LECC Law Enforcement Conduct Commission

Five Years (2017 – 2022) of Independent Monitoring of NSW Police Force Critical Incident Investigations

May 2023

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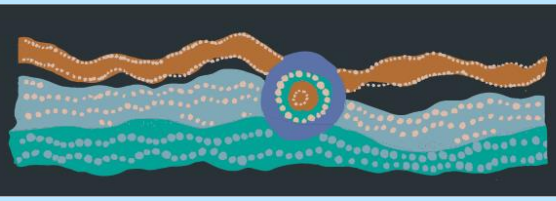
The Law Enforcement Conduct Commission acknowledges and pays respect to the Traditional Owners and Custodians of the lands on which we work, and recognises their continuing connection to the lands and waters of NSW. We pay our respects to the people, the cultures, and the Elders past and present.



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22 May 2023

The Hon. Benjamin Cameron Franklin, MLC
President
Legislative Council
Parliament House
SYDNEY NSW

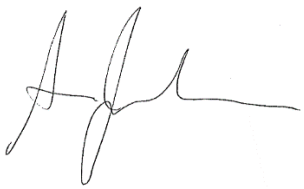
The Hon. Greg Piper MP
Speaker
Legislative Assembly
Parliament House
SYDNEY NSW 2000

Dear Mr President and Mr Speaker

Under section 138 of the *Law Enforcement Conduct Commission Act 2016* (the Act), the Commission provides you with a copy of its report called *Five Years (2017 – 2022) of Independent Monitoring of NSW Police Force Critical Incident Investigations.*

Under section 142(2) of the Act, we recommend that this report be made public immediately.

Yours sincerely



The Hon. Peter Johnson SC
Chief Commissioner

Anina Johnson
Commissioner

Foreword

Whenever the actions of police are connected with the death or serious injury of a member of the public, those actions should be carefully and independently scrutinised.

In NSW, investigations into "critical incidents" are conducted by the NSW Police Force. However, in 2017, when established, the Law Enforcement Conduct Commission was given the function of independently oversighting these investigations. This report reviews the first 5 years of the Commission's oversight of critical incidents. It also recommends improvements that will help the Commission's monitoring of future critical incident investigations and build public confidence in their integrity.

When the Commission monitors a critical incident it considers:

- whether the investigation is fully and properly conducted;
- the lawfulness and reasonableness of police actions both at the time of and, leading up to, the incident;
- any evidence of officer misconduct;
- any systemic safety or procedural issues that arise and the need for changes to NSWPF policies and procedures.

If the Commission has concerns, these are raised directly with NSWPF while the investigation is underway. The Commission's involvement has led police to take a different approach to some critical incident investigations. Police have addressed systemic or procedural issues or responded to concerns about police training or conduct.

The majority of critical incident investigations are conducted in a thorough and objective manner. However, there is scope for improvement:

- Police critical incident investigations are usually linked to coronial and criminal proceedings but are usually finalised only after the court proceedings have finished. This process can take years. The chance to swiftly improve policies and practices is being missed. The Commission recommends that the NSWPF prepare an interim critical incident investigation report before coronial proceedings begin, so that changes are identified and implemented in a timely manner.

- A high proportion of critical incidents involve a person experiencing a mental health crisis. Despite this, police training on how to respond to someone in mental health crisis is currently extremely limited. The Commission supports increasing the training for Police and expanding the Police Ambulance Clinician Early Response Program.

- Police do not usually deal with misconduct identified during a critical incident investigation until after criminal or coronial proceedings have finished. This leads to a risk that misconduct may continue or reoccur.

The Commission's monitoring role reassures victims, families and the public that a critical incident has been thoroughly and fairly investigated. If the recommendations in this review were implemented, the Commission's role would be even stronger.

Contents

Recommendations

List of Case Studies

List of tables

1. Introduction

On 1 July 2017, the Law Enforcement Conduct Commission ('the Commission') was established as a new single civilian agency for the oversight of law enforcement in NSW under the *Law Enforcement Conduct Commission Act 2016* ('the LECC Act').

The Commission assumed all of the functions of the previous police oversight system administered by the Police Integrity Commission and the Police Branch of the NSW Ombudsman. In addition, the Commission was given a significant new responsibility to independently oversight NSW Police Force (NSWPF) critical incident investigations.[1]

A critical incident is an incident involving a police officer or other member of the NSWPF that results in death or serious injury to a person, during a police operation.[2] The NSWPF is required to investigate the actions of its members involved in a critical incident.[3] Where it is in the public interest to do so, the Commission monitors the NSWPF investigation of critical incidents from the time of the incident until the completion of the investigation by police. This provides assurance to the public that police investigations into critical incidents are conducted in a competent, thorough, and objective manner.

In this report, the Commission reflects on the first five years of its activities in oversighting NSWPF critical incident investigations and makes recommendations in relation to how the oversight of critical incident investigations could be improved.

Further information relating to the Commission's critical incident monitoring function can be found on the Commission's website, www.lecc.nsw.gov.au/oversight/critical-incident-monitoring.

1.1 Background to the Commission's responsibility to monitor critical incident investigations

In 2015, former NSW Shadow Attorney General and Shadow Minister for Police, Andrew Tink AM, was commissioned by the NSW Government to consider options for a single civilian oversight model for police. Mr Tink received submissions from the public, key stakeholders and affected agencies and, produced a report entitled Review of Police Oversight ('the Tink Report'), outlining his findings and recommendations.[4]

In addition to recommending a single civilian police oversight model, the Tink Report identified a number of gaps in the existing police oversight system.[5] One gap identified was that there was 'an urgent need' to ensure that critical incidents involving the death or serious injury to a person and arising from an interaction with police, were notified to, and monitored by, an independent civilian oversight authority from the outset of the police investigation into the incident. The NSW Government agreed.

[1] *Law Enforcement Conduct Commission Act 2016*, Part 8.
[2] *Law Enforcement Conduct Commission Act 2016*, ss 108 & 110.
[3] *Law Enforcement Conduct Commission Act 2016*, s113(1).
[4] Review of Police Oversight, Andrew Tink AM, 31 August 2015.
[5] Review of Police Oversight, Andrew Tink AM, 31 August 2015, p 64.

When death or serious injury to a person arises from an interaction with police, the NSWPF initiates a special type of internal investigation, called a critical incident investigation.[6]

Prior to the establishment of the Commission, there was no obligation for the NSWPF to notify oversight agencies of a critical incident. A critical incident investigation would only be monitored by an oversight agency if a complaint had been made about the actions of police, or an oversight agency had otherwise become aware of potential police misconduct, *via* court proceedings or through the media.[7] This was considered insufficient for a number of reasons.

Firstly, critical incidents do not necessarily involve police misconduct. The reality is that from time to time, police are faced with a difficult situation and are required to make unenviable split-second decisions. Sometimes the outcome is tragic and results in the death of, or serious injury to, a person. In such cases, the outcome alone justifies scrutiny of police actions at the time of, and leading to, a person's death or serious injury.

In addition, if there are concerns about possible misconduct, the family members of deceased or seriously injured persons do not usually have sufficient knowledge or information, on which to make allegations of misconduct. In addition, if misconduct is raised in the course of related court proceedings, the issues may not be able to be identified for several months or years after the incident.

That being so, there is a legitimate public interest and expectation that such incidents are investigated in a transparent, thorough, and objective manner. Submissions to Mr Tink expressed concern that having NSWPF officers both investigate and quality review a critical investigation in accordance with the NSWPF Critical Incident Guidelines was not sufficient for the public to be satisfied that the incident was investigated in an independent and impartial manner.[8] These concerns were heightened as a consequence of critical incidents which were oversighted by the NSW Ombudsman, and alleged misconduct later investigated by the Police Integrity Commission. These matters were subject to significant media coverage.[9]

The need for external independent oversight of NSWPF critical incident investigations did not stem from a concern that police would deliberately cover up the wrongdoing of other police. Instead, it arose from a concern that investigating police may have 'understandable empathy' towards officers involved in a critical incident, which has the potential to affect the impartiality of police investigators and internal review officers from the Professional Standards Command (PSC).[10]

The impartiality of police investigators and internal review officers is further complicated by the fact that police have an inherent conflict of interest in the outcome

[6] The critical incident investigation is conducted by a Critical Incident Investigation Team (CIIT) and led by a Senior Critical Incident Investigator (SCII), all of whom come from a different Police Area/District Command than the officers involved in the critical incident.

[7] Review of Police Oversight, Andrew Tink AM, 31 August 2015, p 73.

[8] NSW Bar association submission to Mr Andrew Tink AM, Review of Police Oversight, 1 July 2015, p4.

[9] NSW Ombudsman, *Ombudsman monitoring of the police investigation into the death of Roberto Laudisio-Curti*, a Special Report to Parliament under s 161 of the *Police Act 1990*, February 2013. Police Integrity Commission, *Report to Parliament: Operation Calyx*, June 2013. Operation Calyx was held to investigate whether there was any police misconduct in the investigation by the NSW Police Force into the shooting of Adam Salter on 18 November 2009, following a recommendation from the Coroner.

[10] Submission of State Coroner to the Review of Police Oversight, 1 July 2015, p1.

of a critical incident investigation. Whether a real or perceived conflict of interest, this conflict arises because the outcome of a critical incident investigation has the potential to tarnish the reputation of the police force and/or result in legal or financial liability for the NSWPF.[11]

1.1.1 The role of the Coroner

For critical incidents which involve a death, a mandatory coronial inquest is held to inform the public and family members about the manner and cause of death.[12] In these cases, the Coroner has the power to make recommendations in relation to police practices and procedures.[13] However, there are some limitations associated with the coronial process.

A coronial inquest does not occur until a significant time after the death (Table 9). As a consequence there is a significant delay between the incident, the making of recommendations and the implementation of recommendations that the NSWPF consider are appropriate. If there are problems with the investigation, then it may prove difficult to remedy those problems at the time of the inquest. Also, issues which do not go to the manner and cause of death are not usually examined in the course of an inquest and, thus are not the subject of coronial recommendations. This is problematic because even where police actions do not contribute to the manner and cause of death, there may still be a legitimate cause for concern for families and for the public.

Finally, for a variety of reasons it is not practical for the State Coroner or Deputy State Coroner to monitor a critical incident investigation.[14] The real time monitoring of a critical incident investigation by an independent agency, which is now part of the Commission's responsibilities, was considered important to *'mitigate the risk of evidence being lost or degraded as a result of the occasional reluctance of police investigators to critically examine the actions or motivations of involved officers'*.[15]

The Coroner also has no jurisdiction to consider critical incidents which result in serious injury but which do not involve death.[16] As such, prior to the establishment of the Commission, there was no independent oversight of critical incidents which resulted in serious injury and no external or independent agency review of the operation of policies and procedures in the incident. As outlined in Chapter 2, the Commission's responsibility for monitoring critical incident investigations has addressed this gap.

[11] Office of Police Integrity June 2011 Review of the investigative process following a death associated with police contact; July 2009 Review of the Use of Force by and against Victoria Police, p13.

[12] *Coroners Act 2009*, s 23 and s 27.

[13] *Coroners Act 2009*, s 82.

[14] Submission of State Coroner to the Review of Police Oversight, 1 July 2015, p3.

[15] Submission of State Coroner to the Review of Police Oversight, 1 July 2015, p4.

[16] *Coroners Act 2009*, s 46. The Coroner may have jurisdiction where the serious injury arises of jurisdiction to investigate explosions and/or fires.

2. Oversight of critical incident investigations by the Commission

The LECC Act provides that the Commissioner of Police is to ensure that the actions of members of the NSWPF involved in a critical incident at the time of, and leading to, the critical incident are fully and properly investigated by the NSWPF.[17]

Under Part 8 of the LECC Act the Commission has the power to oversight and monitor the NSWPF investigation of critical incidents if the Commission decides that it is in the public interest to do so. It is the Commission's role to ensure that the NSWPF critical incident investigation is conducted in a competent, thorough, and objective manner.

The LECC Act prescribes the powers and responsibilities that the Commission has in relation to the monitoring of critical incident investigations. The Commission has also entered into formal arrangements with the NSWPF[18] and the NSW State Coroner[19] in relation to its role in monitoring critical incident investigations.

2.1 What is a critical incident?

A critical incident is an incident declared to be a critical incident by the Commissioner of Police. In practice, that responsibility is delegated to the Assistant Commissioner responsible for the Region (the 'Region Commander') in which the incident occurs.[20] Under the LECC Act the Commissioner of Police or Region Commander that has delegation may declare a critical incident where an incident involves a death or serious injury and arises:

- from the discharge of a firearm by a police officer;
- from the use of force or defensive equipment by a police officer;
- from the use of a police vehicle;
- whilst a person is in police custody or while escaping or attempting to escape police custody; or
- as a result of any police operation.[21]

[17] *Law Enforcement Conduct Commission Act 2016*. s 113(1).

[18] Arrangements for the Monitoring of NSW Police Force Critical Incident Investigations between the LECC and NSWPF, in accordance with Part 8 of the *Law Enforcement Conduct Commission Act 2016*.

[19] Memorandum of Understanding for the Monitoring of NSW Police Force Critical Incidents which are also subject to the Coronial Jurisdiction between the Law Enforcement Conduct Commission and NSW State Coroner, in accordance with Part 8 of the LECC Act.

[20] *Law Enforcement Conduct Commission Act 2016*. s 111.

[21] *Law Enforcement Conduct Commission Act 2016*, s 110; Under s 110 the death or serious injury may arise; (i) from the discharge of a firearm; (ii) from the use or operation of defensive equipment; (iii) from the application of physical force; (iv) from use of a police vehicle; (v) while a person is in custody or attempting to escape from custody; (vi) results from any police operation.

The Commissioner of Police or the Region Commander may also declare a critical incident where they are of the view that there are other grounds for considering that it is in the public interest to do so.[22]

Even where an incident has all the features of a critical incident under the LECC Act, the NSWPF has the discretion to declare or not declare a critical incident, although the discretion must be exercised in a reasonable manner.

These events are inherently serious in nature and are likely to have a traumatic impact on the family and friends of a person killed or seriously injured, as well as any person seriously injured. It is therefore important that the NSWPF's decision on whether an event is a critical incident should be properly scrutinised.

Under the LECC Act there is currently no requirement for the NSWPF to notify the Commission of instances where they have considered making a critical incident declaration and have subsequently decided not. As a result, the Commission is unable to determine whether or not the NSWPF exercises their discretion consistently and reasonably.

The Commission cannot interrogate the police database, COPS, to detect incidents that might have the features of a critical incident and, may have reasonably warranted a critical incident declaration. It would also be extremely difficult to develop a strategy to identify relevant incidents. That said, the NSWPF records all of its decisions about whether or not to declare a critical incident on a form, which is known as the P1179 form. It outlines the reasons that a critical incident is declared or alternatively, requires that detailed reasons be given for a decision not to declare a critical incident.

If the NSWPF provided a copy of each P1179 form to the Commission, this would be a simple and effective way for the Commission to satisfy itself, and the public, that the NSWPF exercises its discretion to declare or not declare a critical incident in a reasonable or consistent manner. It might also assist in confirming that the exercise of discretion is consistent across different Regions.

The Commission provided a draft copy of this Report to the NSWPF and made a preliminary recommendation, [23] that the NSWPF implement a procedure to provide a copy of all 'Critical Incident Declaration/Non-Declaration by Region Commander' forms (P1179) to the Commission in a timely manner.

In response, the NSWPF advised that they agreed in part with the preliminary recommendation. The NSWPF supported the recommendation in so far as the 'the P1179 form be provided to the Commission following the *declaration* of a critical incident'. It is already a requirement that police provide the Commission access to documents obtained or prepared for the purposes of the investigation.[24] As such, it is a current requirement and practice to provide the Commission a copy of the P1179 where a critical incident is declared.

[22] *Law Enforcement Conduct Commission Act 2016*, s 111(1)(b).
[23] On 22 December 2022 a copy of this Report in draft was sent to the NSWPF seeking their view of the content and recommendations made prior to the Report being finalised and tabled in Parliament. The NSWPF sought and received advice from several stakeholders including; all Region Commanders, Traffic and Highway Patrol, Professional Standards Command (Investigations Unit), State Crime Command, and Capability Performance and Youth Command. On 10 February 2023 the Commission received a response from police.
[24] *Law Enforcement Conduct Commission Act 2016*, s 114(3)(d).

The NSWPF advised that it does not support the LECC recommendation that the P1179 form be provided to the Commission following a *non-declaration* of a critical incident. The NSWPF stated that under s 111 of the LECC Act, the Commissioner of Police 'may' declare a critical incident and therefore the LECC Act provides the Commissioner of Police 'with absolute discretion' as to whether a critical incident will be declared.

The Commission accepts that under the LECC Act the Commissioner of Police has the discretion to declare a critical incident. However, that discretion must still be exercised reasonably. The Commission and the Coroner have both identified matters that might have reasonably been expected to be classified as critical incidents from the outset, but were not.[25]

The Commission is of the view that access to all P1179 forms would provide a more complete oversight of critical incidents. The P1179 forms would still only include those incidents considered potential critical incidents. However, it would provide a broader basis on which to be satisfied that the discretion to declare or not declare a critical incident is being exercised reasonably and consistently across Region Commands.

If the NSWPF does not agree to provide the P1179 forms, the Commission considers that there should be a change to the LECC Act to require that the Commission be advised whenever the NSWPF makes a decision not to declare a critical incident. In this way, any concerns about that decision are able to be raised contemporaneously.

Recommendation 1: **The NSWPF implement a procedure to provide a copy of all 'Critical Incident Declaration/Non-Declaration by Region Commander' forms (P1179) to the Commission in a timely manner.**

2.2 What does the NSWPF do when a critical incident is declared?

When a critical incident is declared by a Region Commander, a special investigation called a critical incident investigation is initiated. The critical incident investigation is conducted in accordance with requirements under the LECC Act and the NSWPF Critical Incident Guidelines, so far as operationally practical.[26]

A critical incident investigation is resource intensive and requires the mobilisation of significant police resources over and above what may normally be required for most criminal investigations.[27] These resources are diverted from police core responsibilities, which may include serious criminal investigations. Although some of the resources are

[25] Deputy State Coroner, Magistrate E Truscott (21 November 2019). Inquest into the death of Daniel Wall (File no. 2018/131055). State Coroners Court of New South Wales; Deputy State Coroner Kennedy (1 December 2022). Inquest into the death of RW (File no. 2021/00006045). State Coroners Court of New South Wales; Deputy State Coroner, Magistrate E Truscott (5 March 2021). Inquest into the death of Nathan Macri (File no. 2018/305251). State Coroners Court of New South Wales.

[26] *Law Enforcement Conduct Commission Act 2016*, s 113; NSWPF Critical Incident Guidelines.

[27] Depending on the circumstances, when a critical incident is declared, resources involved in the investigation include but are not limited to: the Region Commander, the Region Professional Standard Manager (PSM), Forensic Investigators (Crime Scene, Ballistics, Forensic Imaging), officers from Weapons Tactics & Policy Review, officers from the Professional Standards Command, the Media Unit, the Drug and Alcohol Testing Team, the Police Chaplin, the Police Association NSW, and the Homicide Squad. Many of these resources are recalled to duty when an incident occurs outside of office hours.

only required for a short period, others are required for the duration of the critical incident investigation.

Events leading to a critical incident clearly have a profound impact on the person involved and their family. Determining that an event should be considered as a critical incident investigation also has a significant impact on the police officers identified as being directly involved in the incident. A critical incident investigation may take years to finalise. This means that officers who have already seen the serious injury or death first hand, may continue to relive that event and their part in it, for many years to come. The actions and decisions of the involved officers are also subject to significant scrutiny over the lifetime of the critical incident investigation.

For all of the above reasons, a decision to declare a critical incident is not taken lightly by the NSWPF.

An experienced criminal investigator called a Senior Critical Incident Investigator (SCII) is appointed to lead the critical incident investigation. Incidents that involve a death or imminent death arising from the use of a police firearm, the use of police defensive equipment, the use of physical force by police, or the homicide of a police officer, are investigated by the Homicide Squad. All other critical incidents are investigated by a SCII from a different Police Area Command (PAC) or Police District Command (PD), from within the same policing Region. The SCII is supported by a team of investigators, who with the SCII, form the Critical Incident Investigation Team (CIIT). The CIIT is comprised of officers, from the same Command as the SCII, who has no significant relationship with the police officers involved in the critical incident. In the busy early stages of a critical incident investigation, the policing Region may temporarily provide the SCII with additional resources to assist the investigation.

The purpose of a critical incident investigation is to ensure that the actions of police officers involved in a critical incident at the time of, and leading to, the critical incident are fully and properly investigated[28]. As the critical incident investigation progresses, it is internally monitored by an officer from the NSWPF Professional Standards Command, called the Review Officer[29]. This internal monitoring is important, because critical incident investigations have additional safeguards and requirements, in addition to what is normally required in a criminal investigation. This includes safeguards and requirements to protect the integrity of the investigation, as a consequence of the fact that police officers are investigating the actions of other police officers. The Review Officer is also the nominated contact officer, tasked with facilitating the Commission's independent monitoring of the investigation.[30]

For many SCIIs, when they are assigned a critical incident investigation, despite being experienced investigators, it may be the first critical incident investigation they have led. Critical incident investigations are not criminal investigations and they incorporate different requirements, including considerations of potential misconduct, the need for any changes to policy and practices, as well as any systemic issues arising[31]. The

[28] *Law Enforcement Conduct Commission Act 2016*, s 113(1)

[29] One critical incident had an independent Review Officer not from the PSC as there was an identified conflict of interest with the PSC.

[30] Arrangements for the Monitoring of NSW Police Force Critical Incident Investigations between the LECC and NSWPF, in accordance with Part 8 of the LECC Act, para 37.

[31] *Law Enforcement Conduct Commission Act 2016*, s113(2)

NSWPF Critical Incident Guidelines, the Review Officer and the Commission help ensure these broader requirements are considered.

The NSWPF has the power to revoke a critical incident declaration,[32] and this generally occurs where the injuries sustained were not deemed to have reached the requisite seriousness or the death or serious injuries sustained are not related to the actions of police. Similarly, the Commission may cease monitoring a critical incident investigation.[33] This occurs when the Commission is satisfied that it is no longer in the public interest to continue monitoring the conduct of the investigation. This can be due to evidence indicating a lack of causal connection between the actions of police and the death or the serious injuries sustained. During the reporting period, the Commission ceased monitoring 24 critical incident investigations. This is discussed in Chapter 3.

In almost all cases, the NSWPF keeps a critical incident investigation open until all related coronial and criminal proceedings have been finalised. This is so that any findings made in the critical incident investigation can take into account any issues arising in the inquest or other court proceedings. Critical incident investigations are generally lengthy and complex, and are usually linked to coronial inquests, criminal proceedings and sometimes both. As a result there is often a considerable period of time, in most cases more than two years, between an incident and the finalisation of the investigation.

At the end of a critical incident investigation the Commissioner of Police is required to produce a Critical Incident Investigation Report (CIIR).[34] In practice, the report consists of three parts including, a SCII Report, a Review Officer Report and a Region Report.[35]

In the SCII Report, the SCII is required to outline relevant events and activities leading to the incident and comment on the lawfulness and reasonableness of the actions of police involved in the incident, the extent to which police complied with existing laws, policies and procedures, and whether there is a need to amend or improve policies to mitigate the risks of a similar incident arising in the future. The SCII Report is then forwarded to the Review Officer for internal quality review.

The Review Officer reviews the SCII Report and writes a short report commenting on the quality, timeliness and probity of the investigation conducted by the CIIT before forwarding the SCII Report and the Review Officer Report to the Region Professional Standards Manager (PSM).

