found, to the Dobroyd Head and  
25 Reef Beach areas.  
26

27 In circumstances where Mr Wark's personal items  
28 including his shirt, belt, wallet and glasses were found at  
29 The Gap, it is submitted that it defies logic to conjure  
30 a scenario whereby Mr Wark then took a trip to the Dobroyd  
31 Head area where he happened to be assaulted.  
32

33 Likewise, it seems implausible that Mr Wark would have  
34 travelled to Dobroyd Head and been the victim of an assault  
35 there, with a hypothetical assailant choosing to retain  
36 some items of his clothing and then travelling to The Gap  
37 and depositing them there.  
38

39 Dr Sullivan was asked for his opinion in relation to  
40 the manner of Mr Wark's death. He was of the view that  
41 Mr Wark's behaviour in the days preceding his death and the  
42 circumstances of his death were consistent with suicide.  
43

44 Dr Sullivan observed that Mr Wark was in a state of  
45 significant anxiety and fear for delusional reasons, that  
46 he was markedly restless and he was distressed and seeking  
47 help including from his psychologist. He considered that

1 Mr Wark's actions in buying new clothes and leaving them  
2 neatly folded, with his possessions, to be consistent with  
3 an act of suicide rather than misadventure. He also  
4 considered the presence of the neatly folded items to be  
5 inconsistent with an act of violence or robbery involving  
6 a third party.

7  
8 Commissioner, in conclusion, particularly in view of  
9 Mr Wark's mental state and his known and observed stress at  
10 2pm while at NM's address in Double Bay, it is submitted  
11 that there is a compelling logic to the view reached by  
12 Dr Sullivan. It does appear highly probable that Mr Wark  
13 took his own life while experiencing fears precipitated by  
14 the psychosis he was experiencing.

15  
16 Given this conclusion reached in relation to the cause  
17 and manner of Mr Wark's death, it is not suggested that the  
18 death involved gay hate bias.

19  
20 In relation to the manner and cause of death, it's  
21 submitted that an appropriate description of the cause and  
22 manner of Mr Wark's death would be that it resulted from  
23 multiple injuries sustained in a fall from height after  
24 deliberately jumping from a cliff in the vicinity of The  
25 Gap at Watsons Bay, and that at the time of his death,  
26 Mr Wark was affected by a psychotic episode.

27  
28 Commissioner, that concludes the submission.

29  
30 THE COMMISSIONER: Thank you. Yes.

31  
32 MS WARK: To this day, I have never seen anyone more  
33 scared than Blair was the day before he died.

34  
35 My name is Rebecca Wark and I am the sister of Simon  
36 Blair Wark. I am the youngest of five children. I am the  
37 Chief Executive of Health Infrastructure for NSW Health,  
38 the mother of three children and the director of our  
39 broader family's business affairs.

40  
41 Thank you for allowing me to address you today,  
42 Commissioner.

43  
44 As you will appreciate, 33 years have passed since  
45 Blair's premature death as a 28-year-old. I've had much  
46 time to think about what happened over those days  
47 in January 1990 in and around Sydney Harbour.

1  
2 In this submission, I would like to make two points:  
3 the behaviours that Blair displayed in the immediate days  
4 before his death were dramatically out of character; the  
5 investigations undertaken by NSW Police in 1990 and again  
6 during Strike Force Parrabell appeared to our family to be  
7 cursory and their outcome a foregone conclusion - that is,  
8 Blair was a young gay man and therefore killed himself.  
9

10 There appears to us to have been a complete failure of  
11 the police to consider Blair's behaviour, behaviour  
12 attested to by my parents and me, and his character in the  
13 broader context, that made it easy for them to conclude  
14 that he was just another depressed gay jumper. At any  
15 level, this could only be considered a tragedy.  
16

17 Much of the evidence before the Commission emphasises  
18 Blair's behaviour two days before he died. His alleged  
19 psychotic paranoid outburst and his use of anti-depressant  
20 medication arise repeatedly in the tender bundle. Never  
21 mind that neither my parents nor I had seen such behaviour  
22 from him before. Never mind that he clearly feared for his  
23 life. Never mind that he expressed nothing to suggest he  
24 was contemplating suicide. Never mind that his medication  
25 had successfully managed his depression.  
26

27 There is an underlying implication in all of the  
28 expert testimony that Blair's depression was his  
29 predominant, if not his singular, character trait. It was  
30 not.  
31

