NEW SOUTH WALES
BAR ASSOCIATION

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Mr Andrew Tink AM
Review of Police Oversight
Locked Bag 5111
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Dear Mr Tink

Police Oversight Review

Thank you for inviting the New South Wales Bar Association to contribute to this important reference. The Association does not intend to address all of the Review's terms of reference.

The Association is of the view that the current system for police oversight involves too many separate bodies, the responsibilities of which often overlap with one another, and occasionally give rise to inconsistencies and inefficiencies that are undesirable in the administration of justice.

The Association will not reiterate comments previously made in relation to the inefficiencies of the current oversight system, and wishes to refer to its previous submission to the McClelland Review in that respect (see attached). The Association will, however, address the first term of reference regarding options for a single civilian oversight model. The Association is of the view that it would be desirable to have a single civilian body for police oversight in New South Wales.

The Association has previously recommended the adoption of a model for police oversight similar to that which operates in the United Kingdom (the Independent Police Complaints Commission). While there may be significant advantages involved in adopting policies that have been successful in other jurisdictions, it is acknowledged that this is not universally the case and that it would be necessary to adapt any such policy for the local jurisdiction.

As noted in the terms of reference, the current oversight system involves New South Wales Police Force, the Ombudsman, the Police Integrity Commission, the Inspector of the Police Integrity Commission, the Parliamentary Committee on the Ombudsman, the Australian Crime Commission, the Coroner and Workcover. The Association is of the view that there should be a single body with sole responsibility for police oversight. This body should:

- be independent;
- be adequately resourced; and
- require mandatory and timely reporting of all incidents.

The Association has previously argued for a system of police oversight that involves separate complaint and monitoring functions, the former the responsibility of the Police Integrity Commission and the latter the responsibility of the Ombudsman. However, in light of the issues of overlap and duplication that have arisen from having a multi-faceted oversight model in New South Wales, the Association now suggests that it would be appropriate to have a single body for police oversight, provided that those two functions were kept separate from one another.

The Association would be pleased to consult further in relation to this reference. Should you or your officers have any questions in relation to this submission I invite you to contact the Association's Executive Director, Philip Selth at pselth@nswbar.asn.au or on 02 9232 4055.

Yours sincerely

Noel Hutley
Acting President

SUBMISSION OF THE NEW SOUTH WALES BAR ASSOCIATION TO THE HONOURABLE MR ROBERT MCCLELLAND FOR REVIEW OF POLICE CRITICAL INCIDENTS IN NSW

Introduction

1. The New South Wales Bar Association welcomes this independent review of the investigation and oversight of police critical incidents.

2. This submission has been made after consultation with the State Coroner Ms Mary Jerram, Deputy State Coroner Ms Sharon Freund, the NSW Ombudsman Mr Bruce Barbour together with his Deputy Ms Linda Waugh, and the Law Society of New South Wales. Differing views emerged. The opinions expressed below are those of the New South Wales Bar Association and not necessarily the views of the others consulted.

3. At the outset, the Association recognizes that police play a vital role which is at times dangerous and difficult. It must be recognized that occasions will arise in the proper execution of police duties, which result in serious injury or death to other persons or police themselves. The Association understands that there are on average less than 150 critical incidents each year.

4. For the most part, police carry out their duties and exercise their powers in a manner that avoids the ever-present risks of death or serious injury eventuating. Nevertheless critical incidents, by their nature, attract considerable public concern and media attention. Some recent critical incidents and the public response to them suggest that there is a real need for modern accountability and transparency measures to be implemented. Such measures are common elsewhere[1]. Their use need not interfere with the legitimate and pressing nature of expert police investigation.

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[1] An example is the Independent Police Complaints Commission (IPCC) in the United Kingdom discussed further at paragraph 28-31 of this submission. See http://www.ipcc.gov.uk/sites/default/files/Documents/statutoryguidance/2013_statutory_guidance_english.PDF

5. The Police Force would no doubt accept that the community has a legitimate interest in ensuring that deaths or serious injuries resulting from a police operation are explained, monitored, and kept to a minimum and that when such incidents occur, they are investigated thoroughly and objectively. As with most systems of modern public accountability issues of independence arise. That is especially so when, as in the case of the Police investigation of a Police critical incident, the evidence and any means of establishing the facts, come from the Police itself. Police critical incident investigation bears all the hallmarks of police investigating Police. It has become more notorious in recent years but it has been a longstanding problem. Critical incidents require investigation in a transparent and accountable manner.

