# Annexure A

Ombudsman submission to the review of the Police Act - 6 Feb 2014

Ombudsman
New South Wales

# Review of the *Police Act 1990*

## Submission by the NSW Ombudsman

6 February 2014

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# 1. Introduction

The *Police Act 1990* (the Act) establishes the administration and governance of the New South Wales Police Force (the NSWPF). Section 222 of the Act sets out the requirements for the review of the Act:

(1) The Minister is to review this Act to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives.

(2) The review is to be undertaken as soon as possible after the period of 5 years from the date of assent to the *Police Amendment (Miscellaneous) Act 2006*.

(3) A report on the outcome of the review is to be tabled in each House of Parliament within 12 months after the end of the period of 5 years.

This office has been invited to make a submission to the current review. To assist in the preparation of submissions, the Ministry provided a confidential table to all stakeholders outlining the range of issues or possible amendments identified during previous consultations.

The focus of our submission is on Parts 8A and 9 which set out the framework for the operation and oversight of the police complaints system and the management of conduct within the NSWPF.

When the present scheme for managing police complaints was established, the reforms were intended to create a *'new simplified scheme'* for handling complaints against police officers, and to replace the former discredited police disciplinary system with *'a new scheme for dealing with police officers' misconduct and unsatisfactory performance'*.'[1]

These amendments built on the work of the Royal Commission into the NSWPF, which had found that the former complaints process was:

- *too legalistic, formal, and focused upon punishment*
- *insufficiently focused upon behaviour modification*
- *woefully dilatory, and*
- *subject to an unnecessarily complex appeal process.*[2]

The Royal Commission's analysis at Volume II, Chapter 4 of its Final Report provided the guiding principles for reforming the complaints system. A joint submission made by the Ombudsman, the Police Integrity Commission (PIC) and the Commissioner of Police set out a scheme of proposed reforms aimed at streamlining the complaints system and supporting the philosophy of the Royal Commission's recommendations.[3]

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[1] 'Overview of the Bill', *Police Service Amendment (Complaints and Management Reform) Bill 1998*.

[2] Royal Commission into the NSW Police Service, *Final Report – Volume II: Reform*, May 1997, at [1.47].

[3] The Hon. Paul Whelan MP, Second reading speech, Hansard, Legislative Assembly, 21 October 1998.

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Central to the ongoing reforms recommended by the Royal Commission was an expectation that the NSWPF should lead the way in setting *'proper professional standards'*, then actively do *'whatever it con to encourage its members, in a managerial way, to lift their performance'* and to build confidence in police and the NSWPF.[4]

Having regard to the objects of the Act and policy intent behind it, the remaining sections of this document set out our submissions on amendments required to the Act to improve the oversight and management of police complaints.

The Ombudsman Office would be pleased to discuss or elaborate on any points made in this submission. The contact officers for this submission are:

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[4] Royal Commission into the NSW Police Service, *Final Report – Volume II: Reform*, May 1997, p330.

# 2. Amendments to Part 8A (Complaints about conduct of police officers)

## 2.1 Explaining the functions of the NSWPF, the Ombudsman and the Police Integrity Commission in relation to complaints

There is no general explanation in Part 8A of the Act of the roles of the NSWPF, the Ombudsman and the PIC in relation to the handling of complaints about police or the objects of the scheme.

Although the agencies understand their respective responsibilities, issues of the interpretation and operation of Part 8A arise from time to time between the agencies and people who are unfamiliar with the system for handling complaints about police must read the whole of Part 8A to get an accurate understanding of its basic principles.

To assist in its interpretation, Part 8A should be amended to include preliminary sections that briefly explain the objects of the part and the main functions of the NSWPF, the Ombudsman and the PIC, preferably with reference to the relevant provisions. For example, an introductory section might include information about the following:

*NSW Police Force*

The legislation recognises that the NSWPF – like any other public authority – has principal responsibility for investigating and/or resolving complaints about its personnel and its systems. In doing so, the NSWPF is required to:

- carry out investigations into complaints in a manner that is both effective and timely – s145(1)(a)
- consult and provide certain information to the complainant following investigation – s150(a) and (b), and
- seek complainants' views on whether they are satisfied with the way in which their concerns have been addressed – s150(c)(iii).

*NSW Ombudsman*

Generally, the Act requires the Ombudsman to:

- consider the adequacy of the police handling and resolution of individual complaints – Division 6, and
- keep under scrutiny the systems for handling complaints involving police to ensure the maintenance of standards of integrity and fair dealing – s160(2).

The Ombudsman may also:

- monitor NSWPF investigations, which may include conferring with investigators about the progress of investigations and directly observing interviews conducted by police – s146

- conduct direct investigations into complaints about police where it is in the public interest to do so. Direct investigations may also be concerned with the NSWPF investigation of a complaint and/or any other issues related to the complaint – Division 7
- establish, in conjunction with the PIC (after consultation with the Police Commissioner), guidelines to streamline the handling of complaints – s121 and s122(2).

*Police Integrity Commission*

The PIC is an independent, accountable body whose principal function is to detect, investigate and prevent police corruption and other serious officer misconduct in NSW (see 'Functions of Commission', section 3, *Police Integrity Commission Act 1996*). The PIC's focus is on directly investigating those complaints concerning the more serious types of misconduct.

## 2.2 Defining what constitutes a 'complaint' about police

At present, for a 'complaint' about police to be subject to the provisions in Part 8A, the complaint must:

- be about the 'conduct' of a police officer – *conduct* is defined in section 121.
- must allege or indicate that the police conduct is a criminal offence, corrupt, unlawful, unreasonable, etc – section 122.
- be *'made in writing to an investigating authority'* – section 127.

The definition of *investigating authority* is contained in section 121.

As noted in the discussion below at [2.4], the definition of 'complaint' should also include certain verbal allegations or information about certain police conduct.

Although those who are familiar with these various provisions have reached an understanding about when an allegation about police conduct should be treated as a Part 8A complaint, it would assist when issues arise for there to be a clear and self-contained section containing the definition of what constitutes a 'complaint' about police.

## 2.3 Final determination about whether a matter is a 'complaint'

If there is a difference of opinion between the Ombudsman and the NSWPF about whether a matter constitutes a 'complaint' (i.e. the NSWPF takes the view that a document does not allege or indicate improper or unreasonable conduct by police, but the Ombudsman takes the opposite view), there is no provision which provides a mechanism for resolving the

difference of opinion. At present, the Ombudsman can only challenge the opinion of the NSWPF by instituting proceedings in the Supreme Court, seeking a declaration that the matter in question constitutes a complaint.

Part 8A should include a provision which allows such issues to be resolved without the need to resort to legal proceedings. Given the role of the Ombudsman to oversight the complaints system, it would be appropriate for this office to determine whether a matter constitutes a police complaint or not when there is a difference of opinion between the Ombudsman and the NSWPF.

An appropriate model for such a mechanism might be found in the following provisions of section 139 of the Act, which allows the Ombudsman to override the decision of the NSWPF not to investigate a complaint:

> (4) If the Commissioner decides that the complaint does not need to be investigated, the Commissioner:
> (a) must notify the Ombudsman ...
>
> (5) If the Ombudsman disagrees with the Commissioner's decision that the complaint does not need to be investigated:
> (a) the Ombudsman must notify the Commissioner ...

## 2.4 A positive and statutory obligation to report police misconduct

There have been ongoing issues between the Ombudsman and the NSWPF as to how verbal complaints should be dealt with and how the provisions operate around internal reporting (i.e. clause 49 of the Police Regulation). The issues that the NSWPF has previously raised include concerns that:

- Section 127(5) may prohibit a police officer from reducing a verbal complaint to writing (on the basis that authority only resides with this office or the PIC).
- It may be unclear what police officers are obliged to do if they come across information that is not a complaint but which could point to police misconduct (e.g. a conversation at a police function).
- There is no formal obligation for police to take an 'over the counter' verbal complaint and reduce it to writing, thereby meeting the definition of a 'complaint' under Part 8A of the Act.
- The action of reducing a verbal complaint to writing is problematic for the police officer preparing the report as he or she becomes the 'complainant' for the purposes of Part 8A.
- The wording of the Act and clause 49 of the Police Regulation is complex and it is difficult for a junior officer to understand what their obligations are.

- Questions as to whether police actions were appropriate (from, for example, a member of the public) are not 'allegations' or 'complaints' for the purposes of Part 8A.

It is also worth noting that in *Commissioner of Police v Hughes [2009] NSWCA 306* the Court of Appeal overturned a decision by a judge that a report by a NSWPF employee was not a complaint because the initial information was oral and not within section 127(5).

In response to this issue we suggested that the NSWPF develop adequate policies and guidelines about managing oral complaints including the application of clause 49. The NSWPF has argued that there are difficulties in interpreting the existing provisions and consequently with converting the requirements into plain English.

There is no doubt that clause 49 in its current form is problematic and unnecessarily complex:

> **49 Police officer to report misconduct**
>
> (1) If:
> (a) an allegation is made to a police officer that another police officer has engaged in conduct which, in the opinion of the officer to whom the allegation is made, constitutes a criminal offence or other misconduct, or
> (b) a police officer sincerely believes that another police officer has engaged in any conduct of that kind,
>
> the officer is required to report the conduct or alleged conduct by the other officer to a senior police officer (being a police officer who is more senior in rank than the officer making the report).
>
> (2) This clause does not apply to conduct or alleged conduct:
> (a) that has been made the subject of a complaint under Part 8A of the Act, or
> (b) that has been the subject of evidence or other material given, or submissions made, in the course of criminal proceedings, or
> (c) that has already been reported under this clause to a senior police officer.
>
> (3) A senior police officer to whom conduct (or alleged conduct) by a police officer is reported is required to report it promptly to the Commissioner or a police officer nominated by the Commissioner if the senior police officer believes that the conduct (or alleged conduct):
> (a) constitutes (or would constitute) a criminal offence, or
> (b) could provide sufficient grounds:
> (i) for taking section 80 dismissal action, or
> (ii) for making a reviewable section 173 order or a section 181D order.
>
> (Emphasis added)

The reports that police officers and senior police officers are obliged to make under clause 49 are not required to be in writing. Although many reports will, in practice, be in writing – and become written complaints for the purposes of Part 8A – there are ongoing

inconsistencies in police practices about whether written reports made following oral or verbal reports are complaints under the Act.

The operation of clause 49(3) could also be regarded as being inconsistent with the Act itself in that reports made in writing to a senior officer under clause 49(1) that indicate or allege conduct of a police officer that falls within section 122 must be treated as complaints and recorded on the complaint information system pursuant to section 129. As such, in these circumstances the senior officer should not or is no longer required to turn his or her mind to sub-clause (3).

An officer is only required to report *'an allegation ... that another police officer has engaged in conduct which, in the opinion of the officer to whom the allegation is made, constitutes a criminal offence or other misconduct'*, or where the police officer *'sincerely believes that another police officer has engaged in any conduct of that kind'* (emphasis added). In our view, a requirement for reporting wrongdoing should not include subjective elements (such as 'in the opinion of' or 'sincerely believes').

It is also not explicit that information pointing to misconduct or criminal conduct (e.g. intercepted or recorded conversations, or criminal intelligence) provided to an officer constitutes an allegation. As a matter of practice the NSWPF does report details of intercepted or recorded conversations that imply police misconduct, however it would be beneficial to clarify this in the Act.

In some cases the NSWPF appears to have taken the view that clause 49 limits the circumstances in which police officers are required to report unreasonable or improper conduct by other officers – rather than viewing the matter from the broader perspective that it is good administrative practice for the NSWPF to be alerted to all allegations of possible instances of unreasonable or improper police conduct, so that those allegations can be considered by senior management and, where appropriate, investigated.

A narrow view of the kind of conduct that should be reported and recorded is at odds with the reforms recommended by the Wood Royal Commission, which strongly advocated that local commanders should actively use complaints and a range of other information and feedback, including compliments, to inform continual improvements to the services provided by the NSWPF.

> [4.27] ... A good manager must be alert to all circumstances affecting their area of command that pose risks or potential matters for concern. They must be prepared to intervene and exercise the broad range of options available.
>
> [4.28] This is an important consideration since the complaints system must fit in with the overall managerial approach of the [NSWPF]. It is not confined to misconduct alone...[5]

[5] Royal Commission into the NSW Police Service, *Final Report – Volume II: Reform*, May 1997.

Justice Wood recommended developing a system of local complaint management that significantly broadened the authority of local commanders:

> *... to deal with complaints and take remedial action or impose sanctions on a managerial basis, without recourse to formalities ...*
>
> [Recommendation 71]

The Royal Commission also recommended:

> *Under [this system], on becoming aware of possible misbehoviour, the Local Commander be empowered to initiate an inquiry and to take such action as is considered appropriate in all the circumstances focused, if passible, upon manogerial or remedial measures but in the more seriaus cases oction which may include:*
>
> - *impasition of a reviewable managerial sanctian such as deferral of on increment, loss of seniority, reduction in salary, demotion;*
> - *initiation of the Commissioner's confidence process.*
>
> [Recommendation 72]

It is the Ombudsman's view that as a matter of good administrative practice and to ensure transparency and accountability:

- all written reports that indicate or allege improper conduct should be registered as a complaint
- all verbal complaints by members of the public should be registered as a complaint.

We agree that the Act and the regulation together are unnecessarily complex in respect of verbal and internal complaints and believe any mandatory reporting requirement should be set out in the Act and not the regulation. An instructive and effective example of a clear and succinct statutory duty to report can be found in section 11(2) of the *Independent Commission Against Corruption Act 1988*:

> (2) A person to whom this section applied is under a duty to report to the Commissioner any matter that the person suspects on reasonable grounds concerns or may concern corrupt conduct.

It is our submission that a simple statutory requirement within Part 8A of the Act modelled on section 11(2) should be inserted and that clause 49 be repealed. It is also recognised that a mandatory reporting scheme should be directed toward more serious forms of misconduct. This could be achieved by modelling any new section on section 8 of the *Independent Commission Against Corruption Act 1988* which is the seriousness test or limb for reportable corrupt conduct.

Separately, a new provision should be added to require police to reduce to writing complaints by members of the public about any conduct that falls within section 122 to ensure that these matters are recorded on the complaints information system as required by

section 129 and can be audited by the Ombudsman in accordance with section 160 to ensure compliance with Part 8A.

The new provision should stipulate that the police officer reporting the matter does not become the 'complainant' merely because the police officer reduces an allegation or information to writing. This proposed provision would mirror section 135 – see discussion below at [2.6]. Furthermore, if the source of the verbal information is unknown the complaint may be regarded as anonymous. However, such an amendment should not remove that police officer from the protections afforded under section 206 of the Act and the PID Act. It would be appropriate for both Acts to be amended to provide that a police officer who registers information into the police complaints systems should attract all the protections afforded to a person who makes the disclosure directly.

Such amendments would ensure the objective intended by the Act is met, and that police officers are provided with much clearer guidance on what their obligations are when a verbal complaint is made to them or when they observe or come across information pointing to police misconduct.

## 2.5 Registering information about alleged misconduct

Section 129 of the Act outlines the statutory requirements regarding the registration of complaints. At present, the section does not make it clear that any written information that implies conduct as defined by section 122, should be categorised as a complaint and registered on the complaints system. Previously the N5WPF took the position that a written document that is not framed as a complaint that contains information implying misconduct was not a complaint – for example, a transcript of a lawfully intercepted phone call which details a potentially inappropriate association between a police officer and a known criminal. A transcript of recordings obtained via listening device or general criminal intelligence might also fall into this category.

To put this issue beyond doubt, section 129 should be amended to include any written police record that implies police conduct as defined under section 122.

## 2.6 Ministers and MPs making complaints on behalf of constituents

The Minister or an MP may refer a person's complaint about police to an investigating authority.

Section 135(1) provides:

> The Minister does not become the complainant merely because the Minister refers a complaint made by some other person (a "client") to an investigating authority, except for the purposes of the provisions of this Act that require the complainant to be informed or notified of any matter or given or sent any matter.

Similarly, section 136(1) provides:

> A member of Parliament does not become the complainant merely because the member of Parliament makes a complaint to an investigating authority on behalf of some other person (a "client"), except for the purposes of the provisions of this Act that require the complainant to be informed or notified of any matter or given or sent any matter.
>
> (Emphasis added)

In practice, where a Minister or MP refers a complaint to the Ombudsman, the Ombudsman will usually arrange to contact the complainant, and further communications about the progress and outcome of the handling of the complaint will be made directly with the complainant. (We are not aware of whether the NSWPF or the PIC usually adopts this practice.)

Of course, if the Minister or MP wishes to be kept informed of developments by the Ombudsman, the Minister or MP can advise the Ombudsman accordingly and the Ombudsman will then keep the Minister or MP informed.

However, the provisions highlighted above appear to oblige the Ombudsman (and the NSWPF and the PIC) to write not only to the complainant, but also to the Minister or MP, in any circumstance where the provisions of Part 8A require information to be provided to the complainant. This would appear to be an unnecessary administrative impost, as well as encumbering the Minister and MPs with unnecessary correspondence.

In order to clarify that a Minister or MP who refers a complaint to an investigating authority should be able to elect not to receive updates and advice, we recommend deleting the words in sections 135(1) and 136 (1) highlighted above.

## 2.7 Providing reasons for Commissioner's decision not to investigate a complaint

Section 139(2) provides that:

> The Commissioner may decide that the complaint should be, or does not need to be, investigated.

After deciding that a complaint need not be investigated, the Commissioner must notify the Ombudsman and the complainant of the decision – section 139(4). However, this provision does not require the Commissioner to give either the complainant or the Ombudsman the reasons for the decision.

If the Ombudsman disagrees with the Commissioner's decision, section 139(5) provides a mechanism for the Ombudsman to require the NSWPF to investigate. To exercise this power responsibly, the Ombudsman must be provided with the reasons for the Commissioner's initial decision not to investigate.

By way of contrast, section 140 provides:

> If the Ombudsman decides that the complaint does not need to be investigated:
>
> (a) the Ombudsman:
>  (i) must notify the complainant of the decision and of the Ombudsman's reasons for the decision, and
>  (ii) must send to the Commissioner a copy of the notification ...
>
> (Emphasis added)

It is good administrative practice for any public sector agency to give reasons for its decisions. As it is the policy of the NSWPF to provide reasons for its decision not to investigate a complaint, making this a statutory requirement will involve little or no additional work for the NSPWF.

Section 139 should be amended to include a requirement that the Commissioner give the complainant and the Ombudsman reasons for deciding not to investigate a complaint.

## 2.8 Power of the Ombudsman to 'discontinue' oversight on a particular matter

If the NSWPF decides to investigate a complaint, it appears that the Ombudsman has no power under the legislation to advise the NSWPF that the Ombudsman's office wishes to 'discontinue' its oversight for the purposes of Part 8A of the Act, and that the Ombudsman does not wish to receive a section 150 report about the outcome of the investigation.

