Ombudsman
New South Wales

Ombudsman monitoring of the police investigation into the death of Roberto Laudisio-Curti

A Special Report to Parliament under s.161 of the *Police Act 1990*

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Foreword

It is essential that police thoroughly and objectively investigate incidents where a person is killed or seriously injured during policing activities. The community and families of victims reasonably expect that investigators will determine what occurred and appropriately address any identified criminal conduct, officer misconduct or shortcomings in policy, procedures or training.

The sudden and tragic death of Roberto Laudisio-Curti on 18 March 2012 raised issues of significant public interest both here in Australia and abroad after it was revealed that Mr Laudisio-Curti — an otherwise fit and healthy 21 year-old — died shortly after 11 officers used physical force, multiple Tasers, OC spray, handcuffs and a baton while attempting to arrest him for allegedly stealing two packets of biscuits from a convenience store.

This office decided to actively monitor the police investigation into Mr Laudisio-Curti's death to provide a level of reassurance to members of Mr Laudisio-Curti's family and the community that the investigation would be conducted in an appropriate, accountable and transparent manner.

The purpose of this report is to outline how police investigated Mr Laudisio-Curti's death in the lead up to the coronial inquest and to explain how we monitored the police investigation. The report details issues we identified while monitoring the investigation and our concerns about the failure of investigators to adequately identify and address certain issues during the investigation.

We have made recommendations to ensure that critical incident investigators gather all relevant evidence in a timely, accountable and transparent manner by conducting appropriate interviews — including walk-through or re-enactment interviews — with involved officers and civilian witnesses.

We have also recommended that police guidelines be amended to ensure that investigators are aware of the need to consider and take appropriate and timely action to address issues identified during the investigation, and that a senior officer takes responsibility for, and properly reviews, the investigation before any coronial inquest examining the death of a person during policing activities.

We can see no good reason to delay taking action given that coronial inquests often take many months and sometimes years to be finalised. The NSW Police Force (and not the Coroner) is responsible for identifying and taking appropriate and timely action to address any identified criminal conduct, officer misconduct or shortcomings in policy, procedures or training. The failure to take timely and appropriate action means that the NSW Police Force is abrogating its responsibility to address foreseeable risks to the community and the organisation.

It may come as a surprise to members of the community to know that police investigations into the death or serious injury of persons during policing activities are not automatically subject to independent scrutiny by my office. We are only able to oversight these investigations upon receiving notification of a complaint about the conduct of the officers involved. This means that most critical incident investigations are not subject to any scrutiny by this office.

To overcome this significant gap in the system of independent oversight of police investigations involving issues of important public interest, we have made recommendations for a mandatory notification scheme whereby police would be required to immediately notify my office of all incidents where a person dies or is seriously injured during policing activities irrespective of whether a complaint has been made about the conduct of the officers involved in the incident. We would then be well placed to determine whether it is in the public interest to oversight and monitor any police investigation into the death or serious injury of persons during policing activities.

Bruce Barbour
Ombudsman

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Background

On Sunday, 18 March 2012, Roberto Laudisio-Curti, a 21-year-old Brazilian living, studying and working in Sydney, died in Pitt Street, Sydney shortly after being pursued and restrained by up to eleven police officers who used physical force, multiple Tasers, OC spray, handcuffs and a baton. The officers were attempting to arrest Mr Laudisio-Curti — who at the time was in a LSD-induced psychotic state — for allegedly stealing two packets of biscuits during an earlier incident at a convenience store. Police commenced a critical incident investigation into the death of Mr Laudisio-Curti shortly after he died. Chapter 2 outlines how the NSW Police Force conducted the critical incident investigation.

Why we monitored the critical incident investigation (Chapter 1)

We decided to monitor the investigation so as to provide reassurance to both Mr Laudisio-Curti's family and the community that there would be a level of independent scrutiny of the investigation and to ensure that police conducted the investigation in an appropriate, accountable and transparent manner. We were also mindful of the community's understandable concern about police investigating the conduct of fellow police and recent criticisms of another critical incident investigation by a Deputy State Coroner.

How we monitored the critical incident investigation (Chapter 3)

We monitored the critical incident investigation in real time by regularly reviewing material on police information systems and by observing certain investigative activities such as walk-through interviews with civilian witnesses. We also had a number of meetings with the investigators, the Coroner and Counsel Assisting the Coroner to discuss investigative strategies and material gathered by the investigators. We also had regular contact with the investigators who provided information and explanation of evidence gathered and investigative strategies proposed or undertaken. This contact enabled us to raise any concerns we had with the investigation in a timely manner.

What we identified during our monitoring of the critical incident investigation (Chapter 4)

We identified the following issues and concerns during our monitoring of the investigation.

Availability of material on police information systems

Police provided us with unfettered access to their primary information storage and investigation management system to ensure that we could monitor the investigation in real time. This access meant that we were able to independently access all material on the system at any time from computers in our office. However, on occasion, investigators did not place certain information on the system in a timely manner and appeared to have a practice whereby some material was only placed on the system after it had been reviewed by the Senior Critical Incident Investigator. This delay hindered our ability to examine some material in a timely and judicious manner.

Advice about proposed investigative activities

When we monitor an investigation we can attend interviews and confer with investigators about the conduct and progress of the investigation. Our ability to effectively monitor an investigation is dependent on sufficient advance notice of proposed interviews and investigative activities. On a number of occasions the investigators provided little or no notice of proposed investigative activities despite us stressing the importance of providing us with advance notice and raising concerns during the investigation about the lack of notice of proposed activities.

Identification of civilian witnesses

A civilian witness who saw some of the foot pursuit and final struggle between the police officers and Mr Laudisio-Curti in Pitt Street spoke to and provided details to an officer at the scene of the critical incident. However, investigators only contacted the witness for the purpose of obtaining a statement after a newspaper published details

of what the witness observed some three days after the critical incident. The *Critical Incident Guidelines* state that interviews with crucial witnesses should be conducted at the first reasonable opportunity. It is of some concern that investigators did not contact this crucial civilian witness earlier, although we appreciate that the investigators had a number of competing priorities in the days immediately following the Mr Laudisio-Curti's death.

Interviewing civilian witnesses

The critical incident investigators initially indicated to us that it was standard practice to rely on statements already provided to police rather than conduct interviews with civilian witnesses. We expressed concerns about this practice given that it is usually not clear exactly what instructions or questions the police officer asked the witness when taking the statement. The investigators accepted that it was best practice to conduct video-recorded walk-through interviews and subsequently organised interviews with eight civilian witnesses.

The NSW Police Force *Critical Incident Guidelines* do not currently contain any specific instructions on interviewing civilian witnesses. In order to ensure accountability and transparency, we have recommended that the NSW Police Force amend the guidelines to make it mandatory that critical incident investigators conduct question and answer interviews with civilian witnesses who are willing and able to provide information about the actions of police officers involved in critical incidents.

Walk-through interviews with involved officers

Conducting walk-through interviews or re-enactments with involved officers provides critical incident investigators with an opportunity to better understand what occurred and to clarify any issues arising from initial interviews. Involved officers may be able to recall certain details better when asked questions at the location where events occurred.

The investigators did not conduct walk-through interviews or re-enactments with any of the involved officers as part of this investigation. The investigators appeared to be of the understanding that they could not lawfully order or direct the involved officers to participate in walk-through interviews. The *Critical Incident Guidelines* do not currently contain any explicit information on either the lawfulness or reasonableness of any order or direction to involved officers to participate in walk-through interviews or re-enactments, or the desirability of conducting walk-through interviews or re-enactments. We have recommended that the NSW Police Force seek independent legal advice to clarify whether investigators are able to direct involved officers to participate in walk-through interviews or re-enactments and amend the guidelines to provide guidance on the legal issues and desirability of conducting walk-through interviews or re-enactments with involved officers.

Re-interviewing involved officers

The investigators conducted comprehensive and thorough initial interviews with the involved officers in the days following the critical incident. A couple of months into the investigation the investigators advised us that there were a number of issues they would like to clarify with the involved officers as a result of additional information that they had gathered and analysed.

In response to our suggestion that the investigators interview certain involved officers to clarify any outstanding issues, the investigators advised that the solicitors acting for the involved officers contended that the investigators could not lawfully order or direct the involved officers to participate in further interviews. We asked police to provide us with any legal advice to support the contention that the investigators could not lawfully direct involved officers to participate in further interviews. Police subsequently advised us that there was no impediment to re-interviewing the involved officers.

The investigators did not re-interview any of the involved officers notwithstanding the apparent merit in clarifying issues and inconsistencies arising from their initial interviews. The investigators had scheduled interviews to take place five months after the critical incident, however an internal legal advisor advised the investigators not to direct the involved officers to participate in further interviews given that they had met the 'sufficient interest threshold' for the coronial inquest.

In our view, the investigators should have attempted to re-interview the involved officers earlier given that two months after the incident they had already identified a number of issues they wanted to clarify with some of the involved officers as a result of the information they had gathered and analysed. Clearly, re-interviewing involved officers some five months after the critical incident would have impacted on their ability to accurately recall certain details.

Characterisation of incident at the convenience store as an 'armed robbery'

A council street sweeper who witnessed Mr Laudisio-Curti jump into the caged area of the convenience store called triple-0 believing that a robbery was in progress. The triple-0 operator recorded the incident at the convenience store as an 'armed robbery' on the computer aided dispatch system despite the fact that the street sweeper stated that no weapons had been sighted. The inaccurate characterisation of the incident led police radio to initially broadcast the incident as an 'armed robbery' when requesting urgent police assistance at the convenience store.

We suggested that the investigators examine the inaccurate characterisation, as it appeared to have contributed to the nature and level of response by the involved officers when later pursuing and restraining Mr Laudisio-Curti. The investigators reviewed the triple-0 recording and logs of the emergency call and obtained statements from the triple-0 operator and the Commander of Sydney Radio Operations. The operator believed that weapons were likely to be involved and followed standard operating procedures that require operators to record a robbery involving commercial premises as an 'armed robbery'. The investigators did not advise this office of any further action to address or escalate the problematic requirement in the standard operating procedures, which in our view should be reviewed to ensure that inaccurate characterisations do not re-occur. We understand that police have commenced a review of the procedures to ensure further inaccurate characterisations are avoided.

Assault on Mr Laudisio-Curti

After reviewing certain statements and CCTV footage we formed the view that Mr Laudisio-Curti may have been assaulted by four unknown males shortly before entering the convenience store. We raised the alleged assault with the investigators who responded by issuing a media release and still photos stating that they wished to speak with the males who interacted with Mr Laudisio-Curti. The investigators did not receive any information as a result of the media release and took no further action on the alleged assault.

Taser firing data issue

A review of the evidence gathered by the investigators revealed that the Taser firing data appeared to be significantly inconsistent with other available information, including footage from the Tasers. In particular, the firing data for one involved officer appeared to suggest that the Taser was fired before it plausibly could have been. The investigators advised us that they proposed to visit the manufacturer, Taser International, based in Arizona in the United States of America, for the purpose of raising the Taser firing data issue.

We suggested that the Taser firing data issue might be resolved by attempting to clarify with one of the involved officers how and when the Taser was deployed. We also suggested that the yet to be completed crime scene analysis might shed some light on the issue given that each Taser released unique confetti like markers at the point of deployment. We also expressed the view that seeking advice from Taser International should only occur if absolutely necessary given the potential for a conflict of interest given that Taser International was likely to seek leave to be represented at the coronial inquest. We further noted that Taser International may not be willing to provide independent and impartial advice given their obvious commercial interest should any flaws in the operation of the Tasers be detected.

The crime scene analysis completed after the investigators visited Taser International confirmed that the Taser firing data for one involved officer was inaccurate and unreliable. The report provided by Taser International did not assist in resolving the Taser firing data issue. In our view, the visit to Taser International was premature and should not have occurred before completing the crime scene analysis and re-interviewing the involved officer to clarify how and when the Taser was deployed.

Taser cartridge accountability

During the critical incident investigation the investigators discovered that one of the Taser cartridges deployed at the scene of the critical incident was not signed out in the relevant Taser Register. By a process of elimination the investigators determined which involved officer used the Taser cartridge during the foot pursuit and restraint of Mr Laudisio-Curti.

It is unclear whether any action has been taken to address the failure by the involved officer to sign out the Taser cartridge. It is also unclear whether any consideration has been given to changing the system of signing out cartridges in light of the issue identified during the critical incident investigation. In our view, a review of the system of signing out Taser cartridges should be conducted to ensure accountability for the possession and use of cartridges by officers.

Findings and recommendations arising out of the coronial inquest (Chapter 5)

The Coroner was unable to determine the exact cause of death of Mr Laudisio-Curti, stating that his death arose from complex and multi-factorial causes with no confirmed single identifiable cause. The Coroner stated that it was nevertheless impossible to believe that Mr Laudisio-Curti would have died but for the actions of police.

The Coroner concluded that the actions of a number of the involved officers were reckless, careless, dangerous, excessively forceful and amounted to an abuse of police powers. The Coroner recommended that the Commissioner of Police refer the conduct of the involved officers who used Tasers and OC spray during the pursuit and restraint of Mr Laudisio-Curti to the Police Integrity Commission. The Coroner also recommended that police immediately review policies, procedures and training relating to the use of Taser, OC spray, handcuffing, restraint, positional asphyxia, the accurate categorisation of incidents to police radio, and that signs of mental disturbance in persons the subject of a police report be adequately communicated to other officers.

Our assessment of the critical incident investigation (Chapter 6)

The NSW Police Force *Critical Incident Guidelines* outline the various roles and responsibilities of officers involved in the management, investigation and review of critical incidents. In particular, the guidelines state that the critical investigation team should examine the lawfulness of police action and the extent of police compliance with relevant guidelines, legislation, internal policy and procedures.

The critical incident investigators did not appear to fully appreciate the purpose of the investigation, believing that their role was confined to gathering evidence and compiling the brief of evidence for the coronial inquest. In our view, the preparation of the brief of evidence for the Coroner is but one of a number of important functions of the critical incident investigation team. There are clearly a number of other crucial functions such as:

- examining the lawfulness of police action and the extent of police compliance with relevant guidelines, legislation, internal policy and procedures
- taking appropriate action, including interim management action, to address any criminal conduct or breaches of internal guidelines, policies and procedures, and
- providing information on the findings of the investigation to the Region Commander and other more senior police to ensure that any risks are identified and appropriately dealt with in a timely manner.

The critical investigation team conducted a thorough job in compiling a comprehensive brief of evidence for the inquest. However, despite our repeated requests, the investigators did not provide this office with any documentation containing their analysis of the lawfulness and reasonableness of the conduct of the involved officers and whether their conduct accorded with policy, procedure, guidelines or training. In the absence of such documentation, the only conclusion available is that either the investigators themselves did not conduct any analysis or form any views of the lawfulness and reasonableness of the conduct of the involved officers, or they were unwilling to have their analysis scrutinised by this office. This represents a failure to adhere to the requirement in the *Critical Incident Guidelines* for the critical incident investigation team to examine the lawfulness of the actions of the involved officers and the extent of their compliance with relevant guidelines, legislation, internal policy and procedures.

We are concerned with what appears to be current NSW Police Force practice to rely on the Coroner to determine the lawfulness and reasonableness of the conduct of officers involved in critical incidents. In our view, it is the function of the critical incident investigation team to determine if any of the actions of the involved officers amounts to criminal conduct. If any criminal conduct is identified then appropriate criminal proceedings should be initiated before any coronial inquest. Similarly, there is nothing preventing the critical incident investigation team from identifying and ensuring that appropriate and timely action to address conduct and systemic issues is taken before any coronial inquest.

Coronial inquests often take many months and sometimes years to be finalised. The current NSW Police Force practice of waiting until the finalisation of the coronial process with the expectation that the Coroner will make recommendations to address shortcomings that should have already been identified and addressed during the critical incident investigation is wrong and misconceived. In our view, the NSW Police Force is abrogating its responsibility to adequately identify and address officer misconduct and improve training and procedures by conducting critical incident investigations that set out to achieve nothing more than to investigate the events surrounding the critical incident in order to provide the brief of evidence to the Coroner.

An example of the NSW Police Force shirking its responsibility is illustrated by the failure to adequately examine the Taser use by four officers when pursuing and restraining Mr Laudisio-Curti. Despite having internal procedures that require all Taser use to be reviewed, the Taser Review Panel responsible for reviewing the Taser use deferred

their review on the basis that the critical incident investigation team and the Coroner would examine the use. This led to the farcical situation where the critical incident investigation team suggested that the Taser Review Panel is responsible for reviewing the Taser use of the involved officers while the Taser Review Panel deferred its review because the Taser use was being 'intensively investigated' by the critical incident investigation team.

The day the Coroner handed down the findings and recommendations, the NSW Police Force immediately de-certified the four involved officers from using Tasers. Clearly, this action could and should have been taken by the NSW Police Force in the eight-month period between the critical incident and the finalisation of the coronial inquest. The failure to take action or at least interim action before the coronial inquest in response to what the Coroner described as unreasonable and unjustified use of Tasers by four of the involved officers meant that the NSW Police Force did not adequately address the risk continued Taser use by those officers posed to the NSW Police Force and the community. This failure is indicative of a lack of commitment to ensuring that officers are held accountable for their actions and that internal policies, procedures, guidelines and training undergo continual improvement.

