

**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 Friday, 19 May 2023 at 10am

(Day 55)

Mr William De Mars	(Counsel Assisting)
Ms Caitlin Healey-Nash	(Senior Solicitor)
Ms Emily Burston	(Senior Solicitor)

Also Present:

Mr Mathew Short with Mr Patrick Hodgetts for NSW Police

1 THE COMMISSIONER: Yes.

2

3 MR de MARS: Commissioner, I appear as Counsel Assisting
4 in this matter, which is a hearing by way of documentary
5 tender in relation to the death of Richard Slater.

6

7 THE COMMISSIONER: Thank you.

8

9 MR SHORT: Commissioner, Short, S-H-O-R-T, for the
10 Commissioner of Police.

11

12 THE COMMISSIONER: Thank you very much.

13

14 Yes.

15

16 MR de MARS: Commissioner, can I first hand up a tender
17 bundle of material prepared for this matter. I should have
18 said, that comprises 72 tabbed documents.

19

20 THE COMMISSIONER: Thank you.

21

22 **EXHIBIT #24 TENDER BUNDLE IN RELATION TO RICHARD SLATER**
23 **COMPRISING 72 TABBED DOCUMENTS**

24

25 MR de MARS: Next, Commissioner, can I hand up some
26 proposed short minutes of order and ask that those orders
27 be made under section 8 of the Special Commissions of
28 Inquiry Act relating to certain matters going to
29 non-publication of certain material.

30

31 THE COMMISSIONER: Thank you.

32

33 MR SHORT: Those are by consent, Commissioner.

34

35 THE COMMISSIONER: Thank you very much. Yes, very well.

36

37 MR de MARS: Commissioner, I should also note in this
38 matter there's also a family statement that has been
39 prepared.

40

41 THE COMMISSIONER: Thank you.

42

43 MR de MARS: That can be handed up now. I understand,
44 although strictly speaking, I guess, that's not a matter of
45 evidence necessarily, that those documents have been given
46 numbers, and that will be 25.

47

1 THE COMMISSIONER: Thank you.

2

3 **EXHIBIT #25 FAMILY STATEMENT IN RELATION TO THE DEATH OF**
4 **RICHARD SLATER**

5

6 MR de MARS: Lastly, Commissioner, I would hand up and
7 adopt written submissions that have been prepared in this
8 matter.

9

10 THE COMMISSIONER: Thank you.

11

12 MR de MARS: They have been prepared by Senior Counsel
13 Assisting, Mr Gray, and myself.

14

15 THE COMMISSIONER: Yes, thank you very much.

16

17 MR de MARS: Commissioner, I note at the very outset that
18 the author of the family statement, one of Mr Slater's
19 grandchildren, Yvonne, is present here in court today.

20

21 THE COMMISSIONER: Thank you.

22

23 MR de MARS: Richard Slater died aged 69 on 22 December
24 1980 at Royal Newcastle Hospital. His death followed an
25 assault that had occurred three days earlier, on
26 19 December 1980, at the men's toilet block in Birdwood
27 Park in central Newcastle.

28

29 The toilet block in question was a known beat. It
30 appears probable that Mr Slater's likely assailant assumed,
31 likely incorrectly, that Mr Slater was present at the
32 toilet block to use it as a beat and assaulted and robbed
33 him as a perceived vulnerable target.

34

35 Mr Slater is described in police records as a family
36 man, who had lived at the same address in Newcastle for
37 25 years. He and his wife had an adult daughter, who has
38 since passed away, although he is survived by a number of
39 grandchildren. His youngest grandchild, Yvonne, who I have
40 already referred to, as you're aware, Commissioner, has
41 made a family statement which speaks eloquently to how well
42 regarded and loved Mr Slater was as a grandfather.

43

44 Prior to his retirement at age 65, four years prior
45 to his death, he had been working as a crane driver for
46 BHP Steelworks in Newcastle.

47

1 On 19 December, soon after midday, Mr Slater drove
2 from his family home to the central business district of
3 Newcastle to do some shopping and to buy lottery tickets,
4 as was his practice. After purchasing lottery tickets at
5 a newsagency, he entered the nearby toilet block in
6 Birdwood Park.

7
8 At around 1pm, a man entering to use the toilets found
9 Mr Slater lying on the ground inside the toilet block. He
10 was observed to have blood on his face and was moaning and
11 making gurgling sounds. His trousers and underpants were
12 down just below his buttocks. An ambulance was called and
13 Mr Slater was able to provide his name to paramedics.

14
15 When being asked what happened, he denied being bashed
16 or falling, although he appeared to at least one of the
17 paramedic officers to be confused in his answers. Although
18 his car keys and some lottery tickets that he purchased
19 that day remained on him, his money purse, containing \$30,
20 was missing.

21
22 Mr Slater was admitted to Royal Newcastle Hospital at
23 about 1.35pm in a stable condition. His injuries,
24 including multiple lumps on his skull, swelling under his
25 eyes and to his left ear and multiple contusions to his
26 face, were consistent with being punched and/or kicked.

27
28 Police attempted to interview Mr Slater in hospital
29 but were unable to obtain any coherent information
30 regarding what occurred.

31
32 Mr Slater's granddaughter recalls her mother,
33 Mr Slater's daughter, describing that her father was beaten
34 so badly that he was entirely nonverbal. Professor Michael
35 Besser, a neurosurgeon who has reviewed relevant material
36 for the Inquiry, describes the traumatic brain injury
37 suffered by Mr Slater as very significant.

38
39 At 12.30pm on 20 December - that is, the next day -
40 Mr Slater developed acute pulmonary oedema, consistent with
41 myocardial infarct - that is, consistent with having had
42 a heart attack. This was also consistent with the fact
43 that he had a history of cardiac disease. Treating doctors
44 were able to stabilise him. However, on 22 December, his
45 condition rapidly deteriorated and he died after a cardiac
46 arrest that afternoon.

1 An autopsy was performed by Dr LJ Banathy, who
2 determined the cause of death to be traumatic brain injury,
3 with antecedent cause of myocardial infarction.
4

5 The brain injury included a subarachnoid haemorrhage.
6 Although not reflected in his two autopsy reports, there is
7 a record of Dr Banathy telling police that Mr Slater's
8 injuries were consistent with having been punched in the
9 head, possibly four times, resulting in extensive bruising
10 and fractures to the face bones and a laceration of the
11 left ear, which also caused brain damage.
12

13 He also expressed the view that Mr Slater's chest had
14 been stomped on, causing bruising to the chest and
15 a ruptured spleen.
16

17 In the ensuing police investigation, despite
18 interviewing a large number of people over the months
19 following the death, police were initially unable to
20 clearly identify any person of interest. Although it
21 appears that some suspicion was held in relation to a man
22 by the name of Jeffrey Miller who had been present in the
23 vicinity of the toilet block at around the time of the
24 assault, along with three other people.
25

26 However, with no clear suspect, a very brief coronial
27 inquest was held in Newcastle on 18 June 1981. The
28 presiding Coroner found that on 22 December 1980 at
29 Newcastle Hospital, Mr Slater:
30

31 *... died from the effects of traumatic*
32 *brain damage and myocardial infarction;*
33 *following his admission to that hospital on*
34 *19 December after having been found in*
35 *Birdwood Park, King Street Newcastle, on*
36 *that date, suffering from certain injuries,*
37 *but as to the circumstances of his having*
38 *received those injuries, the evidence*
39 *adduced does not enable me to say.*
40

41 There the matter may have rested. However, in August
42 1982, police had a breakthrough relating to Jeffrey Miller.
43

44 Mr Miller, who I observe at this point, Commissioner,
45 is now deceased, had a substantial criminal record which
46 reflected significant problems he had with drug use. Much
47 of his offending was in the nature of property crime,

1 however, it included offences of violence. At the time of
2 the assault of Mr Slater, he was 20 years of age.

3
4 In late August 1982 a young person, "TM", then aged
5 17, supplied information to the police implicating
6 Mr Miller. In particular, he told police that on the
7 afternoon of the day that Mr Slater was assaulted,
8 Mr Miller had been at his house and had threatened him,
9 saying:

10
11 *You don't want to open your mouth or you*
12 *will end up like the guy in the toilet.*

13
14 Police then re-interviewed the three people who had
15 previously indicated they'd been present with Mr Miller
16 earlier on the day of the assault. While their accounts,
17 upon being re-interviewed, did not suggest that they had
18 directly witnessed Mr Miller assaulting Mr Slater, the
19 accounts taken together provided strong circumstantial
20 evidence that he had.

21
22 Details of the accounts given by Mr Miller's
23 associates and an evaluation of them are set out in the
24 written submission at paragraphs 70 to 98. I will return
25 to key aspects of those accounts later.

26
27 Another aspect of the evidence against Mr Miller came
28 in the form of an implied admission he is said to have made
29 to police when approached by them following receipt of this
30 new evidence, to the effect that he had entered the toilet
31 and assaulted Mr Slater. However, he later sought to
32 retract his admission by stating that he'd entered the
33 toilet with the intention of approaching someone to have
34 sex with, but had exited without approaching anyone.

35
36 As a result of this evidence, Mr Miller was arrested
37 and charged with the murder of Mr Slater. He pleaded not
38 guilty and a committal hearing was held on at least two
39 days, 24 November and 10 December 1982, at what was then
40 referred to as Newcastle Court of Petty Sessions, as
41 a result of which Mr Miller was committed to stand trial in
42 the Supreme Court.

