

**Question on notice:**

**Mr DAVID SHOEBRIDGE:** Could you give the Committee on notice an indication—if you have it now, then fine—of what your current budget is in the space of Corrective Services and how it is allocated?

**Response:**

Currently, budget funding to the NSW Ombudsman is appropriated to the Premier “for the services of the Ombudsman’s Office” under Part 4 (Special Officers) of the annual *Appropriation Act*. The Ombudsman’s Office also receives a modest amount of retained revenue from the provision of training services.

The current internal allocation of funding amongst the various activities and functions of the Ombudsman’s office is set out below. As explained there, while the office has a small dedicated Detention and Custody Team, not all work concerning custodial service issues is performed within that team; the Investigations, Engagement and Aboriginal Inclusion Team and other parts of the office are regularly involved in performing functions that relate to custodial services.

**NSW Ombudsman’s Office Budget 2020/21**

<b>Staffing</b>	<b>ERE Budget</b>	<b>Non-ERE Budget</b>
<b>FTE</b>	<b>‘000</b>	<b>‘000</b>

**Table 1: NSW Ombudsman’s budget (2020/21)\***

Total Budgeted expenses for NSW Ombudsman’s Office (2020/21)	<b>144.9</b>	<b>\$20,089</b>	<b>\$7,756</b>
<i>Less amounts allocated to statutory office holders and whole of office activities:</i>			
<i>Statutory Officers and Senior Executives</i>	<i>7.0</i>	<i>\$2,243</i>	<i>0</i>
<i>Leases and licences / Corporate support functions / Legal and governance / Executive office support / Communications / Data analytics</i>	<i>41.1</i>	<i>\$6,283</i>	<i>\$6,893</i>
<i>Equals Discretionary amount available for allocation to individual functional areas</i>	<b>96.8</b>	<b>\$11,563</b>	<b>\$863</b>

\*Recurrent funding only (excludes capital expenditure).

**Table 2: NSW Ombudsman’s internal allocation of discretionary budget (2020/21)**

Discretionary amount available for allocation to individual functions, currently allocated as follows:	Summary of main functions:	96.8	\$11,563	\$863
Investigations	<p>Investigate and report on conduct of public authorities, and community service providers that may be unlawful, unjust, unreasonable, etc or in the case of community service providers, raises a significant issue of public safety or about appropriate care or treatment.</p> <p>Conduct inquiries under the <i>Ombudsman Act</i> or <i>Community Services (Complaints Reviews and Monitoring) Act</i>.</p> <p>Undertake systemic investigations of maladministration in public or community services.</p>	12.0	\$1,514	\$48
Inquiries & Resolution	<p>Resolve (by way of liaison, preliminary inquiries and conciliation) complaints received about conduct of public authorities or community service providers.</p> <p>Make suggestions for corrective or practice improvement action by public authorities or community service providers.</p>	20.0	\$2,448	\$77
Assessments				
<p>- Detention and custody specialist team** (NB: supported by junior members of the Assessments Generalist team on a rotational basis)</p>	<p>Co-ordinate the provision of oversight and complaint-handling services to inmates of correctional facilities and detainees of youth justice centres.</p> <p>Receive and monitor mandatory notifications (segregations of 24 hours or more) from youth justice centres.</p>	4.0	\$542	\$17