Enabling the Ombudsman's office to 'discontinue' its Part 8A oversight does not mean that the NSWPF will or should cease its own inquiries. Section 149 specifically recognises the ability of the NSWPF to continue investigating a complaint notwithstanding a decision by the Ombudsman that the inquiries should not be treated as an investigation for the purposes of the Act. Rather, a discontinuance mechanism is needed because not all NSWPF investigations require a report to the Ombudsman.

The absence of such power becomes relevant in the following situations:

- The PIC decides that, while it does not wish to investigate or 'take over' the investigation of complaint under section 70 of the *Police Integrity Commission Act 1996*, it nevertheless wishes to 'oversight' the NSWPF investigation of a complaint.

  Once the PIC begins to oversight a matter it is, in practice, inappropriate and a duplication of resources for the Ombudsman to oversight the NSWPF investigation.

  However the Ombudsman has no authority to discontinue his oversight. It may also be that Part 8A (implicitly) requires the Ombudsman to decide whether the NSWPF investigation was satisfactory, even though the PIC is oversighting the matter.

- The NSWPF decides to investigate a particular complaint, but the Ombudsman is of the view that, in the circumstances of the particular matter, there is no need for the Ombudsman to oversight the NSWPF handling of the complaint, or to receive and assess the NSWPF investigation report.

  Again, the Ombudsman does not have the authority to discontinue his oversight.

The Ombudsman has tried to overcome the apparent limitations of the current legislative scheme by entering into a memorandum of understanding with the PIC (after consultation with the Commissioner of Police) about how matters of the type discussed above should be handled. However, this does not really seem to represent an adequate solution to the issues involved.

Amendments are needed to create a mechanism that enables the Ombudsman to formally 'discontinue' his oversight and excuse the NSWPF from having to provide a report to the Ombudsman in relation to a particular matter.

## 2.9 Ombudsman power to require the NSWPF to investigate a complaint – section 140

Section 140 enables the Ombudsman to determine that a complaint received by the Ombudsman should be, or does not need to be, investigated by police. Although section 159 provides that the Ombudsman may initiate an investigation under the *Ombudsman Act 1974* into the conduct of a police officer that is not the subject of a complaint, there is no clear authority to refer such matters to the Commissioner, even if the NSWPF is best-placed to investigate the conduct and it is in the public interest for police to undertake the inquiries.

Section 140 should therefore be amended to enable the Ombudsman to decide that information (that is not a 'complaint') about police conduct should be, or does not need to be, investigated. That is, if it appears to the Ombudsman that any conduct of a police officer could be – but is not – the subject of a complaint, the Ombudsman may notify the Commissioner of the decision that it should be investigated.

## 2.10 Improving the management of 'vexatious' complaints – section 141

The Terms of Reference for the current review of the Police Act indicate that consideration is being given to *'whether vexatious complaints are able to be adequately managed'*.[6]

Part 8A currently provides a broad discretion in relation to determining whether an allegation about police should or should not be investigated. A decision to decline a complaint at the outset essentially means that no action will be taken by either the NSWPF or the Ombudsman, other than advising the complainant of the decision and the reasons for

[6] Ministry for Police and Emergency Services, 'Terms of Reference', received 17 December 2013.

the decision. When deciding whether a complaint '*should be, or does not need to be, investigated*', section 141 states that the Police Commissioner or the Ombudsman:

> ... may have regard to such matters as he or she thinks fit, including whether:
>
> a) action has been, is being or will be taken to remedy the subject-matter of the complaint without the need for an investigation, or
> b) the complaint is frivolous, vexatious, or not made in good faith, or
> c) the subject-matter of the complaint is trivial, or
> d) the conduct complained of occurred too long ago to justify investigation, or
> e) there is or was available to the complainant an alternative and satisfactory means of redress in relation to the conduct complained of, or
> f) the complainant does not or could not have an interest, or a sufficient interest, in the conduct complained of.
>
> (Emphasis added)

It should also be noted that under section 167A, any person who knowingly makes a false complaint about police or gives false information can be fined up to $5,500 and/or imprisoned for up to 12 months.

In addition, section 145 provides the NSWPF with a wide discretion regarding how a complaint is investigated. If at any point an investigation establishes that the complaint is unlikely to be substantiated and or there is evidence that it might be vexatious, the investigation can be discontinued or finalised.

In our view the existing provisions together are adequate for determining whether a complaint should be investigated or not, including those not made in good faith, or which are vexatious or frivolous.

## 2.11 The use of information requested under section 143 for investigative purposes

Section 143 provides:

> (1) For the purpose of determining whether a complaint should be investigated, the Ombudsman may request information from persons other than the complainant.
>
> (2) This section does not authorise the Ombudsman:
> (a) to investigate the complaint or to collect information for the purposes of the investigation of the complaint or of a report under this Part, or
> (b) to interview the police officer the subject of the complaint, or
> (c) to require persons to provide information.
>
> (Emphasis added)

Where the Ombudsman requests information from a person other than the complainant to assist the Ombudsman to decide whether a complaint should be investigated, and the person provides that information, it is clear that the Ombudsman can use the information to determine whether the a complaint should be investigated.

However, section 143 does not authorise the Ombudsman *'to collect information for the purposes of the investigation of the complaint or of a report under this Part'* and this raises a question about whether the information obtained by the Ombudsman can subsequently be provided to NSWPF for the purposes of investigating the complaint, or used by the NSWPF and/or the Ombudsman in investigating and reporting on the matter. Additionally, the purpose or objective behind this limitation or restriction is unclear.

An amendment is needed to clarify whether information obtained as part of this preliminary assessment may be provided to the NSWPF, and how this information can subsequently be used by the NSWPF and/or the Ombudsman. In our view, this office should be able to provide information to the NSWPF for the purpose of investigation where we consider it relevant and in the public interest to do so. Similarly, this office should be able to use such information in our own investigations where it is relevant and in the public interest to do so.

## 2.12 The institution of criminal proceedings, sufficiency of evidence and the Commissioner's approval for the institution of proceedings – section 148

Section 148 of the Police Act provides:

> (1) If it appears to a police officer conducting an investigation that sufficient evidence exists to warrant the prosecution of any person for an offence, the police officer is to cause appropriate proceedings to be instituted against the person.
>
> (2) The Commissioner must inform the Ombudsman of the institution of any such proceedings and of the particulars of the proceedings.
>
> (3) A police officer is not to institute any such proceedings against another police officer without the approval of the Commissioner.
>
> (Emphasis added)

The purpose of this section is to ensure effective responses to complaints where a police officer (either on or off duty) has committed a criminal offence.

There have been some practical difficulties or issues with the operation of section 148 as follows:

- If police attend a scene where a police officer may have committed a criminal offence, the matter is a criminal matter and not yet a complaint investigation (in the sense that no complaint has yet been received or made). In this instance the usual discretion is afforded to a police officer as to whether to charge or not. There is no

formal requirement to record this use of discretion. In this instance section 148 has no application. In our view, an officer in a situation such as this who has committed an offence, regardless of whether or not the officer is charged, has engaged in *'conduct...that constitutes an offence'* (s122 (1)(a)). We are aware of instances where this has not been recorded into the police complaints system.

- If police attend a scene where an off-duty police officer may have committed a criminal offence, the same issues arise in that police can exercise a discretion not to charge.

- In our view, the correct reading of the Act is that it is the 'investigating officer' and not a Complaints Management Team (CMT) who determines sufficiency of evidence to charge. On occasion the NSWPF have suggested that in the context of a complaint investigation, the CMT can be substituted for *'the police officer conducting the investigation'* on the basis that the CMT directs the investigation. The anti-corruption purpose would be defeated if that authority or responsibility could be overridden by a more senior officer or a management group.

- Under section 148(3) if the Commissioner or his delegate determines that proceedings should not be commenced or if already instituted (in some cases) discontinued, there is no requirement for those reasons to be recorded.

- Section 148(1) of the Police Act currently imposes a mandatory obligation on the investigator to cause appropriate proceedings to be instituted against any person if there is sufficient evidence to warrant the prosecution. If there is sufficient evidence to warrant the institution of proceedings against a police officer, then section 148(3) requires the approval of the Commissioner (or delegate) before the proceedings can be instituted. However, section 148(3) does not apply to a civilian.

  The Crown Solicitor suggested (at 4.23 of the 2000 advising titled 'Re: Section 148 of the Police Service Act 1990 – extent of discretion to prosecute') that the scheme in section 148 ensures that discretionary matters other than the sufficiency of evidence are only to be considered at the most senior level. This is to safeguard the integrity of the complaint process by ensuring that criminal conduct by police officers is not covered up in the investigation process by an inappropriate exercise of discretion on the part of the investigating officer.

  The Crown Solicitor noted that section 148 produces a 'curious result' in that the Commissioner (or delegate) can exercise the discretion not to prosecute a police officer by virtue of section 148(3). However, the same discretion cannot be exercised for a civilian. This anomaly should be addressed. There does not appear to be any cogent policy reason why the discretion not to prosecute cannot be exercised in favour of a civilian in the same manner as it is with a police officer.

It is important that practical difficulties, issues or limitations with the operation of section 148 are resolved as it is recognised as an important anti-corruption measure.[7] To achieve this significant changes are required to this section.

To consider the type of amendments needed, it is prudent to consider what section 148 should require from a policy perspective. In our view this section should:

- Require a police officer, who in the absence of a complaint, applies discretionary factors in determining not to charge a police officer who has committed an offence (either on or off duty) to cause those details to be recorded in the police complaints system. This would allow in the first instance, a more senior officer to assess whether that decision was appropriate, and also allows this office to oversight such matters. It is true that this obligation already exists, however we are aware of several instances where this has occurred and no complaint or report has been registered in the complaints management system.

- When a police officer (either on or off duty) is charged with an offence (including by way of any type of penalty notice), the charging police officer should be required to cause those details to be recorded in the police complaints system (this would reinforce the existing provisions to record this information as a complaint).

- In a complaint investigation, the investigating officer (and not a CMT) should have the obligation to commence proceedings when there is sufficient evidence to prefer a charge (i.e. remove any consideration of discretionary factors).

- Section 148(1) should be amended to clarify that the investigation referred to is an investigation conducted under this Part, as a complaint investigation.

- Section 148(3) should be amended to ensure that where a *'police officer conducting an investigation that sufficient evidence exists to warrant the prosecution of any person for an offence'* in s148(1) it is a requirement that such proceedings not be instituted without the approval of the Commissioner regardless of whether that person is a police officer or civilian.

- The Commissioner should retain the authority as set out in 148(3) but should be required to set out in writing the reasons for not commencing proceedings. This is a key decision that can be the subject of public scrutiny and, for this reason, should be delegated no lower than Deputy Commissioner rank, and not to Assistant Commissioners or any other rank.

- Include a provision to efficiently facilitate differences of opinion between the NSWPF and Ombudsman office on the charging or not charging of a police officer (either on or off duty) or a civilian to be resolved. An effective mechanism would be for the

[7] Crown Solicitor's advice dated 15 March 2000, pg 11, paragraph 4.23

> Commissioner and Ombudsman (and not their delegates) to be subject to a statutory mandate to directly resolve the differences.

In our view, the Act should be amended to give effect to the above requirements to ensure the effective operation of the police complaints system.

## 2.13 Provide reasons for the decision to take no further action – section 148A

Section 148A(1) provides that:

> The Commissioner or the Ombudsman may, at any stage during an investigation of a complaint, decide to conclude the investigation by taking no further action with respect to the complaint.

Although Section 148A(4) requires that the complainant be advised of this decision, there is currently no requirement for the NSWPF or Ombudsman to provide reasons for deciding to take no further action. We submit the Act should be amended to require reasons to be provided to the complainant.

## 2.14 Oversight of action taken or to be taken following a complaint investigation

Section 150 currently provides:

> As soon as practicable after the investigation of a complaint has been concluded and a report of the investigation finalised, the Commissioner:
>
> (a) if practicable, must consult with the complainant before making a decision concerning any action to be taken as a result of the complaint, and
> (b) must provide the complainant with advice as to any action already taken, and as to the Commissioner's decision concerning any action to be taken, as a result of the complaint, and
> (c) must provide the Ombudsman with:
>  (i) a copy of the finalised report, and
>  (ii) advice as to any action already taken, and as to the Commissioner's decision concerning any action to be taken, as a result of the complaint, and
>  (iii) advice as to whether or not the complainant is satisfied with the action taken, or to be taken, as a result of the complaint.

Section 151 currently provides:

> **Ombudsman may request information concerning complaint and conduct complained of**
>
> (1) For the purpose of determining whether a complaint has been properly dealt with, the Commissioner must, at the request of the Ombudsman, provide the Ombudsman with the following:

(a) an explanation of the policies, procedures and practices of the NSW Police Force relevant to the conduct complained of, and
(b) such documentary and other information (including records of interviews) as the Ombudsman requests with respect to any inquiries made by the Commissioner or other police officers into the complaint, and
(c) to the extent to which the Commissioner is able to do so, any explanation, comment or information sought by the Ombudsman in connection with the complaint.

(2) The Ombudsman may withdraw the request if the Commissioner objects to providing what has been requested and the Ombudsman is satisfied that the grounds of the objection are well-founded.

(3) Instead of making such a request, the Ombudsman may, in accordance with arrangements agreed between the Ombudsman and the Commissioner, seek information from other police officers.

In the past, the NSWPF argued that the provisions of Part 8A only permit the Ombudsman to oversight the adequacy of a complaint investigation conducted by the NSWPF, and not the action taken or to be taken by the NSWPF as a result of the investigation (i.e. action taken under Part 9 of the Act). It was further argued that considering outcomes such as the taking of reviewable or non-reviewable action does not fall within the ambit of *'determining whether a complaint has been properly dealt with'*.

The Ombudsman subsequently obtained advice from the Solicitor General that this interpretation of Part 8A is incorrect. While the NSWPF has accepted the Solicitor General's advice on this issue, it is recommended that consistent amendments are made to expressly provide that the Ombudsman has the power to oversight the adequacy of the action taken or to be taken by the NSWPF as a result of the Part 8A investigation.

The solution might be to define action as *'including the taking of reviewable or non-reviewable action, systemic and procedural changes or improvements, and court/tribunal proceedings and outcomes, including settlement proceedings and outcomes'* and to amend section 151(b) to include records relating to the taking of reviewable and non-reviewable actions. Amendments in this form would be consistent with the Solicitor General's advice on the issues.

Additionally, although section 150 provides that the Commissioner must provide the Ombudsman with a copy of the final report on the investigation and advice as to any action already taken or to be taken as a result of the complaint, it does not expressly require the Commissioner to provide reasons for the findings of the investigation, or the reasons for any action already taken or to be taken. Section 150 should be amended to require reasons to be provided.

## 2.15 Ombudsman requests for a review of action taken – Section 154

Section 154 provides:

> **Ombudsman may request review of Commissioner's decision on action to be taken on complaint**
>
> (1) If the Ombudsman is not satisfied with the Commissioner's decision concerning any action to be taken as a result of an investigation (including a decision to take no further action), the Ombudsman may request the Commissioner to review the decision.
>
> (2) If the Ombudsman makes such a request, the Commissioner:
> (a) may, but is not obliged to, change the decision, and
> (b) in either case, must notify the Ombudsman of the Commissioner's decision on the request and (if the decision is not to change the decision under review) of the Commissioner's reasons for the decision.
>
> (Emphasis added)

The section appears to confine the Ombudsman to requesting the Commissioner to review action 'to be taken' as a result of the investigation – the Ombudsman cannot ask the Commissioner to review action already taken.

In many cases, the NSWPF's advice on the outcome of a complaint investigation is accompanied by advice on the action or actions taken as a result of the investigation. This is consistent with the reforms recommended by the Royal Commission into the NSWPF, which anticipated that local commanders be empowered to deal with the *'misbehaviour or shortcomings'* of subordinates and to *'act speedily and fairly to resolve'* problems as they are identified.[8]

Nonetheless, there have been instances when the Ombudsman believes that the action already taken is either too harsh or is manifestly inadequate, and that consideration should be given to taking a different action.

An amendment is needed to clarify that the Ombudsman may request the Commissioner to review his decision in relation to action already taken. In this regard it should be noted that section 154(2)(a) makes it clear that the Commissioner is not obliged to change the decision – only that he consider the Ombudsman's request.

Additionally, as we note later in this submission in the discussion at paragraph [4.1], there are amendments to section 173 that have been passed by Parliament, but are yet to be proclaimed. The effect of these amendments is to require the Commissioner to consult with the Ombudsman where the complaint was being overseen or monitored by this office (and with PIC if it was the oversight body) before making an order per section 173(2) or (3) (emphasis added).

[8] Royal Commission into the NSW Police Service, *Final Report – Volume II: Reform*, May 1997, para [4.26]

## 2.16 Complainant satisfaction with the action taken or to be taken as a result of the complaint

A complainant's level of satisfaction with how his or her complaint has been dealt with is an important measure of the effectiveness of complaint-handling processes and of public confidence in the system used by police to identify and resolve concerns.

Section 150(c)(iii) currently requires that the NSWPF must provide the Ombudsman with:

> advice as to whether or not the complainant is satisfied with the action taken, or to be taken, as a result of the complaint.

In 2012-2013, we analysed 350 complaints that were notified to us between 1 July 2012 and 30 November 2012 to assess the way that the NSWPF obtains and records information about complainant satisfaction and how that data was then used.

Our audit identified issues in the systems and processes used for recording the information currently collected by the NSWPF pursuant to section 150. We found no clear guidelines to assist police investigators to consistently determine complainant satisfaction or allow police to distinguish and record complainants' satisfaction with the process, the outcome, and the service they received. Nor was the limited information that was being collected routinely used by police to assess the effectiveness of the complaints system.

In June 2013, we provided the NSWPF's Professional Standards Command with a draft consultation report. As police must already:

- consult with the complainant before taking action as a result of the complaint (section 150(a)),
- advise the complainant of any action already taken or to be taken (section 150(b)), and
- report on the complainant's satisfaction (section 150(c)),

the report included recommendations to the NSWPF to implement measures to identify and separately record information related to these responsibilities. In general terms, this might include creating systems to record and use feedback about: the complaint investigation (*Was the process timely and fair?*); the outcome (*Was it fair and balanced?);* and customer service (*Was communication respectful and timely?).* Such information, if more reliable and accessible, could be a useful tool to assist the NSWPF to assess the effectiveness of the complaints system, inform training and inform policy development regarding complaint handling.

In order to support these changes, section 150(c)(iii) should be amended to include requirements that advice be provided as to whether or not the complainant is satisfied with the investigation process, the outcome of the complaint or action taken, and police communication during the investigation.

## 2.17 Determining the scope of 'own motion' investigations by the Ombudsman

Section 156(1) provides:

> If of the opinion that it is in the public interest to do so, the Ombudsman may make a complaint, together with any investigation of the complaint and any related issues, the subject of an investigation under the *Ombudsman Act 1974*.

The use of the words *'together with'* in this section may suggest that, where the Ombudsman initiates an investigation, the Ombudsman must investigate the complaint and the NSWPF investigation (where there has been such an investigation) and any 'related' issues.