43
44 However, on 18 March 1983, prior to the commencement
45 of any trial, following an application for a no bill made
46 by his legal representative, the prosecution filed a no
47 bill and the matter proceeded no further.

1
2 Commissioner, I also note at this point that on the
3 assumption that Mr Miller was Mr Slater's attacker,
4 assessment of his motivation and the possibility of LGBTIQ
5 bias is not straightforward.
6

7 Mr Miller himself appears to have been gay. Whether
8 he identified as such may be unclear, however, the evidence
9 suggests that he engaged in sexual activity with men at
10 times.
11

12 His three friends and associates on the day appear
13 also to have been members of the LGBTIQ community. The man
14 referred to as "GP" in the written submission is described
15 as homosexual in various police documents, and it is
16 evident that both "RB" and a fourth person who was present
17 with Mr Miller, "RW", were members of the LGBTIQ community.
18

19 Before turning to the investigative steps taken by the
20 Inquiry, at this point it would be appropriate to say
21 something in relation to what the evidence may suggest as
22 to why Mr Slater was present near the toilet block.
23

24 As already observed, the toilet block in Birdwood Park
25 was evidently well known as a beat. A police summary of
26 the matter compiled in 1983 refers to it, to use language
27 adopted in the summary, as a:
28

29 *... renowned meeting place for the*
30 *homosexual element of this area at all*
31 *hours during the day and night.*
32

33 In some respects, any question as to whether Mr Slater
34 may have been attending the toilet block to use it as
35 a beat is a moot point, as the more relevant issue, it is
36 submitted, regardless of Mr Slater's intentions, is what
37 was in the mind of his likely assailant.
38

39 Assuming that person to be Mr Miller, there is clear
40 evidence that, correctly or not, he acted on the
41 understanding that Mr Slater was using the toilet as
42 a beat. Certainly at the time the matter was investigated,
43 police records do not suggest that Mr Slater was visiting
44 the toilet as a beat. Mr Slater's family assumed him to
45 have been heterosexual and have no information suggesting
46 that he may have been gay. There is evidence that
47 Mr Slater was known to have a prostate condition that

1 necessitated he frequently urinated. At the time of the
2 investigation, his then 17-year-old grandson advised police
3 that Mr Slater had stopped at the same toilets, on
4 occasions when he was travelling with him, due to his
5 prostate condition.
6

7 Potentially contrary indications include Mr Slater's
8 denial, upon the attendance of police officers, that he had
9 been assaulted, and the fact that a small amount of semen
10 was detected on Mr Slater's shirt and trousers.
11

12 It's submitted, however, that caution should be
13 adopted in assessing the significance of those matters.
14 The opinion provided to the Inquiry by Professor Besser
15 suggests that the severity of the head injuries Mr Slater
16 sustained would have significantly affected the coherency
17 of answers he gave to attending ambulance officers.
18

19 Further, the semen detected on Mr Slater's clothing
20 appears to have been a minimal amount as it was of
21 insufficient quantity to allow grouping testing to be
22 conducted. It is far from clear that it was deposited on
23 his clothing at the time of the assault.
24

25 The written submission sets out and evaluates in
26 further detail the competing considerations as to whether
27 or not Mr Slater attended the toilet block for the purpose
28 of using it as a beat. In the end, it's submitted that
29 there is not a sufficient basis on which the Inquiry would
30 reach a different view from the understanding of
31 Mr Slater's family at the time.
32

33 I want to turn at this point, Commissioner, to outline
34 steps taken by the Inquiry to look into the circumstances
35 surrounding Mr Slater's death.
36

37 The Inquiry has received helpful information from
38 Mr Slater's granddaughter, Yvonne, concerning her
39 grandfather, the family's recollections in relation to the
40 circumstances of his death, as well as copies of some
41 newspaper articles from the early 1980s relating to the
42 death.
43

44 By summons in May 2022, the Inquiry compelled the
45 production of the police investigative file, which was
46 mainly comprised of police and civilian witness statements
47 as well as typed records of interview with Mr Miller and

1 his associates that were conducted in August and September
2 1982.

3
4 As a result of a subsequent summons and follow-up
5 correspondence, the Inquiry had produced to it crime scene
6 photos and a limited amount of additional investigative
7 material. However, a significant amount of material from
8 the original investigation, including running sheets,
9 investigative notes, have not been produced by the
10 NSW Police Force and it would appear that they have been
11 lost.

12
13 By further summons on 9 December 2022, the Inquiry
14 also sought and obtained copies of criminal records and
15 other background material held by the police in relation to
16 Mr Miller and some of his associates.

17
18 On 7 December 2022, the Inquiry issued a summons to
19 the Hunter New England Local Health District for records
20 relating to Mr Slater but was advised that the Health
21 District was unable to locate any such records.

22
23 In an effort to obtain records of the criminal
24 proceedings that had been brought against Mr Miller, the
25 Inquiry issued a summons to the Office of the Director of
26 Public Prosecutions for New South Wales in response to
27 which that office advised that any relevant records
28 predated the existence of that office and would have been
29 held, instead, by the Clerk of the Peace.

30
31 Efforts to locate the records of that office via
32 a summons to the Department of Communities and Justice were
33 unfortunately not fruitful. The Inquiry was advised by
34 that department that none of Courts and Tribunal Services,
35 the Supreme Court, or any other relevant sections of their
36 department were able to locate any relevant material.

37
38 Unsuccessful efforts were also made to contact the
39 former legal representatives of Mr Miller to see if that
40 might shed some light on the reason for the prosecution
41 that was commenced in 1982 not being pursued to trial.

42
43 Inquiries were also made with the Registrar of Births,
44 Deaths and Marriages concerning certain witnesses. These
45 inquiries established that Mr Miller had died in 1986.

46
47 The witness TM died in 1983 and the witness RW is now

1 also deceased.

2
3 The Inquiry also made contact with two key surviving
4 witnesses, RB, now aged 70, and GP, now aged 62, who were
5 present with Mr Miller for a time on the day of the
6 assault. In the case of GP, the Inquiry was able to take
7 a statement from him.

8
9 Commissioner, two expert reports have also been
10 obtained by the Inquiry. An opinion was sought from
11 Associate Professor Mark Adams, head of the Department of
12 Cardiology at Royal Prince Alfred Hospital. He was asked
13 to address the issue of causation of death in the context
14 of Mr Slater's injuries from the assault and his
15 pre-existing heart condition.

16
17 An opinion was also obtained, as already referred to,
18 from Professor Michael Besser AM, a consultant
19 neurosurgeon, concerning the effect of Mr Slater's head
20 injuries on his comprehension relevant to the comments he's
21 said to have made to those assisting him at the scene
22 shortly after the assault.

23
24 By summons dated 5 December 2022, the Inquiry sought
25 production of the exhibits associated with the original
26 investigation, including blood swabs from the crime scene
27 and Mr Slater's clothing and the blood sample that was
28 taken. NSW Police have been unable to locate those
29 exhibits and concluded that they no longer exist.

30
31 The potential now, obviously, for DNA testing of those
32 exhibits, regrettably, does not therefore now exist.

33
34 Commissioner, the adequacy of the original police
35 investigation is difficult to assess, particularly as at
36 least some of the records relating to it have not been
37 produced to the Inquiry. Media reporting from that period
38 suggested that police had conducted far more extensive
39 interviews than is reflected in the material for the
40 Inquiry, as does a short statement made at the time by the
41 original officer in charge.

42
43 There is some indication in the material that a large
44 part of the initial investigative efforts were directed to
45 interviewing to use the language employed in a police
46 summary, "numerous homosexuals, transvestites and other
47 persons", seemingly because the toilet block was well

1 known, again quoting from the police summary, as a:

2
3 *... renowned meeting place for the*
4 *homosexual element of this area at all*
5 *hours during the day and night.*
6

7 Unfortunately, other material suggests that this
8 approach may also have been informed or at least affected
9 by negative stereotyping, bearing in mind that the offence
10 occurred at a time when homosexuality remained a criminal
11 offence in New South Wales. An early police summary notes
12 that despite the assault taking place in a public toilet
13 "frequented by homosexuals", Mr Slater enjoyed a good
14 reputation and there was no suggestion he was an associate
15 of what is referred to as "a criminal element".
16

17 This would seem to confirm the negative stereotyping
18 that appears to have been inherent in police practices at
19 the time.
20

21 Commissioner, turning to the two matters, the
22 discontinuation of the prosecution and also the question of
23 causation in relation to Mr Slater's death, due to lack of
24 records, including any transcript of the committal
25 proceedings and any record of reasons for the no bill, the
26 reason for the discontinuation of the prosecution of
27 Mr Miller is unfortunately unclear.
28

29 It may be that some of the civilian evidence given at
30 the committal proceedings did not come up to proof.
31 Alternatively, or in addition, it appears that the defence
32 may have raised an issue concerning causation of the death
33 in view of Mr Slater's underlying heart condition and that
34 this may have played a role in the reasoning behind
35 discontinuing the proceedings.
36

37 The police materials contain a letter obtained by the
38 defence from Mr Slater's treating neurosurgeon after the
39 assault that suggests that Mr Slater may have recovered,
40 albeit with a neurological deficit, had it not been for an
41 underlying heart condition.
42

43 It was in order to address the question of causation
44 that the Inquiry sought the opinion of Associate Professor
45 Adams. In his report, Professor Adams outlines the
46 advances in understanding of relevant physiological
47 processes involved since 1980 and expresses a clear view

1 that the cardiac arrest that resulted in Mr Slater's death
2 was precipitated by the assault and consequential extensive
3 injuries Mr Slater received. Professor Besser also
4 addressed this issue and concurred with Professor Adams.
5