The Region PSM reviews the SCII Report and Review Officer Report and comments on any conduct issues or lessons to be learned from the incident, including recommended improvements to systems, policies, procedures or training recommended by the SCII or Review Officer. The Reports of the SCII, the Review Officer and Region PSM are then forwarded to the Region Commander before being forwarded to either the Deputy Commissioner Metropolitan Field Operations or the Deputy Commissioner Regional NSW Field Operations for ratification.

After these reports are ratified by the NSWPF, the CIIR is considered finalised by police, and there is then an obligation on the Commissioner of Police to provide a copy of the

[32] *Law Enforcement Conduct Commission Act 2016*, s 111(4).

[33] *Law Enforcement Conduct Commission Act 2016*, s 114(5).

[34] *Law Enforcement Conduct Commission Act 2016*, s 113(2).

[35] NSWPF Critical Incident Guidelines, 23 December 2019; P1108 Senior Critical Incident Investigator Guidelines and Checklist, p 12; P1143 Review Officer Guidelines and Checklist, p1; P1187 Region Commander Guidelines, p3.

report to the Commission, and also the State Coroner where the incident involves a death.[36]

When the Commission receives a copy of the report, it is reviewed to ensure that all concerns arising in the course of the critical incident investigation have been appropriately addressed in accordance with requirements under s 113 of the LECC Act. It should be noted, however, that in practice, not all requirements under s 113 of the LECC Act are addressed in the CIIR. For example, if potential misconduct is identified in the course of a critical incident investigation, the misconduct is investigated separately by a police officer from the PAC/PD where the misconduct occurred. Similarly, if breaches of the SDP are identified during a critical incident investigation, and these are not considered to meet the threshold of misconduct, they are dealt with by local Safe Driving Panels. Where requirements under s 113 of the LECC Act are not addressed entirely within the CIIR, the Commission considers the outcome of any related misconduct matter investigations, Safe Driving Panels or other actions, when forming a view about whether the requirements under s 113 of the LECC Act have been appropriately addressed.

The Commission is then required to provide advice to the Commissioner of Police and, if the critical incident involved the death of a person, the State Coroner.[37] The advice is required to indicate whether the Commission considers the investigation was fully and properly conducted or alternatively, advise of any concerns if the Commission considers any aspect of the investigation inappropriate.[38] The Commission also publishes a summary of all advice on its website.

2.3 The Commission's Critical Incident and Investigations Monitoring Team

The oversight of NSWPF critical incident investigations is conducted by the Commission's Critical Incident and Investigations Monitoring (CIIM) Team. The structure and function of the CIIM Team has changed over the first five years of operation.

In July 2017, the CIIM Team had five permanent staff members monitoring critical incident investigations. In February 2019, the CIIM Team was increased to six staff members and assigned an additional function of monitoring misconduct matter investigations[39], which is separate to critical incident investigation monitoring.

Since July 2021, the CIIM Team has been reduced to three permanent staff members.

When the CIIM Team monitors an investigation, it does so in real time. That is, the CIIM Team monitors an investigation from the time of being notified of the investigation, as the investigation progresses, and until the investigation is finalised, where it is in the public interest to do so.

[36] *Law Enforcement Conduct Commission Act 2016*, s 113(2).

[37] *Law Enforcement Conduct Commission Act 2016*, s 117(1).

[38] *Law Enforcement Conduct Commission Act 2016*, s 117(1).

[39] *Law Enforcement Conduct Commission Act 2016*, s 101. Under s 101 the Commission can monitor the carrying out of a NSWPF or NSW Crime Commission investigation into an allegation of misconduct against a police officer, as the investigation progresses, and therefore in real time.

The Commission's real time monitoring of critical incident investigations allows issues arising at the time of, and leading to, a critical incident to be identified. Where necessary, these are raised with police contemporaneously. Raising issues in real time ensures the NSWPF critical incident investigators are aware of any concerns held by the Commission as soon as possible. In this way they can be addressed or resolved as soon as practical. Delay can make it more difficult or impossible to resolve problems with an investigation. Real time monitoring also allows the NSWPF to immediately move to mitigate the risks of similar events occurring in the future.

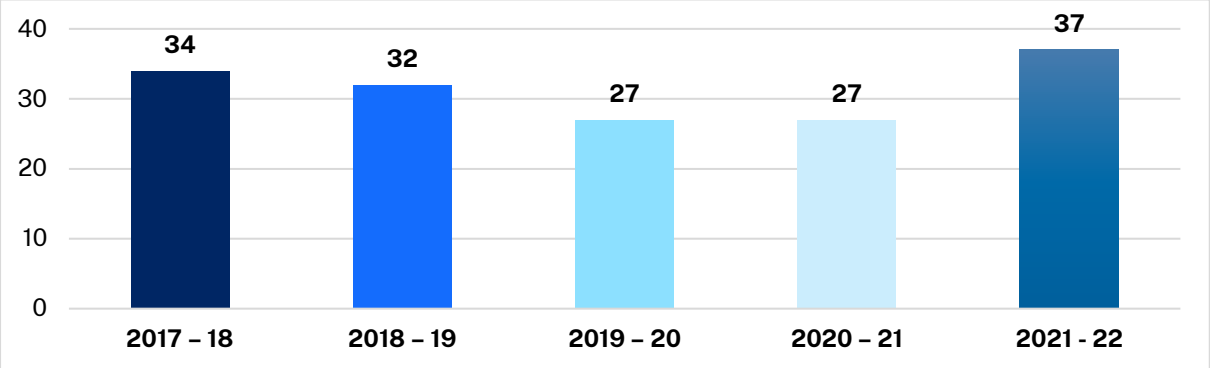
3. Features of declared critical incidents between 2017-2022

From 1 July 2017 to 30 June 2022 there were 157 critical incident declarations made by the NSWPF, ranging from 27 to 37 per year (**Table 1**). The greatest number of declarations were made by Commanders of the Northern (39), North West Metropolitan (32), Central Metropolitan (30), South West Metropolitan (23) Regions, followed by the Western (16) and Southern (17) Regions (**Table 2**).

Of the 157 critical incidents declared from 2017 to 2022, 92 (59%) were declared as a consequence of a death, rather than as a consequence of a serious injury (**Table 3**:).

As mentioned, the NSWPF may revoke a critical incident declaration.[40] If this occurs, the Commission must cease monitoring the investigation of the incident.[41] Of the 157 critical incidents declared from 2017 to 2022, the NSWPF revoked the declaration of 14 (9%). In these cases, the injuries sustained were ultimately not deemed to have reached the requisite seriousness. Alternatively, the death or serious injuries sustained were not related to the actions of police (see Case study 1: SF Beachway).

Table 1: Critical incidents declared by the NSWPF from 1 July 2017 to 30 June 2022



* Years from 1 July to 30 June. It should be noted that the year in which a critical incident declaration was made is tabulated, rather than the year in which the critical incident occurred.

[40] *Law Enforcement Conduct Commission Act 2016*, s 111(4).
[41] *Law Enforcement Conduct Commission Act 2016*, s 114(6).

Table 2: Critical incidents declared by the NSWPF by Region from 1 July 2017 to 30 June 2022

REGION	2017-18	2018-19	2019-20	2020-21	2021-22	TOTAL
Northern	9	6	10	4	10	39
North West Metropolitan	7	10	5	5	5	32
Central Metropolitan	7	5	6	6	6	30
South West Metropolitan	5	5	2	4	7	23
Western	2	4	2	4	4	16
Southern	4	2	2	4	5	17
TOTAL	34	32	27	27	37	157

* Years from 1 July to 30 June. The number of critical incident declarations includes all declarations, including those that were subsequently revoked by the NSWPF.

Table 3: Outcome of critical incidents declared by the NSWPF from 1 July 2017 to 30 June 2022

CRITICAL INCIDENT OUTCOME	2017-18	2018-19	2019-20	2020-21	2021-22	TOTAL
Death	23	12	22	17	18	92
Serious Injury	10	20	5	10	19	64
Other*	1	0	0	0	0	1
TOTAL	**34**	**32**	**27**	**27**	**37**	**157**
Revoked**	3	4	2	1	4	14
Ceased***	2	6	9	5	2	24

* Other, indicates those incidents declared under s 111(b) of the LECC Act as the Commissioner of Police had other grounds for considering it was in the public interest to do so.

** Revoked, indicates those critical incident declarations which were revoked by the NSWPF under s 111(4) of the LECC Act, where the injuries sustained were not deemed to have reached the requisite seriousness or the death or serious injuries sustained are not at all related to the actions of police.

*** Ceased, indicates those critical incident investigations which the Commission ceased monitoring under s 114(5), on the basis that the Commission was satisfied that continued monitoring was no longer required in the public interest, due to sufficient evidence indicating a lack of causal connection between the death and the serious injuries sustained.

Of the critical incident declarations not revoked by the NSWPF, the Commission ceased monitoring 24 (15%) critical incident investigations. The Commission ceased monitoring

these investigations on the basis that it was satisfied that continued monitoring was no longer required in the public interest, due to sufficient evidence indicating a lack of causal connection between the death or the serious injuries sustained and the actions of the NSWPF (see Case Study 2: SF Kyamba).

The Coroner has on occasions also dispensed with the holding of an inquest, where the evidence indicates that the death is not the 'result' of police actions (see Case Study 3: SF Skillman). The Coroner has dispensed with eleven inquests relating to critical incidents declared by the NSWPF to date.[42]

3.1 Critical incident categories

When critical incidents are declared, the NSWPF categorises the incident according to its significant features (**Table 4**). Most critical incidents arise from police operations, the discharge of a firearm by a police officer or from the use of a police vehicle.

The 'police operation' category, which represents about 50% of the critical incidents that occurred between 2017 and 2022, is extremely broad. Under the LECC Act, a police operation means 'any activity of a police officer engaged in while exercising the functions of a police officer, other than an activity for the purpose of a search and rescue operation'.[43]

Many police operations arise from circumstances in which a person suffering a personal or mental health crisis harms themselves at the time of the police attendance. The level of police involvement in such a situation varies greatly. At the time that a person self-harms, police may have just arrived or they may have been attempting to negotiate for some time. In either case, the situation results in a critical incident declaration under the broad category 'any police operation'.

Of the 78 critical incidents deemed by police to have arisen from police operations since 1 July 2017:

- 60% (47) have arisen as a consequence of self-inflicted harm,
- 17% (13) after police have followed but not pursued a vehicle,
- 10% (8) have arisen in the course of avoiding apprehension by police, and
- 13%(10) have arisen as a consequence of other circumstances.[44]

The circumstances around a critical incident can have features of more than one of the categories. Critical incidents arising from the use of a police vehicle are an example of this. If the critical incident arises from a pursuit it is usually deemed to have arisen from the use of a police vehicle. However, in some cases the incident is deemed to have

[42] Strike Forces: Skillman (dispensed 21/12/2018), Harst (dispensed 23/3/2021), Uligandi (dispensed 25/6/2021), Coolati (dispensed 13/5/2020), Britt (dispensed 17/8/2020), Yambil (dispensed 8/12/2020), Badgelly (dispensed 3/7/2020), Talbragar (dispensed 23/6/2021), Dumbarton (dispensed 1/4/2022), Montelimar (dispensed 1/4/2022), Allott (dispensed 15/3/2022).

[43] *Law Enforcement Conduct Commission Act 2016*, s 108.

[44] Critical incident investigations arising from a police operation: **Self-inflicted harm** – Miriyan, Newmoon, Ande, Bangalore, Skillman, Mayfield*, Baranbale, Amey, Wyang, Daces, Uligandi, Coolati, Blasé, Bezel, Newsome, Caltowie, Flanagan, Campton, Yambil, Clapham, Daintrey, Badgelly, Chassela, Carthona, Carlyle, Berncla, Chellow, Talbragar, Lochne, Hollinsworth, Corrina, Nungar, Lintina, Montelimar, Bibbs, Fenton, Allott, Bales, Kapunda, Malga, Janet, Wandgala, Coobar, Chore, Antoid, Kardine, Yallambee (47); **Involving a police vehicle**: Gillendoon, Wirruna, Mertin, Garemyn, Tabis Mulgowrie, Borts, Finschhafen, Algedi, Britt, Arabin, Barrabool, Margot (13); **Avoiding arrest of apprehension**: Warreeah, Andiah, Sohier, Covey, Linthorne, Nunatak, Udall, Binbilla (8); **Other** – Montavella, Beachway, Minstrel, Bises, Wittin, Wheoga, Parrish, Wunulla, Denintend, Gorder (10).

arisen from a 'follow' rather than a 'pursuit' under the NSWPF SDP definition.[45] In that instance, the critical incident may be deemed to have arisen in a police operation. This has occurred on 13 occasions in the reporting period. If one takes this into account, critical incidents arising from the use of a police vehicle would then total 43 and account for 27% of critical incidents and the broad category in a police operation would be reduced to 65 (41%). Critical incidents arising from the use of a police vehicle would be only second to those arising from the broad police operation category.

In the reporting period, 19 (12%) critical incidents involved people identified as being of Aboriginal and/or Torres Strait Islander background (**Table 5**). In six of these incidents a person was seriously injured, whilst in thirteen incidents a person died.

Table 4: Features for critical incidents declared by the NSWPF from 1 July 2017 to 30 June 2022

CRITICAL INCIDENT FEATURES	2017-18	2018-19	2019-20	2020-21	2021-22	TOTAL
Arising from discharge of a firearm by a police officer [a]	7	7	5	5	6	30
Arising from use of force or defensive equipment by a police officer [b]	2	1	0	1	3	7
Arising from use of a police vehicle [c]	4	3	4	8	11	30
Arising whilst a person is in police custody or while escaping or attempting to escape police custody	7	3	0	1	1	12
Arising as a result of any police operation [d]	14	18	18	12	16	78
TOTAL	34	32	27	27	37	157

a Arising from discharge of a firearm by a police officer includes incidents where an officer used a police firearm to self-harm.
b Section 110(b)(ii) & (iii) are combined since a use of physical force usually involves the use of defensive equipment.
c Arising from the use of a police vehicle only includes some incidents involving a police vehicle, some incidents involving police vehicles have been deemed by the NSWPF as arising from a police operation. Those which arose in a police operation and are not included as arising from use of a police vehicle are: 4 (2017-18); 3 (2018-19); 2 (2019-20); 0 (2020-21).
d Arising as a result of a police operation is an extremely broad category and means *'any activity engaged in by a police officer while exercising the functions of a police officer other than an activity for the purpose of a search and rescue operation*' (s 108(1) of the LECC Act).

[45] Under the NSWPF Safe Driving Policy a pursuit is defined as 'an attempt by a police officer in a motor vehicle to stop and apprehend the occupant(s) of a moving vehicle, regardless of speed and distance, when the driver of the other vehicle is attempting to avoid apprehension or appears to be ignoring police attempts to stop them. A pursuit commences at the time you decide to pursue a vehicle that has ignored a direction to stop. A pursuit is deemed to continue if you follow the offending vehicle or continue to attempt to remain in contact with the offending vehicle, whether or not the police vehicle is displaying warning lights or sounding a siren. If the vehicle has not been engaged in a pursuit under the aforementioned definition, and you are not performing a traffic stop or urgent duty driving, it is deemed a 'follow'. There is no policy about how NSW police officers should conduct a 'follow' under the current Safe Driving Policy.

Table 5: Critical incidents involving Aboriginal and Torres Strait Islander peoples from 1 July 2017 to 30 June 2022[46]

YEAR	DEATH	SERIOUS INJURY	TOTAL DEATH AND SERIOUS INJURY	PERCENTAGE OF TOTAL CRITICAL INCIDENTS
2017-18	3	1	4	12%
2018-19	0	1	1	3%
2019-20	2	1	3	11%
2020-21	2	1	3	11%
2021-22	6	2	8	21%
TOTAL	13	6	19	12%

3.2 Notification of critical incident declarations

Once a decision to declare a critical incident is made, the NSWPF is required to *'immediately'* notify the Commission of the critical incident declaration and provide enough information about the incident for the Commission to form a view as to whether it should monitor the investigation.[47]

During the first year of operations (2017-18), the Region PSM notified the Commission of a critical incident declaration on average within 24 minutes of the declaration being made. The Region PSM also provided comprehensive details in relation to the circumstances of the critical incident.

In the second year of operations (2018-19) the NSWPF changed their notification procedures. Instead of the Region PSM notifying the Commission, the on-call Professional Standards Command (PSC) Review Officer notified the Commission of a critical incident declaration. As a consequence of this change, the Commission was notified of a critical incident declaration more slowly (on average within 53 minutes), and the information provided generally was less detailed. This is a product of the fact that, unlike the Region PSM, the PSC Review Officer is not initially privy to firsthand information from those on scene.

In the third (2019-20), fourth (2020-21) and fifth (2021-22) years of operation the PSC Review Officers have continued to notify the Commission of all critical incident declarations, taking an average of 70 minutes, 60 minutes and 58 minutes post declaration respectively.

Although it is clear that the notification of critical incidents have become less immediate and less detailed over time, this has not been detrimental to the

[46] Identification of Aboriginal and Torres Strait Islander peoples is based on records within NSWPF databases, or family or friends identifying the person as such.

[47] *Law Enforcement Conduct Commission Act 2016*, s 112(1)

Commission's ability to decide to monitor a critical incident investigation as our current policy is to monitor all critical incident investigations from the outset regardless.

4. Monitoring of critical incident investigations

Since 1 July 2017 it has been the Commission's policy to monitor all critical incident investigations.

The Commission's policy decision is based on:

- the stable and manageable number of critical incidents each year;
- the public interest and expectations in relation to the independent oversight of critical incident investigations;
- an awareness that in practice, the information available at the time of notification is only preliminary and subject to inaccuracies and/or significant changes; and
- a concern that if the Commission does not initially indicate an intention to monitor a critical incident investigation, the Commission may not be privy to details which would change the Commission's decision in regards to monitoring the investigation.

When the Commission chooses to monitor a critical incident investigation, Commission investigators can:

- attend the place where the critical incident occurred, including a crime scene;
- access transcripts or recordings of interviews;
- observe interviews of involved police officers, but only with consent of the interviewee and interviewer; and
- access documents obtained or prepared for the purposes of the investigation.[48]

These powers are not available until the Commission chooses to monitor the critical incident investigation and notifies the NSWPF accordingly.[49] Without commencing monitoring, it is also unlikely that the Commission would become aware of information that would otherwise cause the Commission to change its decision in relation to the monitoring of a critical incident investigation, unless the Commission became aware of a related complaint or misconduct by some other means.

4.1 Attending the location of the incident

The Commission currently has three investigators permanently attached to the CIIM Team.[50] These investigators operate on a rotating weekly 24 hour on-call roster. In any given week, the on-call Commission investigator is responsible for receiving telephone notifications from the NSWPF when a critical incident has been declared.

[48] *Law Enforcement Conduct Commission Act 2016*, s 114(3).

[49] *Law Enforcement Conduct Commission Act 2016*, s 114(2)

[50] The Critical Incident and Investigations Monitoring Team independently monitors NSWPF Critical Incident Investigations and, complaint or misconduct matter investigations conducted by the NSWPF and the NSW Crime Commission about their officers. This ensures that the quality of the investigation and the findings made are reasonable based on the evidence. These investigations are monitored in real time.

While the Commission may attend the location of the incident, sometimes this is not practical, and not considered an effective use of limited Commission resources. The Commission investigators within the CIIM Team are responsible for deciding whether to attend the critical incident scene. A decision to attend is based on the information provided by the notifying NSW police officer in accordance with the Commission's internal policies and, where necessary, in consultation with the Director Oversight Investigations.[51]

Once a decision to attend or not to attend a critical incident scene is made, the Commission investigator will advise the NSWPF nominated contact officer of the decision. The Commission investigator will then attend the scene, or a nearby location where the CIIT has been assembled, as soon as practicable.

The Commission's Policy regarding attendance at critical incident scenes has changed over time.

From July 2017 to April 2020[52] two Commission investigators attended each critical incident scene. Since April 2020 the Commission sends only one investigator to a critical incident scene unless special circumstances such as the complexity or the location of an incident warrant the attendance of more than one investigator.

When it first commenced operations, the Commission attended all metropolitan based critical incident scenes, and attended regional scenes based on a consideration of the practicalities of attendance. Since February 2020, the Commission undertakes a risk assessment in deciding whether to attend any critical incident scene, including those in metropolitan Sydney.

The Commission considers a variety of factors in deciding whether to attend a critical incident scene. These factors include but are not limited to:

(i) the nature of the incident and the causal connection between the action or inaction of police and the death or serious injury to a person;
(ii) distance to travel to the scene;
(iii) whether the critical incident scene is preserved and/or will be preserved until the Commission arrives;
(iv) the risk of non-attendance at the scene, taking into consideration the profile of the matter and the community, political and media interest;
(v) available sources of evidence documenting the incident including In-Car Video (ICV), Body Worn Video (BWV) and Closed Circuit TV (CCTV);
(vi) availability of a Commission investigator to attend;
(vii) time passed since the incident occurred; and
(viii) safety of Commission investigators.

The Commission does not usually attend critical incidents where:

(i) there is no causal connection between the action or inaction of police and the death or serious injury to a person;
(ii) the incident involves a death or serious injury of a person at a known suicide hotspot; or

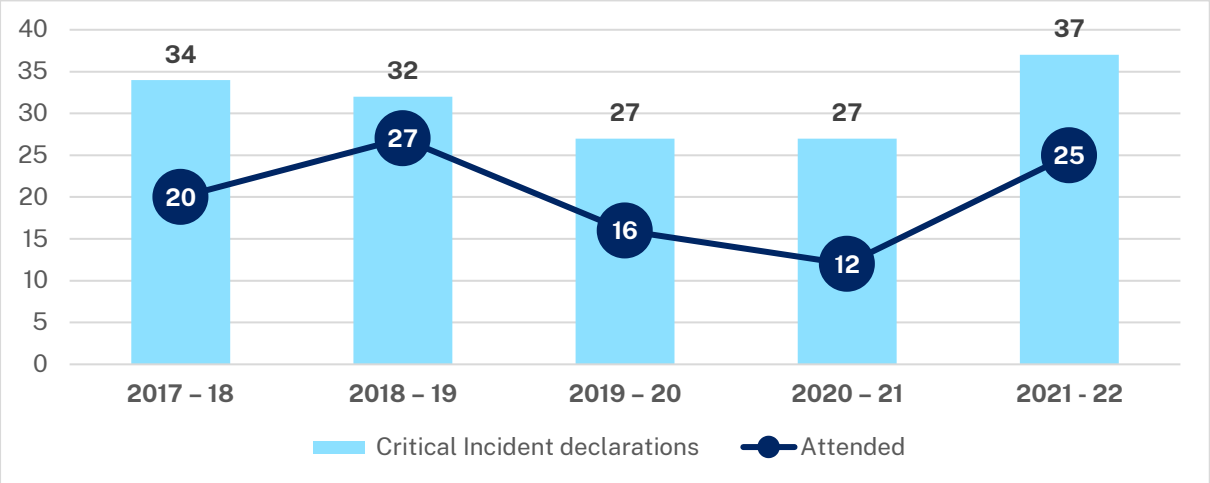
[51] Policy and Procedure for the Monitoring of Critical Incident Investigations, 11 September 2020.

[52] Between the relevant timeframe the Commission's Critical Incident and Investigation Monitoring team had staffing of five to six investigators. This has since been reduced to three investigators.

(iii) the death or serious injury to a person arises from the use of a police vehicle where the police vehicle contains sufficient and operational ICV footage.