6. Police exercise rare entitlements in the exercise of their duties. These include high speed or urgent duty driving,[2] the entitlement to carry and use firearms and other appointments, the right to search person and premises and the power to physically restrain and detain members of the community. These entitlements and powers are frequently employed or exercised in respect of members of the public who are vulnerable because of mental illness, intoxication, immaturity or socio-economic disadvantage. The public appears to require that the Police are accountable in respect of the exercise of those entitlements, particularly where it causes or contributes to the death or serious injury of a civilian or a Police officer. A necessary prerequisite of accountability is the transparency of investigation and review of the circumstances surrounding such incidents.

7. Equally, there is a legitimate public interest in determining whether improvements can be made to police practices and procedures to avoid death or injury in the course of police action. Any suggestion that improvements for greater accountability would hinder investigation should be rejected.

8. The Association considers that the present model for the investigation of police critical incidents provided by the *NSW Police Force Guidelines for the Management and Investigation of Critical Incidents* (the Critical Incident Guidelines) does not provide transparency or adequate accountability mechanisms.

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[2] Subject to the dictates of the NSW Police Force Safe Driving Policy

9. Currently, critical incident investigations exhibit haphazard transparency or objectivity insufficient to ensure public confidence. The present model operates entirely within the NSW Police Force without a transparent system of monitoring and accountability. At present, accountability in respect of critical incident investigations is necessarily accidental or incidental and frequently occurs well after the event.

10. The Association considers that significant improvements can be made to the oversight and reporting of critical incident investigations to guarantee accountability and transparency, both at the time of the investigation and afterwards. It also considers this can be achieved in a manner that is both administratively efficient and cost effective without compromising the legitimate public interest in preventing the disclosure and/or dissemination of information concerning police methodologies.

11. The NSW Government's decision to make the Critical Incident Guidelines publicly available and to provide for the automatic reporting of all critical incidents to the Ombudsman are welcome and important steps towards ensuring accountability and transparency in the investigation of critical incidents. The nature, timing and content of the reporting however is critical to the effectiveness of any monitoring system. Notice by the Police to any monitoring body should be immediate and sufficient to enable a monitoring body to make a proper assessment.

Inadequacies in the current model for critical incident investigations and their oversight

12. The current model for the investigation of critical incidents purports to ensure objectivity and accountability in the following ways. First, it requires that officers from another Local Area Command (LAC) conduct the investigation of critical incidents not involving the use of police firearms or appointments. In the case of critical incidents involving the use of police firearms or appointments, the investigation is required to be conducted by officers from the Homicide Squad. In either case, the Critical Incident Investigation Team (CIIT) is headed by a Senior Critical Incident Investigator (SCII), usually of the rank of Detective Inspector or above. Secondly, at the conclusion of the investigation, the SCII is required to

prepare a report to be submitted to a Review Officer who is not attached to either the LAC where the incident occurred or the LAC to which the CIIT officers are attached. In the case of critical incident investigations conducted by the Homicide Squad, the SCII's report is provided to a Review Officer attached to the Professional Standards Command.

13. All of these mechanisms represent legitimate attempts to achieve objective review and reporting. However, practical experience and public reaction demonstrate that they are not - and are not regarded - as sufficient.

14. The fundamental problem with the current model is that, members of the NSW Police Force are responsible for both the investigation and review of the investigation. This does little to ensure that critical incident investigations are both actually and perceived to be independent, objective, transparent and ultimately accountable. It also creates practical difficulties in the management of the expectations and perceptions of the family of a civilian who has been killed or seriously injured in the course of a police operation and who are likely to be suspicious of information about the progress and findings of the investigation that is provided to them by the very agency they may perceive as having been responsible for that death or injury. That may be particularly so where the NSW Police Force has broadcast information concerning the circumstances of the incident that is subsequently found to be inaccurate or even misleading.[3]

15. These problems were recently highlighted in the inquest into the death of Adam Salter. In his Honour's findings in that matter, Deputy State Coroner Scott Mitchell found the following inadequacies in the critical incident investigation and its review:

    (a) The dissemination of a wholly inaccurate description of the incident in Situation Reports (SITREPs) that remained in the public domain uncorrected for over a day, even though the SCII, who was a signatory to one such

[3] See, for example, the findings of Deputy State Coroner Mitchell at the Inquest into the death of Adam Salter dated 14 October 2011 at [90]-[93].