<b>Discretionary amount available for allocation to individual functions, currently allocated as follows:</b>	<b>Summary of main functions:</b>	<b>96.8</b>	<b>\$11,563</b>	<b>\$863</b>
	Lead visits to correctional facilities and youth justice centres.			
- Generalist team	<p>Receive and respond to complaints about public authorities and community service providers (acknowledge, respond, rapid resolve, refer, or escalate).</p> <p>Receive public interest disclosures (whistleblower reports) from public officials.</p> <p>Receive and respond to inquiries from members of the public, public authorities and community service providers.</p>	23.0	\$2,360	\$75
Public Interest Disclosures	<p>Provide information, assistance and training to public authorities and promote public awareness of the PID Act.</p> <p>Prepare and issue guidelines on the application of the PID Act.</p> <p>Monitor and audit compliance by public authorities with the PID Act</p> <p>Provide monitoring reports and audit reports to the NSW Parliament.</p> <p>Provide policy advice on the PID Act and proposed reforms.</p> <p>Receive statistical reports from Public Authorities on compliance with obligations under the PID Act</p> <p>Convene the PID Steering Committee</p>	6.0	\$747	\$31
Community Services and Strategic Projects	Review and report on community service providers' systems for handling complaints.	7.0	\$946	\$40

<b>Discretionary amount available for allocation to individual functions, currently allocated as follows:</b>	<b>Summary of main functions:</b>	<b>96.8</b>	<b>\$11,563</b>	<b>\$863</b>
	<p>Monitor and review the delivery of community services and inquire into matters affecting service providers and receivers.</p> <p>Promote and assist the development of community service standards.</p> <p>Undertake systemic research and reviews on issues in public administration and community service provision.</p>			
Child Death reviews	<p>Monitor and review reviewable deaths (children):</p> <ul style="list-style-type: none"> <li>• children who die while in care or detention</li> <li>• children whose deaths were due to abuse or neglect or otherwise occurred in suspicious circumstances.</li> </ul> <p>Maintain a register of reviewable deaths in NSW, analyse data to identify patterns and trends in reviewable deaths, undertake research and make recommendations to prevent and reduce such deaths. Report to the NSW Parliament on reviewable deaths.</p> <p>Convene, and support and assist the work of, the NSW Child Death Review Team (CDRT): Maintain a register of all child deaths in NSW, analyse data to identify patterns and trends in reviewable deaths, undertake research and make recommendations to prevent and reduce child deaths. Report to the NSW Parliament on child deaths in NSW.</p>	10.5	\$1,390	\$58
Disability Death reviews and Reportable incident oversight	<p>Monitor and review reviewable deaths of persons with a disability who were living in supported group accommodation or an assisted boarding house.</p> <p>Analyse data to identify patterns and trends in reviewable deaths, undertake research and make</p>	5.5	\$557	\$23

<b>Discretionary amount available for allocation to individual functions, currently allocated as follows:</b>	<b>Summary of main functions:</b>	<b>96.8</b>	<b>\$11,563</b>	<b>\$863</b>
	recommendations to prevent and reduce such deaths. Report to Parliament on reviewable deaths. Receive mandatory reports, and monitor departmental investigations, of disability reportable incidents in supported group accommodation (sexual misconduct, assault, ill-treatment, neglect, unexplained serious injury). (Note: funding for reportable incident oversight function ceased on 31 December 2020. Residual roles will relate to closure of open matters and provision of advice for the NDIS Worker Screening Check).			
Aboriginal Program Monitoring	Monitor and assess prescribed Government Aboriginal programs (OCHRE) under Part 3B of the <i>Ombudsman Act</i> .	2.0	\$269	\$69
Engagement and Aboriginal Inclusion	Receive and respond to inquiries from Aboriginal and/or CALD members of the public.  Ensure complaints and inquiries are handled in accordance with our office-wide cultural competency framework, and provide support (by way of liaison, preliminary inquiries and conciliation) when complaints are received from Aboriginal and/or CALD members of the public relating to conduct of public authorities or community service providers.	3.8	\$487	\$125
External education and training	Co-ordinate the provision of training material and courses to public authorities and community service providers, including in the areas of front-line complaints handling, managing conflicts of interest and good administrative practice.	3.0	\$302	\$299

\*\* The work of the Detention and Custody Team supports and is supported by staff in other areas of the office. For example:

- The Detention and Custody Team leads visits to custodial facilities. Other staff may also attend visits to provide general assistance or specialist advice and support (eg. staff from the Aboriginal Inclusion & Community Engagement Team).
- Members of the Assessments Unit (Generalist Team) assist the Detention and Custody Team by receiving inquiries and complaints from and about custodial facilities, for example, when members of the Detention and Custody Team are visiting custodial facilities. Junior members of the Assessments Unit (Generalist Team) are placed with the Detention and Custody Team on a rotational basis to ensure they have the knowledge and skills to handle custodial matters.
- The Detention and Custody Team forms part of the Assessments Unit.
- Matters relating to custodial services may be escalated from that team to the Inquiries & Resolution Unit as required (eg. if the matter requires more detailed inquiries or dispute resolution to be undertaken).
- Matters that require formal investigation under the *Ombudsman Act* are referred to the Investigations Unit.
- The Inquiries & Resolutions Unit and the Investigations Unit will draw upon the specialist knowledge and advice of the Detention and Custody Team as needed.
- The Public Interest Disclosures Team provides specialist advice and assistance regarding public interest disclosures made by public officials from or about custodial facilities.
- The Engagement and Aboriginal Inclusion Team provides internal training, advice and assistance to ensure Aboriginal inmates and detainees who contact the Ombudsman are treated in a culturally appropriate manner.

## Investigations into deaths in custody: Overview

	Death in a Youth Justice facility	Death in CSNSW custody	Death in Police custody
<b>Coronial investigation</b> (Primary purpose: Identity of deceased, manner and cause of death; may also make prevention recommendations)	<b>Senior Coroner</b> utilising Police investigators	<b>Senior Coroner</b> utilising Police investigators	<b>Senior Coroner</b> utilising Police investigators
<b>Criminal investigation</b>	<b>Police</b>	<b>Police</b>	<b>Police</b>
<b>Internal Investigation</b> (Primary purpose: 'just cause' analysis; identification of systemic flaws; improvement and prevention recommendations)	<b>YJ and JH&amp;FMHN</b>	Private prison operator, <b>CSNSW</b> and <b>JH&amp;FMHN</b>	<b>Police</b> (Critical Incidents Unit) <sup>1</sup>
<b>External monitoring of internal investigation</b> <sup>2</sup>	None (However, where the death is of a person under the age of 18, and there has been 'reportable conduct' involved – ill-treatment, neglect or assault – the investigation would be externally monitored by the <b>Children's Guardian</b> ) <sup>3</sup>	None	<b>LECC</b>
<b>External Investigation</b> <sup>4</sup>	<b>Ombudsman</b> – if reason to suspect misconduct or maladministration falling within the description of Ombudsman Act s 26  <b>Children's Guardian</b> <sup>5</sup> - where the death is of a person under the age of 18, and there has been 'reportable conduct' involved – ill-treatment, neglect or assault.	<b>Ombudsman</b> – if reason to suspect misconduct or maladministration falling within the description of Ombudsman Act s 26	<b>LECC</b>

<sup>1</sup> A critical incident is an incident declared to be a critical incident under s 111 of the *Law Enforcement Conduct Commission Act 2016*.

<sup>2</sup> The Ombudsman could, for the purposes of determining whether an external (Ombudsman) investigation is warranted, undertake 'preliminary inquiries' about an internal investigation by CSNSW or Youth Justice (*Ombudsman Act 1974*, s 13AA) but the Ombudsman does not have a standing duty or power to monitor investigations by either CSNSW or Youth Justice.

<sup>3</sup> The Children's Guardian may monitor the progress of an investigation in relation to reportable allegations and reportable convictions (*Children's Guardian Act 2019*, s 43). The reportable conduct scheme only applies to children (under 18) where particular conduct ('reportable conduct') is alleged or a 'reportable conviction' has occurred. The death of a person aged 18-21 in a youth justice centre could not be monitored by the Children's Guardian (*Children's Guardian Act 2019*, schedule 6).