Since 1 July 2017 the Commission has attended the scene of between 44% and 84% of critical incidents (**Table 6)** each year. The reasons for non-attendance are complicated and usually multifactorial.

Table 6: Attendance at critical incident scenes for critical incidents declared by the NSWPF between 1 July 2017 to 30 June 2022



The most common reason for non-attendance is that from the information provided by police at the time of notification there appears to be a lack of causal connection between the action or inaction of police and the serious injury or death. This situation frequently occurs when friends or family raise a concern for the welfare of a person, and the person self-harms before attending police have a reasonable opportunity to assist or intervene (see Case Study 3: SF Skillman).

In some other cases the critical incident location is situated in regional NSW, and as a consequence of the distance and the incident location it is not possible to attend, while the critical incident scene is still preserved. This situation often arises where there is a death or serious injury arising from a police pursuit in regional NSW and the critical incident scene is situated on a roadway which needs to be forensically processed expeditiously to minimise disruptions to the flow of traffic (see Case Study 4: SF Parrish).

In some cases the critical incident declaration is made retrospectively and there is no critical incident scene to attend (see Case Study 5: SF Garemyn).

During the COVID-19 pandemic of 2019-21, concerns around the safety of Commission investigators and compliance with government restrictions affected attendance at critical incident scenes. In these cases, it was necessary to weigh the benefit and risks of attending a critical incident scene.

Regardless of whether the Commission attends a critical incident scene or not, the Commission monitors all critical incident investigations in real time. That is, the Commission monitors a critical incident investigation from the time of notification, until the investigation is revoked by the NSWPF, ceased by the Commission or finalised by the NSWPF. This includes reviewing all evidence and documents arising from a critical incident investigation.

In addition to attending the critical incident scene, the Commission also frequently attends other investigation related meetings or enquiries. These include reviews of forensic evidence, video walkthroughs, investigative searches and select coronial inquests. Attendance at these related meetings or enquiries often occurs even where the Commission may not have attended the initial critical incident scene.

4.1.1 What the Commission does at the scene of the incident

On attending a critical incident scene or location the Commission investigator meets the NSWPF nominated contact officer at or near the location of the incident, or at the Police Station close to the incident. The Commission investigator is:

(i) briefed in relation to actions taken and to be taken in compliance with the NSWPF Critical Incident Guidelines;[53]
(ii) updated in relation to the facts of the incident;
(iii) updated in relation to the progress of the investigation and enquiries to be made in the immediate future;
(iv) provided an opportunity to review available BWV, ICV or CCTV footage of the incident;
(v) taken to view the critical incident scene where appropriate;
(vi) given an opportunity to raise questions or concerns in relation to the incident and/or compliance with the NSWPF Critical Incident Guidelines; and,
(vii) enabled under the LECC Act to be present as an observer during the interviews of directly involved police officers or other persons, either in person or remotely.

In relation to (vii), it should be noted that although the Commission's investigators have attended and monitored interviews of injured persons, the Commission has never 'live monitored' the interview of a directly involved police officer while it is occurring.

A directly involved police officer is 'any officer, regardless of rank or grade, who by their words, actions or decisions, in the opinion of the SCII, contributed to the incident under investigation.'[54]

4.1.2 Live monitoring interviews of directly involved police

The power to live monitor interviews of directly involved police officers, which is set out in s 114(3)(c) of the LECC Act, has proved illusory, because the legislative provision to observe an interview is contingent on the consent of the involved police officer and the SCII. In every case, the Commission's request to monitor an involved officer interview has been declined by the involved officer, usually on advice from their legal representative. Consent for Review Officers from the Professional Standards Command to live monitor interviews is also frequently declined by directly involved police officers. As a result, from time to time, areas of concern are not raised and clarified at the time of interview. Further enquiries are then required to address issues which might have been

[53] The NSWPF Critical Incident Guidelines specify the roles and responsibilities of police officers who are required to respond to and/or investigate critical incidents, to ensure that all critical incidents are investigated in a competent and objective manner. The NSWPF Critical Incident Guidelines outline the steps that should be taken to: preserve the critical incident scene and evidence; to ensure that police investigators have no conflicts of interest or that they are reasonably managed; to identify involved officers and to ensure that their welfare is managed, that they are separated and drug alcohol tested where required; to liaise with and manage the welfare of the family members of deceased/seriously injured persons; and other procedures necessary to manage risks arising in the course of the investigation.

[54] NSWPF Critical Incident Guidelines, P1108, p5.

resolved more efficiently at the time of interview. In any case, the Commission's experience is that the NSWPF has promptly provided access to interview recordings, as required under s 114(3)(b) of the LECC Act. These interview recordings are reviewed by the Commission in a timely manner and any concerns identified are then raised with the Review Officer to address with the SCII.

4.1.3 Officers declining to provide a version of events

Occasionally, directly involved officers have also declined to provide a version of events for the purposes of the critical incident investigation (**Table 7**). In most of these cases the directly involved officers relied on the privilege against self-incrimination to decline to provide a version of events.[55]

Some of these directly involved officers did eventually provide a version of events, albeit years later, when compelled to do so during related coronial proceedings (see Case Study 6: SF Nalanda) or voluntarily during criminal proceedings (see Case Study 7: SF Cromerty). In other cases, the directly involved officers declined to give a version until they received legal advice or until such time as the toxicology report or cause of death was known.

Where involved officers decline to provide a contemporaneous version of events it hampers the critical incident investigation and also makes the evidence provided at a later date less reliable, given the impact of time on memory. Under s 61 of the *Coroners Act 2009* the Coroner may compel a witness, including a police officer, to give evidence in circumstances where a witness objects to giving evidence due to a claim against self-incrimination. When the Coroner does compel a witness to provide a version, they may be offered a certificate of immunity, which has the effect of preventing the evidence being used against the witness in other jurisdictions. The Commission's practice has been to confirm that police investigators have advised the Senior Coroner with carriage of the matter, where involved officers have declined to provide a version of events.

In September 2021, the Coroner also introduced a practice note requiring police investigating a critical incident to tell the Coroner within eight weeks of the incident if a directly involved officer has provided, will provide or has declined to voluntarily provide a version of events.[56]

The Senior Coroner has the ability to call an early directions hearing to obtain versions of events from any involved officers that do not provide voluntary statements. In SF Stanleigh the three involved officers declined to provide a version of events to the NSWPF critical incident investigators. However, 11 months after the incident the involved officers were compelled to provide a version of events to the Senior Coroner, though they were not subject to questioning. A non-publication order was also granted in relation to the testimony provided by the involved officers, to restrict publication of the testimony while the matter is still being prepared for inquest. Although it is possible

[55] *Baff v NSW Police Commissioner* [2013] NSWSC 1205, provides authority that a police officer is entitled to refuse to answer questions put to him by his employer, in exercise of his privilege against self-incrimination. If a police officer believes that answering questions may lead to self-incrimination, it is not lawful of the police officer's employer to require the officer to answer the questions.

[56] Coronial Practice Note No.3 of 2021, Case Management of mandatory inquests involving section 23 deaths, Commenced 24 September 2021: *11.1 Within 8 weeks of a determination of jurisdiction, the Officer in Charge must provide a preliminary report of no more than five pages to the Senior Coroner and the solicitor assisting or coronial advocate. 11.2 The report should contain the following information: e. The names of any persons identified as officers or employees involved in the death, details of their legal representative(s), and advice as to whether they have provided (or will provide) witness statements voluntarily.*

that the non-publication orders will be lifted at the time of the Inquest, in the interim it is difficult for the Commission to fully discharge its functions under the Act until such time as the non-publication orders are lifted or varied.

Table 7: Critical incident investigations where involved officer/s have declined to provide a version of events between 1 July 2017 to 30 June 2022

YEAR OF CRITICAL INCIDENT	STRIKE FORCE	NUMBER OF INVOLVED OFFICERS DECLINING TO PROVIDE VERSION	VERSION PROVIDED	MONTHS UNTIL VERSION PROVIDED
2017 – 18	Cromerty	1	Declined until criminal proceedings	24
	Dutton	1	Deferred until coronial proceedings	41
	Nalanda	8	Deferred until coronial proceedings	19
	O'Donnell	5	Deferred until cause of death confirmed	18
2018 – 19	Noela	1	Deferred until related criminal proceedings resolved	18
2019 – 20	Balraith	2	Deferred awaiting legal advice	2
2020 – 21	Stanleigh	2	Declined until cause of death confirmed	11
	Kapiti	2	Declined awaiting toxicology	1
	Bibbs	5	Declined until cause of death confirmed	1[a]
2021 - 22	Bromhall	1	Declined on legal advice[b]	Unknown
	Bohemia	1	Declined on legal advice[b]	Unknown

a There were five involved officers who provided a version of events between 1 week and 1 month post incident.
b Version provided was limited to that required under Road Rule 287.

4.1.4 What happens when the Commission does not attend a critical incident scene?

Where the Commission does not attend a critical incident scene, the Commission investigator requests and receives updates from the NSWPF nominated contact officer by telephone and email, when the nominated contact officer attends the scene and as the investigation progresses in the months that follow. In the early stages of an investigation, this allows the Commission to reassess its decision not to attend where appropriate. It also allows the Commission to be kept appraised of the progress of the critical incident investigation and raise questions or concerns in real time, whether or not the Commission investigator attends a critical incident scene.

The attendance phase of critical incident monitoring is usually relatively short. The most resource intensive phase of critical incident monitoring occurs after attendance since it involves the review of all original source documents arising from the investigation, as and when they become available.

4.2 Monitoring of critical incident investigations

The Commission's oversight of a critical incident investigation is generally limited to accessing evidence, requesting information and raising questions or concerns about the evidence or the investigation when they arise. The Commission has no power to 'control, supervise, direct or interfere' with the police investigation of the critical incident.[57]

Whether or not the Commission attends a critical incident scene it monitors every critical incident investigation by accessing and reviewing all documents, audio recordings, and video footage gathered in relation to the critical incident *via* the NSWPF investigations database, e@gle.i. Requests are also made for copies of electronic materials that are too large to be stored within that database.

In the course of reviewing documents, the Commission investigator raises any questions or concerns arising from the evidence with the NSWPF by contacting the nominated contact officer. Under the Arrangements,[58] the NSWPF nominated contact officer is the PSC Review Officer assigned to internally oversight the investigation.

Questions and concerns raised by the Commission investigator with the PSC Review Officer can include matters such as:

(i) compliance with the NSWPF Critical Incident Guidelines;
(ii) the lawfulness and reasonableness of police actions and compliance with NSWPF policies, practices and procedures, at the time of, and leading to the critical incident;
(iii) complaints or evidence of potential officer misconduct;
(iv) the adequacy of, or proposed changes to, relevant NSWPF policies, practices and procedures; and
(v) systemic, safety or procedural issues.

[57] *Law Enforcement Conduct Commission Act 2016*, s 115(4).

[58] Arrangements for the Monitoring of NSW Police Force Critical Incident Investigations between the LECC and NSWPF, in accordance with Part 8 of the LECC Act, para 37.

The Commission may, at any time during the course of a critical incident investigation, advise the Commissioner of Police or, in the case of a death the State Coroner, if the Commission is of the view that the critical incident investigation is not being conducted in accordance with the NSWPF Critical Incident Guidelines, not fully and properly examining (ii) to (v) above, or not being conducted in a competent, thorough or objective manner.[59]

The Commission has escalated a matter in this manner on only one occasion (see Case Study 12: SF Pembury). On all other occasions any concerns identified by the investigation have been raised *via* the PSC Review Officer and been resolved without a need to escalate concerns further.

4.2.1 Compliance with the NSWPF Critical Incident Guidelines

The NSWPF Critical Incident Guidelines outline the roles and responsibilities of police involved in responding to, investigating and overseeing the investigation of a critical incident. The purpose of the NSWPF Critical Incident Guidelines is to ensure the critical incident investigation is conducted in a competent, thorough and objective manner.

Although the NSWPF Critical Incident Guidelines are not mandatory and a departure from them does not affect or invalidate an investigation, police are required to comply with the NSWPF Critical Incident Guidelines so far as is practicable and operationally appropriate.[60]

Since 1 July 2017 two versions of the NSWPF Critical Incident Guidelines have been in operation. A version dated January 2017 was a comprehensive 52 page document with substantial explanation around all aspects of critical incident investigations. It was replaced on 23 December 2019. The December 2019 version of the NSWPF Critical Incident Guidelines is in a significantly revised format, in which the explanation around roles and responsibilities has been replaced by checklists of actions to be taken by each 'police officer role' involved in responding or investigating a critical incident.[61]

Previously, the Police Integrity Commission's *Operation Harlequin* report and the Commission's *Review of 29 Police Force Critical Incident Investigations* report identified numerous issues with police compliance with the NSWPF Critical Incident Guidelines.[62] Both of these reports, considered critical incident investigations that were finalised by the NSWPF prior to the Commission becoming operational. The Critical Incident Investigations and Monitoring team has generally found good compliance by the NSWPF with the NSWPF Critical Incident Guidelines for all incidents occurring after 1 July 2017.

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[59] *Law Enforcement Conduct Commission Act 2016*, s 116(a), (b), (c).

[60] *Law Enforcement Conduct Commission Act 2016*, s 113(3), (4).

[61] Police officer roles include those of the; First Senior Officer at Scene who manages the incident scene until such time as the Duty Officer or Critical Incident Investigation Team arrives; Incident Scene Guard; Duty Officer/Inspector who manages the scene until the Critical Incident Investigation Team arrives and takes over Command; Police Area/District Commander from the incident PAC/PD; Senior Critical Incident Investigator (SCII) responsible for leading the critical incident investigation; PSC Review Officer assigned to internally reviewing the critical incident investigation; Region Commander responsible for the PAC/PD where the incident occurred; and the State Coordination Unit who notifies and mobilises staff to attend and investigate the critical incident scene.

[62] Police Integrity Commission, Project Harlequin, Audit of the NSW Police Force investigations into 83 critical incidents occurring between 1 January 2009 and 30 June 2012; Review of 29 NSW Police Force critical incident investigations, June 2019.

Compliance with the NSWPF Critical Incident Guidelines is likely to have been assisted by a number of factors.

Firstly, prior to January 2017, PSC Review Officers attended and quality reviewed only those incidents involving the homicide of a police officer, or deaths involving the discharge of a police firearm, the use of police defensive equipment or the use of physical force by a police officer. The majority of incidents, however, required the Region Commander to appoint a senior police officer from an independent Command within the same Region to act as the Review Officer for the investigation. The problem was that although both the Review Officer and SCII were senior criminal investigators, they may have had no previous experience in reviewing or running a critical incident investigation. This meant that Review Officers and SCIIs often had limited knowledge of the NSWPF Critical Incident Guidelines, resulting in issues with compliance. The current NSWPF practice of requiring a PSC Review Officer to attend and quality review all critical incident investigations provides some continuity and a level of expertise regarding the investigation of critical incidents. Although the PSC Review Officer does not have the authority to make or set investigative directions, the PSC Review Officer does maintain close communication with the SCII and provide advice as to requirements under the NSWPF Critical Incident Guidelines.

Secondly, when a critical incident is declared, the investigator from the Commission's CIIM team liaises with the PSC Review Officer from the time the critical incident is declared. Having monitored more than 157 critical incident investigations, the Commission's CIIM team has developed substantial experience with the NSWPF Critical Incident Guidelines and the monitoring of critical incident investigations. The CIIM team raises issues and concerns in relation to compliance as the investigations unfold, so that issues are often addressed immediately.

Finally, the current iteration of the NSWPF Critical Incident Guidelines,[63] which uses concise checklists to explain the responsibilities of each officer involved in the critical incident investigation, appears to provide clearer instruction and as a result, improved compliance.

The Commission's observation is that where non-compliance with the NSWPF Critical Incident Guidelines has occurred it appears to have been unintentional (see Case Study 1: SF Beachway), impractical to comply (see Case Study 8: SF Newmoon), or there has been a difference of opinion about the compliance issue (see Case Study 6: SF Nalanda).

4.2.2 Reviewing the lawfulness and reasonableness of police actions

In the course of a critical incident investigation, the NSWPF must examine and report to the Commission and the State Coroner (if applicable) on the lawfulness and reasonableness of the actions of police involved in a critical incident, and whether police officers involved in the incident complied with relevant NSWPF policies, practices and procedures.[64]

When monitoring a critical incident investigation, the Commission communicates with the NSWPF about any issues the Commission identifies that relate to:

[63] NSWPF Critical Incident Guidelines December 2019

[64] *Law Enforcement Conduct Commission Act 2016*, s 113(1) and s 113(2)(a).

- the lawfulness and reasonableness of the actions of police involved in a critical incident; and
- compliance with existing NSWPF policies, practices and procedures.

The Commission will request information or raise these issues with the Review Officer (see Case Study 11: SF Auras).

In the course of monitoring critical incident investigations from 2017-2022, the Commission has raised concerns on numerous occasions. This has included but is not limited to:

(i) inconsistencies between versions of events provided by involved officers and witnesses;
(ii) concerns about police actions when dealing with an intoxicated person (see Case Study 4: SF Parrish);
(iii) concerns about compliance with and, the adequacy of, existing NSWPF policies and procedures (see Case Study 5: SF Garemyn); and
(iv) concerns about the reasonableness of police actions which bring to light apparent gaps in policy or procedures (see Case Study 13: SF Gilholme);

To date, there has only been one occasion where the Commission has had to escalate concerns to the Commissioner of Police under the LECC Act.[65] This was done because the Commission had a different opinion to that of internal NSWPF advice, and the issue needed to be quickly resolved to ensure that any prosecutions could be commenced within the statutory timeframe (see Case Study 12: SF Pembury).

4.2.3 Complaints and evidence of officer misconduct

Under s113(2)(c) of the LECC Act, a critical incident investigation must examine and report on any complaint made about the conduct of police officers involved in the critical incident.[66]

A complaint may be made by a family member of a person seriously injured or killed during a critical incident, by a person seriously injured during a critical incident, by a police officer or by another person.

Following a critical incident declaration, police must advise the seriously injured person or a family member of a person seriously injured or killed that the Commission is monitoring the critical incident investigation, as well as how to make a complaint.[67] To ensure this obligation is met, the Commission and the NSWPF have agreed on a standardised notice to communicate the required information to family members.[68] The written advice provides general information about the Commission's role in monitoring critical incident investigations and how to make a complaint about police conduct (Appendix A).[69] The NSWPF have complied with this obligation on all occasions in the period 2017-2022.

[65] *Law Enforcement Conduct Commission Act 2016*, s 116(a).
[66] *Law Enforcement Conduct Commission Act 2016*, s 113(2).
[67] *Law Enforcement Conduct Commission Act 2016*, s 118.
[68] Arrangements for the Monitoring of NSW Police Force Critical Incident Investigations.
[69] The notice is entitled 'The Role of the Law Enforcement Conduct Commission (LECC) in Monitoring the NSW Police Force (NSWPF) Investigation of Critical Incidents' and is attached to the 'Arrangements for the Monitoring of NSW Police Force Critical Incident Investigations' which provides practical guidelines in relation to how the Commission and the NSWPF will

The LECC Act also requires that a critical incident investigation examine and report on whether the investigation has uncovered evidence of officer misconduct.[70] If this occurs, the SCII has a legal obligation to report the misconduct[71] to a senior officer[72] for further consideration and action, which may or may not include interim management action.[73]

If a complaint is raised by a family member, or if evidence of officer misconduct is uncovered in the course of the critical incident investigation, a separate investigation, called a misconduct matter investigation, is usually initiated to investigate more closely whether the allegations of misconduct are supported by the evidence.

Where the allegations of misconduct relate directly to a critical incident, and also involve coronial or criminal processes, the misconduct matter investigation is usually not finalised until the coronial or criminal matters are resolved. This is because misconduct issues that relate directly to the outcome of a critical incident are closely examined in the course of the coronial or criminal proceedings, and findings made in the misconduct investigation are affected by evidence and findings made in other proceedings.

Where misconduct matters are not directly linked to a critical incident, the allegations are not investigated by the CIIT. Instead, the allegations of misconduct are referred to the PAC or PD to which the officer is attached for investigation, findings and where appropriate management action to ensure that the conduct does not recur in the future. These misconduct matters are usually dealt with while related criminal or coronial proceedings are on foot. These misconduct investigations are also subject to review by the Commission, to ensure the investigations are appropriately conducted and the findings reasonable and based on the evidence.

Although critical incident investigations closely examine the actions of police leading up to and during a critical incident, the evidence shows that critical incidents do not often involve officer misconduct and do not often result in misconduct matter investigations.

Since 1 July 2017, 25 (16%) of the 157 critical incidents have an associated misconduct matter (**Table 8**).[74] Eight of these critical incident investigations have more than one misconduct matter linked to them. Taking this into account, there have been a total of 35 misconduct matters directly or indirectly linked to critical incident investigations.

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cooperate to facilitate the monitoring of critical incident investigations in accordance with Part 8 of the LECC Act 2016. The notice was drafted by the Commission and the NSWPF to ensure consistent information to family members.

[70] *Law Enforcement Conduct Commission Act 2016*, s 113(2)(d).

[71] Police Act 1990,s 211F.

[72] NSWPF Critical Incident Guidelines (23 December 2019), Senior Critical Incident Investigator Guidelines and Checklist, Item 20.

[73] Interim management action is action taken by management on a temporary basis to manage a risk that an individual may pose whilst in the workplace. Interim risk management may involve assigning an individual to alternative or restricted duties, additional supervision, mentoring, or retraining, until an investigation is completed and findings are made in the relevant investigation.

[74] **2017-18** - SF Cromerty (LMI1702860, P1702959, and a verbal civilian compliant to Commission); SF Baxes (LMI1703763); SF Erlinya (MIR2018-0553, MIR2019-0966, EXT2019-1174), SF Auras (MIR2018-0370, MIR2018-0943, EXT2019-3949); SF Garemyn (MIR2020-1371); SF Montavella (LMI1801092); SF Nalanda (EXT2021-1147); **2018-19** – SF Mulgowrie (MIR2018-0818); SF Gari (MIR2020-0316); Finschhafen (MIR2020-0817, MIR2020-0819); Casey (EXT2019-1186, EXT2019-1250); SF Pembury (MIR2019-0912); SF Newsome (MIR2019-0796, MIR2019-0590); Noela (MIR2019-0878); **2019-20** - SF Besborough (MIR2019-1241; EXT2019-2837); SF Parrish (MIR2020-0828); SF Netley (MIR2020-0603); SF Algedi (EXT2022-2510); **2020-21** – nil; **2021-22** – SF Carlma (EXT2021-2741); SF Binbilla (EXT2021-3202); SF Bromhall (MIR2022-0237); SF Phase (AOM2022-0022); SF Mingelo (MIR2022-0579); SF Selm (EXT2022-0237); SF Bohemia (MIR2022-0827; CASE2022-4176).

Table 8: Misconduct matter investigations arising from critical incident investigation between 1 July 2017 and 30 June 2022

YEAR	CRITICAL INCIDENT DECLARATIONS	NUMBER (%) LINKED TO MISCONDUCT MATTERS	TOTAL MISCONDUCT MATTERS	DIRECT LINK*	INDIRECT LINK*
2017-18	34	7 (21)	12	8	4
2018-19	32	7 (22)	10	6	4
2019-20	27	4 (11)	5	4	1
2020-21	27	0	0	0	0
2021-22	37	7 (19)	8	8	0
Total	157	25 (16)	35	26	9

* A 'direct link' is an allegation of misconduct that goes to the actions of police leading up to the critical incident or in relation to the critical incident investigation, and is therefore material to the matter. An 'indirect link' includes evidence of misconduct which is uncovered or linked to the critical incident matter which does not involve the actions of police leading to the critical incident or involve the critical incident investigation.