SITREP, should have been well aware by the time he signed the document, that there was available evidence to contradict the assertions within it;[4]

(b) The conduct of a video recorded walkthrough interview[5] with the officer who discharged her firearm and killed Mr Salter that was deeply flawed because instead of eliciting information from the officer, the SCII went out of his way to provide much of the evidence himself and to ignore material which suggested a view or views contrary to his preconceived version of the circumstances surrounding the incident.[6]

(c) The failure to conduct video recorded walkthrough interviews with any of the paramedics who were present at the time of the incident and whose versions of events contained several marked differences from the versions of the involved police officers.[7]

(d) The misrepresentation in the Critical Incident Investigation Report of police evidence as being consistent and supported by the evidence of Mr Salter's father and ambulance officers.[8]

(e) The uncritical acceptance of the Critical Incident Investigation Report by the Review Officer, who not only "gave his colleague's report a clean bill of health" but also expressed the opinion that "all involved officers performed their professional duties in a highly commendable fashion both at the time of the incident and over the following days."[9]

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4 Ibid.

5 The recent decision of *Baff v NSW Commissioner of Police* [2013] NSWSC 1205 *might* reduce or end the use of directed interviews and video walkthroughs but the point concerning objectivity remains valid.

6 Ibid at [95]-[111].

7 Ibid at [121]-[122].

8 Ibid at [118].

9 Ibid at [124]-[125].

16. His Honour concluded that the investigation was inadequate, apparently prejudiced and chiefly directed, as far as his Honour could tell, to avoid embarrassment to Police.[10]

17. Even where there has been a relatively sound investigation, such as in the investigation of the death of Roberto Laudisio Curti, the absence of an automatic independent monitoring of the investigation was a source of distress for the family who were articulate about it in the media. This can expose the police to suspicion and criticism that may be unnecessary and unwarranted.

18. Putting to one side the role of Coronial investigations and proceedings, the system of accountability in respect of critical incidents is currently spread across at least 4 agencies:

    (a) The NSW Police Force;

    (b) The Police Integrity Commission (PIC);

    (c) The NSW Ombudsman; and

    (d) The WorkCover Authority of NSW (WorkCover).

19. It is not correct that this provides excessive supervision or intrusion into police work. Nor is it true that there is duplication arising from the work of these bodies. Each body conducts a different function. However, on present arrangements, none can provide independence of investigation in critical incidents.

20. Ordinarily, the involvement of WorkCover in a Police critical incident is limited to events involving death or injury to a police officer. It is directed to questions of liability of the NSW Police Force for breaches of applicable work health and safety legislation and improvements to work practices, policies and procedure. As a substantial employer whose employees are frequently exposed to serious risks to their health, safety and welfare, it is appropriate that the Police Force is subject to WorkCover supervision. That supervision is directed to issues affecting the health,

[10] Ibid at [128].

safety and welfare of employees rather than the integrity of any particular investigation. The Association does not consider that the involvement of WorkCover does or would either contribute or interfere in ensuring that critical incident investigations are objective, transparent and accountable.

21. The inquest into the death of Adam Salter highlighted the problems associated with the delay in the review of critical incident investigations which exists under the current model. The deficiencies in the investigation of Mr Salter's death only came to light because ss 27 and 23 of the *Coroners Act 2009* required an inquest be held and that it be conducted by a senior coroner. Indeed, having found the investigation to be flawed, the Deputy State Coroner nevertheless declined to refer the matter to the PIC on the basis that it was open to Mr Salter's family to make a formal complaint to the PIC.[11] On 18 October 2011, counsel for Mr Salter's family lodged a complaint with the PIC concerning the investigation of the death, which became the subject of Operation Calyx.[12]

22. The haphazard manner in which critical incident investigations may come to be monitored is also evident in the case of the Ombudsman's monitoring of the police investigation into the death of Roberto Laudisio Curti, which essentially arose from media reporting of the incident and a mindfulness of the criticisms of Deputy State Coroner Mitchell in relation to the investigation into the death of Mr Salter.[13]

23. It is significant that both the PIC's Operation Calyx and the Ombudsman's monitoring of the police investigation into the death of Roberto Laudisio Curti arose out of critical incidents involving a death. Critical incidents involving a death generally attract a greater degree of public and media interest and attention and are in any event the subject of mandatory coroners' inquests. However, not all critical incidents result in the death of a person. Under the present system, critical incident investigations that do not involve a death will only be the subject of independent monitoring or scrutiny

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[11] Ibid at [129].

[12] PIC Report to Parliament – Operation Calyx dated June 2013 at pages vi – vii.