32 Blair was in no way a perpetual slave to whatever  
33 bleak thoughts he might have occasionally shared with  
34 friends and medical professionals. Indeed, it's  
35 informative that no statements in the tender bundle raise  
36 any concerns about the efficacy of Blair's prescription.  
37 It worked well for him.  
38

39 When I last saw Blair at our family home on the  
40 morning of 9 January 1990, he believed that it was unsafe  
41 for him to remain in our home as he considered that this  
42 also placed us at risk of physical harm from those he  
43 thought were trying to harm him. He was scared for his own  
44 life and he was scared for our safety. He was dead less  
45 than 24 hours later.  
46

47 My memories of Blair do not in any way align with the

1 description in the tender bundle that you have before you,  
2 Commissioner. Blair took care of himself and respected his  
3 body. He swam regularly, he ate healthily, he walked  
4 a lot. He was handsome and strong.

5  
6 Blair was enviably artistic. He created beautiful  
7 paintings and leather work. He studied art, he created  
8 art, he taught art. He worked in an art school. He made  
9 regular forays to the Art Gallery of New South Wales with  
10 our mother, with whom he had a close relationship and whose  
11 companionship he sought for those excursions. His  
12 paintings hung in my parents' home and hang in my home -  
13 a daily reminder of an observant, curious, expressive,  
14 imaginative son and brother.

15  
16 Blair had an infectious chuckle that I still conjure  
17 in my head more than 30 years after I last heard it. When  
18 he laughed, his eyes crinkled, his cheeks inflated and  
19 no-one within earshot could resist being swept up in his  
20 joy.

21  
22 Blair had a love of finding words within five-letter  
23 words. His artistic signature was "earth" with a dotted  
24 line around the "art" within it, art being the centre of  
25 the earth. He had a rubber ink stamp made of it and it was  
26 on all of his prints and work. Another example of his love  
27 of words within words was "ear" within "heart" - listen to  
28 your heart.

29  
30 Like many creative souls, Blair could be provocative,  
31 often witty, and sometimes surly too. He could be  
32 withdrawn. But Blair was a young gay man navigating life  
33 at a time when Australian society ridiculed and at times  
34 was openly hostile to homosexuality, as this Commission has  
35 so unflinchingly shown, and I thank you for your work in  
36 that regard.

37  
38 As a consequence, there was much we didn't know about  
39 his life and his lifestyle. The police could ascertain  
40 even less about his life and lifestyle, since they only  
41 knew him in death.

42  
43 Various investigations, inquiries and civil cases  
44 associated with gay hate crimes have been reported in the  
45 national and international press since Blair died. Each  
46 one added to my family's doubts about the adequacy of the  
47 initial investigation into Blair's death. Whether Blair's

1 death was a gay hate crime or not, it is plain to even  
2 a new reader of material in his matter that there are some  
3 very curious circumstances which surely warranted proper  
4 investigation.

5  
6 Each has reminded us that we lack any explanation as  
7 to what caused Blair's so-called fall from height. No  
8 answers.

9  
10 My family has lived with many unanswered questions, in  
11 part because the police left many obvious questions  
12 unasked, but learning to live with unanswered questions  
13 does not mean I am inclined to stop asking them.

14  
15 I remain curious about a number of things. Why did  
16 the investigating police officers not explore the reasons  
17 for someone, possibly but not necessarily Blair himself,  
18 depositing his own belongings at a lost and found desk at  
19 David Jones? Query, is this a clue to a body in Davy  
20 Jones's locker, a metaphor for a body in the ocean? Would  
21 a disregulated and psychotic person carefully plan and  
22 mastermind such a story?

23  
24 Why did the investigating police dismiss my family's  
25 comments about the clothing found at The Gap being nothing  
26 like anything Blair would ever wear - the belt not  
27 handmade, the style at odds with his signature? Why was he  
28 in lace-up shoes when he always wore well-polished boots.  
29 There was an assumption Blair was at The Gap. Is it  
30 possible that Blair was never at The Gap?

31  
32 Why did the investigating police not query the  
33 potential role of MS in Blair's death, given his reluctance  
34 to give a statement and his obvious anger with Blair as  
35 expressed in the letter he wrote. He referred to Blair as  
36 a "confused closet alchy poof", "a selfish prick", and  
37 insisted that "Blair pay me back now".

38  
39 Why did the investigating police put so much weight on  
40 MS's unsigned statement about Blair's character,  
41 particularly his suicidal tendencies, when they had  
42 evidence that MS was an unreliable character, a heroin  
43 addict with form.

