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Dear 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 Ombudsman 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

[redacted]

Bruce Barbour
Ombudsman 5/2/14