Since 1 July 2017, 8 (23%) critical incident related misconduct matters arose as a consequence of complaints being made by family members or friends of the deceased person and/or by family members and/or the seriously injured person:

- In three of these, seriously injured persons or the family members of seriously injured or deceased persons, complained to the Commission about customer service issues including a lack of information or a frustration with the failure of police investigators to return calls.[75] In two of these three, the Commission immediately intervened to ensure police investigators made contact with the complainant, while in the third police immediately addressed the issue.
- There have been five complaints which alleged that police used unreasonable force and, in two of these complaints it was also alleged a police officer was rude to family members or friends. However these allegations were not sustainable on the available evidence.[76]

In practice, it is difficult for family members or the seriously injured person to make a complaint about the actions of police leading up to or during the critical incident itself, since they often do not have enough information or knowledge of the incident to make a complaint.

Twenty seven (77%) of the critical incident related misconduct matters were identified as a consequence of evidence arising in the course of the critical incident investigation, rather being initiated following a complaint being made by a civilian. In five of these cases the misconduct matters were identified as a consequence of concerns raised by the Commission in the course of monitoring the critical incident investigation (see Case

[75] SF Cromerty (a verbal civilian complaint to Commission); SF Erlinya.(EXT2019-1174); SF Selm (EXT2022-0237).

[76] SF Nalanda (EXT2021-1147); SF Casey (EXT2019-1186, EXT2019-1250), SF Besborough (EXT2019-2837), SF Algedi (EXT2022-2510), SF Binbilla (EXT2021-3202)

Study 4: SF Garemyn; Case Study 10: SF Gari; Case Study 11: SF Auras; Case Study 12: SF Pembury and SF Mingelo).

Twenty six (74%) of the misconduct matters have direct links to the critical incident or the critical incident investigation itself. A direct link is an allegation relating to the actions of the officers involved in the critical incident, or relating to the conduct of the critical incident investigation itself. An example is set out in Case Study 7: SF Cromerty. In SF Cromerty, the physical force used by a police officer caused a person to fall, and sustain a fracture, which constituted a serious injury.

The remaining nine (26%) misconduct matters are only indirectly connected with the incident. An indirect link is one where the actions of police are not connected to the manner and cause of the serious injury or death, but relates to other actions taken by police that are linked to the critical incident. An example of this is set out in Case Study 5: SF Garemyn. In Case Study 5: SF Garemyn a lack of diligence in investigating a missing person report delayed the finding of the person's remains, but did not cause the person's death.

4.2.4 Outcomes of misconduct matters associated with critical incidents

Although there have been 35 misconduct matter investigations initiated and linked to critical incidents, not all misconduct allegations were sustainable.

So far, 16 (46%) of the 35 misconduct matters linked to critical incident investigations have resulted in sustained findings being made against subject police officers (**Table 9**).[77] Of the remainder, eight (23%) of investigations concluded that there was no misconduct by the involved officers,[78] and three (9%) have been suspended pending the outcome of related court processes.[79] There were also eight (23%) misconduct matters which were declined for investigation. [80]

It should be noted that where the Commission is not satisfied with the reasons provided for police to decline to investigate a misconduct matter the Commission may require police to investigate the allegation under s 99(3) of the LECC Act. The ability of the Commission to require police to investigate a misconduct matter is dependent on the misconduct matter being categorised as notifiable under the Section 14 Guidelines[81]. In order to ensure that all misconduct arising from a critical incident is notified to the Commission and subject to s 99 of the LECC Act, the Commission has recently included

[77] **2017-18** - SF Cromerty (LMI1702860 – sustained); SF Erlinya (MIR2019-0966 – sustained); SF Auras (MIR2018-0370 – sustained; MIR2018-0943 – sustained); SF Garemyn (MIR2020-1371 – sustained); SF Montavella (LMI1801092 – sustained); **2018-19** – SF Mulgowrie (MIR2018-0818 – sustained); SF Gari (MIR2020-0316 – sustained); SF Finschhafen (MIR2020-0817 – sustained; MIR2020-0819 – sustained); SF Pembury (MIR2019-0912 – sustained); SF Noela (MIR2019-0878 - sustained); **2019-20** - SF Besborough (MIR2019-1241 – sustained); SF Parrish (MIR2020-0828 – sustained); **2020-21** – not applicable; **2021-22** – SF Bromhall (MIR2022-0237 –sustained); SF Phase (AOM2022-0022 – sustained).

[78] **2017-18** - SF Cromerty (P1702959 - not sustained); SF Baxes (LMI1703763 - not sustained); SF Erlinya (MIR2018-0553 - not sustained; EXT2019-1174 - not sustained); SF Auras (EXT2019-3949 - not sustained); SF Nalanda (EXT2021-1147 – not sustained); **2018-19** - SF Casey (EXT2019-1186 - not sustained); SF Algedi (EXT2022-2510 – not sustained).

[79] **2019-20** - SF Netley (MIR2020-0603 – suspended pending outcome of criminal matter); **2021-22** - SF Bohemia (MIR2022-0827 –suspended pending outcome of criminal matter). Mingelo (MIR2022-0259 – suspended due to sick leave).

[80] Police Act 1990, s 132. The Commissioner of Police can decline to investigate a complaint in certain circumstances. **2018-19** - SF Casey (EXT2019-1250 – declined under s 132(b)); Newsome (MIR2019-0796 – declined under s 132(b); MIR2019-0590 – declined under s 132(b)); **2019-20** - SF Besborough (EXT2019-2837 – declined under s 132(a)). **2020-21** – not applicable**; 2021-22** – SF Carlma (EXT2021-2741 – declined under s 132(g)); SF Binbilla (EXT2021-3203 –declined under s 132(b); SF Selm (EXT2022-0237 – declined under s 132(a)); SF Bohemia (CASE2022-4176 – declined under s 132(a)).

[81] The Section 14 Guidelines are a publicly available document published on the Commission's website www.lecc.nsw.gov.au/

this category of misconduct matters as a one requiring notification to the Commission in updated Section 14 Guidelines.

Table 9: Outcome of misconduct matter investigations linked to critical incident investigations between 1 July 2017 to 30 June 2022

YEAR	CRITICAL INCIDENT DECLARATIONS	TOTAL MISCONDUCT MATTERS	SUSTAINED	NOT SUSTAINED	SUSPENDED	DECLINED
2017-18	34	12	6	6	0	0
2018-19	32	10	6	1	0	3
2019-20	27	5	2	1	1	1
2020-21	27	0	0	0	0	0
2021-22	37	8	2	0	2	4
Total	157	35	16	8	3	8

Sustained – where allegations of misconduct were investigated by the NSWPF and findings of misconduct made against one or more subject officers; **Not sustained** – where the allegations of misconduct have been investigated by the NSWPF but findings were not made against the subject officers because there was insufficient evidence of misconduct or because the evidence confirmed that the alleged misconduct did not occur; **Suspended** – where misconduct investigation is not complete but suspended awaiting the outcome of criminal or coronial court proceedings; **Declined** – where the NSWPF has declined to investigate the allegation for a reason under s 132 of the *Police Act* 1990.

Sometimes concerns about the critical incident or the police investigation into the circumstances around the critical incident are raised in the media, rather than by family members or police. When this occurs the Commission has attempted to address these concerns (see Case Study 14: SF Mulgowrie).

4.2.5 Investigation of misconduct matters by the Commission

If a misconduct matter arises from a critical incident, the Commission cannot make a decision about whether to investigate that potential misconduct until the NSWPF critical incident investigation has concluded.[82]

While a critical incident that results in a death is a matter that is subject to examination by the Coroner, this is not the case for critical incidents that are declared following a person sustaining serious injuries. The Commission is responsible for the independent monitoring and oversight of the investigation of critical incidents declared as a consequence of serious injury, as well as those involving a death.

While the Commission cannot commence an immediate investigation itself, the Commissioner of Police may refer a complaint to the Commission with a recommendation that it investigate the complaint.[83] To date, the Commissioner of Police has not referred any complaints relating to critical incidents to the Commission for investigation.

[82] *Law Enforcement Conduct Commission Act 2016*, s 44(9).
[83] *Law Enforcement Conduct Commission Act 2016*, s 113(2)(c).

While a decision by the Commission about whether to investigate must be put on hold while a critical incident investigation is ongoing, the Commission does ensure that any evidence of misconduct arising from a critical incident investigation is considered and addressed by the NSWPF.

To date, there has been no need for the Commission to commence a misconduct matter investigation relating to a critical incident following the finalisation of the critical incident investigation by the NSWPF.

4.2.6 The separation of misconduct investigations and critical incident investigations by the NSWPF

The oversight or monitoring of NSWPF critical incident investigations are governed by Part 8 of the LECC Act. The roles and responsibilities of the Commission and the NSWPF in the oversight of NSWPF misconduct investigations are governed separately under Part 7 of the LECC Act.

The NSWPF also separates critical incident and misconduct matter investigations administratively. Although alleged misconduct may be identified in the course of a critical incident investigation, the allegations are not dealt with by the SCII but are dealt with in a separate misconduct investigation. This can be problematic.

Although, the critical incident investigators have access to, and knowledge of, all relevant evidence gathered in the course of a critical incident investigation, the misconduct matter investigator is generally provided with a short report authored by the SCII. For example, in SF Erlinya the SCII provided the misconduct matter investigator with a short report, summarising the actions and inaction of an officer which may have constituted misconduct. The source documents which supported the allegations of misconduct were not attached to the report. Although the SCII had indicated that the misconduct matter investigator could make contact and request further information, the misconduct matter investigator did not do so. In any case, it would be difficult for the misconduct investigator to know what evidence was available in relation to the misconduct allegations, in order to request it.

The Commission has several concerns with the separation of critical incident and misconduct matter investigations:

- Since a misconduct matter investigation is almost always suspended pending the finalisation of coronial or criminal proceedings, there is likely to be a long delay in taking evidence on the misconduct matter from involved police officers. Those officers may have already given evidence on those events in coronial or criminal proceedings. These factors risk impacting the officer's evidence in relation to the misconduct investigation.
- The misconduct investigator tends to conduct a fresh investigation to test the allegations, which is duplicitous and a waste of resources.
- The findings made in the related misconduct matter investigation are not always congruent with findings that may have been warranted on the basis of all available evidence arising in the critical incident investigation (see Case Study 15: SF Erlinya);
- Any management action may be significantly delayed and will not mitigate risks of similar misconduct occurring in the interim.

- The delay may also affect the fairness of taking management action and therefore the type of management action that is taken. Indeed, given the passage of time, it may be too late to take management action (see Case Study 10: SF Gari).

In order to address these concerns, the Commission is of the view that the NSWPF should introduce a different process to deal with misconduct matters arising from critical incident investigations. The Commission was of the preliminary view that the Region PSM be made responsible for the investigation and findings made in relation to any allegations of misconduct arising from a critical incident investigation. The advantage of this is that the Region PSM has access to the entire critical incident investigation from the outset, and can monitor the critical incident investigation in real time. Along with the Region Commander, they are required to address risks identified in the course of the critical incident investigation. If the Region PSM took carriage of any related misconduct matter investigation, it would reduce duplication of investigative efforts. It would also reduce the likelihood of conflicts of interest arising, as might occur where a misconduct matter investigator from the PAC or PD in which the critical incident occurred, takes carriage of the matter.

In a draft of this Report which was provided to the NSWPF, the Commission made this preliminary recommendation.[84] The Commission suggested that the NSWPF should amend the NSWPF Critical Incident Guidelines and the Misconduct Matters Framework to provide that the Region PSM is responsible for investigating and making findings in relation to any misconduct arising in a critical incident investigation. The Region PSM should also take interim management action while other processes and proceedings are on foot.

In response, the NSWPF advised that they 'agree in part' with the preliminary recommendation. The NSWPF is of the view that unless there are issues arising from a conflict of interest or a lack of resourcing, the misconduct of an officer should be investigated by that officer's Commander and not the Region Commander. The NSWPF do accept that the Region PSM could have responsibility for ensuring that the officer's Commander 'has access to all appropriate and relevant information from the critical incident investigation'.

The Commission supports the process suggested by the NSWPF as an improvement in the current system and has therefore amended the preliminary recommendation.

Recommendation 2: The NSWPF amend the NSWPF Critical Incident Guidelines and the Misconduct Matters Framework to provide that the Region PSM is responsible for ensuring that all appropriate and relevant information from the critical incident investigation is provided to the assigned misconduct matter investigator in a timely manner.

[84] On 22 December 2022 a copy of this Report in draft was sent to the NSWPF in relation to the content and recommendations made prior to the Report being finalised and tabled in Parliament. The NSWPF sought and received advice from several stakeholders including; all Region Commanders, Traffic and Highway Patrol, Professional Standards Command (Investigations Unit), State Crime Command, and Capability Performance and Youth Command. On 10 February 2023 the Commission received a response from police.

4.2.7 Identification of systemic, safety or procedural issues

The CIIT's Critical Incident Investigation Report must consider whether there are any systemic, safety or procedural issues arising from the investigation and, if so, if there is a need for changes to relevant NSWPF policies, practices and procedures. Such changes may prevent other similar safety or procedural issues from occurring, and as such are one of the most significant benefits of a critical incident investigation. Changes to policies, practices and procedures are usually addressed in recommendations within the Critical Incident Investigation Report.

By virtue of its monitoring role, the Commission is aware of the nature of recommendations that may be made in the Critical Incident Investigation Report. However, the recommendations are not communicated to the Commission until the NSWPF has finalised its report and a copy of it made available to the Commission.

In practice, the SCII Report (which forms part of the critical incident report) may include recommendations which can be acknowledged and sometimes endorsed in the Review Officer Report. The Region Report sometimes acknowledges the recommendations, but it often does not consider or articulate any actions to be taken in relation to the recommendations made by the SCII.

This is problematic because while monitoring a critical incident investigation, the Commission needs to consider whether the NSWPF has appropriately identified and addressed issues relating to policies, practices and procedures,[85] and any systemic, safety or procedural issues arising.[86] Without advice from the NSWPF, as to the action the NSWPF proposes to take in relation to recommendations, the Commission cannot be satisfied that the identified issues have been, or will be, appropriately addressed.

As a consequence, after reviewing the finalised NSWPF Critical Incident Investigation Report, the Commission has frequently had to seek further advice, as to the consideration of action to be taken, in relation to the recommendations made in the SCII Report. This is particularly so, where the recommendation made does not arise from a coronial recommendation.

Since 1 July 2017, the Commission has identified a range of systemic safety and procedural issues, and after reviewing the NSWPF Critical Incident Investigation Report has engaged with police to ascertain what action, if any, the NSWPF intended to take to address these issues. The Commission has raised the following:

(i) whether the NSWPF has considered the SCII's recommendation that the NSWPF and Corrective Services NSW (CSNSW) consider developing an MOU to specify when a person in custody is the responsibility of the NSWPF or CSNSW to mitigate the risks of similar custody related issues arising in the future (see Case Study 7: SF Cromerty).
   a. The NSWPF advised that they declined to endorse the SCIIs recommendation on the basis that they were of the view that the existing MOU between the NSWPF and Corrective Services NSW was adequate, and the issue arose because of a one-off misunderstanding of procedures by individuals;

[85] *Law Enforcement Conduct Commission Act 2016*, s 113(2)(e) and (f).
[86] *Law Enforcement Conduct Commission Act 2016*, s 116(a).

(ii) whether the NSWPF should give further consideration to whether it would be appropriate to include guidelines in relation to the *'following'* or *'monitoring'* of vehicles which are currently not captured by the existing NSWPF Safe Driving Policy (see Case Study 5: SF Garemyn).
   a. The NSWPF advised that the recommendation will be considered as part of an upcoming wide-ranging review of the NSWPF Safe Driving Policy;

(iii) whether the NSWPF had developed the e-learning module 'Persons at risk of heights', as indicated in response to coronial recommendations made in the Findings for the Inquests into three deaths in the Northern Beaches LGA on 31 July 2018 and Findings from the Inquest into the Death of Aaron McKay on 22 May 2019. The module was unable to be located by a SCII conducting a critical incident investigation on 10 August 2020 (see Case Study 16: SF Clapham).
   a. The NSWPF advised that the development of the module had been delayed due to a number of other priorities including the roll out of the Police Ambulance Clinical Early Response (PACER) program in April 2020 and the NSW Health Suicide Monitoring System (July 2020). The NSWPF also advised that the MHIT were progressing the research phase for the e-learning module and estimated that the module would be delivered by early 2022.
   b. It is unknown whether this module has in fact been delivered at the time of writing.

(iv) whether the use and attachment of BWV cameras to ballistic vests was possible and practicable, though not raised in the critical incident investigation report.[87] In SF Talbragar, a police officer had taken off their normal load bearing vest with a BWV camera and, put on a ballistic vest. As the ballistic vest was not designed to automatically carry a BWV camera, there was no BWV footage of the incident. The Commission was of the view that there were some high-risk situations where the wearing of a BWV camera on a ballistic vest might be warranted.
   a. The NSWPF advised that there was a Klickfast Dockclamp mounting platform available which allows an officer to mount the BWV camera on a ballistic vest and the NSWPF BWV camera intranet page was being updated to provide practical information in relation to the use of BWV cameras on ballistic vests[88].

(v) whether the NSWPF had considered giving the on-call Region Operations Duty Officer, in a regional Police District of NSW, remote access to police radio and CAD, particularly where there are mobile phone black spots.[89]
   a. The NSWPF advised that carrying a police radio whilst off duty and on call presented risks and a mobile phone was preferred notwithstanding mobile phone black spots. The NSWPF also advised that remote access to CAD was not possible at this time.

(vi) whether the NSWPF should consider amending NSWPF Critical Incident Guidelines to specify timeframes for the submission and finalisation of critical incident investigation reports.[90]

[87] SF Talbragar

[88] It was also later identified that in December 2020, the NSWPF sent a state-wide message providing instructions on the use of Klickfast Dockclamps.with ballistic vests

[89] SF Newmoon

[90] SF Derowrie

a. The Professional Standards Command indicated that they were introducing measures to more actively review critical incident investigations, including the timeliness of the reporting phase.

(vii) whether the NSWPF should introduce robust procedures to notify the Commission that a critical incident investigation has been finalised and to provide a copy of the reports to the Commission.[91]

a. The NSWPF Professional Standards Command indicated that they were in the process of upgrading their critical incident database which would assist in ensuring that finalised reports are provided to the Commission once finalised by the NSWPF.

(viii) whether the NSWPF had responded to coronial recommendations handed down one year prior, notwithstanding that the Department of Justice Website indicates that the Department is awaiting a response from the NSWPF.[92]

a. The NSWPF advised that the NSWPF Domestic and Family Violence Procedures and the Code of Practice for the NSWPF will be updated to reflect recommendation 1(b) that police attend and speak to an alleged victim of domestic violence in person unless there are exceptional reasons not to do so.
b. The NSWPF advised that recommendation 1(a), that all reported domestic violence be broadcast as such, even where there is no offence, would not be adopted;
c. The NSWPF advised that they were working with specialist external agencies to develop a training package specific to *'use police to commit self-harm'*.

(ix) whether the NSWPF were taking steps to address the involved officers' lack of understanding of the situational awareness STOPAR training module, as raised by the SCII in the critical incident investigation report.[93]

a. The NSWPF advised that in the 2021-2022 training year, Operational Safety Instructors have delivered face-to-face training scenario-based training modules focused on decision making during domestic violence incidents and incidents where mental health is a factor. These scenarios require that the officers being trained apply STOPAR principles.
b. The NSWPF advised that they would continue to reinforce STOPAR principles into future mandatory training and operational safety scenarios.
c. The NSWPF also advised that the Mental Health Intervention Team (MHIT) and NSW Health are in the process of co-developing a training package to assist the retention of knowledge of the STOPAR de-escalation principle for frontline officers.

The legislative obligation on the NSWPF to consider whether there are any systemic, safety or procedural issues arising from a critical investigation and to make the necessary changes, is one of the most significant benefits of a critical incident investigation. However, these benefits can be diminished by the time taken to consider the need for change and to then implement the changes.

[91] SF Derowrie
[92] SF Gilholme
[93] SF Gilholme

The action to be taken in relation to systemic issues is usually not considered until after the finalisation of the critical incident investigation. As outlined in 4.4.1 for those matters not involving court processes, it takes on average 12 months for the NSWPF to finalise a critical incident investigation. Where there are criminal or coronial proceedings involved it takes on average 18 or 26 months respectively, for the critical incident investigation to be finalised. This significantly delays improvements systems and the mitigation of future risks. There would be a significant advantage to considering improvements to systemic and policy issues at a much earlier point in time, when the issues are first identified by investigators, rather than awaiting court processes and an internal report to be finalised.

Recommendations arising from a coronial inquest are dealt with differently (see 4.2.10 below).

4.2.8 Critical incident investigations falling within the coronial jurisdiction

When a NSWPF critical incident results in the death of a person, a Senior Coroner is required to hold an inquest.[94] An inquest is a public examination of the circumstances around the death. Under the *Coroners Act*, a Senior Coroner is required to make findings as to the:

(i) identity of the deceased;
(ii) date and place of a person's death;
(iii) physical or medical cause of death; and
(iv) 'manner' or circumstances around the death.[95]

Between 1 July 2017 and 30 June 2022 there have been 91 critical incidents which have involved a death and are therefore to be considered under the coronial jurisdiction (**Table 10**).

[94] *Coroners Act 2009*, ss 23(1)(c) and 27(1)(b).
[95] *Coroners Act 2009*, s 81.

Table 10: Status' of coronial matters linked to NSWPF critical incident investigations from 1 July 2017 to 30 June 2022

	2017-18	2018-19	2019-20	2020-21	2021-22	TOTAL
Coronial Matters	23	11	22	17	18	91
Dispensed	2	2	4	3	0	11
Ceased/Revoked	2	2	8	2	1	15
Not finalised	1	2	8	12	18	41
Finalised	18	5	4	0	0	27
Recommendations	8	3	2	TBA	TBA	13
No Recommendations	10	2	2	TBA	TBA	14

Coronial matters – total for year indicated.[96] **Dispensed** – where the Senior Coroner with carriage of the matter decides not to conduct an inquest given the circumstances.[97] **Ceased/Revoked** – indicates those matters where monitoring of the incident was ceased by the Commission and/or the critical incident declaration was revoked by the NSWPF, requiring the Commission to cease monitoring. In these cases, the status' and/or outcome of coronial matters have not been considered.[98] **Not finalised** – indicates those matters where the case has not gone to inquest, or where findings have not yet been handed down as at the 30 June 2022.[99] **Finalised** – coronial matters are matters for which findings have been handed down by the Senior Coroner. These may or may not result in recommendations being made. **Recommendations and/or no recommendation** have been made by the Senior Coroner with carriage of the matter.[100] Where the inquest has not been completed, the recommendations are yet 'To Be Advised' (TBA).