6 It's submitted, therefore, that the Inquiry can
7 readily conclude that the assault was a substantial or
8 significant cause of Mr Slater's death and that the
9 question of causation would not be a barrier to
10 a potentially successful prosecution were there a living
11 suspect.
12

13 It should be noted, however, that the fact that
14 Mr Miller was not charged with a lesser offence, for
15 example, of serious assault upon the discontinuation of the
16 murder prosecution, suggests that the reason for the no
17 bill rested at least in part on other considerations.
18

19 Commissioner, I now make some brief comments about the
20 way the matter was treated by Strike Force Parrabell. In
21 response to all 10 of the individual indicators in the Bias
22 Crimes Indicators Form, it's asserted that there is "No
23 evidence of bias crime".
24

25 This, Commissioner, is in stark contrast to an
26 assessment that was made by Detective Chief Inspector
27 Lehmann in 2013, which the Strike Force Parrabell officers
28 had, and to which the Bias Crime Indicators Form makes
29 reference. That 2013 assessment by that senior officer
30 concluded that the case involved probable gay hate
31 motivation.
32

33 In expressing that view, the 2013 assessment pointed
34 to a number of factors relevant to that probability,
35 namely, those referred to earlier in this submission that
36 the location was a known beat, Mr Slater's denial that he
37 had been bashed, and the presence of traces of semen on
38 some of his clothing.
39

40 The Strike Force Parrabell officers in the Bias Crime
41 Indicators Form, chose emphatic answers with respect to all
42 10 indicators that contradict the view that was expressed
43 in 2013. The form contains no indication of their reasons
44 for doing so. That emphatic assertion that there was no
45 evidence of a bias crime is also made in the Strike Force
46 Parrabell case summary.
47

1 Commissioner, the academic reviewers, according to the
2 case summary, categorised the case as "gay bias related
3 (anti-paedophile)". The "anti-paedophile" reference is
4 baffling. There is absolutely no basis in any evidence
5 relating to the matter for any suggestion that this was
6 a rationale for the attack or that Mr Slater was or may
7 possibly have been a paedophile. On the material available
8 to the Inquiry, any such suggestion is entirely baseless
9 and might rightly be regarded as insulting and false by
10 surviving family of Mr Slater, who, by all accounts, was
11 a much loved father and grandfather.
12

13 It is particularly disturbing, therefore, that when
14 one of the academics was specifically asked about the basis
15 for this conclusion in evidence before this Inquiry, he was
16 unable to offer any reason for it.
17

18 I now make some observations about the case against
19 Mr Miller drawn from the evidence that is before the
20 Inquiry.
21

22 It's noted that some of the relevant civilian
23 witnesses whose accounts implicate Mr Miller have now given
24 two or more separate accounts of written events. For
25 reasons outlined in the written submission, it seems
26 apparent that the accounts given by relevant witnesses in
27 late August and early September 1982, immediately prior to
28 Mr Miller's arrest, are likely to be the most reliable
29 accounts given by those witnesses. It's noted that, in
30 general, the accounts describe the presence of the
31 witnesses at and near the toilet block in Birdwood Park at
32 a time proximate to the time when Mr Slater must have been
33 assaulted.
34

35 In the account of GP, given in 1982, he describes
36 being in a group with Mr Miller, RB and RW, when he walked
37 into the toilet in Birdwood Park to use the urinal and that
38 when he was at the urinal, a man entered and stood at the
39 urinal on his right. He states that the man:
40

41 *... pulled out his penis and stood there as*
42 *if urinating.*
43

44 He said that after he exited the toilet, RW was making
45 sexual references to the toilet being a beat, in response
46 to which he made a reference to there being "only one old
47 bloke in there". He said that Mr Miller then said

1 something that gave him the impression that Mr Miller was
2 then going to enter the toilet for what he refers to as
3 "sexual reasons".
4

5 In his recent statement to the Inquiry, GP casts doubt
6 on the likelihood that Mr Miller had assaulted anyone upon
7 entering the toilet block because he did not consider that
8 there would have been time, because he did not hear
9 anything, and because of Mr Miller's unruffled demeanour.

10
11 Against this, however, is the fact that, in his 1982
12 account, he had indicated that Mr Miller had been in the
13 toilet block for two to three minutes. According to the
14 Newcastle Herald at the time of the committal proceedings,
15 he gave similar evidence at those proceedings.
16

17 The Newcastle Herald article of 25 November 1982
18 reported on GP's committal evidence saying that he was
19 shown a photo of Mr Slater and replied that the man he had
20 seen in the lavatory could very easily be the man depicted
21 in the photograph, but that he could not be sure.
22

23 In evaluating the account given by RB in 1982, it is
24 noted that when contacted by the Inquiry, she disavowed
25 this account on the basis that she's dyslexic and would not
26 have been able to read her record of interview.
27

28 For reasons set out in the written submission,
29 paragraphs 83 to 92, it's submitted that there is, in fact,
30 good reason to consider her 1982 account to be reliable,
31 including because of its consistency with other known
32 facts. In that account, she indicates that she was present
33 with Mr Miller and GP when GP entered the toilet, and that
34 upon GP exiting, he told Mr Miller that there was an old
35 bloke in the toilets, as a result of which Mr Miller said,
36 "I am going to crack it with the bloke in the toilet",
37 which RB said was a term used by homosexuals that means to
38 have sex with another bloke.
39

40 The account went on to say that she then knew that
41 Mr Miller was going to either "crack it with the man", or
42 he was going to "roll him and take his wallet." She then
43 left, indicated that she didn't want any part of it. She
44 states that her reference to "rolling" a man meant that
45 Jeff would have assaulted him and pushed him over and taken
46 his wallet and money. She said, "Jeff is always doing that
47 when he goes around to the toilets."

1
2 In the phone contact that Inquiry officers recently
3 had with RB, she denied knowledge that Mr Miller had
4 committed acts of violence. However, in her 1982 account,
5 she describes an occasion when she witnessed Mr Miller
6 assaulting a gay man at Pipers Nightclub in Newcastle, this
7 man being someone who worked at Newcastle Courthouse, and
8 who she said had doxed Miller into the police. She
9 described seeing Mr Miller bash this person and kick him,
10 as a result of which he was taken to hospital.
11

12 The veracity of this detail of RB's 1982 account, and
13 thereby that account more generally, is supported by the
14 fact that the Inquiry has obtained a record that is
15 consistent with Mr Miller having committed such an assault
16 on a man by the name given by RB at the same nightclub, who
17 is described in the police record as "effeminate". The
18 Inquiry has made unsuccessful attempts to locate and
19 interview the that victim of that assault.
20

21 The witness RW, who was with the group of RB, GP and
22 Mr Miller, gave an account to police in 1982 that's
23 relatively general and contains limited detail, though in
24 general terms it's consistent with the accounts of GP and
25 RB, as to the timing of the group being at or near the
26 toilet block and as to the actions of GP and Mr Miller at
27 the toilet block, although she appears to have left before
28 Mr Miller entered.
29

30 Also of significance, Commissioner, I submit, is the
31 account given to the police in 1982 by TM, the 17-year-old
32 who told police that in the afternoon of the day of the
33 assault, Mr Miller had threatened him by saying:
34

35 *You don't want to open your mouth or you*
36 *will end up like the guy in the toilet.*
37

38 When asked by police what he took Mr Miller to mean by
39 this, he said:
40

41 *I suppose because I knew a lot about him,*
42 *that he was rolling and bashing up people*
43 *in the toilets around Hamilton, Birdwood*
44 *and Centennial Parks. He was also taking*
45 *their wallets. I didn't know at the time*
46 *what he meant when he said "like the guy in*
47 *the toilet". I heard about it either the*

1 *next day or a few days after that a man had*
2 *died.*

3

4 It's also noted that in her 1982 account, RB had said that
5 she was present on the occasion that Mr Miller threatened
6 TM and that Mr Miller did this because TM - and this is
7 quoting the words of RB:

8

9 *... knew too much about Jeff rolling and*
10 *bashing homosexuals and I've seen Jeff belt*
11 *other blokes up for dobbing him in.*

12

13 In particular, these aspects of the accounts of TM and
14 RB seem to suggest not just that Mr Miller was known to
15 opportunistically assault and rob men in toilet blocks, but
16 that he targeted men who he presumed to be gay and/or
17 present at toilet blocks to use them as a beat.

18

19 The other element of the evidence implicating
20 Mr Miller is an implied admission he's said to have made to
21 police. On 1 September 1982, police approached Mr Miller
22 with the inculpatory accounts that had been provided to
23 them by RB, TM and GP. At the time, Mr Miller was in
24 custody on other matters.

25

26 Mr Miller made statements initially to police that
27 appeared to concede his involvement in the matter. He
28 showed police to the toilet block where the incident
29 occurred. According to the investigative officer, upon
30 being told that RB had signed a statement in writing,
31 Mr Miller said, "I knew I couldn't trust that bitch", and
32 complained that RB, "couldn't keep her mouth shut". He
33 conceded that he had, in fact, entered the toilet block and
34 asked as follows:

35

36 *What would happen if I say that old bloke*
37 *had a go at me first?*

38

39 However, when formally interviewed the same day, while
40 admitting to entering the toilet block, he said he was
41 looking to offer sex for money some time after 11am on
42 19 December. He claimed that he'd done so to "big-note
43 himself" with his companions, and that he had lost courage
44 after checking the first cubicle, for reasons he declined
45 to explain, and that he then left without seeing anyone or
46 taking any action. He denied involvement in any other
47 bashings or robberies.