<sup>4</sup> In practice, an external investigation by the LECC (in the case of Police) or the Ombudsman (in the case of CSNSW and Youth Justice) is unlikely to be pursued if the matter is already the subject of coronial and/or criminal investigation and those investigations are considered likely to identify any relevant misconduct or maladministration.

<sup>5</sup> The Children's Guardian may, if the Children's Guardian reasonably believes it is in the public interest investigate a reportable allegation, or investigate the way in which a relevant entity has dealt with, or is dealing with, a report, complaint or notification of reportable conduct (*Children's Guardian Act 2019*, s 46(1)). The reportable conduct scheme only applies to children (under 18) therefore no death of a young person aged 18-21 in a youth justice centre would be investigated by the Children's Guardian (*Children's Guardian Act 2019*, schedule 6).

**Investigation and oversight of deaths occurring in youth justice centres**

	Agency/internal investigation	NSW Coroner	NSW Police	NSW Ombudsman	Office of the Children’s Guardian (OCG)	Inspector of Custodial Services (ICS)	Health Care Complaints Commission (HCCC)
<p><b>Youth justice centres</b></p> <ul style="list-style-type: none"> <li>Operated by Youth Justice</li> <li>Health services by JH&amp;FMHN</li> </ul>	<p>All deaths in youth justice centres are subject to internal review. JH&amp;FMH policy on the management of deaths provides that all deaths are to be reported to the Ministry of Health as a Reportable Incident Brief, and attendance by the Coroner will be arranged by Youth Justice (JH&amp;FMHN, <i>Management of a Death</i> (22 January 2018), pp 2, 6).</p> <p>On becoming aware than a detainee has died, JH&amp;FMHN officer must report the death to the Secretary (<i>Children (Detention Centres) Regulation</i>, cl 136).</p> <p><b>Purpose</b></p> <ul style="list-style-type: none"> <li>Root cause analysis</li> <li>Investigate possible breaches of policies and procedures</li> <li>Examine appropriateness of organisation’s policies, procedures, training etc</li> <li>Determine whether referral to another agency is necessary/warranted.</li> </ul>	<p>When there is a death in custody or as a result of a police operation it is mandatory that an inquest be held by a senior coroner (<i>Coroners Act 2009</i>, ss 23, 27).</p> <p>A coroner may give a police officer directions concerning investigations to be carried out for the purposes of coronial proceedings or proposed coronial proceedings (<i>Coroners Act 2009</i>, s 51).</p> <p><b>Purpose</b></p> <ul style="list-style-type: none"> <li>to enable coroners to investigate certain kinds of deaths or suspected deaths in order to determine the identities of the deceased persons, the times and dates of their deaths and the manner and cause of their deaths</li> <li>to enable coroners to make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies) (as per objects of <i>Coroners Act</i>, s 3).</li> </ul>	<p>Youth Justice will contact NSW Police Force officers to attend the death and act on behalf of the Coroner (JH&amp;FMHN, <i>Management of a Death</i>) (22 January 2018, p. 8).</p> <p>A coroner may give a police officer directions concerning investigations to be carried out for the purposes of coronial proceedings or proposed coronial proceedings (<i>Coroners Act 2009</i>, s 51).</p> <p>The <i>Law Enforcement (Powers and Responsibilities) Act 2002</i> provides for police powers, such as search &amp; seizure (Parts 4 and 5), the establishment of crime scenes (Part 7), and arrest (Part 8).