Of the 91 matters, a Senior Coroner has dispensed with 11 matters as at 30 June 2022, on the basis that the death was determined not to be 'as a result of a police operation'.[101] In these matters, police responded to concerns about the welfare of a person, but were unable to reasonably assist or prevent the person from self-inflicting lethal injuries. The

[96] Coronial matters by year: **2017-18** – SF Derowrie, SF Baxes, SF Dutton, SF Manion, SF Gilledoon, SF Newmoon, SF Wirruna, SF Ande, SF Bunyula, SF Bangalore, SF Erlinya, SF Attest, SF Skillman, SF Auras, SF Andiah, SF Nalanda, SF Harst, SF Mili, SF O'Donnell, SF Garemyn, SF Sohier, SF Beachway, SF Rolph; **2018-19** – SF Daces, SF Finschhafen, SF Uligandi, SF Collati, SF Blase, SF Covey, SF Bezel, SF Newsome, SF Gilholme, SF Bises, SF Caltowie; **2019-20** –SF Campton, SF Besborough, SF Townson, SF Linthorne, SF Britt, SF Amort, SF Balraith, SF Yambil, SF Daintrey, SF Badgelly, SF Parrish, SF Monaghan, SF Chasella, SF Juveni, SF Cathona, SF Netley, SF Echuca, SF Carlyle, SF Berncla, SF Chellow, SF Talbragar, SF Lutea; **2020-21** – SF Lochne, SF Hollinsworth, SF Cichild, SF Omiah, SF Corrina, SF Nungar, SF Arabin, SF Dumbarton, SF Observation, SF Ruttey, SF Montelimar, SF Bibs, SF Udall, SF Stanleigh, SF Kapiti, SF Fenton, SF Allott.; **2021-22** - Bales, Wunulla, Kapunda, Mirsi, Wandgala, Ancilia, Mingelo, Selm, Margot, Emyde, Rajani, Coobar, Cusps, Amice, Bohemia, Airey, Kardine, Yallambee

[97] Dispensed by coroner: **2017-18** – SF Skillman (21/12/2018); SF Harst (23/3/2021); **2018-19** – SF Uligandi (25/6/2021); SF Coolati (13/5/2020); **2019-20** – SF Britt (17/8/2020); SF Yambil (8/12/2020); SF Badgelly (3/7/2020), SF Talbragar (26/3/2021); **2020-21** – SF Dumbarton (1/4/2022), SF Montemlimar (1/4/2022), Allott (15/3/2022); 2021-22 – none dispensed at the time of writing.

[98] Monitoring ceased/critical incident declaration revoked: **2017-18** – SF Sohier (Ceased LECC), SF Beachway (Revoked NSWPF); **2018-19** – SF Daces (Ceased LECC), Uligandi (Ceased LECC); **2019-20** – Yambil (Ceased LECC), Badgelly (Ceased LECC), SF Chasella (Ceased LECC), SF Juveni (Ceased LECC), SF Cathona (Ceased LECC), SF Carlyle (Ceased LECC), SF Chellow (Ceased LECC), Monaghan (Revoked NSWPF); **2020-21** – SF Lochne (Ceased LECC), SF Nungar (Ceased LECC); **2021-22** - Kapunda (Ceased LECC).

[99] Coronial proceedings not finalised: **2017-18** – SF Dutton; **2018-19** – SF Finschhafen; SF Bises; **2019-20** – SF Besborough, SF Townson, SF Linthorne, SF Balraith, SF Daintrey, SF Netley, SF Echuca, SF Berncla; **2020-21** – SF Hollinsworth, SF Cichild, SF Omiah, SF Corrina, SF Arabin, SF Observation, SF Ruttey, SF Bibbs, SF Udall, SF Stanleigh, SF Kapiti, SF Fenton; **2021-22** - Bales, Wunulla, Kapunda, Mirsi, Wandgala, Ancilia, Mingelo, Selm, Margot, Emyde, Rajani, Coobar, Cusps, Amice, Bohemia, Airey, Kardine, Yallambee.

[100] Coronial recommendations made: **2017-18** – SF Derowrie, SF Ande, SF Erlinya, SF Attest, SF Nalanda, SF Mili, SF Sohier, SF Rolph; **2018-19** – SF Covey, SF Gilholme, SF Caltowie.

[101] *Coroners Act 2009*, s 23(2).

time taken for a Senior Coroner to dispense with such matters has varied greatly, ranging from six months to three years from the date of the incident.[102]

In addition to the above dispensations, the NSWPF revoked the critical incident declaration in two matters and the Commission ceased monitoring thirteen matters involving a death. The decision to either revoke or cease monitoring was made in these cases because the evidence indicated that the death either involved a medical episode or suicide that was not related to the actions of police.[103] It is the Commission's view that it is not in the public interest to continue to deal with these matters as critical incidents, or for the Commission to continue its monitoring of the investigation.

At 30 June 2022, of the 91 critical incident-related deaths, inquests into the deaths had been finalised in 28 matters, and 41 matters were yet to be considered by a Senior Coroner. Of the 41 matters yet to be finalised one (2%) was from 2017-18, two (4%) are from 2018-19, four (10%) are from 2019-20, 12 (30%) are from 2020-21, and 18 (44%) are from 2021-22.

4.2.9 Commission attendance at coronial inquests

The oral evidence given at a coronial inquest is additional to the information gathered by police in the course of a critical incident investigation, and may be relevant to the Commission's view as to whether the critical incident investigation was conducted in a full and proper manner and may highlight other issues that ought to be considered.

The Commission has attended a number of coronial inquests relating to monitored critical incident investigations. The decision to attend an inquest, or part of an inquest, is made on a case-by-case basis depending on the Commission's particular interest in the oral evidence to be given, and as a consequence of the difficulties in obtaining transcripts of proceedings.

Notwithstanding the Commission's statutory role in monitoring investigations of critical incidents that have resulted in deaths, the Commission is not on the Coroners Court list of fee exempt agencies. This means the Commission may be required to pay considerable fees to access transcripts from a coronial inquest.[104] At present, Court Services, within the Department of Communities and Justice has agreed to waive fees

[102] The matters include: SF Skillman (incident 20/12/2017, dispensed 21/12/2018 – 12 months); SF Harst (incident 24/2/2018, dispensed 23/3/21 – 36 months); SF Uligandi (incident 3/11/2018, dispensed 25/6/21 – 31 months); SF Coolati (incident 23/11/2018, dispensed 13/5/2020 – 18 months); SF Britt (incident 1/10/2019, dispensed 17/8/20 – 10 months); SF Yambil (incident 11/11/2019, dispensed 8/12/2020 – 13 months); SF Badgelly (incident 3/1/2020, dispensed 3/7/2020 – 6 months); SF Talbragar (incident 15/6/20, dispensed 26/3/21 – 9 months); Dumbarton (incident 30/11/20, dispensed 1/4/2022 – 17 months), Montelimar (incident 17/1/2021, dispensed 1/4/2022- 15 months), Allott (incident 28/6/2021, dispensed 15/3/2022 – 9 months).

[103] The matters include: SF Beachway (death of homeless person due to unrelated medical episode when police attended concern for welfare); SF Sohier (police were making enquiries about a SMV when they located a person in a back yard deceased); SF Daces (police followed a vehicle involved in a DV incident, located VOI and driver with gunshot wound to head); Uligandi (suicide by jumping from verandah of high rise unit); SF Chasella (suicide from cliff near The Gap); SF Carthona (suicide at The Gap); SF Carlyle (police attended a concern for welfare, heard a gunshot and located a person with a self-inflicted gunshot wound); Chellow (person jumped from The Skillion cliff top); SF Lochne (suicide at The Gap); SF Nungar (suicide at Lanslide Lookout at Katoomba).

[104] The fees are outlined on the Form 24 Application for Access to Coronial Documents. When the application for the transcript is made under 3 months the fee is $95 for the first eight pages and $11 per page thereafter. The Commission applied for a 3 day transcript from an inquest relating to SF Parrish which took place in Regional NSW. As the Commission was not on the Coroners Court list of fee-exempt agencies, the Commission was advised that, although the Coroner would allow access to the transcript a fee of $2,273.00 was payable for the document. The Commission applied for a transcript of evidence delivered by one witness in an inquest relating to SF Derowrie, and the Commission was advised that while the Coroner would allow access to the transcript, a fee of $412.00 was required.

for transcripts requested by the Commission on a case-by-case basis. For example, a waiver was granted for transcripts in relation to SF Parrish.

Given that both the Coroner and the Commission are publicly funded entities, pursuing similar statutory objectives, the Commission considers that it would be desirable for the Commission to be included on the Coroners Court list of fee exempt agencies.

4.2.10 Coroner's recommendations to the NSW Police Force

Of the 27 finalised matters, the Senior Coroner with carriage of the matter has made recommendations for the consideration of the Commissioner of Police in 13 (48%) of the matters and no recommendations for the Commissioner of Police in the remaining 14 (52%). Any recommendations made by the Senior Coroner are confined to issues concerning the cause and manner of death, and may improve public safety, by mitigating the risk of a similar death occurring in the future.

Between 1 July 2017 and 30 June 2022, coronial recommendations have requested that the Commissioner of Police give consideration to things such as:

- amending policies to require that police carry one Taser per pair unless there is a good reason not to;[105]
- providing further guidance in relation to positional asphyxia and related causes of death during restraint;[106]
- making specific amendments to the SDP which govern how police officers drive when making traffic stops, or engaging in Urgent Duty or Pursuits;[107]
- policy and training around the use of drug detection dogs, use of strip searches, and discretion around charges for drug possession and personal use;[108]
- providing further training in relation to responding to, assessing and scheduling of persons with mental health problems, and increased collaborative training with the NSW Ambulance Service and NSW Health;[109]
- whether a police officer subject to a criminal complaint investigation should be given a direction that a subject officer should not disclose information about an investigation to a witness or involved person;[110]

[105] Deputy State Coroner, Magistrate E Truscott (5 August 2019). Inquest into the death of Danukul Mokmool (File no. 2017/228552). State Coroners Court of New South Wales.

[106] Deputy State Coroner, Magistrate Stone (21 May 2021). Inquest into the death of Pono Aperahama (File no. 2017/00314530). Newcastle Local Court; State Coroner Teresa O'Sullivan (12 May 2021). Inquest into the death of Jack Kokaua (File no. 2018/54392). State Coroners Court of New South Wales.

[107] Deputy State Coroner, Magistrate Elizabeth Ryan (28 January 2020). Inquest into the death of Andrew Ngo (File no. 2017/373943). State Coroners Court of New South Wales.

[108] Deputy State Coroner, Magistrate Harriet Grahame (8 November 2019), Inquest into the death of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Ngyuen, Joseph Pham, Callum Brosnan, Joshua Tam, Alexandra Ross-King (File no. 2018/283593; 2017/381497; 2018/400324; 2019/12787; 2018/283652; 2018/378893; 2018/378893). State Coroners Court of New South Wales.

[109] State Coroner, Magistrate Teresa O'Sullivan (12 May 2021). Inquest into the death of Jack Kokaua (File no. 2018/54392). State Coroners Court of New South Wales; State Coroner, Magistrate Teresa O'Sullivan (9 September 2020). Inquest into the death of Grace Rohanne Herington. State Coroners Court of New South Wales.

[110] State Coroner, Magistrate Teresa O'Sullivan (7 May 2021). Inquest into the death of S (File no. 2018/114791). State Coroners Court of New South Wales.

- amendments to the Domestic Violence Standard Operating Procedures;[111]
- providing further training and guidance to police about the risks and appropriate response to people using police to commit self-harm;[112]
- amendments to the NSWPF Handbook and the NSWPF Custody Management Standard Operating Procedures to require that the Custody Manager is informed of information that the person in custody has taken an illicit drug and to clarify circumstances in which police are required to obtain medical advice in relation to detainees.[113]
- that the NSWPF introduce a mandatory training course and/or disseminate training material to specify notifications to be made when a person is from the Aboriginal or Torres Strait Island community and emphasise the need to familiarise themselves with local contacts.[114]
- that increased collaborative and scenario-based mental health training involving the New South Wales Ambulance Service, Department of Health and NSWPF, in assessing, treating and scheduling mental health patients, be introduced.[115]
- that the NSWPF and NSW Trains consider developing a policy, guidelines or training to ensure staff have a better understanding of when police can require a person to leave a train, the circumstances in which such powers will be exercised, alternatives to removing a person from a train and preferred stations at which a person can be disembarked.[116]
- that police develop a system to dispatch appropriately trained police officers to respond to and be identified at incidents which involve persons suffering a mental health crisis and with NSW Health consider expanding the funding for the roll out of the PACER program.[117]

Within six months of a coronial recommendation, the Minister or the Commissioner of Police is required to write to the Attorney General and outline any action being taken in relation to implementing the recommendation, or to provide reasons why the recommendation will not be implemented.[118] These responses from the Minister or the Commissioner of Police are published on the publicly accessible Department of Communities and Justice Website. The Commission reviews these responses since they may be relevant to the monitoring of existing or future critical incident investigations and may assist in the identification of recurring systemic issues.

[111] State Coroner, Magistrate Teresa O'Sullivan (30 April 2021). Inquest into the deaths of Gabriella Thompson and Tafari Walton (File no: 2019/81714 and 2019/83697). State Coroners Court of New South Wales.

[112] State Coroner, Magistrate Teresa O'Sullivan (30 April 2021). Inquest into the deaths of Gabriella Thompson and Tafari Walton (File no: 2019/81714 and 2019/83697). State Coroners Court of New South Wales.

[113] Deputy State Coroner, Magistrate C Forbes (4 August 2021). Inquest into the death of Samih Zraika (File no. 2018/150097). State Coroners Court of New South Wales.

[114] Deputy State Coroner, Magistrate Elizabeth Ryan (10 October 2019). Inquest into the death of Jordan Wayne Cruickshank (File no. 2018/142510). State Coroners Court of New South Wales.

[115] State Coroner, Magistrate Teresa O'Sullivan (9 September 2020). Inquest into the death of Grace Rohanne Herington (File no. 2018/391439). State Coroners Court of New South Wales.

[116] Deputy State Coroner, Magistrate E Truscott (22 October 2021). Inquest into the death of Terrence Gray (File no. 2020/7308). State Coroners Court of New South Wales.

[117] State Coroner, Magistrate T O'Sullivan (12 May 2021). Inquest into the death of Jack Kokaua (File no. 2018/54392). State Coroners Court of New South Wales

[118] M2009-12 Responding to Coronial recommendations, NSW Government Premier and Cabinet Memorandum.

Concerns which do not go to the manner and cause of death are not usually examined in the course of an inquest and[119] are therefore not the subject of coronial recommendations. Even where police actions do not contribute to the manner and cause of death, they may still be a legitimate source of concern for families and for the public. As such, even after an inquest, the Commission may identify and raise concerns with police investigators. In Case Study 5: SF Garemyn the Commission raised concerns in relation to compliance with existing policies which appear to have contributed to avoidable delays in locating the remains of the deceased for some seven months after death and six months after the missing person report.

When the Commission is aware that a coronial recommendation has been made, it will monitor the NSWPF response to the recommendation.

4.3 Systemic and organisational issues identified by the Commission

In the course of monitoring critical incident investigations over the past five years, the Commission has identified some recurring systemic and organisational issues. In these cases, the Commission engages with the NSWPF to ensure the issues are considered promptly and action is taken if appropriate.

Some of the issues identified and raised between 2017 and 2022 are outlined below.

4.3.1 Resourcing of the NSWPF Mental Health Intervention Team (MHIT) and training police officers to effectively respond to persons in a mental health crisis

Critical incidents frequently involve an interaction between police and a person experiencing a mental health crisis. Of the 157 critical incident declarations made over the last five years, 68 (43%) of the incidents have involved an interaction with a person in mental health crisis.[120]

The adequacy of the training provided to police officers, to respond to incidents involving a person experiencing a mental health crisis ('mental health training'), has been an issue for the NSWPF, long before the Commission commenced monitoring critical incident investigations. Important coronial recommendations have been made in this regard.

In the inquest into the death of Stephen Paul Hodge, then Deputy State Coroner Teresa O'Sullivan recommended:[121]

> That consideration be given to the greater integration of mental health informed training into tactical options training with an emphasis on de-escalation techniques practiced by role play exercises.

[119] *Conway v Mary Jerram, Magistrate and NSW State Coroner & Anor* [2010] NSWSC 371; *Conway v Mary Jerram, Magistrate and NSW State Coroner & Anor* [2011] NSWCA 319

[120] This may be an underestimate. There are a number of incidents where the mental health status of the involved person is unclear, particularly where the critical incident declaration is revoked by police, where the Commission has ceased monitoring, or the situation is complex and involves other factors such as domestic violence, marriage breakdowns and or drugs and alcohol.

[121] Deputy State Coroner, Magistrate Teresa O'Sullivan (20 April 2018). Inquest into the death of Stephen Paul Hodge (File no. 2015/265616). State Coroners Court of New South Wales.

In the findings from the inquest into the death of Courtney Topic, Deputy State Coroner Elizabeth Ryan also recommended a substantial review of existing defensive tactics and mental health training, with the inclusion of more role-play based learning.[122]

Mental health training has continued to be an issue of concern since the Commission began monitoring critical incident investigations. The Commission has two main concerns around mental health training. The first is whether the resourcing of the NSWPF Mental Health Intervention Team (MHIT) is adequate. The second is whether the mental health training provided to first responding police officers is adequate.

The MHIT is responsible for the provision of policy, strategic and operational advice regarding mental health and suicide interventions, to the NSWPF. The MHIT is also responsible for training all frontline police officers to communicate and manage situations involving persons experiencing a mental health crisis, in order to achieve the best possible outcome for both police and the person in crisis. From monitoring the SF Derowrie critical incident investigation, the Commission became aware that the MHIT consisted of only two full time staff members and one temporary staff member who are expected to perform all functions of the MHIT, including the face-to-face delivery of the training to about 16,000 police officers.

As noted by Deputy State Coroner Truscott in the Inquest into the death of Danukul Mokmool:[123]

> Given the number of tasks of the MHIT, the prevalence of police officers engaging with persons suffering mental illness and, the need for targeted ongoing training, the resources of the unit are minimal to say the least.

Notwithstanding, Deputy State Coroner Truscott's observations, no recommendations were made in relation to the resourcing of the MHIT because it was not an issue that went to the manner and cause of death in that matter. It is nevertheless, a legitimate issue that warranted further consideration by the NSWPF, and something that the Commission expected the NSWPF to consider in the CIIR for SF Derowrie. Ultimately

[122] Deputy State Coroner, Magistrate Elizabeth Ryan (30 July 2018). Inquest into the death of Courtney Topic (File no. 2015/42730). State Coroners Court of New South Wales; Recommendation1: Consideration be given to the MHIT and WTPR establishing and documenting a joint review of training packages for defensive tactics training where mental health is likely to be a relevant factor. Recommendation 2: Consideration be given to the greater integration of mental health informed training into tactical options training, with an emphasis on specific de-escalation techniques practiced by role play exercises. Recommendation 3: Consideration be given to requiring all present Operational Safety instructors to complete the four day MHIT training. This should be undertaken as soon as practicable, while ensuring the availability of Operational Safety instructors to meet ongoing accreditation requirements. Recommendation 4: Consideration be given to the MHIT and WTPR jointly pursuing a program of (1) reviewing international learning with respect to first responder interactions with persons in mental health crisis and (2) designing defensive tactics training that seeks to embody the learning obtained from the review. Recommendation 5: Consideration be given to requiring that all police radio and Triple 000 operators undertake training by the MHIT in skills which will 29 Findings in the Inquest into the death of Courtney Topic better equip them to recognise signs of mental health disturbance in reports from police and civilians. Recommendation 6: Consideration be given to developing criteria by reference to which police radio operators may identify an incident as possibly involving a person in mental health crisis. Recommendation 7: Consideration be given to developing and implementing a system to dispatch four day MHIT accredited officers as first responders in cases which meet criteria indicating possible mental health crisis. Recommendation 8: Consideration be given to developing a mandatory training package for all police officers other than commissioned officers, and specifically including Local Area Commanders, to ensure understanding of the protocol for responding four day accredited MHIT officers. Recommendation 9: Consideration be given to reviewing the four day MHIT program to include more experiential learning, in the form of role play components. Recommendation 10: Consideration be given to offering MHIT booster training on a one to three year basis.

[123] Deputy State Coroner, Magistrate E Truscott (5 August 2019). Inquest into the death of Danukul Mokmool (File no. 2017/228552). State Coroners Court of New South Wales, [204].

this did not occur, because the Mental Health Training scheme was in the process of being overhauled before the SF Derowrie critical incident investigation was finalised.

The other significant concern for the Commission, relates to the contents of, and access to, the Mental Health Training programs.

When the Commission commenced monitoring critical incident investigations, Mental Health Training consisted of two training streams, a one-day Mental Health Awareness Workshop program and a four-day Mental Health Intervention program. Although all NSW police officers received the one-day training, from February 2008 to September 2019, when four-day training concluded, only 2,420 officers (including civilians and police from other jurisdictions) were four day trained.[124] In the Inquest into the death of Danukul Mokmool the NSWPF provided evidence that the MHIT only has the capacity to provide the four day training to 300 police officers per annum. At that rate it would be impossible to deliver the four-day Mental Health Intervention program to all 16,000 NSW police officers in a reasonable time frame. There are less officers four-day-trained annually than the total number of annual new recruits.

This was a concern because there are significant differences in the contents of the two training streams, and only the four-day Mental Health Intervention program contains scenario work. As most police officers are only one day trained, they do not have any mental health specific role play training to prepare them to respond to mental health incidents. Given the high frequency with which junior frontline police engage with persons suffering a mental health crisis, it is concerning that only one day of 16 weeks training is focused on mental health training and that this training does not include role plays.

There was initially an intention that at the end of the four-day Mental Health Intervention program that the accredited officers would be prioritised as first responders to mental health or suicide intervention incidents. In practice, however, there is no process to ensure the deployment of MHIT accredited officers to attend mental health incidents and given the low number of accredited officers it is doubtful that it would be practical. The NSWPF have instead stated that given existing resources, "the development and dissemination of online training to all front-line police officers is logistically more sound and likely to yield better results than to dispatch personnel based on specific qualifications."[125]

Although the Commission first became aware of the issues with the resourcing of the MHIT and the mental health training programs while monitoring SF Derowrie, there were significant delays associated with the NSWPF finalisation of this particular investigation (see Case Study 17, SF Derowrie). Before SF Derowrie was finalised, the Commission became aware that the NSWPF was overhauling its mental health training program, and there was an intention to replace the four-day Mental Health Intervention

[124] Deputy State Coroner, Magistrate E Truscott (5 August 2019). Inquest into the death of Danukul Mokmool (File no. 2017/228552). State Coroners Court of New South Wales; Requisitions for information regarding mental health training were also raised by the Commission and received from the NSWPF in the course of monitoring the SF Berncla critical incident investigation.

[125] Responses to Coronial Recommendations January 2018-December 2018, https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx Accessed 2 September 2022. Response to recommendation 7 from findings of Deputy State Coroner, Magistrate Elizabeth Ryan (30 July 2018). Inquest into the death of Courtney Topic (File no. 2015/42730). State Coroners Court of New South Wales.

program with a two-day program called the Enhanced Policing Practise Module (EPPM).[126]

Instead of raising concerns about the resourcing of the MHIT and the original mental health training programs, the Commission was keen to understand how the new two-day EPPM training program had improved on the four-day Mental Health Intervention program. On the 26 April 2021, the Commission wrote to the NSWPF and requested a copy of all EPPM training materials. The Commission also requested that the NSWPF nominate a person to provide a presentation to the Commission in relation to the EPPM training.[127] The NSWPF declined to provide the Commission with a copy of the EPPM training materials. However, on 25 July 2022, the NSWPF did provide a presentation to the Commission outlining the contents of the EPPM.

In August 2018 the MHIT received approval to conduct pilots for the EPPM. Pilots were conducted between November 2019 and November 2021, before the delivery of the program was suspended. Two hundred and seventeen participants from the Ministry of Health and the NSWPF received EPPM training.[128]

During the presentation the Commission was advised that a number of components of the two-day EPPM training had been removed to reduce the face-to-face course from two days to a one day course which does not include role plays. The Commission was also advised that police officers are not currently receiving the one-day EPPM training and it was unknown when the training would commence.