The *Critical Incident Guidelines* state that the objective of conducting a critical incident investigation is to remove any doubts about the integrity of the involved officers and provide reassurance to the community that any wrong conduct is dealt with and consideration is given to improving police policy and guidelines to avoid reoccurrences in the future. In our view, the community could not be confident or satisfied that the critical incident investigation into the death of Mr Laudisio-Curti achieved its stated objective. The failure of the critical incident investigation team to adequately identify, analyse and address any potential criminal conduct or misconduct by the involved officers or consider changes to policy, procedures or training *before* the coronial inquest is borne out by the scathing findings on the actions of some of the involved officers and the recommendations contained in the report handed down by the Coroner, as outlined in Chapter 5 of this report.

The *Critical Incident Guidelines* have in-built accountability measures that are assigned to the Region Commander and Review Officer from Professional Standards Command. There is no evidence to suggest that either the Region Commander or Review Officer raised any concerns during the critical incident investigation. It is also unclear whether the Region Commander even reviewed the critical incident investigation before the coronial inquest. In any event, there appears to have been a lack of effective leadership during the critical incident investigation. It appears that no one in the NSW Police Force wanted to address the difficult questions surrounding the actions of the involved officers before the coronial inquest.

It is extraordinary that not one NSW Police Force officer seemed to have formed the view that some of the involved officers may have acted inappropriately. The Coroner's unequivocal and damming assessment of the conduct of the involved officers based on the evidence gathered by the critical incident investigation team and heard during the coronial inquest demonstrates that the NSW Police Force failed to adequately identify, acknowledge and address conduct issues before the coronial inquest. The failure of the NSW Police Force to adequately identify, address and resolve conduct issues in a timely manner is patently unfair to the family of Mr Laudisio-Curti and the involved officers. The family is left with a sense of injustice as no action has been taken against the involved officers, some of whom have since been promoted. The involved officers are left with a sense of uncertainty as their conduct will face additional scrutiny.

Shortly after the Coroner handed down the findings and recommendations from the inquest into the death of Mr Laudisio-Curti, the Police Integrity Commission announced publicly that it will investigate whether there was any serious police misconduct or criminal conduct by the officers involved in the pursuit and restraint of Mr Laudisio-Curti. Accordingly, we have ceased any further involvement in this matter due to legislative and administrative arrangements that sensibly ensure that there is no duplication of agency involvement in the oversight and/or investigation of police misconduct issues.

In our view, there are a number of conduct and systems issues that ought to have been addressed by the critical incident investigation team that remain unresolved. We support ongoing independent scrutiny and oversight in this matter whilst noting that it is regrettable that yet another investigation into the critical incident will be conducted by another agency as a result of the failure of the NSW Police Force to adequately identify and address the potential criminal and misconduct issues during their critical incident investigation.

In conclusion, we are of the view that it is the responsibility of the NSW Police Force to conduct an appropriate and accountable investigation into any death that occurs during policing activities. This includes taking appropriate and timely action in relation to any identified criminal conduct, misconduct or systemic issues. The concerns raised in this report demonstrate the abject failure of the NSW Police Force to appreciate and fulfil this responsibility when conducting the critical incident investigation into the death of Mr Laudisio-Curti.

We have recommended that the NSW Police Force amend the *Critical Incident Guidelines* to make it clear that the critical incident investigation team must consider all conduct and systemic issues and take or recommend appropriate action be taken in a timely manner to address any identified criminal conduct, misconduct or systemic

issues before any coronial inquest. This consideration should include a review of the complaint and use of force histories of the involved officers. We have also recommended that the NSW Police Force amend the *Critical Incident Guidelines* to require the Region Commander with responsibility for the critical incident investigation to review the investigation *before* any coronial inquest to ensure that all conduct and systemic issues have been appropriately identified and addressed. The consideration of the conduct and systemic issues, and the opinion of the Region Commander should be documented and recorded.

Mandatory notification of critical incidents to the Ombudsman (Chapter 7)

There is currently no requirement for police to notify this office of incidents involving the death or serious injury of persons during policing activities unless a complaint has been made about the conduct of the officer/s involved in the critical incident. This means that most critical incident investigations are not subject to any independent scrutiny or oversight by this office.

In our view, there will always be occasions where it is in the public interest for there to be some independent scrutiny of critical incident investigations into the death or serious injury of persons during policing activities. Accordingly, it would be preferable for police to notify this office of all critical incidents at the outset irrespective of whether the conduct of any of the involved officers is to be the subject of a complaint notified to this office. We appreciate that the declaration of a critical incident of itself does not suggest the involved officers have engaged in misconduct. The timely notification of critical incidents to this office would ensure that we are well placed to identify any possible misconduct issues in the absence of a complaint and decide whether it is in the public interest to oversight the critical incident investigation.

In our view, such a system would not interfere with or duplicate the statutory role of the Coroner. The Coroner is responsible for examining the circumstances of the critical incident in order to determine manner and cause of death. Our oversight of the critical incident investigation is confined to scrutinising the investigative process to ensure that the critical investigation team conducts an appropriate, accountable and transparent investigation into the critical incident.

There would be a number of benefits associated with our independent oversight of certain critical incident investigations into the death or serious injury of persons during policing activities. Our extensive experience in oversighting police complaint investigations involving serious misconduct means we are well placed to ensure that police adopt appropriate investigative methodologies and strategies when investigating the conduct of police officers. Our oversight of critical incident investigations would engender community confidence in the integrity of the investigative process. Our involvement would also provide some re-assurance to the families of the victims, the involved officers and the community generally that the investigation will be conducted in an accountable and transparent manner. In addition, any real time monitoring of critical incident investigations should ensure that investigations are not subject to later criticism during or following coronial inquests as this can lead to further pain and anxiety for the families of the victims and the involved officers.

In our view, it would be preferable for the notification of critical incidents to this office to be part of a separate process not linked to the complaint handling framework in Part 8A of the *Police Act 1990*. This is because the declaration of a critical incident does not, of itself, suggest that the involved officers have engaged in misconduct. That said, any criminal conduct or misconduct identified during a critical incident investigation will continue to be recorded and appropriately addressed within the complaint handling framework in Part 8A of Police Act.

A statutory scheme requiring police to immediately notify this office of all critical incidents involving the death or serious injury of persons during policing activities would ensure that we were able to make informed decisions about any oversight at a very early stage of the critical incident investigation. The current system already enables us to oversight critical incident investigations involving deaths that are to be examined by the Coroner when a complaint is notified to this office. The proposed scheme would improve the system by ensuring that we are able to oversight any critical incident investigation where it is in the public interest to do so.

It is important to note that the proposal for a mandatory notification scheme would not result in us oversighting every critical incident investigation. We will assess each notification and determine whether it is in the public interest to oversight the critical incident investigation having regard to the nature and circumstances of the critical incident and the information available at the time of notification.

We have recommended that the NSW Parliament consider amending the Police Act to require the NSW Police Force to notify us immediately following all critical incidents involving the death or serious injury of persons during policing activities and to provide us with appropriate powers to effectively oversight critical incident investigations.

Recommendations

Chapter 1. Introduction

This chapter outlines the key events leading up to the death of Roberto Laudisio-Curti and details the reasons for our decision to monitor the critical incident investigation into the death of Mr Laudisio-Curti.

1.1. Events leading up to the death of Mr Laudisio-Curti

A detailed description of the events leading up the death of Mr Laudisio-Curti and the declaration of a critical incident is provided below. The facts are taken from the evidence gathered during the critical incident investigation.

1.1.1. Night out with friends

On Saturday, 17 March 2012, Mr Laudisio-Curti, a 21 year-old Brazilian living, studying and working in Sydney, played two games of soccer. That evening, Mr Laudisio-Curti met up with friends to celebrate St. Patrick's Day. Mr Laudisio-Curti and his friends consumed some alcohol at the home of one of his friends before heading into the Central Business District of Sydney ('the CBD'). Mr Laudisio-Curti and his friends visited various bars and food outlets in the CBD and Kings Cross throughout the night and in the early hours of the following morning.

Sometime between 9.30 and 11.30pm, Mr Laudisio-Curti shared a tab of the drug LSD, or lysergic acid diethylamide, with two friends. Mr Laudisio-Curti's friends noticed that he later began to exhibit signs of being confused, agitated, afraid, scared, restless, euphoric, energetic and paranoid. Mr Laudisio-Curti's friends tried to comfort and calm him down.

At approximately 4.31am on Sunday, 18 March 2012, Mr Laudisio-Curti telephoned his sister with whom he lived and asked, 'Why do you want to kill me?' Mr Laudisio-Curti's sister thought that Mr Laudisio-Curti was drunk and asked him to come home. Mr Laudisio-Curti's sister tried to call him back but the battery on his mobile phone had seemingly run out of charge. Mr Laudisio-Curti's sister contacted one of his friends who confirmed that he was with them in the Kings Cross area.

At approximately 4.41am, Mr Laudisio-Curti's friends convinced him to catch a taxi home. The taxi driver who picked Mr Laudisio-Curti up near the corner of William and Crown Streets, Darlinghurst stated that he looked a little bit worried and was in a hurry. The driver didn't think that Mr Laudisio-Curti was drunk, describing him as a bit 'crazy' or drug affected. A short time later, near the Fish Markets in Pyrmont, Mr Laudisio-Curti suddenly exited the taxi without paying the fare.

1.1.2. Attack on Mr Laudisio-Curti

At approximately 5.00am, four unknown males chased Mr Laudisio-Curti along George Street, Sydney. The males caught up with Mr Laudisio-Curti and pulled him to the ground near the corner of George and King Streets in the CBD. The males kicked and punched Mr Laudisio-Curti until security guards from nearby businesses intervened in response to his pleas for help. The males claimed that they chased Mr Laudisio-Curti to retrieve a mobile phone that he had taken.

1.1.3. Incident at the convenience store

At approximately 5.06am, Mr Laudisio-Curti entered the City Convenience Store just around the corner from where he had been attacked by the four males. Mr Laudisio-Curti told the store attendant that people were trying to kill him. Mr Laudisio-Curti initially asked the attendant to call the police but changed his mind saying that police are bad people. The attendant was concerned for Mr Laudisio-Curti's welfare as he was shirtless with noticeable injuries to his body, including bloodied elbows and a red mark on the left side of his body near his waist.

The attendant provided Mr Laudisio-Curti with some water and biscuits and let him stay in the caged area behind the counter for some 15 minutes. During this time Mr Laudisio-Curti kept saying that people wanted to kill him and that he was a messenger from God. The attendant thought that Mr Laudisio-Curti may have had mental health issues based on what he was saying. The attendant also thought that Mr Laudisio-Curti may have been pretending to be crazy in order to rob the convenience store.

At approximately 5.21am, Mr Laudisio-Curti suddenly ran out of the convenience store after noticing two young German tourists standing outside the store. The tourists entered the store and spoke to the attendant who told them about Mr Laudisio-Curti's claim that people were trying to kill him and that he was a messenger from God.

At approximately 5.22am, Mr Laudisio-Curti returned to the convenience store. The attendant closed the door to the caged area to prevent Mr Laudisio-Curti from gaining access to that area again. Mr Laudisio-Curti, who according to one of the tourists appeared frightened, nervous and in a hurry, jumped over the door crashing down onto the front counter. The attendant asked Mr Laudisio-Curti to leave and he ran out from the caged area. Mr Laudisio-Curti grabbed two packets of biscuits telling the attendant that he needed them to survive. The attendant told Mr Laudisio-Curti to take the biscuits and he ran out of the store.

At approximately 5.23am, a council street sweeper who witnessed Mr Laudisio-Curti jumping into caged area called triple-0 believing that a robbery was in progress. The street sweeper informed the triple-0 operator that Mr Laudisio-Curti had jumped into the caged area of the convenience store and that two young males were standing near the entrance inside the store. The street sweeper advised the operator that no weapons had been sighted. The operator recorded the incident as an 'armed robbery' on the police computer aided dispatch system.

At approximately 5.25am, police radio broadcast a request for urgent assistance for an armed robbery at the convenience store. A minute or so later, two police vehicles with four officers attended the convenience store and spoke to the attendant and the two young tourists.

The attendant provided a description of Mr Laudisio-Curti and indicated which way he went after leaving the store. The attendant told an officer that Mr Laudisio-Curti was 'just crazy' and that he didn't mean to steal anything, noting that Mr Laudisio-Curti did not have any weapons. The officer provided police radio with a description of Mr Laudisio-Curti, stating his last known direction and that no weapons were sighted. [All communications between officers and police radio can be heard by officers tuned in to the police radio channel for the area in which they are patrolling.]

1.1.4. Search for Mr Laudisio-Curti following the incident at the convenience store

For the next 30 minutes or so, a number of police vehicles patrolled the CBD in search of Mr Laudisio-Curti. The internal supervisor at the City Central Local Area Command contacted the City of Sydney Safety Camera Program operators for assistance in tracking down Mr Laudisio-Curti on their cameras located in and around the CBD.

In response to requests for information from patrolling officers, police radio confirmed that Mr Laudisio-Curti stole two packets of biscuits from the convenience store and that no weapons had been sighted.

After leaving the convenience store, Mr Laudisio-Curti went to Curtin Place in the CBD and removed all of his clothing. Mr Laudisio-Curti only put his jeans back on, placing his underwear in his pocket and leaving his shoes and socks behind. Mr Laudisio-Curti then headed south along Pitt Street. A short time later, two officers saw Mr Laudisio-Curti running south along Pitt Street near Hunter Street without his shirt or shoes. The officers did not make a connection between Mr Laudisio-Curti and the incident at the convenience store.

At approximately 5.58am, after receiving images from the City of Sydney cameras, the internal supervisor broadcast over police radio that the 'armed robbery' offender from the convenience store was heading south along Pitt Street toward Park and then Bathurst Streets. The supervisor advised that Mr Laudisio-Curti was in a pair of jeans with no shirt or shoes.

Four police vehicles containing seven officers proceeded to Pitt Street in response to a police radio request for assistance. Another police vehicle with two officers was already in Pitt Street between Bathurst and Liverpool Streets attending to an alleged 'steal from motor vehicle incident'.

1.1.5. Foot pursuit and restraint of Mr Laudisio-Curti

At approximately 6.00am, two officers approached Mr Laudisio-Curti at the corner of Pitt and Bathurst Streets in an attempt to apprehend him. Mr Laudisio-Curti ran from the two officers in a southerly direction along the western footpath of Pitt Street. One of the officers took hold of Mr Laudisio-Curti's left arm but he managed to break the hold.

A third officer who was in Pitt Street attending the 'steal from motor vehicle incident' joined the officers running after Mr Laudisio-Curti down the western footpath and advised police radio that there was a foot pursuit in progress on Pitt Street heading toward Liverpool Street.

A fourth officer who was also attending the 'steal from motor vehicle incident' barged into Mr Laudisio-Curti head-on causing him to fall onto his buttocks. The four officers attempted to restrain and handcuff Mr Laudisio-Curti while he was struggling to break free. The fourth officer fired a Taser at close range into Mr Laudisio-Curti's lower back for seven seconds. The Taser did not incapacitate[1] Mr Laudisio-Curti due to it being fired at close range. Mr Laudisio-Curti managed to get to his feet and flee from the four officers.

A fifth officer arrived on the scene parking a police vehicle on the western footpath to block Mr Laudisio-Curti's path. Mr Laudisio-Curti ran across Pitt Street from the western to eastern footpath. The fifth officer fired a Taser for ten

seconds with one probe hitting Mr Laudisio-Curti in the abdomen. The Taser did not have any effect on Mr Laudisio-Curti as only one of the two probes connected. Mr Laudisio-Curti continued running down the eastern footpath chased by five officers.

A further two officers arrived while Mr Laudisio-Curti ran down the eastern footpath being pursued by five officers. One of the newly arrived officers crash tackled Mr Laudisio-Curti into the Kings Comics shop window causing him to fall to the ground. The fifth officer fired a Taser again for three seconds and a short time later for two seconds, again without any effect as only one probe had connected. A few seconds later the fourth officer who had earlier deployed a Taser in Mr Laudisio-Curti's lower back, fired a Taser at Mr Laudisio-Curti for five seconds after reloading the Taser with a new cartridge. These two Taser firings caused the other officers to hesitate and release their grip, allowing Mr Laudisio-Curti to get to his feet and flee south on the eastern footpath with six officers in pursuit.

Mr Laudisio-Curti crossed the road back to the western footpath. The fourth officer caught up to Mr Laudisio-Curti and shoulder charged him into the Coffee Pitt café shop window. Another officer stopped to take aim and fired a Taser for five seconds into Mr Laudisio-Curti's back, which did incapacitate him, causing him to immediately fall to the ground.

Four officers attempted to restrain Mr Laudisio-Curti by using physical force and handcuffs. A further four officers arrived on the scene. The officers held Mr Laudisio-Curti down and handcuffed him. One officer used a baton to apply pressure to the back of Mr Laudisio-Curti's legs. A total of eleven officers had been involved in the foot pursuit and apprehension of Mr Laudisio-Curti up to this point in time.

While attempting to restrain Mr Laudisio-Curti, an officer yelled out "Stop fucking resisting", resulting in the officer who fired the Taser that brought Mr Laudisio-Curti to the ground to fire it again for a further five seconds. The Taser firing caused incapacitation enabling the officers to roll Mr Laudisio-Curti onto his stomach with his handcuffed hands under his body. An officer then laid across Mr Laudisio-Curti's back. Mr Laudisio-Curti appeared to be under control and some officers got to their feet.