</p> <p><b>Purpose</b></p> <ul style="list-style-type: none"> <li>Investigation of possible criminal offences</li> <li>Assistance with coronial proceedings.</li> </ul>	<p>Anyone can complain to the Ombudsman about the conduct of public authorities, and some public bodies that perform public functions (including privately managed custodial facilities).</p> <p>There are additional statutory provisions providing those detained or in custody with access to the Ombudsman for the purpose of making a complaint. (<i>Ombudsman Act 1974</i>, s 12(3)).</p> <p>The Ombudsman may commence an investigation in the absence of a complaint if it appears conduct is unlawful, unreasonable, oppressive, improperly discriminatory or otherwise wrong (see <i>Ombudsman Act 1974</i>, s 26).</p> <p>The Ombudsman receives mandatory notifications of and monitors the segregation of detainees in youth justice centres if the segregation extends beyond 24 hours (<i>Children (Detention Centres) Regulation 2015</i>, cl 10(2)(a)).</p> <p>If a child (under 18) dies in custody, the death would be a child death reviewable by the Ombudsman. Agencies involved with the child would be required to provide the Ombudsman with full access to records reasonably required to review the death (Part 6, <i>Community Services (Complaints, Reviews and Monitoring) Act 1993</i>).</p> <p><b>Purpose</b></p> <ul style="list-style-type: none"> <li>independent complaint handling and oversight</li> <li>identification of conduct outlined in s 26 of the <i>Ombudsman Act 1974</i> and recommending corrective actions</li> </ul>	<p>Since March 2020 the OCG as administered the reportable conduct scheme for child protection.</p> <p>Reportable conduct includes a sexual offence, sexual misconduct, ill-treatment of a child, neglect of a child and assault against a child (<i>Children’s Guardian Act 2019</i>, Part 4).</p> <p>The OCG oversees how certain organisations, including youth justice centres, investigate and report on reportable allegations and reportable convictions made against their employees, volunteers or certain contractors who provide services to children.</p> <p><b>Purpose</b></p> <ul style="list-style-type: none"> <li>Provide oversight and guidance on investigations of reportable conduct</li> <li>Ensure appropriate action to reportable conduct is taken by the relevant entity</li> <li>Monitor relevant entities’ systems for preventing, detecting and dealing with reportable conduct.</li> </ul>	<p>The functions of the Inspector are to inspect each custodial centre, examine and review custodial services, and to oversee the Official Visitors Program (<i>Inspector of Custodial Services Act 2012</i>, s 6.)</p> <p>The ICS has no jurisdiction to oversee Youth Justice supervision of young people in the community.</p> <p><b>Purpose:</b> To report to Parliament about inspections, examinations and reviews; and matters relating to the functions of the Inspector if in the public interest or requested by the Minister.</p>	<p>The HCCC considers complaints made by people who have concerns about the quality of care and treatment provided to a patient or concerns about the ethical or professional conduct of a health practitioner.</p> <p>(<i>Health Care Complaints Act 1993</i>).</p> <p><b>Purpose</b> The HCCC has a central role in maintaining the integrity of the NSW health system, with the overarching aim of protecting the health and safety of individuals and the community.</p>



