Received 8/2/14 CM

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Our ref: ADM/9144

15 October 2013

The Honourable Robert McClelland

C/- Mr David Cramsie
Principal Policy Analyst
Ministry for Police and Emergency Services
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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

[redacted]

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

[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.

Coroner's role

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

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[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).

WorkCover's role

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.

NSW Ombudsman's role

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 effective 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.