In response to a draft version of this Report, the NSWPF advised that although the EPPM training provided highly specialised training, given the length of the course and the time required to deliver the course, it was not a practical way to train all NSW police officers.

The NSWPF has also advised that the 'NSWPF Crime Prevention Command has engaged with NSW Health and the Ambulance Service NSW and is preparing a holistic training package for all NSW Police officers which will see a combination of face to face, experiential learning, online delivery, Commissioners Directives, defensive tactics/scenario based training and developmental learning delivered to all NSW Police Officers via at least one of these means based on their experience and position within the NSWPF'.

The NSWPF have expressed some concern that NSW Police Officers may be relied upon as experts when responding to persons suffering a mental health crisis, instead of appropriately trained medical professionals.

Since April 2020, thirteen of 45 Police Area Commands or Police Districts have collaborated with various local Health District Mental Health Services, to deliver the Police Ambulance Clinicians Early Response (PACER) program.[129] Under this program, PACER clinicians work with frontline police, when requested by police, to assist with de-escalation of complex mental health incidents, by phone and on site and, by referring

[126] SF Berncla

[127] Commissioners letter

[128] Requisitions for information regarding mental health training were raised by the Commission and received from the NSWPF in the course of monitoring the SF Berncla critical incident investigation.

[129] The thirteen Police Area Commands or Police Districts with PACER include: St George PAC, Northern Beaches, Blacktown, South Sydney, Sutherland Shire, Eastern Beaches, Ku-ring-gai, Campbelltown, Bankstown, Nepean, and Sydney Metro/Precinct (encompassing Surry Hills, Kings Cross and Sydney City PAC/s).
Brisbane Water and Tuggerah Lakes Police Districts

persons in crisis for mental health treatment as appropriate. Although the PACER program delivers significant benefits for police, for the health district and for the mental health consumer, PACER clinicians are available for eight hours per day. As such, the PACER program in its current form is no substitute for the mental health training of police officers. Although there have been coronial recommendations that consideration be given to expanding the funding and roll-out of the PACER program,[130] and the Commission supports expansion of the program, the Commission has also been advised that at this time there is no government funding to expand the PACER program.

In the public interest, and given the prevalence of mental health crises in frontline policing, the Commission is committed to continuing to engage with police in relation to progress with mental health training of frontline police officers.

4.3.2 Application of the Safe Driving Policy by police officers

The NSWPF Safe Driving Policy outlines the expectations and responsibilities of all police employees whilst using police vehicles and performing traffic stops, engaging in pursuits and whilst responding to incidents urgently.

In practice, it can sometimes be extremely difficult to comply with the SDP, particularly when engaging a vehicle in a pursuit. Under the SDP, prior to and whilst engaging in a pursuit, police drivers are required to take into account numerous risk factors and communicate the information to police radio whilst dealing with the unfolding situation. A failure to do so makes it impossible to supervise a pursuit and will result in a breach of the policy.

The policy may also be difficult to understand given that the differing constraints for traffic stops, pursuits and urgent duty driving. Also, there is no guidance in relation to rules that apply when a police vehicle is following rather than pursuing another vehicle under the SDP. The Commission has raised the lack of guidance around a police vehicle following a vehicle with the NSWPF (see Case Study 5: Garemyn). In response, the NSWPF has advised that these concerns will be considered as part of an upcoming wide-ranging review of the NSWPF SDP.

In some cases when there have been breaches of the SDP during a critical incident, the breaches have not been dealt with at the time they are identified.[131] Breaches of the SDP are considered by each Police Command's Safe Driving Panel, which comprises the Local Commander, a Supervisor and when available a Traffic Officer and a Traffic and Highway Patrol Officer. In a recent matter, the Commander of a Safe Driving Panel, declined to convene a Safe Driving Panel to consider possible breaches of Policy until such time as the coronial matter is finalised and the NSWPF CIIR was completed.[132] Given that it takes more than two years for the coronial proceedings to be finalised and on average a further five months for police to complete the CIIR, this process delays considering a possible breach for more than 2.5 years. The Commission has raised concerns that this unnecessarily delays mitigation of potential risks to the public and to police, for too long.

[130] State Coroner Teresa O'Sullivan (12 May 2021). Inquest into the death of Jack Kokaua (File no. 2018/54392). State Coroners Court of New South Wales

[131] SF Gari

[132] SF Selm

In coronial proceedings, where the SDP is at issue, an expert from the NSWPF Traffic Policy Unit is often called to write a report and provide oral evidence in relation to compliance with the SDP. The expert from the NSWPF Traffic Policy Unit sometimes finds additional breaches of policy at this time.[133] As this expert evidence is not provided until a considerable time after the incident, the involved officer/s may not even be made aware of their breaches of policy, until the inquest. It is unfortunate that this analysis is delayed until inquest, since it means that action to mitigate the risk of another breach is considerably delayed. This practice does not appear to be in the best interests of the public or the officers involved in the incident.

For critical incidents which do not come under the coronial jurisdiction, and result in serious injury rather than death, an expert report from the NSWPF Traffic Policy Unit does not appear to be produced as a matter of course. It may be better practice for the Traffic and Policy Unit to review all critical incidents that involve possible breaches of the SDP prior to inquest so that remedial action can be taken sooner rather than later to mitigate future risks.

It is also unclear as to when a breach of the SDP reaches a threshold to constitute misconduct or alternatively not amount to misconduct but result in a notation on the NSWPF Safe Driving System. The Commission has sought advice from the NSWPF in this regard and is awaiting an outcome.[134]

4.3.3 Police officer understanding of STOPAR.

At the time of interview, and during an inquest, police are often asked to explain their actions by reference to STOPAR training. STOPAR is an acronym for Stop, Think, Observe, Plan, Act, Review. It is a framework that is to be used by police officers to plan appropriate responses to policing situations.

It is the Commission's observation that most involved officers do not recall the acronym, and as such have trouble explaining their actions in these terms,[135] even if in practice they apply the framework where it is practical to do so.

The practicalities of stopping, thinking, observing and planning may be limited where a plan has already been predetermined as a consequence of the situation which has unfolded. This seems a small issue to raise in relation to a single critical incident investigation if police are practically applying the training. However, it would appear that if police are expected to explain their actions using the STOPAR framework, police officers should have a better understanding of STOPAR and be able to explain their actions using STOPAR.

The Commission is aware that the NSWPF was attempting to address the STOPAR training issue by requiring that all NSW police officers complete further STOPAR training as part of their Operational Safety Mandatory Training Online in the Mental Health STOPAR 2020-2021 and the Mental Health 2021-2022 training years. It is not clear that this further training has improved police understanding of STOPAR. In a recent critical incident investigation, the four involved officers stated that they were unaware of STOPAR although they had each had completed the online Mental Health STOPAR 2020-

[133] SF Erlinya

[134] SF Gari

[135] A lack of understanding of STOPAR was apparent in SF Derowrie, SF Nalanda and SF Gilholme.

2021 training module.[136] The Commission is awaiting further advice from police as to the contents of the online STOPAR training modules 2020-2021 and 2021-2022.

4.4 Finalisation of critical incident investigations

Whilst monitoring a critical incident investigation, the Commission maintains contact with the NSWPF nominated contact officer in relation to the progress of the investigation until it is finalised. A NSWPF critical incident investigation is finalised when the NSWPF have completed their CIIR, after the conclusion of all criminal and coronial proceedings arising from the incident.[137]

Depending on the complexity of the investigation and delays arising from related criminal, coronial or civil court proceedings, a critical incident investigation may not be finalised for a considerable period of time. Delays also arise after the substantive investigation and court proceedings are finalised, as police investigators prepare the required CIIR. These delays often arise as a consequence of the police investigators with carriage of the critical incident investigation having other work priorities.

4.4.1 Time taken for the NSWPF to finalise critical incident investigations

Between 1 July 2017 and 30 June 2022, only 52 (33%) of the 157 critical incident investigations monitored by the Commission have been finalised by the NSWPF. On average, it took 20 months for these critical incident investigations to be finalised by the NSWPF (**Table 11**). The time taken to finalise a critical incident report can be impacted by whether there are related court proceedings.

The six critical incident investigations which were not linked to criminal or coronial court processes were finalised by the NSWPF within 10 months on average (**Table 11**).[138]

Twenty two finalised critical incident investigations were linked to criminal proceedings (**Table 11**). Of these 22 critical incident investigations, four CIIRs were finalised, before the related criminal matter. The remaining 18 criminal matters were finalised by the court, on average, within eleven months,[139] and took an average of a further eight months to be finalised by the NSWPF.

Of the 26 critical incident investigations subject to the coronial jurisdiction (**Table 12**), six were dispensed with by the Coroner prior to inquest, between 9 and 41 months after the critical incident.[140] It is not clear why these matters were not dispensed with at an earlier time. The remaining 20 critical incident investigations proceeded to Inquest,[141] and the Inquests were finalised by the court on average 26 months after the incident. After the matters were finalised by the Coroners Court it took a further seven months for the critical incident investigation to be finalised by the NSWPF.

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[136] SF Mingelo

[137] *Law Enforcement Conduct Commission Act 2016*, s 108(2).

[138] Strike Forces Spillway, Dawbin, Casey, Algedi, Wittin, and Clapham were not linked to criminal or coronial proceedings.

[139] Criminal proceedings for Strike Forces Cromerty, Miriyan, Warreeah, Mertin, Montavella, Bowle, Baranbale, Tabis, Nairana, Engstom, Pembury were finalised, whilst the criminal proceedings for Coomea and Wolumba were ongoing.

[140] The Senior Coroner dispensed with an inquest into the death under s 25 of the Coroners Act, for Strike Forces Skillman, Talbragar, Britt, Harst, Allott, Coolati

[141] The 14 Critical Incident Investigations which went to inquest and which were monitored by the Commission and finalised by the NSWPF between 1 July 2017 and 30 June 2021 included Strike Forces:Baxes, Manion, Gillendoon, Newmoon, Bangalore, Erlinya, Attest, Andiah, Garemyn,, Blase, Covey, Newsome, Caltowie, Wirruna,

Table 11: Time taken for the NSWPF to finalise critical incident investigations between 1 July 2017 and 30 June 2022

PROCEEDINGS LINKED TO CRITICAL INCIDENT INVESTIGATION	NUMBER	PERCENTAGE	TIME FROM INCIDENT TO FINALISATION	
			Range (months)	Average (months)
None	6	8	8-12	10
Criminal	22	42	7-34	17
Coronial	20	38	22-48	33
Coronial (dispensed)	6*	12	10-41	20
Collectively	52	100	8-48	20

A critical incident investigation is considered finalised by the NSWPF when the Region Report has been ratified and finalised by police.

*Dispensed by Coroner where monitoring was not ceased by the Commission.

Table 12: Time taken for court proceedings to be finalised and time taken for the NSWPF to finalise critical incident investigations after court proceedings between 1 July 2017 and 30 June 2022

PROCEEDINGS LINKED TO CRITICAL INCIDENT INVESTIGATION	TIME TAKEN FOR COURT PROCEEDINGS TO BE FINALISED		TIME TAKEN FOR NSWPF TO FINALISE CRITICAL INCIDENT INVESTIGATIONS AFTER COURT PROCEEDINGS	
	Range (months)	Average (months)	Range (months)	Average (months)
Criminal	1-24	11	1-23	8
Coronial	19-39	26	1-23	7
Coronial (dispensed)	9-41	16	0-7	4

The delays associated with finalisation of critical incident matters by both the Courts and the NSWPF are significant and unfortunate. Until an investigation is finalised, the family members of the seriously injured or deceased do not have the answers they need

to understand what happened to their loved one and whether the serious injury or death was avoidable.

Similarly, until the investigation is finalised the officers involved in the critical incident do not know whether or not their actions during the incident will be criticised. This prolongs their distress at being subject of an internal investigation, and in some cases may even prevent them from being considered for other or higher duties. At the very least, this seems to be unfair, particularly when there is often no evidence of misconduct highlighted from critical incident investigations.

Additionally, until court proceedings are finalised and, a CIIR ratified, there are often very limited actions taken by police to mitigate the risks of a similar incident occurring in the future. In practice, it appears that in most cases the NSWPF waits for recommendations to be made by the Coroner, and recommendations to be made by the SCII in the Critical Incident Investigation Report, before considering actions to mitigate the risks posed by potential shortcomings in policies and procedures.

When critical incident investigations take so long to finalise, it delays both improvements to systems and the mitigation of future risks. This does not appear to be in the public interest or the interests of police officers who may encounter similar situations before any recommendations have been considered and implemented.

The reasons for the delays in the criminal and civil jurisdictions are complex and beyond the scope of this report. The reasons for the delays in the coronial jurisdiction are regularly explained by the State Coroner, in the annual report on deaths in custody and police operations,[142] but also may be a consequence of 'specialist coroners' being 'overstretched and under resourced'.[143]

For coronial matters, the NSWPF critical incident investigation is initially held to a timetable by the Coroner.[144] However, once coronial proceedings are finalised, the CIIR and therefore the finalisation of the critical incident investigation under the LECC Act[145] is the responsibility of the NSWPF.

For police, the reasons for the delay in finalising CIIRs appear to be two-fold. Firstly, police investigators are also responsible for managing a caseload of investigations including serious criminal investigations with time constraints, in addition to the critical

[142] Report by the NSW State Coroner into deaths in custody/police operations for the year 2020, p14 & 17. After the coronial brief of evidence is served on the Coroners Court by Police, and prior to the inquest 'conferences and direction hearings will often take place between the Coroners, Counsel assisting, legal representatives for any interested party and relatives so as to ensure that all relevant issues have been identified and addressed.'... Some delay in hearing cases is at times unavoidable and there are many various reasons for delay. The view taken by the State Coroner is that deaths in custody/police operations must be fully and properly investigated. This will often involve a large number of witnesses being spoken to and statements being obtained. It is settled coronial practice in New South Wales that the brief of evidence be as comprehensive as possible before an inquest is set down for determination. At that time a more accurate estimation can be made about the anticipated length of the case. It has been found that an initially comprehensive investigation will lead to a substantial saving of court time in the conduct of the actual inquest. In some cases there may be concurrent investigations taking place, for example by the New South Wales Police Service Internal Affairs Unit or the Internal Investigation Unit of the Department of Corrective Services. The results of those investigations may have to be considered by the Coroner prior to the inquest as they could raise further matters for consideration and perhaps investigation.'

[143] Carrie Fellner, Coroners call for 'once in a generation change' to how deaths in NSW are investigated' The Sydney Morning Herald (online 23 August 2021) https://www.smh.com.au/national/nsw/coroners-call-for-once-in-a-generation-change-to-how-deaths-in-nsw-are-investigated-20210822-p58kum.h%E2%80%A6,p 2.

[144] Coronial Practice Note 3 of 2021, *Case Management of mandatory inquests involving section 23 deaths*, commencing 24 September 2021 (replacing Coronial Practice Note 2 of 2018, *Case Management of Mandatory Inquests involving Critical Incident Investigations*, commenced 19 November 2018).

[145] *Law Enforcement Conduct Commission Act 2016*, s 113(2).

incident investigation. Secondly, under the NSWPF Critical Incident Guidelines, the CIIR is not required to be completed within a set timeframe, and as such it is not surprising that other investigations are prioritised above finalising critical incident investigations.

The Commission is of the view that the NSWPF Critical Incident Guidelines should include additional guidance around timeframes for the finalisation of critical incident investigations.

This issue has been raised with NSWPF (see Case Study 17, SF Derowrie).[146] The NSWPF have conceded that there is a problem with the timely finalisation of critical incident investigations, but said that prescribing timeframes for completion of CIIRs is impractical given operational and administrative factors which affect timeliness. They have said that to address timeliness issues the Professional Standards Command will send automated emails to the SCII and the Review Officer to remind them that the SCII Report is outstanding.

The Commission's practice in the past five years has been to regularly seek updates on the finalisation of CIIRs. Yet, as noted above, significant delays still exist in the finalisation of these reports. It is unclear how automated reminders from the Professional Standards Command will achieve the timely completion of CIIRs.

The Commission recommends that the NSWPF amend the NSWPF Critical Incident Guidelines to specify timeframes in which CIIRs must be finalised by police, following court proceedings, or where there are no court proceedings. The Commission accepts that there may be reasons that it is not possible for a CIIR to be finalised within a set timeframe. Where this is the case, the reasons for the delay should be documented in the relevant e@gle.i case records and managed by the Region responsible for the investigation.

This change would not however address the issues which arise from delays brought about by protracted court proceedings. Under the LECC Act, the NSWPF is only required to complete a CIIR, 'after the conclusion of all criminal and coronial proceedings arising out of the critical incident'.[147]

The police investigation is usually substantially complete by the time the brief of evidence is submitted for court proceedings, usually about 3-6 months after the critical incident. A report drafted at this time would provide the NSWPF executive with an opportunity to act on systemic issues and recommendations and mitigate risk at a much earlier time.

The Commission is of the view that it would be better practice for the NSWPF to complete an interim CIIR prior to court proceedings. This report should include any recommendations for change and be provided for the consideration of the NSWPF Executive. After the finalisation of court proceedings, a short addendum could be added to the existing report, if necessary, to highlight or address outstanding concerns arising from the court process.

Rather than pre-empt the court outcome, completing the report at an earlier time may assist the Coroner and reduce the need for the Coroner to make recommendations. Completing the report while the investigation is in a more active phase would also have

[146] Law Enforcement Conduct Commission, *Review of 29 NSW Police Force Critical Incident Investigations*, June 2019, p20. Also raised in final advice to the NSWPF for SF Derowrie (Case Study 18).
[147] *Law Enforcement Conduct Commission Act 2016*, s 108(2).

the added benefit of reducing the workload for police investigators after the finalisation of Court proceedings and, therefore minimise delays associated with the finalisation of critical incident investigations after the court process.

For these reasons, in a draft of this Report provided to the NSWPF, [148] the Commission made two preliminary recommendations.

Firstly, the Commission recommended that the NSWPF amend the NSWPF Critical Incident Guidelines, to specify timeframes in which Critical Incident Investigation Reports must be finalised by police, following court proceedings, and where there are no court proceedings. In circumstances where this is not possible, the reasons for the delay should be recorded on the e@gle.i case, and assessed and managed by the Region Commander responsible for the critical incident investigation.

In response, the NSWPF advised that they agreed in principle with the preliminary recommendation, and suggested timeframes for the completion of reports.

The NSWPF proposed that the NSWPF Critical Incident Guidelines be amended to provide that Critical Incident Investigation Reports be finalised within six months of finalisation of criminal or coronial proceedings or within six months after a critical incident is declared for matters which do not involve coronial or court proceedings. It was also proposed that the Review Officer Report component be completed within three months of the SCII Report. The NSWPF emphasised that the proposed timeframes should be considered as guidelines rather than deadlines because police have competing work priorities.

The Commission believes that the timeframes proposed by the NSWPF are too long. Although the Commission acknowledges that police have competing work priorities, expert reports are obtained and the police investigation is completed prior to the finalisation of criminal and/or coronial proceedings, since these materials are provided as evidence in court proceedings. After completion of the police investigation and/or court proceedings, police usually only need to write up the Critical Incident Investigation Report.

Out of fairness to the families of the injured/deceased and, fairness to the involved officers, the Commission is of the view that it would be more appropriate to set a timeframe of three months for completion of the Critical Incident Investigation Report, and to allow one month for completion of the Review Officer component of the Report. In light of this, the Commission makes recommendation 3.

Recommendation 3: **The NSWPF amend the NSWPF Critical Incident Guidelines, to specify that Critical Incident Investigation Reports (including SCII Report, Review Officer Report and Region Report) should be finalised by police, within 3 months of the end of court proceedings, or within 6 months of the incident being declared, if there are no court proceedings. In circumstances where it is not possible for a Critical Incident Investigation Report to be finalised within set timeframes, the reasons for the delay should be recorded on the e@gle.i case, and assessed and managed by the Region Commander responsible for the critical incident investigation.**

[148] On 22 December 2022 a copy of this Report in draft was sent to the NSWPF in relation to the content and recommendations made prior to the Report being finalised and tabled in Parliament. The NSWPF sought and received advice from several stakeholders including; all Region Commanders, Traffic and Highway Patrol, Professional Standards Command (Investigations Unit), State Crime Command, and Capability Performance and Youth Command. On 10 February 2023 the Commission received a response from police.

Secondly, the Commission made the preliminary recommendation that the NSWPF Critical Incident Guidelines instruct officers to complete an interim Critical Incident Investigation Report with recommendations prior to criminal or coronial proceedings, for the consideration of the NSWPF Executive.

The NSWPF did 'not agree' with this recommendation. The NSWPF were of the view that drafting of a report containing interim findings and recommendations 'before all facts are fully known and ventilated' in court proceedings, would create a risk for the NSWPF and, for police investigators.

The Commission does not agree that drafting an interim report and taking action in relation to issues identified would necessarily create a reputational risk for police. On the contrary, it may improve the public's perception of the professionalism and accountability of police. The Commission is aware that NSW Health conducts Root Cause Analyses while coronial matters are awaiting inquest. Where appropriate NSW Health makes recommendations and takes action to mitigate risks while waiting for the inquest to begin. It is not clear why police should not have a similar process to implement improvements and mitigate risks sooner. This may also assist the Coroner and make recommendations less necessary. This would be a win for police and a win for the public. It would not be problematic to add to or amend the findings made in an interim report should new evidence come to light in the course of court proceedings.

Having an interim or draft report prepared prior to criminal or coronial proceedings would also reduce the delay in finalising the Critical Incident Investigation Report after court proceedings, because in many cases no additions would be required before finalising the Report. Of the 27 coronial matters finalised between the 1 July 2017 and 30 June 2022 (Table 10), there were no recommendations made in 14 (52%) of those matters. Where coronial recommendations were made in 13 (48%) matters, the addition to the SCII component of the Report was mostly minor, indicating only that the recommendation was made. In light of this, it is not clear that delaying the drafting of the Report until after court proceedings is warranted given the minor nature of the additions.

The NSWPF were also of the view that the Commission's access to all documents on a critical incident investigation was adequate to indicate the NSWPF views on a matter, issues identified and interim action taken in relation to those issues. However, access to the e@glei case simply sets out the evidence obtained by police during an investigation. It does not necessarily indicate what conclusions or recommendations will be made by police in the CIIR.

Finally, the NSWPF also expressed the view there is no need for an interim report as the NSWPF Critical Incident Guidelines already require the SCII to be alert to 'risks and areas for improvement' during the investigation and bring them promptly to the attention of the Region Commander for action.

Similarly, interim action is often not taken despite issues being identified in the course of a critical incident investigation. Numerous times, the Commission has raised issues with police whilst monitoring a critical incident investigation, but no action is taken until the matter is finalised by the Court or the Critical Incident Investigation Report itself is finalised. Additionally, action that ought to have been taken, may not be taken once a Critical Incident Investigation is finalised due to the passage of time (see Case Study 10: SF Gari).

For these reasons the Commission has not changed the preliminary recommendation. The Commission has made an additional recommendation, Recommendation 5. This will make sure that the Commission is also aware of any risks or areas of improvement in a timely way.