1
2 I note, Commissioner, that this questioning of
3 Mr Miller in 1982 took place prior to the development of
4 current practices and requirements mandating the electronic
5 recording of such interviews of suspects. Nevertheless,
6 assuming the typed record of the initial responses made by
7 Mr Miller is reliable, they clearly provide significant
8 evidence by way of admission implicating Mr Miller in the
9 assault of Mr Slater.

10
11 The two remaining matters that I wish to address are
12 the appropriate findings as to manner and cause of death
13 and the question of potential LGBTIQ bias.

14
15 On the question of manner and cause of death, the
16 evidence that the Inquiry has assembled, considered in its
17 entirety, is strongly supportive of the view that Mr Miller
18 was responsible for the assault upon Mr Slater. However,
19 notwithstanding the considerable force of that evidence,
20 there are a number of reasons why the Inquiry would
21 hesitate to reach a positive conclusion naming Mr Miller as
22 the individual responsible, it is submitted.

23
24 As Mr Miller is deceased, it will never be possible to
25 test the evidence implicating him in criminal proceedings.
26 In the context of such proceedings, the relevant standard
27 to be applied is proof beyond reasonable doubt.

28
29 A particular concern, therefore, is that the record of
30 committal proceedings does not appear to exist. A record
31 of the evidence of key witnesses as tested at the time in
32 those proceedings would be critical, it's submitted, to
33 a full and fair assessment of the reliability of the
34 accounts given by them.

35
36 While Mr Miller's apparent admissions are very
37 significant, as noted, they're in typed form and were made
38 prior to the later standard practice of making electronic
39 recordings of such admissions, and he appears to have
40 disavowed them in subsequent statements made to the police.

41
42 In summary, then, while it appears highly likely that
43 Mr Miller was responsible for the assault upon Mr Slater,
44 in view of the grave nature of the allegation, and the
45 inability of Mr Miller, now deceased, to a contrary view,
46 and the fact that the prosecuting authority as of 1983
47 apparently took the view that there were deficiencies in

1 the case such as to warrant discontinuing the prosecution,
2 it is submitted that the Inquiry would hesitate to make
3 a formal finding declaring that Mr Miller was responsible.
4

5 On the question of causation, the evidence assembled
6 by the Inquiry suggests that there is no bar to finding
7 that the person responsible for assaulting Mr Slater was
8 also responsible for causing his death.
9

10 The medical report produced at the time of the no bill
11 may have left a question mark hanging over this issue,
12 however, it's submitted that the expert opinions of
13 Professor Adams and Professor Besser are such as to
14 establish that the person responsible for the assault
15 should also be considered, at law, to have caused
16 Mr Slater's death.
17

18 It would be appropriate, therefore, for a finding of
19 cause and manner of death to differ slightly from that
20 reached by the Coroner to adequately reflect the causal
21 nexus of the assault as established by the evidence of
22 those two experts.
23

24 It's submitted that an appropriate finding might be in
25 the following terms: that Richard Slater died on
26 22 December 1980 at Royal Newcastle Hospital as a result of
27 myocardial infarction that was precipitated by severe
28 traumatic brain injury received as a result of being
29 assaulted on 19 December 1980 at Birdwood Park in
30 Newcastle.
31

32 Commissioner, I now turn to consideration of the
33 question of gay hate bias motivation.
34

35 If one assumes that Mr Miller was the perpetrator as
36 seems likely, it would appear that he was acting on the
37 basis that he thought it likely that Mr Slater was a beat
38 user. The reasons for this are, firstly, that Mr Miller
39 would undoubtedly have known that the toilet block was
40 a beat; secondly, the evidence of his associates that he
41 said he was going in to the toilet block to "crack it",
42 meaning that he was intending to engage in sex with the
43 occupant; and thirdly, evidence of others that he had
44 a tendency to target beat users as victims of violence
45 and/or robbery.
46

47 Assuming Mr Miller to have been the perpetrator, it's

1 well and truly open to infer that he entered the toilet
2 with the intention of robbery, including the potential use
3 of violence upon the vulnerable occupant, who was someone
4 he presumed was a beat user and was considered to be an
5 easy target of robbery.
6

7 It is submitted that LGBTIQ bias may exist in such
8 a case where an offender discriminatorily selects a victim
9 due to that victim's LGBTIQ status, actual or presumed,
10 even if animus or hate towards the victim did not motivate
11 the crime.
12

13 In Mr Slater's case, his death, if at the hands of
14 Mr Miller, is likely to have involved the targeting or such
15 discriminatory selection of someone presumed to be gay
16 and/or a beat user on the basis that he was therefore seen
17 as a vulnerable target of robbery. It's submitted that
18 such a case, regardless of whether the perpetrator
19 additionally had or exhibited an anti-LGBTIQ animus, is one
20 in which LGBTIQ bias is present.
21

22 Commissioner, those are the submissions.
23

24 THE COMMISSIONER: Thank you.
25

26 MR SHORT: The Commissioner seeks to reserve her position
27 with a view to providing written submissions.
28

29 THE COMMISSIONER: Thank you.
30

31 MR de MARS: I am sorry, Commissioner, one brief matter
32 has been brought to my attention, that it is understood -
33 I think I indicated that Mr Slater had lived in the
34 Newcastle area for 25 years. It seems that that was for
35 a period of 40 years.
36

37 THE COMMISSIONER: Forty years, yes.
38

39 All right. I will give careful consideration to this
40 matter, as I have with others. I, of course, have to
41 receive yet the submissions on behalf of the police.
42

43 There is no doubt that Mr Slater died as a result of
44 a cowardly attack upon him, in circumstances which I will
45 come and deal with more fully in my report.
46

47 Can I just record my gratitude to the family member

1 for responding in the way that you have. Indeed, if you
2 weren't the first, you were one of the first people to make
3 contact with me when my appointment was announced, so
4 I thank you for that, and your grandfather would rightly be
5 very proud of you.
6

7 May I also say that I will take into account your
8 statement when I come to give consideration ultimately to
9 the matter and I just end by, on my behalf and on behalf of
10 everyone involved in this Inquiry, extending my condolences
11 to you and other members of your family.
12

13 I will now adjourn. Thank you.
14

15 **SHORT ADJOURNMENT**
16

17 THE COMMISSIONER: Yes, Mr de Mars.
18

19 MR de MARS: Commissioner, I appear to assist you in this
20 hearing by way of documentary tender in relation to the
21 death of Paul Rath.
22

23 THE COMMISSIONER: Thank you.
24

25 MR SHORT: Short, for the Commissioner of Police.
26

27 THE COMMISSIONER: Thank you, Mr Short.
28

29 Yes, Mr de Mars.
30

31 MR de MARS: Commissioner, may I, firstly, hand up
32 a tender bundle of material that has been prepared in this
33 matter.
34

35 THE COMMISSIONER: Thank you.
36

37 MR de MARS: That, I understand, should be exhibit 26. It
38 comprises 38 tabbed documents.
39

40 **EXHIBIT #26 TENDER BUNDLE IN RELATION TO THE DEATH OF**
41 **PAUL RATH, COMPRISING 38 TABBED DOCUMENTS**
42

43 THE COMMISSIONER: Thank you.
44

45 MR de MARS: Next, Commissioner, can I hand up proposed
46 short minutes of order and ask that those orders be made
47 under section 8 of the Special Commissions of Inquiry Act.

1 They relate to certain matters going to issues of
2 non-publication.

3
4 THE COMMISSIONER: Thank you.

5
6 MR SHORT: Those are by consent, Commissioner.

7
8 THE COMMISSIONER: Thank you.

9
10 MR de MARS: Commissioner, there is a family statement.
11 It has been prepared jointly by a number of family members.

12
13 THE COMMISSIONER: Thank you.

14
15 MR de MARS: I hand that up and that could be marked
16 exhibit 27.

17
18 **EXHIBIT #27 FAMILY STATEMENT IN RELATION TO THE DEATH OF**
19 **PAUL RATH**

20
21 THE COMMISSIONER: Very well, thank you.

22
23 MR de MARS: I think, Commissioner, you have been provided
24 with a copy of written submissions prepared by Senior
25 Counsel Assisting, Mr Gray, and myself, and I adopt those
26 written submissions.

27
28 THE COMMISSIONER: Thank you.

29
30 MR de MARS: Commissioner, there are a number of family
31 present today, and I'm going to come to them directly in
32 just a moment, but I want to commence by observing that
33 Paul Rath died on 15 or 16 June 1977 at a headland near
34 a place known as Fairy Bower in the Sydney suburb of Manly.
35 He was 27 years old when he died.

36
37 He came from a large and close family of eight
38 siblings, who were brought up by their parents in the
39 Sydney suburb of Manly.

40
41 If I can say this, in a remarkable show of family
42 solidarity, 46 years later, all seven of Mr Rath's siblings
43 are either present or watching proceedings today. Present
44 in person are Paul's sisters Janice, Lynda, Helen, Rosemary
45 and Liz. Watching online are Paul's brothers Chris and
46 Gregory. Also in court are Paul's brother-in-law Peter and
47 his nephew Jon.

1
2 Commissioner, Mr Rath was the eldest of the siblings
3 all of whom attended local Catholic high schools. Mr Rath
4 had left school in year 10, at which time he was described
5 as suffering from a nervous breakdown. According to his
6 treating psychiatrist, Mr Rath had a schizophrenic
7 disorder, which was treated with medication, and in the
8 months leading up to his death, in the words of his
9 psychiatrist, he had been fairly well.