A short time later, Mr Laudisio-Curti started to struggle again and the officers who had got to their feet re-engaged in order to restrain him. During the next 51 seconds, one officer fired a Taser in drive stun mode into Mr Laudisio-Curti's lower back on two occasions each lasting five seconds. Another officer fired a Taser in drive stun mode into Mr Laudisio-Curti's shoulder area on five occasions lasting seven, five, fourteen, eight and seven seconds respectively. Another officer deployed some of the contents of three separate Oleoresin Capsicum (or OC) spray canisters into the face of Mr Laudisio-Curti at close range. Mr Laudisio-Curti ceased struggling with the officers at this stage and officers began checking his pulse at regular intervals.

1.1.6. Mr Laudisio-Curti stopped breathing and CPR commenced

Mr Laudisio-Curti stopped breathing approximately a minute and a half after officers first checked his pulse. Two officers rolled Mr Laudisio-Curti over and commenced CPR until Ambulance personnel arrived. An officer inserted the tip of an extendable baton into Mr Laudisio-Curti's mouth to check if he had swallowed his tongue.

Upon arrival, Ambulance officers requested that officers remove the handcuffs from Mr Laudisio-Curti. Ambulance officers attempted to resuscitate Mr Laudisio-Curti for 21 minutes, ceasing at 6.34am when Mr Laudisio-Curti was declared deceased. Police commenced a critical incident investigation shortly after Mr Laudisio-Curti died.

1.2. Ombudsman decision to monitor the critical incident investigation

The death of Mr Laudisio-Curti raised issues of significant public and media interest both here in Australia and abroad after it was revealed that Mr Laudisio-Curti — an otherwise fit and healthy 21 year-old male — died shortly after a number of officers used physical force, Tasers, OC spray, handcuffs and a baton while attempting to arrest him for allegedly stealing two packets of biscuits.

1.2.1. Initial information provided to the Ombudsman by police

On the afternoon of 19 March 2012, the Deputy Ombudsman (Police and Compliance Branch) attended a pre-arranged meeting with the Commander of the Professional Standards Command. The Commander advised that police had commenced a critical incident investigation into the death of Mr Laudisio-Curti. The Commander also advised that no complaint had been received from a member of the public and that police were still reviewing information to determine if the conduct of officers involved in the incident should be the subject of a complaint notified to this office.

1.2.2. Ombudsman contact with the Commissioner of Police

On 19 March 2012, an evening news bulletin aired CCTV footage of an officer firing a Taser into Mr Laudisio-Curti's back as he was fleeing from a number of officers.

On the morning of 20 March 2012, the Ombudsman contacted the Commissioner of Police to discuss the footage aired the night before. The Ombudsman wanted to ascertain if the conduct of the officers involved in the events leading up to the death of Mr Laudisio-Curti would be the subject of a complaint notified to this office. In the absence of a complaint this office does not have the power to oversight critical incident investigations. This issue is canvassed in more detail in Chapter 7 'Notification of critical incidents to the Ombudsman'.

The Commissioner advised the Ombudsman during their conversation that a complaint would be notified to this office.

1.2.3. Police notify complaint to the Ombudsman

On the afternoon of 20 March 2012, we received an internal police complaint raising issues of unreasonable/excessive use of force and non-compliance with the Taser Standard Operating Procedures ('SOPs') by as yet unidentified officers involved in the critical incident. The notification of the complaint meant that we had the power to oversight the investigation into the death of Mr Laudisio-Curti.

On 30 March 2012, the Police Integrity Commission advised this office that it did not intend to oversight the police investigation of the complaint. The Police Integrity Commission requested that police provide them with a copy of the final report at the conclusion of the complaint investigation.

1.2.4. Decision to monitor the critical incident investigation

In most cases the Ombudsman oversights complaint investigations involving more serious allegations. We do this by reviewing how the police conducted the investigation, the findings made and any action/s proposed or taken. That is to say, police have overall responsibility for investigating and resolving complaints about police officers and this office assesses the handling of the complaint after it has been finalised to ensure that it has been properly dealt with.

However, the Ombudsman also has the power to monitor the progress of an investigation if of the opinion that it is in the public interest to do so.[2] We monitor investigations in real time to ensure that they are being conducted appropriately and that the respective interests of all parties are taken into account. We do this by assessing the adequacy of the proposed investigative strategies, reviewing evidence as it is gathered, and providing feedback on particular action to be taken. We may also elect to be present during any interviews with complainants, witnesses or officers.

On 20 March 2012, the Deputy Ombudsman advised the Commander of the Professional Standards Command of our intention to monitor the critical incident investigation into the death of Mr Laudisio-Curti.

We decided that it was in the public interest to monitor the investigation so as to provide reassurance to both Mr Laudisio-Curti's family and the community that there would be a level of independent scrutiny of the investigation and to ensure that the investigation was conducted in an appropriate, accountable and transparent manner.

We were also mindful of the community's understandable concern about police investigating the conduct of their fellow officers. We hoped the knowledge that an independent body would be actively monitoring the investigation might allay some of these concerns.

In addition, we were aware of recent criticisms by a Deputy State Coroner, who had described a previous critical incident investigation conducted by police into the shooting death of Adam Quddus Salter as 'seriously flawed', 'inadequate' and 'apparently prejudiced'.[3] The Deputy State Coroner suggested that the critical incident investigation in that matter '*will have failed to persuade the community that the circumstances surrounding Adam Salter's death were investigated scrupulously and fairly.*'[4]

We did not oversight the critical incident investigation into the shooting death of Mr Salter as the conduct of the officer involved in the shooting has never been the subject of a complaint notified to this office.[5]

1.2.5. Media releases about Ombudsman oversight of the critical incident investigation

On 20 March 2012, the Minister for Police and Emergency Services, the Honourable Michael Gallagher MLC, issued a media release announcing that the Ombudsman will independently oversight the investigation into the death of Mr Laudisio-Curti. The Minister stated:[6]

> *The NSW Police Commissioner and I are pleased that the Ombudsman will have a role in reviewing this specific incident.*
>
> *The NSW Government supports the use of Tasers by police. They are an important tool for police to utilise in certain situations.*
>
> *For frontline police to have confidence in their use of the Taser, the community must have confidence that the use of Tasers is responsible, and having this investigation independently overseen will do that.*

On 20 March 2012, the Ombudsman issued a media release confirming our independent oversight of the critical incident investigation. The Ombudsman said '*all issues relating to the police involvement in this matter will be the subject of appropriate and thorough scrutiny by my office*.'[7]

1.2.6. Initial complaint by Mr Laudisio-Curti's family members

On 28 March 2012, Sebastian De Brennan, a solicitor acting for Mr Laudisio-Curti's family members (Ana Laudisio de Lucca and her husband Michael Reynolds, and Maria Fernanda Laudisio de Lucca) wrote to the Ombudsman raising a number of concerns about the conduct of officers leading up to Mr Laudisio-Curti's death.

Mr De Brennan's letter of complaint stated that the family were concerned about the integrity of the critical incident investigation given that it would be conducted by police. Mr De Brennan urged the Ombudsman to take an active role in overseeing the investigation to ensure that it was independently scrutinised in order to safeguard against any shortcomings in the investigation such as those identified by the Coroner who conducted the inquest into the shooting death of Adam Salter.

On 2 April 2012, the Ombudsman and Deputy Ombudsman met with Mr Laudisio-Curti's family members and legal representatives to explain our role in oversighting and monitoring the critical incident investigation.

1.3. Consultation on the final draft report

On 13 December 2012, we provided a draft copy of this report to the Commissioner of Police. This was to give police an opportunity to provide feedback on the material in the report, to confirm that the descriptions of police processes and practices were accurate, and to provide comments on the draft recommendations.

On 18 January 2013, we received a response from police. Where appropriate, we have included or addressed their comments and feedback, and made changes in this report.

Chapter 2. Critical incident investigation

This chapter outlines some of the key activities of the critical incident investigation team leading up to the coronial inquest.

2.1. Critical Incident Guidelines

The NSW Police Force's *Critical Incident Guidelines*[8] ('the guidelines') outline how officers are expected to deal with incidents involving the death or serious injury to persons during policing activities.

The guidelines contain the following message from the Commander of the Professional Standards Command:[9]

> *The NSW Police Force acknowledges the actions of officers in the execution of their duty can, in some circumstances, result in death or serious injury to a person. Incidents of this nature are often subject to a heightened level of public interest and scrutiny. These incidents are deemed to be* ***critical incidents*** *by the NSW Police Force.*
>
> *These guidelines have been developed to assist in the management and investigation of critical incidents. They are intended to assist officers and provide an outline of the key actions required when managing, investigating and reviewing all critical incidents. The NSW Police Force is committed to investigating all critical incidents in an effective, accountable and transparent manner. If public credibility is to be maintained, such investigations are most appropriately conducted independently. Accordingly, the identification of an incident as a critical incident activates an independent investigative process to be conducted by a specialist and independent critical incident investigation team, and a review of that investigation by an independent review officer. Managing, investigating and reviewing an incident as a 'critical' one should remove any doubts that might otherwise endure about the integrity of involved officers and provide reassurance that:*
>
> - *any wrongful conduct on the part of any members of the NSW Police Force is identified and dealt with*
> - *officer welfare implications associated with the incident have been considered and addressed*
> - *consideration is given to improvements in NSW Police Force policy or guidelines to avoid recurrences in the future.*
>
> *These guidelines are a statement that the community can have full confidence that the facts and circumstances of these incidents will be thoroughly examined and reviewed by the NSW Police Force. These guidelines impose accountability for the investigation of critical incidents at senior levels. In so doing, the community, members of the NSW Police Force and their families can be assured that all critical incidents are handled professionally, with integrity and that the decisions made and processes used are appropriate and reasonable.*

The guidelines state:[10]

> *The NSW Police Force Critical Incident Guidelines apply to the investigation of all deaths or serious injuries which have occurred as a result of an interaction with police. The guidelines detail the key management and investigative requirements for these types of incidents.*
>
> *All NSW Police Force employees involved in the management, investigation and review of critical incidents must follow and apply these guidelines, where appropriate.*

2.1.1. Revised Critical Incident Guidelines

At the time of Mr Laudisio-Curti's death the NSW Police Force was revising the guidelines for the management of critical incidents.[11] The revised guidelines contain some changes to definitions and the roles of officers involved in critical incidents investigations but the key obligations remain largely the same. The revised guidelines came into effect on 24 August 2012 and are referred to throughout this report.

2.2. What is a critical incident?

A 'critical incident' is defined in the guidelines as:[12]

> *An incident involving a member of the NSW Police Force which resulted in the death or serious injury to a person:*
>
> - *arising from the discharge of a firearm by the member*

- *arising from the use of appointments or application of physical force by the member*
- *arising from a police vehicle pursuit or from a collision involving a NSW Police Force vehicle (which includes motorcycles, helicopters and water-borne vessels)*
- *in police custody*
- *arising from a NSW Police Force operation*

or any other event, as deemed by the region commander, that could attract significant attention, interest or criticism from the community, and the circumstances are such that the public interest is best served through an investigation independent of the officers involved.

The death of Mr Laudisio-Curti following the use of appointments (Taser, OC spray, baton, and handcuffs) and the application of physical force by NSW Police Force officers fell within the definition of critical incident in the guidelines.

2.3. Declaration of critical incident

The guidelines state that the Region Commander is responsible for determining and declaring an incident as a critical incident and ensuring that a critical incident investigation team is formed.

The Acting Region Commander for the Central Metropolitan Region declared a critical incident shortly after being notified of Mr Laudisio-Curti's death.

2.4. Commencement of the critical incident investigation

The guidelines state that the critical incident investigation should be supervised, managed and led by a suitably experienced investigator referred to as the Senior Critical Incident Investigator. The guidelines also state that any critical incident investigation into the death of a person as a result of the use of appointments or physical force by police officers must be led by the Homicide Squad and reviewed by an officer from the Professional Standards Command.

A Detective Inspector from the Homicide Squad took on the role of Senior Critical Incident Investigator and a Detective Inspector from the Professional Standards Command filled the role of Review Officer for the critical incident investigation into the death of Mr Laudisio-Curti.

2.4.1. Critical incident investigation team

The guidelines require the Senior Critical Incident Investigator to assemble a critical incident investigation team once a critical incident investigation has been declared.

The Detective Inspector from the Homicide Squad assigned to the role of the Senior Critical Incident Investigator assembled a team made up of officers from the Homicide Squad and Local Area Commands within the Central Metropolitan Region. The Senior Critical Incident Investigator assigned the role of Lead Investigator to a Detective Sergeant from the Homicide Squad.

The critical investigation team initially comprised of 19 investigators and a number of advisors from the Professional Standards Command, the Prosecutions Command (for legal advice), and the Weapons & Tactics – Policy & Review Unit within the Operation Skills Command.

After assembling the critical incident investigation team, the Senior Critical Incident Investigator and the Lead Investigator attended the crime scene to plan and co-ordinate initial tasks such as advising the Coroner of the death, victim identification, crime scene examination, witness identification, and evidence gathering.

2.4.2. Identification of involved officers

The guidelines require the Senior Critical Incident Investigator to identify the involved officers for the purpose of the investigation. An involved officer includes any officer who by words, actions or decisions contributed to the critical incident under investigation.

The Senior Critical Incident Investigator identified a total of 15 involved officers who had some involvement in the investigation of the incident at the convenience store in King Street or in the foot pursuit and restraint of Mr Laudisio-Curti in Pitt Street.

2.4.3. Separation of the involved officers

The guidelines state that involved officers and other witnesses should be separated after any critical incident to ensure that their evidence is not cross contaminated. The involved officers should be informed of the reason for their separation and provided with sufficient welfare support. The emphasis is on separation rather than isolation. Any operational debrief should not occur until all officers have been interviewed.

A senior officer at the scene of the critical incident involving the death of Mr Laudisio-Curti directed all involved officers to attend the muster room of a nearby police station to await the arrival of the critical incident investigation team.

A senior officer not involved in the critical incident stayed in the muster room with the involved officers to provide welfare support and to ensure that the involved officers did not talk about the critical incident.

2.4.4. Direction not to talk about the critical incident

The senior officer who directed the involved officers to the muster room also directed them not to discuss the incident amongst themselves. The Senior Critical Incident Investigator attended the muster room approximately four hours after the critical incident to explain the purpose and function of the critical incident investigation. The Senior Critical Incident Investigator issued the following direction to the involved officers:

> *I am currently conducting a critical incident investigation into the death of an unknown male in Pitt Street, Sydney about 06:30 on Sunday 18 March 2012.*
>
> *In due course it is my intention to interview you in relation to this matter. Until such time, pursuant to clause 8(1) of the Police Regulation 2008 (NSW) which states:*
>
> *"… Police officers are to comply strictly with all lawful orders from those in authority over them …"*
>
> *I direct you not to interfere or compromise the integrity of the investigation in anyway, which includes discussing or disclosing information about this matter to any person you know, or have reasonable cause to suspect is a witness or otherwise involved in the investigation without my authority.*
>
> *You are also reminded pursuant to section 167A(2) of the Police Act 1990 (NSW) that it is a criminal offence to supply investigators with information that is false or misleading in a material particular.*

All involved officers signed a written copy of the direction acknowledging that the direction had been explained and that they understood the provisions of the direction.

2.4.5. Mandatory drug and alcohol testing

Police officers involved in incidents where a person is killed or seriously injured as a result of the application of physical force are required by law to undergo mandatory testing for the presence of alcohol and prohibited drugs.[13]

A Drug and Alcohol Testing Officer from the Professional Command conducted mandatory drug and alcohol testing on all involved officers by obtaining urine and breath samples from all of the involved officers.

None of the involved officers tested positive for the presence of prohibited drugs or alcohol.

2.4.6. Seizing items of clothing and appointments

The investigators seized all relevant items of clothing and appointments (Tasers, OC spray, handcuffs, and baton) from the involved officers for later forensic analysis.

2.5. Involved officer interviews

The guidelines state that interviews with crucial witness such as involved officers should be conducted at the 'first reasonable opportunity'. However, the Senior Critical Incident Investigator may elect to interview involved officers at a later stage having regard to welfare issues such as the mental or physical state of the officer and the amount of time the officers have been on duty. The Senior Critical Incident Investigator should also consider what information or evidence could be lost or potentially compromised when deciding to interview involved officers at a later stage.

The guidelines outline the power of the Senior Critical Incident Investigator to lawfully direct involved officers to answer any questions about their actions during the critical incident. Any failure to comply with a lawful direction can result in criminal and/or disciplinary action being taken against the officer.

The guidelines specify that involved officers should not be directed to answer questions where the Senior Critical Incident Investigator believes that there is sufficient evidence to suggest that the involved officer may have committed a criminal offence. In such cases, the involved officer should be given a criminal caution advising that s/he is entitled to exercise the right to silence and that any answers given may be recorded and later use as evidence against the officer.

2.5.1. Involved officers not interviewed immediately following the critical incident

After consultation with the Acting Region Commander, the Review Officer and other senior officers, the Senior Critical Incident Investigator decided not to interview the involved officers due to the length of time the officers had been on duty.

All but one of the involved officers had completed a 12-hour shift that commenced around 6pm on Saturday 17 March 2012. The Senior Critical Incident Investigator addressed the involved officers for the first time at 10.20am on Sunday, 18 March 2012, some 16 or so hours after most involved officers had been on duty during a busy Saturday night shift.

2.5.2. Initial interviews with involved officers

The Senior Critical Incident Officer decided that the four involved officers who had deployed their Tasers during the critical incident would be interviewed first, followed by the remaining eleven involved officers.

The majority of interviews were conducted on 19, 20 and 21 March 2012. One interview took place on 23 March 2012 and the last interview with an involved officer who was medically unfit to be interviewed earlier took place on 27 March 2012.