[13] Report of Ombudsman's Monitoring of the Police Investigation into the death of Roberto Laudisio Curti dated February 2013 at pages 1 and 11-12.

if a complaint is made to the Ombudsman or to the PIC. They are not automatically the subject of any independent monitoring or scrutiny.

24. In short, there are many critical incident investigations that occur without the Ombudsman's or PIC's knowledge. Such investigations might never come to the attention of either of those bodies unless the Police are required to notify the event. That is particularly so where the critical incident did not involve a death and is not the subject of a coronial proceeding.

25. The coronial system has been quite successful in detecting problems in police critical incident investigations. Nevertheless, there are difficulties in relying upon coronial supervision of critical incident investigations to ensure objectivity, transparency and accountability. The hearing occurs long after the event, particularly in cases where there have been criminal charges laid. The extent to which a coroner is able to examine and scrutinize a critical incident investigation will depend in large part on the extent to which issues concerning the integrity of the investigation adversely impact on the coroner's ability to discharge his or her statutory functions. The workload and resources of the coronial jurisdiction do not always lend themselves to a thorough monitoring or examination of all aspects of a critical incident investigation. Inadequacies or deficiencies that do not impact on the questions of fact, date, place, identity, manner and cause of death may not be examined, even though they may be a source of legitimate concern and distress to family members.

26. Secondly, the role of police officers assisting in coronial investigations of critical incidents involving death can cause confusion and conflict. Presently, the coroner is assisted in critical incident matters involving death by police officers, usually from the homicide squad. The Association understands that the State Coroner was previously assisted by police officers seconded to a Coronial Investigation Unit attached to the State Coroner's Court and subject to the day-to-day direction and control of the coroner. There was a real value in that system. The Association does not necessarily suggest that such an arrangement needs to be recreated. There are obvious benefits in having police officers assist the coroner including in critical incident investigations. Experience suggests that the usual involvement of the Crown Solicitor's Office and

counsel assisting from the private bar under the overall supervision of the coroner is an adequate assurance of actual objectivity. However, a perception issue remains.

27. While the coroner does have the power to give a police officer directions concerning investigations to be carried out for the purposes of coronial proceedings or proposed coronial proceedings,[14] it is a power that is rarely, if ever, directly used. The officer remains under the direction of the NSW Police Force. This can give rise to a conflict and perceptions of conflict between the directions of the coroner and those of the NSW Police Force as to the role of the investigating officer. The Association considers this to be undesirable and avoidable with different reporting and supervision arrangements for officers assisting the coroner.

28. In short, the Association considers that the current system of critical incident investigation lacks transparency and objectivity. It exposes police to opportunities for, and perceptions of, interference with the integrity of the investigation. The current system does not ensure rigorous and objective scrutiny of critical incidents.

Possibilities for improvements

29. Ideally, all critical incidents would be investigated by an independent body with sufficient resources to do so. An example of such a model is the Independent Police Complaints Commission (IPCC) in the United Kingdom.[15] That system provides for the mandatory reporting of critical incidents[16] to the IPCC without delay and in any case not later than the end of the day after the day on which it first becomes clear that

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[14] Section 51(2) of the *Coroners Act 2009*.

[15] A useful explanation of the system is provided in the IPCC's 2013 publication, *Statutory Guidance to the Police Service on the handling of complaints*. See http://www.ipcc.gov.uk/sites/default/files/Documents/statutoryguidance/2013_statutory_guidance_english.PDF

[16] Known as death or serious injury (DSI) matters, although defined in sufficiently similar terms to the definition of "critical incident" in the current Critical Incident Guidelines. For the purpose of this submission, the "critical incident" is used to refer to DSI matters.

the matter is a critical incident.[17] Once a referral is received, the IPCC determines whether the matter should be investigated and the mode of investigation, having regard to the seriousness of the case and the public interest.[18]

30. The mode of investigation may be a local investigation, a supervised investigation, a managed investigation or an independent investigation. A local investigation is one that is carried out by the relevant police service on its own behalf.[19] A supervised investigation is one that is carried out by the relevant police service under the IPCC's supervision.[20] A managed investigation is one that is carried out by the relevant police service but under the direction and control of the IPCC such that the IPCC manages the investigation in terms of its scope, investigative strategy and findings.[21] An independent investigation is one that is carried out by the IPCC itself.[22] Independent investigations are used for the most serious incidents and/or those with the greatest public interest because they cause the greatest level of public concern, have the greatest potential to impact on the community or have serious implications for the reputation of the police service.[23] Although this system appears to allow for the possibility of a critical incident being investigated by the relevant police service, similarly to the current system in NSW, it is more likely that most if not all critical incident investigations would be conducted as either a supervised, managed or independent investigation.