Recommendation 4: **The NSWPF Critical Incident Guidelines instruct officers to complete an interim Critical Incident Investigation Report with recommendations prior to criminal or coronial proceedings, for the consideration of the NSWPF Executive.**

Recommendation 5: **The NSWPF Critical Incident Guidelines instruct critical incident investigators to provide the Commission with information on the 'risks and areas for improvement' identified in the course of the critical incident investigation prior to criminal or coronial proceedings.**

4.4.2 Delays in the provision of final Critical Incident Investigation Report to the Commission

Following the finalisation of the CIIR the NSWPF is required to provide a copy of the report to the Commission and also the Coroner in the case of a death.[149] For the 52 critical incident investigations completed between 1 July 2017 and 30 June 2022, it has often taken a long time and numerous enquiries by the Commission to obtain a copy of the report from police. In 24 matters it took one month or less for the NSWPF to provide a copy or access to the final CIIR.[150] However, in 28 matters it took between two and nine months, and an average of four months.[151]

The NSWPF Critical Incident Guidelines do not provide for a process or person responsible for providing the finalised CIIR to the Commission. Despite the issue being raised with the NSWPF on a number of occasions, the Commission continues to experience delays in the provision of the report once finalised.

The Commission therefore recommends that the NSWPF introduce robust procedures to notify the Commission that a critical incident investigation has been finalised and to provide a copy of the CIIR to the Commission in a timely manner.

When the Commission receives the final report from the NSWPF the Commission considers whether the investigation has thoroughly examined the matters required under the LECC Act.[152] The Commission is required to provide advice to the Commissioner of Police and the State Coroner confirming that the investigation was

[149] *Law Enforcement Conduct Commission Act 2016*, s 113(2).
[150] Strike Forces Gari, Noela, Casey, Wolumba, Derowrie, Manion, Gillendoon, Newmoon, Spillway, Clapham, Sombu, Attest, Baranbale, Coolati, Blase, Covey, Pembury, Newsome, Caltowie, Gilholme, Mili, Rolph, Talbragar, Allott.
[151] Strike Forces: Wittin, Cromerty, Miriyan, Aberdare, Warreeah, Mertin, Dawbin, Montavella, Bowle,Tabis, Nairana, Engstrom, Yarabah, Coomea, Algedi, Gruie, Nunatak, Baxes, Wirruna, Bangalore, Erlinya, Andiah, O'Donnell, Garemyn, Bezel, Skillman, Britt, Harst.
[152] *Law Enforcement Conduct Commission Act 2016*, s 113(2).

'fully and properly conducted',[153] or if the Commission considers *'any aspect of the investigation was inappropriate and advice of its concerns'*.[154]

Between 1 July 2017 and 30 June 2022 the Commission has provided advice to the NSWPF confirming that the investigation was 'fully and properly conducted', because the issues raised by the Commission in the course of monitoring critical incident investigations have been reasonably considered and addressed by the NSWPF. At the time of writing there has only been one critical incident investigation (Case Study 10: SF Gari) where the Commission has provided advice that it considered an aspect of the investigation was 'inappropriate' and provided advice of its concerns.[155]

Nonetheless, on a number of occasions the Commission has either sought further advice or made recommendations to the NSWPF.

This has been necessary because the finalised NSWPF CIIRs often include recommendations made by the SCII. However, it is the NSWPF executive and not the SCII which is responsible for endorsing and implementing recommendations. Unfortunately, the Region Report frequently fails to address the recommendations made by the SCII. This makes it difficult for the Commission to be satisfied that the issues have been properly examined, and the risks identified by the critical incident investigation appropriately mitigated. In these circumstances, the Commission usually seeks further advice from the NSWPF, as discussed at 4.2.7 above. The Commission recommends that the NSWPF amends the NSWPF Critical Incident Guidelines to require the Region Report to include a response to any recommendations made in the CIIR.

In a draft of this Report, which was provided to the NSWPF, the Commission made two preliminary recommendations, [156] both of which were supported by the NSWPF.

Firstly, the Commission recommended that the NSWPF introduce robust procedures to notify the Commission that a critical to upload the finalised critical incident investigation report and to provide the Commission with a copy of that report as soon as practicable. The NSWPF supported this recommendation and advised that once the Critical Incident Investigation Report (including **SCII Report, Review Officer Report and Region Report**) are completed ratified by the Commissioner's Executive Team, the SCII will be instructed to upload the Report to the e@glei case and notify the Commission. In light of this response, the preliminary recommendation has been modified only in a minor way to specify that the process be included in the NSWPF Critical Incident Guidelines and within a timeframe.

Secondly, the Commission recommended that the NSWPF amend the NSWPF Critical Incident Guidelines to require the Region Report to include a response to any recommendations made in the Critical Incident Investigation Report. The NSWPF have indicated that the Region Report template will be amended to address recommendations made in the Critical Incident Investigation Report, including

[153] *Law Enforcement Conduct Commission Act 2016*, s 117(1)(a).

[154] *Law Enforcement Conduct Commission Act 2016*, s 117(1)(b).

[155] Although the SF Gari incident occurred on 8 November 2018, advice under the *Law Enforcement Conduct Commission Act 2016*, s 117(1)(b) was provided to the NSWPF on 3 September 2021 after the critical incident investigation was complete and the Commission's attempts to resolve the concerns with the NSWPF were unsuccessful.

[156] On 22 December 2022 a copy of this Report in draft was sent to the NSWPF in relation to the content and recommendations made prior to the Report being finalised and tabled in Parliament. The NSWPF sought and received advice from several stakeholders including; all Region Commanders, Traffic and Highway Patrol, Professional Standards Command (Investigations Unit), State Crime Command, and Capability Performance and Youth Command. On 10 February 2023 the Commission received a response from police.

recommendations raised by the SCII, conduct issues identified and broader lessons to be learned from the incident. The preliminary recommendation is unchanged.

Recommendation 6: **The NSWPF amend the NSWPF Critical Incident Guidelines to include robust procedures to notify the Commission within seven days of ratification that a critical incident investigation has been finalised, and provide a copy of the Critical Incident Investigation Report to the Commission. The procedures should indicate the person responsible for instructing the SCII to upload the Report and state that the Report should be uploaded as a product so the document is visible to the Commission.**

Recommendation 7: **The NSWPF amend the NSWPF Critical Incident Guidelines to require the Region Report to include a response to any recommendations made in the Critical Incident Investigation Report.**

Case Studies

Case study 1: SF Beachway - A critical incident investigation revoked by NSWPF and failure to comply with NSWPF Critical Incident Guidelines

At 8.00am a member of the public called 000, concerned for the welfare of homeless Person A, who was sitting on the steps of an office building in Sydney. Person A was hunched over and shaking and appeared unwell. Police attended the location and spoke to Person A about his health. During this conversation Person A stood up but then suddenly fell forward, causing Person A to hit their head on a concrete step. Person A appeared to struggle with their breathing and began to lose consciousness, so Police requested the attendance of the NSW Ambulance. Person A went into cardiac arrest and police commenced CPR. The NSW Ambulance attended the location and conveyed Person A to hospital where he was declared to be deceased. A critical incident arising from a police operation was declared, and the Commission attended and monitored the critical incident investigation. One month after the incident the critical incident declaration was revoked as the evidence of an independent witness and CCTV footage indicated that police who spoke with Person A did not have any physical contact with Person A prior to him falling and the post mortem of Person A found that Person A was suffering from a number of untreated medical conditions, and any one of those conditions could have been responsible for Person A's death. As required under the LECC Act, the Commission ceased monitoring the investigation from this point.

Prior to the Commission ceasing its monitoring, the Commission became aware that the critical incident was not initially managed in accordance with the NSWPF Critical Incident Guidelines. Knowing that the incident was a potential critical incident, an officer from the incident PAC took a statement from an independent witness. This is contrary to the NSWPF Critical Incident Guidelines which require an officer from the Critical Incident Investigation Team, from an independent PAC, to investigate the matter to eliminate a potential conflict of interests arising. In addition, it was initially thought that the two police officers who dealt with Person A, had been returned to the Police Station. It turned out however, that the two involved officers had been left guarding the critical incident scene until 11.50am, and allowed to walk back together to the Police Station unsupervised. Although the two involved officers were directed not to talk about the incident, during the subsequent interviews it was disclosed that the two involved officers did discuss the incident. The NSWPF Critical Incident Guidelines require that involved police officers be returned to the Police Station and separated, or at least supervised, to ensure that they do not discuss the matter and potentially contaminate the evidence they provide for the purposes of the investigation. Although the failure to comply with the NSWPF Critical Incident Guidelines did not ultimately affect the outcome of a critical incident investigation, as the declaration was revoked and the death was not the result of the actions of police officers, the Commission sought advice as to what action would be taken to mitigate the risk of similar failures arising in the future at the involved PAC. The Commission was later advised that the issues were bought to the attention of the officer who had taken the statement notwithstanding the potential conflict and with the officer who was responsible for the management of the involved officers. In addition, all the Detectives at the PAC received a presentation in relation to the management of critical incidents presented by the PSC Review Officer.

Case Study 2: SF Kyamba - A critical incident investigation ceased by Commission

About 7.30pm police attempted to stop a utility vehicle which was being driven erratically on the freeway. Police commenced a pursuit for a very brief period before discontinuing the pursuit. The

utility vehicle continued along the freeway against the flow of traffic and collided with a truck. The driver of the utility vehicle was flown to a nearby hospital with what initially appeared to be life threatening injuries. Due to the proximity of the pursuit to the collision, a critical incident was declared.

The Commission monitored the police investigation of the critical incident for three months and reviewed the evidence gathered. The evidence suggested that the driver of the utility vehicle had been travelling at excessive speed with a high blood alcohol level. There was no evidence to suggest that the two involved police officers had materially contributed to the collision, or had engaged in any misconduct. In the fourth month after the incident, the driver of the utility vehicle had almost fully recovered.

In light of the evidence and the recovery of the seriously injured person, the Commission was of the view that it was not in the public interest to continue to monitor the critical incident investigation and notified the NSWPF that the Commission had ceased monitoring the investigation.

Case Study 3: SF Skillman - Death not the 'result' of police actions

About 10.25pm a Security Consultant contacted 000 in response to an activation of the fence-line alarms surrounding the Gap Park, which prevent people from accessing the cliff face. Police attended the location and, in the distance saw a person on the wrong side of the fence line. Police said, *'Hey, its police can we have a chat'*, but there was no response from the person. Police shone their torches in the direction of the person, but the person shuffled away and police lost sight of the person. Police conducted a search of the area utilising resources from Police Rescue, Marine Area Command and the Air Ambulance Helicopter and a deceased person was located at the base of the cliff. Police declared a critical incident and a critical incident investigation was commenced. The person was identified and suicide notes located. A brief of evidence was submitted to the Deputy State Coroner. On the evidence, the Deputy State Coroner formed the view that there were no suspicious circumstances and no evidence to indicate that anyone other than the deceased person was involved in the death. The Deputy State Coroner also formed the view that an inquest was not mandatory because the circumstances of the death were not the 'result' of a police operation as required under s 23 of the *Coroners Act*. For these reasons the Deputy State Coroner decided not to hold an Inquest.

Case Study 4: SF Parrish - Critical incident scene on a roadway in a regional location and duty of care issues

NSW TrainLink staff contacted police and requested that police attend a regional train station in northern NSW to remove a passenger who was intoxicated, without a ticket ($2.50) and allegedly abusive to staff. About 9.10pm police attended the train station and told the passenger that they were not allowed back onto the XPT train. The next train was not due at the station until the following morning. Police drove the passenger from the train station to a rest area about 7 kilometres out of town on the side of the Pacific Highway, so that he could hitch a lift home, about 146 kilometres away. The rest area had a toilet block and a rotunda for shelter. About 10.00pm the passenger was hit by a motor vehicle travelling south on the pacific highway. Passing cars stopped to assist the injured person and to direct traffic until police and the NSW Ambulance arrived. The injured person was conveyed to hospital but had sustained fatal injuries. A critical incident was declared by the NSWPF at 10.40pm and the Commission notified of the declaration at 12.35am. The Commission's on call investigator did not attend this incident for two reasons. Firstly, the Commission's on call investigator was attending a metropolitan critical incident which

had occurred on the same date. Secondly, the critical incident had occurred in northern NSW and therefore the scene would not be able to be preserved until the Commission attended, as the incident scene was on the Pacific Highway and blocking the flow of traffic. Although the Commission did not attend this critical incident scene, the Commission did monitor the critical incident investigation. In the course of monitoring this investigation the Commission raised a number of issues with the police investigators via the Review Officer. One of the main issues raised was whether it was appropriate or reasonable for police to have taken the passenger to a remote rest area to hitch a lift home, given his level of intoxication and other relevant circumstances. Police investigators advised that the duty of care issue was being considered as part of a misconduct investigation. After the mandatory coronial inquest, the misconduct investigation was finalised and sustained findings made against the subject officers.

Case Study 5: SF Garemyn - A retrospectively declared critical incident and concerns about compliance with and adequacy of existing NSWPF Policies and Procedures

About 4.00am a police vehicle observed a speeding motor vehicle. The police vehicle followed the motor vehicle for about five minutes, over seven kilometres, and at speeds in excess of the speed limit. To avoid being apprehended by police, the driver abandoned his motor vehicle on private property surrounded by bushland. Police located the abandoned vehicle shortly after and looked for the driver for about 30 minutes. Police were unable to locate the driver, hindered by the cover of darkness and dangerous terrain. Police left the scene. Around this time the driver fell from a 9.5 metre rock ledge sustaining fatal injuries. Later the same morning police attended the location and arranged for the vehicle to be towed to a tow yard. Police made no investigations in attempt to identify the driver or vehicle owner.

One month later the driver's family members made a missing person report, but the report was not initially investigated in a diligent manner. On several occasions the driver's family members contacted police in relation to the progress of the missing person investigation. Six months after the missing person report, police located the skeletal remains of the driver a short distance from where he had abandoned his vehicle. One month later, after a preliminary review of the case by the State Coroner, the NSWPF retrospectively declared a critical incident arising from a police operation. The Commission was notified of the declaration and commenced monitoring the critical incident investigation.

A coronial inquest was held and although the Deputy State Coroner expressed concerns about the delays in locating the driver's remains, the Deputy State Coroner made no recommendations, as the delays did not go to the manner and cause of death.

The Commission however did raise a number of concerns in relation to failures to follow existing policies and procedures, which appear to have contributed to the delay in locating the remains of the driver. The NSWPF responded positively to the concerns raised by the Commission by: *(i)* reminding all staff within the Command of their obligations under the NSWPF Administration of Contract Towing and Unclaimed Vehicle Certificates Procedures; *(ii)* by circulating applicable Six Minute Intensive Training (SMITs) scenarios and reviewing them in shift briefings to reinforce requirements; and *(iii)* by reminding supervisors to identify apparent lack of attempts to locate a vehicle owner and/or take follow up action.

The Commission also raised other concerns in relation to existing policies and procedures. To address those concerns the Command:

(i) introduced a check of GPS function in all vehicle equipped with a Mobile Data Terminal (MDT) during the weekly vehicle checks;
(ii) updated the existing policy for the Administration of contract towing and unclaimed vehicle certificates to now include procedures for the disposal of

vehicles, requiring that electronic records be made on EFIMS and in the COPS event;

(iii) introduced regular inspections to ensure that staff comply with the new procedures for the disposal of vehicles; and

(iv) initiated a Part 8A misconduct matter investigation in relation to the quality of the investigation of the initial Missing Person Report. The investigation resulted in sustained findings being made against the subject officer and the taking of appropriate management action in relation to the failure.

As a consequence of the NSWPF response the Commission was able to advise that it was satisfied that the critical incident investigation was fully and properly conducted. The Commission also commended the NSWPF for their cooperative response and positive action taken in relation to the concerns raised.

At the time of providing this advice, the Commission also made a recommendation in relation to one concern raised by the Commission which was not addressed by the Police District or Region Response. In the coronial findings the Deputy State Coroner noted that police had followed or monitored the deceased's vehicle over a distance of at least seven kilometres and at speeds in excess of the speed limit. Although satisfied that the police vehicle did not pose a risk to other road users in the circumstances, her Honour was of the view that the SDP should at least provide some guidelines as to how such a 'follow' or 'monitor' should be conducted. The Commission agreed with the Deputy State Coroners view and therefore recommended that the NSWPF give further consideration to whether it would be appropriate to include guidelines in relation to the *'following'* or *'monitoring'* of vehicles which are currently not captured by the existing NSWPF SDP. The NSWPF have since advised that the views of the Coroner and Commission regarding guidance in relation to 'following' and 'monitoring' vehicles will be taken into account as part of an upcoming wide-ranging review of the NSWPF SDP.

Case Study 6: SF Nalanda - Involved police officers declined to provide a version of events until compelled to do so in coronial proceedings 19 months later

About 9.30am a number of people reported Person A riding a bicycle towards on-coming traffic in an inner city suburb of Sydney. When Police attended and attempted to detain Person A, Person A resisted. Police used physical force and defensive equipment to restrain Person A. Person A was placed in an ambulance and taken to hospital as an involuntary patient. Person A absconded from hospital and three of the officers who had earlier dealt with Person A, attempted to stop him. Initially Person A tried to evade police before running directly at them. Officer A discharged a Taser and Person A fell to the ground. Police then restrained Person A on the ground, eventually applying handcuffs. About 2 minutes later Person A stopped breathing. Police immediately commenced CPR and called an ambulance. Person A was taken to hospital by ambulance and declared deceased a short time later. A critical incident was declared by the NSWPF.

On the basis of legal advice, six of the involved police officers declined to be interviewed regarding the second interaction with Person A. Nineteen months later, each officer gave evidence at the inquest after being issued with a certificate under s.61 of the Coroners Act 2009.[157] At inquest three of the officers provided evidence that they had received legal advice to not make any notes about the incident.

[157] Section 61, Coroners Act, allows witnesses to apply for a certificate to prevent their evidence being used against them in a variety of other contexts. The Coroner usually provides a certificate if there are reasonable grounds for the witness to object to giving evidence if it may prove that they have committed an offence or are liable to a civil penalty.

The Coroner found that the cause and manner of death of Person A to be a malignant ventricular arrhythmia without myocardial infarction, precipitated by multiple factors including positional asphyxia, exertion and use of Taser, superimposed upon Person A's underlying heart disease.

The Coroner made a number of recommendations in relation to the police training and response to situations where a person is suffering a mental health crisis.

Case Study 7: SF Cromerty - Involved police officer declined to provide a version of events until criminal proceedings 24 months later and a directly related misconduct matter arising in the course of the critical incident investigation

At court, a person was granted conditional bail, which required that a surety be paid. The Police Prosecutor, suspected that the person could not meet the surety condition, and requested that officers from Corrective Services NSW (CSNSW) attend the court to take custody of the person while the bail papers were prepared. When the CSNSW Officers attended the Court, there was a verbal dispute between the Police Prosecutor and a CSNSW Officer over whether the NSWPF or CSNSW were responsible for the custody of the person. The verbal dispute escalated when taken from the courtroom into the busy foyer, ending abruptly when the Police Prosecutor pushed the CSNSW Officer forcibly to the chest, causing the CSNSW Officer to fall backwards onto the floor. As a consequence of the fall, the CSNSW Officer was conveyed to hospital where it was established that he had fractured a hip and required hip replacement surgery and a long period of rehabilitation. As a consequence of the serious injury sustained a critical incident arising from the use of physical force by a police officer was declared. The Commission attended and monitored the critical incident investigation. As entitled due to the nature of the incident, the involved Police Prosecutor declined to provide a version of events to critical incident investigators, relying on the privilege against self-incrimination, as he was entitled to do.[158]

The involved Police Prosecutor was subsequently charged with assaulting the CSNSW officer and a misconduct matter investigation was initiated but suspended pending the outcome of criminal proceedings. Whilst the criminal proceedings were on foot the involved officer was placed on office based duties. Ultimately, the involved Police Prosecutor provided evidence during criminal proceedings 24 months after the incident. Although the Court was satisfied that the involved Police Prosecutor caused grievous bodily harm to the CCNSW Officer, the Court was not satisfied that the involved Police Prosecutor's actions were reckless and the Court dismissed the charges. Notwithstanding the outcome of the criminal matter the NSWPF misconduct investigation found that although the involved Police Prosecutor's actions were not unlawful, they did amount to unprofessional conduct. Sustained findings were made against the involved Police Prosecutor and appropriate remedial management action was taken to mitigate the future risk of similar issues arising in the future.

Case Study 8: SF Newmoon - Involved police officers left to guard critical incident scene due to resourcing in regional area and therefore not practical to comply with the NSWPF Critical Incident Guidelines

Police received a call for assistance from a friend of Person A, after Person A had threatened to *"put a gun to himself"*. Officer A attended the home of Person A, which was in a regional location

[158] The privilege against self-incrimination is a basic and substantive common law right, *that a person may refuse to answer a question, or to produce any document or thing, if doing so may* expose the person to being convicted of a crime, *Sorby v Commonwealth* (1983) 152 CLR 281, 288. In *Baff v NSW Police Commissioner* [2013] NSWSC 1205, the court ruled that any direction by the Commissioner of Police to direct a police officer to answer questions asked of him about his conduct was not lawful in circumstances where the police officer has claimed the privilege against self-incrimination.

in NSW, to conduct a welfare check. Officer A knocked on the front door and attempted to speak to Person A but he refused to open the door, and said that he had petrol and LPG gas bottles and he would blow himself and police up, if Officer A did not leave the premises. Officer A withdrew from the premises and called for assistance. Officer B, Officer C and Officer D attended the location to assist Officer A from other regional police stations. The NSW Fire & Rescue and the NSW Ambulance also attended the location on standby. Subsequent attempts to engage Person A were also unsuccessful. Police withdrew to the street, evacuated neighbours from their homes, and requested negotiators attend the location. Shortly thereafter the weatherboard house burst into flames and police attempted to force entry to assist Person A but were forced to abort their attempts. NSW Fire & Rescue extinguished the fire and Person A was located in the front left room of the premises, with severe burns to about 90% of his body. Person A was conveyed to hospital but died as a consequence of his injuries. A critical incident was declared.

Officer A, B, C and D were all identified as officers directly involved in the critical incident. Under the NSWPF Critical Incident Guidelines, to protect the integrity of the investigation, involved police officers should be separated, removed from the critical incident scene and returned to the police station. However, in this case, it was not practical to comply with the NSWPF Critical Incident Guidelines because the premises was in an isolated part of NSW and it would have taken a considerable time for officer resources to arrive from other locations to relieve the involved officers. As a consequence the involved officers were required to secure the critical incident scene and maintain a crime scene log until critical incident investigators arrived.

Case Study 9: SF Nalanda- Conflict of interests in a critical incident investigation

In this matter, several officers responsible for the investigation of the critical incident declared conflicts of interest with a number of the officers directly involved in the critical incident. Most of these conflicts arose from the professional working relationships they had with directly involved officers. The SCII deemed these conflicts to be manageable and directed the relevant investigators to have no role investigating matters relating to the relevant directly involved officers. However, Officer B, disclosed that one directly involved officer, Officer C, was an ex-colleague and the partner of a personal friend.

The Commission considered the risk to be an unacceptable risk and raised concerns with the SCII. The SCII was of the view that since the friendship was between Officer B and the spouse of Officer C, the conflict was manageable, by ensuring Officer B had no role investigating matters that related to Officer C. Several days later, Officer B was removed from the investigation after he was approached by the spouse of Officer C enquiring on the progress of the investigation.