The Lead Investigator and another detective from the Homicide Squad conducted the majority of interviews with the involved officers who used physical force and/or appointments during the foot pursuit and apprehension of Mr Laudisio-Curti. Two other detectives from the Homicide Squad conducted the remaining interviews.

At the commencement of the interviews the interviewers directed the involved officers to answer all questions and produce any document or thing as requested. The interviewers reminded involved officers that:

- the NSW Police Force *Code of Conduct and Ethics* requires officers to answer questions honestly and truthfully, and to not willingly or negligently make any false, misleading or incorrect statements, and
- it is a criminal offence to supply investigators with information that is false or misleading in any material particular.

The interviewers canvassed a wide range of issues with each of the involved officers to establish what occurred in the lead up to Mr Laudisio-Curti's death. The interviewers asked the involved officers detailed questions about:

- the information broadcast over police radio about the incident at the convenience store and Mr Laudisio-Curti's movements after leaving the convenience store
- the actions of Mr Laudisio-Curti including observations of his demeanour and his reaction to the attempts by the involved officers to apprehend him
- the actions of involved officers including the use of any physical force and/or tactical options and the justification for the actions
- the actions of the involved officers after Mr Laudisio-Curti had been brought to the ground and handcuffed, and
- the actions of the involved officers and Ambulance officers after Mr Laudisio-Curti's pulse could no longer be detected.

The interviewers also asked the involved officers to indicate on diagrams and maps where specific actions occurred. The interviewers also elicited other information such as location of police vehicles and items of interest.

The average length of the interviews was an hour and 45 minutes. The shortest interview took 50 minutes and the longest interview lasted an hour and 55 minutes.

All involved officers elected to have a legal representative present during their interviews and consented to the electronic recording of the interviews.

2.6. Collecting CCTV footage

The critical incident investigators visited numerous businesses in and around the CBD and Kings Cross in order to locate any Closed Circuit Television ('CCTV') footage capturing Mr Laudisio-Curti's movements from the time he met up with friends on the evening of Saturday, 17 March 2012 until the time of his death on the morning of Sunday, 18 March 2012.

The investigators obtained copies of CCTV footage from close to 50 cameras located in and around businesses and streets in the CBD and Kings Cross. Some cameras were located within businesses and others were outside on awnings. The investigators also obtained extensive footage from cameras inside the convenience store in King Street and the City of Sydney Street Safety Cameras located on streets in the CBD and Kings Cross.

The footage allowed investigators to map out the various locations that Mr Laudisio-Curti visited at particular times. The footage also captured certain actions of the involved officers while attempting to apprehend Mr Laudisio-Curti in Pitt Street.

The investigators compiled relevant footage into a DVD depicting Mr Laudisio-Curti's movements in time order. The critical incident investigators provided the DVD to various experts to assist them in forming their opinions about the medical state of Mr Laudisio-Curti and the use of force and tactical options by the involved officers. In addition, certain parts of the footage were played during the coronial inquest.

2.7. Identifying witnesses

On Sunday, 18 March 2012, police issued two media releases advising of the commencement of the critical incident investigation into the death of Mr Laudisio-Curti.[14] The media releases urged anyone with information about the events in King Street or Pitt Street to contact Crime Stoppers.

The investigators identified a number of persons who witnessed some part of the events at the convenience store in King Street and in Pitt Street. The investigators also identified the friends that Mr Laudisio-Curti had been with in the hours before his death, the taxi driver that picked Mr Laudisio-Curti up during the evening and the security guards who witnessed four males attack Mr Laudisio-Curti in George Street shortly before he entered the convenience store on King Street.

The investigators obtained statements from all identified witnesses. The investigators also travelled to Melbourne to interview a witness who saw the first struggle some of the involved officers had with Mr Laudisio-Curti in Pitt Street.

2.8. Walk-through interviews with civilian witnesses

In the early hours of 12 April 2012, the critical incident investigators organised for Pitt Street, Sydney to be closed off between Bathurst and Liverpool Streets for the purpose of conducting walk-through interviews with eight civilian witnesses.

The investigators placed police vehicles in the same positions they were in on the morning of the critical incident and utilised a mannequin to assist witnesses describe what they observed. The investigators conducted the interviews at particular locations along Pitt Street where certain events occurred. They also interviewed a civilian witness in a hotel room above Pitt Street from where the witness observed certain actions of the involved officers.

The investigators asked each of the civilian witnesses detailed questions about:

- what they saw and heard, including where they were when making their observations
- the actions of Mr Laudisio-Curti
- the actions of the involved officers, and
- their impressions about the actions of Mr Laudisio-Curti and the involved officers.

All civilian witnesses consented to the video recording of the walk-through interviews. The average length of the interviews was 19 minutes. The shortest interview took 8 minutes and the longest interview lasted 28 minutes. An interpreter participated in one of the interviews.

2.9. Other information gathered during the critical incident investigation

The critical incident investigators gathered information from a number of other sources including:

- statements from Mr Laudisio-Curti's family members, friends, and acquaintances
- statements from non-involved officers who performed investigative tasks at the convenience store or at the critical incident scene
- statements and medical information from the Ambulance officers who attempted to resuscitate Mr Laudisio-Curti
- firing data and audio-visual recordings from the Tasers deployed by four of the involved officers
- recordings of the triple-0 call and the police radio (VKG) communications
- statements from the witness who called triple-0 and the triple-0 operator who took the call
- reports from the forensic pathologist who conducted the autopsy on Mr Laudisio-Curti
- reports from medical experts including a Toxicologist, Cardiologist, Psychiatrist, and Emergency Medicine Physician
- reports from experts on policing issues including a professor with expertise in the use of force by police
- reports and statements detailing forensic analysis of the critical incident scene and appointments seized
- statements from NSW Police Force subject specialists on the use of force and tactical options
- Standard Operating Procedures and training materials for the use of handcuffs, batons, OC spray, and Tasers
- training and complaint histories of the involved officers, and
- Mr Laudisio-Curti's medical records from Brazil.

2.10. Visit to Taser International

The critical incident investigators reconstructed the actions of the involved officers by reviewing:

- interviews with the involved officers
- interviews with civilian witnesses
- the available physical evidence
- audio-visual footage from the Tasers ('Taser Cam'), and
- CCTV footage.

The review revealed that the Taser firing data appeared to be significantly inconsistent with other available information, including Taser Cam footage. In particular, the firing data for one involved officer appeared to suggest that the Taser was fired before it plausibly could have been.

On 27 June 2012, the Lead Investigator and an officer attached to the NSW Police Force Weapons & Training – Policy & Review Unit travelled to Arizona in the United States of America for the purpose of raising the firing data issue with the manufacturer, Taser International. They provided the four Tasers used by the involved officers to Taser International for the purpose of downloading and analysing the firing data. They also provided a 'letter of instruction' from the Crown Solicitor's Office requesting a response to a series of questions about the way times are recorded on the Tasers and the use and effects of Tasers.

On 3 September 2012, Taser International provided a report to the critical incident investigators. The report stated that the Tasers used by the involved officers were found to be operating within the manufacturer's specification. The report contained detailed information on how firing data and Taser Cam footage is recorded. In particular, it outlined how the Taser is subject to 'clock drift' which needs to be corrected by synchronising the Taser with an outside source. The report also noted that there is a two-second boot-up period for the Taser Cam which means that if a Taser is deployed immediately after being switched on the first two seconds will not be recorded on the Taser Cam. However, the report did not address the firing data discrepancies and nor did it address many of the questions contained in the letter from the Crown Solicitor's Office.

The critical incident investigators formed the view that the Taser firing data was inaccurate and unreliable due to the fact that it was inconsistent with all of the other available information and evidence. The investigators determined the timing and sequence of Taser deployments by the involved officers using the other available information outlined above rather than by relying exclusively on the firing data.

2.11. Preparation of the brief of evidence for the Coroner

One of the important functions of a critical incident investigation involving the death of a person during policing activities is the preparation of the brief of evidence for the coronial inquest.

The investigators regularly liaised and met with the State Coroner and Counsel Assisting the Coroner (instructed by the Crown Solicitor) to ensure that all relevant evidence was gathered for the coronial inquest.

The brief of evidence compiled by the investigators enabled Counsel Assisting the Coroner to formulate the issues to be examined by the State Coroner and provided the evidentiary basis to determine those issues during the coronial inquest.

Chapter 3. Ombudsman monitoring activities

This chapter outlines the things we did to monitor the critical incident investigation.

3.1. Monitor agreement between the Ombudsman and the NSW Police Force

The Ombudsman has the power to monitor an investigation if of the opinion that it is in the public interest to do so.[15] When monitoring investigations we may elect to be present as an observer at interviews conducted as part of the investigation and confer with the investigators about the conduct and progress of the investigation.[16] We exercise our monitoring powers in accordance with arrangements agreed to between the Ombudsman and the Commissioner of Police.[17]

The arrangements relating to our monitoring of investigations are set out in 'the Monitor Agreement',[18] which relevantly states:

- The Ombudsman can identify matters as needing to be examined or taken into consideration by the investigator.
- The Ombudsman may choose to confer with the investigator to obtain information about the investigation.
- The Ombudsman has the right to be present as an observer during interviews with complainants, witnesses and involved officers.
- The investigator is to make contact with the Ombudsman case officer to identify which interviews the Ombudsman has an interest in and suitable dates and times for those interviews.
- All reasonable attempts must be made to accommodate the Ombudsman's attendance, but interviews should not be unduly delayed if an Ombudsman's representative is unavailable.

3.2. Letter to police advising of our intention to monitor the critical incident investigation

On Tuesday, 20 March 2012, after a number of preliminary telephone conversations, the Deputy Ombudsman wrote to the Commander of the Professional Standards Command to inform of our decision to monitor the critical incident investigation.

The Deputy Ombudsman's letter advised that we did not propose to observe the initial interviews with the involved officers. We made this decision based on the fact that the critical incident investigators had already conducted most of the interviews with involved officers and the electronically recorded interviews with the involved officers would be available for review shortly after.

The Deputy Ombudsman also advised that in order to effectively monitor the critical incident investigation, we needed police to provide us with information and updates on investigative activities in a timely manner.

The Deputy Ombudsman requested that the following information be provided as soon as practicable to enable us to fully appreciate what occurred in the lead up to Mr Laudisio-Curti's death:

- The names and registration numbers of the involved officers.
- A copy of all VKG ('police radio') communications pertaining to the critical incident.
- A copy of the triple-0 recording reporting the alleged armed robbery.
- A copy of all situation reports produced by police.
- A copy of all COPS (Computerised Operational Policing System) entries created in relation to this incident.
- A copy of all records created by the involved officers including their notebook entries.
- A copy of the records of interview and/or statements with the involved officers.
- A copy of any records of interview or statements from witnesses.
- A copy of all Taser Cam footage related to the incident.

- A copy of any CCTV footage from the City of Sydney Safety Cameras related to the incident.
- A copy of any CCTV footage from the convenience store located in King Street, Sydney.
- Any documentation concerning the information officers obtained from the convenience store employee including details of when this information was obtained.
- Any other information and/or documentation that would assist us to appreciate the nature and scope of the critical incident investigation.

3.3. Initial discussions with police

On 21 March 2012, the Commander of the Homicide Squad contacted the Deputy Ombudsman to discuss our monitoring of the critical incident investigation and to provide an update of the investigative activities and information collected to date. The Commander welcomed our monitoring of the critical incident investigation and advised that we would have unrestricted access to all material gathered during the investigation.

The Commander of the Professional Standards Command contacted the Deputy Ombudsman proposing a meeting on 23 March 2012 to discuss our monitoring of the critical incident investigation. The Commander advised that the police contact for the critical incident investigation would be the Senior Critical Incident Investigator. The Deputy Ombudsman advised that we were happy to meet but our first priority was the assessment of material already gathered by the investigators.

3.4. Access to police information systems

E@gle.i is the primary information storage and investigation management tool that police use for complex investigations including critical incident investigations. Investigators utilise e@gle.i to record information about proposed tasks and activities undertaken, and to store material and evidence gathered during investigations.

This office does not ordinarily have access to e@gle.i for our complaint oversight work. We requested access to e@gle.i for the purpose of monitoring the critical incident investigation on the basis that access to e@gle.i would ensure that we were able to effectively monitor the investigation in real time. We also believed access to e@gle.i would be expedient for both this office and police as it would avoid us having to make frequent requests for material and investigators being diverted from their investigative tasks to provide material in response to our requests.

On 22 March 2012, police organised for us to have access to e@gle.i. The Commander of the Homicide Squad advised that not all material was on e@gle.i at that point of time given that the investigation had just commenced. The Commander also advised that certain material such as CCTV footage and electronically recorded interviews were not capable of being stored on e@gle.i and that investigators would provide this information to us separately.

On 22 March 2012, we accessed e@gle.i to review the material that had been already uploaded onto the system. We reviewed a number of police reports about the critical incident, witness statements and Taser Cam footage showing the deployment of Tasers by four of the involved officers.

We continued to access e@gle.i on a regular basis throughout the investigation to review all material gathered by the investigators. In addition, investigators provided us with any material that could not be uploaded onto e@gle.i such as CCTV footage, the electronically recorded interviews with involved officers, the video-recorded walk-through interviews with the civilian witnesses and crime scene and post mortem photographs.

3.5. Initial meeting with police

On 23 March 2012, the Deputy Ombudsman and the Ombudsman Principal Investigator (Police Division) met with the Director of the Serious Crime Directorate (responsible for the Homicide Squad), the Commander of the Homicide Squad, the Acting Commander of the Professional Standards Command, the Review Officer, the Senior Critical Incident Investigator and the Lead Investigator.

The Deputy Ombudsman outlined the Ombudsman's monitoring role and referred to provisions in the Monitor Agreement that allow us to be present and observe interviews with involved officers and witnesses. The Deputy Ombudsman stressed the importance of timely information about any proposed investigative activities and the provision of material not available on e@gle.i. The Commander of the Homicide Squad committed to providing assistance in whatever way possible to enable us to effectively fulfil our monitoring role.

The Lead Investigator outlined the sequence of events leading to Mr Laudisio-Curti's death as understood by the investigators based on their initial inquiries and interviews with involved officers. The Lead Investigator provided us with the majority of material requested in the Deputy Ombudsman's letter of 20 March 2012 and indicated that the remaining material would be provided the following week.

3.6. Attendance at Major Crime Review meeting

On 27 March 2012, the Ombudsman Principal Investigator attended a major crime review meeting convened by the critical incident investigation team. The following people addressed the meeting:

- The Senior Critical Incident Investigator provided an overview of the nature and scope of the investigation.
- The Lead Investigator outlined the information gathered to date and the investigative activities undertaken and planned.
- The crime scene examiner outlined the exhibits gathered at the scene of the critical incident and from the involved officers.
- Officers from the Weapons & Tactics – Policy & Review Unit provided some general information on the use of Tasers.
- The forensic pathologist detailed the injuries observed during the post mortem examination on Mr Laudisio-Curti. The forensic pathologist stated that the cause of death could not be determined at that stage and that further tests would be conducted.

3.7. Attendance at initial briefing of the Coroner by investigators

On 4 April 2012, the Ombudsman, the Deputy Ombudsman, and the Ombudsman Principal Investigator attended a verbal briefing of the State Coroner by the Senior Critical Incident Investigator and the Lead Investigator. The Commander of the Homicide Squad was also present at the briefing.

The State Coroner and the Ombudsman outlined their respective roles in relation to the critical incident investigation. The State Coroner noted that the role of the inquest is to establish the manner and cause of death of Mr Laudisio-Curti. The Ombudsman noted that our role was to ensure that the investigation was conducted in an accountable and transparent manner and that the investigators identified and addressed any conduct or systemic issues.

The Lead Investigator provided an overview of the investigation and outlined the evidence gathered to date. The State Coroner discussed possible dates for the coronial inquest with the investigators with a view to conducting the coronial inquest from 8 October to 19 October 2012.

3.8. Monitoring of interviews with civilian witnesses

On 12 April 2012, the Ombudsman Principal Investigator observed the investigators conduct the walk-through interviews with the civilian witnesses. (See above at 2.8 'Walk-through interviews with civilian witnesses' for more details.) Also observing the interviews were officers from the Weapons & Tactics – Policy & Review Unit and the Review Officer from the Professional Standards Command.

3.9. Meeting with investigators to discuss the Taser firing data issue

On 16 May 2012, the Deputy Ombudsman, the Ombudsman Police Division Manager and the Ombudsman Principal Investigator met with the Lead Investigator and the Commander of the Homicide Squad to discuss the Taser firing data issue that had been identified during the investigation.

The Lead Investigator explained the inconsistencies between the firing data and the other evidence gathered and advised that investigators were proposing to travel to the United States of America to seek advice from the manufacturer, Taser International, given the lack of experts here in Australia to resolve the issue. (See 2.10 'Visit to Taser International' for more details.)

We expressed the view that seeking advice from Taser International should only occur if absolutely necessary given the potential for a conflict of interest given that Taser International was likely to seek leave to be represented at the coronial inquest.

We suggested that the Taser firing data issue might be resolved by attempting to clarify with one of the involved officers how and when the Taser was deployed. We also suggested that the yet to be completed crime scene analysis might shed some light on the issue given that each Taser released unique confetti like markers (known as Anti Felon Identification tags or AFIDs) at the point of deployment. That is to say, the crime scene analysis might pinpoint where the involved officer deployed the Taser.

We further noted that Taser International may not be willing to provide independent and impartial advice given their obvious commercial interest should any flaws in the operation of the Tasers be detected.