				<ul style="list-style-type: none"> <li>Monitor and review reviewable deaths; and formulation of recommendations for the prevention or reduction of deaths of children (s 36 <i>Community Services (Complaints, Reviews and Monitoring) Act 1993</i>).</li> </ul>			
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Note:

- The Independent Commission Against Corruption is responsible for investigating, exposing and preventing corruption involving or affecting public authorities and public officials in NSW (*Independent Commission Against Corruption Act 1988*).
- ‘Notifiable incidents’ (including a death) arising out of the conduct of a business or undertaking must be notified to SafeWork. *Work Health and Safety Act 2011*, Part 3. See also [Incident notification | SafeWork NSW](#)
- People who deliver certain services to children are ‘mandatory reporters’ if they have reasonable grounds to suspect that a child is at risk of significant harm (*Children and Young Persons (Care and Protection) Act 1988*).
- The Law Enforcement Conduct Commission has no powers or functions to oversight the operations and services within youth justice centres or the supervision of young people in the community by Youth Justice.
- Relevant Youth Justice policies are not publicly available.

**Investigation and oversight of deaths occurring in correctional centres and other adult custodial facilities<sup>6</sup>**

	Agency/internal investigation	NSW Coroner	NSW Police	NSW Ombudsman	Inspector of Custodial Services (ICS)	Health Care Complaints Commission (HCCC)
<p><b>Correctional centres</b></p> <ul style="list-style-type: none"> <li>Operated by CSNSW</li> <li>Health services by JH&amp;FMHN</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Operated by private provider</li> </ul> <p>Junee CC operated by GEO Group Australia, which also provides health services.</p> <p>Parklea CC operated by MTC-Broadspectrum. Health services provide by St Vincent's Hospital Sydney Ltd</p> <p>Clarence CC operated by Serco Group, which also provides health services.</p>	<p>All deaths in correctional centres are subject to internal review. JH&amp;FMH policy on the management of deaths provides that all deaths are to be reported to the Ministry of Health as a Reportable Incident Brief, and attendance by the Coroner will be arranged by CSNSW (JH&amp;FMHN, <i>Management of a Death</i> (22 January 2018), p. 2).</p> <p>The governor of a correctional centre must give written notice to a coroner immediately after becoming aware of the death of any inmate who is in the custody of the governor (<i>Crimes (Administration of Sentences) Act 1999</i> s 74).</p> <p><b>Purpose</b></p> <ul style="list-style-type: none"> <li>Root cause analysis</li> <li>Investigate possible breaches of policies and procedures</li> <li>Examine appropriateness of organisation's policies, procedures, training etc</li> <li>Determine whether referral to another agency is necessary/warranted.</li> </ul>	<p>When there is a death in custody or as a result of a police operation it is mandatory that an inquest be held by a senior coroner (<i>Coroners Act 2009</i>, ss 23, 27).</p> <p>A coroner may give a police officer directions concerning investigations to be carried out for the purposes of coronial proceedings or proposed coronial proceedings (<i>Coroners Act 2009</i>, s 51).</p> <p><b>Purpose</b></p> <ul style="list-style-type: none"> <li>to enable coroners to investigate certain kinds of deaths or suspected deaths in order to determine the identities of the deceased persons, the times and dates of their deaths and the manner and cause of their deaths</li> <li>to enable coroners to make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies) (as per objects of <i>Coroners Act</i>, s 3).</li> </ul>	<p>CSNSW will contact NSW Police Force officers to attend the death and act on behalf of the Coroner ((JH&amp;FMHN, <i>Management of a Death</i> (22 January 2018), p 8).</p> <p>A coroner may give a police officer directions concerning investigations to be carried out for the purposes of coronial proceedings or proposed coronial proceedings (<i>Coroners Act 2009</i>, s 51).</p> <p>The <i>Law Enforcement (Powers and Responsibilities) Act</i> provides for police powers, such as search &amp; seizure (Parts 4 and 5), the establishment of crime scenes (Part 7), and arrest (Part 8).</p> <p><b>Purpose</b></p> <ul style="list-style-type: none"> <li>Investigation of possible criminal offences</li> <li>Assistance with coronial proceedings.</li> </ul>	<p>Anyone can complain to the Ombudsman about the conduct of public authorities, and some public bodies that perform public functions (including privately managed custodial facilities - see <i>Crimes (Administration of Sentences Act 1999</i>, s 246).</p> <p>There are additional statutory provisions providing those detained or in custody with access to the Ombudsman for the purpose of making a complaint (<i>Ombudsman Act 1974</i>, s 12(3)).</p> <p>The Ombudsman may commence an investigation in the absence of a complaint if it appears conduct is unlawful, unreasonable, oppressive, improperly discriminatory or otherwise wrong (see <i>Ombudsman Act 1974</i>, s 26).</p> <p><b>Purpose</b></p> <ul style="list-style-type: none"> <li>independent complaint handling and oversight</li> <li>identification of conduct outlined in s 26 of the <i>Ombudsman Act 1974</i> and recommending corrective actions.</li> </ul>	<p>The functions of the Inspector are to inspect each custodial centre, examine and review custodial services, and to oversee the Official Visitors Program (<i>Inspector of Custodial Services Act 2012</i>, s 6.)</p> <p>The ICS has no jurisdiction to oversight people in the community subject to CSNSW supervision (eg. parole).</p> <p><b>Purpose:</b> To report to Parliament about inspections, examinations and reviews; and matters relating to the functions of the Inspector if in the public interest or requested by the Minister.</p>	<p>The HCCC considers complaints made by people who have concerns about the quality of care and treatment provided to a patient or concerns about the ethical or professional conduct of a health practitioner.</p> <p>(<i>Health Care Complaints Act 1993</i>)</p> <p><b>Purpose</b> The HCCC has a central role in maintaining the integrity of the NSW health system, with the overarching aim of protecting the health and safety of individuals and the community.</p>