44  
45 Why did the investigating police not query the  
46 circumstance around my brother being in a long-term sexual  
47 relationship with Father KN, whom he met at Sydney

1 University, not at art school, during his second degree  
2 studying a BA and Dip Ed - a now deceased alcoholic abusive  
3 practising Catholic priest. Indeed, they cohabited in the  
4 manse.

5  
6 Why did KN give Blair pocket money and money to pay  
7 his accounts when Blair's only known debt was the bond  
8 payment which KN had already refused to pay? Were the  
9 police not curious as to what account he was covering? Why,  
10 given Blair's mention of Michael Hutchence and the Chinese  
11 triads, did they not, as a matter of due diligence, pursue  
12 that as a line of inquiry? After all, according to  
13 a contemporary Google search, Hutchence was recording an  
14 album at Rhinoceros Studios in Darlinghurst at that time.  
15 It's entirely possible that, as old school friends, they  
16 may have been in contact.

17  
18 Why were the police unable to find Blair's files  
19 during Strike Force Parrabell until I provided them with  
20 copies of relevant documents?

21  
22 I will always wonder what the police might have  
23 learned had they applied Blair's curious, imaginative  
24 approach to their investigations. What if they had asked,  
25 "Might we be missing something here?" But they didn't.  
26 Instead the finding that Blair's death resulted from  
27 multiple injuries sustained from a fall from height became  
28 a fitting metaphor for our family's emotional journey since  
29 10 January 1990. The Coroner did not say that Blair died  
30 from suicide or misadventure, his multiple injuries are  
31 unexplained.

32  
33 A less lazy, more open-minded investigation could have  
34 added much to Blair's narrative. I remain convinced, as  
35 did my parents until their aged deaths, that no matter how  
36 Blair died, the investigation by NSW Police Force had been  
37 narrow minded, with outcome bias. He was a gay and on  
38 anti-depressants, therefore, he jumped.

39  
40 Vivian Gornick, journalist, essayist and teacher,  
41 distinguishes between two elements of personal narrative.  
42 The first is a description of what happened, the situation.  
43 The second is the need to describe some of the subjective  
44 truths that underpin and surround the situation. It's this  
45 second part, the story, that tries to make sense of the  
46 situation and to offer a constructive contribution to  
47 society's collective learning.

1  
2 I thank the Commission for giving me the opportunity  
3 to highlight the importance of investigating not only  
4 Blair's situation but also his broader story.

5  
6 I hope that one day, investigating police officers,  
7 Coroners and supporting medical officers, will be more open  
8 to stories as scaffolding for so-called facts. I dare them  
9 to be as observant, curious and imaginative as Blair was  
10 and to accept that stories can help make them make sense of  
11 a situation and offer a constructive contribution to our  
12 collective knowledge.

13  
14 In making this statement, I am highlighting that  
15 my brother's situation, as it is laid out in more than  
16 300 pages of dry, allegedly objective facts and expert  
17 statements, is only one part of his and my family's  
18 personal narrative. I make this statement to ensure that  
19 when my three children, my nieces and nephews or my future  
20 grandchildren, or anyone else who is curious about Simon  
21 Blair Wark, investigate him online, that they will find not  
22 just a situation but a relevant and telling story from  
23 which we can all learn.

24  
25 I make this statement to remind you that the situation  
26 is never the same as the story.

27  
28 Standing here today, I am encouraged by this  
29 Commission's willingness to re-evaluate tragic events that  
30 were taken for granted. I am grateful that families have  
31 had the opportunity to ask you to reconsider so many  
32 senseless deaths. I am grateful for my family, my deceased  
33 father and my recently deceased mother.

34  
35 I wish you success and courage as you continue to  
36 recalibrate, reevaluate and reconsider my brother's early  
37 death.

38  
39 THE COMMISSIONER: Thank you, Ms Wark.

40  
41 Mr Mykkeltvedt?

42  
43 MR MYKKELTVEDT: We will provide some submissions in  
44 writing, your Honour.

45  
46 THE COMMISSIONER: All right.

47

1           Ms Wark, may I, on behalf of myself and the Inquiry,  
2 extend to you and your family my deepest condolences. What  
3 you have put to us this morning is insightful and will be  
4 taken carefully into account when we go back and reevaluate  
5 the materials again, and so I thank you very much for your  
6 contribution this morning.

7  
8           I will now adjourn, thank you.

9  
10         **AT 12.46PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**  
11         **ACCORDINGLY**

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