On 29 May 2012, the Senior Critical Incident Investigator discussed the Taser firing data issue with the State Coroner who agreed with the proposal to seek advice from Taser International.

3.10. Regular contact with investigators

The Senior Critical Incident Investigator and Lead Investigator maintained regular contact with the Ombudsman Principal Investigator via telephone calls and emails. The Deputy Ombudsman and the Commander of the Homicide Squad also discussed any issues or concerns as they arose.

The investigators generally, but not always, provided us with timely updates on material gathered, proposed investigative activities and other information relevant to our monitoring of the critical incident investigation. The investigators regularly responded to our requests for information and explanation about the evidence gathered and investigative strategies proposed or undertaken.

Our regular contact with investigators enabled us to raise any concerns we had with the investigation in a timely manner. See chapter 4 for details of some of the issues raised with investigators.

3.11. Meeting with Counsel Assisting the Coroner

On 9 July 2012, the Ombudsman wrote to the State Coroner offering to meet with Counsel Assisting the Coroner at the inquest to provide information about our monitoring of the critical incident investigation and our preliminary views of the conduct of the involved officers that may be of interest or assistance to Counsel Assisting.

On 23 August 2012, the Ombudsman, Deputy Ombudsman, Ombudsman Legal Counsel and the Ombudsman Principal Investigator met with the Counsel Assisting the Coroner and a Senior Solicitor from the Crown Solicitor's Office. A wide range of issues were discussed at the meeting including the use of force, particularly Tasers, by the involved officers and the adequacy of training and procedures that regulate the use of force by officers.

At the meeting the Ombudsman informed Counsel Assisting the Coroner that we planned to release the final report of our two-year review of the use of Tasers by NSW Police Force officers shortly after the coronial inquest had heard all of the evidence.[19] The Ombudsman noted that the report would address issues surrounding the adequacy of current SOPs and training for the use of Tasers, but would not examine the incident resulting in the death of Mr Laudisio-Curti as it did not occur during the review period.

Chapter 4. Issues identified during our monitoring of the critical incident investigation

This chapter outlines issues we encountered while monitoring the critical incident investigation.

4.1. Availability of material on police information systems

As noted above at 3.4 'Access to police information systems', e@gle.i is the primary information storage and investigation management tool that police utilise for critical incident investigations. The *Critical Incident Guidelines* state that '*[t]he Senior Critical Incident Investigator is to ensure that the investigation is recorded on e@gle.i which will be the primary storage facility for all documents relating to the critical incident investigation*.'[20]

Once we decided to monitor the critical incident investigation into Mr Laudisio-Curti's death, police promptly provided us with unfettered access to e@gle.i. Our access to e@gle.i meant that we could independently access all material on e@gle.i at any time from computers in our office.

Overall, our regular use of e@gle.i meant that we were able to effectively monitor the critical investigation without having to regularly contact investigators to request information and updates. We could review material gathered by the investigators as soon as it was placed onto e@gle.i.

However, on occasion, investigators did not place certain information onto e@gle.i in a timely manner and appeared to have a practice whereby some material was only placed onto e@gle.i after it had been reviewed by the Senior Critical Incident Investigator.

The delay in placing material onto e@gle.i and the practice of reviewing material before uploading it onto e@gle.i hindered our ability to examine some material in a timely and judicious manner. The practice of reviewing material before uploading it onto e@gle.i also had the potential to diminish the effectiveness of e@gle.i as an information and investigation management tool due to the fact that the information holdings were not always up to date.

We understand that investigators are able to store documents on e@gle.i that can be worked on and amended over time before being finalised. Documents stored on e@gle.i in this manner can be searched and viewed by anyone with permission to access the investigation. Accordingly, there does not appear to be any impediment to material being immediately uploaded onto e@gle.i and reviewed by the Senior Critical Incident Investigator at some later time.

In our view, it is essential that investigators involved in large and complex investigations ensure that information about planned activities, outcomes of investigative tasks and any analysis of gathered evidence is made available to all investigators at the first available opportunity. Otherwise the potential benefits of e@gle.i as an information sharing and investigation management tool will be lost.

Any future oversight and monitoring by this office of police investigations maintained on e@gle.i will require a genuine commitment from investigators to place all material on e@gle.i in a timely manner. Otherwise, in order to discharge our statutory responsibilities effectively, we will be left with little choice than to make frequent requests for information and updates from investigators resulting in scarce resources being diverted from investigative tasks.

4.2. Advice about proposed investigative activities

As noted above at 3.1 'Monitor agreement between the Ombudsman and the NSW Police Force', when we monitor an investigation we can attend interviews and confer with investigators about the conduct and progress of the investigation.

Our ability to effectively monitor an investigation is dependent on timely advice from investigators about proposed investigative activities. We are only able to attend interviews if we are provided with sufficient notice of the time and place of interviews. Our capacity to have input into and observe certain investigative activities is also dependent on adequate notice of what is proposed.

At our initial meeting with investigators we stressed the importance of providing us with adequate notice about proposed investigative activities. Nevertheless, on a number of occasions investigators provided little or no notice of proposed activities despite our repeated requests for advance notice. This meant that we did not observe or have any input into certain investigative activities such as the taking of statements from witnesses.

The investigators initially utilised e@gle.i for recording proposed investigative activities in the 'Task List' section. However, while we could see what activities were proposed, the list did not provide sufficient detail of when and where the activities would be undertaken. In addition, the investigators ceased using the 'Task List' six weeks after the investigations commenced.

The investigators did not create and follow an investigation plan for this investigation, which further limited our ability to appreciate what investigative tasks were planned.

A number of the failures to provide us with adequate advance notice of investigative activities occurred in the first couple of weeks of the investigation when investigators were organising activities at a rapid pace.

However, investigators also failed to provide notice of activities even after we raised concerns about the lack of notice of proposed investigative activities. For example, the investigators only provided details of the visit to Taser International once officers had departed the country. Investigators also conducted a follow-up interview with Mr Laudisio-Curti's soccer coach without providing advance notice and conducted further inquiries in relation to the characterisation of the triple-0 call as an 'armed robbery' without informing us in advance to ascertain if we would like to attend.

While we appreciate that providing us with information about proposed investigative activities required some additional effort by investigators, the failure to provide timely advice impacted upon our capacity to effectively monitor or have input into certain investigative activities.

The investigators in this matter appeared to be unaccustomed to oversight and monitoring by this office and did not appear to fully appreciate the requirements of the Monitor Agreement.

4.3. Identification of civilian witnesses

As noted above at 2.7 'Identifying witnesses', the investigators identified and obtained statements from witnesses who observed some of the events in the lead up to Mr Laudisio-Curti's death.

A civilian witness who saw some of the foot pursuit and final struggle between the involved officers and Mr Laudisio-Curti spoke to an officer at the scene of the critical incident. According to the witness, the officer took brief notes of the details provided by the witness.

Two days after Mr Laudisio-Curti's death a newspaper published details of what the witness observed, including the fact that the witness had spoken to police. The newspaper contacted the witness after the witness' sister emailed the newspaper advising that her brother had seen the foot pursuit and restraint of Mr Laudisio-Curti by the involved officers.

After seeing the newspaper article the investigators contacted the witness and obtained a statement the following day, some three days after the critical incident. This witness later participated in a walk-through interview and gave evidence at the coronial inquest.

The *Critical Incident Guidelines* state that interviews with crucial witnesses should be conducted at the first reasonable opportunity. There is little doubt that this witness was a crucial witness willing and able to provide an independent account of some of the actions of the involved officers. It is of some concern that the investigators did not contact this key civilian witness earlier, although we appreciate that the investigators had a number of competing priorities in the days immediately following Mr Laudisio-Curti's death.

4.4. Interviewing civilian witnesses

During our initial meeting with police on 23 March 2012, the critical incident investigators indicated that they did not propose to conduct interviews with civilian witnesses who had already provided statements to police. The investigators stated that it was standard practice to rely on written statements for civilian witnesses.

We had concerns with this practice given that it is usually not clear exactly what instructions or questions the police officer asked the witness when taking the statement.

We also noted that a civilian witness whose first language was not English made the following comments in a statement to police:[21]

- *'I did not see any excess violence.'*
- '[The involved officers] *did not yell out anything inappropriate, it was very professional.'*

- *'From what I saw of the police actions I did not believe they hurt* [Mr Laudisio-Curti]. *I thought what they did was appropriate.', and*
- *'I am not for or against police, but from what I saw there was no police brutality, from me there was no excess of violence and it was fine. I wanted to tell the police this because people are quick to call police brutality and I thought I could be useful as a witness. If I would have seen excess violence I would have to tell it.'*

On 26 March 2012, the Deputy Ombudsman emailed the Commander of the Homicide Squad outlining our concerns as follows:[22]

> *... I have read the available witness statements and have considered the possible implications of not conducting any recorded interviews/walk through interviews with civilian witnesses for this particular investigation.*
>
> *I have come to the view that it would be prudent and beneficial to this critical incident investigation for recorded interviews/walk throughs to be conducted with key or critical witnesses. My reasons for coming to this view are as follows:*
>
> - *All police officers identified as being involved have been asked and have participated in a recorded interview (except one who is not yet able to be interviewed due to medical reasons); it is equally important in my view, to obtain evidence from witnesses in the same way and in the form of their own words on the events that occurred and what they witnessed, and for the lead investigator to be able to ask probing and clarifying questions where required during interview.*
> - *To obtain a verbatim account from each witness of what they witnessed so that the question of investigator interpretation (particularly for witnesses who have English language difficulties/English as a second language) or bias in questioning of an investigator to obtain the statement is not arguable in any proceedings.*
> - *The coronial inquest into the death of Adam Salter was critical of the failure of police to conduct walk through interviews with relevant witnesses and as such, the police investigation into this matter should take steps to ensure this potential criticism cannot be mounted again by conducting recorded interviews/walk through interviews with all relevant civilian witnesses.*

On 26 March 2012, the Senior Critical Incident Investigator responded to the Deputy Ombudsman's email as follows:

> *We have considered conducting video recorded walk-though interviews with* [the civilian witnesses]*, and readily accept that this is best practice. We are currently in the process of trying to facilitate this course of action, as we endeavour to cause the least disruption to both vehicular and pedestrian traffic in the crime scene location.*[23]

The Senior Critical Incident Investigator also advised that additional civilian witnesses had been identified and would be interviewed. As outlined earlier at 2.8 'Walk-through interviews with civilian witnesses', the investigators conducted video-recorded walk-through interviews with eight civilian witnesses on 12 April 2012.

The walk-through interview with the civilian witness whose comments are quoted above revealed that the witness did not see much of what occurred during the final struggle between Mr Laudisio-Curti and the involved officers on the ground outside the Coffee Pitt café:[24]

> *Investigator: ... but whilst the gentleman without the shirt* [Mr Laudisio-Curti] *was on the ground, did you see his actions at all ---*
>
> *Witness: No.*
>
> *Investigator: --- anything that he did?*
>
> *Witness: No, no. Like, I saw what happened but, ah, I won't, I won't be able to, to say exactly what was happening.*
>
> *Investigator: Yeah.*
>
> *Witness: I think it was just, were just, like, fighting, moving, you know, to, to, to get out of this situation. But, you know, I didn't see, like if he was violent or not, if he just wanted to escape, or I didn't see that, didn't see that.*

The witness commented on the actions of the involved officers during the walk-through interview as follows:[25]

> *Investigator: ... did you hear the police say anything else to him at all other than the, the screaming, the, "Get down, get on the floor", that you described?*
>
> *Witness: No, no, no. Um, you know, as I said in, in that day, um, I don't know what is, are the rules in the police if you, like, what you need to do, when you need to do it, but from what I've seen, I didn't see anything like ah, I*

didn't see violence. Yeah, I mean, it was violent because, you know, it was all everything, but I didn't see anything inappropriate or everything, what they were saying. I didn't hear anything like bad or inappropriate, just that's what I can say, you know.

The *Critical Incident Guidelines* make it clear that involved officers and witness officers should be promptly interviewed as part of the critical incident investigation. However, there is no specific reference to interviewing civilian witnesses who are willing and able to provide information about the actions of police officers involved in critical incidents.

In our view, to ensure accountability and transparency, critical incident investigators should conduct question and answer interviews with all crucial witnesses, which includes civilian witnesses who observed the actions of involved officers.

Recommendation

i. The NSW Police Force amend the *Critical Incident Guidelines* to make it mandatory that critical incident investigators conduct question and answer interviews with civilian witnesses who are willing and able to provide information about the actions of police officers involved in critical incidents.

4.5. Walk-through interviews with involved officers

Conducting walk-through interviews or re-enactments with involved officers during critical incident investigations provides investigators with an opportunity to better understand the timing and sequence of events and to clarify any issues arising from initial interviews. Involved officers may be able to recall certain details better when asked questions at the location where events occurred.

All involved officers indicated during their initial interviews that — based on legal advice from their solicitors — they would not willingly participate in a walk-through interview at the scene of the critical incident.

The investigators did not conduct walk-through interviews or re-enactments with any of the involved officers as part of this critical incident investigation. The investigators appeared to be of the understanding that they could not lawfully direct the involved officers to participate in a walk-through interview in addition to their initial interview.

The solicitors acting for the involved officers advised investigators in writing that their clients would not freely participate or comply with any order or direction to participate in walk-through interviews.

The solicitors contended that any order to participate in a walk-through interview would not be lawful under either section 201 of the *Police Act 1990* or clause 8(1) of the *Police Regulation 2008*. The solicitors also contended that any direction would not be authorised by point 5 of the NSW Police Force *Code of Ethics* which states, '*An employee of NSW Police must comply with any lawful and reasonable direction given by someone in NSW Police who has authority to give the direction*.'[26]

The solicitors noted the legal restriction on recording interviews without the consent of the involved officers as a further reason why their clients would not comply with any order or direction to participate in walk-through interviews.

We appreciate that section 7(1) of the *Surveillance Devices Act 2007* restricts the audio recording of any type of interview without the consent of the involved officer. However, this legal restriction does not prevent investigators from seeking the consent of involved officers to record interviews. In circumstances where an involved officer did not consent to the recording of the questions and answers during an interview, the investigators could nevertheless conduct the interview by recording in writing the questions asked and responses given during an interview. While conducting an interview in this manner may be onerous, it would overcome the legal restriction on audio recording and ensure that investigators obtained all relevant observations about the critical incident from the involved officers.

We are aware of judicial authority that supports the practice of investigators directing officers to provide details of their actions and observations during the course of their duties.[27] However, we are not aware of any judicial authority suggesting that investigators are not able to conduct walk-through interviews with involved officers. We note that section 48(1) of the *Interpretation Act 1987* appears to authorise investigators to direct involved officers to participate in more than one interview.

Accordingly, we are unable to appreciate the legal basis for the contention that investigators may not lawfully order or direct involved officers to participate in a walk-through interview in addition to their initial interviews.

The *Critical Incident Guidelines* appear to envisage that there will be occasions where critical incident investigators conduct walk-through interviews with involved officers by stating that the Review Officer should:

> *Consult with the Senior Critical Incident Investigator and where practical, attend to independently observe any electronically recorded walkthrough conducted with an involved officer or witness.*[28]

However, the *Critical Incident Guidelines* do not contain any explicit information for the Senior Critical Incident Investigator on either the lawfulness or reasonableness of any order or direction to involved officers to participate in walk-through interviews or re-enactments, or the desirability of conducting walk-through interviews or re-enactments.

Recommendations

ii. The NSW Police Force seek legal advice from the Solicitor General to clarify the issue of whether critical incident investigators are able to direct involved officers to participate in walk-through interviews or re-enactments.

iii. The NSW Police Force amend the *Critical Incident Guidelines* to provide guidance on the legal issues and desirability of conducting walk-through interviews or re-enactments with involved officers.

4.6. Re-interviewing involved officers

The critical incident investigators conducted initial interviews with the involved officers in the days immediately following the critical incident when information about the events surrounding the critical incident and the actions of the involved officers was emerging.

In our view, the investigators conducted thorough initial interviews by asking appropriate questions to elicit information about the events leading up to the death of Mr Laudisio-Curti and the actions of the involved officers. (See above at 2.5.2 'Initial interviews with involved officers' for more details.)

In the weeks and months following the initial interviews, the investigators gathered and analysed additional information relevant to the critical incident investigation, including:

- autopsy reports
- CCTV footage
- recordings of the triple-0 call and the actions of the triple-0 operator
- police radio communications
- audio-visual data from the Tasers utilised by the involved officers, and
- observations of civilian witnesses.

On 16 May 2012, during a meeting to discuss the Taser firing data issue (see 3.9 'Meeting with investigators to discuss Taser firing data issue'), the investigators advised us that there were a number of issues they would like to clarify with involved officers as a result of the additional information gathered and analysed.

We suggested that the Taser firing data issue might be resolved by re-interviewing one of the involved officers. We also suggested that the investigators should consider re-interviewing other involved officers to clarify any inconsistencies or ask questions about matters that were not known at the time of the initial interviews. In response to the suggestion that involved officers be re-interviewed, the investigators advised us that the solicitors acting for the involved officers had written to them contending that the investigators could not lawfully order or direct the involved officers to participate in further interviews.

On 24 May 2012, we wrote to the investigators raising concerns about the contention that investigators could not lawfully re-interview the involved officers. We asked police to provide us with any legal advice to support the contention that investigators could not lawfully direct involved officers to participate in further interviews. We also raised our concerns with the NSW Police Force General Counsel. The investigators and General Counsel subsequently advised that there was no impediment to re-interviewing the involved officers. After receiving this advice, we asked investigators on a number of occasions about the scheduling of the further interviews.