In practice, the Ombudsman's 'own motion' investigations focus on the matters or issues that appear to require investigation. It is essential that the Ombudsman has the flexibility to determine the scope of the inquiries needed in each instance, rather than having to investigate all aspects of a complaint.

An amendment is needed to make it clear that the Ombudsman may investigate the complaint and/or the N5WPF investigation of the complaint and/or any 'related' issues.

## 2.18 Compelling police officers employed by the Ombudsman to give evidence

Section 165 provides (emphasis added):

> Neither the Ombudsman, nor an officer or special officer of the Ombudsman who is not a police officer, is competent or compellable, in any legal proceedings, to give evidence or produce documents in respect of any matter in which he or she is or was involved in the course of the administration or execution of this Part.

It appears that this provision was intended to allow any police officers currently employed by the Ombudsman, who had been previously been involved in complaint handling or complaint investigations while they were in the NSWPF, to be able to give evidence about such matters.

Yet the section is framed in such a way that police officers employed by the Ombudsman could be compelled to give evidence or produce documents about their handling of police complaint matters in the course of their employment with the Ombudsman. This would appear to be an inappropriate exception to the general immunity of Ombudsman officers from giving evidence or producing documents related to the performance of their duties under Part 8A, and should be amended.

## 2.19 Admissibility of documents

Section 170 provides:

> **Certain documents privileged**
>
> (1) A document brought into existence for the purposes of this Part is not admissible in evidence in any proceedings other than proceedings:
> (a) that concern the conduct of police officers, and
> (b) that are dealt with by the Commissioner, by the Industrial Relations Commission or by the Supreme Court in the exercise of its jurisdiction to review administrative action.
>
> (2) Subsection (1) does not apply to or in respect of:
> (a) a document comprising a complaint, or
> (b) a document published by order of, or under the authority of, the Presiding Officer of a House of Parliament or either House, or both Houses, of Parliament, or
> (c) a document that a witness is willing to produce.
>
> (3) Subsections (1) and (2) do not operate to render admissible in evidence in any proceedings any document that would not have been so admissible if this section had not been enacted.

There are questions about whether the application of this provision may pose practical problems in the effective conduct of criminal and coronial proceedings. There is no doubt that the intent behind section 170 is to ensure Part 8A documents cannot be used in civil proceedings, however section 170 has only operated to frustrate processes in connection to coronial proceedings and there is reasonable concern regarding criminal proceedings. It may also be the case that section 170 may impact the admissibility of documents that might be sought to be used for the prosecution of an offence under the 'detrimental action' provisions of the *Public Interest Disclosures Act 1994*, or proceedings seeking an injunction against detrimental action under section 20A of that Act. It would be unfortunate if the first proceedings brought under the *Public Interest Disclosures Act 1994* could not commence because of the operation of section 170.

On the basis that we cannot identify any cogent reason why this provision should apply to criminal prosecutions and coronial proceedings, we recommend that consideration be given to amending section 170(1) to include additional exceptions being for criminal prosecutions and coronial proceedings.

We also submit that the Coroner be consulted on the issue of section 170 before any decision to amend (or not) is made which relates to the coroner's jurisdiction.

## 2.20 Exercising the privilege against self-incrimination

The decision in *Baff v New South Wales Commissioner of Police* [2013] NSWSC 1205 (*Baff*) on 30 August 2013 significantly changed the presumed power of the NSWPF to direct officers, whether suspected of a criminal offence or not, to answer questions that may incriminate them. Previously, the NSWPF believed that where an officer was departmentally directed to attend an interview and ask questions that the officer must obey that direction. It was acknowledged that that interview could not be used in evidence against the officer as the evidence was given without being able to exercise the privilege against self-incrimination.

The judgment in *Baff* has changed that position. Her Honour Adamson J stated at para [111]:

> *The relevant common law privilege is available as a substantive right to persons such as the plaintiff who are suspected of, but have not been charged with, a criminal offence, from being compelled to answer questions the answers to which may incriminate them, and from being compelled to answer questions by persons in authority on the relevant subject matter. The plaintiff is suspected of a criminal offence; he has not been charged. The Commissioner, or his delegate, who has directed him to attend an interview, is both a police officer and a person in authority.*

Further, at para [115]:

> *... The Commissioner, or relevant superior officer, is entitled to direct the plaintiff to attend the interview and is entitled to ask him questions. However, once the privilege is claimed, the Commissioner or his delegate is not entitled to direct the plaintiff to answer any question in respect of which privilege has been claimed. Once the plaintiff claims the right not to answer any questions at all relating to the incident, the Commissioner or his delegate are not entitled to require the plaintiff to answer any question, whether or not the particular answer would tend to incriminate him.*
>
> (Emphasis added)

Accordingly, once the privilege is claimed, the Commissioner (or his delegate) cannot ask the subject officer any questions at all about the incident including questions about what that officer witnessed others doing.

NSWPF have released the following Complaint Practice Note 13/02 which details investigator's duties and obligations following the decision in *Baff* should an officer raise the privilege. The relevant portions are:

> In practical terms:
>
> 1. a police officer may still be directed to attend a departmental interview or answer a directive memorandum.
> 2. an investigator is still entitled to question the officer. However, once the officer claims the right not to answer any question or questions relating to the incident on the basis that they may incriminate themselves criminally, the investigator is not entitled to require the officer to answer.

It is important to note that the officer must exercise the privilege. It cannot be assumed or implied. Therefore, the officer's response and exercise of privilege should be formally recorded.

An officer may still choose to respond to a directive interview or memorandum, or may otherwise decide to voluntarily give a version of events. Evidence voluntarily provided by an officer may be used in the determination of the complaint.

Where an officer exercises the privilege, the following points are relevant.

- Whether an interview is described as criminal or non-criminal has no effect on the right to claim the privilege. The test is whether the police officer believes they may self-incriminate.
- No action can be taken against the officer by reason of his or her refusal to answer questions about an incident.
- Adverse inferences cannot be drawn as a result of the officer's refusal to answer questions.
- The claiming of the privilege does not prevent the NSW Police Force from taking departmental action on the basis of evidence collected from other sources in relation to the incident.
- Investigators should therefore ensure that all other enquiries have been exhausted and all available evidentiary sources have been considered.

It should be noted that the privilege against-self incrimination does not apply where a compulsory demand is provided for in legislation. For example, an officer will be required to submit to a breath test or drug test.

This office makes no submission as to what, if any, legislative amendment is required in response to the decision in *Baff* where an officer is suspected of committing a criminal offence.

It should be noted that the report *Oversight of Police Critical Incidents* by the Hon. Robert McClelland has recommended that consideration be given to amending the Act so that any statement made in good faith by a police officer in response to questions about their involvement in a critical incident:

(a) is not, without the consent of the police officer who gave the statement, admissible in any civil or criminal proceedings against the police officer if the proceedings relate to the conduct in connection with which the statement was made, and
(b) may not be used as the basis of taking action under Section 181D or reviewable or non-reviewable action (within the meaning of Section 173) against the police officer.

In our submission on the report by Mr McClelland we have not supported the above recommendation. If a similar proposal were to be made to deal with the issues raised by *Baff* in the context of complaint investigations, we would not, for the same reasons, support that proposal. Accordingly, if such a proposal were to be considered by the Ministry we would request the opportunity to provide submissions on what we regard as the clear problems with the operation of such a proposal.

## 2.21 Claims of privilege where there is no suspicion of involvement in a criminal offence (Baff continued)

While *Baff* is clear on the rights of an officer who is suspected of committing a criminal offence, the position of an officer who is not a suspect is unclear. As with a suspected officer, a non-suspected officer can be directed to attend an interview. However *Baff* clarified the rights of a suspected officer to claim the privilege against self-incrimination but did not clarify how the NSWPF could proceed where the right to silence is invoked by a non-suspected officer.

This office acknowledges that a blanket legislative solution may be inappropriate or unfair as the following scenarios show:

1. A non-suspected officer is directed to attend an interview and during the course of that interview his or her admissions change their status to one of being a suspect.

2. An investigator may hold certain views that a person may be a suspect but has no proof of same and so holds out that to the officer that they must answer all questions as the *Baff* protections are not available to them.

The uncertainty surrounding non-suspect officer's abilities to make a *Baff* claim has a detrimental effect on investigations where officers have witnessed criminal behaviour by a colleague but for reasons of misplaced loyalty or fear of reprisal invoke *Baff* so that they do not have to implicate their colleague.

A possible solution is that where a non-suspected officer is directed to attend an interview and they wish to invoke *Baff* they should advise the NSWPF prior to the interview. Should the NSWPF continue to make the demand on the basis that the officer is not suspected of being involved in a criminal offence, that officer can apply to the courts for a determination as to whether *Baff* is available to them.

The alternative is that the NSWPF seek a court order each time this situation arises however that is considered a costly and unworkable arrangement given the NSWPF cannot know if a person may incriminate themselves by answering questions or if they are simply refusing so as not to provide inculpatory evidence against another.

## 2.22 Mandatory notification of critical incidents

As a separate review has been commissioned on the oversight of critical incidents, we make no submission here on this topic. Our submission on the critical incident review has been submitted to the Director General of the Department of Premier and Cabinet. We have assumed that amendments to the Act regarding the oversight of critical incidents will be made in conjunction with amendments arising from this review.

# 3. Amendments to Part 9 (Management of conduct within NSW Police Force)

## 3.1 Different decisions by the Police Commissioner and the Industrial Relations Commission (IRC) on termination matters

There are have been a number of IRC cases which have highlighted the differing views between the IRC and the Commissioner of Police as to whether a person is suitable to continue in position of police officer. In these instances the Commissioner has removed a police officer under section 181D having lost confidence in the person's suitability to be a police officer, however the IRC has take the view that the decision of the Commissioner was harsh, unreasonable or unjust and in most of these cases, have reinstated the officer.[9]

As outlined in section 181D of the Act the Commissioner in making his decision has regard to the officer's competence, integrity, performance or conduct.

> **Commissioner may remove police officers**
>
> (1) The Commissioner may, by order in writing, remove a police officer from the NSW Police Force if the Commissioner does not have confidence in the police officer's suitability to continue as a police officer, having regard to the police officer's competence, integrity, performance or conduct.
>
> (Emphasis added)

Section 181E sets the circumstances under which a dismissed officer may seek a review.

> **Review generally**
>
> (1) A police officer who is removed from the NSW Police Force by an order under section 181D may apply to the Industrial Relations Commission (referred to in this Division as the "Commission") for a review of the order on the ground that the removal is harsh, unreasonable or unjust.
>
> (Emphasis added)

Section 181F sets out how the IRC should proceed.

> **Proceedings on a review**
>
> (1) In conducting a review under this Division, the Commission must proceed as follows:
> (a) firstly, it must consider the Commissioner's reasons for the decision to remove the applicant from the NSW Police Force,

[9] We have not compiled a list of cases however the NSWPF should be able to provide such a list if required.

(b) secondly, it must consider the case presented by the applicant as to why the removal is harsh, unreasonable or unjust,
(c) thirdly, it must consider the case presented by the Commissioner in answer to the applicant's case.

(2) The applicant has at all times the burden of establishing that the removal of the applicant from the NSW Police Force is harsh, unreasonable or unjust. This subsection has effect despite any law or practice to the contrary.

(3) Without limiting the matters to which the Commission is otherwise required or permitted to have regard in making its decision, the Commission must have regard to:
(a) the interests of the applicant, and
(b) the public interest (which is taken to include the interest of maintaining the integrity of the NSW Police Force, and the fact that the Commissioner made the order pursuant to section 181D (1)).

In a number of cases we do share the concern of the Commissioner with IRC decisions to reinstate officers who have demonstrated behaviour which seriously brings into question their integrity and ability to uphold the law. Police officers are entrusted with powers and authorities which far exceed what is typically afforded to another public sector employee – and the corruption and misconduct risks associated with the police profession are higher than elsewhere in the government sector.

On this issue we make no further submission as we are aware that there are number of options being considered and no doubt a lengthy submission has been made by the Commissioner of Police on this topic. We agree that changes are required and would be happy to consider any options being canvassed to address this vexed issue.

Ombudsman
New South Wales

# 4. Amendments to other Police Act provisions / interrelated Acts

## 4.1 Schedule 2.2[1] Police Integrity Commission Amendment Act 2005 No. 5

Our attention has been bought to the, as yet, uncommenced Schedule 2.2[1] of the *Police Integrity Commission Amendment Act 2005* No. 5. Schedule 2.2[1] has been drafted to insert an additional two sections 4(A) and 4(B) into section 173 of the Act.

Section 173 gives the Commissioner the power to take action with regard to misconduct or unsatisfactory performance. Such action includes a reduction in rank or grade, a reduction in seniority, a deferral of a salary increment or any other action (other than dismissal or imposition of a fine) that the Commissioner thinks appropriate. The Commissioner may take such action whether or not the misconduct or unsatisfactory performance has been the subject of a Part 8A complaint (or criminal charges).

Currently built into section 173 are safeguards against the misuse of these powers per subsection (5) in which the Commissioner must serve notice on the subject police officer identifying the conduct upon which he intends to make a proposed order, the subject police officer must also be given seven days to serve notice that he/she intends to make written submissions regarding the proposed order and if so, the Commissioner must take into consideration those submissions prior to making any order.

Division 1A and particularly s174 of the Act also provide some protection for subject police officers for a review by the Industrial Relations Commission where he/she can show that the order for reviewable action was outside the powers of the Commissioner or unduly harsh, unreasonable or unjust.

Schedule 2.2[1] seeks to insert an additional condition on the use of the Commissioner's power in that prior to making an order per section 173(2) or (3), where the subject police officer was the subject of a complaint per Part 8A, the Commissioner must consult with the Ombudsman where the complaint was being overseen or monitored by this office (and with PIC if they were the oversight body) before making such an order (emphasis added).

In terms of the PIC, s184A of the Act already mandates that where a subject officer is the subject of a PIC investigation the Commissioner *must* consult with PIC prior to making any orders per s173(2) or (3) or s181D.

It would appear that the new s173(4A) is a complementary section for this office enabling us the same consultation powers as PIC, but for the additional power for PIC to be consulted on decisions made per s181D. The second reading speech confirms this. It should be noted that PIC oversee a far smaller number of complaints than this office.

It is our view that Schedule 2.2[1] is consistent with our role under Part 8A and more particularly section 154, and should be commenced.

## 4.2 Interaction between the Police Act and the Industrial Relations Act

Section 80(3) currently provides:

> *The Commissioner may dismiss any such probationary police officer from the NSW Police Force at any time and without giving any reason.*

Section 218 current provides:

> **218 Industrial Relations Act 1996 not affected**
>
> (1) The *Industrial Relations Act 1996* is not affected by anything in this Act.
> (2) Subsection (1) does not limit section 44 or 89 or any provision of the *Industrial Relations Act 1996*.

From a summary of the High Court's decision in *Commissioner of Police v Eaton & Anor* [2013] HCA 2:

> On appeal by special leave to the High Court, the appellant submitted that the terms of s 80(3) of the *Police Act* were inconsistent with a right to review under the IR Act. The Court, by majority, agreed and allowed the appeal. The majority held that the *Police Act* indicated a legislative intention that a decision made under s 80(3) to dismiss a probationary police officer was not to be subject to review by the IR Commission. This was indicated in several ways including the manner in which s 80(3) was framed, suggesting as it did that the appellant's power to dismiss was unfettered. There was incoherence between reasons not being required by s 80(3) and the matters to be considered by the IR Commission in determining an unfair dismissal claim and, in addition, the relief available under the IR Act was at odds with the appellant's right under s 80(3) to dismiss. The majority also considered that an anomalous position would result if probationary police officers were given greater procedural rights under the IR Act's unfair dismissal regime than confirmed police officers whose unfair dismissal claims are regulated by the *Police Act*.

We support a proposal to amend or repeal section 218 in accordance with the decision of the High Court.

## 4.3 Inconsistencies between the Act and Public Interest Disclosures Act

There are many inconsistencies between the Act and the *Public Interest Disclosures Act 1994* (PID Act) which need to be addressed at some stage. For example, section 20 of the PID Act makes it a criminal offence for a person to take detrimental action against a person that they believe or suspect has made a public interest disclosure. Section 206 of the Act makes it a criminal offence for a police officer to take detrimental action against a person who has made a "protected allegation" about a police officer (a "protected allegation" can include a public interest disclosure about the conduct of a police officer). However, there is no

criminal offence committed where the detrimental action was taken against someone that the police officer believe or suspected has made the protected allegation.

The penalty for a criminal offence under section 20 of the PID Act is twice that applicable under that section 206 of the Police Act.

In our view, this review is not the forum for dealing with the range of issues relating to the operation of the Act and the PID Act. However, it would be an appropriate interim measure to amend the Act (section 206(4)) to provide that the PID Act takes precedence over the Act where there is a conflict.

Earlier at [2.4] of this submission, we recommend amendments to clarify the obligations on police officers to reduce verbal complaints to writing. If implemented, a police officer who submits a report about a verbal complaint should not become the 'complainant' merely because he or she reduces an allegation or information to writing. However, as we also noted at [2.4], care is required to ensure that such an amendment does not remove important protections afforded under section 206 of the Act and section 20 of the PID Act. In our view, both Acts should be amended to provide that a police officer who registers information on the police complaints systems should attract all the protections afforded to a person who makes the disclosure directly.

### 4.4 Disclosure of confidential information

The Police Act does not contain an offence provision relating to the improper disclosure of information by police. Currently, such conduct may involve an offence under section 62 of the *Privacy and Personal Information Protection Act 1998* or the common law offence of misconduct in public offence.

Given the access of police to a wide arrange of confidential information and the need to maintain public confidence in the NSWPF a new offence provision should be added to the Police Act relating to improper disclosure of information by police or by other NSWPF employees.

# Annexure B

Ombudsman Special Report into monitoring of the police investigation into the-death-of-Roberto-Laudisio-Curti-February-2013

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*

**February 2013**

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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**

# Contents

# Executive summary

## 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 Tasars 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

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. ....30**

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. ....31**

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. ....31**

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. ....46**

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. ....46**

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. ...49**

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. ....49**

# 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 wes 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' 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 Merch 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 crimnal 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 requira 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 intarviews 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 intarviews 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. Coroniel 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 ection 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 incidants 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 investigetion enabled us to raise arees 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 fect 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].
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7. NSW Ombudsman, Media Release, 'Ombudsman confirms independent oversight of the Police Taser investigation', 20 March 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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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.
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66. *Police Integrity Commission Act 1996*, s.70(5).
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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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# Annexure C

NSW Ombudsman submission to the review of the investigation and oversight of police critical incidents 15 October 2013

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15 October 2013

The Honourable Robert McClelland

C/- Mr David Cramsie
Principal Policy Analyst
Ministry for Police and Emergency Services
david.cramsie@mpes.nsw.gov.au

Dear Mr McClelland

**Ombudsman submission to your review of the investigation and oversight of police critical incidents**

I refer to your email of 25 September 2013 inviting a submission from my organisation to assist you to conduct the above review.

Please find attached the NSW Ombudsman submission to your review.