10
11 Mr Rath had previously worked at the House with No
12 Steps, although at the time of his death he was not in paid
13 employment and received a pension.

14
15 His Catholic religion was important to him and at the
16 time of his death he was doing voluntary work as
17 a catechist at local schools and he regularly attended
18 church. He was known to go on frequent and regular walks
19 from the family home around the local area, including quite
20 often to the Fairy Bower headland.

21
22 It might be helpful at this point if I could ask for
23 a map, which I think is an attachment to the submission,
24 briefly to be brought up on the screen.

25
26 Commissioner, marked with the blue marker you will
27 see is the location in Manly of the Rath house, which was
28 in Pittwater Road in Manly. Just to orientate things, you
29 will see the narrowing of the land area and on the bottom
30 portion of that, you'll see where Manly Wharf is, and
31 opposite that the beach side, and in terms of evidence as
32 to potential areas where Mr Rath would walk, one of those
33 locations was known to have been the Fairy Bower headland,
34 which one sees consistent with the marker of where his body
35 was found, the purple marker.

36
37 From evidence, Commissioner, you're previously aware
38 of, there is a fairly, if I can put it this way, pleasant
39 coastal walk that one can take up to Shelly Beach along the
40 waterfront and then up to the car park area and then
41 a track that leads to the headland.

42
43 Commissioner, at around 4.30pm on Wednesday, 15 June
44 1977, one of Mr Rath's younger brothers, Gregory, saw and
45 briefly spoke with Mr Rath at the family home on Pittwater
46 Road where they both lived.

47

1 A little bit later, in the early evening of 15 June,
2 it appears that Mr Rath's sister, Helen Colman, saw and
3 spoke with him when he dropped by her flat in Denison
4 Street in Manly, which was only some 300 metres from the
5 family home. Ms Colman thinks that Mr Rath indicated to
6 her, on leaving her flat, that he was due to meet someone,
7 but that he would not tell her who this person was. That
8 occasion of Mr Rath going to Ms Colman's flat is the last
9 known sighting of Mr Rath prior to his death.

10
11 At around 7.20am the next morning, Thursday, 16 June
12 1977, Mr Rath's body was discovered, wedged between rocks,
13 in a crouched position, some distance from the base of the
14 cliffs at Fairy Bower headland. He was dressed in a suit,
15 the trousers of which were down at approximately mid-thigh
16 level exposing his underpants and upper thighs. One of his
17 shoes and a set of rosary beads that belonged to him were
18 located on the rocks nearby.

19
20 It's noted, Commissioner, that the location of
21 Mr Rath's death appears to be very close to the location
22 where Mark Stewart died one year earlier in 1976, that
23 being another death that this Inquiry has examined and one
24 that involved a fall from Fairy Bower headland.

25
26 The map could probably come down at present.

27
28 Injuries to Mr Rath's body were generally consistent
29 with a fall from height. Whether or not he may have
30 received some injuries prior to such a fall and whether his
31 death should be considered suspicious is a topic that
32 I will come to.

33
34 In relation to the initial investigation, in 1977,
35 that investigation was limited in scope. From a very early
36 stage, police approached the death as one that had not
37 involved foul play, and this seems to be the reason for its
38 very limited compass. Investigative opportunities that may
39 have been of assistance, if explored at the time of the
40 death, are now impossible to pursue.

41
42 In the written submission at paragraphs 31 to 41,
43 observations are made concerning the historical context in
44 which the police investigation occurred.

45
46 Without going to all the detail here, that context,
47 it's submitted, was one that was not conducive to

1 considering and detecting whether a death in these
2 circumstances may have been a gay hate homicide.

3
4 Undoubtedly, Commissioner, assaults of gay men
5 occurred in areas of the Northern Beaches of Sydney during
6 the 1970s. As was noted in submissions made in connection
7 with the death of Mark Stewart, there's a documented
8 instance of a gay hate homicide in a suburb near Manly in
9 late October 1975.

10
11 Further details of that matter can be found in
12 exhibits previously tendered to the Inquiry, and that
13 matter is also referenced in the written submission and at
14 tabs 32A and B of this tender bundle.

15
16 Commissioner, I mention that matter not to suggest any
17 association between it and Mr Rath's death but, rather, to
18 demonstrate that ideally, one might have hoped that
19 potential offending motivated by gay hatred would be
20 a consideration in the minds of police officers in that
21 era, particularly when investigating a death occurring in
22 proximity to a beat.

23
24 The extent of understanding among local police of the
25 existence of a beat at Fairy Bower at the time appears to
26 have been variable. In the matter of Mark Stewart, the
27 investigating officer professed not to be aware of the
28 beat. By contrast, the officer in charge in the present
29 matter clearly acknowledged its existence in the report of
30 death to the Coroner that he signed on 17 June 1977, the
31 day after the body was found.

32
33 It will be appropriate at this point if we could bring
34 up tab 1, which is the report of death of the Coroner, on
35 the screen.

36
37 Commissioner, if I could I direct your attention,
38 firstly, to the dates on that document, you can see at the
39 top a stamped 18 June but the typed entry 17 June, and
40 I think if we can just scroll to the very bottom,
41 Commissioner, you'll see the Glebe Coroners Court stamp
42 bearing the date 17 June 1977.

43
44 If we stay with the document framed that way, in that
45 first full paragraph, Commissioner, you'll see reference to
46 the body being conveyed to the City Morgue, Detective
47 Sergeant Ezart of Chatswood Scientific Branch attending the

1 scene, and then this reference:

2
3 *... due to the fact that this area is*
4 *frequented by homosexuals and the deceased*
5 *trousers were partly removed*
6 *a precautionary anal swab was taken by*
7 *Dr Fletcher on 16/6/77 at the City Morgue.*

8
9 Can I also direct your attention, Commissioner, to the
10 fact that, notwithstanding that entry, the final typed
11 portion of the document says in capital letters:

12
13 *NO SUSPICIOUS CIRCUMSTANCES.*

14
15 Commissioner, it does seem extraordinary that in that
16 report made the day after the death, on the one hand, the
17 concerning combination of the location being a beat and the
18 fact that Mr Rath's trousers were partially down clearly
19 seems to have been recognised; while, on the other hand,
20 the report concludes that there are no suspicious
21 circumstances.

22
23 This was notwithstanding the fact that, as at 17 June,
24 the results of penile and anal swabs that had been taken on
25 16 June seemingly had not yet been obtained, nor had the
26 autopsy been conducted.

27
28 That document could come down.

29
30 In his statement for the coronial brief, the officer
31 in charge said that he:

32
33 *... made an examination of the ledge from*
34 *where the deceased apparently fell,*
35 *however, I found no notes left by the*
36 *deceased or signs of a struggle.*

37
38 That appears to be the extent of any attempt, so far as
39 it's documented, to search or inspect the vicinity of the
40 cliff top.

41
42 Of course, where a death resulting from a fall from
43 a cliff top had involved foul play, one would not
44 necessarily expect to find positive evidence indicating
45 that a struggle had taken place.

46
47 There does not appear to have been any canvassing of

1 local residents even though the location is described
2 accurately as being close to the end of Bower Street in
3 Manly. Bearing in mind that Mr Rath's father provided
4 a statement to police indicating that his son would
5 ordinarily have attended church at 7.30pm that evening,
6 it's also notable that there's no indication as to whether
7 any inquiries were made at the church to see if Mr Rath had
8 attended.

9
10 It's far from clear how the possibility of foul play
11 was so readily dismissed, other than by recognising that
12 the social environment and policing practices of the era
13 meant that the police were unlikely to devote time and
14 resources to considering and detecting whether a death in
15 these circumstances may have been a gay hate homicide.

16
17 The autopsy that was performed at the time recorded
18 that there were numerous externally obvious injuries.
19 These included a large bruise and a good deal of
20 superficial oedema overlying the right eye and cheek, old
21 blood issuing from both nostrils, a small amount of blood
22 present in the right ear, which appeared to be passive, as
23 it's described in the autopsy, in nature, and not
24 associated with any skull fracture, bruising to the right
25 upper arm, bilateral compound comminuted fractures of the
26 lower legs and extensive bruising of the anterior chest
27 wall.

28
29 Other significant injuries were fracturing of the
30 sternum and a number of ribs and spinal fractures at
31 C7 level, that being near the base of the neck, and at
32 L1 level, that is, the top of the lumbar spine or lower
33 back. There was no skull fracture observed.

34
35 The forensic pathologist at the time described the
36 cause of death simply as "Multiple injuries".

37
38 The Inquiry has had the autopsy report reviewed by
39 Dr Linda Iles, the head of Pathology Services at the
40 Victorian Institute of Forensic Medicine. I'll come to
41 some of the detail of that review later. Suffice to say
42 that Dr Iles considers the original autopsy and report to
43 be somewhat deficient and limited in certain respects.