Note:

- The Independent Commission Against Corruption is responsible for investigating, exposing and preventing corruption involving or affecting public authorities and public officials in NSW (*Independent Commission Against Corruption Act 1988*). The *Independent Commission Against Corruption Act 1988* also applies to privately managed correctional centres (*Crimes (Administration of Sentences) Act 1999*, s 245).
- 'Notifiable incidents' (including a death) arising out of the conduct of a business or undertaking must be notified to SafeWork. *Work Health and Safety Act 2011*, Part 3. See also [Incident notification | SafeWork NSW](#)
- The Law Enforcement Conduct Commission has no powers or functions to oversight the operations and services within correctional centres or the supervision of people in the community by CSNSW.
- Relevant CSNSW policies and policies of private prison operators are not publicly available.

<sup>6</sup> Includes 24-hour court cell complexes, diversionary centres (residential facilities), transitional centres.

**Investigation and oversight of deaths occurring in police custody and during police operations**

	<b>Agency/internal investigation</b>	<b>NSW Coroner</b>	<b>NSW Police</b>	<b>LECC</b>	<b>Office of the Children’s Guardian (OCG)</b>
Police custody or during police operation	<p>The Commissioner of Police is to ensure that the actions of members of the Police Force involved in a critical incident at the time of, and leading up to, the critical incident are fully and properly investigated by the NSW Police Force (<i>Law Enforcement Conduct Commission Act 2016, s 113</i>).</p> <p>The Commissioner of Police may declare an incident to be a critical incident if it involves the NSW Police Force and exhibits the feature of a critical incident, or has other grounds for considering it is in the public interest to do so (<i>Law Enforcement Conduct Commission Act 2016, s 111</i>).</p> <p>The features of a critical incident are an incident that results in the death of, or serious injury to a person and the death or serious injury:</p> <ul style="list-style-type: none"> <li>• arises from a discharge of a firearm by the member involved,</li> <li>• arises from the use or operation of defensive equipment by the member involved,</li> <li>• arises from the application of physical force by the member involved while exercising any function as a police officer, or</li> <li>• arises from the use of a police vehicle by the member involved (including its use as a passenger),</li> <li>• arises while the person is in custody or while escaping or attempting to escape from custody, or</li> <li>• appears to be likely to have resulted from any police operation.</li> </ul> <p>(<i>Law Enforcement Conduct Commission Act 2016, s 110</i>).</p> <p>The Commissioner may revoke a critical incident declaration at any time (<i>Law Enforcement Conduct Commission Act 2016, s 111(4)</i>).</p> <p>Critical incident guidelines stipulate that, at the conclusion of the coronial inquest, the senior critical incident investigator will prepare the final critical incident investigation report, which includes any comments or recommendations by the Coroner.<sup>7</sup></p> <p><b>Purpose</b></p> <ul style="list-style-type: none"> <li>• Investigation of critical incidents.</li> </ul>	<p>When there is a death in custody or as a result of a police operation it is mandatory that an inquest be held by a senior coroner (<i>Coroners Act 2009, ss. 23, 27</i>).</p> <p>A police operation means any activity engaged in by a police officer while exercising the functions of a police officer other than activity for the purpose of a search and rescue operation (<i>Coroners Act 2009, s 23(2)</i>).</p> <p>A coroner may give a police officer directions concerning investigations to be carried out for the purposes of coronial proceedings or proposed coronial proceedings (<i>Coroners Act 2009, s 51</i>).