Please do not hesitate to contact me further if you wish to discuss any aspect of the submission.

Yours sincerely

Bruce Barbour
**Ombudsman**

Ombudsman
New South Wales

# NSW OMBUDSMAN SUBMISSION TO THE REVIEW OF THE OVERSIGHT OF POLICE CRITICAL INCIDENTS CONDUCTED BY THE HONOURABLE ROBERT MCCLELLAND

## Introduction

The death or serious injury to persons during policing activities attracts significant public and media interest. The government, community and the families of victims expect that there will be thorough and impartial investigations into such incidents to establish what occurred, whether there was wrong-doing by any involved person and to take timely and appropriate action to address any identified shortcomings in police systems and procedures.

The NSW Ombudsman accepts that the NSW Police Force ('NSWPF') has unique skills, expertise, and resources to effectively investigate incidents involving the death or serious injury to persons during policing activities. It is appropriate for the NSWPF to investigate the actions of its officers involved in critical incidents given that it has primary responsibility for investigating and addressing any identified criminal conduct, misconduct by officers, or deficiencies in police policy, procedures, practices, training or systems.

In order to ensure public confidence in NSWPF critical incident investigations involving the death or serious injury to persons during policing activities, it is essential that there be a robust and effective system of external independent oversight of these investigations.

It is the view of the NSW Ombudsman that the current system of oversight of critical incident investigations does not provide an adequate level of accountability, transparency, and external independent scrutiny of those aspects of the critical incident investigation concerned with police misconduct and systemic and procedural matters. The reasons for this position are articulated throughout this submission.

### The investigation of critical incidents by the NSWPF

The NSWPF has developed *Critical Incident Guidelines* to assist in the management, investigation and review of critical incidents.

A critical incident is defined as:[1]

> 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

[1] NSWPF, *Critical Incident Guidelines*, August 2012, Version 5, p.9.

- 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 *Critical Incident Guidelines* contain the following message that outlines the intent and purpose of the guidelines:[2]

> 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 *Critical Incident Guidelines* state under the heading 'Scope':[3]

> 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] NSWPF, *Critical Incident Guidelines*, August 2012, Version 5, p.6.
[3] NSWPF, *Critical Incident Guidelines*, August 2012, Version 5, p.8.

The *Critical Incident Guidelines* contain the following instructions about how critical incidents are to be investigated:[4]

> The SCII *[Senior Critical Incident Investigator]* will lead a team in the investigation of all critical incidents. The primary role of the SCII is to ensure critical incidents are rigorously and thoroughly investigated.
>
> The CIITs *[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.
>
> The investigation of any criminal offences that may have been committed outside of the critical incident may be undertaken by local police or a specialist investigation team separate to the CIIT.
>
> These two investigations will generally be conducted in parallel. While the two investigations are ultimately addressing distinct issues, crossovers between the two may occur. How the evidence for the respective investigations is to be obtained in such circumstances should be determined by consultation between the two investigation teams prior to undertaking this process.

and:

> The CIIT 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.[5]

## Current roles of agencies during a critical incident

Police officers are required to exercise extraordinary coercion which sometimes involves the use of pursuit, restraint, and other applications of force supported by appointments such as handcuffs, batons, OC spray, Tasers and firearms. It is therefore appropriate that the actions of police officers are thoroughly investigated and subject to both internal and external review, particularly when the use (or misuse) of this coercion is in connection with the death or serious injury to persons during policing activities.

The following is an outline of the statutory roles of the various agencies involved in critical incidents. The nature and extent of the role and involvement of agencies will vary depending on the circumstances surrounding the critical incident. The outline will be referred to when discussing the specific issues under review.

### NSWPF's role

The NSWPF provides 'police services' which include the prevention and detection of crime and protecting people from injury or death.[6] The Commissioner of Police is responsible for the management and control of the NSWPF,[7] including the investigation of critical incidents as outlined in the *Critical Incident Guidelines*.

The Commissioner of Police (and his delegates) may take to take a range of actions under Part 9 of the *Police Act 1990* to address any misconduct or unsatisfactory performance of police officers. The Commissioner of Police may take action whether or not the misconduct or

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[4] NSWPF, *Critical Incident Guidelines*, August 2012, Version 5, p.26.
[5] NSWPF, *Critical Incident Guidelines*, August 2012, Version 5, p.28.
[6] *Police Act 1990*, s.6
[7] *Police Act 1990*, s.8.

unsatisfactory performance has been the subject of a complaint under Part 8A of the Police Act and whether or not the police officer has been prosecuted or convicted of an offence in relation to the misconduct or unsatisfactory performance.[8]

The purpose of critical incident investigations is to establish what occurred by collecting evidence from the police officers involved and other witnesses and sources. The collection of evidence serves important yet, separate purposes:

- it enables the NSWPF to identify and take timely and appropriate action to address any criminal conduct, misconduct by officers or deficiencies in policy, procedures, practices, training or systems, and

- in the case of a critical incident involving a death, it enables the NSWPF to gather evidence to assist the Coroner conduct an inquest to establish and make findings about the identity of the deceased person and the circumstances of the person's death.

It is important to recognise that the question of criminality is one for police to investigate, and for the Office of the Director of Public Prosecutions to consider. Police are responsible and have the statutory authority to conduct an investigation to obtain the proofs for the elements of a criminal offence and to prefer a charge. Police cannot be directed by the Coroner on this aspect of their critical incident investigation.

The death of a person involved in a critical incident must be reported to the Coroner by the NSWPF.[9]

The Coroner has no role where a person involved in a critical incident incurs serious or other injury.

A senior coroner, being the State or a Deputy State Coroner,[10] is required to hold an inquest into the death of a person during policing activities.[11] The State or Deputy State Coroner has the discretionary power to give directions, including directions to police officers, concerning investigations to be carried out for the purposes of any coronial proceedings or proposed coronial proceedings.[12] In practice, the critical incident investigation team gathers the majority of evidence and prepares a brief of evidence without the need for formal directions from the State or Deputy State Coroner.

The main statutory function of the Coroner is to hold an inquest to establish and make findings about:[13]

- the death of the person

- the identity of the deceased person

[8] *Police Act 1990*, s.173(4).
[9] *Coroners Act 2009*, s.35(1).
[10] *Coroners Act 2009*, s.22.
[11] *Coroners Act 2009*, s.23 & s.27(b).
[12] *Coroners Act 2009*, s.51(1) & s.51(2).
[13] *Coroners Act 2009*, s.81(1).

- the date and place of the person's death, and

- the manner and cause of the person's death.

The Coroner may also make recommendations considered necessary or desirable in relation to any matter connected with the death.[14] The Coroner may make recommendations about public health and safety or that a matter be investigated or reviewed by a specified person or body.[15] The Coroner may or may not make recommendations concerning police conduct issues that are relevant to the manner and cause of death.

The Coroner is not responsible for investigating whether any criminal offences have occurred as this would be incompatible with the judicial function exercised by the Coroner and is the responsibility of the NSWPF.

If a person has been charged by the NSWPF before or during the inquest with an indictable offence that raises the issue of whether the person caused the death, then the Coroner may only conduct the inquest for the purpose of taking evidence to establish the death; the identity of the deceased person; and the date and place of death and must thereafter suspend the inquest.[16]

If at any time during the course of an inquest, the Coroner forms the opinion, having regard to all of the evidence given up to that point in time, that:

- the evidence is capable of satisfying a jury beyond reasonable doubt that a known person had committed an indictable offence, and

- there is a reasonable prospect that a jury would convict the known person of the indictable offence, and

- the indictable offence would raise the issue of whether the known person caused the death with which the inquest is concerned

then the Coroner may suspend the inquest (this is the usual course of action) or the Coroner may continue the inquest and make and record findings and recommendations. The Coroner is required to forward to the Director of Public Prosecutions the evidence adduced at the inquest and a written statement signed by the Coroner that specifies the name of the known person and the particulars of the indictable offence concerned.[17]

Any written record of the findings and recommendations made by the Coroner must not indicate or in any way suggest that any person has committed an offence.[18]

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[14] *Coroners Act 2009*, s.82(1).
[15] *Coroners Act 2009*, s.82(2).
[16] *Coroners Act 2009*, s.78(1)(a) & s.78(2).
[17] *Coroners Act 2009*, s.78(1)(b), s.78(3) & s.78(4).
[18] *Coroners Act 2009*, s.82(3).

The WorkCover Authority of NSW (or WorkCover) is responsible for the promotion of productive, healthy and safe workplaces for workers and employers in NSW. WorkCover is also responsible for administering and ensuring compliance with work health and safety laws.

Under the *Work Health and Safety Act 2011*, the NSWPF has an obligation to immediately notify WorkCover about any death, serious injury or illness, or dangerous incident that occurs to an employee, contractor or member of the public as a result of policing activities or operations (that is, an incident arising out of the work carried out by a business or undertaking or workplace).[19]

WorkCover has the power to investigate and prosecute breaches of work health and safety laws. In practice, if there is an indication or suggestion that the incident involves criminal conduct, then WorkCover works collaboratively with the NSWPF to investigate the incident as WorkCover only has the power to prosecute breaches of work health and safety laws.[20]

If the incident involves a death, the Coroner will determine the manner and cause of death of the person while WorkCover investigates and prosecutes any breaches of work health and safety laws that may have caused or contributed to the death.

Our primary role in the police complaints system is to oversight the handling of more serious complaints about police officers. The NSWPF has primary responsibility for investigating and resolving complaints about police officers in a timely and effeetive manner and we ensure that complaints have been properly dealt with by the NSWPF.

We are able to specify matters that need to be examined or taken into consideration by the NSWPF when investigating a complaint.[21] We oversight complaints by reviewing finalised investigation reports to ensure that the investigation, findings made and any action to be taken (including no action) is appropriate in all of the circumstances.[22]

If we are not satisfied with the investigation or actions taken, we can request further information or explanation,[23] request further investigation[24] or request a review of any action to be taken.[25] In addition, we can prepare a report for the Commissioner of Police and Minister for Police outlining our concerns about the complaint investigation or a particular decision.[26] Where it is in the public interest to do so, we can also prepare a special report to Parliament which may be made public by the Parliament.[27]

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[19] *Work Health and Safety Act 2011*, Part 3 'Incident notification'.
[20] Pursuant to a Memorandum of Understanding between the Chief Executive Officer of the WorkCover Authority of NSW and the Commissioner of Police.
[21] *Police Act 1990*, s.145(1)(b).
[22] *Police Act 1990*, Division 6 of Part 8A.
[23] *Police Act 1990*, s.151.
[24] *Police Act 1990*, s.153.
[25] *Police Act 1990*, s.154.
[26] *Police Act 1990*, s.155.
[27] *Police Act 1990*, s.161.

We can directly investigate a complaint and/or the complaint investigation if we determine it is in the public interest to do so.[28] We can also initiate an 'own motion' investigation if it appears that the conduct of a police officer could be, but is not, the subject of a complaint.[29] However, we would not exercise our 'own motion' power in relation to a critical incident given that the NSWPF has primary responsibility for investigating critical incidents, which includes gathering evidence and preparing a brief of evidence for the Coroner in cases involving deaths.

We can also monitor the progress of a complaint investigation if we are of the opinion that it is in the public interest to do so.[30] 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.

We are only able to oversight and monitor a critical incident investigation if a member of the public or a police officer makes a complaint under Part 8A of the Police Act about a police officer involved in the critical incident. In practical terms, this has meant that under the current system very few critical incidents involving the death or serious injury to persons during policing activities are oversighted by this office.

### Police Integrity Commission's role

The Police Integrity Commission's principal functions are to detect, investigate and prevent police misconduct, and as far as practicable, it is required by law to turn its attention principally to serious police misconduct by NSW police officers.[31]

The Police Integrity Commission is unlikely to oversight the investigation of critical incident investigations by the NSWPF given its principal function in the detection and investigation of serious misconduct and corruption.

Recent experience has shown that the Police Integrity Commission only becomes involved in critical incidents when other agencies such as the Coroner have identified serious misconduct issues during the investigation of critical incidents (e.g. Operation Calyx).[32]

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[28] *Police Act 1990*, s.156.
[29] *Police Act 1990*, s.159.
[30] *Police Act 1990*, s.146.
[31] *Police Integrity Commission Act 1996*, s.13.
[32] Operation Calyx examined the critical incident investigation into the death of Adam Salter. There was no complaint made in this matter, so the investigation had no independent and external oversight.

## Specific issues under review

### A. Whether the NSW Police Force *Critical Incident Guidelines* provide adequate guidance and clarity to ensure critical incident investigations are rigorous, timely and objective;

The current *Critical Incident Guidelines* prescribe processes that have the potential to result in rigorous, timely and objective investigations that are appropriately managed and reviewed by senior officers of the NSWPF.

However, while the current guidelines prescribe reasonably adequate processes, the failure of critical incident investigators and review officers to perform the roles and functions prescribed in the guidelines in some instances has led to inadequate investigations attracting criticism by a Deputy State Coroner,[33] the NSW Ombudsman[34] and the Police Integrity Commission.[35]

Non-compliance with the processes prescribed in the guidelines defeats the intent and purpose of the guidelines. The most thorough and comprehensive guidelines will not result in a transparent and accountable critical incident investigation unless there is:

- a genuine commitment by the critical incident investigators and review officers to faithfully adhere to the requirements of the guidelines in a timely and effective manner
- an appropriate level of internal review and independent external oversight to ensure that any non-compliance with the guidelines is able to be identified at the earliest available opportunity, and
- a preparedness by the executive level of the NSWPF to address any identified non-compliance with the guidelines or issues raised by external oversight agencies.

Any non-compliance with the guidelines that is not properly addressed by the NSWPF has the potential to erode public confidence in the ability of the NSWPF to impartially and objectively investigate critical incidents.

In our February 2013 report on the *Ombudsman monitoring of the police investigation into the death of Roberto Laudisio-Curti* we made recommendations aimed at strengthening the guidelines. Recommendations 4 and 5 sought to address specific instances of non-compliance with the guidelines by the critical incident investigators and review officers. In particular, recommendations 4 and 5 sought to address the failure of critical incident investigators and review officers to properly examine, identify and address any conduct or systemic issues *before* the inquest into the death of Mr Laudisio-Curti.

During our monitoring of the critical incident investigation into the death of the Mr Laudisio-Curti, the NSWPF suggested that it was not appropriate to examine and address any identified criminal conduct or misconduct before the inquest, and that to do so would be to act

[33] Magistrate Scott Mitchell, Deputy State Coroner, Findings of the inquest into the death of Adam Quddus Salter, 14 October 2011.
[34] NSW Ombudsman, *Ombudsman monitoring of the police investigation into the death of Roberto Laudisio-Curti*, February 2013.
[35] Police Integrity Commission, Report to Parliament – Operation Calyx, June 2013.

peremptorily, exposing the NSWPF to criticism. The NSWPF also raised the potential for relevant material to be first disclosed by witnesses at the coronial inquest as another reason why criminal and misconduct matters could not be dealt with prior to the coronial inquest. The NSWPF did not indicate whether this was its interpretation of the guidelines or whether it had formed the view that the guidelines are incorrect. In any case, it is evident that the guidelines require further clarification on these issues.

In our view, critical incident investigators should investigate and address any criminal conduct, misconduct and systemic issues (such as deficiencies in policy, procedure, practice or training) in a timely and effective manner and should not wait until after an inquest has been finalised given that inquests usually take months and sometimes years to be finalised.

The argument that the NSWPF would be acting peremptorily or be subject of criticism for charging a person with a criminal offence or making findings on police misconduct prior to a coronial inquest has no basis. Once the NSWPF has evidence of a criminal offence occurring and has established the necessary proofs for the charge to be made, they should, as they would in any other investigation (which would similarly come before a court), prefer the charge.

Whether it is a coronial proceeding or a court matter, there is always the possibility of new evidence emerging – this is not a basis to not charge a person with a criminal offence, provided that, at the time of charging, it is reasonable to consider that there is sufficient admissible evidence to support the charge. Similarly a finding that a police officer has engaged in misconduct (e.g. used excessive force) has no bearing on the Coroner's function to make findings relating to the death of a person. There is no legal or public policy reason that misconduct findings cannot or should not be made prior to a coronial proceeding.

While we appreciate that the Coroner may direct that police officers conduct certain investigations for the purpose of any coronial proceedings or proposed coronial proceedings, the Coroner has no statutory authority to direct the NSWPF to not fulfil other responsibilities such as identifying and addressing any criminal conduct, misconduct or systemic issues that are encountered during a critical incident investigation.

It is the responsibility of the NSWPF — and not the Coroner — to investigate and take appropriate action to address any identified criminal conduct. It would not be appropriate for the Coroner, a judicial officer, to formally direct the NSWPF on how to conduct a criminal investigation given that the NSWPF is responsible for investigating any criminal conduct.

The Coroners Act specifically envisages that before or during an inquest the NSWPF may charge a person with an indictable offence that raises the question of whether the person caused the death that is the subject of the inquest.

In addition, if sufficient evidence of an indictable offence emerges during an inquest, the Coroner may suspend the inquest and refer the matter to the Director of Public Prosecutions for consideration of charges. Any inquest is only commenced or resumed once issues of criminal conduct have been finally determined, which demonstrates the reasons why critical incident investigators should endeavour to identify and take appropriate action to address any criminal conduct at the earliest opportunity.

It is also the responsibility of the NSWPF — and not the Coroner — to investigate and take appropriate and timely action to address any identified misconduct. The Commissioner of

Police (or his delegates) and not the Coroner has the statutory power under Part 9 of the Police Act to take action with respect to a police officer's misconduct or unsatisfactory performance. Any significant delay by the Commissioner of Police (or his delegate) to take action in response to a police officer's misconduct would be unfair to the officer and may be considered harsh, unreasonable or unjust upon review.[36]

The Commissioner of Police is responsible for the management and control of the NSWPF. This includes taking timely action to address any identified systemic issues such as deficiencies in policy, procedures, practices and/or training.

In our view, there is no impediment for the NSWPF to take timely and appropriate action to address any criminal conduct, misconduct or systemic issues identified during critical incident investigations involving the death of a person which will be examined by the Coroner.

Coronial inquests are usually not finalised for many months and sometimes years after the incident that led to the death occurred. For this reason it is incumbent on the NSWPF to identify and take (or at least recommend) timely and appropriate action (or interim action) to address any identified criminal conduct, misconduct or deficiencies in policy, procedures, practices and/or training.

While the Coroner may recommend that certain matters such as officer conduct or systemic issues be reviewed by a specified person (such as the Commissioner of Police) or body (such as the Police Integrity Commission or the NSW Ombudsman) at the conclusion of an inquest, this is not the primary function of the Coroner. Nor is there any guarantee or requirement for the Coroner to consider police conduct unless it relates to determining the manner and cause of death.

In any event, if the NSWPF takes timely and appropriate action to address any identified criminal conduct, misconduct or other deficiencies before the inquest, the Coroner may not have to make recommendations about these matters. In addition, taking timely and appropriate action would remove potential risks to the organisation. For example, if the critical incident investigation identified that an officer required re-training in the use of appointments (such as a Taser); any delay in conducting the re-training may result in further improper uses by the officer.