31. At the end of a critical incident investigation, the investigator must submit a report to the IPCC and send a copy to the appropriate authority. The IPCC must then determine whether the report indicates that a person serving with the police may have committed a criminal offence or behaved in a manner justifying the bringing of disciplinary proceedings. If it decides that it does, it will notify the appropriate

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[17] Paragraph 14C, Sch 3 of the *Police Reform Act 2002* (UK) and Regs 4, 7 and 8 of the *Police (Complaints and Misconduct) Regulations 2012* (UK).

[18] Paragraphs 5, 14, 14D and 15, Sch 3 of the *Police Reform Act 2002* (UK).

[19] Paragraph 16, Sch 3 of the *Police Reform Act 2002* (UK).

[20] Paragraph 17, Sch 3 of the *Police Reform Act 2002* (UK).

[21] Paragraph 18, Sch 3 of the *Police Reform Act 2002* (UK).

[22] Paragraph 19, Sch 3 of the *Police Reform Act 2002* (UK).

[23] *Statutory Guidance to the Police Service on the handling of complaints* at page 130.

authority, which must then record the matter as a "conduct matter" and consider whether it should be referred to the IPCC to be dealt with as such.[24]

32. There is much to commend the British system. Ideally, the Association would support the introduction of such a system in New South Wales. However, it is accepted that geographical considerations and limited available financial resources may make such a system impracticable in New South Wales at the present time.

33. Generally, the Association considers that there ought to be scheme for the monitoring of critical incident investigations by an independent body. It is the submission of the Association that the Ombudsman's Office would be a good and cost effective independent body to carry out the monitoring. Whatever body is chosen to do the monitoring, it should have the following characteristics:

    (a) A positive obligation on the NSW Police Force to immediately notify the independent body of any critical incident as soon as it is declared to be a critical incident;

    (b) A power in the independent body to determine whether or not the investigation of the critical incident requires monitoring by it;

    (c) The independent body should have the capacity to immediately allocate appropriately trained and experienced officers to monitor a critical incident investigation either as an individual or as part of a team;

    (d) The monitoring officers should have the right to attend the crime scene, request and receive reports and information concerning the investigation and its progress, view exhibits, access police photographs, attend all witness interviews, receive all police communications and written reports and to require a written statement of actions undertaken by police investigators prior to the arrival of a monitoring officer;

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[24] Paragraphs 24A – 24C, Sch 3 of the *Police Reform Act 2002* (UK).

(e) The monitoring officers should be empowered to record any relevant observations or events, to make sound recordings of any observations and to take photographs provided they do so in a manner that does not interfere with any aspect of the police investigation;

(f) The monitoring officers should not have the power to control, supervise or interfere with the police investigation, but should simply monitor what occurs;

(g) Where a monitoring officer observes an apparent departure from appropriate conduct or the Critical Incident Guidelines, he or should be empowered to draw that apparent departure to the attention of the SCII, but not otherwise require or direct a change in police actions;

(h) When the SCII disagrees with the monitor, the monitor should immediately reduce the observation to writing. If the SCII remains in disagreement and decides against a change that responds to the monitor's observation, written reasons should be provided by that SCII within 24 hours of the observation being communicated to the SCII;

(i) At the conclusion of the investigation, the independent monitoring body should be required to produce a critical incident report to each of the Commissioner of Police, the Minister and, where death has occurred to the Coroner. Where possible misconduct in the investigation has been identified, a body responsible for the investigation of such conduct should be notified;

(j) There should be limitations on the information that may be published by the independent body similar to that provided by s 163 of the *Police Act 1990* in respect of the publication by the Ombudsman of "*police critical information*";

(k) The monitoring officers should be subject to strict confidentiality as to any matter monitored until the independent body's critical incident report has been finalised; and

(l) Except as set out below, the monitoring body and its officers should not engage with witnesses or family members affected by a police critical incident,

nor act in any way that would interfere with the ordinary role of the police. Nevertheless, the monitoring body and its officers should be able to:

(i) Inform family members and witnesses of their presence in a monitoring role;

(ii) Receive any complaint or observation and communicate that complaint or observation if authorized by the family member or complainant to the senior investigating police officer;

(iii) Inform family members or others of the appropriate body for complaint; and

(iv) Encourage and facilitate communication between family members and any police officer nominated by the SCII as an appropriate officer for family inquiries.