</p> <p><b>Purpose</b></p> <ul style="list-style-type: none"> <li>• to enable coroners to investigate certain kinds of deaths or suspected deaths in order to determine the identities of the deceased persons, the times and dates of their deaths and the manner and cause of their deaths</li> <li>• to enable coroners to make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies) (as per objects of <i>Coroners Act, s 3</i>).</li> </ul>	<p>A coroner may give a police officer directions concerning investigations to be carried out for the purposes of coronial proceedings or proposed coronial proceedings (<i>Coroners Act 2009, s 51</i>).</p> <p>The <i>Law Enforcement (Powers and Responsibilities) Act</i> provides for police powers, such as search &amp; seizure (Part 4), the establishment of crime scenes (Part 7), and arrest (Part 8).</p> <p><b>Purpose</b></p> <ul style="list-style-type: none"> <li>• Investigation of possible criminal offences</li> <li>• Assistance with coronial proceedings.</li> </ul>	<p>Part 8 of the <i>Law Enforcement Conduct Commission Act 2016</i> governs oversight of critical incidents. This provides:</p> <ul style="list-style-type: none"> <li>• The Commissioner of Police must ensure the LECC is given notice of the making of a critical incident declaration immediately after it is made (s 112).</li> <li>• The LECC may monitor the conduct of the critical incident investigation if in the public interest (s114), including being present during an interview (with the consent of the person being interviewed and the senior critical incident investigator)<sup>8</sup></li> <li>• The LECC must exercise this function in accordance with any arrangements between LECC and the Commissioner of police, and any directions of the Coroner (s 115(3))</li> <li>• The LECC cannot control, supervise, direct or interfere with the carrying out by police officers of their function of investigating the critical incident (s 115(4))</li> <li>• The LECC may provide advice to the police about certain matters during the course of the critical incident investigation (s 116).</li> <li>• The LECC may make public advice it has given at any time after the conclusion of the critical incident investigation (s 117(8))</li> <li>• The LECC must postpone making a decision about a police misconduct matter if the subject of the misconduct matter is the conduct of a police officer who was involved in a critical incident that is the subject of an investigation until the conclusion of any critical incident investigation of the incident (s 44(9) and 119).</li> </ul> <p><b>Purpose</b></p> <ul style="list-style-type: none"> <li>• Oversight of critical incidents.</li> </ul>	<p>From March 2020 the OCG administers the reportable conduct scheme.</p> <p>Reportable conduct includes a sexual offence, sexual misconduct, ill-treatment of a child, neglect of a child and assault against a child (<i>Children’s Guardian Act 2019, Part 4</i>).</p> <p>The OCG oversees how certain organisations, including NSW Police, investigate and report on reportable allegations and reportable convictions made against their employees, volunteers or certain contractors who provide services to children.</p> <p><b>Purpose</b></p> <ul style="list-style-type: none"> <li>• Providing oversight and guidance on investigations of reportable conduct</li> <li>• Ensuring appropriate action to reportable conduct is taken by the relevant entity</li> <li>• Monitoring relevant entities’ systems for preventing, detecting and dealing with reportable conduct.</li> </ul>

<sup>7</sup> Law Enforcement Conduct Commission, *Review of 29 NSW Police Force critical incident investigations* (June 2019) p 22.

<sup>8</sup> ‘In every critical incident investigation to date, involved police officers have refused to consent for the Commission investigator to be present or to remotely observe their interviews. This appears to be a consistent and state-wide position taken by police officers involved in critical incidents. The power to observe interviews of involved officers in critical incident investigations, as it currently stands in the LECC Act, appears to be an illusory power.’ Law Enforcement Conduct Commission, *Annual Report 2019-20*, p 55.