It is also worth noting that during our monitoring of the critical incident investigation into the death of Mr Laudisio-Curti, the NSWPF also suggested that the critical incident investigation was being conducted on behalf of the Coroner and that the coronial inquest is part of the investigatory process undertaken by the NSWPF. Both of these points are incorrect. The critical incident investigation is not conducted on behalf of the Coroner (as stated previously, it can and does serve multiple functions). Nor is it correct to state that the coronial inquest is part of the police investigation process – the coronial inquest is a separate, independent judicial process and is not part of the executive arm of government (which the NSWPF is).

In summary, it is our view that the *Critical Incident Guidelines* can be further enhanced to provide the guidance needed to ensure that investigations are rigorous, timely and objective.

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[36] *Police Association of New South Wales on behalf of Adam Tregonning, and New South Wales Police Service* [2000] NSWIRComm 14; *Police Association of New South Wales (on behalf of Kim Gilmour) and Commissioner of Police* [2009] NSWIRComm 51; *Burrows v Commissioner of Police; Giardini v Commissioner of Police* [2001] NSWIRComm 333; and *Owens v New South Wales Police Service* (1998) 87 IR 1.

In particular, greater clarification about the precise roles of the NSWPF and the Coroner during critical incident investigations involving deaths is required, as well as clearly articulated specifications as to when certain investigative functions ought to be carried out (i.e. the timing for criminal charges, findings of misconduct, and recommendations to address systemic and procedural weaknesses). However, it is equally if not more important, to recognise that the most clearly articulated guidelines will have no benefit if critical incident investigators and review officers fail to comply or adhere to the requirements of the guidelines.

B. Whether operational, legal and other barriers exist to the NSW Police Force publicly reporting the outcomes of critical incident investigations, and how these may be resolved;

The public reporting of outcomes of critical incident investigations will go some way to enhancing accountability and transparency and engendering public confidence in the process. However, it is unclear whether such reporting could extend to publishing the full contents of all critical investigation reports given the potential to:

- impact on the privacy and/or reveal the identities of involved officers, victims and civilian witnesses
- prejudice criminal proceedings where charges are outstanding
- influence the handling on any subsequent departmental investigations, or
- reveal confidential police information or methodologies.

In some instances it may not be possible to make the outcomes of critical incident investigations publicly available until the finalisation of criminal, coronial and/or disciplinary proceedings. In some cases it may be that only a redacted version of the final critical incident investigation report can ever be published. It should also be noted that these reports are not finalised until after the completion of criminal and coronial proceedings so there can be significant delays of months or years depending on the matter. The delay in publicly reporting outcomes of critical incident investigations may lead to some public disquiet as the reasons for the delay may not be easily explained or readily appreciated by persons or organisations with an interest in the outcome.

It is the view of this office that the reporting of outcomes in each individual matter (by way of releasing the full critical incident investigation report, a redacted version or a summary) needs to be dealt with on a case-by-case basis and in consideration of the above issues.

C. Whether improvements can be made to the oversighting of critical incidents to guarantee accountability and transparency, including:

i. how and when oversight responsibilities are allocated between different agencies,

ii. what gives rise to, and the purpose of, that oversight, and

iii. whether there is any unnecessary duplication of roles or responsibilities;

There is a significant public interest in ensuring that all critical incidents involving the death or serious injury to persons during policing activities are conducted in an impartial, accountable and transparent manner.

A system of robust, independent, external oversight of critical incident investigations conducted by the NSWPF will engender public confidence and allay understandable concerns about police investigating the conduct of other police.

In order to improve accountability and transparency, the current system requires some modification to ensure that this office is able to make informed decisions about whether it is in the public interest to oversight (and, where appropriate, monitor) a critical incident investigation from the outset.

We submit that it would be appropriate for this office to have the capacity to oversight any critical incident investigation if we form the view that it is in the public interest to do so having regard to the available facts at the time of the critical incident.

It is our view that our capacity to oversight critical incident investigations from the outset should not be limited to matters where a complaint has been made about the conduct of a police officer involved in a critical incident.

We are well-placed to ensure that the NSWPF conducts impartial and thorough critical incident investigations that are accountable and transparent given our considerable skills, expertise and experience in oversighting the investigation of complaints conducted by the NSWPF and other agencies.

The Police Integrity Commission would retain responsibility for detecting and investigating any serious misconduct or corruption that occurred during a critical incident investigation which may be identified by this office during our oversight of the investigation, by the Coroner during a coronial inquest, or by any other person or agency.

The purpose of our oversight of critical incident investigations would be to ensure that the NSWPF conducts an impartial and thorough investigation that determines what occurred in a timely and effective manner. We would also ensure that investigators appropriately identify and address any criminal conduct, officer misconduct or deficiencies in NSWPF policy, procedures, practices, training or systems.

In order to make informed decisions about whether to oversight (and where appropriate monitor) a critical incident investigation, we would require the NSWPF to immediately notify

this office of all critical incidents involving the death or serious injury of persons during policing activities.

This mandatory notification would include all currently available details of the incident and surrounding circumstances to enable us to make a preliminary assessment of what, if any, involvement we will have in the critical incident. We are not proposing to oversight all critical incident investigations without an increase in funding and resources.

The Government has announced that the Commissioner of Police will advise this office of all critical incidents, not only those that are subject to a formal complaint. The NSWPF has determined to do this by simply adding the Ombudsman to its media distribution list and as such this office only receives the same information deemed suitable by the NSWPF to be released publicly through the media. Without any additional powers, we are still unable to oversight those critical incidents that are not the subject of a complaint.

In order for us to effectively oversight (and, where appropriate, monitor) any critical incident investigation where we determined it was in the public interest to do so, we would require additional powers similar to those contained in Part 8A of the Police Act, including the power to:

- specify matters that need to examined or taken into consideration by the investigation (see s.145(1)(b) of the Police Act)
- monitor the critical incident investigation, including attendance at any interviews (see s.146 of the Police Act)
- require information, documents and explanations be provided in a timely manner (see s.151 of the Police Act), including unfettered access to police information systems so as to minimise the impact that Ombudsman information requests might have on police investigators
- request further investigation by specifying reasons for the request (see s.153 of the Police Act)
- request that certain decisions be reviewed (see s.154 of the Police Act)
- prepare a report (including an interim report) to be provided to the Commissioner of Police and Minister for Police containing such comments and recommendations as the Ombudsman considers appropriate in relation to the investigation or decision (see s.155 of the Police Act), and
- make a special report to Parliament on any matter arising out of the exercise of the of the Ombudsman's critical incident oversight functions (see s.161 of the Police Act).

In addition, there needs to be a legislative mechanism for resolving any disagreements about the handling of the critical incident investigations. If the critical incident investigators fail to implement suggestions or recommendations made by the Ombudsman, the Commissioner of Police should be required to set out in writing the reasons for any actions (including no action) or decision/s. This requirement should be set out in the legislation and not subject of delegation.

In our view, the proposed modification to the system of oversight of critical incident investigations will not result in any unnecessary duplication of roles or responsibilities. The serious nature of critical incidents means that there is always a potential for a number of agencies with different roles and responsibilities to be involved in critical incidents at various points in time.

The NSWPF will continue to conduct critical incident investigations and prepare briefs of evidence for the Coroner in cases involving deaths.

The NSW Ombudsman will continue to oversight (and where appropriate monitor) critical incident investigations to ensure that the NSWPF conducts thorough and impartial critical incident investigations and that any criminal conduct, officer misconduct or other deficiencies are identified and addressed in a timely manner.

The Coroner, assisted by Counsel Assisting and the Crown Solicitor's Office, will continue to determine the identity, date, place and manner and cause of death of persons during policing activities and where appropriate recommend that a specified person or body investigate or review matters identified by the Coroner.

WorkCover will continue to investigate and take appropriate action to address any issues of workplace health and safety.

The Police Integrity Commission will continue to detect and investigate instances of serious misconduct and corruption, including instances that are identified during critical incident investigations.

We note that perceptions of duplication can occur when the NSWPF fails to conduct an appropriate critical incident investigation and the Police Integrity Commission subsequently investigates the failings and deficiencies of the investigation.

In the case of the investigation into the death of Roberto Laudisio-Curti, the NSWPF conducted the critical incident investigation that was oversighted by this office. At the conclusion of the coronial inquest into Mr Laudisio-Curti's death, the State Coroner recommended that certain officer conduct issues be referred to the Police Integrity Commission.

The recommendation by the State Coroner had the ability to create the perception of duplication because it resulted in yet another agency becoming involved in the matter. However, the involvement of a further agency in the matter was the direct result of the NSWPF failing to adequately identify and address conduct issues before the inquest. This failing was the central criticism we made in our special report to Parliament concerning the police investigation into the death of Mr Laudisio-Curti.

## D. The need for amendments to relevant legislation, or practices or procedures (such as Critical Incident Guidelines) to be given further consideration by the Government.

### Legislative changes

As outlined above at C., any enhanced role of the NSW Ombudsman in the oversight of critical incident investigations would require legislative amendment so as to provide for additional powers.

In our view, these powers should sit outside Part 8A of the Police Act to ensure that any oversight of critical incidents by this office is seen as being separate and distinct from our complaints oversight function.

We recognise that not all critical incidents will raise officer conduct issues and for this reason it is preferable to have a complementary suite of powers outside of the complaints framework in Part 8A of the Police Act.

If the Government adopts the proposal we submit that this office should be consulted in the drafting of the legislation.

### Changes to the Critical Incident Guidelines

Our monitoring of the critical incident investigation into the death of Roberto Laudisio-Curti revealed that the NSWPF had some fundamental misconceptions about the proper roles and functions of the various agencies that may have some involvement in critical incidents.

For example, the NSWPF suggested that the Coroner was responsible for the critical incident investigation and appeared unable to appreciate that the investigation served a number of purposes. The NSWPF also suggested that the involvement of multiple agencies (the Coroner, Counsel Assisting the Coroner, the Crown Solicitors Office and the NSW Ombudsman) caused confusion, conflict and inefficiency.

In our view, there appears to be a need for greater clarity and understanding about the respective roles and responsibilities of the various agencies that may have some involvement in critical incidents. Accordingly, it would be useful for the *Critical Incident Guidelines* to contain a section that accurately details the respective roles and functions of the various agencies involved in critical incidents. This section would assist critical incident investigators to understand and appreciate the respective roles and responsibilities of all agencies that may have some involvement in critical incidents. The section should also allay any concerns about unnecessary duplication.

# Annexure D

NSW Ombudsman response to the report by the Hon Robert McClelland on the Oversight of Police Critical Incidents Jan 2014

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Attention: Ms Mandy Young
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Dear Mr Eccles Chris,

**NSW Ombudsman response to the report *Oversight of Police Critical Incidents* by the Hon Robert McClelland**

Thank you for giving me an opportunity to provide feedback on Mr McClelland's report and the recommendations contained therein.

I am pleased that Mr McClelland has endorsed recommendations (vi) and (vii) in my special report to Parliament on the *Ombudsman monitoring of the police investigation into the death of Roberto Laudisio-Curti*. I note the widespread support for additional oversight of critical incident investigations outlined in his report.

I welcome the fact that Mr McClelland has recommended that the Government consider the creation of a mandatory notification scheme with additional oversight powers for my office. Clearly, any expansion of statutory powers will need to be carefully considered to ensure that they will work effectively in practice. I therefore anticipate that there will be detailed consultation with my office before any proposed legislative changes are considered by Parliament.

That said, I wish to advise that I have significant concerns about the proposed model of oversight outlined in Mr McClelland's report. In my submission to Mr McClelland's review, I detailed what I believe to be the minimum necessary requirements for a robust and effective model of external civilian oversight for critical incident investigations. The model recommended by Mr McClelland falls well short of those minimum necessary requirements. (A full copy of my submission to Mr McClelland's review is included at Attachment A.)

Clearly, I am unable to support a new function for this office that merely provides a veneer of additional scrutiny of critical incident investigations. To do so would expose my office to the possibility of criticism and diminished public confidence by supporting an ineffectual oversight framework. Any system of oversight must be effective if it is to be credible.

My response is divided into three parts. I firstly set out the principles that I believe are essential for any new scheme to be credible. I then address some of the issues raised in Mr McClelland's report that concern our oversight of the investigation into the death of Roberto Laudisio-Curti. I then provide specific responses to the recommendations made by Mr McClelland.

Principles for creating an effective and credible system of additional oversight for critical incident investigations

- Any new scheme should take into account and be modelled on the provisions that currently provide for an appropriate and effective level of oversight for police complaint investigations.

- Any new scheme should not derogate from or involve the removal of powers from the system of oversight of police complaints that has been working effectively in practice for 15 years.

- Any new scheme should recognise that the majority of critical incident investigations will not involve the Coroner as they will be examining serious injury and not death to persons during policing activities.

- Any new scheme should mandate immediate notification of critical incidents to this office and require the NSW Police Force to provide unfettered access to information concerning the critical incident and its investigation.

- Any new legislative provisions should be straightforward and clear so as to avoid any confusion or conflict over the scope and purpose of the provisions.

- All relevant stakeholders should be consulted in the development of any new scheme.

Issues related to our oversight of the investigation of the death of Mr Roberto Laudisio-Curti

Mr McClelland's report contains a number of statements and contentions about our oversight of the investigation of Mr Laudisio-Curti's death that, while on their face appear reasonable, are factually inaccurate or wrong.

Before addressing each individual recommendation, I will first address some of the comments and views expressed by Mr McClelland concerning our oversight of the critical incident investigation into the death of Roberto Laudisio-Curti. This is important because Mr McClelland draws upon these comments and views to support his suggestions for improvement and recommendations.

- *Language*

Mr McClelland states (at 7.17) that he has observed '*an intensity and emotiveness of language in some reports by the Ombudsman*' but does not refer to any examples involving this office. I

can advise that in the Roberto Laudisio-Curti matter, in accordance with established practice, I provided the NSW Police Force with a draft of the special report seeking their comments and views on the content and recommendations before finalising the report. The NSW Police Force did not raise any concerns with the language in the report.

I take my obligation to be accurate, fair and balanced in reports seriously. I take care to express my views in language that appropriately conveys the views that I have independently formed. I accept that some language used to describe an agency's deficiencies or failings may cause some discomfort. However, the focus should be on the substance of any criticism rather than the manner in which it has been expressed.

- *'Inconsistent evaluation' of the adequacy of the police investigation*

Mr McClelland states (at 7.25) that '*it has been most regrettable that experienced police officers investigating the circumstances of the death of Roberto Laudisio-Curti were on the one hand praised by the State Coroner but subject to strong criticism by the Ombudsman on the other. This outcome can only have been distressing for Mr Laudisio-Curti's family and unsettling for the general public.*'

And in the section discussing the issue of duplication, Mr McClelland states (at 7.115), '*A stark example of the problem of differences of approach and potential impact on public confidence was highlighted in the Ombudsman's Report into the death of Mr Roberto Laudisio-Curti. In that report the Ombudsman was highly critical of the conduct of police investigators whereas, as has been previously noted, the State Coroner made special mention of their valuable assistance.*'

I am unable to appreciate Mr McClelland's views on my assessment of the critical incident investigation. In my special report to Parliament, consistent with the praise of the State Coroner, I stated (at page 39) that '*The critical 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 inquest.*'

The only 'inconsistent evaluation' of the adequacy of the police investigation related to the failure of investigators to adequately consider conduct and systemic issues. In particular, I expressed the view in my special report (at page 44) that it was extraordinary that not one NSW Police Force officer seemed to have formed the view that some of the involved officers may have acted inappropriately. I also expressed reservations (at page 44) about the objectivity of the NSW Police Force officers attached to the specialist Weapons & Training – Policy & Review Unit who opined that the use of all force and tactical options by the involved officers was reasonable and justified. I would also note that the State Coroner did not turn her mind or make any comment on the question of whether the investigators complied with the requirement in the *Critical Incident Guidelines* to identify and deal with any wrongful conduct.

Thus the only 'inconsistent evaluation' was between the NSW Police Force and the other bodies who independently examined the conduct of the involved officers. The State Coroner

criticised the conduct of a number of involved officers and referred her concerns to the Police Integrity Commission. The Police Integrity Commission examined the available evidence (without conducting any further investigation) and referred a brief of evidence to the Office of the Director of Public Prosecutions with a recommendation that consideration be given to the prosecution of some of the involved officers. The Director of Public Prosecutions subsequently determined that there was sufficient evidence to charge four of the involved officers with common assault with the additional charge of assault occasioning actual bodily harm for two of the four officers. The officers have been charged and are currently before the courts.

- *Sequential oversight*

Mr McClelland suggests (at 7.109) that I had a concern with sequential oversight in the Roberto Laudisio-Curti matter. Mr McClelland formed this view on the basis of my comment in the special report that it was regrettable that another investigation by another agency, namely, the Police Integrity Commission, had to occur.

I think it is useful to quote the full paragraph to highlight what my concern actually was. On page 45 of the special report I made the observation that:

> *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.*

Then in a section discussing the Police Integrity Commission involvement following the coronial inquest I made (later on page 45) the following comment:

> *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.*

As is clear from the full quote of my comment, my concern was not with sequential oversight, but rather, the failure of the NSW Police Force to conduct an adequate investigation.

- *Failure to 'vacate the field'*

Mr McClelland suggests (at 7.112) that there was an inconsistency between my decision to oversight the critical incident investigation in the lead up to the coronial inquest and my decision to vacate the field to enable the Police Integrity Commission to investigate officer conduct following the inquest.

It appears that Mr McClelland may not fully appreciate the operation of Part 8A of the *Police Act 1990* ('Police Act'). I am only able to exercise oversight powers under Part 8A of the Police Act when a complaint has been notified to this office. In the Laudisio-Curti matter, a

complaint had been notified to this office. In accordance with section 146 of the Police Act, I determined that it was in the public interest to monitor the investigation.

The Minister for Police and I issued separate media statements advising that this office would independently oversight the investigation into the death of Mr Laudisio-Curti. The Minister of Police stated that '*The NSW Police Commissioner and I are pleased that the Ombudsman will have a role in reviewing this specific incident.*'

I exercised my statutory oversight functions to monitor the critical incident investigation that was investigated otherwise than under Part 8A of the Police Act pursuant to section 149(1) of Police Act. It is my view, that the unilateral decision of the Commissioner of Police to suspend or defer the Part 8A complaint investigation, does not and cannot preclude me from exercising my oversight powers given that the suspension or deferral occurs by virtue of section 149(1) of the Police Act which is situated within Part 8A.

It would be odd if the Commissioner of Police could effectively stymie my powers under Part 8A of the Police Act by unilaterally declaring that a complaint investigation had been suspended or deferred and that it would be investigated without Ombudsman oversight outside of Part 8A. It would appear that the Minister for Police and the Commissioner of Police agreed with my interpretation of the oversight powers as both referred to me having a role in the oversight of the investigation.