Case Study 10: SF Gari - Failure to take interim management action and serious breaches of the SDP dealt with outside the misconduct management system

About 2.30pm officers A, B and C were patrolling in an unmarked police vehicle (PV1) when they observed a motor vehicle driving erratically, in moderate traffic. Officer A activated lights and sirens on PV1 and attempted to pull the offending motor vehicle over, but the driver ignored the signal to stop and continued to drive for several kilometres. PV1 continued to follow the offending motor vehicle but did not inform police radio that PV1 was in pursuit of the offending motor vehicle, as required. Eventually the offending motor vehicle was forced to stop at a red light and Officers A, B and C attempted to approach the motor vehicle on foot. The motor vehicle drove at police before driving off. Officer A advised radio that the motor vehicle had injured Officer B. A marked highway patrol vehicle (HWPV1) heard the radio broadcast and proceeded towards the last known

direction of the offending motor vehicle. HWPV1 drove towards the location on urgent duty, in excess of the speed limit, on the wrong side of the road into oncoming traffic and approaching red traffic lights and activated emergency warning devices only intermittently, for about 3 minutes. HWPV1 then located the offending motor vehicle and advised police radio they were in pursuit. The pursuit continued for about two minutes, during which time the offending vehicle drove at speed, through red traffic control signal intersections and on the wrong side of the road on several occasions before the marked highway patrol vehicle terminated the pursuit. Seconds after terminating the pursuit the offending vehicle collided into a truck at a four way intersection. The driver of the offending vehicle and, the driver of the truck sustained serious injuries and as a result a critical incident was declared by the NSWPF.

Three months after the incident, on reviewing all of the evidence, including the ICV footage, BWV footage and police radio recordings, the SCII formed the view that officers from PV1 and HWPV1 had collectively breached eight clauses of the NSWPF SDP.

To mitigate the risk that the involved police officers may breach the SDP in the same way in the future, the Commission immediately sought advice as to the management action taken in relation to the breaches and whether the breaches, which appeared to constitute misconduct information, would be dealt with as a misconduct matter. The Review Officer advised that the breaches had been dealt with by the local Safe Driver Panels and some officers had received training and/or decertification as a consequence. The Review Officer also advised that they did not believe the breaches would be dealt with as a misconduct matter, and they would be added as a notation on the Safe Driving System record for each officer.

The Commission requested copies of the records confirming the action taken in relation to the breaches, on multiple occasions. They were ultimately provided the information eight months after the request was originally made. The documents indicated that although the involved officers were advised four months after the incident of the sections of the SDP they had breached, no action had been taken in relation to the breaches until nine months after the incident. Notwithstanding the serious nature of some of the breaches of the SDP, the involved officers were given 'advice and guidance' in relation to the breaches, when more serious management action might have been warranted if the breaches had been dealt with in a more timely manner.

Fourteen months after the incident the South West Metropolitan Region (SWMR) Professional Standards Manager raised concerns regarding the matter and strongly recommended that a Part 8A misconduct matter be created. The SWMR Commander agreed. The Commission remained concerned that the NSWPF did not seem to have a clear process to determine when breaches of the SDP reached a threshold that required the conduct be registered and dealt with as a misconduct matter.

At the time of finalising the oversight of this matter, the Commission requested further advice and information in relation to interim risk management processes, and the reasons that no interim management action was taken in relation to the breaches of the SDP for nine months, notwithstanding several enquiries being made by the Commission in this regard. The NSWPF were unable to advise why no action was taken in relation to the breaches for nine months.

As a consequence, and for the first time, the Commission provided advice that it had concerns in relation to the investigation, under s 117(1)(b) of the LECC Act. The Commission also recommended that: *(i)* the NSWPF consider introducing safeguards, to ensure that action is taken in a timely manner to mitigate the risk of future breaches of the SDP; and *(ii)* the NSWPF consider introducing an objective test and guidelines to assist investigators in determining when a breach of the SDP meets a threshold such that it amounts to misconduct or otherwise. The Commission has been advised that the recommendations have been referred to the Traffic and Highway Patrol Command, who are in the process of conducting a comprehensive review of the Safe Driving Policy. At the time of publishing this report, the Safe Driving Policy review had not been finalised.

Case Study 11: SF Auras - Concerns about the lawfulness of arresting and strip searching of witnesses and concerns around the change of plans to arrest

A police operation was initiated to arrest Person X for a series of alleged aggravated sexual assaults. At the time of the operation Person X was drinking in the beer garden of a busy metropolitan hotel with Person Y and Person Z. Officer A, Officer B and Officer C entered the hotel. When Officer A approached Person X to execute the arrest Person X produced a knife and stabbed Officer A in the abdomen. Officer B and Officer C discharged their police firearms at Person X, who as a consequence died at the scene. Officer A also sustained serious injuries requiring surgery. A critical incident was declared.

In the course of monitoring the investigation the Commission raised a concern that it appeared that witnesses, Person Y and Person Z, were escorted to a nearby police station and unlawfully strip searched. It also appeared that no formal record of the strip searches had been made. In response, police initiated a misconduct investigation. Although police conceded that the witnesses had been erroneously strip searched, police attributed the error to a mistaken belief that Persons Y and Z were suspects rather than witnesses. Police were of the view that the mistaken belief was understandable in the circumstances given the chaotic nature of the critical incident scene. For this reason, police investigators made no findings against the police who were involved in the strip search. Findings were however made in relation to the failure to create a record of the strip searches, and as a result advice and guidance was provided to the officer involved.

In this matter the Commission also separately raised concerns with the NSWPF regarding the manner in which Officer B and Officer C changed prearranged plans for the arrest of Person X, without notifying Officer A of the change of plan. Those changes meant that Officer A was proceeding under the assumption that he would engage Person X with an element of surprise, whereas Officer B and Officer C proceeded to draw their firearms and alert Person X to the police intentions. The NSWPF indicated that they did not consider Officer B or Officer C committed any misconduct. The Coroner also raised concerns in relation to the failure of Officer B and Officer C to apprise Officer A about their change to the original arrest plan in the coronial findings.[159] During the inquest police conceded that devising 'a separate plan without full acknowledgement from all involved' was dangerous and 'generally considered an unsound operational practice'.[160] As the Coroner concluded that the communication failures arose from 'individual errors of judgement, and did not reflect any deficiency in NSW Police policy or training',[161] no recommendations were made in this regard.

Case Study 12: SF Pembury - Concerns about manner of driving, reliance on internal legal advice and advice to the NSW Police Force during the course of a critical incident investigation

About midday, the police radio requested that police urgently attend a premises where a women was holding a baby who appeared to be unconscious. Six police vehicles responded to the request for assistance. One of the responding police vehicles was a marked police vehicle containing Officer A and Officer B. Officer A drove the police truck at speed with lights and sirens activated. When the police vehicle entered an intersection controlled by a single-lane roundabout, Officer A drove the police vehicle over the top of the roundabout and collided with a BMW sedan which had entered the roundabout. Although an eight year old child in the front passenger seat of the BMW sedan was unharmed, the female driver of the vehicle sustained a broken pelvis. As a consequence of the serious injury sustained by the driver, a critical incident was declared. The Commission attended and monitored the investigation.

[159] Deputy State Coroner, Magistrate Elizabeth Ryan (25 January 2022). Inquest into the death of Nick Newman (File no. 2018/28682). State Coroners Court of New South Wales, paragraph 162.

[160] Deputy State Coroner, Magistrate Elizabeth Ryan (25 January 2022). Inquest into the death of Nick Newman (File no. 2018/28682). State Coroners Court of New South Wales, paragraph 164.

[161] Deputy State Coroner, Magistrate Elizabeth Ryan (25 January 2022). Inquest into the death of Nick Newman (File no. 2018/28682). State Coroners Court of New South Wales, paragraph 173.

In compliance with the NSWPF Critical Incident Guidelines and the Police Act, the SCII reported Officer A's manner of driving, as potential misconduct, to a senior officer. A misconduct matter investigation was initiated. It was alleged that Officer A had negligently driven the police vehicle which collided with the BMW sedan. Around five months after the incident the SCII sought legal advice from the NSWPF Operational Legal Advice Unit (OLAU) as to whether there was sufficient evidence to warrant charging the police driver with: Dangerous driving occasioning GBH (s 52A(3) of the *Crimes Act 1900* (NSW)); Negligent driving (s 117(1) of the *Road Transport Act 2013* (NSW)); and/or Driving at a speed dangerous (s 117(2) of the *Road Transport Act 2013* (NSW)). Around one month later, the OLAU advised it considered there was no reasonable prospect of convicting the police driver for the above listed offences or other breaches of the Road Rules 2014.

Noting that advice had been sought from the OLAU, rather than the Officer of the Director of Public Prosecutions (ODPP), and the statute of limitations under the *Road Transport Act* were set to expire imminently, the Commission wrote to the Commissioner of Police under s 116(b) of the LECC Act and requested that consideration be given to the urgent referral of the matter to the ODPP for consideration of sufficiency of evidence. The NSWPF obtained urgent advice from the ODPP and a Court Attendance Notice was served on Officer A for the offences of *'Negligent driving (occasioning grievous bodily harm)'* and *'Drive recklessly/furiously or speed/manner dangerous.'* At court, Officer A pleaded guilty to negligent driving, occasioning grievous bodily harm. No conviction was recorded against Officer A, who was sentenced to a six month conditional release order.

The Commander of the NSWPF Professional Standards Command commended the Commission's work, writing; *'I would like to thank the LECC in identifying this matter and bringing it to the attention of the NSWPF quickly so we were able to resolve the issue and ensure an appropriate response was undertaken.'*

Case Study 13: SF Gilholme- Reasonableness of police conducting a concern for welfare for a DV related matter by telephone rather than in person

In this matter Person A died at the hands of Person B in a domestic violence context. When police attempted to apprehend Person B, Person B moved towards police with an apparent intention to provoke police to shoot him. The attending officers then discharged their firearms and Person B died a short time later. In the course of the critical incident investigation the evidence indicated that in the hours proceeding the domestic violence incident, a friend of Person A, had contacted police concerned about the welfare of Person A, because she was concerned that Person B would harm Person A after a number of friends had received a strange phone call from Person B. The friend also indicated that Person B had been violent to Person A in the past. Police attended Person A's home but no one was at the residence. Police eventually spoke to Person A by phone, at which time Person A told police that she was okay. Although the Commission accepted that police made a number of efforts to investigate the concern for welfare raised by the friend, the Commission was concerned that police would confirm the welfare of a person who may be the victim of serious domestic violence via telephone rather than in person. If the welfare of a person is conducted by telephone it is not possible to be sure of the identity of the person to whom police are speaking, whether they are under duress and are, in fact, unharmed. The Commission raised this concern with the SCII who advised that there was nothing in the Domestic and Family Violence SOPS 2018 which required that a concern for welfare must be conducted in person. Ultimately the State Coroner addressed this particular issue by recommending that the Commissioner of Police:

(1) Consider amending NSW Police Force policy, including if appropriate the Domestic and Family violence Standard operating Procedures and the Code of Practice for the NSW Police Force Response to Domestic and Family Violence, in order to:

- *a. Clarify the requirement to record a CAD message as 'Domestic Violence' where the circumstances reported by the informant relate to suspected domestic violence, even where no offence is reported.*
- *b. Clarify that, where a report relates to domestic violence, responding police officers should attend and talk to the alleged victim personally, unless there are exceptional reasons not to.*

Case Study 14: SF Mulgowrie - Concerns about the critical incident and the quality of the critical incident investigation raised in the media

A critical incident was declared after a serious motor vehicle accident between a NSW Police Force (NSWPF) Traffic & Highway Patrol vehicle and a vehicle driven by Person A at the intersection of Connels Road and The Kingsway, Cronulla. The Commission was notified shortly after the critical incident was declared, and officers from the Commission attended the scene of the incident and continued to actively monitor the progress of the critical incident investigation

Concerns about the critical incident and the quality of the critical incident investigation were raised in the media. In response to the concerns and, in effort to reassure the public, the Commission issued a media release. The media release advised that the Commission's staff had attended the critical incident scene and continued to monitor the investigation to ensure that the investigation is conducted in thorough and objective manner. The media release also advised that in the course of monitoring the investigation, the Commission would also independently consider whether the NSWPF critical incident investigation appropriately considers the reasonableness of the actions of members of the police force and any systemic, safety or procedural issues arising from the actions of police.

Case Study 15: SF Erlinya - Multiple misconduct matters linked to misconduct investigation

The NSWPF Traffic and Highway Patrol Command were conducting a large scale random breath testing operation, when police signalled for Vehicle A to stop. Vehicle A did not stop and police pursued it. The driver of Vehicle A lost control and collided with a tree. The driver died as a consequence of injuries sustained during the collision and a critical incident was declared.

There were three complaints arising from this critical incident investigation.

Firstly, there was a complaint that the CIIT had failed to respond to emails and provide advice to family members of the deceased as to the progress of the critical incident investigation. As soon as the Commission became aware of this issue, the Commission contacted the Review Officer and requested that arrangements be made for the SCII to make contact with family members in an effort to provide advice sought by the family, and this occurred.

Secondly, there was a complaint that a Senior Officer had allowed a television crew into the critical incident scene contrary to policy and left them unsupervised and compromising evidence. The Commission was not notified of this misconduct matter whilst monitoring the critical incident investigation, but rather discovered the matter after the complaint investigation was finalised and while the critical incident matter was awaiting inquest. It was of particular concern to the Commission that the misconduct matter investigator did not request or consider documents that were obtained during the course of the critical incident investigation, which were directly relevant to the issues raised in the misconduct matter. In the Commission's view, the apparent failure to consider the evidence already provided by these witnesses, or to make enquiries with them to clarify their evidence in relation to the misconduct allegations, compromised the quality of the Part 8A investigation and the findings that the allegations were not sustained. Due to the passage of time, the NSWPF declined to take any further action in relation to the concerns raised by the Commission.

Finally, there was a complaint that one of the involved officers, Officer A, had breached several sections of the SDP during the pursuit. Sustained findings were ultimately made against Officer

A, and a Region Commander's Warning Notice was issued. During coronial proceedings an expert witness from the Traffic Policy Unit provided evidence that seven other involved officers also breached several sections of the SDP. However, when the Region Safe Driving Panel reviewed the evidence they formed the view that the breaches were relatively 'minor' in nature and took no further action, though a notation was made in the Safe Driving System.

Case Study 16: SF Clapham - Follow up of coronial recommendations and SCII recommendation regarding e-learning module

A family member raised concerns about the welfare of their brother who was missing and had left a suicide note. It was feared that the brother might go to a nearby suicide hot spot. A message was broadcast over police radio and, police searched for the person eventually locating him on a rock ledge down a cliff face. Police attempted to negotiate with the person for about 30 minutes before he pushed himself off the rock ledge into a rocky area with shallow water below. The person sustained serious but not life-threatening injuries and a critical incident was declared as of a consequence of the seriousness of the injuries sustained.

In the CIIR the SCII identified a corporate issue for the consideration of the NSWPF. Although, in response to previous coronial recommendations from 2018,[162] the NSWPF had informed the Attorney General that they were '*developing a customised e-learning module 'Persons at risk of heights',*[163] the SCII indicated he had been unable to locate the e-learning module. The SCII, supported by the Review Officer, sought comment from '*subject matter experts regarding the need to develop an e-learning module for operational police when dealing with persons at risk at height*'. When the Commission reviewed the CIIR, which includes a Region Report, there was no advice as to the status of the e-learning module. The Commission therefore sought advice from the NSWPF in relation to the status of the module. The NSWPF advised that the development of the module had been delayed due to a number of other priorities including the roll out of PACER Clinicians in April 2020 and the NSW Health Suicide Monitoring System (July 2020). The NSWPF also advised that the MHIT were progressing the research phase for the e-learning module and estimated that the module would be delivered by early 2022. This advice indicates that the NSWPF was still to take action in relation to recommendations made in relation to four deaths, which occurred between May 2016 and March 2017, six years after the first incident, and four years after the original recommendation. The NSWPF response indicated that the e-learning module was due to be delivered more than 24 months after the SF Clapham critical incident.

Case Study 17: SF Derowrie - Time taken for the NSWPF to finalise critical incident investigations

Deputy State Coroner Truscott found that *Person A died on 26 July 2017, at Central Railway Station, Eddy Avenue Sydney, of a gunshot wound to the head, as a result of a police operation. He was experiencing a psychotic episode and was shot by police officers in circumstances where he ran at police with scissors in his hands.* The Commission monitored this critical incident investigation.

[162] Deputy State Coroner, Magistrate Harriet Grahame (31 July 2018). Inquest into three deaths in the Northern Beaches LGA (File no. 2016/00147533; 2016/00273179; 2017/00108066). State Coroners Court of NSW. The findings recommended that: *The NSW Police Force works to develop a short training course focused on the skills required for de-escalating situations where a person is threatening self-harm by jumping from a height. The course should be designed for, and offered to, first-response officers in those commands with the highest incidence of suicide by jumping from heights*; Deputy State Coroner Grahame's findings were reiterated in a subsequent inquest. Deputy State Coroner, Magistrate Elizabeth Ryan (22 March 2019). Inquest into the death of Aarron McKay (File no. 2017/001916). State Coroners Court of NSW.

[163] NSW Government Communities and Justice website (justice.nsw.gov.au) and the Government Responses to Coronial Recommendations page, January to December 2018

The coronial proceedings for SF Derowrie were finalised by Deputy State Coroner Truscott on the 5 August 2019. The Commission subsequently sought advice as to the status of the CIIR on several occasions. The Commission was advised that since about January 2019 the SCII had not been able to finalise the critical incident investigation because they had been prioritising another high profile inquest matter. On 19 October 2020, the Commission was advised that the high profile inquest had been finalised and the SCII would now be able to prioritise and finalise the CIIR for SF Derowrie. However, the Commission had to make several more enquiries in relation to the status of the CIIR, before it was finalised by police on 7 July 2021, and provided to the Commission for review on 30 August 2021.

Appendix A

LECC
Law Enforcement
Conduct Commission

The Role of the Law Enforcement Conduct Commission (LECC) in Monitoring the NSW Police Force (NSWPF) Investigation of Critical Incidents

The LECC independently monitors the NSWPF's investigation of critical incidents.

A critical incident is an incident involving a police officer that results in death or serious injury to a person. The LECC monitors the investigation of critical incidents from the time of the incident until the completion of the investigation by police to provide assurance to the public and the next of kin that police investigations into critical incidents are conducted in a competent, thorough and objective manner. In doing so, the LECC considers whether the NSWPF has adequately considered the following:

- the lawfulness and reasonableness of the actions of NSW police officers involved in the critical incident;
- the extent to which the actions of the NSW police officers complied with relevant law and policies and procedures of the NSWPF;
- any complaint about the conduct of involved NSW police officers and any evidence of misconduct;
- the need for changes to relevant policies, practices and procedures of the NSWPF; and
- any systemic, safety or procedural issues arising from the actions of NSW police officers.

If the LECC forms the view that the investigation is not being conducted in an appropriate manner, the LECC can advise the NSWPF and/or the Coroner of its concerns and make recommendations in relation to the concerns identified. The NSWPF is required to consider and respond to concerns and recommendations raised by the LECC. The LECC may make the advice that it has given to the NSWPF or the Coroner public after conclusion of the critical incident investigation.

If you have queries about the Critical Incident Monitoring role of the LECC please contact the Commission's switchboard number (02) 9321 6700 or email *cimonitoring@lecc.nsw.gov.au*.

You have a right to make a complaint if you are dissatisfied or concerned about the conduct of a NSW Police Force employee. Complaints must be made in writing, either directly to the Commissioner of Police or through the NSW Police Force Community Portal at *customerassistance@police.nsw.gov.au*. A complaint may also be made in writing to the LECC at Level 3, 111 Elizabeth Street, Sydney NSW 2000, by email at *contactus@lecc.nsw.gov.au* or *via* the Commission's website at *www.lecc.nsw.gov.au*.

Glossary

GLOSSARY	DESCRIPTION
BWV	Body Worn Video
Commissioner of Police	Commissioner of Police includes a police officer with delegated authority to act on behalf of the Commissioner of Police.
Commission's Monitoring Investigator	The person nominated by the Commission as the Commission's primary contact/s for the critical incident.
CIIM	Critical Incident and Investigation Monitoring
CIIR	Critical Incident Investigation Report. The CIIR consists of three parts including a SCII Report, a Review Officer Report and a Region Report, and is completed by the NSWPF after the police investigation and any related criminal and/or coronial court proceedings are complete.
CIIT	Critical Incident Investigation Team. The group of NSW police officers tasked to investigate the circumstances around the incident when a critical incident is declared by the NSWPF.
Defensive Equipment	Equipment (such as a Taser gun, capsicum spray, baton or handcuffs) issued to a member of the NSW Police Force for the purpose of exercising the functions of a police officer.
Director Oversight	The Commission's Director Investigations – Oversight.
e@gle.i	The NSWPF case management system on which all critical incident investigation related documents are stored and accessible. The Commission has read only access to most but not all parts of a critical incident investigation through this case management system.
EFIMS	Exhibits Forensic Information and Miscellaneous (Property) System
ICV	In-car video
Investigative search	Any search carried out at the scene of a critical incident or connected with the investigation of a critical incident, including but not limited to searches carried out under the authority of a coronial investigation scene order, search warrant, crime scene warrant or with the authority of the property owner.
Directly Involved Officer	A directly involved officer is any officer, regardless of rank or grade, who by their words, actions or decisions, in the opinion of the SCII, contributed to the incident under investigation. An officer who is present and does not involve themselves in activities which have contributed to the incident occurring is not a directly involved officer. A person's mere presence at the scene is insufficient.
LECC Act	The *Law Enforcement Conduct Commission Act* 2016.
MHIT	Mental Health Intervention Team
NSWPF	New South Wales Police Force.

NSWPF Nominated Contact Officer	The Senior Critical Incident Investigator (SCII) or a member of the NSW Police Force nominated by the SCII as the nominated contact officer. Under the current Arrangements this is the critical incident Review Officer from the Professional Standards Command.
PAC	Police Area Command. In metropolitan areas in NSW police are organised in to local clusters known as PACs. These clusters consist of a number of police stations.
PACER	Police, Ambulance, Clinicians, Early Response program.
Person in Custody	A reference to a person in custody is a reference to a person who has been detained by, or is otherwise in the custody of, a police officer, including being placed under arrest or being apprehended or being taken to or from a mental health facility under the Mental Health Act 2007 or to or from a hospital or other medical facility.
PD	Police District. In regional areas of NSW police are organised into regional clusters known as PDs. These clusters consist of a number of police stations.
Police Operation	Any activity engaged in by a police officer while exercising the functions of a police officer other than an activity for the purpose of a search and rescue operation.
PSC	Professional Standards Command of the NSWPF.
Region Command	Region Commands consist of a number of Police Area Commands (PACs) or Police Districts (PDs) or Specialist Commands.
Region PSM	The Region Professional Standards Manager (PSM) is an officer of the rank of Inspector attached to the Region Command which manages a number of PACs or PDs. The role of the PSM is broadly to investigate and/or oversee the investigation of matters relating to conduct within the Region.
Review Officer	The independent officer from the NSWPF responsible for monitoring and reviewing the probity and transparency of the investigation. The Review Officer is almost always from the Professional Standards Command but may be from another independent Command.
SCII	The Senior Critical Incident Investigator is the officer responsible for the investigation of the investigation of a critical incident.
SDP	Safe Driving Policy
Serious Injury	An injury that threatens or is likely to threaten the life of the person or that results, or is likely to result, in the person sustaining permanent and significant physical impairment or disfigurement and includes the infliction of a grievous bodily disease on the person or the destruction of the foetus of a pregnant woman.
STOPAR	Stop, Think, Observe, Plan, Act & Review. STOPAR is a model for critical thinking
Vehicle	A motor vehicle, trailer or other registrable vehicle within the meaning of the Road Transport Act 2013 and includes an aircraft or vessel.