(m) The monitoring officers should be competent and compellable in the event of future disciplinary, coronial proceedings or criminal proceedings.

(n) A monitoring role is designed to maintain and ensure administrative regularity rather than for the investigation of wrongdoing. For that reason, the Association considers that the independent body responsible for monitoring critical incident investigations should not exercise a role in the investigation of complaints in respect of the critical incident or its investigation. That is, the monitoring of critical incident investigations should reside in one body and the investigation of complaints concerning the incident and its investigation should reside in another. Complaints concerning police action in critical incidents should be handled by the PIC.

34. The Association notes the recommendations of the NSW Ombudsman in his report on the police investigation into the death of Roberto Laudisio Curti concerning the mandatory notification of all critical incidents to the Ombudsman as part of a separate process not linked to the complaint handling framework in Part 8A of the *Police Act 1990*. The Association agrees that such a scheme should also provide the

Ombudsman with appropriate powers to effectively monitor all critical incident investigations where it considers that it is in the public interest to do so. It is the logical body to perform the role of monitoring so long as it does not also administer a police complaints or disciplinary role in respect of critical incidents.

35. The Association acknowledges that the Ombudsman has traditionally been a good body for receiving public complaints about questions of communication or problems with the administration of public bodies, including complaints about police conduct. That office has considerable expertise in opening lines of communication and overcoming issues of bureaucratic behaviour, mishaps in management or unreasonable administration.

36. However, complaints arising from critical incidents and their investigation have a particular significance in this State. The Association considers that the most appropriate body for the investigation of misconduct arising from a critical incident and/or its investigation is the PIC, which has become an important part of the investigation of police misconduct and corruption since its establishment following the Police Royal Commission in the 1990s. For that reason, the Association submits that the PIC should not be a monitoring body. Inevitably, its role as a discipline related anti-corruption body would conflict with its role as a monitor of critical incident investigations.

37. It is submitted that a scheme that provides for the Ombudsman to play a monitoring role only, with the PIC being responsible for the handling of all complaints arising from the critical incident and/or its investigation would avoid duplication in the oversight of critical incidents and their investigation.

38. The Association also submits that investigations of critical incidents where a death has occurred would be improved by providing for the release of police officers assisting the coroner, from instruction or direction in respect of the critical incident investigation by the NSW Police Force so that those officers are subject to direction solely from the coroner in respect of that critical incident investigation.

39. Another matter that the Association considers worth considering is the appointment of appropriately qualified counselors to assist the family of a deceased person to cope with the psychological impact of the incident and death, the media scrutiny which such incidents tend to attract and the emotional impact of the critical incident investigation itself. The counselor or psychologist might act, where appropriate, as a conduit or liaison point between the investigators, the monitoring body and the family.

Legislative Amendment

40. The creation of a scheme for monitoring critical incident investigations of the kind suggested above would require some relatively limited legislative amendments as follows:

    (a) There would need to be some amendment to the *Police Act 1990* and the *Ombudsman Act 1974 to* provide for a scheme for the mandatory immediate notification of all critical incidents to the NSW Ombudsman separate from the complaints system provided in Part 8A of the *Police Act 1990.* Those amendments could also include provision for specific powers and responsibilities in the Ombudsman to carry out monitoring and reporting as described at paragraph 29 above. There would need to be amendments to the *Police Act 1990,* the *Ombudsman Act 1974* and the *Police Integrity Commission Act 1996* in order to effect a transfer of the current jurisdiction of the NSW Ombudsman to receive complaints about police conduct arising from a critical incident or its investigation to the PIC.

    (b) There would need to be some amendment to the *Coroners Act 2009* and the *Police Act 1990* to provide that police officers investigating deaths that occurred in police custody or in the course of a police operation to be subject to the ultimate direction and control of the coroner in respect of the critical incident investigation but with an obligation of cooperation between the NSW Police Force and the Coroner's Office.

(c) A statutory definition of *"critical incident"* would be necessary so that legislative change to accommodate it is not undermined by a subsequent change in the definition in the current Critical Incident Guidelines. The definition in the current Critical Incident Guidelines is a good definition.

(d) If the Government decides on legislative change, it is submitted that the new legislation should incorporate an assessment and review of the changes within a specified period, for example, 12 to 18 months of the commencement of the new scheme.

Dated 15 October 2013

Phillip Boulten SC

President