I made the decision to 'vacate the field' when the Police Integrity Commission commenced an investigation because of the effect section 70(5) of the *Police Integrity Commission Act 1996* ('PIC Act') which deemed the original complaint not to be Part 8A complaint. That is to say, once there is no longer a Part 8A complaint, I am no longer able to exercise any oversight functions under Part 8A of the Police Act.

The Police Integrity Commission and this office have various roles in the oversight and investigation of police complaints. As I pointed out in my special report to Parliament (on page 45), section 70(5) of the PIC Act sensibly ensures that there is no duplication of agency involvement in the oversight and/or investigation of police misconduct allegations.

Accordingly, there was no inconsistency between my decision to oversight the critical incident investigation and my decision to cease involvement in the matter once the Police Integrity Commission commenced an investigation. In any event, any concerns about the power to oversight critical incident investigations should be resolved by ensuring that any new scheme sits outside of Part 8A of the Police Act.

- *Inconsistent instructions*

Mr McClelland refers (at 7.170) to the potential for 'inconsistent instructions' between this office and the Coroner during a critical incident investigation involving a death. Mr McClelland suggests that '*a critical incident investigation, involving death, is intended to be shaped by instructions from the Coroner and a Part 8A investigation can be shaped by instructions from the Ombudsman'.*

The Coroner has the discretionary power to direct that police officers conduct certain investigations for the purpose of the coronial proceedings. This Omhudsman has no power to direct or issue instructions to investigators. We can only request that certain matters be taken into account. There is no obligation on the Commissioner of Police to accede to any requests as he has the discretion to investigate as he thinks fit.

Accordingly, I do not accept the contention that oversight of critical incident investigations has the potential to cause inconsistent instructions. I would note that the investigators, rather than the Coroner or the Ombudsman, are responsible for conducting and 'shaping' the investigation. However, if the investigators feel that that there are 'inconsistent instructions', then these should be raised with the Coroner who in turn could discuss and cooperatively resolve any differences with the relevant agency.

Ombudsman response to recommendations

***Recommendation 1***
**That the NSW Police Force makes the Critical Incident Guidelines publicly available and continues the approach of amending those guidelines as required and in consultation with relevant stakeholders.**

I support making the NSW Police Force *Critical Incident Guidelines* publicly available so as to increase community awareness of the roles, responsibilities and expectations of police officers involved in the investigation of critical incidents.

I also support continued improvement in police practices via amendments to policy and procedures such as the *Critical Incident Guidelines* in response to suggestions or recommendations made by the NSW Police Force, the Coroner, the Police Integrity Commission and/or the Ombudsman.

***Recommendation 2***
**That the NSW Police Force amends the Critical Incident Guidelines to include, as part of the Region Commander's responsibilities to report to the NSW Police Force Executive on the outcomes of critical incident investigations, specific advice on why interim action was or was not taken.**

I support this recommendation in principle noting that it is confined to the issue of interim action.

Mr McClelland states (at 7.43) that he endorses the substance of recommendation (v) in my special report to Parliament. However, recommendation (v) is aimed at increasing internal NSW Police Force accountability of critical incident investigations by requiring the Region Commander with responsibility for the critical incident investigation to ensure that all conduct and systemic issues have been identified and appropriately addressed during the critical incident investigation and *before* any coronial inquest in cases involving deaths.

I support the taking of appropriate interim action to address any potential risks before the completion of a thorough investigation. However, the action that can be taken by the investigators and reviewed by the Region Commander should not be confined to interim action.

As detailed in my submission to Mr McClelland and in my special report to Parliament, any identified conduct and systemic issues can and should be addressed *before* any coronial inquest. I am unaware of any cogent legal or public policy reasons why the NSW Police Force cannot take timely and appropriate action to address any identified criminal conduct, misconduct and/or systemic issues *before* any coronial inquest given the respective statutory roles and responsibilities of the NSW Police Force and the Coroner.

***Recommendation 3***

**3.1 That the NSW Police Force should, in the case of critical incidents involving death, prepare a Review of the Critical Incident Investigators Report which should be made publicly available as soon as is reasonably practicable after the Critical Incident Report has been completed.**

I support this recommendation. In my view, the Review report of any critical incident investigation involving serious injury should also be made publicly available.

**3.2 The Review should include as much information as the Commissioner of Police considers necessary and appropriate to inform the public of the nature of the critical incident, the police response and the outcome of the Critical Incident Investigation including any response to Coronial findings and recommendations.**

I support this recommendation.

**3.3 The Review should not include:**

- **any sensitive operational information;**
- **confidential police methodology;**
- **the identity of any witness or informant;**
- **information which is prohibited from disclosure under another law (including the *Privacy and Personal Information Protection Act 2002* [sic], and the *Telecommunications (Interception and Access) Act 1979* (Cth));**
- **information that could prejudice law enforcement or endanger the life, property, health or safety of any person;**
- **any information that was the subject of coronial or criminal non-publication orders.**

I support this recommendation.

**3.4 The Review should not be publicly released until;**

a. **the completion of any criminal proceedings arising out of relating to the critical incident, or**

**b. the completion of any disciplinary proceedings arising out of or relating to the incident.**

I support this recommendation. The NSW Police Force should provide regular updates on its website advising when it is anticipated the Review report will be released and any reasons for not releasing it.

**3.5 That any person who is the subject of adverse comment in the Review should be given the opportunity to object to publication of the Review in part or in whole before the Review is made publicly available.**

I support this recommendation. The NSW Police Force should record the reasons for any decision to redact or omit information from the Review report and make the reasons public.

***Recommendation 4***

**4.1 That the Commissioner of Police, the State Coroner, the Police Integrity Commissioner, the Ombudsman and the General Manager of the WorkCover Authority constitute a Committee to ensure issues relevant to the investigation and oversight of police critical incidents are reviewed and resolved on a regular basis. The Committee may also include representatives of other agencies and other appropriate persons either permanently or on an as needs basis.**

I do not support this recommendation. My participation in a committee of this nature has the potential to create negative perceptions regarding my independence and impartiality.

However, I do support cooperative discussions on an as need basis. I would note that heads of agencies currently work co-operatively and constructively to discuss and resolve any issues that may arise during investigations.

**4.2 That consideration should be given to the first items for discussion of the Committee including;**

I would have reservations about the utility and value of discussing some of the listed items as outlined below.

**a. the impact of language used in reports,**

I do not see the utility in discussing the impact of language use in reports. Each agency is responsible for determining appropriate language, content and recommendations in their reports. It would be inappropriate for agencies to attempt to influence or control the content of reports of other agencies.

It is my usual practice to provide the Commissioner of Police with an opportunity to comment on the content and proposed recommendations before I finalise any report. I then carefully consider any feedback before finalising the report.

**b. the appropriate role of Counsel Assisting,**

The appropriate role for Counsel Assisting is a matter for the Coroner and Counsel Assisting and perhaps the Crown Solicitor who instructs Counsel Assisting. The Coroner is a judicial officer and Counsel Assisting is usually a member of the independent bar. This office has no jurisdiction over these officers or coronial proceedings.

**c. the potential impact of *Baff v Commissioner of Police***

There is utility in agencies discussing the potential and actual impact of the decision in *Baff* given that some claims of privilege against self-incrimination may affect the manner in which critical incidents are investigated. Agencies could track the instances and circumstances in which the privilege has been claimed to note any trends such as police officer witnesses claiming the privilege and the impact this has on the critical incident investigation.

**d. refocusing of the objectives of the Wood Royal Commission,**

I do not see any utility in discussing the principles and recommended reforms of the Wood Royal Commission given that most of these have been implemented in Parts 8A and 9 of the Police Act and have been in operation for 15 years.

The Commissioner of Police has a wide discretion to take appropriate action ranging from non-reviewable action to reviewable action and dismissal in response to any identified misconduct or performance issues. This is consistent with the managerial approach envisaged by Justice Wood in 1997 where he stated (at 4.26 in Vol 2 of the Final Report):

> *A presumption should exist that having expended considerable resources in recruiting and training each member, the first recourse will be to remedial rather than punitive action, but that in return those whose behaviour has grossly offended against proper standards of integrity and honesty should not expect anything other than an early exit from the Service.*

This office supports the taking of remedial rather than punitive action in appropriate circumstances. However, taking appropriate action requires an investigation to first establish what occurred and to determine who is responsible. This process is not a 'quest for blame' or 'scapegoating', rather it is an objective, fair and accountable approach to ensure police officers are only held to account when it has been established that they failed to meet expected standards of conduct.

**e. reviewing modern strategies aimed at accident prevention where relevant, and**

It is unclear what purpose would be served by discussing this item. The NSW Police Force continually strives to improve policing practices by addressing any identified shortcomings through appropriate changes to policy, practices, guidelines and training.

**f. the development of a "*Framework for Cooperation*".**

I do not see any utility or benefit in developing a formal framework to regulate practices that currently work effectively. I would not support an artificially prescribed process that sought to regulate how I exercise my statutory functions or how I do business with other agencies.

As noted above, various heads of agencies already work in a flexible and cooperative manner to resolve issues of concern when they arise. This involves discussions on a case-by-case basis having regard to the individual facts and circumstances of each case.

**4.3 The "*Framework for Cooperation*" should establish the order of precedence of and overarching principles for cooperation in respect to the oversight of police critical incidents such that it clarifies:**

- **a. the role of each agency and the purpose of investigations undertaken by it,**
- **b. the order of precedence between the courts and oversight agencies to give precedence to:**
  - **i. the criminal process**
  - **ii. the Coronial process**
  - **iii. the Police Integrity Commission**
  - **iv. the Ombudsman**
- **c. the order of precedence between investigatory agencies to give precedence to;**
  - **i. investigations by the New South Wales Police Force**
  - **ii. investigations by the WorkCover Authority of New South Wales**
- **d. notification of events and commencement of investigations,**
- **e. sharing of investigatory information and use of shared information,**
- **f. the obligation to avoid prejudicing Coronial or criminal proceedings,**
- **g. appropriate public comment,**
- **h. dispute resolution, and**
- **i. joint training.**

As already indicated, I do not support the development of a framework of cooperation. In my view, it would be unhelpful and counter-productive to attempt to outline an order of precedence given that each agency has its own statutory roles and responsibilities that serve different purposes. Each critical incident will need to be investigated in a manner that takes into account the particular facts and circumstances surrounding the incident.

Importantly, I note that the Coroner has no statutory role in the case of serious injury, which is likely to be the majority of critical incident investigations.

I appreciate that there appears to be a need for greater clarity and understanding about the respective role and responsibilities of agencies that may be involved in a critical incident. However, as outlined in my submission to Mr McClelland (on page 15), it would be preferable for clarification to be outlined in the *Critical Incident Guidelines*.

**4.4 That the NSW Police Force, the State Coroner, the Ombudsman, the Police Integrity Commission and the WorkCover authority consider entering into new Memoranda of Understanding based on the principles of the Framework for Co-operation.**

I do not support this recommendation given my reservations about the development of a framework of cooperation outlined above.

**4.5 That the NSW Police Force, the Ombudsman, and the Police Integrity Commission consider developing a training and relationship enhancement program consisting of:**

**a. Creating an induction and subsequent training modules in respect to each Agency's core functions, responsibilities and methods, and**

I do not see the utility of this recommendation. My office regularly participates in across-agency information and training sessions in which we explain our statutory role and responsibilities and how we conduct business.

**b. Executive level secondments, or other appropriate arrangements, to achieve a better understanding of the functions, skills and investigative/oversight methods of each organisation.**

I do not support this recommendation. The current employment framework provides adequate opportunities for professional development. In my view, executive level secondments would involve significant challenges for organisations and require further consideration of how this may work in practice.

***Recommendation 5***

**That the Government give consideration to proposing legislative amendments to the *Police Act 1990* to include a new Part that provides for the oversight of critical incident investigations by the Ombudsman, such that:**

**5.1 *"critical incident"* and "*serious injury*" are defined consistently with the use of those terms in the Critical Incident Guidelines.**

I support this recommendation. It is important to have a statutory definition of what is a 'critical incident' and what constitutes 'serious injury' so as to remove any doubt about when oversight powers may be exercised.

**5.2 Critical incidents are investigated in accordance with the Critical Incident Guidelines issued by the Commissioner of Police.**

I do not support this recommendation. It would be peculiar to have a statutory obligation to require the NSW Police Force to investigate critical incidents in accordance with guidelines promulgated solely by the NSW Police Force.

While I appreciate that the *Critical Incident Guidelines* may be amended in response to suggestions or recommendations by oversight agencies, there is no requirement or guarantee that the NSW Police Force will adopt such suggestions or recommendations.

In my view, there should be a statutory obligation, similar to section 145(1) of the Police Act, requiring the critical incident investigator:

- to conduct a timely and effective investigation into any critical incident, and

- to have regard to any matters specified by the Commissioner, the Coroner (in cases involving deaths) or Ombudsman as needing to be examined or taken into consideration.

An obligation such as this would enable this office to independently assess the adequacy and quality of the investigation rather than merely holding the NSW Police Force to account based on its own criteria of what is an appropriate investigation in the *Critical Incident Guidelines*.

In addition, as outlined in my submission to Mr McClelland (on page 13), there needs to be a legislative mechanism for resolving any disagreements about the handling of critical incident investigations. While the Commissioner of Police should retain the discretion to cause the critical incident to be investigated as the Commissioner thinks fit (for example, see section 144(2) of the Police Act), the Commissioner of Police should nevertheless be ultimately responsible and accountable for the quality of the investigation and any decision-making during the investigation. Requiring the Commissioner of Police to set out in writing the basis for any decision subject to disagreement between our organisations would not impact on the Commissioner's discretion to investigate the critical incident as he or she thinks fit.

**5.3 The NSW Police Force shall advise the Ombudsman of the occurrence of a critical incident, as soon as it is reasonably practicable to do so.**

I support this recommendation in principle. However, the NSW Police Force should be required to immediately notify the Ombudsman of all critical incidents. The requirement 'as soon as reasonably practicable' may result in delayed notifications with the potential to adversely impact on our capacity to make informed decisions about our oversight of critical incident investigations.

**5.4 The information provided by the NSW Police Force should include sufficient details of the incident and surrounding circumstances to enable the Ombudsman to decide whether to provide oversight of the investigation of the incident.**

I support this recommendation in principle. However, it would not be appropriate for the NSW Police Force to determine what information this office requires when making a decision about whether to oversight a critical incident investigation.

The NSW Police Force should be required to provide this office with all available details of critical incidents at the earliest stage possible. This office can only make appropriate determinations of what involvement, if any, we are to have in the oversight of a critical incident investigation by assessing all of the available details and surrounding circumstances of critical incidents.

The Government announced that the NSW Police Force would advise this office of all critical incidents. The NSW Police Force has implemented this requirement by simply adding this office to the media alert distribution list sent to media outlets. In my view, this level of notification is unacceptable. Any legislative scheme should require the NSW Police Force to

notify this office directly and provide this office with all available details of critical incidents at the outset and throughout the critical incident investigation, including unfettered access to NSW Police Force information systems so as to minimise any impact of requests for information on investigators.

**5.5 The Ombudsman may provide oversight of the investigation of the critical incident if the Ombudsman considers that it is in the public interest to do so provided that such oversight;**

- **is conducted in accordance with arrangements agreed between the Ombudsman and the Commissioner of Police,**
- **does not include the power to supervise, control or direct the course of the police investigation, and**
- **does not adversely impact upon the timely completion of the investigation.**

I do not support this recommendation given that its intent and purpose is to prevent the Ombudsman from monitoring critical incident investigations. In my view, there would be little utility in Parliament providing this office with additional, yet limited and ineffective oversight powers.

Critical incident investigations examining the death or serious injury to persons during policing activities, more than any other area of policing, should be the subject of robust external oversight, which is only possible when agencies are given appropriate and effective powers.

My submission to Mr McClelland outlines (on page 13) what I consider to be the minimum necessary powers required for this office to effectively oversight (and, where appropriate, monitor) any critical incident investigation.

The relevant discussion in Mr McClelland's report outlines why he has recommended the Government consider giving the Ombudsman the power to oversight without any capacity to monitor critical incident investigations.

Mr McClelland states (at 7.116) '*...with oversight (rather than monitoring) the potential for conflicting requests/directions being made by the Ombudsman and the Coroner is minimal. It is also far more manageable in terms of prioritising the Coronial process.*'

Mr McClelland refers (at 7.120) to '*adopting a common sense position whereby the Ombudsman is empowered to provide oversight of the investigation of critical incidents without exercising intrusive powers that have the potential to interfere with either the process of investigation or, in the case of a death, a Coronial inquest.*'

Mr McClelland recommends (at 7.121) that '*the Government give consideration to amending the Police Act with a specific part requiring notification of police critical incidents to the Ombudsman to undertake appropriate oversight without exercising powers which have the potential to unreasonably intrude into the investigative process or the Coronial process by making requests or giving directions that may be at odds to those given by the Coroner.*'

Mr McClelland also proposes at (7.122) that any suspension or deferral of the Part 8A complaint investigation should '*also result in the powers of the Ombudsman under section 146 of the Police Act being suspended.*' This is to ensure that '*the only oversight provided by the Ombudsman should be that which I am proposing to be included in a new Part in the Police Act.*'

Mr McClelland is recommending that the Government consider giving limited oversight powers to this office that do not include the power to monitor a critical incident investigation. Mr McClelland is also proposing the removal of our current capacity to monitor a critical incident investigation in circumstances where a complaint has been made about the conduct of a police officer involved in a critical incident.

In my view, it is essential that any statutory scheme for the oversight of critical incident investigations should contain a provision similar to section 146 of the Police Act making it clear this office has the power to:

- monitor critical incident investigations when determining it is in the public interest to do so, and

- be present as an observer during any interviews and other investigative activities conducted as part of the critical incident investigation.

I would not support an additional oversight role for this office that did not include the power to monitor a critical incident investigation where I determined it was in the public interest to do so.

For the reasons expressed in my special report to Parliament and in my submission to Mr McClelland, I do not agree with the contention that this office's monitoring of a critical incident investigation has the potential to unreasonably intrude on the coronial process given that the statutory role of this office and the role of the Coroner are separate and distinct. In addition, I note that the majority of critical incident investigations examining serious injury rather than death will not involve a coronial process.

This office would not and does not seek the power to supervise, control or direct the course of a critical incident investigation, as having such powers would be incompatible with any independent external oversight function. We would be required to remain at arm's length from any critical incident investigation given that it would be our role to review and critique the investigation.

The principle of remaining at arm's length also applies to the Coroner, who, while having the power to direct that police officers conduct certain investigations for the purpose of the coronial proceedings (pursuant to section 51(2) of the *Coroners Act 2009*), may nevertheless have to be critical of any deficiencies or failings in the investigation that emerge during the coronial proceedings.

The purpose of our oversight of critical incident investigations would be to ensure that the investigation is conducted in an appropriate, accountable and transparent manner. One of the

most effective ways of performing this role is by monitoring the investigation in real time. We would monitor critical incident investigations by reviewing proposed investigative strategies and activities and by observing interviews and investigative activities. As noted above (under recommendation 5.4), providing this office with unfettered access to NSW Police Force information systems would minimise requests for information so as to not adversely impact upon the investigators and the timely completion of the investigation.