On 25 June 2012, after discovering a progress report on e@gle.i indicating that the investigators proposed to serve directive memoranda on the involved officers, we wrote to investigators seeking clarification of the proposal to issue directive memoranda rather than re-interviewing the involved officers as previously advised. A directive memorandum is a direction to an officer to provide a written response to questions contained in the memorandum.

On 29 June 2012, the investigators advised that directive memoranda were being considered as investigators did not envisage asking many clarifying questions.

On 6 July 2012, we wrote to investigators asking them to re-consider the decision to use directive memoranda instead of re-interviewing the involved officers. We suggested that re-interviewing involved officers would be a more transparent and effective investigative strategy to clarify any issues or inconsistencies with involved officers. We also noted that interviews allowed investigators to ask follow-up questions in response to answers given by the involved officers. The investigators agreed that re-interviewing would be a more appropriate method of clarifying issues with involved officers.

On 25 July 2012, the investigators advised us of their proposal to re-interview 10 of the 15 involved officers to clarify certain matters. We advised that we would observe the further interviews with the involved officers and asked to be provided with timely information about the scheduling of these interviews and the questions to be asked.

On 3 August 2012, the investigators advised us that investigators would be re-interviewing the involved officers on 13 and 15 August 2012 by way of typed record of interview.

On 3 August 2012, the investigators advised us that the Counsel Assisting the Coroner strongly opposed any re-interviewing of the involved officers at this stage on the basis that any inconsistencies or clarification of the initial interviews with the involved officers could be done during oral evidence at the coronial inquest.

On 8 August 2012, the investigators advised us that they still proposed to re-interview the involved officers in order to clarify some of the actions of the involved officers, especially the actions leading up to and during the final struggle with Mr Laudisio-Curti.

On 20 August 2012, the investigators and Counsel Assisting the Coroner met with the State Coroner to discuss the proposal to re-interview the involved officers.

On 21 August 2012, the investigators advised us that Counsel Assisting the Coroner withdrew the objection to investigators re-interviewing the involved officers after learning that we would be present to observe the interviews and appreciating that the purpose of the interviews was limited to clarifying certain issues arising from the initial interviews.

On 22 August 2012, the investigators advised us the solicitors acting for the involved officers indicated that their clients would not comply with any direction to participate in a further interview on the basis that their clients had been advised by Counsel Assisting the Coroner that they met the 'sufficient interest threshold' for the coronial inquest. Meeting the 'sufficient interest threshold' means the officer will be required to give evidence at the inquest as an interested party to the proceedings.

On 24 August 2012, the investigators sought internal legal advice on the question of whether the involved officers should be directed to participate in further interviews. The internal legal advisor advised investigators not to direct the involved officers to participate in further interviews given that they had met the 'sufficient interest threshold' for the coronial inquest. The advisor suggested that the involved officers had met their obligation to provide information about their actions and what they had witnessed by participating in the initial interviews.

The investigators did not re-interview any of the involved officers notwithstanding that there appeared to be merit in re-interviewing them to clarify issues and inconsistencies arising from their initial interviews.

It is understandable that investigators had a number of issues that they wished to clarify with the involved officers given that the initial interviews occurred immediately following the critical incident before precise details of what occurred were known.

In our view, the investigators should have attempted to re-interview the involved officers well before mid-August 2012, given that by 16 May 2012 they had already identified a number of issues they wanted to clarify with some involved officers as a result of the information they had gathered and analysed. Clearly, re-interviewing involved officers some five months after the critical incident would have impacted on their ability to accurately recall certain details.

4.7. Characterisation of the incident at the convenience store as an 'armed robbery'

The triple-0 operator who received the emergency call from the council street sweeper recorded the incident at the convenience as an 'armed robbery' on the computer aided dispatch system despite the fact that the caller only reported a robbery in progress and stated that no weapons had been sighted.

The inaccurate characterisation of the incident led police radio to initially broadcast the incident as an 'armed robbery' when requesting urgent police assistance at the convenience store. Subsequent broadcasts over police radio stated that no weapons had been used during the incident.

We suggested that the investigators examine the inaccurate characterisation issue as it appeared to have contributed to the nature and level of response by the involved officers when later pursuing and restraining Mr Laudisio-Curti in Pitt Street.

The investigators reviewed the triple-0 recording and logs of the emergency call and obtained statements from the triple-0 operator and the Commander of Sydney Radio Operations to establish why the incident was broadcast as an armed robbery.

The triple-0 operator stated the incident was recorded as an armed robbery based on a belief that weapons were likely to be involved. The operator also noted that the triple-0 Standard Operating Procedures ('triple-0 SOPs') require operators to record a robbery involving commercial premises as an 'armed robbery'.

Apart from the investigative activities described above, the investigators did not advise this office of any further action to address or escalate the issue identified with the triple-0 SOPs.

In our view, the triple-0 SOPs should be reviewed to ensure that inaccurate characterisations of reported events do not re-occur. We understand that police have commenced a review of the SOPs to ensure further inaccurate characterisations are avoided.

4.8. Assault on Mr Laudisio-Curti

After reviewing four statements and CCTV footage depicting the attack on Mr Laudisio-Curti by four unknown males, we formed the view that Mr Laudisio-Curti may have been assaulted shortly before entering the convenience store.

We raised the alleged assault with investigators who responded by issuing a media release appealing for any person who saw or interacted with Mr Laudisio-Curti in the hours before his death to come forward.[29] The media release stated that investigators wanted to talk to the men who interacted with Mr Laudisio-Curti in George Street around 5am on Sunday, 18 March 2012. The investigators released still photos of the men from CCTV footage in the hope that the men would be recognised.

The investigators did not receive any information as a result of the media release. The investigators did not take any further action on the alleged assault after issuing the media release.

4.9. Taser firing data issue

As discussed above at 3.9 'Meeting with investigators to discuss the Taser firing data issue', we had certain reservations about the proposal by the investigators to seek the advice of Taser International before completing the crime scene analysis and before attempting to clarify the issue with the involved officer who deployed the Taser.

The crime scene analysis completed after the investigators visited Taser International confirmed that the Taser firing data for one involved officer was inaccurate and unreliable. In addition, the report provided by Taser International did not assist in resolving the Taser firing data issue.

In our view, the visit to Taser International was premature and should not have occurred before completing the crime scene analysis and re-interviewing the involved officer to clarify how and when the Taser was deployed.

4.10. Taser cartridge accountability

During the critical incident investigation the investigators discovered that one of the Taser cartridges deployed at the scene of the critical incident was not signed out in the relevant Taser Register. By a process of elimination the investigators determined which involved officer used the Taser cartridge during the foot pursuit and restraint of Mr Laudisio-Curti.

Clearly, it is of concern that the involved officer failed to sign out the Taser cartridge as each cartridge contains unique AFIDs (Anti Felon Identification tags) that indicate where a Taser has been deployed. It is difficult to establish who deployed a Taser at a location if the AFIDs for a cartridge cannot be matched to a particular officer. This has the potential to defeat the in-built accountability mechanism that AFIDs offer.

It is unclear whether any action has been taken to address the failure by the involved officer to sign out the Taser cartridge. It is also unclear whether any consideration has been given to changing the system of signing out cartridges in light of the issue identified during the critical incident investigation.

In our view, a review of the system of signing out Taser cartridges should be conducted to ensure accountability for the possession and use of cartridges by officers.

Chapter 5. Coronial inquest

This chapter outlines the issues examined at the coronial inquest into the death of Mr Laudisio-Curti and the findings and recommendations made by the State Coroner.[30]

5.1. Issues examined during the inquest

The issues examined during the coronial inquest were as follows:[31]

1. *The manner and cause of Roberto's death*
2. *The categorisation of the incident at the King St store as an 'armed robbery'*
3. *The lawfulness of the arrest including*
   a) *whether there was a proper basis or reasonable suspicion justifying the arrest*
   b) *the degree of force used*
   c) *the reasonableness of the degree of force used*
4. *Whether police management of the incident conformed with*
   a) *policies then current relating to use of force*
   b) *any applicable training relating to the use of force regarding*
      i. *positional asphyxia*
      ii. *monitoring of vital signs*
      iii. *use of Taser devices*
      iv. *use of OC spray*
5. *Compliance with any standard operating procedures relating to police interaction with persons showing signs of mental health issues or drug affection.*

5.2. Evidence given during the inquest

The inquest heard evidence over 10 days from Monday, 8 October 2012 till Friday, 19 October 2012. A total of 28 persons gave evidence at the inquest including:

- the 15 involved officers
- a non-involved officer who attended the King Street convenience store
- the forensic pathologist who performed the autopsy on Mr Laudisio-Curti
- four medical experts
- a Professor of Criminology and Criminal Justice with expertise in police use of force
- three civilian witnesses
- the Senior Critical Incident Investigator
- the Lead Investigator, and
- the Training Co-ordinator attached to the NSW Police Force Weapons & Tactics – Policy & Review Unit.

5.3. Findings made by the State Coroner

5.3.1. Cause of death

The State Coroner made the formal finding:

> *That Roberto Laudisio Curti died shortly after 6am on March 18, 2012, in Pitt Street, Sydney, in the State of New South Wales, of undetermined causes, in the course of being restrained by members of the New South Wales Police Force.*[32]

The State Coroner referred to the opinions of the medical experts who all agreed that no direct cause of death could be attributed to:

i. the use of Tasers in probe or drive stun mode
ii. the use of OC spray
iii. Mr Laudisio-Curti's use of LSD
iv. excited delirium, or
v. anatomical causes.

The State Coroner noted that two medical experts disagreed on the question of whether Mr Laudisio-Curti died as a result of positional asphyxia, which occurs when the position of a person's body interferes with their ability to breathe.

One medical expert opined that Mr Laudisio-Curti's death was caused by the weight of the involved officers on his body which prevented him from breathing. However, another medical expert suggested that there was no scientific basis for establishing positional asphyxia as a single cause of death of Mr Laudisio-Curti.

The State Coroner stated that:

> *Roberto's death clearly arose from complex and multi-factorial causes, with no confirmed single identifiable cause. Nevertheless, it is impossible to believe that he would have died but for the actions of police. All of the medical experts agreed that his death was not coincidental.*[33]

5.3.2. Actions of police

The State Coroner concluded that '*[i]n the pursuit, tasering (particularly in drive stun mode), tackling, spraying and restraining of Roberto Laudisio Curti … the actions of a number of the [involved] officers were … reckless, careless, dangerous, and excessively forceful*' and amounted to '*an abuse of police powers.*'[34]

The State Coroner commented that:

> *Roberto's only foes during his ordeal were the police. There was no victim other than Roberto, no member of the public who suffered an iota from his delusionary fear. Certainly, he had taken an illicit drug, as has become all too common in today's society. But he was guilty of no serious offence. He was proffering no threat to anyone. There was no attempt by police to consider his mental state. He was, in the words of* [the convenience store attendant]*, "just crazy". Left alone, there is not a shred of evidence that he would have caused any harm, other than to himself.*[35]

The State Coroner found that current training and understanding of the Taser SOPs is not adequate, stating that officers should be clearly taught the circumstances in which Tasers should or should not be used and educated more deeply in the exact meaning of the SOPs.

The State Coroner queried whether probationary constables should be armed with Tasers, noting that the 'wild and uncontrolled use' of a Taser in drive stun mode by a probationary constable in this matter suggested no understanding of when to use a Taser despite recent training.

The State Coroner stated that the incident at the convenience store should not have been characterised and broadcast as an 'armed robbery' by police radio. The State Coroner accepted that the re-broadcast of the incident as an armed robbery over police radio by the internal supervisor when updating officers on the movements of Mr Laudisio-Curti along Pitt Street was a genuine, but vital oversight. The State Coroner stated that the oversight partly contributed to the frenzied and out of control behaviour of some of the involved officers, half of whom joined in the pursuit of Mr Laudisio-Curti without knowing what he was suspected of having done.

The State Coroner was satisfied that the involved officers had a proper basis to arrest Mr Laudisio-Curti given that when first attempting to apprehend him, as the involved officers suspected on reasonable grounds that he was responsible for a robbery.

The State Coroner made the following observations of the actions of the involved officers:

> *No thought whatsoever was given to Roberto's mental state. According to the evidence, at no stage did he act aggressively, to any member of the public or officer, other than to struggle wildly to escape the pain he was experiencing from being tasered, drive stunned, sprayed and lain upon by 'half a ton' of police officers (as* [one involved officer] *described it). As all the civilian witnesses, and a few officers, told the court, at all times Roberto was merely trying to get away. No one had told him he was under arrest, or why. We now know that he was almost certainly in a psychotic state of paranoia and fear, but this did not translate into any violence other than his need to flee. While not all uses of force by Police were excessive, the attempted arrest of Roberto involved ungoverned, excessive police use of force, principally during the final restraint.*[36]

The State Coroner concluded that some, but not all, of the Taser deployments during the pursuit of Mr Laudisio-Curti were justified. The State Coroner stated that '*[a]fter Roberto had fallen to the ground and been handcuffed, no further use of Taser or of the OC spray by any officer was justified, consistent with SOPs, or necessary, and in fact worsened the situation.*'[37]

5.4. Recommendations made by the State Coroner

The State Coroner directed the following recommendations to the Commissioner of Police:[38]

1. *That the conduct of* [the involved officers who deployed Tasers and OC spray] *during the pursuit and restraint of Roberto Laudisio Curti be considered for disciplinary charges.*
2. *That the actions of police during the pursuit and restraint of Roberto Laudisio Curti be referred to the Police Integrity Commission.*
3. *That there be an immediate review of the contents of the relevant NSW Police Standard Operating Procedures and associated training relating to the use of Taser, OC spray, handcuffing, restraint and positional asphyxia to:*
   a) *ensure that officers are aware of the dangers of:*
      i. *positional asphyxia;*
      ii. *the multiple use of Tasers and their use in drive stun mode;*
      iii. *the multiple use of OC spray;*
   b) *ensure that guidance provided to officers is clear and consistent, in particular removing the term "exigent circumstances";*
   c) *review the criteria for the use of Tasers;*
   d) *consider imposing limitations on the use of Taser in certain circumstances;*
   e) *consider prohibiting the use of Tasers drive stun mode, other than where officers are defending themselves from attack;*
   f) *improve training techniques and education in the appropriate and/or prohibited use of all the above;*
   g) *consider whether Probationary officers should continue to be authorised to carry Tasers;*
   h) *ensure that the safe management of risks of asphyxia by crush, restraint or position are included not only in the SOPs for the use of OC spray but wherever use of force must be applied to a person by a police officer.*
4. *That there be a review of communication procedures to ensure that signs of mental disturbance in any person the subject of a police report be communicated, and officers trained further to respond accordingly.*
5. *That there be an examination of NSW Police VKG procedures to ensure accurate categorisation of any incident reported.*

5.5. Police response to the recommendations made by the State Coroner

On the day the State Coroner handed down the findings and recommendations arising out of the inquest into the death of Mr Laudisio-Curti, the Commissioner of Police issued a media release stating that the NSW Police Force:[39]

- accepted and will immediately adopt all five recommendations
- had commenced a review of the training and SOPs with regard to the use of Tasers, other appointments and methods of restraint
- was already examining recommendations made by the Ombudsman in the recently released report, *How are Taser weapons used by the NSW Police Force?*[40]
- had commenced an examination of VKG/police radio procedures
- would review communication procedures with regard to the notification of mental disturbance with any appropriate changes to training to follow, and
- had initiated complaint investigations into the actions of some of the involved officers with the Professional Standards Command, noting that the State Coroner recommended that the Commissioner refer the actions of the involved officers to the Police Integrity Commission.

Chapter 6. Ombudsman assessment of the critical incident investigation

This chapter outlines our overall assessment of the critical incident investigation.

6.1. Purpose of the critical incident investigation

The Terms of Reference for the critical incident investigation stated that the role of the investigators was '*to investigate the critical incident involving the death of Roberto Laudisio-Curti on the 18th of March 2012 in Pitt Street, Sydney.*'[41]

The Terms of Reference stated that the Senior Critical Incident Investigator '*will be responsible for the timely and professional submission of the brief of evidence.*'[42]

The *Critical Incident Guidelines* ascribe the following responsibilities to the Senior Critical Incident Investigator:

- lead the critical investigation team
- ensure that the critical incident is rigorously and thoroughly investigated
- report any criminal behaviour or misconduct by police officers to a senior officer pursuant to the obligation in clause 49 of the *Police Regulation 2008*, and
- report any identified systemic, safety or procedural issues so that appropriate action can be taken.

The *Critical Incident Guidelines* outline the role of the critical investigation team in the following manner:

> *The critical incident investigation team's responsibility is to investigate those matters that constitute the critical incident and to examine the circumstances surrounding the critical incident itself. This includes the prosecution of any person for any offence found to have been committed and / or the presentation of a brief of evidence to the on duty State / Deputy State Coroner.*[43]
>
> *The critical incident investigation team will conduct a full investigation of the incident including relevant events and activities leading to the incident.* ***The team should examine the lawfulness of police action and the extent of police compliance with relevant guidelines, legislation, internal policy and procedures.***[44] [Emphasis added.]

The investigators conducting the critical incident investigation into Mr Laudisio-Curti's death did not appear to fully appreciate the purpose of the investigation. At one point during the investigation, police issued a media release[45] stating that the critical incident investigation was being conducted on behalf of the Coroner, which suggests that the investigators understood their role as being confined to gathering evidence and compiling the brief of evidence for the coronial inquest.