44
45 An inquest was held at Glebe Coroners Court on
46 16 September 1977. The coronial records are brief. The
47 only statements of substance taken from family members were

1 from Mr Rath's father, Elwyn, and his youngest brother,
2 Gregory, then aged 14, who at that stage was thought to
3 have been the last person known to have seen Mr Rath.
4

5 The Coroner's finding was that Mr Rath died between
6 the 15th and 16th day of June 1977 at Fairy Bower, Manly,
7 of the effects of multiple injuries sustained then and
8 there when he fell accidentally on to rocks at the foot of
9 a cliff.
10

11 Whether the positive finding of accident, while
12 dismissing the alternative possibilities of suicide or foul
13 play, is appropriate, based on the Inquiry's consideration
14 of all the material, is a key matter that I will come to.
15

16 The Inquiry has taken a range of steps to attempt to
17 shed further light on the circumstances surrounding
18 Mr Rath's death. On 11 May 2022, the Inquiry requested
19 the coronial file in relation to Mr Rath's death, a file of
20 44 pages was produced to the Commission in late May 2022.
21

22 Through a series of summonses and correspondence
23 with representatives of the NSW Police Force, it emerged
24 that the only investigative material held by police that
25 went beyond the contents of the coronial file was a
26 one-page police occurrence pad entry made on the day
27 Mr Rath's body was found.
28

29 Summonses were also issued to the Registrar of Births,
30 Deaths and Marriages for Mr Rath's birth and death
31 certificates, as well as to the Department of Forensic
32 Medicine, which produced a file containing material most of
33 which was already contained in the coronial file, although,
34 helpfully, it contained the report to Coroner document that
35 was just put on the screen, which was not in the coronial
36 file.
37

38 The Inquiry also made attempts to locate Dr O
39 Reichard, who was Mr Rath's treating psychiatrist, however,
40 it was ascertained that Dr Reichard passed away in 2005.
41

42 As already mentioned, the Inquiry obtained an opinion
43 from Dr Linda Iles. The Inquiry also sought the opinion of
44 expert forensic psychiatrist, Dr Danny Sullivan, as to
45 Mr Rath's psychiatric history and state at the time of his
46 death.
47

1 More recently, arising out of Dr Iles's report, the
2 Inquiry has sought the opinion of a forensic scientist as
3 to the staining evident on Mr Rath's clothing.
4 Supplementary submissions will be prepared in relation to
5 any matter arising after the relevant report is received,
6 as is required.

7
8 Records relating to weather and other meteorological
9 data for 15 June 1977 were obtained, as was a copy of
10 The Manly Daily newspaper article that reported the death
11 at the time.

12
13 As to those data relating to weather, it's noted that,
14 in relation to conditions on the night, firstly, 15 June
15 is, of course, close to being the shortest day of the year.
16 The records indicate that sunset on 15 June was 4.53pm and
17 sunrise on 16 June was 6.58am. Temperatures in Sydney
18 appear to have been in a range between 13 and 17 degrees
19 Celsius during the relevant period of time. There was no
20 rain reported at North Head over this period, and the state
21 of the moon was such to suggest that it would have been
22 a dark night.

23
24 Commissioner, Inquiry officers also spoke with
25 Ross Parry, now retired, but who was the officer in charge
26 of the original investigation into Mr Rath's death. While
27 Mr Parry had no independent recollection of Mr Rath's death
28 or the surrounding investigation, he did confirm his
29 understanding of the Fairy Bower headland being a location
30 for gay men to meet in the 1970s and 1980s.

31
32 It's also noted that on 2 August 2022, Inquiry lawyers
33 visited the Fairy Bower headland and North Head with a view
34 to pinpointing the location where Mr Rath's body was found
35 using scene photographs taken at the time of the original
36 investigation. It was possible to pinpoint the precise
37 crevice between rocks at the base of the headland where
38 Mr Rath's body was found. This was of assistance in the
39 consideration of the evidence relating to the likelihood or
40 otherwise of Mr Rath falling from the cliff above this
41 particular site. This visit and some of the photos taken
42 as a result are referred to in the statement of
43 Ms Healey-Nash at tab 38 of the tender bundle.

44
45 Inquiry officers also met with a number of Mr Rath's
46 siblings in November 2022. Subsequently, the Inquiry has
47 met with or held phone conferences with a number of

1 Mr Rath's siblings that have resulted in statements being
2 taken from Helen Colman, Gregory Rath and Janice Rowan.

3
4 Commissioner, they'll be found in the tender bundle,
5 I understand, at tabs 36, 37 and 37A.

6
7 The Inquiry also took steps to determine whether any
8 exhibits had been retained to see if forensic testing of
9 items might be possible. The report of death to the
10 Coroner describes the clothing found on Mr Rath being
11 a suit, jumper, shirt, socks, shoes, underpants and
12 singlet. It also states that property and clothing was
13 destroyed on the authority of Mr Rath's mother.

14
15 As already noted, photographs taken at the crime scene
16 appear to indicate the presence of blood on several
17 distinct areas of clothing. Further, a forensic biology
18 report refers to penile and anal swabs having been taken
19 and tested, with the penile swabs testing positive for the
20 presence of semen.

21
22 Correspondence the Inquiry has had with the police and
23 FASS has confirmed that these samples have not been
24 retained.

25
26 At the time of Mr Rath's death there was no DNA
27 testing capacity available to the NSW Police Force. Had
28 either the swabs or the clothing been retained, it now
29 would be possible to conduct DNA testing of both the
30 clothing and swabs to determine whether any other person's
31 DNA could be detected. However, obviously enough, that
32 possibility no longer exists.

33
34 I turn now, Commissioner, to consideration of the
35 evidence.

36
37 Commissioner, the evidence that the Inquiry has been
38 able to obtain from Ms Helen Colman and Mr Gregory Rath is
39 potentially quite significant. Gregory was thought to have
40 been the last family member to have interacted with Mr Rath
41 when, at 4.30pm on 15 June 1977, he sought Mr Rath's
42 assistance with removing his wetsuit after he'd returned
43 from an after-school surf at the local beach.

44
45 Gregory has told the Inquiry that at the time, his
46 mother told him to tell the police that Mr Rath was in a
47 good frame of mind when he last saw him, and that he held

1 no concerns about his brother's mental state. Gregory is
2 of the view that his mother told him to do so in order to
3 "protect Catholic values". As a 14-year-old, he felt
4 obliged to do as his mother asked.
5

6 Gregory has told the Inquiry that, in fact, in his
7 view, his brother was not necessarily in a good frame of
8 mind when he last saw him. He recalls that his brother did
9 not make eye contact with him and that he appeared to have
10 something on his mind and be, in Gregory's words, "in a
11 deep place". Gregory is of the belief that at the time his
12 parents thought it quite likely that Mr Rath had taken his
13 own life.
14

15 The account given at the time by Mr Rath's father,
16 Elwyn Rath, who has now passed away, is notable for the
17 fact that it stresses that he was of the view that his son
18 was in a good mood when he last saw him. He says that
19 Mr Rath was clumsy and that his reactions were affected by
20 the medication that he took. Elwyn Rath explicitly states:
21

22 *Both my wife and I are certain beyond doubt*
23 *that our son would not take his life as he*
24 *never said or did anything to indicate*
25 *this.*
26

27 He goes on and says:
28

29 *While he did suffer from nerves he was*
30 *never really depressed and being a very*
31 *devoted Catholic person, to take his life*
32 *would be contrary to his religious beliefs.*
33

34 The tenor of Elwyn Rath's statement appears to be
35 consistent with observations made by Gregory that his
36 parents were at pains to avoid there potentially being
37 a conclusion reached that their son had taken his own life.
38

39 In the absence of other substantive investigation by
40 police, it's perhaps not surprising, therefore, that the
41 officer in charge also supported the view put forward by
42 Mr Rath's parents that Mr Rath's death was an accident.
43

44 In his statement, the officer in charge expresses the
45 view that he could find no evidence that Mr Rath had taken
46 his own life. He concludes:
47

1 *In my opinion the deceased went to the*
2 *Fairy Bower area at a time when it was*
3 *almost dark and whilst on the ledge*
4 *apparently lost his footing and fell to his*
5 *death.*

6
7 Putting aside for the moment the possibility that foul
8 play was involved, it's submitted that objectively there
9 seems to be little to necessarily support the theory of
10 accident over suicide, apart from the view expressed by
11 Elwyn Rath that he and his wife did not believe Mr Rath
12 would have taken his own life.

13
14 Perhaps of greater import than Gregory's impressions
15 of his parents' intentions is that Gregory has also told
16 the Inquiry that Mr Rath told him, about a year prior to
17 his death, that he, Mr Rath, was gay, and that Mr Rath had
18 gone on to tell him, in effect, that he would have sexual
19 relations with a male friend who would stay overnight with
20 him at the family home on occasions. This evidence is
21 potentially of significance in considering the
22 circumstances in which Mr Rath potentially visited the
23 Fairy Bower headland, a known gay beat.

24
25 Moving to the information provided to the Inquiry by
26 Mr Rath's sister Helen, details of that account are set out
27 at paragraphs 85 to 96 of the written submission.

28
29 At the time of her brother's death, she was 18 years
30 old, had recently moved out of home and was in a
31 relationship with a man in his early 30s, who I will refer
32 to as "AB". AB was a teacher at the Catholic school that
33 her two younger brothers attended. They lived in a flat in
34 Denison Street in Manly, about 300 metres from the family
35 home.

36
37 Arising from Helen's account, the following matters
38 are noted: Helen has told the Inquiry that on the evening
39 of 15 June 1977, Mr Rath unexpectedly visited her at the
40 flat in Denison Street. AB was not present at the time.
41 It was dark and it was evidently after Gregory had seen
42 Mr Rath at 4.30pm.

43
44 The circumstances of that visit gave rise to Helen,
45 over time, coming to harbour some suspicion that AB could
46 in some manner have been involved in meeting Mr Rath on the
47 night of his death and in events connected with his death.