The purpose of monitoring critical incident investigations is to provide an opportunity for any investigative shortcomings to be identified and raised with the investigator at the earliest opportunity. If we identified investigative gaps or deficiencies during our monitoring activities, we would immediately bring these to the attention of the investigator who is responsible for the supervision, control and direction of the investigation. I would not support any guidelines or communication protocol (as raised at 7.152 of Mr McClelland's report) that attempted to limit what issues or feedback this office could provide directly to the critical incident investigators.

The process of monitoring may be inaccurately characterised as supervision by equating the process of observing with supervision. However, as part of our monitoring function, we observe interviews and/or investigative activities as independent observers. In effect, we do not supervise these activities as we do not play any active role in, have responsibility for, or control or direct these activities.

The current Monitor Agreement for Part 8A complaint investigations agreed to by the Ombudsman and the Assistant Commissioner of the NSW Police Force Professional Standards Command relevantly states (in clause 29):

> There is no obligation for NSW Police to act on matters raised by the Ombudsman. However, the officers concerned should ensure that they can justify their actions in response to matters raised by the Ombudsman and document the reasons on the complaint file. [Emphasis added.]

There is no reason why a similar clause could not feature in any agreement outlining the arrangements agreed by the Ombudsman and the Commissioner of Police for the monitoring of critical incident investigations.

As noted above (under recommendation 5.2), the Commissioner of Police should retain the discretion to cause the critical incident to be investigated as the Commissioner thinks fit. The investigator should be responsible for supervising, directing and controlling police officers involved in the critical incident investigation.

The current monitor power in section 146 of the Police Act enables the Ombudsman to be present as an observer and to confer with the investigator about the conduct and progress of the investigation. There is no reference to any power to supervise, control or direct the course of the investigation and nor should there be given the limited role of the Ombudsman as an independent observer while monitoring an investigation.

In my view, there is no reason for any additional legislative provisions that enable the Ombudsman to monitor critical incident investigations to derogate from the wording of the

current monitor provision. Terms such as supervise, control and direct lack sufficient clarity and in the context of beneficial legislation may lead to differing and unintended interpretations, which in turn may result in tension and disputes over the scope of any additional power.

In summary, it is my firm view that any additional oversight powers should not prevent this office from monitoring critical incident investigations. Any such limitation would raise serious questions about the purpose, effectiveness, value and utility of any additional oversight powers and could not in all good conscience be supported by me.

**5.6 The Ombudsman may, after completion of the critical incident investigation report, publish a report on any oversight undertaken by his office and any such report may be responded to by the Commissioner of Police.**

I do not support this recommendation. Mr McClelland opined (at 7.153) that I should not publish any report on my oversight of a critical incident investigation until the NSW Police Force completes the critical incident investigation report. However, the reasons for this view are not clear.

Currently, I may, at any time, make a special report to Parliament that is made public on any matter arising in connection with the exercise of my functions under Part 8A of the Police Act (see section 161 of the Police Act). This recommendation would, in effect, curtail my ability to make a special report to Parliament until after the completion of critical investigation report by the NSW Police Force.

For example, if there were currently such a provision, I would have been prevented to this day from tabling and making public my special report to Parliament on the *Ombudsman monitoring of the police investigation into the death of Roberto Laudisio-Curti*. This is because, as I understand it, the NSW Police Force has yet to complete the critical incident investigation report concerning the death of Mr Laudisio-Curti, which occurred on 18 March 2012.

In my view, the discretion to make a report to Parliament with a recommendation that it be made public should not be contingent or dependent upon the action or inaction of the NSW Police Force. I should retain the discretion to independently determine when it is in the public interest to make a report to Parliament. I think the community would be rightly concerned about any attempt to stymie my capacity to make public reports outlining any concerns I have. Clearly, public confidence is maintained by having an independent and robust system of oversight that supports and encourages agencies to make their concerns public when it is in the public interest to do so.

It is established practice of this office to provide the Commissioner of Police with an opportunity comment on the content of the report and any proposed recommendations before finalising any report. Accordingly, I do not have any concerns with continuing to provide the Commissioner of Police an opportunity to provide a response to any report. In addition, I support publishing the NSW Police Force response and any other correspondence relating to

the contents of the report on the NSW Ombudsman website as suggested by Mr McClelland (at 7.153).

**5.7 The Ombudsman is not to publish information whose publication may, in the opinion of the Commissioner of Police, prejudice the investigation or prevention of crime, or otherwise be contrary to the public interest.**

I do not support this recommendation. Currently, when exercising functions under Part 8A of the Police Act, I am not prevented from publishing information in reports if I form the opinion that the circumstances so warrant (see section 163(7) of the Police Act).

When making determinations about whether to include certain information in reports, I take into account the views of the Commissioner of Police. However, this recommendation would remove the discretion I have to publish such information in circumstances where I form the opinion that it is warranted.

It would be concerning if the Commissioner of Police could, in effect, determine what information could be used in my reports. Mr McClelland's does not articulate any reasoning for this recommendation in his report.

**5.8 Any statement that is made in good faith by a police officer in response to questions about their involvement in a critical incident:**

- **(a) is not, without the consent of the police officer who gave the statement, admissible in any civil or criminal proceedings against the police officer if the proceedings relate to the conduct in connection with which the statement was made, and**
- **(b) may not be used as the basis of taking action under Section 181D or reviewable or non-reviewable action (within the meaning of Section 173) against the police officer.**

I do not support this recommendation. The community expects police officers involved in incidents resulting in the death or serious injury to persons to act with integrity by being open and honest about what occurred and to take personal responsibility for their actions. A police officer's candour should not be dependent on any protections that preclude appropriate action being taken in response to any established misconduct. Police officers, like other government employees and members of the public, should be held to account for their actions in the workplace.

In relation to any alleged criminal conduct, it is my view that police officers suspected of committing a criminal offence should be treated no different to other members of the public, including availing themselves of protections such as the right to silence and the privilege against self-incrimination. However, police officer witnesses who are not suspected of any criminal offence should not be permitted to hinder any critical incident investigation by claiming the privilege against self-incrimination when the circumstances do not warrant or support the claim.

Mr McClelland states (at 7.154) that he has observed '*a drift away from the principles of the Wood Royal Commission and, in particular, there is a need to refocus on broader systemic issues with a view to preventing errors occurring in the future. Noting the goal of examining critical incidents with a view to minimising the prospect of future injury I have formed the view that any impediment to police officers involved in a critical incident giving a full and frank account of events should be removed.*'

I accept that one objective of critical incident investigations is to identify broader systemic issues with a view to preventing similar occurrences in the future. However, another essential objective is to conduct a fact-finding investigation to determine whether any criminal conduct or misconduct contributed to the death or serious injury under investigation. It is vital that investigators accurately establish what occurred and determine who was responsible.

Only once the task of determining who did what has concluded can the question of appropriate action to be taken be considered. It is at this point that remedial rather than punitive action may be considered. As noted above (under recommendation 4.2(b)), consistent with the reforms recommended by Justice Wood, the Commissioner of Police (under Part 9 of the Police Act) has a wide discretion to take a range of actions to address any criminal conduct or misconduct that has been established by an appropriate, thorough, and objective investigation. When deciding what appropriate action to take, the Commissioner of Police can take into account mitigating factors such as mistakes or errors of judgement that occurred as a result of split second decisions made under the pressure that can sometimes accompany certain policing activities.

Mr McClelland states (at 7.156) that he has based this recommendation on the protection in section 211D of the Police Act. I note that the protection was introduced '*to enable an officer to attempt to resolve a complaint by alternative dispute management procedures where it is appropriate to do so* [and] *in general these procedures will only be utilised in complaint matters at the more minor end of the spectrum.*'[1]

Clearly, critical incident investigations involving the death or serious injury of persons during policing activities do not invite resolution by alternate dispute management procedures and are not akin to complaint matters at the more minor end of the spectrum. Accordingly, it would not be appropriate to extend this protection to officers involved in critical incident investigations. I would not support it and I imagine that the community and the families of victims would have some difficulty understanding and supporting it.

**5.9 The power of the Ombudsman to provide oversight of a critical incident investigation under these provisions is not in derogation of any other powers of the Ombudsman except that, if the Ombudsman chooses to exercise such other powers, the Ombudsman must refrain from further exercising powers under these provisions.**

I do not support this recommendation. I would not accept any restriction on the appropriate use of powers by my office.

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[1] NSW Parliamentary Hansard, Legislative Assembly, The Hon. Paul Whelan (Minister for Police), 9 November 1999, pages 2457-8.

It is unclear what this recommendation is seeking to achieve. I note that at 4.98 to 4.100 of his report Mr McClelland erroneously refers to powers in Part 4 of the *Ombudsman Act 1974* that are not relevant to police conduct by virtue of section 25AA of the Ombudsman Act. This may be source of some confusion about the nature and scope of powers that I am able to exercise.

***Recommendation 6***
**That subject to any legal advice on the matter, the NSW Police Force give consideration to further amending the Critical Incident Guidelines to specifically provide that, consistent with the relevant provisions of the Coroners Act, the Critical Incident Investigation Team shall provide such assistance as is required by the State/Deputy State Coroner, including any instruction to which an inconsistent instruction has been provided from another agency.**

I do not support this recommendation. The starting point of any critical incident investigation is the determination of whether the death or serious injury involved any criminal conduct by the police officers or other involved persons. The responsibility for investigating and taking timely action to address any criminal conduct, misconduct or systemic issues rests with the NSW Police Force and is not dependent on instructions from the State/Deputy Coroner or any other organisation.

In my view, it would be preferable for the *Critical Incident Guidelines* to appropriately outline the various statutory roles and responsibilities of organisations that may be involved in a critical incident investigation. The guidelines should state that when oversighting critical incident investigations, the Ombudsman might make suggestions or raise issues about investigative activities; that these should be considered by investigators; but need not be followed if there are valid and documented reasons. The guidelines should also specifically state that the Ombudsman does not have the power to issue instructions to investigators so as to remove any doubt about who is responsible for the investigation.

I appreciate that in cases of death the State/Deputy Coroner may direct or 'instruct' police to conduct investigations for the purpose of the coronial proceedings whose primary purpose is to establish the time, place, identity and manner and cause of death. I also appreciate that an important function of the critical incident investigation is to prepare a brief of evidence for the Coroner. However, the State/Deputy Coroner is not responsible for ensuring that the critical incident investigators conduct an adequate and timely investigation and take appropriate action to address any identified criminal conduct or misconduct.

The majority of critical incident investigations will involve serious injury and not death and so the question of a coronial inquest and instructions from the Coroner do not arise. However, if any tension over inconsistent instructions emerges during a critical incident investigation, it would be prudent for the relevant heads of agencies to meet to discuss the tension and attempt to resolve any concerns.

***Recommendation 7***

**7.1. That the Government consider obtaining advice from the Crown Solicitor as to whether a decision by the Commissioner of Police to suspend or defer an investigation under Part 8A of the *Police Act* 1990, in order to avoid prejudicing a Coronial Inquest relating to a critical incident, has the effect of suspending the powers of the Ombudsman to monitor such an investigation.**

I support this recommendation in principle. The recommendation raises a range of complex and technical legal issues about the operation of the existing scheme of oversight under Part 8A of the Police Act. All relevant stakeholders should be given ample opportunity to provide submissions on the issues to be clarified in any request for legal advice.

**7.2. That the Government give consideration to requesting the WorkCover Authority of NSW to amend the WorkCover *"Compliance Policy and Prosecution Guidelines"* to more clearly define circumstances where cooperation with other agencies is appropriate including by refraining from investigating a matter if that matter is being investigated by another law enforcement agency and continuation of the investigation by WorkCover may adversely impact on that other investigation.**

This recommendation has no application to my office.

**7.3. That the Government give consideration to proposing an amendment to section 21(2) of the *Police Integrity Commission Act* 1996, (relating to interference with other Court proceedings), to replace the word *"may"* with the word *"must"*.**

This recommendation has no application to my office.

**7.4 That the Government give consideration to proposing an amendment to Section 10 of the *Police Integrity Commission Act* 1996 to include, as an additional exception to the prohibition of police officers being employed/seconded by the PIC, circumstances where the PIC is participating in a co-operative scheme with another Agency.**

This recommendation has no application to my office.

***Recommendation 8 – Longer term efficiency and effectiveness***
**That the Government give consideration to requesting the Police Integrity Commission and the Independent Commission against Corruption confer with a view to examining the feasibility of those Agencies entering into a Memorandum of Understanding to facilitate the sharing of staff, resources, expertise and capabilities.**

This recommendation has no application to my office.

***Recommendation 9 – Media Policy***
**9. That the Government convene a meeting between the NSW Police Force, the Coroner, the Police Integrity Commission, the Ombudsman and the Police Association of New South Wales with a view to those organisations conferring regarding developing a mutually agreed media protocol in respect to critical incidents to ensure that any public**

**comments made do not pre-empt investigative findings. Consideration should be given to including in that protocol:**

I do not support this recommendation. In my view, negative perceptions about independence and impartiality could arise for oversight agencies who are seen to confer or work closely with government or organisations over whom they exercise oversight and investigative functions.

**9.1 Identification of who should be authorised to make statements to media at critical incidents on behalf of the respective organisations, either individually or collectively.**

I do not support this recommendation. In my view, the heads of all agencies should independently determine when it is necessary, appropriate and in the public interest to make a media statement. I would not authorise any other agency to make statements on behalf the Ombudsman.

**9.2 Guidance regarding the content of the media statement including;**

- **a. acknowledgement of the tragedy,**
- **b. reassurance of the community as to public safety,**
- **c. expressing concern about the welfare of any person who suffers injury and, in the event of death, the welfare of the family of the deceased,**
- **d. expressing concern as to the welfare of any police involved,**
- **e. in the event of death - stressing that the matter will be the subject of the Coroner's inquest,**
- **f. stating that there will be a thorough police investigation and, in the case of death, that police investigators will forward a brief of evidence to the Coroner to assist with the inquest,**
- **g. stating that the police investigation will be the subject of active oversight by the New South Wales Police Professional Standards Command who may also report to the Coroner,**
- **h. stating that the investigation may also be independently overseen by the Ombudsman and or the Police Integrity Commission,**
- **i. advising that neither the police investigation nor the oversight will prejudge the outcome of the Coroner's inquest.**

The above list of factors should be considered by any organisation that proposes to issue a media statement concerning a critical incident. The list is useful for the NSW Police Force who is often required to issue media statements following critical incidents. In addition, the NSW Police Force should consider the implementation of more rigorous controls to prevent the unauthorised disclosure of information to journalists during critical incident investigations.

Final comment

Once again, thank you for providing me with an opportunity to comment on Mr McClelland's report and the recommendations he has made. Please do not hesitate to contact either myself

or Linda Waugh (Deputy Ombudsman, Police & Compliance Branch) if you require any further information or clarification.

Yours sincerely

Bruce Barbour
**Ombudsman** 5/2/14

# Annexure E

Legislative reviews by the Ombudsman of new powers conferred on police

**Annexure E – Legislative reviews by the Ombudsman of new powers conferred on police**

| Legislation conferring review function | Description of powers/offences under review |
|---|---|
| **Current reviews** | |
| *Crimes (Criminal Organisations Control) Act 2012* | Allows police to apply for declarations and orders to restrict the associations and activities of members of a 'criminal organisation'. |
| *Crimes (Consorting and Organised Crime) Act 2012* | Amended the Crimes Act 1900 to modernise and clarify the offence of consorting, making it an indictable offence punishable by up to three years imprisonment. |
| *Firearms and Criminal Groups Legislation Amendment Act 2013* | Gives police powers to search a person subject to a firearms prohibition order, and related premises and vehicles without a warrant. |
| *Firearms and Criminal Groups Legislation Amendment Act 2013* | Allows police to search restricted premises for weapons and other articles and creates offences committed by owners and occupiers of restricted premises relating to reputed criminals attending or managing such premises. |
| **Completed reviews** | |
| **Legislation conferring review function** | **Description of powers/offences under review** |
| *Crimes Legislation Amendment (Police and Public Safety) Act 1998* | Makes the custody of a knife in a public place an offence and allows police to conduct searches for knives and to give directions in public places to people whose behaviour amounts to obstruction, harassment or causes fear. |
| *Police Powers (Vehicles) Act 1998* | Allowed police to request identity information from passengers in vehicles in certain circumstances. |
| *Crimes (Forensic Procedures) Act 2000* | Allowed police to take DNA samples from suspects, volunteers and 'serious indictable offenders'. |
| *Police Powers (Drug Premises) Act 2001* | Gave police powers to search suspected drug houses, and to move people on if police believe they are purchasing or supplying drugs |
| *Child Protection (Offenders Registration) Act 2000* | Allowed police to keep a register of people living in the community who have committed offences against children. |
| *Crimes Legislation Amendment Act 2002* | Regulates the detention of people arrested during the execution of a search warrant. |

| **Completed reviews** | |
|---|---|
| **Legislation conferring review function** | **Description of powers/offences under review** |
| *Police Powers (Vehicles) Amendment Act 2001* | Gave police additional powers to require people in vehicles to identify themselves and other passengers. |
| *Children (Criminal Proceedings) Amendment (Adult Detainees) Act 2001* | Limited the age to which young people can remain in juvenile custody. |
| *Police Powers (Drug Detection Dogs) Act 2001* | Regulates how police use drug detection dogs ('sniffer dogs') in the community. |
| *Firearms Amendment (Public Safety) Act 2002* | Allowed police to use dogs to detect firearms or explosives in a public place without a warrant. |
| *Justice Legislation Amendment (Non-association and Place Restriction) Act 2001* | Allowed police and courts to place restrictions on the places that a person can be in and the people they can associate with — when determining bail conditions, imposing a sentence or allowing parole. |
| *Police Powers (Internally Concealed Drugs) Act 2001* | Allowed police to carry out internal searches using x-ray, CAT scans or magnetic resonance imaging on people suspected of swallowing or otherwise internally concealing a prohibited drug for the purposes of supply. |
| *Crimes Legislation Amendment (Penalty Notice Offences) Act 2002* | Allowed police to trial the issue of 'on-the-spot' fines for specific criminal offences, such as shoplifting, and to take fingerprints in the field. |
| *Crimes (Administration of Sentences) Amendment Act 2002*<br>*Summary Offences Amendment (Places of Detention) Act 2002* | Provided correctional officers with increased powers to stop, detain and search people other than inmates to reduce the amount of prohibited items entering correctional facilities. |
| *Police Powers (Drug Detection in Border Areas Trial) Act 2003* | Allowed police to trial check points in border areas for the deployment of drug detection dogs ('sniffer dogs'). |
| *Terrorism Legislation Amendment (Warrants) Act 2005* | Allowed police and the Crime Commission to execute covert search warrants. |
| *Terrorism (Police Powers) Amendment (Preventative Detention) Act 2005* | Allowed police to hold people suspected of involvement in terrorist-related activities in preventative detention. |
| *Law Enforcement (Powers and Responsibilities) Act 2002 - Part 7 'Crime Scenes'; Part 5, Division 3 'Notices to produce document'; Part 4, Divisions 2 and 4 'Searches on arrest or in custody'* | Regulates police powers for setting up crime scenes, allowed police to issue notices requiring financial institutions to produce information about their customers relevant to criminal investigations, regulates the safeguards connected with searching people after they have been arrested or why they are in custody. |

| **Completed reviews** | |
|---|---|
| **Legislation conferring review function** | **Description of powers/offences under review** |
| *Law Enforcement Legislation Amendment (Public Safety) Act 2005* | Introduced after the Cronulla riots. Allowed police to prevent or control 'large scale public disorder' incidents. |
| *Police Powers Legislation Amendment Act 2006 - Police Powers (Drug Detection Trial) Act 2003* | Allowed police to randomly stop and screen vehicles with drug detection dogs in areas where there is intelligence and evidence suggesting that drugs are being couriered on a regular basis. |
| *Police Powers Legislation Amendment Act 2006 - Impact of Criminal Infringement Notices on Aboriginal communities* | State-wide scheme enabling police to issue penalty notices to any adults who appear to have committed a limited range of certain offences, mostly relating to minor incidents of offensive conduct, offensive language and larceny/shoplifting. |
| *Crimes (Criminal Organisations Control) Act 2009* | Allowed for police to apply for declarations and orders to restrict the associations and activities of members of a 'criminal organisation'. |
| *Identification Legislation Amendment Bill 2011* | Allowed police to require that a person uncover their face when being identified, by removing any item covering their face such as a niqab or a motorcycle helmet. |
| *Summary Offences Amendment (Intoxicated and Disorderly Conduct) Act 2011* | Allows police to give a direction to an intoxicated person to leave a public place on the grounds that their behaviour is disorderly and creates a new offence for the continuation of intoxicated and disorderly behaviour in a public place within six hours of a move on direction. |

# Annexure F

State Coroner's response to report by Mr McClelland
(included in the consent of the State Coroner)

Last year, both the NSW Ombudsman and the Police Integrity Commission (PIC) expressed disquiet about aspects of the response of the NSW Police Force (NSWPF) to two fatal critical incidents. Consequently, the State Government retained the Honourable Robert McClelland to review the administrative arrangements regulating the way in which the NSWPF and relevant external agencies investigate and oversee such events.