In our view, the preparation of the brief of evidence for the Coroner is but one of a number of important functions of the critical incident investigation team. There are clearly a number of other crucial functions such as:

- examining the lawfulness of police action and the extent of police compliance with relevant guidelines, legislation, internal policy and procedures
- taking appropriate action, including interim management action, to address any criminal conduct or breaches of internal guidelines, policies and procedures, and
- providing information on the findings of the investigation to the Region Commander and other more senior police to ensure that any risks are identified and appropriately dealt with in a timely manner.

6.2. Brief of evidence for the coronial inquest

The critical incident investigation team conducted a thorough job in compiling a comprehensive brief of evidence for the coronial inquest. The team is to be commended for gathering all relevant evidence and preparing an informative brief of evidence for the coronial inquest.

However, as will be discussed in what follows, it is what the critical investigation team did not do that is cause for most concern.

6.3. Taking action on conduct and systemic issues

As noted at 1.2.3 'Police notify complaint to the Ombudsman' and 1.2.6 'Initial complaint by Mr Laudisio-Curti's family members', an internal police complainant and Mr Laudisio-Curti's family members complained about the conduct of the officers involved in the events leading up to Mr Laudisio-Curti's death.

6.3.1. Suspension of complaint investigation

Ordinarily, allegations of police misconduct are investigated under the provisions of Part 8A of the *Police Act 1990* 'Complaints about conduct of police officers'. However, where the alleged misconduct relates to officers involved in the death of a person during policing activities, the complaint investigation is suspended by police on the basis that the conduct of the officers will be examined by the critical incident investigation team.

The suspension of the complaint investigation is necessary due to the restriction in section 170 of the Police Act which prevents any material about the conduct of a police officer gathered during a complaint investigation from being used in non-disciplinary proceedings such as coronial inquests.

The practice of suspending complaints when a critical incident investigation is on foot is supported by section 149(1) of the Police Act which states that nothing in Part 8A of the Police Act prevents police from investigating any matter relating to a complaint otherwise than under Part 8A of the Police Act. In addition, police can take disciplinary action to address any misconduct that has not been the subject of a complaint under Part 8A of the Police Act.[46]

This office supports the practice of suspending complaints given that the *Critical Incident Guidelines* require:

- the critical incident investigation team to examine the lawfulness of police action and the extent of police compliance with relevant guidelines, legislation, internal policy and procedures, and
- the Senior Critical Incident Investigator to report any identified systemic, safety or procedural issues so that appropriate action can be taken.

6.3.2. Requests for information on the analysis of officer conduct and systemic issues

Our role in oversighting critical incident investigations involving the death of a person during policing activities is to ensure that police:

- conduct an appropriate, transparent and accountable investigation, and
- adequately address any criminal conduct, misconduct and/or systemic issues raised in complaints or identified during the investigation.

Chapter 4 details some of the issues we raised to ensure that the investigators conducted an appropriate investigation. What follows is an account of how we endeavoured to get investigators to identify and address conduct and systemic issues before the coronial inquest.

From the commencement of the critical incident investigation we made a number of requests for the investigators to provide us with information about the identification and action taken to address any criminal behaviour or misconduct by the involved officers. For example, on 26 March 2012, the Deputy Ombudsman emailed the Commander of the Homicide Squad with the following request:

> *… as you conduct this investigation, it is possible that investigators will find evidence of inappropriate and/or wrong conduct by the involved officers and in this circumstance senior police will take the necessary interim measures to effectively deal with this (the obvious one being if a Taser use was unreasonable or not in accordance with the SOPs the officer would be de-certified). Could you please keep me informed of any views or conclusions on police conduct and any interim measures taken?*[47]

On 16 May 2012, during a meeting to discuss the Taser firing data issue, the Commander of the Homicide Squad advised us that the conduct of the involved officers would be examined in the ensuing few weeks as the evidence was gathered and analysed.

On 21 May 2012, the Commander of the Homicide Squad advised that '*if any information suggesting wrong-doing (i.e. a use of force which is unjustified) arises then that is/should be dealt with immediately via a report to a CMT [Complaint Management Team]. The same applies with safety issues – they should be reported up the chain of command immediately.*'[48]

On 31 May 2012, we wrote to the investigators after discovering the following statement in a progress report by the Senior Critical Incident Investigator on e@gle.i:

> *At the present time the tactical options utilised by the involved officers are within policy and guidelines as defined by W&T – P&R [Weapons & Training – Policy & Review].*[49]

We asked the investigators what consideration of the use of tactical options by the involved officers had occurred and where the information and reports of this consideration could be located. We specifically asked whether the use of the Tasers by the involved officers had been considered by the Taser Review Panel.

On 7 June 2012, the investigators advised us that they had discussed the tactical options used with officers from the Weapons & Training – Policy & Review Unit who advised that the actions of the involved officers were within policy and guidelines. The investigators also advised that the Central Metropolitan Region Taser Review Panel had '*declined to review this particular incident as it was undergoing an intensive investigation and any issues will be raised by the State Coroner at the Inquest*.'[50]

On 25 June 2012, the Ombudsman Principal Investigator emailed the Senior Critical Incident Investigator stating:[51]

> *In the absence of details of the analysis that led to the conclusion that the tactical options were within policy and guidelines, this office is not in a position to appreciate how the conclusion was reached.*
>
> *In our view, there should be a discrete and detailed analysis of each and every use of force by the involved officers. This analysis should examine the use of Tasers, OC spray, batons, and physical force to determine whether it was lawful, reasonable and in accordance with any policy, procedures or guidelines.*

On 6 July 2012, the Deputy Ombudsman raised the lack of information about the analysis of the conduct of the involved officers with the Commander of the Homicide Squad in the following terms:[52]

> <u>*Review of the use of force/tactical options utilised by the involved officers*</u>
>
> *On 29 June 2012,* [the Senior Critical Incident Investigator] *advised that 'the Weapons and Tactics – Policy and Review personnel … were of the opinion … that the Involved Officers utilised their respective tactical options within policy and guidelines.'*
>
> *We have not been provided with any information or documentation outlining the analysis that led to this opinion. I understand that* [a Sergeant from the Weapons & Tactics – Policy & Review Unit] *is preparing a statement and that this may contain an analysis of the various uses of force/tactical options utilised by the involved officers. However,* [the Senior Critical Incident Investigator] *suggested that the statement 'will possibly not be completed for some time.'*
>
> *I understand that the main brief of evidence is due to be served by 13 July 2012. Please advise whether* [the Sergeant's] *statement will form part of the main brief of evidence and whether it will contain a discrete and detailed analysis of the various uses of force and tactical options utilised by the involved officers. That is to say, will the statement contain an analysis of the use of Tasers, OC spray, batons, physical force and other tactical options and an opinion as to whether each use/option was lawful, reasonable and in accordance with any policy, procedures or guidelines.*
>
> *I understand from conversations with you that the critical investigation team will examine the conduct of the involved officers as part of their investigation. It has now been some three and a half months since the incident and I have not seen or reviewed any analysis of the conduct of the involved officers.*
>
> *In particular, there is some use of Tasers, OC spray and batons which occurred after Mr Laudisio-Curti had been taken to the ground that on their face do not appear to accord with the relevant SOPs and procedures.*
>
> *Essentially I am not able to effectively fulfil the monitoring function if I am unable to determine what action the investigators have undertaken, what conclusions have been drawn, and the justification for those conclusions.*

The Deputy Ombudsman also raised concerns about the lack of review of the Taser use as follows:[53]

> <u>*Review of Taser use by the Taser Review Panel*</u>
>
> *On 7 and 29 June 2012* [the Senior Critical Incident Investigator] *advised that the Central Metropolitan Region Taser Review Panel ('CMR TRP') 'declined to review this particular incident as it was undergoing intensive investigation and any issues arising will be raised by the State Coroner at the Inquest.'*
>
> *The determination by the CMR TRP does not accord with the NSWPF Region Taser Review Panel SOPs or the SOPs for the use of Electronic Control (TASER) Devices by the NSW Police Force ('Taser Use SOPs'). These SOPs require all operational Taser usage to be reviewed to ensure compliance with the Taser Use SOPs.*

It is unclear why the CMR TRP has not reviewed the Taser use by the involved officers and documented their view/s as to whether the various uses accord with training, the Taser Use SOPs and LEPRA [Law Enforcement (Powers and Responsibilities) Act 2002]. It is also unclear whether the Taser Executive Committee has considered why the Taser use has not been reviewed by the CMR TRP.

While I appreciate that the Coroner may examine the Taser use as part of the coronial proceedings, the SOPs sensibly require the Taser use to be reviewed shortly after use to ensure that any misuse is identified and addressed. I also note your advice (and that of PSC [the Professional Standards Command]) that any issues relating to police conduct and/or systemic issues will be identified and dealt with as the investigation progresses and will not be delayed until after the coronial process. As such, there is no reason why the normal NSWPF process for considering Taser use matters should not be followed. I also note there is nothing in the relevant SOPs or any other policy of procedure justifying any exception to the documented review processes.

Please advise why the Taser use in this matter has not been reviewed by the TRP. I also note that the available documentation indicates that 'intensive investigation' of the Taser use has been undertaken. Can you please provide details of that analysis.

The investigators responded to the concerns we raised by stating that the review of Taser use is a matter for the Central Metropolitan Region Commander who indicated that the review had been suspended and not declined '*pending the outcome of the critical incident investigation and ultimately the comprehensive review of the entire matter by the State Coroner*.' [54]

The material provided to and reviewed by this office did not contain any analysis of the conduct of the involved officers. A sergeant attached to the Weapons & Training – Policy & Review Unit opined the following in a statement prepared for the coronial inquest:

… I am of the opinion that the Police officers involved acted within the scope of organizational policy/procedure and training practice guidelines as provided by the New South Wales Police Force.[55]

However, the statement did not contain any analysis that led to the opinion.

6.3.3. Failure to identify and address conduct and systemic issues

The investigators did not provide this office with any documentation containing their analysis of the lawfulness and reasonableness of the conduct of the involved officers and whether their conduct accorded with policy, procedure, guidelines or training.

In the absence of such documentation despite our repeated requests, the only conclusion available is that either:

- the investigators themselves did not conduct any analysis to form any views of the lawfulness and reasonableness of the conduct of the involved officers, or
- the investigators were unwilling to have their analysis scrutinised by this office.

There is also no evidence that the investigators reviewed or had adequate regard to the complaint or use of force histories of the involved officers to determine if any of them had a past history or pattern of unreasonable use of force.

This represents a failure to adhere to the requirement in the *Critical Incident Guidelines* for the critical incident investigation team to examine the lawfulness of the actions of the involved officers and the extent of their compliance with relevant guidelines, legislation, internal policy and procedures.

The *Critical Incident Guidelines* require investigations into the death of persons during police activities to be led by detectives from the Homicide Squad. This requirement appears to be sensible recognition that any death of a person during policing activities is a homicide necessitating detailed examination of whether the actions of the involved officers were lawful and justified.

There is no evidence suggesting that the critical incident investigation team considered whether the actions of the involved officers amounted to criminal conduct such as manslaughter, affray or common assault. This is a significant failure given the critical incident investigation team is responsible for examining the conduct of the involved officers to determine if any of their actions amount to criminal conduct.

As noted above at 6.1 'Purpose of critical incident investigation', the investigators appeared to be of the misguided belief that their sole function was to prepare a brief of evidence for the Coroner who would examine the lawfulness and reasonableness of the conduct of the involved officers.

We note with concern that it appears to be current NSW Police Force practice to rely on the Coroner to determine the lawfulness and reasonableness of the conduct of officers involved in critical incidents. In two recent media releases about separate critical incident investigations involving the death of two men during the policing activities, police stated that a critical incident investigation team from the Homicide Squad is investigating the circumstances surrounding the incident and that '*[a]ll information will be provided to the Coroner who will determine the cause of death and make any findings about the events leading to the man's death*.'[56]

In our view, it is the function of the critical incident investigation team to determine if any of the actions of the involved officers amounts to criminal conduct. If any criminal conduct is identified then appropriate criminal proceedings should be initiated before any coronial inquest. Similarly, there is nothing preventing the critical incident investigation team from identifying and ensuring that appropriate and timely action to address conduct and systemic issues is taken before any coronial inquest.

It is in the public interest for an officer alleged to have committed any criminal offences to be placed before the courts at the first available opportunity. Coronial inquests are ordinarily suspended where a person has already been charged by police with an indictable offence or where the Coroner forms the view during an inquest there is sufficient evidence of an indictable offence connected with the death.[57]

It is also in the public interest to ensure that any identified conduct or systemic issues (such as changes to training or procedures) are addressed in a timely manner. It is the responsibility of the NSW Police Force and not the Coroner to take appropriate action to remedy identified shortcomings in officer conduct or internal training and procedures.

The role of the Coroner is to determine the identity, date, place, and manner and cause of death.[58] The Coroner's written findings must not indicate or in any way suggest that an offence has been committed by any person.[59] The Coroner may also make certain recommendations in relation to matters connected with the death,[60] but does not have the power to make any binding determinations about criminal or disciplinary issues connected to the conduct of the involved officers. The courts adjudicate issues of criminal liability and the NSW Police Force is responsible for taking disciplinary action with respect to officer misconduct and unsatisfactory performance.[61]

Any action taken to address criminal or other misconduct by the involved officers or to improve procedures or training before a coronial inquest will not interfere with the role of the Coroner. The Coroner may be assisted by the provision of an objective appraisal of the conduct of the involved officers and any information about the implementation of changes that address identified shortcomings in police policy, procedures or training that may have caused or contributed to the death.

The NSW Police Force does not need recommendations from a Coroner in order to take appropriate and timely action against involved officers or to implement changes to policy, procedures or training.

We are not alone in our view on the respective roles of the Coroner and the NSW Police Force. During his opening remarks at the inquest into the death of Mr Laudisio-Curti, Counsel Assisting the Coroner, Jeremy Gormly SC made the following observations:

> *The essential issues in this matter will be manner and cause of death. The coronial jurisdiction which has ancient British roots is one designed first and foremost to objectively establish what happened, to explain any death, whatever its cause. Whether there is blame to be attributed, as her Honour has said, in the cause of a death may be an important matter to find out but this is not the jurisdiction where that's done. Indeed, where a coroner establishes that there is evidence of a criminal act that caused a death, the inquest must effectively terminate and a criminal process would then takeover. This jurisdiction is not a disciplinary jurisdiction, it operates as an inquiry and to make recommendations as the coroner may consider necessary. Issues of civil consequence or disciplinary or criminal action therefore are a matter for another time and another day.*[62]

The community reasonably expects the NSW Police Force to identify and take action to remedy any shortcomings in officer conduct or systems in a timely and effective manner. To do otherwise may expose officers and members of the community to unnecessary and avoidable risk of harm.

Coronial inquests often take many months and sometimes years to be finalised. The current NSW Police Force practice of waiting until the finalisation of the coronial process with the expectation that the Coroner will make recommendations to address shortcomings that should have already been identified and addressed during the critical incident investigation is wrong and misconceived.

In our view, the NSW Police Force is abrogating its responsibility to adequately identify and address officer misconduct and improve training and procedures by conducting critical incident investigations that set out to achieve nothing more than to investigate the events surrounding the critical incident in order to provide the brief of evidence to the Coroner.

An apposite example of the shirking of responsibility is illustrated by the failure of the NSW Police Force to adequately examine the Taser use by four of the involved officers. Despite having internal procedures that require all Taser use to be reviewed, the Taser Review Panel responsible for reviewing the Taser use deferred their review on the basis that the critical incident investigation team and the Coroner would examine the use.

This is a farcical situation where the critical incident investigation team says the Taser Review Panel is responsible for reviewing the Taser use of the involved officers while the Taser Review Panel says that it has deferred its review as the Taser use is being 'intensively investigated' by the critical incident investigation team.

In our view, the Taser Review Panel should have performed its specialist function and reviewed the Taser use of the involved officers soon after the incident as required by the SOPs. The Taser Review Panel members have considerable expertise in reviewing Taser incidents and were better placed than the officers from the Weapons & Training – Policy & Review Unit to determine whether the use was lawful, reasonable and in accordance with the SOPs.

The day the State Coroner handed down the findings and recommendations, the NSW Police Force immediately de-certified the four involved officers from using Tasers. Clearly, this action could and should have been taken by the NSW Police Force in the eight-month period between the critical incident and the finalisation of the coronial inquest.

The failure to take action or at least interim action before the coronial inquest in response to what the State Coroner described as unreasonable and unjustified use of Tasers by four of the involved officers meant that the NSW Police Force did not adequately address the risk that the continued Taser use of those officers posed to the NSW Police Force and the community. This failure is indicative of a lack of commitment to ensuring that officers are held accountable for their actions and that internal policies, procedures, guidelines and training undergo continual improvement.

As noted above at 2.1 'Critical Incident Guidelines', the NSW Police Force has stated that the objective of conducting a critical incident investigation is to remove any doubts about the integrity of the involved officers and provide reassurance to the community that any wrong conduct is dealt with and consideration is given to improving police policy and guidelines to avoid recurrences in the future.

In our view, the community could not be confident or satisfied that the critical incident investigation into the death of Mr Laudisio-Curti achieved its stated objective. The failure of the critical incident investigation team to adequately identify, analyse and address any potential criminal conduct or misconduct by the involved officers or consider changes to policy, procedures or training before the coronial inquest is borne out by the scathing findings on the actions of some of the involved officers and the recommendations contained in the report handed down by the State Coroner, as outlined in Chapter 5 of this report.