1
2 Careful consideration has been given to that
3 suggestion in light of all the material that is before the
4 Inquiry, and while it can be understood why the unusual
5 circumstances of Mr Rath's death have led to that
6 suspicion, ultimately, it's submitted that there is not
7 cogent evidence that would suggest that AB was, in fact,
8 involved in meeting Mr Rath that night.
9

10 It's submitted that of greater significance is that
11 Helen has told the Inquiry that having stayed at her flat
12 for around 20 minutes, when Mr Rath left, he told her that
13 he was meeting someone, but that when she asked who that
14 person was, her brother told her that it was confidential.
15

16 Helen has told the Inquiry that she did not come
17 forward with this information at the time of Mr Rath's
18 death at the request of AB. According to Helen, AB was
19 concerned that if she were to become involved in a coronial
20 investigation, the nature of their relationship might
21 become known to his employer and might threaten his job,
22 given her young age and the fact that her brothers were at
23 the school where he taught.
24

25 According to Helen, AB's fears, in fact, proved
26 correct as he lost his job later in 1977, when their
27 relationship came to the attention of the school in
28 unrelated circumstances.
29

30 It was not until Helen was contacted by this Inquiry
31 in 2022, some 45 years after the death of Mr Rath, that her
32 recollection of relevant events was recorded in the form of
33 a statement. Such a lengthy passage of time necessarily
34 means, without any reflection whatsoever on Ms Colman, that
35 her 2023 evidence needs to be considered with an
36 appropriate degree of caution because of the passage of
37 time.
38

39 It's also noted that since approximately 2013, the
40 NSW Police Force and, in due course, Strike Force Parrabell
41 had been aware that Helen may have had relevant information
42 concerning AB and events surrounding her brother's death.
43 However, the police have never sought to speak to her or
44 question her about such matters.
45

46 Commissioner, another key aspect of the evidence
47 emerging from the Inquiry's review of the matter is the

1 review conducted by forensic pathologist Dr Iles. Before
2 commenting on that review, it's worth saying something
3 about the distinctive position in which Mr Rath's body was
4 found.

5
6 The scene visit made by the Inquiry which enabled the
7 precise spot where Mr Rath's body was found to be
8 pinpointed was of assistance in assessing how Mr Rath's
9 body came to be in its resting position.

10
11 At this point I would ask for the statement at tab 38,
12 in particular the attachments by way of photo that appear
13 to that statement, to be brought up on screen. It might be
14 appropriate if I could get you to go to the last of those
15 photos first.

16
17 I'll just briefly take you through these
18 progressively. That photo, Commissioner, if you see the
19 area of what I might describe as yellow-orange-coloured
20 rubble in an area between two boulders, is the location
21 that was pinpointed where Mr Rath was.

22
23 If we then go up to the preceding photo, that simply
24 gives one some greater perspective on the terrain in the
25 vicinity with the cliff in the background, an area of
26 vegetation and one can see, in the bottom left corner, that
27 relevant area.

28
29 If we perhaps go to the next photo, that's another
30 shot of the vegetation in that area just before one gets to
31 the rocky area. That photo may also be of assistance in
32 giving some perspective on the lateral distance between the
33 cliff and the location where the body was. It's noted that
34 at the time that photo was taken, independently of the
35 Inquiry, someone can be seen abseiling down a rope, and
36 that might assist in getting some sense of the lateral
37 distance and perspective.

38
39 If we could go up, I think, to the next shot, that is
40 a shot that is identified as, if one sees the red circled
41 area, what would appear to be the location, most likely
42 location, from which Mr Rath fell or went off the cliff.

43
44 Then if we go up again, some pinpointing has been done
45 to try and indicate the relative positions of the cliff
46 edge and the location of the body. Again, that gives some
47 perspective on the area of vegetation between the cliff and

1 the rocks.

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Commissioner, at first instance, it may seem curious that a person would land in a seated position after a fall of this nature, however, having viewed the location where the body was found and the lateral distance from the ledge, it seems likely that Mr Rath may have first impacted the sloping area of vegetation near the base of the cliff before tumbling further to his position in the rocks adjacent to the vegetation.

This would potentially account for his body's resting position as well as the fact that his body was some distance from the cliff face. However, the nature of the injuries appear to be consistent with Mr Rath's legs having taken the initial impact of the fall on to the sloped vegetation area before the body came to its resting position in the rocks near the vegetation.

There's some comment by Dr Iles on these matters that I'll come to, but for these reasons, it's not submitted that the distinctive body position is itself necessarily a cause of suspicion. Moreover, it's difficult to see how or why a third party would have altered Mr Rath's body position after the fall had occurred, particularly given how difficult the area would have been to access and particularly after dark.

Coming to Dr Iles's report, while allowing for changes in autopsy practice that have occurred over time, Dr Iles noted the absence of a number of matters from the original autopsy report that made a review of the matter challenging. These included: the limited description of external injuries including ambiguity as to what was meant by the expression "old blood issuing from the nostrils", and there being no indication of the origin of the passive blood identified in the right ear; that there was no description of any injuries to the fingers of both hands, despite seeing photographs appearing to suggest such injuries; that there was no description of cutaneous injuries to the lower legs, the absence of which is unusual given the description of extensive fractures as described in the autopsy report; the specific location of bruising to the right upper arm not being indicated; no description being given of the presence or absence of anogenital injuries or of the presence or absence of scalp bruising; and there being no comment regarding whether there was

1 spinal injury associated with the C7 and L1 spinal
2 fractures, this being the most serious of the injuries
3 described.
4

5 More generally, Dr Iles observed that accurate
6 external and internal injury descriptions ideally
7 documented by photos along with relevant negative
8 observations are required in order to correlate injury
9 patterns with scene finding and to test propositions around
10 injury causation and event reconstruction.
11

12 She also observed that given that Mr Rath was
13 prescribed two anti-psychotic medications that may cause
14 sedation, toxicological analysis for drugs other than
15 alcohol would have been advisable.
16

17 Dr Iles expressed the view that the nature of the
18 lower leg fractures was in keeping with a fall from
19 a height with the primary impact forces being directed
20 through the feet. The absence of any associated pelvic
21 injuries was surprising and may have been overlooked.
22

23 Dr Iles also commented on the significance of the
24 distinctive position in which Mr Rath's body was found.
25 She considered it extremely unlikely that the body would
26 have been placed in its position by persons unknown, given
27 that Mr Rath had injuries in keeping with a fall and the
28 difficulty in accessing the site.
29

30 Absent her own analysis of the topography, she was
31 unable to say whether Mr Rath may have landed directly in
32 the position. The fall on to the grassy area above the
33 rocks, followed by the body tumbling into position, could
34 have accounted for the position, in her opinion.
35

36 Dr Iles did not consider it likely that Mr Rath could
37 have fallen and then moved himself into his final position
38 as his injuries were such that he would not have had the
39 capacity to do so after initial impact.
40

41 It appeared to Dr Iles that the spinal injuries would
42 have been the cause of Mr Rath's death, particularly in the
43 absence of any documented head injury other than bruising.
44 Dr Iles was of the view that death was rapid in onset.
45

46 Dr Iles cautioned that the emission of semen after
47 death is a relatively common post-mortem phenomenon and

1 that the detection of semen from the penile swab at
2 autopsy, unless it's demonstrated by DNA analysis to have
3 come from another individual, should not be interpreted as
4 evidence of recent sexual activity.

5
6 What Dr Russell meant by "old blood issuing from the
7 nostrils" was not clear to Dr Iles. She considered it
8 possible that it was a reference to dried blood which could
9 have issued as a result of injuries sustained either during
10 or prior to the fall.

11
12 She was of the view that the bruising to Mr Rath's
13 right eye, cheek and upper arm could have been sustained in
14 the fall, particularly if there were secondary impacts in
15 addition to the primary impact.

16
17 Without knowing the particular location of the upper
18 arm bruising, it was not possible for her to reach a view
19 as to whether or not this could be considered suspicious.

20
21 She observed that the lowered trouser position may
22 have been a prompt for penile and anal swabbing that
23 occurred but that the incomplete nature of the autopsy
24 examination made it difficult to determine the significance
25 of the trouser position.

26
27 In particular, there was no recorded observation as to
28 whether the trousers were fastened or loose or
29 tight-fitting, nor was there any documented detailed
30 anogenital examination. She expressed the view that, on
31 first principles, the trouser position should have been
32 a prompt for a more thorough examination at the scene and
33 autopsy.

34
35 Dr Iles also made note of the fact that the scene
36 photographs appear to indicate a degree of injury to
37 Mr Rath's fingers. Whilst she acknowledged that a spectrum
38 of injuries could occur in a fall, she again observed that
39 the lack of any detailed documentation of the nature of
40 these injuries made it difficult for her to make any
41 comment on them.