His report makes recommendations aimed at improving those arrangements. The Department of Premier and Cabinet has invited responses to those recommendations from interested stakeholders. These are the responses of the State Coroner to the recommendations that may impact on coroners. They relate solely to critical incidents resulting in death as a coroner has no role otherwise.

***Summary of State Coroner's response***

Based on the author's experience[1], for the reasons set out below and subject to certain qualifications, the author is of the view that following a fatal critical incident: -

- Experienced Homicide Squad detectives, properly supported and resourced, are best placed to gather the evidence needed to establish who did what, to whom, where and when.

- Because of their understandable empathy for the police officers involved in such incidents homicide detectives and over-viewing police officers have difficulty objectively assessing whether what was done by the police officers involved was reasonable and/or necessary.

- An independent, expert agency needs to monitor and overview these investigations as they occur and there needs to be a mechanism for quickly addressing shortcomings when they are detected.

- The various office-holders and agencies with responsibility for responding to such incidents need to work collaboratively while maintaining their independence and utilising agreed protocols to resolve conflicts.

The State Coroner acknowledges that police officers involved in fatal critical incidents frequently suffer severely as a result of being suddenly thrust into dangerous and volatile situations. In his view they must be supported, as must the family and friends of the primary victims.

[1] The author has been involved in investigations, oversight of police and research into policing for 25 years: 1987 – 90 RCADIC; 1991 – 2000 Criminal Justice Commission; Head, School of Justice QUT (the author wrote and delivered post graduate courses in organised crime and corruption investigation); 2003 – 2013 State Coroner Qld (the author presided over all but two of the inquests into police related fatalities in Qld in that period).

**Recommendation 1**

*That the NSW Police Force makes the Critical Incident Guidelines publicly available and continues the approach of amending those guidelines as required and in consultation with relevant stakeholders.*

***State Coroner's response***

The State Coroner supports this recommendation and understands the Government has accepted it and that it is being implemented.

The State Coroner understands the current Commissioner as a matter of practice involves stakeholders in reviews of the Critical Incident Guidelines and submits this should be made mandatory.

**Recommendation 2**

*That the NSW Police Force amends the Critical Incident Guidelines to include, as part of the Region Commander's responsibilities to report to the NSW Police Executive on the outcomes of critical incident investigations, specific advice on why interim management action was or was not taken.*

***State Coroner's response***

The State Coroner supports this recommendation. As soon as there is basis for reasonable concern that an officer has engaged in serious misconduct, the duty of care the NSWPF owes the rest of its members and the public mandates that interim action be taken to limit the opportunity for further aberrant behavior. As the investigation and inquest proceeds, those concerns may be confirmed, in which case formal disciplinary action can be taken, or disproven, in which case the interim sanctions can be withdrawn.

**Recommendation 3**

*3.1. That the NSW Police Force should, in the case of critical incidents involving death, prepare a Review of the Critical Incident Investigators Report which should be made publicly available as soon as is reasonably practicable after the Critical Incident Report has been completed.*

***State Coroner's response***

The State Coroner supports this recommendation.

*3.2. The Review should include as much information as the Commissioner of Police considers necessary and appropriate to inform the public of the nature of the critical incident, the police response and the outcome of the Critical Incident Investigation including any response to Coronial findings and recommendations.*

*3.3. The Review should not include;*

- *Any sensitive operational information;*
- *Confidential police methodology;*
- *The identity of any witness of informant;*
- *Information which is prohibited from disclosure under another law (including the Privacy and Personal Information Protection Act 2002, and the Telecommunications (Interception and Access) Act 1979 (Cth);*

- *information that could prejudice law enforcement or endanger the life, property, health or safety of any person;*
- *any information that was the subject of coronial or criminal non-publication orders.*

*3.3 The Review should not be publicly released until;*

*a. the completion of any proceedings arising out of or relating to the critical incident, or*
*b. the completion of any disciplinary proceedings arising out of or relating to the incident.*

*3.5. That any person who is the subject of adverse comment in the Review should be given the opportunity to object to publication of the Review in part or in whole before the Review is made publicly available.*

***State Coroner's response***

The State Coroner supports each of these recommendations and has nothing to add.

**Recommendation 4**

*4.1. That the Commissioner of Police, the State Coroner, the Police Integrity Commissioner, the Ombudsman and the General Manager of the WorkCover Authority constitute a Committee to ensure issues relevant to the investigation and oversight of police critical incidents are reviewed and resolved on a regular basis. The Committee may also include representatives of other agencies and other appropriate persons either permanently or on an as needs basis.*

***State Coroner's response***

The State Coroner generally supports this recommendation and agrees that regular meetings between office-holders and agencies involved in the investigation of fatal critical incidents would be of benefit: it is likely that contentious issues will arise periodically and regular meetings could minimise misunderstandings and provide a forum focused on continuous improvement.

*4.2. That consideration should be given to the first items for discussion of the Committee including;*

*a. the impact of language used in reports,*
*b. the appropriate role of Counsel Assisting,*
*c. the potential impact of Baff v Commissioner of Police.*
*d. refocusing on the objectives of the Wood Royal Commission,*
*e. reviewing modern strategies aimed at accident prevention where relevant, and*
*f. the development of a "Framework for Cooperation"*

***State Coroner's response***

The State Coroner is confident that each of the office-holders and agencies referred to in the Recommendation 4.1 are fully cognizant of the impact of language and only use strong language when they consider the circumstances warrant it.

The role of counsel assisting is essentially a matter for the Coroner. Counsel assisting has no authority independent of that delegated to him/her by the Coroner. Arrangements that the State Coroner agrees will regulate the manner in which he and the Deputy State Coroners interact with other office-holders and agencies involved in critical incident investigation will bind counsel assisting.

The State Coroner is not aware of any evidence indicating that relevant objectives of the Wood Royal Commission have become obscured.

*4.3 The "Framework for Cooperation" should establish the order of precedence of and overarching principles for cooperation in respect to the oversight of police critical incidents such that it clarifies:*
*a. the role of each agency and the purpose of investigations undertaken by it,*
*b. the order of precedence between courts and oversight agencies to give precedence to;*
*i. the criminal process*
*ii. the coroniel process*
*iii. the Police Integrity Commission*
*iv. the Ombudsman*
*c. the order of precedence between investigatory agencies to give precedence to;*
*i. investigations by the New South Wales Police Force*
*ii. investigations by the WorkCover Authority of New South Wales*
*d. notification of events and commencement of investigations,*
*e. sharing of investigatory information and use of shered information,*
*f. the obligation to avoid prejudicing Coroniel or criminal proceedings*
*g. appropriate public comment,*
*h. dispute resolution, and*
*i. joint training.*

***State Coroner's response***
A *Framework for Cooperation* could usefully document the principles the parties agree should regulate their actions and interactions and stipulate the priority to be given to their respective responsibilities.

*4.4 That the NSW Police Force, the State Coroner, the Ombudsman, the Police Integrity Commission and the WorkCover Authority consider entering into new Memoranda of Understanding based on the principles of the Framework for Co-operation.*

***State Coroner's response***
The State Coroner agrees memoranda of understanding should detail arrangements to avoid unnecessary duplication of investigative effort and unintended interference in the processes of other participating agencies. They should provide mechanisms for the resolution of disagreement or conflict between the office-holders or agencies involved in critical incident investigations.

**Recommendation 5**
*That the Government give consideration to proposing legislative amendments to the Police Act 1990 to include a new Part that provides for the oversight of critical incident investigations by the Ombudsmen, such that:*

***State Coroner's response***
In paragraph 7.92 the report identifies the purposes of a critical incident investigation and overview as:-

- an objective investigation that establishes the facts;
- an independent assessment of compliance with policies and procedures;

- an independent assessment and testing of the substance of the investigation and its findings;
- recommendations for systemic improvements and the holding of individuals to account for serious misconduct or criminal offences.

The State Coroner generally agrees with that analysis.

The State Coroner considers the Homicide Squad has the necessary expertise and resources to undertake the best investigation to establish the facts.

It is the view of the State Coroner that police officers may have difficulty objectively assessing the reasonableness of the operational activities of other officers, particularly when a death has resulted from the involved officers' actions.

It is not suggested police officers investigating deaths that occur in an operational setting deliberately seek to "cover-up" misconduct or "run dead". Rather, in the State Coroner's experience, the understandable empathy more senior officers feel for the junior officers usually involved in these incidents can undermine the impartiality of investigating and reviewing officers. Because the primary victim frequently precipitates the deadly interaction by aberrant behaviour, there is a tendency to characterise the involved officers' actions as a matter of operational judgment that can't be validly critiqued.

Consequently, for the assessment of compliance with police policies to be independent, it needs to be undertaken by an agency external to the NSWPF.

Similarly, if the testing of the findings and substance of the investigation is to be independent that also needs to be undertaken by an external agency.

The State Coroner considers the Ombudsman can initially best undertake these tasks, notwithstanding they will be further considered during the inquest and by disciplinary or prosecuting authorities if the evidence warrants it.

To mitigate the risk of evidence being lost or degraded as a result of the occasional reluctance of police investigators to critically examine the actions and motivations of involved officers, real time monitoring of the investigation by an independent agency is essential.

The Ombudsman has power to monitor the investigation of a critical incident that is the subject of a complaint being investigated pursuant to Part 8A of the Police Act. It is a moot point whether that power continues if the Commissioner of Police suspends or defers the complaint investigation.

The power to monitor is contained in s146 of the Act. It provides the Ombudsman may be present during interviews and may confer with the investigators about the conduct and progress of the investigation. Those powers must be exercised in accordance with arrangements agreed between the Ombudsman and the Commissioner.

It is important that the monitoring or oversight of an investigation does not negatively impact upon it, as would occur if the investigators were given inconsistent or impractical directions. In view of the limited and circumscribed power of the Ombudsman to monitor under s146, it is difficult to envisage this occurring provided the section is strictly complied with.

There is however a risk that confusion could arise if the Coroner was also seeking to influence the direction of the investigation and the Ombudsman was unaware of that.

The risk of the Ombudsman unintentionally exceeding his power and/or of conflict between the suggestions of the Ombudsman and the directions of the Coroner could be avoided by an MOU detailing how these respective functions will be exercised. An MOU has the advantage of flexibility – the parties can vary it as experience dictates.

On balance, however, the State Coroner considers that in view of the importance of these issues a more definitive articulation of the principle role and power of each office-holder or agency in the process is desirable.

Accordingly, the State Coroner supports the recommendation that provisions detailing the Ombudsman's power to monitor the investigation of critical incidents be inserted in the Police Act.

*5.1 "Critical incident" and "serious injury" are defined consistently with the use of those terms in the Critical Incident Guidelines.*

***State Coroner's response***
The State Coroner supports this recommendation

*5.2 Critical incidents are investigated in accordance with the Critical Incident Guidelines issued by the Commissioner of Police.*

***State Coroner's response***
The State Coroner supports this recommendation, subject to the comment under Recommendation 1 that it be mandatory for the Commissioner to consult with stakeholders when reviewing the Guidelines.

*5.3. The NSW Police Force shall advise the Ombudsman of the occurrence of a critical incident, as soon as it is reasonably practicable to do so.*

***State Coroner's response***
The State Coroner supports this recommendation

*5.4. The information provided by the NSW Police Force should include sufficient details of the incident and surrounding circumstances to enable the Ombudsman to decide whether to provide oversight of the investigation of the incident.*

***State Coroner's response***
The State Coroner supports this recommendation.

*5.5 The Ombudsman may provide oversight of the investigation of the critical incident if the Ombudsman considers that it is in the public interest to do so provided that such oversight:*

*is conducted in accordance with arrangements agreed between the Ombudsman and the Commissioner of Police,*

*does not include the power to supervise, control or direct the course of the police investigation, and*

*does not adversely impact upon the timely completion of the investigation.*

***State Coroner's response***

The State Coroner supports this recommendation subject to the arrangements in relation to the investigation of fatal critical incidents also being agreed by the State Coroner.

As detailed above, the current power of the Ombudsman to monitor investigations does not extend to supervising, controlling or directing the course of the investigation and the State Coroner does not recommend that it be enlarged.

*5.6 The Ombudsman may, after completion of the critical incident investigation report, publish a report on any oversight undertaken by his office and any such report may be responded to by the Commissioner of Police.*

***State Coroner's response***

The State Coroner supports this recommendation.

*5.7. The Ombudsmen is not to publish information whose publication may, in the opinion of the Commissioner of Police, prejudice the investigation or prevention of crime, or otherwise be contrary to the public interest.*

***State Coroner's response***

The State Coroner supports this recommendation.

*5.8 Any statement that is made in good faith by a police officer in response to questions about their involvement in a critical incident:*

*a. Is not, without the consent of the police officer who gave the statement, admissible in any civil or criminal proceedings against the police officer if the proceedings relate to the conduct in connection with which the statement was made, and*

*b. May not be used as the basis of taking action under Section 181D or reviewable or non-reviewable action (within the meaning of Section 173) against the police officer.*

***State Coroner's response***

The State Coroner does not support completely this recommendation. Police officers are members of a disciplined force with exceptional powers. Part of the safeguards against abuse of those powers is the ability of the Commissioner to require officers to account for their actions. It is essential to the maintenance of public confidence in the NSWPF that officers who may be guilty of misconduct are held to account and that appropriate remedial action is taken.

Therefore, while officers should not be required to forego their privilege against self-incrimination in the criminal investigations, officer safety and public safety mandates that compelled answers should be admissible in administrative and disciplinary proceedings.

*5.9 The power of the Ombudsman to provide oversight of a critical incident investigation under these provisions is not in derogation of any other powers of the Ombudsman except that, if the Ombudsman chooses to exercise such other powers, the Ombudsman must refrain from further exercising powers under these provisions.*

***State Coroner's response***

The State Coroner supports this recommendation.

**Recommendation 6**

*That subject to any legal advice on the matter, the NSW Police Force give consideretion to further amending the Criticel Incident Guidelines to specifically provide that, consistent with the relevant provisions of the Coroners Act, the Critical Incident Investigetion Team shall provide such assistance as is required by the State/Deputy state Coroner, including any instruction to which an inconsistent instruction has been provided from another agency.*

***State Coroner's response***

The State Coroner supports this recommendation and notes that if the State Coroner's response to Recommendations 4 and 5 are accepted there will be minimal opportunities for inconsistent instructions being given to the Critical Incident Investigation Team.

**Recommendation 7**

*7.1. That the Government consider obtaining advice from the Crown Solicitor as to whether a decision by the Commissioner of Police to suspend or defer an investigation under Part 8A of the Police Act 1990, in ordar to avoid prejudicing a Coronial Inquest relating to a critical incident, has the effect of suspending the powers of the Ombudsman to monitor such an investigation.*

***State Coroner's response***

If the State Coroner's response to Recommendation 5 is accepted this issue will be obviated.

*7.2 That the Government give consideration to requesting the WorkCover Authority of NSW to emend the WorkCover "Compliance Policy and Prosecution Guidelines" to more clearly define circumstances where cooperation with other agencies is appropriate including by refraining from investigeting a metter if that matter is being investigated by another law enforcement agency and continuation of the investigation by WorkCover may adversely impact on that other investigation.*

***State Coroner's response***

The State Coroner supports this recommendation.

**Recommendation 9 Media Policy**

*9. That the Government convene a meeting between NSW Police Force, the Coroner, the Police Integrity Commission, the Ombudsman end the Police Association of New South Wales with a view to those organisations conferring regarding developing a mutually agraed media protocol in respect to critical incidents to ensure that nay public comments made do not pre-empt investigative findings. Consideration should be given to including in that protocol:*

*9.1. Identification of who should be authorised to make statements to media at critical incidents on behalf of the respective organisations, either individually or collectively.*

*9.2. Guidance regarding the content of the media statement including:*

*a. acknowledgement of the tregedy,*
*b. reassurance of the community as to public safety,*
*c. expressing concern about the welfare of the family of the deceased,*
*d. expressing concern es to the welfare of any police involved,*

*e. in the event of death- stressing that the matter will be the subject of the Coroner's inquest,*
*f. stating that there will be a thorough police investigation and, in the case of death, that police investigators will forward a brief of evidence to the Coroner to assist with the inquest,*
*g. stating that the police investigation will be the subject of active oversight by the New South Wales Police Professional Standards Command who may also report to the Coroner,*
*h. stating that the investigation mey also be independently overseen by the Ombudsman and or the Police Integrity Commission,*
*i. edvising that neither the police investigation nor the oversight will prejudge the outcome of the Coroner's inquest.*

***State Coroner's response***

In view of the compelling evidence that media statements can affect the recall of witnesses and the confidence of the public in the integrity of the investigation, the Stete Coroner supports this recommendation.