The *Critical Incident Guidelines* have in-built accountability measures that are assigned to the Region Commander and Review Officer from Professional Standards Command. The Region Commander '*has ultimate responsibility for the management, investigation and review of all critical incidents that have occurred within the geographical boundaries of their region*.'[63] The Review Officer performs the function of risk manager who is required '*to monitor and review the probity and transparency of the investigation*'.[64]

There is no evidence to suggest that either the Region Commander or Review Officer raised any concerns during the critical incident investigation. It is also unclear whether the Region Commander even reviewed the critical incident investigation before the coronial inquest. In any event, there appears to have been a lack of effective leadership during the critical incident investigation. It appears that no one in the NSW Police Force wanted to address the difficult questions surrounding the actions of the involved officers before the coronial inquest.

6.4. Issues to be addressed following the coronial inquest

It is extraordinary that not one NSW Police Force officer seemed to have formed the view that some of the involved officers may have acted inappropriately. The State Coroner's unequivocal and damming assessment of conduct of the involved officers based on the evidence gathered by the critical incident investigation team and heard during the coronial inquest demonstrates that the NSW Police Force failed to adequately identify, acknowledge and address conduct issues before the coronial inquest.

The objectivity of the officers from the Weapons & Training – Policy & Review Unit who opined before and at the coronial inquest that the use of force and tactical options by the involved officers was reasonable, justified and within the scope of policy/procedure and training practice guidelines must be questioned. Clearly, it is problematic to seek expert opinions on the extent of the involved officers' compliance with guidelines and training from officers who have some responsibility for developing and implementing the guidelines and training.

The failure of the NSW Police Force to adequately identify, address and resolve conduct issues in a timely manner is patently unfair to the family of Mr Laudisio-Curti and the involved officers. The family is left with a sense of injustice as no action has been taken against the involved officers, some of whom have since been promoted. The involved officers are left with a sense of uncertainty as their conduct will face additional scrutiny.

6.4.1. Further complaints by Mr Laudisio-Curti's family members

On 9 November 2012, Sebastian De Brennan, the solicitor acting for Mr Laudisio-Curti's family members, wrote to the Commissioner of Police to formally complain about the conduct of six of the involved officers. In particular, the family alleged that the involved officers variously used unnecessary, unreasonable, inappropriate, unwarranted, disproportionate and grossly excessive force by deploying multiple Tasers and OC spray during the foot pursuit and restraint of Mr Laudisio-Curti. The family requested that appropriate charges be considered including assault, affray and perjury in relation to the evidence two involved officers gave at the coronial inquest.

6.4.2. Ombudsman involvement following the coronial inquest

Ordinarily, we would continue to oversight the critical incident and complaint investigations following the finalisation of the coronial process to follow up on any new or outstanding issues and the implementation of recommendations made by the Coroner. However, as discussed below at 6.4.3 'Police Integrity Commission involvement following the coronial inquest', we have ceased any oversight of the critical incident and complaint investigations.

In our view, there are a number of conduct and systems issues that ought to have been addressed by the critical incident investigation team that remain unresolved. The State Coroner has made recommendations covering the majority of issues that require further examination (see 5.4 'Recommendations made by the State Coroner').

6.4.3. Police Integrity Commission involvement following the coronial inquest

On 14 November 2012, the State Coroner handed down the findings and recommendations of the inquest into the death of Mr Laudisio-Curti. The State Coroner recommended that the Commissioner of Police refer the actions of the involved officers during the pursuit and restraint of Mr Laudisio-Curti to the Police Integrity Commission.

On 16 November 2012, the Police Integrity Commission, an independent statutory body whose principal function is to detect, investigate and prevent police corruption and other serious officer misconduct, announced that it '*will investigate whether there was any serious police misconduct or criminal conduct by NSW Police Force officers in the pursuit and restraint of Roberto Laudisio-Curti on 18 March 2012*.'[65]

The announcement by the Police Integrity Commission that it would be investigating the conduct of the officers involved in the pursuit and restraint of Mr Laudisio-Curti resulted in us ceasing any further involvement in the matter due to legislative and administrative arrangements that sensibly ensure that there is no duplication of agency involvement in the oversight and/or investigation of police misconduct issues.[66]

We support ongoing independent scrutiny and oversight in this matter whilst noting that it is regrettable that yet another investigation into the critical incident will be conducted by another agency as a result of the failure of the NSW Police Force to adequately identify and address the potential criminal and misconduct issues during their critical incident investigation.

6.4.4. Concluding comment

It is the responsibility of the NSW Police Force to conduct an appropriate and accountable investigation into any death that occurs during policing activities. This includes taking appropriate and timely action in relation to any identified criminal conduct, misconduct or systemic issues.

The concerns raised in this chapter demonstrate the failure of the NSW Police Force to appreciate and fulfil this responsibility when conducting the critical incident investigation into the death of Mr Laudisio-Curti.

Recommendations

iv. The NSW Police Force amend the *Critical Incident Guidelines* to make it clear that the critical incident investigation team must consider all conduct and systemic issues and take or recommend appropriate action be taken in a timely manner to address any identified criminal conduct, misconduct or systemic issues *before* any coronial inquest. This should in all cases include a review of the complaint and use of force histories of the involved officers.

v. The NSW Police Force amend the *Critical Incident Guidelines* to require the Region Commander with responsibility for the critical incident investigation to review the investigation *before* any coronial inquest to ensure that all conduct and systemic issues have been appropriately identified and addressed. The consideration of conduct and systemic issues, and the opinion of the Region Commander should be documented and recorded.

Chapter 7. Notification of critical incidents to the Ombudsman

This chapter outlines the current position in relation to the notification of critical incidents and details a proposal to require police to notify all critical incidents to the Ombudsman.

7.1. Current position regarding the notification of critical incidents

As noted in Chapter 1, we were able to oversight the critical incident investigation into the death of Mr Laudisio-Curti as a result of the complaint notified to this office by police. However, there is currently no requirement for police to notify critical incidents to this office in the absence of a complaint. This means that most critical incident investigations are not subject to any independent scrutiny or oversight by this office.

A complaint can be made by a member of the public or a police officer who forms the view that the conduct of an officer involved in the critical incident constitutes a criminal offence or other misconduct. All police officers are obliged to report any conduct that in their view constitutes a criminal offence or other misconduct.[67] However, the officers conducting the critical incident investigation are unlikely to form such a view before carefully examining the evidence gathered during their investigation.

The current lack of a requirement for police to promptly notify this office of all critical incidents in the absence of a complaint limits our ability to oversight certain critical incident investigations from the outset.

7.2. Proposal for a mandatory notification scheme

Critical incident investigations often involve issues of important public interest that attract significant political and media attention. The timely notification of all critical incidents to this office by police would enable us to make informed decisions about the need or benefit of any independent oversight before or at the commencement of the critical incident investigation and the likelihood of any misconduct being identified during the critical incident investigation.

7.2.1. What we achieved by oversighting the critical incident investigation into the death of Mr Laudisio-Curti

Our oversight of the critical investigation into the death of Mr Laudisio-Curti allayed some of concerns held by Mr Laudisio-Curti's family members and the community about police investigating the conduct of fellow police.

In addition, our real time monitoring of the investigation enabled us to raise areas of concern during the investigation thereby ensuring that the investigators conducted a thorough investigation into the events surrounding the death of Mr Laudisio-Curti that the family, the community and the Coroner could have confidence in.

In Chapter 3 of this report we outline the nature and breadth of our monitoring activities. Chapter 4 discusses some of the issues we identified whilst performing our monitoring role. Chapter 6 outlines our overall assessment of the critical incident investigation including our concerns about the failure to adequately identify and address any criminal conduct, misconduct or systemic issues before the coronial inquest.

We are confident that many of the issues identified in Chapters 4 and 6 will be addressed by police in any future oversight and monitoring of critical incident investigations. Most of the issues we encountered were largely a result of the fact that this is the first time this office has actively monitored a critical incident investigation.

7.2.2. Ombudsman oversight of critical incident investigations

In our view, there will always be occasions where it is in the public interest for there to be some independent scrutiny of critical incident investigations into the death or serious injury of persons during policing activities. Accordingly, it would be preferable for police to notify this office of all critical incidents at the outset irrespective of whether the conduct of any of the involved officers is to be the subject of a complaint notified to this office.

We appreciate that the declaration of a critical incident of itself does not suggest the involved officers have engaged in misconduct. The timely notification of critical incidents to this office would ensure that we are well placed to identify any possible misconduct issues in the absence of a complaint and decide whether it is in the public interest to oversight the critical incident investigation.

7.2.3. Respective roles of the Coroner and the Ombudsman

In our view, this office's oversight of critical incident investigations into the death or serious injury of a person during policing activities does not interfere with or duplicate the statutory role of the Coroner.

The death of any person while in police custody, while escaping or attempting to escape police custody, or as a result of or during the course of police operations must be examined by a Coroner at a coronial inquest.[68]

The Coroner does not look at matters where a person has been seriously injured during policing activities.

The Coroner's role is to inquire into and make findings about the manner and cause of death of a person.[69] The Coroner may also make recommendations considered necessary or desirable in relation to any matters connected with the death.[70]

Put simply, the Coroner is responsible for examining the circumstances of the critical incident in order to determine manner and cause of death. Our oversight of the critical incident investigation is confined to scrutinising the investigative process to ensure that the critical investigation team conducts an appropriate, accountable and transparent investigation into the critical incident.

One of the functions of the Coroner is to ensure that any death is properly investigated.[71] The Coroner may direct a police officer to conduct investigative activities for the purpose of the coronial proceedings.[72] In practice, the critical investigation team is responsible for preparing a brief of evidence for the Coroner to assist in the determination of manner and cause of death. The critical incident investigation team regularly updates the Coroner on the nature and scope of the investigation and the evidence gathered without the Coroner issuing formal directions.

If a Coroner were to issue a formal direction to the critical incident investigators, then our role would be limited to oversighting the investigation conducted as a result of the direction rather than the decision of the Coroner to issue the direction.

The Ombudsman also has a role after the Coroner hands down the findings and any recommendations arising out of the coronial inquest. We continue to oversight the critical incident investigation by following up any recommendations made by the Coroner that concern policing policy, practices, procedures or misconduct issues. We may also follow up any broader systemic policing issues arising from the coronial inquest into the particular facts and circumstances of the death examined by the Coroner.

In addition, we oversight most investigations into any alleged or identified misconduct by the involved officers to ensure that police take appropriate management or disciplinary action to address the misconduct.

7.2.4. Benefits of Ombudsman oversight of critical incident investigations

In our view, there would be a number of benefits associated with our independent oversight of certain critical incident investigations into the death or serious injury of persons during policing activities.

Our extensive experience in oversighting police complaint investigations involving serious misconduct means that we are well placed to ensure that police adopt appropriate investigative methodologies and strategies when investigating the conduct of police officers.

Our oversight of critical incident investigations would engender community confidence in the integrity of the investigative process. Our involvement would also provide some re-assurance to the families of the victims, the involved officers and the community generally that the investigation will be conducted in an accountable and transparent manner.

In addition, any real time monitoring of critical incident investigations should ensure that investigations are not subject to later criticism during or following coronial inquests as this can lead to further pain and anxiety for the families of the victims and the involved officers.

7.2.5. What is required to implement a mandatory notification scheme

As noted above at 7.1, the current position is that critical incidents are only notified to this office when a complaint alleging criminal conduct or misconduct of the officers involved in the critical incident is notified to this office.

In our view, it would be preferable for the notification of critical incidents to this office to be part of a separate process not linked to the complaint handling framework in Part 8A of the Police Act. This is because the declaration of a critical incident does not, of itself, suggest that the involved officers have engaged in misconduct.

That said, any criminal conduct or misconduct identified during a critical incident investigation will continue to be recorded and appropriately addressed within the complaint handling framework in Part 8A of Police Act.

A statutory scheme requiring police to immediately notify this office of all critical incidents involving the death or serious injury of persons during policing activities would ensure that we were able to make informed decisions about any oversight at a very early stage of the critical incident investigation.

The current system already enables us to oversight critical incident investigations involving deaths that are to be examined by the Coroner when a complaint is notified to this office. The proposed scheme would improve the system by ensuring that we are able to oversight any critical incident investigation where it is in the public interest to do so.

It is important to note that the proposal for a mandatory notification scheme would not result in us oversighting every critical incident investigation. We will assess each notification and determine whether it is in the public interest to oversight the critical incident investigation having regard to the nature and circumstances of the critical incident and the information available at the time of notification.

In our view, any mandatory notification scheme will only function effectively if police are required to make timely notifications to this office of all critical incidents involving the death or serious injury of persons during policing activities.

In addition, we will only be able to effectively oversight critical incident investigations if we have the power to require police to provide all information about the incident to this office in a timely manner and to actively monitor investigations in real time.

Recommendations

vi. The NSW Parliament consider amending the *Police Act 1990* to require the NSW Police Force to notify the NSW Ombudsman immediately following all critical incidents involving the death or serious injury of persons during policing activities.

vii. The NSW Parliament consider amending the *Police Act 1990* to provide the NSW Ombudsman with appropriate powers to effectively oversight critical incident investigations involving the death or serious injury of persons during policing activities.

The Ombudsman has had preliminary discussions with the Commissioner for Police and the Minister for Police who have expressed in principle support for the proposed mandatory notification scheme.

Endnotes

1. A correct Taser application in probe mode causes neuromuscular incapacitation, involving involuntary muscular contraction and temporary loss of muscular control. For further information see: NSW Ombudsman, *How are Taser weapons used by the NSW Police Force*, October 2012, pp.31-32. The report can be found at: <http://www.ombo.nsw.gov.au/news-and-publications/publications/reports/police/how-are-taser-weapons-used-by-nsw-police-force>.
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3. Magistrate Scott Mitchell, Deputy State Coroner, Findings of the inquest into the death of Adam Quddus Salter, 14 October 2011, <http://www.coroners.lawlink.nsw.gov.au/agdbasev7wr/_assets/coroners/m401601l7/99_salter,adam.pdf> accessed 22 October 2012, paragraphs [124] and [128].
4. ibid, paragraph [124].
5. The Police Integrity Commission is currently conducting an investigation (Operation Calyx) into various aspects of the critical incident investigation into the shooting of Adam Salter. See <http://www.pic.nsw.gov.au/files/News/Calyx%20public%20notice.pdf> accessed 23 October 2012.
6. Minister for Police and Emergency Services, Michael Gallagher, Media Release, 'Minister announces NSW Ombudsman will independently oversight Taser investigation', 20 March 2012.
7. NSW Ombudsman, Media Release, 'Ombudsman confirms independent oversight of the Police Taser investigation', 20 March 2012.
8. NSW Police Force, *Critical Incident Guidelines*, August 2012.
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10. ibid, p.8.
11. NSW Police Force, *Guidelines for the management and investigation of critical incidents*, February 2007.
12. NSW Police Force, *Critical Incident Guidelines*, August 2012, p.9.
13. *Police Act 1990*, s.211(2A) & (7).
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15. *Police Act 1990*, s.146(1).
16. *Police Act 1990*, s.146(2).
17. *Police Act 1990*, s.146(3).
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20. NSW Police Force, *Critical Incident Guidelines*, August 2012, p.28.
21. SD, Statement of a witness, 18 March 2012.
22. Email from the Deputy Ombudsman to the Commander of the Homicide Squad, 26 March 2012.
23. Email from Senior Critical Incident Investigator to the Deputy Ombudsman, 26 March 2012.
24. SD, Transcript of walk-through interview, 12 April 2012, p.17.
25. ibid, pp.15-16.
26. NSW Police Force, *Code of Conduct and Ethics*, http://www.police.nsw.gov.au/__data/assets/file/0015/4326/Code_of_Conduct_and_Ethics.pdf accessed 21 November 2012.
27. *Police Service Board v Morris* (1985) 156 CLR 397.
28. NSW Police Force, *Critical Incident Guidelines*, August 2012, p.36.
29. NSW Police Force, Media Release, 'Police seek further witnesses as investigation into death of Brazilian student continues', 30 June 2012.
30. Magistrate Mary Jerram, NSW State Coroner, Findings of the inquest into the death of Roberto Laudisio-Curti, 14 November 2012, <http://www.coroners.lawlink.nsw.gov.au/agdbasev7wr/_assets/coroners/m401601l4/curti%20decision%2014%20nov%202012.pdf> accessed 14 November 2012.
31. ibid, p.8.
32. ibid, p.30.
33. ibid, p.28.
34. ibid, p.21.
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37. ibid, p.25.
38. ibid, pp.31-32.
39. NSW Police Force, Media Release, 'NSW Police adopt coroner's recommendations', 14 November 2012.
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44. ibid, p.28.
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51. Email from the Ombudsman Principal Investigator to the Senior Critical Incident Investigator, 25 June 2012.
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55. [Sergeant attached to the Weapons & Tactics – Policy & Review Unit], Expert Witness Statement, 24 September 2012.
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58. *Coroners Act 2009,* s.81(1).
59. *Coroners Act 2009,* s.81(3).
60. *Coroners Act 2009,* s.82(1).
61. *Police Act 1990*, Division 1 of Part 9.
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64. ibid, p.35.
65. Police Integrity Commission, Media Release, 'Media Release – Roberto Laudisio-Curti', 16 November 2012.
66. *Police Integrity Commission Act 1996*, s.70(5).
67. *Police Regulation 2008*, cl.49.
68. *Coroners Act 2009*, s.27(1)(b).
69. *Coroners Act 2009,* s.81(1).
70. *Coroners Act 2009,* s.82(1).
71. *Coroners Act 2009,* s.10(1)(b).
72. *Coroners Act 2009,* s.51(2).

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