42
43 Apart from the very limited nature of the documented
44 autopsy examination, the primary matter of concern noted by
45 Dr Iles was the staining that can be seen in the scene
46 photographs of various areas of Mr Rath's clothing, which
47 she states is likely to be blood, dirt or a combination of

1 both. She expressed that view as follows:
2

3 *The staining of Mr Rath's clothing, in my*
4 *view, particularly if the staining is due*
5 *to blood, is the most concerning element of*
6 *the materials under review. It is out of*
7 *keeping with the scene and circumstances as*
8 *described, along with autopsy findings as*
9 *documented.*

10
11 She went on to strongly recommend that the photographs be
12 reviewed by a forensic biologist.
13

14 Consequently, as I've already indicated, the Inquiry
15 has sought a report from such a person in order to address
16 the concern identified by Dr Iles. Unfortunately, at the
17 present time, that report has not been finalised and
18 completed, and it will be tendered at a later date,
19 Commissioner, is the intention, along with any appropriate
20 supplementary submissions.
21

22 Dr Iles was of the view that cause of death could
23 reasonably be described as:
24

25 *Spinal injuries sustained in a fall from*
26 *a height.*
27

28 However, she noted that the cause of death does not imply
29 manner of death. Based on the medical evidence, she was of
30 the view that it was not possible to distinguish between
31 whether the fall was due to accident, suicide or homicide.
32

33 As earlier noted, the Inquiry also obtained a report
34 from forensic psychiatrist Dr Danny Sullivan in relation to
35 Mr Rath's diagnosis, medications and likely cause of death.
36 Dr Sullivan noted that relevant information in relation to
37 Mr Rath's condition was sparse and lacked detail, but
38 observed that he had no basis to dispute Mr Rath's treating
39 psychiatrist's diagnosis of schizophrenia.
40

41 He observed that Mr Rath's medications had been
42 prescribed in moderate and low doses respectively. He
43 noted that the side effect of restless legs can be a common
44 effect of the medication haloperidol in particular, and
45 that the medications would have led to stability in mood
46 and functioning. They would have also resulted in a degree
47 of sedation and reduced facial movement, and would possibly

1 have slowed Mr Rath's reactions. However, without
2 reference to Mr Rath's symptoms, Dr Sullivan could not
3 comment further on the likely effect of the medications.
4

5 Dr Sullivan noted that speculation about Mr Rath's
6 behaviour at the time of his death is limited by the
7 paucity of relevant material. As a consequence, his
8 discussion of the possible alternative causes of death is
9 necessarily limited and inconclusive. He did not think
10 that any particular conclusions could be drawn from the
11 presence of the rosary beads, or from a note that was
12 located in Mr Rath's pocket which I note, Commissioner, was
13 a piece of prose writing, as the presence of such items
14 would appear to have been usual for Mr Rath.
15

16 Commissioner, I now want to very briefly make some
17 comment on the treatment of the matter by Strike Force
18 Parrabell in 2016. Generally, the treatment of the matter
19 in the Bias Crimes Indicators Form is in keeping with the
20 limited nature of the review conducted by Strike Force
21 Parrabell in that it merely repeats various portions of
22 statements from the original investigation and does not
23 seek to explore significant outstanding matters including
24 Mr Rath's sexuality.
25

26 It is apparent from the material produced to the
27 Inquiry by NSW Police that police and Strike Force
28 Parrabell officers were aware of Helen Colman's concerns
29 about the potential involvement of a man known to her and
30 the possibility that the matter may have been a gay hate
31 crime.
32

33 However, it is noted that Strike Force Parrabell
34 officers made no reference to those concerns in the Bias
35 Crimes Indicators Form, and that it would seem, on the
36 material produced to the Inquiry, that neither Strike Force
37 Parrabell nor NSW Police generally took or have ever taken
38 any steps to pursue those matters.
39

40 The Parrabell case summary simply concluded that there
41 was no evidence of a bias crime and remarkably makes no
42 reference to the area being a known beat, despite the
43 report to the Coroner made at the time effectively
44 identifying it as such.
45

46 Commissioner, I now turn to consideration of what I
47 might describe as alternative hypotheses in relation to

1 Mr Rath's death.

2

3 I make these observations, Commissioner, I guess with
4 the qualification of the outstanding report that has been
5 mentioned during the course of submissions.

6

7 Firstly in relation to the possibility of suicide, at
8 the time of the original investigation in 1977, it appears
9 that a high level of significance was placed on the account
10 of Elwyn Rath as to Mr Rath's "happy and normal
11 disposition" in the lead-up to his death.

12

13 Additionally, Gregory Rath's account at that time that
14 his brother appeared to be happy, made at the urging of his
15 mother, may well have contributed to the original
16 dismissability of the possibility of suicide. That said,
17 there is no clear indication that Mr Rath was contemplating
18 suicide in the lead-up to his death.

19

20 Consistent with what Dr Sullivan has said, apart from
21 confirming that Mr Rath evidently had a significant
22 long-term mental disorder, there's limited information in
23 the brief report prepared by Mr Rath's treating
24 psychiatrist that assists in evaluating the likelihood that
25 Mr Rath may have died by suicide.

26

27 It's submitted that the possibility, however, that
28 Mr Rath deliberately took his own life cannot be ruled out.
29 This is particularly so given the evidence that has come to
30 the Inquiry's attention suggesting that the information
31 provided to the original investigation perhaps painted
32 a more optimistic picture of Mr Rath's mood than was
33 justified, and given that the alternative possibilities of
34 accident or foul play cannot be positively established.

35

36 In relation to the possibility of accident, it's
37 submitted that there's no compelling evidence pointing
38 to the likelihood that Mr Rath's death was an accident.

39

40 Elwyn Rath's references to his son being clumsy,
41 complaining of aching legs and having slowed reactions,
42 find some support in the observations that Dr Sullivan has
43 made about the potential effects of the anti-psychotic
44 medication that Mr Rath took. However, his father also
45 observed that it was a location that his son was familiar
46 with and would regularly visit and it would therefore seem
47 likely that the terrain would be familiar to him.

1
2 Given the position of Mr Rath's trousers, one, perhaps
3 speculative, possibility is that Mr Rath could have been
4 masturbating or urinating at the time of his fall. If so,
5 a further speculation might be that that might have
6 rendered an accident or a fall more likely. However, such
7 speculations are essentially fruitless. It's submitted
8 that as with the possibility of suicide, the possibility of
9 an accident also cannot be ruled out, particularly in the
10 absence of a clearly established alternative.

11
12 In relation to the possibility of foul play,
13 Commissioner, it's noted that no evidence was located at
14 the cliff top indicative of a struggle or assault having
15 taken place there. It's suggested, however, that very
16 little weight can be given to the absence of such evidence
17 in circumstances where such a death can readily be affected
18 by a simple push and where the autopsy report may not have
19 adequately documented any external injury.

20
21 The combination of the fact that Mr Rath's trousers
22 were at mid-thigh level and the known status of the
23 location as a beat was sufficient for the police, in
24 conjunction with a doctor at the morgue, to decide that it
25 was appropriate to take anal and penile swabs from Mr Rath.
26 It would appear that, at that stage, police entertained
27 some suspicion that Mr Rath may have been engaged in a
28 sexual act at the time of his death and that another person
29 may have been present.

30
31 In summary, features of this matter that suggest the
32 possibility that Mr Rath may have been the victim of foul
33 play, it's submitted, are as follows: firstly, the absence
34 of particularly compelling evidence in support of
35 alternative hypotheses; secondly, the fact that the death
36 occurred in the vicinity of or at a beat; thirdly, evidence
37 concerning Mr Rath's sexuality that indicates the
38 possibility that Mr Rath may have been visiting the
39 location because it was a beat; fourthly, the possibility,
40 based on Helen Colman's account, that Mr Rath had arranged
41 to meet a person at or near the location; fifthly, the
42 possibility, based on the position of Mr Rath's trousers
43 and where he came to rest, that Mr Rath may have had his
44 pants lowered prior to falling from the cliff and that this
45 occurred either while he was present with another person or
46 that someone approached him, having seen Mr Rath in that
47 state of undress; and lastly, the many uncertainties

1 concerning the pattern of what it seems is likely to be
2 blood that was on Mr Rath's clothing and the possibility
3 that these were the product of an act of violence that
4 occurred prior to Mr Rath falling from a cliff.
5

6 Commissioner, as to the question of bias, in light of
7 the uncertain state of the evidence as to the circumstances
8 of Mr Rath's death, it's submitted that it's not possible
9 to determine whether Mr Rath's death was a homicide and
10 therefore it's not possible to determine whether it was
11 a result of an LGBTIQ hate crime, although it may have
12 been.
13

14 In relation to manner and cause of death, as to the
15 cause of death, Dr Iles suggests that an appropriate
16 description would be:
17

18 *Spinal injuries sustained in a fall from*
19 *a height.*
20

21 It's submitted that this should be adopted in preference to
22 the Coroner's more general finding of "Multiple injuries".
23

24 As to the manner of death, the evidence available to
25 the Inquiry at present is insufficient to support
26 a positive finding preferring any one of the three
27 possibilities, namely, suicide, accident or foul play.
28 It's submitted, therefore, that the Coroner's finding that
29 the death was the result of an accident should not be
30 adopted by the Inquiry. Accordingly, it's suggested that
31 the Inquiry should find that Mr Rath died on 15 or 16 June
32 1977 as a result of spinal injuries sustained in a fall
33 from a height, the cause of which cannot be determined.
34

35 Those are the submissions.
36

37 MR SHORT: The Commissioner reserves her position.
38

39 THE COMMISSIONER: Thank you.
40

41 Along with all of the matters before me, I will give
42 this matter, of course, careful consideration.
43

44 This hearing today is not the end of the sadness that
45 this family has suffered over some 46 years. It was
46 a profoundly sad day I'm certain for each and every one of
47 you when your brother was found deceased at the foot of the

1 cliffs.

2
3 I will give, as I have said, careful consideration to
4 all of the matters, and I'm very grateful, both for your
5 attendance today and for those watching online, and I'm
6 very grateful for the statement that you have thoughtfully
7 put together, because it is of some assistance to give me
8 a further insight into your brother's mental state and into
9 his activities on the night.

10
11 Perhaps I can conclude by extending my sincere
12 condolences to each and every one of you, both here and
13 watching at home, and to other members of your family. In
14 due course, I will write a report and, in due course, you
15 will see what I have to say about it, and I will now
16 adjourn the proceedings. Thank you.

17
18 **AT 12.28PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
19 **ACCORDINGLY**

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